



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

PROCEEDINGS

ADVANCING PROVINCIAL AND TERRITORIAL PUBLIC HEALTH CAPACITY FOR HEALTH EQUITY: PROCEEDINGS



May 29 and 30, 2014 in Toronto

With funding from the Canadian Institutes for Health Research, Institute for Population and Public Health

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The National Collaborating Centre for Determinants of Health (NCCDH), hosted by St. Francis Xavier University, is one of six National Collaborating Centres (NCCs) for Public Health in Canada. 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 NCCDH focuses on the social and economic factors that influence the health of Canadians and applying knowledge to influence interrelated determinants and advance health equity. Find out more at nccdh@stfx.ca. The other centres address aboriginal health, environmental health, healthy public policy, infectious disease, and methods and tools. Find out more about all NCCs at <http://www.nccph.ca/en/home.aspx>.

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Introduction and background

In the spring of 2014, the National Collaborating Centre for Determinants of Health (NCCDH) and partners co-hosted a two-day workshop to stimulate more integrated action at the provincial and territorial (P/T) level across Canada to direct public health resources to reduce the avoidable gap between the least and the most healthy. *Advancing provincial/territorial public health capacity for health equity*, held in Toronto, May 29 and 30, was attended by over 30 P/T public health senior leaders and decision-makers. Only the Yukon was, with regret, unable to participate. Nearly all provinces and territories had two participating representatives. The majority of Chief Public Health Officers attended, as well as a mix of Deputy Chief Medical Officers, Executive Directors, Assistant Deputy Ministers and, in the case of three provinces, regionally-placed Medical Officers (See Appendix 1).

The event was funded by a knowledge dissemination grant from the Canadian Institutes for Health Research, Institute for Population and Public Health (CIHR-IPPH), and was jointly conceived, designed and delivered by the following partners:

- Connie Clement, Scientific Director, NCCDH
- Benita Cohen, Associate Professor, Faculty of Health Sciences, University of Manitoba
- André Corriveau, Chief Public Health Officer, Department of Health and Social Services, Northwest Territories
- Marjorie MacDonald, CIHR/PHAC Applied Public Health Chair, School of Nursing; Adjunct Professor, School of Public Health and Social Policy, University of Victoria
- Heather Manson, Assistant Professor Dalla Lana School of Public Health, University of Toronto; Adjunct Professor, University of Waterloo; Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario
- Hannah Moffatt, formerly Knowledge Translation Specialist, NCCDH; currently Population Health Equity Initiatives Leader, Winnipeg Regional Health Authority (RHA)
- Louise Potvin, Professor, Department of Social and Preventive Medicine, Université de Montréal; Scientific Director, Centre Léa-Roback sur les inégalités sociales de santé de Montréal
- Robert Strang, Chief Public Health Officer and Chief Medical Officer of Health, Nova Scotia

The partners set the following objectives for the workshop:

- share new research that could help P/T and territorial public health organizations better integrate health equity into their policies and practices;
- exchange proven and promising applied practices across provinces and territories;
- identify priority knowledge and practice gaps;
- clarify processes and roles that will support continued pan-Canadian networking to improve the knowledge-to-action cycle needed to advance health equity; and
- contribute to the development of a common agenda to guide health equity practice, policy, and research through action on the social determinants of health over the next five years.

A post-event participant evaluation was implemented. Participants rated the event very positively in that it offered new information, contacts, resources and opportunities to speak with counterparts from across the country about equity issues. (Detailed findings were shared with participants.)

DAY 1

Welcome and context

Connie Clement, Dr. Robert Strang and Dr. Louise Potvin opened the event by setting the context.

Connie, as chair of the event planning group, noted the renewed energy for health equity work across the country. She said this gathering flowed from a conference held in Saskatoon in May, 2013 — *Developing a health equity agenda: from a shared vision to policy* — that began the task of developing a pan-Canadian ‘agenda’ to guide public health equity practice, policy and research.

Connie explained that the agenda for *Advancing provincial and territorial public health capacity for health equity* was informed by information from three sources:

1. The *four public health roles for advancing health equity action*^a promoted by the NCCDH.¹ These roles are increasingly being adopted, across the country, at the local, regional, and provincial/territorial levels. An example at the provincial level is Nova Scotia’s incorporation of the roles in the health equity and social justice requirement section of their *Public Health Standards*.²

2. An NCCDH survey of Canadian approaches to health equity that informed a report, *Toward Health Equity: Canadian Approaches to the Health Sector Role*,³ taken by the Public Health Agency of Canada (PHAC) to the 8th Global Conference on Health Promotion in Helsinki, Finland in June, 2013. This report identified Canadian approaches under three themes:

Build a foundation for action

- **Leadership.** Individuals or groups that promote health equity and take action to put the other elements in place.
- **Supportive environments.** Anchors within organizational guiding documents to integrate health equity as an organizational priority.
- **Capacity.** Staff and partners who have the resources and skills they need to advance the agenda, enhance internal and public awareness of the issues, and promote action across sectors.

Create and use a strong knowledge base

- Build surveillance and monitoring capacity of organizations.
- Support research to inform action.
- Fund knowledge translation and exchange.
- Implement performance measurement and evaluation supports within organizations.

Collaborate with non-health sector partners

- Create structures that support intersectoral action at the national level (e.g., Canadian Council on Social Determinants of Health), provincial level (e.g., Saskatchewan’s Regional Intersectoral Committees) and regional level (e.g., Saskatoon Health Region’s co-chairing, with the United Way, of the city’s Poverty Reduction Partnership).

3. A pre-event survey of this event’s participants inquiring about their level of understanding of health equity language and actions being taken within their jurisdictions. Respondents perceived public health practitioners as more likely to have the knowledge and attitudes for health equity work than to have the skills and tools needed to do this work. We also learned that few jurisdictions have accountability measures for their work to address the social determinants of health and health equity.

^a 1) Assess & report; 2) Modify interventions; 3) Partner with other organizations; 4) Participate in policy development

Dr. Louise Potvin set the research context and considerations for the event. She said the importance of this work is evident in the research finding of a 20-year gap in life expectancy between the lowest and highest income groups in Canada. She pointed to the five themes from the *Rio Political Declaration on Social Determinants of Health*⁴ as a frame for ongoing research related to public health practice and health equity:

1. Adopt better governance for health and development
2. Promote participation in policy-making and implementation
3. Further reorient the health sector towards reducing health inequities
4. Strengthen global governance and collaboration
5. Monitor progress and increase accountability

Louise highlighted that robust surveillance systems are essential for effective research and praised the CIHR-IPPH for its role in fueling the burgeoning, over the past 15 years, of research centres focused on measuring the nature of social inequalities in health.

