Designing a Process to Deliver a Comprehensive Obesity Reduction Strategy (CORS) for British Columbia

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EXECUTIVE SUMMARY

Background

The overarching policy challenge being addressed by this 598 project is the increasing prevalence of obesity in British Columbia (BC). The long-term outcome sought is a reduction in its prevalence. The Health Officers Council of BC has resolved to develop a Comprehensive Obesity Reduction Strategy (CORS) for the province. The Provincial Health Services Authority (PHSA), due to its provincial mandate and experience in cross-sector processes has been tasked with managing the development of this strategy. PHSA has formed a twenty member Task Force of health sector leaders to help steward the process. A process was required to engage other sectors and stakeholders in building CORS from the beginning. The purpose of the 598 project is to design a process for engaging and organizing stakeholders in building a Comprehensive Obesity Reduction Strategy (CORS) for British Columbia.

Methodology

A Conceptual Framework that identifies key issues and considerations in responding to the obesity epidemic as well as criteria for setting up multi-sector collaborations; a framework for organizing the structures and process for CORS; support materials (such as Terms of Reference) for use by the various structures; and considerations for successfully implementing the proposed structures are the deliverables of this project. These deliverables were arrived at primarily through a literature search that explored the nature of the obesity issue; current approaches in responding to the issues; the nature of cross sector approaches and criteria for engaging multiple stakeholders in collaborative processes. This literature was drawn from academia as well as government and non government research bodies. A brief organizational assessment was also undertaken to assess organizational capacity to undertake the phases of the process.

Findings

The literature indicates that obesity is a complex issue. Though the condition ultimately results from individuals consuming too many calories and not expending enough of them, the epidemic has resulted from changes in societal values and socio-economic and cultural environments. The environment has a significant influence on the choices people make, therefore, reversing the epidemic requires addressing the many factors that shape a population's food and activity choices. What is required is a paradigm shift at several levels, and in order to achieve that, a comprehensive, multi-faceted, multi-level, multi-stakeholder response that changes the food and physical activity environments is required. The task is to make the healthy choice the easy choice.
Complex Issues like obesity requires action in multiple settings from many sectors and actors. Cross-sector approaches can mobilize dispersed resources and give access to many perspectives, knowledge, expertise and resources; necessary criteria for shifting paradigms. Collaborative processes can effectively harness this and move stakeholders to take ownership of the issues. Engagement is a specific approach to working across sectors – a requirement for successful collaborative processes. Leadership of the convening organization, engaging the right people in the right way; structures to effectively organize people and processes and resources to support their work are critical to successful stakeholder engagement.

The CORS Organizing Framework

To engage a broad range of sectors and stakeholders in developing an “implementable” CORS for BC, the following structures are proposed.

- **The Obesity Reduction Task Force.** The Obesity Reduction Task Force, made up of health sector leaders, to provide overarching stewardship to the process; assemble the final strategy and oversee its implementation.

- **Provincial Level Collaborative.** A Provincial Level forum that brings together high-level decision-makers from government, industry, not-for-profit societies, professional agencies, academia and provincially organized umbrella and citizen groups; to cultivate interest and seek commitment and action to reverse the obesity epidemic.

- **Community Level Collaborative.** A Community Level forum that brings together high-level decision-makers from community based organizations such as local governments, parks and school Boards, schools, chambers of commerce, community based not-for-profit agencies and local industry, as well as citizen groups; to cultivate interest and seek commitment and action to reverse the obesity epidemic.

- **Content Specific Working Groups.** Three content specific Working Groups that bring together content experts from relevant sectors; to review, assess and propose strategies and interventions that could transform the food and physical activity environments as well as propose treatment options.

- **Working Group on Data, Evaluation and Research.** A fourth Working Group on Data, Evaluation and Research to draw relevant expertise in supporting the Provincial and Community level Collaboratives and the three content Working Groups with the data, monitoring, evaluation and research requirements.

This structural framework will assist PHSA and the Task Force to engage a diversity of stakeholders in the right way, to build the CORS for BC.
Recommendations for Moving Forward

The CORS development process is on a tight time line and currently has limited, dedicated human and financial resources. The process is nearly at the half way mark and the engagement process is just beginning. The remaining time and the resources available will pose significant challenges to building cohesion and the relationships that a process such as this needs, to cultivate buy-in from a diverse group of sectors and stakeholders. The current mandate in the current time line with currently available resources may be too ambitious an undertaking. However, if the process is altered, attaining an “implementable” strategy may still be possible. The following two options are proposed for consideration.

Option One – Same Time Line, Adjusted Plan

Form the four working groups and develop a draft CORS and use this as the draw to engage the decision-makers at a Spring 2010 forum. Launch the final CORS strategy in the Fall of 2010 as planned, however, recognize that full buy-in from decision-makers may not have happened by this time. Continue negotiations to implement the CORS beyond launch, understanding that revisions to the CORS may be required based on negotiations.

Option Two – Changed Time Line, Changed Plan

Utilize the time between the present and September 2010 to mobilize a multi-sector interest in the obesity reduction strategy and do the research and preparation required to develop a CORS for BC. The current CORS process will be an agenda setting phase where an evidence based case can be built for CORS, while exploring emerging opportunities (such as the renewal of ActNow and the budget cycle) that could be leveraged for a multi-year strategy. The Summit planned for the Fall of 2010 could be the opportunity to rally multiple sectors to the CORS where the “ask” for multi-year resources could be made to a multi-sector audience.

Concluding Remarks

A Comprehensive Obesity Reduction Strategy addresses a significant issue and meets a glaring gap in British Columbia. There is a great deal of interest in this initiative in many quarters; nevertheless, engaging the right people in the right way and getting their buy-in to implement the strategy will not be an easy task. A process this complex needs adequate time and resources to deliver successful outcomes. A process such as this must also ensure that all the right people are at the table; including populations that may require extra effort to engage. The CORS for BC is too important an initiative not to be given its due time and resources.
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1 INTRODUCTION

Obesity is not a new issue. What is new is its prevalence. In the past two decades the rate of obesity among adults and children has more than doubled (Tjepkema, 2005). The World Health Organization has classified obesity as a pandemic. Worldwide, 1.6 billion people are overweight and 400 million of them are obese (“WHO”, 2009). The more concerning issue is that these numbers are growing rapidly – by the year 2015, 2.3 billion people worldwide are expected to be overweight with 700 million of them expected to be obese (“WHO”, 2009). Being overweight and obese are major risk factors for developing chronic diseases – from heart disease and stroke to diabetes, musculoskeletal disorders and some types of cancers (PHO, 2006; “WHO”, 2009). Chronic diseases are now the leading cause of death around the world (WHO, 2006). In 2005, 35 million people died from chronic diseases globally (WHO, 2006). In North America, eighty percent of the disease burden results from chronic diseases (PHO, 2006). Increasing weight of a population has many consequences.

The impacts of being overweight and obese are costly to individuals, families and societies alike (PHO, 2006; Tjepkema, 2005; “WHO”, 2009). Not surprisingly, many nations are starting to take action to reverse these troubling trends. However, neither Canada nor British Columbia has developed comprehensive approaches to tackling the obesity epidemic to date. To meet this gap, in April 2009, the Health Officers Council of British Columbia passed a unanimous resolution to develop a Comprehensive Obesity Reduction Strategy (CORS) for the province. The resolution calls for a strategy that is not directed at government alone; it has the goal of mobilizing multiple sectors and stakeholders to commit resources and action towards reversing the obesity epidemic.

The Population and Public Health Program (PPH) of the Provincial Health Services Authority (PHSA) was entrusted with managing the development of this comprehensive strategy. To steward its development, PHSA formed a twenty member Task Force, of largely health sector leaders. The Task Force aims to develop a strategy that will be implemented; therefore, wishes to involve those parties that will be needed for implementation, also in the development of the strategy. This required the Task Force to find a mechanism for engaging and organizing these actors.

PHSA and the Task Force had initially planned to host a large forum to rally sectors and stakeholders to the issue and identify both a framework and organizing mechanism to guide the strategy development. Given the timeframe for organizing this event, the planning group realized that the task was too ambitious and altered the process. The revised process moved the forum to Fall 2010 to be a mechanism for launching the final CORS. This required PHSA and the Task Force to develop the infrastructure to build the CORS and PHSA decided to undertake this task through a Master of Public Administration (MPA) 598 project.
The purpose of this 598 project is to design a process for engaging and organizing a multi-sector multi-stakeholder collaboration to build the CORS for BC. The project takes a small but important step in an ongoing process that began with the resolution of the Health Officers Council. This project report is organized as follows: Section 2 provides background on the project which includes an introduction to the obesity epidemic and its manifestation in BC; the key players behind the CORS and their respective roles in the initiative; and the purpose and scope of this 598 project.

Section 3 provides the methodology used to arrive at the deliverables with a brief discussion of strengths and limitations of the approaches used. Sections 4, 5, 6 and 7 describe the literature reviewed; with Section 5 describing the nature of the epidemic through an account of how the framing of it has evolved over the years; Section 5 identifying key areas and approaches for intervening in the epidemic; Section 6 describing the nature of working across sectors and Section 7 identifying key considerations for setting up processes for engaging stakeholders in cross-sector collaboration.

Section 8 synthesizes the literature reviewed to form a conceptual framework for designing cross-sector processes. This section identifies the key elements of successful cross sector processes. Section 9 draws on the conceptual framework to propose options for organizing the work of the CORS and includes the option chosen by PHSA and the Task Force. Section 10 appraises the start-up phase of the CORS process and based on this, anticipates the evolution of the next phases. Potential challenges are identified and options for addressing these are proposed. Section 11 concludes with ideas for enhancing the CORS development process.
2 BACKGROUND

This 598 project sets out to design a process to assist PHSA and the Task Force in rallying a broad range of stakeholders to take action on the obesity epidemic. To provide context to the project, the section begins by defining and describing the epidemic and its impact in BC. Roles, responsibilities, and linkages between the key players driving the strategy – namely, the Health Officers Council (HOC) of BC, the Provincial Health Services Authority (PHSA) and the Obesity Reduction Task Force (Task Force) are clarified next. The section concludes with a clarification on the role and scope of this 598 project in the CORS development process.

2.1 The Issue

Obesity is a major contributor to chronic diseases which is a significant health issue in British Columbia (PHO, 2006). Yet, to date, BC does not have a comprehensive strategy or plan for tackling this issue. In 2006, the Select Standing Committee on Health of the BC Legislative Assembly undertook a community consultation process to understand how the government should respond to childhood obesity. The report (2006) that was produced makes 36 recommended actions for various sectors; however, no plan or resources were put in place for its implementation. In 2008, the Childhood Obesity Foundation held a two day forum to investigate this same issue. Though both processes contributed valuable insights on the issues in BC, neither process led to comprehensive plans, strategies or actions on how to address the obesity epidemic in BC. This is the gap that the HOC of BC have resolved to address.

Obesity is an issue about excess body weight. Body Mass Index (BMI) or the ratio of weight in kilograms divided by height in meters squared is the standard indicator for measuring overweight and obesity (PHO, 2006; Tjepkema, 2005). A BMI in the range of 25 to 29.9 is considered overweight while a BMI of 30 or more is considered obese (CIHR, 2004; Tjepkema, 2005; “WHO”, 2009). But, as a measure, BMI has limitations (Tjepkema, 2005). For example, BMI is not considered an accurate measure for gauging overweight and obesity in athletic and or muscular individuals (greater muscle mass), certain ethnic groups (average BMI differ from standard BMI) or the elderly (lesser muscle mass)(Tjepkema, 2005). Abdominal obesity and certain medical tests are more accurate measures of obesity; however, BMI is the most convenient and efficient indicator currently available for screening overweight and obesity at a population level (Tjepkema, 2005). BMI is calculated from measured or self-reported height and weight. In self-reporting, people tend to overstate their height and understate their weight; which can skew prevalence rates (Tjepkema, 2005).

In the past two to three decades, BMI indicates that the prevalence of overweight and obesity has increased to epidemic levels in British Columbia, Canada and
around the world (Tjepkema, 2005; “WHO”, 2009). Measured BMI from the 2004 Canadian Community Health Survey found 23.1% of Canadians 18 years and older to be obese while a further 36.1% were overweight (Tjepkema, 2005). In some sub populations, this rate was even higher. The prevalence of obesity among aboriginal people was more than double the Canadian average (Lear et al., 2007). Among the Canadian provinces BC had the lowest obesity rate at 19% (18% of men and 20% of women) (Tjepkema, 2005). However, BC tied for first place with Prince Edward Island in the overweight category at 40% of the population recording overweight (Tjepkema, 2005).

In 2004, nearly 60% of Canadian and BC adults were overweight or obese (Tjepkema, 2005). This is a significant concern because overweight and obesity greatly increases the risk of developing Type 2 diabetes, cardiovascular diseases, some types of cancers and musculoskeletal disorders (CIHR, 2004; Tjepkema, 2005; “WHO”, 2009). Excess weight is also associated with psychosocial disorders, functional limitations and disabilities (Tjepkema, 2005).

Obesity has many costs – especially to the healthcare system. In 2000, the annual cost of obesity care to BC’s healthcare system was estimated at approximately $380 million (PHO, 2006). The indirect cost to the BC economy resulting from lost productivity was estimated at $830 million (PHO, 2006). These costs are believed to be underestimates given that the rates of obesity used for the study was based on self-reported BMI. Nevertheless, the BC healthcare system and the economy are bearing a massive cost for a largely preventable health condition.

**Figure 1:** Obesity rates, by province and sex, household population aged 18 or Older in Canada, excluding territories, 2004.

The most worrisome trend in the obesity epidemic is the increasing prevalence of obesity among children and adolescents. In 2004, measured BMI indicated that 8% of Canadian children ages 2-17 were obese and a further 18% were overweight (Select Standing Committee on Health [SSCH], 2006). In 1978/79, the previous time when BMI was measured, 3% of 2-17 year olds were obese and 12% were overweight (SSCH, 2006). In twenty five years, the percentage of overweight and obesity among Canadian children and youth has grown from 15% to 26% (SSCH, 2006). Of further concern is the prevalence of obesity among children under the age of six. In 2004, 6% of children under the age of six were obese; while this was not an issue 25 years earlier (SSCH, 2006).

As with adults, overweight and obesity in children and youth leave them more vulnerable for developing chronic diseases. In fact, chronic diseases such as Type 2 diabetes and high blood pressure that were once considered adult onset diseases are now showing up in childhood and adolescence in greater numbers (SSCH, 2006). Overweight and obese children, often grow up to be overweight and obese adults (SSCH, 2006). A major concern is the possibility that for the first time in history, we are raising a generation of children that may have shorter lifespans than their parents (SSCH, 2006).

Figure 2: Overweight and obesity rates, by age group, household population aged 2-17, Canada (excluding Territories), 1978/79 and 2004.

Source: Select Standing Committee on Health. (2006). A strategy for combating childhood obesity and physical inactivity in BC. Legislative Assembly of BC.
Generally, it is understood that overweight and obesity results from consuming too many calories and not expending enough of them. For the most part, past interventions have targeted behaviour change at the individual. With no sign of abating the epidemic, research and experts are redefining the issue. The emphasis is shifting from the individual to systems and environments. Section 4 provides greater insight into how this understanding has evolved, based on a review of salient literature.

2.2 The Health Officers Council of British Columbia

The Health Officers Council (HOC) of BC, with their resolution, has catalyzed the development of a CORS for BC. A not-for-profit society made up of Medical Health Officers (MHO), the society acts on issues that pose a threat to public and population health in BC. Though a formally established organization, the society is essentially a network of members with no physical infrastructure or financial resources to undertake complex projects. The executive director of the PPH program at PHSA is a member of this society. This connection, PHSA’s provincial mandate and the PPH program’s experience in convening on issues and supporting multi-stakeholder processes made PHSA a natural fit to step in to the role of the convening organization for the initiative.

2.3 Provincial Health Services Authority

The Provincial Health Services Authority (PHSA) is one of the six health authorities in British Columbia and the only health authority with a provincial mandate. Governed by a Board of Directors this quasi government organization is responsible for planning, funding, delivering and evaluating tertiary and quaternary healthcare services across the province.

PHSA has three primary roles (PHSA, 2009). They include:

- Governing and managing eight provincial healthcare agencies and organizations including the BC Cancer Agency, the BC Centre for Disease Control, BC Children’s Hospital, BC Mental Health and Addictions Services, BC Renal Agency, BC Transplant, Women’s Hospital and Health Centre and Cardiac Services BC.
- Collaborating with regional health authorities to plan, coordinate and fund the delivery of other highly specialized and resource intensive provincial services (e.g. trauma services)
- Achieving system improvements and coordination in other areas of healthcare (e.g. emergency services, population and public health).

Led by a President and Chief Executive Officer, the Executive Team at PHSA stewards the organization to reach its overall goal of “better health for the people.
we serve” (PHSA, 2009). The organization does this by focusing on four strategic priorities: Operational Excellence, Knowledge Innovation, System-wide improvements and Population and Public Health. PHSA is interested in moving beyond crisis management – to anticipate emerging risks and opportunities in order to provide more thoughtful responses (PHSA, 2009). In this regard, PHSA serves an important role in facilitating multi-stakeholder dialogue and coordinating provincial action to achieve common goals (PHSA, 2009). Harnessing the potential of partnerships and networks is one of three enabling strategies used by the organization’s leadership (PHSA, 2009).

