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CITÉ-ID LIVING LAB

Gouvernance de la résilience urbaine

Urban resilience governance

Gobernanza de la resiliencia urbana

Executive summary of the study on the implementation of community action plans to fight COVID-19 in Greater Montreal

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In context

Past experience during the Ebola, SARS and Zika epidemics shows that communities actively engaged in finding solutions are better at cooperating to contain such crises. The World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the International Federation of Red Cross and Red Crescent Societies (IFRC) and the scientific community all recommend integrating communities into efforts to prevent and control the ongoing COVID-19 pandemic.

This report uses the 'whole-of-society' approach that recognizes the essential contribution of civic groups, community organizations and inter-organizational networks to crisis response. It also relies on a network-based crisis management approach that involves collaborative governance and multiple levels of resilience.

During the current pandemic, the COVID Quebec Fund funded by the Jarislowsky, Trottier, Molson, and Mirella and Lino Saputo Foundations has supported community action plans (CAPs) to fight COVID-19. Other funders supporting the CAPs include the Azrieli, Echo and J. Armand Bombardier Foundations, and the Jewish Community Foundation of Montreal. Funding for the CAPs was provided in two phases, from July 2020 to December 2021 in nine territories across Greater Montreal, and then from January to October 2021 in 26 territories. The CAP's objective was twofold: to support screening efforts, preventive measures and vaccination campaigns, and ensure an organized response to pandemic-related social issues. Local players in Greater Montreal, such as community, municipal and health network organizations (CIUSSS/CISSS and public health), were mobilized and brought together in these efforts.

To understand the CAPs' impact, the Foundation of Greater Montreal (FGM), which managed the COVID Quebec Fund, asked ENAP's Cité-ID LivingLab to study the initiative. Conducted in collaboration with the Montreal Regional Public Health Department (DRSP) and researchers from McGill University's Department of Epidemiology, the study uses both quantitative and qualitative methods to analyze the impact of CAPs in the fight against COVID-19 and the possibility of perpetuating the CAP model. The study has three distinct objectives.

The first objective is to understand the context of CAP governance, implementation and impact on organizations and collaborative dynamics. This analysis focuses on levers and barriers encountered during implementation, as well as the CAP's achievements. This helps assess to what extent the CAP served to strengthen the intra- and inter-organizational capacities of local actors.

The study's second objective is to determine the CAP intervention model's suitability for crisis response. This involves identifying conditions that favour or limit its sustainability, and extracting lessons learned by participating organizations that might help other communities wishing to reproduce the CAP model.

To meet these first two objectives, eight of the 26 Greater Montreal CAPs funded in the COVID Quebec Fund's second phase were selected to represent a diversity of territorial scales, CIUSSS/CISSS and organizations. Data collection took place from April to November 2021, in a total of 123 data collection activities: focus groups, non-participant observation, semi-structured individual interviews and reflexive workshops.

The third objective concerns the impact of CAP activities on the main indicators monitored during the COVID-19 pandemic. This quantitative analysis was carried out in collaboration with the Montreal Regional Public Health Department (DRSP) and researchers from McGill University's Department of Epidemiology. The data, collected by three regional public health departments (Montreal, Laval, Montérégie), covers 133 neighbourhoods.

Impacts of CAPs on pandemic monitoring indicators

Seven indicators were selected to quantitatively measure the impact of CAP activities: the number of positive cases, the number of screening tests, the number of positive cases after screening, the number of hospitalizations, the number of deaths

and the number of first and second doses of vaccine administered. The objective was to trace how these indicators evolved in the different territories under study (Montreal, Laval, and Longueuil), compare indicators between communities according to the number of funded CAP phases in each, and explore the relationship between CAP interventions and these indicators.

