Making it Work: Integration in Action

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HOW THE NETWORK
OF P/T ALLIANCES
IS CREATING CHANGE

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Final Report
February 28, 2006

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EXECUTIVE SUMMARY

The Chronic Disease Prevention Alliance of Canada (CDPAC) is a national network of organizations and individuals who share a common vision for an integrated system of chronic disease prevention in Canada.[1] Constituted in 2001, CDPAC strengthens linkages among established, new, and emerging chronic disease prevention initiatives in Canada. CDPAC's mission is to foster and sustain a coordinated, countrywide movement toward an integrated population health approach for prevention of chronic diseases in Canada through collaborative leadership, advocacy, and capacity building.

Since its inception, CDPAC has worked closely with its provincial and territorial counterparts to share expertise and provide practical assistance and support. In 2004, CDPAC formally developed the Network of Provincial/Territorial Alliances to facilitate ongoing dialogue and information exchange among all jurisdictions. Network members include those Alliances that are leading the way in integrating action for chronic disease prevention and health promotion in every province and territory. Two representatives from each jurisdiction participate in the Network.

At this time, in each jurisdiction, the Alliances are at different stages of development. Some of the more recent Alliances are very interested in learning from the experiences of others in the Network. In response to this interest, CDPAC prepared this report to synthesize the experiences and accomplishments of the P/T Alliances to date. The report provides a "snapshot" of some of the Alliance work being done across the country at this time. It is designed to inform policy-makers and practitioners about the Alliance-building process – the crucial first step in pursuing integrated, collaborative action for chronic disease prevention and health promotion.

At this time, there are formal "Alliances" for chronic disease prevention and health promotion in place in nine jurisdictions, including: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia[2], Prince Edward Island and Newfoundland and Labrador. Representatives of each of these Alliances provided the information on which this report is based.

Benefits of Alliance building

Based on the experiences of the existing Alliances, there are many benefits to building Alliances. These include: becoming an effective force for change, building capacity for integrated action and enhancing knowledge development. The Alliances have created enhanced visibility for an integrated chronic disease prevention and health promotion

[1] While CDPAC was created to reduce chronic disease, it is understood that primary prevention includes health promotion and that the two cannot be distinguished.

[2] Although Nova Scotia has a provincial Chronic Disease Prevention Strategy in place, and an Advisory Council that is providing advice to the Minister, an Alliance for chronic disease prevention does not exist at this time. A coalition addressing tobacco – Smokefree Nova Scotia – also currently exists in the province. The response to the questionnaire was completed by the Nova Scotia Alliance for Healthy Eating and Physical Activity.

agenda. They have increased members' credibility and clout, and in many cases, they have been effective advocates for change. They have facilitated collaboration among members, reduced duplication of effort, and increased information sharing and multi-sectoral decision making. The Alliances provide a mechanism for responding quickly to emerging issues and communicating common messages to a broad audience. They help members consolidate and leverage resources to achieve common goals. The Alliances offer a forum for members to connect, network and partner within and across sectors, and they provide unique opportunities to develop professional and community capacity for integrated action on chronic disease prevention and health promotion.

Forces for Change

The forces leading to the emergence of Alliances include: the growing tide of evidence regarding the impact and costs of chronic disease, and the increasing recognition among key players of the need for a fundamental paradigm shift, involving collaborative, integrated action by stakeholders in many different sectors. In every case, the Alliances have resulted from a combination of engagement/dialogue, commitment, and the investment of time and resources (financial and human).

Challenges in Alliance building

There are many challenges involved in Alliance building. These include, for example, the need to:

- compile the evidence and make the case for integrated action
- clarify a collective purpose/mission
- identify shared priorities and strategies
- balance diverse perspectives
- build relationships and maintain partnerships
- obtain resources and find ways to get the work done
- monitor progress, and
- adapt to constantly shifting environments.

Maintaining the Momentum: How the Alliances Keep Moving Forward

Once a formal Alliance is established, the momentum must to be maintained. The Alliances must overcome many challenges. The key first step is to articulate the work that the Alliance will do, including making the case for integrated action, defining integrated action, clarifying the parameters of integrated action, and identifying shared priorities and strategies. It is also crucial for Alliances to find adequate resources to carry out their work, including establishing a model for obtaining and managing funding and other resources effectively. The challenges for the Alliances are to find (sustainable) funding to, among other things: create a functioning infrastructure with adequate human resources, support working groups, pay for travel, cover communications costs and conduct evaluation. Alliances meet these challenges by pursuing all avenues for funding and in-kind support from NGO, government and private sector sources, and then leveraging these resources in mutually beneficial ways. Alliances also need to structure

their collaboration and set up balanced and effective governance structures, which facilitate efficient decision making, foster broad participation and input, and ensure that ongoing efforts are made in key areas.

Alliances and governments at all levels need to establish effective and mutually beneficial working relationships. This requires patience, persistence and creativity, but there are significant benefits for both governments and the Alliances. Building an effective working relationship with government includes addressing issues related to communication and confidentiality. Where Alliances make an explicit commitment to advocacy, this can create some discomfort for government representatives involved, and requires creative solutions.

Alliances also need to develop the capacity to monitor and evaluate their work. Although the Alliances recognize the importance of this task, the lack of current capacity means that few formal evaluations have been conducted at this point (with some exceptions).

Achieving Results: The Accomplishments of the Alliances

Despite the relative youth of many Alliances, they have already accomplished a great deal. They have further developed the knowledge base for integrated action on chronic disease prevention and health promotion by conducting research and producing reports and resources that "make the case" for integrated action. They have built professional and community capacity for integrated action. They have successfully influenced and worked with governments at all levels. Often, the Alliances have been involved in or responsible for developing jurisdictional strategies. The success factors have included: the commitment of members, effective engagement and collaboration of diverse stakeholders, a commitment to building relationships and trust, collective expertise and leadership, and the ability to find and manage available resources and achieve results. The ongoing challenges for the Alliances include: insufficient resources, constantly changing environments, the management of diversity, and the continuing need to influence changes in government agendas.

Moving Beyond Alliance Building: Building a System for Chronic Disease Prevention and Health Promotion

At this point, the Alliances are moving beyond the process of Alliance building. They are working toward building the system of integrated programs, policies, research, surveillance and resources that is necessary to positively influence the determinants of health and reduce chronic disease in Canada.

1. INTRODUCTION

The Chronic Disease Prevention Alliance of Canada (CDPAC) is a national network of organizations and individuals who share a common vision for an integrated system of chronic disease prevention in Canada.[3] Constituted in 2001, CDPAC strengthens linkages among established, new, and emerging chronic disease prevention initiatives in Canada. CDPAC's mission is to foster and sustain a coordinated, countrywide movement toward an integrated population health approach for prevention of chronic diseases in Canada through collaborative leadership, advocacy, and capacity building.

Since its inception, CDPAC has worked closely with its provincial and territorial counterparts to share expertise and provide practical assistance and support. In 2004, CDPAC formally developed the Network of Provincial/Territorial Alliances to facilitate ongoing dialogue and information exchange among all jurisdictions. Network members include those Alliances that are leading the way in integrating action for chronic disease prevention and health promotion in every province and territory. Two representatives from each jurisdiction participate in the Network.

At this time, in each jurisdiction, the Alliances are at different stages of development. Some of the more recent Alliances are very interested in learning from the experiences of others in the Network. In response to this request, CDPAC prepared this report to synthesize the experiences and accomplishments of the P/T Alliances to date, and provide a "snapshot" of some of the Alliance work being done across the country at this time.[4]

1.1 Purpose of the Report

This report is a practical tool that documents the knowledge and expertise that the Alliances are gaining, as they become the leading forces for integration and change within their jurisdictions. It is designed to inform policy-makers and practitioners working in many different sectors across the country about the Alliance-building process - the crucial first step in taking integrated, collaborative action for chronic disease prevention and health promotion.