PHSA recognizes that the prevention of chronic disease is central to its mission (PHSA, 2009). The Population and Public Health Program (PPH) focuses on knowledge development and surveillance; providing data analysis and interpretation to inform policy and practice, in the prevention of chronic disease in BC (PHSA, 2009). In 2009, the PPH program was reorganized around newly established Centres in Population and Public Health (CPPH). This reorganization was intended to improve coordination of prevention activities across PHSA agencies and programs; while linking with external agencies, to address current and emerging population and public health issues in the province. This scheme strategically positions the PHSA–PPH team to support and manage the CORS for BC.

2.4 The Obesity Reduction Task Force

PHSA formed a twenty member Task Force to steward the CORS development process. Their goal is to develop a comprehensive strategy based on evidence and built on existing successes. It is responsible for mobilizing multiple sectors and stakeholders; including all three levels of government, industry and the business community, the not-for-profit sector and communities; to commit resources and take action in this wholly preventable epidemic.

The Task Force membership is drawn primarily from health sector organizations. These include the Health Officers Council of BC, the BC Medical Association, the Ministry of Healthy Living and Sport, all relevant PHSA agencies and programs, Regional Health Authorities represented by MHO, the Public Health Agency of Canada, Canadian Pediatric Society and the Childhood Obesity Foundation. Academia is represented by the University of British Columbia, Simon Fraser University and the University of Victoria while the not-for-profit sector is represented by the Heart and Stroke Foundation–BC Region, Dietitians of Canada–BC Region and the BC Healthy Living Alliance.
2.5 Purpose and scope of the Project

PHSA and the Obesity Reduction Task Force need to engage a broad range of sectors and stakeholders in building the strategy. Structures and processes are necessary to engage and mobilize these people to work on a common agenda. The purpose of this project is to design the process that will assist PHSA and the Task Force to engage diverse stakeholders in the strategy development process.

To know which sectors and stakeholders to engage – it was necessary to have a broad understanding of how the epidemic is currently understood and how others were approaching and responding to the issue. To establish a process that can mobilize buy-in from other sectors, it was necessary to understand the critical requirements in setting up effective and meaningful multi-stakeholder collaborations.

Therefore, a priority task of this project included reviewing literature on the nature of the obesity issue, responses to the epidemic, the nature of cross-sector processes and considerations for engagement of multiple sectors and stakeholders. This review informed and shaped the key deliverables which include a conceptual framework for setting up multi-sector collaborations, an organizing framework including structures and processes; support materials for use by the various structures; and suggestions for successfully implementing the proposed structures.

Directing the implementation of this framework, facilitating the work groups, developing the strategy or implementing the strategy are not within the scope of this project. However, this report could serve to provide important background, if PHSA and the Task Force decided to evaluate the CORS development process at a future date.
3 DELIVERABLES AND METHODOLOGY

There are four main deliverables for this project. They include:

- a conceptual framework that identifies the key considerations in responding to the obesity epidemic and key criteria for setting up multi-sector collaborations; to guide the design of structures and process for CORS for BC;
- an organizing framework that identifies the structures and processes;
- support materials (such as Terms of Reference) for use by the various structures; and
- considerations for successfully implementing the proposed structures.

This section describes the methodology that was used to arrive at these deliverables and briefly discusses the strengths and limitations of methods used.

3.1 Literature Review

All the deliverables are based primarily on a review of relevant literature. Some consultation was sought from select Task Force members in relation to framing the obesity epidemic. A brief organizational assessment was also undertaken to assess organizational capacity to undertake the phases of the process.

Four areas of literature were reviewed for this project. These reviews included:

- Understanding the nature of the obesity issue;
- Understanding current approaches in responding to the issue;
- Understanding the nature of working across sectors and
- Criteria for engaging multiple sectors and stakeholders in collaborative processes

The literature was drawn from academia as well as government and non-government research bodies. The literature on obesity and complex problems was accessed primarily from Task Force members. However, this was supplemented by additional literature accessed via online and manual searches. The Medline full text database was searched for the key words “obesity reduction and framework or strategy” while bibliographies of selected articles were searched manually.

The review of obesity literature set out to elucidate the questions (1) “How is the obesity epidemic currently framed and understood?” and (2) “What broad approaches are currently recommended for intervening in the epidemic?” Recognizing that there are many different types of frameworks, the interest here was to review ones that could guide action. This was important as the framing of the issue determines the actions and the actors that are needed in a response. The purpose of this review was to inform the conceptual framework and setting-up of
working groups. Reviewing literature for successful action that could be included in the CORS, or for recommending suitable literature for consideration by the CORS, process was not within the scope of this project. This will be a key responsibility of the working groups.

Of all the literature reviewed on the obesity landscape, the *Foresight – Tackling Obesities: Future Choices Project (Foresight Project)* (2007) stood out, easily, as the most comprehensive framework currently available on the obesity epidemic. The report is a product of an extensive undertaking by the Foresight Program of the UK Government Office for Science that set out to systematically map the complexity of the issue/s and understand approaches for long-term and sustainable responses. Over a two year period, the *Foresight Project* undertook comprehensive and systematic reviews of literature; undertook scenario planning and quantitative modeling to develop possible future scenarios; and involved over 300 UK based and international experts and stakeholders from government, industry and academia in cross-sector and interdisciplinary analysis. Since the Task Force embraces this report as the most salient for CORS in BC, this 598 project relied heavily on the *Foresight Project* report.

The *Foresight Project* (2007) and other literature indicate that effective responses to obesity require action from multiple sectors and stakeholders. This implies a cross-sector policy and management challenge of considerable complexity. Given that the focus of this project revolved around designing an engagement process, literature was also reviewed to understand the rationale for working across sectors as well as criteria for effective stakeholder engagement.

This literature was accessed through a search of online databases such as Academic Search Elite and Medline as well as Google and Google Scholar for various combinations of the key words “cross-sector”, “cross-sectoral”, “horizontal”, “policy-making”, “collaboration”, “stakeholder engagement.” Manual searches for articles in chosen bibliographies supplemented the online search in exploring the question “What are the key considerations and options for setting up effective and meaningful multi-stakeholder collaborations?”

### 3.2 Conceptual Framework, Structures and Support Materials

The obesity literature helped to understand how the issue was currently framed, the drivers of the epidemic, the determinants of obesity and issues related to diverse populations. The literature also helped to identify strategic areas and key elements that will need consideration in designing strategies and interventions to tackle the obesity epidemic.

The World Cancer Research Fund (2007) developed a strategic framework for intervening in obesity as a means to preventing cancer. It identifies a range of actors that are needed to implement this framework and provides an appreciation for the broad range of sectors that will need to be engaged (see Appendix 5).
Matching this framework to the 108 variables in the *Foresight Project* (2007) and considering these actions and actors within a BC context helped to see that a BC strategy would need to be organized at two different jurisdictional levels, meaning at provincial and community levels (see Appendix 6).

Literature on working across sectors, which was also reviewed for themes, helped to learn various mechanisms that are used for this purpose and considerations for working across sectors. Literature on stakeholder engagement provided the criteria for support materials and recommending implementation considerations. The report entitled “Moving from the Heroic to the Everyday: Lessons Learned from Leading Horizontal Projects,” authored by Hopkins et al. (2001), documents a year-long roundtable discussion of Canadian public services Executives that led horizontal initiatives. This report stood out for its comprehensiveness and was relied on heavily for this 598 project.

Based on the literature reviewed two options for organizing the stakeholders were developed and written in a ten paged discussion paper. This paper, which was circulated to the parties a week in advance of a focus group meeting (October 2, 2009), served as a tool to seek input on the framework from PHSA and the Task Force. Feedback from this meeting and further deliberation at PHSA helped to finalize the preferred option, which was delivered to the client in a four paged summary document (see Appendix 1).

### 3.3 Strengths and Limitation of Methodology

All methodologies have strengths and limitations. Given the nature of this assignment, the interest here was to review literature that “framed the issue for action” and draw on the learning and insights from others that had worked on obesity strategy frameworks. And, as the *Foresight Project* (2007) discovered, holistic framing of the issue or comprehensive frameworks available for review were limited. The extensive work undertaken by the *Foresight Project* made this piece of literature a significant strength; especially since that level and rigour of investigation would not have been feasible for a Masters level project. Access to Task Force members – some of whom are considered “experts” on obesity issues and research in Canada was also one of the strengths. The task of finding relevant articles in a sea of literature was made efficient due to the expert knowledge of the Task Force members.

Nevertheless, an over-reliance on the *Foresight Project* report could be a limitation. Furthermore, Foresight developed its Obesity System Map for the UK context, which has a central governance structure. BC on the other hand is within a federated governance structure involving three separate levels of governance. In the BC context, decisions, especially in the food environment, are not only impacted by provincial and local level decisions but also federal and global policies. Therefore, direct application of the Foresight framework (Obesity System Map) to BC may pose some challenges. The map would still apply in terms of the
areas and criteria that need to be considered for a BC strategy but the extent of interventions may be limited on account of jurisdictional boundaries.

This may not be a significant issue given that a common concern related to the Obesity Systems Map is its complexity. Some view the map too complex and overwhelming. However, the *Foresight Project* (2007) has applied a weighting system to identify greater points of leverage, many of which can be tackled at a provincial level.

Not finding strong BC or Canadian literature for review was both a surprise and a limitation. This project reviewed the report of the Select Standing Committee on Health of the Legislative Assembly of BC (2006) on Childhood obesity, as well as the report of the Ontario Chronic Disease Alliance (2009). As mentioned previously, the BC report lists 36 recommendations for action while the Ontario report simply lists their current initiatives related to obesity prevention. Neither report was useful for framing the issue or understanding a rationale for the proposed responses.

The review of literature on working across sectors and multiple stakeholders was found to be mainly descriptive. Some literature mentioned the absence of evaluation of these processes as a current gap. In such a context, it would have been useful to interview personnel that have both developed or been part of cross-sectoral processes to gain practical insight on issues, challenges and promising practices. But, given the six week timeframe to present a preliminary design to the client so that work groups could get started, time was not available to seek ethics approval or conduct and analyze interviews. Hence, the over reliance on the “Moving from the Heroic to the Everyday: Lessons Learned from Leading Horizontal Projects” report which was based on a consultative process.

Despite these limitations, this project adds value in its systematic consideration of key factors and elements in designing a process for building the CORS. All too often, group processes are undertaken without much consideration of such factors. As will be better elucidated in Sections 6 and 7, on the review of literature on working across sectors and stakeholder engagement, successful processes require careful planning.
4 OBESITY – THE NATURE OF THE ISSUE

This section presents the literature reviewed to address the question “How is the obesity epidemic currently framed and understood?” This is pursued by exploring how the framing has evolved over the years through the review of several frameworks designed to “frame the issue for action.” The drivers of the epidemic and challenges in responding to the epidemic are explored next and the section concludes with a summary definition of the obesity epidemic.

4.1 The Obesity Epidemic – Evolution in Understanding

The literature suggests that the perception of and response to the obesity epidemic has evolved over the years. Well into the late 1990s, obesity was seen as a clinical issue and the response was primarily focused on treating the individual (Kumanyika, 2007). When people’s environments were considered (for example schools, churches, community centers and work places), they were merely places where behaviour changing interventions were supported. Even prevention efforts that were targeted at the whole population were focused on encouraging individuals to change their behaviour. Kumanyika (2007) makes the observation that at least in the United States, “the obesity epidemic occurred while a majority of the population was attempting to lose weight” (p. 90).

Noting that person focused interventions were not making an impact, researchers started to draw on prevention frameworks and theories of public health and health promotion (Kumanyika, 2007). Understanding of obesity evolved to a public health issue with the focus intervention shifting to the reduction of risk factors – for individuals as well as the population as a whole. The risk reduction approach considers people’s environments and how improvements here could support healthy behaviour. This transported the dialogue to upstream factors; or the factors that exert influence on people’s choices and behaviours, but are beyond the control of the individual. The role of public policy and the environment in mitigating the epidemic were installed in the obesity discourse.

Kumanyika (2007) observes that at present, the prevalent thinking is that curbing the obesity epidemic requires a two pronged approach. It requires health promoting public policies and environments, combined with efforts that motivate people to adopt healthy behaviours. Many frameworks have been developed to support these two approaches with varying degrees of utility (Kumanyika, 2007). Some of the frameworks are described as broadly conceptual, helping to understand the scope and nature of the issue; some identify targets and strategies and help to inform planning; some are useful for interventions at the clinical level and some are useful for framing issues for action (Kumanyika, 2007).
4.2 Evolution of Frameworks

It is the frameworks that “Frame the Issue for Action” that are of interest to this project, because these help to mobilize communities to an issue and support the development of public policies (Kumanyika, 2007). The basic Ecological Model, the Ecological Model proposed by Booth et al., the Canadian Population Health Model, Bray’s Epidemiological Model, International Obesity Task Force’s Causal Web and Foresight UK’s Obesity Systems Map are all frameworks that illustrates the issue to identify actors that need to be mobilized for policy and other action.

The Ecological Model

The ecological model frames the issue from a socio-ecological perspective “emphasizing the importance of the social and environmental context in which individuals live and make choices” (Kumanyika, 2007, p. 102). This model, depicted in concentric circles or ellipses, illustrates the multiple levels of environment – from home to society that has an influence on the individual. It illustrates the need for multi-level action. Booth et al. (2001, in Kumanyika, 2007) have also illustrated the many variables and levels that can influence people’s eating and physical activity behaviour. Figure 3 provides a depiction.

Figure 3: Framework for determinants of physical activity and eating behaviour

A gap in the ecological model approach is that it does not make any linkages between the multiple levels or variables nor do they identify points that may bear greater leveraging power; leaving the impression that it might be possible to act on any or a few factors and impact the obesity epidemic.

**The Canadian Population Health Model**

The Canadian Population Health Model, based on the Ottawa Charter for Health Promotion (1986) provides a version of the ecological model (Kumanyika, 2007). This model is depicted as a cube with determinants of health (biological as well as societal factors) on one axis, sectors and actors that can impact the determinants on a second axis and instruments of intervention (various actions) on a third axis; with values, assumptions, experience and evidence forming the base of the cube (Kumanyika, 2007). Figure 4 provides a depiction.

**Figure 4: Canadian Population Health Model**

As the Foresight Project (2007) notes, the determinants of obesity are the same as the determinants of health, therefore this model can serve as a planning and analysis tool for improving overall population health. Kumanyika (2007) says that Flynn et al. (2006) have adapted this model for childhood obesity. The cube model extends the basic ecological model by more clearly identifying the actors and by including values, assumptions, experience, evidence and strategies to the deliberations; but still does not make linkages between factors nor weight the potential points of intervention.

**Epidemiological Model**

Bray (2004) in Finegood (submitted in 2009) proposes an epidemiological model where food, like toxins and viruses act on a host to cause disease. This model proposes that fat acts on the brain which in turn acts on the fat and introduces the concept of feedback loops. Bray’s model not only links biological and environmental factors but by introducing the concept of feedback loops begins to position obesity as a complex issue. This is a key advancement on the ecological model. Finegood (submitted in 2009, p.2) observes Bray’s interpretation is that “the genetic background loads the gun and the environment pulls the trigger,” and says that Bray’s solution to the issue is for ideas that do not demand effort on the part of the individual.

**The Causal Web**

Kumanyika (2007) and Finegood (submitted in 2009) note that the Causal Web, developed by the International Obesity Task Force, expands on the social and environmental factors proposed by the Ecological model to also include process. As shown in Figure 5, process means the linkages between levels and variables, suggesting a convergence of these levels and variables to impact the individual. But, the Causal Web lacks the feedback loops of the epidemiological model.

Recognizing that obesity results from energy intake and expenditure at the individual level, the Causal Web organizes the multitude of factors in a matrix. Levels are organized laterally, with the level that has the most direct influence being closest to the individual. The settings, sectors and processes that make up each level are then organized vertically. Interrelationships are illustrated by arrows which converge on the individual’s environment. This model suggests unidirectional connections between variables suggesting a compounding effect on the individual.

Finegood (submitted in 2009) notes that the Causal Web helps “to illustrate the diversity of factors affecting individuals and suggest……need to implement many ideas that don’t demand effort on the part of the individual” (p.2). Finegood (submitted in 2009) also notes that the Causal Web depicts the obesity issue as a complicated problem; however, because it does not include feedback loops – "a
hallmark of a complex adaptive system,” (p.2), it fails to illustrate obesity as a complex problem.

**Figure 5: The Causal Web**

![Causal Web of Societal Influences on Obesity Prevalence](http://www.phac-aspc.gc.ca/ph-sp/php-psp/php3-eng.php#Developing)


Accessed: November 23, 2009. (See appendix 5c. for a more enlarged version of the diagram).

**The Obesity Systems Map**

Finegood (submitted in 2009) sees the Obesity Systems Map produced by the UK Government Office for Science’s *Foresight Project* as the most comprehensive obesity framework to date – one that depicts the epidemic as a complex issue. The *Foresight Project* maps this complexity through the identification of 108 variables that are interrelated and linked via 300 connections that form a system of feedback loops.

