EVALUATING SUCCESSFUL PARTNERSHIPS IN PLANNING FOR HEALTHY COMMUNITIES

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ABSTRACT

Intersectoral collaborations between planning and health partners have emerged as a solution to mitigating the problems of urban health. Understanding what makes these partnerships successful by evaluating precedents in the local context provides a useful resource for action. Adequately evaluating the successes of intersect oral evaluation requires work in developing an analytic framework for assessment. This study analyzes a case study around the partnership work evolving around the Region of Peel's built environment and health initiatives. Through the analysis of key informant interviews and documentation a logic model framework for the partnership is hypothesized and discussed in the context of its potential application within an evaluation program.

Key words:

Intersectoral partnerships; collaborations in public health and planning; healthy cities evaluation; logic model analysis

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Introduction

The historical alignment of public health and planning professions is seeing a renaissance in tackling major urban health issues: understanding what is required of a "healthy city" has been reconceptualized as a joint task. Consequently, intersectoral collaboration has emerged as a potential avenue to reshape aspects of the city and the built environment where deleterious effects on health raise a host of problems intractable for the disciplines in isolation. A precursor to replicating success in collaboration is to define that vision of success and understand the pathways leading from action to outcomes. This is the work of evaluation, which helps stakeholders in the project and others who hope to access its benefits understand the complex transformations of networks, norms and skills that are the hallmark of collaboration.

The following study analyzes intersectoral collaboration through a case study in Ontario's Peel Region that aligns the work of public health and planning in developing more supportive environments for health outcomes. While grounding the design in the literature of healthy cities and evaluations, its findings are intended for practical use. The following pages illustrate data collected from interviews with partnership stakeholders and from documentation about the factors that facilitate success within the collaboration. The study frames this data in such a way as to support evaluation activities for this project and similar cases in the Ontario context.

Chapter I: Literature Review

i. Urban Health Problems

The complexity of urban issues has long been characterized as a major challenge to planners seeking to remedy the "wicked problems" of the city, due to the diversity of city stakeholders and fluid nature of urban issues' scope, timeframe and available remedies (Rittel and Webber, 1984). Urban health embodies such a longstanding, though perhaps not intractable, problem, where the fields of public health and urban planning grapple with the tools and conditions for the healthy city and seek both new frames for the issues and tools to address them.

The links between population health and social and environmental factors have been extensively explored in the literature and policy frameworks for action on the "social determinants of health" (SDOH). Both epidemiological and place-based studies revealing the rootedness of health inequities in the inequitable distribution of political, social, and economic resources (Baum, 2009; Dahlgreen & Whitehead, 1992; Jacobs et al, 2009). The consequence for public health, in seeking to fulfill its mandate in redressing these health inequities, is a reconceptualization in many jurisdictions so that "strategies aimed at particular issues need to be complemented by attention to those root causes of poor health: poverty, discrimination, poor housing and other social inequities" (Karpati, 2004; Corburn, 2009). In looking towards the "causes of the causes" of health, the approach in population health not only transcends the idea that individual and environmental conditions are sufficient explanations for health, but also crosses over into domains partially administered by civic leaders and planners. Social determinants of health for individuals and groups interface with their social position, stress, early-life support, educational status, employment, working conditions and unemployment, and access to food, housing, transportation and health services (Raphael, 2006; WHO, 2008).

The benefits and failures of intervening in the root causes of health are particularly relevant at the local scale, and healthy cities require attention to the combination of the forces that drive both the nature and the distribution of health outcomes at a local level (Krieger, 2008). The impacts of urban spaces and planning processes on population health have been well-researched, whether it is the effects of place, neighbourhood and context (Cummins et al, 2005; Diez-Roux, 2001, 2002; Frumkin, 2005; Geronimus, 2000; Macintyre et al, 2002) or the health effects of land use projects, policies plans affecting urban conditions and the built environment (Evans et al, 1994; Yen and Syme, 1999; Wellesley, 2013). The nature of the relationship between health the form of human settlements - the shape of the

city and aspects of the built environment - is conceptualized by the World Health Organization in the settlement health map below (Barton and Grant, 2011).

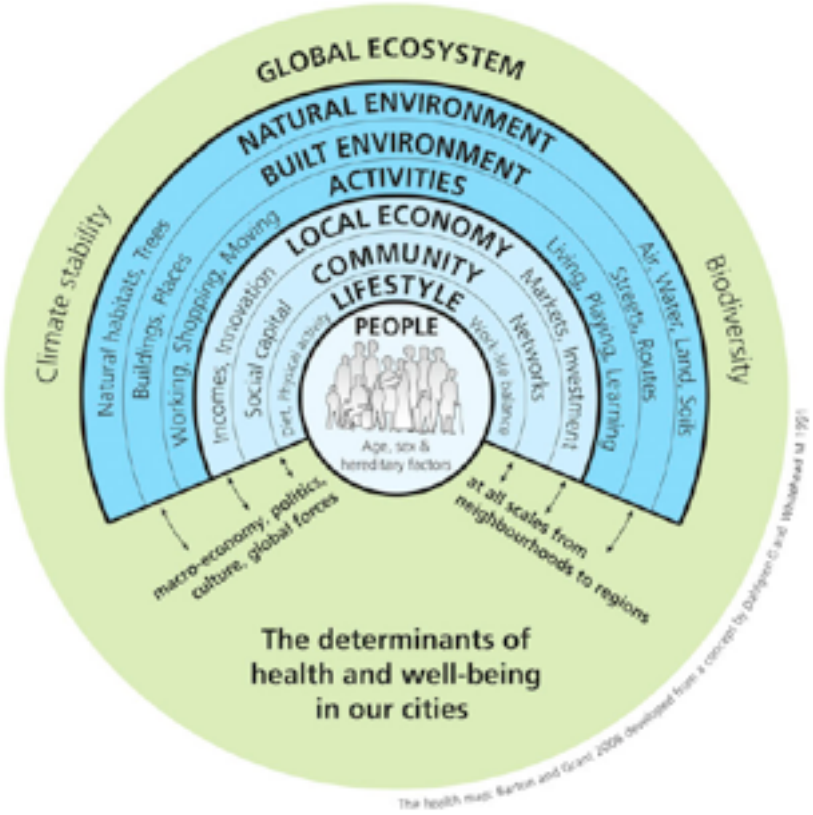

Figure 1: Settlement health map illustrating the impacts of human settlement form on health (Barton and Grant (2011)

The intersection of social and environmental impacts on health has prompted an extensive exploration of what constitutes the "healthy city" and what type of interventions are most effective in reducing health inequities (Baum, 2009; Gamm, 1998; Green et al, 2009; Macintyre et al, 2002).

The failures of early responses to urban health

Early alignment between public health and municipal governments attempted to remedy the health problems of cities - whether through sanitation infrastructure, the separation of uses through zoning, creation of building codes, housing regimes, or the neighbourhood as a mechanism for municipal service delivery (Corburn, 2009). However, in many cases these transformations had ultimately perverse effects, exacerbating inequalities in health, whether along racial or economic lines (Babcock, 1966; Isaacs, 1948). Ultimately, the idea that health-promoting outcomes could be manufactured by technocratic “city science” delivered by public health and planning departments, their divisions

reinforced by academic and professional boundaries (Peterson, 2003), crystallized with urban renewal projects of the 1960s and 70s. Meeting profound resistance by citizen groups from the poor inner-city neighbourhoods ravaged by public works projects, the planning and public health professions began to question their foundational practices (Babcock, 1966; Corburn, 2009; Mohl, 2000). While participatory planning practices developed by building coalitions with these community groups and social movements, public health saw the rise of social epidemiology, which used the model of interconnected social and economic factors to explain the unequal distribution of health outcomes in urban settings (Krieger 2001; Link and Phelan, 2000; Geronimus, 2000; Fitzpatrick and LaGory, 2000; Young, 2006).

The legacy of scientific city planning is apparent in many current processes designed to mitigate urban ills (Lawrence, 2003; Geronimus, 2000; Wilkinson, 1996). Jason Corburn (2009) points out that environmental impact assessments ignore health outcomes, despite the evidence of impact between the two. Others characterize the integration of health in planning as a reductive exercise that seeks to know whether a project meets health-based environmental standards, and fails to adequately deal with either the socially determined aspects of health or issues of health equity (Kuehn, 1996; Lawrence,2003; Geronimus, 2000; Wilkinson, 1996). In effect, harmful health effects may have their origins in some of the prominent norms and practices of planning. Barton and Grant outline a typical example where planning institutions facilitate market-driven urban development trends that promote car-dependent lifestyle (2011). Individuals choices for more active lifestyles are thus constrained by lack of opportunity, exacerbating health inequities for those with fewer resources and choices, and results in poorer long-term population health. Duhl and Sanchez characterize the problem that "urban planning can and does serve as a form of primary prevention and contributor to health outcomes" with the implication that "a holistic approach to building cities is key." (Duhl and Sanchez, 1999:8)

The emergence and implications of collaborative problem-solving

More optimistically, urban planning's responsibility for creating and exacerbating urban health problems comes with a similar opportunity to mitigate these problems. This would theoretically occur by embedding knowledge and better practices recognizing the connection between place and health into planners' influence over activities occurring well before the environmental review process. Such activities might include regional, city and secondary plans that shape communities, and the zoning and tax codes that provide both the scope and incentives for development (Corburn, 2009:65). This represents a major shift in the traditional approach to urban planning practice, and has been the subject of a vast body of literature and applied research practices on "healthy cities", "healthy urban planning",

and focused literatures such as those on health and built environment. What, then, are the transformations in practice that are required of healthy city planning? Barton and Tsourou simply describe healthy urban planning as planning for people in cities (2000) ; Jason Corburn elaborates on this definition:

"A […] challenge for the new politics of health city planning is to address the disciplinary specialization, bureaucratic fragmentation, and professionalization currently plaguing both planning and public health and acting as a barrier toward crafting a coordinated, healthy city research and action agenda. New models of collaborative research and urban governance will need to accompany the construction of new, cross-disciplinary and sector coalitions both within and outside government." (Corburn, 2009: 84)

While action by health and city stakeholders has been siloed throughout much of the 20th century (Peterson, 2003), there is nonetheless a historic precedent for partnership (Corburn, 2009; Rosen, 1971). Emerging from this precedent is a transdisciplinary notion of healthy city planning, which since the 1990s, has been constantly articulating itself through theory-building and practical application of healthy cities projects (Barton and Grant, 2011). While their impacts on health outcomes and health equity are still gaining coherence (de Leeuw, 2012), some ideas have emerged that are relevant for further study.

