CHRONIC DISEASE PREVENTION INITIATIVE

2005 - 2007 PROGRESS REPORT

A Report to the Joint Management Committee of the Chronic Disease Prevention Initiative, prepared by the CDPI Evaluation Committee (December 2008).

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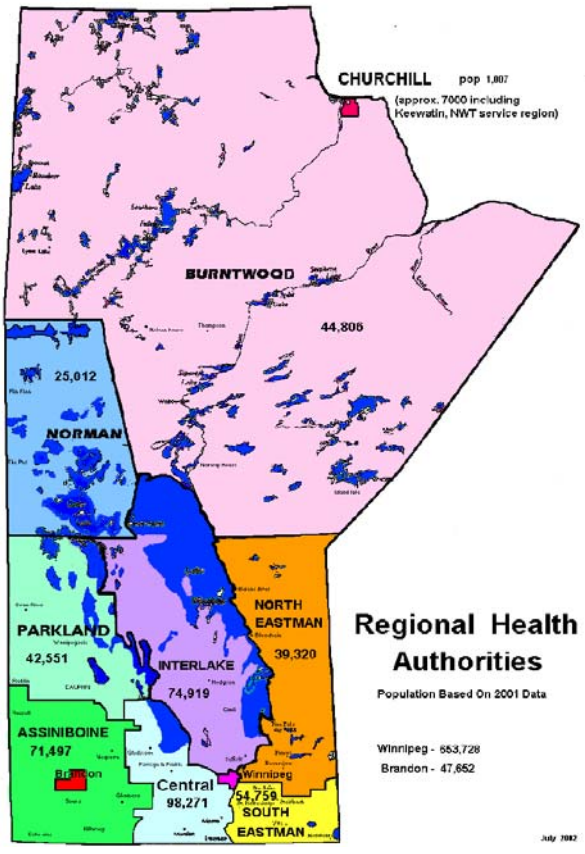
INTRODUCTION

The Chronic Disease Prevention Initiative (CDPI) 2005 - June 2007 Progress Report is presented to the Joint Management Committee (JMC) of the CDPI by the CDPI Evaluation Committee. This is the second CDPI report. The initial report, *Capacity Building with Manitoba Communities for Chronic Disease Prevention,* was published in May 2006, by the Rural Development Institute at Brandon University.

CDPI is a community-led approach to chronic disease prevention and is the first demonstration project of its kind in Canada. A five-year project, CDPI builds on local partnerships, citizen engagement and community development to address common modifiable risk factors (smoking, physical inactivity and unhealthy eating). The initiative is designed to promote sustainability by engaging communities in local actions; encouraging evidence-informed approaches; and developing ongoing partnerships. Since September 2005, all partners including Manitoba Health and Healthy Living, the federal government's Integrated Strategy on Healthy Living and Chronic Disease Initiative, regions and communities have contributed resources to CDPI.

CDPI expands on and strengthens a number of healthy living programs already underway in Manitoba. As of June 2007, 10 regional health authorities (RHAs) and 83 communities across the province were actively participating.



COMMUNITY STORIES

Following are samples of community stories about how the Chronic Disease Prevention Initiative was activated across the province. These stories are excerpted from the June 2006/07 community activity monitoring forms.

Rural

Little Saskatchewan is a First Nations community of 1,000 people located seven miles from Gypsumville (Interlake RHA). CDPI was led by the chief and council of Little Saskatchewan. They completed the PATH Planning Process as their first step. Their plans included:

- planting and harvesting a community garden
- a community feast from the garden
- a walking club, offered year-round (indoors in winter) with a leader/co-ordinator
- a summer slow pitch and winter floor hockey league (a fitness leader and community co-ordination training has been identified)
- youth to be involved in a tobacco education program

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The Heart and Stroke Foundation of Manitoba (HSFM) partnered with CDPI on a physical activity challenge for staff of the North Eastman RHA. HSFM contributed materials and prizes. Eight staff registered 4,535 minutes of physical activity during their work day in May 2007.

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Based on local data taken from their Youth Health Survey to guide youth programming, a CDPI community facilitator in the Interlake RHA approached the City of Selkirk's recreation director to initiate a physical activity project for junior high students. An existing program offered after-hours activities through the Lighthouses program with support from Manitoba Justice. The program provided activity and other needs for youth (including at risk individuals) in Grade 6 through Grade 9.

Partnering with Lighthouses representatives, the CDPI co-ordinator and committee received funding to increase the hours of supervised activity, healthy snacks and monthly nutrition presentations. One focus has been to encourage youth to drink healthier beverages in place of soft drinks. The school's policies were also adjusted to provide facilities and equipment during non-school hours. Word has spread and more youth are now attending (over 300). There are plans to extend the program to three more schools, including elementary schools.

The program has increased its contact hours from five to 15 hours per week. CDPI made a huge difference as more hours are offered and a wider variety of activities. For the first time, a summer program was offered three days a week. Participants included young people from reserves who have increased their levels of confidence, learned new health information and enhanced their social skills and networks in a safe, supervised location.

A major partner is the Youth Coalition. Other partners include: the local school board and school administration/staff; the City of Selkirk's recreation department; Lighthouses, Manitoba Justice, volunteers and community youth.

