SPINNING THE WEB OF COMMUNITY CAPACITY BUILDING

Primary Prevention of Diabetes in Saskatchewan
Reflections and Lessons Learned

Prairie Region Health Promotion Research Centre
University of Saskatchewan, Saskatoon
March, 2004

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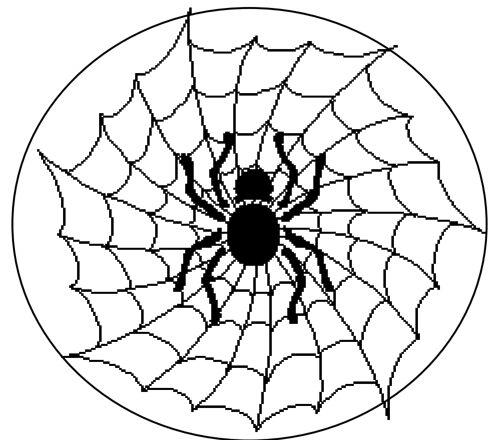

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The report is meant to fulfill the project mandate as set out by Health Canada, Saskatchewan Region, but also to 'give back' to the community-based projects and be a way to share capacity built through diabetes prevention work.

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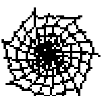
Judi Whiting and Colleen Zubkow
Project Staff



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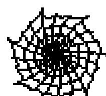

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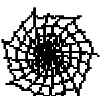


Executive Summary

Purpose of the Project

During the time of the Canadian Diabetes Strategy (CDS) (1999 – 2004), funding was provided to establish effective diabetes prevention strategies. The overall purpose of this project, Primary Prevention of Diabetes in Saskatchewan (PPDS), was to document the contribution of diabetes prevention projects in Saskatchewan in developing capacity for people, organizations and communities to promote health. The data, lessons learned and recommendations that result will be used to

- enhance development and capacity building work
- guide future primary prevention work related to diabetes and other chronic health conditions
- identify recommendations and next steps for action

Capacity building was chosen as the study focus as it is a vital component of community development. Capacity building is

> *an approach to the development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors to prolong and multiple health gains many times over.*[11]

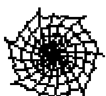
Capacity building can be both a way of working and also a result of the work done. Given the diversity of the projects, a broad concept such as this facilitates an overview across many projects. The focus on capacity building also derives from a belief that funding, as provided through the CDS, does not arrive in a community in a vacuum. Hopefully, the funding opportunity provides a platform to continue and enhance approaches which are working towards addressing determinants of health.

Participants in PPDS

Participating groups were from three CDS streams:

- Ten groups were funded through the Aboriginal Diabetes Initiative (ADI). Their funding was based on submission of a work plans to address not only diabetes prevention but also the two other mandated areas of care/treatment and lifestyle support.
- Two groups received funding nationally through a proposal submission process in the Metis, Off-Reserve Aboriginal and Urban Inuit Prevention and Promotion program (MOAUIPP). Their focus was only on prevention and health promotion and both were located in mid-size Saskatchewan cities.
- Six groups received funding regionally in the Prevention and Promotion stream through a proposal submission process.

A total of seventeen focus groups, representing sixteen projects, were held with a total of 105 participants. Twelve of the projects have given permission to report on their specific project activities. These summaries are in Appendix A.



Project Design

The project design was informed by several resources:

- Key project values were assuring dignity and confidence building, communication and relationships, critical thinking and learning. These values guided the work with projects and gave the direction for this report.
- Experts in community development and capacity building formed a Reference Group and an external community researcher was available for advice. The Reference Group gave guidance in design and met to review results and assist with formation of conclusions and recommendations. The community researcher assisted with specific aspects of design and methodology.
- A literature review of capacity building was done. The focus of this report is the capacity building achieved by prevention projects so the full review is not reported here.

PPDS was not an evaluation of the participating project groups or their work. Rather it was a description of progress made in the community development and capacity building implicit within the CDS. The output is the common threads and themes around capacity building and sustainability.

The methodology used a qualitative approach. A recorder took notes during the focus group discussions. Each project was asked to review and revise the notes. The review by the projects validated the PPDS staff understanding and interpretation. Analysis tables were developed around each capacity indicator and sustainability and major themes were created. Two reviewers validated the themes and the continuums to describe capacity building for each indicator.

There are limitations to the methodology selected:

- There was no audio recording of the groups so notes are not verbatim.
- There was a guide for selection of focus group participants. The selection for group members was made in each community by the contact person.
- The amount time spent with each project was limited. PPDS did not attempt to fully understand the project activities in-depth, but rather to access capacity building.
- Capacity building was the filter for PPDS, but not necessarily that for the projects.

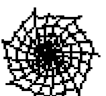
Findings and Lessons Learned

The findings and lessons learned are presented for each of the capacity indicators and sustainability. As several groups worked with schools, this data is presented in the report as a case study to summarize capacity building, lessons learned and challenges. There are several appendices which provided additional resources related to capacity building

Below are brief definitions for each capacity indicator and sustainability as well as the key findings and lessons learned.

Diabetes as a prevention focus

- It was important to groups, particularly those in or working with First Nations, to have funding to work on diabetes prevention.
- Attitudes and perceptions about possibilities for diabetes control and prevention are starting to change. Champions for prevention are emerging in communities amongst their members.



- Change is happening – healthier food choices are being made, there are alternatives to get healthy foods and more people are active.

Lessons learned:
- Groups working with the population health promotion model (PHP) found it was easier to 'sell' diabetes than the PHP model as the project focus.
- Strides made in the community will go beyond diabetes prevention.
- A few groups found that the diabetes focus was not wholistic and they worked towards a wholistic approach. They believe there is a need for this approach.

Leaderships as a Capacity Indicator

Leadership capacity building is about the leadership created amongst community members and the diversity of people who are involved in leading. Professionals often become or are put into the role of the expert and leader. In building capacity, professionals need to resist this role and work with rather than for community members.

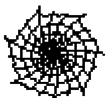
Findings:

- In these projects most of the leadership came from the Health Sector. In some projects there was an intersectoral leadership team. Almost all of the latter teams were formed for this project.
- Where community leadership occurred, it was planned as part of the project strategy and took a lot of support for development and sustainability. Unless community-based leadership development was part of the plan, it did not occur.
- It was not possible to fully assess the projects' leadership mandate for action. Mostly, it seemed to occur within the leadership team rather than from community-given direction.
- Two variables appeared to facilitate the quality of some projects' work: members of the leadership team are longstanding workers in the community and a supportive and stable local government exists.

Lessons learned:
- Some groups, in retrospect, felt they would have derived benefit from community-based leadership.
- Capacity building for community-based leadership takes commitment, time, planning and ongoing support.
- Becoming a leader means building one's self confidence and having a belief in what you are doing.
- When capacity building for leadership occurs in a group setting, it will take time to build trust, confidence and mutual support. Group members may learn that there are different ways of leading and working together.
- There is often local leadership and wisdom, such as with Elders. Listen to the Elders and involve them.

Partnerships as a Capacity Indicator

Strategic partnerships are integral to population health promotion work. Working together in partnership can enhance power and influence if there is trust and the network is supportive of all the members. Professionals may be challenged by the need for service delivery versus the time needed to invest in partnerships.



Findings:
- Partnerships were important in doing diabetes prevention work.
- Most of the partnerships in these projects were brought together to do this specific project.
- Several partnerships were able to connect with a pre-existing or a developing interagency group in the community. This was positive and supportive of prevention work.
- Relationships with formal leadership were variable. Few groups received active support from their formal community leaders and few attempted to work with local government.
- Most projects wanted to work with a school(s). There were few examples where this desire translated into a full partnership with common vision and goals.

Lessons Learned:
- Relationships are key.
- Groups which had or sought organizational support felt it was important.
- Learning to work together has challenges.
- If the partners are in different geographical locations, this can add to complexity
- There are many challenges in working with schools whether working from the 'top down' or 'bottom up'. There are multiple groups to consider in a school environment
- Other job demands may limit time and energy available for partnership building.

Resources as a Capacity Indicator

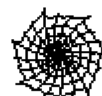
Capacity building for resources is about working towards supportive environments which will address the determinants of health. While health education has a role, it is an early step in capacity building. As with leadership, eventually there needs to be a shift from professional-directed to community-directed involvement.

Findings:
- Capacity building focused on health education and accessibility of resources.
- Knowledge through health education was gained in most communities.
- Accessibility was acknowledged as a need in many projects. Strategies to introduce community members to physical activity and healthy food choices were common.
- A few projects provided small grants as a resource for groups to take action. All had criteria for the grants and a selection process.

Lessons Learned:
- Giving small community-based grants from project funds can extend the resource base and participation in a project. Some found that the availability of grants created an expectation that could not always be met.
- While making resources available in a community is positive, think beyond the immediate tangible resource to maintenance and sustainabilty.
- Some activities were resource intensive – the energy and time commitment were not always anticipated.

Building Connections with Others as a Capacity Indicator

Participation with active involvement, creation of social networks, representative membership and management of barriers, foster community connections, augments the social capital or social support networks in a community. The latter is a determinant of health.



Findings:

- In the few communities with lower levels of connectedness and high staff turnover, the relationships between the health sector and the community were not strong.
- In projects with higher levels of participation, influencing variables appeared to be
    - a deliberate plan to enhance connections and social networks
    - support of the leadership in the community and/or key organizations related to the project
- Some projects lamented the lack of participation and said they did not know how to enhance it
- Several groups were hoping to have volunteers to assist with project work or for sustaining an activity. For the most part this volunteerism did not materialize. Where volunteers were evident, it seemed to evolve from small groups where trust and confidence had been established and people had a personal desire to see something happen. Sometimes potential volunteers were provided with learning opportunities.

Lessons Learned:

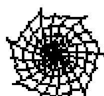
- Reducing barriers to participation helps (examples babysitting, transportation)
- Most groups would like greater community involvement/participation – there is a need to learn to be more people focused rather than program focused. While some projects said they learned this, others would like to make this change.
- Connections with parents were usually missing no matter how the project worked with the school/education sector.
- Work with a single community rather than trying to tie several communities together in an artificial way.
- Genuine involvement of people is important, but unsure how to make this happen.
- Getting people to volunteer their time is challenging.
- Giving people skills and support may enhance motivation and community involvement.

<u>Reflection or 'Asking Why' as a Capacity Indicator</u>

Reflection is about learning and looking beyond what is happening to determine connections asking why something is working, not working and gaining understanding of movement towards long term goals.

Findings:

- There was diversity in the building of capacity for reflection. Not all groups knew about or were able to use this process during their project.
- Groups with regular times for reflection were fewer. Taking time for reflection appeared to be either, their usual way or working and/or a function of their leaders.
- Some groups became immersed in activities and felt they had 'no time to think'.
- The required evaluation process often stimulated reflection.
- A few groups used learning opportunities to build their capacity in 'asking why' and to analyze. Usually these groups had spent time working on a vision for their work.
- When given the opportunity, for example through participation in PPDS, almost everyone could make connections between their work and community changes. It was sometimes more challenging to analyze how a change happened (or did not) or what would be needed to sustain a change.



Lessons Learned:

- Take the time needed to look at lessons learned. When you 'study' what is happening in your project, you will find out what has worked well, what will work.
- Start small and then branch out slowly, remember it takes time. Do some planning before you act.
- A large scope to a project or too many planned activities can make a project too challenging.
- At the beginning give people the time to have their say rather than jumping in with the money, especially if you are an outsider.
- Consider the best use of paid project staff. This additional support can buy not only time to do the work, but also time to allow reflection. There may also be a down side to paid staff:
    - staff gone, project stops
    - other staff members do not integrate the community development work into their job
    - transfer from paid staff to others takes time and planning and may require organizational support

Sustainability

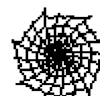
Sustainability is more than the ongoing nature of a specific program. It is sustaining the capacity of individuals, organizations and communities to mobilize, as needed, for new health promoting action. Many factors can contribute to sustainability, for example, the relevance of work to the community and local community and program variables.

Findings:

- There have been many successes in diabetes prevention interventions in Saskatchewan. Some community members are becoming the change they want to see.
- Sustainability is not an idea which most projects have addressed directly. A few groups considered sustainability right from the start of their project. Others are only considering this as the funding closes or they realize that some of their initiatives may not be sustainable.
- There are positive examples of organizational support that will enhance sustainability. A few groups have had to work hard to get initial organizational support and to retain it.
- Knowledge and skills have been acquired through community-based health education. Funder-supported education opportunities have helped to influence change in the projects' work.
- Most groups believe that the partnerships and connections built with community members will continue. Two groups which have completed their funding are examples of this sustainability.
- The sustainability of purchased or locally developed resources is unsure

Lessons Learned:

- Investments in people can have longer term benefits. One example is the training fitness instructors for communities with few recreation resources.
- Learning opportunities are an investment and participants can take their knowledge and skills to other locations or other projects or use them for their own benefit. In one project, three of the group members who were unemployed at the start now have jobs.
- Sustainability is not just about money. Role models and mentors and those who consistently work in their 'quiet' ways can influence change.
- Strides in community change go beyond diabetes and its prevention.



Recommendations

The recommendations were developed in two streams: those directed to community projects and those directed to funders. Again they are presented by each capacity indicator and sustainability.

RECOMMENDATIONS FOR COMMUNITIES:

Diabetes as a prevention focus

- A disease prevention focus can be important and give direction to community-based work. Several groups said they had already been doing prevention work, but it was not necessarily linked with or called diabetes prevention. Building on existing strengths and connecting to work already done is important
- In addition to the disease-specific focus, health workers can think about both the project at hand and also the opportunities it does and will provide for building community capacity and community development

Leadership

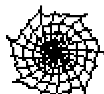
- As groups continue their diabetes or other prevention work, they are encouraged to assess the diversity of their leadership and current strengths.
- As leadership solidifies either in the Health sector or within an intersectoral leadership team, consider working towards capacity building for leadership amongst community members.
- Recognize that developing leadership capacity in others or 'leading from behind' will take time and effort, but the capacity built has the potential to add to the health of the community.
- Where community-based leadership has been established, continue to foster and promote this involvement.

Partnerships

- Partnerships can add value to prevention work; enhance sustainability and capacity so a community can address health determinants.
- If partnerships are new, they will need ongoing nurturing. While an activity(ies) may help focus a group, it is also important to pay attention to:
    - creation of common vision and goals
    - group process as well as the group's actions/activities
    - deal with conflict and different perceptions 'up front'
    - consider smaller numbers to begin and then grow the partnership from a base of strength
- When projects end, think about how the partnerships can support other community based work to promote health and address determinants of health.

Resources

- In ongoing diabetes prevention work, consider moving beyond health education to strategies that involve community members in creating supportive environments.
- A small grant process with well defined criteria, an accessible application process and relevant selection criteria, can extend resource mobilization in a project.
- Capacity building may be needed to support and give confidence to community members to write a grant application and be able to implement their project.
- The Canadian Diabetes Strategy has facilitated the development of many learning resources all across Canada. Find out what has already been done before creating more.



Building Connections with Others

- Assess the social supports in the community; determine the strengths, connections or usual ways of working together.
- Make many overtures to get people involved. Try to build diversity and include people with different perspectives. Listen to the voices of the community. Listen for their values. Show respect and dignity.
- Work to get group diversity, and then work with those who show up ensuring their involvement is genuine and follows community development principles.
- When working in the schools, find ways to involve parents. Multiple strategies and time commitment may be needed.

Reflection/Asking Why

- Give yourselves permission to build in time for reflection. This can be short and regular times – for example, sharing circles at the start or end of a project meeting.
- Use tools to help with reflection – see ideas in the report Appendix.
- In project planning, think big, but consider starting small and learn from your work to build the next stage or phase.
- When there is paid project staff,
    - talk about and learn how to integrate capacity building and community development into everyone's work
    - prepare for the transition when paid staff is no longer available – use observations and reflections to assist with this transition

Sustainability

- Recognize your successes – celebrate them and build on them in your next project.
- Look at where you want to go in the long term to address determinants of health, not just the immediate goal for a project.
- Recognize the importance of knowledge and skill transfer to other aspects of community development and capacity building and actively promote and enhance this.

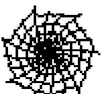
RECOMMENDATIONS FOR FUNDERS

About diabetes and capacity building

- Continue to fund disease specific projects while also focusing concurrently on broader dimensions of health – population health promotion: strengthening community action, supportive environments and healthy public policy.
- Assist communities, through the funding process, to take a multi-focused approach that includes capacity building and community development.

About proposals for funding

- Funders may be able to encourage new roles for professionals and support building community-based project leadership.
- Emphasize quality of partnerships versus quantity. Request a small number of partners who can provide information about their actual or potential contribution to a project not just a 'letter of support'
- Require reflection or 'asking why' as part of the project process.
- Encourage process outcomes as well as quantitative ones



- When the project will be done by a new team or a team working in a new way, consider small amounts of developmental funding and time that will yield a foundation on which to build project activities and outcomes.
- Require sustainability planning as part of the project development process.
- Encourage groups to report beyond successes. To support reflection and 'asking why' and build community strength, there is much to be learned from things that did not work out as anticipated.

About sufficient time for building capacity

- Allow sufficient time pre-application deadline and/or when funding is received for groups to work on partnership development.
- Recognize that groups working on leadership capacity building will need time for results to happen – process will be as important as projects results.
- Building connections with others/social support is often invisible work.
    - Acknowledge that building connections or social networks is important and recognize efforts that have and will be made in this area of capacity building. Allow the necessary time for pre-project work to build relationships in the community.

About building capacity through learning with funding opportunities

- Consider providing learning opportunities for:
    - leadership development amongst sectors
    - practical, 'how-to' perspectives on professionals taking different roles, such as 'leading from behind' using community development principles
- Learning about partnerships is likely to be an ongoing need.
    - If there are new partnerships, consider providing learning opportunities that are practical and inter-active.
    - As partnerships are evolving, learning needs may direct different learning opportunities such phases of group development, conflict resolution.
- Provide resources and learning opportunities for projects to gain knowledge and skill in sustainability planning

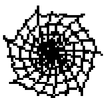
- Ensure that any learning opportunities are for both the professionals and the community members. Projects recognized benefits from the funding provided by Health Canada, Saskatchewan Region for ongoing learning

- Review the results of both the Saskatchewan Health PHP evaluation and the Health Canada, Saskatchewan regional workshops as examples of funders who supported both learning and reflection for community projects.

About sharing results from funding initiatives

Resource development, implementation and evaluation happened during the time of Canadian Diabetes Strategy.

- Find accessible methods to share these resources across the country.
- It will be important not only to share tangible resources, but also to share ways to engage communities in the use of the resources and ways of working on resource mobilization which are less tangible (spiritual, cultural, political)



Introduction

In late 1998 the federal government announced a five year (1999-2004) Canadian Diabetes Strategy (CDS). The strategy included funding for diabetes prevention initiatives through three streams (Prevention and Promotion; Aboriginal Diabetes Initiative for First Nations On-Reserve and Inuit in Inuit Communities; and, Aboriginal Diabetes Initiative for Metis, Off-Reserve Aboriginal and Urban Inuit). Saskatchewan groups received funding from all three streams.

The overall purpose of this project, Primary Prevention of Diabetes in Saskatchewan (PPDS), was to document the contribution of diabetes prevention projects in Saskatchewan in developing capacity for people, organizations and communities to promote health.

The data, lessons learned and recommendations will be used to
- enhance development and capacity building work
- guide future primary prevention work related to diabetes and other chronic health conditions
- identify recommendations and next steps for action

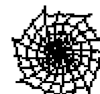
The Funding Strategies and Participation in the Present Study

1. Aboriginal Diabetes Initiative (ADI) – First Nations On-Reserve and Inuit in Inuit Communities Program (FNOIIC). In Saskatchewan Region all funds were distributed to First Nations communities based on submission of work plans. The ADI has three components: care and treatment; prevention and promotion; lifestyle support.

   Ten ADI-funded groups participated in PPDS.
   - There was good geographical distribution of the groups: 2 from the southern communities, 4 from the central communities and 4 from northern communities.
   - One focus group was conducted at the Tribal Council level, one group had only community members participating, 3 groups were from independent First Nations and 7 groups were members of a Tribal Council
   - Six groups had direct access to ADI funding and 4 received no direct funding, but had access to support staff from their Tribal Council

2. Aboriginal Diabetes Initiative – Metis, Off-Reserve Aboriginal and Urban Inuit Prevention and Promotion Program (MOAUIPP). This funding was allocated through a proposal submission process nationally. The program's funding was administered from Ottawa. The program focus was prevention and promotion.

   Four projects were funded in Saskatchewan. One of these projects also had funding from Health Canada, Saskatchewan Region. Two projects completed



their funding March 31, 2003. The other two projects, with funding continued to March, 2004, participated in PPDS.

These groups had the support of a Health Canada Project Coordinator, but did not receive education related to project development.

3. Prevention and Promotion – Regional Funding. In Saskatchewan seven projects were funded regionally based on a proposal submission process. Six of the projects participated in PPDS. Four projects completed their funding March 31, 2003 and one began its funding in early 2003. One project also had funding from Saskatchewan Health.

   These groups had the support of a regional Health Canada Project Coordinator. The Coordinator organized three workshops for the projects:

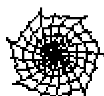
- Soon after funding was awarded, there was a workshop on program evaluation (September 2001).

  The workshop had three primary objectives for participants:
  - Describe the logic of their program goals and activities
  - Identify key elements in their program evaluation activities
  - Plan their evaluations including identifying desired outputs, outcomes, and linked indicators, and outline evaluation data collection methods using a program logic model approach

  During the workshop groups had the opportunity to work on their evaluation plan and some also realized they needed to reduce the scope of their project to be more realistic and reflective of the available time and funding.

- A telehealth session on the "Tickle Trunk" tools was presented in November 2001.[1] The evaluation indicated that participants appreciated the Telehealth format for the training because of the convenience and the ability to connect with others across the province. It was also noted that the technical problems, the limits of the locations and the pacing of the training were unsatisfactory for some. Overwhelmingly respondents said that the practical application of the Tickle Trunk resources was the most helpful portion of the training. Following the session there was a 50% increase in the use of the Tickle Trunk.
- Workshop on Partnerships, September 2002. All regionally-funded diabetes prevention projects were invited to this two day workshop and attended with other Population Health funded projects.

  The workshop goal stated: participants will implement a partnership development strategy designed to sustain their population health work. The



specific objectives were that by the end of this workshop, participants would have:

1. built on their existing understanding of how to integrate partnership development and community capacity-building into their population health work, using the Labonte workbook "How our programs affect population health determinants: A workbook for better planning and accountability" as a starting point
2. applied tools designed to develop, sustain, evaluate and terminate, if appropriate, partnerships
3. identified or renewed opportunities to develop partnerships in Saskatchewan and elsewhere
4. developed the beginnings of a partnership development strategy for their population health project that allows them to build community capacity and work towards project sustainability

Generally the response to the workshop was positive. The attendance by a variety of Health Canada funded projects provided an opportunity for networking with others beyond those with a diabetes focus.

