Participatory Methods for Inuit Public Health Promotion and Program Evaluation in Nunatsiavut, Canada

by

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ABSTRACT

PARTICIPATORY METHODS FOR INUIT PUBLIC HEALTH PROMOTION AND PROGRAM EVALUATION IN NUNATSIAVUT, CANADA

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Engaging stakeholders is crucial for health promotion and program evaluations; however, understanding how to best engage stakeholders is less clear, especially within Indigenous communities. This thesis research used participatory methods to: (1) co-develop a whiteboard video as a public health promotion tool in Rigolet, Nunatsiavut, and (2) develop and validate an evaluation framework for Inuit public health initiatives in Nunatsiavut, Labrador. Data were collected through interactive workshops, community events, interviews, focus-group discussions, and surveys. Results indicated the whiteboard video was an engaging medium for sharing public health messaging due to incorporation of contextually relevant elements. Inuit participants identified four foundational evaluation framework components to conduct appropriate evaluations, including: (1) community engagement, (2) collaborative evaluation development, (3) tailored evaluation data collection, and (4) evaluation scope. This research illustrates stakeholder participation is critical to develop public health initiatives including their evaluations in Nunatsiavut, Labrador and should be considered in other Indigenous communities.
ACKNOWLEDGEMENTS

First, I would like to sincerely thank my wonderful committee members Drs. Sherilee Harper, Steven Roche, and Andrew Papadopoulos. Thank you for your tremendous support, guidance, and mentorship. You all challenged me and encouraged me to step outside of my comfort zone to accomplish incredible things during my time at the University of Guelph. I am grateful for all the knowledge you shared with me, the insight you provided in developing and completing the research project, and the contributions you made to writing drafts, presentations, and applications. My accomplishments are a reflection of my incredible committee members and I hope to reflect their positive influence in all my future endeavors. Thank you to both Sheri and Steve for meeting with me regularly to chat and discuss the research project. I know you have many other responsibilities and I truly valued your time. Thank you, Sheri, for taking me on as a master’s student and for your patience and ongoing support and encouragement. I am so grateful to you for the amazing experiences I have had over these past three years, experiences that wouldn’t have been possible if you had not taken me on as a student.

I would like to thank my community research partners, Inez Shiwak and Charlie Flowers. Thank you, Inez, for your immense help with absolutely everything, from planning our research events to spreading the word and encouraging participation, to just making sure everything went smoothly. Thank you for making me feel so welcome in Rigolet and for making my trips go so well. I truly appreciated getting to work with you and valued all your time and energy. I will never forget your creativity and beautiful crafts! Thank you, Charlie, for your help with the video, and other research pieces and events in Rigolet, I am so grateful that I got to meet and work with you. Thank you to the youth in Rigolet: Alison, Brady, Brittney, Mackenzie, Rodney, and Ryan for working on the video with me. It was so wonderful to get to work with you all. I would also like
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I would like to thank Michele Wood from the Nunatsiavut Government for her unwavering support of our research, her incredible personality that made traveling to Happy Valley-Goose Bay seem like visiting an old friend, and her work ethic to ensure everything would work smoothly for us. Michele, I will never forget my first trip to Goose Bay and your immense hospitality when I was snowed in and you took the time to take me around Goose Bay! Thank you to the other Nunatsiavut Government staff as well for their involvement in the project and support for the work.

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STATEMENT OF WORK

Funding for the research was obtained by Dr. Sherilee Harper. University of Guelph and Nunatsiavut Government ethics approval was obtained by Dr. Sherilee Harper and Manpreet Saini. Interview, focus group, survey, and youth workshop consent forms, scripts, and question guides were created by Manpreet Saini with guidance and assistance from Dr. Sherilee Harper, Dr. Steven Roche, Dr. Andrew Papadopoulos, and Inez Shiwak. Participant recruitment was coordinated by Inez Shiwak and Michele Wood. The youth workshop was coordinated by Manpreet Saini, Nia King, and Inez Shiwak. Interviews and focus group discussions were conducted by Manpreet Saini and Nia King, with assistance of Inez Shiwak. Member checking discussions were coordinated by Inez Shiwak, and conducted by Manpreet Saini.

Whiteboard ideas were developed by six youth workshop participants from Rigolet: Alison, Brady, Brittney, Mackenzie, Rodney, and Ryan. Whiteboard storyboard development was completed by Manpreet Saini and Inez Shiwak. Input on the script, images, and storyboard were provided by Dr. Sherilee Harper, Dr. Steven Roche, Inez Shiwak, the Rigolet youth participants, Charlie Flowers, Rigolet community members, Michele Wood, Michelle Kinney, Tina Buckle, Dr. Andrew Papadopoulos, Dr. Victoria Edge, Dr. James Ford, members of the Harper Lab (Lindsay Day, Kate Bishop-Williams, Rebecca Palmer, Alexandra Sawatzky, Vivienne Steele, Laura Jane Weber, Kaitlin Patterson, Stephanie Masina, Jacqueline Middleton, and Anna Manore), Anna Bunce, Dr. Warren Dodd, Jessica Demurs, Dr. Andria Jones-Bitton, Dr. Ashlee Cunsolo, Dr. Jennifer McWhirter, Dr. Mai Pham, Dr. Thomas W. Piggott, and Ken Diplock. Manpreet Saini and Dr. Steven Roche met with Tivoli Films Inc. to discuss video development ideas and the storyboard. Dr. Steven Roche was the liaison with Tivoli Films to discuss deadlines and edits, and obtain completed images and video drafts. The narration of the video was completed by Jack
Shiwak and narration recording was completed by Inez Shiwak. Ideas for music were provided by Inez Shiwak and Charlie Flowers, and final music for the video was selected by Charlie Flowers. Image renderings of the scenes, and final video editing and production were completed by Tivoli Films Inc. The community launch of the whiteboard video was hosted by Manpreet Saini, Carlee Wright, Inez Shiwak, and Charlie Flowers. Participant recruitment for surveys, and interviews for the evaluation of the whiteboard video was completed by Inez Shiwak. Surveys and interviews were conducted by Manpreet Saini.

Audio recordings of interviews and focus group discussions were transcribed by Manpreet Saini and Nia King. Transcripts were analyzed by Manpreet Saini using ATLAS.ti®. Qualitative data analysis for all chapters was completed by Manpreet Saini with the assistance of Drs. Sherilee Harper, Steven Roche, and Andrew Papadopoulos.

The chapters within this thesis were written by Manpreet Saini. Edits and feedback were provided by Drs. Sherilee Harper, Steven Roche, and Andrew Papadopoulos, and Nicole Markwick.
POSITIONALITY STATEMENT

With qualitative research, it is important for the researcher to outline and explain their position and reflect on their assumptions, beliefs, and biases (Berger, 2015). My personal position and perspective as a researcher may present biases, which are important to address in order to maintain the validity within, and reliability of, the research (Berger, 2015). I am a first-generation Canadian-born female student, born to Indian immigrant parents.

As a first-generation Canadian, and the daughter of Indian immigrant parents, I can begin to understand the value of culture and tradition to Indigenous populations of Canada; in some ways, it is similar to the value of Indian culture and tradition to my family and myself. Similarly, I can understand the desire to hold on to and incorporate culture and tradition in a Western, white-dominated society, as my family also attempts to uphold their culture and traditions within this society. Understanding and recognizing the importance of these values helped me begin to understand the community of Rigolet’s desire for and perceptions of participation in research and development.

As a student and early career researcher, I recognize the privileges I have due to my socioeconomic status, education, and residence in southern Ontario. Before embarking on my MSc, I had little experience working with Indigenous communities; however, I was aware of the past colonial history of Canada and its Indigenous peoples. I was also aware of the negative research legacy that was left by previous unethical health research that was conducted in the Arctic, as well as the neocolonial-style of research that too often still persists today. In my research, I recognize that these privileges can impact how the Inuit community views me and perceives my presence in the community. Being aware of this, I became careful of my actions, behaviours, and mannerisms as I conducted my research with the community. I wanted to increase the community’s
comfort with me as an outsider, and I tried to foster a positive relationship with everyone who I met in the community. I also recognized that I represented my advisor and lab group, who have strong positive relations with the region where this research was carried out. Thus, I had a strong desire to conduct research that would uphold this positive relationship, be beneficial to the community, and be strongly rooted in and led by the community. I recognize that this desire and belief, and my personal perceptions towards community participation in research and development, could be different from the regional and community members who participated in the research.

To minimize the impact of my positionality and personal perceptions on the research, I used various qualitative validity strategies, including the audit trail, member checking, peer debriefing, and collaboration (Creswell & Miller, 2000). I used these strategies so the community was accurately heard and given the opportunity to respond to interpretations made from the results. Additionally, they were involved in the study to help generate research that would, in the end, be beneficial to, and reflective of the lived experiences and desires of the community.

REFERENCES


# TABLE OF CONTENTS

ABSTRACT ........................................................................................................................... ii

ACKNOWLEDGEMENTS ..................................................................................................... iii

STATEMENT OF WORK ........................................................................................................ vi

POSITIONALITY STATEMENT .......................................................................................... viii

TABLE OF CONTENTS ....................................................................................................... x

LIST OF TABLES .................................................................................................................. xii

LIST OF FIGURES ............................................................................................................... xiii

CHAPTER 1
DISSERTATION SUMMARY ............................................................................................ 1

CHAPTER 2
INTRODUCTION, LITERATURE REVIEW, AND THESIS RESEARCH GOALS & OBJECTIVES .................................................................................................................... 3
   Introduction ...................................................................................................................... 3
   Literature Review .......................................................................................................... 4
   Thesis Research Goals & Objectives ............................................................................. 16
   References ..................................................................................................................... 17

CHAPTER 3
A PARTICIPATORY INUIT HEALTH PROMOTION WHITEBOARD VIDEO .................... 27
   Description ..................................................................................................................... 27
   Whiteboard Storyboard ................................................................................................. 28

CHAPTER 4
PROMOTING INUIT HEALTH THROUGH A PARTICIPATORY WHITEBOARD VIDEO 39
   Abstract ......................................................................................................................... 39
   Introduction .................................................................................................................... 40
   Setting ........................................................................................................................... 41
   Intervention .................................................................................................................. 42
   Outcomes ..................................................................................................................... 46
   Implications .................................................................................................................. 49
   Conclusions .................................................................................................................. 51
   References ..................................................................................................................... 53
Figures .................................................................................................................................59

CHAPTER 5
ENGAGEMENT, COLLABORATION, AND KNOWLEDGE CAPTURE: AN EVALUATION FRAMEWORK FOR INUIT PUBLIC HEALTH INITIATIVES ........................................63
   Abstract .................................................................................................................................63
   Introduction .........................................................................................................................64
   Methods ..............................................................................................................................66
   Results .................................................................................................................................70
   Discussion ...........................................................................................................................79
   Conclusion ..........................................................................................................................83
   References .........................................................................................................................84
   Figures .................................................................................................................................92

CHAPTER 6
SUMMARY, STUDY LIMITATIONS, FUTURE DIRECTIONS, AND CONCLUSIONS ....95
   Summary .............................................................................................................................95
   Research Limitations .......................................................................................................98
   Future Directions .............................................................................................................99
   Conclusions ......................................................................................................................102
   References .......................................................................................................................103

APPENDICES .......................................................................................................................106
   Appendix A .......................................................................................................................106
   Appendix B .......................................................................................................................108
   Appendix C .......................................................................................................................110
   Appendix D .......................................................................................................................116
   Appendix E .......................................................................................................................119
   Appendix F .......................................................................................................................120
   Appendix G .......................................................................................................................125
   Appendix H .......................................................................................................................127
LIST OF TABLES

Table 2.1. Search terms used to find relevant literature on conducting health research, participatory evaluation of public health interventions, and effective public health interventions for Indigenous populations. .................................................................26
LIST OF FIGURES

Figure 4.1. The participatory whiteboard video development process used in a public health campaign to share public health messaging around acute gastrointestinal illness in Rigolet, Canada..........................................................59

Figure 4.2. Illustrative photos of community events used for the co-development and presentation of the whiteboard video with Rigolet community members, health professionals and decision makers. A-D: Youth workshop activities and outcomes, E-F: Community open house to share work of youth and obtain community input .................................................................60

Figure 4.3. Description of interviews, focus group discussions, and surveys conducted in Happy Valley-Goose Bay and Rigolet, Canada in July 2015 and August/September 2016, including location, number of participants, participant characteristics, and average duration of each data collection activity........................................................................................................61

Figure 4.4. Images from the whiteboard video “Keeping Stomach Illness Out of Rigolet”. Images share messaging around (A) washing hands for 20 seconds, (B) storing food appropriately, (C) cooking food thoroughly, (D) boiling brook water after heavy rain and snowfall, and (E) cleaning water containers. (F) A summary list of all key messages described through the video was also provided at the end of the video .................................................................62

Figure 5.1. Map showing the partner region of the Labrador Inuit Land Claim Settlement Area governed by the Nunatsiavut Government, and its five communities: Rigolet, Postville, Makkovik, Hopedale, and Nain. Graphs show demographic information for the region including (i) population size based on community, (ii) sex, and (iii) Indigenous identity.................................92

Figure 5.2. Details of methods used for data collection and analysis, including number of semi-structured interviews and focus group discussions, location, number of individuals involved, and characteristics of the participants, as well as a summary of the thematic analysis procedure ......93

Figure 5.3. Final evaluation framework for Inuit public health initiatives in Northern Labrador, as co-developed with Inuit health professionals, decision-makers, and community members from Northern Labrador........................................................................................................94
Chapter 1
DISSERTATION SUMMARY

Formatted for submission to the International Journal of Circumpolar Health
Submission Type: Dissertation Summary

Title: Participatory Methods for Inuit Public Health Promotion and Program Evaluation in Nunatsiavut, Canada

Institution: University of Guelph

Degree: Master of Science in Epidemiology

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Abstract: Engaging stakeholders is crucial for health promotion and program evaluations; understanding how to best engage stakeholders is less clear, especially within Indigenous communities. The objectives of this thesis research were to use participatory methods to: (1) co-develop and evaluate a whiteboard video for use as a public health promotion tool in Rigolet, Nunatsiavut, and (2) develop and validate a framework for participatory evaluation of Inuit public health initiatives in Nunatsiavut, Labrador. Data collection tools included interactive workshops, community events, interviews, focus-group discussions, and surveys. Results indicated the whiteboard video was an engaging and suitable medium for sharing public health messaging due to its contextually relevant elements. Participants identified four foundational evaluation framework components necessary to conduct appropriate evaluations, including: (1) community engagement, (2) collaborative evaluation development, (3) tailored evaluation data collection, and (4) evaluation scope. This research illustrates stakeholder participation is critical to develop and
evaluate contextually relevant public health initiatives in Nunatsiavut, Labrador and should be considered in other Indigenous communities.

Required Headshot:
Chapter 2
INTRODUCTION, LITERATURE REVIEW, AND THESIS RESEARCH
GOALS & OBJECTIVES

INTRODUCTION

Indigenous populations all over the world often face great health disparities, resulting in higher prevalence and incidence rates of illness, as well as lower life expectancies than non-Indigenous populations (Gracey & King, 2009). The root cause of these disparities include differences in social, cultural, political, and economic factors between Indigenous and non-Indigenous populations (Adelson, 2005). Collectively these factors are referred to as the ‘social determinants of health’, and include social support, access to health services, living conditions, education, income, and employment (King, Smith, & Gracey, 2009). Over the years, much applied research and public health promotion has been done in an effort to understand these social determinants of health, and reduce the health disparities in Indigenous populations (Adelson, 2005; Owens et al., 2012). To help reduce these disparities, research and public health promotion must effectively integrate culture, livelihoods, values, and ways of knowing to lead to better collaboration, and improved adoption and support for these research efforts (Bird, Wiles, Okalik, Kilabuk, & Egeland, 2008; McShane, Smylie, Hastings, Martin, & Tungasuvvingat Inuit Family Resource Centre, 2006; Smylie et al., 2009). Indeed, integration of Indigenous knowledge, and collaboration with Indigenous stakeholders throughout the research process, could support the development and evaluation of culturally appropriate public health initiatives.
LITERATURE REVIEW

This literature review aims to identify and synthesize relevant literature on bridging health research and practice; conducting community-based participatory research; exploring Indigenous public health communication and promotion; and evaluating public health initiatives. Relevant literature was found through database searches (PubMed, Web of Science & Google Scholar) using a series of search terms (Table 2.1) and through the review of article reference lists for relevant citations. Articles identified in the search were included for review if their titles and abstracts contained information pertaining to public health communication with Indigenous people, evaluation frameworks for public health programs, and/or the use of participatory methods in public health initiative development and evaluations with Indigenous populations.

