



BC HEALTHY LIVING ALLIANCE
COMMUNITY CAPACITY BUILDING STRATEGY

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THIS IS AN INITIATIVE OF THE BC HEALTHY LIVING ALLIANCE



IN PARTNERSHIP WITH

Health Authorities in BC, the Public Health Agency of Canada and 2010 Legacies Now

THIS DOCUMENT WAS PREPARED BY A WORKING GROUP OF THE BC HEALTHY LIVING ALLIANCE

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- The Community Capacity Building Working Group
- Canadian Cancer Society
- Canadian Diabetes Association
- Heart and Stroke Foundation of BC and Yukon
- Union of BC Municipalities
- Association of Public Health and the BCHLA Secretariat

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DEFINITION OF ACRONYMS USED IN THIS REPORT

AS! BC	Action Schools! BC	CCF	Community Capacity Facilitator (BCHLA)	CDP	Chronic Disease Prevention
BCCA	BC Cancer Agency	CCS	Canadian Cancer Society	HA	Health Authority
BCHLA	BC Healthy Living Alliance	CDA	Canadian Diabetes Association	HLP	Healthy Living Program
BCRPA	British Columbia Parks and Recreation Association	CDL	Community Development Leader (BCHLA)	HSF	Heart and Stroke Foundation
CAH	Community Action on Health				

DEFINITION OF TERMS

Capacity building: A tool used in the field of community development to develop capabilities that create or direct action or change within the community. There are three main areas in which capacity building is focused — individual, organizational and social. The combination of all three is what creates the longer term stability and strong foundations for individual, organizational and community change.

Community: A geographic area or population group targeted for BCHLA healthy living initiatives, and defined in consultation with regional network partners.

Community capacity: Facilitator: An individual assigned to lead capacity building initiatives at the regional level.

Community development Leader: An individual assigned to work with specific populations or communities on capacity building. These individuals will work to engage the community and to help with needs assessments, consultation, identifying opportunities, facilitating grants/resource support, and capacity building.

Health region: Refers to the boundaries established for regional health authorities.

Population health: Refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. (PHAC, 2007)

COMMUNITY CAPACITY BUILDING STRATEGY

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EXECUTIVE SUMMARY

Strategic Framework

The BCHLA has identified capacity building as a critical element of health promotion and a population based approach to addressing risk factors related to tobacco, physical activity and healthy eating. A review of the evidence (Chapter 7) clearly supports capacity building as a necessary condition for the development, implementation and maintenance of effective community-health promotion and disease prevention programs. Interventions which take into account and build upon existing community capacity are more likely to be successful in accomplishing desired change than those which are adopted in a more traditional top down manner (Neale et al. 2001, Minkler et al. 2001, Goodman et al. 1998).

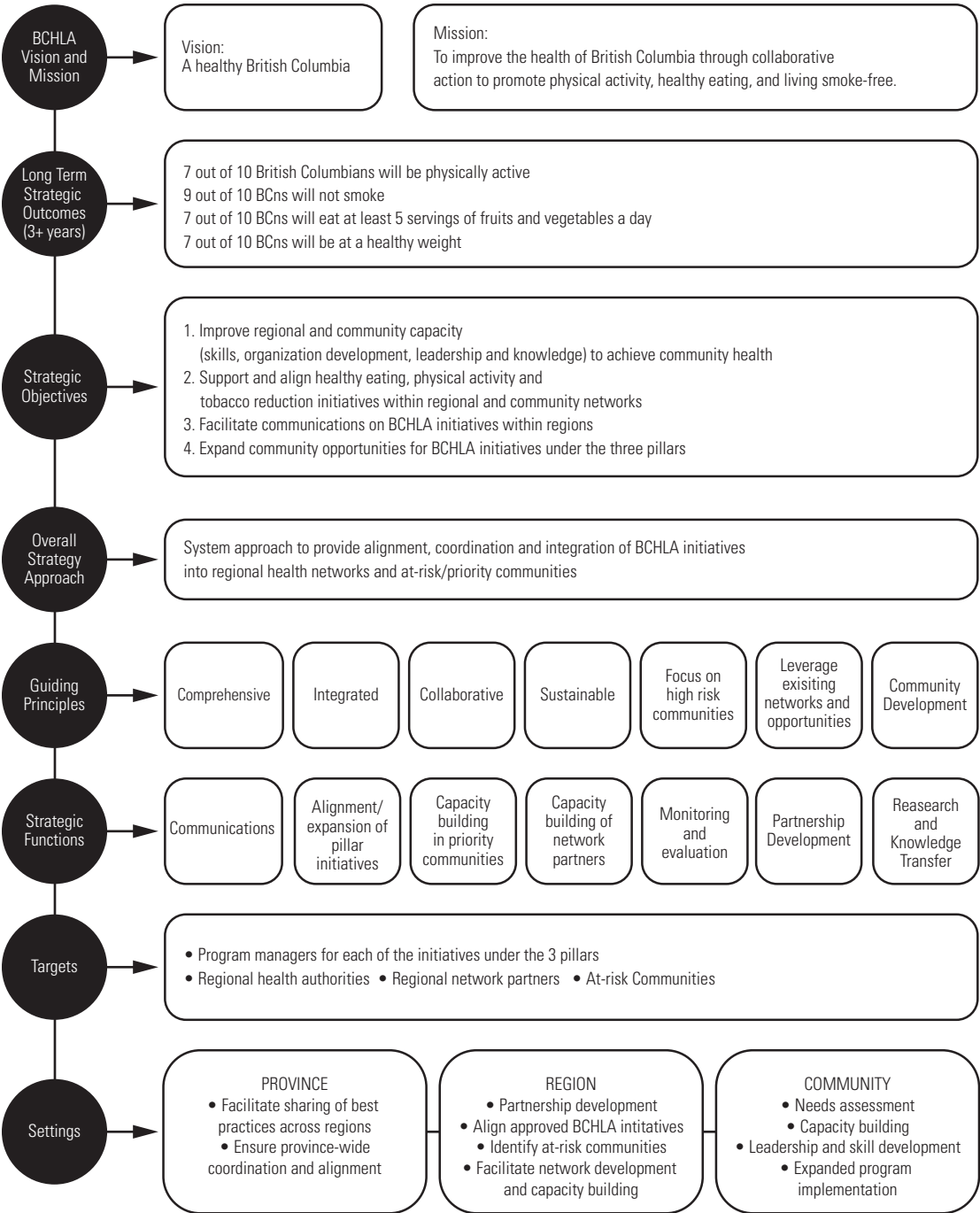
The community capacity building strategy is based on the direction outlined in the BCHLA Conceptual Framework, a best practices review and consultations with representatives of health authorities, Active Communities, ActNow BC, 2010 Legacies Now and other experts in community development (Appendix C). The strategy is built upon the following foundations (Chapters 3 and 4):

Interventions which take into account and build upon existing community capacity are more likely to be successful...

- **Focusing on** capacity building initiatives that reduce the prevalence of **risk factors related to the three pillars** – reducing tobacco use, and improving physical activity and healthy eating. While many other factors influence community health, a focused approach is necessary to achieve BCHLA objectives within a relatively short period of time.
- The **regional level**, based on health region boundaries, **will be the entry point** for BCHLA capacity building. This acknowledges the unique characteristics and requirements of each health region, existing infrastructure, and the work of health authorities and other potential partners in community development.
- **Leveraging existing regional networks** and community development initiatives to accelerate implementation wherever possible to promote sustainability, improve the effectiveness of capacity building initiatives and maximize the use of resources;
- **Building Capital within Communities** with a focus on areas such as local leadership, civic participation (human capital), building networks and partnerships (social capital), and organizational development. This will build resources within communities to develop, implement and sustain community health initiatives.
- **Focusing on high priority/at-risk communities** for capacity building based on 1) population health data; 2) gaps remaining after target communities have been identified for BCHLA approved interventions under each of the three pillars; and 3) the knowledge and experience of regional network partners.
- **Implementing a community development approach** whereby the approach outlined in this report is flexible and adapted to the specific resources and capabilities within each health region and community to ensure that community specific needs are being addressed.

The Strategic Framework for the Community Capacity Building Strategy is shown in Figure 1.

Figure 1: Community Capacity Building Strategy Framework



Summary Community Capacity Building Strategy

Capacity building will focus on fostering and sustaining regional and community networks to create opportunities for improving community health, and on aligning BCHLA approved initiatives under the three pillars with regional and community partners. The four main functions of the capacity building initiative are shown in Figure 2, and include:

1. Facilitating Regional Network Development and Capacity Building

Within each health region (5), BCHLA will assign a Capacity Building Facilitator to work with the regional partners to establish a network of organizations with a focus on community health. Where networks currently exist, the capacity building initiative will bring additional support and capacity to expand community health initiatives. The Facilitator’s role includes:

- Establish/leverage regional and community networks to achieve BCHLA objectives for capacity building;
- Provide the region with a central source of information on BCHLA initiatives;
- Support the alignment of BCHLA initiatives in the region;
- Facilitate capacity building within the regional network and in at-risk communities;
- Building partnerships with regional and community organizations;
- Assist with the grant application and review process;
- Monitor and assist with evaluation of outcomes.

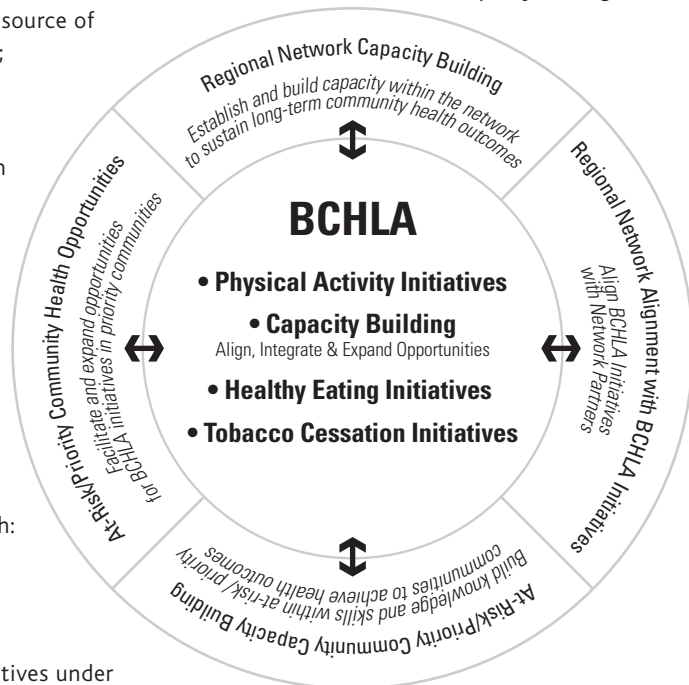
The regional network will assist with:

- Developing a coordinated and integrated approach to capacity building in the region;
- Aligning implementation of initiatives under each of the three pillars;
- Coordinating activities to avoid duplication and to leverage opportunities;
- Identifying at-risk and priority communities for capacity building, in addition to those already targeted by the initiatives under each pillar;
- Implementing capacity building in at-risk communities;
- Establishing success indicators and expected outcomes for capacity building.

