

Chapter 3

In Search of Empowering Health Research for Marginalized Populations in Urban Settings: The Value of a Transdisciplinary Approach

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The urban environment has become an important determinant of health in the context of increased urbanization over the last century (Freudenberg, Galea, & Vlahov, 2006; Galea & Vlahov, 2005). Along with a growth in urbanization has come increased socio-economic disparities and marginalization among populations living in many urban centres (O'Campo & Yonas, 2005). Social, political and economic processes have led to the unequal development of urban areas and health inequities in these environments. Such health inequities place socio-economically disadvantaged and marginalized populations (i.e. individuals experiencing stigma, social exclusion, a lack of economic resources) at greater risk of morbidity and mortality, and lower quality of life (Geronimus, 2000; World Health Organization Knowledge Network on Urban Settings (WHO KNUS), 2008). The social and economic conditions that lead to the poor health of these populations contribute to feelings of powerlessness and an inability to gain control over life circumstances, making powerlessness an important social determinant of health (Wallerstein, 2002; WHO KNUS, 2008).

The empowerment of the individual and the development of a sense of control over his/her health have thus been identified as crucial steps in addressing health inequities (Marmot, 2006; Pridmore, Thomas, Havemann, Sapag, & Wood, 2007). However, there is also a need for social interventions that seek to reduce health inequities in urban settings through the building of skills and experiences with which to assist marginalized populations in gaining greater control over their lives (Harpham, 2009; Wallerstein, 1999; WHO KNUS, 2008).

A growing body of research is focusing on the social and environmental factors that contribute to the poor health of socio-economically marginalized populations (Geronimus, 2000; Harpham, 2009; WHO KNUS, 2008). Health research approaches that involve the participation of marginalized populations in various aspects of the research process can facilitate access to knowledge, empowerment and capacity-building to affect social change with which to improve health in their

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communities (Wallerstein, 1999). In this chapter, we will discuss how collaborative, transdisciplinary (TD) research methods, with careful attention to building equitable research partnerships, present an important opportunity to build capacity to empower the broader community through the production of actionable health research. In our discussion, we draw on examples from research projects exploring health behaviours of marginalized drug users and related harm reduction programming. The examples represent the journey towards TD research taken by a working group engaged in advocacy and research on health risks and harm reduction practices among illicit drug users in Toronto, Canada, in which some of the authors of this chapter are actively involved (Balian and Altenberg). These examples illustrate important features of TD health research well suited to working with and for marginalized populations.

Considering “Transdisciplinarity”

In recent years, it has been recognized that determinants of urban health must be studied in a multisectoral and multi-level way in order to effectively examine their complexity and subsequently problem solve (Harpham, 2009). Furthermore, translating research into practice is an ongoing challenge for research addressing health inequities in urban settings (Harpham, 2009; Roche, 2008; Schulz, Krieger, & Galea, 2002; WHO KNUS, 2008). Research of this nature tends to produce evidence that is accessible primarily to the academic sector and is not easily translatable into social action at community and/or policy levels (Roche, 2008). A TD approach satisfies the growing need for multi-level and multisectoral urban health research as it brings together various disciplines, sectors, perspectives, and resources, and thus facilitates the examination of the problem and the ongoing translation of findings into community- and policy-relevant steps for action.

Nevertheless, while the principles of TD research embrace the involvement of various stakeholders (e.g. academics, service providers, service consumers, policy-makers) and the types of knowledge they may provide (e.g. academic knowledge, lived experience, policy expertise), the term “*trans-disciplinary*” implies a primary focus on the contributions of academic disciplines to the research. This is somewhat counterintuitive to its goal of the equitable integration of various types of knowledge into research and to not privilege one discipline or type of knowledge above others. Such an emphasis on contributions of academic disciplines could possibly undermine research of this nature and imply a “credentialist” approach in which individuals who do not have academic training in a discipline, such as community members with lived experience of a particular phenomenon under investigation, are not welcome or their contributions will not be as valued or respected in the research process as someone with academic training (Travers et al., 2008). Perhaps the term “*trans-disciplinary*” should be revised to foster and guarantee more inclusivity in order to live up to its mandate to bring together various perspectives surrounding complex problems and move beyond traditional research methods and approaches with which to study and solve such problems.

