NCCHPP

NATIONAL COLLABORATING CENTRE FOR HEALTHY PUBLIC POLICY

Developing a Canadian Network for Health in All Policies: Consultations with Actors from Canada and Abroad

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AUTHORS

Hélène Poliquin and Natalia Carrillo Botero
National Collaborating Centre for Healthy Public Policy

UNDER THE COORDINATION OF

Olivier Bellefleur, National Collaborating Centre for Healthy Public Policy

EDITING

Marianne Jacques and Mylène Maguire
National Collaborating Centre for Healthy Public Policy

LAYOUT

Sarah Mei Lapierre
Institut national de santé publique du Québec

REVIEWERS

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About the National Collaborating Centre for Healthy Public Policy

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six centres financed by the Public Health Agency of Canada. The six centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. The NCCHPP is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre in public health in Canada.

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List of Acronyms

CNHiAP	Canadian Network for Health in All Policies
COVID-19	Coronavirus disease
GNHiAP	Global Network for Health in All Policies
HIA	Health Impact Assessment
HiAP	Health in All Policies
MSSS	Ministère de la Santé et des Services sociaux (ministry of health and social services)
NCCHPP	National Collaborating Centre for Healthy Public Policy
NGO	Non-governmental organization
PHAC	Public Health Agency of Canada
SDG	Sustainable Development Goals
WHO	World Health Organization

Summary

Introduction

Health in All Policies (HiAP) is a global initiative rooted in the principles of health promotion and intersectoral actions first introduced by Finland's European Union presidency in 2006 (Ståhl, 2018). More specifically, it refers to "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity" (World Health Organization, 2014, p. i17). As such, it could have great potential for guiding the post-coronavirus disease (COVID-19) pandemic recovery efforts of various actors to promote the health and wellbeing of Canadians while also striving to reduce health inequalities. This report presents the findings of a consultation conducted to inform the project of creating a Canadian Network for Health in All Policies (CNHiAP).

Context

In October 2019, the National Collaborating Centre for Healthy Public Policy (NCCHPP) hosted a pan-Canadian meeting on Health in All Policies (HiAP) in partnership with the Public Health Agency of Canada (PHAC) and Québec's ministère de la Santé et des Services sociaux (MSSS). The meeting brought together a group of actors from different sectors interested in discussing the adoption and implementation of a HiAP approach in the Canadian context. The conclusion of the meeting was a consensus in support of the relevance of the HiAP approach to improving population health and health equity in Canada, and an expression of interest on the part of attendees in continuing to share knowledge and experience on the subject (Diallo, 2020). This report presents the initial steps towards the development of one of the key areas for action identified during the meeting: the development and launch of an intersectoral HiAP network in Canada.

This report presents the findings of a consultation with a select group of individuals who either have expertise related to HiAP or intersectoral work, or bring forward First Nations, Inuit or Métis perspectives to inform this project. These individuals were asked to comment on the need for and the potential scope and structure of a Canadian Network for Health in All Policies (CNHiAP). The consultation was informed by a previously completed review of similar Canadian and international networks conducted by the NCCHPP to document the mission, vision, structure and scope of these networks. This review was used to identify opportunities and challenges for the CNHiAP and provided a set of questions to guide the consultation.

This report is intended to inform Canadian actors involved or interested in the HiAP initiative and uptake at the federal, provincial, territorial and municipal levels, as well as First Nations, Inuit and Métis governments or organizations. The perspective of public health actors was a particular focus of this work.

Methods

Between October 5 and December 17, 2021, a total of 24 semi-structured individual interviews were conducted. Interview grids varied based on whether the participants were selected for their knowledge of or interest in HiAP, their experience in the launch and management of a network related to health promotion or intersectoral actions for health, or because they were members of the Global Network for Health in All Policies (GNHiAP). Grids were shared beforehand with the participants to allow for preparation time. Interviews were recorded and transcribed verbatim. The data was then organized according to pre-existing and emerging themes and categories of themes to allow for

synthesis, analysis and discussion of the findings. All information was anonymized to guarantee the confidentiality of the participants.

Findings

All participants agreed on the relevance of setting up a CNHiAP. However, two important considerations relative to goal setting emerged. First, that the network should promote exchanges among members and second, that it should be action-oriented with practical goals aimed at influencing HiAP uptake in Canada, rather than being solely an information sharing group, even though information sharing and connecting with others remain strong incentives for joining such a network. For the network, this gives rise to the challenge of finding the right balance between those two goals.

Network goals, objectives and activities

Potential goals, objectives and activities of a CNHiAP were associated with the following broader themes:

Goal setting

With regard to the scope of the goals, opinions diverged. Although some participants argued the network should aim for ambitious goals such as the implementation of HiAP at every government level, others cautioned against starting with overambitious endeavours, and suggested focusing, at least at the beginning, on short-term and concrete objectives, and small achievements to foster buy-in, and to build from there.

Capacity building and knowledge sharing

For many participants, the network should be a space that allows people to connect and talk to each other, to share their knowledge and experiences, and to troubleshoot and establish partnerships. Such exchanges are meant to foster learning about concrete experiences of HiAP implementation in Canada and build a solid knowledge base to support HiAP uptake by others.

Development of skills, knowledge, tools and metrics

There is common agreement among the participants that evidence-based knowledge and know-how concerning HiAP are lacking: a “knowledge to action gap.” Therefore, developing knowledge, tools, metrics and data to advance HiAP buy-in and uptake should be a key priority of the network.

Clarifying and articulating HiAP’s concepts and rationale

Participants recognized that HiAP can be a “nebulous” thing and there can be different understandings of what it entails. Therefore, seeking clarification and a common understanding of key concepts and related tools, such as Health Impact Assessment (HIA), appears crucial during the first phases of the network. This involves avoiding public health jargon and adopting language meaningful to partners from sectors other than the health sector, as well as considering integrating HiAP into existing frameworks and government priorities (e.g., wellbeing, determinants of health, Sustainable Development Goals [SDGs]).

Advocacy

Most participants considered that advocacy should also be one of the network's activities. Its form, however, was the subject of debate. Although advocacy should be part of the network's mission, with the objective of supporting HiAP uptake in Canada, caution must be exercised to avoid alienating some members for whom advocating for certain issues could represent a conflict of interest (i.e., government officials). The network should, according to many participants, prioritize soft advocacy and be a facilitator/enabler of the advocacy efforts of third parties.

Political dimensions and implementation

The goal of influencing high- and intermediate-level government officials and policymakers to commit to HiAP was voiced by participants. HiAP is viewed by some as a marriage between technical knowledge and political engagement. Therefore, one priority should be to demonstrate the benefits of HiAP in order to gain support from political leaders and high-ranking officials, and in time have HiAP embedded in legislation.

Network composition, size and membership criteria

Regarding the network's structure, participants insisted on a careful consideration of the membership criteria, which should be guided by previously defined goals and priorities. As for the size, while there was recognition of the "power in numbers," many participants argued that a smaller, more manageable and effective network should be given priority, at least at the beginning. However, an option many participants favoured as a way to manage the potential growth of the network was to create nodes or chapters, based on jurisdictional levels, themes, or other considerations such as geographical regions, time zones, priorities set by First Nations, Inuit and Métis governments and organizations, and official languages.

The inclusion of non-public health actors was favoured by the majority of participants, whereas thoughts on how to integrate them diverged. Some argued that a diverse set of actors should be sought from inception, while others thought they should be invited to join once a core group of founding members, mainly from public health and academia, have decided on the foundations of the network. To that end, many suggestions were made, such as opting for a staged rollout or adopting a network structure based on different levels of engagement. There were also discussions about the profiles of key members to recruit and sectors to prioritize. Participants had different views regarding key characteristics to look for, with most mentioning people in a position of power, who are committed, and are champions of HiAP.

Considerations relative to First Nations, Inuit and Métis perspectives

Participants were asked to comment on the appropriateness and usefulness of a Canadian network for First Nations, Inuit and Métis governments and organizations. However, findings pertaining to this matter are limited, as only two participants brought forward an Inuit or Métis perspective. Consequently, the first and most important observation is that further consultations with First Nations, Inuit and Métis governments and organizations are required, to inform the design and development of the network.

It is recognized that public health collaborations with First Nations, Inuit and Métis governments and organizations have been hindered by various factors and need to be improved. For many participants (Indigenous and non-Indigenous), this background needs to be acknowledged and understood, with the aim of moving towards a non-colonialist approach. The two main recommendations are that First Nations, Inuit and Métis partners should be consulted from inception, not as an afterthought, and that

their perspectives need to be at the forefront of these conversations. It was also emphasized that the network should be a culturally safe space.

Moving away from western definitions and recognizing First Nations, Inuit and Métis conceptions of health and wellbeing, governance, and other related concepts is essential, as is avoiding imposing HiAP as a model intended to replace existing frameworks or worldviews. The most important message was that First Nations, Inuit and Métis partners should be consulted concerning the relevance for them of engaging in this project. While HiAP may appear promising to these partners, it is also crucial to consult them on how, when, at what level, and in which capacity they wish to participate.

Consultations with members of the Global Network for Health in All Policies

Concerning best practices that could be applied to the CNHiAP, five members of the GNHiAP were consulted about their experiences in establishing and managing the Global network. The key takeaways concerned:

- Securing funding from the start for the secretariat and ensuring careful selection of champions/leaders such as the Chair(s) of the network;
- Including a diversity of members and prioritizing committed membership over a large one;
- The most significant benefits of being a member are the opportunities for learning from others and sharing experiences, getting support for troubleshooting, broadening one's perspective of HiAP, being able to showcase one's work, and gaining credibility from peers and partners;
- Investing in getting to know and engaging the membership and on being useful at a practical level to members (the how-to of HiAP);
- The importance of evaluating impacts and achievements, which should be at the core of planning, as well as the principle of equity between members.

Key considerations for the coordination of the Canadian network

Participants shared some of what they thought were more practical, yet important recommendations for the set-up and coordination of the CNHiAP:

- Secure funding from the beginning and carefully select the core group and coordination team;
- Place sustainability at the forefront by planning for the monitoring and evaluation of the network;
- Select membership criteria based on the network's mandate and goals and look for quality of engagement rather than numbers as regards membership;
- Prioritize strategies for member engagement and retention;
- Work with interested parties to define the mandate and avoid duplication with other networks or organizations;
- Consider different structures and forms of governance to determine which will best suit the diversity, needs, and expectations of the membership.

Limitations

This consultation is not without limitations. First, the individuals consulted were mainly from public health or were academics working in the field, most of whom were already very much in favour of HiAP implementation in Canada. Therefore, their perspectives do not necessarily reflect the opinion of most public health actors or actors from other sectors. Second, only two participants provided an Inuit and Métis perspective. Therefore, to inform the development of this project, further consultations with representatives from First Nations, Inuit and Métis governments and organizations would be required, as would reaching out to potential key actors from sectors outside of public health. Nonetheless, the findings can be considered to be a good starting point for planning and developing a CNHiAP.

Conclusion

The consultation confirmed the interest in developing a CNHiAP. It gathered rich and relevant material to inform its planning and development. Visions and expectations in terms of the goals, objectives and activities voiced by the participants will need to be translated into terms of reference for the network, making sure these are pertinent and inclusive of different points of view and priorities, yet realistic and feasible.

1 Introduction

The National Collaborating Centre for Healthy Public Policy (NCCHPP) has partnered with the Public Health Agency of Canada (PHAC) to develop and launch a Canadian Network for Health in All Policies (CNHiAP). Health in All Policies (HiAP) is a global initiative rooted in the principles of health promotion and intersectoral actions first introduced by Finland's European Union presidency in 2006 (Ståhl, 2018). HiAP has been promoted by the World Health Organization (WHO) since 2014 as a way to reduce health inequalities and promote population health by acting on the social determinants of health (e.g., housing conditions, work and income, urban planning, transport options) (Ståhl, 2018; World Health Organisation & Finland Ministry of Social Affairs and Health, 2014). More specifically,

> Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policymaking. It includes an emphasis on the consequences of public policies on health systems, determinants of health and wellbeing (World Health Organization, 2014, p. i17).

The HiAP approach aims to increase awareness of and consideration for the health implications of policy decisions across governmental sectors (Diallo, 2020). As such, it could have great potential for guiding post-COVID-19 recovery efforts that promote the health and wellbeing of Canadians while reducing health inequalities. This report presents the findings of a consultation conducted by the NCCHPP to inform the project of creating a CNHiAP.

