
Lessons Learned From Canadian Experiences With Intersectoral Action to Address the Social Determinants of Health

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Executive Summary

The World Health Organization's Commission on Social Determinants of Health supports countries and global health partners to address the social factors leading to ill health and health inequities. Canada's effort related to the work of the Commission is led by the Canadian Reference Group on Social Determinants of Health that has a mandate to integrate lessons learned from the Commission into policy processes, and to advance dialogue on strategic directions for policy action on the social determinants of health in Canada over the course of the Commission. This paper is intended to contribute to that mandate. It describes and analyzes Canadian experiences with intersectoral action to address the social determinants of health and health disparities across a number of initiatives with the view to inform future work in this area.

The focal point of this paper is eight case studies that provide an in-depth examination of intersectoral activity to address the social determinants of health. The cases are as follows: The Family Violence Initiative, National Homelessness Initiative's Supporting Communities Partnerships Initiative, Aboriginal Self-Government Agreements, Gender-Based Analysis, Manitoba Child Health, Quebec Public Health Law, Saskatchewan Human Services Integration Forum, and the Vancouver Agreement. To set the context for the case studies, an overview of learnings about what is known about effective intersectoral action for health was developed (Section 3.0). Additionally, a *Typology of Canadian Experiences of Intersectoral Activity at Federal and Provincial/Territorial Levels* was developed to provide a high-level overview of intersectoral activities across fifteen Canadian initiatives (Section 4.0).

Each case study is richly described with respect to four areas of study:

Context

"Context" explores the broad environment in which the initiative emerged. It examines: the issue or problem addressed by the initiative and its aims or goals, conditions that motivate the adoption of an intersectoral approach, and factors and conditions that facilitate and challenge intersectoral activity.

Approach

"Approach" explores issues related to the organizational structure for intersectoral action, the mechanisms and tools for intersectoral action, and accountability mechanisms. The role of the health sector, other government sectors, and non-government sectors in intersectoral action on the social determinants is also examined.

Impact

The "impact" area of study examines the initiative's achievements, impact and outcomes attributed to the program, actions to sustain gains achieved, and lessons learned about intersectoral activity.

Reflection

"Reflection" explores the factors that contribute most to the intersectoral nature of initiatives and highlights unique and innovative features. Additionally, this area of study examines ways to support and /or improve intersectoral activity in the future.

Through the lens of eight case studies, this paper uncovered significant insights and learnings about intersectoral action to address the social determinants of health and health disparities.

With respect to context, learnings include:

- The issues addressed in the case studies touch upon several complex issues including: family violence, homelessness, self-government, child and youth well-being, healthy public policy/health impact assessment, gender equality, and supporting socially and economically vulnerable populations.
- All cases explicitly identify intersectoral activity as part of their overall vision, principles, goals or objectives.
- Motivating and facilitating factors for intersectoral action fall into the following categories: the nature and complexity of the issue, history of working intersectorally and precedence (e.g. international movements or national commissions), political will and consequences, central agency support or requirement, expectations for improved service efficiency and effectiveness, and established information and knowledge base.
- Factors that challenge or serve as a barrier to intersectoral action can be classified as follows: limited ISA models, resource issues (e.g. insufficient time, personnel, and money), multiple mandates, lack of leadership, change in government, and denial of the social issue.

With respect to approach, learnings include:

- Overall, “committees” characterize the organizational or administrative structure of the cases reviewed in this paper; and the number of committees varies across cases, as does the type of representation that serves on committees (e.g. political leaders, departmental staff, community leaders).
- Four types of ISA tools or mechanisms surfaced in this review. Information tools such as training materials, shared guidelines and protocols, and information exchange and dissemination were most frequently used. Others include financial mechanisms, accountability methods, as well as committees, as noted above.
- Accountability varies across cases and includes departmental, local-level and shared accountability mechanisms. Shared planning and priority-setting processes often co-exist with shared accountability.
- A variety of roles and activities characterize the health sector in intersectoral collaboration. These include: leadership, coordination, program operations (i.e., planning, implementation and evaluation), funding, knowledge development and mandated-related activities.

With respect to impact, learnings include:

- Achievements related to intersectoral action drawn from the cases reviewed include: improved information gathering and sharing; creation of new, cross-sector partnerships; increased mobilization of the broader community; and the establishment of new mechanisms to facilitate interagency cooperation.
- Achievements related to health include: increased capacity to manage and administer health care services, improved health outcomes and quality of life, and a greater understanding among government departments that health is influenced by a complex set of inter-related factors and conditions.

- Lessons learned are broad and fall into four groups; lessons related to (i) the definition and rationale for intersectoral action, (ii) resource requirements, (iii) intersectoral process and structure, and (iv) political and organizational support for intersectoral activity.

With respect to reflection, learnings include:

- Factors “contributing most” to the intersectoral aspect of the cases reviewed include: the committee structure, annual allocation of dedicated funds for ISA, creation of horizontal accountability frameworks, a requirement for community-based planning, and a new “culture” that recognizes intersectoral action as “the way business is done today.”
- Application of a community development approach, adoption of the Population Health Model, and development of “world class” tools for ISA were some of the “most unique or interesting” aspects of the cases reviewed.
- Future supports to improve intersectoral activity rest on: the creation of a coordinating body to promote ISA, development of practical tools and guidelines, greater involvement of political leaders, improved accountability mechanisms, and sufficient human and financial resources to match the effort required in intersectoral work.

Given these learnings, considerations for future engagement in intersectoral action to address the social determinants of health and health disparities are offered below:

1. How an issue is framed or defined is a key factor in intersectoral work as it impacts decisions regarding who comes to the table and what processes and structures are put into place. This also has implications for resources as well as accountability and financial mechanisms that need to be established.
2. The prevailing context impacts intersectoral work. This includes influences in the larger environment such as: social issues (e.g., increasing awareness of environmental/green issues), economic issues (e.g. expectation for fair and equitable wages), political issues (e.g., governing party and philosophical stance), and historical issues (e.g., long-standing relationship between population subgroups such as non-Aboriginal and Aboriginal peoples). Designing and executing intersectoral initiatives should include a systematic assessment of broad contextual issues to identify conditions that both facilitate (provide an opportunity for) and challenge (serve as a barrier to) intersectoral work.
3. Departments should be strategic in the issues they choose to incorporate into their intersectoral policy and/or program planning to ensure that resources are focused where they are most likely to have an impact, and where conditions for success exist. Departmental leaders should come together with experts in this area to develop criteria to support both the selection of issues as well as how to organize around them. This should be based on global best practices and jurisdictional experience to date.

4. Programs aimed at addressing complex social issues should be *purposefully* aligned with an intersectoral approach. Explicitly stating intersectoral activity as an overarching goal or core objective within the policy or program signals priority status and affirms the central role of intersectoral practices in all aspects of planning, implementation and evaluation.
5. Intersectoral initiatives need to be grounded in a sound rationale – why they are important, to whom, and at what cost; and how working intersectorally will achieve the best return on investment. Making the case for intersectoral approaches increases the likelihood that political actors will become engaged as well as provide the necessary political will to both initiate and sustain intersectoral work.
6. Information about intersectoral methods (e.g., approach, processes, structures, reporting, financing, etc) and intersectoral experiences (e.g. evaluation reports on ISA initiatives from various departments/jurisdictions) should be assembled, packaged, and made accessible to those interested in intersectoral work. Consideration should be given to the establishment of an “intersectoral activity clearing house” that would serve as a repository for best practices related to intersectoral action. It would additionally provide a knowledge base to generate practical tools to support planning, implementation and evaluation of intersectoral initiatives.
7. Given the relative importance of committees in the administrative structure of intersectoral initiatives, effort should be directed at examining what committee structures work best at what level, for what issues or problems, and under what conditions; with a focus on interdepartmental committees at the federal and provincial levels, and broad-based-community collations or committees at the local level.
8. Strong accountability mechanisms reinforce the position that intersectoral practices are to be taken seriously at the leadership and operational levels. There must be ongoing development of accountability mechanisms that articulate the objectives of the initiative, the expected results, and how progress will be measured. While shared accountability mechanisms may be the preferred approach, they require strong, top-level leadership to coordinate activities and ensure that partners are not working at cross-purposes.
9. Financial and funding mechanisms play a central role in facilitating intersectoral collaboration. More emphasis should be placed on developing terms and conditions that allow for flexibility to enter into financial arrangements that align with intersectoral work, including blended or “shared pot” funding.
10. Central agencies have a role to play. Improved guidelines and protocols for intersectoral initiatives would increase clarity among partners at all levels of government and across government departments with respect to intersectoral processes and structures, roles and responsibilities, and reporting and accountability requirements. Being clear about these issues early on increases the likelihood that initiatives will be implemented as planned as well as sustained over the long term.

11. Intersectoral work is resource-intensive. Serious consideration should be given to the allocation of dedicated financial, human and material resources to a level that is commensurate with the time and effort required to undertake this kind of work.
12. Adopting an intersectoral approach does not mean abandoning individual departmental mandates. It requires, rather, the identification of roles, activities and expertise that each sector can bring to bear on the collaborative exercise. Terms and conditions for intersectoral work should be crafted in a way that allows each sector to see its place in the overall picture and determine where it can best add value.

1.0 Background

Throughout the world, vulnerable and socially disadvantaged people have less access to health resources, get sicker and die earlier than people in more privileged social positions. These unfair gaps are growing in spite of an era of unprecedented global wealth, knowledge and health awareness. By far, the greatest share of health problems is attributable to broad social conditions. Yet, health policies have been dominated by disease-focused solutions that largely ignore the social environment. As a result, health problems persist, inequalities have widened, and health interventions have obtained less than optimal results. At the same time, there is evidence that policy, action and leadership to address the social dimensions of health can improve health and access to health care.

The World Health Organization's Commission on Social Determinants of Health supports countries and global health partners to address the social factors leading to ill health and health inequities. Canada's effort related to the work of the Commission is led by the Canadian Reference Group on Social Determinants of Health that has a mandate to integrate lessons learned from the Commission into policy processes, and to advance dialogue on strategic directions for policy action on the social determinants of health in Canada over the course of the Commission. Finding ways to work collaboratively across sectors has long been acknowledged as a way to address the broad social conditions which underlay health inequalities. This paper describes and analyzes Canadian experiences with intersectoral action to address the social determinants of health and health disparities across a number of initiatives with the view to informing future work in this area.

2.0 Report Structure

This paper is comprised of four major sections. Section 3.0 below provides an overview of learnings about what is known about effective intersectoral action. This is followed by a summary of the Typology of Canadian Experiences of Intersectoral Activity at Federal and Provincial/Territorial Levels, which provides an overview of fifteen Canadian intersectoral initiatives to address the social determinants of health. The focal point of this paper is eight case studies that provide an in-depth examination of intersectoral activity to address the social determinants of health. The cases as set forth in Section 5.0 and are as follows: The Family Violence Initiative, National Homelessness Initiative's Supporting Communities Partnerships Initiative, Aboriginal Self-Government Agreements, Gender-Based Analysis, Manitoba Child Health, Quebec Public Health Law, Saskatchewan Human Services Integration Forum, and the Vancouver Agreement. Section 6.0 closes the paper with a summary of findings, analysis and implications for the future.

3.0 Overview of Learnings about Effective Intersectoral Action for Health

A high-level summary of learnings about what is known about effective intersectoral action for health is offered below. This section draws on a corollary piece of work that is currently underway which focuses on the development of international case studies of intersectoral activity to address the social determinants of health and health disparities.

3.1 Context

This section focuses on the types of issues or problems addressed by intersectoral action (ISA), motivators and drivers for the adoption of an intersectoral approach, and factors and conditions that facilitate and challenge intersectoral action.

Intersectoral action is often used on the global, national, sub-national and community levels to address complex policy issues that a single country, region, government, department or sector may not be able to solve on its own. The way in which the issue is framed will often determine which governments, sectors and other organizations will lead the effort to address the policy challenge. Intersectoral action is anticipated to achieve several aims: (i) coherence in policies that address the social determinants of health, (ii) coordinated efforts from government sectors and other organizations in addressing health issues, (iii) sustained commitment from government and other stakeholders to intersectoral action, and (iv) strengthened capacity to implement intersectoral initiatives.

On the global level, intersectoral action has been used to address issues that have widespread impact, such as basic human rights, the environment, health inequities and inequalities, and children's health and safety.⁽²⁾ At the national and sub-national level, intersectoral action has been used to address a range of complex, multifaceted policy issues that target specific populations, such as children, older adults, women and aboriginal people, or specific settings, such as low-income communities, schools and workplaces, through combining the efforts of relevant departments and agencies into a single, coordinated strategy.⁽²⁾ Intersectoral action brings together a wide range of actors and provides a vehicle for discrete groups to work together to address areas of mutual interest at the community level. Community-based initiatives often focus on specific settings, such as a geographic area, a workplace or a school, or on specific issues, such as injury prevention, alcohol abuse or nutrition.⁽²⁾

There a number of key motivators and drivers for working intersectorally to address complex issues. The need to act, often created by lobbying and political pressure from the public, opposition parties, non-governmental organizations, the media and special interest groups, is a key driver for intersectoral action.⁽³⁾ Because strong economies are more likely to have the resources needed for sustained investment in ISA, favourable economic conditions are also an important driver. In fiscal constraints, innovative approaches may enable departments to work horizontally in addressing overlapping organizational mandates.⁽³⁾

Moreover, effective information sharing between citizens and the government drives intersectoral approaches, as it creates a feedback loop that allows governments to

effectively define and respond to issues. Central agencies, such as Finance and Treasury Board, represent another motivating force for intersectoral activity. They are well-positioned to oversee and guide intersectoral approaches, ensure adequate funding, guide policies through formal decision making avenues, and design and monitor compliance through accountability frameworks.^(1,2)

A number of factors and conditions facilitate intersectoral action on health. This includes the adoption of a sound philosophical framework to guide how health is defined and how health issues are approached. For example, a focus on the broader determinants of health, versus specific diseases, supports the participation of diverse sectors because it allows them to envision their role in addressing the issue. A clear rationale for working together also supports intersectoral work; as does establishing clarity from partners on both individual goals and joint goals of the collaboration.⁽³⁾ Similarly, an emphasis on shared values, interests and objectives helps to build trust and respect among partners, further supporting collaborative work. Finally, intersectoral action is facilitated by ensuring adequate communication and consultation within and across sectors; developing a clear, well-planned course of action; and sharing leadership, accountability and rewards among the partners in the collaboration.

Other factors serve as barriers to intersectoral action on health. For example, establishing both vertical and horizontal collaboration (defined below) can challenge intersectoral activity because it requires additional effort and negotiation to reach a shared understanding related to roles, accountability, approaches and goals.⁽³⁾ Lack of interest or support from organizational and political leaders represents another barrier to intersectoral activity. Finally, a lack of clarity around accountability and financial mechanisms have also been identified as a challenging factor for intersectoral activity for health.^(1,2,3)

3.2 Approach

This section addresses organizational structures and mechanisms for intersectoral action, accountability, and the sectors and roles involved in intersectoral action for health.

Two types of collaborative structures exist in intersectoral action; horizontal collaboration works across sectors or groups from the same level of decision making toward a defined set of goals; vertical collaboration works across jurisdictional boundaries to address policy challenges that require decisions by more than one level of government. Intersectoral action is most effective when collaboration is both horizontal and vertical.⁽³⁾ Although accountability for intersectoral action should be shared by all partners, strong, top-level leadership is needed to coordinate the approach and ensure that partners are not working at cross-purposes.

A broad spectrum of tools and mechanisms are needed to support intersectoral action for health. Information tools are needed to translate knowledge into evidence that allows for linkages to be drawn between policies and health determinants.⁽³⁾ Information tools, such as health impact assessments, have facilitated the involvement of multiple parties in developing healthy public policies, both within and beyond the health sector. New

institutional arrangements, for example, cross-sectoral, interjurisdictional fora, have also been shown to be effective in discussing and reaching decisions on complex policy issues. Financial mechanisms, for example, financial allocations for intersectoral activity, incentive and penalty-based approaches, resource pooling and in-kind resources, are also needed to support intersectoral action.⁽³⁾ Notably, although the literature tends to focus on new and innovative tools and mechanisms, most socio-political contexts require major policy directions and related funding allocations through established mechanisms, such as the Treasury Board, to determine government-wide budget planning and priority setting.⁽³⁾

Experience to date indicates an increased need for accountability within intersectoral initiatives. This stems from growing expectations among citizens, non-government groups and others that governments need to be more accountable for the results of their policy decisions.⁽³⁾ Accountability requires those involved in intersectoral initiatives to clarify authority and responsibility; this often falls to a lead sector or organization but requires support from all participating partners. While accountability frameworks have been developed, the difficulty of giving a full account of how all decisions are made, especially in the early stages of planning, when partners are amidst identifying areas of collaboration and their prospective roles, is well recognized.^(1,2)

Intersectoral action for health requires collaboration from multiple sectors, political officials, non-government agencies and civil society.⁽³⁾ Regardless of the issue being addressed, the nature of intersectoral action changes along the policy development, implementation and evaluation continuum, and so do the parties at the table. Different actors, role, abilities and resources are required to design an intersectoral initiative than to implement it and measure its impact. In this respect intersectoral action is a dynamic process.⁽³⁾

The health sector can play diverse roles which are largely determined by the context of the initiative. For example, health can be a leader, partner or supporter; and can undertake a number of activities such as training, funding, and the provision of health services. Government sectors that have traditionally collaborated with health include education, social services, agriculture and environment. Other sectors, such as information and communications, employment, manufacturing, transportation and technology, appear to be absent in horizontal initiatives involving health; although this may not necessarily mean that they are absent from initiatives related to broader health determinants.

Central agencies (e.g., Finance and Treasury Board) also play a critical role in intersectoral action. In addition to initializing horizontal action on complex issues, they contribute to coordinating and overseeing the initiative.⁽³⁾ Moreover, commitment from political partners is important in terms of providing the motivation to act, as well as the resources and structures necessary to support the action.⁽³⁾ Finally, non-government actors have an important place in intersectoral initiatives. The growing number of organizations involved in crisis response, health promotion, education, and community activism signals their importance as partners in addressing social determinants and promoting health equity.⁽³⁾

3.3 Impact

This section provides an overview of the impact intersectoral action, sustainability mechanisms, as well as lessons learned related to intersectoral action for health. Several examples of successful use of intersectoral action can be identified. Intersectoral activity has strengthened economic growth and development, health protection and promotion, public security. It has also been shown to positively impact crime prevention, education, employment, community development, disease prevention, primary care, public health and social cohesion.⁽³⁾

On a global level, the 2002 World Summit on Sustainable Development and the Healthy Environments for Children Alliance, brought together a wide range of actors to address complex global issues, such as protecting the environment through sustainable development and protecting and promoting healthy environments for children.⁽³⁾ On the national front, health inequities and inequalities have been addressed through government-wide policy frameworks and focused efforts on special populations, for example, the homeless, aboriginal populations and women. Sub-nationally, intersectoral action has been successful in improving children's well-being through initiatives such as New Zealand's Healthy Schools and Manitoba's Healthy Child.⁽³⁾ Community-based intersectoral initiatives, such as the Vancouver Agreement, have also been effective in addressing complex socio-economic health determinants, such as homelessness, drug and alcohol abuse and malnutrition.

Intersectoral action has played an important role related to healthy public policy development around the world. The impact of such policies becomes evident from the experience of countries such as Sri Lanka. Intersectoral activity between health, education, agriculture and other sectors led to the development of this country's first poverty elimination program, leprosy elimination program, population and reproductive health policy, and policy for the aged.⁽³⁾ The resulting health improvements have been directly attributed to strong political leadership and collaboration between health and other sectors. The use of health impact assessments has further increased an understanding among policy makers worldwide about the multiple influences on health, and how policies and programs developed in one sector can affect health on a population level.⁽³⁾

A number of actions can be taken to ensure the sustainability of intersectoral activity. First, issues must be chosen with care to ensure that resources are focused where they are likely to have the most impact. Intersectoral activity is a resource intensive; therefore, consideration should be given to the time and resources needed to plan, implement, and evaluate intersectoral initiatives. Once government sectors and other organizations have agreed to work together, their long-term commitment must be secured. Establishing collaboration both across sectors and across jurisdictional boundaries also helps yield a resilient, durable end product, and provides a shield against inaction, flagging interest or disintegration.⁽³⁾ As noted earlier, building on shared values, interests and objectives, while respecting individual mandates and responsibilities, also promotes sustainability by developing the trust and respect that facilitates long-term collaboration.⁽³⁾

A number of actions can be taken to ensure the sustainability of intersectoral action for health. First, issues must be chosen with care to ensure that resources are focused where they are likely to have the most impact. Intersectoral activity is very resource intensive; therefore, consideration should be given to the time and resources needed to plan, implement, and evaluate intersectoral initiatives. As noted earlier, building on shared values, interests and objectives, while respecting individual mandates and responsibilities, also promotes sustainability by developing the trust and respect that facilitates long-term collaboration.⁽³⁾

Some lessons can be drawn about intersectoral action for health. First, intersectoral action appears to work best in less complex decision-making environments.⁽³⁾ Moreover, community-based initiatives, such as the Vancouver Agreement, show that involving people and organizations at the local level increases understanding among decision makers about what the priorities are and how to best address them. Lessons centred on accountability indicate that although accountability for ISA should be shared by all partners, strong, top-level leadership is needed to coordinate accountability requirements and ensure that partners are not working at cross-purposes.⁽³⁾

Effective financial mechanisms to support intersectoral activity are also necessary, with an emphasis on developing systems that enable sectors to pool resources and share budgets. Involving appropriate stakeholders, encouraging decentralization of decision making, increasing awareness of the positive aspects of working collaboratively, and providing incentives for ISA represent additional ways of securing commitment for intersectoral action on health.⁽³⁾ Finally, the broader context impacts intersectoral action. Political, economic and socio-cultural characteristics of the larger environment shape how issues are framed, the tools that are applied and ultimately, the progress that is made.⁽³⁾

4.0 Summary of a Typology of Canadian Experiences of Intersectoral Activity at Federal and Provincial/Territorial Levels

A typology of Canadian experiences of intersectoral action to address the social determinants of health and health disparities was developed to provide a high-level overview of intersectoral initiatives at the federal and provincial levels. The typology consists of three domains that taken together, characterize the various aspects of intersectoral action for health. They are, as noted above: (i) context for intersectoral action, (ii) approach to intersectoral action, and (iii) impacts associated with intersectoral activity for health.

The typology captures the experience of fifteen Canadian initiatives, as follows:

Federal Initiatives	Provincial Initiatives
Aboriginal Self-Government Agreements (1995)	ActNow BC (2006)
Canada's Action Plan for Food Security (1998)	Manitoba Child Health (2000)
The Falls Prevention Initiative (2000)	Quebec's Act to Combat Poverty and Social Exclusion (2002)
Poverty and Social Exclusion (2002)	Quebec's Public Health Law (2002)
The Family Violence Initiative (1997)	Saskatchewan Human Services Integration Forum (1999)
Gender-Based Analysis Policy (2000)	The Vancouver Agreement (Federal/Provincial/Municipal) (2002)
Services Integration Forum (1999)	
Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)	
National Homelessness Initiative's <i>Supporting Communities Partnership Initiative</i> (1999)	
Sustainable Development Strategy 2007-2009: Coordinating the Fourth Round of Departmental Sustainable Development Strategies	
Urban Aboriginal Strategy (2002)	

Besides providing an overview of key features of intersectoral action, the Typology of Canadian Experiences guided the selection of the case studies which are presented in the pages that follow. For the purpose of this paper, a summary typology findings is offer below, and the full typology is included in Appendix A of this report. *Please note that the Typology is in draft form. In the near future, it will be updated and expanded based on the information gleaned from the case studies which provide a more in-depth examination of the issues.*

Typology Summary

A summary of findings related to each dimension of the Typology of Canadian Experiences – context, approach and impact – is provided below.

Context:

- With respect to **level of government**, 9 of the 15 initiatives were at the federal level, 5 at the provincial level, and one involved all 3 levels of government (federal, provincial and municipal).
- Related to **program focus**, the initiatives touched on a wide range of issues that span the social determinants of health. These included: self government, food security, family violence, gender equality, homelessness, falls prevention, child health, chronic disease risk reduction, HIV & AIDS, poverty and social exclusion, human services, sustainable development, and social, economic and community development.
- Factors **facilitating** intersectoral activity included the following:
 - Increased understanding, often through research, of the complex, interconnected nature of societal issues which require cross-Ministry solutions
 - Framing an issue as a “crises” to signal the urgent need for joint action

- Adopting a broad definition of the issue at hand (i.e., health) that touches upon multiple sectors
- Funding arrangements that require partnership development and/or application of a population health/health determinants approach
- A history of working together across sectors in previous efforts
- Factors **challenging** intersectoral action include:
 - change in government
 - difficulty engaging key stakeholders and target populations
 - limited follow-up/implementation of Auditor General recommendations
 - inadequate evaluation of programs

Approach:

- With respect to the **nature** of intersectoral activity, most of the initiatives included in the typology were targeted at specific, at-risk populations including: children, seniors, Aboriginal people, and the homeless population. Other initiatives represented broad policy frameworks which focused on working toward shared objectives, and involved a large number of actors and perspectives in policy development, implementation or evaluation.
- In terms of **sectors and roles**, the health sector assumed a leadership role in 6 of the 15 initiatives examined here, was a partner in 1 initiative, and served in a supporting role in another 8 initiatives. Activities undertaken by the health sector varied and included: research, coordination and planning, surveillance, evaluation, communications, policy development and implementation, and direct services (e.g. harm reduction).
- Some initiatives adopted **accountability mechanisms** that included regular reporting of outcomes/achievements (to the public or Parliament), Treasury Board auditing, and the establishment of government-wide/cross sector goals which tied performance targets/measures to each participating sector.

Impact:

- Regarding **measurement**, several initiatives identified performance indicators to monitor progress over time. While most initiatives focused on health-related measures, only a few identified indicators linked directly to intersectoral activity.
- Some initiatives documented **lessons learned** related to successful intersectoral activity. These included: engaging the right mix of stakeholders early on, promoting cross-sectoral partnership development, clarifying sectors' roles and responsibilities, sufficient allocation of human and financial resources, community-based planning and decision making structures, and guidance and support from central agencies.
- **Sustainability mechanisms** included enshrining the policy/program into law, cabinet approval for long term funding, integrating policy into standard operating procedures, and funding agreements that require long-term solutions.

5.0 Case Studies of Intersectoral Activity to Address the Social Determinants of Health

5.1 Method

5.1.1 Case Study Selection

Eight case studies were selected for an in-depth review of intersectoral activity to address the social determinants of health and health disparities in Canada. They are: The Family Violence Initiative, National Homelessness Initiative's Supporting Communities Partnerships Initiative, Aboriginal Self-Government Agreements, Gender-Based Analysis, Manitoba Child Health, Quebec Public Health Law, Saskatchewan Human Services Integration Forum, and the Vancouver Agreement.

Case study selection reflected the need to include a mix of intersectoral initiatives including: (a) federal and provincial/territorial led initiatives, (b) initiatives with health as the lead sector, (c) an initiative that addressed the determinants of health among Aboriginal people, and (d) an initiative aimed at reducing health inequalities. In addition, case study selection considered the availability of documentation (i.e., reports, publications), and access to people with a good corporate memory of the initiative as well as a willingness to participate in the data collection process. The selection of cases was further informed by consultation with the Canadian Reference Group on Social Determinants of Health and the *Typology of Canadian Experiences of Intersectoral Activity* presented in the pages above.