The idea within healthy planning of the "relational view of place" - that the physical and social characteristics of place are important because of their constructed meanings and their accompanying institutions, networks and processes – has gradually begun to accompany the notion of "place effects on health". Place effects highlight physical determinism and do not always take into account the crucial norms, and formal structures that shape how institutions address social issues (Cummins et al, 2007; Gieryn, 2000; Graham and Healey ,1999; Jackson, 1994; Whyte, 1980). Concretely, re-examining norms implies the reconsideration of the institutions themselves (Healey, 1999) in establishing new solutions for healthy city planning.

Re-examining the norms of professional practice is of concern to planning, but also to public health. Duhl and Sanchez (1990) expalin that not only has the definition of health shifted and effectively broadened, but the leading causes of death in developed nations are attributed now to chronic rather than infections diseases. They posit that these challenges - to strategic planning, resourcing, and capacity to develop workable solutions – demonstrate the need for multisectoral prevention. (Duhl and Sanchez, 1990).

Shared roots in theory and practice have shored up rationales in the past decade for collaborations in both public health and urban planning spheres (Green et al, 2009; Northbridge and Freeman, 2011). For instance, establishing neighbourhood health centres of the early 20th century in the United States that combined clinical and social services for the poor tackled SDOH and health inequities in American cities (Rosen, 1971). Public health and planning never were fully siloed - even in the era of the City Scientific, theories emerged about the importance of health equity to planning's legitimacy (Marsh, 1909). By the 21st century, the disconnect between environmental health and urban planning decision-making has emerged as a major issue to tackle in addressing urban health inequality. The international "healthy city" movement developed by the World Health Organization (WHO) in 1986 committed cities to linking health and planning. The WHO has driven much of the emergence of a co-produced "science of the city" rooted in the theoretical frameworks, methods and available tools of both public health and city planning as well as case studies in preventative, versus curative, approaches to health rooted in collaborative urban governance (Corburn, 2009; Barton and Grant, 2011).

Looking to the research around solutions to urban health problems, the criteria for interdisciplinary action laid out by Freudenberg, Klitzman and Saegert (2009) explain why a collaborative approach best serves the problems of urban health:

1) The problems' causes and consequences are cross-cutting across multiple disciplines;

2) The solution to the problems falls in the bailiwick of multiple disciplines or institutions;

3) The problems are embedded in a complex social /physical environment or multiple sectors;

4) Both fundamental and proximate causes of a health problem are under investigation and stakeholders who work at both ends of this spectrum are needed to understand the issue;

5) If the goal is to fix rather than describe the issue, then stakeholders representing the scope of research to action in policy or programming are needed. (299)

Ultimately, dealing with complex and interconnected major public health issues where the role of urban planning could better support health outcomes highlights the importance of a combined approach (Northbridge and Freeman, 2011). Moreover, it is crucial for planners to investigate more than simply the "formal processes of spatial planning", which could be characterized as such practices as environmental impact assessments, general plans and zoning by-laws (Huxley and Yiftachel, 2000). Planning must also re-examine the processes of decision-making and the macro-policy contexts in which local, place-based projects operate (Healey, 2007).

Jasanoff describes the process of disentangling and critically examining norms of practice in healthy city planning as the "co-production of the science of the city" (2004: 3). Social and political commitments can help widen the scope and relevance of urban regulatory frameworks (Jasanoff, 1990). Concretely, the re-examination of norms implies reconsidering aspects of the institutions themselves (Healey, 1999) in establishing new solutions for healthy city planning. In effect, the WHO Healthy Cities Movement has developed an emphasis on building formal partnerships across agencies to form new communities of practice in research, resource allocation, and strategic planning (Tsourou, 1994).

While historically, planner's legitimacy in establishing sanitarian measures in the 19th century was only ensured by strategic coalition-building within the community sector (Rosencrantz, 1972), there is a continuing rationale to look to coalition-building as an avenue for successful interventions in urban health issues: the built environment alone is stewarded by multiple stakeholders whose capacity to intervene on any of the psychological, social and physical health factors of place is necessarily limited in isolation (Corburn, 2009; Wellesley, 2013).

The relative advantage of partnerships and coalitions over single-entity actors working in isolation or even loose networks is extensively explored in governance literature. One key rationale for our purposes includes the "collaborative advantage", where collaborating organizations produce "unusually creative", or synergetic, outcomes as a result of partnership (Huxham, 1996 in Boydell, 2007). Another is the explanation that concentrating resources, technical expertise, and organizational capacity for the purpose of a common goal enables the success of otherwise weaker actors. Collaboration is then essentially a capacity-building exercise predicated on the fulfillment of shared goals. (Burris et al, 2007)

ii. The role of intersectoral partnerships in urban health solutions

While siloing of health and planning has created barriers to the level of collaboration described above, the re-emergence of attention to the social determinants of health within health assessment frameworks has reignited an interest in forming intersectoral partnerships as one way to address the social and environmental aspects of health (Danaher, 2011; Gamm et al, 1998; Koh et al, 2010). Similarly, **t**he emergence of sustainable systems perspectives within both public health and urban planning has illuminated the need for partnerships. This need is only growing in increasingly complex urban environments and in light of the failures of health promotion within contemporary health delivery systems, particularly at redressing inequitable distribution of good health (Green et al, 2009; Green et al, 2010; Northbridge and Freeman, 2011).

Barton and Grant ascertain that "the importance given by some cities to the need for training, professional development, inter-departmental cooperation and political awareness reinforces the message that organizational development is necessary to tackle healthy urban planning effectively." (Barton and Grant, 2011) The impetus is highest within a well-developed partnership for the idea-sharing and social learning required of policy innovation (Frug,1999: 80), and the norms of practice within respective partner institutions may co-evolve as the partnership progresses (Healey, 1999). The transformation of organizational structure and norms of practice through intersectoral partnerships aimed at planning for healthier communities is the focal point of this research project.

Understanding intersectoral partnerships

What the literature reveals about intersectoral partnerships is that they are widely considered to be an essential tool in addressing urban health issues, whether regional coalition-building as a mechanism to alleviate the challenges of competition for municipal resources and ensure the representation of key, local stakeholders in cities and neighbourhoods (Pastor et al, 2007), or with strong social movements to provide leverage for action (Danaher, 2011; Corburn, 2009; Freudenberg et al, 2009). An evaluation conducted by the World Health Organization of their global Healthy Cities initiative provides a rationale for interdisciplinary partnership at a local level. This rationale includes: a concern for the same population, more opportunities to meet and collaborate locally as compared to the national level, and the historic precedent of public health and planning collaboration (Green et. al, 2009). Other potential benefits to partnerships at the scale of the city derived from these case studies involved more focused investment in upstream policy initiatives to reduce organizations' competition for strategic attention and scarce resources, coordinating action across non-health policy areas of government in health promotion (Green, 2012; WHO, 2008).

Whatever the value of intersectoral action, organizations will only shift their norms and behaviours if the theoretical rationale for collaboration is shored up by the realpolitik of what is possible (Gray, 1985). It is thus useful to consider the conditions for when partnership work is both important and most likely to occur:

- stakeholders are challenged by a multitude of challenging issues;
- problems are perceived to exceed the problem-solving capacities of autonomous stakeholders;
- traditional routines of problem-solving no longer yield results;

- competing agencies or units start creating unanticipated and dissonant consequences of actions that might still be considered 'routine' responses; and
- stakeholder agencies or units recognize mutual and often reciprocal temporal and causal interdependencies.

(Gray, Hueben and de Leeuw in Lipp et al 2012)

The burgeoning literature on healthy city planning and the emergence of widespread responses, including the requirement by the WHO to include the development of intersectoral partnerships in their designation of Healthy Cities would seem to indicate that the conditions are ripe for planning and public health to explore the potential for successful responses to urban health problems through partnership(de Leeuw, 2012; Green, 2012, Barton and Grant, 2011).

Defining the terms

What, exactly, does an intersectoral partnership imply? Stern and Green elaborate a singular "pragmatic definition" of partnership as "a programme that has a high level of commitment, mutual trust, equal ownership and the achievement of a common goal', as distinct from networks which might 'involve sharing information or other resources but not for the explicit purpose of joint working'. (Stern and Green (2005:270). However, El Ansari et al describe a range of configurations for intersectoral collaboration: front line service delivery, jointly managed services, strategic alignment, special-purpose governance bodies and community development initiatives that involve multiple agencies (2001). Moreover, a literature review on partnership processes for health promotion found that terms of partnership - collaboration, cooperation, coordination, coalition, network, alliance and partnership- are often used to describe the same thing (Huxham 1996 in Boydell, 2007), and reveals too that the consideration to the level of integration is important in qualifying partnerships. The WHO's evaluation of their Healthy Cities case studies relating to urban planning reveals a useful framework of these levels of conceptual integration that influence organizational integration and can help us characterize the success of partnerships in the context of urban health.

