**Overview of Core Research Idea:** How can we use population health interventions to support vulnerable families that are an improvement over the current siloed and human resource-intense services?  Would a two- or even three-generation perspective within a vulnerable family change the hierarchy of services offered to whom and for what end? When vulnerable families expose structural barriers to health, how can population health interventions respond systemically?  The *Tackling Vulnerability at its Roots: Building Health Equity for Families (BHEF*) is a program of research and knowledge mobilization at the University of Calgary with a ‘health-in-all approach’ “that systematically considers the health and social implications of policies contemplated by all sectors… [given that] many of the drivers for health outcomes are beyond the reach of the health sector”. 1 The BHEF will boldly seek solutions to these challenging questions in a deliberate step-wise research program that focusses on families facing the most complex of public health issues and posits solutions for parents/caregiver and children and that challenge existing barriers to health and health care. We will clearly engage patients/clients as part of families, service providers, and policymakers as the agents of change responsible for identifying structural barriers and proposing population-level health-system interventions. **Statement of the Problem:** Families living with social determinants like poverty, housing instability or homelessness, mental health issues and unsafe substance use face many barriers to health and health care. Many of the barriers are structural in nature, including limited income to pay for medications and counseling, a lack of affordable housing that is safe and sustainable, and cycling between multiple services and systems like government financial supports, hospitals, foster care and domestic violence or emergency shelters.Families with these complex and intersecting needs become increasingly unhealthy the longer they live in vulnerability and children are at very high risk of repeated vulnerability and poor health in their own adulthood.To adequately address the barriers families face, we must betransformative in our work by taking a multi-generational approach and creating solutions to structural vulnerabilities, not individual ones, and by focusing on root causes which include health inequities. Without this approach, the healthcare system’s capacity to provide equitable and inclusive care for diverse women and children is hindered by misplaced blame that creates stigmatization and distracts from the need for system reform. **Background: *Social Determinants and Health Inequity*:** Determinants of health are social, economic and environmental factors that influence individual and population health outcomes. The expansive list of determinants includes housing, income and social status as well as gender/sex, race/ethnicity/culture, and childhood experiences. 2 **Health equity** refers to the belief that "all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, gender, age, social class, language and minority status, socio-economic status, or other socially determined circumstance".3 Health intervention research that is focused on health equity needs to be upstream. It must act on the determinants of health and be focused on prevention. Interventions cannot be effective if the health issues targeted ignore other issues that are similarly determined, for example, research focused on mental health outcomes that ignores homelessness, and a lack of affordable housing. Health interventions are more likely to be innovative when they are transdisciplinary in both the process of knowledge creation and consideration of outcomes and when they disabuse “myths about what can and cannot be achieved within community-level intervention research [which have]…held the field back...” 4. For real progress, multidisciplinary research is needed that is focused on improving health equity and subsequent health outcomes. This research requires a range of research methods and designs that are dynamic, adaptable and that engage directly with communities who experience health inequities. ***Increasing vulnerabilities***: The landscape for intervention is vast since the prevalence of public health issues in Canada is increasing. Canada’s child poverty rate is within the bottom third of industrialized nations with more than 40% of Indigenous children in Canada living in poverty.5 Every two and a half days in Canada, a woman is killed by her partner.6 Violence against women costs Canadian taxpayers $7.4 billion dollars every year and children who witness violence have twice the rate of mental illness as children who do not.7 Approximately 1.2 million children and youth struggle with mental health issues and by age 25 this number increases to 7.5 million or 20% of Canadians.9 Canadian policy and subsequent practices are only moderately effective to address these complex issues compared with other countries and the health of “Canadians has improved more slowly than that of residents of other wealthy countries, with evidence emerging that health equity is now decreasing.” 