Building a Sustainable Public Health Research Infrastructure in Canada

Sponsored by the CIHR-Institute of Population and Public Health

March 3-4, 2003
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Proceedings of a national meeting about what needs to happen to advance collaborative and successful population and public health research across Canada

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EXECUTIVE SUMMARY

In an effort to strengthen population and public health research capacity in Canada, the Canadian Institutes of Health Research – Institute of Population and Public Health (CIHR-IPPH) organized and hosted the invitational "Building a Sustainable Public Health Research Infrastructure in Canada" meeting in Toronto, Ontario from March 3-4, 2003. The meeting responded to a key recommendation form the CIHR-IPPH sponsored "Building Public Health Research, Education and Development in Canada: A Five Site Consultation" of July 2002.

This meeting was but one part of an ongoing process of dialogue about public health research capacity in Canada and brought together a diverse group of eighty public health leaders from research, practice, community and policy-making arenas. The two main goals of the meeting were: (1) to facilitate the development of a network and infrastructure for public health researchers, practitioners, community advocates and policy makers in Canada; and (2) to develop recommendations and an action plan to foster public health research infrastructure development in Canada.

Participants discussed issues related to ethics, evaluation, capacity building and the application of knowledge to population and public policy and practice. Some key action steps identified by conference participants are:

- To facilitate an on-going dialogue on public health infrastructure in Canada by building on existing local and national infrastructure, as well as by building linkages between CIHR-IPPH, CPHI, CPHA, and others.
- Develop a national repository for public health "evidence", which includes research, resource individuals, networks, articles, etc and provide training so people can make use of evidence.
- To develop a National Public Health Agenda in order to get public health on the broader health agenda, and to nurture linkages and connect research, practice and education in communities of interest.
- To develop sustainable funding infrastructures by encouraging the federal government to contribute resources to build research and invest in developing and training new and experienced practitioners.
- Support capacity building and networking through education and infrastructure development for ethics review boards across Canada in population and population research.

The recommendations offered by participants are far ranging and directed at a variety of individuals, groups and organizations. The ongoing process required to build such an infrastructure across Canada is ambitious and will take time, energy and resources. As such, more immediate action steps are to revitalize and expand the membership of the advisory committee and to facilitate ongoing communication with meeting participants and to support them in communicating back to the broader public health research, policy and practice communities.

Building a Sustainable Public Health Research Infrastructure in Canada

INTRODUCTION

Eighty public health opinion leaders from research, practice, community and policy-making arenas across Canada came together on March 3-4, 2003 in Toronto to talk about "Building a Sustainable Public Health Research Infrastructure in Canada (see Appendix A - Agenda). The two goals of the meeting were:

- To facilitate the development of a network and infrastructure for public health researchers, practitioners, community advocates and policy makers in Canada.
- To develop recommendations and an action plan to foster public health research infrastructure development in Canada.

The Canadian Institutes of Health Research (CIHR) – Institute of Population and Public Health (IPPH) organized and hosted this invitational meeting. The initiative demonstrated the commitment of CIHR-IPPH to strengthen population and public health research capacity in Canada. The meeting was viewed as a vehicle for contributing broad ranging and important advice and for supporting the CIHR-IPPH mission and vision (Appendix Bb- CIHR Population Health Framework). This meeting also responded to a recommendation from the CIHR-IPPH sponsored "Building Public Health Research, Education and Development in Canada: A Five Site Consultation" (July 2002). The meeting was envisioned as one part of an ongoing conversation about public health research capacity in Canada.

The participants were invited because of their known experience and/or interest in collaborative public health research from research, community, practice or government perspectives (see Appendix C, List of Participants). In preparation for a series of structured conversations planned for the two day meeting, they were provided with 1-2 page background information about various models that were determined to be relevant to building Public Health Research Infrastructure in Canada (Appendix D describes the SEARCH, PHRED, Montreal Public Health, ACADRE, Community-Campus Partnerships, the CIHR-IPPH Centres for Research Development, Skills Enhancement for Health Surveillance Program, CURA) The intention was that the participants would focus on how to build collaborative research infrastructure(s) that transcend or integrate the various jurisdictional and organizational structures in which they currently work.

A keynote presentation by Dr. Louise Potvin followed by two panels of speakers served to stimulate the conversations that ensued about building a collaborative research infrastructure in Canada (see Appendix E- Speakers Biographies).

The recommendations offered by the participants are far ranging and directed at a variety of individuals, groups and organizations in addition to the CIHR-IPPH. The ongoing process

required to build such an infrastructure across Canada is ambitious and will take time and energy as well as resources. The meeting on March 3-4, 2003 has provided a starting point, from which to further define and advance this agenda. It is hoped that meeting participants along with many other colleagues will build on the ideas that were articulated at the meeting and that are summarized in this report.

Reflection on Conditions for Success in Public Research in Canada
Louise Potvin, Ph.D.

Born of the modern efforts to put scientific knowledge to the service of human progress, public health is defined as a field of research and intervention aimed at improving the health of individuals and populations. Recently, Lester Breslow called the profound changes that have shaken public health for some twenty years the "third revolution." Echoing the transformations of the institutions that characterize our times, this revolution calls for dramatic changes in both research practices and intervention methods. This presentation proposes that the research practices that are pertinent for the "new public health" take place in a new hybrid space, which researchers are no longer the only ones to control. The contours of this variable-geometry space are marked by: 1) the plurality of the areas of knowledge that are mobilized; 2) the diversity of the relationships between the actors and the knowledge that need to be taken into account; 3) the decentralization of the decision-making processes involved; and 4) democratization. These hybrid spaces form complex systems, the structure of which depends on: 1) the initial implementation conditions; 2) sensitivity to changes in environmental conditions; and 3) the interaction of the actors present.

Kate Waygood, Dr. Penny Sutcliffe and Dr. David Mowat commended Dr. Potvin for her remarks and offered further insights. They spoke about how the formal infrastructure, which mandates public health research, can positively influence public health practice involvement. They also mentioned the importance of participant readiness for collaboration, taking time to develop an understanding of each other, and building a sense of respect and trust for each other. They talked about regularly going back to the broader community of interest to test our research findings because the community can be highly suspicious of such partnerships. They also noted that partnerships with diverse stakeholders require a variety of communication strategies to help break down the barriers between the diverse worlds. Some indicators of success were suggested for effective public health research:

- The public health research system has the capacity to ask and answer the relevant research questions.
- In turn, stakeholders have the capacity to respond and to inform the public health research system regarding the relevancy of questions and offer potential solutions.

Collaborative Research Experience

In order to harness and build on participants' expertise in collaborative public health research, many opportunities for dialogue about building a sustainable public health research infrastructure in Canada were provided throughout the meeting. The first small group session focused on lessons learned with an eye to the future.

Six heterogeneous groups (each comprised of individuals from research, community, practice and policy settings) discussed the lessons learned from their collaborative research experiences. The groups' responses to three questions are summarized according to themes.

1. Key ingredients that led to successful collaboration

- *Vision and Culture*
  -A compelling and common vision, purpose and clear objectives motivate individuals/groups to participate.
  -Creating a culture of collaboration is facilitated by a history of successful collaboration and/or a foundation of sharing values of trust, respect, integrity and inclusion.
  -Inquiry, openness and co-investigation are critical conditions for successful collaboration.

- *Relationships*
  -The "right" people in diverse roles contributing a variety of perspectives (academia, community, agencies and policy makers) recognize their inter-dependence and need for interaction.
  -Effective networks are built on the strength of relationships, the valuing of diverse perspectives, and the balancing of power and equity.

- *Leadership, and Planning and Communication*
  -Passionate champions for collaboration with the skills in facilitative leadership can strongly influence successful collaboration.
  - Planning for change in incremental steps, and taking advantage of timing and opportunities help to advance the vision.
  -Communication strategies should be planned to facilitate the internal collaboration and to market the results to the broader community.

- *Infrastructure and Capacity*
  -Building on existing strengths and infrastructure i.e. organizational capacity supported through the availability of human and financial resources, time, skills, information/knowledge and flexible structure reinforces collaborative activities.
  -Developing new structures and new skill sets for relationship building, partnerships and networks heighten the possibilities for success.

-Ensuring sustainability by having the necessary resources (time, skills, knowledge, and money) to engage in continuous reflection (learning and evaluation) and to develop the necessary accountability structures.

