Wageningen University - Social Sciences

MSc Thesis Chair Group Health and Society (HSO)

Sustainability of community-based health initiatives consisting of intersectoral collaborations

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Abstract

Background; Intersectoral collaborations are a commonly used and valued approach to tackle current public health issues and disparities. Different sectors working together is a complicated and complex process. There are accumulated insights in the field of health promotion about factors playing a role in the effectiveness of intersectoral collaborations. However, there is a lack of knowledge about the development of collaborations over longer period of time and how they are sustained.

Research aim; This resulted in the following research question; *What are the facilitating or hindering factors of sustainability of an intersectoral collaboration?* The aim of this research was to assess and analyse what the conditions are for making health initiatives consisting of intersectoral collaborations sustainable in the community.

Method; A qualitative multiple case study design has been chosen in order to retrieve in-depth knowledge about the intersectoral collaborations of health initiatives. This multiple case study used two qualitative methods; interviews and document analysis, and regarded a most different cases design. The data was collected from six selected Dutch community-based health initiatives, which was analysed on the basis of the factors of the Model of Sustainable Intersectoral Collaborations, particularly developed for this study.

Results; The cases showed similar results. The factors of the model were represented and indicated important. The following external factors were indicated to influence the collaborative process and as conditions for a sustainable intersectoral collaboration; the representation of relevant societal sectors, community involvement, management and funding. The following factors were indicated to be part of the collaborative process and as lessons for a sustainable intersectoral collaboration; trust building, shared mission, clear roles and responsibilities, intermediate outcomes and visibility, and commitment to the process.

Conclusion; All the factors of the Model of Sustainable Intersectoral Collaborations played a facilitating or hindering role for the sustainability of a health initiative consisting of an intersectoral collaboration, of which community involvement, trust building and intermediate outcomes and visibility played the most important role.

Keywords; *intersectoral collaboration, sustainability, health initiative, Model of Sustainable Intersectoral Collaborations, MSIC, multiple case study*

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List of abbreviations

RVS — Raad voor Volksgezondheid & Samenleving

NPP — National Programme Prevention

AAH — All About Health… (Alles is Gezondheid…)

WHO — World Health Organisation

HiAP — Health in All Policies

WoS — Whole of Society approach

HALL — Healthy ALLiances

MSIC — Model of Sustainable Intersectoral Collaborations

WUR — Wageningen University & Research

1. Introduction

1.1 Intersectoral collaborations

In the recent years, a development of public-private partnerships and multiple stakeholder initiatives manifested in order to tackle public health issues (Mark, 2019). Health promotion theory and practice has shifted its focus from policies and individual behaviour change towards advocating engagement and partner building (Dixon, Sindall, & Banwell, 2004). The increase of chronic diseases demanded a different approach, shifting the focus to a community and organisations level (Held, Hawe, Roberts, Conte & Riley, 2020; Koelen, Vaandrager, & Wagemakers, 2008). An approach where organisations from different sectors are working together to achieve health promotion goals, which otherwise often would not be accomplish independently or alone (Held et al., 2020; Jones and Barry, 2018; Koelen et al., 2008). This is needed because the causes of chronic diseases are often multidimensional and an organisation alone does not have the resources to tackle the complex health issues (Koelen et al., 2008). This way of health promotion emphasises the importance of working with other domains beyond the health care sector, in order to improve the public health (Corbin et al., 2018; Corbin, 2017; Peters et al., 2016; Dixon et al., 2004).

Working together with partners from domains outside the health care sector allows to address underlying causes of public health issues, conditions, and health disparities (Corbin, 2017). Such as socioeconomic inequality, being underlying condition for certain chronic diseases. During the last decade in the Netherlands, but also in other western countries, health disparities have grown, as stated by the Council for Public Health and Society (Raad voor Volksgezondheid & Samenleving) [RVS] (2020). The RVS also indicates that health policies focus too much on the individual and there is the need for a broader view. Health disparities are shown to arise for a large part from factors outside the health care domain, such as working and living conditions (RVS, 2020; Corbin et al., 2017). These conditions are shaped by people's living environment, where they are born, grow, live, work and age, which are in turn shaped by distributions of money, power and resources. Economic, political and social factors like education, income and social position play an important role in people's experienced health, development of health, access to health and health inequalities (Macaulay, Mazzei, Roy, Teasdale, & Donaldson, 2018; Bartley, 2016; Wilkinson and Marmot, 2005). These factors can also be indicated as the social determinants of health, which makes collaborative effort of different domains a key strategy in health promotion (Jones and Barrry, 2018; Corbin, 2017).

Collaborative effort of different domains includes organisations of different sectors. For clarification an example will be given regarding a fictional collaboration to address overweight in a community. A health promoting institution, funded by the government, initiated a lifestyle project. Volunteers of the local community centre offer food coaches and workshops. The centre is funded by the municipality from the public sector. Additionally, a company from the private sector, in this case a local supermarket, participates by offering healthy food. Lastly, the local physician of the health care sector refers community members to the project. These kinds of collaborations between different sectors are already often taking place in the Netherlands, which will be elaborated on later. This so-called intersectoral approach is indicated to be capable of improving the ways of tackling the current public health issues and especially health disparities (RVS, 2020, Corbin et al., 2017).

Working with multiple sectors can be considered as an intersectoral collaboration, which can be defined as; organisations (also referred to as partners) engaging in an agreement (partnership) to work synergistically towards a common envisioned goal beyond their own scope of activity (Seaton et al., 2018). Synergy entails the degree to which this partnership will combine complementary strengths, perspectives, values and resources of all participating partners to achieve better outcomes (Jones and Barry, 2011). Intersectoral collaborations of organisations are a commonly used and valued approach to tackle public health challenges (Gebo and Bond, 2020; Held et al., 2020; Stolp et al., 2017). Therefore, it is considered and indicated as an important way to promote health, as it became integral part of health promotion practice and research (Christensen, Burau, & Ledderer,

2018; Corbin, Jones, & Barry, 2018; Seaton et al., 2018; Jones and Barrry, 2018; Stolp et al., 2017; Jones and Barry, 2011).

1.2 The complexity of intersectoral collaborations

Different sectors working together is a complicated and complex process, as they differ in organisational structures, agendas and resources, making collaborations challenging (Gebo and Bond, 2020; Stolp et al., 2017; Naaldenberg et al., 2009). Research has focused on investigating this intersectoral collaboration complexity, in order to gain knowledge on what facilitates and hinders collaborations in health promotion interventions (Christenen et al., 2018). Currently, there are accumulated insights in the field of health promotion about factors playing a role in the effectiveness of intersectoral collaborations (Held et al., 2020). This includes factors like trust and leadership, which were presented in multiple studies to be important predictors of intersectoral collaborative functioning (Stolp et al., 2017; Jones and Barry, 2011). However, within the field, there still remains little consensus about these factors (Stolp et al., 2017), and future research should carry on investigating factors indicated to facilitate or hinder collaborations (Seaton et al., 2018).

In addition, there is a need for more in-depth studies covering the interactions among people and organisations involved in an intersectoral collaboration in health promotion (Christensen et al., 2018; Corbin et al., 2018). It is important to study the relationships between organisations, to provide insights into the effectiveness of the intersectoral collaboration (Gebo and Bond, 2020). Next to the complexity of an intersectoral collaboration itself, it is also difficult to evaluate the effectiveness of health interventions due to the long-term scope and complex interconnectedness (Reumers et al., 2021).

The complexity also lies in the context, to what extent the outcomes of seemly effective health intervention evaluated in local community can be obtained in another context (community). The specific context plays an important role for evidence-based decision making. Practices show that sometimes it is mistakenly assumed that a health intervention, being effective in his own context, will have the same outcomes in another context (Schloemer and Schröder-Bäck, 2018). Therefore, basing health promotion on evidence-based decisions making is complicated. This so-called transferability of health interventions is rarely addressed in the literature and is an indication for need for further research (Schloemer and Schröder-Bäck, 2018).

Christensen (2018), Corbin et al. (2018) and Jones & Barry (2018) indicate there is a need for more empirical studies to provide additional detailed insights into how these intersectoral collaborations develop, interact and contribute to successful partnerships and outcomes. This includes more research on how to further develop scientific methods and monitor these kind of collaborations (Wold and Mittelmark, 2018; Hernandez-Aguado and Zaragoza, 2016; Bartley, 2016). This also includes the factors playing a role in collaborations, where the lacking consensus comes forth from the variation in conceptualisation and measurement of the factors. The development of a more consistent approach of this conceptualisation and measurement would strengthen the evaluations of health promotion collaborations. This could enable more advanced understanding of the ways to support and enhance collaborations, by being able to verify findings and understand the effects of factors at different stages of the intersectoral collaborations (Stolp et al., 2017).

Even though there is an increase of literature and knowledge about intersectoral collaborations, there is, as described, still a gap in verifying findings of these kind of collaborations in the field of health promotion (Hernandez-Aguado and Zaragoza, 2016). On the other hand, as also indicated by Gebo and Bond (2020) and Corbin et al. (2018), on the subject of intersectoral collaboration, it is interesting and important to integrate knowledge from other scientific fields, such as public administration and management on collaboration processes and elements. Within the field

of public administration, much research has been done on collaborative governance, which could be of help to fill this gap in the health promotion field.

1.3 Collaborative governance

The concept of collaborative governance is in line with intersectoral collaboration, being defined as a collective decision-making process based on interactions between two or more organisations that aim to achieve consensus for joint problem solving and value creation (Douglas et al., 2020a). It often involves crossing the boundaries of organisations to convey a public purpose like health promotion, what otherwise could not be accomplished (Ulibarri et al., 2020). The literature on collaborative governance, indicated as a related form of intersectoral collaboration, has enabled several models describing the conditions of collaborative performance (Douglas, Berthod, Groenleer, & Nederhand, 2020b). For example the Model of Collaborative Governance of Ansell and Gash (2008). The main variables of this model are; starting conditions, institutional design, leadership and collaborative process, which are the indicators for collaborative performance (divided into more specific variables). There is already much known about collaborative governance design, process and rationale (Ansell et al., 2020). However, there is a lack of knowledge about the development of collaborations over longer period of time and how they are sustained (Ulibarri et al., 2020). An explanation for this could be, as appeared from the research by Bekker, Helderman, Lecluijze, Jansen and Ruwaard (2016), that it can take five to ten years for partners to develop solid relationships within their collaboration, which entails that effects of a collaboration and sustainability are often not observable within the time frame of research studies. Despite, the public administration field can still offer comprehensive amount knowledge on intersectoral collaborations.

Besides, the need of long-term studies to learn about the development of intersectoral collaborations over longer period time and sustainability, there are also other research methods to gain more knowledge. Methods such as one-to-one interviews can still give insights and help to fill the gap in verifying findings and the factors playing role at an intersectoral collaboration (Jones and Barry, 2011). Conducting interviews could be alternative to require this more in-depth knowledge needed on the interactions between people and organisations involved in an intersectoral collaboration in health promotion. Regarding health promotion, knowledge from public administration field could be of support when investigating intersectoral collaborations of health initiatives.

Throughout the Netherlands there are health initiatives consisting of intersectoral collaborations. Some of these health initiatives are affiliated with a Dutch national health programme. This national health programme tries to stimulate collaborative governance. The health programme will be discussed within the next subtitle and the concept of health initiatives will be elaborated and defined.

1.4 All About Health ''Alles is Gezondheid''

In the Netherlands there is a National Programme Prevention [NPP] focusing on decreasing the amount of people developing chronic diseases and stabilising health differences. One way the Dutch government is trying to achieve this ambition is through the governmental programme called ''All About Health…'' (in Dutch; ''Alles is Gezondheid…'') [AAH], which is one of the elements of NPP. The AAH programme can be seen as a facilitating platform, enabling connections between different existing, often fragmented, small scale and ad hoc health initiatives in society. Next to this, it encourages the establishment of new health initiatives aiming to start a social health movement by increasing collaboration, scale and focus (Bekker et al., 2018; Bekker, Helderman, Lecluijze, Jansen, & Ruwaard, 2016). In this programme, the government does not have a steering (top-down) role, but an equal position related to the initiatives. Through the programme the government facilitates

bottom-up initiatives combining public, private and civil society organisations (Bekker et al., 2016). Health initiatives can be defined as:

''bottom-up social innovations taken by civil society actors and organisations to enhance the health of their constituents in collaborative networks across domains and sectors, in non-hierarchical partnership, and with a focus towards experimenting, learning and adapting their practice to improve health'' (According to the definition of societal initiatives by Reumers et al., 2021, p.2)

In order to establish collaborative intersectoral health initiatives, there is a need for facilitation and developing networks and connections (Macaulay et al., 2018; Corbin, Jones, & Barry, 2018). This facilitation requires knowledge and skills, so as to create effective partnerships between different domains and empowerment of community-based health initiatives (Corbin, Jones, & Barry, 2018). The Dutch government tries to fulfil this facilitative role through the governmental programme AAH by offering a platform for networking and connections.

The AAH programme has been and is currently examined by independent academic public health research team by means of a process evaluation. Currently the focus of the evaluation is on how to ensure the intersectoral collaborations of the health initiatives can be structurally embedded and made sustainable, while also still advancing the social health movement and its innovations. Regarding this embedding and sustainability, it would be interesting to look at the development of the initiatives. From the first process evaluation it became clear that most of the initiatives were in explorative phase of collaboration. A phase directed at building relationships and exploring common grounds towards developing a health promotion goal. In this phase, partners are not depending on one another yet (Bekker et al., 2017). Currently, the programme and some of its initiatives have existed for a few years, thus they could be expected to be in a more entrepreneurial collaboration phase. In this phase the organisations have developed common concrete goals, conditions and rules, and depend on each other. This entrepreneurial collaboration phase is also about self-monitoring and evaluation; there is no need for external incentives to carry on, due to this self-organisation (Bekker et al., 2017). These are important aspects of sustainability.

1.5 Make the Next Move and research focus

This research will focus on the sustainability of health initiatives in the community. To gain more knowledge about facilitating and hindering factors of an intersectoral collaboration, more insights of the interactions among the people and organisations involved and the conditions for structurally embedding the health initiative in the community. In other words, obtaining knowledge about the development of intersectoral collaborations (health initiatives) towards sustainability. This will be done through multiple case study research, making use of document analysis and interviews (interviews as indicated in order to require in-depth knowledge).

This research has the possibility to and will focus on a particular set of initiatives pledged to the AAH programme. This set of initiatives is participating in the competition, initiated by AAH, called Make the Next Move. Within the facilitative role of the government, the competition was created at AAH to give periodic incentives for more far-reaching activities by pledge holders of the health initiative by providing a public stage (Bekker et al., 2016) (Pledge holders will be elaborated in the next chapter). Participants of this competition are expected to be beyond the explorative phase and have concrete goals, defined scope, innovative character, potential for upscaling and opportunities for innovative financing (Allesisgezondheid, 2020). This gives the opportunity to execute in-depth qualitative analysis of several cases regarding development of an intersectoral collaboration (health initiative) towards sustainability. Therefore, will this study investigate the registered initiatives of the competition Make the Next Move. This will be done by means of a multiple case study to explore experiences of the bottom-up community-based health promoting initiatives and how they operate,

in order to assess and learn what the appropriate and enabling conditions of an intersectoral health initiative are for sustainability and structurally embedding in the community.

1.6 Research aim and question

The aim of this research is to assess and analyse what the conditions are for making health initiatives consisting of intersectoral collaborations sustainable and structurally embedded in the community. The experiences of a selection of community-based health initiatives (of the competition Make the Next Move of the AAH programme) form the basis to verify findings for the lacking knowledge about interactions, development over time and the factors that hinder and facilitate intersectoral collaborations in health promotion. Which leads to the following main research question;

- *What are the facilitating or hindering factors of sustainability of an intersectoral collaboration?*

In this case sustainable means that the health initiatives are able; to carry on their health promoting activities within their own organisations without the need of external incentives (Bekker et al., 2017), to sustain their intersectoral collaboration (Koelen et al., 2008) and to be a self-sustaining entity (Ulibarri et al., 2020). This provisional definition of sustainable will be used for this study, which is based on descriptions from the literature indicated in the definition about the evolvement towards a developed intersectoral collaboration. The results of this study may lead to a revision of this definition.

The theoretical framework will give insights on intersectoral collaborations and their facilitating or hindering factors, which provides information about the factors indicated important for sustainability according to literature. This enables to analyse, how the intersectoral collaborations operate at the selected health initiatives of Make the Next Move 2020 and are possible made sustainable in the community. The sub-questions in order to answer main research are therefore formulated at the end of the chapter 2 Theoretical framework. The experiences of these health initiatives enables to learn about the conditions and lessons for an effective sustainable intersectoral collaboration (by looking at similarities and differences).

This chapter introduced the concept of intersectoral collaborations in the field of health promotion. Thereafter, the complexity of intersectoral collaborations and how the field of public administration can be of support were discussed. Subsequently, the Dutch All About Health programme was explained, the research focus on health initiatives of Make the Next Move described and lastly the research aim and question.

2. Theoretical framework

This chapter contains background information from the literature about intersectoral collaborations. Next to, this background information, several theoretical models of intersectoral collaborations are elaborated and discussed. This will provide information for the research question about the facilitating or hindering factors. One of the included models is a newly developed model particular for this study. Several sub-questions are formulated on the basis of the factors of this model in order to be able to answer the main research-question.

Theoretical background information

This part of theoretical framework will focus on the concepts of intersectoral collaborations. Thereafter, describing the introduced All About Health programme in more detail. Including explaining the concept of a ''pledge'', connected to the programme. Finally, the importance of the community in health initiatives is elaborated.

2.1 Concepts of intersectoral collaborations

The intersectoral approach is a central element of promoting public health and health equity according to World Health Organisation [WHO], which established a framework focusing on this approach called Health in All Policies [HiAP] (WHO, 2013). HiAP aims to integrate health considerations in the development, implementation and evaluation of policies. This integration emphasises on the implications of policies decisions on health across all domains and levels of the government. Thereby, having the intention of generating intersectoral collaborations as a core element of health promotion (Corbin, Jones, & Barry, 2018; Pinto, Molnar, Shankardass, O'Campo & Bayoumi, 2015).

Intersectoral collaborations for health promotion are becoming more common today, as described in the introduction. Nonetheless, was this intersectoral approach already been highlighted in 1986 by the WHO with the Ottawa Charter for Health Promotion (Stolp et al., 2017). One of the guiding principles expressed in the Ottawa Charter focuses on call for policy makers to optimize population health through coordinated action by different sectors within and beyond the health sector. No sector on his own has the resources, access and trust relationships to cope with the wide variety of social determinants of health (Koelen et al., 2008). The public health field increasingly focuses on social determinants of health, including environmental factors, leading to concepts like HiAP (Korfmacher, 2020).

HiAP builds on the Ottawa Charter for Health Promotion, which also calls for an integrated approach of the individual, community and society. There is a need of looking on the individual, social and structural level in order to create a supportive environment for health interventions to be effective. This includes the importance of citizen participation and empowerment. Especially, intersectoral collaborations addressing all levels (bearing in mind the socio-environmental context), are shown to be key for the effectiveness of health promotion (Wold and Mittelmark, 2018).

Currently in health promotion programs many public health interventions address multiple levels. The interventions do not only address the individual but interpersonal, organisational and community levels interacting with health as well. The aim to strengthen the interventions on the basis of multiple levels has more sustainable effect than a single level intervention (McCormack, Thomas, Lewis, & Rudd, 2017). Multiple levels approach includes public-private partnerships, which is considered as an important element of this intersectoral approach and in developing effective health promotion initiatives.

There is an increased coverage in literature of public-private partnerships and it has taken his place in the health promotion (Hernandez-Aguado and Zaragoza, 2016). This also applies to partnerships between academics, public and voluntary organisations, being widely present in health promoting literature, in which is indicated that these kinds of intersectoral collaborations are

essential for effective implementation and sustainability of community-based health promotion (Estacio, Oliver, Downing, Kurth, & Protheroe, 2017). As stated there is shift of focus and increase of literature about the role of organisations outside healthcare sector within society to address public health in local communities through social living environment conditions and factors (multiple levels). In this manner, it is suggested that community-based health initiatives by the means of acting on social determinants of health, not only the individual but furthermore the community health can be improved by collaborative effort of different sectors (Macaulay et al., 2018; Corbin, 2017).

The government can stimulate this integrated approach of multiple levels. Collaborative action by the government and society can be characterised as a transition from ''government to governance'' and can be regarded as Whole of Society [WoS] approach. WoS approach is in line with HiAP framework by directing to including different actors (government, public, private organisations and civil society) in collaborative governance arrangements, aiming to strive for same social values, interests and ambitions in relation to public health (Bekker et al., 2018; Bekker, Helderman, Jansen, & Ruwaard, 2017). This results in collaborative intersectoral health initiatives. The WoS approach requires trust-generating institutional conditions (Bekker et al., 2018), something the Dutch government with his facilitative role is trying to enable for the AAH programme.

2.2 Elaboration All About Health programme

AAH makes use of these approaches in order to promote health and reduce health inequalities with the underlying thought that promoting intersectoral collaborations and knowledge exchange would increase the reach and impact of health initiatives (Bekker et al., 2017). In this manner, coming to partnerships which would be on the first sight not that obvious. This results to unique outcomes where knowledge and experience exchange between different sectors brings more effective ways to address public health issues.

These partnerships are established through so called ''pledges''; 'a public statement by which an organisation expresses commitment and an active contribution to the realisation of governmental health goals by conducting specific activities.' (Bekker et al., 2018, p.20). The pledges can be formulated by the organisations themselves and there are no requirements, ensuring no thresholds to participate in this health movement are experienced (Bekker et al., 2018). There are various motivations for organisations to make a pledge at AAH; first of all is the recognition of the importance of health of their target group, inspiring or lack of implementation of health innovations and more extrinsic motivations as public visibility through for example corporate social responsibility (Bekker et al., 2018; Bekker et al., 2017; Bekker et al., 2016).

Especially, with civil society organisations, recognition by the government is important as this creates legitimacy and status, which in turn improves access to networks, collaborations and knowledge (Bekker et al., 2018; Bekker et al., 2016). This recognition enabled by AAH can increase the impact and reach of health initiatives. Besides, at the backstage making a pledge at AAH programme can endorse the health interventions and own activities from the initiatives by the facilitation process on the background. In addition, at the frontstage giving opportunities of showing the public the created intersectoral collaboration offered by the platform of AAH serving as a stage, increasing legitimacy and chance on possible new partnerships and resources (Bekker et al., 2016; Bekker, van Egmond, Wehrens, Putters & Bal, 2010).

New partners from other sectors within a pledge indicate that through the health interventions/activities belonging to the pledge, they became more aware of the importance of health and the influence they can exert on health themselves and with the new the intersectoral collaboration (Bekker et al., 2016). This awareness and activation of a social health movement is eventually the aim of the AAH. A social health movement in order to address the increasing amount of people living with chronic diseases and growing health disparities (in line with NPP long term

goals). These chronic conditions and disparities are often related to living environment influencing the health status as addressed in the introduction (Macaulay et al., 2018; Bartley, 2016; Wilkinson and Marmot, 2005). Next to living and growing up conditions, this also regards available networks and health services (Bartley, 2016).

There is a growing recognition in the society of the need for collective action on these public health issues. People are becoming aware of the social determinants influencing their personal life-style related health problems (Bekker et al., 2017). Realising it is not only individual personal matter. This increased awareness goes well with wanted social movement and the need to create cohesion in health interventions and activities. In addition, the hope for more organisations committing themselves to the movement, whether or not by the means of a pledge. This includes organisations such as a community centers, schools, sports clubs and companies, where people are present on a daily basis and a supportive and healthy environment is of importance.

These organisations have to work together in intersectoral collaborations, which is needed for the social movement in order the further create the naturalness of health being incorporated in the daily living environments of people. Within the shift towards intersectoral collaborations between organisations, there is also the need of shifting from the individual towards community-based health interventions. Most of health interventions in health promotion were targeted at individual level and very few at community level (Wold and Mittelmark, 2018). However, as indicated in order for health interventions to be more effective, next to individual, also the social and structural levels of the environment of people has to be addressed (Macaulay et al., 2018; Wold and Mittelmark, 2018; McCormack et al., 2017). Dixon et al. already indicates in 2004 the limitations of focussing on individual behaviour change to improve health, which is confirmed by Bartley (2016) calling this the ‘’lifestyle drift’’. Also AAH programme itself, during annual congress in 2020, laid emphasis on community instead of individual-based approach in health interventions by introducing the thematic topic: ‘’from ego to eco’’ (Alles is gezondheid; LIVECAST: VAN EGO NAAR ECO, personal communication, November 6, 2020). This can be translated into; instead of individual organisations working on individual health issues only from within their self-interests, towards collaborations of different organisations working together on community health issues from a common interest.

2.3 Community-based health initiatives

Community is identified as crucial to integral health governance, policy and action. Involving the community is found to be essential when addressing the social determinants of health (de Leeuw, 2017). When community-based health initiatives act on social determinants of health on the basis of intersectoral collaborations, not only the individual but also the community health can be improved (Macaulay et al., 2018; Corbin, 2017). Community involvement is described by Jones and Barry (2011) to be vital component for health promotion in collaborations. Community members being actively involved in setting up health interventions. Whereat, the community is working in equal partnership with health professionals to not only solve indicated health problems but also define health problems advocated by the community members themselves. A community can exist of a wide range of perspectives, which shows the need of sufficient heterogeneity of organisations involved in the collaboration. Having broad divers amount of organisations, which can be offered by the intersectoral approach, results in more effectiveness (Jones and Barry, 2011).

However, despite the increasing recognition of community health interventions depending on intersectoral collaborations, institutional support for the collaborations seems not well developed (Korfmacher, 2020). Korfmacher indicates this may partly due to the lack of understanding what contributes to successful collaboration (2020), which is discussed in detail in the introduction. There is a lack of descriptions of contextual factors in the evaluations on the impact and effectiveness of intersectoral collaborations for health promotion. Factors such as the relationships, roles and

responsibilities and their relation to the observed outcomes of the interventions (Pinto et al., 2015). The effectiveness of community-based health interventions in health promotion and strengthening the community action is unclear. For that reason more research is needed by public health researchers to further develop scientific methods and monitoring, as this approach has only been subject to minimum assessment (Wold and Mittelmark, 2018; Hernandez-Aguado and Zaragoza, 2016; Bartley, 2016).

Nevertheless, the potential of such approach for health promotion through intersectoral collaborations remains recognised, only a clear comprehensive path has yet to be established (de Leeuw, 2017). de Leeuw also indicates empowering communities to make decisions about resources generation and allocation regarding health promotion is essential. However, the community-based approach is still in an evolutionary stage of much broader social development (2017). This bottom-up approach of communities controlling health promotion activities, is something which is especially common in the AAH programme (bottom-up health initiatives making a pledge). This gives the opportunity to learn from the experiences of the health initiatives affiliated with AAH programme, in order to develop a more clear path about the intersectoral collaborations in health promotion within the community-based approach.

Theoretical models

This part of theoretical framework elaborates on three models. One model from within the field of health promotion; The Healthy Alliances framework, and one model from the field of public administration; the Model of Collaborative Governance. Moreover, it is included how these two models their factors and concepts relate to each other. Following from these two models, a new combined third model is developed and described; the Model of Sustainable intersectoral collaborations. This model includes the factors and concepts of the other two models indicated to be of importance for sustainability. The factors of the model form the basis for the sub-questions of this study. First The Healthy Alliance framework is discussed. Thereafter, is the Model of Collaborative Governance elaborated and finally the newly developed Model of Sustainable Intersectoral Collaborations. At the end, the sub-questions are formulated.

2.4 The Healthy ALLiances [HALL] framework

The Healthy Alliances framework has been based on insights from literature on collaboration processes and on research of coordinated action in practice, in the field of health promotion and public health (Koelen, Vaandrager & Wagemakers, 2012). Coordinated action is the term used by researchers of the HALL framework for intersectoral collaborations. This means also coordinated action is defined as collaborations of different sectors to increase the effectiveness in health promotion, as intersectoral collaborations in the introduction.

During their research for developing the framework it became apparent, intersectoral collaborations are difficult to establish and even more difficult to sustain. Therefore, they continued to study collaboration and participation processes. On the basis of experiences, health promotion programmes, case studies and literature two frameworks were developed. The first one is from the study of Koelen et al. (2008), which describes six factors identified to achieve and sustain intersectoral collaboration. These factors will be given extra attention, as the aim of this research is to specifically investigate this sustainability. The second framework is from the study by Wagemakers, Vaandrager, Koelen, Saan, and Leeuwis (2010), which describes levels and variables of intersectoral collaborations. This study focused on (community) participation, which was defined as a social process of taking part in activities to bring change or improvement in community life and community members identifying their needs and priorities (Wagemakers et al., 2010). Successive research showed that the context in which the organisations their collaboration functions and participants

personal characteristics, have a significant influence on how the intersectoral collaborations develop and are sustained (Koelen et al., 2012). These research studies and two frameworks eventually resulted in the HALL framework.

The HALL framework categorises three groups of factors, which can hinder or facilitate the collaboration. The three groups of factors are displayed in figure 1; institutional factors, interpersonal factors (of the participants in the collaboration) and factors related to the organisation of the collaboration (referred to as alliance). The institutional and personal factors are depending on the organisations participating in the collaboration. These two groups are influenced by, and influences, the factors related to organisation of the collaboration. This is demonstrated with two-directional arrows, indicating that institutional and interpersonal factors can be turned from barrier to facilitator by the organisational factors. The three groups determine the successfulness of the intersectoral collaboration, indicated with the unidirectional arrow, having all a distinctive influence on the functioning of the health initiative. From the three groups, all the factors will be shortly discussed and explained.

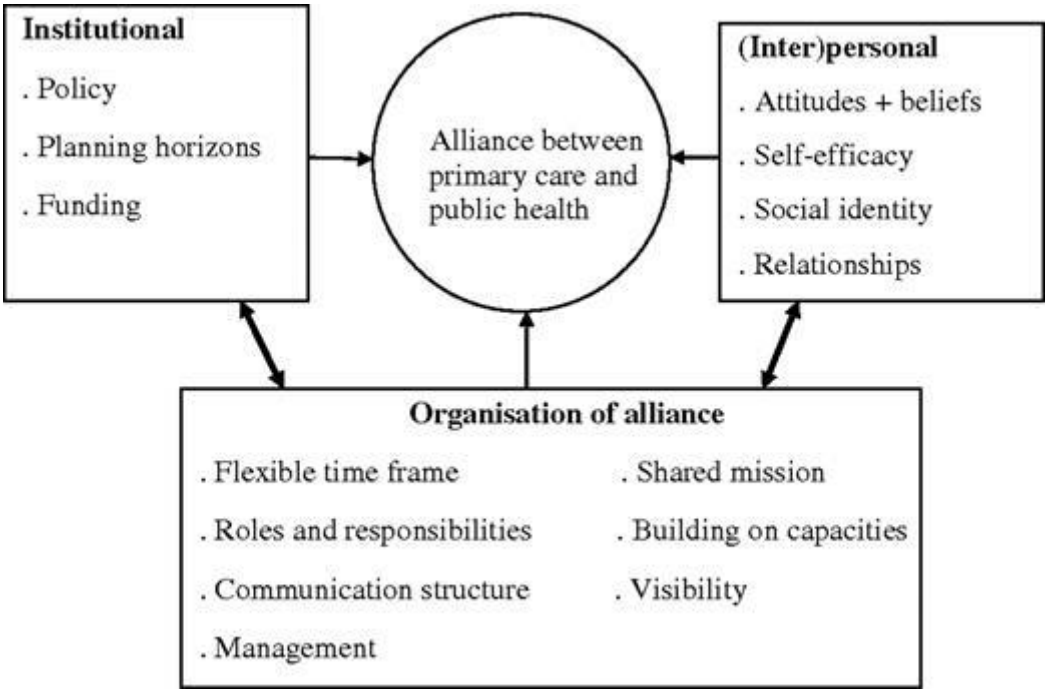

Figure 1. The Healthy Alliances framework (Koelen, Vaandrager & Wagemakers, 2012).

2.4.1 Institutional factors

Institutional factors group from HALL framework exists of the factors; policy, planning horizons and funding mechanisms. These factors are about the circumstances or incentives of the institutional and economic environment established in the organisations that are part of the intersectoral collaboration. These institutional factors are able to facilitate or hinder the collaboration (Koelen et al., 2012). The three indicated factors will be elaborated, starting with policy.

The **Policies** of the different organisations in the intersectoral collaboration often have a different focus as they come forth from different sectors. For example, the medical sector focusing on the individual and curing, whereas public health sector focusses more on the population and prevention. This also applies to one being mainly disciplinary and the other interdisciplinary. However, it is indicated that policies for health promotion are often not bound to one discipline or department, including other areas which are not directly linked to health (for example, economics, education, social affairs). As explained in the introduction, it is realised that more sectors have to be

included regarding public health. In practice different policy areas have trouble finding and aligning each other. There is focus of accountability, different areas being held accountable for their own sector, such as finance and time spend in the collaboration. Therefore, in order to align the policies there is often a need of an outsider in the intersectoral collaboration (Koelen et al., 2012). This could be a health professional or something as the facilitative platform of AAH, bringing the different organisations of different sectors and their policies together.

Planning horizons, regards the time-span the different organisations within the collaborations have in mind. Some organisations want immediately action or results, others see the importance of taking time. Some want to look back at what happened (anticipate on the problem), others want to look forward (searching opportunities). It is important to realise that some sectors are more focused on short-term thinking and others on long-term thinking. In the case of public health, mostly it takes time to see wanted or expected changes in the community. Thereby, it is often the case that the estimated time span and reach of the health programme or intervention turned out to be unrealistic to bring about change.

Funding, the last and third institutional factor. Funding can come from various agencies; municipality, insurance company, scientific agency. When speaking of funding for themes such as health, traditionally often most money goes to medical technology and less to prevention and health promotion. Besides, when there is investment in prevention and health promotion this is often for single-risk-factor programmes (for example; alcohol consumption, smoking, nutrition) (Koelen et al., 2012). However, as stated, health issues are mostly complex, as they are influenced by the social environment including different social determinants of health. This complexity makes it less investable by funders, as with this complexity showing effectiveness of health interventions becomes far more difficult (compared to a single-risk-factor programme). In addition, prevention shows often only results on the long-term. Consequently, when there are limited financial resources or budget shortages, it is easier to cut investments for this kind of health interventions. Lastly, sometimes organisations within the health initiative are competing for the same funds. This could be due to again less available resources and budget shortage or financing structures and policy strategies pushing the health initiative to stay with theme-based aims (Koelen et al., 2012).

2.4.2 Personal and interpersonal factors

The personal and interpersonal factor group from the HALL framework exists of the factors; attitudes and beliefs, self-efficacy, social identity and personal relationships. These factors are about the personal characteristics and individual opinions the organisations of the collaboration are bringing in (Koelen et al. 2012). These four interpersonal factors will be elaborated.

Attitudes and beliefs, are indicated to be significant barriers or facilitators for a successful intersectoral collaboration. The overall attitude about working with organisations and people from other sectors is important. Mostly, newly participating organisations in a collaboration do not have experience in working with people or professionals from other sectors. Some organisations and people expect working with other sectors as something useful, where others expect it to be a waste of time. The different organisations have to be willingly to invest resources and time in the collaboration. This can be counteracted by the lack of belief in the value the other organisation can bring in or the view of the others profession. Therefore, building mutual value, tolerance, respect and trust is important for establishing an intersectoral collaboration (Koelen et al, 2012). Trust is an important concept which is part of one of the factors indicated to be important for the sustainability of the intersectoral collaboration (roles and responsibilities). Trust is also reflected in the Model of Collaborative Governance.

Self-efficacy, relates to the reality that collaborations with other sectors is often a new way of working, as mentioned at attitudes and beliefs, which involves other competencies and regards

the organisation and his people their belief in their ability to perform in these new collaborations. The different sectors have professionals from different disciplines, which requires transdisciplinary cooperation. When there is lack of experience or training in these kind of transdisciplinary collaboration, this can lead to feeling of insecurity about the role one as organisation or person takes in the collaboration. Therefore, regarding self-efficacy is it important one has the belief in the capability of making a difference in an intersectoral collaboration (Koelen et al., 2012).

Social identity, every organisation has his own identity, however for the intersectoral collaboration it is important there is a development of a shared identity. This entails, it becomes meaningful for the organisations to be part of this collaboration. Being part of the collaboration must be of value and positively contribute to the organisation representation. In short, aligning the identity of the organisation with the social identity of the intersectoral collaboration (health initiative). Common aims and mutual willingness to invest time and effort contributes to strengthen the social identity. Organisations will tend to continue with the collaboration when being part of has positive effect on their identity (Koelen et al., 2012).

Personal relationships, success of the collaboration depends on the nature of the relationships within the organisations and people. Again trust plays important role, learning to trust each other is essential for a successful collaboration. Something which takes time, as there is a need of acceptance of possible different visions and liking one and other. For example, if the relationship is diminishing in trust this will be at the expense of the productivity and effectiveness of the collaboration (Koelen et al., 2012). Therefore, is it important to build and maintain personal relationships.

2.4.3 Factors relating to the organisation of the collaboration

Factors relating to the organisation of the collaboration factor group from the HALL framework exists of the factors; flexible time frame, shared mission, clear roles and responsibilities, building on capacities, communication structure, visibility and management. Above are the institutional and interpersonal factors described, how these factors are manifested depends on the characteristics of the organisations participating in the collaboration. These factors can differ between the organisations and in order for collaboration to be successful it is important these differences are handled. The just mentioned seven factors can contribute to this differences (Koelen et al., 2012). These factors partly correspond with the six factors identified by Koelen et al. (2008) to be important for the sustainability of intersectoral collaborations. For each factor to which this applies, this will be emphasised and explained at the following elaboration of the seven factors.

Flexible time frame, something important to take in mind, as it takes time to develop intersectoral collaborations. It involves processes as creating common language and, as already indicated as important concept, trust. Also a shared vision in the collaboration for the health initiative on the problems and opportunities takes time to build. It can takes months or even years before a collaboration functions accordingly and has established this common language, trust and shared vision. When striving for such well-functioning collaboration, the participating organisations have to realise to calculate time into the planning for this phase of building relationships. Often this is not taken into the time frame, which can lead to disappointments, as expected results in the current planning are not forthcoming (Koelen et al., 2012). These points are also partly reflected by the already elaborated institutional factor planning horizons and interpersonal factor relationships.

Shared mission, is identified as an important factor for the sustainability. Koelen et al. (2008) includes the factor shared mission under aims and objectives. The organisations part of the intersectoral collaboration enter with differences in aims and objectives, because their institutional environment, and different perspectives on what has to be achieved and how to execute this (Koelen et al., 2012). The organisations of the intersectoral collaboration need to recognize the common

mission for the health problem on which they work together.

This includes agreeing on problem definition, aims and objectives, but also to agree to disagree on other things. Sometimes all organisations seemly initially agree on the aims and objectives, but many expectations stay implicit. For example, discussions about the meaning of concepts such as health could be forgotten, which can cause that expectations about outcomes of the intervention are not discussed and are different. This may lead to conflict. Open discussion can solve these conflicts, by making the implicit explicit. This also includes for underlying differences, after which collaboration process will be improved (Koelen et al., 2012; Koelen et al., 2008). Resolving conflict can even lead to stronger relationships.

The shared mission has better chance to succeed, if the organisations realise the health initiative activities are important to each and cannot be achieved alone (Koelen et al., 2012). Lastly, especially in start-up phase, as described by the factor flexible time frame, it is important to find agreement about the mission of the collaboration. This on the basis of open communication, explicit discussion and accepting differences (Koelen et al., 2008). To conclude, a clear plan consisting of common goals, outlined activities and timetable supports to structure the process of a shared mission (Koelen et al., 2012; Koelen et al., 2008).

Clear roles and responsibilities, is identified as an important factor for the sustainability. Intersectoral collaborations entails different professions, which brings different skills and expertises. However, it is difficult to describe and define for each expertise their role and responsibilities in the collaboration. Nonetheless, in order for the collaboration to be effective, clear role descriptions are required, which are needed to be developed consensually (Koelen et al., 2012; Koelen et al., 2008). Thereby, keeping their skills and expertise in mind.

Expectations about roles and domain protection can lead to frustration and hinder the collaboration (Koelen et al., 2012). There is a need of trust and involvement. Again trust plays a role, as people have to develop the trust that others can fulfil their role and responsibilities. Experiences of working together can make clear how roles and responsibilities work out in practice and can give an indication for any adjustments. This also emphasizes the importance of building relationships, where getting along, compromising and sharing knowledge and work are aspects influencing the success of the intersectoral collaboration. Again open discussion about the potential roles and responsibilities, including shared expectations of the contribution each is bringing in, is crucial (Koelen et al., 2008).

Building on capacities, is a factor which builds on the different skills and expertises of people from the different participating organisations. The variety of skills and expertise is the added value to intersectoral collaborations**.** As described in the introduction, different sectors working together can achieve more than a single sector or organisation. Differences between the organisations determine the successfulness of the health initiative. Each organisation from his own sector bringing their expertise, contributing to intersectoral collaboration by doing what they are good at, and building on each other's expertise (Koelen et al., 2012).

