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Publisher: Routledge

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Journal of Aging & Social Policy

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wasp20>

Collaborative Partnership in Age-Friendly Cities: Two Case Studies from Quebec, Canada

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Accepted author version posted online: 13 Nov 2013. Published online: 13 Nov 2013.

To cite this article: Journal of Aging & Social Policy (2013): Collaborative Partnership in Age-Friendly Cities: Two Case Studies from Quebec, Canada, Journal of Aging & Social Policy, DOI: [10.1080/08959420.2014.854583](https://doi.org/10.1080/08959420.2014.854583)

To link to this article: <http://dx.doi.org/10.1080/08959420.2014.854583>

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LRH S. Garon et al.

RRH Collaborative Partnership in Age-Friendly Cities

Collaborative Partnership in Age-Friendly Cities: Two Case Studies from Quebec, Canada

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This article aims to explain the collaborative partnership conditions and factors that foster implementation effectiveness within the AFC (age-friendly cities) in Quebec (AFC-QC), Canada.

Based on a community-building approach that emphasizes on collaborative partnership, the AFC-QC implementation process is divided into three steps: 1) social diagnostic of older adults' needs; 2) action plan based on a logic model; and 3) implementation through collaborations. The AFC-QC promotes direct involvement of older adults and seniors' associations at each of the three steps of the implementation process, as well as other stakeholders in the community. Based on two contrasting case studies, this paper illustrates the importance of collaborative partnership for the success of AFC implementation. Results show that stakeholders, agencies, and organizations are exposed to a new form of governance where coordination and collaborative partnership among members of the steering committee are essential. Furthermore, despite the importance of the senior associations' participation in the process, they encountered significant limits in the capacity of implementing age-friendly environments solely by themselves. In conclusion, we identify the main collaborative partnership conditions and factors in the AFC-QC.

KEYWORDS age-friendly cities, community building, collaborative partnership, mixed methods, Québec

INTRODUCTION

In recent years, initiatives to adapt both built and social environments have increasingly raised awareness among policymakers to address challenges related to an aging population (Lui, Everingham, Warburton, Cuthill, & Bartlett, 2009). The World Health Organization (WHO) has helped to refocus the best contributions from this series of initiatives by publishing *Global Age-*

Friendly Cities: a Guide (AFC). Without proposing a specific “instructions manual” to ensure the outcome, this guide explains different actions through eight fields¹ within the competence of cities interested in tailoring their infrastructures and services to older adults’ needs. Despite its recent development, the AFC movement has expanded considerably (Buffel, Phillipson, & Scharf, 2012). Built on the work of the WHO AFC initiatives, the Government of Canada issued another guide, but this time for rural and remote communities (Government of Canada, 2007). Thus, there are several hundred cities and rural communities throughout the world committing to become more “age-friendly.”² Since 2007, seven Canadian provinces have undertaken an AFC process (Plouffe & Kalache, 2011; Plouffe, 2011; Plouffe & al., 2013).

Based on two contrasted cases studies (among seven),³ this paper aims to explain the collaborative partnership conditions and factors that foster implementation effectiveness within the AFC in Quebec (AFC-QC). We first expose our main theoretical background, which helps us to develop and evaluate the AFC-QC process: a collaborative partnership embedded in a community-building approach (Chaskin, Brown, Venkatesh, & Vidal, 2001). Secondly, we present an overview of the AFC-QC design and process. Finally, from a collaborative partnership perspective, we illustrate several conditions and factors that may determine success or failure of the AFC-QC process. The strength of the partnership relationship was critical to the differences in what was accomplished in each of the two cases.

BACKGROUND

In 2008, the Quebec Seniors' Secretariat became interested in the WHO's concept of the AFC and mandated a research team to develop a research-action model, including a structured evaluation process (Garon, Beaulieu, Veil, Paris, & Bigonnesse, 2012). The goal was to implement the AFC-QC in seven pilot projects: five mid-sized municipalities (20,000 to 150,000 inhabitants), one district of a large city and one remote regional county, which itself comprises 22 municipalities across a territory of 11,970 miles (or 0.5 person by mile). In both the programming and research processes, the AFC-QC is based primarily on a participatory approach. Often called a "bottom-up" approach, it implies that people are in better positions to talk about their own situations and to help discern solutions to their problems, often more effectively than these predefined by experts who are detached from their reality (Greenhalgh, Kristjansson, & Robinson, 2007).