2. Obstacles that have hindered effective collaboration. (Some of these obstacles mirror the key ingredients for successful collaboration that are listed above)

- *Infrastructure and Capacity*

-The ever-present need for, and pursuit of, adequate and sustainable resources and skills including:

- funding;
- human resources;
- time for relationship building, which is often limited by short timelines for grant writing and producing results;
- information and data;
- skills and knowledge of the general public; and professionals in public health, practice, research and collaboration;
- skills and knowledge of researchers in understanding the community and practitioners' expertise, priorities and communication needs.

-The present infrastructure "supporting" public health research collaboration is ill equipped to handle the complexity resulting from:

- the lack of public understanding of what constitutes public health;
- the differential power, capacity and politics of and between various groups;
- different emphases on research, development and/or action;
- colliding timeframes – i.e. long for research outcomes, short for political expediency;
- reward systems that do not generally support collaboration (e.g. tenure, advancement in universities);
- lack of ability or agreement to measure success; and,
- cultural differences in bureaucratic vs. informal processes; theoretical vs. practicality of research; and different ways of knowing.

- *Competition*

-Competing for research grants and taking credit for research projects often create barriers to collaboration.

-Valuing only knowledge and research that is peer reviewed may exclude alternative research methodologies and community access to research opportunities, e.g. "Participatory action research which is effective at building relationships and engaging community is not always valued or rewarded in academia."

-There is a lack of clarity about who owns the intellectual property.

-Diversity of partners leads to challenges in bridging differences.

3. Different collaborative strategies to achieve success

- *Opportunity Costs & Accountability*
  -Develop accountability structures, frameworks and definitions for accountability and high quality collaborative research e.g. engage process evaluators.
  -Identify and design collaborative research funding initiatives that work.
  -Capitalize on the complementarity of funding partners and current funding framework models, e.g. Global Health Research Initiative.
  -Provide communities with an institutional capacity to participate.
  -Take advantage of "natural experiments".
  -Capitalize on opportunities in the current political climate (e.g. reframing "healthy living").
  -Incorporate various methods of research and evidence uptake strategies to inform granting criteria and policy development.
  -Take the long view – attend to sustainability and results while maintaining flexibility to respond to change processes.

- *Language and Frameworks*
  -Speaking with a collective and consistent voice about what we know: develop the language, frameworks and values of public health collaboration.
  -Create support for the value of a public health approach and use this lens to increase awareness and understanding among a broader constituency.
  -Simplify the messages.
  -Develop multi-level strategies and frameworks for collaboration.

- *Knowledge Transfer or Exchange*
  -Refine our knowledge transfer methods and capabilities.
  -Put greater emphasis on mixed methods; validate qualitative, lived experience and best practice knowledge as well as quantitative and scientifically rigorous knowledge
  -Support young new researchers in developing the skills they require to pursue collaborative research careers (e.g. Summer Institutes).
  -Develop post graduate programs in public health research, which include the development of collaborative and partnership building skills to facilitate knowledge transfer and exchange.

- *Incentives*
  -Build in incentives for researchers to collaborate.
  -Build in funds for developing collaborative relationships as part of research budgets (e.g. development grants).

APPLICATION OF COLLABORATION PRINCIPLES

The conversation about collaborative research moved from principles to application. Before breaking up into discussion groups, a four-person panel shared their experiences using different mechanisms for collaboration associated with public health research. The panelists were Charlene Beynon from the PHRED program in Ontario; John O'Neil from the ACADRE Centre; Michel Rossignol from Montreal; and, Sarah Hayward from the SEARCH program in Alberta. The challenge posed to the panelists was to consider successful mechanisms and "not so" successful mechanisms that they have encountered in their work. All speakers mentioned the importance of carefully structuring teams of people; paying attention to the agenda and "workspace"; and the importance of convergence of values about collaboration and the purposes of the work itself. The speakers cautioned about the tendency to underestimate the difficult challenges associated with collaborations to bridge research with practice. They spoke of the energizing achievements that are possible and the discouraging setbacks that are inevitable. The above-mentioned themes that emerged from this panel served to bring closure to the morning's discussions and provided a thoughtful platform for the afternoon session.

The meeting participants worked in small groups to focus on a topic of their choice. Each group was asked to apply the principles of collaboration to one of the following four possible topics:

1. Ethics in population and public health research
2. Evaluation research: implications for population and public health research and practice
3. Capacity building through population and public health education
4. Application of knowledge to population and public health policy and practice

Three goals framed these discussions:

- To identify the key issues faced in the context of this topic area
- To determine which principles and methods of collaboration are most applicable to the topic
- To propose a series of actions for advancing the topic

Highlights of the conversations are as follows:

1. Ethics in population and public health research

Key Issues

A number of challenging issues were identified and examined, which provides a sense of the subject's scope, and the limitations of the NSERC/CIHR/SSHRC Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Guidelines as it relates to the conduct of population and public health research.

- Boundaries
  -What are the boundaries of public health research?
  -How do we address the need for transparency and consistency?

- Training
  -What kind of training and education do researchers and Ethics Review Board member's need? How and whose role is it to deliver this training?

- Consent
  -What are the alternatives to individual consent in population and public health research projects?

  -What does community consent mean?
  -When might it be inappropriate to go to an individual for consent?
  -Would CIHR be able to develop and disseminate a template of best practice guidelines for when consent is required in the context of population and public health research, to complement the Tri-Council Guidelines for getting consent from, for example, community-based organizations.

- Children

  -How can we address the challenges regarding the involvement of children in research? Such as:
  -passive parental consent
  -continuing review/re-consent (e.g. when children become adolescents in the context of a longitudinal study)
  -involving them in participatory research

- Participatory action research (PAR)
  -How can we address the challenges faced in participatory research? Such as:
  -continuing review
  -the competency of ethics review boards to appropriately review PAR research projects
  -ethics review conducted by "partners" in addition to Ethics Review Boards

- Data

  -What must we consider when archiving data? Issues surrounding data collection, retention and data sharing (with funding agencies) were raised by participants.

- Risk Management
  -How should we define "minimal risk" to subjects in the context of population health research?

- Ethics Review Boards (ERB) in Population Health
  -What should the role and functions of an ERB be? Possible functions include:
  - offering advice
  - holding veto power
  - inviting ad hoc members as experts
  - conducting face-to-face evaluations
  - ensuring continuity and transparency in processes

However, given the high degree of variability between ERBs, it was felt that these boards could be better supported in order to fulfill their potential role as resources to facilitate the ethical conduct of population and public health research.

Proposed Actions

Given the lack of consistency in the practices of ethics review boards' reviews across Canada, transparency of processes and methods must be ensured. Three actions were proposed:

1. Ensure appropriate representation on a steering committee charged with the responsibility to review the Tri-Council Guidelines so that revisions take into account population and public health research issues.
2. Collect relevant case studies from population and public health research to help facilitate an understanding of minimal harm and risk/benefit ratios in this research context.
3. Support capacity building and networking through education and infrastructure development for ethics review boards across Canada in population and public health research.

2. Evaluation Research: Implications for Population and Public Health Research and Practice

Key Issues

- What is Evaluation Research?
  -Evaluation Research components include context, impact (outcomes) and process
  -Terminology can be confusing. Is evaluation research, research that relates to program effectiveness?
  -Why is evaluation a type of research? Evaluation suggests that something is already in place.
  -Finding a politically correct label might lead us to choose Applied Health and Social Research.

- Is evaluation different from research?
  -There is considerable debate regarding whether evaluation is research, rather than getting on with the research.
  -Evaluation research does not necessarily need to be done in an academic centre, especially if new knowledge is not produced and training opportunities are not provided for students.

- What is new knowledge?
  -Community and university-based researchers may answer this question differently

- What should be evaluated? Topics and methods?
  -There are few funding vehicles specifically for evaluation. Evaluation generally has to piggyback on 'capital R' research programs.
  -Entering a participatory process with communities who want to learn how to do evaluation may take several years of pre-evaluation work, which is not funded as research.
  -Agencies have different capacities (staff, time, money) to engage in research.

- Who should do the evaluation - university-led, community-led, and/or private sector researchers?
  -University-based researchers should produce knowledge and tools to facilitate evaluation research.
  -Researchers based in universities may be better equipped than private firms to represent community interests and produce more generalizable knowledge.

  -Communities feel entitled to university involvement in research because universities are publicly funded through government but they do not want to participate in university research if it is not useful to the community.
  -Negotiation is critical to meet the needs of both the community and university researchers. Being honest about goals and expectations upfront can help reduce misunderstandings later on in the research process. (See Appendix B - 10 Commandments of Community Research.)

