

**CHRONIC DISEASE  
PREVENTION INITIATIVE**

**2007 – 2009  
PROGRESS REPORT**

**A Report to the Joint Management Committee of the  
Chronic Disease Prevention Initiative, prepared by the CDPI  
Evaluation Committee (March 2010).**

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# TABLE OF CONTENTS

EXECUTIVE SUMMARY	
Introduction	3
Accomplishments	4
Lessons Learned	5
Conclusions: Moving Forward	7
INTRODUCTION	
Background	8
Report Overview	9
COMMUNITY STORIES	
Northern	11
Rural	12
Urban	12
ACCOMPLISHMENTS	
General	14
Chronic Disease Prevention Model	16
Implementation of Community Led, Evidence Informed Activities	17
Strong Partnerships for Sustainable Initiatives	22
Integration and Alignment of CDPI Activities with Existing Programs	25
Enhancement of Capacity to address Health Disparities at Community, Regional, and Provincial Levels	26
LESSONS LEARNED	
Effective Systemic Practices	30
Transformative Change and Community Development Challenges	31
CONCLUSIONS: MOVING FORWARD	34
APPENDICES	
1: CDPI Participating Communities	36
2: Report References	38
ACKNOWLEDGEMENTS	40

# EXECUTIVE SUMMARY

## Introduction

The Chronic Disease Prevention Initiative (CDPI) is an innovative demonstration project started in 2005 to improve the health of Manitobans. It takes a comprehensive, systemic, community-based approach to preventing premature morbidity and mortality from cancer, cardiovascular disease, Type 2 diabetes, kidney disease, and lung disease by addressing modifiable risk factors such as smoking, physical inactivity, and unhealthy eating. CDPI is designed to promote sustainability by engaging communities in local actions, encouraging evidence-informed decisions and actions, and developing ongoing partnerships. The initiative is supported by a coalition that includes the Alliance for the Prevention of Chronic Disease, Manitoba Health (MH), the Public Health Agency of Canada (PHAC), Regional Health Authorities, and partnerships with many other organizations and groups. CDPI expands on and strengthens a number of healthy living programs in the province. It is community led, regional health authority coordinated, and government supported.

The overall goal of the initiative is “to develop and implement a sustainable and transferable chronic disease prevention model based on the principles of community development (holistic, process focused, empowerment, sustainable, and flexibility/innovation) resulting in an increased capacity of communities to prevent chronic disease at the local level.” The CDPI goal is further defined through its four objectives:

1. Community led, evidenced informed activities towards primary prevention of chronic disease are implemented
2. Strong partnerships for sustainable initiatives are established
3. Chronic disease prevention activities are integrated and aligned with existing programs
4. Capacity to address health disparities and to improve the health of Manitobans is enhanced at community, regional and provincial levels

The two year period reviewed in this report is one of consolidation of many successful activities, of increased confidence and capacity of the participants, and of dealing with various challenges. There are increased numbers of community and regional activities, and progress regarding community development, capacity building, partnership development, resource development, plus refinement of governance processes such as planning, funding, monitoring, and evaluation.

The initiative is demonstrating transformative change in how people work together, and in how they think and act regarding chronic disease prevention. This change vision includes the provincial system and links with regions, regional networks, community capacity and activities, and individual behaviour to address chronic disease risk factors and build supportive environments.

As of March 2009, 83 communities in 10 health regions including 21 First Nation communities and 7 Métis communities are participating in the initiative, representing a potential reach of approximately 330,000 Manitobans. The communities are northern, rural, urban, large, small, and demographically and economically varied. People involved in CDPI are a diverse group: volunteers, community leaders, Regional Health Authority (RHA) staff, and people in local and provincial organizations.

Nationally, CDPI's impact has recently been honoured by the Tommy Douglas Celebration of Medicare Award for Excellence in Interdisciplinary Achievement in the Area of General Disease

Management 2009, presented by New Health Professionals Network (NHPN). Provincially, CDPI communities of Hamiota, Kenton, Miniota, and Oak River, represented by The Daily Health Awareness Team (DHAT), won the RehFit Foundation's Healthy Living Award in the group category at the 11th annual awards dinner, held in Winnipeg in April 2009. The awards celebrate the people in communities who promote and encourage healthy and active living.

## Accomplishments

### Monitoring Data Highlights

Anecdotes regarding the activities in many of the 83 communities are in the CDPI [Healthy Together Now, Chronic Disease Prevention Initiative, Manitoba Stories](#). Numeric and thematic data are from the Community Monitoring Forms analysis. Monitoring data highlights also include information from Community Capacity Building Tool (CCBT) reports, and evaluability assessment interviews.

The community activity monitoring forms have self-reported information on the activities in the communities using, at least partially, CDPI resources. In the period of this report, 765 monitoring forms were submitted and analyzed, 387 in 2007-2008 and 378 in 2008-2009, identifying 65,429 participants directly involved in these community activities. They were supported by 1814 paid staff and 3625 volunteers.<sup>1</sup>

The most often reported benefits were increased knowledge, health, and wellness (86%), gaps addressed (75%), and increased capacity and skills (60%).<sup>2</sup> The highest area of focus for the activities was physical activity (63%), followed by healthy eating (44%), then tobacco reduction (14%).

Seventy percent of the activities are described as for individuals/groups, with the other significant type as educational / instructional (37%). The participant type noted most frequently is that of everyone (39%), followed by babies and young children (26%), adolescent girls (16%), adolescent boys (15%), women (10%), men (8%), families (8%), and seniors (6%).

The participation rates are identified as meeting or exceeding expectations 71% of the time. Seventy-eight percent of the activities involve volunteers, with 18% of the activities relying totally on volunteers. Sixty-nine percent of the activities involve 1-4 paid staff, 10% 5-8 paid staff, and 3% 9 or more paid staff. Twenty-two percent of the activities cost less than \$100, 22% cost \$100 - \$500, 18% cost \$500 - \$1000, and 27% cost over \$1000.

The Community Capacity Building Tool (CCBT), another major source of data, is a self-assessment tool developed by PHAC to track changes in community capacity to address health issues during the course of funded projects. It has 9 domains, most with several "scales" or items represented by questions. It was completed by 55 sources in regions and communities in 2008, after training and facilitation assistance through CDPI by Health in Common. The responses, and the analysis, include both quantitative and qualitative data.

The domain with the highest average strength<sup>3</sup> (88%) is "Obtaining Resources" from inside and outside the community. Another high average (84%) is in "Sense of Community", related to trust and collaboration.

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<sup>1</sup> This number is not discrete individuals. Individuals could have been involved in more than one activity.

<sup>2</sup> Many of the percentages add up to more than 100% as each activity could have several characteristics related to the questions.

<sup>3</sup> Ratings of *we're there* and *nearly there*, 3 and 4 on a 4 point scale

Four domains have average strengths between 73% and 71%. “Participation” is about involving target populations, community members, and other stakeholders in project activities, such as making decisions and evaluation. “Skills, Knowledge, and Learning” uses and develops those qualities in participants, “Linking with Others” creates partnerships with individuals and organizations to deal with issues, and “Role of External Supports” is about getting supports from funding agencies and other external resources.

The other three domains have lower ratings of strengths. “Leadership” (65%) is about developing and nurturing leaders, “Community Structures” (53%) is about linking with and strengthening smaller or less formal community groups and committees, and “Asking Why” (51%) is a community process of uncovering root causes and solutions regarding community issues.

## **Meetings Highlights**

Many productive gatherings have occurred and been documented, including annual Share & Learns, where participants from community, regional, and provincial CDPI activities learn, network, and share best practices. Participation in these has been increasing.

A December 2008 Strategic Planning consultation brought together 50 significant CDPI stakeholders who identified many CDPI strengths, voiced strong support for the initiative, and championed the systems approach to widespread involvement and shared governance. They also identified many opportunities including growing interest in CDPI related activities, untapped local leaders, and evolving roles of health care practitioners.

## **Provincial Level Activity**

The essential functions of strategic planning, funding, and monitoring of the CDPI are conducted through the Joint Management Committee (JMC), along with the two committees reporting to JMC, the Evaluation Committee (EC) and the Training Committee (TC), plus a training coordinator position established with the Assiniboine Regional Health Authority.

JMC and EC formed and maintained partnerships, organized committees to plan and coordinate the initiative progress, communicated with partners and stakeholders, planned and coordinated monitoring activities, and began the complicated CDPI evaluation process.

JMC and TC enhanced capacity to address chronic disease at the provincial, regional, and local level. The committees focused on capacity building through planning and resource allocation for regional training plans, partnership development, provision of self-serve resources for committees and individuals in all parts of the initiative, and coordination of meetings and conference participation.

## **Lessons Learned**

### **Effective Systemic Practices**

CDPI participants often refer to the initiative as community led, regional health authority coordinated, and government supported. The CDPI leaders have identified themselves as learning the following over time:

Community led means the following:

- Develop local planning committees, champions, and people to facilitate action
- Use action plans with per capita funding
- Start where community is at and address barriers to participation
- Leverage additional resources
- Build on community pride and “can-do” attitude
- Facilitate local data collection about risk factors

Regional Health Authority coordinated means the following:

- Work with existing groups and relationships to build partnerships and sustainability
- Create regional committees (support for training plans, surveillance)
- Share learnings across the regions: monitoring forms, granting programs, RHA board support, success stories
- Focus on high-risk communities
- Draw on evidence for decisions and planning
- Make it easy for communities to participate

Government supported means the following:

- Develop appropriate funding and funding mechanisms
- Demonstrate leadership, accountability and evaluation
- Provide support for committees for communication, coordination, and joint planning
- Liaison with other departments and facilitating linkages

Overall

- Sharing knowledge, resources, expertise, evidence based information and problem solving solutions is important and takes time
- Communities recognize the need to prevent chronic disease – get out of their way
- Understanding community traditions is important
- Use existing structures and groups
- Don’t let jurisdictions get in the way – people can work around perceived barriers
- Be flexible
- Recognize the inherent challenging dynamics in transformative change and community development work and provide supports

## Challenges

There are many challenging questions and dynamics in a complex initiative like the CDPI. Ninety-five percent of the respondents at a November 2009 Share & Learn identified that they had experienced rapidly changing expectations, information, behaviour, people, teams, activities, workload and / or administrative processes. This is referred to as the “whitewater” of change and is unsettling. As well, individuals experiencing those kinds of change dynamics often resist at least some of the imbalance, demonstrating challenging behaviours. Overall, only 29% of the same Share & Learn respondents said that they and their fellow CDPI participants were dealing with resistance effectively.

