

*inter*sections

A NEWSLETTER OF THE INSTITUTE OF GENDER AND HEALTH

vol. 4 no. 1

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Canadian Institutes of Health Research

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Canada

Building Partnerships in Sex, Gender and Health Research

Partnership building and collaboration are essential to achieving CIHR's goal of improved health for Canadians and a more effective health care system. But what does collaboration mean to those of us on the front lines of gender and health research? Because every cell is sexed and every person is gendered, our work reaches into every corner of health research and its application. The cross-cutting nature of IGH's mandate is unique, and strategically positions us to educate and influence other institutes and organizations about the need to integrate sex and gender considerations in health research. Establishing interdisciplinary partnerships in priority areas that involve overlapping mandates is a key mechanism through which IGH builds capacity and spreads the message that integrating sex and gender is a matter of robust and ethical science.

While our commitment to fostering interdisciplinary research partnerships will continue, it is also important to remind ourselves that working in partnership is more than simply collaborating across research disciplines. In this issue of *Intersections*, we explore the bigger meaning of partnership building in sex, gender and health research – including the challenges, opportunities and benefits that come when we join forces with those outside of our academic and geographic boundaries to address the complex health issues facing Canadians and the global community. The pages that follow are a window into how partnerships during all phases of the research process can be an engine for research excellence; new conversations, perspectives and opportunities; more creative and empowering approaches to knowledge translation; and most importantly – greater impact. While the benefits are clear and compelling, partnerships are not always easy to initiate and sustain. This issue offers key insights and strategies for partnering successfully at a variety of levels, and shows what can be learned when we put our professional relationships under the microscope to better understand the science of effective collaboration.

I hope the following pages inspire you to broaden the meaning and scope of partnership building in your own work, and to seek out new opportunities for collaboration and collective impact.



Dr. Joy Johnson

IGH

INSTITUTE OF GENDER AND HEALTH

The Institute of Gender and Health (IGH) is one of the 13 institutes that make up the Canadian Institutes of Health Research (CIHR), the federal government agency responsible for funding health research in Canada. IGH is the only organization in the world with the mandate to fund research on gender, sex and health.

The mission of IGH is to foster research excellence regarding the influence of gender and sex on the health of women and men throughout life, and to apply these research findings to identify and address pressing health challenges.

For more information, including funding opportunities, please visit our website at:

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Intersections seeks to showcase excellence in Canadian gender, sex and health research. We welcome proposals for spotlighting cutting-edge researchers, profiling research achievements and innovations and highlighting success stories in knowledge translation and training. To submit your ideas or to request further information, please contact igh.admin@ubc.ca

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PHOTO: CHAD GALLOWAY

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PELLETIER

The Science of Collaboration

Unpacking the evolution of relationships within the CIHR Team in Gender, Environment and Health

The CIHR Team in Gender, Environment and Health was created in 2008 to develop new approaches and methods for the integration of sex and gender in environmental and occupational health research. To achieve this goal, the Team brought together scholars and practitioners from a number of areas to explore

different methodologies through knowledge mobilization.

But a team is more than a list of complementary disciplines or sectors and more than an addition of its individual parts; it emerges from the interactions between its members.

The patterns formed by the various types of relationships between team members enable – or not – the creation of a resilient network, which can then sustain knowledge creation and exchange.

A key aim of the Team is to foster knowledge exchange between the fields of occupational and environmental health, between Canadian researchers, and between disciplines. Recognizing that relationships are a necessary vehicle to achieving this goal, from the outset the Team planned a longitudinal communication network analysis to capture relationship patterns and their evolution. Sociometric questionnaires were sent to all team members – including students, awardees and collaborators. The first questionnaire (QT₀) queried about the relationships of members prior to joining the team and was followed by the circulation of a second questionnaire (QT₁) a year and a half later. The questionnaires ask about professional contacts and collaborations, personal and intellectual exchanges not related to work, and trusting relationships.

Open-ended questions are also posed to investigate the relevance of the Team’s understanding of concepts such as sex and gender, transdisciplinarity, and collaboration.

Here, we share five key findings from our QT₀ and QT₁ questionnaires, which explore relationship patterns across three dimensions: domains (occupational and environmental), disciplinary fields (health, social and natural sciences) and languages (French and English).

I. The diagrams in *Figure 1* show the network structure of collaborative relationships prior to joining the Team (QT₀). Each dot represents a team member and the lines between dots indicate whether the two members reported that they collaborate together (defined as having co-published, having a research project together, or having organised a course or a conference together). Dots on the side reflect persons for whom no such dyadic collaboration was declared. In all of the diagrams, fault lines are evident along the three dimensions of study – showing how relationships mostly existed between people working in the same domain, sharing the same language or belonging to the same disciplinary field.

II. Results of our network analysis show the growth of inter-dimensional

relationships as the Team evolved. Prior to the creation of the team, collaborative relationships between research domains were only reported by 37% of members; one and a half years later, this number grew to 51%. Similar increases in collaborative relationships were also seen across language groups (15% at QT₀ to 26% at QT₁) and disciplinary fields (33% QT₀ to 38% at QT₁). While these results are promising, we wanted to link increases in inter-dimensional relationships more explicitly to our exchange activities, such as our annual general meeting, bi-monthly webinars, cafés scientifiques, and multi-centric working groups, designed to address specific methodological issues. First, we created an index based on the participation of Team members in these activities. Second, we correlated this index with an individual’s number of newly created relationships (from QT₀ to QT₁). The results were highly significant and close to 40% of the new collaborations emerged between members of the same multi-centric working group.

