

HEALTH INEQUALITIES IN AN URBAN, SUBURBAN AND RURAL AREA – SOCIAL DETERMINANTS AND THEIR INTERACTION

A study and its implications

Health inequalities are of utmost concern in the minds of public health officials and researchers around the world. In 2006, a Québec research team headed by Maria De Koninck, Professor in the Department of Social and Preventive Medicine at Université Laval, published the findings of a study¹ on this topic. Conducted over a four-year period, the study shed light on the social determinants of health inequalities in populations inhabiting three areas in the Québec City region.



A few months after the preliminary findings of the study were released, the Québec Population Health Research Network (Knowledge Sharing and Application Group) invited various stakeholders such as researchers, decision-makers in health and community development, and front-line workers in health and social services, to comment on the significance of the findings and reflect on future directions.

This document constitutes a report of this process. It presents both a summary of the principal findings and an analysis of the impact they may have on potential action. Finally, inspired by the comments of the stakeholders, future directions are suggested in terms of both research and intervention.

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1. This study was funded by the Canadian Population Health Initiative (CPHI) of the Canadian Institute of Health Information (CIHI).

Overview of the Study and its Findings

How can the health status of populations with similar socioeconomic status be different?

This is the question at the root of the research project entitled *Inégalités de santé et milieux de vie : déterminants sociaux en cause et leurs interactions* (“Health Inequalities in an Urban, Suburban and Rural Area – Social Determinants and their Interaction”). To answer this question, the research team used a multi-perspective approach, resulting in the division of three areas in the Québec City region into neighbourhood units. The purpose was to study the influence that people’s milieus (neighbourhood, family and workplace) could have on their health status. The areas were studied over the course of four years. Their selection was based on their scores on the material and social deprivation index.² Material deprivation is mainly associated with education, employment and income, whereas social deprivation refers primarily to single parenting, marital status, and living alone. These indicators were selected for their known associations with a large number of health problems, their affinities with the material and social forms of deprivation and their availability by a certain level of census area. The study could therefore examine why the populations of these areas, though their scores on the material and social deprivation index were similar, had contrasting health statuses.

Though the areas were located in different zones – downtown, suburban, and rural – location as such was not a criterion for their selection and no comparative analysis based on geographical zone was made of the results.

To do thorough research, the project team used a combination of various approaches, from processing administrative data and conducting a population survey, to doing individual interviews and surveying key informants in the field. Throughout the process, an advisory committee composed of stakeholders working in community development and health was available to the researchers. Consulted at various times during the research project, the committee helped improve the survey instruments, validate interpretations and adjust the research strategies being employed.

For each area studied, a detailed monograph was produced. Beyond local characteristics, certain general observations emerged, which are outlined in the sections that follow.



Main Findings

BASIC PREMISE

Over the years, numerous associations have been observed between economic, social and demographic characteristics of a particular area and the health status of its population. Much research has demonstrated that the inhabitants of disadvantaged areas are at higher risk of health problems than those of more advantaged areas. However, the first finding of Maria De Koninck’s research team has added a level of complexity to such analyses. The creation of neighbourhood units by the researchers has confirmed that disadvantaged status is not a binary factor. In other words, it is not an all-or-nothing attribute of a particular area. Rather, as the researchers have clearly demonstrated, though certain basic trends can be identified in each of the areas, many economic, social and demographic realities can coexist inside one and the same area.

2. The suburban area was advantaged in terms of socioeconomic status, the rural area was socially advantaged but materially disadvantaged, and the downtown area was disadvantaged both socially and materially.

HIGHLIGHTS

Health indicators

- ➔ Life expectancy at birth was higher in the suburban area (81 years) than in the rural (79.4 years) and downtown (77.1 years) areas. Significant differences were observed within areas among neighbourhood units. Two neighbourhoods in the downtown area had more than a 10-year difference between them in terms of life expectancy.
- ➔ Healthy life expectancy, defined as expected number of years to live with no moderate or severe disability, was also higher in the suburban area (76 years) and rural area (75 years) compared to the downtown area (70.6 years). However, the difference was less pronounced among women than men.
- ➔ Be it mortality, long-term disability or hospitalization, the health of the inhabitants of the downtown area was affected earlier in life than that of people living in the suburban and rural areas.

Lifestyle habits

- ➔ The highest rate of smoking was observed in the downtown area (27.3%). However, exposure to second-hand smoke was higher in the rural area (46.5%). The lowest rates of smoking and exposure to second-hand smoke were observed in the suburban area (20.4% and 31.3% respectively).
- ➔ Frequency of physical activity (four times a week or more) was highest in the rural area, closely followed by that in the downtown area. Manual work in the agriculture and manufacturing sectors may in part explain this phenomenon. Physical activity in the downtown area compared to the other two areas can hypothetically be explained by the notion that a large part of the population living there may, in the majority of cases, move around on foot.

Food security and body weight

- ➔ The highest percentage of people reporting food insecurity was found in the downtown area (17.4%) and the lowest in the rural area (9.1%).
- ➔ A higher percentage of people with insufficient body weight were in the downtown area (6.5%) compared to the rural (5.3%) and suburban (3.4%) areas. In contrast, the highest percentage of overweight people was observed in the rural area (40.8%). The difference between this percentage and that of people in the downtown area was particularly pronounced. Slightly less than a third of people in the downtown area were overweight.

Use of health care services

- ➔ Use of health care services for physical problems was higher in the downtown area. This was also observed for mental health problems. Proximity to second- and third-line health care services may in part explain these findings.
- ➔ Access and use of dental services was, however, lower in the downtown area. The overall economic situation being generally more difficult in the downtown area may explain this finding.

Reported health status

- ➔ In general, the majority of people living in the three areas reported they were in good or excellent health. However, the proportion reporting this was lower in the downtown area. The findings also varied according to sex and age in each of the three areas.
- ➔ The rate of long-term disability (6 months or longer) was higher in the downtown area compared to the other two. This was also the case for short-term incapacity (15 days).

Mental health

- ➔ The perception of the populations with regards to their mental health varied from good to excellent in each area. However, people in the suburban area had the highest rate in terms of feeling relaxed and free of worries, all the time or often (89.1%).
- ➔ The feeling of being in control of their lives – an important predictor of physical and mental health –, was significantly lower in the downtown population. The findings tend to confirm the associations already established between scores on the deprivation index and health indicators. In general, people who reported poor or passable health were more likely to report a lower level of feeling in control.

Education

- ➔ Compared to the other two areas, a higher number of children in the downtown area entered elementary school with learning deficits. This trend continued all the way through primary school. There were also a higher number of school dropouts in the downtown area compared to the other two areas.

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- Social dynamics**
- ➔ An aging population was observed in each of the three areas studied. Therefore, this demographic element by itself cannot explain health inequalities.
 - ➔ Greater concern for social problems (poverty, suicide, crime) was observed in the downtown area. The most positive perception of social dynamics was observed in the rural area, yet varied by neighbourhood unit.
 - ➔ Participation in community life was virtually the same in all three areas, at approximately 23%.
-

- Connection with the local community**
- ➔ The sense of belonging and having roots in the community was higher in the rural area compared to the downtown one.
 - ➔ Social isolation was less prevalent in the rural area compared to the downtown one. The downtown area contained the highest number of single-parent families and people living alone.
 - ➔ People chose the suburban area as a place to live because of social ties, often with plans to start a family. The majority of respondents reported living in a family situation.
 - ➔ In the rural area, identity was mainly associated with the area where people live, whereas in the suburban area, elements such as shared characteristics and values (family, etc.) fostered a sense of social cohesion.
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- Work**
- ➔ Lack of work and employment instability were higher in the downtown area. Approximately 20% of the downtown population were receiving employment insurance payments.
 - ➔ In the rural area, family ties were reported as a kind of “security blanket” during difficult times associated with work.
 - ➔ The highest rate of dissatisfaction with working conditions was reported in the suburban area. Interestingly, the highest employment rate was also reported there.
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OBSERVATIONS

1

The material wealth of the populations in the three areas contributed to the disparities in health status. The more disadvantaged a population, the lower the health status indicators. This was the case not only on the area level, but also on the neighbourhood unit level. Material conditions had both a direct and indirect influence on health in terms of people being able to fulfill their needs, and acquire and maintain lifestyles with healthy lifestyle habits.

Therefore both living conditions and culture (values, norms) should be taken into account in how health inequalities develop. Material wealth was also associated with the employment status of a population and their score on the deprivation scale. It should be noted that the most disadvantaged populations were those not in the labour force and the most socially isolated.

2

The local area had an influence on health because of the relationship populations develop with their milieu and the material and social conditions it offers. The local area and the milieus in which people circulate must be taken into consideration in differences in health. Their roles are complex and multidimensional. Analysis of their influence on health revealed interactions among the composition of the population, the context in which people's lives develop and the social and cultural dynamics characterizing the population. The local area played a role in the characteristics of health status by contributing to a sense of individual control and community empowerment. The concordance or lack thereof among the criteria of a milieu considered "appropriate" (reference milieu) and the characteristics of the local area may have had an impact on the sense of control, which is a strong predictor of health status. The feeling of being in control may not only be individual but also collective, and may affect the social dynamics of the milieu.

- 3 Populations living in the same area shared certain characteristics. The material and social contexts of the area attracted certain populations and excluded others. The characteristics of the local area supported the development of social relationships and the social and cultural capital of these populations. Furthermore, even though available resources such as health care and social services, family services, educational institutions, and recreation facilities were viewed in a positive light because they may be equivalent in different areas, this does not necessarily mean that they are appropriate or effective when taking into account people's needs and the preventive and counterbalancing roles these resources can play in terms of the negative aspects of a particular area.
- 4 The family milieu also influenced health status. It should be recognized that the family, as the foundation of social ties, plays an important role in conjugating the influence of the workplace and local area. This is why the absence of family ties as a fundamental source of social ties should be counterbalanced by another type of social network that can act as a protective factor when the workplace or local area cannot fulfill material and social needs.
- 5 The influence of the workplace milieu, namely whether one had a job or not and the working conditions of a job, interacted with that of the family milieu, and that of the local area or milieu (which may or may not have affected the employment trajectory). A comprehensive approach to understanding population health should take into account the combination and interaction of these three influences.