This report is intended to inform Canadian actors involved or interested in HiAP initiatives and their uptake at the federal, provincial, territorial and municipal levels, as well as by First Nations, Inuit and Métis governments or organizations. The perspective of public health actors was a particular focus of this work.

2 Context

In October 2019, the NCCHPP organized a pan-Canadian meeting on HiAP in partnership with the PHAC and Québec's ministère de la Santé et des Services sociaux.[1] This meeting brought together 25 participants affiliated with federal and provincial governments, regional health authorities, First Nations and Métis organizations, and universities from across Canada. It confirmed the interest in HiAP as a promising approach to improving population health and health equity in Canada, and the desire of participants to continue sharing knowledge and experience on the subject.

In order to support implementation of the HiAP approach in Canada, three key areas for action were identified during the meeting: (1) build the evidence base to support capacity building and implementation; (2) lay the groundwork for a common understanding of HiAP across sectors and; (3) launch an intersectoral HiAP network in Canada (Diallo, 2020).

The present document concerns the third key area for action, the launch of a HiAP network. The first step in this work was to explore the operating conditions of similar Canadian and international networks to help map out possible options for the CNHiAP. This work identified opportunities and challenges for the CNHiAP, proposed options for its mission and structure (e.g., its purpose, form, membership), and provided a set of questions to guide discussions on its development.

As the second step, the NCCHPP conducted interviews with a variety of actors with the main objective of gathering their perspectives on this project. More specifically, the objective of this consultation was to increase our understanding of the following dimensions:

1. Added value and utility of a CNHiAP;
2. Potential objectives, scope and activities for the CNHiAP;
3. Promising practices in terms of HiAP knowledge exchange and capacity building;
4. Promising practices in terms of network management and engagement with members;
5. Potential members' contributions to the CNHiAP.

[1] To learn more about this Pan-Canadian Meeting on HiAP, visit: https://ccnpps-ncchpp.ca/pan-canadian-meeting-on-health-in-all-policies-hiap/.

3 Methods

To select the participants, the NCCHPP developed jointly with PHAC a list of individuals known to be involved in HiAP or in intersectoral actions for health, or to be interested in these approaches. A first set of interviews was conducted with key actors involved in knowledge exchange about HiAP within the GNHiAP. Given the similarities and possible connections between the CNHiAP and the GNHiAP, interviews with international participants were thought to be valuable for informing the creation of the CNHiAP. A second set of interviews was conducted with Canadian actors, mainly potential network members; that is, health or public health civil servants at the federal, provincial, territorial and regional/local levels, members of First Nations and Métis governments or organizations and academic HiAP experts who could be interested in participating in a CNHiAP. Participants in this second category were selected because of their role in implementing a HiAP approach in their own jurisdiction or because they had demonstrated interest in HiAP or other intersectoral actions for health, or because of their affiliation with Inuit, Métis and First Nations governments or organizations. Representatives of Canadian networks related to health promotion and intersectoral actions for health were also contacted to get a better understanding of specific challenges to and facilitators of network management in Canada.

Individuals on the list of potential participants (n=36) were contacted by email and invited to participate in a Zoom interview. Twenty-four interviews were conducted from October 5, 2021 to December 17, 2021. The large majority of the participants were from Canada (20), with 4 being from other countries and members of the GNHiAP. Interviews were conducted in English (22) or French (2) and lasted an average of 1 hour (from 30 minutes to 2 hours).

Table 1 Participant Characteristics

Characteristics of participants (non-mutually exclusive)	Number
From Canada[1,2]	20
From outside of Canada	4
Members of the GNHiAP	5
Identifying as women	13
Identifying as men	11
Identifying as Indigenous or working for an Indigenous organization	2
From public health (governmental organization)	13
From a non-governmental organization (including those with a public health focus)	5
From academia	9
Total of participants	**24**

1- Canadian participants were from the following provinces or territories: Alberta (3); British Columbia (3); Newfoundland and Labrador (1); Nova Scotia (2); Ontario (5); Prince Edward Island (1); Québec (3); Saskatchewan (1); Yukon (1).

2- Government level or type of organization (non-mutually exclusive) of Canadian participants: Federal (2); Provincial (4); Territorial (1); Regional/Local (2); Academia (8); Indigenous organization (1); Non-Governmental organization (3).

A short text presenting the context (See Appendices 1 and 2) of this consultation as well as a question grid were sent ahead to participants to allow for preparation time. Grids varied according to whether the participant was a member of the GNHiAP, had experience with or was interested in HiAP or had experience with the launch and management of a network (See Appendices 3 to 5 for interview grids).

All interviews were conducted by the first author of this report, were audio recorded, and were transcribed verbatim. Participants were sent a synthesis of their interview and asked if they wished to add further information. Six participants requested minor changes, which were made.

The material was analyzed by both authors, guided by pre-established and emerging themes, then grouped into themes and categories in one main document. The authors compared their analyses and discussed themes and subthemes and links between them, all of which helped refine and regroup the findings presented in this report. All data were anonymized to ensure participants' confidentiality and names were replaced by numbers. The recordings were destroyed and any individualized notes were filed confidentially once the report was completed.

4 Findings

This section presents participants' perspectives and considerations concerning:

- the need for a CNHiAP;
- goal setting, potential objectives, scope and activities for the CNHiAP;
- membership composition, size and criteria for the CNHiAP;
- First Nations, Inuit and Métis perspectives within the CNHiAP;
- coordination and sustainability of the CNHiAP.

The findings also comprise a synthesis of GNHiAP members' experience relative to membership composition, perceived added value of being a member, most significant activities and achievements of the GNHiAP, as well as challenges related to its set-up and coordination.

4.1 The need for a Canadian Network for Health in All Policies

As an initial observation, all participants underscored the relevance of launching a CNHiAP and were very enthusiastic about this project.

> Don't give up! It's the right thing to do! And it's not always easily understood as a policy, but I think if we have enough knowledge exchange and support for this kind of network at a national level, it will really filter down and help us provincially and locally (P17[2], public health, provincial).

HiAP is said to occupy a special niche. People involved in HiAP therefore feel the need to exchange with and to get support from one another. Participants also argued that there is a need to learn about Canadian HiAP initiatives as well as for more contextualized data and research surrounding the approach. Although they value hearing about international HiAP experiences, some participants mentioned that these are often not translatable to Canadian socioeconomic, cultural and political contexts: "When we look globally for lessons learned, some of them sound good but they wouldn't work in a Canadian context" (P2, academia).

4.2 Considerations relative to goal setting for the network

This section presents the goals that participants saw as most central for a CNHiAP.

4.2.1 General considerations relative to goal setting

Before presenting the detailed findings, there are two important considerations relative to goal setting we wish to highlight that emerged from the interviews. The first consideration is that promoting opportunities to exchange, share knowledge and build capacity should be, according to many participants, the main goal of the CNHiAP. The second important consideration is that most participants wanted an action-oriented network aimed at influencing HiAP uptake in Canada and not just a "talking group". For the network, this implies finding the right balance between these two goals.

Indeed, while some participants shared very ambitious hopes for HiAP uptake in Canada, i.e., a HiAP approach "that is normalized at every level of government across Canada" (P15, public health, territorial) or that "eventually fosters healthy, thriving and successful Canadians" *(*P22, non-governmental organization), most advised focusing on simpler, more realistic and practical objectives

[2] To ensure confidentiality, participants' names were replaced by numbers.

for the network, such as creating a competency framework, mapping and documenting HiAP experiences across Canada or supporting the development of concrete projects. This stems from the fact that adopting HiAP as an approach is not self-evident; it is even countercultural for sectors and agencies used to working in silos. Therefore, still with regard to this second consideration, participants cautioned against having excessive expectations during the initial stages of the network's existence. As HiAP "touches on all determinants of health" (P10, academia), challenges related to the choices of priorities are inevitable since priorities will vary according to members' interests and affiliations (e.g., levels of government). This implies that choices will need to be made to set realistic goals and prevent the network from becoming too big, unmanageable, and diluted to the point of losing its utility to members. Therefore, many thought it would be better to start small with limited goals, ideally with pilot projects, and by counting on small wins such as merely succeeding in bringing together a group or being able to agree on a common understanding of HiAP. As mentioned by a few participants, the creation of a HiAP network in itself gives credibility to the approach:

> I think what helps me is being able to point to other jurisdictions that are doing the same work. I think that really demonstrates that we're not just shooting for the moon, this is what is happening across Canada and happening internationally. I think that's really helpful. […]. I see that as being a really central component: how we support each other to continue this work (P4, public health, provincial).

4.2.2 GOALS RELATED TO KNOWLEDGE SHARING AND CAPACITY BUILDING

The development and sharing of knowledge and capacity building are two of the main goals envisaged for the CNHiAP. These goals are aimed at different audiences, including the members themselves, the public health community in general, which comprises public health students, and a broader public, including policy analysts, policymakers, government officials and partners from different sectors.

a. Connecting with other actors engaged in HiAP across Canada

The participants formulated goals for networks in general, such as allowing people to connect and talk with each other, share their knowledge and experiences, and establish partnerships. Here is an example of the most common answer concerning what could be the goal of the future network:

> I think probably the easiest ones would be knowledge exchange and capacity building, I think there would be some great sharing across the country from folks who are involved in this work and then that would help build capacity of those who are maybe newer to the work (P7, public health, local/regional).

Some participants also suggested the network could provide a space in a trusting environment where members could troubleshoot together, discuss the root causes of problems, such as health inequalities, to help "connect the dots" surrounding the social determinants of health, and find collective solutions to these problems. "One advantage of a HiAP network is […] when you need help with something, you have a list of people that you can reach out to" (P15, public health, territorial).

Participants particularly wanted to learn about what is being done in HiAP in Canada at different jurisdictional levels. HiAP is seen as "a niche," and actors working in that space thus feel isolated with little opportunity to exchange. The network could help fill that gap. There is a large appetite for hearing about first-hand experiences with developing initiatives. They want to hear about the what, the how, for whom, and by whom? In the words of one participant: "The biggest thing is storytelling and example sharing and then it can be supported with toolkits and webinars" (P4, public health, provincial).

Many participants suspected HiAP initiatives are occurring in Canada and that the network could help highlight them to a larger audience and build knowledge around HiAP implementation in varied contexts. Great value was also placed on learning from initiatives that fall under the umbrella of HiAP; that is, that are very much related to HiAP without being explicitly identified as such by the actors:

> There's work going on at different levels of government from different types of organizations and groups. Sometimes, they might not even be aware that what they're doing would fall under the umbrella of Health in All Policies and sometimes they are, but they don't necessarily have the benefit of learning from one another and collaborating, sharing resources, experiences, what's worked, what hasn't, essentially all the things to advance the work in Canada a little bit quicker than having to do it all on your own and other things as well (P23, public health, provincial).

Many saw value in sharing experiences related to HiAP (e.g., advocacy work, implementation, intersectoral work), with like-minded and passionate people, especially through informal, in-person and “off the record” exchanges.

> We have to wrestle with the problem together. More dialogue is required and the network must not be one directional communication. People are doing interesting work and they should be presenting and members should also have a lot of opportunities to exchange and not just attend presentations, webinars, etc. (P6, public health, local/regional).

Some participants also stated that small jurisdictions could benefit from the network’s support and national leadership especially if larger jurisdictions are active members of the network. “And so, especially given that we're a small jurisdiction, the value of a national network would really help us” (P17, public health, provincial). It was also suggested that larger jurisdictions can learn a great deal from the smaller provinces and territories, and First Nations, Inuit and Métis governments and organizations in Canada. Opening dialogue and fostering exchanges between jurisdictions can provide a two-way learning experience.

> The network can help foster support between jurisdictions. Being a small jurisdiction, it’s very useful to have people to talk to. Folks in the South have often challenges connecting with people in the North. Things are happening without us even knowing about it [research, programmes, etc.]. […] Also, larger jurisdictions have things to learn from smaller ones, with very specific sociodemographic landscapes and political and geographical contexts (P15, public health, territorial).

b. Building the evidence base

All participants mentioned that there is a paucity of evidence-based knowledge concerning HiAP, which makes it difficult to make the case for its implementation to actors outside of public health. For instance, many mentioned the need to show governments that HiAP can bring higher return on investment, or that it does have a positive impact on the health and wellbeing of the population. However, this presupposes the existence of a strong knowledge base (evidence) to draw on, when in fact, it is rather limited, even though there is a growing consensus among the public health sector that the approach is pertinent. To address this gap, some participants suggested the network should work on developing more evidence, forming a strong knowledge base to measure the impact of the HiAP approach, work that would include identifying a potentially separate set of metrics related to HiAP:

> We have the pan-Canadian database on health inequalities which has about 70 metrics. But the network could work together on a smaller set of health equity metrics as well as identify priority areas to address (P21, public health, federal).

