RURAL DEVELOPMENT INSTITUTE

CAPACITY BUILDING WITH MANITOBA COMMUNITIES FOR CHRONIC DISEASE PREVENTION

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Rural Development Institute, Brandon University

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RDI functions as a not-for-profit research and development organization designed to promote, facilitate, coordinate, initiate and conduct multi-disciplinary academic and applied research on rural issues. The Institute provides an interface between academic research efforts and the community by acting as a conduit of rural research information and by facilitating community involvement in rural development. RDI projects are characterized by cooperative and collaborative efforts of multi-stakeholders.

The Institute has diverse research affiliations, and multiple community and government linkages related to its rural development mandate. RDI disseminates information to a variety of constituents and stakeholders and makes research information and results widely available to the public either in printed form or by means of public lectures, seminars, workshops and conferences.
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Capacity Building with Manitoba Communities for Chronic Disease Prevention

Final Report

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1. Introduction

According to its charter, the Chronic Disease Prevention Initiative (CDPI) is a grassroots, community-led venture established to facilitate the reduction of chronic disease among community members in Manitoba. With the goal to "improve the health of Manitobans", the CDPI builds on local partnerships, community member engagement, and community development processes. The initiative addresses common modifiable risk factors such as smoking, lack of physical activity, and unhealthy eating at the community level. The five-year initiative of the Diabetes and Chronic Disease Unit, Manitoba Health, and their CDPI project partners was designed to encourage sustainability, partnerships, and collaboration at community, regional, and provincial levels. The initiative supports community-led projects that address modifiable risk factors in at-risk communities throughout Manitoba.

In March 2006, Manitoba Health signed a contract with the Rural Development Institute (RDI) of Brandon University, a centre of excellence helping to strengthen rural and northern communities through applied research using community development principles and processes. Researchers at the RDI were requested to assist in the identification of training and capacity building that would be required to implement the CDPI projects. RDI researchers reviewed 54 Community Action Plans and conducted interviews with 20 CDPI executive and program leaders and facilitators with each of the regional health authorities in Manitoba. Information from both sources provided an increased understanding of the variation that exists in 1) structures and processes being used to undertake the CDPI in different regions; 2) the stages and levels of community engagement and project planning that has occurred; 3) resource capacity, availability, and allocation; and 4) the training, education and capacity building needs that currently exist and are anticipated in the future. Other challenges experienced by regions since the inception of the CDPI project are identified from the perspectives of those interviewed. Regional representatives were candid with their concerns and willing to offer suggestions and recommendations for moving the CDPI forward.

This report includes detail of the contract activities, discussion of the findings from the proposals and the interviews, and recommendations of strategies for moving forward with the CDPI in general and undertaking evaluation in particular.

2. The Role of RDI

In late March 2006, Manitoba Health contracted RDI to assist in the assessment of community capacity building, project monitoring, and evaluation needs related to the CDPI in partnership with the health regions of Manitoba. As an independent third party, researchers from RDI gathered information to identify education/capacity building needs, project challenges, and recommendations to move CDPI forward.

To gauge needs for communities, regional committees, and regional facilitators, and regional leaders, RDI reviewed 54 Community Action Plans supplied by Manitoba Health and conducted interviews with 20 CDPI executive and program leaders and facilitators. Past involvement of RDI researchers with Regional Health Authorities (RHAs) and rural/northern communities, in addition to the work of the RDI in

community development, rural and northern population health, project development, and evaluation uniquely positioned the RDI to assist Manitoba Health and its partners in this endeavour.

RDI functions as a not-for-profit research and development organization designed to promote, facilitate, coordinate, initiate and conduct multi-disciplinary academic and applied research on rural and northern issues. RDI provides an interface between academic research efforts and communities by acting as a conduit of rural research information and by facilitating community involvement in rural development. RDI projects are characterized by cooperative and collaborative efforts of multi-stakeholders.

3. Contract Activities

The contract between Manitoba Health and the RDI included seven main activities. These activities were undertaken during the period of March 29, 2006 to May 4, 2006. Each activity in the contract was intended to contribute to building a greater understanding of community capacity building, project monitoring, and evaluation needs related to the CDPI. Specifically RDI was requested to:

1. Participate in meetings to plan for the assessment of knowledge transfer and capacity building, including meetings with the Project Management Office (PMO), the CDPI Joint Management Committee (JMC), and the Evaluation Committee (EC) of the CDPI/JMC.
2. Conduct and analyze interviews with representatives of the Regional Health Authorities, including but not limited to the CDPI Lead and the Executive Lead as identified by the Health Programs and Services Executive Network (HPSEN) to determine capacity building needs at the RHA, regional and community level.
3. Analyze 49 CDPI Community Action Plans and make recommendations concerning common capacity building needs.
4. Conduct an inventory [by region] of the CDPI Regional Committee (RC) to identify if a RC exists, the status of the RC, the evolution of the RC, the membership (including sectors and organizations represented); perceived purpose of the RC; existence of an agreed upon Terms of Reference; and project supports, educational strategies and capacity building activities needed by the RC.
5. Identify specific and realistic approaches and solutions to address the common capacity building needs of the communities participating in the CDPI.
6. Identify appropriate project supports, education strategies and capacity building activities that respond to the identified needs of the RHAs, Regional Committees and CDPI Regional Facilitators and volunteers.
7. Develop a final report to inform the next phase of the CDPI.

3.1 Project Communication

Throughout the project, RDI maintained communications with PMO-Manitoba Health, the JMC, and the EC Co-chairs through meetings, phone conferences and the submission of progress reports. Progress reports were submitted on April 10, April 17, and May 1.

3.2 Community Action Plan Review

Researchers at RDI received and reviewed 54 Community Actions Plans from Manitoba Health. This process included plans from each health region, with the exception of Churchill RHA, which is not currently at the CDPI proposal submission stage. The Northern and Aboriginal Population Health and Wellness Institute (NAPHWI) submitted plans from 5 northern communities beyond those submitted by health regions. Of the 54 plans received, not all plans were complete or contained all of the requested information.

3.3 Regional Health Authority Interviews

PMO/Manitoba Health directed that Executive Leads and CDPI Leads from 10 regions were to be included in the interviews and NAPHWI would be included if possible. Including Churchill RHA was considered to be premature at this time as the region was not in a position to submit project proposals as yet. Staff of the PMO office provided RDI researchers with a list of 9 CDPI Executive Leads and 9 CDPI Leads to be contacted. Contact information, for one region and for NAPHWI, was not included. For some regions the Executive Lead and CDPI Lead had been identified by the region as the same person, for some regions the CDPI Lead role was filled by two people. When RDI researchers talked with Executive Leads in some regions they added CDPI Leads; sometimes adding 1 name sometimes 2. Sometimes these names were official CDPI Leads, other times they were 'unofficial' or they were regional facilitators or key community facilitators. Suggestions were made regarding other valued sources of information that may be considered in the future as contact was beyond the scope of this project. A list of these resources has been provided to the PMO under separate cover.

