CAPACITY BUILDING:

THE EXPERIENCE OF HEALTH EDUCATION WORKERS IN THE YUKON

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B.Sc.N., University of Saskatchewan, 1971

Thesis Submitted in Partial Fulfillment of

The Requirements for The Degree of

Master of Science

in

Community Health Science

The University of Northern British Columbia

February 2006

Canada

ABSTRACT

Population health literature holds that influencing the determinants of health will enable health inequities to be redressed and health outcomes improved. The question arises of how determinants of health can be addressed in community health practice. The study explores the use of a capacity building approach as a means to address health determinants in the Yukon context.

Research was conducted with Yukon health education workers, through individual and small group interview, to explore their understanding, experience and observations of the outcomes of capacity building. All participants were associated with the Yukon College Public Health and Safety unit as employees or program instructors. Participants were randomly selected from four Yukon community size groupings, to allow identification of common themes across varied settings.

Findings about capacity building are reported in relation to meaning, process, health education worker role, Yukon context and effects of activity. Predominant themes that emerged indicate the importance of building on strengths, achieving an end of immediate importance within the context and living in relationship with the community when undertaking capacity building activity. Implications for policy, community health practice, and further research are identified.

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CHAPTER ONE

Introduction

The question of how to influence determinants of health as a community health practitioner working within the health care system has perplexed me. Population health literature holds that influencing the determinants of health will enable health inequities to be redressed and health outcomes improved (Chomik, 2001; Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Capacity building offers an approach to working with people in a community to enable them to effectively address determinants of health and to improve health outcomes (Bopp, GermAnn, Bopp, Baugh Littlejohns, & Smith, 2000; Hawe, Noort, King, & Jordens, 1997; World Health Organization, 1997). A capacity building approach may offer a way of redressing health inequities and improving health outcomes in the Yukon population. However, it is important to understand capacity building in the context in which it occurs in order to be responsive to that context. (New South Wales, 2001; Smith, Baugh Littlejohns & Thompson, 2001). The study has been undertaken to gain knowledge that can inform practice with potential to influence determinants of health.

Background

The background section presents contextual information on which the research project is based. This includes information on health inequities in the Yukon, an exploration of the potential for capacity building to address health inequities, description of the Yukon context and an explication of the perspective that I bring to this project.

Health Inequities in the Yukon

Health inequities exist in the Yukon. Problems with health and social outcomes persist despite significant investment in Yukon health and social services. Inequities are reflected in death rates due to accident and injury that are more than three times the national average (Timmermans, 1999), life expectancy that consistently falls below the national average (Cappon, 1991; Timmermans, 1999; Yukon Health and Social Services, 1995, Yukon Health and Social Services, 2003a) and the perception that alcohol and drug abuse is a serious problem (Timmermans, 1999; Yukon Department of Health and Social Services, 2003b). Whitehorse residents have higher income, lower unemployment and higher education than those in rural communities, reflecting economic and social disparity within the Yukon (Timmermans, 1999). Health, in turn, is related to these socioeconomic disparities. Self-rated health, considered a reliable indicator of health, has been shown to increase with increases in income adequacy and quality of life for Yukon people (Yukon Bureau of Statistics, 1994). This information suggests that Yukon health inequities are related to social and economic factors, with rural residents more likely to be affected by poor health. Health status improvements among Yukon people that have occurred over the last 25 years, particularly in the area of children's health, have been attributed to progress in facilitating self-determination and community development (Timmermans, 1999). Learning how community health practitioners might work effectively to further improve health status in the Yukon is a driving interest behind this study.

Potential of capacity building to address health inequities

Capacity building is identified as one of the ways that community development can occur and that health determinants can be addressed. In their research as health promotion

practitioners, Smith et al. (2001) describe capacity building as the "essence of community development" (p.31). Bopp et al. (2000) link capacity building and health determinants in their definition of community capacity as "the ability of people and communities to do the work needed in order to address the determinants of health for those people in that place" (p.14). Increasing community capacity was identified as one of the priorities for health promotion in the Jakarta Declaration on Leading Health Promotion into the 21st Century (1997). The Declaration clarified that health promotion "improves both the ability of individuals to take action, and the capacity of groups, organizations or communities to influence the determinants of health" (p.4). Hawe, King, Noort, Jordens & Lloyd (2000) explain the value of capacity building succinctly:

> The rationale for capacity building is simple. By building sustainable skills, resources and commitments to health promotion in health care settings, community settings and in other sectors, health promotion workers prolong and multiply health gains many times over (p.2).

A capacity building approach holds potential to address health inequity through enabling action on health determinants, action that occurs, at least in part, at a collective or community level. It is, at heart, a hopeful approach, that may be accessible to practitioners in working with individuals, organizations and communities and may truly facilitate the achievement of health gains in Yukon communities. Given this potential, it is a matter of interest to understand the practice of capacity building in the Yukon, to determine if and how this approach is being used, and to what effect. As a group that has identified themselves as taking a capacity building approach, the work of a group of Yukon health education workers is studied in order to gain understanding of such practice. This study is a first step in understanding the potential for a capacity building approach to be useful in addressing health inequities in the Yukon.

Yukon Context

The Yukon is "the great, big broad land way up yonder" immortalized in the poetry of Robert Service. It is a vast, sparsely populated land in the northwest corner of Canada. Approximately three-quarters of the 30,255 Yukon citizens live in the capital city of Whitehorse, with the balance living in sixteen communities throughout the territory. Rural Yukon communities range in size from 57 to over 1800 people (Yukon Government, 2004), all but one of which are accessible by road within one to six hours drive of Whitehorse. First Nations people make up approximately one quarter of the population. The Yukon is a wilderness land that has been home to First Nations people for millennia and that continues to cast its spell on newcomers as it did on Robert Service.

Government plays a large role in the life of the Yukon. At several levels, governments in the Yukon are responsible for delivering health and social services and other services that impact on the determinants of health. Federal, territorial, First Nations and municipal governments all have a role in public administration. Directly, public administration accounts for 25.8% of the Yukon economy (Yukon Government, 2003). Further economic activity is attributable to government expenditures on goods and services. Federal, municipal and territorial government employees represented 36.3% of the total employed workforce in 2002; this figure does not include employment by First Nations governments (Yukon Government, 2003). We are a population that is extensively governed. The question of whether and when we are well governed is, of course, contentious. An indication of the contentiousness is that three different political parties held office in the Yukon between 2000 and 2004. The role of government is emphasized for two reasons; one is to note the extent to which governments at different levels are responsible for health and

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social service delivery, the other is to illuminate the extent to which the exercise of power is operational in the Yukon through these government structures. Both of these factors are relevant to the practice and policy context in which capacity building occurs.

Working within the territorial health care system, I have often heard that there is need for capacity building in the Yukon. Such comments may come from First Nations workers, from health professionals, from people active in non-government organizations. In order to gain a better understanding of what capacity building means and how to build it, it is useful to learn how it is undertaken in the Yukon. The Yukon College Public Health and Safety (YCPHS) manager indicated that the YCPHS unit takes a capacity building approach to their work. The mandate of the unit is not a written one, but has been described by the manager as being openness and effort to make safety training and health promotion accessible to Yukon people, using resources such as Red Cross first aid training courses, food safe programs and health promotion. The unit is part of the Yukon College Professional Studies division, whose primary goal is to develop and deliver programs and services that enhance access to employment for students, or assist them in achieving professional objectives (Yukon College, 2004a). The YCPHS unit functions within Yukon College, which strives as an organization to help learners develop "a healthy balance of their whole person: intellectual, emotional, spiritual, social and physical", with knowledge and skills for successful living, to apply problem-solving strategies to a variety of decision-making situations and to contribute to their communities (Yukon College, 2004b, p.1). With their orientation to a capacity building approach, a network of instructors throughout the Yukon, and a health promotion focus in their work, the YCPHS instructors are a knowledgeable, Yukon-wide and accessible group of people from whom much can be learned. This group provides a window into understanding

capacity building and influence on determinants of health through their role in community education.

Personal Perspective

My perspective is that of a macro community health practitioner, operating from the assumption that addressing broad issues of social policy can affect individual and collective well-being, consistent with the views of Ricks and Charlesworth (2002). I believe that if a community can function more effectively, its members will be healthier and happier. I assume that it is both possible and important to improve health status. Health disparities in our society are a social injustice and, as a citizen, I share with others a responsibility to redress such injustice. The study is consistent with my social policy interests.

Professional and personal experiences have contributed to the perspective brought to this research. In my professional life, I started as a nurse working in the community health field, moved into community development and then health policy work and am now coordinating primary health care transition activity as an employee of the Government of Yukon Department of Health and Social Services. I have lived in the Yukon for the better part of three decades and, throughout that time, have held a keen interest in health issues affecting Yukon people. My experience both informs and limits my ability to understand health issues. Embedded, as I am, in a life of positional power arising from relative affluence, education, professional and employment status, I assume that there is much that is within my control with respect to the determinants of my own health. With this fairly strong sense of personal power, I may be limited in my ability to understand the perspective of those with less experience of empowerment. However, I have also had personal experiences from which I have learned much about the limits of my power; these situations have taught me to

cope with what I can control when much is spinning out of control in my world. As I have learned to find my own answers in such situations, I have also come to recognize and respect the need for and value of finding one's own solutions to life's dilemmas. My philosophical and practical interest in capacity building approaches arises from my range of life experience.

In delineating the perspective that I bring to this project, it is relevant to define my understanding of health. The definition most congruent with my own experience and thinking is that health is the "capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish, Green, Ratner, Chomik & Larsen, 1996, Background section, para 5). The World Health Organization definition of health, by comparison, states that health "is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1946). The World Health Organization definition aims for an ideal that is unachievable, whereas my understanding of health is that it can be accessible despite disability, disease or distress, reflecting an ability or capacity to cope with physical, mental and/or social adversity. Although the World Health Organization definition has remained extant over time, the organization has recognized in their health promotion literature that to achieve the state of health, an individual or group must be able to identify and realize aspirations, satisfy needs and change or cope with their environment (World Health Organization, 1986). In addition, the Bangkok Charter for Health Promotion (World Health Organization, 2005) offers a concept of health as a "determinant of the quality of life and encompassing mental and spiritual well-being." (p. 1). The health promotion focus taken by the World Health Organization (1986) emphasizes the ability to respond to life circumstances, as does the definition of Frankish et al. (1996). However, the World Health Organization perceives the response to life challenges as a route to a state of complete well-

being rather than a manifestation of health in it's own right. In contrast, Frankish et al. (1996) indicate that abilities in adapting, coping and responding to life challenges define health, such that it could be accessible to people affected by disease or disability. I prefer the Frankish et al. (1996) definition because it enables an understanding of health on both individual and collective levels that respects that health can be achieved in the face of circumstances that are less than ideal and in which we can each take an active role.

It is from the perspective framed by my views as a community health practitioner, my experience and observations in professional and personal life and my understanding of health that I have approached this research project.

Purpose

The purpose of the study is to gain an understanding of capacity building process and outcomes within the Yukon context. Research on capacity building has not previously focused on experience in a northern Canadian context, including the Yukon.

Within the main purpose of the study, there are several components. These components include attention to the context of the Yukon and to differences within the Yukon experience, as well as examination of the concept of community capacity and indicators of such capacity. The components within the purpose are discussed here.

The study pays specific attention to the context of the Yukon with respect to capacity building. The Yukon as a northern context shares characteristics with rural communities such as geographically distinct locations, small populations and limited infrastructure as identified by Smith et al. (2003), but is also distinct in a number of ways. Distinctions between the Yukon context and other rural communities include the relative isolation of

spatial communities and the complex political environment, factors expected to influence contextual knowledge about capacity building.

The Yukon is not a homogeneous environment. Therefore, the study also seeks to understand capacity building in Yukon, with attention to differences that arise within experience in this context. Differences in size of communities, employment and education opportunities and culture/ethnicity all give rise to differences in the experience of living in the north. Research in a variety of settings in the Yukon illuminates such differences.

In order to understand capacity building, there is a need to examine the concept of community capacity, a term often linked in literature with the concept of capacity building (Bopp et al., 2000; World Health Organization, 1997). Rural settings are considered to be promising settings in which to advance knowledge about community capacity (Smith et al., 2003). To the extent that there are similarities between rural and northern experience, the north is also a promising setting in which to advance such knowledge. There is growing interest in developing indicators to evaluate or measure community capacity (GermAnn & Smith, 1999; Gibbon, Labonte, & Laverack, 2002; Hawe et al., 2000). Community capacity indicators are thought to be useful for assessing the ability of community members to work together on health determinants (Smith et al., 2003) and to determine whether capacity building is effective in contributing to improved population health outcomes over time (Taylor & Soal, 2003). This study sheds light on the links among community capacity and indicators of community capacity, in relation to Yukon experience of capacity building.

Research Question

The research question to be explored was articulated as: what is the meaning and experience of capacity building for health education workers in the Yukon context?

Knowing that the Yukon College Public Health and Safety unit identifies itself as taking a capacity building approach, the people working in the unit can be considered to be a group from whom much can be learned about capacity building in the Yukon. Workers with the unit have the knowledge that makes it possible to learn about the process and outcomes of capacity building in the Yukon context.

Conclusion

The study addresses the question by exploring literature on capacity building, undertaking qualitative research with health education workers to answer the question and reporting the findings from that research. The findings are discussed in relation to the new knowledge gained and in relation to existing literature. Key themes emerging from the Yukon study are identified, with discussion of concomitant implications for research, policy and practice. The understandings gained about capacity building practice and health workers' roles in this context may be of value in addressing health inequities in and beyond the Yukon.

CHAPTER TWO

Literature Review

This literature review outlines the social theory premises for the study, previous research on capacity building and related concepts. Social theory is explored to situate the study within a philosophical frame of reference. Meaning, process and outcomes of capacity building are reviewed in order to understand the work that has preceded this study and to frame the research methodology in light of that knowledge. Concepts related to capacity building are reviewed in order to situate the study design within the body of related thought on population health, socioeconomic influences on health status, social capital and community resiliency. The review of literature provides a foundation from which further knowledge of capacity building can be gained.

Social Theory

The social theory foundation for this study has been informed primarily by the work of Charles Taylor and Anthony Giddens. Giddens (1993) endeavours to offer a unified approach to social theory acknowledges different frames of meaning as the starting-point of analysis. He takes the view that the production of society is brought about by the active constituting skills of its members in interaction that involves (attempted) communication and the operation of both power and moral relations. He holds that structure occurs as a condition of interaction and as a consequence of it, a concept he describes as 'duality of structure' (Giddens, 1993). He incorporates the empirical-analytic perspective into a frame of meaning by noting that enquiry is relative to interests that stimulate the enquiry and to the extent of knowledge already possessed by the enquirer, both of which arise from interaction.

Giddens sees power as integral to action and interaction. In his words, "action intrinsically involves the application of 'means' to achieve outcomes…power represents the capacity of the agent to mobilize resources to constitute those 'means'" (p.116). Although, this is an extreme simplification of the ideas put forward by Giddens, the intent is to show his integration of understanding different ways of being within a coherent framework. In essence, interaction, including the exercise of power, is the foundation of our ways of being in relation to each other, with structure occurring as both a means and an end to this interaction.

Taylor (1991) puts forward the idea that society suffers from malaise arising from individualism, the primacy of instrumental reason and the consequences of these for political life in terms of alienation from public life and consequential loss of political control. He makes the case that there are moral ideals that we ought to desire, although they have become debased or trivialized in their expression.

Behind the malaise of individualism is the moral ideal of being true to oneself or 'authenticity', in Taylor's view. This authenticity does not occur in isolation, but against a horizon of significance that is independent of individual will and that arises from interaction. He argues that this connection to a wider whole is something that we need to recover, in part, through dialogue which both ties us to others and provides a background of intelligibility against which things take on importance and which enables us to define ourselves. The dialogue to which he refers is part of the process by which construction of social reality occurs (Taylor, 1991). In other words, recovery of authenticity will counter the malaise of individualism through dialogue that places us in interactive relationship with others and within a wider context of intelligibility or significance.

Taylor describes the second malaise of modernity as the primacy of instrumental

reason. By instrumental reason, he means the kind of rationality we draw on when we

calculate the most economical application of means to a given end, leading to emphasis on

cost and efficiency above other criteria. Though it has lost sight of its moral sources,

instrumental reason has arisen from the moral ideals of rationality, that is, self-responsible,

self-controlling reason, and benevolence, with respect to improving the conditions of life and

relieving suffering (Taylor, 1991). Instrumental reasoning is reflected in positivist and post-

positivist assumptions. Taylor proposes that the moral ideals of instrumental rationality

provide the foundation for enframing it within an ethic of caring rather than one of control or

dominance over nature. Instrumental reason has benefit provided that it is applied in service

of people rather than in control over them.

Taylor's third area of malaise is with respect to political life, where our challenge is

to:

> combine in some non-self-stultifying fashion a number of ways of operating, which
> are jointly necessary to a free and prosperous society but which also tend to impede
> each other: market allocations, state planning, collective provision for need, the
> defence of individual rights and effective democratic initiative and control (1991, p.
> 110).

The consequence of weakening democratic initiative is fragmentation, as we become

"increasingly less capable of forming a common purpose and carrying it out" (p.112).

Fragmentation grows to the extent that people no longer identify with their political

community and by the experience of political powerlessness. However, Taylor believes that

the vicious circle of fragmentation and powerlessness has potential to be a virtuous circle

(p.118). Successful common action can bring a sense of empowerment and also strengthen

identification with the political community. A vigorous democratic life, engaged in a project

of re-enframing could also have a positive impact on the atomistic and instrumental stances generating shallow modes of authenticity (Taylor, 1991). Taylor holds a lamp that enables us to see the strength of the ideals behind societal malaise that offers an encouraging perspective on the potential within society to achieve *'grandeur'*. This prospect of achieving such *grandeur* is enticing.

Together, Giddens (1993) and Taylor (1991) offer a way of being grounded in interaction, that both ties us to other people and provides a broader background of intelligibility or horizon of significance against which to strive to achieve authenticity. The exercise of power is an element of all interaction, one that includes but is not limited to control over others; it is the means by which resources are mobilized to achieve ends. Striving for personal authenticity, within an ethical framework of benevolence or caring for others can provide the basis for effectively dealing with the tensions within our society and for moving into successful common action. The discussion of capacity building will be undertaken in relation to the theoretical stances articulated by Giddens and Taylor.

Meaning of capacity building

Definitions of capacity building, the thinking behind the approach, and the relationship of capacity building to health promotion are discussed under this heading.