RECOMMENDATIONS FOR ACTION

- 1 The principles guiding strategies for the redistribution of collective wealth should especially target the most disadvantaged populations, whose financial situation influences the conditions of the areas in which they live and contributes to deleterious social dynamics. Strategies should also target families with children in disadvantaged populations.
- 2 Employment and income are determining factors that act directly and indirectly on the development of health inequities. They should be recognized as such in terms of providing the rationale for significant investment that can break the cycles of exclusion from the labour market.



- 3 In the health and social services sector, programs and services should be expanded to provide ongoing, intensive, individualized monitoring and follow-up for disadvantaged populations, without excluding wider-scale common programs. In addition, these programs should be oriented towards empowering people at the bottom of the social ladder to counter a certain fatalism that is both social and health-related. Emphasis should be placed on successes in a disadvantaged population to give a feeling of hope and control of one's destiny. Public policy should be based on solid knowledge of the factors that influence the life paths of citizens.
- 4 In disadvantaged areas, interventions recognized as being effective in early childhood should be expanded in order to prevent learning deficits at entry into elementary school. They should also provide a means for mothers to accomplish personal goals (trade or profession, education, respite, etc.).
- 5 In the education system, it should be recognized that different socioeconomic groups have different needs. Therefore, specific approaches reflecting these differences should be applied in terms of allocating resources.
- 6 Even though there seems to be no consensus on the benefits of socioeconomic diversity,³ it should be encouraged to counter homogenization (see page 9).
- 7 In local areas, effort should be devoted to developing and maintaining a feeling of belonging and social cohesion by ensuring conditions are in place that foster the development of social and cultural capital.
- 8 Greater effort should be devoted to countering negative perceptions people have of their local area and neighbourhood and encourage the development of positive perceptions.

3. Socioeconomic diversity can be defined as follows: In a given geographic zone, people with varying incomes and/or cultural origins live in the same area, come into contact with or socialize with one another, or frequent one another's businesses, thereby giving the area a heterogeneous quality.

Interpretation – Stakeholders’ Analyses and Comments

Invited for a one-day workshop entitled *The Development of Health Inequalities – Shedding Light on the Findings of Research on the Phenomenon and Recommendations for Action*, decision-makers from the health and social service sectors and researchers presented their comments on the significance of the findings.

Although they were aware of some of the results, everyone involved supported the relevance of the project. Decision-makers, practitioners in the field and researchers agreed on the importance of conducting this kind of research. The results were considered useful because they questioned practices, went beyond the usual discourse on health and sought the input of a variety of stakeholders. They revealed existing disparities, among and within the areas that were studied.

With regards to methodology, the workshop participants unanimously commended the use of both quantitative and qualitative methods, as well as the cross-referencing of individual data with those in large data banks. They also expressed their strong approval of the division of the areas into neighbourhood units, thus providing the opportunity for more in-depth analyses and a better understanding of people’s everyday lives. Everyone attending also agreed that having an advisory committee had made an invaluable contribution to the process, particularly by fostering relations between researchers and people working in the field.

Prospectively, the study and its findings made participants aware of the importance of the wealth and range of information derived from the various study participants. As a result, the message was heard that inter-sector action is the key to informed decision-making and that program and service planning should benefit from the contribution of school boards, health and social service institutions and municipal administrations. Participation of field personnel in this process – community organizers, social workers, etc. – also would appear to be essential.

In terms of knowledge sharing, the vast majority of decision-makers, stakeholders, workers in the field and researchers indicated that the study’s recommendations could be implemented in their particular field of action. However, some had reservations about socioeconomic diversity, especially because this could lead to the negative effects of gentrification. They underlined the importance of careful planning if such an approach were to be implemented. Nevertheless, given this, stakeholders who expressed their opinions in this workshop were more than satisfied with the results, and felt that this type of research process could and should be reproduced in other regions.

Stakeholders acknowledged this type of research requires considerable allocation of resources, and therefore suggested it would be advisable to do such research on a more modest scale while conserving the two fundamental characteristics, namely the division of areas into neighbourhood units and the strategy of knowledge sharing with an advisory committee. The participation of public health institutions in producing this type of analysis should be considered, and the time has come for research groups to work together to prevent repetitive or parallel research.

Future Directions

Beyond observations based on the findings, both stakeholders and researchers identified various future directions. They indicated what can be envisaged in terms of research, decision-making and interventions.

DECISION-MAKING AND INTERVENTIONS

- ➔ Expand the definition of “health” in descriptions of services offered by institutions and other relevant bodies.
- ➔ Reaffirm the importance of “local” and foster interventions based directly in the community.
- ➔ Prioritize the combination of community action and government action.
- ➔ Foster the development of new public policies targeting health promotion.
- ➔ Focus on accessibility to ensure health is an attainable value.
- ➔ Mobilize and gather together key stakeholders and decision-makers around the dual goals of health and community development.
- ➔ Learn to direct investment of resources towards the people and areas that need it the most, so that large-scale policies match their specific needs.
- ➔ Drop the current process of governing in silos.

RESEARCH

- ➔ Foster data sharing.
- ➔ Give priority to research that results in findings that can be applied by people working in the field, management personnel and partners, in order to improve practices.
- ➔ Conduct more in-depth study to further document how deleterious situations develop in order to understand the mechanisms of accumulation. Further study social exclusion, especially in isolated populations and those excluded from the labour market. Gain a better understanding of the interaction of these two phenomena.
- ➔ Conduct more in-depth study to further document differences among and within local areas and between the health of men and the health of women.
- ➔ Conduct further research to gain a better understanding of the mechanisms underlying protective factors.
- ➔ Further compare and contrast rural and urban areas in terms of both the mechanisms underlying health inequalities and those at play in specific sub-groups such as youth and women.

Conclusion

To summarize, the study entitled “Health Inequalities in an Urban, Suburban and Rural Area – Social Determinants and their Interaction” reveals that the mechanisms underlying differences in health are complex and can be better explained by the interaction of many factors. It seems clearer that the many interactions and relationships people have with their local community has an influence on their health. The study also revealed that social ties or the lack thereof are fundamental in the development of social inequalities in health, since they affect how people perceive the area in which they live and the milieu in which they circulate.

The complexity of this chain of interactions illustrates to what degree social inequalities in health remain a major challenge for decision-makers and society at large. Nevertheless, vigorous action should be undertaken to combat these inequalities. In light of the scientific knowledge available and the opinion of stakeholders in the areas under study, the priority seems to be that interventions should be planned and implemented by sectors working together in a multi-dimensional fashion.

In terms of research, recommendations for further directions have been stated above. A major priority of the Québec Population Health Research Network (QPHRN) is to continue to build capacity in research on social inequalities in health. By devoting the first issue of its PopHealth Notes series to this question, the QPHRN is demonstrating the importance it ascribes to this type of research. By shedding light on a study of three Québec City areas, we hope to encourage research that examines the reality of local health issues in the province of Québec, with a scope that largely transcends boundaries.

QPHRN

Created in 2002, the Québec Population Health Research Network (QPHRN) is a network of approximately 600 researchers working in the fields of public health, population health, health care services, health policy and health and society. Its mission is to support research infrastructure, innovative, multidisciplinary scientific activities and publications, champion a new generation of young researchers by funding graduate studies, and foster knowledge sharing. Its ultimate goal is to identify, understand and act on the social determinants of health to improve the health of populations. The scientific director is Dr. Gilles Paradis.

Knowledge Sharing and Application Group

The *PopHealth Notes* series is an initiative of the QPHRN's Knowledge Sharing and Application Group (*Axe Partage et utilisation des connaissances*). The group's research mandate is to sensitize researchers, public policy decision-makers, central and regional managers, and local workers in the field to the findings of health and population research and the issues raised by them. The group's activities reflect a two-pronged role – supporting other research themes of the QPHRN and initiating new projects designed to increase the sharing and application of knowledge in population health. The group is composed of Pierre Bergeron (INSPQ [*Institut national de santé publique du Québec*] and QPHRN), Marie-Claire Laurendeau (INSPQ and QPHRN), Pierre Joubert (INSPQ and QPHRN), Joseph Lévy (UQAM [*Université du Québec à Montréal*] and QPHRN) and Karine Souffez (QPHRN).

PopHealthNOTES

The research team of “Health Inequalities in an Urban, Suburban and Rural Area – Social Determinants and their Interaction” was mainly comprised of:

Maria De Koninck
Principal investigator
(Université Laval)

Marie-Jeanne Disant
Coordinator
(Université Laval)

Michèle Clément
(CSSS de la Vieille-Capitale)

Anne-Marie Hamelin
(Université Laval)

Robert Pampalon
(INSPQ)

Ginette Paquet
(INSPQ)

Michel Vézina
(Université Laval)

CREDITS

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The *PopHealth Notes* series presents summaries of the main research projects and innovative events organized in the context of the work of the QPHRN.

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190 Crémazie Blvd. E.
Montréal, Québec
H2P 1E2

www.santepop.qc.ca

<http://portail.santepop.qc.ca/en/index.html>

To obtain a printed version of an issue in this series or for any question regarding this publication, please contact:
Karine Souffez
514-864-1600, ext. 3607
karine.souffez@inspq.qc.ca

For any questions on the contents of this issue, please contact:

Maria De Koninck
418-656-2131, ext. 7208
maria.dekoninck@msp.ulaval.ca

Author of the study: Maria De Koninck, Université Laval

Author of the French version of this text:
Guyline Boucher, Agence MédiaPresse

Coordination: Marie-Claire Laurendeau with the collaboration of Karine Souffez

Graphic Design: Lucie Chagnon

Translator: James Lawler

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**Inégalités de santé et milieux de vie:
déterminants sociaux en cause et leurs interactions**

AVENUES FOR REFLECTION ON THE ETHICS OF KNOWLEDGE SHARING

AT WHAT POINT SHOULD RESEARCH-GENERATED KNOWLEDGE BE TRANSFERRED?

