

**Community Coalitions Capacity  
to Incorporate  
Stroke / Chronic Disease  
Prevention**

**- Issues & Opportunities -**

Ontario Prevention Clearinghouse  
Stroke Prevention Project  
June 2002



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## EXECUTIVE SUMMARY

This report describes three separate but related studies designed to:

- a) Provide a preliminary overview of the health promotion infrastructure in Ontario, and
- b) Identify issues and opportunities to consider as plans develop for a coordinated approach for the primary prevention of chronic disease in Ontario.

Innovative programs, initiated by the former Community and Health Promotion Branch (now the Public Health Branch) of the Ontario Ministry of Health and Long-Term Care have led to major developments in community health promotion coalitions. With the current interest in a comprehensive strategy for stroke and chronic disease prevention it is timely to identify the issues and opportunities for community health promotion coalitions as a part of this system. The three studies in this project contribute to that agenda.

Study 1 provided an initial look at this provincial system from the context of coalitions, especially those working with the risk factors for stroke prevention. As the work progressed, it became apparent that there are many other coalitions, some with a broader mandate than primary prevention, either formed or forming.

The current data shows considerable variation in the geographic boundaries and the audiences targeted. Some coalitions are regional such as the cancer coalitions and can potentially reach a large number of people. Other coalitions work in discrete communities or are linked to health unit regions such as the heart health coalitions.

Similarly, the mandates of these coalitions vary widely with some doing primarily advocacy (e.g. tobacco coalition) whereas others work at a strategic planning level and coordinate groups that may cover the complete spectrum of care from primary prevention to treatment to palliative care. Others are focused on primary prevention through healthy lifestyles programming and policy development.

The health promotion coalitions have different sponsoring organizations that may not be linked to a broader system (i.e. the public health). There may be different roles performed by sponsoring organizations and some coalitions may lack the support that has been available through the provincial OHPRS.

The findings show that many coalitions whose work is primary prevention are active in communities across Ontario. However, this infrastructure consists of coalitions in varying stages of development, with unique mandates, different models for development and support and different geographic boundaries and regions. The large and growing number of coalitions working in health promotion raises questions about ways to build a coordinated network for chronic disease prevention.

Study 2 compared coalitions working in the Ontario Heart Health Program. The models used by 'expanded' heart health coalitions (coalitions working in health promotion of heart disease as well as at least one other chronic illness) are compared to those who are

working in heart health exclusively. The factors assisting coalitions to expand their mandate as well as the barriers they have overcome were explored.

Numerous differences were found between expanded and not expanded coalitions. Overall, coalitions who have expanded beyond heart health have demonstrated more active partnership recruitment and involvement and leadership by the coordinator. Overall, the expanded coalitions tended to present as more active, dynamic, opportunistic coalitions whereas not expanded coalitions appeared to be stalled or in a holding pattern. Specific findings include the following:

- Expanded coalitions tended to have larger and more active steering committees.
- Expanded coalitions had higher recruitment of new members during year 3 of the OHHP (which was before and during the time expansion issues were being discussed).
- Expanded coalitions tended to emphasize the community mobilization function of the Coordinator, whereas not expanded coalitions tended to focus on a communication/coordination function.
- Human resources (i.e. coalition membership and leadership of the coordinator) were identified as major support factors for expansion.
- Although the turnover of heart health coordinators was comparable between the two groups, there were differences in perception. The not expanded coalitions perceived the turnover to be a greater problem than expanded coalitions. Also, not expanded coalitions were without a coordinator for a longer period of time.
- Health units from expanded coalitions reported that a higher priority was given to heart health in the year 2000 compared to health units from the not expanded coalitions (statistically significant comparison,  $p < .05$ ).
- Health units from expanded coalitions also tended to have a higher coordination of tobacco, nutrition and physical activities within their organization.
- Expanded coalitions had begun discussing expansion earlier than non-expanded coalitions, used more processes and were more favorable to further expansion into chronic disease prevention.
- Not expanded coalitions tended to have a higher number of coalition members from public health.
- Not expanded coalitions described more difficulties in maintaining community partners because of reporting and documentation.
- Health units from not expanded coalitions had a stronger perception of barriers that they believed were inhibiting heart health promotion in their communities.

These results suggest that the strongest, most basic requirement for expansion capability is to have a local structure with strong leadership along with shared ownership. What appears to be essential is a full-time coordinator who has strong community mobilization skills.

These results also support a sponsoring agency role where leadership/support is provided in the context of a coalition with shared ownership among all partners in the coalition. Such a structure leads to more engaged, active partners and more active processing of expansion possibilities.

Coalitions also faced challenges to their expansion capability. One challenge was related to the impacts of funding uncertainty. Another challenge related to the nature of the community, especially for regions with a population widely dispersed. Program requirements for the OHHP i.e. planning and reporting, were identified as an inhibitor to expansion.

However, the provincial coverage of the OHHP coalitions, their broad risk factors, the successful partnerships and examples of community mobilization to a chronic disease shows a potential for OHHP coalitions to become chronic disease prevention coalitions. However, further learning and developments are needed to bolster OHHP expansion.

In Study 3 a small sample of health promotion coalitions working with other risk factors or diseases was studied to determine capacity to expand to a chronic disease approach.

Differences in coalition structures highlighted the unique cultures and values that develop in coalitions. Although each structure appeared to fit the needs of the members, the variability may create challenges in collaboration across coalitions.

In all coalitions, the role of coordinator was recognized as essential for the ongoing survival of the coalition. This role, requiring community development and community mobilization expertise, coordinates the issues from the community, brings and keeps partners around the table and balances the coalition's relevance to the needs of the community with the funded mandate from the MOHLTC.

One difference between the groups of coalitions was their perspectives about expansion to chronic disease. Although most heart health coalitions were in favour of broadening their mandate to a chronic disease approach, most of the Focus communities and the cancer coalition did not see their mandate expanding to other diseases.

There was some indication that the work of other coalitions was not always well understood and in a few cases there were expressed concerns about competition for partners by other coalitions.

### **Issues and Opportunities**

- There is readiness and openness in a maturing primary prevention infrastructure to form a network for the primary prevention of chronic disease.
- Examples and models of integration of stroke and other chronic diseases are developing.
- There has been growth in knowledge about the critical success factors and impediments for effective coalition development and functioning and resources to support coalition functioning.
- There are perceived benefits projected of working in a chronic disease framework.
- There is a concern about the fragmentation in our current system.

- Definition of community and appropriate segmentation of audiences and geographic areas to address chronic disease prevention is needed.
- Uncertainty of sustained provincial funding is having a negative impact.
- Effective approaches to health messages need further study.
- Partnership development is complex and requires highly skilled leadership. Methods to support partnership development needs to be developed.
- Diversity in partnerships and the potential for value conflicts in broad coalitions need further study.

## INTRODUCTION

This project was initiated as part of a larger initiative of the Ontario Prevention Clearinghouse Stroke Strategy which includes the report: *Stroke in Ontario: Towards an Integrated Approach to Primary Prevention*.<sup>1</sup> It evolved into a collaborative project with the provincial evaluation of the Ontario Heart Health Program, in order to maximize learning and the application of findings, and to minimize response burden by local coalitions.

Multi-sectoral community coalitions are widely used to address health problems such as heart disease, smoking, alcohol and drug abuse. An extensive literature base demonstrates the use of partnerships and coalitions for health promotion. This report describes three separate but related studies designed to a) provide a preliminary overview of the health promotion infrastructure in Ontario, and b) identify issues and opportunities to consider as plans develop for Ontario to move towards the primary prevention of chronic disease.

Specifically, this report provides a comparison of coalitions; some that have initiated an expanded mandate, and others who have not. It compares and contrasts coalitions working in different programs and with different mandates. Factors that support heart health coalition expansion to a chronic disease approach were studied.

### Context

A number of current initiatives are in place or developing in Ontario that impact on health promotion.

- The province is developing strategies, notably for cancer, stroke, diabetes and asthma. Each of these strategies has a preventive component. Despite considerable overlap in the content of these preventive components, there is a tendency developing to have separate funding, infrastructure and accountability within each strategy. The mechanisms to resource and deliver these preventive components at the local level are not well worked out;
- A number of provincial Health Promotion Resource Centres are moving to more closely coordinate their activities into a single system;
- The province has a mature tobacco control strategy and is in the process of developing nutrition and physical activity strategies following similar models;
- The Ontario public health system through its Mandatory Health Programs and Services Guidelines has a mandate to develop and deliver a Chronic Disease Prevention Program;
- Through the Ontario Heart Health Program (OHHP), there are in place 37 community coalitions to foster local partnerships to prevent heart disease and promote heart health; and

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<sup>1</sup> *Stroke in Ontario: Towards an Integrated Approach to Primary Prevention* by Steve Manske; Christina Mills; Maureen Dobbins; Roy Cameron. *Centre for Behavioural Research and Program Evaluation*, June 2002.

- Parallel community initiatives have developed for the risk factors of alcohol (Focus) and tobacco and for cancer prevention.

There exist at present, in Ontario, innovative strategies, resources and capacity to prevent chronic disease. However, the funding and positioning at the provincial level have tended to be through disease-based packages, which has resulted in a somewhat fragmented approach at the local level. Through the experience with the Continuation Working Group (CWG) and the Stroke Strategy, there has been some preliminary work done to examine ways to broaden current health promotion initiatives beyond a single disease focus.

In Ontario, a broad based delivery system for primary prevention has been evolving over the past 20 years. This system includes:

- The provincial government who through funding practices establishes roles and mandates for health promotion through-out the province;
- For profit NGO's with multiple mandates and direct links to local community health promotion organizations;
- Not for profit provincial organizations usually directly linked to the province by funding to provide service and resources to local communities;
- Coalitions with diverse values, mandates, governance and players;
- Individuals with different values experiences and roles, some of whom act within work groups, organizations or coalitions.

Innovative programs, initiated by the former Community and Health Promotion Branch of the Ontario Ministry of Health and Long-Term Care have led to major developments in community health promotion coalitions. The OHHP through its application process and program structure has contributed to formation of and evolution of heart health coalitions across every health region in the province. Similarly, through the Focus Community Program community coalitions began in 9 and are now working in 22 communities to prevent substance abuse problems. With the broader Ontario Health Promotion Resource System and other initiatives, other creative approaches to coalition models have been used. An extensive variety of tobacco coalitions and councils exist across the province, as do community driven coalitions facilitated by skilled community animators from the Healthy Communities Program and active living facilitators from the Active Living Community Action Project (ALCAP).

Funding for the active living facilitators has ended and both OHHP and Focus program funding ends in March 2003. It is therefore timely to identify the issues and opportunities for community health promotion coalitions. The three studies in this project contribute to that agenda.

This project is rooted in the direct experiences of the Ontario Heart Health Network. With OHHP funding until March 2003, leadership within the Ontario Heart Health Network formed the Continuation Working Group (CWG) to explore opportunities for sustainability and growth. The CWG proposed that the OHHP coalitions become a stable part of a more coordinated system to prevent chronic disease.

As part of the consultation process for the CWG plan, heart health coalitions were asked if they were in favor of a broader chronic disease prevention role. Eighty-seven percent said they were in favor. Further, 15 coalitions (39.5%) had already expanded their work beyond heart health, with most of these coalitions including cancer prevention (13/15), and/or diabetes (8/15) and/or stroke (6/15). The Ontario Heart Health Network's Continuation Working Group has recommended building on the existing capacity of heart health coalitions to promote a broader chronic disease prevention strategy at the community level.

This work provides a snapshot of some of the health promotion coalitions across Ontario. The work is reported in three parts.

Study 1 provides an initial look at this provincial system from the context of coalitions, especially those working with the risk factors for stroke prevention. An attempt was made to include other coalitions with similar mandates. However, due to the complexity it is noted that the picture is not complete. As the work progressed, it became apparent that there are many other coalitions, some with a broader mandate than primary prevention, either formed or forming.