Planning and conducting the interviews was an evolving process with much cooperation from the regional representatives. Their willingness and desire to contribute thoughts, perspectives, and ideas ensured participation from all regions. Of the initial list of 18 contacts, 2 were duplicate names, leaving 16 contacts to be made. Some Executive Leads suggested interviewing them along with the CDPI Leads in their region to be sure they were "on the same page and sending the same messages". Overall 16 interviews were conducted with 20 individuals participating. All regions were contacted and participated; contact was not achieved with NAPHWI. Of the 10 regions, 8 Executive Leads participated. In 2 regions, the Executive Lead declined to talk with researchers and deferred to the region's CDPI Lead. Generally CDPI Executives were pressed for time but responded to key questions or made appointments for follow up conversations.

CDPI Leads were generally easier to reach, but often equally pressed for time. CDPI Leads or key project leaders were interviewed from all 10 regions. When regions did not have CDPI Leads listed or CDPI Leads were the same as Executive Leads, other names were added. These second individuals were contacted for interviews to ensure a second perspective and extend input from each region in the data collection.

From April 11 to April 27, RDI researchers conducted the 16 interviews using the interview guide (Appendix A), which consisted of 18 questions. As regions were at different places in the development of the CDPI, exact wording of questions had to be adapted. Interviews were expected to take approximately 30 minutes to complete. Often interviews took up to an hour depending on the desire for detail of participants in sharing their information, thoughts and suggestions. On occasion, respondents called back to share further reflection and ideas. Generally participants were pleased to be asked for input and were appreciative of the interest.

3.4 Final Report

Prior to the development of the final report, researchers from RDI were invited to make a forty-minute presentation of the analysis and findings from the proposals and interviews to date, at a joint meeting of the JMC and the EC on April 25, 2006. The findings resonated with those in attendance and are elaborated upon within this final report. Details of the findings, organized to consider variations in regional realities, education and capacity building needs, and other challenges related to the CDPI, follow. Quotations from the conversations with regional respondents are used throughout the discussion of the findings to provide evidence and assist in clarifying the thoughts and ideas they have chosen to share. Recommendations of strategies for moving forward and evaluation garnered from the regions and analyzed with reflection and discussion by RDI researchers conclude the report.

It should be noted that the findings included in this report only reflect the perspectives from the regions. RDI was not requested nor did researchers seek the perspectives of Manitoba Health, the Project Management Office, the Joint Management Committee and the Evaluation Committee for inclusion in this report. In keeping with the principles of research ethics, researchers explained to those who were interviewed that the questions regarding the current status of their projects would be analyzed by region and the questions requiring their perspectives on the CDPI would be aggregated so that no respondent or region would be apparent. Submission of this report completes the contract between Manitoba Health and the RDI.

4. Variations in Regional Realities

Findings related to variations in regional realities include differences across regions in CDPI structures and processes, current status of the initiative and regional capacities. Tables have been constructed to illustrate the variations across regions in the CDPI management and organizational structures, regional committee structures and processes, and stages of current activity including next steps. Discussion of the variations in RHA capacities considers RHA, regional and community differences and is aggregated across regions.

4.1 CDPI Structures and Processes

Interviews with CDPI Executive and CDPI Leads illustrated great variation within regions regarding organizational structures to implement CDPI. Variation was apparent within the Executive Lead, CDPI Lead, Regional Facilitator, Regional Committee, Community Facilitator, and Community Committee ranks and levels. Related differences

in processes and timelines for implementing CDPI were also noted across regions and communities. Of particular note are the variations that are used within regions to fulfill their commitments for providing Regional Facilitators.

4.1.1 Executive Leads

Executive Leads involved with CDPI hold similar portfolios although not always the same, across regions. As a result of their similar portfolios, most Executive Leads indicated that they may have regular opportunities to interact with other Executive Leads through existing meetings.

Although regional roles were often similar, the level of involvement and support provided by Executive Leads varied. Some Executive Leads noted their engagement at the board level and senior management level, others at the regional committee level; others were connected and demonstrated support for the project at the community level. Executive Leads delegated substantial responsibility to the CDPI Leads and/or Regional Facilitators.

4.1.2 CDPI Leads

CDPI Leads came from vast variety of portfolios, and were often program leaders with roles and titles such as Executive Director, Planning and Evaluation; Healthy Living Program Leader; Primary Health Care Leader; Primary Health Care Manager; Health Promotion Coordinator; and Public Health Program Manager. In addition to holding different portfolios, CDPI Leads may be at different levels of their respective regional organizations. Due to these circumstances, CDPI Leads expressed a concern that they do not have an opportunity to network with CDPI Leads from other regions. The diversity of portfolios at the CDPI Lead provides opportunities for a diversity of expertise. However, the variation of portfolios does not provide natural networking opportunities.

4.1.3 Regional Facilitator

The CDPI Charter identifies that each RHA is expected to designate a 1.0 equivalent full-time (EFT) position to serve as a Regional Facilitator. Regions fulfill this commitment in various ways; from 1 person, to 3, 5, or sometimes 6 or more individuals. Interviews with CDPI leads indicated that some health regions are struggling to meet the 1.0 EFT position as well as transportation and other costs of the project. As such, some CDPI Executive and CDPI Leads noted that Regional Facilitators have not been formally designated in their regions. Other regions noted that CDPI fits well with their ongoing initiatives and projects. In these regions, the identification and allocation of resources for CDPI has been easier to manage. Commitment by Regional Facilitators in EFT varies for 0.1 to 1.0, depending on the number of individuals sharing the 1.0 EFT position. Among regions with designated Regional Facilitators, there is great variation among their formal roles within the region. Regional Facilitators come from positions such as Health Promotion Staff, Public Health Nurses, Community Health Developers, Community Liaisons, and Wellness Facilitators. An overview of the structures of CDPI Executive Leads, CDPI Leads, and Regional Facilitators is documented in Table 1.

Table 1: CDPI Executive Leads, CDPI Leads, and Regional Facilitators

Region	Executive Lead	CDPI Lead	Regional Facilitator
Urban			
Winnipeg	Dr. Sande Harlos Medical Officer of Health	Dr. Sande Harlos Medical Officer of Health	Genevieve Jones Dina Delaronde WRHA employees, titled Community Facilitators
Brandon	Bev Cumming ED Planning & Evaluation	Bev Cumming ED Planning & Evaluation Nancy McPherson (unofficial) Population Health Planner Analyst	2 x.1 EFT + 4 x.2 EFT Leadership Team Nancy McPherson & Donna Epp plus 4 leads, 1/theme
Rural			
Assiniboine	Debbie Clevett VP Community Health Services	Pam Walker Public Health Program Manager	EFT will be filled by Health Promotion Team (5 members)
Parkland	Linda Kulkarni VP Community Health	Sherri Buhler Director, Public Health	3 Health Promotion Coordinators more than an EFT
Central	Debbie Nelson Chief Nursing Officer & Reg. Lead, Prof. Practices & Programs	Jane Curtis Healthy Living Program Leader	CDPI Coordinator Cheryl Pearson
Interlake	Doreen Fey VP Planning	Judy McKinnon Health Promotion Coordinator	EFT - Judy McKinnon, Public Health Nurses (input varies), Health Information Analysis Manager
North Eastman	Judy Coleman VP Programs & Services	Debbie Viel Primary Health Care Manager	Wellness Facilitator in each of 3 districts, RHA employees
South Eastman	Betty MacKenzie VP Community & Long-term Care	Lynn Prevost Public Health Supervisor	Private contractor 2-4 days/month; CDPI Lead & Manager, admin time, education by Public Health staff
Northern			
Burntwood	Gloria King VP Health Services	Jennifer Santerre-Smith, Manager of Public Health and Clinical Nutrition Lynn Watkins, Health Promotion Coordinator	Community Liaisons, RHA employees
NOR-MAN	Pat Bilquist ED Community & Long-term Care	Margot Gray Regional Care Advocate for Women's Health; PHC Leader	Margot Gray (CDPI Lead) Have 5 Regional Community Health Developers

