PROMISING PRACTICES FOR CONNECTING KNOWLEDGE TO ACTION FOR HEALTH EQUITY

by

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Abstract

In 2008, the Commission on Social Determinants of Health established the unfair and disproportionate distribution of power, resources, and money as the root causes of health inequities. These socioeconomic and political causes are resistant to change, therefore creating a tenacious gap between knowledge and action for health equity. Grounded in critical pedagogy, this dissertation involved three studies to illuminate practices for overcoming this knowledge-to-action (KTA) gap. The first study mapped practices in the field of health equity by examining literature in the field of health equity. This **scoping review** showed modest integration of evidence about root causes of health inequities, with about half of 330 articles framing health inequities without referring to known causes. Among 110 empirical articles published post-2008, half oriented their work in ways that did something to illuminate or interrupt root causes of inequities. A **critical interpretive synthesis** was then conducted, focusing on articles where authors integrated evidence about root causes of health inequities and attempted to respond directly. Qualitative analysis of the studies' designs, results, and conclusions identified of a set of four promising KTA practices, grouped into ways of structuring systems, working together, doing research, and doing knowledge translation These ways of doing were found to influence (and by influenced by) how *attuned* one is to the evidence about causes of inequities. In the third study, experts in health equity and knowledge translation contributed to a series of **critically reflective dialogues** to deeply explore how contributors oriented themselves to health equity and what they believed was promising for connecting KTA in their field. These dialogues nuanced and extended findings from studies 1 and 2, supporting the need for fostering *equity attunement* as a central promising practice. Four promising ways of thinking—relationally, reflexively, responsively, and tenaciously—were also identified, and each fit into an integrated framework for advancing health equity action by aligning ways of thinking and doing around a central effort to foster *equity attunement*. Together, these three studies provide practical and applied steps that can be taken to advance a health equity action among academics, students, health professionals, leaders, and others.

Lay Summary

Health inequities are unfair differences in health caused by how power, resources, and money are distributed in society. Resolving these differences means finding evidence-informed ways to shift the structures, systems, and patterns in society that lead to this unfair distribution. Using three different studies, this dissertation looked at published literature and engaged experts to find out what practices are most promising for resolving health inequities. Results indicate how we *think* about equity guide what we *do* in response. By using these evidence-informed promising ways of thinking and doing, people can support greater attunement to what health inequities are and what we can do to reduce their presence in society. This study contributes to theory and evidence that academics, students, health professionals, and anyone interested in health equity can draw upon as they work together to advance health equity.

Research Program Design

The three studies comprising this critically reflective inquiry were independently designed and conducted by KP with supervision from committee members, through meetings and written feedback. Conceptual evolution of the study design was greatly influenced by these meetings, but data generation, analysis, and interpretation procedures were carried out in their entirety by KP. Writing was, for the most part, completed by KP, followed by written and verbal feedback from the committee members that was then integrated by KP.

Publications

A version of the scoping review that appears in Chapter 3 has been published:

Plamondon, K., Bottorff, J., Caxaj, C.S., & Graham, I. (In press). The integration of evidence from the Commission on Social Determinants of Health in the field of health equity: A scoping review. *Critical Public Health*.

Authorship contributions: KP conceptualized and conducted the work for this study with guidance from JB, CCS, and IG. JB, CCS, and IG provided substantive comments that were used in subsequent revisions of the manuscript and approved final submission.

Ethical Approval

The research protocol for the study reported on in this dissertation was approved through a harmonized review between the Interior Health Research Ethics Board (Record #2016-17-038-H) and the UBC Behavioural Research Ethics Board (Certificate # H16-02501) on 11 November 2016.

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List of Abbreviations

AR	Action research
CBPR	Community based participatory research
CCGHR	Canadian Coalition for Global Health Research
CIS	Critical interpretive synthesis
CSDH	Commission on Social Determinants of Health
GHR	Global health research
iKT	Integrated knowledge translation
KT	Knowledge translation
KTA	Knowledge-to-action
SDH	Social determinants of health
WHO	World Health Organization

Acknowledgements

Mitakuye-Oyasin

(all my relations)

Dedication

For the grandmothers who hold me up and cleared a path for my feet to walk.

Glossary

Global health research	Research that "prioritizes equity and improved well-being for all people worldwide. Global health research studies transnational health issues, determinants, and solutions; involves and collaborates with many disciplines within and beyond the health sciences; and is undertaken in order to inform (and be informed by) policy at the local, national and global levels" (CCGHR, 2013b, p. 3 as adapted from Koplan, 2009).
Health equity	Health equity is inherently normative because it involves ethical judgements about fairness and justice. It is "the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage" (Braveman & Gruskin, 2003, p. 254). Social advantage and disadvantage refer to relative positions of power and privilege in society and can be associated with a wide range of intersecting factors such as wealth distribution or the impacts of social discriminations (e.g., racism, ableism, sexism, etc.).
	In this dissertation, the ***field of health equity*** is used to describe the broad range of professions and scholarly disciplines that align their mandates with advancing health equity, including (but not limited to) global health, population health, public health, and other social-justice driven disciplines (e.g., social work) or focused groups within applied health professions (e.g., nursing) or academic health research (e.g., anthropology). Notably, this term is *not* often used by these professions and scholarly disciplines to situate themselves—something that reflects the fragmentation in a field where, regardless of the topical focus, the root causes and ultimate goals of action (i.e., moving toward health equity) are, in essence, the same.
Health inequities	Health inequities are fundamental differences in health that are created through human decisions, policies, and actions. They are "unnecessary, avoidable and unfair" (EQUINET Steering Committee, 1998).
Knowledge-to-action work	The wide range of practices and activities that go into connecting different kinds of knowledges (e.g., empirical, tacit) with action. Practicing knowledge translation is included in knowledge-to-action work.
Knowledge translation	"A dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system" (Straus, Tetroe, & Graham, 2009, p. 165).

Practice	Here, I draw upon Kemmis' (2008) description of 'practice' as habitual or customary actions, the understanding of which are constructed both objectively (from an outsider perspective) and subjectively (from an insider perspective).
Praxis	The demonstration of relationship between thinking (and theory) and *doing*, an act of "creative consciousness" involving intentionally pursuing *informed* action (Freire, 1985b; Kemmis, 2008) that involves examining and responding to daily, routine actions (i.e., practices).
Reflexivity	The demonstration of relationship between thinking, striving for praxis in research, and *being*. An act of critical self and collaborative reflection about positionality, situatedness, intersectionality, and identity and their relationship to assumptions, values, and beliefs (Lincoln, Lynham, & Guba, 2018; Pillow, 2003) that involves examining and responding to social structures and the legitimization of knowledge (and knowledge claims) and power.
Relationality	Relationality is a concept that, for purposes of this study, is inspired by relational theories (Gweneth Hartrick Doane, 2014a; A. Edwards, 2005; Gergen, 2009). It is a term that reflects a relational stance in practices, theories, and ways of thinking; that is, relationality is a stance of assuming the connections between people, ideas, organizations, bodies of knowledge, and contexts all include something relational (Plamondon & Caxaj, 2017). It involves both philosophical and operational domains, akin to how the term criticality might be used to describe the stance adopted by people using critical theories to guide their work. I anticipate this concept of relationality will evolve through the process of inquiry.
Wicked problems	Wicked problems are multifarious social system problems, marked by conflicting interests and values where contexts and particularities are inextricably linked to and interactive with others; they are intensely complex and resistant to resolution (Rittel & Webber, 1973; Waddock, 2013).

Chapter 1: Introduction

1.1   Background

Equity is a concept of justice. It is about fairness and reasonableness (*Oxford English Dictionary Online*, 2015). Grounded in principles of distributive and social justice (Faden & Powers, 2008), *health equity* is "the absence of systematic disparities in health (or the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage" (Braveman & Gruskin, 2003, p. 254). *Health inequities* are, thereby, unfair, avoidable, and systematic differences in health-damaging experiences and health outcomes. Vast health inequities exist both within and between countries and are invariably connected to socioeconomic and structural determinants of health (Donkin, Goldblatt, Allen, Nathanson, & Marmot, 2018; Labonte & Schrecker, 2011; Michael Marmot & Allen, 2014). Knowledge about the causes of health inequities surfaced centuries ago.

Early public health and social medicine advocates argued that improving health necessitated improved social and policy environments (e.g., Brown, Cueto, & Fee, 2006; La Berge, 1992; Monteiro, 1985). In 2008, through the culmination of a massive global effort to accumulate research evidence on the causes of inequities, the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) declared that "social injustice is killing people on a grand scale" (CSDH, 2008, p. 0). The CSDH argued that health inequities were "not in any sense a 'natural' phenomenon but…the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (sic, CSDH, 2008, p. 1). The CSDH evidence and calls for action provoked a shift in the health research paradigm away from a focus on downstream, clinical, and bio-behavioural problems and toward the structural and systems issues shaping health (P Ostlin et al., 2011). Yet, continued monitoring of structural and social determinants of health (SDH) in a variety of settings (Bailey et al., 2017; Bryant, Raphael, Schrecker, & Labonte, 2011; Came & Griffith, 2018; Donkin et al., 2018; Michael Marmot & Allen, 2014) show significant lingering gaps between what is known about advancing health equity and what is being done to achieve it.

Responding to the structural conditions that inhibit health equity evokes ethically and morally urgent obligations (Soloman R Benatar & Brock, 2011; Solomon R Benatar, Daar, & Singer, 2003; Solomon R Benatar & Singer, 2010; Forman, Cole, Ooms, & Zwarenstein, 2012; Lowry & Schüklenk, 2009; Nixon, 2006a; Pinto, Birn, & Upshur, 2013; Ruger, 2006). In the CSDH report and other calls that followed (M. Marmot & Bell, 2012; Michael Marmot, Allen, Bell, & Goldblatt, 2012; Popay, 2012), advancing health equity was framed as a complex challenge of governance (Lee, 2010; Ottersen et al., 2014) and of connecting and knowledge with action. Leading global health organizations and governance bodies recognize the importance of connecting what is known about underlying causes of health inequities with action in policies, practices, and continued research (Commission on Health Research for Development, 1990; Ministerial Summit on Health Research, 2004; World Health Organization, 2011,

2014). The challenges of arriving at greater health equity are thus entangled in the practice and science of knowledge-to-action (KTA).

Several major platforms for connecting KTA for health equity have evolved since the release of the CSDH report, again with a notably strong Canadian presence. In an effort to advance research that could address health inequities, several Canadian initiatives that emerged in the new millennium, including the Global Health Research Initiative and the Canadian Coalition for Global Health Research, recognized the role of research in strengthening and capacity building in health systems, and as an essential tool for addressing health inequities (Di Ruggiero et al., 2006; Neufeld, 2006; Neufeld & Spiegel, 2006). The establishment of National Collaborating Centres for Public Health, for example, introduced structural supports for synthesizing evidence and advancing knowledge and best practices in public health (Medlar, Mowat, Di Ruggiero, & Frank, 2006). Each of the six specialized areas of the collaborating centres are relevant to the KTA work of addressing health equity, including determinants of health, methodologies and tools, Indigenous[1] health, healthy public policy, infectious diseases, and environmental health. The launch of these initiatives paralleled trends in the broader field of health research, where the need for more explicit connections between knowledge and action spurred the rapid evolution of knowledge translation (KT) as a field of research and practice.

Advancing health equity presents challenges that stem from a variety of sources: (a) the wicked nature of problems underlying health inequities (Petticrew et al., 2009); (b) the persistence of silos across and within health and social sectors (Carey & Friel, 2015); (c) the complex divides between academic and policy worlds about expectations and practicalities of using evidence to promote equitable health policies (Carey & Crammond, 2015a); and, among other challenges, (d) academic cultures that disincentivize engagement (e.g., Bell, 2014; Crane, 2010; John, Loewenstein, & Prelec, 2012). There is a critical need for more evidence-informed practices for the KTA work of advancing health equity. What we do as research actors should be informed by the most promising evidence and knowledge about what works; yet, the distinct lack of theory development (Rycroft-Malone, 2007) limits this praxis. Despite growth in both the fields of KTA and health equity research, there is little documented about *how* to advance evidence-informed action for such a wicked problem.

1.2   Trends in Knowledge Translation Sciences, Theories, and Practices

Theories, research, and practice in KT evolved rapidly over the last two decades, though ideas about explicitly connecting health research with health policy and practice appeared in the early 1990s (e.g., Lomas, 1993). Canadian institutions, particularly the Canadian Health Services Research Foundation, also made important contributions to promoting roles (e.g., knowledge brokers) (Conklin, Lusk, Harris, & Stolee, 2013), frameworks (Best et al., 2009), and practices (e.g., deliberative dialogue)

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[1] Note that this centre is named the National Collaborating Centre for Aboriginal Health. I choose to use the word *Indigenous* here and throughout the dissertation for both consistency and out of respect for language that is evolving.

(Jonathan Lomas, Culyer, McCutcheon, McAuley, & Law, 2005) for connecting research with action. Over the last ten years, funding agencies have also made efforts to structurally enable KT science and practice through granting mechanisms (Graham & Tetroe, 2009; Holmes, Scarrow, & Schellenberg, 2012; Kerner, 2006; Shea, 2011b). Global health research, a major contributor to the field of health equity, has made a strong and consistent contribution to the evolution of thinking in the field, particularly in the establishment of innovative KT platforms (e.g., Guindon et al., 2010; Kasonde & Campbell 2012; McKibbon et al., 2013) and in capacity building for KTA work (Bergström, Peterson, Namusoko, Waiswa, & Wallin, 2012; S. Campbell, 2012; Law, Lavis, Hamandi, Cheung, & El-Jardali, 2012). These contributions have been expanding alongside the growing field of health equity.

Divides between what is known to be 'good' and evidence-informed and what is actually done by healthcare and health research actors remain wide (Bowen, 2015; Bowen & Graham, 2013; Gweneth Hartrick Doane & Varcoe, 2008; Morris, Wooding, & Grant, 2011). These disconnects limit peoples' and systems' capacities to act on the knowledge they have or acquire. They can also lead to system inefficiencies (Best & Holmes, 2010; Bowen, 2006; Walsh et al., 2012); missed opportunities for acting on key health policy issues (Graham & Tetroe, 2007; Nabyonga Orem et al., 2013; Ssengooba et al., 2011); and continued neglect of health inequities (Guindon et al., 2010; Koh et al., 2010). Complicating matters, descriptors of KT vary widely, with more than ninety terms used to describe what it is and what it is supposed to do (Colquhoun, Letts, Law, MacDermid, & Missiuna, 2010; McKibbon et al., 2013; Shea, 2011a). However, the variety of approaches in KTA fall broadly into six domains (Plamondon & Oelke, 2018), each with distinct paradigms that differ in the way KTA gaps are conceptualized and approached.

Just as different research methodologies are attuned to particular kinds of questions, different KTA domains respond to different kinds of knowledge-to-action problems. Assumptions underlying KTA approaches can be more or less suited to complexity (Best & Holmes, 2010). The predominance of positivist and post-positivist approaches in health research sets a stage for binary languages and generalizable approaches to research that are less attentive to context than they are to generating large-scale evidence (Reimer-Kirkham et al., 2009). Some approaches problematically separate 'knowledge' from 'knowers', splitting what is known from who and where it might be actioned (Gweneth Hartrick Doane & Varcoe, 2008). Complex problems, where some evidence is available but evidence-informed solutions are not fully developed (or working), require responses that are compatible with the complex social environments in which those solutions need to unfold. Evidence supports the adaptation of KTA approaches to complex social contexts in which health and health services research unfolds (Bowen, Botting, Graham, & Huebner, 2016; Gatrell, 2005; Kannampallil, Schauer, Cohen, & Patel, 2011; Leykum et al., 2014). Inclusive, engaged processes for prioritizing research questions and interpreting and applying research results are supported by evidence (Bowen & Martens, 2005a; Cashman et al., 2008; Kidd & Parshall, 2000; Ted Schrecker, 2013; Trofanenko, 2008). Such approaches fall under KTA domains that are more relational or process focused.

Integrated KT (iKT) conceptualizes KTA work as embedded within complex systems. It involves ongoing non-linear social processes to promote trust, open dialogue, and collaborative relationships (Armstrong & Kendall, 2010; Bowen & Martens, 2005a, 2005b; B. Campbell, 2010; Duguid, 2008; Gagliardi, Fraser, Wright, Lemieux-Charles, & Davis, 2008; Ssengooba et al., 2011; Walsh et al., 2012) among the many stakeholders involved across KTA contexts (Graham et al., 2006; Graham & Tetroe, 2007). In iKT, KTA gaps are problematized in relation to process issues of inclusivity and knowledge production (Bowen, 2015; Bowen & Graham, 2013, 2015) and the role of researchers is likely to be situated alongside, rather than separate from, others. For these reasons, the KTA work of iKT tends to be more explicit about the relational aspects of the work. Generally, iKT approaches embrace the assumption that KT is process-oriented and comprised of continuous cycles of research-informed practice and policy and practice- and policy-informed research. Common among various models and frameworks proposed as guiding scaffolds for iKT (e.g., Graham et al., 2006; Lomas, 1993) are assumptions that effective connections between research and action are best enabled in participatory, inclusive environments that allow for the consideration of evidence or knowledge-generating activities in the context of local systems (Best & Holmes, 2010) and the tacit knowledge of stakeholders who comprise systems (Kothari, Bickford, Edwards, Dobbins, & Meyer, 2011; Sibbald et al., 2012). Lapaige (2010) argued that iKT was about the "transcendence of frontiers (sectorial, disciplinary, geographic, cultural, and cognitive)" and "integration of knowledge beyond these frontiers" (p.34). Integrated KT thus carries underlying relational, ontological, and epistemological assumptions that are more closely aligned with those of this study.

Other KTA approaches that fall within a spectrum of approaches compatible with critical theories include community-based participatory action research (CBPR) or action research (AR), engaged scholarship, and Indigenous KT (Plamondon & Oelke, n.d.). Briefly, CBPR and AR, though not frequently considered in the KT literature, are fundamentally concerned with processes of generating knowledge and action (Minkler & Wallerstein, 2008). These traditions emerged in the mid-twentieth century, rejecting positivism and the separation of knowledge from practice. They flourished in 1970s Latin America, where liberation theory and emerging critical theories supported a fundamental shift in how people were positioned within research and education processes. Social and distributive justice are often foundational frames for CBPR/AR, making this approach well suited to local place-based responses to inequities (e.g., Minkler, 2010). Engaged scholarship can involve a broad range of methodologies and approaches to both research and KT, but it characteristically positioned the role of research as a public good in service to community (Bowen & Graham, 2013). The possibilities for engaged scholarship are through the "intentional public purpose and direct or indirect benefit to society" through collaborative, action-oriented responses that might involve teaching, research, or service (Bowen, 2015, p. 185). Indigenous KT encompasses decolonizing approaches to research and KT, challenging dominant epistemologies through acts of reclamation and transformation (Estey, Kmetic, & Reading, 2008; Smylie, Olding, & Ziegler, 2014). Collective responsibility for knowledge and supporting people in community to live a good

life are elevated, with explicit recognition of human existence as part of a greater whole (Smylie et al., 2009, 2014). Though less evidence is currently available about the specifics of how these KTA approaches work to advance shifts in policy or practice environments, their histories and philosophical foundations offer transformative possibilities for health equity.

1.3   The Evolving Field of Health Equity

A rapidly growing field, academic, and professional focus on health equity falls primarily under the closely related domains of population, public, and global health. Population health is primarily interested in the study of "why there are different disease burdens or risks amongst different social groupings" (p. 6), sometimes framed as a re-politicization toward recognition of the social origins of public health (Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005, p. 6). Public health is historically rooted in social justice, wherein early public health interventions largely focused on the living conditions of the poor (Donohoe, 2013; N. C. Edwards, 2009). Some argue that "global health and public health are indistinguishable", with both considering health as a holistic concept of well-being wherein processes and policies at population levels deeply influence an individual's life trajectory (Fried et al., 2010). For the purposes of this dissertation, and because the origins of the initial research questions lay in global health research (GHR), this section will focus primarily on health equity work in global health. By health equity 'work', I am referring to any kind of effort to respond to health inequities, including through research, KT, practice, activism, advocacy, and/or policy.

Virtually absent from the literature until the 1950s, the term global health was increasingly prominent in the peer-reviewed literature in the latter half of the twenty-first century and exploded in use after the year 2000 (Brown, Cueto, & Fee, 2006). In contrast to earlier notions of tropical medicine or international health (Macfarlane, Jacobs, & Kaaya, 2008), global health purported both the awareness of and the need for research on, the inherently global nature of health issues and the complexity of connections between macro-level processes and policies and local disparities in health and disease (Labonte & Spiegel, 2003). Though definitions are varied and debated (Bozorgmehr, 2010; Fried et al., 2010; Koplan et al., 2009; Simms, 2014), global health often focuses on "transnational issues, determinants, and solutions" (Koplan et al., 2009, p.1995), equity, and systems thinking (Daibes & Sridharan, 2014; Pinto & Upshur, 2009). Academic global health work is rich with debates about what it is, with little dialogue about the complexities of why it is done and how it ought to be done.

High demand for academic involvement in the ethically challenging context of global health raises questions about how GHR and global health education (including practice experiences) are developed, reviewed, conducted, sustained, and evaluated. Concerns have surfaced about the opportunistic nature (Crane, 2010), distinct responsibilities of researchers (Benatar & Singer, 2010), the paucity of lower-middle income country infrastructure for ethical review and oversight (Bhutta, 2002; Ravinetto et al., 2011), and the complexity of justice issues associated with GHR (Hunt & Godard, 2013). This field of research and practice carries an implicit commitment to critical stance in KTA work, reflected in the

inclusion of awareness of inequities and their causes and relational practices among core competencies for trainees (Arthur, Battat, & Brewer, 2011; Cole et al., 2011a; Hatfield, Hecker, & Jensen, 2009; Jogerst et al., 2015). Recognizing the inseparability of the inequities inherent to their research projects from the inequities that their research examines, people involved in GHR endorse guidelines for equitable and action-focused engagement in research (CCGHR, 2015; Musolino, Lazdins, Toohey, & Ijsselmuiden, 2015). These endorsements acknowledge that not all engagement in GHR has the potential to, or even intention of, addressing inequities.

For example, Canadians may find themselves grappling with ethical dilemmas provoked by the same issues that motivated their engagement in GHR (Pinto & Upshur, 2007). Contradictions embedded within the purported altruism of GHR highlight questions about the nature, opportunism, and underlying motivations of researchers. Within GHR, untreated epidemics like HIV/AIDS can be "simultaneously envisioned as a socio-medical ill and instrumentalized as a scientific asset by American universities seeking to engage in "global health" activities" (Crane 2010, p. 79, emphasis in original). Research designs and reports in GHR can construe poverty and inequity as inevitable states of existence (Brisbois, 2014), posing the risk of missing an important opportunity to challenge, rather than accept, or worse, entrench disparities. Indeed, the ways in which GHR is legitimized evoke a range of conceptual constructions of the world, not all of which recognize or align with the evidence about what causes health inequities (Brisbois & Plamondon, 2018). These concerns, paired with the urgent need for evidence informed responses to health inequities, make critically reflective inquiry about equity-promoting KTA practices relevant and important.

In the context of GHR because the discipline often involves KTA actors from 'Northern' (wealthy) countries and 'Southern' (previously colonized) countries. Health equity work is intensely complex and tied up in socio-economic, political, and historical conditions that are entrenched in global systems of power and hegemony (Escobar, 1988, 2012; Paynter, 2014). Though research demonstrates that people involved in GHR have consistent and deep desires for their work to contribute to creating greater and more equitable health worldwide (CCGHR, 2013b, 2013a), gaps remain in articulating how this might be achieved. Research might have a role to play in creating evidence-informed solutions to the wicked problems of an unfair, unjust global political economy (Pauly, 2013; Ruckert & Labonté, 2014), but it can also pose risks of reinforcing inequities (Brisbois, 2014; CCGHR, 2015). People involved in GHR can mitigate this risk by critically examining the choices they make and moving toward more equity-centred approaches (CCGHR, 2015). However, the field as a whole is grappling with how to operationalize these choices in ways that can overcome persistent political resistance to changes that could advance health equity. This study will contribute to enable meaningful KTA for research aimed at addressing health inequities by examining promising practices in KTA with a particular interest in relational and critical domains of practice.

1.4   Positioning Myself as the Researcher

My curiosity about KTA for health equity evolved from immersion in global health research that began with a master's thesis and evolved to include national leadership roles with the CCGHR. My involvement included contributions to the development of key resources to support capacity building for mentorship, leadership, and knowledge translation[2]. As chair of the Policy Influence Program for the CCGHR, I became the principal investigator for a series of dialogue-based studies about Canadian involvement in global health research called the Gathering Perspectives Studies. In this role, I worked with a network of leading researchers interested in issues of health equity. This research involved connections with hundreds of people from across Canada and around the world. Participants in these studies collectively asserted that the 'what' and 'why' of global health research was about advancing equity; yet they frequently struggled with how to do it. Many reasons for this disconnect were alluded to, but commonly cited challenges included academic and funding environments incompatible with health equity work and fragmentation in the field of global health research (CCGHR, 2013b, 2015; Plamondon, Walters, Campbell, & Hatfield, 2017). Our research team also identified some uncomfortable realities, including shadows of colonialism that seemed to dwell beneath the surface of Canadian involvement in global health research.

One of the exciting outcomes of the Gathering Perspectives Studies was the creation of a set of principles for global health research (CCGHR, 2015). The principles were well received by colleagues in global and public health, both in Canada and around the world. They are being used widely to support training, curriculum design, reflexivity (Cleaver, Magalhaes, Bond, Polatajko, & Nixon, 2016), research design, and priority setting (CCGHR, 2018). My experience with these studies and the work that followed, including the development of a number of specialized training institutes for equity-centred research and knowledge translation, left me unsettled. As more dialogue unfolded, the gap between intent and outcome in this field became louder. Further, as my coursework took me further into the literature for the fields that had originally grounded my pursuit of doctoral studies, I found myself increasingly unsettled by disconnects between highly complementary bodies of literature, namely global health research, public health, ethics, knowledge translation, and governance. I also became acutely aware of a shared desire for a more authentic engagement in the field.

Importantly, this study emerged, and is shaped by, positionalities that extend beyond my immersion in global health. The disconnects I experienced academically reflected those I continue to navigate in my life and healing journey. I am a Canadian woman of mixed ancestry who grew up in the Kootenay and Okanagan regions of British Columbia. My maternal grandmother was Plains Cree, born on the Fishing Lake First Nation in Saskatchewan. My maternal grandfather was Irish, a first-generation immigrant. My paternal grandfather is Quebecois and Jewish, with roots traceable to first settlers in

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[2] Many of these resources remain part of the core suite of open-access tools provided by the CCGHR and are available at www.ccghr.ca.

Canada, and my grandmother was German. My family's stories are reflections of the colonial history of Canada, which blended and silenced cultures through marriage and institutionalization.

I have experienced health inequities through poverty, class, and intergenerational trauma. I read as White; however, my friend Oyun once observed that I was very sad about my Whiteness. I think she was right, because the weight of what Whiteness symbolizes in the world has always evoked a deep sorrow for me. I've struggled with it often, unsure of how it constricts what portions of my lived experience are relevant to share outwardly and what fits better as part of the puzzle to hold quietly—respecting the empathy, compassion, and understanding it evokes for me while honouring others whose voices have been more silenced than mine. I am one of many in my family who have struggled with post-traumatic stress and mental illness, and I am the first person in my family to go to university. I became a nurse, which my family was proud of. Following my nursing degree, I studied critical population health and health policy in my master's degree. I travelled a lot during this time, living in Nicaragua and studying in Vietnam. It was a time of transformational learning for me and allowed me to understand things about political economy that shattered how I understood myself in the world at that time.

I am also a mother of two beautiful boys, whose ancestry is even more mixed than mine. I want these boys to grow into connected, attuned humans who know who they are and where they come from. I hope they grow into stewards of the Earth who care deeply for her and for others around them. My hope for them and the world they will grow up in drives my passion for this work and draws me to Freire's work. My uncle Joe is teaching me about my Indigenous ancestry, and I am keen to learn. He made drums for my children and I and taught us how to care for them. I want my children to hold this piece of them with reverence, so that it lives in the voices of their children. Joe told me a story about an Indigenous group from the South Americas who identify as 'the brothers'. The brothers embrace a worldview of deep interconnectedness—so deep is this connection that their language has no words for individual or separation. For these people, all living things are one and the same. Their worldview resonates with my spiritual beliefs. All of these perspectives, experiences, and positionalities and surely others—because we are all complex beings shaped by both what we recognize as important and what we do not see in ourselves—are inseparable from who I was as the researcher in these studies.

1.5 Research Questions

My response to my own lived experience of tensions, limitations in the literature, and evidence from the Gathering Perspectives Studies, guided the overall research question driving this series of studies: *What practices demonstrate promise for advancing KTA for health equity?*

To answer this question, a series of three distinctive and complementary studies were designed. The overall design of this study is grounded in critically reflective inquiry (Lyons, 2010) and the epistemological methods of Freire (Freire, 1997). Though each study sought to elucidate evidence-informed promising practices, they involved different sub-questions and distinct data sources (Table 1.1). The first two studies elucidated promising practices from the published literature with a shared focus on

KT and health equity. The third focused on elucidated promising practices through dialogue with KT and health equity experts.

Table 1.1

Three Studies to Illuminate Promising Practices for Advancing KTA for Health Equity

Study Description	Research Questions
Scoping Review Reviewed published literature (2000-2016) with a shared focus on KT and health equity, positioning the CSDH as a moment in time from which trends could be purposefully examined.	What is the breadth of scholarly activity in the periods leading up to and following the release of the CSDH report? How was evidence on root causes of health inequities integrated into publications/research?
Critical Interpretive Synthesis Focusing on selected articles from the scoping review, what practices demonstrated promise for connecting KTA for health equity? Selected articles were research studies or literature reviews that demonstrated integration of evidence on root causes of health inequities and were oriented toward action on these root causes.	In published literature that demonstrates strong integration of evidence about causes of health inequities: What does the evidence point to as more promising practices for connecting KTA? What contexts are described as enabling or supportive of these promising practices?
Critically Reflective Dialogues Engaged in a series of critically reflective dialogues with experts in KT and/or health equity, focused on understanding how these individuals pursue health equity work and what they believe to be the most promising ways of advancing health equity in the field.	How do KT and health equity experts orient their work (and themselves) toward health equity? Drawing on their experience and knowledge in the field, what do KT and health equity experts believe: • Is promising for connecting KTA for health equity (i.e., enables action on the known causes of health inequities)? • About the role of power in health equity work? • Warrants further reflection and challenge (e.g., assumptions, ideologies, and values) in health equity work?

In the first study, a scoping review was conducted to examine trends in the integration of evidence about causes of health inequities in scholarly publications related to connecting knowledge-to-action for health equity. This review positioned the CSDH report as an important moment from which such trends could be examined. Authors' portrayals of and orientations toward health inequities were assessed in 330 articles published between 2000 and 2016. The second study was a critical interpretive synthesis (CIS) that involved a qualitative analysis of 10 literature reviews and 22 research studies published after the CSDH report (2008-2016). Each of the articles analyzed were chosen for being more promising because they demonstrated explicit integration of evidence about root causes of health inequities and

articulated more productive orientations to these causes through their study designs or research questions. With an interest in identifying evidence-informed promising practices, these articles were analyzed for specific recommendations or emerging evidence for connecting KTA for health equity. Finally, the third study involved a series of critically reflective dialogues with experts and practitioners whose work spans some element of KT and/or health equity. These interviews served to explore the third set of questions outlined above. In the next chapter, I provide a detailed discussion of the methodological foundations for these three studies.

Chapter 2: Methodological Foundations

I began the process of situating this study through immersion in a broad, but highly complementary reading of theories and methodological approaches. In the early stages of study design, because of my own experiences in practicing KT, I was deeply intrigued by concepts of *relationality*. Relationality is a stance of assuming the connections between people, ideas, organizations, bodies of knowledge, and contexts all are, in essence, relationships (Plamondon & Caxaj, 2017). I pursued relational social theories that positioned human beings as ontologically (and therefore epistemologically) relational (e.g., Gergen, 2009; Hosking, 2011; Stetsenko, 2008) and considered operational theories of relationality. Among these were Doane and colleagues' concept of relational consciousness, which is about inter-relationships among people, their contexts, and possibilities (Gweneth Hartrick Doane, 2014b, 2014a; Gweneth Hartrick Doane & Varcoe, 2007, 2008) and Edward's description of relational agency, which speaks to the collective capacity to act as a whole toward a common goal (A. Edwards, 2005, 2011, 2012). Struck by the paucity of focus on relationality in the KT literature, I also looked to feminist social theories, including Fletcher's discussion of the invisibility of relational practices (Fletcher, 1999). My reading of these theories consistently affirmed the relational nature of KTA work. I believed these theories would provide a useful lens for extending KTA theory and practice to illuminate something new and promising for advancing health equity. Relational theories maintained a presence throughout the study, influencing both the focus and premise for engagement in inquiry.

Relational theories were also informative when making choices about how to pursue inquiry about the KTA work of health equity. Full of 'good intentions', my work in global health research illuminated confusing inconsistencies that challenged notions of identity and legitimacy within the field of health equity. Further influencing the choice of theory and methodological foundations was a recognition of my own positionality as deeply embedded in the field. I wanted to design a study that could open a door for grappling with big questions about the legitimacy, impact, ethics, and morality of the work. With optimism for a future where health equity is a real possibility and a belief that research and KT can contribute to realizing this possibility, this study was grounded in the work of Paulo Freire and others who follow in his critically reflective and dialogic epistemology (Freire, 1985b, 1997; Giroux, 2010; Kincheloe, 2008; Mayo, 2004; Shor & Freire, 1987). Using Freire to ground inquiry positioned consciousness-raising at the centre of an ongoing process of reflexivity. The process became one of critically reflective inquiry (Lyons, 2010), drawing on evidence and experience to generate new insights while making space for transformation of subjective experience(s) through dialogue (e.g., Shor & Freire, 1987). In the next section, I describe both Freire-inspired critical pedagogy and critically reflective inquiry as a methodological process for research.

2.1 Paulo Freire's Critical Pedagogy

Perhaps the most globally recognized educator of the 21st century, Paulo Freire made substantial contributions to educational theory in Latin America and beyond (Morrow & Torres, 2002, p. 2). He was

born to a middle-class Brazilian family, yet like many during the Great Depression, experienced extreme poverty in his childhood. After studying law, he focused on literacy education, first with the peasants and farmers who were part of the illiterate 60% of the Brazilian population. Freire's "literacy training for citizenship building" (p. 7) was transformative, nearly doubling the number of eligible voters at a time when literacy was an eligibility requirement for the vote in presidential elections (Morrow & Torres, 2002). A liberal catholic, his work is often described for its alignment with liberation theology, an anti-imperialist movement in the 1960s that was part of a growing political and social awareness.

Freire's work emerged at a tumultuous time in world history. The stability of the post-World War II global governance bodies was challenged throughout the 1960s and 1970s, intensified by the 1980s collapse of the Soviet empire, an oil crisis, and a global debt crisis (Bordo & James, 2000). Freire's The Politics of Education (Freire, 1985) was released at a time when Latin America was in the midst of violent revolution and contra-revolutions that were both hopeless and hopeful. Like German philosopher, Jürgen Habermas, Freire's critical theory was, in part, a response to concern for societal failures induced by oppressive institutions and the elevation of capitalism at the expense of human need (Morrow & Torres, 2002). For these reasons, the roots of critical pedagogies can be traced to critiques of capitalism, sparked by theorists from the Frankfurt school of critical theory and advanced within the anticolonial revolutionary contexts of the 1960s and 1970s (Crotty, 1998; Kincheloe, 2008). Common to these theories are attentiveness to power and the construction of social systems and structures that create and reinforce injustices (Kincheloe & McLaren, 2003). Morrow and Torres (2002) point to these philosophers' recognition of the paradox of a democracy that "takes place in the context of capitalism" (p. 3). Their passionate critiques of the silencing produced by a capitalist democracy continue to resonate in current critical pedagogical thought (e.g., hooks, 2010). The Pedagogy of the Oppressed (Freire, 1997), born of resistance to the hopelessness of capitalist oppressions, proposed dialogue and reflexivity as essential tools for a dialogic and engaged democracy enabled through liberating education and revolution.

Freire's writing is characterized by compassion and faith in humanity's facility to transform the world into a more beautiful, compassionate, and balanced place. He appreciated the human capacity to engage in philosophy, critical reflection, and transformation and maintained a profoundly hopeful gaze over a challenging context. An advocate for critical thought, Freire encouraged readers of his own work to consider his arguments from a position of questioning (Freire, 1985). Problematizing the dominance of education approaches that promoted rote memorization over critical thinking, Freire suggested that the goal of 'banking education' was to "…kill our curiosity, our inquisitive spirit, and our creativity" (Freire, 1985, p. 2). His pedagogical theories provided an alternative. Radically departing from models that promoted oppressive conformity, Freire described the role of students and readers as adopting a "critical vision," wherein the reader strives to uncover deeper meanings by enacting their agency through questioning not only the text, but the writer of the text and the socio-historical situation of the text. To study, according to Freire, was an "attitude toward the world" and an act of "thinking about experience" (Freire, 1985, p. 3) from a position of curiosity, modesty, and humility. "To study is not to consume ideas,

but to create and re-create them" (Freire, 1985, p. 4, emphasis in original). Freire argued that humans were reflective and philosophical beings that existed dynamically and interactively with reality. He proposed that consciousness and oppression were interrelated, with the latter flourishing in the absence of the former.

In Freire's critically dialogic epistemology, *conscientization* or consciousness-raising, lay at the heart of cultural action, cultural revolution, and eventually freedom. For Freire, a true revolution was relational, dynamic, future oriented, and transformative, wherein the people become subjects in the "precarious adventure of transforming and recreating the world" (Freire, 1985, p. 82). The process relied upon utopian revolutionary advocates and leaders who renounced injustice and facilitated praxis, a perpetual union of action and reflection, toward an authentically liberating critical consciousness. This process required an ongoing commitment to avoid passive fallback into the myths of previously constructed oppressions and to avoid the oppressed becoming oppressors. Beyond inspiring educational reform, Freire's ontological and epistemological theories opened new possibilities for reconstructing social relationships. He described relationships between learner and facilitator, for example, as essentially dialogic and grounded in a deep respect for co-engagement in critical reflection. To engage in such a relationship was deeply transformative, and transformation was a struggle against both an oppressive reality and one's self. His work continues to resonate in new critical theories, including the principles of intersectionality that explicitly acknowledge issues of power, reflexivity, equity, and resistance-resilience through dialogic approaches (Hankivsky, 2012, 2014). Freire's revolution was a struggle against arrogance, materialism, and hopelessness toward humanity. It demanded an intense act of faith in the capacity of humanity, and of one's self, to overcome an incomprehensibly difficult task.

When used in research, critical pedagogies guide researchers to identify "productive aspects of power" (p. 439), with attention to how value choices shape the production of knowledge and drive an intention to illuminate and disrupt status quos (Kincheloe & McLaren, 2003). The criticality in critical pedagogies invites researchers, in the design and execution of research, to engage in deep reflexivity and self-awareness; acknowledge the intersectionality of oppressions; be attentive to global systems of inequity; recognize the symbolic nature of language as the essential means for communicating; and accept that all thought is mediated by power and values (Kincheloe, 2008). Friere's hopefulness for humanity and belief in humans as curious, imaginative, reflective, and philosophical beings make critical pedagogy a theoretical foundation for research that invites reflection on past and present as a means for actively constructing an alternate, more equitable future. He conceptualized consciousness and oppressions as interrelated, focusing most intensely on the dominator-dominated relationships between what he called the 'third world' and the 'metropolis' (referring to imperialist, colonial powers). These relationships were described as existing within different modes of culture and levels of awareness, wherein a culture of silence served to reinforce oppressive relationships that cause suffering for both oppressors and the oppressed. Freire suggested that when the dominated become aware of their own oppression, they must choose to either break or restore silence—proposing that freedom from oppression

could be sparked through the engagement in critical dialogue toward consciousness-raising that would be, in and of itself, transformative (Freire, 1985b, 1997). This spirit of optimism and solidarity makes Freire-inspired critical pedagogy a compelling foundation for the context of this study.

2.2   Critically Reflective Inquiry

Though there is no one standard definition, reflective inquiry is a means for the "conscious interrogation of the social, cultural, and political contexts of learning" (Lyons, 2010, p. 4). Lyons (2010) offers an interpretive framework that characterizes reflective inquiry along three major branches, each influenced by different theorists who gave shape to current conceptualization: (a) reflective inquiry as thinking, informed by John Dewey (1938); (b) reflective inquiry as a way of knowing, shaped by Donald Schön (1991); and (c) reflective inquiry as critical consciousness for interrogating contexts through dialogue, informed by Friere (1997). Often used as a means to support professional education, critically reflective inquiry can also be used as a methodological approach to research (Lyons, 2010). Directly informed by Freire's propositions about consciousness-raising, this mode of inquiry relies on dialogue between people who explore how power and society are working to privilege some groups over others. Adults learn through processes of reflection on the problems they face every day (Brookfield, 2005), but critical reflection elevates the importance of examining the role of power in illuminating and understanding these problems. To be critically reflective evokes an assumption that "the minutiae of practice have embedded within them the struggles between unequal interests and groups that exist in the wider world" (Brookfield, 2010, p. 216). Humans, by nature, make sense of the world and their experiences in it by constantly ascribing (often contradictory) assumptions that shape how we "explain situations, solve problems, and guide actions" (p. 216). The process of critical reflection, therefore, involves processes of recognizing and unpacking how these assumptions shape what we believe we know, understand, and should do. Professional capacity to navigate complexity, in turn, requires capacity to examine normative assumptions, issues of fairness, and social consequences and ethical implications of situations professionals will encounter when they enter into practice.

Debate about purpose and need is common in professional education, where curriculum and training on critical reflection is often explored as a response to a desire to prepare professionals who can navigate complexity. Critical reflection is embraced in professional education as a means for developing more adaptable, flexible professionals who are conscious and responsive to "the way one thinks and acts" (p. 6) in the context of complex problems (Lyons, 2010). This situates critical reflection as a counter-response to mechanistic reductionism that can dilute the experience of becoming a professional, where the process ought to be something deeply human and centred around exploring meaning and values, it is too often restricted to an "alienating trade school" (Lyons, 2010, p. 7) that focuses more on mastering tasks than on becoming. For the professionals who are also scholars, whether in sciences, nursing, or law, entry involves not only the development of specialized expertise, but the process of becoming also involves developing a deep understanding of moral and ethical obligations (e.g., Kvale & Brinkmann,

2015) and the ontological and epistemological tools used to legitimize knowledge-generating processes and knowledge claims (Lincoln et al., 2018; Rose, 1997). Becoming a scholar, by virtue of professional obligations and responsibilities, then, necessitates capacity for critical reflection.

