Strategic Directions for Community Engagement In Rural Health Planning:

Implementing Findings from a Provincial Study

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rigorous evidence for sustainable rural health services

BCRHN
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Introduction and Context

Based on anecdotal information from rural residents across BC and previously published research, there is a lack of rural community engagement in healthcare planning and research in BC[1]. This gap is leading to centralized, urban-based decision-making and research findings which may not capture the differential lived experiences of rural residents[2]. Recent BC-specific research that investigated the experiences of rural residents found that 90% of respondents (n=707) felt that their needs were not adequately represented in health planning, and a further 86% felt their needs and concerns were not genuinely acted upon. As one respondent noted,

"Most of us feel completely left out of any decision-making processes that affect the state of our local healthcare. There is very little contact or community involvement on the part of [the] Health Authority who own and operate our facility."

Although many participants noted that they had participated in outreach efforts initiated by their Health Authority or special interest group, the topic priorities of the individual or community were often not acknowledged and for some, the yield of the engagement felt pre-ordained, as noted below:

"I have found there is often already a plan in place before the consultation, they are using the consultation to validate the plan rather than listen to the needs of the community to inform the development of a plan or service."

Ultimately, rural community members voiced the desire for more accessible ways to be included in setting the priorities for engagement and ensuring those doing the engaging had a clear understanding of community context. This necessarily required *accountability* to recurse back to the community to describe how the yield of the engagement was incorporated into quality improvement, health service decision-making or planning.

Although the Gap Analysis pointed to the aperture in rural community engagement, we did not query participants regarding the *next steps* needed in improving rural community engagement. Through funding from Health After2020, we actioned the commitment to community-engaged planning by recursing back to rural community members through a series of focus groups to *member check* original findings and have rural community members identify appropriate next steps. This strengthened the original engagement by providing an additional layer of evidence-based direction for policy and decision-makers. As we navigate the growing effects of health care challenges in rural communities, including emergency room closures, lack of local access to primary care providers, lack of local screening and diagnostic services (for example, ultrasound) and the financial and practical challenges of leaving the community for care, engaging with rural communities *in a way that meets their needs* becomes increasingly important. We feel the regional engagements have strengthened the evidence-base which can action next steps. Each section in the findings (below) presents themes of importance for such planning, following immediately by recommendations for action.

Background

The Mandate for Including Rural Community Voices in Health Care Improvement and Planning

Community engagement is recognised as an important process to improve the responsiveness of the healthcare systems to address the needs and priorities of the communities accessing the health service[3] [4] [5] [6]. It serves an essential role in policy planning and evaluation, providing community members opportunities to voice their unique needs and help shape local healthcare services that address their needs[7].

The Alma Ata Declaration of 1978 acknowledges that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care"[8] [9]. Despite the Declaration and growing recognition of the importance of community engagement, there remains a gap between community voices and implementation of healthcare services that represent local community needs[10].

In Canada, the planning and delivery of healthcare services falls under the jurisdiction of provincial governments[11]. While BC has acknowledged the importance of patient-centred health care and has taken measures to include patient voices in health care planning (see 'The British Columbia Patient-Centred Care Framework'), (British Columbia Ministry of Health, 2015)), this framework fails to include a *community* perspective, rather than solely patient perspectives in addressing the collective health care needs and challenges of rural communities of BC.

In BC, the Ministerial Mandate for the Minister of Health establishes the accountabilities of the Minister of Health to the Premier and the people of BC (BC Ministry of Health, 2025). One of the four priority areas include improving and strengthening the public health care system. Mandate letters emphasize that the Ministry of Health has an obligation to "listen" and "respond" to the priorities of British Columbians—and in effect calls for community engagement in health planning (BC Ministry of Health, 2025). In addition to the Ministerial Mandate, in the 2024 Budget Consultation Report, the Select Standing Committee on Finance and Government Services of B.C. recommends "a shift towards community-driven planning" for rural and remote communities (Legislative Assembly of BC, 2023). Despite the Government's recognition of the importance of community engagement in rural healthcare planning, there is limited information on how this is undertaken in BC.

Challenges Including Community Voice in Health Care Improvement and Planning

Community participation in healthcare planning is a challenging task due to the lack of consensus around the definition of engagement. In British Columbia, the International Association for Public Participation's (IAP2)[12] engagement spectrum is commonly used, which includes five levels: inform, consult, involve, collaborate, and empower. However, the purpose of engagement is crucial to consider regardless of the theoretical framework used. An example of the purpose can be drawn from the Australian Government Department of Health mandates that Community Advisory Committee boards provide a community perspective to ensure that decisions, investments, and innovations are patient-centered, cost-effective, locally relevant, and aligned with local care experiences and expectations[13].

Successful community engagement requires a paradigm shift in healthcare policy development that values the specialized knowledge yielded from science-based methodologies and recognizes individual, local, community, organizational, and holistic knowledge. Incorporating the community voice in decision-making is part of this new paradigm. However, for this to happen, community involvement must be met with system recognition of the value of such involvement and established mechanisms for including the yields of community voice in decision-making.