Communication structure, is identified as an important factor for the sustainability. Intersectoral collaborations involve a continue process of decision making, in which information exchange is necessary from the various participating organisations. Communication structures are needed for this information exchange, in order for the intersectoral collaboration to be successful. The creation of communication infrastructure will facilitate sharing ideas, experiences and enable discussion. This includes establishing protocols for internal and external communication. In addition, both formal and informal communication are important aspects of the communication structure (Koelen et al., 2012; Koelen et al., 2008). It is indicated that informal communication can be very productive and collaborating on the basis of open-mind, active learning and innovation is important (Koelen et al, 2012). Developing communication infrastructure is time consuming, in particular during

the start-up phase of the collaboration. There is a possibility of differences in knowledge and communication abilities between organisations. Consequently, it is important to build capacity for all the participating organisation to access information (Koelen et al, 2008). A sound communication structure will enable to take decisions for the health initiative between and within the organisations of the intersectoral collaboration.

Visibility, is identified as an important factor for the sustainability and can function as an incentive for involvement, action and continuation of the intersectoral collaboration. Visibility can be a motivation for the organisation to stay committed to the health initiative. It can also be of use for interests of funding agencies and politicians. Visibility was divided into three categories, visibility of activities, visibility of the individual contributions and visibility of outcomes (Koelen et al., 2012; Koelen et al., 2008).

Visibility of activities is about the focus on what is done by the intersectoral collaboration. If the activities of the health initiative are visible (for example presence in the community local media). Visibility of the individual contributions emphasizes what each participating organisation is personally contributing. This with the underlying thought that it keeps the individual organisation motivated to remain part of the intersectoral collaboration (for example, propagate personal goals/values or corporate social responsibility) (Koelen et al., 2008). Visibility of outcomes is often seen as important, because as mentioned it works as incentive for the organisations and the outcomes are often important for financial and political support. To this respect it is important to have realistic goals for outcomes on both long- and short-term (Koelen et al., 2012; Koelen et al., 2008).

In practice, as already mentioned before, the expected outcomes of a health initiative of a change in health status are often not reasonable within the reach and timeframe of the health programme of the collaboration. This address long-term outcomes which can take years. Therefore, determining short-term outcomes is needed. This could include increasing awareness and knowledge of a certain health problem, participation of organised activities or a collaboration with another organisation. The latter is about the possibility to see the participation of an organisation in the intersectoral collaboration as an objective, something which can be forgotten but is an important outcome (Koelen et al., 2012; Koelen et al., 2008). These short-term outcomes need evaluation, active feedback and discussion. Realistic outcomes expectations can encourage and unrealistic can discourage the sustainability of the health initiative, as the visibility of the outcomes has a great influence on motivation for the participating organisations to keep contributing (Koelen et al., 2008).

Management, is identified as an important factor for the sustainability. Management gives structure to the collaboration process. This firstly requires leadership and secondly a supportive framework (Koelen et al., 2012; Koelen et al., 2008). Leadership is also reflected in the Model of Collaborative Governance. Regarding intersectoral collaborations a leadership style of facilitating and empowering is needed, including stimulating participation of the different organisations. In best case the manager is a neutral person, which can understand the differences between the organisations. This is needed in order for the capability to bridge between and identify opportunities for the shared mission (Koelen et al., 2012).

For the manager it is important to establish a good communication structure and stimulate sharing ideas, information and experiences. The manager needs to have the following characteristics; flexible, committed, practical and be a visionary, motivator and listener (Koelen et al., 2012; Koelen et al., 2008). Since management activities exists of initiating debates, developing realistic plans and weighing up the different wishes and possibilities of the participating organisations. It is important these activities do not only take place formally. A supportive framework can assist the manager, by the development of a clear structure, outlined goals, roles and responsibilities and including a timetable to structure the process. This framework should be partly flexible, being capable to respond to changes and integrate experiences (Koelen et al, 2008). In reality, the intersectoral

collaborations often concentrate on achieving their goals instead of the management of the collaboration process. However, management is an important factor, which most effective on the community level, for creating structure for an effective collaboration (Koelen et al, 2012).

These were the factors relating to the organisation of the collaboration factor group from the HALL framework. However, only five of these factors were identified as important for sustainability and Koelen et al. (2008) described six factors. This concerns the following last factor.

Representation of relevant societal sectors, including community members. Including different sectors in an intersectoral collaboration is a requirement. Koelen et al. (2008) indicates the importance of involving representatives of variation of societal sectors, including formal and informal organisations. This makes it possible to address different perspectives and reach a wide range of population. Health initiatives regards often community involvement. Approaching community members to ask them merely to participate in the implementation of a health intervention or programme seems not effective. It is important to involve the community members in needs assessment and asking for remarks on research results. This is a stimulating strategy for involvement. In addition, including the experience of being part of the decision-making makes clear the community members are taken seriously. Especially, this needs assessments is important as to sustain community members involvement. The activities of health promotion must be in line with their needs. This could lead to having to first address the problems experienced by the community members than those indicated of importance by the participating organisations of the intersectoral collaboration (Koelen et al., 2008).

To conclude and for clarification, the following six factors are identified by Koelen et al. (2008) as important for the sustainability of intersectoral collaborations; representation of relevant societal sectors including community members, shared mission, clear roles and responsibilities, communication infrastructure, visibility and management. Intersectoral collaborations are becoming more common and thereby the need to consider what kind of factors facilitate and constrain collaborations regarding sustainability (Seaton et al., 2018). Sustainability is today and will be in future even more important aspect for health promotion. Building and sustaining effective intersectoral collaborations is a main point from the HiAP approach for health promotion and acknowledges the need for further development and enhancement of knowledge (Jones and Barry, 2018). These factors highlighted by Koelen et al. (2008) and discussed above are important for achieving ánd sustaining intersectoral collaborations. Different concepts and aspects discussed at these factors like for example trust, common goals, skills and expertise's, time planning, respect and mutual value are contributing to the sustainability of the collaboration process (Estacio et al., 2017; Koelen et al., 2008).

2.5 Model of Collaborative Governance

Many of the factors described in HALL-framework have concepts which are elaborated in the Model of Collaborative Governance. For example the concept trust, which is already mentioned to play important role at different factors of the HALL-framework. The model of Collaborative Governance offers support for the HALL-framework by elaborating on the underlying concepts of the factors of the framework. These concepts describe the processes/aspects needed in order to achieve a factor such as shared mission. Therefore, all concepts of this model will be connected to the factors of the HALL-framework, to clarify and extend the understanding of the underlying collaborative process and starting conditions of an intersectoral collaboration. Especially, starting conditions is of added value, as the factors of the HALL-framework are focused on importance for a successful collaboration. The framework does not go explicitly into the conditions to establish or start a collaboration. This makes the Model of Collaborative Governance a suited addition for the theoretical framework of this study.

The Model of Collaborative Governance is developed in a study by Ansell and Gash from 2008. Before describing the different concepts of the model, first the formation of this model will be shortly addressed. The model is based on meta-analytical study of literature on collaborative governance by reviewing 137 cases of an implementing intersectoral collaboration in a particular sector. These cases included a wide range of different policy sectors, including from public health, education and social welfare. Due to high variation in the kind of cases and the lack of standardisation, in order to develop one model, the researchers made use of a strategy called successive approximation. This strategy involves taking subsets of cases and develop a common model for these cases and subsequently test the developed model by a second (new) subset of cases in order to enhance the model. The study included four subsets/successive rounds, which resulted in lot of variables, but in order to make it useful for policy makers and practitioners the model was simplified. This simplification led to the representation of key variables of common findings across the cases (Ansell and Gash, 2008).

The Model of Collaborative Governance is dived into four boxes of broad variables with the corresponding concepts which are visually displayed at figure 2. Ansell and Gash indicate the broad variables can be disaggregated into more fine-grained variables (2008), which will in this study be regarded as underlying concepts in order to make a difference with the factors (variables) mentioned at the HALL-framework. The broad variables include starting conditions, institutional design, leadership and collaborative process, with special attention to the latter. The collaborative process is set as the core of the model, where the corresponding concepts are presented in a cycle, as the process is iterative and nonlinear. The other three broad variables; starting conditions, institutional design and leadership are indicated as essential contributions for the collaborative process. These three broad variables can also be seen as the context influencing the collaborative process as indicated with the arrows in figure 2. Lastly, the collaborative process influences the outcomes of the intersectoral collaboration. Within the next paragraphs the broad variables with their corresponding concepts will elaborated and as indicated connected to the HALL-framework.

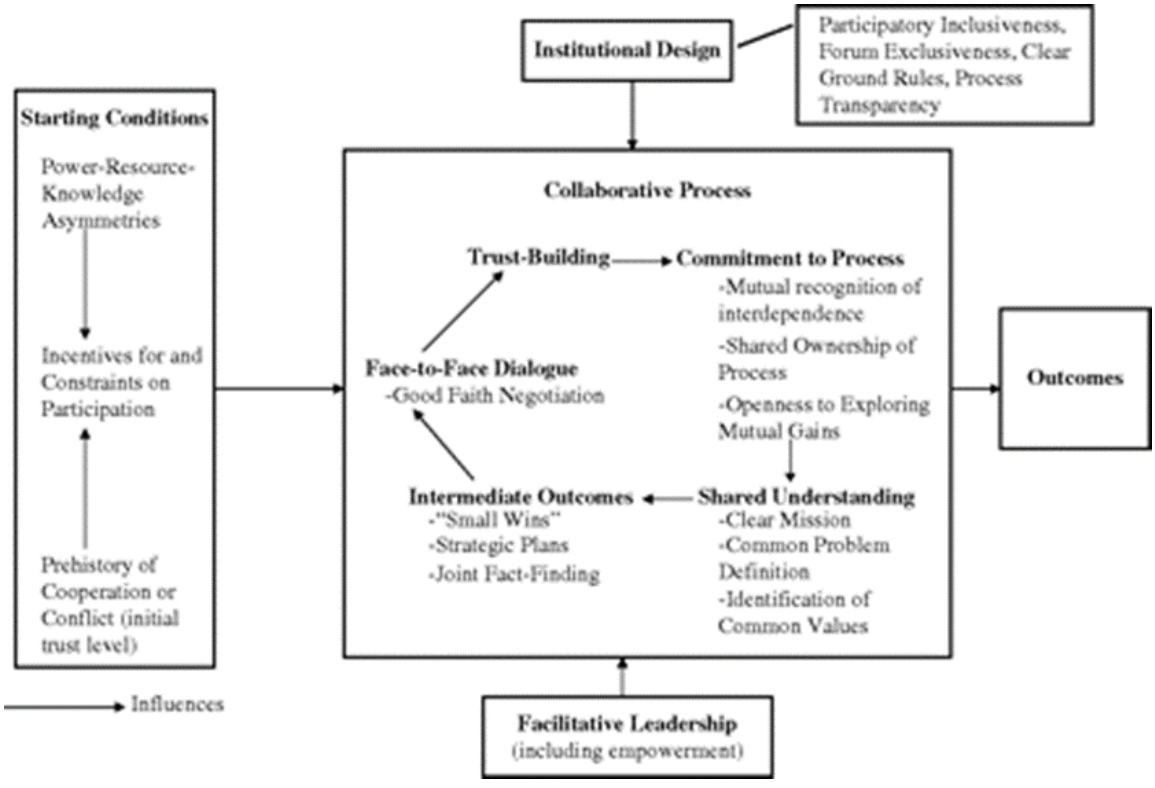

Figure 2. Model of Collaborative Governance (Ansell and Gash, 2008).

2.5.1 Starting conditions

The starting conditions present at the beginning of a collaboration can facilitate or discourage cooperation between the organisations involved. The starting conditions determine the fundamental levels of trust, conflict and social capital, which in turn can become resources or liabilities for the collaboration. The following underlying concepts of starting conditions are influencing these levels; imbalances between the resources or power of different stakeholders, the incentives that stakeholders have to collaborate and the past history of conflict or cooperation among stakeholders (Ansell and Gash, 2008). These concepts are elaborated below.

Imbalances between the resources or power of different stakeholders, is something which occurs regularly. Sometimes certain participating organisations do not have resources to participate or participate equally in comparison with other organisations in the collaboration. This makes the intersectoral collaboration sensitive to exploitation by the organisations with more resources in place. This can lead to distrust or low commitment of the other organisations. Especially, when organisations do not have the organisational infrastructure to represent themselves in the process of forming the collaboration or are capable to engage in the discussions due to lack of expertise or time. There are ways to empower underrepresented organisations. The intersectoral collaboration needs, in order to be effective, committed to implement a strategy of empowerment for better representation of disadvantaged organisations, when certain organisations are not capable to participate in a meaningful way due to an imbalance in power or resources (Ansell and Gash, 2008).

The incentives that stakeholders have to collaborate, are partly depending on the expectations about what the collaboration can bring in terms of results against the resources needed. Regarding the often voluntary participation at intersectoral collaboration of an organisation, it is important to understand what the incentives are to participate. An incentive to enter a collaboration can predict the successfulness of a collaboration. Incentive to participate increases when an organisation perceives their participation is in line with desired policy outcomes. In addition, it will also increase as an organisation perceives dependency on the cooperation with the other organisations to achieve their goals. Incentive to participate decreases when an organisation perceives their participation is purely of an advisory role or a formality. Another decrease of incentive to participate is when organisations with same fundamental shared values experience difficulty to collaborate as they perceive their goals can also be achieved individually. As displayed in figure 2, the incentive to participate also depends on previous discussed concept of imbalances in power and resources. Differences in power and resources influences the willingness of organisations to participate. Therefore, is interdependency an important aspect as an incentive to participate in an intersectoral collaboration. This means organisations perceive that their goals cannot be achieved without each other and outcomes of the collaboration are respected (Ansell and Gash, 2008).

The past history of conflict or cooperation among stakeholders, will hinder or facilitate the collaboration. If different organisations who are about to participate in a intersectoral collaboration have a history of conflicts, this can result to low levels of trust, low commitment, manipulation or misleading communications. This can lead to vicious cycle of suspicion. However, when organisations have a high interdependency, a large conflict can potentially create an opportunity as a powerful incentive for an intersectoral collaboration. Ansell and Gash (2008) also indicate that from literature many successful collaborations have come to realise that their goals could not be achieved without engaging in a collaboration with organisations having opposed interests. In contrast to conflict, when the organisations have a history of successful cooperation, this can result to high levels of trust and social capital leading to a virtuous cycle of collaboration. To conclude, when there is a history of conflict between organisations, the intersectoral collaboration is not likely to be successful, except if the organisations are highly interdependent. In addition, the organisations could take action to improve low levels of trust and social capital. Again interdependency plays a role as at the concept of

incentives to participate in an intersectoral collaboration, where incentive to participate itself also is influenced by history of conflict or cooperation (see figure 2).

As already mentioned the HALL-framework does not go explicitly into the starting conditions for a collaboration, making these three concepts an added value to the theoretical framework of this study. There are some moderate connections to make with the personal and interpersonal factors and a factor relating to the organisation of the collaboration. The factor attitude and beliefs can relate to these three underlying concepts, as attitude can be shaped by imbalances of power and resources or history of conflict or cooperation determining the level of trust, respect and view of organisations to one another. Belief can be connected to incentive to collaborate regarding the view of the organisation's own contribution towards the collaboration, which can also by connected to the factor self-efficacy. The factor social identity also relates to concept of incentive to collaborate, regarding depending on the results of the collaboration (possibility of creating a shared identity). In other words, considering if it is meaningful to be part of the collaboration. The factor shared mission (relating to the organisation of the collaboration) can also be connected to the underlying concept of incentive to collaborate. Organisations realising they need each other and cannot reach their goal or mission alone determines incentive to participate and ultimately the establishment of a shared mission. This also emphasizes the mentioned interdependency of these concepts at starting conditions. Shared mission can also be influenced by history of cooperation and developed mutual respect. Lastly, incentive to collaborate is also underlying concept of the factor visibility. The starting conditions will influence through incentive to participate the collaborative process, as also facilitative leadership influences this process, which will elaborated next.

2.5.2 Facilitative leadership

Leadership is indicated in many studies as important for contributing to the collaborative process (Ansell and Gash, 2008), also the HALL-framework expresses leadership to be important at the factor Management. Leadership entails components as setting and maintaining ground rules, trust building, facilitating discussion/negotiation and explore mutual gains (Ansell and Gash, 2008). Koelen et al. (2012) and Ansell and Gash (2008) both point out the need for a facilitative leadership style at an intersectoral collaboration (collaborative governance) in order to empower and involve the different organisations. Facilitative leadership is found to be important for bringing different organisations together to collaborate. The role of the facilitator is to make sure the integrity of all organisations participating in the collaboration is preserved during the development of the collaboration. Facilitation done by a third party or mediator can benefit the negotiations if they get stuck in the details or the gains for an organisation (Ansell and Gash, 2008).

When there are imbalances between the resources or power of different organisations, there is a need of empowerment for better representation of disadvantaged organisations in order for the collaboration to be effective, as previously discussed. Leadership is essential for this empowerment of disadvantaged organisations in the collaboration. The leader has to balance the power between the organisations and investigate the possibilities for mutual gain, by the means of giving the opportunity to all participating organisations (also the disadvantaged) to speak and stimulate listening to each other. In order to establish a balanced negotiation and stimulate the collaboration, a leader often has to intervene in a more directive approach. Therefore, the leader should, next to focusing on promoting and safeguarding the collaboration process, also have skills such as; promoting active participation, be in control and have influence, facilitating productive group dynamics, extend the scope of the process, stimulate creativity, empower, be transparent and make credible decisions to the satisfaction of all participating organisations. Effective facilitative leadership can be expected to need leaders with high skill, high demand of resource and to be time consuming (Ansell and Gash, 2008).

Next to imbalance of power, leadership is also essential when there is distrust, conflict or low incentive to participate. In this case it is important the leader takes more the role of a honest broker. Imbalance of power or resources can also lead to just mentioned three components of distrust, conflict and low incentive. It is up to the leader to again empower the disadvantaged organisations. However, this can lead to tensions as it could jeopardise the perception of the role of a honest broker (neutrality). This situation or high conflict can be an inducement for mediator from the outside having no interest in the outcome. The intersectoral collaboration is more likely to be effective when the mediator has the trust and respect of all the participating organisations. Especially, a so-called organic leader could benefit the collaborative process. An organic leader is someone respected and trusted from within the community (of the organisations) (Ansell and Gash, 2008).

Facilitative leadership is clearly an underlying concept of the factor management from the factors relating to the organisation of the collaboration. Management gives structure to the collaboration process. This firstly requires leadership and secondly a supportive framework (Koelen et al., 2012; Koelen et al., 2008). Also Koelen et al. (2012) indicates the need of someone who can bridge between the organisations and identify opportunities for the shared mission. In addition, if possible, the leader should be a neutral person. Koelen et al. (2008) mentions a leader should establish communication structure, make clear the roles and responsibilities and include a time frame for the collaboration process. These structure elements are also factors discussed at the HALL-framework, which can partly be ascribed as elements of a supportive framework for a leader. Lastly, facilitative leadership is also a concept of the factor policies, as Koelen et al. (2012) indicate, in order to algin policies, there is a need of an outsider.

2.5.3 Institutional design

The institutional design is about the ground rules of the collaboration, which is essential for the legitimacy of the collaborative process. Clear set ground rules and transparency are also important for trust building. Transparency entails that the organisations experience confidence in the group negotiations to be genuine and there are no private agreements made between two single organisations. As discussed above this is a moment where the role of the leader comes in. The leader has to make sure the negotiations are transparent and the organisations feel the collaboration process is fair. This includes making sure power is balanced. Here, an important part is played by clear and constantly applied ground rules (Ansell and Gash, 2008).

Next to the importance of an open and transparent collaborative process also inclusiveness or access is a fundamental part of the institutional design. In order to establish an effective collaboration all organisations who are affected by or care about the to be addressed issue should be included. This also includes organisations with opposed views, which could mean there are disagreements about participating organisations. However, a wide range of organisations contributes to a successful collaboration (excluding organisations will compromise the legitimacy of the process). This includes actively looking for organisations to involve in the to be addressed issue, including small firms or community organisations or underrepresented organisations. Wide range of representation in the collaboration will ultimately represent a broad based consensus. For example, a health intervention widely supported by the whole community. Lastly, inclusiveness is also connected to the incentive to participate, for instance the fear of being excluded or existence of other options of collaborations (Ansell and Gash, 2008).

Intersectoral collaborations are often in favour of consensus, although this will not always be achieved. Ansell and Gash (2008) indicated that in the literature there is less agreement about the importance of consensus rules. The question is whether all decisions made in the collaboration should call for consensus. Consensus rules can be criticized to simplifying the outcomes, so as to potentially satisfy the highest possible number of the participating organisations. However,

consensus is also often perceived as promoting representation of all the individual organisations viewpoints and stimulating more cooperation (Ansell and Gash, 2008).

Another component of institutional design is making use of deadlines. Deadlines are needed for the sometimes endless discussions at intersectoral collaborations due to high variety of views and amount participating organisations. On the contrary, deadlines also limit the scope of the discussions and the course of the collaboration. This could reduce incentive for long-term participation. Therefore, it is important when making use of deadlines, to keep in mind scheduling enough time for certain processes and to create realistic time tables (Ansell and Gash, 2008).

Several connections can be made to institutional factors of the HALL-framework. In order to align polices (factor of the framework) of the different sectors of the organisations, the underlying institutional design concept of consensus is needed to accomplish this alignment. Deadlines is an underlying concept of the factors planning horizons and flexible timeframe. Setting or discussing deadlines influences the time-span the different organisations have in mind. In addition, as mentioned above, also at factor flexible time-frame it is emphasized that intersectoral collaborations need time to develop. The collaborations should take into account time needed for certain processes (as for example building relationships). Therewithal also the factor planning notes the importance of creating a realistic time frame, which can be shaped by agreed deadlines. Lastly, the institutional factor funding could shape the inclusiveness, as financial resources can the determine which organisations can or are willing to participate in the collaboration. These discussed institutional design concepts influence the collaborative process.

2.5.4 Collaborative process

The collaborative process is the core of the Model of Collaborative Governance by Ansell and Gash (2008). As already mentioned this process is iterative and presented in a cycle (see figure 2). The cycle can be regarded as a simplification, however it does indicates the way of a continuous process influencing the collaboration. A collaboration seems to depend on going through this cycle between the different concepts. The concepts are face-to-face dialogue, trust building, commitment to the process, shared understanding and intermediate outcomes. The concepts influence each other step by step. The process often starts with face-to-face dialogue and ends with the intermediate outcomes, which in turn influences the face-to-face dialogue to start the cycle over again. This cycle of the collaborative process keeps going and remains important throughout the collaboration (Ansell and Gash, 2008). This process can also be regarded a learning process. The concepts will be discussed one by one in the order just presented.

Face-to-Face Dialogue, is necessity for an intersectoral collaboration in order for organisations to identify the opportunities for mutual gain and consensus building. As face-to-face allows for direct dialogue breaking down any prejudices, stereotypes or other communication barriers. This is partly due to body language and appearance. Face-to-face dialogue is not only a form of communication for negotiation, but is also the beginning of a process for trust building, creating mutual respect, shared understanding and commitment to the collaborative process. However, it is possible that sometimes face-to-face dialogue on the contrary reinforces prejudices, stereotypes or status differences. Still it is expected that in order for a collaboration to be effective it cannot without face-to-face dialogue. The literature especially shows stereotypes being broken down by a face-to-face dialogue (Ansell and Gash, 2008).

Trust Building, is already mentioned a lot at different factors of the HALL-framework and within this Model of Collaborative Governance as important concept for an intersectoral collaboration. It is widely acknowledge trust building between the participating organisations plays a key role when establishing a collaboration and during the negotiations. It is common for intersectoral collaborations, working with new organisations of different sectors, there is a presence of lack of

trust among the organisations. So, when there is no history of cooperation, trust still has to be developed, build or established. On the other hand it is also possible for organisation to have a history of conflicts, which results to trust building becoming a main aspect of the collaborative process. The magnitude of the conflict will determine the difficulty of building trust. In both cases of no history of cooperation or history of conflict developing trust will take time. The facilitative leader of the collaborative process should realise, trust building is a time consuming aspect, which needs long-term commitment to achieve the anticipated goals of the collaborations. Therefore, it is important to schedule time in the planning, a time-table or time-frame for trust building. If participating organisations of the collaboration are not prepared to invest time and budget for trust building, Ansell and Gash note that they should not take part in the collaboration (2008).

Commitment to the Process, is indicated to be an essential concept for establishing an effective collaboration. Commitment is connected to incentive to participate in an intersectoral collaboration. An incentive to participate could regard mutual interests of organisations in addressing certain health issue for example. Another incentive to participate could be to make sure the perspective of the organisation is taken into account. In addition, also obligations of organisations to their own objectives or maintaining legitimacy are incentives to participate. These incentives to participate form a foundation for commitment to the collaboration. Commitment to the process is about developing trust and belief that honest negotiations for mutual gains are the best way to accomplish the organisations goals. Commitment also entails the willingness to accept the results of negotiations or discussions between the different organisations, also when the compromises are not completely supported. Sometimes an organisation can feel pressure to agree to the consensus made (even when they do not completely agree), affecting their commitment to the process. In that case commitment also depends on the trust of other organisations to respect the interests and perspective of this organisation. This shows the importance of once again the concept of trust. In addition, the importance of honest and transparent procedures during the negotiations of the collaboration for commitment (Ansell and Gash, 2008).

Another aspect of commitment is ownership. Ownership is about the feeling of shared responsibility for the collaboration and the collaborative process. The participating organisations of the collaboration cannot simply only criticise the process, but are also responsible for (owning) the decision-making process together with the other organisations who could have opposing views. Again trust is essential for shared responsibility. Trusting that the other organisations also take on ownership and do not take advantage. Commitment and ownership can be enhanced when the involvement of the organisation increases, which could be hindered by power or resources imbalances (as explained at first concept of the starting conditions). Also different perceptions about which organisations should take the initiative in the collaboration could hinder the shared ownership. Next to ownership, also high interdependence can enhance the commitment to the collaboration. Organisations which need to keep cooperating with the other organisations in order to achieve their goals, will have higher commitment to the collaboration. Lastly, in some cases of an intersectoral collaboration some organisations are participating, because of a mandated cooperation, which could impair real commitment (Ansell and Gash, 2008).

Shared Understanding, about what the different organisations can achieve together is something which has to be developed during the collaborative process**.** Shared understanding is often referred to differently in the literature, as for example common ground, alignment of core values and shared mission (Ansell and Gash, 2008). Shared mission is indicated as important factor for the sustainability of the intersectoral collaboration in the HALL-framework. Shared mission is described as organisations needing to recognize the common mission for the (health) problem. This includes agreement on aims and objectives (Koelen et al., 2012; Koelen et al., 2008). In addition, both Ansell and Gash (2008) and Koelen et al. (2012) mention, agreeing on a problem definition is part of

shared understanding (/mission). Shared understanding from this Model of Collaborative Governance and shared mission of the HALL-framework can be considered as the same factor, which focuses on agreement of needed knowledge or resources for addressing the common problem of the collaborating organisations.

Intermediate Outcomes, are indicated as critical process outcomes which are essential for creating a drive that can lead to a successful intersectoral collaboration. Next to, intermediate outcomes offering concrete outputs of the progress. It is suggested that a collaboration is more likely to pursue when the purpose or advantages of the collaboration are concrete. This includes possible, so-called, small wins for the collaboration. These small wins send feedback into the collaborative process. This could trigger a virtuous cycle of commitment and trust building. Intermediate outcomes with small wins can be crucial when organisations have a history of conflict and there is a need of trust building. In addition, small wins can be essential for investments or funding. Intermediate outcomes and small wins can be an incentive to keep participating in the intersectoral collaboration. However, sometimes the organisations have ambitious goals that cannot easily be deconstructed into intermediate outcomes. In that case the organisations could focus on, in order to build trust, in an early stage exploring the overall value of the intersectoral collaboration (Ansell and Gash, 2008).

These underlying concepts have some clear connections to the factors of the HALL-framework. Shared understanding will be disregarded in this respect, as it can be considered as entirely the same as the factor shared mission of the HALL-framework. One of the most recurring underlying concept is trust building. Several factors of the framework indicated trust building as an important for developing a successful intersectoral collaboration. The factor attitude and beliefs and personal relationships explain importance of trusting the other organisations through the view of each other and by maintaining and building relationships. Thereby, with the factor clear roles and responsibilities, developing trust that the other organisations have the skills and can fulfil their roles and responsibilities. Lastly, it is important to realise it takes time to developed trust, as explained at the factor flexible time frame. The literature and the HALL-framework regularly mention trust as important concept. Therefore, is the Model of Collaborative Governance by adding trust building as a concept, a valuable addition to the theoretical framework of this study.

Commitment to the process is an underlying concept of a lot of the factors from the HALL-framework. Starting with the factors attitudes and beliefs and self-efficacy, where commitment emerges in the willingness to invest resources and time in the collaboration, belief in the value of the other organisations and belief in the capability to make a difference and perform as organisation in the intersectoral collaboration. Commitment also arises from willingness to accept different views or incentive to participate by mutual interests, each one towards creating a shared identity connected to the factor social identity. Social identity involves, it becomes meaningful for organisations to be part of the collaboration, where ownership is a part of the underlying concept of commitment to the process (feeling of shared responsibility for the collaboration). The same applies to the factor shared mission. The factor building capacities, about different skills and expertise's of the organisations connects to interdependence enhancing commitment to a collaboration. Organisations needing to keep cooperating and build on each other's capacities in order to achieve their goals, have higher commitment to the collaboration. Lastly, commitment to the process is also connected to the factor visibility. It can function as an incentive for involvement, action and continuation of the intersectoral collaboration, being a motivation for the organisation to stay committed to the health initiative.

Visibility is also influenced by the underlying concept of intermediate outcomes. To be specific, visibility of outcomes. Intermediate outcomes are needed, in order to create visibility on the short-term. These can on their turn create incentive to participate or keep contributing to the collaboration. The visibility of intermediate outcomes can also be of importance for financial support, which shows also a connection of intermediate outcomes being an underlying concept for the factor

funding. Last connections will be made with the underlying concept of face-to-face dialogue to the factors personal relationships and communication structure. Regarding the factor communication structure, it is indicated that both formal and informal communication are important, where face-to-face dialogue could play a role by breaking down any prejudices, stereotypes or other communication barriers. Especially, informal communication can be productive and be important for developing personal relationships. The factor personal relationship is about learning to trust each other and liking one and other, where face-to-face dialogue could be supportive.

2.6 Model of Sustainable Intersectoral Collaborations

It is essential to take note of the factors and underlying concepts indicated to be important for an intersectoral collaboration, in order to understand the functioning of an intersectoral collaboration. The HALL-framework complemented with the Model of Collaborative Governance elaborated above, provide this understanding by describing these factors and concepts. These descriptions of the factors and concepts with their interconnections offer a theoretical foundation. On the basis of this theoretical foundation, a new combined model has been developed. This model contains the most important considered factors and concepts for this study on sustainability of intersectoral collaborations. These factors will be the main focus of the research (including for the feasibility of this study). The factors and the model are displayed in figure 3.

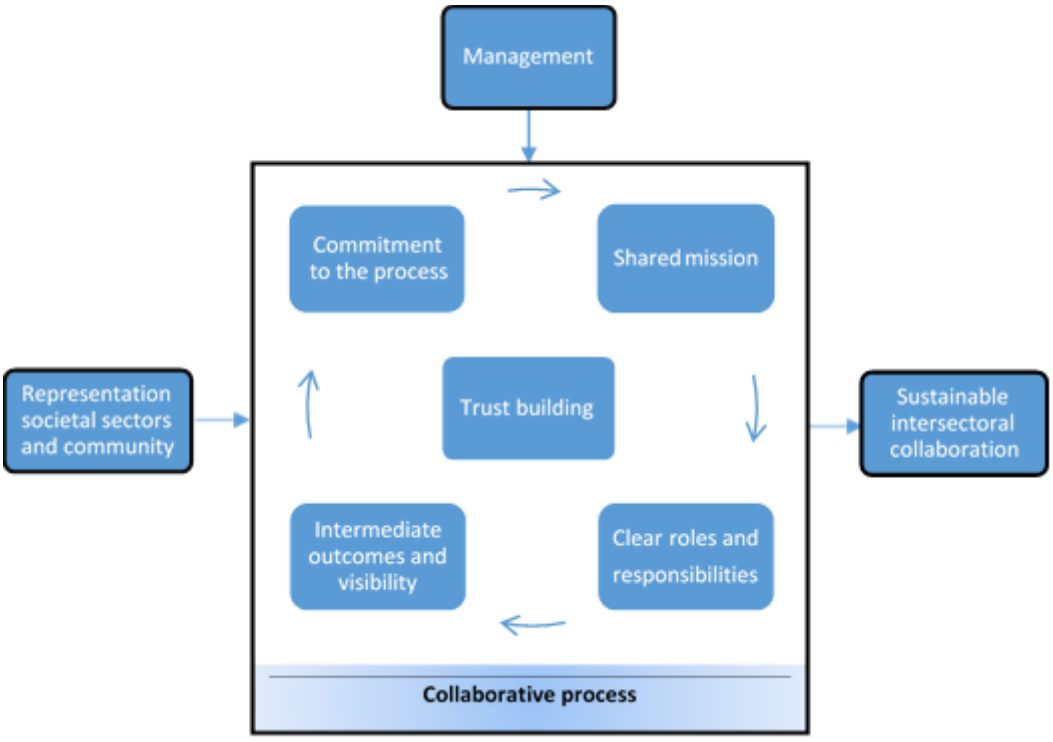

Figure 3. Model of Sustainable Intersectoral Collaborations [MSIC].

This model contains the six factors of the HALL-framework indicated to be of importance for the sustainability of an intersectoral collaboration. In addition, the model contains four concepts of the collaborative process of the Model of Collaborative Governance, which are being perceived as the core of a collaboration. Together they form the Model of Sustainable Intersectoral Collaborations [MSIC]. The other factors and concepts from the theoretical framework are excluded from this model, as they were not indicated important for the sustainability or perceived as the core of the collaborative process. The elaboration of this combined model will start with two factors influencing the collaborative process; management and trust building.

Management is one the factors of the HALL-framework indicated to be of importance for sustainability (Koelen et al., 2008) and can be connected to the underlying concept of facilitative leadership. Facilitative leadership is also presented as a factor influencing the collaborative process in the Model of Collaborative Governance (see figure 2). Consequently, the factor management can be divided into facilitative leadership and communication structure, both explained within the factor management as two essential components. These two components are also described separately within the previous framework and model, of which communication infrastructure is also indicated as important for sustainability. Furthermore, the factor management (also often referred to as leadership) and trust building are identified multiple times in literature and different studies as important factors for an intersectoral collaboration (Stolp et al., 2017; Jones and Barry, 2011). Trust building plays a key role during whole process of developing and maintaining an intersectoral collaboration (as indicated in the literature, the Model of Collaborative Governance and the HALL-framework). This is the reason why trust-building is removed as one of the steps of the collaborative process cycle and being instead presented in the middle, to show trust-building is a factor influencing and is part of every step in the complete collaborative process.

The collaborative process of this model (displayed as a cycle) has similarities with the collaborative process of the Model of Collaborative Governance. Ansell and Gash (2008) regard this process as the core of their model and of a collaboration, therefore this is also included in the Model of Sustainable Intersectoral Collaborations. In the MSIC, the process is also presented in a cycle, because of the non-linear and iterative character of a collaborative process. Again the cycle can be regarded as a simplification, but indicates it is a continuous process influencing the collaboration. However, the collaborative process of the MISC differs of the collaborative process of the Model of Collaborative Governance, as it includes different and overlapping factors. It includes three of the six factors indicated to be of importance for sustainability of an intersectoral collaboration from the HALL-framework; shared mission, clear roles and responsibilities and visibility.

Shared mission, as explained, can be regarded the same as the concept of shared understanding, which is a concept of the collaborative process of the Model of Collaborative Governance. In the MSIC, it has been chosen to use word shared mission instead of shared understanding with assumption that ''mission'' describes the scope of this factor better (not only understanding each other but also working together towards a common mission). Developing a shared mission is indicated in both the HALL-framework and the Model of Collaborative Governance as essential for addressing a joint problem.

After defining the shared mission, it is important to make clear the roles and responsibilities of each participating organisation in the intersectoral collaboration. The factor clear roles and responsibilities is included in the collaborative process, because it is also important to discuss and have shared expectations about the contributions each organisation (with their to be determined roles and responsibilities) will bring in (Koelen et al., 2008). Clear roles and responsibilities descriptions need to be developed consensually, as is the case with developing a shared mission.

When the shared mission and clear roles and responsibilities are established, intermediate outcomes and visibility are becoming to play a role. Visibility is paired with intermediate outcomes in this model because there are intertwined. Intermediate outcomes are needed, in order to create visibility on the short-term. Next to the importance for sustainability, visibility is indicated to function as an incentive for involvement, action and continuation of the intersectoral collaboration. Visibility of the outcomes has a great influence on this motivation for the participating organisations to keep contributing (Koelen et al., 2008). Intermediate outcomes are therefore indicated as critical process outcomes.

Next to these three factors from HALL-framework there is also another concept; commitment to the process. Commitment to the process is also part of the collaborative process of

the Model of Collaborative Governance. On this aspect the collaborative process of the MISC overlaps (also partly on the concepts intermediate outcomes and shared mission). Commitment to the process is an essential part of the collaborative process. Commitment to the process is connected to incentive to participate in an intersectoral collaboration, which is influenced by the intermediate outcomes and visibility.

The commitment to the process, influenced by intermediate outcomes and visibility, will change the developed shared mission, which on his turn changes the roles and responsibilities. This continues influencing one another step by step (indicated with the arrows in Figure 3). This iterative cycle of the collaborative process keeps going and remains important throughout the collaboration (it could be regarded as a learning process).

As mentioned the collaborative process of the Model of Collaborative Governance overlaps with the new Model of Sustainable Intersectoral Collaborations. With also commitment to the process included and elaborated, all concepts of the collaborative process from the Model of Collaborative Governance are included. The reason that precisely these concepts are included is that they are together by Ansell and Gash (2008) perceived as the core of a collaboration. However, trust building as mentioned, being shifted outside the cycle and face-to-face-dialogue being excluded. Excluded, because it can be regarded as an aspect of communication structure, which is incorporated within the factor management in this model.

Management and trust building both continuously influence the collaborative process. Management by mainly giving structure to process and trust building being important at every step in the cycle. Each of the factors and concepts in cycle individually cite in their descriptions, that developing trust is an essential part of that factor or concept. Management can be perceived as an external contextual factor influencing the process, as indicated with the arrow in Figure 3. Next to these two factors influencing the collaborative process is another external factor, which is the last and sixth factor indicated to be of importance for sustainability.

The factor representation of relevant societal sectors, including community members. Including different sectors in an intersectoral collaboration is a requirement, involving representatives of a variation of societal sectors (including formal and informal organisations). Wide variation of organisations will in the first place influence the to be formed shared mission, clear roles and responsibilities. Thereafter, together with community involvement, play important role at the intermediate outcomes and visibility and commitment to the process. Health initiatives regard often community involvement. This includes not only letting community members participate in the implementation of a health intervention or programme but also involving the community members in the collaborative process. Community involvement is described by Jones and Barry (2011) to be vital component and essential by de Leeuw (2017) for health promotion in collaborations. This representation and community involvement together with management, the collaborative process and trust building will be needed in order to reach a sustainable intersectoral collaboration.

2.7 Research sub-questions on the basis of the MSIC

Taking the Model of Sustainable Intersectoral Collaborations into account with the formulated main research question in the first chapter, it can be divided in several sub-questions. The sub-questions will regard factors indicated in the model and will focus on the health initiatives (cases). In order to answer the main research question the following sub-questions are formulated;

Main research question;

- *What are the facilitating or hindering factors of sustainability of an intersectoral collaboration?*

Sub-questions;

1. *How does the health initiative ensure representation of relevant societal sectors and include community members?*
2. *How has management been arranged within intersectoral collaboration of the health initiative?*
3. *How has trust-building been arranged within intersectoral collaboration of the health initiative?*
4. *How does the intersectoral collaboration within the health initiative operate according to the factors of the collaborative process (shared mission, clear roles and responsibilities, intermediate outcomes and visibility, and commitment to the process)?*
5. *How do these factors of the MSIC relate to a sustainable intersectoral collaboration?*

These sub-questions will make it possible to answer the main research question. The sub-questions will result in a description how the participating organisations of the health initiative interact with each other. This gives the possibility to compare the different health initiatives (similarities and differences). After the comparison, an assessment can be made if there are universal ways for making a health initiative consisting of an intersectoral collaboration sustainable in the community (lessons and conditions).

3. Methodology

This chapter describes the methods used in order to answer the main research question and sub-questions. First, the study design will be shortly addressed, thereafter the data collection and selection procedure, subsequently the operationalisation and process-indicators. Thereafter, the data analysis will be discussed. Following, the two used methods; document analysis and interviews will be elaborated. Lastly, the validity and reliability will be explained and some ethical considerations will be addressed.

3.1 Study design

A qualitative multiple case study design has been chosen, in order to retrieve in-depth knowledge about the intersectoral collaborations of health initiatives. A case study method focusses on analysing contemporary bounded systems (cases) through a comprehensive and in-depth data collection by one or more methods, containing multiple sources of information (Gustafsson, 2017). This multiple case study used two qualitative methods; interviews and document analysis.