5.1.2 Data Collection

Data was collected from key representatives from each of the eight initiatives through a semi-structured interview process. Interviews were conducted by telephone. All interviews were audio-taped (with participant consent) and then transcribed to facilitate subsequent analysis and writing.

5.1.3 Areas of Study

Like the typology above, the case study interviews addressed the following areas of study: context, approach and impact; "reflection" was also examined. These are described more fully below.

Context

"Context" explores the broad environment in which the initiative emerged. It examines: the issue or problem addressed by the initiative and its aims or goals, conditions that motivate the adoption of an intersectoral approach, and factors and conditions that facilitate and challenge intersectoral activity.

Approach

“Approach” explores issues related to the organizational structure for intersectoral action, the mechanisms and tools for intersectoral action, and accountability mechanisms. The role of the health sector, other government sectors, and non-government sectors in intersectoral action on the social determinants is also examined.

Impact

The “impact” area of study examines the initiative’s achievements, impact and outcomes attributed to the program, actions to sustain gains achieved, and lessons learned about intersectoral activity.

Reflection

“Reflection” explores the factors that contribute most to the intersectoral nature of initiatives and highlights unique and innovative features. Additionally, this area of study examines ways to support and /or improve intersectoral activity in the future.

5.2 Case Studies

Eight case studies of selected federal and provincial/territorial experiences with intersectoral action to address the social determinants of health/health disparities in Canada are presented below. Case studies tell a story of each initiative, based on the information provided by key informants. For the purpose of this report, people who participated in the data collection process are referred to as, “the case respondent.” To illustrate or emphasize key points, case respondent comments (both direct and paraphrased remarks) are sprinkled throughout the case study reports and are noted in quotation marks and italicized font.

Case Study 1: The Family Violence Initiative

Federal initiative
Health sector as lead
Families who experience violence as focus

Context

Today’s Family Violence Initiative has evolved from a nearly thirty-year history of federal activity on family violence in Canada. The creation of the “*National Clearinghouse on Family Violence*” in 1982 preceded the launch of the “*Child Sexual Abuse Initiative*” in 1986, followed by two successive *Family Violence Initiatives* through the mid-1980’s and early 1990s. The current, third initiative, launched in 1996, renewed the federal government’s commitment to reduce family violence in this country.¹

¹ This case study focuses on the Family Violence Initiative initiated in 1997 and continuing through to present day.

From its inception, the Family Violence Initiative was envisioned as an effort to increase federal interdepartmental cooperation and coordination. The need for interdepartmental cooperation on family violence was warranted by the following: the multifaceted nature of the issue, the consequent need for a multidisciplinary perspective, and the fact that various aspects of family violence fall within the mandates of many different departments.

The Family Violence Initiative defines family violence broadly. Family violence includes physical, psychological and sexual abuses, not just in relationships of kinship, but also in relationships of intimacy, dependency and trust. Fifteen federal government departments work to meet the overarching goals of the Family Violence Initiative which are (a) to reduce or prevent family violence in Canada, and (b) to achieve a more effective and efficient interdepartmental, coordinated response to family violence. Specifically, the initiative seeks to: (a) promote public awareness of family violence and the need for public involvement, (b) strengthen the criminal justice, health and housing systems' ability to respond to family violence, and (c) support data collection, research and evaluation related to family violence.

The case respondent for the Family Violence Initiative offered insight into the "fit" and rationale for adoption of an intersectoral approach at various levels of government. He gave an example of a battered woman who comes to a community hospital emergency department where immediate interagency coordination is critical (e.g. between police and child welfare). He differentiates this from planning and policy activities at the federal level which seek coordination among federal departments, but does not involve interaction with program recipients (i.e., "real people"). The case respondent poses a question: *"Does the same rationale stand as firmly at the Federal level as it does at the local level, or even at the Provincial Level?"* And, he suggests an answer to this question which raises a question about the feasibility of transferring of the concept of intersectoral action from the local to the federal level: *"There may have been an overly optimistic assumption as to what can be achieved at the federal level in terms of intersectorality as opposed to the local level."*

Several factors that support or facilitate intersectoral activity within the Family Violence Initiative were uncovered in the case study interview. One facilitating factor is the Initiative's funding pattern, whereby funding is provided through regular and ongoing departmental programming, and an additional annual allocation of \$7 million is shared among member departments to supplement those expenditures as well as ensure coordination of interdepartmental activity. The development of policy documents and guidelines on horizontal management by central agencies, especially the Treasury Board Secretariat, further supports interdepartmental cooperation, as does the ongoing work of a number of interdepartmental committees and working groups. Additionally, intersectoral action has been supported by the creation of accountability and reporting frameworks which in the words of the case respondent, *"made explicit the fact that this was seen as a coordinated, cooperative effort among the member departments."*

However, intersectoral action within the Family Violence Initiative has also faced a number of challenges. Of significance is the lack of consensus and clarity as to exactly what is meant by interdepartmental coordination and horizontal issue management.

Other barriers include: resource constraints for partnership development and implementation, and the diversity of populations at risk of family violence (e.g. women in the home and seniors in care facilities). Additionally, staff turnover, inadequate clarification of accountability requirements and complex performance reporting mechanisms continue to challenge interdepartmental activity within the Family Violence Initiative today.

Approach

While eleven federal departments contributed to earlier renditions of the Family Violence Initiative, fifteen departments are involved today (Please see Appendix B for a full list of member departments and activities). To coordinate the activities of the member departments, an administrative structure was put in place. This consists of several committees, led by a Steering Committee comprised of departmental representatives at the Director General level. The Steering Committee meets infrequently, when major decisions are required. The Interdepartmental Working Group (IWG), which meets quarterly, is comprised of one representative from each member department. It is the main operational vehicle for the Initiative. Reporting to the IWG are two subgroups, each with its own focus: the Interdepartmental Evaluation Working Group and the Aboriginal Family Violence Working Group.

To complement its administrative structure, the Family Violence Initiative draws on a variety of tools and mechanisms to bring member departments together. Through the Results-Based Management and Accountability Framework (RMAF), departments are responsible for regular progress reporting to the Treasury Board. Each department submits its own RMAF to Treasury on an annual basis, and the Public Health Agency of Canada will submit an umbrella FVI RMAF which will describe both collective and individual member activity. Besides serving as the Initiative's accountability framework, the FVIRMAF supports the interdepartmental effort, by, in the words of the case respondent, "*being one of the major sources of glue that keeps drawing people together.*"

Information sharing represents another mechanism to bring member departments together within the Family Violence Initiative. For example, federal departments come together to develop presentations for visiting foreign delegations who want to learn more about Canada's response to family violence. Closer to home, representatives of federal departments join together to coordinate messages and offer a "common face" to Provinces and Territories when they meet to discuss family violence issues with their provincial and territorial counterparts. While the Family Violence Initiative is wholly federal, and does not technically include the provincial/territorial governments and NGOs, it communicates with other governments and the non-government sectors frequently to facilitate projects and coordinates information sharing.

Since its inception, the Family Violence Initiative has been led by the health sector. Today, the Public Health Agency of Canada is responsible for overall leadership and coordination. It chairs all the interdepartmental meetings, coordinates and co-chairs the FPT meetings, and writes and disseminates meeting minutes. It is also responsible for the management of the *National Clearinghouse on Family Violence*. When asked what

additional roles would be suitable for the health sector within multi-departmental initiatives, the case respondent cited the possibility of having greater authority over a collective budget, as is the case in some other multi-departmental or horizontal initiatives. He explained that intersectoral cooperation could be increased if the lead sector had “*more power to direct activities at the money-spending level.*”

Funding for Family Violence activities is derived from a number of sources: (i) annual allocation of 7 million dollars to be shared among member departments, (ii) funding from regular departmental budgets of the members (e.g. Status of Women Canada provided funding to support initiatives aimed at eliminating systemic violence against women and the girl child), and (iii) funding from departments to co-fund initiatives or projects of mutual interest among member departments. In addition, there are memoranda of understanding among Family Violence Initiative member departments. For example, when the Department was responsible for managing the initiative, Health Canada provided some of its additional allocation to the Department of Indian Affairs and Northern Development Canada to provide an inventory of studies about family violence in First Nations communities. Family Violence member departments identify broad priorities for funding (e.g. an enhanced focus on needs of Aboriginal people) but specific funding criteria are set by each department separately.

Member departments take on a wide range of activities. Canada Mortgage and Housing Corporation delivers the Shelter Enhancement Program and in certain circumstances provides capital funding for new emergency shelters and second stage housing. Department of Justice Canada reviews, researches and reforms criminal justice legislation and policy, funds community-based family violence projects and provides public legal education and information support regarding family violence. The Royal Canadian Mounted Police supports community-based workshops on victims' issues, sexual assault, and relationship violence, and assists communities in using problem-solving approaches to family violence. An interdisciplinary and holistic approach to family violence is reinforced by broad contributions across multiple federal departments within the Family Violence Initiative.

Impact

Performance reports suggest that the Family Violence Initiative has “*added value to Canadian efforts to address family violence.*” This is evidenced by the following: an enhanced ability to gather data and provide useful information about family violence to provinces and communities; promotion of research projects that have contributed to: an increased understanding of family violence, its dynamics, and long term effects; and increased readiness and capacity of various sectors (e.g. health, housing and justice) to respond to family violence issues and incidents.

It appears that the intersectoral nature of the Family Violence Initiative has resulted in the outcomes of the Initiative being more fully communicated. For example, Statistics Canada produces an annual statistical report on family violence in Canada. This information supports communications between departments.

Varying levels of intersectoral action have been demonstrated by the Family Violence Initiative over time. The case respondent suggested that the current Family Violence Initiative falls short of full horizontal management because it does not engage in a fully shared process of planning and budgeting, which in his view, could be seen as a key measure of intersectoral action: *“I think in many cases, there is too little consideration of what the others are doing. We make our plans too independently....If you are not doing joint planning together in terms of how you are going to spend your allocated money, you have a way to go before you reach the optimal level of intersectorality.”*

This view aligns with those who conceptualize intersectoral action along a continuum, where limited collaboration between partners occurs at one end (e.g. merely in the form of information sharing), moderate cooperation occurs in the middle (e.g. application of the shared information for cross-fertilization of knowledge and work plans), and full engagement of partners occurs at the opposite end (e.g. formal agreements on common objectives and cost-sharing).

Several lessons learned can be drawn from the experience of the Family Violence Initiative regarding effective interdepartmental activity at the federal level. Those lessons lead to the conclusion that the following actions should be ensured by the relevant authorities:

- Provide a clear, credible and persuasive rationale for applying an intersectoral approach, and specify the type/level of horizontal management that is expected (i.e., along the continuum described above)
- Provide pointed directives for member departments, specifying their role, responsibilities and expectations vis-à-vis interdepartmental activity, including funds that they are expected to devote to cost-shared efforts
- Explicitly allocate human and financial resources for intersectoral work within each participating department
- Formally express support for intersectoral policies at the highest levels of government administration
- Provide incentives to senior officials to support and engage in horizontal management
- Ensure guidance and support from central agencies to those responsible for horizontal management, including consistent guidelines related to performance measurement
- Institute policies and practices to minimize staff turn-over and maintain corporate memory within the intersectoral program

These lessons offer valuable insight on what can be done to further increase intersectoral action within federal initiatives that seek to address health and social conditions.

Reflection

When asked to reflect upon the Family Violence Initiative, our case respondent shared what he believed to be those features which contributed most to the intersectoral nature of the Initiative. He reiterated the following: the Initiative's committee structure that allowed members to come together in a coordinated fashion, the additional annual allocation of funds (\$7 million) devoted specifically to interdepartmental coordination, and the creation of frameworks for accountability and reporting.

Looking ahead, our case respondent suggests that intersectoral activity could be further advanced through: the creation of a central coordinating body that would provide incentives, explicit and imperative guidelines for intersectional action, and improved terms and conditions of the government bodies involved. To close, our case respondent offered a cautionary note to those working within horizontal programs regarding the ever-changing nature of intersectoral activity and the implication of such for the future: *"Even the intersectoral nature of the Family Violence Initiative itself is evolving... conclusions you may draw today about intersectoral action, might not be fully appropriate two years from now."*

Case Study 2: National Homelessness Initiative's Supporting Communities Partnership Initiative

Federal initiative

Human Resources and Social Development Canada (HRSDC) as lead

Health sector as supporter

People who are homeless or at-risk of homelessness as focus

Context

In the late 1990's homelessness was becoming a crises in large and small cities across Canada. The issue was complex; both the people and the factors that led them to becoming homeless were varied and diverse. It became apparent that homelessness could not be solved by any one level of government or sector and that the key to fully addressing the issue was dependent upon governments and community organizations working in partnership, to pool resources and efforts. The Government of Canada recognized that those on the front-lines, who worked directly with the people who were homeless or at-risk of homelessness, were best placed to identify effective solutions at the local level.

In 1999, the Government of Canada announced the National Homelessness Initiative (NHI), a three-year initiative designed to help ensure community access to programs, services and support for alleviating homelessness in communities located in all provinces and territories. The Supporting Communities Partnership Initiative (SCPI), a key component of the NHI, was launched to create a more integrated and inclusive approach to the issue. SCPI operates within the framework of five broad objectives

intended to provide sufficient latitude to address the wide range of homeless issues facing communities. They are as follows:

- Ensure that no individuals are involuntarily on the street by making available sufficient shelters and adequate support systems
- Reduce significantly the number of individuals requiring emergency shelters, and transition and supportive housing (by providing, for example, low cost housing, health services, early intervention, prevention initiatives)
- Help individuals move from homelessness through to self-sufficiency, where possible
- Help communities strength their capacity to address the needs of their homelessness
- Improve the social, health and economic well-being of people who are homeless

Under the administration of the NHI, SCPI received \$305 million dollars for its first phase funding (1999-2003) to address the diverse needs of Canada's homeless population. Sixty one communities were funded by SCPI during the first three years. Early work was grounded in the development of a community plan which would serve as a vehicle to bring diverse groups together and ensure the best use of community resources. This involved community partners working in concert to assess gaps and needs, map out services that already existed, identify priorities, and design and implement projects to address priority needs.

During the second funding phase (2003-2007), communities continued with project implementation which ranged from developing comprehensive needs assessments of this population, improving or constructing shelters, offering transitional housing, and providing support services and facilities. Community assessment of performance against their community plans also took place at this time. The most recent funding phase (2007-2009) was renewed under the present government and renamed the Homelessness Partnering Strategy earlier this year. It focuses on homelessness people living with mental health and/or substance abuse issues who have been discharged from mental health facilities and institutions.

The intersectoral nature of the SCPI stems from several influences. In the view of the case respondent, the Minister of State responsible for the Initiative played a lead role. Given her vision and background, she was committed to engage all partners: *"We had an extremely activist Minister. She was proactive and very clear in her vision.... She worked to ensure agreements with every province and territory to sit at the planning tables, and she knew that the only way to really address homelessness was to engage all levels of government and all sectors of society"*. This was paired with endorsement by two Ministers over the term of the Initiative for community-driven approaches: *"The two Ministers had 'grassroots level' backgrounds... They both believed that if you equip communities with what they need, they will be able to address local problems, locally."*

Cabinets of the day responded favourably to a call to action from municipalities for greater intersectoral action. During this time, both the federal and provincial governments believed that housing and homelessness were outside their jurisdiction, and municipalities were left with the responsibility to solve the issue. At a summit sponsored by the Federation in 1998, mayors from large Canadian cities stood up and said “*we can’t do this on our own, we need help.*” Cabinet agreed that federal leadership was needed. But, they also emphasized that the federal government would not be the only player, so an intersectoral and partnership approach to homelessness was embraced as a way to move forward.

Findings of the Report of the Auditor General of Canada (1995) on horizontal management issues (1995) further facilitated intersectoral action within SCPI. The report identified structural weaknesses that serve as a disincentive for participation and cooperation between departments. This influenced the SCPI to move beyond traditional approaches. Additionally, intersectoral activity was encouraged by groups and organizations that supported and had a history of working collaboratively on large-scale societal issues. This included the Canadian Mental Health Association which understood the link between mental health and homelessness, and the Canadian Institutes for Health Research which promoted broad-based knowledge transfer about homelessness, and in the view of the case respondent, “*helped to make linkages between health and housing instability.*”² Research that was conducted through SCPI’s partnership with the Canadian Institutes for Health Research helped SCPI identify common issues with other agencies such as Health Canada. The research served as a vehicle to engage other partners.

At the local level, the community planning process required the involvement of different stakeholders which reinforced an intersectoral approach. So too did the requirement for communities to match federal funding at the local level. Cost-sharing further encouraged working across sectors, as noted by our case respondent: “*This forced provincial and municipal governments, private foundations, the private sector, and the public to work together to raise money.*”

Other issues challenged the SCPI’s attempt to be community-driven and intersectoral. First, denial was an issue. Some community officials were not prepared to acknowledge that homelessness was a problem in their area, let alone work together to generate local solutions. As well, it proved difficult to get all the stakeholders together to participate throughout the planning cycle. While the Phase 1 planning process was obliged to be broad and inclusive, it became clear over time that some sectors were not represented, especially with respect to youth and Aboriginal peoples. This forced the NHI to require proof from municipalities that communities had all the required partners engaged for Phase 2 planning and decision making.

Additional challenges to intersectoral activity centered on financial issues. While additional funds were anticipated to support horizontal action as part of the Phase 2 funding, they were not provided by Cabinet. Moreover, silos began to surface with respect to access to available resources. According to the case respondent, “*there was*

² Note: The case respondent used the term “housing instability” versus homelessness in order to capture individuals who are not homeless but are living in unsuitable and overcrowded housing.

a sense of competition for available resources from the various players,” versus a combined effort to effectively apply the resources. Allocation of funding was also a challenge. The SCPI allocated funding on a fiscal year and communities typically undertook their work on a calendar year. Monies that were not expended in one fiscal year had to be “reprofiled” for the next year. This required Treasury Board approval and given that the decision by Treasury Board did not take place until the subsequent fall, this created some worry among the SCPI community leaders that they would not be able to spend the resources allocated to them in order to carry out their work. However, the Treasury Board approved all the “reprofiling” each year of the initiative.

Approach

As noted above, the National Homelessness Initiative falls under the umbrella of Human Resources and Skills Development Canada (HRSDC). Administration of the Initiative was delegated to the National Secretariat on Homelessness (NSH) for which the Minister of Labour is responsible. Within HRSDC, the NSH was given the task of administering three components of the NHI, one of which is the SCPI.³ Besides HRSDC and Labour, federal representation includes: Canadian Housing and Mortgage Corporation (CHMC), Status of Women Canada, Immigration Canada, Justice Canada and Social Development. The participating departments were involved all along the SCPI process including planning, development and evaluation. At the federal level there is a close relationship between the NHI, responsible for dealing with homelessness, and the CHMC, responsible for housing policies and a number of programs related to social and affordable housing. As such, these two departments fund some programs jointly.

To further increase horizontal action, the newly instituted Homelessness Partnering Strategy (HPS) comprises an ADM-level committee that meets three times per year. With its expanded focus on mental health and addictions impacts on homelessness, the HPS has invited participation from both Health Canada and the Public Health Agency to sit at the table to provide direction for cooperative action.

Likewise, several partners come together at the community level. Provincial representatives vary by province since housing and homelessness fall under one Ministry in some provinces and under several ministries (with overlapping responsibilities) in other provinces. Non-government and community agencies also participate at the local level, as do representatives from the private sector. Accountability, at the community level, involves community leaders reporting back to their own community on progress against their community plan. They must also report on progress to the federal level which includes an accounting of project results and outcomes. At the federal level, the NHI conducts evaluations, and reports the findings on their website on a regular basis.

With respect to the role of the health sector, Health Canada was listed as a partner on the original Treasury Board submission for the NHI. The case respondent held the view that the health sector played a limited role in the SCPI at the federal level, especially in the early days, which largely took the form of participation in interdepartmental meetings.

³ The other two initiatives under the administration of the NHS are Youth Homelessness and the Youth Employment Strategy.

He believed, however, that health sector involvement was greater at the project committee level where provincial and federal health representatives typically participated in project planning and decision making and co-funded some local initiatives.

At the federal level, the health sector's involvement centered on the link between people living with HIV/AIDS and the need for housing among this population. The case respondent noted that: *"Health did cooperate, but not in any proactive way..... They came to us around the whole issue of AIDS and issues of housing, I believe within the context of the International AIDS conference held in Toronto."* The respondent also talked about the Minister of State's interest in fetal alcohol syndrome and how her interest and advocacy led to some partnerships and shared funding with PHAC regional offices at the project level.

When asked what role he would have the health sector play, if he could do it over again, the case respondent pointed the need to define homeless as a health issue: *"I would have Health begin to recognize that housing is a determinant of health, housing instability is a serious public health issue that needs to be addressed as a housing and homeless issue, but also a health issue. At this stage, I am still not convinced that there is recognition of it as a health issue."*

Impact

Assessment of the SCPI over its first three years reveals successful mobilization of the broader community to address homelessness. Under the direction of the Minister of Labour and Federal Coordinator on Homelessness (2003), ten communities were asked to respond to questions related their experiences during the planning phase of the initiative. The communities acknowledged the value of the SCPI with respect to the following: promoting a community-based, multidisciplinary planning approach, increasing collaboration with partners, and awareness-raising about the homelessness issue. Specifically, the SCPI enabled the creation or continuation of many local homelessness projects and programs. It was also instrumental in creating new and unique partnerships, increasing awareness of the issue and building community capacity to effectively address the issue.

Notably, the SCPI facilitated the creation of effective intersectoral mechanisms for setting priorities and allocating resources at the local level. It appears too that the needs of the homeless population are now being met across the "housing continuum" (e.g., people on the street, in shelters, or in transitional housing). Our case respondent captured this accomplishment as follows: *"Communities have achieved most of their objectives not only in terms of mobilizing communities, but in terms of.....ensuring that in every community there is a continuum of supports and services to meet the needs of homeless people no matter where they fall along the continuum."*

At this time, communities are continuing to assess the progress made against their original community plan, determining what further supports are needed to help homeless people, and building on the strengths of the partnerships that have been fostered to date. Looking back, our case respondent shared one important lesson learned related to intersectoral activity within the SCPI. It centered on the issue of trust within partnerships:

“Oh I would say..... it takes a lot of good faith and diligence, and it is all founded on building trust... building trust between sectors, building trust within sectors, and nurturing those relationships.”

Regardless of achievements to date, there is no mechanism in place to ensure the sustainability of the SCPI over the long term. Classified as a “B-based program,” SCPI does not enjoy secured funding. However, since its inception, federal funding has been extended or renewed three times, which in the words of our case respondent “*shows that we have adequately made our case.*” And, plans are underway to renew or extend funding under the new Homelessness Partnership Strategy beyond 2009. As noted above, matching funds are required at the community level as part of the community planning process which also requires communities to explain how their activities will continue once SCPI funding ends. This is expected to encourage the development of sustainable long-term strategies to continue the effort to address homelessness within SCPI communities.

Reflection

When asked to reflect upon the SCPI experience, our case respondent believed that “*the monitoring of community plans to ensure representation of all interests,*” contributed most to the intersectoral aspect of the program. When queried about what was the most unique or innovative feature of the SCPI, our case respondent referred to its community development approach: “*The insistence on this being a community-driven initiative ensured that those most affected by the issue were involved in the solution.*” Looking ahead, our case respondent identified the “*engagement of deputy ministers from across departments*” as a way to improve or support intersectoral activity within SCPI in the future. As noted earlier, this feature has been built into the Homelessness Partnering Strategy, the most recent iteration of the National Homelessness Initiative. A Deputy Minister level committee has been developed and funds have been allocated for interdepartmental activities at the federal level. Discussions regarding potential collaboration at the Federal level are still at a preliminary stage.

Case Study 3: Aboriginal Self-Government Agreements

*Federal initiative
Indian and Northern Affairs Canada as leader
Health sector as supporter
Aboriginal self-government as focus*

Context

The concept of Aboriginal self-government is not new. Aboriginal peoples in Canada have long expressed their aspiration to be self-governing, to chart the future of their communities, and to make their own decisions about matters related to the development and preservation of their distinctive cultures. Aboriginal peoples also maintain that they

have an inherent right of Aboriginal self-government; a right which they believe should be recognized by all Canadians.

In August 1995, the federal government acknowledged the inherent right of self-government as an existing Aboriginal right. Recognition of the inherent right is based on the view that the Aboriginal peoples of Canada have the right to govern themselves in relation to matters that are internal to their communities, integral to their unique cultures, identities, traditions, languages and institutions, and with respect to their special relationship to their land and their resources.

Pursuant to the *Inherent Right of Self-Government Policy*, self-government arrangements for First Nations may be negotiated as a part of comprehensive land claims agreements.⁴ As such, the Canadian Government agrees to constitutionally protect particular aspects of self-government agreements as treaty rights under section 35 of the *Constitution Act, 1982*. The Inherent Right Policy was developed subsequent to a comprehensive consultation process with both Aboriginal representatives and provincial and territorial governments. The core objective of the policy is to ensure that Aboriginal peoples have greater control over their lives and to achieve this through negotiated settlements.

The 1995 release of the Inherent Right of Self-Government Policy was followed by the Royal Commission on Aboriginal Peoples (RCAP) in November 1996. The RCAP Report centred on a vision of a new relationship, founded on the recognition of Aboriginal peoples as self-governing nations with a unique place in Canada. It set out a 20-year agenda for change, recommending new legislation and institutions, additional resources, a redistribution of land and the rebuilding of Aboriginal nations, governments and communities. Specifically, the RCAP called for early action and increased investment in four areas; healing, economic development, human resources development, and the building of Aboriginal institutions.

The federal government's response to the Royal Commission on Aboriginal Peoples was set forth in *Gathering Strength – Canada's Aboriginal Action Plan*. Like the Inherent Right Policy that preceded it, *Gathering Strength* outlines a long term policy designed to improve the quality of life and self-sufficiency of Aboriginal peoples. It would meet this goal by renewing partnerships with the Aboriginal people of Canada, supporting arrangements for self-government, affirming treaty relationships, negotiating fair solutions to Aboriginal land claims, developing new fiscal relationships to foster self-reliance, and strengthening Aboriginal economic development. *Gathering Strength* affirms that treaties will continue to be the basis for the ongoing relationship between Aboriginal peoples and the Crown.

The federal government of the day recognized that one pathway to implementing the inherent right of self-government was through the courts and the judicial system. However, given the differing views about the nature, scope and content of the inherent

⁴ The 1973 Comprehensive Land Claims Policy was reaffirmed in 1981 with a focus to obtain certainty respecting ownership, use and management of lands and resources by negotiating an exchange of claims to undefined Aboriginal rights for a clearly defined package of rights and benefits set out in a settlement agreement. Amendments were made to the policy in 1986 which provided for greater flexibility in land tenure, and better definition of subjects for negotiation.

right; litigation would be lengthy, costly and would tend to foster conflict. Therefore, legal resolution should be a last resort. Negotiations among federal and provincial governments and Aboriginal peoples became the preferred approach; and negotiated agreements the most practical and effective way to implement the inherent right.

Since the early 1990s, the federal government has been working in partnership with provincial governments and individual or groups of First Nations to meet the goal of self-government for Aboriginal peoples. To date, 24 Final Agreements have been signed and ratified (between 1993 and 2005), 16 Agreements in Principle have been reached, and nine framework agreements have been negotiated.