Study 2 offers a comparison of coalitions working in the Ontario Heart Health Program. The models used by 'expanded' heart health coalitions (coalitions who are including the prevention of heart as well as at least one other disease) are compared to those who are working in heart health exclusively (not expanded). Factors assisting coalitions to expand their mandates as well as the barriers overcome are explored.

In Study 3 a small sample of health promotion coalitions working with other risk factors or diseases was studied. As with the OHHP coalitions, results are presented about the coalition functioning with an attempt to determine capacity to expand to a chronic disease approach. Part 3 includes a discussion of similarities and differences between heart health and other coalitions, primarily Focus coalitions.

## **STUDY 1: A Preliminary Profile of Some Health Promotion Coalitions in Ontario**

This part provides an initial look at the provincial system from the context of coalitions, especially those working with the risk factors for stroke prevention. An attempt was made to include other coalitions with similar mandates. However, due to the complexity in the health promotion system in Ontario the picture is not complete. As the work progressed, it became apparent that there are many other coalitions, some with a broader mandate than primary prevention, either formed or forming.

### **METHOD**

Web sites of the Ontario Health Promotion Resource System (OHPRS) were reviewed to identify community coalitions as well as key contact information. Key informant interviews were conducted to identify additional community coalitions. Descriptions of coalitions supported by the OHPRS and some others were summarized.

### **RESULTS**

Review of the web sites of the OHPRS and their links identified a wide variety and number of coalitions operating in communities. The following OHPRS coalitions were identified: Health Communities, Heart Health, Focus, Tobacco and Active Living Coalitions (in transition). These coalitions are described below.

Also, from key informant interviews a variety of other coalitions were identified. Some new disease specific coalitions were identified, cancer and diabetes, as well as a number of others, some that are in early stages of development. See Table 1.

This summary describes an infrastructure of community coalitions that are working primarily in primary prevention. The description does not address the relationships between coalitions operating in the same communities. What is not addressed is the degree of collaboration occurring between coalitions and similarly the degree of competition in terms of resources and audience attention.

Appendix 1 lists the coalitions by geographic regions.

**Table 1: List of Health Promotion Coalitions – May, 2002<sup>2</sup>**

<b>TYPE OF COALITION</b>	<b>OHPRS – COALITIONS</b>	<b>NON-OHPRS COALITIONS</b>
A. Generic – Health Promotion	Healthy Communities *	
B. Disease Specific	Heart Health*	Cancer Regional Networks*
		Diabetes Coalitions
C. Risk Factor Specific	Tobacco Coalitions (OTN)*	Community Partnership Programs – Breakfast for learning
	FOCUS Communities (Alcohol) – community based *	Injury and Family Abuse Coalitions
	Active Living – model under development	Anti-poverty coalitions
	Community Action Teams (OPHEA) – physical activity	
	Nutrition networks – health unit dieticians	
D. Channel Specific		Health Promoting Hospitals (workplace health)
		ELMA (Employee Lifestyle Management Alliance) – workplace coalitions
		Dental group
E. Audience Specific		Healthy Pregnancy and Child Development Coalitions
		Rural Women’s Coalition
		Ontario Fathering Initiative

\* Described below

## **GENERIC COALITION**

### **Healthy Communities**

The Ontario Healthy Communities Coalition (OHCC) seeks to achieve social, environmental, and economic health and well-being for individuals, communities and local governments. By bringing together a broad-based group of communities and provincial organizations, spanning the social, environmental, economic, and political spectrums, coalition members share a common goal of creating healthier communities.

<sup>2</sup> Material is presented from organizations’ websites and from interviews with key contact people.

They actively support the Healthy Communities movement by building networks and establishing new methods for planning and decision-making.

The support of provincial associations has been very important throughout the development of the OHCC, and will remain so in the future. The associations form a valuable network for reaching into communities with the Healthy Communities message, and provide support to the OHCC through resources and in-kind services.

Provincial Association members of OHCC include:

- Association of Local Official Health Agencies (ALOHA)
- Association of Ontario Health Centres
- Economic Developers of Ontario Inc.
- Federated Women's Institutes of Ontario
- Local Employment and Trading Systems (LETS)
- Ontario Association of Landscape Architects (OALA)
- Ontario Prevention Clearinghouse (OPC)
- Ontario Professional Planners Institute (OPPI)
- Ontario Public Health Association (OPHA)
- Ontario Social Development Council (OSDC)
- Ontario Society for Environmental Management (OSEM)
- Parks and Recreation Federation of Ontario
- Social Planning Network of Ontario

Ontario Healthy Communities provides support to communities through regional Community Animators (resource persons) who have expertise in community development, strategic planning and facilitation. They work closely with communities to identify and provide the training and development requirements.

The Healthy Community Coalition's goals and objectives are to:

- Encourage collaboration among community groups and support the planning and implementation of Healthy Communities initiatives within local communities
- Assist in planning local and regional activities
- Link local and regional leaders and organizations
- Assist local groups with the media promotion of their activities
- Provide opportunities for members of local communities to network and share information with other communities
- Provide consultation and facilitation services on such topics as:
  - consensus and coalition building
  - conflict resolution
  - fundraising
  - strategic planning
  - visioning
- Increase awareness and understanding of OHCC and the benefits of the Healthy Communities movement within their region.

Community animators are invited in at the grass roots level e.g. to assist in planning a community event. They assist in networking groups, help share stories and do a professional assessment. They do have a proactive role, which is negotiated by the animators. The healthy community animators strive for long-term influence of public policy – economic, social-environmental.

Animators are valued at the community level because they are highly skilled, and are neutral. They are not aligned with any specific group. They try to avoid duplication, increase coordination and over time, get to know who might be doing similar work in an area.

Healthy Community animators and local initiatives are supported by the Ontario Healthy Communities Centre. The Centre receives approximately 50% of its funding from MOHLTC with additional funds from Health Canada and Environment Canada's joint Community Animation Program, the Ontario Trillium Foundation, and from donations, sales of goods and services and other sources.

### ***Unique Features***

- Focus is on social, environmental and political conditions more than behaviors
- Highly skilled neutral local facilitators
- Facilitators have provincial coverage
- Connections formed with provincial partners

## **DISEASE SPECIFIC**

### **Heart Health Coalitions**

In 1990, the Heart Health Action Program provided funding to five Ontario communities for a five-year demonstration project. Two of these funded projects built on existing heart health initiatives whereas three were new. Initial funding was \$250,000 per year to new sites and \$125,000 per year to existing sites.

The five demonstration sites were to establish community-based heart health programs and to take a community development approach. They were given a task of building commitment to community heart health initiatives among local individuals and organizations.<sup>3</sup>

In 1998, the Community and Health Promotion Branch and Public Health Branch (MOHLTC) implemented the Ontario Heart Health Program (OHHP). This province wide program provided \$3.4 million per year for five years. Communities were required to provide \$2 in-kind contribution to every \$1 in funding received from MOHLTC. The health units sponsor all but one heart health project.

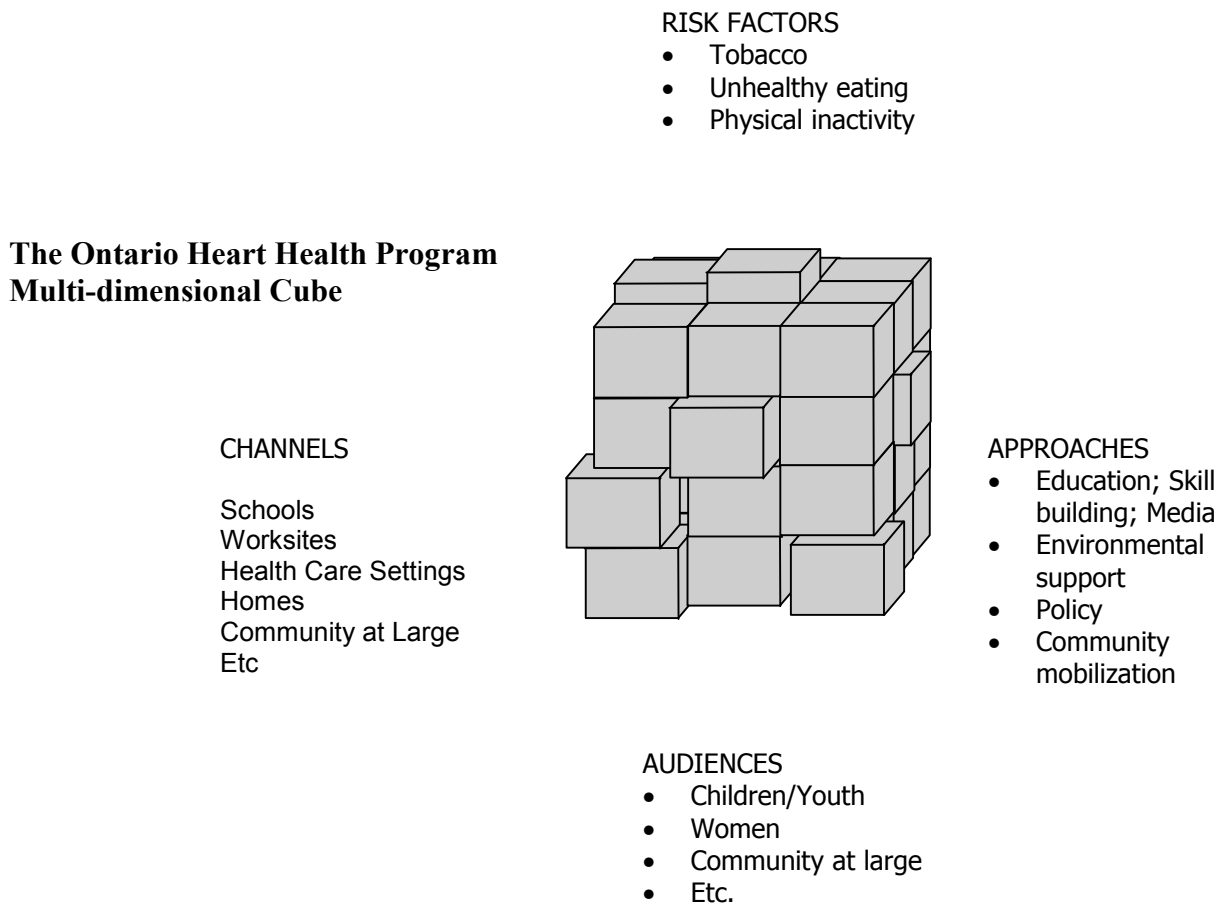
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<sup>3</sup> The Heart Health Action Program, Final Evaluation Report, December 1995, 4.

The goal of the OHHP is to reduce the prevalence of the modifiable risk factors (smoking, physical inactivity and unhealthy eating) associated with cardiovascular disease. The provincial objectives are grouped into three categories: programming, knowledge, and behavior.

The framework is the health promotion cube. Heart Health coalitions are mandated to address the three behavioral risk factors of tobacco, unhealthy eating and physical inactivity, using a multi-risk factor approach, and a variety of approaches and channels to reach a variety of audiences. See Figure 1.

Figure 1: **Health Promotion Framework**




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Local heart health projects are required to build on and develop clear links between the project and other heart health activities within the community. The intent is to support long-term sustainability for heart health initiatives by using more long lasting approaches to health promotion and develop connections with existing structures to support heart health programs. Many report links with the Mandatory Programs offered by the Health Unit.

At this time, 37 OHHP coalitions are funded until March 2003. These coalitions are supported by the OPHRS and by a specifically designated one, the Heart Health Resource Centre. The OHHP Coalitions are described in detail later in this report.

### *Unique Features*

- Provincial coverage of heart health coalitions by linking them to Health Units
- Healthy lifestyles approach used predominantly positions them to expand into chronic disease prevention
- Strong networking within the heart health system with demonstrated internal leadership for innovation (OHHN and CWG)

### **Cancer – regional networks**

Cancer Care Ontario (CCO) does most of its work through eight regional divisions across the province. These divisions, called CCORs, include networks of all those who provide cancer services, from family doctors, cancer centres and hospitals to home care agencies and the Canadian Cancer Society. Membership includes at least 40-50% survivors, family or patients. Other members tend to be health professionals from the host hospital and community. They provide for a continuum from primary prevention through to palliative care.