- What are the challenges?
  - generalizability of research from one or a few communities;
  - going beyond local level to address larger policy questions;
  - funding this kind of research
  - mechanisms to identify bottom up questions (i.e. emanating from local communities)
  - evaluating the impact of routine public health activities on communities.

Guiding Principles

1. Surveillance systems are required on an ongoing basis but are often time-limited
2. Interventions should be innovative.
3. The perspective that standardized protocols should be applied to the intervention design may be unrealistic.
4. It is desirable to replicate studies at different times, in different places or contexts, and with different populations. The accumulation of knowledge and identification of what "knowledge level" justifies policy decisions is very much in demand.
5. It is important to have a 'Research and Development' approach.
6. The evaluation approach should be matched to the stage of development of the phenomenon being studied.

Proposed Actions

1. Conduct research into our own public health research processes and practices.
2. Obtain institutional funding to support an infrastructure for public health research and collaboration.
3. Hold public discussions regarding research funding for population and public health.
4. Put a mechanism in place to coordinate the "bubbling-up" of questions and ideas from communities to various levels of government. Build linkages between various public health research models at the provincial/territorial and community levels and between public health researchers and practitioners.
5. Identify facilitators to bring together research teams, governments (provincial and national levels) and communities.
6. apply 10 commandments of community based research (appendix B)

Health Canada and CIHR could jointly support multi-jurisdictional research and program initiatives at the national level (versus regional approaches).

3. Capacity Building through Population and Public Health Education

Key Issues

- "Capacity Building" should be better defined through educational vehicles
  -What models and vision do we share for building capacity?
  -What skills do we need in order to undertake research?
  -What skills do we need to access and use research findings?

- Educational vehicles should reflect the interdisciplinary and diverse nature of public health research and practice. We need to tap into the wealth of knowledge from other disciplines beyond the traditional health sciences, e.g. anthropology,

geography, psychology.
-link rural and urban health, small and large universities, universities and public health units, and expand professionally-based programs.
-develop capacity for community-based researchers and practitioners along side the model of grant-funded researchers.

- Infrastructure is critical
  -Funding options for education inside and outside university programs should be expanded.
  -Models should, in part, be built from already existing models.
  -New educational supports should be tested and targeted to identified needs.
  -Collaborative alliances and partnerships across traditional boundaries are likely to be part of the solutions.

Principles and Methods of Collaboration

- Adhere to the principles of Adult Learning
  1. Enable life long learning.
  2. Support laddering or spiral learning opportunities.
  3. Enhance research excellence for broader purpose and in various environments (broaden definition of excellence beyond traditional measures).
  4. Encourage multi-and interdisciplinary educational frames.

Proposed Actions

1. Target capacity building and training to existing needs.
2. Sustain, augment and ensure quality of existing educational vehicles for traditional health sciences researchers.
3. Develop and implement a variety of strategies at multiple levels to address limited resources and incentives, lack of flexibility and interest; include and extend distance and practice-based educational programs and networks.
4. Consider the creation of a national level degree granting authority to implement new mechanisms for shared credentialing such as cross-institute or between provincial recognition or "laddering" up through a broader and more integrated notion of a continuing education system, through a variety of certificates, and other program approaches.
5. Continue to extend and enhance our ideas of what constitutes "excellence", in research, especially at CIHR.
6. Influence governments (national, provincial/territorial, regional) and others to invest in developing and training new (students) and experienced practitioners to upgrade their research skills and knowledge base - e.g. 'learning in place' and community-based sabbaticals.

4. Application of Knowledge to Population and Public Policy and Practice

Key Issues

- Dissemination
  -Take information out to communities (extend the reach of our knowledge base to a broader audience) and learn from communities in a way that is readily accessible, particularly in rural contexts.
  -Disseminate knowledge using a variety of vehicles; (e.g. we experience knowledge loss when peer reviewed journals do not accept certain forms of research. The process of conducting the research is often not captured in peer-reviewed journals).
  -Facilitate peer learning and interactive dialogue that are underused vehicles.

- Role of Practitioners
  -Many practitioners have no "professional" affiliation. Increasingly, practitioners are being spread more thinly and are increasingly removed from the community.
  -Change in practice and research will not happen without supporting community change.

- Knowledge and Knowledge Transfer (KT)
  -Knowledge of community can inform policy.
  -Universities need to recognize their role and responsibility to the community.
  -Research about how practices change should be done before implementing knowledge transfer strategies so we can build capacity to adapt practice based on current evidence.
  -Although a critical mass of programs is working on how to transfer knowledge, we need system-wide analysis of these approaches.

- Marketing of Knowledge
  -Knowledge transfer activities need to be anchored in a "broader determinants of health" framework.
  -Systems and organizations as well as individuals should be targets of our marketing efforts.

- Funding and Research Planning
  -The funding process is labour intensive; planning needs to go beyond grant acquisition to include implementation of the research plan.
  -Participatory action research is not as well funded and recognized as "legitimate" research as is quantitative research.
  -There is a "disconnect" between research, and policy and practice.
  -Resources are needed to adopt evidence-based change programs (e.g. consultation, training, technical advice).
  -Evidence uptake structures are needed that facilitate the translation of research into policy and practice.

-Reward mechanisms need to be revisited by funding agencies and not limited to only peer reviewed publications. If the research is not in a peer reviewed, well-respected journal, there may in fact be limited opportunities for knowledge exchange.

- Other Problems
  -We need to have a body of knowledge to support knowledge exchange. Public health research theme-teams, which are funded to bring knowledge together from particular areas, could help.
  -There are few rewards for introducing new knowledge for practitioners and policy makers.
  -The focus on the university, as the primary place for research, is problematic and limited in the long-term.
  -The regulatory constraints of collective agreements can be obstacles to knowledge exchange and its application, especially if job descriptions are so narrowly defined that individuals do not have the scope to respond and "take up" new knowledge.

Principles and Methods of Collaboration

1. Access to knowledge, services and information for practitioners.
2. As Knowledge Exchange processes evolve, fund research on how to effectively do it.
3. Real partnerships take time and resources.
4. An effective learning culture requires practitioners, policy-makers and researchers to be involved as partners in learning and in peer learning.
5. Recognition and valuing of diverse values and ethical tensions need to be identified and confronted constructively.
6. Commitment from policy-makers, granting agencies and others regarding change and implementation must be assured.
7. Reward mechanisms for knowledge exchange and effective policy/program change are needed.
8. Staff and money must be allocated for knowledge exchange networks.

Proposed Actions

1. Develop a national repository of public health "evidence", which includes research, resource people, networks, articles, annotated bibliographies, consensus statements, etc. Provide training so that people know how to use this evidence.
2. Develop a capacity building infrastructure including knowledge brokers and networks, and an appropriate reward system.
3. Establish national theme teams to disseminate existing research.
4. Develop a process to help practitioners design research questions.
5. Develop individual and system capacity (includes funding).

6. Develop a public health research priority agenda and process (which includes a Knowledge Exchange component). Build in scholarships of discovery, integration, education and, application.

RECOMMENDATIONS FOR ACTION

Even if some of the ideas emerging from this meeting cannot be implemented immediately, they will guide the path forward. Knowledge has been exchanged, ideas, challenges and opinions influenced. The last session of this meeting was dedicated to identifying more concrete recommendations for action. These are all reported here so that further work can be initiated to design, test, refine, implement and evaluate progress across a number of key areas. These recommendations and the shared perspectives will continue to inform and contribute to our goal of building a sustainable public health research infrastructure in Canada.

1. Facilitate on-going dialogue

a) Continue the dialogue and momentum initiated during this meeting *(Note: As an initial step, CIHR-IPPH and CPHA will host a networking breakfast at CPHA's conference in May 2003).*

b) Build on existing local and national infrastructure.

c) Provide opportunities for building linkages (CIHR-IPPH, CPHI, CPHA, others).

d) Ensure diverse community voices are heard.

e) Enhance support for practice-based research.

f) Continue to clarify the scope of what needs to be accomplished.

g) Recognize that priorities will vary by organization and jurisdiction.

2. Identify a National Public Health Agenda

a) Develop a national public health agenda to get public health on the broader health agenda.

b) Create public health theoretical frameworks.

c) Provide granting incentives for public health training exchanges between academics, practitioners or clinicians and policy makers.

3. Nurture Linkages

a) Identify interests and build connections.

