PROCEEDINGS

RESEARCHER-PRACTITIONER HEALTH EQUITY WORKSHOP: BRIDGING THE GAP

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The workshop brought together public health researchers, policy-makers, and practitioners working on the social determinants of health and health equity across Canada and globally. We would like to thank all those who attended for their active participation and contributions to the workshop that was intended to strengthen the links between evidence and action for health equity. A special word of thanks to all of the speakers and discussants for their contributions to the design with examples from the local and regional levels of how evidence and action can be brought together to make a difference in health equity.

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Diana Daghofer, Wellspring Strategies researched and wrote the case studies and also wrote the workshop report. Raymonde D'Amour, Groupe Intersol Group, served as facilitator during the workshop.

ABOUT THE WORKSHOP HOSTS

National Collaborating Centre for Determinants of Health

The National Collaborating Centre for Determinants of Health is one of six National Collaborating Centres (NCCs) for Public Health in Canada. Established in 2005 and funded by the Public Health Agency of Canada, the NCCs produce information to help public health professionals improve their response to public health threats, chronic disease and injury, infectious diseases, and health inequities.

The National Collaborating Centre for Determinants of Health focuses on the social and economic factors that influence the health of Canadians. The Centre translates and shares information and evidence with public health organizations and practitioners to influence interrelated determinants and advance health equity.

Canadian Institutes of Health Research Institute of Population and Public Health

The Canadian Institutes of Health Research (CIHR) is the Government of Canada's health research investment agency. CIHR's mission is to create new scientific knowledge and to enable its translation into improved health, more effective health services and products, and a strengthened Canadian health care system. Composed of 13 Institutes, CIHR provides leadership and support to more than 14,100 health researchers and trainees across Canada. The CIHR Institute of Population and Public Health (CIHR-IPPH) aims to improve the health of populations and promote health equity in Canada and globally through research and its application to policies, programs, and practice in public health and other sectors.

Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health

Institute of Aboriginal Peoples' Health (IAPH) fosters the advancement of a national health research agenda to improve and promote the health of First Nations, Inuit and Métis peoples in Canada, through research, knowledge translation and capacity building. The Institute's pursuit of research excellence is enhanced by respect for community research priorities and Indigenous knowledge, values and cultures.

National Collaborating Centre for Healthy Public Policy

The National Collaborating Centre for Healthy Public Policy (NCCHPP) has a mandate to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge related to public policy that is likely to have a positive impact on the social, economic, and environmental determinants of health.

Canadian Institute for Health Information- Canadian Population Health Initiative

The Canadian Institute for Health Information (CIHI) is an independent, not-for-profit corporation that provides information on Canada's health system and the health of Canadians. As part of CIHI, the Canadian Population Health Initiative (CPHI) explores patterns of health within and between population groups to foster a better understanding of factors that affect the health of individuals and communities. We also seek out and summarize evidence about "what works" at a policy and program level to contribute to the development of policies that reduce inequities and improve the health and well-being of Canadians.

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1) Individual opp...
to act on

Explore possibilities for
collaboration c̄ PPl.
met at meeting.

2) Opportunity we hope others
will act on

& NCCDH/CIHR-IPPH/
CPHI etc. develop/host → bring forward
discussion around to CRE a proposal
related to
way

1.
INTRODUCTION - HEALTH EQUITY: LAY OF THE LAND AND FUTURE DIRECTIONS

Public health professionals have a strong commitment to helping all people reach their full health potential. They share the conviction that public health practice is improved when it is informed by evidence. This means acting on the social determinants of health (SDH) with proven approaches to improve health equity across Canada and globally.

A workshop of public health practitioners, policy-makers and researchers working on the social determinants of health and health equity was convened jointly by the National Collaborating Centre for Determinants of Health (NCCDH), the Canadian Institutes of Health Research-Institute of Population and Public Health (CIHR-IPPH), and their partners, in Toronto on February 14-15, 2012. The workshop aimed to strengthen relationships between researchers and practitioners to address health inequities, a complex and intra-jurisdictional challenge. Three themes were threaded through the event: advancing health equity, integrating research and practice, and translating knowledge into action. A number of methods, tools and approaches were presented to link evidence and action, including case examples and research-in-progress.

Using a combination of presentations and participatory/interactive components, the workshop was designed to:

- Examine approaches to recognize health inequities and increase ability to use tools to address health equity during research, program planning, implementation, and/or evaluation building on an environmental scan *Integrating Social Determinants of Health Equity into Canadian Public Health Practice* (NCCDH, 2011).
- Strengthen ability to integrate scholarly research and practice-based evidence into planning, implementing and evaluating public health interventions, as well as to monitor action and create opportunities to adjust based on emerging evidence.
- Identify opportunities for sustained knowledge translation and create stronger links between researchers and public health practitioners who are addressing health equity.

2.

OPENING REMARKS - Dr. Nancy Edwards, Scientific Director, CIHR-IPPH and Connie Clement, Scientific Director, NCCDH

Moving from Research

Nancy Edwards opened the workshop by noting that health inequities cannot be understood in isolation of their policy and political contexts, including social structures and resource distribution patterns. There is a clearly established link between the economic gradient and health equity, but efforts must take into account more complex 'distal' factors in health inequity, including macro, historical and dynamic influences.

Research remains focused on understanding inequalities. Several recent reviews have noted that the majority of published and funded research in population and public health is descriptive in nature, with far less focused on interventions (Milward, Kelly & Nutbeam, 2001; Sanson-Fisher, Campbell, Htun, Bailey & Millar, 2008; McNamara, Sanson-Fisher, D'Este & Eades, 2011; Di Ruggiero, Rose & Gaudreau, 2009). There needs to be a shift in research to integrate theories that are consistent with systems approaches; to incorporate mixed methods designs that examine contextual influences; and to include comparative policy research and natural experiments.

Population and public health research approaches must adapt by moving:

- from understanding determinants, to examining the impact of coherent, multi-level interventions and policy;
- from describing socioeconomic gradients, to interrogating health inequities and their mitigation;
- from controlling context, to understanding the influence of context on interventions;
- from studying intervention components, to examining complex interventions within complex adaptive systems.

