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CPHFRI Co-Director Accepts New Position at UVic!



Our Co-Director, Trevor Hancock, has recently moved from his position as a Medical Consultant in Population and Public Health at the Ministry of Health to take up a new position as a Professor and Senior Scholar at the new School of Public Health and Social Policy at the University of Victoria.

The School opened in August with a first intake of 35 students in the MPH program. The entire program is offered on-line, with students from throughout BC and across the country spending three intensive one-week sessions on-site over the two years of the program. The program proposal approved by the University Senate indicated that the program would be based to a large extent on BC's Core Public Health Functions Framework, and would have a strong focus on equity and on social policy, so Trevor is a natural fit. He will be teaching courses on population health

and health promotion, public health practice, healthy public policy and supportive environments for health.

Starting in September 2012 the new School will also be offering an on-line 3rd and 4th year BA in Health and Community Services and a Diploma in Aboriginal Health Leadership. Indeed, Indigenous Health is a key focus for the new School in both the MPH and BA; the faculty members include Jeff Reading – Director of the Centre for Aboriginal Health Research at UVic and first Scientific Director of CIHR's Institute of Aboriginal Health Research – and Charlotte Reading, a leading Aboriginal Health researcher with interests in sexual and reproductive health, HIV/AIDS and the cultural determinants of health.

Although Trevor will remain a Co-Director of CPHFRI, we needed to find a replacement as the Policy and Knowledge User Co-Director. We have been fortunate to be able to recruit Warren O'Briain, Executive Director of Communicable Disease Prevention, Harm Reduction and Mental Health Promotion at the Ministry, to replace him. Warren has completed a Master's degree at Royal Roads and has a strong interest in research. He is already a Principal Knowledge User on our latest grant, where his central involvement in the Ten Year Mental Health Plan and in the core programs in Mental Health Promotion and in the Prevention of Harms from Substance Use make him an invaluable resource. So we welcome Warren to the team – look for a profile in the next newsletter!

We welcome submissions to future newsletters!

Please send event listings, research highlights, funding announcements, etc to cphfri@uvic.ca

Check us out online at: web.uvic.ca/~cphfri

Announcements:

- ◆ Our apologies for not sending out an August newsletter. Our Research Coordinator who normally edits the newsletter was busy having a baby! Heather Wilson Strosher, CPHFRI Research Coordinator, is pictured to the right with her new daughter, Maryn, who was born on August 15th.
- ◆ Shannon Turner, BA, Bsc, MSc, Phd fellow was recently awarded an Interdisciplinary Graduate Scholarship to support her doctoral research on Violence Prevention Advocacy. The study concerns the efficacy of social media as a health promotion instrument for violence prevention advocacy. The research will focus on the implementation of a national violence prevention charter, and the methods employed involve social complexity theory, social network analysis, and the New Science of Networks. Watch this newsletter for news regarding this research and links to the VPC when it is posted!
- ◆ Laura Tomm-Bonde has officially passed the Family Nurse Practitioner Objective Structured Clinical Exam (OSCE) and the American Nurses Credentialing Center (ANCC) and is now officially registered as a Family Nurse Practitioner in British Columbia. Congratulations Laura!



CPHFRI would like to acknowledge our primary funders



Public Health Agency of Canada

PHABC Advocacy Summer School

The second annual Public Health Association of British Columbia (PHABC) summer school was July 5th and 6th this year. The two day advocacy session involved of public health experts in research, policy-making and community engagement from across the province. Two CPHFRI student members attended and we provide you with a brief summary of the key ideas.

Public health advocacy is: “speaking, writing or acting in favour of a particular cause, policy or group of people —often aims to reduce inequities in health status or access to health services” (PHAC, *Core Competencies for Public Health in Canada*, Release 1.0). For example, we could plan to improve the health of a community by addressing a specific public policy being implemented in this setting that relates to health. In order to address the structural issues facilitating or interfering with health, such as the social determinants of health, we need to come together and advocate for change that will have an impact on upstream conditions.

People involved in advocacy work hope to facilitate change, whether through policy, programs, practice, or behaviours. In doing so, there are several considerations for advocacy work to be more successful. For instance, it is important to know who is responsible for the decision you are hoping to influence and how they make decisions. This will help to frame the issue, as to who to speak to about what, and how to frame the approach. As in any argument, it is important to know your allies, and who is against the position or policy and why. Additionally, when planning an advocacy case, aim for a human rights argument and refrain from focussing in on economic benefits. We know that public health is a more cost effective means to reduce the burden of illness compared to the health care system because more money on the health care system reduces what can go toward public housing, education, income security and other public services. However, the economic argument applies to long term outcomes, but most importantly people have the right to equitable environments that foster health. Finally, a key element to advocacy work is that it may best be achieved in collaboration and partnership. Not only is there power in numbers, but coalitions provide safety through distribution of ideas (no one person sticks their head up too high to be singled out as a target), and sharing resources offers greater efficiency.