Cancer networks include members from the CCO board and community representatives and the Canadian Cancer Society. Medical Officers of Health chair six of these coalitions. The geographic regions differ from the broad health regions in Ontario and link to the Regional Cancer Centres.

Networks have been formed in clinical areas such as radiology, supportive care, surgical oncology and education (e.g. Continuing Medical Education), and prevention and screening. The latter work closely with the tobacco coalitions and with the public health departments. They have been encouraged to work with the heart health coalitions. Network coordinators are staff of the treatment facilities.

The Terms of Reference for the Ontario Network for Cancer Prevention include to:

- Coordinate the primary prevention activities of the Cancer Care Ontario Regions (CCORs) Prevention and Screening Networks.
- Provide advice to the Head, Division of Preventive Oncology, about the prevention activities of CCO.
- Provide a forum for discussion about key prevention issues and strategies for Ontario.
- Act as an advocate for cancer prevention.

As part of a strategic planning process, the Central East Network has identified its support for the establishment of the Toronto Cancer Prevention Coalition. The goal is to reduce cancer incidence by creating a high profile and effective multi-stakeholder coalition that advocates for prevention policy, education and action at the local

government level and beyond, and planning for the Cancer Prevention Policy Conference.

### *Unique Features*

- CCORs (Regional Networks) provide leadership for their region
- Regional network membership tends to include key decision makers e.g. MOHs
- Prevention subgroups responsible for primary and secondary prevention

## **RISK FACTOR SPECIFIC**

### **Tobacco Coalitions**

Tobacco coalitions began forming in mid 1970's with about 30 operating by the mid 1980's. Expansion has occurred over the past 5 years with 71 tobacco coalitions currently operating. Tobacco councils or coalitions may be as small as 1 or 2 people or as large as 20 or more members.

Tobacco councils are active in tobacco control activities including advocacy for smoke free public places, and workplaces. They are not accountable to their local health department and in fact need to remain independent to be able to do advocacy. Health units are frequently a department of the municipality and are not able to be involved with advocacy work directly. Health unit staff tend to work closely with the councils (e.g. doing background research etc), but the tobacco coalitions do the public part of the work e.g. presentations, canvassing etc.) In many cases, the coalition is "run" by a health unit staff person, who participates as part of a tobacco control role in the health unit. Some are linked to heart health coalitions whereas some consist completely of volunteers. Membership is recruited at the local level and these coalitions appear to be self-sustaining.

The councils reportedly operate on a "shoe-string" budget, with meeting space donated by the health unit and receive donations from Heart & Stroke (H&S) or the Lung Association. They may receive community grants (about \$2000) for Non- smoking Week Activities.

Their most promising accomplishment is in by-law development. In some communities this has generated a lot of volunteers. Currently, smoke free bylaws cover over half the population. Northern Ontario is less well covered and has higher smoking rates and different reactions to bylaws and regulations and controls.

### Work with other coalitions

- When heart health coalitions started there were some struggles for membership. H & S members often left the tobacco coalitions and became part of heart health. People complained about multiple meetings, being asked to sit on numerous heart health subcommittees e.g. tobacco representatives were requested on workplace, school, community at large where tobacco was a risk factor.

- Some tobacco coalitions may work with Healthy Communities and with Focus communities at the local level.
- In the North they are located in smaller geographic regions, serving a smaller population.

The tobacco coalitions have a history of growth over the past years. They have no paid staff but do receive resources and support from the provincial organization, the Ontario Tobacco-Free Network (OTN). They are linked to other tobacco councils by a list serve. Membership recruitment is an ongoing issue.

Re: Chronic disease prevention (CDP) - Tobacco coalitions would probably continue to work as they are currently doing. Some might want representation on a CDP coalition whereas others would want to stay independent. They might be integrated on the community education, smoking cessation and smoking prevention side.

#### The Ontario Tobacco-free Network (OTN)

OTN is a provincial interagency network consisting of the Canadian Cancer Society, Ontario Division, the Heart and Stroke Foundation of Ontario and the Ontario Lung Association. The network is funded by the Ministry of Health and Long Term Care and supported in-kind by the head offices of CCS, HSFO, OLA and the Ontario Campaign for Action on Tobacco (OCAT).

The OTN helps link the local interagency smoke-free councils coordinated by public health staff and community volunteers, to these grassroots agencies. The mandate is to support the provincial local tobacco-free councils in their tobacco control educational and advocacy work throughout Ontario.

OTN's role is to support by offering information and resources and encouraging collaboration with local health agencies. Their role is not to mandate the coalitions and there are many differences in the local coalitions.

#### ***Unique Features***

- Tobacco coalitions appear to be self sustaining with very little direct funding
- Continuous growth in number across Ontario
- Very strong support from health units

#### **Focus**

The Focus Community Program is an initiative of the former Community and Health Promotion Branch in partnership with the Emergency Health Services Branch. The goal of the Focus Community Program is to prevent problems, including injuries, associated with alcohol and other drug use and like the OHHP, uses the cube as its framework. This program has funding until March 2003.

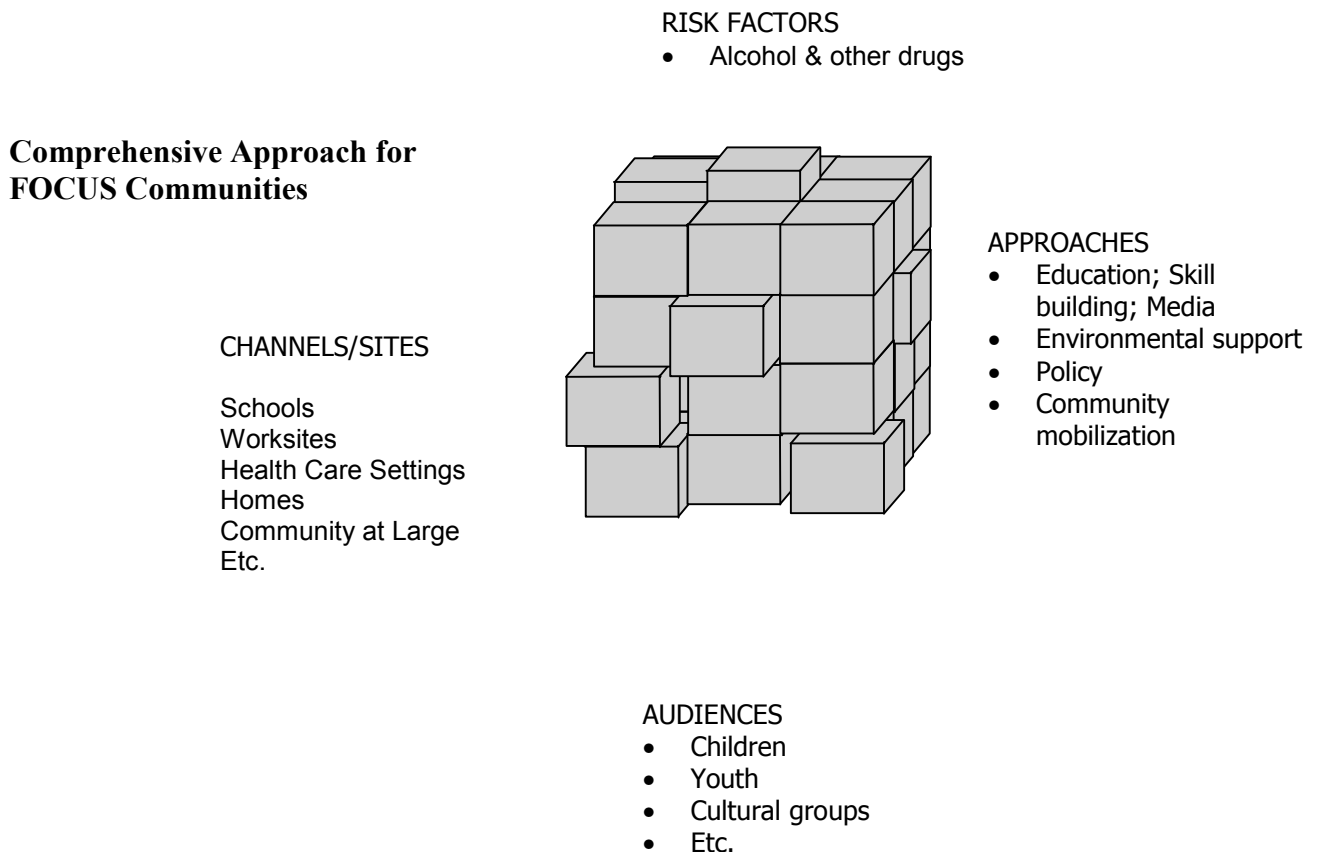
Focus Communities began in 1991 with 9 demonstration sites selected because of community capacity and community issues. The initial approach was on illicit drugs. In 1993 the Provincial Strategy for Substance Abuse Prevention was formed with a subsequent shift to include alcohol prevention in the Focus Communities. In 1996, two Healthy Lifestyles Coalitions joined the original 9, then in 1998 the number of Focus Communities increased to 22. In 1998, funding was given for 5 years.

Of the 22 Focus sites, eight are sponsored by health units with others sponsored by community organizations or centres, or centres for addiction and mental health.

Coordinators are hired for their knowledge and understanding of community development and capacity building, understanding of health promotion and how it works with the community. Although the knowledge of alcohol and other drugs is important, the feeling is that it can be readily learned. Other assets include project management and experience in working with a coalition.

Focus Communities are supported by a provincial resource centre, The Focus Resource Centre.

Figure 2:



### *Unique Features*

- Focus communities were selected according to specific community needs and community capacity.
- Most Focus coalitions are in jurisdictions smaller than health unit jurisdictions
- They have a variety of sponsoring organizations (Centres for Addiction and Mental Health, health units, hospitals)
- Although working with a healthy lifestyles approach, Focus Communities work within the mandate of drug and alcohol prevention and injury prevention related to drug and alcohol.

### **Active Living Community Action Project (ALCAP)**

The Active Living Community Action Project (ALCAP) supports local physical activity leaders through Community Facilitators who increase awareness about active living. They conduct training, encourage collaboration between groups, and support the planning and implementation of active living programs.

The four ALCAP Community Facilitators provide a multitude of services and support to leaders year round. Their areas of coverage in Ontario are Northwestern Ontario; Northeastern Ontario; Southern Ontario; Greater Toronto Area. This program which has been in operation for 6 years with funding operating the end of June 2002. It is being reformed based on a planning document currently under discussion. Most coalitions are reportedly self-sustaining with the ALCAP facilitators playing an advisory role. Many are linked to health units usually through the heart health initiative.

A new resource centre is in formation.

### **AUDIENCE SPECIFIC COALITIONS**

#### **Healthy Pregnancy and Child Development Initiative**

Using a population health approach, health units have received funding from MOHLTC for a Healthy Pregnancy and Child Development Initiative in collaboration with existing services, programs and organizations. The intent is to establish and /or strengthen collaborative, multi-sector community-based projects in the area. The project targets people planning pregnancies, expectant parents, and families and caregivers of children aged 0-6 years. This initiative is just beginning.

#### **Injury and Family Abuse Prevention**

Using a population health approach, health units have recently received funding from MOHLTC for an Injury and Family Abuse Prevention Initiative. This initiative is to develop a multi-sector coalition and 4 year plan to address childhood injury (0-6 years of

age) and family abuse prevention (directed toward children 0-6 years of age and/or pregnant women).

## **DISCUSSION**

An infrastructure of coalitions whose work is primary prevention is currently in place across Ontario. These coalitions frequently have unique mandates, use different models for development and support and therefore provide a unique opportunity for learning.