Results show that the indicators follow upward or downward trends through the different waves of the pandemic in Quebec and the deployment of vaccination campaigns. When we compare indicators according to the CAP funding a community received (funding over none, one or two phases), we find that the number of screening tests increases earlier in funded than in unfunded territories. Results also show that, although funded communities record low rates of vaccination at the start of the campaign, the trend reverses and record high rates of vaccination are achieved in August and September 2021. The analysis does not enable us to conclude that CAPs are the sole cause of the differences observed, or to estimate what these trends would have been without CAP implementation. Analyses do, however, confirm the selection of communities prioritized by the Quebec COVID Fund.

Origin and objectives of CAPs

The model was inspired by international community engagement initiatives during health crises and by WHO recommendations. The CAP financed the coordination and implementation of concerted actions involving community organizations, municipalities, the health system and other sectors in a given territory (neighbourhood, borough, municipality, metropolitan area).

During the first round of CAP funding, the main objective was to curb the transmission of COVID-19. Goals then expanded to include protecting people at high risk of mortality and supporting the vaccination campaign.

In all, 26 CAPs were implemented across Greater Montreal. The nine CAPs funded in the first phase (summer 2020 to December 2020) focused on territories most affected by the pandemic. The second phase began between January and April 2021 and ended between August and October 2021.

Actions aimed at preventing infection (i.e. distribution of masks), detecting cases, supporting people while sick (i.e. help during quarantine, mental health supports), raising awareness of preventive measures, screening, vaccination, providing support for testing and vaccination (i.e. transportation), as well as support for seniors and people at risk.

According to data collected by the CAPs, awareness activities reached more than 490,000 people in Montreal, Laval and Longueuil by the end of the two funding phases.

We were not able to gather the data necessary to explore links between CAP interventions and the COVID-19 indicators. Our analysis emphasizes the need for digital infrastructure that would enable a shared view and joint management of data in order to strengthen capacities for coordination among organizations in terms of intervention and monitoring.

Results of CAPs on the capacities within and between organizations

The analysis of pre-existing levers and barriers during implementation shows that the CAPs improved the intra- and inter-organizational capacities of participating local actors. The improvement was greatest in community organizations, but was also seen in municipal and health sector organizations.

Levers and pre-existing barriers

The pre-existing levers and barriers correspond to starting conditions for CAP implementation.

Organizations experienced the beginnings of the pandemic differently. Some had difficulty coping with increased needs and shifting priorities, while others adapted fluidly. The ability to adapt was based on quality human resources, as well as know-how (i.e. management experience, knowledge of issues and population needs, experience in leading awareness campaigns) and interpersonal skills for carrying out projects (relational skills with users, bond of trust with the public, commitment, versatility, leadership, ability to work under

pressure, sense of belonging to a local neighbourhood).

Generally, organizations had to deal with significant obstacles. Many were weakened due to the exhaustion of human resources. In addition, community organizations suffer from chronic underfunding and their resources are stretched thin. Staff recruitment and retention issues were frequently raised.

Finally, territories that benefited from levers such as a good history of collaboration and permanent funded coordination mechanisms were able to put CAP actions in place more quickly. In communities with fewer such levers, CAPs enabled the development of new collaborative practices.

Intra-organizational capacities during CAPs

Results show that the CAPs initially contributed by providing financial, human and material resources to existing organizations. Funding also allowed organizations to enhance their services and add paid hours for staff, and alleviated financial stress. The extension of funding for the maintenance of certain activities enabled them to adapt to the pandemic reality.

The Quebec COVID Fund also made shared resources available to community organizations to support their interventions. Examples include the support provided by the Canadian Red Cross and the Co-Vivre program, the collection of data via the KoBo tool, and the facilitation of communities of practice.

With regards to obstacles, funding was granted on the basis of planned actions and the human resources these would require, but was often insufficient, as the efforts involved regularly turned out to be greater than anticipated. In addition, the limited duration of the funding, and its unpredictability undermined organizations' planning capacities.

