

April 2014

# Promoting Health Equity: An Evaluation of a Knowledge Translation Project Led by the Saskatoon Health Region's Public Health Observatory

*June 2012 to June 2013*

Final Report

Conducted for: Public Health Observatory, Saskatoon  
Health Region

Conducted by: Mel Brockman, University of  
Saskatchewan



## Table of Contents

---

List of Tables.....	iii
List of Acronyms and Abbreviations.....	iv
Executive Summary .....	vi
1. Preface.....	1
2. Introduction.....	1
2.1 Activities.....	3
2.1.1 <i>Video (Della: Hurdles to Health)</i> .....	3
2.1.2 <i>Dissemination of Student Health Survey Results</i> .....	5
2.1.3 <i>Dissemination of Health Disparities Research and KT Work</i> .....	7
2.1.4 <i>Health Equity Summit and Mobilize! Forum</i> .....	8
2.1.5 <i>Evaluation and Monitoring</i> .....	10
2.2 iKT/Collaboration .....	11
2.3 Logic Model .....	13
3. Purpose of Evaluation.....	13
3.1 Focus of Evaluation .....	13
3.2 Scope of Evaluation .....	14
3.3 Intended Use and Users of Evaluation Findings.....	14
4. Methodology .....	14
4.1 Records Review .....	15
4.2 Key Informant Interviews.....	15
4.2.1 <i>Participants</i> .....	15
4.2.2 <i>Interview Questions</i> .....	16
4.3 Online Survey with Health Equity Summit Participants .....	16
4.3.1 <i>Respondents</i> .....	16
4.3.2 <i>Survey Instrument</i> .....	17
4.4 Online Survey with PHO Network .....	17
4.4.1 <i>Respondents</i> .....	17
4.4.2 <i>Survey Instrument</i> .....	17
5. Results and Discussion.....	18
5.1 Project Design and Implementation (Process Evaluation).....	19

E1. Were all activities carried out as planned? .....	19
E2. Were the activities carried out on schedule? .....	22
E3. Were the target audiences reached? .....	23
E4. Was the process well documented and supported by the literature? .....	26
E5. Were the activities consistent with the definition and intent of KT? .....	28
E6. Which activities or tools were most effective and which were least effective? .....	30
4.2 iKT Approach (Process Evaluation).....	41
E7. How much input did partners have in the project? .....	41
E8. What are partners' perceptions of PHO's engagement and collaboration practices?.....	42
E9. What are staff member's perceptions of PHO's engagement and collaboration practices? ..	45
E10. Was iKT achieved?.....	48
5.3 Short-term Outcomes (Learning) .....	49
5.4 Intermediate Outcomes (Behaviour/Action) .....	53
6. General Discussion .....	61
6.1 Limitations of Evaluation.....	64
7. Recommendations.....	66
References.....	72
Appendix A: Planned Knowledge Translation Activities for Promoting Health Equity in Saskatoon .....	80
Appendix B: Logic Model for Knowledge Translation Aimed at Promoting Health Equity in Saskatoon....	86
Appendix C: Evaluation Matrix .....	87
Appendix D: Interview Questions.....	90
Appendix E: Survey Questions and E-mail Messages.....	93
Appendix F: Comments from Survey with Health Equity Summit Participants .....	101

## List of Tables

---

Table 1. Degree to Which Project Activities are Consistent with Definition and Intent of KT (p. 29)

Table 2. Evaluation Results from Groups that Watched *Della* Video (p. 51)

## List of Acronyms and Abbreviations

---

CBO	Community-based organization
CCSDH	Canadian Council on Social Determinants of Health
CIHR	Canadian Institutes of Health Research
CMHO	Chief Medical Health Officer
CVC	CommunityView Collaboration, Saskatoon Health Region
CUMFI	Central Urban Métis Federation Inc.
CUISR	Community University Institute for Social Research
DMHO	Deputy Medical Health Officer
HPD	Health Promotion Department, Saskatoon Health Region
HPS	Health Promoting Schools program, Saskatoon Health Region
HQC	Health Quality Council (Saskatoon)
iKT	Integrated knowledge translation
KT	Knowledge translation
MLA	Member of the Legislative Assembly (of Saskatchewan)
NCCDH	National Collaborating Centre for Determinants of Health
NGO	Non-governmental organization
PHO	Public Health Observatory, Saskatoon Health Region
PPH	Population and Public Health, Saskatoon Health Region
SDH	Social determinants of health
SHS	Student Health Survey

SPHERU	Saskatchewan Population Health and Evaluation Research Unit
SPI	Saskatchewan Prevention Institute
SPRP	Saskatoon Poverty Reduction Partnership
SRIC	Saskatoon Regional Intersectoral Committee
The Region	Saskatoon Health Region
U of S	University of Saskatchewan

## Executive Summary

---

### Preface

Between June 2012 and June 2013, the Public Health Observatory (PHO) within the Saskatoon Health Region (the Region) led a knowledge translation (KT) project pertaining to health disparities and inequities in Saskatoon. An evaluation of this project was to be completed internally, but due to a staffing change, the evaluation did not take place as originally planned. To obtain an outside perspective of its KT processes and outcomes, PHO decided to use the grant funds devoted to evaluation activities to contract an external evaluator. I was hired in January 2014 to conduct the evaluation.

### Project Overview

In February 2012, PHO obtained a Canadian Institutes of Health Research (CIHR) KT supplement grant. The grant was used to extend the Region's work surrounding health disparities, which started in 2006 under the *Reducing Health Disparity in Saskatoon* CIHR research grant (PHO, 2012). The objectives of this research program were to (1) investigate health disparities Saskatoon, including their determinants; (2) implement and evaluate evidence-based population health interventions aimed at promoting health equity; and (3) pursue integrated KT (iKT) to prompt intersectoral action toward increasing health equity in Saskatoon. Given the completion of the first two research objectives, PHO set out to further pursue the third objective, iKT.

The KT activities were aimed at two primary audiences: the community and decision-makers. Five main activities were carried out: (1) the creation of a short video entitled *Della: Hurdles to Health*, which profiles a working poor family living in Saskatoon to illustrate the impact of poverty on health (premiered at the Broadway Theatre in Saskatoon); (2) dissemination of results from the 2010/11 Student Health Survey, which assessed health disparities among students in grades 5 to 8 living in Saskatoon and the surrounding area; (3) dissemination of the 2006 health disparities research and PHO's KT work; (4) a conference that brought together professionals from across Canada to work on a national agenda for health equity (the Health Equity Summit), and a community forum to discuss health equity (Mobilize!), both of which were held in Saskatoon in May 2013; and (5) evaluation and monitoring, including a public opinion survey surrounding awareness of the social determinants of health (SDH) and support for evidence-based policy options that can reduce health disparities.

### Purpose and Type of Evaluation

The purpose of this evaluation was to assess the effectiveness of PHO's KT project in terms of promoting awareness of health disparities and facilitating action that can serve to reduce these disparities and increase health equity. Also of interest was the degree to which iKT was achieved, from the perspective of both Region staff (within PHO as well as other departments) and the partners involved. As this was a relatively short-lived endeavour and the first of its kind for PHO, the evaluation was intended to provide information that can be used to improve PHO's KT and iKT practices. A combined process and outcome evaluation was carried out. A process evaluation ascertains how well a program/project is operating and

whether it is being implemented as intended (Rossi, Lipsey, & Freeman, 2004). Process evaluations are especially useful for newer programs in that they provide feedback that can inform changes in practice. This falls in line with the improvement-focused model adopted for this evaluation. An outcome evaluation aims to assess the states of conditions that a program/project sets out to change (Rossi et al., 2004). In light of the timeframe during which data collection occurred (throughout the project and roughly eight months post-project), the outcome evaluation questions addressed short-term (i.e., learning-based) and intermediate (i.e., action-based) outcomes.

## **Methodology**

The evaluation employed a combined qualitative and quantitative (i.e., mixed methods) approach and involved three components: (1) a review of PHO's records pertaining to the project; (2) key informant interviews with Region staff as well as individuals outside of the Region who had some level of involvement in the project or PHO's KT work; and (3) online surveys with both the Health Equity Summit participants and individuals within PHO's network. Seventeen out of the 24 identified key informants could be reached for an interview. This included six staff members, 10 non-Region individuals (grant partners and other partners, as well as a representative from an organization that was external to the grant), and Della Kinequon (from the *Della* video). The survey with Summit participants was completed by 20 out of the 58 individuals it was sent to (response rate = 34%), and the survey with PHO's network was completed by eight individuals (response rate = 10% or less). Data collected throughout the project were utilized as well (e.g., evaluation forms completed by individuals who watched the *Della* video).

## **Key Findings**

Analyses were aimed at assessing what worked well in this project and what did not work well or could be improved. Given that this evaluation was improvement-focused, a thorough examination of project design and implementation was undertaken, which included an assessment of PHO's engagement and collaboration with partners and other stakeholders. The highlights of the project are the creation of a high-quality KT product – the *Della* video – and the advancement of work in the health equity field through the Health Equity Summit. The video is a KT tool that has been used by PHO and other agencies to increase awareness and understanding of health disparities and inequities, while the Summit has laid the groundwork for local, provincial, and national action to promote health equity. Although certain issues emerged in the process evaluation, they are thought to largely be a function of insufficient time and resources relative to the number and scope of activities that were planned. One of the main takeaways that surfaced is that the most effective activities were those in which the most resources were invested and which evidenced multiple KT principles (e.g., creativity, collaboration, tailoring activities and messages to the target audience).

This evaluation uncovered several strengths and positive outcomes associated with this project, some of which are outlined below.

- The *Della* video was a very successful undertaking in that it is generally perceived as a high-quality, effective KT tool; has been used by agencies locally, provincially, and across Canada to demonstrate the relationship between poverty and health; generated increased awareness and



understanding of health disparities and inequities among members of the general public as well as decision-makers; and motivated some individuals to desire a more active role in reducing poverty. Importantly, Della and her family benefited from their participation in the project, which underscores the merit of engaging individuals with lived experience of poverty and health issues.

- The Summit was also largely successful despite the fact that the overarching goal of creating a national agenda for health equity was not actualized. Many individuals who attended the Summit gained new insights into health equity, learned from the work of others in the field, perceived that their support for health equity initiatives increased as a result of participating, and indicated that they and their agencies have used the knowledge gained from the Summit to guide their work. While a national agenda could not be formulated, there was a perception that the Summit was an important step toward attaining this goal.
- The *Della* video and the Summit were deemed to be the most effective activities because they (1) were congruent with the definition and intent of KT; and (2) sought to use innovative dissemination and engagement strategies to make knowledge more widely known, relevant, and understood among the community and decision-makers.
- The public opinion survey was a valuable KT research activity, as the findings regarding public awareness of SDH as well as public support for interventions will be utilized to guide PHO's future health equity work and to support its advocacy efforts in the political realm.
- In light of the time, funding, and staffing available for this project, as noted by a staff member, "if you look at what was accomplished...it was stretched quite far." The process issues identified in this evaluation should not take away from the fact that effective KT work was accomplished in spite of these constraints.
- Several non-Region key informants appreciate that the Region has started to take an active role in addressing health disparities and inequities. Many also noted that they are pleased to be partners with the Region and the health disparities research has served a crucial function in their agencies' programming.

Some of the main process issues that emerged and represent areas for improvement include:

- Many of the planned activities with the school community did not come to fruition even though children and youth have been identified as a priority population. However, the Region was carrying out other KT work at the time and staff noted valid challenges to meaningfully engaging with the school community. On the other hand, one non-Region key informant perceived that outreach to a particular school division was absent. This indicates that there are conflicting perspectives as to why these activities did not take place and that better connections need to be fostered between PHO and the school divisions.
- While the two broad categories of target audiences – the community and decision-makers – were reached, key informants and Summit participants perceived that some groups should have been targeted but were not effectively engaged, including decision/policy-makers and high-level politicians within the provincial government, community members (particularly those with lived experience), and Aboriginal organizations. Thus, the targeting of some key interest groups was

not fully realized. In addition, it was somewhat unclear as to which specific sub-groups PHO was most interested in engaging and why, along with what kinds of attempts were made to engage these sub-groups and how successful they were.

- Process-tracing issues were identified (e.g., unclear documentation, limited research-based rationales for project decisions), which may pose challenges to replication efforts and to PHO's ability to serve as a model for other agencies pursuing KT work.
- Although positive results emerged from the Summit, it appears that dialogue surrounding a national agenda for health equity has not been sustained. Perhaps there will be renewed engagement due to the release of the event report in February 2014. The Mobilize! forum, which aimed to attract community members, was not overly well attended, suggesting that this attempt to engage the general public was not as successful as the Broadway Theatre event.
- It was determined that PHO's objective of employing an iKT approach in this project was not achieved, particularly in regard to collaboration with community partners. This is supported by the records as well as key informants' perceptions of the level of collaboration that occurred between PHO and community partners. Ambiguity with respect to expectations surrounding project team members' roles and responsibilities is believed to be one of the main factors underlying this finding.

The activities carried out under PHO's KT supplement grant had followed previous KT activities (e.g., policy and program changes), occurred in conjunction with other KT activities (e.g., the Health Promoting Schools program), and laid the groundwork for future KT activities (e.g., the public opinion survey results will be used to guide interventions). Thus, PHO's KT work is an ongoing endeavour in which incremental advances are being made toward reducing health disparities and inequities in Saskatoon. These advances are being aided by an intersectoral community network that includes groups such as the Saskatoon Poverty Reduction Partnership (SPRP) and the Saskatoon Regional Intersectoral Committee (SRIC). PHO and other Region teams have been addressing health disparities and inequities in Saskatoon since 2006, and are increasingly influencing provincial and national health equity efforts due to the Region's leadership role in the field.

### **Limitations**

Five limitations to the evaluation were identified: (1) because KT related to the health disparities research has been ongoing since 2006, it was difficult to distinguish the effects and perceptions of previous KT activities from those of the KT activities that were specific to this grant; (2) while the majority of the key informants participated in the evaluation, response rates for all other data collection activities were quite low; (3) recall issues were apparent among key informants, which weakened the ability to obtain thorough and accurate responses; (4) as qualitative research is inherently subjective and the evaluator lacked knowledge of the context and history of the project, interpretations may have been shaped by her preconceptions to some extent and, inadvertently, may not have incorporated all relevant pieces of information; and (5) due to the nature of the data that were available and the limitations of this evaluation in terms of scope, the outcome evaluation revealed more about the influence of the KT activities on learning than on actions.

## Recommendations

Fifteen recommendations were formulated and are described in greater detail in the report. They are aimed at improving PHO's KT and iKT processes.

- 1) Create a comprehensive conceptual table at the outset; preferably, prior to submitting the grant application.
- 2) Provide potential partners with enough information to make an informed decision about whether they are willing and able, time- and resource-wise, to sign on to the grant.
- 3) Involve committed partners and other stakeholders (e.g., individuals with lived experience) in the conceptualization of the project; preferably, prior to submitting the grant application.
- 4) Collaboratively create a "game plan" and clearly articulate project team members' roles and responsibilities at the outset.
- 5) Establish process-tracing procedures at the outset.
- 6) Continue to strive toward better internal communication and coordination.
- 7) Be more specific in the identification of target audiences and target sub-groups within them.
- 8) Focus on the quality of the activities, not the quantity.
- 9) As a team, develop a project plan that is proportionate to the time and resources that will be available across all team members.
- 10) Continue to explore creative communication and dissemination strategies to engage the general public in order to go beyond "preaching to the choir."
- 11) Give people specific options for actions they can take to make a difference.
- 12) Invest the most time and resources in activities aimed at increasing health equity locally and provincially.
- 13) Articulate the desired actions that will be prompted by the KT activities.
- 14) Identify at the outset what will be measured for evaluation purposes and design measures accordingly.
- 15) Strive to achieve higher response rates with data collection activities.

## 1. Preface

---

Between June 2012 and June 2013, the Public Health Observatory (PHO) within the Saskatoon Health Region (hereafter referred to as “the Region”) led a knowledge translation (KT) project pertaining to health disparities and inequities in Saskatoon. An evaluation of this project was to be completed internally, but due to a staffing change, the evaluation did not take place as originally planned. To obtain an outside perspective of its KT processes and outcomes, PHO decided to use the grant funds devoted to evaluation activities to contract an external evaluator. I was contacted by PHO in late 2013 and met with staff to discuss the evaluation. PHO officially hired me in January 2014.

## 2. Introduction

---

Broadly speaking, KT is a process through which knowledge or research evidence becomes more widely known and used for the benefit of society (Leadbeater, Banister, & Marshall, 2011). Thus, KT has two overarching goals: raising awareness and promoting action (Canadian Institutes of Health Research [CIHR], 2012). It involves the “transmission of information that is relevant and in a form that is meaningful to all those who might benefit from it. It therefore informs, guides, and motivates” knowledge users (Bennett & Jessani, 2011, p. xxiii). Knowledge users are typically individuals or groups with the ability and authority to make decisions about policies, programs, and practices (Bennet & Jessanie, 2011; Bowen, Botting, & Roy, 2011). However, KT can also be directed at the general public, as they along with decision-makers have the ability to influence the public policy agenda (Institute of Population and Public Health, n.d.; Straus, Tetroe, & Graham, 2009). The goal of KT is to close the gap between knowledge and practice (i.e., the know-do gap; Bowen et al., 2011). This process, which is also referred to as knowledge-to-action, goes beyond mere dissemination to finding strategic ways to prompt evidence-based action and decision-making (Bowen et al., 2011; Straus et al., 2009). CIHR (2012) identifies three categories of KT strategies:

- **Diffusion (letting it happen):** communication through mechanisms that require little customization.
- **Dissemination (helping it happen):** development of messaging that is tailored to the audience and/or context.
- **Application (making it happen):** where the evidence is sufficient, applying knowledge more intensively to deliver key messages (e.g., through activities such as workshops and tool development).

In February 2012, PHO obtained a CIHR KT supplement grant entitled *Promoting Health Equity in Saskatoon*. The grant was used to extend the Region’s work surrounding health disparities, which started in 2006 under the *Reducing Health Disparity in Saskatoon* CIHR research grant (PHO, 2012). The objectives of this research program were to (1) investigate health disparities Saskatoon, including their determinants; (2) implement and evaluate evidence-based population health interventions aimed at promoting health equity; and (3) pursue integrated KT (iKT) to prompt intersectoral action toward increasing health equity in Saskatoon. In iKT, “researchers and knowledge users work collaboratively to

determine the research questions, decide on the methodology, interpret the findings, and help disseminate the research results” (Bowen et al., 2011, p. 12). The assumption underlying iKT is that treating knowledge users as equal partners in the research process will make findings more relevant to knowledge users, thereby increasing uptake (CIHR, 2012).

The findings that emerged from the health disparities research demonstrated that income often had the strongest independent association with health disparities in Saskatoon (PHO, 2012). With this baseline established, the Region’s Population and Public Health (PPH) division engaged in a process of shared agenda-setting through over 200 community consultations to determine next steps for research and action (Cushon et al., 2012). PPH surveyed a random sample of 5,000 Saskatoon residents about their awareness of health disparities in the city and their support for certain intervention options. As children were deemed a priority population in community consultations, systematic literature reviews were conducted on child and youth health disparities. PPH also designed and administered the Student Health Survey (SHS) in 2006/07, 2008/09, and 2010/11 to measure health disparities among students in grades 5 to 8. The *Health Disparity in Saskatoon* report includes a systematic review of 46 evidence-based policies that have been found to promote health equity (Lemstra & Neudorf, 2008). One of the key policy recommendations was the creation of a strategic multi-year plan to reduce poverty (Cushon et al., 2012). This led to the formation of the Saskatoon Poverty Reduction Partnership (SPRP) in 2010. SPRP is an intersectoral coalition of citizens, researchers, and decision-makers (PHO, 2012). The policy options are informing SPRP’s Community Action Plan to Reduce Poverty.

Given the completion of the first two research objectives, PHO set out to further pursue the third objective, iKT. The KT activities were aimed at two primary audiences, the community and decision-makers (PHO record 1<sup>1</sup>), in order to facilitate both bottom-up and top-down action to increase health equity (Baum, 2007). The community was described as representing interest groups, community agencies, and the general public (PHO record 1). Decision-makers within sectors that play a role in the social determinants of health (SDH) were targeted; for example, members of the Saskatoon Regional Intersectoral Committee (SRIC), which is comprised of representatives from provincial and federal government, health districts, school divisions, Aboriginal organizations, and community-based organizations (CBOs). Below are the goals and objectives that were identified in the project charter for the KT supplement grant (PHO, 2012).

#### **Goals of KT Supplement Grant**

- To promote awareness about health disparities in Saskatoon.
- To encourage action that will promote health equity and reduce health disparities in Saskatoon<sup>2</sup>.

---

<sup>1</sup> In the interest of simplicity, records that were reviewed for the evaluation are referenced numerically.

<sup>2</sup> Health disparities refer to the existence of differences between groups (e.g., men and women), whereas health inequities are differences that are presumed to be unjust (Bowen et al., 2011).

## **Objectives of KT Supplement Grant**

- To work with advisory groups/partners to effectively develop and target messages about health disparities.
- To disseminate targeted messages about health disparities research results to the community and decision-makers.
- To disseminate targeted messages about the SHS results to children/youth and their families.
- To disseminate targeted messages about how to promote greater health equity, to the community and decision-makers.
- To generate community and decision-maker support for actions that promote greater health equity.

## **2.1 Activities**

This section summarizes the key activities that were carried out under the KT grant. Appendix A contains an updated version of the work plan that was developed for this project. The work plan consists of the planned activities along with whether or not they were completed or are ongoing. The mapping of the KT activities was based on a review of available records as well as conversations with staff who were involved in the project.

A KT project coordinator, Amanda Clarke, was hired at 0.6 full-time equivalent for one year (PHO, 2012). All completed activities associated with the grant took place between June 2012 and June 2013. PPH was the primary Region division involved in the project, primarily PHO followed by the Health Promotion Department (HPD).

### **2.1.1 Video (Della: Hurdles to Health)**

The intent of this short video was to illustrate health disparities in Saskatoon through story (PHO, 2012). The vision for the film was to “promote awareness about health disparities in Saskatoon that will encourage action for change, by sharing the research evidence and the first hand stories of Saskatoon residents” (PHO record 2). The eight-minute video was planned and produced between June and November of 2012. It was produced by the project coordinator and the PHO program manager of research and evaluation, Jennifer Cushon, and directed and edited by Antonio Hrynchuk of Fahrenheit Films. The project coordinator met with three people (one man, two women) whose stories could potentially be featured in the film. One of the women did not want to appear on film, and the man was previously in a low-income situation but was not at the time of filming (staff member, personal communication). Therefore, Della Kinequon was featured in the film. Della has a husband, Albert, and two school-aged sons, Jaydan and Jarett. She is living with diabetes and arthritis (SPRP, n.d.). Della was deemed a good fit to portray the impact of poverty on health because she has various roles that many people can identify with: wife, mother, community member, volunteer, and employee (staff member, personal communication). Della indicated that she wanted to participate in this project because she felt that her family’s story needed to be shared, as many people in the community are facing similar challenges (PHO record 3). The following synopsis accompanies the film on SPRP’s website and on YouTube (Della Hurdles, 2012; SPRP, n.d.):

*“Della: Hurdles to Health* is a film that follows the life of a woman and her family in Saskatoon, Saskatchewan. The film provides a glimpse into the family’s daily struggles as a working poor family and illustrates how poverty affects health and wellbeing. Issues of housing, childcare, nutritious, accessible and affordable food, diabetes, and social supports are explored. A call to action ends the film - let’s learn, share and influence to make a difference in our community!”

The film reflects the realities of working poor families living in Saskatoon:

“One of the myths this story [tackles] is that people are poor because they do not work. Della proposes that her family is ‘working poor’ and a growing number of families are facing similar experiences in Saskatoon. Della’s husband, Albert, works as many hours as he can a week, but even with a minimum wage, living comfortably with a family is not easy. Della is trained in administration, but due to costs of childcare, stayed at home to raise the children. What is not usually taken into consideration is the number of hours Della has contributed in unpaid work and volunteerism. Della is an active member of the community, as a peer leader of the LiveWell with Chronic Disease program at Saskatoon Health Region, and a participant in community events. She is well known within different social circles and professional networks in Saskatoon.” (PHO record 3)

The film also features local decision-makers who share their expertise on SDH. These individuals include Cory Neudorf, Chief Medical Health Officer (CMHO) of the Region; Felix Thomas, Chief of the Saskatoon Tribal Council; and Lynda Brazeau, Executive Director of the Saskatoon Friendship Inn.

On November 19, 2012, the *Della* film and two other locally-produced films were premiered at a free public event at Saskatoon’s Broadway Theatre. The event was put on by PHO and HPD, the University of Saskatchewan (U of S) and the Saskatoon Food Bank & Learning Centre (PHO record 4). The two other films were *Seven Days of Hunger: Experiences of Blades Coach Lorne Molleken* (re: Food Basket Challenge; the Region, Saskatoon Food Bank & Learning Centre, Saskatoon Friendship Inn, & Fahrenheit Films); and *Let’s Start a Conversation About Health....and talk about more than healthcare!* (PHO; adapted from the Sudbury & District Health Unit). The event was called *The Starting Point: Saskatoon Experiences of Poverty and Health*. This title was chosen because the films aim to engage residents who may not be overly conscious of poverty issues in Saskatoon (PHO record 5). The event was one of several efforts in HPD’s *There is More to Poverty* campaign and was seen as an opportunity to build support and momentum for SPRP’s Community Action Plan to Reduce Poverty (Bandara, 2012).

Promotion of the event occurred through various means, including posters, Twitter, a Kijiji ad, and announcements on several community agencies’ websites and Facebook pages (e.g., Saskatchewan Prevention Institute [SPI], United Way of Saskatoon, YWCA; PHO record 6). There was also local media coverage, and Della appeared on television to promote the event (e.g., on CTV Saskatoon News at Noon; PHO record 7). A few staff stated that the event was well attended, with one staff member estimating that approximately 100 people were in attendance. Heather Morrison, a local radio host, MC’d the event and also served as a moderator for the panel discussion following the showing of the films. The panel



consisted of CMHO Cory Neudorf, Chief Felix Thomas, Julie Kryzanowski (Deputy Medical Health Officer [DMHO] of the Region and Co-Chair of SPRP), Della, and Food Basket Challenge participant Deborah Bryson-Sarauer of Family Service Saskatoon (PHO record 5). The discussion revolved around panel members' views and experiences surrounding health and poverty, as well as actions that can be taken to address poverty in Saskatoon. This relates to the call to action that was made at the event: attendees were asked to make a difference by visiting SPRP's Act Now! online resource (PHO record 5) and signing up for SPRP's monthly newsletter (PHO record 8).

Following the premiere, the *Della* film was widely distributed through PHO's local, provincial, and national networks (PHO, 2012). It has been presented by Region staff at several meetings and has also been utilized by external organizations to demonstrate the effects of poverty on health. A few key informants described the video as a good context-setting tool for presenting data. Examples of organizations that have used the video as a KT tool or have posted the video on their website or Facebook page include Public Health Ontario, CHNET-Works! (Population Health Improvement Research Network, University of Ottawa), and Vibrant Communities Canada (part of Tamarack – An Institute for Community Engagement; PHO record 6; staff member, personal communication). To assess the video's effectiveness as a KT tool, feedback was collected from certain groups that viewed the film (e.g., feedback forms were provided at the Broadway Theatre premiere).

### **2.1.2 Dissemination of Student Health Survey Results**

As mentioned, three SHSs were carried out, with the most recent one taking place in 2010/11. This self-report survey was designed to measure the overall health of children in grades 5 to 8, and to assess whether health disparities exist based on social and economic factors (PHO, 2013). The survey was administered in schools within two city school divisions (Saskatoon Public Schools, Greater Catholic Schools;  $n = 4,314$ ) and two rural school divisions (Horizon, Prairie Spirit;  $n = 1,469$ ). Findings indicated that students attending schools in low-income neighbourhoods in Saskatoon perceived themselves to be less healthy, physically and psychologically, than those attending schools in higher-income neighbourhoods. This led PHO (2013) to conclude that targeted health promotion efforts are required in low-income neighbourhood schools, as are policy changes that can influence SDH. One of the key actions that flowed from the survey results was the implementation of the Health Promoting Schools (HPS) program in the fall of 2012 (PHO record 9). HPD works in partnership with school divisions and community partners to deliver this comprehensive program, wherein "students, teachers, parents, school staff, community groups, agencies and institutions work together on key priorities for improving learning and health" (Region, n.d.1). HPS is currently operating in 20 schools in Saskatoon's core neighbourhoods and in surrounding rural areas (Region, 2013).

