



## Message from the Scientific Director

**I** am writing this letter as I fly home from Brussels, having been at an independent expert advisory group meeting to discuss the future of public health research in the European Union Framework Programme for Research and Innovation. This is just one example of how our Institute is working with international colleagues to foster cross-learning on a range of issues that are pertinent to our strategic directions. Contributing to these types of deliberations extends the reach and impact of our Institute's efforts to build the field of population health intervention research.

There have been a number of recent opportunities for these kinds of interactions. I attended the World Congress of Public Health Associations event in Ethiopia in April. Some highlights of this Conference are provided in this newsletter. Erica Di Ruggiero attended the American Public Health Association Conference, Sarah Viehbeck and I attended the European Public Health Association Conference, Emma Cohen and Kim Gaudreau attended the CIHR Gender and Health Research Conference, and I also attended the Second Global Symposium on Health Systems Research. These venues provide an important means to work with other partners to foster joint initiatives between CIHR and international funding agencies. These have already led to a number of joint initiatives and funding opportunities. Among these are the series of symposia on population health intervention research held jointly with the CDC, meetings with journal editors that led to a call for papers on popula-

tion health intervention research in Preventive Medicine, and joint efforts to strengthen the area of population health ethics.

Institute Advisory Board (IAB) members continue to play a critical role in helping to build these networks and the opportunities afforded by them. I want to thank IAB members who completed their terms with us this summer—they have each left an indelible mark on the Institute. Susan Kirkland ably served as our Vice Chair and provided highly valued input on evaluation matters. Margaret Whitehead completed her second term with the IAB. The depth of her reflections on determinants of health and evaluation and the links she helped to forge with research councils in the UK was much appreciated. Tim Evans was one of our global health gurus, who added critical and pragmatic insights to our deliberations. Norman Daniels was the ethics designate for our board and provided expert advice from this perspective. We will miss all of



**Dr. Nancy Edwards**  
Scientific Director  
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them. But IAB membership renewal continues; at our October IAB meeting, we welcomed three new members, who bring international experience and diversity to our Board. David Peters is Professor and Associate Chair of the Department of International Health and Director of the Health Systems Program at Johns Hopkins Bloomberg School of Public Health. He is a Canadian, originally from Manitoba. Mark Petticrew is a Professor of Public Health Evaluation in the Department of Social and Environmental Health Research in the Faculty of Public Health and Policy at the London School of Hygiene and Tropical

Medicine and has worked with the IPPH-funded Population Health Intervention Research Centre at the University of Calgary and participated in our population health intervention research conference earlier this year. Angus Dawson is Professor of Public Health Ethics and Head of Medicine, Ethics,

Society & History at the University of Birmingham, UK. Angus is our new IAB ethics designate. He was based at the University of Toronto from 2007-2009 and continues to be involved in a number of projects in Canada including being part of the working group that produced the recent white paper on ethical

considerations relating to non-research public health interventions for Public Health Ontario. We look forward to their ongoing contributions at our board meetings.

Wishing you and your networks a wonderful fall and winter and see you again in 2013!

## — INSIDE THIS ISSUE —

<b>Applied Public Health Chair Feature: James Dunn .....</b>	<b>3</b>
<b>Programmatic Grant Feature: PATHS Equity.....</b>	<b>4</b>
<b>Student Corner .....</b>	<b>7</b>
<b>Redesigning Care Models for HIV Positive Indigenous Women in Indonesia .....</b>	<b>7</b>
<b>Investigating Public Health Approaches to Controlling Drug Use Harm .....</b>	<b>8</b>
<b>IPPH Students Reflect on Summer Employment .....</b>	<b>9</b>
<b>Public Health Conferences .....</b>	<b>10</b>
<b>World Congress of Public Health.....</b>	<b>10</b>
<b>Increasing Policy Influence and Engagement of National Public Health Associations in Africa: Progress and Challenges .....</b>	<b>10</b>
<b>Towards Global Health Equity: Opportunities and Threats .....</b>	<b>11</b>
<b>Finding the Air Space: The Contribution of Public Health Associations to the Protection of Exposure to Tobacco Smoke .....</b>	<b>12</b>
<b>Key Lessons .....</b>	<b>13</b>
<b>Canadian Public Health Association Conference .....</b>	<b>14</b>
<b>Public Health: Thinking Towards a System 3.0 .....</b>	<b>14</b>
<b>Perspectives on Health Inequity: Local to Global Food Insecurity .....</b>	<b>16</b>
<b>Participants in the Spotlight: Dr. Nonsikelelo Mathe .....</b>	<b>17</b>

## Applied Public Health Chair Feature: James Dunn

Article by Andrea Hill, Student, CIHR-IPPH

**T**he redevelopment of Toronto's Regent Park social housing neighbourhood may only be in its initial stages, but one of Canada's leading researchers in housing and health is already convinced the project is on the right track.