1) Basic recognition within the partnership of environmental health and the role of settlements on health systems (shelter, access to food and clean water, effective sewage treatment).

2) Recognition of the impact of settlement planning and design on health. Examples include attention to resources for healthy lifestyles (parks, food sources), healthy environments (unpolluted air, green space and walkable neighbourhoods). While this level of integration may permit the accrual of extra political

support and resources for the outcomes of "poorly integrated planning" it does not deal with the transformation of environments or conditions for health.

3) Health is fully integrated into the planning process, and is both present and integrated with other themes of sustainability in the planning process at local, city and regional levels. It relies on the bridging of silos and collaborative practices and programmes. (Barton and Grant, 2011)

Integration at this third level is evidently the most desirable, but also the more difficult to accomplish in the context of healthy urban planning- requiring profound changes to the norms influencing the way that things are planned and the way that things are done. Barton and Grant suggest that these changes can ultimately be supported by knowledge exchange and reflective discourse on values between partners" (2011). They caution that if the practitioner is to apply the research and available tools in transforming their practice, it is necessary to further investigate what other qualities in a partnership are liable to lead to viable solutions to the problems of urban health.

The qualities of successful intersectoral partnerships

The typology of successful partnerships has been explored fairly broadly at the international level and constitutes a robust body of knowledge surrounding the value of collaborative planning practice, meaningful stakeholder engagement, strategic and long-range alignment of budgets and priorities that constitute effective partnerships in bridging health inequities, particularly in relation to urban planning (Gardner et al, 2010; Green, 2012; Health Development Agency, 2003; Lipp et al, 2012; Macintyre et al, 2002).

In terms of what requirements exist for the formation of an effective framework for healthy city planning, research on emerging case studies points to: the identification of and a shared commitment to common ground in their institutional missions, goals or agendas across departments and programs (Katz, 2006); a recognition of each partner's unique contributions/expertise; longevity of the partnership; developing processes for resolving issues (Freudenberg et al, 2009). A framework by the Heath Development Agency as framed by Geoff Green, with elements duplicated in El Ansari et al, Jones and Barry (2011) states that the qualities of successful partnerships in integrating health objectives into the "well-being and health of local populations" include:

1) Working across boundaries;

2) Partnership arrangements and accountability structures;

3) Planning arrangements (strategies);

4) Community involvement;

5) Members' (political) involvement;

6) Joint priorities, indicators and targets;

7) Reducing inequalities and tackling deprivation;

8) Using flexibilities - pooled budgets, joint posts and integrated services

("Planning Across the Local Strategic Partnership, Health Development Agency, 2003 in Green, 2012)

In order to maintain a partnership, specific skills and resources that develop and organize the partnership's assets and membership are needed. Duhl and Sanchez suggest that "the ability to set goals, mediate between member and collective needs, effective leadership and decision-making processes are key to ongoing success"(1999: 26). Similarly, challenges to effective partnerships have been enumerated: the realpolitik of transforming planning processes with potential health ramifications is complex, as norms are deeply embedded within planning departments; there is insufficient training to establish the cultural sensitivities, common vocabulary and mutual understanding instrumental in effective co-production; the actual regulatory authority of even successful partnerships; and the influence of private sector development interests seeking stability rather than innovation (Bergeron, 2011; Corburn, 2009; Freudenberg et al, 2009).

The vision of success is far from unified, however. Certain universal qualities of success, such as effective community engagement, are rooted in values of inclusion assumed to be embedded in both sectors, and warrant exploration (Lipp et al, 2012). Moreover, monitoring the balance between activities that support the maintenance of the partnership structure itself and the outcomes it produces is necessary in qualifying whether success is both meaningful and sustainable (Duhl and Sanchez, 1999: 26). Duhl and Sanchez (1999) identify a "final component" necessary for the maintenance of a coalition: assessing its accomplishments, either as short term or long term changes. Assessment, either through formal or informal evaluations, can ultimately help illuminate the ways that intersectoral partnerships are an effective tool to deal with the wicked problems of urban health.

iii. Assessing the effectiveness of intersectoral partnerships

Developing an understanding of what is needed for successful intersectoral partnerships is a necessary part of achieving real solutions to urban health issues. The work of the WHO has piqued the interest of various levels of government internationally who have participated in the Healthy Cities pilot work, and there is a need to develop the evidence base about whether partnerships add value to policy,

or warrant the allocation of further resources (El Ansari et al, 2011; Boydell, 2007). Evaluation methods provide a systematic review that assesses the effectiveness of an intervention (Duhl and Sanchez, 1999; Mark et al, 2002; Scriven, 1967). While WHO Healthy Cities evaluations have revealed that partnerships remain a core component of success in Healthy Cities, they substantiate the concern of methodological challenges and the complex need to attune our ways of understanding the outcomes of collaboration to the "multifactorial nature of this concept." (El Ansari et al, 2001; Lipp et al, 2012).

Measuring the accomplishments of intersectoral partnerships and assessing their value for healthy urban planning is a challenging proposition. The diversity of actors involved in different stages and outcome areas of healthy cities makes it difficult to propose a general theory of effectiveness: success is contingent on the local context and the values intrinsic in this judgment of effectiveness (Duhl and Sanchez, 1999; Lipp et al, 2012). Compounding the complexity of assessing urban health issues is the fact that evidence of effectiveness in partnership structures is a contested research area - the shifting of norms and development of activities within partnerships are in fact characterized by complexity and uncertainty, without a clear path to success (Lipp et al, 2012).

While early findings are promising in developing theories and frameworks for effective intersectoral partnerships on healthy city planning (Bergeron, 2013; Danaher, 2011), best practices in a Canadian context limited. The value of local assessments is that it helps researchers and practitioners develop concrete observations about interventions in the complex causal systems they operate in (de Leeuw, 2013; Koh et al, 2010; Macintyre et al, 2002). The lack of standardized metrics to establish the effectiveness of intersectoral partnerships can frustrate local efforts in establishing success (Northbridge and Freeman, 2011; Wellesley, 2012). The need for "objective" measures in assessment is described as a necessity for intersectoral action that coordinates governance strategies, local action, and funding streams (Green et al, 2009; MacIntyre, 2002; Wellesley Institute, 2012). In effect, the lack of evaluation standards in intersectoral collaboration has been attributed to the transience of previous collaboration efforts between public health and planning over the course of the 19th and 20th century (Banerjee and Baer, 1984).

Beyond measurements and indicators, it is useful to consider how partnerships function, the process measures that de Leeuw articulates as a major component of WHO evaluations research over the past decade (2013). Looking to the emergence of the "science of team science" that guides interdisciplinary practice (Freudenberg et al, 2009), it is useful to understand the conditions for successful partnership, including prevailing attitudes toward partnership and projects; looking at

collaborative processes including knowledge transfer from one discipline to another; the amount of time members perceive to be necessary for completing the team project; collaborative outcomes around dissemination and impact of project; generally looking at the evaluation of transdisciplinary collaboration that will provide the greatest insights into what constitutes a successful partnership (Fuqua et al in Freudenberg et al, 2009).

So, while the development of indicators and measurement tools can be considered an ultimate objective for assessing the success of intersectoral partnerships, it must be preceded by the elaboration of "a more rigorous analytical framework and theory-informed approach to reviewing partnership and collaboration parameters" (Lipp et al, 2012). Answering key questions about the evidence behind quality, effectiveness and efficiency, ownership and accountability within the partnership structure, and feasibility of the activities is intrinsically linked to enhancing outcomes (Danaher, 2011; de Leeuw, 2013).

Given the need for further research and concrete tools for evaluating partnerships in planning for healthy communities, the objective of this study is to investigate a case of intersectoral partnership and the ways that this partnership's work is linked to successful results. This analysis will support a broader evaluation program for the case study and add to an understanding of intersectoral partnerships in planning for healthy communities in Ontario.

Chapter II: Methodology and Study Design

The call from Ontario researchers Bergeron and Levesque to develop standardized measurements and conceptual frameworks for collaborative partnerships (2011) should be approached with a mix of methods that identify and explore issues in a way that allows some standardized measure of effectiveness, while gaining greater insights into the meanings and embedded norm within practices (Jones and Liburd, in Freudenberg et al, 2009). Filling in the gaps of healthy cities research ultimately requires the evaluation of the policy processes, development of norms and networks among organizations that contribute to healthy urban development (Tankano, 2003). This in turn requires "unconventional, intuitive and holistic measures to supplement the hard data". Mapping the roles, relations and objectives within partnerships and ultimately establishing criteria for success that can be measured through quantitative means is one place to start. (Hancock and Duhl, 1988; Lipp et al, 2012).

Drawing on these methodological considerations, this study is designed to assess the qualities of a case in intersectoral partnerships in the domain of health and urban planning that lead to success. The value in this approach is that it sets the up a framework for evaluation of the partnership process as well as its products, consequently expanding local research about intersectoral action and testing existing frameworks of successful partnerships integrating public health concerns in planning.

i. Case Research

The decision to use a case study method is guided by the qualities Robert K. Yin outlines in selecting appropriate methods for research. Case research can answer questions about "how" and "why" the partnership functions, the investigator has multiple sources of data covering a number of variables, yet too little control over events to run an experiment, and the focus is on a "contemporary phenomenon within a real-life context. (Yin, 2008:18).

