Sustainable capacity building among immigrant communities: the Raising Sexually Healthy Children Program in Canada

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SUMMARY

The Raising Sexually Healthy Children (RSHC) program is a peer-to-peer leadership training program for immigrant parents in Toronto, Canada. It was established in 1998 with the goal of promoting family sex education and parent–child communication. This evaluative study examined the developmental processes and outcomes of the RSHC program to identify the strengths, challenges and insights that can be used to improve the program. It employed a multi-case study approach to compare the RSHC programs delivered in the Chinese, Portuguese and Tamil communities. Data collection methods included focus groups, individual interviews and document analysis. The cross-case analysis identified both common and unique capacity building processes and outcomes in the three communities. In this paper, we report factors that have enhanced and hindered sustainable capacity building at the individual, group/organizational and community levels, and the strategies used by these communities to address challenges common to immigrant families. We will discuss the ecological and synergetic, but time-consuming processes of capacity building, which contributed to the sustainability of RSHC as an empowering health promotion program for immigrant communities. We conclude the paper by noting the implications of using a capacity building approach to promote family health in ethno-racial-linguistic minority communities.

Key words: immigrant communities; family sex education; capacity building; sustainable programming

INTRODUCTION

Background

The demographics of Canada have changed significantly over the last three decades due to globalized movements of people through migration. Toronto, one of the most culturally diverse cities in Canada and worldwide, is chosen by many new immigrants as the place for settlement. Between 2001 and 2006, Toronto received ~267 855 immigrants, who represented one-quarter of all newcomers to Canada (City of Toronto, 2006). The 2006 Census reported that almost half (49.4%) of Toronto’s 2.5 million population was born outside of Canada; and close to two-thirds of Torontonians speak a language other than Canada’s two official languages (English and French) at home. It is estimated that over 140 languages and dialects are spoken in Toronto (City of Toronto, 2006). These demographic changes transform the landscape of health and social care. For instance, immigrant parents who
have not integrated successfully into Canadian society often undergo prolonged stress. Some immigrant parents experience a sense of incompetence as they struggle to learn a new system of education and socialization. Many do not know how to apply previously acquired parenting skills within a social context that is unfamiliar to them (Florsheim, 1997; Maiter and Usha, 2003). There is an increasing need for culturally and linguistically accessible health information for immigrant parents and their children.

### Sexual health of immigrant youth

Immigrant youth living in disadvantaged neighbourhoods bear a disproportionate burden of negative sexual health outcomes, including sexually transmitted infections and unplanned pregnancy (Pole et al., 2010). While factors contributing to negative sexual health outcomes among youth are multiple and complex, the literature suggests that home is an important setting for sexual health promotion. Evidence suggests that the rate of teen pregnancy and sexually transmitted infections (STIs) rises as the household income level declines (Toronto Public Health, 2009). Other studies suggest that parenting styles and family communication may influence young people’s sexual decision-making (de Graaf et al., 2010). A Canadian survey (Byers et al., 2008) found various barriers that prevent parents from talking to their children about sexuality: parents’ concerns about having adequate knowledge, their discomfort in talking about sexual health and negative attitudes toward sex education. Byers et al. (2008) concluded that even short interventions designed to increase parent–child communication, parents’ knowledge about age-appropriate comprehensive sexual health education and their comfort level in talking about sexuality can improve the quality and depth of sex education at home. Thus, while sexual health promotion programs such as the RSHC are not able to mediate structural factors such as household income, they can provide knowledge and skills that help parents be more open to communicate with their children about human sexuality at home, and therefore indirectly promote the sexual health of immigrant youth.