At the same time, she said, there continues to be a global paucity of data on the effectiveness of actions to address social health inequalities.^b She stressed that “our learning does not trickle down.”

Dr. Robert Strang introduced the practice context and interests for this event. He highlighted that health is a P/T responsibility and applauded this rare opportunity for P/T leaders to learn together and share expertise about a specific focus of their work. Public health is a natural leader in health equity work because it uses population and social determinants of health lens in its work. Rob pointed to four priorities for P/T public health organizations:

1. look for and support early adopters at the local level;
2. find ways to scale up local innovation;
3. engage communities most affected by health inequities; and
4. foster public conversation to generate awareness of, and support for, policy change and to put pressure on politicians.

^b Louise cited France’s Cancer Plan 2003-2007 as a notable exception.



Dr. Benita Cohen, University of Manitoba, MB

Provincial and territorial experiences: Successes and challenges in influencing health equity

In short presentations, representatives of each participating province and territory described their successes and challenges in narrowing the gap between the least and most healthy, under the three categories described above: build a strong foundation for action; establish and use evidence (knowledge base); and collaborate with others outside the health sector.

TABLE 1: PROVINCIAL AND TERRITORIAL HEALTH EQUITY SUCCESSES

| Province/ Territory | Foundation for Action | Knowledge Base | Collaborate with non-health sector partners |
|------------------------------------|---|---|---|
| Alberta | <ul style="list-style-type: none"> Online leadership discussion Alberta Health Services (AHS) has dedicated team within Population, Public and Aboriginal Health for the promotion of health equity (HE) AHS established the Aboriginal Health Program and Wisdom Council AHS developed a Promoting HE Framework Plan to engage Albertans in a discussion about wellness & SDH | <ul style="list-style-type: none"> AHS resource development: HE glossary; Populations Vulnerable to Poor Health Outcomes Report Surveillance and monitoring: AHS & Government of Alberta drafting a conceptual framework towards an Alberta deprivation index | <ul style="list-style-type: none"> Government Social Policy Framework Poverty & homelessness elimination strategies |
| British Columbia | <ul style="list-style-type: none"> Development of First Nations Health Authority <i>Public Health Act</i> requires medical health officer and provincial health officer reports Guiding Framework for Public Health BC Health Strategy to 2017 has focus on rural/remote & high needs populations Core public health programs review. Equity is lens for developing programs, accountability Conducted equity-focused health impact assessment of sexually transmitted disease and infection-related programs Recognition at policy & decision-making levels that equity impacts health outcomes | <ul style="list-style-type: none"> BC Surveillance Plan will include references to inequity Equity Lens in Public Health research project in collaboration with U of Victoria & health authorities Provincial support for Public Health Association of BC conference Equity indicators identified for monitoring Partnership between health authorities to increase awareness, develop tools | <ul style="list-style-type: none"> Cross-government Ass't Deputy Minister committee on health Ministries of Education & Agriculture partnership on school fruit & vegetable program, & food security Healthy Families BC focuses on partnerships with local governments and NGOs |
| Manitoba | <ul style="list-style-type: none"> HE is a strategic priority Has a Population HE Unit Winnipeg RHA has a HE position statement & report & staff with responsibility for HE | <ul style="list-style-type: none"> Winnipeg RHA Authority resources | <ul style="list-style-type: none"> Poverty reduction & social inclusion strategy Housing First approach |
| New Brunswick | <ul style="list-style-type: none"> Health & inclusive communities wellness strategy HE a strategic priority Capacity for HE work | | |
| Newfoundland & Labrador | <ul style="list-style-type: none"> Population Health Branch established in 2011 HE work initiated within regions through the Wellness Advisory Council | <ul style="list-style-type: none"> RHA capacity for health promotion work Surveillance & monitoring: Communicable Disease Control, & Newfoundland & Labrador Centre for Health Information | <ul style="list-style-type: none"> Poverty reduction strategy |
| North West Territories | <ul style="list-style-type: none"> Political will is high Recognition that health starts at home Focus on healthy children & families | | <ul style="list-style-type: none"> Planning process with communities; focus on community-identified priorities |

TABLE 1: PROVINCIAL AND TERRITORIAL HEALTH EQUITY SUCCESSES CONT.

| | | | |
|---------------------|--|---|--|
| Nova Scotia | <ul style="list-style-type: none"> Position: <i>Coordinator, Health Disparities</i>, is part of Public Health's Healthy Communities team. Engages across Public Health, Department of Community Services & with other partners Policy: HE is one of 5 cross-cutting protocols of the Nova Scotia Public Health Standards. The protocol is a deliberate articulation of the expectations for incorporating HE factors in all public health practice Practice: piloting use of HE lens using the four public health roles for HE action | <ul style="list-style-type: none"> Renewed efforts in population health status reporting at local level Local work supported by the Understanding Communities Unit (new capacity in surveillance & epidemiology) | |
| Nunavut | <ul style="list-style-type: none"> HE interwoven in work of the health department | <ul style="list-style-type: none"> Social determinants of Inuit health acculturation housing productivity | <ul style="list-style-type: none"> The size of the territory allows for good partnerships across sectors. Food Security Action Plan came out of Poverty Reduction Plan |
| Ontario | <ul style="list-style-type: none"> Ontario Public Health Standards, 2008 <i>Make No Little Plans: Ontario's Public Health Sector Strategic Plan</i> (2013) SDOH nurses in each health unit HE Impact Assessment Tool used widely All health reports talk about inequities | <ul style="list-style-type: none"> Renewal of Public Health Systems research project | |
| PEI | <ul style="list-style-type: none"> Public health staff passionate about HE (e.g., Public Health Association conference) Clinics for newcomers & Aboriginal peoples Needle exchange program | <ul style="list-style-type: none"> Chief Public Health Officer Report & Health Trends has first-time mention of income & education Reports about incidence of chronic diseases | <ul style="list-style-type: none"> Government attention to poverty reduction, early learning, & economic development |
| Quebec | <ul style="list-style-type: none"> Public Health Act provides levers for action HE part of Medical Officer of Health role | <ul style="list-style-type: none"> Deprivation index Monitor 18 deprivation indicators Poverty reduction & mental health support policy scans by National Collaborating Centre for Healthy Public Policy | |
| Saskatchewan | <ul style="list-style-type: none"> Integrated health system; thinking & acting as one Flat structure Reducing inequities part of Ministry's strategic plan Equity champions in some regional health authorities (RHA) Some RHAs have dedicated staff developing & using equity tools to change programs & policies | <ul style="list-style-type: none"> Saskatoon's Public Health Observatory Saskatchewan Population Health & Evaluation Research Unit does equity research, surveillance, knowledge translation, performance evaluation & HE audits Health Promotion group focused on HE not lifestyles | <ul style="list-style-type: none"> Saskatchewan Population Health Council includes First Nations Provincial & regional inter-ministerial committees Strong leadership at other human service ministries & organizations |
| Federal | <ul style="list-style-type: none"> Focus on evaluation, science, grants & contributions Health Portfolio partner commitments PHAC Plan to Advance HE 2013-2016 Health Equity Matters, strategic plan (2009-2014) from CIHR's Institute for Population and Public Health First Nations and Inuit Health Branch Strategic Plan | <ul style="list-style-type: none"> Data collection & analysis on 56 indicators & 13 dis-aggregators. PHAC Best Practice Portal added equity consideration | <ul style="list-style-type: none"> PHAC collaborations with federal departments, Canadian Council on the Social Determinants of Health, Pan-Canadian Public Health Network |