4.1.4 Regional Committees

To assist in delivering CDPI, the CDPI Charter requests that a Regional Committee be established in each region. Similar to the diversity among the CDPI leads, diversity exists among the Regional Committees (see Table 2). Where regions are in relations to the roll out of CDPI often paralleled the development of Regional Committees. In some regions, a transition of existing committees to a CDPI Regional Committees was underway. In other regions, CDPI Leads indicated that, *"previous regional committees are being realigned for purposes of the CDPI and changes are being made to add broader representation from sectors beyond health."*

The structure of each Regional Committees varied across health regions. Often previous experiences guided regions in the formation of the committee, its membership, role, and responsibilities. Within some regions, the CDPI process began with the formation of community committees, while in other regions it began with Regional Committee. Six of the 10 health regions currently have RCs, while two regions are the in formative stages of development. The remaining two regions had not begun the process of establishing a RC as of April 2006.

Table 2 Regional / Community Organizational Structures / Processes for CDPI

Region	Regional Committee		T of R	Community Committee
	Status and Structure	Perceived/Current Role		
Urban				
Winnipeg	- Just striking committee now to connect two projects	- Will look at cross cutting issues, collaborate, address practical issues - cash flow, central supports, evaluation; share what is learned and what is needed between the two communities; & provide content expertise	Not yet	- Develop proposals; extend membership - Community facilitator co-chairs "CDPI Committee" is community committee
Brandon	- Not formed at present - Similar format to the Westman Healthy Living Coalition	- Give local approval to projects and funding; oversee project, lead initiative, ensure RHA does what it needs to; act as change agents; guide implementation of CDPI process	Not yet	- None at moment
Rural				
Assiniboine	- Health Promotion Committee in placed for 3 years; membership 15-25 individuals/organizations	- Use CDPI Charter to develop a regional process to work with communities; act as advisory group for working with communities; review proposals, guide funding	Yes	- In each community, to develop proposals. - Membership varies by community
Parkland	- Committee membership from previous committee; health promotion coordinators members	- Commit to the success of the project; provide a network of resources; work with communities; & provide a formal link to the JMC - Membership is open; individual communities not at table	Yes	- Community committees have been established around clusters.
Central	- Healthy Living Program Team was in place before CDPI, making some additions	- Vet proposal and provide progress on process, give guidance & direction to RF; promote programs, engage communities, work with communities in developing plans, monitoring plans, and evaluation	Yes	- Facilitator worked with core group in each community cluster to develop proposal
Interlake	- Membership will change, based on the sub-committees	- Support communities; provide resources and tools to further develop CDPI in the region	Yes, from earlier group	- Committees in each community, prepared applications through PATH Process
North Eastman	- Does not exist yet	- Overall planning, making sure tasks are done, other needs as arise	No yet	- Committees have been formed
South Eastman	- Membership - Chairs, Vice Chairs of District Health Advisory Councils, others	- Decision making body to oversee development, implementation of work plans; guide projects; select community initiatives for funding	Draft	- DHAC is community advisory group - No community contracts as yet
Northern				
Burntwood	- Currently building the committee, have 3 subcommittees formed	- Will monitor implementation of action plans & what works, identify assistance need by communities; support & mentor communities in the use of resources, such as the tool kit; build stronger profile as a RC	Draft	- Early stages of community committee development
NOR-MAN	- Committee exists, membership needs broader representation	- Will be to provide guidance and almost drive the project; facilitate the process	Not yet	- Early stages of community committee development

The membership, among the regions with established RCs, consistently includes representation from the RHA. Membership in the RC varied across regions, with representation from community members and representation from multiple sectors of the community. Each region with a RC established noted the presence of Terms of Reference, either in draft or final format. Some regions adapted the terms of reference template provided by the PMO, while others utilized past experience and existing terms of reference to develop their terms of reference for the RC.

The roles and responsibilities of the RC, across regions, hold both similarities and differences. All regions noted that a main responsibility of the RC is to guide and assist communities in implementing successful CDPI projects. Roles and responsibilities that were not homogenous across the regions included decision-making on funding and other monetary issues, providing expertise to communities on chronic disease, reviewing/vetting community proposals, and providing guidance to Regional Facilitator(s). In three instances, health regions had Steering Committees engaged in CDPI. The role of these Steering Committees was in some instances to provide advice to RCs and in others to make decisions. In all cases the Steering Committee or Executive acted as a conduit to the RHA Board of Directors and RHA Executive Management. It should be noted that not all regions are developing the role of RC's in a manner that is consistent with their statements regarding the RC's perceived role. Given the varying states of the Regional Committees and other regional and community structures, accountability for project management and financial management often remained unclear.

4.2 Regional Status of CDPI

Through interviews, RDI recognized that regions are at different stages in the CDPI process. Some regions are building community engagement, others focusing on healthy living education, and others are preparing to implement projects and hire community facilitators. It is important to note that regions are at different places within the roll-out of the CDPI, which will affect the education and training required and resources needed to move forward with the CDPI.

Community Action Plans have been developed for communities across each of the health regions. The involvement of community members in building these plans varies, from minimal to full community engagement. For regions where communities have not been highly involved in building the plans, RHAs are now engaging community members in discussions about the CDPI initiative or are working to bring different groups in the community together to build community inclusive proposals.

In many instances, the PMO received incomplete plans. Often missing or incomplete were components related to planning for project evaluation. Common understandings and expectations of participatory evaluation currently are not noted at the community, RC, Regional Facilitator, and provincial levels. Knowledge of evaluation and the presence of necessary skills were not apparent in all plans and should be considered for future training and education. Most regions do not have concrete plans and are awaiting an evaluation framework from the EC before proceeding.