CAN PRELIMINARY RESULTS BE TRANSFERRED?

WHAT ARE THE RESPECTIVE RESPONSIBILITIES OF RESEARCHERS, KNOWLEDGE BROKERS, AND DECISION-MAKERS IN THE DECISION-MAKING PROCESS?

HOW CAN THESE PRACTICES BE BETTER SUPERVISED, AND SHOULD THEY, IN FACT, BE SUPERVISED?



The practice of knowledge sharing raises a number of ethical issues for which there are no ready answers. This is why the Québec Population Health Research Network (QPHRN) organized a colloquium during the May 2007 ACFAS convention, bringing together ethicists, population health researchers, decision-makers and interveners working in knowledge sharing, to discuss the ethical issues surrounding the ways in which decisional and interventional settings make use of research.

Three general conclusions resulted from the colloquium. This edition of the PopHealth Notes series presents these conclusions as approaches that could enrich current thinking on the topic.

CONCLUSION

1

Knowledge sharing involves numerous challenges

Knowledge sharing is most often understood as a strategy for solving problems.

Knowledge sharing aims at helping decision-makers arrive at informed research choices. It is meant to stimulate organizational innovation; give citizens greater access to research results; and enable community organizations to transform these results, over time, into strategies for action. Yet although knowledge sharing leads to remarkable knowledge exchanges, it also introduces sizeable difficulties for those involved. It requires researchers, stakeholders, decision-makers and journalists to step outside their comfort zones. The involvement of previously excluded non-university stakeholders in the research process tends to shake up current practices. This is why the colloquium's speakers stressed the importance of addressing the new demands that go along with knowledge-sharing practices.

The accounts below, given during the colloquium by a researcher, a knowledge broker and a decision-maker respectively, concretely illustrate the ethical issues faced by these three players.



JOANNE OTIS

A RESEARCHER'S EXPERIENCE

Joanne Otis, a professor in UQAM's Department of Sexology and Chairholder of the Canada Research Chair in Health Education, explained that the main ethical issues facing researchers engaged in the knowledge sharing process involve negotiating and sharing responsibility with research users. She particularly referred to the matter of the rights and powers of both these sets of players with regard to research data; possible biases towards certain communities; and, above all, the risks run by each group of actors. In her view, compromise is a necessary element of the knowledge-sharing process, because it sparks synergy between the imperatives of science and urgent community needs.

Ms. Otis also spoke about the additional workload inherent in knowledge sharing as well as its impact on researchers' careers. Participation in community activities and in one-off media interventions takes time away from the production of scientific articles. Her own experience as a researcher in the OMEGA study, which was conducted in conjunction with Montreal's gay community and community organizations and clinical stakeholders, also made her aware of the fears engendered by knowledge sharing (for example, the fear of disappointing the target community); the high degree of investment required; and the moral obligation to continue the relationship with research users once a study is over. Ms. Otis expressed her conviction that, despite these difficulties, the OMEGA study could not have been carried out without formal community involvement and without the nurturing of links of trust and reciprocity with those participating in the research project.



GINETTE BOYER

A KNOWLEDGE BROKER'S EXPERIENCE

The aim of knowledge brokering is to create links between researchers and decision-makers in such a way as to facilitate interactions between them. The knowledge broker's role, which is still a new one, is to buttress the development of clinical and organizational practices, and increase the use of research-generated knowledge by means of science-popularization activities, animation and networking. Ginette Boyer, of Sherbrooke's CSSS-IUG, has worked in the field of knowledge brokering for the last several years. In her talk, she mentioned four issues surrounding a broker's role:

- 1) his or her professional identity;
- 2) the process of knowledge appropriation;
- 3) network building;
- 4) the popularization of knowledge.

In essence, Ms. Boyer sketched the challenges knowledge brokers face in working without the help of a well-defined skills profile; intervening in work overload or crisis situations; becoming personally involved in a variety of settings while at the same time remaining honest and impartial; and faithfully rendering researchers viewpoints without simplifying them or taking credit for them. In short, she said that transparency is essential to fulfilling a broker's duties, obliging brokers to remain alert for any shifting terrain with respect to their personal biases and values.



DENIS A. ROY

A DECISION-MAKER'S EXPERIENCE

Denis A. Roy, Director of Information and Knowledge Management for the *Agence de la santé et des services sociaux de la Montérégie*, places ethics at the heart of any decision to invest in knowledge application rather than in services. Addressing this matter from the standpoint of the responsibility of health system managers towards the population, Mr. Roy maintained that a decision-maker's ethical involvement requires him or her to narrow the gap between what is scientifically recognized and what organizations actually do. In his opinion, implementing knowledge sharing in the network is, therefore, necessary for enlightened decision-making using evidence-based data, and that this imperative goes above and beyond organizational cultures, administrative constraints, or interest-group preferences. Mr. Roy also stressed that there are challenges that go along with knowledge sharing per se. One example he gave is that it is hard to identify the people who should participate directly in knowledge-sharing activities, since this decision involves political considerations.

CONCLUSION

2

Several ethical viewpoints are valid

*In light of these challenges, an ethical question arises:
how can we succeed in "getting it right?"*

The ethicists present at the colloquium agreed that the answer to this question lies in how each person understands the concept of knowledge sharing. Each definition has its own particular ethical emphasis, and each is as valid as the other. To illustrate this point, Dr. Hubert Doucet, a professor at *Université de Montréal* in Bioethics and Director of GREB (*Groupe de recherche en bioéthique*), and Burleigh Trevor-Deutsch, Director of the Ethics Office at the Canadian Institutes of Health Research, reviewed the most common definitions of knowledge sharing, demonstrating how each relates to a specific view on ethics. Their comments are summarized below.

KNOWLEDGE TRANSFER

The term “transfer,” widely used in the field of knowledge sharing, refers to the communication of research results by the scientific community to those working in the field, for the purpose of improving the quality of life of potential users of these results. Knowledge transfer involves the ethics of experts, with those who know reaching out to those who do not know.

DEMOCRATIZING KNOWLEDGE

This interpretation of knowledge sharing makes links with the community a fundamental precept. The focus is on each citizen’s right to access research results. Here, however, communication is still basically unilateral.

KNOWLEDGE EXCHANGE

Knowledge exchange aims at solving problems through cooperative efforts between researchers and decision-makers. It functions through mutual learning that is continuously fed by research results. This process is based on collaboration and interaction which have at heart the equality of all stakeholders. Partnership is necessary here, as a right and a responsibility. However, citizen involvement is still not a part of this definition.

CITIZEN INVOLVEMENT

The European Commission’s “dialogue workshops” provide the best illustration of this form of knowledge sharing. These workshops bring together researchers, decision-makers, non-governmental organizations and concerned citizens so that they can share, debate and assess the implications of research in terms of actions that have political impact. The citizen’s viewpoint forms the core of this approach, which is based on the values of equality, cogeneration of knowledge and participatory democracy. Moving beyond mere access to research data, the concept also involves recourse to several sources of knowledge, including the experiential knowledge of citizens themselves.

One basic value transcends these four concepts: the opening-up of the research process to potential users. This aim, however, in and of itself, is not enough to guide stakeholders when conflicts of interest or complex situations arise. When this happens, the practice of knowledge sharing enters unknown territory, and organizations tend to revert to the “trial and error” method.

*At present, we are learning as we go, with no guidelines, and it is hard to know whether we are doing what must be done **correctly and fairly.***

Joanne Otis

In view of the demands faced by researchers, knowledge brokers and decision-makers when practicing knowledge sharing, it is becoming vital to draw up clear and effective standards for guiding the work of each stakeholder.

CONCLUSION

3

Guidelines are needed

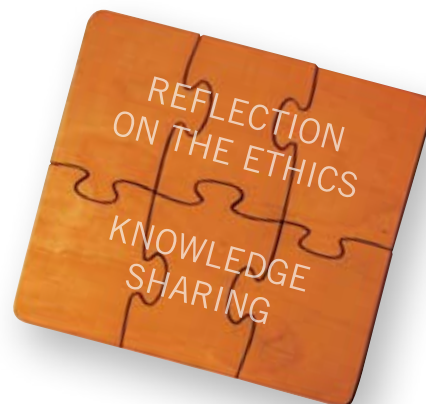
The involvement of stakeholders in the research process must be planned and orchestrated, because it requires negotiation among all players.

The more the model favours citizen involvement, the greater the need for guidelines. All the colloquium's speakers agreed that the time has come to build a standards framework based on managing these deliberations in order to guide the practice of knowledge sharing. Participants expressed the view that the creation of venues and mechanisms for exchanging views on ethical matters is proving to be one of the most promising avenues for supporting knowledge sharing. Managing such proceedings can take various forms and can be kept current by means of:

- formal arrangements or agreements in principle, clearly setting out the concerns of all parties;
- an independent entity, mandated to help players manage the uncertainties that may arise along the way;
- mechanisms enabling citizens to come into contact with researchers;
- rules requiring each granting agency to explain its ethical models on knowledge sharing in clear terms, so as to guide the actions of researchers and scientific organizations.

What role does ethics play in this process?

Ethics helps us: probe the myriad facets of any problem issue; develop a critical point of view; and facilitate choices so that all players can peacefully coexist. More specifically, applied to knowledge sharing, ethics can contribute to stimulating collective thinking about each player's responsibility, thus harmonizing relationships among players. The colloquium's participants stated that, among other things, ethics helps clarify the various parties' expectations and provide ongoing support for interaction between researchers and research users. In addition, if researchers do take practitioners' temporal and cultural constraints into account (and vice-versa), this will encourage researchers, decision-makers and those working in the field to better harmonize their pace of work. A gap has always existed between the logistics of knowledge advancement in the research community and the operational logistics guiding players in the field. In sum, players directly involved in knowledge sharing can only gain from including ethicists in their reflection processes. In this respect, the primary contribution this colloquium will have made is to give specialists in these two areas an opportunity to discuss these issues.