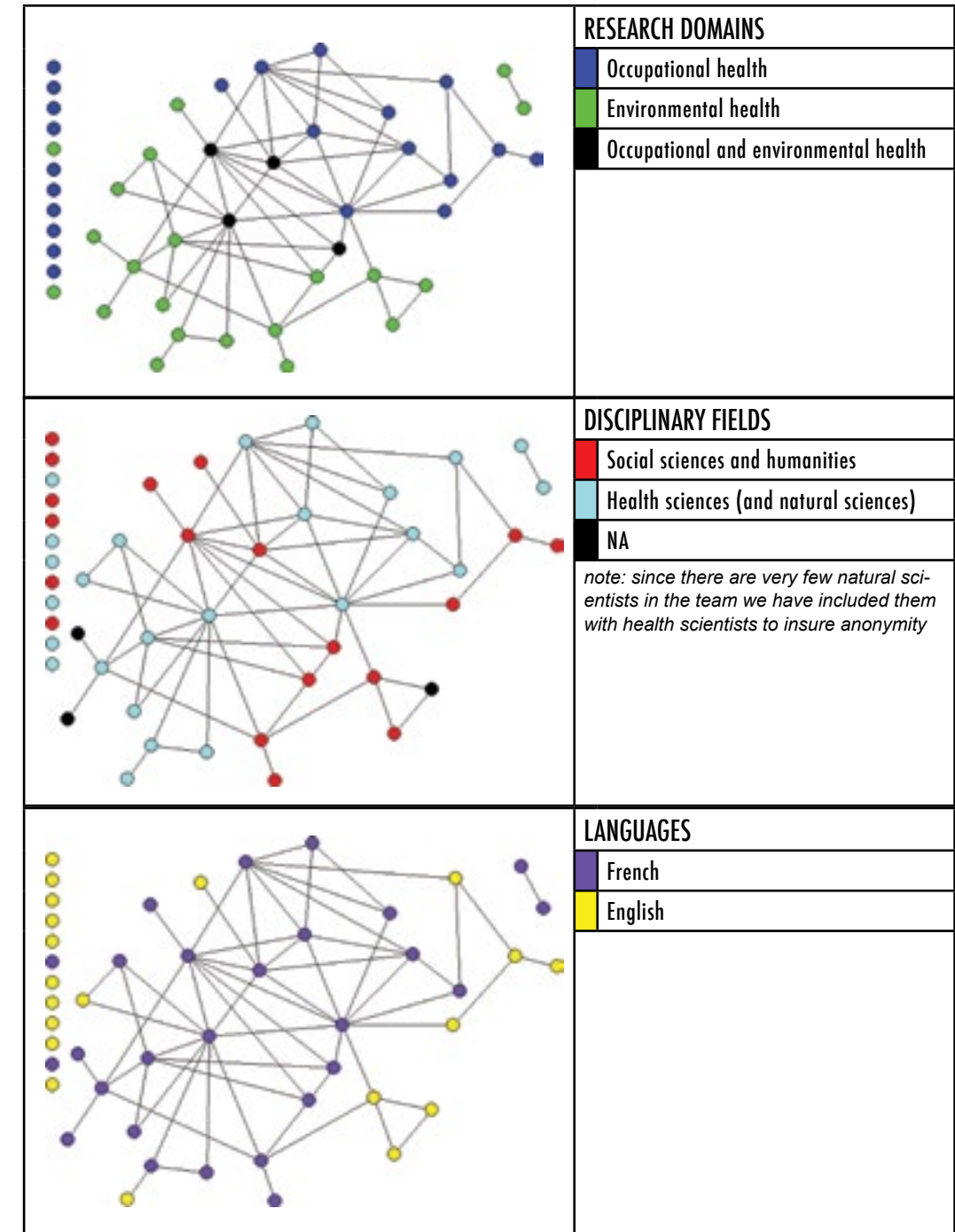
“Results of our network analysis show the growth of inter-dimensional relationships as the Team evolved.”



Everyone’s opinions matter, even those of students and trainees, who are treated equally with their senior academic mentors.”

III. Another major aim of the Team is to support young researchers through our scholarship program and through opportunities to interact with more senior team members. Our network analysis found that 33% of the new relationships formed during the first year and a half of the Team’s evolution occurred between younger scholars (25-34 years) and their more senior colleagues. This success was echoed throughout the open-ended responses shared by awardees, including references to forging new professional relationships that are crucial for future academic endeavors, and opportunities to discuss sex and gender considerations with more experienced team members. In the words of one young researcher: “Everyone’s opinions matter, even those of students and trainees, who are treated equally with their senior academic mentors. There is genuine respect that motivates all to work harder and reach common goals.”

IV. For such a diverse team to strive and develop, team members must trust one another. Our study measured two aspects of trust that have been shown to have an impact on the development and the duration of professional relationships: professional trust (trust that the other is considered an “expert” in her or his field) and personal trust (a belief that others



would not “let us down”). A year and a half after the Team was established, professional trust had increased greatly, with 61% (137) of the professional trust relationships being new. For personal trust relationships, there was a 55% increase (equivalent to 47 new relationships). Through the Team’s activities, members have had many venues to meet with one another, present their work and discuss methodological issues – efforts that have led to a better understanding of

one another’s expertise and in turn, more trust. The notable increase of personal trust relationships testifies to the values of support, openness and equity that are fundamental to the Team.

V. Groups of a certain size tend to organise themselves around a “core-periphery” structure, where a core group of individuals have noticeably more relationships with members than those located at the periphery.

Figure 1 - Collaborative relationships between groups by dimension prior to creation of the Team (QT₀)

(continues on page 15)

PreVAiLing against violence

How the Preventing Violence Across the Lifespan Research Network is partnering for global change

Nadine Wathen, Donna Stewart, Jeffrey Coben, Helen Herrman, Harriet MacMillan

Intimate partner violence and child maltreatment are complex problems. We know they are common across countries and cultures, and cross-cut socio-economic lines. They are also more likely to occur across generations; people with exposure to violence in childhood are more likely to be victims or perpetrators of violence as adults. Violence happens in all kinds of relationships and can occur in different forms, including physical, sexual, emotional and financial.

The effects of violence are many and significant. All forms of child abuse (including those mentioned above as well as neglect and witnessing violence in the home) are associated with developmental issues and mental and physical health problems throughout the lifespan. Similarly, intimate partner violence can lead to homicide and has been linked to a number of physical and mental health conditions, including chronic pain, depression, gastrointestinal disorders, and heart disease. In addition to harm to the woman, intimate partner violence during pregnancy can cause direct harm to the fetus, which can result in pre-term birth or injury and low birth weight. Exposure to violence is also associated with risky health behaviours, including alcohol and drug abuse, smoking, unsafe sexual behaviour and physical inactivity.

Given the numerous types of violence and the variation (or in some cases, overlap) in

who commits and experiences it, to even begin to address family violence requires a multi-sectoral perspective – including a shift in social norms regarding gender roles. From the health-care perspective, a key challenge is to understand the many health-specific, health-related and non-health related causes and consequences of violence - and what, specifically, the health sector can offer individuals and other systems as part of this multi-pronged approach. One key way to do this is to link emerging knowledge in violence prevention with those who need to make decisions to improve policies and practices at multiple levels.