–Create nodes (teams of 3-5 researchers, centres and networks) locally/regionally, provincially/territorially, nationally (horizontal strategy).
–Connect research, practice and education in communities of interest (vertical strategy).
–Develop opportunities for secondments, practica and sabbaticals between partnering organizations.
–Define and communicate 'success' early on and what that means to different people.
–Facilitate movement beyond territorialization of interests.
–Structure funding processes so that community partners can really sign off on projects.
–Allow enough time for 'Request for Proposal' processes so that partners can get together.

b) Create a public health research network to link and promote the sharing of best practices initiatives.

c) Focus on what is manageable by building on what exists

–Focus on priorities and outcomes for public health and public health research at local/regional levels;
–Support existing links to facilitate a developmental process.
–Foster interchanges between existing structures, build on existing strengths; connect researchers to existing societies and initiatives to build networks.
–Allow people to build local/regional linkages– do not require national outcomes from local/regional workshops initially.
–Develop reporting mechanisms for network partners to report back to local partners who support infrastructure development.

d) Suggestions for CIHR-IPPH

–Support the development of linkages as an ongoing process and not a series of 'one-off' events.
–Provide a coordinating function.
–Offer seed money to build linkages using a 'venture capital' mentality (e.g. 3/10 is a very good success rate).
–Create smaller pots of funding for more local/regional meetings, workshops, and other opportunities to facilitate linkages.
–Organize an annual scientific meeting, possibly in conjunction with the annual CPHA conference, where more formal linkages could be advanced.
–Consult with stakeholders to foster the development of evidence uptake strategies.
–Play a role in developing a focused direction and national public health research agenda.

4. Implement a variety of education and communication strategies

a) Communicate with researchers and decision-makers concerning how to enhance their respective capacities to access, appraise, adapt, and use existing evidence to inform policy and practice. Create multi-directional learning opportunities for both researchers

and practitioners to identify and address applied research priorities and to participate in creating new knowledge.
b) Establish national theme teams to disseminate existing research.
c) Consider alternate strategies for training practitioners other than graduate schools.
d) Provide educational opportunities for decision-makers on how to use evidence. (For example, the Canadian Health Services Research Foundation (CHSRF) research scientists are required to engage in knowledge translation; so, their mandate is not just generating research.)
e) Develop social marketing strategies to improve uptake of evidence and facilitate knowledge translation.

5. Develop sustainable funding infrastructures

a) Encourage the federal government to contribute resources to build research and include incentives for training infrastructure (e.g. through matched funding).
b) Stratify funding so that it is distributed more equitably to help level the playing field across regions of the country.
c) Make provisions to cover related operational costs (e.g. telephone charges, furniture) related to the conduct of research.

6. Create infrastructure to support public health research

Participants discussed the creation of a new organization to act as a broker between universities and service agencies; creating Public Health Research Chairs with links to CHSRF, SSHRC, funding researchers to work in practice environments; facilitating the involvement of researchers, policy makers and practitioners together in deciding the research questions; funding new emerging teams of university, community and practice collaborators.

Some suggestions for structural options as independent structures or combined with/building on each other for supporting public health research, local capacity building, professional training and knowledge exchange (especially with policy makers) were:

Centres of Excellence

Participants discussed the possibility of the creation of an Institute (e.g., "Canadian Institute of Public Health Policy and Practice Research" – see below) and/or networked partnerships based on different foci/strategies (e.g. policy, disease prevention, vulnerable groups etc). This will require sustainable local partnering, which should be a part of the funding formula. A three-tiered funding model, based on the Canada Research Chairs model, could be employed. Under such a model, Tier I would be on a 7 year cycle (renewable indefinitely) and Tier II would be on a 5 year cycle (renewable once). These Centres of Excellence could engage in research, capacity-building (local

groups),training programs and knowledge translation activities. The participants identified the Canadian public health research models (see Appendix D), the Healthy Communities Model, and the Canadian Consortium of Health Promotion Research Centres as potential models.

An arms length NGO (e.g. Canadian Institute of Public Health Policy and Practice Research) could be created and have among its responsibilities the following:

-"Troll" databases on key policy/practice questions generated by local research partnerships.
-Collect information on determinants and intervention (policy/practice) research.
-Provide secretariat to "partnerships" in linking research centres of excellence.
-Develop and sustain a knowledge bank and database of researchers.

Evidence-based repository of all Public Health research evidence

-A core group should house evidence from research and take the lead on marketing for public health – e.g. CPHA, CIHR. In addition, the repository could be positioned as good for sustainability, mentoring and support for junior researchers. The repository would also help strengthen research proposals in the field.
-Develop a website to include the existing models of Public Health research infrastructure in Canada (see appendix D for descriptions of the models).
-Identify gaps in the existing models and get CIHR to fund centres that address the gaps.
-Build an infrastructure that is supported by electronic and face-to-face communication strategies.
-Use practice to inform research.

Conclusion

There was general agreement about the need to strengthen population and public health research infrastructure and capacity. At the same time, there were many divergent points of view about how best to achieve this broad goal. The following recurring themes will need to be further addressed to ensure ongoing momentum in follow-up to this meeting:

1. We need further discussion on the values/assumptions/principles that guide population health and public health practice models as well as the research priority setting process.

2. We need to improve our mutual understanding and recognition of the relative contributions and skills of researchers, policy makers, community and practitioners.

3. We need to ensure that we have the credibility and capacity to ask and discover answers to public health research questions.

4. We need to ensure that we have the mechanisms and infrastructure to challenge and build public health and research agendas,

5. CIHR and others should continue to invest in building connectivity and linkages. The funds should be considered as "venture capital" investments, recognizing that there will be successes and failures. We need to be sensitive to the fact that it is very difficult to build and sustain collaborative relationships but it is very easy to break them down.

6. CIHR and others must be encouraged to design creative funding programs that take into consideration the diverse needs of stakeholders,

7. Multi centre/virtual centre research infrastructure has the most potential to meet the diverse needs across Canada.

8. These Recommendations for Action must be considered by both CIHR and other relevant partners – for example, Canadian Public Health Association, Canadian Population Health Initiative, etc.

CIHR-IPPH and many participants committed to moving forward on the issues and recommendations identified at this meeting. Some of the necessary steps are being planned in partnership with CPHA and others. These steps will help to sustain the momentum and encourage early collaborative progress to be made in support of building a sustainable population and public health research infrastructure for Canada.

APPENDIX A

Building a Sustainable Public Health Research Infrastructure in Canada

CIHR-IPPH MEETING

March 3-4, 2003
Metropolitan Hotel, Toronto

PROGRAM AGENDA

Objectives:

- To facilitate the development of a network and infrastructure for public health researchers, practitioners, community advocates and policy makers in Canada.
- To develop recommendations and an action plan to foster infrastructure development in Canada.

March 3, 2003 8:30 am – 4:15 pm

8:30 am – 9:00 am	**Arrival, registration and refreshments** (Victoria Foyer)
9:00 am – 9:15 am	**Welcome** – John Frank (Toronto) • Set the context and review objectives • Introduce facilitator, Ruth Armstrong
9:15 am – 9:45 am	**Keynote Presentation** – Louise Potvin (Toronto) *"Critical Factors for Success in Public Health Research in Canada"*
9:45 am – 10:05 am	**Response to Keynote Presentation** (Toronto) Kate Waygood, David Mowat, Penny Sutcliffe
10:05 am – 10:25 am	**Questions and comments from participants** (Toronto)
10:25 am – 10:40 am	**Break** (Victoria Foyer)
10:40 am – 11:45 am	**Identify the lessons learned** *(success and challenges) from collaborative research across Canada – refer to variety of collaborations (discussions in small groups as assigned)*

	• Group A (San Francisco, 26th Floor) • Group B (Seattle, 26th Floor) • Group C (Vancouver, 2nd Floor) • Group D (Los Angeles, 26th Floor) • Group E (Denver, 26th Floor) • Group F (Toronto, 2nd Floor)
	Post results of discussion on flip charts (Toronto)
11:45 am – 1:00pm	**Lunch** (Mezzanine Café)
1:15 pm – 2:00 pm	**Mechanisms for collaboration** (Toronto) Sarah Hayward (SEARCH), Charlene Beynon (PHRED), John O'Neill (ACADRE), Michael Rossignol (Montreal)
	Summary of small group discussion – Ruth Armstrong
	Questions and comments from participants
2:00 pm – 3:30 pm	**Building on critical factors for success, what do we need to do to address the collaborative issues in:** *(each small group will address one topic area)* *(includes informal break)*
	• Ethics (Denver, 26th Floor) • Evaluation research connecting research and practice (A) (Seattle, 26th Floor) • Evaluation research connecting research and practice (B) (Los Angeles, 26th Floor) • Capacity building through education (San Francisco, 26th Floor) • Application of knowledge to policy and practice (A) (Vancouver, 2nd Floor) • Application of knowledge to policy and practice (B) (Toronto, 2nd Floor)
3:30 pm – 4:00 pm	**Report back from groups** (Toronto)
4:00 pm – 4:15 pm	**Close and adjourn for the day** (Toronto)
6:00 pm – 8:00pm	**Participants Dinner** (Mezzanine Café)