In terms of project management, every region has at least one contact for each the Executive Lead and CDPI Lead. Some regions have identified multiple contacts as the

role of the 1.0 EFT position is shared among several individuals. Just over half of the regions have established a RC and formalized their RC's terms of reference. For the remaining health regions, this will be one of their next steps in moving forward with CDPI. Although challenging in some regions, most have also identified an individual or team of individuals as Regional Facilitator(s). Beyond Regional Facilitators, some regions are preparing to hire community facilitators to implement CDPI projects. Although it is recognized that health regions are at different stages in rolling out CDPI, the regions themselves do not necessarily know where other regions are regarding structures or processes. No formal means appears to be in place to facilitate communication among regions. Table 3 provides an overview of CDPI current status and next steps across regions.

Table 3 Regional Status of CDPI Project Development

Region	Current Status	Next Steps
Urban		
Winnipeg	- Community committees in place linked to existing groups	- Extending Community Committees Developing RC
Brandon	- Conducted all day workshop with NGOs representatives, & community organizations, Community Action Plan submitted for region, RFs identified, adapting inter-regional RC	- Planning to hire Community Facilitator, adapting RC, revising Terms of Reference for the RC, establishing roles & responsibilities of RFs
Rural		
Assiniboine	- Community committees in place in 12 communities, RC established with strong working history, some additions being made	- Hiring Community Facilitator, seeking hiring guidelines, seeking financial management information, seeking information on evaluation requirements
Parkland	- Community clusters and committees established, RC established	- Working with community clusters and committees; seeking financial management guidelines
Central	- RF and RC in place prior to CDPI, some additions related to sub-committees	- Communities engaged; seeking information on financial management, and information on evaluation
Interlake	- RC in place and working with communities, RFs in place	- Moving forward and implementing projects in communities, evaluation
North Eastman	- Wellness Facilitators assisted in building 2 plans, community committees in place	- Building RC, hiring community facilitator, seeking evaluation information
South Eastman	- Locally driven & RHA coordinated process, engaged District Health Advisory Councils	- Finalizing RC terms of reference, seeking to engage communities
Northern		
Burntwood	- Communities excited about potential projects, proposal writing skills being developed, assistance needed in goal setting, project development, implementation & evaluation	- Revising proposals to include objectives, plans for implementation and evaluation
NOR-MAN	- Agency proposals, communities coming together to move beyond current proposals, at risk communities not well engaged	- Increasing community engagement, building community committees, finalizing RC terms of reference
NAPHWI	- 5 Community Action Plans have been received, assistance needed in continuing to build plans re proposal writing - goal setting, project development, implementation, evaluation	- Representatives from NAPHWI could not be reached.

4.3 Regional Capacities

> *"We want to come along side of great things the community is doing; support work in process; fit with networks, capacity and relationships already there."*

While beyond the scope of this contract, discussion of the variations of regional differences in RHA capacities, and community capacities must also be considered in planning and implementing the CDPI. Regions vary in the sizes and numbers of communities they serve; resources, expertise and numbers of staff to do the work; and the geography, distances to be covered, transportation infrastructures available, time required and cost for travel; and the competing priorities within each region for the allocation of resources. One interviewee stated, *"Our challenge is engaging people and communities across the geography."* Another suggested, *"Funding is not provided for travel of the community facilitator; that will be a challenge for us."*

Each urban region serves a multiplicity of neighbourhoods and nearby municipalities; each rural and northern region a multiplicity of rural municipalities, towns, villages, First Nations, and isolated communities. Cultures, languages, organizational structures, governance, jurisdictions, resources, and capacities for learning vary across the multiplicities. These factors influence the abilities of regions to engage and work with communities, and the abilities of communities to respond to efforts of engagement and undertake projects in ways that can ensure successful outcomes.

Regional representatives reported efforts to align the CDPI with current structures and programs. *"We want to come along side of great things the community is doing, support work in process, fit with networks, capacity and relationships already there."* Therefore, the unique histories of RHA evolution in the development of regional committees; previous allocations of staff to health promotion and prevention programs; and changes in regional management contribute to the complexities of regional planning for the CDPI.

The variations in regions and the communities they serve result in regional realities that influence the ability and willingness of regions to allocate resources to the CDPI. These variations are born out in the variations of regional structures and processes, in addition to the variation in the current status of CDPI in different regions.

5. Education and Capacity Building Needs

Through the review of the CDPI project proposals and the interviews with RHA representatives capacity building needs were identified at the RHA, regional and community level. Emerging themes for capacity building centred around the topics of community development; chronic disease prevention; project visioning and creation; project management and evaluation; and integrated communication.

5.1 Community Development

Regions were at various stages in their work of engaging communities. Some regions were currently educating residents on the topics of healthy eating, physical activity and tobacco reduction. The plan for their next step is to inform their communities about the CDPI and invite participation. Their needs centre around building knowledge and skills to

engage communities and move to project development using collaborative strategies. *"We need to beef up existing skills and gain confidence."* Other regions have moved to community engagement, with varying degrees of success. *"We need to build skills in working with larger groups, larger communities." "Different communities have different needs, respond to different approaches."* Some of these regions are seeking training and education in motivating participation, building relationships, creating partnerships, collaborating, and maintaining participation. *"We need education on motivating community members to come together to work on such initiatives; the benefits of coming together as a committee and as a community to set and achieve goals."* Still other regions are looking for knowledge and assistance in mediating diverse perspectives, determining strategies for decision making, managing conflict, working to reach consensus, sustaining relationships, and building community capacity. Knowledge of community development and different levels of skills in facilitation were identified and recognized as important for CDPI Leads, Regional Facilitators, and Community Facilitators.

"Identify the movers and the shakers, those involved with primary prevention in the community, like the recreation people, the champions."

Many regions report successful concerted efforts of their staff to engage on individual levels with community members and build relationships with residents and their organizations. Others are moving successfully along trajectories of building participation and developing projects. One respondent stated, *"In a small community, when staff changes are going forward, it is very difficult and relationships have to be rebuilt."* Another acknowledged, *"[Our facilitators] have excellent community development skills, credibility and profile within the community."* The type and level of community development knowledge that is sought varies depending upon the evolution of the partnership between the region and the community in their iterative community development process, within and beyond the CDPI. *"In communities there is huge trust of the health promotion team. Some of our greatest critics are on board and working with us."* Those regions that have moved farther in the implementation of the CDPI identified work completed and knowledge gained. Some regions were ready to hire community facilitators and stated that they are seeking individuals with knowledge, skills and capacity related to community development and associated activities.

"Look for right opportunities and be sensitive to their needs."

Although representatives continued to identify community development learning needs of current staff, potential community facilitators, and community members, all regions have had some successes. Regional representatives offered such wisdom as *"Identify the movers and the shakers, those involved with primary prevention in the community, like the recreation people, the champions." "Friendship Centres provide leadership and access to the Aboriginal populations in communities." "Look for right opportunities and be sensitive to their needs."* They shared lessons learned and it became readily apparent that the leaders and staff in every region have knowledge and experience to offer to the learning of their colleagues within and across regions.

5.2 Chronic Disease Prevention

The three specific CDPI topics of healthy eating, physical activity, and tobacco reduction resonated within all health regions. Some regions identified a fourth focus, that of 'stress management' or, 'mental health'. Their collective rationale was the evidence of the contribution of stress and poor mental well-being to chronic disease and its inseparable overlap with motivation and/or ability to address the other three risk factors.