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This CDPI project in the Assiniboine RHA developed a skating rink on a local lake. Over 400 people skated there over the holidays. The weather got colder in January and February and attendance declined. The cost for developing the area was estimated at $1,000. However, there was more volunteer support than expected so the actual cost was only $590.

The organizers are hoping to make improvements for next year, including a warm-up area for skate removal, better lighting, more seating and perhaps a fire pit. They will also set aside funds to pay someone to clear the ice after snowfalls. Community members were very enthusiastic.

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The Healthy Living Project in Sandy Bay/Amaranth held 12 cooking classes for young adults (primarily women) who were clients of the Prenatal Nutrition, Diabetes and Life Skills programs. Ninety-four participants learned about nutrition and meal planning based on *Eating Well with Canada's Food Guide*.

Planners would like to expand the program in future to include community members. They will need to look into using school facilities for a larger kitchen space.

The Sandy Bay Health Centre provided funding for this project.

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In the Interlake RHA, CDPI sponsored a "Lungs are for Life" presentation to 50 Grade 6 students in Arborg and Riverton (CDPI communities) and another 50 students in two non-CDPI communities. Local high school students delivered these presentations. Results of an evaluation recommended smaller groups of students. No CDPI funds were required for this initiative.

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In May and June 2007, a smoking cessation program, "Commit to Quit" was offered in Beausejour-Brokenhead First Nation. This program had previously been successfully delivered in Winnipeg.

Of the 11 participants who registered, six attended the whole program. Of those six, one quit smoking by the end of the program and all others had targeted quit dates within six months. The program will run again; there will be a refresher course for the original participants; a follow-up will assess quit/reduction rates.

The course was offered on a cost-recovery basis and the RHA provided funding for facilitator costs.

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A healthy eating workshop in Niverville began with a grocery-store tour and label-reading instructions. The group then went to a hall and heard a presentation on healthy eating. Several resources were distributed, healthy snacks were provided and participants were very pleased with the evening.

The turn-out wasn't as large as expected, given the advertising involved. The intended audience was young families, but several middle-aged and senior people attended. The presentation was geared to younger people. In future, either the advertising must be more specific or the materials more general.

Contributions from partners for this event included volunteer time from the District Health Advisory Committee, space from the Health Corner, free ads in the *Steinbach Carillon* newspaper and volunteer time from the Big Way Grocer.

Urban

In the Brandon RHA, CDPI partnered with ***in motion*** to hold a kick-off walking parade and proclamation ceremony. This included a Couch Potato Race with participants from the media, city police, the mayor, Healthy Living Minister Kerri Irvin-Ross and local sport enthusiasts. Anticipated costs were lower than expected because of donations (used couches, prizes, volunteers from Brandon University, labour for the construction of race couches).

Not as many people came for the event as had been anticipated, but for future events, there will be more effort in creating awareness. The next similar event will plan for more activities, and will get volunteers involved sooner.

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The William Whyte Residents Association (WWRA) and the Tai Chi Society of Canada partnered with CDPI to provide tai chi classes for seniors for 10 weeks beginning in January 2007. Fifteen individuals (eight of them seniors) participated over the 10-week period.

The group continues to attend tai chi classes at different locations because of the connections made during this initiative.

CDPI funds went to instruction costs, an honorarium for the class co-ordinator, refreshments and delivery of certificates. The Winnipeg RHA and the City of Winnipeg contributed space and a volunteer to open and close the building.

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A Youth at Risk program in the north end and Point Douglas neighborhoods of Winnipeg offered a sweat lodge and feast that was planned by and intended for high school boys and girls. Sixty students were invited to an Elder's property for the sweat lodge and a discussion on healthy ways to deal with issues. The day also provided a greater sense of cultural awareness for both First Nations and non-First Nations students.

Northern

In Thompson, the Addictions Foundation of Manitoba (AFM) and CDPI worked together to set up a fitness program for residents in treatment. Manitoba Hydro and Manitoba Hydro employees contributed money, and nursing students contributed time, both of which contributed to the success of the initiative. Indoor activity equipment was purchased, including a Bow Flex machine and a treadmill.

Over six months, 96 adult clients participated in daily physical activity. Participation was lower than expected, so staff will be more active in recruiting and encouraging future participation. The fitness program will continue to be part of the treatment schedule.

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In Wabowden, 275 students from the local school, community members and several community organizations worked together to refurbish the only greenhouse in the area. CDPI funds and contributions from partners allowed the purchase of the materials needed to fix the greenhouse at the school. The project successfully brought community and partners together to get ready for gardening and healthier eating in the future.

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CDPI funds contributed to the development and construction of a children's playground in Cranberry Portage. There were extensive fund-raising efforts in the community and even though the project was slightly over budget, the playground was completed and opened. It now provides a safe place for children to play and be active.

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In Flin Flon, CDPI funds contributed to the development of a soccer field that will have an economic as well as a physical activity impact on the community. Organizers hope to host regional high school tournaments, local tournaments, provincial competitions and other recreational events.