The case selected is work at the regional level in Peel - primarily the alignment between regional bodies in Public Health and Planning to develop joint work on supportive environments for health. Peel Region is an upper-tier municipality in the province of Ontario, and encompasses three lower-tier municipalities: Brampton, Caledon and Mississauga. The regional-level divisions of Peel Public Health and Peel Public Works (formerly known as Planning, and referred to as Planning in this study for clarity) are the main stakeholders that emerged in the analysis, who report to Peel Regional Council. The built environment and health initiatives work has, however, expanded to include the three local area

municipalities, the Federal Council of Transportation Engineers, and the Medical Officers of Health in municipalities across the province. The analysis in Chapter III offers information about the qualities of the partnership between Public Health and Planning and its expansion.

ii. Methodologies for Evaluating Intersectoral Partnerships

Despite the rhetoric behind developing intersectoral partnerships in healthy urban planning, there is in effect fairly limited evidence around how to best adopt changes leading to success. (Asthana et al, 2002: 218) As a result, methodological insight into how best to approach the evaluation of such programs is similarly limited. What evidence does exist is drawn from literature around evaluations and research on partnerships as they relate to organizational development, health promotion and policy.

The main focus of the wider suite of WHO Healthy Cities evaluations has been around measuring successful outcomes. It is this type of research which drove much of the longitudinal data collection around integrated and sustained collaboration through questionnaires and case study research (Lipp et al, 2012). However, Peel's work, which began in 2005, is at the point where it can only begin to answer "how" the partnership process works, rather than to what extent it works well. Creating opportunities for less sedentary lifestyles in Peel is a lengthy endeavour. The necessary shift from sprawl to compact development patterns must be preceded by changes to policy and plans, which can themselves span many years if they are appealed to the Ontario Municipal Board, and reshaping the built environment is a long-term, continuous process.

Why evaluate?

The previous chapter outlined the rationale for assessing the effectiveness of intersectoral partnerships and supports the argument in the literature that evaluation is the approach to use in doing so. Underpinning the focus on evaluations is both the need to justify resource allocation and to identify what works and does not in order to guide practice (Boydell, 2007). The rationale of intersectoral partnerships is ultimately to improve the situation (Freudenberg, Klitzman and Saegert, 2009: 299), and evaluations can assist in developing a sense of the merit and worth of what is being evaluated (Scriven, 1993). Merit in this case is described as the quality of performance of a program or policy; worth is considered to be the value of the program's effects on social good (Patton, 1997; Scriven, 1993; Mark et al, 2000).

However, evaluation activities may extend beyond the measurement and assessment of outcomes, and can focus instead on the "sensemaking" aspects of the components and values driving the project at hand (Mark et al, 2000). In effect, so-called "summative evaluation" where merit and worth is assessed at the end of a project, may not provide sufficient information about "how" and "why" a project succeeded or failed and will have limited impact on how projects are supported politically and funded. Thus, questions about how and why the partnership operates in the ways that it does are closer to the concerns of this study, aligned more closely with mid-stream formative evaluation (Wholey, 1996).

Designing the evaluation program

In practice, the reasons for the evaluation will guide the ways the evaluator will collect and subsequently assess data (Scriven, 1967). The purposes of evaluation frame the questions asked in the evaluation, the types of data needed, and the range of solutions the evaluation is intended to support (Mark et al, 2000). It is important for the partnership stakeholders to be involved in conceptualizing the goals of an evaluation to facilitate the use of the evaluation (Davidson, 2012). Nevertheless, this study can hypothesize some basic evaluation goals for Peel Region:

1) Demonstrating the merit and worth of work to date in relation to longer-range objectives;

2) Understanding and assessing the consistency of processes leading to successful outcomes in order to either correct or replicate these processes.

Another major consideration stems from the "realist paradigm" in modern theories of evaluations design (Mark et al, 2000), and the criterion of "actionability" for the evaluation program associated with Patton's utilization-focused evaluations (Davidson, 2012; Patton, 1997). The realist paradigm suggests:

- investigating underlying mechanisms and structures that influence events and experiences;
- prioritizing practice and the lessons drawn from practice;
- combining any methods is appropriate as long as they support evaluation and do what they are designed to do;
- thinking in terms of an evaluation program, since no single evaluation can provide all the information needed for current and future needs (Mark et al, 2000:137).

The benefits of realist evaluation in healthy cities research are that it drives the production of a context-specific theory of how the program works, bringing to light the causal mechanisms that interact with the context of the program in order to achieve specific outcomes. (De Leeuw, 2011). El Ansari goes

on to suggest that "it is important to know more than whether it works if the evidence is to be of practical use. This type of knowledge is much more likely to be revealed by evaluations that use the 'mechanics of explanation' (El Ansari et al, 2001: 222).

In order to test the mechanisms of change within successful partnership configurations, efficacy studies using randomized controlled trial design would be ideally suited to building valid and reliable conclusions from the evidence gathered (El Ansari et al, 2001; Yin, 2008). However, community-level initiatives typically do not lend themselves well to experiments, and the focus of this study is intended to encompass not just a single mechanism but the wider range of factors influencing successful partnership functioning. As a result, it is preferable to look to qualitative methods - participant observation, focus groups or interviews - in order to explain the change process and answer questions about how and why collaboration works in certain contexts. (El Ansari et al, 2001). As for data collection through surveys, the exact nature of definitions surveys require (of successful outcomes and the mechanisms leading to success) mean surveys are unsuitable for data collection. Therefore interviews are methodologically the best strategy for research to better understand effective partnerships, as interviews can provide data about perceived causal inferences and explanations (Yin, 2008).

Considering the aforementioned goals and working within a realist paradigm, the following assumptions guided the study design:

- Investigating the relationship between partnership structure, activities and outcomes should be a priority: interviews are better suited to this task than surveys.
- Methods should deliver rich insights into group and individual attitudes about "what is" and "what should be" related to how the partnership operates and as well as how it achieves its goals. Qualitative data is well-suited to this task.
- Analysis should conceptualize the mechanisms for change and assess conceptual gaps either between and among different stakeholder groups or between the case and generalized theory.
- The goal of the study is to develop a reference point that can be used for an evaluation program. This evaluation program should be designed by its users (Mark et al, 2000:137).

Logic Modeling Analysis

In evaluations of intersectoral partnerships in planning and health, there is a precedent for using logic modeling to assess the "process measures, intermediate outcome measures and distal outcome measures that correspond to stages of partnership activity" (Fawcett et al, 1995 in El Ansari et al, 2001).

Thinking about collaborations as processes as well as outcomes can help break down the ways that partners can benefit from learning to work intersectorally (Asthana et al). More generally, logic modeling is considered useful in evaluations for complex chains of events. (Yin, 2008) A logic model can lend clarity to the long timelines and complexity of work within the Peel case study.

Logic Modeling (Adapted from W.K. Kellogg Foundation , 2004)

Purpose:

Often called a program theory, a logic model describes how a program/policy/process works and what its results should look like. The elements and presentation of the logic model can vary, but all essentially map out the connections between the "planned work and intended results."

A logic model helps reveal the underlying assumptions in the project about what happens and in what order for the desired results. Clarifying assumptions can:

- build the narrative needed to communicate progress to funders and stakeholders;
- help program design and implementation by developing a shared understanding of what is supposed to happen, highlighting any problems (such as logical inconsistencies or poor practices) in how this process is supposed to work, and identifying program areas that need developing;
- develop capacity for monitoring and evaluation in identifying which program areas are most important in achieving the results so that they can be prioritized for data collection and tracking, and identifies what is and is not being tracked to demonstrate success.

A logic model is essentially a snapshot of the program at one point in time - it should be revisited as priorities, resources and programs shift, outputs become more clear or change, and the program gets closer or further away from its "intended results".

How to Use a Logic Model

Logic modeling can set the stage for measurement: it makes sense of the components of the program work that will be assessed, and defines what constitutes the outcomes that should be measured.

There are two main tasks:

1) Collecting the components:

Identifying program work and its results will inventory the inputs, outputs, and outcomes and operating context for the program. Collecting data from all stakeholders involved-

staff, participants, stakeholders such as governing boards and partners – helps make the connections between what the program is expected to do and what it actually does.

2) Analyzing relationships between components.

One way of tracing the connections is to ask questions about outcomes first and "backwards-map" - asking what the final product is and then what needed to be in place before that, and what needed to be in place before *that*. Prioritizing outcomes in the discussion can also develop consensus around what success looks like, specifically: vague or unrealistic goals may mask a poorly-defined vision of success that cannot, ultimately, be evaluated. (Aspen Institute, 2003)

Another potential practice in logic modeling is to develop a theoretical proposition ahead of observations, to then compare the predicted and observed outcomes, as a type of pattern matching analysis (Mark et al, 2001). The development of a conceptual framework emerges from theory-driven evaluations approaches, which build our understanding of the assumptions and mechanisms underpinning a given program (Coryn et al, 2009).

How exactly either of these tasks is carried out, should reflect the particular resources and limitations of the evaluation activities as well as the goals of the evaluation on the whole.

iii. Application of Logic Modeling in the Research Design

Data collection:

- Selection of data sources (political resolutions, position statements, strategic reports, tools, interviews with key informants) that could show the range of logic model components, including processes, resources and the social aspects of the partnership process, not only the products and results of the work itself.
- Questioning technique (semi-structured interviews using backwards-mapping approach) that prioritized the articulation of successful outcomes, clarified assumptions about conditions for success and linked components in the logic model.