Knowledge of these topics varied by region. Some regional representatives reported expertise within the region; others identified expertise within the Regional Committee; others within the CDPI Lead; and others within Regional Facilitators or those fulfilling the regional EFT commitment. *"The RHA team is well informed, but training needs to be done at the RC level."* Some facilitators reported, *"We have the facilitation and community development skills, we do not have the content expertise."*

In general knowledge about creating change, behaviour change, motivation, and fostering participation in health promoting lifestyles was deemed as important and again regions varied in their capacity within this realm. Regions need to understand *"principles for building support for people to be able to move forward with simple but healthy choices."* A facilitator needs to know *"How to be an internal change agent."* Other respondents warned, *"Let's remember not to blame the victim and focus on how to facilitate behaviour change without considering we need to provide education and training about influencing the environment, policy, the system – to change to support people to change."*

Over and over again support for the Healthy Living Resource Institute was voiced. *"We need the Institute up and running." "We are waiting to be able to access the resources we anticipate from the Institute." "We need tools from the Healthy Living Resource Institute, what is easy, what is fun, what is useful, what works and is known to work."*

Knowledge of "Best Practices" was a priority for all regions. Best Practices referred to strategies, programs, and projects that had demonstrated success in facilitating change and improving health outcomes. Best practices might be *"tangible training needs such as how to run a community kitchen, an after school program for kids, or a walking program for seniors". "Within the region we have the content pieces and the health promotion pieces, [we] need training to support partnership building, best practices, examples of what works." "We need information on best practices at the community level."*

> *"We need information on best practices at the community level."*

Regional representatives spoke of KEN the Knowledge Exchange Network and regaled its potential and usefulness. Others suggested translation of longer reports and case studies into more user-friendly formats for use with communities of varying levels of literacy and uptake capacity. *"KEN should help, it has much to offer. Sometimes needs to make it easier for communities to use."* Some representatives reported their ability to use the material and do the knowledge translation, but regretted the lack of time to commit to such activities and requested assistance and support from within the CDPI provincial infrastructure and the proposed Institute.

> *"We need tools from the Healthy Living Resource Institute, what is easy, what is fun, what is useful, what works and is known to work."*

5.3 Project Visioning and Creation

Upon review of the Community Action Plans and in discussion with regional representatives, RDI researchers identified a need to build community capacity in goal and objective setting. Goals set by communities in some regions appear very difficult to achieve or evaluate. Communities, Regional Facilitators, and RC need to ensure that plans have realistic and well-articulated goals from which indicators can be developed for measurement. Projects need to be created and supported in meaningful and useful ways at community, regional, and provincial levels.

During the interviews some regional representatives reported having skills in using the 'PATH Process' and had implemented this process with communities in the region. Some experienced frustration as they found the format required for project submissions to be less than compatible with their work in communities, creating additional work in the translation for staff.

The plans received by Manitoba Health vary greatly in quality and adherence to traditional standards. Plans contained incomplete components and unclear language regarding goals and objectives. As the communities participating in CDPI are deemed to be at-risk, flexibility is needed at all levels related to project development and proposal writing. It is important to recognize that in many communities capacity to develop formal proposals is not currently available and that this project will be addressing and building these capacities in communities. It is also useful think about the degree of formality and proficiency required by communities in proposal writing and project development. Discussion regarding educational priorities in working with communities bears consideration.

> *"Keep expectations realistic according to the level of the development of the community where the project is being developed."*

5.4 Project Management and Evaluation

The importance of education and skill development in project management is identified through discussions with regional representatives and apparent in review of proposals. Regional representatives noted that knowledge and skills in project coordination, decision making related to project management, financial management, and volunteer management as well as report development and writing are needed to ensure success of the CDPI at Regional Committee and community levels. Further, skills in the various phases of project management moving from visioning and goal setting to action planning, implementation, and evaluation are considered essential.

Through the review of the Community Action Plans, it was recognized that some communities had limited measurement and evaluation indicators included in their plans. In a few of the plans no mention of evaluation processes is noted.

While regional representatives reported being at different stages in the CDPI, all recognized the challenges of evaluation and their needs for education and skill building in this area. They offered comments related to their concerns regarding evaluation related to

1) community capacity and realistic expectations, 2) indicator selection, and 3) a standardized process.

"Manitoba Health needs to be flexible as some communities do not have the skills for implementation or evaluation."

"Community members have their own agenda, of what they feel helps. They will use tools but are more intuitive and ear-to-the-ground regarding evaluation. [We] need to make evaluation easy for the community; not research level work for community. We have data people and this is a partnership. We will take the information they collect and help them to make use of it."

"How do we help people to tell their stories then turn them into measurable outcomes? What will be the outcomes; understanding, partnerships, community planning, and better health?"

"Evaluation – training on indicators, and statistics, and ability to look at community health assessment data."

"[We] need consistency of [the] provincial program, standardized tools, a standardized process to work on evaluation."

Apprehension was shared about different types of evaluation for different purposes, *"We are concerned that within the CDPI partners different purposes for evaluating exist. Evaluating a new program at a local level is different from evaluating at a national perspective as a proving ground; different agendas for the projects, for the evaluation."*

Similar to other variations across regions, the stages of their work on evaluation and their perspectives varied.

"This survey is premature, as we do not know yet, [we are] just getting started."

"Evaluation is huge; we haven't begun to look at that. [It] needs much attention right from the start at all levels. [We] need facilitators to know what works."

"We have grave concern about evaluation and seek comfort that it will be taken care of by the province."

"We would like input into the evaluation process and framework development, to share plans with our Regional Committees and provide feedback as this work evolves."

"We have an evaluation framework but need compatible tools to apply it. If the province wants a standard approach they need to provide the tools."

"We have not put enough time into evaluation, but again it is a resource question."

The thoughts within many regions were summed up by this participant, *"It is more about how do we help community members to stay excited, not kill the motivation with evaluation burden."*

Regions have many skills at the RHA level, however, transfer and application at the Regional Committee and community levels may be more of a challenge. While RHAs had the

"How do we help people to tell their stories then turn them into measurable outcomes? What will be the outcomes; understanding, partnerships, community planning, and better health?"

necessary skills, their staff sought standardized processes, formats and guidelines for various activities such as financial management, community facilitator role descriptions, and hiring practices to be used for the CDPI. Regional representatives suggested that provision of these resources and project supports by the provincial infrastructure of the CDPI would facilitate a consistent approach across regions, reduce duplication of effort, and allow regional staff to focus their attention in teaching and facilitating the application of these tools and processes within communities.

