

# Identifying and strengthening the structural roots of urban health in Canada: participatory policy research and the urban health agenda

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**Abstract:** An urban health research agenda for health promoters is presented. In Canada, urban issues are emerging as a major concern of policy makers. The voices raising these issues are from the non-health sectors, but many of these issues such as increasing income inequality and poverty, homelessness and housing insecurity, and social exclusion of youth, immigrants, and ethno-racial minorities have strong health implications as they are important social determinants of health. Emphasis on these and other social determinants of health and the policy decisions that strengthen or weaken them is timely as the quality of Canadian urban environments has become especially problematic. We argue for a participatory urban health research and action agenda with four components: a) an emphasis on health promotion and the social determinants of health; b) community-based participatory research; and c) drawing on the lived experience of people to influence d) policy analysis and policy change. Urban health researchers and promoters are urged to draw upon new developments in population health and community-based health promotion theory and research to identify and strengthen the roots of urban health through citizen action on public policy. (*Promotion & Education*, 2007, XIV (1): pp 6-11)

**Key words:** urban health, social determinants of health, participatory research, health policy

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Health promotion has a long tradition of emphasizing community action to influence the determinants of health. One of health promotion's achievements was the *Healthy Cities Movement* which emphasized community participation and intersectoral action in support of healthy public policy (Ashton, 1992). The recent *Belfast Declaration on Healthy Cities* reflects a commitment by European municipal leaders to apply these principles to reduce health inequalities and poverty, promote citizen influence, and address social exclusion (World Health Organization, 2003).

Despite the notable successes of Healthy Cities in Europe, there is reason to be concerned about the current state of urban health research and policymaking in Canada. While Canada was the birthplace of Healthy Cities, the movement there is now moribund (Raphael, 2001b). Policy-makers take little notice of its principles and show little awareness of how emerging urban issues influence health (Raphael, 2001a). Urban health researchers generally pursue medically-oriented agendas concerned with access to health care rather than ensuring citizen control over the determinants of health. Indeed, "health promotion" in Canada has largely deteriorated into an emphasis on "choosing healthy lifestyles" to the exclusion of structural analysis of the mainsprings of health (Raphael, 2003a). This has occurred as urban environments in Canada have deteriorated.

## KEY POINTS

- **Emerging urban health issues are centred on the social determinants of health.**
- **These social determinants of health are shaped by public policy decisions.**
- **Urban health promotion research and action must be concerned with public policy issues and how these decisions influence health.**
- **Health promotion theory and practice must draw upon community members' understandings of these issues in order to develop an agenda for promoting health in urban communities.**

## Urban issues and urban health in Canada

Urban issues are a major concern of Canadian municipal, provincial, and federal policy makers (Government of Canada, 2004c). Increasing income inequality and poverty, homelessness and housing insecurity, and social exclusion of racial minorities, new immigrants, and the economically disadvantaged are profoundly important to health (Auger, Raynault, Lessard, & Choinière, 2004; Galabuzi, 2005). Yet concern about these urban health issues is being raised not by the health sector but by a variety of municipal, charitable, and advocacy organizations. The relative silence from the health sector is puzzling as these issues are clearly related to health as out-

lined by Health Canada, the Canadian Public Health Association, and the World Health Organization in numerous documents (Canadian Public Health Association, 2001; Health Canada, 1998; Wilkinson & Marmot, 2003). The association between these urban issues and urban health comes about through the concept of the social determinants of health (Marmot & Wilkinson, 2006; Raphael, 2004b).