Just as in other professions that have struggled with mechanistic reductionism and task-focused education, professional scholars are not necessarily characterized by their capacity for critical reflection. Gaps between intention and action, and the uncomfortable silences identified through the CCGHR Gathering Perspectives Studies described earlier, were illustrative of the need for critical reflection in the field of health equity. Indeed, critical reflection and reflexivity being recognized as core competencies for students and professionals (including researchers) in the field (Cherniak et al., 2017; Cole et al., 2011a). Indeed, research on research is increasingly called for by leaders within the field of health equity (Commission on Social Determinants of Health, 2008; Fine, 2012; Musolino et al., 2015; Nixon et al., 2018). Each of this study's research questions focus, in some way, on examining the professional knowledge of connecting KTA for health equity. These are, in essence, critically reflective questions— turning a gaze at the relationship between values, norms, and ways of working within the field of health equity and the orientation and effectiveness of contributions from this field.

The topical focus of this dissertation research is, in a way, reflective of the tensions that qualitative inquiry (broadly) has been grappling with. In alignment with the 'reflexive turn' in social sciences, this study follows the marked departure from objectivity (Altheide & Johnson, 2011). In a time of great global uncertainty, qualitative inquiry is pivotal to exploring "philosophical, epistemological, political, and pedagogical issues for scholarship and freedom of speech in the academy" (Denzin, 2009, p. 13). It continues to challenge the threats to legitimacy exerted through the privileging of paradigmatic approaches, including neoconservatism and positivism, that sit in contradiction to the social justice orientations (Denzin, 2009) more suited to disentangling complex health inequities. Similarly, these paradigms serve to propel other dominant discourses including biomedicine and neoliberalism (Hanson, 2017; Lee, 2010; Raphael, 2015), both of which perpetuate policy environments that are known to entrench health inequities. For these reasons, and the desire to operationalize the kind of critically reflective dialogue proposed by Freire, critically reflective inquiry was chosen as the methodological foundation for this study.

2.3   Assumptions

A few assumptions warrant explicit attention, many of which reassert elements of the theoretical foundations just described. Perhaps most important was a normative assumption that health inequities are unfair differences in health (Kawachi, Subramanian, & Almeida-Filho, 2002). Extending from this assumption, I was informed by public and global health ethics that suggest the human-caused nature of health inequities makes them unacceptable (Benatar et al., 2003; Nixon, 2006b; Pinto et al., 2013). Further, the work was shaped by an assumption that researchers are situated in social worlds embedded in and influenced by, broader societal contexts that make health equity work difficult to pursue. Another

assumption is that KTA work involves routine ways of doing KTA. These were considered practices that could be subjected to the same reflective standards accepted by other practice-based professions (e.g., nursing, medicine, education). Woven throughout the study is a deep appreciation for the influence of lived experience and situated perspectives on how humans understand our world, wherein interpretations are co-constructed through interaction (relationships) with the world and in the world (Freire, 1974, 1997; Van Manen, 1997). Finally, as described above, the study is positioned in the context of critical theorists who argued that power works to shape society in ways that are self-reinforcing, but that power structures can be changed through critical reflection aimed at understanding the operational structures of society that do so (Freire, 1985b, 1997). This work was pursued as a beginning step in critically reflecting on how, as researchers interested in health equity, our field of scholarship works to respond to the best evidence available about health inequities and their causes.

2.4 Quality and Rigour

Attention to quality and rigour in this study was guided by Tracy's (2010) eight "big tent" criteria for excellent qualitative research (worthy topic; rich rigour; sincerity; credibility; resonance; significant contribution; ethical; and meaningful coherence) and an elaboration of her concept of 'credibility' in the context of interviews that generated dialogic data (authenticity; comprehensiveness; integrity; legitimacy; and responsiveness), as described by Plamondon, Bottorff, & Cole (2015). These criteria, including an overview of the strategies employed in this study to satisfy said criteria, are described below (Table 2.1).

Table 2.1

Quality Criteria and Strategies to Achieve Them

Criteria	Description	Strategies Employed to Achieve Quality and Rigour
Worthy Topic	Topic is relevant, timely, significant and interesting	• Topic directly identified through engagement in national study and desire to generate clear insights into how to practice and advance an equity agenda • Study complements and extends major initiatives established to advance health equity work such as the Equity Lens in Public Health initiative (e.g., B. Pauly, Shahram, Dang, Marcellus, & MacDonald, 2017a) and the National Collaborating Centre for Determinants of Health • Global policy and governance mechanisms focused on Sustainable Development Goals (United Nations, 2017), many of which directly relate to root causes of health inequities
Rich Rigour	Study uses sufficient, abundant, appropriate, and complex theoretical constructs, data, sample, data collection, and analysis.	• Thorough exploration of theoretical foundations completed prior to study design, including comparison and elimination of other possible approaches • Theoretical constructs woven into each of three distinct, but complementary studies • Criteria for scoping review and CIS led to identification of a broad and rich body of literature • Analytical framework acknowledges the dialogic nature of data generated through interviews, adapting procedures for data handling in ways that honour interpretive integrity
Sincerity	Reflexivity about positionality of researcher. Transparency in methods and challenges.	• Reflexive praxis served as a foundation for beginning the process of inquiry, from theoretical immersion, to problem identification and study design, to writing up • Questioning positionality, including deep reflexivity on issues of identity, embraced (see Chapter 7) • Methods described in depth for each study • Challenges of inquiry discussed in the study conclusions (Chapter 6) and explored through reflexive practice • Explicit recognition of this study as an iteration in what could be a continuous process of critical reflection on the practice of KTA work for health equity, recognizing its position as one contribution among many

Criteria	Description	Strategies Employed to Achieve Quality and Rigour
Credibility	Research involves thick description, showing rather than telling, triangulation or crystallization, multivocality, and member reflections.	• Representation of study findings includes thick description, drawing on direct quotes and agreed-upon interpretations to demonstrate particular insights • Attentiveness to crystallization integrated throughout study process, striving for moments when ideas take on recognizable shape and form • Multivocality achieved in literature reviews through selection of interdisciplinary databases and broadly inclusive search terms • Multivocality achieved in dialogues through attention to diversity in perspective and positionality
Resonance	The presentation of the research influences or affects readers through aesthetic, evocative representation; naturalistic generalizations; and transferable findings.	• Presentation of findings offered using traditional academic prose, complemented with the integration of poetic interpretation and reflexive poetry (Chapter 7) • Interpretation involves exploration of metaphor • Writing involved deep attention to language, with presentation of provocative ideas in ways that invite curiosity rather than defensiveness[3]

Significant Contribution	The research provides a significant contribution conceptually, practically, morally, methodologically, and heuristically.	• Practical tools used to guide the procedures for this study, and relevant for use in other research, included:
		  ○ An analytical framework developed through previous dialogic research (Plamondon, Bottorff, & Cole, 2015)
		  ○ A heuristic for assessing how something is oriented in relationship to root causes of health inequities[4]
		• Studies designed to evolve identification of evidence-informed promising practices
		• Write up includes implications of study findings
		• Study findings directly relate to practices for scholars and practitioners interested in advancing health equity

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[3] I am grateful to reviewers who took time to provide constructive and illuminating feedback on the manuscripts, particularly for the scoping review. Their comments drew attention to how my word choice could set a stage that invites dialogue and further critical reflection.

[4] This heuristic was pilot tested in a number of different settings, including use with public health practitioners and with global health researchers. In both cases, the heuristic was easily understood and believed to provide a practical tool for assessing options for action.

Criteria	Description	Strategies Employed to Achieve Quality and Rigour
Ethical	The research considers procedural, situational, culturally-specific, relational, and exiting ethics.	• Study underwent review by two research ethics boards (Interior Health and UBC Behavioural Research Ethics Board) • Ethical questions considered in analytical processes for literature reviews • Relational ethics (Gweneth Hartick Doane & Varcoe, 2007; Lahman, Geist, Rodriguez, Graglia, & DeRoche, 2010) consistently exercised throughout study process (see Chapter 6)
Meaningful Coherence	The study achieves what it purports to be about, uses methods and procedures that fit its stated goals, and meaningfully synthesizes literature and findings.	• Strove for congruency in theoretical foundations, methodological approach, data generating methods, and analytical processes characterized by congruence • Processes of synthesizing and engaging woven throughout study design

2.5   Study Design

Three studies contributed to this dissertation: (1) a scoping review; (2) a critical interpretive synthesis of literature; and (3) critically reflective dialogues (Figure 2.1). Each of these studies is described below, with detailed procedures for each provided in subsequent chapters (3-5). Four different data sets were generated to support these studies (Table 2.2). As new data emerged, it was considered in conjunction with existing findings to support a continuous process of synthesizing and engaging.
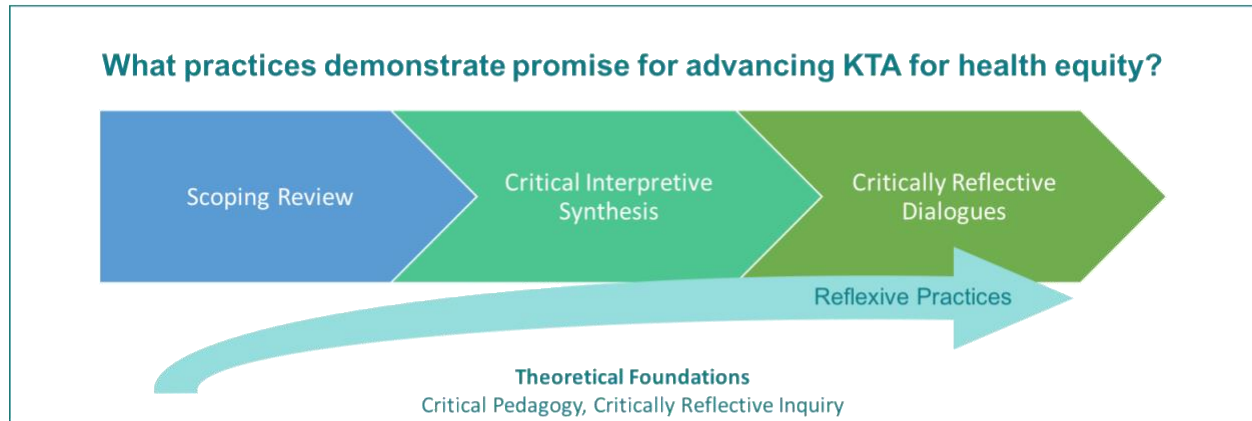
Figure 2.1. Visual overview of three studies.

Table 2.2

Data Sets

	Scoping Review	Critical Interpretive Synthesis	Dialogic Interviews	Reflexive Praxis
Data Sources	Articles *Searches in interdisciplinary databases for literature with both an interest in health equity and a declared knowledge-to-action purpose.*	Articles *Purposefully selected subset of literature from scoping review, selecting for empirical studies and literature reviews that demonstrate greater integration of CSDH evidence and calls for action.*	Audio recordings of conversations Transcripts of audio recordings Notes taken by myself or by contributors to dialogue (if voluntarily given to me) while in conversation Documents or resources contributors provided to me	Reflexive journals Poetic transcriptions, poetic interpretations Memos (analytic, interpretive) created throughout the study process

2.5.1   Scoping Review

A scoping review is "a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge" (Colquhoun, Letts, Law, MacDermid, & Missiuna, 2010, p. 1292-94). The review was guided by Arksey & O'Malley's (2005) five procedural steps for scoping reviews: (1) identifying the research question; (2) identifying relevant literature; (3) iterative selection; (4) charting data; and (5) collating, summarizing, and reporting results. The scoping review explored literature published in periods leading up to and following the release of the CSDH report, grouped by publication years 2000-2008 and 2009-2016. This grouping positioned the CSDH report as a notable moment in the availability of evidence about causes of health inequities in which trends in how health inequities were portrayed could be examined. A detailed description of scoping review procedures and results is provided in Chapter 3.

2.5.2   Critical Interpretive Synthesis

Dixon-Woods and colleagues (2006) proposed critical interpretive synthesis as an innovative and responsive method for reviews of literature that are empirically and theoretically grounded while also useful for informing policy. This method is a suitable means to systematically consider "a large, amorphous and complex body of literature" (p. 9), particularly when the starting question is "fuzzy" (p.3) and not explicitly hypothetical (Dixon-Woods et al., 2006). The process begins with systematic scoping searches, followed by purposive sampling that evolves dialectically alongside theory generation (Dixon-Woods et al., 2006). As the process unfolds, researchers can attend to new questions that emerge. Data are read and re-read using constant comparative analysis, careful review for content, and coding and re-coding against emergent theoretical constructs. Qualitative analysis thus drives the interpretive synthesis of data, leading to the development of concepts and theory rather than an exhaustive descriptive review, making purposive sampling both appropriate and necessary (Dixon-Woods et al. 2006). The critical in this method is reflected by researchers' commitment to questioning underlying assumptions, the ways in which the literature constructs concepts, and underlying influences of authors' choices in proposing solutions. These questions align well with those underlying critical pedagogy and its efforts to expose and disrupt hidden assumptions. More details on the procedures for the CIS and a detailed discussion of results are provided in Chapter 4.

2.5.3   Critically Reflective Dialogues

Critically reflective dialogues unfolded as the results from the literature reviews were analyzed. The interviews invited critical reflection on preliminary findings from Studies I and II in the context of contributors'[5] own experiences and knowledge. In contrast to conventional approaches to 'interviewing',

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[5] The label contributor is used here, rather than the more conventional 'participant'. This is a direct attempt to convey positionality contrary to conventional interviews, where people are invited into inquiry

where researchers and participants are often positioned asymmetrically in one-way instrumentalized conversations (Kvale & Brinkmann, 2015), these encounters were fluid and dialogic. The structure and evolution of this series of dialogues was informed and guided by discussions of how to support critical reflection (Brookfield, 2010; hooks, 2010; Shor & Freire, 1987). Through purposeful conversation and the use of critically reflective question prompts, contributors to dialogue (including myself, as researcher) became co-constructors of meaning and insight (see Appendix B). Our conversations began with an explicit intention to engage in reciprocal dialogue wherein we shared responsibility for evoking reflection and posing questions with a desire for consciousness-raising. These interactions provided opportunities for drawing on experience, knowledge, and discomforts to generate new insights while also making space for our subjective experience(s) of an object of dialogue (Shor & Freire, 1987) to be transformed. The process began with an initial set of interviews with people identified from the literature as 'experts'. Discoveries in early interviews informed expansions in sampling, seeking contributors whose expertise could respond to new questions, and emerging insights. The process ultimately included 17 contributors over a series of 22 dialogues, each lasting between 1-2 hours. The dialogues were all generative of insights, affirmations, and challenges to promising practices; explorations of positionalities and issues of power; and ideas about how to advance a more progressive practice of health equity. More detail on the ways in which dialogues unfolded, and the insights they offered, are provided in Chapter 5.

2.5.4   Reflexivity

In qualitative research, reflexivity is a recognized means of "making visible…how we do the work of representation" (Pillow, 2003). It is an act of examining researchers' choices and ways of doing in context and their impacts. This "conscious experiencing of the self" enables a "coming to know the self within the processes of research" (Lincoln et al., 2018). Characterized by an explicit aim of both doing and thinking in new ways, the practice of reflexivity is one of taking purposeful steps toward transformation (Hibbert, Coupland, & MacIntosh, 2010, p. 48). Reflexivity involves adopting a relational gaze to both consider oneself in relationship to others and one's thoughts, ideas, beliefs, and knowledges in relation to what we do (Doane, 2014a). Though often contemplated through an individual and introspective lens (May & Perry, 2014; Pillow, 2003), it extends to outward-looking and collective practices (Hibbert et al., 2010) that support the troubling aspects of social structures and systems of power (Hanson, 2017; Pillow, 2003). Inspired by Freire's critical pedagogy, reflexivity supported an explicit attempt to embody a praxis[6] of critically reflective inquiry in this study and served a central means of honouring the commitment to purposeful and productive power analysis.

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by someone who is initiating, managing, and driving inquiry ('researcher'). The dialogic methods and assumptions underlying this study call into question the legitimacy of a label that elevates any one person over another, or that treats differently the responsibility of critical reflection between 'researcher' and 'participant'. This language is an effort to move toward more descriptive phrases. I also use 'people invited' or 'people contributing' to identify the source or topic of a sentence.

[6] See glossary for definition.

2.6 Ethical Considerations

In the context of critically reflective inquiry, researchers face an ethical imperative to adopt a praxis of criticality and design research processes that are mutually beneficial and respectful (Atkinson, 2007). As a researcher, issues of positional power are a central ethical consideration in research design. This consideration is complicated in the critical spirit of Freire, who argued that

> in order for the struggle to have meaning, the oppressed must not, in seeking to humanity (which is a way to create it), become in turn oppressors of the oppressors, restorers of the humanity of both. This is the greatest humanistic and historical task of the oppressed: to liberate themselves and their oppressors as well. (p. 44)

Extending Friere's *Pedagogy of the Oppressed* into inquiry therefore demands deep and consistent reflexivity, challenging the researcher to engage in bold acts of critical consciousness regardless of the discomfort that this may pose to the researcher. These considerations were woven throughout the study, using threads of intense self-reflection to tie the research process together as it unfolded. Further, this study relied on a relational and dialogic engagement between researcher and contributors. Of particular concern was engaging in ethics in an ongoing, relationally-driven manner (Bergum & Dossetor, 2005; Brickhouse, 1989; Brydon-Miller, Kral, Maguire, Noffke, & Sablok, 2011; Lahman et al., 2010). The study complied with all local research and research ethics protocols and received approval from the Interior Health and UBC Behaviour Research Ethics Boards (Certificate # H16-02501).

Chapter 3: Scoping Review

3.1   Background

In 2008, the release of the Commission on Social Determinants of Health (CSDH) report, *Closing the Gap in a Generation*, marked a historic contribution to the scientific evidence aimed at motivating action on these claims. Building on preceding milestones, such as the Alma Ata Declaration (International Conference on Primary Health Care, 1978) and other movements to advance upstream action for a more equitable world (e.g., Black, 1980; Marmot, 2005), the report established an irrefutable relationship (Brassolotto, Raphael, & Baldeo, 2013; Lee, 2010) between poor health and the "inequitable distribution of power, money, and resources" (CSDH, 2008, p. 2). Declaring that "social injustice is killing people on a grand scale" (p. 256), the CSDH called for widespread reorientation of public, professional, academic, and political thought around health as shaped by upstream, structural, and sociopolitical drivers.

The CSDH invited researchers and research users (policy-makers and practitioners) to dramatically reorient their attention around two goals: (a) clearly problematizing systematic differences in health and health outcomes as inequitable, avoidable and having socioeconomic, political, and historical causes and (b) pursuing and applying research that could lead to advancing health equity action through solution-oriented designs. Their recommendations framed the challenge of "closing the gap in a generation" as knowledge-to-action work, calling for applied, interventional, and integrated knowledge translation approaches to research (CSDH, 2008). The CSDH qualified that such efforts needed to be grounded in the evidence that establishes a causal relationship between structural determinants of health (e.g., policy environments), physical and social environments (e.g., impacts of gender inequities), and health inequities. Further, in their report, the CSDH called for interventions aimed at building capacity to understand this body of evidence, and to recognize and challenge the roles of power and privilege in society.

The CSDH declared social and policy environments as clear determinants of health, but nearly a decade after its release, scholarship, practice, and policy remain primarily centred on individual, behavioural, and biomedical interventions and the specious potential of neoliberal policy to improve health (Baum & Fisher, 2014; Hanson, 2017; Labonté, 2011; Raphael & Brassolotto, 2015). Yet, in the growing "field of health equity" (Lapaige, 2010, p. 37) there is increasing acceptance of systematic differences in health as avoidable and unfair. This is demonstrated by shifts away from a discourse of health inequalities and toward discourses of health equity that recognize the role of political economy in differentially shaping health along social status and power (Michael Marmot & Allen, 2014; Raphael, 2015). For example, competencies for global health, a field defined for its focus on improving health equity (Koplan et al., 2009), include knowledge of the social determinants of health and the socio-political complexities implicated in examining power dynamics (Cherniak et al., 2017; Cole et al., 2011b). Although these shifts are encouraging, they are themselves embedded in sociopolitical and economic contexts that are known to perpetuate health inequities (Kirkland & Raphael, 2017; Labonte & Schrecker, 2011). It

remains to be seen if these shifts are actually reflected in the practice and scholarship unfolding in the field of health equity. The aim of this study was to explore the scholarly literature for trends in the portrayal of and response to, health inequities as framed by the CSDH. This scoping review is, to the best of my knowledge, the first to examine the scholarly literature for the integration of CSDH evidence and principles for action on health inequities.

3.2   Methods

A scoping review is "a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge" (Colquhoun, Letts, Law, MacDermid, & Missiuna, 2010, p. 1292-94). The review was guided by Arksey & O'Malley's (2005) five procedural steps for scoping reviews: (1) identifying the research question; (2) identifying relevant literature; (3) iterative selection; (4) charting data; and (5) collating, summarizing, and reporting results.

3.2.1   Identifying Research Questions

The purpose of this scoping review was to examine published literature related to action on health inequities, with a particular interest in trends framed around the CSDH evidence on causes and calls for action, such as application of evidence in the portrayal of health inequities and alignment of scholarly publications with CSDH calls for actions, including authors' orientations toward root causes. The questions guiding this study, were as follows:

(1) What was the breadth of scholarly activity related to acting on health inequities during the period leading up to and following the CSDH's report?

(2) How did scholarly activity demonstrate integration (Table 3.1) of CSDH evidence, calls for action of the evidence, and calls for action detailed in the CSDH report?

Table 3.1

Demonstrations of Integration of CSDH Evidence or Calls for Action

Integration by…	Description
Citation	Citation of the CSDH report or related documents
	Related documents include CSDH Knowledge Networks, Marmot articles related to the CSDOH or social determinants of health, country-specific responses to the CSDOH, or the Solar & Irwin (WHO) Conceptual Framework for action on SDOH, Bamako Statement, and/or Rio Declaration.

Integration by…	Description
Portrayal of Inequities	Portrayal of health inequities as unfair, avoidable, human-caused and rooted in the ways in which power and privilege produce systems and structures that unfairly distribute power, money, and resources in society.
Alignment with Principles for Action	Alignment of study design and/or substantive foci with CSDH principles for action.
Productive Orientations to Root Causes	Integration of CSDH calls for shifting attention, both in research and policy, toward sociopolitical (power) and economic root causes of inequities.

3.2.2   Identifying Relevant Literature

The next step in this scoping review involved a systematic search for peer-reviewed literature published between 2000 and 2016 and indexed in the CINAHL, Eric, EMBASE, Medline, and/or PsychINFO databases. I searched for publications related to connecting knowledge to action for health equity. Because a diversity of language is used to describe work, theories, frameworks, and research that aims to connect knowledge with action (Shea, 2011b), a list of knowledge translation terms used in other peer-reviewed systematic reviews (Yost et al., 2015) were adapted for this scoping review (Table *4.1*). The terminology of health equity and knowledge-to-action did not map well with subject headings in selected databases, necessitating keyword searches of titles, abstracts, and author-identified keywords. Recognizing the potential for imprecise results with keyword searches, a purposeful selection of 4 highly relevant articles (Carey & Crammond, 2015a; Davison, Ndumbe-Eyoh, & Clement, 2015a; Masuda, Zupancic, Crighton, Muhajarine, & Phipps, 2014; Rasanathan & Diaz, 2016) were cross-referenced in PubMed by searching for 'similar articles' to ensure comprehensiveness. Due to resource limitations that made translation unfeasible, searches were limited to English language publications.

Table 3.2

Search Terms in CINAHL, ERIC, EMBASE, Medline, and PsychInfo

Concept	Search Terms
Connecting knowledge to action	(knowledge OR evidence OR research OR guideline*) near to (utiliz* OR utilis* OR uptake OR transfer OR translat* OR transmit* OR transmission OR effectiveness OR populari* OR exchange OR synthes* OR transform* OR linkage* OR disseminat* OR implement* OR exchange)
Acting for health equity	(health OR social) near to (inequit* or equit* or equal* or unequal* or justice* or injustice* or disparit*)

3.2.3   Iterative Selection of Articles

I then compiled articles identified using the search strategy described above and removed duplicates before beginning preliminary screening. This first screening effort involved reviewing titles and

abstracts to eliminate articles unrelated to issues of health equity. When a decision about exclusion could not be made using titles and abstracts, full text was reviewed. Articles lacking potential connection to the research questions were excluded. The remaining articles were then reviewed in greater depth to select articles for review. As suggested by Arksey and O'Malley (2005), in this study I subjected articles to post-hoc inclusion and exclusion criteria, based on the research question and new familiarity with the subject matter. Articles were included if in-depth review satisfied each of four criteria: (a) implicit or explicit knowledge-to-action focus; (b) orientation to addressing health inequities; (c) systems setting (i.e., context was not a singular clinical care setting); and (d) dealt in some way with how to address health inequities. If one of these four criteria were not satisfied, the article was excluded.

3.2.4   Data Charting

Data charting involved in-depth review of articles and data extraction using a Microsoft Excel database, with validation of a random selection of 33 articles (10% of total sample) by a research assistant. When there were areas of disagreement between the research assistant and I, consensus was reached by discussion. As each article was reviewed, data were extracted for particular characteristics (year, document type, source journal) and demonstrations of integration of the CSDH evidence or calls for action. Definitions of each of the data extractions, including how they were assessed, are provided below (Table *4.2*). Integration of CSDH in articles was assessed by examining problem and purpose statements, research questions, language, use of evidence and theory, and rationalization of findings. Drawing from the CSDH claim that health inequities are not a naturally occurring phenomenon, but rather are the cumulative result of human-created social and policy environments (2008), we reviewed articles for how health inequities were portrayed. We were specifically interested in whether articles contextualized health inequities as having known root causes. This included whether or not authors acknowledged that there are reasonable, evidence-based explanations for the existence of health inequities (i.e., socioeconomic, historical, and/or political contexts) wherein power and privilege play an important role. Articles were categorized as problematizing inequities if health inequities were described as avoidable; unfair; and in direct relationship to socioeconomic, historical, and/or political inequalities. When systematic differences in health and health outcomes were named without offering explanations or referring to causes, articles were assessed as naturalizing inequities.

Table 3.3

Data Extraction Elements and Definitions

Component	Categories	Description
Publication timing	Year	Year of publication
	Pre-CSDH	Publications falling between 2000-2008
	Post-CSDH	Publications falling between 2008-2016
	Research	Reports of investigative studies that generate primary data

Component	Categories	Description
Document type	Discussion	May be methodological or substantive, discusses issues or presents scholarly arguments (>1500 words)
	Commentary	Presents an argument or perspective (<1500 words), usually labelled as 'commentary' by the journal editors
	Program Report	Describes the nature, characteristics, or progress of a program (without primary data)
	Literature Review	Reports of investigative studies focused on analysis of published literature (including syntheses)
Cite CSDH?*	Direct	Directly cite CSDH (2008) *Closing the Gap in a Generation*
	Related articles	Cite CSDH Knowledge Networks, Bamako Statement, Rio Declaration, Marmot articles related to the CSDOH or social determinants of health, country-specific responses to the CSDOH, or the Solar & Irwin (WHO) Conceptual Framework for action on SDOH
	No	Does not cite the CSDH or related articles
Portrayal of health inequities	Problematize	Authors' explicitly present health inequities as avoidable, unfair, inequitable, and in direct relationship to root causes of socioeconomic inequalities (e.g., health inequities exist because of social, economic, or other inequalities)
	Naturalize	Authors do not clearly contextualize systematic differences in health as unfair, inequitable, or having causes (e.g., health inequities simply exist and can be observed, but are not explained)
Refer to role of power and privilege	Yes	Authors directly articulate the empirically established relationship between health inequities and the ways in which power, privilege, or associated concepts (e.g., oppression, colonization, injustice) work in society to create systems or structures that result in advantage and disadvantage
	No	Authors do not directly articulate the empirically established relationship between systematic differences in health and the ways in which power, privilege, or associated concepts (oppression, racism or other 'isms') work in society to create systems or structures of advantage and disadvantage
Alignment to CSDH Principles for Action*	Principle 1 *Improve daily living conditions*	a. Applied, interventional, integrated knowledge translation types of study designs b. Focus on gender equity, early childhood development, age equity, human rights c. Focus on socially protective policy environments (e.g. health, education, social infrastructure, poverty reduction) d. Cross-sector collaboration at micro-meso-macro levels (municipal, regional/provincial/national, global)

Component	Categories	Description	
	Principle 2 *Tackle the inequitable distribution of power, resources, and money*	e.	Applied, interventional, integrated knowledge translation types of study designs
		f.	Capacity building for equity work, especially in public sector
		g.	Interventions aimed at increasing capacity to recognize and challenge power and privilege in society
		h.	Interventions targeting redistribution of power, money, or resources (e.g., levelling up strategies)
		i.	Governance-related interventions, including creating processes and places for engagement/inclusion of four key governance actors (government, civil society, non-government organizations, and private sector)
		j.	Cross-sector collaboration at micro-meso-macro levels
	Principle 3 *Measure and understand the problem and assess impact of interventions*	k.	Applied, interventional, integrated knowledge translation types of study designs
		l.	Creation and testing of data monitoring systems that operationalize health inequities (and health equity), particularly across multiple sites
		m.	Interventions aimed at applying health equity monitoring systems in policy and/or program development, particularly through use of feedback loops
		n.	Interventions that build capacity for policy makers, health practitioners, and the public to understand, recognize, and act upon social determinants of health
		o.	Social determinants of health research
	None		No alignment to CSDH Principles for Action identified

*Assessed for post-CSDH publications (2009-2016); all criteria derived directly from CSDH report (2008)

Finally, the orientation toward root causes was assessed using a heuristic that was inductively devised for the purposes of this study. This heuristic defined a range of possible orientations toward root causes (Table **3.4**), framed along a spectrum of progressively more productive orientations (interrupt, illuminate) and progressively less productive orientations (acknowledge, dismiss, distract, discredit) authors could take relative to the role of power and privilege and the socioeconomic, historical, and/or political roots of health inequities.

Table 3.4
Spectrum of Possible Orientations Toward Root Causes of Inequities

Orientation		*The framing of research problem, questions, study design and/or intervention in the study…*
Progressively more productive orientations ↑	Interrupt	Opens possibilities to interrupt root causes by describing efforts that could cause a disturbance to or alter conditions that contribute to root causes
	Illuminate	Helps clarify or explain root causes
Progressively less productive orientations ↓	Acknowledge	Legitimizes or recognizes the importance of root causes, but does not go further to understand how root causes work or could be interrupted
	Dismiss	Naturalizes health inequities by not paying attention to root causes
	Distract	Diverts attention away from root causes by placing the site for intervention at the individual level through behaviourist, biomedical, and/or neoliberal policy interventions
	Discredit	Implicitly questions the reliability of evidence about root causes of health inequities and/or attempts to advance arguments against evidence of root causes by describing the evidence as false, incomplete, or debatable

3.2.5   Collating and Analyzing

Finally, data were collated and analyzed to provide a descriptive map of trends within selected literature. First, basic descriptive statistics and chi-square tests were conducted using SPSS10. For example, this analysis included the distribution of publications by year, document type, and authors' portrayals of health inequities. Qualitative assessment of articles followed, with particular attention paid to how health inequities were naturalized or problematized and by examining the ways in which authors revealed different orientations to health inequities.

3.3   Results

The initial search of databases identified 1777 articles after removing duplicates. Preliminary screening resulted in elimination of 1243 articles. Continued screening against inclusion and exclusion criteria resulted in 309 articles. During the in-depth review and data abstraction process, 21 articles were identified through hand searching reference lists. Among the 330 articles ultimately included were 132 discussion articles; 102 research studies; 67 commentaries; 23 literature reviews; and 6 descriptive reports of programs or initiatives (Figure 3.1). Of these, 54 were published in the pre-CSDH period (2000-2008) and 276 were published in the post-CSDH period (2009-2016). Publication volume grew steadily year over year, with less than 10 publications per year between 2000 and 2005 and more than 30 per year by 2012 (Figure 3.3). The number of publications in 2011 (n=11) dropped anomalously. Though no clear rationale for this anomaly was found in the literature, the dip may have been related to the 2008 global economic recession and subsequent decreases in research funding.
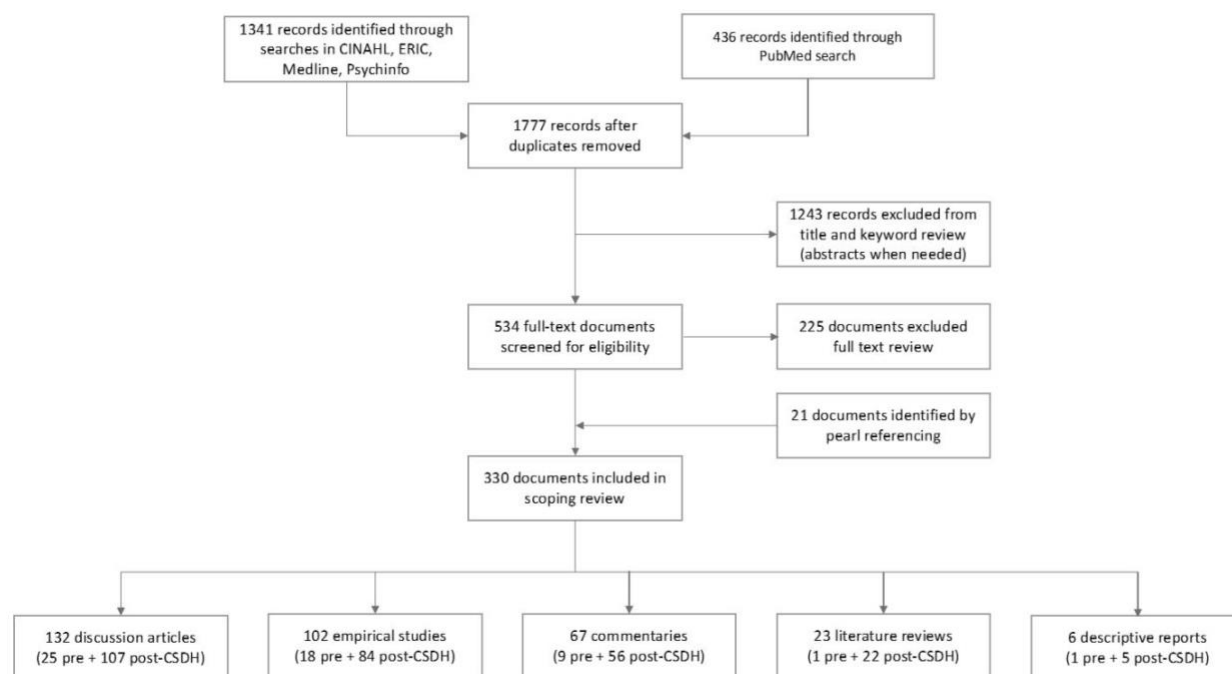
Figure 3.1. PRISMA flow diagram of search and selection results for scoping review.

3.3.1 Trends in Source Journals and Disciplinary Fields

Publications included in this review spanned a range of discipline-specific (e.g., nursing, medicine, social work) and interdisciplinary journals (e.g., health policy, public health, ethics). The most frequently publishing journals were Social Science & Medicine (n=16), BMC Public Health (n=15), the American Journal of Bioethics (n=15), the American Journal of Public Health (n=13), Health Promotion International (n=13), the Journal of Urban Health (n=10), and the International Journal for Equity in Health (n=9). Among the 15 articles published in the American Journal of Bioethics, one was a discussion paper with 14 commentaries in response[7].

3.3.2 Citation of CSDH or Related Documents

Among the 279 articles published between the years 2009 and 2016, 59% (n=163) cited the CSDH directly or indirectly: 43% (n=119) direct citation, 16% (n=44) related citations. In 41% (n=116) of the articles, the CSDH or related documents were not cited. The proportion of articles citing the CSDH report or related documents did not significantly change year over year during this period (χ^2 = 4.979, p=0.760), noting the anomalously small number of 2011 publications all included citation.

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[7] A complete listing of articles included in this review are available from the author upon request.

3.3.3   Portrayal of Health Inequities

In total, 51% (n=170) of articles problematized health inequities by describing them as rooted in causes such as socioeconomic inequalities or the unfair distribution of social or structural determinants of health (48%, n=28 of 54, in the period leading up to the CSDH report and 52%, n=144 of 278, in period following). Pearson chi-square tests showed no significant difference in the portrayal of health inequities among articles published in the periods before (2000-2008) and after (2009-2016) the CSDH report (χ^2 = 0.623, p=0.366). In the pre-CSDH, 25% (n=14) of authors acknowledged power and privilege in relationship to causes of health inequities compared to 30% in the post-CSDH period (n=84). Pearson chi-square test of this 5% difference between periods was not significant (χ^2 = 0.644, p=0.387). Figure 3.2 provides a visual overview of these distributions, grouping the portrayal of health inequities and acknowledgement of power and privilege for articles in the periods before and after release of the CSDH report. The proportion of articles problematizing versus naturalizing health inequities by year of publication has remained steady at about half and half each in the periods before and after the CSDH (Figures 3.2 and 3.3).
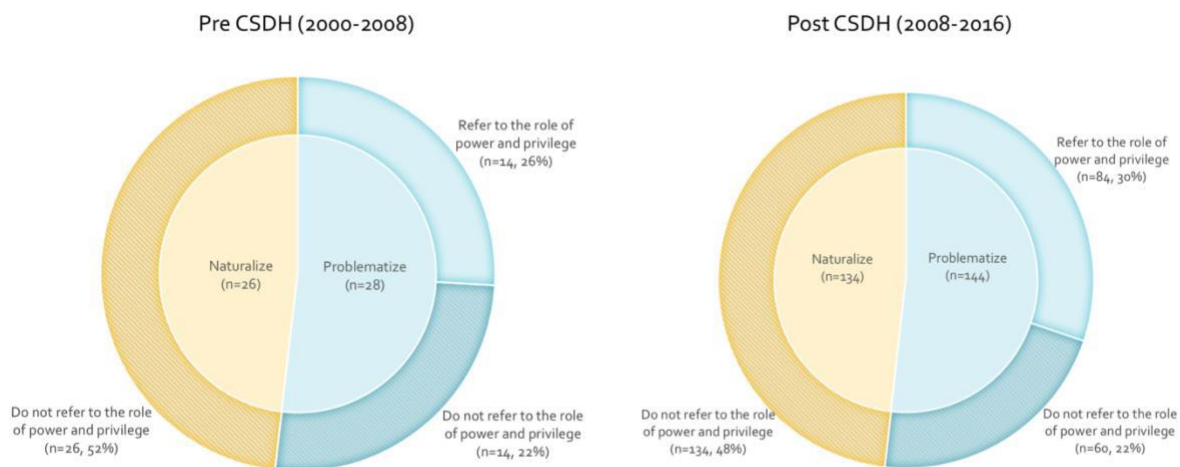
Figure 3.2. Portrayal of health inequities in the periods before and after the CSDH report.

In Figure 3.2, pre- and post-CSDH distribution of publications by portrayal of systematic differences in health and health outcomes, with publications problematizing (dark) versus naturalizing (light). The outer ring breaks this portrayal down further by showing the proportion of publications that did and did not refer to role of power and privilege in creating systems and structures that cause health inequities.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
■ Problematize	0	1	1	1	0	2	7	5	9	12	10	8	11	22	23	31	25
□ Natrualize	1	0	0	0	2	4	9	4	8	12	14	3	18	15	16	23	33
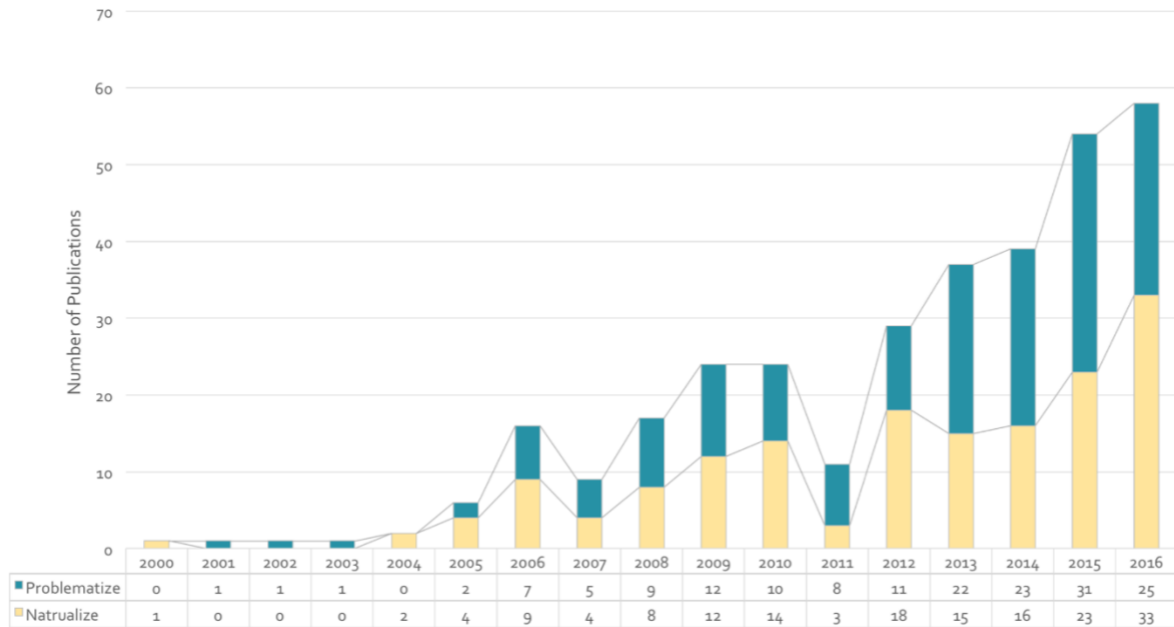
Figure 3.3. Portrayal of health inequities by year of publication.