This study regarded a most different cases design, because the aim is to explore similarities and differences between the cases on process inputs and outcomes, allowing identification of universal ways for making a health initiative sustainable into the community (Gustafsson, 2017). This so-called contrasting of cases will eliminate all factors not linked to an identical outcome (Berg-Schlosser and De Meur, 2009), in this case a sustainable health initiative.

3.2 Data collection and selection procedure

The data was collected from a selection of the health initiatives registered at the competition Make the Next Move from AAH (n=34, 2020), of interest and value to this research and willing to the take part in this study. This concerned the following selection procedure; **(1.)** the health initiative consists of an **intersectoral collaboration** containing at least two organisations, **(2.)** the health initiative has already been **further developed** (beyond the start-up of activities / already carrying out the activities associated with the initiative), **(3.)** the health initiative is **community-based, (4.)** there is **community involvement** in the health initiative and **(5.)** finally the health initiative is **willing to participate** in this research. The selected health initiatives received an invitation for participation via their email addresses (see Appendix 8.4). In addition, this study regarded a most different cases design, so there was also a selection procedure concerning; **(6.)** the cases **differ** in health promotion **goals and target groups**, **(7.)** the cases **differ in scope of participating organisations** in the collaboration (amount of organisations) and the amount of **different sectors** included, **(8.)** the cases **differ in existence and duration** of the health initiative, **(9.)** the cases **differ in amount of community members** participating in the health initiative and **(10.)** the cases **differ in scale** (local, regional, national).

The selection procedure regarding the first five selection criteria are displayed in figure 4. In the first step the health initiatives from which the organisations are from one sector or exists from one organisation or consist of someone self-employed are excluded. In the second step of this figure are the initiatives excluded, which indicated to be still in a pilot-phase or, of which only a concept is developed. The third step regards the excluded initiatives of which the community members are not being actively involved in setting up health interventions/activities. The fourth and last step are the health initiatives which did not want to participate in the study. The included and excluded health initiatives are included in the Appendix 8.3.

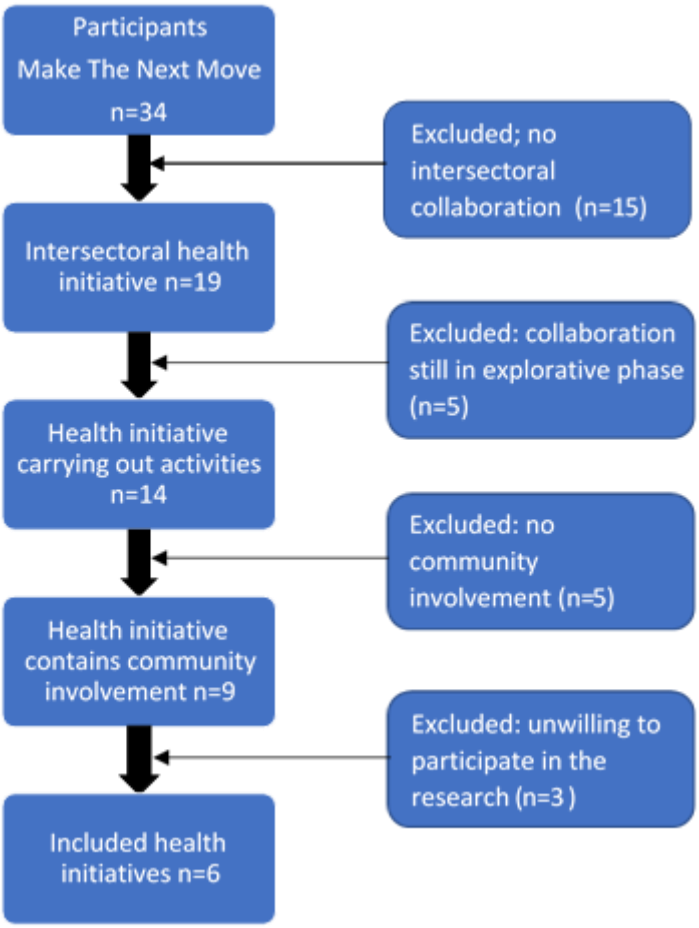

Figure 4. Selection procedure of the cases.

As displayed at figure 4, this selection process resulted in six different health initiatives (cases) being included for this research. The last five selection criteria regarding the most different cases design are included in table 1 for these six cases. Each criteria for each case is shortly described. In general the cases differ according to the selection criteria. Regarding scale a clarification may be needed, there are two national and two local initiatives included. However, also two national-local initiatives, which means a local approach in different municipalities throughout the Netherlands. A short description of each individual selected case is included after the table.

Most different cases design						
Regarding the selected health initiatives and the selection criteria						
Cases	Health promotion goals and target groups	**Scale (local, regional, national)**	**Amount of community members**	**Amount of organisations (Approx.)**	**Amount of sectors (Approx.)**	**The existence and duration of the health initiative**
Gezondheids-ambassade	Improving the overall health of the residents.	Local	1 municipality	11	3	2014-present
Montfoort Vitaal	Aim to add two vital years of life for every resident of the municipality. Focus; youth.	Local	1 municipality	24	4	2012-present

Voel je Goed	Eating and exercise advice for people with low-literacy.	National	40 municipalities	3 (per municipality)	3	2016-present
Doortrappen	Elderly continue to cycle safely for as long as possible.	National	150 municipalities	7 (per municipality)	4	2018-present
Voedselapotheek Wijkaanpak	Increasing the health skills of residents regarding healthy eating behaviour.	National - local	2 neighbourhoods of 2 different municipalities	13 (per municipality)	4	2020-2021
Gezonde Buurten	Healthy neighbourhoods for residents and municipalities. Focus; children.	National - local	13 neighbourhoods of 9 different municipalities	6 (per municipality)	3	2018-present

Table 1. *Most different cases design in line with the selection criteria*

Gezondheidsambassade:

This health initiative is executed at one municipality in a district with multiple neighbourhoods, at which they aimed having the community members investigate how they can make their neighbourhood and themselves healthier. This is established with a training for community members in order to develop and implement own health activities. This is made possible by one independent facilitative organisation with the support of local organisations and professionals from 2014 onwards.

Montfoort Vitaal:

This health initiative is executed at one municipality, at which they aimed to add two vital years of life for every community member of the municipality. They focused on an active and healthy lifestyle, with activities regarding sports and exercising. Thereby, making use of the active presence of associations and prioritising the youth in the municipality. The intersectoral collaboration exists from local organisations from 2012 onwards.

Doortrappen:

This health initiative is executed at approximate 150 municipalities throughout the Netherlands, at which they aimed to have elderly continue to cycle safely for as long as possible, accompanied with health benefits and a better quality of life. This is done by raising awareness and interventions for behaviour change or adaptations regarding the bicycle. The intersectoral collaboration exist from national and local organisations with eventually hoping to realising less accidents with cycling elderly (from 2018 onwards).

Voel je goed:

This health initiative is executed at approximate 40 municipalities throughout the Netherlands, at which they aimed to tackle overweight and perceived ill health, by improving health literacy of lower educated adults with low literacy. This is established with an intervention of individual counselling by a dietician and group lessons/activities in health literacy by a volunteer. The intersectoral collaboration exist from national and local organisations from 2016 onwards.

Gezonde buurten:

This health initiative was executed at 13 neighbourhoods in 9 different municipalities, at which they aimed to develop a green and healthy neighbourhood in co-creation with the community members. The focus of health neighbourhood is on creating a place (with nature), where community members meet (social cohesion), exercise, play and learn about healthy food or lifestyle (with a focus on children). The national and local organisations of this intersectoral collaboration facilitate and support the community members designing their healthy neighbourhood (from 2018 onwards).

Voedselapotheek Wijkaanpak:

This health initiative was executed at two neighbourhoods in two different municipalities, at which they aimed to improve health skills among the local community members and making healthy food more accessible. This intersectoral collaboration existed of designers, professionals, local organisations and community members, which worked together towards a healthy and social food landscape. This initiative was a programme of one year (2020-2021) at which activities were organised that focused on collaborating, sharing knowledge and the needs of the community members.

3.3 Operationalisation and process-indicators

The data analysis of documents and interviews is based on the factors of the Model of Sustainable Intersectoral Collaborations. For this analysis procedure these factors needed to be operationalised. This was on the basis of certain process-indicators. These process-indicators are developed during the first project evaluation of the AAH programme by Bekker et al. (2016). This evaluation has resulted in the development of process-indicators based on observations from health initiatives and on literature from the public administration field (including the previous discussed Model of Collaborative Governance of Ansell and Gash (2008)). Accordingly, the process-indicators are indicators providing an indication of the progress of the initiatives, in order to be able to monitor and evaluate the health initiatives (for example, the scope and number of participating organisations or activities). The process-indicators are displayed in appendix 8.1. By making use of these process-indicators, this study will contribute to the indicated need of the development of a more consistent approach of conceptualisation and measurement of intersectoral collaborations in health promotion. In addition, the results of this research may be valuable for the current process evaluation of AAH by using the same process-indicators . There are some process-indicators elaborated or added following the descriptions of the factors at the theoretical framework.

All the eight factors of the Model of Sustainable Intersectoral Collaborations are operationalised with these process-indicators, which is included in a table at appendix 8.2. For example the factor '*the representation of relevant societal sectors, including community members*' was operationalised with the following indicators; number of partners, more than two different domains, direct contact with target groups of citizens, feedback mechanisms, transparent adaptation and improvement and process activities such as reflective working visits, dialogue tables, experiential learning. The first two indicators address the importance at this factor of including different relevant sectors in an intersectoral collaboration. The other mentioned indicators address the importance of community involvement. Direct contact and feedback mechanisms with the community members for remarks on the initiative, which can be done with for example process activities such as reflective working visits. Next to, the importance of being transparent towards to community about adaptations and letting them participate in decision-making. These indicators are used to analyse the retrieved documents of the health initiatives and interviews, on the factor of the representation of relevant societal sectors, including community members. This also applies for the other factors of the MSIC with their linked process-indicators.

In addition, this operationalisation was also used for the development of the interview questions. For example, the factor management with the process-indicator; stimulating participation, empower and involve; *How does the management stimulate participation, empowerment and involvement of the various organisations?* The interview questions based on the operationalisation of the factors with the process-indicators are displayed in the appendix 8.7 (interview guide). Most process-indicators have been incorporated in potential follow-up questions.

3.4 Data analysis

The forms of data that have been collected consist of documents and interviews. The selected health initiatives have been asked to provide material on the initiative and their intersectoral collaboration. The documents ranged from institutional reports to meeting notes. The provided documents have been assessed whether they contribute in answering the research question. This on the basis of the potential occurrence of factors and concepts of the theoretical framework, in particular the factors of the Model of Sustainable Intersectoral Collaborations. In addition, the selected health initiatives have been asked to participate in an interview. The interviews were held with the representatives of the health initiatives following an interview guide. The conversations have been recorded and served as data for the analysis.

Both the data collected with the document analysis and interviews are analysed by the means of the method coding. Coding entails the categorisation of fragments of the data with keywords (codes). This enables to compare and conceptualise the data. The fragments consist of phrases, sentences or paragraphs, being parts of texts from the documents or interviews. Codes can also be grouped into categories. The categorisation system of coding will lead to an index of codes. This allows the researcher to identify similar information, detect frequencies and patterns within the data (Cohen, Manion & Morrison, 2017), which made it possible to recognise universal ways on how intersectoral collaborations (health initiatives) are made sustainable in the community. In addition, an overview of codes, makes differences and similarities between cases clear. The codes and categories are used to convey, explain and support the interpretation of research data.

The analyse procedure of coding for this research regarded theoretical coding and partly open coding. The procedure started with theoretical coding, from which follows an observation how the codes and categories in the data relate to each other (to compare to MSIC and integrate into theory) (Cohen et al., 2017; Thornberg & Charmaz, 2014). The described factors of the theory (in this case MSIC) have been the basis for the formed codes. This entails the codes are decided upon in advanced, in contrast to open coding. In addition, there was open coding in order to be responsive to the data. This means adding, modifying or adjusting codes in response to the data (Cohen et al., 2017). Open coding is about making a new code for a fragment to describe and categorise that fragment. During the open coding it was aimed to localise patterns and notable matters (Scheepers, Tobi, & Boeije, 2016) beyond the theoretical codes, which could be of value for the research.

The coding process was finished when the data was considered to be saturated. This means the data from new documents from a health initiative are consistent with the previous codes and categorisation of fragments from the other processed documents and no more new codes are added (Scheepers et al., 2016). In other words, additional documents (data) do not add anything more to comprehend the data (Cohen et al., 2017). The coding procedure had first been executed with the document analysis (as the results from this analysis could potentially direct the questions of the interview) and secondly with the obtained data of the interviews. Thereby, also keeping in mind new formulated codes during the open coding at the document analysis. Before the data from the recorded interviews could be coded, they had to be transcribed (writing down what has been said word for word). For the procedure of coding, a computer programme called ATLAS.ti was used. This

enabled efficiency, overview and working systematically, as codes and categories could be saved, tracked and edited in the documents (Scheepers et al., 2016).

3.5 Document analysis

The study regarded a qualitative document analysis, which aimed to make an in depth analysis of the messages contained in the documents (Scheepers et al., 2016). The documents which have been analysed concern material, both on paper and online, that selected health initiatives were able to provide regarding their intersectoral collaboration (for example, progress, final or evaluation reports, see Appendix 8.9). It was aimed to use material from the past four years to obtain the most recent image of the intersectoral collaboration (the last process evaluation was 2014-2017, so the focus of this study was on material from 2017 and onwards). This qualitative analysis tried to discover the hidden or underlying meanings of the messages in the documents (Scheepers et al., 2016). The focus has been on the appearance and expressing of the factors of the Model of Sustainable Intersectoral Collaborations. These factors are operationalised with process-indicators, which is explained at 3.3.

The focus of the document analysis concerned an interpretative document analysis. This type of document analysis is about open perspective and trying to develop new concepts and/or extend the factors/concepts of the theoretical framework (Pleijter, 2006). This procedure has cumulative character, using the factors and concepts from the theoretical framework as guiding for the development of a theoretical model. The relationship between the documents and the theoretical framework are not predetermined, these guiding factors were used to organise aspects of the material and understand the content (Pleijter, 2006). This way of trying to define factors was a systematic manner to reveal similarities between the documents of the different selected health initiatives (Pleijter, 2006). The interpretative research approach focuses on people and in this case also the participating organisations of the health initiative. The focus on their interpretations and indicated implications on how they perceive the intersectoral collaboration is made sustainable.

Next to, a document analysis, is interviewing also known as a suitable method for this type of research (Pleijter, 2006). The document analysis and interviews focused on answering the research question guided by the formulated sub-questions. The results of the document analysis partly directed the interview, as any missing information in the documents regarding answering the sub-questions, was given extra attention in the interview.

3.6 Interviews

Interviewing enabled to go in-depth about the intersectoral collaboration of the health initiative. The document analysis provided insight into which aspects should be given more attention to during the interview and which information was still missing or needed elaboration. This study regarded formal interviews, at which the health initiatives have been informed about the interviews and to be discussed topics. Appointments have been made about when and where the interview would be conducted (Scheepers et al., 2016). The interview itself regarded a semi-structured interview. A semi-structured interview consists of pre-made open-ended questions and semi-structured interview guide, which contains the topics the researcher wants to explore. In order to compare results of interviews for the use of this research, the interview guide served as a purpose to explore the different health initiatives more systemically and comprehensively, along with keeping the interview focused on topics of value to the research (Jamshed, 2014).

The interview questions are based on the factors of the Model of Sustainable Intersectoral Collaborations from the theoretical framework. For example, the following interview question regards the factor trust-building; *''What is being done within the health initiative to build trust between the different organisations?''*. This main question had possible follow-up questions, for example; *''How is time and space guaranteed for building trust?''.* The complete interview guide and

interview questions are included in appendix 8.7. The questions are developed on the basis of the process-indicators of the factors of MSIC, which is elaborated at 3.3

The interviews were conducted with the representatives of the health initiatives. One representative of each health initiative (resulting in six interviews). The representatives were beforehand asked if the interviews could be recorded (all agreed). Recording enabled to capture the data more effectively (Jamshed, 2014), which is explained in more detail at 3.7 Validity and reliability. Three of the six interviews took place online, through a communication software, due to covid-19 measures. These interviewees felt uncomfortable with a physical interview or measures at that time taken by the Dutch government prohibited a physical interview. During the execution of the interviews, these measures from government were highly variable (weekly changes), allowing three interviews to be conducted physically. From a recent research by Archibald, Ambagtsheer, Casey, and Lawless (2019) the communication software Zoom was indicated as suitable tool for the collection of qualitative data through interviews, because its relative ease of use, data management features and security. The similar software Microsoft Teams was used (utilising a secure university account). All representatives of the health initiatives had access to the suggested communication software and had no preference for another communication software.

3.7 Validity and reliability

In a qualitative document analysis plays the researcher an important role in the analysis, because it is constantly about the own interpretation of the researcher of the material. Therefore, in comparison with quantitative document analysis, much less fixed procedures are used. This makes it difficult to measure the quality of qualitative research, because there are no criteria, as is often the case with quantitative research. For that reason is important to be as transparent as possible about the used methods and analyses, in order to ensure the reliability and validity of the research (Scheepers et al., 2016). The importance of transparency also applies to the analysis of the data from the interviews. There is again a personal interpretation when coding the data, as with the data from the documents. A coding programme can offer more transparency, as all decisions and actions can be documented. This study made use of the coding programme called Atlas.ti 9, which advanced operating systemically, provided structure and increased reliability (Scheepers et al., 2016).

According to Pleijter (2006) there several ways to ensure intern validity. Of which the following are included; writing down all decisions made during the analysis together with argumentation (again transparency), including reporting of data, theoretical foundation and method triangulation. In this case, the method triangulation consist of a document analysis and interviews, which are used to determine whether the results of both methods partially correspond in the study. Triangulation is used in qualitative research in order to test validity by using information from different sources, to develop comprehensive understanding of the subject and assure research quality (Carter et al., 2014).

Next to, method triangulation, there was also data triangulation. The two different methods allowed for collection of different types of data (information). The different types of data are the retrieved documents and the information gained through the interviews. In addition, there are also multiple different cases, as data sources for this research. Including different types of health initiatives (cases) increased the validation of the data (Carter et al., 2014).

In addition, in order to increase the reliability of the data resulted from the interviews, there was a preference for recording the interview (with permission) in order to be able to transcribe the interviews. This because making notes during the interview is relatively less reliable and there is always the chance of missing some possible important points. Transcription enables to generate a word for word transcript of the interview. Besides, recording allowed the researcher to better focus on the interview content and the interviewee's verbal communication (Jamshed, 2014), which

improved the quality of the interview. In addition, it was important that the interviewer at the beginning took a non-directive role, in order to give the interviewee the possibility to explain what they experience as important. Thereby, trying to avoid preferred answers by the interviewer. On the other hand, there have been also directive parts of the interview, in order to determine the course and to provide the necessary information for the research (Scheepers et al., 2016).

3.8 Ethical considerations

While collecting data from the health initiatives, some ethical considerations were kept in mind. First was to obtain informed consent. The participating health initiatives had to understand, what participation in the study entailed. The initiatives were informed, about how and which kind of data would be collected and how the data would be analysed. In addition, the use and processing of the data has been taken into account, with regard to possible sensitivity and privacy of the data. Participants were informed, that the data would only be accessible and used by researcher of this study and Wageningen University & Research [WUR]. The data is saved and stored in a secured environment of the university. The participants had to agree to and sign an informed consent form, which is included in appendix 8.5.

Regarding interviews it is explicitly needed to ask permission to record interviews. This allowed to capture the data more effectively, as explained above. However, it was considered some people would not agree to be recorded (Jamshed, 2014) and alternatives having to be discussed. This concerns the ethical principle of respect for autonomy. This principle safeguards the capability of the participants to make their own decisions during the research and ensuring these decisions are respected. This also regarded the capability to stop the interview at any moment. In addition, the principles of non-maleficence and justice were addressed, which is about ensuring no harm would be done to participants during the research and they would be treated fairly (Scheepers et al., 2016). All the interviewees agreed to be recorded.

The proposal of this study has been reviewed by the Social Sciences Ethics Committee (SEC) of the WUR. The committee has concluded that the proposal deals with ethical issues in a satisfactory way and that it complies with the Netherlands Code of Conduct for Research Integrity. This ethical approval is included in Appendix 8.8.

4. Results

In this chapter the results of the analysis of documents and interviews of the six cases are described. The data from both the documents and interviews are analysed on the basis of the factors of the Model of Sustainable Intersectoral Collaborations. Each factor of the MSIC is individually discussed. First, sustainability is described. Secondly, the factors influencing the collaborative process are discussed and thereafter the factors of the collaborative process. The process indicators have been used for the elaboration of each factor, which are included in an overview in appendix 8.2. Lastly, the presence of some additional factors of the theoretical framework and from the open coding are described. The latter, are recurring concepts in the documents and interviews, which are expected to be valuable for the research.

4.1 Types of data used

In appendix 8.9 an overview is given of the kind of documents of each included case (health initiative) that have been analysed. The documents ranged from invitations, meeting minutes and presentations to progress, evaluation and final reports. In total there are 35 documents analysed, of which predominantly these reports. In addition, the websites (including some video's) of the initiatives were assessed. It is important to note that the kind of documents partly influences the presence of the certain factors. For example, in these reports many intermediate outcomes are presented or community involvement being highlighted.

The in-depth interviews were conducted with the representatives of the health initiatives. This resulted in six different interviews, which all approximately had a duration of one hour and a half. All these interviews were recorded. The recordings and transcripts served as the data.

Comparison between data of interviews and documents showed that the results regarding the factors are in general the same. Few notable differences are discussed in this chapter. In appendix 8.12 there is a data analysis of each factor divided into data from the documents and data from the interviews with more elaborated detailed information, examples and clarifications.

In addition, there was an opportunity to observe a team meeting of an initiative and to conduct short interviews with experts in the field of health promotion and representatives of different health initiatives at a network meeting of the AAH programme. The observation and short interviews are both described in a brief report, which is included in appendix 8.13. Information from the observation and short interviews confirmed the findings at results from the documents and interviews.

4.2 Sustainable intersectoral collaboration

Sustainability was defined in the documents and by the interviewees as the health initiative being capable to carry on. Several ways of reaching this capability were described in both the documents and interviews. The most prevalent indicated way was the health initiative becoming part of the system. This respected for example the initiative being incorporated in policy plans (for example of municipality, province, school), becoming part of structural financing and monitoring of the results (intermediate outcomes and visibility). Resulting in the health initiative not being temporarily, but becoming part of working methods, regular tasks and regular financing. However, most often and important indicated way of the capability of the health initiative to carry on was becoming part of the local network in the community.

Community involvement was indicated as the key in order to achieve a sustainable health initiative. The initiative is more likely to sustain when community members are being involved in development of the initiative and the activities (or developed activities themselves). The local network also plays a role in making the initiative sustainable in the community. Involving local organisations ensures sustainability for the long-term and the initiative connecting to the systems in place. The initiative becoming assimilated into the local network of the community. Community involvement was indicated to be part of a sustainable health initiative. The health initiative being able to carry on by the means of self-organising ability of the local community (organisations and community members) to execute the health activities on their own.

This was also regarded as a self-sustaining entity in the community, which is in line with the provisional definition of sustainability of this study; *health initiatives are able to carry on their health promoting activities within their own organisations without the need of external incentives, to sustain their intersectoral collaboration and to be a self-sustaining entity*. Only a small, but important, addition has to be made; *… within their own organisations ánd community without the need … .* Most of the cases of study aim that at some point the initiative can be transferred from the initiators to community members and local organisations. The capability of the health initiative to continue to exists after initiators have left. The community (organisations and community members) taking care of management and maintenance of the facilities and organisation of the activities (self-organising ability). The following quote describes this community involvement as answer to the question what an initiator understands by a sustainable health initiative.

''Nou, dat als wij weg zijn, als wij, als initiatiefnemers, dat het dan alsnog overeind blijft, dat de gemeenschap het over neemt en of dat nou, de gemeenschap, nou bestaat uit de bewoners of een combinatie met professionals.'' (Interviewee 4, 2021)

Translated: "*Well, that when we are gone, as initiators, that it will still exist, that the community will take over and whether that is, well, the community, consisting of the community members or a combination with professionals.*"

Several initiatives also mentioned they look for the possibilities in the local network to position the health initiative (in Dutch ''Landingsplaats''), who or which local organisations are capable to take over? (including willingness). It was noted by several interviewees after the community (local network) takes over or adapts the initiative, there should always be the possibility to still ask for support or stimulation from an external professional institution. For example when a leader (driving force) stops and one can still fall back on a professional organisation. In the following quote, an interviewee describes this transferring of the health initiative activities (in this quote, with ''initiative'', an ''intervention'' of the health initiative is meant);

''… om een landingsplaats te creëren, zeg maar, dus als wij een hardloop initiatief starten. En dan willen we dat in één of twee jaar steunen en daarna willen we het loslaten, maar dan willen we wel zeker weten dat daarna doorgaat. En nou ja, dat is, dat is ons ons spel, zeg maar … Maar wij kunnen niet alles we wij, wij kiezen ervoor, aan het begin van een initiatief te staan. Op het moment dat we dat initiatief weer kunnen loslaten, dan doen we dat, dus onze vaardigheid zit hem ook in het loslaten. Ja, en het laten landen bij anderen.'' (Interviewee 3, 2021)

Translated: ''*… to create a landing place, so to speak, so if we start a running initiative. And then we want to support that in one or two years and then we want to let it go, but then we want to make sure that it continues after that. And well, that is, that is our game, so to speak … But we cannot do everything we, we choose, to be at the beginning of an initiative. The moment we can let go of that initiative, we will, so our skill is also in letting go. Yes, and let it land with others."*

The intersectoral aspect of the collaborations was also indicated to be important for the sustainability of the health initiatives. Connecting different sectors and establish a network enables to make the health initiative sustainable. Cross pollinations (of knowledge and resources) between sectors stimulates the collaboration and makes it possible to identify opportunities. These cross pollinations and integrated work were indicated to be necessary for the health initiatives to succeed. It was noted that this intersectoral approach also requires more effort, as the different sectors have to speak the same language, which is sometimes difficult. Nevertheless, showed the results that a bottom-up approach with community involvement is also needed to reach a sustainable health initiative. Needs assessments, understanding and investigating what the community members want, increases the chance the health initiative is better received by the community and ultimately a higher chance of sustainability. Thereby, the community members being regarded as equal partners in relation to all other participating organisations (professionals) of the intersectoral collaboration.

Lastly, two additional factors were found in both the documents and interviews to play a role for the sustainability; funding and energy (which will be addressed at 4.5). Next to, the factors of the MISC, of which the results are individually discussed in this chapter. It was mentioned sustainability is also about what works and should be continued. The successful parts or health activities being continued and unsuccessful parts or activities ended. For example, one initiative did not succeed to eventually make the health initiative sustainable and therefore also did not continue (partly also due to funding). However, there were certain parts, health activities, that were continued after the initiative ended. The successful health intervention; the healthy shelf at the supermarket is being extended to other neighbourhoods in the community. All the cases are still in development towards sustainability. Including, the transition of the local community eventually taking over the health initiative. To conclude, sustainability was described as the health initiative being capable of carry on by the means of being incorporated in the existing systems and through community involvement.

These aspects of sustainability for each case are displayed in table 2. Community involvement was present at all the cases of this study (both local organisations and community members). However, all cases are still working towards the health initiative being incorporated in systems. Monitoring and evaluation systems are in all initiatives in place. The health initiatives being incorporated in policy plans is something the cases are trying to achieve, at some municipalities this was already succeeded. None of the cases established to becoming part of structural funding instead subsidies.

Cases	Community involvement (community members and organisation)	Imbedding/incorporated in systems		
		Monitoring and evaluation	Incorporated in policy plans	Structural financing
Gezondheidsambassade				
Montfoort Vitaal				
Doortappen				
Voel je goed				
Gezonde Buurten				
Voedselapotheek wijkaanpak				

Table 2. *Extent to which cases achieve levels of self-defined sustainability*

4.3 Factors influencing the collaborative process

In this section the results of the two external factors influencing the collaborative process at the MSIC will be discussed. First, the representation of relevant societal sectors, including community members, which was described as the importance of involving representatives of variation of societal sectors and needs assessments of the community members. Secondly, management, which was indicated to give structure to the collaborative process.

4.3.1 The representation of relevant societal sectors, including community members.

The results for the factor representation of relevant societal sectors, including community members largely correspond between the documents and interviews. The factor was highly present in the documents, which could be expected as the cases had to be intersectoral and community involvement also being a requirement. In one of the documents it was stated that this intersectoral aspect of the collaboration makes the health initiative successful (see quote below). This is because of being able to use each other's expertise, strengths and experiences in different areas to tackle the (complex) health issue.

''Uit huidig onderzoek blijkt dat de samenwerking tussen verschillende domeinen en werkgebieden een van de succesfactoren is van het programma.'' (p.2 Managementsamenvatting 2021, Doortrappen).

Translated: *"Current research shows that the collaboration between different domains and work areas is one of the success factors of the program."*

At the different initiatives it was often stated new collaborations have been made with organisations from sectors they have never worked with before. However, a few times it was also mentioned that connecting different sectors can be difficult, as they are not used to working with each other.

The intersectoral collaborations mostly existed from the following sectors; the social welfare/health sector, the public sector, the private sector and the education sector. These were also indicated as the most relevant sectors for the health initiatives, at which social welfare organisations were pointed out to be very helpful to establish the health initiatives. It was explained they have experience with including the community members and building a local network (or already established a local network). Especially, organisations from public sector (municipality or ministry) indicated welfare organisations as very helpful. From the health initiatives of this study the collaboration often involved, organisations of a welfare institution, a municipality, a foundation and sometimes of higher education. In the appendix 8.6 there is a table with some examples of organisations for each sector. Not all organisations of each initiative are incorporated. This table is to give an idea of what kind of organisations participate in these initiatives.

Something important to point out is the difference in scale of initiatives and the consequences for the kind of participating organisations in the intersectoral collaboration. The intersectoral collaborations of the cases of this study all exist from local organisations from the communities at which the health initiative is executed. However, the national initiatives are being implemented at several communities, which results in also participating organisations operating on regional or national level being part of the intersectoral collaboration. Creating a local network on the other hand was seen as most important for the health initiative.

Combining the expertise's and networks of different sectors contributed to the implementation and execution of the health initiatives. Establishing a local network of organisations at community was indicated as important aspect for the sustainability of the health initiative.

Moreover, community members were also regarded as a relevant partner for the intersectoral collaboration of the health initiative.

Involving local community members and local organisations from the start, was indicated as very important by all initiatives. The community involvement was the most represented factor in the documents. In the cases of this study, the community members where asked; what they think is important, what they think can improve health or involve the neighbourhood. The community members themselves came up with ideas for health interventions, which shows a bottom-up approach. No pre-made interventions from the top. One of the health initiatives their execution was built on community members, where these citizens are getting trained and supported to set up their own health activities, which could be regarded as ultimate community involvement.

During meetings the input of community members was actively asked; ideas, reactions, wishes about what they would like to address or learn regarding health (issues). In addition, at some initiatives also which role they would like to play within the initiative (what they would like to contribute, setting up health activities or supporting activities for example). These inputs of the community members are used for needs assessments, about what the community wants to achieve, what effort is required to achieve this and who or what (knowledge and resources) are needed. Several of the initiatives described that the needs (or wants) of community members are leading. However, adapting to the needs of the community members, sometimes resulted difficulties in connecting to wishes of the participating organisations of the health initiative (need of flexibility of the organisations). It was several times mentioned that at these meetings with community members, it is not about providing information but really going into dialogue with the community members about health and what they would like to change. In addition, it was described when working directly with community members (through for example community workers or neighbourhood coaches), one constantly gains input about their needs.

This input also gained through process activities. For example; reflective working visits, dialogue tables, experiential learning. In both the documents and interviews process activities such as visiting health activities, starting dialogue at the local supermarket, attending coffee breaks and going into the neighbourhood were mentioned. These are moments at which directly is asked about the experiences with the health initiative or about health in general. This visiting and dialogue was done, by programme leaders/initiators and project leaders/coordinators to keep in touch with the community and to experience themselves how the health activities are received (experiential learning and personal contact). The next quote illustrates a combination of direct contact with target group, needs assessments and process activities. In this quote ''they'' refers to the coordinators of the initiative.

''Zij geven aan dat het hierbij helpt om in gesprek te gaan met de doelgroep. Het gaat er dan om dat de ouderen niet alleen worden uitgenodigd om ergens aan deel te nemen, maar dat ook het gesprek wordt aangegaan over wat er leeft onder de doelgroep en welke wensen en behoeftes zij hebben. Het gebruiken van een bestaand netwerk en aansluiten bij bestaande activiteiten helpt hierbij.'' (p.28 Interim report Monitoring and Evaluation 2021, Doortrappen)

Translated: *''They indicate that it helps to enter into a dialogue with the target group. This means that the elderly are not only invited to participate in something, but that a discussion is also started about what is going on among the target group and what wishes and needs they have. Using an existing network and joining existing activities helps with this.''*

Actively asking for input from the community members could also be regarded as a feedback mechanism (process-indicator). The input is taken into account and is processed as well as possible within the health initiatives (adaptations or improvements). It was noted, that sometimes it can also

be difficult to involve community members.

Next to, retrieving input or getting input from the community members, there is also a next level of community involvement; being part of decision-making. So community members being able to take control by having co-determination and to actively influence the health activities executed in their own neighbourhoods. An example of how community members are part of decision-making is for instance the so-called neighbourhood safari, at which in this case children explore their neighbourhood with the initiators of the initiative (which one also could regard as a process activity) to think, dream and show how the neighbourhood could be used in a different way and could be improved. With support a design was made and again assessed by the children. Another example was a healthy shelf at a local supermarket for and by the community members with their healthy recipes and healthy products (with assistance of some professionals). They made the recipes and decided which new healthy and sustainable eating habits they wanted to try and expected to be important. At two initiatives it is described that the initiators only assisted and the community members made the decisions (they are the executors, the organisations of the intersectoral collaboration give support). One also speaks of co-creation. Giving the community members the possibility to give input, feedback and co-determine will, according to different initiatives, increase commitment and self-esteem.

It was highlighted in the documents and all interviewees agreed that community involvement is an important factor for sustainability of the health initiative. It was something which was indicated one should stimulate for sustaining health initiatives. Community involvement (both community members and local organisations) from the start increases the likelihood of the adaptation of the health initiative in the community. Most initiatives of this study are based on community involvement and aim to ultimately put the initiative in the hands of the community (shifting of responsibility). Therefore, was community involvement mentioned to be part of the sustainability of a health initiative. Relying on the self-organising abilities and maintenance/management of the community. However, for the sustainability of the health initiative, it was also stated there should be a professional institution which facilitate this process and keeps available for support when needed. To conclude, community involvement was indicated important in order to maintain/sustain the health initiative in the community. Community involvement was established by creating a network of local organisations (from different sectors; the social welfare/health, public, private and the education sector) and direct-contact with community members through meetings and different process activities, needs assessments and community members being part of decision-making.

The effect of no community involvement

Several initiatives indicated without community involvement, the health activities or health initiative are not likely to be adopted. They provided examples of top-down health activities which were not sustained, as community members stopped participating. The health activity was not aligned with their needs. This resulted in the development of health activities with community involvement, in order to achieve a sustainable health initiative.

Textbox 1. *Example of the effect of no community involvement.*

The table 3 below shows the level of the cases of this study regarding community involvement. Representation of relevant societal sectors is not included, as all cases are intersectoral and exist of multiple relevant sectors (see also table 1, at the method). Community involvement was present at all initiatives. At one of the initiatives, community members took a part in the development of the intervention by providing their input on the health issue. However, after the development was completed, there was no possibility for participants of this initiative to give input in the execution of the intervention. On the contrary of the other initiatives, where input could be provided throughout

the entire process and community members are part of decision-making, of which two initiatives the community members make the most decisions (the intersectoral collaboration only supports/facilitates).

Cases	Community involvement	Community involvement during whole process	Community members part of decision making	Community members taking the most decisions
Gezondheidsambassade				
Montfoort Vitaal				
Doortappen				
Voel je goed				
Gezonde Buurten				
Voedselapotheek wijkaanpak				

Table 3. *Self-reported community involvement*

4.3.2 Management

Management of the intersectoral collaborations (health initiatives) was described as relationship management. The maintenance of the contact between all the different participating organisations. In both the interviews and documents the importance of knowledge exchange between the organisations of the intersectoral collaboration was pointed out. In these intersectoral collaborations on needs each other's expertise and knowledge (interdependency). Inspiration on how to tackle certain health issues, reciprocity and sharing knowledge was indicated to be part of management and to be a key aspect for an intersectoral collaboration. This is something leaders or managers of the health initiatives try to facilitate.

Management can be divided in leadership and communication structure. Tasks of a leader were, next to knowledge exchange, indicated to be stimulation of participation, empowerment, involvement and connecting of organisations and community members. Thereby, identifying opportunities, by discussing these needs and wishes (with taking into account the financial resources and the capacities). Stimulation was also described as the leader putting him or herself in position of the other organisations and think from within their interests. In the interviews in comparison to documents, several qualities of a leader were mentioned (for example; perseverance, flexibility and creativity), which were all declared to be important to create and identify opportunities. A leader has to ensure to keep the collaborative process going.

Directing the different participating organisations of the intersectoral collaboration, one needs means of communication. Meetings were mentioned mostly as a form of communication. In the documents the frequency of the meetings was often not clear. In the interviews, on the other hand, frequencies of monthly, quarterly, biannually, annually were mentioned. These meetings were between all the participating organisations. Besides, of course also meetings with community members, as all cases indicated the importance of community involvement. It is interesting to mention that during meetings there was also space for feedback between the participating organisations (allowing to make improvements). This feedback and communication at meetings shows a learning process, where clear communication is essential, as described at the quote below.

''Soms verlies je een partner tijdens het project en soms haken er weer aan. Goede communicatie is essentieel.'' (p.39 Final report 2021, Voedselapotheek Wijkaanpak)

Translated; *''Sometimes you lose a partner during the project and sometimes others hook up again. Good communication is essential."*

Different forms of management structures were described in both the documents and interviews. At the national initiatives different levels of leaders within management structure were mentioned. There is a programme leader or team, regional advisors and local coordinators/project leaders. The coordinators are often responsible for one municipality at which the health initiative is executed. A regional advisor is in charge of multiple coordinators, which is coordinated by the programme leader or team. These leaders facilitate the health initiatives on different levels with connecting and supporting organisations (national and local organisations). The quote below is an example of coordinators of different municipalities coming together at meetings for knowledge exchange. This shows there is also knowledge exchange between the different communities, next to knowledge exchange between the different participating organisations.

''Daarnaast organiseert het programmabureau kwartaalbijeenkomsten die als prettig worden ervaren door alle gemeentecoördinatoren. Het bevorderen van kennisdeling tussen de gemeentecoördinatoren onderling wordt als een toegevoegde waarde gezien … Hier halen zij inspiratie uit om in eigen gemeente toe te passen. Een aantal coördinatoren geven aan dat tijdens

deze bijeenkomsten bestaande ideeën over de aanpak van het programma worden bevestigd en er nieuwe ideeën worden opgedaan.'' (p. 37 Master thesis public value 2021, Doortrappen)

Translated: *''In addition, the programme office organises quarterly meetings that are experienced as pleasant by all municipal coordinators. Promoting the sharing of knowledge between the municipal coordinators is seen as an added value… They get inspiration from this to apply in their own municipality. A number of coordinators indicate that during these meetings, existing ideas about the approach of the programme are confirmed and new ideas are gained.''*

At the local initiatives the initiators described another form of leaders. They also had leaders, but indicated, ''leading from the back''. There is a person who pulls the cart, however, they worked together with for example a steering committee. These leaders are subservient to the community. They do not described themselves as leaders, but as people who are pro-active (stimulating the collaboration) or being facilitators. In addition, at these local cases, these people could also be regarded as organic leaders, people respected and trusted from within the community.

Management was also indicated to play a role for the sustainability of the health initiative. For example, one interviewee indicated, the health initiative is currently still being partly executed with leading of a Dutch ministry. Again, as described at the factor sustainability, the ministry, as initiator of the initiative, aims to transfer the health initiative, including the management of the initiative, towards another platform (local organisations or network). Regarding the sustainability of a health initiative, it was indicated management should be incorporated to ensure continued existence of intersectoral collaboration (and the health initiative). To conclude, management was indicated as an important aspect to create structure and knowledge exchange for an intersectoral collaboration, as well as stimulate participation, empowerment, involvement and connecting of organisations and community members (relationship management and identifying opportunities). This is especially needed with different sectors working together.

The effect of no management

A health initiative described that due to the lack of management and no formal appointed leaders, participating organisations dropped out of the intersectoral collaboration. This resulted in the realisation of initiators of the initiative to take the lead. The initiators took a leader role and started to stimulate the organisations and keep them involved with evaluation meetings. The health initiative started to develop a management structure in order to sustain the intersectoral collaboration. However, the initiators still did not wanted to be regarded as ''managers''.