Community development work has inherent tensions, e.g. working with communities “where they are” *and* moving forward, responding to local interests *and* meeting the initiative mandate, respecting established practices *and* challenging them, working with local leaders *and* growing leadership.

The CDPI has additional challenges coordinating systems and processes at various levels, in various places, with various levels of partnership. Therefore, there are evolving planning and monitoring forms and processes, incomplete information, and communication gaps.

It is not surprising that for individuals and the initiative overall, sometimes the journey has its ups and downs.

## **Conclusions: Moving Forward**

A priority for action is the development of a go forward plan to build on the momentum and opportunities. CDPI participants stress the importance of including community leadership, of continuing to improve communication, and of continuing resource and tool development. There are opportunities to continue to improve the planning and monitoring processes, and good data like the Monitoring Forms and CCBT analyses for consideration in setting priorities.

Staff and volunteers could be supported through strengthened structures and processes, e.g. role clarification, and through attention to the challenging change and community development dynamics.

One of the greatest challenges, and greatest lessons, is that while these challenges can be somewhat anticipated, they must be individually and collectively “learned through”. Four questions, plus some sub questions, can guide this process of ongoing review or “building the road as you travel” through both individual and collective learning.

1. What are we experiencing?
  - What activities, processes, results, ups, downs, etc?
2. What stands out for us from that?
  - What do we like, not like, feel surprised by, feel worried about, etc.?
3. So what - what conclusions do we draw?
  - What can we generalize?
  - What are the dos and don'ts, best practices, etc.?
4. Now what – what action will we take based on our conclusions?
  - What plans will we make?
  - What will we try, when will we next check on it, etc?

The CDPI has made significant progress and has great momentum, an evolving effective model, many committed participants, and much still to contribute. All participants look forward to even healthier Manitobans.

# INTRODUCTION

## Background

The Chronic Disease Prevention Initiative (CDPI) is an innovative demonstration project started in 2005 to improve the health of Manitobans, grounded in a population health approach. Six out of ten Canadians are living with at least one chronic disease and chronic diseases are the leading causes of death in Canada.<sup>4</sup> It is widely believed that prevention is the best option for fighting chronic disease.

This initiative takes a comprehensive, systemic, community-based approach to preventing premature morbidity and mortality from cancer, cardiovascular disease, Type 2 diabetes, kidney disease, and lung disease by addressing modifiable risk factors such as smoking, physical inactivity, and unhealthy eating. CDPI is designed to promote sustainability by engaging communities in local actions, encouraging evidence-informed decisions and actions, and developing ongoing partnerships. CDPI expands on and strengthens a number of healthy living programs in the province.

In 2005, a coalition including representatives from the Alliance for the Prevention of Chronic Disease, Government of Manitoba, Regional Health Authorities, and the Public Health Agency of Canada formed in order to lead the design of the initiative. Funding from both Public Health Agency of Canada and Manitoba Health started April 1, 2005 to March 31, 2010<sup>5</sup>. In October 2005 the Project Charter outlining the direction, implementation, management, and evaluation of CDPI was signed by the participating partners including the Province of Manitoba, ten Regional Health Authorities, the Alliance for Prevention of Chronic Disease, and the Northern Aboriginal Population Health and Wellness Institute (NAPHWI). These signatory parties made commitments for the entire five year CDPI project timeline and agreed to contribute significant resources to the project through funding or in-kind resource support. These groups also take part in the governance of the CDPI through the Joint Management Committee (JMC).

In 2008, funding totalling \$2.8 million was flowed to regions from Primary Care and Healthy Living Division to enhance and sustain regional capacity for an integrated team approach to chronic disease prevention and healthy living across the province.

As of March 2009, 83 communities in 10 health regions including 21 First Nation communities and 7 Métis communities are participating in the initiative, representing a potential reach of approximately 330,000 Manitobans. The communities are diverse in size, geography and demographics. People involved in CDPI are a diverse group: volunteers, community leaders, Regional Health Authority (RHA) staff, and people in local and provincial organizations. See *Appendix 1* for a list of the participating communities.

The CDPI utilizes a community development approach that is community led and designed. Partners believe that health promotion, disease prevention, and community development are inextricably linked.<sup>6</sup> The CDPI is coordinated by regional health authorities and supported by government. There are many people working in different systems bringing skills and expertise to collaborative efforts which contribute to the complexity of this initiative.

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<sup>4</sup> From Health in Common, CDPI website, <http://www.healthincommon.ca/cdpi>

<sup>5</sup> Manitoba Health has annualized funding to continue to support chronic disease prevention.

<sup>6</sup> This philosophy is supported by a significant body of literature and large numbers of prominent organizations worldwide.

## Report Overview

This report provides an overview of the CDPI from July 2007- March 2009, a story with many perspectives: the participants in the activities, community committee leaders, regional committee leaders, and the members of the provincial committees. Included are indicators of progress, generally and in terms of the CDPI goal and objectives, plus lessons learned and considerations in moving forward.

This report follows up on the 2005 - 2007 CDPI Progress Report and draws significantly on many other CDPI sponsored reports and related documents. One of the major accomplishments has been the systematic gathering of information that can now be used to describe the initiative. The major data sources are the compilation of the community stories, the analysis of the submitted Monitoring Forms on the community activities, the analysis of the submitted Community Capacity Building Tool information, the summary of interview data from the evaluability assessment, and reports and minutes of various meetings and committees. See *Appendix 2* for a complete list of references.

The period reflected in this report has been one of great progress in terms of quantity and quality of community and regional activities, capacity building, partnership development, communication among partners, and refinement of governance processes.

CDPI has been breaking new ground, planting many seeds, determining what growth to nurture, and celebrating and sharing successes in a complex and dynamic environment. The initiative is demonstrating transformative change in how people work together, and in how they think and act regarding healthy behaviours. The impact of this initiative was acknowledged recently when New Health Professionals Network awarded CDPI the 2009 national Tommy Douglas Celebration of Medicare Award for Excellence in Interdisciplinary Achievement in the Area of General Disease Management.

The overall goal of the initiative has been revised as a result of an evaluability assessment and now reads: “to develop and implement a sustainable and transferable chronic disease prevention model based on the principles of community development (holistic, process focused, empowerment, sustainable, and flexibility/innovation) resulting in an increased capacity of communities to prevent chronic disease at the local level.”

The CDPI goal is further defined through its objectives:

1. Community led, evidenced informed activities towards primary prevention of chronic disease are implemented
2. Strong partnerships for sustainable initiatives are established
3. Chronic disease prevention activities are integrated and aligned with existing programs
4. Capacity to address health disparities and to improve the health of Manitobans is enhanced at community, regional and provincial levels

The principles inherent in the goals and objectives are defined in CDPI documents such as the *Healthy Together Now* materials and are included on the CDPI section on the Health in Common website.

- Grassroots: Community members identify, initiate and lead projects.
- Evidence-informed: Evidence is used to plan and design each project and to measure its effectiveness.
- Integrated: CDPI aligns and blends with existing programs to add value and enhance their reach.

- Focused: Projects target priorities or disadvantaged populations as identified by communities.
- Sustainable: Strong partnerships and community ownership promote lasting effects.

CDPI has set itself a challenging, complicated vision of changing people and their systems. It is supporting many layers of change and transition in community, regional, and provincial structures and processes, and in individual mindsets and behaviours. This is transformative change requiring reframing of expectations of the present and the future, restructuring of behaviour patterns, and recreating new systems. Transformative change involves changes in assumptions (paradigm shifts), changes in culture (how we do things around here), and continuous learning and adjustments to plans as reality unfolds. CDPI participants have experienced these dynamics and the associated challenges and are learning to deal with them.

## COMMUNITY STORIES

At its heart, CDPI is about community members identifying ways to strengthen their communities while strengthening their own and their neighbours' healthy behaviours. These community members have demonstrated creativity, collaboration, and persistence in planning and participating in various activities in 83 communities.

Healthy Together Now, Chronic Disease Prevention Initiative, Manitoba Stories is a collection of stories written by Rosetta Projects for the Healthy Together Now Communication Toolkit. The introduction to the Manitoba Stories sets the stage for the stories of these activities:

“The CDPI parameters encourage a huge variety in the way projects can be administered and what they can be. Each project fits a community’s needs. Many grew out of existing projects or dovetailed into them, and these partnerships are encouraged by the Initiative.”

Here are some examples, condensed from Community Stories by Rosetta Projects. The full stories, and many others, are available at <http://www.healthincommon.ca/cdpi/community-showcase/><sup>7</sup> or in the Healthy Together Now package.

### **Northern**

#### ***Cross Lake***

Eugennie Mercredi started the Blue Light project in November 2007. With funds from CDPI, she bought blue light bulbs and with her partner Reg Mercredi went door-to-door. If people said their house was smoke-free, she gave them a blue light bulb. By Christmas, there were a lot of blue lights in Cross Lake and “it really looked awesome.” Mercredi advertised the project on local radio and TV stations and distributed pamphlets, posters, stickers, and signs that say “Second-hand Smoke Kills.” With material from the Manitoba Lung Association and the Manitoba Cancer Society, she made a package about what smoking does to people. In this First Nation community of 6,700 people, many people smoke, but the Mercredis believe awareness is growing and most people are smoking outside. Every year on May 31, people are challenged to give up smoking for 24 hours and are given tips on what to do instead.

#### ***Pikwitonei***

School principal Dana Tattrie is grateful to the Burntwood Regional Health Authority for funding a school snack program through the Chronic Disease Prevention Initiative. The program provides awareness of healthier food choices, an opportunity to try a wide variety of healthy snacks normally not available in their small community, and helps students to better concentrate on their school work. Snacks are chosen for their nutritional value and most often include fruits, fruit juices, milk, and yogurt. “Students look forward to their daily snack and are always willing to try new foods,” said Tattrie. It is a great benefit to everybody that the school is able to work closely with the Health Centre and other community groups.

The CDPI committee was also the driving force behind the purchase of physical fitness equipment that is used in the annual Terry Fox walk and community walks with adults, elders, and children.

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<sup>7</sup> Health in Common (HiC), formerly Healthy Living Resource Clearinghouse, is a major CDPI partner, hosting a CDPI section on their website, plus offering services and resources supporting CDPI and other Manitoba health strategies and networks.

