Workshop 2004

Ways of Improving the Connection Between Surveillance, Policy and Public Health Programs

Ottawa, Ontario

November 5 and 6, 2004

RECORD OF PROCEEDINGS

Prepared by the Centre for Surveillance Coordination

Public Health Agency of Canada
Agence de santé publique du Canada

Canada

Table of Contents

Table of Contents 2
Introduction 3
The Public Health Agency of Canada 3
Workshop 2004 3
Workshop Structure and Materials 4
Workshop Definitions 4
Record of Proceedings 5
Workshop: Opening Remarks and Participants 5
Box 1: List of Workshop Registrants 6
Session One: Surveillance Information 8
Session Two: Surveillance Information for Policy-making 10
Session Three: Public Health Program Delivery 11
Workshop Findings: Results from Breakout Sessions 13
Breakout Session One 13
BOX 2: What works to keep connections between surveillance, policy & program delivery? 14
BOX 3: Key features of successful connections between surveillance, policy & program delivery. 15
BOX 4: Resources for keeping the connections between surveillance, policy & program delivery. 16
Breakout Session Two 17
BOX 5: The elements of surveillance that best inform policy-making. 17
Breakout Session Three 18
BOX 6: Key Factors in Successful Public Health Program Delivery 18
Discussion 19
Summary 21
Appendix One – Workshop Agenda 22

Introduction

The Public Health Agency of Canada

The Public Health Agency of Canada (PHAC) is mandated to strengthen the nation's ability to protect the health and safety of Canadians. A key component of this mandate is the enhancement of public health surveillance systems through development of new surveillance systems, better analysis of existing data, improved dissemination of information and overall enhancement of surveillance through online tools, standards, skills development and development of data around risk factors and determinants for chronic disease.

The Centre for Surveillance Coordination, within PHAC, aids development, maintenance and use of health information through surveillance tools and standards and public health training. The Centre for Chronic Disease Prevention and Control, also within PHAC, provides leadership in chronic disease prevention and control through integrated policy and program development, surveillance, and knowledge development and dissemination.

Workshop 2004

In 2004, PHAC, in cooperation with the US Centers for Disease Control and Prevention, developed W*orkshop 2004: Ways of Improving the Connection Between Surveillance, Policy and Public Health Programs*, an interactive workshop focussed on risk factor surveillance in public health.

Addressing the risk factors and determinants of chronic diseases, through the application of effective public policies, programs and services, does much to prevent and control chronic disease. Effective policies, programs and services however, depend on effective knowledge transfer and the continuous communication of surveillance information related to the population's health. Strong, positive and ongoing interaction between the areas of surveillance information, policy development and program delivery is fundamental to effective prevention and control of chronic disease.

Recent initiatives have documented ongoing gaps in generating and using chronic disease risk factor and determinant surveillance information. However, progress is being made on closing these gaps, within Canada and internationally, and this provided the impetus for developing ***Workshop 2004,*** as a forum for learning about some of the success stories.

Workshop Structure and Materials

Workshop participants heard about a series of successful public health initiatives in Canada and internationally, via a series of panel presentations and discussions. Through facilitated small group work in breakout sessions, participants then discussed these initiatives, assessed the applicability of the initiatives, and identified some of the requirements for implementing similar strategies.

Results of the small group discussions were recorded on paper throughout the workshop, for immediate discussion purposes and to form the basis for the written report.

Workshop Definitions

Surveillance is defined as "the tracking and forecasting of any health event or health determinant through the continuous collection of high-quality data, the integration, analysis and interpretation of those data into surveillance products (such as reports, advisories, warnings) and the dissemination of those surveillance products to those who need to know. Surveillance products are produced for a specific public health purpose or policy objective. In order to be considered health surveillance all of the above activities must be carried out."[1]

Policy is defined as a set of principles guiding decision–making.[2] Health policy is further defined as the actions of government and other players, which are aimed at maintaining and improving the population's state of health. It includes the factors that influence health – which often do not fall within a health department's direct responsibility.[3] Policy-making is a cyclical process whereby problems are identified, policy is developed, implemented, and (ideally) evaluated.[4]

A public health program is defined as any organized public health action or activity: for example, direct service interventions, community mobilization efforts, research initiatives, surveillance systems, policy development activities, outbreak investigations, laboratory diagnostics, and communication campaigns.[5]

---

1 National Health Surveillance Network Working Group; Integration Design Team. Proposal to Develop a Network for Health Surveillance in Canada, p. 6.