1.2 Methodology

To prepare this report, CDPAC developed and distributed a questionnaire to all members of the Network of P/T Alliances.[5] Nine jurisdictions provided formal responses to the questionnaire (see list of Existing Alliances below). This report synthesizes the information that respondents provided, and includes specific examples to illustrate key points.[6] Although the members of the Network of P/T Alliances reviewed the contents of this report, CDPAC takes responsibility for any errors or omissions.

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[3] While CDPAC was created to reduce chronic disease, it is understood that primary prevention includes health promotion and that the two cannot be distinguished.
[4] The report provides some key examples of the work that is underway in various jurisdictions at this time.
[5] The questionnaire is available on request from info@cdpac.ca.
[6] Where available, Alliances' websites were also reviewed.

2. THE CURRENT LANDSCAPE: OVERVIEW OF EXISTING PROVINCIAL TERRITORIAL ALLIANCES

2.1 What is a P/T Alliance?

For this report, the term "Alliance" refers to all the "groups of groups" currently participating in the CDPAC Network of P/T Alliances. This broad – and intentionally flexible – definition reflects the fact that, in practice, the "Alliances" are at different stages of development. Some are still "under development," while others have been active for a number of years.

Although this report refers to them all as "Alliances," in reality, the members of the Network of P/T Alliances are somewhat "similar but different" entities. For example, some call themselves "Alliances," others use the term "Coalition" or "Network"[7], and some do not use any of these terms.[8] They vary in terms of structure and other specific features. Nonetheless, they are all examples of how integrated action for chronic disease prevention and health promotion works in practice.

Regardless of their unique features, the collective experience of the P/T Alliances have a lot to teach about the challenges involved in collaboration and integrated action, and results that can be achieved through commitment, perseverance and creativity.

2.2 What Alliances Exist at this Stage?

Although alliance-building work is underway in every jurisdiction, at this time there are "formal" Alliances in place in nine jurisdictions.

[7] Alberta Healthy Living Network is a "network," according to the WHO definition: "A network is a grouping of individuals, organizations and agencies on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust."

[8] Even those that do not use these terms have agreed, for the purposes of this synthesis report, to be referred to collectively as "Alliances," based on the role they are playing within their jurisdiction.

Existing Alliances[9]

Manitoba (1997-): Alliance for the Prevention of Chronic Disease www.apcd.mb.ca

Nova Scotia (2000-): Nova Scotia Alliance for Healthy Eating and Physical Activity [10]www.hpclearinghouse.ca/index.asp?section=alliance&page=home

Alberta (2002-): Alberta Healthy Living Network www.health-in-action.org/AHLN

Newfoundland and Labrador (2002-): Provincial Wellness Advisory Council & Regional Wellness Coalitions.[11]
www.health.gov.nl.ca/health/publications/pdfiles/Provincial%20Wellness%20Strategy%20Issue%20III.pdf

New Brunswick (2002-): Healthy Eating Physical Activity Coalition of New Brunswick www.hepac.ca

British Columbia (2003-): British Columbia Healthy Living Alliance www.bchealthyliving.ca

Ontario (2003-): Ontario Chronic Disease Prevention Alliance www.opha.on.ca/projects/ocdpa.html

Prince Edward Island (2003-): Prince Edward Island Strategy for Healthy Living[12]
www.gov.pe.ca/photos/original/hss_hl_strategy.pdf

Saskatchewan (2004-): Chronic Disease Prevention Alliance of Saskatchewan[13]

[9] This list is organized according to the year in which the Alliance was officially formed, based on the information provided in the submissions and on websites. All subsequent examples boxes in this report reflect this chronological order. Additional information on provincial initiatives is available on the CDPAC website at: www.cdpac.ca/content/initiatives/provincial.asp.

[10] Although Nova Scotia has a provincial Chronic Disease Prevention Strategy in place, and an Advisory Council that is providing advice to the Minister, an Alliance for chronic disease prevention does not exist at this time. A coalition addressing tobacco – Smokefree Nova Scotia – also currently exists in the province. The response to the questionnaire was completed by the Nova Scotia Alliance for Healthy Eating and Physical Activity.

[11] The Council functions as an "alliance" and was appointed to advise the provincial government on the development of a Wellness Strategy. The Regional Wellness Coalitions function as a "network of alliances" supported by Regional Health Authorities.

[12] While the Strategy is not a separate "alliance" as such, it represents a unification of the collective vision of existing Alliances (Healthy Eating Alliance, PEI Active Living Alliance, and the PEI Tobacco Reduction Alliance), NGOs and other partners to address common risk factors for chronic disease. The Strategy is guided by a Joint Steering Committee, which includes representatives from these stakeholder organizations.

[13] The Alliance began in 2001 as an initiative entitled Partners in Risk Reduction, with funding from the Canadian Diabetes Strategy. The name of the group was officially changed to Chronic Disease Prevention Alliance of Saskatchewan in 2004.

3. THE BENEFITS OF ALLIANCE BUILDING

Based on the experiences of the Alliances, there are many significant benefits to building Alliances. Overall, the benefits include becoming an effective force for change, building capacity for integrated action, and learning from each other.

3.1 Becoming an Effective Force for Change

Alliances become effective forces for change because they benefit from:

Enhanced visibility for an integrated chronic disease prevention and health promotion agenda: As organizations and individuals come together within an Alliance, there is an exponential increase in the credibility and visibility of integrated chronic disease prevention and healthy promotion, among decision makers and the public.

Increased credibility and clout: By working together, Alliance members combine and compound their credibility and clout. They build on the existing authority and influence of each individual member organization. As a result, belonging to an Alliance can give Alliance members greater influence, including the potential to influence governments and other stakeholders.

Effective advocacy: For most Alliances[14], one of the most important benefits of building an Alliance is to become an effective advocacy tool. Often, Alliance members can send strong messages to governments, and members can take strong positions to support the Alliance on key issues.

3.2 Building the Capacity for Integrated Action

Alliance building increases the capacity for integrated action because Alliances benefit from:

Increased capacity for collaboration: Being part of an Alliance increases each member's capacity to collaborate with others to initiate work that will have an impact. Working together within an Alliance increases coordination, reduces duplication of effort, and facilitates information exchange and multi-sectoral decision making.

Enhanced communications capability: Alliances are often able to respond quickly to emerging issues. They provide a mechanism for developing and sending common messages out to a wide volunteer and/or population base.

Leveraging of resources: Although scarce resources are a constant reality for most organizations, working together within an Alliance can be an effective means of consolidating and leveraging resources for common goals.

[14] Not all Alliances include advocacy in their mandate or mission statement. This issue is discussed in more depth later in this report. (See Section 5.4 Working with Government.)

3.3 Learning from Each Other

Building Alliances provides opportunities to learn from each other through:

Knowledge development and capacity building: Just as CDPAC's Network of P/T Alliances provides a facilitated venue for Alliances across the country to learn from each other, each jurisdictional Alliance offers its members a forum for connecting, networking and partnering with others, within and across sectors. Alliance members benefit from differing perspectives on issues and the cross-fertilization of knowledge and expertise. As members work together and integrate their knowledge and initiatives, they learn from others' experiences and increase their understanding of "what works" in areas such as program delivery, communications and advocacy. Alliances offer unique opportunities for professional development, and increased community capacity.

4. GETTING STARTED: THE ORIGINS OF THE PROVINCIAL/ TERRITORIAL ALLIANCES

4.1 Forces for Change

Although the specifics differ in each jurisdiction, the forces that have led to the formation of Alliances have included some key ingredients, including:

Evidence: It was no longer possible to ignore the fact the growing tide of evidence: the data that showed Canadians gaining weight, being less active, and becoming ill with an array of preventable diseases. The statistics contained in the seminal reports – combined with the analyses of the health cost impacts (fiscal and human) – made it clear that something fundamentally different had to be done.