...to Action

Connie Clement recognized the many promising practices applied in public health work, including innovation and effective leadership. Unfortunately, too often these remain isolated cases, as practitioners lack the means to evaluate and share their experiences. Knowledge translation and increased funding for applied intervention research aim to fill this gap. Other ways are required to share emerging knowledge and support partnerships for more rapid uptake of successful practice methods.
While public health, with its inter- and multi-disciplinary approaches to addressing complex issues, is well suited to champion health equity, many practitioners still struggle to work beyond understanding SDH to taking action on them. The following four roles, developed by the Waterloo Regional Health Unit (in Ontario), found widespread agreement among public health practitioners in 2010 consultations (NCCDH, 2011):

- **Assess and report** on the health of populations, describing the existence and impact of health inequalities and inequities and effective strategies to address those differences;

- **Modify/orient public health interventions** to reduce inequities including the consideration of the unique needs and capacities of priority populations;
- **Engage** in community and multi-sectoral collaboration to address the health needs of populations through services and programs; and,
- **Lead/participate and support** other stakeholders in policy analysis, development and advocacy for improvements in the health determinants/inequities.

Ten promising and evidence-informed practices for local public health action were identified by the Sudbury and District Health Unit (Sutcliffe et al., 2009; SDHU, 2011):

- Targeting with universalism
- Purposeful reporting
- Social marketing
- Health equity target setting
- Equity focused health impact assessment
- Competencies/organizational standards
- Contribution to evidence base
- Early childhood development
- Community engagement
- Intersectoral action

These four roles and ten practices are reflected in much of the work currently undertaken by public health practitioners. The challenge remains to build and spread the uptake of intervention evidence, while maintaining strong rigour. "Gold-standard" methods that take into account the complex, context-specific intervention environment – not met by systematic literature review methodology – have yet to be developed. A paradigm shift is required in the way problems, needs and assets are understood; in how viable solutions are conceptualized; and in the partnerships forged between researchers and practitioners.

3.

BRIDGING PRACTICE AND RESEARCH

Challenges

In small groups, participants, active as researchers, practitioners, decision-makers, or students working to advance health equity, reflected on the successes or challenges they have encountered in bridging practice and research.

They noted broad challenges, including a general resistance to change, regulatory or policy barriers, a lack of time and resources, and a dearth of opportunities to share knowledge. The complex nature of the issues was cited as contributing to a lack of understanding about the determinants of health and the mechanisms required to address health inequities. Competing priorities and an unsupportive political climate were also noted as posing significant challenges to addressing health equity.

Most challenges identified, however, were clustered around implementation and research issues. Participants pointed to a lack of training in health determinants; concerns about their role as advocates; difficulties in 'scaling up' local successes, given the importance of context; and challenges in finding and applying appropriate evidence. Again, the complexity of the issue was raised, as in the following quote:

> "There is so much information and so many potential engagements, it is difficult to know how to narrow efforts to something specific and doable."
>
> WORKSHOP PARTICIPANT

Finding data that is local and comparable across jurisdictions in Canada, or that relates to specific groups, including Aboriginal populations, was a concern, as was the time lag between the generation and application of research evidence. Constraints around funding, and finding researchers and appropriate knowledge synthesis approaches to address health equity were also cited as challenges. Finally, barriers to collaboration between various sectors, disciplines and jurisdictions were raised.

...and Successes

A number of participants recognized the commitment to health equity as a strategic or policy priority within their organizations. Many more recognized the passion and growing momentum shown through action on the determinants of health. An often-named success was the collaboration occurring between researchers, practitioners, the community and other stakeholders, including individuals living in vulnerable circumstances. In some cases, these involve formal links between practitioners and academic organizations. In others, direct links have been made with very senior levels of government. Better sources of information and tools to address health determinants were lauded, along with an increased understanding of, and dedicated funding to, health equity initiatives.

4.
AT THE CROSSROADS OF ACTION ON HEALTH EQUITY: CASE STUDIES

Four case studies were discussed at the workshop, using a progressive disclosure method.[1] The cases reflect one or more principles of promising practice in SDH practice (described in Connie Clement's opening remark), as carried out in locations across Canada. Cases were chosen to reflect organizations at various stages in the application of SDH principles. Public health organizations were prioritized in the selection; however, recognizing the importance of actions outside of the health sector to improve health equity, one non-public health case was also identified.[2]

A. BUILDING LEADERSHIP COMPETENCY IN PUBLIC HEALTH

Dr. Jocelyne Sauvé, Medical Officer of Health, La Montérégie Regional Health Authority

Amendments to the act governing the delivery of health and social services in Quebec, passed in November 2005, changed the face of public health delivery in that province. Front-line community service facilities, that had addressed health promotion and disease prevention in the past, were merged with long-term care facilities and hospitals. Public health services were to be delivered by managers who often had little or no experience in public health. Dr. Sauvé saw an opportunity to integrate a population-health perspective into the new service delivery structures, by training the new managers in public health. In this workshop, participants strategized on how a similar approach could be used to promote health equity within public health leadership.

B. MAKING THE CASE FOR HEALTH EQUITY INTERNALLY: WINNIPEG'S EXPERIENCE

Dr. Sande Harlos, Medical Officer of Health, Winnipeg Regional Health Authority

A 2008 report on urban health showed that people living with the lowest socioeconomic status in Winnipeg were showing up in city hospitals at two or three – sometimes even five – times the rate of its wealthiest residents. Winnipeg had among the highest differences in hospitalization rates between low and high socio-economic status groups in Canada. The report provided relevant, local and comparative health data – a catalyst for action on health disparity in that city. Public health leaders used the opportunity to strengthen ties with anti-poverty and other community organizations, and to raise the profile of health inequity with senior management. This case study describes the efforts of public health staff to cast a health equity lens over all aspects of the Winnipeg Regional Health Authority, including health services delivery and long-term care.

[1] The progressive disclosure method shares information about a case study in stages. At each discussion point, participants are asked to consider decisions and next steps based on their knowledge and experience. After each discussion, someone involved in the actual experience shares decisions, events and learning from the real-life project being analyzed. The method is designed to enhance participation and optimize reflective learning. (Adapted from: Curriculum for Culturally Responsive Health Care, Ring JM, Nyquist JG, Mitchell S, Radcliffe Publishing, 2008.)