2. Aligning BCHLA Approved Initiatives With Network Partners

Capacity building will establish a systems approach to developing and implementing community health initiatives. The Facilitator will work with regional network partners to align and integrate BCHLA approved interventions under the three pillars with other complimentary activities. Opportunities to leverage resources and build upon the work of regional and community partners will be identified. This will increase the reach of BCHLA initiatives, maximize the use of resources and promote sustainability.

Figure 2: The four main functions of the capacity building initiative



3. Facilitating Capacity Building at the Community Level

Five to seven priority/at-risk communities will be identified within each health region and engaged to build capacity towards improved community health. Community Development Leaders (CDL) will be assigned to each health region to work with individual communities to implement health related initiatives and capacity building. Twelve FTEs – 2 per health region, with one additional CDL in both the interior and the north to address the large geographic areas – are proposed. However, the allocation of FTEs within each health region will be determined by the Facilitator and the Network once priority communities are identified.

Within each community, champions and community-based action teams will be engaged to conduct broader consultations and to identify and implement initiatives to improve community health. Champions and action team members will be trained in leadership and community development to build capacity within communities to sustain health initiatives.

4. Expanding Opportunities within At-Risk/Priority Communities

Once engaged, at risk communities will identify and pursue priorities for improving the health of their community. Priorities that align with BCHLA objectives and targets may be eligible for grant funding, and for interventions approved for implementation under the three pillars. The regional and community level processes are shown in Figures 3 and 4 below:

Figure 3: Capacity Building Functions, Regional Level

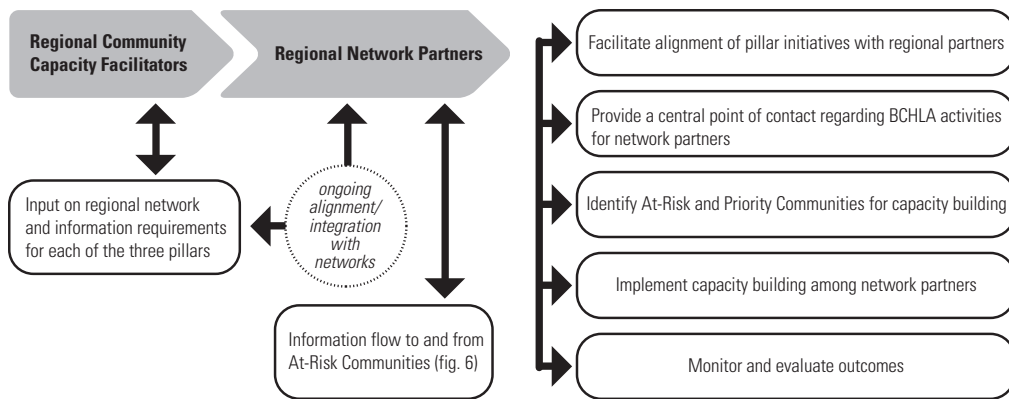
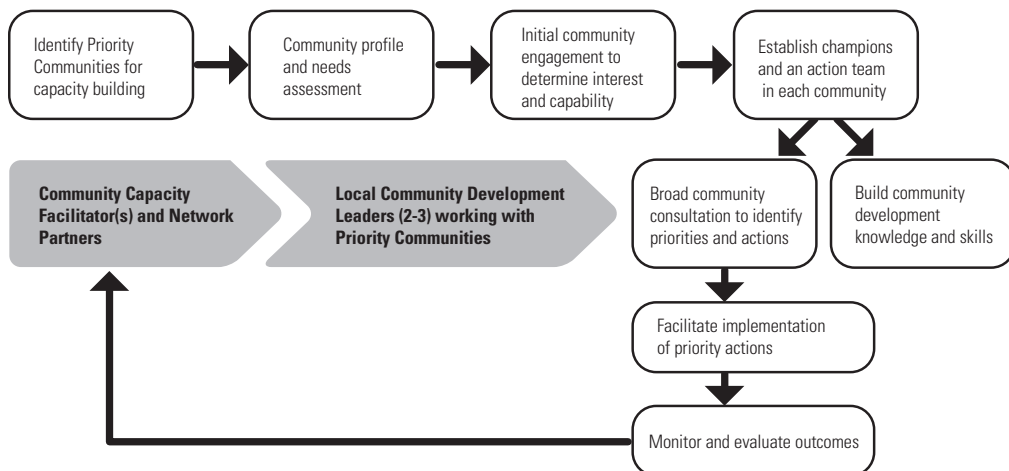


Figure 4: Capacity Building Functions, Community Level



1.0 INTRODUCTION

The BCHLA has identified capacity building as a critical element of health promotion and a population based approach to addressing risk factors related to tobacco, physical activity and healthy eating. Capacity building is a necessary condition for the development, implementation and maintenance of effective community-health promotion and disease prevention programs (Goodman et al.1998). Interventions which take into account and build upon existing community capacity are more likely to be successful in accomplishing desired change than those which are adopted in a more traditional top down manner (Neale et al. 2001, Minkler et al. 2001).

Capacity building for the purposes of improving health is about “enhancing the ability of an individual, organization or a community to address their health issues and concerns” (Ontario Prevention Clearinghouse, 2002)

By building capacity, BCHLA will ensure that interventions under each of the three pillars are aligned with the activities of other partners, and that communities have the skills and resources to sustain community health initiatives.

Community capacity is the set of knowledge, skills, participation, leadership and other resources needed by a community to effectively address local issues and concerns (NSW Health Dept, 2001)

This report presents a recommended approach for community capacity building as part of the BCHLA commitment to improve the health of British Columbians. The approach is based on the BCHLA Conceptual Framework, consultations with health and community development practitioners and a review of better practices.

The Community Capacity Building Strategy was developed under the guidance of a lead BCHLA member from the Canadian Cancer Society, along with four members of the Community Capacity Working Group from the Canadian Diabetes Association, The Heart and Stroke Foundation of BC and Yukon, the Union of BC Municipalities and the Association of Public Health of BC.

The process for developing the Capacity Building Strategy involved the following key steps:

Step 1	<p>Research to identify:</p> <ul style="list-style-type: none"> · A Strategic Framework (functions, settings and targets), including guidelines I the Conceptual Framework; · Effective practices for health related, capacity building programs;
Step 2	<p>Analysis of the existing BC environment to support capacity building by:</p> <ul style="list-style-type: none"> · Identifying resources currently in place (Appendix B); · Consultation with Health Authorities and other organizations involved with community health and wellness (Appendix C); · Identifying opportunities for capacity building to add value to BCHLA approved initiatives under the 3 pillars and within at-risk communities.
Step 3	<p>Develop a Recommended Approach based on the Conceptual Framework, the results of consultations, identified gaps and the direction from the Working Group.</p>
Step 4	<p>Develop an Implementation Strategy outlining the approach and costs for implementing recommendations.</p>

2.0 BACKGROUND

The British Columbia Healthy Living Alliance (BCHLA) was formed in 2003, and is the largest health promotion team in the province. It is composed of organizations that aim to further a mission to “improve the health of British Columbians through leadership that enhances collaborative action to promote physical activity, healthy eating and living smoke-free”. The BCHLA’s focus is on the risk factors and determinants that contribute to cancer, cardiovascular disease, chronic respiratory disease and diabetes. The group has wide-spread reach across the province, engaging 40,000 volunteers, 4300 health and recreation professionals, and 184 local governments.

The BCHLA has set targets for risk factor reduction for 2010:

- 9 out of 10 British Columbians are non-smokers
- 7 out of 10 British Columbians eat at least 5 servings of vegetables and fruits
- 7 out of 10 British Columbians are physically active
- 7 out of 10 British Columbians are at a healthy weight

These targets translate to improvements in the health of the population such that:

- 225,000 fewer British Columbians will smoke
- an additional 948,000 British Columbians will eat five or more servings of vegetables and fruits per day
- an additional 351,000 British Columbians will become physically active
- a total of 349,000 more British Columbians will achieve a healthy weight

The targets and intentions of the BCHLA are in line with the goals and key initiatives of ActNow, including Active Communities, BC Healthy Communities, Action Schools! BC, the School Fruit and Vegetable Program, and activities targeted at reducing the use of tobacco.

As a first step in contributing to the achievement of the ActNow and BCHLA targets, the BCHLA developed *The Winning Legacy*, which identified 27 strategic recommendations for evidence-based interventions. The importance of moving forward with *The Winning Legacy* recommendations was recognized by support, in the form of a \$25.2 million one-time grant, from the provincial government in 2006. To make the best use of these funds and to design strategies true to the goals of the BCHLA, guiding principles were established and include:

- Utilizing a population health approach, recognizing that many factors influence health;
- Addressing populations and geographic areas where need is high and readiness for change is evident;
- Fostering integration across risk factors, the three strategies, the prevention-management continuum and jurisdictions;
- Building upon existing programs, experiences, and networks where possible;
- Basing decisions and actions on the best available evidence;
- Focusing on a small number of initiatives, which will have significant impact;
- Respecting the unique strengths, experience, expertise, and various levels of participation of organizations and individuals that make up the Alliance.

3.0 POLICY FRAMEWORK FOR CAPACITY BUILDING

In June 2007, the BCHLA published the Conceptual Framework for an Overall Strategy for the \$25.2M Grant. The Conceptual Framework contained guidelines for commitments and investments in capacity building, which included:

- BCHLA members recognize the importance of linking and aligning with the regional health authorities in this work, as well as other important sectors;
- Network development varies across the province, and there is no formal linkage between networks;
- Resources will be placed where risk is highest and there is readiness in the community;
- Impediments to network development exist – geography, special populations, lack of local leadership – and need to be considered;
- Investment in capacity building will:

Conceptual Framework for an Overall Strategy for the BCHLA Grant		
Healthy Eating	Physical Activity	Tobacco
Strategy	Strategy	Strategy
Plans for Initiatives		
Implementation of Guidelines	Physical Activity Quick Win	Smoke Free Quick Win
Initiative	Initiative	Initiative
Targeted Healthy Weights Initiative		
1) Supports initiatives under all 3 strategies <i>COMMUNITY HEALTH PROMOTION CAPACITY BUILDING NETWORK INVESTMENT</i>		
2) Investment in high risk communities		
←	Communications / Public Policy Strategy	→

Figure 6: Conceptual Approach to Investment in Community Health Promotion Capacity Building

- Be flexible to meeting local needs;
- Build on existing platforms and activities within the current networks in the health authority boundaries;
- Enhance coherence, and avoid confusion;
- Bring focus to the three pillars and targets identified in the Winning Legacy.

