

Case Study: Bridge for Health, Vancouver, Canada

Key features:

The case study of Bridge for Health, a grass-roots network, describes how a 'co-op' model contributes to building ownership and accountability for health promotion and population health. It facilitates equality in decision-making (1 member = 1 vote), promotes mentoring and youth engagement (as many members of Bridge for Health are young people) and mobilizes more inclusive and participatory models for realizing population health and well-being.



Key features of the work that could potentially be adapted/adopted elsewhere include:

1. How to use the social and intellectual capital available to an organization, as Bridge for Health has done, to bring about change and 'grow' the model of participation for improved population health and wellbeing.
2. Applying the co-op model, as used by Bridge for Health to enable Bridge for Health's organisational practices that are consistent with the network's underlying values and principles of participation and as a vehicle for social change.
3. The Bridge for Health 'Healthy Business Framework', which is focused on strengthening workplaces as a key arena for citizen participation in health, through the improved engagement and empowerment of working adults/employees.

Introduction to the site and its practices:

Canada is a high-income country, with few formal vehicles for direct public participation in health system decision making beyond general participation in the political system. Bridge for Health (B4H) was founded in 2013 as a Vancouver-based volunteer network to foster collaboration, knowledge-sharing and social action to promote citizen engagement in health. As a grass-roots network, its initial focus was on promoting, intersectoral action for health at a local and national level, including health policy engagement.

Three years later, B4H has evolved into a service-oriented social enterprise focused on three core service areas: community capacity building; advocacy and influencing; and research and consulting. Examples of initiatives for fostering engagement to date include: a local youth health literacy project using PhotoVoice in British Columbia; a monthly speakers' series in partnership with Burnaby Metrotown Library; a social media platform for youth to engage in global health discussions linked to the World Health Organisation (WHO) health promotion conference (2016); and co-hosting a national town hall with the Prevention of Violence Canada coalition and the provincial and national Public Health Association in Ontario. The B4H social enterprise uses a co-operative model ('co-op' model), launched in fall of 2016. It was developed based on two years of consultation with community members, thought leaders in public health and business, NGOs and government agencies, as well as students and academics around the world. The co-op model fits the B4H collective leadership approach and its values associated with empowerment, collaboration and citizen engagement.

The case study was prepared in February 2017 by Sarah Simpson, TARSC consultant with key informant input from Paola Ardiles Co-Founder, B4H and Rebecca Zappelli, Co-Founder, B4H Co-op and focal point for the site.



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Context:

British Columbia is the western-most province of Canada (see map), with a population of more than four million people located between the Pacific Ocean and the Rocky Mountains. Vancouver is largest city and metropolitan area in British Columbia and is one of the most ethnically and linguistically diverse cities in Canada (Wikipedia 2017). Canada is one of the healthiest nations in the world with British Columbia being the healthiest province of Canada. A 2010 report found that residents of the province had the best health behaviours in Canada, including the lowest rates of cigarette smoking, of heavy alcohol drinking and unhealthy weight and the highest rate of participating in active or moderately active physical activities. Of the ten chronic conditions reviewed, women had lower prevalence rates than men for four chronic conditions (diabetes, cardiovascular disease, cancer and chronic obstructive pulmonary disease) and higher rates for hypertension, asthma, depression, dementia, osteoarthritis and rheumatoid arthritis. Prevalence rates for all ten chronic conditions increased in both men and women in British Columbia in recent years. Increases were found in all age-standardized disease prevalence rates except cancer. There are health inequalities within the province. For example, the Northern Health Region had the highest prevalence rates and increases in noncommunicable diseases such as for hypertension, cardiovascular disease and asthma (Provincial Health Services Authority, 2010).