CDPI BACKGROUND

The Chronic Disease Prevention Initiative came about as a result of the growing awareness of the burden of chronic diseases such as heart disease, stroke, cancer, diabetes and/or obesity on Manitoba society. To build a case to support the implementation of the initiative, data on chronic disease and its risk factors in Manitoba was gathered.

- In 2001, the Manitoba rate of current smokers (28 per cent) was the highest in Canada (23 per cent).
- In 2000/01, 40 per cent of Manitoba males, aged 20 to 64 years, had a body mass index (BMI) that exceeded 27 (females 31 per cent), and another 19 per cent had a BMI of 25 to 27 (females 14 per cent). These exceeded the national percentages.
- In 1999, Manitoba had the highest provincial incidence of end-stage renal disease in Canada: 22.9 per 100,000 population (men at 26.1 and women at 19.8).
- In 1996, cancer, circulatory and respiratory disease deaths accounted for almost 50 per cent of the potential years of life lost in Manitoba: cancer accounted for 1,644 years for both sexes per 100,000 population; circulatory disease for 1,119 for both sexes; and respiratory disease for 298 for both sexes. These Manitoba rates exceeded the national percentages.

The Alliance for the Prevention of Chronic Disease led the initial planning and development of the CDPI. In September 2002, a CDPI Planning Committee was established, consisting of key decision-makers representing federal and provincial government, non-government organizations and regional health authorities. This group had met previously to discuss the development of an initiative for chronic disease prevention modeled on the Heart Health Project. The committee held a provincial consultation workshop in November, 2002 to define partner roles; identify partner expectations; build consensus; encourage commitment and identify potential resources. Subsequently, a funding proposal was developed and submitted to the Public Health Agency of Canada.

While negotiations took place between the province and the federal government, the planning committee signed a contract with a local consulting firm to develop a project charter. It clearly set out each partner's contribution to the CDPI as a whole, and described the initial accountability structures and processes for the CDPI specific to:

- direction and oversight
- planning and implementation
- management and evaluation

The charter's original signatory parties were those organizations that could make a five-year commitment to CDPI and who agreed to provide resource contributions such as funding or in-kind supports:

- Alliance for the Prevention of Chronic Disease
- Manitoba Health and Healthy Living
- Northern Aboriginal Population Health and Wellness Institute (NAPHWI)
- Manitoba's 11 regional health authorities

The Public Health Agency of Canada (PHAC) along with MHHL are funding partners. PHAC is committed to CDPI through the Integrated Strategy on Healthy Living and Chronic Disease Initiative.

The planning committee disbanded in November 2004 when Manitoba Health took the lead for CDPI.

GOALS AND STRUCTURE OF CDPI

Goals

The goals of the CDPI are to achieve:

- community-led, evidence-based approaches to primary prevention
- strong partnerships for sustainable initiatives
- integration and alignment with existing programs for added value
- enhanced capacity to address health disparities and improve the health of Manitobans

Structure

The primary functions of all the structures are to support and fund the prevention initiatives, from planning to evaluation, and to help partners collaborate, communicate and co-ordinate activities.

The structures, initially planned and described in the charter, were revised with consideration for available funding and existing relationships between RHAs and communities. The planned project management office was not funded, therefore its functions were largely provided by departmental staff of the Chronic Disease Branch with MHHL (formerly known as Diabetes and Chronic Diseases Unit of the Public Health Branch). The proposed RHA and community structures were in place for some regions, but not all, when the initiative proposals were first submitted.

- At the provincial level, the CDPI Joint Management Committee (JMC) was put in place to provide policy direction, overall project planning, communication and accountability. Its initial members included Manitoba Health and Healthy Living, the Alliance for the Prevention of Chronic Disease, a representative from each of the urban, rural and northern RHAs, the RHA Planning Network, the Northern and Aboriginal Population Health and Wellness Initiative (NAPHWI) and the Public Health Agency of Canada (PHAC) (ex officio). When NAPHWI's mandate expired in the second year, its communities were transferred to the closest RHA for funding and support.

Two JMC committees were established at the onset: the CDPI Evaluation Committee and the CDPI Risk Factor Surveillance Working Group. These committees were charged with the planning and implementation of processes for monitoring, evaluation and developing capacity for risk factor surveillance at the community level. The Surveillance Working Group presented *The Final Report on Findings for Regional Surveillance Needs and Capacity*, to the JMC in June 2007.

The Capacity Building/Training Committee was established early in 2007 and became part of the JMC. The role of the training committee was to identify CDPI training needs and to develop, implement and evaluate an annual CDPI training plan at the provincial, regional and community levels. With approval from the JMC, the CDPI Training Committee plan to meet the identified capacity building and training needs of CDPI partners and participating CDPI communities. An initial training plan was developed and presented at the JMC meeting in June 2007.

- In the charter, regional committees were envisioned to be consistent structures in each RHA. However, practical limitations were evident early in the project, resulting in local adaptations to that proposed structure. The intent of the regional committees remained, no matter what form they took. The committees were to provide regional-level planning and implementation, direction and oversight; governance and funding processes; feedback and accountability reports; and, support and capacity building to participating communities. How the roles of the regional committees are fulfilled continues to vary from region to region.