Given these considerations, a 'hybrid' model was proposed (Figure 1). Investments will be made in key initiatives, which are:

- Proposed under the strategies developed for each pillar; and/or,
- Already underway through other ActNow activities of BCHLA members.

By supporting initiatives under the three strategies, BCHLA will ensure that there is integration and coordination among the initiatives, but also with other activities occurring within the health region. An integrated, systems approach to program delivery will occur in communities that can be easily identified, are ready and capable, and can be readily engaged.

Secondly, there will be considerable investment in establishing health promotion networks in selected communities (either geographic or population based), where there is a high burden of risk, limited capacity and leadership. A community development approach to capacity building will be used to enhance the capability of these communities

to plan and implement initiatives that contribute to healthier communities.

Investments at the community level will include (in priority order):

- Fostering local leadership development and increasing community participation and awareness;
- Building new and strengthening existing networks within the community and with other at risk communities in the region;
- Innovative grant programs, which provide effective technical support to recipients and will contribute to people together to work on issues, projects or programs;
- Investments in enablers such as travel funds, workshops, conferences, and technology support;
- Investments in existing resources (tool kits, education resources).

Community capacity building is also consistent with the Ministry of Health's direction outlined in the Model Core Program (BC Ministry of Health, 2007). This program identifies the core programs that must be provided by health authorities in the delivery of healthy communities programs. The program recognizes policies and strategies that are fundamental to achieving progress and successful outcomes in health care in BC. These include:

- Shifting the culture of an organization/community on all levels to integrate health promoting values and priorities;
- Expanding linkages, collaboration and partnerships among groups and organizations to strengthen public health programs;
- Building political commitment throughout the community including decision makers, the grassroots and special interests groups;
- Identifying meaningful priorities through consultation, a 'population lens', an 'inequities lens' and/or other group health assessment processes
- Strong community development, capacity-building and community development resources and processes.

While consistent with the policy framework, BCHLA capacity building must be set within the context of current community development activities. Consultations and the inventory of current activities (Appendix B) identified numerous capacity building initiatives being implemented by government and non-government agencies throughout the province. For example, BC Healthy Communities and Active Communities are working throughout BC and have established networks and programs in place. Implementation of the Model Core Program includes a gap analysis that can provide valuable information on at-risk communities. The Canadian Cancer Society has Community Action Coordinators around the province and most health authorities have dedicated staff and resources for community engagement and capacity building. These examples demonstrate the variety and extent of community development initiatives currently underway in BC.

To be successful within a relatively short timeframe, the BCHLA capacity building initiative will need to establish partnerships with existing, compatible organizations and, where possible, build upon existing networks and information systems within regions and communities.

To be successful within a relatively short timeframe, the BCHLA capacity building initiative will need to establish partnerships with existing, compatible organizations and, where possible, build upon existing networks and information systems within regions and communities. This will help to accelerate capacity building and will result in a more effective, systems approach to implementation. Furthermore, establishing and leveraging partnerships will help to build sustainability for community development initiatives after BCHLA funding ends.

4.0 CAPACITY BUILDING GUIDING ASSUMPTIONS

The following concepts and assumptions have been used in developing the capacity building strategy, and are consistent with the Conceptual Framework and the better practices review.

- **Focus on Risk Factors Related to the 3 Pillars**

BCHLA capacity building will focus on initiatives that reduce the prevalence of risk factors related to the three pillars – reducing tobacco use, and improving physical activity and healthy eating. While many other factors influence community health, a focused approach is necessary to achieve BCHLA objectives within a relatively short period of time.

- **Regional Approach**

The regional level, based on health region boundaries, will be entry point for BCHLA capacity building. This acknowledges the unique characteristics and requirements of each health region, existing infrastructure, and the work of health authorities and other potential partners (e.g., BC Healthy Communities) in community development. The regional context provides the opportunity to leverage the knowledge, programs, resources and networks of existing organizations, which will be used to support capacity building at the community level.

- **Leveraging Existing Networks**

The inventory of capacity building resources (Appendix B) identified significant variation in existing networks, infrastructure and capabilities across health regions. Some regions have well developed infrastructure and resources for working with at-risk communities, while others have relatively few resources dedicated to community development.

Although this report outlines a specific approach to BCHLA capacity building, implementation will be flexible to the circumstances in each health region and community. Where possible, existing infrastructure and networks will be leveraged to achieve BCHLA objectives. A systems approach will link initiatives and partners working to achieve similar objectives in community health and thereby minimize the potential to 'silo' implementation of specific initiatives under each of the pillars. This will accelerate implementation, promote sustainability, improve the effectiveness of capacity building initiatives and maximize the use of resources.

- **Building Capital within Communities**

Capacity building within targeted communities will focus on areas such as local leadership, civic participation (human capital) local and regional networks and partnerships (social capital), and organizational development. By focusing on these three areas, the strategy ensures that a knowledge base is built by the community and remains within the community.

Better Practices for Capacity Building

- Community ownership of the process
- Defined target communities
- Clearly articulated goals mechanisms for decision making and outcomes/indicators to be achieved
- Understanding of local health issues
- Strong local leadership and champions within communities
- Political will on all three levels of government
- Infrastructure – systems support, skills, knowledge, and financial and staff resources
- Organizational capacity building
- Collaboration and information sharing
- Strong networks and Partnerships in implementation
- Sufficient time and flexibility for the process of community development

Building local leadership within communities will be a primary component of capacity building. Focusing resources (both financial and human) on leadership development results in a stronger, more aware and more actively engaged community.

- **Selecting Priority Communities**

Capacity building will focus on those communities with the greatest need and/or where there is a significant opportunity to build capacity within existing programs and resources. Identifying priority communities will be informed by 1) population health data; 2) gaps remaining after target communities have been identified for BCHLA approved interventions under each of the three pillars; and 3) the knowledge and experience of regional network partners.

Capacity building will focus on those communities with the greatest need and/or where there is a significant opportunity to build capacity within existing programs and resources.

- **Sustainability of Community Health Initiatives**

While BCHLA funding is short term (2 – 3 years), the success of the initiatives under the three pillars will be determined, in part, by long term system and individual and community behavioural changes. The approach to capacity building needs to address the capability of all those engaged (individuals, organizations and communities) to sustain initiatives to improve community health.

- **Community Development Approach**

Community capacity building needs to be geared to individual community needs, strengths and desires (Barr et al. 2006). A 'one size fits all' approach is not effective. The approach needs to adapt to the specific resources and capabilities within each health region and community to ensure that community specific needs are being addressed.

5.0 RECOMMENDED BCHLA COMMUNITY CAPACITY STRATEGY

Capacity building will focus at the regional level, as defined by health region boundaries and within communities where there is a high prevalence of risk factors. The focus will be on sustaining regional and community networks to create opportunities for improving community health, and on aligning BCHLA approved initiatives under the three pillars with regional and community partners. The four main functions of the capacity building initiative are shown in Figure 2, and include:

1. Facilitating Regional Network Development and Capacity Building

Within each health region (5), BCHLA will assign a Capacity Building Facilitator to work with the regional partners to establish a network of organizations with a focus on community health. Where networks currently exist, the capacity building initiative will bring additional support and capacity to expand community health initiatives.

The regional network will guide capacity building in the region, and help to identify priority/at-risk communities for capacity building. Specifically, the regional network will assist with:

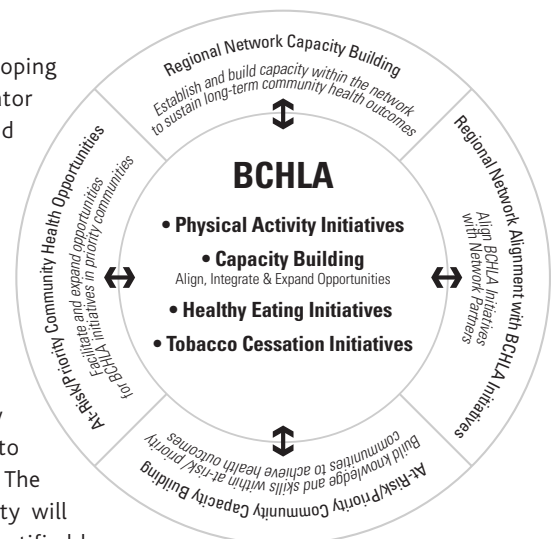
- Developing a coordinated and integrated approach to capacity building in the region;
- Aligning implementation of initiatives under each of the three pillars;
- Sharing information to avoid duplication and to leverage opportunities;
- Identifying at-risk and priority communities for capacity building, in addition to those already targeted by the initiatives under each pillar;
- Implementing capacity building in at-risk communities;
- Establishing success indicators and expected outcomes for capacity building;
- Facilitating connections with priority communities in each region to support capacity building.

2. Aligning BCHLA Approved Initiatives with Network Partners

Capacity building will establish a systems approach to developing and implementing community health initiatives. The Facilitator will work with regional network partners to align and integrate BCHLA approved interventions under the three pillars with other complimentary activities. Opportunities to leverage resources and build upon the work of regional and community partners will be identified. This will increase the reach of BCHLA initiatives, maximize the use of resources and promote sustainability.

3. Facilitating Capacity Building at the Community Level

Working closely with network partners, BCHLA capacity building will identify and engage at-risk communities to build capacity towards improved community health. The specific needs, strengths and priorities of each community will be assessed and actions taken to implement initiatives identified by the community. Capacity building will also focus on strengthening local leadership by providing community development training.



4. Expanding Opportunities within At-Risk/Priority Communities

Once engaged, at risk communities will identify and pursue priorities for improving the health of their community. Community priorities may include a full range of activities aimed at improving community health, some of which may not be directly aligned with the BCHLA pillars. Within this process, the Capacity Building Facilitator will provide information to the community on the BCHLA approved initiatives. Communities may choose to pursue one or more of these initiatives, and will be assisted by the Facilitator to engage the appropriate BCHLA implementation team. This may include funding support from the Community Capacity Building budget.

Once engaged, at-risk communities will identify and pursue priorities for improving the health of their community.

5.1 GOAL OF STRATEGY *(Figure 3)*

The BCHLA Capacity Building Initiative will contribute to achieving the BCHLA targets for 2010:

1. 9 out of 10 British Columbians are non-smokers
2. 7 out of 10 British Columbians eat at least 5 servings of vegetables and fruits
3. 7 out of 10 British Columbians are physically active
4. 7 out of 10 British Columbians are at a healthy weight

The target audience is the BC population, with specific emphasis on communities with higher prevalence rates for risk factors related to tobacco use, poor nutrition and physical inactivity.

5.2 OBJECTIVES OF THE STRATEGY

Community capacity building is both a means and an end in itself. On the one hand, the initiative will focus on aligning planned interventions under each of the three pillars. At the same time, capacity building will engage and mobilize at-risk communities to develop the tools and knowledge to improve their own community health.