The 2016 Canadian Index of Wellbeing report which looked at trends for 1994-2014 found that the gap between gross domestic product and wellbeing is considerable and growing. The Index is a composite of eight domains across which wellbeing is measured: community vitality, democratic engagement, education, environment, healthy populations, leisure and culture, living standards and time use. In the 'healthy populations' domain, life expectancy had improved and there are positive outcomes such as declines in teen smoking. However Canadians are not rating their overall health as positively as before and people on low incomes have been most affected in this domain (Canadian Index of Wellbeing, 2016). This is mirrored at the provincial level. British Columbia is doing relatively well on health behaviours compared to other provinces, but it does not rank as highly as other provinces in terms of self-reported physical or mental health and quality of life. Residents ranked seventh (out of 13) in perceiving their health as excellent or very good, ninth in perceiving their mental health as excellent or very good, had the third highest ranking in perceiving their life stress as quite a lot, and ninth lowest in being satisfied or very satisfied of their lives (Provincial Health Services Authority, 2010).

Canada's Aboriginal population in 2006 was 5.4% of the population and composed of three distinct groupings: First Nations (North American Indians), Inuit and Métis. The Inuit are a distinct population of Aboriginal people and the Métis population consists of people of mixed First Nation and European ancestry who identify themselves as Métis. Métis are distinct from Status Indian people, Inuit, and non-Aboriginal people and are not entitled to the provisions of the *Indian Act* (Office of the Provincial Health Officer, 2012). First Nations and Métis are disproportionately affected by conditions such as diabetes, hypertension, heart disease, tuberculosis, HIV and foetal alcohol spectrum disorder, with First Nations people living on reserves experiencing a higher rate of physical injuries than the Canadian average (Office of the Provincial Health Officer, 2012). While Inuit populations are less affected by these conditions, in part due to more traditional and less sedentary lives, they are 'catching up' due to current trends in lifestyle and diet (Marchildon, 2013). There were 196,075 Aboriginal people living in British Columbia (2006) including: 129,580 North American Indian, 59,445 Métis, 795 Inuit, and 6,255 identified with multiple or other groups (Office of the Provincial Health Officer, 2012).

Canada has 13 provincial and territorial health care systems that operate within the 1984 Canada Health Act. The Act sets out the standards to which provincial health insurance programmes must conform to receive federal funding (Canada Health Transfer): universality, portability of coverage among provinces, public administration, accessibility, and comprehensiveness, the latter defined as medically necessary health services provided by hospitals and physicians (Marchildon 2005 in Hutchison et al., 2011). The provinces and territories administer their own universal health insurance programmes, covering all provincial and territorial residents according to their own residency requirements (Health Canada, 2013a in Allin and Rudoler, 2016). Organization and delivery of health services is the primary responsibility of provinces and territories. Most have established regional health authorities to plan and deliver publicly

funded services locally. Regional Health Authorities also commonly fund and deliver hospital, community, and long-term residential care, mental and public health services. In British Columbia, the Ministry has overall responsibility for ensuring that quality, appropriate, cost effective and timely health services are available for all residents. Health service delivery of a full continuum of health services is the primary responsibility of the five regional health authorities. The Provincial Health Services Authority, is responsible for managing the quality, coordination and accessibility of services and province-wide health programmes (Ministry of Health, 2016). Each British Columbia health authority has an Aboriginal health team that leads the work for the health authority in developing and implementing its Aboriginal Health Plan. The authorities have all signed partnership accords with First Nations Health Council Regional Caucuses to facilitate greater collaboration with the First Nations Health Council, the First Nations Health Authority and the local regional health authority (Aboriginal health directorate, no date).

Canada has few formal vehicles for direct public participation in health system decision making beyond general participation in the political system. The elected Regional Health Advisory boards introduced as part of regionalization, were meant to extend participation, however most board members are appointed by provincial ministers or ministries of health. This means that participation is largely limited to input from self-selected or appointed citizen advisory groups (Marchildon, 2013). Archived content of the Public Health Agency Canada (2013) identifies a continuum of activities from communication, consultation, to citizen engagement for ensuring opportunities for meaningful input by citizens in health priorities, strategies and evaluation. This includes five public involvement strategies: 1) inform and educate, 2) gather information and views through listening activities, 3) discuss with or involve stakeholders to encourage discussion to influence final outcomes, 4) engage citizens to encourage them to talk to each other and to shape policies and decisions that affect them and 5) partner to empower citizens and groups to come up with the solutions and implement them (Public Health Agency of Canada, 2013).