Moreover, the AFC-QC relies on a community-building approach, that is, a comprehensive process by which stakeholders of a local community gather together to act towards the improvement of the quality of life of older adults. Community building corresponds to actions that engage individuals and local organizations concerned by a situation they wish to transform by joining their forces. This approach refers to a different way of acting in the public policy framework and generates social ties (Chaskin et al., 2001). Often discussed but rarely applied in Quebec,⁴ this approach promotes the participation of all members of civil society, municipal apparatus, and elected officials. It enhances collaborative partnership between various stakeholders by sharing information, discussing problems or specific issues, agreeing on

common goals and actions. In the AFC-QC context, community building constitutes a critical condition to the overall success and effectiveness of the implementation.

RESEARCH METHODOLOGY

One of AFC-QC's research objective is the evaluation of implementation performed by checking not only if the program has been implemented as planned, but what worked or not by identifying characteristics, mechanisms, and approaches that lead to success or failure—basically, that lead or not lead to a collaborative partnership embedded in a community-building approach. This case-study approach focused on multiple-cases analyses (Yin, 2009), which is particularly suitable for the realistic evaluation. This strategy aims to explain and understand the AFC-QC throughout the context, the mechanisms, the outcome patterns as well as the combination of all these components (Pawson & Tilley, 1997). Our data collections are based on mixed methods (Creswell & Clark, 2010) in a short longitudinal design (2008 to 2012; see Table 1).

In this paper, the data analyzed were collected throughout a series of focus groups with steering committee members, several logbooks, and press reviews provided by project managers,⁵ minutes of the steering committee meetings, the diagnostic and action plan reports, one survey on collaboration (Mattessich, Murray-Close, Monsey, & Wilder Research Center, 2001) and one on organizational networks (Provan, Veazie, Staten, & Teufel-Shone, 2005).⁶ In all, data were analyzed by triangulation.

THREE-STEP MODEL

The AFC-QC's model involves three steps: the social diagnostic, the development of an action plan, and the implementation of projects. A cycle lasts over five years, the first 18 months of which carry out the diagnostic and the development of an action plan. Because the AFC-QC's model is more demanding for municipalities than WHO's guidelines, this action plan must be adopted by the municipal council. The AFC-QC detailed model is illustrated by Figure 1. It has greatly influenced the WHO's guidelines.

Steering Committee

None of the steps can be accomplished without the involvement of the steering committee. Its role is to stimulate commitment and to facilitate the achievement of each of the three steps, to implement actions, to disseminate information, and to participate in the mobilization of the community's participants and decision makers. The steering committee plays an extensive role in facilitating coordination and collaboration.

The overall composition of the steering committee varies from one case to another. It consists generally of 6-18 members from seniors' organizations and associations, public health and social service institutions, municipal apparatus, as well as an elected municipal official. Few private sector representatives sit on the committee, apart from some homeowners for older adults or representatives from financial institutions (such as credit unions).

Step 1 - Social Diagnostic

The social diagnostic is essential to the success of the subsequent steps of the AFC-QC process. This operation allows the emergence of a vision shared by all stakeholders on the committee who face the reality of aging in their specific community. In the case of the Quebec experience, three sources of data collection ensured the rigorosity of the social diagnostic (Table 2).

Step 2 - Action Plan

After having taken into account the older adults' needs and having appropriated the appraisal of the community, the steering committee draws up an overview of the situation. First, the steering committee highlights the overall findings of the social diagnostic (strengths and weaknesses) and defines values and policies that will guide the municipality and its partners in their intervention to improve older adults' lives.

Based on findings, the steering committee members prioritize actions. Then, a plausible and efficient implementation scenario emerges in terms of available resources. The recommended action plan model is based on a logic model approach (Funnell & Rogers, 2011) resting on the principles of results-based management (CIDA, 1999).