To promote awareness of, and action on, the survey findings, several dissemination activities took place leading up to the start of the KT project in June 2012. For example, participating schools were sent a fact sheet on the overall survey results as well as the results pertaining to their respective schools (PHO records 9 and 10). In addition, between November 2011 and March 2012, a staff member met or spoke with several school staff and principals to discuss the results and fact sheets (PHO record 11). Following



this dissemination and consultation process, an online KT survey was administered in May 2012 to assess whether schools had used results from the SHS. The survey was sent to 143 individuals from participating schools, 43 of whom completed the survey (Kershaw, 2012). Respondents included principals, public health nurses, School Community Council presidents, and education directors. Kershaw (2012) reports that just under two-thirds of respondents indicated that they had use the SHS results in some way, such as for program and policy planning and implementation, and to educate staff and the broader school community. Reported benefits that resulted from these activities included the development of new programs, increased awareness of student health issues, and improved behaviours among students.

In terms of KT activities that took place during the grant period, first, a dissemination/communications plan was drafted over the summer of 2012 (see PHO record 12). One of the first action items in this plan was to meet with each of the four school divisions that participated in the SHS to discuss strategies and tools aimed at engaging students, parents, school staff, principals, and school boards in child and youth health promotion (PHO records 9 and 10). Meetings were held with communications representatives from the school divisions, and these individuals expressed interest in pursuing further dissemination efforts (PHO record 9). Student engagement ideas included video and social media projects that would raise students' awareness of the SHS data and encourage health-promoting behaviours. It was thought that parents could be engaged through newsletters and presentations at School Community Council meetings. Through internal meetings, dissemination was coordinated with other Region initiatives aimed at children and youth (e.g., HPS, Early Child Health Report; PHO record 12). To avoid duplication of dissemination efforts, consideration was given to provincial initiatives relating to the health of young people, including the Saskatchewan Alliance for Youth and Community Well-Being (SAYCW) and the Saskatchewan Population Health and Evaluation Research Unit's (SPHERU) Smart Cities, Healthy Kids study (PHO record 12; staff member, personal communication).

In the fall of 2012, an interactive computer game application (app) for youth aged 11 to 14 was developed by three computer science undergraduate students from the U of S; however, the game was not tested and implemented (Haggag & Larson, 2013; PHO record 13). (Reasons why certain KT activities were not completed are discussed later in the report.) The U of S students developed two "serious" games, which are designed to be both fun and educational, and integrated them into Facebook. As the goal was to develop games aimed at encouraging health-promoting behaviours, a sleep game and a nutrition game were created. Haggag and Larson (2013) state that the app can be used as a prototype; that is, it has "provided a shell that can be filled with content and graphics later when more resources are available" (p. 5).

The project coordinator and SPHERU did a joint presentation at Saskatoon's Frances Morrison Library in November 2012. The project coordinator presented on the SHS results, while SPHERU presented results from the Smarty Cities, Healthy Kids study (PHO record 13). The purpose of the presentations was to share information about students' health and well-being along with how researchers have used this information. The event was called *In Their Own Words: Adolescents Talk about Their Health* (PHO record

14). It was advertised via the Library News magazine, Facebook, posters, e-mail, and the Saskatchewan Knowledge to Action Network for Early Childhood Development (a.k.a. kidSKAN; PHO record 15). Roughly 40 people attended the event, the majority of whom were youth associated with SPI's youth leadership team (staff member, personal communication). The remaining attendees mainly consisted of individuals working in the education and health sectors. Attendees were provided with evaluation forms to complete following the presentations.

To prepare for the release of the 2010/11 SHS report, *Student Health Survey: Evidence to Action*, a dissemination plan was drafted in the fall of 2012. In December 2012, the SHS results were communicated internally to the Region's senior leadership team and board of directors (PHO record 13). The report was made available externally in January 2013 through mass e-mail distribution and social media outlets (e.g., the Region's Facebook page and CommunityView Collaboration [CVC] website; PHO record 12). The release also received local media coverage (PHO record 16) and was featured in at least one out-of-province newspaper (see Winnipeg Free Press, 2013). To communicate the SHS results to parents, an insert was included in school newsletters in February 2013 (PHO record 13). Lastly, in May 2013, a short follow-up survey was distributed via e-mail to individuals who had received the SHS report and fact sheets. The survey was designed to collect feedback on these materials in terms of whether they met people's needs and how they had been used in the school community (PHO record 17).

### **2.1.3 Dissemination of Health Disparities Research and KT Work**

Dissemination of the health disparities findings and progress on the policy options has been ongoing since the research program started in 2006. Within the KT grant period, dissemination took place through a Twitter feed that was started by the CMHO, the submission of a paper for publication, the submission of a policy brief to the federal government, and the creation of a report that details three of the policy options aimed at reducing health disparities in Saskatoon (Sharpe, Dow, Rahmani, & Morris, 2013; PHO record 13; staff interviews). The paper submitted for publication was titled "Advocacy for Health Equity: The Population and Public Health Journey" (Cushon et al., 2012), which was a proposed chapter on practice experiences relating to PPH's public policy advocacy. The paper was not accepted (PHO record 13). The policy brief was submitted to the federal government's Standing Committee on Finance as part of the Income Inequality in Canada Study (Parliament of Canada, 2013). This paper was written by the CMHO and outlined the link between income and health (PHO record 18). The final report for the study mentions work done by SPRP (see Rajotte, 2013). Lastly, the report on three of the policy options – social assistance rates, access to health resources, and housing – was produced for SPRP by four student researchers from The Policy Shop, a student-managed consulting firm operating within the Johnson-Shoyama Graduate School of Public Policy (U of S/University of Regina; Sharpe et al., 2013). The three policy options were selected on the basis of SPRP's established priorities.

With respect to sharing KT experiences, in March 2013, the project coordinator spoke about PHO's KT work at the Toronto Workshop for Lead Users of Population Health Information in Health Care (PHO record 13). In addition, the DMHO presented at a KT workshop that was held during the Canadian Public Health Association's (CPHA) annual conference, which took place in Ottawa (CPHA, 2013). The

presentation was titled “Promoting Health Equity: Using Integrated Knowledge Translation to Inform Policy and Practice” and included a summary of PHO’s KT approach and outcomes of the project (PHO record 19).

#### **2.1.4 Health Equity Summit and Mobilize! Forum**

Part of the KT grant funding was used to hold a Health Equity Summit, a one-day conference that was hosted in Saskatoon in May 2013. The Summit was seen as an opportunity for PHO to showcase its work and learnings on promoting health equity through intersectoral action (PHO record 13). Event planning and organizing started in August 2012. The event was put on by the National Collaborating Centre for Determinants of Health (NCCDH), the U of S (Saskatchewan Health Research Foundation Conference Grant), and the Canadian Council on Social Determinants of Health (CCSDH; NCCDH, 2014). It was titled *Developing a Health Equity Agenda: From a Shared Vision to Policy and Practice*. The purpose of the Summit was to:

- bring together an engaged and active national multi-sectoral audience to address social determinants of health and advance health equity approaches, and to build a sustainable network of networks;
- profile health equity work occurring locally, provincially, and nationally that may include evidence, best practices, and a set of recommendations for future work; and
- contribute to the development of an agenda to guide health equity practice, policy, and research through action on the social determinants of health over the next five years (NCCDH, 2014, p. 2).

The Summit featured panel speakers, presentations from Canadian and international experts, and group work sessions (NCCDH, 2014). The *Della* video was shown as well (staff interview). Of the 183 people who were invited (PHO record 20), 64 attended. Attendees were individuals working in the field of health equity/SDH and included (in descending order of frequency): public health practitioners, public administrators/policy-makers, researchers, non-governmental practitioners, professions other than those listed, and students. As would be expected, Saskatchewan had the most representatives (just under 30), with Ontario having the next highest number of representatives (10). There were representatives from all but four provinces/territories: Yukon, Quebec, Nunavut, and Newfoundland and Labrador.

Speakers and panelists included:

- Cory Neudorf, CMHO of the Region and Assistant Professor at the U of S.
- Julie Kyrzanowski, DMHO of the Region and Co-Chair of SPRP.
- Peggy Taillon, President and CEO of the Canadian Council on Social Development (CCSD) and Chair of CCSDH.
- Hannah Moffatt, KT Specialist at NCCDH.
- Connie Clement, Scientific Director at NCCDH.
- Margo Greenwood, Academic Leader at the National Collaborating Centre for Aboriginal Health.
- Laurel Rothman, National Coordinator of Campaign 2000.

- Ed Buller, member of CCSDH and retired Director of the Aboriginal Corrections Policy Division within Public Safety Canada (PHO record 21).
- Rick Trimp, Senior Vice President, Population and Public Health, Alberta Health Services.
- Fran Baum, Matthew Flinders Distinguished Professor and Australian Research Council Federation Fellow; Director, Southgate Institute for Health, Society and Equity as well as South Australian Community Health Research Unit (via videoconference). (NCCDH, 2014)

There were two panel sessions. The first was titled “Health equity: Past, present, and future” and employed a “celebrity interview” format, wherein “a large group of people [is enabled] to connect with a leader or an expert (the celebrity) as a person and grasp the nuances of how that person is approaching a challenge” (Liberating Structures, n.d.). The panelists were Connie Clement, Cory Neudorf, and Margo Greenwood. In addition to discussing past, present, and future approaches to promoting health equity, panelists reflected on “the essential ingredients needed for a Canadian health equity agenda” (NCCDH, 2014, p. 6). The second panel session was called “Experiences from the field” and involved short presentations from practitioners who have demonstrated leadership in this area: Julie Kyrzanowski, Rick Trimp, Laurel Rothman, and Ed Buller. Speakers shared their perspectives on the key elements required to promote health equity, challenges they have faced and how they overcame them, and the pieces needed for a Canadian health equity agenda.

With regard to group sessions, Claire Betker, Senior KT Specialist with NCCDH, facilitated a discussion on the strengths, weaknesses, opportunities and threats (SWOT) of developing a Canadian health equity agenda (NCCDH, 2014). SWOT offers a situational analysis that can facilitate the development of feasible solutions to issues. Participants were divided into groups that took turns writing ideas on flip charts corresponding to the four SWOT categories. Another group-based session was called “Ideas and actions to move a health equity agenda forward,” in which participants reflected on what influences them personally and within their organizations to take action that can advance health equity. Lastly, in small groups, participants engaged in a “game plan” activity to identify health equity objectives, targets, stages of intended tasks, success factors, challenges, and team resources.

The Summit ended with a “crowd sourcing” activity where participants wrote down what they considered to be the best idea of the day, and what first step they would take to put that idea into action (NCCDH, 2014). Participants then traded cards and rated each other’s ideas for innovativeness. Cards were scored and the top 10 ideas and actions were announced.

Summit participants were asked to complete an evaluation form at the end of the event. Feedback was summarized in an evaluation report written by a public health master’s student at the U of S, who was completing a practicum placement with NCCDH (Adesina, 2013). Dissemination activities associated with the Summit included live tweets on Twitter (Moffatt, 2013), circulation of an event summary to participants (NCCDH, 2014), and posting short videos on YouTube of eight speakers/panelists sharing their insights on a health equity agenda (SaskatoonHealthReg, 2013a). In addition, the project coordinator made a blog entry on NCCDH’s website (Clarke, 2013), which includes a summary of the

event as well as a call to continue the health equity conversation by discussing ideas in the Health Equity Clicks online community (must be a registered member).

On the evening of the day the Summit was held, NCCDH, U of S, and the City of Saskatoon put on a forum titled “Mobilize! For our Community’s Well-being” (PHO record 22). The forum took place at Station 20 West, a community centre that is in close proximity to the city’s core neighbourhoods. Four intended outcomes were identified for this event:

- Raise awareness and understanding about those who are marginalized in the community (e.g., those with low income, Aboriginal persons, newcomers, homeless persons).
- Brainstorm realistic solutions for inclusivity and engagement, allowing all residents to participate fully in society, particularly persons in low-income situations.
- Use the outcomes from the day portion of the conference to inform the evening’s community forum (e.g., highlight best practices in equity from communities across Canada).
- In the long-term, inform decision-making for program and service delivery and policy change at local, provincial, and national levels. (PHO record 23)

The forum was open to the public and was promoted in various ways, such as posters and e-mail distribution lists (e.g., SPRP, Region e-communications; PHO record 23). Personal invitations were sent to representatives from stakeholder groups as well as grant partners (e.g., school divisions, SRIC, U of S). Summit attendees and persons with lived experience of low-income and health inequities were encouraged to attend. Approximately 35 people attended the forum, including some key decision-makers (e.g., representatives from Saskatoon Public Schools, the Region, and SPI).

Speakers included Ed Buller (spoke about mobilization in Aboriginal communities), Laurel Rothman (spoke about the struggles of families and children and how Campaign 2000 has mobilized around poverty issues), and Connie Clement (provided an overview of the Summit proceedings; PHO record 23). To provide an opportunity for audience engagement, there was a discussion period at the end of the event. As with the Summit, an evaluation form was administered after the event to collect feedback.

### **2.1.5 Evaluation and Monitoring**

A portion of the KT grant funds was allocated to evaluating the project (PHO, 2012). PHO set out to continuously evaluate and monitor the KT activities and associated outcomes. To this end, an evaluation and monitoring plan was developed at the outset of the project (PHO record 13; see PHO record 24 for plan). Monitoring was to occur throughout the project and was to include tracking of actions taken on the health disparities research. Evaluation of outcomes and preparation of an end of grant report was to occur by the end of the KT grant period; however, the project coordinator was hired for a new position and was therefore unable to complete this task (staff member, personal communication).

As previously mentioned, 5,000 Saskatoon residents were surveyed in 2006 as part of the *Reducing Health Disparity in Saskatoon* research program. In terms of awareness of health determinants, the majority of respondents did not demonstrate a concrete understanding of the magnitude of health

disparities in Saskatoon by income level (Lemstra, Neudorf, & Beaudin, 2007). Further, most appeared to believe that health risk behaviours are due more to lifestyle choices than income status. Respondents were particularly supportive of intervention options aimed at children. Support was also relatively high for interventions such as developing a targeted, multi-year plan to reduce poverty and removing clawbacks on work earnings/including work earning supplements (Lemstra et al., 2007; Lemstra & Neudorf, 2008).

Funding from the KT grant was used to replicate this survey to see if awareness of health determinants, as well as support for intervention/policy options, has changed since the original survey was conducted. The U of S Social Sciences Research Laboratories (SSRL) was contracted to conduct the survey (PHO record 25). Some of the original survey questions were retained, while some were revised and a few were added. For example, to better understand residents' views toward ways to cover the costs associated with implementing interventions, the taxes option was broken down into several components (e.g., increase corporate taxes, increase municipal property taxes; PHO record 26; staff interview). To date, a report has been completed by a practicum student but not yet released to the public; in early 2014, a briefing note on the survey findings was prepared for the SRIC co-chairs, who forwarded it to Members of the Legislative Assembly of Saskatchewan (MLAs); and publications are scheduled to be completed over the summer (staff interviews).

## **2.2 iKT/Collaboration**

In line with the iKT approach, a PHO staff member e-mailed a group of partners the following call for input prior to the completion of the KT supplement grant application (August 2011):

“The Public Health Observatory, Saskatoon Health Region is putting together a knowledge translation grant proposal to share our health disparity research findings (2008). [...]

Our health disparity research findings have informed interventions in elementary schools, the development of a Saskatoon Poverty Reduction Action Plan, and the introduction of health care equity audits in the Saskatoon Health Region. However, this knowledge translation grant is a unique opportunity to think outside of the box, and we want to find innovative ways to move the analysis piece to interventions and support similar work in the Saskatoon community.

We will need assistance from partners in the areas of a) providing advice on potential knowledge translation activities. For example, to provide us with advice about how your organization and clients could best receive messages, whether the information should be in traditional formats or 'newer' tools such as social media, graphics, etc.; and b) providing letters of support to accompany our knowledge translation grant application.

We would be thrilled if you/your organization could be involved in this proposal in some capacity. [...]

We look forward to hearing from, and working with, you on this proposal.” (PHO record 27)

As per the project charter (PHO, 2012), the KT project team consisted of:

- Two principal applicants: the Region’s CMHO and the PHO’s program manager of research and evaluation.
- Four co-applicants: representatives from SPHERU, the University of Alberta’s School of Public Health, Saskatoon Public Schools’ Research and Measurement Department, and the U of S Computer Science Department.
- Eight partner agencies/collaborators (wrote letters of support for the grant application):
  - SPI
  - United Way of Saskatoon and Area
  - Community University Institute for Social Research (CUISR)
  - Central Urban Métis Federation, Inc. (CUMFI)
  - Greater Catholic Schools
  - Saskatoon Public Schools
  - SRIC
  - Health Quality Council (Saskatoon; HQC)
- Eight project advisors: six Region staff members (one of whom later became the project coordinator), one representative from Greater Catholic Schools, and one representative from SPHERU.

Advisory groups that PHO set out to work with to develop and target messages were comprised of the partner agencies listed above, whose target populations include children and youth (e.g., SPI, school divisions) and Aboriginal people (e.g., CUMFI; PHO record 1). In March 2012, a KT grant team meeting was held to discuss ideas, roles, and responsibilities (PHO record 28). Taking part in the meeting were representatives from the Region (6), SPHERU (2), U of S Computer Science Department (1), University of Alberta’s School of Public Health (1), SPI (1), and SRIC (1). The project coordinator and PHO’s program manager of research and evaluation met with SPHERU in June 2012 to review the work plan (PHO record 29). As mentioned, representatives from the school divisions were consulted with regarding the SHS results. In addition to these documented meetings, a number of one-on-one conversations with partners took place throughout the project (staff member, personal communication).

As per the above review of the KT activities, collaboration also occurred with:

- Saskatoon Food Bank & Learning Centre (*The Starting Point* event);
- Saskatoon Tribal Council (*Della* video);
- Saskatoon Friendship Inn (*Della* video);
- a family with lived experience of low income and health issues (Della Kinequon and family);
- U of S students (research, evaluation, computer game, report on policy options, public opinion survey); and
- national agencies in the SDH field (NCCDH and CCSDH; Health Equity Summit and Mobilize! forum).



## 2.3 Logic Model

Appendix B contains a proposed conceptualization of the logical chain of connections between KT project components and the intended ultimate impacts of reduced health disparities and inequities in Saskatoon (Bowen, n.d.). Categories of activities are included rather than activities specific to this particular KT project, because it does not seem plausible that this project alone will produce the changes needed to achieve the desired outcomes. In other words, it is believed that KT efforts will need to be ongoing for several years before the long-term outcomes can be realized. The target audiences represent some of the main groups that should be considered in terms of tailoring messages to maximize accessibility and uptake. In accordance with common practice for constructing logic models, the proposed short-term outcomes revolve around learning (e.g., knowledge, attitudes), the intermediate outcomes are action/behaviour-based, and the long-term outcomes reflect conditions (e.g., social, economic; University of Wisconsin – Extension, n.d.).

## 3. Purpose of Evaluation

---

The purpose of this evaluation was to assess the effectiveness of PHO's KT project in terms of promoting awareness of health disparities and facilitating action that can serve to reduce these disparities and increase health equity. Also of interest was the degree to which iKT was achieved, from the perspective of both staff (within PHO as well as other departments) and the partners involved. As this was a relatively short-lived endeavour and the first of its kind for PHO, the evaluation was intended to provide information that can be used to improve PHO's KT and iKT practices rather than to render a judgement regarding the merit of the project (Bowen, n.d.). This is in line with PHO's interest in better understanding iKT approaches relating to health equity (PHO record 24). This evaluation may also serve a research function by offering new knowledge in the KT field, particularly since there is currently limited existing research that has explored what KT strategies are effective in promoting health equity (Bowen et al., 2011; Bowen, n.d.).

### 3.1 Focus of Evaluation

A combined process and outcome evaluation was carried out. A process evaluation ascertains how well a program/project is operating and whether it is being implemented as intended (Rossi, Lipsey, & Freeman, 2004). The focus is on issues such as performance in conducting activities, project strengths and weaknesses, the degree to which the target audience(s) is being reached, how organized the project is, and whether data is collected adequately enough to inform an outcome evaluation (Bowen, n.d.; Community Interventions for Health, n.d.; Rossi et al., 2004). The objective is to both describe project performance and determine whether it was satisfactory (Rossi et al., 2004). Process evaluations are especially useful for newer programs in that they provide feedback that can inform changes in practice. This falls in line with the improvement-focused model adopted for this evaluation. Process evaluations are also seen as a crucial adjunct to outcome evaluations because they can provide information regarding the quality and quantity of activities that are associated with the attainment of outcomes. As outlined in the evaluation matrix in Appendix C, several of the process evaluation questions were



designed to address project design, delivery, reach, and performance. The remaining process evaluation questions were specific to iKT, as PHO specified that an iKT approach would be utilized in this project. An outcome evaluation aims to assess the states of conditions that a program/project sets out to change (Rossi et al., 2004), in this case awareness and actions surrounding health disparities and inequities; and eventually, reduced health disparities and increased health equity (see logic model). In light of the timeframe during which data collection occurred (during the project and roughly eight months post-project), the outcome evaluation questions in the evaluation matrix only address some of the short-term and intermediate outcomes. These pertain to learning- and behavioural-based outcomes that were deemed measurable.

### **3.2 Scope of Evaluation**

Because dissemination efforts have been ongoing since 2006, the data collection tools were designed to address activities that were specific to the KT grant, though this was sometimes challenging. For example, as some activities were an extension of previous KT efforts, and other KT work not related to this grant was occurring simultaneously, information pertaining to non-grant-specific activities inevitably surfaced. However, given the purpose of this evaluation, results pertaining to the KT grant activities were of primary concern.

Evaluating outcomes is not to be confused with measuring program effect or impact; that is, the portion of a change in outcome that can be attributed to exposure to a program/project (Rossi et al., 2004). Due to the difficulties associated with establishing causation in research and evaluation, it is generally more feasible to investigate whether a project has conceivably *contributed to* certain outcomes (Bowen, n.d.). Results are reported to highlight potential areas of promise rather than to make definitive conclusions surrounding the project's effectiveness in terms of achieving outcomes. Because outcome evaluations are often more successful when a program's processes have been operating effectively for a few years (Health Communication Unit, 2007), this evaluation focused more on assessing process than outcomes.

### **3.3 Intended Use and Users of Evaluation Findings**

PHO and HPD will be the primary users of the evaluation results. Personnel can use the findings to inform and improve future KT work surrounding health equity (PHO record 24). The evaluation may also offer learning opportunities with respect to who the messages resonated with, effective KT activities/tools and iKT strategies, and things that could be done differently to further facilitate action that will reduce health disparities and inequities in Saskatoon.

## **4. Methodology**

---

This evaluation employed a combined qualitative and quantitative (i.e., mixed methods) approach. It is believed that the two methodologies have the potential to complement one another: quantitative data are useful in identifying general patterns regarding the variables of interest, while qualitative data can highlight the unique aspects of individuals' views and experiences. Utilizing a mixed methods approach is an example of triangulation, whereby more than one method or data source is used in an effort to

enhance the credibility of results and interpretations (Bowen, n.d.). The evaluation involved three components: (1) a review of PHO's records pertaining to the project; (2) key informant interviews with staff as well as individuals outside of the Region who had some level of involvement in the project or PHO's KT work; and (3) online surveys with both the Health Equity Summit participants and individuals within PHO's network.

#### **4.1 Records Review**

The records for this project are housed in a folder on PHO's shared file server. This folder consists of 688 electronic documents, each of which was reviewed for relevance to the evaluation. Roughly 200 documents were deemed relevant. Files were separated according to whether they provided evaluation data (e.g., summary of feedback from Broadway Theatre event) or data about the design and implementation of the activities. For documents in which the connection to the project was unclear, clarification was sought from staff.

#### **4.2 Key Informant Interviews**

Key informants for this project were selected on the basis of the records review and conversations with staff. Due to geographical and/or scheduling constraints, all but two of the interviews were conducted by phone. Interviews took place between February and March 2014. The evaluator started each interview by introducing herself, describing the purpose of the evaluation and why they were selected to participate, and asking for permission to record the conversation. All participants provided consent to have the interview recorded. Interviews ranged in length from eight to 45 minutes (median = 35 minutes). Because of Della's unique role in this project, it was felt that presenting her data would reveal her identity. Della was contacted to discuss this, and she provided consent to being personally identified in the report. As Della's feedback was positive, this was not thought to be ethically problematic. Della was provided with an honorarium as a token of appreciation for her participation. It should be noted that, although care was taken to avoid reporting data that could potentially reveal other participants' identities, it is possible that some readers may recognize ideas as belonging to certain individuals or organizations. This possibility is heightened by the fact that the pool of interviewees was fairly small and mainly consisted of individuals who were known to have had some type of role in the project.

##### **4.2.1 Participants**

A total of 24 individuals were identified as interview candidates. Seventeen of these individuals, including Della, were interviewed; the remaining seven could not be reached during the data collection period. In the interest of attempting to maintain participants' confidentiality, Region personnel who were interviewed are collectively referred to as "staff" ( $n = 6$ ), while individuals from outside the Region are collectively referred to as "non-Region" ( $n = 10$ ). As an additional measure of safeguarding confidentiality, demographic information (e.g., sex, age) is not reported and demographic identifiers (e.g., "she") are not used. Staff included representatives from different Region departments as well as the senior leadership team. The group of non-Region participants was comprised of grant partners and other partners, as well as a representative from an organization that was external to the grant.

### **4.2.2 Interview Questions**

The interviews were semi-structured; that is, an interview guide served as a general agenda and was used flexibly in order to attend to information pertinent to the participant (Smith, Flowers, & Larkin, 2009). Follow-up questions were asked where necessary. To gauge whether there is a shared conceptualization of what KT means, most interviews began with the question “What is your understanding of knowledge translation as it relates to health research?” Questions were designed to elicit information that could be used to address the evaluation questions. Some of the questions were the same for staff interviews and the non-Region interviews (e.g., “Can you recall the knowledge translation activities that were carried out?”; “In your view, were there any people or groups that could benefit from knowledge translation activities but were not targeted in this project?”). To assess the degree to which iKT was achieved, both staff and non-Region key informants were asked to discuss the other party’s engagement tactics. The questions were reviewed by a staff member. See Appendix D for the three main interview guides that were used for the interviews (staff, partners, Della). Questions were tailored to each participant, and for reasons such as time constraints and inapplicability, participants were not asked all of the questions.

### **4.3 Online Survey with Health Equity Summit Participants**

The purpose of this survey was to assess whether taking part in the Summit had a perceived influence on participants’ views and actions surrounding health equity. As participants’ e-mail addresses were located in PHO’s records (record 30), it was possible to distribute a link to the survey via e-mail. On the advice of a staff member, an e-mail was sent to representatives of the partner agencies involved in the Summit (NCCDH and CCSDH) to apprise them of the survey and the questions being asked. NCCDH gave the survey the “go-ahead.” The survey was e-mailed to participants on February 21, 2014 and a reminder e-mail was sent on March 3, 2014. Because some of the participants were interviewed for this evaluation and were asked questions that covered the same topics as those in the survey, the survey was not sent to these individuals. See Appendix E for the e-mail message containing the survey link.