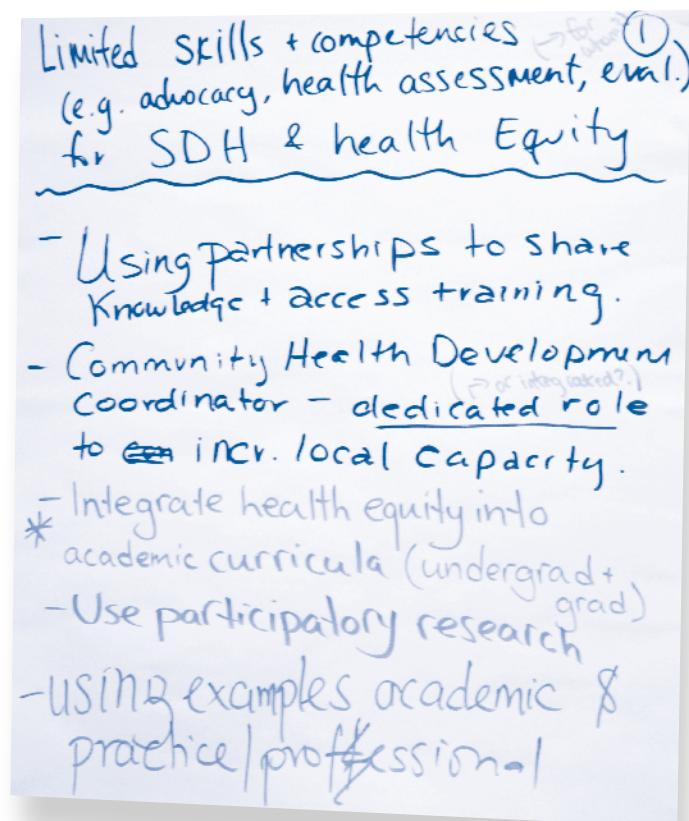
(L. TO R.) Dr. David Allison, NL; Dr. Heather Morrison, PEI; Dr. Gaynor Watson-Creed, Capital Health, NS

The challenges identified by participants were many and varied. P/T presentations flagged the importance of establishing whole of government—even whole of society—approaches, recognizing that many, if not most, policies that will improve health equity beyond health sector control. Yet within the health sector, equity is seen as part of the public health portfolio. Challenges identified by provinces and territories were the following:

- insufficient systems, especially regarding measurement and reporting, e.g. infrastructure; deficiency of data and data linkages, including mechanisms to identify incremental change over time; minimal effort or methods to measure impact of resource shifts (to or away from equity-related foci); equity not being integrated into clinical care performance measures
- lack of coordinating mechanisms and high level intergovernmental, inter-departmental collaboration; shortage of equity-focused policy, legislation and strategies; few cross-sector/cross-jurisdiction funding models; health equity seen as public health issue, yet drivers rest outside public health and health care systems
- staff capacity, e.g. knowledge, skills, and also diversity among public health staff, and lack of clarity regarding roles and expectations, making it difficult to mobilize action
- evaluation, including difficulty to demonstrate outcomes of interventions; inadequate understanding of how to scale up (vertically and horizontally); limited feasibility to replicate successes (e.g. from urban to rural and remote jurisdictions, where context and capacity differs); and need to focus efforts where a health equity approach will add most value
- communicating complexity; limited language clarity; dearth of media coverage of inequity issues and profile for live-experience voices; few business/economic case tools
- how to move beyond philosophical commitment (words) to mobilize people and action, and because this isn't clear, fatigue related to advancing health equity
- how to sustain effort and impact when government changes and commitment diminishes; inadequate commitment at high levels of government

In the provincial-territorial presentations, the following positive cornerstone activities were noted by one or more representatives:

- visible leadership commitment
- investment in people and organizational structures (e.g., dedicated positions, teams or units)
- incorporating health equity into strategic priorities
- creating public health observatories^c
- producing health status reports with a health equity lens
- initiating research projects
- prioritizing intersectoral partnerships such as poverty reduction coalitions and inter-governmental committees
- advocating for health-in-all policies



In the discussion following the presentations, participants urged taking a more holistic approach to health, one that incorporates human capability/ability, community capacity and social/environmental settings. Public health needs to showcase its health equity initiatives and increase the transparency of this work. It also needs to focus on partners' needs and agendas, and learn how to use less health-focused language. Leading in this way, from within the health sector, sets an example for non-health sector partners.

Participants stressed that populations experience multiple types of deprivation and sources of inequality. Current work tends to focus on material aspects of inequity, such as income, while being comparatively silent about racialized and gender-based inequities. If there is desire to highlight "how social inequality gets under our skin," we must examine the multiple dimensions of social stratification and how the structures of society maintain this hierarchy.

To build a robust knowledge base, we must invest in both data systems and intervention/evaluation cycles. Innovative and emerging research approaches (e.g., realist reviews, mixed methods, participatory action research) can help us answer intervention questions more quickly and identify types of interventions that can worsen health inequities.

^c Note that this was in reference to Saskatoon. There are currently no P/T level observatories, although in a few cases, provincial departments or agencies contributed to a portion of observatory functions.

DAY 2

Learning from research: how to build organizational capacity for health equity

Day 2 of the workshop began with presentations from four researchers who have studied how organizational capacity for health equity work is built and sustained. Both of the NCCDH's environmental scans, *Integrating social determinants of health and health equity into Canadian public health practice*⁵ and *Boosting momentum: applying knowledge to advance health equity*⁶ found that organizational capacity varies widely across the country, yet is critical to effective health equity work.

a. Organizational capacity for public health equity action

Dr. Benita Cohen, Associate Professor, University of Manitoba, discussed a research-based conceptual framework she and a multi-university and practitioner team have developed. The research focused on the question: What constitutes organizational capacity to develop and sustain equity-focused population health initiatives? The researchers conducted a literature review and interviews with 16 Canadian public health equity champions in seven provinces. Study findings led to the development of a *Conceptual Framework of Organizational Capacity for Public Health Equity Action [OC-PHEA]*.⁷

Within the Framework, OC-PHEA is defined as the ability of an organization to

- identify health inequities;
- mobilize resources; and
- take effective action to reduce them.