Definitions of capacity building

Despite the volume of literature about capacity building, there are relatively few definitions. Smith et al. (2001) define it as "a process of working with a community to determine what its needs and strengths are, and to develop ways of using those strengths to meet those needs" (p. 31). Hawe et al. (1997) describe what capacity building does, how it does it, and why it has value, rather than defining the term. An action-oriented focus is

apparent in their description that what capacity-building does is "deliver(s) health gains not only in association with the health problem of interest, but also on a wider front as a result of the problem-solving focus of the multiplier effect"(p.38). By this, I understand Hawe et al. to mean that problem-solving that enables health gains in one area contributes to gains in other areas. Hawe et al. describe how capacity building delivers health gains by "building sustainable skills, resources and commitments to health promotion in health care settings, community settings and in other sectors, (that) health promotion workers prolong and multiply health gains many times over"(Hawe et al., 2000, p.2). Multiplying health gains is the reason why capacity building has value. Multiplying health gains is crucial to extending competence to address not only the health problem of current interest, but also other health issues (Hawe et al., 1997). There is interest in capacity building within disciplines other than health, including social work (Poole, 1997), environmental protection and management (Gomez Gonzalez Cosio, 1998) and resource management (Mendis & Reed, 2003). Common to capacity building in all disciplines is the process of developing ability to identify and solve problems. Definitions consistently build on the values of interactive relationships and on empowerment through collective action. Community or collective action is implicit in all the definitions, as is a strengths-based approach to identifying issues and solving problems.

Labonte and Laverack (2001a) indicate that capacity building has both constitutive elements, ends in themselves, and instrumental ones, that is, means to an end. Rather than attempting to resolve this dialectic, they choose to take a path recognizing the confluence of these ideas. Thus, they identify as capacity, those "elements of peoples' day-to-day relationships, conditioned and constrained by economic and political practices, that are

important determinants of the quality of their lives, if not also of communities' healthy functioning" (p.112). Thus, an understanding of capacity building incorporates the ideas that it is both a means, or a process, and an end that achieves a purpose such as achieving health gains or meeting needs. Labonte and Laverack call attention to the link between individual and community health, a link found to be relevant in this study.

Community capacity and capacity building are closely associated terms. Bopp et al. (2000) define community capacity to mean "the ability of people and communities to do the work needed in order to address the determinants of health for those people in that place" (p.14). Smith et al. define it as "the degree to which a community can develop, implement and sustain actions for strengthening community health" (p.33). Common to all definitions of community capacity is a focus on processes of action and relationship to effect change towards the end of improved health in communities. There is considerable overlap between the terms community capacity and capacity building.

Labonte and Laverack (2001a) focus their work particularly on *community* capacity building. They describe community capacity building as an "increase in community groups' abilities to define, assess, analyze and act on health (or any other) concerns of importance to their members" (p.114). Labonte, Bell Woodard, Chad & Laverack (2002) say that "community capacity-building, like the related concepts of community development and empowerment, is about increasing the capabilities of people to articulate and address community health issues and to overcome barriers to achieve improved outcomes in the quality of their life" (p.181).

Like capacity building, community capacity building is understood to constitute both means and ends. Kwan, Frankish, Quantz & Flores (2003) state, "Although a program may

include the building of community capacity as an objective (an end), community capacity is more often thought of as a means to better quality of life and healthier communities" (p. 45). They see community capacity building as a process that is re-iterative and cyclical with no actual end because communities are not static entities. Both constitutive and instrumental elements of community capacity building are seen to have relevance in this study.

This is a point at which it is useful to clarify the definition of community. A community is understood to mean "specific groups and networks of groups organizing around specific issues, generally but not always spatially bound" (Labonte & Laverack, 2001a, p. 116). Spatial communities have geographical boundaries, which may overlap, and people may live in and have an affinity for multiple spatial communities at a given time. Non-spatial communities are based on affinity, for instance with racial or professional groups, rather than geography and may transcend, overlap with and/or be contained within spatial boundaries (Frankish, Kwan and Flores, 2002). It is argued that there is no sound reason for excluding either spatial or non-spatial communities from the study of community capacity (Kwan et al., 2003). In this study, communities are considered to include both spatial geographic communities and non-spatial communities of interest within the Yukon context.

Capacity building definitions commonly include reference to a process of working with people in communities, achieving health gains and to increasing capabilities among people to address health issues. Terms closely related to capacity building are community capacity building and community capacity. In light of the emphasis on community, a definition of that term is also relevant. The definitions point to the need for further exploration of the process and outcomes of capacity building activity. First, the thinking

behind capacity building is explored and set in context with health promotion concepts.

Thinking behind capacity building

The thinking behind capacity building has arisen from a number of sources. Ivan Illich (1976) held that the level of health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population. He considered that the ability to cope, or process of adaptation, can be enhanced but never replaced by medical intervention or by the hygienic characteristics of the environment. The relationship of empowerment and participation with health promotion, and with capacity building as part of the health promotion tradition, is recognized as being fundamental to good health (Hancock, Labonte, & Edwards, 1999). Other authors have identified that building capacity from the strengths found in a community is an approach to asset-based community development that provides an alternative to a problem-focused approach. (Kretzmann & McKnight, 1993; Restrepo, 2000). Arising from thinking about empowerment and asset-based community development, the idea is emerging that health can be improved by supporting community-level activity. Collective or community level activity is seen as an effective means to address health inequities. Capacity building offers an approach that can enable such collective activity to occur.

Capacity building as an approach to health promotion

Exploration of the concept and practice of capacity building in relation to achieving improved health outcomes is frequently found in health promotion literature. Capacity building is an approach to health promotion. There is not full agreement on how health promotion is best approached. Laverack and Labonte (2000) have identified two different health promotion discourses, one espousing a top-down disease prevention/lifestyle change

approach, the other a bottom-up community empowerment approach. The disease

prevention/lifestyle management approach emphasizes individual responsibility, is oriented

to solving problems defined by an outside agent, through education or improved services.

Outside agents deliver services and act as the primary decision makers. There is low

community control of resources or ownership. Evaluation is undertaken in relation to the

specific risk factors and quantifiable outcomes (Laverack & Labonte, 2000). Having some

understanding of these two discourses enables an understanding that capacity building is

most closely aligned with an empowerment approach to health promotion.

The empowerment approach to health promotion is gaining ascendancy, as indicated

by a number of sources. For instance, the World Health Organization defined health

promotion as "the process of enabling people to increase control over, and to improve, their

health" (World Health Organization, 1986, p. 1). The guiding principles of action, as well as

the means of action articulated in the Ottawa Charter for Health Promotion focus on

collective action directed to improvement of individual and collective health conditions

(Erben, Franzkowiak, & Wenzel, 2000; World Health Organization, 1986). The Jakarta

Declaration claimed that health promotion has an impact on determinants of health, health

inequities, human rights and the building of social capital (World Health Organization,

1997). The Declaration also included the priority to "increase community capacity and

empower the individual" (p.2). GermAnn and Smith (1999) align capacity building clearly

with the empowerment approach. They argue that capacity building is not a program, but a

philosophy and practice "based on the values of empowerment, equity, and social justice" (p.

3). The literature indicates that capacity building is an approach to health promotion

consistent with an empowerment approach and having potential to address the determinants of health.

Capacity building clearly has a place in the realm of health promotion. The question that arises is how a capacity building empowerment approach can be incorporated within programs that do not have this explicit intent. The Yukon College Public Health and Safety (YCPHS) Unit, with its capacity building approach to all activities, including health promotion, first aid instruction and ambulance attendant training, is focused more explicitly on capacity building than on health promotion. As most prospective participants are involved in teaching first aid, the emphasis is on health education. The YCPHS Unit provides an interesting setting in which to explore the health promotion influences achieved by taking a capacity building approach to health education. We know little about the attitudes, working practices and skill sets that are used in putting the capacity building approach into practice.

Summary

The connection between empowerment and capacity building has been clearly demonstrated in the literature reviewed. Conceptually, capacity building has the potential to address the malaises of modernity identified by Taylor (1991), by reducing our atomism and increasing our ability to act collectively towards a common purpose. The potential benefits of acting collectively to a common end form the foundation for the belief that health gains can be multiplied by a capacity building approach. In health and other sectors, work in capacity building is being undertaken in the belief that this is the route to developing ability to identify and solve problems, building on the values of interactive relationships at a number of levels and on empowerment through collective action. The literature review of capacity

building, thus far, contributes to an understanding of the meaning of the term. The subsequent section shall explore the process of capacity building.

Process of Capacity Building

In order to understand the process of capacity building, literature has been reviewed with respect to approaches, purposes, activities and actors. Approaches to the process are seen as multi-faceted or as occurring along a continuum. Activities occur at multiple levels. Actors include agencies, practitioners and community members, each with different purposes. In examining the process of capacity building, the interrelationships among the approaches, activities, actors and purposes involved in the capacity building process are shown and the pivotal importance of the health promotion worker identified.

Approaches to capacity building

The bottom-up empowerment approach to health promotion builds strength and capacity to address problems identified by the community through building community control, resources and capacities. (Laverack & Labonte, 2000). Outside agents respond to the needs of the community, whose members are the primary decision makers. Community control of resources and ownership is high and evaluation is undertaken by documenting changes of importance to the community (Laverack & Labonte). Capacity building is consistent with bottom-up programming whereby "the outside agents act to support the community in the identification of issues which are important and relevant to their lives, and enable them to develop strategies to resolve these issues" (Laverack & Labonte, p. 256).

Although the top-down and bottom-up approaches identified by Laverack and Labonte (2000) are not necessarily mutually exclusive in practice, it can be difficult to accommodate both. Parallel program and empowerment tracks are suggested as one way to

accommodate the goals of both approaches (Labonte et al., 2002; Laverack & Labonte). In

practice, this involves working to link programs with a particular risk factor focus with a

capacity building approach, by intentionally seeking to enhance capacity domains (Gibbon et

al., 2002).

Hawe et al. (2000) present capacity building as a continuum of activities that cross

both the top-down and bottom-up approaches described by Laverack and Labonte (2000).

Research conducted by Hawe, King, Noort, Gifford & Lloyd (1998) points to the challenge

of accommodating both risk-factor and empowerment approaches to health promotion. They

described capacity building, an empowerment approach, as a hidden activity within health

promotion work. The perspective of Hawe et al. (1998) is consistent with the idea of

community capacity building as a parallel track to other health promotion programming

activity.

GermAnn and Smith (1999), on the other hand, position themselves as favouring an

empowerment process approach. They call for "attitudes, working practices and professional

skill sets that differ from those which have dominated traditional models of health service

delivery" (p.3). This approach would require a philosophical shift in the approach to health

promotion that is more transformative than the parallel-track or continuum approaches. It is

also an approach that is less likely to be adopted as it would require a reorientation of health

systems that is unlikely to occur (Gibbon et al., 2002).

The process of capacity building can also be understood as embodying four different

approaches (Crisp, Swerissen, & Duckett, 2000). Though identified separately, the

approaches are not necessarily exclusive. Crisp et al. identify these as a top-down

organizational approach, a bottom-up organizational approach, a partnerships approach and a

community organizing approach. The top-down organizational approach involves structural, resource, policy and practice commitments to support capacity building. The bottom-up organizational approach is summed up as being most effective when there is commitment within an organization to continuous learning and improvement. Partnerships among or within organizations that might not otherwise have a working relationship is another way of building capacity. The assumption behind this approach is that health promotion efforts can be optimized through such relationships. The community organizing approach involves working with communities, especially the most disenfranchised members, to solve health issues. The complexity of this approach is acknowledged. While successes are cited in their work, potential shortcomings include the development of unrealistic community expectations and the need for resources of time, skill and commitment, resources that are least likely to be available among the disenfranchised (Crisp et al.).

Activities of capacity building

Hawe et al. (2000) begin to address this question of how to work together by defining at least three activities of capacity building. These activities are building infrastructure for health promotion program delivery, building partnerships and organizational environments so that programs and health gains are sustained and building problem-solving capability. The first level, building infrastructure, involves elements such as planning and evaluation, skills required to enable program delivery. Capacity building of infrastructure has derived mainly from the interest in ensuring local ability to address health priorities set elsewhere, including such priorities as cancer control and cardiovascular disease prevention. The second level involves developing networks to maintain programs beyond a limited funding period. The third level, problem-solving capacity, moves into the realm of addressing the risk conditions

that affect health status. It is particularly at this level that inequities in health are likely to be addressed (Hawe et al.). The potential to improve the ability to address health inequities makes the process of capacity building an exciting area of study.

To understand the process of working within a community, the ideas of levels or continuums of capacity building activity are useful. Hawe et al. (1998) identify five different levels or aspects of capacity building activity; these are individual, within health care teams or groups, within organizations, across organizations, and within communities. These levels correspond with the community empowerment process which proceeds along a continuum involving personal empowerment, development of small mutual groups, community organizations, partnerships and social and political action (Laverack, 2001). The concept of multiple levels or a continuum of capacity building activities provides a link between the terms capacity building and community capacity building by emphasizing that capacity building includes community level action and that community capacity building encompasses individual-level activity. In order to understand the meaning of capacity building toward community empowerment, it is useful to recognize that the activity occurs on a continuum from individual to collective levels of action.

Actors and their purposes in capacity building

Labonte and Laverack (2001) identify three actors in health promotion capacity-building relationships; these are government or non-government health agencies, health promotion practitioners and community groups/members. The purpose of capacity building is somewhat different from each of these perspectives. The purposes of capacity building for the respective actors described by Labonte and Laverack correspond closely to the activities described by Hawe et al. (2000). For health agencies, the purpose of capacity building is for

program delivery and for supporting relationships with health promoters and community groups. This purpose corresponds with Hawe et al.'s activity of building infrastructure for health promotion program delivery. For health promoters, the purpose is to build program sustainability and develop relationships with community groups, corresponding to the activity of building partnerships and sustainability articulated by Hawe et al. For community groups and members, the purpose is to sustain programs and to develop generic qualities of healthy functioning, corresponding to the problem-solving activities of Hawe et al. The work of Labonte and Laverack begins to clarify the relationships that are involved in capacity building activities or processes.

Summary

The processes at play in capacity building activity include an array of approaches, activities and actors, with different purposes and approaches at work in relationships among the actors. The pivotal role of the health promotion practitioner as the link between the community and the health agency has emerged in this exploration of capacity building process. The health promotion practitioner has roles in supporting the development of partnerships and community organization, sustaining programs and relating to the health agency. However, it is the extent to which health promotion practitioners move from a focus on program maintenance and sustainability to focus on developing problem solving capability of community members and groups that they empower those community members to develop their capacity for healthy functioning (Hawe et al., 2000). Other writers take the view that practitioners cannot empower others, but that empowerment can be facilitated through an enabling process (GermAnn & Smith, 1999; World Health Organization, 1986). At the time that Hawe et al. first examined capacity building in 1997, it was a relatively new

concept. Since then, the term has moved into common usage in health and a wide range of

other areas (Kwan et al., 2003), but it is not clear what approaches, or activities are now

encompassed in capacity building practice. Exploring the experience of health promotion

practitioners enables us to gain insight from their practice knowledge.

Outcomes of Capacity Building

Rationale for examining outcomes

Taylor (1991) advises that instrumental reason is of benefit when applied to

improving the conditions of life and relieving suffering. Considerable work has been done to

understand capacity building, community capacity and capacity in order to be able to assess

whether capacity building is an approach that achieves health gains, as its supporters claim it

will. Since it is argued that capacity building is instrumental to multiplying health gains,

there is seen to be need to measure both health gains and capacity building (Hawe et al.,

1997). As capacity building moves towards creating problem-solving capability, control

over the nature of the health issue addressed is relinquished by the health system (Hawe et al,

2000, p. 8). Although capacity building proponents argue that this will undoubtedly bring

wide gains, it is anticipated that measurable gains at the population level will occur over the

long term and that there is need for outcome indicators of the process itself (Hawe et al.,

2000). Most agencies and funders have mandates and objectives for which they need to be

accountable (Gibbon et al., 2002). As Smith et al. (2003) note, "accountability issues are

fundamental here" (p. 25). While outcome measurement is relevant to accountability for

capacity building approaches, the validity of such measurement is its grounding within the

practice context or situation (Hawe et al., 2000; Smith et al., 2003). Outcome evidence is

required if community capacity building is to have credibility and support over the long run. Grounding such evidence in the Yukon context is needed to ensure validity.

There are a number of reasons for gathering evidence of the outcomes of capacity building. These reasons include the need for understanding the effectiveness of capacity building process and outcomes (Hawe et al., 2000), for informing practice (Bopp et al., 2000) and for situating practice within an empowerment philosophy (Smith et al., 2001). The philosophy and practice of capacity building emphasize working on health issues identified by community members rather than on those identified by health professionals (Smith et al., 2001). This means that measures of effectiveness must be specific to the community, as is the definition of the problem and the solution (Bopp et al., 2000, Laverack and Labonte, 2000). Bopp et al. argue that methodology to research effectiveness will be characterized by use of both qualitative and quantitative data and by accommodating both process and outcome measures. These are compelling reasons for examining capacity building outcomes.

Assessment processes can point the way for learning and action needed for the community and can guide work done by health promoters. As such, they constitute "a form of critical reflection for future stages of community work" (Bopp et al., 2000, p. 15). Although the pressure to measure effectiveness of capacity building feeds "the outcome fetish" (Bopp et al, p.11), the approach to doing so can apply instrumental reason in the service of people rather than in control over them, as Taylor (1991) would recommend.

Domains and indicators

Domains of community capacity and indicators of capacity building have been developed in an effort to gain understanding of process and outcomes of capacity building practice that may be measurable before health outcomes in disease and morbidity incidence

have changed. These domains and indicators are discussed here, followed by a summary of the points of debate with respect to measurement issues.

Domains of community capacity are understood as the "qualities of a capable community" (Labonte & Laverack, 2001, p. 116). Several groups have undertaken to identify such domains. (Bopp et al., 2000, Kwan et al., 2003, Labonte & Laverack, 2001). As Labonte and Laverack note, "there is no definitive set of characteristics that describe a capable community; but neither do such capabilities vary infinitely by each community or situation" (p. 117). Consistent with that observation, there are substantial overlaps among domains identified by different groups.

Labonte and Laverack (2001) identify nine domains of community capacity: participation, leadership, organizational structures, problem assessment, resource mobilization, 'asking why', links with others, role of outside agents and program management. Their domains were subjected to theoretical and face validity tests as well as field trials, though they make no claim that this is a "'true', or even 'best practice' template" (p.117). Domains identified by Labonte and Laverack are not situated in a particular context, they are aspatial.