Visionaries: In every jurisdiction, key individuals – including practitioners, policy-makers and researchers working in non-governmental organizations, academia, government and elsewhere – recognized the need to shift the focus away from making separate efforts to address specific issues and diseases toward a shared focus on the common risk factors underlying these problems. These individuals saw that making this paradigm shift work would require collaborative, integrated action on the part of stakeholders in many different sectors.

Dialogue: In every case, Alliance building began by bringing key individuals from different organizations together in meetings, workshops, and conferences. In some cases, the first step was a meeting of key NGOs with a specific view to beginning an Alliance for integrated action. In other cases, the need for Alliance building emerged as various stakeholders involved in existing federal or provincial initiatives decided to build on their achievements by shifting toward a broader emphasis on common risk factors.

Commitment: Even the earliest steps in building Alliances required commitment and support from individuals and organizations in order to: compile, analyze and report on the evidence, spread the word, and bring people together. Often, individuals and organizations participated in an ongoing process of dialogue and negotiation that, over time, led to forming the Alliances.

Time and resources (human and financial): Beyond the initial impetus provided by the early thinkers and the initial discussions among stakeholders, it takes time – and resources – to lay the groundwork for the "official" formation of an Alliance.

The Emergence of the Alliances

Manitoba (1997-): Based on the success of the Heart Health Projects, the project leaders recognized the potential of integrated action at the community level. They organized workshops and promoted dialogue among various players throughout the province. Eventually, they brought the key NGOs together. After 18 months of deliberations, the Boards of the six member organizations – Canadian Cancer Society, Manitoba Division; Heart and Stroke Foundation of Manitoba; Manitoba Lung Association; Canadian Diabetes Association – Manitoba/Nunavut Region; The Kidney Foundation of Canada, Manitoba Branch; and CancerCare Manitoba – approved the Alliance for the Prevention of Chronic Disease on Oct. 1, 1997. The Diabetes and Chronic Disease Unit, Manitoba Health and the Public Health Agency of Canada later became ex-officio representatives in the Alliance.

Nova Scotia (2000-): The impetus for the Nova Scotia Alliance for Healthy Eating and Physical Activity[15] was a major report on the obesity issue. After the presentation of the obesity report at a meeting, stakeholders decided to focus on common risk factors. At a subsequent meeting, these stakeholders formed the Alliance. Cancer Care Nova Scotia and the Nova Scotia Department of Health hosted stakeholder meetings and provided coordinating support and leadership for first year of the Alliance, until the Coordinating Committee was established.

Alberta: (2002-): In 2001, equipped with key research evidence from the Alberta Heart Health Project, representatives from Health Canada, Alberta Health and Wellness and several NGOs (including the Alberta Cancer Board) held an initial meeting to discuss working together on chronic disease prevention. At that meeting, they made plans to hold a forum for all potential stakeholders. In 2002, the Forum, organized by the Canadian Diabetes Association with funding from government, resulted in the formation of the Alberta Healthy Living Network later that same year (and the subsequent development of the Alberta Healthy Living Framework).

Newfoundland and Labrador: (2002-): The Newfoundland Heart Health Program successfully demonstrated the feasibility and sustainability of community action, and moved the province toward a focus on wellness. The Regional Wellness Coalitions are an extension of the coalitions originally established by the heart health program. The provincial government appointed the Provincial Wellness Advisory Council in 2002 to advise the provincial government on the development of a Provincial Wellness Strategy.

New Brunswick (2002-): The Healthy Eating Physical Activity Coalition of New Brunswick originated among stakeholders who participated in meetings sponsored by the Canadian Diabetes Strategy. The Canadian Diabetes Association and the Heart and Stroke Foundation of New Brunswick were founding members of the Coalition. The Canadian Cancer Society is now the NGO Co-Chair organization. Over the last three to four years, HEPAC has evolved to its current structured membership format including Steering Committee, Advisor and Affiliate members. Strategic priorities and associated working groups are established to move work forward.

British Columbia (2003-): After analyzing the impact of chronic disease prevention on the provincial health budget, the provincial health ministry organized a meeting of key NGOs in 2003. This meeting led to the formation of the British Columbia Healthy Living Alliance, which began meeting regularly to discuss shared targets. An extensive research review process (the results of which appeared in 2004) and the hiring of a part-time Director increased the momentum for action.

[15] Although Nova Scotia has a provincial Chronic Disease Prevention Strategy in place, and an Advisory Council is providing advice to the Minister, an Alliance for chronic disease prevention does not exist at this time. The response to the questionnaire was completed by the Nova Scotia Alliance for Healthy Eating and Physical Activity.

Ontario (2003-): Based on the recommendations of a seminal report by the Centre for Behavioural Research and Program Evaluation (CBRPE) entitled, Stroke Prevention to Health Gain Report, a number of key individuals, including representatives of the Ontario Public Health Association, Cancer Care Ontario, Centre for Behavioural Research and Program Evaluation, and the Ontario Prevention Clearinghouse first met in 2002 to discuss integrated action for chronic disease prevention. Other NGOs soon joined this ad hoc group, including the Canadian Cancer Society, Canadian Diabetes Society, Osteoporosis Society, Centre for Addiction and Mental Health, Heart and Stroke, The Lung Association, and a number of Resource Centres. After hiring a manager for three months (with seed money provided by the Ontario Public Health Association), the Ontario Chronic Disease Prevention Alliance was officially formed in February 2003.

Prince Edward Island (2003-): Recognition of the rising health costs, combined with the September 2002 agreement of FPT Ministers on the Pan-Canadian Healthy Living Strategies, led the provincial government to hold a series of meetings and consultations with stakeholders in 2002. The work of the Canadian Cancer Society, the Heart and Stroke Foundation, the Lung Association and the Canadian Diabetes Association across multiple risk factors had also stimulated interest in collaborative approaches. Since the PEI Healthy Living Strategy was announced in 2003, the Healthy Eating Alliance, PEI Active Living Alliance and PEI Tobacco Reduction Alliance have served on the Strategy's Steering Committee.

Saskatchewan (2004-): In 2001, funding from the Canadian Diabetes Strategy led to the founding of a group called Partners in Risk Reduction in 2001, the forerunner of the current Alliance. The Canadian Diabetes Association and the Heart and Stroke Foundation of Saskatchewan (with the support of the Canadian Cancer Society) obtained the initial funding for the original partnership. By 2004, a Memorandum of Understanding and Terms of Reference had been approved for the Chronic Disease Prevention Alliance of Saskatchewan (and these were revisited in 2005).

4.2 Challenges and Solutions

Establishing an Alliance is not necessarily a smooth process: it requires commitment, time, and resources. Some of the challenges involved are inherent in trying to bring people together and keep them working together. The challenges involved are not necessarily unique to the "start up" phase – many of them may continue throughout the evolution of the Alliances. These challenges include the need to:

- compile the evidence and making the case for integrated action
- clarify a collective purpose/mission
- identify shared priorities and strategies
- balance diverse perspectives, build relationships and maintain partnerships
- obtain resources and find ways to get the work done
- monitor progress, and
- adapt to constantly shifting environments.

Dealing with these challenges requires planning, persistence, and leadership. Alliances need to find common ground while recognizing the autonomy (and the contributions) of all partners. Alliance building is also an ongoing balancing act: the partners need to work through process and, at the same time, find ways to achieve results, which then inspire a continued commitment to collaborative, integrated action.

5. MAINTAINING MOMENTUM: HOW THE ALLIANCES KEEP MOVING FORWARD

5.1 Articulating the Task

Some of the first steps in Alliance building involve articulating the task. This includes making the case for integrated action for chronic disease prevention and health promotion and clarifying how this "fits in" with other key concepts. It includes developing a mandate or mission, as well as a set of guiding principles, and often an overall vision. Alliances also clarify the parameters of the role(s) they will play and identify shared priorities and strategies to be pursued.