Inter-organizational capacities in the CAPs

The CAPs contributed to increasing five categories of inter-organizational capacities. First, they supported the responsiveness of public and community organizations to deal with the health crisis. Second, they contributed to a larger, better adapted and more effective response by recognizing the mutual interdependence of the actors involved. The initiative facilitated the pooling of data and sharing of resources, and led to a better alignment of the approaches, actions, and expertise of organizations. The CAPs also increased the ability to anticipate population needs through the involvement of a variety of actors. In addition, this plurality of perspectives promoted the ability to identify new solutions. Finally, the CAPs helped consolidate capacity for inter-organizational collaboration through the development of common, shared understanding; the strengthening of bonds of trust between actors; and the achievement of intermediate results or quick wins.

Conclusion

The results show that the CAPs enabled a majority of organizations to improve existing services (often for vulnerable populations), develop new services or intervention practices, especially with regards to COVID-19 prevention, and enhance collaboration. Finally, the funding enabled organizations to hire additional human resources to meet the needs arising from the crisis and develop new partnerships, thus ensuring that organizations could promote awareness among other organizations of their particular mission and contributions.

Collaborative governance and CAP

As an initiative bringing together several types of organization for concerted action at local level during a crisis, CAPs had to rely on collaborative processes. The study examined the types of governance adopted by CAPs in order to draw lessons for the future. Collaborative processes were analyzed based on three sets of considerations (Ansell and Gash, 2007) :

1. Starting conditions between organizations: power relationship, sharing of resources, motivations for and constraints on participation, and history of cooperation or conflict.

2. Structure of the collaboration: criteria for including and excluding organizations, clarity of operating rules, and transparency of the process.

3. Exercise of facilitative leadership: actor with role of guardian of the collaborative process to ensure efficient implementation.

Community organizations	Organizations public	Capacity consultation	Donors public/philanthropic	Elected
Intervening on the issues of the territory Having developed a relationship of trust with the population and other organizations With recognized expertise Being adequately funded (mission, project and participation in concerted actions)	Committed to local consultation Long-standing partners for the realization of concerted actions Performing various roles: public service provider, funder, coordinator, facilitator, collaborator, mobilizer, etc.)	Between community and public organizations Detectable by presence: mechanisms for sectoral and intersectoral consultation, strategic planning, action plans, concerted actions, etc. Recognition of the complementarity of approaches and mutual interdependence	Working in synergy (among themselves and with other actors, especially those from the community) In order to maximize the consistency of funding programs and reporting methods	Demonstrating a political will to put local issues on the agenda Supporting inter-organizational collaborative work with public policy development

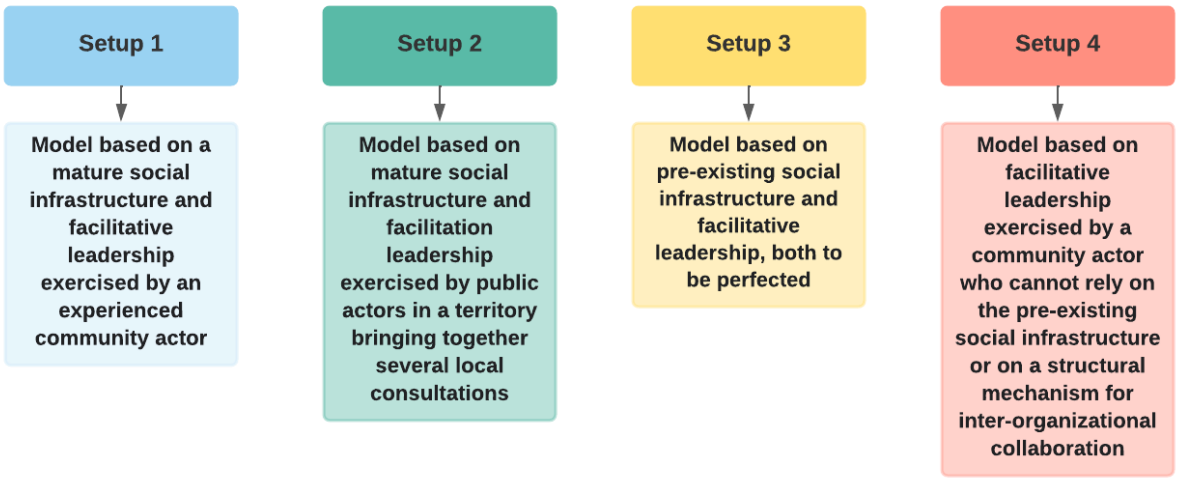
Although the structure appears similar from one CAP to another, notably because of funding criteria, the same cannot be said for starting conditions and facilitative leadership.