- The Healthy Living Resource Clearinghouse (HLRC), currently known as Health in Common, was envisioned to support the CDPI project through the co-ordination of training, information and resources focusing on the three modifiable risk factors: unhealthy eating, physical inactivity and smoking. The Healthy Living Resource Clearinghouse was built into the structures of CDPI from the beginning. The planning and development process began in 2007 (the second year of the five-year demonstration project). Early in the process, a decision was made to have the HLRC's scope of activities broaden to include Manitoba's seven pillars of healthy living: active living; chronic disease prevention; healthy eating; healthy sexuality; injury prevention; mental health promotion and tobacco reduction.

Process

The JMC provided leadership and support in the development of the CDPI processes. As this report was being developed, there were shifts in some of the processes, ranging from funding to reporting requirements, to help facilitate the implementation of the community-led prevention activities.

<u>Funding</u>
When the CDPI was launched in 2004, two components were proposed by the federal government for the demonstration project: funding through a grant or contribution mechanism and a supportive enabling system. The initial federal solicitation for proposals was for a grant. Grants can be provided to provinces/territories by the Public Health Agency of Canada for one-time, non-renewable activities of limited duration (no longer than 12 months). It was anticipated that the next solicitation would be for a contribution agreement, with a view to establishing a multi-year agreement.

CDPI support is provided by the three key funding partners: federal and provincial governments and the regional health authorities. While the federal and provincial governments provide monetary resources to the initiative, the RHAs largely provide in-kind contributions (1.0 FTE dedicated to chronic disease prevention).

To facilitate chronic disease prevention activities in communities, combined dollars from federal and provincial governments are distributed to the regions. The regions (upon satisfaction with the action plans submitted by the communities) distribute the money to CDPI participating communities for capacity building, training, surveillance, evaluation and other community level activities. The regions are accountable for the government funds. The regions also ensure that the communities remain accountable to them.

Community Action Plans

For the first year of funding, each participating community provided an initial proposal, including a detailed work plan, budget and evaluation plan. The JMC took on the responsibility of reviewing the proposals and requesting revisions before releasing the funds to the RHAs for distribution. In the second year, and in all subsequent years, regional committees (or their equivalent) endorse and forward proposals for approval. The JMC may require additional information before funds are released to the RHAs for distribution to each community per regional processes. Funds are distributed by Manitoba Health and Health Living to regions through funding letters.

Activities

Several activities, such as capacity building, community-led prevention initiatives (community action plans), evaluation, monitoring and communication, have taken place at various levels of the demonstration project to implement CDPI.

Capacity Building

One of the basic premises of this project is the need to improve capacity at all levels, provincial, regional and community, for planning and providing primary prevention activities at a community level. Not only do communities benefit from information and skill development, the organizational participants (ex: JMC and regional CDPI leads) are attempting to plan and manage a complicated funding cycle and challenging monitoring requirements while providing practical support to community committees.

Early in implementation, the Rural Development Institute (Brandon University) was contracted to do an assessment of capacity building with Manitoba communities for chronic disease prevention. As a way of building capacity, the CDPI Forum was held in March 2007, bringing together provincial, regional, and community participants. The forum created an opportunity for CDPI communities to learn from each other. In May 2007, a CDPI Training Work Plan was developed. The purpose of the work plan is to build and sustain the CDPI regional healthy living activities, through knowledge, skills and resources.

Community-led Prevention Initiatives (community action plans)

Participating communities work with their RHAs, local stakeholders, community organizations, schools, municipalities and individuals to identify health promotion and chronic disease prevention activities focused on tobacco reduction, healthy eating and physical activity. By using the best available information, the community action plans were developed in the first year and are updated annually. (Examples of community stories are found at the beginning of this report.)

Evaluation

For the five years of this funding cycle, a full evaluation will be completed by an external consultant. The evaluation will focus on the achievements and efficiencies of the organization itself, and on capacity building, partnership development and participation achieved through the community initiatives. Intervention evaluation will not be required for the formal CDPI evaluation. It is important to emphasize that the only community responsibility for the formal evaluation will be the monitoring forms and a measure of capacity using the Community Capacity Building Tool (CCBT) from PHAC. However, the CCBT was introduced much later in the demonstration project so the results will not reflect capacity building from the beginning of the project to the end. It will measure capacity building from the time the tool was implemented (the fourth year) up to the end of the project. Individual regions may support separate evaluations of community initiatives on their own.

Monitoring

Each community initiative is responsible for completing and submitting a community activity monitoring form, twice a year, to the regional committee. The committee then summarizes the information and submits a report, along with copies of the individual forms, to JMC. Monitoring forms provide information to describe participation, what is being accomplished, how funds are being spent, and how partners are engaging.

Communication

A formal communications strategy had not been developed as of June 2007, although communication activities, such as consultation meetings and the March Forum fulfill some of that function. Regional CDPI leads and executive leads have been established and it is expected that JMC members will communicate with their respective jurisdictions. Central structures such as the JMC and the Evaluation Committee are not expected to communicate directly to communities. Communication within regions is of course, locally determined. Communications between regions is recognized as important and is facilitated by committee work.

