Determinants of Health, Health Policy & HIV/HCV Prevention Among Youth in Atlantic Canada

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1. **Background** on my program of research
2. **Examples of current research projects**
3. **Health Promotion, determinants of health & intersectionality**
4. **Example: Our Youth, Our Response** study
5. **Shameless pitch** – MA Health Promotion, PhD in Health, Post-Doctoral Fellowship
6. **Q & A**
7. **Coffee**
PART ONE

Overview of my research unit
Jacqueline Gahagan, PhD

- Worked in public health
- PhD in medical sociology
- STBBI research/health equity
- Director of the GAHPS Unit
- Professor of Health Promotion
- Head of the Health Promotion Division in the School of Health and Human Performance
- Cross appointments in Community Health & Epidemiology, International Development Studies, Gender Studies, Nursing, and Occupational Therapy
GAHPS Unit Vision

To bridge the gaps in health knowledge in order to improve health equity and health outcomes.
Gender & Health Promotion Studies
Unit Mission

We seek to **improve health equity and health outcomes across the life course through community-engaged health promotion research, policy analysis, and knowledge translation at local, national and international levels.**

We do this by informing policy, programming and practice through health promotion research that considers the **intersectional nature of the determinants of health.**
Gender & Health Promotion Studies Unit

Core Values

* Equity and Diversity
* Engagement
* Intersectionality
* Accessibility
* Relevance
PART TWO

Examples of current research projects
Cancer's Margins and the Choreography of Knowledge: Toward a Queer Biopolitics and the Mobilization of Public Health Knowledge

3-year national interdisciplinary research project on the breast and gynecological experiences of LBQ women and transgender people to:

1. document what knowledge informs decision-making by sexual and/or gender minority breast or gynecologic patients;
2. analyze intersectional relationships between gender, sexuality and cancer healthcare experiences; and
3. schematize how patients, care networks and healthcare providers share knowledge that influences decision-making.

Semi-structured interviews in Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba and British Columbia followed by video stories.
Reducing Stigma, Promoting Resilience: Population Health Interventions for LGBTQ Youth

This multi-site, multi-disciplinary program of research involves researchers and knowledge-users from seven Canadian provinces and three U.S. states aims to:

* document the trends in health inequities, risk and protective factors among LGBTQ youth (and those perceived as such by their peers),
* develop an inventory of the strategies used to promote safe and supportive schools, and to identify the policies that have evidence of effectiveness, both through analysis of population survey data and community participatory evaluations of exemplar schools, school districts, and partnering community agencies.
HIV point-of-care-test (POCT), although not currently available in Nova Scotia, has become a means of increasing HIV testing uptake rates in communities that are often least likely to engage with conventional HIV testing and related clinically-based interventions.

The purpose of this HIV POCT pilot study was to determine:
Acceptability and uptake rates using POC testing, and
Prevalence of HIV among hard-to-access populations in Halifax who may be street involved, currently using injection drugs and/or on methadone maintenance therapy.
Sexually Transmitted Infections Research Network

An intersectoral network of researchers, public health decision makers, and community-based organizations working together to:

identify and address pressing HIV/STI prevention issues; and
develop appropriate policy interventions that involve collaboration between groups.
The purpose of this work is to measure the health of Nova Scotia’s gay, lesbian, bisexual, transgender, intersex, and queer (GLBTIQ) communities. The current phases include:

* developing a multisectoral community advisory committee;
* completing a scoping review of existing methods in measuring LGBTQ health; and
* conducting community consultations across the province with a variety of stakeholders (including members of LGBTQ communities and healthcare providers).

Advance our understanding of exposure to HIV risks, risk contexts, and the capacity to respond to risks in transnational contexts.
CHIWOS: The Canadian HIV Women’s Sexual and Reproductive Health Cohort Study

National, multi-methods study of HIV-positive women aimed at:

* understanding barriers to and facilitators of women-specific HIV/AIDS service use, and

* examining the use of women-specific services among more marginalized and stigmatized communities to determine correlations with improved sexual, reproductive and mental health outcomes.
PART THREE

Health Promotion,
Determinants of Health
and
Intersectionality
KEEP CALM AND HEALTH PROMOTION
The World Health Organization defines Health Promotion as... “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions” (WHO 2012).
Health promotion is directed towards **action on the determinants or causes of health outcomes**.

Health promotion utilizes **close co-operation of sectors beyond health services**, reflecting the diversity of conditions which influence health.

Health promotion works with government at all levels to help shape appropriate and timely **policy and programming responses to ensure that the ‘total’ environment** (which is beyond the control of individuals and groups) is conducive to health.
“The social determinants of health are “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness.” (WHO Commission on the Social Determinants of Health, 2008)

“Structural interventions refer to public health interventions that promote health by altering the structural context within which health is produced and reproduced.” (Blankenship et al., 2000; Des Jarlais, 2000; Sumartojo, 2000)

Structural interventions seek to improve “the risk environment” (Barnett & Whiteside, 1999; Rhodes et al., 2005).