Bridging the Health Research to Practice Gap

A gap exists between the production of health research and its application to practice, which results, in part, from stakeholders’ inability to use research evidence to inform decision-making (Graham et al., 2006; Straus, Tetroe, & Graham, 2011). A process to address this gap and move research results, or knowledge, into action is described by a variety of terms, including, but not limited to knowledge exchange, knowledge mobilization, and knowledge translation. Knowledge exchange refers to a “two-way process of sharing knowledge between different groups of people” (Shaxson et al., 2012, p.2). Knowledge mobilization is “a two-way process that makes use of the existing stock of knowledge and co-creates new knowledge to help foster change” (Shaxson et al., 2012, p.2). Knowledge translation is defined by the Canadian Institutes for Health Research (CIHR) as “a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians,
provide more effective health services and products and strengthen the health care system” (CIHR, 2015).

When looking at the health of Indigenous populations, Indigenous scholars attribute this research to practice gap to the use of Western-based methods to conduct research and produce knowledge, without consideration for, or inclusion of Indigenous knowledge (Smylie et al., 2004; Smylie, Olding, & Ziegler, 2014). Understanding, integrating, and privileging Indigenous knowledge systems are crucial to ensure that health research, and resulting practices and recommendations are appropriate and effective within Indigenous populations.

**Health Models and Knowledge Systems: Western and Indigenous Ways of Knowing**

The biomedical model of health, which is typically used and applied by Western researchers and practitioners, focuses on the biological causes of disease; however, the social determinants of health are becoming increasingly acknowledged as important for understanding and developing effective public health initiatives to improve health and reduce rates of illness (Baum, Bégin, Houweling, & Taylor, 2009; Koh et al., 2010). Conversely, the Indigenous model of health takes a holistic view, where health encompasses the health of the community and environment as an extension of one’s health (King et al., 2009; Stephens, Nettleton, Porter, Willis, & Clark, 2005). As presented by Sawatzky and colleagues (in press), Nunatsiavut Inuit identified “a variety of pathways that helped both individuals and communities achieve and sustain good health and wellbeing – pathways which spanned physical, mental, emotional, social, and spiritual dimensions. Most importantly, all participants identified the land as the underlying determinant for all dimensions of wellbeing, placing emphasis on its roles as a “healer”, “teacher”, “connector”, and “kin”. As such, the land served to both shape and reinforce pathways for good wellbeing.”
Beyond the foundational differences in the definitions of these health models, there is a difference in the knowledge systems that underpin these models as well. Western knowledge systems have been described as linear. The system “involves the organization of individual data into abstract theoretical systems, composed of multiple components, each of which requires a “specialist” to be fully understood. Translation of scientific knowledge to members of the larger society is not prioritized, and through processes of self-authentication science is set apart by its practitioners from other forms of knowledge production” (Smylie et al., 2003, p.141). Comparatively, Indigenous knowledge generation is based in stories. These stories contain values and processes, which are integrated to produce knowledge. This system is more cyclical, with knowledge turning into wisdom, and wisdom producing new stories (Smylie et al., 2003).

**Community-Based Participatory Research**

Community-based participatory research (CBPR) has been a growing approach for conducting research with various populations and communities (Dick, 2006, 2009). This approach focuses on using participatory methods in all phases of the research process: research development, implementation, and interpretation and application of results (Cargo & Mercer, 2008; Israel, Schulz, Parker, & Becker, 1998). Strategies for this approach ensure the research question and study design are developed with strong community input and leadership. This form of research ensures the research addresses concerns of the community, encourages recruitment, fosters development of community capacity and ownership, and ensures methods are not “disruptive” (Cargo & Mercer, 2008). Furthermore, it ensures the research meets the needs of the community and end-users (Cargo & Mercer, 2008). Some challenges do exist with CBPR, and can include limited funding, time commitments, lack of trust, power distribution, and determining who represents the community (Israel et al., 1998).
CBPR with Indigenous Populations

Indigenous people across the globe have faced instances of researchers arriving into their communities, completing research, and leaving without bringing research results back (Adelson, 2005; Castleden, Morgan, & Lamb, 2012; Ferreira & Gendron, 2011; Pufall et al., 2011). Since Indigenous people often are not provided the opportunity to lead, understand, and learn from the research conducted in their communities, it has been argued that the actions of researchers and the overall research process have contributed to the colonization of Indigenous people (Stephens, Porter, Nettleton, & Willis, 2006). Furthermore, researchers have failed to take into account local, Indigenous knowledge as Western scientific knowledge and research methods are too often considered objective and superior (Simonds & Christopher, 2013). In response, the support for, and importance of, CBPR is increasingly emphasized by funding agencies, researchers, and research participants (Simonds & Christopher, 2013). Many Indigenous scholars posit that CBPR allows the inclusion of the community and the acknowledgement of Indigenous knowledge throughout the research process, in order to decolonize both the research process and the researcher-community relationship (Castleden et al., 2012; Cochran et al., 2008; Simonds & Christopher, 2013). Through this process, communities and other stakeholders who are impacted by the research are involved in the research process and are a part of the research team, thereby developing relationships among non-Indigenous and Indigenous researchers to engage in co-learning and co-creation of knowledge (Castleden, Garvin, & Huu-ay-aht First Nation, 2008; Castleden et al., 2012; Koster, Baccar, & Lemelin, 2012; Suarez-Balcazar, 2005). The value in local and Indigenous knowledge, and learning from the individuals in the community, is an integral and defining piece for success of the research process. The Canadian Tri-Council Funding Agencies have reflected the importance of this in their ethical protocols, where appropriate
engagement of Indigenous partners is required for research that will be conducted on Indigenous lands, with Indigenous participants, and/or relates to Indigenous culture, history, artefacts, traditional knowledge, or language (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014).

**Participatory Methods, Public Health Communication & Promotion**

Participatory methods can be applied to the development of public health initiatives for health promotion (Wallerstein & Duran, 2010). Health promotion is defined within the Ottawa Charter for Health Promotion, as “the process of enabling people to increase control over, and to improve, their health” (World Health Organization, Health and Welfare Canada, & The Canadian Public Health Association, 1986, p.2). The charter outlines five areas of focus for health promotion action, including: development of policy that promotes health; maintenance of environments that support healthy work and living conditions; development of community capacity for action; development of personal skills; and, finally, redirection of health services away from a strictly clinical focus (World Health Organization et al., 1986). In Indigenous contexts, it is important to consider the cultural relevance of public health promotion initiatives and outputs.

**Cultural Relevance of Health Promotion Initiatives**

Effective health promotion requires an awareness of cultural and social factors (World Health Organization et al., 1986). Culturally relatable tools and interventions tend to have a greater acceptance by communities and individuals (Kreuter & McClure, 2004). This acceptance can facilitate positive change and reduce health disparities in Indigenous communities. For example, Inuit often value face-to-face interactions, stories, and visual learning methods (Latycheva et al.,
which could be integrated into health promotion tools or interventions. Furthermore, Elders, who are older, well-respected individuals that hold traditional knowledge within communities, and the knowledge of Elders tends to be valued by all members of the community (McShane et al., 2006; Racicot-Matta, Wilcke, & Egeland, 2016; Smylie et al., 2009; Yohannes, 2009). In one study, Elders shared their Indigenous knowledge through stories recorded on DVDs and this was positively received by youth viewing the DVDs (Yohannes, 2009). In other work, Elders sharing stories and information through digital storytelling was valued by participants to preserve the knowledge and stories of Elders that would be lost otherwise (Cunsolo Willox, Harper, Edge, ‘My Word’: Storytelling and Digital Media Lab, & Rigolet Inuit Community Government, 2012). Elders, therefore, have a role in transmitting knowledge and developing initiatives to increase the success of these information-sharing methods. These cultural attributes can provide information to co-develop relevant and effective health promotion initiatives with Inuit communities.

While there is clear support for culturally relevant tools and interventions, their overall impact on health disparities is unclear (Fisher, Burnet, Huang, Chin, & Cagney, 2007). A systematic review conducted by Fisher and colleagues (2007) examined the use of “cultural leverage” in interventions targeted to ethnic groups to reduce health disparities. They found while these interventions were developed with community members, the exact usefulness of the studies were unsubstantiated. In some instances, studies showed positive health outcomes for the interventions; however, long term impacts on health disparities were lacking evidence (Fisher et al., 2007). Similarly, studies examining various health promotion tools in Inuit communities have been considered useful (Alvarez et al., 2016; Haggarty, Craven, Chaudhuri, Cernovsky, & Kermeen, 2006; Racicot-Matta et al., 2016); however, there is a lack of empirical evidence to
demonstrate a resulting decrease in health disparities. In other instances, health promotion tools have shown promise through short-term evaluations and through community members’ demonstration of intent to change behaviour (Johnson et al., 2011; Racicot-Matta et al., 2016). At this time, there is limited knowledge on the efficacy of culturally relevant tools to reduce health disparities within Inuit communities, due to a lack of both short-term and long-term evaluations.

**Tools for Information Sharing**

Understanding cultural contexts can support the development and use of novel tools and approaches to share public health information. For instance, research has illustrated the importance of stories in public health promotion, and furthermore, the preference for visual, audio, or oral materials as opposed to written resources (Johnson et al., 2011; Latycheva et al., 2013; Racicot-Matta et al., 2016; Smylie et al., 2009). More specifically, sharing health-related information via TV series (Johnson et al., 2011), radio dramas (Racicot-Matta et al., 2016), and digital storytelling (Cunsolo Willox, Harper, Edge, 'My Word': Storytelling and Digital Media Lab, & Rigolet Inuit Community Government, 2012) have been well received by Inuit community members.

Oral narratives can reflect the aural aspects of Inuit culture, and embody the storytelling traditions of many Inuit (Pauktuutit Inuit Women of Canada, 2006), and these narratives are particularly effective when the narrator is deemed relatable (Kreuter et al., 2007; Racicot-Matta et al., 2016). Oral narratives communicated via media such as TV shows, radio dramas, digital stories, and whiteboard videos, can also be produced using participatory approaches. Participation in developing the messages, as well as the medium to communicate the messages, allows for the development of community capacity, facilitates the exchange of knowledge, and promotes cultural continuity within the community (Alvarez et al., 2016; Racicot-Matta et al., 2016). The oral
narrative must have an engaging storyline, and the ability for listeners to relate to the character (Racicot-Matta et al., 2016). For instance, Racicot-Matta and colleagues (2014) noted youth behaviour changes and increased preference for Elder narratives in radio dramas on soft drink consumption: one focus group of youth found the Elder narrative more relatable compared to the youth narrative, and both youth focus groups demonstrated interest through altered body language when listening to the Elder narrative (Racicot-Matta et al., 2016). As such, the ability to relate to the character in the story is comprised of a combination of various cultural and social factors (i.e. respect for Elders and their knowledge).

**Whiteboard Videos for Sharing Information**

One medium that is built around storytelling elements is the whiteboard video. This video format includes the animation of images drawn on a whiteboard accompanied by audio components comprised of an overlaid vocal narration, sound effects, and music. The animation shows the evolution, or development, of images, which help to visually depict and support the story. The drawings can be done by an artist on a whiteboard, or can be done using computer software. For the hand-drawn format, a camera is used to capture the motion and movement as the artist draws. From here, time-lapse editing is used to speed up the animation so the hand is viewed drawing the images faster than real-time to fit with the speed of narration. The whiteboard video is a customizable and visual tool that has the ability to include relevant pictures and colours, which is something culturally desired by many Indigenous populations (Latycheva et al., 2013). Additionally, the script and audio narration of the whiteboard video can be framed in a storytelling manner, another characteristic often culturally desired (Cunsolo Willox et al., 2012). While this is a novel medium to sharing public health information with Inuit communities, a whiteboard video was found to be appealing, relatable, and engaging by First Nations and Métis partners when it
was used to share research results with two communities located in the Northwest Territories (Bradford & Bharadwaj, 2015).

**Evaluating Public Health Initiatives**

*Established Evaluation Frameworks*

Public health programs must be evaluated to assess their efficacy and impact, and to inform decisions in regards to future development and/or implementation. There are many evaluation frameworks presented in the literature (Goodman, 1998; Tebes, Kaufman, Connell, Crusto, & Thai, 2014; Wimbush & Watson, 2000), and by various health organizations such as the Centers for Disease Control and Prevention (CDC), Public Health Agency of Canada (PHAC), Public Health Ontario (PHO), and CIHR (Bowen, 2012; Centers for Disease Control and Prevention, 1999; Milstein, Chapel, Wetterhall, & Cotton, 2002; Ontario Agency for Health Protection and Promotion (Public Health Ontario), Snelling, & Meserve, 2016; Porteous, Stewart, & Sheldrick, 1997).

The CDC outlines a cycle of six steps with four categories of standards to ensure effective evaluations. The six steps include: (1) engaging stakeholders, (2) describing the program, (3) focusing the evaluation design, (4) gathering credible evidence, (5) justifying conclusions, and (6) ensuring use and sharing of the lessons learned (Centers for Disease Control and Prevention, 1999; Milstein & Wetterhall, 2000). Central to an effective evaluation, the CDC framework incorporated four groups of standards: utility, feasibility, propriety, and accuracy standards. These standards ensure that the evaluation is designed and conducted in an effective manner. In comparison, PHAC has designed a toolkit to assist individuals with evaluation design (Porteous et al., 1997). This framework has five cyclical steps: (1) focusing the evaluation, (2) selecting methods, (3)
developing tools, (4) gathering and analysing data, and (5) making decisions. PHO provides ten steps to consider for conducting evaluations. These ten steps include: (1) clarifying the program, (2) engaging stakeholders, (3) assessing resources and evaluability, (4) determining evaluation questions, (5) determining methods, (6) developing evaluation plan, (7) collecting data, (8) processing and analysing data, (9) interpreting and sharing results, and (10) applying the findings (Ontario Agency for Health Protection and Promotion (Public Health Ontario) et al., 2016). Lastly, CIHR provides a module for evaluating health research. This module is targeted towards researchers with limited experience with conducting evaluations. As such, it is structured into five sections including (1) an overview of evaluations, (2) steps for preparing an evaluation, (3) steps for developing the evaluation, (4) a discussion of special issues in evaluation, and (5) evaluation resources (Bowen, 2012).

These frameworks have a range of steps and components but foundational to all frameworks are engaging stakeholders, describing the program, developing an evaluation design, gathering data to inform the evaluation, justifying conclusions, and sharing lessons learned. Importantly, all frameworks identify the need for stakeholder involvement to capture different perspectives, and to identify different needs and uses of the evaluation (Bowen, 2012; Centers for Disease Control and Prevention, 1999; Ontario Agency for Health Protection and Promotion (Public Health Ontario) et al., 2016; Porteous et al., 1997). These frameworks discuss the importance of focusing the evaluation plan and provide information surrounding the use of different methods, such as interviews, focus groups, surveys, and observation. While quantitative methods (e.g. surveys) can provide evaluation data for statistical analysis, qualitative methods (e.g. interviews and focus group discussions) can provide more in-depth and detailed evaluation data surrounding a particular initiative (Goodman, 1998).
Participatory Evaluations

Participatory evaluation involves the collaboration of the evaluators and stakeholders, such as the personnel delivering the program, as well as the end-users of the program (Cousins & Earl, 1992; Cousins & Whitmore, 1998). Participatory evaluation, as presented by Cousins and Whitmore (1998), includes three characteristics: control of the evaluation process, stakeholder selection, and depth of participation. Control of the evaluation process refers to the extent of control maintained by the researcher (Cousins & Whitmore, 1998). Stakeholder selection can vary from inclusion of only primary users of the program to inclusion of all possible groups (Cousins & Whitmore, 1998). Aside from an evaluation committee, other individuals tasked with implementing the plan and using the resources should be consulted as well (Wallerstein, 2000). Finally, depth of participation refers to how involved an individual will be with the evaluation. Depth of participation can range from participating as consultants for select steps or full engagement in all steps for the evaluation (Cousins & Whitmore, 1998).