OC-PHEA consists of two domains—the Internal Context and External Enabling Environment—which create or limit opportunities at the organizational level. Inclusion of the external domain within the framework recognizes the embedded nature of public health within broad socio-economic, political, and cultural structures and systems, and the significance of the reciprocal influences between public health and its communities. Each domain is described by three dimensions: values and beliefs; commitment and will; and enabling infrastructure. For example,

internal organizational infrastructure components that support public health equity work include

- governance structures that mandate equity action;
- assigned accountability for equity action;
- sustained core funding and flexible allocation for health equity action
- a workforce with equity action skills;
- effective communication and advocacy for equity action, both within and beyond public health boundaries; and
- strong relationships and partnerships with community and other sector partners, based on shared health equity goals.

Benita emphasized that if public health wants to reduce the gap between the most and least healthy, we need organizational systems devoted to creating greater health equity, and alignment of those systems with organizational standards, roles, and discipline-specific competencies. The OC-PHEA framework suggests that optimal organizational capacity would exist if all dimensions of the internal and external domains of OC-PHEA were strong and well-supported by health equity champions at all levels. Until that optimal state is achieved, differing levels of capacity will be found among organizations and also within organizations at different points in time and in relation to the equity issue that is being addressed. Yet, even without optimal capacity, an organization will have some ability to identify health inequities, mobilize resources, and take action to reduce inequities.

b. Renewal of public health systems

Dr. Marjorie McDonald, Professor and CIHR/PHAC Applied Public Health Chair, Nursing, University of Victoria, described the *Renewal of Public Health Systems (RePHS)*⁸ project. The RePHS project was designed to examine similarities and differences between the implementation of health equity policy interventions in British Columbia and Ontario. Two public health programs were selected as exemplar cases: in Ontario, a healthy living (chronic disease prevention) initiative; and in BC, a sexually transmitted infection prevention initiative. Twelve health authorities are involved in the research, six in each province.

Using a complexity lens, the project focused on two research questions:

- What factors/contexts influence or affect the implementation of HE policy interventions?
- What have been the impacts/effects of HE policy interventions on staff, the organization, the populations served, other organizations, and communities?

The research involved methodological techniques of situational analysis, concept mapping, and social network analysis. It also included in-depth qualitative, semi-structured interviews and focus groups with 75 public health directors, managers and practitioners in BC and Ontario. The cross-cutting themes of the research were equity, human resource management, and the relationship between public health and primary care.

The research team conducted a descriptive analysis of how public health practitioners understand health equity. Health equity was frequently understood as equal access to quality health care or public health services, with an understanding that equal access to services can be affected by factors such as geography, language, ethnicity, aboriginal status, and disability. The practitioners holding this view saw equity work as intervening to improve the ability of specific populations to access services.

Few participants understood health equity as access to the opportunities or resources needed to achieve and maintain health. Those who did have this understanding were more frequently in higher levels of the organization. Even less often did practitioners refer to health equity as “achieving equal health outcomes.” These differences in understanding present challenges when public health is asked to promote health equity. However, a consensus is emerging that the World Health Organization (WHO), Braveman and Gruskin and Whitehead and Dahlgren provide good foundational definitions.^{d, 9-13}

The researchers found a growing emphasis on 1) using data to identify health inequities; 2) integrating an equity lens with established planning processes; and 3) improving access to services for selected populations. Over all, study participants thought that integrating an equity viewpoint into public health standards and core functions resulted in more equity-sensitive programs and services; the creation of health equity offices; more full-time dedicated health equity positions; and the integration of equity work into more job descriptions. In addition, they felt that formally-imbedded equity language increased the visibility of the work and helped document changes.

^d To address the gap in common terminology, the NCCDH, at the time of this event was developing parallel French and English glossaries of common terminology about SDH and HE. The glossaries ([English](#), [French](#)) are now available.^{12,13}

The research found that health equity action frequently shows up in a focus on specific populations. In Ontario, this work is categorized as “targeting priority populations,” whereas in B.C. the language is “serving vulnerable and marginalized groups” (e.g., Aboriginal peoples). Health equity action is also seen in access and equity policy, in the hiring of culturally competent staff or staff with languages other than English, in the creation of health equity positions or offices, and in staff training.

Marjorie noted these challenges in promoting health equity:

- an inadequate understanding and lack of consensus on the meaning of health equity;
- lack of clarity in how to identify and define priority populations, including lack of guidance and weak language in policy;
- tension between universal and targeted programming. In BC, the concept of “proportionate universalism”^e is being applied to STOP AIDS (Stop and Treat for Optimal Prevention of HIV/AIDS), and sexually transmitted infection prevention, drawing on the work of Clyde Hertzman^f
- inadequate government support and political roadblocks;
- organizational barriers and communication issues;
- geographic disparities in service provision; and
- standardization of services.

In summary, Marjorie noted the following facilitators of public health action identified through the research:

- talking about equity;
- having a common language and understanding;
- high quality training with follow-up;

- recruiting culturally diverse staff;
- access to and sharing of local data, especially for populations experiencing inequities
- management commitment (going beyond lip service); and
- sustained funding.

Dr. Heather Manson, Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario and a core partner in the RePHS project, spoke next. Within its mandate to provide scientific and technical advice to public health partners across Ontario, Public Health Ontario is undertaking a project to provide province-wide guidance in 1) understanding the term “priority population”; 2) identifying priority populations; and 3) examining the priority population policy mandate and its application. This project consists of a scoping review, role-based survey and key informant interviews.

The researchers found that study participants’ perceptions of how well the concept of priority populations was understood differed depending on their role in their organization. For example, 73% of Medical Officers of Health agreed that the definition of priority populations was well understood in the health unit, while only 21% of SDOH nurses and 36% of epidemiologists agreed with this view.