2 Spasoff, R.A. p.3 Epidemiologic Methods for Health Policy. 1999 Oxford University PressNew York.

3 Ruwaard et al., 1994 :27 in ff Spasoff, R.A. p.3 Epidemiologic Methods for Health Policy. 1999 Oxford University Press, New York.

4 Spasoff, R.A. p.3 Epidemiologic Methods for Health Policy. 1999 Oxford University PressNew York.

5 MMWR Recommendations and Reports Framework for Program Evaluation in Public Health September 17, 1999/48(RR11); 1-40

Record of Proceedings

The record of proceedings is arranged as follows: a participant list, a brief description of and highlights from each panel presentation, workshop findings from the breakout sessions, discussion of results, and an appendix containing the workshop agenda.

Workshop: Opening Remarks and Participants

Dr. Larry Chambers, Élisabeth Bruyère Research Institute, welcomed participants to the workshop, reminding them of the goal of the workshop: to identify ways to improve the connections between chronic disease risk factor surveillance, policy-making and public health program delivery. Dr. Chambers also reviewed the three specific objectives for the workshop:

1. Identify key factors in fostering the links between health surveillance, public health policy and programming.

2. Identify ways to use the key factors and elements of success in individual jurisdictions.

3. Discuss the implications for public health in using the key factors and elements to improve the interaction between all three components; specifically in the areas of: funding/resources; public health human resources; and national leadership.

Dr. Chambers and the workshop facilitator, **Raymonde D'Amour**, also briefed participants on the structure and operating environment for the workshop, emphasizing that the key word for this workshop was *interactive* – to facilitate information exchange, to evaluate approaches and to acquire some practical strategies.

Box 1 below lists the names and focus areas for the sixty registrants from across the country, representing a variety of public health professions and specialties.

Box 1: List of Workshop Registrants

REGISTRANT AND AFFILIATION	REGISTRANT AND AFFILIATION
Amira Ali **SPEAKER** Ottawa Public Health, ON	Vincent Dale **SPEAKER** Canadian Community Health Survey, Statistics Canada
Alan Amey Centre for Chronic Disease Prevention & Control Public Health Agency of Canada	Dr. Catherine Donovan Health and Community Services Eastern Newfoundland NL
Dr. B. Christofer Balram Provincial Epidemiology Service Fredricton, NB	Dr. Denise Donovan Direction de la sante publique de l'Estrie Sherbrooke QC
Sam Bediako-Cra HECS Health Canada, Ottawa ON	Jillian Flight Drug Strategy and Controlled Substances Programme Health Canada, Ottawa ON
John Bower Cypress Health Region Swift Current SK	Dawn Friesen Alberta Health and Wellness Edmonton AB
Dr. Khami Chakani Cypress Health Region Swift Current SK	Gavin Giles Lakehead University Thunder Bay ON
Dr. Larry Chambers **SPEAKER** Élisabeth Bruyère Research Institute, Ottawa ON	Janet Hatcher Roberts Canadian Society for International Health Ottawa ON
Dr. Arun Chockalingam Institute of Circulatory and Respiratory Health, CIHR Vancouver BC	Jo Ann Heale Wellington-Dufferin-Guelph Health Unit Guelph ON
Bernard Choi Centre for Chronic Disease Prevention & Control Public Health Agency of Canada, Ottawa ON	Dr. Alison Hill **SPEAKER** South East Public Health Observatory Oxford UK
Cora Cole Cape Breton and Guysborough/Antigonish Strait Health Authorities NS	Alan Hotte Centre for Surveillance Coordination Public Health Agency of Canada, Ottawa ON
Lise Coulombe First Nations and Inuit Health Branch Health Canada, Ottawa ON	Dr. Garry Humphreys Peterborough County City Health Unit Peterborough ON
Dr. Robert Cushman **SPEAKER** Ottawa Public Health Ottawa ON	Dr. Jean R Joly Laboratoire de Santé publique du Québec Ste-Anne-de-Bellevue PQ
Caroline Da Silva Centre for Surveillance Coordination Public Health Agency of Canada, Ottawa ON	Deborah Jordan **SPEAKER** Centre for Surveillance Coordination Public Health Agency of Canada, Ottawa ON
Dr. Anne Kearney School of Nursing Memorial University of Newfoundland St. John's NL	Dr. Thomas Melnik **SPEAKER** New York State Department of Health Albany NY
Gloria Keays Alberta and Health Wellness Edmonton AB	Dr. Christina Mills Canadian Cancer Society Ottawa ON
Pierre Lejeune Public Health, Dept of the Cree Territory of James Bay, Montréal QC	Amy Nahwegahbow National Aboriginal Health Organization Ottawa ON