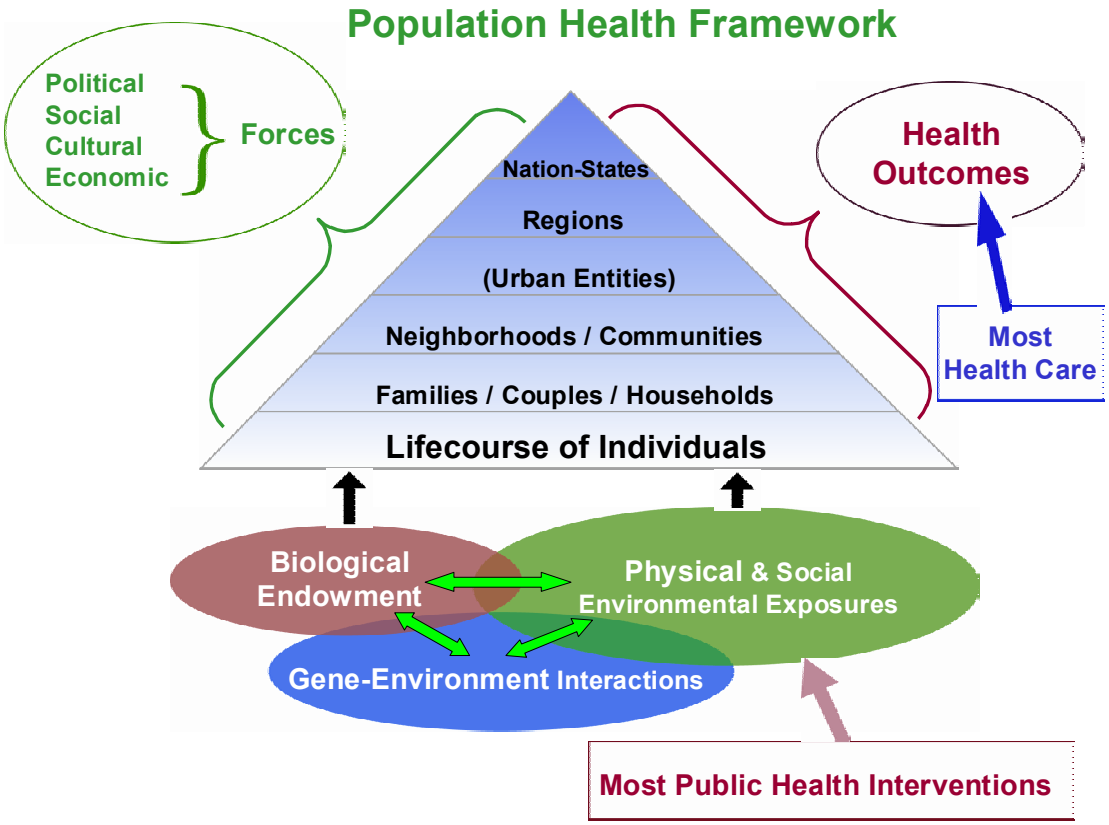
March 4, 2003 8:30 am – 2:00 pm

8:30 am – 9:00 am	**Arrival and refreshments** (Victoria Foyer)
9:00 am – 9:30 am	**Review outcomes from March 3rd** (Toronto) **Review objectives and format for the day** (Toronto)
9:30 am – 10:45 am	**Develop ongoing action plans and recommendations** *(discussions in small groups as assigned)* • Identify the scope of what needs to be accomplished • Identify recommendations and actions that move the agenda forward • Group A (San Francisco, 26th Floor) • Group B (Seattle, 26th Floor) • Group C (Toronto, 26th Floor) • Group D (Los Angeles, 26th Floor) • Group E (Denver, 2nd Floor) • Group F (Toronto, 2nd Floor)
10:45 am – 11:00 am	**Break** (Victoria Foyer)
11:00 am – 12:00 pm	**Report back on Action Plans** (Toronto) **Feedback from participants** (Toronto)
12:00 pm – 2:00 pm	**Lunch and Closing Remarks: Where to from here?** – John Frank **Evaluation** (Toronto)

Prepared by the Advisory Committee: Ann Casebeer, Larry Chambers, Erica Di Ruggiero, Madonna MacDonald, Louise Picard, Michael Rossignol, Jane Underwood

APPENDIX B

Population Health Framework*
(Canadian Institutes of Health Research – Institute of Population & Public Health)



* CIHR-IPPH (2002). Mapping and Tapping the Wellsprings of Health: Strategic Plan 2002-2007. accessible on the Web, http://www.cihr-irsc.gc.ca/e/institutes/ipph/13789.shtml.

APPENDIX C

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Appendix D

Background Materials

The descriptions in this package were assembled as part of the CIHR- IPPH commitment to identify and provide information on key funding mechanisms, models and opportunities that are available to support research capacity for public health. It is hoped that the descriptions will assist participants at the meeting to conceptualize a network and infrastructure for public health researchers, practitioners, community advocates and policy makers in Canada.

The following Program descriptions are included in this package:

- ACADRE
- CIHR - Centres
- Community Campus Partnerships for Health
- CURA
- Montreal
- PHRED
- SEARCH
- Skills Enhancement for Health Surveillance

National ACADRE Networks

Program Description

The purpose of ACADRE is to develop a network of supportive research environments across Canada that will facilitate the development of Aboriginal capacity in health research. There are 8 centres across Canada and are all affiliated with a university.

Funding

The ACADRE Centres are funded for 3 years - up to $500,000 per year. These Centres can be renewed for another 3 years, based on their successful evaluation(s).

Sponsoring Agencies

The 8 ACADRE centres receive their funding from the Canadian Institutes of Health Research - Institute of Aboriginal Peoples' Health.

Host Sites /Contact Information/ Theme areas

BRITISH COLUMBIA
Roderick McCormick, PhD
Department of Counseling Psychology
Faculty of Education
University of British Columbia
1985 West Mall
Vancouver, BC V6T 1Z4
Tel: 604-822-6444
Fax: 604-822-8944
Email: rod.mccormick@ubc.ca

*ACADRE Name: What Works? The Four R's of Aboriginal Health (Respect, Relevance, Reciprocity, Responsibility)

Four Theme Areas:

- Community health strengths for developing health assessments and ethical research practices;
- Enacting Responsibility Toward Aboriginal Cultural Knowledge;
- Holistic wellness in mental health and addictions;
- Community motivated emerging research themes.

ALBERTA
Malcolm King, PhD
173 HMRC
University of Alberta,
Edmonton, AB T6G 3S2

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Fax: 780-492-4878
Email: malcolm.king@ualberta.ca

**Proposed ACADRE Name: A National Aboriginal Health Research Training Initiative*

Three Theme Areas:

- Chronic health issues (diabetes, heart diseases, lung diseases
- Child health, including FAS/FAE, nutrition issues, acute illness
- Addiction, mental health, suicide.

SASKATCHEWAN
Eber Hampton, PhD
Saskatchewan Indian Federated College (SIFC)
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3737 Wascana Parkway
Regina, SK S4S 0A2
Tel: 306-779-6211
Fax: 306-584-0955
Email: ehampton@sifc.edu

*ACADRE Name: Indigenous Peoples Health Research Centre (IPHRC)

Four Theme Areas:

- Chronic Diseases, nutrition & life style
- Indigenous healing: addiction (includes FAS), mental health, and judicial system
- Health delivery and control (includes ethics, community development & governance)
- Prevention & environmental health.