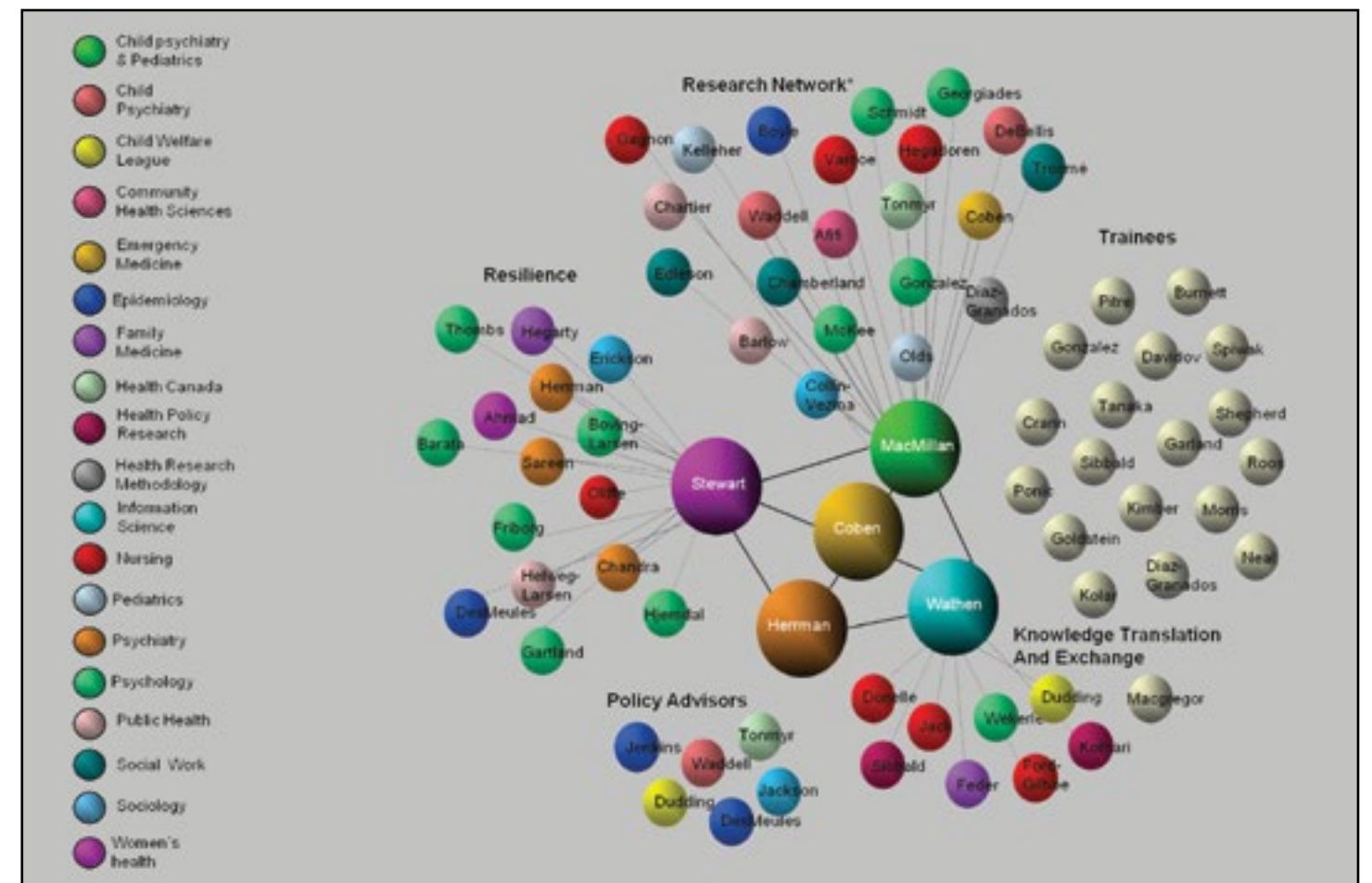
Researcher-Knowledge User Partnerships

There is growing emphasis on finding ways to ensure that scientific evidence is incorporated into the decision-making processes of those providing health care, and those developing the policies governing how public health care dollars are spent. One way to do this is what CIHR has termed *integrated knowledge translation (iKT)*, which essentially means having the ultimate users of knowledge involved in research at key times in its development, implementation and communication. This integration will lead to research questions and data of more direct relevance to “real world” problems, and form key conduits for sharing knowledge and research findings. Ultimately, this increased

buy-in should lead to the actual use of research evidence in health decision-making.

The PreVAiL Network

In late 2007, the CIHR Institute of Gender and Health launched a new funding opportunity to address knowledge gaps regarding the interactions of gender, mental health and addictions by finding innovative ways to build bridges across research, policy, program and practice domains. These ‘Centres for Research Development’ were designed to support interdisciplinary teams of researchers and their stakeholders in the development of integrated programs of research and knowledge translation. The Centres would not only design and test new interventions, but also examine the influence of gender and sex on mental health and related policies and programs. Led by Dr. Harriet MacMillan at McMaster University along with co-Principal Investigators Drs. Donna Stewart (University of Toronto) and Nadine Wathen (Western University), our team decided on an international approach, given the global scope of the issue of violence, the role of gender, and its impact on mental health. Our first order of business was to approach two international colleagues – Dr. Jeffrey Coben from West Virginia University, and Dr. Helen Herrman from the University of Melbourne – to co-lead the team. Given the nature of the Centre requested by CIHR, the decision regarding



The PreVAiL Research Team

an iKT approach was obvious. However, a key issue was what knowledge user partners to engage. How could we create a global research network around gender, mental health and violence prevention, and link Canadian researchers and decision-makers to these international experts?

So began the process of building the Centre for Research and Development in Gender, Mental Health and Violence Across the Lifespan, which came to be known as PreVAiL. To build an interdisciplinary research team, our five co-leads considered their own networks of colleagues actively engaged in research in the areas of child maltreatment and intimate partner violence, and their mental health consequences. Our team agreed upon three main objectives for PreVAiL, the first of which was to increase knowledge about the links between mental health impairment, gender and exposure to child maltreatment. To help meet this objective, we established a guiding principle that all research would employ gender and sex-based analysis to understand the impact of both sex (biology) and gender

(the social construction of identity), and their interplay, in the causes and consequences of violence and trauma.