Social determinants of health are the political, economic, and social forces that influence health at the individual, group, community and population levels (Raphael, 2004a). These factors have as much, if not more, impact on health as do traditional medical and behavioural risk factors (Davey Smith, 2003). This has been known since the early Whitehall studies but is frequently ignored in favor of individual risk-factor approaches to health (Nettleton, 1997). Evidence indicates that the incidence of a variety of health issues including chronic diseases such as Type II diabetes and cardiovascular disease is caused largely by factors related to poverty and material deprivation across the life-span and not by diet, activity, and tobacco use as traditionally espoused (Raphael, Anstice, & Raine, 2003; Raphael & Farrell, 2002). While Canada has been a world leader in conceptualizing social determinants of health through work in health promotion and population health (Restrepo, 1996), its leadership in these areas has slipped (Canadian Population Health Initiative, 2002).

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A focus on urban health with a renewed emphasis on the social determinants of health therefore appears timely. Many political, economic and social challenges – all of which influence people’s health – are based in urban communities (Government of Canada, 2004c). We outline an urban health research and action agenda of four components: a) an emphasis on health promotion and the social determinants of health; b) carried out through community-based participatory research; c) that explores the lived experience of people; d) to effect policy analysis and change.

We first identify some emerging Canadian trends in urban and urban health issues and then explore the four components of our urban health research model. These trends should be recognizable to urban health promoters in many nations. We link the model to the emerging emphasis on participatory democracy and how civil society can influence public policy, thereby promoting health. We also consider supports and barriers to implementing our approach and consider its relation to the goals outlined in the *Belfast Declaration on Healthy Cities*.

### Renewed emphasis on urban environments in Canada

There has been a flurry of recent federal/provincial activities related to the social determinants of health of income distribution and poverty, homelessness and housing insecurity, and social exclusion of racial minorities, new immigrants, and economically disadvantaged youth (Canadian Mortgage and Housing Corporation, 2002; Government of Canada, 2004b). Urban issues are the focus of organizations such as the Federation of Canadian Municipalities (Federation of Canadian Municipalities, 2003), the Conference Board of Canada (Conference Board of Canada, 2003), and the National Council on Welfare (National Council of Welfare, 2002a, 2002b, 2004), among others. Many city-based organizations such as United Ways (Capital Region United Way, 2003; United Way of Ottawa, 2003; United Way of Winnipeg, 2003) are documenting deteriorating social and economic conditions. To illustrate, the United Way has reported on declining median incomes of families and individuals, increasing poverty among children and youth, and spatial concentration of economic disadvantage during the 1990’s in Toronto, Canada’s largest city (United Way of Greater Toronto, 2004; United Way of Greater Toronto & Canadian Council on Social Development, 2002). The Centre for Social Justice in Toronto has provided leadership in raising issues of increasing wealth and income inequalities (Curry-Stevens, 2003; Yalnizyan, 1998, 2000).

These findings suggest profound shifts in the lived experience of urban residents with strong implications for health and well-being (Galabuzi, 2001, 2004, 2005). Yet little research is being done by urban health researchers into income, housing, and exclusion issues and how these influence health (Bryant, 2004). Even fewer studies recommend policy directions. Indeed, the urban health field is dominated by researchers whose work is illness-based and dominated by epidemiological methods.<sup>i</sup> Their research focuses on disease incidence and access to health care and services in urban centres. The 3<sup>rd</sup> International Conference program was more accepting of alternative approaches to health<sup>ii</sup> and the 4<sup>th</sup> Conference emphasizes innovative approaches to promoting urban health.<sup>iii</sup>

Nevertheless, at the 3<sup>rd</sup> International Conference on Urban Health, noted scholar Meredith Minkler discussed how epidemiology and medical journal guidelines explicitly discourage policy-oriented discussions (Minkler, 2004b). Our model calls for an urban health approach that focuses on the social, political and economic factors that influence health. Figure 1 illustrates these components.

#### Component 1: Health promotion and the social determinants of health

*Health promotion is the process of enabling people (and communities) to increase control over (the determinants of health), and to improve, their health* (World Health Organization, 1986).