MANITOBA
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Email: oneilj@Ms.UManitoba.CA

*ACADRE Name: ACADRE Program

Four Theme Areas:

- Population health
- Health services research
- Child development and health
- Ethics

ONTARIO
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***Official ACADRE Name: Anisnawbe Kekendazone (Aboriginal Knowledge)**

Three Theme Areas:

- Prenatal Health
- Youth Risk and Resiliency
- Knowledge Transfer/Communication

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Email: kue.young@utoronto.ca

*ACADRE Name: Centre for Aboriginal Health Research Development in Ontario (CAHRDO)

Three Theme Areas:

- Prevention and Control of Chronic diseases
- Mental health of Children and Women
- Culture, Health and Healing

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Beauport, Quėbec G1E 7G9
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Fax: 418-666-2776
Email: eric.dewailly@crchul.ulaval.ca

*ACADRE Name: Centre for Inuit Health and Changing Environments

Three Theme Areas:

- Changing Environments and Inuit Health
  A. Inuit Health Contaminants
  B. Inuit Health and Climate Change
  C. Chronic Diseases and Changing Environments
- Environmental Public Health Surveillance and Monitoring in Inuit Regions
- Inuit Knowledge and Western Science in Environmental Health Research.

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*ACADRE Name: to be determined (Atlantic Region ACADRE Centre)

Three Theme Areas:

- The Determinants of Health
- Undertaking Preventive Measures
- Mental Health and Addictions

CIHR Centres for Research Development "Understanding and Addressing the Impacts of Physical and Social Environments on Health"

Program Description

The Institute of Population and Public Health (IPPH) launched the first ever *CIHR Centres* program in one research area, "Understanding and Addressing the Impacts of Physical and Social Environments on Health", in September 2002. This initiative will provide interdisciplinary teams of researchers and their stakeholders with core infrastructure support to access other research funds to develop integrated programs of research and knowledge translation that help to understand and examine the health impacts of policy and programs that affect the quality of these environments, and design and test new interventions to achieve population-level health benefits. Key stakeholders must be represented in the governance structure of an eligible Centre.

The initiative has been designed in direct response to feedback received from population and public health (PPH) stakeholders from the research, policy and practice communities, who were consulted as part of a 10 city national tour conducted by the Institute of Population and Public Health, in partnership with the Canadian Institute for Health Information - Canadian Population Health Initiative

These stakeholders identified a general lack of infrastructural capacity for interdisciplinary PPH research partnered with research users. One of the key funding mechanisms therefore suggested by stakeholders to help address these "differences in capacity" is Centre Grants, which provide core infrastructure support to facilitate the sort of interdisciplinary teams and community/policy-maker/decision-maker partnerships required to ensure the conduct of relevant PPH research and its application into policy and practice (http://www.cihrirsc.gc.ca/institutes/ipph/publications/charting_the_course_e.pdf).

Status Update

Twenty-five of the 39 Letters of Intent submitted to this competition have been invited to submit full applications by mid May 2003. Peer review will follow shortly thereafter with notification of decision by early August.

Key objectives

- Align capacity building with strategic health research themes and knowledge exchange activities of participating Institutes.
- Better position interdisciplinary teams of researchers, in newly emerging and less developed fields, for accessing open-competition (investigator-initiated) research funding.
- Promote networking and mentoring across researchers and existing institutions.
- Foster meaningful interactions with research users such as policy makers, public and voluntary sector program administrators, and clinical and public health practitioners.
- Create a sustainable path for the activities of Centres for Research Development, with committed multi-year funding.

- Facilitate capacity building in regions of Canada with underdeveloped research strengths.

Outcomes

- The research capacity built appropriately reflects the thematic priorities and knowledge exchange activities of participating Institutes.
- Improved health research in newly emerging and less developed fields.
- Improved integrated approach to health research resulting from increased collaboration.
- Evidence of meaningful interactions with a variety of research users.
- Activities of Centres for Research Development are sustained in the long term.
- All regions able to further develop research strengths. Equalization of national access to health research funding.
- Key stakeholders represented in the governance of the Centre.
- Written progress reports submitted every two years outlining progress towards the Centre's key objectives, including a discussion of the progress of each funded trainee
- An interim report submitted in year four.
- Annual conference/workshop organized by CIHR, in collaboration with partners, to share experiences, ideas, and best practices across programs and to work together in achieving the objectives of the Centres.
- A variety of regular and ongoing knowledge exchange activities that engage potential research users.

Funding

The total amount available for this initiative per year is $1.6 to $2 million. The amount may increase if additional funding partners decide to participate. The maximum amount awarded for a single grant is $400,000 per year.

Funding will be provided for a period of up to six years, subject to a satisfactory interim review during the fourth year. This is a non-renewable grant.

Partners

The CIHR Institute of Population and Public Health is leading this initiative. It is anticipated that other CIHR Institutes and external partners currently being actively recruited will join IPPH in support of these teams of researchers.

Contact Information
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Community-Campus Partnerships for Health (CCPH)

Program Description

Community-Campus Partnerships for Health (CCPH) is a non-profit organization that promotes health through partnerships between communities and higher educational institutions. Founded in 1996, they are a growing a network of over 1000 communities and campuses. CCPH has members throughout the United States and increasingly the world who are collaborating to promote health through service-learning, community-based research, community service and other partnership strategies. These partnerships are powerful tools for improving health professional education, civic responsibility and the overall health of communities.

Key Activities

- Building the capacity of communities and higher educational institutions to engage each other as partners.
- Incorporating service-learning into the education of all health professionals.
- Recognizing and rewarding community-based teaching, research and service.
- Developing partnerships that balance power and share resources among partners.

Selected Products:

- **Partnership Matters** provides information about funding opportunities and other important news through CCPH's electronic discussion group and biweekly online newsletter.
- **conferences** and **institutes**
- **Publications** - for free or at a discount. **Partnership Perspectives** magazine, free to CCPH members, features practical and thought-provoking articles on building partnerships.
- **member directory**, listserv,
- **CCPH Mentor Network** of trainers and consultants.
- Influence policy on issues, including funding for community-campus partnerships, Healthy People 2010 objectives and faculty promotion and tenure.

Funding

- Individual, student and organizational memberships.
- A mix of public and private funders for projects.

Partners
Participants in CCPH are affiliated with colleges and universities, community-based organizations, health care delivery systems, foundations and government. Our members include administrators, faculty, staff, students, clinicians, researchers, educators, civic leaders and policymakers who come from urban, rural and suburban communities in the United States and around the world. They reflect the diversity of health professions disciplines, including dentistry, allopathic medicine, osteopathic medicine, nursing, pharmacy, physical therapy, physician assistants, psychology, public health and social work.

Contact Information
www.ccph.info

(Note: this information was excerpted from the CCPH website and reviewed by Sarena Seifer)

Community-University Research Alliances (CURA)

Program Description

The Social Sciences and Humanities Research Council of Canada (SSHRC) is an arms-length federal agency that promotes and supports university-based research and training in the social sciences and humanities.

SSHRC's CURA program is based on an equal partnership between organizations from the community and the university. It provides co-ordination and core support for planning and carrying out diversified programs of activities that reflect the CURA program objectives, and are centered on themes/areas of mutual importance to both founding partners and closely related to the existing strengths of the university partner(s).

In each CURA, the partners jointly define and bring together one or more academic disciplines in order to target one or more research themes or areas. These themes or areas should be sufficiently broad to lend themselves to the full range of activities described above. Possible examples include: youth, poverty, culture and the arts, tourism and recreation, First Nations issues, socialization, integration of persons with disabilities, violence, the aging population, globalization, social justice, local and regional economic development, health and welfare, community capacity, social indicators, cultural heritage management, religion and society, gender issues and environment and sustainable development.

A university researcher or an individual from the community environment direct the CURA and champion its goals. The director:

- provides leadership and intellectual guidance for the development of the program of activities, and
- is supported by researchers, by graduate and undergraduate students (where possible), by the partner organizations, and, as needed, by professional staff.

The most recent call required a Letter of Intent by November 15, 2002 and a formal application (by invitation only): June 30th, 2003

Key Activities

Each CURA's program of activities includes:

- a research component (short-term and long-term projects, action research, etc.);
- an education and training component (in the context of research projects, apprenticeships, activities credited as part of coursework, etc.); and
- a knowledge-transfer component (workshops, seminars, colloquia, publications, public lectures, etc.).

The project partners jointly define a CURA's program of activities as well as the participatory arrangements under which individual researchers and research teams will carry out that program of activities. The partners should continue to develop and refine the program of activities and, in addition to strengthening the original alliance, should also recruit new partners during the period of the grant.

Funding

The Web-based application process is two-pronged: a Letter of Intent (LOI) stage, and the formal application stage.