Bopp et al. (2000) identify seven domains: shared vision, sense of community, participation, leadership, resources, knowledge and skills, communication and ongoing learning. The domains were developed in stages that included literature review, participatory action with rural communities and reflection on the literature, process and findings. Their domains are grounded in both theoretical and community experience.

Hawe et al. (2000) identified indicators of capacity building, rather than domains of community capacity. Hawe et al.'s nine indicators are: strength of coalition, opportunities to

promote incidental learning among other health workers, opportunities to promote informal

learning among other health workers, program likely to be sustained, learning environment of

a team or project group, capacity for organizational learning, capacity for an organization to

tackle a health issue, quality of program planning, and community capacity to address

community issues. Although there is overlap with community capacity domains identified by

Labonte & Laverack (2001) and Bopp et al. (2000), Hawe et al.'s indicators are linked more

with the process of capacity building than with community capacity.

Kwan et al. (2003) identify three levels of community capacity: individual,

organizational and community. The individual level includes characteristics of people as

individuals, such as personal attitudes, knowledge, skills and practices or behaviour. The

organizational level involves characteristics referring to formal organizations or agencies,

including how organizations function and the environment in which they function.

Community level characteristics are broader than individuals or single organizations and

include "informal and formal networks between organizations and between individuals and

organizations in the community, the infrastructure within the community, and the networks

and resources from outside (external) to the community" (Kwan et al., p. 17). Kwan et al.

note the challenges in achieving consensus on what community capacity is, on finding valid

and reliable measures of community capacity and of reflecting the collective element of

community capacity that is more than a sum of individual measures. Although the effort

involved in understanding and measuring community capacity may have value in

determining over time whether capacity building is effective, it is likely that there will always

be limits in attempts to find objective measures of a dynamic process.

Debate occurs with respect to the range of events that are considered health outcomes. Some programs have the goal of reducing mortality and morbidity while others see endpoints in relation to change in health risk behaviours, environmental hazards or public policy, considered to be intermediate indicators on the path to changed disease incidence (Hawe et al., 2000). There is debate about the extent to which intermediate indicators can be used to define endpoints of health promotion programs, the extent to which health in a positive sense can be measured as an outcome of health promotion, the limitations of evidence of effectiveness for disadvantaged and minority groups and whether empowerment is a process or dimension of health (Hawe et al., 2000). This debate about health outcomes occurs before beginning to talk about the measurement of community capacity or capacity building activity. Within discussion of community capacity, there is debate about how to determine rank of different domains, who determines it and how it is validated (Bopp et al., 2000; Labonte & Laverack, 2001b). For instance, how is it decided whether there is high or low community participation, by whom is it decided and can the rank be confirmed among different assessors? It is important to articulate the main points of debate within the discussion of capacity building, so that findings from the Yukon study can be understood within this framework. The debates will not be resolved through the proposed study.

Summary

A point of frequent agreement among the groups that have developed community capacity domains or capacity building indicators is the need for communities to have the flexibility to translate capacity building outcomes into their own terms; one size will not fit all communities (Hawe et al., 2000; Labonte & Laverack, 2001; Smith et al., 2003). To Smith et al.'s argument for the value of distinguishing between urban and rural settings, I add

the argument for the value of further distinguishing northern settings. In addition to the geographically distinct locations, small populations and limited infrastructure characteristic of rural communities, the Yukon setting is characterized by greater spatial isolation of geographic communities and a complex political environment, differences that may contribute unique understanding to the knowledge of capacity building practice.

Concepts related to capacity building

Determinants of health

A number of factors are known to influence and contribute to health. These factors, commonly called the determinants of health, include social, physical and economic environments, early childhood development, personal health practices, individual capacity and coping skills, human biology and health services (Chomik, 2001, p.11). Chomik further defines socioeconomic environments to include the factors of income, income distribution and social status, social support networks, education, employment and working conditions and social environments (p.12). Determinants of health include individual choices, such as smoking and exercise. Beyond individual choice, thinking on determinants of health recognizes that there are social structural influences on health outcomes, which arise from domains of influence beyond the individual (Dunn & Hayes, 1999).

Population health

To the extent that community capacity building is effective in acting on determinants of health, it is linked to population health concepts. Population health refers to the health of a population as measured by health status indicators and is a concept that incorporates recognition of the influence of determinants of health. Population health is an approach that focuses on the interrelated conditions and factors in the environment that influence the health

of populations, and advocates taking action that will reduce inequities that put some at a disadvantage in attaining and maintaining optimal health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999, p. 7).

Health equity

Pursuing equity in health means eliminating health disparities associated with social disadvantage or marginalization (WHO Task Force on Research Priorities for Equity in Health, and the WHO Equity Team, 2005). The unequal distribution of the social and economic determinants of health presents a challenge to reducing health inequity. Health inequity is reflected in health status that has been shown to occur along a gradient that remains extant in relation to socioeconomic status across time, place and specific causality (Mustard & Frank, 1994). A growing body of research on the economic aspect of this gradient supports the idea that it is relative, rather than absolute, income inequality that is associated with health disparities. (Dunn, 2002; Kawachi & Kennedy, 1997; Wilkinson, 1999) Thus, it is wide income disparities within a population that contribute to health disparities rather than inability to meet the basic needs of life. It is argued that it is psychosocial influences as much or more than economic ones that are relevant in understanding the health gradient (Blakely & Kawachi, 2002; Veenstra, 2001; Wilkinson, 1999; Wilkinson & Marmot, 2003). This argument holds that there are psychosocial pathways associated with relative disadvantage that act in addition to the direct effects of absolute material living standards. (House, Landis & Umberson, 1988; Wilkinson & Marmot, 2003). While recognizing the importance of the psychosocial environment, it is difficult to separate economic from psychosocial influences. For instance, both low income and social exclusion have been identified as contributing to heart disease (Raphael, 2001).

A focus only on psychosocial influences could contribute to victim blaming at the community level and counter movement towards structural change (Lynch, Davey Smith, Kaplan & House, 2000). Exploring capacity building as an approach that has potential to influence determinants of health may provide insight into a way to reduce health disparity and improve health equity in the Yukon and elsewhere.

Social capital

Social capital is a concept related to capacity building and population health. There is a growing, though not conclusive, body of thought that population health could be improved through development of social capital and social cohesion by influencing norms and strengthening bonds of civil society (Krieger, 2001). Though there is debate about the definition of social capital, consensus is beginning to emerge that the term refers to norms, values and networks that facilitate collective action. (Cote, 2001; Putnam, 1995; Woolcock, 2001) Lomas (1998) posits that there are potential benefits to implementing and evaluating community-level interventions rather than those interventions that attempt to modify individual health behaviours. The concept of social capital as a route to improved population health is criticized for emphasizing individual responsibility through social marketing rather than collective social action through health promotion (Erben et al., 2000) and for being a vague term that risks misspecifying social phenomena (Earls & Carlson, 2001). Although social capital is a concept linked to capacity building, it is less focused on application in practice. It points to the importance of relationships, connecting in this way with the social determinants of health and with the relational characteristics of capacity building.

Community resiliency

Community resiliency is defined as the ability of a community to respond to adversity and, in so doing, reach a higher level of functioning (Kulig, 2000). According to Kulig, "therefore, the community as a whole experiences health which in turn can lead to improved health status among its residents" (p.375). Community resiliency is related to both the means of capacity building through community level process and the end of achieving a beneficial impact on population health.

Summary

Concepts related to capacity building have been discussed to provide some sense of the connection that exists between it and other areas of thought within and beyond the health field. The intent has been to draw attention to the existence of the ideas, to indicate how they are linked with capacity building and to articulate some of the debate within these realms, particularly as such debate may relate to capacity building. This exercise helps to set capacity building within a larger context within the health field.

Conclusion

The literature review establishes the conceptual foundation for the study, followed by exploration of the meaning, process and outcomes of capacity building. Related concepts have been discussed. The review points to the value of exploring the meaning and experience of community building practice in the Yukon context, in the interests of understanding how health outcomes might be improved through such practice in the Yukon and elsewhere.

CHAPTER THREE

Methodology

In order to study the experience of capacity building in the Yukon, research was undertaken with the health education workers working with the Yukon College Public Health and Safety unit. In this chapter, the study research method is explained, including discussion of approach, setting, participant selection, conduct of interviews, data collection and analysis, rigour and ethics.

Research Method

Approach to research design

The research was designed to apply a qualitative description approach (Sandelowski, 2000). Sandelowski describes this approach as categorical, less interpretive than interpretive description and not requiring a conceptual or abstract rendering of data (p. 335). By categorical, Sandelowski means that the method already exists, though it is relatively unacknowledged. By interpretive description, she means that researchers are not required to move as far from or into their data and by not requiring conceptual rendering of data, recognizes that the product is complete and valued in itself. During data analysis, the approach moved within the qualitative description approach to one of interpretive description, becoming grounded in an orientation acknowledging the constructed and contextual nature of experience, while allowing for shared realities (Thorne, Reimer Kirkham & MacDonald-Emes, 1997). The reason for moving along the continuum of qualitative description towards interpretive description was for the purpose of exploring to an ever greater extent, the meanings and explanations that could have application in capacity-

building practice. (Thorne, Reimer Kirkham and O'Flynn-Magee, 2004). The application of

this interpretive description approach is explained more completely in the data analysis

section. Thus, the study moved within the continuum of qualitative description from what

was originally expected to be thematic description to become interpretive explanation

(Sandelowski & Barroso, 2003).

The study design drew on a study conducted by Hawe et al. (1998) that explored the

meaning and experience of capacity building in a variety of health promotion practice

settings in Australia. In their study, six focus groups were conducted with health promotion

workers with the intent of finding "shared patterns and issues across the heterogeneity of

practice approaches" (p. 286). Like their Australian counterparts, Yukon participants were

asked about their understanding of the meaning of capacity building and their experience

with this practice, with respect to process, outcomes and issues. For reasons explained

below, after the first interview, Yukon participants were asked first about their work, the

process, outcomes, helps and hindrances and then about meaning in relation to capacity

building. As in the study conducted by Hawe et al., shared patterns and issues were sought

across a range of practice settings among a variety of practitioners.

Setting

The study was set in the Yukon, with participants selected from various communities

throughout the territory. The Public Health and Safety unit is located at Yukon College, in

Whitehorse, Yukon. The five employees of the unit are based in Whitehorse and have

responsibility for program delivery there and in communities outside Whitehorse. The

network of instructors who assist in program delivery included 86 people at the time of the

study. Network members generally live in the community in which they conduct programs. Programs are offered in communities throughout the Yukon.

Participant selection

To address the research question, interviews were conducted with workers employed in the Public Health and Safety unit at Yukon College (employees) and with some of the people in Yukon communities who instruct programs for that unit (network members). Together, the employees and network members are referred to as health education workers. The rationale for choosing this group of health education workers is followed by an explanation of how participants were selected.

There were several reasons for undertaking the research with the health education workers associated with the Public Health and Safety unit at Yukon College. The reasons for choosing this group included their knowledge about capacity building, my ability to interview them free of conflict of interest, their experience across a range of settings within the Yukon context, the ability to maintain confidentiality due to group size and their willingness to participate.

All employees of the Yukon College Public Health and Safety unit were selected to participate in the study. Network members were selected by choosing a sample from four community size groupings. Community size groupings were identified as Whitehorse, large, medium and small. (See Table 1) The majority of participants were selected from Whitehorse, the main population center of the territory. The initial plan to choose one rural community at random from each of the three size groupings was modified slightly, as described below. When a rural community name was drawn, all network members in that community were invited to participate in the interview. The intent of this selection strategy

was to obtain participation by workers practicing across a wide variety of settings to allow

for identification of common themes (Patton, 1990).

Table 1 Community by size grouping and population with number of network members

Community grouping	Community name	Community population	Number of network members
Capital	Whitehorse	22,425	60
Large (500-2000)	Dawson City	1,788	5
	Haines Junction	790	3
	Watson Lake	1,551	3
Medium (200-499)	Carcross	414	1
	Carmacks	409	-
	Faro	345	3
	Marsh Lake	279	1
	Mayo	395	3
	Old Crow	265	1
	Pelly Crossing	285	2
	Ross River	344	-
	Teslin	417	1
Small (<200)	Beaver Creek	109	1
	Burwash Landing	75	1
	Destruction Bay	57	1
	Tagish	186	-
		30,255	86

Participants from Whitehorse other than the unit employees were selected by random

draw from a list of a total of 60 instructors. In soliciting participation, it became apparent

that contact by phone initially, even if only to leave a message, was more successful than

initial contact by email. From the total of 30 names drawn in Whitehorse, 10 instructors

were willing and able to be interviewed.

When a community name was drawn, all instructors from that community were

contacted by phone, followed by an email. Due to confusion on my part, a participant that I

had thought lived in a small community actually lived and did most of his teaching in a

nearby medium sized community. Therefore, two medium sized communities are represented in the study, rather than one, as had been planned initially.

Participants selected and consenting to interviews included the five employees of the Yukon College Public Health and Safety unit, ten instructors from Whitehorse, two from a large sized Yukon community, three from medium sized communities and one from a small community. The participant selection process ensured that a wide range of community experience would be represented in the study, and that the selection of prospective participants was unbiased.

Conduct of Interviews

A brief explanation about capacity building was provided by email to prospective participants so that they would have some idea of what I wanted to discuss with them. Although wording varied slightly, explanations were consistent with the sample provided below, which was sent to potential participants in a community outside Whitehorse:

> So that you know where I'm coming from, I understand capacity building as being the indirect work done in developing and delivering programs. It may have effects in addition to the particular focus of the health education activity. I think capacity building is a process that can help to improve health outcomes in the Yukon and I am interested in learning more about it for that reason. To that end, I would like to interview you about your understanding of the meaning, process and outcomes of capacity building in relation to your work with Public Health and Safety programs. (Horton, J., June 2004)

My intent was to give some indication of the topic to be discussed, without being directive in seeking a particular response.

Ten interviews were conducted with a total of 21 people. Five of the interviews were conducted with individuals and five with groups ranging from two to five participants.

Interviews were conducted between June 7, 2004 and August 12, 2004. The period during which interviews were conducted coincided with a heat wave, always an event of

some wonder in the Yukon, and one which influences other things in the environment. For instance, the heat contributed to extreme fire hazard conditions and to forest fires throughout the territory. In one interview, an active fire within a few kilometres of the participant's home was certainly on that person's mind during the interview; in another instance, the participant expressed fatigue from two weeks of involvement in enforcing a fire ban along a fairly long stretch of highway. A number of participants who were also members of their local volunteer ambulance services were involved in and affected by recent accidents in their area, to which they made reference during their interviews. The summer period during which interviews were conducted may have influenced the ability to recruit participants, and certainly influenced the events that participants were dealing with in their lives.

Interviews were conducted in person where feasible, by videoconference as a second choice, and by telephone if no other options were available. Seven interviews were conducted in person, one by videoconference until a power failure in the community made it necessary to switch to teleconference and two were conducted by telephone.

Data collection

Small group interviews were the preferred interviewing technique because of the benefits of gaining perspectives from several people together and of acknowledging the team aspect of practice by engaging the participants as a group (Hawe et al., 1998, Patton, 1990). Individual interviews were conducted when there was only one person involved as an instructor in a community or when an individual interview was most convenient for the participant. Using both small group and individual interviews proved to be a practical approach to learning about capacity building experience in a range of Yukon situations.

In both group and individual interviews, the intent was to ask participants to respond from their experience to questions exploring the following themes, drawn from Hawe et al. (1998):

1. The meaning of the term capacity-building

2. The process or steps in capacity-building

3. The outcomes of capacity-building

4. Facilitators, dilemmas and issues in conducting this style of work in the Yukon

Questions developed to guide the exploration of themes are provided in Appendix A.

Following feedback from, and reflection on, the first interview, I realized that asking first about the meaning of capacity building was not comfortable for participants and, for one person, led to the perception that I was looking for a particular response. To ensure greater comfort for participants, and to reduce the potential for responses to be skewed by trying to give me a particular response, I rearranged and refocused the questions to ask people about what they did in their work with Yukon College Public Health and Safety unit, the process or steps in that activity, the outcomes, the facilitators and hindrances to them in relation to the activity and, finally, if and how they saw that as capacity building. This order of questioning allowed people to move from describing their concrete activities to the observations that they had made in relation to those activities and then to their reflections on the concept of capacity building in relation to those activities. The interview questions thus moved from concrete to abstract concepts in a flow that I perceived to be a logical one for the participants and, I believe, facilitated their comfortable involvement in the interview. This shifted the focus of the interview such that participants discussed the process of outcomes of the activity in which they were involved rather than the process or outcomes of capacity building as such. From

my perception, interviews subsequent to the first one appeared to be more comfortable for participants, and for me. Findings reflect this shift in order and focus of the questions.

Participants consistently asked for an explanation or definition of capacity building before or during the interview. Prior to or during each interview, I responded to the question of what I meant by capacity building. The answer was not exactly the same in each case. An example of a recorded answer is provided below:

> Capacity building is something that I have got interested in because of its ability to help people influence the determinants of health for themselves. So it's something that's kind of an indirect consequence of some of the other kinds of health education activities or health promotion activities quite often. And it's because of that potential that it has to really have the sort of ripple effect of these other benefits that I'm interested in learning more about what happens when people like yourselves are actually instructing a program or organizing for it or seeing the outcomes of it, so that's what I'm wanting to talk with you about. (Horton, June 21, 2004)

The explanations that I provided were not notable for their consistency or coherence. They did constitute some direction in the interview, however, and likely influenced the responses to questions about the meaning of capacity building.

Data Analysis

Data analysis was undertaken in a series of stages. These stages align with classifications of data described by Sandelowski (2003), though the final stage was most consistent with the interpretive description approach described by Thorne et al. (1997, 2004). Sandelowski describes a typology of qualitative findings on a continuum, including no finding, topical survey, thematic survey, conceptual/thematic description and interpretive explanation. Though Sandelowski does not anticipate using the typology in an iterative way, such a progression occurred during data analysis. These stages are described below.

Initially, a thematic survey approach incorporated all data within a framework drawn mainly from Hawe et al. (1998, 2000) and included the categories of process, outcomes and

capacity building. Findings with respect to outcomes and capacity building were grouped into those that affect the individuals involved, those that affect others and those that affect the community. Consistent with the understanding of thematic surveys articulated by Sandelowski & Barroso (2003), themes or concepts from existing literature were used to label and organize the data.