At a local level, community leadership must work alongside operational leadership to feed into Regional Health Authority leadership and provincial tables advising on implementation. This requires the integration of local community voice within a quality improvement, data-driven framework to reflect the needs of the community in policy development. To ensure that community voices are incorporated into policy and decision-making, we must establish a framework that promotes the necessary linkages. This involves developing system accountabilities by answering the question, 'What culture change needs to occur to increase receptivity of the output of community-oriented voice into policy and decision making?' This involves grappling with, in close collaboration between communities and decision-makers, the fundamental question of *community-derived qualities of engagement*. Based on findings from the Gap Analysis, to date British Columbia has not determined community-directed next steps for community engagement.

Community-Centered Approaches to Engagement

Community-centered approaches to engagement, particularly those emphasizing active participation and the involvement of local leadership, have been widely recognized as essential for sustainable and equitable health and social outcomes. Tobias et al. [14] highlight the importance of Community-Based Participatory Research (CBPR) in fostering respectful, reciprocal research relationships with Indigenous communities, demonstrating how collaboration with local leadership can enhance the relevance and impact of health initiatives. Similarly, Yuan et al.[15] emphasize the significance of community engagement (CE) in public health, noting its role in reducing inequalities and promoting social justice, though they call for more large-scale studies to better understand its implementation and effectiveness. The role of active involvement is further underscored by Boothroyd et al.[16], who discuss Active Involved Community Partnerships (AICPs) as a framework for co-creating implementation infrastructure, integrating local knowledge, and fostering shared responsibility. Place-based approaches, as explored by Rong et al.[17], further emphasize the importance of trust and power-sharing as key facilitators of community engagement, particularly in marginalized and disadvantaged communities. Chaisson et al.[18] provide a case study of the Alberta Healthy Communities Approach (AHCA), demonstrating how multisectoral partnerships, combined with strong local leadership, can lead to more effective community-led actions on health determinants. Meanwhile, Etchegary et al.[19] illustrate the practical application of community engagement in identifying research priorities through town halls, reinforcing the necessity of inclusive and participatory decision-making. Collectively, these studies underscore that meaningful community engagement requires intentional strategies that prioritize relationship-building, power-sharing, and sustained local involvement to ensure long-term success.

Considering Cultural and Contextual Factors (Understanding rural life and cultural sensitivity)

Understanding and integrating cultural and contextual factors are paramount when engaging with rural and Indigenous communities to ensure that initiatives are both respectful and effective. Looking to contexts outside of North America, Appiah[20] emphasizes the importance of establishing trust with local knowledge keepers, such as chiefs and community elders, highlighting how culturally sanctioned engagement fosters community acceptance in rural Africa. Similarly, Shadowen et al.[21]demonstrate the value of Community-Based Participatory Action Research (CBPAR) in rural India, showing that involving local voices enhances community empowerment and ensures that action taken is relevant to the community's social and cultural contexts. In the Canadian context, Smylie et al.[22] stress that cultural competence is essential for improving Indigenous health outcomes, highlighting the importance of interventions grounded in cultural knowledge and traditions. Curtis et al.[23] expand on this by advocating for cultural safety, emphasizing dismantling power dynamics and a focus on the broader social determinants of health. Beard et al.[24] provide a framework for understanding how socioeconomic and cultural factors, such as rural stoicism, Indigenous status, and migration patterns, shape health outcomes in rural Australia, underscoring parallels in access disparities and community cohesion challenges. Collectively, these studies reinforce that effective rural engagement strategies must account for both individual and structural determinants of health, ensuring that interventions are contextually appropriate, culturally sensitive, and community driven.

The Use of Technology in Community Engagement

Integrating technology into rural community engagement offers potential to enhance health equity through increased access to services and community engagement by bridging the gaps created by physical distance and geographical barriers. However, several challenges must be addressed regarding the accessibility and feasibility of technology use for community engagement in rural BC. Seaton et al.[25]emphasize that technological solutions alone are insufficient; they must be accompanied by improved infrastructure, stakeholder collaboration, community-oriented training, and ongoing support. Similarly, Lindberg et al.[26] highlight that in rural health contexts, strong relationships between providers and patients are crucial, and a balance of digital and in-person interactions is necessary to maintain effective care. Correa and Pavez[27]identify additional barriers in isolated communities, such as geographical isolation, aging populations, and economic contexts, which influence attitudes toward digital technologies. Moving outside of the health planning context, Mehra et al.[28] discuss the importance of promoting community engagement by addressing issues of marginalization and digital divides, in the context of rural libraries in the Appalachian region. Collectively, the literature highlights the importance of context-specific strategies that combine technological advancements with cultural sensitivity and robust support systems to enhance rural community engagement effectively using technology.