Textbox 2. *Example of the effect of no management*

Table 4 shows which cases had a clear management structure in place and which cases had no formal management structure.

Cases	No formal management structure	Clear management structure
Gezondheidsambassade		
Montfoort Vitaal		
Doortappen		
Voel je goed		
Gezonde Buurten		
Voedselapotheek wijkaanpak		

Table 4. *Management structure*

4.4 Factors of the collaborative process

The factors of the collaborative process of the MSIC exist of; Trust building, which was indicated as trust built between the participating organisations of the intersectoral collaboration. Shared mission, which was indicated as agreement on aim and objectives. Clear roles and responsibilities, which was indicated as clear descriptions according to the expertises. Intermediate outcomes and visibility, which was indicated as the drive for the intersectoral collaboration and commitment to the process, which was indicated as the incentive to participate. These are all discussed individually.

4.4.1 Trust building

Trust building was not represented in the documents. However, all representatives of the health initiatives stated at the interviews that trust building does play an important role for a sustainable intersectoral collaboration. This shows that if factor is not well represented within documents, this does not implies the factor is not perceived important. Regarding sustainability, trust building was indicated to be essential. It is needed to invest time into the collaborations and have patience to build a firm foundation. It was mentioned, when organisations have developed trust in the intersectoral collaboration and the other organisations, they will be committed to work on the health initiative. It was explained it is about relationships between the organisations. If these are well established, there will also be trust. It takes time to developed relationships and trust. A quote below from one of the interviewees displays the regarded importance of trust building.

''Alles begint met vertrouwen, elk initiatief. Ik ken nog geen enkel initiatief, wat zonder vertrouwen succesvol scoorde.'' (Interviewee 3, 2021)

Translated: *"Everything starts with trust, every initiative. I don't know of any initiative yet that scored successfully without trust."*

Trust building was also mentioned to play a role at different factors of the collaborative process. Trust will already be built during introduction of the organisations in the collaboration. The process of making clear what the capabilities and expertise of each organisation are (management, roles and responsibilities), will contribute to the trust building. Moreover, trust will be continued to be developed in the following steps of the process. During consensually developing health interventions/activities (shared mission) and at accompanying results of the health initiative (intermediate outcomes and visibility). Showing already achieved results can gain trust for organisations to (still) participate in the intersectoral collaboration and as already said built trust leads also to commitment to process. This corresponds with trust building placed in the middle of the collaborative process at the MSIC, playing a role at every step.

Results (intermediate outcomes and visibility) were especially indicated at the interviews to be important aspect for building trust. Three interviewees mentioned their health initiatives had to show results in order to build trust. This also applies for health interventions of the health initiatives. Organisations want to see results and if the interventions are effective, before they have the trust to participate in the intersectoral collaboration. It was also mentioned that the recognition of external research institution in the effectiveness of the intervention is helpful to create trust (an objective measure). One can also see this as having to prove yourself as a meaningful health initiative.

Other aspects which were mentioned in order to build trust between the different organisations are; dialogue, respect, honesty, openness and transparency. Open discussion about for example the different interests of the organisations and accompanying possibilities, was indicated as important for trust building. Thereby, agreeing on things which are not possible and open discussion

about difficulties one experienced. Moreover, it was mentioned an organisation should not keep things hidden from the other participating organisations and keep to their promises and responsibilities. This all could also be regarded as relationship management.

Relationship management (trust) also concerns the possibility to give each other feedback. This can regard evaluations about the relationships between the organisations in order to strengthen or gain back trust. Relationships between organisations can be influenced by earlier collaborations or history of cooperation (process-indicator), which also affects trust. Experiences of working together before can have positive or negative effects on developed trust. The cases of this study indicated all this had mostly positive effects, as to some extent already a level of trust had been built. Moreover, it was recognized that trust has to develop over time (process-indicator). However, there also could be a history of conflicts, negatively affecting trust.

Restoring trust could be needed when there are conflicts between organisations. All interviewees on the other hand did not wanted to use the term conflict. They indicated that there were no conflicts within the organisations in their intersectoral collaborations, but sometimes there were disagreements. It was for example mentioned that an organisation (or a person) did undertake activities within the initiative, which they were not assigned to (not sticking to their role descriptions and expertise's within the collaboration). Disagreements were solved with open discussion. Again openness and transparency were mentioned as important aspects, in order to ensure trust among each other is sustained or restored.

Trust between the participating organisations of the health initiative is needed in order for an effective intersectoral collaboration. It ensures organisations are committed and the initiative will be sustained. To conclude, trust building is indicated as an important factor, which has to be developed over time during whole collaborative process and is established by the means of experiences (results, relationship management and history of cooperation) made within the intersectoral collaboration, safeguarded by aspects such as dialogue, openness and transparency.

The effect of no trust building

At one health initiative one of the participating organisations felt they could not bring in their ideas. The intersectoral collaboration was in his first year and the trust had not been strongly developed yet. There was no trust of this organisation in the other organisations or leaders that they would get the chance to propagate their ideas. Therefore, decided several people of this organisation to stop with participating in this intersectoral collaboration. This made sustaining the health activity of which they were responsible more difficult. This showed that within the collaboration process one had to devote time and attention (space) for trust building.

Textbox 3. *Example of the effect of no trust building*

Table 5 below displays which cases perceived trust building relevant for the intersectoral collaboration or important for the sustainability of the health initiative.

Cases	Trust building relevant	Trust building important for sustainability
Gezondheidsambassade		
Montfoort Vitaal		
Doortappen		
Voel je goed		
Gezonde Buurten		
Voedselapotheek wijkaanpak		

Table 5. *Trust building*

4.4.2 Shared mission

At every case in the documents the shared mission of the intersectoral collaboration was clearly formulated with a problem definition, accompanying objectives, clear plan of common goals and outlined activities. It was stated that the vision of the community members on the health issues should also be incorporated. Moreover, it was also confirmed in order to determine public value one should consult the local context. The importance of developing goals and a mission was indicated to structure the process of the intersectoral collaboration and working towards a functioning health initiative (results). Noted was that one also should formulate how the collaboration is going to achieve this shared mission. The formulation of concrete objectives was considered as important as the formulation of the shared mission.

However, what already seemed from the documents, was confirmed at the interviews, the representatives would not regard their health mission of the initiative as a ''shared'' mission. The initiators of the health initiative (which regarded often a single or few persons of one or two organisations) developed a mission or vision and the other organisations were invited or joined this health mission (which created intersectoral collaborations). Organisations join these intersectoral collaborations for different reasons or interests, but eventually all striving for the same predetermined health mission. The fowling quote displays this aversion of the word ''shared''.

*''Nee, ik worstel een beetje over het woord gedeeld. Ik heb, maar dat is iets persoonlijks. Alle neuzen moeten in dezelfde richting staan. Ja, dat vind ik dus niet. Dus, wij hebben met het gezondheids-initiatief***** gewoon een missie gekozen, omdat wij daar als stichting ons senang bij voelde en die missie verhoudt zich tot de andere missies van andere organisaties. … Dus, weet je, ik vind het woord consensus vind ik altijd wel al een mooi woord. Er zit een verschil tussen iedereen is voor en niemand is tegen. En, dat is, er is consensus.''* (Interviewee 3, 2012)

Translated: *''No, I struggle a little bit about the word shared. I have, but that's a personal thing. All noses should be in the same direction. Upon which I do not agree. So, we simply chose a mission with the health initiative*, because as a foundation we felt comfortable with it and that mission is related to the other missions of other organisations. … So, you know, I always think the word consensus is a nice word. There is a difference between everyone is for and no one is against. And, that is, there is consensus.''*

(***** in the context of anonymity, the name of the initiative has been omitted from the quote.)

The last sentence of this quotes connects to the discord in also the literature about the correct word. As described in the theoretical framework, shared mission, is often differently referred to. This interviewee preferred the use the word consensus. In the perspective of consensus is showed, as also said by other representatives of the health initiatives, that the organisations within intersectoral collaboration have their own goals or interests. However, they find each other in a common aspect, the health mission or health issue they want to address or contribute to.

Regarding the national initiatives, one mentioned, there is no shared mission, as locally at every community the participating organisations differ. So, again the initiators developed a (in this case national) mission and local networks of organisations endorse this mission. These national initiatives of this study are part of larger programmes with an even broader mission (at which they could be regarded as interventions). It was even stated that some participating organisations did not become part of the health mission, but only promoted or served the goals and objectives. Apart from not using or consider as ''shared'', all initiatives had formulated a mission (problem definition, aims and objectives)

The differences between the organisations were accepted and seen as a stimulation for the collaborative process. This was also described as an organically process. The differences between the

organisations also results in different views on the health issue, contributing to establishing new ways to tackle the complex health issue and realising the health mission.

Interdependency, an aspect of intersectoral collaborations, also enables to tackle these complex health issues and achieving the mission. Interdependency was described as the health mission not being able to be achieved alone, one depends on the expertise from other organisations and working together in order to be able to execute the health activities of the health initiative. For example, again one mentioned that organisations from social welfare/health sector enabled easier access to the community members for the other organisations. Noticeable, is that in the documents interdependency was not represented and in the interviews on the contrary constantly agreed upon to play an important role for the sustainability of the intersectoral collaboration.

Considering sustainability, offers a ''shared'' mission an agreement or affiliation between the organisations about what the health initiative stands for, therewith increasing long-term commitment/involvement. This entails working together, apart from the different interests, towards a common goal. To conclude, (shared) mission, was described as a handhold about what the intersectoral collaboration wants to achieve regarding the health initiative and indicated to be important to set priorities (objectives, activities, goals), align different interests and the realisation of interdependency.

The effect of no shared mission

At one of the health initiatives certain participating organisations only collaborated for financial incentive, not to join the health mission of the initiative. When these organisations realised they did not make enough money (profit), they stopped participating at the intersectoral collaboration. They did not care about the ''shared'' mission to improve the health of the community members or the dependency of these organisations to be able to continue the health intervention (including not looking for a different way in which they could still contribute to the health mission). This resulted in this particular health intervention not being sustained. The health initiative was still looking for new organisations (with the same ambition) for the execution of this health intervention, which resulted in the development on a this theme of health within the initiative being currently at a standstill.

Textbox 4. *Example of the effect of no shared mission.*

In the table 6 below is showed that almost all cases their health mission was developed by the initiators. The participating organisations join the health mission with their own goals and interests. No ''shared'' mission, but striving for the same ambition regarding the health issue. However, one could still regard this a shared mission, but not as a jointly developed mission.

Cases	Shared mission	Mission developed by initiators
Gezondheidsambassade		
Montfoort Vitaal		
Doortappen		
Voel je goed		
Gezonde Buurten		
Voedselapotheek wijkaanpak		

Table 6. *Shared mission*

4.4.3 Clear roles and responsibilities

Roles and responsibilities of the participating organisations were described and mentioned, but rarely clearly defined within both the documents and interviews. Some roles were shortly highlighted in the documents (with some indicated tasks) and at the interviews there was sometimes a small elaboration on indicated roles within the intersectoral collaboration. However, overall, there was a lack of consensually developed clear roles and responsibilities descriptions of the participating organisations (or community members). Again also at this factor one could dispute the word; ''clear''.

This lack could be explained by different views described by the interviewees regarding roles and responsibilities. Some interviewees described a clear division in roles and responsibilities and others described a more organically way of dividing roles and responsibilities. The latter could explain the lack of consensually developed clear role descriptions. Beforehand, there were no roles or responsibilities discussed, but organisations took organically certain roles within the collaboration according to their expertises. Or experiences of working together, built relationships and history of cooperation between organisations, resulted in organisations taking automatically certain roles or responsibilities within the intersectoral collaboration. Often it was clear what an organisation could bring in or add to the intersectoral collaboration, accordingly to their expertise (shared understanding of contributions, keeping skills and expertise in mind). This resulted in responsibilities of organisations (or leaders) within the initiatives sometimes being more clear defined.

Roles and responsibilities regarding leaders within the initiatives were somewhat more elaborated. The national initiatives described more clear division of roles of leaders at different levels. It was indicated at the national initiatives, there is programme leader or team coordinating different regional (or province) advisors which on their turn coordinate the local project leaders/coordinators. These local project leaders there role was described as being responsible for recruiting and stimulating local organisations and community members for participating in the health initiative. However, the approach of the execution of this role of these project leaders were indicated to really differ between the community/municipalities the health initiatives are executed. The regional advisor role was described as sharing the experiences between the different communities (enabling to learn from each other), next to offering support or advise. The programme leader was also often the initiator of the initiative.

At both national and local initiatives the role of the initiators were described. Almost all the initiators of the initiatives their role was described as a facilitator; bringing together and maintain contact with all participating organisations and keeping in check the needed resources. Thereby, also keeping people motivated (see management), assign the organisations to relevant tasks (taking their expertise into account) and promote the health initiative (visibility). The local initiatives described the division of roles and responsibilities as a more organically process. It was indicated for example that the initiators assessed which kinds of expertises and networks (organisations) were needed for execution of the health initiative and if there were organisations willing to participate in the intersectoral collaboration. Or during meetings it was asked which organisations could support or execute a certain tasks/responsibilities. The national initiatives also indicated on the local level somewhat more freedom in division of roles.

Regarding, responsibilities, the final accountability was indicated to rest at the initiators of the health initiative. Transparency was indicated as key to ensure this accountability. Moreover, it was noted, the initiators should not only be transparent about the achieved results, but also setbacks, failures or problems towards funders and participating organisations. A way in which they ensure this accountability is by the means of progress reports or monitoring. These reports were often send towards a municipality or a ministry (which are often participating organisations in the intersectoral collaboration but also often partly funders). These public organisations often have accountability

towards the community members (taxpayers) about the effectiveness of the health initiative. Accountability was also ensured by for example quarterly meetings of the participating organisations, or personal contact between people keeping each other in check about progress (external reach agency was also mentioned).

Regarding importance of clear roles and responsibilities for sustainability it was indicated to play an important role. Clear roles and responsibilities allows to know who or which organisation does what, which provides more clarity and prevents misconceptions. This also enables to address each other on tasks or hold accountable for responsibilities (because it is visible/transparent/agreed what everyone should do). An overview of roles is especially important for an intersectoral collaboration, at which different sectors (expertises) are working together (see quote below). To conclude, apart from roles divisions being made beforehand or happening organically, clear roles and responsibilities are indicated important for the health initiative, as it provides clarity about who is doing what and can be held accountable.

''Je moet elkaar daar ook op aan kunnen spreken hè, want het is juist in zo'n samenwerking, moet ook iedereen zijn rol goed vervullen, want anders werkt het niet. Het is extra door die afhankelijkheden, wil je dat goed beleggen.'' (Interviewee 6, 2021)

Translated: *"You also have to be able to hold each other accountable, because it is precisely in such a (intersectoral) collaboration that everyone has to fulfil their role well, because otherwise it will not work. Particularly because of those dependencies, if you want to secure that well."*

The effect of no clear roles and responsibilities

A representative of a health initiative described a lesson learned regarding clear roles and responsibilities. At the first municipalities at which the health initiative was implemented they experienced barriers and tension about who is responsible for what and who one can turn to for certain tasks. There were no formally described role descriptions. However, after this experience they decided to develop and define clear formal roles and responsibilities descriptions for each participating organisation (or representatives of the organisations). This for clarity about who one can turn to for support or accountability and make the intersectoral collaboration more sustainable.

Textbox 5. *Example of the effect of no clear roles and responsibilities.*

Table 7 below shows how the division of roles and responsibilities of each case is situated. Clear roles and responsibilities descriptions were indicated to be important, however were only present at one initiative.

Cases	Organically division roles and responsibilities	Formal division roles and responsibilities	Clear role and responsibilities descriptions
Gezondheidsambassade			
Montfoort Vitaal			
Doortappen			
Voel je goed			
Gezonde Buurten			
Voedselapotheek wijkaanpak			

Table 7. *Clear role and responsibilities*

4.4.4 Intermediate outcomes and visibility

In both interviews and documents intermediate outcomes and visibility showed to be intertwined. This justified to choice of pairing intermediate outcomes and visibility in the MSIC. The following quote gives an example of intermediate outcomes and visibility being intertwined.

''Het afgelopen jaar lag de nadruk qua communicatie op het lokaal zichtbaar maken van de schop-in-de-grond-momenten, het aankondigen van de buurtactiviteiten en de oplevering van de buurtplekken.'' (p.8 Annual report 2020, Gezonde Buurten)

Translated: *"Over the past year, the emphasis in terms of communication was on making the shovel-in-the-ground moments, announcing the neighbourhood activities and the completion of the neighbourhood places visible locally."*

Increasing awareness, about the health issue and the health initiative within communities (which directly links to visibility) was the most mentioned and described intermediate outcome (and objective). For example, raised awareness about the possibility for community members to join health activities in the neighbourhood to improve their health, at the same time also increases the visibility of the health initiative (again intertwined). Awareness was perceived to be important for the participation of the community members and visibility of the health initiative.

Participating community members increase the visibility of the initiative and the health issue on their turn by word of mouth advertising within their networks. This regards for example conversations in the neighbourhood about the health activities. This was indicated as the so-called ripple effect. This ripple effect was present at several initiatives (cases), being defined as participating community members also influencing their direct living environment (family, neighbours, etc.) with their acquired health skills/knowledge.

Nevertheless, all the health initiatives made extensive use of communication channels to increase visibility among community members about the health initiative. There were several means of communication indicated; social media, (local) newspapers and the websites were mentioned most often as communications channels for increasing visibility. Many of the channels were used for regular messages about intermediate outcomes or upcoming health activities or events in local online and offline media. Moreover, actively going into the neighbourhoods of the communities for direct conversations with the community members, including a well-known organisation or presence at other events, were also mentioned to increase visibility.

Next to increased awareness, there were also intermediate outcomes of more concrete output. For example a health festival, a new collaboration partner or a vegetable garden. Many intermediate outcomes and outputs were described in the documents (which could be explained by the documents primarily being reports about the results of the initiative) and most important ones were confirmed/repeated in the interviews. Most of these outputs resulted in also more visibility of the health initiatives in the municipalities or neighbourhood. Appendix 8.10 gives general idea of mentioned intermediate outcomes in the documents (not everything is included).

The documents regarded mainly progress and evaluation reports about intermediate outcomes and visibility of; health activities, satisfaction of the community members, the health initiative and intersectoral collaboration. The interviewees referred to these reports when speaking about intermediate outcomes and visibility. The reports could also be indicated as intermediate outcomes. The progress and evaluations reports were used as feedback mechanisms for adaptations and improvements (process-indicators). The described intermediate outcomes and visibility could give an impulses to initiative; learning from each other, enthusing or inspiring each other (for example the different local project leaders), establish possible new collaborations, maintain support

(process-indicator) and retrieving funding or investments (process-indicator).

It was explained intermediate outcomes and visibility is also about organisations (or people's) ability to show what they have achieved with the health initiative, which was more emphasized during the interviews. Organisations being able to show they are involved with this health initiative. This visibility of the participating organisations of the collaboration could also be an incentive to participate. The (positive) intermediate outcomes of the health initiative, could make it interesting for organisations to stay linked to the initiative. This again addresses intermediate outcomes and visibility being intertwined. Intermediate outcomes and visibility could motivate organisations to stay committed and remain part of the intersectoral collaboration.

Organisations being motivated through intermediate outcomes and visibility to stay involved was indicated to be a necessity for a health initiative to become sustainable. This shows the connection to the following step in the collaborative process of the MSIC, the factor, commitment to the process, which will discussed at 4.4.5. In addition, funding was mentioned to be important for the sustainability (see also 4.5). Intermediate outcomes and visibility could secure current or future investments. It was stated in order for sustainability, one would need the health initiative to become part of structural financing (part of the system or being incorporated at the budget of one (or more) participating organisations). The visibility of intermediate outcomes was also stated to contribute to show the added value of the health initiative to the community or possible new partners for the intersectoral collaboration. This includes political interests, as many health initiatives are being (partly) funded by the government. These public institutions want to show intermediate outcomes and possible effectiveness of the health initiative to the public. To conclude, intermediate outcomes and visibility can function as an incentive for involvement, action (adaptations and improvements) and continuation (investments and commitment) of the intersectoral collaboration.

The effect of no intermediate outcomes and visibility

An initiator of one of the health initiatives explained that before the health intervention could be implemented, they had to show effectiveness. Their health intervention is one of the many health interventions out there. Without being evidence-based, the intervention of the health initiative would not be adopted by municipalities or secure investments (money and resources). To develop a sustainable health initiative, intermediate outcomes and visibility of the effectiveness was needed before they could roll out the initiative (and organisations willing to participate).

Textbox 6. *Example of the effect of no intermediate outcomes and visibility*

Table 8 shows all the cases indicated intermediate outcomes and visibility to be relevant and important for sustainability of the health initiative. Moreover, all the cases reported their intermediate outcomes and visibility (in progress or final or evaluation reports).

Cases	Intermediate outcomes and visibility relevant	Intermediate outcomes and visibility important for sustainability	Intermediate outcomes and visibility reported
Gezondheidsambassade			
Montfoort Vitaal			
Doortappen			
Voel je goed			
Gezonde Buurten			
Voedselapotheek wijkaanpak			

Table 8. *Intermediate outcomes and visibility*

4.4.5 Commitment to the process

Commitment to the process of the intersectoral collaboration was predominantly established by organisations or people being motivated to tackle the health issue, which the health initiative addresses. This mostly regarded intrinsic motivation. The personal motivation of people from the participating organisations. Commitment to the process was also indicated in both the documents and interviews to be person dependent. The commitment to the process of an organisation depending on the intrinsic motivation (enthusiasm) of a person (an employer of a participating organisation of the intersectoral collaboration). It was noted that person dependency is also a vulnerability for the intersectoral collaboration, regarding replacement and sustainability. The following quote describes this person-dependency accompanied with vulnerability for the intersectoral collaboration.

''Vaak zeg ik dan gewoon het valt of staat met een bepaald persoon en daarom zie je ook wel weer vaak, als die persoon dan wegvalt, kunnen we weer helemaal opnieuw beginnen. Dan is het de toewijding van die persoon die zo doorslaggevend is. … Maar het is zo afhankelijk van personen en dat zou eigenlijk minder het geval moeten zijn, hè? En daarom is die indeling ook zo belangrijk, want dan zit het in het systeem ingebed en niet afhankelijk van een persoon, van de toewijding van een persoon. … En dat als je iets kunt borgen, dan is het daar ook niet alleen van afhankelijk hè? Want dan is een opvolger ook, dan is het voor de opvolger ook weer een taak en niet afhankelijk van of hij of zij er iets mee heeft.'' (Interviewee 6, 2021)

Translated; *"Often I just say it stands or falls with a certain person and that is why you often see, if that person disappears, we can start all over again. Then it is the commitment of that person that is so decisive. … But it's so dependent on people and that should really be less the case, huh? And that is why that division (roles and responsibilities) is so important, because then it is embedded in the system and not dependent on a person, on a person's commitment. … And if you can make it sustainable (health initiative), then it doesn't just depend on that, does it? Because then there is also a successor, then it is also a task for the successor and not dependent on whether he or she is committed."*

In last part of the quote and stated at different documents and interviews, if a person drops out, get sick or has less time available in order for sustainability, the health initiative actually should be able to carry on without depending on one person (which could be achieved with clear roles and responsibilities descriptions for replacement or support of an external organisation). Regarding some of the health initiatives this is not always the case. However, intrinsic motivation of participating organisations or people to commit to the health initiative was still stated as an important aspect for the sustainability of the health initiative. Organisations being motivated and inspired to work on the health activities and to be part of the collaboration (incentive to participate).

In addition, mutual interests and reciprocity were also mentioned to be important for commitment to the process. A win-win situation for the participating organisations and the intersectoral collaboration (health initiative) was several times mentioned. For example, the visibility of the health initiative and organisations works both ways. Stimulating commitment in respect to mutual interests was also about investigating how one can contribute to the goals of the participating organisations with the health initiative.

Intermediate outcomes and visibility or proof (by external research agency) of the health initiative being effective, could also be reasons for organisations to participate (incentive to participate) or stay committed to the intersectoral collaboration. The health interventions or activities being evidence-based and acknowledged was indicated to contribute to the commitment of

organisations and incorporation of the initiative into the (local) systems (which contributes to the sustainability). The intersectoral aspect also contributed to the commitment to the process, enabling organisations to access knowledge and expertises of different sectors (interdependency).

Commitment to the process was also ensured by keeping the organisations involved (management). This could also be established with ownership or feeling of shared responsibility. If the participating organisations of the intersectoral collaboration feel they have ownership of the health initiative, this will contribute to the commitment to organise the health activities. In addition, giving community members also a sense of ownership, improves their commitment to the process as well. This could be regarded as an important aspect considering the importance of community involvement at the cases of this study. When community members assist in developing ideas they feel more committed to the process (health initiative). This shows again that the community itself can/should be considered as a partner. Lastly, appreciation of participating organisations or people was also mentioned to be helpful for commitment to the process. To conclude, commitment to the process was established through mutual interests, ownership and predominantly intrinsic motivation of the participating organisations or individual persons.

The effect of no commitment to the process

Multiple health initiatives indicated when participating organisations or people did not feel ownership of the health initiative or were not committed to the addressed health issue or had no interests in participating anymore, these organisations or people on certain moment dropped out of the intersectoral collaboration. Dependency on these organisations or people resulted in an impairment of the development towards a sustainable health initiative, which happened several times at some of the cases (see also some of the other textbox examples at the factors). This resulted in certain health activities of the initiatives not being able to be continued.

Textbox 7. *Example of the effect of no commitment to the process.*

Table 9 below shows all the cases indicated commitment to the process relevant for the intersectoral collaboration and important for the sustainability of the health initiative. Except one case, at which commitment to the process was described as something natural.

Cases	Commitment to process relevant	Commitment to process important for sustainability
Gezondheidsambassade		
Montfoort Vitaal		
Doortappen		
Voel je goed		
Gezonde Buurten		
Voedselapotheek wijkaanpak		

Table 9. *Commitment to the process*

4.5 Additional factors

Next to the factors of the MSIC, some other factors from the theoretical framework or through open coding were identified and represented in several documents and the interviews. They will be shortly explained. First the factor funding will be elaborated, which was also addressed in the theoretical framework. Thereafter, will be public support, facilitating and energy discussed, which could be regarded as concepts of factors at the MSIC. These recurring concepts and factor in the documents and interviews were expected to be valuable for the research.

Funding

The factor funding also appeared to play an important role for the health initiatives. Funding was described at theoretical framework at the HALL-framework (2.4.1). At this description it was mentioned that sometimes health initiatives are competing for the same funds, because of limited available financial resources (or financing structures and policy strategies pushing the health initiatives to stay with same health aims). This was something which also became apparent in the documents and interviews.

Some of the initiatives of this study originated from health issues the government wanted to tackle and made funding available for. It was indeed experienced that securing funding for the health initiative can be difficult due to competition due to still often limited amount of budget available for health promotion. Subsidies from the public organisations (government, ministries, provinces and municipalities) for health interventions were also indicated to change every few year, which results in every time reconsidering which health topics/activities are going to be prioritised.

Budgets, investments, funds, all determined the capacities of the initiatives to execute their health activities. Most of the cases, needed, had to apply, received or could claim a certain budget/financial support from public organisations (often the municipality) for executing health activities of the health initiative. Some cases also received funding from participating foundations, funds or local entrepreneurs. The following quote gives an example of funding by a foundation of a health activity of free consultations with a lifestyle coach at the local pharmacy (Stichting Voorzorg Utrecht - foundation, Orion - pharmacy). However, the health initiative hoped to find a way for more structural financing of this health activity.

''Om de drempel laag te houden en ook mensen met een kleine(re) portemonnee te bereiken, biedt Orion bij wijze van pilot het gesprek gratis aan. Stichting Voorzorg Utrecht neemt vooralsnog een deel van de kosten voor haar rekening. Aan de hand van de opbrengsten wordt in een latere fase bekeken of structurele financiering eventueel mogelijk is.'' (p.16 Final report 2020-2021, Voedselapotheek Wijkaanpak)

Translated: *"In order to keep the threshold low and also to reach people with a small(er) wallet, Orion is offering the conversation free of charge as a pilot. For the time being, Stichting Voorzorg Utrecht is responsible for a part of the costs. Based on the proceeds, it will be examined at a later stage whether structural financing is possible*.''

Health initiatives depending on subsidies, which are set for a period of time, makes them vulnerable regarding the development towards sustainability. These are not structural funds, which result in a difficult continuous process of looking for funding. One has to reapply for subsidising every time over again, with the chance of being excluded and the health initiative not being sustained. Several of these cases received subsidies from public organisations, however it was noted that the initiative should become incorporated at financial budget of these organisations in order for the development towards a sustainable health initiative. Structural funding provides certainty of being

able to execute the health activities. This structural financing was also indicated as an option to be incorporated at other participating organisations of the intersectoral collaboration. Next to public organisations, also a private organisation such as a health insurance company could possibly enable structural funding. Moreover, funding could be incorporated at the budgets of multiple participating organisations of the intersectoral collaboration.

However, the effectiveness of the health initiative is often a barrier for this structural funding. It was indicated that the investors often want assurance the health interventions/activities are effective, before they invest. Health promotion on the other hand, often takes a long period of time to show possible effectiveness. Intermediate outcomes and visibility can offer a solution in this respect, as explained at 4.4.4. Funding was also mentioned at other factors of the MISC, including as part of sustainability (4.2). To conclude, funding was stated as influencing the collaborative process regarding the capability to execute the health initiative.

The effect of no funding

One of initiatives experienced one year being excluded from subsidies of the municipality (another initiative received the budget for which they had applied). This resulted in health activities not being able to be continued or to support community members with their activities. This showed the need for structural financing. Representatives of the health initiative indicated the need of being incorporated at budget of the municipality, as they perceived their health initiative should be a basic provision for the community. However, structural funding was not yet accomplished.

Textbox 8. *Example of the effect of no funding.*

Public support (in Dutch ''draagvlak'')

Public support was described as support from within the community to execute or implement the health initiative. Public support was mentioned several times within the documents at different cases and by two interviewees. Public support was mentioned to be needed before the health initiative can take off and support by the community members as a success factor for the progress of the health initiative. Therefore, could public support be regarded as a concept of the factor community involvement at the MSIC.

It was indicated one could increase public support by involving local organisations in the intersectoral collaboration. Familiarity of the local organisations could advance the trust among the community members in the health initiative. For example, one initiative established a steering committee of community members who are representatives of different kinds of local organisations (sports associations, schools, childcare, etc.) within the municipality, in order to create public support. The representatives are highly involved in the community.

Public support was also described to be important to for the development towards a sustainable health initiative. Public support is needed for the initiative being incorporated into the community, which is something different cases of this study aim to achieve. Several representatives of the initiatives regards this assimilation of the initiative by the community as the road to sustainability. Public support could facilitate the initiative being taken over and be continued by the community, when the initiators leave. This takeover could be done by community members or local organisations or a combination of both. It was mentioned that community members do not always have the capacity to maintain the initiative on their own and therefore a combination with a local organisations is needed for sustainability. It was stated that public support also makes it easier to raise funds and involve community members with the health initiative or activities. To conclude, public support is needed for the health initiative in order to be implemented at the local network and community.

Facilitating

In the documents and the interviews of the different initiatives it became apparent that several initiatives are, just as AAH programme, a kind of facilitator bringing organisations with the needed resources together. The initiators, programme leader, coordinators/project leaders or regional advisors were indicated as facilitators who bring the different needed organisations for an intersectoral collaboration together to execute a health initiative in a community. This often also included facilitating the establishment of a local network of organisations and community members. In addition, it was also mentioned these leaders facilitate knowledge exchange between the different organisations. This facilitating process could be regarded as an aspect of the factor management (elaborated at 4.3.2). Management was also described as important for knowledge exchange and connecting organisations. However, some initiatives explicitly mentioned facilitating instead of management (one did not wanted to be regarded as a manager but as a facilitator).

The concept of facilitative leadership at the theoretical framework from the Model of Collaborative Governance (2.5.2), also describes this facilitation process by a leader. However, from the cases from this study it appears this not always regards one person, but multiple people of one organisation facilitating the intersectoral collaboration. This was also shortly addressed at the factor shared mission. The initiators of the initiative developing a mission, taking a facilitating role and invite organisations to join their health mission. These initiators form the intersectoral collaboration and as an organisation coordinate and facilitate the other organisations at the health initiative.

As already explained, at the cases these initiators indicated they eventually want the health initiative being able to continue on his own within this facilitated local network. This was described as the ultimate goal; the health initiative being sustained within the community by the local organisations and community members, which was also regarded as a development towards sustainability. The following quote below describes this facilitating process (of one leading organisation). To conclude, facilitating provides a way for the health initiative to be incorporated at the local network and community.

''De partners, zeg maar, lokaal, die moeten echt hebben dat het hun interventie is, hé. Dan zijn wij als stichting helemaal niet belangrijk, het moet hun interventie zijn en die moeten Veendamse of Bergen op Zoomse of Middelburgse kleuren hebben gekregen. En, wij zorgen gewoon voor de randvoorwaarden dat zij door kunnen en daar zijn wij als stichting totaal niet belangrijk, vind ik. Alleen achter de schermen maken wij het mogelijk dat zij het kunnen doen.''* (Interviewee 6, 2021)

Translated: *''The partners, local, they really have to feel it is their intervention. Then we as a foundation* are not important at all, it must be their intervention and it must have been given Veendam or Bergen op Zoom or Middelburg colours (/aspects, assimilated in the community). And, we just provide the preconditions that they can continue and we as a foundation are not important at all, I think. Only behind the scenes, do we make it possible for them to do it."*

(*the name of the foundation has been omitted from the quote due to anonymity)

Energy

Energy was mentioned by different interviewees and several times in the documents as an important aspect for the health initiative. This mostly regarded the energy of the community members to commit to create or participate in the health activities. Community members finding (own) time and energy to invest in the neighbourhood. It was indicated that this can be difficult. However, focusing on the health issues the community members want to address, with the support of the intersectoral collaboration, could stimulate the community members to invest time and energy. Moreover, it was also mentioned that community members are getting inspired by each other's energy or the enthusiastic reaction of someone activates the energy at another community member.

When there is energy within the community to address the health issue, this will contribute to the commitment of the community members to the health initiative on the long term. It was stated at some cases that the initiators of the initiative followed the enthusiasm and energy of the community members regarding the health interventions. Furthermore, it was also mentioned that the initiators looked for local organisations which showed energy to get started with the health issue the initiative wanted to address. In addition, in order to create and develop a local network, it was explained that there is a need of the creation of energy, which must be created through meeting people in real-life (not online).

This energy could also be regarded as a part of intrinsic motivation, which shows the connection to the factor commitment to the process (4.4.5). Energy could be considered as a concept of commitment to the process. Both commitment to the process and energy were also indicated to be person dependent. For example, when an enthusiastic person with a leading role stops, the energy can drain away from the health initiative with possible consequences for the sustainability. This personal motivation of people and dependency was ascribed to both the community members and the people (professionals) from the participating organisations. When professionals or community members are personally motivated to address a certain health issue, the health initiative is more likely to be sustained. The following quote displays this importance of intrinsic motivation of community members;

''Nou ja, plezier, klinkt heel flauw, maar ik denk ook, dat merk ik altijd. Kijk. Vrijwillige inzet gaat natuurlijk gewoon om intrinsieke motivatie en zolang het niet meer leuk is, zolang het geen energie meer, als het geen energie meer oplevert, dan houdt het gewoon snel op. '' (Interviewee 1, 2021)

Translated: ''*Well, fun, sounds very lame, but I also think, I always notice that. Look. Voluntary commitment is of course just about intrinsic motivation and when it is no longer fun, when it no longer produces energy, if it no longer produces energy, then it just stops quickly.''*

This quote shows something important to note, energy can be temporary. To maintain this intrinsic motivation, relationship management was indicated. It was explained as keeping track of the flow of the energy. Trust, shared mission and appreciation of people were also indicated to keep the motivation and energy (commitment to the process) on track. To conclude, energy is the enthusiasm of the community members and the people (professionals) of the participating organisations to work on a particular health issue.

5. Discussion

In this chapter the main findings are discussed. The sub-questions, with respect to factors of MSIC, are answered according the results. This will be accompanied with a reflection of the literature. Thereafter, the Model of Sustainable Intersectoral Collaborations will be revised. Subsequently, is the study design assessed and finally, several suggestions are made for future research.

5.1 Relation of the factors of the MSIC to a sustainable intersectoral collaboration

To start, regarding most different cases design; the cases differed in health promotion goals and target groups, differed in scope of participating organisations in the collaboration (amount of organisations) and the amount of different sectors included, differed in existence and duration of the health initiative, differed in amount of community members participating in the health initiative and the cases differed in scale (local, regional, national). See table 1 in the method for overview of these aspects of the cases. Nevertheless, showed the initiatives concerning their intersectoral collaboration in general similar results, as depicted at the previous chapter. Only with respect to scale there was a slight difference between the cases. The national initiatives deviated sometimes from the other cases (mainly with respect to management and clear roles and responsibilities). This will be addressed in upcoming paragraphs. First, defining of sustainability by the cases will be discussed.

Sustainability was described by the cases as the health initiative being capable of carry on by the means of being incorporated in the existing systems and through community involvement. All the cases indicated the health initiative should be capable to carry on by the means of self-organising ability of the local community (organisations and community members) to execute the health activities on their own. So a self-sustaining entity in the community and the initiative becoming integrated into the local network of the community. This correspond with the provisional definition of sustainability at the introduction; *health initiatives are able to carry on their health promoting activities within their own organisations without the need of external incentives, to sustain their intersectoral collaboration and to be a self-sustaining entity*. However, the addition of *community* to this definition has to be made.

Final definition of sustainability

The health initiatives are able to carry on their health promoting activities within their own organisations and community without the need of external incentives, to sustain their intersectoral collaboration and to be a self-sustaining entity.

Textbox 9. *Final definition of sustainability of health initiatives according to this study.*

It is important to note that the outcome of a sustainable intersectoral collaboration (health initiative) is described as being integrated into the community. This entails the community is taking part in the execution and decision-making of the health initiative, of which community involvement is required as input (see also figure 5 at 5.2).

As it was explained most of the cases of study aim that at some point the initiative can be transferred from the initiators to community members and local organisations. The capability of the health initiative to continue to exists after initiators have left. The community taking care of management and maintenance of the facilities and organisation of the activities. However, this transferring to local community was not established at any of the cases yet. This also includes for the health initiatives being incorporated in the systems. None of the cases established to becoming part of structural funding. The health initiatives being incorporated in policy plans is something the cases are trying to achieve, of which two cases (Gezonde buurten and Doortrappen) at some municipalities already accomplished. On the contrary, monitoring and evaluation systems were at all initiatives in place and community involvement was present at all the cases (both local organisations and community members).

The study of van Dale et al. (2020) also indicated to importance of connecting to existing policies in order to sustain the intersectoral collaboration (and health initiative). This study included the importance of advocating for political support, which was also shortly mentioned by different interviewees as this study. Moreover, also securing long term funding and sufficient resources were mentioned to be important for the sustainability of the health initiative (van Dale et al., 2020; Tell, Oldeide, Larsen & Haug, 2022). The study of de Jong, Tijhuis, Koelen & Wagemakers (2022) also addressed the importance of community involvement for the sustainability of the health initiative.

The following paragraphs will be attributed to the factors of the MSIC. They will be individually addressed and the research sub-questions will be answered accordingly (which are described at 2.7). In addition, the relation of each factor to a sustainable intersectoral collaboration will be addressed.

Representation of relevant societal sectors and including community members: The intersectoral approach of the health initiative ensured relevant societal sectors were included. The intersectoral collaborations mostly existed from the following sectors; the social welfare/health, public, private and the education sector. These were also indicated as the most relevant sectors for the health initiatives, at which social welfare organisations were pointed out to be very helpful to establish the health initiatives. Community involvement was indicated important in order to maintain/sustain the health initiative in the community. Community involvement was established by creating a network of local organisations (from different sectors) and direct-contact with community members through meetings and different process activities, needs assessments and community members being part of decision-making. In addition, the community members being regarded as equal partners in relation to all other participating organisations of the intersectoral collaboration. There were differences on level of community involvement between the cases. One national initiative (Voel je Goed) had only community involvement at beginning of the development of the initiative in comparison to involvement during the whole process at the other cases.

van Dale et al. (2020) indicated the importance of bringing relevant sectors together around a common interest (certain health issue) and the engagement of people and communities of interest for co-creation. Thereby, creating an effective mix of different partners, of which the public and private sector were highlighted. de Jong et al. (2022) also mentioned that community involvement could support the intersectoral collaboration in building a local network. This study highlighted participatory action research; researchers and community working together to develop interventions to address the issues the community perceived the most important. This community involvement was also (as already mentioned) indicated to improve the sustainability of the health initiative. The study of Tell et al. (2022) described the importance of user perspective when developing an initiative or health activities, in line with the results of this study regarding the importance of community involvement. Tell et al. (2022) also mentioned that the needs of the community should be the central aspect of the intersectoral collaboration in order for the health initiative to succeed. Including utilising the resources in the local community through the intersectoral collaboration.

It is important to consider what one would understand as ''community''. In this study it was described as the community members and local organisations of a municipality or neighbourhood. However, the question remains if these community members and local organisations are indeed representative for the whole community. At the study of Wagemakers et al. (2007), this was also considered and proposed one can speak of a community when community members can identify with the organised group of people of the neighbourhood.