A subsequent iteration of data analysis moved to differentiation of the data, within a framework that moved closer to the research question by exploring the meaning and experience of capacity building for participants. At this stage, the analysis remained strongly linked to themes of existing research on capacity building experience, interpreting data in relation to the activities described by Hawe et al. (2000), the actors and their purposes decribed by Labonte & Laverack (2001) and the approaches articulated by Crisp et al. (2000). Again corresponding with the typology of Sandelowski & Barroso (2003), this stage was one of conceptual or thematic description, interpreting data in relation to concepts developed by other researchers.

The final stage in data analysis was movement into interpretive explanation (Sandelowski, 2003, p. 914) or what Thorne et al. (1997) call interpretive description. Sandelwoski indicated in 2000 that qualitative descriptive studies are "less interpretive than 'interpretive description' in that they do not require researchers to move as far from or into their data" (p. 335). However, Sandelowski et al.'s (2003) later explication of interpretive explanation as "transformation of data to produce...fully integrated explanations of some phenomenon, event or case" (p. 914) is consistent with Thorne et al's (1997) understanding of interpretive description as an approach "grounded in an interpretive orientation that acknowledges the constructed and contextual nature" of experience (p. 172). The final stage

of data analysis involved a process of moving more deeply into the data, consistent with interpretive description described by Sandelowski (2000), and moving to interpretive description by "asking 'what is happening here?'" (Thorne et al., 2004, p. 14). The data were re-examined to identify patterns and themes to make sense of the most important ideas conveyed and to access their meaning in a new manner, consistent with the approach described by Thorne et al. (2004). At this stage, for instance, critical examination led to identifying the role of the health education workers as a finding of importance. Though drawing from the method of qualitative description articulated by Sandelowski et al. (2000, 2003), the final stage of data analysis was most closely aligned with interpretive description as described by Thorne et al. (1997, 2004). As Thorne et al. (2004) anticipate this analytic process was a challenge.

Interview recordings were transcribed verbatim and transcriptions studied to identify common themes. As described above, several iterations were required to identify the key themes emerging from the data. Initially, all interview material was included in the management of data. Gradually, the textual material was winnowed to include only the data that spoke most clearly to differentiated themes.

The data included in the findings are those that speak to the meaning and experience of capacity building for Yukon participants in this study. A sample of a data management table is included as Appendix B. The data are discussed in the sections on study findings.

Rigour

Rigour has been assured in several ways. One was by ensuring the adequacy of data by selecting participants by purposeful sampling from a number of different locations in the Yukon. A second was by careful documentation of the evidence and a third by drawing on an

earlier study for purposes of comparison and verification (Morse, 1994). I also needed to

take steps to ensure that the perspective of participants was reflected in the findings. As a

long-time member of the Yukon community and a community health practitioner, I share

some experience, knowledge and assumptions with research participants. This perspective

has contributed to my ability to understand their experience, though there has also been

potential for this to hamper my objectivity, for instance, by limiting my conscious awareness

of assumptions behind the words used to describe experience. Several approaches have been

used to balance this embedded perspective and to ensure authenticity. First, I have engaged

in critical self-reflection to identify assumptions and/or other blind spots, using journal

keeping as an aid to the reflective process. A second approach has been to request all

participants to review interpretation of data with respect to their quotations. A third approach

has been iterative review of research findings and conclusions by thesis committee members

for the purpose of identifying assumptions and/or blind spots. Most frequently, changes have

been made to be explicit about, rather than assume knowledge of, the experience of Yukon

life. Rigour has thus been assured through study design and methods and by taking deliberate

steps to balance my embedded perspective.

Ethics

In addressing ethical questions, it was necessary to consider my own place within the

Yukon community. Politics was an element of this research in terms of personal and

positional relationships, and the corporate powers and policies of the Government of Yukon

(Punch, 1994). As an employee of the Department of Health and Social Services,

Government of Yukon, I am obliged to refrain from publicly criticizing policies on which I

may have influence from within government. As a member of the Whitehorse and Yukon

communities, I have established relationships and a need to maintain the integrity of both present and future relationships. As a student exploring issues related to community health with academic honesty, this presented a challenge. Having multiple roles imposes constraints requiring particular attention to ethical issues that go beyond that which might be required for a researcher with a less complex relationship with her community. Undertaking research despite such constraints may contribute to moving towards critical assessment and debate within the Yukon community.

Ethical issues were addressed by careful research design, by addressing consent issues, by assuring confidentiality of findings and by considering ongoing relationships with participants. These issues are discussed below.

Research design

Care was taken to design a research project that would allow meaningful exploration of a question of importance with a group of community health practitioners who are working at arm's length from my area of employment. It is acknowledged that the concern with loyalty to workplace ethics reflects power relationships within the Yukon civil service and could be seen as a limitation on academic independence. In undertaking analysis of findings and drawing conclusions, academic freedom to advance knowledge was balanced with accountability within the context in which the research was undertaken (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 2005). Although the subject of the study is relevant to my work in the public service, and may be applied in that context, the research was undertaken in such a way that it was clearly separate from work activity.

Analysis focuses on issues rather than specific organizations. Capacity building knowledge has been gained while maintaining both academic integrity and respect for my employer.

Consent

Participant consent was gained at two stages, at the time of the initial interview and on review of the quotations used, with the accompanying interpretation of findings. Written consent was obtained from each participant at the time of the interview. Once findings had been written, I sent their quotes and my interpretation of their words to each participant, asking each person to let me know if they agreed to my use of their words with the interpretation as written. All participants confirmed their consent to be quoted though, in some cases, they requested amendment to the quotations to correct grammar or clarify meaning. These amendments have been accepted, albeit with some reluctance on my part because of the slight change in voice of participants. The amendments have changed words from the way they were spoken to a more correct and formal construction. As a person who rarely speaks coherently, I appreciate and accept the desire to make such changes, though I regret the loss of the participant's original words. In no cases were changes to the interpretation requested, or required, as a result of the amendments. This process has enabled the participants to be informed and to provide consent at two stages.

As unit employees were asked by their manager to participate rather than being selected through random draw, a certain hesitancy to answer questions during the interview raised my concern that individuals may have felt pressured to participate. A post-interview discussion led me to believe that the hesitancy arose from confusion about what I was asking rather than from pressure to participate. Any unacknowledged pressure to participate, was balanced by the opportunity for each individual to withdraw consent at any time, should they

so choose, and by the second request for consent. If there was initial pressure to participate, the pressure was ameliorated by the post-interview discussion and consent process.

Confidentiality

Anonymity could not be guaranteed to participants; however, confidentiality beyond the interview groups has been assured. Neither participant nor community identities have been revealed in reporting the findings in order to ensure that participant identities are not revealed directly or indirectly. Although the assurance that individual and community identity would be treated as confidential, not all participants wanted this assurance. One participant noted her pride in the work she does and indicated that I could openly use her name and community. The assurance of confidentiality was considered to be of importance in order to facilitate participant ability to speak freely without concern that this would be seen as disloyalty to the organization. In this respect, health education workers, when discussing their work experience, could risk censure and, in light of this risk, the proposed precautions with respect to consent and confidentiality in reporting findings were consistent with ethical principles guiding research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 2005). In a population as small as the Yukon, revealing identity of participants could inadvertently reveal the identities of people to whom participants referred. The latter group would not have opportunity to provide consent to such disclosure. The limitation on reporting on specific community details was required to respect the professional, organizational and ethical constraints on the participants and on the researcher.

Ongoing relationships

An important ethical matter to be considered was the nature of my relationship with the research participants. Although I did not know all of the participants prior to the interviews, I did have established relationships with some through work or other interests. Although these relationships may have contributed to my ability to gain access and acceptance among participants (Punch, 1994), there was risk that the nature of my existing relationships could constrain the rigour of analysis. I am not involved in direct supervisory relationships with any of the participants, nor am I able to exercise independent power in their interest or that of their program with respect to allocation of financial or other resources. I am, however, able to exercise influence over allocation of resources that may benefit their programs. A more subtle consideration is that of honouring mutual trust in present and future relationships. This trust was respected by being very clear about the intent of the research and the questions that were to be posed prior to obtaining participant consent and by offering potential participants freedom to accept or decline the request to participate. Before and after interviews, assurance was offered that information about programs and participants would be held in confidence, as has been mentioned. Participants were also assured that research analysis would be thoughtful, honest and considerate of the implications of their involvement in the project (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 2005; Punch, 1994). As mentioned previously, participants were provided with the opportunity to comment on the analysis associated with quotations used from them as a way

of ensuring their comfort with the interpretation given to their words. The ongoing

relationship that I may have with participants has been respected in several ways.

Ethical considerations have been addressed through attention to study design,

addressing consent issues, assurance of confidentiality of findings and attention to respect for

ongoing relationships with participants.

Conclusion

The methodology was designed to ensure that the research could contribute to the

body of knowledge about the meaning and experience of capacity building in general, and

particularly about that meaning and experience in the context of the Yukon. The participant

group was chosen because of their experience in capacity building work throughout the

Yukon in association with an organization to which the researcher was able to gain access

without being compromised by conflict of interest concerns. Data collection methods were

adapted to the circumstances presented by the situation. Rigour has been assured through the

design and systematic approaches to authentication of analysis. Ethical issues have been

addressed, with particular consideration of issues arising from undertaking research as a

member of a relatively small population center, where confidentiality issues, multiple roles

played by individuals in relation to the community and ongoing relationships are all relevant.

Implementing this methodology has generated new knowledge about capacity building,

reported in the following chapters.

CHAPTER FOUR

A bud opening in the sunshine: The meaning of capacity building

Introduction

The intent of the research has been to learn about the meaning and experience of

capacity building by health education workers in the Yukon. Workers were asked to describe

the process of undertaking an activity, what helps and hinders that process, what they saw as

the outcomes of their work and whether and how they saw capacity building as being part of

their work. In responding, participants spoke of their successes, their challenges and the joys

they have found in their work. It is my regret that all of the wisdom they imparted cannot be

recorded here. In all interviews, participants asked for an explanation of what I meant by

capacity building. With a brief explanation of capacity building, for instance, as "one of the

things that happens as part of a health education or health promotion activity…with indirect

effects that are beyond the activity themselves and that have the potential to influence

determinants of health", participants responded with interest and insight to the questions

about it, based on their thoughts, observations and experience. Meaning is understood as the

significance ascribed to activity, while experience is understood as knowledge arising from

observation or practical acquaintance (Canadian Oxford Dictionary, 1998). Findings about

the meaning of capacity building are discussed in this chapter, followed by chapters on

participant experience and observations in the Yukon context.

Role of the organization

The role of the Yukon College Public Health and Safety (YCPHS) organization was

not explored directly in questions to participants, but emerged in the course of interviews. As

the organizational role is germane to the findings, a brief discussion of that role is useful to set the findings in context. Prior to undertaking the interview, the employee members of this group identified themselves as taking a capacity building approach to their work. Staff from the YCPHS organization were among the participants interviewed for the study; their roles encompass both organizational and instructional work making it difficult to distinguish between the organizational and front-line roles, and impossible to do so while respecting the confidentiality of participants. The organizational role was identified as one of facilitation and support for the activities of the health education workers.

An example of how the organization facilitates capacity building is in the development of the network of instructors, as described by one participant:

> (In) 1996 or 1998, the College said, "Why won't you teach first aid?" And I said, "Well, I can't because you have to be an instructor." "So, we'll pay for you to be an instructor." So, the College asked me to be an instructor so that's when I started actually teaching for Yukon College Public Health and Safety. (5A)

The organization is actively involved in recruiting people to become instructors and in providing support for them to do so. In doing this facilitation work, the organization acts as a catalyst to enable the instructors to apply their skills in instruction in their communities.

The organization also supports the health education workers in undertaking their activity. Many participants described how such organizational support was seen as helpful to them. One participant described the many aspects of organizational support in these words:

> It's definitely easy to do.... They're very well organized in the office. They have everything set up. They're very accommodating for people, when people call on the spur of the moment. They try and find instructors. They always have the equipment ready for you. They have all the forms in place. I guess one of the things that they just did recently that was a big help is they did like a, what they called a Red Cross symposium, which was sort of like a professional development type day, and that was very helpful. It was a little bit inspiring because it got you together with people and ... brought some speakers in with some current sort of information and things, and

that type of thing I think is very valuable because sometimes you can feel very isolated teaching. (4A)

The support includes the organization and provision of resources such as instructors, equipment and administrative management. It also includes professional development opportunities that enable both ongoing learning and the opportunity to be together with other people with similar interests and experience.

One theme to be explored in the research study was the facilitators, dilemmas, and issues for workers in capacity building. When the order of questions was changed to move from describing the process to reflections of capacity building, the questions related to this theme were changed, such that participants were asked what helped and hindered them in their work, rather than what helped or hindered capacity building. With the questions worded in relation to their work, the responses were not specific to the experience of capacity building and, as such, have not been explicitly reported in the study findings.

The study focuses on capacity building from the perspective of health education workers, but the organizational context within which this group works is part of the complete picture of the capacity building work. It is in order to paint the full picture that the organizational role has been discussed preparatory to presentation of other findings.

Meaning of Capacity Building

The meaning of capacity building was sometimes expressed in conceptual terms and sometimes expressed as reflections by participants on the significance of their activity. The themes that emerged were that capacity building meant building on strengths, building on opportunities, empowerment, and relationships beyond the individual. The themes, often intertwined with each other, are described in this section.

Building on strength

For participants, building on strengths means helping people to develop their existing

abilities and potential to achieve new knowledge and skills. Participants indicated that there

is potential for everyone to build capacity in their own lives and that this occurred through

building on the strengths within that person. For participants, building on strengths means

that there must be belief that strengths exist, as abilities and potential for achievement, and

that there must be recognition of the strengths and a response to their existence. These

elements of belief, recognition and response are discussed here.

Building on strengths starts from the belief that strengths exist. Although many

participants implied this belief, the belief was made explicit in the statement below:

> I think there's almost an unwritten philosophy in the department and from how I see it
> is, number one is respect for every individual and every individual's ability to build
> their own capacity, and in doing so, to increase the capacity built around them, be it
> Faro, you know, in their own community or all the way up to the national and when
> we talk about Red Cross, I say that's an example of international contacts and ability
> to influence. (1E)

The participant clearly expresses her foundational belief that every individual has ability to

build their own capacity and that of the people around them. The participant also identifies

the interrelationships linking individual to collective capacity that can reach beyond the

individual as far as influence on international activity. A basic element of building on

strengths is the belief that there are strengths in every individual on which to build.

In order to act on the belief that every individual has strengths on which to build,

there must be recognition of strengths when they exist. Thus, part of the meaning of building

on strengths requires understanding the strengths that people have. One participant

illustrated this understanding when she identified the strength of self-reliance among the

people with whom she works:

> And they're very reliant people on themselves. They like to take care of themselves,
> so you give them the knowledge, and it's there. (5A, amended)

Without the understanding on the part of the participant, there would be no recognition of the

strengths that exist, and therefore, no ability to respond to the strengths. The participant links

learning with empowerment, seeing that knowledge enables people to increase their self-

reliance. Recognizing strengths is essential to being able to build on those strengths.

In addition to believing in and recognizing strengths, building on strengths means

being able to respond to the strengths that exist. One participant identified the existing

knowledge of people she worked with as a strength on which she builds in working with

them. In this case, the knowledge of anatomy and physiology that comes from the

experience of hunting is transferred into the experience of learning first aid.

> ... when we go over anatomy and physiology, I try to make it relevant to what the
> students had experienced. Most of the participating students have been hunting so
> they know from cutting the moose where the heart is; they know where the lungs are.
> This makes them relate to what is being taught and that makes them feel good
> because they know something.
>   And this is the teaching method that we like to apply by incorporating the
> practical skill and knowledge of the participants. Just because the student may have
> difficulty in reading or difficulty with math, he or she may have other knowledge that
> I'm sure he or she is pretty good at, so let's just work on those strengths and steer in
> that direction. (2A, amended)

Embedded in this statement is the participant's understanding that the people with whom she

works may not always have experienced success in learning, for instance, in reading or math.

So also, is the participants' understanding of the kind of knowledge that the students do have

that comes from her awareness of the lives and lifestyles of the people in that community. In

describing her approach to teaching, the participant indicates her belief that her students have

strengths, her recognition of the strengths that they have and her response of teaching in a way that can help the students learn from those strengths. The participant builds on opportunity as well as on strength by building on success in one area of an individual's life to achieve success in another. The meaning of building on strengths is put into practice by responding to the strength of knowledge from one area, hunting, to build knowledge in another area, first aid.

In speaking about the meaning of capacity building, participants identified building on strengths as one theme, linked with the themes of building on opportunities, empowerment and interrelationships. Building on strengths means that there is respect for individuals and the strengths they bring to a situation, that there is awareness of the strengths that exist to build upon and that there is a response to support the existing strengths. Participants are aware of the strengths and able to recognize them because of their understanding of the people with whom they work. Responding to the strengths means assisting students to apply the knowledge and abilities that they have in one area of life to learning in a different area. The elements of belief, recognition and response are elements of the theme of building on strengths within the meaning of capacity building.

Building on opportunity

Participants indicated that building on opportunities meant responding to chances to achieve a goal when such possibilities arise. Participants indicated that building on opportunities is part of the meaning of capacity building. Implicit within the idea of building on opportunities is the intent of doing so to a particular end, that is, an opportunity is used to achieve a vision for improvement in some aspect of community life. Building on opportunities may mean expanding the range of groups to whom participants offer a learning

or development experience in a community, or using success in one area to achieve success in another, at both individual and community levels. These elements of building on opportunity are not exclusive of each other. The words of the participants indicate how they understand building on opportunities as part of the meaning of capacity building.

Participants indicated that building on opportunity could mean expanding the range of groups to whom a learning or development experience is offered in the community. Several participants told of identifying and acting on opportunities that present themselves. In the example below, the participant originally taught first aid only to people providing volunteer emergency services in the community. This led to other opportunities:

> And then if there is an interest shown by people in the community, I'll teach courses. So I started including or making them open to people in the community because it's obviously a community oriented organization and we've got more people taking it who are not active volunteers (in emergency services) who take it because they want to learn. And then I had a request last year to teach some courses for child/infant first aid and CPR. We had all of a sudden a whole bunch of kids arrive out here and concerned parents who know we'll get there when they call us (i.e. ambulance) but to be able to take care of their kids at home before we get there or do things that they don't have to call the ambulance for. (8A)

The participant identified and acted on interest that was expressed in the community by making first aid classes available to a wider group of community members than he had taught initially. In taking advantage of the opportunity to expand the range of people in the community to whom first aid instruction was made available, the participant helped individuals become more able to cope on their own in emergencies, thus becoming empowered through greater self-reliance. This example illustrates that building on opportunity to achieve an end is part of the meaning of capacity building.