Equally as important as inviting committed researchers was ensuring active and engaged partners who would help us shape priorities, and act as conduits to their decision-making contexts. Given the global focus of the Centre, we decided to focus on national and international level partners. This included agencies and departments in the Canadian federal government and their counterparts in other countries (such as the Public Health Agency of Canada and the US Centers for Disease Control and Prevention), as well as agencies whose scope of work is global, such as the World Health Organization (WHO) and the World Federation for Mental Health. It was also important to include non-government organizations, such as the Canadian Coalition on Community Safety, Health and Wellbeing, and the Canadian Mental Health Association.

Now in its third year, PreVAiL’s partnership model can boast a number of international

successes, from both a research and knowledge translation perspective. For example, through its links with the WHO, PreVAiL became a member of the *WHO Violence Prevention Alliance (VPA)* and has taken a lead role in their new Research Agenda Project (RAP) Group. PreVAiL team members implemented an international research priority-setting process for violence prevention and published a manuscript with broadly applicable priorities in the online, open access journal *BMC Public Health*. PreVAiL sub-teams have begun to address these priorities, including a planned project between PreVAiL and the Pan-American Health Organization (PAHO). In addition, the forthcoming WHO Guidelines for the Health Sector Response to Intimate Partner and Sexual Violence Against Women included several PreVAiL researchers, largely by virtue of the link with WHO’s Gender, Violence and HIV/AIDS Division.

Partnerships fostered through the PreVAiL Network have sparked new linkages and projects that would otherwise not have been possible. An example of a new type

of international project emerging from the Network is “*The relationship between physical intimate partner violence and sexually transmitted infection among women in India and the United States*”, which is led by Rae Spiwak (a PreVAiL trainee and PhD student at the University of Manitoba), two PreVAiL researchers, and a PreVAiL partner from the WHO. The Canadian co-PIs have written an invited position paper on intimate partner violence for the Canadian Psychiatric Association, which will be published in a forthcoming issue of the *Canadian Journal of Psychiatry* and have a strong likelihood of influencing policy and clinical practice. Also, a number of PreVAiL researchers and trainees are involved in evaluating an intimate partner violence intervention in the context of the US Nurse Family Partnership (NFP) home visiting program. This project has evolved such that the province of British Columbia committed \$23M in funding to implement the NFP provincially, with \$5M for a randomized controlled trial to evaluate its effectiveness, including evaluation of the new intimate partner violence component. Similarly, a project newly funded by CIHR and led by Drs. Marilyn Ford-Gilboe and Colleen Varcoe (with involvement of several other PreVAiL researchers) will evaluate an online safety decision aid for women experiencing



Members of PreVAiL at the May 2011 PreVAiL Trainee Workshop

important insights about PreVAiL’s partnership model. Firstly, PreVAiL is perceived as a community, and our people and their commitment to violence prevention are viewed as essential to its success. Partners spoke highly of the benefits of PreVAiL meetings for networking and building international


In summary, PreVAiL has developed an effective international networking model that brings together over 50 researchers and decision-making partners in order to address the complex and multi-sectoral issue of gender, mental health and violence across the lifespan. As Dr. Mikton of the WHO says “For us, the

“Thanks to our partnership with PreVAiL, we have been able to extend our network of international violence prevention experts, and enhance the scientific quality of our work. PreVAiL has become one of our most important and valued partners.” - Dr. Christopher Mikton, Department of Violence and Injury Prevention and Disability, World Health Organization (WHO/VIP)

intimate partner violence. The project presents an exciting opportunity for international comparisons; the online decision aid, which will be adapted to the Canadian context, was developed and is being tested in the US, in Australia by PreVAiL member Kelsey Hegarty, and in New Zealand.

Our ongoing Partnership Evaluation Project aims to identify the quality of partnerships within the PreVAiL network, their evolution over time, and the capacity of partner organizations to utilize research. The first phase of the evaluation project, which used surveys and interviews with researchers and partners, has identified areas of strength and those requiring further development. Our preliminary results have generated three

linkages. Secondly, our evaluation results show a strong level of partnership engagement in the project; of the partners interviewed, 75% have high or moderate involvement in PreVAiL’s formal activities, such as team meetings, teleconferences and the Delphi research priority- setting process. Lastly, nearly all of PreVAiL’s partners see it as a knowledge sharing network. PreVAiL is seen to have “opened lines of communication”; partners reported that they often turn to PreVAiL when they need information and value the ability to call upon PreVAiL researchers for expertise and advice. Most view face-to-face meetings as the most effective method of sharing information, but noted the utility of the Team Newsletters, topic-specific teleconferences, and one-off conversations with researchers.

most important role a network like PreVAiL can play is to provide access to a pool of highly competent and knowledgeable specialists in the field of violence prevention who can, through collaborations, enhance the quality of our work.” 

The PreVAiL Research Network is one of three Canadian Centres for Research Development in Gender, Mental Health and Addictions, funded by the CIHR Institute of Gender and Health. PreVAiL Co-Principal Investigators include: Nadine Wathen, Donna Stewart, Jeffrey Coben, Helen Herrman and Harriet MacMillan. PreVAiL research summaries, progress updates and other information can be accessed at www.PreVAiLResearch.ca

Reporting Equity in Systematic Reviews: The Prisma Equity Extension


By: Vivien Runnels

Some populations (including women and girls, people living in poverty, and certain racial groups) have limited or unequal access to health interventions and experience differences in health outcomes. Health inequity refers to avoidable differences in health which are unfair and unjust.¹ While systematic reviews are designed to assess and transfer information about the effectiveness of health interventions, they are also an important means of transferring knowledge about health inequities. Reporting equity in systematic reviews is critical for building an evidence base of interventions that address and justify action against inequities in health, including those that exist along sexed and gendered lines.

Although there is available guidance on conducting equity-focused systematic reviews, there has been no guidance on *reporting* them. Failing to report equity-focused reviews can inadvertently perpetuate health inequities by limiting our capacity to understand and address any differential effects of an intervention. Adding an equity ‘lens’ to widely endorsed reporting guidelines, such as the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement, can have important implications for decision makers using systematic review evidence.

The Campbell and Cochrane Equity Methods Group developed reporting guidelines for equity-focused systematic reviews as an extension of the PRISMA Statement, called PRISMA-E 2012. The project had two main goals: (1) to provide structured guidance on transparently reporting methods and results in equity-focused systematic reviews, and (2) to legitimize and emphasize the importance of reporting health equity results. PRISMA-E 2012 is designed at minimum to raise both systematic reviewers’ and users’ awareness of disadvantage and inequities, with sex and gender being one category across which disadvantage may exist. Equity extension items have been added to different sections of systematic reviews. For example, the standard PRISMA item for the Abstract calls for a structured summary, including background, objectives, data sources and other applicable components. The equity extension to the Abstract item expands on this by instructing authors to “present results of health equity analyses (e.g. Subgroup analyses or meta-regression),” focusing attention on specific steps in reporting that are needed to demonstrate equity or inequity.