"The early results of the Regent Park study are showing improvements in housing satisfaction, neighbourhood satisfaction and people's feelings of safety and security," says James Dunn, Applied Public Health Chair of the Canadian Institutes of Health Research and the Public Health Agency of Canada. "It's kind of an affirmation that what they're doing is correct."

Dunn, who is also an associate professor at McMaster University and a scientist at St. Michael's Hospital in Toronto, primarily studies how housing interventions and policies affect the health of populations. He began studying the health impacts of the six-phase Regent Park redevelopment in 2005, shortly after the City of Toronto approved plans to rebuild the neighbourhood of 12,500 residents. Back then, the neighbourhood was solely comprised of social housing units intended for people with the lowest incomes. Now it is gradually being transformed into a mixed-income community. The revitalization project, which is entering its second phase, is expected to take 15 years.

Researching the effects of such a redevelopment is a natural fit for Dunn who has long been fascinated with how people's living situations

affect their health.

"We know that there's a social gradient in health whereby the greater your income the better your health status, but that probably underestimates the true level of inequality that exists in Canadian society," Dunn says. "Housing is a pretty significant engine of inequality, but it doesn't show up on people's reported income."

Dunn started his career doing cross-sectional research which involves looking at people's health and living conditions at a single point in time. But he quickly realized that valuable information about housing and health could be obtained by tracking people over an extended period.

"Every day people are moving from one residence to another," Dunn explains. "So if there's some way I can harness that and wrap a study design around it, then it will be really incredibly valuable from a research and a decision-making perspective."

And that's exactly what Dunn is doing.

In Regent Park, his research team is interviewing tenants in various stages of the redevelopment. Baseline interviews were completed during phase one of the project and



**Dr. James Dunn**

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Scientist, St. Michael's Hospital

further interviews will be conducted as the redevelopment unfolds.

Following people over a long time period like this is a difficult and lengthy procedure, Dunn says. But it's a process that ensures an essential body of knowledge is collected and considered.

"People live complicated lives and they can be difficult to get a hold of," Dunn explains. "It's very costly to keep track of people and follow them through time because they tend to move, change phone num-



bers, that sort of thing, quite frequently.”

In addition to studying the health of Regent Park tenants, Dunn is also evaluating a neighbourhood development initiative underway in Hamilton and is doing work in the Greater Toronto Area looking at adult mental health and child development in families who are placed in subsidized housing for the first time.

It's cutting-edge research like this that led to Dunn being named William Lyon Mackenzie King

Visiting Professor in Canadian Studies at Harvard University's Weatherhead Center for International Affairs last year. While at the Boston campus, Dunn shared his research experiences with students and colleagues and rubbed shoulders with some of the other big names in neighbourhood development research.

“It was just fabulous on so many levels — I learned a ton,” Dunn says.

At Harvard, Dunn says he was able to build connections that may prove invaluable as he experiments with

new technologies that could enhance his research in Canada. In particular, he is planning to purchase a special vehicle equipped with high-tech cameras so that he can analyze videos of neighbourhoods for signs of physical and social disorder — factors that are associated with population health outcomes. The equipment, which has been previously used to study American neighbourhoods, could be ready to make its debut in Hamilton as early as this spring. It will be the first time such technology has been used in Canada.

## Programmatic Grant Feature: PATHS Equity

*Principal investigators Drs. Pat Martens, Marni Brownell, Alan Katz, and Dan Chateau and 14 co-investigators received one of 11 Programmatic Grants in Health and Health Equity funded by CIHR-IPPH and other partners. “PATHS Equity” is an acronym for “Pathways To Health and Social Equity.” This is a program of research that looks into what works to reduce the socioeconomic gap in health and wellness outcomes for Manitoba's children. Dr. Martens (PM), director of the Manitoba Centre for Health Policy, talks about this research with Elaine Burland (EB), the research project manager for the Manitoba Centre for Health Policy.*

### **EB: Can you describe your program of research?**

PM: We are undertaking a series of inter-related sub-projects, each of which will assess the impact of various interventions aimed at improving the health and social outcomes for children. In the final stage of the program we will look at the combined effects of being exposed to these interventions.