Analysis

- Using an applicable logic model framework as a basis of comparison for the data collected from the case study. Doing so develops readers' understanding of how the local context affects broader

theories of partnership working (El Ansari et al, 2001) and better situates the Peel partnership within the field of effective healthy planning partnerships. UK researchers Asthana, Richardson and Halliday have developed a framework for partnership evaluation in the context of Health Action Zones (local intersectoral partnership initiatives aimed at health equity solutions) that is comprehensive in addressing the issues around partnership-building, is grounded in practice, and is sufficiently rigorous to allow comparative analysis between case studies (Asthana et al, 2002: 782). See Appendix C for the framework elements and analysis of the case study's consistency with its suggested components.

- A draft logic model was developed from the review of project documentation and shown to key informants to prompt questions about the relevance and gaps in various model components as well as the relationships between them.

Summary of methods

I. Preparation:

- Theoretical proposition of logic model (Asthana et al HAZ partnership model)
- Purposive selection of key informant interview candidates.
- Identification of material for document analysis (selection criteria based on material's potential for logic modeling analysis)

II. Data collection:

- Document analysis: highlight instances of Asthana et al model components in case study's process documentation including resolutions from Council meetings, conference websites and reports.
- Key informant interviews (semi-structured): preparation of questions about partnership working and other mechanisms leading to success factors. Use of a draft logic model as the basis for discussion (see Appendix A for sample questions).

III. Data analysis:

- Testing the theory: highlight differences between observed characteristics and those predicted by in the logic model.
- Logic model development: using findings from interviews and document analysis the logic model components are elaborated, and their relationships are described.

IV. Products

- Peel Region Built Environment and Health Initiatives logic model chart and analysis
- Framework for integrating logic model into an evaluation plan.

iv. Limitations

The time between project scoping, evaluation design, data gathering and analysis and reporting is significantly shorter than typical external evaluation activities. Accessing the range of stakeholders within the partnership would reflect a more holistic picture in the findings. However, the external position of the investigator and the shortened timeframe to build relationships and bonds of trust needed to access data presented social and logistical barriers to accessing key informants in the partnership. The subjective nature of responses raises the issue that data gathering may present inaccuracies affecting the validity of the study, given that respondents may be "may be biased toward achievement" in order to justify the efforts of their program. (Lipp et al, 2012: 4). This is a common thread in healthy cities evaluations where self-reporting was not substantiated with external outcomes assessment (El Ansari et al, 2001; Barton and Grant, 2011)

Chapter III: Analysis of Findings

i. Overview

Peel Public Health has undertaken a series of projects in alignment with Planning at the regional level. Alignment has facilitated not only joint work on healthier built environments, but also the expansion of the partnership network into other disciplines aligned with the planning field, such as transportation engineering. It has also facilitated Peel Public Health's access to municipal development stakeholders. Concurrently, the Region is seeking political support for healthier planning policy and investments at the provincial level and building interregional coalitions to reach higher levels of government. Finally, collaboration with experts and direct outreach to municipalities and the development industry have also contributed to moving the partnership's work forward.

The nature of partnership work in Peel is both formal and informal. On the one hand, a Peel Regional Council resolution in 2005 formally directed the alignment of planning and public health staff and joint work such as the Healthy Development Index and subsequent Health Background Study Framework has been supported and in the case of Peel's Active Transportation Study and subsequent Plan, funded. On the other hand, the strategic alignment and working relationships between leaders in Planning and Public Health is not an institutionalized partnership with defined roles and responsibilities – although these may be set out at the project level. Along with the absence of identifiable accountability structures beyond joint reporting to Regional Council on progress, it is clearly not formal structures, but relationships that move the work of health and the built environment forward. Moreover, the partnership processes are responsive to current political and fiscal conditions and interprofessional networks: interviews indicate that staff have been starting to see the value of partnership work in different areas and have been expanding the network accordingly.

The 2012 report from Peel Public Health on Creating Supportive Environments for Health lays out some of the explicit principles underlying the partnership work within Public Health's portfolio:

- Strategic planning and work is intentionally intersectoral. It identifies the Regional Planning department, lower-tier municipalities, school boards, developers, public opinion, and higher levels of government as potential partners.
- Multi-year action plans that are designed to accompany strategic planning will identify objectives, prioritize action and establish and an understanding of baseline conditions. Action

> planning is designed to be iterative, seeking alignment with partnership initiatives to achieve a longer reach and prioritize more timely action. (Peel Public Health, 2012)

With these considerations in mind, the logic model on the next page visually summarizes the context for partnership, Peel Region's partnership activities, resources and processes (inputs), the immediate results of partnership work (outputs), and what results are expected in the medium-term (outcomes) and the long-term (impacts). The components of the logic model (context, inputs, outputs, outcomes, impacts) and the relationships between them emerged from the analysis of key informant interviews and documentation (see Appendix C for the list of documentation used). Following the logic model table is a narrative describing the connections between components with further analysis around the conceptual linkages and gaps between what has already occurred what is expected to occur in planning healthier communities in Peel. A separate section characterizing of some of the challenges identified to date in partnership work and provides an additional layer of analysis around how the partnership functions, and offers insights into planning an evaluation assessment, which is explored in greater detail in Chapter IV.

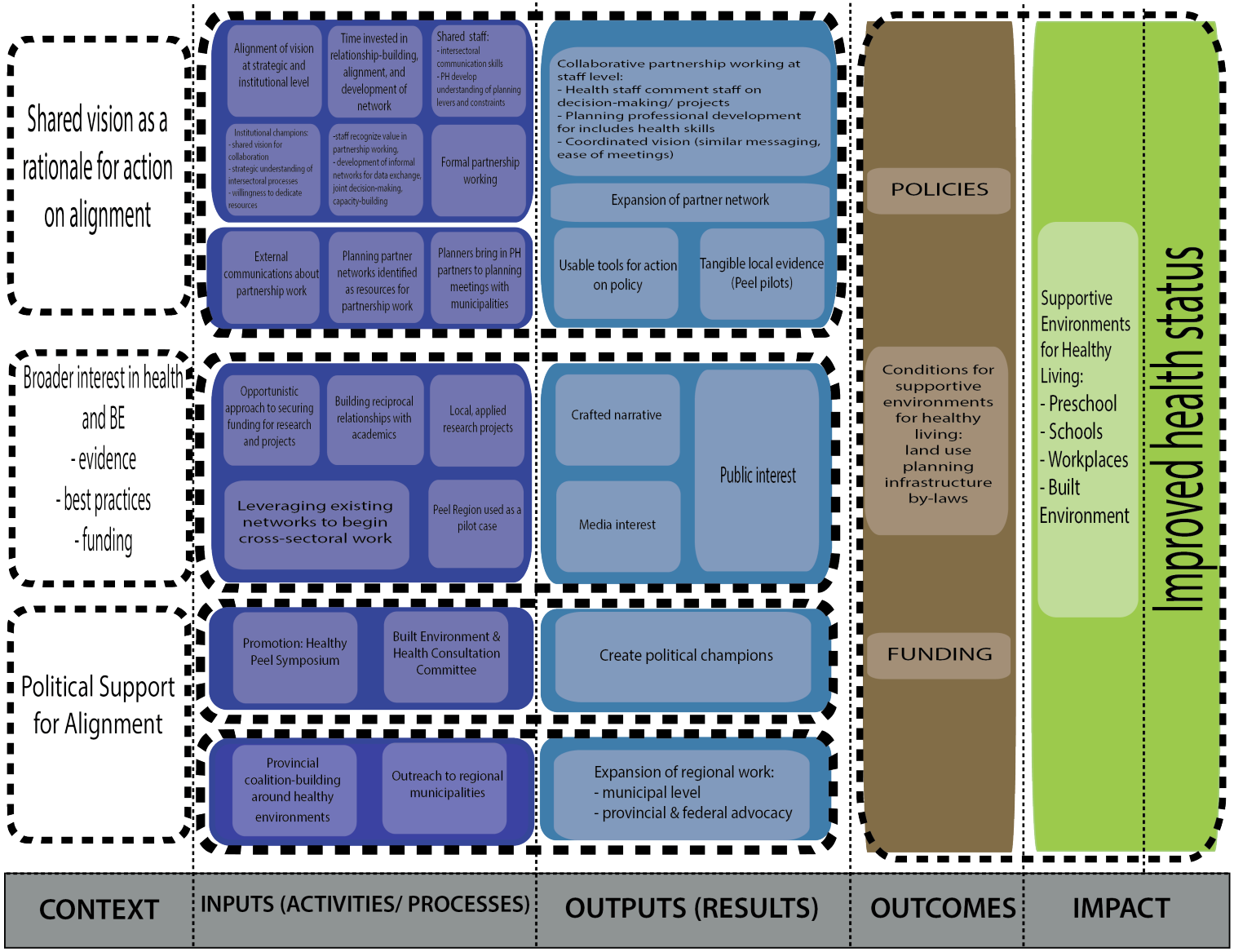

Figure 2: Peel BE & Health Initiatives Logic Model Analysis

ii. Logic Model Analysis

A. Context and Resources

Peel's work on alignment did not simply begin in 2005, although the period following the Regional Council resolution directing staff in Planning and Public Health to work jointly on the healthy built environment portfolio could be characterized as a shift from developing a rationale for action to taking action itself.

Political Context:

Political support for alignment came from Public Health staff's work to increase Regional councilors' basic understanding of the role of environments in obesity & diabetes, essentially laying the groundwork for action on the issue. Peel's position as a rapidly-growing municipality provided the facilitating fiscal conditions for innovation and investment.