REGISTRANT AND AFFILIATION	REGISTRANT AND AFFILIATION
Christian Lapensée Ottawa Public Health/Canadian Institute of Public Health Inspectors Ottawa ON	Jay Onysko Centre for Chronic Disease Prevention & Control Public Health Agency of Canada, Ottawa ON
Dr. Hal Leitch First Nations and Inuit Health Branch Health Canada, Ottawa ON	Dr. Geraldine Osborne Department of Health and Social Services Iqaluit NWT
Karen Loewen Centre for Chronic Disease Prevention and Control Public Health Agency of Canada, Ottawa ON	Stéphane Perron Agence d'évaluation des technologies et des Modes d'intervention en santé (AETMIS) Montreal QC
Fardosa Loyan Centre for Chronic Disease Prevention and Control Public Health Agency of Canada , Ottawa ON	Louise Picard **SPEAKER** Provincial PHRED Program Sudbury & District Health Unit Sudbury ON
Susan Mackenzie Centre for Healthy Human Development Public Health Agency of Canada, Ottawa ON	Ruth Plant Public Health Agency of Canada Ontario and Nunavut Region, Toronto ON
Sylvie Martel **SPEAKER** Ministère de la santé et des services sociaux du Québec, Québec QC	Dr. Robert Pless Centre for Surveillance Coordination Public Health Agency of Canada, Ottawa,ON
Dr. David McQueen **SPEAKER** Centers for Disease Control and Prevention Atlanta GA	Sylvia Robinson Vancouver Island Health Authority Victoria BC
Kelly McQuillen Manitoba Health Winnipeg MN	Angel Roca **SPEAKER** Centers for Disease Control and Prevention Atlanta GA
Louise McRae Public Health Agency of Canada, Ottawa ON	Dr. Donald R. Schopflocher Alberta Health and Wellness, Edmonton AL
Dr Saqib Shahab Sunrise Health Region Yorkton SK	Susan Taylor-Clapp First Nations and Inuit Health Branch Health Canada, Ottawa ON
Linda Senzilet Health Policy Branch Health Canada, Ottawa ON	Carol Toone Centre for Surveillance Coordination Public Health Agency of Canada
G. Shahein Eastern Ontario Health Unit Cornwall ON	Dr. Steve Whitehead **SPEAKER** Saskatoon Health Region Saskatoon SK
Heather Stacey Centre for Infectious Disease Prevention and Control Public Health Agency of Canada Ottawa ON	Chandrani Wijayasinghe First Nations and Inuit Health Branch Health Canada Edmonton AL
Dr. David Strong Calgary Health Region Calgary AB	Elizabeth Wright Centre for Surveillance Coordination Public Health Agency of Canada Ottawa ON

Session One: Surveillance Information

Dr. Chambers chaired the first panel discussion, which concentrated on the types of surveillance underway at various organizational levels in Canada and the USA.

Dr. Thomas Melnik (New York State Department of Health) provided an overview of the US Behavioural Risk Factor Surveillance System (BRFSS). He described BRFSS methodology – random digit dialling and computer assisted telephone interviews, and noted the importance of a core questionnaire, with additional optional content to be added at the discretion of participating states and territories. Dr. Melnik presented some typical outputs at state and national levels. While highlighting the strengths of BRFSS (a standardized protocol, content flexibility, timeliness, comprehensiveness and standards that permit monitoring over time), Dr. Melnik also noted that BRFSS is an important source of information that may be combined with other information sources to meet the jurisdictions' need for local level information for assessment, planning, and evaluation requirements. Dr. Melnik concluded with a brief discussion of New York State's approach to local level collection – using the BRFSS protocol to develop a series of modules for reporting at the county level.

Dr. Stephen Whitehead (MOH, Saskatoon Health Region) talked about the experience of using the Canadian Community Health Survey (CCHS) as a source of provincial and regional data for risk factor surveillance. He noted the overall goal of the CCHS: to provide timely cross sectional estimates of health determinants, health status and health service utilisation at provincial and sub provincial levels. Once final, CCHS results for provinces and their regions are transferred to the provinces. Each province may then analyze and transform the data into information for dissemination across their regions and organizations.

Overall, there is a rich potential for CCHS data use by regions: for needs assessment, priority setting, advocacy, policy- making, research and monitoring. Dr. Whitehead provided some examples of Saskatchewan's use of the data: contributing to the annual *Health Status Report*, mapping of risk factors at regional levels, lifestyle factors sorted by socio-economic sector, and self-reported health by socio-economic sector.