The feedback loops suggest the need for multiple, multi-facetted and balanced approaches to any action, to mitigate unintended consequences on one variable that might result from action on another variable (Foresight Project, 2007). Such an approach is also important because the *Foresight project* found that among this multitude of variables, no single influence dominated (Foresight Project, 2007). *Foresight Project’s* (2007) 108 variables which are categorized in to seven themes illustrate the biological to societal influences on an individual’s energy balance (energy intake and expenditure) as well as the multi level, multi-sector response required to impact these influences. The Obesity Systems Map defines the issue as a complex problem where many systems – from biological to social, interact to impact the energy balance in the individual. Hence it is an issue that cannot be mitigated with simple, single or short term responses.
4.3 Drivers of the Obesity Epidemic

Kumanyika (2007) observes that when developing effective solutions to problems, it is necessary to identify factors that either cause or perpetuate the problem and then reflect on these to determine potentially useful action. Swinburn et al. note that understanding the causative and protective factors for weight gain provides clear leads for intervention (2005, p.29). Haire-Joshu et al. (2007) say that individual’s diets and physical activity are influenced by industrialization, urbanization, economic development and increased food market globalization. The Foresight Project sees the obesity epidemic as a product of a “homeostatic biological system struggling to keep pace with a fast changing world where the pace of technological revolution outstrips human evolution” (Foresight Project, 2007, p.7).

In other words, though obesity results from consuming too many calories and not expending enough of them at the individual level, the epidemic has resulted from changes in our lifestyles and everyday environments. While our environments have
become revolutionized, human biology remains stubbornly adapted to our primordial origins – continuing to conserve and accumulate energy (Foresight Project, 2007). In fact, our current environments that make the unhealthy option the easy option (or sometimes the only option); and requires effort on the part of the individual to not gain weight suggests that the obesity epidemic might, in fact, result from a passive process (Foresight Project, 2007).

Technological advancements, shifts in social values and broad social developments have given people easy access to energy rich food and decreased our need to expend energy (Foresight Project, 2007). Kumanyika (2007), Haire-Joshu et al. (2007) and Lang and Rayner (2007) comment on the structural issues that contribute to over-consumption of calories, such as agricultural polices that support the over production of calories from sugars, fats and meats, especially in North America and Europe. Lang and Rayner (2007) observe that if agriculture was to meet the dietary guidelines set forth by the WHO or follow the European diet, Europe would be producing much less sugar, fat, meat and oils. As Kumanyika (2007) notes, agricultural policies in the US continues to support the production of more calories even though the need for labour has decreased. She sees the incongruence between government’s nutrition policies and agricultural policies akin to giving subsidies to tobacco growers while promoting anti-smoking.

Lang and Rayner (2007) see the globalization of the Americanization diet (meaning over-consumption, large portion sizes); the rise of the car culture; technological advances that marginalize everyday physical activity; the widening distance between home, work and shops; plentiful availability of food leading to over-consumption; replacement of water with sugar drinks and the rising influence of large commercial concerns that frame what is available and what sells as the key drivers of the epidemic. They (2007) see these as being underpinned by shifts in values and supported by social, structural and technological changes. Kumanyika (2007) notes that in the current social milieu technological advancement is viewed as essential; while structural changes support these cultural, political and economic interests.

Lang and Rayner (2007) further note how commodification of food has created a boon in the processed food industry. Hobbs observes that, “a worldwide proliferation of processed foods high in sugar, fat, sodium and calories and low in dietary fibre, coupled with less frequent and less vigorous physical activity.....” (2008, p.9) is causing excess weight gain of epidemic proportions. Kumanyika (2007) cleverly notes that free market policies, which are believed to be capable of creating balance, are not working because both hunger and obesity are increasing simultaneously. As the Foresight Project (2007) summarized and was mentioned in this report earlier, the main drivers of the obesity epidemic are changes in values, technology and people’s environments; hence, attempts to change the individual will not produce the desired impacts. As Meadows (1999) observes, what may be required is a change in paradigm which can begin with changes in policies as well as changes made to our environments.
4.4 Challenges in Responding to the Issue

Lang and Rayner (2007) identify three key challenges in responding to the obesity epidemic (2007). They include: competing diagnoses of the issues; concern that placing restrictions on food and lifestyle might lead to “nanny-states;” and issues with evidence.

The Challenge of Framing

This section has already noted the shift in how experts have framed obesity and how the issue has evolved to depict its complexity. Noteworthy is the prevalence though of “old thinking” in some important places. For example, Hobbs (2008) notes that in the US, where nearly 134 million people are overweight or obese and 1 in 523 people under the age of 20 live with diabetes, the primary policy objective, especially in the most recent eight years, has been to emphasize personal responsibility for diet and exercise.

Haire-Joshu et al. (2007) observes that the US government supports over 300 initiatives addressing some aspect of obesity, but these are neither coordinated nor comprehensive. They also observe a lack of initiatives addressing systemic issues in food production, distribution, transport as well as policies that address active living. Lang and Rayner (2007) note that in the US, social marketing campaigns are still heavily focused on changing individual behaviour.

The Challenge of Evidence

An issue that affects the framing of obesity as well as a response to it is the issue of evidence. Most literature suggests that in the healthcare sector, evidence based medicine (EMB) is a preferred method for selecting interventions. Kumanyika (2007) notes that Random Controlled Trials (RCTs) is the gold standard in evidence based medicine. She observes that RCTs offer a high degree of internal validity, however, external validity or the applicability of evidence is not a criterion for assessing the rigour of research. The EMB model and RCTs have proved to be limiting both in a population health context as well as when intervening in complex issues (Swinburne and Kumanyika, 2005). In a population context, it is not possible to control the environment for variables and since interventions are directed at the whole population, it is not possible to find control groups. Both criteria are critical factors in RCTs.

Lobstein and Summerbell (n.d.) note that the need for controlled studies has led researchers to settings such as schools that allow for at least some degree of control which bias the available evidence. They suggest that it is another reason not to be limited by evidence based medicine. The Foresight Project (2007), overall, found the evidence on successful interventions to be weak, posing a challenge to proposing solutions. The evidence they did find indicated that the reason current strategies are failing to have sufficient impact was because they do not offer the
range and depth of interventions needed by a complex issues such as obesity. Lang and Rayner (2007) say that at least in some part, the difficulty in translating evidence in to practice stems from policy cacophony. Since obesity can be theorized in various ways and is divided by ideological distinctions, there is a multiplicity of research and actions lending to divergent voices and uncoordinated action.

4.5 A Complex Problem

Petticrew et al. (2009) describe obesity as a wicked issue, meaning that it is a complex problem which is difficult to define and one with no immediate solution. Hunter (2009) observes that “wicked issues defy easy or single bullet solutions” (p.202). Plsek and Greenhalgh, cited in Holden (2005) echo this when they state that a complex issue or system has many parts that act in ways that are not always totally predictable, and whose actions are interconnected so that action on one part can change the context for other parts. Lang and Rayner (2007) note the importance of not just investigating drivers but also how they interact when searching for solutions to complex problems.

Silverglade (2008) argues that “eating better is not simply a matter of personal responsibility” (p.54); policy initiatives are needed to make the healthy choice the easy choice. But Kumanyika (2007) notes that many see eating and physical activity as personal choices and behaviours, though she notes that the rise in childhood obesity might be challenging this perspective. A complex issue like obesity will need both strategic and comprehensive solutions.
5 RESPONDING TO A COMPLEX PROBLEM

This section presents the literature reviewed to address the question “What broad approaches are currently recommended for intervening in the epidemic?” Literature was reviewed to draw themes on critical factors in responding to complex problems. These include critical stages in the life course, approaches, levels, settings and sectors. Specific factors that may need to be considered for certain populations were also noted. The section concludes by noting the type of responses needed when dealing with complex problems.

5.1 Life Course Approach

Petticrew et al. (2009) notes that complex problems require interventions spanning the life course of a population. However, the Foresight Project (2007) states that in the case of obesity, there are some stages in the life course that are deemed to be more malleable to intervention. These include critical stages of metabolic plasticity (e.g. early life, pregnancy, menopause); critical life transitions (e.g. leaving home, becoming a parent) and times when shifts in attitudes can happen (e.g. diagnosis of illness).

Among these malleable stages, prenatal, early childhood and middle childhood are seen as influential stages for establishing healthy eating/nutrition behaviours while middle childhood is seen as critical for building physical activity skills (Foresight Project, 2007). Since, pregnancy and parenting are also malleable stages; and since parental obesity is an indicator of childhood obesity; the Foresight Project (2007) proposes a focus on children and their families. They clarify that a focus on children and families does not mean targeting interventions directly at them; rather, it means priority targeting of the settings they normally occupy such as schools, work places and community settings.

5.2 Prevention and Treatment Approaches

Petticrew et al. (2009) say that prevention is the preferred approach to tackling complex issues. Kumanyika (2007) states that prevention efforts should follow the full continuum, from primordial prevention (earliest stage for developing risk); to primary prevention (the prevention of weight gain prior to diagnosis); secondary prevention (intervening after the disease has manifested though still in the early stages) and finally tertiary prevention (treatment of advanced disability to avoid death and disability). Schmid (1995) and Kumanyika (2007) note the importance of prevention efforts spanning from universal approaches (environmental and policy measures that reach whole populations); to those reaching potentially high risk populations (e.g. education and skill building programs) and targeted approaches directed at those diagnosed with obesity.
Since the obesity epidemic has resulted from transformed socio-economic and cultural environments that influence food consumption and physical activity, Hobbs, (2008), and Schmid (1995) note that broad based prevention strategies are needed to transform food and physical activity environments. They observe that this will require significant political will.

As the *Foresight Project* (2007) predicts for the UK and echoed by others elsewhere, even with effective prevention strategies, obesity will remain a dominant issue for at least the next forty years. Therefore comprehensive approaches to reducing the impact of obesity will require treatment and management strategies, to minimize the disease burden on the individual as well as society.

5.3 A Layered Approach

The *Foresight Project* (2007) notes the importance of prevention efforts to be targeting the same behaviour (healthy eating) at multiple settings. Settings are the spaces that people inhabit and can be the home, an organization (day care, school or work place), the community or the whole society; and serves as the arena that mediates the intervention. People who have policy and program responsibility in these settings are the direct targets of intervention (*Foresight Project*, 2007). For example, daycare operators, school personnel, employers, local government, policy makers from government and industry are the targets of interventions. The literature says that to achieve a single change in behaviour, interventions are needed at several levels. For example, evidence suggests that breastfed infants have a higher likelihood of maintaining healthy weights in later years (*Foresight Project*, 2007). Norway has achieved impressive levels of breast fed infants (75% of infants up to the age of six months) through multilevel measures such as education, excellent maternity benefits (labour standards) and work place support for breast feeding such as daily leaves for breast feeding (up to 2 hours per day) and on site child care (employer support) (Lobstein and Summerbell, n.d.).

5.4 Cross Sector Approach

The obesity reduction framework developed by the World Cancer Research Fund (WCRF, 2009) identifies interventions that require action from nine different sectors and actors (government, industry, media, civil society, schools, workplaces and other institutions, health and other professionals and people) across four dimensions (physical environment, economic, social and personal dimensions). Stirling et al. (2007) mention the importance of engaging stakeholders from the main elements of the issues landscape – for example engaging the key agents in the food chain (farmers, food processors, retailers, caterers and consumers) as
well as professional interests and public and private sectors. From the commercial sector, including both large and small enterprises is recommended.

Lang and Rayner (2007) echo the need for “solutions that work across policy boxes, not just within them” (p. 167). Some of the “policy boxes” they identify include: agriculture (because policy affects what is produced); manufacturing (for ingredients, portions and products); retail (for planning, prices, availability and locations); education (for health knowledge and skills); culture (for the shaping of consciousness around food and physical activity); trade (for product pricing and terms of trade); and economics (for differential taxation and subsidy of foods)(2007, p. 167).

The Foresight Project’s (2007) seven areas for intervention (Social Psychology, Individual Psychology, Physiology, Food Production, Food Consumption, Physical Activity Environment and Individual Physical Activity) also illustrate the need for multi-level, multi-sector, multi-stakeholder action. EPODE is a program in France that engages a community’s Mayor as a champion – who is turn involves schools, industry and other stakeholders to plan actions to reduce childhood obesity in their community. However, Hobbs (2008) notes that when multiple stakeholders are engaged, it is understandable that competing interests might prevail. Working effectively across sectors and with multiple stakeholders will be explored in more detail in Sections 6 and 7.

### 5.5 A Portfolio of Interventions for a Complex Problem

The literature suggests that interventions act to regulate risk or stimulate change; and can include public education, skill development, policies, regulations, legislation, incentives such as subsidies and disincentives such as taxes. Some of these interventions can be passive or active.

Schmid (1995) recommends using a mix of active and passive interventions as used in the reduction of motor vehicle fatalities; where a mix of interventions like road improvement, better designed motor vehicles, speed limits, seat belts, air bags, seat belt and drunk driving legislation and enforcement of these laws, education campaigns that promote seat belt use and safer driving were utilized.

Likewise, complex issues such as smoking reduction strategies have successfully used a combination of interventions – adjusting the price to make products less accessible; placing controls on product promotion and changing the product to make it less harmful (Schmid, 1995). Removal of subsidies that lower the price of unhealthy foods, taxes on junk food, standardization of core dietary requirements, food labeling, restrictions on food marketing to children, reducing screen time, increasing park and play spaces and improving their safety, bike and walking paths and increases in community density are repeatedly cited in the literature as potentially helpful interventions.
Operating in a milieu of wicked problems that provide no definitive answers, the Foresight Project (2007) and other literature recommend using a portfolio approach to interventions, similar to that of an investment portfolio of a bank. This means adopting a mix of interventions including ones that are low risk for failure but may provide lower yield (meaning the interventions are supported by evidence but the intervention has limited reach) with those that have potential for higher yield but are at a higher risk for failure (population level interventions that currently may not be supported by adequate evidence but have the potential to achieve greater outcomes) (Engelhard et al. 2009; Foresight, 2007; Lobstein and Summberbell, n.d.).

5.6 Effective and Cost-Effective Solutions

To intervene in the obesity epidemic, a greater range of interventions are required. Most literature recommend designing strategies and interventions based on the best available evidence and then evaluating these to create practice based evidence (Foresight, 2007; Huang et al., 2009; Petticrew et al., 2009; Swinburne and Kumanyika, 2005; WHO, 2004).

Noting that evidence is about providing information of value for certain purposes, Kumanyika (2007) recommends using simulation modeling, case histories and logic models to create practice based evidence. Roux et al. (2004) propose conducting economic evaluations of potential interventions to understand which interventions might be the “best buy” for the resources.

Comparing costs (resources that are expended) and benefit (to society) of competing solutions could help to identify the most effective and cost-effective suite of interventions. Assessing interventions using common health outcomes supports fair comparisons, helping the prioritization of intervention for inclusion in a portfolio (Haby, 2006). The ACE-Obesity Project (2006) did this for thirteen interventions in the Australian context. Drawing on the best available epidemiological and economic data, they identified six interventions that were effective and cost-effective (Haby, 2006). More importantly, through a stakeholder process, the ACE-obesity project applied a second stage filter for assessing acceptability, feasibility, sustainability and equity of potential interventions.

Where definitive solutions and strong evidence is lacking, using a suite of interventions, assessing their cost-effectiveness and evaluating their effectiveness provides a promising approach for responding to wicked problems.

5.7 Equity and Other Considerations

The literature observes several issues that need attention in developing obesity prevention strategies. Equity considerations, potential contradictions between
obesity and eating disorders messaging and the need to join forces with other complex issues for consolidation of policy efforts have been mentioned.

Kumanyika (2007) notes the higher prevalence of obesity among some ethnic minorities and populations with lower socio-economic status – especially lower income women. She notes the tendency for victim blaming or the tendency to interpret the higher prevalence in these group as a result of some inherent deficit. She cautions the need for sensitivity around how public health policy or problems are framed. Lobstein and Summberbell (n.d.) points to the issue that in some cultures or ethnic groups, being fat is highly desired, so they may not understand nor appreciate the concern around obesity.

Neumark-Sztainer (2005) cautions against inadvertent harm that obesity messaging and approaches can cause in the area of eating disorders and disordered eating. A more integrated approach to the prevention of obesity and eating disorders – taking in to account the full spectrum of eating and weight concerns; and developing comprehensive messaging on both issues and communicating a common language is recommended. Rohrer et al. (2005) recommend promoting healthy lifestyles instead of ideal body weights.

The Foresight Project (2007) recommends joining forces with other policy tables where relevant, for consolidation of effort as well as congruence in policy. In particular, they note the parallels between efforts in the Climate Change arena and see a benefit in joining forces. Reducing personal automobile use is an example of a policy objective sought for by both obesity reduction and climate change tables.

5.8 Need for Multifaceted, Comprehensive and Long-Term Response

Lang and Rayner (2007) observe that “obesity is the manifestation of inappropriate societal structures framing what people eat and do” (p.168). It is widely understood that obesity results from an imbalance between energy intake (food) and expenditure (expenditure) but the epidemic results from a matrix of factors. And as Lang and Rayner (2007) observe, instead of being “locked in to disciplinary boxes,” obesity requires a multifaceted, comprehensive, long term and society wide response to affect any meaningful change.