Incorporating Local Knowledge (Rural Wisdom and Asset-Based Community Development)

Incorporating local knowledge into decision-making and policy development is essential for fostering sustainable and effective outcomes in rural community development. Asset-Based Community Development emphasizes leveraging existing community strengths, such as individual talents, local associations, and institutional capacities, to address local challenges and enhance quality of life[29]. This approach contrasts with traditional development models that often prioritize external partnerships over community engagement and local stakeholder involvement and view rural communities through a deficit lens[30]. By focusing on the community's inherent assets, asset-based community development promotes equitable and long-term solutions that are relevant to the local social and cultural context [31]. A study conducted in Western Canada applied the asset-based community development framework to support healthy aging in a rural community, highlighting the importance of community participation in identifying and mobilizing local assets to address issues such as healthcare access, transportation, and housing[32]. The collaborative effort involved academic researchers, health authorities, municipal leaders, and local stakeholders, demonstrating the effectiveness of integrating local knowledge into policy development to enhance community well-being. These studies collectively illustrate the critical role of local knowledge and community engagement in shaping policies and initiatives that resonate with the unique contexts of rural communities.

Fostering Collaborative Decision-Making

Fostering collaborative decision making is contingent on building strong relationships based on established goals.[33] This depends on identifying key partners in rural communities and developing trust through transparency and consistency.[34] A practical action is to engage "early and often" and keep the dialogue open to avoid misunderstandings. One of the objectives of the engagement, beyond priority-setting, is establishing shared goals through aligning objectives (outputs of mutual benefit) and collaboratively identifying a vision or aims to achieve.[35] Once this foundational piece is established, the pragmatics of clarifying roles and responsibilities helps define contributions of each partner[36] and establish an accountability structure to keep track of progress.[37] Key indicators of success include ensuring an inclusive decision-making process through engaging diverse perspectives[38] and fostering participatory decision-making and committing to transparency and clear communication by keeping all partners informed of progress through accessible communication channels.[39]

Some authors suggest the importances of creating a collaborating framework through documents such as Memorandum of Understanding to formalize the partnerships (articulating expectations, goals, roles and timelines)[40] and mechanisms for conflict resolution.[41] Further, effective paradigms include early attention to sustainability planning through long-term funding, resources and leadership.[42] Several authors noted the importance of feedback loops in whatever process is established to allow for adaptation, course correction and continuous quality improvement[43].

Methods and Approach

Summary

In 2023, the UBC Centre for Rural Health Research (CRHR), in partnership with the BC Rural Health Network, conducted a gap analysis to improve community involvement in healthcare planning titled, Advancing Community Engagement in Healthcare in Rural BC. In addition to highlighting the vast disparities in community engagement in rural health planning, the Gap Analysis yielded several recommendations aimed at improving community involvement and engagement in health care planning in rural and remote areas such as fostering community engagement and transparency through the establishment of Community Engagement Units (CEUs) and implementing transparent reporting systems as well as collaboration and knowledge exchange among rural health authorities.

Following up on the work of the Gap Analysis, we conducted pan-provincial regional focus groups geared toward understanding and developing the actionable next steps based on results and recommendations from the Gap Analysis. We hosted seven virtual focus groups over Zoom between May 23rd and July 25th, 2024, for local community members, service providers and local leaders (n=68). The first two focus groups included participants from Interior Health Authority (n=24). The following four focus groups were focused on the Northern Health Authority Region (n=16) and the Island Health Authority region (n=17). The final focus group focused on the Vancouver Coastal Health Authority region (n=11).

Recruitment

Recruitment for the focus groups was done through the BC Rural Health Network's monthly newsletter, which has a recipient base of over 700 rural residents, local leaders and decision makers. Direct recruitment was done through emails to local leaders and rural 'community champions' identified through previous community outreach work conducted by the BC Rural Health Network. See appendix 1 for recruitment poster and message. To ensure inclusivity, we disseminated the recruitment material to groups and individuals within community who work directly with diverse individuals within community. Despite our efforts, the focus groups were generally homogeneous with the participants predominantly being white adults. However, we did see diversity in geographic location, professional background, and lived experience.

Data Gathering

Each focus group lasted 1.5 hours, and started with a high-level overview of the findings from the Gap Analysis and the purpose of the focus groups. Participants were asked two questions to guide the discussion: 1) "What does effective engagement in health planning look like to you?" 2) "What needs to change at a local, regional and provincial level to affect this?".

Analysis

Discussions from each focus group were recorded using Microsoft Teams and were then manually transcribed, adjusting for clarity, and removing excess noise and unrelated dialogue. Thematic analysis of the seven transcripts and qualitative data analysis was done using NVivo software to identify common themes and ideas among health authority regions. Thematic analysis is a method of searching and organizing a dataset to identify, analyze and report repeated patterns through qualitative coding and generation of "themes" [44]and is an appropriate methodology when the goal of a research project is to understand participants' experiences, thoughts, and behaviors. It involves six steps including[45]:

(1) Familiarization with the data through reading and re-reading transcripts;

(2) Generating initial codes (a means of simplifying the data) and systematically coding a subset of the data. This was done directly in NVivo by the community-based researcher and was validated by the generation of a code-book that the research team agreed represented the meaning of the data. Coding was done inclusively (including context for understanding) with a commitment to include 'negative case examples' (those excerpts that do not resonate with the emerging themes).