10 Women, children, Black, Indigenous, and people of color are disproportionately impacted by social issues and subsequent poor health outcomes, and so, ***health inequity is inherently gendered and racialized***. Paying attention to both vulnerable women and their children is important because social determinants are often intergenerational.8 There is growing evidence of increasing health and social issues including mental illness, suicide ideation, poverty and domestic violence and households with children are the hardest hit11 because children are particularly vulnerable because of their developmental stage.13  These issues will take generations to recover from.14 Underpinning all of these issues are structural and systemic barriers to equity and the impacts and effects of health and social sector responses on vulnerable women and children. This type of research is the focus of our BHEF*.* ***Community-based participatory research*** (CBPR) has emerged within the last several years as a research paradigm meant to bridge the science to practice gaps by transforming the research relationship and prioritizing social action as the primary objective of evidence-based inquiry. “CBPR expands the potential for the translational sciences to develop, implement, and disseminate effective interventions across diverse communities through strategies to redress power imbalances; facilitate mutual benefit among community and academic partners; and promote reciprocal knowledge translation, incorporating community theories into the research.” 15 However, while CBPR shows promise and potential, there is still a lack of research on the long-term effects and public health impact. 16 The proposed BHEF is grounded in CBPR and has the potential to add to the scholarly discourse and knowledge given its six-year term. When research does not translate into policies and programs, it fuels an ongoing degree of mistrust, frustration, and unwillingness of decision makers to participate in future partnerships.17 It is necessary for BHEF to include decision-makers to inform evidence-based service delivery. Political inaction results from ‘ivory tower’ research that is detached from the practicality of daily life for the purposes of publications that are only accessible to academics.18 Research conducted in this siloed manner prevents translation into policy and practices that families rely upon. **U*nderstanding EDI***: Equity is the moral framework that guides the fair and non-discriminatory treatment of each individual. Not to be confused with equality, equity does not mean treating each person in the same way, but rather meeting that person’s needs while considering their unique background and situational context. Diversity is the myriad of characteristics that make each person unique. These include, but are not limited to: age, sex, gender, race, ethnicity, religion, sexual orientation, ability, parental status, and educational background. Inclusion is the culture of embracing and celebrating difference. It is the willingness to accept every person as who they are, to not treat difference as value-laden (i.e., being different does not mean being less than), and to honour and respect that each individual can make meaningful contributions to their family, community, and society. The harms of colonization mean that there are historically excluded and underrepresented populations and fairness regarding these unbalanced conditions is needed to assist in the provision of inclusive opportunities to all groups. As such, EDI is both a strategy and an outcome of the proposed program. ***Understanding Vulnerability:*** Poverty, violence, trauma and homelessness are often intersecting and result in social exclusion and high-risk behaviors.19 Vulnerable families often have to navigate multiple and complex systems such as welfare, children’s services and justice systems, and health, mental health and addictions services.In 2018, the Canadian Medical Association Journal declared ‘vulnerable populations’ as one of four priority areas, defining these groups as “those that experience adverse health outcomes compared with the general population by virtue of both internal and external factors”.22 The vague language around ‘internal factors’ leaves the root causes of vulnerability open to interpretation. In a critical discourse analysis of ‘vulnerability’, Katz et al. (2020)23demonstrated how the term promotes bias and stigmatization and obscures the role of decision-makers in creating vulnerability through inequitable systems and policies. The results from these studies implied that vulnerability is an inherent characteristic, immune to the effects of system reform and immutable in nature. There is a need for a critical reflection on the ways in which ‘vulnerable populations’ research overlooks systemic pathways to change and unfairly characterizes ‘internal factors’ as the cause of vulnerability. **Progress to Date: An Established Platform for Research.** The applicant led 18 months of research and consultation in 2019-2020 and again in 2022 to: 1) Articulate gaps between community and academic partnerships for research and action. 2) Develop a community of practice with health and service providers who work with ‘vulnerable’ families. 