It is abundantly clear that obesity is not an issue that the health sector alone can address. The obesity epidemic requires the engagement of all relevant sectors and stakeholders to work collaboratively and seek change. Therefore, the effective engagement of multiple sectors and stakeholders is an imperative and factors that must be considered for this will be explored in the next two sections.
6 WORKING ACROSS SECTORS

The review of obesity literature underscores the importance of a cross-sector, multi-stakeholder response to tackling the obesity epidemic. This requires the effective harnessing of a broad range of sectors, mandates, organizations, interests and actors to work towards a common goal. This, in itself, is a complex undertaking which requires insight on what is entailed in working across sectors and with multiple stakeholders. In this section, literature is reviewed on the cross-sector approach to explore its nature and drivers and mechanisms for working across sectors; with particular emphasis on collaboration. Strengths and challenges of the approach are also reviewed briefly.

6.1 The Cross-Sector Approach

Traditionally, the mandate and responsibility for public policy making has rested with government. And traditionally, governments have formulated public policies by working within departmental silos and hierarchies. The literature indicates that this type of governance is changing. Decision-making and management of key societal and policy issues, is moving from the strict control of government and hierarchies within it to more horizontal or across-sector approaches.

The basic tenet of the cross sector approach is that organizations work across mandates, disciplines and organizations to “…create coordinated and optimal division of labour between teams, departments, regional branches and occupational functions” (Canadian Center for Management Development [CCMD], 2000, p.3). The Public Health Agency of Canada [PHAC] (2008) sees the cross-sector approach working laterally across agencies, at the same level of decision making and jurisdiction, as well as working vertically across jurisdictional boundaries and levels of government. Noteworthy is that decision-making and management of policy issues is being distributed across levels of government and many departments within it, as well as organizations and interested actors outside of government. Though government remains a central actor in these processes, increasingly, they may not be the dominant player (Pal, 2006).

PHAC (2008) sees cross-sector action as a strategy for dealing with complex issues that no single government agency or even whole government can address alone. Bakvis and Juillet (2004) see the cross sector approach as the coordination and management of activities between two or more organizational units. Hopkins et al. (2001) see horizontality as a tool for bringing diverse actors together and aligning their authorities to achieve a common purpose.
6.2 Drivers of Cross-Sector Action

The cross-sector approach, which is still an evolving phenomenon in government, has been precipitated by several factors. The emergence of New Public Management as a model of governance has been a key factor in horizontal governance (Pal, 2006). This is changing the management philosophy of government and pushing government to work across boundaries (Bakvis and Juillet, 2004). Working across governments and government departments promises a more coordinated and efficient approach to public decision making.

Increasing complexity of issues that cut across the mandates of individual government departments is another driver of cross-sector action (Bakvis and Juillet, 2004; Hopkins et al., 2001; Pal, 2006). Effective solutions to these complex issues require multiple perspectives, expertise and a whole government response; while the scale, workability and sustainability of solutions require different approaches (Bakvis and Juillet, 2004). Pal (2006) notes that as the complexity and technicality of issues increase, policy makers need to work with researchers and other expertise – not just interest or lobby groups.

For governments that are challenged with finding the necessary resources within their own realms, seeking private-public partnerships has become a priority. Thus, they cooperate with and mobilize policy actors outside their hierarchical control (Bakvis and Juillet, 2004; Pal, 2006). Pal’s (2006) observation is that for government – working across sectors is recognition of their own limitations but also a means of offloading responsibility on others. The Public Health Agency of Canada (2008) notes that, increasingly, governments are interested in being part of the processes to set the parameters, but defer to others to implement policy. Lenihan (2009) underscores the point that when public agencies are involved in cross sector processes, it should be about exercising their authority appropriately – not abdicating it.

Hopkins et al. (2001) note that cross-sector action is also driven by changing societal values. Ideas and innovation that urge improvements to public services in knowledge-based societies; increasing demands made for seamless, single window services; greater scrutiny of government actions; a less deferential public; increasing demand by citizens and interest groups wanting involvement in decisions that impact them, and the importance of including them to find feasible and acceptable solutions are all factors that distribute the policy process outside of government (Bakvis and Juillet, 2004; Hopkins et al., 2001; Pal. 2006).

Within the health domain, since the Alma-Ata declaration (WHO, 1978), health has been understood as a condition that is impacted by a wide range of social, environmental, cultural and economic factors. When such issues interact to influence a population’s health, the cross-sector approach allows public agencies to marshal their resources to engage the broader public, so that they play a role in
defining and implementing strategies and solutions to achieving wellness (Lenihan, 2009).

In fact, ActNow, a cross sector and whole government approach to preventing chronic diseases, has been evaluated by PHAC (2009) as not only a promising cross government approach to promoting health, but also a successful approach in including civil society in collaborating on a common purpose.

6.3 Mechanisms for Cross-Sector Action

Cross-sector action happens within policy communities and networks and there are many mechanisms for harnessing these communities and networks.

Policy Communities and Networks

Pal (2006) defines a “policy community” as a broad set of actors who understand the ideas and terminology that define a policy area and have some level of interest in the policy issue. These communities are crucial to policy development which requires not only information from all perspectives but also an interest in implementing decisions; which can be assisted if the decision is coherent to all interests (Pal, 2006).

“A policy network” is a subset of the policy community, made up of a range of actors from government, interest groups, agencies, associations, media, individuals and academia. These are individuals and agencies that have a higher investment in the policy issue, attempt to influence it, are connected to each other via some mechanism, and interact with one another (Pal, 2006). Policy networks include decision makers as well as the attentive public whose role it is to generate ideas and discussion (Pal, 2006). “Policy networks are webs of usually stable and ongoing relationships which mobilize dispersed resources so that collective (or parallel) action can be orchestrated toward the solution of a common policy problem” (Kenis and Schneider, 1991, p.36 in Pal, 2006, p247).

According to Van Waarden (1992) cited in Pal (2006) major dimensions of policy networks include actors, function, structure, institutionalization, rules of conduct, power relations and strategies. The members of networks are usually referred to as stakeholders – people or organizations that have a significant interest in the issue and have an interest in seeing it resolved (Pal, 2006). It is recognized that every stakeholder owns part of the problem as well as part of the solution, hence have a stake in the process (San Martin-Rodriguez, 2005).

Levels of Involvement

Cross-sector action is usually facilitated through a policy network and the manner in which the networks are organized can fall on a continuum based on the degree of involvement. Hopkins et al. (2001) have outlined three levels of involvement.
• At the most informal level, or what Hopkins et al. (2001) term Horizontal attitude and culture, cross-sector work involves informal ties, simple facilitation and sharing of information.

• At the next level up, or Horizontal coordination (Hopkins et al., 2001), cross sector work involves both aligning structures and activities of multiple units, organizations or sectors and coordinating actions; to reduce overlap, duplication and any barriers within the group to achieving common objectives (Bakvis and Juillet, 2004; Hopkins et al., 2001). Gray (1989) refers to coordination as institutionalized arrangements between networks of organizations.

• At the most involved level, Collaboration, participating organizations share mandates, decision-making, resources, work and an interest in achieving a common objective; which are then integrated across the organizations (Bakvis and Juillet, 2004; Hopkins et al., 2001). Bakvis and Juillet (2004) see collaboration as an active and dynamic process. Gray (1989) sees collaborations as temporary forums which help to develop consensus on a problem to seek mutually agreeable solutions as well as take action on those solutions.

Partnerships are formalized collaborative arrangements made through memoranda of understanding and legal contracts (Bakvis and Juillet, 2004). They are more common between public and private/not-for-profit partners (Bakvis and Juillet, 2004). Though coordination, collaboration and partnership are often used interchangeably in the working milieu of horizontality, these mechanisms use different approaches, engaging different levels of commitment and relationship (Bakvis and Juillet, 2004).

6.4 Conditions and Approaches for Collaboration

Collaboration, a particular mechanism of working across sectors, is both a forum and a process through which parties to a problem can explore commonalities and differing perspectives of the issue; to arrive at solutions that are more wholesome and cannot be achieved by one party alone (Gray, 1989). Gray (1989, p.10) argues that collaborations are useful when:

• problems are ill defined or there are disagreement on how the problem is defined
• stakeholders have vested interest but are also interdependent
• stakeholders are not organized
• there is disparity of power and resources among stakeholders
• different levels of experts and information are required
• the problem is technically complex and scientifically uncertain
different perspectives lead to adversarial relations
incremental and unilateral efforts have not produced solutions and
existing processes are either insufficient or have exacerbated the problem.
Collaboration clearly is a preferred approach to addressing complex problems; therefore the preferred approach for facilitating a solution to the obesity epidemic.

San Martin-Rodriguez (2005) note that collaborations are usually voluntary processes and this combined with the many perspectives and interests implies a need for negotiation. Gray observes that “…central to the notion of collaboration is the concept of shared power” (1989, pp. 112) to both define the problem as well as plan action. Interdependence; solutions that arise from constructively dealing with differences; joint ownership of decisions; assumption of collective responsibility by stakeholders for actions and a process that is emergent are key aspects of collaboration (Gray, 1989).

Gray observes the “importance of process……in planning and conducting successful collaborations” (1989, p. 93). Noting the importance of well designed and managed processes in successful collaboration, Gray (1989) outlines three critical phases in collaborative processes. The phases include:

• The Problem setting phase when stakeholders are brought to the table to meet face to face, to acknowledge the issue and agree on working together. Identifying stakeholders, developing a common definition of the problems, assessing capacities and resources of the convener are all important considerations of this phase. Gray notes that “unless this step is satisfactorily undertaken, future efforts are unlikely to succeed” (1989, p. 58).

• The Direction setting phase involves the setting of ground rules on how stakeholders will interact with one another; setting of the agenda on what the group will do together; organization of task/sub groups to manage the flow of work (noting that the optimum size for effective work groups is 12-15); sharing of information together; considering and reaching agreement on options.

• In the Implementation phase, members ensure that their constituents know about the rationale for the agreed upon options; build external support to seek resources; develop structures to oversee implementation and monitor the implementation, ensuring execution of responsibilities and achievement of targets.

Collaborations include the interests and participation of stakeholders, improve relationships among them and enhance the acceptance and implementation of solutions (Gray, 1989).
6.5 Strengths and Challenges of Cross-Sector Approaches

The literature identifies many strengths of the cross-sector approach. Working outside one’s own organizational boundaries helps parties to see different aspects of the issue. Encouraging diverse perspectives can lead to more comprehensive analysis as well as solutions that are greater and more valuable than can be achieved with limited perspectives (Bray, 1989 cited in Lasker et al. 2001; Gray, 1989). If properly designed and managed, cross-sector approaches can lead to comprehensive, new and better ways of thinking and help to break new ground while consolidating skills and resources (Gray, 1989; Lasker et al., 2001; Weiss et al., 2002).

Howlett (2002), cited in Pal (2006) note that when the same policy actors are involved in shaping policy, only incremental change typically happens. Paradigm changing policy options require a break from past policy traditions as well as new ideas and interests. The cross-sector approach engages these other interests, strengthens relationships and provides the opportunity to engage people that, otherwise, could block plans of action (Gray, 1989; Lasker et al., 2001; Weiss et al., 2002). Cross-sector dialogue and information-sharing can strengthen capacity of people and organizations to address problems (Weiss et al., 2002) and helps to change the way communities conceptualize and solve problems.

PHAC (2008) found that cross-sector action was more effective and efficient at finding sustainable solutions to health issues than when the health sector acted alone. San Martin-Rodriguez (2005) found the literature to suggest that working across organizations is “an efficient, effective and satisfying way to offer health care services (p.132). PHAC (2008) also found that cross-sector action had the ability to bolster community development and was used in a wide variety of policy domains such as crime prevention, sustainable development, education, employment public health, public security and social cohesion.

Challenges

Hopkins et al. (2001) note some challenges associated with cross-sector action. Though effective in the longer term, working across sectors can be inefficient in the short term; increasing the number of partners, the amount of logistics and planning, and requirement for more resources (Hopkins 2001; PHAC, 2008; Weiss et al., 2002). The number of partners involved can pose logistical challenges.

Pal (2006) observes that true partnerships imply a degree of equality and shared responsibility, often not a comfortable prospect for those used to working in hierarchical formats. Lasker et al. (2001) point to tension and conflict that is inherent in group decision making processes. D’Amour (2005) and San Martin-Rodriguez (2005) saw discipline-based socializing as a barrier to collaboration. Hopkins et al. (2001) noted the potential danger of “group think” that could move
decision making towards the lowest common denominator, instead of considering more challenging options.

PHAC (2008) points out that the way a policy is framed determines which agencies become involved while which agencies become involved can also determine how policies are framed. Either approach can bias policy outcomes. PHAC (2008) also found that keeping focused, sustaining commitment, balancing competing objectives, accounting for results, the capacity to develop plans for multiple sectors and overseeing implementation could be challenging in cross-sector action. Hopkins et al. (2001) saw issues related to accountability, especially when cross-sector action can become disconnected from lines of authority. Smith et al. (2009) note that while partnerships incur significant cost; currently, there is no evidence that partnerships actually deliver results.

6.6 The Better Approach

It is clear that working across sectors is a prudent approach, given the increasing complexity of problems and diminishing resources available, especially to government. It is also a smart approach as it consolidates many perspectives, resources and intelligence, to find better and more effective solutions. Nevertheless, working across sectors is a complex task that requires thoughtful planning, skills and competencies and a range of resources. The next section will explore the dimensions that are important for setting up effective cross-sector processes.
As issues become complex and spill over mandates of single organizations, working across sectors is becoming the norm. To be effective, these processes need to be set up and managed with some degree of competency. As Bakvis and Juillet (2004) noted, when organizations come together, it is the people that work together. In this section, literature is reviewed to identify the criteria that contribute to successfully engaging stakeholders in effective collaboration.

### 7.1 Essential Elements: Trust, Leadership, Capacity

Hopkins et al. (2001) sees working across sectors as more an art than a science. Among the elements that the literature identifies as important to effective processes, trust and leadership feature prominently.

Nearly all the literature reviewed identifies “trust” as the most indispensable element for successfully working across-sectors. Smith et al. (2009) found high levels of trust and shared goals to be key success factors in collaborative processes. Bakvis and Juillet (2004) describe “trust” as the all important lubricant that helps move processes forward; especially in situations of conflicting mandates, goals, objectives and interests. Hopkins et al. (2001) see trust as the glue that keeps processes together.

Reminding us that trust is built over time and exists between individuals, Bakvis and Juillet (2004) cautions that history among participants can help or hurt trust relationships. San Martin-Rodriguez (2005) states that in building trust, over and above time, patience and previous positive experiences can help. Gaining credibility through small and simple actions, not using relationships for some hidden agenda, not playing games or favourites or engaging in otherwise divisive behaviour all lend to building trust (Bakvis and Juillet, 2004). It must be noted that trust can also quickly evaporate, and can take considerable amount of time to restore, if ever, pointing to the need for adroit leadership.

The literature indicates that leadership of both people and convening organizations is critical to nurturing and strengthening trust; and a critical factor in the success of cross-sector processes. The ability to convey a vision of collaborative practice is critical to leadership (San Martin-Rodriguez, 2005). Usually, though one or two people take the lead in getting a process started, in successful collaborations, this leadership is distributed depending on circumstances, skills and personal strengths of members (Hopkins et al., 2001).

Leadership must also possess the power to influence and persuade, though this is best exercised through dialogue, active listening and mediation of conflict (Bakvis and Juillet, 2004; Hopkins et al., 2001). The ability to bring people together,
manage relationships, facilitate deeper exchange of views and ideas (even when they are controversial), ability to identify systemic linkages and communicate areas of mutual interest (to overcome goal conflicts and sources of resistance), courage to act when full consensus is elusive and the ability to deliver projects on time and budget are all central to leadership. So is managing transitions, of both facilitators of the process as well as participants. Furthermore, initiatives have their ups and downs and participants can get distracted by other priorities so leadership is critical to keeping a group motivated and maintaining momentum.

PHAC (2008) observes that capacities of the convening organization as well as its managers that support the process lends to leadership. Adequate resources, guiding policies, formalized decision making processes and accountability frameworks contribute to organizational leadership (PHAC, 2008). Relationship building, negotiation, contract management, risk assessment and performance measurement skills are integral to management leadership (Langford, 1999 in Pal 2006).

7.2 Fostering Collaboration: Partners, Structure, Process, Evaluation

Effective collaborations do not happen simply because a group of people have been brought together (D’Amour et al. 2005). Collaborations, which are mostly voluntary processes, require the involvement of several skill sets and expertise. Efforts are required to harness this power to build a dynamic, interactive and cohesive team (D’Amour et al., 2005; Hopkins et al., 2001; Lenihan, 2009; San Martin-Rodriguez, 2005). Mobilizing teams is a key step in engaging partners and teams require both structure and process – meaning people, ways to organize them and processes to keep them connected and working.

Engaging Partners: The Right People at the Right Time in the Right Way

Early and open engagement; involving the right people in the right way; involving different stakeholders at different levels of intensity; having open and transparent processes for selecting stakeholders and ensuring that the network is broad and inclusive are important elements for building teams (Lenihan, 2009; PHAC, 2008). Gray (1989) argues that stakeholders need to be seen as legitimate and what constitutes legitimacy include people with expertise that is essential to the process; sufficient variety of expertise to match the complexity of the issue; people who have authority to agree to decisions; and people who will be required to implement the decisions. San Martin-Rodriguez et al. (2005) observe that engaging people as members of a community and linking back to community issues and wellbeing is an effective engagement strategy.

Since stakeholders may come to the network with different capacities, resources, skill, preparation and sophistication; building a shared understanding of concepts and vocabulary or “developing a common language” is mandatory for successful teamwork (Lenihan, 2009). San Martin-Rodriguez et al. (2005) remind that a
diverse membership would be rooted in diverse philosophies and theoretical perspectives of their organizations and professions; and that reflective practice can help teams to understand differences and value other perspectives.

