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ORIGINAL ARTICLE

# Equity-focused knowledge translation: a framework for "reasonable action" on health inequities

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**Abstract**
*Objectives* To identify gaps in procedural approaches to knowledge translation and outline a more relational approach that addresses health inequities based on creating collaborative environments for reasonable action.
*Methods* A literature review encompassing approaches to critical inquiry of the institutional conditions in which knowledge is created combined with a process for encouraging reflexive professional practice provide the conceptual foundation for our approach, called equity-focused knowledge translation (EqKT).
*Results* The EqKT approach creates a matrix through which teams of knowledge stakeholders (researchers, practitioners, and policymakers) can set common ground for taking collaborative action on health inequities.
*Conclusions* Our approach can contribute to the call by the WHO Commission on the Social Determinants of Healths for more reasonable action on health inequities by being incorporated into numerous public health settings and processes. Further steps include empirical applications and evaluations of EqKT in real world applications.

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## Introduction

Health inequities are a major global health priority, reflecting a longstanding public health agenda connecting social and environmental injustices to population level health inequalities. For example, in Canada, recent strategic directives reflect a more ensconced commitment to health equity in research (CIHR 2009), policy advocacy (National Collaborating Centre for Determinants of Health 2010), and practice (Ontario Agency for Health Protection and Promotion 2009; Lemstra and Neudorf 2008; Vancouver Coastal Health 2006). There is also a concern about policy inaction as health inequities continue to widen in many jurisdictions (Friel and Marmot 2011; Goesling and Firebaugh 2004). According to the WHO Commission on the Social Determinants of Health (2008), health inequities persist because of an inability or unwillingness to act on entrenched social injustices, due to ideology, lack of leadership, and societal indifference.

To address the injustices at the root of health inequities, the Commission appeals to *reasonable action* for global action on health inequities:

> Where systematic differences in health are judged to be avoidable by *reasonable action* globally and within society they are, quite simply, unjust. It is this that we label health inequity. (p. 26, emphasis added)

While it seems a truism to say that social injustices and resulting health inequities are unreasonable, it is also evident that it is not a *lack* of reason that permits them to exist, but rather *competing* rationalizations of their sources and

continued existence. Such reasons may originate in vested interests, opaque decision-making processes, and dogmatic ideologies that are operative within society. For Sen (2009), of the key to achieving justice is to confront these forms of bad reasoning head on:

> …central to the point in dealing with [injustices] is that prejudices typically ride on the back of some kind of reasoning–weak and arbitrary though it might be. Indeed, even very dogmatic persons tend to have some kinds of reasons, possibly very crude ones, in support of their dogmas…*There is hope in this, since bad reasoning can be confronted by better reasoning*. (Sen 2009, p. xviii, emphasis added)

In this sense, the concept of knowledge translation, now widely embraced among policymakers, researchers, and practitioners provides one way to consider how to create conditions for better reasoning within decision-making. In this paper, we aim to contribute to this effort by outlining a framework, called equity-focused knowledge translation (EqKT) that provides a means to move toward better reasoning in knowledge translation practice.

The EqKT framework departs from the prevailing procedural focus in knowledge translation that focuses on the movement of knowledge *objects* (e.g., scientific facts, policy best practices), through better alignment of knowledge production and decision-making domains (Graham et al. 2006). Instead, EqKT proposes a relational perspective on knowledge *subjects*, emphasizing how the conditions of knowledge production and use *influence* not just what we decide to do with knowledge, but what stakeholders are to be, in terms of *how we act* within and through knowledge. This approach recognizes the relationship between knowledge and power in the institutional, communicative, and regulatory conditions of knowledge production and use that are either reasonable (equity producing) or not (inequity producing).