Letter of Intent: Up to $20,000 (to assist in development of Formal Application)

Grant: Up to $200,000 annually for up to five years

Partners

Organizations from the community and academic sectors

Contact Information

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Direction de la santé publique de Montréal-Centre (DSP)

Observatoire montréalais des inéqualité sociales et de la santé (OMISS)

GRIS (Groupe de recherche interdisciplinaire en santé)

Program Description

Direction de la santé publique de Montréal-Centre (DSP)

The Province of Québec is divided into regional health boards, each with a director of Public Health Services. In Montréal, seven Community/Public Health departments were merged in 1993 when the organization became a Directorate of Public Health within the Régie régionale de la santé et des services sociaux de Montréal. There is an administrative relationship with two teaching hospitals: Hôpital Maisonneuve-Rosemont (Université de Montréal) and McGill University Health Centre.

The Directorate of Public Health (Direction de santé publique – DSP) is responsible for assessment of health needs of the population and development of the most effective prevention interventions, surveillance and control of communicable and non communicable diseases, dealing with real or perceived public health emergencies and developing expertise in health promotion and disease prevention. The Regional Public Health Program, based on a national program template (www.msss.gouv.qc.ca/f/documentation/publica/index.htm) includes six targets: social inequalities in health, prevention in health care, peoples' development, promotion of lifestyle and security, surveillance of biological, chemical and physical threats and knowledge of the populations' health (www.santepub-mtl.qc.ca).

The Directorate is organized in 4 departments: Occupational and Environmental Health, Infectious Diseases, chronic diseases (including cardiovascular disease, cancer, diabetes) and Human and Social Ecology (population health/health promotion). In addition to the four program areas, are support services including administration, planning, communication and research and education. Of note is that the DSP has "research" included in their official mandate and mission. The staff provides consultation and support to the CLSC's [Centre local de services communautaires] which provide direct social and health services including vaccinations in the community. At the DSP there are about 410 employees; approximately 200 professional staff whose activities include a variable amount of research and not more than five staff are paid partly by the university. Forty (40) people have university appointments at McGill University or Université de Montréal. There is an executive position of Coordinator of Research and Teaching. As recognized by university colleagues: "It is a unique setting with the highest level of public health expertise outside of a university in Canada".

Observatoire montréalais des inéqualité sociales et de la santé (OMISS)

(http://www.santepub-mtl.qc.ca /omiss.html) This community-based initiative was established in May 2001 in follow-up to the DSP's activities and commitment to recognizing the broad determinants of health including poverty (1998 Report on social inequalities of health). The goal of OMISS is to produce information for decision-makers on social inequalities and their health consequences, develop a research agenda and sensitize funding agencies to these priorities.

GRIS (Groupe de recherche interdisciplinaire en santé) has over 30 researchers who focus on determinants of health, evaluation of interventions and health care system.

Key activities

- Public health surveillance and control of disease and illness
- Applied Public Health research and program evaluation
- Dissemination of information

Outcomes/products

- Annual reports on social inequities and their health consequences available in French and English on PDF format. www.santepub-mtl.qc.ca.

Funding

The total budget at DSP is approximately $10 million with $3 million allocated to research which is expected to increase over the next two years as they hope to create a research centre in public and population health. Funding is from the Ministère de la santé et des services sociaux. Research funds are from various sources including FRSQ and CIHR.

The operating grant of GRIS is from the FRSQ. Research funds come from various sources including FRSQ and CIHR.

OMISS is an initiative funded by the DSP and University of Montreal. The observatory has now generated funds from FRSQ, CIHR and other sources.

Partners

University of Montreal, McGill University, DSP-Montréal Centre, Concordia University, University of Quebec at Montreal, local centre for community services (CLSC) and others.

Contact Information

www.santepub-mtl.qc.ca –

OMISS: www.omiss.ca

GRIS: www.mdsocp.umontreal.ca

PHRED

(Public Health Research Education Development Program)

Program Description

Based on the teaching hospital concept, the PHRED Program was established in Ontario in 1986 with each designated site requiring a formal affiliation agreement between a university and a Public Health Department. The PHRED Program, which is grounded in practice, provides practical training for future public health professionals and helps to guide and encourage public health research. The program operates at five sites and has evolved by increasing the inclusion of practitioners in the planning and dissemination of research evidence.

This Ontario PHRED program is a successful model resulting in an impressive publication track record and a national and international reputation. Both research and education initiatives are influencing policy and practice and vice-versa.

Key Activities

- Applied public health research and program evaluation
- Education of students and Public Health practitioners

Products

Examples include:

- NutriSTEP, a national research project involving Ontario and 5 provinces, designed to develop an inexpensive screening tool to identify pre-school aged children at risk for nutritional problems.
- Effective Public Health Practice Project (EPHPP) i.e. systematic reviews of the literature www.city.hamilton.on.ca/sphs/ephpp.
- Benchmarking of Public Health Programs and Services e.g. Heart Health Coalitions, Breastfeeding Supports, and School Health. www.benchmarking-publichealth.on.ca.
- Evaluations e.g. Ontario's Universal Influenza Immunization Program.

Funding

- PHRED is funded 50/50 by the Ontario Ministry of Health and Long-Term Care and the local municipal governments.

Partners

The Provincial Steering Committee provides overall direction to the Public Health Branch for the PHRED Program, and ensures that the PHRED Program is responsive to the needs and priorities of the public health system. Membership of the Steering

Committee is currently under review, with a view to having national representation e.g. CIHR.

The PHRED sites work in a partnership with each other under the auspices of the provincial PHRED Operations Committee.

Sponsoring Agencies:

- Ontario Ministry of Health and Long-Term Care
- Local municipalities

Host Sites

- City of Hamilton and McMaster University and University of Guelph;
- Kingston, Frontenac and Lennox & Addington Health Unit and Queen's University;
- Middlesex-London Health Unit, The University of Western Ontario, and Brescia University College;
- City of Ottawa and The University of Ottawa; and
- Sudbury & District Health Unit and Laurentian University.

Contact Information

www.phred-redsp.on.ca

PHRED Site	Director	Email
Hamilton	Ms Jane Soldera	jsoldera@hamilton.ca
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Middlesex-London	Ms Charlene Beynon	cbeynon@uwo.ca
Ottawa	Dr Geoffrey Dunkley	geoffrey.dunkley@ottawa.ca
Sudbury	Ms Louise Picard	picardl@sdhu.com

SEARCH
SWIFT EFFICIENT APPLICATION
OF RESEARCH IN COMMUNITY HEALTH

AHFMR ALBERTA HERITAGE FOUNDATION FOR MEDICAL RESEARCH

SEARCH (Swift Efficient Application of Research in Community Health)

Program Description
The SEARCH Program is a two-year health research and professional development program for community-based health professionals, sponsored by their health organizations. It is designed to help health organizations answer local problems with good information by developing their people.

The SEARCH Program of practice-based training and networking provides education, training, mentoring and research collaboration through a virtual learning community of managers and health professionals in partnership with university-based researchers and teachers. The program develops participants' skills and knowledge across three inter-linked themes: creating, choosing and using evidence in context. It facilitates collaborative research projects to address priority questions identified by participants' organizations.

The participants are selected and sponsored by Alberta's health authorities, physician groups, and other health agencies. Throughout the two years, participants engage in residential face-to-face instruction, online learning and collaboration between modules and project work within their current work sites, and in multi-sectoral teams.

Key activity
Educational program

Outcomes/products

- An ongoing active network of individuals around the province who are well placed to ensure that health research valued, relevant and rigorously conducted.
- Results of applied research projects that have been undertaken as a component of the educational program.
- Changes in organizational culture where staff have participated in the SEARCH program.
- Changes in university capacity where researchers have contributed to the program.
- A virtual community of practice where information is rapidly accessed and exchanged.

Funding
SEARCH is funded by the Alberta Heritage Foundation for Medical Research with participant salaries being paid by their respective sponsors.

Partners

SEARCH is a partnership of the Alberta Heritage Foundation for Medical Research with the Alberta Health Care System and several faculties at the Universities of Alberta and Calgary.

Sponsoring Agencies:

AHFMR (www.ahfmr.ab.ca)
U of A (www.ualberta.ca), Faculties of Medicine, Nursing and Business
U of C (www.ucalgary.ca), Faculties of Medicine and Nursing

Program Partners include:

Alberta Health and Wellness
Alberta Regional Health Authorities
Alberta Mental Health Board
Alberta Rural Physicians Action Plan

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Health Canada Santé Canada

Skills Enhancement for Health Surveillance Program

Program Description

The Skills Enhancement for Health Surveillance program is an Internet-based continuing education training initiative for health practitioners in local public health departments and regional health authorities across Canada. The goal of this initiative is to increase public health practitioner's skills in the following areas:

- epidemiology
- surveillance
- information management

Given that the foundation for effective health surveillance in Canada is the ability to use and understand information, very specific skills are required. However, these skills vary across the country and are limited in many public health jurisdictions. The "Skills Enhancement" program will provide training opportunities that may otherwise be unobtainable or unaffordable.