Advocacy work has many challenges. Public health problems and policies are complex and are ill-defined. The issues often have blurry boundaries, and public policies are shaped by the values and interests of the persons developing them. Timing is important to move forward when the decision maker or community is interested in exploring change. Additionally, all the key elements need to be worked out of potentially adopted policies, such as any known costs, feasibility, necessary technical support, political or public acceptance of the change, and alternative solutions to the “problem”. Building trust and relationships are crucial because advocacy work demands a long term commitment, and small steps are important to recognize as part of the process. Farah Shroff told us that changing systems is always hard work, requires courage, and involves conflict.

Michael Pennock left us with 5 simple rules:

- If you are advocating for an intervention, make sure it is evidence-based
- Keep it simple
- Use appropriate rates
- Tell a story
- Never make assumptions

In the end, one of the main messages we took away from this advocacy summer school was the acrostic phrase Northern Health Authority uses to guide their work in population health - IMAGINE.

Invest upstream and for the long haul

Multiple strength-based strategies

Address the determinants of health

Grassroots engagement

Intersektoral partnerships

Nurture healthy public policy

Evidence-based decision-making

Submitted by Wanda Martin and Megan Kirk, CPHFRI Doctoral Students

PHABC Health Literacy Summer School

Health Literacy: Reinforcing Population Health Promotion

Following the two-day public health advocacy summer school session, participants across the province explored the field of health literacy. This additional two-day segment of the Public Health Summer School allowed for discussions that spanned across health literacy models, relevant tools and resources and an exploration of multiple programs and projects based in BC that are currently supporting improvements in health literacy outcomes.

Health literacy has a significant impact on health. Health literacy was defined as a local public health core competency development priority area in BC through PHABC assessment work and is closely related to the communications competencies as outlined in PHAC, Core Competencies for Public Health, Release 1.0. For more information about core competency development work in BC please see: <http://www.phabc.org/modules.php?name=Contentcomp>

Key messages from the health literacy segment of the Public Health Summer School include:

- Literacy allows individuals to understand and utilize information to support their participation in daily activities and the world around them, inclusive of home, community, work, school, etc.
- Literacy is not just about reading and writing. Literacy encompasses social interaction, oral communication skills, the use of technology, navigating systems, critical thinking, problem solving and more.
- Literacy skills can be learned and practiced – the learner needs to be ready, interested and actively engaged in the learning process to successfully develop his or her skills. Knowing your audience is important to tailor appropriate materials, mediums and messages for effective communications/comprehension.
- Strong literacy skills can support improved understanding and practice of healthier choices, improved self-management and improved outcomes pre/post interaction with the health care system (eg. surgery).
- The use of plain language and visual imagery can help to ensure clear communication and understanding of information.

Work in health literacy requires:

- ◆ An operational definition of literacy
- ◆ An integration of your definition into a theory of change
- ◆ Specific and measureable objectives, indicators and variables
- ◆ Specific standards and a plan for defining success

Local work that was highlighted in this segment of the Public Health Summer School included: Patients as Partners Program, Provincial Child and Youth Healthy Living Initiative, Living Life to the Full Community Courses, The Council of Senior Citizens' of BC, The Richmond Public Library and The Tri-Cities Literacy Committee Toolkits for Immigrant and Refugee Populations.

To access more information about the health literacy segment of the Public Health Summer School, please access the following Wiki page link: [http://2011bcpublichealthsummerschool.pbworks.com/w/page/39348770/2011 BC Public Health Summer School%21](http://2011bcpublichealthsummerschool.pbworks.com/w/page/39348770/2011%20BC%20Public%20Health%20Summer%20School%21).

Upcoming continuing education events hosted by the PHABC and partners will be continuously updated online at www.phabc.org.