... to create “enabling environments” (Tawil, Verster & O’Reilly, 1997) for HIV programmes and for improved health outcomes.
A DIFFERENT WAY TO DIE

Of the top 10 causes of death, here are the ones that most disproportionately affect each province.

Source: Statistics Canada; 2014

MACLEAN'S
Building healthy public policy
Creating supportive environments
Strengthening community action
Developing personal skills
Reorientating health services
Risk continuum

- NO PROBLEMS
  - NO RISK
    - HEALTH ENHANCEMENT
  - LOW TO MODERATE RISK
    - RISK AVOIDANCE
  - HIGH RISK
    - RISK REDUCTION

- PROBLEMS HAVE DEVELOPED
  - HEALTH PROMOTION
  - HEALTH RECOVERY
  - EARLY INTERVENTION
  - TREATMENT REHABILITATION
Social Determinants of Health: The ‘shopping list approach’

**Social-Physical-Economic-Services Determinants**

- Income & income inequality
- Education
- Race/ethnicity/gender & related discrimination
- Built Environment
- Stress
- Social support
- Early child experiences
- Employment
- Housing
- Transportation
- Food Environment
- Social standing
Context-specific strategies tackling both structural and intermediary determinants

Key dimensions and directions for policy

Intersectoral Action
- Policies on stratification to reduce inequalities, mitigate effects of stratification
- Policies to reduce exposures of disadvantaged people to health-damaging factors
- Policies to reduce vulnerabilities of disadvantaged people
- Policies to reduce unequal consequences of illness in on social, economic and health terms

Social participation and empowerment

- Monitoring and follow-up of health equity and SDH
- Evidence on interventions to tackle social determinants of health across government.
- Include health equity as a goal in health policy and other social policies

What determines health?
Think about investigating ‘contexts’ to identify intersecting synergies of inequities or axes of oppression in HIV/HCV prevention.
**Intersectionality**

- Shifts away from additive models of determinants of health to explore how they **overlap and intersect in context** (Crenshaw, 1991)
- The effects of **social categories** are intertwined (Hancock, 2007)
- **Power** (in all its forms) is ubiquitous (Hankivsky, 2011)
- **Access to health care** offers a clear example: heterosexual women with HIV/AIDS were invisible given the focus on gay men...

An intersectional approach would argue we need to look at both gender AND sexuality as interconnected
Health policies can have a profound impact (and lingering effects) at both the individual and population health levels.

Helpful in health policy analysis to understand the differential impact of policy outcomes on particular social categories or social positions (Do only certain populations benefit from the policy? Who is missing?)

Transformative approach through the use of intersectionality allowing for a more nuanced understanding of power hierarchies and axes of inequity (Hankivsky, 2012).
Key Areas of HIV Social Research

- **Basic Social Research**
  - Social Drivers/Determinants
  - Underlying factors that fuel epidemics and affect response to them

- **Social (“Structural”) Interventions**
  - Policy-Legal Change
  - Institutional Change
  - Environmental Enablers
  - Shifting Harmful Social Norms
  - Catalysis of Social and Political Change
  - Empowerment of Communities

- **Social/Behavioral Aspects of Biomedical Technologies**
  - Desirability, meaning, access, uptake, adherence

- **Social Impacts**
  - Demographic and household changes
  - Governance and security
  - Gender dynamics
PART 4

*Our Youth, Our Response* Research Example
Project Overview

Building capacity for effective youth-oriented HIV/HVC prevention policy and programing responses across the Atlantic region.
Our Youth, Our Response:

Building Capacity for Effective HIV/HCV Prevention Policy and Programming Responses Across the Atlantic Region
The Atlantic region faces health inequities & higher rates of chronic disease than the rest of Canada (GPI Atlantic, 2005).

Canadian youth experience unique risk factors that can lead to HIV/HCV/STIs (NS Roundtable of Youth Sexual Health, 2006).

Low uptake of testing, undiagnosed, limited access to treatment and care (Public Health Agency of Canada, 2009).

Need to look at the policy & programming efforts to meet the HIV/HCV prevention needs of youth.
What HIV/HCV primary &/or secondary prevention policies exist in the Atlantic region [& do these address youth-specific prevention issues]?

What differences or gaps exist in our current approaches for youth [gender, diversity, equity]?

How can identified gaps inform refining the future HIV/HCV prevention approaches for/by/with youth?
Project Background

* OYOR research team
  * Dalhousie University, Memorial University, University of New Brunswick, University of Prince Edward Island

* Community partners
  * Heartwood Centre for Community Youth Development, Phoenix Youth Programs, & Halifax Sexual Health Centre

* Community (CAC) and youth (YAC) advisory committees
Overview

Year 1: POLICY
Scan of existing HIV &/or HCV prevention policies

Year 2: INTERVIEWS
In-depth interviews with those working in health, education, corrections, etc.