Making the case for integrated action

One of the critical tasks in building and maintaining momentum is making sure that everyone involved understands the need for integrated action. Given the diversity of stakeholders that need to be engaged, and depending on the number and type of organizations involved, it can take a significant effort to get everyone "on the same page." Most Alliances have worked hard to clarify what integrated action is all about, why it is important, and who should be involved and how.

Tools that Alliances have used to compile the evidence and "make the case" for action include, for example, reports on key issues and shared risk factors (including recommendations for action), research/literature/intervention reviews, cost-impact analyses, environmental scans, mapping exercises and position papers. Sometimes these tools have provided the initial impetus for an Alliance, or helped Alliance members develop a more developed understanding of the rationale for action. In some cases, these tools support advocacy efforts, or help recruit stakeholders and generate buy-in from other sectors.

"Situating" integrated action

The phrase "collaborative, integrated action for chronic disease prevention and health promotion" is a mouthful. And there are many other important terms and concepts that relate to this work. To help members (and others) better understand and "situate" how integrated action "fits in," many Alliances have found it helpful to use some of the CDPAC tools to "situate" their work, including CDPAC's definitions (www.cdpac.ca/content/faqs/alliance_definitions.asp), shared vision and guiding principles (www.cdpac.ca/content/about_cdpac/shared_vision.asp).

Examples of Definitional Tools

Some Alliances have found it useful to provide access to definitions of key concepts and terminology as "framing" material. Some examples include:

Manitoba: The Alliance for the Prevention of Chronic Disease website refers to CDPAC's website definitions. In addition, the Alliance's website includes the definition of integrated action from the WHO Global Forum for Integrated NCD Prevention and Control.

Alberta: The Alberta Healthy Living Network describes key concepts underlying healthy living on its website.

In some cases, Alliances have also found it helpful to articulate the principles on which integrated action is based.

Examples of Guiding Principles

Alberta: Principles are contained in the Alberta Healthy Living Framework.[16] They include definitions of the following principles: integrated approach, population health and holistic approach, evidence-based and sustained strategies, and comprehensive and long-term preventive focus.

Ontario: The Ontario Alliance for Chronic Disease Prevention has developed a set of Guiding Principles.

Prince Edward Island: The PEI Healthy Living Strategy has established a set of Guiding Principles.

A number of Alliances have chosen to link integrated action for chronic disease prevention and health promotion to a broad vision for the future.

Examples of Visions

Alberta: "Albertans lead healthy lives in healthy communities."

New Brunswick: "For every New Brunswicker to lead a healthy lifestyle."

Prince Edward Island: "Optimal health for all Islanders."

Clarifying the parameters of integrated action

All Alliances have found it helpful to articulate their mandates. These serve as "filters" for helping Alliance members and others understand what the Alliances are and what they do (or do not) do. Most Alliances have been able to include advocacy[17], collaborative leadership and capacity building within their mandates (and have delivered in all three of these areas).

Whenever there are major shifts in the environment, such as the implementation of a government strategy, Alliances may revise their mandates to ensure they continue to be responsive and relevant.

[16] The Alberta Healthy Living Network has developed a Framework document that contains all of the components discussed in this section of the report including guiding principles, vision, mandate, priority strategies, etc. The Framework is a guide for all those involved in the Network.

[17] Many, but not all, of the Alliances have included advocacy in their mandate. For further discussion of this issue see section 5.4 Working with Government.

Examples of Mandates and Mission Statements

Manitoba: [The Alliance for the Prevention of Chronic Disease will advocate for] "a sustainable, comprehensive and effective primary prevention system for Manitoba." [Note: The Alliance adopted this new mission in 2005. The Alliance no longer focuses on strengthening health care capacity because other organizations, the government and the public have now embraced this agenda. In addition, a recently announced provincial Chronic Disease Prevention Initiative will focus on capacity building in Manitoba communities. To reflect this new environment, the Alliance has identified this new role for itself. The components of a chronic disease primary prevention system include: 1) evidence-based goals, programs and policies, 2) resources and training for effective primary prevention outcomes, 3) surveillance and evaluation system, and 4) sustained and sufficient funding for a primary prevention system.

Alberta: "To provide leadership for integrated, collaborative action to promote health and prevent chronic disease in Alberta"

Newfoundland and Labrador: The Provincial Wellness Council's responsibility is to advise the Department/Government on strategy/policy/programming and to monitor the Government's progress on implementing a Provincial Wellness Strategy. The responsibility of the Regional Wellness Coalitions is to develop and deliver programs and policies related to wellness in their regions.

British Columbia: "Advocacy, collaboration, capacity building."

Ontario: "To improve the health of Ontarians through leadership that supports collaborative action to promote healthy living and to address the determinants of health necessary for chronic disease prevention."

Prince Edward Island: [The mandate of the PEI Strategy for Healthy Living is] "to promote collaborative efforts to address three common barriers to health." "The PEI Strategy for Healthy Living, through its partners, will collectively encourage and support Islanders to take measures to address the common risk factors that contribute to chronic disease (tobacco use, unhealthy diet, physical inactivity)."

Identifying shared priorities and strategies

One of the most crucial tasks for Alliances is identifying shared priorities and strategies for integrated action. Many Alliances have used CDPAC's Strategic Directions to help get this process started (www.cdpac.ca/content/about_cdpac/strategic_directions.asp).

Examples of Priority Actions and Strategies for Integrated Action

Manitoba: The five priorities related to the Alliances' new mission include:
1) sustainable funding for primary prevention in Manitoba
2) appropriate evidence-based goals in primary prevention
3) effective surveillance system for prevention
4) qualified human resources for primary prevention, and
5) evidence-based primary prevention policies.

Alberta: The priority strategies for the Alberta Healthy Living Network include:
1) Awareness and Education
2) Healthy public policy development
3) Partnership Development and Community Linkages
4) Best Practices
5) Surveillance
6) Health Disparities
7) Research and Evaluation.

The Network intends to strengthen existing partnerships that support healthy living. The ANLN addresses the issues of healthy eating, physical activity, tobacco reduction, mental health and injury prevention within a population health approach. The Network supports the development of new initiatives at the local, regional and provincial level in settings such as schools, RHAs, recreation facilities, worksites and restaurants.

British Columbia: In British Columbia, the BC Healthy Living Alliance has established specific targets. By the year 2010, among British Columbians:
- 9 out of 10 do not smoke
- 7 out of 10 eat at least 5 servings of vegetables and fruits
- 7 out of 10 are physically active.

Ontario: The Alliance's priority is to develop the Chronic Disease Prevention Strategy.

Prince Edward Island: The Healthy Living Strategy focuses on: policy development, increasing collaborative action, capacity building that strengthens community action and creates supportive environments.

5.2 Finding the resources

Finding funding and other types of resources and managing them effectively is a central issue – and an ongoing challenge – for Alliances. There are many different funding models in place, but all of the Alliances face significant resource challenges. They have developed creative approaches to try and overcome these challenges.

Obtaining support

It takes resources, both financial and human, to "take the ball and run with it." Without adequate resources, coordination of and support for Alliance members depends on the amount of time members can "donate" from their other responsibilities. For some Alliances, the human resources to support the Alliance remain "side of desk" commitments from individuals working within member organizations. Unfortunately for the Alliances, being able to "do a lot with a little" can leave the impression that few resources are required.

In fact, to really make progress, Alliances require financial resources for many different types of tasks at various stages, including:

- Facilitating the process of dialogue and communication involved in starting an Alliance ("seed money" to get things started)
- Setting up and staffing a coordination secretariat (paying for salaries, supplies, equipment, office space, services and support)
- Covering the cost of communications, including face-to-face and electronic meetings (travel, facilities, AV, teleconferences, reporting) among members
- Supporting the decision making process, including strategic planning, proposal preparation, financial and progress reporting, etc.
- Supporting and implementing the vision of the working groups, and
- Conducting specific projects, including, for example, research, consultation, framework development, communications initiatives, website development, and so on.