Objectives for the BCHLA Healthy Capacity Building Strategy are:

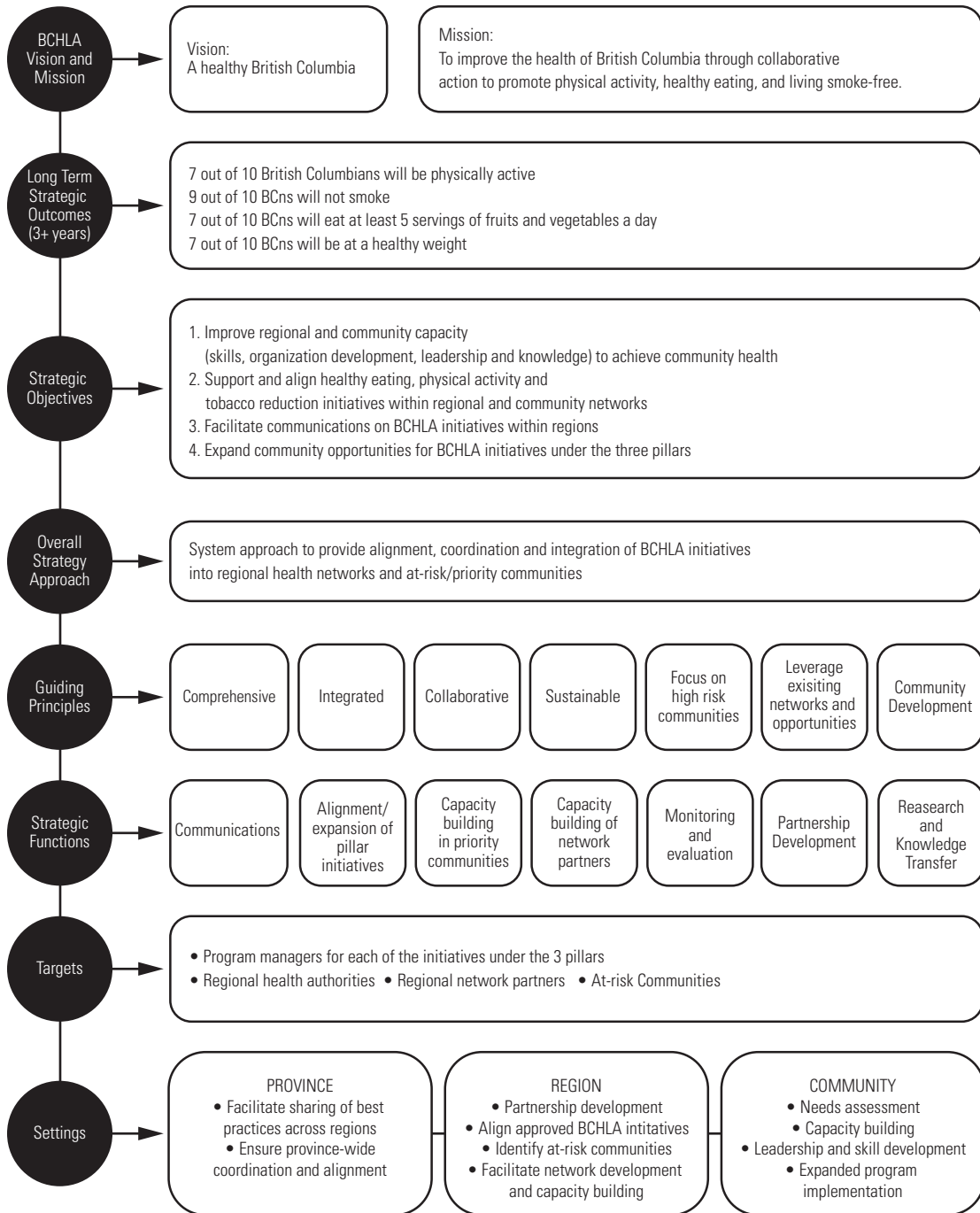
Relating to existing BCHLA initiatives:

1. Support implementation of BCHLA approved initiatives under the three pillars - physical activity, healthy eating and tobacco cessation – within the health regions.
2. Identify and align BCHLA approved initiatives with regional network partners.
3. Provide a central point of contact and information on BCHLA initiatives.
4. Seek opportunities to expand initiatives under the three pillars into identified at-risk communities.

Relating to Community Development:

1. Build capacity and capability to achieve improved community health (as defined by the BCHLA 2010 targets):
 - a. Work with regional network partners to develop the knowledge, resources and skills for ongoing community-health development.
 - b. Identify priority communities, in consultation with regional network partners, to provide capacity building to achieve BCHLA targets;
 - c. Engage priority communities, foster local leadership and community participation in community health initiatives.
 - d. Strengthen resources and capability for ongoing community development related to community health and the BCHLA 2010 targets.

Figure 3: Community Capacity Building Strategy Framework



5.3 CAPACITY BUILDING TARGETS

Capacity building is an effective health promotion tool that can lead to improvements in the health of communities, but also in their capability to develop locally directed, sustainable positive change. Those who will benefit directly from the capacity building initiative include:

1. Project and Program Managers for initiatives under the 3 pillars

Managers will benefit from having a regional Capacity Facilitator ('the Facilitator') to assist with the alignment and integration of initiatives within the health region. The Facilitator will provide an important tactical and communication link between the initiatives and regional health related activities. This includes identifying network and information requirements, target communities, facilitating communications and developing sustainability strategies.

2. Regional Health Authorities

Health Authorities will benefit by having one point of contact for organizing, integrating and aligning initiatives under the 3 pillars. They will also benefit from the direct action that BCHLA will take in each region to improve community health, and the incremental value of combining compatible interventions.

3. Regional and Community Partners/Networks

Regional and community networks and partners will benefit from the increase in capacity building resources, direct improvements in community health, leveraging potential with complimentary programs, and from improved knowledge and skills gained in community development. The structure of the both the regional and community level partnerships and networks will aim to engage a broad stakeholder representation such as local government, businesses, and community based organizations.

Capacity building is an effective health promotion tool that can lead to improvements in the health of communities, but also in their capability to develop locally directed, sustainable positive change.

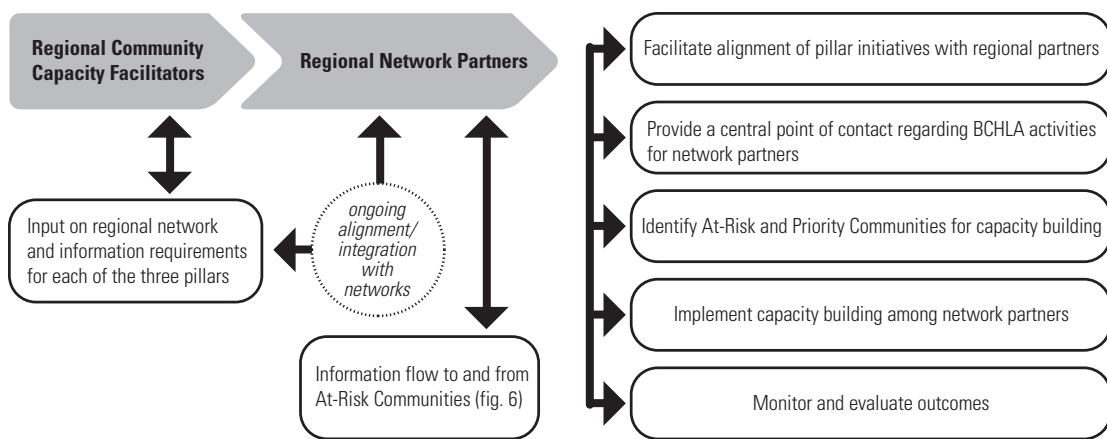
4. At-Risk/Priority Communities

At-risk/priority communities will benefit significantly from improved organizational development, establishing community champions, increased knowledge and skills for community development and the direct benefits from community health interventions. At-risk communities will become healthier communities, and better able to organize, plan and sustain strategies for improving their community.

5.4 REGIONAL CAPACITY BUILDING FRAMEWORK (Figure 4)

The Facilitator, assigned to each region, will first consult with potential partners (e.g., health authority, BC Healthy Communities, Community Action Coordinators) to assess the capability of existing regional networks and organizations before developing a preferred approach to capacity building. While this report outlines a structure for implementation, the preferred approach will leverage existing resources and will be flexible to the unique needs and opportunities within each region.

Figure 4: Capacity Building Functions, Regional Level



Specifically, the regional level capacity building process will include:

Five Regional Facilitators

BCHLA will retain one Capacity Building Facilitator in each health region for a two year period, beginning in the fall, 2007. The Facilitator should be hired from, and located within, the region to maximize familiarity with the communities and network partners, and to quickly establish trust and credibility. This includes consideration of hiring the Facilitator from within an existing compatible organization where there is sufficient capacity to support the role.

The Facilitators' role will be to:

- Establish/leverage regional and community networks to achieve BCHLA objectives for capacity building;
- Facilitate the alignment BCHLA initiatives in the region;
- Provide a central source of information on BCHLA initiatives in the region;
- Promoting capacity building within the regional network and in at-risk communities;
- Manage implementation of capacity building, including succession and leadership planning, development of technical skills (facilitation, grant applications etc.) and organizational development;
- Building partnerships with regional and community organizations;
- Assist with the grant application and review process;
- Monitor and assist with evaluation of outcomes.

Building the Regional Health Networks

Network development will vary by region depending on what networks currently exist, geography and levels of community and regional interest. The approach used by Facilitators will be flexible to each health region’s situation, and will build on existing networks and opportunities.

Functions of the regional network may include:

- Identify alignment opportunities/linkages with BCHLA approved interventions;
- Identify high risk communities;
- Create of vision, goals , indicators and outcomes unique to each region;
- Define guidelines for grant applications and review applications;
- Assist in the initial at risk community engagement process;
- Provide mentorship and training for the community based action teams;
- Develop a sustainability and succession plan for regional and community health;
- Facilitation of training for community champions;
- Develop and support partnerships, sharing of information best practices and advocacy; towards healthier communities within the region.

Initial consultations to determine an approach to network development should include, but not be limited to, the following:

- Regional health authority community development and public health staff
- Appropriate government agencies
- BC Healthy Communities
- Active Communities
- NGOs working in capacity building in the region
- Other major groups as identified in consultation with the above partners.