Health promotion is based on a commitment to improve health and well-being by developing healthy public policy (World Health Organization, 1986). Health promotion has its origins in structural analyses of health issues based on the application of social science methods to health problems (MacDonald & Davies, 1998). The most succinct statement of the principles and values

of health promotion are in the Ottawa Charter for Health Promotion (World Health Organization, 1986).

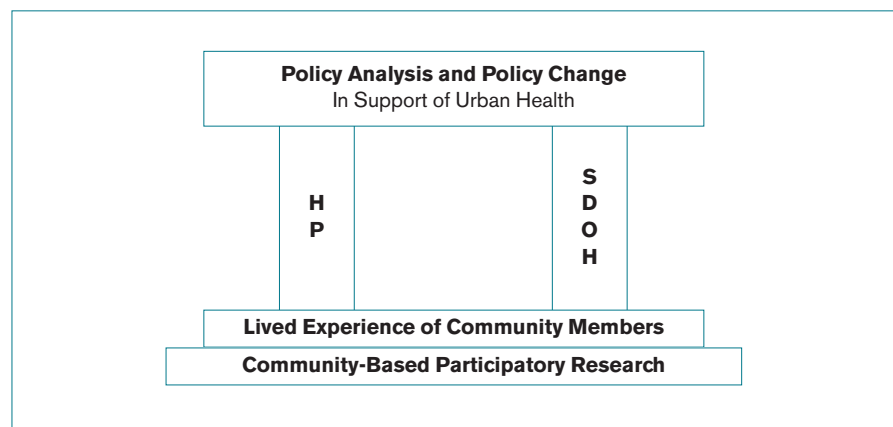
In line with its predominantly structural approach to promoting health, the Charter identifies the prerequisites for health of peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. A structural approach is one that is primarily concerned with how a society distributes economic and social resources among the population (Labonte, 1997). It has roots in the field of political economy and considers public policy as resulting from the influence of political and economic forces (Coburn, 2006). Five action areas are outlined: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services. Two of these areas are especially relevant to our model: strengthening community action and building healthy public policy. The prerequisites of health are now spoken of as social determinants of health.

The mantle of urban health leadership in Canada is now held by Montreal. The Montreal Region health unit outlines four key dimensions of urban health: the natural and built environment, the political and social environment, health infrastructure, and social and community infrastructure (Lessard, Roy, Choinière, Lévesque, & Peron, 2002). Montreal is notable as one of only a handful of Canadian health units embracing a broader determinants agenda (Raphael, 2003a).

#### Component 2: Community based participatory research (CBPR)

*CBPR holds immense potential for addressing challenging health and social problems, while helping bring about conditions in which communities can recognize and build on their strengths and become full partners in gaining and creating knowledge*

Figure 1. Components of the Urban Health Research and Action Agenda.



and mobilizing for change (Minkler, Wallerstein, & Hall, 2002, p. 20).

CBPR in urban health is superior for many reasons to mainstream research approaches (Minkler, 2004b; Minkler et al., 2002). It provides capacity-building opportunities for community members. It ensures research is community-relevant by focusing on community members' lived experiences. CBPR also has the potential to effect changes in public policy.

CBPR is research that engages community members as research partners to collaboratively tackle community-relevant issues. Studies take place in the community rather than research labs and offer capacity-building opportunities so skills remain in the community once a study is complete (Parker, Margolis, Eng & Henriquez-Roldan, 2003). CBPR moves from a model of academic ownership to one of joint ownership with communities (Manson, Garoutte, & Turner Goins, 2004). CBPR also requires an intellectual commitment to look at the day-to-day lived experiences and understandings held by community members (O'Brien Teengs & Travers, 2006.)

The benefits of CBPR are apparent in the context of traditional approaches to health science research. Such research has typically not been particularly focused on improving the health and well-being of community members. And such research is rarely concerned with identifying and challenging existing power structures that may oppress, marginalize, or threaten the health of individuals (Minkler, 2004a).

