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Résumé

L'application de principes de sensibilisation pour améliorer les pratiques modernes de traduction des connaissances en matière de santé des femmes

Nancy Poole

Dans le cadre des modèles traditionnels de traduction des connaissances portant sur les soins de santé, le chercheur « expert » transmet des connaissances empiriques aux praticiens de façon descendante. De nouvelles approches redéfinissent les interlocuteurs qui participent à la traduction des connaissances, le type de preuves acceptées et la façon d'animer le processus de partage des connaissances. La participation multisectorielle et les processus de synthèse collective des données probantes multiplient les possibilités d'application des connaissances dans la pratique et à l'échelle des politiques selon des façons qui favorisent un renforcement mutuel et qui se penchent sur les inégalités structurelles. L'auteure examine l'application de pratiques de sensibilisation féministe dans des communautés de pratique virtuelles, en tant que cadre de travail viable pour la traduction des connaissances portant sur des problématiques de santé complexes. Utilisant les résultats préliminaires d'une étude, elle démontre comment l'application d'une analyse collective dans le cadre d'un processus collaboratif – qui constitue la base de la recherche axée sur l'action féministe – mène les participants à poser des gestes engagés.

Mots clés : traduction des connaissances, communautés de pratique, communautés virtuelles, sensibilisation féministe, recherche axée sur l'action féministe

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Using Consciousness-Raising Principles to Inform Modern Knowledge Translation Practices in Women's Health

Nancy Poole

In traditional models of knowledge translation in health care, the "expert" researcher disseminates empirical knowledge in a top-down manner to practitioners. Newer approaches extend our view of who needs to be involved in knowledge translation, what counts as evidence, and how knowledge exchange can be facilitated. Multisectoral participation and processes for collective synthesis of evidence increase the potential for the application of knowledge in practice and policy in ways that are mutually reinforcing and address structural inequities. The author examines the use of feminist consciousness-raising practices in virtual communities of practice as a viable framework for knowledge translation on complex health issues. Using the preliminary findings of a study, she discusses how collective analysis in collaborative processes — which is at the heart of feminist action research — leads to engaged action by participants.

Keywords: knowledge translation, communities of practice, virtual communities, feminist consciousness-raising, feminist action research

Introduction

The feminist practice of consciousness-raising (CR) can provide a framework for contemporary knowledge translation in virtual communities of practice (VCoPs). The British Columbia Centre of Excellence for Women's Health (BCCEWH), in collaboration with the Canadian Women's Health Network and the Canadian Centre on Substance Abuse, has successfully implemented VCoPs based on the principles of CR. This article considers their characteristics and processes in light of current conceptualizations of best practices in knowledge translation and illustrates how adopting CR as a framework can inform the evolution of modern knowledge translation practices.

Although the development and evaluation of these VCoPs are still in progress, this is a good time to present this CR-related virtual knowledge translation practice, for three reasons:

- It provides a view of knowledge translation related to health issues, such as substance use by pregnant women and mothers, which require

attention to social determinants of health and complex shifts in attitudes, practice, and policy in a range of settings.

- It uses the lenses of gender and diversity to examine "the divergences of gendered power" (Bradley, 2007, p. 36) within the knowledge translation approach. This largely uncharted territory is of increasing interest to women's health advocates and health policy and research bodies such as Health Canada (2003) and the Canadian Institutes of Health Research (2007).
- It invites discussion as an approach that fosters the active involvement of all those in a position to influence health practices and polices in collective understanding, reflection, and action (Reimer Kirkbam, Baumbusch, Schultz, & Anderson, 2007, p. 36), supported by virtual technologies. This focus on involvement and action is linked to feminist-informed participatory action research as discussed in the nursing research and practice literature. It is also linked to the current discourse in the knowledge translation field related to facilitation and context as factors influencing the implementation of evidence (Rycroft-Malone, Harvey, et al., 2004).