Participants indicated that an aspect of building on opportunities means building on previous success. One example given above described building on one area of knowledge

(hunting) to apply in another area (first aid). Building on previous success may also mean expanding from one to several locations, as described below:

> I work with Yukon Food for Learning, which supports nutrition programs for all the schools in the Yukon. … It started off with just Whitehorse Elementary School and now we have a program in almost all of the Yukon schools, just two more to go. (1D)

This example illustrates that programs do not need to be established on a universal basis available to an entire population in the beginning. By expanding the Food for Learning program, better nutrition has steadily become accessible to more school children. Participants indicated that success in one area helps to achieve success in another, illustrating the meaning of building on opportunity as an element of capacity building.

Building on opportunities is predicated on having knowledge of what and where opportunities might exist and on seeing possibilities for achieving a desired end. One participant built on the opportunity to expand first aid programming to empower people to become more self-reliant and one person steadily expanded the scope of a school nutrition program. Building on opportunities may start with a participant offering a program to a new group or expanding to new locations based on success in one place. For participants, building on opportunities means that they are sufficiently aware of themselves and their communities to be able to identify when there is potential to take action that could lead to an end that matters to them and to take that action.

Empowerment

To empower is defined by the Canadian Oxford Dictionary (1998) as to "provide with the means or opportunity necessary for independence and self-assertion", to "make able" or "to give power to" (p.458). Empowerment is defined as "the means by which people experience more control over decisions that influence their health and lives" (Laverack &

Labonte, 2000, p. 255). Empowerment can occur at individual, organizational and community levels, with individual empowerment being "people's self-efficacy and control in their lives" (Wallerstein, 2006, p.18). Participants expressed ideas about individual empowerment in terms that indicated understanding it as a bottom-up process of enabling others rather than a top-down one of giving power, an understanding that aligns most closely with the Laverack and Labonte definition of the term. For instance, participants described empowerment as providing the means for people to achieve independence or self-sufficiency. Several participants spoke of the work of enabling people to become more self-reliant or more able in their own lives, speaking of empowerment without giving it that name. In one discussion, empowerment was the word used by participants to give meaning to the values of reduced reliance on resources from outside the Yukon and of gaining knowledge or skills for personal change. As one person described her experience, another person in the group gave that experience the name 'empowerment' and identified what made it that.

> So I just had a thought I just wanted to comment on because, thinking about the Advanced course that I teach, that it used to be that the students that take that course used to have to access that course outside the Yukon or we had to bring instructors up from outside the Yukon, so what I have heard since we've been teaching that course here is that certainly there are students now that come back to take it or look forward to taking it in the Yukon with local instructors who can understand how things are in the Yukon, or how things are in rural Yukon, what resources you have to respond to things, and I think that's a positive thing, too, that they're here rather than going off to the large city centre where they have, you know, there you call the cardiologist, you call the neurologist, and we don't have that so we have to build our course to how you would deal with things with what we have here right now and I think that's been a good thing. And I would agree with (another participant) in that, yeah, it's often with my students, too, we talk about risk factors because certainly we see people at risk every day but you often forget about your own health and what we can do to improve our health as well. So I think that certainly becomes aware in the course. (9A)

> Both of those things are really empowering, too. At the local level to realize that ... (a) you don't have to depend on outside resources or, (b) that you can change your life if you do things. There's a real empowerment focus that can happen in both those factors. (9B)

Empowerment was articulated by this participant as enabling reduced dependency on resources outside the Yukon and providing the means to improve personal health. Reducing dependency on resources from outside the Yukon means that there is increase in self-reliance within the Yukon and, at the same time, an increase in the relevance of the teaching because it is based on 'how things are in the Yukon'. Increasing the knowledge of what can be done to improve personal health means that people have greater opportunity to be independent in self-care. Empowerment as providing the means for people to become more able to be independent was given specific meaning in the areas of self-reliance and self-care.

The concept of empowerment as an element of capacity building was sometimes described without being named. The idea of people expanding, expressed below, is consistent with the meaning of empowerment as enabling or giving power to people.

> when I think of capacity building... I think of people sort of expanding... To me, capacity is about skills and knowledge and how you use those things in the community and hopefully when somebody goes through a first aid course, it's not just what to do in an emergency but it's a whole, everything that goes along with that. (4A)

In speaking of people expanding, the participant indicated her understanding of empowerment as including new skills and knowledge, but extending beyond the specific skills and knowledge to 'everything that goes along with that'. The concept of empowerment, whether or not it was named as such, was identified as an element of capacity building. For the participants, empowerment meant enabling people to achieve greater independence in self-reliance or self-care and in helping people expand beyond the specific skills being taught.

Having effect beyond the individual

The idea of empowerment as people expanding within themselves and in relation to

their community provides a natural transition to the idea that capacity building means starting

with an individual but having effect beyond that individual. For participants, relationships

beyond the individual mean that the increased knowledge, skills, and abilities achieved by an

individual have effect beyond the individual. Participants observed that the effect of their

work extends beyond individuals to their influence on families and communities and beyond

specific knowledge and skills to influence on other sectors of the community. Sometimes

the extent of the interrelationships cannot be known. One person spoke of the

interrelationships metaphorically when she compared the individual to a closed bud:

> And I think that one thing leads on to another, so the bud gradually opens up to more
> sunshine, with the result that he or she feels better about himself or herself, and that
> hopefully gets passed on towards the family and benefiting the family members as
> well. (2A, amended)

The relationships beyond the individual are tied to the learning that an individual has

acquired but extend beyond the individual in their influence on family and community.

Some participants noted building in one part of community life contributes to

increased capacity in other areas. One participant described the intertwined nature of effects

of different sectors within a community.

> And that's the whole thing though about capacity is that it's really hard to take it out
> and put it into one discipline because there's so many things that are intertwined and
> interlaced …. I think that everything sort of ties in and, for example, like in (a Yukon
> community) for example, if the community can build, like the health affects the
> economy which affects the social structure which affects the ability to go to school
> and learn things and everything, like you can't take one thing out and look at it on its
> own because one thing affects all the other things that are there…It ties together.
> (4A)

Relationships beyond the individual include influence in different sectors or disciplines of community life in a way that 'ties together', including health, economy and social structure.

Some participants indicated that the interrelationships of capacity building are not necessarily something that they are able to know. One participant described this as a ripple effect, starting with specific skills but going beyond those skills:

> I think any kind of learning has a ripple effect. It's obviously indirect. You're probably not going to notice it in many cases. But everybody is so interlinked and inter-related in so many ways that we don't even know about, it's got to. Again, I teach first aid so people know what to do, it's perhaps not only you're helping the people when they have to deal with a first aid situation but you might be helping someone who's travelling with that person. I mean everything is interrelated, my goodness. Not just even the specific skills but everything around it. (10A)

For this participant, the expansion of influence beyond the individual is not just about applying a skill, but about increasing knowledge and ability that has an effect on others in ways that cannot be known.

Although tied to learning specific skills, participants noticed that part of the meaning of capacity building is the interrelationship between the skills gained by an individual and the effects beyond that individual. Building individual capacity ripples out to building community capacity such that the individual and community cannot be separated from each other. Effects ripple from the individual to the family and community, from one discipline or area of community life to another and to areas of life that are interlinked and intertwined within and beyond the knowledge of participants.

Conclusion

The meaning of capacity building articulated in this section is grounded in the Yukon experience and the understanding that the participants have of that experience. Based on their words, capacity building has meaning with respect to building on strengths and

opportunities in the Yukon context, to empowerment, and to relationships beyond an individual. Building capacity is predicated on the participants' ability to recognize and act on strengths and opportunities to build their own capacity and that of the people in the communities around them. Empowerment can mean enabling people to increase independence, for instance, by reducing their reliance on outside resources or by gaining the tools for better self-care. The concept of empowerment was illustrated in experience such as expanding to school nutrition programs, making learning opportunities accessible to fellow ambulance service members, or enabling parents to be more skilled and confident in caring for their children. In articulating the meaning of capacity building, participants consistently spoke of individual learning that had effect beyond that individual in the communities of which they are part. This is an important insight into the link between the ideas of individual capacity building and community capacity building. Yukon participants indicate that the link is made through the work of individuals who have gained knowledge and skills by building on strengths and opportunities, have been empowered through that experience and through that empowerment have the potential to have impact on the broader community.

Most participants did not have an established idea of the meaning of capacity building at the outset of the interviews. However, after a brief explanation of the concept, participants described their thoughts and practice in ways such that the meaning of capacity building became clear. Thus, one conclusion that became apparent was that a conceptual understanding of capacity building was not required as a precursor to capacity building practice. Capacity building practice in the Yukon context is described in the following chapter.

The meaning of capacity building is multi-faceted, in the experience of participants. It stems from a belief that every one has capacity to build, and is fuelled by a vision that some aspect of life can be improved for individuals and for communities. Capacity building means building on strengths and building on opportunities, it means empowering people to expand in their lives and it means impacts that include effects on individuals but go beyond individual to influence families and communities, in ways that are sometimes known and sometimes far beyond what we can know. Capacity building means a bud opening in the sunshine.

CHAPTER FIVE

Working together: Process and role of health education worker

The understanding of capacity building developed for most participants from their experience of teaching first aid classes. Their understanding evolved from the observations and practical acquaintance with capacity building that they made in the course of that experience. Four main themes emerged in the experience described by participants. One was the process involved in undertaking an activity. A second was the role of the health education worker, a role that is at the heart of the experience of capacity building. A third theme was the relevance of the Yukon context in the experience. The final theme was the effect or outcomes of the teaching, including but going beyond the skills taught. The themes about process and role of the health education worker are discussed in this chapter, followed by discussion of contextual factors and effects of capacity building in Chapter Six.

Process

Participants were asked to respond to a question about the process or steps that they go through in undertaking an activity. The steps identified in the process included initiating activity, organizing program delivery and teaching the courses. The teaching process included advance preparation and adjusting to the needs of the group. Some participants were involved only in teaching, while others were involved in all steps of the process. Participant responses to the questions about process are provided in this section.

Initiating activity

A part of the process in undertaking an activity is initiating it. One story told by a

participant who became a first aid instructor illustrates the complexity involved in initiating

an activity. The community did not have ambulance service at the time that her story started.

> So, her and I talked and I said, "Why don't we do a first aid program?"
> Well, she looked at me and said, "Well, it's been done before."
> "Oh." I didn't know the history so then I started talking to a couple of people and
> they said "Yes, it's been done but they (the instructors) won't come out here
> anymore"
> I said, "What do you mean they won't come out here?"
> "Well, people won't show up."
> So I called them (i.e. Yukon College) and I said, "What's the problem?"
> And they said "Well, they've come out about five times, nobody has shown up for the
> class or one person has shown up late... so we're just not going to put the money into
> it"...
> So (the other community person) and I sat down and said "Well, why aren't people
> showing up?" So we had a good conversation about what she thought the issues
> were. She said, "Well, it's early in the morning". It was in the wintertime, right.
> People ... at that time had very little running water, had wood stoves, so by the time
> you got your kids up, breakfast made, it's ten o'clock. You're supposed to be at a
> course at 8:30 in the morning because the instructors come out and they have their set
> hours and they have to get you into that little notch. And so, then she said, "the other
> thing is, then if they rush, they haven't eaten, so they're tired and they're hungry."
> So I made breakfast and she went and got everybody out and the instructor came and
> did the course. We had 14 people...And 14 people passed and we got our ambulance
> crew and our ambulance, right like that.
> This was the first community development project that I was active in and was
> successful - it taught me a lot. We worked together and achieved what we wanted to.
> ...We had to get that ambulance crew going because they wouldn't give us an
> ambulance. (5A, amended)

The story provides a rich illustration of the process of initiating activity within a community.

An idea, what some would call a vision, to have a first aid program in the community was

identified and discussed with another person in the community. However, a problem in

implementing that idea was identified, based on previous experience. Together the two

people identified a possible solution to the problem. They talked with people and learned

more about the previous experience in that community. They tried to figure out the factors

that had prevented the activity from being successful in the past and found ways to address those factors. They accomplished something for and with the community that enhanced community self-sufficiency by getting an ambulance service started. The story illustrates how complex it is to initiate activity in a community, the teamwork required, the value of inside knowledge of the community, as well as the need for outside resources and the ability to mobilize those on behalf of the community. The story also illustrates the very tangible benefit that can be gained from such activity. Within this story, there is a vision that things could be improved and a description of the process involved in bringing that vision to reality. The story is an examplar, not just of the complexity of work involved in initiating an activity, but also of the role played by the participant in doing so.

Organizing program delivery

Network members identified steps in undertaking an activity that were specific to organizing program delivery. These steps included planning and scheduling the courses to be offered, communicating about and preparing for the activity, as described below:

> In the old days, we used to advertise the courses and say that once the course was full, we would proceed with it, but we found that this method was not really very efficient, so we pre-set a timetable for the courses when they were going to happen. As a result come September I would have a list made up right until June of when and what courses are going to be, what the cost is, what is the maximum/minimum number of students in it and how long the course is going to be. This gets posted around the community, plus it gets faxed to every organization we can possibly think of in (the community). We also advertise this to (a nearby community)… and the schools, the teachers. Also word-of-mouth is very effective because people don't look at posters…. we have a sheet where people come and register and we just add the names to the list and … We then get an instructor organized, let him or her know that the course is happening, and we get everything ready for the instructor. All the supplies and training materials are in the College, so we don't have to bring anything in, and we are ready to proceed with the course. (2A amended)

> And the other thing in the small communities, they're very spontaneous about when they need things. …So if something comes up in November that this group is being started, but they all have to have first aid, well they can call on the local instructor,

where if they have to bring somebody up from Whitehorse, whose time is booked for the next three months, you can't adapt. (5A)

The participants indicated that program delivery was modified over time in response to lessons learned about what is effective. The specific logistics may vary for different groups, but the steps are essentially the same; planning for delivery of programs occurs according to the needs of the community, communication with key persons occurs and the space, instruction and equipment is organized for program delivery. Knowledge of the community is revealed in these accounts, including the knowledge of what will effectively enable program delivery in a community. Planning for program delivery requires awareness of and ability to mobilize the resources in the way required to achieve success in that community.

Teaching

Teaching was identified as part of the process of undertaking an activity. Standardization of the Red Cross curriculum limits ability to modify first aid course content, but there is enough flexibility that participants put their own stamp on program delivery. Participants described the teaching process in terms of advance preparation and of adjusting to the needs that arise when instruction is in progress. These findings are presented here.

A number of participants spoke of their advance preparations for teaching, including preparing for their audience, augmenting their teaching resources and adjusting class size. In the examples below, participants describe how they make these advance preparations:

> And the first thing that I need to know is who am I instructing ... if you're dealing with a group of teenagers, or if you're dealing with Parks Canada who's back for their recertification every single year, you've got to really approach it with a little bit of a different manner. So you need to know who your audience is. (6A)

> ... it's our job to have our teaching resources together ... that's something that I think we all build over time and add to and it evolves. (3D)

And also the nice thing is that I can keep the class size small here because I'll just do it several times and include everybody by the time it's over. And so you don't have these big classes where people get bored and fall asleep. (8A)

Advance preparation for teaching is not unique to first aid instruction; it does, however,

facilitate the interaction between the participant, working as a health educator, and other

members of the community. The interaction in the teaching setting is personal; participants

indicate that this is apparent to them in planning for the size of the group, anticipating the

prior knowledge and interests of the group and preparing relevant course materials. Advance

preparation is an aspect of the teaching involved in undertaking an activity.

A number of participants indicated that their teaching approach varies according to

the needs of the group being taught. In these instances, the instructors respond to the

circumstances that emerge while they are teaching. Adaptation to the needs of a group being

taught often requires an immediacy of response to a situation that arises in the class setting:

> There's a lot of extra time put in, because of, I'd say, literacy issues within the community and within the people in the group. Or fright issues. People get nervous about performing in front of other people so if I think that they can do it, I just say, "Well, why don't you and I do it later after the class. You just stay later and I'll go through it with you", something like that. Because there are people that just can't "perform" in front of others when they are learning things for the first time – I am one of them. (5A, amended)

> And of course every group's different so the way you might explain one thing might be completely different with one group as compared to another. Or the gender makeup of the group, for example, with some groups where it's primarily women, we have a lot more discussion about women and heart disease, because of more recent findings and things like that. If there's more people who are parents, we might talk about more things pertinent to children.... I have my lesson plans. I have my teaching aids, my activities, everything all laid out. But I try and read the group, so that if something that's of interest comes up that you can divert and sidetrack for awhile and then still come back and make sure that you cover the core material." (4A)

> Sometimes it's the buddy system. You take somebody with more experience and put them with somebody with less experience. Because our program takes more days, more hours, to deliver, we have an opportunity of taking somebody who's got absolutely no experience and we can buddy them up with ten people over the period

of the time that they've got there. So they end up being able almost osmotically to be
able to kind of pull in the knowledge that these other people have got. (6B)

The examples above indicate that participants modify their teaching approach according to

learning needs of participants, according to the interests of the group, and according to

learning styles, often with recognition of the strengths that people bring to a particular way of

learning. The examples illustrate that there is value seen in teaching in ways that involve

hearing, seeing and doing in order to facilitate learning in different ways. As in advance

preparation, responding to the needs that arise in the teaching setting involves personal

interaction, but in a way that must be accommodated as a need arises. The examples indicate

that the participants are attuned to the needs that arise in the instructional setting and are

adept at making adjustments to meet these needs using the resources available. Participants

enable achievement for the people they are teaching, in part because of understanding and

adapting to the needs that those people present during the instructional experience. Adjusting

to the needs of the group is part of the teaching process.

Participants described their activity as including initiating activity, organizing

program delivery and teaching courses. In some cases, initiation and organization was done

by others within the organization, with participants involved only in the teaching; in other

cases, participants are involved multiple aspects of the process. In their teaching activity,

participants described their advance preparations and their adjustment to the needs of the

group according to the issues that arise while a course is in progress, taking advantage of the

interest, knowledge and strengths of the people being taught. The activity in which

participants are engaged includes multiple aspects of program initiation and delivery.