Rationale for action on alignment:

While healthy built environments are now a core component of Public Health's strategic direction on Supportive Environments for Healthy Living, the long-term vision for Planning in Peel is for compact communities that also support active and healthy lifestyles: the vision of success is a shared one. This vision provides a natural rationale for action on alignment in Planning and Public Health's work that operates at a political and institutional level. The underlying assumption is that messages about health can leverage and justify good planning, while planning can act as a useful tool for healthy outcomes.

Broader interest in health and BE:

It is important to acknowledge that the work in Peel has not occurred in a vacuum. Existing interest in both implementation research for healthy communities and partnership working meant that academic partnership opportunities, funding, and best practices from other jurisdictions were available to support Peel's work. Identifying and leveraging these opportunities was a crucial part of the process.

B. Impacts/Long Term Outcomes:
Developing a shared vision of success

The long-term goals of Peel's partnership work on healthy communities are fairly clear for Public Health: reducing the prevalence chronic diseases and mitigating risk factors that result from unhealthy

environments. Public Health assumes that the shift in health outcomes must be preceded by a shift towards supportive environments for healthy living. Baseline measurements of disease prevalence and risk factors have been established in Peel that act as a proxy for health improvement successes, and can help establish progress along these long-range goals.

Population health, while a laudable goal for planning, is not a sufficient condition for success. Urban and regional planners frame successful outcomes more broadly than the public health agency. In effect, the primary planning document at the regional level, Peel's Regional Official Plan, acknowledges health within its four "primary goals":

- create a healthy community
- recognize the importance of the environment
- recognize the importance of a vibrant economy
- support balanced growth and development

(Peel Region Official Plan, 2013).

While a broader frame might dilute the goals of health within planning, the goal of creating "supportive environments for healthy living" has made it possible to establish a common vision of long-range success. Aligning public health action with planning priorities in energy consumption, pollution, traffic congestion and injury rates was an important piece in boosting the supportive environments agenda, as planning partners saw mutual benefit in several areas to partnership.

Necessary Conditions for Success

Peel Public Health's first priority, in consultation with academic experts, was converting their shared vision of success into specific opportunities for actionable work. The assumption in strategic planning was that defining opportunities for action in light of factors specific to Peel Region would help address "the magnitude of the challenge and the finite set of available resources." (Peel Public Health, 2012: 44) The four priority areas selected (Preschools, Schools, Workplaces, Built Environment) came out of a feasibility analysis that considered Public Health's sphere of influence, opportunities to build on action already underway, resource requirements, and the extent of project impacts on the population.

It is self-evident that planners should be key partners in influencing the Built Environment priority area. The role of increasing options for physical activity and active transportation, developing healthy food policy, and attending to socioeconomic status in Preschool, School and Workplace interventions fall similarly within the planning bailiwick.

Some of the conditions identified in creating these supportive environments for health include building the infrastructure necessary for walking and cycling, capitalizing on opportunities for healthy land use planning - mixed use zoning and development that improves walkability and cyclability and proximity to services - and establishing policies that govern more active use of spaces and access to healthy food. Adequate funding and appropriately aligned legislative and strategic policies were identified as the necessary preconditions for implementing infrastructure and development projects and transforming regulatory policies and practices.

C. Inputs: Projects, Processes, People

Building Buzz about Supportive Environments for Healthy Living

Interviews identified a number of catalysts to create and sustain interest among politicians, the general public, and staff for action on healthier built environments. The first of these was the Healthy Peel by Design symposium held in 2012 that drew a large group of stakeholders to a Mississauga venue and featured what were described as attractive and exciting presentation of best practices from New York City. Healthy Peel by Design created the necessary buzz to identify political champions for the built environment and health agenda. These champions were later formalized in a Consultation Committee, which would attract political capital to the alignment of work at conferences and in Council and support demonstration projects in their wards, further building the case for moving from policy to action.

Decision-makers within Public Health realized, too, that in order to transform built environments, interventions would need to happen at multiple levels, not simply at the regional scale. Advocacy work for changes in local, provincial and federal planning policy had the added benefit of boosting Peel's work at the regional scale. Advocacy involved coalition-building and using this coalition to provide commentary from the Chief Medical Officers of Health (MOH) in Ontario around the Provincial Policy Statement, GTHA Growth Plan and support for transit funding.

On the municipal end, Peel Public Health reached out to municipalities and supported their strategically important projects, such as Caledon's Community Improvement Plans and Brampton's Framework for Sustainable Development. Their proactive approach created the conditions for promoting both the use of the health-related development tools, and the shift in norms to bring health staff in as consultants to planning processes. Regional Planning staff also supported this process in bringing Public Health staff to meetings with municipalities, and the remaining municipality in Peel, Mississauga, ultimately also engaged with health staff. While Peel's Medical Officer of Health secured

Council approval to conduct advocacy, the general strategy has been for staff to take leadership on multi-level interventions without waiting for explicit direction from Council. The method to this process is that project work, and thus project results, might be delivered more expediently and further shore up the political support for their agenda.

Developing Resources that Move Policy to Action

Another catalyst for action was contracting academic experts to develop a range of work. Some of this work was strategic planning prior to the launch of the Supportive Environments report. Putting resources into conceptualizing the intersectoral process was valuable for Peel Health, given the challenge of scale in the alignment work they had undertaken. Using an understanding of best practices and a combination of Regional and external funding for research, experts were able to expand the strategic vision beyond the built environment and set the stage for longer-range partnership networking. Academics also produced background research such as the Diabetes Atlas, as well as functional tools such as the Healthy Development Index and Health Background Study that might be leveraged in developing "quick wins" for the region's vision of success.

Setting up this work involved identifying reciprocal benefits with academic partners who had an interest in developing locally relevant work, as well as funding for these projects. Funding was produced in some cases by jointly applying to grants such as the Healthy Canada by Design funding for action.

Public Health has been the primary client of academic consultants in these joint tools. Nonetheless, ensuring the involvement of planning staff in the development of tools provided useful insight into what would work best in their respective professional practices. One such idea was to use quantifiable standards that could be applied at the site level that mirror existing planning metrics (e.g. Noise level assessments) that were included in the Healthy Development Index tool. The result of these collaborations has been a series of applied research studies in the Peel context. These are necessary evidence to help demonstrate the value of funding work around supportive environments for health and safeguard against challenges to its legitimacy at the OMB or otherwise.

Adding to the growing body of evidence that supportive environments for healthy living are necessary and possible in Peel, Peel Region's Resolution HE-B1 designated the Region of Peel a "model employer". This put resources into design, facilities and service improvements to promote physical activity and healthy food choices among the Region's workforce. Paths for active transportation were

integrated into the redesigned site plan for Peel Region buildings, showing tangible evidence of this early success in the spaces both within and around buildings.

Key People

Institutional champions – that is, major decision-makers influencing partnership work - at both Public Health and in Planning appear to have driven much of the process at both the strategic and working level. An understanding of the need to seize opportunities for action at the forefront of the agenda and to invest in the time and resources necessary for a functional partnership were vital assets for the development of a working partnership. One resource is a shared staff member who was described as bridging collaborative barriers, such as professional jargon, and supporting intersectoral education so that Public Health could learn about constraints and levers in the planning profession and Planning could learn about how to incorporate health considerations and use joint tools in developing and approving plans and policies. The interpersonal and communications skills of institutional champions were reported to have shored up both cross-departmental relationships and access to the networks of experts who have supported the intersectoral work at different stages.

At the staff level, a recognition in both disciplines of the reciprocal benefits of aligning the health and planning agendas and joint working appears to have changed the norms of networks for data exchange and decision-making. Public Health staff are looped into new meetings with Planning staff, such as with Transportation Planning and with stakeholders at municipalities. Moreover, an increasing understanding of intersectoral work has prompted the inclusion of cross-sectoral competencies into professional development. Public Health developed an understanding of planning's levers and constraints, while Planning worked to effectively implement the tools that integrated health concerns into the planning process, such as the Healthy Development Index.

Networking Effects

Collaborative working between Planning and Public Health staff ultimately expanded the partnership network to involve other key players in the built environment and transportation planning, such as the national association governing transportation engineers, in projects. Strong relationships and buy-in around the joint agenda supported external communications about the rationale for aligned project work. For instance, partners co-presented on joint panels and at conferences, and formal and informal linkages between public health partners and planning's own networks moved the networking process along. Another activity that emerged out of work with municipalities were the resolutions in

Mississauga and Brampton to network with planning's professional associations (CIP and OPPI) as partners in health.

D. Partnership Results (Outputs)

The "outputs" or results of Peel's supportive environments initiatives aligning health and planning are the necessary precursors to the adequate funding and appropriately aligned legislative and strategic policies that sustain longer-range outcomes for the project.

Creating political champions

Politicians with a political and personal interest advocate for the issues in Council, which are intended to provide emerging policies the requisite "teeth" (funding and political direction). A challenge to building political will on the issue is that the mismatch of project cycles and electoral timelines makes success a moving target. With decades-long timelines in shifting the built environment and four-year election cycles, champions for healthy environments cannot be counted as consistent assets from projects' inception to their results. The rationale for healthier built environments may need to be re-stated and influence rebuilt in order to maintain momentum and funding for projects. However, the instrumental value of championship, even transitory ones, is in getting pilots off the ground and in sustaining broader public interest in the approach.