PRISMA E-2012 was published in October in *PLOS Medicine*.² The authors’ next

steps include disseminating the reporting guidelines to increase their uptake, evaluating the effects on reporting equity (including sex and gender) in prospective studies, contacting journal editors to request their endorsement of PRISMA-E 2012, and conducting an evaluation to determine whether journal endorsement of PRISMA-E 2012 impacts reporting of equity considerations in systematic reviews. We also hope that over time, requiring reporting of equity and sex and gender in systematic reviews may influence primary researchers to report more on study characteristics, provide sex disaggregated data, and reflect on the applicability of their findings. In addition, we hope that endorsement of these guidelines by journals will encourage and improve transparency and comprehensiveness of reporting of systematic reviews, therefore improving their relevance for clinical practice and policy making. 

The Campbell and Cochrane Equity Methods Group and authors of the PRISMA Equity Extension sincerely thank CIHR and the Rockefeller Foundation for funding support. For more information, visit <http://equity.cochrane.org>

¹ Whitehead, M. (1992)
² Welch et al. (2012)

NEWS

New CIHR Research Chairs in Gender, Work and Health

The CIHR Institute of Gender and Health (IGH) and its partners are pleased to announce the funding of nine new CIHR Research Chairs in Gender, Work and Health:

Dr. Ivy L. Bourgeault, University of Ottawa
Dr. Angela Colantonio, University of Toronto
Dr. Julie Côté (CIHR-IRSSST Chair), McGill University
Dr. Tamara Daly, York University
Dr. Mieke Koehoorn, University of British Columbia

Dr. Olga Kovalchuk, University of Lethbridge
Dr. Joy MacDermid, McMaster University
Dr. Peter Smith, Institute of Work and Health
Dr. Allison M. Williams, McMaster University

The Gender, Work and Health Chair opportunity was launched by the CIHR Institute of Gender and Health in partnership with the CIHR Institute of Musculoskeletal Health and Arthritis, the CIHR Institute of Population and Public Health, the Canadian Centre for Occupational Health and Safety and the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSSST).

The specific objectives of the Gender, Work and Health Chair Program are to support leading researchers to develop their programs of research in gender, work and health; to build

capacity for research on work and health that accounts for gender and sex; and to foster the translation of that research into gender- and sex-sensitive policies and interventions that improve workers’ health. A unique feature of this Chair Program is a knowledge translation (KT) partnership with the Canadian Centre for Occupational Health and Safety (CCOHS), a not-for-profit federal department corporation mandated to promote the total well-being of working Canadians. CCOHS will be the official KT Partner for the Gender, Work and Health Chairs. Using web-based technology and their extensive network, CCOHS will expand the reach and impact of the Chairs’ work.

For more information visit: <http://www.cihr-irsc.gc.ca/e/46464.html>

BUILDING PARTNERSHIPS IN THE NORTH

A Conversation With Jody Butler Walker from the Arctic Institute of Community-based Research



In June 2012, the CIHR Institute of Gender and Health held a round table discussion in Whitehorse, Yukon, focused on building partnerships for gender and health research in the North. The discussion was a productive exchange between IGH's Institute Advisory Board and staff, and key stakeholders from government, health care, the non-profit sector, and Aboriginal health organizations in the Yukon. Among the participants was Jody Butler Walker, Co-founder and Executive Director of the Arctic

Institute of Community-Based Research, who has spent nearly 30 years living North of 60° and working in various research settings in all three territories. Here, we connect with Jody to discuss opportunities, challenges and successful strategies for building health research partnerships in Canada's North.

At the round table meeting we discussed key principles that must be in place when community members and health researchers work together in the North. We discussed the need for showing humility, and were reminded of the importance of honouring the principles of OCAP (ownership, control,

access, possession) when working with Aboriginal communities. In your experience, what other principles need to be in place when community members and researchers work together in the North?

Building meaningful health research partnerships in the North takes time, trust, respect and resources. Trust and respect take shape through acknowledging multiple types of expertise that partners bring, listening carefully, checking assumptions by asking clearly articulated questions, giving back as well as taking, compensating community-based team members for their expertise, using plain language, and following through on your commitments. From a Community-Based Research (CBR) perspective, it is also essential that the research be focused on local priorities, whether on a territorial-wide or a community-specific basis. Working with communities to help to identify their research priorities may be necessary, and it shouldn't be assumed that such a list of priorities exists. Community members need to be involved in all stages of the research process to guide the development, implementation and evaluation of projects, which means that capacity building and knowledge translation are inherently part of CBR projects. This adds time and cost to the overall project, but it's an essential principle for research partnerships to be successful in the North. This up-front investment will continue to pay off in the future, as building capacity also provides for future partnership opportunities to occur.

What are some other common assumptions that health researchers should avoid when pursuing partnership building and projects in the North?

Researchers need to be careful to not "lump" all territories together and remember the unique contexts present across Canada's North. For example, perspectives of 'rurality' can vary depending on where one is situated. People who live in the capital city of each Territory tend to refer to rural regions outside the capital as 'the communities', whereas from a general Canadian perspective Whitehorse, Yellowknife and Iqaluit are likely considered 'rural'. Another assumption that southern-based health researchers may bring to the North is that their work can be completed on a tight schedule. A number of unpredictable and unavoidable factors can influence schedules in the North. Sometimes the people you want to meet with in

a community on a particular day are called on to deal with another issue. It's better to build in some extra time to the trip in case this situation arises. 'Helicopter researchers' (who fly in and out in a very short time) miss important opportunities to make informal connections and gain a more informed sense about the community, and risk being perceived as self-serving, which can undermine partnership development.

What are some of the challenges of building health research partnerships in the North?

In addition to the time frame required to undertake community-based research in the North, another big challenge are the vast distances separating the region from the majority of academic researchers. Given the importance of face-to-face contact to relationship building with Northern communities and organizations, this distance ultimately needs to be bridged for partnerships to germinate. There are no universities in Canada North of 60°, which limits the degree to which researchers and community members can gather, discover common ground, and

“For research outcomes to be sustainable, the context surrounding complex community health issues must be acknowledged.”

pursue partnerships on specific projects. While unplanned contact is generally limited, if there are meetings or conferences that take place in the North and researchers are willing to travel the distance to develop partnerships, they may not be adequately resourced to do so. Partnership building in the North can therefore be particularly challenging in times of fiscal restraint. Understanding how to engage communities in meaningful ways can also be a significant challenge. Unless there is specific attention and intention to engaging communities in plain language discussions, there can be little communication that actually takes place, despite the temporary bridging

of the distance. Specific challenges related to organizing plain language meetings from a southern-based academic perspective include who to invite and partner with in the community, how to frame the topic in a meaningful way, and how to identify and follow-up on desired outcomes.