In Figure 3.3, publications problematizing health inequities are shaded dark, whereas those naturalizing health inequities are shaded light. The proportion of articles problematizing versus naturalizing health inequities is steady at about half and half each in the periods before and after the CSDH. The portrayal of health inequities by authors citing the CSDH or related documents is shown in Figure 3.4. A significantly larger proportion of authors who cited the CSDH or related documents also problematized inequities (n=111 of 163, 68% compared to n=33 of 116, 28%; χ^2 = 48.706, p=0.000). Some authors directly cited the CSDH (n=31, 11%) or related documents (n=21, 8%), yet continued to portray health inequities as naturalized by inaccurately citing or citing particularly benign language from the CSDH report without reference to context or causes. Finally, some authors post-CSDH effectively problematized inequities without citing the CSDH (n=33, 12%), drawing on other bodies of theory or evidence to shape their arguments.
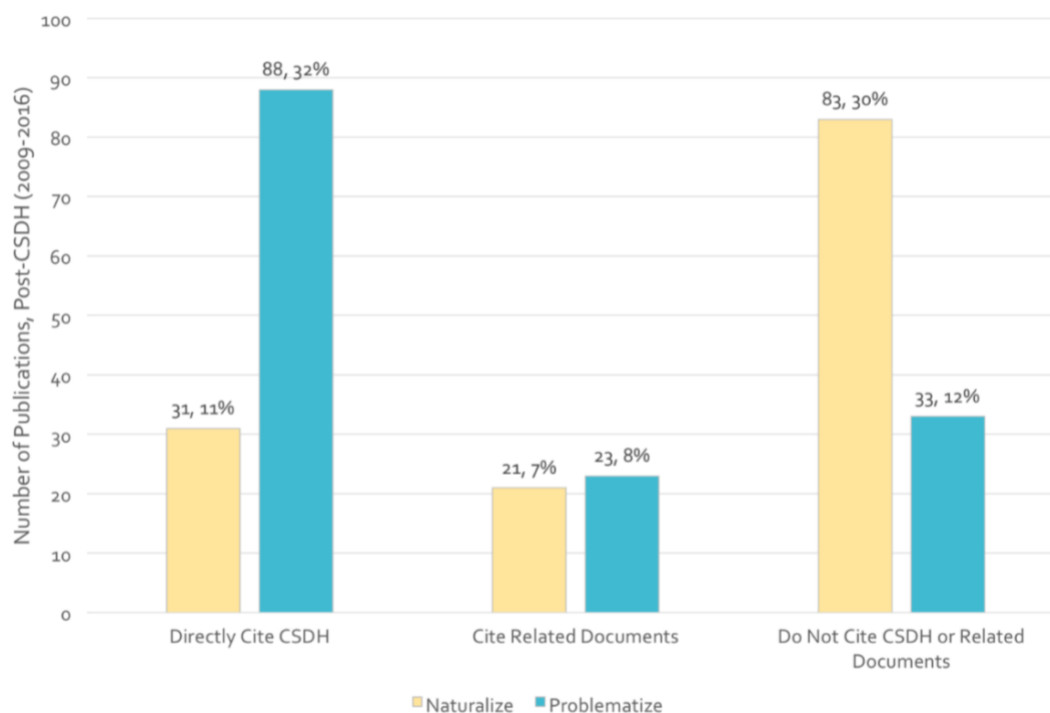
Figure 3.4. Portrayal of health inequities by citation of the CSDH or related documents.

In Figure 3.4, articles that naturalized health inequities are portrayed in light bars, and those that problematized these differences as health inequities are portrayed in dark bars. Percentages reported are a proportion of the total number of articles for the post-CSDH period (n=279). Qualitative analysis of the how authors' portrayals of health inequities were achieved, revealed distinct discursive patterns among authors problematizing versus naturalizing inequities. For example, Blas et al. (2008) portrayed health inequities as a problematic result of avoidable socioeconomic inequalities. These authors examined the work of the 9 knowledge networks supporting the CSDH in compiling evidence about promising interventions. They framed social determinants of health in the context of "causal chains [that] run from macro social, political, and economic factors to the pathogenesis of disease" and called for continued refinement of evidence on these causal pathways (p.1684). Authors who acknowledged the relationship of power or privilege to causes of health inequities (n=14/54, 26% pre; n=84/279, 30% post-CSDH) tended to explicitly acknowledge the assumptions underlying their portrayal of health inequities.

In another example, Chircop, Bassett, & Taylor (2015) adopted a critical lens in their scoping review on intersectoral collaboration for health equity. Their review framed health inequities as the result of decision making and policy, which they argued were "influenced by neoliberal ideologies of decision-makers, who maintain the discourse that in a free market economy, everyone has equal access to societies' resources, thus negating privileged positions of social groups by virtue of class, race/ethnicity and gender" (p. 179). This was also exemplified in Young and McGrath's (2011) analysis of discourses of health equity, social justice, and social determinants of health among Australian state and federal health

policy documents. These authors explicitly described health inequities as rooted in power and social injustice and used this framing to inform their analytical focus on how the characterization of health inequities influenced policy.

In contrast, articles in which authors naturalized health inequities (n=26/54, 48% pre; n=134/279, 48% post-CSDH) did not reference evidence about root causes and tended to focus attention on behavioural or biomedical explanations or interventions. For example, Ir et al. (2010) began their empirical article by describing equity as an "overarching goal of public health policy in many countries for several decades" (p. 200). They addressed the need for an "equity-oriented approach" in health systems, with interventions that "reach the poor" (p. 200); however, the authors focus entirely on superficial remedy (access to healthcare finance funds) without reference to causes of poverty in Cambodia. Although these authors stated a goal of "translating knowledge into policies that promote equity" (p. 201), their research focused on remediating the impacts of poverty through an individual-level intervention. In another example, authors of an interventional study on perinatal health promotion in Malawi reported that "health equity improved significantly over the study period" (Callaghan-Koru et al., 2013, p.1). The claim was predicated on an assumption that improved birth indicators (maternal and new born care at facility, and new born care practices such as breastfeeding, delayed bathing, skin-to-skin contact) were proxy measures for health equity. Their study involved monitoring biomedical and behavioural outcomes of the individual-level interventions, without referring to broader contexts of inequities. Women participants in the study were presented simply as poor, lacking access to essential perinatal services, unknowledgeable, and in need of intervention, and despite the behavioural focus of the study, it was celebrated as a successful contribution to health equity.

Many authors described their work as being about health disparities (n=9, 17% pre; n=25, 9% post-CSDH). Authors using this language frequently referred to 'racial' or 'ethnic' differences in health outcomes and frequently described these differences as a symptom of inherent characteristics or behaviours of these groups (e.g., Chin et al., 2012; Dankwa-Mullan, Rhee, Williams, et al., 2010; Fullilove, Green, Hernández-Cordero, & Fullilove, 2006). In a systematic Cochrane review of evidence on the impact of interventions driven by community coalitions, Anderson et al. (2015) described "unfavourable ethnic and racial disparities in health status" as the research problem. This language effectively normalized the existence of disparities as an unfortunate and inevitable consequence of divergence from the behaviours and characteristics of the dominant population. This aligned with similar discursive patterns found in other articles where authors' writing choices naturalized the portrayal of health inequities.

3.3.4   Alignment with CSDH Principles for Action

Demonstration of integrating CSDH principles for action in study design or focus were assessed for 110 post-CSDH publications (2009-2016), including research studies (n=80, 73%), evaluations (n=8, 7%), and literature reviews (n=22, 20%). When exploring how these empirical studies aligned with the

CSDH Principles for Action, the vast majority showed alignment with at least one of the three principles, as follows: improve daily living conditions (n= 20, 18%); tackle the inequitable distribution of power, resources, and money (n=37, 34%); and measure and understand the problem, study the impact of interventions (n=36, 33%). A small number of articles assessed showed no alignment with a CSDH principle for action (n=15, 14%). Examples of the variation observed in integrating CSDH principles for action in study design/focus and intentions toward root causes, with a brief description rationale are provided in Table 3.5.

3.3.5   Orientation to Root Causes of Inequities

Half of the post-CSDH empirical studies showed progressively more productive orientations to health inequities through their attempts to illuminate (n=46) or interrupt (n=9) root causes (Table 3.5). The remaining 55 studies (50%) were progressively less productive in orientation, by acknowledging root causes without responding to these causes in study question or design (n=13), disregarding (n=22), distracting (n=17), or either implicitly or directly discrediting evidence on root causes (n=3, see Figure 3.5). For example, in a literature review (Knopf et al., 2016) authors examined the impact of school-based health clinics on "advancing health equity" (p. 114). Here, evidence regarding root causes of health inequities was implicitly discredited through what appears to be omission of key literature on causes of health inequities in combination with research questions focused exclusively on health outcomes tied to risk behaviour and healthcare utilization. The article provides an analytical framework that features exclusively bio-behavioural pathways to health equity. Although there is no direct statement in the review contravening the evidence presented by the CSDH or related documents, the fact that this systematic literature review was titled 'advancing health equity' despite providing no grounding in the evidence or literature on social determinants of health, implied a rejection of the body of evidence about root causes of health inequities.
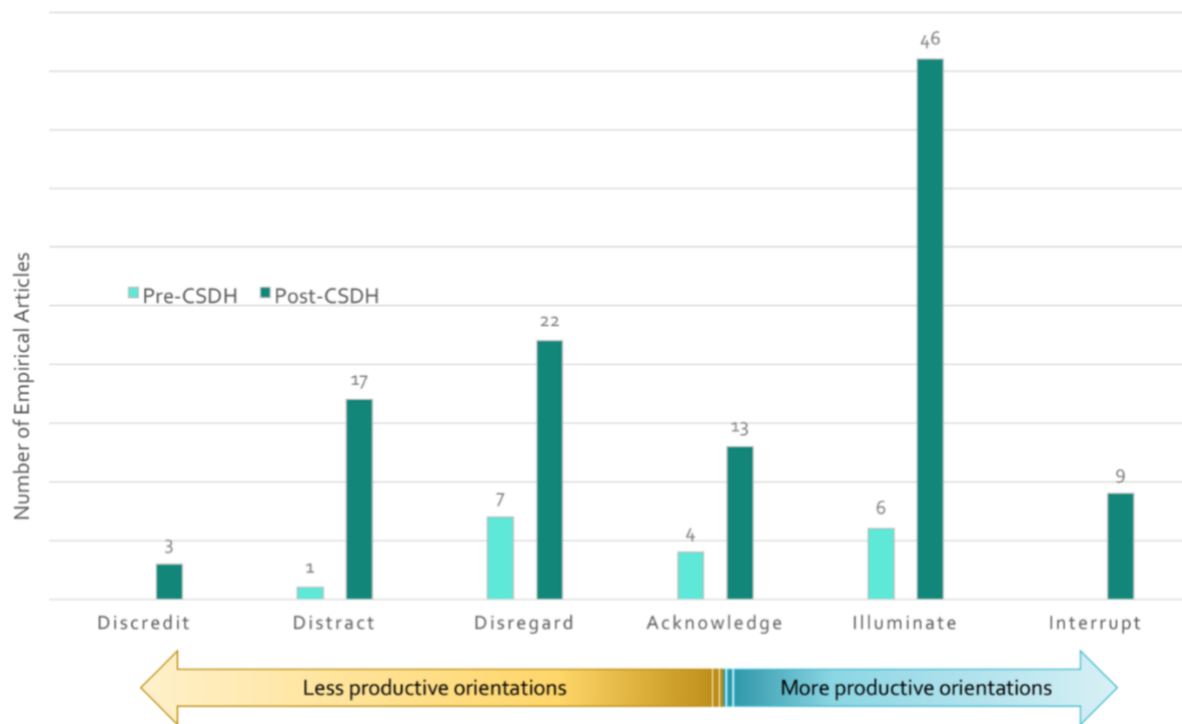
Figure 3.5. Distribution of post-CSDH (2009-2016) empirical publications by orientation toward causes of inequities.

In Figure 3.5, each line shows the distribution of articles along the spectrum of possible intentions toward root causes. The columns on the left of the graph (n=8, 44% pre-CSDH; n=42, 38% post-CSDH) correspond to studies that were progressively less productive due to an orientation of dismissing, distracting from, or discrediting evidence about causal roots of health inequities. The columns to the right (n=10, 56% pre-CSDH; n=68, 62% post-CSDH) correspond to studies that were progressively more productive in their attempts to acknowledge, illuminate, or interrupt causes of inequities.

Table 3.5

Rationale and Examples of Different Orientations Toward Root Causes of Health Inequities

		Demonstrations of Integrating CSDH Evidence and Responding to CSDH Principles for Action				
Example Article	**Citation**	**Portrayal of Health Inequities**	**Attendance to the Role of Power & Privilege**	**Study Design**	**Alignment with CSDH Principles**	**Orientation to Root Causes of Inequities**
(Browne, Varcoe, Ford-Gilboe, & Wathen, 2015)	Cite the Public Health Agency of Canada on the country's response to CSDH	Problematized inequities, describing them as "socially constructed, unjust, and avoidable differences in health and well-being between and within groups of people" (p. 2).	Directly acknowledged the role of power in their discussion of cultural safety, which aims to "redress inequitable power relations" (p. 4).	Interventional case series, building capacity for equity-responsive, trauma-informed, and culturally safe practice among primary care providers.	Principle 1 Principle 2	**Interrupt** Acted on awareness of power and privilege among care providers, with an aim to disrupt systems and structures that reinforce inequities. The authors attempted to create more open systems of care.
(Borde, Akerman, & Pellegrini Filho, 2014)	Cite Brazilian CSDH + Evidence and Measurement Knowledge Network	Problematized health inequities by acknowledging the health inequalities along social gradients and the complexity of social and historical roots (p. 2082).	Social health inequities described as "related to forms of social organization and to the asymmetries of power characterizing contemporary capitalist societies" (p. 2083).	Applied design, examined and mapped capacities for doing social determinants of health research in Brazil.	Principle 1	**Illuminate** Explored foundational capacity to research and acted on social determinants of health.
(Davison et al., 2015a)	Cite CSDH	Problematized inequities by referring to "systematic, unfair, and avoidable inequalities" (p.1) in health, and directly naming health inequities as related to "some form of historical or contemporary injustice" (p. 1).	Authors discuss how some knowledge-to-action models incorporate considerations of power, but this was not a named criterion for assessing models' orientation toward health equity.	This scoping review applies a 'health equity' score to articles using six criteria.	Principle 3	**Acknowledge** Recognized the importance of causes of health inequities and attempted to examine knowledge-to-action models for their sensitivity to "health equity challenges" (p. 3) but did not go further.

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		Demonstrations of Integrating CSDH Evidence and Responding to CSDH Principles for Action				
Example Article	**Citation**	**Portrayal of Health Inequities**	**Attendance to the Role of Power & Privilege**	**Study Design**	**Alignment with CSDH Principles**	**Orientation to Root Causes of Inequities**
(Prasad et al., 2013)	Cite CSDH	Naturalized inequities by identifying urban slums as a concerning global trend without explaining what is driving urbanization or contributing to the existence of slums.	Not discussed	Evaluated the experience of select cities in the Americas using the Urban HEART tool.	Principle 3 (research focused on social determinants of health, but did so without attention to their causes)	**Disregard** Described the study as a response to the CSDH but did not include any reference to evidence or nature of root causes. Results focused on symptoms rather than on causes.
(Pratt & Loff, 2013)	No	Naturalized inequities by stating that "global health disparities" exist and need the help of product development. No contextualization or evidence for causes of health inequities was provided.	Not discussed	Methods vaguely described as "evaluating the contribution of three PDPs [product development partnerships]" (p. 1968).	None identified	**Distract** Provided no rational explanations for the existence of 'health disparities.' Focused on the critical need for trial research and product development, thereby avoiding attention to why disparities exist or how they could be resolved.
(Knopf et al., 2016)	No	Naturalized inequities by describing inequalities in health and educational outcomes, including risk behaviours, as "well documented" (p. 114) among poor, ethnic and racial minorities without reference to any explanatory 39ocio-political, economic, or historic context.	Not discussed	Systematic literature review of impacts of school-based health clinics on "advancing health equity."	None identified	**Discredit (implicit)** Despite a declared intention and hypothesis that SBHC can 'advance health equity', the authors focused exclusively on bio-behavioural health outcomes of poor and ethnic and racial minorities. The causal framework proposed effectively internalizes health inequities within individuals or racial/ethnic groups by delineating biobehavioural causal pathways to health equity.

3.4   Discussion

Despite general agreement on the strength of evidence and reasonableness of explanations for health inequities, this scoping review showed limited integration of the evidence advanced by the CSDH. Nearly half of the articles identified in this review justified and framed their work without acknowledging socioeconomic, political, or historical causes or contributing factors. Fewer still were explicit in connecting these causal contexts to the role of power and privilege in society. Further, trends in how health inequities were framed were consistent in the periods of scholarly work preceding and following the CSDH report. Though it was encouraging to discover that articles that included citations of the CSDH or related documents were more likely to include portrayals of health inequities as problematic, there was a sizable number of articles that included a citation of the report and still naturalized inequities. Therefore, citation of the CSDH report did not necessarily lead to integration of the evidence or principles for action outlined in their report. Such disconnects have been noted in other research about how health equity work is taken up in public health, health systems, and in the media (e.g., Hanson, 2017; Raphael, 2011; Raphael, Curry-Stevens, & Bryant, 2008; Rideout, Oickle, & Clement, 2016). In these cases, authors described the difficulties of doing work that focuses on the structures and systems contributing to health inequities.

Despite these disconnects, some encouraging trends were identified. In particular, half (n=55, 50%) of post-CSDH empirical studies were oriented to progressively more productive actions on root causes of inequities. Studies with these orientations included research goals of illuminating something new about the ways in which we understand causal roots of health inequities (e.g., F. E. Baum, Laris, Fisher, Newman, & Macdougall, 2013; Carey & Crammond, 2015b; Farrer, Marinetti, Cavaco, & Costongs, 2015; Knight, 2014; Mtenga, Masanja, & Mamdani, 2016; Ndumbe-Eyoh & Moffatt, 2013; Ruckert & Labonté, 2014; Shareck, Frohlich, & Poland, 2013), with some (n=9) describing important steps toward interrupting root causes through interventional or action research studies (Andermann, 2016; Browne et al., 2015; Cacari-Stone, Wallerstein, Garcia, & Minkler, 2014; de Andrade et al., 2015; Kelaher et al., 2014; McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston, 2016; Murphy, Hatfield, Afsana, & Neufeld, 2015; B. B. Pauly, MacDonald, Hancock, Martin, & Perkin, 2013; Tolhurst et al., 2012). These articles are useful examples of how the integration of evidence on root causes leads to problematizing health inequities and referring to the role of power and privilege. In these articles, the research problem, questions, and study designs are framed in ways that, at a minimum, acknowledged root causes of health inequities. In contrast, articles with orientations that distracted from the complex socioeconomic, political, and historic roots underlying health inequities often conceptualized research problems in ways that implicitly naturalized portrayals of health inequities. These articles did not include an integration of evidence about root causes and paid limited attention to the role of power and privilege.

When I took a step back to critically reflect on these findings using a critical theory lens, I was struck by how the absence of attention to root causes mirrored power structures and dominant ideologies that shape society. Other researchers point to the conflict between dominant ideologies, such as neoliberalism, capitalism, or individualism and what is known about the socioeconomic, historic, and

political roots of health inequities (Kirkland & Raphael, 2017; Raphael, 2011). These conflicts can make it difficult to recognize the impact of dominant ideologies on the ways in which health equity work is being understood and legitimized. In the health equity-focused domain of global health research, for example, authors evoke different representations of the world, "discursively constructing sites in which studies can legitimately take place" (Author, 2018, p. 142). Such discursive constructions emerge from normative assumptions about the world and are achieved through choices made about language and particular presentations of evidence (Wodak, 2011).

In this scoping review, I was particularly curious about trends in discursive choices authors made in portraying health inequities and orienting health equity work to root causes. One discursive choice could be to name systematic differences in health between racial, gendered, or socioeconomic groups without providing context about known causes, effectively presenting health inequities as natural or mysterious and disconnected from issues of power and privilege. Although this choice may appear benign, it involves some form of rejection or dismissal of the compelling evidence to the contrary (see, for example, Brisbois, 2014; Escobar, 2012; Sparke, 2009). It is possible that some authors actually believe in a normalized explanation of systematic differences in health and health outcomes. Authors committed to such an explanation may be unaware of their epistemological biases and normative assumptions or may be convinced by data that, by virtue of the way indicators are constructed, inappropriately identifies, for instance, race instead of racism as the cause. Further, there are significant power structures within academic institutions that may restrict researchers' senses of freedom to adopt a progressively more productive orientation to root causes of inequities, including their own sociopolitical climate and pressures related to the assessment of academic performance (Plamondon et al., 2017; Raphael, 2008). By understanding the factors contributing to why research and scholarly work may not be aligning with what we know about root causes of inequities, the study findings point to an important difference between awareness of the CSDH and understanding, acceptance, and application of its evidence and recommendations.

I found Brassolotto, Raphael, and Baldeo's (2013) study of public health action on social determinants of health a useful frame for contemplating this finding. They explored "intellectual hurdles" wherein "scientists must overcome the barriers posed by their prior views" (Brassolotto, Raphael, & Baldeo, 2013, p.1-2) by drawing on Bachelard's concept of epistemological obstacles (Tiles, 1984). They found that public health professionals' worldviews shaped the ways in which they understood social determinants of health and the degree of acceptance of the evidence on root causes of health inequities. The authors concluded that "inaction on the [social determinants of health] results from epistemological barriers that result from internalized discourses and traditions that treat health as divorced from the societal contexts in which it occurs" (p. 13). Epistemological obstacles may well be serving to reinforce preoccupation with individualist, behavioural, biomedical, and neoliberal political ideologies in health sciences.

Epistemological barriers in the field of health equity are deeply embedded in the language and social systems of health sciences, which for centuries have revolved around a biomedical conceptualization of health research, systems, and policy (Clarke, Mamo, Fosket, Fishman, & Shim, 2010). These barriers limit the potential to examine the complex and competing interests, values, and standards of proof implicated in taking action on social determinants of health (Ted Schrecker, 2013). This scoping review revealed a broad body of literature, much of which relied on systems of inquiry ill-suited to examining or redressing root causes of health inequities. The significant 'downstream' or behaviourist focus in public health (Lucyk & McLaren, 2017) and other fields of health equity risk reinforcing the underlying systems and structures that cause health inequities by relying on the "benevolence narrative" (Hanson, 2017, p.e1) and disregarding or distracting from evidence on causal roots. Our findings validate others' critiques of the scholarship of 'health equity' for its acquiescence to the dominance of individualism, bio-behaviourism, and neoliberalism (Brassolotto et al., 2013; Hanson, 2017; Lucyk & McLaren, 2017; Raphael, 2015; Raphael, Brassolotto, & Baldeo, 2014; Raphael et al., 2008), discursive patterns of overlooking causes of inequities (Brisbois, 2014; Brisbois & Plamondon, 2018), and exploitive, colonial research partnerships (Crane, 2010).

Research is not a neutral endeavour, but rather is situated within the broader political economy and power structures within society that heavily influence the ways in which research is funded and prioritized as well as how researchers (and research users) seek to identify and understand a problem. Overcoming epistemological barriers requires critical contemplation of alternative perspectives and capacity to recognize the influence of epistemological assumptions and systems of power. There is an emerging awareness of the need for building capacity to do so, particularly in recognizing the impacts of unfair advantages and disadvantages in society. In research and scholarship on connecting knowledge to action for health equity, how a problem is framed sets the trajectory of possible solutions. "When power analysis [i.e., attention to how power and privilege work in society] is added to the CSDH, it makes more visible the ways in which intersecting advantages and disadvantages work to shape who accesses care, what care they get, and who lives and who dies" (Nixon, 2017). In light of the evidence available about the remediable nature of health inequities, and the limited integration of this evidence observed in this scoping review, there seems a need for attention on how to support health research systems and researchers both to overcome epistemological barriers, so their choices can focus on more equity-centred ways of thinking and responding to health inequities.

A recent study about principles for guiding equity-centred global health research revealed that, although researchers' intentions were strongly focused on equity, they often struggled to put these intentions into action (CCGHR, 2015). This elusiveness of a praxis of equity is, in part, related to the intense wickedness of health inequities (Buse, 2013). Further, the study's focus on literature with an identifiable 'knowledge-to-action' intention evokes opportunities to advance thinking in the (also relatively new) field of knowledge translation, where theory and practices are still very much in development. Although the CSDH presented evidence alongside ethical and moral arguments for action, global

governance in an era of economic and political globalization makes the coordination of action on causes of health inequities particularly complex (Lee, 2010). Disconnects between intention, evidence, and action warrant urgent reflection and further examination of the kinds of strategies, interventions, and metrics that can serve to operationalize action on causes of health inequities. Peer review, for example, could play a more active role in validating or challenging discursive choices to shift research and scholarship in health equity toward progressively more productive stances. Further, researchers themselves are subjected to power structures that can serve to limit their capacity to overcome these disconnects, including indirect threats, such as the undervaluing of health equity work in tenure and promotion reviews; precariousness; and the influence of austerity-driven economization of academic work environments (Conesa Carpintero, 2017). Researchers also face direct threats of violence against academics who challenge the status quo. Overcoming the epistemological barriers exposed in this study will require bold innovations in health equity education, research, and funding, including expanding scholarly capacity to recognize, examine, and interrupt systems of power and privilege, such as preoccupations with dominant ideologies.

3.5   Limitations

The research questions were framed around our acceptance of the CSDH as an important moment in time along a continuum of health equity advocacy that calls for social, economic, and political reform. Embedded in our questions is an assumption that health equity matters and because they are informed by critical public and global health ethics, the human-caused nature of health inequities makes them unacceptable (Solomon R Benatar et al., 2003; Nixon, 2006b; Pinto et al., 2013). They also reflect an assumption that scholarly work should have been influenced by the CSDH. However, we do note that the CSDH report itself was not the only germinal contribution to the global evidence or calls for action on causes of inequities. Other major efforts to draw attention to the need for interrupting inequalities in health preceded the CSDH (e.g., the 1978 Alma Ata Declaration) and followed it (e.g., the Bamako Call to Action (2008) and Rio Declaration on Social Determinants of Health (World Health Organization, 2011)). The results of this scoping review are limited to articles that explicitly framed their work in the context of 'knowledge translation' and were indexed in the five selected databases. There may have been more literature that had a knowledge-to-action intention, but the authors did not label their work in this way. Further, our review is limited to assessing the content presented by authors. What authors did not write or make explicit could not be assessed.

3.6   Implications

This scoping review paints a picture of modest response to the CSDH's culmination of evidence on root causes of health inequities. The CSDH was not the first, nor last global effort to shift attention away from biomedical, technocratic interventions for sickness in favour of acting on the systems and structures that manifest the systematic differences in health and health outcomes that are health inequities. The evidence is unequivocal: health inequities are avoidable; they are rooted in the maldistribution of power, money, and resources and can be undone by human actions. The global

visibility and recognition of the CSDH as a germinal contribution to the field of health equity makes it difficult to reconcile the omission of evidence on causal roots in such a large volume of scholarship. At a minimum, this finding raises important questions about the language, transparency, and ethics of scholarship in this field. These questions could include a focus on how research, and the social and political structures in which academic work is embedded, can effectively contribute to progressively more productive orientations to root causes of health inequities. To be effective at achieving progress toward a greater health equity worldwide, this diverse, diffuse, and multidisciplinary field of health equity needs to pay close attention to the ways in which scholarship contributes to or reinforces health inequities. If neither a lack of knowledge nor interest are driving this dissonance, then other critical gaps in connecting knowledge to action demand attention. One critical gap indicated by the findings of this review is the persistence of epistemological barriers among researchers involved in the field of health equity. Another is conflict in values and assumptions within the field, pointing to the need for dialogue about norms in the field and how to better align intentions with action for health equity. Attention is urgently needed on how to overcome practical and epistemological barriers and on what works (and what doesn't) in designing research and knowledge translation that addresses root causes of health inequities rather than the symptoms alone.

Chapter 4: Critical Interpretive Synthesis

4.1   Background

Focusing on empirical articles and literature reviews, this second study sought to identify promising practices for connecting KTA for health equity. Drawing on the widely-accepted evidence about health inequities (e.g., Marmot & Friel, 2008; McNeill et al., 2016; Ottersen et al., 2014; CSDH 2008), this study rested on the assumption that advancing health equity involves interrupting routine practices that serve to maintain the unfair distribution of power and resources in society. Despite the strength of evidence and a suite of accompanying policy recommendations (e.g., United Nations, 2017; World Health Organization, 2011), connecting KTA for health equity remains limited in policy arenas shaped by colonial legacies (Came & Griffith, 2018) and neoliberal ideology (Baker et al., 2018; Labonté, 2012). Leaders in the field of health equity describe this poor response as a by-product of "inadequate or ineffective knowledge translation" combined with discordant ideologies (Bryant, Raphael, Schrecker, & Labonte, 2011, p. 54) and epistemological barriers (Brassolotto et al., 2013). As described in the scoping review, these barriers limit the alignment between evidence and action in the design, implementation, analysis, and presentation of research (Plamondon, Bottorff, Graham, & Caxaj, 2018). Recognizing these barriers is informative insofar as it identifies something important about KTA gaps in the field of health equity. But recognition of a barrier does not provide practical steps for overcoming it. This study was an effort to understand how people doing research and KT within the field of health equity might overcome the multiple forces working against productive health equity action.

A key research question guided this critical interpretive synthesis (CIS): *What promising practices for connecting KTA for health equity are evident in the literature?* Practices were understood as habitual, customary actions objectively and subjectively constructed through the routines people carry out in social contexts (Kemmis, 2008). *Promising* practices were defined as those for which there is some empirical evidence to suggest they work productively toward a desired outcome. They apply to multiple domains, including (but not limited to) research, knowledge translation, advocacy, health professional practices, and policy. In essence, promising practices are evidence-informed approaches to routine, daily work of the multiple, complex actors implicated in connecting KTA for health equity. To the best of my knowledge, this is the first review to critically examine promising and empirically-derived strategies for advancing productive action on the root causes of health inequities.

4.2   Methods

Critical interpretive synthesis involves systematic analysis of an often "large, amorphous and complex body of literature" (Dixon-Woods et al., 2006, p. 9), using research questions that are *not* explicitly hypothetical (Dixon-Woods et al., 2006). This type of review relies on qualitative analysis, interpretation, and synthesis of literature (Dixon-Woods et al., 2006). The process invites attention to critical theory and is iterative, flexible, and responsive to emerging findings. With an interest in *practices*,

and given the subject matter for this study deals with overcoming issues of power and privilege in society, this study was informed by Friere's critical pedagogy (1985b, 1997). Freire held a deep optimism and respect for human agency in acting for health equity. He asserted that power imbalances in society are perpetuated by routine and often unrecognized activities, reinforced by the daily, routine acts of both the oppressed and privileged. He postulated that humans are intensely creative and curious beings who, through dialogue and reflection, can become more wakeful to their participation in practices that generate inequities. Friere (1985b, 1997) argued this consciousness-raising is a pathway for transforming systems of power and privilege. In the context of this study, attention to critical pedagogy provided a lens through which the routine practices of researchers *and* those related to the settings in which their research occurred, could be examined.

I reviewed empirical studies and literature reviews published in the period following the CSDH report (2008-2016) to identify evidence about how practices can contribute to productive shifts toward action on the root causes of health inequities. The initial search for this CIS was conducted alongside that of the scoping review, which sought articles with a declared intention of mobilizing knowledge to advance action for health equity screening. However, the CIS narrowed the search further with a focus on empirical studies and literature reviews. Searches conducted in CINAHL, ERIC, EMBASE, Medline, PubMed, and PsychInfo (Table 4.1) led to identification of 330 studies. These articles were screened against criteria aimed at selecting for integration of evidence about causes of health inequities (i.e., problematized health inequities) and productive orientation toward these causes (i.e., acknowledge, illuminate, or interrupt; see Table 3.4 for more details).

Table 4.1

Search Terms, Inclusion, and Exclusion Criteria

Criteria	Description
Connecting knowledge to action	(knowledge OR evidence OR research OR guideline*) near to (utiliz* OR utilis* OR uptake OR transfer OR translat* OR transmit* OR transmission OR effectiveness OR populari* OR exchange OR synthes* OR transform* OR linkage* OR disseminat* OR implement* OR exchange)
Focus on health equity	(health OR social) near to (inequit* or equit* or equal* or unequal* or justice* or injustice* or disparit*)
Inclusion Criteria	1. Empirical studies (research, systematic literature reviews, syntheses) 2. Published post-publication of CSDH (2008-2016) 3. Implicit or explicit knowledge-to-action intention 4. Orientation to addressing health inequities 5. Problematized health inequities by citing evidence of socioeconomic, historical, political roots and/or the maldistribution of resources, money, and power (e.g., CSDH) 6. Study is clearly positioned in a productive orientation toward root causes of inequities (i.e., seeks to acknowledge, illuminate, or interrupt root causes).
Exclusion Criteria	1. Naturalized systematic differences in health and health outcomes 2. Did not discuss role of power and privilege in health inequities

Criteria	Description
	3. Orientations toward root causes were not productive (disregard, distract, discredit)
	4. Did not present an argument about how to connect knowledge to action for health equity
	5. Did not present results (e.g., study protocol)

Included articles were qualitatively analyzed with the support of Nvivo 11 for Mac and Microsoft Excel to manage and organize data. In the first reading, descriptive data elements such as bibliometric information were extracted (Table 4.2) and articles were assessed for clarity and quality (Dixon-Woods et al., 2006) (Table 4.3). The next reading involved preliminary content analysis using categories derived from the research question and insights from the scoping review. Constant comparative analysis (Glaser, 1965) guided the consideration of content through subsequent readings. As content was coded, interpretive notes and insights were documented. Each stage involved exercising curiosity about explicit and implicit assumptions embedded in an article's language, study designs, analytical approaches, and claims. Importantly, articles were considered as promising *in and of themselves*. This meant that attention was placed both on how the researchers approached and framed their work *and* on the reported results. Nvivo queries supported the exploration of coded content for patterns and insights, using memos to capture relationships with other relevant literature. In the final reading, articles were reviewed for gaps, silences, and omissions. Emergent findings were shared regularly in dialogue with the supervisory committee.

Table 4.2

Data Extraction Elements

Element	Description
Bibliometric data	Author, year, source journal, discipline, location
Study purpose	Direct quotation of statement of aims, goal, or purpose
Methods	Methodology and data generating approaches Assessment of the clarity and quality of research methods
Practices tested or derived	Specific actions, processes, ways of working that are either tested or emerge from the study findings
Evidence for promising practices	Arguments, research findings, and claims made by authors about strategies, facilitators or barriers, or approaches that demonstrate some degree of promise for connecting KTA for health equity

Table 4.3

Assessment Criteria and Scores for Clarity and Quality of Research Methods*

Prompts	No Absent, unidentifiable (Score=0)	Not Clear Vague, partial (Score=1)	Yes Clear, well described (Score=2)
(AO) Are the aims and objectives of the research clearly stated?	No clear statement of aims and objectives	Aims and objectives implied, but difficult to discern	Aims and objectives explicitly stated and easily identifiable
(DES) Is the research design clearly specified and appropriate for the aims and objectives of the research?	Study design does not align with aims and objectives. And/or Little to no description of methodological approach provided.	Study design somewhat aligned with aims and objectives. And/or Some description of methodology provided, but with gaps or use of generic language used to describe methodology (e.g., 'qualitative').	Study design aligns with aims and objectives and Methodological approach and theoretical foundation clearly described.
(MET) Do the researchers provide a clear account of the process by which their findings were produced?	No clear description of study process of data generation, making it impossible to replicate study.	Data generation and analytical processes vaguely described—would be difficult to replicate study.	Methods and analytical process clearly described, consistent with methodological approach and theoretical foundation—would be possible to replicate study.
(D) Do the researchers display enough data to support their interpretations and conclusions?	Insufficient data presented to support authors' claims.	Difficult to discern if data is sufficient to support authors' claims.	Data presented is compelling and clearly supports authors' claims.
(AN) Is the method of analysis appropriate and adequately explicated?	Analytical processes inadequate or absent; not clearly or coherently linked to conclusions.	Analytical processes vaguely described; difficult to determine coherency with study design and findings.	Analytical process well described, coherent with methodology, and logically connected to authors' conclusions.

*Criteria derived from Dixon-Woods et al. (2006)

4.3   Results

Of the 330 articles screened, 224 non-empirical articles were excluded. Considering the remaining 106 articles against inclusion and exclusion criteria resulted in 10 literature reviews (4 scoping reviews, 3 syntheses, 1 realist review, 2 rapid reviews) and 22 research studies (Figure 4.1). Because articles were selected for their integration of evidence about root causes of health inequities, all included articles portrayed health inequities as unfair and avoidable, with known causes. Descriptive data extracted from literature reviews are presented in Table *4.4*, while those from research studies are

presented in Table *4.5*. Articles varied in terms of clarity and quality. Out of a maximum possible score of 10, assessments of clarity and quality ranged from 2 (n=1) to 9 (n=4) for literature reviews and 3 (n=1) to 10 (n=4) for research studies. Of the 10 literature reviews, the vast majority included at least some description across all of the categories of assessment, with most (n=7, 70%) scoring between 8 and 10. Scores for research studies were more varied, with 27% (n=6) assessed as having absent or unidentifiable content in each of the five categories (i.e., scored 5 or lower). Another 31% (n=7) of research studies were missing information in at least two categories of assessment (i.e., scored between 6 and 7) and 41% were assessed as relatively strong and clear (i.e., scored between 8-10).
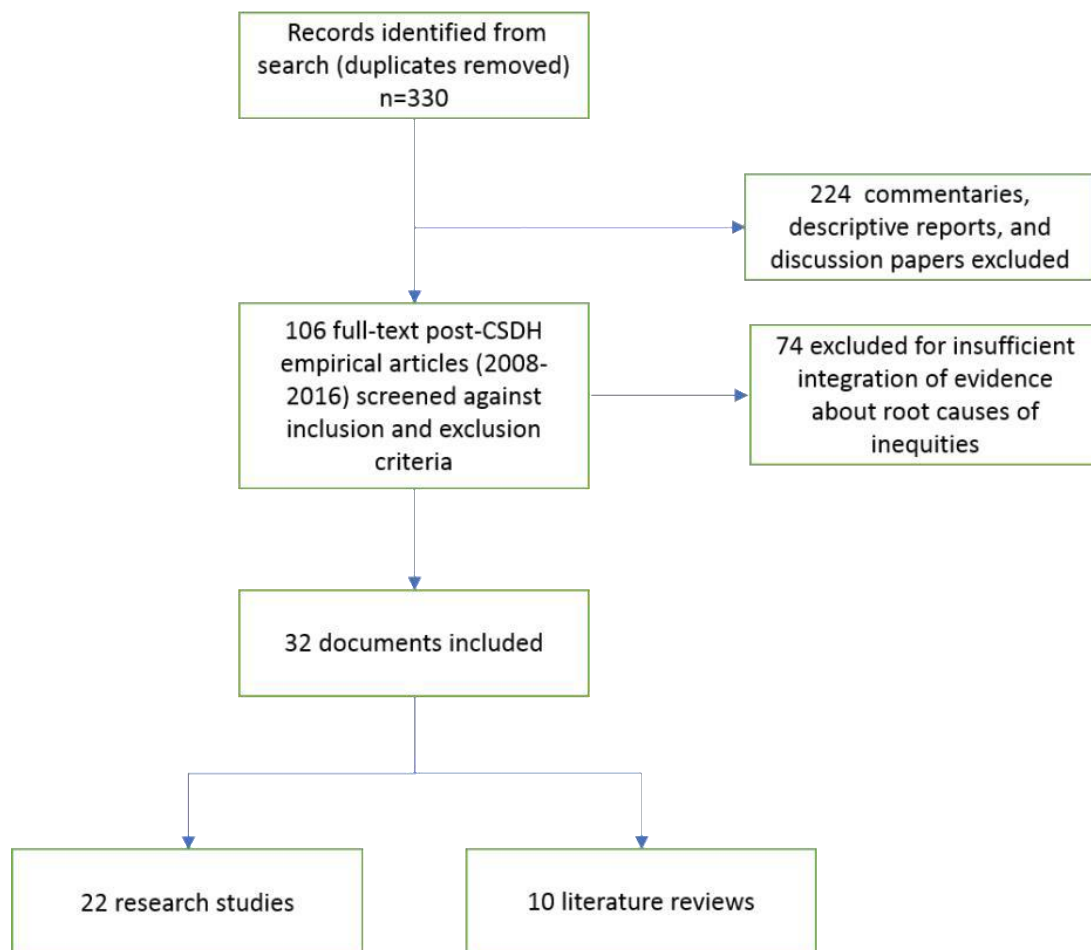
Figure 4.1. PRISMA flow diagram of search and selection results for CIS.