Heather said that because understanding of equity varies with role, experience and perspective, many perspectives are needed, including those of people with lived experience of deprivation. Interventions need to be tailored for specific contexts. It is difficult to find key points of leverage, given the complex, nonlinear chains of interventions with multiple synergies and feedback loops.¹⁵

^e “Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism.”¹⁴ See also http://earlylearning.ubc.ca/media/publications/proportionate_universality_brief_-_final.pdf

^f For more information on Clyde Hertzman see [Human Early Learning Partnership](#), of which Clyde was founding director. Hertzman led the WHO Social Determinants of Health Commission’s [knowledge hub for early child development](#).

c. Wicked problems

Dr. Louise Potvin, Professor, Department of Social and Preventive Medicine, Université de Montréal and Scientific Director, Centre Léa-Roback sur les inégalités sociales de santé de Montréal, said health equity presents “wicked problems.” A wicked problem is “complex, difficult to define, with no immediate solution, and one where every wicked problem can be considered to be a symptom of another problem.”¹⁶ Characteristics of wicked problems are

- no definitive formulation of the problem;
- every problem is essentially unique;
- every problem could be considered a symptom of another problem;
- for research purposes, the stopping rules related to an intervention are external rather than internal;
- solutions are not true or false, but worse or better;
- no immediate or ultimate test of a solution;
- every solution is a one-shot operation; and
- the planner has no right to be wrong.

Louise explained that starting to define a wicked problem is part of acting on the problem. Each intervention contributes to the definition of the problem; new connections are made between previously unconnected entities in an iterative process. Wicked problems are best addressed by creative, bold and innovative interventions that push our understanding of the problem. In designing bold interventions, Louise emphasized, a voice must be provided to people excluded by social processes. Attention to inclusiveness is important, given that many innovative social interventions are informed by the same structures of domination that produce health inequities.

Since wicked problems cannot be solved by applying solutions tested elsewhere, intervention research cannot tell practitioners what to do. Instead, it can help practitioners define the problem and reflect on

the processes, outcomes and changes in a specific context. Intervention research can also provide spaces to reshape the structural power imbalances between the stakeholders in a wicked problem.

d. Participant reflections on the organizational capacity findings from researchers

Following the presentations by the four researchers, participants reflected on how the research resonated in their practice. The following ideas were raised:

- Make health equity understandable across perspectives. Some participants favoured increasing consistency in the definition and usage of health equity terms. Others thought a mixed understanding did not deter action. It was noted that because health equity is a manifestation of social equity, we must talk about our values and the kind of society we want in our discussions.
- As change agents, public health organizations are consciously trying to move individuals and the health sector in general, in the direction of health equity. Public health staff’s important leadership contribution is to know when to lead from the front, when to follow, and when to be cheerleaders. Staff must be able to function well in each of these roles.
- More health system resources need to be allocated to addressing the social determinants of health and health equity.
- For some, identifying priority populations is not complex; it requires using data to identify inequitable health outcomes. Others argued that data availability and quality vary widely (e.g., data collection and use are influenced by community or organizational preferences). These influences need to be considered during planning processes.



Dr. Saqib Shahab, SK (L) and Dr. Brian Emerson, BC (R)

- Wealth distribution mechanisms contribute significantly to social inequalities in health, and public health is participating in efforts to change these mechanisms. This arena of action creates dilemmas for intervention researchers who want to participate in these political spaces without altering or distorting them. Research processes can easily reconfigure conversations in public and political spaces.¹⁷
- Public health organizations that get involved in participatory research projects develop a better understanding of the problem under investigation. As well, participatory research can contribute to public health capacity to address future issues through partnerships and confidence-building.
- An important area for public health action is to build public awareness of health equity, the SDH, and the need for policy solutions.¹⁸
- While some participants think health equity is a non-partisan issue that can survive political party changes, others question the commitment to health equity, given prevailing societal and political paradigms and priorities. This debate highlights the complexity of the challenge.

Lessons from Europe

Connie Clement presented health equity updates from Europe. A recent report (European Commission, 2013) found that the inequality in infant and child mortality in European countries had dropped 26% (35% for males; 27% for females). However, the research found an increase in inequality in mortality rates for people 15 years and older, especially for men and 15 to 24 year olds.

The WHO Office for Europe¹⁹ produced a guide for national governments wanting to address inequities in health. It recommends strategies for within a set of action stages, and emphasizes that everyone can “do something, do more, do better” at each action stage. Recommendations are provided for

- securing political commitment and cross-sector cooperation;
- assessing the extent of the problem, knowledge gaps and points of intervention;
- determining optimal organizational arrangements, financial requirements, and responsibilities; and
- drawing up action plans at all levels (what actions, by whom, with what funds, with what expected output).

Connie explained that while *few* European countries have policies that emphasize health equity, there is action. Most European policies to reduce inequities focus on vulnerable populations or universal delivery, rather than gradient-sensitive solutions. Recent achievements include improvements in data, collaborations across countries, and more non-health sector involvement. On the other hand, existing policies are seldom scaled up, implementation is slow to follow policy change, and monitoring and evaluation are inadequate.

Lessons from Canada

In May 2013, the NCCDH and other organizations hosted a forum in Saskatoon with the idea of developing a health equity agenda for Canada. The forum objectives were to

- bring together an engaged, national, and multi-sectoral audience to address the SDH and build a sustainable network of networks;
- profile health equity work occurring locally, provincially, and nationally; and
- contribute to the development of an agenda to guide health equity practice, policy, and research, through action on the social determinants of health, over the next five years.

The top ideas⁹ that emerged from discussions at this forum were:

- use data to create a burning desire for change
- build a business case that can generate political capital
- allocate time and resources for meaningful community engagement

- work across sectors and frame communications for diverse audiences
- build organizational capacity for equity work

Connie summarized the NCCDH's 2014 environmental scan,⁶ which was designed to assess changes in the public health landscape – related to action on health equity – in the four years since the NCCDH's 2010 environmental scan.

The 2014 scan identified the following successes, challenges and opportunities for action.

Successes

- greater momentum; a “health equity buzz”
- leadership commitment, as exemplified in Canada’s commitment to the Rio Declaration
- an increase in organizational structures, staff, and strategic priorities related to health equity
- visible health equity champions
- a significant research and evidence contribution
- action from other sectors

Challenges

- translating interest and commitment into action
- building a more consistent capacity for equity work, across sectors
- building skills and competencies (e.g., assessment and surveillance, research and evaluation, policy analysis and advocacy, community engagement)
- building understanding of public health and health equity terms
- communicating health equity ideas beyond the public health sector
- measuring impact

⁹ See www.liberatingstructures.com/12-2510-crowd-sourcing/ for a description of the 25/10 crowdsourcing technique used to generate the top ideas