To date, Alliances have obtained their financial (and in-kind) support from member organizations (including governments). "Seed money" has come from, for example, a donation of funds by a non-profit organization involved in the start up process, or from a provincial or federal government department deciding to host a meeting or a consultation process. Ongoing funding has, in some cases, been provided by the joint contributions of the "founding members" of the Alliance, or through successful proposals submitted to provincial or federal funding programs associated with major government strategies such as the Canadian Diabetes Strategy. Project funding has been provided by many different sources including member organizations in the non-government and public sectors. Generally speaking, membership fees do not appear to contribute a significant proportion of alliance funds but "every little bit helps" the Alliances' coffers. In some cases, Alliances have taken on contract work on behalf of government departments.

Sources of funding are obtained through a variety of processes, including engaging representatives of government departments in Alliance decision-making bodies, maintaining ongoing dialogue and negotiations with government funders (to generate new funding and continue/expand funding), preparing and submitting proposals to government departments, developing Memoranda of Understanding and Affiliation Agreements (for members' in-kind and financial support), and developing budgets for the Chair to use as basis for soliciting funds from member organizations.

Current Funding Models

Alliances' resources are used for many different activities. The following information highlights where resources have been allocated for infrastructure. In general, those Alliances with secretariat support have found it much easier to move an integrated chronic disease prevention and health promotion agenda forward in their jurisdictions.

Manitoba: Each of the six member organizations on the Council provides financial contributions to the Alliance. The Council is made up of either the Regional Director or the Chief Executive Officer and a senior board member from each organization. These individuals are in a position to make decisions about their organizations' budgets, including the allocation of resources to the Alliance. Some of these resources are used to support a Secretariat (including a Managing Director position).

Nova Scotia: The two co-lead organizations (Cancer Care Nova Scotia and the Nova Scotia Department of Health) and member organizations provide in-kind support for the Alliance. The co-lead organizations provide in-kind staff support for coordination and administration as well as core funding support. The other member organizations provide project funding as needed/available, as well as in-kind supports that include staff time, travel costs to attend meetings, skills (facilitation or evaluation), and utilization of an organization's infrastructure to support Alliance work. The Health Promotion Clearinghouse provides in-kind support by housing the Alliance's web page.

Alberta: Coordinating Committee Members, including the provincial and federal governments, provide funding for the AHLN. Resources include government grants from provincial and federal departments, as well as resources provided by the nine member organizations that are signatories to the AHLN Affiliation Agreement for in-kind and financial support. Resources are used to support office operations, salaries (Manager and Administrative Assistant), travel, operation of the working groups, and to carry out grant criteria for specific projects.

Newfoundland: The provincial Department of Health and Community Services pays the expenses of the Provincial Wellness Advisory Council and provides administrative support via the Wellness Team within

the Department. The Council does not have a budget of its own. The Department funds the Regional Wellness Coalitions and also provides indirect forms of support, including teleconferences, workshops, and the development of resources. Regional Health Authorities provide administrative support for the Coalitions. Some Coalitions have obtained small amounts of money from other sources.

New Brunswick: The provincial Department of Health and Wellness provides funding for the Coalition. Resources are used to support the Secretariat (one part-time salary and meetings).

British Columbia: The Alliance is self-funded: the members of the Coordinating Committee provide the funding. The Alliance establishes a budget and then encourages members to contribute either financially or in-kind, according to their capacity. Some of these resources are used to support the Secretariat.

Ontario: Funding is provided by the federal and provincial governments. Initially, the Alliance obtained three months' funding from Health Canada (now PHAC), followed by one full year of funding. The provincial Ministry of Health and Long Term Care (now the Ministry of Health Promotion) also contributed some funds. The Alliance has received a second year of funding from PHAC. The Canadian Cancer Society provides significant in-kind resources for meetings and AV support. Member organizations donate skilled staff to serve on working groups and provide knowledge exchange and advocacy. Resources are used to support the Alliance's secretariat (including a manager position and some administrative assistance) and to undertake specific projects, including the development of a provincial strategy.

Prince Edward Island: Financial and in-kind resources for the Strategy come from the federal government, the provincial government and the NGOs, community groups and others involved in the Strategy. Federal contributions have supported project work as well as support to attend meetings (national and regional) to develop networks. Provincial government has provided core funding and project grants. In-kind support from NGOs and community groups has included the provision of meeting space, minute taking, supplies, technical expertise, etc. NGOs and community groups have also provided financial resources for specific projects.

Saskatchewan: The Canadian Diabetes Association and the Canadian Cancer Society each contribute an equivalent annual amount to cover the Alliance's meeting costs. Saskatchewan Health covers the travel costs for some members to attend meetings. Other members cover their own travel costs and provide staff-time as in-kind contributions.

Managing resources

The way in which the Alliances manage their resources tends to depend on whether or not the Alliance has an infrastructure in place. Where an Alliance has been able to hire staff, such as a Manager or Managing Director, that individual assumes responsibility for managing the resources (and reporting to the Alliance's decision-making body), while a member of the Alliance assumes the financial/legal responsibility for receiving and reporting on government funding. In Manitoba, the Alliance for the Prevention of Chronic Disease is in the unique situation of having incorporated as a legal entity.

For Alliances without infrastructure, there are two scenarios: either 1) the representatives of those organizations that provide resources take responsibility for managing their organization's contribution to the Alliance, and tracking it back to their organizational budget, or 2) a leading NGO member of the Alliance (such as the Co-Chairing organization) assumes the responsibility of managing either all of the Alliance's resources on its behalf, or those devoted to a specific project.

Resource challenges

The main resource challenges for the Alliances are to find (sustainable) funding for:

Creating a functioning infrastructure with adequate human resources: Although the Alliances have shown that a little bit of money can make a big difference, Alliances could do so much more if they had adequate secretariat support, including resources for coordination (i.e. a dedicated Coordinator position) and administrative support. Even in those Alliances that have some staff, managers may not have adequate administrative support. Similarly, where staff are in place, but are being paid out of both operations budgets and project grants, the need to fulfill project requirements (often for different government departments) can fragment staff capacity to carry out operational tasks.

Supporting working groups: Alliances need financial and human resources to implement the vision of the working groups, and avoid overtaxing volunteers who provide valuable input.

Paying for travel: For Alliances working in some rural and remote regions, travel is a significant cost.

Communications (internal and external): Alliances play a critical role in facilitating information sharing and communication among many players. The tools to facilitate this process (meetings, conferences, websites, etc.) cost money. In addition, reaching out beyond the Alliance membership to send messages to broader audiences is also expensive, e.g. implementing a communications strategy requires additional resources.

Evaluation: Although they recognize the value of evaluation, most Alliances do not have the capacity (human or financial) to conduct formal evaluations of their work. (See section 5.5 Measuring Progress.).

Other challenges include:

Lack of professional and volunteer capacity: Often there is strength in numbers as Alliances amass a greater volunteer base in terms of numbers. However, in some parts of Canada, there are limited numbers of both professionals and volunteers available to become involved.

Insufficient knowledge of funding sources: Alliances need to know about available funding sources and how to apply for these resources.

Creative strategies to overcome resource challenges

The Alliances use a variety of creative strategies to deal with resource challenges. These include, for example, the following:

Promotion and advocacy: The Alliances pursue all possible avenues for funding and in-kind support from NGO, government and, in some cases, corporate sources. These strategies include, for example, persuading funders that the Alliances play a key role in

providing collaborative leadership; investing in communications to increase buy-in by promoting the activities and accomplishments of the Alliances; extending the membership base; advocating for multi-year secretariat funding; engaging local politicians to influence those at the provincial level; building on the influence of national NGOs at the regional level; and adjusting Alliances activities to align with funders' priorities, needs and intended outcomes.

In some cases, the Alliances identify specific projects that members can rally around and commit funds to. They ensure that these projects are collaborative, address multiple risk factors and include plans to sustain the activity beyond project completion.