Table 4.4

Data Extraction and Assessment Summary, Literature Reviews

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Andermann (2016) Medicine, Canada	Taking action on the social determinants of health in clinical practice: A framework for health professionals	To provide "concrete actions" that clinicians can use in their daily practice to help address SDOH (p. E474).	Realist review	Individual, neighborhood, and community-level health equity practices of practitioners (especially physicians)	Interrupt	AO(0) + Des(0) + Met(1) + D(1) + An(0) PRISMA guidelines not followed	2
Carey, Crammond, & Keast (2014) Population Health, Australia	Creating change in government to address the social determinants of health: How can efforts be improved?	"to identify lessons from the exiting [sic] body of evidence JUG [joined-up government], which can help strengthen IPIs currently being implemented, through a meta-analysis of joined-up government initiatives" (p. 5).	Meta-synthesis of policy research	Systems-level interventions for leveraging health equity, using Johnston's intervention level framework and Meadow's 12 places to intervene	Illuminate	AO(2) + Des(2) + Met(1) + D(2) + An(1) PRISMA guidelines followed	8
Chircop, Basset, & Taylor (2015) Nursing, Canada	Evidence on how to practice intersectoral collaboration for health equity: A scoping review	"to generate insight into the current scientific literature to scope out the extent of peer-reviewed publications on intersectoral collaboration for public policy toward health equity, and to identify gaps in the literature about evidence-based approaches to	Scoping review	Intersectoral collaboration as a practice for policy action for health equity	Illuminate	AO(2) + Des(2) + Met(1) + D(2) + An(1) PRISMA guidelines not followed, but scoping review methodology clearly described	8

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
		intersectoral collaboration practices for health equity- oriented policy action" (p. 180).					
Cohen & Marshall (2017) Nursing, Canada	Does public health advocacy seek to redress health inequities? A scoping review	"to obtain an overview of the literature related to public health advocacy, with a particular interest in the extent to which this literature addresses the goal of reducing the social, environmental and structural causes of health and social inequities" (p. 310)	Scoping review	Public health advocacy for reducing the social, environmental and structural causes of health and social inequities	Illuminate	AO(1) + Des(2) + Met(2) + D(2) + An(2) Advocacy not defined PRISMA guidelines followed	9
Davison, Ndumbe-Eyoh, & Clement (2015) Public Health, Canada	Critical examination of knowledge-to-action models and implications for promoting health equity	"to identify existing knowledge to action models or frameworks and critically examine a promising subset of them as to their utility for promoting or supporting health equity" (p. 2).	Scoping review	Knowledge-to-action frameworks that describe ways to bridge the *know-do gap*	Acknowledge	AO(2) + Des(0) + Met(2) + D(2) + An(2) PRISMA guidelines not followed	8

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Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Farrer et al. (2015) Public Health, Belgium	Advocacy for health equity: A synthesis review	"to synthesize the evidence in the academic and gray literature and to provide a body of knowledge for advocates to draw on to inform their efforts." (p. 392)	Critical interpretive synthesis	Advocacy, defined *as a deliberate attempt to influence decision makers and other stakeholders to support or implement policies that contribute to improving health equity using evidence*	Illuminate	AO(2) + Des(2) + Met(2) + D(2) + An(1) PRISMA guidelines followed	9
Ndumbe-Eyoh & Moffatt (2013) Health Sciences, Canada	Intersectoral action for health equity: A rapid systematic review	"to examine the impact and effectiveness of intersectoral action as a public health practice for health equity through action on the SDH" (p. 2)	Rapid systematic review	Intersectoral interventions, policies and programs, undertaken by the public health sector in collaboration with governmental and non-governmental sectors outside of health	Illuminate	AO(2) + Des(2) + Met(2) + D(2) + An(1) PRISMA guidelines followed	9
Newman et al. (2015)	Addressing social determinants of health inequities through settings: A rapid review	To provide "a rapid review of what settings-based health promotion approaches are effective in addressing the social	Rapid review	Work in settings that has reduced, or shown promise in reducing, health inequities;	Illuminate	AO(2) + Des(2) + Met (1)+ D(2) + An(0)	7

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Geography, Australia		determinants of health inequities" (p. 127).		settings approaches that address social determinants of health; and policy and programme work in settings		PRISMA guidelines not followed; analytical processes not described	
Shareck, Frohlich, & Poland (2013) Social Medicine, Canada	Reducing social inequities in health through settings-related interventions: A conceptual framework	To understand how a settings approach can inform action to reduce social inequities in health by identifying challenges and "proposing a 'settings praxis' to help overcome them and inform an innovative, equity-focused use of the settings" (p. 40).	Scoping review	How to avoid exacerbating inequities through settings approaches; what (and how to apply) elements of a settings approach specifically focus on reducing social inequities in health	Illuminate	AO(2)+ Des(0) + Met(1) + D(2) + An(1) Scoping review methodology not described; PRISMA guidelines not followed	6
Weiler et al. (2015) Sociology, Canada	Food sovereignty, food security and health equity: A meta-narrative mapping exercise	"1) to map key narratives from scholarly research on intersections between food security and health equity and (2) to identify evidence of how food sovereignty interventions can be implemented to promote health equity" (p. 1081).	Narrative synthesis	How to apply food sovereignty principles to health equity research and practice, which emphasizes communities' power to democratically	Illuminate	AO(2) + Des(2) + Met(1) + D(2) + An(2) Clear analytic framework provided; PRSIMA guidelines followed (although	9

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Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
				manage food systems resources and trade		flow chart not provided)	

*Discipline and location reported for primary author

Table 4.5

Data Extraction and Assessment Summary, Research Studies

| | | | | | | **Assessment of Articles** | |
Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Baum et al. (2010) Public Health, Australia	Can a regional government's social inclusion initiative contribute to the quest for health equity?	To examine "the evidence to determine if a social inclusion initiative is a useful aspect of government action to reduce health inequity" (p. 475).	Rapid appraisal using case studies	Social inclusion initiative Apply the WHO Social Exclusion Knowledge Network framework	Illuminate	AO(1) + Des(1) + Met(1) + D(1) + An(2) Document review + policy analysis + key informant interviews (n=10)	5
Baum et al. (2013)	"Never mind the logic, give me the numbers": Former Australian health	To report "empirical information relevant to theoretical debates about political and other factors	Qualitative	Policy windows for action on SDH	Illuminate	AO(1) + Des(0) + Met(1) + D(1) + An(1)	4

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Public Health, Australia	ministers' perspectives on the social determinants of health	influencing translation of evidence into policy. It reports on the views of twenty former health ministers about policy opportunities during their tenure to address SDH and health inequities" (p. 139).		Apply Kingdon's Policy theory		Interviews with former health ministers (n=20) No specific qualitative approach named	
Blanchard et al. (2013) Health Promotion, France	Improving policy and practice to promote equity and social justice: A qualitative comparative analysis building on key learnings from a twinning exchange between England and the US	"to share and develop a better understanding of strategies for actions that can effectively address the SDH and social injustice" (p.46).	Qualitative	Learning exchanges used as a means to identify and examine lessons learnt, drivers, factors for success and strategies that work for action on SDH	Illuminate	AO(1) + Des(1) + Met(2) + D(1) + An(1) Questionnaires (n=16 organizations) No specific qualitative approach named, state use 'thematic analysis' in analysis	6
Borde, Akerman, & Pelligrini (2014)	Mapping of capacities for research on health and its social determinants in Brazil	"to contribute to the identification of capacities for research on health and its social determinants in Brazil by mapping research activities and the scope of SDH research as well as	Mapping study	Health research systems and capacity for SDH research	Illuminate	AO(1) + Des(0) + Met(2) + D(1) + An(1) Literature reviews + semi-structured key	5

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Public Health, Brasil		research system structures, policies and networks defining research on health and its social determinants in Brazil, focusing on the developments since the establishment of the World Health Organization Commission on SDH (CSDH) in 2005" (p. 2082).				informant interviews + database (knowledge translation platforms) consultations No specific mapping methodology described	
Brassolotto et al. (2014) Health Policy, Canada	Epistemological barriers to addressing the social determinants of health among public health professionals in Ontario, Canada	"to examine our assumption that there might be epistemological challenges to PHUs applying [social determinants of health] concepts… [and] to understand the worldviews of public health officials concerning these issues" (p. 2).	Qualitative interviews	Daily public health work	Illuminate	AO(1) + Des(0) + Met(1) + D(2) + An(2) No specific qualitative approach named; orientation to root causes of health inequities well described	6
Cacari-Stone et al. (2014)	The promise of community-based participatory research for health equity: A	To explore how community-based participatory research (CBPR) responds to two knowledge-to-action challenges: "1) the gap	Descriptive case study	Community-based participatory research practices	Interrupt	AO(1) + Des(0) + Met(0) + D(1) + An(1)	3

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Public Health, United States of America	conceptual model for bridging evidence with policy	between scientific evidence and policy action based on evidence, and (2) the difficulty of mobilizing civic engagement for policymaking in the United States" (p. 1615).		Derive a framework linking CBPR and policy making		No specific qualitative approach named	
Carey & Crammond (2015) Epidemiology & Public Health, Australia	Systems change for the social determinants of health	To review evidence on joined-up approaches, illuminating 'system leverage points' and how action for change can be effective in complex systems that determine health outcomes.	Policy analysis	Systems-level approaches for leveraging action on causes of health inequities Analytical framework includes an adapted version of Meadow's '12 places to intervene in a system'	Illuminate	AO(1) + Des(2) + Met(2) + D(2) + An(2)	9
deAndre et al. (2015) Medicine, Brasil	Social determinants of health, universal health coverage, and sustainable development: Case studies from	To "assess the experiences in the design and implementation at national scale social programmes underpinned by intersectoral action and social participation aimed at addressing social determinants of health,	Case series*	Health systems collaboration with other sectors to address upstream determinants of	Interrupt	AO(0) + Des(1) + Met(1) + D(1) + An(2) Document review + secondary analysis of public health outcomes data	5

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Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
	Latin American countries	improving health, and reducing health inequities" (p. 1344).		health; universal health coverage		(n=4 cases: Brasil, Chile, Columbia, and Cuba) Strong analysis of sociopolitical and historical contexts	
Estey et al. (2010) Knowledge Translation, Canada	Thinking about aboriginal KT: learning from the Network Environments for Aboriginal Health Research British Columbia (NEARBC)	"to highlight the complexity of Aboriginal KT (a shorthand used by the authors to refer to KT in Aboriginal health research contexts), but also areas for action" (p. 83).	Exploratory case study	Indigenous approaches in knowledge translation	Illuminate	AO(2) + Des(1) + Met(1) + D(2) + An(1) Interviews with people involved in the Network Environments for Aboriginal Research British Columbia (n=10)	7
Gore & Kothari (2012) Health Sciences, Canada	Social determinants of health in Canada: Are healthy living initiatives there yet? A policy analysis	"to evaluate healthy living initiatives in BC and ON that focus on healthy eating and physical activity based on their approach to the social determinants of health and health inequities" (p. 3).	Policy analysis	Healthy living initiatives Derive an analytical framework to assess policies for type of initiative (life-	Illuminate	AO(2) + Des(2) + Met(1) + D(2) + An(2) Searched documents, website, database, and health organizations to	9

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
				style, environment, or structural) and mechanism (direct program, blueprint, or building block)		identify initiatives in 2 Canadian provinces (n=60 Ontario initiatives; n=61 British Columbia initiatives)	
Grundy et al. 2014 Global Health, Cambodia	Improving average health and persisting health inequities: Towards a justice and fairness platform for health policy making in Asia	To "describe the existing trends in inequity reduction" in eight Asian countries (Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Phillipines, Vietnam) …"and then to consider the implications of these findings for the practice of health policy making at national and global level" (p. 875).	Case Comparison	Wealth re-distribution and universal access policies	Illuminate	AO(1) + Des(1) + Met(1) + D(1) + An(1) Literature review + secondary analysis of Demographic Health Survey Data No specific methodological approach named	5
Kirst et al. (2017) Psychology, Canada	Addressing health inequities in Ontario, Canada: What solutions do the public support?	To "examine the relationship between how the public attribute health inequities and support for targeted vs. broader health equity interventions" (p. 2).	Survey study with multivariate analysis	Public knowledge and opinion about health equity; call for messaging that connects health inequities with distribution of power and privilege	Illuminate	AO(2) + Des(2) + Met(2) + D(2) + An(2) Telephone surveys (n=2006)	10

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	**Assessment of Articles** Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
				between rich and poor			
Knight (2014) Public Policy, USA	Shifting public health practice to advance health equity: Recommendations from experts and community leaders	To "build on the *Unnatural Causes* campaign by gathering and disseminating recommendations about public health strategies for achieving health equity" (p. 189).	Qualitative	Documentary as means of raising public awareness of nature and context of health inequities	Illuminate	AO(1) + Des(1) + Met(1) + D(2) + An(1) Interviews (n=29)	6
Labonté et al. (2014) Population Health, Canada	Is the Alma Ata vision of comprehensive primary health care viable? Findings from an international project	To explore how mentored research teams using an integrated knowledge translation approach (teams included triads of junior + senior researchers and research users) could integrate health equity work through primary health care initiatives in 20 teams from multiple countries	Case series*	Action on structural and SDH through comprehensive primary healthcare	Illuminate	AO(2) + Des(1) + Met(1) + D(2) + An(1) Synthesis of findings from 20 different studies using a common mentored and integrated knowledge translation approach; methodological foundations for synthesis not described	7

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
McPherson et al. (2016) Nursing, Canada	Swimming against the tide: A Canadian qualitative study examining the implementation of a province-wide public health initiative to address health equity	To "examine the strategy of developing and implementing equity-focused positions to improve public health organizational capacity to act on SDH and advance health equity" (p. 3).	Descriptive qualitative case study	Public health nursing practices	Interrupt	AO(2) + Des(2) + Met(2) + D(2) + An(2) Interviews (n=42) + document review (n=226)	10
Mtenga, Masanja, & Mamdani (2016) Social Science, Tanzania	Strengthening national capacities for researching on social determinants of health (SDH) towards informing and addressing health inequities in Tanzania	To explore "the SDH landscape in Tanzania. Specifically, the conceptualisation, nature, extent and reach of SDH research, supporting national systems and processes for SDH research" (p. 3).	Research systems mapping	Cultivating structure and capacity for health research systems Some gaps in methodological clarity, but strong integration of SDH capacity-building framework and comprehensive discussion of methods (process) and results	Illuminate	AO(1) + Des(1) + Met(2) + D(2) + An(1) In-depth stakeholder interviews (n=34) + policy analysis + SDH research outputs (published) from 2005 onward	7

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles	
						Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Murphy et al. (2015) Health Sciences, Canada	Making a commitment to ethics in global health research partnerships: A practical tool to support ethical practice	To create processes and tools for enabling "respectful, mutually beneficial, and effective North–South research partnerships" (p.141).	iKT/PAR	Equity-promoting practices for research partnerships, especially in global health research	Interrupt	AO(2) + Des(1) + Met(1) + D(2) + An(2) Engaged consultation + dialogue using local case studies Consultations held in South Asia, Africa, & Latin America, n≈30 per site	8
Povall et al. (2014) Public Health Policy, UK	Health equity impact assessment	To "determine whether or not a new HEIA [health equity impact assessment] methodology is needed to examine the health equity impacts of global, regional, national and local financial and public policies" (p. 622).	Mixed methods*	Health equity impact assessment methodologies and equity-attunement	Illuminate	AO(2) + Des(2) + Met(1) + D(1) + An(2) Scoping review + interviews (n=14) + workshops (n=19)	8
Raphael & Brassolotto (2015)	Understanding action on the social determinants of health: A critical realist analysis of in-depth	To "consider the factors that shape local PHU action on the SDH through a critical realist analysis" (p. 1) by "elucidating the existing societal structures and powers that enable	Critical realist approach	Leadership practices and perspectives of public health leaders and workers	Illuminate	AO(2) + Des(2) + Met(2) + D(2) + An(2)	10

						Assessment of Articles	
Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Health Policy, Canada	interviews with staff of nine Ontario public health units	SDH-related activities and identifying factors that either facilitate or prevent the activation of these structures and powers. We also consider how institutional factors interact with personal characteristics of MOHs and features of local jurisdictions to shape the form of SDH activities" (p. 3).				Document review + interviews (n=18)	
Raphael, Brassolotto, & Baldeo (2014) Health Policy, Canada	Ideological and organizational components of differing public health strategies for addressing the social determinants of health	To "investigate how individual characteristics of Medical Officers of Health (MOH) and unit staff (e.g. background training, personal experiences and understandings of the SDH), community features (e.g. urban versus rural, political climate and governance structures) and organizational features (e.g. central versus devolved SDH structures, leader- ship and training) account for these differences in PHUs' SDH activities" (p. 856).	Qualitative	Ideological and organizational characteristics relationship to the type of SDH work carried out in public health units Findings suggest a need for more structural approaches	Illuminate	AO(1) + Des(1) + Met(1) + D(2) + An(1) Document analysis + interviews (n=18)	6

Authors (Year) Discipline, Location*	Title	Study Purpose	Methods	Practices Examined or Derived	Orientation to Root Causes	Assessment of Articles	
						Clarity/Quality Assessment AO + Des + Met + D + An Comments	Score
Tolhurst et al. (2012) International Health, UK	Intersectionality and gender mainstreaming in international health: Using a feminist participatory action research process to analyse voices and debates from the global south and north	To "contribute to the debate on the implications of [the] failure for future action for gender equity in health" through "productive dialogue" that brings "together the voices of disparate actors, first heard in a series of four seminars held during 2008 and 2009, involving almost 200 participants from 15 different country contexts" (p. 1826).	Feminist participatory action research	Research, policy, and knowledge translation practices for promoting gender equity	Interrupt	AO(2) + Des(2) + Met(1) + D(2) + An(2) Dialogues (n=200+)	9
Young (2011) Health Sciences, Australia	Exploring discourses of equity, social justice and social determinants in Australian health care policy and planning documents	To assess how "social determinants understanding [is] demonstrated in Australian health policy documents," questioning if an SDH or alternate framework prevails (p. 369).	Discourse analysis	Use of SDH language and discourses in policy writing at "micro (word searching), meso (documentary overview and reflection) and macro (sociopolitical reflection) levels" (p. 370)	Illuminate	AO(2) + Des(2) + Met(2) + D(2) + An(2) Analysis of policy documents (n=8)	10

*Discipline and location reported for primary author

4.4 Advancing KTA for Health Equity Involves Advancing Equity Attunement

Through their research questions and study designs, these 32 articles assessed health equity action in a variety of settings, ranging from research and KT, to policy and practice (Table 4.6). Virtually all articles focused on understanding receptivity to or influencing alignment with evidence about root causes of health inequities. The frequency of this interest and analysis of the ways in which authors attempted to understand and influence degrees of alignment with evidence about root causes of health inequities, led to development of an analytical concept called *equity attunement*. To be *attuned* is to "make receptive or aware; accustom or acclimatize; make harmonious" (Oxford English Dictionary, 2015). Equity attunement was defined as the degree to which something or someone is receptive, aware, accustomed or acclimatized, and/or harmonized with the best available knowledge about health inequities. Composed of three distinct considerations, the concept of equity attunement evolved directly from articles' consistent focus on the health equity impacts of how health inequities are framed.

Three commonalities were found among articles in their descriptions of how framing of health inequities directly influenced the potential impact of health equity work: recognition of health equity work as socially embedded; explicit problematizing of health inequities and framing them as actionable; and integration of a political economy lens. The frequent descriptions of these three considerations as leading influencers of the direction and impact of health equity work, gave rise to equity attunement as a central concept from which promising practices for health equity unfold. The first consideration, situating health equity work as embedded in social contexts, was related to acknowledging social complexity. In all 22 articles, researchers suggested that meaningful health equity work required recognition of the social contexts in which health inequities are experienced. Authors frequently acknowledged health inequities as socially situated and constructed, drawing from both the CSDH and social theory to support their assertions. For example, in their equity-focused assessment of KT frameworks, Davison and colleagues (2015b) explicitly framed health equity work as involving individuals who "engage in organizations that, in turn, exist in social environments" (p. 7). In another example exploring KT *as* health equity work, Estey and colleagues (2010) explored what this means in the context of Aboriginal health. These authors described KT as a deeply relational process, where effort is made to "increase our mutual understanding of something" (p.83) in community. The authors pointed to the importance of inclusion and bringing diverse voices to the table to generate knowledge, clearly framing the work of KT and health equity as socially situated.

Problematizing health inequities and framing them as actionable, the second of these considerations, was important to equity attunement because of its role in setting the directional gaze of any kind of health equity work. All of the included studies framed health inequities as rooted in social determinants of health. Yet, several studies revealed that when health equity work was grounded in individualist or bio-behavioral constructions of health inequities, the direction of practice took attention and resources away from the known causes (Andermann, Pang, Newton, Davis, & Panisset, 2016; Baum et al., 2013; Baum, Newman, Biedrzycki, & Patterson, 2010; Brassolotto et al., 2013; Cohen & Marshall,

2017; Farrer et al., 2015; Gore & Kothari, 2012; Newman, Baum, Javanparast, O'Rourke, & Carlon, 2015; Raphael et al., 2014; Shareck et al., 2013; Weiler et al., 2015; Young & McGrath, 2011). Researchers also found that how health inequities were portrayed directly influenced how and where KTA work was prioritized. When health inequities were problematized, priority was placed on doing work to affect upstream and structural determinants of health equity (McPherson et al., 2016; Raphael & Brassolotto, 2015; Raphael et al., 2014). Without this frame, researchers found that priority tended to fall to individualist, behavioural work (McPherson et al., 2016; Raphael & Brassolotto, 2015; Raphael et al., 2014). However, when health inequities were understood as being tied up in systems and structures, KTA interventions were conceptualized as such. For example, McPherson et al. (2016), provide an in-depth discussion about how embedding dedicated SDH nursing roles required deep attention to system structures, including how power and resources are distributed within health systems bureaucracy. This example illuminates the need for thinking about how the framing of health inequities *within* institutions and structures directly shapes the kinds of health equity action that can evolve.

In one scoping review (Cohen & Marshall, 2017), authors concluded that the literature on public health advocacy for health equity reflected "a neoliberal preoccupation with individual responsibilities for healthy lifestyles and decisions" (p. 322). In another qualitative study using in-depth, semi-structured interviews with leaders from 21 public health organizations (Knight, 2014), researchers found that despite participants' consistent problematizing of health inequities as unjust and avoidable, not enough was being done to address health inequities in public health practice. They called for public health efforts that distinguish SDH and "their structural precursors in social and political institutions" (Knight, 2014, p. 193), with transformation toward ideology "collective action and responsibility" (p. 195). Collectively, these findings, which point to the need for responses to the injustices of health inequities, are grounded in a belief that they are actionable.

Finally, several articles explored the degree to which acknowledgement of political economy shaped the orientation of health equity work (Blanchard et al., 2013; de Andrade et al., 2015; Gore & Kothari, 2012; Knight, 2014; Raphael et al., 2014). Evidence in several studies pointed to the need for politicized models of social determinants of health (Gore & Kothari, 2012) that explicitly situate health within political sciences and political economy frames (Brassolotto et al., 2013; Raphael & Brassolotto, 2015; Raphael et al., 2014). Together, researchers used these three considerations to explore how attuned organizations or professionals were to the evidence about root causes of health inequities.

Table 4.6

Attention to Notions of Equity Attunement Among Literature Reviews and Research Articles

Equity Attunement Assessed in…	Articles
Policy environments	(Baum et al., 2013, 2010; Blanchard et al., 2013; Carey & Crammond, 2015b; Grundy, Annear, Chomat, Ahmed, & Biggs, 2014; Povall, Haigh, Abrahams, & Scott-Samuel, 2014; Tolhurst et al., 2012; Young & McGrath, 2011)

Equity Attunement Assessed in…	Articles
Health practice settings	(Andermann, 2016; Blanchard et al., 2013; Brassolotto et al., 2013; Gore & Kothari, 2012; Raphael & Brassolotto, 2015; Raphael et al., 2014)
Healthcare systems	(Labonté, Sanders, Packer, & Schaay, 2014; McPherson et al., 2016)
Health research systems	(Borde et al., 2014; de Andrade et al., 2015; Mtenga et al., 2016)
Research or KT approaches	(Cacari-Stone et al., 2014; Davison et al., 2015b; Estey, Kmetic, & Reading, 2010; Murphy et al., 2015)
The general public	(Kirst et al., 2017; Knight, 2014).
Settings	(Newman et al., 2015; Shareck et al., 2013)
Inter-sectoral action/collaboration	(Carey, Crammond, & Keast, 2014; Chircop, Bassett, & Taylor, 2015; Ndumbe-Eyoh & Moffatt, 2013; Weiler et al., 2015)
Advocacy	(Cohen & Marshall, 2017; Farrer et al., 2015)

4.5   Emergent Promising Practices for Advancing Health Equity

Four distinct groups of promising practices for connecting KTA for health equity were identified: ways of structuring systems, ways of working relationally, ways of doing research, and ways of doing KT. Each worked collectively on and were collectively influenced by equity attunement (Figure 4.2). An overview of these practices and the evidence-informed ways of achieving them is provided below. A more detailed discussion of the evidence to support these practices follows and is organized around the four kinds promising practices.
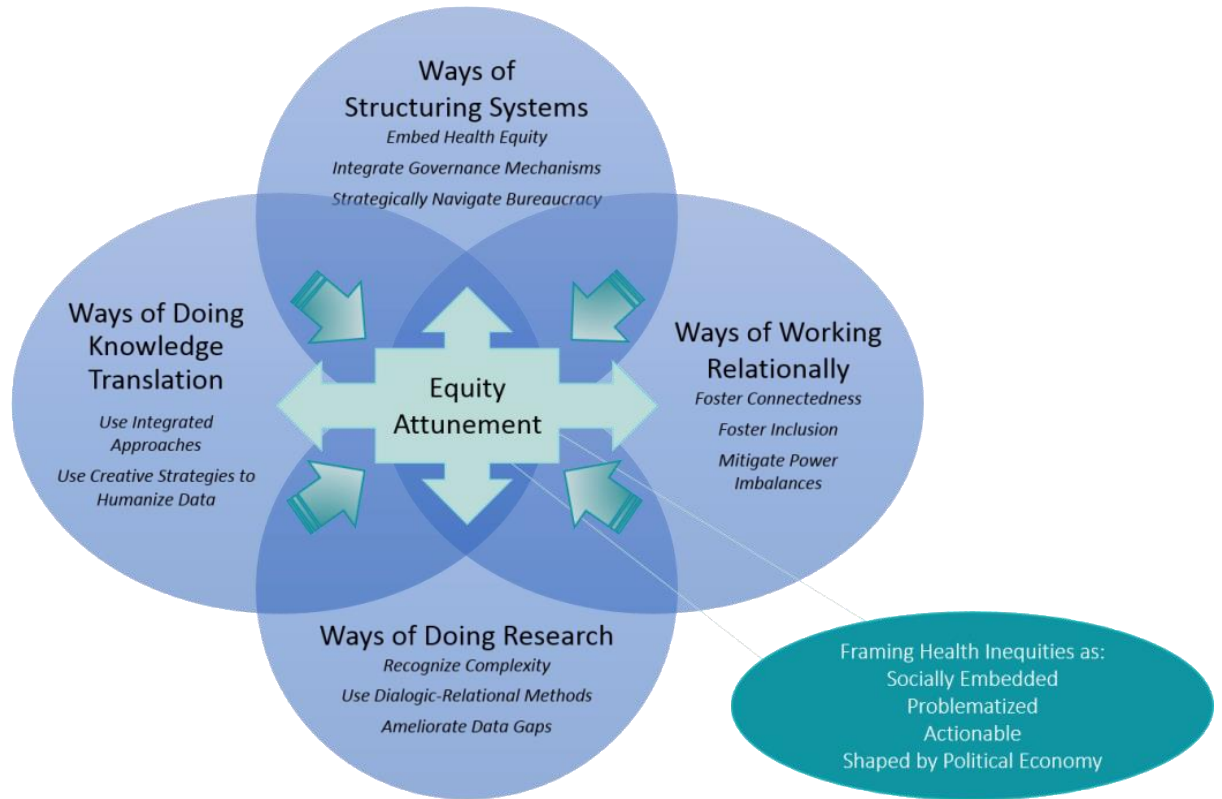
Figure 4.2. Promising KTA practices for health equity.

4.5.1 Promising Practices for Structuring Systems

Systems are "a set of connected things or parts forming a complex whole" (Oxford English Dictionary, 2015). They are the socially constructed, interconnected mechanisms and patterns that enable implementation of ideology, values, and evidence in policy and practice. Promising practices for structuring systems were defined as mechanisms and patterns for which there was evidence that they enable health equity work. These patterns unfold through *governance*, which entails the processes and mechanisms through which inclusion, agenda setting, and implementation planning for health equity are carried out (Kelaher et al., 2014). Three promising practices for structuring systems in ways that can support KTA for health equity were: (a) integrate (defragment) governance mechanisms; (b) embed a policy of health equity at systems-levels; and (c) strategically navigate bureaucratic hierarchies. Among the studies reviewed, researchers examining systems settings consistently reported that the architecture of systems influenced how social determinants of health or health equity work unfolded. Though much of the literature pointed to the need for attention to issues of governance, only 3 studies explicitly focused on governance issues (Carey, Crammond, Malbon, & Carey, 2015; Chircop et al., 2015; Labonté et al., 2014). Notably, among these 3 studies were 2 robust scoping reviews and a large international case series.

Governance was indirectly explored through 4 additional studies that focused on healthcare systems. In these 4 studies, authors concluded that healthcare systems are promising targets for structural interventions for health equity (Borde et al., 2014; Labonté et al., 2014; McPherson et al., 2016; Raphael & Brassolotto, 2015). However, each of these studies also pointed to the political vulnerability of health equity agendas, problematizing the broader sociopolitical hierarchies within which healthcare systems operate. Evidence from these studies and 3 additional literature reviews suggested that bureaucratic hierarchies and structures of these systems play an important role in how health equity action work can unfold. More promising were savvy governance structures that recognized the nature of bureaucracies and the need for clearly aligned health equity agendas with structural mechanisms to enable action (Brassolotto et al., 2013; Carey et al., 2014; McPherson et al., 2016; Newman et al., 2015). For example, McPherson et al. (2016), examined the impact of senior and middle management support on a health equity agenda and the role of a dedicated nursing role focused on social determinants of health. In this qualitative case study, researchers found that the positioning of social determinants of health nurses within the healthcare system was a key determinant of the efficacy and direction of their work. In another example, despite provincial mandates for these nurses to be involved in reporting about the impact of their roles, some were excluded and did not have a voice in shaping what or how health equity work was reported. In these cases, management did not solicit their input.

This finding was reinforced by a scoping review on public health advocacy (Cohen & Marshall, 2017). These authors reviewed research in which public health nurses reported feeling powerless because of administrative constraints, particularly when demands exceeded resources. Further, nurses' reports highlighted the constraints they experienced as a result of excessive workloads, apathy, and incoherence between the downstream focus that tends to dominate healthcare and the upstream demands of health equity work (Cohen & Marshall, 2017). Both studies examined embedded roles with direct responsibilities for health equity work. Both McPherson et al. (2016) and Cohen and Marshal (2017) noted that vulnerability to bureaucratic culture, hierarchy, and norms only reinforces the need for strategic positioning and support of health-equity-oriented roles. Two sets of authors found that because the livelihoods of people working in such roles depend on their performance within bureaucratic structures that are resistant to change, the ways systems are structured and governed can restrict health equity work (Labonté et al., 2014; McPherson et al., 2016). In their analysis, McPherson and colleagues (2016) included a discussion of the social and political power of nurses in hierarchical health systems, pointing to the influence of intense systems complexity on the capacity of specifically-designated SDH nurses to do structurally-oriented health equity work. The influence of social positioning and power were also discussed by Labonté and colleagues (2014) in order to explain findings related to health equity work in their examination of the role of community health workers in primary health care in an international case series project.

Table 4.7

Promising Ways of Structuring Systems

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
Embed a policy of health equity at systems-levels	Integrate human rights obligations with KT messaging (e.g., health inequities data) to advance high-level integration of health equity.	Blanchard 2013, Cohen 2017, Davison 2015, Farrer 2015, Labonté 2014, Mtenga 2016, Newman 2015, Povall 2013, Shareck 2013.
	Integrate a commitment to health equity as a foundational principle and/or strategic goal in governance structures, such as governments (municipal, regional, provincial/state, federal), public agencies (e.g., healthcare systems, educational systems), and professional bodies.	Borde 2014, Brassolotto 2013, Cohen 2017, Knight 2014, Labonté 2014,; McPherson 2016, Raphael 2014, Raphael 2015, Weiler 2015.
Integrate (defragment) governance mechanisms *This practice is particularly promising when also using promising practices for working relationally.*	Identify, assess, and adapt governance processes and bodies involved in making decisions about who is involved, what is to be achieved, and how it is to be implemented (Kelaher, 2014) for health equity (and equity-related) work, striving for transparency.	Baum 2010, Carey 2014, Chircop 2014, de Andrande 2015, Labonté 2014, McPherson 2016, Newman 2015, Raphael 2015, Shareck 2013.
	Use tools that enable integrated (i.e., cross-sector and discipline) governance, such as equity-sensitive health impact assessments, health-in-all policies, or joined-up or whole-of-government approaches to address health equity issues and needs at the population level.	Baum 2010, Brassolotto 2013, Carey 2014, Chircop 2015, Knight 2014, Newman 2015, Povall 2014, Raphael 2015, Shareck 2013.
	Actively engage education sectors in efforts to embed health equity in policy, with particular attention to raising public awareness of the relationship between political economy and social justice in school settings (i.e., with children and youth) and enhancing both knowledge and capacity through the education of health professionals (nurses, physicians, allied health) and social workers.	Andermann 2016, Cohen 2017, de Andrande 2015, Farrer 2015, Gore 2012, Newman 2015, Raphael 2015, Weiler 2015.
Strategically navigate bureaucratic hierarchies	Be attentive to bureaucratic culture and norms and issues leadership, accountability, influence, and authority when embedding health equity work or dedicated roles.	Brassolotto 2013, Carey 2014, Chircop 2014, McPherson 2016, Raphael 2014, Shareck 2013, Young 2011.

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
	Align health equity agendas with structural mechanisms to enable action.	Brassolotto 2013, Carey 2014, McPherson 2016, Newman 2015.
	Cultivate health equity champions and leaders.	Blanchard 2013, Brassolotto 2013, Cacari-Stone 2014, Carey 2014, Davison 2015, de Andrande 2015, Labonté 2014, Raphael 2014, Raphael 2015.

4.5.2 Working Relationally as a Promising Practice

During this study, three promising ways in which actors, both individual and organizational, can work together were found: (a) foster connectedness; (b) foster inclusion; and (c) mitigate power imbalances. These practices were about illuminating and fostering greater connectedness between people, ideas, organizations, bodies of knowledge, and/or contexts. More promising approaches explicitly focused on equity or social justice (Davison et al., 2015b) and combined structural approaches (i.e., upstream, structural determinants of health) with some kind of power analysis (Murphy et al., 2015; Povall et al., 2014). Working in transdisciplinary, cross-sector ways was found to be promising because of its contribution to continuity and sustainability (Baum et al., 2010; Blanchard et al., 2013; Cohen & Marshall, 2017; Farrer et al., 2015). These authors described working across disciplines and sectors as a buffer to short-term political and budgetary cycles that can constrain action for health equity in research studies. Other benefits of this way of working included enhancing collective appreciation for the contributions of different domains of research (Borde et al., 2014; Davison et al., 2015b; Estey et al., 2010); enabling context-responsiveness (Davison et al., 2015b; McPherson et al., 2016); and enhancing capacity to navigate complexity (Baum et al., 2013; Borde et al., 2014; Chircop et al., 2015; Davison et al., 2015b; Estey et al., 2010; Labonté et al., 2014; Mtenga et al., 2016; Ndumbe-Eyoh & Moffatt, 2013; Newman et al., 2015; Shareck et al., 2013). This broad range of benefits provided a strong foundation for exploring nuance in fostering inclusion as a promising practice.

One research article demonstrated how fostering inclusion is a promising practice by asking questions and purposively seeking to overcome inequities in why, who, and how particular people or groups are engaged in health equity work (Murphy et al., 2015). This study and one other (Labonté et al., 2014) were designed purposefully to enable genuine, non-tokenistic mechanisms for giving voice to historically excluded groups. Based on their international case series, Labonté and colleagues (2014) described how a more inclusive process of decision making could have contributed to more informed and equitable allocation of resources when an ambulance (with no recourses for a driver) was purchased for a region with no roads, but only waterways. These authors highlighted the "difficulties that local communities often experience in gaining access to the higher level economic and policy decisions that condition and constrain their local community efforts" (p.11). In 2 other studies, authors concluded that

participation in health equity research or KT is not *de facto* inclusive and yet, necessitates inclusivity to advance equity action (Estey et al., 2010; Labonté et al., 2014).

Several articles explored how fostering inclusion of non-scientific and non-health actors was important in health equity work. In these examples, fostering inclusion involved 'thinking outside the box' of actors traditionally engaged in research or knowledge translation. Researchers found this necessary because health equity work was recognized as a process of transforming social and political environments that rely on political will and public sentiment (Baum et al., 2013; Brassolotto et al., 2013; Gore & Kothari, 2012; Raphael & Brassolotto, 2015; Raphael et al., 2014). Often, because of the clashes between dominant political ideology and cultural norms, appealing to public sentiment and political will requires challenges to dominant discourses of things like 'deservingness' (Knight, 2014). Findings in the included studies indicated that creating an environment of pressure on decision makers and power-holders was important (Farrer et al., 2015), with public engagement as a key mechanism to do so (Borde et al., 2014; Carey et al., 2014; Cohen & Marshall, 2017; Newman et al., 2015).

Evidence also supported the opportunistic practice of leveraging power and resources, both within research processes and generally in health equity work (Andermann, 2016; Blanchard et al., 2013; Labonté et al., 2014; Murphy et al., 2015). This practice was categorized as relational because it requires recognition of the interconnectedness of people and power in the active construction of social worlds. Largely in discussion sections, some authors suggested the need for greater awareness and *mitigation* of power imbalances in health equity work (Raphael et al., 2014; Shareck et al., 2013; Tolhurst et al., 2012). Recognizing health inequities as driven by the maldistribution of resources and money, Blanchard and colleagues (2013) found through their qualitative analysis that these upstream issues remained underfunded and marginalized in high-level policy structures that play an important role in national and global distribution of money and resources. Leveraging resources and effort to advance health equity was also described in an international case series (Labonté et al., 2014), where the primary health care initiatives were leveraged to address issues of health equity. Though imperfect, researchers found that primary health care reforms were contributing to efforts to understand and acknowledge SDH and advance broader, community engagement on issues of health equity.

Table 4.8

Promising Ways of Working Relationally

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
Foster connections and connectedness to enable more responsive, complexity-sensitive health equity work	Adopt transdisciplinary, cross-sector approaches to health equity work across multiple levels (i.e., local/municipal, regional, national, and international/global), maintaining an upstream-structural focus.	Baum 2010, Baum 2013, Blanchard 2013, Borde 2014, Brassolotto 2013, Chircop 2015, Cohen 2017, Davison 2015, de Andrande 2015, Estey 2010, Farrer 2015, Gore 2012, Kirst 2017, Labonté 2014, McPherson 2016, Mtenga 2016,

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
		Ndumbe-Eyoh 2013, Newman 2015, Raphael 2015, Shareck 2013, Weiler 2015
	Identify and examine underlying assumptions and discourses, with attention to how they shape the ways in which health inequities are framed and responded to (especially taken-for-granted assumptions underlying dominant discourses, such as neoliberalism, individualism, and bio-behaviourism).	Brassolotto 2013, Farrer 2015, Grundy 2014, Mtenga 2016, Raphael 2015, Weiler 2015, Young 2011
	Cultivate networks and supported learning communities as platforms for responsive collaboration and learning that can open new possibilities for doing structural health equity work.	Andermann 2016, Blanchard 2013, Labonté 2014, McPherson 2016, Mtenga 2016, Raphael 2014, Raphael 2015
	Take advantage of windows of opportunity on issues that, though narrow, could be creatively leveraged to respond to shared social and structural determinants of health.	Blanchard 2013, Farrer 2015, Gore 2012, Knight 2014, Labonté 2014, McPherson 2016, Tolhurst 2012
	Create a culture of collective responsibility and action; fostering a willingness to share roles and expertise is encouraged along with responsibilities and collective action.	Davison 2015, Estey 2010, Knight 2014, Wieler 2015
Foster inclusion of non-academic partners, with particular attention to those who may be historically excluded due to race/ethnicity, culture, gender, sexual orientation, Indigeneity, ableness, or other –isms	Actively assess for and mitigate inequities of why, who, and how particular people or groups are engaged in health equity work.	Murphy 2015, Labonté 2014, de Andrande 2015
	Create inclusive priority-setting and integrated KT processes.	Cacari-Stone 2014, Gore 2012, Murphy 2015, Knight 2014, Borde 2014, Labonté 2014, Mtenga 2016
	Include 'outside-the-box,' non-scientific and non-health actors, such as the media, social movements, and other actors that appeal to public sentiment and political will in health equity work.	Borde 2014, Brassolotto 2013, Cacari-Stone 2014, Carey 2014, Cohen 2013, de Andrande 2015, Farrer 2015, Gore 2012, Kirst 2017, Knight 2014, McPherson 2016, Newman 2015,

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
		Raphael 2014, Raphael 2015, Weiler 2015
Mitigate power imbalances	Adopt a standard practice of critically reflecting on, assessing, and mitigating the distribution of power among all actors engaged in (and affected by) all health equity work.	Blanchard 2013, Murphy 2015, Raphael 2014, Shareck 2013, Tolhurst 2012, Young 2011
	Leverage power and resources to mitigate historical and contextual power imbalances.	Andermann 2016, Blanchard 2013, Labonté 2014, Murphy 2015
	Use equity-sensitive tools to assess, monitor, and purposively elevate voices that have been historically silenced or subjected to structural power inequities in both health-equity responsive governance mechanisms and research processes.	de Andrande 2015, Estey 2010, Knight 2014, Murphy 2015

4.5.3   Promising Practices for Doing Research

Three promising research practices were found in this body of literature: (a) recognize complexity; (b) use dialogic-relational methods; and (c) ameliorate data gaps. Among these articles, recognizing complexity spanned the entire research process, from problem definition to targets of intervention and navigating research partnerships. This was illustrated by calls for attention to *systems* over vulnerable populations in the conclusions drawn on the basis of a scoping review by Chircop et al. (2015). In this scoping review, the authors identified a risk of missing the mark when populations disproportionately suffering consequences of health inequities are defined as the problem (rather than the structural contexts that led to their suffering). In another example—an international qualitative study—context sensitivity was described as acknowledging history and understanding the complex landscape well enough to foster inclusion (Blanchard et al., 2013). Similarly, the use of dialogic and relational approaches was identified in three studies. Researchers called for greater inclusion of non-dominant (Borde et al., 2014; Cacari-Stone et al., 2014; Davison et al., 2015b), particularly dialogue-based research because such approaches take "better account of the complexities inherent in health problems, particularly health inequities" (Borde, 2014, p. 2089). Inherent in dialogic approaches is a commitment to engagement. These approaches are therefore responsive and support navigating complexity in relationship with communities, opening possibilities for political action.

Data considerations arose as an important health equity issue in 8 studies (Blanchard et al., 2013; Borde et al., 2014; de Andrade et al., 2015; Gore & Kothari, 2012; Grundy et al., 2014; Mtenga et al., 2016; Povall et al., 2014; Tolhurst et al., 2012). Notably, researchers frequently problematized current systems for collecting and reporting data as insufficient. Data aggregation, common in epidemiology and population health, was described as problematic for its impacts on masking unfair distribution of health improvements along social gradients (Povall et al., 2014; Tolhurst et al., 2012). Grundy et al. (2014) and Mtenga et al. (2016) found that hidden, taken-for-granted assumptions related to data aggregation artificially inflated health equity gains. As an example, the former showed that despite "overall gains in aggregate child survival…the rate of child mortality decline is not being distributed evenly across societies" (Grundy et al., 2014, p. 879), with survival rates increasing at a lower rate in lower socioeconomic groupings. Without the insights from Grundy's study, the use of aggregate data could play an inadvertent role in inflating progress toward equity, or worse, entrenching inequities by virtue of making them invisible. Based on the findings of these studies, aggregation poses risks of extending population boundaries that may or may not reflect how societal structures are experienced or lead to inequities.