#### **4.3.1 Respondents**

The survey was sent to 58 participants and 20 responded, representing a response rate of 34%. This is not an optimal response rate but is consistent with online survey response rates reported in the literature (e.g., Hamilton, 2009; Nulty, 2008). Despite slight differences in the occupational categories used in this survey and those reported in the NCCDH event summary (NCCDH, 2014), it appears that those working in non-governmental organizations (NGOs) were over-represented in the survey (35% of the survey sample versus 11% of all participants), while those working in regional health authorities were under-represented (24% of the survey sample versus 36% of all participants). Proportions were similar for the categories of academia and public administration/government. The majority of participants were female (63%) and 46 to 65 years old (70%). Due to an oversight, participants were not asked to report where they live.

### **4.3.2 Survey Instrument**

SurveyMonkey was used as an online survey platform because it is well known, widely used, and can be used free of charge for smaller surveys. The questions were primarily closed-ended (see Appendix E). Sample items include: “Participating in the Summit prompted me to take action to increase health equity” (rate on a five-point scale ranging from *Strongly disagree* to *Strongly agree*); and “Did your agency take any action(s) as a result of the Summit proceedings?” (yes or no). Some questions asked participants to elaborate on their responses by typing comments (e.g., types of actions taken). The survey concluded with a few demographic questions.

## **4.4 Online Survey with PHO Network**

The purpose of this survey was to assess (1) whether the health disparities research has influenced individuals’ work and/or the work of their agencies; and (2) individuals’ knowledge and opinions of the KT activities that were carried out. The distribution of the survey link was facilitated by the Region’s CMHO, who e-mailed it to a number of leaders and decision-makers working in the areas of health and/or health equity. The survey was e-mailed on March 3, 2014. See Appendix E for the message that accompanied the survey.

### **4.4.1 Respondents**

The survey was sent to Saskatchewan Medical Health Officers ( $n = 19$ ), the Region’s board of directors ( $n = 9$ ), SRIC members ( $n = 20$ ), and the Urban Public Health Network Medical Health Officers ( $n = 25$ ). A request was also made to have the survey sent to CCSDH members ( $n = 25$ ), but it is not known whether this occurred. Eight individuals responded to the survey, though data for one participant were not usable because this individual indicated that they were not aware of the health disparities research. As it is not known exactly how many people received the survey, it is not possible to calculate the response rate; however, it is clear that it was very low (roughly 10% or less). For this reason, and because some participants reported not knowing about some of the main KT activities (e.g., four out of seven were not aware of the *Della* video), most of the data generated from this survey were deemed insufficient in terms of being able to address the evaluation questions.

### **4.4.2 Survey Instrument**

As with the survey of Summit participants, SurveyMonkey was used for this survey. Again, the questions were primarily closed-ended (see Appendix E). A sample item includes “For each of the following activities carried out/tools created, please choose the response that best captures your knowledge and engagement with these activities/tools” (four response options; e.g., *I’m aware of this activity/tool and it has impacted my work*). Some questions asked participants to elaborate on their responses by typing comments (e.g., ways in which research has informed their work). The survey concluded with a few demographic questions.

## 5. Results and Discussion

---

Results are organized by the sections and evaluation questions outlined in the evaluation matrix in Appendix C. Wherever possible, multiple sources of data are used to provide justification for evaluative statements. Quotes that are used to illustrate points are not entirely verbatim (e.g., fillers such as “you know” were not included, previously defined acronyms were used in place of full phrases).

As mentioned, key informants were asked to reflect on what KT means in the context of health research. There was agreement for the most part, with the key themes resembling some of the core tenets of KT and iKT: (1) finding ways to ensure that research has an impact in terms of prompting action (e.g., in the development of health programming, policies, and practice); (2) communicating research-informed messages in a way that will resonate with target audiences and be understood; and (3) collaborating and engaging with target audiences to incorporate their input into the entire research process. The following extracts illustrate these themes:

“To me, it’s being able to put what we know into action, from the research that’s done locally and by PHO or other partners in the community, but also looking more broadly to the research base, finding out what works and then being able to communicate that to a wider, diverse audience. It’s being able to take what we know in health and be able to translate it to things that make sense for our partners; for example, in the education sector or in the non-profit community sector or in the business community. It’s trying different things, beyond published papers and information leaflets and that type of thing. The *Della* video is a good example of something that’s a little bit different, or community discussions or just different approaches to getting the message out to people.” (Staff)

“As researchers, you don’t just go in there, do the research, and leave without involving the population or community or the decision-makers that will be affected by the outcomes of your research. The point around KT is to be able to engage people from the very beginning, to bring them in and actually try to understand what their research questions might be, to ensure the work you do, from a research perspective, is meaningful and there’s good uptake on implementing whatever your findings might be, or really understanding the findings clearly enough to apply some sort of change or some sort of improvement around the research question.” (Staff)

“KT is that activity that happens to bridge the know-do gap. We know a lot of things based on research, evidence-based sort of information, but a lot of this information doesn’t necessarily get acted on by those who need to act on it, whether they be policy-makers, decision-makers, program planners, practitioners. So it’s trying to close that gap in a powerful way.” (Non-Region)

“Using the information that has been found through scientific research and forming it into a message or some type of document or form of information dissemination that is useful for a

particular audience; and that audience can be as broad as the general public, or it can be narrower so that it meets the needs of a particular professional group.” (Non-Region)

One non-Region individual had a unique perspective on KT, stating that “the textbook definition of KT” involves institutions and professionals translating knowledge to the local community, especially the core neighbourhoods and vulnerable populations; that is, bringing “knowledge to where that knowledge is absent.” This individual believes that “real KT” involves significant dissemination efforts and numerous discussions with community members and groups, individual and community capacity-building to mobilize for advocacy and action, and journeying with community members and groups to lobby for changes that will impact people’s health. This is in line with a bottom-up KT approach wherein action and change is driven by the community (Baum, 2007). It is also congruent with iKT, which is another term for community-based participatory research (CIHR, 2012). This suggests that this individual conceptualizes KT as inherently requiring iKT with the community.

The following sections include an analysis of what worked well in this project and what did not work well or could be improved. Given that this evaluation was improvement-focused, a thorough examination of project design and implementation was undertaken, which included an assessment of PHO’s engagement and collaboration with partners and other stakeholders. The highlights of the project are the creation of a high-quality KT product – the *Della* video – and the advancement of work in the health equity field through the Health Equity Summit. The video is a KT tool that has been used by PHO and other agencies to increase awareness and understanding of health disparities and inequities, while the Summit has laid the groundwork for local, provincial, and national action to promote health equity. Although certain issues emerged in the process evaluation, they are thought to largely be a function of insufficient time and resources relative to the number and scope of activities that were planned. In addition, in the words of a staff member, “part of a grant is learning. You can’t be perfect all the time, so you’ve gotta learn where things don’t necessarily work.”

## **5.1 Project Design and Implementation (Process Evaluation)**

### ***E1. Were all activities carried out as planned?***

As can be seen in the work plan in Appendix A, most of the planned activities were either completed or are ongoing. The largest number of planned activities that were not completed were those involving engagement with the school community regarding the SHS results: (1) implementation of the computer game; (2) presentations to schools, school boards, and School Community Councils; (3) creation of a Facebook page to create a forum for discussion; (4) creation of a video for the poverty awareness curriculum; and (5) student and teacher forums in certain school divisions. Other activities that were not carried out pertained to dissemination of the health disparities research and progress stemming from the research: (1) establishment of online discussion forums and a community of practice on CVC, a PHO-housed, web-based tool that contains various resources (PHO record 1); (2) distribution of progress on policy options and a plain language fact sheet; (3) development of interactive presentations to be posted on relevant websites; and (4) development of podcasts to be posted on relevant websites. The

remaining activities that were not completed include a few conference presentations and the evaluation.

For some of these activities, the reasons why they were not completed are quite straightforward. With regard to the two conferences, for example, one could not be attended due to a lack of available grant funding (staff interview), while the International Conference on Urban Health did not take place in 2012 (it took place in 2011 and not again until 2014; Belo Horizonte Observatory for Urban Health, n.d.; International Conference on Urban Health, n.d.). According to the last iteration of the work plan (PHO record 13), the Facebook forum for students was not implemented because the Region's communications team prefers to route social media activity through its existing accounts. The use of CVC to facilitate engagement regarding health disparities and health equity did not occur during the grant period; however, some of the KT grant funds have since been used to release health equity-related information using infographics (staff member, personal communication). Lastly, as previously indicated, the evaluation was not completed due to a staff change and the need to go through a hiring process.

The key informant interviews illuminated some of the perceived reasons why other activities were not carried out. With respect to activities pertaining to the school community, some staff indicated that the SHS results were being used to inform both the HPS program and HPD's poverty curriculum resource. In addition, the Region's CMHO spoke about health disparities at several teacher conferences during the grant period. In other words, KT work was occurring with the school community but was not connected to the KT grant. One staff member noted that discussions occurred with the schools but that the presentations and forums did not work out even though attempts were made. This was seen as being due to PHO not being invited to meetings along with challenges in being able to meaningfully engage with schools because they are bombarded by requests to participate in initiatives. In contrast, one non-Region individual perceived that no outreach attempts occurred with a certain school division and that no effort was made to translate knowledge to the school community. Challenges to meaningful engagement with schools were noted by other staff as well, as evidenced by comments such as "It's hard to make inroads" and "How do you engage with schools when their focus is becoming more and more around learning objectives that they're accountable for?" Some staff offered ideas as to how these challenges might be overcome. The key themes are timing and internal communication and coordination.

"It's really just a matter of maybe four or five months where you can actually do some of these things, and then you're just one of other curriculum priorities that had been set for that year. It also comes down to individual teachers – how much they are interested in what it is that we're doing and how much they personally buy in to it. [...] I think it's a skill for people in KT just to recognize where there's a window and to put the energy and resources where it's gonna work rather than put time and energy into kind of chipping away at something that's moving slowly when your window isn't that big."



“We have multiple people and departments in PPH that are building relationships with the school divisions. I think we need to be better at connecting that work together, ‘cause the school divisions don’t see it as different. They don’t understand the differences between PHO and HPD, or the nurses, or the HPS program. It’s all the Region to them. [...] There are nurses engaged with those schools, so invite them into those conversations, or schedule meetings around when the nurses can be there. When you’re meeting with groups of principals or superintendents, let’s go together to have those conversations versus finding out later, oh, we had that conversation, we talked to the superintendent about that. Or talking to a superintendent who said, I met with so and so last week and you didn’t know about that? So it’s a bit of the information management, but also kind of a function of letting other people know, and often we think, who needs to know about this?, and we don’t think to go outside of our departments, so it’s just kind of broadening what that lens is.”

The former staff member indicated that the Region’s engagement tactics with the school community are evolving:

“I think the school system is a good example of an organization that we’ve learned a lot about in the past year. It’s about getting to know individuals in positions, but then it’s also getting to know how the positions are placed in the organization and how responsibilities are divided and who’s responsible for approving certain decisions. We’ve been working hard to learn that and, I think, becoming more effective in how we’re working with the school divisions. But it takes times, and then people move, structures shift, so you do have to keep on top of it and keep re-learning that.”

For the computer game, it was noted by staff that it was not tested and implemented with students because of a lack of time and personnel with expertise in the area. It was also felt that the game lacked the sophistication required to capture the attention of youth, who are exposed to many forms of advanced technology. A non-Region individual alluded to insufficient resources, estimating that it is “probably a \$100,000 project on its own.” As to what the issues might have been, this individual stated:

“It could’ve been some lack of clarity. Maybe neither party had enough expertise in the other’s area. [...] That’s a competitive marketplace, and in terms of app development for health disparities, I think you’d need to do a lot more focused work with somebody that really knew both areas – health disparities and what you might do through social media or apps – for that to be successful. I’m not surprised that it wasn’t successful. I think it was very ambitious, and often you kind of do realize partway through projects that some grand ideas you might’ve had, you might not be able to pull them off.”

Since effective KT is typically time-consuming (Banister, Leadbeater, & Marshall, 2011) and this project took place over a relatively short timeframe, it would seem that the quality of the activities should be emphasized over the quantity. As such, it does not seem necessary – or even possible – to comment on



whether the number of activities was appropriate or sufficient. What is more important is why certain activities were not carried out. As discussed by one staff member, not completing some of the school activities, including the computer game, represents missed opportunities: “We didn’t strategically identify how to engage and involve students in the use of the SHS data.” That the game was not implemented due to time and resource constraints is understandable, but that students did not engage with the game in any way lowers the credibility of the endeavour from a KT perspective. This is supported by the fact that this was one of the key activities included in the “Rationale for Supplemental Activities” section of the KT grant application (PHO record 1). For this reason, and because children and youth have been identified as a priority population in the Region’s health equity agenda (PHO, 2012), it may have been prudent to prioritize the school community activities over some of the others. Having said that, with the Region conducting other KT work in the schools leading up to and during that time (e.g., HPS program), perhaps additional activities were not as crucial or might have overloaded the school community. This possibility was not explored. While staff perceive that engagement efforts were made, at least one non-Region individual reported dissatisfaction with PHO not following through on its commitments. This suggests that there needs to be a “better connection between the Region and the school divisions” (staff interview) to ensure that young people can be effectively targeted in KT projects. Staff did not touch on why the health disparities-related activities were not completed, though it is reasonable to assume that it was due to planning for more than was reasonably possible:

“I think we were probably over-ambitious in what we thought we could achieve in a year. I think another challenge is that when we manage grants out of this office, basically, we have funding for one position, and it was only a half-time position. And then we have the manager, who’s also busy with a million other things.” (Staff)

A non-Region individual said that PHO should not be faulted for being ambitious, because “in KT, sometimes you just have to try stuff, and some stuff just doesn’t work.” In assessing this and other evaluation questions, it appears that time and resource constraints were one of the main reasons why certain elements of the project were not actualized.

## ***E2. Were the activities carried out on schedule?***

A number of dissemination activities are ongoing and, thus, are not subject to a timeline. The CVC upgrades and the evaluation are both roughly 10 months behind schedule. With regard to CVC, one staff member said the process of turning the website into a more interactive tool (versus simply a data collection tool) has been ongoing for over 10 years, which was described as disappointing. During the grant period, upgrades to the site were put on hold for funding reasons (PHO record 13).

Apart from potential funding issues, it is not known why there have been ongoing delays with making CVC a more interactive dissemination tool, but it appears that there is progress being made on that front. Although CVC has the potential to facilitate KT with a broad audience (PHO record 1), it is not particularly time-sensitive; rather, it is likely more a matter of the sooner, the better. Time is crucial for conducting evaluations, however, making the delay in this regard problematic. For example, many of the

individuals who were interviewed reported difficulties in recalling aspects of the project or their involvement therein, which weakened the ability to obtain thorough and accurate responses.

### ***E3. Were the target audiences reached?***

The community and decision-makers were the target audiences that PHO identified for this project (PHO record 1). Activities that were geared toward the community/general public were the *Della* premiere and panel discussion at the Broadway Theatre, the school newsletter insert on the SHS results, the Mobilize! forum, and the public opinion survey. Decision-makers were targeted primarily through the dissemination of health disparities and health equity information along with the Health Equity Summit. There is evidence that outreach was attempted with relevant community sub-groups previously identified (e.g., business sector, faith community; PHO record 1) as well as local and provincial leaders. For example, the *Della* premiere was promoted to churches, businesses, city councillors, and MLAs (PHO record 30). The records and interview data suggest that attempts were made to engage some of the interest groups that were not reached or were less prominently represented, including Aboriginal organizations (several were invited to the Summit; PHO record 20), high-level provincial politicians (deputy ministers and assistant deputy ministers within the Ministries of Health, Social Services, Education, and Advanced Education were invited to the Summit), and individuals with lived experience/first voice (encouraged to attend Mobilize! forum; PHO record 23). Individuals with lived experience were involved in three ways: creation of the *Della* video, the panel at the Broadway Theatre event (*Della* was a panel member), and attendance at the Broadway event (PHO record 31).

Key informants were asked if they felt that there were any groups that could benefit from KT activities but that were not targeted or reached in this project. Responses included:

- **Provincial government (decision/policy-makers).** A staff member felt that PHO “probably could’ve done more around working with provincial government” and needs to engage in more relationship-building with this group, not only in the health sector but across various sectors. This individual discussed several challenges in this process, such as geography, limited knowledge of what is happening at the provincial level, not having a designated policy analyst at PHO, and potential backlash (e.g., the government may not be receptive to certain messages). Another staff member perceives competition between Saskatoon and Regina as an obstacle to building relationships with the provincial government: “The fact that the main medical university is in Saskatoon and the government is in Regina has long been an issue for the Region.” For this project in particular, the former staff member felt that individuals working for the provincial government should have been engaged sooner and more aggressively. One non-Region individual said that “there was a question of, where are the politicians?” at the event.
- **Certain community leaders.** According to one staff member, some key groups were not represented at the Summit, which aimed to attract community leaders and health equity experts (PHO record 1). That is, it was thought that a few agencies sent representatives who

were not in higher-level positions and therefore did not necessarily feel comfortable participating in a discussion about a national-scale agenda. A non-Region individual questioned why speakers were brought in from outside the province rather than showcasing the knowledge of local leaders in the health equity field.

- **Individuals with lived experience.** A staff member recollected that, while there was first voice representation in the project (e.g., Della and family), there seemed to be less representation at the events held (Broadway Theatre show and the Summit). One non-Region individual stated that, in events like the Summit, it is important to recognize individuals with lived experience “as experts of their conditions.” This also emerged in the written feedback provided on the Summit evaluation forms, and a recommendation was made to invite community members and first voice individuals to future events of this nature (Adesina, 2013).
- **Aboriginal organizations.** It was noted by a staff member that few Aboriginal organizations were represented at the Summit. Indeed, it appears that only two out of the 15 to 20 invited Aboriginal organizations were represented at the Summit (PHO records 7 and 20). This staff member stated that individuals with lived experience and Aboriginal organizations are often the “toughest to engage in ways that are meaningful to them.” Another staff member said that it can be difficult to meaningfully engage with First Nations and Métis groups because “they’re stretched so thinly” and often “just don’t have the time.”
- **The community in general.** The non-Region individual who believes that KT should involve institutions and professionals translating knowledge to the local community felt strongly that PHO missed the mark in terms of achieving “the genuine KT of actually being with people and working with them in the communities” to “make sure the responses are more methodical and driven by community goals and aspirations and resources, and that the community is part and parcel of this whole endeavour.” Accordingly, this individual stated that the KT activities “had little, if anything, to do with actually moving to an action phase to reduce health disparities.” The activities were also described as “misplaced” and a “complete and utter failure.”

At a basic level, PHO succeeded in reaching its two primary target audiences: the community (primarily through the *Della* video) and decision-makers (primarily through the Summit). However, these broad categories are not overly useful in terms of gauging whether PHO targeted the most relevant audiences and targeted them effectively. One important community sub-group that was targeted but not effectively reached was the school community, particularly youth. On the other hand, an important sub-group that is typically under-represented in community initiatives featured prominently in the project through the *Della* video and the Broadway Theatre event: individuals with lived experience. This is a positive step but appears to be the only activity that these individuals were actively involved in, which is not in line with PHO’s “policy in place around people with lived experience being involved in all the activities at some level” (staff interview). The video was shown at the Summit, which can be considered first voice representation, but this is not thought to constitute meaningful involvement in the event.

Overall, it appears that a concerted effort was made to reach some key individuals and groups at both the community and decision-maker levels. Despite these attempts, some key informants and Summit participants felt that certain groups were not sufficiently reached at both of these levels; namely, community members, individuals with lived experience, and politicians. With respect to engaging the community, a non-Region individual said that the Region needs to “get closer to the people,” while acknowledging that it can be time-consuming and expensive. Pursuing fewer KT activities likely would have allowed for more intensive attempts to engage the groups and individuals deemed most critical to advancing health equity. This may have been aided by a prioritized list of target groups and individuals within the two broad categories. A record of who should/would be specifically targeted and why could not be located. In addition, although certain community sub-groups were identified, it was sometimes unclear in the records as to what types of engagement and promotional activities were carried out to attract these sub-groups.

It is not known if and how many individuals from different sub-groups were reached. However, it is recognized that collecting this type of data from individuals attending public events would not have been feasible. Given the online availability of tools and materials, it is also not possible to determine who is accessing and viewing them. Hence, it is difficult to ascertain the number and types of community members who were reached by this project.

Because there is a record of who attended the Summit, it is easier to determine which leaders and decision-makers were reached. According to one staff member, the project was intended to have not only a local focus but a “big picture” perspective in terms of trying to connect the Region’s health equity work to that of other agencies and practitioners across Canada. The intent was also to expand and strengthen health equity work by reaching out to non-health sectors such as education. Given that most provinces/territories were represented at the Summit, the goal of a national audience was attained, although, for logistical reasons, Saskatchewan was over-represented. The attempt to engage non-health sectors was less successful, with fewer than 10 participants working in areas outside of health and SDH (PHO record 7). This was also observed by some of the participants who provided feedback at the end of the event. These respondents alluded to the notion that “this audience probably knows much of the information” (Adesina, 2013, p. 15), suggesting that the scope of sectors may need to be broadened to move beyond a “preaching to the choir” situation. For instance, one individual stated, “So much common ground - however, are others in other sectors also ready for these discussions?” (p. 14). A non-Region individual said they did not need to attend the Summit because “they already know this stuff.” This individual felt that community members and groups should have been engaged in the conversation instead of having a forum where “knowledge swirls among professionals.”

Because Aboriginal people have disproportionately higher rates of poor health outcomes than non-Aboriginal people, PPH has devoted a significant amount of time to consulting with Aboriginal leaders and service providers (Cushon et al., 2012; Lemstra & Neudorf, 2008). Thus, Aboriginal organizations are a key interest group; however, few organizations were represented at the Summit. Similarly, none of the high-level politicians who were invited attended. There were, however, a few upper-level provincial

government representatives in attendance (e.g., directors). Overall, then, while the Summit attracted leaders and decision-makers from across Canada who brought influential expertise to the table, as one of the staff members noted above, “some of the key groups that needed to be there weren’t there.” Despite this issue, as will be discussed under E6, several Summit participants and key informants felt that the Summit was beneficial in terms of advancing work in the health equity field. As well, a non-Region individual noted that attempts to branch out beyond the “usual suspects,” to non-health sectors and politicians, was “positive and innovative” and reflected a form of “risk-taking” in that individuals with varying perspectives on health equity were invited to provide input.

In terms of key informants’ thoughts on relevant groups that were not reached, first, it is reasonable to conclude that enhanced targeting of provincial politicians and local leaders, both within and outside of the health sector, would have been worthwhile, particularly for the Summit. Second, while there is certainly merit to the bottom-up approach to KT, definitions of KT often make mention of translating knowledge to decision-makers, as they have the power to enact program and policy changes (e.g., Bennet & Jessanie, 2011; Bowen et al., 2011). According to Leadbeater et al. (2011), KT can operate both in community contexts and political contexts. Further, Baum (2007) contends that “in order to crack the nut of inequity, practical action is needed both from governments as well as the civil society” (p. 94). A non-Region individual discussed the merits of getting both leaders and community members involved in KT activities:

“I think [PHO] did [the *Della* video] the right way, ‘cause they got people that were like the Dellas involved, but they also got – whether it’s the leadership or some of the people that speak up for these people, or the advocates or the lobby groups – part of that as well. I think if you just have the Dellas involved, without some of the political people involved, their messages don’t get the attention that they should.”

Another non-Region individual noted that those doing KT work often get asked why there is not more community involvement in these endeavours. This individual indicated that some agencies that are geared toward KT within the field of public health “have taken a KT approach that is about working with public health practitioners who might work with intersectoral groups, or within their community engagement strategies, to move knowledge into action.” Therefore, it is not felt that KT activities which are not primarily aimed at the community are necessarily misplaced, as effective KT with leaders and decision-makers may catalyze and/or strengthen community-based efforts to enact change.

#### ***E4. Was the process well documented and supported by the literature?***

As somebody who is external to the Region and has no background or experience in KT, it was time-consuming and challenging to piece together the events of this project and to distinguish between KT and non-KT activities. This is not surprising, as external evaluators’ lack of knowledge regarding context, history, and organizational roles has been identified as one of the main disadvantages to external evaluations (Bowen, n.d.). Because various staff members were involved in this project, authored the documents that were reviewed, and have access to the shared file server that houses the project

records, this assessment is geared toward the process-tracing of the team rather than that of any particular individuals who were involved. It should be noted that, following the review process, the evaluator learned that documents which might have been pertinent to the evaluation were located elsewhere on PHO's shared file server. In addition, for ethical reasons, PHO could only provide pertinent documents that did not contain sensitive information. Due to time constraints, a review of other PHO files and documents was not feasible; consequently, the assessment outlined below was limited to documents within the KT project folder.

Some of the key issues encountered in the records review were:

- Ambiguous file and document titles.
- Various iterations of one document, sometimes with no clear indication as to which one is the most recent.
- Lack of contextual details (e.g., dates, roles of people identified and who those people are, who created the document and why, use of undefined acronyms).
- Inclusion of documents with no clear relevance to the project.
- No folder consisting of only data pertinent to the evaluation.
- Language inconsistencies: health disparities versus health equity.
- Little documentation of having used the literature to inform KT, iKT, and other activities.

To be fair, these issues would probably arise in most external reviews of an organization's records, as staff likely have a shared understanding of roles, projects, relationships, and so on. In other words, it is understandable that documents are often created, perhaps unconsciously, with an internal audience in mind. This only becomes an issue if staff turnover occurs or, in this case, if an external evaluation is commissioned. In some of the key informant interviews, it was noted that the Region is seen as a leader, "champion," and "groundbreaker" in the health equity/SDH field. For this reason, PHO has the potential to serve as a model for other health agencies that wish to pursue KT work. The issues mentioned above may pose certain barriers to this, as might the amount of time that lapsed between the completion of the project and the evaluation. For instance, the recall issues observed in the interviews may have resulted in descriptions and interpretations that inadvertently lacked pertinent information. Although most staff who had involvement in the project are still employed with the Region at the time of this writing, if those individuals leave the organization and PHO looks to the project records to develop future KT initiatives, it could prove difficult to utilize the records to their full potential.

Another challenge was that, with so many interconnected activities occurring within the Region at any given point in time, staff may not be able to readily identify what activities fall under a particular initiative or grant. This was mentioned by two key informants, with a staff member stating, "It all kind of blurs together in my mind around what's PHO-funded and what's grant-funded" and a non-Region individual commenting that, "typical with KT, things start to all sort of bleed together." To take an example, some key informants brought up a Café Scientifique event called "Minding the Health Gap," which was held in March 2012 at the Saskatoon Farmers' Market (SaskatoonHealthReg, 2013b). Speakers at the event, including Senator Hugh Segal, spoke about the links between poverty and health.

This was a KT activity that was not funded through the KT grant but was included in the KT grant records. While this is fairly trivial and this event is still worth mentioning as a community-oriented KT activity, PHO had noted that efforts would be made to “differentiate between the outcomes associated with previous KT activities and...supplemental KT activities through process tracing” (PHO record 1, p. 7). Again, this only becomes an issue when, for grant accountability reasons, evaluations need to assess activities that were specific to the grant being evaluated. In this case, it would not have been feasible to map out and assess all of PHO’s KT work related to health disparities and health equity.

In regard to the use of “health disparities” or “health equity,” the two terms are inter-related yet distinct. The nature of the relationship between these two principles is not clearly articulated in the records, creating some confusion as to what outcomes the activities are intended to produce. In terms of using the literature to guide project design and implementation, some literature is referenced in the grant application (PHO record 1) and the project folder contains relevant literature, but it cannot be determined to what extent past research might have been used to support decisions made on the activities that were ultimately pursued. A staff member indicated that “brainstorming” occurred with “staff and partners on the grant, to come up with some of the more creative idea.” While this can be a good starting point, it is important to consult the literature to add and refine ideas prior to project implementation.