Some of the regional health authorities have created community engagement teams such as Vancouver Coastal Health, who have a range of ways for engaging communities, including the community engagement advisory network, public advisory committees, patient and public consultations, community participation and capacity building for VCH staff for engaging with patients and families regarding their health care needs (Vancouver Coastal Health, 2014). In early 2015, the Ministry of Health in British Columbia engaged in a discussion process with health authorities, workers and service partners' proposals to support reorientation of the system in alignment with the 2014 strategic plan and priorities. A primary and community care forum in Vancouver was also held (Ministry of Health, 2015). A regular Commonwealth fund survey of public views of the health care system (2013) found that among Canadian respondents, 50% thought fundamental changes were needed and 8% thought the system needed to be completely rebuilt (Mossialos et al., 2016). The democratic engagement domain of the Canadian Index of Wellbeing refers to being involved in advancing democracy through political institutions and activities. In relation to this domain, the 2016 Index report found that Canadians are participating more in democracy, as measured by increased voter turnout and a decrease in the voter age gap. However only 2% of Canadians volunteer for a political party or advocacy group, only 66% felt satisfied with how democracy works in Canada and only 35.5% had confidence in Parliament in 2014 – a new low (Canadian Index of Wellbeing, 2016).

Setting Priorities for the British Columbia Health System (2014) outlines the strategic plan for the British Columbia health care system by the Ministry. This was followed by a series of policy papers focused on key health care priorities to help government, health authorities and providers remodel the health care system to better meet the needs of the patients (Ministry of Health, 2014). The overarching goal of Setting Priorities is “to meet population and patient health needs” listed as staying healthy, getting better, living with illness or disability and coping with end of life. One of three goals are supporting the health and well-being of citizens. Two of the eight priority areas for service delivery and action are: to implement a targeted and effective prevention and health promotion through a co-ordinated delivery system using nudging as an instrument for behavioural change; and to implement a provincial system of primary and community care built around inter-professional teams and functions (Ministry of Health, 2014).

The participatory practices:

Bridge for Health started in 2013 as a self-organized local and global network that aims to shift the public dialogue about health from illness to wellbeing in Vancouver, Canada. Paola Ardiles founded the network based on her lived experiences and her work in the field of health



promotion, including as founding manager for Canada's first provincial multi-sectoral health literacy network in the area of mental health and substance use. One of Paola's motivations was having a network for health promotion that incorporated a more holistic view of health and provided greater opportunities for individuals and communities outside of the health system to have a say and to be agents of change. To start, she held a meeting with a group of 20 people that she knew, but who did not necessarily know each other, to advance her initial idea. Many of the participants had a shared sense of purpose about creating health beyond the health system, but many were also frustrated in the workplace, including those working in the health system, about how to bring about change. The network has evolved organically over 3 years, taking time to identify where B4H can best contribute, such as in working in collaboration with existing initiatives and moving towards the co-op model, described later.

B4H has a strong focus on broadening the field and practice of health promotion, including health literacy, to incorporate a more holistic view of health, the social determinants of health and to ensure citizen engagement (Casteleijn, 2014a). It seeks to: "... to ignite a global movement to strengthen democracy by ensuring that people are engaged in the decision-making processes that ultimately shape their health." (B4H, 2016a) This includes participatory activities to shift or 'disrupt beliefs about health' away from health care and illness to wellbeing, from seeing only top down solutions to bottom up solutions, by enabling others to gain control over the conditions that impact on their health, and by taking responsibility for engaging with other sectors (Ardiles, 2016).

We recognize that 'health' is a complex, dynamic and holistic concept. We also recognize that health is a fundamental right, and that each and everyone of us has a role to play in terms of creating healthy communities, whether at home, in schools or at work. (B4H, 2016b)

Bridge for Health is guided by the following principles: **engagement** defined as actively involving individuals and collectives in the production and co-creation of opportunities, processes and outcomes; **empowerment** defined as accessing and realizing personal and/or collective power to promote the psycho-social, political and cultural strengths of individuals and communities; **enablement** which is creating connections and positive patterns of interaction that allow individuals and collectives to develop and grow by building on strengths; and **ease** by supporting collaboration in ways that are self-organizing and organically contribute to the overall goals of Bridge for Health.