[2] Working documents were shared at the workshop and subsequently refined to reflect participants' suggestions. The edited versions are available at www.nccdh.ca

C. IMPROVING HEALTH EQUITY IN SASKATOON: FROM DATA TO ACTION

Dr. Cory Neudorf, Medical Officer of Health Saskatoon Regional Health Authority

This case study profiles the process used by Saskatoon Health Region to document and address health inequities in that city. *Health Disparity in Saskatoon: Analysis to Intervention* (Lemstra and Neudorf, 2008) presented neighbourhood-level health data and explored policy options to address the underlying social determinants of health. The health team used local data as the basis for engaging a wide range of partners and Saskatoon residents, to plan and implement a program that would begin to address the vast differences in health between residents of the city's poorest and richest neighbourhoods. They faced, and were able to overcome, a number of challenges, as described in this case study.

D. EMPOWER THE COMMUNITY: NEW BRUNSWICK'S APPROACH TO OVERCOMING POVERTY

Stéphane Leclair, Executive Director, New Brunswick Social and Economic Inclusion Corporation

In April 2010, New Brunswick passed into law an act adopting *"Overcoming Poverty Together: The New Brunswick Economic and Social Inclusion Plan"*. The plan was developed through a consultative process that involved over 2500 citizens. It was designed to empower communities to set and implement their own poverty reduction plans, through twelve Community Inclusion Networks now in place throughout the province. This new approach requires a clear understanding of community issues and a culture shift among local organizations, which have not traditionally cooperated on joint goals. This case study describes how the communities are overcoming various challenges, including developing evidence-based solutions to their issues in the absence of academic research support.

E. PLENARY – DID RESEARCH AND PRACTICE MEET?

Researchers Dr. Marie-France Raynault and Dr. Jeff Masuda acted as respondents, commenting on what they had observed as participants in two case discussions about the link between research and practice, the structures and tools that made the linkages possible and the role played by local context. They also commented on the feasibility of 'scaling up' these interventions for provincial or national gain to support the linkage of evidence and action towards health equity.

Marie-France Raynault, Centre Léa Roback, Montreal

The intervention led by the **Saskatoon Health Region** provided a number of lessons that can be applied more broadly. Rigorous data is at the heart of an effective intervention, preferably published in peer-reviewed publications. Rigour and comparison are keys to success in presenting information that helps change policies. Politicians do not want to be the 'last in class.'

A clear understanding of key audiences and their potential reactions to research is also critical. Investing the time and effort to communicate to stakeholders well in advance of public disclosure is an effective strategy. Understanding the values of the broader population is important to anticipate public reaction to proposed changes.

While engaging the business community in initiatives has some real advantages, care must be taken that vigorous business voices do not overtake

the agenda, or impose their way of working on other groups. Economists, in particular, must be part of the conversation; yet they sometimes drive the public agenda, based on ideologies that may need to be challenged at times.

New Brunswick's initiative has shown innovation in engaging participants at both a very high level and in local implementation. Four government ministers are present on a provincial advisory board, and at the local level, Community Inclusion Networks involve local government, business, not-for-profit and citizen representatives. On the other hand, while addressing local issues, it is important that Networks' plans focus on creating equity and are based on evidence.

A challenge in working with researchers is that they are not trained to take a broad perspective. Their way of working is generally very specific and focused. One way of encouraging common measures would be to hold a competition between provinces, gauging how each is doing in achieving equity goals. The European Union uses such an approach to fight poverty – the "Open Method of Coordination."

Jeff Masuda, University of Manitoba
The current environment provides many opportunities to engage with researchers and work together to influence policy. There has been a sea-change in how to go about advocating for particular policies, including health equity. Knowledge is far more accessible, and leadership is no longer dependent on organizational structure.

Policies are produced and evolve through a fast diffusion process. Researchers, particularly those in the social sciences, often make their careers out of policy transfer, which is increasingly being developed on a collaborative basis, rather than being driven by lone organizations. The case studies applied that approach by being nimble in 'grabbing' the diffusion process to advance health equity.

Factors for success in promoting health equity are:

- leadership, not dependent on the organizational structure;
- common best practices;
- communities of practice, involving people from different sectors to collaborate on solutions;
- using emotions that everyone can relate to, no matter what their position, when advocating for health equity;
- moving away from the 'programmatic fix' to one based on policy change;
- applying established approaches to local context.

Knowledge networks provide opportunities for communities of practice to share knowledge and experiences. The Quebec Population Health Research Network, the Urban Public Health Network and others are available to help scale up local initiatives into a broader movement.

"The role of public health is to find the many people who understand health equity and offer our services."

RESEARCH DISCUSSANT

5.

KEYNOTE ADDRESS - EVIDENCE AND ACTION IN HEALTH EQUITY: THE INSITE SUPERVISED INJECTION FACILITY

Dr. Kora DeBeck, Postdoctoral Fellow and Research Associate, BC Centre for Excellence in HIV/AIDS

Dr. Kora DeBeck was involved in the scientific evaluation of Insite, Vancouver's supervised injection facility, and played a lead role in its knowledge translation activities. Its continuing operation is largely due to broad communication of its evaluated success, and the engagement of a wide range of supporters.

Insite was established in 2003 in conjunction with Vancouver Coastal Health. It was granted an exemption from the Controlled Drug and Substance Act to provide health services to an under-served population, and to address public safety issues brought about by widespread injection drug use in the neighbourhood. A requirement of the exemption was that the project be rigorously evaluated.

A focus of the research team was to integrate knowledge transfer into the evaluation process. Twenty peer-reviewed articles were published based on the evaluation results, which found that Insite was meeting its goals. Additional communication tools included plain language summaries and reports; published commentaries and editorials; a website; media engagement; presentations to policy-makers, the public and other stakeholders; and a strategy to engage the scientific community to advocate for evidence-based policy. Knowledge translation efforts brought the research evidence to the public and scientific and health system communities, and resulted in broad-based support from the governments of British Columbia, the city of Vancouver, the Canadian Medical Association, the Canadian Nurses Association and the general public, among others.

Despite overwhelming confirmation of the success of Insite in meeting its goals, Canada's Health Minister was "not convinced by the evidence." He put on hold the decision to extend the exemption to allow Insite to continue operating, and stopped further sites from being established.