An example of candidate organizations that could be included in a network is presented in Figure 5. Key steps in setting up the network include:

- The initial meeting will focus on outlining the general purpose for the network and identifying potential partners who need to be engaged.
- Based on direction in the initial meeting, the Facilitator will bring together potential network partners comprised of a broad range of stakeholders, which include government, businesses, community organizations and non-government organizations with interests common to the BCHLA objectives and strategic pillars. In some cases, it may be more feasible to establish networks based on sub-regions or HSDAs, depending on the size and complexity of each health region. Terms of reference for the Network will be required.
- Regional Networks will meet at least 2 times per year over the two year period to implement and share information on community capacity building, and to acquire knowledge and skills to enable the network to continue working beyond the BCHLA’s two year funding program. Funding will be provided to support travel and venue requirements.

Figure 5: Example of Regional Network Candidate Organizations from Interior Health

- Interior Health Public Health
- BC Healthy Communities’ Facilitator
- Canadian Cancer Society CAC
- BC Cancer Agency CD
- Children’s First Initiatives
- Government
- BC Food Systems Network
- Kootenay Boundary Healthy Living Alliance:
 - IH East Kootenay Community Developers
 - NGOs
 - Community Food Action Initiative
 - BCRPA Active Communities members
 - YWCA/YMCA
 - ECD Coalitions
 - UBCM funded groups through Community Health Promotion
- Okanagan Healthy Living Alliance (umbrella group)
- Thompson Cariboo Shuswap Healthy Living Network

- The Facilitator, in consultation with network partners, will develop the following key foundations for the network:
 - Clear vision, mission and expectations for the regional network;
 - Network terms of reference and operating guidelines;
 - Identification and creation of shared goals (short and long term);
 - Development of mechanisms for decision-making;
 - Co-development of indicators and framework for success within the high risk communities;
 - Conduct a skills inventory for the regional network for the purpose of providing support and training to the local communities;
 - Ensure the flow of information and skills occurs both from the regional network to the community and from the community to the regional network.

Aligning Initiatives under the 3 Pillars

- Facilitator(s) will meet with the project/program managers for each of the three pillars to identify common network and information needs within each health region.
- For some approved interventions under the three pillars, networks may already be established and identified outside of the regional framework. Where this occurs, the Facilitator may not need to take any action to align the intervention but will simply ensure that information about the intervention is available to network partners.
- The Facilitator will conduct a one-day work session with the network partners and program managers to establish the linkage/alignment between the approved initiatives under the three pillars, and other regional activities. This will establish synergies among initiatives, helping to avoid duplication of activities and building on existing initiatives. It will help to accelerate implementation and improve communication between all partners.
- Where required, the Facilitator will assist project/program managers for the three pillars with developing a sustainability strategy for their interventions.

Central Information Source

- The Facilitator will be a central source of information for network partners on BCHLA activities (both under the three pillars and for capacity building) in the region and funding opportunities. They will also assist in addressing issues among the partners related to BCHLA activities.
- The Facilitator will facilitate communications and the exchange of best practices among network partners and community leaders through online newsletters, website portals and an annual conference. As much as possible, the Facilitator will use the resources (newsletters, web) of network partners to distribute information on BCHLA initiatives in the region.
- The Facilitator will contribute to inter-regional communications and information sharing, will assign community development leaders, screen grant funding requests, and will report to the Program Manager on the overall capacity building initiative in the region.

Identification of Priority Communities for Capacity Building

- The Facilitator will work with network partners to identify and assess at-risk and/or priority communities for capacity building at the regional and community levels.
- Population health data will be used to initially identify priority communities. This information will be supplemented with input from network partners on the need, interest and capabilities of particular communities.

- Five to seven at-risk/priority communities will be identified in the first year in each health region (25 – 35 in total). Depending on the scope of capacity building requirements, additional communities may be identified in the second year.
- Information on community needs and priorities will flow up to the Regional Network. The Facilitator and the Network may identify common capacity building requirements across priority communities, which may be eligible for funding assistance.

Financial Support for Community Capacity Building

- Criteria and administrative procedures for receiving financial support through the BCHLA Community Capacity Building initiative will be developed by a provincial Advisory Group comprised of the Capacity Building project manager, the lead organization, and other selected members from the BCHLA Operating Committee. The Advisory Group will provide input on the criteria for grant eligibility, application review and evaluation process, the amount of individual awards and accountability procedures. A review of best practices in regards to administration and criteria for grant programs is highly recommended.
- Financial support will be provided on a regional basis for:
 - Regional network establishment and for building sustainability;
 - Capacity building for the network and its partners (e.g., training, skill development);
 - Travel and meeting expenses for network partners;
 - Production of materials to support communication and capacity building;
 - Project or program specific grants that contribute to community health and the BCHLA targets for risk factor reduction;
 - Sharing of best practices regional and province wide.

The Community Capacity Facilitator will be responsible for financial management at the regional level.

Capacity Building and Educational Requirements

The level of development required for each regional network will depend upon the capacity and capability within existing networks. It is recognized that some regions may require significant support and resources, while others with established networks may require less support to implement initiatives directed at the risk factors identified by the BCHLA.

Capacity Building training for the regional networks will occur within the first 4 months and will focus on three main areas:

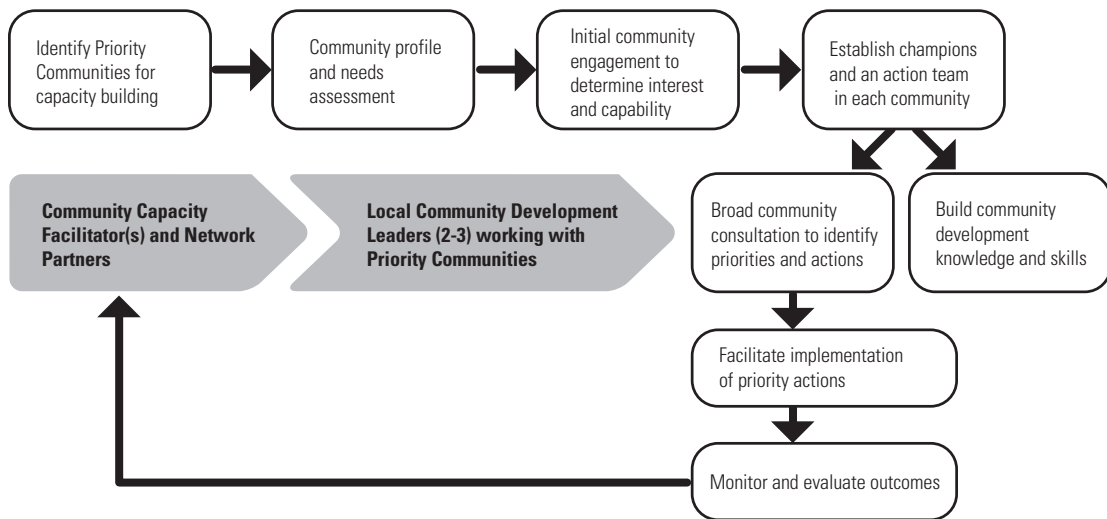
- Building/ reviewing of basic building blocks (vision, mission, goals, skills inventory, success indicators);
- Introduction/overview to community development; this will include systems thinking, sustainability and strategic planning;
- Partnership development (guidelines, best practices).

5.5 COMMUNITY LEVEL (Figure 6)

At the community level, capacity building will:

1. Identify and assess the needs of at-risk and/or priority communities, not directly addressed under the three pillars, for capacity building.
2. Engage at-risk and/or priority communities and assist them in broader community engagement and assessment to identify priority actions for improving community health. These actions may include programs, resource development or infrastructure to improve community health.
3. Build capacity (leadership and skills training) within communities to achieve outcomes related to the risk factors for healthy eating, physical activity and reducing tobacco use.

Figure 6: Capacity Building Functions, Community Level



Specifically, the community level process will include:

- The Facilitator will work with the network partners to identify at-risk/priority communities using population health data and the partners’ knowledge and experience. Once identified, the Facilitator will complete a profile of the community identifying the risk factors, alignment with other community development and health initiatives and its state of readiness.
- A community development function will be implemented, either as a new initiative or building on existing community initiatives. Where necessary, Community Development Leaders (CDL) will be hired to support the community capacity building process. The current budget assigns 3 FTEs for the north and interior health regions, and 2 for health regions in the lower mainland and Vancouver Island; the additional FTE in the north and interior is necessary to address the large geographic areas. How these positions are best assigned and filled will be determined by regional Facilitators and network partners.
- CDLs will support building organizational capacity for community based organizations responsible for administering community initiatives. The CDL will draw on the skills and resources of those in the regional network prior to bringing in outside consultants.

- The CDL will identify a contact in each community to serve as a 'community liaison'. The community liaison will provide basic support to identify possible champions in the community, identify risks and opportunities, and assist with communications and organization. The community liaison will be an experienced volunteer or similar resource and will receive compensation and training for providing assistance.
- Within each community, champions will be engaged and an action team established to identify community health priorities and initiatives. The champions and the action team will take the lead role in engaging the broader community with the support of the CDL and possible seed funding.
- Broader community consultation will serve to identify priorities for community health that may be brought forward for BCHLA funding and/or for action by other network partners. Part of this process will include determining whether BCHLA approved initiatives under the three pillars should be expanded into the at-risk community.
- The community, through the champion, the action team and the results of the consultation will determine its own priorities for community health. Where these priorities align with the BCHLA pillars, funding may be provided out of the capacity building budget.

Note: Communities may already have organized groups or teams focused on related community development initiatives (e.g., Active Communities, BC Healthy Communities initiatives). In such cases, the CDL may work within existing structures to build capacity for community health.

- Community Development Leaders will assist the community in developing the following key foundations for capacity building:
 - Clear vision, mission and expectations for the regional network;
 - Identification and creation of shared goals (short and long term);
 - Development of mechanisms for decision-making tools and methods;
 - Development of indicators and framework for success within the communities;
 - Ensure the flow of information and skills occurs both from the regional network to the community and from the community to the regional network;
 - Support implementation of initiatives to achieve community health;
 - Assist the community with applying for BCHLA grant funds.
- The CDL and the Facilitator will monitor the success of capacity building initiatives and report to the Program Manager.

Capacity Building and Training Requirements

At the community level, capacity building will focus on two main areas:

- Community Development leaders
- Community Champions

Community development leaders will be trained within the first three months of implementation. Training will include a 2-day session to establish a common understanding of the BCHLA goals for capacity building and the overall structure and approach to implementation. The session will review community development techniques, sustainability planning, methods for community engagement, networking and partnership development and cultural sensitivity training. Training will occur on a regional level which will provide an opportunity for further network development between the CDL's.

Community Champions will receive leadership training to provide them with knowledge of leadership strategies, an understanding of their own style and capacity for leadership, group dynamics and facilitation, conflict resolution and problem solving, and goal setting and visioning.