As with CBPR, participatory evaluation includes community members in decision-making, and supports deep participation which can ensure that the evaluation strategies and resulting recommendations are agreeable with the end-users (Jacob & Desautels, 2013; Preskill & Jones, 2009). Additionally, participatory methods help ensure the evaluation and its recommendations are appropriate, feasible, and useable (Cousins & Earl, 1992; Cousins & Whitmore, 1998; Johnson, Toal, King, & Volkov, 2009; National Collaborating Centre for Aboriginal Health, 2013). Without consultation, the communities and the individuals tasked with carrying out evaluations may negatively view the evaluations. The evaluations can be seen as unnecessary or even a burden on individuals working as local evaluators, and the overall community (Wallerstein, 2000). Engaging
stakeholders increases diversity of perspectives, and increasing diversity can ensure the evaluation appropriately assesses the initiative (Gilliam et al., 2002; Preskill & Jones, 2009).

Participatory approaches can be used to construct culturally appropriate evaluations and can ultimately help ensure that the evaluations are valid within these diverse cultural settings (Conner, 2004). Meaningfully engaging stakeholders in the evaluation process can help develop evaluation capacity (Cousins, Goh, Clark, & Lee, 2004; Preskill & Boyle, 2008), and change attitudes towards evaluations (Preskill & Boyle, 2008). In the context of Indigenous populations, the use of participatory evaluation methods has been cited as a critical success factor in addition to the cultural context of the evaluation (Brandon, 1998; Chouinard & Cousins, 2007; Jacob & Desautels, 2013). As with health research, using participatory methods may decolonize evaluation approaches, and improve cultural validity of findings (Castleden et al., 2012; Conner, 2004).

Summary

Participatory methods can be used to develop contextually relevant public health initiatives and evaluations, as well as foster positive relationships with Inuit communities. While examples of participatory evaluation are present in the literature (Chouinard & Cousins, 2007; Cousins & Whitmore, 1998; Gilliam et al., 2002; Jacob & Desautels, 2013; Wallerstein, 2000; Zukoski & Luluquisen, 2002), strategies and tools for guiding participation of Inuit in evaluation of health programs for their communities is lacking. Further research is needed to determine approaches for participatory evaluation of Inuit health programs. Identifying and understanding these approaches is important to develop effective and impactful public health initiatives and evaluations.

Through ongoing dialogue with community partners and government employees, Inuit from Nunatsiavut identified the need for more culturally appropriate dissemination strategies.
Additionally, upon reviewing the literature, there were no specific evaluation frameworks relevant to Inuit experiences. As such, we undertook the following research goals and objectives to understand participatory public health initiative development and evaluation with our research partners from the Inuit Land Claim Agreement Area, led by the Nunatsiavut Government.

THESIS RESEARCH GOALS & OBJECTIVES

The goals of this thesis research are to:

1. Co-develop and evaluate a whiteboard video as a public health tool by:
   a. Collaboratively developing a whiteboard video about acute gastrointestinal illness (AGI) in Rigolet, Labrador, with local Inuit youth, community members, and government partners (Chapter 3); and
   b. Evaluating the short-term outcomes and perceptions of the use of the whiteboard video as a public health communication tool within the community (Chapter 4).

2. Co-develop an Inuit public health evaluation framework for use in Northern Labrador by:
   a. Characterizing Inuit identified components of effective evaluation; and
   b. Creating and validating an Inuit public health evaluation framework (Chapter 5).
REFERENCES


Table 2.1. Search terms used to find relevant literature on conducting health research, participatory evaluation of public health interventions, and effective public health interventions for Indigenous populations.

<table>
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<th>Research Topic</th>
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<th>Exposure</th>
<th>Outcome</th>
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<td>Public health program OR public health intervention OR public health tool OR public health media</td>
<td>Inuit OR cultural experiences OR examples OR evaluation</td>
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Chapter 3
A PARTICIPATORY INUIT HEALTH PROMOTION WHITEBOARD VIDEO

_Formatted for submission to the International Journal of Epidemiology
Submission Type: Photo Essay_

DESCRIPTION

Inuit culture relies on oral and visual elements, with storytelling being an important cultural tradition. These foundational values in Inuit culture can and should be used to inform and shape public health programs to garner more interest and community relevance. The goal of this project was to co-develop with Inuit youth and community members, a whiteboard video to share public health messaging surrounding acute gastrointestinal illness (AGI). Six youth from Rigolet aged 11-12 years old were involved in a three-day workshop to develop ideas for the whiteboard video. Further community feedback on the video and the youths’ ideas was obtained through a community open house. The youth and community members provided feedback throughout the process and provided approvals for the final whiteboard images. The narration was completed by a local community member. Below are still images from the 4 minute and 46 second in length video with the accompanying narration transcribed underneath. The whiteboard video debuted in Rigolet on August 30, 2016 at a video screening event (with an audience of approximately 40-50 community members) and it was also shared with health professionals, decision makers, and community members in person on August 31, 2016, and September 1, 2016. It was launched on YouTube™ (http://bit.ly/rigoletwhiteboardvideo) on September 30, 2016 and can be found at: https://rigoletwhiteboard.com. This educational whiteboard video could be an effective tool to share information and increase intention to change behaviours to prevent AGI in the community of Rigolet.
“This is Alison, Brady, Brittney, Mackenzie, Rodney, and Ryan. They are six Inuit kids living in the beautiful, remote community of Rigolet, Nunatsiavut!”
“They love being out boating, fishing, and walking on the boardwalk.”

“The health of their community matters a lot to them. So they loved how the people of Rigolet helped researchers from the University of Guelph when they came ‘round town a few years back.”
“Remember those door-to-door surveys that Inez, Marilyn, Charlie and Dina were doing? They were working with the town council and Sherilee, to understand and prevent stomach illness here in Rigolet.”

“The kids learned that there’s a lot of things that can cause these pains - like bacteria, viruses, and even a parasite. The kids call em all ‘germs’.”
“These germs can be anywhere – in water, food, the environment, and on your hands.”

“When they get inside your stomach they can give you diarrhea!”
“The good thing is that everyone gave Inez, Marilyn, Charlie, Dina and Sherilee really good information in the surveys. Based on the survey results, there’s a few things the kids want people in Rigolet to know.”

“First, the kids say it’s really important to keep your hands clean! Your hands can pass germs on to people and things - so washing them with soap and warm water is best. To get rid of all the germs, wash your hands for 20 seconds- that’s how long it takes to sing the happy birthday song twice. But don’t worry you don’t have to sing it out loud.”
“Washing your hands is extra important if you’re having belly pains – you don’t want to make others sick! You should always wash your hands after feeding or cleaning up after your pets. When you’re at the cabin, the kids say to bring hand sanitizer or have a wash basin only for handwashing. You’re less likely to get sick this way.”

“The kids say that you can also prevent belly pains by being careful when you prepare and cook food. Germs like to hang out in raw meat, vegetables, and other food from the store. Country foods can have these germs too.”
“The kids say to make sure to wash your fruits and vegetables before you eat them.”

“You also wanna make sure any food you’re cooking isn’t spoiled. Keeping your food real cold is a good way to keep it free from germs, because they really don’t like cold temperatures.”
“These germs don’t like hot temperatures either, so cooking your food all the way will destroy the germs. These things can really help prevent those hard pains.”

“The other thing to think about is water. The kids and their families usually go to nearby brooks for water – but after a heavy rainfall, or a big snowmelt, more germs end up in the water – so after it rains, boil the water hard before you drink it. This is more important now with changing weather patterns caused by climate change.”
“The kids learned that an even bigger problem is that your water containers can have germs in them too. So, your dirty containers can turn clean water into dirty water!”

“So when refilling your jug, you shouldn’t just rinse it – you should use hot soapy water or a bleach solution to clean everything that comes into contact with your water. After cleaning, remember to rinse with clean water, to get rid of any leftover soap or bleach!”
The kids learned some important stuff from the surveys that will help Rigolet be healthier. The kids are going to keep doing these things with their families - they will be washing their hands often, cleaning their cooking surfaces, carefully preparing and cooking their food, boiling brook water after it rains hard, and cleaning their water containers regularly.

“They’re really glad this research was done and it couldn’t have been done without all of your help – so thanks Rigolet for keeping the community safe and healthy!”
Research Team


Special thanks to the funders & others that provided their expertise

FUNDERS:
Chapter 4

PROMOTING INUIT HEALTH THROUGH A PARTICIPATORY WHITEBOARD VIDEO

Formatted for submission to the Canadian Journal of Public Health
Submission Type: Innovations in Policy and Practice

ABSTRACT

SETTING: The Inuit community of Rigolet, located in the Labrador Inuit Land Claim Area, experiences high rates of self-reported acute gastrointestinal illness (AGI) compared to southern Canada.

INTERVENTION: A whiteboard video tool was collaboratively developed with Rigolet youth, community members, and key regional stakeholders to share public health recommendations for reducing the risk of AGI. The video debuted in Rigolet at a community event in August 2016 and was later provided online for community members, and local and regional health departments. The research team evaluated the efficacy of the video, to share and facilitate retention of public health information based on evaluation strategies identified by community members, government representatives, and researchers.

OUTCOMES: Community and government viewers reported the whiteboard video was novel and engaging. Evaluation participants articulated that the video was suitable for promoting Inuit health due to the use of locally-relevant visuals and a narrative, which reflect art and storytelling traditions of Inuit. Furthermore, participants indicated the opportunity for community members to contribute to and co-develop the video was meaningful and ensured relevance of the video to community members. Short-term outcome results suggest that the whiteboard video is likely to reinforce health knowledge and encourage behavioural change.
**IMPLICATIONS:** The results suggest this educational whiteboard video will likely be an effective tool to share information and increase intention to change behaviours to prevent AGI in the Inuit community of Rigolet. Furthermore, this medium may be a useful health promotion tool among other Inuit and other Indigenous communities in Canada.

**Keywords:** Inuit, health promotion, community-based participatory research (CBPR), acute gastrointestinal illness, Nunatsiavut, whiteboard video

**INTRODUCTION**

Indigenous people of Canada often experience disparities in health outcomes,\(^1\)\(^2\) including higher incidence rates of infectious disease, higher prevalence of chronic diseases, and lower life expectancies when compared to the Canadian average.\(^3\)\(^7\) These disparities can be attributed to social determinants of health, including colonial legacies, socio-economic status, access to healthcare and public health services, food insecurity, racism, and social exclusion.\(^8\)\(^9\)

The Truth and Reconciliation Commission of Canada and its seven health-related Calls to Action represent a renewed commitment to “close the gaps in health outcomes”\(^10\) p.2 between Indigenous and non-Indigenous communities in Canada.\(^10\)\(^11\) Indigenous scholars have posited that past attempts to close these gaps have been ineffective because “externally imposed strategies fail to take into consideration local understandings of health and illness and local mechanisms of sharing knowledge”.\(^2\) p.436 Indeed, research indicates that communities and individuals are more likely to change health behaviour when public health interventions are culturally appropriate and locally relevant.\(^12\)
Research suggests that for Indigenous Inuit in Canada, preferred public health promotion tools reflect cultural values, such as using storytelling to share information, and developing skills through observation.\textsuperscript{2,13–17} Whiteboard videos are a novel public health tool, which incorporate visual, audio, and oral elements with a narrative and storytelling component. The whiteboard video depicts live, hand drawing images on a whiteboard, which has been recorded and sped up to match an audio component consisting of an overlaid vocal narration, sound effects, and music. Considering the need for contextually relevant tools to share and facilitate retention of Inuit health information, the goal of the project was to co-develop a whiteboard video with Inuit youth, community members, and government partners, and evaluate its efficacy to share and facilitate retention of public health information about acute gastrointestinal illness (AGI) in Rigolet, Labrador.

\textbf{SETTING}

Rigolet is one of five remote communities in the Labrador Inuit Land Claims Area (hereafter referred to as Nunatsiavut), governed by the Nunatsiavut Government. The community has a population of 305 residents with 155 males and 150 females, and 84\% of residents identify as Inuit.\textsuperscript{18} Rigolet is a young population, with approximately 24.6\% of the population under the age of 18.\textsuperscript{18} The town is remote and only accessible by plane during the year or by boat/ferry service during the summer. Residents engage in many cultural outdoor activities such as hunting, trapping, fishing, and gathering food.\textsuperscript{19,20} Spending time on the land is important to cultural identity and Rigolet residents often visit cabins located outside of the community to engage in cultural activities, including hunting, and fishing.\textsuperscript{20,21} Rigolet youth also spend time on the land with their
families, while also participating in other activities such as spending time with friends, playing sports, and using social media such as Facebook™.22

**Acute Gastrointestinal Illness in Rigolet**

AGI is characterized by symptoms of acute vomiting and/or diarrhea.23 The estimated annual incidence of self-reported AGI is three times higher in Rigolet than southern regions of Canada.24 Furthermore, Rigolet community members infrequently seek medical assistance for AGI symptoms, limiting the ability to successfully apply Euro-centric systems of enteric illness surveillance.25,26

**INTERVENTION**

**Whiteboard Video Development**

A whiteboard video was co-developed with Inuit youth in Rigolet, with input from community members, government representatives, and researchers. The goal of the video was to disseminate research results,19,24,25 and public health information to community members on how to reduce the risk of AGI. Co-creating the whiteboard video involved the following iterative steps: (1) identifying need for the video, (2) video planning (including identifying and developing public health messages to be communicated), (3) illustrated storyboard development, (4) narration and music selection, (5) video production and post-production editing, and (6) video dissemination (Figure 4.1; Appendix A).

**Community Engagement for Whiteboard Video Development**

Over the years, ongoing dialogue and communication among the community, the research team, public health practitioners, and government representatives indicated that a novel, participatory approach was needed to share information with community members in a way that
reflects and respects Inuit culture. As a result, a whiteboard video medium was suggested to community research partners as a method to share health information about AGI. Numerous community engagement and collaborative development methods were employed throughout the development, production, and dissemination stages of the video, including a youth workshop, community open houses, government stakeholder meetings with regional Nunatsiavut Government partners, semi-structured interviews, and focus group discussions. In addition, the research team maintained close contact with participants via in-person meetings, telephone calls, emails, and social media communication with youth, other community members, health practitioners, and government stakeholders.

**Youth Engagement**

Youth aged 11-12 were invited to participate in a three-day workshop in Rigolet in July 2015: six youth (3 males and 3 females) participated, representing majority of Rigolet youth in this age group. The workshop introduced the youth to the project and the whiteboard video concept and used activities to develop whiteboard video components, including community relevant public health messages, script language, character look, character names, local visuals, and local narrators (Figure 4.2 A-D and Appendix B). In December 2015, the youth reviewed and selected character elements for the video, and the youth attended a group meeting in May 2016 to review the illustrated storyboard and provide feedback. Throughout the process, a Facebook™ group was used to exchange information about the video and its development with the youth.

**Community Open Houses**

A series of community open houses were hosted in Rigolet from July 2015 to May 2016 to engage community residents in the co-development of the whiteboard video (Figure 4.2 E-F). First,
a community open house in July 2015 was used to introduce the whiteboard video project to the community. Community members were invited to participate in activities at three stations. The stations provided community members with an opportunity to (1) view a sample whiteboard video to understand the concept and approach; (2) review the youths’ ideas (obtained and summarized from the youth workshop), public health messages to be communicated by the video, and script for the video; and (3) complete a survey to provide feedback on youth’s ideas, images, and script for the whiteboard video, as well as provide information about health information seeking behaviour. Additional research open houses featured updates on the progress of the whiteboard video and elicited feedback from community members. The final community open house was held in May 2016 to share illustrated whiteboard images and clips of the recorded narration, and receive feedback from community members.

**Interviews & Focus Group Discussions**

Interviews and focus group discussions were conducted initially to capture whiteboard development ideas and, subsequently, evaluations of the final video product (Figure 4.3, Appendix C-E). Both methods were used to collect relevant information given the geographic distribution of participants, timing and availability, and other study logistics. Locally based key decision makers, health professionals, and community members, in Rigolet, and regional Nunatsiavut Government partners, in Happy Valley-Goose Bay, were invited to participate in audio-recorded, semi-structured interviews and focus group discussions that took place in person, in Rigolet and Happy Valley-Goose Bay in July 2015 and late August/early September 2016. The interview and focus group discussions conducted in July 2015 addressed participants’ opinions on the whiteboard video, identification and development of public health messages to be communicated in the video, and the use of whiteboard videos in the community to share health information (Appendix C and
The interviews and focus group discussions conducted in late August/early September 2016 addressed participants’ opinions and evaluation of the final whiteboard video product (Appendix E).