Key Components of the TD Approach and Their Contribution to Research on the Health of Marginalized Populations

Despite such terminological limitations, there are several components of a TD research approach that can facilitate empowerment of marginalized populations with respect to health. In this section, we illustrate this argument through a broader, theoretical discussion of key components of the TD research approach, specifically drawing on qualities of community-based research (CBR) methods. Then, the discussion shifts to the first-hand experiences of co-authors Raffi Balian and Jason Altenberg in conducting community-based research on drug use-related risks and harm reduction programming needs in Toronto, Canada. Their experiences illustrate the importance of these components to the production of actionable health research and also present practical challenges in this process.

Collaborative, Participatory Methods in the Production of Cross-Sectoral Knowledge

A key component of TD research is that it involves collaboration not only across academic disciplines but with non-academic community stakeholders and policy-makers as well (Balsiger, 2004; Stokols, 2006; Wickson, Carew, & Russell, 2006). This type of intersectoral collaboration facilitates the action-oriented nature of TD research, whereby the emphasis of academic collaborations on research and the emphasis of community groups on community action are linked. Such a linkage facilitates the building of mastery and empowerment of stakeholders and participants through raised awareness of the problem, knowledge sharing, and skills development and, subsequently, the more effective, direct translation of research findings into public policies (Stokols, 2006).

Empowerment through the collaborative dimension of the TD approach is consistent and aligned with the principles and methods of CBR. The compatibility of the TD approach and CBR methods is evident in CBR's definition as "systematic inquiry, with the participation of those affected by the issue being studied, for the purposes of education and taking action or affecting social change" (Green & Mercer cited in Leung, Yen, & Minkler, 2004, p. 504). CBR methods can empower marginalized populations through the involvement of community partners and those affected by the issue of study in all aspects of the research process, including conceptualization, data collection, analysis, interpretation, and ongoing knowledge translation. In theory, this involvement creates power-sharing between academics and community members, thus shifting authority over the research process away from experts and allowing for equal ownership of the research and subsequent findings. Collaboration between academics and community participants in CBR assists in identifying the social factors that affect the health of these communities and promotes building on community member/participant strengths and knowledge to effectively address these factors (Schulz et al., 2002). This results in findings that

are more responsive, “accessible, understandable, and relevant” to the interests and needs of participants and thus are more translatable into community-level social change (Leung, Yen, & Minkler, 2004). Furthermore, involvement of community members in all aspects of the research process validates their lived experience, which can be further motivation to affect social change.

However, the process of academic and community collaborations in the context of TD and CBR research can be challenging. A debate has emerged as to whether there is a disjuncture between CBR theory and practice in the sense that, in reality, the extent of community involvement in all stages of the research process may be less than desired. A recent analysis of CBR experiences in Canada showed that involvement of academic researchers and service providers was high in almost all stages of the research, whereas community members were the least engaged (Flicker, Savan, Mildenerger, & Kolenda, 2008). A low level of involvement of community members in CBR may relate to power imbalances and differing research agendas between collaborators. For instance, academic researchers and community members often have different agendas in that researchers seek to gain knowledge to problem solve on a broad level whereas community members typically seek to gain skills in order to problem solve within their local communities. In the process of partnering, academic researchers, equipped with research skills and funding, may take on the leadership role and may only consult community members at the beginning and/or end of the project, and/or may not present results to community members in an accessible way that is useful for the local community (Wallerstein, 1999).

In order for a TD approach that incorporates CBR methods to be empowering, it is extremely important that partnerships between the various sectors be equitable and negotiable in order to ensure that community partners who represent marginalized populations have a voice to advance the research endeavour (Benoit, Jansson, Millar, & Phillips, 2005). Without such equitable partnerships, the research collaboration can suffer from mistrust between partners and/or perceptions of “credentialism” and/or “tokenism”, making the research findings less relevant and credible within the community setting. The consequences may in turn lead to lowered capacity within the community to address the complex health issue of study and create mistrust towards future research (Roche, 2008; Travers et al., 2008; Wallerstein, 1999).