As participants came from several Health Canada programs it is not possible to isolate the responses of those who were part of diabetes prevention projects.

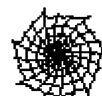
- In addition, the Project Coordinator provided resources for the funded projects to attend the Summer School on Physical Activity held at University of Saskatchewan, August, 2001. Four project groups participated.

Other Diabetes-Related Activities

Immediately prior to and during the time of the Canadian Diabetes Strategy, in Saskatchewan there were several major initiatives to stimulate thinking and action around diabetes prevention and building community capacity. Each will be reviewed briefly.

1997 – 2000 *Saskatchewan Advisory Committee on Diabetes*. This committee was initiated by the Saskatchewan Minister of Health in response to the increasing number of people with diabetes in Saskatchewan, particularly amongst Aboriginal people. The work of the committee was presented to the Minister in April, 2000 as *Diabetes 2000: Recommendations for a Strategy on Diabetes Prevention and Control in Saskatchewan*.[2]

Of note in the document are two sections, one on the primary prevention of type 2 diabetes and, the other, on diabetes and Aboriginal peoples. The section on primary prevention provides evidence for primary prevention, principles for



action, and defines priorities and recommendations for action. The appendix is a primer on diabetes prevention. The section on Aboriginal issues, recommends for primary prevention, the development of a culturally sensitive, community-based, wholistic model of prevention strategies to reduce the incidence of diabetes.

August, 1999 Health Promotion Summer School – This Summer School focused on determinants of health, causation, principles of and strategies for health promotion practice. The School divided participants into theme groups to discuss and apply the learning. One theme group was on diabetes prevention. For some this was a precursor to the Saskatchewan Health call for demonstration site proposals.

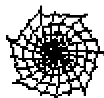
1999 – 2003 *Primary Prevention of Diabetes – Seven Demonstration Sites, Saskatchewan Health*. In 1999 Saskatchewan Health initiated a call for proposals for demonstration sites using a population health promotion model for diabetes prevention. The Department's document, *Population Health Promotion Practice in the Primary Prevention of Type 2 Diabetes*,[3] provided guidance to applicants and was used widely by others later on as an introduction to diabetes prevention. The Department funded seven demonstration sites from January, 2000 - March 2002, with five receiving additional one-year funding in 2002-03.

Saskatchewan Health provided several capacity building workshops for the Health Districts and their partners and the demonstration sites:

- *Getting Started*, September 1999 for Health Districts and their partners provided orientation to the population health approach and the preparation of proposals
- *Evaluation Planning Workshop*, March 2000 for the funded demonstration sites, gave projects more information about evaluation and time to apply an evaluation model to their own project.
- *Partnerships: Building on our Shared Experiences*, October 2000, was open to all Health Districts and their partners and demonstration sites. The focus was on evidence for working in partnerships, readiness to partner, what to do when the going gets tough and the care and feeding of partnerships. Throughout there were opportunities for small group discussions.
- *Planning for Sustainability*, March 2001, was hosted for the demonstration sites and allowed participants to examine what they wanted to and could sustain beyond the life of their project. Each project had an opportunity to develop a plan to achieve sustainability.

The results from the final evaluation report[4] on the application of the population health model by the demonstration sites are summarized in Appendix B.

February, 2002 – *Build Better Tomorrows – Working Together on the Determinants of Health*,[5] a 2½ day workshop co-sponsored by Health Canada and Saskatchewan



Health was planned in partnership with representatives of a wide cross section of organizations. The program was designed so that participants would:

- Learn about conditions that support health
- Know what communities are doing to prevent diabetes
- Learn about the eight population health promotion ideas
- Strengthen connections among health professionals

PPDS Project Design

Project Values

PPDS used a Human Centered Development (HCD) approach in both the project design and implementation of the methodology. Human centered development means

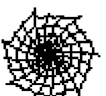
> "development with a human emphasis that recognizes the importance of dignity and confidence building, communication and relationships, critical thinking and learning, and relevant and empowering actions ... creating opportunities for people and communities to pursue goals that are their own and which aim to improve the quality of their lives..."[6]

With HCD as a foundation and guidance by the Reference Group, project staff ensured that the interaction with individuals and groups followed all the HCD principles. Given the nature of community development and capacity building, we planned not only to gather the experiences and learning from community projects, but also we hoped to leave behind the opportunity for reflection on practice and community based knowledge for future work. Based on the comments at the conclusion of almost every session, we believe that the discussions did provide an opportunity for reflection.

The values were also used as a framework to write about the results, create the recommendations and provide resources in the Appendix to promote and enhance capacity building and community development.

Methodology

Two expert sources provided input into the methodology for PPDS and were also involved in reviewing results and forming recommendations: a Reference Group[7] and an external community researcher[8].



PPDS Project Questions

PPDS was not an evaluation of the funded projects. It was a 'cluster' evaluation. Cluster evaluation

> "focuses on progress made toward achieving the broad goals of a programming initiative. It looks across a group of projects to identify common threads and themes that, having cross-confirmation, take on greater significance. Cluster evaluation provides feedback on commonalities in program design, as well as innovative methodologies/best practices." [9]

The long term promotion and prevention goal of the Canadian Diabetes Strategy (CDS) is prevention of type 2 diabetes where feasible. Related long-term outcomes are

- Development of multi-sector approaches with greater intra- and inter-sectoral collaboration and consistency of actions
- Prevention of diabetes
- Build capacity to manage sustainable diabetes programs
- Provide lifestyle support services to First Nations and Inuit people

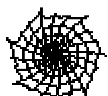
Given the community development component of the CDS evaluation strategy and the desire for strengthening of community capacity as an intermediate outcome, the focus for PPDS was developed around capacity building. In the short time for which funding has been available for projects[i] Health Canada, Saskatchewan Region wanted to determine:

1. What capacities were developed, enhanced or changed during the lifespan of the projects?
2. What capacities are/will be sustainable?
3. What are the lessons learned?
4. What are the recommended practices for capacity building and the next action steps?

Methods

Based on the review of the capacity building literature, a summary paper was developed for the Reference Group in May 2003. Using this paper as a guide, the Reference Group discussed indicators of community capacity building and recommended five key ones for PPDS. The number of indicators was limited as it was not possible to explore them all given the short contact with each group. PPDS attempted to maximize the number of participating groups.

Using the recommended capacity indicators, an interview guide was developed for focus group discussions. The guide was reviewed by external experts including a member of the Reference Group with experience working with First Nations communities and the external community researcher.



[i] In this report the term 'project' refers to both proposal-driven, funded projects and also the work plan driven activities in First Nations communities in Saskatchewan.

The project proposal and interview guide were reviewed and approved by the University Of Saskatchewan Behavioural Research Ethics Board.

Focus Groups
As previously described seventeen focus groups were done representing sixteen projects. One hundred and five persons participated in the discussion groups. One project, a large partnership, was unable to participate as a whole and four key informant interviews were done with partnership members[ii].

The same facilitator led all the groups. The focus group process used the journey wall concept[10] to represent the life of the project. Projects were asked to talk about the time prior to the project, what prompted the need for the project and then to discuss how they got organized to do the work. Rather than follow the interview guide directly, and in accordance with the project values, the questions were interspersed with the story told by the project members. During the break, the facilitator reviewed the guide and then raised the questions which had not been included in the discussion of the project's journey. This method seemed to be both informative and relaxing for the participants. Many were surprised at the extent of their accomplishments.

A recorder was present for all the group sessions. Notes were taken as close to verbatim as possible. A typed copy of the notes was sent back to each project for validation. Projects were also provided with a short summary and could decide if they wished to have this published in the report. The summaries are in Appendix A.

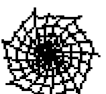
Data Analysis
Analysis tables were developed by combining all the data about each indicator from all focus groups. The major themes were verified by two other observers. Each of these observers attended about half the groups as the recorder.

The themes were then compared to relevant literature about the capacity indicator. Using both the literature and the PPDS findings data, a continuum was created for the indicator. The data were used to describe the continuum.

The Reference Group received summary data and met to review the findings, original questions and to develop the conclusions and recommendations.

PPDS Project Limitations
1. The specific context of each CDS-funded project was not the same. There were differing physical, economic, political, organizational and cultural environments in which the CDS-funded projects occurred. Not all projects were at the same 'stage' when they participated in PPDS. Some had completed their final evaluation; others

[ii] The key informant interviews were not used in data analysis as the focus and goals of their project were not congruent with the community-based initiatives. The key informants' comments were considered with others in the recommendations.



had gone on for 2-3 years and one for only one year. A few projects, mainly due to staff turnover, were 'in limbo'.

2. There were some limitations inherent in the methodology selected:
   - Participants did not receive the questions in advance. There was no audio recording of the sessions. A second facilitator took notes. A transcript of the session was sent back to every group to validate that our understanding and interpretations were correct.

   - The selection of focus group participants was done by the key contact for each project. This individual received written guidelines for selection and these were discussed before the selection began. The representativeness in the focus group membership may have been affected as the selection process was not independent.

   - The amount of time spent with each project was limited. The average focus group lasted about 2½ - 3 hours. This was a generous donation of time by busy people. Many groups also had written documents to supplement the discussions, but usually, for the purpose of PPDS, there was greater depth in the discussions than in a written material.

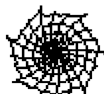
     PPDS was not about project evaluation or an in-depth understanding of the project activities, but rather the use of project experience to describe capacity built. Not everyone found it easy to articulate their capacity in different areas. Being sensitive to the group and applying the project values, not all questions were asked in all groups. Capacity building was the filter for PPDS, but not necessarily that for the projects.

Spinning the Web of Community Capacity

It can be useful to create an analogy to explain and understand complex ideas.

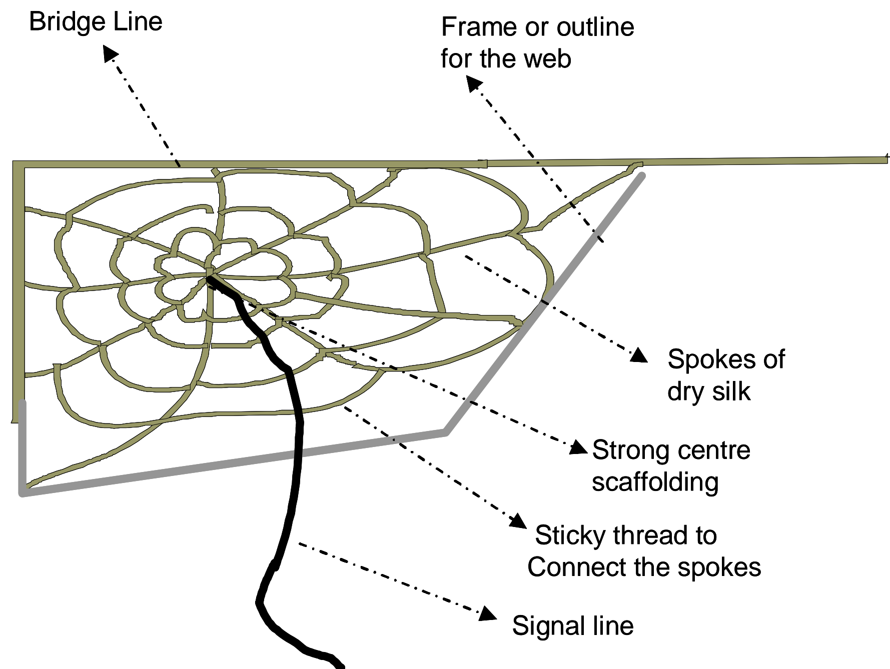
Community capacity building is not a single concept or idea. Capacity building can be both a process or way of working and also a result or outcome of work done. Given the diversity of the projects, a broad guiding definition of capacity building was needed for PPDS. In addition, the capacity building has likely occurred on multi-levels (individual, organization/agency and community) both prior to and during the funding period. The following definition of capacity guided PPDS:

> *Capacity building is an approach to the development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over.*[11]

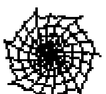


Community capacity building can, in many ways, be compared to the work of a spider building a complex and intricate web. There are invisible parts to both web making and capacity building. The finished web, like capacity in a community, has strength, provides nurturing and needs to be nurtured.

Figure 1: Building a Spider Web



The Spider Web Analogy	Capacity Building in Communities
• Delicate, complex webs are strong and work day and night for the spider	• Capacity building is both delicate and complex and includes many variables. To strengthen the community and continue on beyond a single project, sustainability needs to be considered throughout the project work
• The first silk thread is the bridge line that supports the whole	• Communities have a bridge line that is found in the strength and working together of individuals, groups, sectors and organizations
• First the spider builds the frame or outline	• Funding for initiatives such as diabetes prevention can provide a framework and impetus for capacity building
• The spoke lines are dry silk and the spider can walk on these as the web building continues	• The capacity built in communities can be described using indicators. The indicators show communities the important parts of capacity building, progress made, where to go next.
• To build the spiraling to connect the spokes, the spider spins a strong dry silk scaffolding at the centre	• There is always some capacity in a community. A good starting point is finding the strengths and assets in the community
• The spider then starts a single strand of sticky thread and working	• The capacity indicators are not stand alone, but rather inter-connected. The greater the inter-connectedness in a



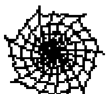
from the inside out, connects all the spoke lines. The longer the spider works, the larger the web will be.	community, the greater the capacity. The connections are amongst individuals, groups, sectors and organizations and these can build a web of capacity over time.
• The spider does not become entangled in the web if it walks on the spokes as these are made of silk and are not sticky	• As capacity building is multi-faceted, community members and workers need to figure out how to work together for a common vision or goal, how to solve problems together and share decision making.
• The simplest webs are irregular and on the ground	• Start small, recognize that strength may not be equal in all areas of capacity, work towards building and involvement of the community
• The spider makes a signal line attached to the hub of the web to vibrate to warn of danger or the arrival of dinner!	• Community members and workers need to build themselves a signal line to allow them to step back from the activities or project to reflect on what's working or not and why. Reflection enhances capacity.
• Some spiders always stay at the centre of their web; others live off the web.	• For change to occur, tension must be present both in the minds and hearts of people between the way things are and the way they would like them to be. Capacity building means moving away from the comfortable centre, building the web larger and working with the tension in a constructive way.

The spider web analogy cannot carry on completely. Spiders know innately to walk on the silk threads of the web so they will not get stuck. In the web of community capacity building, workers and community members frequently wonder where to go next and sometimes get stuck! Spiders do not need to learn how to make a web and they can make one in less than an hour. Community capacity building is ongoing, takes time and progress can seem slow. At times it can be hard to see the web building or to have a sense of being finished. Community members and workers need to learn how to build and sustain community capacity. Hopefully, while there will always be challenges along the way, there will also be lessons learned that make the next part of the web easier to build.

Learning from discussions with diabetes prevention projects

The following section reports on the common themes found in discussions with community members and workers.

To begin there is a discussion of observations about diabetes prevention as groups started their project work.
Then each of the five capacity building indicators (connecting with the community, leadership, partnerships, reflection, resources) is reviewed. The capacity indicators are



like the spokes on a spider's web. The spokes represent a continuation of capacity building observed in the PPDS projects. The further along on a spoke, from left to right, the greater the potential for involvement of a community in creating its own health and generally the more potential for capacity.

The creation of the spoke for each indicator is not meant to place a value on or judge the work done by the projects. It is only used to describe accomplishments. A core foundation or solid base is important and the diabetes prevention work may have helped some groups to build or strengthen their base and perhaps move further along the continuum. Gains can continue to build in new diabetes prevention or other health promotion work.

Together all the spokes are necessary for building community capacity. The whole is more than the sum of its parts. It is artificial to separate them as there are many inter-connections. The separation is made here for a better description of the work done.

In addition to the PPDS findings, there is an introduction to the capacity indicator with a brief definition and description. This is not an extensive review of the literature. Other useful writing about capacity building indicators and their use is found in the Footnotes section of the appendix[12].

Lastly, there is a section on sustainability of project work and capacity built.

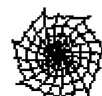
Getting Started on Prevention Work

To begin each discussion group, participants were asked how they got started in diabetes prevention work, what prompted action, what was happening in the community, what were people saying. Amongst the First Nations participants a common response focused on the negative attitudes about diabetes and the seemingly sudden awareness of the degree of diabetes complications such as amputations, dialysis and blindness. The 'attitudes' were common amongst both the people already diagnosed with diabetes and other community members. The other variable which sometimes sparked action was the diagnosis with diabetes of a child or young adult in the community.

> *No attention was paid to diabetes until there was a client on dialysis. Two others soon followed ... Then diabetes became something that was talked about in the community*

> *... they were afraid to talk about diabetes – they just assumed in First Nations that diabetes would happen – it was like they did not understand or have the power in realizing that they could prevent diabetes*

Other groups said they had been working on what might now be termed 'diabetes prevention' for some time, but they might have called it by a different name or their work may not have been as extensive as during the CDS funding period.



Some groups used information or data to get them started. One group did an extensive screening of all school children (1000+) and although they did not find anyone with diabetes, they did find that many children were 'heavy'. Another project, which had done an extensive screening with adults, presented the data to small groups asking community members about their thoughts and ideas for what needed to happen to prevent diabetes.

The opening questions prompted some to talk about changes they had seen in their life time – the integration of different foods into the diet over time – white flour, junk food, sweets; the loss of gardening skills and gardens as a source of fresh vegetables; walking as an everyday activity – it became a sign of poverty, if you had money you drove rather than walked.

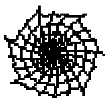
In the few non-First Nations groups that participated in PPDS, the origins of the prevention work were not as personal and tended to be seen as a gap in services. Professionals often recognized the high incidence of diabetes, the need for more prevention efforts.

Leadership as a Capacity Indicator

In the literature, leadership as a capacity indicator is described as the leadership amongst community members. Without a strong base of actively involved residents, there will be less capacity in a community.[13] Leadership needs to spread amongst a wide variety of persons with different networks, skills, interests, power bases and can include both formal leaders (such as those who are elected, appointed or health workers) and informal leaders. Often leadership for projects, such as the diabetes prevention ones, may start with the paid staff or professionals and then be transferred to the community members. This transfer is usually a gradual process and capacity building may include the development of new leaders.

Community capacity will be greater when the leaders, no matter the source, respond and are accessible to the community members, the leaders are …"visible and involved, promote cohesion and involvement, support members' planning and decision making and provide opportunities for members to make active contributions outside meetings."[14]

Bopp and Bopp[15] discuss leadership provided by professionals in community development. They suggest that professionals need to resist the role of "expert" or problem solver and work at leadership from behind, working *with* rather than for people, facilitating so that others will learn and develop. Often projects or activities are initiated by professionals and it will take deliberate action to move towards community empowerment and control. Bopp and Bopp's suggested mechanisms for this movement are: capacity building of leadership; accountability to both funders and the community;



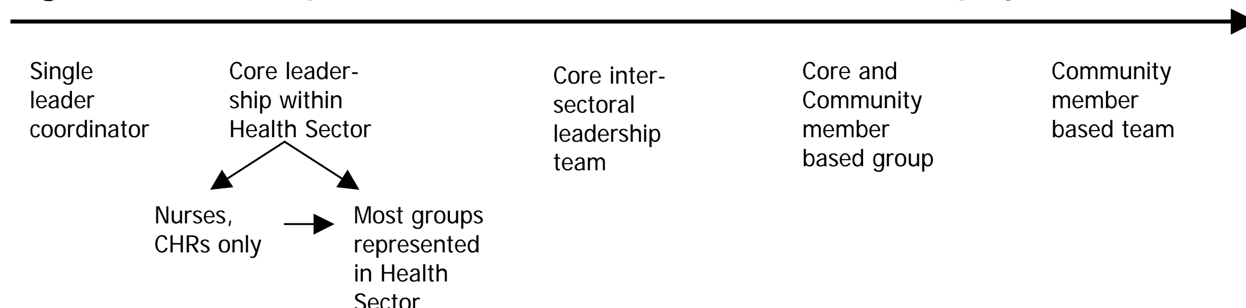
facilitating a shifting of roles so that the professional becomes someone who provides technical support and mentors others.

One of the population health promotion principles focuses on working towards empowerment and public participation. Part of empowerment is leadership in decision making and taking action that will affect the community's health. Primary prevention work can be an opportunity to foster community-based leadership.[16]

Leadership in Saskatchewan projects for diabetes prevention

Several types of leadership were found in communities working on diabetes prevention. The leadership range included: a core leadership team within the Health sector; a core inter-sectoral leadership team or a combination of a core leader/team and a community based group(s) sharing responsibility and accountability for leadership. Two potential dimensions were added at opposite ends of the continuum: a single leader/coordinator and a community member team carrying most/all of the leadership responsibility/accountability for the project.

Figure 2: Leadership as a continuum in Saskatchewan diabetes projects

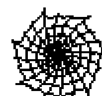


None of the communities relied on a single leader or coordinator. If there was an identified paid coordinator/worker for diabetes prevention, this individual was part of a leadership team either within the Health sector or an inter-sectoral team.

In the majority of groups, leadership was based within the health sector and most groups brought together several types of health workers. Examples of the types of workers included: CHRs, diabetes project worker(s), community health nurses, Home Care nurses, addiction worker(s). In one group, it had become their practice to form a project team with all types of health workers represented and sharing accountability and decision making for any major health initiative.

This group is the formal leadership. It works well to get the different ideas and you don't feel so alone in what you are doing.

There were several examples of a core inter-sectoral leadership group for the project. Frequently involved sectors were Health, Education, Recreation, Community-based organizations or groups.



In three groups leadership came from two sources: a core professional or group and a community member group. In all cases, this community leadership evolved over the time of the project. Originally the professionals had all or most of the leadership function. The professionals worked deliberately to evolve, promote and sustain the community leadership. All three groups gave examples of the fragility of the community leadership and support needed to sustain it.

None of the projects started, or had at the time of the data collection, a group of community members who functioned without core leadership from professionals.

Other aspects of leadership in projects

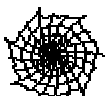
Responsiveness to community needs by the leadership:
It was not possible to fully assess this dimension. There were some examples of an organized determination of community needs via surveys, needs assessments. It was not always clear how results were used and if feedback was given to those who were surveyed.

Some found prevention to be an extension of pre-existing work and they often carried on their leadership in the 'usual' way. Examples include: one community with a long term community development strategy and an annual community meeting to discuss health issues; a pre-existing working relationship between sectors (health/education) which carried on with its mandate.

Many groups were forming new relationships and leadership was responsive to group needs and interests. Many groups had few or no community members as part of the project leadership.