In sum, a number of process-tracing and clarity issues were found to pose challenges to the review process. There was also limited evidence of the use of past research to guide project design and implementation decisions. These issues may pose future challenges in terms of being able to replicate the KT work that was done for this project. It is important to reiterate that this evaluation is improvement-focused. The Region has been identified as a leader in the field of health equity/SDH and may, therefore, be looked to for KT ideas. Those ideas will be better formed and more useful to others if documentation of the process (e.g., rationales for decisions, engagement experiences) is more precise. However, it is acknowledged that this is easier said than done. In the grand scheme of this project, it would be understandable if record-keeping was secondary to collaborating meaningfully with partners and developing effective KT tools and activities. It is plausible that the latter activities were prioritized and that more detail-oriented process tracing was simply not feasible. In the words of one staff member, forgetting to document things “happens all the time” because staff are busy and often pressed for time. This relates to a recurring theme that emerged in the interviews: time and resources are perennial challenges in grant-funded initiatives. In an ideal world, there would be adequate time and resources for relationship-building and collaboration, project coordination, and process-tracing. As it was evident that this was not the case for this project, it is believed that the root of the issue was insufficient time and resources rather than the team’s ability to document processes and organize records.

#### ***E5. Were the activities consistent with the definition and intent of KT?***

The non-Region individual who described the KT project as a “complete and utter failure” prompted an examination of the literature to assess the degree to which some of the main activities meet the definition and intent of KT as outlined in section 2. The perceived level of fit for each activity was



classified as low, medium, or high. The results are summarized in the table below, in order from high to low levels of fit.

Table 1. Degree to Which Project Activities are Consistent with Definition and Intent of KT

Activity	Level of Fit
<i>Della</i> video	High
Computer game for youth	High
School presentations and student forums	High
Interactive social media tools (e.g., CVC)	High
Health Equity Summit	High
Mobilize! forum	High
Dissemination of SHS report	Medium
Conference presentations, journal publications	Medium
Replication/public opinion survey	Low
Follow-up questionnaire with those who received SHS report	Low

Activities seen as highly fitting the definition and intent of KT include those that sought to use innovative dissemination strategies to make knowledge more widely known, relevant, and understood among the community and decision-makers, which, in turn, *may* facilitate action that can reduce health disparities and inequities (Bennett & Jessani, 2011; Bowen et al., 2011; Leadbeater et al., 2011; Straus et al., 2009). The word “may” is emphasized because this project and this evaluation did not employ research methods capable of reliably capturing whether the KT activities facilitated action that led to changes in health disparities or inequities. Most of these activities fall within two of the three categories of KT strategies identified by CIHR (2012): dissemination (i.e., helping it happen), in that messaging was tailored to the target audiences; and application (i.e., making it happen), in that evidence was applied to activities such as workshops and tool development in order to deliver key messages more intensively (CIHR, 2012).

Dissemination of the SHS results along with conference presentations and journal publications meet the definition of KT (i.e., diffusion/letting it happen; CIHR, 2012) but were classified at the medium level because these strategies are typically more appropriate in the early stages of research (CIHR, 2012). According to CIHR (2012), activities should be more creative and non-academic when the target audience is not the research community. Lastly, the public opinion survey and the follow-up questionnaire with individuals who received the SHS report were classified as having a low level of fit because they are not seen as activities that can result in KT in and of themselves. In other words, a survey “could demonstrate a difference, but then the KT wouldn’t be in survey; it would be in communicating that survey at some latter point. Asking the question is not a KT activity” (non-Region interview). A staff member partly agreed with this comment, stating:

“I think it’s almost pre-KT, because in a way, it’s gathering where your public is at in terms of their basic level of understanding around social determinants. It tells you what you need to do in



terms of how to bring evidence forward: What key messages do we need to be emphasizing? Where do we need to do more work to work with the public? It's hard to do KT with the public, to be meaningful, but that's where I think we can take some of our findings and try to dig a little bit deeper in doing some focus testing, and understanding a little more where some of those views might be coming from, what that means, then, in terms of trying to take the data and evidence and best practice forward and say, 'Given your view on this piece, how does this resonate with you?' [...] So I wouldn't necessarily say a survey is KT, but in my mind, it's kind of like laying the groundwork. It's informing the researchers as to where they and the department need to do a better job."

This suggests that doing surveys can be used to measure the potential influence of previous KT efforts and to inform future KT efforts. Therefore, as outlined in the project charter (PHO, 2012), surveys can be seen as a KT evaluation and monitoring activity. The lack of fit with the definition and intent of KT is merely a semantic issue. An easy solution to rectify this would be to clearly articulate the function of surveys and other research activities in KT projects. However, it is thought that these activities should be secondary to those in the high category given that the grant funding is KT-specific. The purpose of this exercise was to rank the activities according to their potential to translate existing knowledge into action. From a justification of resource allocation standpoint, most activities should be in the high category, which appears to have been the case for this project.

#### ***E6. Which activities or tools were most effective and which were least effective?***

The key informant interviews revealed that the *Della* video and the Summit are the most top-of-mind KT activities that took place. As evidenced by the project records and the interview data, this corresponds to the larger amount of resources that were put into these two activities relative to the other activities.

Many individuals who have seen the *Della* video believe that the experience has influenced their awareness and understanding of poverty and its relationship to health (discussed in more detail in section 5.3). In terms of reach, it is evident that the video has been widely circulated by various individuals and organizations, posted on several organizations' websites, included in some organizations' newsletters that are distributed to a large number of people, and referred to in meetings (key informant interviews; PHO records 6 and 32). This has not only occurred locally but provincially and nationally as well. The Broadway Theatre event was promoted through various streams, drew local media coverage, and was well attended (PHO record 6; staff interviews). On April 14, 2014, the view count on YouTube was just under 6,000 (Della Hurdles, 2012; SaskatoonHealthReg, 2012). The vast majority of viewers live in North America, with roughly 90% residing in Canada (Della Hurdles, 2012). One individual posted the following comment on YouTube: "Thank you for uploading this video. We screened this last Sunday at St. Martin's United Church at an education event about poverty in Saskatoon" (SaskatoonHealthReg, 2012). This demonstrates that the video is being used by others as a KT tool. Another example is the Lung Association of Saskatchewan's use of the video in its curriculum for educating health care professionals (PHO record 32). This has occurred in other parts of Canada as well. For instance, two external groups used the video to demonstrate the impact of poverty on health. One of these groups included health

promotion professionals working with Public Health Ontario and the other was a university class in Ontario (PHO record 33). Feedback was received from PHO staff via e-mail and was also collected from the two Ontario groups. Below are some of the comments that were made about the video (PHO records 32 and 33). The comments reflect the emotional impact of the video as well as the desire to share the video with others.

“Putting a face to this issue brings it home.” (Public Health Ontario employee)

“It was very moving! I took my son with me and we both found it very humbling. We live deep in the heart of the west side and have raised our children here. It was a very good reminder of the plight of our neighbours. The evening was very well done. I saw Della on CTV Morning Live. She is an unbelievably courageous woman.” (Director at the U of S)

“THANKS for sharing this. It is an awesome film so congratulations on a job well done. I will certainly pass this onto my friends, family and colleagues.” (Staff member)

“Amazing video showing the determinants of health from a Canadian perspective. We’ll be showing this to our students in the Advocates in Global Health Program at Dalhousie University. My heart goes out to Della and her family, coming from someone whose mother lives in similar conditions. Structural poverty is unacceptable. Thank you for the resource!” (Representative from Dalhousie University)

“In all the years I’ve been here, I’ve heard so many stories, and I rarely cry. I watched the film and it pushed me over the edge. They are such a tight family unit – it was so inspiring to me.” (Representative from local radio station)

Key informants also spoke very highly of the video in terms of its quality and its utility in communicating health disparities to individuals who may not be aware of or understand SDH:

“I think where that video really plays a role is for people who don’t normally see or hear or breathe poverty [...]. Della does such a wonderful job of presenting her reality without making it anybody else’s issue. She just presented it as it was. It wasn’t about blaming government. It wasn’t about blaming the community. It was about, this is the life we live even though we have a fully employed person in our home.” (Non-Region)

“I think it’s very, very powerful as a KT tool. I keep telling people the statistics are important for one sub-group of people, but statistics need to be brought to life, and telling stories is a very powerful way. I think it was really well done in the sense that it showed poverty strikes the working poor – breaking down stereotypes. [...] It’s something that has been very effective in communicating multiple issues at once, and then when you focus on some of the data or talk

about it afterwards, people have it crystallized in their mind what you're actually trying to talk about." (Staff)

"I believe in stories being very important. That's why Della is memorable to me. It impacted a lot of people and it was circulated widely, and in terms of going forward with transferring knowledge, I think using stories to support data is very important, because if you want people to capture the information, they have to feel it, and the story's going to help them feel it." (Non-Region)

"It allows us to take the message out to other groups we deal with, like our board, and it puts it in a way that's not so dry." (Non-Region)

"The *Della* video really did reach a lot of people that we haven't otherwise reached. Last year I was in several conversations where people were either sharing about it or talking about it or talking about how they were moved by it. Whether that translated into action, I can't say, but certainly awareness-raising. The video was pretty powerful in that way, and in circles that I hadn't otherwise heard people talk about it – people around diabetes prevention, those kinds of things. [...] It was a perfect tool for reaching people we weren't already working in health equity, which was the intent, so I think that was a very useful tool for that." (Staff)

"It's a very effective video. It's very poignant and very well done video that really gets not only to the mind but the heart of people." (Non-Region)

"I think the *Della* video was probably one of the most effective activities, because they did a very good job of storytelling around what health disparities look like, on a much more personal level [...]. I thought that video did a really great job in terms of explaining to people what this very difficult concept is. Even the language around it is really hard – health disparities. I think over time people might have an idea what that is, but the language around SDH and health disparities and inequities and inequalities, it's just very complicated for people." (Non-Region)

These extracts highlight the context-setting role the video can play in terms of representing "a story that can help capture the message trying to be put forward" (staff interview). This was exemplified at a Region board meeting in which the video was played prior to presenting on a report: a staff member indicated that board members said the video was "the most powerful thing said that morning, that it really set the context for the report by showing it first; it drove it home for them." These findings suggest that the video is an effective tool for both raising awareness and increasing understanding of SDH.

Those who attended the Broadway Theatre event felt that it was successful:

"The theatre was quite full. It was good. [...] There were questions from a moderator and from the public so we could have a bit of an exchange on these issues. It was great to see Della and

her family there, to be able to talk very eloquently. That was probably the most powerful thing, for her to just be able to be real with people, and she got a bit emotional. [...] I thought it was well done, and just having her there to react to that, give a little bit more detail to people, I thought she was the star.” (Staff)

“I think it was a good experience [...]. This is not acting; these are people that are in our neighbourhood and they’re a victim of health disparity on the wrong side.” (Non-Region)

“I thought it was a great event. The theatre was filled with people from the community. It seems sometimes, when we have these community events, it’s the same faces that show up, but that night it seemed to be new faces in the audience, which was exciting. The panel discussion was great. There were lots of good questions from the audience, and people seemed interested in both the videos and the discussion afterwards. [...] The conversation and the feedback was very positive about the films and the panel discussion.” (Staff)

Lastly, Della herself has experienced many benefits from participating in the video and being a panel member at the Broadway Theatre event. The first quote above suggests that the experience may have played a capacity-building role, which a staff member indicated the Region is trying to do more of in order to encourage the participation of first voice individuals in programs and initiatives. Della described the filming of the video as “very fun.” At the Broadway Theatre event, people came to speak with her afterward, saying things such as “You’re a very courageous woman” and “You’re very open to be able to share your life with other people.” Many key informants spoke fondly of Della, with one staff member stating, “What a champion that woman is. She’s amazing. Her spirit is just incredible.”

In terms of how things have progressed in Della’s life since the project, she and her family had an “experience of a lifetime” when they were chosen as the C95 Radio Christmas Wish family for 2012 (PHO record 34). They received toys, food, and a car. There is a video on YouTube that captures the joyous moment when Della and her sons found out they had won (Ebert, 2012). The car improved their quality of life, as Albert was better able to get to work sites and having a car helped with things such as getting groceries and getting the boys involved in extracurricular activities. Della indicated that their family is still experiencing challenges but that things are getting better because Albert is getting more hours. In addition, Della currently has a part-time job doing childcare for a program called Food for Thought, which is sponsored by the Region. Food for Thought is a prenatal program aimed at helping women and their children to achieve improved health (Region, n.d.2). Della also volunteers as a peer leader for this program. She has a volunteer role as a teacher/facilitator for a six-week program called LiveWell with Chronic Conditions, another program that is offered by the Region (Varsity View Community Association, n.d.). Through her involvement in this program, she has learned various techniques for dealing with her own chronic conditions (e.g., diabetes). Della takes on these and other volunteer roles because she likes getting involved in the community and also because they provide educational opportunities. It is clear that, through her involvement in the KT project and some of the Region’s other programs, Della is strongly connected to the Region and is grateful for the work they do in the community: “Lots of

opportunities have sprung up, and the Region has just been so supportive with things like that for us, and I just love getting involved in every one of them. I'm so glad they're there, that they do things like this, 'cause as small as it may seem right now, I know that in the future there's gonna be more done about it."

The next most talked about activity was the Summit. By connecting and strategizing with national partners such as NCCDH, it was felt by PHO that its learnings and expertise could be leveraged to advance health equity at the national level. This relates to the perception that, due to its innovative and unique activities, the Region is a leader in the health equity/SDH field (key informant interviews). For example, NCCDH used the Region as a case study because of "the focus on the public health role in thinking about how we report on and assess health status, and how that can help support us work intersectorally or with communities" to address health disparities and inequities (non-Region interview; see NCCDH, 2012).

Evaluation forms that were administered at the end of the event were completed by 23 of the participants, representing a response rate of 37%<sup>3</sup> (Adesina, 2013). With respect to the distribution of professions and regions, respondents were fairly representative of the overall group (as per data reported in NCCDH, 2014). Adesina (2013) notes that many respondents were grateful for the opportunity to brainstorm and interact with individuals who had a variety of backgrounds and specialties. Nearly all respondents believed that the three objectives of the event were partially or fully met. Perceiving that objectives were fully met was highest for "Bring together an engaged and active national multi-sectoral audience..." ( $n = 11$ ), followed by "Profile health equity work occurring locally, provincially and nationally..." ( $n = 7$ ) then "Contribute to the development of an agenda to guide health equity practice, policy, research through action..." ( $n = 6$ ). Below are statements that respondents were presented with, along with the numbers of respondents who selected "Agree" or "Strongly agree":

- The Summit delivery addressed the items outlined in the invitation and agenda (20).
- The correct mix of participants was present to fully discuss the issues (14).
- The appropriate mix of speakers and panel participants was present (16).
- The flow and organization of the Summit was maintained throughout the event (20).
- The Summit sustained my interest and participation throughout the event (18).
- The Summit was effectively facilitated (21).
- By attending this Summit, I gained knowledge that I will use in my work (20).
- I have been connected with people/groups that I can collaborate with (21).

The relatively lower levels of agreement for the statements pertaining to the right mix of participants and speakers are in line with the view of the staff member who felt that key groups were not in attendance, as well as with some of the written feedback provided by respondents (see E3). As mentioned, a few respondents also felt that community members and individuals with lived experience should have been invited.

---

<sup>3</sup> Adesina (2013) reports a response rate of 43% but indicates that 23 out of 63 participants completed an evaluation form, which works out to 37%.

The majority of respondents ( $n = 14$ ) felt that the the presentations and discussions were relevant to the development of a national health equity agenda. The remaining participants either believed this was partially true or responded “other.” In response to the question “How much progress do you think was made in developing a health equity agenda?”, one respondent selected “Very much,” 11 selected “A little,” six selected “Not sure,” and five selected either “Not much” or “Not at all.” In contrast, most of the online survey respondents reported that participating in the Summit increased their understanding of health disparities and their support for initiatives aimed at promoting health equity. This suggests that individuals were influenced positively by the Summit despite feeling that the overall goal was not met. A perceived reason why the goal was not met emerged from the open-ended questions in the event evaluations: that there was too much to cover in one day to be able to develop a national agenda. This was also discussed by a non-Region key informant: “I think one of the things we had to do in thinking back about it, was really considering our overall objective [...], this *lofty* goal of creating an agenda; and to think about how that’s possible, what we could’ve *really* done with a one day event.” This individual along with a staff member expressed that expectations might have been too high. For the staff member, the Summit was “a little underwhelming,” partly due to the absence of certain individuals in high-level positions, which resulted in “some very useful comments and suggestions” being brought forward and “others that were not of that scale.” However, despite not arriving at the overarching goal of developing a coherent national agenda, these individuals discussed the ways in which the Summit was still valuable in terms of advancing work in the field and providing “a start to a framework for a national action plan on reducing disparities” (staff interview):

“Even for those [who were not in high-level positions], people came away from it with ideas on how to move forward locally or within their frame of reference, which was still good. There was a good report that came out of it that fed into reports that NCCDH was doing on workshops around health disparities across the country. So I think it will feed into what will become a national framework. [...] I think the groundwork has been laid and a few steps have come forward, but it was a bit too early to fully realize all of those goals. [...] Looking back at it through that retrospective, I think you can see that it still had a lot of value. It was just a little different than what we had originally envisioned.” (Staff)

“[T]his activity is one of many in our approach to get to action. So in that way, of hosting the event, of having people brought together, of [having an event] report, we have done quite a lot. So there has been quite a lot of success.” (Non-Region)

The latter individual also felt that there is no way to determine what action might have flowed from the Summit, and that the agenda is a work in progress:

“A lot of things we’re not going to be able to measure, like people meeting each other in person or knowing if they ever picked up the phone after to connect. That’s a success story, but it’s often hard to know if that happened or measure or understand it. [...] We’re continuing to strive towards that goal, so some of the...work is continuing. [It’s about] trying to really align and

understand the goals across the country, understand where there has been movement, and capitalizing on some of that momentum.”

An example of work that is continuing was provided by a staff member, who said that the Summit has helped inform the Region’s emerging health equity plan. Other key informants who talked about the Summit generally said that it was useful, as illustrated by the following extracts:

“The conference was quite good. Very dynamic discussions. A lot of people came, and lots of people who were from outside Saskatoon and Saskatchewan, so that was good. Even for people from other areas in Saskatchewan, you always go to these things and see people you don’t see all the time. It’s such an issue in Saskatchewan because it’s a big province and it requires lots of travel to see people, so these things that bring people in to talk and focus outside of their work environment are quite good. I’m sure there are things that came out of that for other attendees as well.” (Non-Region)

“I think the activities did generate quite a bit of engagement, particularly the Summit, around decision-makers. It was a targeted audience, so it was pretty key in terms of having people think at a strategic level around health equity.” (Staff)

The comments provided in the online survey were somewhat more mixed (see Appendix F for comments not reported here):

“Great job, keep up the great work. Thank you for taking this process to the next level and helping develop leadership.”

“I was already quite aware of your work and regularly make reference to it, so this particular meeting did not necessarily move me to new action. I was disappointed though with the agenda that was developed as it did not consider the implications for health services as much as I would have liked.”

“The opportunity to meet with and collaborate with some excellent minds on the topic from many different perspectives was very important in setting up opportunities for future work and coalescing action on health equity in Canada. The Summit allowed for a less focused and more comprehensive intersectoral framework to be designed that will/can guide future action on health equity work. The fact that the report will be on the NCCDH website is fantastic - many more people will use the document than would do so if it were on the Region’s website only. Thank you for the opportunity to engage on this issue - thank you for your leadership.”

“I think the goals of the Summit were pretty lofty, and the time frame was super tight.”



One non-Region key informant suggested that developing a health equity agenda on a national scale can feel overwhelming, while a staff member believes that the task will require buy-in from leaders in the federal government:

“I find it very challenging. It’s hard to wrap my head around Canada being such a diverse and large and different country, but what does that actually look like in practice, or even in theory, in an agenda? A list of three major bullet points? What does that mean? If you think about the World Health Organization, they set three broad goals in the commission’s work, and people really like those three goals, but when it actually gets down to action within those three, I do find it quite challenging, because they’re pretty high-level. It’s hard to act. They take a lot of different strategies to get to that work.” (Non-Region)

“The bigger question is: is Canada ready for [an agenda]? Until the federal government wants to step forward and accept and embrace that sort of approach, we aren’t going to get one.” (Staff)

As mentioned in some of the extracts, one of the follow-up activities from the event was the circulation of an event and evaluation summary to participants. Another follow-up action included the distribution of the eight short video clips that feature speakers from the event, which are on YouTube (SaskatoonHealthReg, 2013a). At the time of this writing, the view counts range from 40 to 280, indicating a modest level of reach. A few months after the event, PHO and NCCDH attempted to continue the conversation through a blog post in NCCDH’s online community, Health Equity Clicks. Two questions were posed: (1) What do you think needs to be included in a national health equity agenda?; and (2) What actions will help move this forward? (Ugolini, 2013). To date, there are four responses in this thread. These same questions accompany each of the videos, but no comments have been made for any of the videos. Hence, in these two formats, there has been very little dialogue since the event occurred. However, one non-Region key informant believes that the report and the videos can add to the growing body of health equity work:

“What was really nice about the videos is that they are a final product that can be looked at again and again. That’s a solid takeaway. I think the evaluation report is also a nice, solid product that can be passed around and used in the future. So in that way, we’re gonna have at least two solid KT products, and what we need to continue to do is look forward to the next steps, the next approaches.”

Interestingly, only one key informant discussed the Mobilize! forum that took place that evening. However, four key activities were outlined to interviewees in order to aid recall: the *Della* video, the Summit, activities surrounding the SHS results, and the public opinion survey. Thus, the absence of this activity in discussions could have been a result of key informants either not remembering or not attending the event. The lone comment on the event was provided by a non-Region individual:

“It wasn’t overly well attended. I...think that wasn’t as advertised as well as it maybe could’ve been. The speakers and such that came to it at the end of the day and the conference attendees,



I think a lot of people that were in town for the conference were not that interested in doing something in the evening when they'd been doing this intensive discussion all day. They took advantage of people being in town to give a talk at Station 20 West, but there was only a handful of people there, so that probably didn't go as well as it could have."

This perception is consistent with data from the evaluation forms that were completed after the event: in response to the question "What did you like least about the community forum?", the most common response was "Poor attendance." The records indicate that 30 to 35 people attended, including the event organizers (PHO records 23 and 35). Of the 14 individuals who completed an evaluation form, eight indicated that the forum sustained their interest, with the remainder either reporting a neutral response or not selecting a response. In addition, nine respondents reported that they had gained new knowledge/understanding during the forum. Therefore, in spite of low attendance, there was evidence that those who were there felt engaged and perceived that they learned something.

An activity that some staff members described as highly beneficial was the public opinion survey. For example, one staff member was particularly interested in the survey because it was seen as "the biggest broad-brush measure of how much impact [the Region] has had with the public as a whole." In discussing the value of conducting this type of research, this individual alluded to the bottom-up approach to attaining health equity:

"The survey was one of the most important research goals because a lot of our activities in preceding years, before we got the grant, had been focused on improving public awareness and support. We also focused on trying to get specific policies and programs up and running, but we knew that for sustained success or progress, we needed to get the public supporting and demanding it, because that's ultimately what bends political will. So we needed to see whether all of that effort – social marketing campaigns, media coverage, how we worked it into many aspects of what we were doing – [had] an impact on the public."

The preliminary findings from the survey suggest that there have been some shifts in public opinions in terms of increased support for many of the policy options and increased understanding of SDH (staff interviews). There was also fairly high support for financing health equity initiatives through various types of taxes. This represents a change from the last survey, possibly due to the fact that personal income tax was the only option available in that survey (staff interview). While acknowledging that changes cannot be directly attributed to the Region's efforts, one staff member said, "[I]t's logical to think that we had a part in that because of all the work we've been doing in this area." This was echoed by another staff member: "I do feel like the products we've developed and the studies we've put out there, in their small way, are filtering into people's psyches." In addition to measuring whether awareness and opinions have improved since 2006, the survey is seen as a key source of data for PHO's and other Region teams' planning activities. According to one staff member, "in some ways, keeping tabs on public views is very useful. It helps us to get our heads around, how do we position certain

messages and where do we need to do more work?” Another staff member described this as assessing “community readiness” for certain interventions.

Based on the available evidence, it appears that the *Della* video was the most effective activity in this project. This conclusion takes into account several factors, including congruence with the definition and intent of KT, success in reaching the target audience, level of reach/distribution, perceived quality and effectiveness, level of engagement generated in the community and beyond, and salience in people’s memories. In terms of targeting the general public, it is evident that PHO developed a dissemination vehicle that took into account the recommended KT principles of using non-technical and creative messaging along with online technologies (CIHR, 2012) to effectively communicate messages surrounding SDH. Additionally, the video involved the diffusion, dissemination, and application of knowledge (CIHR, 2012). Importantly, the video along with its debut at the Broadway Theatre had first voice representation, with Della and her family experiencing benefits as a result of their participation. Della has become well connected to the Region through her involvement in the project and subsequent volunteer work and employment in Region-led programs.

The selection of the video as the most effective activity is further supported by the fact that it was the activity most likely to be identified without prompting in the key informant interviews. As well, when key informants were directly asked which activities were most effective in achieving KT, the video was mentioned most often. A non-Region individual described the making of the video as a “pretty big process” and said that it required a lot of planning. This is supported by the relatively high number of planning and tracking documents included in the records. The video has received an overwhelmingly response from those who have seen it, and many external organizations have used it to demonstrate the impact of poverty on health. Thus, the amount of resources that was devoted to the creation and dissemination of the video has resulted in a tangible, effective, and valued KT tool that the Region and other agencies can continue to use increase awareness and understanding of health disparities and inequities.

Responses to the video were not uniformly positive, however. The non-Region key informant who criticized the KT activities stated, “A video that the community probably largely doesn’t see is not going to help someone’s health improve at all – to be clear, at all.” The first part of this comment may be true, as the video was circulated widely but did not “go viral,” so to speak, in Saskatoon (i.e., 6,000 views on YouTube is positive but not overly high). Another non-Region individual questioned whether “the average citizen” has seen the video and said that it is often a challenge “to try to not speak to those who already know – preaching to the choir, so to speak.” This was echoed by a staff member, who said that public events are a good avenue for engagement with the community, but “you’re usually attracting people who are interested in the material, so you don’t always engage people who think differently.” This may mean that renewed dissemination efforts are required in order to increase exposure to the video, and beyond community members who may already be ideologically or behaviourally engaged in equity-related causes. The second part of the comment, that the video will not improve health, may be true as well. However, as outlined in the logical model, it is not hypothesized that KT activities will

directly lead to improved health; rather, the activities are expected to increase both awareness of health disparities and support for improving health equity. In turn, this may lead to actions that can facilitate the structural changes that are needed to increase health equity and improve health. It is important to focus on increasing knowledge and inducing more supportive attitudes as a first step, since attitudes have been found to be a fairly robust predictor of future behaviour (e.g., Kraus, 1995). As the feedback collected during the project primarily measured knowledge/understanding, and being informed does not necessarily lead to actions that can produce desired outcomes (e.g., Ajzen, Joyce, Sheikh, & Cote, 2011), more research is needed on the video's potential influence on people's attitudes toward health disparities and health equity.

The Summit is thought to be the next most effective activity. As with the *Della* video, this activity involved diffusion, dissemination, and application of knowledge (CIHR, 2012). In comparison to the video, however, the Summit was deemed to have been less successful in terms of reaching the target audience as well as level of reach/distribution, perceived quality and effectiveness, and level of engagement generated in the community and beyond. There also was not active first voice representation, and the opportunity to facilitate top-down action could not be actualized due to the fact that high-level politicians did not attend. If one overlooks these factors along with the perceived lack of success in arriving at a national agenda for health equity, the Summit can be seen as a constructive endeavour in which participants felt engaged, gained new insights, appreciated the opportunity for intersectoral interaction, and perceived benefits to being involved. Attempts to keep participants engaged in a discussion about a national agenda following the Summit were largely unsuccessful. However, as will be discussed in section 5.4, results from the online survey indicate that learnings from the Summit have informed some individuals' work. As the staff member states below, actions that can advance health equity will likely be gradual. Similarly, actions flowing from the public opinion survey results remain to be seen because the report is not yet finalized.

“I think for the Summit and the replication survey, it's still too early to be able to identify whether actions will take place. [...] We're [knowledge] users, so for sure there's gonna be action coming from both of those; and from PPH too, 'cause we're developing a health equity strategy, which we didn't have before these activities. So that, I think, is action as a result of this, even if it's more internally-focused, it's organizationally-focused, so it moves the Region along. [...] I do think they have high potential; it's just too early to be able to say.”