Given these challenges, what practical advice or successful strategies can you share with researchers and funders looking to develop health research partnerships and projects in the North?

It's important to ensure that we move beyond the description of problems and that research strives to meet the needs identified by communities. For research outcomes to be sustainable, the context surrounding complex community health issues must be acknowledged. Developing and distributing plain language descriptions of funding opportunities well in advance of the proposal due date would be very helpful in facilitating communications between potential partners about specific topic areas. Dedicating resources for community engagement from the

beginning streamlines proposal development and implementation, as face-to-face interactions are by far the most effective way to build partnerships in the North. Involving Northern-based organizations with a similar focus to that of the researcher can also help to expand on what's already been developed and build on existing partnerships. **IGH**

Left image: Norma Kassi and Jody Butler Walker (co-founders of AICBR) near Old Crow, Yukon.

To learn more about the Arctic Institute of Community-Based Research visit www.aicbr.ca

PARTNERING for RELEVANCE and IMPACT

Creating gender-transformative health promotion for women

WHY IS IT THAT GENDER, LONG RECOGNIZED AS ONE OF the key social determinants of health, has rarely been integrated into health promotion manifestos, programs or policies? This was one of our first findings when we reviewed the past 40 years of key health promotion documents. This question underpins the work of our CIHR Team in Promoting Health in Women—known as PhiWomen.

While our work began by focusing on bringing gender into health promotion, we soon realized that would not be enough, and now aspire to create gender-transformative health promotion for women. This means that we are not content to simply integrate sex and gender considerations into health promotion activities, policies and programs, but rather to do so with a clear view to transforming gender in the process. This way, health promotion will not only enhance women's health, but also women's status at the same time. For example - if young girls could be deterred from smoking cigarettes based on messages about how smoking reduces their attractiveness to boys, some would say "why not" if such an approach works? But gender-transformative health promotion would question this, arguing that smoking prevention programs offer an opportunity to establish motivations in girls that are self-focused, perhaps to do with their own worth, health and future. These longer lasting and more thoughtful approaches not only address health, but also address gender norms.

Upon finding the current state of health promotion to be gender blind, PhiWomen set out to create a new Framework for introducing gender and equity into health promotion activities. Ready to tackle the dual and lofty goal of gender-transformative health

promotion head on, we knew that the use of strategic partnerships would be critical to guide the development process and multiply our impact.

Health promotion is a wide field with many players. From the outset, we identified a three-way focus for our work: policy, research and health services. In addition to reflecting each of these vantage points through our three co-PIs, these perspectives are ever present in our research, case study development, theorizing, and approach to collaboration. Because health promotion takes place in a range of ways and settings, we must address these multiple aspects in order to change practice in deep and meaningful ways.

From the outset, we actively sought out numerous partnerships in order to create a relevant Framework, and more importantly one that was likely to be taken up by agencies and individuals in a range of settings. After kick-starting the development process with an extensive literature review, we approached our Team and Advisory Committee members to not only generate principles but also ideas and new approaches for rectifying shortcomings in accepted health promotion practice. This engagement raised the bar on our work, as it helped us to understand that women's health

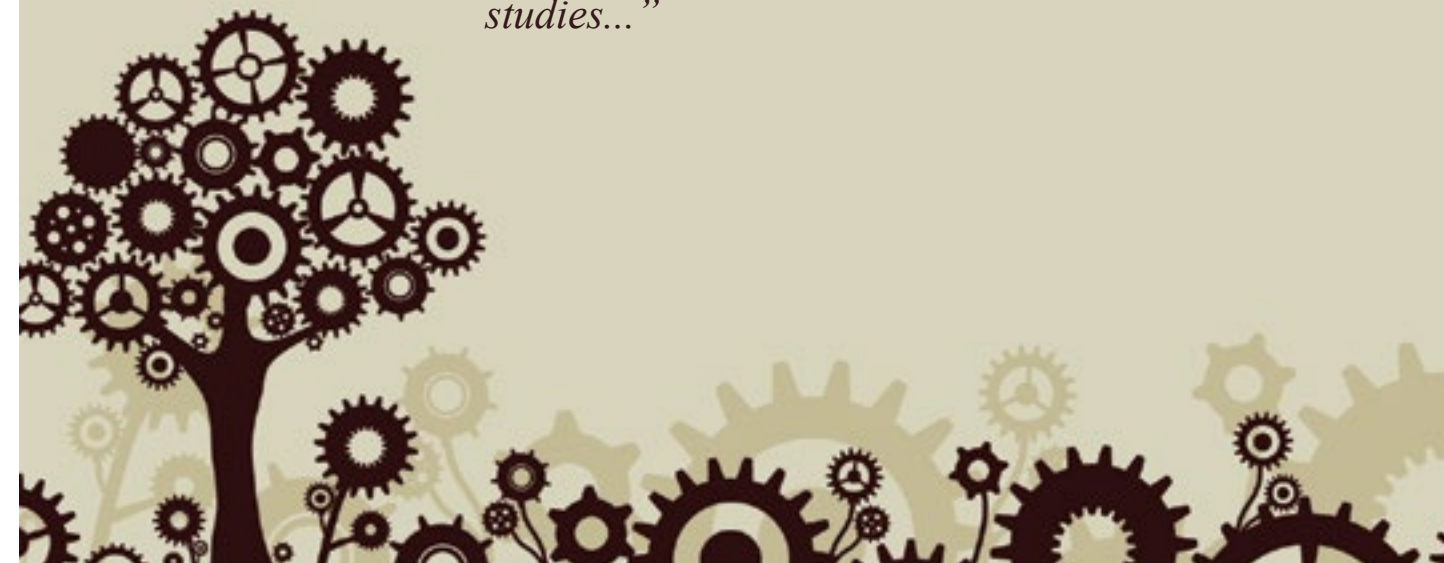
inequities were not going to disappear through standard health promotion, but rather required a conscious addressing of improving girls' and women's status and roles in order to see lasting improvements.