Management: Management was indicated by all cases as an important aspect to create structure and knowledge exchange for an intersectoral collaboration, as well as stimulate participation, empowerment, involvement and connecting of organisations and community members. This is especially needed with different sectors working together. Regarding the sustainability of a

health initiative, it was indicated management should be incorporated to ensure continued existence of intersectoral collaboration (and the health initiative). Between the cases there were different management structures. The national initiatives described management of different levels of leaders and the local initiatives of one leader or team. This difference can be explained by the large-scale approach of national initiatives at multiple municipalities.

Management (including leadership and communication structure) and knowledge exchange were also indicated as important aspects for an intersectoral collaboration at the scoping review study (of 52 studies) of Esmaili et al. (2021) and by the study of de Jong et al. (2022). Next to, understanding the different perspectives of the organisations, monitoring relationships and generation of new ideas (Esmaili et al, 2021). Leadership was also indicated at the study of van Dale et al. (2020) is a key factor for an intersectoral collaboration. Especially, benefits of leadership at national level was emphasised (at of course national health initiatives with different regions). Next to the ability of the leader to inspire and keep the organisations engaged, also ability to be inclusive of diverse partners and be collaborative and transparent in decision-making process were mentioned.

The additional concept found within this study, facilitating, was something which also was mentioned at the study of de Jong et al. (2022). This study described a broker role. This role was described as facilitating process of network building, connecting the different sectors and community members and guiding the knowledge exchange, which is in line with the described facilitating process of the initiators at the health initiatives of this study. The initiators being facilitators, bringing different needed organisations with the needed resources together and facilitate knowledge exchange. This can be regarded as aspect of management. de Jong et al. (2022) indicated this broker (or at this study called facilitator) role, enables the intersectoral collaboration to thrive by crossing the boundaries of the different sectors and making knowledge of different expertises of the organisations more accessible.

Trust building: Trust building was indicated by all cases as an important factor, which has to be developed over time during the whole collaborative process and is established by the means of experiences (results, relationship management and history of cooperation) made within the intersectoral collaboration, safeguarded by aspects such as dialogue, openness and transparency. Trust between the participating organisations of the health initiative is needed in order for an effective intersectoral collaboration. It ensures organisations are committed and the initiative will be sustained. Regarding sustainability, trust building was indicated to be essential.

Trust building was also indicated as important factor for an intersectoral collaboration by Esmaili et al. (2021) and by de Jong et al. (2022), which needs time developed and can be built at regular meetings (face-to-face) (Esmaili et al., 2021). Trust was mentioned to be essential for effective communication, which on turn is needed to prevent conflicts. Social interaction between the participating organisations and capacity building for framing relationships were also indicated important. de Jong et al. (2022) also stated that history of cooperation could be an advantage to the intersectoral collaboration.

Shared mission: (Shared) mission, was described by all cases as a handhold about what the intersectoral collaboration wants to achieve regarding the health initiative and indicated to be important to set priorities (objectives, activities, goals), align different interests and the realisation of interdependency. However, ''shared'' was disputed, as at all the cases the initiators of the health initiative developed a mission, at which organisations with similar ambitions joined. Considering sustainability, offers a ''shared'' mission an agreement or affiliation between the organisations about what the health initiative stands for, therewith increasing long-term commitment/involvement. This entails working together, apart from the different interests, towards a common goal.

Tell et al. (2022) explained that an unified understanding of the health mission by the participating organisations (with similar ambitions) is crucial for establishing and maintaining an

intersectoral collaboration. A shared mission was also indicated important for the sustainability of the health initiative with an intersectoral collaboration by van Dale et al. (2020). Esmaili et al. (2021) indicated shared context as an important factor for the mobilisation of an intersectoral collaboration in health promotion, which included a shared mission (involving value or goals) and resources integration. Lastly, shared mission was also mentioned by de Jong et al. (2022) and Tell et al. (2022) to be important for commitment of the participating organisations to intersectoral collaboration. Tell et al. (2022) also indicated, reciprocity, with respect to the organisations their own (secondary) interests and (side) goals, as important motivation for long-term participation.

Clear roles and responsibilities: Clear roles and responsibilities are indicated by all cases as important for the health initiative, as it provides clarity about who is doing what and can be held accountable. However, there were no clear roles descriptions (except at one national case, Voel je goed). This shows contradiction between indicated importance and implementation. Again the national cases differed from the other cases. They had a formal division of roles and responsibilities. The other (local) cases described a more organically way of dividing roles and responsibilities. This difference could be explained by national initiatives having beforehand role divisions formulated when executing the same health initiative in different municipalities. Regarding importance of clear roles and responsibilities for sustainability of the intersectoral collaboration, it was indicated it allows to know who or which organisation does what, which provides more clarity and prevents misconceptions. This also enables to address each other on tasks or hold accountable for responsibilities. An overview of roles is especially important for an intersectoral collaboration, at which different sectors (expertises) are working together.

Clear roles and responsibilities was also identified by Tell et al. (2022) to be important for creating structure within the intersectoral collaboration. In addition, the different expertises were also seen as valuable for complementary skills and knowledge (resources), which built trust and showed interdependency (Tell et al. 2022). Clarifying the division of roles was also indicated important by de Jong et al. (2022). In this study, a network analysis supported the participating organisations of a health initiative to clarify the roles and tasks, including the division of responsibilities.

Intermediate outcomes and visibility: Intermediate outcomes and visibility can function as an incentive for involvement, action (adaptations and improvements) and continuation (investments and commitment) of the intersectoral collaboration. Organisations being motivated through intermediate outcomes and visibility to stay (or become) involved was indicated to be a necessity for a health initiative to become sustainable. In addition, intermediate outcomes and visibility could secure current or future investments (funding). It was stated in order for sustainability, one would need the health initiative to become part of structural financing (part of the system or being incorporated at the budget of one (or more) participating organisations). All the cases indicated intermediate outcomes and visibility of importance, which were included in reports.

de Jong et al. (2022) described achievements and generating visibility as important processes for intersectoral collaborations. This study also noted difference in the kind of achievements (as with this study at appendix 8.10); regarding the health initiative (for example the health activities), but also regarding the collaboration itself (for example involvement of a new partner). The achievements and the visibility of the achievements were also indicated to contribute to commitment of the participating organisations and continuation of the intersectoral collaboration. It was also described that in order to evaluate the collaboration, one needs intermediate outcomes. Visibility of the achievements was also mentioned to encourage investment and local government support. Again, as within the interviews of this study, also the study of de Jong et al. (2022) indicates the importance of acknowledgement (of the health activities and the collaboration) through intermediate outcomes and visibility for commitment and investment.

Commitment to the process: Commitment to the process of the intersectoral collaboration was indicated by all cases to be established through mutual interests, ownership and predominantly intrinsic motivation of the participating organisations or individual persons. The commitment to the process of a participating organisation could depend on the intrinsic motivation of a person (an employer of that organisation). It was noted that person dependency is also a vulnerability for the intersectoral collaboration, regarding replacement and sustainability. However, intrinsic motivation of participating organisations or people to commit to the health initiative was still stated as an important aspect for the sustainability of the health initiative. Organisations being motivated and inspired to work on the health activities and to be part of the collaboration (incentive to participate).

Tell et al. (2022) also indicated the feeling of ownership to be important for commitment to the process (and motivation). In the study of Tell et al. (2022), interviewees like the interviewees at this study distinguish working with people instead of organisations, including person dependency. Personal motivation about the addressing a particular heath issue was also indicated as an incentive to participate. Appreciation of contributions of the participating organisations, as within this research, was also found to stimulate commitment to collaborative process. Evaluation about the health initiative or feedback mechanisms were indicated by de Jong et al. (2022) and van Dale et al. (2020) to facilitate the collaborative process and sustain commitment to the process.

To conclude, there were no large differences between the factors of the MSIC in the cases and the results of this study were consistent with those of other studies. The small differences at the national initiatives are explained by the health initiative being executed at multiple municipalities. All the factors of the MSIC show to play a role for the sustainability of the intersectoral collaboration. However, the following factors of the MSIC were indicated most important; community involvement, intermediate outcomes and visibility, and trust building. High occurrence of a factor in the documents corresponded with indicated importance of that factor at the interviews. Community involvement and intermediate outcomes and visibility were highly represented in the documents and indicated as most important factors at the interviews. However, trust building was also indicated as most important for the sustainability of the intersectoral collaboration at the interviews, but had a low representation at the documents. This could be explained by trust building being indicated as a natural continuous process and therefore not specified in the documents.

5.2 Revision of the Model of Sustainable Intersectoral Collaborations

Regarding the Model of Sustainable Intersectoral Collaborations, several adaptations can be made following the results of the cases. Nevertheless, all the factors in the model were represented in the documents and at the interviews indicated to be important for sustainable intersectoral collaborations. There was a difference in importance and representation between the factors (see previous paragraph). So, the original model itself was confirmed/verified at this study. However, looking at the results one adaptation (splitting of an factor) and one addition should be made.

The factor ‘’the representation of relevant societal sectors, including community members’’ should be divided into two factors. Community involvement is mentioned frequently in both interviews and documents as a single important factor with his own indicators. When looking at the results and literature, community involvement seems to play such dominant role that it should take its own place in the model as external factor influencing the collaborative process. The community is also regarded as a relevant partner to be represented within the intersectoral collaboration.

The four additional factors (4.5) found with open coding should be considered to be incorporated in the model. Three of the four factors could be incorporated as process-indicators or concepts of factors already in the model. The concept of facilitating could one regard as a form of management structure (so could be included at the factor; Management). Public support could one regard as part of the factor community involvement and energy could be regarded as a concept of

the factor commitment to the process. However, the fourth additional factor, funding, could be considered as a possible addition to the model, being a factor on his own. Funding was described as a factor in the HALL-framework (at 2.4.1). However, funding was not taken into account in the MSIC, as it was not specifically indicated to be important for sustainability or as the core of the collaborative process. Nonetheless, when looking at the literature and the obtained results of this study (indicated importance), funding should be considered as an external factor influencing the collaborative process and sustainability. Below, these suggested revisions of the model are displayed at figure 5.

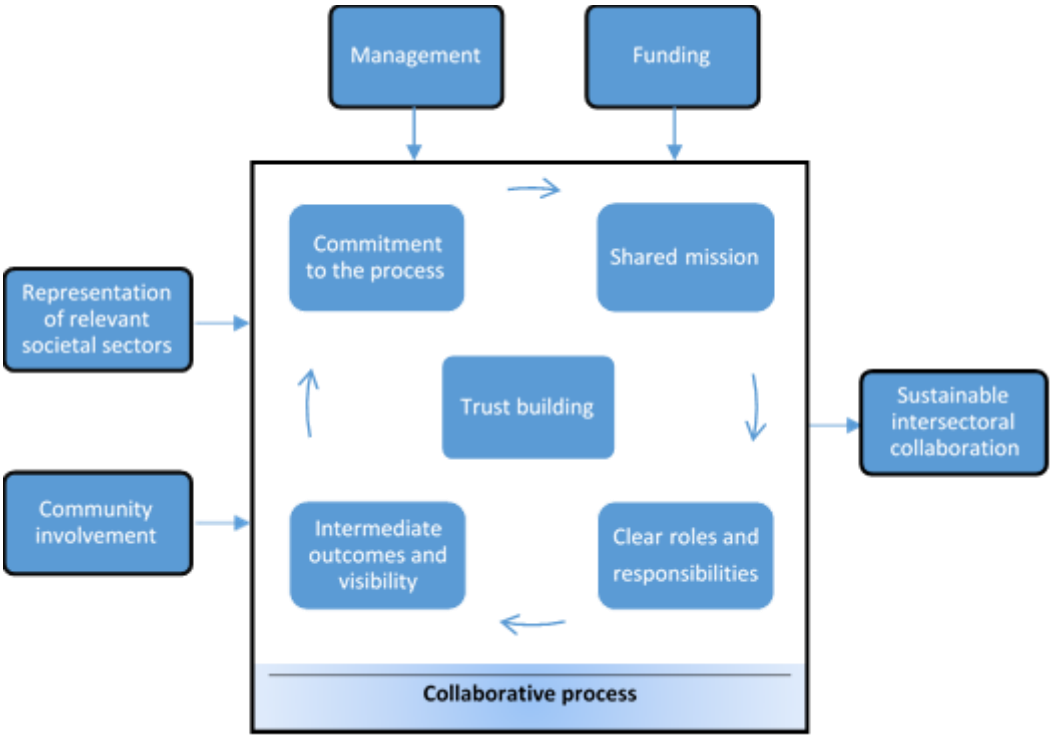

Figure 5. Revised Model of Sustainable Intersectoral Collaborations [MSIC].

Lastly, trust building was replaced as one of the steps of the collaborative process to the middle of the collaborative process. This was done as from literature and descriptions of the factors of the other steps it appeared that trust building was indicated to play important role at every step of the collaborative process. The results of this study confirmed that trust building was indeed an important factor during the whole collaborative process.

van Dale et al. (2020) indicated that making use of a framework (such as MSIC) is an important basic element for collaborations. A planned or systemic approach was recommended as valuable for a successful intersectoral collaboration, when implementing health activities or interventions. A framework provides a structure and a common understanding of an approach, which allows to evaluate the conditions for success (how different factors connect). To conclude, the Model of Collaborative Governance indeed showed to be supportive for elaboration of the HALL-framework and a combination of both models suitable for analysing intersectoral collaborations on sustainability.

5.3 Study design

The limitations and strengths of the study design will be discussed. Including the implications for reliability and validity of the results of the study. First the limitations are discussed, after which the strengths will be pointed out.

Limitations

Community involvement appeared to be an important factor for the sustainability of the health initiative. However, all cases of this study included had community involvement (as it was a selection criteria). At two cases, the health initiatives were even predominantly based on community involvement. This could give a distorted picture of the importance of community involvement. Nevertheless, was community involvement (both community members and local organisations) also deemed important at other studies (de Leeuw, 2017, Corbin, 2017; Jones and Barry 2011).

All the cases are health initiatives from the Netherlands. This could limit the generalisability of the results on an international level. Especially, the importance of funding for sustainability of the health initiative could be differ between countries, due to different financial systems. However, due to most different cases design, the health initiatives differed on health promotion goals and target groups, scope of participating organisations and sectors included, existence and duration, amount of community members participating and scale (see table 1 at method 3.2). Which makes the results more valid and generalisable to other health initiatives consisting of intersectoral collaborations at the Netherlands.

There is no intercoder reliability. Only one researcher has conducted the coding process, which could result to researcher bias. This includes possible subjectivity of the researcher at the interpretation of the data. No comparisons have been made between different researchers. In addition, there was no time to repeat the coding process by the researcher. So, reliability of the interpretation of the data should be considered. However, due the making use of the software Atlas.ti the coding process is documented, which advanced operating systemically, provided structure and increased reliability (Scheepers et al., 2016). Moreover, also a coding scheme is included. This makes replication of the coding process possible (to check for researcher bias).

There also could be self-reporting or progress bias, as the health initiatives delivered their own documents and were asked to described their thoughts during the interview about the intersectoral collaborations' progress instead of objectively measurement. This could possibly give a too positive picture. To partly counter this effect it was explicitly mentioned during the interviews one should also describe any experienced barriers. The interviewees did described more barriers than presented in the documents. However, in the case of the retrieved documents of the health initiatives, some initiatives also included reports of external research institutions (no self-reported data). Lastly, only one representative of each health initiative was interviewed, resulting in obtaining only one perspective of the intersectoral collaboration. The lack of different perspectives could also have resulted to bias.

Strengths

The method and data triangulation of this study (documents analysis and interviews) increased the validity of the study, as the results of both methods largely corresponded. Next to, different methods to obtain the data and the different sources of data, also the most different cases design contributed to validity of the study (Carter et al., 2014). The multiple case study provided detailed information about the interactions and facilitating or hindering factors at an intersectoral collaboration of different health initiatives. Moreover, the high amount of analysed documents in combination with interviews allowed to obtain good overview of what these cases indicated important for the sustainability of the health initiatives.

The different cases show similar results regarding the factors of MSIC. Moreover, only four other factors were identified as important besides the factors of MSIC, of which three could be classified as concepts of the factors of MSIC and another as a factor from theoretical framework. Open coding did not resulted in occurrence of many other factors/concepts or factors from the models described at theoretical framework (HALL-framework and the Model of Collaborative Governance). So, next to, the theoretical choices for selected the factors of MSIC, the choice for the factors in MSIC are also justified by the results of this study. Subsequently, this study is the first confirmation of a new more compact model for sustainable intersectoral collaborations (MSIC). A compact model combined from the most important parts of two models (the core of the collaborative process and factors indicated important for sustainability) focused on intersectoral collaborations from two different scientific fields (respectively Health Promotion and Public Administration).

5.4 Future research

The MSIC is a compact combined model from different scientific fields about intersectoral collaborations of which could be used to analyse these kinds of collaborations in future research more conveniently/manageable in comparison to comprehensive existing models from the current literature. Moreover, the factors of the model were operationalised with process-indicators from previous evaluations (on intersectoral collaborations), contributing to the needed development of a more consistent approach of conceptualisation and measurement of intersectoral collaborations in health promotion.

Future research is needed to verify and confirm the MSIC. This includes several studies making use of the model for an analysis of intersectoral collaborations. For example an another multiple case study with different cases. This preferably should involve also cases at which there is no community involvement, in order to test the indicated importance of community involvement at this study (as all cases had community involvement, see 5.3 limitations).

Moreover, a comparative analysis could be executed. One of initiatives will receive a report of an external research agency with also recommendations on sustainability. For future research it would be interesting to compare the recommendations on sustainability with the recommendations of this research or including this report in the document analysis.

Lastly, as already shortly mentioned, this study made use of the process-indicators also used by the research team conducting the current process evaluation of AAH programme. This programme of the Dutch government facilitates health initiatives by offering a platform for networking and connections. Due to the use of the same process-indicators, the results of this study could potentially be used for the overall project evaluation of AAH.

6. Conclusion

In this chapter the main research question is answered. A conclusion is drawn regarding facilitating or hindering factors of sustainability of an intersectoral collaboration. In addition, several recommendations for health initiatives are given. The main research question is; *What are the facilitating or hindering factors of sustainability of an intersectoral collaboration?*

6.1 Conclusion

This study provided insights into experiences and processes of intersectoral collaborations at community-based health initiatives. In-depth qualitative analysis of several cases offered confirmation of the hindering and facilitating factors for a sustainable intersectoral collaboration. In addition, providing a basis for the lacking knowledge about the interactions at intersectoral collaborations at health initiatives over longer period of time. This resulted in an understanding of the conditions and lessons for a sustainable intersectoral collaboration in a community.

The conditions for a sustainable intersectoral collaboration at a health initiative are; including relevant societal sectors, a management structure in place, structural funding and indicated most important, community involvement (local organisations and community members). Community members should be seen as an equal partner in the collaboration. These conditions are external factors influencing the collaborative process. The lessons of the collaborative process for a sustainable intersectoral collaboration at a health initiative are; develop a shared mission, make a clear division of roles and responsibilities, use intermediate outcomes and visibility as incentive, ensure commitment to the process and, indicated most important during the whole collaborative process at every step, taking time for building trust between the participating organisations. These conditions and lessons are the factors of the Model of Sustainable Intersectoral Collaborations. To conclude, all the factors of the MSIC played a facilitating or hindering role for the sustainability of a health initiative consisting of an intersectoral collaboration, of which community involvement, trust building and intermediate outcomes and visibility played the most important role.

6.2 Recommendations

The following recommendations are for health initiatives trying to become sustainable in the community. The recommendations follow from the results of this study. Each recommendation is shortly elaborated.

1. Establish an intersectoral collaboration to tackle complex health issues

Once more, as according to literature, the intersectoral approach showed to be key in order the tackle current complex public health issues and health disparities. The complex health issues are often multidimensional. Working together with other sectors allows to address underlying causes of health issues, such as working and living conditions (social determinants of health). Combining expertises and knowledge exchange of different sectors was indicated to contribute to the sustainability of the health initiative. The most relevant indicated sectors to include organisations for the establishment of an intersectoral collaboration in a health initiative were; the social welfare/health, public, private and education sector.

2. Enable community involvement at the health initiative

The most prominent result of this study for sustainability was the indication of the importance of community involvement. The community taking part in the execution and decision-making of the health initiative. Especially important when one aims to integrate the health initiative into the community. Community involvement from the start increases the likelihood of the adaptation of the health initiative in the community. Community involvement can be established by creating a network

of local organisations (from different sectors, especially social welfare organisations) and direct-contact with community members through meetings, process activities or needs assessments.

3. Ensure that the health initiative is being incorporated in existing systems

This translates into the health initiative being included in a policy plan, part of structural funding or monitoring and evaluation of results. Especially, structural funding was perceived important. It was stated in order for sustainability, one would need the health initiative to become part of structural financing. This could be accomplished by being incorporated at the budget of one (or more) participating organisations. For example, the health initiative being incorporated in the municipality policy plan and therewith also obtain structural financing.

4. Create commitment to the process at the participating organisations

Organisations being motivated and inspired to work on the health activities and to be part of the collaboration (incentive to participate) is needed for sustainability. Commitment to the process of the intersectoral collaboration could be established through mutual interests, ownership and predominantly intrinsic motivation of the participating organisations or individual persons. The following recommendations could also create commitment to the process.

5. Present intermediate outcomes and visibility of the health initiative

Intermediate outcomes and visibility can function as an incentive for involvement, action (adaptations and improvements) and continuation (investments and commitment) of the intersectoral collaboration. Organisations being motivated through intermediate outcomes and visibility to stay (or become) involved was indicated to be a necessity for a health initiative to become sustainable. In addition, intermediate outcomes and visibility could secure current or future investments (funding). Intermediate outcomes and visibility can be determined by monitoring and evaluation systems and be presented in progress reports.

6. Invest time to build trust for firm foundation of the intersectoral collaboration

Trust building has to be developed over time during the whole collaborative process. Trust is established by the means of experiences (results, relationship management and history of cooperation) and safeguarded by aspects such as dialogue, openness and transparency. Trust between the participating organisations of the health initiative is needed in order for an effective intersectoral collaboration. It ensures organisations are committed and the health initiative will be sustained.

7. Develop a mission, clear roles and responsibilities and a management structure

A mission, clear roles and responsibilities and a management structure stimulate organisations of the intersectoral collaboration to become or remain involved and committed to the health initiative, which is needed for the initiative to become sustainable. Management could be established by appointing a leader(s) or facilitator(s) (as the term leader has been disputed several times at local health initiatives). A mission could be established by setting out objectives and an agreement between the participating organisations about a common goal. Clear roles and responsibilities could be established by an overview of role descriptions.

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8. Appendix

8.1 Process-indicators

Process-indicators
1. Degree and development phase of local networking across the domains:
- number of partners;
- more than two different domains;
- type and intensity of activities and communication,
- growth from exploratory to entrepreneurial networks;
- follow-up and spin-off
2. Degree and utilization of knowledge exchange between these domains:
- generation of new ideas,
- new knowledge and
- feedback for improvement
- adaptation, revision or replacement of activities or partners
3. Experienced change in awareness of one's own influence on health and prevention in the various domains.
4. Experienced functioning of the cooperation within pledges:
- degree of intrinsic motivation of partners,
- growth of problem-solving skills,
- shared identity and shared implicit rules
5. Experienced quality of coordination and network management at the level of the pledge, the regional network, the Programme Office and the central government:
- degree of perceived time and space for ideas, networking and innovation,
- trust (quality of relationship management, feedback, "process hygiene" (= reliable fulfilment of agreements) and conflict management)
- reciprocity (doing justice to interests, ambitions, problem solving)
6. Development in goals, working methods, size (learning and adaptation cycle):
- appropriate scale,
- action orientation,
- direct contact with target groups of citizens
- feedback mechanisms,
- transparent adaptation and improvement,
- scaling up perceived obstacles to the responsible authority
7. Experienced relationship between pledges and desirable role of the national government:
- see also under number 5. In addition:
- ambassador's role,
- equivalence among government and partners,
- interdepartmental coordination,
- follow-up signals through institutional adjustments in procedures, structures and rules
8. Experienced return on investment:
- Investment (tangible and intangible) and
- revenues (= reciprocity rather than expedience)
9. Assurance: Ideas and experiences in the field on how to achieve lasting change and effects:
- process conditions time and space, trust, reciprocity
- in order to maintain support continue testing during process
- inspire and share knowledge instead of upscaling (= imposing)
- network interests continue to be assessed against public values and interests (inclusion)
10. Accountability:
- combination and coherence between quantitative indicators and qualitative case descriptions and experiences;
- horizontal accountability to equal partners and the public;
- formative evaluation aimed at adjustment and improvement
- process activities such as reflective working visits, dialogue tables, experiential learning (having it done or undergoing yourself)

Table 10. *Process-indicators, developed during the first project evaluation of the AAH programme (Bekker et al., 2016)*

8.2 Operationalisation factors of the Model of Sustainable Intersectoral Collaborations.

Operationalisation factors of the MSIC
The representation of relevant societal sectors, including community members:
- number of partners
- more than two different domains (sectors)
- direct contact with target groups of citizens including frequency (needs assessments)
- feedback mechanisms (with the community members, part of decision-making)
- process activities such as reflective working visits, dialogue tables, experiential learning
- transparent adaptation and improvement activities according to feedback
Management (including communication structure and facilitative leadership)
- type and intensity of activities and communication
- stimulating participation, empower and involve
- presence of neutral person (mediator, organic leader)
- balanced negotiation and identify opportunities
- degree of perceived time and space for ideas, networking and innovation
- inspire and share knowledge instead of upscaling (= imposing)
Degree and utilization of knowledge exchange between these domains: - generation of new ideas, - new knowledge and - feedback for improvement - adaptation, revision or replacement of activities or partners
- protocols for internal and external communication
- both formal and informal communication
Trust building
- trust (quality of relationship management, feedback, "process hygiene" (= reliable fulfilment of agreements) and conflict management)
- process conditions time and space, trust, reciprocity
- history of cooperation
- history of conflicts
- schedule time (time-consuming)
Shared mission
- shared identity and shared implicit rules
- Agreeing on problem definition, aims and objectives
- Open discussion and communication (making the implicit -> explicit)
- network interests continue to be assessed against public values and interests (inclusion)
- Interdependency
- Accepting differences
- A clear plan of common goals, outlined activities and timetable (structure to the process)
- Agreement of needed knowledge or resources
Clear roles and responsibilities
- Consensually developed role descriptions (keeping skills and expertise in mind) (open discussion)
- Shared understanding of contributions (each organisation/person brings in)
- Experiences of working together and building relationships (give an indication for any adjustments)
- reciprocity (doing justice to interests, ambitions, problem solving)
- scaling up perceived obstacles to the responsible authority
- horizontal accountability to equal partners and the public
Experienced return on investment: - Investment (tangible and intangible) and - revenues (= reciprocity rather than expedience)
Intermediate outcomes and visibility
- Concrete outputs of the progress

- short-term outcomes such as; increased awareness, participation activities, satisfaction, included organisations
- growth from exploratory to entrepreneurial networks
- follow-up and spin-off
- incentive to keep participating
- appropriate scale
- action orientation
- needed for funding or investments (financial or political support)
- in order to maintain support continue testing during process
- feedback mechanisms (small wins -> send feedback)
- formative evaluation aimed at adjustment and improvement
- transparent adaptation and improvement
Commitment to the process
- degree of intrinsic motivation of partners (incentive to participate)
- mutual interests
- growth of problem-solving skills
- obligations towards own objectives (accountability) and maintaining legitimacy
- willingness to accept (compromises)
- respect, honesty and transparency (during negotiations)
- ownership (feeling of shared responsibility)
- involvement (power and resource imbalances)
- interdependency
Sustainable intersectoral collaboration (provisional)
- able to carry on their activities within their own organisations without the need of external incentives
- able to sustain their intersectoral collaboration
- able to be a self-sustaining entity

Table 11. *Operationalisation factors of the MSIC based on the process-indicators*

8.3 Included and excluded cases according to the selection process

Included and excluded participants of Make the Next Move 2021	
From 34 participants 25 are excluded and 9 included that have been sent an invitation of which 5 were willing to participate.	
Included	Criteria
1. Gezondheidsambassade	
2. Gezonde buurten	
3. Healthy by Design	not willing to participate
4. Voel je goed!	
5. Doortrappen	
6. Voedselapotheek wijkaanpak	
7. Wowijs app	not willing to participate
8. Montfoort Vitaal	
9. Integrale Wijkaanpak Hoensbroek	not willing to participate
Excluded	Criteria
1. Kenniscentrum Positieve Gezondheid	no intersectoral collaboration
2. Fitcoin Health Community	no intersectoral collaboration
3. Meer meedoen met een fysieke beperking	no intersectoral collaboration
4. Vital forest	no intersectoral collaboration
5. Wandelcoaching	no intersectoral collaboration
6. (W)eten (B)eter Te Eten	no intersectoral collaboration
7. Revolving Diabetes Remission Fund	no intersectoral collaboration
8. Diabetes Type 2 Leeftijd- en Preventieonderzoek	no intersectoral collaboration
9. Stadsgeneeskunde	no intersectoral collaboration
10. Groeikaarten	no intersectoral collaboration
11. Samen met de arts komen tot de best mogelijke diagnose	no intersectoral collaboration
12. Harty Party	no intersectoral collaboration
13. Fnl online	no intersectoral collaboration
14. Vitale en sportieve organisaties	no intersectoral collaboration
15. Alle kinderen en jongeren doen mee	no intersectoral collaboration
16. Groene Plaatsmakers	pilot-phase
17. #Thatslife	pilot-phase
18. Regiethuis	pilot-phase
19. Waddenwonen	pilot-phase
20. Revolving Diabetes Remission Fund	concept-phase
21. 30dagengezonder	no community involvement
22. Beter in het Groen	no community involvement
23. FitGaaf!-app: Met Gamification naar gezond gedrag	no community involvement
24. Net Employability Standard	no community involvement
25. Minuutje het spel	no community involvement

Table 12. *Included and excluded cases of the health initiatives of Make the Next Move 2021*

8.4 Invitation to participate

Geachte mevrouw, heer (naam geadresseerde)

In deze mail nodig ik u naar aanleiding van uw deelname aan de Make the Move award van Alles is Gezondheid uit voor een documentenanalyse en een interview in het kader van een afstudeeronderzoek. Ik ben Jeffrey de Heij, Masterstudent aan de Universiteit van Wageningen. Ik studeer momenteel Health, Communication and Life Sciences, waarbij ik de specialisatie Gezondheid en Maatschappij volg. Op het moment ben ik bezig met mijn afstudeerscriptie. Dit onderzoek vindt plaats onder begeleiding van dr. Marleen Bekker, projectleider van de ZonMw evaluatiestudie van Alles is Gezondheid vanuit de Universiteit Maastricht.

Het doel van mijn onderzoek is om inzicht te verkrijgen in hoe intersectorale samenwerkingen op het gebied van gezondheidsbevordering kunnen worden gewaarborgd in de maatschappij (verduurzaamd). Met andere woorden, wat de geschikte en ondersteunende voorwaarden/condities zijn voor duurzame en structurele inbedding van het initiatief in de gemeenschap.

Dit zal gebeuren aan de hand van het analyseren van documenten betreffende het initiatief en een diepte interview van ongeveer 1 uur (bij voorkeur bij u ter plaatse maar zo nodig online). Alle informatie zal vertrouwelijk worden behandeld en zal geanonimiseerd worden verwerkt in rapportages volgens de richtlijnen van de universiteit. Bijgaand vindt u een toestemmingsformulier met uw rechten, die u ondertekend retour kunt zenden. Dit is een wettelijke verplichting. Desgewenst kunt u een conceptrapportage van tevoren inzien om feitelijke onjuistheden recht te zetten.

De resultaten van het onderzoek zullen uiteraard met u gedeeld worden en zullen ook gedeeld worden met de onderzoekers van de eerder genoemde ZonMw evaluatiestudie naar Alles is Gezondheid. De uitkomsten van het onderzoek kunnen u mogelijk ook nieuwe inzichten bieden over het waarborgen van een initiatief. Mochten er nog vragen zijn, kunt u het volgende e-mailadres mailen; jeffrey.deheij@wur.nl

Alvast bedankt en ik zal binnen een week telefonisch contact met u opnemen of een herinnering sturen om uw reactie te vernemen.

Vriendelijke groeten,

Jeffrey de Heij

Masterstudent, Health, Communication and Life Sciences, Wageningen University & Research

8.5 Informed consent form

Naam onderzoeksproject	Het waarborgen van gezondheidsinitiatieven in de maatschappij. Een kwalitatief onderzoek naar intersectorale samenwerkingen binnen meerdere gezondheidsinitiatieven (van ''Make the Next Move'').
Doel onderzoek	Het doel van dit onderzoek is om inzicht te verkrijgen in hoe intersectorale samenwerkingen op het gebied van gezondheidsbevordering kunnen worden gewaarborgd in de maatschappij (verduurzaamd). Met andere woorden, wat de geschikte en ondersteunende voorwaarden/condities zijn voor duurzame en structurele inbedding van het initiatief in de gemeenschap.
Gang van zaken onderzoek	Wat vragen wij van u? Het opsturen van documenten over het desbetreffende gezondheidsinitiatief. Deze documenten zullen worden gebruikt voor analyse. Deelname van een woordvoerder/vertegenwoordiger van het gezondheidsinitiatief aan een interview. Van het interview wordt een audio-opname gemaakt. Het transcript van het interview wordt gebruikt voor analyse.
Potentiële risico's en ongemakken	Er zijn geen fysieke, juridische of economische risico's verbonden aan uw deelname aan deze studie. Uw deelname is vrijwillig en u kunt uw deelname op elk gewenst moment stoppen.
Vertrouwelijkheid gegevens	Uw privacy is en blijft maximaal beschermd. Onderzoeksgegevens worden geanonimiseerd. Er wordt op geen enkele wijze vertrouwelijke informatie of persoonsgegevens van of over u naar buiten gebracht. De audio-opnamen, formulieren en andere documenten die in het kader van deze studie worden gemaakt of verzameld, worden opgeslagen op het beveiligde (versleutelde) netwerk van Wageningen Universiteit.
Vrijwilligheid	Deelname aan dit onderzoek is geheel vrijwillig. Zonder opgaaf van redenen kunt u uw deelname voortijdig afbreken. Als u vragen of klachten heeft, neemt u dan a.u.b. contact op met; jeffrey.deheij@wur.nl

Toestemmingsverklaring	Met uw ondertekening van dit document geeft u aan dat u; goed bent geïnformeerd over het onderzoek, de manier waarop de onderzoeksgegevens worden verzameld, gebruikt en behandeld. Ik ga akkoord met deelname aan dit onderzoek. - Ik verklaar hierbij op voor mij duidelijk wijze te zijn ingelicht over de aard en methode van het onderzoek, zoals uiteengezet in het informatieblad voor dit onderzoek. - Ik stem geheel vrijwillig in met deelname aan dit onderzoek. - Mijn anonimiteit is gewaarborgd en mijn antwoorden of gegevens zullen onder geen enkele voorwaarde aan derden worden verstrekt, tenzij ik hier van te voren uitdrukkelijk toestemming voor heb verleend. - Deelname aan het onderzoek zal geen noemenswaardige risico's of ongemakken met zich meebrengen, er zal geen moedwillige misleiding plaatsvinden en ik zal niet met aanstotend materiaal worden geconfronteerd. - Ik geef de onderzoeker toestemming om tijdens het interview (geluid) opnames en notities te maken. - Het is mij duidelijk dat, als ik toch bezwaar heb met een of meer punten zoals hierboven benoemd, ik op elk moment mijn deelname, zonder opgaaf van reden, kan stoppen. Datum: ……. Naam: ……. Handtekening: ……

Contactgegevens
Onderzoeker: jeffrey.deheij@wur.nl
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Kijk op https://www.wur.nl/nl/Over-Wageningen/Integriteit-en-privacy.htm voor meer informatie over uw rechten die te maken hebben met uw gegevens.

8.6 Organisations per sector

Organisations per sector			
This classification of organisations is a own assessment, one could possibly classify certain organisations differently. Not all organisations of each initiative are incorporated. This table is to give an idea of the kind of organisations participating in these initiatives.			
Social welfare/health sector		**(mostly general local organisations)**	
social/welfare/community workers	district nurses, general practitioners	occupational therapists, physiotherapists	AAG (Advice and Administration Group)
care and welfare institutions	dietician	pharmacy	Syntein
Public sector			
municipalities (in which the health initiatives are executed)	VNG (association of Dutch municipalities)	GGD (municipal health service)	
RIVM (National Institute for Health and Environment)	RWS (Ministry of Infrastructure and Water Management)	local organisations; community centers, playgrounds, libraries, cultural institutions.	
Private sector			
Entrepreneurs:	**Research organisations:**	**Foundations:**	**Volunteer organisations:**
Het Knoopunt	Pharos	Stichting Wegwijs	Vrijwilligerscentrale Asterdam
Het eetschap	Platform 31	Stichting Kinderhulp	de Voedselbank (food bank)
Wandawandelt,	Voedingscentrum	Stichting Eigenwijks	de Zonnebeloem
Voedingsacedemie	Kenniscentrum Sport	Stichting Leergeld	Wereldtuin Verdeliet
Eet echt eten		Stichting SWOM	neighbourhood sports coaches
Voedselapotheek		Stichting Piëzo	
Pakhuis de Zwijger		Stichting Jantje beton	
local organisations; bicylce shops, sports associations, child care, supermarkets		Stichting Lezen en Schrijven	Instituut voor natuureducatie en duurzaamheid
Education sector			
VU Vrije Universiteit Amsterdam (university)	geluksprofessor (Professor of luck)	Het Kompas,	students
HvA Hogeschool van Amsterdam (college)	HAS Hogere Agrarische School (college)	primary schools	

Table 13. *Organisations per sector*

8.7 Interview guide

Introduction

Bedankt dat u wilt deelnemen aan dit interview. Dit interview is erop gericht doormiddel van uw ervaringen inzicht te verkrijgen in hoe deze intersectorale samenwerking op het gebied van gezondheidsbevordering opereert en wordt gewaarborgd in de maatschappij (verduurzaamd). Met andere woorden, wat de geschikte en ondersteunende voorwaarden/condities zijn voor duurzame en structurele inbedding van het initiatief in de gemeenschap. Er zijn geen foute antwoorden. Ik ben op zoek naar uw ervaringen of perceptie. Participatie aan het dit interview is geheel vrijwillig en mag op elke moment indien gewenst gestopt worden. Het interview zal ongeveer één uur duren, afhankelijk van hoeveelheid informatie die u wilt delen. Zoals vermeldt in het ondertekende toestemmingsformulier, is het waardevol voor de analyses van het onderzoek, dat het interview wordt opgenomen en eventuele aantekeningen worden gemaakt. Bent u er nog steeds mee akkoord dat het interview wordt opgenomen? Alle antwoorden zullen vertrouwelijk worden behandeld en geanonimiseerd. Dit betekent dat informatie enkel gedeeld zal worden met de Universiteit van Wageningen en de onderzoekers van de evaluatiestudie van Alles is Gezondheid en de informatie in het onderzoeksrapport niet te herleiden valt naar uw gezondheidsinitiatief. Als laatst hoeft u een vraag niet beantwoorden als u dat niet wenst. Heeft u nog vragen voordat we beginnen aan het interview?

Dan zal de opname vanaf nu beginnen en de recorder worden aangezet.

Het interview bestaat uit acht blokken te beginnen met duurzaamheid (het borgen en verankeren van het gezondheidsinitiatief). Voordat we beginnen kunt uw wat vertellen over het initiatief zelf?

Sustainability

1. Wat verstaat u onder het borgen en verankeren van het gezondheidsinitiatief in de gemeenschap (duurzaamheid)?

Eigen definitie: Duurzaamheid betekent in dit geval dat de gezondheidsinitiatieven in staat zijn; om hun gezondheid bevorderende activiteiten binnen hun eigen organisaties uit te voeren zonder de noodzaak van externe prikkels, hun intersectorale samenwerking te behouden en een zichzelf in stand houdende entiteit te zijn.

(In this case sustainable means that the health initiatives are able; to carry on their health promoting activities within their own organisations without the need of external incentives (Bekker et al., 2017), to sustain their intersectoral collaboration (Koelen et al., 2008) and to be a self-sustaining entity (Ulibarri et al., 2020).)

2. Hoe ver staat het gezondheidsinitiatief volgens u betreffende deze borging en verankering/ verduurzaming in de gemeenschap?

3. Hoe verloopt het samenwerkingsproces en hoe heeft dat volgens u invloed op het borgen en verankeren/verduurzamen van het initiatief?

4. Welke factoren/elementen denkt u dat van belang zijn voor het borgen en verankeren /verduurzamen van de intersectorale samenwerking betreffende het gezondheidsinitiatief?

De volgende blokken zullen factoren betreffen van het intersectorale samenwerkingsproces gerelateerd aan duurzaamheid.

Representation of relevant societal sectors, including community members

1. Klopt het dat uw gezondheidsinitiatief bestaat uit zoveel X partners/organisaties en welke verschillende sectoren zou u aan deze organisaties koppelen?