Of particular significance is the role that the Summit has played in the formation of the Region's health equity strategy. This indicates that, at a minimum, action will occur locally, which can advance the goal of promoting health equity in Saskatoon. It is not possible to estimate the extent to which provincial and national progress has been made as a result of the Summit. The public opinion survey will also shape the Region's health equity work. Therefore, from the perspective of potential for future action that can increase health equity, these activities show promise. As previously discussed, the act of conducting a survey is not a KT activity but is an important research activity that is relevant to KT work.

With respect to the remaining key activities, the attempts to engage schools and students in the use of the SHS results were unsuccessful, and the Mobilize! forum was well received but was not well attended by leaders and the general public. One of the main takeaways from these results is that the most effective activities were those in which the most resources were invested and which evidenced multiple KT principles (e.g., creativity, collaboration, tailoring activities and messages to the target audience).

#### **4.2 iKT Approach (Process Evaluation)**

The core principle of iKT is that knowledge users should be involved throughout the entire research process (CIHR, 2012). CIHR (2012) states that “[e]ach stage in the research process is an opportunity for significant collaboration with knowledge users” in various activities, including the “crafting of the message and dissemination of the results” (p. 2). iKT has traditionally gone by other names, such as participatory action research and community-based participatory research (CIHR, 2012). With regard to dissemination activities aimed at raising awareness and promoting action, collaboration with partners and other relevant individuals can aid in the creation of targeted messaging. These principles were used to guide the evaluation of whether PHO achieved its iKT objective: to work with advisory groups, including grant collaborators/partners, to effectively develop and target messages about health disparities (PHO, 2012; PHO record 1). PHO set out to “work with [advisory] groups to map networks for dissemination, to determine key messages and which mediums should be used...as well as cultural appropriateness” (PHO record 1, p. 13). For the purposes of this evaluation question, collaboration with the research partners and community partners outlined in the grant application was of primary interest (e.g., SPHERU and representatives from community agencies, respectively; PHO record 1).

#### ***E7. How much input did partners have in the project?***

In August 2011, prior to PHO’s submission of the KT grant application, a staff member e-mailed partners to request (1) letters of support to accompany the application; and (2) suggestions for potential KT activities and for messaging that would be well received by the partner agencies and their target populations (PHO record 27). Recipients of this e-mail included the two principal grant applicants, one of the four co-applicants (i.e., research partners), two of the eight project advisors (staff members), and five of the eight community partners. The three community partners that did not receive the e-mail were SPI, Greater Catholic Schools, and CUISR. A record of responses to PHO’s call for suggestions could not be located, nor could any other communications that may have been sent to or received from partners. When asked about their input in the project, none of the key informants from partner agencies indicated that they provided suggestions for the grant application; however, in light of the amount of time that had lapsed since the application was submitted (over two years), inability to recall involvement may have been an issue.

It appears that only one project team meeting took place, and this was in March 2012, prior to the hiring of the project coordinator and the start of the project. The purpose of the meeting was to discuss roles and responsibilities as well as the work plan (PHO record 28). A few key informants recalled that several individuals participated via telephone. Twelve members of the 22-person project team took part in the meeting, including the two principal applicants, five project advisors (four staff members, one non-

Region individual), three research partners, and two community partners. The meeting minutes indicate that the research partners and community partners in attendance provided ideas, offered to assist with the activities, and were interested in being kept informed on the progress of the project. The only other known meeting occurred in June 2012 (the month the project coordinator was hired) and included three individuals from SPHERU (research partner) and two staff members (the project coordinator and PHO's program manager of research and evaluation; PHO record 29). The purpose of this meeting was to review the work plan and prioritize deliverables.

While it is known that input was solicited, due to potential recall issues and the possibility that input was provided but not recorded, it is difficult to ascertain the extent to which partners had input in the grant application and the design of the project. Based on the records, it appears that five of the eight community partners wrote a letter of support for the grant application but did not provide suggestions or participate in the project team meeting (United Way of Saskatoon, CUISR, CUMFI, Greater Catholic Schools, and HQC); two community partners wrote a letter of support and participated in the team meeting (SPI and SRIC); and one community partner wrote a letter of support and was involved in discussions with PHO in relation to the project (Saskatoon Public Schools). This suggests that community partners may have had minimal input in the conceptualization and design of the project. Results from the records review and the key informant interviews suggest that SPHERU, a research partner, had the most involvement in the project. For instance, SPHERU was a key resource for the creation of the *Della* video, as they had prior experience in producing videos for KT purposes (non-Region interview). SPHERU also disseminated some of PHO's KT work via its kidSKAN network. Through the planning and organizing of the Summit, there was also a fair amount of collaboration that occurred with national partners.

#### ***E8. What are partners' perceptions of PHO's engagement and collaboration practices?***

There were mixed views among partners in terms of what it was like to work with PHO on this project. In terms of favourable impressions, one individual felt that "getting better connected with people in the Region" was a benefit of being involved and that the collaboration helped in their agency's relationship-building with the Region. Another individual said that they "really appreciate the partnership of the Region" in their work and that the Region is "probably the main cog" in their organization. In addition, several community partners discussed the important role that the health disparities research has played in their agency's programming. For example, one individual stated, "Our organization has really shape-shifted around those disparities and it's caused countless activities," while another noted that "the health disparity research really helped the community have a different conversation, and the value of having that data has been very helpful to all of us." Some grant partners and non-grant collaborators spoke about the Region's engagement practices in general terms, with one individual believing that the Region has "a good handle on who the stakeholders or partners are and do a good job of casting that net and bringing them into the process," another stating that "there's a lot more collaboration happening" between the Region and community agencies, and another indicating that the Region uses "quite an inclusive approach." When one of these individuals was asked why they wanted to be involved in the project, they responded that they and their agency are committed to doing "anything that brings light to

[quality of life issues] and magnifies that and signifies that [...] because we all have a responsibility to help out our neighbours and our citizens.”

Unfavourable impressions emerged as well, particularly among two community partners who felt that PHO was merely interested in obtaining a letter of support rather than engaging in meaningful collaboration:

“[We wrote a letter] and that’s kind of where it ended. From our perspective as an organization, that’s typical of the Region’s KT efforts: meeting at the outset and then not a lot of relationship or reciprocity throughout. [...] We were not involved and are always willing to be involved. We’re not involved in these things because we just don’t have any outreach. When letters of support are achieved, we say goodbye and we typically don’t see folks from the Region at all after that. [...] The Region isn’t typically available for these kinds of things, or at least not with any tenacity whatsoever.”

“I do remember when the request came in, and because it was about reducing health disparities, obviously that’s an area of interest for our organization...so to get the information out, I thought that it would be a worthwhile project to do that. [...] But there wasn’t very much interaction with our organization throughout the process. So basically, I think our role in the whole thing was simply to write that letter of support. [...] I felt they needed a letter of support to make it look like there was community involvement, but that it wasn’t genuine in terms of actual participation and involvement. That happens often with academic organizations: they need a letter of support, but once they’ve got it, they don’t *really* take the time to find out what community-based, non-profit organizations can contribute to the process. It’s more of a, we need you, now you’ve written a letter, now we don’t need you anymore. [...] Personally, at least, and professionally, if I’m going to commit to something, I want to be involved and contribute, not just be a token – we need you because you’re a CBO.”

The former individual indicated that their organization “signed on” to the grant because of a commitment that PHO made in terms of delivering certain KT activities. As a result of their negative experience with this project, they said that they would be reluctant to support future Region KT initiatives. They also discussed the practices of a team that is currently collaborating in a meaningful way with their organization: sharing information, offering to present the information in the community, making themselves available, frequent updates and inquiries, and seeking input to ensure the project is reaching who it needs to reach. This individual, while critical of PHO’s approach, said that they recognize their organization’s perspective may be unique because of how invested they are in addressing health disparities.

The latter individual’s sentiment about tokenism relates to another partner’s view that “it probably looked good on the grant” to have a certain individual sign on, but PHO was not able to capitalize on the contribution they could have made to the project. When the individual who discussed tokenism was asked what their expectation would be in terms of involvement, they said they would like some sort of

follow-up and perhaps progress reports. They'd also expect to be "at the table in helping to form the project and move it forward." However, they acknowledged that more involvement in project planning may not have been feasible:

"It's hard to say [if I would've liked more involvement]. In an advisory capacity, perhaps, but it's hard to say. We always like to be involved in everything, but really, time is a big constraint, so even if we had liked to, we might not have been able to participate more."

In addition, this individual recognized that incorporating the input of various partners is "easier to say than do":

"I think that when it comes right down to it, I'm sure that people who were working on the project would have found it very frustrating to, in a timely fashion, get what they needed from other people, including us, because it takes so much longer to really get information. I'm also thinking that what they did, and this is a guess, but I would hope that they spent more of their time getting input from the people who the information was about: the people who live in core neighbourhoods, who live in some situation of vulnerability. If that happened, that truly is more important than having other organizations help. [...] I just think they probably got too busy and had to meet their deadlines, and it was probably just too difficult to keep people in the loop. [...] And that's fair, 'cause we've been there too."

In contrast to these two individuals' views, one community partner was satisfied with the level of involvement they had:

"I think we were good. I think there's a big history of that collaborative working together [...]. All these activities are connected and each one of us has taken a different sort of ownership or leadership on an area that we put resources and leadership into."

A few community partners attributed collaboration challenges to the fact that the Region is a large, bureaucratic organization. For example, one individual said that "sometimes it's hard for large organizations and the machinery of organizations to turn around and stop naval-gazing and actually look outward." Another individual discussed the community's perception of the Region as well as issues with the Region's internal communication:

"I think it's a very large bureaucracy, so oftentimes, because it is so large, the community perspective is that the Region is one organization. You often find that they are coming to community meetings to actually communicate with one another. It sometimes can be like dealing with the government. In other words, the right hand doesn't talk to the left hand. From the community's perspective, you're all the Region, so there's some misunderstanding on our part too, or some assumptions [...]. It's sometimes the same with the university: you're dealing with one part of the university, and another part of the university doesn't know you're dealing



with that part of the university, and so you end up having a conversation with them about, ‘You guys need to talk to each other first and then talk to the community.’ It’s like you’re sort of organizing them, ‘cause it’s big and I understand that, and so sometimes the accountability is difficult when you’re in such a large organization. As community members, you need to appreciate that, but at the same time, the Region needs to understand the community’s perspective and their accountability, which is a bit different – a bit more immediate and a bit more local.”

This individual qualified their criticism of the Region’s internal communication by stating, “It’s sort of hard to mention that, ‘cause we all need to do a better job of that – letting each other know what each of us is doing within an organization.” The observation that the Region is perceived as one organization was also made by a staff member, who noted that Region departments are working on improving internal communication and coordination.

These findings suggest that different partners had different expectations of what their role would be in this project after signing on as a collaborator. Both favourable and unfavourable impressions emerged, with some individuals expressing appreciation for the Region’s partnership and their role in addressing health disparities, and others expressing frustration over their perceived lack of involvement in the project. The latter views are problematic from an iKT perspective and may pose challenges to future KT projects in terms of whether certain partners will decide to become involved. While some partners criticized PHO’s engagement and collaboration practices, they were self-critical as well, with one partner acknowledging that “true” iKT would have proven time-consuming and difficult.

#### ***E9. What are staff member’s perceptions of PHO’s engagement and collaboration practices?***

Some staff members’ views resembled those discussed above with respect to partners’ level of involvement in the project. That is, although it was felt that partners were committed and engaged, as one staff member noted, they were not as involved as would be expected with an iKT approach. One staff member recollected that advisory group members generally did not have much involvement. This individual also said that the Region could strengthen their inclusion of CBOs and community members with lived experience. This is partially in line with the perception of one of the partners, who said that the Region should focus more on collaborating with individuals with lived experience.

Some staff members talked about the strong relationships with partners that have developed over time as a result of the health disparities research and the implementation of interventions. For instance, the following staff members suggested that the results of previous efforts to engage and consult with community partners fed into the work that was done for the KT project:

“Through the process of engaging people throughout the last three or four years, and seeing what’s reaching people and what isn’t and hearing their frustrations expressed one on one and in various committee meetings that you’re at, that’s really what is a more rich content that informed what it is we needed to do next [...]. In terms of new suggestions coming forward at



one or two advisory committee meetings, that probably had minimal impact, but it was an affirming of, did we hear you right and are these the things that are needed? At least that was able to be accomplished.”

“I think our process of stakeholder engagement and consultation and getting input and direction and some collaboration...happens extremely well. I think that’s a real strength of all the departments in Public Health and the people who work there. We’re very community-oriented in our approach to KT.”

Staff perceived that certain challenges can impede efforts to engage in more intensive collaboration with community partners, including a lack of shared understanding of the work that is required in a KT project, a lack of control over how engaged partners will be, and time and resource constraints:

“We found it somewhat difficult to get meaningful participation from all of those community groups because there’s a research objective and some expectations around the grant, that it’s not so much people have a direct understanding of what it is that needs to be accomplished. So translating what you’re wanting to do – What does KT mean and what are the activities that are going to be used to forward this idea in the community? – people may not be able to think on the spot about that, regardless of what community you come from.”

“In terms of collaboration and cooperation, in terms of how much our community partners are taking this and running with it themselves, I think that’s variable and it really depends on who we’re connecting with. I think it also depends on how information flows in our partner organizations.”

“I think [one] challenge is, especially with First Nations and Métis groups, that they’re so stretched so thinly that it’s really, really difficult to engage in a meaningful way, that’s meaningful to them as well. Their participation is a challenge, and sometimes it’s because they don’t wanna have anything to do with you, but sometimes it’s because they just don’t have the time, and that’s tough.”

Two other staff members talked about a lack of clarity with regard to team members’ roles and responsibilities:

“We have to articulate who’s at the table and for what reasons. [...] I think that was a bit messier at that time, ‘cause some people had multiple roles. There were some of us who were part of SPRP. There were many of us who were connected to CBOs. But did we necessarily feel that that was what we were being asked to bring to the table? I don’t know that I ever articulated that or understood that.”

“Where can we work with collaborators? On the IT stuff, I don’t know how far we were able to go with those collaborators, and I think that maybe that’s part of that ownership – feeling like they’re part of the grant, they’re connected to it very clearly and strongly, and they know their role, and they have some key deliverables that they’re committed to from the very beginning. Those are the kinds of things I think are important.”

The importance of ownership was discussed by a non-grant collaborator as well:

“My own personal opinion is that a lot of people...if they don’t buy in right away, they’re reluctant to buy in later because they weren’t at the table. A lot of people don’t own things that they didn’t start, and that’s just human nature. If you invest time and effort in the project, you own it.”

In terms of ways to overcome some of the challenges identified, one staff member discussed a need to clearly outline team members’ roles and responsibilities at the outset of the project and to review them periodically to avoid frustration and disengagement:

“[We need] some kind of tool that articulates [team members’ roles and responsibilities]. [...] Thinking back to the last time I saw a project charter, it is very focused on organizing...internal work. If we can broaden that tool or use another tool – almost like a spidergram in terms of, who are we all connected to, whose role is it to connect to those organizations, are you a planner or a collaborator? Just some visual way to describe that. I think that would be really helpful. [...] It’s messy, and it needs to be messy in a lot of ways, but at various points in time, you can say, right now, where are we at, who’s connecting with who and why, and those kinds of things. That may change between when you’re having that conversation and the next time you have that conversation, but if you don’t build in those conversations, I think people either become disengaged or unclear about what their role is, or frustrated with what they hoped their role would be and not seeing that through, which isn’t any fault of the people who are doing work, because they’re moving forward with it in the best way they know how.”

A non-grant collaborator noted that the Region “might have a bigger hand [in initiatives] because they’ve got more resources” than most CBOs. From a collaborative point of view, a staff member indicated that this can be detrimental to attaining balanced involvement from the Region and community partners:

“I think one of our biggest challenges as the Region is that we’re seen as the Region. It’s that, oh, it’s the Region taking over again. I think we have a hard time with that, especially when we work with CBOs. We definitely have more resources. [...] When we work with smaller CBOs, where either there’s no one who works on this stuff or it’s somebody who wears 25 hats, trying to keep up with everything in the community, it’s hard not to sort of say, we’ll lead that because we have the capacity to do it, but I think sometimes that can harm us because then we’re seen as

trying to take it over. I know a lot of what [one Region department] does try to do is support the work in the community, but it still needs somebody to bring the stakeholders together, somebody to organize things, somebody to nurture it. So it's a fine balance."

This staff member believes that this can be addressed by finding ways to be as connected as possible to "existing projects rather than try to re-invent the wheel or start something fresh." That is, "what are some of the key pieces that we can bring to tables that have already got things going?" This individual also discussed the time-consuming nature of stakeholder engagement but stated that "it's worth it in the end because not only do you make the stakeholders feel special, but it resonates for them, in their setting. They get it, from their point of view." It was suggested that PHO take the time to go to one stakeholder at a time to foster meaningful involvement.

In sum, staff felt that community partners were engaged in the project but were not overly involved in shaping the KT activities that were carried out. Some discussed the role of the Region's prior engagement and collaboration practices, with one staff member suggesting that the intent in this project was to affirm partners' perspectives prior to implementing the activities. This was alluded to by another staff member as well, who said that partners played more of an approval role than a feedback role. Challenges to meaningful engagement with community partners were identified, as were suggestions for overcoming them in the future. One of the key challenges noted was the lack of clarity with respect to team members' roles and responsibilities.

#### ***E10. Was iKT achieved?***

For the health disparities research program that started in 2006, iKT was evidenced by PPH's engagement in a process of shared agenda-setting through over 200 community consultations (Cushon et al., 2012). Based on the definition and intent of iKT along with the available evidence, it appears that iKT was not achieved in this particular project, for the following reasons:

- Both staff and partners perceived that community partners had minimal involvement in the conceptualization and design of the project. The omission of meaningful collaboration with community partners is not consistent with the iKT approach and represents a missed opportunity in terms of developing and disseminating effective messages.
- A few community partners signed on to the grant with the expectation that they would be asked for input and would be kept informed on the progress of the project. These individuals felt that their inclusion was tokenistic and expressed dissatisfaction with PHO's engagement and collaboration practices.
- Only one project team meeting was held during the project, and it was attended by less than half of the team members. In addition, this was not a face-to-face meeting (all but one team member worked in Saskatoon at the time). While one-on-one interactions occurred throughout the project, there is no record of who was interacted with and how often, and what their input might have been.

CIHR (2012) identifies two types of KT: integrated and end-of-grant. While iKT was sought, it is believed that end-of-grant KT was achieved in that, for the most part, PHO and one of its research partners, SPHERU, developed and implemented “a plan for making potential knowledge-user audiences aware of the knowledge...gained” from the health disparities research (CIHR, 2012, p. 1).

As with other process issues that have been identified thus far, it appears that iKT was not achieved primarily because it was not feasible, time- and resource-wise, to meaningfully collaborate with four research partners and eight community partners. This suggests that expectations surrounding level of involvement need to be determined prior to developing a KT grant application, so that potential partners can make an informed decision about signing on and PHO can ensure that the number of partners included can be adequately managed with the resources that will be available. The apparent disconnect between some community partners’ expectations surrounding involvement and PHO’s engagement and collaboration practices is partly a function of the lack of clarity regarding team members’ roles and responsibilities. Based on the project charter, it is not clear what the expectations were for the four categories of team members (i.e., principal applicants, co-applicants/research partners, collaborators/community partners, and project advisors). Consequently, it is not known to what extent PHO planned to work with certain team members to effectively develop and disseminate key messages about health disparities.

One of the partners captured the essence of iKT and suggested that it was not achieved for this project:

“I think the level of engagement was there. It was okay. What might be useful to mention here is that the engagement needs to be sustained throughout the project, so I think that KT itself has to be done in a way that is more participatory, more integrated, that actually starts at the beginning, probably with the proposal development and submission, to the very end. [...] We try to find people who might be interested in receiving information on this research project, and at the end of the project, KT, we have to go from that kind of practice more to an iKT approach where we involve and engage knowledge users right from the get-go, and we sustain that engagement throughout the project until the very end, when we are in the dissemination phase. I think we need to use the iKT approach for KT activities too. [...] If there’s an advisory committee in place for the health disparities KT project and they were called at the beginning of the KT project, then they ought to be followed through with. In other words, they should be called together time and time again, to get advised, to get direction, and to get them involved in the KT right from the beginning to the end. I feel like it only happened at the beginning, not in the middle and not at the end, until I received this call.”

### **5.3 Short-term Outcomes (Learning)**

To evaluate both the short-term and intermediate outcomes, three main sources of data were used: (1) evaluation forms completed by individuals who watched the *Della* video; (2) surveys with Summit participants (at the event and for this evaluation); and (3) key informant interviews. Evaluation forms for the *Della* video were distributed to three different groups: those who attended the Broadway Theatre

event (evaluated the event as a whole), a university class in Ontario, and health promotion professionals in Ontario.

**E11. Have the KT activities contributed to increased awareness and understanding of health disparities and their determinants?**

At the Broadway Theatre event, 13 individuals (four men, seven women, two unspecified) aged 25 and older completed an evaluation form (PHO record 31). Most respondents' reported economic situation ranged from living in poverty ( $n = 5$ ) to living comfortably ( $n = 5$ ). All respondents either agreed or strongly agreed that the event (1) helped increase their awareness of factors that impact health, and (2) helped increase their understanding of the issues and barriers that people living in poverty face.

In the university class that watched the video, 11 students (10 women, one unspecified) aged 19 to 24 completed an evaluation form (PHO record 33). Economically, all respondents' situations ranged from living comfortably to living wealthy. As with the Broadway Theatre evaluations, all respondents either agreed or strongly disagreed that watching the *Della* video increased their awareness of factors that impact health as well as their understanding of the issues experienced by people living in poverty.

Lastly, 29 health promotion professionals (17 women, seven men, five unspecified) completed evaluation forms (PHO record 33). Respondents were 19 and older, with the majority ( $n = 21$ ) falling between the ages of 30 and 60. All but one respondent was living comfortably to wealthy. Most respondents ( $n = 26$ ) agreed or strongly agreed that watching the *Della* video increased their awareness of the factors that impact health, while three respondents disagreed. It is possible that the latter respondents disagreed because they were already aware of health determinants due to their line of work, which was alluded to by some of the non-Region key informants. All respondents felt that watching the video helped to increase their understanding of the issues and barriers facing people who live in poverty.

These findings indicate that the *Della* video was an effective KT tool in terms of its ability to increase awareness and understanding of health disparities and the issues faced by individuals who live in poverty. This was evident across three different types of groups – local community members, university students in Ontario, and health promotion professionals and Ontario – demonstrating that the video is generally effective across individuals with various backgrounds, living in or outside of Saskatoon. The results are summarized in the table below.

Of the 20 Summit participants who completed the online survey, 14 agreed or strongly agreed that taking part in the Summit increased their understanding of health disparities and their determinants. Four respondents provided a neutral response, and two either disagreed or strongly disagreed. As with the health promotion professionals in Ontario and some of the non-Region key informants, due to respondents' line of work, the latter responses may reflect an existing understanding of health disparities rather than a perception that the Summit was an ineffective KT activity. However, neither possibility could be verified nor were they alluded to in the comments that were provided. The majority

Table 2. Evaluation Results from Groups that Watched *Della* Video

	Broadway Theatre (N = 13)		University Class in Ontario (N = 11)		Health Promotion Professionals in Ontario (N = 29)	
	A/SA	D/SD	A/SA	D/SD	A/SA	D/SD
Helped increase awareness of factors that impact health	13	0	11	0	26	3
Helped increase understanding of the issues and barriers that people living in poverty face	13	0	11	0	29	0

A/SA = either agreed or strongly agreed.

D/SD = either disagreed or strongly disagreed.

of respondents ( $n = 15$ ) felt that the Summit was either effective or very effective in promoting awareness of health disparities. Four respondents responded neutrally, while one felt the Summit was ineffective in achieving this objective. All but three of the 23 individuals who completed an evaluation form at the end of the event agreed or strongly agreed that, by attending the Summit, they gained knowledge that would be used in their work (Adesina, 2013). Among those who evaluated the Mobilize! forum, all but one respondent agreed or strongly agreed that they gained new knowledge and understanding as a result of attending. Overall, then, it appears that the Summit and the Mobilize! forum effectively increased several individuals' awareness and understanding of health disparities and their determinants.

Given that the key informants were already well versed in SDH, most were not asked whether the KT activities affected their understanding of health disparities. However, a few non-Region individuals discussed the impact on their understanding, with one stating that the *Della* video was helpful because "it puts a face on the issues." For one non-Region individual, the KT activities affected their understanding of how to address health disparities; and for another, the *Della* video enhanced their existing understanding of health disparities:

"I think it gives me more information on it and it sort of broadened the discussion. I think it's also had an impact on figuring out, when you have all this information about health disparities, how do you actually put it into practice in a health region to try and affect people's health outcomes, to try and improve them? It's been a good process that way."

"I think a tool like a video can always remind people who are already working in the area. I think for people who don't experience vulnerability through their workplace or conditions of poverty and have no idea about that, something like that video is an excellent tool, because it's right

here in our backyard. So for an organization like ours, who is working in that area all the time, it probably didn't increase our knowledge, but it certainly enhanced it."

Together, these findings suggest that the *Della* video, the Summit, and the Mobilize! forum had an impact on various individuals' awareness and understanding of health disparities and their determinants.

***E12. Have the KT activities contributed to increased support for initiatives aimed at reducing health disparities?***

Among some of the Broadway Theatre respondents, there was evidence that support for playing a personal role in reducing poverty increased as a result of watching the videos: one respondent perceived themselves as an aware and silent supporter before the event and a leader after the event; and seven respondents perceived themselves as aware and silent supporters before the event and occasional supporters after the event (PHO record 31). Being an aware and silent supporter means that one is ideologically but not behaviourally engaged in poverty reduction (staff member, personal communication). Therefore, these findings suggest that some respondents may have felt compelled to act to help reduce poverty after watching the videos. For the university students who watched the *Della* video, the influence on support for playing a personal role in reducing poverty was less pronounced, with two respondents perceiving a change in their role: from aware and silent supporters to occasional supporters (PHO record 33). In the group of health promotion professionals in Ontario, two respondents perceived themselves as occasional supporters before watching the video and leaders afterward; and six respondents perceived themselves as aware and silent supporters before watching the video and occasional supporters afterward (PHO record 33). These results are positive, as they suggest that watching the *Della* video may prompt some individuals to desire a more active role in poverty reduction.

With respect to the 20 Summit participants who completed the online survey, 13 agreed or strongly agreed that participating in the Summit increased their support for initiatives aimed at reducing health disparities and increasing health equity. As discussed under the next evaluation question, some respondents indicated that the Summit served to reinforce health equity work that is already in progress. Hence, the perceived increase in support for initiatives may mean that the Summit played a motivational role for respondents. Six respondents provided a neutral response, and the remaining respondent disagreed. Again, the latter responses may reflect existing support and, thus, a perception that one's support cannot and does not need to be increased.

As with the influence on key informants' understanding of health disparities, it was not expected that these individuals would feel that the KT activities affected their support for initiatives aimed at reducing health disparities. For example, one non-Region individual stated, "I didn't need to be swayed" and another said, "I already supported [initiatives], so [the project] just underlines that they're worthwhile initiatives." However, one staff member discussed the motivational role of the *Della* video:

“[F]or me personally, the first few times I watched it, I couldn’t watch it without choking up, so it definitely has affected me. In that way, it makes me feel even more compelled to do what I do, ‘cause you can come to work every day and feel like, oh, nothing’s changing, but for me, it’s like, no, we have to keep doing this. This is an uphill climb, but we need to make a difference and we are in a position where we can make a difference, so I think that’s the kind of thing that is a motivator that keeps me going. [...] And it’s not something that I leave at work either; it’s with me all the time. I take those messages in my mind; it’s part of who I am.”