## **Rural**

### **Hamiota, Kenton, Miniota, and Oak River**

*These CDPI communities are represented by The Daily Health Awareness Team (DHAT). They won the Healthy Living Award in the group category at the 11th Annual Healthy Living Awards, held in Winnipeg in April 2009 and hosted by the Reh-Fit Foundation and the Province of Manitoba. The event is designed to be a celebration of the people in communities who promote and encourage healthy and active living.*

The DHAT committee's goal was to use CDPI funding to increase physical activity in the schools and to do so in a fun and challenging way. The "Boot Camp" took place in four schools and was based loosely on the RCMP P.A.R.E. (Physical Ability Requirement Evaluation) program, using items already available in the school. "You don't need special equipment, you can just pull together what you have and make it fun," said Wilson. As well, everyone, from Kindergarten to Grade 8, and with a variety of physical abilities, could participate. The 100 meter obstacle course, outlined with yellow police tape and balloons, involved walking, pushing, pulling, carrying, lifting, vaulting, jumping, climbing, and running.

Another successful CDPI venture was a healthy eating challenge in the schools. Students were challenged to bring (and eat!) all four food groups in their lunches. At the end of the challenge, the class that had eaten the most fruits and vegetables won a cooking class. Changes were happening in the larger community as well with the encouragement of the CDPI committee. Restaurants were asked to provide healthier options, such as serving salad dressing on the side, adding whole wheat items, and baking instead of deep-frying some foods. Placemats were printed with healthy options such as 'load your pizza with vegetables instead of meat', and information on what is a healthy serving size.

Last year the FIT Family Fun Challenge was an open-ended photo contest. Families were encouraged to take photos of their families being active. There were prizes for the winners, 50 entries, and a great variety of activities showcased. This year FIT included a geo-caching challenge, an outdoor treasure hunt using Global Positions System (GPS) technology (available for participants to borrow) to find caches on trails in their municipality.

## **Urban**

### ***Brandon***

Brandon has over 100 area gardeners and numerous organizations involved in its Community Garden Network (CGN). The CGN was conceived in the fall of 2007 when a group of community partners came together with a vision of unifying the city's various gardening programs. Brandon gardeners are working together as part of the network along with Samaritan House Ministries, the City of Brandon, Healthy Brandon, Agriculture and Agri-Food Canada, and the Brandon Neighbourhood Renewal Corporation. The CDPI community gardening program had been able to acquire city resources that the older community garden projects had been unable to obtain, like water.

Thirty garden plots were prepared along with 16 raised beds for people with mobility issues. Real advancement in the gardens was seen when the gardeners themselves were given control to set the layout of the garden and make decisions on their own. Based on requests from the

gardeners, composting and freezing workshops were provided at the site. Both sessions were well-attended, and a communal spirit developed among the gardeners.

Additional funding has been secured from *Neighbourhoods Alive!* and Wal-Mart Canada's *Green Fund*, and it appears that a common direction of cooperation has taken root and will now be difficult to dislodge. "It's more of a philosophy, and a direction we're all moving in that is not dependent on government funding," said McPherson.

### ***Point Douglas, Winnipeg***

A very successful program, funded by CDPI, has been a joint project bringing the generations together for fun in the swimming pool. The Seniors Coalition teams up with five local daycares for a weekly swim. CDPI funding provides swimsuits for the children and healthy snacks. Seniors not only keep fit with the swimming, but are also able to have contact with children, something that is especially important to the elderly that might not have grandkids in the area.

CDPI funding also helped to purchase kitchen equipment so people can gather for potluck lunches several times each month, improving the sense of community in the building.

Another popular and successful project has been a Mass Food Handlers certification program, on preparing nutritious, tasty, and safe food using only crock pots, can openers, and cans. Together with the City of Winnipeg, the Seniors Coalition ran the course in two different locations for church groups, community centres, and school parent councils. The certification program was so successful that calls keep coming in asking them to do it again.

A children's drop-in soccer program provided children with a place to play, proper footwear, and a healthy snack. It started with about 30 children and has grown to a point where the city has taken it over as a funded inner-city project.

# ACCOMPLISHMENTS

## General

The two year period reviewed in this report is one of consolidation of many of the successful activities of the initiative's middle two years, and of increased confidence and capacity of the participants at all levels of the initiative. The number of communities involved has increased from 56 to 83. Several CDPI components are converging: community development, local surveillance, capacity building, and evaluation. The national award was previously referenced: there are other testaments to overall CDPI progress.

CDPI presented "Thinking and Working as a System: Integrated Chronic Disease Prevention in Manitoba" at the Chronic Disease Prevention Alliance of Canada's (CDPAC) 3<sup>rd</sup> Annual Conference in November 2008. Several general elements of success were outlined:

- Increased ability to work together to create supportive environments
- Partnerships at multiple levels
- New communities of practice formed such as Partners in Planning for Healthy Living (PPHL)
- Community-led initiatives blended into existing programs and services
- Resources combined to extend reach
- High risk populations working on community determined issues of priority
- Growing leaders
- Shift in attitudes and approaches to chronic disease prevention
- Valuing the different ways communities get things done

Staff and volunteers from all over the province express strong support for the initiative, and for the importance of the systems approach including widespread involvement and shared governance. To inform strategic planning by the Joint Management Committee (JMC), 50 stakeholders came together in December 2008 to share their assessment of the current situation and determine how to move chronic disease prevention forward. Table 1 below is a summary of a brainstorming exercise at that meeting. It identifies strengths and opportunities that attest to the optimistic positive culture.

**Table 1 Positive Culture Indicators, CDPI Strategic Planning Meeting, December 2008**

Current Strengths	Areas of Opportunity
<p><b>Activities / Information</b></p> <ul style="list-style-type: none"> <li>• 83 communities have been involved</li> <li>• Some high profile activities like the "blue light" garner considerable attention and have visible impact.</li> <li>• There is an increased use of information and evidence related to healthy living, system-wide and in the communities</li> </ul>	<p><b>Activities / Information</b></p> <ul style="list-style-type: none"> <li>• Our successes have built a positive reputation.</li> <li>• There is interest in more community stories.</li> <li>• Chronic disease is a hot topic in the media.</li> <li>• Communities are interested in strengthened ownership.</li> <li>• There is increased information about how to build healthy community environments.</li> <li>• Many people are interested in knowledge exchange.</li> <li>• Many people are interested in building a robust local evidence-based approach.</li> <li>• People are interested in understanding the</li> </ul>

	<p>determinants of health.</p> <ul style="list-style-type: none"> <li>• Technological advances e.g. Carelinks, You tube, enable creative linkages with certain populations.</li> <li>• People are interested in targeted marketing related to community appeal and how community connectedness make places great to live in.</li> </ul>
<p><b>People</b></p> <ul style="list-style-type: none"> <li>• The people involved are committed to the community-led philosophy and highly engaged.</li> <li>• The people involved demonstrate personal flexibility with regards to learning as they go along and accommodating difference.</li> <li>• The people involved support collaborative leadership processes rather than hierarchies.</li> </ul>	<p><b>People</b></p> <ul style="list-style-type: none"> <li>• There are local leaders not yet tapped for engagement with the work.</li> <li>• The potential for peer leadership is great.</li> <li>• Other communities are interested in participating.</li> <li>• There are many healthy aging people (and people living with chronic disease).</li> <li>• There are developing models of private sector engagement and partnerships – e.g. workplace employers, corporate support, funding support, funding from sources other than government.</li> <li>• Some communities are more knowledgeable and making demands.</li> </ul>
<p><b>Structure / System</b></p> <ul style="list-style-type: none"> <li>• The seed dollars enable and validate the process, and the principle of partnership is demonstrated in the pooling of funds from various sources.</li> <li>• The combination of community, regional, and provincial participants provides the variety of perspectives and connections essential for integrated action and shared access to those funds.</li> <li>• The overall systemic capacity related to healthy living has increased by using various system strengths. The RHAs' existing capacities are leveraged and they can mould and structure the resources appropriately for their region, considering needs, interests, and other activities. They and the communities are able to reach an audience missed by other methods such as social marketing.</li> </ul>	<p><b>Structure / System</b></p> <ul style="list-style-type: none"> <li>• There is growing interest in the alignment, coordination, and/or integration of healthy living activity, service delivery systems, and allied and non-traditional health professionals.</li> <li>• Many of the roles of health practitioners are evolving.</li> <li>• There are beginnings of primary care reform and that interest can be leveraged.</li> <li>• Health has opportunity to learn about community development.</li> <li>• "In Motion" is a simple, straightforward approach – we can learn from it.</li> <li>• We are influencing policy development e.g. physical education, no smoking in cars.</li> </ul>

The next sections in the report will describe the chronic disease prevention model and then the progress toward the goal and objectives, incorporating highlights of reports from various meetings, several sources of monitoring data, and information on provincial level activity from minutes of the CDPI committees. The progress is synergistic: while the data will be presented in reference to one or another of the goal and objectives, often that progress is also linked to one or more of the other aspects.

## Chronic Disease Prevention Model

The CDPI goal is “to develop and implement a sustainable and transferable chronic disease prevention model based on the principles of community development (holistic, process focused, empowerment, sustainable, and flexibility/innovation) resulting in an increased capacity of communities to prevent chronic disease at the local level.”

This goal contains 3 main elements: chronic disease prevention model, community development principles, and increased capacity of communities to prevent chronic disease. The second and third parts of the goal are outlined more fully in the CDPI objectives and are discussed later in the report. The first part of the goal references a sustainable and transferable disease prevention model. This model is an evolving set of structures, processes, tools and resources to support the governance, administrative, and information needs of such a complex initiative, and is outlined in Table 2 below.

**Table 2 CDPI Model Elements**

<b>Structure</b>	<b>Processes</b>	<b>Information Management / Accountability</b>	<b>Resources</b>
<p><i>Formal &amp; informal partnerships</i></p> <ul style="list-style-type: none"> <li>• Charter partners</li> <li>• Resource partners</li> </ul> <p>E.g. Health in Common, Partners in Planning for Healthy Living, CancerCare, PHAC, RHAs</p> <p><i>Committees</i></p> <ul style="list-style-type: none"> <li>• Provincial governance</li> <li>• Provincial working</li> <li>• Regional</li> <li>• Community</li> </ul>	<p><i>Funding mechanism</i></p> <p><i>Communication strategy</i></p> <p><i>Planning Supports</i></p> <ul style="list-style-type: none"> <li>• Community action plans</li> <li>• Training plans</li> </ul>	<p><i>Planning &amp; reporting forms and tools</i></p> <ul style="list-style-type: none"> <li>• Committee workplans and summaries</li> <li>• Community action plan worksheet</li> <li>• Community action plan proposal review form and summary</li> <li>• Memorandum of Agreement (between RHAs and community projects)</li> <li>• Community activity monitoring forms/cover sheet</li> <li>• Regional community activity monitoring summary template</li> <li>• Community Capacity Building Tool (CCBT)</li> <li>• Progress Report</li> <li>• Regional Training Plans</li> <li>• Contribution agreement (between PHAC &amp; MHHL)</li> </ul>	<ul style="list-style-type: none"> <li>• Health in Common website</li> <li>• KEN (Knowledge Exchange Network ) Canadian Cancer Society Manitoba</li> <li>• In Motion – Manitoba provincial strategy, network, and resources</li> <li>• Healthy Together Now: Manitoba Stories</li> <li>• What’s In Your Lunch – nutrition display boards</li> <li>• MANTRA (Manitoba Tobacco Reduction Strategy)</li> <li>• Partners in Planning for Healthy Living (PPHL)</li> </ul>

## Implementation of Community Led, Evidence Informed Activities

Information on progress in 2007 - 2009 related to implementation of activities, and to the elements of “community led” and “evidence informed”, is available from several sources.