This analysis allows us to identify four governance models. The typology is based on two factors: the existence of a mature social infrastructure in the community before the crisis (see Table 1), and the type of facilitative leadership exercised by public or community actors.

Figure 1 shows the four configurations of the collaborative governance model. These configurations are important to consider because they explain the level of ease or difficulty involved in implementing the CAPs depending on the environment in which they were deployed. The trajectories experienced by each CAP vary according to the configuration observed.

Communities with mature social infrastructure and pre-crisis facilitative leadership capacity (configurations 1 and 2) had a head start in dealing with the COVID-19 pandemic. The CAPs allowed them to intensify collaboration and activate a collective response to the health crisis more quickly. In communities with less social infrastructure and leadership capacity (configurations 3 and 4), the CAPs instead contributed to the development of inter-organizational collaboration.

Diagram 1: Typology of the governance model



A model for responding to emergencies

According to the representatives of public and community organizations in the CAPs studied, this intervention model made it possible to respond to the complex challenges of the health crisis. First, local collaboration between organizations fostered the broad and active participation of a variety of actors. From a strategic point of view, the main actors were a community actor acting as guardian and facilitative leader, as well as municipal and health sector actors (CIUSSS/CISSS). Implementation of the CAPs relied on other actors, including numerous community organizations and volunteers from the general public.

Finally, results show that the inter-organizational collaborative approach used intensively over recent months in the CAPs enabled effective crisis responses, but also that the capacities developed can be used later during recovery, as well as more generally for the development of community resilience.

Conditions for sustaining the model

One important lever for sustainability is the collaborative experience gained by local actors participating in the CAPs, which leads to the development of new organizational relationships and increased trust.

In addition, local municipal and health authorities, as well as community organizations, believe that the CAP model works well and should be mobilized again for future crises. Actors' willingness to pursue implementation of the model can serve as a lever. For some CAPs studied, the model's sustainability depends on anchoring it within existing public policies, such as the regional social development policies of municipal actors or institutional recovery plans. Another lever is found in the collective learning accumulated and evident in mid-term and final CAP reports.

Finally, the establishment of a coordinating body that brings together public and philanthropic funders supporting social action (through the development of coherent, harmonized funding programs and accountability procedures) appears as a key lever for the sustainability of the CAP model.

Among the obstacles to sustainability, one crucial barrier pertains to the end of CAP, which means contracts are not renewed for employees hired within the program and may lead to professional burnout as working conditions deteriorate. The implementation of actions or projects becomes more

difficult in the absence of continued funding. This situation can also erode collaborative ties and joint organizational responses, at least in terms of health crisis management.

Eight observations on the implementation of CAPs

1. A mature social infrastructure increases multi-level resilience

The results of the study show that a mature social infrastructure at local level (Table 1) increases multilevel resilience, i.e. the resilience of organizations, collaborative networks and communities. Resilience makes it possible to better cope with crises. The more mature the pre-existing social infrastructure, the more local actors can react quickly and in a concerted manner to problems that arise or are exacerbated by crises.

In the context of an increase in the number and consequences of crises worldwide, the development of a mature social infrastructure will improve the ability to cope with shocks and stresses at local level.

2. The community approach increases community resilience

The alignment between municipal and health authorities at local level and the CAPs' model of mobilizing community organizations traditionally excluded from crisis management contributes to:

• better ways of dealing with social problems generated or exacerbated by the pandemic;

• the development of interventions adapted to different populations, for example for screening and vaccination.

In addition, the proximity of community organizations to local populations and the trust they enjoy, give them capacities that complement public bodies. For example, they are better able to reach vulnerable people and understand their needs.