Dr. Whitehead also noted the challenges of the CCHS: the potential can only be realized with sufficient capacity for analysis, interpretation and dissemination, data access can be problematic, and there are some methodological issues. The CCHS provides opportunities as well-: there is the potential to build capacity through training initiatives, regional resource units, and collaboration on analysis is now being actively explored.

Ms. Amira Ali presented a snapshot of the Rapid Risk Factor Surveillance System (RRFSS), an Ontario-based survey system that uses monthly telephone surveys to collect information at local health unit levels. The surveys consist of core content (agreed on by all participating units) supplemented with optional unit-specific content. Ms. Ali described the methodology for RRFSS, the conduct of the surveys, and some of the recent outcomes. The interviews are conducted monthly and analysed centrally at York University, and results are turned around within six to eight weeks of collection. Ms. Ali emphasized the benefits of RRFSS: flexibility, local focus, and proven utility for public health practice. Challenges for the sustainability of RRFSS include securing continued funding for the necessary support at local and central levels.

Session Two: Surveillance Information for Policy-making

Dr. David McQueen (US CDC, Atlanta) chaired the second session, which provided an opportunity to focus on the kinds of surveillance data currently being used to provide information for public health policy-making. Dr. McQueen began the session by reminding the participants that surveillance does not exist for its own sake; rather it operates to provide information to allow for informed policy-making and program delivery.

Angel Roca (US CDC, Atlanta) provided two examples of surveillance data informing policy. Data gathered through the Behavioural Risk Factor Surveillance System on obesity and diabetes were transformed into compelling visuals (obesity maps, for example) to demonstrate the seriousness of the problem. These visuals had a significant impact on the population in general and policy making in particular.

The Pregnancy Risk Assessment Monitoring System (PRAMS) produced analyses that directly affected the planning, adjustment and conduct of specific interventions (SIDS prevention, reduction of tobacco use in pregnancy, folic acid intake). Individual states were able to take their own data and use it to develop state-specific interventions.

Dr. Alison Hill discussed the public health observatory system in the United Kingdom. Public health observatories support local and regional organizations in risk factor surveillance in a number of ways, including: conducting community surveys; providing expertise (methodology consults, toolkits); developing standardized content for surveys; developing and providing applications for visuals; and disseminating national work at regional levels. Dr. Hill provided some examples of the output from observatories, stressing that one of the most important functions of the observatories is to provide public health intelligence: to link at national, regional and local levels and thereby facilitate links within and between levels.

Vincent Dale presented information on the Canadian Community Health Survey and its utility for public health policy making. Mr. Dale provided an overview of the CCHS, noting the core and optional content of the survey, and the ability to provide data at national, provincial/territorial and regional levels. The consultative process for content development was outlined, along with dissemination strategies, and some examples of core and optional content were provided. Mr. Dale closed by noting that nutrition is a major focus of the current survey cycle, and that future challenges for CCHS include timeliness, response to emerging issues and the need for local level information.

Session Three: Public Health Program Delivery

Deborah Jordan (PHAC) opened the final session of the workshop, noting the theme from the previous day: surveillance is a tool for public health practice, and must inform policy- making and program delivery. Ms. Jordan reviewed PHAC's commitment to developing and enhancing public health surveillance capacity in general, including surveillance for chronic disease risk factors and determinants.

Sylvie Martel presented Quebec's experience, in particular the conditions for bringing the surveillance function up to date and making it useful to decision making. She addressed different aspects of the public health environment in Quebec, including public health legislation, which recognizes surveillance as an essential public health function and sets forth the objectives of surveillance. It also assigns the responsibility for surveillance to specific authorities (the minister and the public health directors of the 18 health and social services regions) and confers on them the right to request the information necessary for implementation of a surveillance plan. The legislation states that surveillance plans must be developed, submitted to a public health ethics committee and reassessed periodically.

Overall, the public health environment in Quebec is conducive to the implementation of surveillance. Quebec has a favourable legal environment and the public health environment is a valuable interface where the various partners in the health care system can work together. As well, Quebec has a public health program with surveillance policies, priorities and objectives. Other favourable conditions include examination and review of the surveillance function carried out by both the operators and the users of surveillance. Further enabling conditions include the existence of a surveillance plan that identifies surveillance needs in Quebec, and the environment that has been created to implement it, including a public health information centre that serves as a one-stop shop for data sources on the joint surveillance plan.