The five key contributions that CBPR offers to understand and promote community-based health are to:

- provide voice (e.g. power, capacity, control) to communities and their members;
- increase theoretical and practical knowledge about community health;
- improve health through community action;
- identify community issues requiring action; and
- effect political and social change.

Further details concerning each of these contributions of CBPR are available elsewhere (Park, 1993).

### Component 3: Lived experience of people

*If public health research is to develop more robust and holistic explanations for patterns of health and illness in contemporary society, and contribute to more appropriate and effective preventive policies, then the key is to utilize and build on lay knowledge – the knowledge that lay people have about illness, health, risk, disability and death (Williams & Popay, 1997, p. 267).*

There are especially compelling theoretical and practical reasons for favoring a

lived experience approach. A criticism of traditional approaches to understanding community health is their inability to focus upon the lived experience of people (Bryman, 1988). Lincoln has argued that the most effective way of understanding health-related issues is by discerning individuals' perceptions and constructions of events (Lincoln, 1994). Exploration of the meaning of health and staying healthy among community members provides rich insights that cannot be assessed by traditional approaches (Blaxter, 1990; Popay & Williams, 1994). The increasing popularity of qualitative methods is a result of the failure of traditional methods to provide insights into the determinants – both structural and personal – of health.

This missing piece in health research has been termed interactive knowledge (Park, 1993). It is derived from lived experience and is also known as constructivist, naturalistic, ethnographic, or qualitative knowledge. Its focus is the meanings and interpretations individuals place on events. Its theoretical bases are phenomenology, symbolic interactionism, and grounded theory (Lincoln & Guba, 1985).

A related form of understanding is critical or reflective knowledge, examples of which draw upon insights and approaches suggested by materialist or structural, and feminist theory (Fay, 1987). Critical knowledge is derived from reflection and action on what is right and just. It considers how societal structures and power relations promote inequalities and disenable people. The goal of research is to illuminate these health-harming societal structures and to raise consciousness about the causes of problems and deriving means of alleviating them.

Lived experience and critical approaches are important for engaging communities in research activity and assuring their voices are heard by policymakers. Such activities help counteract the drive towards weakened democratic structures increasingly common in urban areas. This trends calls for active community involvement in addressing policy issues that influence the social determinants of health.

### Component 4: Policy analysis and change emphasis

*Policies shape how money, power and material resources flow through society and therefore affect the determinants of health. Advocating healthy public policies is the most important strategy we can use to act on the determinants of health (Canadian Public Health Association, 1996, p. 1).*

Thinking about health and its determinants increasingly focuses on the distribution of resources within societies and how

these influence health (Raphael, 2003b). Also important are government decisions that determine how resources are distributed (Raphael & Curry-Stevens, 2004). These issues are illuminated by analyses of how governments systematically differ in how issues of income, housing, employment, healthy child development and others are managed (Langille, 2004). Shifting government policies in Canada have contributed to deteriorating urban environments. To counter these health-threatening policies and promote health-supporting ones, it is vital to understand how policy is made at every level of government (Bryant, 2002, 2003).

Theories of policy change help us understand the policy change process. Recent developments – termed learning approaches to policy change – consider the role of knowledge and ideas in the policy change process. These models help make explicit core epistemological beliefs (i.e., ways of knowing and understanding problems) of political actors as they create and select knowledge to bring about particular policy outcomes. An understanding of the motivations of people and groups responsible for policy change can help bring about policy outcomes.

For example, social spending – which results in either strong or weak programs in support of health – is shaped by the political ideology of the government of the day, public perceptions towards those in need, and the dominance of particular approaches to evidence deemed legitimate to inform these issues (Bryant, 2006). Swedish national and local governments – supported by public opinion – have an ethos of supporting vulnerable populations illustrated by their spending at 31% of its GDP on social spending. In contrast, Canada (18% of GDP), the US (14.6% GDP), and UK (20% of GDP) spend rather less and show corresponding weakness in social programs and population health (Organization for Economic Cooperation and Development, 2003).