The core principle of the EqKT framework is that equity enhancing decisions (i.e., better reasoning) must attend to the relationships that we have with knowledge and, by extension, with each other in collective processes of knowledge formation and its use toward health equity objectives. Such relationships can be achieved by a collective commitment to examine and guide *what* knowledge to produce, *how* it should be communicated, and *what* impacts it is expected to deliver. To make our case, we first provide an account of the progress and limitations in knowledge translation, focusing on prevailing positivism in the field. Second, we argue for a "Third Wave" in knowledge translation that reflects a post-positivist turn from "Second Wave" population health research. Finally, we set out parameters of an approach that is guided by *critical inquiry* and *reflexive practice* as two necessary conditions for collective knowledge translation practices aimed at achieving health equity.

## The state of the art in knowledge translation

Knowledge translation stems from a longstanding effort in dissemination research and practice to address imbalances between knowledge production and application (Kitson 2008). While the term is widely adopted, its theoretical and empirical development is nascent, with Graham et al. (2006) Knowledge-to-Action (KTA) model being the most widely accepted approach, at least in the Canadian context. The basic tenet of the KTA model is to guide the complex and dynamic nature of knowledge-to-action processes, by placing knowledge production and its application into a cyclical, iterative process. By aligning producers of research and decision-makers around the specific "steps" within the knowledge-to-action cycle, proponents suggest that more effective and efficient knowledge translation can take place.

But mainstream knowledge translation practice rests upon two assumptions that may limit its ability to discern whether action can enhance health equity. First, an implicit positivism within knowledge translation models depend upon a "banking approach" to knowledge, implying that if the 'right amount' of the 'right' facts (e.g., existence of a disparity in a measurable population health outcome) can get to the 'right' people (e.g., an agent with authority and capacity to enact a decision), then health equity will be enhanced. However, this approach misses a crucial point: it assumes that health inequities are the result of a knowledge deficit or a knowledge-to-action gap, rather than due to intentional priorities, and interests such as productivity, prosperity, austerity, or competitiveness, common in neoliberal approaches to health governance (Coburn 2000, 2004).

A second, assumption in conventional KT practice is that stakeholders share a common aim, understanding and ability to work together. This assumption implies that barriers to knowledge translation arise mainly from procedural constraints (e.g., organizational obstacles, resource constraints, or time), as opposed to epistemological distances or uneven power relations. The remedy is to improve communication by 'getting everyone in the same room' and using a shared model. But what is not addressed is, "who" decides what knowledge is, when knowledge is ready for translation, what participants are necessary to effectively translate knowledge, which KT model should be used, and when to know if stakeholders are equally prepared, willing, and capable to engage in knowledge translation. A mechanism is needed to respond to differences, limits, and politics in relation to the power to define the conditions of knowledge translation, particularly when

there is ostensible agreement on a common goal—to reduce health inequities—but in fact there lacks common ground on how health inequities are even defined, let alone acted on.

## The need for 'Third Wave' knowledge translation

Scientific evidence does not exist in a vacuum, nor is it the only form of knowledge to account for social injustice. There are many alternative explanations for social inequalities in health, each invoking justification for (in)action, such as economic (e.g., no good cost-benefit analysis), ideological (e.g., the "deserving poor"), or political (e.g., fixed, short term election cycles). Disagreements even exist among proponents of health-centric explanations (e.g., blame the system or victim). Thus a problem of the knowledge deficit model is its limited account for sources, strategies, and effects of particular knowledge claims and their effects within a wider arena of stakeholders, including politicians, lobbyists, the media, activists, and the general population. There is a need for critical contextual analysis of how health inequity priorities are identified or obscured, prioritized or marginalized, and acted upon or dismissed. By interrogating how priorities emerge, it becomes possible to identify underlying logics that create proximate organizational limitations, procedural antecedents, and ideological leanings that obscure if not obstruct health equity aims.