The tri-level nature of the negotiation process – involving federal, provincial and First Nations representatives – necessitates an intersectoral approach to final agreements. The nature and scope of issues compounds this requirement. Issues that surface as “items of negotiation” could include, for example: governing structure, elections and leadership selection processes; Aboriginal language, culture and religion; adoption and child welfare; marriage; education; health, social services; policing; property rights; land management; natural resource management; agriculture; hunting, fishing and trapping; housing; local transportation; and licensing and regulation of local businesses. These issues span government departments at both the federal and provincial levels. An intersectoral approach ensures that the mandates of both levels of government are represented, and that First Nations’ priorities and concerns are part of that mix.

Intersectoral collaboration is further facilitated by a broad-based desire for certainty around Aboriginal issues. Unresolved issues with respect to land and resources could result in negative consequences for governments. According to our case respondent, one of the greatest motivators of bringing parties together was, *“to create certainty around rights, resources and land in order to mitigate the short, medium and long-term effects on the economy.”* In his view, *“investors would be reluctant to come and sign contracts worth millions of dollars... for logging, for example... if there were legal issues surrounding who actually has the title to that land.”* Generating clarity around items of negotiation mitigates the threat to the economy and its political leadership.

While intersectoral activity underpins self-government negotiations, it also adds to its complexity. Our case respondent referred to the difficulties faced when multiple and varied parties (and their related mandates) become engaged in the process: *“There were lots of players at the table, each with their own interest... This increased the degree of complexity of arriving at a negotiated settlement.”* Changes on the political landscape pose another challenge. It becomes difficult to coordinate the negotiation process and build on progress being made amidst political elections, both at the federal and provincial levels, as well as within First Nations groups (many of whom have elections every two years). Finally, intersectoral activity can be jeopardized by prevailing issues that shape the context for negotiation; especially issues that are “high profile” and/or have emotional overtones. Our case respondent provided an example related to issues linked to the environmental sector: *“People become sensitized to the issue which can make the work more difficult.”*

Approach

An administrative structure oversees the Aboriginal self-government negotiation process. At the federal level, the Department of Indian and Northern Affairs (DIAND) leads the Aboriginal self-government portfolio. The Minister of Indian Affairs has a mandate to enter into negotiations with First Nations, the Inuit, and Métis groups in the north. The Federal Interlocutor for Métis and Non-Status Indians enters into negotiations with Métis south of the 60th parallel and Indian people who reside off a land base. Under DIAND's leadership, the Claims and Indian Governance Directorate (in British Columbia, the Federal Treaty Negotiation Office assumes this role) represents all federal departments, agencies and the people of Canada in the negotiations with First Nations. It acts as a "coordination point" and pulls together all the various sectors whose mandates align and whose interests would be impacted by the final negotiated settlements.

While all federal departments are involved in negotiations, some become more engaged than others. When reflecting upon the Nisga'a experience, our case respondent highlighted the significant contribution from Health Canada: *"Health Canada was one of the Federal government departments that we were constantly including at the main table, and at side tables to discuss health issues.... While all sectors played a role, certainly Health Canada was a bigger player in the deal."* By and large, the items of negotiation determine the role and degree of involvement by various sectors.

On the provincial scene, the Ministry of Aboriginal Relations and Reconciliation oversees the treaty process. Provincial ministries provide representation to enter into Aboriginal self-government negotiations; in the case of First Nation groups, they identify representatives, often through election, from within. Additionally, non-government sectors link to the negotiation process through two types of consultative bodies: Treaty Negotiation Advisory Committees at the provincial level, with representation from various interests such as business, forestry, fishing, and tourism; and Regional Advisory Committees with representation from municipal bodies and a variety of community interests. Both the provincial and regional advisory committees are involved throughout the negotiation process and are consulted when new agreements come forward. According to our case respondent, *"Through these consultative bodies, the non-government sector has a tremendous influence on the nature of the agreements."*

Finally, the legal system may be drawn in when consultation and negotiation processes break down. Our case respondent illustrated the need for the legal sector when he shared the following: *"It's mainly consultation, but don't forget too that the court decisions don't stop... Not always can we get agreement around some things, so people go to the court to get resolution."*

These various levels and layers of representation bring their voices to Aboriginal self-government agreement negotiations. While the negotiation process varies somewhat across agreements, it typically consists of the following six stages:

Stage 1:

The First Nation submits a *Statement of Intent* to enter into treaty negotiations with Canada, the involved province and its treaty commission. This document includes what the First Nation considers to be its traditional territory with justification for its claim.

Stage 2:

The provincial treaty commission approves the Statement of Intent as being a legitimate claim; followed by a mandatory 45-day period during which the Statement of Intent is proclaimed.

Stage 3:

The third stage centres on the development of a *Framework Agreement* where the three parties involved (federal, provincial, First Nation) agree on the following: the subject matters for negotiation, how the negotiations will be structured, the degree of “openness” of the negotiations, and the structure of the negotiation teams. The Framework Agreement is signed by all three parties to the negotiation.

Stage 4:

In the fourth stage, substantive *Agreement in Principle* (AIP) negotiations begin. Topics are generally chosen from the list set out in the Framework Agreement, although the process does not prevent any party from raising new issues. Broad principles are negotiated on selected topics and drafting begins on the details of an agreement. These negotiations lead to the initialling and eventual signing of an AIP, which is a non-legally binding document used as the foundation for negotiations of the Final Agreement. The AIP is ratified by each of the parties in a manner outlined within the agreement itself.

Stage 5:

Negotiations are completed on any unresolved matters and the *Final Agreement* is drafted. A Final Agreement details agreements reached between the Aboriginal group, the province or territory, and the federal government on all issues at hand, including resources, financial benefits, self-government and land ownership. The final agreement must be ratified by all the principal players. Ratification happens through a vote among the First Nation, and via the passage of enabling legislation in the Provincial Legislature. At the federal level, the Final Agreement is passed through the House of Commons and Senate, is proclaimed by the Governor General and Supreme Court Justice, and receives Royal Assent to become law.

Stage 6:

The Final Agreement moves into implementation. The Government of Canada requires that a separate implementation plan for all self-government agreements to be approved in conjunction with Final Agreements. Implementation plans must identify the activities, timeframes, and resources that have been agreed upon to give effect to the agreement. Issues related to affordability, efficiency, capital requirements, duplication of services, feasibility and capacity must also be addressed.

Federal negotiators have at their disposal several mandates to guide them through the Agreement in Principle and Final Agreement negotiations including, the Comprehensive Claims Policy and its various revisions, and the Inherent Right Policy. Generic mandates provide instructions to negotiators on general, non-financial topics. The acquisition of a mandate provides an opportunity to establish and solidify relationships with other parts of the Department of Indian and Northern Affairs as well as with other federal government departments. Often, federal negotiators use mandates/guidelines from Health or Environment or other sectors to inform their negotiations.

Specific mandates also play a role. For example, a settlement offer from the Chief Federal Negotiator (pre AIP) requires a specific mandate from Cabinet. Similarly, to sign an AIP and start negotiating a Final Agreement, a specific mandate is required. Finally, to initial a Final Agreement and carry out the federal process of ratification, yet another mandate is required. These kinds of processes provide an accountability mechanism for the negotiation process.

Impact

While reaching a Final Agreement with British Columbia's Nisga'a First Nation represents a major accomplishment related to Aboriginal self-government, much work remains. (Please See Appendix C for information on the Nisga'a Final Agreement.) Our case respondent summed it up this way: *"The federal treaty negotiations have not realized their full potential yet... however, they have reached some milestones... The Nisga'a Treaty is one."*

A feature achievement of the Nisga'a Treaty centers on health care. As far back as 1990, the Nisga'a Valley Health Board concluded a Health Care Transfer Agreement with Health Canada which conferred responsibility for delivering health care and health promotion programs to the Nisga'a people. Eight years later, Health Canada and the Nisga'a Valley Health Board entered into another agreement which transferred funding and responsibility for delivering non-insured benefits such as prescription drugs, optometry services, dental care and medical transportation. Moreover, the Nisga'a Valley Health Board signed an agreement with the BC Medical Services Commission and the Northwest Aboriginal Health Council to provide physician and other services in the some regions of the province. Working across sectors allows for all relevant sectors to provide input on issues that affect health.

Taken together, these agreements illustrate the ability of parties to focus efforts on a single issue (health) in order to build community capacity and maximize benefit to people. In the words of our case respondent: *"These agreements established the Nisga'a as leaders in the administration and delivery of community-based health programs and services... Pretty big stuff."*

Several lessons can be drawn from the Aboriginal self-government negotiation process to help identify key contributors to success. The learnings below are principally drawn from the Nisga'a experience, and include:

- Federal negotiation teams must establish close links with the Department of Indian and Northern Affairs and other government departments as this contributes to approvals for innovative solutions to resolve negotiation issues.
- It is important to understand the role of negotiation mandates and ensure that mandates are appropriate to the local circumstances in order to facilitate agreement among parties.
- Negotiation teams must have the skill set and aptitude to cultivate interpersonal

relationships of trust and openness with each other and with other parties at the negotiation table.

- It is important to understand that personal relationships developed during the negotiations help overcome major challenges. Moreover, the building of new relationships is not restricted to the three parties at the tables; often, regional alliances develop with authorities in the broader community (such as municipal governments).
- Negotiation teams must establish and maintain effective communication links with the public and third parties, including opponents of the process, in order to understand the nature of opposition to the negotiations.
- The crafting of self-government agreements must consider the context in which they are being developed.
- Successful conclusion of one self-government treaty holds educational and instructional value for subsequent negotiations.

Reflection

Upon reflection, our case respondent shared his view on the role of intersectoral activity in the Aboriginal self-government negotiation process. He reflected on how working collaboratively across levels of government and government departments helped to address long-standing issues between governments and First Nations in this country: *“Involving all players at all levels allowed them to work toward bridging the cultural divide that has existed for so long.”*

When asked if he had any final comments, our case respondent commented on how his own thinking changed along the way; moving from skepticism in the early days, to a deep sense of personal satisfaction:

I guess until I was immersed in this work and witnessed it actually happening I would have bet a lot of money that getting such a large diverse set of departmental interests to work together to achieve the end result would have been almost impossible. But I have seen it produce the desired end product, the treaties. And yes it was clearly one of the hardest, most intense, most demanding parts of my working life, to be a part of that, but hugely satisfying when it came to pass... This is nation building, pure and simple.”

Case Study 4: Gender-Based Analysis

*Federal initiative
Status of Women Canada as leader
Health as supporter
Gender equality as focus*

Context

Over the last several decades, Canada and other countries around the world have been adopting strategies to advance gender equality. Gender equality refers to women and men having equal conditions to realize their full potential; to contribute equally to national political, economic, social and cultural development; and to benefit equally from the results. Gender equality involves women and men as partners in the quest for fairness to benefit their own lives as well as the future well-being of their sons and daughters.

At the Fourth United Nations World Conference on Women held in Beijing in 1995, nations developed an ambitious political declaration and platform for action to achieve greater equality. By adopting the Beijing platform, governments throughout the world committed themselves to the effective integration of a gender perspective into their operations, policies, planning and decision-making. Governments also adopted the obligation to carry out gender impact assessments, which consider the effects of government bills or programs on gender before decisions are made.

In response to the Beijing Platform, the Government of Canada, under the leadership of Status of Women Canada (SWC), developed the *Federal Plan on Gender Equality* (1995-2000), followed by the *Agenda for Gender Equality* (2000-2005).⁵ The Federal Plan on Gender Equality rests on a number of observations. Despite progress to date, women have not achieved full equality with men nor gained access to all levels of decision-making in Canadian society. As well, women in Canada experience different realities that are the outcome not only of gender, but also of age, race, class, national and ethnic origin, sexual orientation, mental and physical disability, region, language and religion. As such, the Federal Plan for Gender Equality values diversity and seeks to achieve equal outcomes for both women and men in the quest for an equitable society.

The Federal Plan offers a statement of commitments and a framework for gender equality based on the concerted effort of 24 federal departments and agencies. Specifically, the plan consists of eight objectives focused on improving the status of women across various dimensions:

1. Implement gender-based analysis throughout federal departments and agencies.
2. Improve women's economic autonomy and well-being.
3. Improve women's physical and psychological well-being.
4. Reduce violence in society, particularly violence against women and children.
5. Promote gender equality in all aspects of Canada's cultural life.
6. Incorporate women's perspective in governance.
7. Promote and support global gender equality.
8. Advance gender equality for employees of federal departments and agencies.

The themes of the Federal Plan carried into the second iteration of Canada's gender equality policy, the *Agenda for Gender Equality* (2000-2005), which renewed the federal government's commitment to gender equality. Under this policy, Status of Women

⁵ Currently, Status of Women Canada has a new approach to gender based analysis but has not articulated a formal plan..

Canada received \$20.5 million over 5 years to work toward the following goals: (i) accelerate the implementation of GBA, (ii) meet international commitments and treaty obligations, (iii) engage Canadians in the policy process, (iv) enhance voluntary sector participation in achieving gender equality, and (v) engender policies and programs as a shared responsibility between SWC and other government departments. Both these policies are grounded in the Government of Canada's recognition that intersectoral collaboration among federal government departments and agencies is fundamental to the successful development and implementation of policies aimed at gender equality.

Gender-based analysis (GBA), an analytical tool to assist in integrating gender considerations into policy, planning and decision-making processes, underpins both the Federal Plan and the Agenda for Gender Equality. Our case respondent characterizes gender-based analysis as, "*a policy tool to address gender equality in all its forms and across all of the Federal government... and to help other departments engender their policy processes.*" With capacity building as part of its mandate, the Gender-Based Analysis Directorate, under the leadership of Status of Women Canada, assists other federal departments in incorporating gender-based analysis into their own programs and policies. In addition, it provides tools and training to support GBA.

Several factors promote an intersectoral approach to gender-based analysis. Intersectoral action aligns with the character of the issue. In the words of our case respondent: "*The issues relevant to gender and women's equality, by their very nature, cross government departments.*" Moreover, gender equality spans levels of government. Issues such as health and education principally fall under provincial mandates; and often, the delivery of gender equality programs occurs at the regional or local level: "*So,... the fact that the issues we work on for women are not just federal jurisdiction has really necessitated this intersectoral approach.*" Gender-based analysis, therefore, rests on a broad-based partnership that involves governments at all levels, women's organizations, non-governmental organizations, voluntary organizations and private institutions.

When asked to comment on factors or conditions that challenged an intersectoral approach to gender analysis, our case respondent singled out the voluntary nature of the program. Despite the mandate of the Status of Women Canada to facilitate GBA within other departments, there is no requirement for the other departments to comply. The Status of Women Canada, therefore, wields little influence over its sectoral partners. Our case respondent characterized it this way: "*If we go knocking on the door, we have no clout.... We don't have a leg to stand on because it is not a mandatory requirement for any sector to engender its processes...so they may, or they may not.*" The voluntary nature of gender-based analysis contributes to a lack of accountability on behalf of other federal departments to work toward, or report on, progress.

A lack of political will was also identified as a challenging factor. Our case respondent linked this to developments on the global scene whereby gender equality issues undergo an "*ebb and flow*" of activity based on the government of the day: "*We see this internationally where you have status of women machinery that does well for a long time, and then, sort of flunks out... we are in the flunking out stage because we do not have the political will right now.*"

Finally, cross-sectoral approaches to gender-based analysis have been challenged by the perception, both within and outside government, that significant progress on gender equality has already occurred in Canada; and that the gap between women and men is closing. According to our case respondent: “*The current rhetoric around gender equality is that women in Canada are equal... so why de we have to bother.*” In her view, this perception has served as a barrier to other sectors to contribute to gender equality efforts in recent years.

Approach

In 1999, the Gender-Based Analysis Directorate was established as part of an effort to step up the pace and enhance the progress toward gender equality for the 2000 to 2005 period. To fulfill its role, Status of Women Canada, through the GBA Directorate, developed a six-point strategy consisting of training, tool development, policy case studies, research/information/education, evaluation and accountability, and coordination. To assist in the development and coordination of GBA activities, Status of Women chairs an Interdepartmental Committee on Gender-Based Analysis, which consists of representation from seventeen federal departments. The participants range from senior analysts to managers to directors (four departments have GBA champions at the Assistant Deputy Minister Level).

Starting in 2000, several of the departments serving on the Interdepartmental Committee established “gender focal units” to promote gender-based analysis of policies and programs within their own department. A number of departments have since abandoned their units, but seven continue this work today, including Citizen and Immigration Canada, Human Resources and Skills Development Canada, Social Development Canada, Canadian International Development Agency, Justice Canada, Health Canada and Finance Canada.

This limited uptake of gender-based analysis over the past five years was featured in a report from the House of Commons Standing Committee on the Status of Women,⁶ which was formed in 2005 to study gender-based analysis across federal departments. In its report entitled, *Gender-Based Analysis: Building Blocks for Success*, the Standing Committee concluded that, “*the use of gender-based analysis across government departments has been uneven*” (p. 2). At the same time, they provided examples of how gender-based analysis has been effectively integrated within some departments. These are summarized below.

- Citizenship and Immigration, through the development of a five-year strategic plan, in keeping with the *Immigration and Refugee Protection Act* and the requirement to report to Parliament, developed a framework for GBA, covering

⁶ The List of Witnesses for the Standing Committee on the Status of Women included departments who participated in gender-based analysis as well as some individuals with expertise in the area. The Committee report also incorporates some of the views expressed by representatives of equality-seeking organizations and women’s groups who participated in roundtable consultations before the decision to study GBA was taken by the Committee in 2004.

- the period 2005-2010. It outlines the department's objectives principles, activities and reporting steps related to GBA, tied to branch business plans.
- CIDA has been implementing the GBA training program (see below) for the past 15 years. Its Gender Equality Division is headed by a director and situated in the Policy Branch. In addition to the division, each of the programming branches either has a gender equality specialist or has identified a gender equality point person. Together, these staff makes up the gender equality core group, which fosters discussion and exchange of best practice within the Agency.
 - The former HRDC launched a department-wide policy on GBA to provide a framework for the department's ongoing efforts in this area. It has created a network of gender advisers (trained in GBA) who serve as contact points for sharing GBA information with branch officials.
 - Indian and Northern Affairs' Women's Issues and Gender Equality Directorate coordinated the implementation of that department's gender-based analysis policy by ensuring that it was reflected throughout the department's business lines, both within headquarters and regional offices. The Directorate is supported by a network of gender equality analysts in all branches and regions of the department.
 - Justice Canada adopted its policy on gender equality analysis in 1997, requiring the review of every issue with respect to its impact on gender equality. It is currently improving the practice of GBA throughout its operations.
 - Health Canada, Citizen and Immigration, Indian and Northern Affairs, and the former HRDC have all adapted Status of Women Canada's training materials to meet their departmental needs. Officials trained in GBA use their knowledge to improve the department's work in GBA.
 - Additionally, Health Canada launched a five-year implementation plan in 2003 under the umbrella of its Women's Health Strategy that includes a gender-based analysis policy, projects such as the development of women's health indicators, and support for research. Our case respondent indicated a high level of support for GBA from Health Canada and suggested this was due to the health sector's understanding of the multiple factors (and their interconnectedness) that contribute to one's condition/health: *"Health was always there... they get GBA because it is the intersection between systemic, social and environmental factors, and the convergence of those factors that impact equality."*

As noted above, tools and training materials have been developed by the GBA Directorate to support gender-based analysis. The training materials facilitate work across departments and serve as a tool for intersectoral collaboration. Other tools supporting intersectoral cooperation for gender equality include working groups to address specific gender related issues (e.g. gender equality indicators) and an E-Bulletin, which helps to keep individuals across government departments informed of GBA activities.

The overall purpose of gender-based analysis training is to ensure that program and policy analysts learn how to apply GBA in their daily activities. Specifically, the training seeks to: (i) develop an understanding of how GBA can improve the policy/program development and/or implementation process to support gender equality, and (ii) how GBA is applied through the different steps of development and implementation.

Additionally, a “Train the Trainer” program was launched in 2003. It offers Train the Trainer workshops for selected candidates on a regional basis, and provides a GBA Trainer Manual that describes the approach to GBA training. Over the past few years, trainers have participated in both domestic and international GBA training. While some departments have eagerly accepted GBA training, others have not. Our case respondent linked the weak response to GBA training to a lack of commitment from upper-level management: *“Sometimes only administrative assistants showed up at the training because there is no senior management buy-in.”*

Accountability has been significantly challenged within the GBA program. Largely, this is attributed to a lack of mechanism that requires federal departments to consider gender in their policy and program processes (let alone implement GBA). Realization of the government’s commitment to gender equality rests on improved accountability. In a statement to the media, the Chair of the Standing Committee on the Status of Women called for clearer and stronger accountability measures for the existing policy: *“We do not accept that the current passive approach to gender analysis by central agencies and individual departments is enough. It is time to do business differently. It is time for a policy with real teeth and measurable results.”*

To increase accountability, the Standing Committee on the Status of Women proposed a series of building blocks including strong participation by equality-seeking organizations, and reporting mechanisms which will make it easier to determine whether departments are making progress in incorporating gender considerations into their work. This would require cooperation from federal central agencies including Finance Canada and the Treasury Board Secretariat. In its response to the Standing Committee’s report, the Government of Canada indicated that, *“Status of Women Canada will continue to work with both federal departments and the central agencies...to ensure a GBA lens is applied to any new proposals, and to increase accountability for the application of GBA within government structures and mechanisms.”*

Impact

To date, evaluation of gender-based analysis by the GBA Directorate has centred on the GBA training program. Pre and post questionnaires are used to demonstrate the uptake of the program and to assess whether it has been appropriately applied. Our case respondent claimed that outcome evaluation of the current policy is challenged by the absence of any adoption or reporting requirements: *“Since there is no mechanism to enforce the adoption of GBA in other departments, there is no way to evaluate/verify the work by those who claim that they do GBA.”* .” However, Status of Women Canada is currently working with the three central agencies (i.e., Treasury Board, Finance and Privy Council Office) to ensure that gender outcomes can be tracked and that departments can be held accountable for the integration of GBA.

As noted earlier, in its study of gender-based analysis across government departments, the Standing Committee on the Status of Women found that the implementation of gender-based analysis differs significantly between departments and agencies. Moreover, when gender units have been established, they typically have few staff and

resources, are located in the lower ranks of the bureaucracy, and have minimal or no mechanisms for ensuring that GBA is actually achieved. Challenges notwithstanding, the Standing Committee on the Status of Women uncovered several lessons learned and identified a set of enabling factors for gender-based analysis to inform future work.

These include:

- Ensure availability and access to data to support the application of gender analysis on policies and programs (e.g., disaggregated gender data and qualitative information on gender differences)
- Incorporate gender equality at all levels and in all types of activities, from policy formulation through to program design and project planning, implementation and assessment
- Encourage input from the voluntary sector and advocacy from NGOs in the policy process
- Garner commitment for GBA from department staff at all levels, and ensure buy-in from senior management with assigned responsibilities and accountabilities.
- Institute organizational structures, procedures and norms that promote gender equality
- Allocate adequate resources, both human and fiscal, to build capacity for GBA
- Implement accountability mechanisms so that departments and agencies share responsibility for gender equality

Reflection

When asked to reflect on the most unique or interesting aspect of gender-based analysis, our case respondent identified two things. First, the fact that a number of federal departments have developed their own gender units and have modeled their training and tools on those of SWC. As well, our case respondent referred to the “world class” training tools and materials developed by the GBA Directorate to build capacity for gender-based analysis across government; acknowledging that the tools have been used by countries around the world.

When asked how intersectoral activity and gender-based analysis could be improved or better supported in the future, our case respondent replied in a way that aligned with the findings of the 2005 report of the Standing Committee on the Status of Women. Based on her experience, she believes that future work in gender-based analysis would benefit most from enforcing accountability and garnering the political will to move the agenda forward.

Case Study 5: Healthy Child Manitoba

Provincial initiative
Healthy Child Manitoba as leader
Health sector as partner
Children and youth as focus

Context

Healthy Child Manitoba is the Government of Manitoba's long-term, cross-departmental prevention strategy to improve the well-being of Manitoba's children. Through a combination of financial and community-based supports, Healthy Child Manitoba provides a continuum of supports through adolescence, with a focus on the most critical stage of early childhood development, from the prenatal period to preschool years.

With “*the best possible outcomes for all of Manitoba's children,*” as its vision, Healthy Child Manitoba works across departments and sectors to meet its goals aimed at raising children who are healthy, safe and secure, successful at learning, and socially engaged and responsible. It embraces the following principles to guide its work: a community-based approach to service planning and delivery, inclusiveness of families and children, access to a comprehensive and integrated spectrum of services, and public accountability.

Through the 1990's, several prevailing factors motivated the development of Healthy Child Manitoba and its embodiment of an intersectoral approach to healthy child and youth development. Existing service delivery models, most of which were developed in the 1950's and 1960's, were not sufficiently meeting the needs of children. Typically, they addressed a single-disease or problem, and failed to adequately consider the multiple influences on child and youth well-being. At about the same time, the Progressive Conservative Premier of the Province, through a number of economic summits, identified early childhood development as a driver for improving the economy. This generated political will within government to examine new approaches to healthy child and youth development.

In 1993, the Minister of Health commissioned a review of potential new models that could work in the context of Manitoba. They were as follows: (i) continue with the existing voluntary participation in interdepartmental work, (ii) create one “super ministry” to address all issues surrounding children and youth, and (iii) adopt a “shared governance” model where ministries would work collaboratively toward common interests related to this population. The “shared governance” model was recommended to cabinet and the Children and Youth Secretariat was established (1994) with a mandate to coordinate child and youth development policies at the government and community level, under the *ChildrenFirst* Strategy. Shortly after, in 1995, the province released a cross-sectoral report, entitled *The Health of Manitoba's Children* (Postl et al), Canada's first (and to date, only) population health report on children.

In March 2000, the newly elected New Democratic Party government expanded on the foundation of the previous government's Children and Youth Secretariat, with the Premier's establishment of the Healthy Child Committee of Cabinet (HCCC) and Healthy Child Manitoba. Responding to the growing evidence of the importance of investing in human capital, this new model of governance was mandated to create multi-level, horizontal infrastructures in government and community to improve children's outcomes.

In essence this meant reinventing government and community around the best interests of children, refocusing investments in prevention and early intervention, and using strategic research and evaluation to advance child centred public policy.

The Finance Minister and Treasury Board linked strong children and families with economic viability; this position provided a rationale for heavy investment in early childhood development. Our case respondent related this development as follows: *“We had an amazing Finance Minister and Treasury Board that said ‘yes, this is a social and economic imperative, we need to improve how we invest in our children.’”*

Parallel initiatives were underway at the federal level. Manitoba was working with other provinces on the National Children’s Agenda, and as a signatory to the 2000 Federal/Provincial Territorial Early Childhood Development Agreement, received new federal funding to build on provincial revenues for supporting intersectoral initiatives aimed at healthy child and youth development.