Feminist Consciousness-Raising

In the late 1960s and early 1970s feminists put considerable thought into how women's knowledge had been subjugated and how to bring forth evidence from women's lived experience to promote social change. New York Radical Women has been credited with introducing the practice of feminist CR at the first National Women's Liberation Conference in Chicago in 1968 (Shreve, 1989). The feminist CR model usually involved a three-stage process of sharing, analysis, and action planning. The first step was to gather the experiences of group members on a particular theme or issue. After each member had shared her experiences, the group would discuss the common elements in their experiences and how that commonality related to the overall status of women. Then the group would often strategize, take action, and assess the impact of this action in an iterative process. Keating (2005), in a recent discussion of modern CR practice, describes the pedagogic and movement-building contributions of this initial CR model as (1) making explicit the political implications of women's so-called personal lives, (2) introducing non-hierarchical and transformative spaces for thinking about and acting upon one's own and each other's different situations, and (3) providing a model for creating knowledge and theory in a participatory and collective manner.

Keating (2005) goes on to show how the search for commonalities as the analytic focus of the second-wave feminist CR method could

downplay important racial, class, national, and other differences within this unity, and obscure inequitable power relations. To counter this homogenizing tendency, she proposes "coalitional consciousness building" as a contemporary CR model that would engender awareness and solidarity across multiple lines of difference, specifically:

1. locating experience (sharing experiences related to a theme while paying close attention to the contexts and histories in which the experiences being articulated are being played out)
2. seeing resistance to multiple oppressions (examining the experiences with an eye for the multiple relations of oppression and resistance at play) and
3. coalitional risk taking (exploring the barriers to and possibilities for coalitional action) (p. 94)

This model has proven to be relevant in current approaches to knowledge translation, specifically in the design of virtual communities being sponsored by the BCCEWH in Vancouver, Canada. In these VCoPs, participants examine the context of their own health and that of marginalized women, the multiple relations of oppression and resistance at play in these contexts, and the possibilities for coalitional action with regard to the analyzed experiences and contexts.

Contemporary Knowledge Translation Practices

Traditional knowledge translation models in health have been based on views of evidence, researcher, end users of knowledge, and processes of translating knowledge that differ from the feminist perspective. In early translation models, knowledge was typically seen as empirical in nature, created by the researcher as "expert," transmitted from the top down, through one-way instructive learning processes, to practitioners who were not "epistemologically active" (Broner, Franczak, Dye, & McAllister, 2001).

Expanded Conceptualizations of End Users of Knowledge

A number of researchers have explored the limitations of uniprofessional (Ferlie, Fitzgerald, Wood, & Hawkins, 2005) and unisectoral engagement in knowledge translation. They have also argued for the inclusion of multiple types of care provider and for diversity among managers and administrators in particular health-care settings and among health-system decision-makers and policy-makers (Elliot & Popay, 2000; Gallop et al., 2006). Feminists have identified *women with health problems* and *women's health advocates* as important participants in integrated participatory action

research and knowledge translation processes (Kirby, Greaves, & Reid, 2006; Maguire, 1996). Expanded views of who should be involved in knowledge translation are linked to emerging work on how systemic conditions come together to reproduce conditions of inequality (Morris & Bunjun, 2007) as well as newer views of science and the construction of knowledge (Nowotny, Scott, & Gibbons, 2001).

Expanded Views of What Counts as Evidence

With multisectoral involvement in knowledge translation processes, it is important to consider evidence other than that produced by research (such as nurses' practice-based evidence) in any effort to improve health-care practice and policy (Chunharas, 2006; Pang, 2007; Rycroft-Malone, Seers, et al., 2004). Knowledge translation experts no longer view evidence as a commodity or as "a thing that can be 'put into' a system" (Kitson, 2008); they now view it as constructed from multiple sources and applied following negotiation (Reimer Kirkbam et al., 2007; Rycroft-Malone, Seers, et al., 2004). Accordingly, the researcher as a producer and interpreter of evidence has also shifted — and new forums are needed so that a range of participants can identify, co-construct, and consider multiple sources of evidence.