**Whiteboard Video Release**

The whiteboard video debuted in Rigolet on August 30, 2016 at a video screening event. There, surveys (Appendix F) were used to collect community perspectives on the whiteboard video as a medium for communication and the final whiteboard video tool. The video was also shared with local health professionals, decision makers, and community members in person on August 31, 2016, and regional health professionals and decision makers on September 1, 2016. It was launched on YouTube™ on September 30, 2016. At the time of writing, the video is available online through the project website (https://rigoletwhiteboard.com), YouTube™ (http://bit.ly/rigoletwhiteboardvideo), and Facebook™ (http://bit.ly/rigoletwhiteboardfacebook), and was delivered to local and regional health authorities via USB and the online link.

**Evaluation Data Analysis**

Interviews and focus group discussions were analyzed using thematic analysis. Verbatim transcripts were produced from the audio recordings, and a research team member coded the transcripts by paragraph/idea. Coding was facilitated by the qualitative analysis program ATLAS.ti (Version 7.5.10). A research team member then grouped codes to develop themes surrounding the efficacy of the video development process, as well as using a whiteboard video for sharing public health information. Peer debriefing was used to ensure trustworthiness of the findings. The research team member shared themes and interpretations with other research team members.
to ensure validity. Verbatim quotations have been provided to provide context and square brackets have been used, where appropriate, to clarify participant responses.

A member of the research team examined responses to surveys from the research open houses and video screening to generate exploratory proportions using statistical software StataSE 14. The research team member explored questions pertaining to narration, language, use of video to share information, and intent to change behaviour.

**OUTCOMES**

A short whiteboard video (4 minute and 46 seconds) was produced discussing locally developed public health messaging about ways to reduce the risk of AGI, including washing hands, preparing food, consuming brook water, and cleaning water containers (Figure 4.4). Information was collected from 54 individuals over the course of the video development, and 37 individuals during evaluation of the video (Figure 4.3).

**Overall Perceptions of the Whiteboard Video Medium**

All participants in the evaluation of the final whiteboard video responded positively. When the whiteboard video project was introduced in July 2015, the whiteboard video medium was found to be engaging, with participants stating that the tool was “different”, “eye-catching,” and that “it [does] keep your attention”. During evaluation of the final whiteboard video, participants explained that the video was engaging and helped to reinforce public health messages because of the novelty of the tool and the stimulation of both aural and visual senses. As one interviewee stated,

“See, you got the audio from Jack [the local narrator] talking, and the music, and you got the visuals from the pictures, and then you got the list [of public health action items] that you’re actually reading along with. So, I mean you got three different ways to remember [the public health message], right?”
Respondents perceived the whiteboard video format to be more memorable, “interesting,” and “better” than other public health promotion tools such as posters, pamphlets, and other video formats. All community members who completed a survey reported that the video was a good way of sharing the information. Furthermore, participants believed that the contextually relevant features of the video (i.e. community images, personal connection to video participants, and language) and community engagement process in creating the video played a role in the positive response of community members to the content of the video. As a regional health professional described,

“I really like the graphics ‘cause they’re as local as you can get. Like, it is Rigolet ... It’s very local, that’s what’s very good. People are going to relate to the images, they’re going to relate to the people, even though it’s cartoon. And people pay more attention when it’s in their context and it’s things that are familiar to them. So, I liked it [the video] for sure.”

Another regional health professional stated about the video,

“You can tell by looking at this that it was done right. Because I looked at other [public health promotion] products... [that are] supposed to be for Aboriginal Inuit, and the graphics are not applicable at all. So, it goes to show that the engagement that you have with the community came across in the video.”

The Whiteboard Video Narrative

The overall whiteboard video narrative, including the local voice, language, and storytelling feel, were also positively received. The youth decided to use a local community Elder as the narrator for the video because they felt he was an authoritative figure and had a distinct voice. Many community members enjoyed the narrator choice, stating it was familiar, distinct, and authoritative. Additionally, one respondent brought up “tradition,” saying that Elders “have the most clout and most say.” Multiple community members suggested that the voice of the youth
participants should have been included as well because it would have added to their ownership and participation in the video. Aside from the local Elder who was enlisted, some participants stated that any person could have done the narration, although they expressed that a local voice was “more effective.”

Participants emphasized the importance of language at the community level and the importance of a local narrator. Nearly all survey responses rated the language as being “easy” or “slightly easy” to understand. Additionally, the majority of community survey respondents stated they “really liked” or “somewhat liked” the narration, and that they “really related” or “somewhat related” to the voice used in the narration. One government employee discussed the use of clear language and a local narrator in the final video, stating,

“You almost notice when you have more of clinical language [in public health messaging] ... People sort of stumbling over their words or you can tell this is not at all what they’d be speaking about normally. So, I found you really merged that really well so it sounded as though Jack [the local narrator] could have actually been [saying those public health messages] if you went up to his office and had a cup of coffee.”

Intent to Change Behaviour

Participants believed that the whiteboard video reinforced knowledge and awareness, and helped to motivate intent for behavioural change towards the adoption of AGI prevention practices. Through the surveys, nearly all of respondents stated they would follow one or more of the tips outlined in the video. Through a focus group, a regional Inuit health professional discussed her experience with the messaging regarding cleaning water containers, stating,

“For me personally, I grew up in a community where there was no running water ... People go pick up their water using buckets and dippers. And I mean, I worked at DHSD [Department of Health and Social Development] as a nurse and I never really thought of telling mom [about safe water handling tips] ... But I guarantee when I go home this evening and talk to them that’s the first thing I’m going to
say. That’s the first thing I’ll say because I never thought about it, so already I can tell you if it’s having that sort of transcending effect on me; it will have a transcending effect on other people who are living in the communities and have those practices.”

This sentiment was expressed by local community members who also discussed messaging from the video that stood out to them and was now visually “engrained”. One community member stated,

“Now I have these images. So, right now as I think of washing my hands, I think of those balloons and [the narrator] saying sing happy birthday twice ... Or further on, the germ lying back in the container floating around. You know? I mean those images are there, so when I look at my [water] container there.... I’ll think about it.”

**Potential Uses for the Video**

Participants noted that the video was “good” and “useful” for all age groups in the community. A local health professional stated that she felt her “playgroup kids which are 3 and 4 year olds would understand that.” Another community member stated about the video, “I’m sure it would be useful for anyone in Rigolet. Like, even the seniors.” Additionally, both local and regional health professionals expressed the possibility of using this tool in collaboration with existing public health programs for school children. Due to the short video length, the tool was also seen as being easily screened to other groups by targeting locations or situations in which they already congregate, such as “card games over to the DHSD [building], the seniors’ building, and then [the youth] like to congregate at the youth centre...Anywhere there is a gathering of a group of people, just put the video on.”

**IMPLICATIONS**

This study showed that whiteboard videos can be an effective tool to deliver health messages. In Indigenous communities, the whiteboard video provides a means of communication
that is different from historically written forms of health communication. The whiteboard video can be shared easily via social media, which is an important communication platform for many Indigenous communities. For instance, Facebook™ is a social media site widely used in Rigolet and neighbouring communities in Nunatsiavut to communicate and maintain networks with individuals across the region. Indeed, the ability to share the video through social media complements the cultural importance of social networks in many Indigenous communities, reflects the role that social support networks often play in promoting Indigenous health, facilitates peer-to-peer sharing of information within the community, as well as allows individuals to contextualize and discuss the information in the video. Considering the ability of the tool to share health information that is customized to local contexts, the whiteboard video can serve as an engaging tool to disseminate Indigenous public health messages.

Lessons Learned

This paper outlines an innovative example of how participatory approaches can be used to co-develop an effective communication tool to share Inuit public health information. While we present an example of a whiteboard video communicating AGI prevention messages in one Inuit community, this medium and process can be applied to other public health topics in other communities. This medium and process can work particularly in remote communities given the ability for the video to be easily shared and customized to include pictures, colours, and narratives that are locally relevant and culturally desirable.

The lessons learned through the process were reflective of challenges and opportunities identified more widely within community-based participatory research and evaluation strategies, including time, funding, and developing trusting relationships. Based on our evaluation results
and reflections by the team, we believe that meaningful collaboration was foundational to the success of the tool. Indeed, partnerships and collaboration between community members and health practitioners are key to developing successful public health programs that address community concerns.\textsuperscript{35} We strove to create meaningful, reciprocal, and respectful partnerships with community and regional partners throughout the project.\textsuperscript{39,40} Importantly, these community and regional partners collaboratively engaged in agenda setting and decision-making throughout the health tool development and implementation. This is critical in moving from involvement of community members in the process, to meaningful collaboration, where community members not only contributed to, but controlled the program, including identifying what topics should be addressed to how to address them. Meaningful collaboration has immense implications when applied in a context that has historically been disempowering through the imposition of research activities on Indigenous communities.\textsuperscript{37,40–43} The team was also cognizant that this form of participation can also unintentionally exclude some people;\textsuperscript{36,39,40} as such, we were attentive to who was (and was not) participating, in what capacity, and to what end. For this project, these discussions with partners led to the identification and subsequently, engagement and collaboration of youth to be agents of local community change.\textsuperscript{39} Finally, these meaningful collaborations and partnerships ensured that our process and the whiteboard video respected, reflected, and built from local social networks, which helped facilitate sharing and exchange of public health information in a way that was culturally appropriate and locally relevant.\textsuperscript{36,44}

**CONCLUSIONS**

Contextually relevant tools and programs developed through participatory methods can improve the acceptance and retention of health information in Indigenous populations. This project aimed to create a contextually relevant whiteboard video, through participatory methods in
partnership with the Inuit community of Rigolet to share public health information about AGI. Results indicated that the video was positively received and encouraged discussion around the messaging provided. Reflections on the positive response to the video indicated that the collaborative and participatory approach was a success. Creative contextually relevant approaches to sharing public health information, such as whiteboard videos could encourage sharing and retention of public health messages to change health behaviour and reduce burden of illness.
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Figure 4.1. The participatory whiteboard video development process used in a public health campaign to share public health messaging around acute gastrointestinal illness in Rigolet, Canada.
Figure 4.2. Illustrative photos of community events used for the co-development and presentation of the whiteboard video with Rigolet community members, health professionals, and decision makers. A-D: Youth workshop activities and outcomes, E-F: Community open house to share work of youth and obtain community input.
Figure 4.3. Description of interviews, focus group discussions, and surveys conducted in Happy Valley-Goose Bay and Rigolet, Canada in July 2015 and August/September 2016, including location, number of participants, participant characteristics, and average duration of each data collection activity.
Figure 4.4. Images from the whiteboard video “Keeping Stomach Illness Out of Rigolet”. Images share messaging around (A) washing hands for 20 seconds, (B) storing food appropriately, (C) cooking food thoroughly, (D) boiling brook water after heavy rain and snowfall, and (E) cleaning water containers. (F) A summary list of all key messages described through the video was also provided at the end of the video.
ABSTRACT

Objectives: This study identified and characterized components of participatory evaluation of Inuit public health initiatives, and then developed and validated an evaluation framework for use in Northern Labrador.

Methods: Semi-structured interviews (n=7) were conducted throughout Northern Labrador with health professionals and decision-makers. To provide community-level perspectives and to contextualize the insights provided by regional stakeholders, semi-structured interviews (n=11) and three focus group discussions (n=13 participants) were conducted with groups of health professionals, decision-makers, and community members in Rigolet. Thematic analysis was used to inductively identify and characterize components necessary for Inuit public health evaluations. Then, these Inuit-identified components were used to create an Inuit public health evaluation framework. The evaluation framework was then piloted and validated by applying it to evaluate a whiteboard video that was used to share public health information regarding acute gastrointestinal illness in Rigolet.

Results: Four foundational components were identified as important for the evaluation of Inuit public health initiatives: (1) community engagement, (2) collaborative evaluation development, (3) tailored evaluation data collection, and (4) evaluation scope.
Conclusions: The results of this project highlighted foundational components for an Inuit public health evaluation framework, which can be used to encourage engagement and application of strategies for meaningful evaluations.

Keywords: participatory evaluation, Inuit, health services, health protection, health promotion, public health, Nunatsiavut

INTRODUCTION

In recent years, public health institutions have increasingly invested in developing evaluation capacity (1–5) and widely advocated that evaluation activities should be inseparable from public health practice (6). Evaluations are important to understand the use and impact of a given effort, ranging from evaluating the impact of specific health tools to entire health programs (7). There are multiple evaluation frameworks that can be used to evaluate health efforts. For instance, frameworks have been put forth by the Public Health Agency of Canada (PHAC), Public Health Ontario (PHO), the Centers for Disease Control and Prevention (CDC), and Canadian Institutes for Health Research (CIHR), among many others (6,8–13). Many of these commonly used evaluation frameworks identify ‘critical’ steps such as engaging stakeholders, describing the program, developing an evaluation design, gathering data to inform the evaluation, justifying conclusions, and sharing lessons learned in the evaluation process (8–10).

While the importance of evaluation is widely acknowledged (11,12,14), public health studies have indicated that evaluation resources, skills, and institutional support are still often lacking and research in this area is generally underdeveloped (15–17). Meaningfully engaging stakeholders in the evaluation process can help address these challenges (18), as it helps develop evaluation capacity (17,19), changes institutional and personnel attitudes towards evaluations (19),
and improves the ability to evaluate complex programs (20). Engagement of stakeholders also brings in diverse perspectives, which can contribute to ensuring the evaluation adequately assesses the contextual relevance of the initiative (18). Indeed, it is well established that engaging stakeholders is a crucial step in health program evaluations; however, understanding how to best engage stakeholders in evaluation is less clear.

One increasingly popular approach to engaging stakeholders in health evaluation is the use of participatory methods (18). Participatory evaluation methods simultaneously engage evaluators and end-users to ensure evaluation strategies generate appropriate, feasible, and helpful recommendations for end-users (7,21,22). Furthermore, when evaluators and end-users are not involved in the development of the evaluation, they may view the evaluation as unnecessary, burdening, or irrelevant (23). With a participatory approach, the evaluation and the resulting recommendations are often valued by evaluators and end-users (24,25).

In the context of Indigenous health programming, there is limited research investigating how to adapt or create new evaluation methods to be culturally sensitive and locally appropriate (26,27). Of the research that has been conducted, the use of participatory evaluation methods has been cited as a critical success factor (26–28). Participatory methods in evaluations can facilitate the inclusion of the Indigenous worldviews of evaluators and/or end-users; worldviews that are crucial to understanding how health initiatives address health disparities. As such, similar to the use of participatory methods in health research (29), using participatory methods may help to decolonize evaluation approaches. Furthermore, participation in evaluation can ensure that contextually relevant information is identified and culturally appropriate methods are used, leading
to contextually relevant evaluations and, ultimately, improvements in the adoption of recommendations to improve public health initiatives (30–32).

Considering there is limited research investigating how to meaningfully engage stakeholders, and even less research investigating public health evaluations in Indigenous contexts, the goal of this study was to co-develop an Inuit public health evaluation framework for use in Northern Labrador, Canada. Specifically, the objectives were to: (i) characterize Inuit identified components of effective evaluation, and (ii) create and validate an Inuit public health evaluation framework. While this framework was co-developed by and for Inuit in Northern Labrador, it could be applied to other Indigenous contexts.

**METHODS**

**Nunatsiavut Land Claim Area**

The Labrador Inuit Land Claim Agreement Area (hereafter referred to as Nunatsiavut) spans the northern coast of Labrador and contains five communities (south to north): Rigolet, Postville, Makkovik, Hopedale, and Nain (Figure 5.1). Nunatsiavut is governed by the Nunatsiavut Government at regional levels, and Inuit Community Governments at the municipal levels. The Nunatsiavut Government carries distinct roles and authority, covering areas such as health and social development, education and economic development, culture and language, lands and natural resources, finance and human resources, justice, and community matters (33).

**Research Approach**

A community-based, participatory approach guided the research process (29); Inuit led the identification of the research question, co-designed the data collection methods, participated in
data collection, contributed to interpreting the results, and participated in all results sharing activities (i.e., community events, conference presentations, publications).

Data Collection and Analysis

This qualitative study used modified grounded theory (34) to explore participant perspectives and experiences to develop, apply, refine, and finalize a novel Inuit public health evaluation framework. Data collection occurred at regional and local levels. At the regional level, participants included key stakeholders who act as health initiative evaluators and/or end-users, including government representatives, health professionals, and decision-makers. To provide community-level perspectives and to contextualize the insights provided by regional stakeholders, additional data were captured from community members and local health professionals in Rigolet, Canada. There were two iterative steps of regional and local data collection and analysis: (i) identifying and characterizing components of effective evaluation, and (ii) co-creating and validating an Inuit public health evaluation framework.