As for demonstrating HiAP can be a good return on investment, participants highlighted how fundamental the economic argument, including profitability, is to convincing politicians and decision makers of HiAP's benefits. Therefore, developing return on investment indicators for healthy public policies, would be key to this discussion.

> You know, obviously with health taking 45 to 55% of the budget, if we can save money on the health side, perhaps that money would be available for these other sectors, and so perhaps that becomes part of the argument (P2, academia).

> It's about, I think, creating an environment where there is a buy-in, which can be really challenging, because a lot of it [the buy-in] comes with economic benefits, return on investment, with a lot of politicians and decision makers wanting to see economic results and return on investment (P15, public health, territorial).

c. Creating a knowledge repository on HiAP

Also highlighted by the participants is the need for knowledge translation based on the existing evidence, targeted to key audiences, including non-health sectors, concerning HiAP's usefulness, how it gets adopted by jurisdictions and how it influences intersectoral actions. Highlighting successes so that others can see that HiAP is possible seems particularly useful for its uptake according to many, and thus constitutes a potential goal for the network: "People have to see themselves that these efforts are worth it" (P20, non-governmental organization).

Even with the limited extent of existing evidence, most participants hoped that the network would become a reference hub for HiAP, a sort of "clearinghouse," "knowledge repository," or a very comprehensive hub (through a website for example) with information on HiAP that would allow people to connect with others working in that space in Canada. One participant suggested for instance that a section of the website could be restricted to members only. Some participants also envisaged that the network could also contribute to training public health practitioners and students across Canada to become future advocates for HiAP. Also mentioned was that the CNHiAP could provide valuable information to people who are new to HiAP, which could be useful considering, for instance, the high turnover of public servants. Some suggested that the network could support a community of practice on HiAP. Needs most mentioned were for sharing existing resources such as tools and metrics and guidance surrounding their use; for best practices supported by scientific research and case studies; for a "standardized framework" for HiAP; for experiences of successful HiAP implementation; and for knowledge of what is done in Canada and abroad in terms of HiAP (See box 1).

> The network can also have the function of simply being a bit of a clearinghouse for, first of all, enumerating the activities that are going on across Canada, it gives a chance for people to get a wider sense of who else is working in this space in Canada that they can identify with and potentially connect with if they have concerns or problems or questions (P23, public health, provincial).

d. Guiding people and new projects and bridging the "knowledge to action gap"

Participants stressed that there is a lack of know-how and limited sharing of what is available on HiAP implementation, a "knowledge to action gap" (P8, public health, federal). Many suggested the delay in implementing HiAP is due to the fact that it is often portrayed as not being a "natural kind of thing" (P2, academia) or "not an easy thing to do" (P18, academia). A general idea expressed by participants is that HiAP appears to be complicated and a poorly defined process and that this can be a disincentive for governments and other actors. Therefore, several participants suggested the network identify HiAP projects to increase their visibility, but also to support them.

> […] Health in All Policies is not like a clearly defined process. […] I think there's a real kind of disincentive even for governments who are interested in the idea; it's not an easy thing to do. So, I think there's a need for guidance and what that guidance looks like. Again, it's not going to be a cookbook, it's not going to be like a clear here's how you do it, because every jurisdiction is so unique and has its own desires and challenges and history and it's got to be so. So, I think there's a real need for that kind of knowledge exchange to support governments where they are doing what they're trying to do, whatever that is basically (P18, academia).

Moreover, many participants suggested that the network could potentially support concrete projects such as pilot projects with seed money, for instance by using a matching funds scheme. Also, a few participants from academia stated they were interested in helping out governments (e.g., through interventional research or HIA or knowledge transfer related to policies). It was also suggested that the network could contribute to this goal by putting governments and organizations working in that space in contact with researchers and people experienced in HiAP implementation.

> So, perhaps one objective is to do interventional research [...] By putting researchers in contact with people in the field who develop different initiatives, these can be closely followed. […]. We haven't talked about HiAP's instruments, there is obviously HIA. So, could this be a core or a starting point from which to work, a means for moving towards more health in all policies? [...] Could such a network lead to or generate concrete projects to be funded? (P1, academia).

BOX 1 — KEY TAKEAWAYS ON GOALS RELATED TO KNOWLEDGE AND CAPACITY BUILDING

Below are some of the more concrete means that were suggested by participants to support knowledge sharing and capacity building:

- Seek the engagement of a variety of members (e.g., from public health, academia, governments);
- Contribute to building a common understanding and language around HiAP;
- Build the evidence base on HiAP effectiveness, for example, on the economic benefits of HiAP, how objectives of other sectors align with health objectives, or the value of intersectoral work for tackling complex problems;
- Expand the evidence base for HiAP;
- Synthesize and mobilize existing evidence to expand the know-how surrounding HiAP implementation (knowledge to action gap);
- Create a knowledge repository or clearinghouse where people can get cutting edge information on HiAP (best practices, guidelines, courses, latest news);
- Provide opportunities for networking and knowledge exchange among members including informal exchanges through in-person meetings;

BOX 1 — KEY TAKEAWAYS ON GOALS RELATED TO KNOWLEDGE AND CAPACITY BUILDING (CONT'D)

Below are some of the more concrete means that were suggested by participants to support knowledge sharing and capacity building:

- Form a community of practice to help members break through isolation;
- Support HiAP initiatives through coaching, intervention research or other incentives;
- Offer members opportunities to showcase their work;
- Keep members up to date and informed through conferences, webinars, meetings, and newsletters;
- Support partnerships for research and assessments related to HiAP (e.g., HIA);
- Support practitioners interested in HiAP but who are not there yet in terms of a structured HiAP approach;
- Contribute to the training of a variety of actors on HiAP, such as public health practitioners and public health students.

4.2.3 GOALS RELATED TO CLARIFICATION AND ARTICULATION OF HIAP RATIONALE AND CONCEPTS

a. Clarifying concepts while steering away from public health jargon

To many participants, avoiding public health jargon appeared essential for buy-in of intersectoral partners. Also, quite a few participants mentioned that HiAP can be a nebulous thing and that very likely people have different understandings of what it entails. Therefore, many suggested that the network, in its early stages, work towards clarifying and developing a shared understanding of key concepts such as "health," "intersectoral action," "determinants of health" and "intersectoral governance."

> In my opinion, the network cannot bypass this step of discussing what we mean: 'Is it this? It isn't this! What is it then?' And having everyone agree to a certain degree on what we understand by Health in all Policies (P10, academia).

Some participants also felt that clarification is also needed concerning the tools surrounding HiAP, such as HIA, which are sometimes confused with the approach itself. Since HiAP requires a subtle understanding of complex problems and collaborative mechanisms for working with other sectors, many participants thought that developing a common language across sectors would facilitate the work that needs to take place amongst diverse actors.

HiAP itself would be the first concept to clarify with many suggesting adopting a broad and holistic vision of the concept. To many, this means being inclusive of initiatives that might not be called HiAP but that do fall under the umbrella of HiAP. Moreover, several participants clearly said that they avoid mentioning the word "health" when exchanging with their partners because the term health might be a "deterring factor." Rather, many stated preferring concepts that speak more to partners from sectors other than health, such as poverty, housing crisis, social justice, prosperity, quality of life, and economic development. Some also mentioned avoiding terminology such as "social inequalities in health" or "social determinants of health" which can be unclear to many and are often considered public health jargon. One participant, speaking of the experience of working with actors outside of the health sector said: "You cannot use the term social determinants of health or they'll go running for the hills. They do not understand it, they don't understand how that impacts anything! […] and we don't do a very good job of showing that" (P20, non-governmental organization). Quite a few

participants therefore said they would rather use terms like “equity,” “equality,” and “inclusion” that are generally better accepted and understood by different audiences.

Interestingly, in Finland, wellbeing is a more accepted concept as compared to health according to one participant: “They [public health representatives] want to use the wellbeing and health promotion concepts to discuss with the municipalities and the citizens […] because wellbeing as a concept is more neutral” (P16, public health). Another participant spoke of the experience of working across sectors and framing HiAP around outcomes their partners are looking for (such as equity or poverty reduction). When asked if the term “Health in All Policies” was used, this person responded:

> No, no we're much more covert than that. The language that we use is a reflection of the social determinants of health, but without deliberately calling it that […] Equity is something that they're very much aware of, and so we will often use that as a mechanism to begin that conversation (P4, public health, provincial).

Another important consideration is how to name the future network. For instance, many participants stated that they would like to have “wellbeing” included in the network’s name. “Wellbeing in all policies,” for instance, or “Partnership for Health and Wellbeing in All Policies,” were suggested. A wellbeing approach[3] was seen by quite a few participants as a way to move beyond a healthcare, disease and lifestyle-oriented vision of health, and away from the risk of “lifestyle drift.”[4] However, no matter what the network ends up being called, the majority of participants indicated that its coordination team and members should seek to communicate clearly to a range of different audiences including those outside the health sector.

> I think, no matter what the network gets called we're going to have to figure out how to communicate its importance and its intention with different languages for a range of different audiences. […] And they're not going to necessarily care about Health in All Policies […] or social determinants of health, even though that's what they are doing. But we can meet them and say: 'What you're doing really matters to our mandate of Health in All Policies’ (P14, academia).

At the same time, some reasons were also voiced by a few participants for maintaining the HiAP name. One of them is that HiAP is a recognized concept within the scientific literature and broader international community. This recognition could potentially help to build the evidence base for HiAP (as opposed to wellbeing, for instance) and support its credibility and therefore attractiveness for governments. Additionally, developing a common language and terminology around HiAP could strengthen the collective voice in its support and add legitimacy to the argument in favour of its implementation, thereby contributing to health promotion and the reduction of health inequalities, the ultimate goals of HiAP.

Finally, there is a general concern that too much time spent in debating concepts may paralyze actions. Therefore, many argued that, without overly debating conceptual issues, efforts should be made to render core HIAP concepts more appealing through clear and simple articulation of the approach, of the reasons behind HiAP, and of the benefits associated with its adoption for decision

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[3] Governmental wellbeing approaches are based on a vision of social, human, economic and environmental progress that goes beyond standard economic measures such as gross domestic product and that is adopted in order to support what matters most to people, namely their wellbeing, without compromising the future of the planet or the wellbeing of future generations (Morrison & Lucyk, 2021; Poliquin, 2022).

[4] Lifestyle drift refers to a “tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors” (Popay et al. 2010, p. 148 cited by Baum & Fisher, 2014). It can also refer to a “recurrent slippage” that occurs as policy statements move from over-arching principles to strategic objectives” (Williams & Fullagar, 2019, p. 22).

makers and other key audiences (see Box 2 for the main recommendations relative to concept clarification).

BOX 2 — KEY TAKEAWAYS ON THE CLARIFICATION AND ARTICULATION OF HIAP RATIONALE AND CONCEPTS

Speak the same language and understand what HiAP is and is not

- Work on clarifying and developing a shared understanding of core HiAP concepts;
- Consider framing HIAP using other terms such as "wellbeing," "health and wellbeing," "equity," or "justice."

Avoid public health jargon and use inclusive language

- Speak the language that potential partners are most familiar with (e.g., language aligned with their corporate priorities);
- Adopt an inclusive approach to HiAP by thoughtfully considering the choice of words such as health, wellbeing, justice, and equity;
- Look for and include HiAP initiatives that are named differently;
- Consider adopting a broad vision of HiAP to be inclusive of HiAP-related initiatives instead of spending a lot of time on concept clarification and delimitation.

b. Lens fatigue: Envisioning a HiAP approach within existing frameworks

Making the approach applicable and realistic for different government sectors was, according to many, one possible goal for the network that can contribute to HiAP uptake in Canada. While participants felt that HiAP's principles are generally well understood, they thought, on the other hand, that their practical and operational dimensions (the how-to) are perceived as rather complex. This, according to many participants, contributes to the implementation difficulties experienced or anticipated by many government officials and other actors.