### Raising Sexually Healthy Children Peer Parent Leader Training Program

The Raising Sexually Healthy Children (RSHC) Peer Parent Leader Training Program, which was developed by Toronto Public Health (TPH) in collaboration with multiple ethno-specific community partners, entered its second decade in 2009. The program was conceived in 1998 when TPH staff and service providers in five ethno-cultural-linguistic communities (Chinese, Portuguese, Spanish, Vietnamese and Tamil) held a meeting to explore how to address challenges relating to sexual health faced by immigrant parents and youth. As a result, the RSHC was developed and implemented in each of these five communities. The overall goal of the RSHC program is to enhance family sex education and parent–child communication on sexual health issues. It aims to help immigrant parents acquire contextual knowledge about their children’s sexuality and develop effective communication skills to create a supportive and open environment at home. Furthermore, the RSHC uses a ‘train-the-trainer model’ to build capacity in each community through enhancing leadership, participation and empowerment among immigrant parents. The model also promotes community ownership and collaboration among stakeholders in each community to strengthen the sustainability of the program (Toronto Public Health, 2000, 2008). The sexual health promoters of TPH and health educators in each community collaboratively deliver 20–25 h of Peer Parent Leaders (PPLs) Training Workshops in English. The trained volunteer PPLs then organize and hold community workshops or group discussion sessions in their own languages for their peers, that is, parents within their ethno-cultural communities. Over the past 10 years, the program has been successfully expanded to include 12 diverse communities in Toronto (Toronto Public Health, 2008).

Given the demand for sustainable capacity-building through community-based interventions in public health and the changing social contexts of Toronto’s diverse populations, TPH decided to conduct an external evaluation of this longstanding intervention in three communities—Chinese, Portuguese and Tamil. The purpose of the evaluation was to guide program improvement and identify transferrable knowledge to be used in other communities sharing similar contexts. This paper presents the overall results of this evaluative study.

### Capacity building: a framework

This study employed the concept of ‘capacity building’ as a framework to analyse the processes
and outcomes of the RSHC program. Although capacity building has been a buzz word in the field of health promotion since the mid-1990s (Raeburn et al., 2007; Simmons et al., 2011), the word ‘capacity’ has been employed in fairly loose and divergent ways that refer to: knowledge and skill; competence; empowerment; self-determination; leadership; participation; partnership; social capital; social cohesion and so on (Crisp et al., 2000; Ontario Prevention Clearinghouse, 2002; Jackson et al., 2003; Smith et al., 2004; Laverack, 2007; Raeburn et al., 2007). From the different conceptualizations, we specifically adopted the definitions developed by the former Ontario Prevention Clearinghouse (OPC) and the World Health Organization (WHO). The OPC defined ‘capacity building’ in the following way:

Building capacity means working on multiple levels. People, organizations, and communities do not exist in isolation. Each is part of and affected by the other. By increasing the capacity of one, we can also strengthen others, and progressively build a strong, integrated system that supports one another. Strong, capable individuals build strong, capable organizations, leadership skills and resources that can share their capacities in coalitions, partnerships and collaborative efforts with other organizations [(OPC, 2002), p. 2].

The term ‘capacity building’ was officially added to the WHO Health Promotion Glossary in 2005 with the following definition:

Capacity building is the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners, the expansion of support and infrastructure for health promotion in organizations, and the development of cohesiveness and partnerships for health in communities [(Smith et al., 2006), p. 341].

The terms ‘capacity’ and ‘capacity building’ defined by the WHO and the OPC overlap with each other; both recognize that ‘capacity’ can be built at multiple levels through various forms of action. Therefore, ‘capacity building’ is better understood as ecological and synergetic interactions between individuals and their surroundings (Raeburn et al., 2007). ‘Capacity building’ is considered not only as a goal and outcome but also as an on-going process of interventions (Smith et al., 2004; Simmons et al., 2011). This evaluative study thus aimed to examine the capacity built through the RSHC programs in both process and outcomes at the individual, group/organization and community levels.

METHOD

This evaluative study was conducted from 2009 to 2010, 10 years after the RSHC program was implemented. The study employed a multiple case-study approach that involves collecting and analysing data from several cases for comparison. Case study allows the evaluator to explore the program from various angles with multiple sources of evidence (Yin, 2003; Merriam, 2009). The RSHC programs in the Chinese, Portuguese and Tamil communities were selected for cross-case analysis, since these three communities have been participating in the program from its conception. They also represent a large proportion of Toronto’s diverse immigrant population, as Chinese, Portuguese and Tamil are three of the top-ten non-English and non-French languages spoken at home in Toronto (City of Toronto, 2006). It is important to note that the RSHC program uses ‘language’ as a key criterion to define its program for ‘ethno-cultural-linguistic’ communities. Therefore, each of the three aforementioned communities includes multiple ethno-cultural sub-groups, and members of each community do not necessarily reside in one concentrated area of the city. For instance, in the context of the 10-year RSHC programs, the Portuguese community included parents from Portugal, Brazil and Angola, and the Chinese community included parents from Hong Kong (Cantonese speaking) and Mainland China and Taiwan (Mandarin speaking). Since ethno-racial groups in Canada often self-identify with more than one ethnic origin, it is difficult to determine the population size of each ‘ethno-cultural’ community. We thus estimated the size of the three communities in Toronto by using the number of people who reported these three languages as one of their mother tongues. Table 1 presents the population size and a historical overview of the RSHC programs in the three communities.