(3) Thematic development involved grouping codes by relationship to one another to form themes, with attention given to higher order codes ('parent codes') to identify the broad thematic landscape and lower-level codes to provide insight into particular

characteristics[46]. Themes were then interpreted and developed through collective analysis to being generating ideas about connections between codes and themes, leading to patterns that being to answer the research questions.

(4) Once themes are completed, they are reviewed specifically with an eye to ensuring accurate reflection of participants' meaning and intent and to collapse redundant themes together[47].

(5) Once themes were deemed consistent and representative, they were defined and named, using the language of participants.

(6) Finally, the themes were consolidated in a narrative to create the project report.

Findings

Insight from participants across the seven regional focus groups was based on their response to the question, "What are the next steps in implementing findings from the Gap Analysis?" (see https://bit.ly/4c2Mp4N). Responses were consolidated within four themes: (1) improved community engagement; (2) attention to mechanisms of decision-making. (3) the need for increased system accountability; (4) the need for transformational change, Each theme is described below and includes recommendations for action. `

IMPROVED COMMUNITY ENGAGEMENT

For participants in this study, *relationships* were an essential precursor to effective community engagement ("solid, trustworthy, respectful relationships"), whether between community members and local government or communities and Regional Health Authorities or the province. Further, the relationships need to be longitudinal so the accrued knowledge of a community is part of the institutional knowledge base. This was seen to be one of the biggest challenges to productive relationships ("...right now, we're in the great retirement [phase] and that is just aggravating...because the person you talk to this week isn't there next week"). Participants also recognized that beyond enduring relationships, having the right individuals ("someone with actual decision-making abilities") to connect with community groups is essential to effect change.

Once relationships are established, they become a conduit to engagement with *the community setting the agenda*. Several participants noted engagements they had participated in based on pre-set topics with no flexibility to include other pressing, local issues. Although a paradigm shift, community-derived prioritization was seen as essential. As one participant noted,

...there needs to be some sort of regular engagement where the agenda is not set by whatever policy you're trying to consult on, where the community sets the agenda about

what they want to talk about, and you bring the things that are relevant to that. And so letting the community set the agenda that matters for them instead of coming out with purpose-driven meetings.

Relatedly, when engagement opportunities were regional and held outside of the community, participants emphasized the importance of having someone who “can speak for the town, who lives in the town… to talk about what they need”.

Once relational needs are addressed, participants offered other key enablers for effective engagement including regularity, community agenda-setting (as opposed to “purpose-driven meetings”), and ensuring at least a portion of each meeting is open to anyone who would like to attend. Some participants suggested this would counteract the propensity for engagement “… only… when things are going wrong”.

Others described the process as necessarily being “grassroots” (“[Our network] was very effective, but that came from grassroots and… I really think that that’s the way to go”).

Whatever the nomenclature, the imperative of the engagement was recognized by all with the consequences being planning – and outputs – misaligned with community needs. Others pointed out that this engagement happens “on different levels”, with non-profits, volunteers and “individual consumers or health care”, and the voices of all are essential to understanding community needs.

Finally, according to participants in this study, the engagement process and associated planning also needed to be transparent and co-developed between the community and health planner. This, however, was usually not the case. As one participant noted:

When we talk about effective engagement and health planning, there’s so much that’s going on behind the scenes that the regular person doesn’t know about or finds out about a year down the road. I was just at a meeting last week where [Health Authority] pulled out all this information that they’ve done in [our region] in the last few months or last year and [we] had no idea.

Beyond the general guidelines for adequate engagement, participants in all regional focus groups were clear on the characteristics of community engagement processes, which included inclusivity, practical and transparent planning and attention to barriers (see below). Several participants referenced ‘community engagement units” as a promising practice to increase health system accountability, by providing a conduit between Health Authorities or the Province and local communities.

Attention to vulnerable populations

A thematic concern about perfunctory engagement was the lack of representation of those who do not usually have a voice in health planning, but who are heavy users of health care resources (“…people who are most vulnerable are those who are most isolated and those voices are missing too in terms of effective engagement”). Engagement with these populations requires intentional planning by those initiating the out-reach, which is often difficult at a distance and without a social understanding of the community. As one participant said,

If you want the voices of lived experience, it's not enough to say everyone is welcome. You know, we invite everyone to participate in this engagement process [and] that completely doesn't work, and part of that is cultural. But also it's because many people... who are disenfranchised are not stepping up to say, 'oh, I'm sure they want to hear from us'.