ACKNOWLEDGEMENTS

COLLOQUIUM ORGANIZING COMMITTEE

Michel Bergeron

Office for Research Services and Development,
Université de Montréal

Joseph Lévy

Knowledge-sharing Group, QPHRN;
Department of Sexology,
Université du Québec à Montréal

Guillaume Paré

Research Ethics Committee,
*Agence de la santé et des services sociaux
de Montréal / Direction de santé publique*

Nathalie Pinsonnault

Colloquium Co-chair
*Centre de recherche Léa-Roback sur
les inégalités sociales de santé à Montréal*

Louise Rousseau

Colloquium Chair
*Équipe de recherche appliquée en santé (ERAS);
Direction de santé publique de Montréal*

Karine Souffez

Knowledge Sharing Group, QPHRN

CONFERENCE SPEAKERS

Ginette Boyer

*Centre d'innovation, de recherche et
d'enseignement, CSSS-IUG de Sherbrooke*

Hubert Doucet

Bioethics programs,
*Université de Montréal;
Groupe de recherche en bioéthique (GREB),
Université de Montréal*

Joanne Otis

Department of Sexology,
*Université du Québec à Montréal;
Canada Research Chair in Health Education,
Université du Québec à Montréal*

Denis A. Roy

*Agence de la santé et des services sociaux
de la Montérégie*

Burleigh Trevor-Deutsch

Ethics Office, Canadian Institutes
of Health Research (CIHR)

QPHRN

Created in 2002, the Québec Population Health Research Network (QPHRN) is a network of approximately 600 researchers working in the fields of public health, population health, health care services, health policy and health and society. Its mission is to support research infrastructure, innovative, multidisciplinary scientific activities and publications, champion a new generation of young researchers by funding graduate studies, and foster knowledge sharing. Its ultimate goal is to identify, understand and act on the social determinants of health to improve the health of populations. The scientific director is Dr. Gilles Paradis.

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For a print version of a *PopHealth Notes* or for questions regarding this publication, please contact:
Karine Souffez
514-864-1600, ext. 3607
karine.souffez@inspq.qc.ca

To access the colloquium's presentations (in French only):
http://www.santepop.qc.ca/acfas_e.asp

Coordination: Marie-Claire Laurendeau, Karine Souffez

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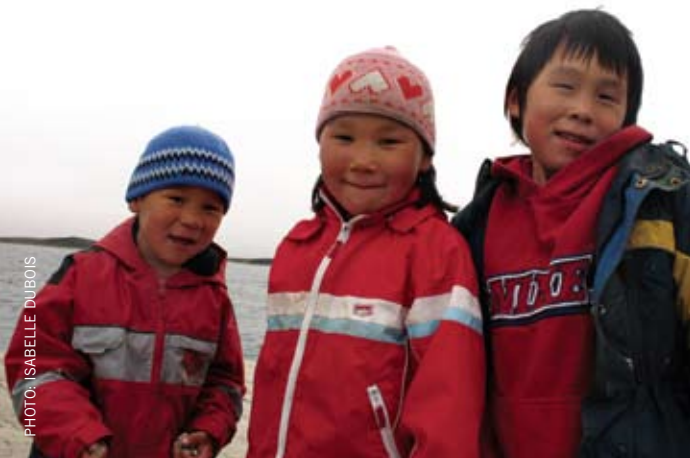
ABORIGINAL YOUTH AND SOCIAL INEQUALITIES IN HEALTH

Invest in aboriginal youth today for healthy communities tomorrow

On November 21, 2007, the Institut national de santé publique du Québec, with funding from the Ministère de la Santé et des Services sociaux du Québec, Health Canada (First Nations and Inuit Health Branch) and the National Collaborating Centre for Aboriginal Health (UNBC), held a theme day on the health of aboriginal youth as part of the *Journées annuelles de santé publique*. Entitled *Miser sur la jeunesse autochtone aujourd'hui pour des communautés en santé demain* (Invest in aboriginal youth today for healthy communities tomorrow), the day covered the health of aboriginal youth not from the perspective of worrisome data and

the magnitude of their problems, but from a pro-active and intervention perspective to address social inequalities in health.

This special day also provided an opportunity to learn about innovative projects that are contributing to improvements in the health and wellness of aboriginal youth and their communities. Indeed, the programs, measures, intervention tools, and communal projects presented had a common goal of taking action on various social determinants that have protective effects on health by being rooted in the realities of native communities. These initiatives, described in this summary report, can be regarded as signposts of more profound changes that will help current and future generations blossom into healthy communities...



CONTEXT | THE ISSUE OF SOCIAL INEQUALITIES IN HEALTH

People under 30 years of age constitute 60% of the aboriginal population of Québec. Native youth often grow up in poor living conditions and difficult environments. Moreover, economic and social problems combined with a succession of traumatic experiences and sociocultural dislocation have a lasting impact on the health and well-being of young aboriginals and their communities.

Socioeconomic and health indicators tend to highlight these problems by pointing to the darkest realities of native communities – poverty and unemployment, abuse, addiction (smoking, drugs, gambling), obesity and suicide, are among those most frequently reported. These data, which can contribute to stigmatizing these communities, do not reflect the diversity of aboriginal youths' situations. The problems are not of the same magnitude in all communities, since contexts and conditions can vary from one community to another.

In 2001, the percentage of the First Nations population under 30 years of age was 61.1%, compared to 38.8% for the population of Canada as a whole.¹

However, these indicators reveal the magnitude of social inequalities in health faced by First Nations and Inuit compared to non-native people. They are called “social” inequalities because they are not the result of individual factors

(genetic, biological, etc.), but are related to social, political, economic and cultural processes. Indeed, disparities in health between native and non-native people are above all the result of different social constructs, leading to marginalization of aboriginals, whether in their own communities or in urban settings. It is therefore urgent to eliminate processes which have deleterious effects on the health of the current generation of First Nations and Inuit and those who will succeed them.

MAGNITUDE OF SOCIAL INEQUALITIES IN HEALTH

SELECTED HEALTH AND SOCIAL DATA

(as of the early 2000s)

Among the First Nations and Inuit of Canada

- The mortality rate in native children is three times that of non-native children. Suicide is among the main causes of death in First Nations children and youth (10 to 24 years of age).²
- In First Nations, 20% of births involve a teenage mother vs. 5.6% of births in Canada as a whole.³
- Reported cases of chlamydia are seven times higher than those for Canada as a whole. In addition, although aboriginal people formed only 3.3% of the population of Canada in 2002, they accounted for 5% to 8% of existing cases and 6% to 12% of new cases of HIV infection in that year.⁴

First Nations in Québec compared to the population of Canada as a whole

- Life expectancy is six to seven years shorter.
- Diabetes is two to three times more common.
- Obesity rates are two to three times higher.
- From early childhood on, the risk of experiencing poverty, abuse or placement is three to five times higher.⁵

SELECTED SOCIOECONOMIC DATA

(as of the early 2000s)

Among the First Nations and Inuit of Canada

- The unemployment and poverty rate is three times higher than that of the non-aboriginal population. Nearly half (47%) of First Nations people living on reserves have an annual income below \$10,000. Approximately 60% of aboriginal children under six years of age live in poverty.⁶
- Approximately 5% of registered Indians, 7% of Métis and non-registered Indians, and 2% of Inuit have obtained a university degree or certificate, compared to 18% of people in Canada as a whole.² Nearly half (48%) of aboriginal people 20 to 24 years of age living outside of reserves have not completed high school, compared to 26% of all Canadians in this same age group.⁶

Among the First Nations of Québec

- One out of four are unemployed.
- Approximately half of adults have not completed high school.
- Two out of three women have an annual income lower than \$10,000.
- Almost half (44%) of children live in single-parent families.⁵

BUILDING HEALTHY COMMUNITIES

Issues and Challenges



PHOTO: ISABELLE DUBOIS

Though prevention and health promotion activities for youth can contribute to building healthy communities, they cannot be conducted in only one intervention sector using one model, nor can they be accomplished without the cooperation of the target population, their families, friends, and stakeholders.

Furthermore, improving the health and well-being of aboriginal communities cannot be limited to a strict framework of curative activities, since there are anterior processes that can contribute to altering physical and mental health. Unhealthy lifestyle habits and difficult living conditions are very often related to discrimination, loss of identity, low self-esteem, and shared suffering associated with marginalization. In prevention and health promotion interventions, it is therefore of primary importance to foster individual and collective empowerment, strengthen cultural

factors, cultivate social cohesion, reinforce parenting and social skills, and build self-esteem as well as focusing on healthy lifestyle habits.

The initiatives presented during the theme day on the health of aboriginal youth are aimed at reducing social inequalities in health by strengthening various health protection factors and targeting social determinants, not just individual ones. Most of these projects have been developed by aboriginal individuals, organizations and communities involving not only youth, but also adults and elders in a variety of ways and levels of participation.

INITIATIVES CONTRIBUTING TO REDUCING HEALTH INEQUALITIES

Innovative projects presented during the theme day on the health of aboriginal youth: descriptions of their context, goals and activities.

Chî Kayeh

PEER EDUCATION PROGRAM IN CREE HIGH SCHOOLS ON SEXUALITY

CONTEXT Launched in 2005 as pilot project in two Cree communities, Waswanipi and Waskaganish, the Chî Kayeh Program on Sexual Health for High School Students was developed after a large-scale public consultation in these two communities involving elders, parents, school principals, teachers, religious educators, doctors and nurses. Young people's opinions on sexuality and relationships were also taken into account in developing the program.

GOALS Given the ongoing high incidence of sexually transmitted infections in the *Iiyiyu Aschii* – the Cree Lands of James Bay – the Chî Kayeh program was designed for high school students. Integrated into the curriculum, it targets the prevention of sexually transmitted diseases and aims to reduce the number of unwanted pregnancies. The program is meant to inform but also to develop knowledge, know-how, and know-how-to-be. It contributes to youth being able to grow and blossom in the emotional, social and sexual aspects of their lives.