The current data shows considerable variation in the audience for different coalitions. The geographic boundaries and regions vary, as do the audiences targeted. Some coalitions are regional such as the cancer coalitions and can impact a large number of people. Other coalitions such as the tobacco coalitions are numerous, with over 60 reported at this time, but tend to have smaller community boundaries. Heart health coalitions are tied to the health unit regions, CCORS are associated with Regional Cancer Centres, Focus Communities are based in selected communities identified as high risk and with recognized capacity to support the coalition.

Similarly, the mandates of these coalitions differs, with the regional cancer networks involved in strategic planning and coordinating subgroups that may cover the complete spectrum of care from primary prevention to treatment to palliative care. In contrast, tobacco coalitions advocate for tobacco control legislation within their municipality.

These coalitions have different sponsoring organizations who may not be linked through a broader system. There may be different roles performed by sponsoring organizations and some coalitions may lack the support that has been available through the provincial OHPRS. The provincially funded coalitions (Heart Health, Focus) receive support from a designated resource centre as well as by a system of resource centres (OHPRS). With new coalitions forming such as in cancer and diabetes, a question to be explored would be the accessibility of these new coalitions to OHPRS support.

Another difference is in the positioning of work. For example, the behavioral approach used by the heart health coalitions is different from the broader social environmental mandate for healthy communities. Yet another difference between these coalitions is their approach to sustainability. Coalitions within the OHHP and in Focus are involved in sustainability planning in order to maintain not only their interventions but also their coalitions. In contrast, the healthy communities coalitions seek to sustain healthy communities through healthy public policy and appear to place less emphasis on ongoing sustainability of local coalitions.

Current funding for several of the programs sponsoring these coalitions is ending within one year. The question raised is are these coalitions sustainable without Provincial Program Funding.

The large and growing number of coalitions working in health promotion raises questions about ways to build a coordinated network for chronic disease prevention. With the variability noted, communication and collaboration across coalitions may be challenging.

This snapshot of the health promotion coalitions in Ontario forms only a part of the picture. Further research would be useful to:

- Identify a more comprehensive list of coalitions working in primary prevention;
- Compare mandates and missions for these coalitions vis a vis primary prevention;
- Clarify the roles of provincial and local organizations in forming and sustaining the coalitions;
- Obtain information about reach and program outcomes for existing coalitions.

## **STUDY 2 Factors Influencing the Expansion Process Among OHHP Coalitions**

### **STUDY QUESTIONS**

1. What factors and conditions support heart health coalitions to expand their mandate beyond heart health?
2. What factors and conditions inhibit heart health coalitions from expanding their mandate?

### **METHODS**

#### **Design and Sample Selection Process**

This study compared characteristics and processes between two groups of OHHP coalitions: one group of coalitions that had expanded their mandate to address one or more diseases other than heart health (e.g., diabetes, cancer, stroke), and another group of coalitions that had not expanded their mandate.

Coalitions self-identified as expanded or not in a survey completed between December 2001 and January 2002. The survey was included as part of the review of the initial plan for the continuation of the OHHP, prepared by the Continuation Working Group on behalf of the Ontario Heart Health Network. Fifteen of the 37 heart health coalitions identified that they were offering prevention initiatives in one or more disease areas including stroke, cancer, diabetes and osteoporosis. These coalitions were defined as 'expanded' for the purposes of sample selection for this study.

A sample of 16 OHHP coalitions was selected for this study. The sample size was determined based on two main criteria: the ability to provide meaningful results while minimizing response burden on the local projects. Eight pairs of coalitions were selected, matched as closely as possible on characteristics other than expanding or not to address chronic diseases other than cardiovascular disease. The sample was selected to represent diversity more than central tendency, in order to provide the most meaningful results for Ontario.

Information from the CWG survey and the provincial evaluation of the OHHP was used to characterize coalitions on a number of matching criteria. Essential criteria to meet for matched pairs were as follows:

- at least three pairs with coalitions that started before the OHHP (i.e., <1997) and three that formed for the OHHP
- at least three pairs with <3 Heart Health Coordinators during the first three years and three pairs with >3 Heart Health Coordinators (preferably including cases with a high number of months without a Coordinator for those with high turnover)
- at least two coalitions addressing stroke
- at least one coalition addressing two or more diseases in addition to heart health
- at least two pairs from northern Ontario and two pairs from Southern Ontario

- at least one pair from eastern Ontario, one pair from western Ontario, and one pair from central Ontario

A number of additional criteria were also considered. To the extent possible, the sample also included:

- at least one pair with a high population density and one pair with a low population density
- at least one pair with additional funding and one pair without (i.e., <\$5,000 additional revenue)
- at least one pair with high per capita funding from the province and one pair with low per capita funding
- at least one pair with a high number of coalition members and one with a low number (indicator of size of coalition)
- at least one pair with a high number of public health members and one with a low number (indicator of public health participation)
- at least one pair with a high level of implementation and one with a low level
- at least one pair with a large increase in implementation from 1994 to 2000 and one with a small increase
- at least one pair with an increase in implementation from 1997 to 2000 and one with a decrease in implementation

Expanded coalitions were selected first to meet the essential criteria. For each expanded coalition, a coalition that had not expanded was selected from the same health region. The coalition selected was the one that was as similar as possible on essential and additional criteria (above).

Two electronic messages (see Appendix 2) were sent to all Heart Health Coordinators to provide background on this study. Then an initial telephone contact was made to the selected 16 coalitions to invite their participation. The telephone contact was also used to verify status as expanded and not expanded. Three of the selected coalitions were replaced based on changes since completing the CWG survey.

The resulting sample included 16 coalitions that met the essential criteria. During data collection, one coalition that had self-identified as 'expanded' was judged to be 'not expanded'. This coalition was included in the 'not expanded' group for analyses; thus, 9 coalitions were included in the 'not expanded' group and 7 in the 'expanded group'.

A detailed description of the coalitions is included in the results section, since characteristics of the coalitions were used to help understand the reasons for expansion to a broader mandate.

### **Data Collection and Analysis**

This study included a quantitative component and a qualitative component, as follows:

## **Quantitative Component**

The main purpose of the quantitative component was to describe characteristics of the coalitions, including contextual, organizational and programming characteristics that may help to explain the difference in OHHP coalition mandates (i.e., expanded versus not expanded). Specific indicators in these categories were selected from quantitative data collected as part of the OHHP provincial evaluation. With permission from the local projects, several data sources were used, including:

- Health unit surveys, mainly for the period 2000, but also trends over time from previous surveys (1994, 1996, 1997)
- Organization and Management Report, year 3
- Financial and In-kind Contributions Reports, year 3
- Activity Reports, year 3
- Coalition Reflections, year 3
- Demographic variables from Statistics Canada Census

The full set of indicators is included in Appendix 3. Analyses were performed by the provincial evaluator, who was familiar with the strengths and limitations of the data. For each of the indicators, results were compared for the 'expanded' and 'not expanded' groups of coalitions. For most indicators, trends were identified based on descriptive data. Statistical tests of comparison were performed with a small subset of indicators.

## **Qualitative Component**

An in-depth telephone interview was completed with the Heart Health Coordinator from each of the 16 coalitions. Interview questions were shared with respondents in advance of the interview (see Appendix 1, Interview Schedule A for 'expanded' coalitions, Interview Schedule B for 'not expanded' coalitions). All interviews were completed by the same interviewer during May and June 2002, and lasted one hour on average. Individual interview summaries were prepared. A thematic analysis was completed for each interview question. Analyses were completed by the primary researcher for this project and the provincial evaluator. An iterative process was used to identify key findings.

## RESULTS

Results are organized into three sections:

- **Activities of Coalitions with an Expanded Mandate:** This section provides a detailed description of activities carried out by ‘expanded’ OHHP coalitions to address diseases other than cardiovascular disease. Activities do not necessarily reflect all options. However, they represent initial attempts by coalitions in Ontario to address more than one chronic disease.
- **Characteristics of OHHP Coalitions:** This section includes quantitative and qualitative results that provide a rich description of OHHP coalitions. The focus of findings is on comparisons between the expanded and not expanded coalitions.
- **Expansion of OHHP Coalitions:** This section describes interview results on the process undertaken by OHHP to expand their mandates or to maintain a focus on heart health. Findings compare expanded and not expanded coalitions.

### Activities of Coalitions with an Expanded Mandate

Table 2 shows the diseases included in the prevention initiatives offered by the expanded coalitions. In addition to heart health, two coalitions reported doing cancer prevention, two offered stroke prevention, one offered diabetes prevention whereas the other two offered cancer, diabetes and/or stroke prevention.

Table 2 Other diseases addressed by OHHP coalitions with an expanded mandate

Other diseases	# of expanded coalitions
Cancer	2
Stroke	2
Diabetes	1
Multiple diseases	2
Total	7

OHHP coalitions used a wide range of activities to address other diseases. Some activities are linked to one disease; some are linked to more than one disease; and some activities refer only to common risk behaviours or conditions. To address diseases in addition to heart health, one strategy was to introduce new activities. Another strategy was to incorporate new messages into existing activities. Below are excerpts from interviews that illustrate the wide range of activities to address one or more of stroke, cancer, diabetes and osteoporosis.

- Information about stroke is shared with CPR training.
- In active living or in healthy eating work we weave in stroke messages.
- Promote signs and symptoms of stroke, living with stroke as part of programs to specific audiences e.g., women and heart health (signs and symptoms). But, even the urban planning initiative and neighbor sidewalk initiative can be seen as stroke prevention since stroke risk factors are addressed.
- Coordinator wrote a feature in the newspaper (her regular column) then a whole series about stroke in February as part of Heart and Stroke month – major focus in newspaper was on stroke.
- Radio ads around topic of stroke were broadcast.
- Shared the resource *Towards an Integrated Strategy for Stroke* with the coalition to educate them about stroke. The coalition was very receptive and suggested developing a pamphlet about stroke. The Coordinator formed a work group to develop a pamphlet with risk factors of diseases including stroke. This was disseminated through the coalition's regular channels i.e. 3 school boards, day care, work-sites, diabetes network, and women's wellness. It is a great teaching tool and Health Unit really liked it. The back of the pamphlet includes resources in the community for healthy living.
- Had a really strong partner from the Heart and Stroke Foundation. Wanted to keep her at the table and asked what she needed to get from the coalition to continue. They began doing health symposiums together where health risk appraisals (including stroke) are done.
- Held two large health symposiums where a well-known resident, a stroke survivor, spoke about the impact of stroke. A doctor talked about the signs and symptoms and prevention. The turn out was larger than expected at 170 participants.
- Do health risk assessments including stroke and diabetes.
- Now also use the stroke presentation kit from the Heart and Stroke Foundation to make presentations to community groups.
- With diabetes have a nutrition symposium where diabetes educator (a heart health partner) takes the lead.
- Focus communities work with heart health day camp program and have an interactive one hour session for children. They also use the interactive booth at fall fairs, etc. They do physical activity, substance abuse.
- Heart Health also works with events Focus is hosting – we add physical activity, nutrition, and tobacco.
- Have never offered specific heart or cancer programs. We work around risk factors – e.g grocery show we offer recipe cards that provide healthy eating. Have never talked about stroke. We were invited to be part of a Regional Stroke Centre (RSC) steering committee and shared about the programs they offer. Would like to link up the RSC if funding continues and if coalition would like to link up.
- In the Heart Smart Women's Symposium we shared information about cancer and stroke. There were 300 participants. The information was presented through risk factors.
- In the past year, library group held an evening on Heart Smart for women. Speakers included a woman who had survived a heart attack, a registered dietician, a Nurse Practitioner, and coordinator. They discussed cardiovascular disease and

cardiovascular health, which included stroke. We learn to link things together. Looked at risk factors etc.

### **Characteristics of OHHP Coalitions**

Appendix 3 provides detailed results of the quantitative and qualitative results that describe the coalitions with and without an expanded mandate. In this section, main similarities and differences are summarized, to provide a basis for explanation of main factors influencing the expansion process. Results are organized according to the conceptual framework, including contextual, organizational (coalition and health unit) and programming factors.