Expanded Conceptualizations of the Facilitation of Knowledge Translation

Although they are decreasing in prevalence, one-way didactic methods still characterize much of knowledge translation. This stands in contrast to efforts that involve and empower end users in the construction of knowledge. New approaches for facilitating knowledge exchange and application are characterized by nonlinear processes of exchange, interactivity, and longer-term relationships, such as communities of practice (Chunharas, 2006; Harvey et al., 2002; Kothari et al., 2006; Walter, Nutley, & Davies, 2006).

Wenger (1998) and others have argued for communities of practice as contexts for social learning. In these contexts people with a common interest/practice voluntarily come together for collective learning, knowledge creation, collaborative problem-solving, and other activities that involve reflection on practice (Cox, 2005). Communities of practice as collective, emancipatory social learning environments have the potential to address key barriers to research utilization in nursing. Such barriers include emotional exhaustion (Estabrooks, Midodzi, Cummings, & Wallin, 2007), lack of mental time and energy (Thompson et al., 2008), and lack of control (Jacobs, Fontana, Kehoe, Matarese, & Chinn, 2005), as well as the interaction of these barriers with organizational factors such as leadership, opportunity for nurse-to-nurse collaboration, and a positive

learning culture (Cummings, Estabrooks, Midodzi, Wallin, & Hayduk, 2007).

Greenhalgh and others (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Tugwell, Robinson, Grimshaw, & Santesso, 2006) have reported refinements outlining who needs to be involved in knowledge production and translation and how to address context-specific barriers to such involvement. However, these descriptions of knowledge translation strategies still do not involve multiple holders of different kinds of knowledge, support multidirectional collaborative learning processes, or attend to contextual barriers and supports in ways that are comparable to those of the CR model.

Linking Consciousness-Raising to Modern Knowledge Translation Practices in Women's Health

Over the past 11 years, researchers and knowledge translators at the BCCEWH have been facilitating multisectoral collaboration related to both research involvement and knowledge exchange on women's health issues. This multisectoral production and use of research has been critical to the creation of relevant, useful knowledge. In 1999 a group of 80 women's health researchers from across Canada met to discuss and develop the Fusion Model of integrated health research (Greaves & Ballem, 2001). In the fusion approach, researchers and their collaborators are invited to address (a) challenges associated with defining and creating authentic intersectoral research partnerships, (b) issues of power and conflict, (c) the integration of knowledge exchange at all stages of the research process, and (d) academic and bureaucratic obstacles. Using the Fusion Model, the BCCEWH has involved researchers, decision-makers, health-care providers, and women's health advocates in all research and knowledge translation endeavours. As technology has become available, BCCEWH researchers have used virtual methods for engaging other researchers and end users of evidence related to women's health. The use of technology has served to increase involvement and to bridge distances and other forms of diversity, with the potential for much broader exchange and application to practice and policy.

VCoPs: Coalescing on Women and Substance Use: Linking Research, Policy and Practice

> *The virtual community helped me feel less isolated and let me know that there was a community of experienced academic and practical experts that could provide me with information and assist in addressing questions and issues.* (VCoP participant from Northwest Territories)

> *I liked discovering people who are doing work aligned with mine…and the potential for making ongoing connections with some of them.* (VCoP participant from Nova Scotia)

The VCoPs are evolving in partnership with the Canadian Centre on Substance Abuse and the Canadian Women's Health Network, with the financial support of Health Canada. The project is national and engages geographically distributed, multisectoral participants, supported by technology, to build consensus on "better practice and policy" related to women's substance use and addictions in Canada. The VCoPs are facilitated by a BCCEWH researcher, drawing on CR, feminist-informed participatory action research (Brydon-Miller, Maguire, & McIntyre, 2004; Corbett, Francis, & Chapman, 2007; Kirby et al., 2006), and "appreciative inquiry" (Reed, 2007).