Since 1999, Manitoba’s investment in early childhood development has increased by 64 million dollars. In the view of our case respondent, the province had structures in place to receive and allocate the federal funding, which helped to support provincial funding for intersectoral collaboration on child and youth issues: *“When the federal money came to us, our horizontal structures make it easier for us to involve all the partners in combining the federal and provincial resources to connect programs and initiatives from several departments to improve outcomes for children. We were able to move forward much more quickly becausewe did not get caught up in the silos.”* According to our case respondent, this was not necessarily the case in other provinces, *“resources were allocated through traditional departmental structures which is complicated because early childhood development issues are often addressed by more than one department.”*

Emerging theory and research served as additional factors that facilitated an intersectoral approach to child and youth wellness in Manitoba. Much of the discourse in the late 1990s centred on “population health,” which recognized the social, economic and environmental influences on health, and called for cross-sectoral and coordinated approaches to service design and delivery. Our case respondent described the influence of population health this way: *“It was the era of the determinants of health... Everyone acknowledged that early childhood development crossed all the determinants and needed to be interconnected. This knowledge base was a huge driver, and the Healthy Child Manitoba model is based on it.”* Moreover, Manitoba’s efforts aligned with new research in this field. Studies demonstrated, for example, the effectiveness of multiyear, early intervention programs; and the promise of holistic and integrated systems that involved partnerships with parents, children and youth, and communities.

While several factors were working in its favour, Healthy Child Manitoba faced some challenges related to working horizontally. Shifting the “culture of government” from traditional (i.e., siloed) to “enlightened” (i.e., collaborative) approaches is always challenging. A preference for the status quo was well entrenched within the bureaucracy. Our case respondent summed up this challenge as follows: *“The hardest issue we are working on is within the bureaucracy per se.... in ‘interdepartmental land,’ as we call it, there are staff who have not yet been exposed to working in a horizontal infrastructure.”*

Moreover, new people enter the bureaucracy continuously which requires ongoing education and reinforcement of intersectoral approaches: *“It is an ongoing focus with new people... explaining to them why we are doing things this way instead of the ways we have always done things.”* At the same time, twelve years into this way of working our respondent reported that this model of horizontal collaboration is all some government staff have known and they proceed as a matter of course, *“we have always worked across departments and sectors to improve kid’s outcomes”*.

Additional barriers to intersectoral action within Manitoba’s initiative included: a lack of established models or mechanisms to guide work across departments and sectors, and challenges associated with designing processes for spending money across departments, and challenges in building and funding an evaluation system that links evidence to resource allocation and resources to results.

Approach

A number of entities characterize Healthy Child Manitoba’s organizational and administrative structure, from the provincial to community level. This is summarized in the box below.

Box 1: Healthy Child Manitoba Structure

Government of Manitoba → Healthy Child Committee of Cabinet → Health Child Deputy Ministers’ Committee → Executive Director/Healthy Child Manitoba Office & Secretary to the Healthy Child Committee of Cabinet → Provincial Early Childhood Development Advisory Committee → Healthy Child Interdepartmental Committees (program and planning, policy and evaluation) → Parent-Child Coalitions → Program areas → Healthy Child Policy Development, Research and Evaluation
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The Healthy Child Committee of Cabinet develops and leads child-centred public policy across government and ensures interdepartmental cooperation and coordination with respect to programs and services for Manitoba’s children and families. As one of a select number of committees of Cabinet, the existence of the committee signals healthy child and adolescent development as a top-level policy priority of government. Under the auspices of the Healthy Child Committee of Cabinet, Healthy Child Manitoba has its own budget and has access to resources from other government departments. Manitoba has developed innovative structures in government and in community dedicated to improving the health and well being of children and youth, and added these to the traditional executive structure of expenditures and development of most governments. The challenge is how best to organize societal institutions, especially the public service, to effectively meet the needs of the cross-sectoral system through community development.

Today, approximately half of all the ministers in the Manitoba government serve on the Healthy Child Committee of Cabinet. This includes representation from: Aboriginal and Northern Affairs; Culture, Heritage and Tourism; Family Services and Housing; Health; Healthy Living; Justice; Education, Citizenship and Youth; Labour and Immigration; and Status of Women. The Premier appoints various departmental Ministers to chair the HCCC which, according to our case respondent, reinforces the government’s whole-of-

government approach: *“The Committee is chaired by various Ministers which is important because our message is that it is not up to any one person..... So no one Minister is responsibility for kids; it is a government-wide responsibility.”* The deputy ministers of the partner departments are designated as the Healthy Child Deputy Ministers’ Committee to assist the Healthy Child Committee of Cabinet in carrying out its responsibilities.

Headed by an Executive Director and the Secretary to the HCCC, the Healthy Child Manitoba Office serves as staff and secretariat to the Minister and Deputy Minister committees. Working across departments and with community partners, the Healthy Child Manitoba Office undertakes two major activities: (i) program development and implementation, and (ii) policy development, research and evaluation. Two interdepartmental committees with representation from the above, as well as the departments of Finance, Conservation, Intergovernmental Affairs and the Community Economic Department Committee of Cabinet, are responsible for these functions. They regularly review requests for funding, oversee the provincial research and evaluation strategy, monitor outcomes, and garner funds from various departments to support intersectoral initiatives. The central office and the HCCC have access on an as-needed basis to the Provincial ECD Advisory Committee which assists in identifying and assessing community strengths and needs related to children and their families.

Finally, 26 Parent-Child Coalitions have been established at the community level - 12 within Winnipeg and 11 across the rest of the province, as well as 3 province-wide committees serving aboriginal and francophone families. Parent-Child Coalitions bring together local strengths and resources from different sectors to support existing activities and help groups start new activities that reflect each community’s diversity and needs. Governance structures are organic to facilitate community development because the mix of risk and protective factors for healthy child development differ from community to community. Through an established funding process, coalitions receive leverage funding for programs across four key areas: parenting, nutrition, literacy, and capacity building. Parent-Child Coalitions include a broad mix of community stakeholders, for example: parents, early childhood educators, friendship centres, school districts, regional health authorities, child and family service agencies, faith organizations, private businesses, police services, cultural organizations, funding organizations and other interested groups.

According to our case respondent, the Parent-Child Coalitions (PCC) represent an effective mechanism to support intersectoral collaboration for the benefit Manitoba’s children and youth. They, along with the ECD Advisory Committee, serve the essential function of maintaining outside pressure on government and collaborate horizontally with government through Healthy Child Manitoba in a knowledge action cycle. These parallel structures at the political (HCCC) and community (PCC) levels support child centred public policy development and implementation. In her view, before the Coalitions were in place, *“everyone wanted to split the allocated funds, take their piece... and continue to work on what they thought was important for early childhood development ...without considering what others are doing.”* Under the Parent-Child Coalitions, all players work as a cohesive unit toward shared aims: *“Now, they plan together and work together to come up with solutions that actually improve kids’ lives.”*

When asked to comment on the role of the health sector, our case respondent noted contributions from the province's Regional Health Authorities and Public Health. Representatives from these groups are key members of the Parent-Child Coalitions and provide health-related advice and services for children and youth. For example, the Families First Program provides a "universal screen" to evaluate whether there are issues in the family that need to be addressed (such as parent alcohol use, need for social support, and health of the mother). Those families who score high on the initial screen undergo a more in-depth interview process with Public Health; and those in need, are referred to a Home Visiting Program. While the Families First Program is managed by the Regional Health Authorities; the training of home visitors, standard setting, and program evaluation remain the responsibility of the provincial government.

Additionally, the health sector has contributed to Healthy Child Manitoba at a theoretical level. Our case respondent acknowledged the role of the "Population Health Model" in the development of the Children and Youth Secretariat/Healthy Child Manitoba, and its related ability to garner support for intersectoral action: *"I think, quite honestly, that this would not have happened if we had not used the population health model.... It brings together all the pieces of a whole person and a whole family and a whole community in a way that allows the individual beliefs of each of the departments to move forward."* Under the umbrella of Healthy Child Manitoba, all sectors are deemed equal. While Health serves on all the committees, it shares leadership of those committees with other partner sectors.

Upcoming legislation is expected to enshrine Healthy Child Manitoba's organizational and administrative structure into law. The Healthy Child Manitoba Act is scheduled for third reading in the fall of 2007. The Act defines the roles, responsibilities, and operations of the Healthy Child Committee of Cabinet, Healthy Child Manitoba Office, Provincial Healthy Child ECD Advisory Committee, and Parent-Child Coalitions. In addition, the Act address issues related to "requiring and disclosing information." The Healthy Child Manitoba Act, according to our case respondent, *"is enabling legislation which would put into law all the structures ... and also put into law the ability to share information."* With the pending passage of the Healthy Child Manitoba Act, Healthy Child Manitoba, and its commitment to an intersectoral approach, will be embedded into the fabric of the province of Manitoba for the long term.

Impact

According to the Healthy Child Manitoba Act, the Healthy Child Committee of Cabinet may require the Healthy Child Manitoba Office to evaluate government policies, programs and services that directly impact children and their families. The Healthy Child Manitoba Office has developed a Provincial Evaluation Strategy to develop and implement a long term research, evaluation and accountability infrastructure. It consists of five major components: community data initiatives, provincial program evaluations, population-based research, specialized evaluations, and community capacity building and knowledge exchange. At least once every five years, the Healthy Child Manitoba Office will provide the Healthy Child Committee of cabinet a report on the status of Manitoba's children in relation to achieving its policy goals.

Additionally, the Healthy Child Manitoba Office is required to prepare an annual report on its activities. For the first time, the 2005/06 reporting year required the Healthy Child Manitoba Office to report on a standardized set of performance measures. Performance indicators and targets are intended to provide the Government of Manitoba with meaningful and useful information about Healthy Child Manitoba's major activities and achievements on an ongoing basis. The 2005/2006 measures provide a baseline from which to measure progress. The data from the performance indicators contributes to the measurement of the overall health of Manitobans.

Measuring progress in child-centred public policy is dependent on child-centred research and evaluation capacity inside and outside of government. The Healthy Child Committee of Cabinet has mandated province-wide implementation of the Early Development Instrument, longitudinal research and randomized control trials as well as partnerships with other governments, national and international research networks and scientific centres of excellence. The best evidence supports policy making across departments and sectors. Healthy Child Manitoba is mandated to bridge government and community towards sustained, systemic culture change for children's outcomes.

Translating the best scientific research at both the political and community level is a challenge, but provides a shared understanding of the best policy mix of universal, targeted and clinical approaches; the role of the gradient; the need to determine effectiveness and efficiency through rigorous evaluation design and the realization that improving horizontal collaboration means greater challenges for accountability.

When asked to share any lessons that were learned from the Healthy Child Manitoba initiative, our case respondent stated the following: *"Systems can change."* She went on to say that change, with respect to intersectoral action, is dependent upon the following: political support, a strong theoretical base, and effective administrative structures. In her view, *"Systems can change if you have the right ingredients in place.... If you don't have the political will, if you don't work with a strong knowledge base, and if you don't have the right structures supporting an "inside engine" with dedicated funding, staff and resources.... change will not occur."* The need for establishing cross-departmental estimates and budgeting processes that *"allow for spending across sectors,"* represented another lesson learned; as did the importance of allocating sufficient time to make the "culture shift" within government departments, *"so people at all levels become enthusiastic, and then have time to shift their thinking."*

Reflection

Looking back, our case respondent identified the application of the Population Health Model as the most interesting and innovative aspect of Healthy Child Manitoba: *"The Population Health Model allows the bridging of political to bureaucracy to community.... It brings together all the key players across all the sectors, and that to me, is what is most unique and innovative about this. Putting children at the centre of public policy is key to improving their outcomes."* When asked to look to the future, our case respondent identified three factors that would facilitate or improve intersectoral activity within Healthy Child Manitoba: passage of the Healthy Child Manitoba Act, supporting

vigorous evaluation (RCT's) to measure progress on improving outcomes for Manitoba's children, and sustaining the political will to "*stay the course*" over the long term.

Case Study 6: Quebec Public Health Law

Provincial initiative

Ministry of Health and Social Services as leader

Healthy public policy/health impact assessment as focus

Context

Several initiatives characterize Quebec's province-wide public health policy over the past two decades. These include a *Public Health Act* which sets forth public health functions and affirms the authority of the Ministry of Health and Social Services (MHSS) over other governmental sectors to protect, maintain and improve the health and well being of the population; a provincial institute which brings together experts in public health; and a comprehensive program of public health services that strives to address the boarder determinants of health and well-being. These entities work together to support public health and intersectoral action on the social determinants of health at the provincial, regional and local levels in the province of Quebec.

Quebec's *Public Health Act* was adopted in 2001 to "*protect the health of the population and the establishment of conditions favourable to the maintenance and enhancement of the health and well being of the general population.*" The Act was implemented to advance health promotion, prevention, surveillance and protection province-wide. Its development was motivated by limitations inherent to its predecessor - *the Public Health Protection Act* of 1972. The Public Health Protection Act did not describe ways in which Ministry officials or regional public health authorities were expected to meet their obligation to protect the public's health. Additionally, the 1972 legislation failed to specify how public health authorities could acquire the necessary information that would allow them to meet this responsibility.

Under the Public Health Act, the MHSS is empowered to undertake intersectoral action to develop and implement public policies that support the health of Quebec's population. The intersectoral aspect of the legislation was shaped by broader influences that dated back to earlier decades. This included the emergence of what has been called the "new public health" in the mid-1980's. New public health approaches extend beyond the core functions of public health (e.g. health surveillance, risk factor reduction, health protection) to embrace a broader view of health. They examine health through a wider lens which considers the relationship between lifestyle, living conditions, and supportive environments; and their cumulative effect on population health disparities and outcomes.

Through the 1980s and 1990s, countries around the globe embraced new approaches to public health and developed policies to reflect such. European and Scandinavian countries, for example, crafted health policies that recognized the broader influences on health (and their interrelatedness) and acknowledged the potential for intersectoral

approaches to address them. Canada's experience was embodied in the Ottawa Charter, which in the view of our case respondent, *"was critical in informing the new public health legislation in the province of Quebec."*

Factors closer to home further facilitated the embodiment of intersectoral action in Quebec's public health policy. Quebec is the only province in Canada that has integrated health and social services within the same government department (MHSS). This enables the inclusion of a "social agenda" alongside traditional aspects of public health. Additionally, the establishment of the Health and Wellbeing Council in 1992 meant that actions on social development and the activities of public health were mutually supported and coordinated in the province. Both these areas endorsed population-based approaches with an emphasis on prevention, promotion and the role of intersectoral activity. The Health and Wellbeing Council helped to mobilize public and community stakeholders to address social conditions province-wide that could ultimately impact the health of the population. The Council was comprised of representatives from different ministries, research bodies, public organizations, NGOs and various health and social networks.

However, intersectoral activity faced a number of challenges. Some *"discomfort"* was expressed by other sectors about the role of Public Health in areas that were not typically under its control. There was a sense from other government departments that health was *"taking over,"* working outside its mandate, and establishing a place of dominance with the public sector. Our case respondent provided an example that centred on health's involvement with an advisory panel on injury control related to automobile accidents: *"The Insurance Board for the automobile industry questioned what Public Health was doing advising people about topics outside its domain."*

The working relationship between health and other sectors varies based on past experience and how closely mandates align. In the words of our case respondent, intersectoral activity, *"is easier with Ministries where we have traditional links, especially in the social sectors.... and is more difficult with ministries a bit farther from our preoccupation, and where there is no culture of working together."* Besides issues related to working across sectors, implementation of Quebec's public health policy was also challenged with the election of a new, economically conservative, provincial government in 2003.

Approach

Three key initiatives helped transform public health in Quebec and set the stage for intersectoral action on the determinants of health: (i) creation of the Public Health Institute in 1998, (ii) development of the Public Health Act in 2001 (introduced above), and (iii) implementation of the Public Health Program in 2003. These three initiatives are described below, with a greater emphasis directed at the Public Health Act.

The *Public Health Institute* (Institute national de sante publique/INSPQ), established in 1998, serves as an advisory body to the MHSS. Through its linkages with provincial universities and academic centres, the Institute provides a critical mass of experts who work to build capacity for health promotion and surveillance province-wide. The Institute

supports the Ministry and regional authorities in developing public health research, disseminating knowledge, and supporting the exchange of international experts. Sixty percent of INSPQ's total budget is funded by the MHSS, and the balance is covered by various grant projects that are primarily funded by MHSS and then by other ministries, research agencies and the Federal government. A team within the INSPQ conducts health impact assessments of Article 54 (see below) and has a mandate with the National Collaborating Centre on Health Public Policy for knowledge transition and synthesis. In the latter instance, the INSPQ and the government work together to agree upon research priorities.

Passing the new Public Health Act Legislation in 2001 signifies the second key aspect of public health policy development in Quebec. Article 54 of the Act stipulates the following:

The Minister is by virtue of his or her office the advisor of the Government on any public health issue. The Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population. In the Minister's capacity as government advisor, the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population.

As such, all Ministries and agencies are required by virtue of the Public Health Act to consult the Minister of Health and Social Services when they are formulating laws or regulations which could have an impact on health. It is then incumbent upon the Ministry to advise the government. To meet the expectations of Article 54, the MHSS adopted a twofold strategy:

1. Establishment of an intra-governmental *health impact assessment* process, which can be defined as follows: "A combination of procedures, methods and tools by which a policy, program or project can be judged for its potential effects on the health of the population and the distribution of those effects within the population." (Ratner et al, 1997). The HIA process consists of five steps which all provincial government departments must work through to assess the health impact of their policies: screening, framing and preliminary assessment, in-depth analysis (where necessary), adjustments and decision-making, and assessment and follow-up. HIA is a mechanism that requires input from non-health government sectors, and when undertaken early on in the policy process, permits constructive adjustments before the policy is adopted and/or implemented.

A Legislation Committee has been established within the MHSS to guide the HIA process. The Committee evaluates policies being developed in other ministries; and, in consultation with other ministries, helps to develop methods to protect the population from adverse effects of a policy or build on opportunities to promote improved health. Each government ministry has a designated person who serves as a link between that ministry and the MHSS, and who works closely with the Legislation Committee to foresee and evaluate the health impact of their respective ministry's work.

2. The second strategy to meet the requirements of Article 54 is support for research which includes funding for the development of tools to examine *a priori* and *a posteriori* effects of public policy on health, as well as support for knowledge transfer and the development of documents to inform government ministries and agencies about the possible health impacts of laws and regulations being developed. This component comes under the auspices of the MHSS and two major university granting agencies, the FQRSC and FRSQ.

Our case respondent identified the central role of the MHSS and its Minister in the development of the Public Health Act: *“Health has been a key driver of this initiative since the very beginning... and the role of the Minister was of key importance.”* While health assumed a leadership role, its mandate is very much dependent upon mutual cooperation from all government sectors and civil society: *“It was very important to put Health in the legislation and confer legitimacy for Public Health to be the initiator, but not the only one responsible... This is something that the whole government and the whole society is responsible for.”*

When asked about additional or preferred roles for the health sector, our case respondent indicated an expanded role for the health sector within various settings or “environments” where opportunity exists for health improvement. This requires building stronger linkages with, for example, schools and the workplaces: *“We know that one of the very effective ways to work is through different environments.... If I had it to do differently, I think I would put a stronger focus working with those environments in an intersectoral fashion.”*

The third major aspect of Quebec’s public health policy, the ten-year Public Health Program, was developed in 2003 to ensure similar services in all regions of the province. The Public Health Program is funded by the MHSS and monies are directed to the regions and local units for service delivery. The Program consists of a set of services and interventions aimed at reducing health inequalities through strengthening individual potential, supporting community development, and working across sectors for improved health.

The Public Health Program facilitates collaborative work at both the regional and local levels. Our case respondent shared an example at the regional level where the representatives from public health work closely with municipalities on two issues: environmental protection and citizen safety related to, *“protection and support for cyclists and pedestrians.”* On the local front, the Healthy Cities initiative provides a good example of intersectoral activity: *the Healthy City projects are very active in intersectoral action.”* This program brings people together from various sectors on a regular basis to plan for improved health and well-being among city-dwellers. Most of the work at the regional and local levels extends beyond government representation to include community groups and non-government agencies.

Individual groups or projects at the regional and local levels are accountable to their own administrative structures, and are required to report back on established indicators and targets on a regular basis. Our case respondent sees a need for ongoing process evaluation *“so that people know where we are at,”* and effectiveness of public health

programs and interventions can be assessed. At the “higher levels” such as the Public Health Institute, accountability requirements focus on financial responsibility versus intersectoral activity: *“At the Institute we are accountable to the National Assembly... but that is done mostly on a financial basis... intersectoral activities are not really questioned... so there is no real process of accountability of that nature.”*

Taken together, these three integrated and comprehensive policy instruments – the Public Health Institute, the Public Health Act and the Public Health Program – serve as the infrastructure for Quebec’s healthy public policy at the provincial, regional and local levels. They also represent a set of tools to address the social determinants of health at the managerial (Public Health Institute), legislative (Public Health Act), and programmatic levels (Public Health Program).

Impact

When asked to respond to questions about the impact of Quebec’s public health policy, our case respondent provided examples of progress related to intersectoral activity, but warned that there is still much work to be done: *“We are still struggling with silos.... Some sectors are still reluctant to work together, so this is a work in progress.”* Intersectoral activity in Quebec’s public policy process has led to an increased level of information sharing between sectors, and a greater understanding among all departments that health is influenced by a complex set of inter-related factors and conditions: *“It is easier to work with other sectors now because knowledge transfer is more effective between sectors... and people better understand that decisions in one sector impacts others, and health is part of that.”* Increasingly, ministries are consulting with the INSPQ, prior to designing and/or implementing policies. For example, the Institute provided research evidence to the ministerial committee looking at the use of cellular phones while driving.

Several lessons can be drawn from the Quebec experience. One relates to how the health sector approaches intersectoral work, and the need to frame issues in a way that relates to other sectors. Our case respondent noted that, *“As long as we were talking to them only about health issues and not issues that related to them... we were not able to find a common ground.”* Without establishing a shared path to move forward together, the health sector stands at risk of being seen as *“imposing its own agenda,”* and reinforcing the view among some government departments that, *“health is an imperialist system... dominant one over the others.”*

Another insight gained from the Quebec experience is that intersectoral initiatives need to focus their attention away from money (and how it is allocated) to how funds can be used most effectively to achieve higher aims. Our case respondent reflected upon the Quebec experience this way: *“We have struggled with intersectoral action because a major focus has become how much of the pie each partner will get.”* Finally, an understanding that intersectoral activity needs to be supported at every level, *“including government, regions and municipalities,”* surfaced as a lesson from the Quebec experience.

Reflection

Looking back, our case respondent believes that intersectoral action in public health is not so much, *“about a legislation, or a program, but is, I would say, a day-to-day process that you have to follow.”* It is a way of doing business. The process of learning from and sharing information with all government sectors was identified as the most interesting aspect of Quebec’s public health policy process. Looking ahead, our case respondent identified greater cooperation between the federal government and the provinces *“on intersectoral work for health”* as a worthwhile endeavor. This should extend beyond traditional aspects of public health to include, for example, intersectoral action to address the increasing burden of chronic disease at the population level.

Case Study 7: Saskatchewan Human Services Integration Forum

Provincial initiative

Saskatchewan Learning as leader

Health sector as partner

Socially and economically vulnerable citizens as focus

Context

Since the early 1990s, Saskatchewan has been taking steps to improve the lives of children, families and communities through efforts aimed at integrating human services. Much of the ground work of today’s Human Services Integration Forum was initiated by its predecessor, the Associate and Assistant Deputy Ministers’ (ADMs’) Forum on Human Services. The ADMs’ Forum was established in 1994 in response to the need for more senior government coordination of a number of initiatives and the growing demand for holistic and integrated human services for Saskatchewan’s population. The ADMs’ Forum was renamed the Human Services Integration Forum (HSIF) in 1999.

Since its inception, the HSIF has been working to provide innovative, responsive and effective services that address the needs of the most vulnerable people in the province; build on the strengths of individuals, families and communities; and increase capacity to contribute to the social and economic health of Saskatchewan’s citizens. Specifically, the HSIF seeks to: (a) establish and maintain mechanisms to promote and facilitate interagency collaboration and integrated planning and service delivery, (b) identify and address barriers to integrated service, (c) provide funding and policy support for integrated services, (d) provide education supports to human service providers, and (e) make the most efficient and effective use of resources.

Human services supported by the HSIF to meet these objectives are varied and span government and non-government sectors. They range from preparing children for school, to youth transition to the labour force, to building safe, secure and supportive communities. All services align with a set of principles that embrace shared responsibility and mutual respect, a holistic and client-focused approach, community participation, cultural affirmation, and a focus on early intervention and prevention. Accountability and

affordability are two additional principles that ground the work of the HSIF as it seeks to better the lives of people in this province.

By the end of the 1990's, Saskatchewan had made significant accomplishments in human services, and the HSIF believed that they had an opportunity to shape future directions into the next decade. Several factors motivated a movement away from traditional models of service delivery to integrated, intersectoral approaches. Like other provinces at the time, Saskatchewan was facing with the need to re-examine its use of existing resources to ensure they were being used in the most efficient and effective means possible. Demographic trends indicated that those groups of people who drew most on human services were increasing in numbers, and that this would translate into a greater demand for services. Moreover, the human service sectors were facing changing expectations from their population who increasingly expected people and communities to be involved in the planning, delivery and evaluation of programs and services that affected them. The HSIF embraced an intersectoral approach to address these issues and move human services planning and delivery into the future.

While long-standing and shared values among the human service sectors supported collaborative work, challenges to intersectoral approaches also existed. First, each human service had its own mandate which translated into different approaches and models of care. This was compounded by differing service delivery boundaries. In the late 1990s, Saskatchewan was divided into 6 social service regions, 7 education regions, 30 health districts and 119 school divisions. Furthermore, separate and siloed information systems for each human service made working across the system and sharing information very difficult.

These system-level challenges were compounded by narrower issues on the ground. *"Time and patience"* were identified by one of the case respondents as a disincentive to intersectoral action to improve human services in the province when she stated the following: *"Time can be the 'maker' or 'breaker' of initiatives..... When you are working in an intersectoral way, it requires consensus and developing and taking a broader perspective and coming to some agreement about direction, which really takes time."* A lack of visible, *"top to bottom"* commitment from participating organizations and limited senior-level commitment to collaborative work within departments further challenged intersectoral activity within the human service sectors in the province.

To address these challenges, the HSIF adopted a set of key strategies that would pave the way for intersectoral action.

- *Work collaboratively* – The HSIF recognized the need to work collaboratively with both traditional agencies as well as groups that were not traditionally involved in, for example, building community networks, setting common goals, joint planning, and shared responsibility for decisions, resources and outcomes.
- *Integrate services* – HSIF shifted its focus from the mandates of a particular agencies or organizations to the needs of people. This required joint planning and coordination to design and deliver a continuum of "seamless" services for clients and communities.

- *Share information* – While human services providers acknowledged the need to respect privacy and confidentiality in dealing with personal client information, the HSIF raised the need for information sharing if services were to be effectively integrated.
- *Integrate case management* – Especially for complex cases, the HSIF supported service delivery through teams with representation from all service agencies, working in partnership with clients and families.
- *Work with communities* – HSIF adopted a community development approach to service delivery to build on existing strengths and resources within communities and generate local solutions to local needs.
- *Evaluate projects and focus on outcomes* – In recognition that evaluation is an important component in resource management and services, the HSIF supported measurable outcomes to determine service effectiveness.

Taken together, the strategies above set the stage for intersectoral action by the HSIF. Additionally, intersectoral action was facilitated by a history of multi-sector collaboration within other provincial initiatives,⁷ especially, *Saskatchewan's Action Plan for Children*, a precursor to the HSIF. In the view of one case respondent, the topic for collaboration – children – was a “comfortable” area of shared interest across stakeholders: “*Children represented a non-threatening place for people to come together... they were prepared to put aside hats and any perceptions that might be called ‘stove piping’ because this was an area that they had a strong shared interest.*” This sentiment carried over to the work of the HSIF which had a broader mandate to address the social and economic needs of the population at large.