Community groups and individuals launched a case in the Supreme Court of British Columbia. Due, in part at least, to the active KT strategy carried out by the research team, the lawsuit attracted many supporters, including health and civil liberties organizations. After winning a constitutional exemption in BC, the Insite decision was appealed by the Minister of Health to the Supreme Court of Canada. The Supreme Court ruled that shutting down Insite, which it saw as a health care facility, would violate the Charter of Rights and Freedoms' guarantees of life, liberty and security of the person. It ordered the Federal Minister of Health to grant an exemption to allow Insite to operate.

Victory in this case came from the combination of high-quality research evidence with a detailed KT strategy. Peer-reviewed articles were vital to withstand public and political scrutiny. The use of multiple media and strategies, media engagement and a focus on building relationships of trust with policy-makers and stakeholders early in this multi-staged story created a climate of support. Ultimately it was the actions of stakeholders, particularly community groups and service providers, that resulted in the continuation of this evidence-based program.

6.
RESEARCHER PANEL

A panel of CIHR-funded researchers showcased tools that link evidence to action for health equity. They discussed approaches to generating research questions and plans for knowledge translation. The researchers also explored opportunities for increased engagement of practitioners and decision-makers on health equity-related issues locally and beyond.

A. REDUCING HEALTH INEQUITIES: INTEGRATING AN EQUITY LENS IN PUBLIC HEALTH

Dr. Marjorie MacDonald, CIHR/PHAC Applied Public Health Chair, Professor, School of Nursing, University of Victoria

The Core Public Health Functions Research Initiative (CPHFRI) examines the implementation and impact of the core public health functions framework in British Columbia. The Equity Lens in Public Health (ELPH) research program, led by Dr. Bernie Pauly and co-led Dr. MacDonald at the University of Victoria, is a program within CPHFRI that aims to contribute knowledge about health inequities reduction, through four inter-related studies over five years. All four studies explore aspects of the provincial core functions framework, with knowledge translation and exchange (KTE), equity, partnerships and methodological development as cross cutting themes. In particular, the team focuses on research methods relevant for studying complex adaptive systems.

The ELPH research examines the integration of an equity lens into two core public health programs: mental health promotion and preventing the harms of substance use. The study currently underway focuses on the theoretical relevance and practical utility of health equity tools.

KTE is integrated into every aspect of the process, to "strengthen and improve health sector innovation for reducing health inequities." All team members are, at different points in time, knowledge users and also knowledge producers. Knowledge users were involved in identifying the research questions, and will be involved in interpreting the data and disseminating the strategies. Involving them in an ongoing, iterative process allows the team to make mid-course adjustments, if required.

Although data are not yet available in the current study, experience in a related study revealed some implementation problems in the first round of data collection and analysis – gaps in the evidence-to- practice process and the absence of evidence-informed and targeted implementation strategies. Getting feedback part-way through the process allowed the team to enhance implementation mid-stream.

To date, an inventory of documents assessing 163 health equity tools has been gathered. The practical utility of the tools will be assessed through a concept mapping approach that engages public health practitioners involved in developing and implementing health equity plans, or programs related to mental health promotion or the prevention of substance use harm. The process will lead to a set of criteria for effective tools.

B. USING GEOGRAPHIC MAPPING TOOLS TO UNDERSTAND HEALTH EQUITY AND SUPPORT LOCAL ACTION: THE OTTAWA NEIGHBOURHOOD STUDY

Dr. Elizabeth Kristjansson, Associate Professor, School of Psychology, University of Ottawa

The Ottawa Neighbourhood Study began in 2005, based on the premise that the place we live can impact health and health inequalities. The researchers were interested in working with people in the community to make the data relevant and useful. Inspiration from the Brooking Institute in Philadelphia, and precedents in Toronto, Vancouver and Montreal demonstrated the value of such data in supporting work to promote health equity.

For success, it was important to have decision-makers and others from the community buy into the process and use the data gathered. As such, the steering group included only four academics and was made up mostly of representatives from neighbourhoods, public health and local businesses.

The goals of the project included gathering data on determinants of health, health status and health inequalities within well-defined neighbourhoods, and developing an understanding of which factors contribute to health and health inequalities. Profiles were developed for each neighbourhood, and shared with policy makers and citizens.

Once neighbourhoods were defined, with the input of local residents, data was gathered from a wide variety of sources, including the Canadian Community Health Survey, the Rapid Risk Factor Surveillance System (an ongoing telephone survey), the National Ambulatory Care Reporting System and the Early Development Instrument of children's readiness to learn in school. The information, including socio-economic, demographic, housing, community engagement, built environment and health indicator data now comprises one of the largest such sets of data in the world.

Charts, maps and neighbourhood profiles were disseminated, demonstrating the significant inequalities in both health determinants and outcomes between and within neighbourhoods. Interactive mapping and neighbourhood profiles are available online (http://staging.neighbourhoodstudy.ca/), allowing users to filter by various elements (e.g. socioeconomic status in relation to fast food outlets), and get data on their neighbourhoods compared to others. The surveillance data shows correlation between factors, but does not imply causality.

Ottawa Public Health has become a key partner in disseminating the evidence, and the Ottawa Neighbourhood Study has emerged as an important decision-making tool for Ottawa city planners, school boards and community programmers, among others. The website has been named as the best source of data on the city and its residents, with users commenting that they "use this every day." Plans for the future include continuing to update the data and working with users to ensure that it remains as informative as possible. The researchers are also hoping to expand this award-winning research project throughout Eastern Ontario.

Mapping is emerging as a powerful public health tool to chart and interpret data around health inequity. It is being used in a number of Canadian cities, and can be linked with evidence-based storytelling, including approaches using photographs or video, to add very powerful, personal qualitative information. Other applications, such as concept mapping or social networking analysis bring a new level of understanding to issues.

C. COMMUNITY-BASED PARTICIPATORY RESEARCH WITH ABORIGINAL PEOPLES: LINKING EVIDENCE AND ACTION FOR HEALTH EQUITY

Dr. Colleen Dell, Associate Professor, University of Saskatchewan

From Stilettos to Moccasins was a community-based research project that resulted in a music video and health intervention workshop. It began in 2005, with a diverse, community-based team that included elders, women who had experienced addiction issues, researchers, policy-makers and treatment providers. People of many different backgrounds and ethnicity brought their experiences to the table.