Building public interest

Public support beyond political championship is conceived as a longer- term requirement of the joint work, as it is considered by key informants to be too soon to gauge examples of success in this area. Building public support requires creating the right narrative: one that is locally relevant and turns the best evidence into a tangible vision of the qualities of the communities that could sustain the best possible health outcomes. Building media interest to develop public awareness is another branch of this strategy. The rationale for clear local evidence of the problem and pilot projects leading to solutions that are easily communicated to a broader public is that support is needed for public funds.

Building tangible local evidence:

One strategy for delivering successful pilot projects is to develop usable tools for action on policy. The best example of how project work has shifted to meet this objective over time is that the Healthy Development Index for Peel, initially produced as a conceptual framework, has had funding allocated for

refinement and piloting. It has been complemented by a Health Background Study Framework tool, and will soon be joined by Healthy Development Checklist that makes including health considerations in development projects more developer-friendly. The assumption underlying this process is that it is crucial to build tangible evidence of how healthy environments can actually function in Peel.

Collaborative partnership work:

A great deal of activity stemmed from partnership work at the staff level, deemed to have moved from "ad hoc consultation" typical of previous intersectoral work into meaningful and reciprocal partnership working. Three components were identified as evidence of improvement:

- Health staff were brought in to comment on planning decision-making/ projects;
- Professional development was adapted to include capacity-building in health assessment tools;
- A coordinated vision of success has manifested itself in the similarity of interdepartmental messaging and easier communication in interdisciplinary strategic and working meetings.

Twinning objectives and investing in partnership processes such as shared resources, meetings and intersectoral skills development between both partners resulted in the promotion of partnership work at panels and conferences. For instance, a recent growth management workshop under Planning's sphere of influence included health as one of key points: the need for growth to occur within a healthy communities structure. In identifying guest speakers, Planning asked Public Health for recommendations on experts on health and the built environment who had experience with growth.

The networks and influence that each partner brings to the table has not only expanded promotion, but has catalyzed additional work such as suburban road standards reassessment. Certain other networking effects have been identified as a result of a strengthened partnership with planning staff: connections to other stakeholders, such as transportation engineers and municipal planning departments, enable the promotion of the healthy planning agenda in a wider sphere.

Expansion of regional work:

The pursuit of a joint agenda on healthy communities integrated the expansion of the partnership's influence beyond the region alone. It was necessary to develop an understanding of the planning system to identify where planning could leverage development and where higher-order (provincial and federal advocacy) or lower-order (municipal development and planning) interventions were necessary to promote this agenda.

iii. Challenges in Peel Region's built environment and health initiatives

Separating out the challenges in the partnership work from the logic model clarifies its conceptual gaps. Challenges are essentially points of tension where inputs do not lead smoothly to outputs associated with successful outcomes. The specific challenges in this case were:

- Marginal amount of activity aimed at building public support through media buzz. NIMBYism relating to the proposed shift from sprawl to compact development patterns has been identified as a current and potentially major future barrier to the project as a whole.
- Building political will: the long time frame between action and success: even short-range outcomes such as changes to the built environment extend far beyond political cycles. Politicians are subject to different influences and risk dropping support when it comes to a decision to commit resources or political capital.
- Difficulty in establishing clear attribution pathways between projects and outcomes: there are no comparison groups and measuring shifts in health outcomes is a difficult process.
- Scale of the work in driving change at provincial level: the documents are not only out-of-date, but the process to change the PPS, Growth Plan is slow and subject to OMB appeal.
- Designing appropriate tools: not all of the elements of healthy built environments are easily set at thresholds that can be incorporated into the current planning assessment process (e.g. Complete Streets). This illuminates the need to develop cross-sectoral competencies so that planning can transform the tools relating to health.
- Practical challenges of intersectoral work:
    - Differences in processes (approvals process, documentation and timelines). Public health is flexible to shift action and approach as evidence shifts, while other disciplines may be less flexible and be driven by industries and standards. Communication about what is being compromised by the above hurdles can help.
    - Time needed to collaborate is difficult to obtain. The next best solution is to keep partners informed of decisions and work.

Chapter IV: Next Steps: Evaluation Planning

The way logic model analyses are used in support of evaluations planning varies according to the goals of the evaluations process. Goals are themselves influenced by the evaluation timing, resources, users and the scope of the project. The diagram below, from the W.K. Kellogg Foundation's evaluations handbook, highlights variations.

The Table below describes the relationship between a successful program and the benefits derived from the use of logic models.

Program Elements	Criteria for Program Success	Benefits of Program Logic Models
Planning and Design	Program goals and objectives, and important side effects are well defined ahead of time.	Finds "gaps" in the theory or logic of a program and work to resolve them.
	Program goals and objectives are both plausible and possible.	Builds a shared understanding of what the program is all about and how the parts work together.
Program Implementation and Management	Relevant, credible, and useful performance data can be obtained.	Focuses attention of management on the most important connections between action and results.
Evaluation, Communication, and Marketing	The intended users of the evaluation results have agreed on how they will use the information.	Provides a way to involve and engage stakeholders in the design, processes, and use of evaluation.

How Logic Models Better Position Programs Toward Success.

Figure 3: How Logic Models Better Position Programs Toward Success (W.K. Kellogg Foundation, 2004)

However it is ultimately mobilized, this study's logic model analysis is an asset that can support evaluation activities around Peel's work in the following ways:

1a. Inventories the resources, processes and activities that are required for specific results;

2a. Frames connections between components (inputs, outputs, outcomes) of the logic model;

3a. Describes the partnership's "vision of success": specific, actionable outcomes that can eventually be attached to indicators and assessed.

Given the limitations of this study, the logic model should be refined with a larger and more diverse sample within the partnership stakeholders, and revisited over time. Moreover, to evaluate the process, stakeholders must go one step further than making sense of the activities and assess the merit of the

outputs and outcomes above to create good measures and benchmarks (Mark et al, 2000). Questions might assess:

> 1b. How should the partnership work prioritize its results and outcomes and consequently highlight its key activities?
>
> 2b. How strong are the connections between partnership work and its results and what other variables might be involved?
>
> 3b. What are appropriate indicators, thresholds, and measurement tools for each outcome?

i. The implication of partnership working on evaluating results:

Peel's current framework for assessing success around action on healthy built environments is the "comprehensiveness of [its] portfolio" (Peel Public Health, 2012). Goal-setting around the healthy built environments agenda has been guided by expert opinions from public health, which is reasonable given the role Peel Public Health has taken in driving the process of alignment with planning priorities and staff. However, given the strength of current collaborations with Peel Planning and the expansion of the partnership network, it might be worthwhile to include partners in the strategic priority-setting process, setting the standards against which project success can be measured. Getting contributions and buy-in from partners would not only establish action within a more comprehensive framework, but from a program improvement standpoint, would also identify opportunities to leverage the partnership's expanded capacity to intervene and access new resources available outside of Public Health.

Projects emerging from the partnership are conceived as a valuable mechanism to sell the public on the value of Peel's work and leverage further resources and support. Health outcomes are an attractive goal, but the difficulty of attributing health outcomes directly to projects and the prospect that changed environments might fail to prompt the uptake of healthier lifestyles could diminish support for project work over the long term. Conversely, the benefits of healthier community plans are more easily tracked and measured. Reductions in pollution, reduced injury rates, community designs that retain an aging population, and other metrics of building compact and health-supportive communities *are* attributable to planning interventions. There is thus a better guarantee of measuring success by considering the outcomes articulated by both planning and health and tracking both in the assessment.

ii. Assessing what is working in the partnership approach:

As the analytic component of this work reveals, Peel's collaborative approach, although formally supported by Regional Council, is underpinned by deepening relationships between staff, the support of

divisional leaders and external support for healthy environments in Peel. This particular structure lends informal qualities to the partnership as expressed in Chapter III, which raises some difficulty in tracking and assessing its activities and results. Moreover, the unit of analysis is not a single partnership between public health and planning at the regional level. Rather, it is more accurately understood as an evolving network: the successes of the project are deeply entwined with burgeoning collaborations with transportation, municipalities and supportive coalitions with interested academics, higher orders of government, and other leaders in health and the built environment in Ontario.

Nevertheless, in order to provide any measure of continuous improvement of the whole action process, Peel should attempt to understand and assess the value of the intersectoral process that has not motivated action around its supportive environments for healthy living agenda. This would help contextualize its work within the context of action research planning healthy communities and demonstrate the value of its choices in achieving success over the longer term.

The framework that Peel Public Health lays out for assessing their projects on health and built environment acknowledges the need to track both the metrics of shifting policy and whether the shifts actually had the desired effects. (Peel Public Health, 2012: 55) Doing so will involve descriptive questions such as which and how many areas were impacted and to what extent - the outputs laid out in the logic model represent a good starting point for what to measure.

To date, Peel Health has not formally identified specific measures for success around partnership work itself, but has identified a current capacity to track some activities. Measurable activities include co-presentations at conferences and in Council meetings, joint meetings attendance. Evaluations work could further explore the scope of collaborative opportunities to date by investigating how public health issues and individuals are positioned on planning's meeting agendas and the converse.

In addition, given the primacy of time allocated to build relationships, it might be valuable to further develop the timelines for partnership work in order to better understand and replicate this intersectoral competency. With institutional champions playing such a pivotal role in nurturing these relationships, it might also be worth exploring the tactics of key leaders in both departments in order to understand how their assets and skills contributed to more effective intersectoral collaboration. Another possibility in developing the partnership further is to consider ways that the attributes of individuals can be institutionalized, to minimize the risk of losing both the resources and networks individuals bring to the table if circumstances change. (Asthana et al, 2012)

The challenges identified around insufficient time to work collaboratively, and the remaining barriers to effective partnership work related to mismatched processes speak to the need to further examine which cross-sectoral competencies are needed so that all parties, including new additions to the partnership network, can take the initiative to problem-solve around barriers to effective intersectoral work. Identifying these competencies and tracking which ones lead to a more streamlined process and how will allow Peel to rechart its course if needed, as well as demonstrate the value of its approach.