ACCOMPLISHMENTS

The accomplishments of the CDPI have been captured through the community activity monitoring forms submitted twice a year to the regional committees. At the provincial level, CDPI accomplishments have also been noted. For example, the Chronic Disease Branch of Manitoba Health and Healthy Living has, since the inception of CDPI, provided dedicated staff to CDPI, supervised consultants (surveillance and evaluation) and regional funding. At the regional level, in-kind contributions to CDPI have been provided in terms of infrastructure and personnel.

At the community level, various activities relating to chronic disease prevention have been monitored. Between September 2006 and March 2007, 310 monitoring forms were submitted. Approximately 12 forms were not reviewed, as they were illegible. The totals are reported in the table and presented in the chart below. Even though the final version of the monitoring forms was distributed before the September 2006 to March 2007 reporting cycle, almost 50 per cent of the communities used one of the two previous versions. The information was not completely consistent, but the results do give insights on what has been offered through the CDPI and the response from the community and partners.

Chart 1 illustrates the total number of participants: volunteers, paid staff and activity participants. In six months, nearly 30,000 participants were reported.

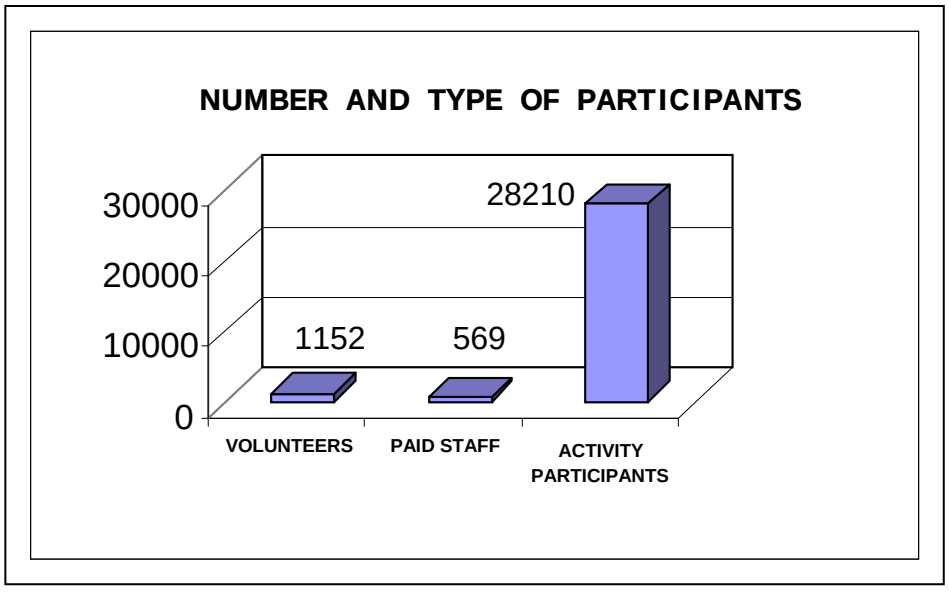

Chart 2 illustrates the main focus of each activity. Many communities reported multiple purposes for their activities.

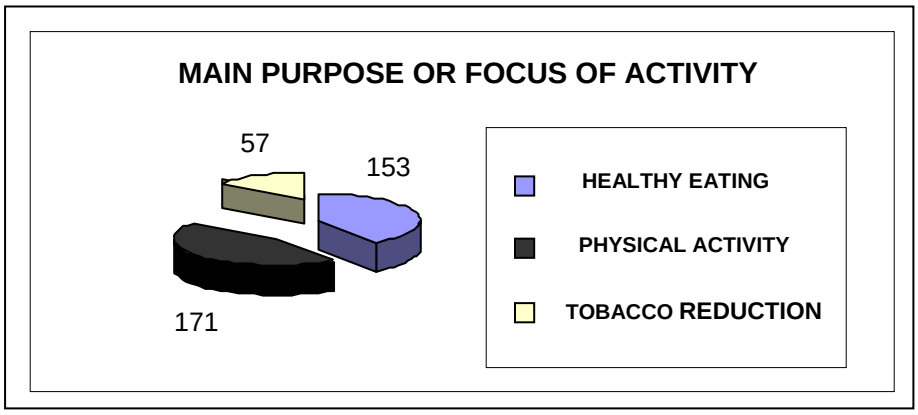

Chart 3 shows the number of activities where benefits were observed from the CDPI initiatives in the following areas:

- gaps addressed
- volunteers encouraged
- partnerships built/strengthened
- capacity/skills increased
- knowledge increased