When our Framework was ready in draft form, we established an extensive consultative process spanning Australia, Canada and the UK, through which we revised and refined our Framework and its accompanying tool. This process engaged 140 people over a range of media, including e-surveys with YouTube videos, both web-based and in-person focus groups, and key informant interviews.

Since the beginning of PhiWomen, we have partnered with Women's Health Victoria - a leading health promotion organization for women in Victoria, Australia. This partnership continues to be a touchstone for collaboration as we move forward with our work. The ability to engage with members

“We knew that the use of strategic partnerships would be critical to guide the development process and multiply our impact.

“...our Team includes an impressive array of researchers and policy makers... These links have enabled PhiWomen to access a range of current examples of health promotion for our research studies...”




of Women's Health Victoria as Advisory Group members, research team members, co-creators and co-authors (as well as focus group organizers and participants) has been a critical opportunity for ensuring that our work was not limited to Canadian understandings of health promotion and gender.

Our Advisory committee reflects our core aim, representing leadership in mainstream health promotion, hospitals and health services. In addition, our Team includes an impressive array of researchers and policy makers who have keen interests and experiences in a range of health promotion issues such as substance use, mental health, violence, housing, chronic disease prevention, physical activity, and heart and maternal health. These links have enabled PhiWomen to access a range of current examples of health promotion for our research studies, and involve a cross-section of players in each of these initiatives. Our Team and Advisory Group together represent 16 organizations and institutions, spanning government, advocacy groups, health charities, universities, hospitals and community programming.

The collective research projects and case studies of PhiWomen reflect even more partnerships and engagement. For example, Wendy Frisby and Pam Ponc worked with Chinese immigrant women in community settings to advance ideas of gender, women and physical activity. Nancy Poole and I are engaged with national organizations invested in reducing risky alcohol use in women and girls by revising risky drinking guidelines to make them sex-specific. Ann Pederson, Karin Humphries and Lynne Young are conducting research to understand how women and men approach the behavioural changes recommended following an acute myocardial infarction. These examples reflect the broad sweep of health promotion, and the necessity to engage partners from community agencies and international health organizations, to health services and health policy makers. They also reflect the incredible importance of infusing sex and gender into health promotion research and practice.

Health promotion is a grand, broad field that is full of promise and potential innovation – both as a key mechanism for reducing the cost

curve in health care, as well as for enhancing health and wellbeing. But to achieve these lofty goals, health promotion also needs to be comprehensive, respectful of all of the determinants of health, tested and effective. There is still plenty to do to create more effective health promotion for women. Our work in developing an overarching Framework for gender-transformative health promotion (and a tool for implementing its principles) is likely to raise the bar and shift the agenda for the decade to come. Its impact, however, will ultimately depend on securing and maintaining strong partnerships between sectors, and exchanging expertise in the process. 

Promoting Health in Women (PhiWomen) is supported by an Emerging Team Grant from the CIHR Institute of Gender and Health. For more information visit www.promotinghealthinwomen.ca

Lorraine Greaves is at the BC Centre of Excellence for Women's Health and is Co-PI of PhiWomen, along with Karin Humphries (UBC) and Jan Christilaw (BC Women's Hospital and Health Centre).

When a Mother Lives: Sharing Innovations in Global Health

Gina Ogilvie, Ian Roe and Sheona Mitchell

Cervical cancer is often called ‘a case study in health equity’. Despite being almost entirely preventable through human papillomavirus (HPV) vaccination and screening, over 275,000 women unnecessarily die from cervical cancer each year and over 80% of cases occur in low and middle income countries. Cervical cancer is the most common

cause of cancer for women in Africa, where access to vaccination and screening is limited due to cost and infrastructure constraints. Even if the HPV vaccine was readily accessible, screening would still be required to prevent cervical cancer among the millions of women already infected with HPV, and to prevent the 30% of HPV-related cancers not affected by the vaccine. In order to bridge the cervical cancer divide and respond to the growing call for action on prevention, we need to create a solid evidence base of feasible screening approaches that could be implemented on a global scale.

Cervical cancer has traditionally been screened with Pap smears and by visual inspection with acetic acid. While both continue to be used globally, they require a practitioner to conduct a pelvic examination – a known barrier for some women. Limited health human resources and access to clinical facilities are also significant barriers in low and middle income countries. HPV testing has been shown to improve detection of pre-cancerous lesions and, in contrast to traditional screening approaches, HPV vaginal specimens can be collected by either a clinician or the woman herself.

Over the past six years, our global team of researchers, clinicians and community partners have been working together to explore innovative HPV screening opportunities using self-collected specimens in Kisenyi, Uganda. In 2011, our team began a pilot HPV self-collection study in Kisenyi as part of an integrated reproductive health program. Women aged 30-69 years were invited to provide a self-collected specimen for high-risk (hr) HPV testing by outreach workers at their homes and places of gathering in their community. Of the 206 women approached, 199 women provided a specimen and 17.6% [35] were hr-HPV positive. Results were provided to thirty women [85%] and 74% [26] of hr-HPV positive women attended their colposcopy appointments. Four women were later diagnosed with precancerous lesions that needed to be treated. Our team also conducted qualitative research to determine the role of embarrassment in preventing cervical cancer. This pilot study confirmed that an integrated reproductive health program with self-collection for hr-HPV in the community is feasible and acceptable to women in a



PHOTO: CHAD GALLOWAY

Hajat Hanifa Namuddu, community leader and ASPIRE project participant.

setting with a high prevalence of cervical cancer.

In 2011, our team began the creation of a documentary to translate knowledge from our experience in Kisenyi. Entitled ‘When a Mother Lives’, the goal of the documentary was to spread a positive message to funders and policy makers on how practical and sustainable action around cervical cancer screening can be taken in places where no screening exists. Although it isn’t always easy, we believe that communicating ideas with clarity and a sense of empowerment is instrumental in knowledge translation practice. We brought these principles into our own KT work by creating a documentary that explores a simple question: *what happens when a mother lives instead of dies?*

So began a year-long journey of filming, transcribing, internalizing and editing more than 20 hours of footage and over 25 interviews with various stakeholders in the project, including Ugandan researchers, clinicians, the Ministry of Health and community members. The ASPIRE Process is portrayed as an ecosystem consisting of six distinct, yet mutually reinforcing steps -

Educate, Mobilize, Collect, Test, Treat, and Grow – which collectively provide a road map for how a cervical cancer screening program might be realized in low income settings like Kisenyi. By transporting the viewer into the lives of the women, the video also brings greater understanding to their experiences and provides motivation to move forward for change. The process of filming the video itself was transformational as women were given a voice to tell their stories and voice their hopes for the future.