Approach

Four levels comprise the HSIF’s administrative structure. The initiative is overseen by the recently established Human Services Deputy Ministers Group, which overlays the HSIF. Both these groups have representation from each of the seven participating departments: Learning, First Nations and Métis Relations, Community Resources, Corrections and Public Safety, Culture and Recreation, Health and Justice. These groups provide overall support to the Regional Intersectoral Committees (RICs, described below), work to remove barriers to interagency cooperation and collaboration, and provide ongoing funding for the RIC coordinator positions as well as costs for central coordination.

Currently, there are nine RICs located throughout the province. While the Human Services Deputy Ministers Group and the HSIF aligns departments at the provincial level, the RICs provide a mechanism for intersectoral activity at the regional level. In the

⁷ Other provincial intersectoral initiatives underway at the time included: *Integrated School-Linked Services*, *Health Renewal*, *Family Violence Strategy*, *Housing Initiatives*, *Aboriginal Policy Framework*, *Sport and Recreation Strategy*, and *Justice 2001*.

view of the case respondents, RICS play a very significant role at the regional level and provide a much needed “*regional presence and an opportunity for people to work together in human services through regional planning processes.*”

The RIC coordinators are responsible for overall service provision and coordination and strategies to build community capacity. The RICs comprise representation from provincial and federal government departments as well as non-government agencies, including: health districts, school divisions, regional colleges, housing authorities, police, and tribal councils and Métis organizations. A number of roundtables and subcommittees complement the RICS at the local level. Their current activities include:

- Supporting community-based planning systems for human services.
- Establishing data collection/information sharing strategies, including the development of community profiles in some regions.
- Encouraging the formation of interagency groups (i.e., action teams) to address issues affecting vulnerable children, youths and families; in particular, Early Childhood and Youth at Risk.
- Supporting existing community interagency groups with planning advice, project funding and communication support.
- Conducting reviews of various grant programs such as the Community Initiatives Fund, Prevention and Support Grants (RIC’s make recommendations on whether or not to fund and amount of funding to a central committee), Students Employment Experience Funds (RIC’s review and make final decisions), and the Federal Crime Prevention Fund (RIC’s provide input and information for the adjudication to consultants who make recommendations to a Federal review panel).
- Providing support for the implementation of an integrated case management approach for complex needs cases.
- Facilitating community involvement in consultation processes related to, for example, Early Childhood, National Children’s Agenda and Role of Schools.

As is the case with all key cross-government strategies in Saskatchewan, the HSIF has developed an accountability statement that delineates the roles and responsibilities of all departments involved. Under the HSIF model, each participating ADM is accountable to his or her Deputy Minister, but shares responsibility to move the initiative forward.

Shared accountability is exemplified in the “Ministers’ Commitment,” which introduces one of the HSIF’s early policy documents, entitled, *Working Together* (1996). The Ministers’ Statement asserts: “*As Ministers responsible for human services in Saskatchewan, we believe that our Departments and Secretariats must work together collaboratively to support the new service integration approaches for the benefit of Saskatchewan People....By working together, we can achieve better outcomes for*

Saskatchewan people and communities.” The Ministers’ Commitment is signed by the seven participating departments.

With respect to roles, four of the departments identified above contribute to funding the work of the HSIF. The Ministry of Health shares costs with the other departments to support positions associated with the HSIF (Executive Director) and RIC structures (Coordinators). RIC tables are generally co-chaired by more than one sector. The sectors represented by the co-chairs will change over time. Health Authority representatives currently co-chair some of the RICs in conjunction with representatives of other sectors. The HSIF is co-chaired by two departments, to date, Health has not held the role of Chair at the DM or ADM levels. The health authorities are very involved at the regional and local levels, especially with respect to the provision of health-related services. Each sector is equal at the HSIF and RIC tables and all government departments and non-government partners have been involved in the planning cycle from the beginning.

Besides its committee structure, the HSIF has applied various mechanisms to support the intersectoral nature of the program. Most notably is the development of a number of handbooks to increase understanding and skills related to intersectoral/interagency activity. These handbooks were developed in the late 1990s and align with the key strategies to facilitate intersectoral action discussed above. Each handbook provides detailed information to support interagency collaboration on human services. They are entitled as follows: (i) *Interagency Projects: An Evaluation Guide* (1997), (ii) *Sharing Information to Improve Services for Children, Youth and Families* (1997), (iii) *Integrated Case Management* (1998), and (iv) *Working with Communities* (2000).

Other information-based mechanisms have been used to advance intersectoral action within the HSIF. The initiative invites speakers from other jurisdictions to share their experiences and insights related to human services. For example, a visit from officials from the state of Hawaii’s *Healthy Start Program* helped shape the intersectoral perspective of the Province’s Early Childhood program. Additionally, to extend the practices and principles initiated in the *Integrated Case Management Handbook*, the HSIF sponsored the development of an *Integrative Wraparound Information and Training* package to meet the educational needs of human services personnel related to clients with complex needs. Coordinated through the RICS, this program trained 60 individuals from the RICS who then trained several hundred human service providers from both government and community agencies province-wide.

Further illustration of using information as a tool for intersectoral activity, the HSIF worked through its RIC coordinators to develop a number of practice protocols for service providers. The protocols detailed best care practices on how to optimally respond to complex cases from a multisectoral and interdisciplinary perspective.

These efforts moved the HSIF closer toward its aim to build community capacity for human service delivery across the province; they also changed the way services were designed and delivered in the province. One case respondent acknowledged the role of the HSIF in transitioning human services planning and delivery from traditional to integrated approaches when she stated the following: *“The work of the Forum became*

the foundation for how we planned strategies to improve the lives of men, women and children in our province..... It became the foundation for how we worked together.”

Impact

Interagency Projects: An Evaluation Guide, one part of the Human Services Handbook Series, was developed in 1997 to encourage evaluation of HSIF programs and activities. This document provides a step-by-step guide to program evaluation and was written for those working in the health, social services, education, justice recreation and housing areas. The publication provides a rationale for evaluation, offers methods and processes to plan for and conduct an evaluation, and provides strategies to analyze data and report on findings. Additionally, the guide describes the two core aspects of evaluation: implementation evaluation which focuses on activities related to the operation of the program, and outcome evaluation which centers on what the program has accomplished, that is, the results achieved.

While some anecdotal evidence exists about the impact of the HSIF, it appears that limited systematic evaluation has occurred. Those involved in different aspects of the Initiative believe that progress had been made toward the program's objectives, but that achievement of objectives has been illusive in the face of shifting environments: *“Our objectives have changed as the environment has changed... I don't know that you can ever say that you have ever truly achieved them.... I think you are constantly working towards them.”* To date, examples of perceived program impacts related to the intersectoral nature of the HSIF point to the establishment of collaborative networks and new mechanisms to facilitate agency cooperation.

One of the challenges to evaluation and outcome measurement has been, in the view of the case respondents, the difficulty of isolating what was achieved by whom. With respect to the impact that the health sector has had on HSIF initiatives, one case respondent made the following comment: *“There are a number of outcomes that the initiative has achieved, but we are working as a whole, so I don't think we can say some outcomes are solely due to Health; but, if you were to speak to Health directly, they would say that they have been able to achieve some outcomes as a result of the intersectoral work.”* Under the HSIF model, perceived accomplishments are viewed as a shared effort by all partners involved.

Looking back, several lessons can be drawn from the HSIF experience regarding intersectoral work at the provincial, regional and local levels:

- Keep learning. Draw on the experiences of other provinces and other jurisdictions around the world to build effective intersectoral approaches to human services.
- Measure outcomes and document program progress from the start. Reflecting back, the case respondents acknowledged the need for systematic monitoring and evaluation: *“If we were able to start over today... the context for planning has really changed across the public sector to put a stronger focus on outcomes, so*

back in 1993 we should have paid more attention to outcomes and documenting what we achieved and learned.”

- Understand the contribution of individual mandates within the context of intersectoral work. An understanding of the mandates of all partners at the table facilitates the identification of service gaps and overlaps. This is a fundamental step in the planning and implementation of joint work. *“We have learned over the years that individual mandates remain important.”*

Reflection

When asked to respond to a query about what was the most interesting or innovative aspect of intersectoral activity within the HSIF, the case respondents identified two features. First, they referenced a *“cultural change in the way government works together.”* In their view, working collaboratively across sectors is the way business is conducted today in the province of Saskatchewan; and, that, *“the way things were done in the past - working within silos - is now inappropriate.”*

Secondly, the case respondents pointed to cost sharing as a unique feature of the HSIF. They provided the example of the RIC coordinators who are *“being paid by several departments,”* which in effect means that each participating department, *“holds a piece of the overall budget.”* To close, the case respondents commented on what could be done to improve or further support intersectoral work in the future. They identified the need for dedicated time for people to work in this fashion: *“You cannot do this off the side of your desk... you truly have to be able give intersectoral work the time that it needs.”*

Case Study 8: The Vancouver Agreement

Tripartite initiative

Federal and Provincial ministers responsible for the Vancouver Agreement and the Mayor of Vancouver as leads

Health as supporter

Economic, social and community development as focus

Context

The Vancouver Agreement is an innovative urban development initiative through which the governments of Canada, British Columbia and Vancouver collaborate and coordinate resources for projects and initiatives to make a healthy, safe and sustainable place to live and work for all residents. The Vancouver Agreement commits government partners to work together with communities and business in Vancouver on a coordinated strategy to promote and support sustainable economic, social and community development.

The first phase of the Vancouver Agreement was from 2000 to 2005. Initially, the Agreement did not have designated funding. The government partners collaborated to contribute and leverage funding for community-based projects that addressed area

challenges. As work continued through 2001-2002, a strategic plan was developed by the management of the Vancouver Agreement, and a small secretariat was established to coordinate the increasing number of community projects. In 2003, in order to implement the strategic plan, the federal and provincial ministers responsible for the Agreement announced that they would each contribute \$10 million to the Vancouver Agreement and the Mayor of Vancouver announced the contribution of the City's Downtown Eastside (DTES) Capital Fund, staff and administrative support. The Vancouver Agreement was renewed for a second five-year term extending to March 31, 2010, however no additional funds were attached to the Agreement.

The initial focus of the Agreement is to support positive solutions to the economic, social and public safety challenges through innovative community development projects in the city's Downtown Eastside.⁸ Vancouver's Downtown Eastside was once a vibrant commercial and entertainment district in the heart of the city. By the late 1990's however, urban decay, including drug dealing on the area's main streets, crime, street prostitution, and homelessness prevailed on the streets of what was now known as Canada's poorest neighborhood.

During the early stages of the Agreement, community consultation determined the priorities of area residents, businesses and community organizations. This resulted in the Vancouver Agreement partners – the federal, provincial and municipal governments – identifying three overarching goals to support the transformation of the community to a safe and healthy place. Agreement partners also identified several strategies and a mix of programs and services to achieve those goals. An overview of the Agreement's approach is provided in Table 1.

Table 1: Vancouver Agreement

Goals	Strategies	Program/Services
<ul style="list-style-type: none"> ○ To increase economic development in the Downtown Eastside ○ To improve the health of area residents ○ To increase public safety 	<ul style="list-style-type: none"> ○ Economic development and job creation ○ Dismantle the area's open-drug-scene ○ Turn problem hotels into safe, clean places to live ○ Make the community safer for the most vulnerable, particularly women, youth and children 	<ul style="list-style-type: none"> ○ Training and employment programs ○ Drug & alcohol addiction programs with a focus on harm reduction and law enforcement ○ Housing programs with a focus on improving single-room occupancy hotels ○ Services for women engaged in street prostitution, mothers with addictions ○ Services for youth including those who are sexually exploited, estranged, living on the street, have addictions, mental illness ○ Services for aboriginal people including increasing training and employment choices ○ Making good food available

Note: This case study focuses on the first phase of the Vancouver Agreement, 2000-2005. For an overview of goals, strategies, outcomes and priorities for the second phase of the Agreement (to March, 2010), please see Appendix D.

⁸ Vancouver's Downtown Eastside includes the neighborhoods of Chinatown, Gastown, Strathcona, and Victory Square.

Right from the start, the Vancouver Agreement was grounded in intersectoral action,⁹ involving all levels of government and their respective departments, as well the private sector, non-governmental agencies and community residents.

A number of factors facilitated an intersectoral approach to improving conditions on Vancouver's Downtown Eastside. First, for many years, governments and community organizations sought solutions to the myriad of health, public safety, social and economic problems that burdened the Downtown Eastside. Significant effort and funding from a variety of sources had been committed to the area; but services were uncoordinated, and there was a growing sense of limited returns. Our case respondent described it this way: *"Initially the Agreement was designed to address the duplication of services and identify gaps in funding... It was anecdotally stated that there was \$1 million of public programming going into the Downtown Eastside for programs and services every day, with no appreciable change of life for the people living there."* The Vancouver Agreement was formed because governments recognized that by coordinating efforts and working more closely together, and with community and business groups, they could achieve long-term sustainable solutions.

Additionally, an intersectoral service model was required to address the complexity of the human condition for the estimated 20,000 people living in the area. Crime, drug use, prostitution and homelessness were on the rise. Hepatitis, HIV/AIDS and other sexually transmitted diseases had reached epidemic proportions, which led to the declaration of a public health crisis in 1997. Each level of government has some jurisdiction over these issues. It became apparent that government and non-government sectors had to come together to generate shared solutions. In the words of our case respondent: *"It was pretty clear that... the problems were problems that no single level of government could deal with on its own."* Under the Vancouver Agreement, parties recognized the need to overcome barriers and work collaboratively for improved community conditions.

Finally, intersectoral action was facilitated by a high level of trust among the leadership of the Vancouver Agreement. The original members of the Management Committee, from federal, provincial and municipal governments, had a long history of working together, and in some cases, were personal acquaintances for over two decades. Moreover, each member of the leadership team had a deep personal commitment to working collaboratively on priority issues, and each expected the same from others. Our case respondent spoke about the shared dedication for collaborative work and its driving force in the Agreement: *"All the team was intersectoral and intergovernmental...once a community need or priority was identified, coming up within the best solution became everyone's business.... this was not only expected, it was the culture of the Agreement."*

Even though support for intersectoral action in the Vancouver Agreement was high, challenges emerged. The tripartite model of governance that underpinned the Vancouver Agreement was unprecedented. There were no solid examples to draw from, and no road maps to follow. Our case respondent recalled that processes and

⁹ Within the context of this case study, reference to intersectoral action includes working across levels of government (intergovernmental).

structures were designed as the initiative moved forward; as such, Vancouver Agreement leaders felt that they “*were swimming upstream the whole time.*” Departmental mandates and budgets served as additional barriers. Each department came to the table with its own mandate, rules and regulations, as well as terms and conditions for spending money. Over time, this challenge was partially addressed through some shared funding arrangements, however a shared funding model was never fully implemented (see below).

Finally, the intersectoral nature of the Vancouver Agreement faced several changes in government – seven changes across federal, provincial and municipal governments over the first four years. According to our case respondent, this interrupted the momentum of the initiative, and required ongoing communication with political leaders: “*Every time there was a change of government it was like we had ...to take six steps back because we had to start all over again, and rebrief new Ministers and rebrief new Deputies and central agencies.... It was a very big challenge.*”

Approach

To meet its goal to promote and support sustainable economic, social and community development, the Vancouver Agreement established a governance structure that consists of the following:

Policy Committee – The federal and provincial governments each appoint a Minister responsible for the Vancouver agreement and the Mayor of Vancouver represents the municipal government. This committee has ultimate responsibility for the Vancouver Agreement, including decision making and accountability.

Management Committee – Each government partner is represented by an executive-level staff member from the lead agencies. This includes the Western Economic Diversification Canada for the federal government, the BC Ministry of Community Services from the provincial government, and the City Manager’s Office for the municipal government. The committee is responsible for intergovernmental relationships, external communication, monitoring and evaluation, investment decisions, and oversight of operational activities.

Coordination Team – This is the primary operational committee responsible for implementing the Agreement’s strategic plan. The team meets bi-weekly, and also conducts regular meetings with task teams who work on specific priorities (e.g., employment, housing, drug addiction, and youth initiatives). Task teams include representatives from each level of government, and community and business groups. Task teams work closely with the Coordination Team to maximize opportunities and address challenges.

Coordination Unit – A small secretariat comprised of an Executive Coordinator and staff dedicated to administration, communications, and program implementation. The Coordination Unit oversees the day-to-day work of the Vancouver Agreement.

The organizational structure of the Vancouver Agreement changed over time. After a review of the Agreement in 2004, a decision was taken to reduce the number of task groups and committees. Even though the Agreement's committee structure served as a mechanism to bring parties together, it added to its complexity. This challenged daily operations as well as the ability to monitor progress. Some people were feeling that the Agreement was becoming *"too bureaucratic"* and drifting away from its community-based roots. So, as stated by our case respondent, *"we focused the organization down, reduced the number of committees, reduced the levels of bureaucracy, and drove things back to the community."*

The Vancouver Agreement's shared governance model is reflected in its funding mechanism. As noted earlier, the Agreement originated without designated funding. It was expected to *"dovetail"* existing federal programs from different departments with provincial and municipal services so that the needs of the community could be met. Later, the initiative received designated funding when the federal and provincial governments contributed \$10 million each; augmented by municipal funds from the City of Vancouver's Downtown Eastside Capital Fund.

Vancouver Agreement funds are used to establish or support programs that address its goals to increase economic development, improve health, and increase public safety in the Downtown Eastside. Typically, Agreement funds complement other available funding sources. Once funding priorities are identified through community consultations, the Agreement's task teams look for potential funding from existing government programs, and community and private agencies and foundations. When such funding is limited or not available, the Vancouver Agreement may bridge the funding gap or support the project in full.

To account for funds, reporting on performance measure occurs at two levels. According to our case respondent, because the budget originates from many departments, *"we were able to report performance measures not only in a linear way back to individual departments, but we had horizontal frameworks and reporting mechanisms as well."* Other financial accountability mechanisms include a review of the Agreement by both the federal and provincial Auditor General, as well as a requirement on behalf on the Agreement's committees to submit their financial reports, with signed-off financial statements, to the Management Committee on a regular basis.

In keeping with one of the original Vancouver Agreement priorities to identify gaps in and duplication of government services, the Agreement acts to add value to the individual and collaborative activities of the three governments through planning, implementation, investment, monitoring and evaluation. This requires the participation of various government departments whose mandates align with the community priorities being addressed.

Human Resources and Social Development Canada, for example, joins the table for issues related to homelessness, as does the Status of Women Canada when the focus shifts to women's issues. Justice Canada plays a lead role with respect to crime and illegal drugs, and Heritage Canada oversees issues regarding culture and

the arts. Western Economic Diversification Canada leads when small business and economic development are under discussion. It also plays a role with respect to coordinating the contribution from the various federal departments involved in the Agreement. Besides financial contributions discussed above, federal and provincial ministries and departments provide staffing (sometimes, seconded), access to existing programs and related best practices, as well various types of in-kind contributions.

The health sector is an important player in the Vancouver Agreement. Federally, Health Canada is part of a Federal Caucus, along with Western Economic Diversification Canada, Indian and Northern Affairs Canada and Justice Canada. At the local level, the health sector represents the front line, involved in all aspects of program/service planning, developing and implementation.

When asked to comment on the role of the health sector, our case respondent described it as “critical,” given that many people living on the Downtown Eastside are, *“for the most part, multiply challenged,”* with a variety of physical and mental health issues. She acknowledged too the leadership role of the Vancouver Coastal Health Authority in opening several life skills counseling centres, and managing the supervised intravenous drug injection site and the heroin maintenance program. Our case respondent pointed to increased capacity at the regional level when queried about what additional or preferred role she would have the health sector play: *“If I had it to do over again, and I was the Deputy Minister of Health Canada, I would make sure that my regional people had a lot more tools at their disposal and a lot more decision-making ability.”* This reflects the perspective that community improvement is best placed in the hands of local people.

Vancouver Agreement partnerships extend to the non-profit sector. Non-governmental organizations are considered a window to the needs of the community. They typically engage with the Agreement’s task teams to identify key issues and generate integrated solutions to the areas they represent (e.g. homelessness, drug use prevention).

Finally, the private sector has forged partnerships with the Vancouver Agreement. Companies such as Bell Canada, Rona, and the Royal Bank of Canada have made significant financial contributions. Financial support has also come from local business. Interestingly, private sector donations are linked to the upcoming Vancouver 2010 Olympic and Paralympic Winter Games. Even though the Vancouver Agreement was signed before Vancouver won the bid for the Olympics, corporate sponsors are asked to choose from a ‘menu of options’ to indicate how they will contribute to improvements on the Downtown Eastside. This is part of the Olympic Games’ Community Benefits Agreements which is signed by all corporate entities seeking sponsorship. Close collaboration between representatives of the Downtown Eastside, the Vancouver 2010 Bid Corporation and the Vancouver Organizing Committee for the 2010 Olympic and Paralympic Winter Games has made this arrangement possible.

Impact

When asked to respond to questions about the impact of the Vancouver Agreement, our case respondent reflected that the Agreement represents an ambitious and long-term vision. She noted that while much remains to be done, progress is being made: *“I don’t think we will ever achieve everything... but I think that we have made a lot of progress.”* Additionally, our case respondent shared lessons learned about intersectoral action, and emphasized the need for time and effort: *“It is really hard work... and takes a tremendous amount of time.”* She commented too on the role of “process” and its link to relationship-building in intersectoral work: *“The process is absolutely critical because without it, the relationships don’t get built and the levels of trust don’t get built.”* Trust, in her view, is a key facilitating factor for intersectoral collaboration.

In a recently published document entitled, *The Vancouver Agreement: The First Five Years*, the three government partners to the Agreement highlighted areas where progress had been made and identified several positive trends. Table 2 below provides a summary of the Agreement’s accomplishments with respect to each of its four core objectives.

Table 2: Vancouver Agreement Impact by Agreement Objective

Objective	Progress / Impact
Improved health & quality of life	<ul style="list-style-type: none"> ○ Death rates due to alcohol and drug use, alcohol and drug overdoses, HIV/AIDS, and suicides have been declining since 2000 ○ Better access to primary health care has been facilitated with the opening of four new health clinics since 2003 ○ Improved coordination of addiction services is being achieved through, for example, a central telephone referral services for adult addiction treatment
Economic & employment development	<ul style="list-style-type: none"> ○ Between 2000 and 2005, 53 development projects were completed (housing, health-related, mixed use) ○ An employment strategy has been developed to improve job and training possibilities, especially for those who are unemployed and underemployed ○ Employment income increased by 3% for men and 12.7% for women between 2000 and 2003
Safe & secure housing	<ul style="list-style-type: none"> ○ Increased quantity and quality of social housing between 2000 and 2005 ○ Increased number of beds or living units (by 259) in Special Needs Residential Facilities ○ Completion of the first pilot project of the Single Room Occupancy Housing Program
Community safety & security	<ul style="list-style-type: none"> ○ Decreased property crime by 14% between 2000 and 2005 ○ Development of a number of public-realm and streetscape improvements ○ Expanded and improved partnerships between the Vancouver Police Department, other government agencies, and community and business partners

In recent years, the Vancouver Agreement has received a number of recognitions and awards. In June 2005, the Vancouver Agreement was one of eight recipients worldwide of a United Nations Public Service Award for improving transparency, accountability and responsiveness in the public service. Also in 2005, the Vancouver Agreement Management Committee was presented the Partnership Award by the Association of Professional Executives of the Public Service of Canada for best practice in achieving unique and inspired partnerships and for being a model for other cities in Canada and around the world. Innovation and creativity in governance led the Institute for Public Administration of Canada to award its highest annual prize for innovative management to the Vancouver Agreement in 2004.

Reflection

When asked to reflect upon the Vancouver Agreement, our case respondent shared what she believed contributed most to the intersectoral nature of the initiative. She pointed to the complex nature of the problem being addressed, and the need to adopt a comprehensive approach to solution finding: *The fact that we were dealing with social issues, health issues, issues of justice.... We took a very holistic approach in trying to build a sustainable community.* When queried about the most unique or innovative feature of the Vancouver Agreement, our case respondent referred to the role of the community, and offered this insight: *“Don’t be driven by inside government. Don’t be driven by what already is....be driven by the outside in, be driven by community needs.”* Looking ahead, our case respondent identified increased financial and human resources, as well as *“a greater appreciation for the use of intersectoral activity as a tool for meeting community-based challenge”* as ways to improve and support intersectoral activity in the future.

6.0 Analysis and Learnings

This section moves away from individual cases to examine and summarize what has been learned about intersectoral action to address the social determinants of health across the cases studied in this paper. The Overview of Learnings presented in Section 3.0 and the Typology of Canadian Experiences (Section 4.0) provide the context for the findings presented here. Four federal initiatives were reviewed in the previous pages: the Family Violence Initiative (FVI), the National Homelessness Initiative’s Supporting Communities Partnership Initiative (SCPI), Aboriginal Self-Government Agreements (ASG) and Gender-Based Analysis (GBA). The federal initiatives were complemented by three provincial initiatives: Healthy Child Manitoba (HCM), Quebec Public Health Law (PHL), and Saskatchewan Human Service Integration Forum (HSIF). The Vancouver Agreement (VA), a federal-provincial-municipal initiative, rounds off the eight cases examined here. An analysis of learnings is provided below, organized by the context for, approach to, impact of, and reflections related to intersectoral action.

6.1 Context

Learnings related to context include the issue or problem being addressed and related aims or goals, conditions and factors that motivate or facilitate an intersectoral approach, and conditions and factors that challenge intersectoral activity.

6.1.1 Issues and Aims

The issues addressed by the cases in this paper touch upon several problems and issues, including: family violence, homelessness, self-government, child and youth well-being, healthy public policy/health impact assessment, gender equality, and supporting socially and economically vulnerable populations. All the cases in this paper identify explicit objectives aimed at improving the life and circumstances of certain population groups. Some cases are very broad in scope; others more narrow. Take, for example, Quebec's Public Health Law which seeks to establish conditions favourable to the "maintenance and enhancement of the health and well-being of the general population;" as compared to the Vancouver Agreement, which focuses more narrowly on building a healthy and safe place for people who live within a geographically-defined area (Vancouver's Downtown Eastside).

While variation exists across cases regarding the type of issues addressed and target populations, similarity prevails with respect to an emphasis on intersectoral action. All eight cases make reference to intersectoral activity as part of their overall vision, principles, goals, or objectives, as evidenced below.

- One of the overarching goals of the Family Violence Initiative is to "achieve a more effective and efficient interdepartmental, coordinated response to family violence."
- The SCPI initiative sought to "establish a more integrated and inclusive approach to the homelessness issue."
- With respect to the Aboriginal Self-Government case, intersectoral action underpins its overall goal to "ensure that Aboriginal peoples have greater control over their lives and to achieve this through negotiated settlements."
- Healthy Child Manitoba identifies a "cross-departmental prevention strategy" as means to achieve the best possible outcomes for Manitoba's children.
- As part of the legislation, Quebec's Public Health Act, requires all sectors to work with the health sector to identify the health impacts of proposed policies and regulations.
- "To establish and maintain mechanisms to promote and facilitate interagency collaboration and integrated planning and services delivery" is one of the four goals that guide the HSIF case.
- Similarly, the GBA case includes "the implementation of gender-based analysis throughout all federal departments and agencies," as one of its eight objectives.
- Finally, the Vancouver Agreement "commits government partners to work together with communities and business in Vancouver" as a way to promote sustainable economic, social and community development.