New leaders/informal leaders/formal leaders in projects:
The specific 'work' of two projects was to develop leadership - one in school children and the other in parents/community volunteers. In both cases specific strategies were used for leadership development. In another community, youth and younger workers were identified as the future leaders, not specifically related to prevention. This community's philosophy included a responsibility to mentor and develop these new leaders.

In some cases, people with diabetes, as they became more confident about themselves, and acquired a perception that diabetes can be self-managed/controlled were then informal leaders in changing the perceptions of others – telling their own story to other community members, in schools or other groups and encouraging the need for diabetes prevention.



Elders were mentioned as leaders in prevention work. A few groups identified a gap in their program as Elders were not involved. Some acted on this gap; in other cases it

was just recognized. The range of Elder involvement varied: minimal (came when invited to classes) to increasing and extensive involvement (taking a leadership role in bridging between health/education and working with school age children)

Leadership sometimes emerged outside the formal project through community based grants of small amounts of money. Sometimes this was given to formal/professional leaders or organizations/agencies, but also there were some examples of the grants facilitating small numbers of community members to take leadership and action such as holding a community walk for diabetes, planting a community garden.

With the exception of the projects mentioned above, there was little evidence of the formal/professional leadership consciously devolving the leadership with a vision and plan from themselves to others in the community. Some would like to see this happen, but question 'how'. Perhaps some needed time first to build their internal relationships amongst the professional workers as they often cited examples of stronger working relationships amongst the members of the health staff.

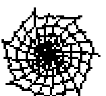
Other comments:
There were other comments about leadership that were not prevalent in more than one or two groups, but may inform leadership capacity in diabetes prevention.

- Some groups identified 1-2 leaders who had the vision or spark to get their project started. It appeared that the individuals may have been the early spark, but ongoing leadership was shared.
- The quality of the project leadership was sometimes related to specific variables: turn over or stability of the health workers, strength of or respect for an individual.
- The change or planned exit of paid staff also provided opportunity to re-focus and think about alternatives for leadership.

At the conclusion of discussion around leadership, several groups indicated a desire for more community based leadership/volunteers. In groups that did attempt to disperse the leadership, there was recognition that this is difficult, takes time, takes planning and needs some ongoing support to be sustained.

Partnerships as a Capacity Indicator

Forming strategic partnerships is a basic tenet of a population health approach. It is challenging for a single group or sector of society on its own to address health determinants.[16] Structures are the inter-organizational networks in a community and how they work together. By building the capacity of 'working together' it may be easier to address health, social and other issues.[13] Community mobilization is better when networks amongst organizations and groups are developed. Power and influence have the potential to be greater. The presence of inter-organizational networks or



partnerships will not on its own increase capacity. If there is distrust or suspicion, turf protection, the network will not support its members.

There is always a risk that if the network or partnership started because of the appearance of external funding, such as for diabetes prevention, when the funding stops, people will stop coming.[15] Bopp and Bopp recommend limiting the number of partners in order to build a group with trust, common vision and capacity rather than just a list of names on paper to indicate support. A challenge may be the requirement of partnerships by the funding agency.

Bopp and Bopp also discuss structures in the context of conflict between a service delivery model versus a community driven approach. The desire for a service or the prompting of external funding may lead to professionals identifying issues or problems and then trying to solve them. Some community members may be involved, but it is the professionals who set the goals, objectives and success indicators. The core of community development and capacity building is community members both learning and then finding their own solutions. Eventually the thinking and energy of the community members needs to drive the process.

Partnerships in Saskatchewan projects for diabetes prevention

To review the networks or partnerships in the projects several dimensions were considered:

- Was the partnership a new one formed for this initiative or an extension of existing 'working together'?
- Which sectors were included in the partnership and what was the extent of the inclusion?
- Did the community have a pre-existing inter-agency group(s)? Did the personnel or groups involved in diabetes prevention have or make connections with the inter-agency group?
- Did the partnership group consist of front line workers, formal leaders, or both and what was the connection to formal leadership in organizations?

Due to the scope of discussions with projects, not all of the above questions were answered in-depth. There was enough information to create a 'spoke' of the partnership structures in diabetes prevention.

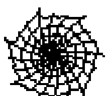
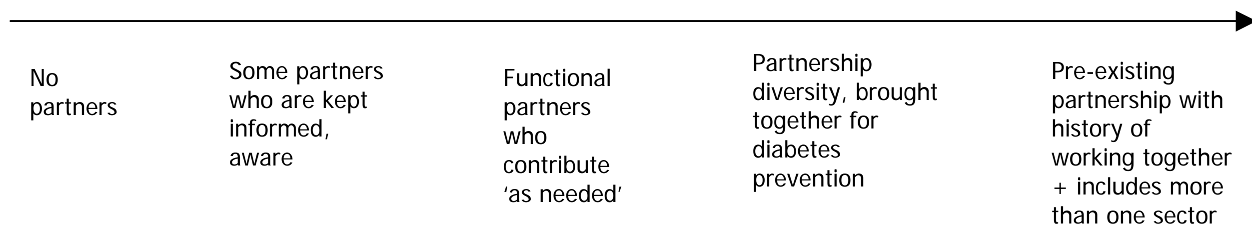


Figure 3: Partnerships as a continuum in Saskatchewan diabetes projects



None of the diabetes projects actively engaged in prevention were in the 'no partners' category. Even when the leadership was limited to the Health sector, groups had partner-type relationships, at some level, in other sectors in the community.

> *There was some attrition from the beginning meetings, many did not come along and stay involved. Some people changed jobs and no one replaced them … some were too busy and they did not send someone else. People needed to have more than just an advisory role to keep them involved in the project so they did not fall away.*

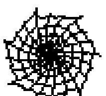
Some groups, who had solicited many letters of support, considered the letter writers as partners and did make an effort to keep these supporters informed and aware of their activities. These supporters were rarely asked to contribute and did not regularly come to partnership meetings. However, the supporters were often referred to in project discussions as partners.

Functional partners were those who got involved on an 'as needed' or ad hoc basis. Examples of this level of partnership might be a 'partner' who sponsors an event, makes a donation, or has limited, but specific, interaction with the group by requesting a presentation etc. Or the prevention workers may ask the partner, 'can we make a presentation?'

Partnership diversity brought together specifically for diabetes prevention was common. The groups in this category may also have functional and/or 'kept informed' partners. In the partnerships with diversity, work was done to create a vision, goals and work together for common outcomes.

Usually the diversity partnerships were new, particularly for those outside the sector holding the prevention funding. These groups had never worked together or had only worked together in a limited way on other projects or community initiatives. The challenges of partnership building are well documented in other diabetes prevention work, community project descriptions and the literature. The diabetes prevention groups enjoyed all of these challenges to a greater or lesser degree. For the most part, groups were happy with and excited about the new connections.

> *The partnership between Health and Recreation is a new link. There is information sharing and we can access each others networks.*



Pre-existing interactive partnerships were less common amongst the diabetes prevention projects. To be in this category a partnership needed to exist prior to the diabetes prevention work and to have evidence of partnership building – vision, goals, objectives, plans and evaluation together.

A few examples around partnership stand out in the diabetes prevention projects:

- One group with a pre-existing and longstanding partnership between health and education was able to work at both the front line worker level in the partnership and to get the attention of the decision makers (Boards) in both sectors. Discussions between the Health and Education Boards led to a decision to remove the pop machines from all the community schools.

- Only a few groups described linkages between their partnership and the formal community leadership or government. Groups implied that things related to health were not a concern to the community leadership unless specifically identified by the Health sector.

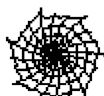
> *…they know what's going on, they approve our minutes and will get back to us if needed. Everything must be good as nothing comes back. It's not a priority around their table, but if we brought something up … they are supportive, but leave health to the experts*

- One potential partner, not always mentioned in other sources, was the local community store. In some communities there was only one store and the travel time and conditions to larger stores were challenging. Several groups recognized the need to work with their local store to increase the access to affordable, healthy food choices. Not everyone attempted to work with the local store. If they tried to work with the local store, most felt they were unsuccessful.

  One group, with a newly established community store, was able to change the selection available in the store, getting more variety and the availability of healthy food choices. In exchange, the health workers encouraged the use of the store with the prenatal food vouchers, purchase of healthy foods from the local store for community events. The successful change seemed to arise from working together by several members of the health sector and local government and the commitment to bring business to the store whenever possible.

- Some partnerships already had or were able to establish linkages with the community's inter-agency community. Some described benefits in working together to address issues such as recreational activities and resources for youth.

- Partnerships between Health and Education were mentioned frequently. As there are so many facets to this type of potential partnership and capacity



building requires inclusion of all the areas it is addressed in a separate section as case study later in the report.

Resources as a Capacity Indicator

The concept of resources can be very broad. Only selected aspects of this indicator, as described in the literature were found in the PPDS data.

Goodman et al[13] talk about two types of resources or capital: the traditional (property and money) and social capital (knowledge and skills of people, cooperation and new associations amongst people). Building capacity means building two types of resources:

- Increasing access to and sharing of resources inside and outside of a community
- Building social capital which is the generation of trust, confidence, relationships and cooperation amongst community members

The discussion of social capital is found in the next section on building connections.

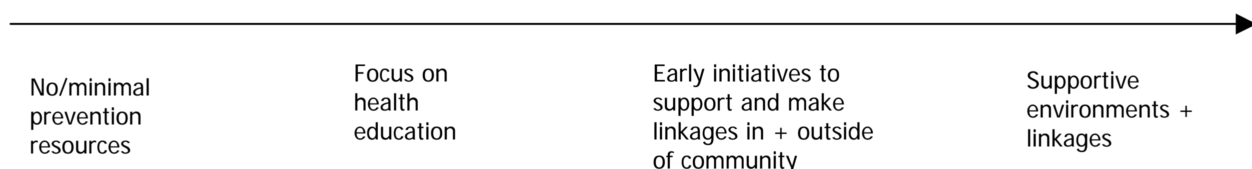
Bopp and Bopp identify seven domains for capital: spiritual, cultural, natural, knowledge, social, political, financial/infrastructure. They believe that investment is needed in all the domains.[15]

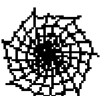
In population health terminology, resource capacity building aligns with creating supportive environments. As above this is not only the physical environment, but also access to resources, implementation of policies, economic development and putting financial resources towards working on determinants of health. Creating supportive environments is a broad idea or concept.[16]

Resources in Saskatchewan communities for diabetes prevention

Discussion of this indicator illustrated the diversity of the work being done in communities. The use of the word 'resources' in questions to the project groups, usually brought forward discussion of tangible resources. Probing questions were attempted to access information about less visible resources.

Figure 4: Resources as a continuum in Saskatchewan diabetes projects





Two groups had minimal prevention activity at the time of our discussions. There is further elaboration on this in the next section, building connections.

Health Education Many groups started their resource investment with a focus on knowledge about diabetes as a disease. Most advanced to provide information about diabetes prevention particularly related to healthy eating and increasing physical activity. A few groups seem to have made a conscious decision to focus on the prevention components and to not worry about whether or not people/students understood diabetes as a disease.

There was also investment in the purchase or development of resources and making them accessible to others.

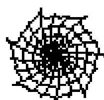
Early Initiatives to Support and Create Linkages Early initiatives to create supportive environments were seen in many projects. If the resource mobilization was primarily initiated by health workers and still required their involvement to exist, then this category was used to describe the activity.

Examples of early initiatives included walking clubs and walking pathways in communities; healthy food choices available at public gatherings and meetings, in school vending machines and canteens. Some projects tried to make healthy choices more accessible to community members. A frequent connection was with the Good Food Box program. Increasing access may also have included cooking classes, community kitchens or trips to a local grocery store to find out that the same dollars can purchase healthy food as well as the alternatives. Some project staff obtained reduced fees or passes for group members to swim or use a local gym.

Some projects attempted to make community members more aware of and facilitate the use of resources already available in their community. For example, one group had a 'pathway challenge' both to increase physical activity, but also to get community members out using the existing pathway. They involved local media in promotion and local merchants donated prizes.

Almost all projects described new connections and linkages within their own community. Common examples included the schools and some school workers such as the community coordinators; Elders; local media and groups willing to get involved in and support aspects of a project. Connections or linkages outside a community were not as common, but often included resources that would increase accessibility for community members such as the local Good Food Box program.

Supportive Environments and Linkages Often examples given of supportive environments were started by the project team and/or professionals in the community. Resource mobilization is an opportunity to eventually move along the continuum from a reliance on health worker support to either a collaborative effort or independent action by community members.



Often community members were involved as participants, but appeared to assume little responsibility for decision-making or continuation of the activity. For example, some communities used to have a walking club, but the health workers no longer have time to organize it. So the club has stopped and no one from the community has taken up the initiative. Or, a walking path has been built, but there is no one to pull the weeds so usage has diminished. The Good Food Box, a positive and supportive initiative, was often operated solely by health workers with no involvement of community members. The health workers take orders, collect money, pack and deliver the boxes.

There were examples of supportive environments where community members are in a more active role, for example:

- One project group recognized that very small communities in their area had few recreation resources. They organized and subsidized training for fitness instructors. The instructors took the training and then became a resource in their local community. A follow-up review several months later indicated a high retention rate for the instructors and 75 percent actually using their training.
- In some communities, the project direction has been to involve community members in assuming responsibility for the Good Food Box program. This can be challenging at times, but eventually gives the ownership for the resource to the community.
- Many of the examples of changes in food choices at community events are now expected and promoted by community members.

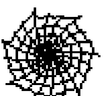
One other example

Three groups used a granting process for small projects. All of these projects had criteria for the grants. When grants were provided at the 'grassroots' level in a community, this had the potential to develop resource capacity as well as other skills, confidence and promoted working together and addressed diabetes prevention issues.

Building Connections with Others as a Capacity Indicator

Building connections refers to two ideas found in the literature: participation and building social capital. Each is described briefly.

Participation means the inclusion of individual community members in local events. This is germane to building capacity. To build capacity, participation must go beyond simply 'being there'. Goodman et al[13] describe several elements important to participation: active involvement, creation of social networks, a group of participants which is representative of the community, management of barriers to participation (transportation, child care etc), and, engagement of participants on issues of common concern. "Without grassroots involved in defining and resolving needs, community empowerment is not possible, and needs assessment can become a process of social control."[17]



Many variables can influence how people chose or are able to participate; for example, skills, level of volunteerism, community history of participation, opportunities and inclusiveness provided for participation.

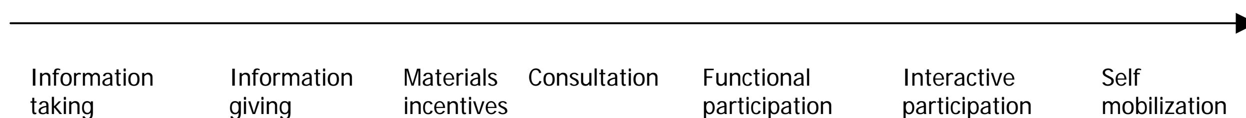
A newer term in the capacity building literature describes building "social capital" in a community. Social capital represents knowledge and skills of people, cooperation and new associations amongst people. Building social capital is the generation of trust, confidence, relationships and cooperation amongst community members. Building social capital goes beyond getting people out to events, counting the number of participants; it is the building of foundations of connectedness amongst people.

One of the determinants of health is availability of social support networks. Social support networks represent a sense of belonging within a community, being able to give and receive help, respecting others and the diversity in cultures, beliefs and attitudes amongst people.[16]

Building Connections in Saskatchewan projects for diabetes prevention

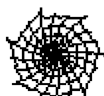
Participation is used as a proxy for the broader ideas behind building connections found in the literature. Both Goodman et al. and Bopp and Bopp describe "levels" of participation. The description of participation and potential to build social support networks found in PPDS will use Bopp and Bopp's participation scale[18], with slight modifications to the definitions, to match the findings in diabetes prevention projects.

Figure 5: Participation as a continuum in Saskatchewan diabetes projects



Information taking can occur through surveys, needs assessments and the participation is often passive. Results of information taking may or may not be given back to individuals or the community as a whole. A few groups talked about the information gathering activities. It was not always clear how the information was used or whether or not there was feedback to the community. One group used the needs assessment process as a basis for awareness and then building a partnership. Another group used the needs assessment to narrow the project scope to communities with the least amount of resources.

Information giving might include project activities, what will be happening, and be communicated by means such as newsletters, media announcements. Almost all projects had many presentations about diabetes and diabetes prevention and these would also fall into this category.



Material incentives used to garner participation were common in the prevention projects. Sometimes these were described as smaller prizes to get people engaged, raise awareness, and reward activities such as logo or poster contests. Incentives were also used to teach or provide a resource; for example, water bottles to be used when walking, coupons to try out a Good Food Box. There were examples too of the improvement in the quality of incentives over time. In one community, when a group member, also the school janitor, learned about healthy snacks, she changed the prize she gave for the cleanest classroom from pop and chips to yogurt tubes or a healthy snack.

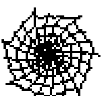
One example that may be considered in the incentive category, illustrates the value of having access to funding to build social support networks. This project paid an honorarium to its community team members (there was only one professional in the group) for attendance at meetings. The honorarium respected the time commitment to the group and honoured the wisdom brought to the group by its members. It is important to recognize that the driver was not the incentive, but rather the community development principle. It was far beyond paying for participation. However, some professionals commented on the use of incentives and wondered about the appropriateness of their use or whether 'they would still come out' if the incentive was not provided.

Consultation can be a process used by project organizers. There is no obligation to involve those giving their opinions in the decision making or to act on the viewpoints heard. There were a few examples of consultation in the projects. It seemed to be used as an awareness activity to build interest, sometimes to give feedback to the community about the 'diabetes problem'.

Functional participation means that people participate by forming groups to meet pre-determined objectives related to a project. Initially these groups tend to be externally directed or facilitated, but there is the potential for becoming self-directed. Many groups formed because of diabetes prevention work. There is good potential for them to be sustained. Some examples

- Several women who participate in a community action group talked about getting together and deciding to cook. Sometimes they cooked for others in the community as well as themselves and delivered meals. They exchanged recipes. On their own they approached the Chief and Council and got funds to start cooking, buying the staples (flour etc) and they also contributed some of their own resources.
- Walking groups or clubs were common. In one community the group has been sustained for over two years with a consistently large number of participants (more than 100), the age of participation is going down and more people who do not have diabetes have joined.

Interactive participation means participation in analysis that leads to action plans; group members make the decisions and come to have a vested interest in sustaining action.



There were fewer examples of this level of participation.

- In one completed project, school children in grades 4-6 volunteered to work together on a team for diabetes prevention. They participated in a learning event and during the workshop developed their own action plans. On return to school, they implemented the plan with the support of teachers, the project or community coordinator and as much as possible, with their own initiative. This was a large undertaking and took developmental time. It is too soon to assess the sustainability and the leadership role these children may have as they move through higher school grades.
- In one project the core group of parents/community volunteers has evolved over time, taking on increasing responsibility and decision making. Their participation level is now moving towards self-mobilization as the formal funding ends and the group is committed to continue and expand its work.

In both of the above examples, the depth of participation did not 'just happen'. The project planners knew that trust, confidence, relationship building and cooperation would be needed for action to occur. They worked to build the connections amongst people.

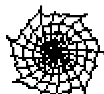
Self-mobilization means that people participate by taking the initiative independently; mentoring and role modeling are actively encouraged.

- One group described a longstanding community-wide philosophy and commitment to mentoring of children, youth and young adults. The value of mentoring appeared to pervade much of the decision-making and participation in projects and community activities.

> *We expect the best out of people and people respect each other. No matter what workshops are offered, old and young people come to learn even if the topic does not apply to them directly. ... people get dressed up and feel good about getting out and socializing. When there is a workshop, the Chief and Council come and that helps to set the tone. They come but they do not interfere, they value the knowledge of the health staff.*

- One group talked about being a role model They started at a policy level. The Health Board decided that they did not want to see unhealthy eating and physical inactivity any more in the community. They have given each Health staff member 20 minutes per day for physical activity. Staff members are encouraged to be visible when they use this time and many are out walking in the community, some adding more walking time taken from their own meal break. They observed more groups from some of the other community offices are walking now.

> *It is a very powerful tool to be a quiet role model.*



Volunteerism and Social Support Networks

Volunteerism in communities was coveted by many projects. Depending on the context of volunteering, participation could be functional, interactive or self mobilization.

The availability of volunteers was discussed often. Many projects wished for more volunteers and said they did not know how to make this happen. Groups had differing views on volunteerism.

> *Families go and volunteer as packers for the Good Food Box … we encourage our parents to get involved in this program and get involved in the community.*

One project described the almost spontaneous volunteerism which happened in the group. The group process of forming relationships, trust, and mutual support was followed by individual group members taking the initiative to bring resources back to the group, bringing healthy snacks, sharing rides. When this happened, the health worker encouraged and fostered this. It was not a common occurrence in projects.

Others despaired that no one will volunteer or help unless they are paid. In contrast, in another project, where the gathering took place after the noon meal, one woman, who admitted to being on social assistance, had baked healthy cookies for the whole group and brought a copy of the recipe for everyone.

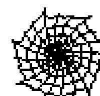
> *It is hard for those who are unemployed and poor to think about volunteering. Volunteers are usually those who have paid work.*

Only one project discussed development of a formal volunteer program and this is one of their major activities for the final year of funding.

Challenges in Building Connections

At the time of our discussions with projects, two were inactive and had no active community participation in diabetes prevention. Both could describe limited initiatives in the past, not always rooted in the health sector. In the descriptions provided by both groups, there was a sense of lack of connectedness amongst the community members, frequent change-over of health staff (nurses and health directors) and it did not appear that the notion of preventing diabetes had 'sold'. The social support networks in these communities appeared to be low and examples were given that might indicate elements of distrust. In one of the communities it appeared that there was a strong community based group but the connections with the health sector were limited and there was some distrust of professionals.