### **EB: What is the goal of your program of research?**

PM: Our goal is to understand and evaluate the impact of specific interventions on the

health and well-being of children using administrative databases. We will evaluate the interventions to see which ones are associated with improved outcomes for children — in other words, which ones are associated with better health and well-being and reduced inequities. As well, we will explore the potential benefits and impacts on health inequities from integrated child health programs and policies. For selected outcomes we will examine additional factors that hinder or facilitate the reduction of inequities for children.

This work will help to enhance population-based methods for measuring equity using administra-

tive data, thereby creating a capacity for understanding what works to reduce inequity in children's outcomes.

### **EB: Who is on the research team?**

PM: The team consists of research scientists, graduate students, regional and provincial policy makers and planners, NGOs and clinicians. The Manitoba Centre for Health Policy (MCHP) has an internationally acclaimed team of scientists and houses one of the most comprehensive administrative data repositories in the world, so we are extremely well-positioned to conduct this re-



Drs. Alan Katz, Elaine Burland, Pat Martens, Marni Brownell and Dan Chateau of the PATHS Equity project

search. There is also strong commitment and support from top-level institutions, government and regional health authorities.

**EB: Why do you focus on children?**

PM: We are building on the findings of a 2009 report by Canada’s Chief Public Health Officer (*Growing Up Well – Priorities for a Healthy Future*). The impact of socioeconomic status (SES) on a child’s developmental opportunities was identified as a key issue – the best returns on investments are those that contribute to children’s well-being, which in turn reduces future spending on health, social and justice services. Our research covers many

of the recommended areas of intervention including adequate housing, environments (home, school, community), family influences, early care and development, access to primary care, school readiness, breastfeeding, physical activity and nutrition.

We are extremely well-positioned to explore what contributes to ‘growing up well’ by building on a province-wide capacity and commitment to evaluating health and social programming and by extending this work to examine how interventions reduce inequities in children. Strong relationships already exist between MCHP, policy makers, planners and social agencies and this will facilitate a ‘research to action’ approach<sup>1,2</sup>.

**EB: What kinds of interventions are you studying?**

PM: We will be examining 13 different interventions, plus studying the feasibility of developing a new “indicator” for public health and examining mechanisms that lead to inequity through a qualitative analysis.

The 13 interventions being studied are:

- 1) the Baby Friendly Hospital Initiative,
- 2) the Physician Integrated Network,
- 3) an Early Intervention for ADHD,
- 4) the Early Psychosis Prevention and Intervention Program,
- 5) In-School Teen Clinics,
- 6) the Healthy Baby Program,



- 7) the Families First Home Visiting Program,
- 8) Social Housing,
- 9) Community Schools Investigator's Summer Learning Enrichment Program,
- 10) Healthy Buddies,
- 11) Roots of Empathy,
- 12) Full-Day Kindergarten, and
- 13) Signs of Suicide program.

To develop a new indicator for public health, we are hoping to approximate a public health sensitive conditions indicator parallel to the Ambulatory Care Sensitive Conditions indicator that was developed in relationship to hospitalizations. This indicator looks at chronic conditions such as asthma, diabetes and hypertension that can be managed in the community but could result in hospitalization in an acute care facility. We will use a Delphi process to examine what conditions would have been avoided if proper public health care were in place.

**EB: What are your data sources and research methods?**

PM: We will be using many of the population-based databases in the Repository at the Manitoba Centre for Health Policy

(MCHP). These contain anonymized data on health and social service use and outcomes, including vital statistics, use of physicians and hospitals, immunizations, educational outcomes, early childhood intervention programs, child welfare, social assistance and use of public housing.

Our methods will build on previous work at MCHP published in *Health Inequities in Manitoba: Is the Socioeconomic Gap in Health Widening or Narrowing Over Time?*<sup>3</sup> which measured whether socioeconomic gaps in health are widening or narrowing over time. We will create neighbourhood income groupings using postal code and census data in order to examine geographical and socioeconomic inequities, the pathways to children's health and social equity and the effects of various health and social program and policy interventions.

Our research team will work collaboratively using an integrated Knowledge Translation approach which involves knowledge users in the entire process – they help formulate the research questions, review the analyses and communicate and apply the findings. This leads to evidence-informed decision-

making. Each individual sub-project has its own team, including researchers and knowledge users, and its own specific objectives. All will assess whether the intervention was associated with a change in outcomes and/or gradients and whether it reached its target population.

**EB: Compared with conventional operating grants, what is the value of a programmatic research approach?**

PM: The benefit of a programmatic grant compared to conventional operating grants is the ability to examine the combined effects of the individual sub-projects. In this program of research we can answer the questions “what happens to children with multiple exposures to different interventions?” “Which intervention or combination of interventions appears to have the biggest effect on outcomes?” “At what level do interventions show the biggest benefits or the greatest decrease in inequity – are targeted or universal interventions more effective (i.e., should the intervention be at the level of individuals, families, schools, communities or the province)?”