It also covers peer and social pressures related to sexuality which young people face. Traditional Cree values related to sexual health are also presented.

ACTIVITIES Chî Kayeh is essentially based on *aashumii*, namely peer education. First, students in Secondary 3 and 4 are taught Cree traditions and values related to sexual health, then learn about risk behaviours, teenage pregnancies, fetal alcohol syndrome, peer pressure, waiting until later to have sexual relations, and condom use. On one of the three last themes indicated in the previous sentence, students must then prepare and give an oral presentation to their classmates. After the content of their message is considered clear and appropriate for younger schoolmates, they then give the presentation to students in Secondary 2.

Projects in Native Friendship Centres

BEING A YOUNG ABORIGINAL IN AN URBAN SETTING

CONTEXT Located in various towns and cities in every province of Canada, Native Friendship Centres offer a wide

range of services – assistance, training and education for aboriginal people living in an urban area. They help

reduce isolation and strengthen ties to the local community by fostering social integration. In 2001, the Urban Aboriginal Youth Council (UAYC) was created through the incentive of native youth who were actively involved in the eight Friendship Centres in Québec. Members of the UAYC act as

spokespersons who initiate or support the development of projects specifically addressed to youth in Native Friendship Centres.

GOALS These projects foster social inclusion, the promotion of native culture, and the creation of bridges between native and non-native cultures. Projects have objectives such as strengthening self-esteem, transmission of traditional knowledge, acquisition of leadership skills, and the development of various social and parenting skills.

ACTIVITIES Native Friendship Centres have initiated a variety of projects. The Mëmëgwashi Gala of the Val-d'Or Centre provides a window into educational achievement through annual awards to graduating students in the region, from kindergarten to university. The Mothers Circle in La Tuque and the Auassiss Daycare Centre in Québec City focus on developing parenting skills and supporting single mothers. The Senneterre and Montréal Centres organize activities in the forest under the supervision of elders and offer workshops on traditional native skills such as woodworking, leather tanning and snowshoe-making. The Sept-Îles Native Friendship Centre provides support to Cégep (junior college) students, either helping them find accommodation or in their academic life (e.g. tutoring).

In Canada as a whole, 48% of aboriginal people live in urban centres; in Québec, the figure is 37%.⁷

To learn more about the Regroupement des centres d'amitié autochtones du Québec, visit their website at:

http://www.rcaaq.info/anglais/index_ang.html



Positive discrimination to reduce inequality

BECOMING A DOCTOR...

CONTEXT The percentage of aboriginal people who have a university degree is much lower than that for the population in general. Living in isolated communities and lack of emotional, social and financial support are some of the factors which have a negative influence on the pursuit and achievement of studies at the university level. In addition, although

there is a real need for medical personnel in these communities, very few aboriginals have jobs in the health and medical sector. Canada has developed

a program to foster the enrollment of Inuit, Métis and First Nations students in faculties of medicine.

GOALS This program is designed to increase the number of aboriginal doctors, but also reduce the severe shortage of medical personnel in native and Inuit communities. Having aboriginal doctors in these communities would facilitate communication and trust between patients and doctors, thereby contributing to the quality of health care. This positive discrimination program has also had symbolic effects. Aboriginal general practitioners and specialists show young native people that it is within the realm of possibility to succeed in university and then hold positions that are deemed of high value in the social ladder.

Through a variety of measures, positive discrimination aims to equalize opportunities for populations **who have experienced systematic discrimination.**

ACTIVITIES The program is voluntary and is arranged through an agreement with the government of Canada and a faculty of medicine. A number of universities have already accepted and applied these positive discrimination measures by adopting prescribed criteria to pre-admit young aboriginals into the medical program.

The Well-Being of First Nations Youth in Québec

A COLLECTIVE ISSUE AND CHALLENGE

CONTEXT Created in 1994, the First Nations of Quebec and Labrador Health and Social Services Commission has as its mission the promotion and monitoring of the physical, mental, emotional and spiritual health of aboriginal individuals, families and communities in Québec and Labrador by providing comprehensive programs in health and social services adapted to native culture. As a collective issue, the health of aboriginal youth is one of the main priorities of the organization.

GOALS To improve the well-being of children and youth, the Commission develops and employs a variety of means, including sensitization tools, prevention programs and provision of services to assist children and families and is involved in the social development of communities. Given that the well-being of a child is significantly related to that of the family but also interwoven with that of his/her community, the Commission acts at various levels in various fields in terms of health protection, prevention and promotion.

ACTIVITIES The Commission has developed a number of tools to sensitize children and youth, and their families, to health issues, such as those designed for community workers in sexual health and HIV prevention or those on nutrition for families. In addition, the Commission assists and supports communities in the implementation or improvement of programs and services for young

Learning to cook healthily

NOURISHING THE BODY, SPIRIT AND HEART...

CONTEXT Colonization and its after-effects have profoundly affected the lifestyles and diet of aboriginal peoples. Diabetes, obesity, heart disease, and anemia are increasing. The origins of these diseases can be related to diet but also living conditions and lifestyle habits. Fighting the effects of malnutrition in native communities means intervention in terms of nutrition knowledge and cooking skills but also the social practices associated with diet. This is the goal of the “Learning to Cook Healthily.”

GOALS The project leader of “Learning to Cook Healthily” puts his talents as a chef to good use in many Cree and Atikamekw communities. He helps develop knowledge and skills in eating a healthy diet, while communicating a passion for cooking. Participants in this program go beyond knowledge and skill acquisition in healthy cooking, since they tend to nourish their spirit and heart as well as their body.

ACTIVITIES The project leader designs and presents training sessions/workshops to youth, families, and staff and clients of institutions providing food services (youth homes, daycare centres, high schools, restaurants and hotels) to familiarize them with healthy cuisine adapted to the aboriginal context. The recipes taught are delicious, simple and easy to make – they require little preparation and are developed from products and ingredients which may or may not be part of the traditional



PHOTO: CASSP/NOI

people and their families. One of the current projects targets front-line social services to reduce the number of child placements. In this pilot project, interventions not only target families but also entire communities.

diet, and that are affordable and locally available. The pleasure of the senses, socialization and sharing of traditional knowledge is also on the menu of these workshops. The success of this project goes way beyond increased consumption of fresh vegetables and healthy foods – pride and professionalism are also outcomes of the course, as a young cook eloquently put it.

Comic books

A PREVENTION AND PROMOTION TOOL FOR CHILDREN AND YOUTH...

CONTEXT Because certain prevention and promotion campaigns are not adapted to the context of young aboriginals, they often prove ineffective. This is of major concern given the seriousness of health problems facing them. Confronted with this fact, the *Healthy Aboriginal Network*, located in British Columbia, decided to seek the participation of native youth in the development of prevention and promotion tools adapted to their cultural world. Hence many comics covering drug abuse, diabetes, suicide, stereotypes, body image and mental health have been created by and for native youth.

GOALS The comic book, besides being a very popular medium among youth, provides a means of using the symbolic power of images and storytelling to address sensitive topics and communicate messages. By soliciting the help of young aboriginals in the scripting and illustration of comics, the project founders were able to dramatize the experiences of young natives in cultural codes that integrate their own values, life experiences and imagination.

Identifying with situations and heroes in history which bear witness to the resilience of a people helps strengthen self-esteem, pride in being native, and fosters the capacity to act individually and as a group to confront adversity.

ACTIVITIES The first comic book in this project was published in 2006. Entitled *Darkness Calls*, it tells the story of a young aboriginal who, after a series of failures and humiliations, develops suicidal thoughts. However, his experience with a native spirit helps him turn things around... This work was very successful – more than 50,000 copies of the original edition were sold across Canada. A new French edition is currently in circulation and a short animated film narrated in Gitksan, a native language of the Canadian West, has been made based on the original work.

To learn more about Darkness Calls, visit the following website:
<http://www.thehealthyaboriginal.net/>



Annual canoe trip

BY EXPLORING THE LAND AND WATERS, A COLLECTIVE IDENTITY IS DISCOVERED AND A SENSE OF SELF...

CONTEXT Kitcisakik is a small Anicinape community in the Abitibi-Témiscamingue region, located on the shore of Lac Dozois. Not having the legal status of a reserve, its members do not have access

to basic services which other Quebecers take for granted, such as electricity and running water. With no school,

children seven years of age and over must leave the family home each week to attend school in Val d'Or. In 1992,

GOALS The annual canoe trip provides a means of rallying youth, elders and families around a group project in which everyone can take part. It provides a way of getting in touch again with native traditions and strengthening the ties that bind the community together. Exploring the territory provides an opportunity to discover the roots of collective identity and get to know oneself better. It is a way of revisiting the history of each and every participant, thereby setting the foundations upon which children and youth can construct their own lives and grow as individuals and members of a group.

ACTIVITIES In 2007, 55 people in 28 canoes undertook the 15-day trip. As the days and kilometres went by, the adults and elders initiated the youths into the traditions which are part of the heritage to be passed on to the next generation, such as canoeing, relationship with the environment, spirituality, etc. Evenings provided an opportunity to share special stories, to talk about problems with alcohol and drugs, but also to give an account of one's experience of healing or to express one's hopes and aspirations, dreams and plans. Holding this event every year, with a growing number of participants, bears witness to its importance in the life of this native community.

To learn more about the community of Kitcisakik, visit their website at: <http://www.kitcisakik.ca/accueil.htm>



wishing to address the many problems families in the community face, Kitcisakik community workers established an annual canoe trip on the lakes and rivers of the Anicinape territory.

Wapikoni Mobile

PROJECTING ONESELF ON THE
SCREENS OF THE WORLD AND
INTO THE FUTURE...

CONTEXT Culture plays a primary role in individual and collective development. Music, writing, dance, painting or filmmaking are a few of the many ways of sharing and expressing one's

For additional information on the Wapikoni Mobile project, visit their website at: <http://www.onf.ca/aventures/wapikonimobile>



culture. Because of their isolation from major urban centres, young aboriginals are distanced from the creative and cultural scene. The Wapikoni Mobile project provides a way for young native people to penetrate the centres of creation and distribution while remaining in their community.