> *In ___ physical health is managed by crisis. Prevention is not common practice. People don't worry about their grandchildren getting diabetes, they don't talk about it … people* [in 2002] *were not admitting they have diabetes, it had a negative connotation. People were more comfortable at home than at a public workshop. People were not talking about diabetes prevention …* [at the school] *kids said they did not know someone with diabetes. There is likely no visibility to diabetes (people monitoring their blood sugars). … In general, in the community exercise is viewed as work – it is not a social activity, not a lot of families out walking.*



> *At times there are two very separate communities … even though the communities are split at times, people are still friends. …* [in discussion of a potential project] *the community needs to own this so when the professionals leave, it does not fall apart*
>
> *– community member*

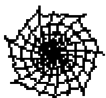
Reflection or 'Asking Why' as a Capacity Indicator

Reflection, or 'asking why', is an ability to reflect on assumptions underneath ideas or actions; consider arguments and ambiguities; understand how the community environment can influence behaviour; and, to analyze how change happens, or not, over time.[13] Goodman et al also talk about this indicator as an ongoing cycle of reflection, making connections that eventually lead to a new understanding by a community or a group. "… reflection is a lived activity of action and reflection within one's community for the purpose of challenging assumptions and creating change toward the core public health values of democratic participation and equity."[19]

Reflection is a 'self-corrective guidance mechanism' and one that is ongoing, needs constant feeding from the community membership and others in order to know if the direction taken will achieve the desired outcomes.[15]

Bopp and Bopp express reflection in another way, learning. "Learning is the process of acquiring new information, knowledge, wisdom, skills or capacities that enable us to meet new challenges and to further develop our potential … *Unless people are learning, community development is not happening*."[20] They talk about four types of learning:

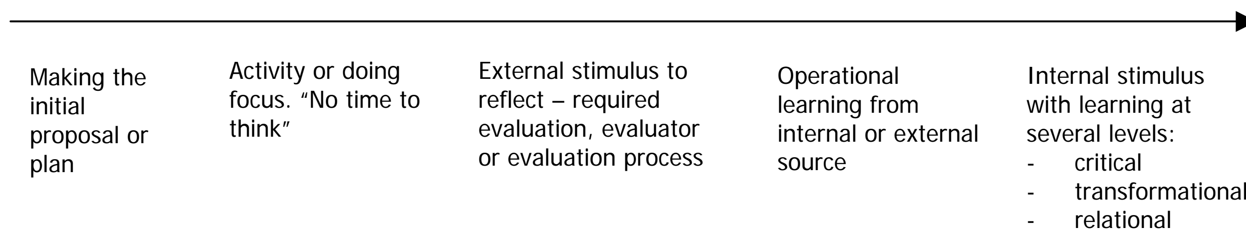
- Critical – analyzing situations and behaviours in a broad context of the actual situation, behaviours, and influences – social, economic, political, cultural. This analysis leads to a discovery of the root cause of what needs to change. A parallel would be examining community conditions and being able to connect them to determinants of health. The obstacles and barriers to addressing the determinants would be identified and articulated.
- Transformational – seeing the possibilities and potentials from within and then creating a vision that is both attainable and sustainable
- Relational – learning that is for inter-personal wellbeing. It is the practice of values that promote good human connections. This is learning that occurs with other people as it involves learning habits, ways of working together when people are together.
- Operational – all the learning that needs to happen in order to achieve what needs to be done in development. Its components are information; knowledge and wisdom; new skills; new behaviours/habits; and, new values and attitudes



Reflection or Asking Why in Saskatchewan projects for diabetes prevention

The identification of reflective activity is not as direct, of course, as talking about a pamphlet or resource developed. Most groups found the questions around reflection challenging. Sometimes, to prompt analysis, groups were asked 'why' a program aspect worked or did not work. Again, for many, this type of question was difficult to answer. Only six groups could provide concrete examples of 'asking why' during their diabetes prevention work. For others, it was sometimes possible to abstract the 'asking why' process from their discussion of other issues.

Figure 6: Reflection/Asking Why as a continuum in Saskatchewan diabetes projects



The first time many groups applied a reflective approach to diabetes prevention was in development and writing of their proposal or work plan. Sometimes a 'spin off' reflection time happened when their proposal was approved and needed to be carried out or implemented. Some groups talked about a realization that their plan would not work exactly as written and more thinking and development would be needed. Groups took different tacks at the beginning – either jumping into the activities or a 'doing' phase or moving to an internal examination of where they wanted to be by the end.

When asked to talk about how hard or easy it had been for the group to look at what was happening during the project and figure out what was working or what needed to change, responses were along the 'spoke' or continuum above.

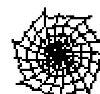
A few groups had little response and said they were 'too busy' doing the project work and had little time to stop and figure it all out. This response was most often received from groups working with proposal driven funding and short timelines. Some, but not all of these, had scaled back their focus, but still felt the pressure to "do".

We were overwhelmed with the demand of our three main foci – we really never had time to change our mind.

We never really had time to step back and take a look at what we are doing – I do not know how to answer that question.

Some groups related their 'asking why' to an external stimulus, the required program evaluation and begrudgingly stated that even though they did not like evaluation, there were some benefits and learning to be gained. Often this was described as a 'must do' and any derived benefit or learning was a

The evaluation we were forced to do every year – I hate it – but it helps us reflect



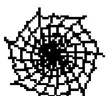
surprise.

Some groups described what might be considered operational learning. For example,

- From the Health Canada workshop on logic models and evaluation, some groups immediately realized that they needed to narrow the scope of their work. One group used its logic model to drive the process and as a benchmark along the way.
- Another group attended a Health Promotion Summer School on physical activity. During their school week, they organized their own daily meeting to reflect on learning. One of their conclusions was the recognition of a gap in knowledge and skills in their work group about health promotion processes. They decided that their next project worker needed to have this background to complement existing staff knowledge and skills and to enhance community development.
- One group realized that they were focusing too much on the physical aspects of diabetes, not having the impact that they wanted. They decided that they were lacking knowledge and skill in the spiritual way of working. This group sought out an external resource, held a staff workshop and then brought in a new partner, their community Elders to give them guidance and support in their program work.

> *We became aware that the spiritual and mental needs had been neglected in diabetes and diabetes prevention. We needed to find a better way to meet this need. ... The workshop showed us a lot about listening ... we needed to listen to understand what people are saying. This brought more depth to diabetes. ... This helped us to see we need our Elders with us. When the Elders speak, they speak from a broader range of wisdom than just the physical knowledge.*

An internal stimulus or drive within a group for ongoing reflection was not as common. In those groups where it did happen, to a certain extent it appeared to be an unconscious, automatic, and ingrained way of working. It may have also been a reflection of the group's leadership.



- *We had a sense that we wanted to do things differently than we had ever done before – we had tried a lot of things already –we were really trying to build capacity within the community and we focused on sustainability from the start … our main goal has been to support communities to take action, and not take over, before we have mainly worked in a way that was all health staff driven.*
- *We were not able to guide* [previous worker] *as we did not have the picture ourselves yet at that point. … A new focus and a new process slows down the process a bit, it gives us time to step back and look again, to reflect on the direction we are going, we are in a learning process ourselves. … We are weaving this work all together more now.*
- *Flexibility – starting in one direction and then seeing the need to change course … taking time to reflect in the thick of doing the work … we needed to organize to look at what was working and what wasn't – we started to meet every two weeks and examine what was happening … we started keeping track of what was being done and then we could see the patterns and make changes.*

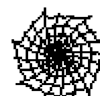
One project that formed a strong community-based team of community members was able to describe relational learning in their group. Their experience may have been true for other groups, but few could articulate the experience and learning.

When we first got together it took awhile to figure out what to do and how to do it – we met a great many times … and the funding really helped because the community members received honoraria – so we could meet often to develop as a team and that was our work – and to develop what we wanted to accomplish – we would put a lot of time into this – to make sure that we talked it out and that we all agreed on what were going to do. We had to do a lot of planning – everything was accounted for – it took a lot of organization. It helped going away and going to conferences[i] *– we had so much fun and this helped build our group – we went out for supper – not just what we learned at the conference, but sharing the conference as a group was really important. This was not an everyday experience for a group that was building team work and working together around the project. … Doing this project – diabetes prevention was important, but a lot of other things that happened along the way were also very important*

Sustainability

Sustainability means looking at the big picture. Going back to the analogy, it is the whole spider web and all the parts of the web must be considered in building sustainability for any capacity gained during a project time and possibly leveraging this capacity in another project or aspect of community development.

Sustainability is larger than the ongoing nature of a specific program. "What is more important to sustain is the capacity for individuals, organizations and communities to mobilize themselves, when required, to initiate new action for new health challenges."[21]



Holder and Moore[22] in a review paper that summarizes papers from a conference on community action research identify variables that contribute to long-term sustainability, maintenance or institutionalization of project based community interventions. They identify four main variables that enhance sustainability:

1. Community Relevance - community believes project is important to its own needs and concerns.
2. Local Factors
   - Honoring community values and cultural relevance, community involvement in development
   - Cultivating key leader support – active and visible community leaders' support
   - Using local staff – use respected community leaders who know and understand the social and cultural context of the community
3. Program Factors
   - Developing local people to support the prevention intervention
   - Maintaining flexibility – using community opportunities, emphasis on locally supported topical areas
   - Celebrating success early – documentation and early public celebration of success
4. Overall Goal
   - Policy and structural changes in the community. Prevention becomes part of the routine and regular life of the community

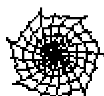
Sustainability in Saskatchewan projects for diabetes prevention

At the time of the discussions with projects, two groups were no longer receiving funding and had written their final report. They were able to discuss both their sustainability planning and what is or will continue on.

The other groups will continue to receive diabetes prevention funding until March, 2004. With one exception, all groups have been operational for two or more years. Most of these groups found the questions about sustainability difficult to answer. In a very few cases, the sustainability questions were kept to a minimum as it was obvious with the current struggles, there was little to sustain. The group with the most recent funding used the discussion opportunity to gather for a further day and held a workshop on sustainability to develop their plan.

The themes from the discussion of sustainability are reported using both the capacity indicators already introduced and a few ideas which emerged as themes in the data, but do not fit neatly into one of the five capacity indicators.

Be the change you want to see These words from Ghandi quoted by Bopp and Bopp emphasize the importance of positive role modeling with living examples of the desired



solutions. The principle applies not only to individuals, but also to organizations. *By walking the path, we make the path visible.*[23]

In some groups there was spontaneous discussion of role modeling and mentoring and several examples have been given in the discussion of capacity indicators. Sometimes the modeling was deliberate and planned, in others situations it emerged as 'discovery' in the reflection of the discussion group.

- The Health staff started a weight loss group for themselves, saying 'We want to get lighter as a staff'.
- The pop machine is gone from the Health Centre, staff members are making healthier choices for their own meals, and they patronize the local store to support healthy choices.
- Since parents have become more involved with the school through the project, they notice that their children are now becoming more involved with the school, more comfortable in the school.

> *My older children did not get involved in the school, but now that I am involved in the school as a parent, now my younger daughter is involved in the school … our kids are more comfortable in school now – it becomes more like a family*

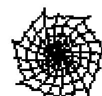
There were several positive examples of organization support for community development, sustainability and diabetes prevention work.

- The ban on smoking in the Health Centre has now spread to all the community offices and the Elders Lodge and the group members observed that more community members have quit smoking.
- The Health Board 'giving' each staff member 20 minutes per day for physical activity has already been mentioned
- In the Education sector, the school's values and principles of community education fostered the initiation of the project and was the underpinning for the community group development process[24]
- One organization's way of working allowed the project worker to be autonomous, yet feel supported and guided as needed, and to take some risks to advance the process.
- Some First Nations groups described the significance of the active and visible support of Chief and Council and/or the Health Portfolio Director to their work.

> *… has flexibility in her position to do this outreach work, she is not limited or under too many rules or restrictions … [she] does not have to jump through the hoops … sometimes you have to be free to take some risks.*

There were also examples of organizations reluctant to support a project initially or beyond the funding period.

- A few groups said that their organization was initially reluctant to get involved due to the temporary nature of the funding and questioned what would be left or how work would be sustained without any funding. Sometimes the



barrier to organizational support for involvement was perceived as a lack of priority for prevention work. Some believed that this is changing in their organization, with greater priority now being given to prevention.

- One group planned to continue aspects of their project work by incorporating some of the role of the temporary project staff into the role of a permanent staff member. The organization initially rejected this, but was persuaded by the individual's front-line manager.

<u>Ongoing application of acquired knowledge and skills</u> The ongoing application of knowledge and skills gained in the prevention work was seen in three ways: formal learning opportunities for the project team members; ad hoc learning opportunities applied to action; and, personal development and learning.

Transfer of learning from the event to application and action is always a desired outcome. A model developed by Michaela Berkowitz[25] and based on the work of Kirkpatrick[26] and others helps to explain the variables in the transfer of learning. The model examines both factors that affect post event transfer of learning as well as the four levels of transfer of learning: reaction/ satisfaction; learning and retention; application/behaviour change and observed actions that result from the learning. The model is represented schematically in Appendix E.

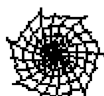
Two ideas are important to remember when using this model:

- It takes time to move through the levels and for behaviours and actions to occur.
- The further away in time from the program, the more difficult it can be to create direct links between program and observed changes.

Formal learning opportunities through funder-organized workshops, a provincial conference and other learning opportunities that projects created for themselves have already been described. Several groups described the formal learning and how they were able to use this knowledge in the project work and their belief that they will continue to apply the knowledge. One group expressed appreciation that their funder permitted two persons from the project to attend workshops. Not only could information be shared with others in their group, but the permanent staff member who attended continued to bring the knowledge to the forefront with the group.

The informal learning through presentations to community members, in schools and other locations appears to have translated in smaller communities into action.

- In many First Nations communities it has become the expectation that healthy foods will be served at community events such as Treat Days, pow wows and meetings. If food is catered, the caterer must make healthy food selections.
- Different choices are now available in community schools and students appear to be making the healthier choices more often. This is long term work and may have started pre-diabetes prevention funding. Some schools have removed pop machines, others have alternative selections available and



healthier choices are possible at snacks or meals. In one community the teachers actively discourage unhealthy food choices being brought into the school.

Connected to informal learning and/or provided opportunities, are the personal development learnings which have happened. There appears to be a strong perception in many communities or there is a growing awareness that something can be done to prevent diabetes. Some of this change in attitude does have to do with the influence and new thinking of people with diabetes. Although this is not primary prevention, these people and the message they are putting out to their fellow community members is starting to change. People have more self confidence and sense of personal control. Some have become advocates and do public speaking about diabetes and the need for prevention. This change is prevalent in First Nations communities.

The enhancement of self-esteem, self-confidence and a willingness to volunteer was seen in other projects in people without diabetes. This change was dependent on the project focus, participation level of community members.

I gained self confidence to speak up and that you could work with people that you might not like, you could put that aside, I learned if I know my stuff, I could lead

Partnerships have potential for sustainability. The two groups which have completed their funding have been able to sustain partnerships. In other groups, the sustainability of the partnership and ways of working together was frequently mentioned.

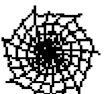
Because of the familiarity of working together, some projects are talking about the possibilities of working with new provincial programs such as *in motion*[27] and SchoolPlus[28]. A few projects already have connections to *in motion*. One project has joined the Health Region's diabetes program team as the prevention team.

Resources

The sustainability of resources brought forth four themes of discussion. The themes connect to the diabetes prevention projects based on their activity areas.

- Program Resources. Many projects acquired or developed resources for themselves or for use by others such a school teachers. Some groups have an expectation that the resources will continue in use. Others believe that there will need to be ongoing promotion and follow-up. Some projects had plans for introduction and promotion of new resources and ongoing maintenance. Others focused on acquiring or development of the resource and did not consider the marketing or maintenance functions.

- Resources to increase accessibility. Some of the linkages made with other groups or organizations will continue. One example is the Good Food Box (GFB) program. The GFB program is connected to healthy eating, affordable



foods not only for diabetes prevention, but also for the prenatal program and community members who would like this alternative.

- Resources for sharing learning with others. A few programs have created a resource to pass on their experience, lessons learned and program tools. Examples include a program manual for creating school-based teams of children who are champions for prevention in their school, a CD with instructions and tools for a community-wide fitness challenge, and another group plans to give presentations to other schools in their community to talk about their success and to encourage other schools to a similar program development.

Building Connections

Many new connections amongst community members were built. Examples were found in volunteering to sustain aspects of a project. In the programs where volunteering has started, there is an expectation that this will continue. The drive to continue appears to be internal, from the group and individual members, rather than from an external source.

- One group hopes to enhance the volunteer dimension through creation of a formal volunteer program.
- The group which supported the training for fitness instructors is partially subsidizing more training and also inviting all the instructors from different communities to a workshop for networking and further learning.
- When the parent/community volunteers in one group were asked what will happen after the funding stops, they answered simply, 'we will still be here'.

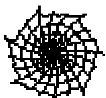
Schools: A Case Study of Capacity Building in Diabetes Prevention

As fourteen of sixteen projects who participated in PPDS had schools as a component of their diabetes prevention work, this section reviews capacity building within schools as a case study to illustrate capacity building reflections and lessons learned. Of the fourteen projects, only two had schools as their only focus. In one case the project grant was given to the school and the Health sector was involved as an occasional consultant and participant. In all other cases, funding was held within the Health sector.

Ways of working with schools

Most groups said that they wanted to direct their prevention efforts towards children and youth and hence schools were a natural venue for their efforts. In the fourteen projects, there were four ways of working with schools:

- The majority had what could be described as an 'ad hoc' relationship. For the most part this involved health education: presentations in classrooms, the occasional activity such as a Health Fair. Usually there was minimal indication



of follow-up or continuing contact between the presenters and the school. The two sectors did not have a common planning mechanism for prevention work.

- In one case the core working group for the project had both Health and Education as members. This group was able to work at both the front-line worker level and also at the Board level for policy change.
- In one case the project worked with the school children as the change agents within their own school. This could be described as a 'bottom up' approach.
- One group worked from within the community school with only one professional coordinator and the remainder of the team being parents/ community volunteers.

Capacity Indicators and Working with Schools

To illustrate capacity close to the conclusion of the diabetes prevention funding, Figure 7 represents the five indicators (leadership, working with partners, resources, building connections and asking why) on a spidergram. Circles of varying sizes were used to show where groups are working along the continuum.

A Brief Review of Capacity Indicators

Each continuum or spoke is reviewed briefly as the details have already been presented earlier in this report.

Most of the leadership for projects to work in schools is based in Health sector teams. It is less common to see the leadership from health and education together or from education alone in PPDS projects.

Most of the partnership with schools can be described at the 'kept informed' and/or 'functional' place on the continuum. Workers in the health sector often had good working relationships with the schools and found the classrooms accessible for health presentations. Gaining access to classroom is not the same as a partnership in which both sectors have common goals.

Some groups were connecting with the education sector through a community inter-agency group. For some this was ongoing and for others this was new with potential for partnership building. A small number of groups, with a pre-existing partnership, were able to add a diabetes prevention perspective to their ongoing work.

Health education in a variety of formats was the most common way of building resource capacity in these projects. Supportive environments for accessible healthy food choices and options for physical activity are increasing. A small number of projects provided examples of school based role models and volunteers doing diabetes prevention work.

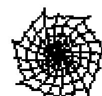
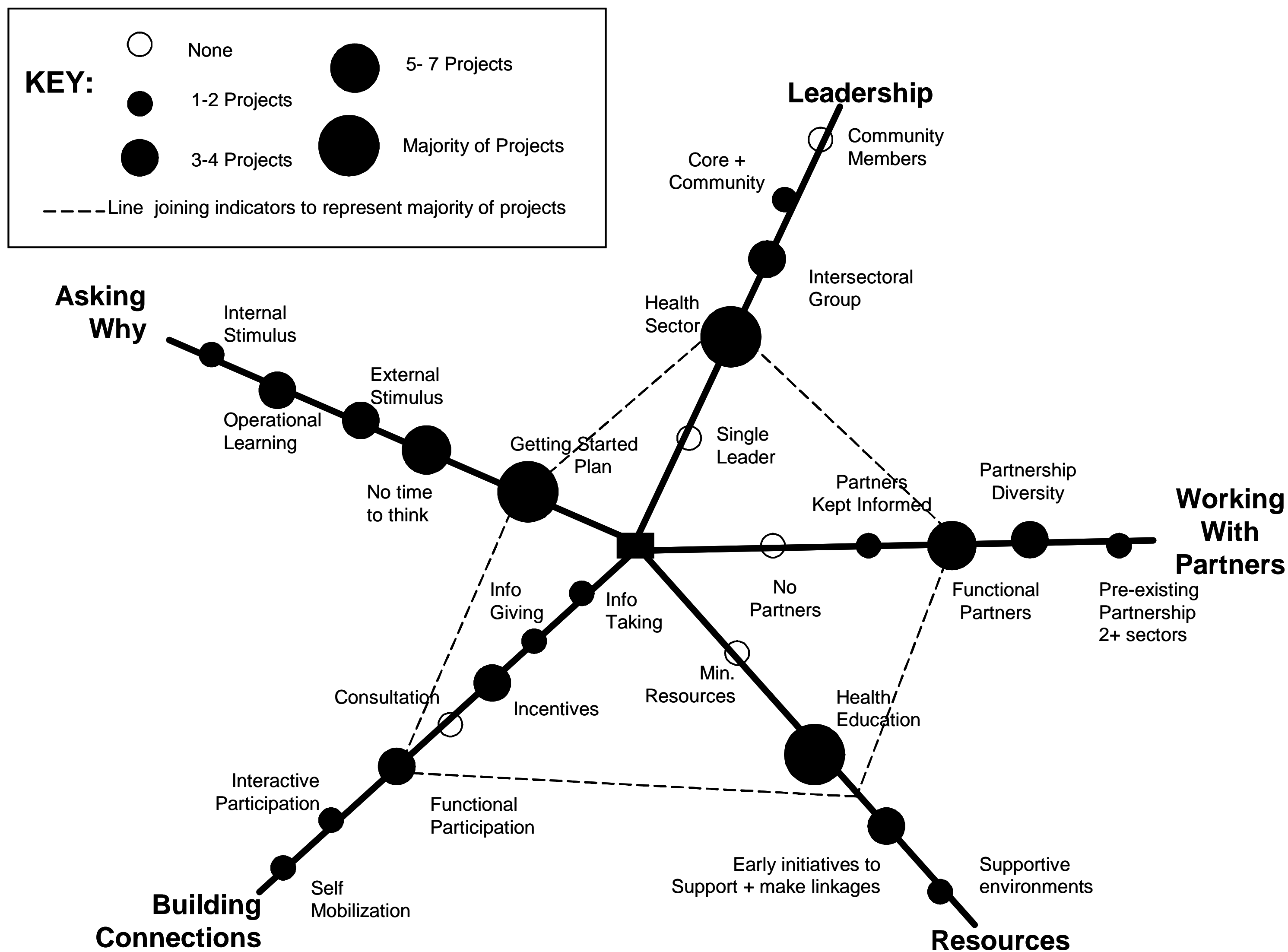


Figure 7: Capacity Indicators and Diabetes Prevention Work in Schools



Building connections within schools is complex and multi-level. A school community may include: school boards, school administration, teachers, other school-based workers, parents, children and youth. Most projects tended to build less capacity in this area. If there was deliberate effort to build capacity, it occurred in groups working primarily within schools, with pre-existing partnerships and an intersectoral leadership team.

The time taken by a project to 'ask why' in relation to working with schools was similar to the way this was done overall by the project. Groups started their work with some reflection on what to do, how to do it, who to involve, but as time went on 'asking why' diminished. The challenge of getting the work done and other job demands was prevalent. For some an external stimulus or a need to learn to get the work done assisted with reflection.