Successful teams integrate the knowledge and skills of the members to benefit the group process (D'Amour et al., 2005). Weiss et al. (2002) note that optimizing the use of members’ time and resources; and roles that match their interests and strengths contribute to team synergy. Seeing the link between member contributions and group outcomes encourage teamwork (San Martin-Rodriguez et al., 2005). Building on small successes that demonstrate viability of the team helps to promote a sense of accomplishment.

Providing Structure: Increasing Resiliency and Continuity

The literature indicates that structures play a key role in sustaining relationships over time and are indispensable for building strong teams. These can be informal or formal. Informal structures require less logistical support and include simple facilitation of information (Hopkins et al., 2001). Formal structures require consistent and quality data and documentation (Hopkins et al., 2001). Formality, helps to establish operating systems which can provide resiliency during times of change – especially when managers of processes change or representatives of partner organizations rotate over time. However, Hopkins et al., (2001) caution that overly elaborate structures can overshadow contact and commitment among participants.

The right choice of structure depends on the goals of cross-sector action and the tasks it will undertake (Hopkins et al., 2001). Usually, longer term and larger scale processes require formal structures with documentation and formal accounting, in particular, when resources, authority and important decisions are shared across mandated authority. Formal Structures include:

- co-chaired advisory committees that provide systematic means for identifying and discussing issues;
- joint decision-making committees or networks that provide participatory processes for resolving issues and finding solutions;
- temporary coordinating centers that bring together decision makers in time limited situations;
- councils that bring senior officials together to share information and coordinate policy and
- new agencies that are established to implement policy decisions.

These structures are usually governed by Terms of Reference that provide general direction for everyday activities; written agreements that help to bridge mandates and spell out accountability; protocols that set the ground rules and terms of engagement; memoranda of understanding on sharing resources and communications; and mandate letters that provide partners with requisite approval to proceed.
Fostering an Open and Productive Process: Building Collegiality and Momentum

The Canadian Centre for Management Development (2000) states that dialogue is indispensable for effective processes. They describe dialogue as “shared inquiry” and a “way of thinking and reflecting together” and an experience that takes place between people – not organizations (CCMD, 2000, p.3). It is also about “candid conversation” and “respectful exchange of ideas” which include suspension of quick judgments and careful listening (CCMD, 2000, p.3 & 4). Dialogue is important especially at the beginning to develop conceptual clarity of the initiative. It is also important to keep processes on track as well as for reflection during evaluation. (CCMD, 2000, p.5). CCMD (2000, p.4) notes that dialogue helps to:

- “bring people with different experiences, ideas, expertise and roles together to place them on an equal footing;
- solve problems jointly;
- identify and scrutinize deeply held assumptions, preconceptions, and received wisdom;
- breakdown pretensions, dissolve social rituals that build walls between people, and disrupt unproductive routines;
- come to collective judgments and, in so doing,
- generate trust and a shared commitment to act jointly; and build credibility and persuasiveness of those engaged in dialogue.”

To avoid unfruitful dialogue, CCMD recommends that dialogue should deliver “a list of key lessons learned,” “a list of tangible actions” and “a commitment to further dialogue.” (2000, p.10).

Since power differences and a culture of autonomy, individualism, specialization as well as domination, control and territorial behaviour are destructive to the team process, nurturing interpersonal relationships can help to establish respectful and collegial processes (San Martin-Rodriguez et al., 2005). Lenihan (2009) notes the importance of informal or formal mechanisms for rewarding stakeholder for their “cost” (time and energy) of participation. Reward and recognition act as incentives in getting cooperation.

Creating an environment that values collaboration, communication strategies, discipline, processes that help understand differences in perspective, conscious strategy to intercept turf protection, acknowledging the tension between accountability to own organization as well as the group process, and reflection and adjustment all help to promote teamwork. Champions at a high level, good communication, right money at the right time, schedules and deadlines, tracking performance and measuring results, using this information to improve performance are helpful tools in motivating teams.
Developing a Shared Framework: Working Towards a Common Understanding

A shared understanding of key issues, goals and results is critical to the success of working across sectors. Investing time and patience at the beginning to develop a framework from a common fact base, with appreciation for different perspectives and values can serve as a strong foundation for future action (Hopkins et al., 2001). The framework should clarify the goal/s, objectives and results as well as roles and responsibilities and how stakeholders will contribute, though it needs to be recognized that these can evolve with the initiative (Lenihan, 2009; Pal, 2006).

PHAC (2008) notes that in the health domain, frameworks that favour a determinants approach (instead of a disease-driven approach) helps many partners to see a role for themselves. The process for developing the framework is said to be as valuable as the framework itself.

Encouraging Evaluation: Promoting Progress, Learning, Accountability,

Since results focused strategies are particularly effective in working across sectors, measuring performance is extremely important to the cross-sector process. Therefore an evaluation framework, performance measures and mechanisms for integrating evaluation need to be part of the shared framework.

Evaluation is important to provide a means of accounting to the partners, the public and government bodies for action and resources. CCMD (2000) states that key features of an evaluation framework should include the assessment of process and strategic planning, credibility, culture and trust, communication, leadership, resources and accountability (p.13).

Essential Factors in Fostering Collaboration

This section has identified many factors that foster collaborations. Chief among them are the right people, or the legitimate stakeholders that needs to be engaged. Paying attention to their capacities and the contributions they can make is also important. Structures, be they formal or informal, help to hold the stakeholders and support their work. Process, especially dialogue, is essential for keeping the work flow well greased. A common framework to work from and evaluation helps collaborations to see shared purpose and accomplishments which are essential for keeping processes directed and moving.

7.3 Convening Organization: Identifying Collaborative Leadership Capability

San Martin-Rodriguez et. al (2005) and others outline several criteria that a convening organization should possess to shepherd a productive collaborative process. The first includes fostering an organizational philosophy and culture that values trust, fairness, openness and integrity. Organizations that support
participation, shared decision-making, open communication, freedom of expression, independence and risk taking are better equipped to support collaboration (PHAC, 2008; San Martin-Rodriguez et al., 2005).

A second set of criteria included more instrumental considerations. This includes having the necessary tools and resources, administrative support, coordination capacity and communication mechanisms (San Martin-Rodriguez et al., 2005). It also requires that the organization has standards, policies, rules, procedures, protocols, standardized documents, well-organized meetings, and clarity of roles for participating personnel (San Martin-Rodriguez et al., 2005).

Executives and managers who lead collaborations must possess sufficient skills and expertise for engaging diverse stakeholders and the analytical capacity to provide synthesis and analysis of data generated by the process (Lasker et al. 2001). And, the executives and managers involved in coordinating such processes need to establish realistic objectives and maintain contact with vertical structures associated with their departments and ministries to secure authority and resources, for the purposes of accountability (PHAC, 2008).

Lindquist (2005) found that the capacity of the convening organization was critical to cross-sector processes. Ability to seek strategic advice from inside and outside the organization (from others who have managed similar processes); recruiting the human resource talent needed for the work; establishing communication networks both within and outside the organization to communicate information is a timely manner; dedicated space and working with the stakeholders effectively can increase the effectiveness of the process.

7.4 Collaboration: An Art and a Science

Building effective cross-sector collaborations to address complex policy challenges is both an art and a science. Many elements and factors influence the success and effectiveness of collaborative processes. This includes having sufficient leadership and resources to: drive cross-sector actions; tap into and engage the knowledge, skills and capacity of the stakeholders; design the structures and process; and support the collaborative partners.
8 DISCUSSION AND CONSIDERATIONS

This section discusses the key components of the conceptual framework that maps the process from policy challenge to policy outcome. The overarching policy challenge being addressed by this project is the increasing prevalence of obesity in BC. The long-term outcome sought is a reduction in its prevalence. The Obesity Reduction Strategy that the Health Officers Council of BC has resolved to develop is the policy intervention that will address this policy challenge. The Provincial Health Services Authority and the Task Force have been tasked with managing the process to build the strategy.

This section provides a walk-through of the conceptual framework developed for this project to put the policy challenge, desired outcomes, the process, and criteria for evaluating aspects of the process in perspective. A visual depiction of the framework can be found on the next page in Figure 7. The section begins with a brief description of the policy challenge. It then draws on the key strands of the literature reviewed in Section 4-7 to both provide the context to and identify key elements of an organizing framework. The section concludes by providing the key steps in the life cycle of a process.

8.1 The Policy Challenge

The literature indicates that obesity is a complex issue. Though the condition ultimately results from individuals consuming too many calories and not expending enough of them, the epidemic has resulted from changes in socio-economic conditions, technological advancements and aspirations, and changes in values, systems and environments. Structural and systemic issues such as agricultural policies (that stimulate the over production of calorie dense foods) and industry practices such as larger portion sizes (that encourage the over consumption of food) are examples of the environmental influences that urge the consumption of excess energy. The rise of the car culture and low value placed on energy expending daily activities are examples of how technology and values affect people’s choices.

Knowing that the environment plays a significant role in the choices people make, reversing the epidemic requires addressing the many factors that influences a population’s food and activity choices. What is required is a paradigm shift and in order to achieve that what is required is a comprehensive, multi-faceted, multi-level, multi-stakeholder response.
Figure 7: From Policy Issue to Policy Outcome: A Conceptual Framework
8.2 Response Considerations

Responding to the obesity epidemic requires the addressing of issues in the food and physical activity environments, to make the healthy choice the easy choice. To achieve that, several important factors will need to be considered.

Coordinated Response

Currently, many efforts are directed at addressing the issues; however, none, on their own, are making a dent in the epidemic. Disjointed actions from different policy boxes and disciplines and lack of depth and breadth in response are reasons for poor outcomes. What the issue needs is a broad-based prevention agenda aimed at the determinants of obesity; food and physical activity. Effective treatment strategies are needed for those diagnosed with obesity. Moving forward will involve coordinating many different actors, institutions and their mandate; which will require considerable political will.

A strategy for BC will need a comprehensive and balanced suite of interventions, along with many interventions targeting specific behaviours. Regulations (for example: ban on TV advertising to children or regulation of ingredients in food items), policies, (for example: agriculture policies that support healthier food options; transportation polices that encourage less car use), changes in the built environment (to encourage walking and cycling), interventions in schools (such as inclusion of cooking skills in the curricula; healthy meals in the school cafeteria) are examples of the many policy instruments that are available.

The selected options for interventions will also need to be considered for appropriateness to equity groups who may view obesity differently or may be impacted by it differently. Most importantly, strategies and interventions will need to be considered for acceptability, equitability, cost-effectiveness and sustainability.

The Cross Sector Challenge

A cross-sector approach can mobilize dispersed resources and give access to many perspectives, knowledge, expertise and resources from a variety of sectors, organizations and people. This can help to shift paradigms. Complex issues like obesity requires shifting paradigms and need action in multiple settings from many sectors and actors. Sectors will need to be selected based on the jurisdiction to implement chosen actions while actors with the authority to negotiate and agree on decisions will need to be engaged. Shared decision-making, resources, interest in common or coordinated solutions and successful outcomes that are hallmarks of the collaborative processes can effectively harness this and move stakeholders to take ownership of solutions.
Lessons on Engagement

To be successful, collaborative processes need successful strategies for engaging the stakeholders. And, good processes take more than bringing people together. Leadership of the convening organization to bring the right people to the table; structures and processes to organize and involve them; and trust to glue the group together and lubricate the process are critical to well functioning collaboration.

Transparent and inclusive processes, accountability and evaluation frameworks are important for credibility of the process. These are also important for securing resources and garnering support from the highest levels of participating organizations. Recognizing that all processes have ebbs and flows – schedules, work plans, timelines, celebration of accomplishments and champions to motivate can keep the engagement secure and moving forward.

8.3 The Stakeholders and PHSA as the Convening Organization

As the convening organization, PHSA has the responsibility for engaging the stakeholders. A first level of this engagement formed the Obesity Reduction Task Force. Working in partnership with the Task Force, PHSA is planning the next level of engagement. PHSA and the Task Force need to involve the needed partners that can or have an interest in transforming the food and physical activity environments. This includes the three levels of government and their relevant departments and ministries, Industry, not-for-profit societies, the professional community, academia and citizens.

A primary role of the convening organization (PHSA) is to provide leadership in persuading the right people to come to the table. Capacity of the convening organization to do this is critical to the collaborative process. An organizational philosophy and culture that values trust, openness, fairness, participation, shared decision-making, open communication and risk taking are said to predispose an organization towards an organization’s capacity for collaboration. The ability to provide a variety of planning and logistical support such as strategic planning, arranging meetings, organizing events, communications mechanisms and conflict and problem resolution are also critical requirements of a convening organization. Where feasible, the organization must also provide technical support (e.g. data, evidence review).

Dedication of skilled management support with expertise in managing complex processes such as building relationships, navigating issues, developing and monitoring plans, assessing performance of processes etc., is a priority requirement for convening organizations. The ability to deploy other staff when the process calls for a diversity of competencies and skills is also important. Within the organization, there needs to be a clear division of labour and clarity of roles and responsibilities to ensure fluid processes.
The convening organization must also provide standards (policies, rules, protocols etc.), tools, resources, administrative support, coordination and internal and external communication mechanisms; secure the required resources (dollars, data, evidence etc.) and develop mechanisms for evaluation.

8.4 Key Attributes of an Organizing Framework

The key strands of the literature indicate that well functioning processes are made up of people, structures and processes. Therefore, the key components of an organizing framework for CORS will include the stakeholders (needed to build and implement the strategy), structures for organizing them and the processes for supporting the work of the stakeholders. All processes require resources and time; therefore, this too will be discussed in this section.

People

The literature suggests that collaborative processes benefit from engaging the right people in the right way – meaning, engaging the people that can contribute expertise to the process while matching expertise to roles. CORS will require at least two different types of stakeholders. One type will be people who are at a high level of authority within their organization and have the capacity to negotiate and recommend feasible policy and practice options that are within the domain of the organization’s mandate. Stakeholders in these positions can help to navigate the political process to get buy in at the highest levels of their organization – a mandatory requirement for implementing new ideas and strategies. The role of these stakeholders at the CORS table will be to negotiate feasible strategies.

Higher level decision-makers will not have time to sift through material and select strategies and interventions. To deliberate on evidence and promising practices and select the interventions, another level of stakeholders will be needed. These would be people from relevant sectors with expertise in policy, research and knowledge of current BC initiatives. Expertise will also be needed on obesity related issues.

Furthermore, the suite of policy instruments that will be considered for the strategy will fall in different jurisdictions. In the BC context, expertise will need to be drawn from and represented by federal, provincial or local government as well as national, regional or local industries.

Diverse population groups are differentially impacted by obesity (socio-economically disadvantaged; aboriginal people; mental, cognitive, physical or other impairment; regional/community differences in capacity and resources). Moreover, issues such as eating disorders can be exacerbated by obesity messaging. And, different priorities and implementation strategies may emerge for different groups. For these reasons, it will be important to engage stakeholders with expertise and perspective in these areas and issues.
With much higher rates of prevalence, obesity is a significant health issue for the aboriginal population. Finding appropriate solutions for this population will need to be a priority action. Inundated with issues, aboriginal people may require special incentives and approaches to become engaged in a broad provincial process. However, it is worth noting that becoming engaged in a broader societal process may not be of interest to the aboriginal leadership, who, increasingly, wish to chart their own processes in a manner that suits their interests. If the aboriginal groups and organizations wish to participate in a broad provincial process, they will need a great amount of time to both accept and trust that process.

**Structures**

Structures play a key role in not only organizing the people and the work but also in sustaining relationships. The right structures can help to involve people in more efficient and effective ways. The CORS process will need formal structures with Terms of Reference that clearly defines a purpose, roles and responsibilities for the participants, rules and terms of engagement. Policies, protocols, decision-making and accountability frameworks will also needed. A key goal will be to match the right stakeholders to the right functions; meaning decision-makers and content experts assigned to proper roles and the myriad content experts assigned to relevant groups. Moreover, it will be important to identify work groups that are logistically feasible and reasonable to manage, for example 12-15 people per working group.

**Processes**

Building a common language and developing a common agenda are required initial steps once the groups have been convened. Trust is essential to collaborative processes and deliberative dialogue can be helpful here. Reflective practice can help to understand the other perspectives in a process that will undoubtedly engage a diversity of perspectives and interest. Developing a shared framework with goals, objectives, outcomes and indicators can help to create a common agenda. It is important that the shared framework also include an evaluation framework to help the group measure success both of the end product as well as the process.

Collaborative processes need work plans to stay the course, with clearly defined deliverables, milestones and timelines. Groups also need agreement on accessing information, evidence and resources, therefore it is important to develop criteria and parameters for acceptability of these. Strategies and mechanisms for internal (within group) and external communication as well as timely communication are essential to successful group process. Protocols for linking with and leveraging with others must also be established.
**Resources and Time**

All processes require both resources and time. As mentioned above, an engagement process has a variety of planning, technical and logistical needs. Some of these needs could be met by the human resources of a convening organization (depending on their capacity); however, some of these needs – such as strategic planning, communications and evaluation frameworks require highly specialized skills. Few organizations will have all these capacities within the organization which requires them to purchase the needed skills from external sources. This requires funding. Logistics such as arranging meetings and organizing events also require funding. In other words, all processes need additional resources, therefore convening organizations must have a realistic assessment of the resource needs and be able to secure them.