Researchers, service providers, policy advocates, community-based advocates, and women with substance use problems are invited (via electronic communication) to enter virtual learning venues, where they identify, organize, and synthesize research and other forms of evidence on emerging topics related to women's substance use and addiction. Following this exchange process, participants create and disseminate documents that describe key issues, resources, and points of provisional consensus for program and policy directions.

Six online learning communities are currently being created, involving participants from across Canada. Members are researchers, service providers, policy-makers, community advocates, and/or women with substance use problems. The six topics for discussion in the Coalescing on Women and Substance Use: Linking Research Practice and Policy virtual communities have been identified through a range of research, service provision, policy, and knowledge-exchange processes engaged in by the sponsoring organizations. These topics are as follows:

1. Integrating addictions support with support on violence/trauma issues in transition houses and other women-serving agencies, as well as promoting integrated violence and addictions policy.
2. Integrating determinants of women's health approaches into research and policy initiatives that are designed to prevent fetal alcohol spectrum disorder (FASD).
3. Integrating women-centred approaches into addictions treatment for mothers and into child protection policy and practice.
4. Integrating women-centred approaches into the understanding and practice of harm reduction and into drug policy and harm reduction frameworks for action.

5. Integrating women-centred approaches into addictions prevention and treatment services serving First Nations and Inuit women.
6. Integrating trauma-related support into addictions treatment settings for girls and women and into systemic treatment policy/guidelines/frameworks.

These topics form the basis for a body of knowledge synthesis, translation, and action, which is intended to have an impact on various elements of the field of substance use and women's health.

Each virtual community works collaboratively for approximately 6 months using a Web-based meeting infrastructure and a shared online workspace. Participants share their expertise and perspectives on women's substance use issues; examine evidence from research, grey literature, and other sources; synthesize the information they have gathered; examine barriers to and supports for change; and discuss how to translate what they have learned into action in the practice and policy spheres. Following this 6-month community-building period, a Webcast facilitates wider discussion of the project's findings. Print and Web-based distribution of consensus documents serves to further broaden the audience. Currently, one community's cycle has been completed, three are in progress, and two are being organized.

The Coalescing project has elicited interest across Canada. Table 1 shows the geographic diversity the communities have spanned to date. Table 2 provides a view of the multisectoral diversity of the Coalescing VCoP participants.

These early outcomes suggest that the Coalescing project has been successful in attracting participants from diverse sectors. The tangible products of the VCoPs are information sheets, articles, and presentations that reflect the broad base of knowledge and experience of participants from multiple sectors. On the topic of mothering and substance use, for example, the mix of representation from both the substance use treatment and child protection fields, as well as the geographical and sectoral mixes, has provided opportunities for enhancing understanding across fields and undertaking sophisticated syntheses of the issues and promising practices. Points of consensus and disagreement are found in the VCoPs' monthly synchronous Webmeetings and the asynchronous online discussions that take place over a 6-month period. Differences in perspective are assumed, welcomed, aired, and examined, and conflict has not disrupted the community processes. For these reasons the virtual environment may well be "pedagogically superior" to face-to-face environments (Alavi & Tiwana, 2002).

Table 1 *VCoP Participation by Province/Territory, Showing Geographically Distributed Interest*

	VCoP 1: Response to Violence	VCoP 2: FASD Prevention	VCoP 3: Services for Mothers and Children	VCoP 4: Women-Centred Harm Reduction
Alberta	1	4	1	2
British Columbia	10	15	10	12
Manitoba	1	4	0	1
Nova Scotia	1	0	2	0
Ontario	6	2	12	8
Saskatchewan	1	4	0	2
Yukon	1	2	1	1
Northwest Territories		5		

Note: Not all those who indicated interest were able to participate, because community size was initially limited to 25–30 people.