**“This work will help to enhance population-based methods for measuring equity using administrative data, thereby creating a capacity for understanding what works to reduce inequity in children's outcomes.”**

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# Student Corner

## Redesigning Care Models for HIV-Positive Indigenous Women in Indonesia

In Papua, Indonesia, where I have worked since 2006 as an anthropologist, rates of HIV infection are increasing faster than elsewhere in the region, with almost 3 percent of the population testing HIV positive. Even though Papua is experiencing a generalized HIV epidemic that disproportionately affects indigenous persons, indigenous voices and experiences have been largely ignored in the government response to the epidemic.

My doctoral project focused on Indigenous persons' experiences of political violence and racism in the context of the Indonesian state's development agenda. When friends and informants from my fieldwork days became infected with HIV and started to die in their twenties, I felt I had to pursue more action-oriented research in which I could play a role in interrogating and re-designing HIV interventions. Funded by a CIHR post-doctoral fellowship, I will explore the impact of indigenous-led population health interventions on women's HIV experiences in Papua.

Exploratory research I conducted earlier this year supported in part by the Victoria, B.C.-based organization, Pacific Peoples Partnership, indicated that HIV services operated by government agencies and indigenous non-governmental organizations reflected starkly different values and approaches with regards to educating, treating, and caring for clients. I wondered about the effects that different models of care have on HIV positive persons,



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especially women, who bear a disproportionate burden of discrimination and stigma, and who increasingly account for most of the newly-detected infections. My research employs qualitative and ethnographic methods to compare the experience profile and health status of women who are receiving HIV treatment from indigenous organiza-

tions and those being treated in government programs. Qualitative and quantitative analyses will identify policy, program, and practice leverage opportunities that are linked to improved health outcomes in order to design and advocate for more effective treatment models.



## Investigating Public Health Approaches to Controlling Drug Use Harm

**G**rowing up in Vancouver allowed me to have an up-close look at the impact drug use can have on individuals and population subgroups. Vancouver's downtown eastside, now famously the site of North America's first supervised injection site, has been the site of twin epidemics of HIV/AIDS and drug dependence for some decades now. Through my research work at the BC Centre for Excellence in HIV/AIDS, I am part of a team of scientists working to investigate evidence-based public health approaches to control the harms of drug use.

As part of this research, perhaps the greatest personal discovery I've had to make is the distinction between drug-related harms and drug *policy*-related harms. For instance, a recent systematic review of the existing peer-reviewed literature on the association between enforcement interventions — such as police crackdowns — and drug-related violence revealed a surprising finding: that the vast majority of scientific

studies investigating this phenomenon reported that drug law enforcement actually significantly increased levels of drug-related violence.<sup>1</sup> Further, a vast scientific literature has demonstrated how the risk of HIV transmission and HIV disease progression among injection drug users is directly linked to certain kinds of enforcement-based responses to drug use.<sup>2,3</sup>

For my doctoral research project, I am identifying risk factors for the initiation of injection drug use among populations living in contexts of vulnerability such as street youth. Using data from Vancouver, it is my hope that this research will serve as a step towards the design and implementation of population health interventions that will prevent people from starting to inject drugs. This prevention has been previously identified as a public health priority by experts in the field of HIV and addictions.<sup>4</sup> I will also address concerns some policymakers in North America have voiced regarding the potential for public health interventions, such as needle exchange programs, to lengthen the



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research.

drug injection practices of their clients. Ultimately, I hope this research can help build a stronger case for interventions that serve the need of our urban populations living in contexts of vulnerability.

**“It is my hope that this research will serve as a step towards the design and implementation of population health interventions that will prevent people from starting to inject drugs.”**

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## IPPH Students Reflect on Summer Employment

*This summer, CIHR-IPPH employed three undergraduate students and one master's of public health practicum student. Students worked on a variety of short- and long-term projects over a four-month period. All were exposed to population and public health research and given an opportunity to apply knowledge from university courses in a professional setting. Two undergraduate students, Alannah Brown and Max Deschner, reflect on a summer that was filled with exciting new experiences and engaged them in meaningful work.*

**Alannah:** As a student in the University of Toronto's Health Studies undergraduate program, I have a background in population and public health. While working for IPPH, I conducted an environmental scan of past CIHR-funded research — a project that contributed to a concept paper for a new initiative. I worked on many other projects spanning different subjects including the built environment and theoretical/methodological innovations. I am fascinated by the field of population and public health and hope to pursue my Master of Public Health in the near future.