3) Identify strategic research priorities. A multi-disciplinary Advisory Committee provided strategic direction and guidance to the project. An environmental scan identified existing models and developed stakeholder engagement strategies. The team conducted 18 one-on-one interviews with existing research, policy and knowledge translation hubs and three focus groups with 43 unique participants from 34 community agencies from across Alberta and collected stories from several families. An Elder from the Blackfoot Community provided advisory support throughout. Results revealed that there is a need, interest and an opportunity for BHEF to leverage, and sustain equitable and reciprocal partnerships between and among researchers, decision-makers and community partners meant to catalyze change through government relations strategies, collective advocacy and innovations in service delivery. The proposed BHEF builds on our previous foundational work and entails system level, trans-disciplinary research meant to incite change. This research program includes a holistic understanding of ‘family’ grounded in the perspective that improving health outcomes overall requires a generational approach and that women and children are equally deserving and in need to support. **Aim and Objectives:** The primary ***aim*** of the *BHEF* is to launch a multi-year program of research to reduce health inequities for women and children that arise from poverty, homelessness, violence, mental health and to create actionable/measurable strategies to break intergenerational vulnerability. ***Objectives:*** 1) Prioritize research that identifies structural barriers to equity; 2) Leverage our Advisory Committee (ie. Elder, patients as part of families, service providers, and policymakers) as the agents of change necessary for identifying and challenging structural barriers; 3) Examine population-level health interventions that will reduce health inequities for vulnerable families. 4) Launch a Health Equity HUB that mobilizes vulnerability research into tangible changes to policy and practice. Four research projectswere identified in the consultation process and the PI has acquired ~$1million in funding to lead the projects noted below. The Chair funds would be used as matching to ensure projects are coordinated, intersecting and advanced to completion, as well, to support innovative mobilization strategies through the HUB.

**Approach/Methodology:** *Implementation Science* is an approach meant to enhance impact in public health research by facilitating the uptake of evidence into changes to practice and policy. However, we agree with the concern of some researchers 25 that there are limitations specific to building health equity, addressing social determinants and structural barriers that Implementation Science cannot address. We would argue, as they do, that community-based participatory research and consistent and authentic stakeholder engagement are approaches that are more appropriate when the primary purpose of the research is to build health equity and challenge and dismantle structural barriers. CBPR and the specific partnerships chosen for the BHEF are what will set this program apart and address structural barriers to equity for women and children. Our previous studies have used the CBPR process successfully. For example, we co-created an *Indigenous Approach to Evaluation*, which includes regular ceremonies, Elder circles and sharing circles as well as oral representation of results. In addition to implementing a new model of supportive housing that includes an Indigenous liaison staff position, a room for ceremony including smudging, and access to Elders on a weekly basis for residents, we have successfully lobbied for funding from the provincial government to add a practical nurse and mental health worker to the existing program. These new positions are supporting residents to access health including mental health supports and supports for substance use. ***Research Priority Areas*:** The BHEF will achieve our objectives by tackling the **four research priorities** identified in the research consultation noted above:

**Short Term (Year one):**

1. **Research that addresses barriers to equity, diversity and inclusion for families.**This means exploring the structural barriers that receive little research attention including identifying and integrating gendered and culturally safe concepts into research, policy and programs and to build community capacity for safe practices in service delivery. This requires engagement with families and recognition of their expertise as necessary to develop interventions.

**Medium Term (Y1-5):**

1. **Upstream research with innovative models and a focus on prevention.** This priority area requires the study of lived experiences with systems like mental health and child welfare. This area will prioritize family reunification and natural supports to help mediate conflicts, strengthen relationships, and nurture natural supports.26 Natural supports aim to provide the necessary in-home resources to help families stabilize their housing situation and relationships and ensure that children and "youth are able to rely on, and contribute to, a life-long network of supportive family, community and peer relationships."27 The goal is to keep families together and ‘out of’ public systems.