Step 3 - Implementation

The last step is to plan and organize the necessary resources for the implementation of actions and to carry out a follow up. In fact, the implementation must produce the expected results of the action plan and contribute to achieving the objectives set by the steering committee. Some

committees engage quickly in actions they consider ripe or for which opportunities arise. Sometimes, projects are somewhat more important and require additional fundraising. The funding provided by the Quebec Government to the AFC-QC mainly pays the project manager's salary. Part of the funding was allocated for some of the projects, but others required substantial human and material resources. To offset these funding issues, although there is no requirement for steering committees to do so, some have responded proactively by quickly seeking new grants.

CONDITIONS AND FACTORS OF SUCCESS OR FAILURE

Our observation is based on two contrasted cases studies. The first case (A) is the “Community-Based Case,” an urban area in a district of a large city with a structured range of services (e.g., public transport) but with little political involvement. The second case (B) is the “Municipal Leadership Collaboration Case,” an average city with fewer services but with high political involvement. To illustrate collaborative partnership conditions and factors that may determine success or failure of the AFC-QC process, we divide this section according to the AFC-QC three-step model.

Steering Committee: A Rooted Network

The creation of a core group of individuals rooted in the community—mainly stakeholders from the municipal apparatus, political representation, and public and community organizations—

represents a critical condition of the AFC-QC's process. Figure 2 shows the composition of each steering committee in 2012.

Case A has a strong community-based membership from older adults' associations and organizations (4 out of 8). This structure of the committee was able to reach 6,000 older adults through associations and community organizations. However, this strong representation of civil society did not share the AFC-QC's process with others. Although the AFC-QC's model promotes a bottom-up approach, case A indicates that if there is a lack of involvement and commitment among stakeholders from various sectors of the community, it may result to a reduction of the AFC-QC scope regarding its eight fields and its implemented projects. For instance, because it has been identified as a major issue by the community organizations, case A focused mainly on social participation through the action plan and the implementation (e.g., the establishment of an annual festival and the improvement of recreational activities).

On the contrary, by its strong municipal leadership (6 out of 11) and its openness to collaborative partnership, case B developed a strategic positioning of the AFC-QC in the municipal apparatus. Also, it had a coherent decision-making method between the committee and the municipal council and an operating structure linked to other existing collaborative structures. The municipality has enhanced the AFC-QC process and implementation by opening its practices to collaborative partnerships with other stakeholders. An example of this unique condition is the establishment of an adapted physical training unit for older adults. This project is commonly found in the AFC-QC outcomes. However, the implementation effectiveness relies on the process rather than the outcome. Indeed, in case B, the whole implementation process of this

project was based on a collaborative partnership: 1) older adults have identified the need of an adapted physical training unit in a public park during the consultations; 2) they have also chosen the type of unit and its location in the city; 3) the municipality has proceeded to its safe installation; 4) the local health and social services center (in partnership with the municipality) has facilitated activities with a kinesiologist; and 5) the municipality publicized the park and the activity in senior homes and clubs. In short, the process was based on a collaborative effort of various stakeholders such as municipal services (civil engineering and recreation), private (senior homes) and public (health and social services center) organizations, as well as community organizations and associations (senior clubs).

Social Diagnostic: Towards a Common Goal

From the consultation process with older adults, we have observed the following: The way we proceed, according to the needs identified by older adults themselves, changes the traditional top-down approach where service providers determine needs and how to respond to them.