Much of the success of the project can be attributed to the respect, understanding and hope that guided the work. Dr. Dell found that she had to leave all stereotypes and her role as a professor behind, and participate as an authentic, sometimes vulnerable, individual. A strong focus on the outcome enabled the team to deflect the negative feelings that sometimes arose from participants, often because past experiences in residential schools, for example, were triggered.

A strong sense of reciprocity pervaded the process, with researchers learning a great deal from the 100 women they interviewed in prisons across the country. As a sign of the value they brought to the process, the women with lived experience were remunerated for the time they devoted. They were also provided with a very meaningful gift: a pearl in its shell on a necklace.

To give back to others in the community, the research team and women interviewed created a song and music video – *From Stilettos to Moccasins* (www.youtube.com/watch?v=1QRb8wA2iHs). While this aspect of the project cannot be evaluated, it emerged as an extremely meaningful outcome. By placing the researchers in an unfamiliar environment, the process created a sense of vulnerability and openness that was instrumental in building relationships with the research participants. The research resulted in a half-day intervention, to offer hope and inspiration to Aboriginal women criminalized due to illicit drug use. It addresses issues of identity and stigma, focusing on the need to claim or reclaim a sense of identity as an Aboriginal woman, in order to heal from substance abuse. The workshop was designed to be easy to deliver and sustainable. The kit includes a video on how to present the workshop, with no other training required. Women with lived experience act as project ambassadors. The workshop kit is provided at no cost to those who wish to present it, with the cost of $200 per kit covered by grants. Groups who can pay for the kits are encouraged to do so, to provide funding for additional distribution of the kits for free.

Issues raised during an open forum with participants included:

- Health equity research often raises **ethical challenges**. A future study within the ELPH research program will look at the ethical issues practitioners face.
- The potential to **involve students** in health equity research to expand their understanding and experience with the issues – Most universities offer community-based research, community service learning or mentorship opportunities to provide that involvement.

- The **intersection between research and advocacy** – Researchers involved in participatory action research are sometimes criticized for losing their impartiality. While many applied researchers take on an advocacy role because they believe in the issues they are working on, it can make other academics uncomfortable. An important strategy to avoid criticism is to be very open and communicate widely about ongoing work and its outcomes. A supportive faculty, along with recognition from key funding institutes, such as CIHR, is certainly helpful.

D. RESPONSE TO RESEARCHER PANEL

Dr. Gaynor Watson-Creed*, Medical Officer of Health, Capital Region, Halifax, Nova Scotia*

Dr. Watson-Creed made her comments as a practitioner whose health region, Halifax, has recently committed to reporting on health equity. She wondered whether the research question is framed differently depending on whether it is led by a practitioner or a researcher. Similarly, she asked whether the conversation changes if other sectors lead the project? Dr. Watson-Creed asserted that she is happy to remain in the conversation, as long as all partners are focused on the same outcome. For example, "harm reduction" can be translated to "problem-based policing" for some audiences, thus increasing common ground. From a decision-making and policy perspective, one strategic approach is to bring dissenting voices into the process from the beginning.

Dr. Watson-Creed was pleased to see integrative knowledge translation as a research theme. Examples of **'trans-local' action** provide evidence of the capacity for local leadership to move initiatives to a national scale, without them being nationally driven. Future research, she hoped, would paint the pathways from determinants to health outcomes, so that policy-makers can truly pay attention.

Lynn Vivian-Book*, Former Assistant Deputy Minister, Income, Employment and Youth Services, and government-wide lead for the Poverty Reduction Strategy and Disability Policy Office, Newfoundland & Labrador*

As a nurse and public health advocate, Ms. Vivian-Book had the unique experience of leading a government-wide poverty reduction strategy from inside several Ministries. Very quickly, she learned the importance of language, having been "shut down" for saying 'social determinants of health' and 'intersectoral collaboration.' Rather than these health-oriented words, 'the circumstances in which people live' or 'partnership' were accepted more often.

The role of researchers is changing, shaped by broad steering committees and participant involvement. In the future, most research documentation will not appear in peer-reviewed journals, but in the media and in public conversation. Non-traditional ways to find and disseminate information are needed, including lived experience, music videos, and resident participation in community mapping.

Structural approaches to embedding health equity have been tried, but not always successfully. An inclusive lens through which to review policies, such as 'poverty and social inclusion,' may best incorporate health, along with other 'lenses,' such as gender, Aboriginal status and disability.

It is also important to identify and be ready with the appropriate research to take advantage of policy 'windows' for health equity. Currently, mental health and addictions, and chronic disease issues appear to be open to intervention.

Comments from the workshop participants focused on:

- The challenge that researchers do not have the same **opportunities to collect data** from individuals as the private sector – Private firms are able to collect information to make money, yet researchers can't do the same thing for societal good. The current environment puts individual rights over those of society.
- Convincing people in the **health care or other sectors to implement population health measures** – Those who are pressured to provide health services sometimes have difficulty seeing opportunities beyond their walls. Horizontal policy development is one way to provide services that impact health from sectors outside of health, such as school food programs being funded by the education sector.

7.

CAPTURE SESSION

A. LINKING EVIDENCE TO ACTION

Using written forms, participants identified factors that make it easier or more difficult to link evidence and action in health equity, when compared to other public health issues. Some people challenged the separation of health equity from other public health concerns, noting that health equity is a lens through which all public health should be addressed.

Facilitators

The following three issues emerged as themes that support linking evidence to action at all levels – local, provincial and national.

- **Health equity as a concept** that is well-understood and embraced by a wide range of people, particularly when it is framed as "fairness". In fact, participants cited fairness as a core Canadian and human value.
- **Convincing evidence,** particularly when it is local. Local evidence was cited as more meaningful and applicable, given that advocacy groups are often in place to take full advantage of evidence that supports their efforts to address inequities.
- **Multi-sectoral action/collaboration** was named as an effective route to action, again, particularly at the local level, where potential partners are better known to each other.

Public health as a supportive environment and leadership were two other themes mentioned, although less frequently than the three cited above.

Generally, the local environment was noted by participants as being the most conducive arena to work towards change, with participants citing action at the local level twice as often as at the provincial or regional levels, and five times as often as at the national level. They noted that issues resonate with the local population, and that results are more easily demonstrated locally.