The key target audience is professional staff working in local, regional, provincial or territorial public health offices, including but not limited to public health nurses, inspectors, health promotion personnel, program managers, nutritionists and when applicable medical officers of health.

Key Activities

A series of Internet-based training modules is offered in both English and French.

Products

- Local public health partners acquire the skills necessary to do effective surveillance.
- Strengthened evidence-based decision-making and planning at the local level to protect and maintain the health of the public.

Funding

- Health Canada
- In-kind contributions from provincial/territorial and regional public health authorities.
- Future plans to sustain the program include exploring funding/grants from provincial/territorial departments, scholarships and bursaries from professional organizations, funding and educational grants from the private sector such as pharmaceutical companies and endowments.

Partners
The partners include federal, provincial, and territorial governments, regional health authorities, local public health departments, and professional organizations such as the Canadian Institute of Public Health Inspectors (CIPHI), Community Health Nurses Association of Canada (CHNAC), Association of Public Health Epidemiologists of Ontario (APHEO), Saskatchewan Epidemiology Association (SEA) and other groups with an interest in surveillance.

Sponsoring Agencies:
Employers who support staff as students and facilitators to be part of this training during work time.

Contact Information
http://www.healthsurv.net/skills

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APPENDIX E

Speaker Biographies

Charlene Beynon, MScN, is a senior manager at Middlesex-London Health Unit (London, Ontario) including Director of Middlesex-London's Public Health Research Education & Development (PHRED) Program and Associate Professor, School of Nursing, The University of Western Ontario. She has nearly 30 years experience in public health and has worked as a district public health nurse, provided public health follow-up for a group of family physicians, as a nursing supervisor and has been with the PHRED Program since 1992. She currently teaches in the community health nursing course at UWO. Previous research and publications have focused on self-efficacy, partnerships, and application of theory to practice. She is currently involved in research related to woman abuse and is the project lead on a benchmarking investigation of dental screening programs in 10 Ontario health units. Ms Beynon is the chair of the PHRED Operations Committee, a group composed of Ontario's 5 PHRED Programs.

Sarah Hayward has a BNSc from Queen's University and an MPH from John Hopkins. As a clinical nurse specialist in public health her research focused on evaluation and outcomes of public health nursing and the synthesis and application of evidence. Combining roles in research, education and practice for over 10 years, Sarah works to build bridges between research and service delivery through partnership, collaboration, and capacity development. Sarah is currently Director of Applied Health Research Programs at the Alberta Heritage Foundation for Medical Research, where she leads the development of programs designed to build capacity across the health system for producing and using research.

Dr. David Mowat is the Director General of the Centre for Surveillance Coordination, Population and Public Health Branch at Health Canada where he has been responsible for the development of the Network for Health Surveillance in Canada – an initiative which aims to develop the capacity to collect, analyze and share information about infectious diseases, chronic disease and injury at local, provincial and national levels in support of evidence-based decision-making. Prior to this, he was a local medical officer of health and Chief Medical Officer of Health for Ontario. Dr. Mowat graduated in medicine from the University of Edinburgh, is a fellow in Community Medicine of the Royal College of Physicians and Surgeons of Canada, and holds appointments at the University of Ottawa and at Queen's University in Kingston.

John O'Neil received his PhD in 1983 from the University of California (San Francisco-Berkeley) in medical anthropology and is currently a Professor and Director of the Centre for Aboriginal Health Research and Head of the Department of Community Health Sciences in the Faculty of Medicine at the University of Manitoba. He also chairs the Advisory Board of the Institute for Aboriginal People's Health at the Canadian Institutes for Health Research and is a CIHR Senior Investigator. From 1993-1996 he was the Research Advisor to the Health and Social Policy Team for the Royal Commission on Aboriginal

Peoples. He has published over seventy-five papers and several monographs on a variety of Aboriginal health issues including self-government and health services, perceptions of environmental health risks, birthing options in remote communities, and health communication.

Michel Rossignol is the Director of Teaching and Research at the Direction de la santé publique de Montréal, and Associate Professor of Epidemiology, Biostatistics and Occupational Health at McGill University. Previously he has worked as an Associate Professor at Université de Montréal in the department of Social and Preventive Medicine. Michel has also held the position of Project Director and member of the Research Ethics Committee at the Jewish General Hospital in Montréal. His areas of research include low-back pain, osteoarthritis, carpal tunnel syndrome, and osteoporosis.

Michel received his BSc in Biochemistry (1978) as well as his MD (1982) from the Université de Sherbrooke. In 1984, he earned an MSc in Epidemiology from McGill University. In 1987, he obtained his FRCPC in Community Medicine at McGill University and in Occupational Medicine from Johns Hopkins University in 1989.

Penny Sutcliffe completed her Royal College Fellowship in Community Medicine (FRCPC) in 1997 through the University of Toronto after she earned a BSc (1986) and MD (1992) from the University of Toronto. She took 2 years of family practice training at Memorial University, Newfoundland and Labrador, and holds a Masters in Community Health and Epidemiology (MHSc 1996) from University of Toronto.

Her work experience has included lots of short-term stints in northern communities (Moose Factory, Sioux Lookout, Labrador, northern Ontario First Nations) before taking the position as the Regional Medical Officer of Health in Thompson, Manitoba and then as Medical Officer of Health/Deputy Chief Medical Officer of Health in Yellowknife, Northwest Territories. Sudbury, Ontario is now home where she accepted the position as Medical Officer of Health/Chief Executive Officer of the Sudbury & District Health Unit in August 2000.

Dr. Sutcliffe has a longstanding interest in what we now call "determinants of health" or the broader factors that influence health over and above individual lifestyle behaviours – these perspectives were greatly influenced by the Masters in Health Promotion that she began before going to medical school.

Penny Sutcliffe has a strong interest in turning the "conceptual into the concrete". How does what we know about health and effective interventions to improve health (including the necessary public health structures and systems) translate into practice?

Kate Waygood graduated from the University of Toronto with a BA in Geography in 1966. She taught High School Geography for ten years prior to moving to Saskatoon in 1977. Kate's interest in urban affairs stems from education in geography and urban studies.

Grassroots involvement in land use issues related to older neighbourhoods sparked her interest in city politics. She has been a member of the Saskatoon City Council since 1979 and believes community involvement in urban planning is an important issue in city politics and policymaking.

As a member of City Council Kate has been active on several committees that reflect her interest in planning issues: heritage and conservation, business improvement projects, community-based issues to do with health, housing and social concerns such as child hunger, poverty and youth not in school.

From 1992-1994, Kate was chair of Heritage Canada, a national organization concerned with the preservation of Canadian heritage. Kate served as a member of the Saskatchewan Heritage Foundation, and Saskatchewan Interim Heritage Council, and is currently Board Chair of Western Development Museums of Saskatchewan. Since 1993, Kate has been a member of Saskatchewan Judicial Council.
As an employee of Saskatoon District Health, Kate works as a Community Developer and is Co-Director of the Community-University Institute for Social Research (CUISR). The Institute is funded by a three year federal grant awarded by the Social Sciences and Humanities Council of Canada with matching funds from the University of Saskatchewan, and support from community-based organizations Saskatoon District Health, and the City of Saskatoon, Saskatchewan Research Council and the private sector.

Appendix F

Ten Commandments of Community-Based Research

- **Though shalt not define, design, nor commit community research without consulting the community!**
- **As ye value outcomes, so shall ye value processes!**
- **When faced with a choice between community objectives and the satisfaction of intellectual curiosity, thou shalt hold community objectives to be the higher good!**
- **Thou shalt not covet thy community's data!**
- **Thou shalt not commit analysis of community data without community input!**
- **Thou shalt not bear false witness to, or about, members of the community!**
- **Thou shalt not release community research findings before the community is consulted (premature exposition)!**
- **Thou shalt train and hire community people to perform community research functions!**
- **Thou shalt not violate confidentiality!**
- **Thou shalt freely confess thyself to be biased and thine hypotheses and methodologies likewise!**

Source: Leland Browne, Executive Director, Community Academy, University of California, Berkeley. In Bor D, et al (editors) Community Health Improvement through Information and Action: An Anthology from the Health of the Public Program. Health of the Public Program Office, University of California, San Francisco CA. 1995