B4H Co-op Launch, 2016 © Bridge for Health 2016

After two years of consultation with community members, thought leaders in public health and business, non-government organisations (NGOs), health authorities, students and academics at home and internationally, B4H decided to become a social enterprise (see *Appendix 1*) that focuses on three core service areas: 1) community capacity building, 2) advocacy and influencing and 3) research and consulting.

In December 2016, B4H was incorporated as a **co-operative association** with four female co-founders and 32 members. The model enables collective leadership and promotes a shift in conceptualizing knowledge sharing, to one in which public health solutions are generated both within informal systems (i.e. communities, schools and workplaces), and formal systems (i.e. health and social care systems). For example, co-ops and credit unions use a system of one-member/one vote, not one-vote-per-share and this helps them to serve common interests and ensure that people control the organization (B4H, 2016c). Such a model enables the co-op to undertake socially innovative research and consulting with local businesses and organizations to co-design healthy social and built environments that promote wellbeing (Ardiles, 2016). Other advantages of the co-op model are that it: allows member-owners (criteria currently being defined) to solidify social and economic links in the community; builds confidence and skills through mentoring and knowledge sharing; promotes inclusiveness, collective leadership and shared ownership and offers varied levels of engagement via general and 'worker' memberships.

B4H also established a global expert advisory group and core team with a wide range of skills in: public health, equity, business administration, project management and evaluation, community engagement, IT, education and leadership development. Individuals that comprise the global expert advisory group were

identified by the co-founders because they were leaders in their field and could contribute to B4H strategy development and global engagement. The co-op has also established links to academic partners around the globe, and network contributors that are experts in various fields contributing to B4H's strategy and content. In 2017, B4H will be developing the mechanism to support local and global network contributors to become formal co-op members that is, to formalize their shared ownership in B4H as a legal entity (i.e. receiving a membership share).

Examples of initiatives for fostering engagement to date include: a local youth health literacy project using PhotoVoice; a monthly speakers' series in partnership with Burnaby Metrotown Library; facilitating a social media platform for youth to engage in global health discussions linked to the 2016 WHO health promotion conference; and co-hosting a national town hall with the Prevention of Violence Canada coalition and the provincial and national public health association in Ontario. Town halls bring together broad sector representation to discuss progress, current violence prevention issues and guidance in moving forward. The town hall meetings have representation that potentially includes public health associations, researchers, educators, practitioners, government, nongovernment organizations and interested citizens. Most of these activities are linked with and build on the field of health promotion, with a focus on building an upstream and holistic view of health literacy. To date, many health literacy initiatives focus on individuals or specific diseases, often failing to acknowledge core health promotion principles of empowerment, the influence of the determinants of health and the importance of citizen engagement. Many health literacy and citizen engagement initiatives tend to focus on adults rather than young people. Among youth the needs of those who are disadvantaged are often not so well addressed or considered (Casteleijn, 2014a).



Youth engagement © Bridge for Health 2015

These research gaps were explored in the Bridge for Health *Moving Health Literacy Upstream Project* (2014-2015), with under-served youth aged 15-21 years in Vancouver, specifically urban Indigenous youth, newcomers and those living in poverty. Partnering with local community partners (RedFox Healthy Living Society and Big Brother Association of British Columbia), the Phase 1 project used PhotoVoice, an approach to engagement that applies participatory photography and digital storytelling methods. This project explored how upstream health literacy approaches could be incorporated into an existing youth healthy living initiative, the *Youth Warrior Program*. The *Youth Warrior Program* aims to support and empower youth from lower socioeconomic backgrounds with the goal being to engage youth in a range of participatory activities via weekly 2-hour workshops (from 17-19.00) focused on the development of life and leadership skills. It is delivered in conjunction with BigBrothersVancouver and United Way (Casteleijn, 2014a, 2014b). Participatory activities included researcher led icebreaker exercises to engage youth in talking about how they define health, the factors they perceive as having a positive or negative influence on their health, how they think voting and or other social factors that relate to their health and wellbeing. Workshops were also utilized, arranged by youth coordinators within the *Youth Warrior Program* and focused on themes such as; personal health, community engagement and physical activity. Group discussion was a key component of each workshop, with a theme was introduced to the youth to stimulate critical thinking and dialogue. Using the concepts explored, youth took photos (using their cell phones) in their community or neighbourhood of things that remind them of health and wrote up a short paragraph explaining why they made the photo(s) and what the photo says about their perception of health and wellbeing.