In fact, through the consultation process, older adults have introduced ideas that might have not been introduced by service providers. For instance, with the social diagnostic, steering committee members in case B acknowledged that a portion of the older adult population was living alone and left behind by service providers. The appropriation of the diagnostic based on consultations allows committee members of case B to acknowledge older adults' needs and to challenge the improvement of the living conditions of older adults—a challenge that cannot be undertaken single-handedly. On the contrary, without a complete social diagnostic, the AFC-QC's process can be at risk of failing. For example, case A has not consulted older adults

because the steering committee members considered that they already had done a consultation of their needs by a community forum in 2005 (two years before the AFC-QC). Therefore, the diagnostic of case A was not referring to the immediate needs of the older adults, but rather to the agenda of community organizations and associations. Such approach seems to have led to the withdrawal of other stakeholders because they cannot recognize themselves in the chosen goal. Therefore, the AFC-QC's scope of process and implementation is reduced. Without a common starting point, the commitment of different stakeholders was difficult to have, even impossible, in case A. As revealed by our analysis of WHO's fields covered by the action plan of case A, it did not cover topics such as transport, safety at pedestrian crossings, or access to public places and housing since the needs assessment had not been done on these issues. In addition, the positioning of the AFC-QC under the responsibility of community organizations does not allow them to require the municipality for any improvements. Since there were no elected officials appointed in the steering committee, and the administrative officer did not hold a leadership position in the municipal apparatus, it was rather impossible to obtain a common goal during the diagnostic stage.

Action Plan: A Commitment

In case B, the action plan was integrated in the agenda of municipal services (police and fire departments, public works, urban planning, recreation and community life), in the priorities of community organizations and associations, as well as in the practice of health and social services centers, and constitutes a condition of implementation success. All committee members acknowledged each other's missions and interests, and clarified the responsibilities attached to

the action plan in relation to their combined expertise. In the municipal stakeholder's words: "The concern of the municipality regarding the action plan is not to end up with all the actions to implement, but to foster partnerships and that all stakeholders do their fair share, due to their role, as well as to avoid taking the place of others" (case B, focus group, 2012).

Case A, however, gives the opposite example and highlights the importance of coherence between the diagnostic and the action plan. As we already saw, case A did not consult older adults. Thus, their older adults' needs with regard to the built environment (e.g., to adapt sidewalks and street lights, add public benches or physical training units in public parks) did not appear in the action plan. There is a concern about the lack of commitment from the municipal government because it did not associate with the AFC-QC process. Again, this reflects the issue of collaborative partnership among different stakeholders, whose professional expertise and organizational mission are complementary to each other, in the success of implementing initiatives affecting all of the eight fields of older adults' needs.

Implementation: Acting Together

THE POWER OF NETWORKING

Networks of collaborating municipal apparatus, as well as public and community organizations, give an understanding of the structure of relationships between steering committee members. Case B was particularly well networked from the outset; that is., members already belonged to several organizations in addition to those where they were formally working.

As implementation progressed, it became interesting to consider the organizations solicited by committee members in their efforts to promote the success of the AFC-QC projects. It can easily be seen from Figure 3 that the relationships between municipal services and community organizations intensify. However, it is also clear that these solicitation relationships are outside the formal sphere of the organizations to which the members belong. This observation indicates that relationships are well embedded during the AFC-QC's implementation. Also, the solicitation networking reflects the efforts made by committee members to deploy the AFC-QC's action plan. The network data reveal a vast configuration of membership links and solicitation that reflects this committee's dynamism about collaborative partnership. As claimed by a member of the steering committee: "The AFC-QC allows us to [...] work in collaboration partnership [...]. We cannot work in silos anymore" (Case B, focus group, 2012). The members have invested their networks, relied on the AFC-QC, which helped formalized mechanisms (e.g. task forces, sectorial subcommittees, etc.) and strengthen its action.

In 2010, all committee members in case A responded to the organizational networks survey. We observe a concentration of membership in associations and community organizations with 14 links out of 22 (63%). Therefore, case A seems to have a networking dynamic but attached to a familiar network, already existing before the beginning of the AFC-QC process. In 2012, there was an important reduction of the network. There was only 50% (4 out of 8) of the participation. Municipal governments and administrations are no longer visible in Figure 4. This situation can be explained by the fact that at the time the survey was distributed, the AFC-QC process was completed (in other words, there were no more financial resources). We see that only seven links of solicitation in 2012 sustained from the 21 in 2010. Members of the steering committee

expressed their disappointment of not being able to have the support of elected officials, or find another financial resource that would have helped them to keep some projects of the action plan going: “And if you do not have the political consent, we can do nothing. They give us nothing” (Case A, focus group 2012). The overall picture shows a core of committed people who pursue the AFC-QC process and try to get an involvement from the municipal government and a better recognition of what they have accomplished in the community and of what it could be like in the near future.