One participant spoke of "lens fatigue" (P2, academia), referring to the risk that policymakers and other important actors across different sectors might be unreceptive or even unable to integrate another policy lens unless obliged to. The issue of legitimacy was also raised: By what right can public health actors ask others to adopt HiAP? This can be perceived as an imposition of their ways of operating or a form of health imperialism. This is why many participants doubt HiAP can be implemented if cross-sectoral actors don't have an imperative to act on it. Also, quite a few participants mentioned that HiAP has much common ground with wellbeing initiatives and other frameworks such as that of the SDGs. Therefore, in the same vein, some participants suggested considering incorporating HiAP within existing frameworks (e.g., SDGs, Wellbeing) to avoid "adding" another lens and instead to utilize frameworks which are already a priority for governments : "I think the Sustainable Development Goals, in particular, which are targets that, again, many national governments have […] we can demonstrate how a Health in All Policies approach can meet those specific challenges […]" (P18, academia).

4.2.4 GOALS RELATED TO THE POLITICAL DIMENSIONS OF HIAP

Since most participants argued for the need for concrete HiAP implementation in Canada, having access to and influencing high and intermediate-level politicians, policymakers, policy analysts and other interested parties in order to get a real commitment to implement HiAP, is one of the main goals envisaged for the future network. The following findings relate to the political aspects of HiAP implementation and their implication for the network.

a. The importance of leadership from governments and high-ranking officials to influence uptake

For many participants, leadership from high-ranking and middle-level officials would increase the credibility and attractiveness of the CNHiAP and influence HiAP practice. Most agreed that having governments and senior level decision makers as members could contribute to the achievement of many of the CNHiAP's goals: "I think we need leadership at the highest level possible so whether that's our prime minister or someone working at that level" (P8, public health, federal). One way to involve governments is therefore to engage with officials by identifying synergies between their political interests or agendas, such as achieving the 17 SDGs, acting on climate change, non-communicable diseases, etc., and the networks' objectives. The idea is to "capitalize on political and other stakeholders' interest to demonstrate they are contributing to the health and wellbeing of their community" (P18, academia). For instance, one participant mentioned that changes in legislation surrounding HiAP usually occur when political will coincides with organizations (such as non-governmental organizations) influencing the agenda.

Quite a few participants also saw a window of opportunity in the current pandemic situation, which highlighted the pervading social inequalities across Canada and the need to work more collaboratively across sectors. They saw recent collective actions focused on a communicable disease as providing stepping stones toward a broader focus on the determinants of health. Therefore, many participants shared the idea that the network could seize this moment to support HiAP uptake: "Right now [the COVID pandemic] is a key time for innovative transformation, where our social sectors or economic sectors want to be at the table with the health sector […]" (P21, public health, federal).

b. Obtaining legislative changes in favour of HiAP

According to many participants, one key component for HiAP implementation is to have legislative levers in place to provide a favourable environment and mandate. Therefore, one of the goals many participants foresaw for the network was for it to contribute to a mandate which would introduce a set of expected outcomes surrounding HiAP, for instance at a provincial level.

> What it requires is something like a Newfoundland model where it is written into the Act. Then there's a set of people who have responsibility for outcomes […] So, the network would contain policy leaders, research experts, knowledge mobilizers. But it's got to start with that core accountability (P21, public health, federal).

HiAP is about intersectoral governance and viewed by some participants as a marriage between technical knowledge and political engagement.

> The best examples I've heard [of HiAP implementation] are when legislation put in place clearly defines what it is and under what contexts it should occur. That enables it to be more consistently applied. Eventually what we've seen in some places, and not only as their legislation, but as support governance structure that gets put in place to enable this approach to actually work across affected departments. So, it's not just left up to whether someone participates or not, there's actually an enabling governance structure and accountability built in. So, I think that's what's really needed (P23, public health, provincial).

c. Supporting policymakers and informing public health actors on policy making

One avenue envisaged by many participants for promoting HiAP was to influence its uptake in the development of public policies. This is a two-fold objective. On the one hand, several participants mentioned that the network should reach out to governments and policymakers with the intention of contributing to a better understanding of how to integrate HiAP into policy development. This could be done through, for instance, providing them with policy briefs, examples of policies that are inspired by HiAP, or information on key determinants of health. Also, a few participants suggested creating a repository of HiAP policies and tools to guide HiAP policy development in varied jurisdictions. Some mentioned this could be particularly helpful to some smaller jurisdictions across Canada: “I also think that it really would be beneficial to have […] a sort of virtual repository because I remember when I was writing policy and I had nothing to guide me and had never written policy before […]” (P24, public health, provincial).

On the other hand, building the knowledge and capacity of public health actors regarding public policy processes and the political realm in general (such as the political agenda, the policy cycle, windows of opportunity and policy making) are also considered essential to influencing decisions and policies within people’s own organizations and at different levels of governments. Participants highlighted how these skills can greatly encourage engaging in conversations with politicians and decision makers and making the case for HiAP. Some participants suggested activities that could be conducted by the network, such as training in policy making, policy monitoring or conducting scans to help actors seize windows of opportunity.

BOX 3 — KEY TAKEAWAYS ON GOALS RELATED TO POLITICAL SUPPORT AND HIAP UPTAKE

- Fostering the buy-in, political will, commitment and leadership of high and middle-level government officials;
- Training HiAP actors on political processes and policy making in order to influence political decisions;
- Undertaking HiAP knowledge transfer activities for government officials from various sectors;
- Working on influencing public decisions, policies and legislation to support HiAP uptake;
- Translating HiAP principles and concepts into a simple and familiar language to facilitate its adoption by governments and different sectors (e.g., through work on guidelines, framing of HiAP).

4.2.5 GOALS RELATED TO ADVOCACY

According to the vast majority of participants, advocacy should also be one of the network's goals, although not necessarily during the first phases of the network. Many advised that the network should first study the challenges associated with HiAP uptake in Canada and produce documents that could serve to guide advocacy objectives. Areas most mentioned surrounding advocacy were focused on obtaining funding for HiAP projects and promoting uptake by governments, commitment from governments, legislation in favour of HiAP, increased buy-in from various interested parties, and more granular data to build the HiAP evidence base in order to demonstrate its usefulness and legitimacy.

Nevertheless, most participants argued that advocacy needed to be done cautiously to avoid alienating members such as government officials or putting them in positions of conflict with their organizations. In this context, many participants envisioned a "soft advocacy" approach (i.e., not necessarily direct advocacy) for the network. From this perspective, the role of the network could be to enable partners to be effective advocates through knowledge translation (e.g., case studies of successful implementations, policy briefs, statements, literature review) and networking facilitation. Finally, some suggested linkages with advocacy groups that would be at an arm's length from the network and government authorities, which would contribute to making their message part of a collective voice. This would be an ideal solution for many participants.

> Well, I certainly think there needs to be advocacy. I guess it depends on the nature of the network and who's leading it because not all organizations are allowed to do advocacy. But I think it would be essential to have some sort of an advocacy arm to it, whether that's the network itself or some sort of a partner organization (P9, academia).

4.3 Considerations relative to network composition, size and membership criteria

Participants shared their views on the membership: ideal composition, member engagement, scope and the possible internal structure that would facilitate its proper functioning and sustainability. Participants mentioned that the goals and priorities for the network should be set prior to determining membership criteria. Notwithstanding this important consideration, most participants mentioned that an advisory committee will need to be created in order to establish these initial goals and set criteria for membership.

4.3.1 CHARACTERISTICS OF MEMBERS: POWERFUL PEOPLE AND CHAMPIONS

As a primary consideration for the selection of members, for the majority of participants, recruiting leaders was deemed essential, that is people in positions of power (e.g., high-ranking or middle-level officials) or able to influence decision-making, or champions described as charismatic and passionate people who enjoy and are good with team work, whether from academia, governmental agencies or non-governmental organizations. Champions were also described as people with a "spirit of collaboration" (P5, non-governmental organization), interested in and aware of the value HiAP holds, and who can "think boldly." Consequently, participants also saw value in recruiting individuals that are not in a position of authority as they might be freer to express themselves, as compared to others, such as government officials: "If you have people who aren't in authority, they don't have any power, but they can think boldly, whereas if you have people in authority, they have power, but they can't necessarily think boldly" (P8, public health, federal).

Carefully choosing individuals who are motivated to work towards HiAP implementation and who can contribute to this goal was mentioned as the most valuable criterion to consider. Moreover, some participants thought that members who play a role in the implementation or adoption of HiAP would be very valuable to the network and potentially contribute to the achievement of the broader goal of HiAP adoption.

> I think that what would be the biggest value would be a group of people that could provide concrete examples of how to get started in Canada […] I think you really want people that have a stake […] But unless there's actually something tangible for the stakeholders, it's never going to happen [i.e., HiAP uptake] (P2, academia).

4.3.2 A DIVERSE AND INCLUSIVE NETWORK

Another element that seems crucial for most participants is to aim for a future network that will be diverse, inclusive and representative of provinces and territories and Canada's cultural diversity, an often-overlooked aspect of similar national initiatives. According to one participant:

> One of my greatest concerns in Canada is that when we do things we don't always see Canada as a whole, with three territories and 10 provinces, and we have a lot of effort in our big provinces, you know British Columbia, Alberta, Ontario. And we tend not to have input or inclusion of people from Québec, from the Maritimes, from the North. And I think it's essential that we look at the balance if we have a network […] because the territories are so often left out and they're a very wonderful part of Canada. And looking at the makeup of the network, it should reflect Canada's diversity. Because we are a multicultural country, and we should reflect that if we're creating a Canadian network, it should be truly reflective of Canada (P24, public health, provincial).

It must be noted that a few participants, all from public health, suggested launching the network only with public health actors and academics in order to reach a common understanding of HiAP, to make sure a common language is used to speak about HIAP, and to better define the project.

> Once we [i.e., public health] have consensus as a group on priorities either that exist now, or that are upcoming or issues, then we may wish to invite representation from other sectors, who are leading those as well as subject matter experts (P8, public health, federal).

However, most participants believed that it is better to bet on a mix of actors at the inception of the network rather than to begin solely with a group of public health professionals. The main idea would be to avoid the network ending up being a closed group of public health actors, no matter how committed they may be, who are talking to each other rather than engaging with actors from other sectors, as they should. Therefore, ideally, according to most participants, members should come from a variety of backgrounds, have different roles in various organizations and jurisdictions across Canada (e.g., from the public health sector, non-governmental organizations, First Nations, Inuit and Métis governments and organizations). Also, many mentioned that members occupying different roles at the federal, provincial, territorial and municipal levels should be sought (e.g., senior and middle-level management, policymakers, policy analysts, policy leaders).

> From my perspective, the whole purpose of Health in All Policies is that it's not a conversation that's exclusive to public health, right. Like, it's not happening in this realm, it's out here. And I think in order to be successful, we need to hear the stories and examples from those actors that are part of other sectors where we would be doing that engagement, where we would be forging those relationships doing the policy development work. So, I really think that representation is important (P4, public health, provincial).

4.3.3 SECTORS OR THEMES TO TARGET

Despite the diverging opinions regarding the initial membership (i.e., whether or not to start only with public health actors), the vast majority of participants believed that the network should eventually evolve into an intersectoral network. One sector that appeared to be particularly important to reach out to is finance. Other sectors most mentioned include the environment, education, and social services sectors (even though in some provinces social services and health are within the same department). Although implementing an intersectoral network can appear more challenging, many thought it would lead to richer exchanges and help create needed alliances between public health actors and those of other sectors:

> It is certainly more difficult to implement an intersectoral network because it involves reaching out to people whose involvement [with HiAP] is not necessarily known. However, probably the biggest benefit that can be derived from it is to have more significant interaction between public health actors and those from other sectors. (P1, academia).

Choosing a restricted number of sectors to keep network goals realistic was also suggested by a few participants. Moreover, rather than looking for the "best" sectors, some participants recommended a pragmatic targeting of partners with whom public health has developed the greatest affinity or who demonstrate a desire to adopt a HiAP approach, regardless of the sectors: “I think it almost doesn't matter what the sector is as long as it's willing to engage and sees potential benefit. Those would be the best sectors to pick, the ones that are the most willing” (P2, academia).

4.3.4 SIZE OF THE NETWORK

Some participants argued that there is *“*power in numbers*”* and therefore see advantages in creating a large network, notably to have the opportunity to share a common language, knowledge and goals across diverse audiences. However, most agreed that the network should avoid becoming a huge group that loses its value to its members. Therefore, the membership should, according to most participants, be limited at least during its initial phases in order for it to be effective and manageable, to avoid diluting the mandate, and to allow sufficient time for members to exchange. Many warned that with a larger network, meetings are more likely to generate less dialogue and resemble *“*more of a lecture kind of session*”* (P4, public health, provincial).