Submitted by Kayla Pompu, PHABC Public Health Summer School Coordinator

Dynamic Modeling for Health Policy: Understanding Social Determinants of Health and Reducing Health Inequities

The University of Saskatchewan hosted the third annual workshops on Dynamic Modeling for Health Policy July 18-20, 2011. Marjorie MacDonald, Ruta Valaitis and graduate student, Wanda Martin, were among 30 participants from across North America. This workshop series is a forum for convening small groups of mathematical/computational modellers, policymakers, community organizations, and domain experts who share a common interest in applying dynamic modeling to health policy concerns. The theme of the third workshop in this series was leveraging dynamic modeling to better understand the broader determinants of health, and to produce momentum for promoting equitable health for all.

Systems dynamic modelling is a qualitative and quantitative modelling process for understanding complex systems over time¹. It involves feedback mechanisms that can be pictorially represented through causal loop diagrams, and simulation models. Systematic dynamic modelling can describe a system for managing complex situations, and help to make sense of the interaction of diverse information as well as ways to interact with the system¹. Group model building is a process that builds a causal model capturing ideas from a broad range of people. While individuals are often faced with narrow mental models, dynamic models document how a group describes the way system works around a specific problem, to recognize levers in the system for taking action toward change. "Group model building is a process in which team members exchange their perceptions of a problem and explore such questions as: what exactly is the problem we face? How did the problematic situation originate? What might be its underlying causes? How can the problem be tackled?"²

The workshop provided the opportunity to experience a group model building process with the guidance of Dr. Peter Hovmand from Washington University in St. Louis. We modelled the problem of health inequities. In the course of five hours, we identified major causes of health inequities, built a causal loop diagram, and considered points of leverage in the system where health inequities could be reduced. As an introduction to causal loop diagrams, the workshop included case studies on modelling for the challenge of obesity³ (Diane Finegood), modelling the determinants of health in complex policy environments (Aziza Mahamoud), participatory modelling HIV-AIDS (Kristen Hassmiller Lich), environmental participatory modelling (Krystyna Stave), and modelling social structures to support healthy aging (Sara Metcalf). We also discussed qualitative mapping tools and strategies such as using photovoice and concept mapping together (Nasim Haque), various modelling tools (Geoff McDonnell), and rich data sources for modeling insight (Mohammad Hashemian and Lisa Lix).

I left Saskatoon considering how I can use the concept mapping brainstorming statements for my dissertation work to generate a causal loop diagram. I also left with a list of references and recommendations for further exploration on group model building and simulation models. The value in the group model building is the participatory nature of identifying the problem, the causes of the problem, and the most important and feasible ways to move toward solutions. If the goal of the workshop was to produce momentum for reducing health inequities, it certainly has stimulated thinking on next steps and future research.

Submitted by Wanda Martin, CPHFRI Doctoral Student

Nathaniel Osgood, <http://www.cs.usask.ca/faculty/ndo885/Classes/SDTutorialTestRun1/index.html>

Vennix, J.A.M. (1996). Group Model Building: Facilitating Team Learning Using System Dynamics. Wiley, p.3.

Violence Prevention Advocacy: A Core Function in Public Health?

Over the last few years, the role of advocacy in public health has been a major topic of discussion at the core programs steering committee table, during strategic planning within health authorities for public health services, and as part of the considerations for the new public Health Act. As described on page 3, advocacy also served as the focus of a two day workshop at the 2011 PHABC Summer School.

Understanding the nature of advocacy, the role of the public health workforce and health service delivery system is an important precursor to full implementation of the core programs of public health. Some discussions have made the distinction between "Small a" and "Big A" advocacy. Neither has been well defined, perhaps due to the range of corporate agendas public health practitioners deal with, so it is preferable to keep the parameters loose. For those working in health authorities it might be fair to suggest the following definitions. If we agree that "Small a" advocacy is that which occurs in the day to day completion of public health activities it would be an understood component of the work flow, whereby practitioners advocate for public health issues in community meetings, engage supportive advisors and clinical interventions for clients in need and develop programs and services based on a population health targets. Big A advocacy would be those activities that draw public and media attention and require executive approval. It would be very helpful to know how public health practitioners understand this aspect of their work, and in particular how it relates to violence prevention a new core program in public health in BC?

Advocacy is a vital component of violence prevention, due to the range of violence prevention opportunities for health systems. Specifically, Health Authorities can help to manifest environments conducive to positive health outcomes through surveillance and reporting, prevention interventions like home visits by public health nurses, and the formulation of healthy public policy through community based partnerships. In each of these activities there is a component of advocacy. In some cases it is based on risk assessment and the implementation of prevention strategies at the family level. In others, it is the promotion of safe and violence free workplaces throughout the community. Advocacy includes a wide range of activities, from raising public awareness of risk factors, to strengthening protective factors like promoting the use of effective lighting to make neighbourhoods more walkable and safe.