### Community Activities Implemented

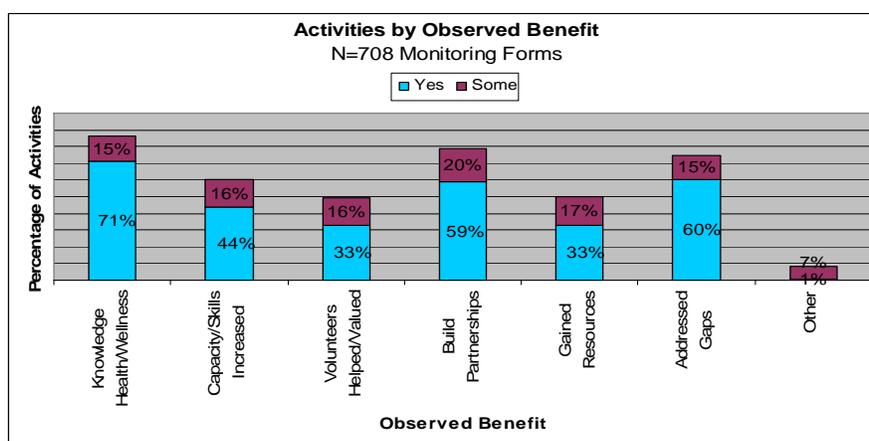
#### Monitoring Data Highlights<sup>8</sup>

Community Activity Monitoring forms provide self-reported information on community activities. In the period of this report, 765 monitoring forms were submitted and analyzed, 387 in 2007 - 2008 and 378 in 2008 - 2009. The analysis provides data related to several aspects of the CDPI goal and objectives.

In 2007-2009, 65,429 participants engaged in community activities<sup>9</sup> with support of 1814 paid staff and 3625 volunteers<sup>10</sup>.

The following charts show data in the following categories: observed benefits, focus of activities, types of activities, types of participants, participation rate, number of volunteers involved, number of paid staff involved, and the cost of the activities. Many of the percentages add up to more than 100% as each activity could have several characteristics related to the questions.

**Chart 1** below shows the observed benefits of activities. Eighty-six percent of the activities were reported to increase knowledge, health, and wellness, 75% addressed gaps, and 60% increased capacity and skills.

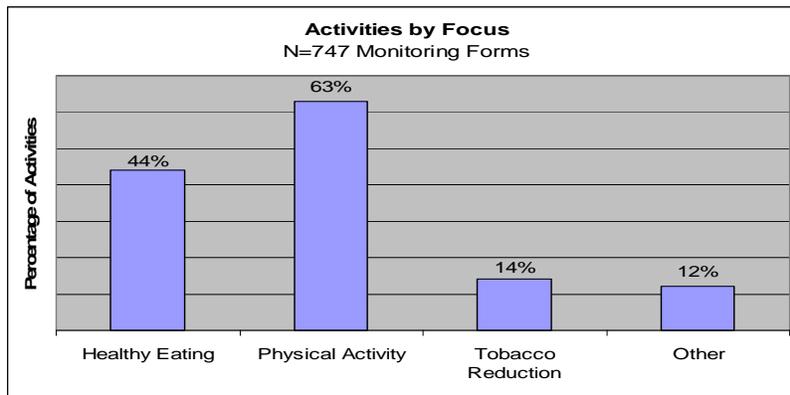


**Chart 2** below shows the foci of the activities as mostly related to the three pillars of the CDPI. Many activities are focused on more than one pillar, e.g. a community garden combined with a healthy feast would be both healthy eating and physical activity. Of the 12% categorized as “other”, 48% were identified as including a focus on mental health and social support.

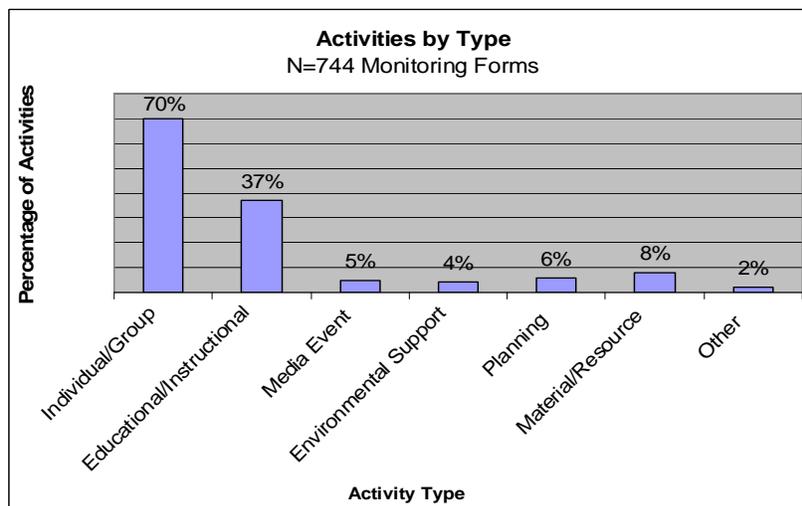
<sup>8</sup> *Monitoring Highlights* sections include information from Community Activity Monitoring Forms, Community Capacity Building Tool (CCBT) reports, and evaluability assessment interviews.

<sup>9</sup> This number is not distinct individuals but rather participants who may have attended multiple activities.

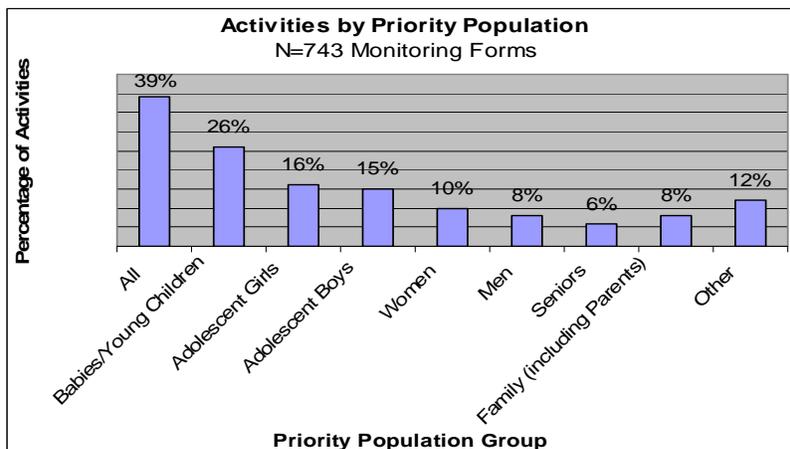
<sup>10</sup> The number is not distinct individuals but rather individuals who may have supported multiple activities.



**Chart 3** below shows the types of activities. Most (70%) are interactive involving individuals and/or groups. Thirty-seven percent are considered to be educational / instructional.



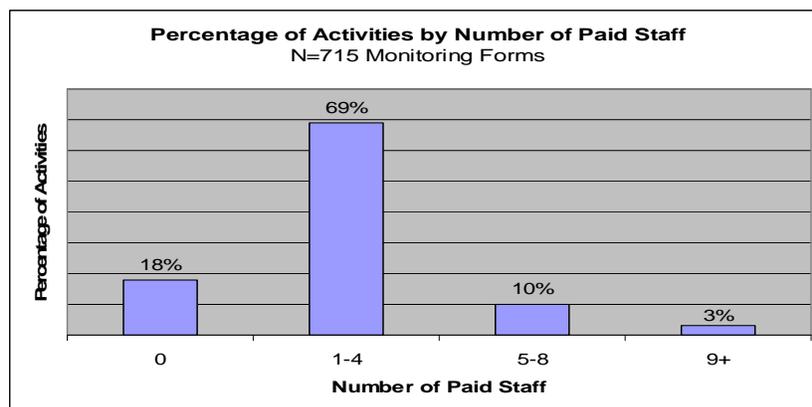
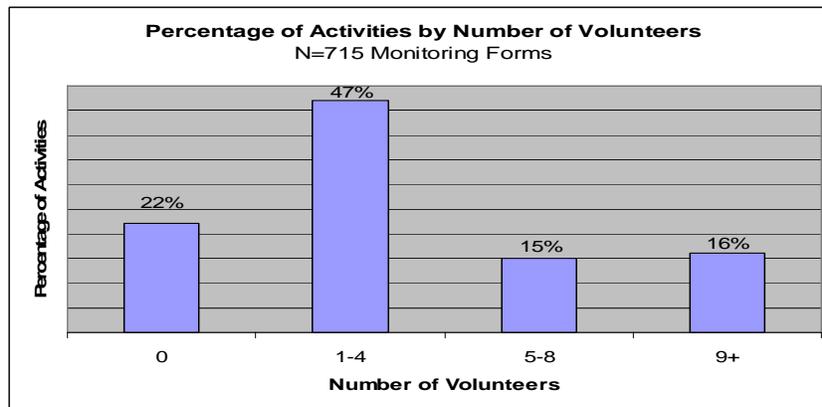
**Chart 4** below shows the percentage of priority populations involved in activities. The largest percentage is community oriented, potentially involving everyone. Overall there is close to gender parity in the participants.



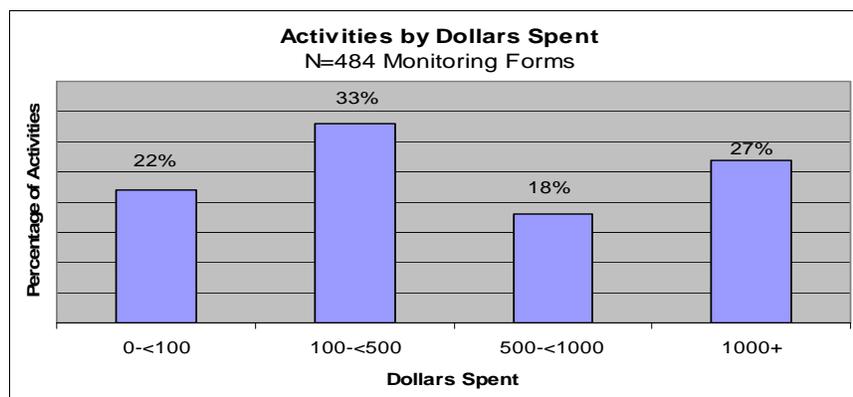
**Chart 5** below shows respondents' rating regarding their satisfaction with the participation. Since "average" is the rating if participation is what was expected, these are positive ratings.