> There is the notion of the right tension between being inclusive, sufficiently inclusive that it is credible, and sufficiently nimble that it actually takes hold and moves, because the relationships inside the organization builds across geography and sectors and demographics (P22, non-governmental organization).

4.3.5 JURISDICTIONAL LEVELS AND OTHER KEY PLAYERS

A few participants mentioned that the three levels of government are all contributing to the success of HiAP. However, most participants thought that for pragmatic reasons, the network will need to choose which levels to support (federal, provincial/territorial, or local/regional). The membership of a provincial government was highlighted as something to be sought to bolster the credibility of the CNHiAP, to further the HiAP agenda and to incite other provinces to adopt HiAP.

A few participants expressed hesitancy to include municipal actors, mainly to avoid diluting the priorities of the network. One suggested that the municipalities could get guidance from a provincial government member. In contrast, others thought that municipalities and regions were key actors to target for membership because they are the ones who translate federal and provincial policy into action and “are closest to the ground, trying to do the work” (P20, non-governmental organization).

Therefore, their success stories can possibly be leveraged to attract champions for HiAP and influence decision makers to adopt HiAP. Also, it could be valuable to seek other interested parties such as community-based organizations and non-governmental organizations (NGOs), since "A lot of the work that we would now consider a Health in All Policies approach is actually done by NGOs and community-based organizations" (P23, public health, provincial). However, since it is impossible to include all potential members, it was also suggested by a few participants that having one particular member "act as a representative to a broader group" (P22, non-governmental organization) could be an interesting option.

4.3.6 CHAPTERS OR NODES

Even if HiAP can rally multiple members, many participants mentioned that contextual differences (e.g., across Canadian jurisdictions or sectors) need to be addressed, acknowledging communities are not homogeneous across the country and that public policies also have to be sensitive to culture and diversity. To address these Canadian differences and also for practical considerations (e.g., the difficulty of arranging meetings due to time zones, extended geographical area, two official languages, government levels), many suggested the creation of nodes or chapters that could be based on levels or type of government (e.g., urban, provincial, territorial, First Nations, Inuit and Métis); on particular themes (inequalities, climate change, the environment, Indigenous rights, immigration); on geographical regions (e.g., Atlantic provinces, Western provinces or Northern territories), or on languages. Some participants also suggested the creation of an international chapter. A few mentioned that the network could be an opportunity for Canada to regain the international leadership in health promotion it once had with the Ottawa Charter.

Members could therefore choose to be part of specific chapters while also being part of the core group in order to avoid missing out on other important conversations.

> Of the size? It depends on the connections we are trying to establish […], to keep it manageable because of the size and the relationships you form. I mean, there are many ways to do this. We can have a larger group and then bring a smaller group together that are doing similar work, I can really see the value in that. If that's the case, the network can be larger and I don't think the number is necessarily a problem […] I think the idea is to bring people with enough common ground that the conversation is relevant. It is harder to connect to everything. If people can self-select the chapters they are interested in, by the type of work that they do or connect to the level of jurisdiction they are operating in vs. the topic, I think that's how we could tackle it (P6, public health, local/regional).

4.3.7 THE CONTRIBUTION OF MEMBERS AND THE SUSTAINABILITY OF THEIR ENGAGEMENT

For many participants, the success of the CNHiAP will rely heavily on its ability to gather diverse members and capitalize on their expertise and contribution to the network. The challenges of bringing together a group of diverse members (backgrounds and profiles), especially from outside of the health sector, and keeping them engaged were discussed. When asked how to attract intersectoral partners, one participant mentioned that the network will need to frame HiAP as something that is beneficial to them: "how it improves their work and how it will help serve their clients or the people that they represent, I think we need to lead with that, how this is beneficial for them" (P4, public health, provincial).

Also, participants with experience in implementing a network stressed how important it is to know the members well, as well as their incentives for being part of the CNHiAP and how they wish to contribute. Examples of valued activities are, for instance, for academics, being able to present their

work and find potential research collaborators. For others, it could be, as was expressed by the participants, taking a leadership role in the network, for instance in relation to a specific chapter or project.

Incentives for participating in the CNHiAP could also include attending conferences, and obtaining seed money for small projects or student grants. To ensure engagement, participants also suggested giving members meaningful opportunities to contribute, such as by showcasing their work, hosting webinars or writing papers to be posted on the CNHiAP website. To sustain interest, many also think it is important that the network activities strike a fair balance between formal and informal exchanges. In-person meetings and conferences (national and international), participants suggested, are also highly appreciated by people who generally enjoy travelling and getting the chance to meet in person. It should be noted that several participants mentioned the 2019 Pan-Canadian Meeting on HiAP in Québec City as a rich experience that allowed them to share with others informally about HiAP.

BOX 4 — KEY TAKEAWAYS REGARDING MEMBERSHIP SIZE AND CRITERIA

- Goals and priorities for the network should be set prior to determining membership criteria. However, an initial advisory committee needs to be created to do so;
- Many thought the membership should be limited at least during its initial phases in order for the network to be effective and manageable and keep the goals realistic;
- While a few participants suggested launching the network only with public health actors and academics in order to define the project and reach a common understanding, most preferred to bet on a mix of actors from the inception of the network;
- Despite some diverging opinions regarding the initial membership (i.e., whether or not to start only with public health actors), the vast majority of participants believed that the network should eventually evolve into an intersectoral network;
- The majority of participants found it would be just as valuable to recruit champions of HIAP and charismatic and passionate people as to recruit people in positions of power;
- Both core group and larger network memberships should ideally comprise, according to participants, members from a variety of backgrounds and be representative of provinces and territories and Canada's cultural diversity;
- It was considered that, apart from adequate funding, the sustainability of the network will rely on its ability to gather diverse members, capitalize on their expertise and keep them engaged in the network;
- To address contextual differences and practical considerations (e.g., time zones, extended geographical area, official languages, government levels) and to better reach the various network goals, many suggested the creation of nodes or chapters.

4.4 Considerations relative to First Nations, Inuit and Métis perspectives

All participants, non-Indigenous and Indigenous, were asked this question: "What would be needed for a CNHiAP to be appropriate, respectful, and useful for Indigenous organizations?" The findings in this subsection come mostly from the perspective of non-Indigenous participants, since only one identified as Indigenous and one was affiliated with an Indigenous organization. Therefore, further consultations with First Nations, Inuit and Métis governments and organizations would be needed to gather more in-depth information on the value these governments or organizations see or not in the

HiAP approach as their understanding and vision of health may be different from those conveyed by the concept of HiAP. While recognizing that priorities vary across First Nations, Inuit and Métis governments and organizations, it is also crucial to better understand if and how they envision their involvement in the network.

4.4.1 Gaps in public health collaborations with First Nations, Inuit and Métis governments and organizations

Many participants indicated that public health collaborations with First Nations, Inuit and Métis governments and organizations need to be improved. They said such collaborations have been hindered partly due to jurisdictional complexity, colonialism, and lack of knowledge on how to engage meaningfully.

According to one participant from an Indigenous organization, the Métis nation already applies a social determinants of health approach. Therefore, a HiAP framework and the associated tools could potentially help carry forward actions already taking place. For instance, the Métis nation's multidimensional conception of health and wellbeing includes the land and communities, making land claims and treaties inseparable from HiAP. Also, First Nations, Inuit and Métis perspectives, recognized as more holistic and therefore aligned with HiAP principles, are seen to represent a potential significant contribution to the advancement of HiAP: "I think Indigenous communities could be very helpful, very helpful in thinking about HiAP, given their understanding of health which is already multi-circular" (P10, academia).

For all these reasons, most participants thought First Nations, Inuit and Métis perspectives need to be foremost in conversations surrounding the creation of the network.

4.4.2 Need to consult First Nations, Inuit and Métis governments and organizations from inception

Participants suggested consulting First Nations, Inuit and Métis governments and organizations and seeking Indigenous leadership (either from individuals or organizations) from the inception of the network. Most importantly, many participants thought First Nations, Inuit and Métis members should contribute to the development of the CNHiAP's vision and mission and not be invited to join during a later phase.

> It is not just about sending an email to somebody to say: 'Okay, do you want to participate in this network?' No, I think we need to have a meaningful engagement with the three Indigenous groups, a respectful engagement and to understand that they have leaders and that they have people who can make decisions […] (P5, non-governmental organization).

Colonialism, Indigenous rights, empowerment and self-determination are also central elements to be considered in the development of the network.

> But it takes time, you have to build the trust. That's not something you can do quickly […], you've got to undo some negative stuff first, but there's a saying in the Indigenous world: "nothing about us without us". Don't plan for us unless we're included because it won't work. […] And we need to listen to them. It is hard, it's something, it can't be unwieldy, it can't be so big that it can't function, and yet it also has to be representative and that's always the challenge (P24, public health, provincial).

Additionally, a few participants recommended that the network explore the possibility of providing incentives (monetary or otherwise) to facilitate First Nations, Inuit and Métis members' participation and being clear on what is expected from them. Participants also suggested that since Indigenous organizations receive a lot of demands to participate in national groups and in various projects while having limited resources, providing them with the right information that enables them to choose if they want to participate generally, and in which projects specifically, is one way to make good use of their time: "One important thing is the Indigenous organizations don't have enough capacity to be part of all the conversations and all the networks or working groups. That's why it's better to try to engage them with specific initiatives, specific projects" (P5, non-governmental organization).

4.4.3 Making the network culturally safe

Quite a few participants thought organizations or governments might be reluctant to get involved in the network as HiAP can be seen as another colonial approach and not necessarily serving their best interests. Therefore, to connect with First Nations, Inuit and Métis partners, participants suggested moving away from a rigid and narrow western perspective and towards inclusion of different languages and conceptions (of health or wellbeing), ways of knowing, and ways of viewing problems and solutions. Some participants advised that non-Indigenous members be trained in cultural safety to recognize their individual biases (by, for example, learning about decolonization). Also, according to one participant, HiAP should not be presented or seen as an attempt to replace other frameworks (e.g., the holistic medicine wheel approach).

> I think, yes we'd want to ensure that it's [HiAP] aligning with the needs of Indigenous organizations. Also, being very clear that is not seeking to replace what already exists, whether those are models or understandings, but is kind of complementary (P5, non-governmental organization).

4.4.4 Setting goals that align with First Nations, Inuit and Métis priorities, knowledges and principles

Many participants felt that creating an Indigenous chapter could be a way to ensure that First Nations, Inuit and Métis priorities are addressed. Some mentioned for instance the importance of the Truth and Reconciliation Commission and how these recommendations align with the core of HiAP. "Now that we have the Truth and Reconciliation, it is going to be much more holistic and much better for the health of all Canadians" (P24, public health, provincial). Finally, many believed that ensuring Indigenous representation is essential to aligning the work of the CNHiAP with the principles of Truth and Reconciliation and not reproducing the colonial legacy.

> Having Indigenous organizations there ensures that the Health in All Policies agenda includes issues where institutionalized racism might be perpetuated regardless of the work you're trying to do, so making sure that there's an Indigenous lens or component to the Health in All Policies work is important (P23, public health, provincial).

Along with ensuring integration of core principles, an Indigenous chapter, it was suggested, could also facilitate learning and sharing of First Nations, Inuit and Métis knowledges and know-hows. The chapter could for instance help raise awareness of Indigenous governments, organisations and communities using HiAP (or a similar approach) and enable others to learn from their principles and implementation.

4.4.5 Further consultations needed

Due to the limitations already presented, further consultations are needed regarding the interest of First Nations, Inuit and Métis governments and organizations in joining an eventual network, the characteristics such a network would need to have and how they would wish to be involved. To many participants, there needs to be further reflection on how to consult these governments and organizations. One participant emphasized the importance of, rather than starting with the concept of HiAP, first consulting First Nations, Inuit and Métis partners to find out what matters most to them and going on from there, using a bottom-up approach, to identify issues such as housing, transportation, and climate. Also important is asking partners how much policies on such issues matter to them, while avoiding public health jargon. In this participant's words:

> You're going to get far more feedback from that kind of approach rather than saying we have a network in HIAP. To a lot of people, it's another acronym. I'll be totally honest and we have billions. It's another acronym that doesn't mean anything [...] Because what we've been doing wrong is regarding top down, and we need to go bottom up and think much more about how we consult (P24, public health, provincial).