Leveraging resources: Alliances seek opportunities to leverage resources, in mutually beneficial ways. This includes, for example, promoting members and enhancing their profiles (as a benefit of belonging to the Alliance), conducting shared media campaigns, and co-hosting conferences with organizations that have strong conference planning processes in place. It is helpful if government funding includes a commitment to leverage resources, and if there is flexibility in terms of proposal preparation, and project start and end dates.

5.3 Structuring the Collaboration

The Alliances recognize that collaboration requires structures that ensure effective and efficient decision making, broad-based participation and input, and a productive approach to accomplishing specific tasks and moving forward in priority areas.

Setting up governance structures

Governance structures are the mechanisms through which the Alliances make joint decisions for action. They also establish how various Alliances' members will participate in the Alliance, and the roles they will play. Given the impact of these structures on decision making and getting the work done, setting up governance structures is a critical task.

In setting up governance structures, Alliances have to balance their need to be:

- Credible
- Inclusive of/representative of key stakeholders
- Knowledgeable
- Stable
- Flexible
- Collaborative
- Efficient, and
- Effective.

Decision-making mechanisms

All Alliances need leadership and a mechanism for making decisions. This means assembling a group of representatives who can work together to make strategic decisions in a timely manner. Given the importance of this role, the size and make up of the decision-making group affects an Alliance's credibility, expertise, stability, nimbleness, authority, capacity, and overall ability to facilitate effective collaboration among stakeholders.

Credibility: Decision-making bodies that include diverse members from various sectors add to the Alliances' credibility as organizations that are representative and reflective of different perspectives. It enhances buy-in and strengthens the power of the Alliances' voice, but that has to be balanced with the time and energy involved in balancing those different perspectives.

Expertise: Decision-making bodies must also include organizations and/or individuals who have appropriate expertise in key areas (and this may involve recruiting specific members and evolving to accommodate new members and their contributions).

Stability: Stability is important. Frequent turnover on the decision-making body can delay and disrupt the work of the Alliance. At the same time, there are significant demands on individuals' time and energy that need to be recognized and adequately supported.

Nimbleness: Within ever-changing jurisdictional environments, decision-making bodies must be able to respond and make decisions quickly. It is very helpful if the decision making body is a group that can be convened frequently (or regularly) to have timely discussion of issues.

Authority: If the representatives are senior level decision makers within their organizations, they can bring this authority to the Alliance table.

Capacity: The make-up of the decision-making body impacts on the overall capacity for integrated action. For example, the involvement of government representatives in decision-making bodies can have an impact on the Alliances' capacity to play an advocacy role (see section 5.4 Working with Government).

Ability to facilitate collaboration: The decision making body must be capable of facilitating collaboration and integrated action by organizations and stakeholder groups who, very often, are competing for scarce donor dollars and/or government funding.

Within the current Alliances, the decision-making bodies have different names (Council, Coordinating Committee/Executive Committee, Steering Committee, etc.), but their roles tend to be somewhat similar and include: setting priorities, strategic planning, decision making, and overseeing operations (where secretariat infrastructures exist). In addition, they play other important roles including facilitating information sharing and coordination, leveraging resources, maintaining a jurisdictional focus, and monitoring progress.

In some Alliances, all members are represented on the decision-making body, but often, the Alliances have decided, for practical reasons, that an effective decision-making body needs to be a smaller sub-group. Often the members of this group include those organizations that partnered to set up the Alliance. These organizations are often those who provide resources (financial and in-kind) to support the work of the Alliance.

Examples of Decision-making Mechanisms

Manitoba: The governing Council includes the Chief Executive Officers of all six of the member organizations, plus a senior board member from each organization. An additional six members at large provide expertise in key areas. There are also two "ad hoc" members (non-voting positions), which include a representative from each of the provincial and federal governments.

Nova Scotia: There is a 10-member Coordinating Committee.

Alberta: There is a 25-member intersectoral Coordinating Committee, but there is also a smaller Executive Committee that focuses on operations.

Newfoundland and Labrador: Ministry of Health and Community Services appoints the members and Chair of the Provincial Wellness Advisory Council. The Regional Coalitions have either core executive groups or larger decision-making bodies.

New Brunswick: Has a Steering Committee with government, non-government and private sector members.

British Columbia: There is a Coordinating Committee with voting and non-voting members, and an Operations Committee.

Ontario: The core partners are the group that acts as the Steering and Executive Committee.

Prince Edward Island: There is a Steering Committee.

Saskatchewan: There is a Steering Committee.

Many Alliances have found it helpful to develop tools to define the roles and responsibilities of the members of decision-making bodies, and the tasks to be carried out. These tools have included Memoranda of Understanding, and Terms of Reference. Often, the Alliances have utilized CDPAC's Memorandum of Understanding as a starting point for developing their own tools.

Memorandums of Understanding signed by members of the decision-making body may specify, among other things, the financial contributions that members are expected to make to the Alliance. Terms of Reference provide operating guidelines for either the Alliance as a whole, the decision-making body, or the working groups. Terms of Reference clarify the manner in which Chairs, Co-Chairs and members make decisions, share responsibilities and workload.

Mechanisms for participation and input

Members are the Alliances source of strength. Member organizations provide the credibility, creativity and support that Alliances need to be effective forces for change. The number of members in the Alliances impacts on practical issues such as the volunteer base, and on the extent to which the Alliance is seen to be representative, inclusive and intersectoral. Given that decision-making bodies cannot carry out all of the work that needs to be done, other members are a critical source of input and energy. The size and scope of its membership base gives strength to an Alliance's "voice," so Alliances have engaged organizations from health and many other sectors. Alliances may have members from:

- Federal government departments
- Provincial government departments
- Municipalities
- Non-profit organizations
- Professional organizations
- Regional health authorities
- Regional alliances and networks
- Academia and the research community
- Aboriginal groups, or
- Other groups.

Examples of the Alliances "Reach"

Alberta: Has over 100 intersectoral members.

British Columbia: Collectively, BCHLA members capture the attention of over 40,000 volunteers, 4,300 health and recreation professionals, and 184 local governments across British Columbia.

For practical reasons, Alliances with many members – or who want to incorporate and include more members – have found it helpful to distinguish different levels or types of membership. Membership categories tend to reflect differing roles and levels of involvement. In general, while a relatively small group of members may be represented on the decision-making body, the broader membership often includes many more organizations and individuals who contribute in a variety of ways, including participating in working groups or committees. In British Columbia, for example, provincial NGOs and regional alliances are welcome to join the Alliance as general members, while individuals can become subscribers. In Alberta, the Network includes 100 intersectoral members and "affiliate" members. Ontario also has "affiliate" members (these are members who may participate in working groups, but who have not signed the Memorandum of Understanding and are, therefore, not expected to make a financial contribution to the Alliance). In Nova Scotia, the "broader membership" includes 100 organizations.

As an Alliance grows, it can be very helpful to establish clear criteria for membership categories and to articulate the benefits and responsibilities of each. In order to avoid

conflicts due to hierarchies, all categories of members need incentives and opportunities to be involved in a meaningful way and to reap the benefits of membership.

It is important that Alliance members recognize the benefits of belonging to an Alliance. Consequently, the Alliances try to ensure that members can clearly "make the link" between the work of the Alliance and their own agendas. In addition, they make an effort to promote member organizations on their websites and elsewhere, in order to enhance their members' profiles.

Some of the Benefits of Alliance Membership

The benefits of membership, as identified by the Alberta Healthy Living Network, include:
- networking with other individuals and groups through the listserv, forum and other events;
- learning about potential partners for integrated action
- utilizing the resources of the AHLN, including the Alberta Healthy Living Framework, as a tool for action planning (and linking with others who are working to achieve a plan for integrated healthy living in the province)
- mobilizing and advocating for the [Alberta Healthy Living] Framework's priority strategies
- linking with national and international initiatives including CDPAC and the Pan Canadian Healthy Living Strategy
- participating in the Health in Action database
- participating in the mapping of healthy living groups across the province
- being part of a network that can leverage resources from government and other sources, and
- participating in ongoing educational opportunities to learn about and share experiences.