Two main traditions of inquiry in population health research illustrate the difference between evidence of the existence of health inequalities, and the interrogation of their sociopolitical antecedents, commonly referred to as Second and Third Wave research (Östlin et al. 2011, see Fig. 1[1]). Second Wave research is premised on the use of quantitative population-based and spatial analysis as the means to *expose* the existence and characteristics of social inequalities in health in relation to geographic and demographic factors, and thus inform public health interventions to mitigate them. But, Second Wave research has fallen short in accounting for the conditions that create social inequalities in health and allow them to persist over space and time.

Third Wave research addresses this lacuna by focusing on *explaining* the underlying societal arrangements through which health inequities manifest, and thus informing action to change such arrangements at the political level. Third Wave research builds upon decades of theoretical development and empirical demonstration within the social sciences; exploring the historical, psychological, sociological, and geographical dimensions of health inequities as rooted in political ideology, culture, and economy. Unlike the bird's eye view of Second Wave research, social theories of health provide in-depth accounts of health as a function of and in society, connecting these to systemic structures to overcome the artificial distinction between research "about" the world and action "in" the world. In the sense Third Wave research focuses not just on how social injustices "get under the skin" to disrupt health, but also "getting under our skin" in terms of prompting more critical orientation to our own knowledge work as well as to others who are complicit in rationalizing social injustice.

Through the contributions of Second and Third Wave research, we know inequities are becoming more severe and globally ubiquitous resulting in coalesced advocacy at all levels to address root causes in social injustice. But efforts to translate this knowledge into action have been equivocal—little progress has been made in alleviating social injustice or reducing inequities. This paradox of a "normative" state of inequity and seemingly insurmountable barriers to tackle them suggests we have not learned how to "act". "Learning to act" is the definition of and formidable task for, EqKT.

## Equity-focused KT: implementing the 'Third Wave'

We argue that knowledge translation to address health inequities can be more effective by embodying a Third Wave paradigm. For each wave of population health research, it is possible to characterize corresponding knowledge translation practice. Knowledge translation of the First Wave, or 'biomedical' tradition in research, centres on evidence-based practice, where scientific insights on biological mechanisms of disease and interventions are provided to clinicians to improve the health of individuals. Similarly, in Second Wave knowledge translation, typified by Graham et al.'s (2006) KTA model, evidence-based population health knowledge is scaled up to organizational and system levels, where best practices are shared among knowledge translation actors to support desired outcomes. But how to translate Third Wave research has been underexplored.

Part of the challenge is that the positivist approach in knowledge translation (Rycroft-Malone 2007) conforms to a *pluralist* perspective of policy, which views knowledge translation as the application of the 'most accurate', 'most valid' or 'most reliable' facts to move decision-makers toward better (i.e., more evidence based) health policies and practices (Raphael et al. 2008). By contrast, Third Wave health research applies social constructionist epistemology where objective knowledge by the distant observer (Blaikie 2007) is rejected in favor of a willingness to intervene in the

[1] The "First Wave" refers to the biomedical perspective in health research, which, in its focus on physiological vulnerabilities and clinical outcomes, has limited relevance to health equities, except insofar as it takes up the lion's share of health research funding in Canada and around the world.