GOALS Created in 2004, this mobile film and recording studio addresses the needs of young aboriginals to express their creativity, sensibility and culture. It is designed to train native emerging talents. With the Wapikoni Mobile, youths have the equipment they need to produce and distribute their musical and audiovisual creations. Beyond the technical aspect, Wapikoni Mobile gives aboriginal youth a voice, so that they can exteriorize their emotions, express their vision of the world, develop confidence in themselves, and project themselves on the screens of the world and into the

future, creating a vital representation of their reality. The films and CDs they produce also provide a means of discovering native communities in a much more optimistic and favourable light than statistics and preconceptions may indicate.

ACTIVITIES Since its launch in 2004, the Wapikoni Mobile is traveling to an increasing number of places – 11 communities comprising five different First Nations (Atikamekw, Algonquin, Innu, Mohawk and Cree) are now receiving regular visits. Since 2006, three permanent studios have been operating in the communities of Wemotaci, Kitchisakik and Mashteuiatsh. At each stop the Wapikoni Mobile makes, volunteer trainers helped by social workers introduce a dozen aboriginal youths to sound recording, and shooting and editing short films. The studio is a meeting place where learning and self-worth are at the heart of the creative process. The productions are then presented in the community and elsewhere upon request. The success of certain films, which have received national and international awards, bring well-warranted attention to these communities.



CONCLUSION

This special day devoted to aboriginal youth revealed that, despite the persistence of social inequalities in health, there are projects in communities whose dynamism and synergic effects are indeed contributing to improving the health and well-being of aboriginal children and youth.

The various initiatives presented during this special day bear witness to the diversity of ways in which social inequalities in health can be combated and the need to understand them in a broader definition of health. The ways and means of fighting against social inequalities in health cannot help but be numerous and varied, since their ramifications are equally numerous and run deep.

In conclusion, one can only hope that these examples of structural change be supported and integrated at various levels. As the First Nations of Quebec and

Labrador Health and Social Services Commission has stated, by focusing on the vitality of First Nations and their youth, we are ensuring a vibrant future for Québec society as a whole.



PHOTO: C5SSPNOL



PHOTO: SUZANNE BRUNEAU

SCIENTIFIC COMMITTEE OF THE ABORIGINAL YOUTH HEALTH DAY

Odile Bergeron, Research Officer, Aboriginal Health Unit, Institut national de santé publique du Québec

Suzanne Bruneau, Coordinator, Aboriginal Health Unit, Institut national de santé publique du Québec

Martine Drolet, Program Officer, Sexual and Mental Health Programs, Public Health Department, Cree Board of Health and Social Services of James Bay

Manon Dugas, Director of Ushiniichissuu (Youth Team), Cree Board of Health and Social Services of James Bay

Sandro Echaquan, Nurse, Centre de santé de Manawan

Pierre Joubert, Scientific Director, Research, Training and Development, Institut national de santé publique du Québec

Marie-Anne Kimpton, Research Officer, Aboriginal Health Unit, Institut national de santé publique du Québec

Lily Lessard, Research Officer, Aboriginal Health Unit, Institut national de santé publique du Québec

Sophie Picard, Coordinator, Health Sector, First Nations of Quebec and Labrador Health and Social Services Commission

Nathalie Rosebush, Aboriginal Affairs Advisor, Affaires autochtones et régions nordiques, ministère de la Santé et des Services sociaux du Québec

Nibisha Sioui, Doctoral Candidate in Community Psychology, Université du Québec à Montréal (UQAM)

Stanley Vollant, M.D., Director, Aboriginal Health Program, Faculty of Medicine, University of Ottawa

SPEAKERS AND PANEL MEMBERS

Manon Barbeau, Filmmaker

Marlène Beaulieu, Planning, Programming and Research Officer, Public Health Department, Cree Board of Health and Social Services of James Bay

Julie Courtois-Girard, Partnership Coordinator, Regroupement des centres d'amitié autochtones du Québec

Sandro Echaquan, Nurse, Centre de santé de Manawan

Mélanie Gagnon, Coordinator, Canada Research Chair in Health Education, Université du Québec à Montréal (UQAM)

Richard Gray, Coordinator, Social Services Sector, First Nations of Quebec and Labrador Health and Social Services Commission

Margo Greenwood, Scientific Director, National Collaborating Centre for Aboriginal Health, University of Northern British Columbia

Ashley Iserhoff, Deputy Grand Chief of the Grand Council of the Crees and Vice-Chairman of the Cree Regional Authority

Pierre Joubert, Scientific Director, Research, Training and Development, Institut national de santé publique du Québec

Hop Lam Dao, Health Chef, Healthy Restaurants and Cafeterias Project, Crees of Eeyou Istchee and Atikamekw of Manawan

Hélène Michel, Community Worker with Women, Kitchisakik Health Centre

Sean Muir, Executive Director, The Healthy Aboriginal Network

Mélissa Nepton-Riverin, Medical Student, University of Ottawa

Nibisha Sioui, Doctoral candidate in Community Psychology, Université du Québec à Montréal (UQAM)

Eva Ottawa, Grand Chief and President of the Council of the Atikamekw Nation

Nyshan Ottawa, Apprentice Head Cook, Otapi High School, Manawan

Kim Picard, Youth Coordinator, Québec Native Women Inc.

Sophie Picard, Coordinator, Health Sector, First Nations of Quebec and Labrador Health and Social Services Commission

Roch Riendeau, Coordinator of Front-Line Services, Kitchisakik Health Centre

Craig Ross, Youth Coordinator, Native Friendship Centre of Montréal

Mike Standup, Mohawk Healer, Kanawaghe

Stanley Vollant, M.D., Director, Aboriginal Health Program, Faculty of Medicine, University of Ottawa

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For a print version of a *PopHealth Notes* or for questions regarding this publication, please contact:

Karine Souffez
514-864-1600, ext. 3607
karine.souffez@inspq.qc.ca

Authors

Marie-Jeanne Disant
Catherine Hébert
Odile Bergeron
Suzanne Bruneau

Translation

James Lawler

Coordination

Marie-Claire Laurendeau
Karine Souffez

Graphic design: Lucie Chagnon

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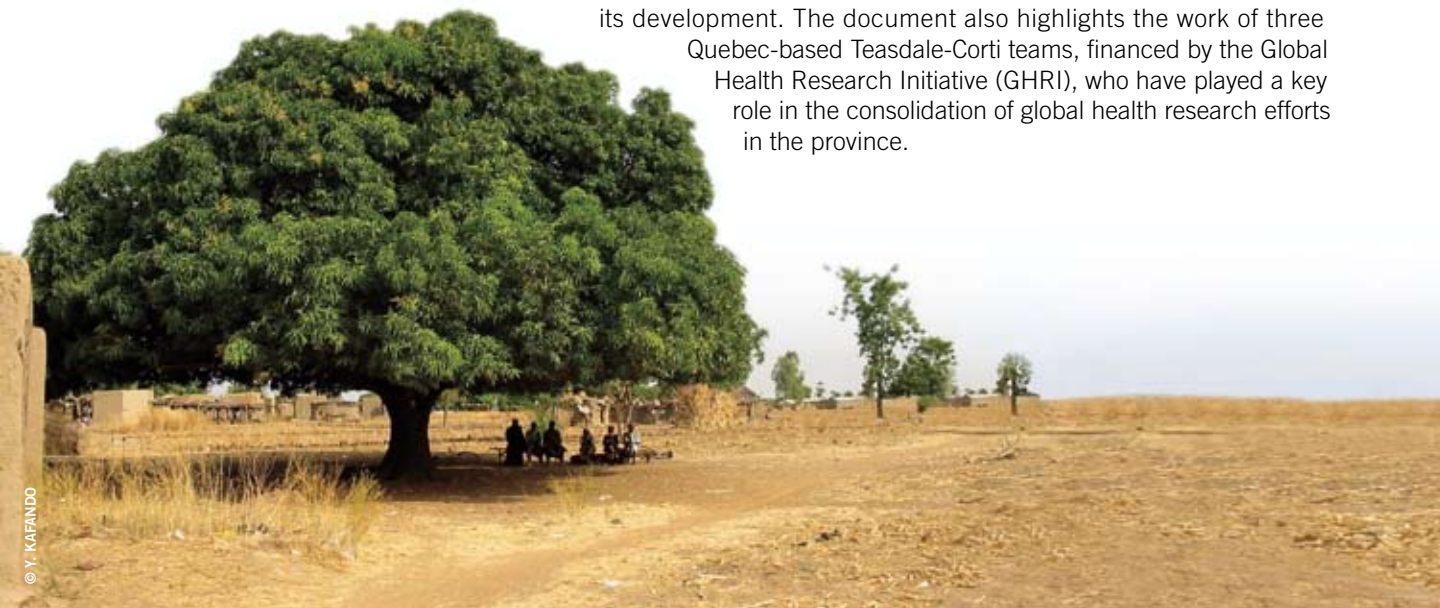
Institut national
de santé publique

Québec 

GLOBAL HEALTH RESEARCH IN QUEBEC

Social inequality, the degradation of ecosystems, sedentarity, poor food habits and stress know no borders. It is these transnational issues that global health research addresses and seeks to improve through interventions in health protection and promotion.

This PopHealth Notes aims to foster awareness among the public health research community on the significant contributions of global health research in Quebec. A growing number of researchers across the province are investing themselves in this domain. This document therefore addresses issues pertaining to training, the development of research capacities, and career opportunities in the field of global health available to young researchers. It presents a brief portrait of global health research in Quebec and identifies several recommendations to further favour its development. The document also highlights the work of three Quebec-based Teasdale-Corti teams, financed by the Global Health Research Initiative (GHRI), who have played a key role in the consolidation of global health research efforts in the province.