Role of health education workers

In describing the process of capacity building in the Yukon, participants identified the pivotal role played by the health education workers. This was not something to which the participants drew attention; they were not seeking or claiming credit for things that had been accomplished. However, it was apparent from the stories that were told that the role played by them was an essential element in the things that were accomplished. Six areas were identified in which the health education work role is played. These areas are initiating activity, building their own capacity, enabling achievement, understanding the meaning of experiences for those with whom they work, building relationships and a final area that I have called living in relationship with community. These six aspects of the health education worker role are discussed in this section.

Prior to undertaking this discussion, it is important to clarify that the roles played by participants occur within a context of organizational support, described in Chapter 4. Embedded in the experience of capacity building for the participants is the opportunity that is provided to them to develop skills, pursue interests, gain confidence in their abilities and to receive support in providing service in their communities. Staff from the YCPHS organization were among the participants interviewed for the study; their roles encompass both organizational and instructional work making it difficult to distinguish between the organizational and front-line roles, and impossible to do so while respecting the confidentiality of participants. Although the differentiated roles of the organization and health education workers have not been pursued in this study, opportunities and support are provided to the health education workers by the Yukon College Public Health and Safety (YCPHS) organization.

Initiating activity

The participants, in their role as health education workers, frequently initiate activity in their community. One participant made this observation:

> The instructors are not always waiting for us to offer them programs. They come and they want to be doing things, different things, like they know they will receive support. Like they're not, you know, sometimes people will sit and wait. OK, what's going to happen next? But they will come forward and they have these ideas that they would like to start themselves and receive the support for it. (1C)

It was clear to this participant that many of the health education workers are involved in initiating activity. As discussed in the process section, initiating an activity can be a complex process that involves many components. The story of initiating a first aid program in a community in order to obtain community ambulance service illustrated this complexity. In initiating the activity, the participant started with an idea that something in her community could be improved, built relationships within and beyond her community, learned from previous experience and secured the necessary resources to undertake the activity. She developed an understanding of community circumstances and learned how to work with those to enable achievement and to empower community to achieve greater self-sufficiency. Through her work, she created opportunity that did not previously exist in the community.

In other situations, initiating an activity may be more straightforward, as described by this participant:

> I am a long-term ambulance attendant on the (community) ambulance.... And when it came to recertifying our first aid or CPR, it was always quite a hassle to get someone up to teach us. So, an opportunity presented itself (to become an instructor) and I grabbed it. ... it's mostly for in-house, our own ambulance crew....I've also done it for the RCMP and I've done it for the highways crew this spring. Teaching first aid courses here in (the community), just to make it a little easier. But mostly for emergency services. (10A)

This participant had a goal to improve life in her community, that is, to provide better access to first aid instruction for the emergency services providers. She recognized that she could do something to achieve that goal, took advantage of an opportunity to gain instruction skills and put her new skill to use in providing instruction in her community. The participant took advantage of an opportunity to build her own capacity, the means by which she was able to bring her idea to fruition. In both examples, participants identified a vision or end that they hoped to achieve and a process for achieving that end. In both cases, the end achieved was in the interests of the larger community. In initiating activity, the participants enabled capacity building in the community through their own actions.

Building own capacity

As mentioned above, participants may take opportunities to build their own capacity as a step to providing an opportunity to build capacity in their communities. Many participants spoke of their own development in becoming a first aid instructor. Consistently, their intent was to use their own increased capacity to build capacity in their community. The following story illustrates this pattern:

> I originally joined because we need ongoing training here ... and it was very difficult time-wise for people to go to town to get the training. When I joined four years ago we just did not have adequate training. No one was up to date in first aid, CPR. And I was approached by someone. I can't remember who approached me, and (I) took the course three years ago at the College to become a certified instructor. (8A)

In the example given, the need for community first aid instruction was seen, a way of addressing the need was identified to the participant, and the participant responded by becoming qualified to provide instruction. Although this story is told to illustrate how participants take advantage of opportunity to build their individual capacity as a step to building community capacity, it also shows the elements of initiating an activity that were

discussed above. The lived experience of initiating activity and building their own capacity

is integrated for participants, one activity does not necessarily stand in isolation from other

activities. Development of skill and ability is based on an individual's own interest and on

the opportunities that enable them to progress in pursuing their interests. The words of

participants reflect an interest in and commitment to community interests evidenced by their

decisions to accept opportunities to build their own capacity in the interests of better serving

those broader interests.

Enabling achievement

The participants have a role in enabling achievement in their community. It was

explained earlier that the meaning of capacity building includes building on strengths and

building on opportunities. The health education workers are the people who recognize

strengths and opportunities, who do the work of building on them and who enable

achievement in doing so. For participants, enabling achievement can include making

learning opportunities accessible and overcoming their own biases. One participant

described the enabling aspect of the capacity-building role in broad terms:

> I do see it as part of our work, just by nature of the training that goes on in
> Whitehorse or any of the communities. … our programs are enabling for people to do
> little steps or great steps towards employment or just completing something. Not
> necessarily, you know, a university degree or something, but for some people, that
> can be a real sign of achievement, and also for those who are highly educated, it takes
> them down a different pathway as well. (1A)

The participant makes the point that the work of enabling achievement includes making

opportunities available for all people who are interested in being involved in the programs.

Achievement can be enabled regardless of where a person may be starting from in terms of

their previous level of education or other achievements.

Several participants spoke of dealing with literacy issues in enabling achievement. They indicated that it is the attitude brought by the instructor not the level of literacy that affects the ability to achieve. One participant put it this way:

> I think my biggest issue with capacity building is literacy. You can't build it unless the people understand what you're talking about. And like I said, I've done a little bit of research. It's not very much, but my understanding that the literacy level is lower than we expected and we need to accept that rather than challenge it. .... people watch very carefully in these courses, and they very much learn from watching, so if I do a dressing a certain way, then they will learn it. But if I tell them how to do that dressing a certain way, they can't learn it, because the words are difficult. When words are too hard for someone to understand, they spend a lot of energy just on understanding the words and miss the lesson being taught. Or they stop listening as it is just too tiring. Let's use both the common words and the showing to teach them. (5A, amended)

Literacy is an area where the approach taken can enable achievement. Starting from where people are, rather than where somebody else thinks they should be reflects a philosophical orientation of respect for each person. It means believing in every person having capacity to learn if they have the opportunity to do so in a way that is accessible to them. It is the health education workers who make learning opportunities accessible through their understanding of the people with whom they work; in doing so, they enable achievement.

Enabling achievement is not always easy for instructors. It can mean having to stretch pre-conceived notions on their part to make opportunities accessible to people who might otherwise have been excluded from participation. This participant laughed at himself as he described his own evolution in one situation:

> One little story you might enjoy is - it was a year ago, I'd advertised a course. I got a call from this girl who knew me and she wondered what the age cutoff was for the class. She was only 16. I thought, oh jeez....I knew that a couple of the people in the course were in their fifties. The rest were in their thirties and forties. Oh boy. So I called the college and talked to (one of the staff) and she said there is no cutoff age, as long as they're physically able to do the CPR, but it's up to you. I didn't really want to. Also, the conversation, you know, when you've got somebody that age, as opposed to adults, the conversation is different and it's such a big jump. So anyways,

I said okay, we'll do it. I said, "You're going to have to pay out of your own pocket" because, of course, you figure our volunteers for the ambulance are paid for by the government but "you'll have to pay out of your own pocket, 135 bucks", but she'd been saving. That's a lot of money for a kid. And I gave her the books. She memorized the books, basically, before the class. And she was essentially the star pupil. She got the highest score on the written test, did just, it was amazing. ...she's going into health care at some point when she grows up – she's already very mature. It was just amazing. She wrote me a thank you card afterwards because she knew I had some trepidation about it. And she thanked me for giving her a chance. It was neat. I run into her and her family every now and then, I saw them at Canada Day and she's still so happy about it. She'll tell me about things she's done, with her sisters. They live out in the country and there's always first aid stuff. She hasn't done any life saving, but she will. (8A)

The participant enabled achievement for this young woman because of being able to work through his own concerns about the appropriateness of providing an opportunity for her. He recognized the strengths of interest and commitment that the young woman brought to the situation and overcame his own trepidation to make an opportunity available to her. In these stories, there is evidence of the participant's understanding of the needs and desires of people in their community and a willingness to meet challenges as necessary in order to work with the people to provide an opportunity to meet those needs and desires. The attitude and approach of health promotion workers is a critical factor in enabling achievement.

Understanding meaning

Participants told stories that indicated their recognition of the personal and emotional meaning of experiences in the lives of people they instruct. Their ability to understand such meaning is a part of the role that they play in their work. The story below is one of several that indicated an understanding of the meaning of experiences in people's lives:

First Aid is a very personal thing to these communities. They've had people hurt, they've had people drown, they've had people burn in fires, so whatever topic you're talking about is bringing up memories and I think ...that's where you lose some people if you don't give them the time to talk. Or give them a break to go and get themselves back together. ... I give them time to regroup themselves. And a lot of times, the story will come out as to what the group was thinking. It's usually obvious

when a memory is triggered among two or three people. ... That's a capacity building thing because now they can talk openly about it. They're in a group situation ... you can resolve some issues. ... the first aid stops and we're on to this topic....and then those groups really meld. You know, now this group has experienced this thing together and we've been able to talk about it together. (5A, amended)

Understanding personal emotional meaning of events is facilitated by the ongoing relationships that instructors have with the people in their classes and by awareness of the history or experience that people have had. Both the relationships and awareness provide opportunities to discuss the issues that can arise in the classroom setting or after an incident such as the fatality identified above. Emotional issues can begin to be addressed and resolved in a way that would not otherwise have been available to the people affected. The skill and sensitivity of the instructor, as well as his/her knowledge of community history and experience, enables them to be able to deal with such issues when they arise, to understand the emotional significance of events in their respective communities and be able to work with people in addressing the concerns that arise for them.

Building relationships

Many of the stories told by participants imply the building of relationships within the communities of which they are a part. Building relationships was an aspect of capacity building that was made explicit by some participants, as exemplified in the following story:

... for the ambulance crew, it's just watching the rapport build between my crew, and how they interact with each other. It becomes not only first aid teaching, it becomes ambulance training. We work hard, sometimes in very difficult situations and if you've been training with each other, it helps. Absolutely. (10A)

The participant was not drawing attention to her part in building relationships, but it is through the work done in first aid instruction and the subsequent work in ambulance service that the relationships are built. This story also draws attention to the relationships built

between different parts of community life. Capacity building in first aid instruction is inseparable from capacity building in ambulance service. Living and serving in these two areas of community life, the part played by the participant in building positive relationships among people is a crucial one.

Living in relationship with community

The final area in which the health education worker role is played in capacity building is one that I have called living in relationship with the community. Participants described their work in ways that indicated that they were integral parts of the communities with which they worked. The relationship is reflected in participants' accounts of both their work and the satisfaction found in the work, a satisfaction that is personal but that is gained from awareness of the effect of their work in the broader communities of which they are part.

> And so I can help them. I do extra time, and I don't mind doing it because it does so much for you. And they'll come back quite often and say you taught me first aid, this is what you taught me and they'll tell me.... that's the nice thing about doing it long term, not just dropping in and teaching. You can see the after effect and how people use ideas you have taught them in their everyday life. (5A, amended)

> One thing I find really self-satisfying basically is knowing that there's people scattered all throughout the Territory now that have first aid training that wouldn't have. (3B)

> It's also taking a core of knowledge and touching like so many people. I don't know how many courses that you have taught, but it must be numerous, and if you think how many lives you've sort of touched within your camps and then going even into the family setting, and even out into the public, so you take that knowledge and spread it. (3C)

Contributing to and being valued in their work and life communities are important to the participants. Seeing the benefit of their work over the long term is an additional bonus available to people with ongoing relationships in a community. Their health education work is a source of satisfaction to participants in living in relationship with their communities.

Conclusion

The capacity building process included initiating and organizing activities for some

participants and, for all participants, included teaching. A key to capacity building is the

attitude and approach of the participants to the process. For instance, the flexibility that

participants bring to teaching, in preparing for and responding to the situations that arise in

the instructional setting is a significant element in learning success for the people with whom

they work. The sensitivity, readiness to adapt to different learning styles, ability to recognize

and willingness to address issues important to the people they teach are all attributes of the

health education workers that can contribute to capacity building achievements.

In describing their role as health education workers, it became apparent that

participants contribute significantly to capacity building. Living in relationship with their

communities, the participants are able to initiate activity, they enable achievement,

understand meaning of experience of their fellow community members and build

relationships that facilitate capacity building. As individuals, they have built and are building

their own capacity. In offering service to their communities, they act as the bridge to

community capacity building. As increasingly capable individuals choose to contribute to

the broader community, community capacity building occurs. In so doing, the participants

are individuals who live the meaning of capacity building in the process of their work. Their

role is at the heart of the experience of community capacity building.

CHAPTER SIX

A stepping-stone: Yukon context and effects of capacity building

Contextual factors and effects of capacity building activity were major themes of the findings. The theme of context was separate from but relevant to the capacity building process. The relevance of the Yukon context emerged in relation to the usefulness of skills, credibility of standards and value of Yukon resources. The final major theme identified by participants was the effect, outcome or result of their work, in their observation. The effect includes the specific skills being taught but is beyond those specific skills. Findings on the relevance of the Yukon context and effects observed by participants are described in this chapter.

Influence of Yukon context

Contextual factors are woven throughout the experience described by participants. As has been noted, characteristics of the Yukon include small population centres, separated by long distances and having limited infrastructure. People regularly find themselves in situations where community services are too far away to be of immediate help in an emergency. Such situations can arise when travelling by road between communities or when living or travelling away from communities, as people would do for river trips, hunting or fishing expeditions in remote locations. Participants spoke of three relevant contextual factors tied to the experience of living in the Yukon. These factors, discussed below, were the specific skills being taught having meaning in the Yukon, the skills having credibility within and beyond the Yukon and the need to adapt resource materials to the Yukon context.

Skills have meaning in the Yukon

For participants, capacity building is based on learning specific skills. Participants

noted that the skills that they teach are relevant in the Yukon context; they are likely to be

needed and used. One participant set the context for needing skills clearly:

> Especially living in the Yukon and having these, especially living in rural Yukon,
> these long distances from one town to the next, never mind the way to the hospital if
> you live in Dawson, and it's really important to know that you can do something if
> you should come upon a crash or anything else. (7A)

The participant identifies factors intrinsic to Yukon life. In order to understand the reference

made by the participant, it is useful to know that Dawson, one of the largest communities in

the Yukon, with resources of a health centre and resident physicians and nurses, is a six-hour

drive from Whitehorse, where there are more resources. Implicit in the example above is the

high possibility of being the only person able to provide assistance in an emergency. As the

likelihood of a person needing first aid skills is great, developing those specific skills is

important in the Yukon context.

Some participants described the experience of using the specific first aid skills in

situations that arise in the Yukon due to long distances between communities and the limited

resources available in some locations:

> I have recently taught a re-cert course where I used to work... a week or two later,
> one of the staff there had to rush his wife... to the nursing station in (a community 30
> kilometres away) because she was having a, she basically had a miscarriage but with
> lots of problems and he talked to me afterwards and said, "you know, when I had to
> stop on the road because she went unconscious, it was like the whole first aid course
> kicked in for me". (3A)
>
> I ran into a fatal head-on collision at (a named) Lake and I did all of the things. There
> was nothing I could do for the one guy but I dealt with everybody else, right? So, it's
> the same thing. You've got the first aid training. Well, then you do something about
> it when you're there. (3D) (Note: The lake to which the speaker refers is on the
> Alaska Highway approximately 300 kilometres from the nearest health care services.)

These examples dramatically illustrate both the distance from other resources and the consequent need for first aid skills. The person who had to stop on the road because his passenger went unconscious recognized that only his skills could help her. The person who helped at an accident scene knew there was no one else available to do so. First aid skills are learned and used in the Yukon in a context where the likelihood of needing the skills is high.

Credibility of skills within and beyond the Yukon

A number of participants identified the importance of standards for first aid education in the Yukon context. Standards were seen as important because the Yukon is neither isolated from the rest of the world, nor willing to accept a lower standard of emergency care than elsewhere. Standards ensure confidence that education will be consistent, of good quality and credible within and beyond the Yukon, as described below:

> We know the instructors are current; we know how they're teaching them. ... not anybody can just go teach a Standard First Aid class any way they want to. There is quality out here. There are standards to follow. (1B)

> ...our connection with national agencies enable people to get trained here and have certificates that are valid inter-provincially, inter-territorially. (1A)

Standards ensure that there is a consistent level of competence associated with various levels of certification. Credentials that are recognized through national organizations are one way to ensure that the skills being developed are credible both within and beyond the Yukon. Standards for education ensure that the knowledge that people gain is credible to others, whether that knowledge is applied in the home community or elsewhere in the country.

Need to adapt resources to Yukon context

Due to differences between the Yukon and other Canadian locations where first aid skills are taught, participants indicated that there is need to adapt resource materials to ensure

that they are useful in the Yukon context. This was identified in one discussion about the

limitations of the course content because of its urban orientation, as follows:

> We get a lot of comment about the course, because the course is urban-oriented. (3D)

> I was going to say, it's a little limiting in that. (3C)

> For us, we're always getting questions about, well, it's like three hours to town...
> And, you know, the whole premise of our course is that, well, EMS (Emergency
> Medical Services) is going to be there in five minutes or less, right? (3D)

> We have 20 minutes to wait for an ambulance and it's a long time to wait for an
> ambulance. And I know when I did the babysitting course and I did it with the kids
> who were just out of town, it doesn't touch on anything in the rural setting, so when
> you're trying to teach the kids what to do, it's all urban, and as an instructor, I felt
> very uncomfortable with it because I didn't feel I was giving them enough knowledge
> to handle a situation. So it's easy to say, pick up the phone and dial 911, but even
> some of the kids are not within the 911 area. (3C)

> ...And you know, we put our own little twists on it about, because we've all got the
> radios and everything in the trucks and you just do your continuing care kind of thing,
> basically, and that's about all you can do. So you just try and put your little twists on
> it and still kind of stay to the curriculum of the course. And explain that this (the first
> aid curriculum) is designed as an urban teaching. This is for an urban environment.
> (3D)

The discussion illustrated the need for and challenge of adapting the resource materials and

content of teaching to ensure that it can be applied in the Yukon context. The course

curriculum, valued because of its national credibility, has a strong urban orientation. This

urban orientation limits the practical value that standard first aid programs have in the Yukon

context unless people can make adjustments to the settings in which it will be used.

The participants observed the value of using resources that are relevant in the

Yukon context. One way this is done is by sharing useful information.