Some levers for action were named at the provincial level, particularly poverty reduction strategies and equity-oriented tools in use. At the federal level, granting agencies and organizations that provide leadership on health equity, such as the National Collaborating Centres, the Canadian Institutes for Health Research and the Canadian Public Health Association were named as facilitators to action. The national level was also named as a central repository for information and health data.

Barriers

The issues felt to pose barriers to linking evidence and action for health equity were:

- **Values or ideology**, whereby a culture of individualism or a conservative mindset block action. This barrier was most frequently cited across all levels. When it was linked to a particular level, it was more often national.
- Other issues that held equal weight as barriers, across all levels, were **language or understanding** of health equity; **a lack of evidence or data**, and difficulties demonstrating success; and **implementation issues:** lack of resources, training, skills or power to effect change.

Difficulties in establishing broad support and collaboration with other sectors, and jurisdictional issues were also raised, although less frequently than the four issues noted above. Issues related to 'politics' (e.g. political will, the election cycle) were cited at the provincial and, most often, the national level.

B. TOOLS, METHODS AND APPROACHES

A number of tools, methods and approaches exist to improve or scale-up local initiatives to create provincial /national gain to support the linkage of evidence and action in health equity. However, the value of scaling-up was questioned by some participants, who noted that the "big gains" often happen at the local level. Much innovation in public health has arisen at the local level, which is then taken up at the provincial level. As such, many called for "trans-local", rather than provincial or national initiatives. Policies appear to be more scalable than programs, so it may be that policy structures can be changed to address health equity.

The specific tools cited include health impact and health equity impact assessment tools, used within health environments or other sectors. However, one universal tool was called for, that cuts through the multiplicity of tools. One intersectoral tool that incorporates all the relevant lenses and determinants, including how to address power in a policy context, is the *Intersectionality-Based Policy Analysis Tool* (Institute for Intersectionality Research and Policy, Simon Fraser University).

Effective public health tools can be spread to others, as long as they can be adapted to the local context. Jurisdictional action plans that cut across sectors, such as provincial poverty reduction strategies, provide opportunities to foster ongoing relationships and collaboration with policy-makers.

Ways to bring the equity story to the public are also required. There is a need to develop "sticky" messages, through creative, evidence-based story-telling, videos, music and viral communication. Community mapping involves residents to provide local, easily-understood data to inform such stories. It can be difficult to make community mapping available on a broad scale, however.

To create broad support for health equity action, the public and political groups need to be involved in the conversation. Public surveys, "elevator" talking points and community discussions are needed to influence mainstream perspectives, or to demonstrate to political leaders the public sentiment that already exists. Evidence is required to show the impact of health equity action, but as the example of Insite clearly demonstrated, support from multiple sources is sometimes also required to create the "tipping point" required for action.

Champions are required at the provincial and national levels who understand the policy environment and have appropriate evidence at hand. Emerging leaders must be nurtured to fill this need.

In general, approaches to bring healthy equity to action must be multi-pronged and act on multiple levels. Recommendations must be made to all levels of government, with broad engagement of government departments and organizations required to provide interventions at the population level. Efforts must go beyond poverty, to look at the effect of inequities across the income gradient, bearing in mind that health issues, such as those related to overweight, alcohol and tobacco, extend well beyond the poor in society.

To create the kind of evidence needed to move the agenda forward, there is a need for new research methodologies that take a systems view and developmental perspective, that will underscore the interaction of the many factors that affect health equity over time. At the local level, a combination of qualitative and quantitative approaches may result in powerful evidence. In all cases, support to evaluate complex interventions is required.

> "Just because we are enthusiastic doesn't mean it works. How can we use epidemiological tools to carefully determine what works?"
>
> WORKSHOP PARTICIPANT

While many small successes, effective tools and innovations for health equity are taking place, there is a strong call for better sharing of information, both within the public health sector and outside of it. Health equity products need to be created quickly and shared widely to build up a coherent, easily-searchable body of knowledge. The NCCDH was cited as the ideal organization to act as a hub for health equity knowledge, research and tools – the trans-local link between communities.

C. DESIGNING REGIONAL INITIATIVES INTO PROVINCIAL/NATIONAL PRIORITIES FOR ACTION

Intersectoral and inter-jurisdictional processes are key to putting health equity into provincial or national plans of action. Formalized mechanisms include intersectoral committees and an embedded "equity lens" in all policies, whether through legislation or a determinants of health framework. Informal approaches may include communities of practice, nurturing networks to facilitate the "natural outbreak of ideas," and developing stronger relationships between individuals of different sectors. Champions, NGO groups as well as public health networks could all contribute to this process. It is important that practitioners and researchers are well-versed in the policy-making process, and are aware of windows of opportunities that may open. Researchers must be "policy-savvy" and promote research such that it makes sense to policy-makers.

Local and provincial levels of government were noted as the most influential to health equity efforts, given their role in providing health and social services.

Establishing health equity as a priority remains a challenge. Using both formal and informal approaches to marketing and communication can support this effort. Branding provides recognition among public and senior government officials, while framing an issue can increase understanding among broad audiences. It may be important to bring multiple voices to the discussion, including NGOs, researchers, and the public. Using creative approaches, including mainstream and social media will help "build readiness" for mindset shifts.

Adequate funding must be made available to implement action on health equity. A compelling economic case must be made by measuring the financial impact of equity programs, or conducting an international review of spending

> "We need to put the human face on issues. Calls from constituents make politicians responsive. If local people are onboard, that creates ripples up to decision-makers. Evidence is not enough. We need to change public opinion."
>
> WORKSHOP PARTICIPANT

on equity-enhancing interventions versus health care. It may make sense to provide funding from health budgets to other ministries who can act on the determinants of health. Budgets at the community level, to fund child care centres, women's centres, recreational programs and other initiatives to reach disadvantaged populations are also important.

D. APPROACHES TO GENERATING RESEARCH QUESTIONS

Three key themes emerged from discussions on approaches to generating research questions and embedding plans for knowledge translation: (1) **interdisciplinary discussion,** (2) **using community-based and other local approaches to research,** and (3) creating funding opportunities to support **problem-based research**. Training of researchers to embed KT into their work was also cited as important.

Opportunities for discussion between researchers, practitioners, policy-makers and community members are required to generate research that is relevant to issues of health equity and to the community in question. Community-based research and neighbourhood mapping are two potential research approaches. Funding opportunities for this type of research, and to embed KT into the process, are required. KT should be part of the ongoing process, with expertise from all parties contributing to an integrated plan, rather than relying on a KT specialist to get information to the community.