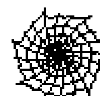
Lessons Learned

Involving parents/community volunteers

> *Our overriding concern is for the children and the community is what drove us to do these things that were hard*
> - parent volunteer

- Parents usually wanted to get involved because of their children and concern for their well-being
- Developing parent/community volunteer leadership takes time and a significant amount of support. Some will be natural leaders, while others will need more support or find the role challenging.
    - If there is a transition from a paid coordinator to a volunteer coordinator expect that the transition will take extra time and attention
    - Providing leadership training helps, but ongoing support is also necessary
    - Although the parent/community volunteer roles varied, from giving classroom presentations to supporting school-based teams of children, it took time to develop self confidence and skill.
    - Parents/community volunteers, during the time of the project, were given an honorarium to acknowledge their time and participation
    - The school environment may or may not have been supportive to the parent/volunteer role. In some cases, they may have been viewed as an intrusion in the school
    - It seemed harder for the project leaders, who were not in the same community as the parents/volunteers, to provide the close support needed and requested.
- Parents can be a resource for professionals. Parents in one group spoke about their experiences talking with other groups and "professionals" seeing them as the one with knowledge and expertise.

> *I had to speak with all these professionals – I thought the professionals should know more than I do – but we spoke about what we were doing, we were telling the professionals.*



Working with teachers/schools

The projects had different ways of working with teachers and different perceptions about how their work was viewed by the teachers. There also appeared to be different expectations of teachers. Only two focus groups included teachers so their perspective is limited.

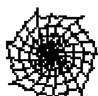
> *It was a quiet way of working. We get along together. The school and the health staff are working together daily. Health and education go hand in hand, making us like cousins.*
> *- school administrator*
> *We are looking at the whole child, not just the mind and encourage healthy ideas*
> *– school teacher*

- When there is a longstanding partnership between Health and Education, the work of the two groups can compliment each other.
- A request from the school can be an opportunity to put the 'power' back to the school. In one project, the school requested help with menu planning. Rather than write a series of menus, the project dietitian held workshops for school cooks to give them the knowledge and skills both to develop their own menus and carry forward in other areas of their work and personal lives.
- The connection with the school may be less direct, but still have a positive spin off for learning. For example,
    - One group needed low-fat muffins as a snack for their project group. They asked the commercial cooking class at the local school to make the muffins for them.
    - One group provided community grants and some were given to schools for their activity and healthy eating programs
- Some groups developed or purchased resources for the schools – a curriculum or toolkit. The success of this strategy was not always clear as it was unknown if the resource was or would be used.
- Many groups had awareness activities in the school: poster and/or logo contests; presentations for teachers; presentations in classrooms; Health Fairs. Two groups did pre/post surveys to try to assess learning.

Working with others who have a role in the school

In some cases there were other 'players' who also had or came to have an interest in the school and became affiliated or connected with the project work.

- In one project the Public Health Nurses were the traditional entry into the school for the Health sector. When the project also wanted to be connected to schools, these two groups needed to sort out their roles. Eventually the project and nurses were able to work together on one common activity.
- In one project when spirituality was identified as a missing component of the diabetes work, this eventually led to the involvement of the Elders in the school and more linkages between the Elders and the health workers. The Director of Education was also involved in this change.
- School Boards have an obvious interest in schools. There was only one example of a project connecting with the school board and this led to a policy to remove the pop machines. While the project felt there were benefits to the 'top down' approach in



terms of leadership and decision making, there were also issues as the change happened quickly without the involvement of teachers, parents or students.

- Several groups described the benefits they have or hope to have through working with an inter-agency group in their community which includes both the school and health and other sectors.

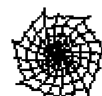
Changes in schools

- Many described changes in schools in terms of accessibility of healthier food and drink choices in vending machines and the canteens.
- There are still challenges in many areas as these venues are also a source of fund raising for the school. Many are finding new alternatives.
- One group has decided that the way to introduce a change in school policy is to 'walk the talk' first in their own agency with a food policy. The policy will then be available to others in the community, such as the schools.
- Where students were directly involved in the project, they are proud of their ability to develop a plan and carry it out. There was learning beyond prevention, for example, learning to work together.
- Where parents were directly involved in the project, it gave the school the opportunity to see the wisdom that lies in the community. It is not just one-way learning from the teachers to the community. It can go both ways.

What are the challenges?

- In some areas the turnover of teachers is high and it is challenging to keep continuity from one year to the next with programs and activities.
- Teachers are busy and may not have time for additional involvement or responsibilities with extra activities.
    - In one project that had a lot of positive involvement with the schools, in the end, it was their perception that the schools saw prevention as the work of the health staff just being done in a different location, the school. According to the health workers, the schools did not see their role in prevention and being a partner and working together.
    - One project found that they had to be careful about expectations raised, for example, with presentations. Once the teachers become aware of presentations, there was a demand that could not always be fulfilled. This group felt they were not just there as 'entertainment', but had an expectation that the schools would take some responsibility for grounding the work in a practical way for or with the students. The project sees this as long term work with ongoing contact at several levels in the schools – from principals to nutrition coordinators.

There has been small positive change – we sometimes go three steps forward and two back – that is the type of progress we make at the school level. We need to strive for policy changes and get everyone on board and be relatively consistent through all schools in the community.



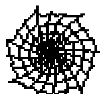
- No matter where the initiative starts, most groups wanted more interaction with the school and many mentioned a connection with parents as a missing link.
- Time is a challenge for everyone. This is evident when trying to involve multiple groups related to schools: administration, teachers, students and parents. Everyone needs to involved for sustained change and role modeling of change. Making policy also takes time and patience and a view to a larger goal.

Conclusions, Lessons Learned and Recommendations

The final section of the report describes the conclusions about capacity building in the Saskatchewan prevention projects who participated in PPDS. The conclusions are reported for each capacity indicator as well as by more general aspects of prevention work. The lessons learned come from the focus group discussions and a few observations made by the Reference Group members. The recommendations are divided into two parts: those directed to communities and those directed to funders. Recommendations were derived from the PPDS participating projects, Reference Group members, the PPDS project staff and principles of community development and capacity building.

Diabetes prevention as the focus

Conclusions about capacity building	It was important to groups, particularly those in or working with First Nations, to have funding to work on diabetes prevention. Diabetes and its complications are seen as an important issue in most communities. Attitudes and perceptions about possibilities for diabetes control and prevention are starting to change. Champions for prevention are emerging in communities amongst their members. Change is happening – healthier food choices are being made, there are alternatives to get healthy foods – gardening, Good Food Boxes, and more people are active, often walking.
Lessons Learned by Projects	Groups working with the population health promotion model (PHP) found: • it was easier to 'sell' diabetes than the PHP model • diabetes was an important starting point for some groups to work with First Nations agencies or communities Strides made in the community will go beyond diabetes prevention. Prevention is an important focus. A few groups found that the diabetes focus was not wholistic and they worked towards a wholistic approach. They believe there is a need for this approach.



Recommendations to communities

A disease prevention focus can be important and give direction to community-based work. Some groups said they had already been doing some prevention work, but the work was not necessarily linked to diabetes. Building on existing strengths and connecting to work already done is important.

In addition to the disease-specific focus, think about both the project at hand and the opportunities it does and will provide for building community capacity and community development.

Recommendations to funders

There are benefits to continuing to fund disease specific projects while also focusing concurrently on broader dimensions of health – population health promotion: strengthening community action, supportive environments and healthy public policy.

Assist communities, through the funding process, to take a multi-focused approach that includes capacity building and community development.

Leadership

Conclusions about capacity building

In the PPDS projects most of the leadership came from the Health Sector. In some there was an intersectoral leadership team. Almost all of the latter teams were formed for this project.

Where community leadership occurred, it was planned as part of the project strategy and took a lot of support for development and sustainability. Unless community-based leadership development was part of the plan, this did not occur.

It was not possible to fully assess the projects' leadership mandate for action. For most part, it seemed to occur within the leadership team rather than from community-given direction.

In some projects the members of the leadership team are longstanding workers in the community. The local government is stable and supportive. These two variables appeared to facilitate the quality of some projects' work.

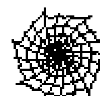
Lessons Learned by Projects

Some groups, in retrospect, felt they would have derived benefit from community-based leadership.

Capacity building for community-based leadership takes commitment, time, planning and ongoing support.

Becoming a leader means building one's self confidence, having a belief in what you are doing.

When capacity building for leadership occurs within a group setting, it



will take time to build trust, confidence and mutual support. Group members may learn that there are different ways of leading and working together.

There is often local leadership and wisdom, such as with Elders. Listen to the Elders and involve them.

Recommendations to communities

As you continue your diabetes or other prevention work, assess the diversity of their leadership amongst community members and current strengths.

As leadership solidifies either in the Health sector or within an intersectoral leadership team, consider working towards capacity building for leadership amongst community members.

Recognize that developing leadership capacity in others or 'leading from behind' will take time and effort, but the capacity built has the potential to add to the health of your community.

Where community-based leadership has been established, continue to foster and promote this involvement.

Recommendations to funders

Funding/proposal requirements cannot easily mandate community-based leadership as the 'readiness' for this development may not be present.

Funders may be able to encourage new roles for professionals and support building community-based project leadership.

Funders can consider providing learning opportunities for:
- leadership development amongst sectors
- practical, 'how-to' perspectives on professionals taking different roles, such as 'leading from behind' using community development principles

Recognize that groups working on leadership capacity building will need time for results to happen – process will be as important as projects results.

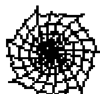
<u>Partnerships</u>

Conclusions about capacity building

Partnerships were important in doing diabetes prevention work.

Most of the partners in these projects were brought together to do this specific work.

Several partnerships were able to connect with a pre-existing or a developing interagency group in the community. This connection was described as positive and supportive of prevention work.



Relationships with formal leadership were variable. Few groups received active support from their formal community leaders and few attempted to work with local government.

Most projects wanted to work with a school(s). There were few examples where this desire translated into a full partnership between health and education with common vision and goals.

Lessons Learned by Projects

Relationships are key.

Groups which had or sought organizational support felt it was important.

Learning to work together has challenges.

If the partners are in different geographical locations, this can add to complexity and challenge

There are many challenges in working with schools in a partnership whether working from the 'top down' or 'bottom up'. There are multiple groups to consider in a school environment: children, teachers, principals, Schools Boards and parents.

Other job demands may limit time and energy available for partnership building. Workers had other responsibilities besides this project.

Recommendations to communities

Partnerships can add value to prevention work; enhance sustainability and capacity so a community can address health determinants.

If partnerships are new, they will need ongoing nurturing. While an activity(ies) may help focus a group, it is also important to pay attention to:

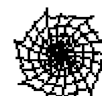
- creation of common vision and goals
- group process as well as the group's actions/activities
- deal with conflict and different perceptions 'up front'
- consider smaller numbers to begin and then grow the partnership from a base of strength

Consider local government in your partnership and how you may be able to gain support for your prevention work, for example, in policy development.

When projects end, think about how the partnerships can support other community based work to promote health and address determinants of health.

Recommendations to funders

Most funding applications require partnerships and recognize the benefits of working in partnership.



Allow sufficient time pre-application deadline and/or when funding is received for groups to work on partnership development.

Emphasize quality of partnerships versus quantity. Request a small number of partners who can provide information about their actual or potential contribution to a project not just a 'letter of support'

Learning about partnerships is likely to be an ongoing need.

If there are new partnerships, consider providing learning opportunities that are practical and inter-active.

As partnerships are evolving, learning needs may direct different learning opportunities such as phases of group development, conflict resolution.

Resources

Conclusions about capacity building

Capacity building focused on health education and accessibility of resources.

Knowledge through health education was gained in most communities.

Accessibility was acknowledged as a need in many projects. Strategies to introduce community members to physical activity, such as walking, and healthy food choices were common.

A few projects provided small grants from their project funding, as a resource for groups to take action. All had criteria for the grants and a selection process.

Lessons Learned by Projects

Giving small community-based grants from project funds can extend the resource base and participation in a project. Some found that the availability of grants created an expectation that could not always be met in terms of available resources.

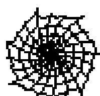
While making resources available in a community is positive, think beyond the immediate tangible resource. Who will pull the weeds on the walking path? Who will deliver the Good Food Boxes? Who will own the resource after the project ends?

Some activities were resource intensive – the energy and time commitment were not always anticipated.

Recommendations to communities

In ongoing diabetes prevention work, consider moving beyond health education to strategies that involve community members in creating supportive environments for healthy eating and physical activity.

A small grant process with well defined criteria, an accessible application process and relevant selection criteria, can extend the



resource mobilization in a project.

Capacity building may be needed to support and give confidence to community members to write a grant application and be able to implement their project. Use community development principles.

The Canadian Diabetes Strategy has facilitated the development of many learning resources all across Canada. Find out what has already been done before creating more.

Recommendations to funders

As resource development, implementation and evaluation happened during the time of Canadian Diabetes Strategy.

- Find accessible methods to share the best quality resources across the country. Methods may include display on the Health Canada website, downloadable PDF formats, contact information.

- It will be important not only to share tangible resources, but also to share ways to engage communities in the use of the resources and ways of working on resource mobilization which are less tangible (spiritual, cultural, political)

Building Connections with Others/Social Support Networks

Conclusions about capacity building

The capacity built in connections with others was done in many ways by project groups.

In the few communities with lower levels of connectedness, high staff turnover and an absence of strong relationships between the health sector and the community seemed to occur.

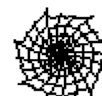
In projects with greater community-level participation, influencing variables appeared to be
- a deliberate plan to enhance connections and social networks
- support of the leadership in the community and/or key organizations related to the project

Some projects lamented the lack of participation and said they did not know how to enhance it

Several groups were hoping to have volunteers to assist with project work or for sustaining an activity. For the most part this volunteerism did not materialize. Where volunteers were evident, it seemed to evolve from small groups where trust and confidence had been established and people had a personal desire to see something happen. Sometimes potential volunteers were provided with learning opportunities.

Lessons Learned by Projects

Reducing barriers to participation helps (examples babysitting, transportation)



Most groups would like greater community involvement/ participation – there is a need to learn to be more people focused rather than program focused. Some projects said they learned this; others would like to make this change.

Connections with parents were usually missing no matter how the project worked with the school/education sector.

Work with a single community rather than trying to tie several communities together in an artificial way.

Genuine involvement of people is important, but unsure how to make this happen.

Getting people to volunteer their time is challenging.

Giving people skills and support may enhance motivation and community involvement.

Recommendations to communities

Assess the social supports in the community; determine the strengths, connections or usual ways of working together.

Make many overtures to get people involved. Try to build diversity and include people with different perspectives. Listen to the voices of the community. Listen for their values. Show respect and dignity.

Work to get group diversity, and then work with those who show up ensuring their involvement is genuine and follows community development principles.

When working in the schools, find ways to involve parents. Multiple strategies and time commitment may be needed.

Recommendations to funders

Building connections with others/social support is often invisible work.

Acknowledge that building connections or social networks is important and recognize efforts that have and will be made in this area of capacity building. Allow the necessary time for pre-project work to build relationships in the community.

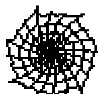
Provide learning opportunities both for the professionals and the community members. Projects recognized benefits from the funding provided by Health Canada, Saskatchewan Region for ongoing learning.

Reflection/Asking Why

Conclusions about capacity building

There was diversity in the building of capacity for reflection. Not all groups knew about or were able to use this process during their project.

Groups with regular times for reflection were fewer. Taking time for



reflection appeared to be their usual way of working and/or a function of their leaders.

Some groups became immersed in activities and felt they had 'no time to think'.

The required evaluation process often stimulated reflection.

A few groups used learning opportunities to build their capacity in 'asking why' and to analyze. Usually these groups had spent time working on a vision for their work.

When given the opportunity, for example through participation in PPDS, almost everyone could make connections between their work and community changes. It was sometimes more challenging to analyze how a change happened (or did not) or what would be needed to sustain a change.

Lessons Learned by Projects

Take the time needed to look at lessons learned. When you 'study' what is happening in the project, you will find out what has worked well, what will work.

Start small and then branch out slowly, remember it takes time. Do some planning before you act.

A large scope to a project or too many planned activities can make a project too challenging.

At the beginning give people time to have their say rather than jumping in with the money, especially if you are an outsider.

Consider the best use of paid project staff. This additional support can buy not only time to do the work, but also time to allow reflection. There may also be a down side to paid staff:

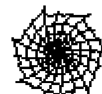
- staff gone, project stops
- other staff members do not integrate the community development work into their job
- transfer from paid staff to others takes time and planning and may require organizational support

Recommendations to communities

Give yourselves permission to build in time for reflection. This can be short and regular times – for example, sharing circles at the start or end of a project meeting.
Use tools to help with reflection – see ideas in the report Appendix.

In project planning, think big, but consider starting small and learn from your work to build the next stage or phase.

When there is paid project staff,



- talk about and learn how to integrate capacity building and community development into everyone's work
- prepare for the transition when paid staff is no longer available – use observations and reflections to assist with this transition

Recommendations to funders

Require reflection or asking why as part of the project process. This might be requested as part of the interim reporting process.

Encourage process outcomes as well as quantitative ones

When the project will be done by a new team or a team working in a new way, consider small amounts of developmental funding and time that will yield a foundation on which to build project activities and outcomes.

Review the results of both the Saskatchewan Health PHP evaluation and the Health Canada, Saskatchewan regional workshops as examples of funders who supported both learning and reflection for community projects.

Provide resources and identify funding for learning to support capacity building. Ensure this funding is shared amongst both professionals and community members.

Sustainability

Conclusions about capacity building

There have been many successes in diabetes prevention interventions in Saskatchewan. Some community members are becoming the change they want to see.

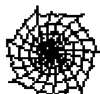
Sustainability is not an idea which most projects have addressed directly. A few groups considered sustainability right from the start of their project. Others are only considering this as the funding closes or they realize that some of their initiatives may not be sustainable.

There are positive examples of organizational support that will enhance sustainability. A few groups have had to work hard to get initial organizational support and to retain it.

Knowledge and skills have been acquired through community-based health education. Funder-supported education opportunities have helped to influence change in the projects' work.

Most groups believe that the partnerships and connections built with community members will continue. Two groups which have completed their funding are examples of this sustainability.

The sustainability of purchased or locally developed resources is unsure



Lessons Learned by Projects

Investments in people can have longer term benefits. One example is the training fitness instructors for communities with few recreation resources.

Learning opportunities are an investment and participants can take their knowledge and skills to other locations or other projects or for their own benefit. In one project, three of the group members who were unemployed at the start now have jobs.

Sustainability is not just about money. Role models and mentors and those who consistently work in their 'quiet' ways can influence change.

Strides in community change go beyond diabetes and its prevention.

Recommendations to communities

Recognize your successes – celebrate them and build on them in your next project.

Look at where you want to go in the long term to address determinants of health, not just the immediate goal for a project.

Recognize the importance of knowledge and skill transfer to other aspects of community development and capacity building and actively promote and enhance this.

Recommendations to funders

Require sustainability planning as part of the project development process.

Provide resources and learning opportunities for projects to gain knowledge and skill in sustainability planning with access provided for both professionals and community members.

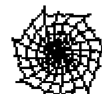
Other Recommendations to Funders

Can funders consider similar application processes and accounting formats to reduce the time spent by a group on project administration?

If funds are available from more than one source, the multiple deadlines and accountabilities can be draining for a project group. Be flexible and use one system.

Consider the evaluation requirements in the context of the length of time available to complete the project. Projects with less than two years may be best to focus process indicators and outcomes as they are building a solid foundation for longer term project outcomes.

Encourage groups to report beyond successes. To support reflection and 'asking why' and build community strength, there is much to be learned from things that did not work out as anticipated



Appendices

APPENDIX A – Diabetes Prevention Projects in Saskatchewan

As the PPDS team was traveling around the province, several groups asked what others are doing in diabetes prevention. To fulfill this request a short summary was written about each project's activities. The summary was sent to the project with a request to edit and also give permission for inclusion in this report. Twelve projects gave permission.

APPENDIX B – Population Health Promotion Ideas

As not all project groups were familiar with population health promotion (PHP) ideas and to illustrate the variety of work which has been done, a brief review of PHP ideas is presented. In addition Figure 8 illustrates the work of the PPDS projects on a continuum to showing increasing influence on determinants of health.

APPENDIX C – Capacity Building Resources

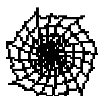
In the data collection and analysis two tools were used – a journey wall and a spidergram. As these tools may be helpful to groups in reflection/'asking why' a brief explanation is given. There is also a short list literature resources.

APPENDIX D - Lessons Already Learned in Community Capacity Building Through Other Studies and Projects

Many groups in Saskatchewan and across the country have worked on capacity building, prevention and/or sustainability. Several reports were provided by Health Canada. These were reviewed and common themes were put in a table format. As well the conclusions from PPDS have been added to the table. This table is of interest as there are common themes emerging. Communities and funders can consider the lessons learned by others in their project planning.

APPENDIX E – Model for Transfer of Learning.

Transfer of learning from the event to application and action is always a desired outcome. This model examines both factors that affect post event transfer of learning as well as the four levels of transfer of learning: reaction/satisfaction; learning and retention; application/behaviour change and observed actions that result from the learning.



APPENDIX A
Diabetes Prevention Projects in Saskatchewan - Summary Reports

Ahtahkakoop First Nation

To begin their diabetes prevention work the Health staff examined what had been successful for them in their Canada Prenatal Nutrition Program and tried to use similar strategies. An outreach worker was hired on a part-time basis to assist with the diabetes program. From the beginning an Elder was involved in the diabetes program. This person helped with the planning and is an active participant in the diabetes workshops.

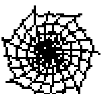
The diabetes prevention work in Ahtahkakoop has focused on the following areas:
- Building community awareness This has been ongoing for several years, particularly at events such as Treaty Days. Changes are gradually being noticed – healthier foods being served at community events, better food choices at the culture camp, people are making different choices when they do their personal shopping.
- Community Physical activity Before the ADI program, the CHRs had an exercise program with a walking club and an exercise program in the clinic. The walking program has continued during ADI.
- Working with the school There have been initiatives working with the school. To raise awareness, students got involved in a contest to create the project logo. There were concerns about vending machine sales and available choices. This has been a challenge as the machines are a source of fund raising. Alternative choices such as milk and fruit for snacks have been introduced. One of the school teachers was a prevention champion by providing fruits and vegetables from his farm for students to sell. Through ADI, a school curriculum was purchased and now teachers have taken on the primary responsibility for this area of education. Funds were provided to the school for purchase of prize incentives to promote increased physical activity for school children.
- Good Food Box The GFB is offered in conjunction with the Prince Albert GFB program and is promoted to prenatal women and people with diabetes and used primarily by ADI clients and Health Staff.