These latter three countries have been governed by parties whose neo-liberal ideology prefers seeing the market as determining resource distribution and a reduced state role in these matters (Bernard & Saint-Arnaud, 2004). This ideology predisposes governments to favor the evidence that justifies these tenets (Teepie, 2000). These ideologies about the nature of the state's role in supporting citizens influence policy-making at every level of government (Coburn, 2001; Coburn, 2004; Coburn, 2006). These policies – while shaped by prevailing ideologies – can be influenced by citizen action (Esping-Andersen, 1985; Langille, 2004).

## Combining democratic process with the social determinants of health

There is a need then, for models that incorporate an understanding of how citizens can use diverse types of knowledge to influence the policy change process. Fischer proposes a model for democratizing policy analysis through a collaborative process (Fischer, 1993). He links scientific knowledge with the practical knowledge held by citizens to address important macro-policy issues. This collaborative inquiry makes the knowledge created by social scientists accessible to citizens to “systematize their own local knowledge”. CBPR creates cooperative relationships between scientists and citizens with the aim of meeting citizens’ basic social needs and welfare (Merrifield, 1989).

CBPR can support democratic empowerment (Gaventa, 1980, 1988). The expert scientist can work with citizens to assess their own interests and make decisions on how to see these interest put into action (Hirschhorn, 1979). To do so requires institutional and intellectual contexts in support of these aims. One example is the Dutch Science Shops where citizens are invited to put forth issues and concerns for scientists to research and to give back solutions to citizens. This process can lead to the formation of an alliance between practitioners and clients to address a social issue. Fischer’s approach requires investigation relevant to specific “real-life contexts and to the formation of goals and purposes” (Stull & Schensul, 1987).

Fischer’s collaborative research model addresses two methodological problems in policy science: the relationships between theory and practice, and empirical and normative inquiry. It links theory with practice and demonstrates how empirical inquiry should involve assumptions about what the world should be like. In the present case, it identifies the need to be explicit about the goals of urban health research and demonstrate a commitment to seeing that such ends are met.

## Discussion

The four-component research and action agenda reflects many principles of the Healthy City approach and the Belfast Declaration such as policy development and citizen participation in decision-making to improve urban population health (World Health Organization, 2003). The Belfast Declaration emphasizes collaborative efforts at all levels and urban governance to meet the needs of citizens, tackle the wider determinants of health, and create effective policies, strategies and tools for action. Specific areas of action are reducing

inequalities and addressing poverty, city health planning, good governance and creating inclusive and safe cities; promoting health impact assessment and shaping and implementing strategies for health.

Our four components provide the analytic tools for working towards these goals. They specify the pathways for citizen participation – community-based research and lived experience – in the development and design of healthy cities through healthy public policy development and change. These components give citizens a voice in project and program development and political decisions. These pathways provide opportunities for capacity-building among citizens to develop academic and community research partnerships to address community issues.

The Healthy City model focuses on local decision-making towards achieving healthy public policy and assumes that governments will be responsive to citizen concerns. The policy analysis and change component in our model assumes the contrary: Governments may not be predisposed to listen to citizens who challenge government policy. Indeed, our model sees citizen engagement as potentially forming the basis for development of social movements to challenge government decision-making.

It is also important to note that our fourth component, *Policy Analysis and Change*, is not limited to municipal policy-making and emphasizes decision-making at senior – provincial, state, or regional as well as federal levels – of government. This component reflects lessons we have learned from the Federation of Canadian Municipalities (FCM) Quality of Life Indicator Project and the Canadian Policy Research Networks (CPRN) Quality of Life Project Approach (Federation of Canadian Municipalities, 2004a; Michalski, 2001). Both FCM and CPRN identify how urban issues are influenced by policy decisions made by senior levels of government.