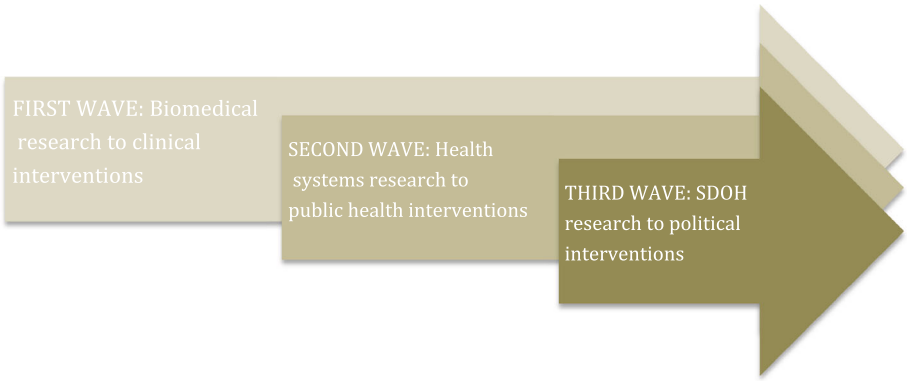


**Fig. 1** Three waves in contemporary health research. Adapted from Östlin et al (2011)

world. A social constructionist approach explores the social, cultural, economic, ethical, emotional, and intellectual conditions of knowledge production (Fook 1999). Ample social science scholarship demonstrates that policies are enacted as much on the basis of ideologies, party politics, vested interests, and even outright prejudice as much as on scientific evidence or expert influence (Fort et al. 2004; Harvey 2005). This perspective on policy is what Raphael et al. (2008) describe as the *materialist* perspective; policies are proposed and rationalized that align with pre-established ideologies which reproduce a particular "accepted reality" that may not coincide with scientific facts, but nonetheless advance particular political objectives.

Thus, a Third Wave approach to knowledge translation would recognize the power relations that underpin policy decisions that arise when certain "accepted realities" are promoted over others. EqKT is not about mobilizing "what we know" (i.e., Second Wave thinking), but introduces a *reasonable* process for understanding and shifting "how we know" so that a more equitable and just reality can be pursued (i.e., Third Wave acting). Building on Sen's appeal for better reasoning we now describe the application of our EqKT framework to build collaborative knowledge relationships to promote health equity.

## Critical inquiry of knowledge

The first component of EqKT is to conceive of knowledge translation as the circumstances that enable particular realities to be accepted, and others to be subordinated or dismissed. Through this view, knowledge translation encompasses all of the techniques that mobilize knowledge and permit it to have effect. Whether formal or informal, driven or unanticipated, such techniques make particular realities possible through the conditions in which knowledge is produced, communicated, and acted upon (see Foucault 1991, 2001). To identify such techniques, we ask:

(a) *How and where is knowledge produced?* Techniques of knowledge production involve the structures that enable the creation of knowledge, including "hard" infrastructure (such as universities, funding organizations, policy units, and think tanks) and also include "soft" infrastructure, including technologies and resources that provide access to knowledge (for instance, online databases, courses, newspapers, and other methods of knowledge storage, aggregation, and interpretation). Analyzing production techniques involves examining where knowledge resides and is channeled within 'hard' and 'soft' infrastructures, by scrutinizing the resources and limits placed on knowledge, as well as the methods or institutions that give certain ways of knowing legitimacy over others. Concomitantly critical inquiry scrutinizes the methods by which knowledge confers legitimacy upon institutions, and their spokespersons over others (e.g., the authority ascribed to universities, conferences, professors as compared to community groups, street protests, elders), as well as the implications of such effects.

(b) *How is knowledge communicated?* Techniques of knowledge communication refer to the discursive power of language in authorizing and delineating boundaries over ways of knowing, including how the language of 'science' elevates certain perspectives over others. Techniques of communication include the narratives that reproduce, reinforce, and legitimize particular claims, including who is as an 'expert' and how expertise subordinates other perspectives (e.g., how quantitative and qualitative perspectives treat people as "data" rather than formidable sources of knowledge and agency). Critical inquiry into techniques of communication involves "thick description" of knowledge claims in order to contextualize the reality claims of the author(s) within their positions in relation to such reality (i.e., above, or apart from reality versus below and embedded within reality).