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Youth engagement © Bridge for Health 2016

Youth Leadership in Health Promotion Global Policy. B4H and the Public Health Association of British Columbia prepared a briefing report to the Scientific Conference for the 2016 global conference on health promotion. Two participatory activities were undertaken: a 90-minute discussion with a diverse group of 11 student leaders about why it is important for youth voices to be heard in conferences; and B4H youth launched a social media campaign from the 7th -30th of September 2015 using the hashtag

#EngagewithWHO. This campaign aimed to provide youth with a platform to share their opinions regarding health promotion issues. The campaign reached 6 601 individuals and organisations. The methods were co-designed, facilitated and analysed by young adult B4H network members. For example, the youth leaders chose the 4 questions posed on the social media site, and supported the analysis of results and the discussion and recommendations. The results from these two activities are captured in Bridge for Health's Engaging the Leaders of Tomorrow: a briefing report on youth engagement for the 9th Global Conference on Health Promotion. This briefing report resulted in the creation of a youth symposium at the World Health Organization's international conference in Shanghai in November 2016. In addition, a video Engaging the Leaders of Tomorrow was produced. This video linked health promotion and youth leadership to the UN Sustainability Goals and was launched at 22nd IUHPE World Conference on Health Promotion, Curitiba, Brazil.

Bridge for Health developed a **Healthy Business Practice framework** (see *Appendix 2*) that uses a systems approach to understand how social and physical environments at work can produce health. Over the last two years, B4H has conducted research to better understand the needs of employers and employees interested in improving health/wellbeing outcomes and how to apply the framework to produce health outcomes. Interviews and focus groups were conducted with business owners, managers, staff and human resources professionals, looking at the needs and gaps related to the social and physical environments that promote health and wellbeing in the workplace. Interviews highlighted that ill-health at work does not stem only from physical inactivity or poor diet, but also from poor workplace culture and employee disempowerment or limited engagement. Despite this, workplace wellness programmes typically tend to focus on getting employees to lead healthy lifestyles, such as encouraging the use of fitness centres or disease management programmes. Hence, many employees do not participate in these wellness programmes. An employee interviewed as part of the B4H research stated:

I wish my company had given us all a raise instead of spending a ton of money on this fancy gym that no one uses because we don't have time. (Key informant in Bridge for Health, 2016d)

Bridge for Health Co-op offers consulting and research services to employers to support them in both identifying health problems in their workplaces, and to work collaboratively with staff and management teams to find innovative solutions. B4H developed a series of 'wellbeing @work innovation labs' for socially driven businesses that are interested in expanding their current social responsibility practices to focus on improving health and wellbeing in their workplaces. The testing phase of the labs was completed in 2016. The innovation labs will be tailored to the specific needs of the business, but all are based on the Healthy Business Practice Framework. Experienced facilitators from B4H will take customers through a design thinking process, where they identify health-related problems and develop their prototypes to test out solutions in their specific workplaces.

As described in the examples above, a range of individuals from the community have been involved in the participatory activities of the network, with a strong focus on youth and on those who are often marginalised. The B4H network contributors range from artists, social scientists, architects, community activists, youth leaders, researchers, educators, and students, as well as health and social service providers. The development of the network has been intentionally organic, to create an inclusive space for interdisciplinary collaboration and citizen engagement and the contributions vary. Some members are interested in contributing skills and working on collaborative projects, others are simply interested in connecting with others who share their passion for promoting health (B4H, 2016e). As B4H has only become a formal legal entity as of December 2016, the specifics of the governance and membership policies (beyond those defined in the legal rules for co-operative associations) are being finalized and will be available by the summer 2017.