#### ***Contextual Characteristics***

- The geographic area served by all OHHP coalitions is the same as the geographic jurisdiction for health units.
- Although population density was comparable, not expanded coalitions tended to serve larger geographic areas than expanded coalitions, implying more rural settings.

#### ***Organizational Characteristics of the Coalition***

- Consistent with the OHHP mandate, all coalitions reported addressing the behaviours of tobacco, physical activity and healthy eating. All coalitions described the approach as “healthy lifestyles” or “multi-risk factor”. Expanded coalitions tended to more consistently describe their approach as “healthy lifestyles”. Expanded coalitions were also less likely to link the lifestyles to heart disease or heart health.
- Expanded coalitions received a slightly higher allocation of OHHP provincial resources per capita.
- Expanded coalitions tended to have more active and larger steering committees.
- Not expanded coalitions tended to have a higher number of coalition members from public health.
- Expanded coalitions had higher recruitment of new members during year 3 of the OHHP (which was before and during the time expansion issues were being discussed).
- Although the turnover of Heart Health Coordinators was comparable between the two groups, there were differences in perception. The not expanded coalitions perceived the turnover to be a greater problem than expanded coalitions. Also, not expanded coalitions were without a Coordinator for a longer period of time.
- The role of the Heart Health Coordinator was somewhat different between groups. Expanded coalitions tended to emphasize the community mobilization function of the Coordinator, whereas not expanded coalitions tended to focus on a communication/coordination function.
- Not expanded coalitions described more difficulties in maintaining community partners because of reporting and documentation.

### ***Organizational Characteristics of the Health Unit***

- Health units from expanded coalitions reported a higher priority given to heart health in the year 2000 compared to health units from the not expanded coalitions (statistically significant comparison,  $p < .05$ )
- Health units from expanded coalitions also tended to have a higher coordination of tobacco, nutrition and physical activities within their organization
- Health units from not expanded coalitions had a stronger perception of barriers that they believed were inhibiting heart health promotion in their communities.

### ***Program Characteristics***

- Quantitative information collected as part of the health unit survey (for the year 2000) and in the year 3 activity reports from OHHP coalitions did not show any differences between expanded and not expanded coalitions in the amount of activity.
- There was a trend for expanded coalitions to be working with more coalitions, especially tobacco coalitions, nutrition networks and healthy communities.

### **Expansion of OHHP Coalitions**

Results in this section are from the interviews with Heart Health Coordinators and relate directly to questions about the process undertaken by OHHP coalitions to choose an expanded mandate or to maintain a focus on heart health. Results are organized by key questions in the interviews.

#### **Timing of Discussion About Expansion**

All coalitions in this sample had discussed the possibility of expanding into chronic disease prevention. Of those who reported expanding ( $n=8$ ), four had included a broader perspective as part of the formation with the OHHP funding. Three sites had formed as heart health and cancer sites. These coalitions reported forming heart health and cancer coalitions due to community needs and key partners. In one of these coalitions the cancer partners left the heart health coalition when a new cancer coalition was formed recently. This coalition is now a heart health only coalition and was treated as a not expanded site in further analysis. In one site that had been part of the demonstration phase they “made a conscious decision to move more toward a healthy lifestyles approach” at the outset of the OHHP.

Table 3 Timing of Coalition Discussion about Expansion

When expansion discussed:	Expanded	Not expanded	Total
At beginning of OHHP	3	1	4
After start of OHHP but prior to CWG	3	2	5
CWG review process	1	6	7
Total	7	9	16

Three of the other four ‘expanded’ sites began broadening after the beginning of the OHHP but prior to the CWG process and one began as part of the CWG experience. Of these newer expanded sites, the availability of diabetes funding was identified as an important factor for two coalitions.

For not expanded sites, two began discussing expansion prior to the CWG process. One coalition had applied for diabetes funding, and the preparation of the proposal was a factor in broadening their perspective. Although funding was not obtained, it has contributed to an ongoing review within the coalition and a decision has now been made to transition into a chronic disease coalition over the next 2 years.

For the other not expanded coalitions, sustainability planning and the work shared from the CWG were factors impacting their review of the issue of chronic disease prevention.

Although there was an ongoing history and trend to expansion beyond a heart health mandate in OHHP coalitions, the review process linked to the CWG report was a factor for 7 of the 16 coalitions in this sample. The healthy lifestyle approach used by these coalitions in promoting heart health provided a way to include prevention of other chronic diseases.

Initially, three of the heart health coalitions formed as heart health and cancer coalitions. It is unknown and raises a question about the relative importance of the link to the Mandatory Program Guidelines by the sponsoring agency or the interests of partners involved in the original proposal to this original formation.

### **Processes Used To Discuss Expansion**

The processes used by the coalitions to discuss expansion appeared to differ. Expanded coalitions described multiple processes including a range of activities such as benchmarking, facilitated sessions, sustainability planning, forming alliances with new

partners, clarifying their vision and mission etc. For example, one site reported the following:

“ Sustainability planning identified other funding opportunities. We applied for diabetes dollars and built on the physical activity and walking initiative. (We enhanced an existing program). ... we found new partners at the community level with this broad approach.... New partners, new funding, new audiences led to expanding the network. The vision and mission process clarified that we weren’t doing just heart health....”

Another perspective from expanded coalitions was the intent to better use resources or to maximize resources by building on what others were doing in the community. This required being well informed about the community, connecting with a variety of “key people”, and forming new working relationships in order to avoid competition.

Three of the not expanded coalitions had participated in a strategic planning process that helped them identify what was needed “to build a supportive environment”. There had been less active processing about expansion in the other six not expanded coalitions.

<b>Table 4</b>	<b>Frequency for expanded coalitions</b>	<b>Frequency for not expanded coalitions</b>
Benchmarking	✓✓	
Shift from heart health to healthy lifestyles	✓✓✓	
Strategic planning / sustainability planning	✓	✓✓✓
Formed new partnerships	✓✓✓✓	
Identified other funding sources	✓	
Being well informed about community groups /champions	✓✓	
CWG review	✓✓	✓✓✓
Positive experiences – success with intitial attempt to broaden	✓	
Facilitated session	✓	✓
Partnering between 2 HH projects		✓
Community forum		✓
Information shared at National level		✓
None used		✓✓

The review of the CWG paper was a process identified by five coalitions.

The expanded coalitions appeared to use more and varied processes to discuss the future expansion possibilities. Differences related to partnership building, identifying community groups and champions, and use of the benchmarking process. The not expanded sites tended to rely on the strategic planning process and sustainability process or a special event around the CWG document review.

### **How was the question about the coalition’s future role in chronic disease prevention received?**

There were differences in the responses to the CWG report between the groups of expanded and not expanded heart health coalitions. In general, there was strong positive support to ongoing or further expansion into chronic disease prevention by expanded sites. Of not expanded sites, five sites supported expansion to a chronic disease approach for their coalitions whereas four others did not.

*Example of positive support* : “There was strong coalition support – groups were really committed to sustainability. It was a win-win situation (to apply). Almost no risk and huge opportunity.”

*Example of qualified support*: - “Mixed reaction – a lot thought it was a good idea. Some disease specific NGO’s had concerns. Also concerned about funding. Not prepared to move to CDP without funding.”

*Example of limited or no support*: - “The group decided that without continued funding they would cease to exist. Not opposed. But no commitment until there is a commitment to funding.”

Table 5 How was question about CDP received?

	Expanded	Not expanded	Total
How received:			
Positive support	6	2	8
Conditional support	1	3	4
Limited or no support	0	4	4
Total	7	9	16

### **Perspectives about Expansion**

Expanded coalitions most frequently attributed their expansion to a community mobilization experience where the vision and goals evolved out of collaboration with the community. For some, partners expressed a desire to move away from a specific disease toward a healthy lifestyle approach. For others, the approach “evolved” by listening to what partners needed to get out of participation in the coalition. As one coordinator stated, “The big thing is to develop relationships, partners.” Another advised that, “We have been successful because we had a larger vision. It has to be the community members who make that plan. It’s not a true coalition if the health department runs the show.”

Comments about expansion from not expanded sites were very different. One coordinator reported that her coalition is not prepared to spend “the time or effort until we know if there is continued funding.” Three others were not interested or uncertain about expanding their coalitions to a chronic disease approach. “Would require an upheaval to do chronic disease prevention.” “Not sure if we have the capacity or if the partners have the mandate or capacity.”

### **Who Participated In the Decision**

The decision making process about expansion occurred at different levels in different coalitions. Most commonly (8/16) decisions were made by the steering committee. In five coalitions, the decision involved the whole coalition. In one coalition, the health unit made the decision. In two expanded coalitions, the expansion had occurred prior to the respondents and they were unsure who was involved with the decision.

Table 6: Who participated in the decision about expansion

Who participated in the decision	Expanded	Not expanded	Total
Steering Committee	3	5	8
Whole coalition	2	3	5
Health Department	0	1	1
Don't know	2	0	2
Total	7	9	16

### **Decisions about Expansion**

At this time, seven coalitions of the sample of 16 have made the decision to expand, and the majority of these are currently ‘expanded’. The most frequent decision by not expanded coalitions is to ‘wait and see’ what happens about funding. One coalition is not pursuing expansion.

“The decision was that the current coalition members would be willing to address chronic disease prevention only if funding was made available.”

These findings identify the differences between the OHHP coalitions. Some have broadened or are broadening into a chronic disease prevention approach whereas others are interested but are not prepared to make changes until there is some assurance of continuing funds. The uncertainty about funding is clearly a block for the ongoing development of some of the coalitions.

Table 7: Decision taken

Decision:	Expanded	Not expanded	Total
Expand	6	1	7
Wait and see	1	5	6
Decision not made	0	2	2
Not in favor of expansion		1	1
Total	7	9	16

### Supporting and Inhibiting Factors to Expansion

Coalitions were asked about factors that they felt helped them to broaden their mandate and factors that inhibited expansion. On average, expanded coalitions identified over 4 broadening factors and three inhibiting factors each. On average not expanded coalitions identified about 3.5 broadening factors and 3.5 inhibiting factors.

Three expanded coalitions each identified the following as factors supporting a broader mandate:

- **Name and logo:** “The name and logo are broad – logo has four components representing the lifestyle factors. It gives the coalition flexibility.”
- **Coalition membership:** “Broad membership helped.”
- **The coalition’s capacity for flexibility and adaptability:** “Community’s capacity for flexibility and adaptability – community is willing to be flexible. It varies with different activities. Various groups will come forward for activities.. allows flexible use of resources.” “We have an amazing group of people. We have never had a conflict. We do get tired and burned out but when we’re together to do things, we have fun.”
- **Leadership by the heart health coordinator:** “Leadership skills of the heart health coordinator include building community capacity, community mobilization...”
- **Risk factors offering a common platform for other diseases:** “Risk factors offering a common platform for other diseases strengthened all healthy lifestyles initiatives-relevant to all diseases.”

Two expanded sites identified funding for heart health as a broadening factor.

At least two expanded coalitions identified the following inhibiting factors:

- **Nature of the community:** “A major factor is the size of the community and lack of service groups.” “It was a big challenge to find ways to keep them feeling as though

they had a say- did not want to be directed. Struggled with appropriate ways to meet their needs.”

- **Coalition name and logo:**
- **Coalition’s ongoing renewal of membership:** “ This is a constant challenge and have to work very hard to keep people. Have nice dinners and good speakers.”
- **Coalition’s infrastructure:** “We are struggling from time to time. Communication has a direction. Steering committee is not always aware of the issues at the working groups.”
- **The Health Unit’s mandate (e.g. Mandatory guidelines):** “Difficult struggle for us to get over. Some heart health programs are offered by the health unit (as part of the CDP program.) not the coalition. Some healthy eating and second-hand smoke initiative are totally independent from the heart health coalition. There is a lack of opportunity to be coordinated and collaborate.”