Further, these researchers argued that the structure of indicators themselves can also mask inequities (Grundy et al., 2014; Povall et al., 2014; Tolhurst et al., 2012). When, for example, health equity indicators reflect societal assumptions, they can indirectly reinforce inequities. One common example of how this can occur was described by Tolhurst et al. (2012), where participants in a dialogue-based study identified the equity impacts of using gender binary indicators. These study participants argued that a lack of attention to gender implicates social constructions of masculinities as much as it necessitates attention to inequities experienced by women, trans, or other gender-diverse groups (Tolhurst et al., 2012). Several authors concluded their articles with calls for greater flexibility in data monitoring systems, with disaggregation enabled across different levels of policy influence (e.g., municipal, provincial/regional, national) (de Andrade et al., 2015; Gore & Kothari, 2012; Povall et al., 2014).

Researchers also pointed to the importance of broadening surveillance systems to make data accessible (Blanchard et al., 2013; Borde et al., 2014). Several articles called for indicators, mechanisms, and methodologies that allow for the longitudinal study of upstream, root-cause kinds of interventions without diluting complexity (Blanchard et al., 2013; Borde et al., 2014; McPherson et al., 2016; Povall et al., 2014; Tolhurst et al., 2012; Young & McGrath, 2011). This was suggested because, although the effects of downstream interventions may be the easiest to measure and monitor, health equity work would be better enabled by data that demonstrates how 'causes of causes' and other structural drivers are changing (or not) in relationship to health inequities over time. The lack of indicators explicitly reflective of structural and SDH also shapes the ways in which health equity work unfolds. In a large study that focused on how primary health care initiatives can involve health equity work, Labonté and colleagues (2014) concluded that "few projects specifically analyzed the equity dimension" (p.3).

An example of the far-reaching impact of insufficient data systems is offered in Young and McGrath's (2011) discourse analysis of Australian healthcare policy. These researchers point to the nature of administrative health data, which frequently relied on aggregate user and systems data, such as healthcare expenditures, as proxies for health equity. They note that "none of the measures…is actually a measure of health improvement, but rather indicate resource usage or activities," with a proliferation of documents that approach health "not as an all-encompassing socio-political outcome as framed by an SDH understanding, but as being about individualized, singular conditions, or even body parts" (p. 372). Their concerns were compounded by narrow applications of health equity concepts that restricted to SDH concerns to access (especially geographic). Based on their discourse analysis they identified a trend to focus on equity access to more clinical services with better health and situated this within a neoliberal capitalist society where "more is good" and so "improved access = better = more is good" (Young & McGrath, 2011, p. 375)

Table 4.9

Promising Ways of Doing Research

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
Design for context, complexity	Consider informing research with foundational theories that are compatible with complexity, such as complexity theory, critical realism, intersectionality, and critical theories.	Brassolotto 2013, Newman 2015, Mtenga 2016, Povall 2014, Raphael 2015, Tolhurst 2012, Weiler 2015
	Adopt context-responsive research designs that acknowledge history and power distribution throughout research and knowledge translation processes.	Blanchard 2013, Brassolotto 2013, Chircop 2015, Davison 2015, McPherson 2016, Mtenga 2016, Povall 2014
	Diversify research approaches to explore complex problems, foster inclusion, and spark civic engagement, using multiple and non-traditional modes (e.g., community-based participatory research) of inquiry.	Borde 2014, Cacari-Stone 2014, Davison 2015, Estey 2010, Shareck 2013, Tolhurst 2012
Use dialogic-relational methods	Consider building team dialogue into research designs as a means of enabling critical reflection about how to operationalize health equity considerations in research and advancing collective understanding and capacity to implement structurally-oriented interventions.	Labonté 2014, McPherson 2016, Mtenga 2016, Murphy 2015, Tolhurst 2012
	Integrate inclusive dialogue as a means of refining and mobilizing responses to evidence about health inequities.	Andermann 2016, Borde 2014, Cacari-Stone 2014, Carey 2014, Estey 2010,

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
		Gore 2012, Labonté 2014, Tolhurst 2012, Weiler 2015
Ameliorate gaps in data platforms and indicators	Create reliable, systematically collected data in mechanisms that can serve as responsive feedback loops.	Borde 2014, Carey 2014, de Adrande 2015, Gore 2012, Povall 2014
	Expand commonly used set of health inequities indicators to include upstream indicators of health equity, social and structural determinants of health, and power distribution.	Blanchard 2013, Borde 2014, McPherson 2016, Povall 2014, Tolhurst 2012, Young 2011
	Make the links between policy decisions (action and inaction) and health clear and compelling, especially between macro-level and health.	Carey 2014, Grundy 2014, Knight 2014, Mtenga 2016, Weiler 2015, Young 2011
	Assess and mitigate the impacts of aggregation, particularly in masking social gradients.	de Andrade 2015, Gore 2012, Grundy 2014, Povall 2014, Tolhurst 2012

4.5.4 Promising Practices for Knowledge Translation

Although there was a surprising paucity of studies that could be considered knowledge translation science, the most promising ways of doing knowledge translation for health equity were: (a) use integrated knowledge translation approaches and (b) use creative approaches to humanize re-presentations of data. In one review article (Davison et al., 2015b), researchers evaluated 48 different knowledge translation frameworks. They concluded that the most equity-responsive frameworks were applied, impact focused, prioritized engagement and were trust-building, emphasized context, built in mechanisms for addressing issues of power, and contained inclusive definitions of the 'knowledge' of KTA. Their discussion points to the importance of inclusivity in integrated approaches to KT, with careful attention to who is engaged and targeted in knowledge translation processes.

For instance, in recognizing the importance of public sentiment, several included studies focused on the public as a target for knowledge translation (Borde et al., 2014; Cacari-Stone et al., 2014; Cohen & Marshall, 2017; Shareck et al., 2013). This was demonstrated in calls for moving toward public health advocacy, shifting attention away from individual and behavioural interventions toward broader conceptualizations of public issues that invite community mobilization. Vehicles for effectively delivering this kind of messaging need to reflect public practices for communication, thereby suggesting the need to engage social media and civic movements. There was evidence to support being creative in developing a curated or storied approach to presenting evidence, and packaging it in ways that present a concise and

compelling story (Farrer et al., 2015) as well as feasible policy options (Baum et al., 2013, 2010). Presenting timely, real-life data to policy makers that is tailored to different decision needs and humanizes problems, was also supported as an effective practice in a meta-synthesis of policy research (Cacari-Stone et al., 2014). Essentially, evidence needs "to be integrated into the system in such a way as to force decision makers to act" (Carey & Crammond, 2015b, p. 8). Fostering this connection was also found to be important within professional education, where training and exposure to lived experiences of inequities can greatly shape the nature of health equity work (Cacari-Stone et al., 2014; Farrer et al., 2015; Gore & Kothari, 2012; Povall et al., 2014; Raphael & Brassolotto, 2015; Raphael et al., 2014). These examples illuminated the importance of evoking empathy and sparking imagination for more compassionate responses that can mobilize human agency to overcome health inequities.

Table 4.10

Promising Ways of Doing KT

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
Practice integrated approaches	Prioritize processes that include a broad range of research users alongside producers in research in social processes that foster trust and dialogue and are responsive to context and issues of power.	Davison 2015, Estey 2010, Labonté 2014, Murphy 2015
	Critically reflect upon and strategically respond to political will and political economy.	Baum 2013, Brasolotto 2013, Raphael 2014, Raphael 2015
	Package evidence in ways that present a concise and compelling story that includes feasible policy options and presents timely, real-life data to policy makers.	Baum 2010, Baum 2013, Cacari-Stone 2014, Farrer 2015
Be creative	Produce non-academic outputs (e.g., documentary, imagery) to share results of research, particularly with the public.	Borde 2014, Cacari-Stone 2014, Cohen 2017, Shareck 2013
	Use metaphors and other arts-based approaches to curating evidence.	Farrer 2015, Knight 2014, Shareck 2013
Use evocative messages that spark empathy and connection.	Humanize data through use of stories told in the voices of people with lived experience.	Cacari-Stone 2014, Farrer 2015, Gore 2012, Kirst 2017, Povall 2014, Raphael 2014, Raphael 2015
	Use stories that illuminate the ways in which structural and social power work to	Cacari-Stone 2014, Cohen 2017, Farrer 2015, Kirst

Promising Practices	How to do it	Citations for supporting evidence (First Author, Year)
	create inequities, countering norms of focusing on individuals and behaviours.	2017, Knight 2014, Povall 2014

4.6 Discussion

Overall, studies in this review were of relatively high clarity and quality. Indeed, some authors specifically emphasized the importance of clarity, transparency, and examination of assumptions in health equity work, particularly in unpacking the impacts of dominant discourses (Brassolotto et al., 2013; Farrer et al., 2015; Grundy et al., 2014; Lau & van Niekerk, 2011; Mtenga et al., 2016; Raphael & Brassolotto, 2015; Tolhurst et al., 2012; Weiler et al., 2015). Yet, the articles included in this review demonstrated a general lack of attention to epistemological underpinnings and methodological foundations. Even in qualitative research, where convention encourages transparency and articulation of assumptions, little was written about methodology. With the exception of a few (Chircop et al., 2015; Tolhurst et al., 2012; Young & McGrath, 2011), authors frequently referred to their studies as simply 'qualitative' with little discussion of epistemological position or assumptions. Evidence to guide research, practice, and policy for health equity could be strengthened by improving clarity and transparency in reporting of research methodology. For qualitative studies, greater attention to widely accepted standards for quality (e.g., Tong, Flemming, McInnes, Oliver, & Craig, 2012; Tracy, 2010) is also warranted.

Most of the articles in this review revealed some degree of caution about the implications of current sociopolitical trends for health equity work. For example, in one synthesis review article, market-led academic reforms were found to reduce the diversity of social science research in health and medicine (Farrer et al., 2015). Such reforms play a deterministic role in the kinds of research made permissible within the institutional structure of academia, whether by way of appealing to funders or tenure and promotion committees. In combination with a historical academic aversion to advocacy, one scoping review (Cohen & Marshall, 2017) found that an environment of market-driven or austerity-focused university reforms could profoundly restrict academic engagement in health equity work. Words such as 'radical' or 'political' that were once used with pride to speak to socially transformative research, are increasingly associated with negative or even extremist practices. These words are actively avoided now. These cautions point to the subtle and far-reaching influences of how dominant worldviews and ideologies create systems and structures wherein inequities thrive, even though the degree of acceptability or legitimacy of health equity work is granted. These findings shed light on how the central concept of equity attunement might play out in institutional settings.

Because these articles were selected for their productive orientation to root causes of inequities, they were all demonstrative of greater degrees of equity attunement than those that did not meet inclusion criteria. However, this collection of articles is similarly demonstrative of the fluidity of equity attunement. Of the total article collection reviewed, only 5 studies and 1 literature review sought to

challenge social systems or structures implicated in the perpetuation of health inequities (Andermann, 2016; Cacari-Stone et al., 2014; de Andrade et al., 2015; McPherson et al., 2016; Murphy et al., 2015; Tolhurst et al., 2012). Though not labelled as 'equity attunement', Gore and Kothari (2012) explored this in their analysis of SDH content in Canadian health policy, which was directed at healthy eating and physical activity. They found a tendency to avoid the socially and politically difficult work of challenging systems rules that enable health inequities. Carey and Crammond (2015b) described the same phenomenon as a missed opportunity, arguing that the greatest leverage for advancing health equity lays within efforts to restructure social systems in favour of health equity. They suggested that "the power of an intervention comes not from where it is targeted, but how it works to create change in the system" (p. 1). The lack of focus on structural interventions could be dually reinforced by a persistent bio-behavioural focus in health equity work, even when efforts are explicitly focused on action for SDH. It seems a critical challenge is in overcoming superficial, downstream tendencies in health equity work (Brassolotto et al., 2013; Raphael & Brassolotto, 2015; Raphael et al., 2014). This says something about the degree of equity attunement but also perhaps about the hesitancy to work at the society and structural levels needed to leverage change.

The four groups of promising practices identified in this study provide a practical foundation for guiding health equity efforts across a spectrum of activities. Results on promising practices for doing research point to the extraordinary role indicators, as the basis of data sets used to define and monitor populations, can play in reinforcing power structures and particular conceptualizations of health inequities. This points to the inadequacy of widely accepted norms in data monitoring systems. It also alludes to the difficulty of measurement and raises questions about how data systems are responding to what is known about the causes of inequities—that is, how effectively are data systems themselves putting knowledge into action for health equity? The assumptions relate to what is legitimized as the 'knowledge' of knowledge-to-action for health equity, both because of the way societal norms become embedded in data definitions and because of ideas of the nature of knowledge. Together, these practices are promising because they functionally serve to resist research proclivity for reductionism and bio-behaviourism that can minimize the multiplicity of actors and mask and distract from the ways in which health inequities thrive in societies. By virtue of their inclusivity and attentiveness to process, dialogic-relational approaches also tend to be more receptive to different knowledge systems. Given the role of administrative and clinical data sets gathered and maintained within healthcare systems themselves, it seems an important way of doing research is to consider active engagement with these systems to advance a more comprehensive consideration of health in the kinds of data that is deemed important enough to collect and monitor.

Potential benefits of some promising practices could be imagined by extending the collective findings back onto these 32 studies. For example, promising practices for working relationally were not universally practiced by researchers whose work was reviewed here. All but 2 of the articles' (Mtenga et al., 2016; Weiler et al., 2015) primary authors were from the health professions or health sciences.

However, all of the articles were published in health-related journals and involved health professions or health sciences in the authorship team. Although health equity work does logically involve health research, the nature of health inequities suggests the need for work across a broader spectrum of actors. Several studies pointed to the need to sensitize health professionals to issues of equity and political economy; however, few called for sensitizing political economy actors (e.g., business, economics, management, political sciences) and other non-health actors (e.g., education, data sciences, engineering) to the relationship between policy and health. Further, despite calls for integrating health equity across sectors while also raising awareness among the public, there were few studies available examining how to advance health equity at an institutional or societal level. These gaps provide support for fostering inclusion as a promising practice. This finding also aligns with principles for equity-centred research and knowledge translation (CCGHR, 2015), which call for purposive mitigation and elevation of voices historically marginalized because of Indigeneity, race, gender, sexual orientation, identity, ability, class, or other forms of social isolation. Therefore, operationalizing a practice of inclusion requires a more global contemplation of who needs to be engaged in order to shift public sentiment and political will.

The results of this review, and particularly the findings related to equity attunement, allude to the importance of cultivating environments of critical reflection. Such contexts would make challenging dominant narratives and assumptions safe and even encouraged. For example, on the basis of their scoping review, Cohen and Marshall (2017) highlighted the "predominance of a societal belief that health inequities are the result of poor individual choices and behaviours" (p. 318). Others identified the "contemporary zeitgeist" (p. 409) as the most frequently cited barrier to effective advocacy for health equity (Farrer et al., 2015). These authors problematized "privatization, deregulation, economic liberalization, the primary role of the private sector in providing services, and the general prioritization of the economic over all other spheres of policymaking" because these encourage governments to withdraw from the kinds of political intervention needed to take action on social determinants of health (Farrer et al., 2015). Individualism and neoliberalism are pervasive in academia and research systems, including funding structures and research priorities that are set by governments. In a context of critically reflective dialogue, as was encouraged in Freire's (1997) critical pedagogy, these values could be examined and deconstructed in ways that could open new possibilities for transformation.

At the deepest root of health inequities is the distribution of power in society. Power is relational and dialectical, working both on and through people in positive and negative ways (Freire, 1985b). Freire argued that there are no absolutes in power, but rather tensions and points of contradiction in social settings where "power is often exercised as a positive force in the name of resistance" (Giroux, 1985, p. xix). Leveraging power implies taking maximum advantage of one's own social power as a means of redistributing power and involves some form of power analysis. Generally, the lack of attention to power analysis in the studies included in this CIS suggests that it is not a standard of practice in this field, or at least in writing about work in this field. Given the role of power in shaping systems and structures that lead to health inequities, it seems important to not take for granted the value of embedding power

analysis in all aspects of KTA for health equity. Introducing a practice of power analysis alongside practices of inclusion and leveraging power, could prove to be a high-impact practice for advancing action for health equity.

This finding validates results of the scoping review that preceded this CIS (Plamondon et al., 2018), as well as other critical reflections (e.g., Brisbois, 2014; Crane, 2010b; Hanson, 2017; T Schrecker, 2013) on the nature of work in this field. The marginalization of health equity work within systems is also echoed in the literature by authors who point to the difficulty of pursuing this work in academia. This is particularly true in the context of a dominant discourse of bio-behaviourism (Hanson, 2017) and the values underlying a broader political economy that elevate the policy priorities which clash with policy environments demonstrating promising progress for health equity (Raphael, 2015). These issues point to the importance of structuring responsive systems that can withstand critical reflection about the ways in which power operates and that can help to strategically position health equity work in ways that leverage social and political power within them. Further, working across disciplines and sectors broadens the scope and scale of health equity work to include non-health and non-academic actors, this lends itself to a kind of inclusivity of people who, by virtue of their discipline or location within society, bring something important and additive to health equity work.

4.7 Limitations

This CIS aimed to critically synthesize promising practices from empirical literature about KTA for health inequities. The search terms relied on authors' use of knowledge translation (or similar) language. There are likely valuable insights available in the broader health equity, social justice, activism, and critical social sciences literature that warrant attention. Articles included in this review were also limited to an eight-year period following publication of the CSDH report. It is likely that publications from 2017 onward would reify and extend the promising practices identified here. Further, this analysis is based on what authors wrote into their articles and so is limited to what content was actually written into articles. Finally, a limitation exists in the nature of this review as part of a doctoral dissertation, meaning the work necessarily fell primarily to a singular person. Synthesis, and the qualitative analysis used to arrive at the results presented here, was inherently subjective. It was shaped by the theoretical foundations informing this dissertation (Freire, 1985b, 1997; Gergen, 2009; Lyons, 2010). My positionality and experiences as deeply immersed in the field of health equity and KT are also inextricable from my analysis. These factors are part of the lens through which this literature was considered. The relevance and resonance of findings may, as a result, vary for readers whose own theoretical foundations, positionalities, and experiences differ from mine.

4.8 Implications

Despite a paucity of research specifically focused on knowledge translation, this review illuminated a suite of promising practices for connecting KTA for health equity. Most critically, this CIS

supports positioning *equity attunement* at the centre of health equity work. This study carries implications for equity-attuned training and capacity building, not only in the health professions but across public sectors and a plethora of disciplines that, by virtue of the social embeddedness of health inequities, could be playing a more active role in advancing action for health equity. In addition to capacity for equity attunement, evidence suggests the need for people involved in health equity work to build capacity in political sciences, advocacy, collaboration, and inclusion. These results broaden traditional conceptualizations of who needs to be involved in health equity work, suggesting a need for greater civic engagement that could be achieved by working in collaboration (while also maintaining critically reflective dialogue) with social movements, arts, community-based organizations, and advocacy groups. This is a finding that challenges notions of who holds responsibility for knowledge translation—it does not fall to researchers alone and should be regarded instead as socially integrated work that requires a broader effort to advance social justice agenda. Combined with promising practices for doing KT, these results open a door for contemplating the inclusion of professional regulatory bodies and universities among the targets of knowledge translation. Advancing health equity is, at its core, a process of fostering public awareness and dialogue about the nature and causes of health inequities, critically reflecting on dominant discourses and assumptions, and mobilizing political will from a more informed and transparent democratic exercise. In the field of health equity, this finding points to the urgent need for critical reflection in fields where normative assumptions can be obscured by resting on the laurels of 'objectivity' and 'neutrality,' which are commonly upheld in positivist approaches to research.

Chapter 5: Critically Reflective Dialogues

5.1   Background

Experts in KT and health equity contributed their reflections and insights in the third dissertation study. Here, a series of critically reflective dialogues extended insights about promising practices for connecting KTA for health equity. While there is little controversy about the importance of health equity in global or public and population health, or even within health systems, the operationalization of this goal has often been repudiated as an unrealistic, unattainable ideal (Labonté, 2016; Pandey, 2018; Yamin, 2017). Preoccupied with the immediacy of downstream issues, doing health equity work can become overshadowed in healthcare systems or government agendas that are pressured to perform under market-driven assumptions (Baker et al., 2018; Raphael, 2015; Ted Schrecker, 2016). Perceived as too complex, too long-term to reap reportable benefits, or too far removed from the comfort of bio-behavioural interventions, health equity 'ideals' are repeatedly articulated and abandoned. Resting on assumptions of the *de facto* benevolence of research, the field can capitulate to the multitude of forces working to reinforce systems and policies known to be generative and reinforcing of health inequities (Crane, 2010a; Hanson, 2017). With a desire to challenge the forces working against advances for health equity, this series of dialogues invited experts in KT and health equity to explore promising ways of advancing evidence-informed action.

As with the other two studies described in this dissertation, critical pedagogy and critically reflective inquiry provided the theoretical foundation. In particular, this study was grounded in three key principles: (a) an assumption that meaning is shaped by power, perspective, and experience; (b) meaning arises from human interaction *with* and *in* the world (Freire, 1997; Van Manen, 1997); and (c) the *process* of engaging in critical reflection is an epistemological means for examining systems of power in transformative ways (Freire, 1985b, 1997). In this series of dialogues, contributors engaged in reflexivity by exploring positionalities and experiences[8] alongside promising practices. The research questions guiding this study were:

1. How do KT and health equity experts orient their work (and themselves) toward health equity?

2. Drawing on their experience and knowledge in the field, what do KT and health equity experts believe:

    o   is promising for connecting KTA for health equity (i.e., enables action on the known causes of health inequities)?

    o   about the role of power in health equity work?

    o   warrants further reflection and challenge (e.g., assumptions, ideologies, and values) in health equity work?

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[8] For more on my own positionality and experiences, and how they relate to this body of work overall, please refer back to Chapter 1.

5.2   Methods

The structure and flow of dialogue were inspired by the idea that critical reflection can be supported by bringing people together at a *table of dialogue* (Shor & Freire, 1987)*.* Shor and Freire discussed how, by placing an idea or 'object of reflection' on this table, people could participate in "a genuine open exchange" (p.16). As they moved around the table, dialogue contributors could consider objects of reflection (research questions, emergent results) from different angles and through different lenses, creating new spaces for exploring and transforming their subjective experiences of that object (Figure 5.1). This *table of dialogue,* therefore, served as an epistemological tool for critical reflection that enabled relationality (see Chapter 2 for discussion on relationality) between and within contributors to the dialogue.
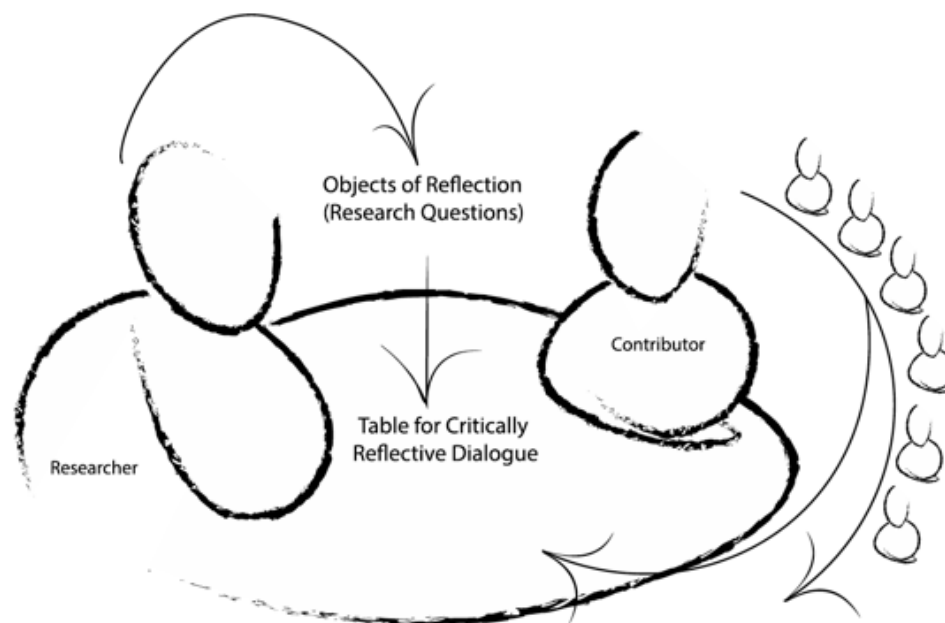
Figure 5.1. Table of critically reflective dialogue.

As the researcher-host, I provided a facilitative structure and flow for dialogue, intentionally connecting each dialogue to others in the series by documenting, writing, re-presenting, and responding to dialogic encounters. This worked well in terms of providing practical continuity, but also because I brought significant expertise as a teacher, facilitator, and registered nurse to the table. This blend of professional experience, my commitment to relational practice and critical reflection, and my own personal disposition were instrumental to creating an open and reflexive environment for dialogue. Because the goal of these dialogues was to support collective critical reflection (Brookfield, 2010; Freire,

1985b; hooks, 2010), both contributors and I acted as co-constructors of understanding with shared responsibility for consciousness-raising.

In this study, each dialogic encounter was conceptualized as a moment for exploring questions that, through writing, could be synthesized and brought forward to extend critically reflective inquiry in new directions. In qualitative research, writing is recognized as a method of inquiry in and of itself (Richardson & St. Pierre, 2018). Writing included the researcher's notes (taken during a dialogue), dialogue summaries, poetic transcriptions, reflective journals, thoughts inspired by exposure to the media (e.g., radio, twitter, news), and outcomes of earlier dialogues—all of which served as starting points for successive iterations of dialogue. Writings became evolutions of reflexivity that involved thinking about each dialogue *through theory*, and then constructing these reflections as emergent, non-prescriptive results, that are "always rethinkable and redoable" (Jackson & Mazzei, 2018, p. 717). As facilitator and data steward, my own critical reflection extended both inward (reflexivity) and outward (considering evolving reflections in the context of external sources). Critical reflection was enabled by connecting a series of people across separate dialogic encounters through the steady presence of researcher-host at the table of dialogue and this constant commitment to writing.

5.2.1 Dialogic Encounters

Each dialogue was a conversational encounter between myself and one or two other people. Conversation began with an explicit acknowledgement of the situatedness, experiences, and perspectives we[9] brought to the table. Practically, each encounter involved: (a) identifying a potential contributor; (b) extending an invitation; (c) negotiating a time and place to connect; (d) engaging in pre-dialogue communication; (e) engaging in a dialogic encounter; and (f) post-dialogue procedures. Pre-dialogue communication began via email to negotiate a time and place for dialogue and invite contributors to complete and share a 'perspectives form'. This form was intended to document demographic information and summarize the theoretical and substantive expertise of the contributors (Appendix A). With the exception of three in-person dialogues, dialogic encounters occurred using *Vidyo*[10], a Canadian-based virtual video conferencing platform. After reviewing and responding to any questions about consent or study procedures, permission to record was obtained. Once granted, recording commenced.

As the dialogue host, I took hand-written notes to highlight key points and identify possible connections, contradictions, questions, or affirmations with other study findings. Dialogues began with introductions, situating ourselves in the context of health equity work. A set of dialogue prompts (Appendix B) served to open new streams of thought and insight. An opportunity for follow-up

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[9] Here, the use of a collective pronoun, *we*, refers to the combination of the researcher (me) and one or two contributors at a single table of dialogue. I use *we* and *our* throughout this chapter when the content refers to something derived from an interaction.

[10] The use of Vidyo for this study was enabled by support provided by Compute Canada (www.computecanada.ca).

conversations and the creation of a dialogue summary was built into the study design to provide time for critical reflection. Encounters closed by summarizing any commitments made to share resources and negotiating an agreement for follow-up. Post-dialogue, *Vidyo* recordings were uploaded to a secure and encrypted folder for transcription by a professional transcriptionist. Next, using the 'memo' feature in NVivo 11 for Mac, a journal entry was made about the experience. When specific resource recommendations arose during dialogues, these were uploaded into the same NVivo file. When a summary was desired by a contributor, I prepared a written synthesis of our dialogue using a combination of transcripts and researcher's notes. I shared draft summaries with contributors for comment and collaboratively edited these until we reached an agreement.

5.2.2 Sampling

In qualitative research, "an appropriate sample size is…one that adequately answers the research question" (Marshall, 1996, p. 523) and typically involves an iterative and responsive approach (Marshall, 1996). Guided by Cheek's (2011) discussion on sample size, I set an anticipated number of participants (Table 5.1) by drawing on experience and practical limitations of this work as a doctoral dissertation (e.g., time and resource constraints). Sampling decisions were informed by a desire for diversity in perspectives and positionalities. Further, decisions were guided by the recognition that the process of critically reflective inquiry would have no finite end point, but rather would involve a continuous commitment to discovery and learning. The process of identifying and inviting contributors began with theoretical sampling (Ritchie, Lewis, & Elam, 2003) by following leads from the literature (i.e., authors of compelling and/or theoretically aligned articles included in studies 1 or 2). Opportunistic sampling (Ritchie, Lewis, & Elam, 2003) was followed by reaching out through existing global and public health networks (e.g., at conferences, professional development events). Using this combined sampling strategy set a broad and exploratory foundation from which the series of dialogues could unfold as insights were generated. With analysis and data generation occurring simultaneously, the emergence of new ideas and insights guided specific recruiting efforts later in the series.

Table 5.1

Overview of Sampling Goals and Strategies

Considerations	Descriptive details
Anticipated numbers	Aimed for approximately 12 dialogues (individuals or small groups of 2-3 people)
	Anticipated 6 will express interest in follow-up dialogues
	Initial intensity sample of 2-3 'expert witnesses' identified from the literature, theoretical and opportunistic sampling to guide recruitment efforts for additional interviews

Considerations	Descriptive details

Strategies for identifying and inviting contributors	Theoretical, guided by:
	
	  a. Alignment with theoretical foundations of the study (e.g., people working in health equity with a foundation in critical theory, critical pedagogy)
	  b. Author of article(s) included in studies 1 or 2
	  c. Theoretical perspectives sought in response to emerging themes, insights
	
	Opportunistic, identified through:
	
	  a. Encounters occurring by virtue of my professional participation in the field of health equity (e.g., attendance at conferences, involvement in networks, participation in professional development and teaching)
	  b. Introductions or suggestions offered by contributors or colleagues

Sought expertise and experience in:	• Health equity work • Knowledge translation research and/or practice

5.2.3   Analysis

Analysis for this study was guided by the use of an integrated analytical framework for dialogic inquiry that involved the use complementary cycles of engaging and synthesizing (Plamondon et al., 2015). This framework provided a theoretical structure for how to make sense of the fit of any one dialogue within the series of dialogues. Within this analytical framework, each dialogic encounter could be considered a cycle of 'engaging' that generated data. In this case, the data included transcripts, memos, dialogue summaries, recommended resources, and researcher's notes. Data generated from a cycle of engaging were then integrated with previously generated data in a cycle of 'synthesizing'. Practically, processes of synthesis involved reading and re-reading data, using writing as a mechanism for meaning-making and highlighting emerging threads for exploration. Moving through complementary processes of engaging and synthesizing supported a continuous process of analysis, wherein dialogues were informed by earlier studies (literature reviews) and insights from preceding dialogues.

Embedded in the analytical framework was a particular set of data handling strategies that sorted data into groupings of thematic similarity. Common qualitative coding strategies (e.g., Thornberg & Charmaz, 2014) were used to organize emerging findings, insights, and newly identified questions as this series of dialogues unfolded. These groupings were connected to the broader dialogue in which it was generated (i.e., inherently connected to the positionality and context of the contributors to a particular dialogic encounter). In qualitative research, this approach to data handling is recognized as a means of avoiding data fragmentation (Maxwell & Chemiel, 2014). Also embedded in the analytical framework was a stance of constant questioning (Willig, 2014), asking of the data, *What is the essence of what is being said?* and *What is missing, silent, or unspoken here?* Examining data for core essences and silences in combination supported the desire to explore assumptions while honouring the tacit, experiential, and

scholarly knowledge of contributors. These data handling strategies, including organizing data, documenting study progress, and reading and re-reading of data were all supported by the use of NVivo 11 for Mac.

5.2.4   Writing and Reflexivity

Reflexivity was foundational to this study. It occurred both in collaboration with others at the table of dialogue and individually, as a researcher moving through my own process of becoming. Different modalities can support a practice of reflexivity, ranging from writing through to more creative media like poetry or art. The process of writing, in and of itself, supports reflective dimensions of inquiry in qualitative research (Denzin, 2009; Richardson, 2005; van Manen, 2006). The aim of qualitative research is to understand, and Schwandt (1999), explained what occurs when we attempt this process:

> when we seek to understand what others are doing and saying, we simultaneously publicly explicate that understanding. In fact, our efforts to present, to articulate to pronounce, or to say what we think we understand are inseparable from our efforts to understand. (p. 456)

Understanding *through learning* in research opens possibilities of how we might engage in re-construction and re-presentation through writing because acts of writing serve as a vehicle for understanding. In this vehicle, words are the medium in the art of writing (Finley & Knowles, 1995). It is an art of approximation, interpretation, and reconstruction—never really the event itself (van Manen, 2006). If we accept that there is no "naked truth, no understanding of naked reality," we can strive through our writing to "touch something meaningful" (van Manen, 2006, p. 721). As a way of writing *through* and writing *into* discoveries that were previously unknown (Pelias, 2011), writing is a praxis of understanding.

Writing, in qualitative research, is an "active struggle for understanding" (van Manen, 2006, p. 713), a fine balance of evoking essence without destroying the very same by substitution of words (van Manen, 2006). No one way of writing is more innocent or valid than another. Leavy (2009b) suggests that poetry can open understanding around complex issues, inviting relational interaction between the researcher, participant, and reader. It is not a shortcut or substitute (Morse, 2004), but rather a complement to work through a well-established methodological lens. My inward-looking personal reflexivity involved a variety of types of writing and art, including journaling, painting, and poetry. This arts-inspired approach provided a provocative set of tools to support crystallization and representing results in evocative ways. The combination of a constant companionship with reflexivity and writing through my analytical thoughts served to integrate meanings in ways that opened new pathways for insight and questioning.

5.2.5   Striving for Crystallization

Striving for coherence and confidence in study results, this study involved attentiveness to *crystallization.* Crystals "grow, change, and are altered, but they are not amorphous…[they are] prisms that reflect externalities and refract within themselves, creating different colors, patterns, and arrays

casting off in different directions" (Richardson & St. Pierre, 2018). Drawing on the crystal as metaphor, crystallization is defined as combining

> …multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts, building a rich and openly partial account of a phenomenon that problematizes its own construction, highlights researchers' vulnerabilities and positionality, makes claims about socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them. (Ellingson, 2009, p.6)

This process is grounded in a desire to reveal complexity and nuance in representations of truths, rather than seeking objectivity or absoluteness. A departure from notions of revealing a "fixed point" of truth through triangulation (Richardson & St. Pierre, 2018), it guides researchers to consider multiple analytic tools. As a crystal works to bend light and reveal more depth and spectrum, the use of multiple genres of analysis and representation creates multiple ways of experiencing and interacting with the substance a study reveals. In Table 5.2 below, I summarize Ellingson's (2009) principles for manifesting crystallization in qualitative research and briefly offer notes about how these principles were achieved in this study. These strategies complemented and extended efforts to strive for quality and rigor in study design (discussed in Chapter 2).

Table 5.2

Principles for Crystallization and Strategies to Achieve It

Principles for Manifesting Crystallization (Ellingson, 2009, pp. 10–11)	Strategies used to support enacting this principle
Offer deep, thickly described, complexly rendered interpretations of meanings.	Use of complementary cycles of engaging and synthesizing; intense engagement in dialogue *and* Writing up of study results involved deep, contextualized descriptions with visuals to demonstrate relationships between ideas
Represent ways of producing knowledge across multiple points of the qualitative continuum, generally including at least one approach evolved from constructivist or postpositivist paradigms and one interpretive, artistic, performative, or otherwise creative analytic approach, including more than one genre of writing (e.g., poetry, narrative, report) and/or other medium (e.g., video, painting, music).	Use of coding and writing strategies common to qualitative research (e.g., data handling strategies of categorizing evolved from the tradition of grounded theory) *and* poetic transcription, poetic interpretation
Include a significant degree of reflexive consideration of the researcher's self and roles in the process of research design, data collection, and representation.	Reflexivity deeply integrated throughout study design and process Include reflexive post-script Poetry and art used to support reflexive practices
Eschew positivist claims to objectivity and a singular, discoverable Truth in favor of embracing knowledge as situated, partial, constructed,	Adopted critical pedagogy and critically reflective inquiry as theoretical foundations, both of which share these assumptions about knowledge

Principles for Manifesting Crystallization (Ellingson, 2009, pp. 10–11)	Strategies used to support enacting this principle
multiple, embodied, and enmeshed in power relations.	

5.3   Situating Study Findings

Contributors (n=17) to this series of dialogues were situated in positions directly or indirectly involved in academic and professional aspects of health equity work. Twenty-one of 22 dialogues occurred between me, the researcher, and one other person and on one occasion, two people joined me in dialogue. The two contributors knew each other well and had worked together on a number of research projects. Few contributors described themselves as having expertise in KT, but they all expressed an understanding of what KT is and how it relates to their work. Ideas, concepts, and the relationships between them began to crystallize after the anticipated number of dialogues (12); however, intriguing streams of thought that emerged during the analytical process led to additional invitations. Each dialogue lasted between 60 and 150 minutes, with a cumulative total of approximately 2640 minutes. Table 5.3 (n=17 contributors + 1 researcher) provides an overview of the perspectives and characteristics of the participating contributors, including myself[11]. Notably, contributors most frequently described themselves as health researchers or professionals with involvement in public or population health, global health, or health systems. All of the contributors reported some form of exposure or immersion in critical social sciences or critical theory and/or ethics. The situatedness of contributors places this series of dialogue as unfolding among 'insiders' with academic and practice experience relevant to health equity.

Table 5.3

Self-Reported Perspectives and Characteristics of Contributors to Dialogue

Characteristic	Description & Data	
Age range	25-34 (n=1) 35-44 (n=8) 45-54 (n=5) 55-64 (n=2) 65-74 (n=2)	
Career stage	Early (n=5) Mid (n=8) Late (n=5)	
Gender*	Other (n=1) Female (n=12) Male (n=6)	
Identify as part of a visible minority	Yes (n=6) No (n=12)	
Role in connecting knowledge-to-action**	Researcher (15)	Manager/Director (1)
	Administrator (1)	Community member (2)
	Funder (1)	Other (2)

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[11] I include myself here out of recognition that I do not enjoy any sort of special objectivity privilege as the researcher. Rather, in alignment with the critical theory underlying this study, I accept that my own social position, privilege, perspectives, experiences, disciplinary, organizational, and theoretical foundations influenced and shaped dialogue as much as any other contributors' may have. See Chapter 1 for more on my own positionality.

Characteristic	Description & Data		
	Student (4)	• organizer/activist	
	Facilitator/broker (3)	• policy advisor/program developer	
	Practice leader (2)		
Discipline**	Health sciences (7)	Health services/systems (7)	
	Public/population health (15)	Other (6)	
	Social sciences (7)	• Social movements, social justice	
	Biomedical sciences (3)	• Disability studies	
	Epidemiology (1)	• Political economy/political sciences	
		• Food systems	
		• Ethics	
		• Theology	
Organizational perspectives**	Government agency (5)	Other (6)	
	Non-government agency (1)	• Funder	
	Academic institution (12)	• Service provider	
		• Social movement	
		• Community	
Geographic perspectives**	Western Canada (7)	Global North (2)	
	Central Canada (3)	Other	
	Eastern Canada (3)	• Northern Canada (2)	
	Maritimes (2)	• Zambia, "Barotseland"/Western Zambia (1)	
	Global South (4)	• National, pan-Canadian (2)	
		• Okanagan, Interior Salish (1)	
Theoretical perspectives***	Critical theories (feminism, ecofeminism, queer, post-colonial, critical social theory)		
	Ethics		
	Indigenous ways of knowing and being		
	Needs-based approaches to health planning		
	Institutional ethnography		
	Interpretivism		
	Marxism		
	Mixed methods		
	Political ecology, political economics		
	Post-colonialism		
	Social theory		

Characteristic	Description & Data	
Content area (substantive) perspectives***	Activist scholarship	Health workforce
	Community and public health nursing	Knowledge translation
	Community engagement	Maternal and child health
	Compassion	Non-communicable diseases
	Critical pedagogy	Northern health
	Cultural safety	Nutrition
	Disability and development	Partnerships
	Environmental health	Physiotherapy
	Evidence-based decision making	Policy process
	Global health	Political economy
	Governance	Population health interventions
	Health equity	Public policy
	Health equity impact assessment	Rehabilitation
	Health leadership	Social and ecological determinants of health
	Health services and systems	Social movements

*Participants listed as many perspectives as they wished, so counts >18 were achieved when participants indicated more than one response.

**Responses were not mutually exclusive. Participants could check as many boxes as they felt relevant.

***Open-ended responses listed by contributors.

5.3.1   Contributors' Descriptions of the 'Field of Health Equity'

Contributors were invited to participate in this study using an *a priori* definition of the field of health equity (see glossary, p. xiv). Virtually all contributors expressed appreciation for the social justice mandate that situates the fields of global and public health as core leaders for health equity action. In the few instances where social justice was not their explicit frame of reference, contributors described their work as related to caring and compassion. Though contributors were largely situated *either* in public or global health or health systems, they all agreed that health equity work spans across these domains. Generally, contributors recognized this field as situated within health, health systems, and social sciences, within which students, teachers, researchers, leaders, and regulated professionals assume responsibility for understanding and acting on issues of equity. Despite being situated either in public or global health, contributors' commitments to health equity were central to their work. Drawing on her immersion in global health research, one contributor expressed her thoughts:

> The primary production of global health research is about trying to address a health inequity problem. It's broadly accepted that it is not boundary-based, it's not geographic, it's based on wherever the health inequity is—if there are two groups where there's an inequity in health between those two groups and you're trying to solve that problem with that impact on health, that's called global health research. (Contributor 3)

Broadly, contributors recognized the field of health equity as increasingly embracing of a social justice lens. Most contributors reflected that progress in this field was propelled by increased attention on social, structural, and ecological determinants of health that expose health disciplines to discourses of justice and power; however, we agreed that this progress is often overpowered or diluted by the dominance of bio-behaviourist ways of framing health inequities.