Several regions requested that timelines and schedules as well as formats for key activities including the submission of progress reports and future applications be standardized and provided well in advance given the time required to work with communities to undertake and complete such activities. The history of previous challenges in the timelines for rolling out the CDPI imprinted immediate concrete needs in the minds of interview participants. *"We need the report outline and timeline for next February now."*

> *"It is more about how do we help community members to stay excited, not kill the motivation with evaluation burden."*

5.5 Integrated Communication

Challenges in communication and difficulties experienced within the CDPI to date were on the minds of interview participants. They identified a need for an integrated communication strategy and training and education in order to ensure that communication was effective at all levels and stages of the CDPI. Respondents recognized that communication is key. Strategies and skills needed to be developed, shared, adapted, and implemented in different and multiple ways. They advised *"Start with the RHA and by doing a better job with us, we can work more effectively with those we connect with."* An integrated communication strategy will facilitate the teaching and learning through multiple linkages at multiple levels.

Training and education related to communication strategies were sought regarding social marketing, public relations, working with the media, and lobbying at various levels within and across communities. Respondents were hopeful that this information would be forthcoming from the provincial infrastructure for CDPI and available through the Healthy Living Resource Institute.

6. Other Challenges

During conversations with Executive Leads, CDPI Leads and other regional leaders, they identified four primary challenges that had been encountered during the earlier and more recent evolution of the CDPI. They spoke of uncertainty with many changes during CDPI and lack of clarity regarding regional and community structures and processes for the CDPI. In talking with people from different regions, researchers noted variations in the understandings and interpretations of the CDPI Charter related to CDPI activities. Expectations were disconnected regarding processes and timelines, roles and responsibilities, as well as anticipated provision of project supports. Communication is challenged between individual regions and the province, within regions, and across regions.

6.1 Uncertainty

Regional representatives complained of experiences of uncertainty and confusion leading to feelings of frustration, often expressed during the interviews. They made statements such as:

"We are worn out with being done to. Even when opportunities arise we have to be careful as it takes a lot of energy to deal with a process like this. We need more regional involvement in developing the process."

"We are very excited about this project, but there have been many glitches."

"We need a clearer picture of the CDPI, it keeps changing. [We] need an organized firm plan so we know what we are doing before we seek community buy in."

"The rules appeared to change as we went. We need an infrastructure to support projects at the regional level. It seems to be a guessing game. We need clearer guidelines, about what is acceptable, what is not acceptable, what is expected of projects."

"Some of our challenges have been not knowing when we needed to get things done by and what kind of reports were needed."

"We are worn out with being done to. Even when opportunities arise we have to be careful as it takes a lot of energy to deal with a process like this. We need more regional involvement in developing the process."

"There are going to be some opportunities missed if someone doesn't get a grip on what is going on."

"We need infrastructure support at the provincial level. A single person dedicated to the project. All provincial people are doing so many things! Who is leading? How can we get support? Who is the point person?"

Participants recognized that this project is unfolding for all and everyone is on a learning curve. *"Good job given their stresses to meet timelines as well."* Region representatives suggested and asked for more input from and discussion with the regions before moving the CDPI forward. Others wanted to move quicker as they are already poised to work with and in communities. *"Communities are ready to get going. We have a commitment to them. [We] need tools now."* Some sought more structure; others sought more flexibility. One regional representative effectively summed up the thoughts of many, stating *"We are glad for this opportunity and appreciate the support and resources. The organization needs to be more effective and the process needs to be more inclusive."*

"We are glad for this opportunity and appreciate the support and resources. The organization needs to be more effective and the process needs to be more inclusive."

Regional representatives recognized the uncertainty that goes along with new opportunity and new endeavours such as building relationships, partnerships and projects with First Nation communities. *"We struggle to build networks that include First Nations and this is the first time we are going to their community. I am very excited to work with First Nations, but I feel a need to be very sensitive and I feel unsure." "This is the best attempt*

at building working relationships between the RHA and First Nation communities to undertake a health project to make a difference in the health of community members. We need to figure out how to work together."

6.2 Interpretation

Uncertainty was compounded by difficulties in interpretation of messages, of documents, of models.

"Provide clear consistent messages to everybody for financial management, roles, expectations, implementation, and evaluation."

"Some of the language used in communication is unclear and open to interpretation; that can lead to difficulties. Sometimes we talk different languages. For example 'Critical Path'. What does it mean? Does it mean the same to everyone?"

"We need clarification of the model. Is it a community development model or a community-based program model?"

Those regions with members on the CDPI committees such as the JMC or the EC seemed clearer in their understandings of the CDPI. Committee members recognized this benefit as did other regional leaders. All regions sought clarification and the sharing of consistent messages through multiple strategies using multiple networks.

Variations in interpretation are often the result of differences in the realities of regions. The variation in regional interpretations has contributed further to the variations and differences in the ways that regions are experiencing and implementing the CDPI.

6.3 Disconnected Expectations

Inconsistencies and disconnected expectations exist between individual regions and the provincial project infrastructure regarding processes and related timelines, roles, project supports, and responsibilities. Disconnect exists between regional expectations of Manitoba Health, the PMO, and the JMC and the expectations of these various bodies of themselves. Mismatch exists between the expectations of Manitoba Health, the PMO, and the JMC regarding the roles and work of RHAs and their staff, Regional Committees, Regional Facilitators, Community Committees and community members and the expectations these groups and individuals hold of themselves.

6.3.1 Processes and Timelines

> *"Honour the principles of community development, as it should be experienced. Funding should not contravene these principles as this can set us up for failure, and make us fail."*

Regional representatives reported that for them the greatest challenge has been the processes that were expected to be used in relation to the timeline that was made available. Some regions were already doing this type of work with similar regional infrastructures and resource allocation of staff as well as preliminary relationships with communities. These regions were in better positions to undertake the CDPI. However the timeline for them was also a "huge challenge". Other regions

experienced varying degrees of frustration and continue to "play catch up". Regional representatives were quite articulate on this issue.

"[Our] biggest concern is the requirements from communities in a terribly short timeframe. This process demonstrates a lack of understanding of how to work with communities, how much work it is and how much time it takes."

"It is unrealistic to do all topics in each community, especially from the start. Community led - must allow it to be!

"Keep expectations realistic according to the level of development of the community where the project is being developed."

"JMC is helpful in not expecting a perfect academic document from communities."

"We all experienced too tight a timeline, too little time to work with communities. It was unrealistic."

"This is a small amount of money for a community. Do not make people jump through too many hoops!"

"Seems like a lot of hoops. Even with local committee approval, JMC still had to approve, and then Manitoba Health too."

"Honour the principles of community development, as it should be experienced. Funding should not contravene these principles as this can set us up for failure, and make us fail."

"You need time if the goal is for community-driven and community-owned projects. It can take a year or two before there is commitment to develop a plan and move to action. We were given 2 months. It is a big concern for communities to own a project. In the regions where the RHA had to push, there is a huge chance that the RHA may carry more ownership than they ought to."

6.3.2 Roles and Responsibilities

Expectations about roles and responsibilities varied across regions. Some perceived project implementation and evaluation as the role of the region, others as the role of the community.

"We need to know how and support the work, but not do the work."

"Careful not to burden people, so the RHA staff put arms and legs to the work."

"We need to create communities that are not reliant on government to do this work."

"Use pre-established forms, not for them to think up, teach them to use them."