Ter verduidelijking enkele voorbeelden; onderwijs (educatie sector), zorg en welzijn (gezondheidszorg sector), bedrijfsleven, particulier, maatschappelijk (private sector), overheidsinstanties (publieke sector)

2. Wat zijn naar uw mening de relevante sectoren voor dit gezondheidsinitiatief?

Eventuele vervolgvraag:

- Komen al deze relevante sectoren ook terug in partners van het initiatief?
- Heeft men keuzes moeten maken in de deelnemende organisaties/sectoren?

Dan gaan we nu meer in op een specifieke partner van het initiatief, de burgers zelf.

Community involvement

3. Hoe zorgt u ervoor dat u direct contact heeft met de doelgroep van het initiatief (en hoe vaak)?

4. Wat doet u om de behoeftes van de doelgroep te bepalen (wat ze zelf nodig achten (needs assements)?

Eventuele vervolgvragen:

- Hoe zorgt u ervoor dat burgers onderdeel uit maken van de besluitmaking?
- Wat voor feedback mechanismes heeft uw ontwikkeld? (bijv. proces activiteiten als dialoog tafels, reflectieve werkbezoeken, leren van ervaringen)
- Hoe zorgt u naar aanleiding van deze feedback voor aanpassing en verbetering? (Is er sprake van transparantie?)

5. Hoe denk u dat betrokkenheid van de gemeenschap (community involvement) een rol speelt bij het borgen en verankeren van het initiatief (duurzaamheid)?

Als laatste vraag op dit onderwerp (in het kader van most different cases design);

- Hoeveel burgers nemen ongeveer deel aan het initiatief?

Management (including communication structure and facilitative leadership)

1. Hoe zou u het management van het gezondheidsinitiatief (de verschillende organisaties tezamen) omschrijven?

Eventuele vervolgvragen;

- Hoe stimuleert het management participatie, empowerment en betrokkenheid van de verschillende organisaties?

(Ter verduidelijk enkele voorbeelden (indien gevraagd); gebalanceerde onderhandelingen (ieder aan het woord) en het identificeren van kansen, inspireren en kennis delen i.p.v. opschalen, mate van ervaren tijd en ruimte voor ideeënvorming, netwerkvorming en innovatie, persoonlijke motivatie)

- Is er sprake van leiderschap en betreft dit een neutraal persoon of organisatie (mediator tussen de verschillende organisaties)?
- Welke kwaliteiten moet deze persoon of organisatie bezitten?

2. Wat voor type en intensiteit van activiteiten en communicatie betreffende de samenwerking tussen de verschillende organisaties van het initiatief vinden er plaats?

(Ter verduidelijking (indien gevraagd); formele communicatie (bijv. wekelijkse vergaderingen) en informele communicatie (bijv. gesprekken bij koffieautomaat), protocollen voor interne en externe communicatie)

Eventuele vervolgvragen:

- Waar hecht men tijdens overleggen waarde aan?
- Hoe waarborgt het management deze waarden?

3. Hoe wordt er gebruikt gemaakt van kennisuitwisseling tussen de verschillende organisaties?

(Ter verduidelijking enkele voorbeelden (indien gevraagd); generatie van nieuwe ideeën, nieuwe kennis, ervaringen en feedback voor verbetering, aanpassing, herziening of vervanging van activiteiten of partners)

4. Hoe denk u dat het management van het gezondheidsinitiatief een rol speelt bij het borgen en verankeren van het initiatief (duurzaamheid)?

Trust building

1. Wat wordt er binnen het gezondheidsinitiatief gedaan om vertrouwen tussen de verschillende organisaties op te bouwen?

(Ter verduidelijking enkele voorbeelden (indien gevraagd); nakomen van afspraken, wederkerigheid, inzet op lange termijn (commitment))

Eventuele vervolgvragen:

- Hoe wordt er tijd en ruimte gewaarborgd voor het opbouwen van vertrouwen?
- Hoe zou u de kwaliteit van het relatiebeheer omschrijven?
- Hoe wordt er gewerkt met en gereageerd op terugkoppelingen (feedback)?

2. Hebben sommige organisaties al eerder samengewerkt? Ja→Hoe denk u deze eerdere samenwerking het vertrouwen beïnvloedt?

3. Is er sprake geweest van conflicten tussen organisaties? Ja→ Hoe denk u dat deze conflicten het vertrouwen beïnvloeden?

Eventuele vervolgvraag:

- Hoe wordt er omgegaan met conflicten?

4. Hoe denk u dat het opbouwen van vertrouwen tussen de organisaties een rol speelt bij het borgen en verankeren van het initiatief (duurzaamheid)?

Shared mission

1. Hoe is de gedeelde missie van de organisaties van het gezondheidsinitiatief vormgegeven?

(Ter verduidelijking (indien gevraagd); duidelijk plan bestaande uit gemeenschappelijke doelen, overeenstemming van de benodigde kennis of middelen, uitgelijnde activiteiten, tijdschema (structuur aan het proces))

Eventuele vervolgvragen:

- Hoe hebben jullie overeenstemming bereikt tot een probleemdefinitie, doel en objectieven?
- **H**oe accepteren jullie verschillen tussen de organisaties?
- Hoe overkomen jullie ervaren barrières?
- Is er sprake van een gezamenlijke identiteit en gedeelde impliciete spelregels? Ja→ Kunt u deze omschrijven? (spelregels; wat verwachten jullie van elkaar)
- Hoe zorgen jullie voor open discussie en communicatie hierover ? (Het impliciete, expliciet maken)

2. Hoe representeert het netwerk de publieke waarden en belangen? In andere woorden; Hoe zorgt het initiatief ervoor dat de gedeelde missie ook relevant blijft voor de gemeenschap.

3. Hoe denk u dat een gedeelde missie een rol speelt bij het borgen en verankeren van het initiatief (duurzaamheid)?

Eventuele vervolgvraag:

- Hoe denkt u dat onderlinge afhankelijkheid een rol speelt bij het borgen en verankeren van het initiatief (duurzaamheid)?

Clear roles and responsibilities

1. Hoe is het verdelen van rollen en verantwoordelijkheden van de verschillende organisaties gegaan? (indien niet toepasselijk; verdeling informele rollen en verantwoordelijkheden?)

Eventuele vervolgvragen:

- Hoe zijn de rolbeschrijvingen ontwikkeld? (ter verduidelijking (indien gevraagd); vanuit consensus, open discussie, rekening houdend met vaardigheden en expertise)
- Zijn hier naarmate de samenwerking nog veranderingen in opgetreden? Wat voor ervaringen lagen hieraan te grondslag?
- Hoe wordt ervoor gezorgd dat het duidelijk is wat elke organisatie inbrengt/bijdraagt?

2. Hoe wordt er verantwoording gedragen naar de andere organisaties (de gelijkwaardige partners) en publiek (burgers))?

Eventuele vervolgvraag:

- Hoe worden ervaren belemmeringen doorgeschakeld naar de verantwoordelijke organisatie? (verantwoording)
- Welke spanningen ervaart u bij het afleggen van verantwoording?

3. Hoe wordt er voor een balans gezorgd in investeringen (materieel en immaterieel (kennis)) en

opbrengsten (wederkerigheid) van de organisaties in de samenwerking (gelijkwaardig relaties)?

Ter verduidelijking; Wederkerigheid als in recht doen aan belangen en ambities van de organisatie of probleemoplossing

4. Hoe denk u dat het verdelen van rollen en verantwoordelijkheden een rol speelt bij het borgen en verankeren van het initiatief (duurzaamheid)?

Intermediate outcomes and visibility

1. Hoe hebben jullie tussentijdse uitkomsten en zichtbaarheid van het gezondheidsinitiatief vormgegeven?

(Ter verduidelijking (indien gevraagd); concrete resultaten van vooruitgang, korte termijn resultaten zoals, verhoogde bewustzijn (awareness), participatie bij activiteiten, aangesloten organisaties, tevredenheid (deelnemers), follow-up and spin-off)

2. Wat wordt er gedaan met de tussentijds uitkomsten als terugkoppeling (impuls)?

(Ter verduidelijking (indien gevraagd); feedback mechanismes (small wins -> send feedback), formatieve evaluatie gericht op aanpassing en verbetering, transparante aanpassing en verbetering, passende schaalgrootte, actiegerichtheid, om de ondersteuning te behouden blijven testen tijdens het proces)

3. Wat is volgens u nodig om van een verkennende naar zelfstandige ondernemende intersectorale samenwerking te gaan?

4. Wat wordt er gedaan om zichtbaarheid van het gezondheidsinitiatief te creëren?

Eventuele vervolgvraag:

- Wat acht u als het belang van deze zichtbaarheid?

(Ter verduidelijking enkele voorbeelden (indien gevraagd); stimulans om te blijven deelnemen (als organisatie aan het initiatief), nodig voor financiering of investeringen (financiële of politieke steun))

5. Hoe denk u dat het tussentijdse uitkomsten en zichtbaarheid een rol spelen bij het borgen en verankeren van het initiatief (duurzaamheid)?

Commitment to the process

1. Hoe zorgen jullie binnen het gezondheidsinitiatief ervoor dat de organisaties toegewijd blijven?

Eventuele vervolgvragen;

- Wat zijn de intrinsieke en excentrieke motivaties van de organisaties om te onderdeel te blijven van het gezondheidsinitiatief (prikkel tot deelname)?

(Ter verduidelijking enkele voorbeelden (indien gevraagd):

Intrinsiek; eigenaarschap (gevoel van gedeelde verantwoordelijkheid), groei van probleemoplossend vermogen, betrokkenheid (bij het aanpakken van gezondheidsprobleem)

Excentriek; onderlinge afhankelijkheid, wederzijdse belangen, verplichtingen (verantwoording) en het behouden van legitimiteit (publieke waarde), betrokkenheid (verschil in macht en middelen))

- Wat acht u als het belang van toewijding tijdens de onderhandelingen?

(Ter verduidelijking (indien gevraagd); bereidheid tot acceptatie (compromissen), respect, eerlijkheid en transparantie)

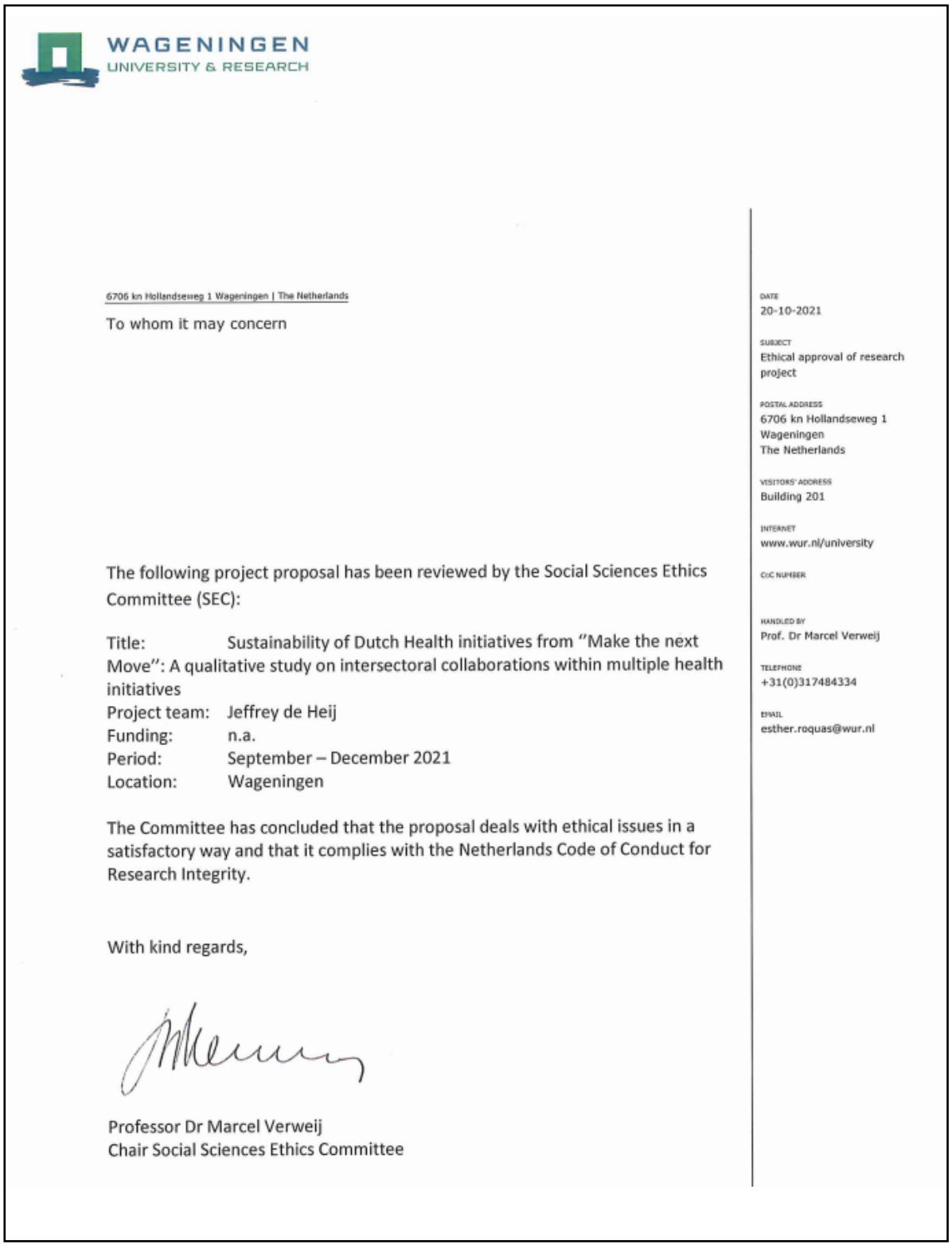
2. Hoe denk u dat toewijding aan het proces (gezondheidsinitiatief) een rol speelt bij het borgen en verankeren van het initiatief (duurzaamheid)?

Concluding

1. Heeft u nog toevoegingen of dingen die u van belang acht voor mijn onderzoek die we nog niet hebben besproken?

Hartelijk bedankt voor uw tijd en de informatie die u vandaag heeft gedeeld.

8.8 Ethical approval



WAGENINGEN
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To whom it may concern

The following project proposal has been reviewed by the Social Sciences Ethics Committee (SEC):

Title: Sustainability of Dutch Health initiatives from "Make the next Move": A qualitative study on intersectoral collaborations within multiple health initiatives
Project team: Jeffrey de Heij
Funding: n.a.
Period: September – December 2021
Location: Wageningen

The Committee has concluded that the proposal deals with ethical issues in a satisfactory way and that it complies with the Netherlands Code of Conduct for Research Integrity.

With kind regards,

Professor Dr Marcel Verweij
Chair Social Sciences Ethics Committee

DATE
20-10-2021

SUBJECT
Ethical approval of research project

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8.9 Types of retrieved documents of included cases

Documents of each health initiative used for document analysis
All documents are coded in Atlas.ti, except the websites and video's
Gezondheidsambassade
Meeting minutes 2017
Plan of action 2017
Progress Report 2017 + 2018 + 2019
Final report 2017 + 2018 + 2019
Funding application 2019
Invitation meeting + report 2019
Script of a meeting + report 2019
Video report 2020
Video interim report 2021
Website
Gezonde buurten
Plan of action
Ambition document
Annual report (2020)
Inspiration booklet
Roadmap (stappenplan) (process approach)
Website and video's
Doortrappen
Interim report Monitoring and Evaluation (phase 2)
Final report (phase 1)
Presentation practical example
Presentation quarterly meeting
Presentation coordinators' meeting
Master thesis public value (chapter 5 results and 6 conclusions and recommendations) + summary
Website
Voedselapotheek Wijkaanpak
Final report 2020-2021
Websites and diverse video's
Montfoort Vitaal
Final report 2020
Progress report 2021
Meeting minutes 2021 (meeting of the participating organisations)
Meeting minutes 2021 (second '')
Policy framework 2017- 2020
Vitality agreement
Website
Voel je goed!
Final report of an impact and process evaluation (Chapter 1, 2, 4 and 6)
Example execution (two examples of different cities)
Example story
Factsheet
Website and video

Table 14. *Types of retrieved documents of included cases*

8.10 Intermediate outcomes of the cases

Intermediate outcomes regarding the:			
Collaboration	**Communication**	**Health activities**	**Health issue**
new connections	conference/ network meetings	kick-off events	increased self-management
maintenance agreements	online platform	information meetings	increased participation
project proposal for health community school	communication resources (posters, flyers, videos, online)	workshops of participating organisations on health themes	(increased) satisfaction of community members about the health activities/interventions
active participation of partners (involvement)	a positive image for the municipality	training trajectories of health ambassadors (also professionals and volunteers)	increased awareness about health at community members or within communities or families
evaluation system	media reports (local and national)	trained health ambassadors	increased exercising
reports of activities	activity calendar	certificate ceremony	less loneliness
new included organisations in the intersectoral collaboration or cases (municipalities at which the initiative is executed)	registration tool for the health interventions (sharing knowledge with other municipalities at which the health initiative is executed)	developed health activities (for example, sports day, cook and walk group, lifestyle trajectory for girls)	healthier choices of community members on food and exercising
a cooperative of local health professionals	inspiration-PowerPoint	supermarket tour video's	lower threshold for health activities
establishment of a foundation	a time-line report	healthy shelf	increased social network (community members)
establishment of agreements	community members evenings	health interventions (e.g. the pharmacy gave prescriptions of vegetables with the medicine)	difficult to increase social cohesion (partly due to corona measures)
organisations appear to have other ambitions	recruitment activities	healthy neighbourhoods; playgrounds, gardens	behaviour change
inspiration event	neighbourhood portraits	health festival	
progress reports or financial reports	website	overview of health activities + amount of participating community members per activity	

Table 15. *Intermediate outcomes (and concrete outputs of progress) of the health initiatives of this study described in the documents.*

8.11 Data storage

Data storage			
Data	**File type:**	**Stored:**	**Accessible:**
Recordings interviews	MP3/MP4/WAV	at Wageningen University & Research secure network	by researchers of Wageningen University & Research
Transcripts interviews	Word	at Wageningen University & Research secure network	by researchers of Wageningen University & Research
Documents of the initiatives	ATLAS.ti 9	at Wageningen University & Research secure network	by researchers of Wageningen University & Research
Signed informed consent forms	Word	at Wageningen University & Research secure network	by researchers of Wageningen University & Research

Table 16. *Data storage*

8.12 Separated data analysis interviews and documents

8.12.1 Sustainable intersectoral collaboration

Documents

The code sustainability was present at all initiatives except one and labelled at different documents (n=45). Remarkable is that sustainability (in Dutch reported as ''borging'' or ''verankeren'') is mentioned several times but not elaborated or defined. Only the approach or descriptions of sustainability who recurred at different quotations are discussed.

Starting with the most recurring approach of sustainability in the documents, community involvement. Community involvement is being described as a part of sustainability. The community members will take care of management and maintenance of the facilities and organisation of the activities (self-organising ability). In one example this maintenance is supported by the municipality and they also follow certain steps (roadmap) that together form a cycle to initiate sustainable change. The first step includes forming a neighbourhood council, of which is spend relatively large amount of time, as experience showed that it offers the higher chance of sustainable involvement. Step four focused on the neighbourhood becoming a self-sustaining entity (still with support by professionals) (in line with provisional definition of sustainability of this study) . One year later the initiators of the initiative give a new impulse to the community to keep the process going. In addition, it is several times mentioned that next to community members also the local network can play a role in making the initiative sustainable in the neighbourhood (involving local community organisations, local organisations from the private sector or local entrepreneurs). In one document it was mentioned involving professionals enables that the initiative connects to the systems in the society, ensuring sustainability for the long-term. The self-organising ability of the community was mentioned multiple times (both the community members themselves and local partners/ entrepreneurs), which partly corresponds with the provisional definition of sustainability of this research; able to carry on their activities within their own organisations without the need of external incentives. One initiative explicitly looks at the presence of a local network and willingness of the community, before they implement any health activities. So reaching a sustainable health initiative by the means of community involvement.

One initiative describes a definition of ''social sustainability''; ''*A socially sustainable approach is a continuous process in which everyone can participate with the aim of strengthening relationships between people*'' (p. 5, Progress report 2018 Gezondheidsambassade). In this case ''everyone can participate'' refers back to community involvement. In addition, some conditions were mentioned, which will be shortly addressed. Openness, a low-threshold process in which everyone can participate and can determine for themselves to what extent they participate. Flexibility, intended results develop with changing wants and needs in a community. Continuity, intended results and effects are self-sustaining. The latter is one of the provisional described indicators of sustainability for this research; able to be a self-sustaining entity.

Another recurring approach of sustainability regards, research. Process and effect evaluations of initiatives result in recommendations for sustainability or monitoring of reach, implementation and sustainability of the initiatives. In one quotation a monitoring and effect evaluation was mentioned to be on the basis of feedback mechanisms, which is an indicator represented at the factors of the MSIC. In one document sustainability was defined in three parts of which monitoring is one. Next to, annual agenda and incorporating the initiative into municipal policy. Also in another documents, imbedding of initiative in policy plans (school, municipality or provincial) or in the welfare system was mentioned as way to make the initiative sustainable.

Lastly it was mentioned two times that training of self-management for people who execute or facilitate the activities of the initiative, expected to contribute to sustainability. There was an example of a health activity which was finished, however, the community members themselves

wanted the activity to be continued, as said by facilitator of this activity (see the quote below). This shows that sustainability is not only on the level of the intersectoral collaboration (being able to carry on their activities within their own organisations without the need of external incentives), but it also applies to the community members being able to carry on their activities within their own community.

''*Zelfs nadat Walk & Go afgelopen was, kreeg ik reacties of we toch niet op de woensdagavond konden blijven lopen, omdat het zo leuk was.*'' (p. 20, Final report 2018, GezondheidsAmbassade).

Translated: *"Even after Walk & Go ended, I got comments about whether we could continue walking on Wednesday evenings, because it was so much fun.".*

Interviews

In contrast to documents sustainability was defined in the interviews by the interviewees (as the result of question 1). Sustainability was defined as the health initiative being capable to carry on. How this could be achieved was somewhat differently described. Firstly, and mentioned most often, the local community being able to execute the health initiative (activities) on their own. This includes that at some point the initiative can be transferred from the initiators to community members and local entrepreneurs/organisations. The capability of the health initiative to continue to exists after initiators have left. In other words, the initiative becoming assimilated into the local network of the community. Community involvement was indicated as the key in order to achieve this. It was mentioned when the community members are already involved in development of the initiative and the activities (or developed activities themselves), the initiative is more likely to sustain (community members keep invested). Several initiatives also mentioned they look for the possibilities in the local network to position the health initiative (in Dutch ''Landingsplaats''), who or which local organisations are capable to take over? It was noted by several interviewees after the community (local network) takes over or adapts the initiative, there should always be the possibility to still ask for support or stimulation from an external professional institution. For example when a leader (driving force) stops and one can still fall back on an professional organisation. In the following quote, an interviewee describes this transferring of the health initiative activities (in this quote, with ''initiative'', an ''intervention'' of the health initiative is meant);

''*… om een landingsplaats te creëren, zeg maar, dus als wij een hardloop initiatief starten. En dan willen we dat in één of twee jaar steunen en daarna willen we het loslaten, maar dan willen we wel zeker weten dat daarna doorgaat. En nou ja, dat is, dat is ons ons spel, zeg maar … Maar wij kunnen niet alles we wij, wij kiezen ervoor, aan het begin van een initiatief te staan. Op het moment dat we dat initiatief weer kunnen loslaten, dan doen we dat, dus onze vaardigheid zit hem ook in het loslaten. Ja, en het laten landen bij anderen.*'' (Interviewee 3, 2021)

Translated: ''*… to create a landing place, so to speak, so if we start a running initiative. And then we want to support that in one or two years and then we want to let it go, but then we want to make sure that it continues after that. And well, that is, that is our game, so to speak … But we cannot do everything we, we choose, to be at the beginning of an initiative. The moment we can let go of that initiative, we will, so our skill is also in letting go. Yes, and let it land with others."*

The following quote describes this community involvement as answer to the question what they understand as a sustainable health initiative.

''Nou, dat als wij weg zijn, als wij, als initiatiefnemers, dat het dan alsnog overeind blijft, dat de gemeenschap het over neemt en of dat nou, de gemeenschap, nou bestaat uit de bewoners of een combinatie met professionals.'' (Interviewee 4, 2021)

Translated: *"Well, that when we are gone, as initiators, that it will still exist, that the community will take over and whether that is, well, the community, consisting of the community members or a combination with professionals."*

Other ways mentioned in which this sustainability of the health initiative (capability to carry on) could be achieved were; materials for initiative being always available, structural financing or something more similar as previous one, the health initiative becomes part of the already existing systems in the community. This entails it is not something temporarily but becomes part of working methods, regular tasks and regular financing (for example the health initiative being incorporated at the policy plans of municipalities). The health initiative becomes permanent and belongs to daily work of people.

Lastly, one interviewee described sustainability as continuability (in Dutch ''Volhoudbaarheid''). This entailed regardless what it is about (organisational, systems, agreements, managament), one can continue (keep it up, in Ducth ''vol blijven houden'') the initiative for the long-term. An example of one health activity which was not continuable due to a system in place (revenue model), was a about a partner (physiotherapist) not being able to make money, which resulted in withdrawing from the activity leading to the activity being ceased (which is also an indicated barrier, of collaborating with certain health sector organisations which have interest in revenue). This resulted in the need of finding a new partner for the activity to start again. So certain current systems were indicated as not continuable and need change, for the health initiative to be capable to become sustainable.

Status of sustainability of the initiatives differ. However, all the representatives indicated that the sustainability of their initiatives still could be improved. One indicated that for large part the initiative is made sustainable in several communities and another one indicated that in none of the of the communities in which the health initiative is executed are made sustainable. All the cases are still in development towards sustainability, however differing in the already established level of sustainability.

One interviewee indicated they did not succeed to eventually make the health initiative sustainable and therefore also did not continue (partly also due to funding). However, there were certain parts, health activities, that were continued after the initiative ended. These successful parts were continued on their own and expanded and further developed. For example the healthy shelf at the supermarket being extended to other neighbourhoods in the community. Another interviewee indicated that you also have to realise which activities you should pull the plug. This shows sustainability is also about what works and should be continued.

The intersectoral aspect of the collaborations, was also mentioned as playing a role in the sustainability of the health initiatives. Connecting people of different sectors to establish a strong and large network. These connections and network enable to make the health initiative sustainable. The intersectoral approach was also regarded as cross pollinations stimulating the collaboration and identifying opportunities. These cross pollinations between sectors and integrated work were indicated to be necessary for the initiatives to succeed. However, one interviewee noted that this intersectoral approach also requires more effort, as the different sectors have to speak the same language, which is sometimes difficult.

Lastly, some interesting comments regarding sustainability were mentioned. Firstly, personal intrinsic motivation (also regarded as energy, see 8.12.9) was indicated as a concept which plays a role at sustainability. Secondly, needs assessments, understanding and investigating what the community members want, increases the chance the health initiative is better received by the community and ultimately a higher chance of sustainability (bottom-up approach). Thereby, the community members being treated as equals in comparison to all other participating organisations (professionals) of the intersectoral collaboration.

8.12.2 The representation of relevant societal sectors, including community members

Documents

The code representation of relevant societal sectors was highly present in the documents (n=108). Als already mentioned the cases had to be intersectoral, so the high occurrence could be expected, as this code was labelled at quotations, where organisations of different sectors were listed or mentioning of partners. In one of the documents is was also stated that this intersectoral aspect of the collaboration makes the health initiative successful. This is because of being able to use each other's expertise, strengths and experiences in different areas to tackle the (complex) health issue.

''Uit huidig onderzoek blijkt dat de samenwerking tussen verschillende domeinen en werkgebieden een van de succesfactoren is van het programma.'' (p.2 Managementsamenvatting 2021, Doortrappen).

Translated: *"Current research shows that the collaboration between different domains and work areas is one of the success factors of the program."*

Another initiative mentions policy officers of a municipality especially appreciate the connection the health initiative has created within the various policy domains. For this initiative they used each other's expertise and resources, which provided an acceleration of the integrated approach at the municipality. At the different initiatives in the documents it was often the case that for the particular health initiative new collaborations have been made, including with sectors organisations never worked with before. For example a collaboration between the agri-food and healthcare sector. There were also collaborations between certain sectors that often recurred in the documents. Mostly for the health initiatives, organisations of the social welfare/health sector, public sector, private sector and education sector were included for the intersectoral collaboration. This often involved, organisations of a welfare institution, a municipality, a foundation and sometimes of higher education. The social welfare/health sector was most often represented in the intersectoral collaborations. Thereafter, the public and private sectors were approximately equally represented and education sector somewhat less. In addition, sports and exercise was also mentioned several times as a sector on his own next to other sectors which were mentioned one or two times, which will be disregarded. In the appendix 8.6 there is a table with some examples of organisations for each sector. Not all organisations of each initiative are incorporated. This table is to give an idea of what kind of organisations participate in these initiatives.

Something important to point out is the difference in scale of initiatives and the consequences for the kind of participating organisations in the intersectoral collaboration. The intersectoral collaborations of the cases of this study all exist from local partners from the community. However, of the included cases there are health initiatives in one single community but also initiatives on a national level being implemented at several communities. Resulting in organisations which operate on regional or national level are also part of the intersectoral collaboration for these cases (so there are different organisations involved on local and regional/national level). So often the health initiatives seek for local partners from the community (where they execute the health interventions) for the collaboration. This includes for the national initiatives, per community a collaboration with other local partners. This results in different participating organisations in each community. This looking for appropriate local partners is also indicated several times with looking for local relevant professionals, which could be of added value to the intersectoral collaboration.

It was described in different documents it is important for the health initiative to create a local network. Moreover, it was mentioned to within these local networks also have diversity and be

intersectoral. An example of involving local partners from the community in initiative, was a health intervention which made use the social neighbourhood team, the neighbourhood sports coaches, mosque and day care locations. These local collaborations exist from supporting each other with resources, for example making locations available for the activities. As well as exchange knowledge, for example the general practitioner referring people to the lifestyle coach. The latter is an example showing this need of the intersectoral aspect of the collaboration, which is clearly illustrated with the quote below.

''Huisartsen zien steeds meer patiënten met gezondheidsvragen waarvoor de oplossing in het sociaal domein of leefstijladvisering te vinden is. Reden genoeg om als professionals uit de publieke gezondheid en huisartsenpraktijk de handen ineen te slaan met bijvoorbeeld welzijnswerkers, wijkverpleegkundigen, buurtsportcoaches en de gemeente. Maar ook diëtisten, leefstijlcoaches, de lokale groenteboer en supermarkten.'' (p.18 Final report 2021, Voedselapotheek Wijkaanpak)

Translated: *''General practitioners are seeing more and more patients with health questions for which the solution can be found in the social domain or lifestyle advice. Reason enough to join forces as professionals from public health and general practice with, for example, welfare workers, district nurses, neighbourhood sports coaches and the municipality. But also dietitians, lifestyle coaches, the local greengrocer and supermarkets."*

This quote looks more like a suggestion, however this working with other sectors does indeed take place in the health initiatives. Once more, as said at the beginning of this factor, it was mentioned multiple times that combining expertise's and networks of different sectors contributes to the implementation and execution of the health initiatives. This also includes sectors which work together that were previously not familiar with each other. In addition, for example, within a municipality, some departments from different sectors which first worked alongside each other have now made connections. This enhanced and expanded the network of the organisation both internal and external. However, a few times it was also mentioned that connecting different sectors can be difficult, as they are not used to working with each other. Unfortunately, experienced barriers are not discussed in-depth within the documents. Only a desire of implementation instruction manual of working with other sectors was mentioned and an example of two sectors having a different view on continuing the health activities during the covid-19 pandemic (according to health sector especially during this time it was important to continue health activities, but the other sector (road safety) thought shutting down activities during this pandemic was a logical and safe option).

Lastly, it was several times mentioned that organisations of the healthcare sector have experience in involving community members (target groups) and the local network, which was indicated helpful for organisations from the other sectors. In multiple documents it was indicated that they find it most important to involve local community members and local organisations from the start. Community members can also been seen as a relevant partner and will be discussed next. As already noted, including community members, was separately coded with another code; **Community involvement.**

The code community involvement had the highest occurrence in the documents (n=148). In every health initiative and almost all documents community involvement was present. One of the health initiatives their execution was built on community members, where these citizens are getting trained and supported to set up their own health activities, which could be regarded as ultimate community involvement. Not only being actively involved in setting up health interventions, but creating these interventions themselves. This also shows a bottom-up approach, in this case the community members themselves came up with ideas for health interventions (what they think is important, what they think can improve health of involve the neighbourhood). No pre-made

interventions from the top.

The process-indicator, direct contact with target groups of citizens (needs assessments, frequency), was highly represented in the quotations about including community members (n=65). This direct contact often happened at meetings with the community members. At these meetings their input was actively asked; ideas, reactions, wishes about what they would like to address or learn regarding health (issues). In addition, at some initiatives also which role they would like to play within the initiative (what they would like to contribute, setting up health activities or supporting activities for example) or let them investigate on how to make the neighbourhood healthier. These inputs of the community members are used for needs assessments, about what the community wants to achieve, what effort is required to achieve this and who or what (knowledge and resources) are needed. The frequency of these meetings for needs assessments was not mentioned very often at the documents, one initiative mentioned at least two meetings with the community members a year and another initiative on a yearly basis. In addition, another document indicates collecting the needs also ensures that these community places for the health activities are actually also being used in the long term. At another document of another initiative they also executed needs assessments of community members, however based on the themes and action points the initiators wanted to address. Lastly, there was an initiative, actually conducting formal research to assess the needs of the community members.

However, not only input on the health issues was asked about, but also on the process within the health initiative. For example, a brainstorm about the communication of the health initiative, which could be connected to another process-indicator; process activities (in this case a brainstorm). The process-indicator, process activities such as reflective working visits, dialogue tables, experiential learning was also well represented. Community involvement was also attempted with these process activities. For example at one document it was said, visiting activities as initiators of the initiative (gaining familiarity and being closer to the community members) enables to get input, they for instance visited the community members at coffee breaks (where they even made use of conversations cards, specially made about and for the initiative). In addition, when wanting to get more people involved, representing the initiative at events at which the target group is present. This being actively involved at existing activities can also been seen as experiential learning. Learning from what happens in practice. Other initiatives also mention reflective working visits and experiential learning at for example cooking or walking activities of community members, enabling to start conversations and gaining input. But also process activities as going into neighbourhood and starting dialogue on the streets at schools, community centers, supermarkets or other busy locations and starting the conversation with for example handing out free vegetables or free bicycle mirrors and assemble. The next quote illustrates a combination of the process-indicator direct contact with target group with needs assessments and this indicator of process activities with reflective working visits. In this quote ''they'' refers to the coordinators of the initiative.

''Zij geven aan dat het hierbij helpt om in gesprek te gaan met de doelgroep. Het gaat er dan om dat de ouderen niet alleen worden uitgenodigd om ergens aan deel te nemen, maar dat ook het gesprek wordt aangegaan over wat er leeft onder de doelgroep en welke wensen en behoeftes zij hebben. Het gebruiken van een bestaand netwerk en aansluiten bij bestaande activiteiten helpt hierbij.'' (p.28 Interim report Monitoring and Evaluation 2021, Doortrappen)

Translated: *''They indicate that it helps to enter into a dialogue with the target group. This means that the elderly are not only invited to participate in something, but that a discussion is also started about what is going on among the target group and what wishes and needs they have. Using an existing network and joining existing activities helps with this.''*

Next to, retrieving input or getting input from the community members, there is also a next level of community involvement; being part of decision-making, which is a part of the process-indicator feedback mechanisms. So community members being able to take control by having co-determination and to actively influence the health activities executed in their own neighbourhoods (being actively involved). One initiative states this could provide a measurable healthier neighbourhood, as according to them real change starts at the core, which is why the community members are in charge of their projects. An example of how community members are part of decision-making is for instance the so-called neighbourhood safari, at which in this case children explore their neighbourhood with the initiators of the initiative (which one also could regard as a process activity) to think, dream and show how the neighbourhood could be used in a different way and could be improved (children are the experts of playing in the neighbourhood). Another example was a healthy shelf at a local supermarket for and by the community members with their healthy recipes and healthy products (with assistance of some professionals). They made the recipes and decided which new healthy and sustainable eating habits they wanted to try and expected to be important. Which was indicated, as a way the behaviour change was more likely to stay implemented. However, not only health improvement, but also creating a stronger community cohesion. At two initiatives it is described that the initiators only assisted and the community members made the decisions (they are the executors, the organisations of the intersectoral collaboration give support). One also speaks of co-creation. Another example of a feedback mechanism in place, was once again asking feedback on an action plan, developed by initiators on basis of the input of the community members, before making the plan definitive. Giving the community members the possibility to give input, feedback and co-determine will, according to different initiatives, increase commitment and self-esteem.

This process-indicator feedback mechanisms is highly connected to the following process-indicator; transparent adaptation and improvement activities according to feedback. For example, at one document it was mentioned during and after projects within the health initiative, there were evaluations with the project team but also with the involved community members. Insights and lesson learned were taken into account for possible adaptations. In addition, within these evaluations, participating organisations indicated they appreciated this co-creation with community members. Another initiative mentioned, during the development of the concepts of the health initiative, they constantly involved the community members in optimising these concepts by trial and error (feedback mechanism and adaptation). Furthermore, there was also an initiative which used feedback rounds for their concepts with community members which had experience in the kind of health interventions they wanted to implement. It was mentioned several times in different documents that community members could provide input and thereafter it would be assessed if there could possibly be made any adaptations or improvements.

Finally, as already indicated at the factor sustainability, community involvement was mentioned to be part of the sustainability of a health initiative. At one document this was clearly described, as displayed in the quote below. In this particular initiative, the community members are being trained as so-called ambassadors, who propagate or support a health activity. In addition, as already described, initiatives being handed over to community members, relying on their self-organising abilities and maintenance/management (shifting of responsibility).

''Ambassadeurschap is een succesvolle vorm om het besef onder bewoners van het belang van een goede gezondheid te bevorderen en daar daadwerkelijk naar te handelen. Deze vorm heeft een duurzaam karakter; Eigenwijks streeft ernaar een beweging op gang te brengen waarbij steeds meer mensen bijdragen aan een gezonder leefklimaat en daar baat bij hebben in hun eigen ontwikkeling.*'' (p.2 Funding application 2019, Gezondheidsammbassade)

Translated; *"Ambassadorship is a successful form of promoting awareness among residents of the importance of good health and acting accordingly. This form has a sustainable character; Eigenwijks* aims to initiate a movement in which more and more people contribute to a healthier living environment and benefit from this in their own development.''* (*Eigenwijks, one of the organisations of this initiative)

Lastly, it is interesting to note some barriers that one initiative experienced. The initiative had a broad view enabling the possibility to still go in any direction, giving to opportunity to develop from the needs of the community members. This was described as instructive, but also as difficult to maintain focus. Adapting to the needs of the community members, sometimes resulted difficulties in connecting to wishes of the participating organisations of the health initiative (intersectoral collaboration). In addition, another initiative mentioned the need of flexibility of the executive organisations, when the questions and needs of the community members are leading. Finally, it is also important to note, apart from being mentioned only once in the documents, it can be difficult to involve community members. For example, community members indicated at one initiative that they already know how to prepare healthy food and did not see the need of an intervention or participating in the health initiative. Eventually, this initiative used this as a starting point for a setting up a health activity at which they can share this knowledge with each other and for the benefit of the community, with supervision of a dietician.

Interviews

Also within the interviews often the social welfare/health, public, private and education sector were listed as the main sectors included in the intersectoral collaboration. The participating organisations mentioned in the interviews from each sector matched with the organisations listed in Appendix 8.6 retrieved form the documents. Again difference was made between organisations collaborating on nationally and locally level. Though in the interviews there was emphasis on ''a broad network'' which was established at the municipalities the health initiatives were executed. This local ''broad network'' included many different local organisations from different sectors. Advantages from this broad local network were mentioned, as an easy way to expand and maintain the intersectoral collaboration. Each organisation brings in his own network, resulting in possibly including more relevant organisations. However, a note to this would be this expanding also included organisations supporting the collaboration once or a couple of times during certain activities and not for the long term. So there will always be a core of organisations that keep the initiative running.

Organisations from the social welfare/health sector were indicated several times to be valuable in including the community members in the initiative. It was mentioned they had already experience with building a local network or already established a local network of community members (including the target group). They could support the other organisations of the intersectoral collaboration in connecting to the community members and develop a network for the health initiative. Especially, organisations from public sector (municipality or ministry) indicated welfare organisations as very helpful and providing a different view on the health issue or approach.

The private sector was often indicated as a sector that could be more involved, but this was also often refuted. Since this sector after some consideration was more involved than first thought (certain health organisations also being private organisations for profit). But unlike in the documents, some barriers were explained in the interviews. For example one of the health initiatives is initiated and partly funded by the government. As a government you cannot favour or involve certain entrepreneurs, in this case you have to for example ask for participation of all the bicycle shops in the community (all entrepreneurs with the same expertise). Another indicated barrier was the health initiative being approach by local entrepreneur for a collaboration. However, it is not always certain

if they want to collaborate on the long or short term and if it regards mutual interest. The initiative wanted to make sure there is reciprocity (process-indicator). In addition, having not a certainty if the person of the local small entrepreneurship drops out, there is someone else who continues. Last experienced barrier, was some health organisations focusing on profit instead of prioritising the health of the community members. This selling of treatments clashes for example with the foundations or voluntary organisations in the same intersectoral collaboration. However, added value of private organisations was also indicated; knowledge and expertise (e.g. on communication or the addressed health issue) or financial support for activities.