Integration of Quantitative and Qualitative Methods

A TD approach nurtures the integration of various research methods derived from different disciplines (Wickson et al., 2006). The integration of quantitative and qualitative methods is particularly important for empowerment in research with marginalized populations. The inclusion of quantitative data can provide information on the extent to which social factors influence the health and health behaviours of marginalized groups. The inclusion of qualitative data can complement the quantitative findings and also fill gaps in explanations left by the quantitative data through the elucidation of rich, contextual information. The inclusion of both types

of methods and subsequent data, thus, allows for a more complete interpretation and explanation of study findings (Tolomiczenko & Goering, 2000). The elicitation of the lived experience of community members is an important inclusion in research on health inequities as it assists public health and epidemiological research in moving beyond its positivistic focus. It does so by situating individuals in the social contexts in which health inequities arise and by elucidating the meanings that individuals “attach to their experience of places and how this shapes social action. . .” (Popay, Williams, Thomas, & Gatrell, 1998, p. 636). The incorporation of qualitative methods and data thus provide greater explanatory power regarding the causes of health inequities and can facilitate greater understanding of the relationships between human agency and social structures that produce these inequities (Popay et al., 1998).

Furthermore, the inclusion of qualitative methods and data provides marginalized populations with a voice to express their stories and to capture their lived experience in meaningful detail. Being provided the opportunity to tell their stories can be an empowering experience for disadvantaged groups who have experienced adversity in life and are likely underserved and unheard with respect to health issues. The rich, detailed data elicited from qualitative, open-ended questions may also resonate with service providers, who may need and appreciate this information in more effectively meeting client health needs (Tolomiczenko & Goering, 2000).

Reflexivity

In order to allow for the empowerment of marginalized populations within the context of the TD research experience, reflexivity, a process in which the researcher reflects and questions the personal experiences that influence his/her interpretations of the data, is an important, yet challenging, component. Given the diverse skills and experiences comprised in the TD research team, issues with power dynamics will likely arise. In order to facilitate collaboration in light of such dynamics, it is recommended in TD work that the researchers become engaged and embedded with the research problem in order to gain an in-depth understanding. To achieve such a level of integration, it is important for the researcher to examine how his/her own position, beliefs, and experiences influence the research process (Wickson et al., 2006). Access to lay knowledge through collaboration with practitioners and marginalized groups in the community can facilitate such embeddedness. For researchers who are ‘outsiders’ to the groups of study, it is through this reflexivity that they can achieve a greater understanding of the lived experiences of these groups. Such a reflexive process may also facilitate a paradigm shift away from a predominant focus on risk and illness in social epidemiological research with marginalized populations towards an applied research approach focused on resiliency that can promote and build capacity for improvements in health among these groups (Harpham, 2009).

Academic and community members not only enter into the research collaboration with different experiences, but, as mentioned earlier, they enter with different research agendas with respect to purpose and outcomes. It is therefore extremely

important for the integrity of the research process that partners acknowledge and understand these differentials by reflecting on the meaning of participation (i.e. ‘who’ is participating, and why?) and how differing social positions or power dynamics may affect the process of participation (Wallerstein, 1999).

The Road to TD Research: Examples of the Evolution of Harm Reduction Research in Southeast Toronto

Injection drug and crack cocaine users are at risk of several health problems including substance abuse or dependence, HIV, hepatitis B and C, and other infectious diseases; endocarditis, skin abscess, mental health problems; and fatal and non-fatal overdoses (Fischer, Pouris, Cruz et al. 2008; Des Jarlais, Diaz, Perlis et al., 2003; Wong, 2001). Substance use and abuse are complex health issues, highly influenced by social, political, epidemiological, psychological, geographic and economic processes and determinants (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). Harm reduction refers to a set of public health policies and programs that seek to reduce the risks and harms associated with injection drug and other types of substance use by providing drug users with new drug use equipment, condoms, information, and support with which to use drugs more safely, without requiring cessation of use (Ritter & Cameron, 2006).

The journey towards TD research on drug use for co-authors Jason Altenberg and Raffi Balian began in the mid-1990s in their work as harm reduction service providers and advocates in Southeast Toronto, Canada. Here, we present this journey through a discussion of their involvement and experiences with three research projects – one unidisciplinary, one interdisciplinary and one TD – on drug use-related risks and harm reduction.