For heart health coalitions who had not broadened their mandate, the factors that at least two coalitions identified as ‘pushing their coalition toward expansion’ included:

- **Provincial and national trends toward chronic disease prevention:** “CWG motivating”
- **Availability of other funding sources:** “Searching for sustainability”.
- **Risk factors offering a common platform for other diseases**
- **Coalition membership:** “recognition that it’s the same partners around different disease tables. Especially in smaller communities it’s very important to avoid this.”
- **Coalition’s decision-making process:** “In most cases have been able to reach consensus – sometimes after a lot of discussion.”
- **History of coalition’s successes:** “Had a very successful social marketing campaign – a real accomplishment.”
- **Availability of funding through the Diabetes Strategy**

At least two of the not expanded coalitions identified the following as factors interfering with, or blocking, the coalition from broadening to a chronic disease coalition.

- **The coalition’s identity, vision & mission and name and logo:** “Some felt concern that there would be public confusion about a change in direction.”
- **Coalition membership:** “Working mainly with single risk factor partners.” “ Disease identity of members.”
- **Lack of human resources and/or leadership by the coordinator:** “ Leadership is getting pooped..... Getting tired of all the paperwork.”
- **The nature of the community:** “We have a large geographic region. It’s impossible to bring people from outlying areas to the coalition meetings.”
- **Reporting requirements:** “The amount of reporting required given the level of funding.”

The differences between the expanded and non-expanded sites are noteworthy. Three of the top five supporting factors for expanded sites were linked to human resources for the coalitions: coalition membership, and coordinator leadership. Although more supporting

factors were identified for non-expanded coalitions, only one was linked to human resources but coalition membership and the lack of human resources and leadership were identified as inhibiting factors by the non-expanded sites. This reinforces the differences in coalition capacity related to leadership and memberships that has surfaced in other areas between expanded and non-expanded sites.

For the non-expanded sites, two supporting factors were availability of funding suggesting that the uncertainty about funding may be having a greater impact for non-expanded sites.

The risk factors offering a common platform for other diseases were seen as a supporting factor in both groups. Promoting smoke free environments, good nutrition and an active lifestyle has a positive impact in prevention of heart disease, diabetes, stroke, and osteoporosis.

Both expanded and non-expanded sites identified the nature of their communities as possible inhibiting factors. Coordinators discussed challenges in reaching out to geographically dispersed and diverse populations. The challenge of ongoing renewal of membership affected both expanded and non-expanded groups and was identified as an inhibiting factor. For expanded sites, the coalition infrastructure and the mandatory program guidelines were inhibiting factors. Non-expanded sites identified the reporting associated with the OHHP as an inhibiting factor.

### **Coalition Membership Changes as a Result of the Expansion Decision**

Over half of the coalitions reported that their membership had changed or was changing as part of the decision to consider expansion to CDP. Some were launching processes to identify new members. For some coalitions, membership was a struggle with two coalitions reporting few or no coalition members at the time of the interviews. One factor limiting membership renewal was the uncertainty of funding, another was the loss of a coordinator.

“It’s hard to attract new partners when we’re in the last year of funding.”

Five of the seven expanded coalitions reported that their membership had grown as a result of their expansion beyond heart health and one other reports that although it hasn’t grown, they’ve been able to keep people who would have left. In some cases, coalitions added members from disease NGO’s such as the Canadian Cancer Society or Canadian Diabetes Association, or brought in representatives from special populations i.e., rural or multicultural associations.

Not expanded coalitions reported that membership had not been impacted, or had decreased. Three coordinators stated that because of the uncertainty related to future funding, they have not been recruiting new members.

It appeared that coalitions who had accepted an expanded mandate have been energized by this decision. The expanded coalitions and the one from the not expanded sample who committed to expansion in the next year all described various processes they were initiating to find new partners, evolving in new directions, initiating processes to learn about new opportunities. This group of coalitions was moving forward.

Table 8 Partnership Changes following decision about expansion

	Expanded	Not expanded	Total
Partner change			
Changed	4	1	5
Changing	1	3	4
No change	2	5	7
Total	7	9	16

In contrast, the majority (although not all) of not expanded sites presented a very different perspective. To illustrate, the following quotes describe the current reality from four of these coalitions.

“People don’t have the energy to change. We’re just managing the status quo.”

“There’s not a lot of energy around the table. No one’s saying ‘let’s try this’. We’re doing the job we set out to do.”

“Have fewer volunteers now. We’re burned out and feel we’ve accomplished our tasks.”

“Really gotten bogged down. Staff are really pressed.”

### **Approach to the Future**

In all coalitions, coordinators were uncertain about the survival of the coalition without funding from MOHLTC. Many reported that partners would sustain specific initiatives if Ministry funding ceased.

“If funding stops, work would be limited and the number of activities would decrease.”

The survival of the coalition was linked to funding for a coordinator who could continue to mobilize community support and develop partnerships.

The respondents expressed an interest in continuing but a number of the coordinators recognized that the health unit might be cautious of entering into a program with the same reporting requirements as the OHHP.

“Health Unit support depends upon the future funding and strings attached to the funding.”

“Need to hear from the Ministry what the intent and structure will be.”

Four of the not expanded sites were uncertain about whether they would seek future funding if it was available. One site stated that future heart health funding should become part of the health units base funding. The other three sites recognized that the community was engaged in other initiatives, or that new funding would need to be balanced with the requirements.

“Haven’t given up – but coalition members left because they didn’t want to spend time doing planning and reporting. We’re in the last year. Just want to get the OHHP done and over with.”

One specific comment from a not expanded site describes the difficulty faced by communities. “Short term funding is great to have but it is a limiting factor. It is not the type of funding that facilitates community development. In order to expand to chronic disease prevention we have to be assured of long term stable funding. It is not cost effective and it’s difficult to plan when money has to be spent in a limited time frame.”

Several heart health coordinators were approaching their health unit to request funds to continue their coalition if funding stopped. None were very optimistic that this would be a viable solution.

“The health unit is very reluctant to free up money.”

These results raise several issues. The first is that although heart health coalitions have been developing sustainability plans, the ongoing sustainability of the coalitions depends upon ongoing funding primarily for a coordinator. Also, given the structure and requirements of the OHHP, there are some sites that may not be willing to continue. In the not expanded sites, the level of reporting, the amount of time spent planning were raised as barriers to future relationships with a program like the OHHP.

## DISCUSSION

The OHHP coalitions provide an opportunity to learn about factors supporting and inhibiting movement to a chronic disease prevention approach. OHHP coalitions are unique in their collective planning for sustainability by envisioning the option of expanding their mandates to include one or more other chronic diseases.

The differences between the expanded and not expanded sites are noteworthy. Coalitions who have expanded beyond heart health have demonstrated more active partnership recruitment and involvement and leadership by the coordinator. Overall, the expanded coalitions tended to present as more active, dynamic, opportunistic coalitions whereas not expanded coalitions appeared to be stalled (i.e., in a holding pattern).

To illustrate, supporting factors for expanded sites were linked to coalition membership, and coordinator leadership whereas the lack of human resources and leadership were identified as inhibiting factors by the not expanded sites. This identifies the critical link between coalition capacity and human resources both of the coordinator and memberships.

Similarly, although it appears that both expanded and not expanded sites had comparable numbers of coordinators, the not expanded were without a coordinator longer, and found the turn over of coordinators more difficult. Two key roles of the coordinators include ongoing communication between members of the coalition, and recruitment of new partners. Without a coordinator, coalitions could face gaps and miscommunication as well as an inability to find new members. This could be expected to stall the momentum of the coalitions.

Expanded sites tended to discuss the idea of expansion earlier than non-expanded sites and had used a broader range of processes to explore the question of expansion. This observation suggests that the issue arose from within the coalition (versus from an external source) and was explored in greater depth. This suggests an openness and receptivity within these coalitions for innovation. Also, since both types of sites report about equal use of resource centres and provincial organizations. This points to the selection and use of processes from an internal source possibly the coordinator or other members of the coalition.

The results suggest a number of factors and conditions that support and inhibit expansion capability and developments. They also suggest interplay between these factors. Expanded coalitions identified the leadership of the coordinator as a supporting factor. Coordinators in expanded sites reported major skills in community mobilization. These were individuals who had negotiated a decision-making role for the coalition to ensure that community partners voices shaped the coalition's mandate. They would be actively listening to the issues being raised by partners and finding ways to offer support to initiatives that supported one or more of the risk factors.

Therefore, these results suggest that the strongest, most basic requirement (for expansion capability) is to have a local structure with strong leadership along with shared ownership. What appears to be essential is a full-time coordinator who has strong community mobilization skills.

Leadership is also from agencies with a mandate and resources most closely aligned with the work of the coalition (e.g., health unit support). Many coordinators identified support from the health unit. The role of the health unit by expanded sites tended to be as partners giving considerable independence and decision-making authority to the coalition.

These results support a sponsoring agency role where leadership/support is provided in the context of a coalition with shared ownership. Shared ownership is among all partners in the coalition, including the health unit. Such a structure leads to more engaged, active partners and more active processing of expansion possibilities. It leads to more openness to re-framing the work of the coalition to more than heart health e.g., healthy lifestyles approach without linking to specific disease, or linking to heart disease and other diseases. It also leads to less discomfort in the context of uncertain funding i.e., coalitions moving forward even without the security of certain funding.

Coalitions also faced challenges to their expansion capability. One major challenge was related to funding. For the not expanded sites, two of the supporting factors for expansion were availability of funding suggesting that the uncertainty about funding may be having a greater impact for not expanded sites. Uncertainty about the future funding could be impacting coalitions in a number of ways: possible loss of coordinators (3 mentioned recent coordinator losses); unwillingness of partners to fully participate when a coalition is in a wrap up phase; and unwillingness of staff to recruit new partners when a future for the coalition is uncertain.

Across both groups, the ongoing survival of the coalition to do chronic disease prevention was linked to funding for a coordinator who could continue to mobilize community support and develop partnerships.

Both expanded and not expanded sites identified the nature of their communities as possible inhibiting factors. Coordinators discussed challenges in reaching out to geographically dispersed and diverse populations. The challenge of ongoing renewal of membership affected both expanded and not expanded groups and was identified as an inhibiting factor. This is also supported by the quantitative data. Not expanded sites tended to be more rural and in more geographically dispersed regions.

Coordinators described difficulties in small communities with few agencies and services personnel with whom they could partner. It was a block to participation for coalition members if they needed to travel to coalition meetings. Small size with few resources and huge distances between communities were inhibitors to successful community collaboration and in turn to expansion. This geographic and resource issue needs to be considered in future funding of coalitions.

Program requirements for the OHHP were identified as an inhibitor. Planning and reporting requirements required considerable time for staff and partners. In not expanded sites, there was a trend to have more health unit staff working with the coalition. The outcome from the interview findings was that coordinators recognized the burden that heart health was placing on health unit staff.

Health unit staff work with the heart health program as part of their in-kind contribution and in some health units as part of their mandatory program guidelines. All health units with expanded sites rated heart health as a high priority compared to about half of the not expanded sites. Health units with expanded sites also rate them as having higher coordination of activities.

The challenge created is that heart health and chronic disease prevention is part of the health unit mandate, and health unit resources are crucial for any long-term sustainability of chronic disease prevention. A dramatic finding was that mandatory programs were rated as a block to coalition expansion. This is confusing since an expanded coalition would address more of the public health mandate. This clearly shows that there is an issue about limited harmony or integration of OHHP activities with health unit mandatory chronic disease prevention program.

However, community partners must also have ownership in the work of the coalition to commit and stay actively involved. Perhaps one challenge is to separate coalition activities from agency activities while clarifying the roles and relationships between partners.

### **Issues and opportunities**

The potential for OHHP coalitions to expand to a chronic disease approach has the following strengths:

- Coalitions have province-wide coverage;
- There are examples of successful integration with partners mandates, including public health;
- Examples of successful community mobilization of resources towards a chronic disease prevention agenda exist;
- The risk factors of OHHP are common for several chronic diseases;
- There has been strong leadership within the Ontario Heart Health Network to develop a local/provincial partnership, which transcends the traditional funder/fundee relationship.