E. OPPORTUNITIES FOR INCREASED ENGAGEMENT BETWEEN RESEARCHERS, PRACTITIONERS AND DECISION-MAKERS

In addition to emphasizing the ongoing importance of interaction between the disciplines, the main opportunities identified for increasing engagement between researchers, practitioners, policy-makers and the broader community were (1) **funding opportunities** and (2) **competency and leadership development.**

Funding that demands interdisciplinary teams, including knowledge users, will result in increased engagement between communities. There are opportunities to broaden the scope of researchers who can contribute to public health, such as social scientists and medical geographers (following the Sax Institute model, which brokers the research and policy worlds). Funding may also be available from untraditional sources, such as municipalities and issue-specific funding, such as that provided through the Canada Mortgage and Housing Corporation or the Canadian Partnership Against Cancer's C*oalitions Linking Action and Science for Prevention*.

Schools of public health can play a strong role in building competencies that bridge evidence to action. Leadership training for early career researchers, practitioners and policy-makers can cultivate leadership potential among new practitioners. Ongoing training opportunities, through deliberative dialogues and cross-sectional discussion, can bring successes from other sectors to the health arena. All of these ways of building competencies can be captured in webinars and other dissemination approaches.

F. STRENGTHENING EXISTING STRUCTURES TO SUPPORT LINKAGES

A number of structures to support linkages between researchers, practitioners and decision-makers were identified, including those based in institutions, funding organizations and training opportunities.

While the National Collaborating Centres were named as possible institutions to bridge research and practice, it was noted that gaps remain in terms of a structure to support intersectoral practice. Academic and government organizations can play a role in rewarding work to strengthen linkages, through tenure and promotions. Participants emphasized the importance of an independent voice on this issue, and the need to avoid duplicating efforts.

Locally, community foundations and NGOs, such as the United Way, were named as linking organizations to provide funding and support participatory research. Opportunities were identified at the municipal level amid initiatives that may not focus on health. Politicians will sometimes offer local venues for input on specific issues. Cross-appointments between academics and practitioners also create a direct link between these two sectors. Chambers of Commerce may provide an opportunity to begin a dialogue on the impact of health inequalities within the workforce, although care must be taken to use "business," and not "health" language.

At the provincial level, similar institutions were named (foundations, members of the business sector, etc.). Groups such as the Population Health Intervention Research Network were also noted. Chief Medical Officers of Health may also act as voices for health equity. In Manitoba, Medical Officers of Health are automatically linked to public health schools, with an expectation of involvement.

A number of national organizations were named as conduits between research and practice, including health organizations such as the NCC's, CIHR, the Urban Public Health Network and the Council of Medical Officers of Health, and groups from other sectors involved in health determinants, such as the Social Sciences Health Research Council, the Federation of Canadian Municipalities, the Canadian Institute of Planners and other professional organizations. Advocacy groups, including the Canadian Association of Food Banks and Canada Without Poverty provide a strong community voice.

Federal institutions clearly play an important role, including government departments such as the Public Health Agency of Canada (PHAC), Environment Canada and Health Canada (including the First Nations and Inuit Health Branch). Canadian Senate committees and the Auditor-General's office are two other institutions that can bring intersectoral issues to the fore.

"Sometimes, our health 'hats' must be left at the door, and a broad perspective be taken. Allow others to take ownership of the issue."

WORKSHOP PARTICIPANT

8.
MOVING TO ACTION - PARTICIPANT COMMITMENTS

A. OPPORTUNITIES PARTICIPANTS COMMIT TO ACTING UPON

Building on the information shared at the workshop, participants recorded opportunities they would commit to acting upon. The workshop theme of interaction carried through this exercise, with the majority of suggestions related to engaging with fellow participants, students or groups with whom public health people do not normally work. Participants noted the importance of using their networks to continue the dialogue and to build relationships with those outside of health who have a strong impact on health equity.

Some suggestions related to day-to-day implementation of lessons learned at the workshop, including:

- Participate on a joint research, policy, decision-makers initiative.
- Based on local data, identify several key policy initiatives and survey appropriate communities to establish a level of support.
- Engage a few key strategic partners as knowledge-users for health status reporting.
- Fine-tune mapping capabilities for locally relevant asset mapping and engage stakeholders in discussions about what matters and what should be done, aligning descriptive indicators, best practices and lived experience, along with other sectors.
- Promote a directed policy dialogue on a subject that is pertinent to the community and inequality in the determinants of health.

A number of participants said they would incorporate the workshop lessons into planning or reporting initiatives, such as health status reports. Others plan to write up and share success stories, evidence-based sound bites and eye-catching statistics. One person even committed to "collect and develop a central database or repository of equity-focused local/ regional programs/ interventions and policies that are being adopted in Canada."

Research and funding opportunities were the focus of many suggestions, with participants committing to include a health equity focus in future work. Some suggested bringing students into their research efforts or developing the complex methodologies required to provide evidence for decision-makers. A number agreed to provide meaningful input to the CIHR funding process, currently being reviewed.

"Do what you promised."

WORKSHOP PARTICIPANT

B. OPPORTUNITIES OTHERS SHOULD ACT ON

Most suggestions for action participants hoped would be undertaken by others focused on the need to create opportunities for researchers, practitioners and policy-makers to engage in partnerships and focused discussions to move health equity forward.

Specific suggestions for research-practitioner-policy engagement were:

- Researchers and funders to continue to encourage policy-research partnerships;
- Ensure funding for community partners (e.g. through community-university research alliances);
- Research and policy-makers to coordinate efforts to be ready to act when policy windows open;
- Through NCCDH, create a space for researchers and practitioners to dialogue to generate research questions on health equity;
- Create a "go-to hub" – NCCDH and other parties;
- NCCDH/CIHR-IPPH/CPHI, etc. bring forward to the Canadian Reference Group, an intersectoral committee about determinants of health supported by PHAC, a proposal to develop/host a facilitated discussion about developing a more systematic research agenda related to health equity;
- Urban Public Health Network to create a subgroup on health equity.