5.4   Results

Strikingly common in these dialogues was reflective conversation about disconnects between intentions, knowledge, and action in the field of health equity. Most contributors reflected on the constancy of encountering this disconnect in their work, either through a personal struggle (e.g., confronting complicity in systems of power and privilege) or through their daily interactions with others in their work or community settings. This struggle was often observed as related to overcoming or countering *ways of thinking* that narrowed the consideration of health inequities and health equity. When contributors explored how they pursue and cultivate KTA for health equity, they often shared specific ways they *thought* about their work or supported others (e.g., students) to think about health equity. They also explored how the very contemplation of health equity led to more or less attuned action—that is, their reflections affirmed that *how* something is done stems from *how it is conceptualized.* Although this series of dialogues reinforced all four promising practices identified in the CIS, providing guidance about *how* KTA efforts could be better aligned at advancing health equity, not all practices were about doing*.* Indeed, contributors to dialogue almost invariably affirmed the notion that ways of doing were extensions of *ways of thinking.*

Four promising ways of thinking were identified in this series of critically reflective dialogues: thinking relationally, thinking reflexively, thinking responsively, and thinking tenaciously. Promising considerations identified for each of these four ways of thinking, including considerations for reflection and dialogue, are provided in Table 5.4. Data supported a clear relationality between equity attunement and the mutually reinforcing relationship between ways of thinking (Figure 5.2). In the sections that follow, each of these promising ways of thinking, along with particular thinking strategies and a complementary set of strategies for enabling the promising way of thinking are offered.
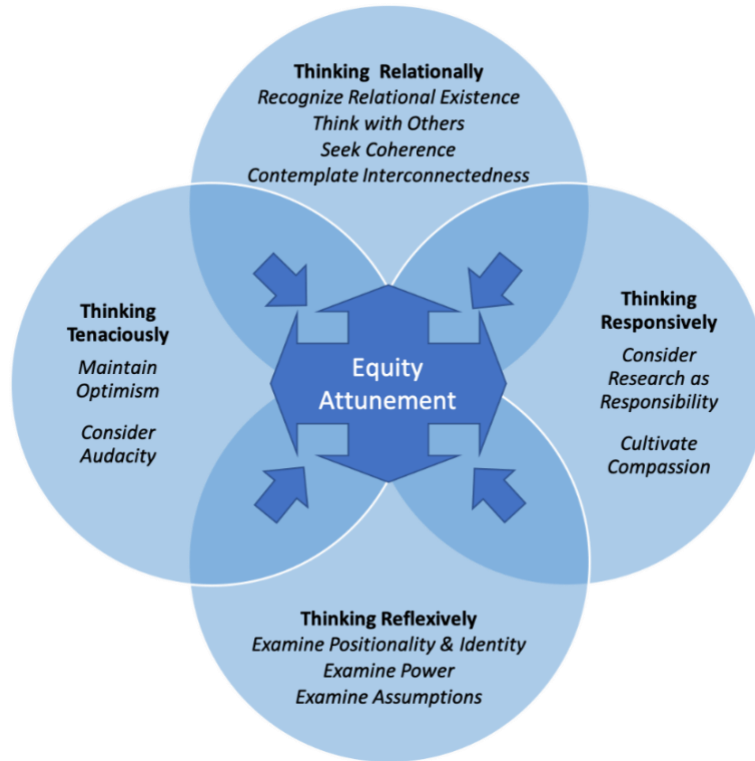
Figure 5.2. *Four promising ways of thinking for connecting KTA for health equity.*

These inter-related and complementary ways of thinking are characterized by sets of distinct promising considerations, each of which can be operationalized through reflection and dialogue around particular focus points (Figure 5.3). Contributors frequently offered examples of how some ways of thinking are more equity attuned than others and can cultivate equity attunement more than others.

Figure 5.3. Relationship between promising ways of thinking, considerations, focus points, and strategies.

Table 5.4

Four Ways of Thinking with Promising Considerations and Focus Points for Reflection and Dialogue

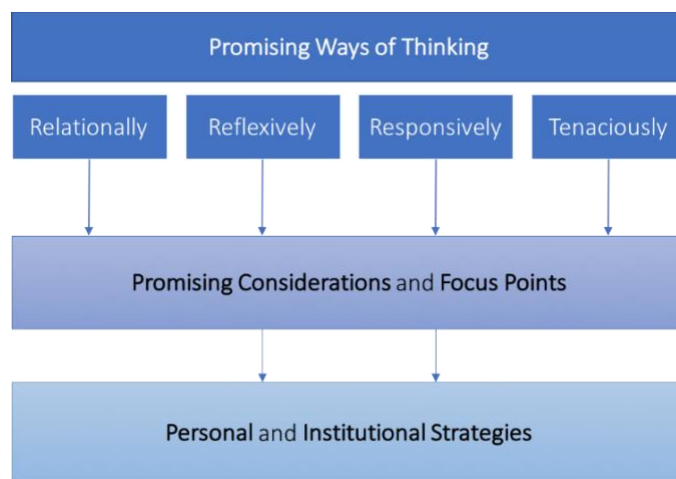| Ways of Thinking	Promising Considerations	Focus Points for Reflection and Dialogue
Thinking relationally	Recognizing human existence as relational	Thinking about ourselves as existing in relationship to others
		Questioning how the dominance of individualism shapes our thinking
		Developing an appreciation for shared humanity and shared ecology
		Seeking collectivity, countering tendencies for individualist competition
	Thinking with a diversity of others	Processing thoughts through dialogue with others (e.g., coming to a 'table of dialogue')
		Engaging in thinking with others whose perspectives are different from our own
	Seeking coherence	Examining the relationships between what we know and what we do
		Intentionally seeking wakefulness to the limits and possibilities of our own praxis
	Contemplating interconnectedness	Thinking about relationships between people, ideas, actions, and sociopolitical and economic contexts implicated in health equity work
		Embracing complexity
		Actively thinking through the connectedness of experience and power across time and place
Thinking reflexively	Examining positionality, identity	Critically reflecting on social position
		Contemplating identity and what it means to yourself and to others
	Examining power	Recognizing and analyzing the role of power and privilege in any context, at multiple levels.
	Deeply examining assumptions	Deeply questioning, striving to unpack multiple layers of assumptions
Thinking responsively	Considering research as responsibility	Designing and doing research in ways that contribute a greater goal of equity
		Challenging assumptions underlying measures of academic 'success', particularly ones that contribute to self-serving benefits
		Defining health equity work as in service to society
		Accepting responsibility for a praxis of equity
		Leveraging social power
		Adopting an empathetic and responsive stance

Ways of Thinking	Promising Considerations	Focus Points for Reflection and Dialogue
	Cultivating compassion	Considering the perspective, experience, and emotions of others and responding with appropriate action[12]
Thinking tenaciously	Maintaining optimism	Adopting a hopeful lens
		Believing in the possibility of a more equitable world
		Recognizing health equity work as a long-term project
	Considering audacity	Embracing boldness
		Thinking big
		Believing in human agency to critically reflect and *take action*

5.4.1 Thinking Relationally

Thinking relationally involved four promising considerations: (a) recognizing human existence as relational; (b) thinking with a diversity of 'others'; (c) seeking coherence; and (d) contemplating interconnectedness.

(a) Recognizing human existence as relational

A relational ontology situates human existence in constant relationship to our own thoughts, to others, and to our environments. It involves thinking about ourselves as existing in relationship to others. Contributors to dialogue demonstrated this way of thinking when they spoke about their work and hopes. They routinely questioned the dominance of individualism, particularly in 'Western' or colonizer cultures. By focusing on one's relationality to others and to their environment, contributors described thinking relationally as an important foundation for being able to recognize systems of power and privilege that generate health inequities. Several contributors remarked that the very possibility of becoming aware of power and privilege necessitated a relational view of the world: power is relational. It cannot exist without relationship to another. One contributor commented on an interaction with an elected official, offering that this official was immediately able to recognize the role of power and privilege in shaping health and was ready to commit to making it part of an election platform, saying, "I know it's not about sugar and French fries, it's about power and influence" (Contributor 14, quoting an elected official). Therefore, this type of relational thinking was considered critical for understanding how power operates and for imagining pathways toward responsive action.

By thinking about our relational existence with others and with environment, contributors held hope that people within the field of health equity could be motivated to do something more equity-attuned and thereby, more transformative. They reflected on how thinking about themselves in relationship to others and to the world supported notions of shared humanity and shared ecologies. In this way,

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[12] This focus point draws on the definition offered by Sinclair et al. (2016) that describes compassion as a virtuous act that involves ways of thinking by seeking to understand the suffering of others and posturing oneself with relational understanding and action.

considering a relational ontology was indirectly explored as a means for enhancing affinities for collectivity and for action. Some contributors spoke to how their roles as leaders, change-makers, or knowledge brokers involved acute awareness of their own relational existence, but also encompassed supporting people and systems to think more relationally. Others described the importance of activism and social movements that involve an inherently relational worldview. Contributors expressed deep concern about the absence of power analysis and relationality in current global politics, with a destabilized political enterprise that endorses national protectionism as though such policies or national positionalities exist without relationship to others (e.g., Brexit, 'America First'). In this current global context, across many dialogues, we agreed there was a need for collective capacity, confidence, and action to question who wins and who loses, who decides, and how this power manifests in real consequences for real people, which means thinking about the world through a lens that illuminates relationships, rather than casting them to the shadows.

(b) Thinking with a diversity of 'others'

Thinking with a diversity of others was promising for multiple reasons. Firstly, contributors spoke to building relationships up and out as a means for enhancing equity attunement through exposure to diverse perspectives. Thinking with others also showed promise for strengthening networks, overcoming epistemological barriers, and improving the coherence and visibility of health equity efforts. This consideration involves connecting with people whose perspectives and experiences are different from our own, purposively creating diverse connections by "*building relationships up and out*" (Contributor 25). By processing thoughts with others, and particularly others who bring different life experience and perspectives to the table of dialogue, one can become more wakeful to their own taken-for-granted positionalities and privileges. Being more wakeful means being better positioned to leverage privilege. Responding to this idea, another contributor agreed that building relationships was central to her health equity work. She described how investing in "real relationships with people" enabled her to use her "position, credibility, and everything that comes with a position of power and privilege in responsive service" (Contributor 11). In these examples, contributors described the act of building relationships as something that helped them become more equity-attuned and responsive.

Several contributors spoke to the importance of thinking with a diversity of others across health disciplines. They commented that thinking with too many like-minded or like-positioned 'others' can perpetuate the dominance of ideologies that inhibit health equity action. Further, contributors frequently emphasized the importance of working across sectors and systems. One contributor noted that, regardless of where you might fall on a political spectrum, there are risks to thinking (and speaking) about health equity work with too many like-minded people:

> Part of the problem is that people are speaking to certain audiences…part of the [KTA} problem is that you end up speaking to the same people over and over again, you're saying things that please the same people over and over again, and you're not doing any work [to affect health equity]. (Contributor 25)

Another contributor spoke to the benefits of thinking with others as a way to open our minds to "epistemological pluralism that enriches the ways we think about what we know, what we do, and how we do it" (Contributor 17). Likewise, several other contributors described the ways in which thinking with a diversity of others served to illuminate our own biases and values. Without it, one contributor noted, epistemological injustices thrive. In addition, thinking with others was identified as a means of overcoming fragmentation and enhancing the visibility of health equity work. Contributors who were working in academic institutions were mindful of a lack of coherence in the field and the consequential lack of visibility in broader circles. Several contributors identified connecting with people outside the field of health equity (e.g., broader field of health, governments, non-health sector actors) as important. Put into the context of what contributors believed was disproportional privilege afforded to biomedical and genomic research funding, contributors considered the act of building relationships up and out as a means for raising general visibility of health equity issues. Like the benefits of eating well, building relationships up and out nourishes our minds so we can think about our work and the world with genuine critical reflection.

(c) Seeking coherence

Around the time I was working intensely with the dialogue data, I had the pleasure of hearing a keynote address from Dr. Christopher Horsethief, a Ktunaxa scholar. Dr. Horsethief explored collective experience of trauma among Indigenous people. He argued that it takes time to process and make sense of this trauma, which necessitates a process of finding individual and collective coherence. He described seeking coherence was a process of integrating traumatic experiences in a way that allows people to move forward. Dr. Horsethief's presentation resonated strongly at a moment when I was grappling with contributors' struggles to make sense of and find peace within a field ripe with incongruencies and tensions (Horsethief, 2018). I credit the naming of this consideration to his work on striving for collective coherence.

Seeking coherence was explored in response to contributors' reflections on incongruencies and tensions in our field. On several occasions, we grappled with why disconnects persist between what is known about the causes of health inequities (i.e., the evidence base for causal roots) and what is done in research, practice, and policy. In many dialogues, our reflections touched on shared experiences of witnessing incoherencies in the field of health equity. Sometimes, contributors and I grappled with our own internal incoherencies. One contributor remarked on how these inconsistencies are reflected in language that narrows health equity work in the health disciplines. She reflected on how even the word 'health' is perceived as "intensely biomedical" (Contributor 3). Narrowly framing issues related to health, she believed, was a major contributor to "being woefully behind in our assumptions," such that despite well-established evidence and knowledge about the social determinants of health, a more structural approach to health equity work is stalled by "the dogmatic nature of disciplines, especially at the academic institutional level" (Contributor 3). Experiences of encountering this kind of dogmatic, narrow conceptualization of health were described as "frustrating," "disheartening," and "troubling" for

contributors (including myself). These reflections pointed to the value of intentionally seeking wakefulness to the limits and possibilities of our own practice and how they relate to norms, assumptions, and common practices in the field of health equity.

Contributors' descriptions revealed a kind of disconnect wherein the knowledge and evidence about causes of health inequities were overlooked, ignored, or co-opted. This incoherence was, for example, experienced through the use of health equity language that 'sounds good', but for which responses were framed in ways that could not possibly result in change. Sometimes this language involved misconstrued evidence about health inequities, but contributors also observed an unconcerned use of health equity language to label or legitimize research or policy that had little to do with health equity. More troubling than the observations themselves was the lack of insight or uneasiness about the incoherence between evidence about health inequities and action in research, policy, or practice. One contributor's comments about this were particularly poignant, describing the impact of a lack of coherence in Canadian contributions to the field:

> If we just said, 'how many people can you talk to in Canada about health equity?', you could tell me thousands. Everybody. It's a term that's thrown around…it's become the same ubiquitous term that many, many other terms are that, you know, scholars just pick up and they sound good…I mean, who's going to object to health equity? That would be like objecting to apple pie, you know. It loses its meaning because of being so ubiquitous. And it's a feel-good word. Everybody says they're working, you know, in the needs of health equity. I listen to the students…we have now in the department a student day of research and a faculty day of research…[and it puts] my heart in my stomach because the vast majority of students within our department…should [know] that this concept is central to everything we do...But instead we have, you know, people studying how many vibrations per minute…affect [workers' health] when they [use machinery]…And somehow, vaguely, things like that will get framed as…a question of health equity, this wonderful concept that we all work for…[And they go] on to offer some kind of bio-behaviourist solution that's not…not at all political, not at all about the underpinnings of where health equity actually comes from (some words adjusted to maintain confidentiality). (Contributor 21)

Although the disconnect between knowledge and action seemed significant, contributors shared concerns about the 'permissiveness' and 'legitimization' of behavioural, biomedical, or otherwise unrelated efforts that, in the end, serve to distract from or entrench the problematics underlying health inequities.

Another important aspect of seeking coherence identified by contributors was that of connecting to the lived realities of inequities. There were many passionate discussions about how much of health equity work was about creating a way to "viscerally shift" (Contributor 4) the ways they understood the systems of oppression and power that give rise to health inequities. This was described as connecting to the human experience of inequities through bearing witness. One contributor described how she allowed herself and granted others access to her own lived experience:

> …at the base of it is that it's an emotional journey for myself in the sense of… like you had shared, you have experienced. You know, we're no longer talking about something over there, it's about my lived experience. And so, in educating, there's always a part of me that I have to tuck away in a safe place, so that I can create vulnerability within myself to create a safe place for people to have true dialogue.

> Because until we can get into that true dialogue and trouble it, only then can we get to the other side. But if we keep resisting or keep denying or keep oppressing each other or opposing each other, we're never going to find that solution together and it really is together that that needs to happen. (Contributor 18)

Contributors described how grappling with incongruencies was something deeply personal and vulnerable, both for people sharing their lived experience and those receiving messages about lived experiences. The topic of incongruencies evoked conversations about tensions contributors experienced in their work, particularly when confronted by their own privilege or complicity in systems of power. One contributor reflected on the tensions tied up in Canada's 150th celebration, where something celebratory for some people in this country was traumatic for others. Another contributor reflected on how grappling with incongruence created vulnerability not only because it sometimes involves sharing troubling or traumatic experiences, but also because it involves admitting the limits and need for life-long commitment to expanding our own reflexivity. For example, sharing a lived experience of institutional racism and intergenerational trauma can, on one hand, be a powerful narrative to open dialogue about the human experiences of inequities; while on the other hand, it exposes the storyteller to vulnerability. The desire for coherence was indirectly referenced by contributors in their reflections about how they work to make more explicit links between policy (as action or inaction) and health consequences. Several contributors described this as "walking a diplomatic line" that involved strategically supporting people in positions of influence to recognize "the impacts of their policy directions on the lives of real people" (Contributor 20). Though contributors did not label it as such, their descriptions demonstrated the ways in which cultivating coherence with others created opportunities to advance equity agendas that might otherwise be overlooked.

(d) Contemplating interconnectedness

Contributors to this study generally described their understandings and work with a great deal of acceptance for the wickedness of health equity problems. Some contributors explicitly embraced complexity theory as a foundation for their work, but the necessity of thinking with complexity was embedded in every dialogue, regardless of contributors' theoretical foundations. "It's very hard for people doing advanced research around health equity because you have to think broadly, you have to think in complexity, and you have to bridge and make connections to understand something that's using innovative thinking" (Contributor 20). Thinking about interconnectedness and complexity in issues of health equity was also described as a means for resisting reductionism. Creating a "place for complexity" was something that could be achieved by using "stories that hold all of the stuff that academic articles can't" (Contributor 4). She described the powerful ways in which students used dance, visual arts, and storytelling to express complexity:

> if you have a story, you don't have to kind of streamline it to be about three themes that fit in an academic paper. It can carry the richness of it, and that's why stories told multiple times from different perspectives in different places, I think, are… are the place for complexity. (Contributor 4)

This was reified by another contributor's recounting of her organization's efforts to build capacity using complexity theory, including the use of story to embrace complexity in different kinds of research. Thinking with complexity, from contributors' perspectives, was critical to being able to orient health equity work in productive ways.

Some contributors cautioned that an absence of thinking about complexity poses risks of perpetuating unintended consequences through health equity work. Reflecting on the feel-good assumptions embedded in the field of health equity, contributors argued that just because someone says their work focuses on addressing health inequities, doesn't mean it will do anything to advance health equity. Indeed, given the complex tensions researchers often navigate in pursing health equity work, superficial considerations of health inequities risk inadvertently reinforcing causes of health inequities. In one dialogue, researchers reflected on how failures of health equity impact assessments[13] were, in part, related to gaps in understanding and capacity. Contributors commented that, although it may sound good in principle, the execution of health equity impact assessments is vulnerable to superficial assessments because of the lack of training or understanding about the complexity of health equity issues. Contributors also revealed complexities in navigating multiple actors and their competing interests. Completing an impact assessment may, for example, be about understanding risks to health equity, but, it is not necessarily designed to mitigate underlying conditions of power. Some contributors reflected on how private industry is often held responsible for completing health equity impact assessments prior to being granted approval to advance infrastructure or extractive projects. Health equity researchers navigating health equity work and relationships with governments, community, and industry can, in this circumstance, face intense tensions, as was noted by one contributor:

> health equity impact assessment is tasked to industry, and they don't know how to do it. They're perfectly willing to do things at a community level to make things better but upholding this broader framework that asks them to look across sectors and that sort of thing was really well beyond their scope. (Contributor 11)

The lack of recognition of complex interconnectedness, contributors reflected, particularly in government-corporate-community relationships and social power, places people already experiencing inequities at greater risk by off-loading responsibility for broader social protections.

Finally, considering interconnectedness and complexity *across time and place* surfaced in several dialogues. Several contributors commented on how their own understandings of power in society and its relationship to the health of people and the planet, evolved through a deep attentiveness to the historical, temporal, and locational situatedness of issues and experiences. Canada's residential schools arose as an example where greater attention to the interconnectedness of inequities over time and place and their shared relationships to power and oppression, has contributed to consciousness regarding the complexity of inequities. One contributor described her thoughts on the importance of discussing events such as the use of residential schools:

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[13] Health equity impact assessments are a tool described by the CSDH as a "support tool for building policy coherence for health equity" (Commission on Social Determinants of Health, 2008, p. 115).

I've found that using examples of where it's gone badly from history kind of helps, I think makes a point. So, for example…residential schools is [an] example, right? But then, when you start to show students that there are many pervasive, persistent structural inequities that have been reproduced, and could continue to reproduce, you know, through policies that we make and continue to reinforce these kinds of inequities for Indigenous people… and residential schools is an example of that that we're still contending with, the consequences. (Contributor 2)

She described her experience as part of something connected to a greater community that stretched for thousands of years in relationship to this land, "when I'm speaking of who I am and where I come from, that's my relationship to not only my kinship but to the land" (Contributor 18). This was one of the most provocative dialogues I had the privilege of hosting during the process of this study. It sparked a great deal of introspective reflexivity for me and opened a process of discovery and identity exploration that was quite unexpected. Our conversation explored the concept of interconnectedness deeply and along with demonstrating other promising ways of thinking, this dialogue is perhaps best represented in the interpretive poem, 'Drawn Onward' shared below (Figure 5.4).

Table 5.5

Promising Activities for 'Thinking Relationally', with Associated Objects of Reflection and Strategies for Enactment

at Personal and Institutional Levels

Promising Considerations	Strategies to enable and empower thinking relationally	
	Personally	**Institutionally**
Recognizing human existence as relational	• Stay informed and critically reflect on local, national, and global issues • Actively consider power, privilege, and political economy in conversations about these issues • Listen to and witness stories shared by groups/communities experiencing systemic inequities • Engage in acts of solidarity or social activism (e.g., march for human rights) • Consider personal contributions in the context of a broader, collective program to advance health equity • Seek exposure to diverse perspectives in choices about reading, media consumption, and social participation	• Model a relational stance in policy development, institutional processes, and teaching/learning strategies • Provide opportunities to critically reflect on power, privilege, political economy, and normative social values in curriculum and professional development • Integrate relational and critical theory into curriculum for health disciplines • Embrace a language of health equity that explicitly acknowledges the role of power, privilege, and political economy • Promote consideration of structural, social, and ecological determinants of health in processes, policies, and curriculum for health disciplines • Incentivize collaborative competition in performance review, funding mechanisms, and teaching and learning initiatives
Thinking with a Diversity of others	• Talk about local, national, and global issues with others • Seek diverse perspectives, practice inclusivity • Build relationships *up and out* by seeking connections outside our own discipline or organization • Actively build skill and capacity to engage in critically reflective dialogue, including skills for identifying and examining your own and others' assumptions	• Model critically reflective conversation in policy development, institutional processes, and teaching/learning strategies • Incentivize transdisciplinary collaboration in performance review, funding mechanisms, and teaching and learning initiatives • Critically examine hiring policies and practices for how they enable or restrict diversity; change them to enable diversity

Promising Considerations	Strategies to enable and empower thinking relationally	
	Personally	**Institutionally**
	• Exercise curiosity and interest when dialoguing with others • Recognize acts of scholarly writing as dialogic, inviting others to engage and actively engaging with others • Identify synergies and opportunities for collaboration	• Create a culture of dialogue, supporting events and curriculum/professional development opportunities that enable dialogic engagement • Support capacity building for critically reflective dialogue
Seeking coherence	• Maintain a practice of reflection about why, what, and how we do routine parts of our work (e.g., journaling, thinking with others) • Seek awareness of the edges of our praxis, particularly in relation to how we connect what we know about health equity to what we do to advance it • Actively push the limits of our awareness of assumptions and how we privilege knowledge • Honestly reflect on *how* we connect (or do not connect) what we know to what we do	• Model seeking coherence in policy development, institutional processes, and teaching/learning strategies • Make explicit the rationale for decisions • Strive for integrity in policy environments, wherein the rationale for decisions aligns with implementation realities • Honestly assess how policies, processes, and teaching/learning strategies are oriented to health equity (e.g., apply heuristic); adjust to move to progressively more productive orientations
Contemplating interconnectedness	• Develop awareness and appreciation for relational, interconnected worldviews such as those common to Indigenous peoples by reading Indigenous literature (fiction and non-fiction) and/or taking courses on Indigenous issues • Develop KT products that demonstrate interconnectedness (e.g., products include acknowledgement of interconnectedness of contexts implicated in the work and of historical conditions that led to current contexts) • Self-reflect on what kind of thinker/learner you are, and with this information in mind, seek ways to develop greater comfort with complexity	• Model ways to acknowledge and honour interconnectedness by, for example, adopting policies about acknowledgements of traditional territory or important historic conditions that continue to influence present contexts • Integrate stories that demonstrate interconnectedness into teaching/learning strategies • Integrate complexity theory into curriculum for health disciplines • Create funding/publishing mechanisms that privilege non-dominant (i.e., non-positivist, other-than biomedical or behavioural) approaches to research

Promising Considerations	Strategies to enable and empower thinking relationally	
	Personally	**Institutionally**
	• Ask questions about how you may be reducing or simplifying the messiness of a problem, examine why this is happening, and challenge yourself to stretch toward considering greater levels of complexity • Examine the influence of mechanistic reductionism (see, for example, Jayasinghe, 2011) in your thinking and consider how this influences your work	• Develop capacity for recognizing and embracing complexity in peer review • Incentivize non-reductionist approaches to health equity work

5.4.2 Thinking Reflexively

Though the invitations and nature of dialogues were structured on assumptions about the value and importance of reflexivity, the data affirm the importance of it as a promising way of thinking for health equity. Contributors consistently illuminated ways in which reflexivity, both within the field of health equity and society broadly, was an important and promising pathway to more meaningful health equity action. Among the promising ways of thinking reflexively, this series of dialogues pointed to the importance of: (a) examining positionality and identity; (b) examining power; and (c) deeply examining assumptions.

(a) Examining positionality and identity

Contributors offered several examples of inviting or facilitating processes of examining positionality and identity in the context of health equity. They explored challenges in doing so, noting that confronting positionality can be ugly and difficult because of the "fragility of people's identity" (Contributor 4). A few contributors described some of their health equity work as supporting students to reflect on positionality and identity, and to explore the moral distress, guilt, shame, and transformation that can evolve from thinking it through with others. This type of reflective thinking was recognized as promising because contributors believed it could open doors for understanding how power and privilege manifest in unequal experiences. Dialogue data revealed that, regardless of where they unfold, conversations about health inequities push against unspoken norms and discomforts and illuminate systematic injustices in ways that evoke confrontations of "one's own complicity in systems of power and privilege" (Contributor 3). Over the series of dialogues, it was clear that making sense of these tensions required a supportive environment and a deeply personal gaze, both for contributors and for the people they support in their roles as researchers, teachers, or health professionals. The absence of supportive environments for reflexive consideration of identity and positionality was witnessed as leading to "unproductive denial or defensiveness" (Researcher).

Countering tendencies toward defensiveness in explorations of identity and positionality emerged in a dialogue where a contributor and I were exploring our roles as teachers and parents. This contributor offered a hopeful reflection about why examining identity and positionality is important and how it can be invited through stories:

> I teach political ecology, so I teach -isms, like racism, colonialism, capitalism…not as monolithic structures that behave a certain way, but as stories that shape us all unequally. They impact us all in really powerful ways, but not equally. So, that's why, when I'm teaching…and I try to do this my kids too…it's not about calling out. Because that call-out culture, where people feel called out as a racist or a colonialist or anything, closes doors. I tend to treat -isms as stories that shape us. The power of this is that, when it is a story, you [can ask]…'how are you in relation to the story?' And then, as we know about stories, we can always remake stories. (Contributor 4)

Contributors' examinations of positionality and identity revealed an ongoing reflexivity, which often began by becoming more wakeful to how societal forces differentially and unequally shape experience and continued by extending this wakefulness to ourselves in relation to others. They reflected on positionality both as individuals, as parts of collectives (e.g., cultural or professional identities), and as institutions (e.g., the Academy). Examining positionality and identity was described by contributors as

emotional and bold work that was often undervalued in health disciplines and particularly infrequent at the institutional level. Some contributors reflected on how Indigenous knowledge systems embrace exploration of positionality and identity as part of human journeying in life. These contributors suggested that attentiveness to our connections to time and relationships with others and the land were important aspects of reflexivity. Pursuing a journey of reflection on these relationships, between self and others and place and time, was understood as an active integration of thinking-doing that is inherently congruent with equity.

(b) Examining power

Examining power was a core part of most contributors' descriptions of their health equity work. They spoke of efforts to support others' examinations of power and practice and they demonstrated their own commitment to thinking about power during our dialogues. Sometimes, examining power was quite general. For example, some contributors reflected on how some disciplines, particularly those grounded in critical theories or intersectionality, were more characteristically attentive to power than others (especially more so than the health disciplines). Other times, contributors expressed their consciousness of the colonial roots of other disciplines and of the academic enterprise in general. Their comments show how the absence of examining power in health sciences, systems, and research was deeply problematic. Several contributors described how the long-reaching shadows of colonialism continue to shape the ways in which power and privilege are seen *or not seen* in society. These shadows were described as influencing what is prioritized, celebrated, and even what counts as knowledge. The shadows were also understood as something that stretched into motivations for being involved in health equity work, reflected in contributors' remarks about the persistence of colonial and paternalistic attitudes.

Contributors' stories were often demonstrative of why examining power matters to health equity work. For example, in examining how health equity work is positioned in the broader field of health, contributors described how the dominance of neoliberal and biomedical ideologies that restrict progress toward health equity occurs because "the biomedical model is ruled predominantly by white power, it is exactly what feeds into the social constructs or social fabric that have led to these causes of inequity" (Contributor 3). This dialogue explored tensions that thrive in the field of health equity, where "good intentions" could often be construed as sufficient, despite the limited potential for biomedical approaches to result in meaningful health equity action. Several contributors reflected on the absence of normative expectations to examine power structures and privileges in this field. Contributors observed that people in the field tend to focus on what is comfortable to see. One contributor reflected on the impacts of a lack attention to power in policy processes:

> …even if they have the best intentions, because they don't have the insight into what that actually translates to at a very, you know, at the roots for somebody who has a very precarious life…so that ignorance sometimes then could mean that they're…developing something with unintended consequences. And…who bears the brunt of the unintended consequences? It's again…those that we're trying to help…so we need to be more nimble and responsive with policy making to be able to have those adjustments take place. (Contributor 17)

This same contributor also shared thoughts on population health surveillance:

> …coming back to being self-reflective, we need to be careful, and we haven't done that enough in public health…because public health can be an oppressive institution, especially when it comes to surveillance practices…we do not want to create again a mechanism that is oppressive…. (Contributor 17)

Another contributor described how shadows of colonial power reached into the lives of her family and community, showing the vulnerability inherent in recognizing the lived experience of colonialism and power. Her reflections show how complex the work of understanding colonial influences can be and involved deeply personal and reflective work both alone and with others, as well as analytical work:

> From the day of birth until we leave the earth, we're in politics and entrenched in it, whether we choose to or not. And when I think of health inequities and the broader scope of that…global to local, colonial history is present in encounters today. It isn't over. Colonialism is often talked of in the past, but it's not recognized very much how it exists in the present and continues to impact lives. And so, when I think of health inequities and equity, I think of just by being born, who I am and where I come from, that that's there. (Contributor 18)

Her work involved training health professionals in cultural safety, supporting them to recognize, examine, and interrupt systems of power and privilege by beginning with understanding their own positionalities in their practice contexts. We explored how this work contributed to health equity by fostering capacity for *allyship*, particularly "because addressing inequities that Indigenous peoples face is not solely the job of Indigenous peoples to work through…allyship is so important" (Contributor 18). "As an Indigenous person sharing and being open can get me this far, but an ally can probably get further…so allyship is so critical for addressing health inequities," she continued. One contributor reflected that "as an ally, to do this work and have meaningful influence, you have to be <u>not</u> driven by ego," (Contributor 21). The concept of allyship and solidarity continued to expand throughout the series of dialogues and was explored as a question (i.e., how to be a good ally) and as a pedagogical challenge (i.e., how to foster a desire and capacity for allyship), both of which were described as necessitating capacity to examine power in society.

(c) Deeply examining assumptions

Tied up in examining power is deeply thinking through and questioning both what our assumptions are and how they influence the why, what, when, where, and how of our work for health equity. This type of reflexive thinking focused on examining the deepest possible assumptions and was something that had occupied much of my own critical reflection. Several contributors commented that the tricky thing with examining assumptions is that they are often so taken for granted and normalized in our ways of thinking and doing that they are virtually invisible. In a few dialogues, I shared my experience at a training course for global health researchers called 'Privilege 101'. One striking exercise implemented during the course was the use of an online video that demonstrated inattention blindness. In the exercise, viewers were invited to count how many times a ball is passed between people in black t-shirts among a group of about six people in both black and white t-shirts. At the end of the exercise, viewers were asked to share their answers and compare degrees of accuracy. The facilitator then asked how many people

noticed the tall person in a gorilla costume that came onto the set, did a dance, and left again. It was shocking to hear how few people actually saw the gorilla! In a few dialogues, we talked about how different kinds of blindness—inattention or wilful—can negatively influence the direction of health equity work. Contributors agreed that inattention blindness extends to the very ways in which health equity and health inequities are conceptualized. Inequities are often conceptualized as 'the problem'. And though health inequities *are* problematic, contributors recognized that deeply and genuinely connecting KTA for health equity involves turning away from inequities themselves and toward the systems of power and oppression from which they manifest.

One contributor described how unexamined assumptions lead to directing attention too far down pathways to inequities:

> A lot of us start way downstream…pointing at health inequities without first establishing why we should care, who has a role to play in this, who caused this, what are the structures we can change in order to stop this from happening? Instead, we keep saying, for example, that people who use injection drugs have higher rates of HIV. Well who cares? If you're not telling us why that matters to begin with, who cares? You're just pointing at a problem that has no solution, that I don't see myself, that I don't understand how I can play a role in it, so I'm out. And that's what we do with almost every health condition that we talk about. And they're people who are already disenfranchised, they're already people that we don't interact with, they're already dehumanized. So, you're just giving us a stat…we're starting at the wrong end. Instead of asking, 'Do you believe that everyone should have an equal right to experience the best health that they can?'—that's the first question…but all of our systems are not set up to support that idea. (Contributor 1)

Contributors frequently reflected on questioning assumptions, touching on multiple kinds of assumptions that need to be examined to be able to inform equity action. Contributors reflected on how, in their teaching efforts, revisiting historical, normalized narratives can serve to illuminate both past and persistent assumptions. One practical example of this stemmed from a conversation about teaching. This contributor used songs from Canadian history to illustrate how underlying assumptions construct particular narratives and contribute to power imbalances. Although the songs are remarkably melodic and beautiful, she reflected that they often suppress the impact of colonial presence in 'frontier' times in ways that romanticize and silence violence. For example, Stan Rogers' rendition of Northwest Passage (available online[14]), is "beautifully moving, impossible to listen to without feeling the music and those pictures of explorers comes into your head," (Contributor 4). But, she suggested, the song is thick with assumptions about valiant explorers and their entitlement to lands without any reference to the violence suffered by, let alone the existence of, Indigenous peoples. Assumptions were also explored metaphorically, using the image of trees and tree rings to consider how stories are kept, witnessed, and experienced (see poetic representations in section 5.5 below for more). Assumptions about knowledge, about human existence, and about morality and ethics were discussed by contributors as implicated in health equity work. Although contributors were resolute in suggesting that assumptions cannot be

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[14] Stan Rogers song, *Northwest Passage:* https://www.youtube.com/watch?v=TVY8LoM47xI.

escaped, they were aware that they are rarely explored in sufficient depth to open new ways of thinking and being.

Table 5.6

Promising Activities for 'Thinking Reflexively', with Associated Objects of Reflection and Strategies for Enactment at Personal and Institutional Levels

Promising Considerations	Strategies to enable and empower thinking reflexively	
	Personally	**Institutionally**
Examining positionality, identity	• Read about critical theory, positionality, intersectionality, power and privilege • Seek diverse sources, including those you would situate as distinct from your own, in your reading about social power • Observe and strive to temper reactions to challenges about power or privilege (e.g., when asked to 'check your privilege,' lean into the challenge with curiosity and an effort to understand rather than adopting a defensive stance) • Reflect on challenges to power and privilege • Support challenges to power and privilege by demonstrating a willingness to listen rather than speak	• Demonstrate awareness of positionality and power across bureaucratic structures, including governing boards and executive teams • Support leaders to develop and model a practice of reflexivity • Invite reflexive dialogue, institutional positionality, and identity (could be accomplished at multiple levels) • Integrate content on reflexivity into curriculum for health disciplines, including provision of opportunity to practice it in safe and supported environments • Create opportunities for reflexive dialogue • Incentivize reflexivity by including it among criteria for performance review and peer review (both funding and publication)
Examining Power	• Understand what privilege is and why it is important • Develop capacity to recognize and analyze power and privilege through reading, training, and/or courses • Develop capacity to talk about power and privilege with others; become aware of where you are comfortable and uncomfortable • Observe and contemplate how your own experiences of power and privilege relate (or do not) to others' experiences	• Support training and capacity building related to power and privilege (e.g., cultural safety training, Power & Privilege 101) • Invite reflexive dialogue about institutionalized imbalances in power through leadership development, strategic planning, or policy development; demonstrate a willingness to listen and respond in meaningful ways • Integrate consistent attentiveness to power and privilege across curriculum for health disciplines

Promising Considerations	Strategies to enable and empower thinking reflexively	
	Personally	**Institutionally**
Deeply Examining Assumptions	• Assume the work of questioning assumptions is never done; adopt a constant commitment to questioning • Ask "Why?" questions repeatedly, reaching for structural or power-related possibilities • Ask questions about why a health equity-related initiative is being celebrated, with attention to underlying assumptions • Think with others about what assumptions might be influencing the way an interaction or initiative (or even a question) might be framed • Use challenges to normalized historical narratives and to illuminate current assumptions • Seek and engage in opportunities to learn from others willing to share alternate narratives or histories through media, art, or community events	• Demonstrate a consistent practice of questioning assumptions in leadership and teaching, opening opportunities for dialogue about difficult topics (e.g., what kinds of colonial assumptions may be shaping the way we are considering this issue or initiative?) • Integrate opportunities for questioning assumptions into curriculum for health disciplines, including the use of learning assessments • Set goals and targets that challenge reductionist, neoliberal, behaviourist, biomedical, or individualist assumptions that pervade health equity work • Demonstrate an institutional value of epistemological diversity; seek and use multiple sources of 'evidence' and 'knowledge' in policy and decision making, teaching, and practice

5.4.3   Thinking Responsively

Thinking responsively evokes ethical-moral considerations of our knowledge (e.g., about root causes of health inequities), roles, positionalities, and power in society in ways that purposefully inform our responses. A contrast to thinking reactively, thinking responsively has to do with contemplating how to achieve authentic coherence in health equity work. It implicates all of the other ways of thinking because it is inextricable from how someone understands their own interconnectedness, positionality and identity, power and privilege, and role in the world. Thinking responsively means intentionally embracing an assumption that connecting KTA for health equity is not neutral and doesn't strive to be—it strives for disruption. The promising considerations for this way of thinking identified through dialogue were: (a) considering research as responsibility and (b) cultivating compassion. As in previous sections, these considerations are described narratively and an overview of personal and institutional strategies for enacting them follow (Table 5.7).

(a) Considering research as responsibility

Contributors across the series of dialogues explored many different ways in which they considered research as responsibility to be an important aspect of KTA for health equity that reflected thinking responsively. Thinking about research as responsibility evoked an important distinction between doing something because it "*sounds good,*" and doing research in ways that contribute to the good of all. It is a recognition that health equity research is tied up in a deep commitment to transforming our own social power into acts of resistance and acts of activism and advocacy that shift us, in our shared humanity, to a more equitable human existence in the world. Evident in the dialogues was a challenge to those working as researchers in the field of health equity to closely examine what we do and how we leverage our social power in a way that responds to and accepts a degree of answerability for, the systems and structures that are productive of health inequities. As a way of thinking, it invites us to imagine who we are in relationship to advocacy, what role scholarship can (and should) play, and how one uses scholarship in service of advocacy and activism. Thinking this way can support challenges to privileged ideologies and interests by opening new dialogues. As one contributor offered, "What does this research mean for society, where is it going, what will it do, what impact will it have?" (Contributor 20)

Contributors were conscious of embracing their responsibility to society as researchers. Contributors' distinctions between work that could genuinely advance health equity versus work that fell short were consistently related to equity attunement and to whether or not research was contemplated as something in service to society. They identified a need to challenge assumptions underlying measures of academic 'successes,' particularly ones that contribute to self-serving benefits. Below, I share an overview of a dialogue where these concepts were well-articulated by a contributor whose reflections touched on how equity attunement and thinking responsibly as a researcher are implicated in the struggle to advance health equity.

This contributor recounted her experiences as an activist scholar in a Central American country. Her story explored feelings of obligation and answerability evoked by being a Canadian researcher

working in communities coping with the increasingly distressing presence of Canadian extractive industries. As her effort to maintain integrity while witnessing the impacts of an intensified presence of Canadian corporations, she found herself increasingly engaged in activist scholarship. Activist scholarship, she explained, is "openly political." It "stems from the work of organized political groups," and is not "done on them, but with them to align scholarship with the advocacy agenda of a political group." It is about leveraging social position as a professor to "impress upon politicians or the media," or to "speak from a place of moral authority," using the power she/he has to do something to meaningfully raise awareness and interrupt the harms of unbridled corporate power. Her conceptualization of 'leveraging' created a foundation for a broad, far-reaching understanding of what kind of research or activism is legitimate.

> I don't work with health [or] people working in health, not directly. It doesn't always have a clear health angle to it. I'm working with groups and communities organized to defend themselves against the onslaught of Canadian capital in the form of Canadian mining companies. That's working at health equity. That's working at the root causes of what's going to be a very destructive practice within their communities.

> Responding to this onslaught of capital is located in the work of health. It's working on deep political, structural things that directly affect people's lives and health. My work aligns with key activist movements. It is a contribution to resist the onslaught and the destruction of international capital arriving in the form of, mostly Canadian mega projects or mining projects, to that country. So, you know, how can I work in health equity and ignore that, being a Canadian? (Contributor 21)

This example illuminated how one researcher embraced her responsibility for a praxis of equity and for leveraging social power. It shows how solidarity, as a scholar, involves direct engagement in listening and telling her story because "they've charged me with doing that, they've asked that this be one of the roles I do" (Contributor 21). She contrasted this acceptance of responsibility with idealized, but often disconnected kinds of scholarship that romanticize the relationship between researcher and a generic idea of "community".