Advocacy often involves coalition building and this is the case in the public health approach. Public health recognizes that multi-sectoral partnerships serve to ensure community and citizen engagement in the issue. They serve to ground the solution in terms of the community's perspective on the issue. This orientation respects the range of jurisdictions and determinants influencing public health outcomes. Utilizing partnerships effectively was described as instrumental to advocacy efforts by most of the presenters in the summer school. The summer school advocacy workshop really highlighted the opportunities and positive outcomes associated with organized and data driven advocacy objectives. The Public Health Agency of Canada has identified Advocacy as a core competency and defined it as follows: *Advocacy— speaking, writing or acting in favour of a particular cause, policy or group of people—often aims to reduce inequities in health status or access to health services.*

Utilizing the ecological model proposed by the World Health Organization, there are many levels in which advocacy as a core competency can be employed to strengthen violence prevention strategies. Following a population health perspective, Public Health practitioners are in a unique position to provide advocacy support at all of these levels.

Submitted by Shannon Turner, CPHFRI Doctoral Student



Health Act, RSBC Chapter 179

World Health Organization, World Report on Violence and Health, 2002

Newly Funded Five-Year CIHR Grant!

In response to a special CIHR call for programmatic research in health and health equity, Bernie Pauly (Nominated PI), Marjorie MacDonald, (Co-PI), Trevor Hancock (Co-PI) and Warren O'Briain (Principal Knowledge User) along with a large team of CPHRI researchers and knowledge-users submitted a proposal to CIHR entitled, *Reducing Health Inequities: The Contribution of Core Public Health Services in BC*. We are pleased to announce that this application has been funded! Previously, we had been successful in receiving development funds through the LOI competition for this special call which allowed us to bring the team together to inform the development of the grant and build on the work of CPHRI. Reducing health inequities is integral to public health renewal in BC and in the Core Public Health Services Framework, both an equity and population lens were included and intended to cut across all programs. In this grant, we will explicitly focus on the integration of the equity lens and the implications for reducing health inequities in BC.

The overall purpose of this program of research is to study, explore, and foster learning about the use of an equity lens during a period of complex system change in public health and develop implications for systemic responses for reducing health inequities. This is a five year project involving four inter-related studies. The goals of this research are to: 1) Identify and understand the contextual influences that promote uptake of health equity as a priority in the health system and the extent to which health inequities associated with mental health and substance use are a priority for health systems; 2) Explore and examine the engagement of public health with other sectors in health inequities reduction in mental health and substance use; 3) Critically analyze the theoretical and practical utility of existing equity tools for policy and inform program development, learning, and capabilities requirements to apply relevant tools; 4) Develop an understanding of the ethical issues encountered by public health practitioners in their efforts to reduce health inequities and the process of managing tensions. We will specifically be studying the integration of an equity lens in relation to two core programs: Promotion of Mental Health and Prevention of Harms of Substances. These core programs along with the Ten Year Mental Health and Substance Use Plan are the specific policy interventions in which we will study the integration of an equity lens and reducing health inequities. We will be using a variety of methods including concept mapping, situation analysis, document analysis and grounded theory to answer the research questions.

This research is based on collaboratively identified research questions that seek to enhance understanding and knowledge in public health for reducing health inequities. Throughout the grant, there are specific knowledge translation activities to share what we are learning and inform the implementation of the research. We look forward to sharing more with you as we undertake this exciting initiative. One of the first activities will be the development of a website that will be linked to CPHFRI and RePHS to help keep you updated on this new initiative.

Feature Graduate Student: Megan Kirk

Life-long learning is something that is always encouraged within the nursing profession. I am happy to say that if there is one thing I have accomplished thus far, it is this! To this very day, I have always been a student. Some might find this existence hard to swallow, but I have enjoyed every minute. I completed both my undergraduate (BScN, 2007) and master's (MSc, 2009) degrees at Queen's University in my hometown of Kingston, Ontario. I began my journey out to BC in September 2009 to start my PhD in Nursing at the University of Victoria, and currently I am completing my second year in the program.