6.1.2 Motivating & Facilitating Factors

Looking across cases, factors that support or facilitate intersectoral collaboration can be grouped into six categories: the nature and complexity of the issue, precedence and history related to intersectoral action, political will and consequences, central agency support or requirement, expectations for improved service efficiency and effectiveness,

and an established information and knowledge base. Examples and evidence from the eight cases related to each of these factors is summarized in Table 3 below. Examples are illustrative and not exhaustive

Table 3: Facilitating factors for intersectoral action

Facilitating factor	Evidence and examples from cases
Nature & complexity of the issue	<ul style="list-style-type: none"> - Issues such as family violence (FVI), gender inequality (GBA), urban degradation (VA), and self-government (ASG) are multifaceted and complex - They require a multidisciplinary solution that draws on the mandates of many sectors (e.g. health, housing, social services, justice)
Precedence & history	<p>Landmark or historical initiatives, movements or documents can set the stage for ISA:</p> <ul style="list-style-type: none"> - The GBA case was influenced by the Fourth United Nations World Conference on Women (Beijing Platform, 1995) which committed governments throughout the world to the effective integration of a gender perspective into operations, policies and decision-making - The Aboriginal Self-Government case was influenced by other initiatives such as the Royal Commission on Aboriginal Peoples (1996) that charted a new course for Aboriginal peoples in Canada and required cooperation among federal and provincial governments and Aboriginal people <p>A history of working together and established personal relationships support ISA:</p> <ul style="list-style-type: none"> - The province of Saskatchewan has a history of multi-sectoral collaboration on a number of provincial initiatives which paved the way for ISA in the HSIF case - Personal relationships and a long history of working together amongst leaders (federal, provincial and municipal) facilitated ISA across three levels of government in the VA case
Political will & consequences	<ul style="list-style-type: none"> - The SCPI case credited the central role of the Minister of State responsible for the initiative and her commitment to engage all partners as a key facilitator for adopting an intersectoral approach - The potential for dire economic and political consequences due to prevailing uncertainty over Aboriginal land claims and self-government motivated collaborative arrangements in the ASG case - In the HCM case, Manitoba's Premier, through a number of economic summits, identified early childhood development as a driver for improving the economy; this generated political will to examine new approaches to healthy child and youth development
Central agencies	<ul style="list-style-type: none"> - Policy documents on horizontal management from the Treasury Board Secretariat and the Report of the Auditor General of Canada (1995) further facilitated intersectoral action (FVI and SCPI) - The Treasury Board's Results-based Management and Accountability Framework reinforced the requirement for the cooperative efforts among government departments on various social issues (FVI)

System / service efficiency & effectiveness	<ul style="list-style-type: none"> - Pressure to ensure efficient and effective use of resources in human services facilitated a coordinated, intersectoral approach to service delivery in the HSIF case - Uncoordinated services in Vancouver's Downtown Eastside led to a growing sense of limited investment on return, and set the stage for coordinated solutions in the VA case
Information & knowledge base	<ul style="list-style-type: none"> - Intersectoral action was supported by emerging theory and research on "population health," which recognized the social, economic and environmental influences on health, and called for cross-sectoral and coordinated approaches to service design and delivery (HCM) - Similarly, "new public health" approaches emerged which moved beyond past a traditional focus of public health (e.g. risk factor reduction) to embrace a broader view of health (e.g. living conditions), further facilitating ISA on the social determinants of health (PHL)

6.1.3 Challenging Factors

Looking across cases, factors that challenge or serve as a barrier to intersectoral action on the determinants of health can be classified as follows: limited ISA models, resource issues, multiple mandates, lack of leadership, change in government and denial of the social issue. Examples and evidence from the eight cases related to each of these factors is summarized in Table 4 below.

Table 4: Challenging factors for intersectoral action

Challenging factor	Evidence and examples from cases
Limited models	<ul style="list-style-type: none"> - A lack of established models and mechanisms to guide work across departments and sectors; few road maps to draw on to inform intersectoral activity (VA, HCM)
Resources	<p><i>Related to time:</i></p> <ul style="list-style-type: none"> - A lack of adequate time to build partnerships to work intersectorally (HSIF, FVI) - Insufficient time to "shift the culture of government" from traditional (i.e., siloed) to collaborative (i.e., shared governance) arrangements (HCM) - Significant time requirement to pull stakeholders together to participate in what were often long planning cycles in the SCPI case - Fiscal timing was a further disincentive for ISA in the SCPI case, whereby funding is allocated to community-based projects on a fiscal year, but communities typically work on a calendar year <p><i>Related to people:</i></p> <ul style="list-style-type: none"> - Staff turnover in the FVI case challenged ISA - The need for ongoing education and reinforcement of IS approaches for new people entering the bureaucracy challenged collaborative work in HCM <p><i>Related to money:</i></p> <ul style="list-style-type: none"> - In the SCPI case, dedicated funding to support ISA action was anticipated in its second phase of funding, but was not provided by Cabinet

Challenging factor	Evidence and examples from cases
Mandates	<ul style="list-style-type: none"> - Departmental mandates and budgets served as a barrier in the early days of the VA (this was resolved later with a shared funding model) - ISA in Quebec's PHL was challenged by some sectors who saw health as overreaching its mandate and becoming "a dominant player" in the public sector
Leadership	<ul style="list-style-type: none"> - ISA was challenged in Saskatchewan's HSIF by a lack of visible "top to bottom" commitment from some participating organizations and limited senior-level commitment within some departments
Change in government	<ul style="list-style-type: none"> - Several rounds of federal, provincial and First Nation's elections challenged IS work in the ASG case - The VA was also challenged by political elections at the federal, provincial and municipal levels
Denial	<ul style="list-style-type: none"> - Some officials were not prepared to acknowledge that homelessness was an issue in their communities (SCPI) - Denial of continuing gender inequalities by some has challenged intersectoral gender-based analysis work in the GBA case

6.2 Approach

Learnings related to approach to intersectoral action on the social determinants of health include: organizational structure for ISA, the mechanisms and tools for ISA, accountability mechanisms, and the role of the health sector, other government sectors and non-government sectors in intersectoral action.

6.2.1 Organizational Structure

Overall, "committees" characterize the organizational or administrative structure of the cases reviewed in this paper. Typically, committees are "layered, with some form of governance committees on the "top" layer, followed by a mix of interdepartmental and/or operational committees on the lower layers. The number of committees varies across cases, as does the type of representation that serves on committees. Committees may be comprised of Ministers, Deputy Ministers, Assistant Deputy Ministers; and departmental representatives at the Director General, Executive Director and Director level. Provincial and community advisory committees and/or coalitions may include political interests as well as individuals and groups whose interests or needs align with the social issue being addressed. A summary of key features of the committee structure of the cases studied in this paper is offered below.

On the federal side, the Family Violence Initiative is headed by a Steering Committee comprised of departmental representatives at the Director General level. An Interdepartmental Working Group, which consists of representatives from each member department, is the main operational vehicle for the Initiative. It is supported by smaller working groups which focus on specific activities (e.g., Evaluation Working Group) or populations (e.g., Aboriginal Family Violence Working Group).

Regarding the Aboriginal Self-Government case, a central office coordinates the various sectors whose mandates align with the items to be negotiated as part of the self-

government negotiation process; complemented by Provincial and First nations committees whose composition similarly reflects the issues on the table. The federal government's Gender-Based Analysis program is headed by a GBA Directorate (within Status of Women Canada), and receives assistance from a GBA interdepartmental committee in the development and coordination of GBA activities. Additionally, "gender focal units," have been established in individual departments to coordinate their own activities in this area.

Two of the provincial cases reviewed in this paper have a multi-layered committee structure which is quite sophisticated. Healthy Child Manitoba is headed by a Committee of Cabinet which ensures interdepartmental cooperation and coordination of all children and family services. A committee of Deputy Ministers assists the Cabinet committee in carrying out its duties. Moving along the committee continuum, operational work is handled by a central office which works with Parent-Child Coalitions to plan and deliver programs at the community level. This "provincial to local" committee structure also characterizes Saskatchewan's HSIF case. It starts with a Deputy Ministers' Group which overlays an Assistant Deputy Ministers' Forum, followed by interdepartmental committees at the regional level (RICs) and a number of roundtables and subcommittees at the local level. RICs, roundtables and subcommittees include broad representation from non-government organizations.

As a tripartite initiative, the Vancouver Agreement pulls together representatives from each level of government on its Policy Committee which consists of the Ministers responsible for the VA at both the federal and provincial level, as well as the Mayor of the City of Vancouver. The VA's Management Committee consists of an executive-level staff member from each of the three lead agencies (Western Economic Diversification Canada, BC Ministry of Community Services, and the City Manager's Office). A Coordination Team reflects multidisciplinary interests and is the primary operational committee responsible for carrying out the VA's strategic plan, with support from a smaller Coordination Unit responsible for daily administration and communications.

6.2.2 Mechanisms and Tools

Four types of intersectoral action mechanisms surfaced from the information provided by our case respondents. Information tools are most frequently used. Others include financial mechanisms, accountability methods, and, as discussed above, committee structures.

Information tools include training materials, shared guidelines and protocols, information exchange and dissemination, and information required through legislation.

- Training materials and programs represent a principal mechanism for ISA in the GBA case. A GBA Training Package is used to train policy analysts how to apply GBA in their daily activities; and a Train the Trainer Program offers a series of workshops to build capacity for GBA at a regional level. The GBA case also uses an E-Bulletin to keep individuals informed about activities across government departments.

- In Aboriginal Self-Government, federal negotiators use information and guidelines provided by various departments (e.g., Health, Environment) to inform the negotiation process.
- The HSIF case applies a number of information tools to support intersectoral activity: (i) handbooks to increase understanding and skills related to intersectoral/interagency activity, (ii) invited speakers from other jurisdictions to share experiences and insights related to service integration, and (iii) practice protocols for care providers that support interdisciplinary and shared care.
- Quebec's PHL rests on a cross-sector information tool. Its *health impact assessment* process requires all government departments to examine the impact of their policies and programs on the health of the population and allows for constructive adjustments to policies before they are adopted and/or implemented.

Financial mechanisms can be dedicated and/or shared.

- The Family Violence case has dedicated money for intersectoral work. Under the FVI's funding pattern, funding is provided through regular and ongoing departmental programming, and an additional annual allocation of \$7 million is shared among member departments to supplement those expenditures as well as ensure coordination of interdepartmental activity.
- A "shared pot" funding model characterizes two other cases:
 - All seven departments that participate in Saskatchewan's HSIF, contribute to the funding of its work on an annual basis.
 - Finally, the Healthy Child Manitoba has its own operating budget and has access to millions of dollars from other government departments.

Accountability

- Accountability and reporting frameworks serve as a mechanism for ISA in, for example, the Family Violence Initiative with coordinated reporting requirements from member departments; as well as the Vancouver Agreement which applies both individual departmental and horizontal frameworks and reporting mechanisms.

Committees

- As discussed above, the committee structure serves as a tool to facilitate intersectoral work within all the cases represented here.
- Interestingly, with respect to the HCM case, Ministers from each provincial department alternatively chair the Cabinet committee to reinforce the government's whole-of-government approach to child and family issues.

6.2.3 Accountability

Accountability varies across cases and includes departmental, local-level and shared accountability mechanisms.

- As with all federal programs since the late 1990s, member departments of the FVI report to the Treasury Board on an annual basis, through the Results-based Accountability Framework (RMAF). Moreover, the lead department (PHAC)

- submits an annual umbrella RMAF which reports collectively on member departments.
- Some federal initiatives extend accountability to the local level. SCPI community leaders report back to their own community on progress against their community plan, and must also report on progress to the federal level which includes an accounting of project results and outcomes.
 - Currently, there is no mechanism in place that requires federal government departments to be accountable for their activities with respect to gender-based analysis. Recent recommendations from the Standing Committee on the Status of Women seeks to increase accountability through a number of measures which will require cooperation from Finance Canada and the Treasury Board Secretariat.
 - Shared accountability mechanisms characterize two of the provincial cases. In the Healthy Child Manitoba case, all departments contribute to an annual reporting on HCM activities. Shared accountability in Saskatchewan's HSIF, takes the form of a "Minister's Commitment" statement which delineates the roles and responsibilities of all departments involved.
 - Accountability is also shared in the Vancouver Agreement where performance reporting occurs at the level of individual departments, and horizontal reporting mechanisms are also in place.
 - With respect to Quebec's Public Health Law, individual groups or projects at the regional and local levels are accountable to their own administrative structures; at the level of the Public Health Institute, accountability requirements focus on financial responsibility, with no requirement to report on intersectoral activities.

Related to accountability, is the issue of sustainability. Two cases made reference to the potential of their initiatives to continue over time. With respect to the SCPI case, a sustainability mechanism is not in place at the federal level. SCPI is classified as a "B-based" program and does not receive secured funding. However, matching funds are required as part of the community planning process and communities are required to explain how their activities will continue once SCPI funding ends. This is expected to encourage the development of sustainable long-term strategies to address homelessness at the local level. With respect to Healthy Child Manitoba, legislation is pending that, if passed, will enshrine HCM organizational structure into law. As such, the project and its commitment to an intersectoral approach will be embedded into the fabric of the province of Manitoba well into the future.

6.2.4 Sectors and Roles

The cases reviewed in this paper illustrate a range of roles and activities undertaken by participating sectors. These include: leadership, coordination, program operations, funding, knowledge development and mandated-related activities. Roles and activities for the health sector, other government sectors and the non-government sector are summarized in Table 5 below.

Table 5: Sectors and roles in intersectoral cases

Sector	Role / Activities	Example
Health sector	○ Leadership	<ul style="list-style-type: none"> - Health provides overall leadership in the FVI case - Health provides overall leadership in Quebec’s PHL case - Health shares leadership in committees to address child and family issues (HCM) - Health is formally listed as partner on homelessness initiative’s Treasury Board submission (SCPI)
	○ Coordination	<ul style="list-style-type: none"> - Health provides overall coordination in the FVI case (e.g., coordinates IDC and FPT meetings in the family violence case, and prepares and disseminates meeting minutes)
	○ Program operations (Related to planning, implementation, evaluation)	<ul style="list-style-type: none"> - Federal and provincial health partners participate in project planning and decision-making on homelessness (SCPI) - Health provides health-related advice and services, standard setting, training (HCM) - Health provides health-related services at regional and local level (HSIF) - Health provides front-line health services, and contributes to all aspects of program planning, development and implementation (VA)
	○ Knowledge development	<ul style="list-style-type: none"> - Health contributes a theoretical basis (e.g. Population Health & “new public health”) to support program development (HCM, PHL)
	○ Funding	<ul style="list-style-type: none"> - Federal and provincial health partners co-fund some local homelessness initiatives (SCPI) - Health shares cost with other departments to support HSIF positions (Executive Director & RIC Coordinators) - Funds FVI
	○ “Preferred or additional role” ¹⁰ for health	<ul style="list-style-type: none"> - Greater authority over budget to support ISA (FVI) - Greater recognition by health of housing as a determinant of health, define homelessness as a health issue (SCPI) - Expanded role for health within various settings or “environments” where opportunities exist for health improvement (e.g., schools and the workplaces) (PHL) - Develop tools and build capacity for health at the local level (VA), and greater flexibility at the federal level to support VA
Other government sectors	○ Leadership	<ul style="list-style-type: none"> - Human Resources and Social Development Canada as leader (SCPI) - Indian and Northern Affairs Canada as leader (ASG) - Healthy Child Manitoba as leader (HCM) - Saskatchewan Learning as leader (HSIF) - Status of Women Canada as leader (GBA)

¹⁰ These findings reflect answers from our case respondents who were asked, “If you could do it over again, what role would you have the health sector play?”

Sector	Role / Activities	Example
		<ul style="list-style-type: none"> - Shared leadership, federal and provincial governments (Ministers responsible for VA) and municipal government (Mayor of Vancouver) (VA)
	<ul style="list-style-type: none"> o Mandate-related 	<ul style="list-style-type: none"> - Fifteen departments take on a number of homelessness-related responsibilities that align with their mandate (FVI) - The items for self-government negotiation (housing, education, health, etc) determine the role and degree of involvement of various sectors at both the federal and provincial levels (ASG) - All federal departments and agencies are required by law to consult the Minister of Health and Social Services when formulating laws or regulations which could impact health (PHL) - Participation of departments whose mandates align with the community priorities being addressed (e.g., crime, addictions, housing) (VA)
	<ul style="list-style-type: none"> o Program operations (Related to planning, implementation, evaluation) 	<ul style="list-style-type: none"> - Seven federal departments involved in planning, development and evaluation of homelessness projects from inception through today (SCPI) - All (7) provincial departments involved in the planning cycle for human service integration from the beginning (HSIF) - Seven federal departments undertake policy analysis that applies a gender perspective (GBA)
	<ul style="list-style-type: none"> o Funding 	<ul style="list-style-type: none"> - Joint funding among some sectors to address housing issues (SCPI) - All (7) participating departments share the cost of the integrating human services (HSIF) - Shared funding from federal, provincial and municipal governments (VA)
Non-government sector	<ul style="list-style-type: none"> o Mandate-related 	<ul style="list-style-type: none"> - NGOs, community agencies, and private sector participate at the local level to provide expertise or support on homelessness issues (SCPI) - NGOs and First Nations groups link to negotiation process through consultative bodies at provincial and regional levels (ASG)
	<ul style="list-style-type: none"> o Program operations (Related to planning, implementation, evaluation) 	<ul style="list-style-type: none"> - NGOs involved in the planning cycle for human services from the beginning (HSIF) - NGOs serve on "task teams" to identify community issues and generate integrate solutions (VA)
	<ul style="list-style-type: none"> o Knowledge development 	<ul style="list-style-type: none"> - Linkage with universities and academic centres to support health activities and surveillance province-wide (PHL) - Generate best practices to address local/community circumstances (VA)
	<ul style="list-style-type: none"> o Funding 	<ul style="list-style-type: none"> - Private sector donations linked to the upcoming Vancouver/Whistler 2010 Olympic Games, whereby corporate sponsors indicate how they will contribute to the benefit of the community (VA)

6.3 Impact

This section discusses achievements, impacts and lessons learned related to intersectoral action to address the social determinants of health.

6.3.1 Achievements and Impacts

Achievements related to intersectoral action and health are as follows:

Intersectoral action:

- An enhanced ability to gather and share information about family violence among provinces and communities (FVI)
- Increased readiness and capacity of various sectors (e.g. health, housing and justice) to respond to family violence issues and incidents (FVI)
- Greater communication of initiative achievements across federal and provincial governments (FVI)
- Increased mobilization and capacity of the broader community to effectively address homelessness (SCPI)
- Creation of effective intersectoral mechanisms for setting priorities and allocating resources at the local level (SCPI)
- Creation of new, cross sector partnerships that were traditionally challenged (ASG)
- Establishment of collaborative networks and new mechanisms to facilitate interagency cooperation on human services (HSIF)

Health:

- Increased capacity to manage and administer healthcare within Aboriginal populations:
 - An Agreement with federal government to confer responsibility for delivering health care and health promotion programs to Aboriginal peoples (ASG)
 - An Agreement with the federal government to transfer funding and responsibility for delivering non-insured benefits such as prescription drugs, optometry services, dental care and medical transportation to Aboriginal peoples (ASG)
 - An Agreement with provincial level to provide physician and other services in some regions of the province (ASG)
- Improved health and quality of life associated with the Vancouver Agreement:
 - Death rates due to alcohol and drug use, alcohol and drug overdoses, HIV/AIDS, and suicides have been declining since 2000
 - Better access to primary health care has been facilitated with the opening of four new health clinics since 2003
 - Improved coordination of addiction services is being achieved through, for example, a central telephone referral services for adult addiction treatment
- Increased information sharing among provincial departments related to the impact of policies/programs on health (PHL)

- Greater understanding among all departments that health is influenced by a complex set of inter-related factors and conditions (PHL, HCM)

6.3.2 Lessons Learned

Lessons learned across the cases examined in this paper fall into four categories. These include lessons related to (i) the definition of and rationale for intersectoral action, (ii) resources for intersectoral action, (iii) intersectoral processes and structures, and (iv) political and organizational support for intersectoral action.

Related to definition and rationale:

- Provide a clear, credible and persuasive rationale for applying an intersectoral approach, and specify the type of collaboration that is expected (e.g. information sharing, interdepartmental committees) (FVI)
- Provide clear directives for member departments that specifies their role, responsibilities and expectations regarding interdepartmental activity, including funds that they are expected to devote to cost-shared efforts (FVI)
- Frame issues to be addressed in a way that other sectors can identify with or relate to (FVI)
- Consider the social, economic, political and historical context in which intersectoral work is undertaken (ASG)

Related to resources:

Time

- Allocate sufficient time to develop partnerships and build a culture of collaborative work within government departments and sectors (HCM, VA)

People

- Institute policies and practices to minimize staff turn-over and maintain corporate memory within intersectoral programs (FVI)
- Do not underestimate the value of trust in partnerships and the need to nurture relationships to move shared work forward and to overcome challenges associated with intersectoral action (SCPI, ASG, VA)
- Allocate sufficient human resources; enough personnel to get the work done (FVI, GBA)
- Acknowledge and encourage the contribution from creative and proactive leaders to support the initiative and move it along (SCPI, PHL)

Information

- Establish and maintain effective communication links (ASG)
- Ensure availability and access to data (GBA)
- Base intersectoral initiatives on a sound knowledge and/or theoretical base (HCM)
- Keep learning; draw on the experience of other jurisdictions who have undertaken intersectoral initiatives (HSIF)
- Understand the contribution of individual mandates within the context of intersectoral work; ensure partners at the table understand each other's mandate (HSIF)

Money

- Allocate adequate resources to support partnership building and information sharing (e.g., travel) (GBA, FVI)
- Focus attention away from money (and how it is allocated) to how funds can be used more efficiently and effectively (PHL)
- Establish cross-departmental estimates and budgeting processes that allow for spending across sectors (HCM)

Related to process & structure:

- Ensure effective administrative structures are in place to support cross-sector work (e.g., committees) (HCM, GBA)
- Establish organizational procedures and norms that promote ISA (GBA)
- Institute systematic and regular monitoring and evaluation; measure outcomes and document progress from the start (HSIF)
- Implement accountability mechanisms so that departments and agencies share responsibility for intersectoral processes and outcomes (GBA)

Related to political and organizational support:

- Political leaders should ensure support for intersectoral policies at the highest levels of government administration (FVI)
- Departmental leaders should garner commitment for intersectoral collaboration from departmental staff (GBA)
- Initiative leaders should ensure support for intersectoral approaches across levels of government (VA, PHL)
- Elected officials should provide incentives to senior officials to support and engage in intersectoral activities (FVI)
- Central agencies should provide guidance and support to those responsible for horizontal management, including for example, the provision of consistent guidelines related to performance measurement (FVI)

6.4 Reflection

Individuals who contributed to the findings presented in this paper (i.e., our case respondents) shared their insights with respect to the following: factors that contributed most to the intersectoral nature of the cases, the most unique or innovative features of the cases, and methods to further support or advance the intersectoral aspect of the cases.

6.4.1 Contributing factors

With respect to the Family Violence case, an interplay of three factors contributed to its intersectoral nature: (i) its committee structure, which allowed member departments to come together in a coordinated fashion; (ii) an annual allocation of funds devoted specifically to interdepartmental coordination; and (iii) the creation of horizontal frameworks for accountability and reporting. The SCPI case highlighted the role of community plans, which facilitated broad interests to join discussions at the homelessness table. In the case of the Vancouver Agreement, the complex nature of urban degradation and a shared commitment to adopt a comprehensive approach to

solution-finding contributed most to its intersectoral nature. These two cases also showed that making the community and its needs the focal point for priority setting helped to overcome siloes. Finally, the acknowledgement by member departments that intersectoral action is “the way that business is conducted today,” and that traditional (i.e., siloed) approaches “are now inappropriate,” were identified by Saskatchewan’s HSIF and Quebec’s PHL as the most significant facilitating factor in their intersectoral initiatives.

6.4.2 Unique Features

According to our case respondents, the most unique, interesting or innovative aspects of the intersectoral cases examined here are as follows:

- Successful application of a community development model within the context of an intersectoral initiative to address issues related to family violence (FVI)
- Using an intersectoral approach to address long-standing issues between governments and Aboriginal peoples (ASG)
- Adoption of the Population Health Model to guide and inform cross-sector services for children and youth development (HCM)
- Learning and cross-fertilization of information between government sectors who assess the impact of programs and policies on health (PHL)
- The development of “world class tools” (e.g., training materials and workshops) to facilitate the incorporation of a gender lens in policy development and analysis (GBA)
- An understanding that community improvement needs to be driven from the inside out, by community needs, not by government interests (VA)

6.4.3 Future Supports

Finally, a selection of methods to support or improve intersectoral activity can be gleaned for the eight case studies examined in this paper. They include:

- Creation of a central coordinating body to promote and build capacity for intersectoral action (FVI)
- Development of practical tools and guidelines to support ISA (FVI)
- Enhanced involvement of political leaders (i.e., at the deputy ministers level) in intersectoral initiatives (SCPI); and similarly, instituting mechanisms to garner and sustain political will for intersectoral collaboration on social issues (GBA)
- “Spreading” intersectoral action to move beyond the determinants of health to include, for example, the burden of chronic disease (PHL)
- Improving accountability mechanism for horizontal initiatives (GBA)
- As noted throughout, increasing financial and human resources to a level that is commensurate with the time and effort required to undertake intersectoral work (VA, HCM, HSIF)

7.0 Summary of Learnings and Considerations for the Future

An analysis across the eight case studies examined in this paper follows. A high-level summary of the findings and considerations for future engagement in intersectoral action to address the social determinants of health and health disparities are offered below.

Context

(Issues, aims, motivating and facilitating factors, challenging factors)

The issues addressed in the eight case studies touch upon several complex issues including: family violence, homelessness, self-government, child and youth well-being, healthy public policy/health impact assessment, gender equality, and supporting socially and economically vulnerable populations. All cases explicitly identify intersectoral activity as part of their overall vision, principles, goals or objectives. Motivating and facilitating factors for intersectoral action fall into the following categories: the nature and complexity of the issue, history of working intersectorally and precedence (e.g. international movements or national commissions), political will and consequences, central agency support or requirement, expectations for improved service efficiency and effectiveness, and established information and knowledge base. Factors that challenge or serve as a barrier to intersectoral action can be classified as follows: limited ISA models, resource issues (e.g. insufficient time, personnel, and money), multiple mandates, lack of leadership, change in government, and denial of the social issue.

Approach

(Organizational structure, mechanisms and tools, accountability, and sectors and roles)

Overall, “committees” characterize the organizational or administrative structure of the cases reviewed in this paper. Committees vary not only in number, but by what types of interests are represented (e.g. political leaders, departmental staff, community leaders, etc). Variation also occurs across tools and mechanisms for intersectoral activity. Information tools such as training materials, shared guidelines and protocols, and information exchange and dissemination were most frequently used. Others include financial mechanisms, accountability methods, as well as committees, noted above. Accountability also takes on different forms and includes departmental, local-level and shared accountability mechanisms. Shared planning and priority-setting processes often co-exist with shared accountability. Finally, a variety of roles and activities characterize the health sector in intersectoral activity to address the social determinants of health. These include: leadership, coordination, program operations (i.e., planning, implementation and evaluation), funding, knowledge development and mandated-related activities.