THE IMPORTANCE OF COLLABORATION

The transition between the action plan and its execution had to be analyzed in terms of cumulative effects on the collaboration between partners. Again, case A highlights the fact that in a context where the AFC-QC process is led by a strong community-based steering committee, several consequences were observed in terms of collaboration. The projects were supported by older adults associations and organizations that had a large influence on the civil society, but they were not able to exercise influence within the municipality. One of the projects sought by the steering committee was the construction of an older adult center. However, even with the support of the municipal administration, elected officials have political priorities dedicated to young families. As one committee member said: “The Mayor announced his interest in younger people rather than older adults” (Case A, focus group 2012). Therefore, this absence of political support has repercussions on the resources (financial, human, etc.) allowed by the municipality.

The steering committee of case B has fully carried out the action plan by ensuring a good collaboration between different stakeholders. This collaboration partnership can be considered as

an outcome *per se*: “Well, if we go back five years ago, our organization was working all by itself. Now, all organizations are here and when it’s time to collaborate they all do: that’s what makes the success” (Case B, focus group, 2012). Indeed, having a common goal and perceiving positive impacts after the implementation of projects can ensure collaborative partnership. In 2012, the municipality brought more attention to different universal accessibility projects with regard to cities’ built environment responsibilities, which required less input from the other stakeholders. Also, to address the problem of financial sustainability to support implemented projects and to develop new projects, the case B steering committee members mobilized themselves and their networking relations to apply for government grants. In other words, case B, which had a heterogeneous collaborative partnership accomplished much more through its age-friendly city initiative than case A, which relied on a homogeneous partnership. This demonstrates the importance of the strength of the partnership relationship as a critical difference in what was or can be accomplished.

CONCLUSION

This paper aimed to explain the collaborative partnership conditions and factors that foster implementation effectiveness within the AFC-QC (Table 3). In doing so, we saw several conditions and factors that may determine success or failure of the AFC-QC process.

Although with the favorable context prevailing in Quebec (dynamic Seniors’ Secretariat, subsidies, social discourse for active aging, fighting structural ageism, government policy on

aging, program to counter mistreatment of older adults, etc.), we acknowledge that all these conditions and factors have contributed to the success of the AFC-QC.

Upstream of the AFC-QC, is the importance of coordinating efforts and fostering collaborative partnership between stakeholders. Indeed, despite the role of the older adults' organizations and associations' participation in the process, they encounter important limits in the capacity of implemented age-friendly environments. The AFC initiatives should lead to a transformation of the traditional top-down approach, not by promoting only a bottom-up approach, but a collaborative partnership, or in Paquet and Wilson (2011) words, a “small g governance approach.” Instead of maintaining an approach that is hierarchical, centralized, and authoritarian, all stakeholders should change to a pluralistic, participatory, and collaborative approach. This change in attitudes and practices “[...] appears to be better equipped to cope with these polycentric coordination challenges, and to reconcile the variety of belief systems at play into a workable accommodation that takes full advantage of the dispersed information, resources, and power under the control of the different stakeholders” (Paquet & Wilson, 2011, p.2).

However, beyond the necessity to change and to communicate with the population, it is of the utmost importance to have a simple model on which there is consensus among stakeholders (Minkler & Wallerstein, 2005). Where the AFC-QC process was evaluated successfully, such as in case B, the community building model was familiar to the municipal administration and the other stakeholders.

To conclude, the importance of collaborative partnership in the AFC-QC leads us to a famous community building quote: “Alone it goes faster, together it goes further.” With that in mind, we get closer to the ideal of a “society for all ages.”

NOTES

¹ Transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, community support and health services, outdoor spaces and buildings

²http://www.who.int/mediacentre/news/releases/2010/age_friendly_cities_20100628/fr/index.html [accessed October 17, 2012]

³ To keep the balance between the editorial guidelines of the journal and the numerous results of the AFC-QC, we chose these two cases because their differences illustrate the diversity of observations made during the evaluation research.