Partly in response to the last just mentioned barrier, an interviewee suggested a new sector; the vitality sector. Prioritising the health of the community member (regarding knowledge, skills and living environment). Combining parts of the health and sports sector, as they were indicated not being able to change the health issues on their own. Next to this new sector, also some other sectors were mentioned. Media as a sector was mentioned a couple of times and again as within the documents sports. To conclude, the most indicated relevant sectors of the health initiatives were, the social welfare/health, public, private and the education sector for the intersectoral collaboration, at which social welfare organisations were pointed out to be very helpful to establish the health initiatives (this was especially mentioned by organisations from the public sector).

Community involvement was indicated as important factor according to the representatives of the health initiatives. Direct contact with the community members was described as something naturally. The intersectoral collaborations of the health initiatives had all organisations or institutions as a partner, which were close to the community members. This regard often local welfare organisations which had already established a local network of community members, as mentioned few paragraphs back. These organisations contain often community workers, of which direct contact with the community members is part of their job. Furthermore, for example, local project leaders specially assigned to recruit community members for the health initiative or volunteers of a foundation which guide community members in the health initiative. Next to, this direct contact through people, also social media was often mentioned as a tool to establish direct contact with the community members (communication channels), of which WhatsApp groups were mentioned most often (and indicated as most effective). This direct contact was mostly on weekly basis both through the community workers and social media.

Needs assessments (process-indicator) is part of this direct contact with the community members. This was also done with meetings or interviews being specially organised for these needs assessments. Several of the initiatives described that the needs (or wants) of community members are leading. One interviewee even stated that they have no interest other than the interest of the community members. It was several times mentioned that at these meetings it is not about providing information but really going into dialogue with the community members about health and what they would like to change. However, again also for these needs assessments it was indicated by some initiatives that this is also deemed as something natural. It was described when working directly with community members (through for example these community members), one constantly gains input about their needs (continuous process of considerations).

This input also gained through process activities (for example; reflective working visits, dialogue tables, experiential learning). The same process activities as within the documents were mentioned, such as visiting health activities, starting dialogue at the local supermarket, attending coffee breaks and going into the neighbourhood. These are moments at which directly is asked about the experiences with the health initiative. This visiting and dialogue was done, by programme leaders/initiators and project leaders/ coordinators, to keep in touch with the community and to experience themselves how the health activities are received (experiential learning and personal

contact). Moreover, at the documents there was an example of conversation cards, within the interviews another initiative mentioned something similar with pictures in order to connect with people with low literacy. At one of the initiatives, community members took a part in the development of the intervention by providing their input on the health issue. However, after the development was completed, there was no possibility for participants of this initiative to give input in the execution of the intervention on the contrary of the other initiatives. Where input could be provided throughout the entire process of the health initiative.

Actively asking for input from the community members could also be regarded as a feedback mechanism (process-indicator). The input is taken into account and is processed as well as possible within the health initiatives. However, several interviewees noted that communication directly towards the community members about the processing of the feedback is not formally organised. An example of input, was a proposal of a community member of a new partner for the collaboration, which after some considerations was made reality by including the organisation in the intersectoral collaboration. In several initiatives the community members also had tasks and responsibilities for the execution of the health activities/intervention. If they do not cooperate, quit or drop out, this could be regarded as direct feedback (and the need of different approach).

Community members having tasks and responsibilities comes partly from being part of the decision-making process. They are asked to organise health activities/interventions (with support) or cooperate in existing activities and they are allowed to determine for example execution or focus or kind of activity. It was noted by one interviewee sometimes in order to involve certain community members one should just start with execution instead of first discussing it for a long time.

Regarding the importance of community involvement for sustainability of the health initiatives all interviewees agreed. However, different reasons were given. For example one interviewee indicated in the community at which the health initiative was executed; it is naturally community members are committed. There is strong community spirit, supporting each other where needed (resulting in high amount of volunteers in the community). Community involvement is already in place and is passed on. It was something which was indicated one should stimulate for sustaining health initiatives. Another reason was community involvement from the start increases the likelihood of the adaptation of the health initiative in the community. Besides, the power of the network of the community members was also indicated, spreading the possible behaviour change to throughout the community. A different reason was, if community members are not involved and the health issue you want to address does not play a role in the lives of the people you want to target, this is not effective at all. Even if the aim is to raise awareness, the community should get involved (on how to). Lastly, community involvement was indicated as important at the initiatives for sustainability, as several initiatives are based on community involvement (they determine what has to be done) and aim to ultimately put the initiative in the hands of the community members. However, for the sustainability of the health initiative, it was also stated there should be a professional institution which facilitate this process and keeps available for support when needed. In addition, it was indicated for sustainability on the long term one should incorporate appreciation for the involved community members.

8.12.3 Management

Documents

Management was represented at all initiatives in different documents (n=68). Management can be divided in leadership and communication structure. Starting with leadership, some initiators of the initiatives mention they stimulate participation, empowerment, involvement and connecting of partners/organisations and community members. This can be connected to the process-indicator;

stimulating participation, empower and involve. It was also mentioned it is important to during the collaboration still involve the participating organisations and sometimes show progress.

The health initiatives on a national level to some degree meet facilitative leadership. They have a so-called programme leader, which has multiple coordinators/project leaders under his/her lead from the different communities at which the initiative is executed (this often regards being appointed to a municipality). These leaders facilitate the health initiatives on different levels with connecting organisations. At one initiative there is also someone between the coordinators and programme leader, who is appointed to control the coordinators of municipalities within one province. In none of the documents, it was explicitly mentioned these leaders are or should be neutral persons (as described in theoretical framework). However, it was stated at some quotations, these leaders gave support and advanced the execution of the initiatives.

At one initiative the programme leader reports to the steering committee. This steering committee meets once a year to discuss and approve the substantive and financial reports. Something that was also pointed out in documents of other initiatives. Another initiative, in one municipality, does also have a coordinator which provide guidance and direction to the health initiative and the participating organisations. They also have a steering committee (consisting of people from local organisations), which also come together at meetings to discuss needs and wishes from the community.

It was pointed out at a quotation that by discussing these needs and wishes, opportunities and possibilities are identified for the different participating organisations. This can be connected to the process-indicator; balanced negotiation and identify opportunities. This identifying of opportunities (also barriers) at meetings was mentioned several times in the documents, including examples of what for kind of opportunities. For example a collaboration of school with the local youth team regarding exercising. Balanced negotiations, was also represented at a quotation, where the initiators focused on getting all the different needs and expectations of the different organisations aligned (by regularly evaluating together at meetings).

At another national initiative the programme leader and project leaders exchange their experiences and knowledge at meetings three to four times per year. Knowledge exchange between different domains was something which was pointed out in several documents and can be connected to the process-indicator; degree and utilization of knowledge exchange between these domains. Once a year, there is a meeting between the programme leader, the project leaders and representatives of the communities of this initiative at which they share experiences and gain inspiration. This can also be connected to the process-indicator; inspire and share knowledge. At one initiative they added two extra meetings especially for sharing knowledge about the execution of the health interventions. Inspiring, enthusing and recruiting organisations or community members as a manager or leader was mentioned several times. However, there was also an initiative mentioning that this enthusing was difficult. Nevertheless, this initiative also stated the importance of knowledge exchange between the organisations during meetings or activities accompanied by new connections and new collaborations between sectors (including with community members). In addition, the generation of new ideas (also a process-indicator). For this particular initiative the initiators experienced many more opportunities for new collaborations and new ideas for further expansion after implementation of one year, which could be connected to the process-indicator; degree of perceived time and space for ideas, networking and innovation. The quote below is an example at which multiple of the just mentioned process-indicators about knowledge exchange come together.

''Daarnaast organiseert het programmabureau kwartaalbijeenkomsten die als prettig worden ervaren door alle gemeentecoördinatoren. Het bevorderen van kennisdeling tussen de gemeentecoördinatoren onderling wordt als een toegevoegde waarde gezien … Hier halen zij

inspiratie uit om in eigen gemeente toe te passen. Een aantal coördinatoren geven aan dat tijdens deze bijeenkomsten bestaande ideeën over de aanpak van het programma worden bevestigd en er nieuwe ideeën worden opgedaan.'' (p. 37 Master thesis public value 2021, Doortrappen)

Translated: *''In addition, the programme office organises quarterly meetings that are experienced as pleasant by all municipal coordinators. Promoting the sharing of knowledge between the municipal coordinators is seen as an added value… They get inspiration from this to apply in their own municipality. A number of coordinators indicate that during these meetings, existing ideas about the approach of the programme are confirmed and new ideas are gained.*''

At one initiative there was a revision of a partner. Within the collaboration this partner went from locally collaborating at some communities to nationally collaborating with this partner at all the communities the initiative was executed or will be executed. So after knowledge exchange it became apparent this partner/organisation could be of more added value. This can be connected to process-indicator; adaptation, revision or replacement of activities or partners. Another initiative determined after an evaluation, which organisations they wanted to continue with and which not, within their intersectoral collaboration.

Several initiatives mentioned next to knowledge exchange between different domains, also knowledge exchange between the different cases (communities) the health initiative was executed. Coordinators of different communities from an initiative wanted more frequently meetings. Thereby, not only sharing knowledge and experiences through the website with examples, but also updates of good examples through e-mail (next to the newsletter). These are examples of means of **communication**.

Communication structure was mentioned at different documents of several initiatives. However, often not in detail. The process-indicator; type an intensity of activities and communication was well represented. So communication activities were expressed, but only one initiative had clearly described a communication structure. Meetings were mentioned mostly as a form of communication, however thereby lacking sometimes information about on which frequency (intensity). Several documents pointed out four times a year, with the programme leader and coordinators or a coordinator with the participating organisations.

One initiative had, as also mentioned at community involvement, a brainstorm with community members about their communication structure and eventually presented a plan for a communication structure with different means of communication. For example social media platforms, website or a newsletter every month. This plan included ideas for internal and external communication, which can be connected to the process-indicator; protocols for internal and external communication. These ideas regard, internal; making clear who is doing what, and external; what is the story of this health initiative and how to bring this with which communication channels. Another example of parts of a communication structure was an initiative having within their communication structure and plans, incorporated a contact person of each municipality in which the initiatives are executed.

Finally, it is interesting to mention that during meetings there was also space for feedback between the participating organisations. At one quotation is was described that during a meeting someone asked for feedback for improvement (which is also a process-indicator). Another initiative stated they learned from the feedback of their partners, allowing to make improvements. This feedback and communication at meetings shows a learning process, where clear communication is essential, as described at the quote below.

''Soms verlies je een partner tijdens het project en soms haken er weer aan. Goede communicatie is essentieel.'' (p.39 Final report 2021, Voedselapotheek Wijkaanpak)

Translated; *''Sometimes you lose a partner during the project and sometimes others hook up again. Good communication is essential."*

Interviews

Management of the intersectoral collaborations was described as relationship management. The maintenance of the contact between all the different participating organisations. Some cases described clear management structures and others cases did mentioned some sort of facilitative leadership, but no formal management structure.

However, at all the cases inspire and share knowledge was mentioned as part of management. In these intersectoral collaborations on needs each other's expertise and knowledge (interdependency). A manager or leader was indicated to stimulate knowledge exchange, organisations inspiring each other on how to tackle certain issues and the appreciation of people for sharing their knowledge. One initiative mentioned during a meeting of coordinators of the health initiative, they should focus on activities which are already taking place in their communities, to get inspired for health activities in the community. About local leaders it was mentioned it is important they make clear when they represent the initiative as a leader or someone of one of the participating organisations, in order to prevent conflicts of interest.

Degree and utilization of knowledge exchange between the organisations of different sectors was something the interviewees mentioned as important and leaders of the health initiative trying to facilitate. It was indicated the organisations really wanted this knowledge exchange, which could be explained by the essence of an intersectoral collaborations (exchange expertises and resources). One initiative developed a tool at which the organisations, also the different locations the health initiative is executed, could exchange knowledge and ideas (in addition, feedback for improvement and revisions of health activities (process-indicator)). Thereby, also organising meetings especially for this knowledge exchange. This knowledge exchange between different organisations of different expertises was also seen as a form of reciprocity.

Balanced negotiation and identify opportunities was also something being mentioned by the representatives of the health initiatives. Also indicated as portfolio management, what can this health initiative with the participating organisations achieve within their financial resources and what are the capacities. This includes also making decisions which aspects cannot be executed or continued given the capacity.

The management structures mentioned correspond to the structures described in the documents. At the national initiatives they mentioned different levels within the management structure. There is a programme leader with a team, regional advisors and local coordinators/project leaders. However, also different layers of organisations, participating organisations on national level and local participating organisations on municipal level. At one of the national health initiative cases, there is for example one programme leader, with four regional advisers which are in charge of multiple local project leaders at different municipalities. These project leaders investigate, how they can support the local organisations of the communities at which the health initiative are executed. Again as within the documents this structure of project leaders and coordinators was described.

However, the local initiatives cases, described another form of leaders. They also had leaders, but indicated, ''leading from the back''. There is a person who pulls the cart, however, they worked together with for example a steering committee. These leaders are subservient to the community. They do not described themselves as leaders, but as people who are pro-active (stimulating the collaboration) or being facilitators. In addition, at these local cases, these people could also be regarded as organic leaders, people respected and trusted from within the community.As a leader keeping in check where the energy of the health initiative is located, and making sure the initiative keeps going (which entails different needs during different phases). Stimulating participation,

empowerment and involvement (process-indicator). Keeping in touch with every participating organisation. This stimulation was also described as the leader putting him or herself in position of the other organisations and think from within their interests. Reciprocity was also indicated, what makes it interesting for the organisations to participate in this intersectoral collaboration? Sometimes, certain organisations do not need stimulation but stay motivated and committed (due to own interests of participating in the health initiative). Lastly, finance and promoting the health initiative were also mentioned as tasks of a leader.

Some qualities of a leader were also mentioned. On interviewee described three core values: recreate, connect and improve. Noted, was that connecting is also about making additions to something already in place. As health initiative connecting with for example a local (sport) association and support, improve and recreate health activities. Other qualities (or characteristics) indicated were perseverance, flexibility and creativity. These were mentioned to be important to create and identify opportunities (process-indicator). Once, the leader was indicated as a mediator between the different participating organisations.

One interviewee described the development towards a partner model, in which all partners are equal. There was no leader or manager. However, all partners being equal and without someone taking responsibility can create barriers. It was emphasised the municipality also being an equal partner with the other organisations in the collaboration. This was sometimes experienced as difficult. The municipality finding it difficult to not determine on his own what needs to be done in the community and the other partners finding it difficult to not look at the municipality, but taking the responsibility themselves instead of keeping the municipality responsible.

Management was also indicated to be important for the sustainability of the health initiative. One interviewee indicated, the health initiative is currently still partly being executed with leading of a Dutch ministry. Again, as described at the factor sustainability, the ministry, as initiator of the initiative, aims to transfer the health initiative, including the management of the initiative, towards another platform (organisations or network (landing place)). Or the health initiative being incorporated at another programme (which is already sustainable), to ensure its continued existence. Such platform could be a network of local organisations at the municipality at which the health initiative is executed (existing for example of public organisations and local entrepreneurs). It was also mentioned that certain organisations could have interests in sustaining or take over the management of the health initiative, for example by the means of corporate social responsibility or commercial interests.

The intersectoral aspect was also indicated as resulting in difficulties about who is responsible for the management and financing. These responsibilities could be passed on, and passed on, from sector to sector, if no one feels full ownership of the health initiative, which results in difficulties regarding sustainability. In addition, one interviewee described a non-committal aspect of their health initiative for organisations to participate in the intersectoral collaboration (lowering the threshold to participate), which could be a danger of organisations easily dropping out of the collaboration. This eventually can be harmful for a health initiative willing to become sustainable.

In order for a management structure, a manager or leader to work properly one needs means of communication. **Communication** structure was shortly stated by some interviewees. They mentioned meetings of different frequency (monthly, quarterly, biannually, annually). These meetings are between all the local participating organisations or coordinators from different municipalities or the programme leader with project leaders. Moreover, also meetings with the programme leader and local organisations, in order to retrieve real practical experiences. Besides, of course also meetings with community members, as all cases indicate the importance of community involvement. Some also stated a newsletter (monthly) for all participating organisations about the health initiative progress and inspirations.

One interviewee, described that the local project leaders often at the beginning divide tasks and responsibilities and later in the process, during the execution, only keep in touch with email and by telephone. Instead of frequent meetings, which was indicated by the interviewee (also programme leader) a something valuable, in order to stay on top of things. However, local project leaders can decide themselves how they want to manage. It was noted, it could be due lack of time that there are no frequent meetings (people from the different organisations having also other tasks outside the initiative). However, it was also stated that informal communication could take place, when working locally, people are more likely to run into each other.

8.12.4 Trust building

Documents

As already noticed in figure 5, trust building is not really represented in the documents. The code of trust building was only labelled in ten quotations (n=10). In these quotations the process-indicator history of cooperation marked the trust building most often. Several times it was mentioned that previous projects or collaborations with organisations had resulted in the building of trust. Both the process-indicators reliable fulfilment of agreements and time, space and reciprocity were found twice for the building of trust. For example it was described it is needed to invest time into the collaborations and have patience to build a firm foundation.

Interviews

I contrary to the documents, trust building was indicated as an important aspect in the intersectoral collaboration at all the interviews. Regarding sustainability it was mentioned, when organisations have trust there are committed to work on the health initiative. In addition, it was indicated this is essential. It was described it is about relationships between the organisations. If these are well established, there will also be trust. A quote below from one of the interviewees displays the regarded importance of trust building.

''Alles begint met vertrouwen, elk initiatief. Ik ken nog geen enkel initiatief, wat zonder vertrouwen succesvol scoorde.'' (Interviewee 3, 2021)

Translated: *"Everything starts with trust, every initiative. I don't know of any initiative yet that scored successfully without trust."*

Trust building was also mentioned to play a role at different factors of the collaborative process. Trust is built during introduction of the organisations in the collaboration. Making clear what the capabilities and expertise of each organisation are (management, roles and responsibilities), will contribute to the trust building. Moreover, trust will also be further developed later in the process. For example, during consensually developed health interventions/activities (shared mission) and accompanying results of the health initiative (intermediate outcomes and visibility). Showing already achieved results can gain trust for organisations to (still) participate in the intersectoral collaboration and as already said trust leads also to commitment to process. This corresponds with trust building placed in the middle of the collaborative process at the MSIC, playing a role at every step.

Results (intermediate outcomes and visibility) were especially indicated at the interviews to be important aspect for building trust. Three interviewees mentioned their health initiatives had to show results in order to build trust. This also applies for health interventions of the health initiatives. Organisations want to see results and if the interventions are effective, before they have the trust to participate in the intersectoral collaboration. It was also mentioned that the recognition of external

research institution in the effectiveness of the intervention is helpful to create trust (an objective measure). One can also see this as having to prove yourself as a meaningful health initiative.

Other aspects which were mentioned in order to build trust between the different organisations are; dialogue, respect, honesty, openness and transparency. Open discussion about for example the different interests of the organisations and accompanying possibilities, was indicated as important for trust building. Also agreeing on things which are not possible (this also connects to process-indicators of shared mission). Moreover, it was mentioned one should not keep things hidden from the other participating organisations. Transparency and openness about for example intermediate outcomes and achievements. This also includes an open discussion about difficulties one experienced and a safe environment for every organisation to speak up. So, also creating space for open discussion. Furthermore, keeping to your promises and responsibilities as an organisation and being able to place yourself in another organisation's their position was mentioned as important. In order to construct these aspects for trust building one should first take time and space for organisations to get acquainted with each other. Besides, every organisation has to be committed to these aspects of trusts building. This all could also be regarded as relationship management.

Relationship management (trust) also concerns the possibility to give each other feedback. Some feedback mechanisms were mentioned, for example a built-in evaluation moment after a meeting of the organisations. This regards evaluation about the relationships between the organisations in order to strengthen or gain back trust. This also includes going back to feedback points from previous evaluations, to see if there has been acted upon (monitoring). Again also at relationship management transparency is mentioned as something important (and at some initiatives even as something natural). In addition, there are also feedback/evaluation moments regarding intermediate outcomes as mentioned few paragraphs back.

Relationships between organisations can also be influenced by earlier collaborations or history of cooperation (process-indicator) and thereby also influencing trust. It was indicated sometimes some of the organisations within the intersectoral collaboration had worked together before, and this had mostly a positive effect on trust, as to some extent already trust had been built (depending on intensity of the collaboration). Moreover, it was recognized that trust has to develop over time (process-indicator). So, earlier collaborations provides a longer time span of organisations knowing each other and knowing (to some extent) what to expect. In addition, history of cooperation also shows the added value of intersectoral collaborations, achieving things on could not achieve alone. Two of the interviewees described a distinction they made; they do not work with organisations but with persons. These persons are part of organisations, but that is not how they approach it. In this case these persons are people of local organisations of which they worked already with before in other projects/initiatives. So they regard this as local people helping each other. One could think in a small community there is higher chance persons (organisations) already knowing each other and having a history of cooperation. However, this does not always directly implies also higher degree of trust, as there could also be a history of conflicts.

Restoring trust could be needed when there are conflicts between organisations. All interviewees on the other hand did not wanted to use the term conflict. They indicated that there were no conflicts within the organisations in their intersectoral collaborations, but sometimes there were disagreements. It was for example mentioned that an organisation (or a person) did undertake activities within the initiative, which they were not assigned to (not sticking to their role descriptions and expertise's within the collaboration). In all the cases this happened, it was solved with open discussion. Again openness and transparency were mentioned as important aspects to deal with conflicts or disagreements, in order to ensure trust among each other is sustained or restored. The disagreements could also regard the different interests of the organisations. Open discussion was again indicated as key and also the realisation that on certain matters one cannot agree. Lastly,

disappointments about the outputs of certain organisations in the collaboration were mentioned as affecting the trust. For example, an organisation after all not being able to execute his tasks for initiative due to lack of time (while other organisations had invested in them).

Finally, trust was mentioned to also facilitate to involve new organisations in the intersectoral collaboration. One organisation from the collaboration can propagate within his own network the trustworthiness of the other organisations in the health initiative. In this way history of cooperation within intersectoral collaboration can show trust building process and convince other organisations to become involved.

8.12.5 Shared mission

Documents

Shared mission was represented in all the initiatives (n=60). The process-indicator of agreeing on a problem definition, aims and objectives, was well represented. For example, in one document they mentioned the organisation of a meeting with a purpose to develop a vision on what this intersectoral collaboration wants to achieve and to determine objectives to achieve these goals. At another initiative also the alignment of clear focus and priorities was pointed out. Describing starting points to give insight in the vision of the collaboration. In addition, in four other documents of different initiatives, within their ambitions, enumerated subgoals were comprehensively formulated. In order to concretely answer the question; what do we want to achieve. Next to, also incorporating the vision of the community members on the health issues. This can be connected to the process-indicator; network interests continue to be assessed against public values and interests. This was also the case at several other initiatives and documents. In one document is was stated the public interest is of more importance than intersectoral collaboration own interest. Moreover, it was also confirmed in order to determine public value one should consult the local context. Lastly, there were also documents at which per subgoals or goal also objectives were enumerated.

Besides, the process-indicator of a clear plan of common goals, outlined activities and timetable was also present several times. For example, in one document an extensively plan of action was developed with outlined activities and goals (based on inputs and previous experiences). This also applies to another initiative, where for continuation, an action plan was developed for an even closer collaboration with the participating organisations. In addition, there was also an action plan which included a clear timetable. In another example, there was a process approach developed with a roadmap of activities. Another initiative mentioned the importance of developing goals, to structure the process and as a result pursuing these goals. They also had a extensively implementation agreement with common goals, outlined activities and time indications.

In several documents the mission of the health initiatives was extensively described, including where they stand for. This relates to the process-indicator shared identity and shared implicit rules. Shared implicit rules regard for example five basic principles one health initiative stands for. The quote below shows a shared implicit rule about community members. In another example, more explicitly, a policy document was made to ensure every organisation was facing the same direction. The second quote below shows that organisations found each other for an intersectoral collaboration due to a similar ambition. However, there was also one case were the initiators took the mission of every individual organisation and looked if they could connect them to a shared mission.

''Wij werken op basis van de kracht van bewoners aan sociaal sterke en leefbare buurten.'' (p.3 Final report 2019, Gezondheidsambassade)

Translated: *"We work on socially strong and liveable neighbourhoods on the basis of the strength of residents."*

''We vonden elkaar in onze gezamenlijke ambitie om gezond eten voor iedereen bereikbaar te maken.'' (p.3 Final report 2020-2021, Voedselapotheek Wijkaanpak)

Translated: *''We found each other in our shared ambition to make healthy food accessible to everyone.''*

Lastly, apart from being mentioned only once, it is interesting to mention that at an initiative also one time, the organisations could not accept differences (process-indicator), as two organisations seemed to have different ambitions, which could not be aligned. Another initiative describes the importance of a shared communication plan when working with multiple organisations across communities in different regions. This could be linked to the process-indicator; open discussion and communication, making the implicit, explicit. Interdependency, also a process-indicator of shared mission, was at one document described as one needs support from other organisations. The ambition could not be achieved alone.

Interviews

In the interviews all representatives were triggered at the word ''shared'' of the factor shared mission. Some representatives would not regard their health mission of the initiative as a ''shared'' mission. The initiators (which regarded often single or few persons of one or two organisations) of the health initiative developed a mission or vision and the other organisations were invited or joined this health mission (which created intersectoral collaborations). Organisations join these intersectoral collaborations for different reasons or interests, but eventually all striving for the same predetermined health mission. The fowling quote displays this aversion of the word ''shared''.

''Nee, ik worstel een beetje over het woord gedeeld. Ik heb, maar dat is iets persoonlijks. Alle neuzen moeten in dezelfde richting staan. Ja, dat vind ik dus niet. Dus, wij hebben met het gezondheids-initiatief gewoon een missie gekozen, omdat wij daar als stichting ons senang bij voelde en die missie verhoudt zich tot de andere missies van andere organisaties. … Dus, weet je, ik vind het woord consensus vind ik altijd wel al een mooi woord. Er zit een verschil tussen iedereen is voor en niemand is tegen. En, dat is, er is consensus.''* (Interviewee 3, 2012)

Translated: *''No, I struggle a little bit about the word shared. I have, but that's a personal thing. All noses should be in the same direction. Upon which I do not agree. So, we simply chose a mission with the health initiative*, because as a foundation we felt comfortable with it and that mission is related to the other missions of other organisations. … So, you know, I always think the word consensus is a nice word. There is a difference between everyone is for and no one is against. And, that is, there is consensus.''*

(***** in the context of anonymity, the name of the initiative has been omitted from the quote.)

The last sentence of this quotes connects to the discord in also the literature about the correct word. As described in the theoretical framework, shared mission, is often differently referred to. This interviewee preferred the use the word consensus. In the perspective of consensus again is showed, as also said by other representatives of the health initiatives, that the organisations within intersectoral collaboration have their own goals or interests, however, they find each other in a common aspect, the health mission or health issue they want to address or contribute to.

Regarding the national initiatives, one mentioned, there is no shared mission, as locally at

every community the participating organisations differ. So, again the initiators developed a (in this case national) mission and local networks of organisations endorse this mission. These national initiatives of this study are part of larger programmes with an even broader mission (at which they could be regarded as interventions). It was even stated that some participating organisations did not become part of the health mission, but only promoted or served the goals and objectives. Apart from not using or consider as ''shared'', all initiatives had formulated a mission (problem definition, aims and objectives)

Sometimes these differences between organisations and different interests could resulted in tension. However, it was indicated as something logical and should happen to keep the collaborative process going. This was also described as an organically process. Again, the difference between working with an organisation and working with a person of an organisation was made, an established bond with a person resulted in better understanding of the differences between the organisations. The differences between the organisations also results in different views on the health issue, contributing to establishing new ways to tackle the health issue and realising the health mission. Asking if one experienced any barriers due to these differences resulted at one interviewee in a metaphor, see quote below.

''Nee, want ze zijn eigenlijk op de rijdende trein gesprongen die wij een soort van in gang hebben gezet en ze willen daar gewoon een bijdrage aan leveren.'' (interviewee 1, 2021)

Translated: *"No, because they (participating organisations) actually jumped on the moving train that we (the initiators) kind of set in motion and they just want to contribute to that."*

This shows again this process of, the initiators developing a health mission and other organisations joining this mission along the way (jumping on the already moving train). In addition, directly after this metaphor the representative did described an experienced barrier, which was something also mentioned by another interviewee (at trust building); organisations eventually not having time to execute their designated tasks. However, this was dismissed as a more practical problem by the representative than a real experienced barrier.

Lastly, it was also mentioned by two representatives, that every organisations wants to improve health, no one is against improving health. Which makes the proposed health mission, not something people will disagree on. However, something one already agrees on, making it implicit a shared mission.

This connects to one representative indication of their existence as organisation is purely based on supporting the community members. They have no other interest than what the community members perceived to be important to improve their health. This is a nice example of the process indicator, network interests continue to be assessed against public values and interests. Another representative confirms this by emphasising, in order to stay relevant one has to be pro-active and to be complementary.

Apart from interdependency being only mentioned once in the documents, it was on the contrary constantly agreed on in the interviews to play an important role for the sustainability of the intersectoral collaboration. Interdependency translates to for example depending on each other expertises (in order to execute the health activities of the health initiative). Again, it was described that organisations from social welfare/health sector enabled easier access to the community members, which was also indicated as an interdependency. Community spirit was also mentioned as showing this interdependency, supporting each other where needed. Interests was also indicated to play role at interdependency, for example benefit from joining or contributing to the health mission or needing the other organisations to achieve your own goal. It was noted that this does not necessarily have to be a problem. Interests could also be linked to increase visibility of an organisation by connecting their name to the health initiative. Lastly, it was also indicated to be important to realise one need each other to achieve the shared health mission and within the

intersectoral collaborations there is interdependency.

In the context of sustainability is shared mission described as a handhold about what the intersectoral collaboration wants to achieve regarding the health initiative. A mission which every organisations within the collaboration stands behind. Working together, apart from the different interests, towards a common goal. Thereby, increasing long-term commitment/involvement. Noted was that one also should formulate how the collaboration is going to achieve this shared mission. The formulation of concrete objectives was considered as important as the formulation of the shared mission, which can be connected to the process-indicator, a clear plan of common goals, outlined activities and timetable (structure to the process).

8.12.6 Clear roles and responsibilities

Documents

The code clear role and responsibilities was present at all initiatives except one and labelled at different documents (n=36). In the documents roles and responsibilities are discussed and mentioned but rarely clearly defined. For example, it is mentioned one should make clear which organisation does what, but subsequently no roles are described and even one time it was indicated the role description and tasks of a partner were unclear. Moreover, in several quotations it was indicated people/organisations commit themselves to certain aspect, but not what this aspect/topic is and the kind of role they take within this aspect. Only at one initiative there was a clear role description of one organisation described with enumerated tasks. This organisation (one person) was appointed to be a coordinator with tasks of directing the activities and the neighbourhood coaches and communicate the activities towards the municipality and steering committee. In addition, for this particular example, also an implementation agreement (reporting about the objectives) with the coordinator was made, which connects to responsibility and the process-indicator accountability to equal partners and public.

Responsibility is somewhat better defined in comparison with indicated roles. For example, one partner has taken the responsibility to ensure a mix of health activities/interventions. At another example it was stated one should consider which sector (organisation) takes responsibility for the outcomes. A third example, highlights a shift of responsibility of the organisations of the health initiative towards the community members and municipality for maintenance. However, there was also a quotation pointing out a coordinator did not have to account for his work on a weekly basis and did not have to actively ask for permission for execution of health activities. Next to this contrary view of responsibility this also shows indication of trust. It was also described that the organisations/people as a group have responsibility for the intersectoral collaboration and the outcomes, but it was not specified who is responsible for what.

On the other hand the process-indicator reciprocity (of this factor clear roles and responsibilities) was more elaborated represented in the documents. For example in one document it was mentioned it is important that the partners see advantages in joining the intersectoral collaboration for achieving their own goals, so it becomes a win-win situation. This win-win situation was also mentioned to be important aspect for a successful collaboration and a situation to strive for. For instance, local partners wanting to contribute to the health of the target group, but also increasing their income by promotion or recruiting new customers (for example the physiotherapist). Another example of reciprocity is two organisations from different sectors (health and sports) reinforcing each other on different topics (health and respect) with their expertise's.

Shared understanding of contributions, was also a process-indicator which was present at quotations. For example; a mid-term evaluation provided insight which partners actively wanted to contribute to the collaboration and which partners were only interested in the outcome. Other

examples were; one partner making use of another partner his expertise/support or shared understanding that every organisation makes a unique contribution to the intersectoral collaboration. Another process-indicator of clear roles and responsibilities is about experiences of working together and buildings relationships, which gives an indication for any adjustments. There was a quotation which displayed this process; where experience of working with a partner in different local communities resulted in an adjustment in the role of this partner and became part of the intersectoral collaboration on national level. As it was clear what this organisation could bring in and add to the collaboration with their expertise. This also connects to the process-indicators of shared understanding of contributions and consensually developing role descriptions with keeping skills and expertise in mind.

Lastly, in one initiative they do have an overview of which roles and tasks the community members have. In addition, they have role descriptions defined like; narrator, health guide, organiser, researcher. However, this is limited to community members and there were no role descriptions for the participating organisations in the intersectoral collaboration. These community members follow a training for setting up a own health activity and receive afterwards a certificate, which gives recognition for the role they play within the health initiative and community. This can be connected to the process-indicator experienced return on investment, which could also been seen as reciprocity (the community members follow a training given by initiators of the initiative, receive a certificate and the initiative realises more health activities). Experienced return on investment also appeared at another quotation, which was about acknowledgement of a partner, so they can invest in the collaboration and show their added value.

Interviews

Clear roles and responsibilities was differently explained by the interviewees. Some had described a clear division in roles and responsibilities and others described a more organically way of dividing roles and responsibilities. However, almost all the initiators of the initiatives described their role as facilitator. Keeping contact with all participating organisations and keeping in check the needed resources. Thereby, also keeping people motivated (see also management), assign the organisations to relevant tasks (taking their expertise into account) and promote the health initiative (visibility). Next to this role at every initiative, the national initiatives described more clear division of roles at different levels and the other local initiatives described this organically process. However, national initiatives also indicated on the local level somewhat more freedom in division of roles.

The national initiatives indicated the different roles on the different levels. A national programme leader or team coordinating different regional (or province) advisors which on their turn coordinate the local project leaders/coordinators. These local project leaders are for example responsible for recruiting local organisations and community members for participating in the health initiative. Such a local organisation is for instance a dietician, which is for example responsible for certain health activities, like a tour in the supermarket about healthier alternatives. The approach or the role these project leaders have really differ between the community/municipalities the health initiatives are executed. One project leader is more focused on recruiting and stimulating participating organisations and another project leader allowed the organisations themselves to make choices. The coordinators on province level (regional advisor) also takes the role to share experiences between the different communities (enabling to learn from each other), next to offering support or advise. One of two national initiatives even has a sheet, also indicated as a blueprint, about which roles there are within the health initiative. However, often the local intersectoral collaboration deviated from this so-called blueprint, which they were allowed to. As the local situation always differs between the communities, who can take certain roles and responsibilities. The other national initiative mentioned that in the first phases of the intersectoral collaboration the project leader

steers more, and later on in the collaboration, the participating organisations are allowed to take more their own path and deviate of their indicated roles and responsibilities.

The other initiatives described the division of roles and responsibilities as a more organically process. It was indicated for example the initiators assessed which kinds of expertises and networks (organisations) were needed for execution of the health initiative and if there were organisations willing to participate in the intersectoral collaboration. This resulted in eventually when executing the health initiative, organisations took certain roles within the collaborations according to their expertises. Which were not beforehand discussed, but happened organically. Or during meetings it was asked which organisations could support or execute a certain tasks/responsibilities. In addition, it was mentioned sometimes this also entailed organisations knowing within their network other organisations which could execute that task, resulting in expanding the intersectoral collaboration.

Another example was that initiators already knew what to expect of organisations as they have worked with them before, which connects to the process-indicator; experiences of working together and building relationships. So history of cooperation (process-indicator trust) results in organisations taking automatically certain roles or responsibilities within the collaboration. Again also the difference between organisations and persons was mentioned. For certain tasks one needs this person and for another tasks that person, who is capable to take the responsibility or role.

Last example was an initiative really focusing on raising awareness about the health issue, so each new participating organisation was a way to reach this goal. Project leaders did not determine what each organisation should bring in (initiative was indicated as noncommittal), as it was voluntary and already helpful they wanted to participate. Therefore, aimed the initiators to make it as easy as possible to execute the health activities, by providing materials and ready-to-use interventions and give possibilities for contributions. This resulted as with the other mentioned examples in organically way of what each organisation brings in.

One representative also indicated one could better described the roles. For example how much control has the steering committee of the health initiative (only advise or also making decisions) or what are the exact responsibilities of a neighbourhood coach? At the moment these roles are still being explored, but could be made more concrete, which provides more clarity and prevents misconceptions.

Regarding the development of the roles of the organisations within the intersectoral collaboration, was mentioned these did not often changed anymore. In the beginning organisations or a person grows in their role, but later on in the process these roles did not changed anymore. However, it was indicated commitment/involvement did could increase over time. Also the developed history of cooperation contributed to a smoother/easier collaboration at new activities. At the start of the initiative it was also indicated some organisations or persons became more prominent in the collaboration and others dropped out or got disengaged. Leaving with a core of committed organisations running the health initiative. Thereby, it was pointed out, one should as initiators also give recognition to these committed organisations or which take much responsibilities.

It was indicated by several representatives that the final accountability rests at the initiators. Moreover, it was noted, the initiators also should be transparent about the achieved results, but also setbacks, failures or problems towards funders and participating organisations. A way in which they ensure this accountability is by the means of progress reports or monitoring. These reports were often send towards a municipality or a ministry (politics) (which are often participating organisations in the intersectoral collaboration but also often partly funders). These public organisations often have accountability towards the community members (taxpayers) about the effectiveness of the health initiative. Accountability was also ensured by for example quarterly meetings of the participating organisations, or personal contact between people keeping each other in check about progress (external reach agency was also mentioned).

All interviewees indicated in the first place they did not experienced tension in being held accountable. Several representatives even mentioned they really strive for transparency. Initiators or project leaders being open about results and actions. Which was by some representatives described as something obvious (which is not always the case, as will follow). If you hold back something (or exaggerate), this could exactly lead to tension. Due to some follow-up questions, some interviewees could indicate some examples of experienced tension. For example one interviewee described a difference between operational accountability and political accountability. In the politics they wanted to bring good news. However, the initiator wanted to stay transparent, so he delivered a so-called 0,9 version of the final report, at which the correct proceedings are stated and if an alderman waned change anything, he was free to do so. However, when someone asked the initiator about the results he refers to the 0,9 version of the final report and not the version of the alderman, which causes some level of tension. Another example, is tension when people do not have time to execute their task for the health initiative. However, sometimes one is aware this person has also many other tasks or executed other tasks correctly and one find it difficult to address someone about that particular unfulfilled task. Sometimes not much can be done about this lack of time (no alternatives).

Regarding importance of clear roles and responsibilities for sustainability it was indicated to play an important role. It allows one knows who or which organisation does what (there is an overview). This also enables to address each other on tasks or hold accountable for responsibilities (because it is visible/transparent/agreed what everyone should do). In addition, it was mentioned this overview of roles is important, especially for an intersectoral collaboration, as explained in the following quote;

''Je moet elkaar daar ook op aan kunnen spreken hè, want het is juist in zo'n samenwerking, moet ook iedereen zijn rol goed vervullen, want anders werkt het niet. Het is extra door die afhankelijkheden, wil je dat goed beleggen.'' (Interviewee 6, 2021)

Translated: *"You also have to be able to hold each other accountable, because it is precisely in such a (intersectoral) collaboration that everyone has to fulfil their role well, because otherwise it will not work. Particularly because of those dependencies, if you want to secure that well."*

It was also indicated important for sustainability that someone wants to take the (leading) role or has interests to continue the health initiative (stimulating). Besides, it was mentioned (from experiences of earlier initiatives) that when this person does not have enough interest in the health initiative, eventually the initiative fades away. Lastly, in contrast, also again this organically process of division of roles and responsibilities was mentioned. The health initiative developing organically towards a sustainable initiative. The following quote describes the reasoning behind this process;

''Ik denk, dat je, als je, alles, echt alles van tevoren vastlegt, dan kan het alleen maar tegenvallen ofzo. Terwijl als zoiets gaandeweg ontstaat of zich ontwikkelt, dan ontwikkelt het zich gewoon en dan is het gewoon wat het is.'' (Interviewee 4, 2021)

Translated: *''I think, that, if you, really nail down everything in advance, it can only be disappointing. Whereas if something like this gradually arises or develops (roles division), then it just develops and then it just is what it is.''*

In addition, it was mentioned this organically developing is also about concepts or activities which turned out not to work. This shows one should address certain things differently. It is important, participating organisations and community members are transparent about these aspects which did not worked for them, in order for this organically process to work.