6.0 IMPLEMENTATION PROGRAM

6.1 ORGANIZATIONAL FRAMEWORK

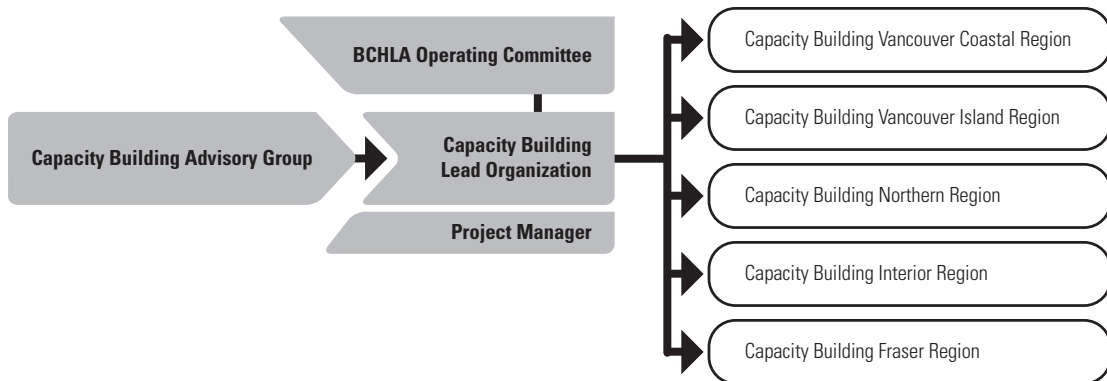
The community capacity building initiative will be coordinated by a lead organization acting on behalf of the BCHLA. A Project Manager will be assigned to provide consistency to implementation on a province-wide scale. The Project Manager, acting on behalf of the lead agency, will provide:

- Overall coordination and management of the capacity building initiative;
- Links to overall management of each pillar strategy;
- A central information source on capacity building;
- A link to other community development programs such as BC Healthy Communities and Active Communities;
- Consistency in the implementation across regions;
- Information and advice on best practices;
- Management inter-regional activities and issues;
- Reporting to the lead agency and BCHLA.

An Advisory Group will be established to advise the lead agency on aspects of implementation including the grant application and review process, relationship guidelines for linking with regional and community partners, capacity building initiatives and overall reporting and evaluation. The role of the Advisory Group reflects the broad scope of capacity building activity across the pillars, and in multiple jurisdictions.

The organizational structure is shown below in Figure 7

Figure 7: Community Capacity Building Organizational Structure



6.2 STAFFING RESOURCE SUMMARY

Implementing the capacity building initiative will require dedicated staff and funding for training, knowledge exchange and community programs and projects. Implementation requirements include the following:

- One program manager to oversee all aspects of implementation on behalf of the lead agency;
- Five BCHLA community capacity facilitators – one per health region;
- Twelve FTE community development leaders to work with one or more high risk/priority communities to identify and address community health issues. The north and interior regions receive one additional FTE to compensate for their large geographic areas.
- Within each community, a designated community champion and action team to lead the community engagement, and the identification and implementation of community health initiatives.
- Grant Funding to support capacity building and infrastructure development for initiatives that align with the BCHLA goals.
- Funding to support community development training and skills for network partners, and community champions and leaders.

Implementing the capacity building initiative will require dedicated staff and funding for training, knowledge exchange and community programs and projects.

7.0 CAPACITY BUILDING BEST PRACTICES

Published evidence from a number of sources was reviewed to identify approaches or components of interventions/ activities associated with capacity building in community health. Publications were searched using PubMed, EBSCO, Google, reference lists from systematic reviews and via reports presented on websites associated with various programs. The evidence to support the role of capacity building in community health is sound.

7.1 EVIDENCE TO SUPPORT BUILDING COMMUNITY CAPACITY

Over the past decade, the importance of capacity building within the health sector and the field of health promotion has received increasing emphasis internationally (Hawe et al., 1997, Crisp et al., 2001, Ebbesen et al, 2004). Capacity building represents a redirection of health promotion activities from population groups to the health system or organizations responsible for health promotion for the purpose of enhancing their ability to develop, implement and sustain health promotion programs and, ultimately, health changes (Hawe et al., 1997; Eades, 2000).

The BCHLA has identified capacity building as a critical element of health promotion and a population based approach to addressing the three risk factors. Capacity (building) is a necessary condition for the development, implementation and maintenance of effective community-health promotion and disease prevention programs (Goodman et al.1998). Interventions which take into account and build upon existing community capacity are more likely to be successful in accomplishing desired change than those which are adopted in a more traditional top down manner (Neale et al. 2001, Minkler et al. 2001).

Building capacity for improved community health contrasts with the more traditional medical intervention approach whereby health professionals prescribe interventions to 'cure' community health issues. For many years, population health studies have concentrated on analyzing determinants from a medical and genetic perspective. However, in the past two decades, the effects of such factors as income, unemployment, poverty, and social networks have become paramount considerations in understanding how the social and economic structures of society affect health (van Kemenade, 2002). Studies increasingly show that communities supported by a substantial stock of social capital, community capacity or social cohesion have better economic and social performance leading to improved community health.

The concept of social capital refers to the features of social organization, such as civic participation, norms of reciprocity and trust in others that facilitates cooperation for mutual benefit. Putnam (1995) defined social capital in terms of four characteristics: the existence of community networks; civic engagement; local identity and a sense of solidarity and equity with other community members; and trust and reciprocal help and support. Coleman (1990) identified several forms of social capital including levels of trust within a social structure, social organizations, norms and sanctions, and information channels. The example used was a resident's association which, after resolving one set of problems, remained as available social capital to improve the quality of life for residents. The more prevalent these networks are in a given community, the more citizens are able to work together toward common goals (Putnam, 1995). By building social capital, collective rather than individualistic goals can be achieved.

Cooper (1999) found that the higher the level of social capital, the more health benefits exist for members of the community. Building community capacity leverages the social capital within a community to enable it to develop, implement and sustain actions for strengthening community health. Strengthening community health refers to the 'process of enabling communities to exert greater control over their physical, social, economic and cultural

environments'. Communities that have engaged citizens with assets in skills and knowledge have stronger capacity, and as a result, tend to be healthier communities.(Neale et al.2001)

According to Putnam (2000), the positive effects of social support vie with the effects of known health risks such as smoking, obesity, hypertension and physical activity. Kawachi (1997,1999) established a positive correlation between social capital and health status using indicators such as the mortality rate and self-rated health status.

Community capacity building goes beyond community mobilization, which is seen as a top-down approach where communities are motivated by a health agency (or group of agencies) to take part in activities/interventions. Walter (1997) identified that processes for building community capacity engage people and organizations as parts of a dynamic system. Capacity building fosters action whereby community members determine their needs and strengths. These unique characteristics are then utilized in addressing the health issue or intervention (Neale et al., 2001). The role of the health professional is to facilitate the process (Smith et al., 2001), not to prescribe it.

7.2 HIGHLIGHTS OF EFFECTIVE PRACTICES

According to Goodman et al. (1998), community capacity can be defined as characteristics of communities that affect their ability to identify, mobilize and address social and public health problems. Critical steps toward the uptake and sustainability of a project involve engaging partners, facilitating their contributions, and transferring ownership, which is critical to sustaining projects after financial and staff resources end (Dressendorfer, et al., 2005).

Community capacity can be defined as characteristics of communities that affect their ability to identify, mobilize and address social and public health problems.

Macleane et al. (2003) identified two key strategies for building capacity as part of the heart health promotion initiative in Nova Scotia. Partnership development included the creation of multi-level partnerships in diverse sectors. Organizational development included the provision of technical support, action research, community activation, consultation and resources. The combination of these two strategies proved to be effective mechanisms for building capacity in heart health promotion.

Building community capacity should recognize community history, be participatory, and use the skills and resources available in professional, academic and community settings. Most importantly, the process must begin from a place of respect for the multitude of perspectives that need to be brought to bear to enhance community capacity to create healthful changes" (Barker, 1998).

The Public Health Association of BC (2006) identified the following components from available evidence on best practice in community capacity building:

- Community groups need to translate general, evidence-based principles into practice tailored to the needs of their neighbourhood;
- Define the nature of local problems by examining local data
- Adopting evidence based approaches for dealing with particular health or social issues;
- Implementing initiatives in partnership with a variety of health and social service sectors, municipal and regional governments, non-profit organizations, community groups and individual citizens.
- Looking for complimentary initiatives
- Ensuring adequate resources
- Encouraging intersectoral collaboration and open communications.

The Community Action for Health (CAH) initiative, implemented by Interior Health (Littlejohns et al., 2007) focused on strengthening community action to improve health and well being related to healthy eating, active living and healthy weights. The initiative was based on the premise that health promotion works through concrete and effective community action in setting priorities, making decisions, and planning and implementing strategies to achieve better health. At the heart of the process was the empowerment of communities and their ownership and control over their endeavors.

Evaluation of the CAH demonstrated that the combination of network development, capacity building and grant funding was effective in increasing network strength, improving knowledge about environmental and policy-level influences on health behaviours, building leadership at the community level, and in delivering projects and programs designed to improve health outcomes. While funding for the year-long program has ended, discussions with IHA staff suggest that many community development initiatives continue as a result of the program's success.

Capacity building has been used successfully for heart health promotion. The Singapore Declaration (Advisory Board Third International Heart Health Conference, 1998) addressed creating capacity by developing a heart health infrastructure and the political will to act at international, national and local levels (Ebbesen et al. 2004). Similarly the Canadian Heart Health Initiative (CHHI) embraced and operationalized capacity building as its focus. The CHHI was a multi phased project between federal and provincial governments in partnership with the Heart and Stroke Foundation. Provincial programs within CHHI are using capacity building as the primary intervention to facilitate the dissemination and delivery of health promotion and prevention programs.

Within the CHHI, the measurement of capacity includes the conceptualization of capacity as well as efforts to build capacity. This includes the ability to build organizational capacity as well as individual capacity. Interventions focus on technical support, action research, organizational consultation, and community activation as mechanism for capacity building (Ebbesen et al., 2004). Other interventions include education, peer networking, developing technical expertise and building a network of champions and enhancing infrastructure.

Capacity building has been used successfully for heart health promotion.

The CHHI included a number of key components developed through research, demonstration programs and evaluation. These included the use of best practices (e.g., coalition models, health programs),

capacity building interventions, and chronic disease research initiatives to examine factors affecting capacity and dissemination of community-based health promotion. Participants in the dissemination phase identified 3 main areas in which provincial projects contributed to the shift toward chronic disease prevention (CDP) and healthy living promotion (HLP):

1. Knowledge and resource development;
2. Coalition and partnership building; and,
3. Policy advocacy and strategy development.

More than two thirds of respondents in the program (n = 95) identified knowledge of capacity building processes (e.g., dimensions of capacity, development strategies, public health infrastructure needs) and development of health promotion knowledge as key components of integrated chronic disease prevention. Forty-four percent of respondents reported that CHHI projects played a lead role in creating partnerships and alliances at multiple levels. More than one third of respondents reported that their provincial projects helped to establish CDP and HLP issues on regional, provincial and national policy agendas (Robinson et al., 2005).