(b) Cultivating compassion

One of the most surprising findings was the frequency in which evoking empathy, human connectedness, and compassion were named as promising for connecting KTA for health equity, a finding that informed the construction of the second way of thinking responsively, namely cultivating compassion. Sometimes, contributors described the difficult balance of allowing oneself to feel empathy when the media is constantly producing reports of "atrocious things" that are so overwhelming the idea of stopping and thinking about the gravity of it all is untenable. "I think about all of those situations and I think about how horrible that all is, and how we just allow that to go on, we just go about our day as if we can work when this is happening in the world!" (Contributor 11a). But despite difficulties in cultivating compassion related to inequities, many contributors reflected on the importance of evoking emotional connections and responses in KTA for health equity work. For example, one contributor commented on the impact of leveraging compassion when describing her work in supporting public health workers to consider equity:

> They'll have the compassion and they'll realize they don't want to enforce something punitive. It creates a way for them to do something—even if they can't do anything to 'fix' poverty, they can see a whole person and change their response to accommodate with compassion, either through their documentation or their follow-up. (Contributor 13)

This contributor and several others recognized the importance of talking about health equity with "compelling stories" (Contributor 20) that create "human connection" and "empathy for the lived experiences" of inequities. Another contributor spoke to this connectedness as a means for "humbly acknowledging oneself as part of a solution," where health equity work is about recognizing our shared humanity and working "from our hearts" (Contributor 18).

The repeated appearance of this concept in dialogues led to the pursuit of dialogue with a compassion scholar, which gave more depth and clarity to what this might mean in the context of advancing health equity. Our conversation began by exploring the definition of compassion as a relational act. Compassion, as he described it, is more than just empathy. It is about "relational understanding and action," involving virtues, values, and qualities of a person or organization, but overall, compassion is about thinking with empathy and then responding in a way that honours the needs, experiences, or feelings of another. Working from a position of compassion is about, "moving us to an initial response to begin to think about how we can do something for this person" (Contributor 23). The active element of compassion makes thinking this way a strategy for going beyond "witness and whine" (Contributor 11b) or passive acts of reflection. Cultivating compassion was therefore promising for connecting KTA for health equity because contributors believed it could mobilize actors to *do something* in response to health inequities. Some contributors explored how it could shift political appetite by giving weight to moral or ethical obligations in decision making. For example, one contributor identified the United States' Obamacare[15] as a policy of compassion, "not because financially it was the most important fiscal move to make, but because it was the "right thing to do" and was better for the collective good" (Contributor 23). Another described the ways in which presenting data alongside stories could compel action because "stories allow people to see themselves in health equity work with optimism and agency" (Contributor 4).

When done with others, thinking with compassion was described as something that could support people, whether they were students or practitioners or decision makers or researchers, to "overcome paralysis" (Contributor 23) and move past feeling overwhelmed. This contributor described compassion as an act of connecting values and beliefs about what is 'right' to give policy attention and legitimacy, even when they conflict with other values and beliefs (e.g., neoliberal economic policies in health, such as privatization). One contributor expressed his feelings on policy environments:

> we know what kinds of policy environments are much better for health equity and what ones are much worse and despite all of this, we persist with those that are worse. It's

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[15] Obamacare is a nickname for the Patient Protection and Affordable Care Act, enacted under the presidency of Barack Obama in the United States of America. It countered neoliberal conventions of minimal government, privatization, and marketization by expanding health insurance coverage to up to 24 million people. More information is available online: https://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

not just in countries that are lower or middle income. In Canada, the erosion of social protection policy environments at virtually all levels, from municipal, provincial and national, these are all eroding, even though we have lots of evidence and lots of advocates saying that this is what's going to be better for health (Contributor 11)

The erosion of social protection policy reflected an environment here in which it is increasingly permissible to pursue policy, despite knowing it is harmful. Perhaps, one contributor reflected, with more room for compassion in policy, doing the 'right' thing would be given more priority than doing the "economically sound" thing (Contributor 23).

Cultivating compassion was also promising because contributors described it as playing an important role in enhancing equity attunement. Several contributors explored the deeply personal process of making oneself vulnerable to witnessing and feeling the spectrum of human experience tied up in power and privilege, and then responding to it. Health equity work, contributors expressed, is "healing work," part of the "personal journeys" (Contributor 17) we need to walk to be effective in our roles. These conversations revealed a relationship between compassion and relational consciousness, suggesting the need for deep reflection on the lived realities of oppressions. Evoking visceral kinds of connections to health inequities has been discussed in other sections of this chapter; however, one powerful example was offered by a contributor reflecting on how she cultivated compassion for the historical trauma of the slave trade. She shared an interactive webpage (available online) that used marine records from 15,790 slave ships to animate the scope and scale of the trade. She commented on how deeply affected students were by witnessing the gravity of this atrocity in a way that humanized the impact:

most of my students say that's one of the most profound two-minute experiences they've had in education because…they worked through one story about the industrial revolution, they didn't see the human capital rendered as slaves that made the world as it is…and how racism played a role in founding the world economically and socially. It makes something like skin colour pretty profound when you think of who has been made to feel human or less than human throughout history, and we're still kind of in those places, right, even globally? When you look at the UN, you see people who are working in health, you know, all those global things that you can think of about shade-ism, as far as who gets to have the power. (Contributor 4)

Cultivating compassion, it seems, can be a powerful tool for inviting learners into dialogue about the very real, grave impacts of power and privilege in society, allowing them to explore difficult topics from a place of caring. Individual and institutional strategies were suggested to build capacity for cultivating compassion (see Table 5.7).

Table 5.7

Promising Activities for 'Thinking Responsively', with Associated Objects of Reflection and Strategies for Enactment at Personal and Institutional Levels

Promising Considerations	Strategies to enable and empower thinking responsively	
	Personally	**Institutionally**
Considering research as responsibility	• Contemplate the ways in which research contributes to health equity action	• Acknowledge the service role academic and health institutions play in society
	• Strive for authenticity and integrity in health equity work	• Demonstrate a high-level commitment to health equity work across the academic-professional enterprise, explicitly identifying health equity work as part of the core service of this enterprise in society. This includes funding agencies, professional associations and colleges, universities (including administration and faculties), and academic journals
	• Consider how research may contribute to reinforcing privileges or oppressions, even unintentionally (e.g., by creating exclusive benefits, reinforcing biobehavioural or individualist explanations for structural problems, not questioning assumptions)	
	• Demonstrate creativity and take risks in developing products that can make more meaningful contributions to advancing health equity than traditional academic outputs (i.e., peer-reviewed publications)	• Examine and revise institutional policies and processes, across all levels, to advance (or inhibit) health equity action
	• Frame health inequities accurately	• Examine and revise academic performance review criteria to elevate the value of contributions that meaningfully advance health equity action, especially those that fall outside of traditional measures of academic success
	• Make clear statements about intentions and assumptions; demonstrate humility in willingness to examine these and respond	
	• Orient health equity work in progressively more productive ways (see heuristic, Table 3.4), investing energy and time in efforts that can, at a minimum, illuminate and more ideally, interrupt	• Demonstrate a high-level commitment to health equity work across the academic-professional enterprise, explicitly identifying health equity work as part of the core service of this enterprise in society. This includes funding agencies, professional associations and colleges, universities (including administration and faculties), and academic journals
	• Purposively align health equity efforts with others; seek synergies and collective action	• Identify and mitigate pressures to satisfy corporate or privileged interests over health equity action
	• Demonstrate and model integrity between ways of thinking and ways of doing in health equity work	• Examine and revise institutional positions, policies, and/or practices that may contribute to inhibiting health equity by people working within that institution
	• Mentor and support others to think about research as responsibility	• Recognize and use positional power to amplify health equity action; take a stand *for* health equity

Promising Considerations	Strategies to enable and empower thinking responsively	
	Personally	**Institutionally**
	• Recognize and use voice as an ally in health equity action, leveraging social position/power and credibility to support social movements and activist efforts for health equity	• Demonstrate institutional allyship, lending social position/power to health equity work
Cultivating Compassion	• Imagine what it would be like to experience something inequitable, unfair, or unjust before assigning judgement • Seek opportunities to witness lived realities of health inequities and allow experiences of emotion in response • Don't avoid witnessing something because it feels too painful or seems too ugly or overwhelming • Talk with others about witnessing and responding to health inequities; critically reflect on and make a commitment to doing something differently, even if quite small • Consider how health equity work could contribute to evoking compassion among others	• Make time and create opportunities for cultivating compassion among people working or learning within institutions • Integrate opportunities, including learning assessments, that involve exposure to lived experiences of inequities into curriculum for health disciplines • Whenever possible, in curriculum, professional development opportunities, or institutional policy and planning, seek and use evocative, storied content that demonstrates the lived experience of health inequities • Elevate the importance of compassion in institutional policies and processes (e.g., integrate compassion, ethics, or 'doing the right thing' as a criterion for consideration in policy or decision making)

5.4.4   Thinking Tenaciously

Thinking tenaciously was not a concept explicitly expressed by contributors, but rather was implicit in the ways they talked about their work. This way of thinking is about recognizing the long-term nature of health equity work in balance with a spirit of hope and optimism. Across all kinds of career stages, contributors described the difficult challenges they faced and the isolation they sometimes felt in their work. Some were more disheartened than others, but none expressed anything that would amount to 'giving up'. Contributors' reflections suggested that genuinely working to connect KTA for health equity demands working against systems of power and sociopolitical and economic environments that are at the root of health inequities. Here, contributors described two activities that helped them to think tenaciously: a) maintaining optimism and b) considering audacity.

(a)   Maintaining optimism

In a lecture on critical population health, my master's supervisor once said, "optimism is the greatest form of social protest" (Labonté, personal communication, 2004). This is something I have held onto, sharing it many times in my own lectures or interactions with colleagues involved in health equity work. This series of dialogues affirmed that Ron Labonté and I are not alone in holding onto optimism. Hopefulness for the future and a general faith in the possibility of a more equitable world were common among contributors. Even when contributors expressed cynicism or exhaustion, they tended to return to a place of optimism by the end of our conversations. For example, speaking about barriers to advancing a health equity agenda, one contributor expressed frustration about the visibility of Canadian contributions to health equity research when compared with Norwegian scholars:

> …[In Canada], health is bio medicalized and individualized. That's the default here. Now in Scandinavia, that's probably the case as well, but the difference is…you might have 100 epidemiologists and you might have five critical social scientists, but because the state in Norway is oriented towards equity and reducing inequalities and the Norwegians have a passion for equity…those five people are listened to. Here, you've got 100 epidemiologists and 100 nutritionists and 100 physiologists and five of us. So not only are we outnumbered, but nobody cares, and nobody listens. (Contributor 14)

Others reflected on how maintaining optimism carried them through long waits between efforts and outcomes. Often arising from reflections about experiences of being overwhelmed or paralyzed by complexity, contributors spoke about maintaining optimism as part of their resiliency, as part of their attempt to resist the "machine of neoliberalism" (Contributor 25), and as part of the way they saw the world. Instead of being overcome themselves, they leaned into the complexity with hope and tenacity. "I'm optimistic and hopeful…greater health equity is possible" (Contributor 1). They described how they grappled and struggled with the tensions they regularly experienced in this field, but almost invariably ended with a statement of optimism. They were inspired by examples where hope, optimism, and a willingness to think relationally served as sparks for change over the long-term.

> And that's part of the imaginary that I think you were talking about that resonates with me as well, is that…how can we…how can we shift…and I have seen shifts around gender fluidity and all kinds of things in my lifetime. So, I do think it's just the norms lead to shifts because…because peoples' experiences are not those norms. So ya,

that's how I stay hopeful. And ya, as you said, it seems so overwhelming that I think people around us are…are the ones that help us to see how those stories shift because they've never really resonated with some people…. (Contributor 5)

(b) Considering audacity

Considering audacity is about having the boldness to intentionally weigh decisions in ways that are wakeful to deeply normalized systems of power and include a willingness to try interventions not yet 'proven.' As one contributor commented, it involves "doing something new, which is a bit risky…we have to try some things and measure them and see what happens…that's scary for people" (Contributor 13). Contributors were conscious of the boldness required to examine systems of power that are so taken for granted they are often invisible. Though unpalatable and politically incorrect to admit, one contributor reflected that "some lives are more grievable than others" (Contributor 4). She referred to Judith Butler's book, *Frames of War*, where Butler argued that the "frames in which we apprehend or, indeed, fail to apprehend the lives of others as lost or injured (or lose-able or injurable) are politically saturated. They are themselves operations of power…" (Butler, 2009, p. 1). The contributor's reflections were focused on how, even in a field purportedly focused on making the world more equitable, there are differentials in the worthiness assigned to some lives over others.

One of the challenges of connecting KTA for health equity reflected in this dialogue, was that the vast majority of humanity is desensitized to systems of oppression or exploitation. We are, instead, sensitized to violations of status quo. By describing a cartoon, one contributor offered a metaphor that exemplified how people can become desensitized to the gravity of health inequities:

That cartoon from Larson where a fish is standing on top of the stairs to the basement and says, "Honey, the basement is dry!" So, the idea is, you get used to it. You swim in there and it seems normal. It seems like the most normal thing in the world. And unfortunately, it leads to really bad things…. (Contributor 14)

Despite the desperate need for health equity to work to reach "far beyond the domain of public health" (Contributor 20), health equity work is an uphill struggle. Contributors to this dialogue frequently referred to the necessity of thinking with audacity. They described their work, by virtue of their desire to disrupt root causes of inequities and thereby violate status quo, as bold. Boldness extended to both contemplating contributors' own work and to holding others accountable. One contributor, for example, expressed frustration about the lack of peer accountability in the distribution of funding for health research:

The millions of dollars that we put into biomedical and genomic research, when there is so much research that shows it only attributes for about 5% of health outcomes, versus this WHOLE body of literature that points to our systems as what contributes…it is mind boggling! (Contributor 1)

In some dialogues, we explored this concept in terms of moving beyond witnessing or documenting inequities to consider how peer accountability could play a role in raising the standard of expectation for integrating evidence about causes of inequities.

Some contributors commented on the importance of resisting temptation to celebrate small change without carefully considering whether said change reinforces complacency. This consideration

was offered by contributors as they explored just how big the health equity agenda is—it is, in essence, an agenda of broad social transformation. As one contributor put it

> Little changes are the enemies of big changes! Let me give you an example: If a public health unit puts out a report that says that single moms are at risk for poverty, marginalization and poor health. And we've responded to that. We've had 400 drop-ins by single moms at our two centres over the last three months. Clearly, we've helped them. But the takeaway message in this environment is 'it's being taken care of'. So much effort is still being put in to managing problems so that the surface-level mess is taken away, when the core of the problem isn't being dealt with at all. (Contributor 14)

The risk of not thinking big is appeasing the status quo and masking underlying social gradients by celebrating superficial solutions. Contributors shared a common belief that action is possible because we, as humans, have the agency to critically reflect and act. Other contributors also spoke about a "need to be fearless" (Contributor 14). Contributors agreed that within the field of health equity, fearlessness was critical to thinking about whether our position is one of capitulation or audacity.

Table 5.8

Promising Activities for 'Thinking Tenaciously', with Associated Objects of Reflection and Strategies for Enactment at Personal and Institutional Levels

	Strategies to enable and empower thinking tenaciously	
Promising Considerations	**Personally**	**Institutionally**
Maintaining optimism	• Actively resist messages of hopelessness or futility, particularly those steeped in assumptions that deny agency or possibility for transformation • Hold onto optimism in the face of negativity, even when it is difficult to see a more positive end in sight • Examine how you are defining and understanding health equity (and not just inequities); purposively adopt hopeful, idealistic definitions • Revisit your definition of health equity over time • Resist pressures to submit to reductionist, fatalistic attitudes in academia • Reflect on the meaning of human existence and relationships in the world, including in relationship to the Earth • Read about and consider the implications of Indigenous knowledge about future-thinking; considering 'all my relations' across time and place	• Invite dialogue to collectively reflect institutional ways in which optimism can be fostered and futility countered • Embrace long-term visioning in strategic planning • Create and support mentoring programs that connect people across institutions
Considering audacity	• Embrace your own agency to do something transformative • Encourage and support others' in their belief about agency for transformation • Critically reflect on what warrants celebration, resisting the temptation to inflate small changes that are likely to be too dilute to represent meaningful steps toward health equity	• Make space for and encourage people working in institutions to 'think big' • Support leadership and creativity in meaningful ways • Recognize the benefits of empowering people within institutions to exercise their agency for transformation • Encourage and make space for critical reflection on how to advance health equity action

5.5   Poetic Representation

Developing poetry is a distinct way of looking at the data generated through dialogues and uses a different way of knowing to allow the data to refract and bend into alternate representations. When examining transcripts, I was struck by the particularly poetic nature of some dialogues—either as a whole, or for what they offered as a collection of dialogic excerpts that offered insights into complex concepts, such as equity attunement and confronting our complicity in systems of power. This poem was generated through a process of poetic transcription that, once considered in context of other study findings, was re-written and represented in a new way. The use of different colours of text signals different sources for the words: text in blue is a direct quote from the contributor, reduced slightly (e.g., eliminating connecting words, pauses, ums and ahs) to poetically represent the essence of the conversation. The text in green is a direct quote from me, responding to and engaging in reflection with the contributor, and reduced in the same way. The text in black is interpretive, revealing something new through metaphor or creative expression about the meanings emerging from the dialogue in context of a broader study. The poem uses a metaphor of 'mirror.' Its construction reflects this metaphor in its visual presentation, construction, and word choice. It is intended to have both columns of a stanza considered at the same time, so I encourage readers to try reading it in different ways—perhaps considering one column as a whole first, then the other and then going back to consider the poem stanza by stanza (Figure 5.4).

drawn onward

a tree is a story of place
told in rings,
banded mirrors reflecting
the forest, the soil, the land
each moment and every seed before it
every tiny evolution
every day and minute and second
time expanding outward and inward
every bit of tragedy and prosperity
every rainfall and drought
hidden story, shaped by time
concentric circles
rhythm of past
and future
listening
connecting
relating
a story of who it is
and where it came from
life embodied
and the journey that it lives

What's important for me to share,
is always my name is Vanessa
I'm from the Okanagan Indian Band
I'm part of the Okanagan Nation
of the seven interior nations,
I have connections
lineage and partnerships and relationships

when I'm speaking of who I am
and where I come from
that's my relationship
to not only my kinship
but to the land

I place myself as part of my teachings
as I learn, my journey is about
who I am
and where I come from
and how that connects to
living structures of inequity
and it is a healing journey

---

health inequities are
a story of colonization
bands of mirrors
painted by
language, systems, structures
intentions
each moment before
and now, and those to come
living fabric
woven by acts of supremacy

when I was young, I rejected politics
sharing his learning, my father said,
you were born political
from the day of birth until we leave,
we are politics. Entrenched in it
Whether we chose to or not
storied lives, shaded by colonial legacies
and the impacts of resisting
and by finding strength and resilience
and a spirit of hope

---

there is an othering, a making of 'they'
in acting our parts in colonization
who is the they, and what do they fear?
what makes them to grasp their hands
tightly gripping to one kind of power
regardless of cost?
or so tight are their clenched fists
they no longer believe in their capacity to
let go
opposing
and oppressing

we are not of the past.
we are not extinct.
but in the face of othering,
we need to be together
to be willing to trouble it together,
in true dialogue
walking through the bumpy, painful path
recreating a new way to see, to voice
to humbly acknowledge oneself
as part of a solution
together

how do they create the other,
pay no heed to what's come before
to see their hand is wrapped around
their own wrist?

individuals create family
and the family creates community
and the community creates nation

we can oppress each other
contradict and impose on each other
find ways to foster disconnectedness

to protect misunderstandings
and avoid empathy
believe in the invisibility of the grasp

a type of truth, that is
born of epistemic injustice
dismissing others as not ourselves
insidious, divisive edifices
echoes of what we did
and didn't want to bear witness to
never naming what we're doing
or who are the they
power by silence. across generations
when there are no answers,
and no one to ask.
Erasure.

when we think of relationship,
we both need to know
who we are and where we come from

to understand where we come from,
we need to see our mistakes, successes
so we can create our future

when we think about relationships
and we hear
(from community, from family and society)
get over it, it's just the past
but atrocities repeat themselves
are barriers to getting through to the other side
of understanding
the past lives in every moment
in the moments I am with my children
It lives in my dreams
It lives in my body
It lives in how I think about the world

drawn onward
if we truly are one community
of human beings, one people
we need to find our balance
spiritually, emotionally
intellectually and physically
and ask: what's out of balance?
what will it take for
our people to hold up the mirror?
to name it
places of resistance
and places where the door is open
and there is willingness

but what is the fear?
What is there to be afraid of by
Reconciliation
what is the fear
of relationship?
but maybe our biggest fear is
picking up the mirror
and owning our part

pressured to silence
to avoid the mirror
to maintain divisive binaries
but if we allow ourselves empathy
how can we be anything but motivated?

empathy has to start
with your own story
linked with the broader
and in the broader communities in society

how do we change structures?
first, I think: *how do I change me?*
because we are all connected
if we truly are a community,
then we are mirrors of each other
we need to find our balance
the so-called "disadvantaged"
are reflections of advantage
the privileged don't want to see
because it's painful
to name what was (is) happening
not everyone was (is) ready to hear
at catastrophic costs

sometimes we can feel like
it's outside of ourselves
we're afraid of each other
but maybe
this is actually just me
in the moment,
linking with the mirror,
confronting our own complicity

pressured to dismiss
it's so important to feel
and not be told that our feelings
are not right in this moment
or should be something else

until we can immerse ourselves in our work
from our lived experience
place and space,
it's just another study

seek a path of compassion   especially around social injustice

If I forget my heart   If I share my story with you
I can only go so far   and you share my story with me
there is no limitation   and we come with our hearts
in seeing each other   instead of just here in our minds,
as human beings first   where can this relationship go

found mirrors   and where we might go
we return to the trees   they speak to us in whispers
ancient stories of place and time   softly singing their tree songs
teachers   a listening invitation
of who we are and where we   pleading with us to
came from   awaken

Figure 5.4. Poetic interpretation entitled, 'drawn onward'

5.6   Discussion

This study sought to reveal pathways for overcoming persistent stumbling blocks in the process of connecting knowledge to action for health equity. Some of these stumbling blocks were framed as gaps in connecting what is known about the causes of health inequities with the kinds of actions directed at resolving them (Kirkland & Raphael, 2017; Raphael et al., 2008). Others dealt with tensions uncovered in global health research, where research revealed how people grappled with transforming equity intentions into meaningful actions (CCGHR, 2013a, 2013b). Still more were tied to issues of power and the dominance of ideologies recognized for their reinforcement of inequitable policy and practice environments (Bryant et al., 2011; Crane, 2010b; Hanson, 2017; Ruckert & Labonté, 2017; Schrecker, 2016). Turning to experts in health equity, health systems, and KT, this series of critically reflective dialogues became a platform for reflection and reflexivity about work *within* the field and *for* health equity. Using the metaphor of a *table of dialogue,* the objects of reflection centred on how contributors oriented their work and what they believed to be promising practices for moving forward. Also on the table were questions about the role of power in health equity work and what questions or issues warrant continued dialogue. As one of the first studies of its kind, these dialogues deeply examined *how* to more effectively connect KTA for health equity and make a substantive contribution to advancing health equity work by identifying promising of ways of thinking and doing that hold promise for advancing equity action.

Although understanding the technicalities of how health inequities are connected to sociopolitical, historically constructed systems of power and privilege is a step toward equity attunement, the findings of this study indicate that the continuum stretches much further. With their roots in the distribution of power and resources in society, health inequities are the outcome of intensely complex and tangled relationships between people, ideas, actions, and sociopolitical and economic contexts implicated in health equity work (Came & Griffith, 2018; Frenk & Chen, 2011; B. Pauly, Shahram, Dang, Marcellus, & MacDonald, 2017b; Pedrana, Pamponet, Walker, Costa, & Rasella, 2016). Equity attunement, as derived from the results of Study 2 (the critical interpretive synthesis), invites a continual process of understanding one's own situatedness within complex, intersecting systems of power. Dialogue results reinforce the idea that relationships between equity attunement and promising ways of thinking and doing are mutually reinforcing. When ways of thinking push boundaries of critical reflection outward, challenging them and using reflexive questions, equity attunement can expand. Similarly, without these challenges, contributors' reflections suggested that institutions, organizations, and individuals can become less attuned. Importantly, study findings suggest that without attentiveness to praxis and reflexivity, equity attunement can slip toward complacency that rests on 'good' intentions without recognizing the potential or actual implications.

These findings suggest that the concept of equity attunement is grounded in praxis and reflexivity. Calls for reflexive, critical inquiry in the field of health equity are not new (Brisbois & Plamondon, 2018; Hanson, 2017; Masuda et al., 2014); however, these dialogic findings indicate that there are specific and practical ways of achieving these goals. By pursuing promising ways of thinking and doing, both

personally and institutionally, those within the field of health equity are engaging in cultivating equity attunement. Further, contributors indicated that ways of thinking drive action. Because health inequities are rooted in issues of power, an equity-informed praxis inherently requires critical examination of positionality, identity, and social systems of power. Contemplated in concert, praxis and reflexivity shape efforts to advance health equity in more equity attuned ways. Therefore, a praxis of equity attunement is dynamic. It has no hard edges that once reached, could allow someone to declare, "Okay, I've arrived. I'm equity attuned, and I have no further reflecting to do." Instead, a praxis of equity attunement is a commitment to continuously practicing critical reflection and unpacking the "relationships between particular thoughts and actions as they confront lived experience" (Kincheloe, 2008, p.120). This type of praxis is also in constant relationship to other concepts, such as ethics and justice and can support necessary challenges to the incoherencies between intentions, knowledge, and actions in the field of health equity.

Results from this study show that these kinds of expansive, boundary-spanning reflections can be developed. There may be ways that these findings can inform teaching and learning strategies for equity attunement, but from the perspectives of contributors, such strategies should primarily rely on making more explicit and relatable connections between colonial acts and lived experiences. These findings align with calls from global and public health, where efforts to make the work of health equity more accessible continue to evolve (see, for example, CCGHR, 2015; Cherniak et al., 2017; Cole et al., 2011a; MacDonald et al., 2016; Nixon et al., 2018; Pinto et al., 2012; Plamondon et al., 2017). Supporting praxis and reflexivity as a peer network, as mentors and teachers, as researchers, and as institutions in society could be powerful mechanisms for shedding light on shadows of power and privilege, allowing people to explore more equity-attuned conceptual frames by questioning assumptions, examining positionality and identity, and revisiting how prior learning may pose particular epistemological barriers.

This study suggests that ways of *doing* health equity work are inextricable from ways of thinking. These results highlight an intimate, relational connection between how health inequities are conceptualized and the ultimate focus of health equity work. Contributors' reflections reiterated the importance of an adage used when talking about power and privilege (e.g., Nixon, 2017): regardless of how good one's intentions may be, intentions are always less important than the impacts or consequences of action. What this means for those of us working within the field of health equity is that we cannot rest on assumptions that a desire to see greater health equity is sufficient. Rather, health equity work demands careful and deep questioning of how epistemological barriers (Brassolotto et al., 2013; Raphael & Brassolotto, 2015) and assumptions might be influencing how we frame our work. This is because the frame sets a critical path[16] along which any effort to connect KTA for health equity can

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[16] A critical path is a concept from project management. It suggests that projects follow a path marked by critical moments that set the direction and possibilities that follow. Though often used for monitoring timelines or outputs, the concept holds that missteps or oversights during the critical path expose projects to the risk of straying from original intent. For more, see the Project Management Institute: https://www.pmi.org/learning/library/take-path-really-critical-5055

unfold. When the conceptual frame is in conflict with the evidence or values underlying health inequities, the trajectories that follow can stray from the necessary focus on root causes. This study suggests that epistemological frames involving reductionist, individualist, and biomedical lenses lead to efforts that focus on *symptoms* rather than *systems* of inequities.

Indeed, 'how' questions have been consistently identified as a challenge for reconstructing systems and policy environments that are more amenable to equity (Labonté, 2012; Nixon et al., 2018). With a resistive kind of optimism, contributors to this study believed there were many promising ways of approaching and doing health equity work that could contribute to overcoming the challenges of connecting intentions with actions. Optimism for cultivating deeper awareness was widely expressed by contributors, often with concrete and tangible examples of progress. As they explored ways of thinking relationally, contributors voiced a need to create places where people can collectively reflect on values and the relationship between health inequities and the social systems that they themselves are part of and actively reinforce. They believed that such places for reflexive dialogue could create opportunities for long-term commitment and relationship to equity, where people can become comfortable raising alarm bells and acting on them. By reflecting on our own experiences and on how we saw this unfolding with others we work with or teach, contributors proffered that equity attunement requires capacity to examine unintended consequences that can contribute to inequities and the ability to responsibly call ourselves out. For example, do we take time to deeply understand how inequities are experienced? To understand our complicity, even if we feel distal to causes? Contributors articulated a need for collective capacity to make explicit the ways in which structures and systems work to entrench and reproduce unfair distribution of power, resources, and wealth. Suggestions for this kind of capacity-building included using examples from history. These essential questions about how to enhance equity attunement provided the foothold affirming promising practices and identifying promising ways of thinking.

This research also illuminates the personal and collective struggles experienced to overcome stagnancies and move past witnessing. Evidence about causal roots of health inequities is unequivocal (Lee, 2010). It is not soft or unconvincing. And although the problems may be genuinely wicked (Came & Griffith, 2018; Lazarus, 2008; Petticrew et al., 2009), the results of this study challenge people situated within the field of health equity (whether or not they identify their work as being about equity) to push past overwhelming complexity and reject paralysis. There is never nothing to be done to change systems of power. History has shown us that remarkable change is possible, even at times when oppressions appear indomitable (Frank, 2017; Parks & Haskins,1992; Sangster, 2018; Truth and Reconciliation Commission of Canada, 2015). As health professionals, researchers, teachers, students, and others involved in global, public and population health, we need to unstick ourselves from any beliefs that the systems around us are too big or complex to change. Lila Watson's quote, often cited by health equity activists and scholars, eloquently spoke to this question of who we are and why we *should* do health equity work: "If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together." The sentiment of this quote stirs good feelings and may even

feed a benevolence narrative within the field. But, just as with equity attunement, there are different layers to understanding the essence of what Watson suggested.

In Canada, it is impossible to think about health equity without considering the histories and relationships between Indigenous peoples, settlers, and newcomers (Greenwood, de Leeuw, & Lindsay, 2018; Hadjipavlou et al., 2018; Kent, Loppie, Carriere, MacDonald, & Pauly, 2017). Yet, Canadian dialogue often situates historical tragedies such as residential schools, as a history belonging to Indigenous people and belonging only to the past. However, Indigenous leaders challenge this assumption, arguing that the history of residential schools is not Indigenous history—it is Canadian history (Justice Murray Sinclare & Truth and Reconciliation Commissioner Marie Wilson, n.d.) and the work of responding to it is far from finished (Bopp, Brown, & Robb, 2018; Morton Ninomiya & Pollock, 2017; Nixon et al., 2018; Philpott, 2018). It is the story of our country and it lives in all of us who are part of this country today, whether we choose to see it or not. This is true of health inequities, too. They are not the story of those suffering the worst of their impacts, it is the story of all of us, of humanity. It is a story about how we organize ourselves and what we decide (or opt to not decide and simply allow) to be okay. Health equity work is about opening a dialogue about the standards of dignity, caring, and fairness we set as a collective in this world.

5.7   Limitations

This is study is a tentative foray into understanding how to improve the exceptionally complex process of connecting KTA for health equity. This representation of results is intended to be a generative, catalysis for thought and dialogue. Disclosure of perspectives and experiences that shaped dialogue was invited through the short pre-dialogue survey. The survey tool invited participants to indicate if they identified as part of a visible minority but did not invite identification as part of Indigenous or LGBTQ+ communities. An open-ended question invited participants to describe their ethnocultural background, but this was not always completed, limiting the capacity to more deeply situate the intersectionalities represented among contributors to this study. The methodology has no set endpoint, wherein suddenly the critical reflection is done. Rather, it is situated in an ever-evolving context, deeply tied to the moment in time that this study, its contributors, and I met. Results arose from interactions between myself and others at particular moments in our own journeys, at particular moments of equity attunement, and within particular positionalities. Because this work is never truly done, there will certainly remain room for greater criticality and reflexivity. These limitations are about my own evolution in equity attunement, and the inevitably limiting boundaries of my own reflexivity. In particular, I know I am limited by my struggle to disentangle my thoughts from the assumptions that are so deeply ingrained in me and perhaps by the naiveté of only beginning a process of critical wakefulness as an adult. As with anyone, my own situatedness has shaped a particular point of reference where others may be far more wakeful than I could be at this moment.

5.8   Implications

In this study, each dialogic encounter opened new possibilities for transformation for those involved in the encounter and, by virtue of our connectedness with others doing similar work, in the field of health equity. The promising ways of thinking proposed here, alongside promising practices identified in the second dissertation study, invite people within the field of health equity to reconsider the ways in which they take up a role in reweaving a social fabric incredibly resistant to change. At both personal and institutional levels, these promising ways of thinking can be supported and propelled through a regular commitment to critically reflective dialogue. Because the findings were generated from a very particular and specialized group of scholars and activists, the promising practices identified and discussed here are most likely to be relevant for others who are similarly positioned within the field of health equity. Interestingly, contributors almost unanimously expressed appreciation for having the time and opportunity for an intellectual, critically reflective conversation. Their expressions were, on one hand, validating because they point to the relevance and importance of the topic. But, they also reveal something about the state of academic discourse. The vast majority of contributors were positioned in organizations where critical engagement with others ought to be a norm. If critically reflective dialogue is absent among those who are employed by academic institutions and who are responsible for mentoring others within these institutions, then this research arguably carries implications for redefining how universities foster place and time for dialogue.

Returning to the how contributors defined the field of health equity, it broadly includes the health profession and the extensive network of teaching, learning, self-regulation, and professional supports that are connected to them. For example, these findings will resonate in health professions and academic disciplines that carry explicit commitments to health equity. The Canadian Nurses Association explicitly calls upon nurses to engage in self-reflection and dialogue, identifying an ethical obligation to contribute to broad societal issues and naming 'promoting justice' as a core value (Canadian Nurses Association, 2017). Further, the Code of Ethics articulates the profession's recognition of the impact of social determinants of health and lays out specific actions, including advocacy "to improve systems and societal structures to create greater equity and better health for all" (Canadian Nurses Association, 2017). Exploring the application of the ways of thinking, promising considerations, focus points, and strategies could serve as an important foundation for further research.

Another implication for research includes a combination of considering how the results of literature reviews in the context of informed and diverse perspectives provided valuable insights to how we and others in the field can pursue our work with greater authenticity and possibility. Some possibilities for pursuing greater health equity include testing the identified promising practices and promising ways of thinking or using the tables as a structural guide for assessing equity attunement at personal and/or institutional levels. Future research could also involve face-testing of the visual framework about ways of thinking (Figure **5.2**). Particularly interesting would be the use of a deliberative dialogue (Boyko, Lavis, Abelson, Dobbins, & Carter, 2012) with different kinds of stakeholders: (a) to invite their reactions and

expand and refine the tools and (b) to support reflection about what is being done and what could be done further. Once refined, the visual frameworks could be used cyclically to assess particularly influential policy arenas (e.g., trends in research funding practices, policies, and outcomes) or universities' institutional commitment to health equity. Further, this study raises questions about how universities and researchers fit in governance models for health equity; how governance is considered in KTA theory and models; how the ideas explored here might be used to influence political will and public sentiment; how pedagogical implications can support promising ways of thinking; and how compassion can play a role in advancing health equity.

This series of critically reflective dialogues extended insights emerging from two previous studies to validate the reciprocal relationship between ways of thinking, ways of doing, and equity attunement. Findings suggest that equity attunement exists in a mutually reinforcing relationship to ways of thinking and doing: they shape and extend each other. When equity attunement is cultivated, people can engage in more promising ways of thinking and doing. And engaging in these promising ways of thinking and doing fosters equity attunement. However, when equity attunement is low, it becomes difficult to engage in these promising ways of thinking and doing and the end outcome seems to be research or KT that is poorly aligned with the best available evidence about causes of health inequities. This study provides a practical pathway for enhancing research and KT efforts in ways that can meaningfully advance evidence-informed action for health equity. I invite readers to consider these results as a non-prescriptive invitation to actively and critically consider the texts within their own context, positionality, and experience.

Chapter 6: Integrating Three Studies

Beginning from a place of unease with tensions I experienced as someone immersed in the field of health equity, this collection of studies framed the persistence of health inequities as a gap in connecting knowledge (i.e., evidence about causes) with action. Across three distinct studies, I sought to identify practices demonstrating promise for connecting KTA for health equity (Figure 6.1). Practices were understood as habitual, routine actions undertaken by people in the field as they navigate health equity work. The three studies evolved in complementary ways, with efforts turning first to the literature and then to KT and health equity experts for evidence to support particular practices as promising because they demonstrated some degree of productive movement toward interrupting root causes of health inequities (see also Table 3.4). Together, the results of these three studies support a number of cohesive concepts and practices that open a path for more intentional efforts to connect KTA for health equity. In this chapter, I revisit the central concept of equity attunement as described by KT and health equity experts, situating these results in the context of those from the literature reviews. I then explore complementarities found in the dialogues for the promising ways of doing that were identified in the CIS. Finally, I provide a framework for advancing health equity action that integrates findings from all three studies.
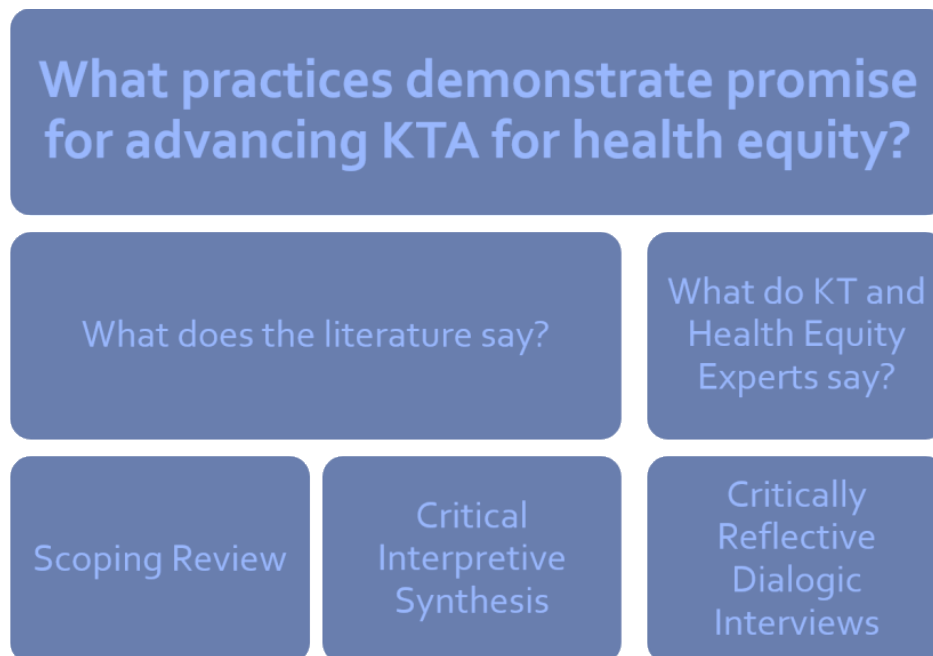

Figure 6.1. Three studies to critically explore what practices demonstrate promise for connecting KTA for health equity.

6.1   Affirming Equity Attunement as a Central Concept

Over the series of dialogues, I became aware of contributors' descriptions of their work and roles in supporting others (e.g., through teaching), as provoking a necessary evolution: from a basic understanding of *what* social determinants of health are to a more sophisticated awareness of how power plays a role in creating structures, systems, and environments that produce these determinants. Connecting KTA for health equity was understood as having something to do with how we operate in global or public health. As one contributor put it, it is a "way that people work" (Contributor 13).

Contributors often grappled with the need for an explicit commitment to reflecting on *and* responding to social power, extending from one's own positionality to the positionalities of organizations, institutions, communities, or networks. Many contributors articulated a relationship between the degree to which these commitments were honoured and *how* health equity efforts could unfold. For example, several contributors voiced concern about collective capacity to recognize the ways in which underlying currents of power give rise to particular sociopolitical environments. Concerns about sociopolitical environments extended to the sites from which health equity work is most often done (e.g., health systems, universities). One contributor described this commitment as "active work" involving "slowly coming to realize that there are several truths [that] come back to the position of power and privilege" (Contributor 17). Yet, the absence of power analysis in our field was noted in several dialogues. "It is missing…and it needs to be tackled overtly to be…actually heard," (Contributor 2) reflected one contributor. Another commented on the resistance to engaging in critical reflection and power analysis, even in academic settings where questioning might be considered acceptable. She suggested that opening reflection on social power involves risk, offering, "If you call people on certain assumptions they make, then you become the problem" (Contributor 17). At times, these gaps were identified as a source of moral distress and tension, particularly when an absence of alertness to the impacts of power resulted in direct reinforcement of inequities.

Contributors' reflections often moved between self-reflection and observation, demonstrating a high degree of tacit and applied knowledge about how to consider one's self in the context of a society constructed by systems of power. They spoke of their own journeys of deepening awareness and explored the need to provoke it in others. Reflecting on her time working in an intensive care unit, one contributor spoke to the distress provoked by being confronted by daily acts of stigma and judgement that reinforced social power. "There I was in ICU, I looked after some of the very earliest people living with HIV/AIDS, and I saw firsthand discrimination by people who [refused care] because of their own discomfort," (Contributor 10). This contributor commented that though these acts of discrimination may have emerged from nurses' fear of an unknown or worry about exposing their children, the *effect* was to isolate and punish people suffering with immense complexity. Rather than approaching their work from a deep awareness of complexities and of the structural inequities that led any patient to be suffering with HIV/AIDS, nurses perceived these patients as somehow untouchable or unworthy. They distanced themselves and legitimized the execution of their social power over patients through fear.