Step 1: Identifying and Characterizing Components of Effective Evaluation

A series of semi-structured interviews (35) and focus group discussions (36,37) were conducted to capture the experiences and perspectives of community members, health professionals, and decision-makers regarding components of effective Inuit public health evaluation (Figure 5.2). Using interviews and focus group discussions allowed participants to decide how they would want to participate and provide input.

Regional and Local Data Collection: Interviews

Semi-structured interviews were conducted in July 2015. The interview guides were developed, tested, and revised prior to their use by sharing the guides with a local research team.
member (Appendix C). Questions for regional health professionals and decision-makers covered their: (i) experiences with developing, implementing, and evaluating health initiatives, (ii) perspectives on participatory evaluation of Inuit health initiatives, and (iii) logistical experiences with evaluations including personnel, procedures, metrics, tools, outcomes, and timing. Questions for community members and local health professionals in Rigolet covered their: (i) experiences with health initiatives, (ii) perspectives on their participation in the evaluation of Inuit health initiatives, and (iii) perspectives on evaluation strategies including, personnel, procedures, metrics, tools, outcomes, and timing. Participants were identified using purposive sampling (38) to capture a breadth of perspectives from health professionals who deliver public health programming, decision-makers who shape public health policy, regional government employees, and community members who receive public health services. The interviews were conducted in English (the first language of participants) (39) and were audio-recorded with permission.

**Regional and Local Data Collection: Focus Group Discussions**

Focus group discussions were conducted in July 2015. Focus group discussions covered similar questions and topics to the interviews, including participants’ experiences with health initiatives, and their perspectives on their participation in evaluation of Inuit health initiatives and evaluation strategies. Focus group discussion guides (Appendix D) were tested and revised prior to their use by conducting a mock focus group with researchers and sharing the guides with a local research team member. Similar to the interviews, purposive sampling (38) was used to identify participants. Participants in the focus group discussions were adult community members, local health professionals who deliver public health programming, and regional government employees. The discussions were conducted in English (the first language of participants) and were audio-recorded with permission.

68
Data Analysis: Thematic Analysis

Audio-recordings of interviews and focus group discussions were transcribed verbatim to produce transcripts for analysis. Thematic analysis (40) and a constant comparative method (41) were used for analysis of the qualitative data (Figure 5.2). First, transcripts and audio recordings were reviewed repeatedly to facilitate familiarity with the data (40). An inductive approach was used to identify ideas and concepts from the data; as such, participant responses were separated from the questions during analysis (40). Initial manual coding (i.e. generating and applying a label to a section of data) (40,42) was done per sentence or paragraph (40), facilitated by the computer software program ATLAS.ti (Version 7.5.10). Codes were compared, assessed, and then collapsed into a more condensed list of codes (40) to create a codebook (42). Finally, the codebook was reapplied to the transcripts. The coded segments were then organized into larger themes; each theme reflected a component of effective public health initiative evaluation (40).

Member checking was used to ensure the identified components of effective evaluation were characterized accurately and consistent with participants’ perspectives and experiences (43). Individuals who had participated in either semi-structured interviews or focus group discussions were contacted to review the components and provide feedback in-person in May 2016. Discussions took place surrounding the accuracy, usefulness, and relevance of the identified components of effective evaluation.

Step 2: Co-Creating and Validating an Inuit Public Health Evaluation Framework

The Inuit-identified components of effective evaluation characterized in the inductive thematic analysis were compared to evaluation frameworks created by the CDC (11), PHAC (8), and PHO (10). The components were compared to existing frameworks and theories to determine
whether an entirely new framework should be created or existing frameworks could be synthesized and adapted to be relevant and appropriate to evaluate Inuit health initiatives. Members of the research team from the region were then consulted via telephone meetings to validate the Inuit health evaluation framework. Using their feedback, the framework was refined accordingly.

For further validation, the evaluation framework was piloted by using a public health tool created for Rigolet. The evaluation took place from August 30, 2016 to September 2, 2016 in Happy Valley-Goose Bay and Rigolet (Appendix G). The tool was a whiteboard video co-developed with Rigolet community members to share public health information about acute gastrointestinal illness. Details of the whiteboard video co-creation process and preliminary evaluation results can be found in Chapters 3 and 4. Throughout the evaluation of the whiteboard video, peer debriefing, triangulation, member checking, collaboration, and audit trails were used to reflect on the evaluation process and inform changes to produce the final framework (43).

The research protocol was approved by the Nunatsiavut Government Research Advisory Committee, and the Research Ethics Boards at the University of Guelph (REB: 15MY015).

RESULTS

Eighteen interviews and three focus groups were conducted (n= 34 participants, Figure 5.2). To validate the framework components, 18 out of the original 34 participants, and 2 additional local health professionals participated in individual or group member checking activities.
Evaluation Framework Components

Four themes representing foundational components of an Inuit public health evaluation framework were identified from data analysis: (1) community engagement, (2) collaborative evaluation development, (3) tailored evaluation data collection, and (4) evaluation scope.

Component 1: Community Engagement- Understanding Motivators and Barriers

Interview and focus group participants emphasized the importance of including community members in evaluations. Participants’ identified two roles that community members could have in evaluations: (i) evaluators and/or (ii) sources of evaluation information. Participants highlighted the importance of leveraging motivators and overcoming barriers to engaging community members in evaluations, which included highlighting the importance of the topic, facilitating inclusive engagement, and ensuring local relevance of the evaluation.

Perceived Importance of the Evaluation Topic: Regional health professionals, regional decision-makers, and local community members discussed the impact of public interest in the evaluation topic on participation. One community member suggested that the topic must be perceived as being personally important, commenting, “for hand washing, some people might think it’s not important... But if you went to the community and said we’re going to do an interview on eating seal meat... then, you might get a higher number [of participants].” To generate interest in the evaluation topic, participants recommended engaging with the media to facilitate recruitment. For instance, a health professional reflected on times when there “was a lot of media [coverage] around [a health topic]” and “it worked.” Furthermore, participants believed one could foster interest in participating in an evaluation by highlighting its importance and relevance to the potential participants. As one regional health professional and decision-maker stated,
“You give the communication from the onset as to what the objective is, that you want to look at health care provision in the community for the betterment of the community...you just have that at the top of every evaluation; or in every focus group, that’s the very first thing you talk about. That kind of keeps it cemented in people’s minds that you’re not just picking ‘cause you’re a nosy parker; you actually want to help to make the healthcare experience as positive as it can be.”

**Inclusive Engagement:** Participants discussed several methods that could be used to engage community members in evaluations, often valuing “community events” and “community meetings,” which reflect the collective values of many Inuit. For instance, one participant stated that the “community loves events” and explained that providing food at events attracts “the biggest crowds,” which reflects Inuit food sharing values. One regional decision-maker stated that “interactive” community displays also effectively reach large numbers of people and generate discussion in the community. While community events were valued, participants recognized that community-level events might unintentionally exclude people, as “some people might not go.” Furthermore, participants explained that community meetings might deter individuals from providing input due to discomfort with providing opinions publicly. As such, participants recommended that opportunities for individual-level engagement are also critical, and could include “household visits” or other forms of “one-on-one contact”; one community member stated “door-to-door” is the “best way to get to people.” Another community member highlighted the need for multiple options for individuals to be involved, explaining,

“Some people will do an interview, [but] they’ll never go out to an open house. But some people will go to an open house, but will say “nah, I don’t want to do an interview,” you know? ... it’s best to reach all the people or the majority of the people, and so maybe different ways of doing things are a good idea.”

Seeking individual-level feedback was perceived as particularly important because “self-doubt” was believed to be a barrier to participation. One community member explained, “some
people might think they don’t know anything about what’s happening... ‘lotta people thinks there’s a right and wrong and then they don’t give it [their opinion].’” A regional decision-maker described a potential method to overcoming this barrier to participation, stating that it is important to make the individuals feel “valued” and express the significance of them sharing their knowledge.

Local Context: One regional health professional and decision-maker described the importance of understanding key characteristics of the community, such as motivators, incentives, and locations to facilitate engagement. She explained,

“Definitely, you definitely have to keep community context [in mind]. You need to know what’s happening, not to plan [the evaluation] on a Bingo night. You need to know... the best way to motivate people or the best incentives, best location for things, and the community dynamics, and ways to engage. If you want to talk to young mothers about marital relationships or something, it’s best to go when most kids are in school and husbands are at work. So, those kinds of community context things [matter].”

Relatedly, regional and local participants identified “participation fatigue” as a major barrier to community engagement in evaluations. For instance, a community member identified issues with interviews being used too often within the community, stating, “almost every time the phone rings, ‘somebody calling you to do an interview.’” Participants also highlighted the need to understand the timing, interest in, and frequency of other events occurring in the community. For instance, one decision-maker described,

“Presentations [are] becoming redundant in the community. And, you know, if you’re coming in a week where they’ve had two [presentations] before that, ... the third one, no matter how interesting it is, the attendance is probably going to be lower for that one than it probably was for the first one.”
Component 2: Collaborative Evaluation Development - Working Collectively with Community Members to Develop the Evaluation Plan

Participants identified the need for regional and local health professionals and decision-makers, as well as community members to be involved in developing an evaluation plan. One regional health professional highlighted the importance of establishing an “evaluation committee.” She indicated,

“Most [evaluation] research projects, I would hope, that there is already a committee established that would be overseeing some of it and the community would be engaged... But, definitely, there needs to be community buy-in and there needs to be people that were involved in the program planning that can identify who the target group was, who the participants were, all that sort of thing.”

Participants indicated that the evaluation committee needs to include external evaluators and community members to capture different perspectives. One community member explained,

“It’s definitely needed to have Inuit people run their own programs, alongside of the [evaluation] researchers from outside. I think that’s a good idea, because the [evaluation] researchers have the knowledge of how to carry these things out, whereas the Inuit have knowledge of what works within their communities. I think it definitely involve us [Inuit] in every stage of the process.”

Furthermore, participants discussed the importance of local community evaluators. One community member explained that the local community evaluator “can go and talk to people and explain things to them, instead of... [an outside evaluator determining] this is the program you’re having here.” One decision-maker stated that a local evaluator could explain, “this is what [we’re] doing, would you like to participate? I feel comfortable with that,” which illustrates the importance of engaging community in developing and conducting evaluations.
Component 3: Tailored Data Collection- Capturing High Quality Evaluation Information

Regional and local participants suggested that diverse and all-encompassing evaluation data must be captured in a manner suited to the participants. This notion was comprised of two subthemes: (i) considering diverse evaluation information and perspectives, and (ii) using a mixture of evaluation methods that are tailored to participants.

Diverse Evaluation Information and Perspectives: Many participants, particularly regional health professionals and decision-makers, explained different end-users and evaluators have a range of evaluation information and perspectives, and these must be represented in evaluations. Two regional health professional and decision-makers described this idea in terms of, “asking the right questions of the right people.” One regional decision-maker further explained that using a set of questions or methods standardized for southern populations is not appropriate in the North:

“I find that with a lot of Health Canada evaluations, they have a standard list of questions that they ask everyone. And, I understand why that is from an evaluation perspective, but a lot of the people at the community level don’t really understand some of the questions because they don’t have that [Southern] perspective.”

Another regional health professional expressed, “a variety of people [need to be] engaged depending on the program,” suggesting that evaluations involving only one type of stakeholder provides a limited perspective. This regional health professional commented on the importance of community engagement, but further elaborated,

“I think if we do a program evaluation with just people who are participants in the program, or at the community level, I think that gives us one sense of how effective people felt it was, but I think you also need that higher level perspective sometimes about how well did it fit into the bigger picture, what were some of the stumbling blocks to implementing, like all of those kinds of things.”
She further described differences in information that community members, “frontline staff,”
“middle” management, and “top” management can provide for an overall program evaluation,
stating:

“They [community members] may not know about the program intent, or the numbers of intakes, or all of these things because that’s not where their strengths are and where their interest is...but you can ask them about the clinics that they go to, why they go to the clinic, why they go to public health, what kinds of services do they get from the daycare, what kinds of services did public health provide, does the community health worker come to their home, and if they do, why?”

She continued to explain that questions for frontline staff could focus on “program administration” and “complexities” around program delivery, while middle managers could provide “program numbers,” “uptakes for different programs,” “planning pieces that need to be in place for things to happen,” ways programs are influenced by participants, “obstacles,” and ways to encourage participation. Lastly, the participant discussed that executive or top level management could provide policy and decision-making information, including “how fiscal financing with our Land Claims Agreement influences where the money is allocated for each of the program areas and...the complexities around [non-insured health benefits] when it comes to drugs, drug delivery, mobilizing people from communities, and what that means on a global scale.”

A regional health professional and decision-maker also indicated that non-program users or individuals “who weren’t directly involved but could be impacted by the program” should be involved in evaluations. Using mental health as an example, she stated that organizations such as family services, clinic health teams, or shelters could be approached to provide a perspective that is “different” from the users of mental health services. These organizations could provide information including impact on their service users, discussions they have heard surrounding the program, and reasons for not participating in the program. Conversely, one community member
who was involved with a gardening program in the community explained, “the ones who are directly involved with the gardening project are probably who we would look at to say, look at what worked, and why didn’t this grow, and why did this grow... because the other community members won’t know.”

A Mixture of Evaluation Methods That Are Tailored to Participants: Regional and local participants discussed the importance of using a variety of methods to effectively capture and collect evaluation data from diverse participants. Participants suggested that surveys, focus group discussions, and one-on-one interviews were common and effective ways to collect data from Inuit community members.

Surveys: Surveys were identified by community members as the most common data collection method, with one community health professional stating, “[an evaluation tool] would probably have to be a survey, I think eh? That’s usually how it’s done from what I’ve seen here anyway.” Another community member explained that, “everyone’s pretty much used to doing surveys” and “surveys is pretty big in Rigolet. We did get a lot of people participating in those.” One community member also stated surveys are “better,” as answering survey questions are “easier” than discussions where can feel “you’re put on the spot.” Importantly, “short” surveys were valued by community health professionals; this sentiment was shared by a regional health professional who explained,

“I find that surveys that you can circle the answer - like from 1 to 5, good 5 or 1 really bad - that you tend to get more feedback, instead of having long summative written responses, but yet having room at the end to add comments.”

Focus Group Discussions: The value of focus group discussions was also identified by all participants. Regional health professionals emphasized focus group discussions as being “good”
if they are “led right” or if “you did it through focused [content] areas; [for example], Elders’ care, pregnant moms, smoking cessation, men’s health.” A community member reflected on this,

“I think meeting with them one-on-one might be a good thing, or in a smaller group with similar people, with similar interests, or whatever you’re trying to do. Because, I think, people are comfortable, talkin’ one-on-one or in a small group as opposed to having a lot of community members around.”

One-on-one Interviews: One-on-one interviews were discussed by a community decision-maker as being “good” for capturing data in certain situations: “some people are comfortable speaking in public, some people aren’t.”

Similar to participants identifying the need to use a variety of methods to engage community members, participants also indicated that a variety of evaluation data collection methods must be used. A decision-maker suggested that as community members become accustomed to certain tools and “over-surveyed” and “over-questioned,” “you have to find unique ways” to encourage participation. Additionally, one community member stated, “different methods of collecting data would be a good idea.”

Component 4: Evaluation Scope- Focusing on Evaluating Positive, Long-Term, Lasting Impacts

One local decision-maker described the importance of evaluating longer-term impacts of programs, and focusing on “positive” impacts. The participant also described the need for success indicators to be measured over the long-term. She explained,

“The evaluation of program “success” becomes a fickle term, because you can say to funders “oh yes, we did these 15 things.” But, after that year period, not one person has done anything. So, what do you consider valuable? What are your measurements here?”
A regional health professional and decision-maker agreed that long-term evaluation was preferred over short-term evaluation, as it can illustrate “progression” as opposed to providing a “snapshot” of the health initiative. She described that with a long-term evaluation, you can capture temporal evaluation data, such as data from several “one-time recipients” over time, follow “chronic” patients over the long-term, and follow patients accessing health care while “mending” over the shorter-term.

**Inuit Public Health Evaluation Framework**

Pre-existing frameworks and guides (e.g. CDC’s framework for program evaluation in public health, PHAC’s program evaluation toolkit, PHO’s evaluation model, and CIHR’s guide to evaluation of health research) have common steps, including developing a working group, collaboratively developing roles, describing the program, developing the evaluation plan, implementing the evaluation plan, and sharing results of the evaluation. The four components identified in this study become foundational to each step, and as such should be integrated into each of these steps (Figure 5.3). The framework was validated by using it to evaluate the whiteboard video on acute gastrointestinal illness (Appendix G).