Factors and inputs affecting the participatory practices:

The co-founder of B4H, Paola Ardiles, brought to the network strong, pre-existing relationships and collaborations with a range of partners and associations - locally, regionally, nationally and globally. This includes: Simon Fraser University, the Public Health Association of British Columbia, the Canadian Public Health Association, the Prevention of Violence Canada Coalition, the Quaich, the International Union for Health Promotion and Health Education, Abrasco Public Health Association of Brazil, and various other B4H network contributors. Pre-existing trust meant that projects such as *Moving Health Literacy Upstream* could proceed quickly because of strong existing partnerships. The co-founder could use these relationships with experts in various fields such as health equity, health literacy and health

promotion to form the B4H Global Advisory Group. In addition, many network members are also leaders of other organizations. For example, Shannon Turner, one of the co-founders of B4H is the Co-Chair of the Canadian national violence prevention coalition, Dais Rocha one of the global advisors is a public health leader in Brazil, and Kristine Sorensen is a leading European researcher in health literacy.

The participatory practices for B4H are still evolving, including the application of the co-op model in the B4H context. Investment in developing the application of the co-op model is based on the belief that the model enables participatory practices that are consistent with the values and beliefs that are fundamental to the network, that is democratic engagement and the collaborative design of solutions. It is evident from WHO's Ottawa Charter's definition of health promotion, that having control over the conditions that impact one's health is an essential part of health generation. Since empowerment is at the heart of health promotion, B4H sees its role as to create the structures and systems that allow people to participate in the decisions that impact their health.

The biggest asset is the social and intellectual capital that B4H have built as a network over the last 3 years that will now serve to grow the co-op. This capital has allowed us to recruit more volunteers that have served a wide range of roles including research support, advocacy and communications and strategic planning-which resulted in the co-op model.
Key Informant Interview with Paola Ardiles, Co-Founder, 2017

The relationships that Bridge for Health have created have also allowed them to extend their reach to thought leaders like Dr Trevor Hancock, who has been promoting the work of the network and creating social media content via [blogs](#) that have brought the network credibility. Conversely, the biggest challenge for B4H is that prior to formalising as a co-op, B4H was a volunteer-driven network. The result of this has been a lack of capacity to track or measure outcomes and changes associating with social participation in B4H.

Perceived or measured outcomes:

B4H is emerging as an organisation and currently in the process of developing its evaluative framework, as a result, the identification of measured outcomes is still in its infancy. To date benefits of engaging with the B4H network that have been reported by its local and global network contributors include opportunities for: knowledge sharing on diverse topics related to health; increase of social capital through expansion of personal/professional networks; relationship building and social support among network members; innovative partnerships and funding opportunities; and collaboration on diverse research or training projects and tool development.

“What do I get out of being part of Bridge for Health? My spirit gets inspired by sharing with like-minded people my passion for creating a world healthier and happier for all its beings. Practically, I get the possibility of implementing sustainability projects that impact the communities I am close to.” Diana Leon, IT specialist interested in working on environmental issues in workplaces, quoted in Bridge for Health (2016e)

The young people who participated in the PhotoVoice project expressed their gratitude at the end of the programme, with some thanking the B4H researcher for the opportunity provided. One of the parents of a youth participant also expressed their appreciation after the community event. In terms of the global health promotion conference, the [video](#) Engaging the Leaders of Tomorrow was launched at 22nd IUHPE World Conference on Health Promotion, Curitiba, Brazil. Also in October 2016, Marco Zenone the youth engagement lead at B4H, had the opportunity to co-host a public leadership pre-conference event and present the video the 6th Global Health Promotion Forum held in Charlottetown, Prince Edward Island, Canada in October 2016.

There are other examples of outcomes. The B4H partnership with Dr. Sandra Milena of REQUIAP, resulted in an invitation for Paola Ardiles as the Co-Founder of B4H, to speak with medical students and faculty about how community engagement can help address the social determinants of health and promote mental health and well-being of patients or clients at the International Symposium of Community Health in Bogotá, Colombia. B4H is often invited to speak or hold workshops with local organisations and businesses, such as at the University of Alberta's, Professional Development Day for Health Promoters, sponsored by the Centre for Health Promotion, where Paola shared how health promotion principles and practices can be taken into another sector to contribute to a social equity agenda. In February 2017, B4H was awarded the Simon Fraser University's Coast Capital Savings Venture Pitch Prize for Social Impact for its Wellbeing @ Work Innovation Lab proposal and its efforts to create participatory approaches in the workplace to promote wellbeing by exploring the root cause of illness at work.