Table 2 *VCoP Participation by Sector, Showing Multisectoral Interest*

Type of Participant	VCoP 1: Response to Violence	VCoP 2: FASD Prevention	VCoP 3: Services for Mothers and Children	VCoP 4: Women-Centred Harm Reduction
Researcher	5	13	5	5
Service provider	13	11	12	15
System planner/ educator	3	13	7	3
Woman with health issue		2		2
Student			1	1
Women's health advocate			1	
	21	39	26	26

The VCoP participants have shared their findings with politicians and a large network of people with similar interests who have a potential role in acting on the synthesis of knowledge. Table 3 provides an overview of the dissemination, engagement, and uptake processes in progress for the first two communities.

Community participants have volunteered for ongoing, collective knowledge generation, illustrating shared commitment to evidence-based action and learning. For example, one VCoP has developed a grant application for forming a interdisciplinary and multijurisdictional research team that continues to undertake and study knowledge translation on FASD prevention as a women's health issue.

When we evaluate these VCoPs we will address questions being identified in the contemporary literature on knowledge translation, virtual learning, and feminist action research, such as:

- How/does the virtual environment support the involvement of more kinds of participants, the inclusion of more kinds of data, and learning and the application of learning?
- How/does the VCoP propinquity help to lift the constraints of class, gender, nationality, and race (Papastephanou, 2005)?
- How/do reciprocity, trust, identification, shared vision, and shared language (Chiu, 2006) emerge to support learning and ongoing collaboration among community participants?
- How/does VCoP participation facilitate the application of evidence to practice by teaching participants how to navigate and collectively make sense of the sea of virtual information (Garrison & Anderson, 2003)?
- How/do participants identify the voluntary, democratic, and non-institutionally based characteristics of the VCoPs as important to their participation, decreased isolation, and ongoing interconnectivity?

Discussion

Evolving practices in the field of knowledge translation are increasingly using inclusive, participatory, and collaborative approaches. Communities of practice are promising exemplars in current knowledge translation. The VCoPs being implemented in the Coalescing project contribute to this evolving field, especially in how they intentionally apply three simple principles of the early radical democratic model of CR.

Sharing

In communities of practice, processes of democratic engagement are central and value personal experience. Wenger (1998) emphasizes the importance of "active involvement in mutual processes of negotiation of

Table 3 *Action Outcomes*

	VCoP 1: Response to Violence (Completed)	VCoP 2: FASD Prevention (Ongoing)
Webcast	Two Webcasts, each with 60–100 participants	
Inquiries from Webcast	Four inquiries received post-Webcast in three provinces requesting further information and discussion to guide programming	
Information sheets prepared	Five information sheets prepared	One information sheet prepared; two in progress
Information sheets posted on Websites	Information sheets posted on four Websites	Information sheets posted on three Websites
Information sheets distributed at conferences	• Regional and provincial conference of social workers in two provinces • Provincial videoconference on connections between violence and substance use • National conference on substance use issues	• One international and two national conferences
Information sheets added to course readings	• Justice Institute of BC course on interconnections between violence and substance use • University of British Columbia nursing seminar	• Professional training packages of ActNow BC – Healthy Choices in Pregnancy

Findings discussed in presentations at conferences	• Webinar sponsored by Yukon Women's Directorate • Three national and provincial conferences	• Two poster sessions at national conferences
Findings presented to policy-makers		Presentation to ministers in the Canada Northwest FASD Partnership
Findings used in briefings for policy-makers		Briefing for a provincial minister of child care and a children's advocate
Findings found to influence agency policy or practice	Prevention Toolkit of BC Specialized Victim Services and Counselling	Cross-site research planned
Collaborative preparation of research proposals	Proposal, submitted jointly with a sexual assault centre, on integrated trauma-informed tobacco treatment	Proposal to Canadian Institutes of Health Research in response to its call for new emerging teams on knowledge translation
Preparation of journal and newsletter articles	Articles published in two publications: *BC Mental Health and Addictions* and *CrossCurrents* (newsletter of the Centre for Addiction and Mental Health)	

meaning" (p. 173) in communities of practice. Virtual communities of practice that are based on CR add another layer of shared experience in a way that closely attends to the contexts and histories in which the participants' experiences are played out (Keating, 2005).