Box 5 — Key takeaways for the inclusion of First Nations, Inuit and Métis governments and organizations

General considerations

- Values and priorities for First Nations, Inuit and Métis governments and organizations can be different from those of non-Indigenous governments and organizations;
- First Nations, Inuit and Métis perspectives are not homogeneous across the country;
- First Nations, Inuit and Métis actors might have some hesitancy to get involved because HiAP can be seen as another colonial approach and not necessarily one that serves their best interests;
- Often resources (human and financial) of First Nations, Inuit and Métis governments and organizations are limited and therefore it might be a good idea to provide sufficient information to enable them to engage in conversations and projects of their choice;
- First Nations, Inuit and Métis approaches and contributions to HiAP can result in unique and valuable contributions to the global development of HiAP.

How to make the network culturally appropriate and avoid colonial approaches

- Involve First Nations, Inuit and Métis governments and organizations and seek Indigenous leadership from the inception of the network;
- Explore First Nations, Inuit and Métis perspectives on HiAP and look for those that may be using the approach;
- Ask First Nations, Inuit and Métis governments and organizations how they wish to be involved;
- Adopt an approach that is not conceptually rigid and defined by a western perspective;
- Adopt a bottom-up approach rather than a top-down approach; Ask First Nations, Inuit and Métis what matters to them and go from there; Ask them about their priorities and what projects they wish to work on;
- Contribute to making non-Indigenous members cognizant of Indigenous peoples' struggles with colonialism and sociocultural and historical conditions affecting their health and wellbeing and of key issues that foster collaboration between Indigenous and non-Indigenous individuals, such as cultural safety.

4.5 Consultations with members of the Global Network for Health in All Policies

Five out of the 24 participants were members of the GNHiAP.[5] An interview grid was designed to support these consultations by learning from their experiences in establishing and maintaining the GNHiAP and exploring promising practices that could be applied to the CNHiAP. More specifically, questions related to the network's structure, governance, activities, membership criteria and composition. Participants were also asked to share some of the challenges and opportunities associated with setting up and operating a network, the benefits of being part of the GNHiAP, as well as what they would do the same or differently if they were to launch a network today.

4.5.1 GNHiAP STRUCTURE AND MEMBERSHIP

a. Structure

Participants were asked what is essential to the functioning of the network. All answered that proper funding and a solid secretariat are key. Since members are all very busy with their regular full-time occupation, a person dedicated to the coordination seems essential. Also, the chair is viewed as a critical presence, a driver. For participants, it was important for a global network that the chair be someone well known internationally, because a key role is to represent the network and to advocate for HiAP. In the context of the GNHiAP, the chair is filled in a rotating three-year mandate, which carries such advantages as giving different members the opportunity of being the chair, which in turn helps them gain traction with local interested parties for HiAP implementation in their jurisdiction. However, it also carries challenges, particularly for leadership continuity.

b. Membership criteria and governance

Membership criteria for the GNHiAP were guided by the principle of the "triangle that moves mountains" from Thailand. These criteria refer to three types of members or "powers" that are needed for change:

1. government or member states because they have authority;
2. civil society to create social movement to change the whole society;
3. academia to create evidence and knowledge to support policy and provide some outsider insights on HiAP activities as well as on ways of working and implementing the approach.

When asked about the ideal size of the membership, participants emphasized that the goal should not necessarily be to have many members, but to have committed members in order to increase the network's efficiency and sustainability.

All GNHiAP participants agreed that accepting a diversity of members was a good idea. The criterion of having 50% of members be countries or sub-state governments was also highlighted as valuable. Other vital aspects considered during the setting up phase of the network were how to ensure the fluid coordination of the governance structure as well as its flexibility, neutrality, and independence. Members therefore chose not to be tied to a particular institution, such as the WHO, although the WHO is an invaluable member.

However, one participant mentioned that it is unfortunate that all members are from the health sector and that the network should target a more diverse membership. This same person argued that the health sector needs to learn how to work with other sectors, for instance, to build a common

[5] All participants are from public health and further details are not provided to avoid identification.

understanding of HiAP. The health sector also needs to avoid "health imperialism" and instead increase its understanding of other sectors' contribution to health.

> Other sectors may feel that this is another health imperialism activity and that the health sector tries to just get the other sectors to do what health sector wants them to do. And it's not a balanced dialogue and balanced intersectoral work. That's why I think that for the implementation and to put HiAP in practice, there is a need to have other sectors in the network (P16, public health).

4.5.2 Added value of being a member of the GNHiAP

Participants were asked about the added value of being part of the GNHiAP. Having the opportunity to learn from others sharing their experiences from a variety of jurisdictions and contexts in a spirit of collaboration and solidarity for global health equity was one of the most common answers. These exchanges contribute to broadening the perspective and refining the practice of HiAP. For instance, experiences of local and regional HiAP implementations in Latin America show that HiAP does not always need to come from a central government as some would argue.

Being in contact with individuals who are very knowledgeable and passionate about HiAP is also highly appreciated for many reasons. Among the advantages of being a GNHiAP member mentioned by participants are the opportunity to troubleshoot and get help in solving complex problems, being provided with a venue to showcase their work and specific projects and also gaining credibility, authority, credentials and leverage within their national contexts thanks to the GNHiAP's strong reputation. All members declared having gained recognition from peers and partners nationally because of their participation in the network: "GNHiAP helps my organization be recognized internationally and be more distinguished nationally. It does scale up my organization to work at the international level, it gives us recognition" (P12, public health).

4.5.3 Most significant activities and achievements

All participants stated that activities that have been most effective in engaging GNHiAP members are in-person meetings, webinars, the website and writing the Global Status Report (Global Network for Health in All Policies and Government of South Australia, 2019).

a. In-person meetings

All participants highlighted the value of in-person meetings and the convening of conferences to consolidate some learning, maintain and foster relationships, build trust, establish partnerships, and spark new projects. Online meetings are also useful for maintaining contact, but all agree that "they are not the same."

> The meetings were important in engaging people. People like to travel. The more we do Zooms and that kind of thing, the more we realize what it is that we valued in face-to-face meetings […] You can start involving the members right away with a face-to-face meeting for instance in planning the next meeting (P13, public health).

All participants highlighted, for instance, the importance of the 2019 meeting in Québec. However, in-person meetings require a lot of resources and participants were also concerned about climate change and equity-related issues that need to be considered. For instance, one participant mentioned that subsidizing travelling costs when there is an in-person meeting for members whose organization cannot afford to travel is a matter of equity and that it should be of concern to the network.

b. Webinars

All the members indicated that the four webinars that were held in 2021, one in each time zone, were a success.

> Webinars that involve network members. Even if they don't allow participants to ask direct live questions, there were a lot of exchanges in the chat. It gives the speaker the opportunity to showcase. It seems to be an easy win activity that is much less expensive than live meetings. It can also give access to a broad audience (P11, public health).

c. The website

The Global Network's website is also considered to be a main achievement according to all participants. Much appreciated, it became a reference source for HiAP: "Our website is also a great source of information which has more diverse information, more details than the WHO website. A 'hub of knowledge' well of resources, videos, documents" (P11, public health).

d. The Global Status Report on Health in All Policies

Without contest, to participants the most recognized contribution of the GNHiAP is the Global Status Report[6] published in 2019. The report has indeed helped promotion and advocacy of HiAP and helped keep the concept alive in the global arena. For instance, participants stated that it influenced an African Union agreement concerning HiAP.

4.5.4 Knowing what they know now, what they would do differently

Participants reflected on what they would do differently if they were to start again. Some of the most central points revolved around securing resources, being helpful to members and maintaining contact with them, despite challenges surrounding time zones, languages and capacities of the various members. More consideration, some suggested, could also have been given to equity among members and evaluation of the GNHiAP.

a. Challenges surrounding resources

A first set of challenges was acknowledged to relate to resources: financial, human, and temporal. Participants commented on the difficulties involved interacting with members due to a small secretariat and the fact that the executive members involved in the Global network also had full-time jobs. Finding the resources to maintain even a small secretariat to guarantee coordination has been difficult. And the fact that the network is not a legal body complicates funding.

Another set of challenges relate to sustainability. Participants emphasized that collaborative work through networks necessitates time and commitment and is often not valued by organizations. This in turn leads to members having to justify their participation in the GNHiAP within their institution, which "can be hard work" since "everything that is horizontal requires extra efforts" (P13, public health).

[6] See: Global Network for Health in All Policies and Government of South Australia (2019). Global Status Report on Health in All Policies. Available at: https://actionsdg.ctb.ku.edu/wp-content/uploads/2019/10/HiAP-Global-Status-Report-final-single-pages.pdf

What they would do differently:

Secure resources: All participants mentioned they would have ensured funding from the start and some type of coordination structure. A person that is dedicated to the coordination only half time is judged insufficient. The ideal would be 2-3 people dedicated to the secretariat. Securing money is also required to support projects and keep the network alive with ongoing activities.

Ask members what they can bring to the network: Some participants mentioned that they should ask members interested in joining the network to gain the support of their organization and to offer some kind of commitment.

b. Challenges surrounding the network's usefulness to its members

Reflecting on their involvement in the network, the participants found that the most active interactions and conversations have been happening among members of the Executive Committee, all of which contributed to the foundational work of the network. However, participants agreed that fewer efforts were put towards meaningfully engaging the extended membership. This is partly due to language barriers and different time zones: "We have done the foundational work, progression to the conceptual understanding of what works, but have not provided opportunities for members of sharing and unpacking. We haven't done the capacity building and knowledge sharing" (P3, public health).

According to a survey conducted by the GNHiAP, members would like to obtain more practical information on how to apply HiAP through sharing of concrete experiences. That same survey highlighted that people are tired of hearing about broad and abstract concepts and want more occasions to exchange. The number one need expressed in the survey is for knowledge exchange with people with experience in implementing HiAP in varied contexts.

What they would do differently:

Provide members with more opportunities to engage meaningfully : connect with others, showcase their work, share best practices and their experiences and play a leadership role in the network.

Ensure member engagement: All participants also thought they should do more to sustain member engagement. Perhaps through "some systematic ongoing activities" (P16, public health) and "shorter sound bites, shorter information" (P13, public health) that is relevant to them (e.g., newsletters, conferences, drop-in sessions[7], informal Zoom meetings).

c. Challenges associated with equity

Equity among members remains an aspect with some practical challenges, such as those associated with working across time zones, since it is not convenient for all members to attend meetings when, for instance, they take place at night in their time zone and when members speak languages other than English, both of these factors being potential barriers to inclusion and participation.

The GNHiAP has provided support in time or in kind to lower income countries to enable participation in its activities such as conferences but is not able to help out as much as it wished due to lack of available resources. Some participants pointed this out as particularly unfortunate considering that these countries are struggling to incorporate HiAP within a context of limited resources and are more likely to drop out of the network.

[7] Drop-in sessions are meant to enable informal discussions between civil servants wanting to troubleshoot HiAP implementation.

What they would do differently:

Create subcommittees in different time zones in order to engage members more in informal meetings. This could be a potential solution and would also give more leadership opportunities to members, but this would require more secretariat resources.

Secure more resources (funding or in-kind) to support members in lower-income countries, enabling them, for instance, to do cases studies, translate reports, attend international meetings or engage in capacity-building activities.

d. Impacts have not been systematically measured

Some participants also observed that there has not been a robust and comprehensive plan for evaluating the network to gauge its success and relevance. Some activities have been evaluated, such as the webinars, and the GNHiAP has conducted two surveys of its members (in the summers of 2020 and 2021). The first one mostly pertained to the implementation of HiAP in members' jurisdictions (what structures were put in place, etc.) and the second aimed to improve understanding of the needs of the members and of sustainability issues.

What they would do differently:

Plan on demonstrating results or impacts, since this is a critical aspect of the sustainability of the GNHiAP. It was also suggested that having clear objectives for the network as well as a plan for measuring results would have been very helpful in securing funding. Additionally, seeing results might help sustain the interest of the GNHiAP members, and increase their satisfaction and engagement, which are also elements that are crucial to the sustainability of the network.

4.6 Key considerations for the launch, coordination and sustainability of the CNHiAP

In light of comments received, the following elements were identified as particularly relevant to the success of the network. While these elements are worth considering, some participants also warned against trying to have everything figured out before the network's launch, as this can lead to endless discussions and no actions being taken. With that warning in mind, the following are fundamental elements raised by the participants to be considered prior to the launching of the network.