The Ahtahkakoop program has also focused on people with diabetes. Staff members feel that some changes have spread through family connections and then wider into the community through such events as cooking classes and tours of the local grocery store. Also diabetes has been recognized as more than the physical aspects. The mental health worker has now become part of the diabetes program.

For more information contact Lisa Little at 306-468-2747.

Community Linkages Supporting
Diabetes Action within a Primary Care Model
Battlefords Family Health Centre, Battlefords Tribal Council Indian Health Services

BTC Family Health Centre is a designated primary care site in North Battleford and it is a fairly new organization in the community. The proposed project received funding from Health



Canada, Saskatchewan Region. The initial focus was on preparing clients of BFHC, over age 12 years, for diabetes screening and possible lifestyle changes. The project focus evolved to a greater emphasis on primary prevention and community outreach and networking.

Over time the participation level increased both in quantity and quality. The participants were the major feedback mechanism to direct the program. Participants, of whom about 85-90% are First Nations, got involved through the program activities, the feedback mechanisms and some also were volunteers and leaders.

A voluntary diabetes screening process was developed and is implemented by the clinic staff members. Participants can choose to speak with the primary care nurse and can also become involved in group programs at BFHC.

Throughout the project there has been the ongoing development of new linkages and connections within the community. This has evolved to a point where the project is now seen as a resource itself by others to make connections with people. Project participants benefited from access to community resources such as free fitness passes, Good Food Box coupons, experience with healthy food choices and learning opportunities. Many sectors have had connections to the program: education, social services, municipal recreation, media, businesses and health related programs.

Program participants met regularly through a "Mug and Muffin" talking and learning session. The participants chose the discussion topics. Through these meetings, participants could connect to community services and receive support to reach out into their community. Prior to attending this program, most of the participants were quite isolated from their community.

In its final year, the project is working on a volunteer development program. This includes building an infrastructure which will support volunteer roles.

The program evaluation to date has shown that there is more community awareness that people feel they can do something to prevent diabetes. New linkages and connections have been built between BFHC and its community in sectors such as health, recreation, social services, education and community businesses.

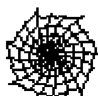
For further information contact Charlotte Hamilton at 306-937-6851

Beardy's and Okemasis First Nation

Beardy's and Okemasis First Nation began their awareness and soliciting of ideas about diabetes and diabetes prevention by doing a community-wide survey. This was started at Treaty Day and followed-up by contact with each household in the community.

Diabetes primary prevention has focused on two areas: walking and awareness in the schools.

- Using the model of the Walpole Island walking program, the Health staff developed a program which featured an awareness brochure, a regular Moccasin Trail newsletter to every household and incentives for walking 100 or 200 miles. They have retained the same walkers over two years with 80% being people who do not have diabetes; 78% women and



most participants either under 19 years or 30-39 years. In 2002 grant proposals were written with community support and a walking path was built. There is now a fund raising committee and they are looking for funding to maintain the path. Schools got involved in walking and using the path.

- The school awareness program has included nursery to grade 8 with interactive presentations made by the nurses. As most children have a relative with diabetes, they were familiar with the disease but did not really understand how it could impact them or about prevention. The Moccasin Trail newsletter includes activities for children. Because of the presentations, the nurses have seen an increase in their invitations back to the school to do prevention work. They have been involved in discussions with children about changes they would like to see in their school. Students recommended healthy food choices and wanted to the school become a smoke-free zone. The Health Team is planning more follow-up with the school.

Other ADI activities have focused on people with diabetes and their families. A workshop series was held at Wanuskewin to provide information and promote the prevention of diabetes complications. Through these workshops the Health staff made new connections with resource persons and saw an increase in the interest of people with diabetes. They are now developing a diabetes clinic with the physicians from Rosthern and the Health Region dietitian.

For further information contact Maureen Esperance-Kinequon at 306-467-4402

Diabetes Education and Action for Life (DEAL) Project

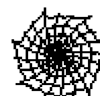
The DEAL project developed from within a community school in Prince Albert, Riverside Community School. The key members of the DEAL Team are parents and community members who have worked with the Community School Coordinator to create and deliver the program.

The DEAL Team presentations and activities are focused around five daily habits: vegetables – eat one more; fruit – eat one more; exercise – move for 15 minutes/day; fat/sugar – eat less sometimes foods; and, I deserve to be happy. The DEAL Team and their partners have translated these daily habits into several activities and events:

- Puppet presentations – pre-kindergarten to grade 3
- Health fair – grades 4-6
- In class presentations, health lifestyles for grades 7-12
- A mini conference with a focus on lifestyle issues including diabetes prevention, healthy snack preparation, healthy and unhealthy choices – drugs, alcohol, gangs, body image for grade 7 students

Partners have included a local service club, the school division, educators who trained the parent/community member presenters and the Canadian Diabetes Association Branch.

In addition to school based activities, the DEAL Team has also been involved in the education of adults through presentations and discussions, a community kitchen, a Good Food Box program and annual poster competition. DEAL Team members, throughout the project, have been able to participate in several training events.



In its final year of funding, the Team is bringing information about the project to other schools in the city, creating posters and a brochure and package for others who would like to have DEAL Teams in their schools.

The leadership for this project has come from within the school and the parents/ community members who have become the DEAL Team. The 'work' of the project included both the activities and also the development of a team through discussion, agreement and disagreement, planning and learning together. The Team members have identified increased knowledge and self-confidence as two of the benefits of being involved. Some of the DEAL Team have used the skills gained and become employed since joining the group.

For more information, contact Delphine Melchert at 306-922-2168.

Heartland Health Region Active (HHR) Living Project

The Heartland project received funding from Saskatchewan Region, Health Canada from September 2001 to March 2003. The project partners were members of the three former health districts in the HHR and the Wild Goose Recreation Association. An Active Living Coordinator (ALC) was hired for the funding term.

There were four core activities in this project:

- Community profiles. The ALC surveyed about 100 communities. The project then focused on those with a population less than 500 as these had the fewest resources for physical activity.

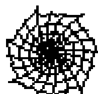
- Presentations. As a result of the contacts made in the community profile process, the ALC offered presentations in communities to promote active living, give information and discuss resources. The ALC was also a resource for information and contacts during the project.

- Community Grants. Four grants were provided to assist communities in increasing physical activity. The grants were available for new or incomplete projects to promote sustainability. There were 33 applications.

- Training of Fitness Instructors. Funding from the project assisted the training of 34 fitness instructors in or close to their home community. These instructors are a local resource for fitness in smaller communities. A few communities 'piggy-backed' on to this and did fund raising for equipment.

- Fitness Challenge. This was piloted in Rosetown and involved 27 teams in a six week event. The purpose was involvement and getting more people active. The challenge was based on the SAHO activity package. The project was both rewarding and time consuming. The AL group has a CD of the challenge and it can be used by other communities.

Since the funded ended, the partnership has continued to meet and carry out the active living mandate of the group through ongoing contact with the fitness instructors trained in 2002-03. Seventy-five percent of the instructors are actively using their training and these instructors, for the most part, are from communities with a population less than 500. New fitness instructor



courses are being planned Jan-March 2004 and participants will be reimbursed up to 75% of their registration fees if they use their training. Also, the Active Living group is organizing a workshop in March 2004 for all the fitness instructors to promote networking, ongoing learning and continued use of skills.

For more information, contact Sheri Taylor at 306-882-4662.

Little Red River First Nation

Little Red River First Nation is a member of Prince Albert Grand Council. Diabetes education and prevention have been ongoing for many years. For more than ten years Health staff members have working in the schools – getting speakers, talking about prevention, helping children to learn about diabetes.

Nutrition is taught in the school (K-12) and healthy snacks have been introduced. There is a new vending machine, but it does have juices as well as pop. The diabetes team from PAGC comes to the community regularly. This team has talked with the teachers to raise awareness and they do some classroom presentations.

There is more walking in the community with more awareness of the benefits. Community activities such as volleyball, hockey are available and might involve not only youth but also adults. The school has an exercise class either after school or in the evening.

For many years workshops have been organized by the CHR for people with diabetes. These are now open to anyone in the community, not only those with diabetes. People are more aware as they have family members with diabetes. The workshops provide information; sometimes there is a healing circle or a cooking class. They are working to get people more involved in the learning, not just listening.

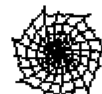
Healthy eating information is also provided in other programs such as prenatal and the Elders group.

Inter-agency meetings have just started and were organized by Education. To begin they are brainstorming ideas and then a plan will be made. The purpose is to make the community better, to make changes.

For more information contact Eliza Bird or Linda Mugford at 306-982-4294.

Ochapowace First Nation

The Ochapowace First Nation diabetes prevention work was built on a history dating back to 1988 of diabetes education and awareness. The programming is also complimentary to community development processes focusing on personal development for community members to build healthy lifestyles and bodies. The development process is for both youth and adults.



This has helped the community to grow in harmony and unity and avoid internal battles against each other.

The community development is also evident in the annual community planning for health with a community-wide consultation. There is a common philosophy in the community that everyone shares responsibility for health. No one does it on their own, everyone shares. There is active mentoring of the younger people. Respect for others is valued and promoted in the community.

The diabetes prevention specific activities have focused on

- Walking and other physical activities The community walking club started in the early 1990s with a focus on community adults. The formal club no longer exists but walking is promoted and people are still walking. There are many walking "challenges" within the community annually; for example, one office may challenge another to walk. There are community wide activity challenges to get more people involved. These increase the sense of community, are fun and provide a social gathering as well as activity

  There is a long term community strategy to have activities for children and youth both to keep them active and to keep them out of trouble.

  The seniors group is active and plans ahead for dancing, walking and social gatherings.

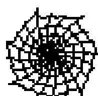
- Healthy eating Healthy eating has been promoted through many activities: cooking classes, access to a dietitian, a snack program in the school, changes to the choices available in the school vending machines – fruit juice, water, subs, fruits and vegetables are now available. The boxing club at the recreation centre has a 'no junk food' policy. If kids bring junk food, they are asked to leave.

  The community has a store that provides milk, eggs and some other healthy foods. Grocery stores are fairly close to the community and group participants observed that 'people are shopping differently now – more fruits and vegetables, less sugar'.

For more information contact Bonnie McKay at 306-696-3557.

Onion Lake First Nation

Onion Lake First Nation began their work in diabetes prevention before the ADI through a survey of 1000 school-age children in the two community schools. The screening did not find any children with diabetes, but did find that many children were 'heavy'. Most children had someone in their family with diabetes. There was already a community concern about the increasing number of number of community members with diabetes and younger age of people at diagnosis.
The prevention work at Onion Lake is a partnership between Education and Health. The partnership is at both the Board level and the front-line worker levels. Together the Education and Health Boards have introduced a school food guide. The guide implementation has seen the removal of pop machines from the school and the availability of healthier food choices in the cold food machines. In the high school much of this food is made by the commercial cooking class (subs, low fat muffins etc). The food guide has supported the work of teachers



and nurses who have provided many awareness, health fairs and education activities in the schools. In one school many of the teachers see themselves as 'role models' in the way that they eat and are active. Children are actively discouraged to bring pop and junk food to school. There are many examples of a 'quiet' way of working and the influence of one person changing then affecting other family members, neighbors and the broader community.

Physical activity is promoted in the schools. Elders living at the Lodge are also involved in regular physical activity and there are increasing opportunities for community members to be active without participating in organized sports. The Health Board has taken a leadership role and gives each of its staff members 20 minutes per day for physical activity. There is an expectation that this time be used for activity and some staff added time from their lunch break to increase their walking distance. Staff members from other organizations such as the Band Office, Learning Centre are seen walking at noon in the community. This reinforces the concept of being active through role modeling.

Some of the other activities have included: promotion through the local radio station – Elders have become involved by talking about diabetes and what they have learned and might do differently; placemats created by school children about healthy living were placed in the local restaurant and a Good Food Box program is just starting.

There are many leaders in diabetes prevention. This prevention work is integrated with other healthy living initiatives that provide similar messages about healthy eating and physical activity.

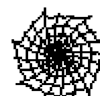
For further information contact Georgina Clements at 306-344-2330.

PAGC Healthy Lifestyle Project

Prince Albert Grand Council (PAGC) recognized the increasing number of urban-dwelling First Nations and Metis people and the potential risk conditions for diabetes in an urban setting and applied for project funding.

The project work began with a formal needs assessment followed by the formation of a fifteen member partnership to provide a community based direction for the program. The major components of the project work have been

- Grants for diabetes prevention Grants up to $1000 have been given out three times during the project. These grants have helped increase awareness of diabetes prevention and have taken the concept of prevention to a diverse range of community groups, much broader than a single project could achieve. One example of a successful grant to create supportive environments is the recent opening of breastfeeding rooms in four different local stores. The breastfeeding initiation rates in the community are high, but the sustainability is not as good. Hopefully a baby friendly environment will encourage mothers to continue breastfeeding. The Good Food Box program used its grant to produce a newsletter promoting healthy eating and the use of fruits and vegetables. The newsletter also has information on diabetes prevention.



- Working with schools This aspect of the project work has been ongoing and evolving. Some of the work involved raising awareness through school presentations and follow-up discussions with principals and teachers. School staff were asked to get involved to reinforce student learning from the presentations and health fairs. The project staff now have a relationship with the community school coordinators. This has resulted in more concrete efforts to work towards school nutrition policies.
- Community Awareness In addition to awareness generated through the granting process, there have been public displays and presentations, post-secondary school presentations, ongoing gatherings at the Friendship Centre. This work resulted in one group totally re-vamping its menus for toddlers and their own employees – there's water and milk now instead of Kool-Aid/juice and pre-fab food has been banned. This group decided that modeling healthy eating to its family participants is important to create an impact.

As funding ends in March 2004, project partners were able to identify several elements of sustainability including the 'working together' of the partners, the concrete outcomes in tools and resources from the granting process and changes in thinking about diabetes prevention in the community.

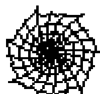
For further information, contact Jan Kroll at 306-953-7253

Sturgeon Lake First Nation

Sturgeon Lake First Nation is a member of Prince Albert Grand Council.

The diabetes prevention work in Sturgeon Lake started around 2000. Before that time there were few services for people with diabetes and diabetes prevention work was limited. The diabetes prevention work has focused in several areas:

- Working with the School The nurses and diabetes team from PAGC have been providing information sessions for students and promoting healthy lifestyles. The nurses worked with the school Principal and the pop machines have been removed as a fund raiser. Individual classes provided a canteen to raise money and sell juices and other healthy items. The school canteen provides healthier choices such as fruit or vegetables and dip. There is a breakfast program for Nursery to Grade 6 and a lunch program, as needed.
- Participating on the Inter-agency committee This committee helps to find the voice of the community. Through this group, the health staff was able to advocate with the Principal, for the purchase of a diabetes curriculum for the school. Follow-up work will be done to implement the curriculum. The interagency group is looking at the development of a youth centre.
- Working with the prenatal program The prenatal program has started a cooking program with classes taught by a community member. The interest is high and staff hope this will eventually expand to the postnatal period and the after school program. Home Economics is no longer provided in the regular school curriculum.
- Good Food Box Fruits and vegetables are more accessible and affordable in the community through the Good Food Box program. This is done in cooperation with the Prince Albert GFB and coordinated by health staff.



- Adoption of the medicine wheel In 2002 the Health Board adopted the medicine wheel concept. Health staff became aware that the spiritual and mental needs had been neglected in their diabetes and diabetes prevention programs. They worked with the Aboriginal Wellness Team (Capital Health, Edmonton) to change the focus in dealing with diabetes. Participants felt that they learned more about listening to understand what people are saying. An advisory committee of Elders has been formed. The Director Education has been involved in the discussions and the Elders may become involved in the schools as well. The involvement of the Elders has helped to meld together all of the knowledge with the spiritual aspects. These changes are just beginning.

In addition many services are now provided for people with diabetes. There are both individual home visits and community workshops. A podiatrist and the PAGC nurse/dietitian team come to the community regularly.

For more information contact: Norma MacPherson: 306-764-9352

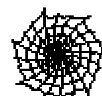
Swift Current Diabetes Awareness Project (SCDAP)

SCDAP was the last group to receive funding through Health Canada, Saskatchewan Region. The funding was received in late 2002, with activities beginning in early 2003. SCDAP has a partnership which forms the steering group (health, recreation, Canadian Diabetes Association). SCDAP has built connections to many community groups including the schools, Broncos Hockey Club, Parks and Recreation for the City and others.

Several activities have been attempted and more are planned for late 2003, early 2004. In addition SCDAP has developed three permanent resources. The resources will be piloted and evaluated in the next few months.

- Teachers Toolkit for grades K to 9 with 23 options related to diabetes knowledge and prevention. The kit is tied to the Sask Health and phys ed curriculums and contains a variety of activities.
- The Activity Calculator is a tool to assist people, no matter their age to figure out how to go about doing physical activity and what the benefits are (not based on calories) – it has four levels of physical activity progression with a foot wear motif – slide out of your slippers, lace up your high tops etc.
- The Body Walk is an interactive educational health fair where kids learn about the different parts of the body and about good health. There are seven different stations including one station devoted to diabetes awareness.

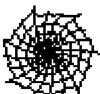
Some of the activities of SCDAP have included:
- Presentations at teachers' in-services in the City and to those who teach Hutterite children
- A project awareness launch
- A Broncos hockey game for Diabetes Awareness Month
- A project newsletter which is distributed to partners and supporters, teachers and others
- Chinook Pathway Challenge – a summer activity to promote use of the community walking path. Local media was involved in promoting this project.



- Summer Parks Program – where they supplied healthy snacks and an activity for the children who participated
- Workshops on reducing the barriers to physical activities

The SCDAP steering group is now examining its sustainability and will be focusing on partnership development, clarifying its vision and goals and finding others in the community with similar interests in chronic disease prevention. The group would like to form a more active partnership with the Swift Current schools and will be examining how this might be achieved.

For more information contact Jenise Tisdale at 778-2267 or Eric Greenway at 1-800-297-7488



APPENDIX B
Upstream – Down Stream – Where Are You Working in the Stream?

In discussions of primary prevention, health promotion or population health, the terms "up stream" and "down-stream" are sometimes used to describe a continuum in working towards addressing the determinants of health. As the Canadian Diabetes Strategy's first five year cycle comes to an end in March, 2004, it may be useful for community groups and health workers to consider where they are in the 'stream'. This reflection will assist with ongoing planning both for diabetes-specific primary prevention work and community development and capacity building.

In the following section there is a brief description of some of the terminology used in population health promotion and this is then linked with some of the key ideas needed for working in the way of population health. Finally, Figure 8 uses examples of activities found in the PPDS data collection to illustrate the range of actions and activities from down-stream to up-stream.

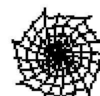
What are the key terms to know?

Health is "a dynamic process involving the harmony of physical, mental, emotional, social and spiritual well-being. Health enables individuals, families and communities to function to the best of their ability within their environment".[29]

Many variables can influence health. In the population health model, these are referred to as determinants of health. "… these factors include: social, economic and physical environments, early childhood development, personal health practices, individual capacity and coping skills, human biology and health services".[30]

Diabetes-related research to link determinants to the incidence of type 2 diabetes has been minimal. Observations found in the literature by Raphael et al[31] make some plausible connections and they advocate for more research in this area. Some of potential linkages they describe include:

1. 26% greater excess risk of diabetes among low income Canadians independent of other behavioural risk factors
2. a study of the precursors of metabolic syndrome among Swedish women with low education (a proxy for lower income) showed an associated 2.3 times greater likelihood of metabolic syndrome even after accounting for age, family history, smoking, lack of exercise and alcohol consumption
3. in Ontario the risk of diabetes is four times greater among low-income women than that seen among high-income women; the rate for low-income males 40% higher, an among lower-middle income males, 50% higher than the well-off.
4. In a Woman's Action Project in Canada, low-income women identified a lack of access to physical activity in the their community as a major factor inhibiting the development of healthy lifestyles for themselves and their families



Three key strategies have been identified for population health promotion[32]:

1. Building healthy public policy. This refers not only to health but to all types of public policy and implies the encouragement of policy makers to consider the impacts on health of all policies. The venue of a policy can vary from workplaces, schools or any level of government. This also implies that those in the health sector needs to work across many sectors, not just within their own area. The strategies may include: advocacy, development of healthy policies, collaborating with others to find out where policy changes can improve health and then working to gain policy implementation.

2. Creating supportive environments. Environment is considered in its broadest context – physical, political, economic, social and the interactions amongst all these aspects. "Our environment is not only physical; it also has social, political, and economic dimensions, and all these aspects interact to exert a powerful influence on health".[33]

3. Strengthening community action. In healthy communities there is sharing and caring and members work together and mobilize their resources and skills, as needed, to solve problems. People have a both a sense of belonging and feel connected to each other. Capacity building is part of strengthening community action. It is, of course, important to start where people are at and build on existing strengths.

The population health approach uses eight key ideas.[34]

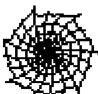
1. Meaningful participation
   Meaningful participation encourages and enables all people to look at problems in their lives and living conditions, decide what is needed, set priorities and act. People may act on development, implementation and evaluation of programs, services and/or policies. To ensure meaningful participation, people need to be supported with tools, skills and resources.

2. Take action on a variety of determinants of health
   Many factors explain why some groups are healthier than others. Health determinants are a range of personal, social, economic and environmental factors. These factors determine the health status of a population. Recognized health determinants are: income and social status; social supports; education; employment and working conditions; physical environments; biology, genetics, gender; personal health practices and coping skills; healthy child development; health services; culture and spirituality.

3. Multi-sector collaboration and partnerships
   Health is more than work done in the health sector. Because the determinants of health are so broad, population health promotion requires the involvement of a wide range of agencies, organizations and individuals, in addition to those in the health sector. Partnerships amongst **many** different sectors of society are needed to improve health.

4. Supportive environments to reduce inequities/remove barriers
   People are more likely to be healthy if they live in surroundings where it is "easy" to make healthy choices. Supportive environments may be created through policy at various levels, economic development and social action.

5. Capacity building and empowering practice
   A community's action and its health can be increased through awareness and knowledge, skill development, knowing how to access resources, developing social networks and learning



from efforts. Empowerment means that people gain confidence and have control over decisions and actions that affect their health

6. Actions that focus on health of the population (not individual)
   Individuals cannot control all the factors that determine personal health or community health. Population health focuses on a community's capacities and actions to promote health.

7. Focus upstream on taking action earlier
   Working upstream means looking beyond the immediate issue or problem. What is the cause? Why is this happening? How early can prevention start? Taking action earlier often means working with children or youth or starting before there is an issue or problem.

8. Evidence based decision making
   Evidence for decision making may come from: traditional knowledge, evaluation, research or knowledge gained through practice and put into a form that guides practice and policy. Using evidence makes sure that practice and policies focus on the right issues, take effective action and give sound results.