(c) *What does knowledge "do?"* Techniques of knowledge governance refer to knowledge put to work at a distance to influence a population's health choices

and behaviors. Techniques of governance are exercised in the management of populations through norms, routines and values that individuals are empowered to abide by as 'good' or 'active' citizens (Cruikshank 1999). In lifestyle approaches to population health, we are motivated to exercise, eat well, and not smoke in order to be healthy (i.e., a behavioral imperative). In doing so, we are also compelled to do our part to produce a healthy population that is more efficient and less costly (i.e., an economic imperative) as opposed to taking political action against social injustices that we see everyday around us and make some of us unhealthy. Critical inquiry into techniques of governance entails the interrogation of strategies through which health discourses encourage personal responsibility for the health (e.g., by becoming self-managing, and compliant with norms and regulations, or taking direct action in pursuit of social and political change). The analysis of techniques of governance makes it possible to discern who is obliged to act to reduce health inequities (e.g., individual victims, public health practitioners, and/or governmental policymakers), and who benefits from such actions (e.g., presumably healthier populations, but also the career advancement of researchers and the institutions that they work in/for).

Together, these techniques of knowledge inquiry offer an interpretative lens for critical analysis of knowledge sources and uses, and provide the basis for reflexive examination of one's own capacities and limitations within knowledge translation practice. Analyzing knowledge translation through one's own use of these techniques illuminates the extent to which we may intervene to support more equity-focused approaches.

## Reflexive practice in knowledge translation

While the substance, boundaries, and functions of accepted realities can be discerned through critical inquiry, *reflexive practice* reveals one's own influence within these systems. Locating our own position in reality construction provides insight into our assumptions, biases, contradictions, and possibilities for justice (Holland 1999; Jasper 2003). In EqKT, reflexive practice identifies possible pathways to overcome poor reasoning, including decisions that prevent or evade social justice. In our framework, reflexive practice includes the following process of self-examination:

(a) *How do we recognize all perspectives? Inclusivity* involves recognizing that power dynamics are the norm in knowledge relationships, particularly when considering the plurality of stakeholders involved in knowledge translation. Within research, exclusive power and influence are often created through specialized institutions, discourses, and practices that reflect classes of experts. Within knowledge translation, affected groups may be seen as mere beneficiaries of research, as opposed to experts whose experiences and contextual understanding can mobilize more just realities independently of formal research processes. Inclusivity is the ability to discern one's own power to include (or exclude) others and to identify where and why power is given (e.g., in terms of social, professional or financial status or personality).

(b) *How can we be transparent about our motivations and limitations?* To be *transparent* means being open and flexible about our goals, biases, and limitations in collective work. In EqKT, transparency means prioritizing the access of those most affected by health inequities to knowledge translation. Being accessible facilitates questions and critique of our assumptions and processes. Openly recognizing and discussing shared limitations provide opportunities to recognize the potential for group transformation, including seeking out perspectives, resources, and opportunities that reveal previously unseen or unacknowledged realities.

(c) *How do we work together toward common goals?* Finally, *humility* as a reflexive practice invokes the notion of "servant leadership" in working collectively (see Morris et al. 2005). Effective leaders work for the benefit of others, many of whom occupy social positions with less influence. Humility is a willingness to check one's own claims to expertise or authority and to realize that our contributions are no more important than—and are in fact often predicated on—the insights and contributions of others, particularly among those perceived as occupying socially disadvantaged positions. Thus, through humility, the locus of action can be as much on transforming one's own organizational priorities as it is on a collective external policy pursuit.

## Integrating critical inquiry and reflexive practice

Our EqKT framework places critical inquiry and reflexive practice on a matrix (Table 1). Working through this matrix provides individuals and groups with a pathway for "reasonable action". Set in this way, reasonable action involves working collectively through the questions in the 13 cells (letters "a" through "m"). The reflections generated from this process provide understanding of 'how we know' in terms of the root causes of social injustices, and