**Max:** My summer position at CIHR-IPPH allowed me to learn more about CIHR's role as a health research funding agency. I was able to see how the research process develops and how stakeholders collaborate to ultimately improve health equity in Canada and around the world. Some of my tasks over the summer included a scan of jurisdictional strategies for community-based primary health



IPPH summer student employees from left to right: **Mr. Max Deschner** (anthropology and political science student at McGill University), **Ms. Rachel Maclean** (Master of public health student at University of Toronto), **Ms. Andrea Hill** (journalism and biology student at Carleton University) and **Ms. Alannah Brown** (health sciences and sociology student at University of Toronto)

care in Canada; drafting an annotated bibliography and helping manage a project related to population and public health economics; and compiling information on past CIHR-funded research. I learned to integrate various stakeholder

perspectives and operate in a team-based environment. I hope to pursue graduate studies in population and public health and health policy in the near future.

**“ I was able to see how the research process develops and how stakeholders collaborate to ultimately improve health equity in Canada and around the world.**

**— Max Deschner**

# Public Health Conferences

## WORLD CONGRESS ON PUBLIC HEALTH

With the target date for meeting the Millennium Development Goals (MDGs) fast approaching, many health researchers, academics and policy makers are wondering just how close we are to meeting these aims. Where better to have this discussion than at the 13<sup>th</sup> annual World Congress on Public Health? The congress, “Towards Global Health Equity: Opportunities and Threats,” brought together thousands of public health workers in Addis Ababa, Ethiopia from April 23-27, 2012. The congress was hosted by the Ethiopian Public Health Association (EPHA), in collaboration with the World Federation of Public Health Associations and the Ethiopian Ministry of Health.

**Luis Caceres**, Independent Consultant, attended the conference and reported on sessions that aligned with CIHR-IPPH strategic research priorities and that examined public health efforts towards achieving the MDGs. The congress included panels, posters and oral presentations from academics, governmental officials, nongovernmental representatives and public health practitioners from around the world. International participants from 120 countries were present, with a strong showing from several African countries thanks to efforts by the African Federation of Public Health Associations.

## Increasing Policy Influence and Engagement of National Public Health Associations in Africa: Progress and Challenges

Five representatives from public health associations (PHAs) in Africa and Canada discussed how non-governmental PHAs are able to influence policy and decision-making despite lack of funding and limited access to decision makers. Presenters spoke on behalf of the African Federation of Public Health Associations, the Public Health Association of South Africa, the Canadian Public Health Association, the Uganda National Association of Community and Occupational Health and the Eastern Central and Southern African Federation of Accountants.

A questionnaire distributed by the World Federation of Public Health



Panelists discuss opportunities and challenges faced by non-governmental public health associations.

Associations found that few PHAs are actively involved in policy making with their respective governments because they lack skills and practice in this field and they don't have stable funding sources. For the most part, the main means of policy engagement identified by those surveyed are participating in and organising conferences and seminars

and having limited engagement with politicians and government officials. Lack of funding is a threat for all associations. They are collecting membership fees and receiving corporate donations to sustain some of their public health activities.

The workshop provided a number of recommendations to strengthen policy influence of PHAs. In



addition to developing advocacy skills, PHAs were encouraged to support and facilitate public health research, including connecting with academics for policy making and working with local community stakeholders to collect evidence. The development of volunteer or member-based working groups on specific

public health issues would help PHAs organise and prioritise their policy ideas. In addition, PHAs ought to follow-up on declarations made at conferences and translate calls to action into action. The credibility of PHAs hinges on follow-up and action with their respective governments and local communities. The presenters

acknowledged that PHAs are uniquely positioned to find common ground and achieve government buy-in on public health policies and action despite the limited financial resources of their organizations.

## Towards Global Health Equity: Opportunities and Threats

This plenary session featured three presentations directly addressing the congress theme, including the Leavell Lecture Award presentation by Ethiopian Professor Redda Tekle Haimanot who was honoured for his contribution to public health in Africa in general, and Ethiopia in particular. The presenters spoke about threats to global health equity and recommended actions to counter these.

Redda noted that the biggest threat to health equity in African countries is the failure to achieve agreed-upon targets. For example, though access to safe drinking water is important for health equity – particularly for rural populations – many African countries have not given the Millennium Development Goal target on water and sanitation the attention, leadership or resources it deserves. National health financing also remains a problem as only six of the 53 African Union members have allocated 15% of their national budget to health as prescribed by the Abuja Declaration. Many



A plenary session at the World Congress of Public Health addressed threats to health equity in African countries.