2. **Data sharing and infrastructure** to mobilize and share data to get information to frontline workers quickly and to share existing data to improve patient/client experience. This includes a systems’ change to openly share existing data and reduce the number of times a client must repeat their story. This also requires creating ‘best practices’ for data governance (who collects, who owns, storage, safety), strengthening data infrastructure for small organizations, mapping of existing data and building data infrastructure to demonstrate the long-term results of prevention.
3. **Examine impact-focused funding, programs, and collaborations.** Impact focused funding requires a demonstration of outcomes including system level changes rather than just outputs. This area requires investigating the components of a well-operated system of care and an evaluation of short, mid and long-term outcomes. This also requires replacing ‘pilot funding’ models with multi-year funding to track long-term outcomes and long-term programs and so requires sharing findings with funders and foundations.

**Long-term (Years 4, 5, 6 and beyond this funding cycle):**

1. Launch a Health Equity HUB to mobilize the findings from our research projects beyond academic publications and presentations. This will include an interactive and searchable website with plain language versions of research reports, translation of research finding’s into policy briefs and supporting community agencies to access funding for expanded programming to bridge gaps and silos between systems based on research findings.
2. Evaluate the impact of the BHEF on building equity for vulnerable families and the impact of the methodological approaches used for whom and what purpose.

**Research Projects:** To examine the research priorities noted above, multiple studies and data collection approaches are necessary.

***Project 1:******Cultural safety and structural racism for Indigenous families*.** This project is a partnership with the Aboriginal Standing Committee on Housing and Homelessness and will assess current capacity within the affordable housing sector to safely house and support Indigenous families. This is a mixed methods study that will be guided by our circle of Elders. Phase one includes online surveys with landlords to understand their current awareness of racism in the housing sector and the legacy impacts of colonization. Phase two will include interviews with families with a history of housing instability to collect stories of their experiences trying to access affordable housing. Phase three includes sharing the findings with the local landlord association and a network of landlords and community housing providers meant to reduce experiences of racism and improve access to safe and affordable housing for Indigenous families. [Priority area 1, matching funds in place].

***Project 2:*** ***Family homelessness prevention through reunification and natural supports:*** This multi-year project will evaluate a natural supports/family reunification approach in-place and designed to divert families from emergency shelters and the child welfare system into stable, supportive housing. This comparative case study includes a secondary analysis of emergency shelter intake data from five shelters across Canada. We will conduct a descriptive analysis of mental health diagnoses, histories of unsafe drug use and treatment and systems interactions from approximately 250 unique families and will conduct follow-up interviews with a sample of youth and their families (N=100) to understand ‘triggers’ or pathways into homelessness as well as assets or relationships that could be built upon or leveraged for homelessness prevention. We will analyze shelter policies, staffing and funding structures to develop the ‘best’ homelessness prevention program. All results will be used to create mobilization products like an adaptable program model and training materials for scale up in communities across Canada [Priority area 2, matching funds in place].

***Project 3: Shared database and multi-sectoral roadmap for data sharing.*** This study builds on study two and includes six youth and family organizations across Canada. We will create common intake questions for youth/families at risk of homelessness and will implement a common and shared database for each site to allow for individual level data entry and capacity for longitudinal analysis to understand family pathways through systems. The six partner organizations have agreed to collect the same 15 questions at each intake and to ‘roll up’ the data to share with Infrastructure Canada, who oversees the Homeless Individuals and Families database (HIFIS). We will also conduct a process evaluation, including analysis of regular team meetings and interviews with each site that will lead to a toolkit of ‘lessons learned’, and guidelines for relationship and trust building. The toolkit will also include shared data policies and procedures for open and shared databases that can be scaled up across Canada. [Priority area 3, partnerships are in place and matching funds will be sought with *United Way of Calgary and Area* and *PolicyWise for Children and Families*: *Data Sharing Strategy*.]28

***Project 4: Housing-Focused Shelters.*** This project is being done in partnership with a national emergency shelter community of practice with more than 20 member organizations. The purpose of the community of practice is to create a paradigm shift in emergency shelters across Canada away from crisis response toward homelessness prevention and being ‘housing-focused’. Phase one will include a systematic review of homelessness prevention models with a specific focus on shelters who prioritize a housing first and rapid rehousing approach. A scan of grey literature in phase two will include a search for organizations who can be approached for follow-up interviews on lessons learned in their shift towards prevention. Phase three will include various mobilization products in plain language including training materials and program models for scale up. [Priority area 4, partnerships and matching funds are in place].