#### **5.4 Intermediate Outcomes (Behaviour/Action)**

##### ***E13. What actions have resulted from the KT activities?***

There was limited information available in terms of what types of actions may have resulted from the KT activities. As discussed above, there was evidence that some individuals’ intentions to play an active role in poverty reduction increased after watching the *Della* video. This is an encouraging finding, as behavioural intention in combination with a realistic sense of behavioural control can result in actual behaviour (Ajzen, 2002). Some of the feedback on the *Della* video (PHO record 32) demonstrates individuals’ intentions to help Della’s family and others living in similar situations:

“I was hoping someone could put us in touch with Della and her family. My husband and I own a plumbing and heating company and would like to reach out to them and try to fix their kitchen sink and washing machine drain at no charge.” (Saskatoon resident)

“It certainly makes you put things into perspective with the holiday season coming closer. I have been thinking about what my Christmas charity will be this year and this film has helped me decide!” (Staff member)

Among the 20 Summit participants who responded to the online survey, 15 felt that the Summit was either effective or very effective in encouraging action that will reduce health disparities. This suggests that several participants believe that the work accomplished at the Summit can enhance efforts to increase health equity. Nine respondents agreed or strongly agreed that taking part in the Summit prompted them to personally take action to increase health equity, eight responded neutrally, two disagreed, and one did not provide a response. Seven respondents indicated that the agency they work for has taken action as a result of the Summit, while nine said their agency did not take action and three responded that they were not sure whether action was taken. Below are respondents’ descriptions of the role that the Summit played in their work and/or the work of their agencies. One of the main themes is that the Summit was perceived as a useful adjunct to health equity initiatives already underway. Some indicated that they would be sharing the knowledge they gained through social media, presentations or lectures, and conversations with colleagues.



“The meeting was reinforcing of work we are doing. I continue to be involved in research related to food insecurity in clinical settings, while our organization continues to explore means of highlighting apparent health inequities and supporting appropriate response.”

“The action was already in motion to plan a similar forum for participants in Manitoba. Knowing early on that this was in the works added legitimacy/fodder to our organizing such a forum provincially.”

“We already had plans to work in this area so not sure the Summit resulted in the action but rather reinforced it.”

“Population Health and also our RIC committee continue to do work related to this.”

“Increasing health equity was already on our agenda and actions were planned. Hearing about others activities helped us to consider what we could integrate/use so as not to reinvent ... We ‘fine-tuned’ our activities through our awareness of what others were doing.”

“Action from the perspective of reading and understanding this area better so that when I am lecturing it becomes part of the message.”

“I am more involved in social media ... My NGO is very focused on health equity already, and we are more actively involved in social media.”

“Initiating dialogue within my work environment. Considering healthy equity implications more closely in my project and program areas.”

“I am doing a public address in April on promoting health equity by considering health in all civic policies ... The Public Health 2014 conference has foci on health equity within its conference agenda. The Canadian Public Health Agency strongly emphasizes health equity in all that it does.”

The follow-up survey that was sent to those who received the SHS report was completed by 15 individuals, including 11 school division representatives and four Region personnel (e.g., public health nurses; PHO record 36). Activities that the SHS results were used for include: strategic planning ( $n = 9$ ), funding proposals ( $n = 2$ ), resource allocation ( $n = 2$ ), citation/reference ( $n = 1$ ), and program development and implementation ( $n = 5$ ). No respondents indicated that they used the results to advance healthy public policy. Therefore, the SHS results were most often utilized in program development, planning, and implementation. Respondents provided the following specific examples of actions taken on the basis of the results:

“This orientation helped me with strategic planning and program development. The school support team of the HPS project used the content a little, but not very much. The content was mostly used as a confirmation that there is still a need to allocate additional resources to low income schools. HPD may have used the content during meetings with Education Directors.” (Staff member)

“We are using these outcomes as a baseline for a yoga program that we are beginning in 2013-14.” (School division representative)

“I reviewed the school specific fact sheet with the...School Community Council at their annual general spring meeting and the fall staff meeting.” (Staff member)

“Our students had low levels of optimal physical activity and higher body mass index compared to the rest of the city. We established a small room (in the gym) with a treadmill and weight training equipment to enhance the existing physical education program.

- Our 2 phys. ed. teachers established a crossfit training session for students from grades 5 to 8.
- The in motion team tried to have a whole school physical activity at least once a month (swimming, gym blasts, skating, dances, walks).
- The primary phys. ed. teacher (kindergarten to grade 4) invited a variety of instructors to come in to enhance the existing program (hip hop, volleyball, yoga) and entice students to participate with something different.
- Given the higher suicide ideation of our students, as a staff we really paid attention to their moods and changes in behaviour. Enlisted the services of our school counsellor to advise us and to work with kids.
- Established a sensory room for students to take frequent breaks if needed. Preventative measures for meltdowns and such.
- Higher incidences of electronic bullying - we have been more on top of things like cyber bullying and overt disrespectful behaviour. We don't tolerate it and deal with it quickly. We are quick to speak with parents about issues. We have involved our school resource officer in more drastic cases.
- Continue to teach our students about health and wellness as well as anti-bullying lessons.” (School division representative)

One school division representative stated their intent to use the SHS results in the future:

“Though we have not formally used any of the information, we are considering using some of the survey results to lead us into a nutrition policy/direction for our school. This is work that may be done with our parent council.”

These findings show that the SHS results are being translated into actions aimed at improving the well-being of children and youth in Saskatoon.

In terms of how the KT activities have guided key informants' actions, one non-Region individual said that the KT activities served as a "good reminder to continue to make sure that we do [our work] thoughtfully, that we're always remembering health disparity; and that when we're developing our programs, we're remembering that piece." For other non-Region individuals, the KT activities did not directly influence their actions because they were already engaged in work relating to SDH. Some of these individuals indicated that the health disparities research prompted action more than the KT project did.

"We have been doing this for, like, 20 years, so the Region's health disparities research hadn't really influenced us. In fact, our activities pre-date the Region's."

"[The *Della* video didn't really influence our work] because we live it every day. It wasn't eye-opening for us on the frontline. We work with people like Della in our community programs, which makes up about two-thirds of the work we do in this organization, so it wasn't surprising to us. [...] We've known about SDH forever...long before the Region even existed. So in terms of our day to day work, it isn't necessarily something that changed the way we operate, because you're singing to the converted here."

"[The video and the Region's other work didn't really influence our work] 'cause we already knew it. We participated in the health disparities report, [and the findings] make up a basis for some of our work. Some of the stuff we already knew from the report anyway...but this gave us quantification on some of those numbers, and we were able to take those numbers and put some real action to it, which led to things like better service. We used it as a basis to have a partnership with [other agencies]."

"I'm not sure [that the KT project has prompted action], but certainly the health disparities research has. We've been driven by that; that's what we do."

In the online survey that was completed by individuals within PHO's network ( $N = 7$ ), some respondents commented on the ways in which the health disparities research has informed their work:

"We gathered a variety of Canadian recommendations to promote health equity. Together with another person in our organization we then did a qualitative analysis to identify themes arising from these recommendations. These themes informed our own regional discussion document and are informing the plan as it develops."

"The policy options suggested in the study guided the development of the priorities of the Saskatoon RIC."

“Planning for programs in core neighbourhoods.”

“Information helped to inform specific work in our department and to conduct analysis within Renal Services.”

“Helped make policy and resource allocation decisions as well as seeking appropriate partnerships.”

Some non-Region key informants commented that it is positive that the Region is taking a more active role in addressing SDH. For instance, one individual said, “The Region, to their credit, they got involved in different things that normally hadn’t been in their repertoire.” Another stated:

“I think it’s great that in the last five to 10 years the Region has been looking at health determinants, because it removes some of the stigma of poverty and it helps people to understand that it’s more than someone else’s fault, and that health is something we should all care about ‘cause it impacts all of us at different points, whether it’s economic or just general community wellness. So I’m glad they’re involved in that.”

As staff were more involved in the project, they were more likely to say that the activities and resulting products have informed their work and will guide future work. One staff member discussed the role of three of the main KT activities in the Region’s health equity work:

“The *Della* video is now something that we pull out and use as an example at multiple different events, so that’s something that’ll have a shelf life. It’s been used at international, national, provincial, and local meetings, so that’s been a powerful tool. The results of the public opinion survey: we’ve just begun to get the dissemination of that out there, but it will result in multiple publications; but most important, trying to see that it will get used by politicians and advocacy groups in terms of policy change, but that’s yet to be determined. [...] I’ve disseminated the Summit meeting report and notes to [senior health officials] from major cities. [...] To the extent that people will start to use that and whether it becomes another document that gets referred to in further national meetings remains to be seen.”

As discussed elsewhere, a few staff members talked about the importance of the public opinion survey results in terms of informing the Region’s health equity planning. This is illustrated by the following staff member:

“I think that the public opinion survey has definitely informed our work, and I think it will continue to do that. I think we really need to sit down and examine it in more detail and understand it. It’ll help move some of our priorities moving forward. We need to use it in our strategic planning and it’s good to be mindful of that.”

Taken together, these findings suggest that, in the realm of health equity, intentions to act as well as actual actions have emerged locally and beyond as a result of the *Della* video, the Summit, the SHS results, and the public opinion survey.

***E14. To what extent is information about health disparities being passed on to others?***

This question is aimed at capturing the degree to which health disparities information is being diffused throughout the social system (Rogers, 1995). According to Rogers (1995), social change can occur when new ideas are diffused, either in a planned fashion or spontaneously, and are adopted by members of the social system. Diffusion is a form of communication that deals with the spread of new ideas; thus, the extent to which health disparities information is being passed on to individuals with minimal understanding of SDH was of particular interest.

As previously discussed, several individuals and organizations have shared the *Della* video (PHO records 6 and 32), indicating that the health disparities message has reached many people. The evaluation forms for the video had a question that asked individuals whether they would tell their friends, family, and co-workers to watch the video online. Affirmative responses were provided by all but one of the Broadway Theatre respondents, six of the 11 university students, and 23 of the 29 health promotion professionals (PHO records 31 and 33). This suggests that the intent to share the video with others was fairly high. As this sharing activity is largely occurring via e-mail and social media, it can be assumed that the health disparities message conveyed in the video has reached individuals who were previously unaware of the relationship between income and health.

Some Summit participants indicated that they have passed their knowledge on to others: half the respondents ( $n = 10$ ) reported that they have shared information with a few people, six have shared information with quite a few people, and two have shared information with many people (the remaining two respondents reported that they have not passed on their knowledge). As this survey question did not allow for differentiation among the types of people that respondents shared their knowledge with (i.e., friends, family, or colleagues), it is not known whether health disparities and health equity messages were passed on to those who were previously unaware of these concepts.

Key informants were asked whether they have passed health disparities information on to others. A few non-Region individuals quantified their level of sharing, with one noting that their agency posts information in an online community that is accessible to over 2,000 people across Canada, one saying that their agency distributes a newsletter to about 1,000 people, and one indicating that their agency shares information to hundreds of people through its provincially-focused conferences. Some key informants tried to quantify their personal levels of sharing as well (e.g., with lots of people, with dozens of people, with about 20 people). A few described the ways in which they have shared information:

“I had the link to the three videos on my Facebook, and I have friends across the world. Lots of them would’ve seen that. We talk about it a lot in our family and broader circles. My personal and professional lives are very blurred. Most of my friends are people who work in this area. [...]

I have brought it up, and certainly these tools made it easier to do that, because then I can expose people to that without them perceiving that I'm preaching. So in their own time, in their own way, they can explore it and they know that they can have and have a conversation with me about it. I think that has been really helpful. Some of the follow-up media that comes out, I share that, primarily through Facebook. Invitations to gatherings. When we had the Broadway event, I invited quite a few people. [...] I think you are responsible for role modelling. You can only control what you yourself do, so I guess as long as I'm consistent with what I'm putting out there and how I'm living my life, others will see that and respect that." (Staff)

"I'm more informed [than the average person]. If we're talking about issues that affect addictions – for example, if I'm speaking with someone who's speaking in a derogatory way about people with addictions – I feel that I'm fairly well armed with information to address some of their anxieties. [...] What I try and do is get people to step into the role of the people that they're criticizing." (Non-Region)

"It's part of teaching my kids too, so I made them watch the video. I think stuff like that is important as a parent, not only professionally but personally. [I share health disparities information with] everybody I know, when they ask me what I do for a living or when I talk about my job – all my friends, my whole family. [...] I talk to my colleagues, whether it's a work-related meeting or whether it's just, hey, have you thought of this? Have you thought of health equity in your planning or your thinking forward? It's good. It's filtering in. Those are the things that I try to talk about as much as I can, 'cause otherwise nothing's gonna change." (Staff)

When asked to discuss some of the reactions they have received upon sharing health disparities information with others, key informants noted both positive and negative reactions. A few of the main themes include the experience of having someone gain new insight, and not experiencing much resistance because the audience is typically like-minded.

"In general, people's response to this stuff has been one of understanding and perhaps a little surprise, and it's allowed them to see issues in a different way." (Non-Region)

"[Responses have been] very positive. People know me, so they know what kind of work I do and what my interests and passions are, so in some ways it's preaching to the compurgator, knowing that it wouldn't be the first time they've heard these messages from me. [...] Some people have been moved differently. With the *Della* video, I did get some comments back saying, I hadn't really thought of it that way or her story's very powerful, so that was good. And people who I hadn't actually heard that from before. Nobody has unfriended me or sent me messages to say, stop putting this stuff on negative comments, but they're all pretty trusted friends." (Staff)

"I remember one group of business people we shared [the health disparities research] with, and I think people are generally uncomfortable that sometimes the information about our

community isn't good, that there really are health disparities. I think people wanna struggle with that – that can't be right. I've had conversations where people challenge the methodology. You have to really emphasize with people that it is a population-based thing. [...] That's been helpful to get people to understand that we do have good health data and now we can actually get a good sense of how well people are doing. [...] I think the next piece is when people's reactions are, what do you want me to do with that? It's hard because you don't wanna disempower people – oh my god, things are really terrible and what do you want me to do about it?" (Non-Region)

"I've had arguments with people. There's some people I don't even associate with anymore because I can't stand their ignorance. I know that's terrible, but some of the comments. I had one particular fellow say, why do you even bother? Basically that poor people are lazy and whatever, and I just can't get over that. [...] It hits me to the core. So people like that, I've tried, but then there's a lot of people that just don't know and don't understand, but once you engage them in conversation, they really do start to understand." (Staff)

"[Responses from those I've shared the *Della* video with have been] positive, in a way that broadens people's understanding a bit more in terms of health being about more than people's individual choices – the whole idea of SDH." (Non-Region)

"I was talking with [someone] who's a teacher...and she was saying that they had a presenter at their Saskatchewan Teachers Federation meeting talking about determinants of health, child poverty, and educational outcomes, and she brought up a conversation we'd had a few years ago that made an impression on her. So I feel like people are listening when I'm talking, even outside of work, so that's nice to know. [...] I wouldn't say [I've experienced] outright resistance. Some people obviously don't think about these things as much as I do; it's not their daily work. I think you're doing KT without even thinking about it in terms of assessing people's openness, and the questions that they ask and the answers that you give are calibrated to their level of understanding and where they're at. But I would say I always try to be...not pushy, but challenging a little bit, hopefully trying to help them think of things in a way that they've never thought before. But the reality is that the friends I've chosen and people that I'm close to share my philosophy, and I think that's kinda natural that that happens, so I wouldn't say that anyone in my closest circles have very divergent opinions." (Staff)

"Obviously, people are like-minded. In your social life you rarely encounter people who are contrary-minded, so you end up speaking to the people who kind of already think the same way you do. So not a whole lot of contrary or spirited discussions. It's mainly, this is the way it should be and how come it isn't? How can we get there? I don't really socialize with people who would be contrary. I suppose I have some family members who need a bit of convincing once in a while, but generally speaking, they understand. They may not have the patience to have a long discussion about it." (Non-Region)

These insights point to some of the successes that these individuals have had in increasing awareness and understanding of health disparities and their determinants among their friends, family, and colleagues. Challenges were noted as well, such as encountering dismissive comments and trying to share information in a way that is not perceived as preachy. The lower level of engaging non-like-minded individuals in dialogue surrounding health disparities is understandable, particularly in the case of friends or family members, since confrontations with those who are closest to us are undesirable. From a diffusion and social change standpoint, however, these individuals along with those who are unaware of or do not understand SDH represent the group for which KT activities are especially crucial.

## 6. General Discussion

---

The activities carried out under PHO's KT supplement grant had followed previous KT activities (e.g., policy and program changes), occurred in conjunction with other KT activities (e.g., the HPS program), and laid the groundwork for future KT activities (e.g., the public opinion survey results will be used to guide interventions). Thus, PHO's KT work is an ongoing endeavour in which incremental advances are being made toward reducing health disparities and inequities in Saskatoon. These advances are being aided by an intersectoral community network that includes groups such as SPRP and SRIC.

PHO and other Region teams have been addressing health disparities and inequities in Saskatoon since 2006, and are increasingly influencing provincial and national health equity efforts due to the Region's leadership role in the field. When asked what sets the Region apart from other health authorities in Canada, a staff member responded:

"I think it's leadership in terms of formal leadership and recruitment. [The CMHO] has done a fantastic job in terms of putting the messages out there. He's a strong systems thinker, so he's making connections all the time. [...] They looked for people with [a health equity/SDH] background, that expertise, that values space...so they are intentionally putting together a team that works in that way."

Another staff member also talked about the role of the Region's leadership, stating that they think the "buy-in is 100% on an intellectual level" in terms of the need to shift resources to "find ways to quit fixing people when they're broken and find ways to keep them whole." This individual believes that the Saskatchewan Ministry of Health knows this as well but that three challenges are standing in the way of change. The first is the "tyranny of acute care," wherein more resources are directed to urgent medical issues than to primary health care, which involves responsiveness to community needs and services related to SDH (Health Canada, n.d.). A non-Region key informant also said that the Region needs to do more to focus on preventative rather than acute care:

"I think there are champions within the Region and they are making changes, but they're not enough. I'm not sure much has changed since the health disparity research in 2006. You hear a lot about what's wrong and you don't hear enough about, have we made any changes? Is it getting better for people? [...] At some point you have to make choices, and I realize how hard



that is. That's a political conversation. When you're talking health disparities, you are talking about structures that aren't working. [...] If we can't make the funding pie bigger, then can we at least reorganize inside a little? I think if the public saw more positive outcomes, they would be okay with spending more money on health care, but it's hard when people don't see that. I think the big thing we really wanted to do was...get people to understand how their quality of life is connected to everybody else's. So if my health is fine, why do I care? I think that's the piece that we're always struggling with."

These insights relate to the other two challenges noted by the staff member: (1) "vested interests in the status quo – professional interests and cultural ways of being in the world – that keep us where we are"; and (2) the politicization of health care. With regard to the latter, this individual talked about the health care system's responsiveness to the socio-political context:

"Health care is so political that politics can trump what we know we should be doing. In the media lately there has been talk of long-term care facilities and the need to improve them. That becomes the political agenda and suddenly we're moving in different direction and the primary health care agenda is put on backburner, which is unfortunate. [In the Region], there's buy-in and understanding that we need to change things, but we would be naive to think it will happen without a lot of heavy lifting and effort. It won't be linear process. The aging baby boomers will probably play a key role because they vote and have strong views. So I think we'll see action in aging and long-term care before changes that are needed around primary health care and youngsters."

Although political factors are perceived to be constraining health equity initiatives at present, this staff member indicated that this may begin to change with CIHR's funding of research support units in Canada:

"The idea behind support units in each province is that government and academia work hand in hand so that policy-makers are involved in all steps of the research process, from the creation of research the question all the way to KT. The support unit is one of best opportunities for government and academia to learn how to understand each other and how to work well together."

This type of collaboration may serve to address some of the political challenges to health equity work that were noted by key informants. In addition, one staff member noted that the Region is "trying to strategically tie [health equity work] to other government initiatives so that it resonates with them." Progress at the decision/policy-making level (top-down action), in combination with the increases in public support for certain interventions that were found in the recent public opinion survey (bottom-up action), could set in motion the structural changes that are needed to increase health equity (Baum, 2007).

This improvement-focused evaluation involved an in-depth analysis of the processes associated with this project to assess (1) the efficacy of the activities with respect to design, implementation, reach, and perceived effectiveness; and (2) the degree to which an iKT/collaborative approach was achieved to design and implement the project. This evaluation also uncovered some of the short-term (i.e., learning-based) outcomes associated with the KT project, primarily in terms of the influence of the activities on awareness and understanding of health disparities and their determinants. Certain intermediate (i.e., action-based) outcomes were evaluated as well, including intentions to play a more active role in poverty reduction, actions taken as a result of the KT activities, actions that will take place as a result of the KT activities, and the level of diffusion of health disparities information into the social system.

This evaluation uncovered several strengths and positive outcomes associated with this project, some of which are outlined below.

- The *Della* video was a very successful undertaking in that it is generally perceived as a high-quality, effective KT tool; has been used by agencies locally, provincially, and across Canada to demonstrate the relationship between poverty and health; generated increased awareness and understanding of health disparities and inequities among members of the general public as well as decision-makers; and motivated some individuals to desire a more active role in reducing poverty. Importantly, Della and her family benefited from their participation in the project, which underscores the merit of striving for first voice representation in health equity initiatives.
- The Health Equity Summit was also largely successful despite the fact that the overarching goal of creating a national agenda for health equity was not actualized. Many individuals who attended the Summit gained new insights into health equity, learned from the work of others in the field, perceived that their support for health equity initiatives increased as a result of participating, and indicated that they and their agencies have used the knowledge gained from the Summit to guide their work. While a national agenda could not be formulated, there was a perception that the Summit was an important step toward attaining this goal.
- The *Della* video and the Summit were deemed to be the most effective activities because they (1) were congruent with the definition and intent of KT; and (2) sought to use innovative dissemination and engagement strategies to make knowledge more widely known, relevant, and understood among the community and decision-makers.
- The public opinion survey was a valuable KT research activity, as the findings regarding public awareness of SDH as well as public support for interventions will be utilized to guide PHO's future health equity work and to support its advocacy efforts in the political realm.
- In light of the time, funding, and staffing available for this project, as noted by a staff member, "if you look at what was accomplished...it was stretched quite far." The process issues identified in this evaluation should not take away from the fact that effective KT work was accomplished in spite of these constraints.
- Several non-Region key informants appreciate that the Region has started to take an active role in addressing health disparities and inequities. Many also noted that they are pleased to be partners with the Region and that the health disparities research has served a crucial function in their agencies' programming.

Some of the main process issues that emerged and represent areas for improvement include:

- Many of the planned activities with the school community did not come to fruition even though children and youth have been identified as a priority population. However, the Region was carrying out other KT work at the time and staff noted valid challenges to meaningfully engaging with the school community. On the other hand, one non-Region key informant perceived that outreach to a particular school division was absent. This indicates that there are conflicting perspectives as to why these activities did not take place and that better connections need to be fostered between PHO and the school divisions.
- While the two broad categories of target audiences – the community and decision-makers – were reached, key informants and Summit participants perceived that some groups that should have been targeted were not effectively engaged, including decision/policy-makers and high-level politicians within the provincial government, community members (particularly those with lived experience), and Aboriginal organizations. Hence, the targeting of some key interest groups was not fully realized. In addition, it was somewhat unclear as to which specific sub-groups PHO was most interested in engaging and why, along with what kinds of attempts were made to engage these sub-groups and how successful they were.
- Process-tracing issues were identified (e.g., unclear documentation, limited research-based rationales for project decisions), which may pose challenges to replication efforts and to PHO's ability to serve as a model for other agencies pursuing KT work.
- Although positive results emerged from the Summit, it appears that dialogue surrounding a national agenda for health equity has not been sustained. Perhaps there will be renewed engagement due to the release of the event report in February 2014. The Mobilize! forum, which aimed to attract community members, was not overly well attended, suggesting that this attempt to engage the general public was not as successful as the Broadway Theatre event.
- It was determined that PHO's objective of employing an iKT approach to this project was not achieved, particularly in regard to collaboration with community partners. This is supported by the records as well as key informants' perceptions of the level of collaboration that occurred between PHO and community partners. Ambiguity with respect to expectations surrounding project team members' roles and responsibilities is believed to be one of the main factors underlying this finding.

## 6.1 Limitations of Evaluation

The conclusions that can be drawn from this evaluation are limited by five factors.

First, because KT related to the health disparities research has been ongoing since 2006, it was difficult to distinguish the effects and perceptions of previous KT activities from those of the KT activities that were specific to this grant. This was particularly apparent in the key informant interviews, as several individuals discussed the influence of the Region's activities leading up to the KT project. The inability to isolate the role of certain activities in producing KT-related outcomes was captured by a staff member:

“We've done so much over the last six years that has been used by other organizations – the

[health disparities] report, information has been picked up and used by various advocacy groups, has been embedded into multiple government reports, NGO reports. So it's attained a life of its own. We couldn't even begin to map out all of that, let alone suggest what's influenced members of the public."

This relates to a challenge that is common to evaluations: establishing attribution (Bowen, n.d.; Cushon et al., 2012). This evaluation has provided insight into some of the contributions the KT activities have made to the goals of increasing awareness of health disparities and encouraging action that will reduce them. However, claims about cause and effect relationships between the activities and outcomes cannot be made.

Second, while roughly 70% of the key informants that were identified could be reached for an interview, the perspectives of those who could not be reached would have provided a more comprehensive assessment of this project. Response rates were fairly low for the Summit evaluation forms (37%), the online survey with Summit participants (34%), the Broadway Theatre evaluation forms (estimated to be between 10% and 15%), the survey that was sent to individuals who received the SHS report (roughly 7%), and the online survey with PHO's network (10% or less). The highest response rate was obtained at the Mobilize! forum (47%). For the *Della* evaluation forms that were completed by university students and health professionals in Ontario, the response rates are unknown. Apart from the surveys with Summit participants, where available demographic information enabled comparisons between the overall group and the sample, it was not possible to determine the representativeness of the other samples that provided feedback. Consequently, the results should be interpreted with this factor in mind and should not be generalized to the populations from which the samples were drawn. In addition, across the three groups that completed evaluation forms after watching the *Della* video, respondents were predominantly female. This may have skewed the results in the direction of more positive responses. For example, in a nationally representative survey of 2,000 Americans, it was found that women were more likely to believe in the power of individuals to make a difference by supporting social causes (Ogilvy Public Relations Worldwide & The Center for Social Impact Communication at Georgetown University, 2011). Women were also more likely to report that they were engaged in social causes and were more willing to display their support for social causes.

Third, recall issues were apparent among key informants, as evidenced by comments such as "[I don't recall because] it was so long ago and I'm into so many things" and "It's so long ago that I really don't remember." Hence, the accuracy of the interpretations that were made is partly dependent on the accuracy of the responses provided.

Fourth, conducting qualitative research is inherently subjective and is, therefore, partly shaped by researchers' preconceptions (Tufford & Newman, 2010). Further, as previously mentioned, a limitation of external evaluations is that the evaluator lacks knowledge of the context and history of the program/project being evaluated (Bowen, n.d.). Another issue was that some pertinent information may have been missed due to certain records not being reviewed. Thus, to some extent, interpretations and

evaluative statements were based on the evaluator’s subjective impressions and, inadvertently, may not have incorporated all relevant pieces of information.

Lastly, due to the nature of the data that were available and the limitations of this evaluation in terms of scope, at this time more is known about the promoting awareness portion of PHO’s goals for this project than the encouraging action portion. As for whether the KT project has moved, or is moving, the community into “an action phase to reduce health disparities” (non-Region interview), this was largely immeasurable because research methods that could address this possibility were not incorporated into the project. As explained in section 1.4 (logic model), it is thought that the success of PHO’s KT work in terms of attaining intermediate and longer-term outcomes will require ongoing KT activities. To measure these outcomes, future KT evaluation and monitoring activities could be designed to examine the influence of KT activities on individuals’ actions relating to health equity.

## **7. Recommendations**

---

The following recommendations are aimed at improving PHO’s KT and iKT processes, which, in turn, may increase the effectiveness of future KT projects that utilize an iKT approach.