Areas for shared learning:

Three areas for shared learning emerge from the case study.

The first is that while financial resources are important for enabling participation in health, having social and intellectual capital is essential. The existing connections, contacts and collaborations that Paola and other co-founders brought to the network, have enabled B4H to evolve into an organisation that reflect the original intent from the first meetings. B4H did receive a small project grant from a credit union in 2016 that enabled the network to explore the best model for structuring the organisation. In addition, they have received resources in kind, such as a Masters student from the Netherlands, who was with B4H for 6 months and who advanced Phase 1 of the Moving Health Literacy Upstream project.

The second area for shared learning is the importance of investing the time to let the model evolve. The co-founders and network members have used the last three years to identify where the network could best contribute, that is where they need to do something new and where they can add value by collaborating with existing initiatives. They have also used the time to better understand the social and intellectual capital that members bring. This has included working with their global advisory circle to get feedback and input as well as other experts in the field. Through this process B4H has identified that the co-op model is best suited to and consistent with the values of members. The co-op model enables Bridge for Health to 'walk the talk' in terms of authentic leadership and representation via its membership structure in which members are also 'investors', which further promotes active engagement, joint decision making and participation of people and communities for change.

The third area for shared learning is about not waiting for the system to respond to or provide the invitation to participate, but instead, to mobilize a ground swell that can work together to make and create opportunities for participation. This does not remove the requirement for health systems to have mechanisms for participation and engagement, nor does it mean that acting at community level will lead to a positive response or rapid change, but it will start a directional movement towards small, incremental social change. This means that in the development of an evaluation framework, B4H will work to develop sensitive metrics and measures that can track and monitor subtle and incremental changes in the processes and outcomes that lead to positive health and wellbeing impact overtime. In addition, a key feature of B4H's success is the strong social and intellectual capital through its members. These members might have access to small project grants or bring resources in-kind, such as students as interns. This ultimately challenges the assumption that the space for participation in health needs to come from the health system and or be accompanied by a project grant.

These areas link to practices that might be adapted or adopted in other settings, particularly the use of existing social and intellectual networks within communities and the application of a Co-op model for community participation. Furthermore, B4H has identified workplaces as an important arena for social action in health, particularly given the amount of time working adults spend at work, and the growing burden of non-communicable diseases globally (B4H, 2016d). As a result, B4H has worked with the businesses in Vancouver to better understand the needs of employers and employees interested in improving health/wellbeing outcomes, so that workplace health and wellbeing programmes might be improved and with better attention to addressing the work environments that produce poor physical and mental health and that contribute to illness and injury at work. Health services may also be interested in advancing participation and a broader view of health by adapting the Healthy Business Framework within their own organisations. Such an approach may support health services to lead by example and engage communities more effectively, particularly in relation to of health literacy and health promotion efforts.

B4H is relatively 'young' and some challenges have been identified, such as in building the consulting service of the network. However, there has been interest and uptake of the approach both within Vancouver and outside of Canada. For example, in early 2017 Paola will spend one week in Brazil working with an organisation to implement the wellbeing@work innovation lab to contribute to improvements in the health and wellbeing of their workplace.