Impact

(Achievements and impacts, lessons learned)

The eight case studies reveal a number of accomplishments, some related to intersectoral activity and some related to health. Achievements associated with intersectoral action include: improved information gathering and sharing; creation of new, cross-sector partnerships; increased mobilization of the broader community; and

the establishment of new mechanisms to facilitate interagency cooperation. Achievements related to health include: increased capacity to manage and administer health care services, improved health outcomes and quality of life, and a greater understanding among government departments that health is influenced by a complex set of inter-related factors and conditions. Lessons learned are broad and fall into four groups: lessons related to (i) the definition and rationale for intersectoral action, (ii) resource requirements, (iii) intersectoral process and structure, and (iv) political and organizational support for intersectoral activity.

Reflection

(Contributing factors, unique features, future supports)

Factors “contributing most” to the intersectoral aspect of the cases include: committee structure, annual allocation of dedicated funds for ISA, creation of horizontal accountability frameworks, a requirement for community-based planning, and a new “culture” that recognizes intersectoral action as “the way business is done today.” Application of a community development approach, adoption of the Population Health Model, and development of “world class” tools for ISA were some of the “most unique or interesting” aspects of the cases reviewed. Future supports to improve intersectoral activity rest on: the creation of a coordinating body to promote ISA, development of practical tools and guidelines, greater involvement of political leaders, improved accountability mechanisms, and sufficient human and financial resources to match the effort required in intersectoral work.

Given these learnings, considerations for future engagement in intersectoral action to address the social determinants of health and health disparities are offered below:

1. How an issue is framed or defined is a key factor in intersectoral work as it impacts decisions regarding who comes to the table and what processes and structures are put into place. This also has implications for resources as well as accountability and financial mechanisms that need to be established.
2. The prevailing context impacts intersectoral work. This includes influences in the larger environment such as: social issues (e.g., increasing awareness of environmental/green issues), economic issues (e.g. expectation for fair and equitable wages), political issues (e.g., governing party and philosophical stance), and historical issues (e.g., long-standing relationship between population subgroups such as non-Aboriginal and Aboriginal peoples). Designing and executing intersectoral initiatives should include a systematic assessment of broad contextual issues to identify conditions that both facilitate (provide an opportunity for) and challenge (serve as a barrier to) intersectoral work.
3. Departments should be strategic in the issues they choose to incorporate into their intersectoral policy and/or program planning to ensure that resources are focused where they are most likely to have an impact, and where conditions for success exist. Departmental leaders should come together with

experts in this area to develop criteria to support both the selection of issues as well as how to organize around them. This should be based on global best practices and jurisdictional experience to date.

4. Programs aimed at addressing complex social issues should be *purposefully* aligned with an intersectoral approach. Explicitly stating intersectoral activity as an overarching goal or core objective within the policy or program signals priority status and affirms the central role of intersectoral practices in all aspects of planning, implementation and evaluation.
5. Intersectoral initiatives need to be grounded in a sound rationale – why they are important, to whom, and at what cost; and how working intersectorally will achieve the best return on investment. Making the case for intersectoral approaches increases the likelihood that political actors will become engaged as well as provide the necessary political will to both initiate and sustain intersectoral work.
6. Information about intersectoral methods (e.g., approach, processes, structures, reporting, financing, etc) and intersectoral experiences (e.g. evaluation reports on ISA initiatives from various departments/jurisdictions) should be assembled, packaged, and made accessible to those interested in intersectoral work. Consideration should be given to the establishment of an “intersectoral activity clearing house” that would serve as a repository for best practices related to intersectoral action. It would additionally provide a knowledge base to generate practical tools to support planning, implementation and evaluation of intersectoral initiatives.
7. Given the relative importance of committees in the administrative structure of intersectoral initiatives, effort should be directed at examining what committee structures work best at what level, for what issues or problems, and under what conditions; with a focus on interdepartmental committees at the federal and provincial levels, and broad-based-community collations or committees at the local level.
8. Strong accountability mechanisms reinforce the position that intersectoral practices are to be taken seriously at the leadership and operational levels. There must be ongoing development of accountability mechanisms that articulate the objectives of the initiative, the expected results, and how progress will be measured. While shared accountability mechanisms may be the preferred approach, they require strong, top-level leadership to coordinate activities and ensure that partners are not working at cross-purposes.
9. Financial and funding mechanisms play a central role in facilitating intersectoral collaboration. More emphasis should be placed on developing terms and conditions that allow for flexibility to enter into financial arrangements that align with intersectoral work, including blended or “shared pot” funding.

10. Central agencies have a role to play. Improved guidelines and protocols for intersectoral initiatives would increase clarity among partners at all levels of government and across government departments with respect to intersectoral processes and structures, roles and responsibilities, and reporting and accountability requirements. Being clear about these issues early on increases the likelihood that initiatives will be implemented as planned as well as sustained over the long term.
11. Intersectoral work is resource-intensive. Serious consideration should be given to the allocation of dedicated financial, human and material resources to a level that is commensurate with the time and effort required to undertake this kind of work.
12. Adopting an intersectoral approach does not mean abandoning individual departmental mandates. It requires, rather, the identification of roles, activities and expertise that each sector can bring to bear on the collaborative exercise. Terms and conditions for intersectoral work should be crafted in a way that allows each sector to see its place in the overall picture and determine where it can best add value.

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9.0 Appendices

Appendix A: Typology of Canadian Experiences of Intersectoral Activity at Federal and Provincial/Territorial Levels

Please note that the Typology that follows is in draft form. In the near future, it will be updated and expanded based on the information gleaned from the case studies which provide a more in-depth examination of the issues.

Project Name	Context			Approach		Impact	
	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
Aboriginal Self-Government Agreements (1995)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Federal <p>Departments Involved:</p> <ul style="list-style-type: none"> - Indian Affairs and Northern Development - Office of the Federal Interlocutor - Health sector - Other federal departments <p>* Lead department is bolded</p>	<p>Program Focus:</p> <ul style="list-style-type: none"> - Inherent right of self-government and negotiation of Aboriginal self-government agreements <p>Objectives:</p> <ul style="list-style-type: none"> - Implement a process that will allow reasonable and practical progress toward self-government - Provide Aboriginal groups with the necessary tools to achieve self-government - Restore dignity to Aboriginal people and empower them to become self-reliant 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - Recognition of the inherent right of self-government under Section 35 of the Canadian Constitution. - The 1984 <i>Comprehensive Land Claims Policy of Canada</i> where self-government arrangements may be negotiated simultaneously with lands and resources as part of comprehensive claims agreements - Royal Commission on Aboriginal Peoples (RCAP, 1996) which advocated a 20-year plan of fundamental structural reforms – treaty, self-government, fiscal, socio-economic, and health and safety risks <p>Challenging Factors:</p> <ul style="list-style-type: none"> - Jurisdictional authority over Aboriginal peoples (e.g. off-reserve Status Indians, Non-Status Indians or Métis groups) 	<p>Nature of ISA:</p> <ul style="list-style-type: none"> - Broad policy framework <p>Mechanisms & Tools for ISA:</p> <p>Legislation/regulation:</p> <ul style="list-style-type: none"> - Legislation that requires address of broad issues that touch on all sectors - Self government negotiators use guidelines from participating departments (e.g. Health, Fisheries) to inform the negotiation process - A Federal Steering Committee ensures the participation in negotiations, as required, of all federal departments and agencies - During the negotiation of a final self-government agreement, an implementation plan is negotiated by the parties to the agreement which identifies what must be done to put the agreement in effect, who will be responsible for 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Supporter <p>Other Gov't Roles:</p> <ul style="list-style-type: none"> - Minister of Indian Affairs and Northern Development has mandate to enter into negotiations with First Nations, the Inuit, and Métis groups north of the sixtieth parallel; the Federal Interlocutor for Métis and Non-Status Indians enters into negotiations with Métis south of the sixty parallel and Indian people who reside off a land base - Ministers of other federal government departments have mandates to enter into sectoral negotiations in their respective areas of responsibility - Negotiations based on tripartite processes with federal and provincial 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - The Federal Steering Committee coordinates implementation of the inherent right within the federal government, and monitors the progress on all self-government negotiations - Aboriginal governments and institutions are accountable to their members or clients for decisions made and actions taken - Aboriginal governments and institutions area accountable to Parliament for funding provided by the federal government as a result of self-government agreements <p>Sustainability Mechanism:</p> <ul style="list-style-type: none"> - Cabinet approval is sought for Agreements-in-Principle and 	<p>Indicators:</p> <ul style="list-style-type: none"> - Annual repots/reviews summarize the activities of the past year for all parties involved in the implementation process - Five year reviews include a detailed analysis of obligations, an examination of impact, and recommendations on how to improve the implementation process

	Context			Approach		Impact	
Project Name	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
				which implementation activity, and when and how these activities will be undertaken	representatives and duly mandated representatives of Aboriginal groups Non-gov't Roles: - Municipalities and third parties have opportunities to provide input into negotiation processes that may directly affect their interests	Final Agreements - Parliamentary approval is sought for self-government treaties and any implementing legislation that may be required	
Canada's Action Plan for Food Security (1998)	Level of Gov't: - Federal Departments Involved: - Agriculture and Agri-Food Canada - Health - Federal departments - Provincial departments - Municipal departments	Program Focus: - Focused effort through broad-based agenda to improve food security both domestically and internationally Objectives: - An enabling environment for food security - Access to food - Sustainable agriculture - Trade leadership (e.g. development of fair and open rules for trade and investment - Emergency prevention and preparedness (e.g., weather,	Facilitating Factors: - World Food Summit (1996, Rome, U.N. Food & Agriculture Organization) where Canada and 186 other countries made the commitment to reduce by half the number of hungry and undernourished people by 2015, and to eventual food security for all - Recognition that food security involves a wide range of issues, many complex and interconnected, that require coordinated efforts across government and community sectors - Builds on existing	Nature of ISA: - Broad policy framework Mechanisms & Tools for ISA: Information: - Knowledge transfer within Canada and between Canada and global partners	Health Sector Role: - Supporter Other Gov't Sectors: - Agriculture and Agri-Food Canada as lead - Federal departments - Provincial governments - Municipal governments Non-gov't Sectors: - NGOs - Civil society organizations - Academic/research community - Private sector - International partners	Accountability Mechanism: - Agriculture and Agri-Food Canada coordinates monitoring of key actions identified in the Plan and publicly reports on them every two years	Indicators: - <i>Food security indicators:</i> food price index, food self-sufficiency ratio, percentage of population undernourished - <i>Social indicators:</i> life expectancy at birth, net school enrolment in primary education, adult literacy rate - <i>Health indicators:</i> infant mortality rate, adult morbidity rates, rate of deaths by infectious disease - <i>Economic indicators:</i> ratio of import prices to export prices

<i>Project Name</i>	<i>Context</i>			<i>Approach</i>		<i>Impact</i>	
	<i>Level of Gov't & Departments Involved*</i>	<i>Program Focus and Objectives</i>	<i>Facilitating & Challenging Factors for ISA</i>	<i>Mechanisms & Tools for ISA</i>	<i>Sectors & Roles</i>	<i>Accountability & Sustainability</i>	<i>Measurement/ Indicators & Lessons Learned</i>
		microbial threats) - Promoting investment and continuing economic viability of Canada's food industry	domestic programs: Nutrition for Health: An Agenda for Action; Gathering Strength: Canada's Aboriginal Action Plan; revisions to legislation, including the Fisheries Act, and other economic, social and environmental programs and policies				<i>Lessons Learned:</i> - Members of Canadian civil society (e.g. NGOs, academics and other interested parties) play a vital role in food security in Canada and abroad; more efforts should be made to engage them - Issues relating to food security are universally complex and require long term commitments from all stakeholders - Given the intersectoral nature of the objectives of the Plan, partnerships are key - Coordination and collaboration of the diverse stakeholders maximizes synergy, clarifies roles, minimizes duplication, and mutually reinforces effort

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							- Cross-sectoral partnerships are particularly important, e.g., linking nutrition and food safety agendas with schools
The Falls Prevention Initiative (2000)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Federal <p>Departments Involved:</p> <ul style="list-style-type: none"> - Health Canada - Veterans Affairs Canada - Health ministries (provincial/territorial) 	<p>Program Focus:</p> <ul style="list-style-type: none"> - A health promotion initiative to prevent falls in the community among veterans and seniors <p>Objectives:</p> <ul style="list-style-type: none"> - Advance understanding and knowledge of effective falls prevention interventions using the population health approach - Develop the capacity of veterans and other community organizations to develop and deliver sustainable community-based health promotion programs addressing falls prevention using 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - The RFP process (Population Health Fund) required projects to apply a population health approach that considered the broad determinants of health - Project funding focused on partnership development among seniors and veterans and their organizations, and other community based organizations involved in falls prevention - Research shows that falls are often the result of a complex combination of factors including individual health practices (e.g., active living, use of medication, nutrition), health 	<p>Nature of ISA:</p> <p>Targeted:</p> <ul style="list-style-type: none"> - Community-dwelling veterans, seniors and their caregivers <p>Mechanisms & Tools for ISA:</p> <p>Financial:</p> <ul style="list-style-type: none"> - Collaboration between sectors is a condition of funding 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Partner <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - Health Canada in partnership with Veterans Affairs Canada - Provincial/territorial health ministries <p>Non-gov't Sectors:</p> <ul style="list-style-type: none"> - Seniors and veterans community-based organizations - Educational institutions/ researchers 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - Regular progress reporting to the funding agency (i.e., the Population Health Fund) <p>Sustainability Mechanism:</p> <ul style="list-style-type: none"> - The initiative was time-limited, ending in 2004. Pilot projects were expected to carry on at the local level. 	<p>Indicators:</p> <ul style="list-style-type: none"> - Development of a falls prevention logic model that describes the outcomes being sought <p>Lessons Learned:</p> <ul style="list-style-type: none"> - Projects benefit from community-based approach and partnership development - Difficulty among stakeholders to understand the population health approach - Difficulty working with two lead departments with respect to how they coordinate their regional offices - Lack of clarity around roles and responsibilities of HC and VAC related to project

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		<p>the population health approach</p> <ul style="list-style-type: none"> - Strengthen the capacity within the two departments to deliver health promotion programming to older Canadians using the population health approach - Promote the independence and quality of life of veterans and seniors 	<p>status (e.g. diseases, fragility), and the physical environment (e.g. home & community)</p>				<p>management and communications</p>
The Family Violence Initiative (1997)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Federal <p>15 Departments Involved:</p> <ul style="list-style-type: none"> - Canada Mortgage and Housing - Canadian Heritage - Citizenship and Immigration - Correction Service - Health Canada - Human Resources and Social Development - Indian and Northern Affairs - Justice Canada - National Defense - PHAC - Public Safety - RCMP 	<p>Program Focus:</p> <ul style="list-style-type: none"> - Prevent family violence which occurs in relationships of intimacy, kinship, dependency or trust; and includes physical emotional, financial, and sexual abuse and neglect <p>Objectives:</p> <ul style="list-style-type: none"> - Effective, efficient and coordinated federal policy development and programming on family violence issues 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - Recognition of the need for horizontal management since family violence issues are multidimensional and cut across federal mandates - Existing awareness of the issue of family violence throughout the government <p>Challenging Factors:</p> <ul style="list-style-type: none"> - Ensuring the involvement of individuals who experience family violence - Persistence of vertical lines of 	<p>Nature of ISA:</p> <p>Targeted:</p> <ul style="list-style-type: none"> - Families who experience violence <p>Mechanisms & Tools for ISA:</p> <p>Information related:</p> <ul style="list-style-type: none"> - Formal statement about collective goals such as avoiding duplication and cross-fertilization of knowledge and workplans - Formal agreements to confirm partnerships related to common objectives, cost-sharing parameters, 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Health sector as leader (PHAC researches the population health consequences of family violence, develops resources and promotes policies, programs and projects that contribute to family violence prevention) 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - Established measures to report to Public Health Agency of Canada on a regular basis 	<p>Indicators:</p> <ul style="list-style-type: none"> - Increased collective activity - Increased partnerships - Special population programs - Increased responsiveness to diversity - Improved information dissemination - Cooperative cost-sharing arrangements between member departments <p>Lessons Learned:</p> <p>Key elements for</p>

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	<ul style="list-style-type: none"> - Service Canada - Statistics Canada - Status of Women Canada 	<ul style="list-style-type: none"> - Enhanced prevention of and improved community response to family violence and the development and implementation of community activities to reduce family violence - Increased public awareness of family violence issues and reduced tolerance for family violence 	authority	and coordinating procedures			effective ISA: <ul style="list-style-type: none"> - Public pressure - Evidence-based rationale for ISA - Requirement for ISA from central agencies - Central agency guidance and guidelines on performance measurement - Clear directives to member departments (specifying role, responsibilities and expectations) - Allocation of human and financial resources for ISA to each department - Formal expressions of support for ISA from highest levels of government
Gender-based Analysis Policy (2000)	Level of Gov't: <ul style="list-style-type: none"> - Federal Departments Involved: <ul style="list-style-type: none"> - Status of Women Canada - Health - All other federal 	Program Focus: <ul style="list-style-type: none"> - Where women and men have equal conditions for realizing their full human rights potential, for contributing to national political, 	Facilitating Factors: <ul style="list-style-type: none"> - International efforts such as the Report of the UN Fourth World Conference in Women (Beijing, 1995) - Federal government's 	Nature of ISA: <ul style="list-style-type: none"> - Broad policy framework Mechanisms & Tools for ISA: <ul style="list-style-type: none"> Information/planning process: <ul style="list-style-type: none"> - GBA Training 	Health Sector Role: <ul style="list-style-type: none"> - Supporter Other Gov't Sectors: <ul style="list-style-type: none"> - Status of Women Canada as lead - All other federal departments 	Accountability Mechanism: <ul style="list-style-type: none"> - Departments report on outcomes Sustainability Mechanism: <ul style="list-style-type: none"> - GBA is integrated 	Indicators: <ul style="list-style-type: none"> Performance indicators have been identified for following desired outcomes: <ul style="list-style-type: none"> - Access: Ability for both women and men to have

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	departments	<p>economic, social and cultural development and benefit equally from the results</p> <p>Objectives:</p> <ul style="list-style-type: none"> - Assess the links between gender and health and between gender and other determinants of health - Identify how life conditions affect women's and men's health status and their access to, and interaction with the health care system - Give equal weight to the knowledge, values and experiences of women and men - Ensure more effective interventions to improve health - Contribute to the attainment of greater equity in health and health care 	<p><i>Women's Health Strategy</i> calling gender-based analysis to programs and policies</p> <ul style="list-style-type: none"> - Increased recognition that health policies and programs often perpetuate gender stereotypes and do not adequately consider socioeconomic disparities and other differences between men and women 	<p>Manual and implementation strategy to accelerate capacity building related to gender issues in government departments and other organizations</p> <ul style="list-style-type: none"> - Part of regular planning process across government 		into regular departmental operating procedures	<p>equal access to policy, programs or legislative activities</p> <ul style="list-style-type: none"> - Inclusion: Representation of women, men, boys, and girls throughout the policy/program development process - Benefits: Advances/ aims intended to result from a policy/program are equally available to both women and me
Leading Together: Canada Takes	Level of Gov't: - Federal	Program Focus: - This initiative signals a renewed	Facilitating Factors: - Number of Canadians living	Nature of ISA: Targeted: - People living with or	Health Sector Role: - Health sector as leader PHAC is	Accountability Mechanism: - Mutual	Indicators: Desired outcomes: - Address the

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Action on HIV/AIDS (2005-2010)	<p>Departments Involved:</p> <ul style="list-style-type: none"> - Health (PHAC, Health Canada) - Correctional Service Canada - Canadian International Development Agency - Foreign Affairs Canada - Human Resources and Skills Development - Industry Canada - National Defense - Indian and Northern Affairs - Office of the Federal Interlocutor - Department of Justice and Attorney General - Social Development Canada Research - Canadian Heritage, Citizenship and Immigration - Provincial/territorial and municipal governments 	<p>and strengthen federal role in the Canadian response to HIV/AIDS. It is an evolution from the Canadian Strategy on HIV/AIDS</p> <p>Objectives:</p> <ul style="list-style-type: none"> - Prevent the acquisition and transmission of new infections - Slow the progression of the disease and improve quality of life - Reduce the social and economic impact of HIV/AIDS - Contribute to the global effort to reduce the spread of HIV and mitigate the impact of the disease 	<p>with HIV continues to grow</p> <ul style="list-style-type: none"> - Poverty, homelessness and other social determinants are fuelling the epidemic - People living with HIV have increasingly complex needs - Stigma and discrimination continue to threaten people with HIV and communities at risk <p>Challenging Factors:</p> <ul style="list-style-type: none"> - History of fractious relationship among HIV/AIDS stakeholders 	<p>vulnerable to HIV/AIDS</p> <p>Mechanisms & Tools for ISA:</p> <p>Institutional arrangement:</p> <ul style="list-style-type: none"> - Establishment in January 2005 of the Government of Canada Assistant Deputy Minister Committee on HIV/AIDS (comprised of ADMs from 12 federal departments) to provide a common platform for horizontal action on HIV/AIDS, and an opportunity for partner departments/agencies to express their strategic directions and plans in a collaborative manner 	<p>responsible for the overall coordination of the initiative, joint planning, monitoring and evaluation, communications, social marketing, national and regional programs, policy development, surveillance, laboratory science and global engagement</p> <p>Health Canada is responsible for community-based HIV/AIDS education, prevention, and related services for First Nations on reserve</p> <p>Correctional Service Canada provides health services to offenders imprisoned for 2 years or more</p> <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - Canadian International Development 	<p>accountability among partners to report publicly on achievements and challenges on an annual basis through the World AIDS Day Report</p> <ul style="list-style-type: none"> - Shared responsibility for many of the social and economic factors fueling the epidemic, including income programs, social and housing services, the justice system, the education system, correctional services and the private sector <p>Sustainability Mechanism:</p> <p>A commitment in Leading Together for a sustained response that includes:</p> <ul style="list-style-type: none"> - Delivery of prevention information in many different ways - Adapting prevention 	<p>social factors/inequities driving the epidemic</p> <ul style="list-style-type: none"> - Increase the awareness of the impact of HIV/AIDS and need for sustained funding for HIV services - Step up prevention efforts - Strengthen diagnosis, care, treatment and support services - Provide leadership in global efforts - Enhance the front-line capacity to act early and stay the course <p>Lessons Learned:</p> <ul style="list-style-type: none"> - Nothing documented yet; however, a stated commitment in the Leading Together document to "learn from our experiences"

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					Agency, Foreign Affairs Canada, Human Resources and Skills Development, Industry Canada, National Defense, Correctional Service, Indian and Northern Affairs, Office of the Federal Interlocutor, Department of Justice and Attorney General, Social Development Canada Research and Correctional Service Canada, and Canadian Heritage, Citizenship and Immigration - Provincial/territorial and municipal governments Non-gov't Sectors: - Health professional groups - Private sector organizations - Canadian Institutes of Health (research) - NGOs - Community-based/voluntary	programs to reflect new knowledge and changing needs - Recognition that prevention programs must be developed for and by people living with HIV/AIDS as part of lifelong disease management - Treatment programs that take into account the complex needs of people living with HIV/AIDS as they age	

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					agencies (forums addressing health and social needs) - People living with and those vulnerable to HIV/AIDS (offer personal experience)		
National Homelessness Initiative's Supporting Communities Partnership Initiative (SCPI) (1999)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Federal <p>Departments Involved:</p> <ul style="list-style-type: none"> - Department of Human Resources - Social Development Canada - Department of Labour - Treasury Board - Health 	<p>Program Focus:</p> <ul style="list-style-type: none"> - Address the needs of homelessness people and those at risk of homelessness at the local level <p>Objectives:</p> <ul style="list-style-type: none"> - Increase services for homeless people - Promote coordinated programs - Build community capacity - Promote broad-based partnerships - Develop information and knowledge about homelessness 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - Data released in late 1999 demonstrating that homelessness was becoming a crises in both large and small cities across Canada - Increased understanding that addressing problem is dependent upon partnerships with all levels of government and community stakeholders <p>Challenging Factors:</p> <ul style="list-style-type: none"> - Ensuring the involvement of groups at high risk of becoming homeless - Engaging the private sector in efforts to establish partnerships 	<p>Nature of ISA:</p> <p>Targeted:</p> <ul style="list-style-type: none"> - Homeless population and those at risk of becoming homeless <p>Mechanisms & Tools for ISA:</p> <p>Financial:</p> <ul style="list-style-type: none"> - Proposal for funding requires SCPI communities to demonstrate cost-matching with other partners 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Supporter <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - Department of Human Resources and Social Development Canada as lead - Labour department - Provincial and municipal governments - Treasury Board (regular audits) <p>Non-gov't Sectors:</p> <ul style="list-style-type: none"> - Private sector - Non-profit agencies - Labour organizations - Volunteer organizations 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - Audit of the SCPI was conducted in July 2004. The objective was to provide assurance to Treasury Board that SCPI is appropriately managed; It covers both the management controls framework and the program financial aspects <p>Sustainability Mechanism:</p> <ul style="list-style-type: none"> - Proposal for funding requires plans that provide long-term solutions to address homelessness which identify how the community 	<p>Lessons Learned:</p> <ul style="list-style-type: none"> - The design features of the SCPI model help to establish an appropriate balance between flexibility for communities and accountability for federal government spending - Community-based planning and decision making processes provides communities flexibility to decide how best to address the problem of homelessness locally, and ensures that funding decisions are guided by a collective plan that sets out

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						intends to sustain activities over time	<p>priorities in keeping with SCPI objectives</p> <ul style="list-style-type: none"> - SCPI helps develop and reinforce the capacity of communities (especially small ones) to respond to homelessness
<p>Sustainable Development Strategy 2007-2009: Coordinating the Fourth Round of Departmental Sustainable Development Strategies</p>	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Federal <p>Departments Involved:</p> <ul style="list-style-type: none"> - Environment Canada - All government departments - Treasury Board - Commissioner of the Environment and Sustainable Development - Health 	<p>Program Focus:</p> <ul style="list-style-type: none"> - Focus is to facilitate a coordinated approach for the fourth round of departmental Sustainable Development Strategies (SDSs) <p>Objectives:</p> <ul style="list-style-type: none"> - Building coherence based on a set of common sustainability goals - Strengthening accountability to Canadians by developing common format standards that will enable roll-up reporting of the federal sustainable 	<p>Facilitating Factors:</p> <p>Multiple government initiatives since early 1990s:</p> <ul style="list-style-type: none"> - 1990: <i>The Green Plan</i> - 1992: The <i>Code of Environmental Stewardship</i> - 1995: Amendments to the <i>Auditor General Act</i> made it a legal requirement for a number of departments and agencies to produce a Sustainable Development Strategy (SDS); and Establishment of the Commissioner for the Environment and Sustainable Development in the AGs Office - 1995: <i>A Guide to Green Government</i> released 	<p>Nature of ISA:</p> <ul style="list-style-type: none"> - Broad policy framework <p>Mechanisms & Tools for ISA:</p> <p>Regular planning process:</p> <ul style="list-style-type: none"> - Development of government- wide goals for SD and departmental requirement to demonstrate their contribution to such 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Supporter <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - Environment Canada as lead - All government departments (departments relate their SDS commitments to support government-wide outcomes, as appropriate to their mandate) - Treasury Board (development of a performance management framework) - Commissioner of the Environment and Sustainable Development (AGs office) 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - Development of a logic model template for federal sustainability goals for use by departments in characterizing their contribution to such - In their SDSs, departments describe their commitments and performance measures to support government – wide outcomes, as appropriate to their mandate. - Departments are responsible for their strategies and reporting on them to 	<p>Indicators:</p> <ul style="list-style-type: none"> - Departments are required to identify essential performance measures to demonstrate progress against the government-wide targets and to enable consistent reporting on results