⁴ The municipal authorities in cities generally establish their own policy and will subsequently validate the social acceptability by formal public consultation. Policies are rarely coupled with an action plan, and often the concrete measures are controlled by the municipal agenda.

⁵For each case, there is a project manager who organizes and coordinates all of the AFC-QC process. This project manager is contracted by the municipality.

⁶ Please contact corresponding author for more information on data collections.

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FIGURE 1 Age-Friendly Cities in Quebec Pilot Project Model

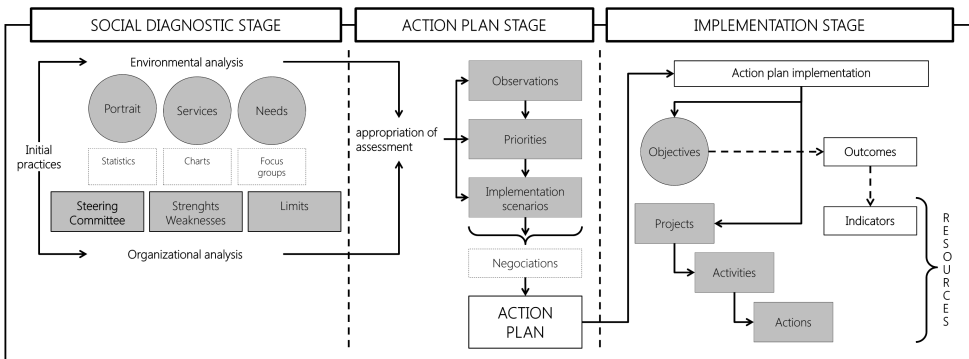


FIGURE 2 Steering Committee in 2012

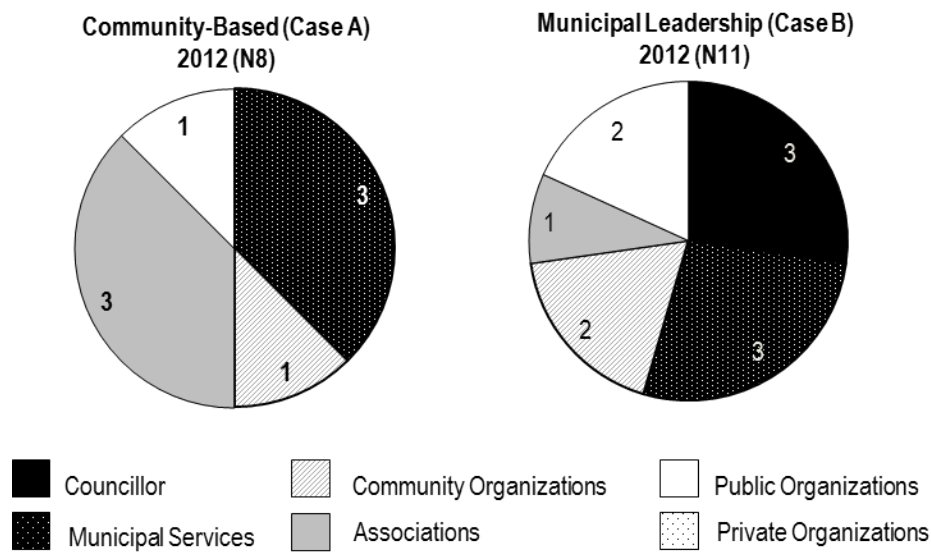


FIGURE 3 Case B — Results on the Organizational Membership and Solicitation Networking in 2010 and 2012