***Project 5: Launch a Health Equity HUB***: The HUB will mobilize the results of health equity research into tangible changes to policy and practice. The PI has acquired ~$1million in funding to lead the projects noted above. The Chair funds would be used as matching to ensure projects are coordinated, intersecting and advanced to completion, as well, to support innovative mobilization strategies through the HUB and process and impact evaluations of the BHEF. A multi-pronged approach to evaluate the partnership approach, relationships and the outcomes of the BHEF will lead to tangible learnings that can be leveraged to ‘tweak and adjust’ the BHEF and seek sustainable funding beyond the APHC Chair. [Priority area 5, matching funding sources will be sought through consultation with the *Canadian Observatory of Homelessness, The Network Centres of Excellence: Making the Shift and the O’Brien Institute of Public Health.*

**Research Principles:** The community-engaged systems-level approach that has been adopted by the BHEF is grounded in the following: 1). *Timely strategies, ethical and impactful research partnerships* between researchers and community/health organizations who are knowledge users/decision-makers. 2). *Access to knowledge for a wide variety of partners* by translating knowledge/evidence to the ‘right’ people in the ‘right’ way to affect policy and system level change. 3). *Active engagement of patients/clients as part of families*, service providers, Elders and policy-makers as partners. 4). *Building research capacity and experience for students and trainees, and community partners.* 5) Adherence to the highest ethical standards including OCAP and TCPS 2 – Chapter 9: Research Involving the First Nations, Inuit and Métis Peoples of Canada. **Governance**: CBPR requires reciprocal partnerships with a multidisciplinary team of knowledge users and lived experience experts. Impact is achieved through such partnerships. The PI has an established and diverse network that will be leveraged into multiple committees. See Appendix B (other attachments) for governance structure graphic. An ***Advisory Committee of People with Lived Experience*** will be supported by the *Collaborative for Health and Home: Women and Children Working Group*. An *Elder Circle* has been formed and will be supported through the *Aboriginal Standing Committee on Housing and Homelessness*. ***A Steering Committee*** has been formed and includes several community agencies, the municipal and provincial governments and two Alberta Health Services Strategic Clinical Networks including the *Indigenous Wellness Core, Provincial Population and Public Health,* and a *Medical Officer of Health* from Alberta Health Services, Calgary Zone (decision makers)*.* All groups will be consulted on outcome measures, as well as interpretation of the results. They will also help decide how best to convey this knowledge to various stakeholders and how best to use this knowledge to achieve the program’s key objectives. Feedback obtained from individuals with lived experience and knowledge users will be used to inform academic publications and presentations, and to guide dialogue with policy makers and health system decision makers. Researchers and students involved in the project will be an additional vehicle of knowledge dissemination through community- and academic-based education. **Dr. Pamela Roach** is an Associate Professor in Community Health Sciences at the University of Calgary and is the training and mentorship lead for the Indigenous Primary Health Care and Policy Research Network (CIHR funded, Principal Investigator is Dr. Lindsay Crowshoe). Dr. Roach will provide support to the Trainees on ethical expectations involving research with Indigenous peoples. **Dr. Meaghan Edwards** is an Assistant professor (teaching) in Community Health Sciences at the University of Calgary. Dr. Edwards is the Education and Community Capacity Building Lead for the BHEF. Dr. Edwards will support trainees with principles of community-based research. A knowledge translation strategy will be co-created but support for national dissemination will be provided through the *O’Brien Institute for Public Health, Centre for Health Policy,* the *Canadian Observatory on Homelessness/HomelessHUB* and *Networks Centres of Excellence, Making the Shift: A Youth Homelessness Social Innovation Lab* (see letters of support from all). **Significance and Impact. *The Approach:*** With the needs of families at the forefront, the BHEF is a program of population health intervention research that generates new knowledge meant to improve health and health equity for women and children. Interventions of note include policies or programs within the health sector, including those related to mental health and addiction, and those likely to intersect or exist within other sectorssuch as housing/homelessness and family/domestic violence. *The BHEF is not specific to Indigenous health but it is not