African countries have not defined what accountability or transparency means for public or private donor partnerships despite this being recommended by the World Health Organization (WHO) Commission on Social Determinants of Health. In short, many African countries are failing to implement accepted targets used to address health equity.

Mr. Rudiger Krech of the WHO called on national governments to address the major challenges of

health inequities, which are determined by the social conditions in which people are born, grow, live, work and age. Although the challenges of health inequities are not new, many countries are still not providing their populations with equitable access to health care and health education. Many people are also facing catastrophic health care costs. And even if they could pay, access to health professionals such

as doctors is a significant barrier, particularly in African countries. As a result, many people delay care until their conditions become serious.

Krech also emphasized the important role that public health associations (PHAs) play in

reminding the public and government about the benefits of investing in public health and the consequences of inaction. PHAs can monitor and report health inequities and advocate for a social determinants of health approach to policy. PHAs can also assist in

reviewing the curriculum for public health program graduates and ensure that students are making good health assessments for positive health policy outcomes in the future.

## Finding the Air Space: The Contribution of Public Health Associations to the Protection of Exposure to Tobacco Smoke



**T**obacco use remains one of the major public health challenges facing the global public health community. In recent years, the health threat of second-hand smoke has led many countries to adopt smoke-free legislation. However, the pace of comprehensive legislation has been slow and, as a result, the laws to protect people from second-hand smoke only address a small proportion of the world's population.

Article 8 of the World Health Organization Framework Convention on Tobacco Control (FCTC) requires the adoption of effective measures to provide protection from exposure to tobacco smoke. Guidelines for the article recommended a comprehensive ban on smoking in public places and workplaces without exemptions. But, as this Congress session shows, support for Article 8 varies across countries.

Representatives from four public

health associations identified opportunities and challenges associated with the article. They also reflected on how their association's projects came to fruition and what steps, partnerships, evidence and commitment were required to move ideas forward and obtain government support for projects.

A representative from the Public Health Association of South Africa reported on a study looking at students' perceptions of the



availability and adequacy of tobacco control curricula. The study found that tobacco use and nicotine dependence are prevalent among medical students and that tobacco cessation services are urgently needed. The curriculum on tobacco control was also found to be inadequate and changes are required to encourage medical students to see themselves as advocates and role models for tobacco control.

A second representative from the association spoke about improving guidance for and capacity of health care facilities to design and implement smoke-free policies. A survey administered by the association to hospital staff and patients indicated that those surveyed lacked knowledge

of any institutional tobacco control policy, the harms of tobacco products or the availability of counseling, cessation services or assistance. Although South Africa has strong tobacco control legislation to ban smoking in hospitals, there is still a need to develop institutional policies to further implement existing legislation.

The Vietnam Public Health Association presented its work on establishing smoke free policies for cities in Vietnam. Through the development of advocacy toolkits and other capacity building training for tobacco control activists, the association encouraged the issuance of provincial directives and the dissemination of non-smoking signs and stickers throughout several Vietnamese

communities.

The Uganda National Association of Community and Occupational Health (UNACOH) conducted a survey of smoke-free policies at hospitals and workplaces. Survey results indicate a lack of knowledge of the harms of tobacco use and, limited availability of cessation services and a lack of any written tobacco control policy. UNACOH formed committees to develop smoke-free policies at some sites. UNACOH also led a series of national stakeholder meetings and galvanized the Ministry of Health of Uganda to finalize the National Tobacco Control Policy and persuaded the Ministry of Labour to highlight tobacco control during workplace inspections.

**“In recent years, the health threat of second-hand smoke has led many countries to adopt smoke-free legislation. However, the pace of comprehensive legislation has been slow and, as a result, the laws to protect people from second-hand smoke only address a small proportion of the world’s population.”**

### — Key Lessons from the World Congress of Public Health —

- Lack of funding is a threat for Public Health Associations (PHA’s).
- PHA’s are in a position to influence policy through a variety of mechanisms
- Volunteer or member-based working groups on specific public health issues could help PHA’s organise and prioritise their policy ideas.
- PHA’s ought to follow-up on declarations made at conferences.

# CANADIAN PUBLIC HEALTH ASSOCIATION CONFERENCE

## Public Health: Thinking Towards a System 3.0

Article by Andrea Hill, Student, CIHR-IPPH

One constant amidst a changing public health landscape in Canada has been the characterization of public health as a “system of systems” at the local, regional, provincial/territorial and federal levels. Now, some experts argue it is time to further develop and coordinate these systems and interlink them with groups outside the public health sector.