**Charts 6 and 7** below give the reported numbers of volunteers and of paid staff. With 78% of the reported activities involving volunteers, the community led aspect of the activities is clear. Eighteen percent of the reported activities rely totally on volunteers. As 69% involve 1 - 4 paid staff, most of the activities are being led by a combination of paid staff and volunteers.



**Chart 8** below, regarding the cost of the activities, shows that 55% of the reported activities cost less than \$500 and 27% of the reported activities cost more than \$1000. The more expensive activities are infrastructure investments such as walking trails and skating rinks.



The review of this monitoring form data adds depth to understanding of these activities. It also raises questions as to whether the most useful information is being collected, plus whether the following results are significant, and if so in what way?

- Only 14% of the activities are related to tobacco reduction
- Comparing the “n” to the total possible of 765 responses shows that many answers to questions are missing on some forms

### ***Activities: Community Led and Evidence Informed***

#### **Meetings Highlights**

The commitments to “community led” and “evidence informed” were identified as key sources of engagement for participants and as a springboard for creativity and innovation in the Share & Learns<sup>11</sup> in February and December of 2008, and in the Strategic Planning meeting in December 2008.

#### **Monitoring Data Highlights**

In 2008, an evaluability assessment assisted in planning for the CDPI evaluation. Interview respondents commented that they observed a clear understanding in others that the theory of CDPI is the three pillars of physical activity, healthy eating, and tobacco reduction, plus community development. They identified great progress in community networking and mobilization, and noted how activities build on each other, giving the example of a walking program sparking an initiative for safe roads, and how people became involved that had initially been against it.

The Community Capacity Building Tool (CCBT) is another major source of data. This is a self-assessment tool developed by Public Health Agency of Canada (PHAC) to track changes in a community’s capacity to address health issues. Fifty-five sources in regions and communities completed the tool in 2008 after training and facilitation assistance through CDPI by Health in Common, and the responses were analyzed. CCBT data addresses 9 domains (themes) of community capacity building. These domains link with various CDPI objectives.

The *Participation* domain<sup>12</sup> is about the active involvement of people in improving their own and their community’s health and well-being. Participating in a project means the target population,

<sup>11</sup> Share & Learns are annual CDPI sponsored meetings bringing community, regional, and provincial CDPI participants together to share experiences and lessons learned and to explore best practices.

<sup>12</sup> The domain definitions are from the PHAC CCBT User Manual, noted in Appendix 2: Report References

community members, and other stakeholders are involved in project activities such as planning, making decisions, and evaluation. Analysis of three of the four questions in this domain show high capacity and one is moderate.

- 87% of respondents identify as strong<sup>13</sup> in using different methods to inform target population, community members, and other stakeholders about the project. Methods mentioned include using a comprehensive media and marketing plan, including methods such as websites, Facebook, individual invitations, databases, email lists, media releases, bus benches, TV commercials, Jumbotron, and a letter home to parents.
- 80% identify as strong in actively involving participants in the project, noting that the activities are community driven, inclusive, diverse, and have varying partners in different projects.
- 73% identify as strong in actively involving a representative range of target population members in the project, noting that composition and engagement are intentionally reflective of the community and are monitored.
- 53% identify as strong in overcoming barriers to participation of the target population in the project. 47% note that they are just beginning to recognize, learn about, and address barriers.

The *Leadership* domain includes developing and nurturing both formal and informal leaders during a project. The respondents rated themselves as doing well or moderately well.

- 62% of respondents identify as strong, noting that they have terms of reference and defined roles in areas of finance, project planning, implementation, and reporting plus roles for facilitator, chair, and project leaders. They know their own and each others' strengths.
- 67% identify as strong in ensuring leader accountability, noting that the guidelines lay out the available funds per intake and the geographic areas of priority, and that monitoring is systematic.
- 67% identify as strong in encouraging and supporting the involvement of informal leaders. Themes include knowing this is pivotal for their projects, the importance of two way relationships, knowing the informal leaders, and knowing how recent capacity training dollars plus core operating amounts increased opportunities for developing leadership capacity.

The *Asking Why* domain refers to refining a project to reflect the community needs through a community process that uncovers the root causes of community issues and promotes solutions. It envisions the community coming together to critically assess the social, political, and economic influences that result in differing health standards and conditions. This domain has mixed ratings.

- 73% of respondents identify as strong in exploring the root causes of the issues targeted by the project. Themes include using the Youth Health Survey, noting that the core of CDPI is root causes, and that they are very conscious of the determinants of health.
- 55% identify as strong in involving the target population in the process of “asking why” while 45% note that they don’t know how to do this, or that they have invited people who do not join in.
- 26% identify as strong in involving the target population in finding solutions to root causes of issues. 74% note that they have not yet developed these relationships and that root causes are a large, difficult topic and will take years to address.

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<sup>13</sup> In this report, the CCBT percentages are for the responses for “nearly there” and “we’re there”, numbers 3 and 4 on a 4 point scale. This has been interpreted as self-identification of strength. Included also are the themes from the responses describing the perceived strengths or challenges.

## **Provincial System Activity**

To be “evidence informed” is to base decisions and actions on valid and reliable information. In chronic disease prevention, “risk factor surveillance” provides planners with evidence regarding the health status and related behaviours in communities and populations. Other types of evidence used at the provincial, regional, and community level in making decisions regarding CDPI activities include the Community Health Assessment data and Canadian Best Practice Portal. The Canadian Cancer Society’s Knowledge Exchange Network (KEN) provides a website and workshops to facilitate planning of evidence-based interventions in communities and to address identified priority health areas.

A CDPI Risk Factor Surveillance Working Group (RFSWG) was formed in 2005 to provide guidance regarding capacity and gaps for community led risk factor surveillance in CDPI communities. The RFSWG presented its report in November 2007. It was shared with Manitoba Health and Healthy Living (MHHL). The Working Group disbanded in August 2007.

In 2007, Partners in Planning for Healthy Living (PPHL)<sup>14</sup> was formed. This is a multi-agency coalition inclusive but outside of government. PPHL members include some CDPI founding members, and the CDPI chose to financially support surveillance activities through PPHL. CancerCare Manitoba became responsible for data analysis and report writing. Many of the regions are using data from surveys based on the Interlake Regional Health Authority Youth Health Survey (first used in 2005) to develop plans for regional training programs. Many regions are also supporting increasing evidence based planning and action through their networks.

Health in Common, formerly the Manitoba Healthy Living Clearinghouse, was created in 2007 by MHHL. Health in Common provides tools and resources to support organizational and community development. Their website houses a CDPI section and those involved with CDPI provide content that includes CDPI reports and the Healthy Together Now Community Stories.

## **Strong Partnerships for Sustainable initiatives**

Partnerships involve sharing vision, sharing commitment to both the vision and to the partnership, and taking joint action. Information regarding progress on partnerships in 2007 – 2009 is available from several sources.

## **Meetings Highlights**

The strengths identified in the Strategic Planning meeting reference partnership strengths, noted in Table 1. The Share & Learns in February 2008 and December 2008 also paid considerable attention to partnership. Participants indicated that collaboration, partnerships, and joint initiatives are the cornerstone to success, and that considerable synergy is gained from partnerships. Also noted was the reminder to look beyond traditional partners, e.g. arts council doing a play with “don’t smoke” messages. Participants advised creating linkages with partners who are already working on prevention and who know the community and the people of the community. They also celebrated the value of the region-to-region sharing and partnering.

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<sup>14</sup> Thanks to PPHL for information regarding risk factor surveillance in Manitoba.

## Monitoring Data Highlights

The Community Monitoring Forms analysis for 2007 - 2009 shows community identification of partnerships in a few different ways. Partnership is identified as a benefit for 79% of the activities and as an unanticipated, spin-off benefit in 34% of the activities. Sixty percent of activities had contributions from partners, reducing the dependence on CDPI resources. However, when asked if the community would do this again without CDPI resources, 44% of the responses identified the need for CDPI resources to continue. The reporting that 78% of the activities used volunteers is an indicator of community level partnerships.

The CCBT *Linking with Others* domain refers to linking with individuals and organizations to help the community deal with issues, e.g. creating partnerships or linking with networks and coalitions.

- 74% of respondents identify as strong in networking with diverse sectors to gain support, noting that this is the small community way of operating. Other themes include that the team represents diverse sectors, and that people take turns as leads.
- 76% identify as strong in providing information to links. Themes include that information is shared regularly with partners, team members report to their workplaces using websites, distribution of minutes, and mass promotion through multiple networks.
- 67% identify as strong in receiving information from links, noting two-way networks are set up.
- 72% identify as strong in working with links to take action on community issues. Themes include noting that community issues are the foundations of all plans, and that they have established a process with different sectors.

Interview data from the evaluability assessment confirms that one of the perceived strengths of the CDPI is partnerships. People spoke of how existing partnerships were enhanced and new ones were developed. Trust is strengthening, e.g. how money is handled. In-kind contributions, where groups donate their staff time, space, or other resources to initiatives, were stated to have tripled due to people becoming more aware of the community connections and opportunities. These partnerships are seen as the source of some spin-off benefits, such as increased consultations, synergies in taking advantage of opportunities, and reduced overlap in efforts. Sharing is not only local and regional but also cross-regional, supported through meetings of district committees, Share & Learns, and the work of the Training Coordinator. The word is spreading and other communities want to get involved with CDPI activities.

## Provincial Level Activity

Partnership has been a primary element at the provincial level since the CDPI's inception: the primary partnership mechanism is the CDPI charter signatories, many of whom are represented on the Joint Management Committee (JMC). The JMC demonstrates the ongoing commitment to collaboration. The essential functions of strategic planning, funding, and monitoring of the CDPI is conducted through JMC. Two other committees report to JMC: the Evaluation Committee (EC) and the Training Committee (TC).

In this section attention will be on JMC and EC, and the data in their minutes related to the partnership objective. These committees formed and maintained partnerships, coordinated the progress of the initiative, communicated with partners and stakeholders, planned and coordinated monitoring activities, and began the CDPI evaluation process.