"Need to train and mentor community members to lead programs."

"When we signed the charter we agreed to provide an EFT, but did not expect all the development work."

The confusion and variation about roles and responsibilities leads to differing perspectives on project supports.

6.3.3 Project Supports

Expectations of guidelines, templates, standardized tools, educational resources, and project assistance anticipated from Manitoba Health, the PMO, and the JMC varied across regions. Currently guidelines on financial management and hiring are primary concerns for many regions.

"Flowing dollars to communities and accountability agreements; needs to be simple so does not scare people away, but articulates what dollars can be used for; needs to fit with the education level of the community."

"We need to know how money will flow, be tracked, accountability for dollars. We are in a hurry-up mode and may move ahead without these pieces in place."

"We need spending guidelines, the list from Manitoba Health was not detailed enough, it was more labour intensive than we expected."

"We are ready to hire a community facilitator, we need a role description, guidelines for communities to use in hiring, what hiring practices are expected to be used."

Some regions wanted work to be done, guidelines and forms to be developed as they did not have the expertise; other regions had expertise but not staff time; others did not have funding to hire people with expertise or to do the work; and for some finding the expertise or people to do the work would be difficult regardless of funding. Of course, timelines in which to get the work done and competing responsibilities further complicated situations and reinforced the desire and need for provincial project supports.

"We need quick fact sheets about CDPI, about why exercise is important, why nutrition is important for adolescents."

"We need internal project types of things. Specific, clear expectations and all the tools that go with it."

"We need more standard communication coming from the province. Need to respect the individuality of the regions but need more standard guidelines."

"We need to feel solid about evaluation expectations for this project."

"We need easy to use tools and templates. Lack of ambiguity, clear upfront on - what, how, and format."

"We need sharing of tools that have been developed, templates that do various pieces; planning tools, evaluation tools, assessment tools, data collection tools, and access to best practices."

6.4 Communications

Two regions recommended that "the province" develop a template for Terms of Reference for Regional Committees. This template exists and attempts have been made to share it with all regions for use with the Regional Committees. Other CDPI Leads had not received other CDPI documents. It would appear that attempts to share information and documents have not always been successful and communication gaps exist. The variations in understandings and expectations further attests to the need for attention to communication structures, processes and strategies.

Through discussions with regional CDPI leaders, it became clear that these gaps exist in varied and sundry places, between the individual region and the province, within the region and between various organizational levels within the RHA, as well as between regions and communities. Communication opportunities are available, however, gaps continue to exist across regions as well as within and between the provincial infrastructures including the PMO and the JMC.

Communication issues were identified between individual regions and the province at different points and due to different factors. Some communication strategies worked better than others. Often interviewees recommended using existing networks. However even when other networks were used, communication issues were not necessarily resolved.

Challenges in communication among CDPI Leads, seemed to be a particular problem related to their varied roles within different regional structures. Careful attention to who has representation on which networks and at what level of an organization may help to ensure that key CDPI leaders and facilitators are informed. A creative and integrated communication strategy has great potential to address many of the identified communication gaps.

Communication between the RHA and First Nation communities has its own challenges and these partners eagerly anticipate its own rewards. *"We need CDPI to link to First Nations and Inuit Health Branch somehow. And in several ways at several levels is perhaps best. We need to learn how First Nations and the RHA can build on what is there and each come to understand the other and build together."*

Funding for projects related to healthy living is becoming available through multiple and diverse streams. Some respondents were frustrated that communication and confusion related to these opportunities tended to create competition and created divisions. *"We were going to write a letter to Manitoba Health to please list the different funding sources so we can understand how it all fits together… different funding opportunities come down through funnels and it is divisive verses pulling people together. Why can't like minded initiatives be under a common source?"*

The variations in understandings and expectations as well as challenges in communication demonstrate that there is much work to be undertaken by provincial, regional, community, and federal partners within the CDPI.

7. Strategies for Moving Forward

During the interviews regional representatives offered their perspectives on project supports, educational strategies and capacity building activities. They identified strategies for moving forward and made recommendations for evaluation structures and processes. Analysis of the interview data coupled with the information gleaned from review of the proposals underpins strategies for moving forward presented within this report.

It is essential that the context of variation among regions be recognized and considered in forward planning. Different strategies are needed with and within different regions; one size indeed does not fit all! Having made that point, however, some regions share some similarities with others and capacity exists within regions to adapt and modify materials

and processes to fit their unique needs and circumstances. It is important to remember that strategies will require prioritization and cost analysis.

Listen to the regions and the communities. Be sensitive to their needs and responsive to their requests. Seek regular, periodic feedback between regions, communities, Manitoba Health, the PMO, and the JMC/EC. This goal is consistent with a community development approach and could effectively be modeled at the provincial level. Regional representatives were generally pleased to be contacted and their perspectives sought through this process. They were willing to share their experiences and appreciated being asked. By implementing this information collection, Manitoba Health and the JMC are demonstrating their desire to move further in this direction.

Promote consistent, community oriented, practical, reliable, relevant, focused, simplified approaches. Simplicity, timeliness, practicality and relevance were the priorities of the regions in describing the types of approaches and information they were seeking. Consistency was always a key consideration.

Share knowledge and resources, in respectful and supportive ways. This goal has considerable potential to address many of the identified concerns. With the support of the JMC and the EC; resources from the PMO/ Manitoba Health and CDPI partners; and input from the regions several strategies might be devised and implemented.

Build a network of CDPI Leads and Regional Facilitators using a list serve or email network, to be used by the province and by these project leaders among themselves. Ensure regular meetings at strategic points, 2-3 times per year.

Revisit disconnects in communication. Create a forum for communicating and sharing information. Perhaps this priority begins with the PMO creating comprehensive inclusive contact listings of key people fulfilling Executive Lead, CDPI Lead, Regional Facilitator, Regional Committee Chair and other CDPI leaders as identified by regions. The PMO, JMC, EC and CDPI leaders depending on the purpose and communication required would use these contact lists.

Share an inventory of all CDPI documents that have been distributed by using the comprehensive contact lists. This process could be used to revisit the communication gaps related to receipt of documents, so all CDPI Leads, Regional Facilitators, Regional Committee Chairs and other key people are able to ensure that they have the most current and complete CDPI information.

Create forums and processes for sharing expertise, strategies, lessons learned, and problem solving across regions. This forum should be used to garner regional input and adapt priorities regarding roles, expectations, and achievable outcomes. The type of forum would depend on the target audience and the purpose of the meeting. During the interviews it was apparent that all regions have knowledge, tools and ideas to share. For example a provincial workshop with Executive Leads, CDPI Leads and Regional Facilitators could provide a venue for development of specific guidelines including the evaluation framework. Those invited to the workshop could be asked to bring tools and strategies that they have found to be effective to share with others. Venues for sharing, celebrating and appreciating each other's work can have a variety of positive outcomes. Using a Delphi method to gather input from potential attendees, could be used to identify

specific issues and resources that could be developed or determine speakers who could be engaged to assist regions in dealing with prioritized challenges. Using a community development approach to create forums can be useful in modeling the process, which is expected to underpin the CDPI.