Experiences with Unidisciplinary Harm Reduction Research

In the fall of 1994, concerned with the number of crack cocaine users in his constituency, a Toronto city councillor asked the public health department to do something about the increasing crack cocaine-use problem. The request went to the needle exchange program at the public health department, and its executive director called a group of workers together, including Balian, to see if there was anything they could do to address the growing problem. The initial meeting at the public health department took place just as crack cocaine was taking hold of Toronto’s most marginalized drug users. At the conclusion of the meeting, the attendees agreed to form a committee to look into a variety of ways to tackle the issue in downtown Toronto.

Their first task was to examine the severity of the problem. For this, a questionnaire was devised to be distributed by harm-reduction agencies and organizations that worked with crack cocaine users. Crack users all over the city of Toronto responded to the questionnaires and when the responses were eventually examined,¹

a disturbing image of the issue began to develop. Almost half of the respondents admitted to having injected crack at least once. Another worrisome factor was the extent of lip burns and mouth sores experienced among crack smokers combined with the liberal sharing of smoking equipment among the community, posing a risk for the spread of infectious diseases. During that period, harm reduction strategies for crack use were not available, and thus, the crack-using community was vulnerable to harms associated with drug-use equipment sharing. Finally, almost one-third of female respondents reported that they had been sexually assaulted after having used crack.

Next, the committee explored the potential of crack pipe distribution as a harm reduction intervention for crack cocaine users in order to reduce the risk of contracting infectious diseases through crack pipe sharing. The working group developed a plan to collect used pipes from crack users and test them for possible HIV, hepatitis, or tuberculosis contamination. Unfortunately, the project could not secure funding due to scepticism regarding the correlation between HIV and crack pipe sharing and the ability of community members to produce credible research; the project was eventually laid to rest. Balian and his partner at the time spearheaded the formation of an advocacy group comprising drug users, called the Illicit Drug Users' Union of Toronto (iDUUT), in response to the lack of accountability towards illicit drug users in general and towards crack users in particular, who, hitherto, had been voiceless.

Despite a lack of research evidence and support due to opinions that the distribution of crack pipes was illegal, the advocacy group developed "safer crack stem kits", consisting of a clean, glass crack stem/tube and other tools to use crack safely, and began distributing them to crack users. Because of the paucity of information regarding crack use and crack users in Toronto, the group also decided to gather as much information as possible during the safer crack stem kit distribution project and began further survey data collection on crack-use patterns and related risk behaviours among crack users. The results of the surveys conducted by iDUUT identified the increased use of crack by marginalized populations in Toronto and frequent crack pipe sharing and other health risk behaviour among these groups. The results were presented at a press conference and were shared with community agencies, the public health department and members of the research/academic community. The results were regarded by many, including epidemiologists, as some of the first and best data obtained from street level crack users at the time.

Due to iDUUT's persistence in approaching the academic research community for support, an academic research team eventually began to take interest and proposed a study to examine used crack stems as a potential vector for infectious disease transmission. Despite mobilization and the collection of valuable research data on the problem by community advocates for years, academic credentials emerged as an important issue for policy change, as it was only once academic researchers were engaged in investigating the problem and had released their findings that the safer crack stem kit distribution program became sustainable through the receipt of municipal and provincial funding. The safer crack kit distribution program gained official support from the city in 2005, more than 10 years after a local politician

raised concern over the problem and community advocates mobilized and began their harm reduction work.

Without this first piece of community action/research, harm reduction programs could not have begun to develop pragmatic strategies (i.e. safer consumption devices) to engage crack cocaine users. A recent evaluation study of a safer crack pipe distribution program in Ottawa has shown that this type of program can reduce the risk of transmission of HIV, hepatitis C and other infectious diseases among drug users (Leonard et al., 2008). This example illustrates that, despite numerous attempts of community members to bring about change through collaborated efforts, ultimately the lack of partnership among community, policy-makers and researchers led to a delay in implementation and benefits of an important public health initiative for marginalized populations. User/activist knowledge and empowerment to mobilize, exemplified in iDUUT's efforts to collect data and initiate safer crack stem distribution, were an important precursor for harm reduction programs and academic researchers to access and further mobilize that community surrounding this issue. Since that time, a relationship among the crack-user community, health services and the research community in Toronto has been built thus demonstrating the need for these key stakeholders to be sitting at the research table at the same time and throughout all stages of the research process.