Table 3 highlights JMC and EC progress related to partnership and alignment at the provincial, regional, and community level.

**Table 3 JMC and EC Progress**

<p>Governance: Partnership</p>	<ul style="list-style-type: none"> <li>• Partner frameworks             <ul style="list-style-type: none"> <li>• contribution agreement with federal government</li> <li>• administrative guidelines for joint monitoring</li> </ul> </li> <li>• Links with regions / partnerships with the RHAs             <ul style="list-style-type: none"> <li>• funding allocations and reporting</li> <li>• Community Action Plans (CAPs) forms and approval process</li> <li>• funding disbursements, e.g. amounts, timing</li> <li>• needs identification regarding RHAs for Chronic Disease Prevention activities more broadly, e.g. 44 new staff positions were created in the RHAs to enhance and sustain regional capacity for chronic disease prevention and healthy living.</li> </ul> </li> <li>• Links with other Mb provincial groups</li> <li>• Health in Common (HiC) e.g. input into Executive Director selection, creation of CDPI section on website, funding for the organization</li> <li>• Partners in Planning for Healthy Living (PPHL)</li> <li>• CancerCare Manitoba</li> <li>• Manitoba Tobacco Reduction Alliance (MANTRA) for smoking reduction training identified in CAPs and Regional Training Plans</li> <li>• Alliance for the Prevention of Chronic Disease</li> <li>• Attention to ongoing, smooth relationships of people and various agencies' systems</li> </ul>
<p>Governance: Planning</p>	<ul style="list-style-type: none"> <li>• Committees             <ul style="list-style-type: none"> <li>• Determination of what committees were needed</li> <li>• Ongoing review of committee membership and recruitment with attention to representativeness and inclusiveness</li> <li>• Annual workplans for each committee</li> </ul> </li> <li>• Strategic Planning session (2008) with major stakeholders, e.g. members of CDPI committees, RHA Executive Leads, MHHL Senior and Program staff, PHAC Senior and Program staff, Health in Common, other organizational representatives interested in chronic disease prevention (50 people)</li> <li>• Working committee established (2009) to draft recommendations for sustainability of CDPI momentum</li> </ul>
<p>Communication Plan / Information Sharing</p>	<ul style="list-style-type: none"> <li>• Attention to effective ways to communicate with major stakeholders throughout the province</li> <li>• Information gathering regarding provincial communication policies for consideration</li> <li>• Decisions regarding distribution and timing of release of reports, resource packages, e.g. Finalization and distribution of 2005-2007 CDPI Progress Report to RHA CEOs, Health Program Service Executive Network (HPSEN), Planners Network, Community Health Assessment Network (CHAN), MHHL, PHAC</li> <li>• Plan to link with Community Health Assessment Network process to further the CDPI evaluation</li> </ul>
<p>Monitoring</p>	<ul style="list-style-type: none"> <li>• Monitoring form revision</li> <li>• Creation of databases for Monitoring and CCBT data by the Chronic Disease Branch</li> <li>• Data entry and analysis of monitoring reports by CancerCare Manitoba</li> </ul>

	<ul style="list-style-type: none"> <li>• Community Action Plan data roll up</li> </ul>
Evaluation	<ul style="list-style-type: none"> <li>• Refinement of logic model and evaluation framework</li> <li>• Development of conceptual framework</li> <li>• Conducting an evaluability assessment of CDPI with the support of an external consultant</li> <li>• Identification of potential knowledge exchange opportunities through evaluation process</li> <li>• Support from Health in Common for evaluation capacity in communities</li> </ul>

## Integration and Alignment of CDPI Activities with Existing Programs

CDPI is designed to link and cross organizational and discipline boundaries, to avoid duplication, and to support existing strengths. There are several sources of information demonstrating this.

### Meetings Highlights

The Share & Learns in February 2008 and December 2008 highlight participants' commitment to using and supporting existing structures (e.g. boards, community process) and how CDPI can extend the work already being done. Part of the identified definition of success is building on existing resources.

### Monitoring Data Highlights

The evaluability assessment interview data includes the perceived importance of the feedback loop from the regions to the communities and with other sectors, and how this enhances facility based services. People speak about the value of expanding existing programs.

The CCBT *Community Structures* domain refers to smaller or less formal community groups and committees that foster belonging and give the community a chance to exchange views and information, e.g. church groups, youth groups, and self-help groups. There are mixed ratings.<sup>15</sup>

- 69% of respondents identify as strong in developing links with pre-existing community structures. Themes include that they have developed partnership guidelines and distributed them widely, and have an annual service provider forum.
- 47% identify as strong in creating new community structures that help community members, with 53% noting that there is no need for this.
- 42% identify as strong in identifying areas for improvement in community structures that the project could work on, with 58% noting that they lack the people to think about or do that, and that CDPI funding is to be kept separate.

### Provincial Level Activity

As previously indicated, CDPI is integrated at the provincial level through JMC and partners with other organizations including: Health in Common, In Motion, CancerCare Manitoba, the Canadian Cancer Society, Partners in Planning for Healthy Living, Alliance for the Prevention of Chronic Disease, and Manitoba Tobacco Reduction Alliance.

<sup>15</sup> A number of respondents wondered if the last two questions in this domain are in the CDPI mandate.

## **Enhancement of Capacity to Address Health Disparities at Community, Regional, and Provincial levels**

Capacity refers to attitude, knowledge, skills, networks, and access to resources. Enhanced capacity is the output of community development work, the precursor to behaviour change, and a major area of focused attention in the CDPI. Progress is documented in several sources.

### **Meetings Highlights**

The Share & Learns in February and December 2008 demonstrated a number of related themes. Participants stressed that people can't assume capacity or lack thereof: it is important to assess and then to identify the supports needed at the community level and the regional level. Local data about capacity and about risk factors are powerful resources and enable local action, bolstering local pride and a can-do attitude.

Local champions are vitally important and they can be supported through Train the Trainer approaches. Local champions can help to engage new champions, build knowledge and skill in the youth, and value the expertise of the elders. It has been helpful in some communities to hire a local community person to bridge gaps and broker partnerships and collaboration.

The December 2008 Strategic Planning session highlighted that the overall system capacity related to healthy living has increased by using various system strengths. The RHAs' existing capacities are leveraged and they can mould and structure the resources appropriately for the region, considering needs, interests, and other activities.

### **Monitoring Data Highlights**

The 2008 evaluability assessment interview data identifies many observations of enhanced capacity: increased awareness, new ideas, enthusiasm, initiative, a belief that things are possible, empowered individuals and groups with growing confidence in their ability as a community, and the commitment of volunteers.

The CCBT *Role of External Supports* domain refers to external supports such as funding bodies in government, foundations, and regional health authorities that can link the communities with external resources and nurture community momentum. This domain has mixed ratings.

- 84% of respondents identify as strong in being provided with project-related information. Themes refer to always being ready to consider best practices, e.g. KEN, Ready Set Grow, RHA, In Motion, regional updates, and the structure of Healthy Brandon.
- 73% identify as strong in external supports having policies that support communities taking action on priority issues. Themes refer to potential partners having similar mandates, to aligning goals with others', and to the band, school, and workplaces having wellness policies and initiatives.
- 65% identify as strong in asking for project related support for organizational operations and projects, noting that they ensure supports are in place and that other linkages are strong.
- 60% identify as strong in asking for external supports such as financial support for organizational operations and projects, noting that there are multiple sources and many in-kind contributions.

*Obtaining Resources* domain includes finding time, money (other than from funding bodies), leadership, volunteers, information, and facilities both from inside and outside the community.

- 89% of respondents identify as strong in accessing internal resources needed for project success, noting solid structure, knowledge, contacts and in-kind resource sharing.
- 87% identify as strong in accessing external resources needed for project success, noting lots of contacts and links.

*Skills, Knowledge, and Learning* domain includes qualities used and developed in the project team, the target population, and the community.

- 76% of respondents identify as strong in developing project team's skills and knowledge, or accessing the skills and knowledge needed for the project's success. Themes include accessing multiple training resources, e.g. skills in active living, Microsoft publisher, working with the media, using media, time management, planning, networking, computer literacy, gardening, using heart rate monitors, text messaging, and web maintenance.
- 71% identify as strong in providing the target population community members with opportunities for learning, noting programs in and out of the community.

*Sense of Community* is fostered through building trust with others and coming together to work on community activities. Collaborations build confidence and courage to feel hopeful about change.

- 84% of respondents identify as strong in the project contributing to the sense of community among community members, noting a focus on and links with community, e.g. Healthy Brandon, Women's Health Matters, meetings about community resources, community walks, community newspapers, community gardens, soup kitchens, good bank, and physical activity month.

## **Provincial Level Activity**

Capacity building is a major focus from a provincial perspective as well, particularly with the Training Committee (TC) and through them, at JMC. The Training Committee was established in the fall of 2007 to identify the CDPI-related training needs in the regions. A training coordinator position was established with an agreement with the Assiniboine Regional Health Authority in November 2007.

The Committee and Coordinator assist regions to develop, implement, and evaluate annual training plans tailored to the needs of participating CDPI communities. The Training Committee and Health in Common work in close partnership, with the Committee focused on training plans, provincial coordination and support, and Health in Common providing a venue for resource sharing.

Table 4 uses information from the minutes of these committees to highlight the progress that JMC and TC have made related to enhanced capacity to address health disparities at the provincial, regional, and local level. The committees focused on capacity building through planning and resource allocation for regional training plans, partnership, provision of educational resources for committees and individuals in all parts of the initiative, and coordination of meetings and conference participation.