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		development goals	<ul style="list-style-type: none"> - 1997: 1st round SDSs tabled in Parliament - 2001: 2nd round SDSs - 2004: 3rd round SDSs <p>Challenging Factors:</p> <ul style="list-style-type: none"> - Minimal follow-up to Auditor General's recommendations 			<ul style="list-style-type: none"> - Parliament. - Roll-up reporting provides departments with a comprehensive overview, at the federal level, of the of progress on goals 	
Urban Aboriginal Strategy (2002)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Federal <p>Departments Involved:</p> <ul style="list-style-type: none"> - Indian and Northern Affairs Canada - Federal Interlocutor for Metis and Status Indians - Human Resources and Skills Development Canada - Western Economic Diversification Canada - Canadian Heritage - Canada Mortgage and Housing Corporation - Health Canada/PHAC - Industry Canada - Justice Canada - Public Safety and 	<p>Program Focus:</p> <ul style="list-style-type: none"> - Urban Aboriginal Strategy (UAS) seeks to enhance coordination, improve horizontal linkages and policy integration within the federal government and partner with other stakeholders to better address the needs of Aboriginal people living in urban centres <p>Objectives:</p> <ul style="list-style-type: none"> - Build organizational capacity within urban Aboriginal organizations, groups and communities at the local level 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - Research over the past decade reveals that urban Aboriginal people are much more likely to experience poverty and ill health than other groups - In the late 1990s, over 20 federal departments were managing over 80 programs that were at least partly targeting Aboriginal people living in cities. However, no real interdepartmental mechanisms were in place to ensure proper coordination of these efforts 	<p>Nature of ISA:</p> <p>Targeted:</p> <ul style="list-style-type: none"> - Aboriginal people living in urban centres <p>Mechanisms & Tools for ISA:</p> <p>Information & financial:</p> <ul style="list-style-type: none"> - Agreement among departments to participate and use the UAS Horizontal Terms and Conditions - "Single window" funding - Horizontal coordination is part of planning process; it is one of four primary activities of the UAS logic model 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Supporter <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - Indian and Northern Affairs Canada as lead - Other federal departments: Human Resources and Skills Development Canada, Western Economic Diversification Canada, Canadian Heritage, Canada Mortgage and Housing Corporation, Health Canada/PHAC, Industry Canada, Justice Canada, Public Safety and Emergency Preparedness 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - Demonstration by pilot cities of progress toward the outcomes set forth in the UAS pilot projects 	<p>Indicators:</p> <p>Anticipated outcomes by 2006:</p> <ul style="list-style-type: none"> - Increased policy recognition of urban Aboriginal issues - Increased federal responsiveness to community needs - Increased strategic management of urban Aboriginal issues on a region-wide basis - Increased academic research and interest in urban Aboriginal work - Increased publicly available statistics and research on urban Aboriginal issues

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	Emergency Preparedness Canada	<ul style="list-style-type: none"> - Develop partnerships with provincial and municipal governments, urban Aboriginal organizations, groups and communities to ensure sustainable community development - Coordinate federal government resources across departments in the pilot project cities in order to focus efforts on addressing the disparity between urban Aboriginal and non-Aboriginal people 			<p>Canada</p> <ul style="list-style-type: none"> - Political leaders: Federal Interlocutor for Métis and Non-Status Indians in the lead Minister, supported by the Office of the Federal Interlocutor within DINA - Provincial governments - Municipal governments <p>Non-gov't Sectors:</p> <ul style="list-style-type: none"> - 50) Community groups and Aboriginal organizations 		<ul style="list-style-type: none"> - Identification of best practices - Improved employment capability and job readiness for urban Aboriginal people - Increased skills and abilities of urban Aboriginal peoples <p>Lessons Learned:</p> <ul style="list-style-type: none"> - Widespread support for the UAS exists in government and among most Aboriginal participants, although some Aboriginal groups are not satisfied with a perceived lack of devolution of control of strategy and funds to representative Aboriginal groups - Lack of long-term vision for UAS among participating governments and Aboriginal representatives - Progress has been made in

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							<p>establishing working partnerships with members of Aboriginal communities, across levels of government and within federal departments and agencies; however, partnerships are fragile in some cases</p> <p>- The implementation of the UAS presents some serious challenges and continued support for the initiative will depend overcoming identified barriers</p>
ActNow BC(2006)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Provincial <p>Departments Involved:</p> <ul style="list-style-type: none"> - Ministry of Health - All provincial ministries that touch on key risk factors addressed 	<p>Program Focus:</p> <ul style="list-style-type: none"> - Risk reduction at the population level (primary prevention related to physical activity, nutrition, tobacco use) <p>Objectives:</p> <ul style="list-style-type: none"> - Improved health - Better disease management - Less chronic 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - Healthy Living" was identified as one of BC's five great goals for the current decade - The 2010 Challenge: "To make BC the healthiest jurisdiction to ever host the Winter Olympic 	<p>Nature of ISA:</p> <p>Targeted:</p> <ul style="list-style-type: none"> - People at risk of chronic conditions <p>Mechanisms & Tools for ISA:</p> <p>Institutional arrangement:</p> <ul style="list-style-type: none"> - Establishment of Minister of State for ActNow, 2006, to coordinate the cross-government 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Leader <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - Provincial ministries that touch on key risk factors <p>Non-gov't Sectors:</p> <ul style="list-style-type: none"> - Municipal leaders - Employers - Schools 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - Establishment of government-wide goals - Requirement for each Ministry to achieve established targets <p>Sustainability Mechanism:</p> <ul style="list-style-type: none"> - Ministries are 	<p>Indicators:</p> <ul style="list-style-type: none"> - Decreased morbidity and mortality from chronic disease - Reduction in tobacco use (10%) - Reduction in obesity (20%) - Increased proportion of population that is physically active

	Context			Approach		Impact	
Project Name	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
		<ul style="list-style-type: none"> disease Reduced costs to the health care system 	<p><i>Games</i></p> <ul style="list-style-type: none"> Recognition that the major risk factors for chronic disease overlap Ministry boundaries Increasing proportion of government revenue toward health care budget <p>Challenging Factors:</p> <ul style="list-style-type: none"> Partners expressed concern over short timeframe to meet program expectations/targets 	<ul style="list-style-type: none"> wide health promotion initiative Establishment of BC Healthy Living Alliance to oversee programs to meet established targets 	<ul style="list-style-type: none"> Health-related NGOs (cancer, diabetes, CVD, lung) BC Recreation and Parks Association Sports organizations Food/agriculture organizations Professional associations Private sector businesses 	<ul style="list-style-type: none"> required to review service plans to ensure that ActNow BC objectives are fully considered 	<ul style="list-style-type: none"> (20%) Increased number of adults who eat recommended number of fruits and vegetables per day (20%) Increased number of women counseled about dangers of alcohol use during pregnant (50%)
Manitoba Child Health (2000)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> Provincial <p>Departments Involved:</p> <ul style="list-style-type: none"> Ministry of Health Ministry responsible for Healthy Living Ministry of Aboriginal and Northern Affairs Ministry of Justice Ministry of Culture, Heritage and Tourism Ministry of Labour & Immigration/ Status of Women Ministry of Education, Citizenship and 	<p>Program Focus:</p> <ul style="list-style-type: none"> Helping children (prenatal to 18 years) to reach their potential by working with families to support children within strong communities <p>Objectives:</p> <ul style="list-style-type: none"> Research, develop, fund and evaluate innovative initiatives and long-term strategies to improve outcomes for 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> A cross-government commitment to work together with communities to overcome historical barriers to healthy, strong communities for children and their families. Growing body of research that demonstrates: (i) the value of high quality child care and preschool experiences, (ii) the need for multiyear, early intervention for 	<p>Nature of ISA:</p> <p>Targeted:</p> <ul style="list-style-type: none"> Children and families <p>Mechanisms & Tools for ISA:</p> <p>Institutional arrangement:</p> <ul style="list-style-type: none"> Establishment of the Healthy Child Committee of Cabinet in 2005 Deputy Ministers Committee comprised of DMs from partner departments Health Child Manitoba Office (secretariat) 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> Leader <p>Other Gov't Sectors:</p> <p>Other provincial departments:</p> <ul style="list-style-type: none"> Ministry responsible for Health Living Ministry of Aboriginal and Northern Affairs Ministry of Justice Ministry of Culture, Heritage, Tourism Minister of Labour & Immigration/ Status of Women Ministry of Education, 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> A provincial evaluation strategy engages all partners to inform and support policy accountability Government and communities share responsibility for ensuring that programs achieve their outcomes and are delivered in a cost-effective manner 	<p>Indicators:</p> <p>Extensive performance indicators established as part of annual reporting process. Examples include:</p> <ul style="list-style-type: none"> Success of communities in facilitating healthy early childhood development Improved school readiness Improved physical and emotional health Improved safety and security Learning success

Project Name	Context			Approach		Impact	
	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
	Youth - Ministry of Family Services and Housing	children - Coordinate and integrate policy, programs and services across government for children, youth and families using early intervention and population health models - Increase the involvement of families, neighborhoods and communities in prevention and early childhood development services through community development - Facilitate child-centered public policy development, knowledge exchange and investment across departments and sectors through evaluation and research on key determinants and outcomes of children's well being	families, and (iii) the need for a holistic, accessible, integrated system, involving partnership with parents, children and youth, and communities		Citizenship and youth - Ministry of Family Services and Housing Political leaders: - Ministers comprise the Healthy Child Committee of Cabinet who develop and lead child-centered public policy across government and ensure interdepartmental coordination of programs and services - DMs share responsibility for implementation of the policy across departments Non-gov't Sectors: - Communities are partners with government in the design, governance and delivery of programs - Community agencies and coalitions drawn from: teachers, school divisions, health authorities, Aboriginal		- Improved social engagement and responsibility - Improved reading - Decreased pregnancy rates Lessons Learned: - One initiative showed that improved social behaviors and decreased levels of physical aggression in children - Teen clinic usage has increased - Evaluation findings related to school readiness will be available soon

	Context			Approach		Impact	
Project Name	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
					organizations, faith organizations, advocates for children with disabilities and cultural organizations - Business community - Families, youth and children		
Quebec's Act to Combat Poverty and Social Exclusion (2002)	Level of Gov't: - Provincial Departments Involved: - Ministry of Employment and Social Solidarity - Ministry for the Elimination of Poverty and Exclusion - Secretary of State for the Status of Women	Program Focus: Addressing poverty and social isolation by: - Progressively transforming Quebec into one of the industrialized societies with the least poverty, according to recognized methods for making international comparisons - Improving the economic and social situation of people living in poverty or marginalized by society - Reducing inequalities that specifically affect people in poverty	Facilitating Factors: - Social movements throughout the 1990s to combat poverty including: World March of Women, and the work of the Collective for a Law on the Elimination of Poverty - Quebec's broad definition of poverty: " <i>The condition of a human being who is deprived of the resources, means, choices and power necessary to acquire and maintain economic self-sufficiency or to facilitate</i> "	Nature of ISA: Targeted: - People who live in poverty and face social exclusion Mechanisms & Tools for ISA: Legislation: - The Act provides for collective involvement of national, regional and local partners to coordinate mechanisms to address poverty & social exclusion Institutional arrangement: - Establishment of an Advisory Committee on the Prevention of Poverty and Social Exclusion, composed of 17 members,	Health Sector Role: - Supporter Other Gov't Sectors: - Ministry of Employment and Social Solidarity as leader - Ministry for the Elimination of Poverty and Exclusion - Secretary of State for the Status of Women Non-gov't Sectors: - 22 civil society groups including organizations representing social assistance recipients, housing, literacy and human rights groups, students' organizations and	Accountability Mechanism: - The government action plan (now developed) requires progress reporting on its fight against poverty every three years. It also creates a monitoring agency - The Minister of Employment and Social Solidarity reports to Government on plan activities in the form of an annual report to the government Sustainability Mechanism: - National Strategy to Combat Poverty and	Indicators: - The Act calls for a government action plan that includes measures and targets to monitor progress

	Context			Approach		Impact	
Project Name	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
		Objectives: <ul style="list-style-type: none"> - Promoting empowerment - Strengthening the social and economic safety net - Promoting job access and employment - Promoting the involvement of society as a whole - Ensuring consistency and coordination of action at all levels 	<i>integration and participation in society.”</i> <ul style="list-style-type: none"> - Costs of poverty and related increasing pressure on public finances and the social and economic safety net Challenging Factors: <ul style="list-style-type: none"> - Change in government and resultant limited implementation of the law 	appointed by the Government , including representatives from the various sectors involved: poverty and social exclusion, management, organized labour municipal, community and other sectors of civil society	<ul style="list-style-type: none"> - trade unions - Regional and local communities - People living in poverty 	Social Exclusion is enshrined in law	
Quebec's Public Health Law (2002)	Level of Gov't: <ul style="list-style-type: none"> - Provincial Departments Involved: <ul style="list-style-type: none"> - Ministry of Health and Social Services - All other government ministries and agencies 	Program Focus: <ul style="list-style-type: none"> - Healthy public policy development through law encourages intersectoral action and gives the Minister of Health and Social Services the power to mandate a health impact assessment of any public policy with the potential for significant impact on the health of the population or sub-populations 	Facilitating Factors: <ul style="list-style-type: none"> - Earlier Public Health Protection Act (1972) did not specify <u>how</u> Ministry officials and public health authorities were to carry out their obligations to protect public health - Only province in Canada that has integrated health care and social services within the same government department - Similar 	Nature of ISA: <ul style="list-style-type: none"> - Broad policy framework Mechanisms & Tools for ISA: Legislation & Information: <ul style="list-style-type: none"> - Establishment of a Health Impact Assessment process whereby, policies or programs are judged as to their potential effects on the health of the population, and the distribution of these effects within the population 	Health Sector Role: Health sector as leader: <ul style="list-style-type: none"> - The Act formally establishes “moral authority” of the health sector over other government sectors by mandating healthy public policy - The Minister of Health and Social Services is the official advisor of government regarding all matters concerning public health. He advises other ministers in order 	Accountability Mechanism: <ul style="list-style-type: none"> - Under the Act, the Minister of Health and Social Services is accountable for public health issues to the legislature 	Lessons Learned: <ul style="list-style-type: none"> - The legislation has helped ensure continuity of policy direction despite changes in government - Grouping of health and social services under a single government department has provided a forum to debate socio-economic issues and an administrative structure to incorporate interests and

	Context			Approach		Impact	
Project Name	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
		<p>Objectives:</p> <ul style="list-style-type: none"> - Promote health, provide support for social and community development, and contribute to the reduction of health inequalities - Support policy developers in researching the most positive effect of a policy/program while attempting to reduce or eliminate potential harmful effects - Make available to ministries and organizations responsible for creating policy, the information necessary to make good decisions 	<p>experience within the environment sector which, in the early 1990s, integrated public health concerns into the EAI process</p> <ul style="list-style-type: none"> - Similar experience with health impact assessment in other jurisdictions (Scotland, Ireland, Great Britain, Wales) <p>Challenging Factors:</p> <ul style="list-style-type: none"> - Change to an economically conservative provincial government in 2003 	<ul style="list-style-type: none"> - Funding research to design new tools for assessing <i>a priori</i> and <i>a posteriori</i> effects of public policy on health; as well as support for knowledge transfer that ensures government ministries and agencies are informed about possible health impacts (Funneled through two major university research granting agencies: MHSS and FQRSC) 	<p>to promote health and adopt policies which will favor improvement of the health and welfare of the population. The Minister must further advise the government on such</p> <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - All other government ministries and agencies - Obligation for all ministries to consult the Minister of Health and Social Services when formulating laws or regulations which could have a significant impact on health <p>Non-gov't Sectors:</p> <ul style="list-style-type: none"> - Private sector - Community sector - Contribute to policy assessment process regarding potential impact on sectors outside government. 		<p>values of diverse groups into the policy process</p> <ul style="list-style-type: none"> - Current weaknesses point to the following: limited assessment by the policy proponent in the HIA process, HIA requests are coming at the end of the policy process, difficulty obtaining expert knowledge, no application of HIA to the social determinants of health and no integration of different health determinants (focus to date has been on health protection such as infectious disease and safety) - Difficulty with diffusion of knowledge of HIA process among government departments, politicians and the general public

Project Name	Context			Approach		Impact	
	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
Saskatchewan Human Services Integration Forum (1999)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Provincial <p>Departments Involved:</p> <ul style="list-style-type: none"> - Ministry of Learning - Ministry of Health - Ministry of Justice - Ministry of Community Resources and Employment - Ministry of Corrections and Public Safety - Ministry of First Nations and Metis Culture - Ministry of Youth and Recreation - Executive Council 	<p>Program Focus:</p> <ul style="list-style-type: none"> - Socially and economically vulnerable citizens <p>Objectives:</p> <ul style="list-style-type: none"> - Establish and maintain mechanisms to promote and facilitate interagency collaboration and integrated planning and service delivery - Identify and address barriers to integration - Provide funding and policy support integration - Provide supports to human service providers to facilitate integration - Make the most efficient and effective use of resources 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - Government, human services were broadly defined, including: health, education and training, social, justice, sport and recreation, cultural and housing services - Growing awareness in the early 1990s of the need to work collectively, and in different ways, in order to address the socio-economic and fiscal pressures challenging the province - Precedence established in earlier government initiatives to adopt coordinated approaches to program delivery (e.g., Justice 20001, Health Renewal, Family violence Strategy). 	<p>Nature of ISA:</p> <p>Targeted:</p> <ul style="list-style-type: none"> - Vulnerable population <p>Mechanisms & Tools for ISA:</p> <p>Institutional arrangements:</p> <ul style="list-style-type: none"> - Establishment in 1999 of the Human Services Integration Forum (this came after the Associate and Assistant Deputy Ministers' Forum on Human Services in 1994) - (11) Regional interdepartmental committees coordinate local implementation and undertake planning for continued integration 	<p>Health Sector Role:</p> <ul style="list-style-type: none"> - Leader <p>Other Gov't Sectors:</p> <p>Other provincial ministries comprising the Forum's Steering Committee:</p> <ul style="list-style-type: none"> - Learning - Justice - Community Resources & Employment - Corrections and Public Safety - First Nations and Métis Culture - Youth & Recreation - Executive Council <p>Non-gov't Sectors:</p> <ul style="list-style-type: none"> - School boards - District health board - Regional colleges - Aboriginal organizations - Community-based organizations - Churches - Voluntary services 		
The Vancouver Agreement (2000)	<p>Level of Gov't:</p> <ul style="list-style-type: none"> - Federal - Provincial - Municipal 	<p>Program Focus:</p> <ul style="list-style-type: none"> - Urban (economic, social and community) 	<p>Facilitating Factors:</p> <ul style="list-style-type: none"> - Public health crises declared in Vancouver's 	<p>Nature of ISA:</p> <p>Place/settings approach:</p> <ul style="list-style-type: none"> - Downtown Eastside 	<p>Health Sector Role:</p> <p>Health sector as supporter</p> <ul style="list-style-type: none"> - Direct services, 	<p>Accountability Mechanism:</p> <ul style="list-style-type: none"> - Three-way responsibility for 	

	Context			Approach		Impact	
Project Name	Level of Gov't & Departments Involved*	Program Focus and Objectives	Facilitating & Challenging Factors for ISA	Mechanisms & Tools for ISA	Sectors & Roles	Accountability & Sustainability	Measurement/ Indicators & Lessons Learned
	<p>Departments Involved:</p> <ul style="list-style-type: none"> - Health - Community Services - Economic Development - Housing - Employment - Women and Youth - Food Security - Public Safety and Crime 	<p>development</p> <p>Objectives:</p> <ul style="list-style-type: none"> - Increase economic development - Improve health of area residents - Increase public safety 	<p>Downtown Eastside community in 1997</p> <ul style="list-style-type: none"> - Complex societal issues such as urban decay, crime, drug dealing and use, and rising HIV infection rates, needed multifaceted approach - Political / public pressure to address issues in this community <p>Challenging Factors:</p> <ul style="list-style-type: none"> - Limited precedence to establish a formal agreement for social change/urban improvement across all 3 levels of government 	<p>of the city of Vancouver</p> <p>Mechanisms & Tools for ISA:</p> <p>Information:</p> <ul style="list-style-type: none"> - Written agreement signed by all three governments in March 2000 as an urban development initiative to revitalize the area in partnership with community organizations and business - The Vancouver Agreement was renewed in March 2005. <p>Financial:</p> <ul style="list-style-type: none"> - Cost sharing: Since 2003, \$10 mil each from Federal and provincial governments, as well as municipal funds 	<p>community health care, harm reduction</p> <p>Other Gov't Sectors:</p> <ul style="list-style-type: none"> - Provincial ministries responsible for community services, economic development, housing, employment, women and youth, food security, public safety and crime - Vancouver Coastal Health Region - Vancouver Police Department - Political leaders: Mayor of Vancouver, Appointed Minister Responsible for the Vancouver Agreement at federal and provincial levels <p>Non-gov't Sectors:</p> <ul style="list-style-type: none"> - Private sector business - Community & advocacy groups - Area citizens 	<p>the Vancouver Agreement: Mayor of Vancouver, and appointed Minister Responsible for the Vancouver Agreement at federal & provincial levels</p> <ul style="list-style-type: none"> - "Accountability" is one of the seven guiding principles in the Vancouver Agreement - In August 2003, the Macleod Institute of the University of Calgary was retained to develop the groundwork for accountability and evaluation frameworks 	

Appendix B: The Family Violence Initiative: Federal Departments and Activities

- **Canada Mortgage and Housing Corporation** delivers the Shelter Enhancement Program and in certain circumstances provides capital funding for new emergency shelters and second stage housing.
- **Canadian Heritage** supports family violence prevention projects for off-reserve Aboriginal women, supports prevention activities for non-English/French speaking members of ethno-cultural communities via ethnic media and English/French as a Second Language programs, aims at reducing media violence, and to a limited extent, conducts research and evaluation activities regarding family violence.
- **Citizenship and Immigration Canada** promotes awareness of family violence through citizenship and immigration policies and programs.
- **Correctional Service of Canada** addresses family violence through research, treatment programs and staff training.
- **Department of Justice Canada** reviews, researches and reforms criminal justice legislation and policy, funds community-based family violence projects and provides public legal education and information support regarding family violence.
- **Department of National Defence** conducts awareness and education training for DND and Canadian Forces (CF) personnel on issues of family violence and violence against women. It provides support, counselling and referral services for service members and their families who are victims of family violence.
- **Health Canada**
- **Human Resources and Social Development Canada** collects and disseminates information related to social policy.
- **Indian and Northern Affairs Canada** funds First Nations' emergency shelters and community-based projects on prevention, intervention, treatment and research on family violence.
- **Public Health Agency of Canada** researches the population health consequences of family violence, develops resources and promotes policies, programs and projects that contribute to family violence prevention.
- **Public Safety Canada (PS)** is responsible for protecting Canadians and helping to maintain a peaceful and safe society. Apart from the contributions of PS Portfolio Agencies, Correctional Services Canada and the Royal Canadian Mounted Police, which are listed individually on this web page, the Department addresses the issue of family violence through a wide range of activities such as: promoting public awareness of family violence issues; support for community based initiatives that aim to reduce family violence and other forms of victimization; developing tools, approaches and research that help contribute to safer communities; and providing Aboriginal community policing services.
- **Royal Canadian Mounted Police** supports community-based workshops on victims' issues, sexual assault, and relationship violence, and assists communities in using problem-solving approaches to family violence.
- **Service Canada**
- **Statistics Canada** works to improve the availability of national data on the nature and extent of family violence.
- **Status of Women Canada** supports projects that lead to systemic changes and alternative, long-term prevention strategies.

(Source: http://www.phac-aspc.gc.ca/nfv-cnivf/familyviolence/initiative_e.html)

Appendix C: The Nisga'a Final Agreement

On 4 August 1998, representatives of the Nisga'a Tribal Council, the federal government, and the government of British Columbia initialed the Nisga'a Final Agreement. The Agreement is intended to settle the land claim of the Nisga'a Nation, located in B.C.'s Nass Valley. It includes provisions related to land, resources, financial compensation and governance. Under the Agreement, the Nisga'a have a central government (Nisga'a Lisims Government) and four village governments, similar to local government arrangements, all of whose structures, duties and functions are spelled out in the Nisga'a constitution.

The Agreement provides for Nisga'a law-making powers over matters such as culture and language, public works, regulation of traffic and transportation, land use, and solemnization of marriages. The Nisga'a would continue to provide health, child welfare, and education services under existing arrangements, but could also choose to make laws in these areas. All Nisga'a law making powers would be concurrent with those of Canada and British Columbia. Under the Agreement, powers related to solemnization of marriages, social services, and adoption apply to Nisga'a people throughout the province, with their consent. The Agreement also provides that people residing on Nisga'a Lands who are not Nisga'a citizens will be consulted about and may seek a review of decisions that directly and significantly affect them and can participate in elected bodies that directly and significantly affect them.

The Nisga'a Final Agreement was ratified by the Nisga'a Nation, the British Columbia Legislature, and the Government of Canada and came into effect on May 11, 2000.

(Source: <http://www.parl.gc.ca/information/library/PRBpubs/prb992-e.htm>)

Appendix D: The Vancouver Agreement, 2nd Phase (2005-2010): Goals, Strategies, Outcomes, Priorities

The Vancouver Agreement seeks to add value to the collective work of the government partners and related public agencies through the goals of:

- *Coordination* by increasing the coordinated efforts of the three governments and related public agencies towards desired outcomes in community change and action.
- *Innovation* by increasing innovation and creativity to achieve changes in how public agencies carry out their work together and in partnership with the private and non-profit sectors.
- *Policy change* by identifying government and public agency policy barriers to effective community change and action, and removing or reducing these barriers.
- *Investment* by increasing public and private investments (financial and human resources) towards desired outcomes in community change and action.
- *Monitoring and evaluation* by identifying key indicators as benchmarks to monitor progress and concrete accomplishments.

In pursuing its goals, the Vancouver Agreement focuses on five strategies:

- Facilitate forums and intergovernmental task groups.
- Initiate joint public agency planning processes.
- Support learning through information sharing, research, evaluation and progress monitoring.
- Conduct research into effective approaches and evaluation of joint public agency projects and make recommendations to enhance effectiveness.
- Invest funds in specific public agency projects and lever additional financial and human resources through partnerships with the private sector.

The desired outcomes for more effective government and community performance in specific neighborhoods and on specific city-wide issues include improved conditions for individuals, businesses and the community as a whole in the following areas:

- Growth in the numbers, size and diversity of local businesses, and diversified employment opportunities for local residents.
- Improved health outcomes for local residents, reflecting increased choices and ability to meet basic needs.
- Improved safety and security and addressing the negative impacts of crime.
- Improved and increased housing options, including affordable rental, supported and transitional housing.

Priorities

Discussions with key stakeholders including residents, community and business groups, and from specific populations such as First Nations, women, and people with disabilities, were conducted to arrive at the three key priorities for the second phase of the Vancouver Agreement which continues through March 31, 2010. While the Vancouver Agreement will continue to focus on its original (1st phase) goals, it will extend its work to

include three new priority initiatives in the second phase. These are: Vancouver's Inner-City Communities, the 2010 Inner-City Inclusivity Initiative, the Accessible/Inclusive Cities and Communities Project.

(Source: <http://www.vancouveragreement.ca>)