Experiences with Interdisciplinary Harm Reduction Research

In 2003, equipped with lessons learned from the previous crack cocaine risks and harm reduction research initiative, Balian, then the program coordinator of COUNTERfit, a harm reduction service program in the South Riverdale Community Health Centre (SRCHC) located in Southeast Toronto, and Altenberg, director at Alternatives East End Counselling Services at the time, partnered with two sociologists at the University of Toronto³ to conduct community-based, participatory action research (PAR) to explore the integration of harm reduction and mental health services. The question of integrating harm reduction and mental health services arose from an active partnership between COUNTERfit and Alternatives and as a result of successful collaboration in service delivery. The mental health service system in the province of Ontario was being reviewed at the time. The need to integrate mental health and substance use programs was an established "good practice" from a policy perspective, given increasing awareness of the challenges experienced by individuals with concurrent mental health and substance use disorders in navigating separate mental health and substance use treatment systems (Altenberg, Balian, Lunansky, Magee, & Welsh, 2004). The details of service integration were still being developed in a variety of settings.

Balian and Altenberg were concerned that the needs of many individuals experiencing concurrent disorders would only be addressed successfully via integrated strategies and programs that also included an integration of harm reduction principles and practices. They wanted to use their experience to impact practice at both the local and provincial levels. Balian and Altenberg approached the academic

researchers for guidance on how to conduct research with this purpose in mind. The PAR qualitative study sought to explore, through a series of focus groups with service providers and service users, how integrated mental health and substance use services might help reduce mental and physical health issues and social problems among drug users in Southeast Toronto (Altenberg et al., 2004). Based on themes generated from the focus groups, the study yielded a number of recommendations for mental health and substance use services, including: the integration of harm reduction and mental health services to reduce stigma towards drug users and increased access to treatment; the inclusion of service components such as community-based outreach and flexible hours; the encouragement of staff qualities such as non-judgemental attitudes and lived experience; the development of harm reduction-based counselling for service users; capacity development for other community programs to incorporate a harm reduction perspective into service provision (Altenberg et al., 2004).

Upon reflection, members of the research team saw many advantages to the partnership. Service users were an integral part of the research process, building research skills by informing research materials and facilitating focus groups. The experience also required the negotiation by partners of differing experiences and agendas affecting the research process. Altenberg notes:

The process of conducting research, collecting and analysing data forced us to come to terms with the difference between our beliefs and experiences and those of service users and other providers who had experiences with mental health, substance use, and harm reduction services. Our academic partners, while sharing our goal to improve services for people with mental health and harm reduction needs, did not have the conviction derived from experience and approached the data with a different lens than ours as service providers and program managers. What we came to the research with as assumptions of truth, our partners questioned. In some way it felt as if our priority was particular outcomes and theirs was the integrity of the process. In holding us to that need for “validity,” we came to more nuanced understandings of the needs of the community we served and forced us to accept, what seemed to us at the time and still seem to be, contradictions in what service users and providers found most useful in addressing mental health and substance use issues (i.e., using a harm reduction perspective in one service but not always in the other).

Since the completion of this study, an Urban Health Team at SRCHC was created that addresses the specific needs of drug users and those with mental health issues. This program was informed by the recommendations that emerged from the project in the sense that unique integrated mental health and harm reduction services have been created, incorporating staff positions for individuals with lived experience. The process of PAR and interdisciplinary research has had an impact on the Team’s vision for the services they provide. It has impacted how they approach interdisciplinary work in that they acknowledge and expect the research team to see things from diverse perspectives, to challenge each other, and in so doing to improve the breadth and depth of how health problems and issues are approached.