The FCM tracks indicators in 10 domains: 1) affordable, appropriate housing; 2) civic engagement; 3) community and social infrastructure; 4) education; 5) employment; 6) local economy; 7) natural environment; 8) personal & community health; 9) personal financial security; and 10) personal safety (Federation of Canadian Municipalities, 2001). The FCM notes that many of these domains are affected by federal and provincial policy changes (Federation of Canadian Municipalities, 2004b, 2004c).

The CPRN identified political rights and general values, health, including health care, education, environment, social programs, personal well-being, community, economy and employment, and govern-

ment as key aspects of quality of life (Michalski, 2001). These are all domains within the purview of federal and provincial governments in Canada. The FCM and CPRN projects show how important policy analysis at all levels of government is in an urban health research agenda.

## Conclusions

Our urban health agenda encourages community-driven research where locally produced knowledge – the lived experience of people – is at the forefront. This agenda ensures that research studies focus on deepening understanding of how political, economic, and social environments influence health. Our urban health agenda emphasizes social change as an endpoint. Local consumption of knowledge will occur through community-relevant research studies that offer clear social change endpoints.

As in the WHO Healthy City program, the explicit orientation is action oriented, community-based, and policy-oriented. The approach moves beyond understanding urban health and its determinants to action to promoting urban health. While such an agenda will provide insights into the processes that shape urban health and how public policy is developed, the primary goal of citizen participation in research and the policy process is the promotion of health for those living in cities.

## Supports and barriers

Supports for this agenda exist. There is increasing emphasis on the social determinants of health in Canada (Government of Canada, 2004a). The WHO’s Commission on the Social Determinants of Health should elevate their prominence in public and urban health discourse (World Health Organization, 2004). There is increased focus on urban policy by a variety of Canadian institutions and agencies such as the United Ways across Canada. The obvious deterioration in urban conditions and associated quality of life apparent in Canadian urban areas should promote receptivity to this new approach.

As one example, Wellesley Central Health Corporation in Toronto has declared itself as an urban health organization in support of research activities that deepen our understanding of the relationship between health status and income and its distribution, housing and homelessness, and social exclusion.<sup>iv</sup> In just one year, the organization has shown leadership by promoting capacity-building toward community-uni-

i [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)

ii [http://www.iuhr.neu.edu/conference/detailed\\_conference\\_guide.html](http://www.iuhr.neu.edu/conference/detailed_conference_guide.html)

iii <http://www.crich.ca/isuhconference2005/call.asp>

iv <http://www.wellesleycentral.com/wellesley/>

versity research collaborations and has funded numerous innovative research initiatives.

Nevertheless, active debate persists in Canada concerning definitions of health and its determinants among the professional community and general public. Medical and lifestyle approaches dominate professional and public modes of understanding health (Canadian Population Health Initiative, 2004). Pointing to and drawing upon WHO and Health Canada documents and recent research should help communicate the approach. Another issue is the perception that the approach could be seen as “political.” This could be countered by drawing attention to the research literature on the social determinants of health and the importance of democratic participation.

Also, the dominant class of urban health researchers is atheoretical medically-oriented, and not particularly action oriented. Some believe there are too few researchers able to meet the criteria of understanding policy analysis and the policy change process. We do not believe this to be the case. Instead we would argue that there are opportunities for collaborations among traditional urban health researchers and social science-oriented policy analysts to conduct innovative, effective research into urban health, its determinants, and means of improving it.

### Towards the future

The model provides the tools to achieve healthy communities and build on the insights of the Belfast Declaration. It emphasizes democratizing and building on existing community traditions and knowledge, and community capacity-building through community-based research and the emphasis on the lived experience of community members. These mechanisms bridge different forms of knowledge to provide critical insights into how structural arrangements foster inequalities in health and social exclusion within urban populations. These insights can lead to policy solutions. Community-based participatory policy research can democratize the public policy change process and enable citizens to contribute directly to influence the social determinants of their health.

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