**Table 1** A practice-based framework for equity-focused knowledge translation

| | | CRITICAL INQUIRY | | |
|---|---|---|---|---|
| | | **1. Techniques of Production** | **2. Techniques of Communication** | **3. Techniques of Governance** |
| PREPARATION | **STEP 1. Situate yourself.** | a. Who am I? (a researcher, policymaker, parent, citizen, etc.) | b. How do I speak? (key ideas, concepts, methods, values, motivations) | c. What do I propose? (individual behaviour change, collective action, systemic transformation) |
| REFLEXIVE PRACTICE | **STEP 2. Inclusivity.** Identify your inclusionary and exclusionary practices. | d. Who is included in my work and who is excluded? What barriers to participation do I uphold? What can I do differently? | g. What circumstances give me the authority to speak? What language do I use? Whose knowledge do I reflect? What can I do differently? | j. Where do I place responsibility for health inequities and action on them (victims, communities, governments)? What can I do differently? |
| | **STEP 3. Transparency.** Discern the extent to which you are transparent to others about your practices. | e. How much value do I place on my own knowledge versus that of my peers? Do I actively seek out other perspectives? What can I do differently? | h. Do I listen before I speak? Do I announce or do I reflect? To whom do I listen? Am I well understood? What can I do differently? | k. How do my contributions work within or against existing power relations? What can I do differently? |
| | **STEP 4. Humility.** Reflect on your approach to leadership. | f. How do I convey my limitations in terms of my status, capacities, vulnerabilities and needs? What can I do differently? | i. How do I my claims to expertise prevent me from recognizing the voices and/or potential contributions of others (i.e., community, professional, academic) and why? What can I do differently? | l. How do I convey my priorities? What can I do differently? |
| TRANSFORMATION | **STEP 5. Reasoned Action.** Use reasoned action with others to envision change. | m. What previously unseen opportunities for equity focused knowledge translation emerge (new collaborations, research questions, new policy prescriptions, new advocacy initiatives)? What can WE do differently? | | |

in discerning our own and other's stake within such systems to identify collective approaches to change. The first step is for each knowledge stakeholder to situate themselves within the production of a particular reality (cells a, b, and c) which sets a process through which to critique that reality (cells d through l) and transform it (cell m).

With techniques of production, reflexive practice allows stakeholders to deconstruct the institutional 'bricks and mortar' from their collective position, including the relative access to institutions among colleagues and partners, as well as those institutions that are not typically given authority. This process allows groups to determine the origins of inclusionary and exclusionary power (cell 'd'), as well as each group member's possible complicity and leverage within this field of power (cell 'e'). Finally, it allows knowledge subjects to identify the collective power in working in service to others' identified aspirations and accomplishments (cell 'f').

Reflexive practice within techniques of communication examines our use of language and claims to expertise as a

basis for exerting authority when making knowledge claims. It provides an opportunity to reflect on the extent to which language reflects the perspectives and priorities of affected people or communities (cell 'g') and determines whether the community's voice is authentic or co-opted by the (mis)interpretations of others (cell 'h'). In seeking community perspectives, reflexive practice debunks the assumption that one has more validity than others, suggesting that collective consciousness-raising can lead to a complete understanding of complex problems as well as appropriate priorities (cell 'I').

Finally, reflexive practice within techniques of governance questions the aims of stakeholders engaged in EqKT. It involves reflection upon the extent individual roles and communities are coordinated or differentiated (cell 'j'), both in terms of positions (e.g., researchers/researched binaries versus knowledge partnerships) as well as the goals within these roles. Through collective reflexivity, it becomes possible to discern how roles are limiting or self-serving (cell 'k'), and how individually produced or initiated strategies contribute to the problem (cell 'l').

Ideally, the matrix in Table 1 can be applied continuously and intuitively, by those committed to working toward common goals. Examples include a research team engaging with a community to study a particular health inequity, a knowledge translation workshop by public health officials to learn how to work together on shared problems, or in direct community action among community leaders who seek to build collective action toward a common solution. In a collective process, each participant works through the matrix to identify their own knowledge practices. Individuals share their reflections with others, thus forming the basis of relationships. Assumptions are mapped out, with both complementary and distinct perspectives juxtaposed and integrated (see Fig. 2). Ideally, the process continues as an inherent part of people's relationships with each other, so assumptions are revisited, and avenues for inclusivity, transparency, and humility identified (e.g., gaps closed, collective changes proposed). Through this cyclical process, gaps, strengths, synergies, and priorities will become clear, and collective strategies for reasonable actions will emerge that are better positioned to advance common equity aims (cell 'm').