Working Up Stream

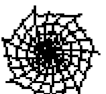
A PARABLE

One day a group of villagers was working in the field by the river. Suddenly, someone noticed a baby floating downstream. A woman rushed out and rescued the baby and brought it to shore. The woman who rescued the baby took it home since nobody else knew what to do with it.

The next day there were two babies floating downstream and the people who rescued those babies took them home. On the third ay there were three babies. Before long, there was a steady stream of babies floating downstream. Soon the whole village was involved in the business of pulling babies out of the stream and ensuring that they were properly fed, clothed , housed and educated.

One day someone decided to go upstream to find out who was throwing all the babies into the water. A huge controversy erupted. One group argued that every possible hand was needed to save the babies since they were barely keeping up the current flow. The other group argued that if they found out who was throwing the babies in, they could stop them and would not need to save babies anymore.[35]

From this story comes the notion of upstream and downstream work. Downstream work focuses on individuals and often on those who are already diagnosed with a condition or at very high risk to develop it. In primary prevention work, it is important to look up stream, determine root causes for individuals to be 'at risk' or frequently diagnosed and then design strategies which work towards addressing health determinants and related to whole populations rather than just individuals. Upstream work reduces barriers and creates supportive environments. Consideration must be given to working with other sectors, using community development and capacity building principles.



Working up stream and even mid stream can be challenging and progress takes time. Usually population health work occurs at multiple points on the continuum. The 'Ask Yourself' box[36] has questions to consider as you do your work.

Ask yourself...

Is my policy, program, service, etc. preventive?

Will it help maintain or improve group health or quality of life or reduce known hazards?

Does my intervention reflect what I found out about the problem's root cause(s)?

Where on the health continuum have I invested/ concentrated my resources and what was my rationale?

How will my intervention(s) maximize savings down the road, and what price tag can I put on those savings in human, social, economic or other terms?

What other long term dividends may be expected?

For example, many of the PPDS projects worked concurrently on mid-stream activities while also addressing current beliefs and perceptions about the reality or possibilities for diabetes prevention.

Working upstream is not necessarily the ultimate in population health work. Unless there is a solid foundation of relationships, capacity and community readiness, policies, for example, will be only paper on the shelf.

Capacity building is not a single activity, rather it is ongoing and made up of many strategies, activities and there are many ways within a community to add capacity. Building capacity is beyond the immediate short term goals, it is the 'how' to a larger long term goals in address determinants of health.

Saskatchewan Prevention Projects Working In the Stream

In Figure 8 the actions and activities from the PPDS projects are aligned along the continuum from down to up stream. The placement of each activity was based on definitions and examples taken from several sources.[37]

Upstream work addresses risk conditions for health. Examples include changing environments, creating healthy policy or guidelines or norms within a community, reducing barriers for all for effective participation by community members.

Midstream work is not as far along in addressing risk conditions and is the work that 'sets the stage' to be able to work further upstream. Examples include planning for capacity building in communities, learning opportunities, reducing barriers for some population segments, health promotion targeting groups and communities.

Downstream work addresses those at high risk for a condition or those already diagnosed. It may include client education, behavioural interventions, self help groups.

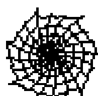
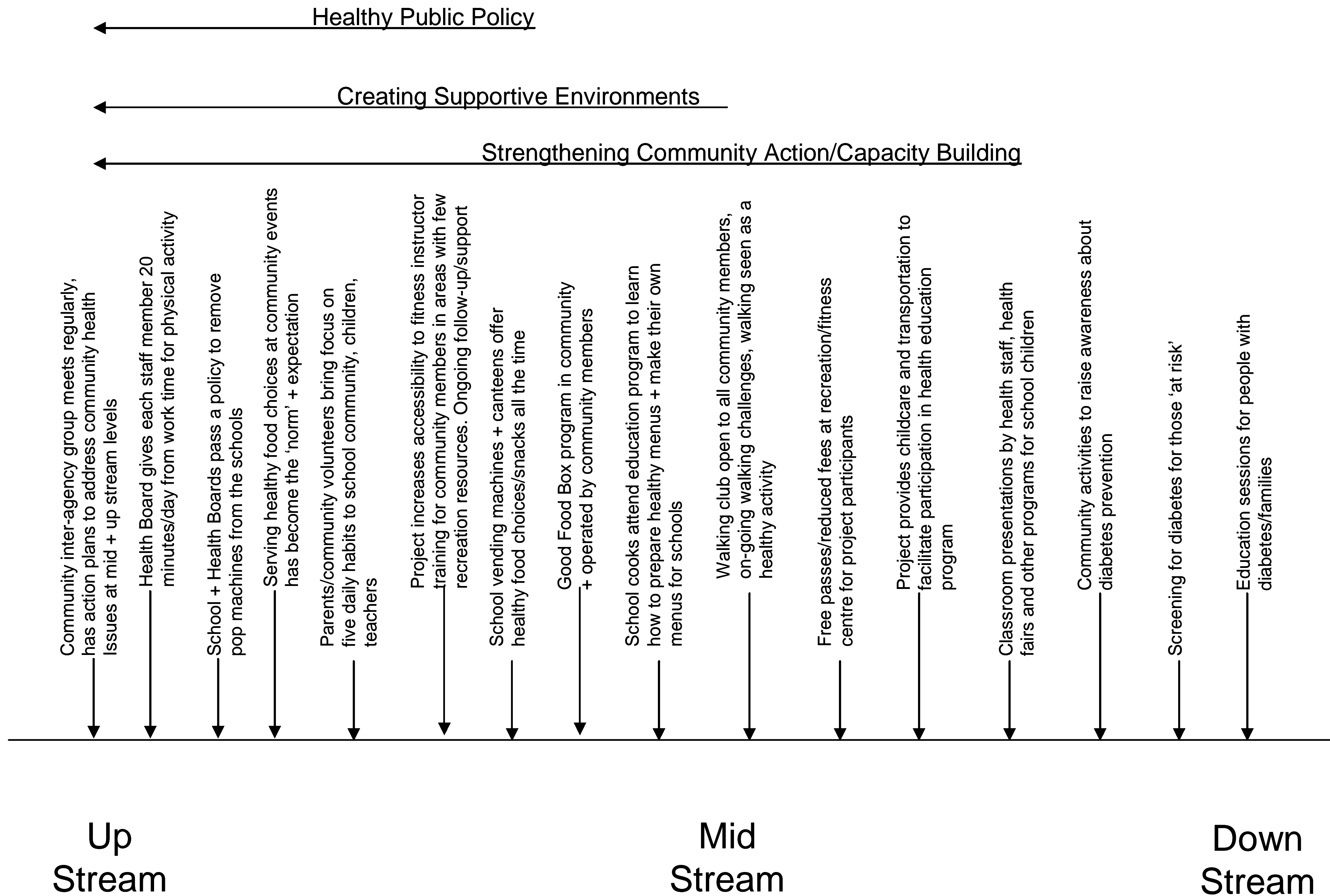


Figure 8: Working Upstream on Risk Conditions and Towards Determinants of Health



APPENDIX C
Capacity Building Resources

Using a Journey Wall to Review Your Project and 'Ask Why'

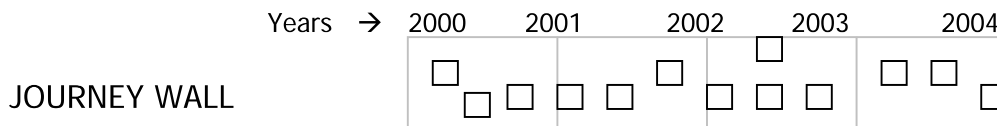
A journey wall is a tool which can be used by groups at various times in the life of their project. It can be used an annual review, at times when the project seems 'stuck' and needs to take another look at what is happening or when new members join. The following description and suggested questions are adapted from Williams[10] and Stanfield[38] and the interview guide for PPDS.

How to create a journey wall

The journey wall process can be done informally. It is often helpful to have a facilitator to guide the process and ask the questions.

Materials

- Room with a large wall space that will be visible to the whole group
- Several sheets of flipchart paper, turned horizontally and aligned side by side
- Cards or small sheets of paper to put above the 'wall' with the significant dates – years or months of a project
- Sticky notes or cards to write down the key project milestones. Sticky notes are helpful as they can be moved around on the wall
- Markers to write on the sticky notes. Large print is helpful so that everyone can see what is written

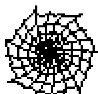


Getting Started

Create a focus question to get everyone stated. The wording depends on the reason for creating the wall. Here are some examples:

- What are the important "markers" that describe the timeframe for which we are reviewing this project? The markers might be events, decisions, involvement of certain individuals or groups, changes or results seen
- How did we get started on this project? What was happening? What were people doing or saying then?
- What are some important events and decisions that got us to where we are now? Who got involved along the way and when?

The writing on the sticky notes can be done by all the group members or they can talk out and the facilitator can write for everyone.



After all the ideas are on the wall, the facilitator, with the help of the group, reviews the journey. Sometimes there will be themes or threads that will show up. These can often be displayed as a continuous line. For example, a project may do work in several areas such as a community committee to support a walking club, a community group to lobby to local store for better access to fruits and vegetables and a parents group. The notes that connect each theme can be put together. Be sure to note any events, happenings, decisions that affect or join together the sub-groups.

The creation of the wall may generate several shorter discussions around the sub-themes or groups in the project or it might be one overall discussion. There is no right way. For each area discussed try to have a series of questions that help everyone to think through and talk about:

- What happened, what did we do so that ____ worked?
- What happened, or did not happen so that ____ did not work as well as anticipated?
- What were the challenges in
  - trying to complete this aspect of the project
  - reaching a decision
  - arriving at a consensus amongst partners or groups
- What has been learned? What are the lessons for next time?
- What difference is being made in the community, for community members?
- Who is supporting the work, who else might get involved?

The following are a series of questions that will help with reviewing the whole project after all the stickies are on the wall. You don't need to answer all the questions in each section, but try to work through all the sections.

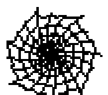
A.
What 'jumps out' at you when you look at the wall?
What do you remember the most?

B.
What are the key values we have used in this project so far?
What surprises you about what has happened so far?
Where have things been more difficult or challenging than expected?
Where have there been unexpected happenings?
What worries you about what has happened so far?

> [NOTE: This question does not have to lead to problem solving right away, rather note the worries or concerns. If group members begin to problem solve, note their thoughts on a separate flipchart page and 'park' them for later discussion.]

C.
Where are we progressing well?

> What has helped us to move ahead?
> What might have held us back?

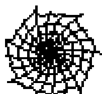


Where are the areas where we are not progressing or feel stuck?

- What has helped us to get as far as we are?
- What are the roadblocks?
- What will it take to get us moving ahead, even in a small way?
- Is this still important to our project and the community? How do we know? Who might we need to ask?

D.

What will we carry on with in the project?
What will we change and how?



Spinning Your Own Web for Community Capacity Building.

In the body of this report the analogy of a spider web was developed. Researchers have used a spidergram[39] to create several continuums of indicators important to community capacity building. Five of those indicators are featured in this report: building connections, critical reflection, leadership, resources and structures.

A spidergram can be used in several ways to:

- Create ratings on a continuum as a measure of pre and post-interventions in a project as part of the evaluation. The pre-assessment indicates areas of strength to build on and areas where development will need concentration. The post-ratings will indicate change (or not) and discussion and other data collection will supplement the ratings.
- Document current status at any time in a project. This can be helpful to stimulate reflection in general, analyze what is working well, challenges or future directions or strategic initiatives.

There is always a need for discussion amongst group members to supplement the rating process. The questions used in the description of the journey wall activity can be used or adapted to facilitate and focus discussion.

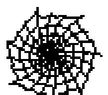
The following pages provide a sample of a spidergram using indicators for sustainability of a project[22].

Participants are instructed to complete the assessment form individually. Then either each person can place ratings on the spidergram or group members can work in pairs to do a combined rating. As above, full group discussion will be important.

These are suggested definitions/questions only. In some of the research, groups found benefit in developing their own definitions that are relevant to their project and to their community.

In all conversations it will be important to understand:

- The wisdom of all contributions
- The thinking behind viewpoints that are widely different – consensus may not always be needed. The divergent thinking often stimulates new ways to examine an issue or challenge
- When thinking is similar – why the rating was not higher or lower



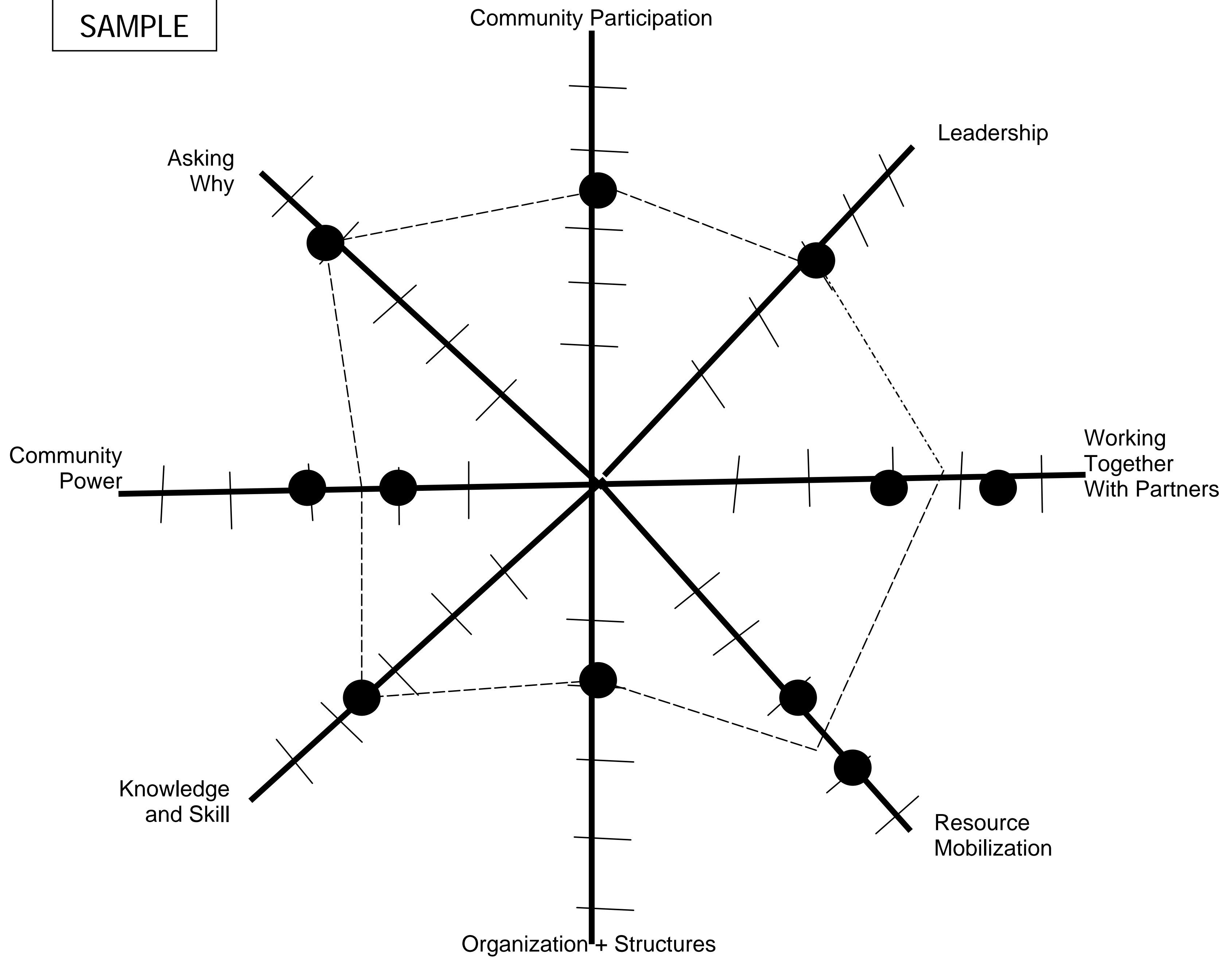
INDICATOR	QUESTIONS TO CONSIDER IN RATING	THOUGHTS/COMMENTS	HOW DID WE DO?
Community Participation	- Who got involved (groups, ages, genders)? - How did we get people involved – listening, making decisions, giving input, helping out or ? - Could more people have been involved? - What was the trust, confidence and cooperation in the community for the project?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed
Leadership	- Who provided leadership for the project? - How was leadership given – asking, telling, talking, listening, encouraging or ...? - Was leadership shared? - Did some new people become leaders during the project? - How often were community members the leaders and not the professionals?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed
Working Together with Partners	- Who were our partners? - How did we work together in this project? - What did we do when we did not agree? - What did we do when we ran into a problem with partners?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed
Resource Mobilization	- What resources (people, relationships, volunteer, in-kind, access) were you to mobilize (get going) during the project that will continue afterwards? - What new resources were added? - What difference will these resources make to the community or to any new work or projects?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed
Organization and Structures	- Are there any new ways of doing things that will help prevent diabetes or other health issues? - Are there any new policies that will guide groups or the community in the future? - Are there any 'risk' conditions for health in your community that have been changed by this project?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed

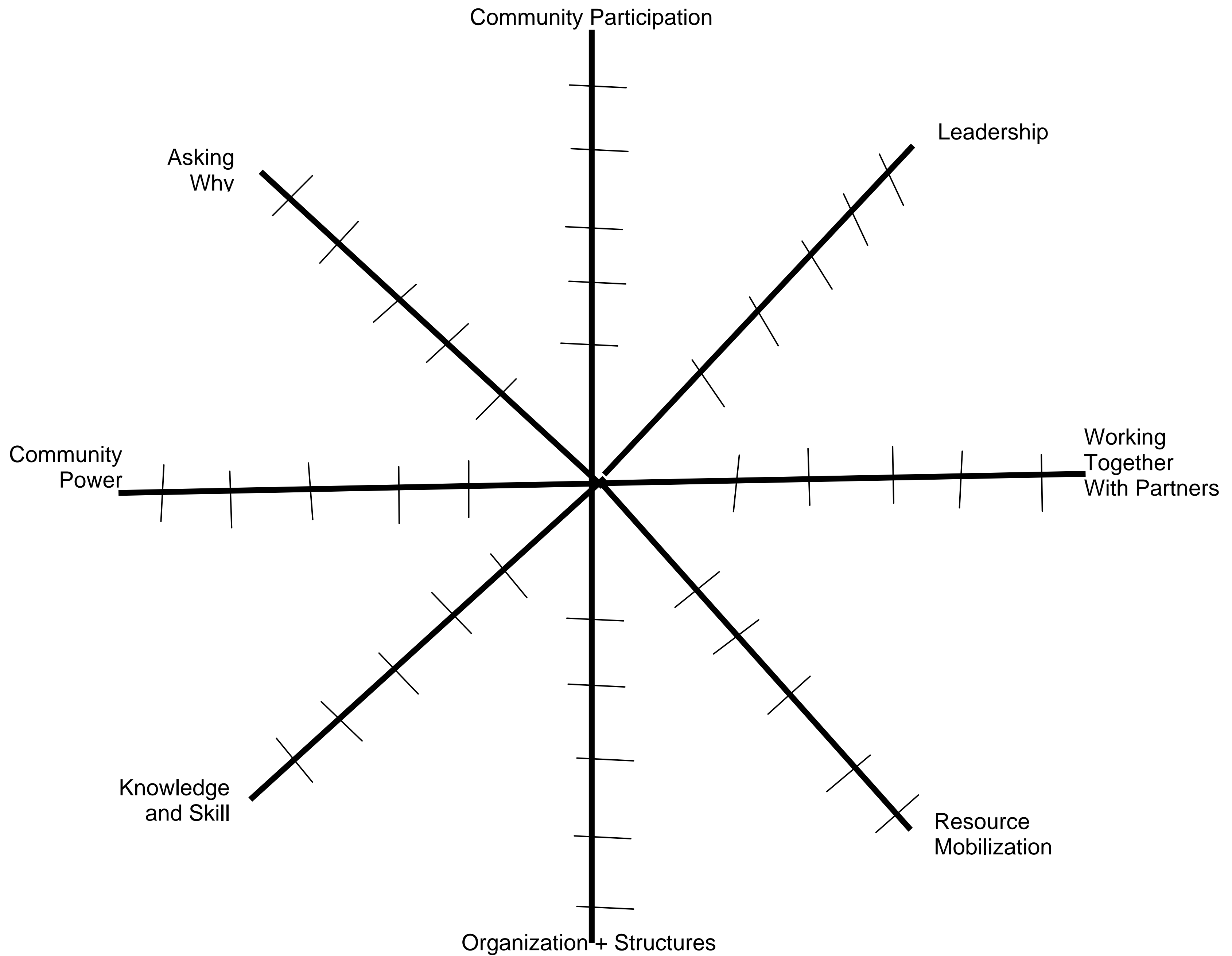
INDICATOR	QUESTIONS TO CONSIDER IN RATING	THOUGHTS/COMMENTS	HOW DID WE DO?
Knowledge and Skill	What are new skills or knowledge do you have from this project that will help you to work with communities in the future? - What new knowledge or skills do you see do you see in others that might help to carry on community work? - What differences will these new knowledge or skills make for the community or you as an individual? - Are there new ways of thinking about diabetes prevention in the community?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed
Community power	- How did we manage change in the community? - What did we do if some did not want to get involved in the project? - How much discussion did we have in the community about the project before it started, during the project? - Who has the power or authority to make this work continue? - What voice will the community have in ongoing work?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed
Asking 'why'	- How easy or hard was it for us to look at what was happening in this project and figure out what worked, what did not work and why? - Can we talk about 'lessons learned' from this project? - How do these lessons affect what will continue after the funding is done?		__Very well done, ready to move on __Fairly well done, minor changes needed __Okay, think about future improvements __Not so well, planning more needed __Very poor, serious consideration needed
Final Question	What is the most important learning in this project about: □ The community □ Working for the community □ What we can do next from this project		

Spidergram Worksheet - SAMPLE

Each 'leg' of the spider represents one of the indicators for sustainability.