Given the complex nature of ‘capacity building’, which involves a wide range of factors, both quantitative and qualitative data were collected through the following three methods. First, face-to-face interviews ($n = 12$) were conducted with three key informants and nine PPLs to
obtain information about the RSHC history, development process and outcomes of the program in the contexts of each community. One key informant, a service provider or a community health educator who knew the program from its early stages, was selected in consultation with community stakeholders from each community. We also purposively selected three PPLs who had completed the training program at different times over the last 10 years—one was a recent graduate, one who graduated 5 years ago, and one who graduated 10 years ago—from each community in order to assess the short-, mid- and long-term perceived outcomes of the program. Each semi-structured interview used open-ended questions and lasted 60–90 min.

Secondly, focus groups were undertaken with community parents who attended the RSHC outreach workshops delivered by the PPLs. The purpose of the focus groups was to explore the experiences of community parents and compare their views with those of the PPLs and service providers mentioned above. Focus group interviews are appropriate for this purpose since they allow the evaluators to hear a range of diverse and/or common perspectives from a relatively large number of participants within the constraints of limited time and resources. Focus groups also enable the evaluators to observe interactions and group dynamics among participants to gain insights about norms and assumptions that are invisible in individual interviews. In addition, the presence of multiple participants in a focus group setting minimizes the power and control of evaluators over the participants; it facilitates the formation of collective testimony or multi-vocal conversations that have been used as a catalyst for collective empowerment among oppressed groups (Kamberelis and Dimitriadis, 2005). In the context of this study, focus groups offered a sense of comfort and familiarity because all community parent participants had attended RSHC workshops and group discussions delivered by the PPLs. Individual interviews would likely have been less well received by the participants.

We conducted three focus groups with a total of 19 community parents: Chinese (n = 5), Portuguese (n = 6) and Tamil (n = 8). Each focus group used semi-structured open-ended questions and lasted 2 hours. Focus groups were conducted in English at a Grade 4 literacy level; a language-specific interpreter was present in each focus group to provide translation support if needed. In the Chinese and Portuguese focus groups, most of the participants were able to express themselves in English. Simultaneous interpretation was required only in rare instances when members discussed specific terms. In the Tamil focus group, many of participants felt more comfortable speaking in their own language; thus, the entire focus group was conducted in both English and Tamil with the help of a simultaneous interpreter.

Table 1: Overview of three cases

Case 1: The RSHC in the Chinese community
Chinese migration to Canada started in the mid-1800s. While the Chinese communities share one written language in simplified or traditional characters, the spoken languages vary according to the place of origin. Since the two major spoken dialects in Toronto are Cantonese and Mandarin, the RSHC in Chinese community deliver programs in Cantonese and in Mandarin separately to those from Hong Kong, Taiwan, Mainland China, and other places. However, many of the peer leaders work together and organize graduation and celebration events together. According to the 2006 Census, there were 419 750 people who reported Chinese (Cantonese, Mandarin and other dialects) as one of their mother tongues, which accounts for 19% of the population of the Toronto Census Metropolitan Area. (Statistics Canada, 2007)

Case 2: The RSHC in the Portuguese community
The history of the Portuguese community goes back to the early 1950s. The RSHC targets four Portuguese-speaking sub-groups: Portuguese from Portugal, the Azores, Brazil and Angola. Although the program targets all of these four sub-groups, the majority of participants in the PPLs training and outreach workshops are Brazilian and Angolan due to recent immigration trends. Although there is no ‘official’ host organization for the RSHC program in the Portuguese community, peer leader training sessions have been held at a community agency where a long-standing key parent leader trainer works. The 2006 Census reported that there were 113 015 (5.1% of the population of Toronto) people who speak Portuguese as one of their mother tongues. (Statistics Canada, 2007)