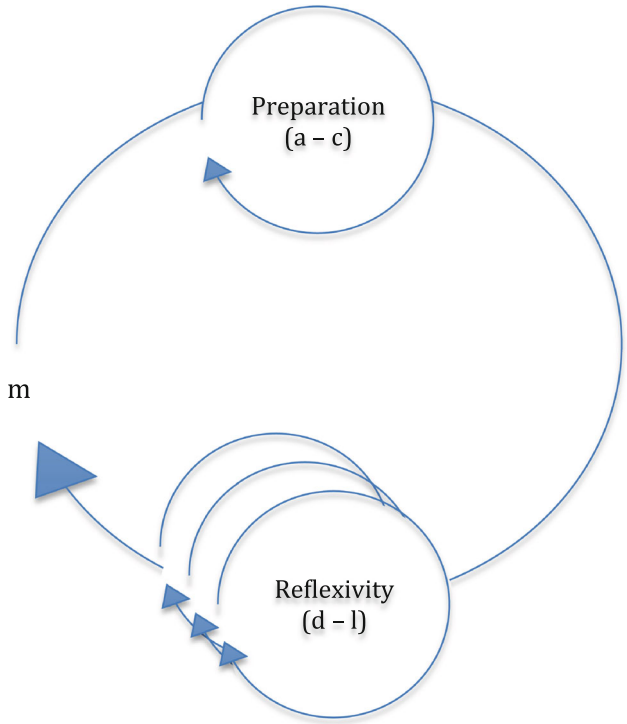


**Fig. 2** Cyclical process of EqKT. Through repeating cycles, both individual and collective 'positions' within knowledge systems are exposed and ultimately acted upon (represented by '*m*')

## Conclusion

In this paper, we have outlined a conceptual framework for EqKT, premised on a notion of knowledge translation as a collective commitment to critical inquiry and reflexive practice. Our framework departs from the procedural focus of more positivist models, arguing for 'Third Wave' knowledge translation that focuses on the relational dimensions of knowledge construction.

The EqKT approach serves three main purposes. First, it provides a means to critically analyze *existing* systems responsible for defining and delineating "how we know" about health inequities. Second, in adopting a reflexive orientation, our approach scrutinizes prevailing systems from one's own position and influence, exposing its flaws, gaps, and openings in relation to its constituent techniques of production, communication, and governance. Third, EqKT provides the opportunity to transform one's own relationship to knowledge, so that in knowledge practice one can learn to work with inclusively, transparently, and with humility to reveal *alternative* realities and pathways for collective action on health inequities.

The outcome of EqKT might entail a resetting of assumptions of knowledge institutions, discourses, and aims (e.g., universities and hospitals as main repositories of health knowledge occupied by scientist 'heroes' and 'progress'; communities as simply beneficiaries or even disenfranchised victims in need of education or guidance). In opening up alternative possibilities, we may discover new forms of expertise and leadership, especially among those worst affected by health inequities. We may uncover the limitations and possible biases within the numerical emphasis of scientific approaches to health equity, which claim to be objective accounts of the

truth, in favour of powerful testimonials of social injustice encounters and resiliences that speak truth to power (Holmes et al. 2006). We may find ourselves opposing governmental policymakers that are beholden to ideology, mobilized by vested interests, as much as they are purveyors of 'evidence' and of 'best practices'. Finally, in mobilizing Third Wave knowledge translation, we may find that the business of health equity is not exclusive to research, policy, regulations, and public awareness campaigns, but may include direct action, including civil disobedience measures communicating anti-poverty, anti-racism, anti-sexism, and anti-corporate messages such as we are witnessing in grassroots led actions taking place around the world.

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