**DISCUSSION**

There is limited literature exploring how to conduct culturally relevant and locally appropriate health evaluations in Indigenous contexts despite calls for evaluation frameworks that reflect and respect local cultures and ways of knowing (30,44). This study aimed to co-develop an Inuit public health evaluation framework for use in Northern Labrador and similar contexts, by characterizing Inuit identified components for effective evaluation, and then creating and validating an Inuit public health evaluation framework containing these components. Regional and
local participants from Northern Labrador indicated that four key components were foundational to effective evaluations: (i) community engagement, (ii) collaborative evaluation development, (iii) tailored evaluation data collection, and (iv) evaluation scope.

Community engagement was viewed as a critical component to a successful evaluation plan; specifically, awareness and consideration of motivators and barriers to community engagement were identified as items to consider when developing and conducting evaluations. Participants identified perceived importance of the evaluation topic, inclusive engagement at the community and individual level, and local context as key factors to consider. These factors are critical in participatory research (29), and participants indicated they play an important role in evaluation projects as well. For instance, meaningful engagement is an important concept for research with Indigenous groups (29). In the past, research topics and methods used have not reflected the needs and preferences of the target groups (29); responding to this problem, the use of participatory methods has been lauded as a way to ensure research conducted within communities is based upon community identified needs and preferences (45,46). Indeed, where “decision-making power and ownership are shared between the researcher and the community involved, bi-directional research capacity and co-learning are promoted, and new knowledge is co-created and disseminated in a manner that is mutually beneficial for those involved” (29, p.160), which, based on our results, also applies to the evaluation of public health initiatives.

Collaborative evaluation development must consider participant fatigue. This concern parallels similar issues of fatigue that are common in research with groups where there is extra burden placed on the community due to resource use and personnel involvement (47), methods used, lack of visible impact, and lack of interest (48). Similar to our results, to combat fatigue,
Clark (48) described the importance of communicating the added value provided by participant responses and the overall project. Moreover, regional and local participants also highlighted the importance of building a team to conduct the evaluation. As such, community-based research principles of meaningful, mutually beneficial, reciprocal, and respectful relationships (47) could be applied to evaluations. Understanding these factors and applying appropriate lessons learned in community-based participatory research to evaluations could ensure evaluations and their results are used and supported by end-users and evaluators.

Collaboration was also identified by participants as a component for effective development of evaluation plans, including tailored data collection plans, which reflects many Inuit societal values of collectivity (49). While participants identified the importance of having a role for external evaluators, they also stressed the critical role of local community evaluators. Involving local community evaluators in evaluations can increase the research and evaluation capacity of those involved by developing and strengthening their skills and knowledge around research and evaluation processes (19,50,51). Through the use of participatory evaluation methods, evaluation capacity can be built for individuals and communities, who can then facilitate on-going or future evaluations (5).

Participants identified different groups of people have different types of evaluation information to provide to public health initiative evaluations. Importantly, evaluation information must be captured using methods that are tailored to each group of participants, which is similar to other research (24). While participants discussed surveys, interviews, and focus groups as evaluation information collection tools, they also reflected on their prior experiences with these methods and discussed the overuse of these methods. As such, evaluations should go beyond these
traditional data collection methods, and consider using other new and innovative methods. For instance, photovoice (52), digital storytelling (53,54), scenario building (55), podcasting (56), and other emerging participatory data collection methods have been successful in the North. Importantly, these methods would allow evaluators to encourage, integrate, and privilege Indigenous knowledge systems (57). Collecting data that reflects Indigenous knowledge could ensure the evaluation data collected are usable by and beneficial for Indigenous communities.

In addition to using methods that ensure evaluation data are usable and beneficial, participants discussed the importance of clearly defining measurable indicators of success. Participants identified that meaningful evaluation meant examining long-term impacts of health initiatives, and critiqued commonly used success indicators. As such, evaluation of Inuit health initiatives should carefully and collectively define what constitutes a successful initiative (58). Indeed, defining appropriate success indicators can ensure evaluations are relevant and meaningful, and will effectively demonstrate the success of the initiative (59,60).

Study Limitations

We identified strategies and tools necessary for evaluations of Inuit public health initiatives in the region of Nunatsiavut; however, it is important to recognize the heterogeneity of Inuit culture, history, conceptualizations of health, health systems, and language across the Circumpolar North. As such, further research needs to be completed to understand the steps and methods necessary for improved evaluations of Inuit public health initiatives in other regions. Moreover, based on feedback and data collected from our participants, we integrated Inuit-identified components with elements of pre-existing frameworks. While there are strengths to this approach (i.e., building from existing evaluation literature), we acknowledge that there are benefits to
completely re-envisioning, re-defining, and de-colonizing Inuit health evaluation, and we encourage further research on this topic.

**CONCLUSION**

This study identified four components that were important to an Inuit public health evaluation framework. These components represent tools, methods, and strategies to promote and facilitate participation of Inuit community members in both the development of evaluations for public health initiatives and in the evaluation of the data collected. Overall, the findings indicated evaluations need to be a collaborative experience between researchers and the community to ensure appropriate methods are used, the community is engaged, and both the evaluation plan and outcomes are identified as important and supported by the community.
REFERENCES


9. Centers for Disease Control and Prevention. Framework for program evaluation in public


28. Brandon PR. Stakeholder participation for the purpose of helping ensure evaluation


FIGURES

Figure 5.1. Map showing the partner region of the Labrador Inuit Land Claim Settlement Area governed by the Nunatsiavut Government, and its five communities: Rigolet, Postville, Makkovik, Hopedale, and Nain. Graphs show demographic information for the region including (i) population size based on community, (ii) sex, and (iii) Indigenous identity (61–65).
**Research Goal**

To determine components and strategies necessary for evaluation of Inuit health programs

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**Qualitative Data Collection**

**Semi-structured Interviews**
- July 2015
- Eighteen interviews were held either one-on-one or in pairs with 21 health professionals and decision-makers in Happy Valley-Goose Bay & Rigolet, and adult Rigolet community members
- In-person, audio-recorded
- Duration: 14-66 minutes/interview

**Focus Group Discussions**
- July 2015
- Three separate discussions held in Rigolet with groups of health professionals (4 participants), decision-makers (3 participants), and community members (6 participants)
- In-person, audio-recorded
- Duration: 30-45 minutes/focus group discussion

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**Qualitative Data Analysis**

Thematic analysis was used:
1. Audio recordings were transcribed
2. Transcripts and audio recordings were reviewed continuously to allow for familiarization with the data
3. Initial coding was done per sentence or paragraph using the computer software program ATLAS.ti (Version 7.5.10)
4. Codes were collapsed, refined, and defined
5. Codes were reapplied to the transcripts
6. Responses were managed to group coding schemes and to identify key themes

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**Figure 5.2.** Details of methods used for data collection and analysis, including number of semi-structured interviews and focus group discussions, location, number of individuals involved and characteristics of the participants, as well as a summary of the thematic analysis procedure.
Figure 5.3. Final evaluation framework for Inuit public health initiatives in Northern Labrador, as co-developed with Inuit health professionals, decision-makers and community members from Northern Labrador.
Chapter 6
SUMMARY, STUDY LIMITATIONS, FUTURE DIRECTIONS, AND CONCLUSIONS

SUMMARY

The research described in this thesis sought to characterize the process and evaluate the initial response to a collaboratively developed, contextually relevant whiteboard video (Chapters 3 & 4), and to present an evaluation framework for Inuit public health initiatives (Chapter 5) within the region of Nunatsiavut in Northern Labrador. The results of this research demonstrated participatory methods for developing and evaluating public health initiatives can be beneficial to ensure public health interventions and their evaluations are relevant and appropriate for Nunatsiavut communities.

Chapters 3 and 4 aimed to co-develop and evaluate the use of a whiteboard video as a public health communication tool within the community of Rigolet, Labrador. The whiteboard video was used to share public health information about acute gastrointestinal illness (AGI). Incidence rates of AGI are much higher in Rigolet than in southern locations (Harper et al., 2015). The research explored if and how a whiteboard video could be used as a suitable medium to share public health information with the community by piloting its use to disseminate AGI information. The development of the whiteboard video was a collaborative project, with youth and community members providing input into various aspects of the video before approving the final product. An evaluation using interviews, focus group discussions, and surveys was conducted to examine initial responses to the video and short-term outcomes. The video was positively received by all partners and community members. The positive response was coupled with a reported intent to change behaviours that seemingly reflected those behaviours discussed
in the whiteboard video. The evaluation results indicated that the positive response to the video was largely attributed to the participation and community input that led to the development of the contextually relevant video. Additionally, the regional government and local Rigolet health professionals found the whiteboard video could be used alongside existing public health programs within the community and region. Similar to the results presented in Chapter 4, the collaborative development of a whiteboard video used to share research results with First Nations and Métis communities in Northwest Territories was also received positively (Bradford & Bharadwaj, 2015). As such, the whiteboard video shows promise as an effective medium for sharing research and supporting public health initiatives within Indigenous contexts.

The research described in Chapter 5 involved co-developing an evaluation framework for Inuit public health initiatives in Northern Labrador. Through interviews and focus group discussions, regional stakeholders and local community members identified components they felt should be foundational to an evaluation framework. Four foundational components were identified: (1) community engagement, (2) collaborative evaluation development, (3) tailored evaluation data collection, and (4) evaluation scope. These foundational components were compared and consolidated with elements of pre-existing evaluation frameworks to produce an Inuit-specific evaluation framework for public health initiatives. This evaluation framework was piloted within Rigolet to evaluate the whiteboard video (Chapter 4). The foundational components identified by Inuit demonstrated the need for and requirement of, community involvement in evaluations of Inuit public health initiatives. This involvement is important, as evaluations by external evaluators who do not understand the relevant context may not identify appropriate evaluation goals or methods. More importantly, there is a need to include end-users and evaluators in evaluating interventions as their knowledge of, perceptions of, and experiences
with the initiative would help form applicable evaluation goals, questions, and outcome indicators (Brandon, 1998; Chouinard & Cousins, 2007; Gilliam et al., 2002; Preskill & Jones, 2009). In communities with distinct cultural values and experiences, the identification of appropriate evaluation strategies is crucial to ensure the resulting findings are appropriately interpreted and useable by stakeholders (Chouinard & Cousins, 2007; Simonds & Christopher, 2013).

It is increasingly evident participatory methods are crucial for research in Indigenous communities, and we found this need for participatory methods extends to public health practice. Indeed, evaluations and public health tool development have traditionally been done by external non-Indigenous peoples, and participatory methods allow for Indigenous perspectives, lived experience, and knowledge to be integrated into public health practice (Simonds & Christopher, 2013). Negative consequences of external non-Indigenous peoples control over research and public health evaluations include but are not limited to negative research relationships and research fatigue (Brunger & Wall, 2016; Wallerstein & Duran, 2006, 2010). By employing participatory methods, researchers and external evaluators are improving community engagement and relations, encouraging incorporation of Indigenous ways of knowing into the research and evaluation process, and increasing likelihood of use and efficacy of initiatives (Chouinard & Cousins, 2007; Cochran et al., 2008). These participatory methods ensure that initiatives and evaluations are better suited for the community and can tackle issues such as negative research relationships and research fatigue. The research in this thesis adds to the literature supporting the need for community and end-user involvement in both public health initiative development and evaluation (Brandon, 1998; Chouinard & Cousins, 2007; McShane, Smylie, Hastings, Martin, & Tungasuvvingat Inuit Family Resource Centre, 2006; Wallerstein & Duran, 2010).
RESEARCH LIMITATIONS

The whiteboard video and piloting of the evaluation framework were focused to one community in Nunatsiavut. However, Nunatsiavut consists of five Inuit communities with varying populations, resources, access to public health initiatives, and research and evaluation experience. This diversity could impact the usefulness of the AGI whiteboard video in the other four communities; however, the participatory process that was used to co-develop the video would be relevant and applicable to other communities in Nunatsiavut, as well as the Circumpolar North. Furthermore, the evaluation framework was created for use in Nunatsiavut; as such, the external validity of the evaluation framework may impact the framework’s usability and usefulness in other Inuit regions.

The whiteboard video was not subject to a long-term evaluation. While intention to change behaviour is promising for subsequent actual change in behaviour (Webb & Sheeran, 2006), a long-term evaluation would also illustrate the ability for a contextually relevant whiteboard video to facilitate behaviour change, and improve health outcomes for individuals. Additionally, the study gathered in-depth qualitative results which is critical for a rich and contextual understanding of participants’ perspectives (Merriam, 2002); however, to see if these results are applicable at a population level, additional quantitative research should be conducted.

The evaluation framework for the region of Nunatsiavut was piloted by evaluating the whiteboard video only, which was a standalone public health tool. Therefore, the evaluation framework was not validated for a larger public health program comprised of multiple tools and components. Furthermore, the final evaluation framework was not qualitatively validated prior to the completion of this thesis (e.g. member checking) (Creswell & Miller, 2000), and the final
framework will be qualitatively validated in summer 2017. Therefore, the exact steps outlined in
the framework in Chapter 5, while reflective of the discussions that took place throughout the
qualitative data collection, need to be confirmed for usability by end-users of the framework.
Finally, while grounded in the qualitative data, the framework was developed by adapting pre-
existing frameworks. An alternative direction would have been to construct a new framework
without utilizing any pre-existing frameworks. While there are strengths to the approach we took
(e.g. such as building from existing evaluation literature), there would be benefits to re-defining
and de-colonizing Inuit health evaluation by constructing a novel framework independent of other
Western models.

**FUTURE DIRECTIONS**

This research has contributed to the growing evidence supporting the need for community-
based public health initiatives, as well as participatory evaluations for these initiatives. Future
research and practical recommendations that stem from this work include:

**Research Recommendations**

- *Long-term evaluation of the whiteboard video:* Our evaluation of short-term outcomes
demonstrated that the community of Rigolet positively received the whiteboard video.
However, demonstrating long-term and lasting behaviour impacts would be crucial to
determining its usefulness in promoting health behaviour for future public health initiatives
(Campbell, Pyett, & McCarthy, 2007; Jolley, Lawless, Baum, Hurley, & Fry, 2007).

- *Compare the whiteboard video medium to other public health tools:* The whiteboard video
was found to be an interesting medium to share public health messaging in a contextually
relevant way. As such, this medium could be utilized to disseminate information for other
public health and non-public health related issues (Bradford & Bharadwaj, 2015). However, future research should examine the effectiveness of this medium versus other commonly used public health tools within the community. Primarily, the focus should be on whether novelty, contextual relevance, and/or elements of the medium itself impact the effectiveness of public health promotion tools in an Inuit context.

**Public Health Practice Recommendations**

- *The need for participatory methods*: The results from our study indicated that participatory methods play a crucial role in the development and evaluation of public health initiatives. While the use of community-based participatory research and participatory methods has been growing in research literature (Dick, 2006, 2009), our studies add to the evidence that participatory methods are beneficial (Cargo & Mercer, 2008; Simonds & Christopher, 2013; Wallerstein & Duran, 2010) and desired by Inuit communities for public health tool development and evaluation.

- *Distribution of the whiteboard video to other Nunatsiavut communities*: The study outlined in Chapter 4 demonstrated that the whiteboard video was positively received in the community involved with its development. Evaluations would determine the reception of this medium and the effectiveness of this medium to share information and encourage behaviour change in the other Nunatsiavut communities. Additional evaluations should examine the applicability and effectiveness of the AGI whiteboard video to other communities within and outside the region of Nunatsiavut. It would be important to determine whether contextually relevant images to one community would result in an impactful public health initiative in the other communities. Additionally, understanding the versatility of these images could inform whether public health initiatives broadly tailored
to the region are effective versus community-tailored initiatives. The applicability of the public health messages might also differ between regions. For instance, while Nunatsiavut Inuit recommended that food be adequately cooked in the whiteboard video, this message would not be culturally appropriate in other Inuit regions where the practice of eating raw and frozen country foods remains an important practice. Understanding factors leading to an impactful initiative in the communities would assist in the future development of effective initiatives for these communities (Campbell et al., 2007; Jolley et al., 2007).

- **Application of the evaluation framework to a multi-component public health program**: The research produced an evaluation framework by identifying foundational components for evaluations of Inuit public health initiatives. The framework was piloted with a standalone public health whiteboard video and not with a public health program comprised of multiple tools and approaches. The application of the framework to a multi-component public health program, would demonstrate its utility, versatility, and effectiveness (Macaulay et al., 1997; Potvin, Cargo, McComber, Delormier, & Macaulay, 2003). This would further validate the use of the evaluation framework and allow for modifications to be made as needed to the framework.