• Year 3: FOCUS GROUPS
  - Focus group discussions
  - Knowledge mobilization & animation
  - Policy reframing
Year 1: Policy Scan

Extent of youth engagement in reviewed documents, by province (n=425)

- Substantial youth focus
- No mention of Youth
- Developed w/ youth

**NS (n=133)**
- Substantial youth focus: 40%
- No mention of Youth: 30%
- Developed w/ youth: 20%

**NB (n=81)**
- Substantial youth focus: 30%
- No mention of Youth: 40%
- Developed w/ youth: 20%

**NFLND (n=149)**
- Substantial youth focus: 30%
- No mention of Youth: 20%
- Developed w/ youth: 50%

**PEI (n=65)**
- Substantial youth focus: 50%
- No mention of Youth: 10%
- Developed w/ youth: 40%
Year 2: One-on-one Interviews

NUMBER OF PARTICIPANTS BY SECTOR (N=48)
- Education (n=12)
- Corrections (n=2)
- Health (n=19)
- Community (n=11)
- Unidentified (n=4)

NUMBER OF PARTICIPANTS BY PROVINCE (n=48)
- NS (n=14)
- NB (n=15)
- NFLND (n=15)
- PEI (n=4)
Year 3: Focus group discussions & KTE

- Focus groups in Nova Scotia with youth, service providers, policy decision makers, public health officials.
- Triangulating data from years 1 – 3
- Developing policy briefs and fact sheets
- Holding a KTE event on April 20 (in Halifax)
- Working with provincial government to mobilize responses through ‘integration’ (STBBI)
1. Engaging youth in the development of HIV/HCV policies & programs

**Background**

* OYOR initiated to bridge policy & programmatic [primary & secondary] prevention approaches

**Policy scan**

* Lack of youth-oriented policies & programs
* Very little youth participation in development

**From the interviews/ focus groups**

* Many participants indicated a desire to increase youth engagement
* Uncertainty as to the best means of doing so [avoid tokenism, unfair inducement, ethical tensions, etc.]
* Youth voice/lived experience vital
2. Expanding Secondary Prevention

Background

- **Policy scan**
  - Lack of youth-oriented policies & programs
  - Very little youth participation in development

From the interviews/Focus groups

- Participants described more primary prevention-oriented programs than secondary
- Where and how can we expand secondary prevention throughout the Atlantic region?
3. Harm Reduction as Opportunity and Challenge

**Background**

* Harm reduction programs are integral part of HIV/HCV prevention in Atlantic region

* Harm reduction can overlap with primary and/or secondary prevention

**From the interviews/Focus groups**

* Participants described harm reduction programs that require support from other programs

* Synergy between harm reduction, and primary / secondary prevention programs represents a means of effectively using limited resources
4. Communication and Collaboration as Key Elements

Background

* Atlantic region faced with limited resources, isolated populations, service fragmentation

* Unique resources and skilled, dedicated individuals scattered across four provinces

Focus groups

* Participants reported frequently seeking support and input of other individuals, organizations

* Formal and informal networks represent a resource that will be invaluable during shift to integrated approach
5. Shifting to an Integrated Model

Background

* OYOR began before shift to integrated model was announced
  * Questions dealt with HIV & HCV prevention together

* Opportunity to identify:
  * Opportunities for integration
  * Programs currently operating under an ‘integrated’ approach

From the interviews/
Focus groups

* Integration was not discussed by participants, even during the most recent interviews

* Some programs currently take an integrated approach [not specific to youth]

* Integration as opportunity for increased youth engagement?
Summary

Year 1: policy scan & analysis

Year 2: In-depth interviews

Year 3 & beyond: Focus groups & KTE

- Major themes
  - Engaging youth
  - Secondary prevention
  - Harm reduction
  - Collaboration
  - Integration

Mobilize for change
Evidence-informed policy decision making
Knowledge translation exchange, mobilization & action

DALHOUSIE UNIVERSITY
Inspiring Minds
Cycle of exclusion, avoidance of health services, and continued HIV/HCV risk and vulnerability

- Service providers exclude or shame youth
- Youth experience and/or fear poor treatment
- Policies neglect or exclude youth
- Low uptake of services; health, economic and social difficulties
- Values shame and blame youth
- Increased risk of HIV/HCV; high rate of HIV among youth
“Social determinants,” “structural factors,” and the “risk environment” or “enabling environment” matter. We must focus our attention on the conditions that shape and constrain health outcomes.

The conditions are of different types.
- Social and cultural
- Political and legal
- Economic
- Physical environment

They operate at different “levels” from micro to macro (or proximate to distal).

The types and levels interact systematically and are context specific.

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Dalhousie University
Inspiring Minds

GAHPS UNIT
We can’t solve every health and social problem, but we can encourage (or discourage) decision-makers to take action and make hard decisions about improving health outcomes!

“I’m a doctor, Jim, not a miracle worker!!”
Where would **you** start mobilizing for change in HIV/HCV prevention and youth?

- Health care providers?
- Youth?
- Teachers?
- Industry?
- Government?
- Health professions?
- Other?
- Don’t know?
PART 5
And now for the shameless pitch...

* Interested in Health Promotion? Dal offers an MA in Health Promotion!
* Interested in a health-focused PhD? Dal now offers a PhD in Health (housed within the Faculty of Health Professions)
* Thinking about a post-doctoral fellowship down the road? Call me!
PART 6: Q & A
Many thanks!

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