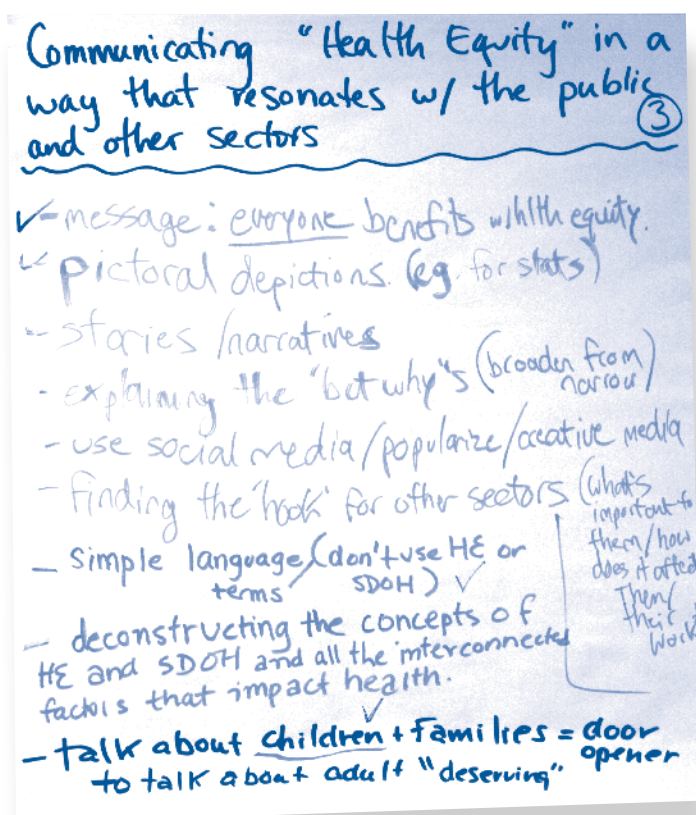
Opportunities for action

- harness existing health equity momentum
- strengthen our networks and our ability to share lessons learned
- profile and support leadership commitments
- align common health equity priorities across the country
- engage other sectors and partners
- further promote and apply the four public health roles for action on health equity
- support knowledge brokering work to fill gaps in capacity, skills and competencies
- clarify health equity terms and concepts
- facilitate difficult conversations

Participants offered the following reflections on Connie's presentation:

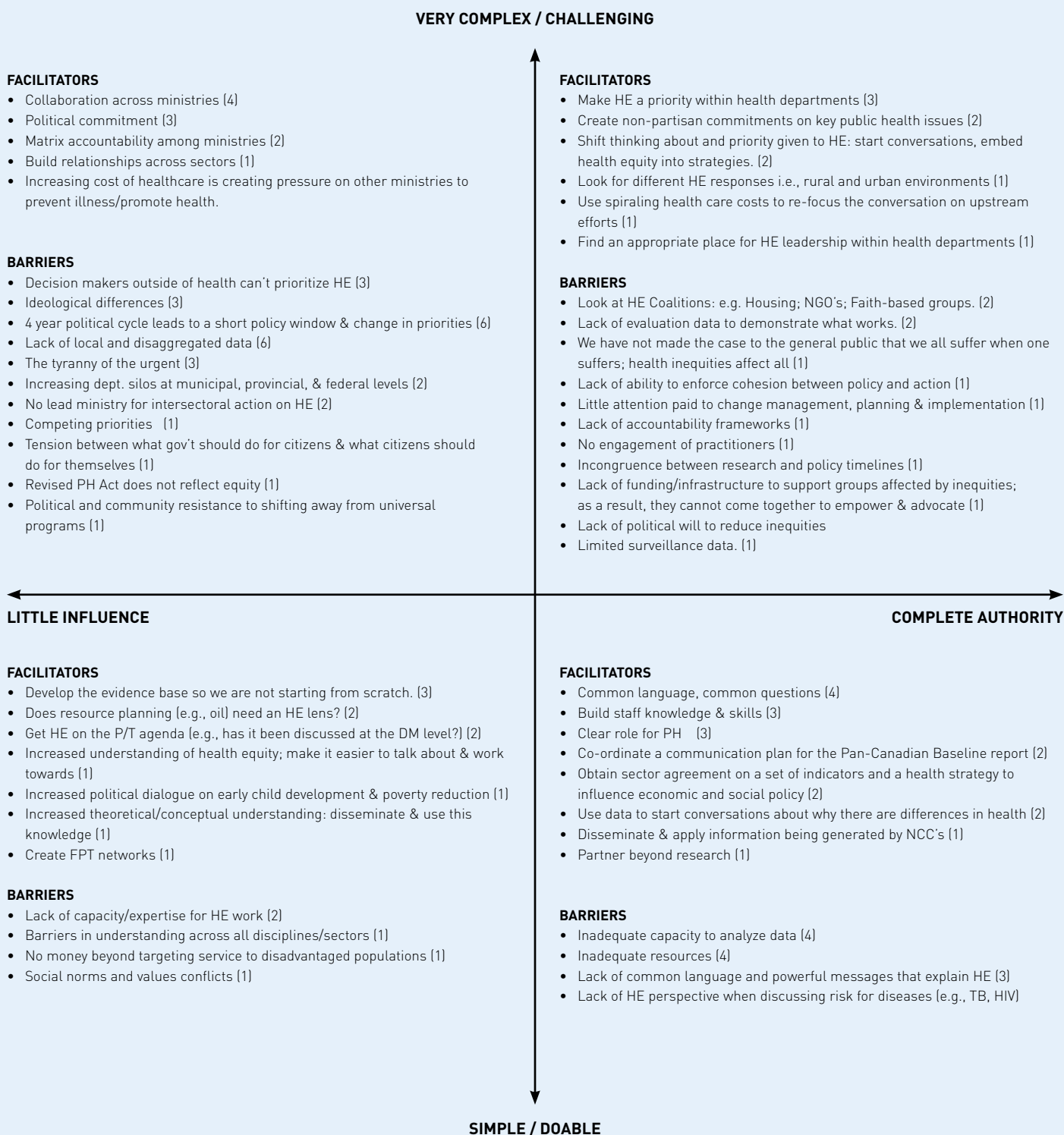
- BC's First Nations Health Authority is a promising initiative that should be watched closely.
- Telling the health equity story to political leadership is critically important; there are lessons to be learned from the political and communication sciences.
- We can learn from the Global South's experiences in social transformation.

- As governments change, public health actors can use data to protect gains and create a desire for more change. Public health can translate interest and commitment to action for politicians.
- The story of public protection from second-hand tobacco smoke suggests it may be easier to affect policy change at a local level than at the provincial level.



Facilitators and barriers to integrating health equity into programs, policies and practices

In small groups, participants discussed facilitators and barriers to integrating health equity into programs, policies and practices. They mapped the facilitators and barriers onto the quadrant shown in Figure 1, based on the extent to which they could influence action in the identified area. The items are listed in each quadrant by order of most agreement.^h



^h Because there were four groups, four, the greatest possible agreement among participants, indicates that all four small groups identified an issue and placed it in the same quadrant.