Mechanisms to get the work done

As a means of capitalizing on members' knowledge and experience and sharing the workload, some Alliances have set up committees or working groups to carry out certain tasks, or focus on specific areas of their mandates. In some cases, these groups are guided by Terms of Reference. While it can be a challenge to enlist broad participation on working groups and ensure that the groups include participants from across the jurisdiction, Alliances' working groups have contributed a great deal including, among other things, hosting conferences, supporting research, designing initiatives and shaping specific strategies.

Examples of Working Groups

Nova Scotia: Networking Working Group (working Groups on Communication and Advocacy are under development).
Alberta: Seven working groups address the seven strategic priorities: partnership development and community linkages, awareness and education; best practices; health disparities; healthy public policy; and surveillance. The awareness and education, and the best practices groups have developed Terms of Reference.
New Brunswick: Six working groups address the strategic priorities including engaging municipalities, recreational facilities, workplace wellness and others.
Ontario: Strategic Planning Working Group

5.4 Working with Government

The Alliances recognize that working with government is a crucial task. They have developed effective working relationships with governments at all levels. Both governments and Alliances reap the benefits of these working relationships. The process of maintaining these relationships – and overcoming their inherent challenges – is ongoing.

Building effective working relationships

Appropriate government investment in integrated policies and programs is a central ingredient in developing integrated approaches to chronic disease prevention and health promotion. Of all the stakeholders involved, governments have the largest resource base. Their actions and decisions are crucial. The Alliances recognize that effective working relationships with government are essential to creating change. Hence, Alliances serve important roles as advocates, advisors, and partners of governments (at all levels). In turn, governments provide varying types of input and support for the Alliances.

In practice, the Alliances have developed effective working relationships with government that encompass different arrangements, across a broad spectrum of engagement and involvement. Alliances that include advocacy as one of their core functions have created mechanisms for ongoing liaison with government, but they operate independently. In other cases, governments played a key role in the creation of the Alliances and now participate as partners in the Alliances' decision-making bodies (although not necessarily with voting privileges). Depending on the Alliance, governments may also provide some level of funding for the Alliances' operations, or contribute financial support for specific projects (through grants or contracts). In other cases, governments have convened or appointed the Alliances to provide input and advice on government strategies.

Government Participation in Alliances' Decision-making Bodies

Manitoba: Representatives from the federal government (PHAC) and provincial government (Manitoba Health) sit on the Council as "ad hoc" members (non-voting "liaison" positions).

Alberta: Representatives of the federal and provincial governments are members of the Coordinating Committee and the Executive Committee.

New Brunswick: Representatives of five provincial government departments participate in HEPAC. One of those government representatives is the Co-Chair of HEPAC.

British Columbia: The Coordinating Committee includes a provincial government representative (non-voting) and a local government (UBCM) representative (voting).

Saskatchewan: Representatives of the provincial government and the federal government participate in the Alliance (in ex-officio capacity).

Benefits of effective working relationships with government

Effective working relationships with governments at all levels offer significant mutual benefits for both Alliances and governments. For governments, these include, among other things: access to the expertise, knowledge and experience of the Alliances and their members in developing and implementing briefing documents, policy papers, and the development of integrated strategies, public "championing" and support from the Alliances for government initiatives and funding announcements, ongoing access to a forum for dialogue and discussion of issues, and assistance in maintaining continuity in communication and information exchange among players involved in a dynamic environment (including among different levels of government and various government departments).

For the Alliances, good working relationships with government can result in information sharing, engaging individuals who can act as "internal champions," obtaining financial support, and better understanding of government priorities for policies and programs.

Challenges in working with government

Although the Alliances have developed good working relationships with governments at all levels, it requires patience, persistence and creativity.

***Communication*:** Keeping the channels of communication open is very important, particularly within dynamic environments. Building relationships and maintaining communication to and from government at a senior level is very important. Some Alliances try very hard to meet/communicate regularly with Ministers and senior government officials. They have found it is helpful to be as transparent as possible, e.g. sharing minutes of Alliance meetings and other information, advising government personnel of their intentions to contact Ministers (and Premiers), and being as specific as possible about what needs to be done and when.

***Confidentiality*:** Government processes for timing funding announcements can sometimes pose difficulties for Alliances' capacity to plan. At the same time, given that there are times when either governments (or Alliances) request or require confidentiality, it is important to understand the different roles of governments and non-governmental organizations, and the parameters within which they must operate.

***Providing "the link" between players*:** Given that there can be significant turnover within governments in a short period of time, Alliances may sometimes be in a position to help maintain connections, linkages and communication within and between different levels of government during periods of significant changes. In addition, governments sometimes view Alliances as providing convenient "one-stop" access to non-governmental organizations, even when Alliance members may not be in a position to "speak" for their organizations. For Alliances, being "the link between players" can be both an advantage, and a potential burden.

Trust: Given the breadth of experience and expertise within the Alliances, it can be a challenge for Alliances to "trust" government personnel, who may or may not have the same extensive background in the field, to develop and implement effective initiatives.

Advocacy: When Alliances make an explicit commitment to engage in advocacy, it may create some discomfort and difficulty for government representatives involved in the Alliance. There are, however, some strategies that Alliances have used to avoid this. In one case, an Alliance has chosen to get around this problem by creating an Advocacy Team comprised of non-governmental members of the Alliance.[18] In other cases, Alliances ask government representatives to serve in ex officio or liaison capacities only, so that they are less likely to feel compromised. In addition, there are times when Alliance members may have their own agendas for government relations/advocacy, and these need to be balanced with the work of the Alliance.

5.5 Measuring Progress

The Alliances recognize the importance of monitoring and measuring progress toward their goals. However, the current capacity to conduct formal evaluation remains limited. There are a number of requirements that need to be met in order to build this capacity.

Evaluation processes

Given the lack of resources available to invest in formal evaluation exercises, to date most of the Alliances have relied on relatively informal "self-evaluations" of their progress. These activities have included tracking and reporting on planned activities against annual work plans, conducting evaluations of specific projects or activities (e.g. workshops), or, in one case, conducting a survey of members. To date, only one Alliance (Alberta Healthy Living Network) has developed evaluation tools and conducted a formal evaluation.[19] The AHLN has developed an Evaluation Framework for the Network. An external consultant has evaluated the AHLN Structure and Processes.[20]

Developing evaluation capacity

Despite the fact that formal evaluations have been limited, the Alliances recognize the importance of developing evaluation capacity. They would welcome the opportunity to obtain and utilize reliable, meaningful evaluation results. Building this capacity, however, will require adequate funding, as well as:

- A commitment to the process of evaluation
- Engagement of Alliance members
- Adequate support (internal and external human resources)

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[18] New Brunswick created a separate Healthy Living Advocacy Team of non-government Coalition members to address advocacy issues. (This is not a HEPAC working group.)

[19] A provincial evaluation unit supports the PEI Healthy Living Strategy.

[20] CDPAC has also done some formal evaluation work, including developing a logic model in 2002, followed by an extensive evaluation study a year and a half later (the results are available on request from info@cdpac.ca). Each year, CDPAC develops indicators of success to measure its progress toward its short-term outcomes, and an external evaluator measures these.

- A collaborative approach
- Development of appropriate, meaningful indicators (valuing both process and outcome measures)
- Streamlined data collection processes
- A shared understanding of what will be reported on, and how the results can be applied
- Dissemination of results, and
- A commitment to using the findings to add value to/inform/change how the Alliances do their work.