> And I think here, too, that even just amongst all the instructors (we) have been
> building a little reference library of so many things here that you've got all sorts of
> options to do any number of things you want to do for any given group ... If you
> want to modify a little bit for a given group of people or whatever, well you've got all

sorts of materials here to work with. And that's all stuff that I think mostly all the instructors have supplied to Public Health and Safety. (3D)

Participants share information that they have found useful for teaching in the Yukon context, in order to help each other adapt to the needs of different groups.

Participants also found that resources that were 'made in Yukon' helped them in their teaching. Recognizing a face in a book could make material more relevant to a learner.

> But I guess the example is we know and we hear it from instructors and we hear it in the office that, boy, it would be great to develop some 'made in Yukon' resources, such as video resources, the book was a good example. (Speaking of *First Aid for Everyone*, a first aid book that was developed in the Yukon) ... people who use that book go, wow, hey, I know this guy. You know, in the picture. And suddenly it's a lot closer to home. And it's a great book. Like it's not like something that was just put in a duo tang or something. It's a professional book. And I think you could have video resources that are the same. (3A)

In the experience of participants, there is need for resource materials that are relevant to the Yukon context because of the limitations of urban-oriented course content. To this end, participants adapt urban-oriented resource materials to the Yukon situation, share resources that they have found useful and rejoice in the existence of Yukon materials when they are available. The resources used in first aid education are of greatest practical use when they are adapted to the Yukon context.

Effects of capacity building

Effects were identified in relation to capacity building for individuals; links were also made between individual and community capacity building. Effects of capacity building seen by participants are described in this section, first as individual effects and then in the link between individual and community effects.

Individual Effects

The discussion of the application of first aid skills in the Yukon identified the value of

the skills being taught. In addition to the benefits directly related to the skills being taught,

participants identified outcomes gained by individuals beyond those immediate skills,

including increased awareness and practice of safe and healthy choices, increased confidence

and self reliance and, for some individuals, using the first aid experience as a stepping stone

to future achievements. Each of these effects is discussed in this section.

More safe and healthy life choices. Increased awareness and practice of safe and

healthy choices by individuals was an effect related to but going beyond the first aid skills

taught. The examples below describe a process of increasing awareness that led to changed

behaviour in situations as diverse as safety practices on the ski hill and healthy eating

practices:

> So when it comes down to attitude changes, one of the biggest ones that's happening right now is the use of helmets for people. I know that the year that I started, I got a helmet and I think there were two others that were helmeted at the end of the season, and now we've probably got about 67% of the crew that wear helmets all the time, and the result of seeing most of the ski patrol wearing helmets now is that we're seeing more adults up there that are helmeted and we're insisting that the rental facility provide helmets as well. (6B)

> I go back to (a particular group) again because I've been there twice now. During the first aid course, we did quite a bit of teaching about eating properly and heart attacks and high fat diets and that kind of a thing, and within that one course, the first one, we moved from having Kentucky Fried Chicken for lunch the first day, to actually having vegetables and dip and really healthy stuff the next day. And that was interesting. But then, when I came back about six months later, actually that was still in effect, so people were still talking about eating healthy, looking at the carrot sticks. ...We made it a joke and everybody was teasing each other and we were really looking at what everybody was having for their meals and came back the next day and talked about what we had for supper even, and that carried through. Now, that's a very small group of people, there weren't all that many people there, but it did carry through to the next time. (6A)

Awareness about safe and healthy choices may be a first step towards change of behaviour

that can subsequently prevent problems such as accidents and injuries from arising in future.

The experiences cited indicate that effects were seen beyond raised awareness to changed

practice. In both these examples, awareness has led to specific behaviour change to increase

safe practice or to eat more healthy diets. Safety is highly relevant to health status in the

Yukon, where the rate of death from accidents and injury for males is more than three times

the national average. (Timmermans, 1999;Yukon Health and Social Services, 2003b).

Raising awareness and encouraging safer and healthier practices could influence long-term

health outcomes in the Yukon. Thus, while gaining knowledge and skill generally is capacity

building, gaining it and applying it specifically in the area of health and safety is part of a

circle of influence on health, safety and well-being.

Confidence. Increased self-confidence or self-esteem among individuals was another

effect observed by participants. Several participants identified increased confidence as an

outcome that occurred as individuals gained and practiced the specific skill being taught.

> The other thing, too, if you're looking at capacity building, there again, not only are they learning the first aid skills but they also learn the confidence.... they need to be able to stand up and speak; they need to be able to take control of a situation; and that's what part of first aid is, is that, OK, you have a problem, I recognize the problem. It's safe for me, and you go into the scene. How bad is this problem? And then they have to specifically tell somebody to get help. You know, like, you in the pink shirt go. They have to take control over it, so that they are learning, I guess it's confidence. (2B)

> I've noticed with some of the more unique groups, like the WCC (Whitehorse Corrections Centre), the Corrections, or like the Youth Achievement Centre, that some people are surprisingly, to themselves and maybe to the people around them, good at what they've done and didn't realize they had this sort of natural ability to pick this up and I think that that's been a really inspiring thing for some people, especially with the encouragement of an instructor saying, "Wow, you're really good at something like this. Have you ever thought about getting in to teaching first aid yourself or a career in health care or something like that." I think that, when someone

can learn and feel good about what they've learned, it does build confidence and boost self-esteem. (9C)

The increase in confidence is closely tied to the specific skills being learned, but builds on those specific skills to develop personal competence that can be applied in other areas of life. Learning how to assess and take control of a situation and to direct others, as described in the first example, can build confidence that can be applied in other circumstances. Likewise, an accomplishment, recognition of the accomplishment and encouragement to take further steps developing on that accomplishment can open the possibility for achievements in life that an individual may not previously have contemplated. Such an experience is consistent with the meaning of capacity building with respect to building on strengths and opportunities and facilitating empowerment, as discussed earlier. The long-term outcome of increased confidence or self-esteem was not described by these participants; in many cases, they may not have an opportunity to observe the long-term effect, but have been able to observe that the effect is fairly immediately seen beyond the specific skills being taught.

Self-reliance. Another capacity-building effect that is related to but goes beyond the skills being taught is increased self-reliance. Participants observed that increased self-reliance for individuals is one of the outcomes that can arise from first aid teaching in relation to caring for themselves and their families.

> I think self-reliance in medicine is so important. It's also, I find this with our own crew here, people understand their own medical conditions better so when they deal with their own physician, their primary care doctor, they can communicate better with them. (8A)

> People come in and say, " I did this, I tried this. This is what they told us in the first aid course." And they will put pressure on it or they will wait until the morning if it's a small cut, and just have it checked out, rather than running in panic to the health centre. Fevers for children – people can take care of a fever for a child rather than calling us up and saying, "what do I do?". They know they can give Tylenol, they know they can bath them down, whatever it takes. (5A, amended)

The value of self-reliance has been identified in the Yukon context as being important in order to cope with situations where other help may not be available. The ability to communicate with health providers about health and the ability to be independent in managing health problems are reflections of self-reliance that participants observed. Self-reliance is seen in the increased knowledge that people apply in looking after their own health and that of their families. Increasing the capacity that people have to exercise independence in managing their own lives and in caring for their families arises from the specific skills that individuals have learned but extends beyond those skills.

Stepping-stone to future achievement. In some instances, participants observed effects that were not linked to a particular attitude, skill or knowledge, but to a more general experience of empowerment, subsequently leading on to other accomplishments. Several examples indicated that individuals have used first aid education as a stepping-stone to future achievements.

> We've got people that started when I did or after I did that are now working with the ambulance service. They've taken it as a stepping-stone. They've had that interest and they've gone on. (6B)

> And we've had more people go on from there. We had one teenager who was kicked out of school, and thought that he'll never do anything well. They put him in the YES program, Yukon Employment Strategy program, and in one of the first weeks he was to do this first aid course ... he was the best student I have ever had. He couldn't read well but somebody had helped him read the book, he had learned to do this stuff and he did better bandaging than I did. And he was so proud. He is now a carpenter in town. And he's great. ... But this was the first certificate he'd got. He told me "It was the first thing I've ever done and finished", so (there is) that incredible sense of accomplishment that comes from doing the first aid course and getting through it successfully. (5A, amended)

A step to future achievements is attributed to providing an opportunity to succeed at something in life, sometimes for the first time. The step may provide an opportunity to

pursue an interest in emergency care into a career in the same field or it may provide an opportunity to demonstrate strengths to oneself and others and, in so doing, recognize that one has strengths that can be further developed in another field of endeavour.

The capacity building effects for individuals occur among people who may not have had many previous successes in their lives. The examples included references to people in jail, people who could not read well, people who may not have seen themselves as being able to do something and finish it. Participants spoke of observing changes in health and safety practices, in ability of individuals to care for themselves and their families and of people being empowered to go on to achievements beyond those made in the first aid classes.

Linking individual and community capacity building

How is the link made between building individual capacity and building community capacity? The findings shed light on this question in relation to individual choices, social responsibility and community service. The findings are discussed below.

Individual decisions. Participants indicated that building community capacity consistently starts with an individual and is taken to the community level according to the choices made by the individual. One participant spoke of this in a general way, another spoke specifically about the experience of instructors in making their own individual decisions:

> We end up, I guess, influencing individual capacity and community capacity by the individuals themselves who are the ones who learn that, "hey, I can do this. I really like doing this". And then that kind of communicates and that builds on itself, so you know, I really see it as building individual capacity and community capacity and where that goes is really up to the individuals and the people in the community. But you can see it often goes a long way and it's quite interesting to watch. (1E)

> I'll also say that by having people throughout Whitehorse and the Yukon coming to take, for instance, our instructor course, they can then take that back to their community and be self-sufficient, whether that community is their place of work,

where they just train their own workers ongoing, or if that community is (a particular community) and they can keep the volunteer ambulance regularly re-certified in CPR or something like that. (1A)

In the latter example, the individual making the decisions to apply their skills in their community is the health education worker. The choice that he or she makes about when, where and how to apply their skills in their community is autonomous. Their decisions exemplify the role of individual choice in contributing to capacity building in a community and the integral role of the health education worker in that contribution. The workers decide when and how often they will teach, and to what groups, within their level of certification. Individuals gain skills, belief in their abilities and enthusiasm about having and using those abilities. The skills and attitudes that exist as potential to be applied in the community are developed according to the interests of the individual. The progression from individual to community capacity building is illustrated by the experience of people who gain instructional skills and knowledge and then choose to apply their knowledge in community service.

Social responsibility. Another effect of capacity building seen at the community level is an increase in social responsibility, understood to mean a sense of serving a collective social good beyond the individual. Participants described how they have seen growth in both the understanding and application of social responsibility in their communities.

> You just have to get the message out sometimes, what social responsibility is. And what it's about and how you can do it. And it doesn't have to be a big thing. It's just little bits of stuff at a time. And if it's driving by somebody's house who's in the course, stop and see if they need a ride, you know, simple things like that. If they have to walk and you don't, you have a car, stop and see if they want a ride. (5A)

> ... the obvious turnout for the fire workers this last two weeks has been amazing. I mean all these people putting in ten-twelve hour days doing patrols here and on standby for fire because it's so hot. It's a lot of energy. We've had, well since a week ago Monday, I think we've had three or four people on duty every afternoon and evening until late ...and people are still starting fires. ... well, they (the

volunteers) wouldn't feel comfortable doing a lot of this stuff, being out all the time, without having the first aid, CPR training. (8A)

In these examples of social responsibility there is a conscious orientation to the well-being of others. That orientation can be shown in informal ways by people learning to support each other in attending classes in very practical ways such as providing transportation or in more formal ways such as volunteer fire fighters in enforcing a fire ban during a period of extreme fire hazard in the Yukon. In both examples, participants observed that people were willing to dedicate time and take on responsibility for the well-being of others in their community.

Community service. Community service is understood as structured involvement of individuals with a community. Participants identified community level effects of capacity building in a number of areas that have already been mentioned, such as providing volunteer ski patrol or fire fighter service. However, community service effects were identified most frequently in relation to providing volunteer ambulance services.

> We see in the first aid end people becoming involved with ambulance in their community. ...once they take the advanced training, they realize there's a door, a potential there that they can go in and serve their community. (1A)

> There's several people that have taken the class and then decide to join (the ambulance service). Not a lot, but somewhat. (8A)

Throughout rural Yukon, ambulance services are provided by volunteers. Because communities are widely scattered, this can mean that volunteer ambulance crews must respond, usually with the assistance of a community nurse practitioner, to any emergencies that arise over a vast area. People involved in emergency situations rely on ambulance services to provide immediate life-saving response, stabilization of conditions and transportation to more advanced medical services. As such, volunteer ambulance service is

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of great value to people who live and travel in the Yukon. The effect of capacity building in enhancing community services can thus be one of particular consequence in the Yukon.

Summary

In examining the effects of capacity building in the Yukon, outcomes have been identified by participants at both the individual and community level. At the individual level, the effects are related to the skills taught by the participants, but go beyond these to influence safe and healthy lifestyle choices, and increased confidence and self-reliance. Empowerment effects may be seen in a general 'opportunity to blossom' or more specifically in using initial achievement as a stepping-stone to future achievements. At the community level, both process and effect of progression from individual to community has been identified in expanding the circle of influence. Effects are seen at the community level in increased social responsibility and in provision of community service. Participants see the effects of capacity in observing people building on strengths and opportunities to become empowered in ways that contribute to their own and their community's health and well-being.

Conclusion

The experience of capacity building described by participants indicates that the practical need for and use of specific skills, the credibility of those skills within and beyond Yukon communities and the use of appropriate resource materials are all relevant in the Yukon context. The experience described by participants indicates that behind the specific skill development in first aid, there is orientation towards being prepared for self-reliance in emergencies, towards coming to the aid of others when needed, towards adapting actions and resources to the situation and towards creating and sharing useful resources. The specific

skills, the standards and resources applied in developing skills and the context in which they are developed are closely intertwined in building capacity in the Yukon.

Capacity building was seen as going beyond specific skills being taught by the participants but it also includes those skills. In the Yukon context, among the group of participants who were primarily first aid instructors, the specific skills taught are important. They are likely to be needed; they are often used. Gaining competence in specific first aid skills contributes to empowering people in self-reliance and self-care. For individuals, participants observed that the effects of their capacity building work goes beyond the specific skills to include influence on healthy lifestyle choices, increased confidence and self-reliance and influencing steps to future achievements. Individual actions move capacity building to the community level, ranging from influence on family and friends, to increased social responsibility to more structured activities of community service in areas such as ski patrol and volunteer fire and ambulance service. In the Yukon context, the reach of capacity building goes well beyond the skills taught and learned, but is grounded in them.

CHAPTER SEVEN

What does it all mean? Summary and implications

Three dominant themes emerged across the discussions of meaning and experience of capacity building, each reflecting a focus study participants identified as important. One theme is building on strengths, a second theme is achieving an end of immediate importance within the context and the final one is living in relationship with the community. These themes are explored, then implications for capacity building policy, practice and future research are discussed.

Themes

Building on strengths

Participants understand and practice capacity building in a way that builds on strengths. This focus reflects the belief that strengths exist, and practice that recognizes and augments those strengths. With this focus, capacity is enhanced rather than built. Participants assume that there is a foundation of capacity that can be expanded rather than built from scratch. In their work with jail inmates and people of low literacy, people who might otherwise be disempowered, participants found that capacity building could happen whenever people were open to learning. Where opportunity exists or is created, strengths can be expanded to empower people in the Yukon context. This theme was identified in relation to the meaning, practice and outcomes of capacity building, as discussed below.

Meaning. The understanding of capacity building articulated in this study includes the four key concepts of building on strengths, building on opportunities, achieving an end of importance in a community and having effect beyond that end. In comparing this understanding with the meaning of capacity building articulated by other writers, these

concepts are shared most closely by Labonte et al. (2002). Although the concept of building on strengths is consistent with the meaning of capacity building articulated by other writers (Kretzman & McKnight, 1993; Labonte et al.; 2002, Restrepo, 2000; Smith et al., 2001), participants in this study placed a more explicit emphasis on this concept, moving towards an understanding of capacity enhancement rather than capacity building.

Practice. The role played by the health education worker gives expression to the meaning of capacity building. It is the health education worker who has the knowledge required to build on strengths, and the relationships that facilitate interaction with others to achieve an end of importance in the community. Participants could build on strengths such as valuing self-reliance or skill at bandaging or work with others to offer programs in ways that would be most effective in their communities. The ability to recognize and respond to strengths highlights the role of the health education worker in bringing the concept of capacity building into practice.

Outcomes. Participants observed strengths growing among community members as an outcome of their work. One participant described this growth eloquently as a bud gradually opening to more sunshine. Participants observed effects that were broader than acquisition of the specific skills they were teaching. They saw capacity built with respect to individuals making healthy personal life decisions, ranging from safety practices to career choices, and with respect to increased confidence and self-reliance. Participants also saw effects that reached beyond the individuals they teach. For instance, they observed that the people they have taught may be better able to care for their families, may take greater social responsibility towards their fellow community members or may become involved in community service work, such as volunteer ambulance or ski patrol programs. Although the

health education workers described the process of their work as being undertaken with individuals and small groups, they sometimes saw that work blossom in the community. Outcomes included enhanced strengths at the individual, family and community level.

An additional point to be made about capacity building practice is that participants experience the outcomes in their own lives as well as observing outcomes among others. Like the people they work with, the health education workers blossom in their work. Participants spoke of their satisfaction, for instance, in knowing that they have touched many people through their work, in having greater value to their employers because of their skills and in the pleasure they take in seeing positive change in their communities. The participants experience the outcomes of capacity building in their own lives as well as facilitating those outcomes for others. Participants build on their own strengths, as well as building strengths in the communities of which they are part.

Achieving an end of immediate importance

Although the potential of capacity building to deliver health gains on a wider front than the health problem of interest has been recognized (Hawe et al., 1997), this study indicates the importance of focussing on the immediate end. The immediate end is the entry point to achieving wider gains. Achieving an end of importance was a theme that emerged in discussion of meaning, practice and outcomes of capacity building.

Meaning. To participants, the meaning of capacity building included building on opportunities to achieve an end of importance in a community. This end of importance is similar to addressing a need or health issue, included in the definitions articulated by Smith et al. (2001) and Labonte et al. (2002), but approaches this from a different direction. Although there is some focus on a deficit in the community, such as a need for standards in ambulance

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service, there is also focus on achieving an end of importance in the community, such as enhancing ability to care for children in an emergency. The immediate end is the focus that engages participation within a community.