Others framed it through the lens of cultural safety, emphasizing that those who represent diversity in the community "are more generally not safe," with another participant blatantly noting, "I worked in First Nations communities for over 20 years as well as living with many neurodivergent folk. I guarantee none of them will be showing up at any large group or townhall meeting". Relatedly, some participants emphasized the importance of a modality of 'data' that respected what marginalized groups had to offer, namely, experiential narratives:

The thing about using stories-based eval and quantitative eval because that is also very relevant in our indigenous communities. First of all, just from a cultural perspective and also just because we don't have the numbers, we don't have the numbers like Vancouver does so it needs to come out in different ways, for sure.

Some participants felt that the way community engagements are currently structured will "never work" due to inherent lack of safety within the health care system. One participant noted that "as soon as they get someone who actually represents a group of people that aren't privileged, ... that person doesn't feel safe in their own context". Others noted a gap in enabling participation from socio-economically marginalized populations, one noting, "...we can't even afford to give honorariums to peers for people that really, really need significant support in having their voice heard". Despite the current lack of system uptake, however, several participants identified the system-level advantage of attending to the needs of vulnerable populations, above our social responsibility. As one noted,

[I] cannot stress this enough, when you cater to the most marginalized, racialized folks in the community, you give everyone an advantage, including the marginalized folks. When you look at the most vulnerable, the homeless, the mentally ill, the people of color, the indigenous folks.

Attention to creating safe spaces for dialogue exceeded ensuring Indigenous cultural safety and included basic safety even for those with agency within the health care and social system. Participants pointed to the need for "psychological safety" to enable the "hard conversations" through good facilitation that recognizes the historical context of the community and specifically, of the conflict.

Practicalities

Most participants offered pragmatic suggestions to facilitate participation in engagement opportunities at a community level, starting with *giving plenty of notice* about the engagement, allowing attendance on-line or in person ("They are generally in the evenings in our Community Center where there's good access, but having the online portion is also really helpful for folks who work and have to be home with families or don't have the energy at the end of the day to sit there") and combining in-person opportunities with on-line and paper surveys that can be distributed. Others emphasized paying attention to and accommodating participants' comfort levels ("Not all people are comfortable talking publicly… if you have a little suggestion box over to the side, it's amazing what comes out of those). Others noted the importance of enabling participation through honoraria, with the assertion that "volunteering has become an economic privilege [which] leaves out so many voices, because people can't afford to volunteer". An additional practical output noted by some was community access to (non-identified) data along with support for interpretation, specifically of regular needs assessments or "community health check-ups". Further, some participants suggested a reporting pathway that by-passed the Health Authorities and went directly to the Ministry of Health.

An additional quality identified across the focus groups was the need to ensure representation from key community groups or, as one participant said, "...making sure that all of the players are identified and willing to come to the table". Suggested key community partners included Ministry of Child and Family Development, representatives from local high schools, from the hospital, BC Ambulance, the RCMP and the recreation centre, privileging an awareness of the importance of social determinants of health. As another participant observed, when this breadth of partners are brought together, "it is amazing how many solutions we are able to find at that table...".

Despite the practical suggestions, however, most participants noted that community engagement is difficult to achieve:

> *Engagement is one thing, but getting it is another. Having worked in a small community here… trying to get members to even come out to a meeting [even] when you make it easy to get to is hard.*

Several participants queried about improvements to communication to "make it work", and wondered what that would look like ("Funding reports, emails, this is not working. So, what do we do?).

Output of Engagement

For most, the efficacy of the engagement from a community perspective rested in the yield: that is, where does the engagement go? As one participant noted, *You bring the community together and they have really good things to say and they know exactly what they need but like who can I pass it on to? I can pass it on to people who you know, are compassionate toward it and everything, but can they make it happen?*

Others were more direct in their expectations, noting the importance of feedback, ever as simple as "Okay, we heard you… [t]his is what we are doing next". The commitment to *action* engagement outputs was fundamental to most participants, with several pointing out the danger of not acting on what was heard: "[They] will lose engagement quickly if it's endless research and no walking the talk". Others recognized that not all community direction can directly inform planning, but noted that "…there really needs to be clear action and if action cannot be taken, there needs to be an explanation". For several participants, this demanded authenticity ("…there is actually a possibility your voice can impact the final decision or change direction"). This was contrasted with predetermined outcomes when the decision had already been made ("… a consultation check-box").

The importance of uptake was also noted when the engagement was arranged at a municipal level: "[W]e did a community survey ourselves to find out what our priorities are and we have all this data and… where do we take it?" Another noted, "What I'm struggling with is… who is listening to us?". This underscored what others described as a missing "pathway", which ultimately led to ineffective efforts. Several participants did note their default approach was to contact their local MLA, but that "it was never satisfying".