6. ACHIEVING RESULTS: THE ACCOMPLISHMENTS OF THE ALLIANCES

Despite the relative youth of many Alliances, they have already accomplished a great deal. First, given the resource constraints that many Alliances face, it has often been a significant achievement just to carry on. But the Alliances have done much more than just "stay afloat." They have all moved steadily forward: engaging partners, creating (and adapting) governance structures, developing strategic plans and priorities, and taking action to develop integrated approaches to chronic disease prevention and health promotion. The Alliances continue to work toward the system of integrated programs, policies, research, surveillance and resources that is necessary to positively influence the determinants of health and reduce chronic disease in Canada.

6.1 Making the Case for Integrated Action and Spreading the Word

The Alliances have further developed the knowledge base for integrated action on chronic disease prevention and health promotion by conducting research and producing reports and resources that "make the case" for integrated action.

Making the Case

Many of the Alliances have found the CDPAC website document entitled, "The Case for Change" (www.cdpac.ca/content/case_for_change/case_for_change.asp), helpful in making the case for change within their jurisdictions. Alliances across Canada have also developed many other tools of their own. Examples include:

Manitoba: Alliance for the Prevention of Chronic Disease has produced two position papers (first paper was produced in 1996 before the Alliance formed, and the second paper was produced in 2002). The Alliance is currently finalizing a third paper, "Building the Case for a Chronic Disease Primary Prevention System for Manitoba."

Nova Scotia: The "Cost of Chronic Disease in Nova Scotia" report provided the foundation for the Provincial Chronic Disease Prevention Strategy.

Alberta: The Alberta Healthy Living Network has produced an economic analysis entitled, *Chronic Disease in Alberta: Cost of Treatment and Investment in Promotion*.

New Brunswick: HEPAC developed a Business Case for Chronic Disease Prevention in New Brunswick in 2002. HEPAC also completed a synthesis document on Media and Marketing.

British Columbia: The BC Healthy Living Alliance has developed an Advocacy Platform, which contains recommendations and an economic analysis.

Ontario: The Ontario Alliance for Chronic Disease Prevention has mapped current collaborations across the province. The Alliance has also produced "Chronic Disease in Ontario and Canada: Determinants, Risk Factors and Prevention Priorities."

The Alliances have also played an important role in facilitating ongoing dialogue and information sharing. The Alliances function as communications and networking "hubs," keeping stakeholders – and potential stakeholders – across different sectors and locations connected, informed and involved. In addition to organizing face-to-face meetings and conferences when needed, the Alliances also utilize technology to keep members informed and connected.

6.2 Building Professional and Community Capacity

The Alliances have played a key role in building capacity for integrated action on chronic disease prevention and health promotion. This includes their demonstrated commitment to provide opportunities for professional development, their ongoing support for program development and community capacity building, and their efforts to put prevention on the agenda of other organizations and alliances.

Examples of Capacity Building

Manitoba: The provincial government has recently announced the Chronic Disease Prevention Initiative, which will focus on community capacity building in Manitoba. The Alliance for the Prevention of Chronic Disease worked closely with the federal and provincial governments to develop this Strategy. In addition, the Alliance has partnered with health regions to host workshops for health professionals, and hosted annual provincial institutes for health professionals. The Alliance has helped put prevention on the agenda of other organizations, including the Manitoba Tobacco Reduction Alliance (MANTRA) and the Manitoba Physical Activity Coalition (PACM).

Nova Scotia: The Alliance has created a provincial healthy eating Strategy (Healthy Eating Nova Scotia) and initiated a provincial program to train health care providers to do physical activity counseling (PACE).

Alberta: Numerous Regional Health Authorities, NGOs, Healthy Living coalitions and government departments are using the Alberta Healthy Living Framework.

Newfoundland and Labrador: The Regional Wellness Coalitions sustain action at the community level, including the creation of innovative programs and inter-regional collaboration.

New Brunswick: HEPAC has supported a regional healthy living workshop and planned an implemented a provincial healthy eating physical activity conference. HEPAC members worked with the provincial government on the development of a school nutrition policy, contributed to discussions about the development of the Provincial Wellness Strategy, and participated in the provincial stroke prevention working group. HEPAC has also made presentations at conferences and workshops involving health professionals.

Prince Edward Island: The PEI Healthy Living Strategy was announced in 2003. Since that time the number of programs that address multiple risk behaviours has increased.

6.3 Successfully Influencing and Working with Government

The Alliances have worked hard to persuade, encourage, support and assist governments to develop and implement Strategies for action. Often, the Alliances have advocated for or been responsible for developing and implementing these Strategies.

Provincial Strategies

Manitoba: The provincial government has recently announced its Chronic Disease Prevention Initiative. The Alliance worked closely with the federal and provincial governments to develop this Strategy.

Nova Scotia: There is a provincial Chronic Disease Prevention Strategy in place, originating from Heart Health Nova Scotia.

Alberta: Alberta Healthy Living Framework

Newfoundland and Labrador: In 2002, the provincial government released Healthier Together: A Strategic Health Plan for Newfoundland and Labrador. A Provincial Wellness Strategy is expected shortly.

New Brunswick: In June 2004 the Province of New Brunswick announced Wellness as the first Strategic Priority of its 2004-2008 Provincial Health Plan. Further details of the Provincial Wellness Strategy were released in 2006.

Ontario: The Alliance is currently developing a provincial Strategy (due March 2006).

Prince Edward Island: The PEI Healthy Living Strategy was announced in 2003.

Saskatchewan: Healthier Places to Live, Work and Play, a population health promotion strategy for Saskatchewan, was released in April 2004.

6.4 Key Challenges

The Alliances' accomplishments have been achieved despite the numerous obstacles and challenges they have encountered at every step. Some of their most critical challenges have included:

Insufficient resources: The Alliances have conducted their work, despite highly competitive environments where resources are scarce and often insufficient.

Dynamic environments: The Alliances have dealt with frequent and ongoing change. Changes in government, restructuring of health systems, and other factors, have created highly dynamic, sometimes chaotic, environments.

Managing diversity: The Alliances have engaged and supported diverse partners from different sectors to work together effectively. Making integration work has required a significant and ongoing balancing act in terms of managing the planning, communications, consultation and decision making processes involved in maintaining partnerships.

Influencing changes in government agendas: The Alliances have worked long and hard to persuade governments to make appropriate investments to support an integrated chronic disease prevention and health promotion agenda.

6.5 Key Success Factors

Despite the many difficulties, the Alliances have achieved results and remain steadfast in their commitment to pursuing an integrated chronic disease prevention and health promotion agenda. The factors that have contributed to their success include:

Passion and commitment: The Alliances could not succeed without the passion and commitment of their members, especially those involved in leadership and decision-making roles. Their belief in the importance of pursuing an integrated chronic disease prevention and health promotion agenda, despite the inevitable challenges and obstacles, is essential. And, in addition to the "core" partners, a broad base of commitment and support from a wide range of stakeholders is crucial to the Alliances' credibility and effectiveness as a force for change.

Engagement and collaboration: The Alliances have demonstrated a unique ability to engage diverse members from within and beyond the health sector. And they have found effective ways to work together collaboratively – by recognizing, respecting and building on the contributions of many different participants.

Relationship building and trust: Through the process of working together, Alliances' members have established relationships and learned to trust each other. They have learned how to communicate effectively with each other, and how to support each other to achieve results.

Expertise and leadership: The Alliances have built on the expertise of their members to persuasively "make the case" for an integrated chronic disease prevention and health promotion agenda. They have relied on members' creativity, energy and leadership to guide them in pushing this agenda forward.

Managing resources and building capacity: Wherever Alliances have been able to access resources, they have consistently achieved "a lot with a little." They have found ways to reduce costs, leverage resources, and make the most of whatever resources are available. The have focused on building the capacity – within the Alliances and within communities – to move the integrated agenda forward.

Achieving results: The Alliances have taken action and achieved results. Their accomplishments have sustained Alliance members' commitment and inspired them to continue to work together to make a difference.