This view was among those expressed by five public health experts from the local, provincial and federal levels who gathered at a panel discussion in Edmonton as part of the Canadian Public Health Association annual conference in June 2012. The discussion, titled “Public Health — Thinking Towards a System 3.0,” featured talk about changes observed in the nation’s health systems over the past year and the challenges and opportunities these changes have prompted.

Public health promotion and service delivery in Canada involves an array of sectors, said Kim Raine, President (now former President) of the Alberta Public Health Association and one of the panelists. No one group can make significant change alone and so agencies and sectors must work in a coordinated way to make real impacts, Raine said. This collaboration is all the more important in a time of nation-wide funding crunches and political change.

Working with and through coalitions can be very edifying

and important, said James Chauvin, Director of Policy Development for the Canadian Public Health Association. He stressed that his organization is able to shine the spotlight on public health concerns by working with provincial and territorial partners as well as through groups such as the Canadian Coalition for Health in the 21<sup>st</sup> Century and the Canadian Network of Public Health Associations.

An example of other successful alliances can be seen by looking at research funding bodies, said Nancy Edwards, Scientific Director for the Canadian Institutes of Health Research - Institute of Population and Public Health. She explained how the organization’s Institutes are aligning some of their investments in strategic Signature Initiatives such as Community Based Primary Health Care. This type of strategic alignment is mirrored at the international level in initiatives such as the Global Alliance for Chronic Diseases.

Groups working together can also be seen at the provincial level, for example by looking at the imple-

mentation of children’s nutrition guidelines in Alberta, said Margaret King, Assistant Deputy Minister of Community and Population Health in Alberta Health and Wellness. These guidelines, which give concrete suggestions for how schools and other facilities can use Canada’s Food Guide, were put in place after a number of provincial ministries and school boards worked together and signed on to the initiative.

Given that informal collaborations have proved successful, the next step may be to create a formal system of collaboration and information sharing between public health bodies that would work within Canada’s federated system of governance, said Gregory Taylor, Director General for the Office of Public Health Practice in the Public Health Agency of Canada. He explained how this proposed system would need to engage in intersectoral work since many issues require input from bodies both inside and outside the public health sector. He used the development of the North as an example — lack of affordable housing, shortage of drinkable





Panelists Dr. Gregory Taylor, Dr. Nancy Edwards, Dr. Garry Aslanyan (facilitator), Dr. Kim Raine, Mr. James Chauvin and Ms. Margaret King took part in a panel discussion titled "Thinking Towards a System 3.0."

water and high incidence of tuberculosis remain pressing issues in Canada's territories. These are important underlying determinants of population health in Canada's north, but these issues cannot be resolved by public health agencies alone, Taylor said.

Though a more formalized

system of public health collaboration was supported by the speakers, they agreed that this system could take many possible forms. Strengthened systems-oriented approaches to public health issues will likely change and evolve over time as public health workers continue to think creatively and public health bodies maintain and

expand strategic collaborations.

The discussion was the third in an ongoing series looking at public health systems thinking in Canada. It was organized and facilitated by Garry Aslanyan, Policy Manager for the World Health Organization's Special Programme for Research and Training in Tropical Diseases.

**“ Given that informal collaborations have proved successful, the next step may be to create a formal system of collaboration and information sharing between public health bodies that would work within Canada's federated system of governance**

## Perspectives on Health Inequity: Local to Global Food Insecurity

Article by Emma Cohen, Knowledge Translation and Communications Officer, CIHR-IPPH

“

Food insecurity is not the flip side of food security,” explains Dr. Lynn McIntyre who spoke at the CIHR-IPPH collaborator session at the 2012 Canadian Public Health Association annual conference. “The former is tied to inadequate income for acquiring food.”

There is no debate that food prices are increasing on a global scale resulting in more and more people living with food insecurity. The photo on the right depicts the amount of food that could be purchased with 5,000 Kwacha (approximately CAD \$1) in the market in Zambia in 2009. The amount is striking when compared to the photo on the left, which depicts the amount of food that could be purchased with the same amount of currency one year prior.

Perhaps as important as debating the causes of the global food crisis are the debates around the potential solutions.

Dr. Evan Fraser, a second speaker, presented four perspectives on solutions:



Figure 1 Food shopping with 5,000 Kwacha in Lusaka, Zambia.  
Source: <http://www.ids.ac.uk/files/dmfile/AccountsofCrisisFINAL.pdf>

- 1) Technologies to produce better food with less effort, e.g. golden rice.
- 2) Regulating the environment
- 3) Distributing food equitably
- 4) Giving people most affected by fluctuations in food prices the power to influence policies

Fraser argues that “we need it all” — a blend of policies that capture the strengths of all four perspectives.