Constraints were also noted, including the varying levels of comprehension/interpretation of the surveillance function, the lack of resources (which limits the ability to act on or contribute to surveillance plans), and issues relating to change management. Among the challenges to be met are development of synergies with other public health functions and activities, adaptation of work processes and production of information for users' needs.

Louise Picard gave a presentation on Evidence-Based Decision Making In Public Health. Ms.

Public Health Agency of Canada Agence de santé publique du Canada

Canada

Picard described the Ontario Public Health Research, Education and Development (PHRED) Program, currently in place in five Ontario health units. Using a Teaching Hospital model, the program aims to provide leadership in research, education and promotion of best practices to inform and improve local, provincial and national public health policy and practice. The PHRED model integrates research, education, policy and practice.

A variety of evidence sources, such as research findings, community surveys, surveillance data, and program evaluation results, are used to produce information that then allows for programming decisions, evaluation and monitoring of interventions. Ms. Picard provided several examples, such as the Northern Ontario Perinatal and Child Health Survey Strategies Initiative.

Ms. Picard further noted that the whole success of the PHRED program relies on making the connections-: between evidence types, between users and data, between sectors, and between government levels. She identified key elements for the program, including strong visionary leadership, funding models that reflect the need for communication amongst all parties, and regional infrastructures to facilitate the connections.

The final presentation on policy came from **Dr. Rob Cushman**, who recounted Ottawa Public Health's experience with enacting by-laws and regulations to eliminate smoking in public spaces (including bars and restaurants). Dr. Cushman related the experiences in meeting with stakeholders, encountering and overcoming resistance at all levels, keeping staff motivated to continue in a campaign that was at times very unpopular, and using the most effective information of all: local, recent, timely data, some of it obtained from Ottawa's Rapid Risk Factor Surveillance System. Dr. Cushman noted that the health unit was able to deal with resistance within some sectors of the community, because there was a clear mandate and objectives, detailed communication plans, identification of stakeholders and other supports, and ready access to pertinent local data.

Workshop Findings: Results from Breakout Sessions

Breakout Session One

Breakout session 1 challenged participants with the following three questions:

1. **Given the surveillance information that we have, what mechanisms and strategies exist to establish and maintain connections between the other two areas – policy-making and program delivery?**

2. **What are the key features of successful connections, and can they be applied in different situations?**

3. **What resources are needed to effect the necessary change?**

Boxes 2 through 4 provide the responses to these questions, supplemented by some general comments.

BOX 2: What works to keep connections between surveillance, policy & program delivery?

WHAT WORKS: Use the data. There are high quality data sources that must be accessed and transformed into information in a timely manner.

COMMENTS:

- We are ''rich in data and lacking in information" - data exist but we fail to transform it into actionable information for practice.
- Data not timely enough: "Good enough" timely data is better than perfect out of date data.
- Rolling up data – collecting locally first – may be better than rolling down information collected at a national level.
- Potential for linking databases must be explored before more money is spent on new data sources.

WHAT WORKS: Communication is key. Specific strategies include:

- Form coalitions and formal partnerships;
- Hold issue workshops involving the collectors, implementers, users, researchers and policy makers, including legislators;
- Promote org. structures facilitating exchanges between front-line workers and policy-makers;
- Make communication as an organizational norm: endorse and employ integration at all levels;
- Provide opportunities for exchange internships between all players.

COMMENTS:

- Good communication, where it exists, thrives in spite of the organizational culture.
- Avoid jargon and acronyms that are rife in all three areas and which constitute a real barrier.
- How organizations talk to each other is key; need to make regular two-way communication from front line collectors to policy makers happen regularly.
- Feedback has to be gleaned from all three groups – use local analysis to do this.
- Sometimes there is not a direct service delivery role to anchor to. Communicate/consult with service delivery agencies and regional health authorities to identify what is important and why.
- Data collectors have to get the results – from reports to implementation to evaluation.
- Opportunity exists now to do this most effectively as reorganization/realignment continues in public health- new ground to break.
- Communication messages quickly lose context as organizations and mandates change so often.

WHAT WORKS: Knowledge translation (KT) is essential. KT is a part of the mission statement. It works when the roles and responsibilities are assigned to positions in the organization, and it is supported by the capacity to identify specific needs for specific partners: contexts, needs, and priorities.

COMMENTS:

- Make common goals where information informs the policy and programs centred on these goals – for instance risk factors/determinants and chronic diseases.
- Must appreciate local needs, cultural differences: what you are collecting had better match the information that you need in order to inform policies and programs.
- Interpret and simplify without "dumbing down".
- Provide context and interpret information to make it resonate with users – statistics must *matter*.