Global Health Research: An overview

Global health research responds to the need to produce and integrate knowledge for interventions and policies that contribute to the achievement of the Millennium Development Goals, three of which are health-related. Global health research is thus defined less in terms of a disciplinary approach, or a particular field of study, but rather by its engagement in public health issues that affect the entirety of the world's population. In this respect, it concerns primarily populations living in low and middle income countries (LMIC), where needs are great and far from being satisfied. These countries shoulder a disproportionate burden of the global preventable mortality and morbidity.

Further information on the Millennium Development Goals of the United Nations can be found at <http://www.un.org/millenniumgoals/>



Global health does not only concern LMIC, however. The interconnection of people, of goods and of ideas is accompanied by a globalisation of environments, of lifestyles, and of public health issues. Recent zoonotic diseases, the extension of the basin of communicable and noncommunicable diseases formerly confined to developing areas of the world or particular climates, are expressions of the globalization of health and illness risks. These issues illustrate the need to implement transnational solutions based on informed knowledge of global processes of production and communication of knowledge.

Global health research is, of course, usually carried out in the context of North-South research partnerships and reflects the concern of the international community to correct the existing imbalances in the allocation of research funding. Nonetheless, it does not only serve LMIC and it does not inscribe itself in a development aid philosophy. Global health research responds to the realities of a multicultural Quebec society open to the world.

This is referred to as the “10/90 Gap”; 10% of health research funds target the needs of 90% of the world's population living in low and middle income countries.



The Quebec community of researchers is particularly active and renowned for its work in several key themes of study: environmental health, women's health, migrants and indigenous peoples, maternal mortality, the epidemiology of the response to HIV/AIDS, international nutrition, the analysis of inequities in health and access to health care, financing and the evaluation of health systems.

The Teasdale-Corti Teams of Quebec

In 2007, 13 teams across Canada were awarded the prestigious GHRI-Teasdale-Corti Team Grants, averaging \$1.5 million each over a four-year period. Four of the successful teams are housed in Quebec's four major universities: Laval, McGill, Montreal and UQAM. The research programmes are representative of the wide spectrum of themes that constitute global health:

- land use, environment and eco-system health [UQAM];
- mental health of populations exposed to organized violence and complex emergencies [MCGILL];
- foodborne, waterborne and zoonotic diseases [LAVAL];
- vulnerability and equity in public policies and health systems [MONTRÉAL].

The Teasdale-Corti teams are widely recognized as an important asset in the consolidation of global health research efforts in Quebec. They dispose of considerable resource-mobilizing potential and may act as catalysts and grounds for convergence of global health research in the province. Above and beyond research programmes, the teams each include strong components in capacity strengthening and knowledge translation. They are led by established researchers and partners in Canada, Africa, Asia and Latin America and the Caribbean. The teams therefore constitute exceptional training environments for students and emerging researchers from Quebec and LMIC.

The following examples of knowledge translation illustrate the contributions of the Teasdale-Corti teams to global health research in Quebec.



POOR LAND USE AND POOR HEALTH: A PROJECT OF SOUND LAND-USE FOR SMALL-SCALE FARMERS OF THE HUMID TROPICS TO IMPROVE HUMAN HEALTH

COUNTRIES

Canada, Brazil

PRINCIPAL INVESTIGATORS

Marc Lucotte

Université du Québec à Montréal,
Canada

José Drummond

Centro de Desenvolvimento
Sustentável, Universidade
de Brasília, Brazil

The PLUPH project (acronym for *Poor Land Use, Poor Health*) is a participative research programme targeting capacity strengthening and knowledge translation, that aims to reduce the severity of two emerging and synergistic health problems widespread in the small-scale farming communities of the Amazon: chronic exposure to mercury through the ingestion of contaminated fish, and the transmission of Chagas disease by triatomines, insect vectors of a potentially deadly protozoa. Recent studies suggest that the two problems – which can lead to serious and insidious effects on the immune, neurological and cardiac systems of humans – are linked to the rapid and generalized degradation of the environment, and in particular to slash-and-burn agricultural practices in the humid tropical forest. The PLUPH project therefore aims to contribute to the primary prevention of these problems by developing and testing sustainable land use practices in three typical pilot communities of the Rio Tapajós region, spanning traditional riverside communities to those recently established as a result of planned government colonization initiatives. The project also aims to spatially model the risk of exposure to mercury and Chagas disease at the regional level taking into consideration geological, topographical, edaphic, vegetation and land use characteristics of the area. The project was developed using a collective approach and is lead by a multidisciplinary team of university researchers from Brazil, Canada, and France, representatives from the Brazilian government (specialized in agricultural development, settlement practices and public health) and local opinion leaders.

Sustainable development of communities and research capacities

The expected results – which will effectively link health, environment and social factors – will contribute to case studies of best practices in sustainable development in small-scale farming communities in humid tropical regions. The case studies will be applicable to other regions of the Brazilian Amazon, or neotropical regions with similar characteristics. Significant knowledge gaps will be addressed through the capacity strengthening of several masters and doctoral students; training comprising an integral component of the programme. All knowledge gained through this project will contribute to the development of a dynamic conceptual model that will serve to communicate integrated findings to knowledge users.



TRAUMA & GLOBAL HEALTH (TGH) PROGRAM

COUNTRIES

**Canada, Guatemala, Nepal,
Peru, Sri Lanka**

TEAM LEADERS

Duncan Pedersen

McGill University, Canada

Víctor López

Centro de Investigaciones
 Biomédicas y Psicosociales,
 Guatemala

Bhogenbra Sharma

Centre for Victims of Torture, Nepal

Marina Piazza

Universidad Peruana Cayetano
 Heredia, Peru

Laksiri Priyadarshana

Chamindra Weerackody
 People's Rural Development
 Association, Sri Lanka

There is growing consensus that political violence, civil wars and armed conflict as well as natural disasters have both short- and long-term health consequences for individuals and communities, substantially increasing the risk of disease, disability, injury, and death from a wide range of causes. In order to better understand this issue, the Trauma & Global Health (TGH) Program aims to build a sustainable research environment in partnership between McGill University and research teams and their host institutions from four LMIC: Guatemala, Nepal, Peru, and Sri Lanka. TGH will enable country teams to conduct a research and action program of advanced studies, capacity building, continuing education, and knowledge translation in the social and cultural dimensions of mental health. The ultimate objective of the program is to reduce the mental health burden of civilian populations exposed to protracted and endemic political violence and episodic natural disasters, foster the process of healing, psychosocial rehabilitation and recovery, and generate improved mental health policies and services in partner countries.



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The research and action program is currently underway in all four countries. A range of capacity building activities have been carried out, among them the First International Global Mental Health Course (GMHC-1), held in Guatemala City, Guatemala, in April 2007, and the GMHC-2 held in Colombo, Sri Lanka, in January 2008. The two courses drew more than 280 participants in both countries. In addition, the “McGill 13th Summer Program in Social and Cultural Psychiatry” was successfully carried out in May-June 2007, within which a Seminar entitled “Rethinking Trauma: Social, Cultural and Psychological Perspectives” was held with 35 students enrolled.

The TGH web page is updated on a regular basis. It contains programme details, and a Resource Centre including a collection of documents, conference videos, opportunities for McGill students, and other relevant materials.

<http://www.mcgill.ca/trauma-globalhealth>



Fast-acting knowledge translation

Peru's coastal areas were hit by an earthquake in August 2007. The epicentre was close to an active fault line 200 km south of the capital city, Lima, and measured 8.0 on the Richter scale. The quake affected the departments of Pisco, Ica and Chincha, killing over 500 people and injuring more than a thousand others. Some 100,000 people were also left homeless. The TGH-JEC team immediately approved \$20,000 in additional funding to respond to the emergency. Marina Piazza, TGH-Peru team leader, in collaboration with McGill-based TGH team, the Peruvian Ministry of

Health, PAHO/WHO, Paz y Esperanza (Peruvian NGO), and the Coordinadora Nacional de Derechos Humanos, organized a field visit to the affected areas. A national workshop (145 participants), followed by a series of workshops at the local level (135 participants) were organized in September 2007 to train professionals, health workers and other first responders from the affected areas in disaster management and psychosocial interventions. The workshops aimed to equip local actors with the necessary skills to effectively respond to emerging needs of earthquake victims.

This example of rapid and timely knowledge translation is only one of the many possibilities that derive from the formation of a team of international experts who work in close collaboration with local partners on the field. Making evidence-informed knowledge readily available contributes to capacity building of local health actors and, ultimately a more effective response to urgent health questions posed by complex emergencies.

“VULNÉRABILITÉ ET ÉQUITÉ EN SANTÉ EN AFRIQUE” TEAM

COUNTRIES

Canada, Burkina Faso, Mali

TEAM LEADERS

Slim Haddad

Pierre Fournier

Université de Montréal, Canada

Baya Banza

Université de Ouagadougou,
Burkina Faso

The health components of the strategic frameworks on poverty reduction and programmes that work toward the attainment of the Millennium Development Goals suffer from a double deficit in terms of available evidence and the development of policies that respond to local realities. The *Vulnérabilité et équité en santé en Afrique* team aims to improve the development and the effectiveness of health policies and programmes in order to better respond to the needs of vulnerable groups and populations.

The team is composed of Canadian and African researchers, among whom seasoned researchers act as mentors for researchers who are beginning their careers or still in training. The programme consists of several research projects grouped into four thematic axes that each target a priority vulnerable group: young girls in urban areas in a context of

vulnerability, pregnant women exposed to an elevated risk of maternal mortality, people infected with HIV or at risk of contracting the virus, poor people at risk of exclusion from health services. The implementation of the projects is enriched by transversal themes of work (analysis of the World Health Surveys, pooling of evidence-based results to guide health systems), and by the systematic integration of the gender dimension – a key determinant of vulnerability. The translation of research results into practice



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Further information on the
*“Vulnérabilité et équité en santé en
 Afrique”* team can be found at

<http://www.medsp.umontreal.ca/vesa-tc/>



and the strengthening of research capacities in partner countries are central activities that are favoured by the composition of the team, which unites Canadian researchers with African researchers, decision-makers, and practitioners.