Case 3: The RSHC in the Tamil community
The Tamil community began immigrating to Canada in the 1960’s. Since 1983 internal political instability leading to riots and armed conflicts in Sri Lanka—also known as ‘Black July’—has resulted in an increase in Tamils leaving the country, many of whom immigrated to Canada. Parents who attend the RSHC programs are diverse and include Sri Lankan, Indian and Malaysian Tamils. The RSHC community outreach workshops by Tamil PPLs are often organized in economically deprived neighbourhoods in Toronto. According to the 2006 Census, 98 265 people (4.4% of the population of Toronto) reported that they speak Tamil as their mother tongue. (Statistics Canada, 2007)
recommended by the community. Recognizing that language translation is an act of interpretation influenced by the translator’s social position (Wong and Poon, 2010), and noticing that the interpreter tended to shorten participants’ responses, we hired a bilingual (Tamil and English) senior undergraduate student as a transcriptionist and asked her to transcribe and translate the entire interview, including what the participants said in Tamil and the exchange between the Tamil interpreter and the participants throughout the focus group interview to ensure that we captured the participants’ perspectives and ideas.

Thirdly, a document analysis of archival data from the host organizations and TPH was conducted to collect the quantitative data and to gain an overview of the output activities in each community. The key documents were in-house program records from 1999 to 2009. We identified the numbers of PPL trainings and outreach workshops, participants in these trainings and workshops, community partners, educational materials produced in each community and the funding resources.

The researchers

The issue of participant-researcher differences in social positions and representations is a central concern in qualitative research. Implicit in these differences are the relations of power based on age, gender, race, class, sexuality, citizenship and so on (Hall, 1990; Kanuha, 2000; Gunaratnam, 2003; Bennett, 2003; Cresswell, 2013). We, who conducted this evaluative study, are all racial minority immigrant women, who have lived in Canada for more than 15 years. Two of us are parents. All of us have worked with marginalized communities in Toronto. We all share critical and social justice perspectives as an underlying framework for our research and practice. Our own migration and settlement experiences enable us to gain certain insights about the challenges and resilience of our participants. However, social identities are fluid and situational, and we do not claim to have an ‘insider’ status. Our awareness that power is implicated in research affected our study, causing us to critically reflect on how our worldviews, social positions and practices influenced how we listened, interpreted and re-presented our participants’ stories.

RESULTS

Sustainable personal competencies and social networks

All PPLs and community parents reported positive effects from the RSHC program on their personal lives. Many described the immediate benefits of the program in terms of increased knowledge about ‘human sexuality and children’s sexual development’, ‘parent–child communication skills’ and ‘parenting strategies in Canadian culture and education system’, all of which led them to reflect on their own personal and cultural values and practices. They also reported their own attitudinal and behavioural change such as ‘becoming more open-minded towards diverse sexual values’ and ‘having better relationships with their children and other family members’. Furthermore, participating in the RSHC program enabled many PPLs and community parents to ‘expand their social networks’, allowing them to share concerns and exchange information with their peers in their cultural communities. Since many participants were newcomers to Canada, this outcome appeared to have contributed to their overall sense of well-being.

The sustainability of these positive outcomes was confirmed by the experiences reported by PPLs who had been involved with the RSHC program for more than 5 years. Many of them noted that their competencies were consolidated and expanded as they continued to apply the knowledge, skills and principles learned in the RSHC to their everyday family life and broader social interactions.

From personal into collective capacity building and empowerment over time

Long-term and active PPL participants and key informants suggested that the benefits of the RSHC had gradually increased and expanded beyond the personal level over time. Comparing the experiences of the recently graduated PPLs with those of the PPLs who had gone through the training more than 5 years ago, the longer-term PPLs reported that their ongoing engagement in community outreach activities contributed to their skill development in new areas such as ‘leadership and organization skills’, ‘group facilitation and public speaking skills’ and ‘mentoring’, which in turn enhanced self-confidence, self-esteem and long-term friendship among
PPLs. Interestingly, however, these additional personal benefits were not reported by PPLs who had not become actively involved in outreach activities after the training.