Multi-stakeholder processes are time consuming affairs. First and foremost, they require time for planning. Ideally, multi-stakeholder processes should involve some of the stakeholders in the planning process which can add an extra dimension to the time required for planning. Relationship building, consensus building, deliberation on potential solutions and negotiation to agree on final solutions are imperatives of engagement processes. Developing a common language and achieving agreement cannot be arrived at without due process, information, and sufficient time. Furthermore, the more diverse the stakeholders that need to be engaged to address an issue, and the larger and more complex the issue in question, the more time that will be required.

Building effective policy networks is both an art and a science. The leadership that drives the process; knowledge, skills and capacity of the stakeholders; skill to engage them and structures and processes that support their work; capacity of the convening organization, including competency of lead managers; and resources and the time to let the process unfold are important factors that contribute to effective processes.

### 8.5 Life Cycle of an Engagement Process

Processes follow four key phases. They include the start-up, problem-setting, direction-setting, and implementation phases. The CORS process will likely follow these phases and would benefit from planning for them.

The start-up phase includes shining the light on the issue, taking the lead to drive the process and getting organized to begin the process. This 598 project falls within the start up phase.

In the problem setting phase, stakeholders are brought together to acknowledge the dimensions of the issue and agree to work together. In this phase, stakeholders are identified; a common definition of the problem is developed and capacities and
resources of the convener are assessed. This phase is critical to the success of the process.

In the direction-setting phase, participants develop, apply and modify ground rules, build an agenda, and establish work groups as required. This is the phase when the group searches for information together, considers options and comes to agreements.

The implementation phase occurs once directions have been set and policy and resource allocation decisions have been made. In this phase group members ensure that their constituents understand the rationale for the decisions that were made. It is in this phase that external resources are sought and the strategies are monitored for execution of responsibilities and achievements of targets.

8.6 Conclusion: From Framework to Options

This section began by drawing on key strands of the reviewed literature to highlight the important considerations in setting up a collaborative process. The obesity literature suggests a need for transforming food and physical activity environments with a view to changing the paradigm in the longer term. This is no easy task and certainly not a task for a single organization or even sector. It requires many perspectives, resources, commitment and the consolidation of many efforts.

The literature also indicates that working with many sectors, stakeholders and interest requires processes and that these require the consideration of some critical factors. These factors which have been reviewed briefly will inform the organizing framework. The next section will discuss the options that were considered by PHSA and the Task Force and the option chosen to undertake the building of the comprehensive strategy.
9 THE CORS ORGANIZING FRAMEWORK – EVALUATING THE OPTIONS CONSIDERED AND CHosen

This section begins by briefly discussing the key features of the two options that were presented to PHSA and the Task Force for organizing the work of CORS for BC. The chosen option is presented next and the section concludes by highlighting the key initial steps that are needed to implement the organizing framework.

9.1 Options Considered

The challenge accepted by this 598 project was to design an organizing framework that would assist the Task Force and PHSA to engage a range of stakeholders in building the CORS for BC. A series of design factors needed to be considered to choose the most strategic yet logistically feasible option for the work that lies ahead. What follows describes the two options that were carefully considered by the Task Force leaders and the PHSA.

Structures to Engage Decision-Makers

In Canada, governance of public policy is organized at three levels – federal, provincial and local government (includes regional districts and municipalities). The first proposed option, termed the bi-level option, recognizes this jurisdictional divide and involves two levels of multi-sector, multi-stakeholder groups involving high level decision-makers from participating organizations. These two groups will, henceforth, be referred to as Collaboratives. One of the collaboratives would consider and recommend strategies and interventions that fall within provincial jurisdiction; and the other would consider the same for strategies and interventions that fall within local or community level jurisdiction. As a provincial process, it was recognized that proposing strategies at the federal level was not feasible without involving other provinces and federally organized interests. Thus, a collaborative at a federal level was not recommended.

The bi-level option provides two mechanisms for setting up the Community Level Collaborative. Community level stakeholders (local government, parks and recreation, school boards, chambers of commerce, local restaurants, grocery stores, sports associations, etc.) could be organized within a specific community; or as a provincial network of stakeholders drawn from communities across the province. For this project, community is defined as a geographic area and it was argued that it made most sense to organize the community-level collaboration within a community (e.g. within a municipality). See Figure 8 for the flow of the bi-level option.
Both the provincial and Community Level Collaboratives would be co-chaired by a task force member and another member chosen by the group. Membership of the provincial collaborative would be made up of representatives with high-level decision-making capacity from provincial level organizations (e.g. executive directors or senior level directors of government, industry and other organizations), and, where feasible, provincially-organized umbrella and citizen groups. Interested task force members will also participate in this collaborative.

Membership of the Community Level Collaborative would be made up of representatives with high-level decision making capacity from community based organizations (e.g. mayors, chairs of parks and school boards and chambers of commerce, principals, executive directors of not-for-profit and community organizations, senior managers in business organizations, and representatives of faith-based organizations and citizen groups). Where feasible, task force members would participate as well.

A second option, termed the single level option, combines the provincial and community level decision-makers in one structure. Members that make up the provincial-level collaborative in the bi-level option and community-level decision-makers drawn from communities across the province would become members in this combined structure.

Structures to Engage Content Experts

It was also proposed that three content-specific Working Groups (for Food, Physical Activity and Treatment) would identify provincial-level and community-based strategies and interventions that could transform the food and physical activity environments as well as identify treatment options for those diagnosed with obesity. The Working Groups would do this by:

- synthesizing the best available research, promising practices and other relevant resources;
- identifying current BC initiatives and evaluated promising practices;
- identifying gaps;
- considering options that require enactment of these at provincial and community levels; and
- reviewing options for acceptability, feasibility, equity, cost-effectiveness and sustainability and propose a suite of options for consideration by the Provincial Level and Community Level Collaboratives.
Working Groups would be co-chaired by a task force member and another member selected by the group. Members would be comprised of individuals from relevant sectors and organizations with expertise and knowledge in policy, research, clinical expertise, BC initiative, equity and other issues and lived experience.

A fourth Working Group will support the provincial and community level collaboratives and the three content working groups with the data they require. They would also provide surveillance methodologies and mechanisms for monitoring obesity in the long term; evaluation strategies for the process and the product (CORS), and assess research needs. This working group would be co-chaired by a Task Force member and another member chosen by the group. Members would include epidemiologists, data experts, evaluation specialists, and researchers.

**Figure 9: Bi-level Option for an Organization Framework**

![Bi-level Option for an Organization Framework](image)

(Arrows indicate communication flow. Overlap indicates overlap in membership.)

**Figure 10: Single level Option for an Organizing Framework**

![Single level Option for an Organizing Framework](image)

(Arrows indicate communication flow. Overlap indicates overlap in membership.)
9.2 The Chosen Option

The options described in the previous sub-section were presented to PHSA and the Task Force at a meeting on October 2\textsuperscript{nd}, 2009. PHSA and the Task Force preferred the organizational framework which provides two separate forums for decision-makers at the provincial and community levels. Though two options for organizing the community collaborative were presented, the group wanted to deliberate further prior to deciding how best to organize the community-level collaborative.

The Task Force agreed with the need for four working groups. They saw it as an imperative that the last group on Data, Evaluation and Research establish strong linkages between all working groups and collaboratives. In particular, it was their wish to ensure that this working group would assist each of the content working groups to develop evaluation questions for the strategies and interventions they would eventually propose. The Task Force also wanted to ensure that the three content-specific working groups will have good communication and even overlap in membership to ensure sufficient coordination among the proposed strategies.

Based on this feedback, the CORS Organizing Framework was finalized as follows:

- **The Obesity Reduction Task Force.** Its role would be to steward the development of a Comprehensive Obesity Reduction Strategy for British Columbia, assemble the final strategy and oversee its implementation. Task Force members will infuse the other groups and Chair each of the groups to provide one level of communication and coordination among the groups.

- **Provincial Level Collaborative.** The role would be to bring together provincial level decision-makers to cultivate a multi-sector interest and commitment in taking action to reverse the obesity epidemic. High level decision makers from government, industry and other organizations and where feasible, provincially organized citizen groups will make up the membership. Task Force members will participate based on interest. (See Appendix 3 for possible membership).

- **Community Level Collaborative.** Similar to the Provincial Level Collaborative, the role would be to bring together community level decision-makers to cultivate a multi-sector interest and commitment in taking action to reverse the obesity epidemic at the community level. High level decision makers from local government, parks and school boards, schools, local industry, community based not-for-profit societies and citizen groups would make up the membership. Task Force members will participate based on interest. (See Appendix 3 for possible membership).

- **Content Specific Working Groups.** The roles of the content specific Working Groups will be to bring together content experts from relevant sectors to
review, assess and select provincial level and community level strategies and interventions that could transform the food and physical activity environments as well as identify treatment options. Membership of 12-15 per group will be drawn from relevant sectors and organization with expertise and knowledge in policy, research, clinical expertise as well as knowledge of BC initiatives, equity and other issues and lived experience. (See Appendix 3 for possible membership).

- **Working Group on Data, Evaluation and Research.** The role of the Data, Evaluation and Research Working Group would be to support the two Collaboratives and the three content Working Groups with the data, surveillance, evaluation and research needs. Membership of 12-15, will include epidemiologists Data experts, evaluation specialists and researchers.

PHSA, as the convening organization, would provide the logistical and planning support to the Task Force and the working groups. These structures are summarized in Figure 11 on the next page.

**Getting Started**

Selecting and convening the stakeholders will be the first step in implementing this framework. In cross sector processes, it is often logistically not feasible to include all those who may want to be included. Some may not be the right people to include where a balance of specific stakeholders might be required (e.g. regional, decision-maker, and expert representation). Therefore, a transparent process for selecting members for the structures is essential for ensuring credibility. (See Appendix 2 for the draft Terms of Reference, Appendix 3 for a list of potential membership and Appendix 4 for a member selection matrix).

An obesity reduction strategy needs to include many sectors and stakeholders for whom their link to the issue may not be obvious, and there may be other sectors (e.g. food industry) that may see an obesity reduction strategy as a challenge to their business. As the literature repeatedly recommends, it is mandatory for the success of any stakeholder engagement process to build common ground, develop complementary perspectives, and help stakeholders see how they might contribute to the issue and take ownership for addressing their piece of the solution. Investing time and energy up front in group or team building would be highly beneficial to the process in the longer term.

It is also important to frame the implementable actions in a way that sectors and stakeholders could see a clear role for themselves, one that would fit squarely in their organization’s mandate (meaning stakeholders are not asked to take on new mandates). They would participate knowing that it would help them to achieve their organization’s goals and objectives. Ultimately, though ostensibly self-serving, their actions would address factors that contribute to the obesity epidemic.
Figure 11: CORS Organizing Framework

**Cross-cutting Lenses**: Socio-economic status, gender, race, culture, ethnicity, language, sexuality, differential abilities, mental health status

**Legend**: Overlapping ovals indicate overlapping membership. Arrows indicate communication flow.

### 9.3 Moving Forward

PHSA and the Task Force now have an Organizing Framework that can assist them to engage the people that are needed for the CORS process. Key steps for implementing the framework have been provided and PHSA started to implement the CORS organizing framework in fall 2009. The next section will critically appraise the process to date as well as its potential evolution moving forward.
10 APPRAISING THE SITUATION TO MOVE FORWARD

Subsequent to the Task Force meeting that defined the key features of the CORS Organizing Framework, PHSA worked internally to finalize the selected option. Once this was finalized, PHSA began implementing the framework and initiated the stakeholder engagement process. This section of the report begins by appraising the start-up phase, from the Health Officers Council of BC resolution to the development of structures; and based on this, anticipates how the process might evolve in the next phases. The section concludes with ideas and options for responding to several anticipated challenges.

10.1 The Start-Up Phase: Taking Stock

The resolution of the HOC of BC marked the start-up of the CORS development process. PHSA, as the convening organization, formed a twenty member Task Force to steward the development of the strategy and together, they commissioned this 598 project to design the structures for the stakeholder engagement process. At the inaugural meeting, the Task Force set the goal of developing an “implementable” CORS for BC and set a timeline for delivering the final strategy for the early Fall of 2010 – very likely September 2010. This set the time frame for the CORS development process at one and a half years. Of this, six months have been spent in the start-up phase.

Building an “implementable” strategy that requires action from multiple sectors and actors requires “buy-in” from them to take the desired action. In the start-up phase, the CORS process engaged only the stakeholders from the health sector who are the drivers of the process. Those stakeholders that will need to implement CORS are not yet at the table. This will need to be the priority task in the next phase.

To develop meaningful interventions for the diverse population of BC, this diversity also needs engagement in the process. A notable absence at the table is the aboriginal interests. This is a significant gap, given the scale of the issue in that community. Since the Task Force and PHSA are committed to developing a strategy that is appropriate to the diversity of this province, finding approaches for engaging aboriginal interests will need priority attention. However, since special approaches are required to engage aboriginal groups and such processes need more time than the CORS development process might allow, aboriginal issues may need to be addressed via a parallel or subsequent process.

There are other equity groups that are also not yet at the table. Culturally and linguistically diverse groups, people with differential abilities, socio-economically disadvantaged groups all have special needs. These are also groups that have differential capacities to participate in cross sector processes. Similar to aboriginal groups, engaging these groups in the CORS process may not be feasible due to
time restraints. However, this will need to be addressed in parallel or subsequent processes.

The CORS process has limited dedicated resources. The bulk of the resources are the human resources supplied by the PHSA-PPH team. Taking a team approach to project management, the PPH team has provided the support that was required in the start-up phase. However, additional resources will be needed to continue to move the project forward.

The literature states that stakeholder processes such as the CORS process requires the dedication of skilled human resources, financial resources and time to evolve the process. As the next phase of the CORS process begins, having the right and adequate resources is critical. To unfold an effective process that can deliver a successful CORS, PHSA and the Task Force will need to address these three critical factors as soon as possible.

10.2 Surveying Beyond: The Problem-Setting, Direction-Setting, and Implementation Phases

PHSA is just starting to implement the CORS framework. The first meeting to engage provincial level decision-makers was held on December 9, 2009. Invitations were sent to high-level decision-makers such as assistant deputy ministers or executive directors of relevant provincial ministries, chief executive officers of provincially based industries, executive directors of not-for-profit societies and other agencies. Though the response was impressive, the meeting did not attract the higher level decision-makers. Instead, the organizations sent representatives who are at a much lower level in the decision chain – people who are content experts from those organizations. As will be noted later, it is critical that high-level decision-makers are engaged, if necessary, at a later stage in the process.

What follows is an analysis of how the CORS process will evolve, identifying the differing requirements for people, structure, process, and resources during each phase. The conceptual framework developed for this study will aid this analysis. Detailed considerations are supplied in Figure 12 (pp.64-65), while high-level implications are reviewed below.

The Problem-Setting Phase: Time to Jell the Groups

The literature suggests that, in the problem-setting phase, stakeholders brought face-to-face are more likely to get agreement on how to work together. This phase also includes developing a common language and building consensus. The CORS process has convened its first multi-sector meeting and there is interest on the part of the participants to be involved in the process. Further opportunities for building trust and a shared understanding will be required. Not all the parties invited
participated in the December 9th meeting. Assessing the meeting for critical absences and encouraging their participation is also important.

The two collaboratives that will involve the decision makers and four working groups need to be formed to begin the group-building process. Getting six groups off the ground requires a significant commitment of staff resources. The PPH team will be able to support this work – especially since they are already engaged in work and processes that can be leveraged for the CORS process (food security, healthy built environment). Planning and organizing meetings as well as the plethora of unaccounted tasks that need attention in-between meetings to “grease processes”, requires a non-trivial amount of staff time. The PPH team will not only need to re-evaluate their over all team deliverables, vis-à-vis the CORS process, but also secure further resources or adjust the CORS process.

The Direction-Setting Phase: Brokering and Negotiating to Get the Work Done

This will be the most involved and taxing phase of the entire process. During this phase the decision-maker collaboratives will undertake analysis and planning activities (strategic and evaluation) that will aid the collaboratives and the working groups to develop goals, priorities, and a common agenda. This planning should ideally commit to a time frame for implementing the final CORS. Will this be a 5 or 10 or 20 year strategy; many decisions in this and future phases will hinge on that time frame.

In parallel, the working groups will be undertaking the myriad tasks associated with selecting strategies and interventions for consideration by the decision-makers. Three working groups that have participants with diverse and vested interests will need to be well managed if they are to come up with a suite of items that can be supported by the whole working group. The three content-specific working groups will need mechanisms for coordinating their planning which will pose additional demands on the group process. The working group on data will need to work closely with the three working groups to provide data and help the groups to develop evaluation criteria.

When the content working groups propose strategies and interventions for consideration by the two collaboratives of decision-makers; these two latter groups will also need extensive support as they deliberate on which suite of actions to ultimately choose for the CORS. This phase will require significant time – at a minimum six to eight months – and significant financial resources. This phase will need additional human resources, over and above what is available from the PPH team.

The Implementation Phase: Transforming the Process

It is hoped that as the strategies and interventions are planned, the decision-makers will consider, anticipate, and negotiate the resource requirements for implementing them. Some actions may only need minimum financial resources
because they may simply re-align existing activities to deliver new and improved outcomes. Other actions will require dedication of new resources. Either way, the resources required for implementation will need to be anticipated ahead of implementing the strategy. Open question include whether this “ask” will be done prior to or after the launch of the final CORS, and who will make the “ask” (the Task Force, PHSA, or other stakeholders). But, these steps are important to recognize and acknowledge.