WHAT WORKS: Need adequate and ongoing resources. Where there is explicit accountability, and a requirement for public reporting, resources will be applied.

COMMENTS:

- Need innovative ways to acquire resources: outsourcing to academic centres for example
- Tie resources to performance measurement/accountability. This is "mutual accountability" policy-making and public reporting that are integrated with implementation plans.

BOX 3: Key features of successful connections between surveillance, policy & program delivery.

KEY FEATURES
Communication Produce meaningful reports and other output – avoidable burden for risk factors for example, then producing projections to allow for planning.
Data Quality Timely, appropriate data facilitates everything: communication, local relevance, integration and policy changes. When all have the info they need, including the context, their knowledge lets them use the data.
Local Relevance Local relevance = readily available, intelligible information. Data resonate at local levels – this is where data are most meaningful. Public interest is key; it gets necessary local buy-in from professionals and users, and decision makers.
Resources Investments in training – this means providing staff with training Informed investing: determination of what is centralized, decentralized and where best investments can be made. Ensure there is adequate staffing – backfill. Integrate training with work
Integration Work towards a seamless process from data to information to knowledge – need a dedicated job for this. The culture of inter-sector collaboration functions best when there are policy makers who can understand surveillance and vice versa, and both who can appreciate what program delivery entails. It works when there is ongoing feedback to decision makers. The necessary buy-in comes when all are involved – users, front line, decision makers.
Leadership Leaders must establish and demonstrate the political will to build coalitions, and to advocate for sustained funding. Establish a national strategy for data. Bureaucracy must facilitate, not hinder the work. Must have informed leadership- content training
Accountability Mandated requirements help – when there are clearly identified core issues where there is an expectation for public reporting.

BOX 4: Resources for keeping the connections between surveillance, policy & program delivery.

REQUIRED ELEMENTS
Data Invest in data at all levels to improve and maintain the quality. Explore new areas of data broader sociologic factors influencing chronic disease, for example Allow the time for collection to permit evidence of trend. Develop the capacity for mapping in the geography at a local level – again increasing local interest. Allow the funding for development of dedicated knowledge translation skills.
Skills For front line workers and for policy makers. Develop skills in a variety of areas: Data use for end users Presentation, dissemination and eliciting community awareness Positioning: how to effectively supply feedback to the national and provincial levels of policy-making is important. Policy considerations for front line workers Training for users of research findings Communication Basic epidemiology, statistics, research methods, assessing the literature, evaluation, computer skills Provide a learning environment within the work of surveillance.
Information Technology Technical resources. IM/IT for management of large databases.
Human Resources Bio statistical and Epidemiological expertise at local levels. Provision for integration of expertise within and between organizations (ie sharing at community levels). Expertise in change management. Expertise/positions in knowledge transfer.
National leadership and community resources Multiple agencies with common goals; organizations that are flexible enough to assume different configurations needed for meeting the needs of different groups.
Financial resources Sufficient and stable over the long term to maintain and bring jurisdictions to a common standard and permit maintenance of standards. Money to be spent in the right way – some economies can be achieved by sharing nationally and internationally.

Breakout Session Two

In the second session's breakout discussions, participants were challenged with the following question (results in Table 4 below):

What do we need from surveillance to best inform policy-making?

BOX 5: The elements of surveillance that best inform policy-making.

ELEMENTS
Topical and timely information Want to be able to get topical information to cope with the emerging issues, the "hot topics", and the headlines (may need to use some political weather vanes for the hot topics). Need good quality data – reliable, credible sources. Data must be collected at appropriate levels. Dedicated, stable funding has to be in place to allow longitudinal data collection. Need data that are useful for economic analyses. Need data standards to permit comparisons across regions, nationally and internationally. Require easily accessible data to provide the necessary information.
Understandable, pertinent information Need better presentation - develop good visuals; exploit available tools to tell stories in pictures. Keep up with technologic developments. Simplify without reducing value – plain language. Use the language of policy makers: dollars, votes – constituents. Do not overload with information. Provide contextual information – package the product to meet specific needs (this presupposes an understanding of the communities of interest). Provide more focused data – this implies better formulation of the question, which in turn implies better communication early on -Involve users in needs identification.
Dissemination Use strategic dissemination. Simple, visually oriented reports, data release to some audiences, released in lay language at times. Make the information "about" groups: Use examples from vulnerable groups to make a point about a needed intervention or issue. Strategically position of the data according to the users. Develop and tend to relationships with media. Market surveillance data in innovative ways – dissemination as well as interventions. We need to evaluate the usefulness of current information. We produce health reports – does anyone (including policy makers) use them?
Knowledge Transfer (KT) Make KT a function of an organization – make it a feature in job descriptions – don't minimize it. Support KT with environmental context; and the media monitoring that is so crucial – know the level of local policy needs/indicators that differ from provincial/national ones. Establish regional resource centres with technical support and national best practices. Enlarge the scope of KT to involve the users of surveillance information in setting the priorities Ensure the infrastructure is there to support optimal KT. Have surveillance knowledge brokered with options to policy makers – and the impact of each option. Link surveillance findings to risk factor research – establish the formal connections so that risk factor research, surveillance and policy –making are functionally linked.