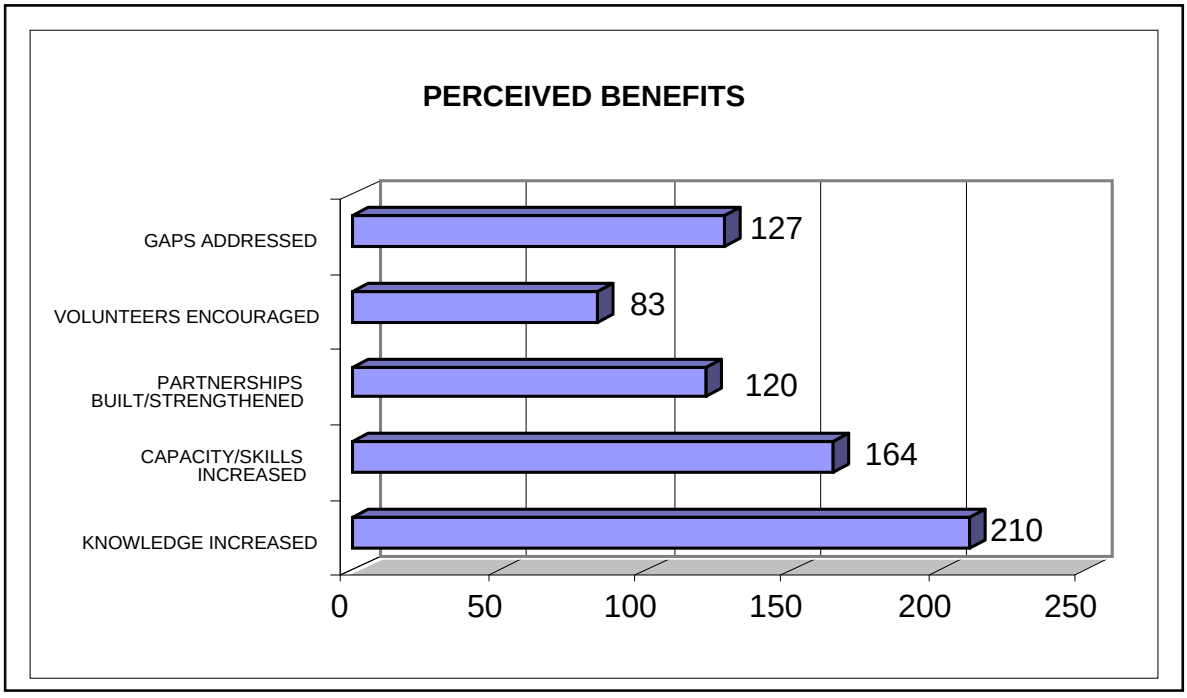

TABLE 1

ORGANIZATIONAL PROGRESS RELATED TO THE GOALS OF CDPI

The Chronic Disease Branch has documented roles, responsibilities, minutes and activities of the JMC, committees and working groups from the first planning stages. This information provided the content for this table.

TIME FRAME / GOALS	Year 1: April 05 - Mar 06	Year 2: April 06 - June 07
COMMUNITY-LED, EVIDENCE BASED APPROACHES TO PRIMARY PREVENTION	• JMC approves operational plan • Regional committees endorsed • Communities work with regional supports to develop proposals, work plans, budgets and evaluation plans for first year funding • Regions identified resource needs and high-risk communities • Approval of 47 Community Action Plans (CAPs) by the JMC for funding in Year One • Manitoba Health and Healthy Living reviewed Community Action Plans (Year One) • Evaluation Committee formed, Terms of Reference approved • Initial draft of financial and monitoring tools developed • Surveillance committee established	• Year Two operational plan drafted • Regional CDPI Lead and Executive Lead identified • Reporting requirements set • Annual approval of funding for CAPs (56 CAPs approved) • CAPs now reviewed by RHA; RHAs submit CAPs to JMC for approval • Determination of risk factor surveillance requirements that align with CDPI goals and objectives • NAPHWI CDPI communities transferred to RHAs • Developed first draft of a monitoring form including consultation meetings with users • Presented evaluation plan and draft monitoring form at Burntwood community meeting • High level evaluation plan presented to forum; monitoring forms presented, discussed and suggestions for improvements encouraged • Monitoring forms finalized for use in future reporting cycles • April 2006 - March 2007 monitoring reports are inconsistent across regions: a combination of piloted forms and final forms are used, resulting in limited ability to create valid reports

TIME FRAME / GOALS	Year 1: April 05 - Mar 06	Year 2: April 06 - June 07
COMMUNITY-LED, EVIDENCE BASED APPROACHES TO PRIMARY PREVENTION		• A common summary reporting form for regional roll-ups not developed, resulting in limited ability to have consistent information for the province as a whole
STRONG PARTNERSHIPS FOR SUSTAINABLE INITIATIVES	• Cancer Care Manitoba connected to risk factor surveillance working group • Partners in Planning for Healthy Living (PPHL) - to support the use of evidence-based planning approaches for healthy living in Manitoba • Knowledge Exchange Network (KEN) • NAPHWI - Five First Nation communities existed, then dissolved in the second year • Alliance for the Prevention of Chronic Disease - support for CDPI in the Healthy Living Resource Institute • *in motion* • Aboriginal Health - MHHL • Finance Department-MHHL • Regional Affairs - MHHL • Health Programs - MHHL • Healthy Populations -MHHL • Regional Health Authorities	• Northern Healthy Food Initiatives (NHFI): exists for the purpose of increasing nutritional options and allowing for informed healthy food choices for northern Manitobans. The NHFI helps northern communities develop their capacity to increase the local production of food for local consumption, increase the availability of nutritional foods, implement strategies to lower the costs for healthy foods, increase awareness of healthy eating, leverage funding for projects, and create food-based economic development opportunities where feasible • Chronic Disease Prevention Certificate Program - available through Red River College Continuing and Distance Education • Community Health Assessment Network
INTEGRATION AND ALIGNMENT WITH EXISTING PROGRAMS FOR ADDED VALUE	• Healthy Living Resource Clearinghouse - Information resource centre to assist in provision of training, information and resources • Heart and Stroke Foundation of Manitoba • Lung Association • Kidney Foundation • Canadian Cancer Society • Canadian Diabetes Association	• *in motion* • Baby First • Regional Diabetes Program • Renal Disease Prevention Project