However, further learning and developments are needed to bolster OHHP expansion:

- Examples and strategies are needed to better harmonize coalition activities into CDP of the public health;
- Coalitions grew and expanded based on dynamic partnership relationships. Strategies (at both local and provincial levels) are needed to more fully engage partner agencies and/or develop realistic expectations about the contributions from various partners

- Linkages with other coalitions are needed as well as an opportunity to learn from the strengths and challenges experienced by other coalitions;
- Effective strategies are needed to reach small, outlying communities and diverse populations.

### **STUDY 3: Comparison of Other Coalitions to Expand their Mandate to Include Other Chronic Diseases**

#### **STUDY QUESTIONS**

1. What are the similarities and differences coalitions in the OHHP, Focus and Cancer coalitions related to coalition structure, sponsorship, partnerships and co-ordination?
2. Are coalitions interested in expanding to CDP?
3. To what degree do the coalitions within this sample collaborate?

#### **METHODS**

##### **Design and Sample Selection Process**

From a review of coalitions working as part of the Ontario Health Promotion Resource System (OHPRS), community coalitions with risk factors for stroke were identified. The Focus community coalitions were selected because of the similarities in the program framework with the OHHP.

Further three heart health coalitions in this sample reported losing members to newly forming cancer coalitions. Key informant interviews were conducted with members of the cancer networks, but only one link to a community coalition was identified. The coordinator of this coalition was approached and asked to participate in a telephone interview.

Discussion of the study questions will include the findings from study 2.

##### **Sample**

A sample of five Focus sites was selected to include original and new sites, high and low population density, sponsorship from health unit and other agencies. One cancer coalition was approached.

##### **Data Collection and Analysis**

Coordinators were initially contacted by electronic messaging to provide them with information about the study including the telephone interview questions and request their participation. This was followed by a telephone call to offer clarification, request participation and schedule the time for the telephone interview. Data was collected in a telephone interview (See Appendix 2, Interview Schedule C).

A telephone interview was conducted with coordinators from five Focus and one cancer coalition during June 2002. These interviews lasted on average 45 minutes. Individual

interview summaries were prepared and a thematic analysis was completed for each interview question. Analysis was completed by the principle researcher.

## **RESULTS**

Results are reported organized by questions. Results of the two programs (Focus and Cancer) are reported separately.

### **Results: Focus Communities**

#### **Primary Work of the Coalition**

In all cases, the Focus communities identified that alcohol and substance abuse are the risk factors they are working with. They consistently use a healthy lifestyle approach through the health promotion framework (the cube).

#### **Coalition Structure**

The coalitions surveyed use a variety of structures that reportedly work for them. As listed below, the sites include advisory committees formed of partners with a coordinator. The role of the advisory committee appears to vary across the coalitions with some overseeing the work of the coordinator and of separate coalitions or work groups. Another model for advisory committee is primarily for communication and sharing information about current work and the partner's work and possibly serving a support capacity to the coordinator.

- One site is a non-profit incorporated organization with a board of directors. The Board serves as an advisory committee and the coordinator works with partners to implement activities. There are many partners including the police organizations, health unit, CAMH, Parks and Recreation, Schools, DHC etc.
- In one site, three separate coalitions serve different parts of the region with a steering committee overseeing the project. The steering committee includes members from each of the coalitions. Major partners include police, emergency workers, child services agencies, mental health, addiction services, schools etc. The sponsoring agency is a Health Unit.
- This coalition has about 30 people, with about 20 active at any one time. They meet monthly and discuss work in progress and show and tell about partners' other work. There is a high commitment to meetings. Key stakeholders initially signed a letter of commitment but have far exceeded the original requirement. This Focus is sponsored by an addiction agency.
- This Focus site has an advisory committee that meets once a month to share information and make recommendations about program. The advisory committee may include partners or participants in the programs, but operates as a support group to the coordinator rather than a true coalition. There is a network of community agencies that the coordinator also belongs to where "project partnerships happen". This project is sponsored by an addiction and mental health agency.

- An advisory committee sets overall goals and objectives and approves plans from the working groups. The subcommittees (working groups) develop their own goals and objectives and plans, although the advisory committee reviews these. Partners include “every resource and agency within the community”. The sponsoring agency is a hospital.

### **Role of Coordinator**

The role of the coordinator was seen from the perspective of community mobilization. In all cases in the sample, the importance of working from the community needs and with community partners were emphasized. Describing their roles as “worker bees” or as the “glue that keeps things together” the respondents identified their primary task as community development.

The role of the coordinator is critical to the survival of the coalition. Although these coalitions were structured to ensure stability of programs, coordinators all stated that if funding were to stop, and the coalition were to be without a coordinator, there was little chance that the coalition could sustain itself, or new initiatives would begin.

### **Role of Partners**

Focus coordinators listed partnerships with representatives from addiction services, police agencies, women’s crisis centres, native organizations, day cares, health unit, emergency workers, schools, media. The lists varied depending upon the resources in the community.

Coordinators describe partnerships with multi-way collaboration. Partners bring their initiative forward to Focus and support Focus initiatives. Partners support one another’s events and programs. Although very clearly focused on their mandates, coordinators shared ways they stretched their boundaries in order to maintain partnership relationships in their communities.

“The only time Focus does expanded work is to partner with another agency. We bend to help each other.”

### **Role of Sponsoring Agency**

Sponsoring agencies were described in a number of ways. They are “just one of the partners”, “a sounding board”, “a relationship that is arms length but mutually respectful”, as a “source to resources” and as “a flow through agency”. The one site in this sample sponsored by a health unit offered that:

“The coordinator is employed by the health unit and is also delivering mandatory program guidelines although this program is funded 100% from the ministry. It is community based and community driven but also fulfilling mandatory program guidelines.”

## **Expansion**

These Focus sites had not discussed expansion to a broader chronic disease mandate with their coalitions. They identified that their mandate from MOHLTC was to work within the area of alcohol and substance abuse prevention and injury prevention and that they were not funded to do other things. For those who considered ways to expand their mandate it was to include other areas closely linked to their mandate.

“We could be doing a lot more just in this area but because of budget constraints we can’t do a lot. . . if we had more funding we would be doing alcohol and pregnancy or alcohol, drugs and diabetes. . . .”

“We’re really structured to work within the mandate of the Ministry. . . . However, we do a lot of initiatives with community partners and there is a lot of give and take with partners e.g. bicycle helmets.”

“If there is a connection that can be drawn with our overall purpose we can link.

Coalition members support each other’s activities. The only limitation is time and we’re pretty stretched. We could fit in stroke under the seniors’ initiatives. I see a link between any kind of elevated medical risks related to drugs and alcohol. I wonder about stroke and the use of street drugs.”

## **Arguments in favor of expansion**

Coordinators identified ways they had supported initiatives not directly related to their mandates through partnership activities yet were able to link this work to some aspect of their mandate. “Have worked in other areas, e.g. brain injury group. These individuals may develop substance abuse issues or may have been brain damaged by a drunk driver – or it could be a self inflicted injury following drugs and alcohol.”

One coordinator took a unique approach, arguing that alcohol and drug problems are symptoms of a deeper problem. “The root causes are poverty, isolation . . . so we’ve always carried out other activities.” This Focus site was one of the original sites that had taken its mandate from community needs. With renewed funding, the coordinator reported, “We had a hard time when MOHLTC wanted us to look at substance abuse and injury prevention because it was the community who decided on what programs were implemented. It was a narrowed focus. We struggled to address a narrow focus.”

## **Arguments against expansion**

Focus Coordinators felt the biggest argument against expansion is that they were given a clear mandate and they are being kept very busy in their work with this mandate. “We’re doing what we’re funded to do.”

## **Membership**

Most coordinators stated that their memberships were not changing significantly. The word used repeatedly was “stable”. Two coordinators identified they were trying to reengage members of their audience (s) to participate in the coalition. In one situation it

was finding ways to involve seniors, in another it was trying to return to more grassroots membership.

Two coordinators identified that partner agencies were attempting to continue with fewer staff. “Now there are fewer people doing more work. Everyone is struggling to keep up with the work they are doing...”

### **Anticipated changes**

Most of the Focus coordinators expressed confidence that funding would not be ending. Some reported that they expected at least one more year of funding whereas others believed that the accomplishments of the Focus sites tended to support continued funding. The risk of losing funding was not a new experience for coordinators who had been part of the original sites. “If we gear down each time we may lose funding, we’d never get anything done.”

However, coordinators felt that although many of their programs and initiatives could be sustained, funding was essential to maintain the Focus coalitions.

“It is important for the funding body to realize the importance of a coordinating body, to motivate, coordinate. Without a coordinator, I see the coalition eventually dying out.”

“There needs to be an investment from the province and from the community. Base funding is very important.”

“The Ministry has such high expectations about sustainability, but with no funding it just won’t happen.”

## **Results: Cancer Coalition**

### **Coalition Structure**

The Cancer coalition is located in a high-density area, linked to the health department. It is described as the largest municipal cancer coalition in Canada representing over 60 agencies and other community partners. The coalition has a steering committee and eight working groups.

Eight working groups, each dealing with a particular cancer risk factor or area of interest, were formed: tobacco, alcohol, dietary risk factors, ultraviolet radiation, occupational carcinogens, environmental carcinogens, physical activity, and the screening and early detection of women's cancers.

The goal of the coalition is:

"To reduce cancer incidence by creating a high profile/effective/powerful/multi-stakeholder/sustainable coalition, evidence and suspect based, which advocates for prevention policy, education and action at the local government level and beyond."

The culmination of the coalition's work to this point is the broad and far-reaching Action Plan for Cancer Prevention and the supporting documents, completed by 6 of the seven working groups,

### **Role of Coordinator**

Coordinator sees her role as facilitating and supporting the work of the working groups.

### **Role of Partners**

Late in 1998, the health unit sponsored what was a founding meeting of the coalition. Individuals, many of whom had been affected by cancer, came together with public health interests, cancer education, research and support organizations, health professionals and academics, health and safety leaders, environmental groups, Cancer Care Ontario, and provincial and municipal elected officials. Together they began the process of combining a range of issues, risk factors and points of view into a single, mutually supportive prevention coalition. The basis of this process, and later its strength, lay in the key principle that, in order to implement a comprehensive, integrated cancer prevention agenda, the role of the expert and the citizen must be balanced.

Founding members also agreed to key values, principles and aspirations for the coalition, including cooperation and collaboration, diversity and accommodation, equity and sharing, responsiveness and orientation to action.

### **Sponsoring Agency**

The health unit initiated this coalition and remains a key stakeholder. One time funding for \$150,000 was received from the Public Health Branch and the Health Unit has been picking up the salary with some support from the CCO network. Working groups have some funds for projects from the Central East Network.

A retreat is planned for the summer and the long-term sustainability will be discussed.

### **Expansion**

There has been no discussion about expansion at this time. The coalition is organizing for cancer prevention. The first 2 years were developmental. With funds from the Ministry, the working group conducted some research, an environmental scan. One more year was spent finalizing the papers then coming up with recommendations and an action plan. They are now starting to implement the recommendations. "The whole experience has been a process."

### **Arguments in Favor of Expansion**

The coordinator identified that over the past year, there has been more discussion about chronic disease prevention. The task for this coalition is to explore how to link. "We

need to learn how we can make linkages with the chronic disease prevention initiatives. Need to understand our role.”

### **Membership**

The coordinator identified that a major strength of this coalition is the mix of members and this coalition contains “a mix of science, research and passion.” Membership includes citizens, including cancer survivors or family members of cancer patients, experts and advocates.

Members are described as having committing considerable time and energy to this developing coalition.

### **Anticipated Changes**

The cancer coalition has been given the task of primary and secondary prevention. The secondary prevention piece has slowed down. “It’s on the back burner and is about 2 years behind the other groups.”

The coalition is having a retreat in the summer to discuss future direction, long term sustainability, staff time and roles of the working groups.