**Table 4 JMC and TC Progress towards Enhanced Capacity to Address Health Disparities**

Planning	<ul style="list-style-type: none"> <li>• Training coordinator consulted with CDPI leads to identify parameter and process for regional training requests</li> <li>• Training plans developed by regions<sup>16</sup></li> <li>• Funding for training plans dispersed to regions</li> <li>• Reports on training plans</li> <li>• Information sharing at JMC about other provincial and local conferences and meetings</li> <li>• Tobacco Action Team/Working Group assessed tobacco reduction approaches</li> <li>• Participation in a provincial working committee about community development needs</li> <li>• Support for community development in the regions and sharing best practices, e.g. use data, engage volunteers, work through the development process</li> </ul>
Partnership	<ul style="list-style-type: none"> <li>• Agreement with Health in Common for training and facilitation of the CCBT and development of regional websites</li> <li>• Regional links/support e.g. Mental Health Champions Network, Youth Health Surveys</li> <li>• Support for the popular Blue Light Project – “How to” guides and a web site hosted by Manitoba Lung Association</li> <li>• Link with Partners in Planning for Healthy Living (PPHL) for surveillance</li> </ul>
Educational Resources	<ul style="list-style-type: none"> <li>• CDPI section on Health in Common website developed</li> <li>• Healthy Together Now kits produced and distributed, including other provinces and territories</li> <li>• CDPI Connections E-newsletter developed</li> <li>• What’s In Your Lunch – display boards regarding healthy eating, 2 sets of boards per region distributed</li> <li>• Provincial resources identified – learning sessions and materials, e.g. Culture Health Tourism &amp; Sports stretch breaks CD, Manitoba Fitness Council, Volunteer Manitoba, Health Behaviour Change Training, MANTRA, Manitoba Lung Association’s Not on Tobacco (N.O.T.)</li> <li>• National resources identified and utilized, e.g. TEIP (Towards Evidence Based Practice)</li> <li>• Pathways to Healthy Living: The Northern Journey video</li> </ul>
Meetings	<ul style="list-style-type: none"> <li>• Share and Learns – annual, increasing participation with each one</li> <li>• Support provided for regional and community representatives to go to CDPAC conference in Ottawa in 2008</li> </ul>

<sup>16</sup> See Table 5 for areas identified in the Provincial Roll-Up Report about the plans

Table 5 notes the areas identified in the training plans submitted to the Training Committee and approved by JMC. X represents each time the area is mentioned in the training plan.

**Table 5 Areas of Training in Regional Training Plans 2007 – 2009**

Region / Winnipeg Centres	Volunteer Training	Community Development	Chronic Disease Prevention Training & Skill Development	Physical Activity Training & Skill Development	Healthy Eating Training & Skill Development	Tobacco Prevention & Cessation Training & Skill Development	Resources to Support CDPI Programming	Coaching and Mentoring	Share and Learn	Food Handling & Food Safety	Youth Health Survey	First Aid / CPR Training	Regional Processes	Promotion & Communication
Assiniboine			xx		xx	x	x	x						
Brandon -no 08/09 info					x			x	x					
Burntwood		xx xx	x	x	x	x	x		x					xx
Central	x				x	x	x	x			x		x	x
Interlake			xx	x	x	x					x		x	x
Nor-Man	x	x	x					x	x					
North Eastman	x		xx xx			x		x			x			
Parkland	x	x	x	x	x					xx		x		x
Point Douglas Winnipeg	x x			xx	xx xx	xx xxx	x							
Seven Oaks Winnipeg		x	x	xx	xxx	x	x	x		xx		x		
South Eastman	x x	xxx	x	x	xx xx	xx xx	xx	x	x				x x	
<b>Totals</b>	<b>8</b>	<b>10</b>	<b>13</b>	<b>8</b>	<b>18</b>	<b>15</b>	<b>7</b>	<b>7</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>4</b>	<b>5</b>

These plans include a total of 108 events<sup>17</sup> that would likely not have occurred without CDPI planning, support and training funds. Regional training is comprehensive; all the regions are active in planning training events. There is also great variety in the regional plans, highlighting the local and regional needs identification and tailored plans. The types of activities planned also vary within the categories<sup>18</sup>, including learning sessions plus supports such as forums, use of consultants, and development of materials. The regional training plans are consistent in addressing components of CDPI including the areas of healthy eating, tobacco prevention and cessation, chronic disease prevention, and community development.

<sup>17</sup> The data is incomplete – the actual number of activities is higher

<sup>18</sup> For more information about this variety, see the CDPI Training Plan Provincial Roll-Ups

## LESSONS LEARNED

The CDPI experience in 2007 - 2009 provides examples of successful practices of an approach that is community led, coordinated by regional health authorities, and supported by government. It also highlights the tensions that are inherent in a transformative change, community development process.

### Effective Systemic Practices

A three-faceted approach for leadership, coordination, and support for CDPI is identified as central to the initiative. CDPI participants believe that given supports, communities will find creative and effective ways to become healthier together. Community stories highlight elements of the three-faceted approach.

Community gardens are now being found in many communities, meeting many and varied needs, and accomplishing many CDPI related objectives. They involve physical activity, healthy eating, engagement with the natural world, environmental sustainability, social interaction (often intergenerational), and use of traditional knowledge and practices. They also typically involve many partners who provide land, water, seeds, tools, knowledge, and skills. The gardens in each community may be organized, resourced, and operated differently, depending on the community and regional context.

The Blue Light Project is another popular initiative, highlighting social pride and pressure regarding smoke free homes. While the placing of a blue light outside is the constant in the projects, the ways in which the individuals learn about the project and decide to place that light will vary from community to community. The project is now in 6 communities and an additional 25 communities have indicated interest.

The participants in both of the above examples may be able to learn about the activity, and about ways to approach it, through networks in the communities or regions, or through provincial gatherings like Share and Learns. They are able to access resources, at least in part, through the provincial processes.

In the November 2008 presentation to CDPAC, CDPI representatives outlined a number of reflections and conclusions regarding the three-faceted approach. They identified the following:

Community led means the following:

- Develop local planning committees, champions, and people to facilitate action
- Use action plans with per capita funding
- Start where community is at and address barriers to participation
- Leverage additional resources
- Build on community pride and “can-do” attitude
- Facilitate local data collection about risk factors

Regional Health Authority coordinated means the following:

- Work with existing groups and relationships to build partnerships and sustainability
- Create regional committees (support for training plans, surveillance)
- Share learnings across the regions: monitoring forms, granting programs, RHA board support, success stories
- Focus on high-risk communities
- Draw on evidence for decisions and planning

- Make it easy for communities to participate

Government supported means the following:

- Develop appropriate funding and funding mechanisms
- Demonstrate leadership, accountability and evaluation
- Provide support for committees for communication, coordination, and joint planning
- Liaise with other departments and facilitate linkages

The overall lessons learned were identified as the following:

- Sharing knowledge, resources, expertise, evidence based information and problem solving solutions is important and takes time
- Communities recognize the need to prevent chronic disease – get out of their way
- Understanding community traditions is important
- Use existing structures and groups
- Don't let jurisdictions get in the way – people (even bureaucrats) can work around perceived barriers.
- Be flexible

To make progress, the initiative has needed the provincial, regional, and community leaders to be enthused and engaged. At the December 2008 Strategic Planning session, participants identified their commitment to the above elements and their need to see those lessons in action in order for them to keep fully motivated.

## **Transformative Change and Community Development Challenges**

The goals, objectives, and model of the CDPI bring a set of dynamics and tensions related to transformative change and community development work. The themes described below reflect previously referenced sources. Also, at the November 2009 Share & Learn<sup>19</sup>, participants were able to anonymously respond to several questions regarding these dynamics and some patterns from their responses are included below.

The CDPI is a catalyst for many of the participants at the different levels of the initiative to experience a rapidly changing context referred to as “whitewater”. It may present as rapidly changing expectations, information, behaviour, people, teams, activities, workload, and / or administrative processes. With these conditions, typical planning strategies may not be possible and / or as effective as expected. It can be hard for well-meaning and skilled people to know what to do, when. November 2009 Share & Learn participants indicated their level of agreement regarding whether the concept and dynamics of “whitewater” reflected their experience.

- |   |     |
|---|-----|
| • We encountered some “whitewater”                      | 95% |
| • Often, reality was different from our plans           | 94% |
| • We are learning and navigating the rapids effectively | 69% |

While the context is one of change and challenge, each individual involved may be personally challenged to change their assumptions, expectations, practices, etc. Typical change dynamics are to try to hold on to the past through denial and resistance (sometimes unpleasant) and then, one hopes, to move into the future with exploration and commitment. November 2009 Share & Learn participants were asked about this model of change dynamics.

- |   |     |
|---|-----|
| • Those change dynamics look familiar – re CDPI | 85% |
| • We are dealing with resistance effectively    |     |

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<sup>19</sup> The percentages are those of the respondents who answered Strongly Agree and Agree.

- Community perspective<sup>20</sup> 38%
- Regional perspective 28%
- Provincial perspective 23%
- We are helping each other explore and commit 85%

CDPI participants commonly refer to needing to start “where the communities are”. This truism can mask the challenges of some communities having limited capacity for self-assessment. A commitment to community-led means understanding and respecting the needs and dynamics of the community and providing support that facilitates capacity building and is not disempowering. This takes time, patience, and skill. The CCBT respondents rated their capacity as relatively low in the following areas:

- Assistance regarding identifying and removing barriers to participation
- Involving the target audience in the process of asking why
- Involving the target population in finding solutions to root causes of issues
- Identifying areas for improvement in community structures
- Creating new community structures that help community members

At the same time, the community, or segments of it, may be asking for roadmaps, or even for transplanting of a program from elsewhere without the community preparation work. This can lead to the “needs or best practice vs. wants or demands” challenge, or the “build capacity vs. deliver programs” tension. Data from the November 2009 Share & Learn validate that this tension is commonly experienced.

- I have experienced the “build capacity” vs. “deliver programs” tension:
  - Participants with “community perspective” 88%
  - Participants with “regional perspective” 91%
  - Participants with “provincial perspective” 90%

An associated challenge may be that the pillars of physical activity, healthy eating, and tobacco reduction have been mandated through the CDPI based on good evidence. The communities themselves may identify other health related interests and they may not currently be aware of or interested in the “evidence”.

Community development is commonly thought of as engaging local leaders in planning and participating in activities, as well as nurturing new leadership, particularly involving people from the margins of the community. This community can be a town, a region, a professional community of practice, etc. Current local leaders have recognition and influence, and a right to expect leadership involvement in activities affecting their community. They also have patterns of thought and of interaction and vested interests that may not promote change. Hence, when building capacity, on whom do you call? Data from the same Share & Learn validate that this tension is commonly experienced.

- We have included new people in leadership roles: <sup>21</sup>
  - Participants with “community perspective” 63%
  - Participants with “regional perspective” 52%
  - Participants with “provincial perspective” 22%

A number of challenges are related to combining community development philosophy with government systems and regions.

- Large systems have large needs for degrees of stability and accountability, yet flexibility

<sup>20</sup> These perspectives were self-chosen

<sup>21</sup> This question was open to interpretation – still, a theme is evident.

is needed to work with emerging and changing plans and actions. Meeting both needs requires well-designed, user-friendly, effective tools for planning, monitoring, and reporting. This often takes considerable trial and error. Also, the system itself must be flexible enough to encompass local variations. Therefore, the relationship between the governments, regions, and the communities must be iterative and evolving. Earlier sections of this report have highlighted challenges with the monitoring process. A number of the monitoring forms have missing information, particularly regarding participation levels and dollars spent. As well, the information about the type of activities is incomplete, with 38% of the reported activities having no real type descriptor. There also is a lack of monitoring information regarding the training plans.