Practice. In initiating programs, the health education worker may have an integral part in articulating the end desired by a community and in finding a way to achieve that end. The health education worker is part of the capacity building gains, not separate from them. Participants were involved in continuous learning, acted as resources in their community and, in so doing, helped to achieve ends of importance within that community.

Acquiring skills in first aid is an end of importance in the Yukon context. The likelihood and experience of using the skills in isolated situations far removed from other sources of help reflects that importance. Capacity building literature sometimes emphasizes achievement of ends beyond specific skills that enable people to address determinants of health and to improve health outcomes (Bopp et al., 2000; Hawe et al., 1997; World Health Organization, 1997.) While the longer-term goals of capacity building are important, this study indicates that the immediate skills gained or learning achieved are the grounding from which wider ends can be achieved. Ensuring that that the immediate skills or learning have relevance in the context is an important entry point to enable the longer term ends to be achieved.

Outcomes. In addition to the outcomes that build on strengths, participants indicated that outcomes achieve the end of influencing determinants of health. Education, in this case in first aid, is a determinant of health in and of itself. Outcomes such as increased confidence and self-reliance and community level involvement extend beyond immediate achievements into the realm of health determinants. To the extent that people become more able to

control their personal health practices and their socio-economic and physical environments, influence on determinants of health is achieved. Through their practice, participants affect determinants of health, consistent with the understanding of capacity building articulated by other writers (Bopp et al., 2000; Hawe et al., 1997; World Health Organization, 1997). The outcomes described by participants affirmed the ability of a capacity building approach to address determinants of health. This is an end of importance.

Living in relationship with the community

The health education worker, living in relationship with their community, is at the heart of the capacity building experience in the findings of this study. It is this relationship that makes possible so many of the achievements in Yukon communities. This focus is manifested in the practice described by participants, by the understanding brought to practice and by the organizational support.

Practice. The participants bring sensitivity to, and sensibility of, the experience of Yukon people to their practice. Participants have knowledge of their communities; they use this knowledge to achieve ends of importance. They build relationships, provide leadership and create opportunities to build their communities. The research participants are living the meaning of capacity building that they articulate; they build on their own strengths as well as those around them, they build on opportunities to achieve ends in the interests of their community, they are empowered themselves to reduce reliance on resources outside the community. As their capacity is enhanced, they, in turn, apply their skills to facilitate the empowerment of others. In this study, it is through the relationships built by the health education workers that capacity building in Yukon communities occurs.

The relationship with the community is reflected in the sensibilities brought to participants' work. Understanding and respecting the experience of their respective communities enables workers to approach teaching situations effectively. The respect shown by the health education worker towards the experience of a community death, for instance, can enable learning to continue as a group works through emotional issues. In less dramatic ways, workers organize program delivery and prepare for teaching, recognizing and acting on the understanding that workers maintaining their required first aid credentials requires a different approach than teenagers taking a program for the first time. Understanding and respecting community experience enables capacity building achievements. Others have noticed that health promotion workers *working* in interactive relationships with community members is integral to capacity building practice (Hawe et al., 2000; Smith et al., 2001; Labonte and Laverack, 2001a; Crisp et al., 2000). The role of the health education worker *living* in relationship with the community particularly distinguishes capacity building practice in this Yukon study.

Organizational support fostered the ability for participants to engage in capacity building practice. The Yukon College Public Health and Safety organization supported the health education workers by providing opportunity to gain skills, by providing the freedom and opportunity to apply those skills and by supporting the workers in applying the skills by using their abilities to teach others. Support was also provided through ensuring that the worker's education enabled program standards to be achieved and maintained, through provision of administrative support to organize classes and through provision of resource materials to support activity undertaken by health education workers. Organizational support facilitated capacity building activity undertaken by participants.

The role of the Yukon health education worker in relation to the community appears to be a more complex relationship than that anticipated by writers who see different actors with different purposes (Labonte and Laverack, 2001a), or different activities at different levels (Hawe et al., 2000). The practice of capacity building described in this study incorporates the different approaches identified by Crisp et al., 2000, though the approaches were not found to be mutually exclusive. One practitioner may simultaneously undertake activity involving Crisp et al.'s top-down, bottom-up, partnership and community organizing approaches. Participants said that they may play several roles, at different levels within their communities and employ a range of approaches in doing so. The roles, levels and approaches identified by others overlap and conflate, reflecting the multi-faceted relationship of Yukon health education workers with their communities in capacity building practice.

Conclusion

The focus on strengths is part of a philosophical framework that frames interaction among the various players involved in the work of the Yukon College Public Health and Safety unit. The players, whether they be employees, network members or people attending programs offered by the former groups, act and interact such that people at each level are able to gain power to achieve outcomes of importance to them. This enables the application of means to achieve outcomes, consistent with the ideas put forward by Giddens (1993). By focussing on strengths, a means is found to enhance people's power to achieve ends of importance to them.

In their interactive relationships with their communities, within a context of significance provided by the intended ends of their activity, participants counter the individualism that disconnects us within our world. In their words, the participants provide

hope that the societal malaise described by Taylor (1991) may have an antidote. In facilitating empowerment, participants counter the political fragmentation and powerlessness of concern to Taylor. Through their work and the work of others with whom the participants live in relationship in their communities, the vicious cycle of societal malaise shifts away from individualism and disempowerment towards a virtuous circle, moving people toward successful common action.

Implications

The study findings point to implications for policy, practice and research. The implications below are drawn from the themes focussing on strengths, relevance in context and relationships.

Implications for policy

Organizational policy support can facilitate capacity building activity. At an organizational level, such support starts with a deliberate and conscious intent to undertake capacity building. From that philosophical orientation, organizational policy can enable capacity building through commitment of funding and resources. Findings of this study indicates that systematically focusing on developing the strengths of people within communities involves recruitment of workers from within communities, supporting education and professional development for those workers, providing resources such as education materials and equipment to facilitate their work and assisting with administrative functions such as registration and arranging for teaching facilities. These findings point to the spaces where policy can support capacity building. In respect to human resource planning, for instance, policy can support actions such as identifying prospective workers from within communities, initiating skill development among community members,

providing opportunity for community members to apply those skills within their communities, and supporting ongoing professional development. Organizational policy can deliberately model the capacity building role of health education workers through processes such as initiating activity, enabling achievement, and building relationships, all of which have been manifested in this study. Organizational policy can further support capacity building through ensuring that administrative services and teaching resources are available to their workers. Such support can enable community people to become resources building capacity in their communities, as the participants in this study have done.

A more subtle policy implication is the potential value of conscious awareness of the capacity building roles undertaken by community workers. In this study, capacity building was an unfamiliar concept to most participants. Increasing awareness of their potential to have influence on health determinants beyond the specific skills being taught may enhance the ability of workers to achieve such influence. Bringing such information into the foreground of awareness could, at least, be a way of acknowledging the contribution made by workers towards enabling people to experience more control over decisions that influence their health and lives. Thus, a policy implication would be to purposefully incorporate awareness of the understanding, approaches and processes that contribute to moving from immediate ends to more long-term gains, that is, to playing a capacity building role.

This study did not produce evidence that community capacity indicators would provide useful information about the impacts of capacity building practice. Capacity building activity outcomes will not likely be measurable at a community level, though the activity may contribute to improved health status and have a positive impact on determinants of health at an individual level. While policy makers need to establish the legitimacy of

capacity building activity for multiple reasons that have to do with system or organizational

funding, support and accountability (Labonte & Laverack, 2001; Smith et al., 2003), there is

risk in trying to link capacity building activity and the achievement of community capacity

too closely. The evidence gathered in this study indicated definite and positive change for

individuals and similar influence on some areas within the community arising from capacity

building activity. The capacity building activity did not, however, require a minimum level

of community capacity as a precursor to action nor was there necessarily indication of change

in capacity at the community or collective level as a consequence of that action. Outcomes

of the activity were often observed at a subtle level unlikely to be revealed by measurement

of community capacity indicators. For instance, it is unlikely that community capacity

indicators would be able to determine that emotional issues arising from injuries or deaths

have been resolved among some people in Yukon communities, and yet such outcomes were

described as occurring and being important among groups with whom participants worked.

At the policy level, this means that the outcomes of a capacity building approach will need to

be assessed qualitatively rather than through indicators of community capacity.

Implications for community health practice

Although organizational support can facilitate capacity building practice, community

health practitioners can take a capacity building approach to their work in communities

regardless of the extent to which such support exists. In their relationships within their

respective communities, practitioners develop an understanding and appreciation of the

context in which they work and of what is important within that context. The relationships

inform the ability to identify changes that can be achieved and to effect those changes.

Practitioners can use their knowledge to achieve ends of importance in communities that

have potential for broader impacts. A capacity building approach can enable community health practitioners to impact the determinants of health for people in their communities.

Implications for research

Further research is needed to determine where we should be looking for measures of the success of capacity building, since, as a society, we require such measures to justify resource allocation.

Research into and subsequent measurement of capacity building outcomes, if pursued in the Yukon, could be of potential benefit if done in a way that is sensitive to incremental changes moving from individual to community levels. Systematic qualitative assessment of outcomes by practitioners may be a useful approach to improve understanding of the effect of a capacity building approach. Such assessment could be useful to organizations in understanding the effect of capacity building and in providing justification to support such an approach.

More work is needed to clarify and distinguish between capacity building and community capacity concepts, the indicators required and the appropriate measures of those indicators. Labonte and Laverack (2001a) create a bridge between the two concepts in recognizing the role of capacity building in impacting determinants on the quality of individual lives "if not also of communities healthy functioning" (p. 112). While both capacity building and community capacity building are recognized as including elements that are ends in themselves and those that are means to an end, work is needed to further distinguish the concepts and clarify the relationships between them.

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Limitations

The study has been undertaken with practitioners working in the field of health education outside of the health care system. No conclusion can be made about the potential for the knowledge gained in this study to be applied successfully within the health care system, or for that matter, whether it is already being applied. Further research would be required to shed light on those questions.

This study gave some suggestion that health status indicators may be affected by capacity building activity. For instance, specific mention was made of increase in safe practices, a behaviour change that could contribute to lowering incidence of accident and injury within the Yukon. Also, the ability to respond effectively and promptly to accidents when they do occur will potentially benefit health status by reducing the extent of injury or lasting harm. Although the examples of possible influence on health status indicators arose from the first aid skills being taught by participants, taking a capacity building approach to different skills could have potential to affect health status indicators over time. Combining capacity building approaches with other strategies could create a comprehensive approach with potential to change health status indicators. In this study, it is not possible to determine health status impacts in the absence of causal links and in the absence of data on accident and injury rates. The health education workers provided a glimpse into some of the areas where health status indicators could be affected by capacity building.

Although the complex Yukon political environment was identified as one of the relevant contextual elements in planning the study, political issues did not arise in discussions of capacity building at the community level. This is not to say that political elements do not exist or do not need to be addressed, but simply that this study did not

produce findings in relation to political considerations. Policy and resource support for a capacity building approach could be mobilized at the political level, but could often be undertaken within organizations without requiring political level endorsement. The capacity building experience described in this study appears to fly below the political radar, using organizational support and community members to undertake activity and achieve outcomes with individuals at the community level.

Conclusion

The last word belongs to the health education workers who made this study possible. After reviewing quotes and interpretation, one participant commented that:

> My experience working with Yukon communities ... tells me you've hit on the very crucial components of capacity building...knowledge, skills, values, credibility and empowerment.

Such affirmation from people at work in capacity building helps assure me that the study is credible and well grounded. It is my hope that this research will provide insight into capacity building practice such that it can continue and expand to effectively move us towards improved health outcomes for the people of the Yukon.

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Appendix A

Interview question guide

Questions by theme

Theme - Meaning of capacity building

What do you understand the term capacity building to mean?
How do you see capacity building as being part of your work?

Theme - Process or steps in capacity building

When you are undertaking a capacity building activity, how do you go about it? What are the things that you do that are part of an activity?
Can you describe a time when you engaged in building capacity? How did it come about? Who was involved? How did they become involved? What did you do? What did others do?

Theme – Outcomes of capacity building

What have you seen as a result of capacity building? For instance, what changes have you seen in individuals, groups or relationships between people?
What would you consider to be a sign of success of capacity building that you have seen?

Theme – Facilitators, dilemmas, issues for workers in capacity building

What have you found helps when you are involved in capacity building? Consider this in relation to things that make this work easier in the community, the organization, among the people you are working with, or other things that come to your mind.

What makes it hard for you to be work in capacity building? Consider this in relation to barriers that come up for you in trying to do capacity building work.

What are the issues that come up for you in doing capacity building work? Consider this in relation to your personal experience in the work, and in relation to factors in the broader environment that affect your work.

Appendix B

Sample section of data management table

Outcomes

Description	Sub heading	#	Example	Discussion
Personal				
Practical Skills that can be applied, and readiness to apply them when needed	Skills that can be applied, and readiness to apply them when needed	1D	I think an outcome is like life skills. Like these are life skills we provide and no matter whether it's being just even with the breakfast program, we provide them with a life skill. They funnel it through the children. We teach them life skills. So it all ends up, there's as an end result. Whether you get training or you've learned something new that you can take into your life, because I mean, first aid, then you provide a skill anywhere, anytime, that could be necessary or needed, whether you're on the soccer field, at home and your child falls down, or behind that car that's in a bad car accident, like these are sometimes necessary things in life and whether it's preventative or just assisting later.	Life skills
		2A	It's not just about first aid. It's also a different avenue for people. It's not, it's a lot of practical stuff. I mean, you can do first aid, you can teach first aid, simply hands on. I mean it's, having the notes and the videos and all that kind of stuff is nice, but it's possible to teach somebody hands on and they can see an outcome because there's a product. You know, like if you bandage a hand, there's a bandaged hand and it looks good, and it's sort of immediate. In other ways, there's, like quite often I'll do first aid, sort of a quick course but with kids, right? And because it's, I guess because it's hands on, they're there and they learn and they pick it up and they retain it, and it's something they can do in the field. The other thing, too, when you're doing, for instance, the Heimlich manoeuvre, the choking aspect, it's amazing how many people said, oh, well, I actually did it and it actually worked, so they have basically saved these people's lives. And the other thing, too, a while ago there was somebody having a heart attack. Well, there were	

			5, 4 or 5 people right there ready to do CPR and they knew how to do it.	
		3C	(skills are) Not (always applied) in the workplace. I'm just thinking with our workplace, all of these people are trained so that, if we have an emergency, I'm the person that's called. Rescue stories and like, I know, we had just finished a course and one teacher was in having lunch with her kids, and one child ran to the bathroom and she followed and the little girl was choking. And she had said, oh, you know, I did the thrust and out it came, so it was sort of one of these success stories that happened. So that's sort of where I see the staff going.	Skills not always applied, even though other people have them, especially if instructor present in a situation. However, there is some application by other people in this workplace setting, as well.
		3D	You know, they'd be more apt to jump in, in a situation because they've had some sort of training, right?	
		3D	I ran into a fatal head-on collision at xxx Lake and I did all of the things. There was nothing I could do for the one guy but I dealt with everybody else, right? So, it's the same thing. You've got the first aid training. Well, then you do something about it when you're there. There was a few people drove by, you know. I was the first one there, so a different kind of story maybe. It's hard to say, but some people drove by because they don't know.	Also practical skills for instructors, that they can apply when needed.
		4A	...you know, if you know what you can do to stop something and you know what you have to do if something happens, you understand a little bit more the implications of an emergency situation, and I think overall people are just more prepared.	
		5A	I don't want you to get on the phone and just say "help, we need help over here," and hang up, and that's happened to me as a nurse, you know. So in the first aid, this has really helped in the community. People will start to tell me who they are and where they are and I say that's what I need to know first. I don't care who it is that's down, what's happened to them, but I need to know where you are so that I can come there	Appropriate dealing with emergency and appropriate connection with health services.

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		6B	And the thing is is that they inevitably run into a situation where they actually have to help somebody. And that usually happens within the first couple of weeks of being on the mountain. And the first thing that happens inevitably is that they go brain dead. And it's, OK, what do I have to do? What do I have to do? And they come in and they fumble their way through it and the guy survives and thanks them profusely for getting him off the mountain. They looked after. But then they go through and do their own mental debriefing. I forgot to identify myself. I forgot to do this. I forgot to do that. But the thing is that they've got into it and they've taken the first move.	
	Opportun ity to blossom	2A	how would I describe a student who comes to the College? I look at them as a closed bud, a flower bud. And as they are learning and as they are feeling better about themselves, the bud just opens right up. And I think the thing is that one thing leads on to the other, so the bud sort of opens up and they basically open to more sunshine, they feel better about themselves, and that hopefully goes towards the family and it helps out there, too. Because these people aren't so angry any more.	Put in capacity building section
Apply in relation to work	Employa bility, requirem ent for work	1A	And they have their employable skills. They can take it here in their own home and then go off and work in northern B.C. on an oil rig or something.	
		2B	Well, I just did a re-cert the other night and we had 8 people here and every one of them, none of them, no, one person was First Nations, the rest were not, but every one of them basically said it was a requirement for work.	
		2A	(leads to) Getting employment actually	
		9B	Whether it's because it's a job requirement, the outcome is very obvious there that if I don't recertify, then what's going to happen to my job? They know this is a requirement and I wanna get a job and if I have this, this enhances my opportunities in terms of getting a job.	
	Leading to career options, choice in educatio n and in	1D	But even volunteers, you know, I know people who start off as volunteer firefighters and that. They're now, that's their career.	

	life			
		2A	And many a time, we'll have people come into the College, sign up for a first aid course or whatever, and the next thing you know they're looking at the ad and say, oh, this looks interesting, maybe I should do this, or do you think I could do this or whatever. The next thing you know, you've got students taking short courses, and then maybe they're coming in to academic courses. It varies.	
		5A	And we've had more people go on from there. We had one teenager who was kicked out of school, he'll never do anything, dadada. They put him in the YES program, Yukon Employment Strategy program and one of the first weeks he was to do this first aid course, and he was the best student I have ever had. He couldn't' read but somebody had read the book to him, he had learned to do this stuff and he did better bandaging than I did. And he was so proud. He is now a carpenter in town. And he's great. Goes to work. If he has to ride his bike, he's there on time, whatever. But this was the first certificate he'd got, he told me. It was the first thing I've ever done and finished, so that incredible sense of accomplishment that comes from doing that first aid course and getting through it. So that's why I really work hard with people who I know are struggling. And like, I've been there long enough, I know some of there issues and their schooling and their lack of education or whatever you want to call it.	Incredibly powerful impact of first aid accomplish ment in affecting person's life.