possible to examine and respond to gendered and racialized inequities without strong partnerships with Indigenous leaders* (see attached Reflections on Indigenous Research). ***The Research:*** This program of research will include the projects noted above which are conceptually linked and implemented over six years. We will prioritize gaps of importance to knowledge users engaged in relevant public policies and programs in health and other sectors. This program deliberately seeks to catalyze a paradigm shift in how systemic barriers are prioritized, and subsequent policy and program interventions to complex public health issues for families are addressed. ***The Innovation:*** The ultimate goal of this program is that structural vulnerabilities will replace individual vulnerability as the lens by which interventions are developed, implemented and evaluated. The BHEF will be about transformation that is meaningful and relevant to the people and organizations directly impacted by it. Through our partnership approach and emphasis on generating evidence to propose changes to policy and programs, the BHEF will contribute directly to actions to reduce health inequity. ***The Outcomes:*** Results will inform collective advocacy plans, well-structured policy proposals/asks, plain language messaging and government relations strategies, and innovative programs that bridge gaps and siloes between sectors and systems. Additionally, the BHEF will assist in the mobilization of research knowledge among partners and facilitate opportunities for true community-engaged scholarship and future employment for trainees by including the meaningful involvement of students through practica and internships. ***In Sum:*** The BHEF will provide backbone support to ensure collective alignment, adherence to the mission, new partnerships, and to build capacity. The BHEF will streamline findings back to decision-makers for implementation into tangible outputs and measurable results and will increase the speed of knowledge mobilization to quickly deliver evidence-based services to families in need. **Applicant.** Dr Milaney has established a successful career as an independent investigator securing >$32 million in peer-reviewed funding as a Principal Investigator or co-investigator since 2014. Her research program is focused on some of the most critical public health issues in Canada: the opioid poisoning crisis, homelessness and the national shortage of affordable housing, Indigenous health disparities, and gaps in services for equity-seeking groups. She holds a multi-year, $1 million CIHR project grant to implement and evaluate a culturally safe harm reduction-housing model for Indigenous peoples experiencing homelessness. In addition, she holds a three-year grant from The Networks Centres of Excellence project to develop and evaluate a youth homelessness prevention program. Both projects are examples of intervention-based research meant to address inequities and shift policy and service delivery. She was invited as a co-investigator on three national projects: a $2.5 million Social Sciences and Humanities Research Council Partnership grant to create and sustain the *Canadian Observatory on Homelessness* and the *HomelessHub*, a five-year, $17.9 million *Networks of Centres of Excellence* project on the Prevention of Youth Homelessness called *MakingtheShift* and a $4.8 million project to assess the effectiveness of Canada’s National Housing Strategy. These projects are generating considerable interest from scholars around the world and are formalizing a partnership with the *European Federation of National Organizations* towards advancing responses to at-risk youth and children globally. Her research has also involved direct discussions with policy- and decision-makers. She was a key member of the University of Calgary’s COVID-19 Strategic Advisory Group that has met regularly with Mayor Naheed Nenshi and his senior administrators in the City of Calgary on COVID-19 transmission and population-based pandemic control interventions. Her role was to advise on the pandemic’s impact on particular population subgroups (i.e. women and children, newcomers, people in low income, people with disabilities and mental health issues, seniors and people living in shelters). In addition, she was named as one of five theme leads (Psychosocial and Behavioural Sciences) for the national CANCOVID network advising Canada’s Chief Science Officer to coordinate and connect pandemic researchers and provide Health Canada with several reports (see attached research contributions for details). She has prepared 35 policy reports, including recommendations for community partners to use for advocacy efforts. Dr Milaney is a sought-after public speaker with 52 invited presentations at conferences, workshops and symposiums and 51 media interviews since 2018. In addition, she has disseminated her work through various social media platforms including 14 YouTube videos. She prioritizes