While I was a master's student at Queen's, I worked in an acute care hospital, mainly in orthopaedics, but I did spend a short time in gynecological surgery and oncology. During this period I also completed my course work and thesis. In my thesis, I explored the influence of work hours on the cardiovascular health of female hospital employees. More specifically, I compared the prevalence of metabolic syndrome indicators (waist circumference, blood pressure, fasting blood glucose, lipid levels, triglycerides), which are associated with a higher risk of cardiovascular disease, in women working regular, 8 hour day shifts compared to those working 12 hour, rotational shifts. I found that after working 6 or more years of shift work, female workers were at increased risk of cardiovascular disease indicators which is parallel with previous findings from the longitudinal Nurses' Health Study in the United States.

Since starting the PhD program at UVic, I have become interested in exploring the ways in which the environment or larger social structures impact the health of Canadians and the ways in which public health research can help to delve into the complexities of such issues. For this reason, and many more, I asked Dr. Marjorie MacDonald if she would be my supervisor and, I applied for the Doctoral Fellowship in Public Health Nursing and/or Public Health Services Research that she offers through her CIHR/PHAC Applied Public Health Research Chair. I am grateful that



Marjorie agreed to be my supervisor and to have received this fellowship and all the opportunities that come along with it. Over the course of this past year I have had many enriching opportunities including: completing a research internship with Marjorie as a data collector for Health Canada's Youth Smoking Survey; attending the Canadian Public Health Association National Conference in Montreal in May; becoming involved in a complexity reading group; and working on a project with an exceptional team of researchers from Ontario, Nova Scotia and BC who are exploring the collaborations or partnerships between public health and primary care.

In terms of my dissertation work, I plan to explore the reality versus rhetoric around health promotion to develop a better understanding of the facilitators and barriers of implementing health promotion policy or practice aimed to address the social determinants of health. The literature that I have reviewed suggests that policy developed to guide practice doesn't necessarily embrace such environmental influences on health, or even if they do, there are impediments to actually following through with such practices. My aim is to tease out how people in public health actually conceptualize or understand health promotion and how they suggest we move forward in improving the health and lives of Canadians. To tackle such questions, I anticipate I will employ a concept mapping methodology to help delve into understanding how public health practitioners, policy-makers, and researchers alike conceptualize health promotion and what they see as important next steps to improving health of our citizens and in creating healthy supportive environments.

Feature Researcher: Lenora Marcellus

I joined the School of Nursing at the University of Victoria in 2009 as an Assistant Professor after many years of working in health authority and provincial positions within the fields of maternal, women, and children's health, including Perinatal Lead for VIHA, Manager of Maternal and Women's Health for the BC Ministry of Health, and Provincial Consultant for the Ministry of Children and Families Development Safe Babies Program. Along the way I completed my Neonatal Nurse Practitioner program at the University of Washington and my doctorate at the University of Alberta. My journey to being connected to the areas of health equity and public health has been a long and interesting one, considering my primary area of research is neonatal nursing. In the 1990s I developed and implemented a program with the health authorities and MCFD to support and educate foster parents who care for infants with prenatal substance exposure. This work spurred me to become more informed about women, pregnancy and substance use, which of course led me to the broader issues of social determinants of health, societal constructions of addiction (particularly for women), and the ethics of care within the context of child protection.

I have just recently joined the CPHFRI team as a co-investigator with the funded equity grant. I have several research projects underway, primarily related in some way at the moment to supporting vulnerable new families. I am a co-principal investigator with Cecilia Benoit on two CIHR grants with the developing HerWay Home program here in Victoria, a one stop wrap around program for pregnant women with substance use issues (modeled after the Sheway program in Vancouver). In this work, inequities related to housing and poverty directly impact the ability of women to parent, and even to retain custody of their children. I am also a member of the scientific evaluation team for the recently announced BC Nurse Family Partnership program. In a pediatric stream, the Safe Babies Program recently received the Sick Kids Rotman Award for Innovation in Paediatric Home Care; our team is currently rolling out an updated curriculum across BC and is receiving calls of interest from other provinces.

Currently I teach and coordinate the community health course in the undergraduate nursing program at UVIC. I am excited to be a part of the CPHFRI team and will be participating as a new researcher. I look forward to learning from you all and contributing to this work.



Feature Knowledge User: Peggy Strass

Many of you may recognize Peggy from the last RePHS newsletter as she was featured as a new BC member. Peggy Strass has been working with Child Youth Family – Public Health Programs in VIHA since 2008 when she and her husband chose to relocate to Vancouver Island from the Alberta Prairies. Peggy's 14 years in public health nursing has provided her with a variety of experiences in clinical, leadership, and research activities. In VIHA, she has worked as a front line PHN in Victoria as well as a Child Youth and Family Clinical Coordinator in Central Island. In March 2011, Peggy accepted a regional position as Project Lead – Public Health Programs for VIHA. She has a passion for nursing leadership in the area of healthy active living and public health prevention programs, and a strong background in maternal child health and reproductive mental health. She has published work in *Canadian Nurse* in 2005 and 2008 on integrated health promotion initiatives that make a difference in communities and are sustainable. Peggy's passion for quality improvement in public health is evident and she is devoted to applying research and evidence into best practice at the front line. She has enjoyed representing VIHA in some of the RePHS meetings to date and looks forward to future involvement with CPHFRI.