4.6.1 Resources and coordination

Coordination of the network is key. Therefore, carefully selecting the coordination team, that is, the secretariat and steering committee which will provide direction to the network once it is formed, is considered critical. For the secretariat, participants recommended looking for individuals who are charismatic, engaged, good communicators, technically skilled and who possess a solid comprehension of policymaking at different jurisdictional levels. Key complementary skills present within the steering committee, are also viewed as essential. One participant from the GNHiAP suggested looking for these characteristics: "1) strategic planner; 2) coordination; 3) communicator; 4) implementor; 5) researcher (academia)" (P12, public health).

One very critical element is to secure funding so this network can grow and be sustainable, especially funding for its secretariat and general operations. Seed money to support projects was also mentioned as an incentive to attract members and create partnerships. Student grants were also suggested as they can significantly contribute to the network's activity (e.g., collecting data, writing

papers, helping out with coordination or presenting): “I think the biggest challenge is funding for the secretariat, you cannot underestimate the time it takes to run a network (keeping information up to date, contact details, the website. It is a lot of work)” (P13, public health).

4.6.2 Engagement of members

Most argued that the quality of the members (e.g., knowledge, engagement, leadership and authority) matters more than their number. However, participants suggested that member retention in a network is often a challenge as people with these qualities are often involved in many groups and networks. A few participants recommended that the network gauge what commitment can be expected from its members. It was also suggested that the terms of reference should include a specific commitment on the part of the members, relative to what they will bring to the network.

Also, all participants stated that connecting with members is key, while also respecting the time they can offer to the network. Box 6 presents a synthesis of participants’ advice on membership retention.

Box 6 — Key takeaways on membership engagement and retention

- Demonstrate the value of engaging, first by establishing concrete goals and expected outputs and avoiding being merely a “talking group”;
- Have a realistic understanding of how members can engage. Gauge what is reasonable to expect from them in terms of engagement and financial or in-kind resources. Asking too much of members could incite them to opt out;
- Explore what works best in terms of type and frequency of meetings and activities and be flexible enough to adapt. Many interesting combinations are possible including having a rotating host function for meetings (each region to host one meeting);
- Provide multiple opportunities for members to see themselves as part of the network, such as through engagement at different levels or rather engagement in specific projects or chapters;
- Know the members well and understand what their incentives are to be part of the network. Amongst the incentives most mentioned by the participants were:
  - Being able to connect with others, share informally and troubleshoot;
  - Getting support for and adding credibility to their HiAP project;
  - Having a leadership role within the network;
  - Being able to showcase what they are doing (e.g., presentations, publications);
  - Building new alliances, collaborations and partnerships, for instance for research, publications, or projects.
- Enquire about members’ satisfaction with the network and if their objectives or expectations are being met in order to adjust activities accordingly to sustain their engagement.

4.6.3 DEFINING THE NETWORK'S MANDATE, STRUCTURE AND TYPE OF GOVERNANCE

The CNHiAP can take different forms depending on its goals. Defining the mandate was therefore judged to be a crucial step that needs to be given considerable time and effort. Box 7 contains the main suggestions regarding the definition of the mandate that participants gave to a potential advisory committee that would be in charge of setting up the network.

BOX 7 — KEY TAKEAWAYS REGARDING THE DEFINITION OF THE MANDATE

- Know the landscape: have a good idea of what HiAP or HiAP-like initiatives are ongoing in Canada, not only to identify potential members but to have a baseline of implementation stages. Mapping HiAP initiatives across Canada can also be one initial objective of the future network;
- Agree collectively on a name for the network, the terms of reference, and the initial set of objectives and priorities. This can be done by the advisory committee or through consultation with a select group of founding members;
- Think about aligning priorities with those of the majority of interested parties while also being mindful of equity issues and changing priorities. A participant with experience in launching and coordinating an intersectoral network suggested letting the members formulate the network's priorities during a two-day conference meeting, allowing them to meet and exchange informally. In contrast, others suggested a gradual setting of priorities, for instance within the first two years of the launch;
- Consider proceeding with a phased approach to priorities, objectives and membership setting. Many think it is better to start small with a limited number of goals, mainly very pragmatic ones;
- Make sure the network does not duplicate or is not perceived to duplicate the mission of another network or entity. Focus rather on creating links, synergies and complementarity with other groups doing intersectoral work or working on specific causes.

Many possibilities were mentioned regarding the structure and governance of the CNHiAP. For instance, many argued that a proper balance between government engagement and support (political and resource-related) is to be sought in order to maintain the independence the network needs to pursue its objectives.

Preventing the network from becoming too big and unmanageable was a major concern. To counter this effect, many solutions were offered, one of them being the creation of subgroups, nodes or chapters to facilitate the coordination of a network composed of very diverse actors. Box 8 sums up the main suggestions.

BOX 8 — KEY TAKEAWAYS ON STRUCTURE AND GOVERNANCE OF THE NETWORK

- Consider a decentralized network with different nodes and chapters and a central hub that connects different nodes together. This has many benefits such as allowing for more activities surrounding the network and providing incentives for members, for instance, to take leadership roles in their area of interest. These could be created based on:
  - Sectors (e.g., social services, education, environment, finance);
  - Themes or particular projects that span jurisdictions and sectors (e.g., housing, poverty, inequalities, environment, Truth and Reconciliation);
  - First Nations, Inuit and Métis priorities;
  - Jurisdictions (e.g., federal, provincial, territorial, municipal/regional);
  - Geographical regions (e.g., Atlantic, western and eastern provinces, territories, rural or urban);
  - Languages;
  - Some also suggested that the network have an international chapter, for instance, to enable cooperation and sharing with lower income countries.
- Consider offering a leadership role to a government entity, while remaining independent. This could be achieved by ensuring the membership of a high-ranking civil servant or a politician. Some participants suggested seeking the leadership of a jurisdiction that has adopted HiAP (e.g., a provincial government). To some, this can be a way to avoid the appearance of health imperialism.
- There could be a two-headed network: A co-leadership of a government lead, not necessarily from public health, and a public health lead, for example.

5 Conclusion

The objective of this consultation was to explore the interest and feasibility of a CNHiAP. The specific aim was to increase our understanding of the added value and utility of a CNHiAP; its potential objectives, scope and activities; promising practices in terms of HiAP knowledge exchange and capacity building; promising practices in terms of network management and engagement with members; and potential members' contributions to the CNHiAP.

The qualitative methods employed contributed to the richness and credibility of the findings. This richness, as evidenced in this report, encompasses different views and sometimes opposing visions of main issues. This does not preclude, however, the possibility of making observations which allow us to identify common points, shared visions and some guiding principles that can inform subsequent steps.

Limitations

The consultation is not without limitations. First, the individuals consulted were almost exclusively actors from the health sector, mainly public health, or were academics working in the field, most of them already very favourably inclined toward HiAP implementation in Canada. Therefore, their perspectives do not necessarily reflect the opinion of most public health actors or actors from other sectors. Key potential actors to engage, such as policy analysts, policymakers and decision makers from sectors other than public health, were underrepresented or not represented at all. Second, since only two participants provided an Inuit or Métis perspective, findings do not adequately reflect the perspective of First Nations, Inuit and Métis governments and organizations. Further consultations with the latter are therefore required, and reaching out to non-public health potential key actors should also be considered.

Addressing these limitations prior to the launch of the network appears essential to informing the development of the network and to ensuring its alignment with key considerations related to Canada's governance structures and cultural diversity. Nonetheless, the findings, supported by the voices of the participants, are relevant to informing and establishing the basis for the planning and development of a CNHiAP.

Added value and utility of a CNHiAP

The first key finding is that there was a consensus that this project is pertinent and worth pursuing. This consultation suggests that there is indeed a gap to fill, mainly that of connecting and supporting people working on and trying to implement a HiAP approach. The timing for the creation of a CNHiAP was also highlighted, as many participants saw a window of opportunity opening for HiAP uptake in Canada in the wake of the pandemic, which demonstrated the need to work more cost effectively and coherently across sectors.

Potential objectives, scope and activities for the CNHiAP

Most participants saw two main and overarching goals for the CNHiAP: knowledge and capacity building and influencing HiAP uptake in Canada, especially through the sharing of tools, knowledge and experiences with implementing HiAP in different jurisdictions. To achieve these goals, the main suggestions were to organize knowledge sharing and learning activities such as online forums, webinars, and face-to-face meetings; to put together a knowledge repository to contribute to guidance on implementation; to expand a body of evidence on HiAP's impacts and effectiveness; to

map existing HiAP initiatives in Canada; and to produce practical documents and tools such as white papers, guidelines or a competency framework on HiAP.

Building trusting and strategic relations and engaging decision makers and politicians in an effort to influence HiAP's uptake by governments in Canada was the second overarching goal emerging from this consultation. For this purpose, capacity building, according to participants, could also include training and support for key diverse audiences to assist them in understanding policy cycles, agenda-setting and policymaking. Facilitating advocacy efforts through knowledge translation and networking as well as supporting concrete HiAP projects were also highlighted as potential activities that could contribute towards this goal.

These goals are interrelated, and the findings allow us to propose a set of key elements and priorities to consider in laying the foundations of the network.

Promising practices relating to HiAP knowledge exchange and capacity building

A first important observation regarding HiAP knowledge was the need to initially work on clarifying key concepts. Although many participants cautioned against spending too much time on conceptual debates, most insisted that the clarification of concepts is an unavoidable step in the process of reaching a shared understanding of HiAP, a necessary stepping stone to establishing the basis for knowledge exchange and capacity building. For this purpose, most participants suggested being inclusive and considering other ways of framing initiatives or approaches that fall under the larger HiAP umbrella. This would mean stepping away from public health jargon and accepting and integrating other sectors' frameworks and ways of working.

Importance of fostering exchanges between members

Most participants deplored the fact that they had few opportunities to exchange and learn from each other about HiAP. They were looking to develop trusting relationships, alliances and collaborations for projects, and to troubleshoot with others. Therefore, participants manifested a significant interest in a network that would facilitate and foster these exchanges. They argued that people want to hear success stories, talk to people "who have done it," consult with experienced HiAP champions, showcase their work and be able to take leadership roles to champion the approach.

Promising practices in terms of network management and engagement with members

The consultation provided important and practical elements to consider relating to network management and member engagement. Guaranteeing a strong secretariat and securing funding for coordination seem essential to the network's success and sustainability. Concerning type and size of membership, some participants thought it would be wiser to start with a small group of mainly public health actors and members of academia in order to better define existing needs and the steps to be taken, to avoid debating these issues in front of a larger audience. However, most participants wished for a diverse and intersectoral membership. Nevertheless, different strategies for achieving this were proposed, the most common being to opt for a gradual rollout of the network, which integrates diverse actors in stages. The main objective should be to keep the network manageable and the goals realistic. This inevitably will require giving careful thought to the size and composition of the membership. Structure and governance possibilities were also discussed, with participants strongly sharing the idea that the structure and governance should reflect Canada's various contexts (geographical, jurisdictional) and cultural diversity. Another largely agreed upon principle was that special attention should be paid to the inclusion of First Nations, Inuit and Métis perspectives, and this should be done from the network's inception.

Maintaining member engagement was probably seen as one of the most critical matters after recruitment. Catering to a potentially large variety of interests, capabilities and experiences as well as to jurisdictional, geographical, time zone, language and cultural differences, was seen as challenging. Potential solutions aimed at keeping members engaged were suggested, such as creating chapters or nodes (e.g., related to certain themes, jurisdictional levels, geographical regions) that could result in higher member satisfaction. Other strategies suggested by participants included being and remaining relevant to them. This will involve ensuring that the coordination team knows members well so it can provide them with incentives such as opportunities for showcasing their work, creating partnerships, working on concrete projects, playing meaningful roles within the network, and accessing relevant and cutting-edge resources (content and tools) useful to HiAP implementation.

Potential members' contributions to the CNHiAP

While this question was not explicitly addressed to the participants, many spontaneously expressed how they could contribute to the network. For instance, academics suggested they could collaborate through interventional research or HIA, supporting specific projects, and building research partnerships. Some participants expressed wanting to take a leadership role in a specific chapter or project. Also, most people interviewed viewed their expertise as complementary to that of others, acknowledging HiAP requires a diverse set of know-how and knowledge*,* that is obtained, notably, by learning from people who have implemented HiAP or similar approaches. It is the combination of this diversity and the synergies that can be created what will constitute the richness and value of the network.