- **Consultation with Nunatsiavut evaluators about utility of framework**: While the framework was built on regional evaluators' perceptions, and grounded with community perspectives from one community in the region, the framework will be shared with all Nunatsiavut evaluators in the summer of 2017 to get their perspectives on its usability (Bryson, Patton, & Bowman, 2011; Creswell & Miller, 2000). This will ensure the framework is applicable for Nunatsiavut evaluators to use.
CONCLUSIONS

The creation of a collaboratively developed whiteboard video informing the residents of Rigolet about AGI resulted in a positively received video that fostered intent to change behaviour. Reflections on the positive response to the video indicated that a collaborative and participatory approach was effective and crucial to its success. The research study on evaluation frameworks identified four components that were important to an Inuit public health evaluation framework. These components represent methods and strategies to promote and facilitate participation of Inuit community members in both the development of evaluations for public health initiatives, and in the collection of evaluation data. Employing participatory methods to encourage meaningful community involvement in the creation and evaluation of public health initiatives can result in relevant public health initiatives and appropriate evaluation strategies.
REFERENCES


APPENDICES

Appendix A: Description of tasks involved in six steps for co-creating the whiteboard video: (1) identifying need, (2) video planning (including identifying and developing public health messages to be communicated), (3) illustrated storyboard development, (4) narration and music selection, (5) video production and post-production editing, and (6) video dissemination in Rigolet, Labrador, Canada.

<table>
<thead>
<tr>
<th>Step</th>
<th>Tasks Completed</th>
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<tbody>
<tr>
<td>Identifying Need</td>
<td>- Community members identified that new methods of dissemination research was needed.</td>
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<tr>
<td></td>
<td>- The whiteboard video was presented to the community as a possible medium and following approval from the community, the development of the video proceeded.</td>
</tr>
<tr>
<td>Video Planning</td>
<td>- This step involved the collaborative development of a script and accompanying conceptual storyboard.</td>
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</tbody>
</table>

**Script Development**
- A draft of the whiteboard video script was developed with youth and community input.
- The script was circulated to public health professionals, researchers, Nunatsiavut Government employees, and community collaborators for feedback on messaging, format, and language.
- The core research team modified the script based on suggested changes and sent to key community collaborators and Nunatsiavut Government employees for final approval.

**Conceptual Storyboard Development**
- The imagery for the video was planned conceptually by reviewing the script line-by-line and brainstorming image ideas.
- Using feedback from the youth and community members on preferred imagery and important community visuals, the research team created a document containing written descriptions of each desired image or scene, which an artist could then use as instructions/guidelines on how to approach the creation of each scene.
- The video image ideas and scenes were then circulated to public health professionals, researchers, Nunatsiavut Government employees and community collaborators for feedback and approvals.
<table>
<thead>
<tr>
<th>Step</th>
<th>Tasks Completed</th>
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| **Illustrated Storyboard Development** | - Tivoli Films Inc., a video production company located in Fergus, Ontario, was contracted to produce the video.  
- The contracted artist illustrated the images from the conceptual storyboard provided.  
- These images were circulated to key collaborators: Nunatsiavut Government employees, community members, and the youth for approval and feedback.  
- Approvals of images from the youth and community members were initially obtained by the local community assistant researcher and subsequently by the researchers during a trip to Rigolet in May 2016. |
| **Narration and Music Selection** | - The youth requested for the narration of the script to be done by a local community member.  
- A local community member was chosen and a local community research assistant recorded his narration of the final approved script.  
- Additionally, while a verbatim script was presented for narration, the narrator was encouraged to speak naturally to ensure the local tone and dialect was captured in the final product.  
- A local community research associate also facilitated decisions surrounding choice of sound track and sound effects for the video. |
| **Video Production and Post-Production Editing** | - With the narration recorded and images approved, production of the video was completed. This involved filming of the artist’s hand while illustrating each image.  
- With filming complete, the video of each image was sped up in editing to match the overlaid narration audio.  
- The core research team reviewed a rough draft of the video to identify any edits, which were incorporated to produce the final version. |
| **Video Dissemination** | - The rough draft of the video was shared with community members at a community screening event. It was also shared with regional government employees at an in-person meeting.  
- The final version of the video was released on the project website (https://rigoletwhiteboard.com), and YouTube (http://bit.ly/rigoletwhiteboardvideo) and it was also shared on Facebook (http://bit.ly/rigoletwhiteboardfacebook) with the community. |
### Appendix B: Activities carried out over the course of the three-day youth workshop to develop ideas and components for the whiteboard video in Rigolet, Labrador, Canada.

<table>
<thead>
<tr>
<th>Day</th>
<th>Activities</th>
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| Day 1   | **Role Play: What would Steve do?** Description: Chart paper was laid out and participants were given markers to provide answers to questions about an Inuit boy named Steve who lives in a community like Rigolet. Questions:  
- On a day like today, what would Steve do?  
- What is Steve’s favourite game?  
- What does Steve like to do for fun?  
- What is Steve’s favourite food?  
- If Steve wasn’t feeling good, what would he do?  
- If Steve had stomach illness, what would he do?  
- Who would Steve see?  
- Who would Steve talk to?  
- Do you think Steve would take medicine?  
- Do you think Steve would leave school?  
- Do you think Steve would tell his parents? His friends?  
**Purpose:**  
- To get an idea of the activities youth would do and what the youths’ day-to-day lives were like.  
- To understand how the youth perceive stomach illness and how they would handle the illness. |
|         | **Graffiti Wall** Description: Using large chart paper, key themes were written out and the youth were asked to write on the chart paper what came to mind when they thought about those words. The words used were: Inuit, Rigolet, Stomach Illness, Every day, Fun, Healthy, and Community.  
**Purpose:**  
- To hear their thoughts on these broader concepts for content and culturally relevant material for the whiteboard video. |
|         | **Location Scouting** Description: Cameras were distributed among the youth for a weekend and they were asked to take pictures out in the community that reflected the community, culture, and things important to share in the video.  
**Purpose:**  
- To get the youth engaged with the project. The pictures would provide ideas for images in the whiteboard video. |
| Day 2 | Review Script | **Description:** Youth were asked for feedback on terms for germs and water containers, as well as local activities and descriptions of Rigolet to include in the script.  
**Purpose:**  
- To make sure the script was using appropriate terms and to make sure the youth got a say in terms used.  
| Character Development | **Description:** Youth were asked to develop the character. They chose the sex, age, job, name, and physical characteristics such as facial features and clothing. They also named potential individuals from the community who could voice the character.  
**Purpose:**  
- To have the youth identify the character and a community member who could narrate the video so the whiteboard video was relevant and community based.  
| Open House Ideas | **Description:** The youth were asked about their thoughts on the set up for the community open house.  
**Purpose:**  
- To make sure the youth had a voice in the open house ideas and, if interested and available, they could help with the open house.  
| Day 3 | Open House & Survey Feedback | **Description:** The ideas and input provided by the adults at the community open house were discussed with the youth.  
**Purpose:**  
- To make sure the youth agreed with the adults’ feedback.  
| Video Storyboard | **Description:** Photos taken by the youth were printed. The script was cut into pieces and separated into potential scenes for the video. The youth were then asked to use the pictures to create an ideal image for the scene in the script. If no image fit, the youth were asked to describe an image they would like to see for that scene.  
**Purpose:**  
- To get image ideas and concepts corresponding to the script for the development of the whiteboard video.  
|
Appendix C: Interview guides for regional and local participants, in Labrador, Canada.

Guide tailored for government employees:

INTRODUCTION

1. To start, can you tell me a little bit about yourself and what you enjoy about your work?
   Name?
   Position?
   Organization?

One of the goals of this project is to develop a set of preliminary guidelines for knowledge transfer and exchange or KTE within Nunatsiavut. KTE is the exchange of information between researchers and community members and policy makers. It refers to the back and forth sharing of knowledge and information. My project hopes to understand the views on sharing and receiving knowledge with researchers from the views of all individuals involved in the research process to help create guidelines for researchers.

PART A: KNOWLEDGE TRANSFER AND EXCHANGE

2. How should researchers share information and results with policy makers?
   What about sharing information and results with community members?

3. How should they get advice or information from policy makers?
   How about from community members?

4. Could you tell me of an example that you know of where researchers effectively shared and obtained information/knowledge?
   What made it so?
   Knowledge exchanged? How were messages exchanged?
   Researchers?
   Local Community members?
   Methods used? Ie booklet, etc?
   Messaging techniques?

5. Do you have any examples you could share where they did not do a good job exchanging information?
   What made this situation different from the one discussed previously?

6. What barriers might researchers face when trying to share or get information from communities or policy makers?
   How do you think they could overcome these barriers?
   Do you face any barriers when trying to exchange information with researchers?

7. How can more researchers be motivated to engage in exchanging information and sharing results?

Following Questions are for Nunatsiavut Government Research Application Reviewers only:
8. What trends are you seeing in the number of applications that include KTE and community engagement components?

9. When assessing the application for the question regarding KTE (“How will Labrador Inuit traditional knowledge be considered and/or incorporated into the research?”), do you have a rubric or evaluation guideline to determine if the project complies with a set of standards?

   **If Yes:**
   a. What determines an acceptable response?
   b. Do you think the rubric or guidelines are an effective tool to evaluate the KTE approaches within the project?

   **If No:**
   a. How would you, as the reviewer, justify what is an acceptable response?
   b. Do you think there should be a predetermined rubric to evaluate the responses?
      - What should be included in the rubric?

10. In your opinion, how have these application questions helped influence the inclusion of Inuit traditional knowledge in research?

**PART B: PARTICIPATORY EVALUATION**

The next topic of interest for our research is developing a participatory evaluation framework for Inuit health programs. Participatory evaluation is an approach where stakeholders are involved in developing and implementing a set of guidelines/methods to see how well or not so well a program is doing.

11. What should we be evaluating for Inuit health programs?
    *How do we evaluate this?*

12. What should a participatory evaluation framework for an Inuit health program include in terms of personnel?
    *Who? - how do you determine who should be involved?*
    *How do you get them involved?*
    *What should stakeholders be involved in throughout the process?*

13. What should it include in terms of strategies used?
    *Town hall meeting? Speaking with community leaders? In-person versus radio or other media*

14. There are three areas of a program that are evaluated: process, implementation and the outcomes. Process involves looking at program development, what are some procedures and metrics that need to be included to evaluate the process for Inuit health programs?
    *Short-term procedures and metrics?*
    *Long-term procedures and metrics?*
    *What would short-term and long-term timelines look like? or is that dependent upon the program being evaluated?*

What are procedures and metrics that should be used to evaluate the implementation of an Inuit health program?
    *Short-term procedures and metrics?*
    *Long-term procedures and metrics?*
Lastly, how about the outcomes of an Inuit health program?
- Short-term procedures and metrics?
- Long-term procedures and metrics?

15. How do you measure uptake?

PART C: WHITEBOARD VIDEO

16. Think of a campaign that has worked well. Now think of a campaign that didn’t work so well. What were the differences in terms of process?
   - What made the effective one effective? What made the ineffective one ineffective?

17. What factors do you think are important when designing a public health campaign for a community?
   - What is important for the community of Rigolet?
   - What is essential for a successful campaign?

18. How effective do you think videos are in sharing information around the community?
   - Familiar with whiteboard videos? (if not show a very brief clip)
   - Issues with using videos or whiteboard videos?
   - What should they include to be successful? (Content, imagery, narration)

19. How best could we evaluate community engagement and response to the video?
   - Survey, Facebook, interviews, etc.

20. How could we determine if this approach is transferable to other communities?
   - Evidence that needs to be collected to suggest this approach is transferable?

21. We worked with the youth to develop a script, would you be interested in reading it?
   - If yes, ensure you have their contact information

CONCLUDING QUESTIONS

22. This concludes my questions, but do you have any additional comments to add or questions for me?
23. Do you feel there is anyone else that I should talk to?
Guide tailored for community members:

INTRODUCTION
1. To start, can you tell me a little bit about yourself and what you like about Rigolet?

One of the goals of this project is to develop a set of preliminary guidelines for knowledge transfer and exchange or KTE within Nunatsiavut. KTE is the exchange of information between researchers and community members and policy makers. It refers to the back and forth sharing of knowledge and information. My project hopes to understand the views on sharing and receiving knowledge with researchers from the views of all individuals involved in the research process to help create guidelines for researchers.

PART A: KNOWLEDGE TRANSFER AND EXCHANGE
2. How should researchers share information and results with community members?
   What about sharing information and results with policy makers?

3. How should they get advice or information from policy makers?
   How about from community members?

4. Could you tell me of an example that you know of where researchers effectively shared and obtained information/knowledge with the community?
   What made it so?
   Knowledge exchanged? How were messages exchanged?
   Researchers?
   Local Community members?
   Methods used? Ie booklet, etc?
   Messaging techniques?

5. Do you have any examples you could share where they did not do a good job exchanging information?
   What made this situation different from the one discussed previously?

6. What barriers might researchers face when trying to share or get information from communities or policy makers?
   How do you think they could overcome these barriers?
   Do you face any barriers when trying to exchange information with researchers?

7. How can more researchers be motivated to engage in exchanging information and sharing results?

PART B: PARTICIPATORY EVALUATION
The next topic of interest for our research is developing a participatory evaluation framework for Inuit health programs. Participatory evaluation is an approach where stakeholders are involved in developing and implementing a set of guidelines/methods to see how well or not so well a program is doing.

8. What should we be evaluating for Inuit health programs?
   What is important to you to know about a health program?
   How do we evaluate this?
9. What should a participatory evaluation framework for an Inuit health program include in terms of personnel/people involved?
   - **Who?** - how do you determine who should be involved?
   - **How do you get them involved?**
   - **What should stakeholders be involved in throughout the process?**

10. What should it include in terms of strategies used?
    - Town hall meeting? Speaking with community leaders? In-person versus radio or other media

11. There are three areas of a program that are evaluated: process, implementation and the outcomes. Process involves looking at program development, what are some procedures and metrics that need to be included to evaluate the process for Inuit health programs?
    - **Short-term procedures and metrics?**
    - **Long-term procedures and metrics?**
    - **What would short-term and long-term timelines look like? or is that dependent upon the program being evaluated?**

What are procedures and metrics that should be used to evaluate the implementation of an Inuit health program?
    - **Short-term procedures and metrics?**
    - **Long-term procedures and metrics?**

Lastly, how about the outcomes of an Inuit health program?
    - **Short-term procedures and metrics?**
    - **Long-term procedures and metrics?**

12. How would you measure uptake of the program?

**PART C: WHITEBOARD VIDEO**

13. Think of a campaign that has worked well. Now think of a campaign that didn’t work so well. What were the differences in terms of process?
    - **What made the effective one effective? What made the ineffective one ineffective?**

14. What factors do you think are important when designing a public health campaign for a community?
    - **What is important for the community of Rigolet?**
    - **What is essential for a successful campaign?**

15. How effective do you think videos are in sharing information around the community?
    - **Familiar with whiteboard videos? (if not show a very brief clip)**
    - **Issues with using videos or whiteboard videos?**
    - **What should they include to be successful? (Content, imagery, narration)**

16. How best could we evaluate community engagement and response to the video?
    - **Survey, Facebook, interviews, etc.**

17. How could we determine if this approach is transferable to other communities?
    - **Evidence that needs to be collected to suggest this approach is transferable?**

18. We worked with the youth to develop a script, would you be interested in reading it?
    - **If yes, ensure you have their contact information**
CONCLUDING QUESTIONS

19. This concludes my questions, but do you have any additional comments to add or questions for me?

20. Do you feel there is anyone else that I should talk to?
Appendix D: Focus group guide for regional and local participants, in Labrador, Canada.

*Interviewer Note:* This guide is a semi-structured focus group guide and is intended to be flexible. The discussion should be conducted in a conversational manner. Since the guide is semi-structured and is to be conducted in a conversation manner, the questions should not be read verbatim, and might be asked out-of-order.

**PREAMBLE**

Thank you for taking the time to attend the focus group discussion today. As the Letter of Information described, it will take approximately 1-3 hours. You can choose not to respond to certain questions and you can withdraw from the study, up until the preliminary data analysis is complete. If you choose to withdraw, your comments and answers will maintained within the recording, since this is a group recording, and individual comments cannot be removed. Please note that this process is essentially a public process. Do not say anything you would not be comfortable saying in public. Respect each others’ privacy by not discussing who attended or what was said, once you leave. Do you have any questions before we get started? Okay, let’s begin [turn on audio recorder].