dissemination for policy action but also presents key learnings for scholarly publications. At present, she has 32 peer-reviewed publications, two under review, and seven that are in the final stages of preparation for submission. Dr Milaney’s approach to addressing health inequities through transdisciplinary partnership and action-focused intervention research has led to tangible changes to policy, practice and public discourse. These include $2 million in government funding for a community housing program for youth with very complex mental health and substance use issues, $750,000 in new health funding to bridge gaps between the health and homelessness sectors; training and capacity building curricula for frontline staff in domestic violence organizations; audit tools to assess organizational policy and practices for dealing with vicarious or secondary trauma in front-line staff; development of the program models for supervised consumption clinics in Alberta, and implementation of a culturally safe housing program for Indigenous peoples with severe substance use disorder. See Appendix C (other attachments) for a sample list of policy reports. In June 2021, Dr Milaney was approached by the Alberta Ministry of Community and Social Supports to lead two projects to identify barriers and facilitators to permanent housing for people with very complex health needs and to develop a ‘state of homelessness’ report that the Minister is using to guide funding and intervention decisions for emergency shelters and housing programs in Alberta. Dr Milaney’s research excellence and impact has been recognized by the following awards: University of Calgary Peak Scholar in Entrepreneurship, Innovation and Knowledge Engagement (2017), Cumming School of Medicine Distinguished Social Accountability Award (2018), O’Brien Institute Societal Impact Award (2018), University of Calgary School of Public Policy Fellow (2018) and a Top 20 Most Compelling Calgarians award (2020), Glenda MacQueen Distinguished Women in Leadership Award (2022). Together with a strong network of community and academic partners, she is poised to catalyze changes that will improve the lives of vulnerable citizens. A CIHR APHC is an important next step in solidifying her national leadership role in health equity research and will launch this work internationally. **Training and Mentoring Record**: Dr Milaney has a strong record of accomplishment in supervising undergraduate, graduate and post-doctoral trainees. Her trainees have been successful in obtaining provincial and national funding including student SSHRC and CIHR awards. They have first author publications in highly ranked journals in their disciplines and have presented at numerous conferences. Of the 16 graduate level trainees who have completed training, all are working in research and policy positions or as leaders in healthcare and the social service sector. She has also mentored more than 70 undergraduate students in community practica and Honors thesis projects. For the next six years, she will recruit and train a total of 10 trainees in community-based health equity research including 4 MSc, 4 PhD and 2 postdoctoral fellows and 8 lived experience experts. She will recruit an additional three to five undergraduate students per year. These students will have the opportunity to complete an eight-month practicum with the BHEF. She has supervised four Indigenous students and will recruit two Indigenous students for this program of research. Trainees will have the diverse skills needed to support this research including qualitative participatory skills and quantitative data collection and analytic skills. In addition to training in Ownership, Control, Access and Possession, ethics in community research and community-based participatory designs, trainees will have opportunities to work with community partners and people with lived experience, providing them with valuable mentoring opportunities and insight into how inequities impact people’s lives and how research is meaningfully translated into action. Trainees will be supported to present at conferences and/or poster events. Members of the research team including collaborators and participants will attend national workshops and conferences for further knowledge translation and shared learnings. Through this program, trainees will participate in biweekly research in-progress seminars and quarterly sessions with the project research committees, thus offering ideal opportunities for mentoring, networking and exploring new collaborations and lived experience engagement. All trainees have the opportunity to participate in hands-on experiences with knowledge users and policy-makers, a unique aspect of this program. The BHEF encourages and fosters a strong team. **Potential Challenges and Mitigation Strategies:** There are four main challenges that can be anticipated: ***1) Challenges of highly sensitive topics and results*** (e.g. political challenges). Decision