At the end of this exercise, participants discussed the following in relation to addressing challenges:

- The Canada Health Act allows for jurisdictional authority over population health.
- Some social analysis can be done by health; how do we make this analysis easier for other sectors to use?
- Lack of political will.
- Local issues drive local action. At the provincial level, issues are more aligned with political parties. How do we move toward nonpartisan action?

What do we still need to know?

In small groups, participants identified the following knowledge-to-action gaps that, if filled, would enhance public health's capacity to act on the social determinants of health. The gaps are organized under five themes.

Communication and public awareness

- a coordinated social marketing strategy
- tools to help public health practitioners tell their stories to people in other sectors; ways to communicate the idea that inequities affect all of us
- a common language across sectors

Knowledge and data

- ongoing health equity surveillance
- ongoing research/decision-making collaborations
- experiential and traditional knowledge translated into data
- intervention data
- commitment to data analysis in urban and rural environments
- evaluation to monitor progress

Coordination and collaboration

- implementation and accountability strategies to smooth the policy-implementation gap
- role of the Canadian Council on the Social Determinants of Health

Roles and capacity of public health

- core values in public health
- continued support for NCCDH
- clear roles for public health practitioners
- guidelines for public health advocacy (e.g., Quebec's funding of advocacy coalitions)

Leadership and change management

- Chief Medical Officer of Health's job description includes advocacy but there is discomfort in exercising this role
- change management capacity

Using networks to strengthen knowledge translation and deepen public health capacity

After the lunch break, Connie Clement, drawing, in particular on research by June Holley,²⁰ described four types of networks, and how the application of networking theories and practices can contribute to organizational effectiveness. Methodically bolstering existing formal and informal networks and nurturing new networks can strengthen knowledge translation and public health action.

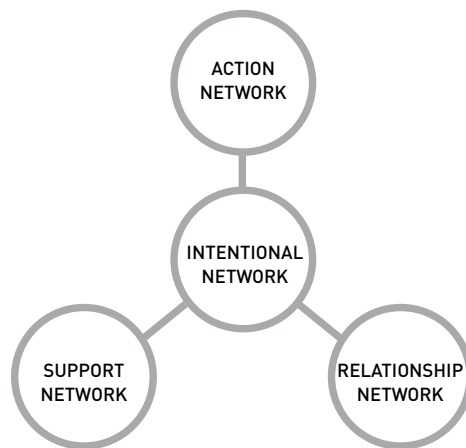


FIGURE 2: TYPES OF NETWORKS

Social sciences and business research shows that effective (so called, 'smart') networks can

- increase communication and awareness of relationships;
- open new resources;
- expand and support leadership;
- encourage collaboration, innovation and learning for breakthroughs;
- increase inclusion and bridge divides;
- result in better outcomes; and
- facilitate scale-up and impact.

During a full group discussion, participants identified the following public health oriented networks that can help leverage public health commitment to health equity action.

- Pan-Canadian Public Health Network Council, group of senior public health officials that reports to the Council of Deputy Ministers of Health.

- The Pan-Canadian Public Health Network, including its Healthy People, Healthy Communities and its Public Health Infrastructure steering committees.
- Canadian Council on the Social Determinants of Health is able to collaborate across sectors (e.g., the Council has produced case studies on Montreal and Saskatoon mapping experiences).
- CPHA and its Canadian Journal of Public Health, especially given the Journal's new interest in practitioner-scholars and the intersection between research and practice. Also suggested was partnering to create special supplements.

The possibility that public health could join and influence non-public health networks was identified. The Canadian Institute of Planners, which has undertaken related work through its [People Matter focus](#), was mentioned as an example. Using journals of networks and organizations was suggested, e.g. Canadian College of Health Leaders, as was supporting public health practitioners and researchers to participate in cross-jurisdiction and cross-sector panels at conferences.

Roles for the NCCDH, and other NCCs, were suggested, including translation of research findings for various disciplines, in collaboration with researchers; considering contributions to text books and being on the agenda for MPH programs more often; and encouraging public health to contribute to the evidence base. It was asked if NCCs could support development of a promising practices database or an online site to share practice experiences.



[L. TO R.] Dr. Jocelyn Sauvé, INSPQ, QC; Sabrina Broadhead, NT; Emma Cohen, CIHR-IPPH

The conversation expanded into exploring influences as well as strategies to expand health equity action. It was encouraged that public health stay current regarding socio-technical networks and social movements, improve our using of mapping, and seek varied and multiple partners (e.g. United Ways and other community-based non-profits). The importance of translocalⁱ learning was stressed and participants wondered how funding and support could be found to support face-to-face field trips and deep engagement across distance.

The gains and losses involved in regionalization of health services were voiced, e.g. closer relationships with primary care balanced out by comparative distance from municipal government and community groups. Frustration in terms of trying to be on the radar with government was expressed, including not being informed at early stages of policy redirects that affect health and inequities. A participant wondered if there was room for improvement in the use of tailored bulletins to specific potential partners. The desire for a stronger business case for public health was expressed.

ⁱ 'Translocal' is a concept that emerged from migrant studies and social geography. Brickell and Datta²¹ define translocal as 'simultaneous situatedness across different locales.' Berkana Institute, a community change organization, uses trans-local to define their theory of change: "We believe that no universal solution exists for the challenges of this time: increased poverty and disease, failing large-scale systems, ecological degradation. But widespread impact does become possible when people working at the local level are able to learn from one another, practice together and share learning with communities everywhere. We have observed that large-scale change emerges when local actions get connected globally while preserving their deeply local culture, flavor and form. And we have called this trans-local learning."^{21, p 4} Translocal also relates to aspects of scalability where replication of an intervention is not feasible without significant modification due to varying contexts.

Action steps

In closing, participants identified and voted on priority actions.^j This list should be considered as reflective of the two day presentations and discussions. Although this list provides guidance, it is not equivalent to an action plan. Proposed actions are listed in order of the number of votes they received, highest to lowest.