In all instances, while it will be important to refine the components identified in this logic model and find ways to measure Peel's success, assessing the value of these collaborative opportunities will remain a crucial piece of demonstrating the merit of the partnership processes currently underway. Questions that establish the thresholds for successful outcomes, and the means by which Peel should conduct its monitoring and evaluation would be best determined collaboratively between Public Health and Planning if possible, in order to capture the synergies within the project.

Conclusions

It is not enough to simply decide to work intersectorally in mitigating the issue of silos around urban health problems. The transformation of organizational structures and norms through intersectoral partnerships is profound: developing an understanding of what makes a successful partnership will be instrumental in this work. Evaluating precedents, preferably in the local context, provides a good starting point for this understanding and establishes best practices. Evaluating the successes of intersectoral partnerships is a complex task: a precondition to developing indicators and measurement tools is establishing an analytical framework that develops parameters for the assessment. Ultimately, this study intends to situate the partnership and process underpinning Peel's suite of initiatives within the literature on healthy cities partnerships: describing aspects of its governance, its representation, its wider goals and methods of achieving these goals.

Collecting documentation and qualitative data from stakeholders in a logic model analysis explores the processes, norms and networks mobilized in achieving successful outcomes, and where ongoing challenges to those outcomes still exist. The analysis produced of Peel's partnership structure is a necessary precedent for an evaluation of outcomes. More extensive definition of cross-sectoral goals, benchmarks and measurement tools to assess the outcomes of the partnership will be necessary. What this provides is insight into the process - facilitating factors and obstacles, conceptual mapping of the underlying mechanisms that are designed to turn goals into successful outcomes. This can support strategic planning both in the ongoing work of the project and in using Peel Region's successes as a template for other local intersectoral partnerships in healthy city planning.

This logic model is a useful resource in evaluating the work behind the Peel built environment and health initiatives. It offers an inventory of what will be evaluated, a theory about how partnership components are connected, and a description of Peel's vision of success. Showing shorter-term outcomes as well as long-term impacts helps Peel build the narrative of what progress it has made and how it is on the path to achieving its long-term goals. After Peel has developed measurable indicators and benchmarks for these indicators, which are needed to actually evaluate how well the goals have been met, the logic model can be used for assessment. Plugging different measurements of indicators into the logic model will allow Peel to understand its progress. Refining the logic model with further stakeholder interviews is a necessary next step in developing consensus about what success for the Region should look like at different stages.

Appendices

Appendix A. Sample Interview Questions

A. Logic Model discussion:

- Confirm timeline
- Identify stakeholders (organizations, people)
- Understand the activities and how they fit together
- Discuss successful outcomes and the conditions for success

B. Questions

1. *Can you tell me about your role in the health and built environment initiatives?*
2. *Describe the partnerships within the project.*
3. *In what ways are / were these partnerships successful? What are the outcomes that show you have been successful?*
4. *What are some of the conditions for these successes?*
5. *What needed to be in place for these conditions? (Backwards map)*
6. *How would you measure these outcomes of success (develop indicators)? How do you know when your indicators are meeting your targets?*
7. *Describe the ways that activities lead to successes in the partnership.*

Appendix B. Data Sources

Key Informant Interviews:

Interviews were conducted with the Peel Public Health component of the partnership (1 interview with upper-level management; 1 interview with manager at operational level) and with an academic partner who has worked with Peel Public Health throughout the duration of partnership work.

Documents Analysis Summary Table

Reports	Resolutions	Other
State of the Region's Health 2005: Focus on Overweight, Obesity and Related Health Consequences in Adults (October 14, 2005) Lawrence Frank Ltd: Evaluating the Public Health Impacts of Land Use Development in Peel: Final Report Peel Public Health (June 4 2012): Report to Council re: Peel Diabetes Atlas	Peel Region Council (December 1, 2005): Special Regional Council Minutes	Presentation: Healthy Canada by Design - Peel Public Health Node (November 24, 2010).
Region of Peel Report to General Committee: September 29, 2008: Health Assessment Tool Initiative to provide quantifiable comment on neighbourhood development proposals CRICH, McMaster, Peel Public Health (2009): Peel Healthy Development Index Gladki Planning Associates (2011): Healthy Development Index Recommendations Report	Peel Region Council (October 30, 2008): Council Minutes. Excerpts from The Council of the Regional Municipality of Peel: - HE-B1 (June 14, 2012) - 2014-53 (January 23, 2014 - HE-B2 (November 8, 2012) - PW –A1 (February 9, 2012)	Correspondence: Healthy by Design Consultant Committee Group
Peel Public Health (2012). Changing Course: Creating Supportive Environments for Healthy Living in Peel .	Peel Public Health: Peel Health Position Statement.	Healthy Peel by Design website & Symposium Report (2009)
Health Background Study Framework; Health Background Study Implementation Strategy (May 27, 2011) - The Planning Partnership Health Background Study Evaluation Report (May 27, 2011) - The Planning Partnership	Town of Caledon (Februrary 14, 2012): 2012-050, 2012-063; City of Brampton (June 6, 2012): C114-2012 City of Mississauga (May 9, 2012): 0112-2012	Provincial Policy Statement, 2014: Key Changes by Policy Area
Peel Public Works (2012). Active Transportation Study Peel Public Works (2012). Peel Active Transportation Plan and Implementation Strategy.		Regional Municipality of Peel Official Plan (2013)

Appendix C. Logic Model Framework Analysis

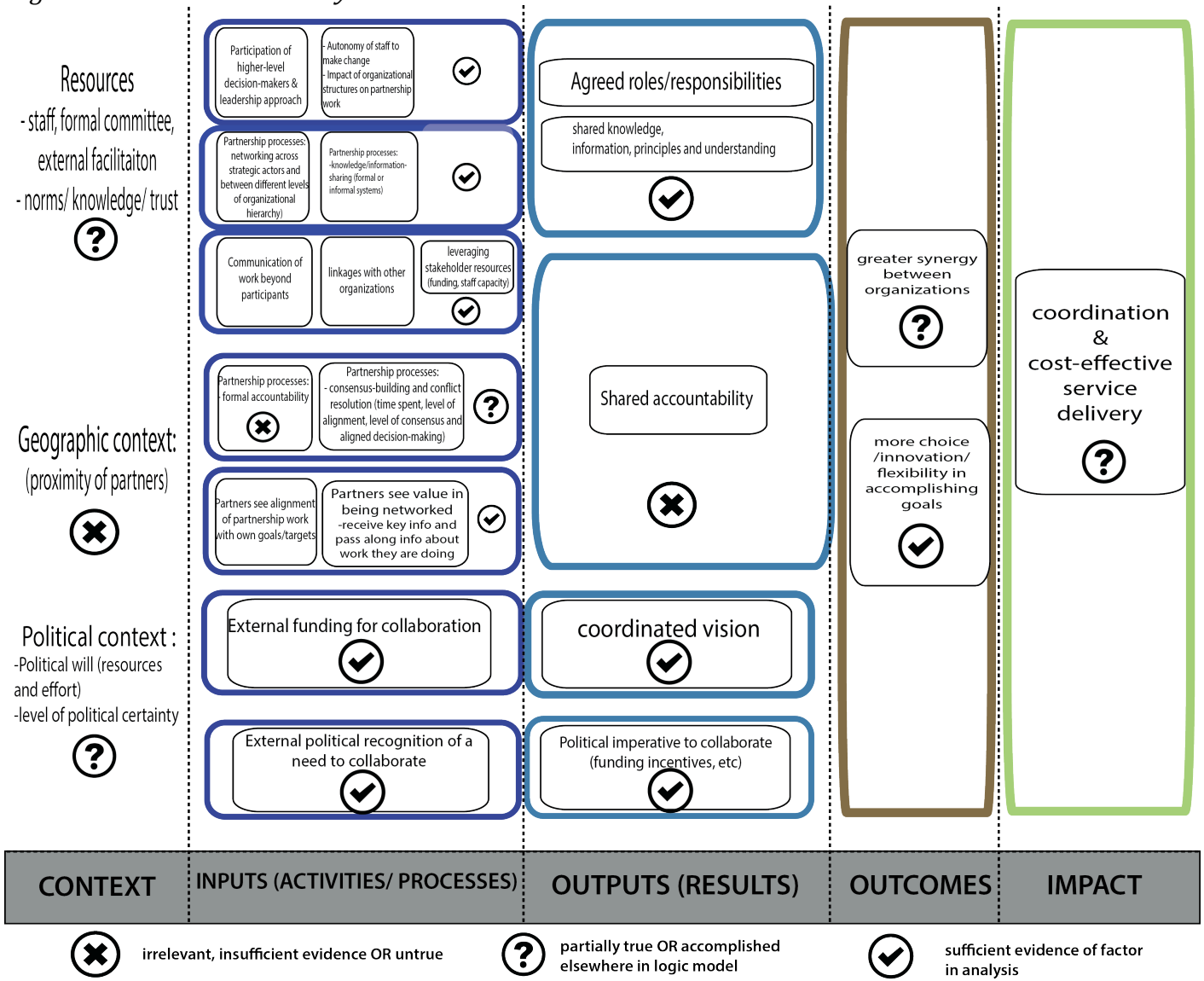

Figure 4: Application of theoretical framework from Asthana et al HAZ partnerships to Peel Region case study

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