**OPENING QUESTION**

1. To start, we are going to do introductions through a game known as Conversation Jenga. One by one you must remove a piece from the tower of blocks and place it on top without making the tower fall. On each piece there will be a question for us to get to know each other and so when you remove a piece, read out the question and provide us with your answer. For the first round, we would like everyone to say their name so we can get to know you all!

**PART A: KNOWLEDGE TRANSFER & EXCHANGE**

Imagine you are in charge of researching a topic in the community. The topic could be for example- an archeological dig, a social science research project or a health research project. Do you have a preference?

Based on this we would like for you to tell us how you would create a study for this topic to include your own knowledge and the other community members.

*How would you reach the other community members?*

- What messaging techniques would you use?
- What methods would you use to both get and share information?

*If it were you, how would you like to be approached?*

[for the above make a list and then ask them to rank depending on the type of answers you get]

OR have a print out picture to represent various methods of knowledge transfer and exchange like surveys, presentations, meetings, open house, radio, video etc and get them to place them on a “thermometer” so whether the idea is “hot” or “not” or along a line of good or bad idea (spectrum). Have one for methods of getting information from the community and one for methods to share the results back with the community.

OR have them vote. So for example, put each picture out, and they put a blue dot on ways it is good to get information from the community and red dot on ways that it is good to share information back with the community.

If there is no response with the above, ask:

1. What do you think about researchers in Rigolet?

*What should researchers NOT do when they are trying to work with communities?*
What should researchers DO when they are trying to work with communities?
How do you think they should include Inuit knowledge?
What should research give to your community? Should research include the community members?

2. What has been your experience with research?
   How do you see researchers working with the community members?
   How does it make you feel when researchers engage the community and use Inuit knowledge?
   Do you like to be involved in research that takes place in your community?

3. Do you have any examples you could share where knowledge was shared well in your community?
   Can you describe what you liked and didn’t like?

4. Do you have any examples you could share where knowledge was not shared well with researchers?
   How could it have been better?

PART B: PARTICIPATORY EVALUATION
Sharing knowledge with the community and getting knowledge from the community are ways that researchers can make sure what they are working on is better for the community. From this, we would now like to look at participatory evaluation. Participatory evaluation is where community members and individuals using a service or program help make decisions about how to test if a program is doing what it was supposed to do. They are also involved in putting the parts of the evaluation plan in place.

The parts of an evaluation:
- Process – planning and development stage of the program
  o Did we involve the right people? Did we have the right resources?
- Implementation – actually running the program
  o Did we do what we wanted? Did we reach the right population? What did the program actually do?
- Outcomes – the results of the program
  o What actually happened because of the program? Did we have any unexpected effects?

For this section, we want you to imagine there is a new flu that is starting to affect people around the world and in Canada. There is a vaccine that has been developed to help fight this flu and the government has created a plan to spread information about the flu vaccine to try to get people to go and get the vaccine. We would like to know, as community members how you would evaluate or judge if this plan is working for your community.

To start, when you think about the flu program, who should be involved in testing if it works?
   Should community members be involved? Or public health employees like the nurse?

I’ve put up chart paper with each of the three areas, and together I would like to go through and ask you all to help generate a list with us about what ways we could use to answer those questions I had mentioned previously and test them for this flu program or any health program.
Examples of procedures:
- Surveys to get feedback before the program is put into place
- Community meetings to talk about the program
- A survey after the program is done?
- Focus groups? Interviews?

Now, with this list, we need to make a timeline of when we would do each of these things to test how our flu campaign is going. [Have a large timeline with weeks, months, years, that they can work on, write each procedure onto a different colored paper depending on which area of evaluation it belongs too, and maybe even have pictures of generic things like a survey or meeting] With each of these I would like you to place them on the timeline of how the evaluation would go.

Ask why have you placed the methods where you have?

PART C: WHITEBOARD VIDEO
From the activity we just completed, you can see how a campaign might be planned and tested for how well it works. We are working on using a whiteboard video as a new way to share public health information. I just recently found out what a whiteboard video is, has anyone else seen one before?

One video that seems to be popular is this one [Show them Dr. Mike Evans - Single best thing you can do for your heart]
We are going to watch this one, and after I would like to know how you found it as a health promoting video.

[After video]
What did you think about this video and the use of the whiteboard drawing?
  Was he interesting to listen to?
  Did you understand the message?
  Do you remember the message clearly?
  Did the message make you think about anything?
  Were the drawings helpful and appropriate?
  What do you think about using this to communicate with community members in Rigolet?
  What kinds of things would you like to see in a video aimed at Rigolet?

How would you test to see if this video did its job to share health information with the community?
  Surveys after the video?
  Group discussions
  Sharing on Facebook?

CONCLUDING THOUGHTS
This concludes my questions, but do you have any comments to add or were there questions you thought I would ask but didn’t? Are there any important points or topics that didn’t come up?

Summarize the discussion and ask: Is this an accurate summary?

Thank you for your time. I want to re-emphasize that everything you’ve shared today will remain confidential and a fake name will be used in any publications or presentations. If you have any questions or concerns regarding today’s interview please do not hesitate to contact me, any member of the research team, or the University of Guelph’s research ethics office. Thanks again for your time.
Appendix E: Whiteboard video interview and group discussion guide for regional and local participants, in Labrador, Canada.

Whiteboard Video Evaluation Discussion Guide

1. What did you enjoy about the video?
   a. Would you watch it again?

2. What didn't you enjoy?

3. What do you think about the images? The narration? The sound?
   a. How important is it that the images are from the community?
   b. How important is it that the narration was done by a local voice?

4. How easy was it to understand the information being shared?
   a. Was it easier than other ways of getting information?
   b. How easy was the language to follow?

5. There are lots of ways to share information, what way do you like best?
   a. Posters? Handouts? The video?

6. Are there tools from the Department of Health and Social Development (DHSD) that you know of that talk about stuff from the video?

7. How would you use this video with other tools to inform practice? (tailored to local DHSD staff)

8. How easy is the information to remember after seeing it through the video?
   a. Do you think you'll remember the information in a few weeks? Months?

9. Did any of the information surprise you?

10. Will you be thinking about any of the things discussed in the video? Or doing more of it now?

11. This project took almost 2 years to complete while video projects done in Southern Ontario take a few months. What are your thoughts on the timing?

12. If we were to do the project again, what should be changed?
    a. What should be kept the same?

13. Were the youth the correct group to involve in the project?
    a. Is there someone else who we should have worked with? (For example, the nurses)
Appendix F: Whiteboard video survey for local participants, in Rigolet, Canada, administered on iPads and through paper form.

Whiteboard Video Evaluation Survey

1. What is your approximate age?
   Child/Minor
   Young Adult
   Middle-aged Adult
   Elder/Senior

2. If you are a minor, you require parental consent to continue. (Have research assistant administering the survey confirm parent/guardian is present with the minor and read the following to them as well as provide them with the information sheet) Dear parent/guardian, the following survey will be used to get feedback on the whiteboard video made for Rigolet. The answers will be kept private and confidential and your child is able to withdraw at any time or skip any questions. If they choose to withdraw, the answers will be deleted immediately and there will be no penalty. There is no foreseen risk with completing the survey. Do you have any questions before we begin?
   Yes
   No

3. Do you provide consent for the individual to participate in the survey?
   Yes
   No

4. (If not a minor, proceed to this question) This survey will be used to get your feedback on the whiteboard video for Rigolet. Your answers will be kept private and confidential and you are free to withdraw from the survey at any time. If you choose to withdraw your answers will be deleted and there will be no penalty. There is no foreseen risk associated with completing this survey. Have you had the opportunity to read the information letter?
   Yes
   No

5. Do you have any questions before we begin?
   Yes
   No

6. Do you agree to participate in the survey?
   Yes
   No
7. Gender of participant: _____________________________________________

8. Did you enjoy the video?
   1  Really did not
   2  Not enjoy at all
   3  Somewhat did
   4  Neutral
   5  Enjoyed

9. Did you like the images?
   1  Really did not
   2  Not like at all
   3  Somewhat did
   4  Neutral
   5  Enjoyed

10. Were the images used in the video relatable?
    1  Not relatable
    2  Somewhat not
    3  Neutral
    4  Somewhat
    5  Relatable

11. Were the images relevant to your lifestyle?
    1  Not relevant at
    2  All
    3  Somewhat not
    4  Neutral
    5  Relevant

12. Were the images relevant to the community of Rigolet?
    1  Not relevant at
    2  All
    3  Somewhat not
    4  Neutral
    5  Relevant

13. Did you like the narration of the video?
    1  Really didn’t
    2  Not like
    3  Somewhat did
    4  Neutral
    5  Enjoyed

14. Was the narration easy to understand?
    1  Hard to
    2  Kind of hard to
    3  Neutral
    4  Easy to
    5  Very easy to
    understand
    understand
    understand
    understand
    understand

15. Did you relate to the voice that was used in the narration?
    1  Really didn’t
    2  Not relate at all
    3  Somewhat
    4  Neutral
    5  Related
    didn’t relate
    to the voice
16. How easy was the language to understand?

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<tr>
<td></td>
<td>Hard to understand</td>
<td>Slightly hard to understand</td>
<td>Neutral</td>
<td>Slightly easy to understand</td>
<td>Easy to understand</td>
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17. Did you enjoy the music of the video?

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<tr>
<td></td>
<td>Did not enjoy at all</td>
<td>Somewhat did not enjoy</td>
<td>Neutral</td>
<td>Somewhat enjoyed</td>
<td>Really enjoyed</td>
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</table>

18. Had you heard about this whiteboard video before this event?

- Yes
- No

19. If yes, how did you hear about it (Check all that apply):

- a. Attended open house in July 2015
- b. Spoke to a researcher in July 2015
- c. Attended open house in May 2016
- d. Liked/followed the Rigolet Whiteboard Video Facebook page
- e. Visited the Rigolet whiteboard video website
- f. Heard about it from a friend, neighbor or community member
- g. Saw a poster
- h. Heard about it on the radio
- i. Other (Specify):

20. Was the information in the video easy to understand?

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<tr>
<td></td>
<td>Really hard to understand</td>
<td>Somewhat hard to understand</td>
<td>Neutral</td>
<td>Somewhat easy to understand</td>
<td>Easy to understand</td>
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21. Did you learn anything new from the video?

- Yes
- No

- a. If yes, what did you learn: 

________________________________________________________________________
________________________________________________________________________
22. Do you think the video was a good way to share this information?

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<td></td>
<td>Bad way to share information</td>
<td>Somewhat bad way to share information</td>
<td>Neutral</td>
<td>Somewhat good way to share information</td>
<td>Good way to share information</td>
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23. Which of the following video tips will you be doing more often:

i. Washing hands even more often
ii. Cleaning cooking surfaces more carefully
iii. Carefully preparing and cooking food
iv. Boiling brook water after it rains hard
v. Cleaning water containers more regularly
vi. Other (Please specify):__________________________________________

24. What other tools from other services do you know about that talk about information from the video?

a. Hand washing posters
b. Handouts
c. Community programs
d. School visits
e. Other: _______________________________________________________

25. Would you be willing to share this video on Facebook?

Yes
Maybe
No

26. Would you show this video to a friend, family member, or other community member?

Yes
Maybe
No

27. Is there anything you would change about the video?

Yes
No

a. If yes, what would you like to change?
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
28. Overall, what was your favourite part of the video?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

29. What was your least favourite part of the video?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Thank you for your feedback and help!😊
Appendix G: Steps and accompanying actions taken for the application of the framework to the evaluation of the whiteboard video, in Rigolet, Labrador, Canada.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description/Accompanying Actions</th>
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<tbody>
<tr>
<td>Step 1: Developing a working group</td>
<td>Research team members including two community research assistants and a regional stakeholder were included in the working group. These core team members identified 8 key individuals/groups from Rigolet to consult for evaluation procedures and tools.</td>
</tr>
<tr>
<td>Step 2: Collaboratively developing roles</td>
<td>Core members of the whiteboard video development team were given roles to review overarching evaluation plans. The key community members asked to provide feedback were given roles to review the materials to ensure contextual relevance.</td>
</tr>
<tr>
<td>Step 3: Describing the initiative</td>
<td>The core members of the whiteboard video development team were familiar with the whiteboard video so this step was not applicable. The key community members who were asked to provide feedback on the evaluation materials, were also familiar with the video but were provided a brief description of the video with the evaluation materials.</td>
</tr>
<tr>
<td>Step 4: Developing evaluation plan</td>
<td>Short term evaluation surveys and discussion guides were drafted for the whiteboard video. Both surveys and discussion guides were created to collect quantitative and qualitative information as laid out in step 4 of the framework (Figure 5.3). Initially the evaluation tools were shared with core team members (step 1 and 2 of the framework), including researchers, two local community research assistants and a Nunatsiavut Government employee. The researchers and two local community assistants approved the tools for use. The Nunatsiavut Government employee identified two questions to add to the surveys regarding how relatable the narrator’s voice was and participant awareness of tools from the Department of Health and Social Development (DHSD) that discussed similar messaging as the video. These questions were also added to the discussion and one of the discussion questions was reworded for clarity. These edits were made and the new tools were delivered with a letter to the 8 community leaders and health workers in Rigolet, who were identified by core team members. Out of the 8, 4 community leaders and health workers responded with some suggested changes to the evaluation tools. Changes consisted of rearrangement and replacement of select words or phrases, restructuring of questions, and addition of prompts. These changes were addressed and the final evaluation documents were created for use. A general call for involvement was placed on Facebook to engage community members in the revision of the evaluation tools but there was no response.</td>
</tr>
<tr>
<td>Step 5: Implementing the evaluation plan</td>
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<td>------------------------------------------</td>
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<tr>
<td>To promote recruitment in the completion of the evaluation, multiple methods were employed. Posters were used to advertise the open house where the video would be screened and surveys would be available. Announcements for the open house were made over the radio, and the event was posted on Facebook. One-to-one visits were made with a few individuals to get in-depth, and qualitative evaluation information.</td>
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<tr>
<td>For data collection, a survey in both paper and electronic form (via iPad and tablet) was available at the open house. The open house had an attendance of approximately 40 people. 16 individuals completed paper surveys at the open house and 1 individual completed it on the iPad. Discussions took place as one-to-one or as group discussions in a semi-structured interview format the following day. A group interview took place with 6 members of the Department of Health and Social Development. Individual interviews took place with two local decision-makers and one interview took place with two community members. The survey was also made available online once the video was launched online.</td>
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<tr>
<td>Only immediate response to the video was evaluated, using intent to change as an indicator of potential to change behaviour. Results of the whiteboard evaluation can be found elsewhere (Chapter 4). Long-term impact evaluation will have to be developed.</td>
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<tr>
<td>Through the application of the framework, strengths and limitations became apparent. Strengths of the framework included connecting with local stakeholders to develop evaluation tools that reflected local context. Limitations of the framework include that even by incorporating the steps that were brought forth by the interviews and discussions, response and participation in both the working group and completion of evaluation was less than desired.</td>
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<tr>
<td>Step 6: Sharing results of the evaluation</td>
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<tr>
<td>Short-term evaluation results will be shared with the community and regional partners through print materials, meetings, presentations and open houses.</td>
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Appendix H: Steps and accompanying actions to take for the final evaluation framework in Labrador, Canada.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description/Accompanying Actions</th>
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<tr>
<td><strong>Step 1: Developing a working group</strong></td>
<td>The working group can include core members involved in the tool or program development in addition to other key stakeholders such as researchers/evaluators, members of the Nunatsiavut Government, members of the local Inuit community government, other community leaders, local medical staff, local research assistant, and community members.</td>
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<tr>
<td><strong>Step 2: Collaboratively developing roles</strong></td>
<td>Individuals included in the working group should be designated roles to indicate the extent of their involvement in the evaluation process.</td>
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<tr>
<td><strong>Step 3: Describing the initiative</strong></td>
<td>Individuals who were not a part of the core team involved in the development of the health tool or program should be given details to be able to accurately develop evaluation tools.</td>
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<tr>
<td><strong>Step 4: Developing evaluation plan</strong></td>
<td>The development of the contextually relevant evaluation plan should include the following features: (1) community engagement, (2) collaborative evaluation development, (3) tailored evaluation data collection, (4) evaluation scope.</td>
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<tr>
<td><strong>Step 5: Implementing the evaluation plan</strong></td>
<td>At this step, the evaluation plan would be implemented for the tool or program.</td>
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<tr>
<td><strong>Step 6: Sharing results of the evaluation</strong></td>
<td>Once evaluation data is analyzed, the results must be shared back with participants and stakeholders.</td>
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