Finally, inviting community organizations to participate in health crisis management alongside public authorities increases the capacity for coordination to enhance community resilience.

3. A collaborative governance model at local level increases inter-organizational resilience

Our results show that a collaborative governance model at local level makes it possible to develop and strengthen inter-organizational resilience, which promotes concerted and coordinated crisis management.

At the heart of this model we find a collaborative process, which depends on:

• the quality of communication between the actors,

• the trust they place in each other,

• their level of commitment,

• the establishment of a common, shared understanding of the issues,

• their ability to collectively determine courses of action,

• their ability to work together to implement them,

• and the achievement of rapid intermediate results (quick wins).

4. The exercise of collaborative leadership is key to operating this model

Collaborative leadership, which corresponds to facilitative leadership (custodian of the collaborative process and its optimization) and distributed leadership (distribution and coordination of roles among the actors involved) has proven to be a decisive factor in operationalizing and implementing CAPs. Collaborative leadership promotes:

• broad and active participation,

• productive group dynamics,

• common, shared understanding,

• establishment of priorities for action,

• achievement of results,

• conflict resolution,

• implementation of the collaborative process,

• mobilization and empowerment of stakeholders,

• mutual trust, and

• complementarity of the roles of various actors.

5. Funding contributes to increasing intra-organizational and inter-organizational resilience

CAPs contribute to the development of key intra-organizational capacities by by providing new resources:

• human: hiring staff to improve the services offered and develop new knowledge.

• material: acquiring information technology and personal protection equipment.

• informational: training, participation and support from the Canadian Red Cross, the CoVivre program, and the community of practice of the FGM and Philanthropic Foundations Canada, along with increased organizational capacities for coordination in emergency situations and training on vaccine hesitancy.

CAPs also foster the development of five categories of inter-organizational capacity:

1. Capacity for collective responsiveness

2. Response and intervention capacity

3. Ability to anticipate

4. Capacity for innovation

5. Collective capacity to take action

6. Community organizations' lack of resources limits their internal resilience

Current project funding practices are criticized for several reasons. First, they impede the retention of trained staff once the project is finished, as well as staff recruitment. The current labour shortage complicates these issues.

In terms of material and informational resources, the pandemic reveals the importance of computer equipment and access to information systems to make informed decisions.

To prepare for future crises and develop the organizational resilience of community actors, some are recommending public and philanthropic funding programs to support the digital transformation, the purchase of IT equipment and the training of staff.

7. Perpetuating the community approach beyond the crisis would enable the consolidation of multi-level resilience

The scientific literature underlines the tendency of organizations to return to siloed management after a crisis, while what is needed is the design and deployment of concerted recovery plans.

Public, community, philanthropic, academic and Canadian Red Cross players express a collective desire to pursue the community approach and inter-organizational collaboration. They emphasize the importance of rebuilding communities that are stronger and less vulnerable to crises in addition to strengthening their resilience.

Five reasons justify this perspective:

1. The pandemic is not yet over. Concerted action is still needed to address its impact on vulnerable communities and individuals.

2. The crisis has highlighted and exacerbated existing, complex social issues that require concerted and collaborative interventions by local actors. The work to be done in these areas is greater than it was before the pandemic.

3. Local communities face more frequent crises of various kinds (natural disasters due to climate change, crime, etc.). This trend is not about to reverse and requires further development of local resilience.

4. The resilience of territories is based on several levers, including the ability of actors to collaborate and act in a concerted manner.

5. The CAP approach not only achieves results during a crisis, but also develops links and capacities useful for the recovery of communities.

Perpetuation of the community approach calls for consideration of the conditions required for its sustainability.

Beyond the willingness of local actors to pursue this approach, several issues require some thought. What institutional design would be best for the model? At what scale(s) should the model be enacted (neighbourhood, borough, metropolitan area and/or city)? Is it desirable to link the model to existing policies, programs and plans of public institutions? Which actors should be called upon to exercise facilitative leadership, and in particular the facilitation and coordination of the collaborative process? How does the model take into account the complexities of community dynamics and local histories of collaboration, conflict and power relations? Who is responsible for funding the model? These questions illustrate the complexity of sustaining collaborative governance based on the community approach and the need to co-construct it with public, community and philanthropic actors on each territory.