Suggestions related to communication and community engagement included:

- Starting and continuing community conversations about health equity (e.g. what it is; why it is relevant, important; etc.);
- Use knowledge translation in your role/as a volunteer to empower the community (NCCDH key role);
- Investigating principles of private sector involvement (building a philanthropic culture in Canada);
- Someone to sell public health and health equity, someone to make it sexy – use creative methods – theatre, art, songs, videos, drawing from the creative arts. Pictures, the art of medicine, capturing people's hearts, creative non-fiction, etc.;
- Communicate to and engage the general public in health equity issues in public fora.

Other suggestions related to creating funding opportunities; in particular, that CIHR fund research with a health equity focus. Participants called for opportunities to train people in health equity. Finally, one participant called for "accountability for action."

The NCCDH was named several times as a potential hub for the evidence base, inventories, examples, success stories and other information to allow people to advocate intelligently for health equity. It was also cited as a potential portal of health equity funding opportunities, linking researchers and potential partners.

9.
CONCLUDING REMARKS AND NEXT STEPS

Nancy Edwards closed the workshop by remarking on how much she had learned from participants. Yet despite the many health equity tools, approaches and models of interaction between researchers and decision-makers, health inequities remain tenacious. The good news is that people can take action with what we already know; research supports this iterative process.

Much of the innovation in public health has arisen at the local level. It is important to document these "golden nuggets" quickly, and make them easily available so people can build on successes and avoid duplication of effort. Stories can be influential, as long as health language and acronyms are left out. There is a strong capacity for trans-local action – moving things to a national scale without it being nationally-driven.

While the policy environment is complex, windows of opportunity sometimes do open. When they do, the right research needs to be available. New methods need to be found to address the "multiple vector of forces at many levels interplaying over time." Mechanisms linking social and structural determinants, interventions and context need to be made explicit and better understood. Costs and benefits to society must also be elucidated, across sectors and system levels.

The CIHR Open Operating Grant program, which funds 70% of its research, was under review at the time of the workshop. Participants were encouraged to provide their feedback, to ensure that the fund is accessible and equitable to all four research pillars. Nancy strongly encouraged everyone to apply for funding, and possibly, to engage social scientists to apply for the type of research needed to support action on health equity.

Advances can be made by examining complex population health interventions within complex adaptive systems, supported by knowledge synthesis strategies and models to fund population health interventions. Methods and implementation systems to scale-up efforts are required, along with stronger interfaces between evidence and practice. There remains a clear gap in research evidence to help us understand what action to take.

Connie Clement confirmed that the NCCDH aspires to be a critical source for health equity information, knowledge and evidence, and to provide a key support structure. NCCDH can be a hub, an accelerator of ideas and promising and proven practices. The essence of NCCDH's Knowledge Translation work includes the roles of conduit, broker, relationship-builder, and bridge between people and information.

In relation to this workshop, NCCDH commits to:

- Promote dialogue and exchange between researchers and practitioners, across provinces and territories, and between Francophones and Anglophones within the NCCDH soon-to-be launched virtual community;
- Ensure that the new NCCDH website, combined with the virtual community, serves as the hub participants asked for;
- Address identified barriers and facilitating factors, and promote effective interventions and joint research-practice models through publications (reviews, cases, evidence

summaries) and educational and exchange events;
- Identify and encourage research and policy responses to evidence gaps;
- Bring evidence to bear in public health leadership development to advance health equity;
- Specifically, develop and disseminate proceedings, release the case studies, post the presentation slides, generate video products highlighting the workshop's central ideas, and use the cases as the basis for webinars to be delivered with CHNetworks.

A. WORKSHOP THEMES

From the outset, the workshop aimed to "strengthen relationships between researchers and practitioners to address health inequities." The interaction between participants clearly met that goal. Both the pledges made by the workshop hosts, and the many individual commitments made at the end of the two-day process, focused on fostering and participating in dialogues at various levels to engage researchers in the work of practitioners, practitioners in research projects, and students and community members in all activities.

Presentations and discussions among participants created a wealth of ideas to build on the workshop objectives and themes.

To **advance health equity**, trans-local action may be an effective model to extend local successes to other locations, without the need for national or provincial structures. Multi-sectoral collaboration is an effective route to action, particularly at the local level, cited as being the most conducive arena to work towards change. Participants should keep an eye open for policy windows, and were given a demonstration of that in action in Winnipeg. Advances in health equity require that champions or leaders be found, or sometimes created, as in La Montérégie.

Gaps in research must be identified and funding opportunities created so they can be filled. A compelling economic case for health equity is required, and there is a need for new research methodologies that provide a systems view to take into account the complex interaction of the many factors that affect health equity over time.

Health equity can be advanced by taking advantage of the fact that it is a widely understood concept that is embraced by many, particularly when it is framed as "fairness." Sticky messages – using non-health language – and creative methods of communication are required, including evidence-based story-telling, videos, music and viral communication. Public surveys, elevator-talking points and community discussions can influence mainstream and political perspectives. Advocacy must be treated carefully, but should not be avoided by public health professionals.

Integrating research and practice can progress by involving practitioners in research through steering committees; through community-based participatory research; and by engaging students in research projects. Many examples exist of the value of integrating lived experience into health equity work.

A wide range of health equity tools exist –at least 163 according the research presented at the workshop by Marjorie MacDonald. Community mapping and health equity impact assessment tools are being effectively used, but an integrated health equity lens is still required.

Data at the local level is particularly meaningful and applicable. It tends to be more relevant to politicians and local decision-makers, and supports the work of advocacy groups ready to take full advantage of health equity evidence. A range of resources exist to provide research support in communities, as the New Brunswick case demonstrated. Strong evidence and local public opinion are important to make the case for action on health equity, as shown in Saskatoon.

The workshop demonstrated a number of successes in **translating knowledge into action**. Knowledge translation is an effective approach to building support for initiatives, as was shown through the Insite and Saskatoon experiences.

CIHR-IPPH will work to raise the importance of health equity among research partners, and embed the issue in research projects and funding opportunities. They will also aim to clarify the key research gaps for population health equity research and reinforce the value of community work by researchers in various ways.

While knowledge is far more accessible, effective tools more available and innovative action on health equity more common than several years ago, participants made a strong call for a "go-to hub" to allow them to access and act upon the latest research and effective practices. The NCCDH committed to stepping up to the call, to act as a central repository and connector for health equity knowledge, research and tools.

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