Contributors were attentive to how this deep awareness could be more or less genuine, but that awareness was always a process of 'becoming' that had no defined end point. They cautioned that in the absence of deep awareness and commitment to reflecting on and responding to social power, academic pursuits in the field of health equity can become nothing more than "token" (Contributor 1). One contributor offered a general critique of the "institution of academia," suggesting that the structures used to guide that work serve to draw resources away from where they are needed while simultaneously reinforcing social exclusion (Contributor 25). For example, sometimes people can work in health equity and "use the words," (Contributor 21) without really seeing how their own position is wrapped up in the positionality of others in society. Referring to people who use the words without really "getting it," one contributor expressed the ways in which low degrees of awareness manifest in a kind of tokenized contribution to health equity:

> They can be in positions where they will discuss health equity, they will use the words, they will have some kind of beating in their heart for something that's out there, that sort of pity of some kind, and perhaps they will dedicate some of their time for some kind of global abstract kind of thinking about things like health equity, but they won't engage directly with them because they don't see the point of doing that. They don't feel connected. They don't sense that there's any connection between their life and the lives of the people that they're talking about. (Contributor 21)

Over the course of this series of dialogues, contributors repeatedly returned to variations of how health equity work requires relational, reflexive awareness that shapes how much they "get it" (Contributor 1, 3, 21). This kind of awareness it is tied up in being willing to understand our own positionality in relationship to others and to the sociopolitical and historical complexities that lead to any given moment. In another dialogue that involved a lot of my own self-reflection, the contributor gently challenged me, nudging me to expand my reflexivity:

> I think there's some amazing things happening with your own self-reflection and your own processing of who you are and where you come from and how it links with your research, one of the things that I think about that isn't there is, you know, we talk about the mirror…what is the fear of recognizing that there's privilege? (Contributor 18)

This comment in particular, sparked new threads of exploration of my positionality and identity. As I worked through examining my own wakefulness (and blurriness), these conversations continued to resound in my thoughts. It seemed to me that what they were describing came back to how attuned people were to the complex issues of power that are intimately tied up in health equity work.

At the time, these insights about reflexive awareness were beginning to crystallize, the concept of attunement was also emerging as something important from the second study in this dissertation. Being attuned is an active verb evoking a *process of becoming* more aware or receptive (*Oxford English Dictionary Online*, 2015). This word resonated with what contributors described as a necessary evolution in the ways they think about themselves and how they approach their work in the field of health equity. In the critical interpretive synthesis (study 2), I described equity attunement as the degree to which something or someone was receptive or aware of the evidence about sociopolitical, historical, economic and structural determinants of health equity. In this study, the concept was nuanced by contributors'

expressions of something deeper, more relational, and more reflexive. Their descriptions illuminated equity attunement as a process of becoming that involves a deeply personal commitment to examining and challenging assumptions, norms, and the distribution of power. Though adopting this stance of questioning involves inherent risk because it means challenging social norms that are often unacknowledged, contributors maintained confidence that equity attunement could be cultivated.

6.2 Affirmations and Extensions of Promising Ways of Doing

With an interest in understanding how promising practices identified from the literature resonate (or not) with KT and health equity experts, I brought early findings from literature reviews into the dialogue setting. These findings included those from (a) the scoping review that examined patterns in the integration of evidence from the WHO CSDH and (b) the CIS that identified four promising ways of doing for connecting KTA for health equity (Table 4.7). Throughout the series of dialogues, contributors affirmed emergent findings from both of these literature reviews. Below, I briefly touch on responses to findings from the scoping review before providing a summary of how the CIS findings were affirmed. I focus on the ways in which dialogue extended insights about promising practices (ways of doing). Because the dialogues added nuance to ways of structuring systems and ways of doing research and KT, I focus primarily on these three practices that were identified in the CIS. Ways of working relationally were affirmed and extended through dialogue that focused on thinking relationally (discussed in depth below).

Contributors were generally unsurprised by the limited integration of CSDH evidence in literature related to addressing health inequities. In response to viewing figures showing trends in the portrayal of health inequities and orientations of health equity work, one contributor suggested that low integration of the CSDH evidence and calls for action was related to a lack of relevance for approaching structural action for health equity:

> We mostly don't use the Commission's major framework because it becomes too complicated…the Commission didn't go far enough. It did not adequately pay attention to colonization, or to the sociohistorical aspects that are so deeply imbedded that they are the foundation on which the structural determinants actually fit. We need to go before causes to pre-causes. (Contributor 20)

Another contributor reflected on the ways in which norms and academic structures contribute to perpetuating work that does not align with the best available evidence about what causes health inequities:

> I don't think [the CSDH] was overly in the awareness of my colleagues. If they're doing research on a specific illness or a specific subpopulation in a specific country, that's what they're doing. We keep spending money and time and resources [on studying] of all kinds on issues [in ways] that are not going to solve the problems. We can describe [health inequities] to every level of detail we want, but that's not going to make them to go away. (Contributor 11a)

This contributor also remarked on these trends, calling them "troubling…frustrating, but not surprising" (Contributor 11a).

There were several ways that CIS findings resonated with contributors' experiences and beliefs about the most encouraging ways to connect KTA for health equity. For example, conversations about structuring systems pointed to the kinds of *systems* warranting attention. Predictably, health and political systems were often discussed, but research and academic systems were also part of contributors' critical reflections:

> The academic institutions themselves, the enterprise of academia certainly doesn't incentivize things that would help, like interdisciplinary or even transdisciplinary teams. Some of these are hard to navigate when the funding structures are set up to incentivize things in a very particular way. (Contributor 11b)

Another contributor argued that both funding and publishing health equity research were limited by "what kind of research gets funding," and the privileging of "post-positivists and RCTs" (Contributor 17). This dialogue alluded to the complexity of research systems. Research systems are made up of constitutional parts, and though they may be independent of each other, each part can work to reinforce particular ideologies and normative values in ways that make it difficult to pursue meaningful health equity action as a researcher.

Contributors consistently highlighted the ways in which research systems (i.e., networks of academic institutions, research funders, and peer-review platforms for publication and KT) mirrored the broader privileging of dominant ideologies. Challenges to the distribution of power stemming from privileged ideologies were discussed as exceedingly difficult and at times, "risky." Awareness of power imbalances, often in environments where equity attunement was low, was acute among contributors. One demonstrative excerpt emerged from a dialogue with a contributor who reflected on her experience of incongruence in a university department with a mandate to promote health equity. When local policy shifts were becoming increasingly harmful to health equity, she witnessed a lack of attunement and action from her academic department. Her reflections pointed to the risk-averse posture that her university assumed. Despite a precedent of working with local policy makers and despite clear evidence that these policy shifts were likely to generate greater inequity, she found her department's response to be depoliticized and reluctant:

> That kind of work [responding to local political shifts] is institutional work, it's policy work, but it doesn't necessarily have the kind of political engagement…with political actors that, I think, is missing in the world of health equity and you know, more politically-engaged scholarship. Where it's more direct and more political, there's nothing that stands out as our department being very political at all or taking any particular stances. (Contributor 21)

In addition to the positionality adopted by universities in response to equity issues, these dialogues about the promising practice of structuring systems also pointed to the need for greater equity attunement in peer review, funding policy and priorities, and assessment of academic performance. This issue relates to and is discussed in more detail below as part of the section on research as responsibility.

Another promising practice identified in the literature reviews and which arose during dialogues, related to ways of structuring systems as they related to integrating governance mechanisms. "Many of the breakdowns in advancing health equity stem not from money or resources, but from the way the

health system is governed," reflected one contributor (Contributor 9). Governance, as described by another contributor, "is what determines how things are done (or not) within systems and how intention moves into and action" (Contributor 3). Several dialogues explored the absence of a "formal governance framework" for both health equity work and theoretical frameworks for knowledge translation. For example, one contributor observed that this absence creates an environment "with no accountability," and "deeply fragmented efforts" (Contributor 3) to connect KTA for health equity. For other contributors, working to advance evidence and equity-informed policy was about the importance of governance in brokering relationships, such as "finding ways to know and adapt, to knowing how to be heard and what relationships are needed to affect the policy environment" (Contributor 9). These dialogues suggested that KT theory and models could be greatly strengthened through the integration of governance considerations.

Neoliberal domination, in the absence of equity-centred governance mechanisms, was identified as reinforcing of the causes of inequities by virtue of dismantling the social protection policy environments known to promote health equity. One specific example of this arose in a dialogue where public policies were explored as mechanisms for operationalizing particular values or systems of beliefs. Here, the contributor offers a reflection on the dominance of Eurocentric assumptions about knowledge and policy process:

> Public policies are not neutral entities, but socially constructed by particular people with particular ideas and particular positions in society, [often from] a more neoliberal background, and through that angle the policies are created. And they advantage and then disadvantage certain populations in society…we need to pay attention to how these systems can be interrupted by a different kind of governance in policy making. (Contributor 17)

This same contributor argued that epistemological norms and ideologies influence systems of governance because "one of the key mechanisms that creates inequities is their trickledown effect through policies, and then effects of policies, and so on" (Contributor 17).

Contributors acknowledged policy processes as incredibly complex, nested within electoral systems that create distance between the electorate and elected. These political systems were described as "parochial" (Contributor 17) serving some needs far more than others, with particular privilege afforded to corporate interests. Further, the absence of "transparency in decision making" was described as a concerning means of maintaining distance and limiting possibilities for robust, critically reflective public dialogue. One contributor expressed frustration about how an absence of transparent governance for health limits capacity to acknowledge and challenge the problematic role of corporate power in policy making:

> If somebody says, "What's a major health problem in this country?" how many people are even in a position to say it's the growth of corporate power and inequality. If you're working for [a major NGO], you'd be out of your job the next day. If you're working in public health, you'd be seen as crazy. (Contributor 14)

Despite the challenges of overcoming forces acting against health equity, policy remained something that contributors believed could serve as an important and promising mechanism for governance that could connect KTA for health equity.

Promising practices for doing research and KT identified in the CIS were also reified through critically reflective dialogues. Of note, the insufficiency of current data platforms and proxy indicators of health equity were raised in several conversations. Contributors generally agreed with the need to create reliable data mechanisms that could support policy (and governance) feedback loops. The inadequacy of current indicators arose through reflections by contributors on how narrowly defined indicators were tied up in issues of power. These reflections centred on "who decides" (Contributor 21) what is worth paying attention to, what indicators are used, and how progress toward health equity is monitored. These were all viewed as related to the degree of equity attunement in the systems and among the people in positions of power within them. In one dialogue, contributors reflected on efforts to collaboratively identify indicators for causes of health equity with partners in a low-resource setting. They faced difficulties with the partner's desire to reduce the problem to its "minimal observable element, which is the behaviour" (Contributor 11b), an experience that was reflected in other dialogues exploring the general preoccupation with biomedical and economic indicators.

Concerns about defining what counts and what is measured led to conversations about the ways in which data are presented. One contributor reflected on the need to produce messages that are "tangible and actionable, rather than abstract and theoretical" (Contributor 9). He advised these messages should be produced in ways that bring policy makers into the research process so that "the process itself sensitizes them by involving them in developing authentic answers" (Contributor 9). Several contributors described the dissonance that can arise from diluting the tragedy of health inequities into population-level counts, affirming the use of story and lived experience as a promising practice for evoking a more accessible, relatable, and compassionate response to (re)presentations of data. In dialogues that focused on KT specifically, contributors reflected on current limitations in the science and theory of KT. We explored how current models do little to address issues of governance, power, or agency. Reflecting on the widely used knowledge-to-action cycle (Graham et al., 2006), one contributor exclaimed that "What's missing is a clear description of the arrows between the boxes—that is about governance!" (Contributor 3).

Further, contributors remarked on the contextual evolution of current models of KT, wherein even integrated approaches were not originally conceptualized for application to wicked problems; but rather as a mechanism for enabling KTA in confined, clearly defined settings. Because health equity work evokes challenges to social structures and systems, contributors called for extending KT thinking beyond the confines of health, political, research, or academic systems and toward broad "civic engagement" (Contributor 25). Some of the ways contributors were exploring this idea included the use of "social network theory" (Contributor 20), wherein KTA for health equity could be explored in the context of social systems. This work pointed to the value of cultivating particular roles within health systems, including

catalyzers, leaders, influencers, connecters, and brokers. Though there was not sufficient time or space to explore this finding in more depth, it lays a foundation for expanding dialogue about the role of governance in the science and practice of KT.

6.3   A Framework for Health Equity Action

Imagine a forest of trees. Recent research demonstrates the incredible collective responsiveness of forests that actively distribute water and nutrients through their root systems to places of greatest need (Elhakeem, Markovic, Broberg, Anten, & Ninkovic, 2018). Using this metaphor, we can think about our global human population like a forest and imagine individual trees as representative of subpopulations. The soil is like the social fabric in which life is rooted. The soil, trees, and forest as a whole are affected by things like policy and social structures and by the distribution of power and resources. Knowledge about the causes of health inequities is like having a detailed report on the health of the forest, showing how changes in the soil are resulting in particular differences among the trees—making some trees thrive and others struggle. Our current report shows that the soil is toxic, and in response, the trees are struggling. However, we do nothing to treat the toxic soil. Indeed, some of us start to argue that the soil where trees are thriving ought to be enough for the trees that are struggling. And in an effort to make sure none of the thriving trees are compromised, the struggling trees are shamed for not thriving. Their symptoms include withered and drying leaves, making them unpleasant to see. Time and resources are poured into pruning the struggling trees, misting the leaves, and applying treatments on top. The soil is ignored entirely. Then we feign surprise and pity when the tree dies.

This seems to be happening in the field of health equity. It is an expansive field that is vastly productive, receiving major public investment, all around the world. This dissertation research illuminated ways in which the work in the field is like tending to a tree in toxic soil, knowing the soil is toxic. It also offered practical, specific things that can be done in policy, teaching, practice, research, and KT. These promising practices involve ways of thinking and doing that exist relationally with each other and to equity attunement. Equity attunement, as derived from these studies, involves the degree to which someone or something is attuned and therefore responsive to the sociopolitical, historical, and economic complexities of health inequities. Attunement extends also to the degree to which someone or something has the capacity to understand and respond to underlying issues of power. In Chapter 5, I described this relationality with equity attunement as something that could expand or contract. Rather than being an endpoint to arrive at, equity attunement is a process of becoming ever-more wakeful and responsive by engaging in constant processes of reflexivity and praxis. Collectively, the results of these studies point to promising ways of thinking, promising ways of doing, and equity attunement as deeply interrelated and mutually reinforcing. Striving for reflexivity through thinking relationally, responsively, reflexively, and tenaciously (ways of thinking) lead to more equity-attuned ways of doing.

Striving for praxis by connecting theoretical and empirical evidence about health inequities with what is *done* in response can create opportunities for greater reflexivity, further expanding equity

attunement. But when equity attunement is low, and health inequities are framed in ways that naturalize their causes, possibilities for engaging in promising ways of thinking or doing are constrained. Praxis is "the complex combination of theory and practice resulting in informed action" (Kincheloe, 2008, p. 120). As described in Chapter 2, reflexivity is an act of critical self and collaborative reflection about positionality, situatedness, intersectionality, and identity and their relationship to assumptions, values, and beliefs (Lincoln et al., 2018; Pillow, 2003). It involves examining and responding to social structures and the legitimization of knowledge (and knowledge claims) and power. A *praxis of reflexivity* is the integration of demonstrating a conscious effort to achieve integrity in the relationship between thinking and theory and doing and being, while ever-striving for greater wakefulness in a process Freire (1997) described as consciousness-raising. These concepts provide a broad frame for considering the goals of thinking or doing in ways that are coherent with connecting KTA with health equity.

Figure 6.2 below provides a visual representation of the ways in which these concepts, as mechanisms for supporting promising ways of thinking and doing, are working together to support equity action (KTA for health equity). The relationships between these concepts are presented as nested. Like concentric tree rings, these concepts exist in constant relationship with each other and with new layers that build onto the core. Ways of thinking comprise the lenses through which one sees the world. Cultivating promising ways of *thinking* (thinking relationally, reflexively, responsively, and tenaciously) is a process of striving for greater reflexivity. Cultivating promising ways of *doing* occurs within our frames of thinking and is a process of striving for praxis—a strong connectedness and coherence between how we think about the world and what we do in response. Together, cultivating promising ways of thinking-doing is related to equity attunement in a mutually reinforcing way: the greater the equity attunement, the greater the possibility for engaging in these promising ways of thinking-doing. Lower degrees of equity attunement will make engaging in these promising practices more difficult and less possible. When collective effort is put toward cultivating all of these, as intimately related and inseparable, we can open pathways for more productive health equity action.
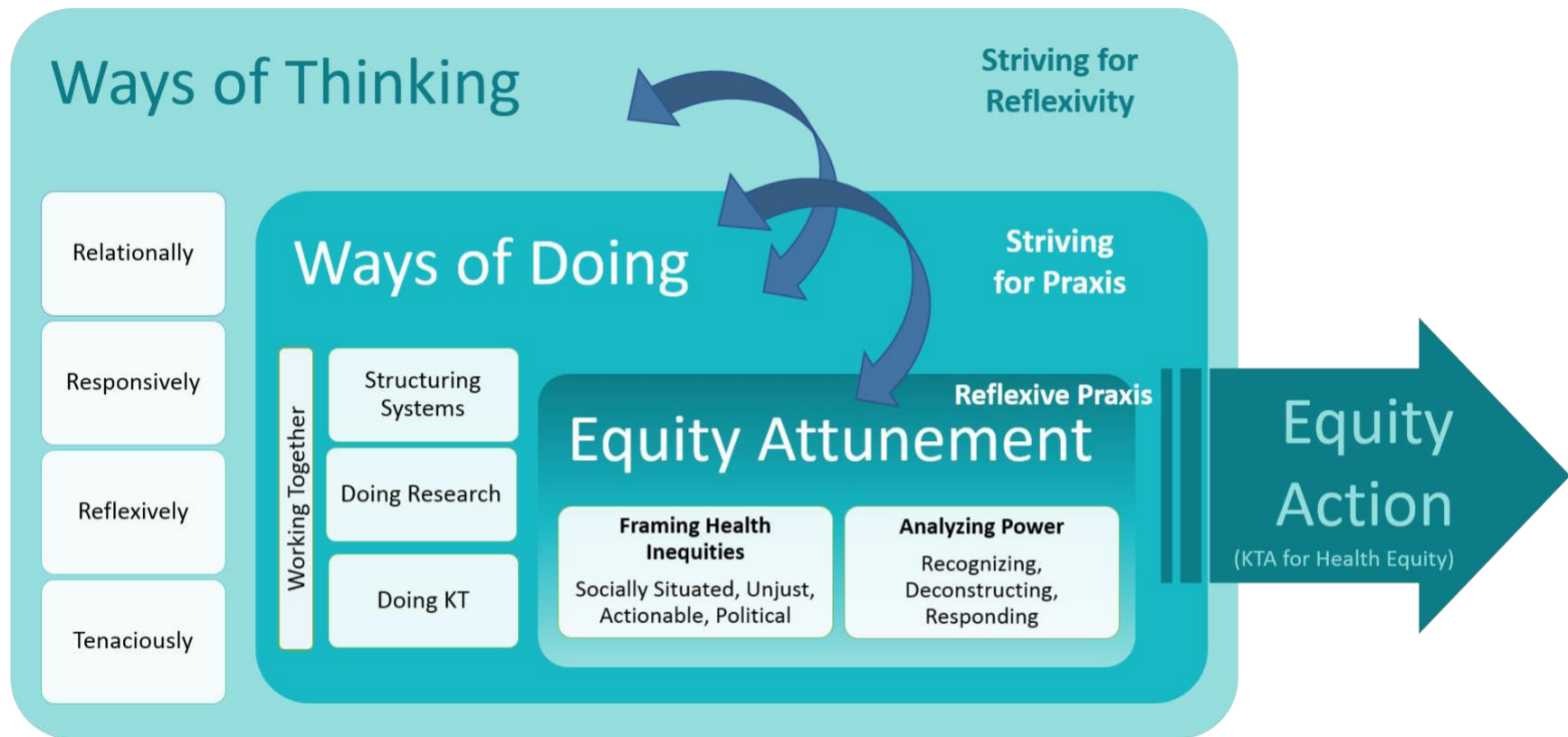
Figure 6.2. Framework for equity action.

Trees and tree rings are useful metaphors for this framework because the conceptualization of the nested relationships between ways of thinking, ways of doing, and equity attunement are shaped by time and by the entire sociopolitical ecosystem from which any effort to connect KTA for health equity might arise. Contemplating interconnectedness across time and place was identified in the critically reflective dialogues as an important strategy for thinking relationally. Yet, time is not a commonly considered element in most KTA frameworks, particularly those that deal with health equity. When it is acknowledged, it is often as a practical consideration for project planning or management (e.g., anticipate it will take time; budget time). Rarely is time contemplated philosophically or critically, for example, as a determinant of current context. The utility of a KT theory, framework, or strategy in terms of serving to support more coherent KTA for health equity could become much more equity-attuned by embracing this way of thinking.

Chapter 7: Synthesis and Conclusion

7.1 Recap

The World Health Organization's Commission on Social Determinants of Health was "created to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it" (Michael Marmot, Friel, Bell, Houweling, & Taylor, 2008, p.1661). Bringing academic, political, and advocacy experts together across nine knowledge networks, commissioners collaborated to compile the best available evidence about health inequities, their causes, and what could be done in response (Michael Marmot, 2009). The CSDH final report, *Closing the Gap in a Generation*, contributed to the accumulation of an irrefutable (Lee, 2010) and "critical mass of knowledge" (Braveman, Egerter, & Williams, 2011, p. 382) demonstrating the relationship between social inequality and health. According to the CSDH (2008), health inequities are

> caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples' lives—their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. (p. 1, sic)

The CSDH made three overarching recommendations: (1) improve daily living conditions; (2) tackle the inequitable distribution of power, money, and resources; and (3) measure and understand the problem and assess the impact of action. A subsequent WHO resolution called upon the international community to recognize the CSDH findings and prioritize action for health equity (62nd World Health Assembly, 2009). The years immediately following the CSDH demonstrated an intense interest in coherent, meaningful action for advancing health equity by mobilizing this established body of knowledge into action. Accumulated evidence and growing interest in responding to issues of health equity shifted the health research paradigm from predominantly upstream, biomedical, or clinical conceptualizations and interventions for health toward a focus on downstream, structural, and systems issues (P Ostlin et al., 2011). Importantly, this shift was accompanied by recognition that research aiming to advance health equity "need[s] to generate knowledge that can be used to confront these trends and promote public, population health interests in a way that preferentially benefits the worst off members of society" (Piroska Ostlin, Braveman, & Dachs, 2005, p. 951).

However, advancing health equity is a complex challenge complicated by the wickedness of problems underlying health inequities and the nature of health equity work as extending far beyond the boundaries of health systems, sciences, or disciplines (Bell, 2014; Carey & Crammond, 2015a; Carey & Friel, 2015; Crane, 2010a; John et al., 2012; Petticrew et al., 2009). Continued monitoring of structural and social determinants of health in a variety of settings (e.g., Bailey et al., 2017; Bryant et al., 2011; Came & Griffith, 2018; Donkin et al., 2018; Michael Marmot & Allen, 2014) show significant lingering gaps between what is known about advancing health equity and what is being done to achieve it. Using three distinct studies, this dissertation responded to this gap by searching for evidence-informed promising practices to connect KTA for health equity. Practices, understood as habitual or customary actions

(Kemmis, 2008), were considered promising when there was identifiable evidence about its contribution to a desired outcome—things that *could* contribute to equity action. With an explicit acknowledgement of the role of power in shaping systems inequities, the study drew from theoretical foundations in Paulo Freire's critical pedagogy (Freire, 1974, 1985b, 1985a, 1997) and a deep respect for relational theory (Gergen, 2009; Hosking, 2011; Stetsenko, 2008). Together, these theoretical foundations, and research questions derived from considering health inequities through the lenses they offered, led to the selection of critically reflective inquiry as a methodology. In this final chapter, I reflect on how study findings could extend to the widely-used knowledge-to-action cycle (Graham et al., 2006), offering considerations for cultivating equity attunement within an integrated KT process. Finally, I explore the strengths and limitations of the set of studies as a whole and provide a beginning exploration of implications and next steps.

7.2   Overview of Studies

Three distinct studies were undertaken (table below), each of which offered new insights into how to explore more productive and coherent connections between knowledge and action for health equity. These studies intended to provide an introspective gaze into the field of health equity[17] to first illuminate trends in practice and then identify the most promising among these. The first study served to map trends and current practices in the field of health equity by identifying and assessing published literature related to KT and health equity. Elements assessed in this study included citation of CSDH or related documents, portrayals of health inequities (naturalized or problematized), alignment with the CSDH calls for action, and orientations toward root causes. In the second study, empirical articles and literature reviews assessed as portraying health inequities as having root causes in social or structural determinants were purposively selected. These articles were analyzed in depth for evidence of promising practices for connecting KTA for health equity. Finally, the third study involved critically reflective dialogues with a diverse group of KT and health equity experts. Contributors explored how their own work was related to health equity, responded to emergent results from the literature reviews, and drawing on their experience and knowledge in the field, reflected on promising ways to connect KTA for health equity. These dialogues also touched on the role of power in health equity work and issues that warrant continued reflection and challenge in the field of health equity. A descriptive summary and overview of important findings from each of these studies are provided below.

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[17] Recall the field of health equity described the broad range of professions and scholarly disciplines that align their mandates with advancing health equity, including (but not limited to): global health, population health, public health, and other social-justice driven disciplines where, regardless of the topical focus, the root causes and ultimate goals of action (i.e., moving toward health equity) are, in essence, the same.

Table 7.1

Overview of Dissertation Studies and Key Results

	Scoping Review	Critical Interpretive Synthesis	Critically Reflective Dialogues
Description	Examined published literature as a reflection of trends in scholarly practices related to: (a) integration of evidence and calls for action from the World Health Organization's CSDH about root causes of health inequities; and (b) orientation toward root causes.	Explored purposively selected literature to extract evidence about promising practices. Selection was for empirical and literature review articles identified in scoping review and assessed as integrating evidence from CSDH.	Explored promising practices in a dialogic setting, using the metaphor of inviting people to a 'table of dialogue' wherein the research questions became objects of reflection and conversation.
Questions	What is the breadth of scholarly activity in the periods leading up to and following the release of the CSDH report? How was evidence on root causes of health inequities integrated into publications/research?	What does the evidence point to as more promising practices for connecting KTA? What contexts are described as enabling or supportive of these promising practices?	How do KT and health equity experts orient their work (and themselves) toward health equity? Drawing on their experience and knowledge in the field, what do KT and health equity experts believe: • Is promising for connecting KTA for health equity (i.e., enables action on the known causes of health inequities)? • About the role of power in health equity work? • Are issues that warrant further reflection and challenge (e.g., assumptions, ideologies, and values) in the field of health equity?
Major Findings	Integration of CSDH evidence and calls for action in scholarly work was modest. About half of included articles described health inequities without reference to known causes. Referral to power and privilege in the creation of systems and structures that	Four distinct kinds of promising practices for connecting KTA for health equity include: ways of structuring systems, ways of working together, ways of doing research, and ways of doing knowledge translation.	Equity attunement can expand or contract in ways that relate to ways of thinking-doing. Equity attunement can be cultivated at individual and organizational/institutional levels. Four promising ways of thinking include: thinking relationally, thinking

	Scoping Review	Critical Interpretive Synthesis	Critically Reflective Dialogues
	enable health inequities was infrequent.	Each of the practices appears to collectively influence and be influenced by how attuned authors were to health inequities.	reflexively, thinking responsively, and thinking tenaciously.
	Much scholarly work purporting to contribute to health equity did so in ways that conflicted with the CSDH's		Promising ways of thinking have a mutually reinforcing relationship with promising ways of doing and with equity attunement.
	characterization of the remediable nature and distribution of health inequities.	There are varying degrees of attunement to issues of equity and the root causes of inequities.	
Substantive Contributions (by study)	Method for assessment of portrayals (naturalizing versus problematizing)	Table of promising practices	Table of promising ways of thinking (individual-institutional)
	Heuristic for assessing orientations to root causes		
Substantive Contribution (overall)	Concept of Equity Attunement		
	Framework for Equity Action		

7.3   Toward More Equity-Sensitive KT: An Open, Adaptive Framework

One widely used integrated knowledge translation model is the knowledge-to-action cycle (Graham et al., 2006). Its evolution is described by the authors as being response to persistent knowledge-to-action gaps and continued application of obsolete research findings in clinical and health systems settings. The KTA cycle positions knowledge creation at the centre of an action cycle. Knowledge creation is presented in a three-phased "funnel," moving from the most raw and vast generation of knowledge inquiry (single studies) and filtering through to a second generation of knowledge synthesis before arriving at the third generation that focuses on tools and products that support knowledge application (Graham et al., 2006, p. 18). The surrounding action cycle includes seven sequential, unnumbered steps: identify the problem + identify, review, and select knowledge; adapt knowledge to local context; assess barriers to knowledge use; select, tailor, implement interventions; monitor knowledge use; evaluate outcomes; and sustain knowledge use. The steps flow together in a continuous loop, with arrows circling around a central action of creating and using knowledge. Understood as an integrated KT model, the accompanying article suggests the importance of relationships, relevance, and responsiveness among actors. The article provides a useful exploration of KTA language and its implicit-explicit intentions, namely that collaborative research processes can lead to

meaningful alignment between knowledge and action. Using this cycle guides researchers to respond to real, current, and complex systems challenges in collaboration with the most likely users of evidence.

Though the KTA cycle (Graham et al., 2006) offers attentiveness to complexity and relationships in a process of generating, refining, and applying knowledge, these study findings illuminate a number of points for enhancing equity considerations within the model. Notably, though the terms that constitute the KTA cycle include relational assumptions, these assumptions are implicit. One immediate way to enhance equity considerations would be to more explicitly acknowledge relational theory in processes of connecting KTA. Yet, relationships and relationality are not explicitly addressed other than to suggest the need to cultivate "appropriate relationships" (Graham et al., 2006, p. 22) (p. 22). Applying thinking relationally to this model would invite contemplation of how the 'problem' of health inequities is framed and by whom. Notions of interconnectedness and coherence (through relational consciousness) would enhance capacity to respond to the wicked nature of health inequities. Further, findings from this dissertation indicate that the contemplation of relationships and relationality is political and influenced by systems of power and privilege. If the central KTA gap deals with advancing health equity, then the KTA cycle must include careful consideration of these issues. The following are some questions for the consideration of power:

- How does the frame (i.e., portrayal of health inequities) influence the way a problem is indented and described?
- What is the 'knowledge' of knowledge-to-action? How are power, epistemological barriers, and epistemological injustices influencing assumptions about what knowledge counts?
- What outcomes warrant attention?
- Who is included in the KTA cycle? Who decides who is included? How are people included?
- How is accountability considered in this process? How is accountability for using and/or integrating knowledge about root causes of inequities being navigated throughout the research process?
- How are assumptions being identified and explored? How are the influences of dominant ideologies (bio-behaviourism, neoliberalism) being contemplated?
- How is governance being considered? What mechanisms are available? How do these mechanisms challenge social inequalities?

These questions and considerations focus on the arrows that connect steps in the KTA cycle, providing more contextual consideration to the process. These are the points in the cycle where attentiveness and mitigation of issues of power can support movement between steps, creating openings for applying promising ways of thinking and doing. Shifting the application of the KTA cycle outside the setting of

clinical health systems and toward KTA for health equity also invites consideration of how to achieve *socially* integrated approaches to advancing health equity.

7.4   Strengths and Limitations

Three distinct studies generated complementary insights about promising ways of connecting KTA for health equity. In previous chapters, I discussed the strengths and limitations of each study in depth. Comments here are restricted to the strengths and limitations in the dissertation as a whole. Among the strengths of this dissertation is the use of multiple modalities (i.e., three distinct studies) to explore a broad question. The goal of the research question is, in essence, about closing the gap between knowledge and action for health equity. I am certainly not the first person to ponder how to do so, but this study represents the only effort to date to systematically assess current practices and identify promising and evidence-informed practices for moving forward. By looking to both the literature and experts in the field, I was able to explore different aspects of the question from different angles to arrive at a place of confidence in study findings. Attentiveness to theory and reflexivity throughout each study also strengthen confidence in findings. As studies unfolded, sometimes in parallel with each other, the analytical process could lean into data with a constant consideration of positionality, power, and assumptions. For example, the third study unfolded in concert with the second. By using repeated dialogues, the study design involved checking and rechecking with contributors and returning to new dialogues with a synthesis from previous dialogues *and* the literature reviews. This strategy contributed to the verisimilitude in the findings and allowed the process of critical reflection to continue beyond the confines of a single encounter. It also created meaningful and unhurried opportunities for contributors and I to extend the contemplation of ideas emerging from a dialogic encounter.

The study's limitations are primarily related to logistics and equity attunement. Logistically, as a doctoral study with a fixed and modest budget, the study was limited in its scope by time and English language requirements. For example, the process of initiating critically reflective dialogues could have continued to explore the face validity of the proposed Framework for Equity Action. Also, appealing for, validating, extending, and exploring the applicability of study findings would be a collaborative dialogue forum, such as deliberative dialogue.[18] Another kind of logistic limitation relates to publishing practices and issues of power and privilege in the realm of academic journals. All three studies relied on published literature—the first two did so because they were literature reviews; the third did so in its reliance on identifying some experts through the published literature. Who is published, when they are published, and what is published are all subject to issues of power and privilege, reflecting inherent inequities (Curry & Lillis, 2018). Equity attunement is mentioned here as a limitation because the ever-unfinished work of critical reflection is constrained by where a person is at in their own journey to be wakeful and attuned to the complex issues inherent in these subjects. The study is, therefore, limited to the degree of attunement

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[18] For a good description of what approaches characterize deliberative dialogue, see (Boyko et al., 2012).

and wakefulness of one of us who contributed to the work was—including myself, my committee, contributors, reviewers. There are always going to be ways to be more reflective, more reflexive, and more equity-attuned. At another time, in another place, I could return to these results and find new ways of understanding and representing.

7.5   Implications

The implications of these three studies are broad and significant. Although in alignment with other efforts to enhance capacity to engage in critical reflection and respond to issues of power and privilege (Masuda et al., 2014; Nixon, 2017) and the social and structural determinants of health (Cole et al., 2011b; Hanson, 2017; Jogerst et al., 2015), the identification of equity attunement as central to the directionality of health equity work is new. Importantly, this study situates the concept of equity attunement in a direct and mutually reinforcing relationship with ways of thinking and doing. The visual framework and its constituent components represent, therefore, an innovative and evidence-informed tool for reimagining the ways in which teaching, learning, scholarship, research, policy, and practice unfold in the field of health equity. In addition to the visual framework, other concrete and practical tools were developed for or from these studies.

For example, the heuristic describing a spectrum of possible orientations toward root causes provides a tangible and easy-to-use tool that can be applied in virtually any setting and by anyone. Complementing this heuristic are a set of practical tables outlining promising practices (ways of doing) and promising ways of thinking. The reflexive questions embedded within these tools also create new opportunities for contemplating how epistemological barriers and epistemological injustices may be influencing the ways in which any given health issue is being framed. Together, these suggestions provide an applied and meaningful set of tools for identifying points where KTA for health equity could be strengthened. They also open a range of intriguing questions for future research. The heuristic has already been piloted informally with public health practitioners. It could be further tested in a range of practice, policy, and research settings. It could also be used to guide policy or discourse analysis or examine trends in health and health research systems. Such research efforts could also serve to strengthen the application of the equity-centred principles for research and KT (CCGHR, 2015) that sparked interest in the dissertation questions and research could play a role in testing interventions for this application.

This research advances integrated knowledge translation theory by illuminating ways in which core practices and models can become more equity-attuned, enhancing possibilities for (a) more integrity in direct efforts to connect KTA for health equity and (b) greater possibility for general KTA efforts to consider issues of equity, and thereby greater health equity. Specifically, the promising practices and visual frameworks derived from this study are innovations that can be used to shape, refine, or develop effective mechanisms to enable more meaningful use of evidence in equity-centred research, ultimately

serving to enhance the integration of research, practice, and policy, while improving health and health equity.

The results of this study are, and will continue to be, published in peer-reviewed academic journals. Plans are also underway for identifying suitable public meetings and conferences for sharing results. Content from this dissertation has been offered in several guest lectures at the University of British Columbia, the University of Ottawa, and the University of Calgary. Content from this study, and building on my previous involvement as principal investigator for the studies leading to the CCGHR Principles for Global Health Research, is also being integrated into a graduate course being offered at several British Columbian universities in the spring of 2019 under the Western Dean's Agreement. One critically reflective dialogue with a colleague in global health resulted in an article, which will become part of a special series on iKT and may lead to other research and scholarship opportunities nationally and internationally. Study findings emphasize how deeply relational the processes of connecting knowledge with action are. Because issues of health equity are embedded in social systems and structures, this dissertation's findings suggest a need for extending current KT thinking to consider integrated processes not only in isolated projects, but also over time and place in ways that can support social transformation in the long-term.

7.6   Conclusion

Freire pointed out that, though human history is marked by periods where a dominant or prevailing sentiment drives society and human relationships within it and the world, they shift over time (Freire, 1985b). These epochs, he suggested, might be marked more or less by integration or adaptation, but change over time is always born of a combination of human thought in praxis with action. The emergence of KT as a field of research and practice could be considered an emerging epoch for research broadly, reflecting a shift in the aspirations, concerns, and general attitudes and opening questions about what research is, what it is for, and what it *should* do. Health equity, though not a new concept, emerged over the last decade as something for which our global human societies have the knowledge and tools to achieve. It too is aspirational and part of a global epoch of uncertainty. On one hand, tremendous potential exists through new technologies and the acute need for human populations to collaboratively respond to global threats such as climate change. But it is also a fragile time. To tip society toward consciousness of the perpetuation of oppressive adaptation will require cultivating a critical mass of equity-attuned humans who share equity as a real, tangible, and achievable aspiration.

This study brings these two aspirational fields, KT and health equity, together by responding to the question about what is promising for connecting KTA for health equity. Study findings provide coherent and practical strategies for how to cultivate equity attunement through ways of thinking and doing. In many ways, the study was a self-check within the field to ask, 'How are we doing with this work of responding to root causes of health inequities?' It turned a reflexive gaze inward on the field of health equity, seeking to identify responses to the important questions about *how* to connect KTA for health

equity. The studies described here revealed many promising *how* answers. But they also revealed the challenges people face within the field, both in navigating environments unconducive to health equity work and in maintaining optimism in a world where political chaos seems increasingly volatile and grim. It is my hope that this study bolsters optimism by providing a wide range of tangible, concrete, and achievable strategies for advancing equity action.

These strategies are offered for consideration by people situated as practitioners, researchers, learners, teachers, policy-makers, advocates, or activists in the field of health equity. Equity attunement can be cultivated in individuals and institutions/organizations. As researchers and health professionals we have a responsibility to (a) hold each other to account when evidence about root causes is not being integrated and (b) do everything in our power to move toward more productive orientations toward root causes of inequities (i.e., promoting equity and reducing inequities). The findings can support people to situate themselves and their efforts in relationship to equity action, inviting them to contemplate particular ways of thinking and doing. Introspectively as contributors to the field of health equity, these findings invite us to look at a mirror long enough to recognize ourselves in context of a broader social fabric. It is an invitation to hold each other to account, using systematic reflection to question how we are working to either expand or contract equity attunement. Cultivating equity attunement within ourselves, our organizations and institutions, and with others, and holding each other to account, requires attentiveness to the alignment between intention and action—recognizing that good intentions are insufficient. It is the outcome and consequences of action, whether intended or not, that matter.

This evidence is not conclusive or irrefutable, but rather suggestive of things that warrant further attention, exploration, and research. Though the promising practices proposed here are suggestive, rather than definitive, they provide meaningful mechanisms for informing the contemplation of current practices and providing direction for future research. These findings support calls for passionate public discourse, suggesting the promise of engaging in inclusive and diverse dialogue that builds relationships up and out, and involves building collective capacity to talk about and digest uncomfortable truths. For those of us in the field, one of the greatest challenges to face is that of building relationships up and out, spanning outside the domain of 'health' in ways that leverage our social power and support a more socially-integrated conceptualization of health equity work. Together, these findings provide a pathway for achieving greater coherence between intention, knowledge, and action.

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Appendix A : Perspectives Form

Relational Practices in the Knowledge-to-Action Work of Addressing Health Inequities
Demographics & Perspectives Form

Thank you for agreeing to participate in the study entitled, *Relational Practices in the Knowledge-to-Action Work of Addressing Health Inequities.*

Please take about five minutes to complete the form below. We would like you to consider the perspectives that you believe you bring to this study. We are also interested in some general demographic information as a means of contextualizing the study results.

Age Category	Role in Connecting Knowledge-to-Action	Stage in Career
☐ 18-25 ☐ 55-64 ☐ 25-34 ☐ 65-74 ☐ 35-44 ☐ 75+ ☐ 45-54	☐ Researcher ☐ Practice Leader ☐ Administrator ☐ Facilitator/Broker ☐ Funder ☐ Manager/Director ☐ Student ☐ Community Member ☐ Policy Maker ☐ Other (describe) Type here	☐ Early career ☐ Mid career ☐ Late career ☐ Retired
Has your education, training, or professional development included content on the role of power and privilege in society? ☐ Yes ☐ No	How do you describe your ethnocultural background? Type here Do you identify as: ☐ Male ☐ Female ☐ Trans ☐ Other Type here	Do you identify as part of a visible minority? ☐ Yes ☐ No

Every person brings a multitude of perspectives to their work and their thinking. We've listed some here. Please check the ones you identify with, and elaborate on others you feel are important (if not listed).		
Disciplinary Perspectives ☐ Health sciences ☐ Public/population health ☐ Social sciences ☐ Biomedical sciences ☐ Statistics ☐ Epidemiology ☐ Health services/systems ☐ Other (describe) Type here	**Organizational Perspectives** ☐ Government agency ☐ Non-government agency ☐ Private Sector ☐ Academic institution ☐ Other (describe) Type here	**Geographic Perspectives** ☐ Western Canada ☐ Central Canada ☐ Eastern Canada ☐ Maritimes ☐ Global South ☐ Global North ☐ Other (describe) Type here

What theoretical perspectives do you bring to this study? Type here	What content area (substantive) perspectives to you bring to this study? Type here

Appendix B : Question Prompts for Dialogues

Focus	Question Prompts
Situating ourselves in the field of health equity	Tell me about your work and how it relates to health equity.
	How does your work get at the *causes* of health inequities?
	Where do you direct your KTA efforts?
Responses to literature reviews	Here are some preliminary findings from literature reviews: What do you think?
	What does this finding tell us about this field of work?
	What do we need to be paying more attention to?
What matters? What works?	What role do(es) researchers or research play in achieving health equity?
	What kinds of KT or KTA strategies do you find useful?
	How do you know your work is making a difference in terms of addressing health inequities?
How do power and other structural factors influence KTA work	How do systems of power or other structural factors play a role in research that aims to address health inequities?
	How do power and privilege influence KTA for health equity?