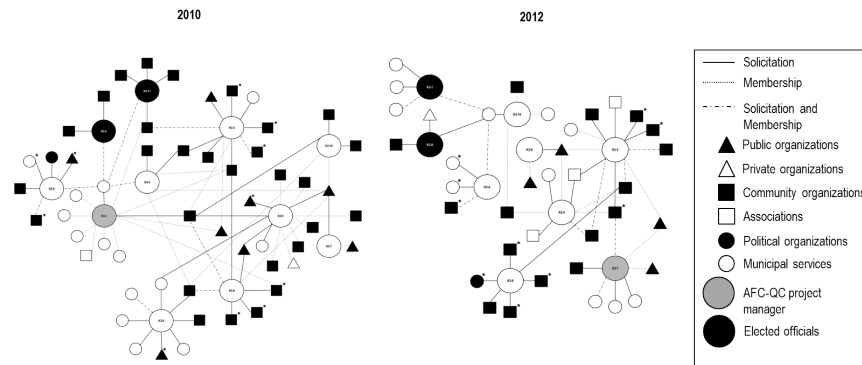


FIGURE 4 Case A — Results on the Organizational Membership and Solicitation Networking in 2010 and 2012

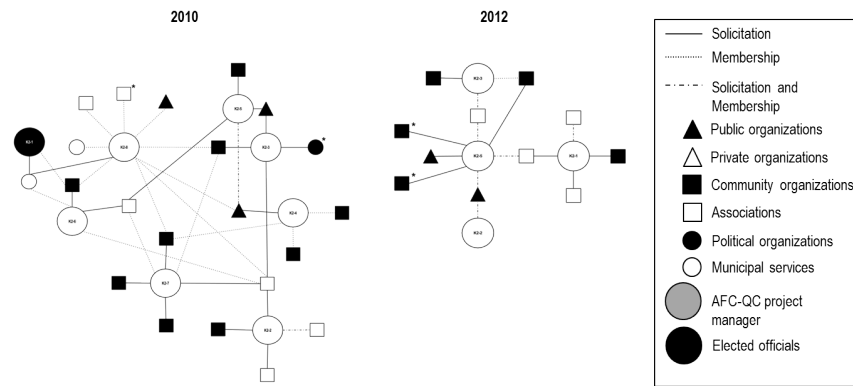


TABLE 1 Mixed Methods to Capture a Complex Reality

	2008	2009	2010	2011	2012	TOTAL
Focus Groups						
Case A	—	1	1	1	1	4
Case B	—	1	1	1	1	4
Logbooks with Press Reviews						
Case A	—	2	3	4	2	9
Case B	—	2	3	2	1	7
Minutes of Committee						
Case A	—	11	9	4	4	24
Case B	3	12	8	2	2	25
Diagnostic Reports						
Case A	—	1	—	—	—	1
Case B	—	1	—	—	—	1
Action Plans						
Case A	—	1	—	—	—	1

Case B	—	1	—	—	—	1
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Organizational Networking Surveys

Case A	—	—	8	6	5	19
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Case B	—	—	11	11	9	32
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Wilder Collaboration Surveys

Case 2	—	—	8	7	5	20
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Case 3	—	—	11	11	10	32
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TABLE 2 Data Collection of Social Diagnostics

The sociodemographic portrait	This data collection describes the locality from a population-based statistical perspective, among others from public and municipal organizations or through the Internet. It includes the rate of persons aged 65 and over, the evolution of population aging, the social, ethnic and economic characteristics, as well as the types of housing.
Grid of services	This data collection relies on a grid of services, programs and policies existing in the locality. This tool gauges services offered and their geographic accessibility.
Consultation on older adults' needs	This data collection uses four focus groups and aims to understand the older adults' perspective of their needs, while taking into account the solutions they offer for a better quality of life and involvement in their community, in accordance with the eight fields identified by the WHO (2007). Three further focus groups are also carried out with services providers (public, private, and community).

TABLE 3 Main Collaborative Partnership Conditions and Factors in the AFC—QC

Steering Committee

- The steering committee members should be rooted in the community and come from diverse sectors.
- An elected official and an administrative officer should be present in the committee.
- A project manager should be dedicated to the AFC-QC's process.

Diagnostic and action plan

- The public consultations with older adults are essential to strengthen involvement of stakeholders around a common goal during diagnostic.
- The action plan should commit various stakeholders in order to ensure implementation.

Implementation

- The stakeholders should use their networks and share responsibilities during implementation.
- A committed elected official is essential to orient political priorities and, therefore, resources (financial, human, etc.) available for implementation.