Experiences with TD Harm Reduction Research

A TD research approach can contribute to the evolution and advancement of theory that has the potential, when set into policy, to build capacity within marginalized communities to improve health. As discussed earlier, injection drug use is a complex health issue that is affected by social, political, epidemiological, psychological, geographic and economic processes (Rhodes et al., 2005). Such complex issues demand a research approach that considers the impact of all of these factors on the health behaviours and outcomes of drug users. Interest in the use of a TD approach is growing in the addiction research field (Abrams, 2006; Sussman, Stacy, Johnson, Pentz, & Robertson, 2004), as the approach facilitates the merging of methods and multiple, relevant perspectives in the exploration of the various intersecting factors that affect substance use and abuse.

Informed by the benefits and challenges of previous unidisciplinary and interdisciplinary research collaborations, Balian and Altenberg became involved as partners in a national, multi-site surveillance project regarding the risk behaviours of injection drug users in Canada. The project sought to increase understanding of the HIV epidemic among injection drug user populations through improved surveillance using epidemiological, socio-behavioural, ethnographic and community-based research (Public Health Agency of Canada, 2006). The project established a national surveillance system to monitor injection drug use (IDU)-related risk behaviours to inform provincial and municipal program planning and evaluation.

The project involved a multi-site team of epidemiologists, physicians, social epidemiologists, public health researchers, community harm reduction program staff, drug users and policy-makers. Each of the seven sites had a lead researcher, and each site was encouraged to create local research questions specific to their particular region. In Toronto, the principal investigator worked with local stakeholders, including service providers, drug users and policy-makers, to formulate research questions relevant to drug-use trends and complex service needs within the Toronto context. Interviewers included individuals with lived experience of injection drug use and were trained on all aspects of the study protocol (Public Health Agency of Canada, 2006). Knowledge translation occurred on an ongoing basis as reports were developed for data specific to each city and each participating site. These results were shared with the sites in aggregate form to provide information on national trends in addition to site specific reports. The efforts of the research team to provide both national and local data on various factors that contribute to IDU-related risk behaviour was a reflection of both a respectful TD process and an understanding of the diverse needs of the research participants. The project honoured the pragmatic needs of the participating community harm reduction programs and recognized that “integrated knowledge translation”, a key component of a TD approach involving the ongoing sharing of study findings with stakeholders (see Chapter 9 for more information), could have a direct impact on programming. The project was truly TD as the process involved respectful partnerships

involving input and involvement of all stakeholders throughout the life of the project, and wide dissemination of findings.

Furthermore, the project facilitated significant capacity-building at the community level necessary to improve harm reduction programming provision and uptake. The SRCHC used the project's site-specific data to inform a wide range of organizational and programming decisions. The site-specific data confirmed suspicions that HIV was exceptionally low in prevalence among drug users in the community served by SRCHC and COUNTERfit. Service providers at the SRCHC were encouraged by these findings and felt that they suggested that their harm reduction program model was effective in maintaining low HIV rates. Hepatitis C virus (HCV) rates, however, were substantially higher among IDUs from all programs and all sites. The project reports stimulated mobilization and development which has led to the creation of a program that offers a unique access point to HCV education, support and treatment for illicit drug users in a community setting. This programming has filled a service gap for the drug-using population in Toronto, who have previously received limited access to HCV treatment, related education or support under the assumption that the chaotic lifestyles of drug users would contribute to low adherence to the difficult HCV treatment regimen (Edlin et al., 2001; Grebeley et al., 2007).

Data from the project also confirmed that the proportion of women accessing harm reduction programs was substantially lower than men. This informed another research project examining the specific harm reduction programming experiences of women and men with the intent to develop a specific harm reduction program for women. This project in turn led to the development of a permanent women's harm reduction program at SRCHC. Drug users continue to be involved in all aspects of the women's harm reduction program development, implementation, and evaluation. This involvement can facilitate empowerment at both individual and community levels. At the individual level, the experiences of drug users are valued and acted upon. This in turn can empower the larger community of drug users with respect to adoption of harm reduction practices through the validation of lived experience and the provision of services that are tailored to their needs.

TD research in an ideal sense should be research that is taken up and applied in policy due to the diverse partners involved in the research enterprise. It should also be equally focused on the needs of all partners. This project is illustrative of the ability of a TD team of academics, service providers, service users and policy-makers to effectively move research into practice through the quick uptake of findings into community program planning for a complex health problem. The project exemplifies the necessity of equitable participation by all stakeholders in research design, in posing relevant research questions, capacity-building within the affected community, and ongoing access to relevant data with which to make TD health research most actionable. It also demonstrates the importance of a willingness on the part of academic partners to support the needs of communities and programs and a reciprocal responsibility on the part of community partners to support meaningful access to community resources, knowledge and participants.