Breakout Session Three

In the final breakout discussion, small groups of participants selected a specific target population (pre-schoolers, teenagers, infants, adult males, and so on), chose examples of programs where surveillance linked to policy and programming had really merged well, and identified the success factors for these examples.

Examples included SIDS prevention in infants; school-based health centres to address specific risk behaviours in teens; and review of statistics for age-related impaired driving. The ensuing discussion not only provided a list of success factors (Box 6), but it also created a dynamic information exchange session for participants.

BOX 6: Key Factors in Successful Public Health Program Delivery

HIGHLIGHTS AND KEY FACTORS
1. The target population is known: unique and important characteristics and context for the target population are factored into all aspects of planning. 2. The target population is directly involved in planning. 3. Resources are allocated to innovative, attractive marketing and packaging. 4. Culturally appropriate messages are developed. 5. Programs addresses literacy, cultural barriers – the target audiences have been well characterized. 6. All providers are involved in the program planning, resulting in greater buy –in for program delivery. 7. All appropriate levels of government are involved from the beginning. 8. Resources are allocated to ongoing monitoring and evaluation of programs, through surveillance. In other words, there is a commitment for surveillance follow-up: compliance, appropriateness, and flexibility to adjust messages.

Discussion

As the five tables above show, a wealth of information was produced from some lengthy and lively discussions in this workshop. However – returning to the original focus of the workshop, the question is – **did the participants identify ways to improve the connections between chronic disease risk factor surveillance, policy-making and public health program delivery?**

Breaking down this overall goal, this question is addressed by considering the constituent objectives, as follows.

What are key factors in fostering the links between health surveillance, public health policy and programming?

A number of programs and approaches were described in the nine presentations for the workshop. From these, and from the discussions, participants identified four key factors: good data, ongoing communication, knowledge transfer, and adequate, stable funding. All factors interact to produce a favourable environment for continually transforming data into information for coherent public health policy-making and program delivery. Tables 1, 2, and 4 demonstrate the overlap between these factors – good data is essential for producing good information, and solid communication links with all partners provides the best chance for identifying the context that becomes part of the knowledge translation process.

Can these key factors and elements of success be applied in individual jurisdictions?

The discussions and identification of key factors, the various presentations, and the exercise in describing successful current programs showed participants that the factors can be applied in many settings. Entire "turn-key" solutions were not provided, and the tone of discussion suggested that this would be an unrealistic expectation in any case. Rather, participants identified selected elements and approaches, and had the opportunity to evaluate these for applicability in their won settings. In general, the following elements had the widest applicability and acceptance: Make connections at local levels; communicate what you know in the most effective way that you can; involve the community in planning, and make effective communication within jurisdictions an organizational imperative.

What are the implications for public health in using the key factors and elements to improve the interaction between all three components; specifically in the areas of: funding/resources; public health human resources; and national leadership?

Participants demonstrated a well-grounded appreciation of the resource implications of improving and maintaining the connections between surveillance, policy-making and public health program delivery. Discussions clearly identified this as an ongoing issue: that insufficient resources limit the full potential of the three areas. Reallocation of resources to public health is of primary importance, so that “public health can do its job”.

The issue of varying capacity was also raised. The ability to conduct public health practice is not evenly distributed across the country, and there is no “quick fix” solution that can be uniformly applied. The challenge is to invest resources appropriately in order to get the maximum benefit, and to raise the standard across the regions. At the same time, jurisdictions that are presently implementing innovative solutions and investing in new ways of doing business must also be supported to allow this work to continue to reap benefits.

Apart from these issues, participants identified some broad categories requiring support, particularly in the areas of acquiring skills for public health workers, attracting and retaining expertise, and having the leadership needed to advocate for and obtain the needed funding.

Summary

The overall goal of the workshop was to identify ways to improve the connections between chronic disease risk factor surveillance, policy-making and public health program delivery. Through a series of presentations, interactive breakout sessions and discussion, Workshop 2004 participants identified six key factors and had informed discussions on the implications for using these factors in their own jurisdictions.