Attention to Barriers

Participants noted several barriers to engagement at a local level, starting with incongruent language norms ("So the community talks in a grass-roots way, and that's [dismissed]"). Although we noted above the appreciation for different modalities of engagement by some of the participants, others pointed to technology as a barrier for many ("Cellular/wifi access is not equitable across the province [and] it's not okay").

Although practical barriers to engagement were noted by many of the participants, ultimately it was the cultural barriers that people felt were the biggest challenges, resting primarily with the perception that "people don't feel empowered to have a voice". Another participant explicitly noted the sentiment of community members that "my voice doesn't matter". According to others, the recourse was re-learning, as a community, that "we all have a voice, and it matters what we say" as part of a cultural re-build. It was this cultural disconnect that, for some participants, underscored a more practical disconnect between "…what one set of people think effective engagement is and what another group thinks it is".

Recommendations:

1. **Establish Formal Partnerships with Community Networks:** Recognize and fund existing non-profit, community-driven organization networks as essential partners

in facilitating ongoing engagement and consultation. Effective networks exist in several regions and at the pan-provincial level. These Community Networks serve as effective intermediaries, amplifying rural voices and ensuring local insights are accurately reflected in policy and planning. They are not controlled by a professional body, are at arms length from all levels of government and are made up of community champions with lived experiences in rural and remote life.

2. **Community-Based Engagement Hubs**: Fund the development of regional community engagement hubs, managed by Community Networks, to facilitate authentic grassroots consultations. These hubs should regularly engage residents and organizations, ensuring sustained dialogue beyond crisis points or isolated consultation efforts. The facilitation and creation of these hubs should specifically ensure that communities lacking the capacity to establish their own engagement platforms are actively supported. Outreach to underrepresented communities must be proactive rather than passive, ensuring equitable representation and participation. Facilitation must respect and accommodate the unique contexts and emotional states of community members. Residents should not be expected to possess specific engagement skills such as conflict resolution or appreciative inquiry. Rather, these facilitation competencies must be the responsibility of skilled facilitators who meet communities on their own terms, allowing space for authentic expressions of frustration, anger, or other emotions as a valid part of the engagement process.
3. **Culturally Safe and Inclusive Outreach:** Allocate dedicated resources for culturally safe, trauma-informed engagement strategies that specifically reach under-represented and Indigenous populations, facilitated by trusted local non-profits and Indigenous community leaders.
4. **Enhance Local Capacity and Resources:** Provide funding and logistical support (e.g., honoraria, childcare, travel reimbursement, digital connectivity) through community organizations to reduce barriers and encourage inclusive resident participation in health consultations and decision-making.

DECISION-MAKING

One of the salient points regarding decision-making brought through the regional engagements was on the importance of local autonomy in decision-making that affected community services. Some participants were specific, noting “[I]f we could go backwards and give [decision-making] back to the communities and get our local administrators and budgets back, I think we could accomplish a lot." However, the concern about this was local resourcing. As another participant noted,

It's just from a local government perspective. I've been on council for 28 years and we have been very wary of taking on any more responsibilities at the local level because we only have ... around 4200 people. So that's our local tax base and we cannot continue to increase the local tax base in taking on more responsibilities that the province has poured on our doorstep.

Others, however, noted legislative constraints on municipalities, namely not being able to run a deficit, constricting the level of autonomy. Others emphasized that at a municipal level,

... we are already at capacity... we don't have enough money to do the things we do now... we don't have enough time to do the things we do now and now we're downloading a provincial responsibility of healthcare into the municipal world and we would need more resources to do that.

Building on this theme, others emphasized the need to "institutionalize" municipal involvement in health care planning but again, alongside being given the tools to be more involved.

Within these natural constraints, however, some participants expressed how they were involved in health planning at a municipal level, with one noting,

I'm probably attending 3 to 4 of these rural medical meetings per month every month. I'm part of every medical trust and scholarship and rural planning around health you could possibly think of. And now we have municipalities that are going over and above and buying their own medical clinics. Like I think municipally, the municipal leaders are doing everything that they possibly can.

Interestingly, participants representing a regional perspective noted similar constraints on resources: "Regional districts are even more structured if they haven't formed an actual service attached to it, with a budget, they can't do anything". As a caveat, several participants noted that advocating for further resources for local or regional planning was a double-edged sword if it meant less resources for health service delivery.

In a broader sense, participants saw decision-making at a provincial level as being inherently economically driven, thus requiring local initiatives to be presented with the cost consequences. This was backstopped for some by assertions that the economic value of rural communities was underplayed in decision-making:

You know, agriculture, resource extraction, the ports, we contribute billions and billions and billions of dollars to the BC economy and... you can't just keep taking without supporting communities.

Beyond the economic value to the province, others appealed to the economic contributions of rural residents: "We are taxpayers. We provide millions of dollars. Tens of millions, hundreds of millions of dollars in revenue to the province to everybody else. We just need to be treated like people".