Access to Healthcare: The selection of indigents

ACCESS TO HEALTHCARE TEAM

Valéry Ridde
Abel Bicaba
Slim Haddad
Yamba Kafando
Maurice Yaogo
Moctar Ouedraogo
Omar Sanfo
Norbert Coulibaly

The access to healthcare component of the *Équipe vulnérabilité et équité en santé en Afrique* initiated their first project in the fall of 2007 in the district of Ouargaye. This project builds upon an action-research project financed by the International Development Research Centre that aims to improve access to the healthcare system for indigents in Burkina Faso. The research project seeks to compare the efficacy of two indigent selection processes that allow a limited group of poor people to benefit from the gratuity of medications and medical consultations in a context where all patients must pay out-of-pocket for health services. To do so, the researchers compared the characteristics of indigents selected by health centre nurses at the time of medical consultation with those selected by a village committee through a participative process prior to medical consultation. Predetermined criteria were not used by either the nurses or the village committee. Preliminary results indicate that the nurses selected people living in households whose characteristics revealed a degree of poverty slightly higher than that of the general population. The village committee, on the other hand, identified individuals who are much poorer and live in the most precarious situations in a general context of extreme scarcity of resources. Analyses led to possible explanations for the difference observed between the two methods of selection. In the case of the nurses, medications provided free of charge come from State allocations. In the case of the village selection committee, the care of indigents is ensured with funds from the local management committee using the profits of medication sales (Bamako Initiative). The villagers believe that in a context of generalized poverty – such as that of Burkina Faso – those who are most extremely affected deserve to be qualified as indigent.



Since the study was carried out, a list of 20 criterion based on the characteristics issued from the community selection has been given to nurses in other health centres who will now use them to select indigents. It remains to be determined whether this targeting process is more effective than the former system.

Training Needs for Global Health in Quebec

One of the main conclusions drawn by young researchers from Canada and LMIC following a workshop for new researchers organized by the Canadian Coalition of Global Health Research in Halifax in 2004 was that doctoral students and postdoctoral researchers need to be recognized as an important resource in the development

For more information on the methods and results of this study, please consult articles 3 and 4 listed in the reference section (page 12).

of research in the field of global health¹. Two young researchers, Valéry Ridde and Katia S. Mohindra, recently undertook a study to explore ways of encouraging students and young researchers to pursue graduate studies in global health. Their study, whose main conclusions are presented below, identifies “opportunities and threats” that global health research faces in the Quebec context and discusses career perspectives in the field.

Main observations of the study

The majority of the main universities in the province offer post-graduate training in public health. Twenty-seven courses were identified that broach the subject of global health from various disciplinary perspectives, including epidemiology, economics, demography, health services administration, etc. In three of these universities (Laval, McGill, Montreal) an introductory course to global health is offered.

The authors counted 36 researchers who actively engage in the field of global health. The proportion of their time devoted to this area of work is variable; ranging from 15 to 100%. Using available information, 56 global health research projects conducted in the last five years were identified in the four universities. This is quite likely an under-estimation as such information is not readily available. Several universities work on similar themes, for instance HIV/AIDS, which is the most commonly studied. Nonetheless, each university seems to have created a niche in a particular area of study; McGill for infectious diseases, Montréal for health systems and UQAM for environmental health.



To further understand the internal and external contexts of the universities with respect to global health, a survey, interviews, and a symposium were held with various stakeholders. Through these activities, the perspectives of students, researchers, professors, deans, and representatives of funding agencies were collected. Table 1 provides a summary of their responses.

TABLE 1 OPPORTUNITIES AND THREATS FOR A QUEBEC UNIVERSITY THAT OFFERS COURSES AND CONDUCTS RESEARCH IN GLOBAL HEALTH

OPPORTUNITIES

- Context of globalizing health problems
- Political will of the university with respect to international issues
- Quebec a leader in the field as compared to other provinces
- Research that is close to populations and their needs
- Recognized importance of reducing prejudices with respect to Southern researchers and promoting the quality of their research
- Outcomes of intercultural exchanges
- More occasions to meet with high level researchers outside the local/national context

THREATS

- Barriers to financing innovative projects
- Limited availability of young professors to forge partnerships that take long to develop
- Requirement for students to focus on other aspects of their basic training
- Universities must offer global health in order to stay competitive and avoid being marginalized
- Possibility of aggravating North-South imbalances if partnerships are not equitable

In summary, the study identified a strong and growing involvement of Quebec universities in the field of global health. Despite variations across settings, there exist several excellent opportunities to further develop this field of research. These results were presented and discussed at a symposium held in May 2007 in Trois-Rivières. The recommendations below reflect these discussions and identify ways to favour the involvement of students, young and new researchers in the field of global health (Table 2, page 10).

TABLEAU 2 RECOMMENDATIONS

To researchers

- Create operational alliances with nongovernmental organizations and civil society
- Systematically foresee the involvement and training of students in research projects
- Participate in the development of a teaching manual and involve students and young researchers in the writing process

To university authorities

- Create teaching and research positions in global health
- Create an internal position on information regarding education and research in global health
- Develop programmes specific to global health (MSc in global health with intervention and research components) and/or include a global health component to all public health courses
- Develop new courses specific to global health, taught in an interdisciplinary perspective in universities where these do not yet exist
- Create a visiting professor position to regularly accommodate professors from abroad

To funding agencies

- Mobilize all the funding agencies in Quebec to organize a doctoral and master's bursary competition specific to global health, without disciplinary restrictions
- Systematically foresee a budget for travel and for the communication of results after data collection in doctoral and master's research bursaries
- Organize a competition for the creation of research chairs in global health for young researchers with support for the development of research partnerships with one or more researchers abroad
- Organize a funding competition for the partnership development and support to emerging projects specific to global health
- Allow postdoctoral researchers to be principal investigators on funding proposals

The Role of the Global Health Research Network of the QPHRN

The union of four major federal institutions (CIHR, IDRC, CIDA, and Health Canada) under the umbrella of the GHRI constitutes an important source of opportunities for Quebec-led global health research. Within this context, the Global Health Research Network of the Quebec Population Health Research Network (QPHRN) was created in 2005 with the aim of promoting competitive Quebec-led research in the domain and to maximize the existing potential in the province. The Network plays an important role in the favourable positioning of researchers from the province in national funding competitions.

Conclusion: Challenges

The diversity in research themes in global health illustrates both the scope and the complexity of the field. The commitment to population health from a global perspective situates it at the crossroads of a variety of fields of study and scientific traditions – fundamental and biomedical sciences, population and social sciences. Global health research is also a field that demands varying degrees of coexistence between fundamental research, strategic research (research on causal mechanisms) and intervention research (development, implementation, evaluation).² This diversity constitutes both a strength and a challenge for researchers in the field who must be able to converge around common interests, values, or practices to contribute to collectively forging an identity distinct to global health research.

The challenge is therefore to engage the community of researchers in a process of appropriation of the complexities of global health and a firm commitment to the formidable task of developing common theories, methods and techniques. Such a commitment would contribute to the redefinition and enrichment of our understanding of the social and biological determinants of health and favour the development, the implementation and the sustainability of effective and equitable health interventions destined for vulnerable populations around the world.

THE ACHIEVEMENTS OF THE GLOBAL HEALTH NETWORK OF THE QPHRN

The Global Health Research Network of the QPHRN devotes its work to three types of activities:

1 Strengthening of Quebec's competitive research advantage

Regular contributions seek to ensure the favourable positioning of Quebec researchers with respect to federal and international funding agencies who promote or finance research in global health. The principal modality consists of granting funds to researchers through a competitive selection process to assist in the preparation of research proposals or the development of partnerships (five competitions held since 2005).

2 Research capacity strengthening

Research capacity strengthening targets primarily students or researchers in the early stages of their careers. Bursaries are offered to encourage student participation in events taking place in Quebec and abroad. The Network supports an annual student-led initiative called the WHO Simulation. It backed a study that sought to analyze the involvement of young researchers and career perspectives in global health (see page 8) and played a leadership role in the development of a proposal that was submitted to CIHR for a strategic training programme that unites the four Quebec-based Teasdale-Corti teams.

3 Support to the research community

Support to the research community is provided in various forms: networking, monitoring, exchange and communication activities, and support to emerging partnerships in Quebec or abroad. Three conferences have been held that brought together the majority of the Quebec community of global health researchers (2003, 2006, 2007). The Network also encourages the *Fonds de recherche en santé du Québec* to support the development of Quebec capacities in the domain.

QPHRN

Created in 2002, the Québec Population Health Research Network (QPHRN) is a network of approximately 600 researchers working in the fields of public health, population health, health care services, health policy and health and society. Its mission is to support research infrastructure, innovative, multidisciplinary scientific activities and publications, champion a new generation of young researchers by funding graduate studies, and foster knowledge sharing. Its ultimate goal is to identify, understand and act on the social determinants of health to improve the health of populations. The scientific director is Dr. Gilles Paradis.

Knowledge Sharing and Application Group

The *PopHealth Notes* series is an initiative of the QPHRN's Knowledge Sharing and Application Group (*Axe Partage et utilisation des connaissances*). The group's research mandate is to sensitize researchers, public policy decision-makers, central and regional managers, and local workers in the field to the findings of health and population research and the issues raised by them. The group's activities reflect a two-pronged role – supporting other research themes of the QPHRN and initiating new projects designed to increase the sharing and application of knowledge in population health. The group is composed of Pierre Bergeron (INSPQ [*Institut national de santé publique du Québec*] and QPHRN), Marie-Claire Laurendeau (INSPQ and QPHRN), Pierre Joubert (INSPQ and QPHRN), Joseph Lévy (UQAM [*Université du Québec à Montréal*] and QPHRN) and Karine Souffez (QPHRN).

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Karine Souffez
514-864-1600, ext. 3607
karine.souffez@inspq.qc.ca

Authors

Slim Haddad
Robert Davidson
Consuelo Errazuriz
Valéry Ridde
Kimberly Munro

Translation

Kimberly Munro

Coordination

Pierre Bergeron
Marie-Claire Laurendeau
Karine Souffez

Graphisme : Lucie Chagnon

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