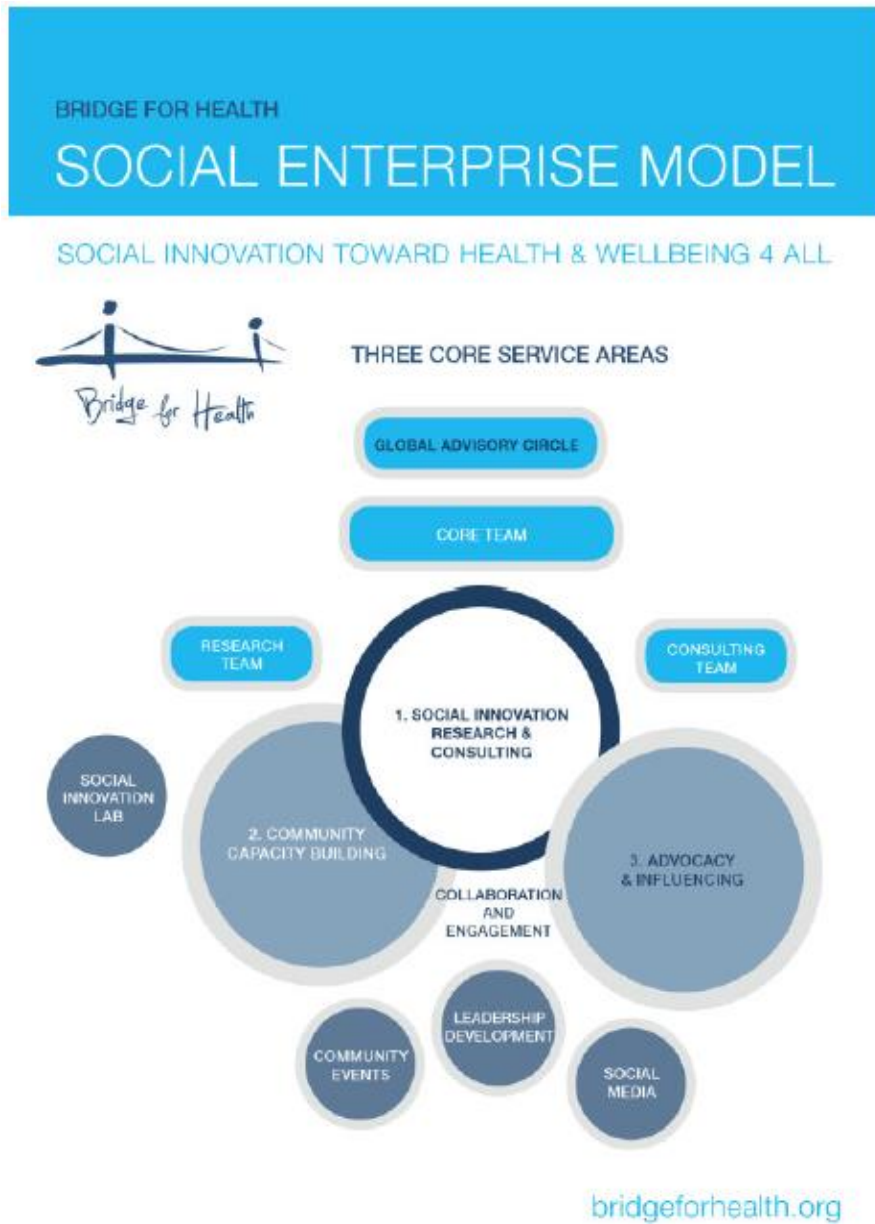
B4H is such a new organisation and very keen to learn from the experience of others. This includes how other sites are: contributing to citizen engagement in population health and innovative approaches and models they have found to be effective; developing sensitive indicators to evaluate organizational impact on social change in health overtime and; models and approaches to engaging workplaces as a key arena for citizen engagement in health and wellbeing.

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Appendices

A1: Bridge for Health Social Enterprise model



A2: Bridge for Health's Healthy Business Practice Framework

BRIDGE FOR HEALTH

HEALTHY BUSINESS PRACTICE FRAMEWORK

SIX BUSINESS PRACTICES TO ADVANCE THE TRIPLE BOTTOM LINE: PEOPLE, PLANET AND PROFITS



PERSONAL GROWTH AND DEVELOPMENT

- Self-awareness and self-reflection
- Authentic leadership
- Communication skills



LEARNING AND WORKING ENVIRONMENTS

- Skills in collaboration and team building
- Building trust, relationships and partnership skills
- Inclusion in decision-making processes



POLICIES AND PROCESSES

- Living wage and/or profit sharing
- Hiring and pay equity
- Flexibility in schedule/work from home



PHYSICAL SPACES

- Décor and access to green spaces
- Designs that improve access to direct sunlight
- Shared open spaces to promote social connection



SOCIAL CONNECTION AND COMMUNITY ENGAGEMENT

- Community investments
- Participation in community (e.g., volunteer work)
- Opportunities for meaningful contributions to support others at work



SERVICES AND SUPPORTS

- Employee wellness programs
- Benefit plans
- Bereavement and sick leave

Adapted with permission from Health Promotion Team, Simon Fraser University.

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