- Communities may be interested in creative, innovative, home-grown, practical initiatives. The governments are likely to be more interested in evidence-based, transferable, best-practice type activities.
- An initiative such as the CDPI was created because people care about others' health. Therefore, regions would like to share resources with everyone. However, there are limits to the resources: the decision was made to work with the current CDPI communities and not to include new ones.
- One of the CDPI objectives is to integrate and align with other activities and systems. This can compete with the participants' desire to build an identity for the activities they are invested in, and contribute to the challenge of evaluating outputs and outcomes as specifically related to CDPI. Also, the limited increase in dedicated CDPI positions, and the corresponding use of existing human resources in the regions and in other programs, has contributed to what people describe as working "off the side of my desk".
- Individuals, and to some extent communities, tend to define their health related needs in terms of their experiences. Governments define their services in terms of their departments and programs. The CDPI is designed to minimize this, but communication difficulties can still result.
- Another communication challenge is that the governments, on the one hand, support local and regional variety in systems and structures, while on the other hand, attempt to design systems to communicate easily with the people in those structures. For example, many resources such as Healthy Together Now, What's In Your Lunch, and web-based information and tools have been developed by or coordinated through CDPI. Those who use them value them, but many people still seem unaware of them. The November 2009 Share & Learn asked participants about their use of, and the value of various resources. Data related to three of the resources are included below.<sup>22</sup>
  - The regional training programs are very useful
    - Participants with community perspective 68%
    - Participants with regional perspective 100%
  - I have used Healthy Together Now
    - Participants with community perspective 40%
    - Participants with regional perspective 62%
  - If I have used Healthy Together Now, it is a very useful resource
    - Participants with community perspective 94%
    - Participants with regional perspective 100%

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<sup>22</sup> Not included here are the responses regarding What's in Your Lunch and web-based resources: those responses show a very similar pattern.

## CONCLUSIONS: MOVING FORWARD

The commitment, energy, knowledge, and skill of the CDPI participants are making a difference. The number of communities has increased and the momentum to expand is strong. Capacity is developing, as is the interest in capacity building. People are learning how to work together differently, all across the province, in alignment with the CDPI goal, objectives, and principles. Change of this nature and magnitude takes considerable time, so while much progress has been made, there is still much to do.

Staff and volunteers have been investing heavily in their CDPI related activities and the uncertainty regarding the future has been an ongoing, significant tension. The most important challenge in moving forward is the development of a go forward plan to continue the work of the CDPI. According to the December 2008 Strategic Planning participants, that plan must ensure that communities are involved from the start and that they are able to be in the lead. They suggested creating a vision that includes both disease prevention and health promotion, attention to the social determinants of health, and funding flexibility from a variety of stakeholders, including perhaps those in the private sector.

Work on that plan is in progress. It is important to build on the momentum and successes, to focus on what is working well, and to solidify those effective practices. An important aspect is increasing community leaders' knowledge about the resources available to them, e.g. *Healthy Together Now*, *What's In Your Lunch*, web resources through Health in Common and KEN, healthy living staff, and surveillance data. There may be other potentially valuable resources to be identified, developed, and linked.

The monitoring tools and process are evolving and can be tweaked to provide more information regarding the type of community activities, the participation levels, and the dollars spent. Tools and processes can be developed for monitoring information regarding the regional training plans, e.g. actual activities, learning objectives, participant numbers, and participant feedback. At the same time, a focus on keeping forms simple and user-friendly is important.

The CCBT data can be reviewed in order to identify areas of strength for cross-community mentoring and areas of need for capacity building supports. Overall, the CCBT respondents rated their capacity as relatively low in some areas. In moving forward, it will be important to assess the significance of the following, and determine whether focused supports are desirable.

- Assistance regarding identifying and removing barriers to participation
- Involving the target audience in the process of "asking why"
- Involving the target population in finding solutions to root causes of issues
- Identifying areas for improvement in community structures
- Creating new community structures that help community members

At the provincial level, work can continue to strengthen structures and processes to support the regional and community level activity, particularly with challenges like how to support high risk communities in developing capacity to sustain projects. This may involve continued evolution and clarification of roles of the key stakeholders and the supports they need.

The upcoming evaluation of CDPI is an opportunity to involve the range of stakeholders in ways that are useful to them and to provide more quantitative and qualitative information, an in-depth analysis of what works and why, and discussion of value for investment.

This can be challenging work for staff and volunteers. It is helpful if they understand the change dynamics, and don't feel personally responsible for challenges they encounter but rather for

figuring out how to deal with them. One of the greatest challenges, and greatest lessons, is that while these challenges can be somewhat anticipated, they must be individually and collectively “learned through”.

Four questions, plus some sub questions, can guide this process of “building the road as you travel” for both individual and collective learning. This process (sometimes known as “after action review” or “debriefing”) builds a culture of learning and accountability. Identifying answers to the following questions will support the key practice of effective learning, and therefore effective change and community development navigation. It is an iterative process, with the action planned in question four leading to the experience to spur the next round of learning.

1. What are we experiencing?
  - What activities, processes, results, ups, downs, etc?
2. What stands out for us from that?
  - What do we like, not like, feel surprised by, feel worried about, etc.?
3. So what - what conclusions do we draw?
  - What can we generalize?
  - What are the dos and don'ts, best practices, etc.?
4. Now what – what action will we take based on our conclusions?
  - What plans will we make?
  - What will we try, when will we next check on it, etc?

The CDPI has made significant progress and has great momentum, an evolving effective model, many committed participants, and much still to contribute. All participants look forward to even healthier Manitobans.

## Appendix 1

### CDPI PARTICIPATING COMMUNITIES March 2009

#### South Eastman Region

The target population is the 43,000 residents living in South Eastman rural communities (representing four district community coalitions) excluding the City of Steinbach.

The four district communities coalitions are:

- South – Rural Municipalities of Piney, Sturtburn and Franklin
- North – Rural Municipalities of Tache, Ste.Anne and LaBroquerie
- West – Rural Municipalities of DeSalaberry and Richot
- Central – Rural Municipality of Hanover (excluding the city of Steinbach)

#### North Eastman Region

- Beausejour/Brokenhead
- Iron Rose District
- Blue Water District

#### Central Region

- Sandy Bay FN
- Winkler
- Altona

#### Brandon Region

- Brandon (5 working groups: physical activity; healthy eating; smoking reduction; stress action and Workplace Wellness)

#### Parkland Region

- Dauphin (City of Dauphin and R.M. of Dauphin) (target population 5,900)
- North-East Cluster: Crane River, RM Lawrence, Spence Lake, Waterhen, Skownan First Nation, Meadow Portage, Mallard, Rockridge, and O-Chi-Chak-Ko-Sipi First Nation, (population 2,400)
- North Cluster: Barrows; Mafeking; Birch River, Bellsite, Red Deer Lake; Baden; Powell; National Mills (Population 1,400)
- North West: Camperville; Duck Bay; and Pine Creek First Nation (Population 2,200)
- South-East Cluster: McCreary, Alonsa, Bacon Ridge, and Ebb and Flow FN, (population 4000)
- Swan River: Town of Swan River; RM Swan River (target population 4,100)
- Former NAPHWI Communities: Sapotaweyak Cree Nation and Wuskwi Sipiik

#### Interlake Region

- Arborg/Riverton
- City of Selkirk
- Lundar/Ericksdale
- Little Saskatchewan

#### NORMAN Region

- District I Flin Flon, Cranberry Portage and Snow Lake
- District II The Pas, OCN and RM of Kelsey

- District III Cormorant, Sherridon, Grand Rapids (former NAPHWI Community), Easterville and Moose Lake.

### **Assiniboine Region**

- Waywayseecappo FN
- Virden and Wallace RM
- Rossburn and RM
- Treherne and RM
- Neepawa ( & surrounding RMs)
- Hamiota
- Minnedosa
- Killarney and area
- Keeseekoowenin FN
- Erickson
- Shoal Lake

### **Burntwood Region**

- Bird/Fox Lake First Nations (BRHA Funded)
- Brochet/Barrens Land First Nation
- Cross Lake/ Pimicikamak Cree Nation (BRHA Funded)
- Garden Hill First Nation
- Gillam
- Granville Lake (BRHA Funded) joined Dec 2008
- God's Lake Narrows First Nation
- God's River (BRHA Funded) joined March 2009
- Ilford/War Lake (BRHA Funded)
- Lac Brochet First Nation
- Leaf Rapids
- Lynn Lake /Marcel Colombe Band/ (BRHA Funded) joined Mar 2009
- Oxford House/Bunibonibee Cree Nation
- Pikwitonei
- Red Sucker Lake First Nation
- South Indian Lake/O-Pipon-Na-Piwin First Nation
- Split Lake/ Tataskweyak Cree Nation (BRHA Funded)
- St. Theresa Point
- Thicket Portage
- Thompson
- Wabowden
- Wasagamack
- 

### **Winnipeg Region**

- Point Douglas Community
- Seven Oaks Community

## Appendix 2

### CDPI 2007-2009 Progress Report References / Resources

Analysing Data Collected from the Community Capacity Building Tool: A Manual for Users, prepared for Public Health Agency of Canada by Donna Anderson, Mary Frances MacLellan-Wright, and Sarah Barber, January 2007

An Evaluability Assessment of the Chronic Disease Prevention Initiative (CDPI): Final Report, G. Braha and Associates, May 2009

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#### CDPI Committee Minutes

- Evaluation Committee Minutes and related documents, e.g. Workplan
- Joint Management Committee Minutes and related documents, e.g. Workplan
- Training Committee Minutes and related documents, e.g. Workplan
- Training Coordinator Report, December 8, 2008 – January 22, 2009, B. Kozak
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Provincial Summary Regional CDPI Training Plans 2007-2008

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Share and Learn Reports

- Made in Manitoba CDPI Successes: Share & Learn February 21 & 22, 2008
- Training Priorities: Share & Learn Session February 21 & 22, 2008
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Summary of CDPI Activities (Action Plans) by Community 2007-2008

Summary of CDPI Activities (Action Plans) by Community 2008-2009

Table of Committee / MHHL Interview Results for CDPI Evaluability Assessment, April 2009

Thinking and Working as a System: Integrated Chronic Disease Prevention in Manitoba,  
Chronic Disease Prevention Alliance of Canada Conference, November 25, 2008, Healthy  
Together Now: Chronic Disease Prevention Initiative

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