Recommendations for the Implementation of Empowering and Actionable TD Research for Marginalized Populations

Based on our theoretical and practical discussions, the TD research approach has many benefits and can potentially empower marginalized populations in various ways. The merging of multiple perspectives and methods in order to explore and address complicated health conditions with multiple antecedents and consequences can contribute to increased explanatory power of findings and inform the development of appropriate interventions. Based on the authors' experiences working in harm reduction service provision and/or research, we take this opportunity to make some recommendations for the production of empowering and actionable TD health research for marginalized populations:

- (1) Community member knowledge is a necessary component in all stages of the TD health research process. In order to begin to effectively research and understand the complex health problems that affect marginalized populations, the harnessing of local knowledge from experts with lived experience is imperative (Roche, 2008). Furthermore, researchers need access to local populations in order to identify appropriate research questions and methods. Research partnerships must be equitable in order to facilitate working relationships between academic researchers and community members in light of power imbalances, differing agendas and potential mistrust. Furthermore, without inclusiveness, equitable community-level involvement and support for the project, it may be difficult to recruit members of the marginalized community affected, who are often difficult to reach, as research participants. In order for TD health research to problem solve for marginalized populations, capacity within the affected community must be built to use findings to raise awareness of the health problem and develop interventions to address the problem (Benoit et al., 2005). Essentially, involvement of community at all of these stages serves to increase explanatory power and the capacity for action from the research produced.
- (2) As our examples have illustrated, there should be willingness to collaborate and trust among all research partners in order to facilitate the balancing of power and arrival at equitable involvement of community in all research stages. Partners should take the time to first consult with all prospective team members in order to ensure that they will be a good fit, thus contributing to the fruitfulness of the collaboration. They must also focus on building trust in order to avoid commonly reported problems in CBR of perceptions of "credentialism" and feelings of "tokenistic" involvement by community partners on the research team (Roche, 2008; Travers et al., 2008). If community partners do not feel that their experiences are valued and are only included in selected aspects of the research, this will erode the empowerment and capacity-building component of the research and diminish the research team's ability to produce actionable findings with which to improve the health of marginalized groups. Tools such as "Terms of Reference" that outline roles, responsibilities and terms of conduct

for all members of the research team can be useful to help build trust and ensure a respectful research partnership.

- (3) An important part of trust building is reflexivity with respect to each partner's social position and the understanding that academic and community partners may have differing agendas with respect to the purpose and outcomes of the research (Benoit et al., 2005; Wallerstein, 1999). As exemplified in the PAR project on concurrent disorders, the research team recognized that they had differing research agendas but were open to learning from the different perspectives and knowledge each brought to the project with respect to goals and outcomes. Only if partners are aware of and willing to negotiate these differing agendas, will harm to the research and capacity-building processes be avoided.
- (4) Finally, there needs to be greater clarity regarding the empowerment and capacity-building goals of TD research projects. Such clarity regarding how marginalized populations want to and will be involved in all stages of the research (e.g. will peer researchers be trained and employed to collect data, will individuals with lived experience be involved in an advisory panel informing all stages, will participatory methods be used whereby research participants generate and analyze the data and disseminate findings, or all of the above?) and how empowerment and capacity-building at the broader community level will be sustained once the research project ends, can guide the realization of empowerment goals through TD research.

The key to the production of empowering and actionable TD health research for marginalized populations lies in the level of inclusiveness of the research process. Representatives of the affected community should participate in all aspects of the research process: conceptualization, data collection, analysis, interpretation and ongoing knowledge translation. However, throughout this process the research team must be cognizant of power dynamics and the needs of all partners (Roche, 2008). Particular focus should be placed on the needs of community partners in order to ensure the relevance of the data collected with which to understand the complex health problems in their local communities. This focus will also serve to promote engagement in future research and program planning that will generate capacity building to develop solutions to the complex health problems of marginalized populations in urban settings.

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