TIME FRAME / GOALS	Year 1: April 05 - Mar 06	Year 2: April 06 - June 07
ENHANCED CAPACITY TO ADDRESS HEALTH DISPARITIES AND TO IMPROVE THE HEALTH OF MANITOBANS	• Engaged Rural Development Institute of Brandon University to assess capacity needs of provincial, regional and community structures. The report gave an insight of where capacity needed to be enhanced to address health disparities and improve the health of Manitobans	• Training plan developed • March 2007 Forum brought together provincial, regional and community participants to discuss progress to date. The forum created an opportunity for CDPI communities to learn from each other • Planning begun for distribution and administration of Capacity Building Tool for support and evaluation data collections • Provided additional dollars to support the implementation of the community action plans

TABLE 2

COMMUNITY PROGRESS RELATED TO THE GOALS OF CDPI
YEAR 2: APRIL 06 - MARCH 07

An external consultant was contracted to write the 2005 - 2007 progress report in early 2007. As part of that data collection process, regions were asked to respond to several questions about their experiences with CDPI structure and processes. Staff from six regions responded. The information gathered through interviews is included in the progress report and is based solely on the external contractors' interpretation of the interviews. Comments are included in the table when they are consistent with the monitoring forms under the heading of "Anecdotal information."

GOALS	
COMMUNITY-LED, EVIDENCE BASED APPROACHES TO PRIMARY PREVENTION	*Monitoring results* • 47 CAPs were initially approved for funding. Monitoring activities were not initiated as funding distribution and initiative implementation were not consistent across the regions. • 56 CAPs were approved for funding for Year 2. • RHAs forwarded 310 monitoring forms for the reporting period of Sept. 2006 - March 2007. Of these: a. 153 had a focus on Healthy Eating b. 171 had a focus on Physical Activity c. 57 had a focus on Tobacco Reduction d. 12 had a focus on Mental Health/Stress reduction Note: The number of activities does not add up to 310 because communities are required to complete a monitoring form after each activity and there are variations in the number and focus of activities by community. • Approximately 75% of the events involved active participation (ex: physical activity, cooking, and gardening) or education/awareness such as health fairs, workshops or classes. *Anecdotal information* • Communities are learning to use a structured process for planning - applying needs assessment information, setting priorities and using decision models. These skills can be used for a variety of purposes within the community. For example, the community of Arborg used its Youth Health Survey results to plan programs for healthy eating among junior high school students. • Evidence-based workshops have had a positive influence on community planning. For example, Assiniboine RHA integrates the topic of evidence-informed approaches at regional forums; Brandon RHA used local assessment data to identify at-risk populations.

GOALS	
STRONG PARTNERSHIPS FOR SUSTAINABLE INITIATIVES	*Monitoring results* • Partnerships have been created and/or strengthened to plan, implement and sustain the CDPI initiatives. The range of partnerships include schools, health centres, churches, media outlets, private businesses, RHAs, NGOs, Aboriginal organizations and provincial government departments. *Anecdotal information*: • Without partnerships there would not have been enough time, resources or energy to implement chronic disease prevention activities. • CDPI is creating an increased awareness of the resources that are able and willing to be involved in chronic disease prevention.
INTEGRATION AND ALIGNMENT WITH EXISTING PROGRAMS FOR ADDED VALUE	*Monitoring results* • The most consistent alignment with an existing initiative/program was with *in motion*. • Integration also occurred as appropriate with regional services and private enterprise such as the Terry Fox Run, Alzheimer's Society, Brighter Futures, Families and Schools Together (FAST), the Addictions Foundation of Manitoba (AFM), Christmas Cheer Board, food banks and Aboriginal youth. *Anecdotal information* • Integration of CDPI funds into existing programs allowed for expansion of reach.
ENHANCED CAPACITY TO ADDRESS HEALTH DISPARITIES AND TO IMPROVE THE HEALTH OF MANITOBANS	*Monitoring results* • Volunteer involvement in chronic disease prevention activities double those of paid staff. • Communities report that activities have the most impact on knowledge gain and capacity improvement. • Over 28,000 participants were reported, however, this does not represent unique individuals. • Many events reported evidence of sustainability or unexpected benefits for participants such as continuing in tai chi beyond the event, skating, cooking and canoeing. • Some CDPI projects created or improved walking trails, skating rinks, soccer fields and playgrounds. The immediate benefits are obvious, but there is also potential for economic benefit for local business. This has been reported for some events/activities in 2006/07 already.