### **1) Create a comprehensive conceptual table at the outset; preferably, prior to submitting the grant application.**

In order to avoid the process issues that were identified, suggested columns include:

- Proposed KT activity.
- Rationale: level of congruence with the definition and intent of KT (including whether the activity will involve diffusion, dissemination, and/or application; CIHR, 2012), supporting literature, past successes in the Region or elsewhere, anecdotal accounts of success, etc.
- Aim: KT or research and evaluation.
- Target audience(s) and target sub-group(s) therein; rationale for targeting.
- Project goal(s) the activity is expected to contribute to.
- Project objective(s) the activity is expect to contribute to.
- Dissemination mechanisms.
- Anticipated outcomes: short-term/learning (awareness, understanding, attitudes); intermediate/action (types of behaviours); future health equity work.
- Region departments and personnel that will be involved.
- Community partners of interest: reasons why they are of interest (e.g., target population, certain expertise), key individuals that should be involved, etc.
- Research partners of interest: same as community partners.
- Other stakeholders that will be engaged (e.g., first voice).
- Strategy for collaboration. (See Horwath and Morrison [2011] for a review of some of the key components of strategic inter-agency collaboration.)
- Facilitators and barriers to collaboration (CIHR, 2012).
- Anticipated amount of time required: minimal, medium, or significant.

- Anticipated amount of resources required: low, medium, or high.
- Potential challenges relating to design, delivery, iKT, resources, etc.

It is thought that going through this exercise could aid in the justification and prioritization of activities. For instance, if a KT grant is obtained, it follows that most of the funding should be directed to activities aimed at KT versus research and evaluation; activities that can reach multiple audiences and sub-groups may be more worthwhile; and so on. This exercise might also identify the key partners that should be approached as grant collaborators. See CIHR (2012) for further suggestions on KT planning.

**2) Provide potential partners with enough information to make an informed decision about whether they are willing and able, time- and resource-wise, to sign on to the grant.**

As it was evident that some staff members and partners were not on the same page for this project, certain elements of the project (e.g., definition of KT, expectations surrounding level of involvement/input) should be agreed upon prior to collaboration agreements being put in place. While the onus is partly on partners to ensure they are clear on the nature and purpose of the project and their involvement therein prior to signing on to a grant, most of the onus should be on PHO to clearly outline these details to partners, and to follow through on any commitments that are made as a condition of partners' endorsements of the project.

**3) Involve committed partners and other stakeholders in the conceptualization of the project; preferably, prior to submitting the grant application.**

As noted by one of the non-Region key informants, it is believed that iKT should start at the beginning of a KT project, "with the proposal development and submission." This may circumvent the perceived lack of involvement that was evident among a few of the community partners who signed on as collaborators for this project. There are different ways this could be achieved. For example, staff, partners, and other stakeholders (e.g., community members, including individuals with lived experience) could complete the above table together, or PHO could complete the table then go through it with partners and other stakeholders to get feedback. Although this level of engagement can be time-consuming, making the effort to develop and sustain positive relationships and to keep open lines of communication has been found to result in effective KT across several contexts (Banister et al., 2011). Further, incorporating roles for community members and individuals with lived experience would address the perception that these groups did not have enough involvement in this project. This would be in line with PHO's goal of using the "nothing about us without us" principle in its initiatives (staff interview).

**4) Collaboratively create a "game plan" and clearly articulate project team members' roles and responsibilities at the outset.**

Ideally, the project team would consist of staff, research partners, community partners, and community members (including individuals with lived experience). When the KT grant is obtained, it is recommended that one or two in-person project team meetings take place to (1) review and reach consensus on the conceptual table, decide on the key activities that should be pursued, and formulate a

work plan for those activities; and (2) outline affiliations and inter-relationships among team members (e.g., conduct a “spidergram” exercise, as suggested by a staff member); and (3) assign specific roles and responsibilities to each team member. Assigning roles and responsibilities may be particularly important for fostering the sense of ownership of the project that a few key informants discussed. It is also recommended that the project team meets at a few points throughout the project in order to revisit the work plan and make adjustments as necessary (CIHR, 2012).

#### **5) Establish process-tracing procedures at the outset.**

To ensure that there is a “paper trail” of how the project was designed and implemented along with what worked and did not work, it is recommended that a variety of documents be created for tracking purposes. This will aid in the ability to distinguish between grant activities and other KT activities, and in the use of previous projects to inform future projects. It will also allow PHO to share its processes and lessons learned with other agencies that are planning KT projects. Examples of activities that might be beneficial to track include:

- Project team meetings and other relevant meetings.
- Contact with partners or other relevant contacts, including the date of contact and a brief summary of what was discussed. (See Landry, Amara, and Lamari [2001] for a discussion of linkage mechanisms between researchers and knowledge users.)
- iKT-related observations (e.g., difficulties connecting with particular partners).
- Engagement activities with target audiences and sub-groups within them (e.g., event promotion, personal invitations to events and responses received).
- Evaluation methods, procedures, and data collected.
- General ideas and impressions (journaling/field notes).

#### **6) Continue to strive toward better internal communication and coordination.**

Some of the key informants indicated that improvements are needed in the Region’s internal communication. One strategy that may assist with this is the adoption of some type of internal system of documenting contacts with other agencies. To take an example of this type of system, the U of S has a database called UFriend, which can be accessed by staff in a variety of departments. The database includes records for all individuals and organizations associated with the university, and contacts can be entered on these records. This allows staff to see who has been in contact with certain individuals and organizations, the dates of contact, and what was discussed. For the Region (or certain departments therein), it might be sufficient to create records for agencies that it works with. This type of tracking could help address some of the communication challenges that were discussed by key informants. For example, if a staff member was going to meet with a certain agency, they could pull up the record for that agency to see the most recent interactions the Region has had with them. Depending on the information that is available, this may prompt a phone call to a colleague who has been in recent contact with the agency, to get clarification on the status of the Region’s relationship with that agency. In essence, this process would allow staff to brief themselves on the Region’s dealings with agencies in order to be prepared in meetings and convey to agencies that the Region engages in effective internal



communication and coordination.

**7) Be more specific in the identification of target audiences and target sub-groups within them.**

CIHR (2012) recommends the following process for targeting specific audiences:

“[The project team] should identify the individuals and/or groups that should know about the research findings. A good plan will demonstrate a detailed understanding of its knowledge-user audience. Audiences should be precisely defined with respect to their sector of work and their role in decision making related to the research findings – simply mentioning clinicians, managers, policy makers, etc., is not sufficiently specific to make clear that the audiences selected are appropriate to the identified goals. [The project team] should try to understand the current state of the audiences’ knowledge, how they tend to use knowledge and the formats in which they prefer to receive their information” (p. 13).

Accordingly, it is suggested that PHO identify both broad target audiences (e.g., the community and decision-makers) as well as specific sub-groups within them (e.g., the business sector and the Ministry of Health, respectively). It may also be useful to identify any known key individuals within sub-groups that should be targeted (e.g., a business owner who is known to support social causes, a high-level politician who is known to be an advocate of health equity initiatives). As mentioned above, engagement attempts with these sub-groups and individuals within them could be documented in order to track progress on reaching specific factions of the broad target audiences.

**8) Focus on the quality of the activities, not the quantity.**

While there is no harm in “thinking big,” it is felt that in future KT projects, if the same amount of resources is available, PHO would benefit from doing far fewer activities. This would free up time and resources to ensure the key activities are well executed from both a KT and an iKT perspective. Employing some of the recommendations outlined above may help to eliminate activities that might be less effective or are not feasible. If end-of-grant KT is pursued rather than iKT, it may be possible to include more activities.

**9) As a team, develop a project plan that is proportionate to the time and resources that will be available across all team members.**

This will inevitably involve a process of trial and error, and it is hoped that the results of this evaluation can serve as one piece of that process. On the basis of this evaluation, recommendations for staffing in future projects of this nature include:

- One part-time knowledge broker/relationship facilitator. A knowledge broker is a liaison between knowledge creators and knowledge users (CIHR, 2012). This individual’s primary responsibility would be to facilitate iKT.
- One part-time project coordinator to manage project operations.
- One part-time position that would be responsible for research/evaluation activities (e.g., survey



design, data entry) and administrative tasks (e.g., process-tracing). University students looking for volunteer experience might be a good option for this position, particularly since there would be no cost to PHO.

If only one part-time position will be available again, the activities should be scaled down accordingly. In addition, end-of-grant KT may need to be utilized rather than iKT, as meaningful collaboration requires an investment of time on the part of both PHO and partners (Banister et al., 2011). One non-Region key informant suggested that, “if we are thinking about hiring staff and have short-term funding for a project...it would almost make sense to make sure the staff were funded for a couple months afterward, to finish things off.”

**10) Continue to explore creative communication and dissemination strategies to engage the general public in order to go beyond “preaching to the choir.”**

To accelerate bottom-up action to advance health equity, it is proposed that messages about health disparities and inequities will have to reach and influence individuals who are not already ideologically or behaviourally engaged in equity-related causes. However, it is recognized that engaging the general public in such causes is a perpetual challenge due to the voluntary nature of associated activities and events. Consequently, perhaps means of “forced” exposure to health disparities messaging are a potential avenue to consider. Examples may include playing the *Della* video before movies start at theatres (during the time that commercials are typically played) and displaying messages on electronic billboards on busy streets. Gladwell (2002) discusses an innovative strategy that a nurse used to increase awareness and understanding of diabetes and breast cancer in San Diego’s Black community. While the results of a series of seminars in Black churches were largely unsuccessful, delivering messages in beauty salons via stylists who were trained to weave information into conversations was found to work well. Thus, the nurse found a “stickier way of presenting information” that was successful in changing women’s attitudes and getting them to go for mammograms and diabetes tests (no pagination specified). Finding new and effective strategies for engaging the unengaged may require a thorough review of the communications and social influence literature.

**11) Give people specific options for actions they can take to make a difference.**

At the end of the *Della* video, viewers are prompted to go to SPRP’s website to “do something about poverty.” Calls to action may need to be more direct and specific to make it convenient for people to get involved if they are ideologically engaged. This was alluded to by a few non-Region key informants. For instance, one stated that, in response to hearing about the health disparities research, some people have asked, “What do you want me to do with that?” Therefore, “you have to show them a path to making a difference” because “people really do want to do something.” Two other individuals talked about this in relation to the *Della* video:

“I felt like, where does this woman live and could we help her? I would love to get her drain fixed for her. Maybe that’s the direction we need to go in terms of [charity] and stuff. If we could find a way to link real needs in families with donors, I think people would be much more

generous.”

“There were conversations in the room about, okay, so what is the next step? I feel bad for Della and her family. What are my policy actions? When we present this video, can we also go to a next step of, what? We need to get to the concrete.”

**12) Invest the most time and resources in activities aimed at increasing health equity locally and provincially.**

This is not to say that it is seen as “wrong” to use KT resources to contribute to a national health equity agenda, as progress at the national level will facilitate changes at the provincial and local levels. Rather, it is believed that the Region can use its leadership role to focus on building local and provincial capacity to address health disparities and inequities. As one staff member noted, “Saskatchewan is in a good spot to be a little laboratory” because “we’re just the right size. [It] offers fabulous research opportunities to do science around key priorities where everyone in world is looking for answers.” To this end, it is recommended that future conferences/Summits be geared toward local and provincial leaders and decision-makers in order to increase the likelihood of top-down action. Targeting a provincial rather than a national audience may allow more time to engage and attract higher-level officials in the provincial government. With a stronger foundation established in Saskatoon and Saskatchewan, the Region may be in a better position to effect change at the national level.

**13) Articulate the desired actions that will be prompted by the KT activities.**

It is recommended that the “encourage action” portion of KT goals be broken down into the specific actions that are deemed necessary to reduce health disparities and inequities. It would also be useful to articulate the kinds of actions that are thought to be needed among broad target audiences as well as target sub-groups therein. The more specific, the better (e.g., a specific policy change versus simply “policy changes”).

**14) Identify at the outset what will be measured for evaluation purposes and design measures accordingly.**

What will be measured should align with the short-term and intermediate outcomes, as these outcomes are the most feasible to measure (Bowen, n.d.). If time and resources permit, consider employing more rigorous evaluation methods in order to enhance the conclusions that can be made about the effectiveness of the project.

**15) Strive to achieve higher response rates with data collection activities.**

The low response rates for most of the data collection activities that were utilized in this project were one of the main limitations of this evaluation. PHO may need to increase efforts to collect evaluation data (e.g., by stressing to people the importance of providing feedback in terms of the role it can play in the Region’s advocacy for policy changes).

## References

---

- Adesina, A. (2013). *National Summit on developing a health equity agenda: From a shared vision to policy and practice*. Internal document, Saskatoon Health Region.
- Ajzen, I. (2002). Perceived behavioral control, self-efficacy, locus of control, and the theory of planned behavior. *Journal of Applied Social Psychology, 32*(4), 665-683. doi:10.1111/j.1559-1816.2002.tb00236.x
- Ajzen, I., Joyce, N., Sheikh, S., & Cote, N. G. (2011). Knowledge and the prediction of behavior: The role of information accuracy in the theory of planned behavior. *Basic and Applied Social Psychology, 33*(2), 101-117. doi:10.1080/01973533.2011.568834
- Bandara, T. (2012). *"The Starting Point" at the Broadway Theater: Depicting the effects of poverty in Saskatoon*. Retrieved from <http://smartcitieshealthykids.com/the-starting-point-at-the-broadway-theater-depicting-the-effects-of-poverty-in-saskatoon/>
- Banister, E. M., Leadbeater, B. J., & Marshall, E. A. (2011). Concluding thoughts. In E. M. Banister, B. J. Leadbeater, & E. A. Marshall (Eds.), *Knowledge translation in context* (pp. 201-207). Toronto: University of Toronto Press.
- Baum, F. (2007). Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health. *IUHPE – Promotion & Education, XIV*(2), 90-95. Retrieved from <http://www.bvsde.paho.org/bvsacd/cd66/FranBaum.pdf>
- Belo Horizonte Observatory for Urban Health. (n.d.). *10<sup>th</sup> international conference on urban health*. Retrieved from <http://medicina.ufmg.br/osubh/en/biblioteca/10th-international-conference-urban-health/>
- Bennett, G., & Jessani, N. (2011). *The knowledge translation toolkit: Bridging the know-do gap: A resource for researchers*. Sage Publications (e-book). Retrieved from <http://www.idrc.ca/EN/Resources/Publications/Pages/IDRCBookDetails.aspx?PublicationID=851>
- Bowen, S. (n.d.). *A guide to evaluation in health research*. Ottawa: Canadian Institutes of Health Research. Retrieved from <http://www.cihr-irsc.gc.ca/e/45336.html>
- Bowen, S., Botting, I., & Roy, J. (2011). *Promoting action on equity issues: A knowledge-to-action handbook*. Retrieved from [http://www.publichealth.ualberta.ca/research/~media/publichealth/Research/Research%20Publications/action\\_equity.pdf](http://www.publichealth.ualberta.ca/research/~media/publichealth/Research/Research%20Publications/action_equity.pdf)

- Canadian Institutes of Health Research. (2012). *Guide to knowledge translation planning at CIHR: Integrated and end-of-grant approaches*. Ottawa: CIHR. Retrieved from <http://www.cihr-irsc.gc.ca/e/45321.html>
- Canadian Public Health Association. (2013). *Moving public health forward: Evidence, policy, practice* [Conference program]. Retrieved from [http://www.cpha.ca/uploads/confs/2013/introductory\\_program\\_e.pdf](http://www.cpha.ca/uploads/confs/2013/introductory_program_e.pdf)
- Clarke, A. (2013). *Developing a health equity agenda: From a shared vision to policy and practice* [Blog post]. Retrieved from <http://nccdh.ca/blog/entry/Healthequity-agenda-SK>
- Community Interventions for Health. (n.d.). *Evaluation*. Retrieved from [http://www.oxha.org/cih\\_manual/index.php/process-evaluation](http://www.oxha.org/cih_manual/index.php/process-evaluation)
- Cushon, J., Clarke, A., Dunn-Pierce, T., Kryzanowski, J., Neudorf, C., & Ugolini, C. (2012). *Advocacy for health equity: The Population and Public Health journey*. Unpublished manuscript, Saskatoon Health Region.
- Della Hurdles. (2012). *Della: Hurdles to Health*. Retrieved from <https://www.youtube.com/watch?v=gLKpywffD4c>
- Ebert, S. (2012). *C95 Christmas Wish 2012*. Retrieved from <https://www.youtube.com/watch?v=arZHcqVNm3Y>
- Gladwell, M. (2002). *The tipping point: How little things can make a big difference* (eBook ed.). New York, NY: Little, Brown and Company. Preview retrieved from <http://books.google.ca/books>
- Haggag, K., & Larson, D. (2013). *Cmpt 412 final report*. Internal document, Saskatoon Health Region.
- Hamilton, M. B. (2009). *Online survey response rates and times: Background and guidance for industry*. Longmont, CO: SuperSurvey. Retrieved from [http://www.supersurvey.com/papers/supersurvey\\_white\\_paper\\_response\\_rates.pdf](http://www.supersurvey.com/papers/supersurvey_white_paper_response_rates.pdf)
- Health Canada. (n.d.). *About primary health care*. Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos-eng.php>
- Health Communication Unit. (2007). *Evaluating health promotion programs*. Toronto: Centre for Health Promotion, Department of Public Health Sciences, University of Toronto. Retrieved from [http://www.thcu.ca/resource\\_db/pubs/107465116.pdf](http://www.thcu.ca/resource_db/pubs/107465116.pdf)
- Horwath, J., & Morrison, T. (2011). *Effective inter-agency collaboration to safeguard children: Rising to*

the challenge through collective development. *Children and Youth Services Review*, 33(2), 368-375. doi:10.1016/j.chilyouth.2010.10.002

Institute of Population and Public Health. (n.d.). *IPPH knowledge translation*. Retrieved from <http://www.cihr-irsc.gc.ca/e/27155.html>

International Conference on Urban Health. (n.d.). *The 11<sup>th</sup> international conference on urban health, Manchester, United Kingdom, March 4-7<sup>th</sup> 2014*. Retrieved from <https://www.icuh2014.com/>

Kershaw, T. (2012). *The Student Health Survey: How did you use the results and what could we improve?* Internal document, Saskatoon Health Region.

Kraus, S. J. (1995). Attitudes and the prediction of behavior: A meta-analysis of the empirical literature. *Personality and Social Psychology Bulletin*, 21(1), 58-75. doi:10.1177/0146167295211007

Landry, R., Amara, N., & Lamari, M. (2001). Utilization of social science research knowledge in Canada. *Research Policy*, 30(2), 333-349. doi:10.1016/S0048-7333(00)00081-0

Leadbeater, B. J., Banister, E. M., & Marshall, E. A. (2011). How-what-we-know-becomes-more-widely-known is context dependent and culturally sensitive. In E. M. Banister, B. J. Leadbeater, & E. A. Marshall (Eds.), *Knowledge translation in context* (pp. 3-11). Toronto: University of Toronto Press.

Lemstra, M., & Neudorf, C. (2008). *Health disparity in Saskatoon: Analysis to intervention*. Saskatoon: Saskatoon Health Region. Retrieved from <http://nccdh.ca/resources/entry/health-disparity-in-saskatoon>

Lemstra, M., Neudorf, C., & Beaudin, G. (2007). Health disparity knowledge and support for intervention in Saskatoon. *Canadian Journal of Public Health*, 98(6), 484-488. Stable URL: <http://www.jstor.org/stable/41994991>

Liberating Structures. (n.d.). *Celebrity interview*. Retrieved from <http://www.liberatingstructures.com/22-celebrity-interview/>

Moffatt, H. (2013). *Developing a health equity agenda*. Retrieved from [https://storify.com/HannahMoffatt/developing-a-health-equity-agenda?utm\\_campaign=&awesm=sfy.co\\_r6LP&utm\\_medium=sfy.co-twitter&utm\\_content=storify-pingback&utm\\_source=direct-sfy.co](https://storify.com/HannahMoffatt/developing-a-health-equity-agenda?utm_campaign=&awesm=sfy.co_r6LP&utm_medium=sfy.co-twitter&utm_content=storify-pingback&utm_source=direct-sfy.co)

National Collaborating Centre for Determinants of Health. (2014). *Developing a health equity agenda: From a shared vision to policy & practice (event summary)*. Antigonish, NS: St. Francis Xavier

- University. Available from <http://nccdh.ca/community/post/HE-agenda-for-canada>
- National Collaborating Centre for Determinants of Health. (2012). *Bridging the gap between research and practice: Improving health equity in Saskatoon: From data to action (case study)*. Antigonish, NS: St. Francis Xavier University. Retrieved from <http://nccdh.ca/resources/entry/casestudy-SK>
- Nulty, D. D. (2008). The adequacy of response rates to online and paper surveys: What can be done? *Assessment & Evaluation in Higher Education*, 33(3), 301-314. doi:10.1080/02602930701293231
- Ogilvy Public Relations Worldwide, & The Center for Social Impact Communication at Georgetown University. (2011). *Dynamics of cause engagement: Understanding the impact of the digital revolution on cause involvement*. Washington, DC: Georgetown University. Retrieved from <http://www.slideshare.net/georgetowncsic/dynamics-of-cause-engagement-final-report>
- Parliament of Canada. (2013). *Standing Committee on Finance*. Retrieved from <http://www.parl.gc.ca/CommitteeBusiness/StudyActivityHome.aspx?Cmte=FINA&Language=E&Mode=1&Parl=41&Ses=2&Stac=8147092>
- Public Health Observatory. (2013). *Student Health Survey: A summary*. Retrieved from [http://www.saskatoonric.ca/images/pdfs/networkresources/SHS\\_A\\_SummaryFINAL.pdf](http://www.saskatoonric.ca/images/pdfs/networkresources/SHS_A_SummaryFINAL.pdf)
- Public Health Observatory record 1. *CIHR knowledge translation supplement grant application*.
- Public Health Observatory record 2. *E-mail from project coordinator to film companies*.
- Public Health Observatory record 3. *Della video one-pager*.
- Public Health Observatory record 4. *Starting Point event poster*.
- Public Health Observatory record 5. *Key messages for Della video*.
- Public Health Observatory record 6. *Starting Point event promotion and sharing activity*.
- Public Health Observatory record 7. *List of Health Equity Summit participants*.
- Public Health Observatory record 8. *Saskatoon Poverty Reduction Partnership sign-up sheet to receive newsletter*.
- Public Health Observatory record 9. *PowerPoint presentation on Student Health Survey*.
- Public Health Observatory record 10. *Submission of Student Health Survey results to senior leadership*

*team.*

Public Health Observatory record 11. *Tracking of meetings with individuals in school divisions to discuss Student Health Survey results.*

Public Health Observatory record 12. *Dissemination work plan.*

Public Health Observatory record 13. *Last iteration of project work plan.*

Public Health Observatory record 14. *Poster for presentation at Frances Morrison Library.*

Public Health Observatory record 15. *Summary of feedback on presentation at Frances Morrison Library.*

Public Health Observatory record 16. *Media coverage of release of Student Health Survey results.*

Public Health Observatory record 17. *E-mail with follow-up survey on how individuals in the school divisions have used the Student Health Survey results.*

Public Health Observatory record 18. *Background information on Standing Committee on Finance's call for submissions (Income Inequality in Canada Study).*

Public Health Observatory record 19. *Presentation on KT work delivered at Canadian Public Health Association conference, June 2013.*

Public Health Observatory record 20. *Final list of invitees for Health Equity Summit.*

Public Health Observatory record 21. *Biographies for Health Equity Summit speakers/panelists.*

Public Health Observatory record 22. *Poster for Mobilize! forum.*

Public Health Observatory record 23. *Follow-up report on Mobilize! forum (for City of Saskatoon).*

Public Health Observatory record 24. *Original evaluation proposal.*

Public Health Observatory record 25. *Social Sciences Research Laboratories agreement for services (public opinion survey).*

Public Health Observatory record 26. *Public opinion survey questions.*

Public Health Observatory record 27. *E-mail request for input in CIHR knowledge translation supplement grant application.*

- Public Health Observatory record 28. *Project team meeting minutes, March 2012.*
- Public Health Observatory record 29. *Minutes for meeting between staff and SPHERU.*
- Public Health Observatory record 30. *Promotional activities for Della video.*
- Public Health Observatory record 31. *Feedback from The Starting Point event at Broadway Theatre.*
- Public Health Observatory record 32. *Summary of feedback and sharing activity for Della video.*
- Public Health Observatory record 33. *Feedback from university students and health promotion professionals in Ontario who watched the Della video.*
- Public Health Observatory record 34. *Letter to C95 Radio about how the Christmas Wish gifts have impacted Della and her family.*
- Public Health Observatory record 35. *Feedback from Mobilize! forum.*
- Public Health Observatory record 36. *Responses to follow-up survey sent to individuals who received the Student Health Survey report.*
- Rajotte, J. (2013). *Income inequality in Canada: An overview*. Ottawa: House of Commons. Retrieved from <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=6380060&Language=E&Mode=1&Parl=41&Ses=2>
- Rogers, E. M. (1995). *Diffusion of innovations* (4<sup>th</sup> ed.). New York, NY: The Free Press. Preview retrieved from <http://books.google.ca/books>
- Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2004). *Evaluation: A systematic approach* (7<sup>th</sup> ed.). Thousand Oaks, CA: Sage Publications.
- SaskatoonHealthReg. (2013a). *Health Equity Summit*. Retrieved from <https://www.youtube.com/watch?v=fUcBgXH-Fek&list=PLtpygcPUjIJ4ygPVkCbsoxGSFeEKUNs3>
- SaskatoonHealthReg. (2013b). *Café Scientifique*. Retrieved from [https://www.youtube.com/watch?v=nw\\_VtGs5lzU&feature=youtu.be](https://www.youtube.com/watch?v=nw_VtGs5lzU&feature=youtu.be)
- SaskatoonHealthReg. (2012). *Della: Hurdles to Health*. Retrieved from <https://www.youtube.com/watch?v=EbMhdm1VuLo>



- Saskatoon Health Region. (2013). *Health Promoting Schools program receives funding boost*. Retrieved from <http://regionreporter.wordpress.com/2013/10/08/hps/>
- Saskatoon Health Region. (2012). *Project charter: Knowledge translation supplement grant, 2012/2013*. Internal document.
- Saskatoon Health Region. (n.d.1). *Health promotion in schools*. Retrieved from [https://www.saskatoonhealthregion.ca/locations\\_services/Services/health-promotion/Pages/HealthPromotionSchools.aspx](https://www.saskatoonhealthregion.ca/locations_services/Services/health-promotion/Pages/HealthPromotionSchools.aspx)
- Saskatoon Health Region. (n.d.2). *Food for Thought*. Retrieved from [https://www.saskatoonhealthregion.ca/locations\\_services/Services/Primary-Health/Pages/Foodforthought.aspx](https://www.saskatoonhealthregion.ca/locations_services/Services/Primary-Health/Pages/Foodforthought.aspx)
- Saskatoon Poverty Reduction Partnership. (n.d.). *Della: Hurdles to Health*. Retrieved from <http://www.saskatoonpoverty2possibility.ca/The-starting-point.html>
- Sharpe, C., Dow, M., Rahmani, Z., & Morris, M. (2013). *Targeted interventions: An investigation into various policies to reduce income-related health disparities in Saskatoon*. Saskatoon: The Policy Shop, University of Saskatchewan. Retrieved from <http://www.saskatoonpoverty2possibility.ca/pdf/2013/SPR.FinalReport.v2.pdf>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research*. London: Sage Publications.
- Straus, S. E., Tetroe, J., & Graham, I. (2009). Defining knowledge translation. *CMAJ*, 181(3-4), 165-168. doi:10.1503/cmaj.081229
- Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, 11(1), 80-96. doi:10.1177/1473325010368316
- Ugolini, C. (2013). *What needs to be included in a national health equity agenda?* [Blog post]. Retrieved from <http://nccdh.ca/community/post/HE-agenda-for-canada>
- University of Wisconsin – Extension Division. (n.d.). *Logic model*. Retrieved from <http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html>
- Varsity View Community Association. (n.d.). *LiveWell with Chronic Conditions program*. Retrieved from <http://vvcasaskatoon.com/2014/01/livewell-with-chronic-conditions-program/>
- Winnipeg Free Press. (2013). *Health region report says Saskatoon area students not active enough*.