The Alberta Heart Health Project (AHHP), focused on four community projects, encouraged community partners to accept ownership and, in turn, to diffuse ownership. Common capacity-building process elements identified across health projects include (Dressendorfer et al., 2005):

1. Creation of partnerships, collaborations and linkages;
2. Mobilization and communication within the community;
3. Development of vision, mission, and political will of the community;
4. The use of systems, organization, knowledge/skills, connectedness and resources of the community health sector.

In the AHHP, the process of community involvement was evaluated to better understand factors that enabled the successful adoption, development and implementation of initiatives in four diverse demonstration projects (Dressendorfer et al., 2005). The underlying premise was that the effectiveness of community heart health projects depended on local participation. The approach recognized the increasing independence of community partners over time, as project leaders and managers moved to transfer ownership to the community. The evaluation revealed that strengthening of local structures, systems, networks and competencies for planning, implementing and managing initiatives were common elements across project structures.

Goodman et al. (1998) identified a number of key dimensions of community capacity: leadership, citizen participation, skills, resources, social and inter-organizational networks, sense of community, understanding of community history, community power, community values and critical reflection. Thematically, these process elements can be integrated into three categorical dimensions (Dressendorfer et al., 2005):

1. **Leadership:** The process of developing partnerships, collaborations and linkages within the community, including the mobilization of volunteers and open communication with stakeholders.
2. **Policy-making:** The process of developing vision, mission, and political will of the target community to implement and sustain a health initiative.
3. **Infrastructure:** The process of developing a supportive system and organization in the health sector, the skills, knowledge and resources for health promotion, and the connectedness between individuals and agencies.

Community building aims to increase individual, organization and community connections both within and external to the community through relationships, coalitions and networks

Keiffer et al. (2004) found that community building strategies include leadership development activities to strengthen their capabilities, as well as training, mentoring and peer support;

mobilizing residents' planning, administering and evaluating programs; and developing and managing budgets and human resources. Community building aims to increase individual, organization and community connections both within and external to the community through relationships, coalitions and networks (Blackwell et al., 2000).

Keiffer (2004) noted that to be effective and sustainable, interventions must be targeted to the stage of community readiness and capacity to change. An element of readiness is community awareness of public health issues and the protective factors that contribute to the health related outcomes. Awareness is essential to the development of political will and the motivation of individuals and organizations to change. Related to this is that the community must be attentive and believe that something can be done to address the issue. Leadership that is able to stimulate and motivate the community is a key element.

Awareness and readiness to change may be enhanced by participation in community planning processes. Community capacity building strategies that actively engage community residents in a more open ended planning process are more likely to be successful (Walter 1997).

Community capacity building strategies may be more successful when the population or community is well defined.

Community capacity building strategies may be more successful when the population or community is well defined. A clear sense of community, including community self-identification with the health issue, results in increased attention to health disparities and subsequent interventions.

This study also found that having dedicated champions as facilitators to bring together different sectors and stakeholders to pool resources and expertise had significant value.

7.3 BARRIERS TO CAPACITY BUILDING

Despite the potential for capacity building, barriers exist and need to be addressed in designing effective strategies. Smith et al. (2001) identified that the continuing belief among some professionals and community members that experts know best and should simply prescribe the 'cure' can preclude a community based approach.

Hawe et al., 1998, noted that implicit in health promotion work is citizen empowerment and share ownership, which in turn creates a culture of invisibility in health promotion in general and capacity building in particular. This invisibility presents a difficulty in recognizing, describing and measuring the process. It challenges attribution of impact of capacity building efforts for individuals and organizations tasked with that mandate. (Ebbesen et al. 2004)

Some of the most common barriers to integrated approaches to capacity building, chronic disease prevention and health promotion include:

1. Lack of clearly defined goals and health outcomes to be achieved by the community;
2. Lack of leadership to unite, motivate and direct actions;
3. Limited or no public support or community voice to contribute to the change effort;
4. Lack of funding and commitment, perceived to be related to competing priorities for policy attention and resource investment in acute care systems;
5. Lack of political will to move forward on integrated CDP and HLP strategies;
6. Inability to mobilize resources to quickly capitalize on opportunities.
7. Competitive nature of NGOs, which at times compromises the potential for partnerships on common risk factors and other issues.
8. Process issues such as the time it takes to develop partnerships and planning and implementation within a community development model.
9. The ability to measure capacity building and its contribution to health outcomes can be challenging given the difficulty in measuring citizen empowerment, the impact of exogenous factors and conflicting perspectives among organizations and key informants. It is also hampered by the short time frame for interventions juxtaposed with the time needed to effect change (Ebbesen et al., 2004).

7.4 SUMMARY OF BETTER PRACTICES

In response to potential barriers, better practices for capacity building include:

- Clearly articulated goals, along with the outcomes to be achieved both by the lead agency, and the regional and community networks.
- An integrated approach to health promotion, whereby more than one risk factor or disease outcome is targeted.
- Leadership – the process of developing partnerships and linkages, mobilizing communities and open communication – for project development and implementation.
- Collaboration and network linkages within and among health authorities and stakeholders to share best practices and to avoid duplication.
- Infrastructure – systems support, skills, knowledge, and financial and staff resources – to enable partners to effectively work together to achieve health outcomes.
- Development of partnerships and organizational capacity building (tech support, research, training, consultation, peer networking).
- Community assessments of risk and capacity (stage of readiness of the community) to provide the basis for targeting interventions in communities where the need is greatest and outcomes can be achieved.
- Well defined populations or communities for capacity building.
- Community consultations to provide insight into the capacity and capability of the community, its existing resources, and the will power necessary to mobilize the community to action.
- Transferring ownership (the vision) to the community to achieve sustainability of the project after financial and staff resources end.
- Adequate time between the initiation of community capacity building and the desired change required to address the health issue. The expected time from the stage of community planning to implementation can take anywhere from 18 months or longer.

8.0 CAPACITY BUILDING INVENTORY

Capacity building is occurring on an ongoing basis in communities throughout British Columbia. To gain an overview of capacity building resources, a cursory inventory was completed in consultation with health authorities, and other government and non-government agencies. The inventory identified that dedicated resources are assigned to community capacity building in every health authority. However, the extent of implementation varies significantly as does the focus, which includes health promotion, capacity building and chronic disease management. The inventory is summarized in Appendix B, with the following highlights:

Capacity building is occurring on an ongoing basis in communities throughout British Columbia.

- Organizations – both government and non-government - recognize the importance of health promotion and capacity building as a means to improve community health and reduce the impact on the health care system.
- Interior Health and Vancouver Coastal Health have made significant progress with plans and programs to build capacity among communities to improve healthy living. Vancouver Island Health Authority has a strategy in place for capacity building and some dedicated resources, but does not have adequate funding to move the strategy forward. Fraser Health is beginning to address capacity building, while the NHA has a network of 13 primary health coordinators in various communities. These coordinators work to strengthen community action to support public policy, and improve outcomes for people with chronic disease.
- Most health authorities identified the need for improved population health data that can be used to identify at-risk populations and target capacity building initiatives.
- Within some health regions, networks are being (or have already been) organized. In many cases, networks are established at a sub-regional level to reflect geography and population distribution. It was acknowledged that the BCHLA capacity building initiative could work within these existing networks to develop capacity for community health initiatives.
- Generally, networks are not well developed and are not interacting or communicating on a consistent and coordinated basis toward common goals or information sharing.
- Active Communities is currently working in 139 communities throughout BC. The program does not have regional staff, although it has a centralized community development person to assist with developing community plans. Active Communities facilitates regional workshops for communities who want to become an 'active' community, and offers a range of tool kits and resources to support the process.
- BC Healthy Communities has 5 part time regional staff working on a broad range of community development initiatives.
- The Canadian Cancer Society has 14 FTEs assigned as Community Action Facilitators to each health region to mobilize communities for action in cancer control.
- There is a wealth of information and resources (tool kits, workshops, information materials) that are available to communities who wish to improve their skills and expertise in community development. The capacity building process can tap into these existing resources through programs such as Active Communities and BC Healthy Communities, among others.

- While there are many government and non-government organizations working on community development in the health regions, there is an identified need for improved coordination, information sharing, and alignment of activities.
- With all of the activity in the province, the opportunity presented by the BCHLA capacity building initiative is considered very significant in promoting community health because of the potential for full time staff and project funding over a two year period. Existing programs do not have the capacity to coordinate the integration/alignment of initiatives under the 3 pillars or to build additional capacity in at risk/priority communities.

8.1 COMMUNITY CAPACITY ISSUES FROM INTERVIEWS

Potential issues, identified through the interviews, which need to be addressed within the strategy included:

Program Coordination	While Health Authorities have expressed support for the initiatives that will be implemented under the three pillars, many identified that implementation would benefit from coordination on a regional scale rather than having each initiative contact and work separately with the health authorities and other potential partners.
Program Alignment	To avoid 'siloing' of individual initiatives and to achieve the incremental benefits of a systems approach, regional coordination is required by BCHLA. This should link, integrate and align BCHLA initiatives to the wide range of community development initiatives operating in the regions.
Focus	Many of those interviewed recommended a strong community health focus on a few high priority/at-risk communities in order to achieve success within a relatively short period of time.
Targeting High-Risk/ Priority Communities	Development of regional networks will play a role in helping to identify at risk communities, but BCHLA needs to do the work to assess risk factors, community readiness and suitable approaches to community engagement.
Network Development	Network development varies by region. However, networks are generally not well developed, organized or with well-designed communication channels. The importance of having networks was strongly endorsed as one major area for BCHLA involvement. Funding support for network development and sustainability was also emphasized.
Community Capacity Building	Health regions identified the need for staff resources and funding to provide network and community organizations with the leadership and community development skills to sustain meaningful and long lasting change for community health.
Funding for Community Projects	Seed funding is required to assist communities in building community health. This can be in the form of small grants for community projects, and for network development and programs.