As the process transitions to the implementation phase, the Working Groups will have no further role and will need to be disbanded. The decision-makers that need to stay involved to oversee the implementation may need to be re-organized into different administrative structures designed for this purpose. This will likely require a different form of staff expertise; and PHSA will need to evaluate the continuing role they may play in supporting the implementation and the human and financial resources that will be required for this purpose.

Challenges on the Horizon

The design and launching of the CORS process is a remarkable achievement. The process is on an aggressive eighteen-month time line to produce a comprehensive strategy. Eight months into the process, however, PHSA is still getting the groups populated. The work required to build more cohesion to undertake their tasks still remains ahead. If eight months were needed to get this process off the ground, it is not realistic to expect that a very diverse group could come together, build cohesion, undertake elaborate work, negotiate and arrive at a final "implementable" strategy in ten months.

With these realities in mind, PHSA and the Task Force have challenging decisions to make, or they will have to re-visit the expectations for what the process might be able to achieve during this time frame. The next part of this section (see 10.3 on “Responding to Challenges: Ideas and Options” beginning on p.66) presents some ideas and options intended to stimulate dialogue and strategic thinking on how to anticipate and address these challenges and pressures.
### Figure 12: Key Requirements of the Process

<table>
<thead>
<tr>
<th>PEOPLE</th>
<th>Start-Up</th>
<th>Problem Setting</th>
<th>Direction Setting</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOC resolution catalyzed the process</td>
<td>Task Force members will steward the process</td>
<td>Task Force members will steward the process and work actively in the selection of strategies and interventions, while playing a role in negotiating the resources required for implementing the CORS.</td>
<td>Task Force will continue to play an active role in leveraging resources and supporting the implementation of the final CORS.</td>
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<tr>
<td>PHSA was appointed as the convening organization and formed the 20 member Task Force. ED and Director of the PPH Team led the work in this phase with PPH staff providing support as needed.</td>
<td>Provincial level collaborative will need to be established and decision makers will need to become engaged in the process</td>
<td>Provincial level and community level decision-makers continue to cultivate the platform for discussing and negotiating feasible strategies and interventions</td>
<td>Which of the decision-makers will need to be at the table to support implementation needs to be decided during this process.</td>
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<tr>
<td>People participating in this phase include the Task Force and PHSA-PPH staff in the initial planning activities.</td>
<td>Setting up of the Community level collaborative will need to be explored and established; and decision makers will need to become engaged in the process</td>
<td>Content experts related to food, physical activity and treatment work on identifying and assessing potential strategies and interventions</td>
<td>W/G on data, evaluation and research will need to provide surveillance and evaluation support.</td>
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<tr>
<td>The major task in this phase was the design of the stakeholder engagement process which was undertaken by this 598 project.</td>
<td>The 4 Working Groups will need to be established and content experts will need to become engaged in the process</td>
<td>Data, evaluation and research experts provide support as required</td>
<td>The three content working groups will need to be disbanded.</td>
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<td></td>
<td>PHSAs – PPH team will continue to manage the process. This phase requires the setting up of 5 groups that are quite different from one another; as well as exploring how best to set up a 6th group.</td>
<td>PHSA – PPH team will continue to manage the process by supporting the two collaboratives and the 4 working groups.</td>
<td>How PHSA will manage the implementation and how the process will be resourced in terms of what funding and human resources will be required will need to be decided. This phase will require far less staff support from the whole of the PPH team.</td>
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<td></td>
<td>This will be a challenging responsibility for one dedicated FTE, which PHSA does not currently have. Based on current and ongoing work of PHSA, it will be possible to deploy the team (4 Managers and an Epidemiologist) to provide this support though a dedicated FTE or consultant will be needed to provide overarching management support for the process...</td>
<td>Initially, the bulk of the efforts will need to be focused on the Working groups that will need to be supported with evidence synthesis, mapping of BC initiatives and techniques for assessing suitability, feasibility and sustainability of strategies and actions</td>
<td>The skills required will be in network management, relationship and project management skills, perhaps of one dedicated staff person.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The skills required will be in network management, relationship and project management skills, perhaps of one dedicated staff person.</td>
<td>Collaboratives will then need to be supported to recommend the strategies and intervention, both to CORS as well as their own organizations.</td>
<td>PHSA will also need to provide surveillance and evaluation support to the ongoing process.</td>
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<td></td>
<td></td>
<td>In both situations, PHSA staff will need to be able to support a diverse group with diverse interests and perspectives to come to agreement. Consensus building and conflict management skills will be of utmost importance.</td>
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<td></td>
<td>This phase will also need research skills and capacity that will need to be brought in, very likely through Consultants.</td>
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<td>PHSA-PPH leadership will need to work with the Task Force in (making the Ask) - securing the resources needed for implementing the CORS</td>
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</table>

<table>
<thead>
<tr>
<th>STRUCTURES</th>
<th>The Task Force and PHSA guided the development of the CORS Organizing Framework</th>
<th>Provincial Collaborative established</th>
<th>2 collaboratives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Explore and establish Community Collaborative</td>
<td>PHSA will also need to provide surveillance and evaluation support to the ongoing process</td>
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</tr>
<tr>
<td></td>
<td>Adopt Terms of Reference for the groups outlining purpose and Roles and responsibilities of membership, decision-making framework and any required policies, rules, protocols</td>
<td>4 Working Groups</td>
<td>The two collaboratives may need to be re-worked for the implementation process. This will need to be decided when the CORS process transitions to the implementation process.</td>
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<td></td>
<td>Revise policies, rules and protocols for the groups and well as PPH team as required</td>
<td>TOR with roles, responsibilities, decision-making, policies, rules, protocols for the new structure will need to be developed.</td>
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</tr>
<tr>
<td>PROCESS</td>
<td>Start-Up</td>
<td>Problem Setting</td>
<td>Direction Setting</td>
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</table>
| • HOC resolution (April 09)  
• Inaugural meeting of the Task Force held in June 09  
• Two working group meetings of the Task Force were held in July 09 – one to identify key literature to shape the CORS process and another to plan for a Fall Summit  
• Informal contact with a few Task Force members during the development of the CORS Organizing Framework  
• Meeting with the Task Force (focus group) held in Oct 09 to seek input on the CORS Organizing Framework. | • Convene face to face meetings of the Provincial Collaborative and the 4 working groups to agree on issue and working together.  
• This phase will see the development of a common language and building of a common problem definition, which facilitates trust and group cohesion. These are imperative for a collaborative process.  
• Several meetings of each of the groups will be required in this phase  
• A communications plan and mechanism will also need to be developed | • Continue dialogue and building trust and cohesion within all the groups  
• Collaboratives will work together to set the agenda  
• All groups will make agreements on how the members will work together  
• Collaboratives will undertake strategic planning to agree on common goals, outcomes  
• Collaboratives and Working Groups will participate in developing an evaluation framework  
• Working groups will seek evidence and promising practices, and scan the BC landscape to develop, assess and choose options  
• Implement the Communication plans | • Will seek resources to implement the strategy  
• Launch the final CORS  
• Implement CORS  
• Maintain the dialogue  
• Monitor the implementation  
• Evaluate the process  
• Evaluate the strategy  
• Monitor changes in outcomes for the BC population |
| RESOURCES | • In the 2009/10 fiscal year, minimum financial resources were dedicated for the CORS development process. Except for meeting expenses, all the planning activities were done by PPH staff.  
• From Resolution to final strategy is currently committed to a 1.5 year time frame. Of that, 6 months have been spent in the start up phase, getting organized and developing the stakeholder engagement framework. | • Several meetings for each of the 6 groups will require funding for meeting expenses  
• Funding or human resources will be required for planning agendas, convening and facilitating meetings.  
• HR will be required for planning logistics of the meetings.  
• Meeting facilitator/s will need to be skilled in dialogue and consensus building.  
• HR or funding will be needed for a communications plan  
• This phase will require significantly more financial resources than PHS currently has and will also require significantly more time from team members than was allocated in the start up phase.  
• It is estimated that each group may need 3-4 meetings, at a minimum, for this phase. Given the busy schedules of people, this could take about 4 months – time that is not currently available based on the CORS timeline. | • This phase will see the proliferation of meetings for all of the 6 groups as the planning and work gets underway.  
• Funding will be needed for meeting expenses  
• Funding for consultants or staff will be required for strategic planning, developing evaluation framework, facilitation, group process, dialogue synthesizing evidence, managing logistics for meetings and events.  
• This will be the most demanding phase for the PPH team in terms of work load which will likely more than double the commitment required in the problem setting phase  
• Decision-maker time for strategic planning and evaluation framework. Being busy people, there could be challenges in getting these activities scheduled  
• Content expert time for project activities  
• Planning activities would require, at a minimum, 2-3 in-person meetings. some of this planning should ideally precede the work of the working groups so that ALL the groups understand the common direction of this initiative  
• Project work will require a minimum of 6-8 meetings, some of which could be arranged via conferencing facilities. Nevertheless this is a phase that, at a minimum, would require six to eight months to do an adequate job. The current CORS time frame does not allow such time. | • Funding to implement strategy. be it a new responsibility being undertaken or adjusting current responsibilities to deliver a better outcome  
• Funding for the launch event  
• Funding or human resources to regroup stakeholders in to a longer term network (and develop required infrastructure), facilitation, dialogue, managing logistics for meetings and events  
• Funding (or other resources) to support the collaborative process  
• Time frame and commitment for all this, especially how long a collaborative network could be supported by PHS and the resources it will require will depend on the term of the strategy. |
10.3 Responding to Challenges: Ideas and Options

At this time, the CORS development process may not have the time or the financial and human resources that is required of a process to deliver an “implementable” CORS for BC. The magnitude of the engagement process required to get this manner of buy-in demands significantly more time, funding and staffing than what is currently available. It is important to PHSA and the Task Force to develop an “implementable” strategy. This could still be possible by making adaptations to the current process. The ideas and options presented here take in to account some of the milestones that have already been set by the Task Force and PHSA.

Option One: Same Time Line, Adjusted Plan

The first option of the two options presented here involves keeping the current time line but revising the plan. Working under the same mandate (delivering an implementable CORS), on the same schedule (September 2010), and with the resources currently available is an ambitious undertaking. The current plan requires engaging decision-makers early on to cultivate their buy-in. There is indication that this may be a challenge. A revised plan may be in order.

An idea might be to first form the content Working Groups and concentrate on developing a draft strategy. The draft strategy might be the draw for attracting and engaging senior decision-makers. This could be done at the forum which is planned for early Spring of 2010. Intense negotiation could ensue between Spring and Fall of 2010 to build the kind of buy-in from multiple sectors. The Task Force has high level health sector leaders that could take the lead, leverage their power and position to encourage this buy-in.

A variant on this option could be to set aside the idea of “engaging” stakeholders in the development phase. Instead, the Task Force could simply consult a diverse range of stakeholders and develop the strategy. In this approach, setting up two collaboratives would not be required. Instead, the three content working groups could identify the strategies for inclusion in the CORS. If significantly more resources were available, consultants could expedite this process and help to deliver a well constructed strategy.

The trade-off here is that the strategies would not have been tested for feasibility of implementation, nor would it have the buy-in from the people and organizations that would need to implement the strategies. To ensure that this is not yet another strategy that sits on a shelf, another process could be initiated after the CORS launch to bring senior decision-makers to the table to negotiate its implementation. Such a process would necessitate revising some aspects of CORS – nevertheless, it would provide an opportunity to achieve the goal of an implementable strategy.
Option Two: Different Time Line, Different Plan

A second option is to use the current CORS process to mobilize multi-sector interest and explore strategic opportunities for getting buy-in and resources for a multi-year CORS. Between now and September 2010, all the groups in the CORS organizing framework could get started. The working groups could do the research not only to identify promising practices to include in a comprehensive strategy but also to develop a case for action. The provincial level and Community Level Collaboratives could use the case for action in exploring strategic opportunities for positioning the “ask” to various stakeholders, for a multi-year CORS for BC.

One of those opportunities might be the renewal of ActNow BC. Government is currently exploring opportunities for transitioning ActNow to the next phase. CORS could be positioned as the strategy that pulls many of the ActNow components together, that could form the framework for the next phase of ActNow.

Another opportunity might be to position CORS on the provincial government budget cycle which happens during the Fall season each year. Though the CORS is clear that it is not a strategy aimed just at government, a significant responsibility for implementing CORS will rest with government. Therefore it makes sense to align the “ask” to government at an opportune time in the budget cycle. The Summit planned in 2010 could be the rallying call for a multi-year commitment for CORS and/or ActNow renewal in the budget cycle of the government.

10.4 Assessing Success: Criteria for Evaluating CORS

Irrespective of the direction that the process might take, PHSA, the Task Force or another body may wish to consider, at a future date, whether CORS accomplished its goals. To assist in the design of an evaluation framework, the following criteria drawn from the conceptual framework developed for this report (see Figure 7) is presented.

- Stakeholders – the right people, participation in the process, contribution/s made, quality of relationship, trust, leadership
- Structure/s – functionality of the groups, frameworks and other guiding materials developed and their usefulness to the process
- Processes – developing common language, shared vision and common goals/objectives and outcomes, communication, decision-making, access to resources and tools
- Role of and support from the convening organization – Leadership, dedication of staff and resources, quality of planning and processes
- Process accomplishments – achievement of milestones and deliverables (and unintended accomplishments)
• Quality of substantive outputs – a workable, credible plan that has credibility with key experts, stakeholders, and decision-makers

• Resources (financial and other) secured from government, stakeholders and well as external sources to achieve the CORS.

These are only high-level criteria. Given the complexity of the obesity challenge, as well as the complexity of the CORS process, developing a full and comprehensive evaluation framework would be a significant undertaking. Nevertheless, it is hoped that this criteria could assist PHSA and the Task Force to understand how well they accomplished process and substantive goals.

10.5 Coming to Terms

The CORS process is a significant undertaking and much has been accomplished in the start-up phase. Based on how the process has evolved thus far, this section highlighted some anticipated challenges in the unfolding of the CORS process. Options were offered for mitigating these challenges with an eye on delivering on the original promise of an “implementable” strategy.

Important challenges lie ahead for the CORS process. The Task Force and PHSA will need to consider these and make some realistic decisions. The options presented in this section could help. However, these are not easy decisions to make and time is of the essence. It may be prudent for PHSA and the Task Force to invest time in discussing these matters.
11 CONCLUDING REMARKS

This 598 project served a small but important role in a longer-term process that is addressing a significant issue and gap in BC. The challenge at hand was to design a process for engaging multiple sectors and stakeholders in the development of an Obesity Reduction Strategy for BC. PHSA and the Task Force, clients in this project, intend to develop an implementable strategy – hence, this was the overarching concept that guided this project. The project explored the criteria that are critical for getting buy-in and commitment in multi-sector processes.

The project developed a conceptual framework that informed the development of the structures in the CORS Organizing Framework, which include six different groups to engage a variety of stakeholders. The project highlighted the different approaches of cross sector processes and underscored the requirement for true collaborative processes where buy-in and commitment from stakeholders is imperative. The project also highlighted some anticipated challenges for the CORS process and provided two options for navigating these challenges. Finally, criteria for evaluating the process were presented.

The following recommendations may enhance the current process in delivering a successful CORS for BC.

1. In light of the findings in this report, re-evaluate the CORS mandate, schedule and available resources and strategize and regroup using options provided in section 10. Consider using a 598 project to develop the “ask” for a multi-year CORS for BC.

2. Consider enhancing the CORS process by including the perspectives of aboriginal and immigrant/refugee populations that are not part of the current process. Consider using a 598 project to develop approaches for engaging the aboriginal population and another project to explore approaches for engaging new immigrants and refugees.

Developing a Comprehensive Obesity Reduction Strategy for BC is an important initiative that addresses both a significant issue and a glaring gap. There is a great deal of interest in this initiative in many quarters; nevertheless, engaging the right people in the right way and getting their buy-in to implement the strategy will not be an easy task. The process must be afforded realistic time lines and given its due resources, in order to reach milestones, and keep the momentum towards achieving desired outcomes. These are all important steps in the achievements of a meaningful and implementable Obesity Reduction Strategy for British Columbia.
REFERENCES


APPENDICES
Appendix 1 – Organizing Framework (for the client)

An Organizing Framework for Developing the Comprehensive Obesity Reduction Strategy for British Columbia

On April 2nd, 2009 the BC Health Officers Council passed a unanimous resolution to develop a Comprehensive Obesity Reduction Strategy (CORS) for British Columbia. The intent is to engage a broad range of sectors and stakeholders, including public policy makers, corporations/industry, non-government organizations and academia; in a collaborative effort to address this wholly preventable and treatable epidemic. The Provincial Health Services Authority is tasked with supporting the development of CORS. An Obesity Reduction Task Force has been formed to steward the CORS development. The Task Force is in the process of setting up working groups to start developing the strategy. Based on a review of literature on the obesity landscape (to understand the complexity of the issue and priority areas for strategic intervention) as well as promising practices in cross-sectoral policy management and stakeholder engagement; this document summarizes an overall framework for organizing the people and processes to build the comprehensive strategy.