Retrieved from [http://webcache.googleusercontent.com/search?q=cache:vY1tOso5\\_UJ:www.newsbcc.com/canada/Health/Health\\_region\\_report\\_says\\_Saskatoon\\_area\\_students\\_not\\_active\\_enough/413640/+&cd=5&hl=en&ct=clnk&gl=ca](http://webcache.googleusercontent.com/search?q=cache:vY1tOso5_UJ:www.newsbcc.com/canada/Health/Health_region_report_says_Saskatoon_area_students_not_active_enough/413640/+&cd=5&hl=en&ct=clnk&gl=ca)

## Appendix A: Planned Knowledge Translation Activities for Promoting Health Equity in Saskatoon

Activity	Timeframe	Persons/Entities Involved (in addition to project coordinator)	Completed	Ongoing	Not Completed
<b>Video (<i>Della: Hurdles to Health</i>)</b>					
Plan and produce film	June to Nov. 2012	Jennifer Cushon (Program Manager of Research and Evaluation, Public Health Observatory [PHO], Saskatoon Health Region [the Region]) and team; Fahrenheit Films	✓		
Showing at Broadway Theatre along with two other videos (event title: <i>The Starting Point</i> )	Nov. 19, 2012	Panel members: Cory Neudorf (the Region's Chief Medical Health Officer), Julie Kryzanowski (the Region's Deputy Medical Health Officer and Co-Chair of Saskatoon Poverty Reduction Partnership [SPRP]), Felix Thomas (Chief of Saskatoon Tribal Council), Della Kinequon (resident featured in film); general public	✓		
Dissemination: post on relevant websites, distribute through social media networks (Twitter, Facebook), etc.	Oct. 2012 onward	Starting Point Working Group in Health Promotion Department (HPD), Food Bank, Saskatchewan Population Health and Evaluation Research Unit (SPHERU), other partners		✓	
Maintain database of evaluations from those who viewed documentary	Oct. 2012 onward	People who went to premiere, Public Health Ontario, university class in Ontario, YouTube Analytics		✓	
Use as KT tool at meetings and presentations	Nov. 2012 onward	Staff, partners, external organizations		✓	

Activity	Timeframe	Persons/Entities Involved (in addition to project coordinator)	Completed	Ongoing	Not Completed
<b>Dissemination of Student Health Survey Results</b>					
Develop dissemination plan	Summer 2012	J. Cushon	✓		
Develop social media tool: interactive game application (app)	Fall 2012	School divisions, computer science undergraduate students from the University of Saskatchewan (U of S)	✓		
Test and implement computer game	Fall 2012	School divisions, Region Communications			✓
Deliver presentations to school boards, principals, and School Community Councils	Summer 2012	SPHERU, Health Promoting Schools program (HPS; within HPD), school divisions, School Community Councils, Developmental Assets			✓
Create Facebook page to share results and create a forum for discussion	Summer 2012	Region Communications			✓
Work with Saskatoon Public Schools to create a video that can be used as a resource (poverty awareness curriculum)	Fall 2012	Research branch of Saskatoon Public Schools, students, teachers, HPS program, Developmental Assets			✓
Student and teacher forums with Greater Catholic Schools, Prairie Spirit School Division, and Horizon School Division	Fall 2012	Teachers, students, school divisions			✓
Develop dissemination plan for one-pager and report	Fall 2012		✓		

Activity	Timeframe	Persons/Entities Involved (in addition to project coordinator)	Completed	Ongoing	Not Completed
Co-presentation with SPHERU at Frances Morrison Library	Nov. 2012	SPHERU's Smart Cities, Healthy Kids study	✓		
Information item for Region board and senior leadership team	Dec. 2012		✓		
Media release, e-mail distribution of report, post report on various sites (e.g., the Region's Facebook page and CommunityView Collaboration [CVC] website)	Early 2013	Region Communications, Bill Holden (CVC Coordinator), PHO staff	✓		
Insert re: survey results in school newsletter sent to parents	Feb. 2013	School divisions	✓		
Follow-up questionnaire to those who received report	May to June 2013	Various	✓		
<b>Dissemination of Health Disparities Research and KT Work</b>					
Twitter feed for health disparities		Region's Twitter account, C. Neudorf's Twitter feed	✓ (partially)		
Establish online forums and community of practice on CVC		B. Holden, J. Cushon, Cristina Ugolini (Manager of PHO)			✓
Distribute progress on policy options and plain language fact sheet on results Develop interactive presentations and post on relevant websites Develop podcasts and post on websites		<i>Health Disparity in Saskatoon</i> report (2008), Population and Public Health (PPH) managers, J. Cushon and team, Region Communications, SPHERU			✓

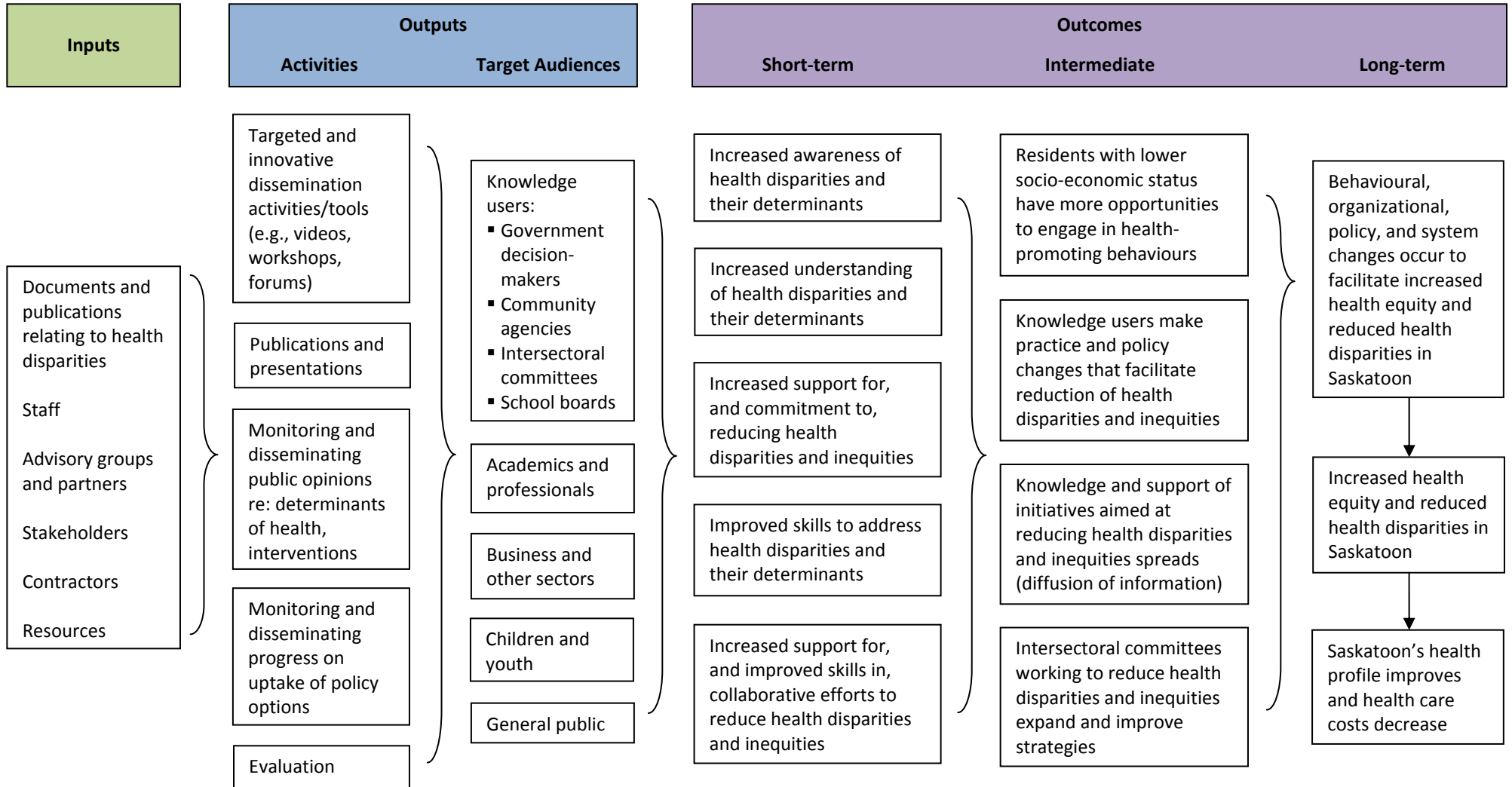
Activity	Timeframe	Persons/Entities Involved (in addition to project coordinator)	Completed	Ongoing	Not Completed
Disseminate key messages	Winter 2012 to summer 2013	C. Ugolini		✓	
Monitor progress on uptake of policy options	Since 2008	<i>Health Disparity in Saskatoon</i> report (2008), SPRP		✓	
Present at International Conference on Urban Health	2012	J. Cushon			✓(N/A)
Develop and distribute policy briefs that outline best practices on promoting health equity	Jan. to Mar. 2013	U of S Policy Shop; local, provincial, and national agencies			✓
Submit policy brief to federal government re: impact of income on health	Spring 2013	C. Neudorf sent a submission to Finance Committee (Income Inequality in Canada Study)	✓		
KT Professional Certificate from SickKids, Toronto (project coordinator received training)	Feb. 2013		✓		
Participate in Toronto Workshop for Lead Users of Population Health Information in Health Care (project coordinator shared KT experiences)	Mar. 2013		✓		
Report on three policies to reduce income-related health disparities in Saskatoon (produced for SPRP)	Spring 2013	U of S Policy Shop	✓		

Activity	Timeframe	Persons/Entities Involved (in addition to project coordinator)	Completed	Ongoing	Not Completed
Present at Canadian Public Health Association (CPHA) KT workshop in Ottawa	June 2013	J. Kryzanowski (presenter)	✓		
Present at Canadian Knowledge Mobilization Forum in Mississauga	June 2013				✓
Submissions for publication	Spring 2013 onward	C. Neudorf and his students, J. Cushon/PHO, SPHERU, research assistants		✓	
<b>Health Equity Summit and Mobilize! Forum</b>					
Hold Summit to showcase PHO's work/learnings and to work on a national agenda for promoting health equity	May 13, 2013	PHO, HPD, SPHERU, National Collaborative Centre for Determinants of Health (NCCDH), Canadian Council on Social Determinants of Health (CCSDH), U of S	✓		
Mobilize! For our Community's Well-being (evening forum)	May 13, 2013	City of Saskatoon's Cultural Diversity and Race Relations Committee (co-sponsorship), Station 20 West, U of S, NCCDH	✓		
Evaluation report on Summit, including summary of feedback from participants	July 2013	Prepared by Abosede Adesina, Master's of Public Health student at U of S (practicum placement with NCCDH)	✓		
Put short video clips of Summit speakers' insights on YouTube	June 2013	PHO, NCCDH, U of S, CCSDH	✓		

Activity	Timeframe	Persons/Entities Involved (in addition to project coordinator)	Completed	Ongoing	Not Completed
<b>Evaluation and Monitoring</b>					
Develop and implement evaluation and monitoring plan	Summer to fall 2012	J. Cushon, C. Ugolini	✓		
Document actions associated with original health disparities research		PHO staff		✓	
End of grant report	May to June 2013				✓
Replication/public opinion survey to see if awareness of health disparities and support for interventions have changed since 2006	Spring 2013	PHO staff, Poverty Free Saskatchewan, B. Holden, SPHERU, Social Sciences Research Laboratories (SSRL) at U of S	✓		



## Appendix B: Logic Model for Knowledge Translation Aimed at Promoting Health Equity in Saskatoon



**Assumptions**

- An iKT approach involves meaningful participation from key stakeholders, which can increase the uptake of research findings.
- Health disparities and inequities exist in Saskatoon and are associated with socio-economic factors (social determinants of health).
- Effective KT strategies result in evidence-based decision-making that can reduce health disparities and increase health equity.

**External Factors**

- Perceptions, assumptions, values, and beliefs surrounding health disparities their determinants.
- Socio-political climate.
- Issue competition and prioritization.
- Duplication of efforts with other organizations, and timing of KT activities.

## Appendix C: Evaluation Matrix

Evaluation Questions	Indicators	Methods and Data Sources
<b>Project Design and Implementation (Process Evaluation)</b>		
E1. Were all activities carried out as planned?	<ul style="list-style-type: none"> <li>• Comparison between planned and actual activities</li> </ul>	<ul style="list-style-type: none"> <li>• Records review</li> <li>• Key informant interviews</li> </ul>
E2. Were the activities carried out on schedule?	<ul style="list-style-type: none"> <li>• Comparison between project timeframe and actual progress</li> </ul>	<ul style="list-style-type: none"> <li>• Records review</li> <li>• Key informant interviews</li> </ul>
E3. Were the target audiences reached?	<ul style="list-style-type: none"> <li>• Comparison between planned and actual audiences</li> <li>• Perceptions of whether target audiences were reached</li> </ul>	<ul style="list-style-type: none"> <li>• Records review</li> <li>• Key informant interviews</li> </ul>
E4. Was the process well documented?	<ul style="list-style-type: none"> <li>• Clarity of documentation</li> </ul>	<ul style="list-style-type: none"> <li>• Records review</li> </ul>
E5. Were the activities consistent with the definition and intent of KT?	<ul style="list-style-type: none"> <li>• Level of fit between selected activities and definition and intent of KT</li> </ul>	<ul style="list-style-type: none"> <li>• Literature review</li> <li>• Records review</li> <li>• Key informant interviews</li> </ul>
E6. Which activities or tools were most effective and which were least effective?	<ul style="list-style-type: none"> <li>• Perceived quality and effectiveness of activities and tools</li> <li>• Self-reported perceptions of effectiveness</li> <li>• Number of views for YouTube videos (<i>Della</i> video, Health Equity Summit clips)</li> <li>• Level of distribution of materials/tools</li> <li>• Promotion and use of materials/tools by external agencies</li> <li>• Perceived level of engagement</li> <li>• Self-reported level of engagement</li> <li>• Attendance at events</li> <li>• Media coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Records review</li> <li>• Key informant interviews</li> <li>• Feedback collected</li> <li>• Online survey with Health Equity Summit participants</li> <li>• YouTube</li> </ul>

<b>iKT Approach (Process Evaluation)</b>		
E7. How much input did partners have in the project?	<ul style="list-style-type: none"> <li>• Perceived level of input</li> <li>• Attendance at meetings</li> <li>• Number of meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Records review</li> <li>• Key informant interviews</li> </ul>
E8. What are partners' perceptions of PHO's engagement and collaboration practices?	<ul style="list-style-type: none"> <li>• Perceptions of PHO's engagement and collaboration practices</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> </ul>
E9. What are staff members' perceptions of PHO's engagement and collaboration practices?	<ul style="list-style-type: none"> <li>• Perceptions of PHO's engagement and collaboration practices</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> </ul>
E10. Was iKT achieved?	<ul style="list-style-type: none"> <li>• Comparison between definition and intent of iKT and actual practices</li> </ul>	<ul style="list-style-type: none"> <li>• Literature review</li> <li>• Records review</li> <li>• Key informant interviews</li> </ul>
<b>Short-term Outcomes (Learning)</b>		
E11. Have the KT activities contributed to increased understanding of health disparities?	<ul style="list-style-type: none"> <li>• Perceived effect on understanding</li> <li>• Self-reported effect on understanding</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Feedback collected</li> <li>• Online survey with Health Equity Summit participants</li> </ul>
E12. Have the KT activities contributed to increased support for initiatives aimed at reducing health disparities?	<ul style="list-style-type: none"> <li>• Perceived effect on support</li> <li>• Self-reported effect on support</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Feedback collected</li> <li>• Online survey with Health Equity Summit participants</li> </ul>
<b>Intermediate Outcomes (Behaviour/Action)</b>		
E13. What actions have resulted from the KT activities?	<ul style="list-style-type: none"> <li>• Initiatives that have stemmed from KT activities</li> <li>• Perceptions of how KT work is being used to inform work of agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Records review</li> <li>• Key informant interviews</li> <li>• Feedback collected</li> <li>• Online survey with Health Equity Summit</li> </ul>

	<ul style="list-style-type: none"> <li>• Perceptions of how KT work has prompted action in personal and professional lives</li> <li>• Self-reported actions at personal and professional levels</li> </ul>	participants
E14. To what extent is information about health disparities being passed on to others?	<ul style="list-style-type: none"> <li>• Reported forwarding of materials/information to others</li> <li>• Self-reported level of forwarding materials/information</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Online survey with Health Equity Summit participants</li> </ul>

## Appendix D: Interview Questions

---

### Staff

1. What is your understanding of knowledge translation as it relates to health research?
2. Can you recall the knowledge translation activities that were carried out?
3. What was your involvement in these activities?
4. In your view, were there any people or groups that could benefit from knowledge translation activities but were not targeted in this project?
5. In terms of translating the health disparities research results into action to reduce health disparities, which activities would you say were most effective? Why?
  - a. Which were least effective? Why?
6. The Health Region aimed for integrated knowledge translation with this project, which involves getting input from partners.
  - a. How involved would you say partners were in the planning process?
  - b. What kind of input did they have?
  - c. In regard to the Health Region's approach to working with community partners:
    - i. What would you say worked well?
    - ii. What didn't work well or could be improved?
7. A number of activities were not completed: development of social media tools to engage youth, the establishment of an online forum for health disparity on the CVC website, delivering presentations at schools, disseminating certain documents surrounding health disparities (e.g., policy briefs), and presenting at certain conferences.
  - a. Do you have any thoughts on why these activities weren't carried out?
  - b. What do you think could've been done differently in order for these activities to have happened?
8. Have the knowledge translation activities, and the health disparities research associated with them, informed your work?
9. Roughly speaking, how many people or organizations would you say you've passed health disparities information on to, including friends, family, colleagues, etc.?
  - a. What kinds of responses have you received from sharing this information?

## Partners

1. What is your understanding of knowledge translation as it relates to health research?
2. Can you recall the knowledge translation activities that were carried out?
3. What was your involvement in these activities?
4. In your view, were there any people or groups that could benefit from knowledge translation activities but were not targeted in this project?
5. In terms of translating the health disparities research results into action to reduce health disparities, which activities would you say were most effective? Why?
  - a. Which were least effective? Why?
6. As a partner in this project, how involved would you say you were in the project?
  - a. What kind of input did you have?
  - b. What did you perceive as benefits to being involved in the project?
  - c. What did you perceive as challenges to being involved in the project?
7. In regard to the Health Region's approach to working with partners to carry out knowledge translation activities:
  - a. What would you say worked well?
  - b. What didn't work well or could be improved?
8. *If involved in activities that weren't carried out:*
  - a. [Planned activity X] was not completed. Do you have any thoughts on why this was the case?
9. Have the knowledge translation activities affected your understanding of health disparities?
10. Have the knowledge translation activities affected your support for initiatives aimed at reducing health disparities?
11. Have the knowledge translation activities, and the health disparities research associated with them, prompted action in your personal and professional lives?
12. Roughly speaking, how many people or organizations would you say you've passed health disparities information on to, including friends, family, colleagues, etc.?
  - a. What kinds of responses have you received from sharing this information?

**Della**

1. What was your understanding of the purpose of the video and why the Health Region wanted you and your family to be in it?
2. What was it like to do the video? For you? For your family?
3. What was the Broadway show like?
4. What was it like to work with people from the Health Region?
5. What effect has this experience had on your life? What's happened since?
6. What would you like people to get out of the video?

## Appendix E: Survey Questions and E-mail Messages

---

### Survey with Health Equity Summit Participants

#### Questions

**Participating in the Summit increased my understanding of health disparity and its determinants.**

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

**Participating in the Summit increased my support for initiatives aimed at reducing health disparity/increasing health equity.**

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

**Participating in the Summit prompted me to take action to increase health equity.**

- Strongly disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

Please briefly describe any action(s) you have taken in your personal and/or professional lives.

**Did your agency take any action(s) as a result of the Summit proceedings?**

- Yes
- No



Not sure

If you answered "Yes," please discuss the action(s) taken by your agency.

**Roughly speaking, with how many people have you shared what you learned at the Summit (including friends, family, colleagues, etc.)?**

None

A few

Quite a few

Many

**The Health Equity Summit was one of several activities that the Saskatoon Health Region conducted to promote awareness about health disparity and encourage action that will reduce this disparity.**

**Please indicate how effective you think the Health Equity Summit was in achieving this objective.**

Very ineffective

Ineffective

Neither ineffective nor effective

Effective

Very effective

**Feel free to provide any other comments you may have in regard to your experience at the Health Equity Summit.**

**In which category does your profession belong?**

Academia

Federal government

Provincial government

Local government

Non-governmental organization (NGO)

Regional Health Authority

Other (please specify)

**Please indicate your gender.**

Male

Female

Other (please specify)

**Which category below includes your age?**

18 to 25

26 to 35

36 to 45

46 to 55

56 to 65

Over 65

***E-mail Message***

Greetings,

My name is Mel Brockman and I am currently contracted with the Saskatoon Health Region (SHR) to conduct an external evaluation of their knowledge translation (KT) project, which took place between June 2012 and June 2013. One of the key activities for this project was a conference entitled *Developing a Health Equity Agenda: From a Shared Vision to Policy and Practice* (a.k.a. the Health Equity Summit). This Summit was held in Saskatoon in May 2013.

You are receiving this e-mail because SHR's records indicate that you participated in the Health Equity Summit. The purpose of this survey is to assess whether participating in the Summit has influenced your views and actions surrounding health equity. The overall purpose of the evaluation is to assess whether the Summit and other KT activities carried out by SHR effectively promoted awareness of health disparity and encouraged action to reduce health disparity/increase health equity.

It is anticipated that the survey will take you approximately 5 to 10 minutes to complete. Your participation in this survey is completely voluntary. Should you choose to participate, please be assured that your responses will be kept confidential; that is, you will not be personally identified in the evaluation report.

Thank you for your consideration. If you have any questions or concerns regarding this survey, do not hesitate to contact me by replying to this e-mail. You may also reach me by phone at 306-291-0429.

The survey can be accessed at the link below. The survey will close on February 28, 2014.

<https://www.surveymonkey.com/s/HJNW3BZ>

Best regards,  
Mel Brockman

### Survey with PHO Network

#### Questions

**Are you aware of the *Reducing Health Disparity in Saskatoon* research program that was conducted by the Saskatoon Health Region in 2006?**

- Yes
- No

**Have the results of this research informed your work in any way?**

- Yes
- No
- Not applicable

Please discuss how the research has informed the work that you do.

**Have the results of this research informed the work of your agency or department in any way?**

- Yes
- No
- Not sure

Please discuss how the research has informed the work of your agency or department.

**Roughly speaking, how many people have you passed health disparity information or materials on to (including friends, family, colleagues, etc.)?**

- None
- A few
- Quite a few

- Many
- Not applicable

The Canadian Institutes of Health Research (CIHR; 2012) defines knowledge translation as “a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system.”

The Saskatoon Health Region obtained a CIHR grant to conduct knowledge translation activities between June 2012 and June 2013.

For each of the activities carried out/tools created, please choose the response that best captures your knowledge and engagement with these activities/tools.

	I'm not aware of this activity/tool	I'm aware of this activity/tool but it has NOT impacted my work	I'm aware of this activity/tool and it has impacted my work	I'm aware of this activity/tool and it has impacted both my work and the work of my agency/department
Creation of a documentary called <i>Della: Hurdles to Health</i> (available on YouTube)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissemination of Student Health Survey results to encourage health-promoting action in schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Equity Summit held in Saskatoon in May 2013 to work on a national agenda for health equity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replication survey of Saskatoon residents' awareness of health disparity and attitudes toward interventions aimed at reducing disparity (first survey conducted in 2006)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Based on the above definition of knowledge translation, to what extent do you think each of the following activities/tools was appropriate?

	Inappropriate	Somewhat inappropriate	Somewhat appropriate	Appropriate	Not sure
Creation of a documentary called <i>Della: Hurdles to Health</i> (available on YouTube)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Inappropriate	Somewhat inappropriate	Somewhat appropriate	Appropriate	Not sure
Dissemination of Student Health Survey results to encourage health-promoting action in schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Equity Summit held in Saskatoon in May 2013 to work on a national agenda for health equity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replication survey of Saskatoon residents' awareness of health disparity and attitudes toward interventions aimed at reducing disparity (first survey conducted in 2006)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**In which category does your profession belong?**

- Academia
- Federal government
- Provincial government
- Local government
- Non-governmental organization (NGO)
- Regional Health Authority

Other (please specify)

**Please indicate your sex.**

- Male
- Female

Other (please specify)

**Which category below includes your age?**

- 18 to 25
- 26 to 35
- 36 to 45
- 46 to 55
- 56 to 65

Over 65

**In which province or territory do you reside?**

Saskatchewan

British Columbia

Alberta

Manitoba

Ontario

Quebec

New Brunswick

Newfoundland & Labrador

Nova Scotia

Prince Edward Island

Northwest Territories

Yukon Territory

Nunavut

Other location (please specify)

***E-mail Message***

Greetings,

My name is Mel Brockman and I'm currently contracted with the Saskatoon Health Region (SHR) to conduct an external evaluation of their knowledge translation (KT) project, which took place between 2012 and 2013. This project involved targeted dissemination of results from SHR's Reducing Health Disparity in Saskatoon research that was conducted in 2006. This research measured health disparity and its determinants and prompted the implementation of evidence-based interventions aimed at promoting health equity.

The purpose of this survey is to assess (1) whether the health disparity research has influenced your work and/or the work of your agency; and (2) your knowledge and opinions of the KT activities that were carried out. The overall purpose of the evaluation is to assess whether the KT activities carried out by SHR effectively promoted awareness of health disparity and encouraged action to reduce health disparity/increase health equity.

It is anticipated that the survey will take you approximately 5 to 10 minutes to complete. Your participation in this survey is completely voluntary. Should you choose to participate, please be assured that your responses will be kept confidential.

Thank you for your consideration. If you have any questions or concerns regarding this survey, do not hesitate to contact me by e-mail ([mel.brockman@hotmail.com](mailto:mel.brockman@hotmail.com)) or by phone (306-291-0429).

The survey can be accessed using the link below. The survey will close on March 4, 2014.

<https://www.surveymonkey.com/s/VSHJLM>

Best regards,  
Mel Brockman

## **Appendix F: Comments from Survey with Health Equity Summit Participants**

---

I think it would have been great for organizers to attempt to get participating organizations to some kind of formal commitment to a Health Equity Agenda and actions going forward, particularly federal and provincial/territorial governments. Would have also been great to have Fran Baum (WHO CSDoH, Commissioner from Australia) speak closer to the beginning of the day; realizing that would have been quite the commitment on her part, as it would have been the middle of the night in Australia. But it was the kind of analysis and language that could have resulted in some more profound dialogue. Would have been productive to spend more time looking at enabling factors and obstacles (and strategies to address those obstacles), to upping the ante on action on social determinants of health to affect health equity gains. Thank you for the opportunity to participate in the Summit and to comment here.

Good to hear about work on the ground and what is happening. Thanks.

Fantastic opportunity to hear from so many working in this area (both presentations) and conversations at the tables. Thank you.

It is not clear how to answer number 6 since I have no contact with other conference participants. I am a social worker in a community non-profit organization, so the information per se is not new to me. We are continually working at reducing the social deficits in our society, involving the medical people in broadening their perspective is key in gaining new allies who have much more social power than the social advocates in the system. The public health and community health people are key to raising issues arising in people's lives and letting all know the short fall in financial and personal resources many people live with and the corresponding relationship to their poor mental, physical, cognitive, emotional , relational and environment realities.

My background is in health but I represented the education sector at the Summit. I found that that the Summit was a little narrowly focused and that made it difficult at times to bring other perspectives into the conversation.

I really enjoyed the opportunity to share ideas and have discussions with colleagues from across the country working at a variety of levels and sectors. That was very valuable to me.

The one thing I did not like was the way Steven Harper and the Sask Government were bashed. Both are doing an excellent job.