## **DISCUSSION**

### **Comparisons between OHHP coalitions and other coalitions**

1. Similarities and differences between in the OHHP, Focus and Cancer coalitions related to coalition structure, sponsorship, partnerships and co-ordination

#### **Coalition structure**

Focus communities and heart health coalitions appear to be structured around a steering or advisory committee that works with the coordinator to plan and implement health promotion initiatives. It appears that the steering/advisory committees in Focus coalitions are less formal and work more as a support mechanism to the coordinators, at least in some situations. This apparent difference may be due to a number of factors including the size of the coalition, the nature of the community, and/or the nature of the partners.

The cancer coalition has adopted a formal organizational structure consisting of an advisory group and clearly mandated working groups. These working groups have been involved in a process over the past two years and there is an impression that all but one had produced its product, a planning document, on schedule. These work groups appear different from the “fluid and flexible” work groups described in some of the heart health sites. Heart health work groups appear to be focused on implementing initiatives and are risk factor or channel or audience based. Planning in heart health tends to occur more at the steering or advisory committee level.

The cancer coalition’s formal structure may be linked directly to the size of the community in which it is based, the size and the complexity of the coalition, as well as the structure of the organizations and agencies participating in the coalition. These factors may also have a direct bearing on the development time for the coalition.

The cancer coalition is city based but has a broader reach; the Focus coalitions are community based, whereas the heart health coalitions serve a much larger health unit area.

The differences in coalition structures highlight the unique cultures and values that develop in coalitions. In the one case, a large coalition working with a blend of members including health professionals working in primary, secondary and tertiary care, public health, research, university settings and a large number of survivors or family members have formed a structure that parallels professional working committees. Similarly, a coalition based in a small rural community does not have access to the number or range of health professionals and works in a way that fits the work and life experiences of its members. Each structure appears to fit the needs of the members, yet this may create challenges in collaboration across coalitions.

## **Sponsorship**

In this study sample, health units sponsored the heart health coalitions, one of the five Focus communities, and the cancer coalition. In many cases, heart health coalitions identified their health unit sponsor as supportive and they valued the resources and participation of the health unit. However, developing partnership relationship with the health unit was challenging for some. None of the Focus communities identified difficulties forming a working relationship with the sponsoring agency.

The way the health unit worked within the heart health coalitions varied across communities. Because health units are mandated to do heart health as part of their mandatory program guidelines there were times when program conflicts occurred. In some health units, heart health activities were the domain of the coalition although health unit staff usually participated in the working groups. In other situations, some heart health initiatives were the health units and others were the coalitions. This division reportedly caused confusion and conflict at times. No other sponsoring agency appeared to be in this type of relationship with their coalitions.

The data does not provide sufficient detail about the interaction between the health unit way of working, the mandatory program guidelines, and the interface with the heart health coalition. It does raise this as an issue for further discussion.

## **Partnership**

The cancer coalition identified its large membership (about 150 members) as its major strength. Membership in this coalition was working around a specific agenda set by the coalition. Although members came from a wide variety of roles, cancer coalition membership was directly linked either professionally or personally with cancer.

Focus coordinators discussed the give and take needed to work with partners. This group, who appeared to stay very focused on their mandate related to drugs and alcohol and injury prevention, shared that the only time they moved outside their mandate was in order to work with partners. Heart health coordinators, primarily from expanded sites also described this collaborative style of working with members.

The orientation of the coalition was reflected in its membership. Heart health coalition members included disease NGO's (e.g. Heart & Stroke, diabetes), health unit, schools, YMCA, municipal parks and recreation, senior centres, libraries, colleges and universities when in the community, trail associations, etc.

Focus communities shared some of the same partners as the heart health coalitions: schools, seniors and health units but also included addiction services, police agencies, emergency services, women's shelters.

## **Coordination**

All coalitions received guidance and leadership from a paid coordinator. Heart health coordinators were health unit staff, part of the in-kind contributions from the health unit. Focus coordinators were directly paid through the MOHLTC funds. The cancer coordinator was paid by the health unit, with support from other partners.

Across all coalitions, the role of coordinator was recognized as essential for the ongoing survival of the coalition. This role, requiring community development and community mobilization expertise, coordinates the issues from the community, brings and keeps partners around the table and balances the coalition's relevance to the needs of the community with the funded mandate from the MOHLTC.

## **2. Are coalitions interested in expanding to CDP?**

### **Responses to Expansion**

The response of the coordinators to expansion differed in a major way. The entire heart health sample had discussed expansion and most (13/16) were in favour of broadening their mandate to a chronic disease approach. It was recognized that funding would be needed in order for the coalition to become a chronic disease prevention coalition.

In contrast, Focus communities and the cancer coalition were aware of the discussions taking place about chronic disease prevention, but most did not see their mandate expanding to other diseases.

The specific mandate for the coalitions impacted on the potential for chronic disease prevention. Focus communities, although participating in healthy lifestyle initiatives, work with the risk factor of drugs and alcohol and injury prevention. Unlike tobacco, unhealthy eating and lack of activity, drugs and alcohol are not the major risk factors linked to other chronic diseases.

There was also a subtle difference in the way coordinators spoke about their work. The Focus and cancer coordinators spoke passionately about work with their risk factors and disease. The energy from the heart health coordinator was heard when they spoke about their work in promoting activity, good food and tobacco free environments not heart health.

## **3. To what degree do the coalitions within this sample collaborate?**

### **Coalition Collaboration**

Appendix 1 is an incomplete listing of community coalitions yet begins to show a picture of many varied community partnerships and coalitions in health promotion across the province. Many heart health coalitions work with tobacco and nutrition coalitions. Fewer work with healthy communities, Focus, cancer or diabetes coalitions. Focus communities tend to work with different coalitions, largely safe communities, injury prevention

coalitions although some reported also working with heart health and healthy communities coalitions.

There was some indication that the work of other coalitions was not always well understood and in a few cases there were expressed concerns about competition for partners by other coalitions.

In terms of creating new coalitions, one finding was that health units were deciding upon which provincial initiatives (and new community coalition) to pursue based on the ministry's expectations. It was reported that "pots of money" were being distributed for the creation of new community coalitions and that decision-making at the health unit was being influenced in part by the constraints or requirements of the provincial funders. What this implies is that new Ministry initiatives are being positioned differently (then for example, OHHP) for health units. This lack of provincial coordination about program expectations creates a difficult situation for existing programs and coalitions.

## **SYNTHESIS: Community Coalitions Capacity to Incorporate Stroke/Chronic Disease Prevention – Issues and Opportunities**

This report provides a comparison of coalitions; some that have initiated an expanded mandate, and others who have not. It compares and contrasts coalitions working in different programs and with different mandates. Factors that support heart health coalition expansion to a chronic disease approach were studied. The purpose was to identify issues and opportunities for moving towards an integrated approach to chronic disease prevention.

One limitation to note is that coalitions are continuously changing. The results presented apply to this current time (June, 2002) and application of the findings will need to take into account changing structures and conditions locally and provincially, including the funding decisions about the OHHP and Focus.

### **Issues and Opportunities**

#### **Readiness and openness of a maturing primary prevention infrastructure toward expansion to CDP**

There has been a significant investment in the development, evolution and resourcing of health promotion coalitions from the province and communities. Through the OHHP, most health unit regions have coalitions working to reduce the risk of tobacco, inactivity and poor nutrition. Most of these coalitions are in favour of expanding their mandates to a chronic disease approach and are well positioned to do so. There is an opportunity for these heart health coalitions to form a network for the primary prevention of chronic disease.

#### **Examples and models of integration of stroke and other chronic diseases are developing.**

Over the past few years coalitions, especially heart health coalitions, have been trying out innovative ways to promote prevention of heart disease, diabetes, stroke by promoting healthy lifestyles. The experience base is building and provides a resource to grow from.

#### **Growth in knowledge about the critical success factors and impediments for effective coalition development and functioning and resources to support coalition functioning.**

Development of coalitions to implement health promotion initiatives takes time. Once initiatives are implemented, they may be sustained but the continuous initiation and renewal of partnership of a coalition is not sustainable without leadership. Coordinators with skills in community mobilization are crucial to continuous development of partnerships. Problems surface when coalitions experience high coordinator turn over.

There are accessible resources to support coalitions including facilitators from Health Communities or from provincial resource centres, such as the Ontario Prevention

Clearinghouse. These resource persons have the skills and credibility to assist communities in reforming health promotion coalitions.

**Perceived benefits projected of working in a chronic disease framework.**

Discussions about chronic disease prevention has surfaced within communities as a way to better use limited resources. Coordinators speak about a limited group who works at the tobacco table, the cancer table, the heart health table etc. A broader chronic disease prevention approach could focus and reduce duplication of limited resources.

In some heart health coalitions, tobacco and active living coalitions have been folded in with the broader coalition. One potential risk for a chronic disease coalition is to become too large and unwieldy. This could occur as members seek to be inclusive. Very large coalitions (e.g. cancer) appear to take considerable time to build and move to implementation. In developing chronic disease prevention coalitions, existing coalitions need to balance the need to be inclusive yet responsive to the needs within the community.

What is yet to be determined is how to grow a chronic disease prevention partnership at the local and provincial levels.

**There is a concern about the fragmentation in our current system.**

In study 1, a number of coalitions exist within the same community. Issues, such as competition between coalition members or with other coalitions can fragment a coalition. Questions to ask include: How many of the same people sit on several coalitions? How many coalitions can a community sustain? What mechanisms make sense to link coalitions with separate yet related mandates and activities?

**Definition of community and appropriate segmentation of audiences and geographic areas to address chronic disease prevention is needed.**

Heart health coalitions formed initially in a region defined by the health department. Many of these regions are large and consist of multiple smaller communities. Focus and the tobacco coalitions formed primarily in smaller geographic areas. Some of the heart health coalitions working in large regions are developing coalitions in smaller communities. Ways to define community and invest in health promotion in smaller communities needs to be explored further.

**Uncertainty of sustained provincial funding is having a negative impact.**

The approach of March 2003, when funding for the OHHP is scheduled to end has created uncertainty in numerous OHHP coalitions. The OHHP coalitions required a 2:1 investment from the community, and communities have a significant interest in their long-term sustainability.

The approach of March 2003, when Focus funding is scheduled to end appears to have created little impact in Focus communities. Focus communities required a 1: 1 in kind contribution but the difference in response may be more attributable to the belief expressed by Focus coordinators that additional funding will come as it has in previous situations.

In order to continue coalitions as part of the health promotion infrastructure, stable funding and support at the provincial and local levels needs to be maintained. A risk of loss of funding can undermine a coalition in several ways, impacting on the retention of coordinators, and in partnership relationships. However, the terms and conditions attached to provincial funding need to be compatible with the agency's requirements, especially for large partners such as the public health.

**Effective approaches to health messages needs further study.**

Members join coalitions for different reasons. Some may come because they have interests in nutrition or in walking trails. Other join to work for disease prevention for which they have a personal or professional interest. However, at this time there is little known about what approach is most effective in maintaining interest and producing behaviour change.

**Partnership development is complex and requires highly skilled leadership.**

A coalition's strength comes from its community partners. Repeatedly, coordinators reported the importance of listening to the community and shaping initiative based on the needs within the community. Yet at times, the mandates, resources and accountabilities of partners create dynamic tensions. There is much yet to learn about what 'shared ownership' involves and what are realistic expectations for partners.

**Diversity in partnerships and potential value conflicts in broad coalitions need further study.**

Successful collaboration and partnerships require the flexibility for coalitions to move within broad parameters in order to address community needs and interests. However, a dichotomy is developing between those who chose to work with healthy lifestyles and those who chose to address social and environmental issues. Can a single coalition support these views? Are these views better addressed by independent coalitions?

Coalitions vary in the level of participation from members of the audiences. Some such as the cancer coalition involve upwards of 40% of the general population. Other coalitions consist largely of agency staff. Questions need to be addressed about these different approaches.