Interestingly, many participants felt attention to rural contributions and needs would benefit local direction as ground-up solutions tended to be more efficient and cost-effective as they built on a clear understanding of local community solutions. The corollary to this, of course, is when decisions are made outside of the community, it was deemed imperative for those making the decisions to "…have a full understanding of the community they are working in". However, several participants highlighted instances of decision-maker engagement in the community, although most were historical:

> *[W]e once had a CAO of the hospital who cared a great deal about the community, lived here all her life. So things were different then because you could take small issues… but it's certainly a step forward that someone cares about those small things, because all the small things built into big things, that if you can fix the small things, then people are happier because they're being listened to.*

Others had more proactive ideas about socializing current decision-makers in the cultural ethos – and geography – of their communities. As one said,

> *I always have this fantasy that whoever the decision makers are… I just take them in my truck and we go do like 'a day in the life'. But it's just like 'you have no idea, like, when you're suggesting this,' it's like [they've] obviously never been here … it's so clear.*

This was concisely expressed by others ("Decision makers need to have skin in the game!", "I wish they would come and spend some time in the areas. See and feel the struggles. Not focus on numbers…").

The Role of Health Authorities in Decision-Making

Most participants in this study had strong feelings about the inadequacy of their interactions with Health Authorities, ranging from having "no communication" from the Health Authority to "…they don't want input, that's too inconvenient". Another participant was more direct, noting, "We used to have a local health services society and then in 2014, [the Health Authority] said thank you, but go away, please. We can do it better". Several participants observed lack of community engagement being directly proportionate to moving up the Health Authority hierarchy, with those in positions of more responsibility having "… very little community engagement and very little lived experience engagement". A contributing influence to HA disconnect for participants in this study was a the large bureaucracy and accompanying lack of transparency. As has been noted elsewhere, this led to unmet expectations by communities:

> [W]e had a meeting with Northern Health and we were expecting to have 3 or 4 meetings with the community here before the end of the year. They kind of promised me. And we're in the middle of June, we still haven't heard anything.

The lack of transparency had additional consequences for communities, including lack of understanding why services may be made. For some, service cuts were understandable in the current fiscal climate ("I understand… you don't want huge deficits [so the] province won't have to bail them out”), but the lack of explicit rationale was challenging. This left community leaders advocating with the HAs with the “limited information they are provided”. Several participants were at a loss about how to provide feedback to the HAs regarding their experiences of the process of engagement itself (“how do we speak out and say [HA], you could be doing more or you could be more flexible? How do we engage in conversations about what's working and not working?”). A further consequence to the lack of transparency experienced by many participants was a lack of understanding regarding perceived differential allocation of resources between communities. As one observed,

> *[I]n some communities, they'll support meals on wheels, not in others. Now I recently saw they are supporting a child childcare center in [neighbouring community]. And it's like, I'm not sure they are transparent about which cause they choose and not choose, you know. We're not on the same playing field in terms of what we can advocate for or not or have these conversations.*

Some participants were clear that the Health Authority model in itself is mired in bureaucracy and does not work, others noting that they had “No faith that there can ever be any real, honest and transparent communication with rural communities” and that the “authoritarian” model had to change. Others noted the shift from a focus on safety and quality care to a culture of financial accountability and risk avoidance. As one participant concisely said, “Get rid of health authorities and go back to local input”.

Study participants offered several recommendations to improve relationships between communities and Health Authorities, including moving from an appointed to an elected board, ensuring board members come from the communities they represent with solid regional representation, and improving the link between *engagement* and *action*. Some participants observed that one way to incent decision-maker action was through media attention on an issue of concern: “[I]f some journalist decides to put some attention on the issue you're talking about, then you get some responses from the province, which I've noticed”. Others advocated for a provincial Rural Minister

> *…that would pay more mind to the rural communities of the province…[which] would give us a better avenue of getting our voices heard to somebody directly. That's all they would do would be rural issues including healthcare. So at least that person would understand and be able to get it voiced to the province.*

One participant expressed concern, however, over “another level of bureaucracy to slow processes down”, noting its efficacy would “all depend on how it is created”.

Recommendations:

1. **Embed Rural Community Representation in Decision-Making Bodies**: Require consistent representation from rural residents and non-profit community groups on provincial and regional healthcare governance and advisory bodies, ensuring community expertise directly informs healthcare policy.

2. **Establish a Provincial Rural Health Advisory Council**: Create a formal advisory council at the provincial level comprising the Parliamentary Secretary for Rural Health, Deputy Minister of Health, CEOs of each Health Authority, and representatives from Community Networks. This Council would meet at a set frequency and provide bi-directional feedback and report actions taken to address issues identified through community engagement processes.

SYSTEM ACCOUNTABILITY

Most participants were in general agreement on the enforceability of accountability for elected officials, one noting "If you're not doing the work that the community wants you to do, they're not going to vote you back in…". Others were less optimistic, asserting "I honestly do not believe the system has any accountability at all" or "It's just an ethereal idea that someone's listening, but no, I don't believe that there is any actual accountability".