For example, a multi-pronged approach to solve today’s food crisis could include technology in the form of satellite imagery that shows ground water level and vulnerability hot spots (technological); a regulatory framework (environmental management); food relief (equity and distribution); and more robust local food systems to help serve as a buffer between small scale producers and

consumers and the market (local food sovereignty).

Poverty alleviation is another ingredient for a solution to food insecurity.

Citing research studies, Dr. McIntyre concluded, “Where you live matters, policies matter, and your source of income matters when it comes to food insecurity.” She also found that the gradient of food insecurity is directly correlated to health outcomes.

The population health challenge is therefore not to increase the number of food banks—not only because two-thirds of Canada’s food insecure do not even use them—but because they are a Band-aid solution to a problem that needs to be addressed by structural changes such as a fair minimum wage and affordable housing.

“*Perspectives on Health Inequity: Local to Global Food Security*” was moderated by Dr. Philip Sherman, Scientific Director of CIHR - Institute of Nutrition, Metabolism and Diabetes. Dr. Evan Fraser, Associate Professor at University of Guelph and Dr. Lynn McIntyre, professor at University of Calgary, spoke at the session.

The CIHR-INMD is the lead on Programmatic Grants in Food and Health with support from CIHR-IPPH and other partners.



## Participants in the Spotlight: Dr. Nonsikelelo Mathe

Article by Emma Cohen, Knowledge Translation and Communications Officer, CIHR-IPPH

**D**r. Nonsikelelo Mathe was born in Bulawayo, Zimbabwe's second-largest city, and moved to London, UK for university studies. She notes that the current average life expectancy for a person born in Zimbabwe is approximately 44 years as a result of a combination of factors that include poor access to safe drinking water and prevalence of infectious and chronic diseases.

As a post-doctoral trainee with Dr. Sangita Sharma at the University of Alberta in the Aboriginal and Global Health Research Group, Mathe is building on her PhD research which focussed on the relationship between body composition —the study of fat, bone and muscle content in human bodies — and the development of cardiovascular disease in different ethnic groups. Mathe's current research is in nutritional epidemiology with a focus on Indigenous populations in Canada and populations in Africa.

Her research is exploring the relationship between diet and chronic diseases such as cancer, diabetes and cardiovascular disease. There has been a noticeable increase in chronic diseases in many African countries, but health systems are not adequately prepared to address this



Nonsikelelo Mathe is a post-doctoral trainee at the University of Alberta. She was a delegate at the 2012 Canadian Public Health Association Annual Conference in Edmonton, Alberta.

burden in addition to the burden of infectious disease. Most chronic diseases are preventable through changes in eating habits and lifestyle, however there is a paucity of research and prevention programs for chronic disease in many African countries.

What excites Mathe most is community-based participatory research. Academics sometimes underestimate the power of local knowledge and how it can influence people's health, she says. When using a community-based participatory approach, you engage communities and realize that sometimes solutions are already there in the community. Community engagement also helps ensure program sustainability and effectiveness.

For example, Mathe has been working with a Nunavut community through a CIHR knowledge translation program that seeks to reduce risk for chronic disease through a nutrition and physical activity intervention (Principal Investigator: Dr. Sharma). The program is a spin-off from a larger program titled "Healthy Foods North" that was also headed by Dr. Sharma. That project involved extensive community engagement to ensure program activities were culturally appropriate and reflected the community's needs.

Mathe intends to return to her home continent and hopes to see the day when average life expectancy is significantly improved in Zimbabwe.

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## Announcements

### Report on the State of Public Health in Canada

The “Report on the State of Public Health in Canada, 2012: Influencing Health – The Importance of Sex and Gender” was tabled in Parliament on October 26, 2012.

It explores the influence of sex and gender on public health and the health status of Canadians. Differences in health experienced by men, women, boys and girls can be attributed to biological diversity as well as the social roles and responsibilities assumed by each of us.

As a society we need to better understand how sex and gender interact with other determinants of health. Policy makers need to consider gender-based evidence when making decisions on programs and initiatives to support more effective and efficient health outcomes.

There is a wealth of experience and knowledge in Canada, and around the world, and there are opportunities for positive change. Throughout the report, there are many examples of what is working well and the differences we can make in the lives of Canadians. Collectively we can influence our health and create a better and healthier future for all Canadians.

For more information, visit the website: <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2012/sum-som-eng.php>

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