1. Increase national reporting of health data by social gradient, and showcase interventions that have levelled the gradient
2. Get serious about Geographic Information System mapping
3. Keep funding NCCDH to sustain a permanent, dynamic and interactive forum on health equity
4. Make health equity part of a population health strategic plan
5. Create a framework for health status reporting that is focused on health equity
6. Conduct equity data analysis among provincial data partners
7. Partner with others to create provincial conversations about the use of language, and work to achieve consensus; define what we mean by health equity
8. Require a one-page, publicly accessible, plain language summary for funded research
9. Build capacity for health equity focused impact assessment (HEIA) at the provincial level
10. Build workforce capacity for health equity work
11. Hire community members to accompany public health staff who are developing and implementing health equity policies and programs
12. Influence the political agenda by illustrating to the public the mutual benefit of prioritizing health inequities
13. Engage networks in crafting clear, discrete roles for public health actors to advance health equity
14. Take health equity to Healthy People/Healthy Communities Steering Committee of the Pan-Canadian Public Health Network for strategic discussion
15. Broadly disseminate the “Let’s talk” series (NCCDH) and embed the ideas in this series in the daily work of public health staff
16. Include health equity surveillance plans from local and regional health authorities in provincial surveillance plans
17. Develop an evidence-based process to sustain dialogue about the analysis of both surveillance data and experiential knowledge in understanding the causes of inequities
18. Promote, through the Pan-Canadian Public Health Network, a series of actions that all provinces and territories can move on to advance health equity. For example:
 - a coordinated social marketing strategy
 - a common health equity surveillance framework
 - use of health equity language in public health standards and performance monitoring, and promotion of this language to other sectors
 - a health-in-all-policies approach
19. Review all health policies with a health equity lens; put health equity language into policies
20. Document and celebrate health equity work and challenges
21. Focus the work of our Coordinator of Health Disparities [a particular jurisdiction’s staff position], in collaboration with NCCDH, on building capacity in our public health workforce

^j See www.liberatingstructures.com/12-2510-crowd-sourcing/ for a description of the 25/10 crowdsourcing technique used to generate the top ideas. In brief each participant indicated action in writing on cards; cards are passed randomly among participants who rank-vote for each proposed action on a scale of 1 – 5. This method captures a group’s response at a particular time to ideas drawn from its members.



Dr. Marjorie MacDonald, University of Victoria, BC

22. Push for a common set of indicators across all jurisdictions in our province
23. Report immunization of children by income quintiles, and show trends retrospectively and prospectively
24. Bring health inequities reports (e.g., CIHI, PHAC) to Public Health Network Council
25. Start the conversation about the “burning platform;” health costs will increase if we don’t focus on health equity
26. Pick one demonstration issue or community, and see it through – from identifying inequities to evaluating interventions

Closing and next steps

At the close of the event, Connie said the NCCDH will report back to the funder (CIHR-IPPH) and, over the course of the next year use this event to help inform and facilitate a conversation about a common agenda that will highlight where we want to go and how we can get there. A common agenda can be used in different contexts, and can identify issues and next steps that are challenging and within the scope of public health. The NCCDH can help facilitate conversations that do not require a budgetary commitment beyond staff time.

Some participants asked for a one-year follow-up at the CPHA conference, as well as updates at regional conferences and forums such as TOPHC, JASP, and PHABC. The participant from IPPH (CIHR) expressed interest in further exploring research questions and areas of interest based on the discussions from the session. Participants announced resources that their organizations will disseminate to provinces and territories, (e.g., two now-released reports from the Canadian Council on Social Determinants of Health (CCSDH),^k an intersectoral advisory group to PHAC, and a soon-to-be-released health equity trends report from Canadian Population Health Initiative of the Canadian Institute for Health information (CIHI).

^k Released from the Canadian Council on Social Determinants of Health: [Communicating the Social Determinants of Health: Guidelines for Common Messaging](#)²² and [Roots of Resilience: Overcoming Inequities in Aboriginal Communities](#)²³

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APPENDICES

Appendix 1: List of participants (information reflects position on May 30, 2014)

| Name | Title | Organization |
|----------------------------|---|---|
| Andre Corriveau | Chief Public Health Officer | Department of Health and Social Services Government of Northwest Territories |
| Anita Moore | Executive Director | Manitoba Health |
| Arlene King | Chief Medical Officer of Health | Ministry of Health Ontario |
| Benita Cohen | Associate Professor | University of Manitoba |
| Brian Emerson | Medical Consultant | Ministry of Health, Government of British Columbia |
| Cathy O'Keefe | Director | Newfoundland and Labrador Provincial Government |
| Connie Clement | Scientific Director | National Collaborating Centre for Determinants of Health (NCCDH) |
| Cory Neudorf | Chief Medical Health Officer | Saskatoon Health Region |
| David Allison | Regional Medical Officer of Health | Eastern Health, Newfoundland |
| Eilish Cleary | Chief Medical Officer of Health | Department of Health Government of New Brunswick |
| Emma Cohen | Knowledge Translation and Communications Manager | Institute of Population & Public Health (IPPH), Canadian Institutes of Health Research-CIHR |
| Gaynor Watson-Creed | Medical Officer of Health | Capital District Health Authority (CDHA), Nova Scotia |
| Gerry Gallagher | A/Director General | Public Health Agency of Canada (PHAC) |
| Hannah Moffatt | Population Health Equity Initiatives Leader | Winnipeg Regional Health Authority (WRHA) |
| Heather Manson | Chief, Health Promotion, Chronic Disease and Injury Prevention | Public Health Ontario (PHO) |
| Heather Morrison | Chief Public Health Officer | Department of Health and Wellness Prince Edward Island |
| James Talbot | Chief Medical Officer of Health | Alberta Health |
| Janelle Budgell | Territorial Coordinator, Community Wellness Programs | Government of Nunavut |
| Jocelyne Sauvé | Associate Vice-President of Scientific Affairs | Institut national de santé publique du Québec |
| Kate Manson-Smith | Assistant Deputy Minister | Ministry of Health Ontario, Health Promotion Division |
| Kathy Jones | Director of Public Health Programs | Department of Health and Wellness Prince Edward Island |
| Kimberley Blinco | Director of Population Health and Public Health Practice | Department of Health Government of New Brunswick |
| Louise Potvin | Professor | Université de Montréal |
| Lydia Drasic | Executive Director, Population Health Strategic Planning & Provincial Initiatives | Provincial Health Services Authority (PHSA) |
| Mana Herel | Manager, Health Equity Integration | Public Health Agency of Canada (PHAC) |
| Marjorie MacDonald | Professor | University of Victoria |
| Michael Routledge | Chief Provincial Public Health Officer | Manitoba Health |
| Robert Strang | Chief Public Health Officer | Nova Scotia Department of Health and Wellness |
| Sabrina Broadhead | Director of Aboriginal Health and Community Wellness | Government of the Northwest Territories Health & Social Services |
| Saqib Shahab | Chief Medical Health Officer | Saskatchewan Government, Health, Population Health Branch |
| Sume Ndumbe-Eyoh | Knowledge Translation Specialist | National Collaborating Centre for Determinants of Health (NCCDH) |



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

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