Several participants observed accountability *avoidance* through assertions of lack of resources for engagement ("... this is just the answer they say to avoid accountability"). Several participants noted the importance for patients' assuming responsibility for enforcing accountability by "knowing our rights and having the knowledge to say... no, this is a cop-out. We need to hold them accountable". However, this was seen as distinct from the system-level accountability of bureaucracy, which lacked inherent and direct feed-back mechanisms. As one participant commented, "...this is where accountability goes out the window". For some, practical and resource issues were seen as a way for accountability avoidance:

I know Zoom is not ideal, but there are other ways than Zoom, and we have data to that. I'm sure you have data of other ways we can engage the community, and that is accessible. So this, to me, is just the answer that they say just to avoid accountability.

The corollary to accountability avoidance was seen to be a commitment to dialogue with community as part of a response to the engagement, within a reasonable timeframe, that provided an overview of how the yield of the consultation would be used in health planning. For a few participants, this was underscored by "knowing our rights".

Several respondents pointed out that only with a standardized and transparent accountability system can there be clarity into whether or not accountability was achieved. However, the *importance* of accountability was recognized by most participants, generally actualized through feedback on suggestions from community members. This was relevant at a local, regional and provincial level in response to any community engagement. Ultimately, however, community consultations thematically identified *health system* *accountability* as a foundational step in the move towards the system transformation that is needed to incorporate community input in health planning.

Recommendations:

1. **Establish Clear Accountability Mechanisms**: Implement a standardized feedback loop mandating timely reporting back to communities after consultations, clearly outlining how input influenced health policy or explaining reasons for non-implementation.
2. **Creation of a Provincial Rural Community Data Platform**: Support the creation of a living, publicly accessible data platform managed collaboratively with non-profit community partners. This platform should integrate qualitative lived experience data with quantitative metrics to reflect real-time rural health and social needs, informing government, regional districts, municipalities, Indigenous communities, and community organizations in planning decisions.
3. **Establish Engagement Targets for Regional Health Authorities** in order to have pan-provincial bench-marks for regional engagement expectations, accompanied by clear reporting metrics from both RHAs and communities.

THE NEED FOR TRANSFORMATIONAL CHANGE

Most participants identified the need for a fundamental shift towards valuing the input of those receiving health care in the planning process and recognized that change is often difficult to evoke due to the weight of bureaucracy and system inertia. This, however, was juxtaposed with the counter-force of community demand for change. As one respondent noted,

> *We're so scared of making mistakes that might make some people angry. People are already angry. People are not having their needs met. So at least try something, learn from it and then edit it and implement it again.*

Most noted that system-initiated *action,* based on community feedback ("… not that's come out of Prince George or Victoria") was the only way to quell the discontent. Some felt this could be strengthened through rural advocacy or through patient-led quality improvement processes while others were more specific, suggesting a system-embedded position to ensure rural community needs were met: "Small rural areas should have an ombudsperson, an advocate, that has a comprehensive understanding of the communities". Several participants emphasized that such community-level advocacy should exceed a narrow definition of 'health' and include community-level social determinants and that regardless of the scope, continuity in change management was essential. As one participant commented, “So much ground and energy is lost in translations when key people move on’. Regardless of the mechanism of action, however, most respondents felt any meaningful system change would likely be protracted.

There was clarity from most that the drivers for system change were contingent on whether or not people working within the system felt the need for meaningful change (“No bells and whistles”) at every level in the health care system (“... the changes in each level are different. Local changes, regional changes, provincial level changes... We cannot have one change without changing others”). Political will was noted as the enabling influence in all of the successful anecdotes conveyed by community members during the focus groups, usually evidenced through a local or regional champion that led the change initiative. A sub-quality of successful change management was de-siloing the health care adjacent services that had an impact of health services, such as local and regional transportation, food access and housing.

Recommendations:

1. **Prioritize Resident and Lived-Experience Perspectives**: Ensure all planning processes formally include resident-driven narratives, prioritizing lived experiences as critical data sources in rural healthcare decision-making.
2. **Pilot Innovative, Community-Led Solutions**: Provide seed funding and regulatory flexibility for rural community organizations to pilot innovative, locally-developed healthcare solutions. Evaluate these pilots for potential provincial scaling.

By prioritizing community voices, especially through trusted community-driven organizations, British Columbia can build a more responsive, accountable, and community-aligned rural healthcare system.

Next Steps:

Through funding from UBC’s Health After 2020, we were able to build on earlier work investigating the gaps in the inclusion of rural community voice in health planning by asking rural communities themselves what changes are required at a regional and provincial level to better effect community input. This approach is congruent with the findings from the initial research which emphasized the importance of the inclusion of *local community direction* in health planning, based on the lived and living experience of those receiving health care, and an understanding of the dangers of not including these voices. To this end, taking direction from rural residents across BC on next steps in effecting more democratic decision-making was essential.

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