8.12.7 Intermediate outcomes and visibility

Documents

The code intermediate outcomes and visibility was highly present in the documents (n=121). There were also sometimes coded separately, visibility (n=43) and intermediate outcomes (n=45). However, at the most quotations, when describing one of the two factors, the other is also often described. This justifies to choice of pairing intermediate outcomes and visibility in the MSIC. The following quote gives an example of intermediate outcomes and visibility being intertwined.

''Het afgelopen jaar lag de nadruk qua communicatie op het lokaal zichtbaar maken van de schop-in-de-grond-momenten, het aankondigen van de buurtactiviteiten en de oplevering van de buurtplekken.'' (p.8 Annual report 2020, Gezonde Buurten)

Translated: *"Over the past year, the emphasis in terms of communication was on making the shovel-in-the-ground moments, announcing the neighbourhood activities and the completion of the neighbourhood places visible locally."*

This initiative made also a so-called impact video of several outcomes in order to demonstrate what the local organisations and community members have achieved within their neighbourhood. Again visibility and intermediate outcomes are intertwined.

The most indicated short-term outcome was increasing awareness (process-indicator) about the health issue and the health initiative itself, which directly also links to visibility of the health initiative. For example, the intermediate outcome; trained health ambassadors, which execute health activities (also an outcome) in the community, raise on their turn awareness about the health issues and health initiative. Thereby, increasing the visibility of the initiative with their health activities.

The visibility of the health initiative becomes even more increased, as the participating community members also raise awareness about the initiative and the health issue within their networks. This was indicated as the so-called ripple effect. This ripple effect was present at several initiatives (cases), being defined as participating community members also influencing their direct living environment (family, neighbours, etc.) with their acquired health skills/knowledge.

The short-outcome, increasing awareness, shows that intermediate outcomes and visibility are intertwined. For example, the intermediate outcome of raised awareness about the options community members have in the neighbourhood to improve their health, at the same time also increases the visibility of the health initiative. There are also intermediate outcomes of more concrete output, for example a health festival, with the aim to raise awareness in the community about health, the health initiative and the possibilities.

Next to, awareness, there are also concrete outputs of progress (process-indicator) mentioned as intermediate outcome in the documents. For example the development of timeless posters and flyers about the health initiative. This again also increases the visibility of the health initiative. Moreover, also outputs like overview of the activities community members have developed. Examples of these concrete outputs and other intermediate outcomes of the cases of this study are displayed at a table in Appendix 8.10.

The table gives general idea of mentioned intermediate outcomes in the documents (not everything is included). The intermediate outcomes are divided in different categories (collaboration, communication, health activities and health issue). Most of these output resulted in also more visibility of the health initiatives in the municipalities or neighbourhoods. One of the initiatives wanted to set up a national campaign (intermediate outcome) to increase visibility of the health initiative, in order to convince other municipalities to implement. In addition, this initiative already inspires other municipalities with presenting intermediate outcomes of the health initiative at

national meetings.

Evaluations reports were also mentioned as intermediate outcomes. One initiative mentioned a mid-term evaluation was executed, in order to keep the partners involved with the health initiative. In addition, the partners were asked to respond on the results of the evaluation. This could one connect to the process-indicator; in order to maintain support continue testing during process. Another initiatives mentioned monitoring of; the intersectoral collaboration, organised activities and satisfaction of the community members. It was indicated at a document that positive results regarding the health initiative and experienced health resulted in continuation and financial support of the municipality for the initiative. This can be connected to the process -indicator; (outcomes) needed for funding or investments.

There is also another relating process-indicator, feedback mechanisms. One document described, each new finished and flourishing healthy neighbourhood (a small win) gives an impulse (feedback) to create more healthy neighbourhoods. Another initiative mentioned monitoring and evaluation being tracked by coordinators (of municipalities) themselves as part of an ongoing feedback and improvement cycle.

The indicators mentioned in previous two paragraphs can be connected to two other process-indicators; formative evaluation aimed at adjustment and improvement, and transparent adaptation and improvement. For example, a communication plan was made during a meeting with the community members and adapted to wishes of the involved community members. Another example, was an initiative letting a formative evaluation being conducted at different cases (to learn for improvement). There was also initiative of which scientific research was conducted in order investigate the effects and also during the implementation using the results of the research to make adaptations. At several initiatives there were evaluations of intermediate outcomes, which itself can also be considered as intermediate outcome. One initiative also describes an evaluation and the lessons learned in a document.

In several documents it is mentioned the health initiatives wanted to increase their visibility. In addition, sometimes it was stated the health initiative or health activities need (more) publicity. External visibility was described as; how does the health initiative represents itself (what is the story) and how is it communicated and which channels are involved? This representation is about profiling what the health initiative entails, what it does and how it thinks about health (issue). The latter, means of communication, were extensively described in the documents for increasing visibility.

Different forms of communication channels were indicated (and some are also added in the table above, as they also could be considered as intermediate outcomes); local media, social media, websites, posters, flyers, newsletter, newspaper, factsheet, interviews, presentations, magazine, online platform, radio, business cards, t-shirts with logo (at health activities), press moments and campaigns. Many of these channels are used for regular messages in local online and offline media, to increase visibility among community members about the health initiative. One initiative indicated to have received a lot of reactions of the community members on the health activities, which indirectly also represents visibility. Community members increasing the visibility on their turn by word of mouth advertising.

The websites of the health initiatives were indicated as central platform for communication and visibility, which was often referred to in the documents. One initiative also mentioned photographs of each project (neighbourhood) and descriptions on their website in order to increase visibility and stimulate and enthuse other neighbourhoods to also implement this health initiative (they also developed an inspiration-PowerPoint). Other initiatives also mentioned visual representation, next to photo's; also illustrations, drawings and infographics of the health activities.

Next to, the communication channels, also some other suggestions were mentioned in the documents to increase visibility; the presence of the health initiative at the other health activities in

the community, involving local alderman, including local organisations, including a well-known organisation in the intersectoral collaboration or expanding the network. Moreover, also well-known previous projects of participating organisations can increase the visibility. Lastly, negative publicity was mentioned only once within all the documents. It was described that visibility could also regard negative aspects (things which went wrong), leading to possible reputation damage.

Interviews

Concerning intermediate outcomes and visibility the interviewees stated mainly using evaluation or progress reports. They indicated fixed moments in the year for these reports (each half year a progress report and at the end of the year a final report). In these reports the executed health activities and results of these activities are recorded (including evaluations of these results). Furthermore, also progress about the health initiative regarding the intersectoral collaboration and visibility of the health initiative. This also included meetings about the initiative (exchange retrieved knowledge and experiences) and for example a newsletter with updates. Meetings about intermediate outcomes with for example different local project leaders were indicated to be very helpful for these leaders to learn from each other, but also to stay enthusiastic. In addition, it was mentioned the initiatives also share this reports to externally, in order to establish possible new collaborations or retrieve any funding or investments (process-indicator).

Regarding visibility the representatives of the initiatives, as within the documents, indicated several means of communication. They mentioned social media, (local) newspapers and the website most often as communications channels for increasing visibility. In these media they report intermediate outcomes or upcoming health activities or events. Increasing the visibility of the health initiative was perceived to important for to reaching the largest possible amount of community members of the target group and increase awareness regarding the addressed health issue. Again also attending other (health) events in the community with workshops, was indicated to increase visibility and to reach more community members (also attending meetings of for example relevant professionals for the intersectoral collaboration). Using different means of communication was indicated to expand the reach of the visibility by creating different ways for discovering the health initiative.

In the interviews there were also some barriers or challenges indicated regarding visibility. One interviewee for example explained that during the recruitment phase of community members, communication channels were extensively used. However, when the health activities were being executed, forgetting to also keep communicating about intermediate outcomes (results). One would like to consistently communicate about the health initiative. This challenge is described in the quote below;

''We zijn vaak vrij zichtbaar In de wervingsfase, hè? Dus dan Facebook, in de krantjes, in weet ik veel wat, en dan vergeten we weleens op het moment dat er dan daadwerkelijk dingen gebeuren of dat de dingen in gang zijn gezet om daarover te blijven communiceren. Dus dat is best wel echt een uitdaging. … om gewoon een keer verhalen op te halen. In video's te doen, dat soort dingen en dan de zichtbaarheid vergroten.'' (interviewee 1, 2021)

Translated: ''*We are often quite visible in the recruitment phase. So, with Facebook, in the newspapers, etc., and then we sometimes forget, when things actually happen or that things have been set in motion, to continue communicating about it. So that is quite a challenge. … just to pick up stories for once. Put it in videos, stuff like that and then increasing the visibility.*"

Another barrier described by two initiatives was they lack of a communication specialist. They mentioned the use of communication channels could be improved. However, both initiatives

indicated they countered this by actively going in to the neighbourhoods of the communities. No visibility through online communication channels (which was also stated did not work for certain target groups), but visibility in the neighbourhood through direct conversations with the community members. Another interviewee indicated that the ''call to action'' (community members deciding to participate), was more important than visibility. Lastly, two initiatives also indicated it is about the community members being actively involved with their health promotion and found it difficult to give attention to visibility of the health initiative in a sense of (self-)promotion. Nevertheless, it was realised, this visibility, is not necessarily for the initiative itself, but also for the community to become aware of the health initiative.

There is also another aspect of visibility of the health initiative regarding the intersectoral collaboration. This was not really addressed in the documents, but does also play an important role, the visibility of the participating organisations of the collaboration. Organisations being able to show they are involved with this health initiative (which could also be an incentive to participate, increasing own visibility). One interviewee mentioned ''mutual visibility'', the health initiative increasing the visibility of the participating organisations and the organisations also increasing the visibility of the health initiative. Eventually, with the addition of intermediate outcomes, this could for both parties be interesting for new collaborations or investments.

It is also about organisations (or people) ability to show what they have achieved with the health initiative. This also addresses again intermediate outcomes and visibility being intertwined. This applies also for political interests, many health initiatives are being (partly) funded by the government. These public institutions want to show intermediate outcomes and possible effectiveness of the health initiative to the public. This visibility of achievements was also stated to contribute to show the added value of the health initiative to the community or possible new partners for the intersectoral collaboration.

These intermediate outcomes are also used as feedback. The importance of using intermediate outcomes was stated, instead of an evaluation after the health activities/interventions are implemented. Monitoring during the execution of the health initiative, enables to make adjustments and improvements directly (process-indicator). It was noted that one also have to ensure that adaptations made according to evaluation reports are eventually also assessed. So, there is a need of a feedback mechanism or feedback loop. Several initiatives indicated they have established such a feedback mechanism for the participating organisations.

One interviewee described an example of feedback retrieved for external research agency on the numbers of children participating in sports activities. One year this participation declined, this was received by agency as lack of effectiveness of the health initiative. However, they only looked at the numbers, in fact many children moved on to sports associations (which was eventually the goal of the sport activities). This showed the importance of interpretation of numbers in reports for feedback. In addition, the duration of the feedback loop on the numbers of participation, in this case took two years, which makes it outdated. Also the quality of research was doubted as the number of participants in the research was low and possible not representative.

Intermediate outcomes and visibility as factor was indicated to be important for sustainability. It was indicated these intermediate outcomes and evaluation reports show if the health initiative activities or interventions works or not. Accumulation of these outcomes, confirms possible effectiveness, which makes it for participating organisations interesting to stay committed or to remain part of the intersectoral collaboration and to develop a sustainable health initiative. This also implies for the visibility of these (positive) outcomes of the health initiative, making it interesting for organisations to stay linked to the initiative. Organisations being motivated through intermediate outcomes and visibility to stay involved was indicated to be a necessity for a health initiative to become sustainable. This shows the connection to the following step in the collaborative process of the MSIC, the factor, commitment to the process, which will be discussed next.

In addition, these intermediate outcomes and visibility could also be interesting for new organisations to participate (expanding the network) and to secure funding. Especially funding was mentioned to important for the sustainability (see also 8.12.9). It was stated in order for sustainability, one would need the health initiative to become part of structural financing (part of the system). The health initiative not being dependent on subsidies every year. However, being incorporated at the budget of one (or more) participating organisations of the intersectoral collaboration (for example, the municipality).

Lastly, as already described, intermediate outcomes and visibility could motivate/stimulate organisations to stay committed. Furthermore, it was also mentioned that it could enthuse people of these organisations or community members to take part in the health initiative. Community members also spreading these intermediate outcomes within their communities (and thereby increasing visibility). As in the documents, this ripple effect was mentioned. It was stated important to realise visibility is not only about communication channels. Visibility was indicated also to depend on community members speaking with each other (word of mouth advertising) and personal relationships. Conversations for example about if one also would like to join the health activities and communication channels as article in a newspaper or a flyer could support this or create recognition.

8.12.8 Commitment to the process

Documents

The code commitment to the process was present at different documents of four initiatives. One of the health initiative initiators stated in a document that after the initiative is handed over to the community, this commitment of local organisations is very important, which is described at the following quote;

''Terwijl betrokkenheid van partners juist heel belangrijk is voor borging van activiteiten voor bewoners na het eind van ons project, midden 2021.'' (p.10 Final report 2020-2021, Voedselapotheek Wijkaanpak)

Translated: ''*While the commitment of partners is very important for the sustainability of activities for the community members after the end of our project, mid 2021.*''

In one document even *sustainable* commitment was mentioned with associated motivators. One of these motivators was mutual interests. Mutual interests is also a process-indicator for commitment to the process and has been mentioned a few times.

However, commitment to the process, was most often described as being motivated to commit to the health issue. Organisations being motivated and inspired to work on own activities and to be part of the collaboration. This can be connected to the process-indicator; degree of intrinsic motivation of partners (incentive to participate). One quotation mentions this incentive to participate is also about partners seeing benefits for achieving their own goals. It was also mentioned, in order for an effective intersectoral collaboration (and commitment), there has to be a win-win situation. This can be connected to the process-indicator, mutual interests. In order to make it more tangible, also an example was given; a library made a meeting room available and in exchange the library was allowed to advertise during events or health activities.

Another process-indicator of commitment to the process was; obligations towards own objectives and maintaining legitimacy. At one document this became apparent at two quotations. Of two partners it was described which themes they watched over and what they stand for within the intersectoral collaboration (for example, exercise and play).

Another aspect, and also a process-indicator, which is often mentioned is the feeling of

shared responsibility, also ownership. In one of the documents of an initiative it is explained that the preliminary work which has been done by finding partners who feel shared responsibility is expected to be an important success factor for organising the health activities. In another document and initiative, shared responsibility was also mentioned as essential. In this particular initiative it was furthermore stated to connect the community also to this shared responsibility and give them a sense of ownership. When community members assist in developing ideas they feel more committed to the process. This shows again the community (target group) itself can/should be considered as a partner. In one initiative it was mentioned several times that the group feeling of community members (being part of and taking part in the initiative) was important for commitment to process.

Commitment to the process was also indicated to be person dependent. In this case the commitment of an organisation to the collaboration depends on the enthusiasm of a person (employer) representing the organisation. In addition it was also mentioned in another document that own intrinsic motivation of a person plays a role. So, the process-indicator, degree of intrinsic motivation of partners, should for this case be extended or being more specified by including also the degree of intrinsic motivation of a person and not only of an organisation (partner). Person dependency was also indicated as a vulnerability, if a person drops out, get sick or has less time available. Regarding sustainability, the health initiative should be able to carry on without depending on one person.

Interviews

The interviewees almost all described, as within the documents, intrinsic motivation of the organisations as the reason for or how the organisations stay committed to the process. The organisations in the collaboration have to be motivated to tackle the health issue. This intrinsic motivation often regard personal motivation of people (from the participating organisations). People who really want to help certain target groups with improving their situation and health. Discussing or improving health was also used as a way to start conversations about underlying problems (social determinants of health; working and living conditions).

In addition, these people having fun to execute or set up health activities. One representative also indicated to give people freedom of choice in how they want to execute the health activities, which is a manner of ensuring they stay committed. This included also the mentioning of a process-indicator of management; space and time for innovation and ideas. Participating organisations having a certain amount of freedom in their roles and responsibilities was also regarded as taking into account mutual interests.

Mutual interests and reciprocity was several times mentioned as important for commitment to the process. Organisations having own interests to stay committed to the health initiative. For example; intermediate outcomes and visibility, needed knowledge and resources (interdependency) and future or other beneficial collaborations. The initiative also has interests in these organisations participating in the intersectoral collaboration (mutual interests). For example, the visibility of the health initiative and organisations works both ways. Intermediate outcomes and visibility, as mentioned before, could be motivation for organisations to stay committed to the intersectoral collaboration. Furthermore, It was indicated, when organisations cooperate within the health initiative, this give them a position to be able to also ask the other participating organisations for support (reciprocity). I was also mentioned in order to achieve commitment or participation of organisations, investigating what one can contribute to the goals of the other (both ways).

Proof that the health initiative works, was mentioned several times by interviewees to convince organisations to participate or stay committed to the process. This was done by showing intermediate outcomes and visibility of the health initiative or conducted (scientific) research by external research agency. For example, one initiative ensured the health intervention was evidence-based and acknowledge by prominent external research institution, before rolling out the initiative nationally. This proof of the health initiative being effective, are recorded and processed in

evaluations reports, of which are analysed in the documents analysis. The health initiative being evidence-based could also ensure the initiative becomes incorporated into (local) system (which on turn contributes to the sustainability).

Commitment to the process was also ensured by keeping the organisations involved. Continually, keeping track of the proceedings of the organisations, through for example meeting, phone calls or newsletter (this could be regarded as management and communication). In addition, also sharing experiences and knowledge between different municipalities at which the health initiative is executed could ensure commitment to the process. The intersectoral aspect also contributes to the commitment to the process, enabling organisations to access knowledge and expertises of different sectors. This intersectoral aspect makes it also more complex to make sure every participating organisation is satisfied. However, it was indicated that this an intersectoral collaboration is needed in order to tackle these complex health issues. It was also explained that the initiators tried to make the participation of organisations as easy as possible (right conditions).

The feeling of shared responsibility was also indicated to play a role for the commitment to the process. If the local organisations in a community feel they have ownership of the health initiative (not the initiators or a national programme leader), this contributes to the commitment. The health initiative being incorporated in the community. In addition, appreciation of organisations was also mentioned by a few representatives to be helpful for commitment to the process.

Regarding sustainability, it was indicated that commitment to process, with intrinsic motivation plays an important role. When the participating organisations are motivated, inspired and feel the urgency (and ownership) to tackle together a certain health issue, it is ensured the health initiative will be sustained and does not slowly disappears. Commitment to the process was even mentioned to be conditional for sustainability. However, as within the documents, I was stated that this commitment to the process is person dependent. The following quote describes this person-dependency is accompanied with vulnerability for the intersectoral collaboration.

''Vaak zeg ik dan gewoon het valt of staat met een bepaald persoon en daarom zie je ook wel weer vaak, als die persoon dan wegvalt, kunnen we weer helemaal opnieuw beginnen. Dan is het de toewijding van die persoon die zo doorslaggevend is. … Maar het is zo afhankelijk van personen en dat zou eigenlijk minder het geval moeten zijn, hè? En daarom is die indeling ook zo belangrijk, want dan zit het in het systeem ingebed en niet afhankelijk van een persoon, van de toewijding van een persoon. … En dat als je iets kunt borgen, dan is het daar ook niet alleen van afhankelijk hè? Want dan is een opvolger ook, dan is het voor de opvolger ook weer een taak en niet afhankelijk van of hij of zij er iets mee heeft.'' (Interviewee 6, 2021)

Translated*; "Often I just say it stands or falls with a certain person and that is why you often see, if that person disappears, we can start all over again. Then it is the commitment of that person that is so decisive. … But it's so dependent on people and that should really be less the case, huh? And that is why that division (roles and responsibilities) is so important, because then it is embedded in the system and not dependent on a person, on a person's commitment. … And if you can make it sustainable (health initiative), then it doesn't just depend on that, does it? Because then there is also a successor, then it is also a task for the successor and not dependent on whether he or she is committed."*

This personal commitment is something which will be discussed at the factor energy at 8.12.9. It was also indicated if organisations are not committed anymore or people leave the initiative, this could possibly be harmful to the sustainability of the initiative. Especially, if there is no replacement. However, if there is a replacement, a fast flow of new people could also be harmful for the development towards sustainability. Starting over again and over again. If the tasks an responsibilities are not written down, it makes it difficult for others to take over. Moreover, some

things cannot be written down and have to be transferred for person to person. So person-dependence, as indicated in the quote, could be harmful to the sustainability of the health initiative. However, it was more predominantly stated that if people are not motivated, eventually the initiative will also run into problems.

Lastly, almost all initiatives were committed to community involvement. Importance of community involvement was also a reason for organisations to commit to the intersectoral collaboration of the health initiative. Nevertheless, it was indicated that involving community members is complicated. However, community involvement was stated important in order to ensure community members will take on the health initiative and participate in the designed health activities.

8.12.9 Additional factors

Funding

Funding was a factor which reoccurred the most at the documents next to the factors of the MSIC (n=38). Funding is also described at theoretical framework in the HALL-framework as a factor (2.4.1). At this description it was mentioned that sometimes health initiatives are competing for the same funds, because of limited available financial resources (or financing structures and policy strategies pushing the health initiatives to stay with same health aims). This was something which also became apparent in the documents. A quotation stated for example that there were many applications for funding, but because of limited budget a certain health activity received only a part of the requested budget. Some of the initiatives of this study originated from health issues the government wanted to tackle and made funding available for.

Within the documents there was mainly shortly stated one needed, had to apply, received or could claim a certain budget/financial support for executing health activities of the health initiative. Financial support for the initiatives came from different institutions; ministries of the Dutch government, provinces, municipalities, foundations, funds and local entrepreneurs were mentioned. For example there was a health activity of free consultation with a lifestyle coach at the local pharmacy, which was partly funded by a foundation. This is explained at the quote below (Stichting Voorzorg Utrecht - foundation, Orion - pharmacy). However, the health initiative hoped to find a way for more structural financing of this health activity.

''Om de drempel laag te houden en ook mensen met een kleine(re) portemonnee te bereiken, biedt Orion bij wijze van pilot het gesprek gratis aan. Stichting Voorzorg Utrecht neemt vooralsnog een deel van de kosten voor haar rekening. Aan de hand van de opbrengsten wordt in een latere fase bekeken of structurele financiering eventueel mogelijk is.'' (p.16 Final repot 2020-2021, Voedselapotheek Wijkaanpak)

Translated: *"In order to keep the threshold low and also to reach people with a small(er) wallet, Orion is offering the conversation free of charge as a pilot. For the time being, Stichting Voorzorg Utrecht is responsible for a part of the costs. Based on the proceeds, it will be examined at a later stage whether structural financing is possible.*''

Another example was a health initiative funded by a ministry of the Dutch government, again due to budget being available for certain health issues the government wanted to address. However, one of their cases (a neighbourhood at a municipality) was made possible and funded without the budget of the government. A different health initiative was also in the first place being funded by a ministry of the Dutch government. However, the coordinators developed a strategy of looking for other funding options at which this health initiative could be accommodated. This was done by

linking the activities to other existing projects (of which budget was already available), as the health activities of this initiative can be executed with relative few financial resources.

Third example of funding is financial support by foundations or funds. One initiative their health activities were realised by different local funds. This particular initiative also assisted the community members in applying for financial support for executing their health activity. In several documents it was mentioned that applications for funding had been approved or budget reports would be composed. In addition, in some documents the budgets reports were incorporated at the appendix of the document.

An initiative stated limited budget could be a barrier/hindering factor for the execution/implementation of the health initiative and potentially a reason to stop. Consequently, this could be regarded as not sustainable. On the contrary, in another quotation from other initiative it was stated that due to limited budget (and other more important health activities) they would investigate how they could finance a certain health intervention in a different way. This shows two perspectives on a limited budget.

Several small connections of funding to other factors were made in the documents. In connection to the factor clear roles and responsibilities, it was stated at a document that the coordinator of the health initiative should look for ways for health activities being able to be executed within the available financial resources. At another quotation there was a connection with the factor intermediate outcomes, as the results of the health initiative led to more financial support. Lastly, more public support of the initiative was mentioned as a factor which makes funding easier.

At the interviews funding also appeared to play an important role for the health initiatives. Budgets, investments, funds, all determined the capacities of the initiatives to execute their health activities. For example, one interviewee described next to the national funding of a ministry for the initiative, there is also a need for local investments, of which the municipality was often one of the investors. The development of the health intervention of this initiative (research and pilots) was funded by a charity fund that is committed to people in a vulnerable situation. After this research showed the intervention was evidence-based, the ministry funded a national roll-out of the initiative.

Another interviewee described that securing funding for the health initiatives can be difficult due to competition due to still often limited amount of budget available for health promotion (as indicated at some documents). An example was given of every year applying for funding at the municipality, at which the municipality often received more applications of initiatives than budget available. This results in some initiatives not receiving funding or being partly funded with consequences in capacity. One representative describes this feels as having to prove yourself as initiative over and over again (instead of a established foundation of trust over the years).

Subsidies from the public organisations (government, ministries and municipalities) for health interventions are as said often limited and result in competition between initiatives for funding. Subsidies were also indicated to differ each year, which results in every year reconsidering which health topics/activities are going to be prioritised. One interviewee indicated that another initiative received a certain budget for which they also applied, which resulted in stopping an activity in order to be able to continue another one. This is again about prioritising of the health activities (management). Due to the limited budgets another interviewee indicated the community members had first to apply for funding of their health activity and afterwards present their health activity during an neighbourhood event to make it insightful what has been established with the funding. This to make sure if the priorities are still right and the community approves.

This depending on subsidies shows the vulnerability of certain health initiatives. Especially, regarding the development towards sustainability. One of the initiatives was ended because there was only funding for one year (except one successful part, which continued on this own), despite of community members being pleased with the initiative. One interviewee explained the health

initiative was not made sustainable in any of the municipalities it was executed, due to every time having to reinvestigate on which subsidies they can rely on. These are not structural funds (there are set for a period of time), which result in a difficult continuous process of looking for funding. It was noted that subsidies from public organisations is not wrong, but should become incorporated at structural fundings. In order to provide certainty of budget for the initiative and to developed towards a sustainable health initiative. This structural financing was also indicated as an option to be incorporated at private organisations. The private organisations participating in the intersectoral collaboration of the health initiative were several times indicated as possible partners which could also enable structural fundings. For example, a health insurance company.

The added value of intersectoral collaborations was also mentioned to be helpful when there is limited budget, building on each other expertises. Again an indication of including organisations from the healthcare/welfare sector, as they already have local networks in place. However, an intersectoral collaboration was also indicated to be a difficulty for funding. Regarding who of the organisations or sectors is responsible for securing funding. It was also indicated difficult for receiving subsidies, as the initiative does not fit into one sector.

Lastly, health initiatives need time to show possible effectiveness. There are no direct results. Health promotion often takes a longer period of time, which makes securing funding also more difficult. Intermediate outcomes and visibility can offer a solution in this respect. Funding was also mentioned at other factors of the MISC to play a role.

Public support (in Dutch ''draagvlak'')

Public support was something which is mentioned several times within the documents at different initiatives (n=11). In one document it was stated that public support by the community members is a success factor for the progress of the health initiative. Another initiative indicates they start with community members who already wanted to be involved with the initiative and activities and share their enthusiasm with the neighbourhood and other community members to increase the public support and involvement. Another initiative established a steering committee of community members who are representatives of different kinds of local organisations (sports associations, schools, childcare, etc.) within the municipality in order to create public support. The representatives are highly involved in the community. The bottom-up approach and creating public support are an important guideline for this initiative. This was confirmed by another initiative, as they indicated that involving local organisations advances the creation of public support and trust among the community members. In addition, it was stated this secures the sustainability of the health initiative. Increasing public support by involving local organisations, but also to eventually ensure the health initiative will be sustained by the local network and community (sustainability).

It was stated that creating public support makes it easier to raise funds and involve organisations and community members. It was also indicated at two quotations it is important to involve organisations from the health/welfare sector in the collaboration in order to create public support. Organisations from the health/welfare sector acknowledge the importance of health activities and have experience within the local networks and involving community members.

At two interviews public support was also described to be important to for the development towards a sustainable health initiative. In order to create public support, one needs local organisations in the collaborations. This created public support by involving the local organisations is needed for the initiative being incorporated into the community, which is something different cases of this study aim to achieve. Several representatives regards this assimilation of the initiative by the community as the road to sustainability. Esurance that initiative will be taken over and be continued by the community, when the initiators leave. This takeover could be done by community members or local organisations or a combination of both. It was mentioned that community members do not

always have the capacity to maintain the initiative on their own and therefore a combination with a local organisations is needed for sustainability. Lastly, public support was also indicated to be needed before the health initiative can take off.

Facilitating

In the documents of the different initiatives it became apparent that several initiatives are, just as AAH programme, a kind of facilitator bringing different partners/organisations with the needed resources together (n=14). One health initiative describes they facilitate groups of community members to organise health activities on health issues they perceived to be important. One leading organisation does this by involving relevant organisations in their intersectoral collaboration. Organisations which can support the community members in setting up and execute the health activities. Another initiative describes the initiators facilitate the coordinators in different municipalities to create a network of organisations and community members. Two other initiatives also described, the initiators facilitating the establishment of a local network of organisations in an intersectoral collaboration for the health initiative at a municipality, of which they eventually hope can continue on their own. So the health initiative is being made sustainable in the community, by doing this with local organisations realising the health activities bottom-up. Again bringing the organisations together with right expertise for the initiative (facilitating).

In one document it was indicated that the initiators of initiative could improve facilitating knowledge exchange between the different municipalities at which the initiative is executed. This could be connected to factor management with the process-indicator; degree and utilization of knowledge exchange. This facilitating of the initiators of the initiatives could on regard as a form of management structure (which is the case at several cases of this study). The concept of facilitative leadership from theoretical framework from the Model of Collaborative Governance (2.5.2), describes the characteristics of a leader regarding facilitating the organisations within in the intersectoral collaboration. It was focused on neutral person, mediator or one leader. However, from the cases from this study it appears this regards not always one person, but one organisation facilitating the intersectoral collaboration. This was also shortly addressed at the factor shared mission. The initiators of the initiative developing a mission, taking a facilitating role and invite organisations to join their health mission. These initiators form the intersectoral collaboration (network) and as an organisation coordinate and facilitate the other organisations at the health initiative.

At the interviews this facilitating of initiatives was also described. The initiators, programme leader, coordinators/project leaders or regional advisors were indicated as facilitators who bring the different needed organisations for an intersectoral collaboration together to execute a health initiative in a community (or neighbourhood or municipality). The interviewees also mentioned, as within the documents, facilitating knowledge exchange between the different organisations (management). Some coordinators experienced that organisations also really wanted knowledge exchange, and provided this through a tool or meetings. It was also explained that a programme leader tried to connect organisations on similar content.

One initiative was created by one organisation (facilitator) connecting all the different organisations and community members from a community which were engaged in health activities, to unite in an intersectoral collaboration. This organisation is also a connector/mediator between the community members and the professional organisations. The organisation provides information about the needs of the community members, which as a welfare organisation works on daily basis with the community members.

Lastly, an interviewee explained as initiator facilitating set-up of the initiative with the needed local organisations and guiding this collaboration for a few years, after which was aimed they

hopefully could continue on their own. This was described as the ultimate goal; the health initiative being sustained within the community by the local organisations and community members, which was also regarded as a development towards sustainability. The following quote describes this facilitating process (of one leading organisation);

''De partners, zeg maar, lokaal, die moeten echt hebben dat het hun interventie is, hé. Dan zijn wij als stichting helemaal niet belangrijk, het moet hun interventie zijn en die moeten Veendamse of Bergen op Zoomse of Middelburgse kleuren hebben gekregen. En, wij zorgen gewoon voor de randvoorwaarden dat zij door kunnen en daar zijn wij als stichting totaal niet belangrijk, vind ik. Alleen achter de schermen maken wij het mogelijk dat zij het kunnen doen.''* (Interviewee 6, 2021)

Translated: *''The partners, local, they really have to feel it is their intervention. Then we as a foundation* are not important at all, it must be their intervention and it must have been given Veendam or Bergen op Zoom or Middelburg colours (/aspects, assimilated in the community). And, we just provide the preconditions that they can continue and we as a foundation are not important at all, I think. Only behind the scenes, do we make it possible for them to do it."*

*the name of the foundation has been omitted from the quote due to anonymity

Energy

Within the documents the code energy (n=28) was something which re-occurred at documents (mostly at documents on one initiative (Gezondheidsambassade)). It was mostly stated at quotations about community members. Community members finding (own) time and energy to invest in the neighbourhood. It was indicated that this can be difficult. However, support of an independent professional organisation could help the community members in investing time and energy in health issues they want to address (their needs against the wishes of the participating organisations of the intersectoral collaboration). In addition, it was also indicated that community members are getting inspired by each other's energy or the enthusiastic reaction of someone activates the energy at another community member.

Next to the community members, also the energy of the initiators of initiative was mentioned several times. For example at some quotations; the initiators of the initiative followed the enthusiasm and energy of the community members regarding the health interventions. In addition, it was described that initiators or coordinators were willing to put more effort in the initiative (even own time) because they were enthusiastic and got energy of the community members enjoying the health activities. Moreover, it was also mentioned that coordinators looked for local organisations/partners which showed energy to get started with the health issue the initiative wanted to address. Thereby, in order to create and develop a local network, it was mentioned there is a need of the creation of energy, which must be created through meeting people in real-life (not online). Lastly, it was stated at a quotation the energy of the initiators of the health initiative was being valued.

This energy could also be regarded as motivation. Motivation in the line with energy (enthusiasm) was also mentioned several times. The intrinsic (personal) motivation of coordinators was indicated to benefit the initiative with a positive appearance or community members having intrinsic (personal) motivation to develop a health activity for the initiative. Thereby, it was also pointed out that the extent to which partners/organisations respond enthusiastically and are involved, remains person dependent. These codes energy and motivation could one classify under the factor commitment to the process (as process-indicators or concepts). As they could be connected to the process-indicator; degree of intrinsic motivation of partners (incentive to participate). Commitment to the process was also indicated to be person dependent (intrinsic

motivation, enthusiasm) and not only on organisation level.

At the interviews, energy was mentioned by different interviewees as an important aspect for the health initiative. Again the energy of the community members to commit to create or participate in the health activities was mentioned, at which the intersectoral collaboration gives support. When there is energy within the community to address the health issue, this will contribute to the commitment of the community members on the long term. In addition, person-dependency of energy was also indicated. When an enthusiastic person with a leading role for example stops, the energy can drain away from the community. As explained several times, this could be harmful to the sustainability of the health initiative. Therefore, again, the importance of being able to rely on an independent professional organisation for support, when needed, was mentioned. This personal motivation of people and dependency was something which was also ascribed to the professionals/people from the participating organisations. When professionals or community members are personally motivated to address a certain health issue, commitment and motivation to contribute to health initiative will be bigger.

This was also addressed as intrinsic motivation and be regarded as an important factor for sustainability. The following quote displays this importance of intrinsic motivation of community members;

''Nou ja, plezier, klinkt heel flauw, maar ik denk ook, dat merk ik altijd. Kijk. Vrijwillige inzet gaat natuurlijk gewoon om intrinsieke motivatie en zolang het niet meer leuk is, zolang het geen energie meer, als het geen energie meer oplevert, dan houdt het gewoon snel op. '' (Interviewee 1, 2021)

Translated: ''*Well, fun, sounds very lame, but I also think, I always notice that. Look. Voluntary commitment is of course just about intrinsic motivation and when it is no longer fun, when it no longer produces energy, if it no longer produces energy, then it just stops quickly.''*

It was mentioned that because of this intrinsic motivation there is no need for stimulating commitment to the process (commitment comes from within people). However, to maintain this intrinsic motivation, appreciation of people and relationship management were indicated. It was explained as keeping track of the flow of the energy. In order to motivate organisations to participate it was mentioned by interviewee one had to develop a more precise shared mission. When trust was built between the participating organisations, this improved the energy to start with the health initiative.

8.13 Observation and short interviews

8.13.1 Observation of a meeting

After one of the interviews with a representative of a health initiative, there was a possibility to attend a meeting of the programme team of the health initiative. The team existed of three members from two different governmental organisations (ministries) and a programme manager (independent consultant). The meeting started with an introduction round, which included an explanation of the aim of this research. After this introduction, the entire meeting of this team was observed (approximately a duration of 45 minutes).

During this meeting several observations were made. First it gave some insights in the forms of communication structure and management. The meeting had both formal and informal aspects. The appointment for a meeting and agenda items being formal aspects. Informal aspects as at the end of the meeting discussing personal circumstances, which can be respected as a part of relationship management, an element of trust building (between the team members).

Another observation relevant to mention is the emphasize on transparency in the beginning of the meeting, which also directly showed because the fact that it was possible to join the meeting and to observe and make notes of the conversations. Next to, mentioning they are completely open about activities and progress to participating organisations of the health initiative. This transparency is an indicator of commitment to the progress.

During the meeting the role description of one of team members was shortly addressed. Which parts within the team she would take on and how much time she would take and had available to execute her tasks and responsibilities. This is an example of consensually developing role descriptions (keeping skills and expertise in mind) making use of open discussion. Initiated by the programme manager, where developing clear role and responsibilities is also a part of management. Role descriptions and a shared understanding of contributions each person brings in, are both indicators from the factor clear roles and responsibilities, which came forward during the meeting.

Next to these observations, some concrete outputs were discussed; attendance at a congress, several workshops, a meeting of participants of the initiative, thematical sessions, evaluation and monitoring report and a national campaign. These outputs can be seen as intermediate outcomes and action orientated. Especially, attendance at a congress and wanting to set up a national campaign are also about visibility. Next to, thematical sessions increasing awareness about the health issue this initiative addresses. This awareness is also strived for with working visits of a minister of the government (briefly mentioned in between). One of the workshops will regard a presentation about monitoring and evaluation, which is also an indicator of the factor intermediate outcomes. Intermediate outcomes can serve as input for evaluation and feedback to make improvements and adjustments. By presenting this in a workshop this also shows again transparency. The other workshop included community involvement and focused on what they would do with the points resulted from the evaluation.

In this workshop the community members will be asked their opinion about these points of the evaluation, which is also the case at the meeting of participants of the health initiative, testing their vision on the health programme. This connects to the factor including the community (community involvement), which also came forward in the documents and during the interview of this initiative. This community involvement regards direct contact with the target group at process activities (as a workshop) with a feedback mechanism.

8.13.2 Network meeting Alles is Gezondheid

There was a possibility to attend the annual network meeting of AAH programme, where several experts in the field of health promotion and representatives health initiatives were present. This resulted in asking four different attendees their view on how a health initiative can be made sustainable (which elements or factors play a role) and what they understand by a sustainable health initiative. These questions are equivalent to the first and fourth question of the interview(guide) at appendix 8.7. Following, there will be a short description of their answers and relation to the factors of the MSIC. The four attendees (health experts and representatives) are made anonymous.

Structural embedding in the local network and community of the health initiative was mentioned by attendee as an explanation of a sustainable health initiative. In addition, it was mentioned there will be still a need of guiding/stimulating institution next to this embedding in the local network. Key to this embedding was declared to be involving the community. Pro-actively looking for local entrepreneurs. An example was given; *Often regarding sustainability it is the case that funding from government after three years runs dry and therewith the initiative comes to an end. The more the importance of embedding the initiative in the local network, including investments of local entrepreneurs. Personally approaching the local entrepreneurs results often in willingness to contribute something for the community. This is also the drive of entrepreneurship. In this case there was eventually more investments from local entrepreneurs than funding from the government. These entrepreneurs are more involved with their local community. This connection to the community may also result staying more committed to the initiative.*

This example connects to the factor representation of relevant societal sectors, including community members. It shows that the private sector of local entrepreneurs are relevant participating organisations for this intersectoral collaboration for sustaining the health initiative. By involving these local entrepreneurs, there is also immediately community involvement. In order to involve these local entrepreneurs and other community members there is a need of visibility. This was also mentioned as an important aspect for sustainability. Visibility was indicated as a way to obtain more participants and more participating organisations. The need of funding and investments is also an indicator of the factor visibility. A tool for this visibility could be a campaign, where including a new partner/organisation in the collaboration and securing investments can also be seen as indicators of intermediate outcomes. Regarding participants of the health initiative, it was mentioned it is important to interact with community members to gain feedback. This feedback mechanisms with the community is again an indicator of the factor the representation of relevant societal sectors, including community members.

This community involvement was also mentioned by other attendees of the meeting as an important element for a health initiative to become sustainable. One mentioned that it was about stimulating and motivating community members to participate in health initiative, but in order to make the health initiative sustainable it also needs to come from the people themselves. Intrinsic motivation to tackle health and being part of the health initiative. Another one mentioned something similarly; the health initiative must not be top-down, but has to be in line with the community members themselves (connecting to their experiences). In order to reach this, it was mentioned that community members should be part of decision-making. This being part of decision-making is an indicator of the factor the representation of relevant societal sectors, including community members. Again this attendee also mentioned it is important community members see it is meaningful to continue the health activities from the initiative. In addition, to this intrinsic motivation, they should also have interests in remaining part of the health initiative.