Cultivate and use multiple interactive strategies for teaching and learning. Regional representatives are rich with knowledge and experience. They recognized and advocated for the use of multiple and interactive types of strategies for their own learning and to use with those who partner and work with them within the communities.

Develop templates, guidelines, and information toolkits. Those interviewed recommended the development of a variety of tools to support the CDPI project. Initially guidelines and formats for financial management and hiring of community facilitators were priorities for many regions. Use of a Delphi method to keep in contact with regions can keep the provincial project infrastructure and resource team informed about needs in the regions and responsive to their requests. Strategies and information on the use and application of tools must accompany the tools.

Get the Healthy Living Resource Institute up and running. Regional leaders are asking for the development and implementation of the Institute as soon as possible. They are seeking information on best practices, healthy lifestyles, fostering and implementing change, strategies consistent with a community development approach, social marketing, communication with the media, volunteer management, project management, development, implementation, and evaluation. Topics that do not fit within the mandate of the Institute will need to be addressed using other strategies.

Use a train the trainer approach between the regions and their respective communities. CDPI Leads in many of the regions were familiar with a train the trainer approach and recognized its potential for working with communities. They agreed that clustering regions for follow up from a provincial session could prepare regional facilitators for the next phase and the extension of these trainers into the communities to build on and continue their work with community facilitators, community committees and community residents.

Demystify evaluation; create a regional evaluation framework and a plan for teaching about and undertaking evaluation. Clarify evaluation as part of a simple process for creating and doing effective projects. Work with regions to design a collaborative evaluation framework and develop related tools. Plan and deliver a provincial workshop on topics broader than but including evaluation with participant sharing and learning. Work with CDPI Leads and Regional Facilitators using 'Train the Trainer' model to teach and undertake evaluation with community members. Design and implement regional strategies for evaluation with regional or community clusters. Provide tools for regions to have at the ready as communities seek their support and assistance with their projects.

Collaboratively design an evaluation framework. Regional representatives have asked for an evaluation framework. Some are working to this end and others are seeking a common framework to be used across the province. Working together to design a framework ensures input from all regions and has potential to provide a collaborative

outcome and consistent approach. The challenge for some will be addressing this pressing need with strategies to foster collaboration while tending to their sense of urgency.

Share this report with the regions. The information contained in this report is the result of a review of proposals from health regions and conversations with regional CDPI leaders. Their willingness to share their experiences, thoughts, and ideas during the interviews is pivotal in efforts to move the CDPI forward. Often they are aware of their own circumstances and those of close regional collaborators, but the vast variations in regional realities related to the CDPI may not be readily apparent to them. RHA leaders are committed to their work in their own regions. However, upon understanding the capacities and needs of other regions RHA leaders are well able to balance their own needs with those of others and have a history of supporting the needs of others. Sharing this report demonstrates a respect and appreciation to regions for sharing their knowledge with the CDPI provincial infrastructures and provides information for their consideration in their future participation and planning.

8. Next Steps

> *"This is the best attempt at building working relationships between the RHA and First Nation communities to undertake a health project to make a difference in the health of community members. We need to figure out how to work together."*

Although each region is a different stage, a sense of excitement exists among CDPI Executives and Leads. This report captures various perspectives gleaned from interviews and information gathered from the Community Action Plans. In particular, this report contains a review of CDPI organizational structures within the health regions, an update of regional activities, and a discussion of regional capacities. RDI provides an assessment of education and capacity needs; discusses challenges pertaining to CDPI; and shares strategies for moving forward.

In drawing this contract to a close, RDI offered, at the April 25 JMC meeting, to convene with members of the JMC and the EC to review findings presented in this report. RDI is available to clarify parameters for potential work regarding CDPI evaluation. Prior to undertaking evaluation capacity building, the CDPI is encouraged to consider the strategies suggested for moving forward. Action on the disconnects in communication, expectations, and project support must be addressed before regions will be ready to fully engage in evaluation capacity building. If the EC and the JMC desire to have RDI work with regions in building evaluation capacity within CDPI, RDI is prepared to submit a proposal for consideration at their request.

9. Appendices

Appendix A Interview Guide

Appendix A: Interview Guide

Interview Guide for Use with RHA Representatives
CDPI Executive Leads and /or CDPI Leads

The Rural Development Institute of Brandon University has been contracted by Manitoba Health to assist RHAs and communities in the planning, implementation and evaluation of various components of the Chronic Disease Prevention Initiative. My name is _____ and I am working with the Rural Development Institute on this project. We are calling the Executive Leads and the CDPI Leads identified by HPSEN to ask for their input as we identify training and community capacity building needs within each RHA, region and community involved in the Chronic Disease Prevention Initiative. You are identified on my list as _____. Are you the right person to talk to about CDPI?

This interview will take about 20 to 30 minutes. Do you have time to do it now? If not what would be a convenient time to talk with you. All interviews must be completed by April 18 and we recognize that people will be unavailable over the Easter break.

Date: _____ **Start time:** _____ **End time:** _____

Interviewee

Name: _____

Title: _____

RHA: _____

Role within CDPI: _____

_____

Contact information: _____

Record of attempts to arrange interview:

_____

Questions

1. What process did your region use to implement the first stages of this project? How were communities engaged?
2. How were proposals developed?
3. What is the region's philosophy regarding the CDPI project and what are the primary goals for the process or the projects overall?
4. Has your region established a Regional Committee? If not when will it be established and when do you anticipate that it will be functional?
5. What has guided or will guide the development of the Regional Committee?

6. We have been asked to document the membership including the sectors and organizations represented on your region's Regional Committee. Can I get that list from you?
7. What is the perceived purpose of the Regional Committee?
8. Does your Regional Committee have an agreed upon Terms of Reference?
9. What project supports, educational strategies and capacity building activities are needed by the Regional Committee?
10. How should project supports, educational strategies and capacity building activities be undertaken?
11. Has your region identified a regional facilitator? Who? Contact information?
12. What skills are needed by the regional facilitator? Do you anticipate that your facilitator has the necessary skills?
13. What training and education do you anticipate will be needed to assist your regional facilitator to carry out responsibilities within the CDPI project?
14. What training and education do you anticipate will be needed at the community level?
15. What strategies would be most effective and efficient in providing that education and training at the community level?
16. What information would be useful or would to assist with the rolling out of this project? Clarification of financial management? Roles? Expectations? Implementation processes? Evaluation processes?
17. Do you have any other comments about the CDPI project implementation and evaluation that you would like to share with us?
18. Who else from your organization should we be talking to in order to ensure that training, education and community capacity building needs are identified and included in the project plan?

Thank you for your assistance. Be sure to record end time on first page.

RDI ADVISORY COMMITTEE

The role of the RDI Advisory Committee is to provide general advice and direction to the Institute on matters of rural concern. On a semi-annual basis the Committee meets to share information about issues of mutual interest in rural Manitoba and foster linkages with the constituencies they represent.