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APPENDIX B: CAPACITY BUILDING RESOURCES

Inventory of Community Development Positions in BC for Assessing Community Capacity for BCHLA Strategy Initiatives in Healthy Eating

Organization	Positions and Description	Regions	Information Source
Canadian Cancer Society	<p>Community Action Facilitators</p> <p>A member of the Prevention Team, this position is accountable for effectively coordinating, implementing and mobilizing cancer prevention initiatives. Particular emphasis will be on engaging communities to create supportive environments for cancer prevention and advocating to municipal and provincial governments and institutions for legislative and policy change in support of healthy public policies. These accountabilities are achieved through a combination of community action, advocacy, and public education, in conjunction with the work of the Health Promotion Facilitator within the region.</p>	<p>FTEs and the city of the regional offices</p> <ul style="list-style-type: none"> • Vancouver Region (Burnaby) 2 CAC • Fraser Valley (Langley) 2 CAC (<i>1 part time CAC in White Rock and Delta, 1 p/t CAC for Langley and Abbotsford, and 1 full time CAC for the rest</i>) • Vancouver Island Region (Victoria) 1 CAC • Northern Region (Prince George) 1 CAC • Kootenay Region (Cranbrook) 1 CAC • Interior Region (Kelowna) 1 CAC 	Sharon Storoschuk, Manager, Health Promotion, CCS
Canadian Cancer Society	<p>Health Promotion Facilitators</p> <p>This position is accountable for effectively coordinating, implementing and mobilizing cancer prevention initiatives. Particular emphasis will be in engaging communities to create supportive environments for cancer prevention and providing health education around the risk factors. These accountabilities are achieved through a combination of community action and public education, in conjunction with the work of the Community Action Facilitator in the Region.</p>	<p>FTEs and the city of the regional offices</p> <ul style="list-style-type: none"> • Vancouver Region (Burnaby) 1 HPC • Fraser Valley (Langley) 1 HPC • Vancouver Island Region (Victoria) 1 HPC • Northern Region (Prince George) 1 HPC • Kootenay Region (Cranbrook) 1 HPC • Interior Region (Kelowna) 1 HPC 	Sharon Storoschuk, Manager, Health Promotion, CCS
Legacies Now	<p>Programs and funding that are linked to communities through partnerships.</p> <p>Centralized structure. However need to link in to BCHLA on regional initiatives to know what's going on.</p>	<p>No regional staff</p> <p>May have staff 'parachuting' into communities to help build capacity for specific initiatives (e.g., literacy)</p>	<p>Stefa Kataway</p> <p>Brenda Le Clair, Strategic Development and Partnerships</p>

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Organization	Positions and Description	Regions	Information Source
Canadian Diabetes Association	<p>Have 3 regional managers, each with community development as a part of their role. They are based in Vancouver, Surrey and Victoria.</p> <p>Also have a provincial volunteer and community development lead based in Vancouver who works with 7 branch coordinators who are based in Vancouver, Victoria, Nanaimo, Surrey, Kelowna and Prince George. All of the branch coordinators have a regional focus so work with communities besides the one they are based in. They do mainly volunteer development and program coordination; however, CDA is in the process of reframing their work to do more community development and mobilization.</p> <p>In total, 11 staff who use a community development or community mobilization approach in their work.</p> <p>Requested e-copy of new public programs and services strategy; Jean to send (this is directing the change).</p>		Jean Blake
BC Cancer Agency	<p>The BC Cancer Agency’s Prevention Programs, with support from the BC Cancer Foundation, recently established a team of Community Prevention Facilitators across BC who build partnerships, assess community needs, facilitate the implementation of community action plans and public education programs and make recommendations for cancer control in their regions.</p> <p>In carrying out their mandate, the Community Prevention Facilitators will focus upon the main preventable risk factors of tobacco, obesity, inactivity, poor nutrition, sun exposure and environmental agents.</p> <p>Schools can take part in the Healthy Living Schools Program, a program designed to recognize those schools which encourage healthy behaviour among the student population.</p>	<p>Part-time positions. The CPCs are consultants.</p> <p>Locations:</p> <ul style="list-style-type: none"> • Interior BC: Kamloops, Rossland • Northern BC: Masset, Prince George • Vancouver Island: Quadra Island/North Island, Victoria/South Island • Lower Mainland: 4 total <p>Information/background on individual CPCs is at: www.bccancer.bc.ca/PPI/Prevention/CPCPublicDisplay.htm</p>	Kathy Pym, Admin Ass’t, Cancer Prevention Programs, BCCA
BC Healthy Communities	Regional Facilitators, plus a director, provincial facilitator, events coordinator and communications coordinator.	0.6 FTE in VCH, VIH, IH, NH. None in FH. (<i>as of July 2006 from Gap Analysis</i>)	Emailed bchc@civicnet.bc.ca for more info on July 9
Heart and Stroke Foundation of BC and Yukon	Mission Specialists	No dedicated full time, paid resources in the regions. Functions are centralized.	

APPENDIX B: CAPACITY BUILDING RESOURCES

Organization	Positions and Description	Regions	Information Source
Community Nutritionists	<p>60 FTE for the province, work through the HAs.</p> <p>Not all work in health promotion areas, some are more specialized/clinical (for example home care, eating disorders), but all HAs/regions have some capacity in health promotion for nutrition. They are organized and communicate through the Community Nutritionist Council of BC, and have four committees that relate to the HE Strategy initiatives, and would be good to consult with: 0-6 Age Committee, School Age Committee, Chronic Disease Prevention (adult) Committee, Food Security Committee.</p>	<p>Committee Chairs:</p> <ol style="list-style-type: none"> 1. Community Nutritionist Council Chair is Sarah Carten 2. Adult Nutrition Committee Chair is Diane Carlson 3. Food Security Committee Chair is Lorainna Stephens 4. School Committee Chair is Melanie Kurrein - co-chairing with Kathy Rhomses 5. Zero - Six Year Committee Chair is Jane Wark 6. Licensing Chair is Carol Murphy <p>60 positions spread throughout the HSDAs.</p> <ul style="list-style-type: none"> • NH: 7 positions (low #, large area) • VIH: 22 positions • FH: 19 positions • VCH: 28 positions • IH: 11 position 	Lisa Forster-Coull, Provincial Nutritionist
Tobacco Reduction Coordinators (Ministry of Health/Health Authorities)	33 Positions.	<ul style="list-style-type: none"> • VCH: Vancouver (3); Richmond (1); North Shore (1); Sechelt (1); Squamish (1); Whistler (1) Powell River (1). • VIH: South Island (4); Central Island (2); North Island (1). • FH: Chilliwack (1); Port Moody (1); Surrey (1). • NH: Northwest (2); Northeast (2); Northern (3). • IH: Thompson-Cariboo-Shuswap (3); Kootenay/Boundary (2); Okanagan (1); East Kootenay (1). 	Tobacco Facts/ Ministry of Health website, contact information for TRCs.
BCRPA – Active Communities	<p>Part of Act Now</p> <p>Community Development manager</p> <p>Active in 139 BC communities</p> <p>Provide regional workshops for active communities</p>	No dedicated regional staff	Trina Sporer

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Organization	Positions and Description	Regions	Information Source
Interior Health	<p>Extensive community development initiative as part of the Community Action For Health.</p> <p>Established 7 regional Steering Committees, who in turn hired part time community developers to implement community-based programs.</p>	<p>7 part time CD specialists hired by the subregional Steering Committees. Funding has expired for these positions, although some have been picked up by the host agencies.</p>	<p>Rose Soneff, Leader Community Development</p> <p>Dr. Nelson Ames Senior Medical Health Officer Nelson.ames@interiorhealth.ca</p>
Vancouver Coastal Health	<p>Geographically-based Community Developers (see below for a job description). They work directly with community health services.</p> <ul style="list-style-type: none"> • 6 FT in Vancouver (one in each CHA) • 3 part-time CDs (Powell River, Sea to Sky, Sunshine Coast) • 2 positions in North Shore • 1 FT position in Richmond (this position is a combination of Community Developer and Community Engagement) • 2 FT in Bella Bella and Bella Coola <p>Within Vancouver they have identified their 4 key areas as:</p> <ul style="list-style-type: none"> • supporting local initiatives that promote health • networking and partnership development with other community agencies • community consultation • organization change within VCH to better meet the needs of the community <p>We also have a couple of other Community Developers that are in other programs</p> <ul style="list-style-type: none"> • 1 FT Addictions (Vancouver) • 1 FT Diabetes Prevention Project (Vancouver) <p>Community Engagement Team Includes: The Community Engagement team works with the community in two main ways. The first is through the 4 Community Health Advisory Committees (Vancouver, Coastal, Richmond and Aboriginal). The second is through program specific community consultations. See attached web page link for more details: http://www.vch.ca/ce/</p> <ul style="list-style-type: none"> • 1 director • 5 team leaders <ul style="list-style-type: none"> • 1 North Shore Coastal • 2 Vancouver • 1 Richmond (same person as the Community Developer) • 1 Aboriginal <p>SMART Fund and Aboriginal Health Initiative Program also have a couple of Community Developers . Promoting health and wellness and encouraging marginalized and vulnerable members of the community to play an active role in their own health is the focus of VCH's SMART Fund . Since 1997, this innovative program has supported non-profit agencies in Vancouver and Richmond (through funding) to develop projects that empower communities to better identify and manage their own health needs. http://www.smartfund.ca/</p> <ul style="list-style-type: none"> • One Manager • 2 Community Developers (one for SMART fund and one or the AHIP) 		<p>Claire Gram, Regional Coordinator, Healthy Communities and Community Food Security, 604 875-5600 ext 67636</p>

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Organization	Positions and Description	Regions	Information Source
Fraser Health	Limited role in community development, other than through the Tobacco Control Program. Recently established a position to begin to look at community development for healthy living.	1 management position assigned. Newly developing area.	Laurie Gould, Executive Director, Primary & Chronic Care Laurie.Gould@fraserhealth.ca
Vancouver Island Health	Work with communities to do population health assessments. Help to identify priorities for building healthy communities, and for obtaining funding.	6 staff, including health analysts. 1 staff position in Duncan	Mike Pennock Dr. Richard Stanwick, Chief Medical Health Officer, Richard.stanwick@viha.ca Dr. Murray Fyfe Medical Health Officer, Murray.fyfe@viha.ca
Northern Health	Have 13 primary care coordinators Their mandate was to work with position officers to take a population based approach to their practice and to identify what the needs are and how well they are doing with the guideline base care, whom the at risk population is, and then to involve health authority staff. The coordinators play a role by helping people manage their illness or live healthier. They work within the community to strengthen community action to support public policy and improve outcomes for people with chronic disease. They do not have specific guidelines for the positions, and some are more successful then others at engaging community.	13 staff at various communities	Judy Huska

APPENDIX C: INTERVIEWS

- Dr. Richard Stanwick, VIHA
- Michael Pennock, VIHA
- Rose Soneff, IHA
- Judy Huska, NHA
- Ted Bruce, VCH
- Heather McLeod Williams, Physical Activity Strategy
- Don Hunter, Physical Activity Strategy
- John Millar, PHSA
- Laurie Gould, FHA
- Ron Duffell, ActNow
- Trina Sporer, BCRPA, Active Communities
- Stefa Katamay, 2010 Legacies Now
- Bruce Lund Canadian Heritage
- Lisa Gibson- Living in Community Project
- Claire Gram, VCH

BC HEALTHY LIVING ALLIANCE

COMMUNITY CAPACITY BUILDING STRATEGY

20 SEPTEMBER 2007

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