‘When a Mother Lives’ is available on the ASPIRE website (www.aspireafrica.ca) and has been shared with key stakeholders in both Canada and Uganda. The video was launched on March 7th in British Columbia in conjunction with International Women’s Day and plans are underway for a Ugandan premiere in summer 2013. **Ug**

The ASPIRE Team received funding for ‘When a Mother Lives’ through an Institute of Gender and Health Priority Announcement in CIHR’s Dissemination Events program.

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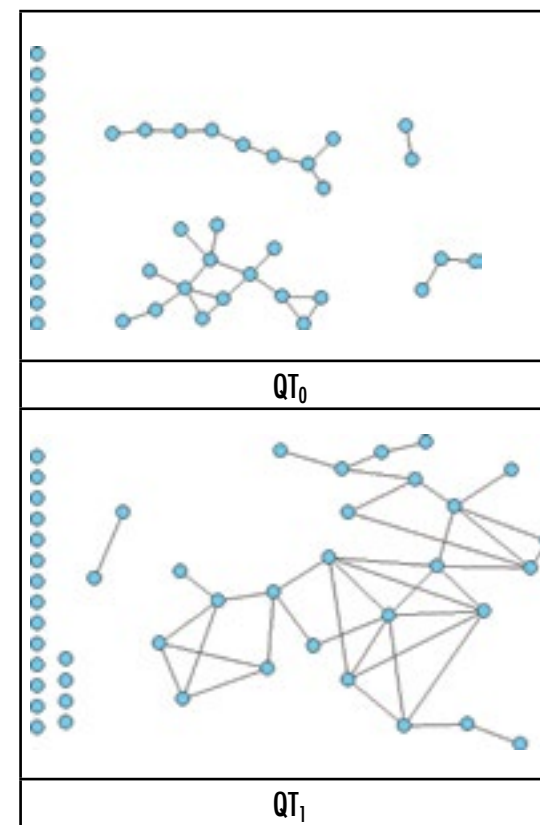


Figure 2 - Collaborative relationships without the five most central nodes.

The core group usually consists of individuals who contribute greatly to holding the group together (often its founders). Should these core members depart, relationships between peripheral team members must be in place to prevent the group from dispersing. Figure 2 illustrates what would have happened to the Team if the five most central members were taken out. While small groupings are evident in the absence of these five key persons at the Team’s onset (QT₀), a year and a half later (QT₁) there is still a network – indicating that we are moving towards the creation of a resilient network. It should be noted that those members no longer connected to the network with the removal of the five most central nodes are either new members or members who have not participated much in the Team activities.

Communication network analysis has proved to be a relevant tool for mapping many of the processes underlying the establishment of a successful transdisciplinary network. Another round of sociometric analysis is scheduled to take place in our fourth year, which will provide further knowledge of the Team’s evolution. Upcoming analyses of the qualitative data will focus on identifying the semantic network (similarities of ‘discourse’ between team members), which we will be able to compare with the communication network in order to track learning and knowledge exchange. **Ug**

Female orgasmic disorder is the persistent or recurrent delay in (or absence of) orgasm following a normal sexual excitement phase that is paired with marked distress or interpersonal difficulty. Even though a lack of female orgasm is one of the most frequently reported sexual concerns, no study has systematically identified the content of such concerns, let alone compared them with the experiences of men. Seeking to do just that, Claire Salisbury is pursuing a PhD in clinical psychology at Western University (supervisor: Dr. William Fisher). Claire’s study is the first of its kind to attain a detailed account of the content of the concerns associated with orgasmic difficulties in both women and men. Claire is one of two recipients of the 2011 CIHR-IGH Award for Excellence in Gender, Sex and Health Research.

Hometown: Hamilton, Ontario
 Last book I read: *Narcissus and Goldmund* – By Hermann Hesse
 Favourite food: It’s a toss-up between sashimi or poutine
 My motto is: Don’t dream it. Be it.
 A little-known fact about me is: I create handmade “Claire’s Cards” for my family and friends during their birthdays.
 When I am not at my computer, I’m most likely: Hiking, sketching, rubbing my cat’s belly, and going out for coffee with friends.
 Something I would like to try once: A visit to Lake Louise

Why is female orgasmic disorder important to study?
 Infrequent orgasm (especially during sexual interactions) is problematic for many women, with up to 70% of females usually unable to orgasm during intercourse (i.e., coital orgasm). Orgasmic difficulties tend to be the first or second most frequently reported sexual concern in women, in both non-clinical samples and those seeking sex therapy. It is important to obtain a better understanding of the content of the concerns associated with lack of orgasm in order to potentially alleviate related distress, both within the couple and the individual.

How did you first become interested in this topic?
 I entered graduate school in clinical psychology with the aim of becoming a practitioner specializing in the areas of sex therapy and gender identity. In order to increase my knowledge base and foster the development of my skills as a budding sex therapist, I decided to dive into the research area of sexual (dys) function. The particular topic of infrequent orgasm caught my eye given the existence of an extreme sex difference: while the majority of men usually or always experience orgasm during intercourse, the majority of women

usually do not. This led me to question whether this sex difference was associated with underlying differences in the beliefs, experiences, and concerns of men and women experiencing orgasmic difficulties.

What impact does your research have on female orgasmic disorder?
 Overall, my findings have shown that young adult men and women tend to hold different beliefs, concerns, and priorities surrounding orgasm occurrence, and do not tend to fully understand that these differences exist. These findings point to the need for an increase in psychosexual education surrounding female orgasm, as well as an increase in sexual communication amongst heterosexual couples in which female orgasm difficulties are prevalent and of concern. I have been able to translate the knowledge gained through my research directly to the public via undergraduate lectures at Western University, a blog promoting sexual health, and an upcoming manuscript. Through conference presentations, I have been able to transfer the knowledge of my findings to intermediaries (such as sex therapists, educators, researchers, and policy makers) who can convey my findings to the public as well. Finally, I have put my research into practice by working with female clients who present with sexual dysfunctions and associated concerns.

Where will your work take you next?
 My dissertation aims to expand on the findings of my thesis by exploring gender differences surrounding orgasm occurrence in an older population, with a focus on couples. One goal is to discover the level of accuracy individuals have regarding the beliefs and concerns they perceive their partners to hold about a lack of female orgasm. **IGH**





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