After you talk with your partner about the two indicators assigned to you, decide what 'score' you would like to give for the indicator and mark it on the diagram with an X. If you cannot come to agreement (or close to agreement), mark two Xs. The lines on the leg, from the inside outwards are:


SAMPLE
Community Participation
Leadership
Working Together With Partners
Resource Mobilization
Organization + Structures
Knowledge and Skill
Community Power
Asking Why


Community Participation
Leadership
Working
Together
With Partners
Resource
Mobilization
Organization + Structures
Knowledge
and Skill
Community
Power
Asking
Why

APPENDIX D: Lessons Already Learned in Community Capacity Building Through Other Studies and Projects

LESSON	PHP Study Sask Creating Healthy Communities 2003[40] N = 46	Saskatchewan Health[4] Demonstration Site Report N = 7	Creative Spice[41] PHP Funded Projects in BC/Yukon N = 11	Evaluation Summary Report[42] CDS Albert	Primary Prevention of Diabetes in Sask N= 16 Health Canada 04
Summary	46 funded projects in SK were interviewed to examine the sustainability of projects after Health Canada (HC) funding ended. Special emphasis on examining role of intersectoral partnerships that continued post funding.	Seven demonstration sites covered more than ½ of the Health Districts in SK were funded for 3 years for primary prevention of diabetes. Used PHP model with proposal criteria based on PHP, and partnerships outside Health.	Synthesis and discussion of lessons learned in 11 voluntary-sector projects in British Columbia / Yukon to put the Population Health Approach (PHA) into action at the community level.	Reports summarizes presentations made by 5 Canadian Diabetes Strategy projects, completed 2001-03 and summarizes projects ongoing 2001-04; n = 4. Completed projects described activities, PHP insights and learning.	Focus groups were conducted with 16 projects to document the contribution of type 2 diabetes prevention projects toward developing capacity for people, organizations and communities to promote health in Saskatchewan.
General Benefits	Funding provided an opportunity to develop a project for the benefit of their community. Funding enabled them to realize a dream, challenge a new territory and take a risk that they otherwise would not have taken.	Opportunity for individuals, organizations and communities to increase their knowledge and skills in using the population health promotion approach (PHP).	PHA confirmed what was already happening. Community workers were addressing health issues from a broad perspective that recognized the influence on health of social, economic and environmental factors interacting with each other. PHA gave projects new credibility in communities. Could test new models for engaging the community in a collective approach to improving health and wellbeing. PHA inspired a high degree of creativity and more community participation than non-profit sponsors usually experienced.	CDS Alberta had 3 funding priorities: 1) promoting and supporting healthy lifestyles for children, youth and families in home, school, workplace and community environments. 2) collaborating with existing networks to build on current chronic disease prevention work related to diabetes. 3) strengthening involvement of sectors outside health in planning, implementing and evaluating collaborative strategies to address determinants of health for diabetes prevention.	Funding to Saskatchewan projects through the Canadian Diabetes Strategy provided resources to • on and health promotion in all First Nations communities, in 4 off-reserve communities and six other centres • create change – healthier food choices are being made, there are alternatives to get healthy foods – gardening, Good Food Boxes, and more people are active, often walking work towards addressing risk conditions

LESSON	PHP Study Sask Creating Healthy Communities 2003[40] N = 46	Saskatchewan Health[4] Demonstration Site Report N = 7	Creative Spice[41] PHP Funded Projects in BC/Yukon N = 11	Evaluation Summary Report[42] CDS Alberta/NWT 02-03	Primary Prevention of Diabetes in Sask N= 16 Health Canada 04
Beneficiaries (target pop)	Several project outcomes turned out to extend beyond the designated beneficiaries. Demonstrated that all life stage groupings were inter-linked and population health gains affected the entire community.	Each project chose its own target group. Had to address 3 issues: 1) Create social/physical environments that support healthier choices, 2) Enhance community action, and 3) Reduce risk conditions for type 2 diabetes. In practice, reducing barriers became the background for the initiative	Explaining PHA concepts was a challenge. The language of PHA was a barrier to understanding. Difficult to explain to community participants because of the jargon in academic and government materials. Challenge to change the view of health to that of a community rather than individual responsibility.	Each project has its own target. Completed projects included: 1. single community 2. school division 3. two school districts (funding to Alta Teachers' Association) 4. measurement model for childhood obesity 5. provincial fitness unit – tested in 2 regions	It was important to groups, particularly those in or working with First Nations, to have funding to work on diabetes prevention. Diabetes and its complications are seen as an important issue in most communities. Attitudes and perceptions about possibilities for diabetes control and prevention are starting to change. Champions for prevention are emerging in communities amongst their members.

LESSON	PHP Study Sask Creating Healthy Communities 2003[40] N = 46	Demonstration Site Report N = 7	PHP Funded Projects in BC/Yukon N = 11	Report[42]	Diabetes in Sask
Leader-ship	Inspired and enthusiastic leadership was key to a successful project both at project management and community levels. Getting the 'right' person for the job was important. Leader needs ability to communicate and to sustain partnerships.	Adjustments for health professionals who were trained to work independently to address problems and deliver programs. Stimulating community action was more difficult without consistent leadership. Community development process needs to be balanced with people's desire to see action and progress. Difficulties with changes among leaders or with the need for further leadership training in communities. Leadership skills and participatory facilitation were critical for groups to stay alive.	Responsibility for the projects to provide leadership in explaining the PHA with the community was inherent in the expectations of the Fund. The projects had widely varying capacities for doing this. Strengths and limits of the voluntary sector need to be better understood and integrated into government planning if the voluntary sector is to be a leader in promoting the PHA.		I of the leadership came from the Health Sector. In intersectoral leadership team. Almost all of the latter teams were formed for this project. Where community leadership occurred, it was project strategy and took a lot of support for development and sustainability. Unless com leadership development was did members of the leadership tea workers in the community. The local government is stable. These two variables appeared to facilitate the quality of some projects' wor

LESSON	PHP Study Sask Creating Healthy Communities 2003[40] N = 46	Demonstration Site Report N = 7	PHP Funded Projects in BC/Yukon N = 11	Evaluation Summary Report[42]	Primary Prevention of Diabetes in Sask N= 16 Health Canada 04
Partner-ships	Partnerships enhanced the capability of delivery and to some extent sustainability of the project. Cohesive collaboration ie intersectoral partnership – appeared to be a key to success.	A project requirement. Communication was the most important variable in partnerships' ability to deliver a program. A broad base of support and achieving results the partners believed were important were critical to keeping a partnership active. Takes time, energy and commitment. Time consuming but increase expertise, impact and resources. Difficult to involve community members as partners. Some groups looked to Sask Health to provide support to help resolve partnership issues.	Requirement for intersectoral collaboration added a high degree of complexity. Ensuring intersectoral collaboration was the greatest challenge. Most were successful with collaboration with health and social services public and non-profit sectors in their communities. Collaboration takes time, energy, resources and leadership. It needs feeding and fuel. Collaboration fatigue was identified with increasing demand for intersectoral collaboration.	For project success, partnerships are key and include: 1) effective communication 2) clear decision making process 3) clear roles and responsibilities 4) supporting structure and good governance – for example, terms of reference 5) building and maintaining relationships Allow time for relationship building.	Partnerships were important in doing diabetes prevention work. Most of the partnerships in these projects were brought together to this specific work. Several partnerships were able to connect with a pre-existing or a developing interagency group in the community. This connection was described as positive and supportive of prevention work. Relationships with formal leadership were variable. Few groups received active support from their formal community leaders and few attempted to work with local government. Most projects wanted to work with a school(s). There were few examples where this desire translated into a full partnership with common vision and goals

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Personnel	Need to identify and retain the right person for the job. Guard against volunteer burnout and staff attrition	Variable opinions about having a coordinator for the project. For a number of projects, eased the workload. Risks that a paid person decreased volunteer involvement and less community action. If there is a coordinator consider sustainability when developing job description and role. Benefits of an Aboriginal person as coordinator when working in Aboriginal communities.	Key to success: find and involve the right mix of people from marginalized individuals and groups to those with influence and power who were interested in active participation and shared a common vision and values. Need support so community members do not 'burn out' and do not give up their efforts to create healthy communities.	Open communication, regular meetings and discussing obstacles with the project's key players was important for the development of good relationships.	

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Project Planning	A small and manageable project that was well planned and funded seemed to have better success than a long term plan that was only partially thought out & inadequately planned/ funded. One time ventures recorded positive outcomes. Awareness was raised about specific future issues. Some spin-offs emerged beyond the original event. For some it was: "grant gone – project ended".	Reducing barriers/creating healthier environments/ working with partners – hard to separate out the components, do not stand alone, takes many elements to make a program. Each program was required to include multiple strategies.	Important to build on the strengths and resources already in communities. Recognize and use existing capacities, support and enhance community networks and collaborations to avoid duplication and competition. Some groups were overly ambitious about what they could accomplish with the time and resources available.	Identified need for systematic planning for project success. This includes: 1) a clear needs assessment 2) community involvement 3) building on existing community resources 4) attention to timelines 5) involvement of diverse comm. groups	PPPDS focused on capacity indicators. 'Asking why' partially addresses project planning. There was diversity in the building of capacity for reflection. Not all groups knew about or were able to use this process during their project. Groups with regular times for reflection were fewer. Taking time for reflection appeared to be either their usual way or working and/or a function of their leaders. Some groups became immersed in activities and felt they had 'no time to think'. The required evaluation process often stimulated reflection. A few groups used learning opportunities to build their capacity in 'asking why' and to analyze. Usually these groups had spent time working on a vision for their work.

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Project Implementation Issues	A need may have been identified in a community, but the community might not be ready to address the need.	May be overwhelmed or discouraged when trying to solve determinants of health issues (poverty etc). These are long term goals, in short term work toward reducing effects of barriers. Identifying some of the barriers to good health led to many practical approaches to reducing their effects. Supportive environments and community action were necessary first steps in order to implement healthy public policies. HPP was most difficult strategy. Policies more likely to be used if supported by the community and environment made it fairly easy.	Most projects found they were not adequately prepared for the complexities and time involved in putting into action an approach that required the involvement of so many different stakeholders with different levels of education, knowledge and experience. Most projects used community development tools and strategies that may not be as effective for ensuring intersectoral involvement as community involvement.	Many relationships with partners were established prior to a project, which allowed the project to 'hit the ground running'.	The capacity indicator closest to program implementation is building connections. In the few communities with lower levels of connected-ness, staff turnover and an absence of strong relation-ships between the health sector and the community seemed to occur. In projects with interactive or self mobilization participation, influencing variables appeared to be • a deliberate plan to enhance connections and social networks • support of the leadership in the community and/or key organizations related to the project Some projects lamented the lack of participation and said they did not know how to enhance it Several groups were hoping to have volunteers to assist with project work or for sustaining an activity. For the most part this did not materialize. Where volunteers were evident, it seemed to evolve from small groups where trust and confidence had been established and people had a personal desire to see something happen. Sometimes potential volunteers were provided with learning opportunities.

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Sustain-ability/ account-ability (general)	Different definitions among project sponsors. Sustainability was generally dependent upon strong leadership, partnerships and community support.	Clearly a legacy from each demonstration site. Partners have become involved in other interagency meetings. They are part of the planning/ implementation of a variety of initiatives. These are not just information sharing meetings. Partners learned that communities generally knew what they needed and how things could be realistically accomplished. Communities have strengths and capacities that can be developed for community action.	To be successful, projects felt they had to change attitudes in their communities from a view of health that focused on health as an individual's responsibility to one that viewed health as a community responsibility. Projects found a lack of models and materials regarding determinants of health and the PHA that were appropriate for the implementation of PH projects at the community level. Need clear acknowledgement by all involved of the time and energy required for intersectoral collaboration and building broad community involvement.		

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Sustain-ability (specifics)	Many pilots achieved sustainability and became established within the culture of the sponsoring organization and their respective communities. Organizations with experience and expertise in funding procedures and human resource support appeared to do well. Good business management was important to sustainability. Some organizations said they need strengths in this area. Lack of business plan hindered sustainability. Long term plan beyond the funding period should be in place before accepting funds. Others noted long wait between application for funding and approval = impediment, prevented active recruitment of partners.	Communities were willing to take action when they understood that type 2 diabetes could be prevented/delayed. Working relationships among groups were strengthened so they will continue to work together on other initiatives. Communities differed in their readiness to take action. Some had difficulty providing examples of what led to community action beyond education about dangers of diabetes. Education may be a component of strengthening community action but stimulating action requires more than telling people there is a problem. For those less familiar with PHP, additional ways were needed to support their growing understanding of assessing community readiness and mobilizing community action. HPP can take time to begin to understand. Need to see examples that are working. Ongoing commitment from heads of some organizations might have helped.		A program champion in the workplace can contribute to the sustainability of an initiative.	There have been many successes in diabetes prevention interventions in Saskatchewan. Some community members are becoming they change they want to see. Sustainability is not an idea which most projects have addressed directly. A few groups considered sustainability right from the start. Others are only considering this as the funding closes or they realize that some of their initiatives may not be sustainable. There are positive examples of orga enhance sustainability. A few groups have had to work hard to get i and Knowledge and skills have been acquired through community-based health education. Funder-supported education opportunities have helped to influence change in the projects' work. Most groups believe that the partnerships and connections built with community members will continue. Two groups which have completed their funding are examples of this sustainability. The sustainability of purchased or locally developed resources is unsure

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Evaluations	Some projects identified their inability to carry out participatory evaluations. Frustration that time, money and lack of human resource capacity hindered a evaluation capacity. Positive about short term benefit, unsure about long term – sometimes community had moved on to address other issues. Easier to evaluate a product than a process.	Provided a workshop for the projects – projects were at different stages when they attended. Some felt did not have the experience, time or funds to do the evaluation, needed more help. Some frustration that more evaluation was required than the funding warranted; having Health District hold the funds created an imbalance of power for some.	Developing and addressing long term and shorter-term objectives and measure of success were also challenging for most. Difficult to develop the indicators of success that encompassed the expectations of all sectors and addressed short and long term objectives.	Projects said they need good evaluation to identify and raise awareness of what difference the project is making in the community. Need longitudinal study on type 2 diabetes prevention and changing behaviours.	

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Funding applications	Frustration with complexities of multiple application procedures and different reporting procedures with multiple funders.	Quote: "hard to get commitment to long term solutions when the funding is short-term." Community development timelines were not always compatible with those required by a project funded to do specific work. Central support by Sask Health reviewed positively – modeled the PHP approach being used with communities. Important that it was ongoing and built on strengths. Funding agencies need to be as clear as possible about all expectations for: collaboration, reporting, communication, evaluation and skill development before funding applications are developed. Getting Started workshop was the most important.	Health Canada needs to recognize the long-term nature of implementing a PHA. 3-5 year initiatives with both long and short term strategies need to be phased in over time. Projects made specific recommendations to Health Canada to facilitate the success of community based population health projects.	Positive response to Health Canada support throughout project: 1) support and resources 2) flexibility to adjust work plans or budgets 3) feedback and direction project workshops (2) Improvements: 1) extend the funding period 2) tighten timelines between proposal submission deadline and funding approval 3) ensure projects set realistic goals and objectives at the beginning	Report contains several recommendations for funders and they are similar to those in other reports and also encourage funders to support learning. <u>Building capacity through learning</u> opportunities for: • leadership development amongst sectors • practical, 'how-to' perspectives on professionals taking different roles • Learning about partnerships is likely an ongoing need. needs may direct different learning • Provide resources and learning opportunities to gain knowledge and skill in sustainability planning • Ensure that any learning opportunities are for both the professionals and the community members. • Review the results of the Health Canada Regional Saskatchewan Health PHP evaluation re. learning activities

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Sharing information	Health Canada encouraged to share lessons learned from projects with other communities.	Terminology was a barrier to understanding at times. Many just found simpler explanations.	Explaining the concepts and clarifying the PHA language was challenging and a barrier to ensuring all participants proceeded from an equal base of knowledge to promote the PHA in communities. Lots of jargon in existing academic and government materials.		Find accessible methods to share across the country resources developed during the Canadian Diabetes Strategy. It will be important not only to share tangible resources but also to share ways to engage communities in the use of the resources and ways of working on resource mobilization which are less tangible (spiritual, cultural, political)

APPENDIX E Model for Transfer of Learning

Education Program

- organization
- methods
- learning content
- environment

Innovation Factor

- perception of complexity and utility of ideas to be applied

Learning Context

Reaction

Individual Learner

- motivation
- personality
- past experiences
- values, skills, knowledge

Community Environment

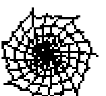
- support from: colleagues, community
- systems
- opportunity to act

Learner Context

Learning and Retention

Application

Actions



Adapted from: Berkowitz, M (2001)

Footnotes

[1] The *Diabetes Prevention Resource Kit for Children*, also known as the *Tickle Trunk,* is a nutrition and physical activity resource developed by the Manitoba Association of Community Health (MACH), Diabetes Prevention Project for Children. Recognizing that Type 2 Diabetes has increased among Aboriginal children living in Manitoba and the epidemic of diabetes among Aboriginal peoples, the program aims to develop age-appropriate diabetes prevention resources that address and promote healthy eating and physical activity at an early age.

The resource included more than 14 educational tools, such as a hand-made Aboriginal elder puppet and script, a story book which covered all four directions of the medicine wheel, a set of cards with recreational ideas for families and resources to educate families about strategies for diabetes prevention

In 2000 this resource was distributed to all of Health Canada's children's programs, some on-reserve projects and ten Saskatchewan Action plan for children's programs. Some of the Saskatchewan Region-funded diabetes prevention projects also received the kit.

The original *Tickle Trunk* is now known as the Diabetes Medicine Bag and more information can be found at http://www.diabetesmedicinebag.com/about/index.html Accessed February 2, 2004

[2] Saskatchewan Advisory Committee on Diabetes. (2000). Diabetes 2000 Recommendations for a Strategy on Diabetes Prevention and Control in Saskatchewan. Regina. Available at http://www.health.gov.sk.ca/mc_dp_diabetes2000report.pdf Accessed February 11, 2004.

[3] Saskatchewan Health. (1999). *Population Health Promotion Practice in the Primary Prevention of Type 2 Diabetes.* Population Health Unit, Saskatchewan Health, Regina Available at http://www.health.gov.sk.ca/ps_diabetest2.pdf Accessed February 11, 2004.

[4] Saskatchewan Health. (2003). *Using a Population Health Promotion Approach: Lessons Learned from the Population Health Promotion Demonstration Sites for Primary Prevention of Type 2 Diabetes.* Population Health Unit, Saskatchewan Health, Regina Available at http://www.health.gov.sk.ca/ps_diabetesT2_lessons.pdf Accessed February 11, 2004

[5] Build Better Tomorrows: Working Together on the Determinants of Health. February 12-14, 2002. Conference Proceedings. Available at http://www.usask.ca/healthsci/che/prhprc/centre/bbt.pdf Accessed February 11, 2004

[6] Mozambique/Canada Project, Training for Renewal Program, Working for Change in the Community and in Organizations, Summer School 2002, Prairie Region Health Promotion Research Centre, Saskatoon, Saskatchewan

[7] Reference Group Members:

- Karen Andres, Project Coordinator, Health Canada, Saskatchewan Region
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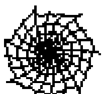
- James Irvine, Medical Health Officer, Population Health Unit, Northern Regional Health Authorities
- Mary Martin-Smith, Population Health Promotion Unit, Saskatchewan Health
- Catherine Miller, Regional Manager, Nursing Programs, Saskatchewan, First Nations and Inuit Health Branch, Health Canada



- Peter Waldbillig, Regional Intersectoral Committee Coordinator, North East Regional Intersectoral Committee

[8] Dr. Katharina Kovacs Burns, Director of Research Planning & Development, Faculty of Nursing, University of Alberta.

[9] W.K. Kellogg Foundation (1998). Evaluation Handbook. P 17. Available at http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf Accessed February 13, 2004.

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[11] NSW Health Department. (2001). *A Framework for Building Capacity to Improve Health*. Gladesville: New South Wales, Australia. Available at http://www.health.nsw.gov.au/pubs/f/pdf/frwk_improve.pdf Accessed February 13, 2004

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Hawe, P, Noort M, King L, Jordens C (1997). *Multiplying Health Gains: the critical role of capacity-building within health promotion programs*. Health Policy 39, 29-42.

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[14] Goodman et al, op cit p 266

[15] Bopp M, Bopp J (2001). *Recreating the World. A Practical Guide to Building Sustainable Communities*. Calgary: Four Worlds Press.

[16] Saskatchewan Health. (2002). *A Population Health Promotion Framework for Saskatchewan Regional Health Authorities.* Regina: Population Health Branch, Saskatchewan Health. Available at http://www.health.gov.sk.ca/ic_pub_3793_skhlthframewk.pdf Accessed February 11, 2004

[17] Goodman et al, op cit p 263

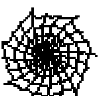
[18] Bopp and Bopp, op cit, p 82

[19] Goodman et al, op cit, p 273

[20] Bopp and Bopp, op cit, p 92

[21] NSW Health Department op cit

[22] Holder HD, Moore RS (2000). Institutionalization of Community Action Projects to Reduce Alcohol-Use Related Problems: Systematic Facilitators Substance Use & Misuse. 35:1&2, 75-86.



[23] Bopp and Bopp, 99

[24] Saskatchewan Learning. Community Education Principles. Available at http://www.sasked.gov.sk.ca/k/pecs/ce/docs/buildcomm/ofhope.pdf Accessed February 15, 2004

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[26] Kirkpatrick DL (1994). Evaluating Training Programs: The Four Levels. San Francisco, Berrett-Koehler Publishers.

[27]Saskatchewan ***in motion*** is a province-wide movement aimed at increasing physical activity for health benefits. Their vision is that the people of Saskatchewan will be the healthiest, most physically active in Canada. ***In motion*** is designed to blend provincial, regional and local resources together with those of community leadership to increase physical activity for health benefits.
More information available at http://www.saskatchewaninmotion.ca Accessed February 13, 2004

[28]School^{PLUS} is a Saskatchewan Learning program to give children and youth what they need to be successful in school and in life and focuses on schools as centres of learning, support and community for all children, youth and their families. Achieving School^{PLUS} is a shared responsibility. It engages families, students, educators and community members in actively working together with human service systems. More information is available at http://www.schoolplus.gov.sk.ca Accessed February 13, 2004

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[32]Saskatchewan Health. (2002). A Population Health Promotion Framework for Saskatchewan Regional Health Authorities. Available at http://www.health.gov.sk.ca/ic_pub_3793_skhlthframewk.pdf Accessed February 11, 2004.

[33] Ibid, p 15-16

[34] Feather J, Zubkow C, Khachatourians L. (2002). *Build Better Tomorrows: Working Together on the Determinants of Health*, Conference Proceedings. Prairie Region Health Promotion Research Centre, p. v-vi

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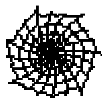

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NOTE: As this report describes individual projects, not as easy to 'fit' into this table. A few observations from reading the project reports:

- Very little funding given directly to health organizations – more likely to be school divisions, large provincial groups (teachers assoc, provincial fitness, Alta Milk, CDA).
- The in-school projects seem to have similar issues re parental/community involvement – not fully able to ascertain how much of the 'partnership' is professional versus community, but seems to be more of the former.
- There have been many resources developed and many appear to be excellent. Has a saturation point been reached in the development of resources? Is there is a need to share the resources AND ensure that they are provided within a context of population health/community development rather than being another 'activity'.