The obesity epidemic is understood as a complex issue that is difficult to define and an issue that has no clear or immediate solution. Resulting from a multi-facetted system of causes, it calls for a comprehensive, cross-cutting, long-term strategy that requires action from multiple stakeholders at multiple levels. Though obesity results from consuming too many calories and not expending enough of them at an individual level, the epidemic results from broad societal changes that have taken place in the past thirty plus years. Changes in values as well as changes in people’s environments that give easy access to high calorie foods and decrease opportunities for expending energy are thought to be the key drivers of the epidemic. Interventions targeting individuals are important; however, to reverse the epidemic a CORS for BC must emphasize the transformation of people’s environments to make the healthy option the easy choice.

From this perspective, a BC strategy would ideally include the following key features:

I. Emphasis on prevention – addressing the key determinants of obesity; food and physical activity.
II. Treatment and management strategies.
III. A portfolio of interventions that,
   • traverse the life course;
   • target a broad set of variables;
   • are aimed at multiple settings (home, daycare, school, worksite, community and society in general) to reinforce the same behaviour; and
   • are cost-efficient, effective, feasible, equitable, acceptable and sustainable.
IV. Engagement, buy-in and action from multiple sectors and actors.
V. Consideration of provincial and community level strategies and interventions (actions).
VI. Epidemiology, surveillance of obesity trends, evaluation and identification of needed research.
To a large degree, the success of the CORS will depend on which sectors and stakeholders are engaged and how they are engaged in the development of the CORS. The following groupings were agreed upon to organize the key stakeholders.

I. The Obesity Reduction Task Force to be responsible for developing the CORS. The Task Force will steward the overall process to develop a CORS that has a high likelihood of being implemented.

II. A Provincial Level Collaborative of stakeholders from government, industry, provincial civil society organizations, academia, researchers, professional organizations, provincially organized citizen groups and other relevant groups; to recommend provincial level actions for the CORS. Stakeholders will need to include people that have authority to influence policies and practices in their organizations, especially from sectors and organizations that have jurisdiction to implement provincial level actions.

III. A Community Level Collaborative of stakeholders that represent the range of organizations as in the provincial collaborative; including people and sectors that have the authority and jurisdiction to recommend community based actions for the CORS. The best mechanism to engage community level stakeholders still requires further deliberation.

IV. Three Working Groups to engage content expertise from government, industry, civil society organizations, professional organization, academia and research organizations; to propose provincial level and community based actions in the areas of the food environment, physical activity environment and treatments/management options.

V. A fourth Working Group to engage technical expertise to provide content and develop tools and processes for epidemiology, surveillance, evaluation and research.

To ensure the best possible and most equitable health outcomes for the BC population, the following principles will guide the development of the CORS.

- **Build a universal strategy that does no harm.**
- **Aim for outcome goals (reduced prevalence of high BMIs), functional goals (increasing healthy eating and active living) and process goals (policy implementation, community engagement and mobilization of resources across all sectors).**
- **Aim for systematic changes in behaviour in society, the market system, organization, community, family and the individual to support healthy living. Behaviours and cues for behaviours will be considered.**
- **Support families, organizations and communities with the capacity to achieve the sought for changes. Know clearly what capacity is needed, how to build it and what would indicate achievement of capacity.**
- **Strive to achieve greater equity in health status for all British Columbians with policies and programs that are relevant to the diversity of the population; including socio-economic status,**
gender, race, culture, ethnicity, language, sexuality, differential abilities and mental health status.

- Build on existing, promising policies and practices.
- Cultivate shared ownership for the CORS and shared responsibility for its outcomes in multiple sectors and stakeholders.
- Where possible, partner with other broad policy initiatives (climate change) that seek similar changes in individual, group and societal behaviour.
- Evaluate the CORS to provide practice based evidence.
- Ensure solid coordination among the work units to improve coherence of the strategy.

Key steps for implementing this framework:

1) Set up the working groups with relevant stakeholders.
2) Build consensus within the multi-sector multidisciplinary groups to pursue common goals.
3) Use strategic planning to develop a logic model (and set the foundation for strong evaluation).
4) Synthesize the evidence on effective strategies/interventions in food, physical activity and treatment/management of obesity.
5) Map current BC policy initiatives related to food and physical activity.
6) Identify potential provincial and community based strategies for the CORS.
7) Hold a Forum in March 2010 to discuss initial findings and plan the next steps in developing the component strategies.
Cross-cutting Lenses: Socio-economic status, gender, race, culture, ethnicity, language, sexuality, differential abilities, mental health status

Legend: Overlapping ovals indicate overlapping membership. Arrows indicate communication flow.

Task Force:
Mandate is to develop the Comprehensive Obesity Reduction Strategy for BC. (Chair: John Millar)

Provincial Level Collaborative:
Mandate is to build the provincial level strategies/interventions for inclusion in the CORS. Membership includes stakeholders with appropriate level of authority to recommend actions to their organizations from sectors that have jurisdiction and mandate to implement provincial level actions. (Co-chairs: Task Force member and other stakeholder)

Community Level Collaborative:
Mandate is to build community level strategies/interventions for inclusion in the CORS. Membership includes stakeholders with appropriate level of authority to recommend actions to their organizations from sectors that have jurisdiction and mandate to implement community based actions. (Co-chairs: Task Force member and other stakeholder)

Content Specific Working Groups:
Mandate is to propose provincial level and community based strategies/interventions to transform the food and physical activity environments as well as propose treatment options. Membership includes content experts from sectors relevant to each content area. (Each Working Group to be chaired by a Task Force member)

Working Group on Data, Evaluation and Research:
Mandate is to provide expertise on content, tools and processes for epidemiology, surveillance, evaluation and research. Membership includes technical experts in each area mentioned. (Chaired by Task Force member)
Appendix 2 – Terms of Reference

Appendix 2a: Draft Terms of Reference for Provincial Collaborative

Obesity Reduction Strategy for BC Task Force
Provincial Level Collaborative

Draft TERMS OF REFERENCE

1.0 PURPOSE
The provincial multi-sector, multi-stakeholder collaborative takes ownership for developing and implementing provincial level obesity reduction strategies for British Columbia. The collaborative supports strategies that:

• are based on science;
• builds on existing successes;
• meets gaps with evidence based and evaluated strategies/practices and
• build cohesion in the comprehensive strategy.

2.0 RESPONSIBILITIES

2.1 Provides expertise, advice and guidance.

2.2 Participates in the development of the purpose, goal/s and expected outcomes of the strategy.

2.3 Advises on the key components and parameters of the strategy.

2.4 Identifies, reviews and synthesizes cutting edge research, promising practices and other relevant resources.

2.5 Shares or contributes resources where relevant.

2.6 Seek funding from a variety of sources.

2.7 Promote the project based on a communications strategy.

2.8 Commits to implementing the strategy.
3.0 MEMBERSHIP

Representatives endorsed by the following agencies:
(These are only a sample of potential member agencies)

- Task Force members
- Provincial Ministries of Children and Family Development, Housing and Social Development, Education, Agriculture, Transport, Finance
- Union of BC Municipalities
- Planning Institute of BC
- Local Government Management Association
- BC Recreation and Parks Association
- Food Industry (Restaurants, Food Distributors, Grocers etc.)
- Leisure and Recreation Industry (Sports associations)
- Media
- Canadian Radio and Television Corporation
- BC Federation of Parent Advisory Councils

4.0 ACCOUNTABILITY
To the Obesity Reduction Task Force.

5.0 OPERATING PROTOCOL

The Chair
- The meetings will be chaired by Task Force member.
- Prioritize items and organize the agenda for meetings.
- Chair the meetings.
- Communicate with other stakeholders on behalf of the Task Force.

The Recorder
PHSA Centres for Public and Population Health will provide secretariat support including:
- Scheduling meetings.
- Developing and circulating agenda.
- Recording and circulating minutes.
- Providing project management support.

6.0 MEETING SCHEDULE
To be based on a work plan.
1.0 PURPOSE
The community based multi-sector, multi-stakeholder collaborative is a community development process that builds cross-sector alliances and recommending and implementing community based obesity reduction strategies for British Columbia. The collaborative supports strategies that:

- are based on science;
- builds on existing successes;
- meets gaps with evidence based and evaluated strategies/practices and
- builds cohesion in the comprehensive strategy.

2.0 RESPONSIBILITIES

2.1 Nurtures collaborative relationships

2.2 Provides expertise, advice and guidance.

2.3 Participates in the development of the purpose, goal/s and expected outcomes of the strategy.

2.4 Advises on the key components and parameters of the strategy.

2.5 Identifies, reviews and synthesizes cutting edge research, promising practices and other relevant resources.

2.6 Shares or contributes resources where relevant.

2.7 Seek funding from a variety of sources.

2.8 Promote the project based on a communications strategy.

2.9 Commits to implementing the strategy.
3.0 MEMBERSHIP

Representatives endorsed by the following agencies:
(These are only a sample of potential member agencies)
- Obesity Reduction Task Force members
- Local Government (Mayor, Council Members, Planners)
- Parks and Recreation
- School Board
- Schools (Teachers and Administrators)
- Parent Advisory Councils
- Student organizations
- Local Food Industry (Restaurants, Food Distributors, Grocers etc.)
- Sports associations
- Local Media

4.0 ACCOUNTABILITY
To the Obesity Reduction Task Force.

5.0 OPERATING PROTOCOL

The Chair
- The meetings will be chaired by Task Force member.
- Prioritize items and organize the agenda for meetings.
- Chair the meetings.
- Communicate with other stakeholders on behalf of the Task Force.

The Recorder
PHSA Centres for Public and Population Health will provide secretariat support including:
- Scheduling meetings.
- Developing and circulating agenda.
- Recording and circulating minutes.
- Providing project management support.

6.0 MEETING SCHEDULE
To be based on a work plan.
Appendix 2c: Draft Generic Term of Reference for Working Groups

Working Group on XXXX
Draft TERMS OF REFERENCE

1.0 PURPOSE
The Working Group on Food is a multi-sector, multi-stakeholder collaboration that recommends provincial level and community based strategies and interventions (to increase healthy eating and decrease unhealthy eating) or (to increase physical activity and decrease sedentary behaviour) or (for treating and managing obesity in diagnosed children and adults); for inclusion in the Comprehensive Obesity Reduction Strategy. The strategies and interventions will be:

- based on evidence
- Build on existing successes
- meet gaps with evidence based and evaluated strategies
- appropriate for the specific needs of populations (e.g. people living with cognitive, mental and physical disabilities)
- relevant and responsive to the socio-economic, ethno-cultural and gender diversity of the BC population
- cost-efficient, effective, feasible, equitable, acceptable and sustainable.

2.0 RESPONSIBILITIES

2.1. Provide expertise, advice and guidance;

2.2. Identify, review and synthesize the best available research, promising practices and other relevant resources;

2.3. Identify current BC initiatives and evaluated promising practices;

2.4. Identify gaps;

2.5. Propose strategies and interventions that can be implemented at both a Provincial and Community level;

2.6. Review potential strategies for acceptability, feasibility, equity, cost-effectiveness and sustainability

2.7. Share or contribute resources where relevant.
3. MEMBERSHIP

Membership on the working group is made up of content experts, drawn from organizations that have the jurisdiction and authority to implement recommended strategies/interventions or are connected to provincial networks and are able to inform strategy development as well as promote recommended strategies. Government, industry/business; not-for-profit organizations and academia are represented by the following agencies:

(Insert member organization).

4. ACCOUNTABILITY

To the Obesity Reduction Task Force.

5. OPERATING PROTOCOL

Chair/s
The Working Group will be Co-Chaired by a Task Force member and another member selected by the group. Co-Chairs are responsible for:

- Prioritizing items and organizing the agenda for meetings.
- Chairing the meetings.
- Serve as a communication link between the Working Group and the Task Force.

The Recorder
PHSA Centers for Population and Public Health will provide support with:

- Meeting logistics (scheduling meetings, developing and circulating agenda, recording and circulating minutes);
- Providing project management support;
- Where feasible, providing content support.

6. MEETING SCHEDULE

To be decided based on work plan – to be developed at the first meeting.
Appendix 3 – Draft List of Membership

Provincial Level Collaborative

- Task Force members
- Provincial Ministries of Children and Family Development, Housing and Social Development, Education, Agriculture, Transport, Finance
- Union of BC Municipalities
- Planning Institute of BC
- Local Government Management Association
- BC Recreation and Parks Association
- Food Industry (Restaurants, Food Distributors, Grocers etc.)
- Leisure and Recreation Industry (Sports associations)
- Media
- Canadian Radio and Television Corporation
- BC Federation of Parent Advisory Councils

Community Level Collaborative

- Local Government (Mayor, Council Members, Planners)
- Parks and Recreation
- School Board
- Schools (Teachers and Administrators)
- Parent Advisory Councils
- Student organizations
- Local Food Industry (Restaurants, Food Distributors, Grocers etc.)
- Sports associations
- Local Media

Working Group on Food

- Ministry of Healthy Living and Sport
- Agriculture and Lands
- Ministry of Housing and Social Development
- Ministry of Education
- Ministry of Community and Rural Development
- Public Health Agency of Canada
- Union of BC Municipalities
- BC Healthy Living Alliance
- Dietitians of Canada
- BC Food Systems Network
- University of Victoria – Dept of Geography
- University of BC – Faculty of Land and Food Systems
- Simon Fraser University – Centre for Sustainable Development
• Planners Institute of BC
• BC Food Processors Association
• BC Vegetable Marketing Commission
• BC Fruit Growers Association
• BC Restaurant and Food Services Association

Working Group on Physical Activity

• Ministry of Healthy Living and Sport
• Ministry of Education
• Ministry of Transportation and Infrastructure
• BC Transit
• Public Health Agency of Canada
• Union of BC Municipalities
• Planners Institute of BC
• BC Healthy Living Alliance
• University of Victoria
• University of BC
• Simon Fraser University
• Planners Institute of BC
• BCPRA
• BC School Sports

Working Group on Treatment and Management

• Organizations that support weight management through self help processes
• Clinical programs involved in weight management through lifestyle changes
• Clinicians and researchers involved in drug therapies
• Surgeons working on Bariatric Surgery
• Clinicians and researchers working on Metabolic Disorders

Working Group on Data, Evaluation, Research

• Epidemiologist
• Data Experts
• Evaluation Specialists
• Obesity Researchers
### Appendix 4 – Member Selection Matrix

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Organization</th>
<th>Policy</th>
<th>Research</th>
<th>BC Initiatives</th>
<th>Lower SES Status</th>
<th>Mental Health</th>
<th>Disabilities</th>
<th>Aboriginal</th>
<th>Immigrant/Refugee</th>
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Appendix 5 – Obesity Frameworks
Appendix 5a: Ecological Framework
(Framework for determinants of physical activity and eating behaviour)

Appendix 5b: Canadian Population Health Model

Source: http://www.phac-aspc.gc.ca/ph-sp/php-psp/php3-eng.php#Developing
Appendix 5c: The Causal Web

CAUSAL WEB OF SOCIETAL INFLUENCES ON OBESITY PREVALENCE

Appendix 5d: Obesity System Map

Appendix 6 – Matrix 1: Merging of the Foresight OP variables and the World Cancer RF Interventions

(The highlighted tick-marks are additional actors that would be needed in a BC context - added by me)

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Personal Psychology

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<td>• Promotion of physical activity especially for children and young people</td>
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<td>• Reformulation of processed meals, dishes, snacks and foods and drinks to contain less sugar, refined starches, fat and salt</td>
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<td>- Priority given to display of healthy foods and drinks in retail and catering outlets</td>
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<td>- Financial and other supports for local authorities, employers and health professionals who promote or prescribe physical activity</td>
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<td>- Increase in freely accessible parks, leisure, play and sports areas</td>
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## Appendix 7 – Matrix 2: Interventions for the BC Context
(Community level interventions are shaded in grey)

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<td>• Advocacy, pressure to encourage government, industry, employers and other actors to improve public health</td>
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<td>• Stricter controls on advertising and marketing infant formula and weaning foods</td>
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### Personal

**Personal Characteristics**

- Consideration of effects of age, sex, size on pattern of diet and physical activity
  
- Promotion of physical activity especially for children and young people

**Physical and psychological states**

- Consideration of physical, mental and emotional states and their relationship with patterns of diet and physical activity

### Individual and Family

- Inclusion of partners and other family members in breast-feeding support

### Knowledge, Attitudes, behaviour

- Promotion of the value of breast-feeding
- Promotion of interventions that include support from knowledgeable family members

### Food Production

- Encouragement of small holdings and home and farm gardens
- Improvements in methods of animal production

### Economic

**Availability and prices**

- Removal of agricultural and other subsidies that damage public health

### Physical Environment

**Climate and terrain**

- Modeling and monitoring impact of climate change on the food system

### Food Consumption

**School and Work**

- Introduction or strengthening of academic and practical nutrition and physical activity in school curricula
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<td>Priority given to display of healthy foods and drinks in retail and catering outlets</td>
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<td>Encourage regular preparation of cooking meals</td>
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<td>Imposition of or increase of taxes and other disincentives on private vehicles</td>
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<td>- Creation and revival of active transportation systems</td>
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<td>- Encouragement of regular physical activity at workplaces</td>
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<td>- Financial and other supports for local authorities, employers and health professionals who promote or prescribe physical activity</td>
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<td>- Increase in freely accessible parks, leisure, play and sports areas</td>
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<td>- Building regular physical activities in to everyday life</td>
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