Feminists have a history of building forums in order to share diverse experiences and to examine and address relations of power. Promoting multisectoral participation instead of dyads (researchers and practitioners or researchers and policy-makers) increases the potential for co-constructed knowledge in practice and policy to be applied in ways that are mutually reinforcing and that address structural inequities. The participants in one VCoP, for example, included researchers, planners, service providers in child welfare and addictions treatment, and mothers with substance use issues. As a result it was clearly demonstrated that service barriers for these mothers will not be removed until we change child-protection policies that discriminate against them (Greaves & Poole, 2007; Hoyak, Poole, Salmon, & Network Action Team on FASD Prevention, 2007).

Analysis

In communities of practice, collaborative knowledge exchange, analysis, and synthesis are key. A community of practice is a unique combination of a domain of knowledge, a community of people who care about the domain, *and* the shared practice that they are developing to be effective in their domain (Wenger, McDermott, & Snyder, 2002). The community's members draw upon multiple sources of information, evidence, and practice and emphasize the kind of analysis that elicits alignment with the experience of others.

The VCoPs examine experiences and other forms of evidence with an eye for the multiple relations of oppression and resistance at play (Keating, 2005). When discussing their practice, and the academic and grey literature on marginalized women's health, VCoP participants have deliberated on issues of invisibility, marginality, stigmatization, oppression, and inaction on women's substance use and addiction, as well as their own current position, agency, and self-efficacy. Participants tend to welcome diverse perspectives and see the "multiple and contradictory discourses, powers and subjectivities" (Ryan, 2001) as a resource for change.

Action Planning

The Canadian Institutes of Health Research (2004) describes the goal of knowledge translation as "accelerat[ing] the capture of the benefits of research for Canadians through improved health, more effective services and products, and a strengthened health care system." Our work suggests that there is more to the "capture of the benefits of research" than this

goal would indicate. The third aspect of our CR model — actively promoting and supporting action — is often missing from current knowledge translation models.

The action focus of VCoP practice is clearly linked to the participatory action research tradition (Wallerstein & Duran, 2003), and specifically to feminist action research (FAR). As described by Reid (2007), FAR is similar to participatory research and knowledge translation. Specifically, FAR integrates subjectivity, involves participants in all phases of the research process, engenders empowerment combined with deepening of social knowledge, and involves a dialectical process of collective reflection and action. In so doing, FAR blends participatory research elements and feminist theory, enabling researchers to "center on women's experience and diversity in practical and explanatory frameworks" (Reid, 2007, p. 35). In FAR there is a particular interest in "translating feminist insights into concrete actions aimed at achieving social change" (Maguire, Brydon-Miller, & McIntyre, 2004, p. xii).

The CR-based communities are designed to help participants "come to critical consciousness" (hooks, 2003, p. 2) — that is, to elicit subjugated knowledges, support reflection on the operation of power and domination, assist with critical thinking, *and* inspire hope, self-efficacy, and coalitional plans for making change in multiple contexts. This action-oriented approach to bridging the "know-do" gap (World Health Organization, 2006), in which complex and often systemic changes are required to improve women's health, can be exemplary to the larger knowledge translation field.

Conclusion

As researchers in the health of marginalized women, we at BCCEWH are interested in what Letherby and Bywaters (2007) describe as "extending social research" to embrace the knowledge translation process. This means both rethinking the whole research process and engaging funders, partners, prospective beneficiaries, and end users as partners in the change process (Bywaters & Letherby, 2007, p. 5). We see the potential for employing feminist consciousness-raising and coalition-building to inform the overall practice of knowledge translation.

Consciousness-raising has been useful as a framework for understanding the core elements of knowledge translation in the development of contemporary *virtual* communities of practice on women's health issues. The explicit focus of CR on action grounded in collaborative learning processes has been foundational in this work. Modern knowledge translation practices, evolving towards the use of multidirectional collaborative learning processes, are, we argue, informed by this virtual and dialogic process of engagement and action.

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