- Public health must have **quality data**, because timely, appropriate data facilitates everything else: communication, local relevance, integration and policy-making.
- **Good communication** is essential to producing meaningful, contextual information with local relevance.
- **Integration is key to achieving a** seamless process from data to information to knowledge.
- Health information from surveillance must have **local relevance –** it has to be locally available and intelligible to be useful for policy-making and program delivery.
- **Resources** have to be available at adequate levels to support the full range of public health functions.
- Strong, informed **leadership** is essential, for fostering the needed partnerships, alliances and coalitions at all levels, and for securing resources.

Appendix One – Workshop Agenda

TIME/DATE	FRIDAY MORNING NOVEMBER 5th	
7:30-8:30	Registration and continental breakfast	
8:30 - 9:00	Welcome Introductions and review of the Agenda	Dr. L. Chambers - Élisabeth Bruyère Research Institute Raymonde D'Amour – Consultant Praxis
	Opening Address	Dr. Paul Gully – Public Health Agency of Canada Dr. David McQueen - Centers for Disease Control and Prevention
9:00 -10:00	**Panel Discussion: Surveillance Information** The Behavioural Risk Factor Surveillance System (BRFSS) - Risk factor surveillance data at state and sub-state levels. The Canadian Community Health Survey (CCHS) - How the province of Saskatchewan uses CCHS data. The Rapid Risk Factor Surveillance System (RRFSS) - Generating local surveillance information.	 Dr. Thomas A. Melnik New York State Department of Health Dr. Stephen Whitehead Saskatoon Health Region Amina Ali - RRFSS, Ottawa Public Health
10:00- 10:15	HEALTH BREAK	
10:15 - 11:30	**Breakout sessions: Surveillance Information** - What mechanisms/strategies are used to establish and maintain the connections between policy-making and program delivery? - Why do these approaches work - what are the key success factors? - Can these approaches be used elsewhere? - What resources are needed for these approaches?	Discussion facilitated by planning committee members
11:30- 12:15	**Report Back: Surveillance Information**	Reporters from each group
12 :15 - 1:00	LUNCH (provided on site)	

TIME/DATE	FRIDAY AFTERNOON NOVEMBER 5th	
1:00 - 2:00	**Panel Discussion: Surveillance Information for Policy-making**	
	BRFSS and policy making	Angel Roca Centers for Disease Control and Prevention
	UK Public Health Observatories and behavioural risk factor policy opportunities	Dr. Alison Hill South East Public Health Observatory
	CCHS data as a policy tool	Vincent Dale Statistics Canada
2:00 - 3:00	**Breakout sessions: Surveillance Information for Policy-making** - What mechanisms/strategies are used to establish and maintain the connections between surveillance and program delivery? - Why do these approaches work - what are the key success factors? - Can these approaches be used elsewhere? - What resources are needed for these approaches?	Discussion facilitated by planning committee members
3:00 - 3:15	HEALTH BREAK	
3:15 - 4:00	**Report Back: Surveillance Information for Policy-making**	Reporters from each group
4:00 - 4:30	Wrap up and adjournment for day	Dr. Larry Chambers

TIME/DATE	SATURDAY MORNING NOVEMBER 6th	
9:00 - 9:15	Welcome/recap of previous day Review of the Agenda	Deborah Jordan, A/Director General, Centre for Surveillance Coordination Raymonde D'Amour
9:15 - 10:15	**Panel Discussion: Public Health Program Delivery** Evidence-based decision making in public health Québec Public Health Program - An Integrated approach: From surveillance to program delivery Smoke-Free Communities: The Ottawa Experience	Louise Picard – Provincial PHRED Program Sudbury District Health Unit Dr. Sylvie Martel Ministère de la santé et des services sociaux du Québec Dr. Rob Cushman City of Ottawa
10:15 - 10:30	HEALTH BREAK	
10:30 - 11:15	**Breakout sessions: Public Health Program Delivery** - What mechanisms/strategies are used to establish and maintain the connections between surveillance and policy-making? - Why do these approaches work - what are the key success factors? - Can these approaches be used elsewhere? - What resources are needed for these approaches?	Discussion facilitated by planning committee members
11:15 - 12:00	**Report Back: Public Health Program Delivery**	Reporters from each group
12:00 - 12:30	Closing Remarks - segue to Global Forum International Showcase Day	Dr. Larry Chambers Dr. David McQueen Deborah Jordan