Implications and next steps

The findings of the consultation with key HiAP actors from public health, academia and non-governmental organizations confirm that there is a need for a HiAP network. It also confirms there is interest from the people working in this area in being part of an intersectoral HiAP network in Canada. This need, initially discussed as an area of action during the Canadian meeting on HiAP in October 2019, has now been articulated as a series of visions, expectations and potential activities that can inform and guide the foundational principles of a CNHiAP.

The main task now is to translate all these visions into the terms of reference that will lay the foundation for the network. It is important to reflect, given the diversity of expectations, on the scope of the network. Careful thought needs to be given to how to formulate a vision and a mission that can encompass the broader and more long-term goals identified, while having realistic and pragmatic short-term goals, specific objectives and sustainable activities. This will also directly impact decisions regarding the network's structure, governance and management. It is also important to note that, while a strong foundation is required to support the launch of this project, some flexibility and creativity will be required along the way to adapt to the potential network's growth and changing priorities, and to negotiate priorities with different interested parties while remaining relevant to members.

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Appendix 1

Context presented to Canadian participants

Context and information on the consultation process

National Collaborating Centre for Healthy Public Policy
Fall 2021

Context

In October 2019, the National Collaborating Centre for Healthy Public Policy (NCCHPP) organized a pan-Canadian meeting on Health in All Policies (HiAP) in partnership with the Public Health Agency of Canada (PHAC) and Québec's ministère de la Santé et des Services sociaux. This meeting brought together 25 participants affiliated with federal and provincial governments, regional health authorities, Indigenous organizations, and universities from across Canada. The pan-Canadian meeting confirmed the interest in HiAP as a promising approach to improving population health and health equity in Canada, and the desire of participants to continue sharing knowledge and experience on the subject. In order to support the implementation of the HiAP approach in Canada, three key areas for action were identified during the meeting:

- Build the evidence base to support capacity building and implementation;
- Lay the groundwork for a common understanding of HiAP across sectors;
- Launch an intersectoral HiAP network for Canada (CNHiAP).

Building on the recommendations and interests expressed during the pan-Canadian meeting on HiAP, and considering the opportunities that HiAP can offer during the COVID-19 recovery period in Canada, for addressing the inequalities exacerbated by the pandemic and for promoting population health, the NCCHPP has partnered with PHAC to develop and launch a Canadian Network for Health in All Policies (CNHiAP).

The first step in achieving this was to explore the operating conditions of similar networks in Canada and internationally to help map out possible options for the CNHiAP. This work identified opportunities and challenges for the CNHiAP, led to the proposal of options for the CNHiAP (i.e., regarding its form, membership, purpose), and provided a set of questions to guide discussions concerning its development. In order to complete this initial step, the NCCHPP will conduct interviews with key stakeholders or key informants to learn more about their perceptions of best practices in terms of network management and also their perceptions of the needs of target network members.

The objective of these interviews is to increase our understanding of the following dimensions, based on key informants' perspectives:

1. Promising practices in terms of network management and engagement with members;
2. Promising practices in terms of HiAP knowledge exchange and capacity building;
3. Added value and utility of a CNHiAP;
4. Potential objectives, scope and activities for the CNHiAP;
5. Potential contributions to the CNHiAP.

Information on the consultation process

You are invited to participate in an interview to be conducted by the NCCHPP team via Zoom or Teams **that should take around 60 minutes.** Questions are included in this document to allow for preparation time. If possible, the interviews will be recorded to facilitate note-taking, data analysis of the collected information, and reporting. The final summary report and any other publications will be anonymized to ensure participants' confidentiality. The recordings will be destroyed and any individualized notes will be filed confidentially once the report is completed. Interviews will be conducted in English or French as appropriate. Within a few days of the interview, the interviewer will send you a synthesis of the interview for validation and, if needed, for the addition of further information that you might judge relevant. We will gladly share our final summary report with you upon request.

Appendix 2

Context presented to participants from the Global Network

Consultations of Key Players Involved in Knowledge Exchange for Health in All Policies Within the Global Network for Health in All Policies

National Collaborating Centre for Healthy Public Policy
Fall 2021

Context

In October 2019, the National Collaborating Centre for Healthy Public Policy (NCCHPP) organized a pan-Canadian meeting on Health in All Policies (HiAP) in partnership with the Public Health Agency of Canada (PHAC) and Québec's ministère de la Santé et des Services sociaux. This meeting brought together 25 participants affiliated with federal and provincial governments, regional health authorities, Indigenous organizations, and universities from across Canada. The pan-Canadian meeting confirmed the interest in HiAP as a promising approach to improving population health and health equity in Canada, and the desire of participants to continue sharing knowledge and experience on the subject. In order to support the implementation of the HiAP approach in Canada, three key areas for action were identified during the meeting:

- Build the evidence base to support capacity building and implementation
- Lay the groundwork for a common understanding of HiAP across sectors
- Launch an intersectoral HiAP network for Canada (CNHiAP).

Building on the recommendations and interests expressed during the pan-Canadian meeting on HiAP, and considering the opportunities that HiAP can offer during the COVID-19 recovery period in Canada, for addressing the inequalities exacerbated by the pandemic and for promoting population health, the NCCHPP has partnered with PHAC to develop and launch a Canadian Network for Health in All Policies (CNHiAP).

The first step in achieving this was to explore the operating conditions of similar networks in Canada and internationally to help map out possible options for the CNHiAP. This work identified opportunities and challenges for the CNHiAP, led to the proposal of options for the CNHiAP (i.e., regarding its form, membership, purpose), and provided a set of questions to guide discussions concerning its development. In order to complete this initial step, the NCCHPP will conduct interviews with key stakeholders or key informants to learn more about their perceptions of best practices in terms of network management and also their perceptions of the needs of target network members.

The objective of these interviews is to increase our understanding of the following dimensions, based on key informants' perspectives:

1. Promising practices in terms of network management and engagement with members;
2. Promising practices in terms of HiAP knowledge exchange and capacity building;
3. Added value and utility of a CNHiAP (for instance in terms of needs or problems encountered that justify the creation of a CNHiAP);
4. Potential objectives, scope and activities for the CNHiAP;
5. Potential contributions to the CNHiAP.

Information on the consultation process

You are invited to participate in an interview to be conducted by the NCCHPP team via Zoom or Teams **that should take around 60 minutes.** Questions are included in this document to allow for preparation time. If possible, the interviews will be recorded to facilitate note-taking, data analysis of the collected information, and reporting. The final summary report and any other publications will be anonymized to ensure participants' confidentiality. The recordings will be destroyed and any individualized notes will be filed confidentially once the report is completed. Interviews will be conducted in English or French as appropriate. Within a few days of the interview, the interviewer will send you a synthesis of the interview for validation and, if needed, for the addition of further information that you might judge relevant. We will gladly share our final summary report with you upon request.

Appendix 3

Question grid for Canadian stakeholders with experience or interest in HiAP or intersectoral actions for health

Consultations with Canadian stakeholders

Name	
Position	
Organization	

Objectives and added value of the network
1. Do you think that there is a need for a CNHiAP? If so, what do you think its utility or the added value of a CNHiAP in supporting and advancing HiAP practice in Canada would be?
2. In your opinion, what would be needed to support HiAP uptake in Canada, and how could a Canadian Network for HiAP contribute?
3. What might the goals, objectives or focus (advocacy, capacity building, knowledge exchange, etc.) of this network be?
4. If you have already implemented a HiAP approach Speaking from the experience **of having already implemented a HiAP** approach in your jurisdiction, what would be the added value of your participation in this network? Would you be looking for any kind of support from the CNHiAP? **Or** Speaking from the experience of **having implemented intersectoral actions to advance health in your jurisdiction,** what would be the added value of your participation in this network?
5. What type of activities do you think would have the best return on investment for the network?
Challenges and opportunities in the Canadian context
6. What, if any, challenges do you see for a CNHiAP that includes a diverse membership from health/public health sectors at the federal, provincial, territorial, local/regional, as well as Indigenous governmental levels and from academia?
7. What, if any, opportunities do you see with a CNHiAP that includes a diverse membership from health/public health sectors at the federal, provincial, territorial, local/regional, as well as Indigenous governmental levels and from academia?
Membership
8. What type of stakeholders should be targeted as members of the CNHiAP?
9. Should the network include members from sectors outside of health and public health? If so, which sectors should we prioritize? If not, why not?
Considerations for Indigenous organizations
10. What would be required of a CNHiAP to be appropriate, respectful, and useful for Indigenous organizations?
HiAP capacity building and knowledge sharing
11. Based on your experience in the HiAP field, are there any specific opportunities or challenges that we should be thinking about in terms of HiAP knowledge sharing and capacity building?
Final comments
12. Do you have any advice for us as we design a CNHiAP?
13. Is there any other information that you wish to share or advice that you wish to give regarding the CNHiAP?
14. May we contact you in the future for additional input to inform the development of the CNHiAP?

Appendix 4

Question grid for Canadian stakeholders with experience in launch and management of a network

Interview questions for Canadian networks' members

Name	
Position	
Organization	

Objectives and added value of the network
1. How did you decide to create a network?
2. How and why did you decide on the composition of the network's membership?
3. Do you have an evaluation or assessment plan to measure the network's impact, performance, or outcomes?
4. How is your network ensuring its sustainability?
Membership, member engagement and retention
5. What type of network structure allows for good engagement with members?
6. What enables or hinders the attraction and retention of members?
7. What could be the challenges of a CNHiAP that includes a diverse membership (i.e. from health/public health sectors at the federal, provincial, territorial, local/regional, as well as Indigenous governmental levels and from universities)?
8. What could be the opportunities of a CNHiAP that includes a diverse membership (i.e. from health/public health sectors at the federal, provincial, territorial, local/regional, as well as Indigenous governmental levels and from universities)?
Network management and activities
9. What enables or hinders the network's activities?
10. What type of activities have proven to be the most effective in engaging members?
11. What have been the most challenging and/or facilitating factors for your network?
12. Knowing what you know now, what would you do differently if you were to establish a (the?) network today?
13. Knowing what you know now, what would you do the same (in retrospect, what were the good ideas, practices, etc. that we should try to learn from and build on)?
Considerations for Indigenous organizations
14. What would be required of a CNHiAP to be appropriate, respectful, and useful for Indigenous organizations?
Final comments
15. Do you have any advice for us as we design a CNHiAP?
16. Is there any additional information that you wish to share or advice that you wish to give regarding the CNHiAP?
17. Would you agree to be contacted in the future to provide additional input to inform the development of the CNHiAP?

Appendix 5

Question grid for Global Network members

Interview questions for Global Network members

Name	
Position	
Organization	
Role in the Network	

Reasons for joining the network and added value
1. For founding members: How and why did the founding members of the GNHiAP decide on the composition of the GNHiAP membership?
2. What do you think is the added value of the network for your jurisdiction/organization and for its members more generally?
Member engagement and retention
3. What type of activities have proven to be the most effective in engaging GNHiAP members?
4. Is there anything that should be changed to ensure member engagement?
5. What enables or hinders the attraction and retention of members?
Network management and activities
6. How have you dealt with the diversity of contexts (levels of HiAP implementation, type of political systems, size of countries, type of organizations [academics, countries, WHO, etc.]) of members?
7. What have been the biggest challenges and facilitators for the GNHiAP?
8. For founding members: Knowing what you know now, what would you do differently if you were to establish a network today?
9. Knowing what you know now, what would you do the same (in retrospect, what were the good ideas, practices, etc. that we should try to learn from and build on)?
Impact and sustainability of the network
10. How are the impacts of the GNHiAP assessed in terms of concrete/tangible results such as target membership, knowledge exchange, engagement with other sectors, health governance/health equity, capacity building for HiAP?
11. Based on your experience with the GNHiAP, what factors are important to fostering its sustainability?
HiAP capacity building and knowledge sharing
12. Based on your experience in the HiAP field, are there any specific opportunities or constraints that we should be thinking about in terms of HiAP knowledge sharing and capacity building?
Final comments
13. Would you have any advice for us as we design and launch a CNHiAP?
14. Is there any other information that you wish to share or advice that you wish to share regarding GNHiAP?
15. Would you agree to be contacted in the future to provide additional input to inform the development of the CNHiAP?

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