GOALS	
ENHANCED CAPACITY TO ADDRESS HEALTH DISPARITIES AND TO IMPROVE THE HEALTH OF MANITOBANS	*Anecdotal Information* • General knowledge of health, wellness and chronic disease prevention increased. • Because of volunteer hours, partnerships and aligning with existing programs/services, CDPI has been able to accomplish much more than funding amounts would indicate. • Planning skills increased. • Increased knowledge of community diversity, strengths and challenges. • Communities and participants were exposed to new activities that address health disparities.

HOW THE CDPI WILL MOVE FORWARD

This is a complex project and not surprisingly, there are few easy answers to the challenges that have arisen in the first few years. The Rural Development Institute of Brandon University reported progress to the JMC in May of 2006. The report details areas that had been successful to date and those areas that needed improvement. The most need for improvement was centred on communication and capacity, especially communicating information that would help build capacity. One of the recommendations was to provide a forum for learning and sharing that all CDPI participants could participate in and benefit from.

The first of what planners hoped to be many such forums was held in Winnipeg on March 8-9, 2007. The 2007 March forum was centrally co-ordinated by Manitoba Health and Healthy Living. A total of 110 people participated in the forum including participants from all nine CDPI regions, Manitoba Health and Healthy Living and other partners. The topics covered at the forum included community planning, a cyber café; Healthy Living Resource Clearinghouse; learning circles for community sharing; regional capacity building; preferred learning styles/communication; and evaluation and monitoring.

What isn't listed - but equally important - was the opportunity for casual interaction, networking and building relationships that the two days provided to attendees. Of note for going forward is the information presented on proposed activities for 2007.

Where To Next?

For communities:

- build momentum
- leverage links with other programs and projects
- implementation of the new monitoring form
- continue to identify needs to regional contacts

For regional committees:

- provide direction, support, oversight and accountability
- advocate for capacity building
- increase communication to communities
- review and approve plans

For the JMC:

- provide policy and governance
- approve funding
- develop project plan and budget
- support regional and community issues
- identify and respond to critical issues
- support and participate in evaluation, monitoring, learning from experience, and building capacity throughout CDPI

For Evaluation:

- monitoring forms analysis
- continued planning for full contracted evaluation project
- support to regions for Community Capacity Building Tool data collections
- write the 2007 Progress Report

For Training and capacity building:

- assess regional and community training and information needs
- prepare inventory of resources
- create provincial and regional training plan
- monthly communiqués

For Surveillance:

- complete needs assessment

For Healthy Living Resource Clearinghouse:

- will become a web-based training and resource centre
- will house a database of resources
- CDPI information will be continually added
- contractor will be hired to build CDPI section of the website
- resources and stories will be posted

The next progress report will highlight accomplishments related to these projected activities.

LESSONS LEARNED

The implementation of the Chronic Disease Prevention Initiative resulted in a number of new primary prevention activities across Manitoba; collaboration of federal, provincial, regional and community partners; innovative chronic disease prevention approaches led by communities and the involvement of volunteers in the community activities. The implementation of the CDPI has been a learning experience for all partners, evolving as the project moves forward with a focus on supporting communities and regions, by making a plan and putting it into action. A central theme running throughout the CDPI experience has been "learning together as we go." Changes in structure and processes occurred to facilitate the implementation of the project, as government, regional health authorities, non-government organizations and community groups formed effective ways to implement a community-led, RHA co-ordinated and government-supported initiative.

The chronic disease prevention initiative has recorded some successes, challenges and lessons learned in the implementation of the CDPI.

The successes of the project noted at various levels include:

- increased capacity/ability to work together to create environments that support healthy living at the local and regional levels;
- community plans and activities linking healthy living activities together to leverage funding and engage citizens and organizations in chronic disease prevention;
- more than 56 communities with organized and supported prevention plans and risk factor reduction activities; and
- enhancement of existing programs and services by incorporating community-led initiatives.

Some of the challenges encountered in the implementation of the project include:

- communication strategy - communication between partners at all levels not adequately developed;
- monitoring and evaluation - delays in moving ahead with capacity assessment (implementation of CCBT); communities felt that there was too much paper work to complete (monitoring forms) and a standard roll-up monitoring form was not developed resulting in communities rolling up results of monitoring forms differently;
- initial challenges in aligning timing of funding with regional and community needs;
- federal funding policies presented challenges in establishing an effective community planning cycle; and
- Healthy Living Resource Clearinghouse was slow in developing and hence slow in providing training, information and resources to support community and regional activities as anticipated.

Lessons have also been learned as a result of the implementation of the Chronic Disease Prevention Initiative that other jurisdictions can incorporate as they adapt this community-led disease prevention model. Overall, community-based chronic disease prevention requires leadership at all levels, commitment to working together and discovery of creative solutions through the eyes of the community to move forward. This involves:

- sharing knowledge, resources, expertise and problem solving/solutions;
- using a community led, region co-ordinated and government supported approach;
- realizing that communities value chronic disease prevention and welcome opportunities to build and strengthen settings that support healthy living;
- using feedback for ongoing evaluation and program development, such as working through the roles and responsibilities of all partners; and
- shifting the review of CAPs from province to region.

By learning from experience, the design, delivery and implementation of CDPI keeps getting better. There is lots of energy, enthusiasm and ideas for working together to create environments that support healthy living, and help community residents reduce their risk for chronic disease.

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