makers/leaders who would need to make the changes that result from the research program could resist changes to policy and service delivery. This challenge will be mitigated by including project partners who are representatives from municipal and provincial governments. In so doing, these research end-users will be included as stakeholders from project inception thereby improving the likelihood of success. ***2) Partnerships and relationship challenges***: The multidisciplinary nature of the BHEF requires a diverse group of collaborators, which may present a challenge given the scope of input they will provide. However, the program partners have been carefully chosen as they have successful track records in collaborative projects, and that there will be a representative, balanced and rich research collaboration. Several of these collaborations are already established including with Indigenous leaders and communities through a formal partnership with Aboriginal Standing Committee on Housing and Homelessness who have supported important projects in the past. The established network can be leveraged to build new partnerships as needed. Potential delays with research progress will be mitigated through regular meetings, individually and with the team, as well as input from relevant experts and collaborators. ***3) Trainee related challenges:*** Recruitment of outstanding trainees may be a challenge. However, given the strength of the training program, the success of previous trainees, and the quality of the training environment these challenges should be mitigated. Dr Milaney is already approached by several outstanding potential trainees each year and as her reputation and collaborations increase, the numbers of trainees will increase. ***4) Research execution challenges***: In the wake of the COVID-19 pandemic and as restrictions are being lifted, barriers to research are not anticipated, however, if public health restrictions are re-enacted, there could be delays. For example, in on-site data collection or engagement with Elders and people with lived experience if technology is a barrier for virtual discussions. Members of the Steering Committee are supporting connections with participants and lived experience experts through their existing programming. These partnerships will be leveraged to ensure our team receives updates and regular check-ins in the event of a return to public health restrictions. We have already established several methods to continue and sustain our research during the current pandemic that we will use so long as necessary. ***Measurement of Program Success***: The success of this program of research will be measured by the number of research collaborations, projects, publications and presentations that will have been established by the end of the six years. In addition, the number of programs, policies and decisions pertaining to health equity that are a direct result of this proposed research program will be enumerated. The program will have achieved tangible changes to policy and practice for each objective. Another key measure of success will include the number of meaningful community recognitions such as invitations to present and share knowledge with community partners and Elders. Finally, success will be measured with the extent of capacity building that results from this program. These can be assessed through formal evaluations by trainees from their various activities, completion of their training programs, presentations and publications, relevant KT activities, success in scholarship and award competitions, and ability to work in a relevant research area based on their career aspirations. ***What success will look like:*** Our formalized partnerships provide seamless information-sharing with a diverse and multi-disciplinary group of knowledge users and ensures research outcomes will be shared effectively within the community that supports families living with vulnerability. The *O’Brien Institute* will support an event to share project findings including a panel discussion with those with lived experience in addition to a discussion of implications to policy and practice. We anticipate multiple scholarly articles, depending on the analysis of results from each project as well as a ‘process’ or methodology publication outlining the CBPR design, including long-term impacts. Findings will be used by non-profit organizations who provide services as well as advocacy groups who support, represent, and are made up of persons with lived experience. Through Dr Milaney’s national connections with *The Canadian Observatory on Homelessness* and the *Networks Centres of Excellence on Youth Homelessness*, data collection tools and all results and recommendations will be shared to enable this research project to be conducted in other cities. Findings will be shared through Elder engagement sessions and the Committees and the research team will seek their guidance for additional dissemination pathways.