Recommendations from the research team

Based on the results of our study, the research team makes seven recommendations:

(1). Provide communities with a permanent mechanism to operationalize the CAP model with a mandate to co-produce and coordinate the community recovery from COVID-19 and strengthen local resilience. This mechanism should anticipate use of the model during other types of crises, such as natural disasters or the disruption of major infrastructure.

• Existing structures sometimes already perform these functions. In this case, they should work to include community organizations participating in the CAPs, as they have generally been excluded from crisis management.

(2). Invite public, municipal and health authorities, community organizations, philanthropic and academic actors, and representatives of the Canadian Red Cross to work jointly within the spheres of civil security, emergency measures, social development and public health to participate in this mechanism. In crisis situations, vulnerable populations are always hardest hit.

• Consider including the broader public as well as vulnerable populations in governance and entrusting them with an active role in co-constructing policies and interventions.

(3). Reflect on the institutional anchoring of the mechanism in order to promote its sustainability, on the levels of intervention and their alignment.

• At the meso scale (city or metropolitan area), municipalities are probably the best placed to exercise facilitative leadership in collaboration with the CISSS/CIUSSS, especially with regards to facilitation and coordination.

• At the micro level (neighbourhood or borough), facilitative leadership benefits from being exercised by a recognized and experienced community organization, on condition that funding is attached to this responsibility. This leadership must be exercised in collaboration with municipal and local health authorities so that collaborative governance is institutionally anchored.

• Ensure that the meso and micro scales of the governance mechanisms are aligned not only with each other, but also with the macro scale corresponding to other levels of government.

(4). Base the mechanism that will operationalize the model on the following principles: openness to a wide range and diversity of actors; equal participation by actors; mutual respect; relevance and usefulness; transparency of the collaborative process and recognition of actors' mutual interdependence and contributions.

(5). Allocate resources (human, financial, material and cognitive) to facilitative leadership (organizing and facilitating the model's operational mechanism), as well as to participating actors (especially those from the local community).

(6). Leave it to the community sector to decide the terms of their participation and initiate discussions with other actors on this subject.

(7). Given that the governance model of inter-organizational collaboration based on the community approach requires changes to public management so that the strategic contributions of all stakeholders affected by a complex issue are recognized and promoted, help public municipal and health administrators develop implementation mechanisms and begin with an awareness and training phase.

• Examples of implementation mechanisms include:

a. Establish a formal inter-organizational collaboration agreement between public, community, philanthropic and academic actors.

b. Set up a community of practice to disseminate best practices in the governance of inter-organizational collaboration and discuss problems encountered during implementation.

vs. Use evidence-based practice approaches to identify innovative solutions to problems encountered by actors in the field.

(8). In order to better document impacts and establish shared visions between organizations, create a dashboard and common platform for community groups, CISSS, CIUSSS, public health departments and municipal administrators, in order to:

• collect data on interventions, public health indicators and determinants of health;

• develop a common vision of a situation and the interventions deployed;

• support the development of local strategic planning on population issues;

• enable monitoring, evaluation and adjustment of interventions based on evidence;

• be used in times of crisis and beyond.

Study authors

The authors of the sections of this report on objectives 1 and 2 are: Geneviève Baril, Joris Arnaud, Julie-Maude Normandin, Myriam Bernet, Loïc Dumouchel, Claude Pilon, Ra-Ma St-Amand and Marie-Christine Therrien. Research on objective 3 of the study was carried out by the Cité-ID team and researchers from the Regional Public Health Department of Montreal (Direction régionale de la santé publique de Montréal) and the McGill Department of Epidemiology. The authors are: Siriac Seboka, Joris Arnaud, Marie-Christine Therrien, Félix Lamothe, Marie-Andrée Authier, David Kaiser, Arijit Nandi, Sam Harper and Holly Aurora Nazar.