Think Tank Summary: Public Health Systems & Services Research

After many months of planning, the pan-Canadian Public Health Systems and Services Research (PHSSR) Think Tank was held on May 26th & 27th, 2011 in Montréal and it was a busy and productive two days! As we've reported in previous newsletters, the purpose of the Think Tank was to identify PHSSR priorities, move toward consensus on a PHSSR agenda, and initiate the establishment of a PHSSR network.

Forty-two participants representing public health researchers, practitioners and policymakers were involved in the Think Tank. The Canadian participants were joined by three international advisors chosen for their public health systems and services expertise: Dr. F. Douglas Scutchfield (known as "Scutch") from the University of Kentucky; Dr. Peter Jacobson from the University of Michigan; and Professor David Hunter from Durham University. Professor Mike Kelly from the National Institute for Health and Clinical Excellence (NICE) was also supposed to be present but had to cancel at the last minute due to illness.

Following a brief welcome and overview, the Think Tank began with the international participants presenting on the state of PHSSR in the US and UK. This was followed by a presentation of the findings of an online survey of PHSSR priorities, as well as a review of the literature. The literature review found the five main areas of published literature in Canada are: 1) Partnerships and linkages; 2) Public health infrastructure; 3) Evidence-based practice; 4) Policy and legislation development; and 5) Health disparities. A non random survey of researchers, practitioners, policy-makers and others (largely from Ontario, BC, Manitoba, Quebec and Alberta) asked respondents to identify their top three priority issues from a list generated through the literature review. Based on 250 responses, the top five priorities are: 1) Evidence-based practice; 2) Public health performance; 3) Public health infrastructure; 4) Health disparities; and 5) Core public health functions. This is largely congruent with the priorities emerging from the literature. Some of the main implications arising from the literature review and survey that might inform the Think Tank deliberations include issues related to: a) Scope and definition of PHSSR; b) Health Promotion and Health Equity; and c) Methodology and Complexity.

In a "fishbowl exercise", a selection of participants, divided into researchers and practitioners/policymakers, shared their perspective on research priorities. It was evident that researchers and knowledge users shared many of the same research interests. This is an important finding as research projects can therefore be designed to incorporate the concerns of both groups; ensuring policy and practice relevance, as well as researcher engagement. The first day concluded with working groups identifying top PHSSR priorities. There was a great deal of focus by both groups on data sets, access to data and research infrastructure. Not surprisingly, researchers were more focused on concepts, frameworks, methodologies, systems thinking and use of data, while the practitioners and policy-makers seemed more focused on issues of relevance to implementation; comparisons across different forms of infrastructure, knowledge transfer, application of theory, and innovation and effectiveness.

The second day of the Think Tank began with a discussion of research priorities based on the proceedings of day one. A draft logic model and a draft research framework were also presented and discussed which included 18 research issues/priorities that were identified on the first day. Next, a panel presented on the link between the emerging PHSSR priorities and the strategic directions of three funding agencies (two Canadian Institutes for Health Research: the Institute of Public and Population Health and the Institute of Health Services and Policy Research, as well as the Public Health Agency of Canada). The participants then split into five working groups: principles and values; research issues; research approaches; research capacity; and network development. The day concluded with discussing the development of a PHSSR network and with closing remarks about next steps.

Future plans include: a) disseminating the results of the Think Tank in Canada and internationally; b) further developing the PHSSR network in Canada and exploring the development of an international network with international partners; c) refining the logic model and research framework in consultation with the network; d) further identifying key research issues in consultation with the field (e.g., Canadian Chief Medical Officers of Health); e) identifying funding opportunities and developing research teams and proposals; and f) develop a five-year strategic plan for PHSSR in Canada.

The presentations from the Think Tank are available on the CPHFRI website, along with a copy of a poster that was presented at Academy Health which includes the draft logic model and research framework (see http://www.web.uvic.ca/~cphfri/research_projects/phsr.htm). The final report from the Think Tank will be posted on our website soon, along with future updates.