Moreover, outreach activities by PPLs not only helped further capacity building and empowerment, but also collective capacity building among PPLs at the group level. The RSHC usually required PPLs to work together as a pair or a team to negotiate outreach activities with community partners and problem solve during community outreach. Direct interactions with community parents in outreach activities enabled the PPLs to gradually gain insights about the challenges and strengths of immigrant parents in their communities and develop a sense of collective identity. This collective identity reinforced the PPLs’ commitment to the RSHC programs and their roles as peer-educators and advocates for comprehensive family sex education. The narratives of many active PPL participants implied that personal and group empowerments intertwine to produce a dynamic cycle that expands and strengthens capacity at the community level. In other words, the study results indicate that individual gain in knowledge and skills does not automatically translate into capacity building and empowerment at the group and community levels. Collective capacity building and empowerment occur only when the PPLs and partnership organizations work together to create ongoing opportunities for the PPLs to engage in different community outreach activities over a number of years.

### Sustainable output activities through community partnerships

Table 2 presents the summary of the RSHC output activities in the three communities between 1999 and 2009. Overall, as reflected in the numbers of trained PPLs and peer trainers, and community parents who participated in workshops delivered by PPLs, all three communities successfully sustained the RSHC, albeit to varying degrees, by carrying out PPL training and outreach activities in almost every successive year, reaching immigrant parents, their family members and other community members through various venues. These include workshops, community events such as cultural festivals and health fairs, media communication about the RSHC on TV and radio and community newspapers. This finding suggests that a community’s ability to develop inter-sectoral partnerships and collaborations is critical to the success and sustainability of a community health promotion program. Furthermore, the RSHC programs in all three communities rely on volunteers, in-kind donations of space and material support from their community partners. Such infrastructure building among community organizations was also essential in sustaining the RSHC program over a period of 10 years with limited resources.

### Factors influencing the outcomes of RSHC programs

The narratives of PPLs, key informants and community parents suggest that there are multi-layered factors influencing access to, and the effectiveness of, the RSHC program in each community. Figure 1 illustrates the facilitating and hindering factors for capacity building at the individual, group and community levels. The following section highlights some key factors.

#### Individual level

The most often cited personal factor that motivate PPLs to stay with the RSHC program was ‘a sense of personal growth’ and ‘feeling of empowerment’ from taking part in the program. Immigrant parents who were unfamiliar with the Canadian education system and culture reported

<table>
<thead>
<tr>
<th>Total no. community</th>
<th>Trained PPLs and peer trainers</th>
<th>Community workshops or group sessions delivered by PPLs</th>
<th>Community parents participating in PPL-led workshops</th>
<th>Media outreach and social media</th>
<th>Large-scale community events (health fairs, festivals)</th>
<th>Community partnerships involved in RSHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese</td>
<td>155</td>
<td>379</td>
<td>4034</td>
<td>82</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>Portuguese</td>
<td>77</td>
<td>81</td>
<td>685</td>
<td>12</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Tamil</td>
<td>95</td>
<td>92</td>
<td>799</td>
<td>6</td>
<td>10</td>
<td>14</td>
</tr>
</tbody>
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that the RSHC helped to increase their sense of competence and enhanced their confidence to deal with challenges at home and in their children’s schools. Many PPLs also reported ‘improved family relationships’ associated with more open communication with their children, partners and in-laws. This tangible outcome of the RSHC in the context of their own families made the PPLs believe in the program, and motivated them to introduce the program to their peers. Key informants and veteran PPLs also suggested that the provision of a small ‘honorarium’ is an important incentive for many new PPLs because it made them feel valued.

Two major barriers impeding PPLs’ further involvement in the RSHC programs were ‘time constraints associated with family demands’ and ‘geographical dispersion’ in each ethno-cultural community. As mentioned previously, most PPLs and community parents participating in the RSHC were recent immigrants. Many newcomer PPLs had limited access to a car, and taking public transportation across the City of Toronto required a substantial amount of time. Since PPLs were most often mothers with young children, picking their children up from school on time was a practical concern. When the burden of time and out-of-pocket expenses exceeded what the PPLs could afford, they often withdrew from the program.

Group/organizational level
A crucial factor facilitating capacity building at the group/organizational level was the creation
of ‘opportunities for the PPLs to actively take part in outreach’ so that they could work with other PPLs and interact with community parents during their outreach activities. Through working together to address challenges and celebrate the successes of the program, ‘friendship’ and ‘mutual support networks’ were established among PPLs. These motivated the PPLs to take ownership of the program, consolidating their collective commitment to promote family sex education. However, the cross-case analysis also revealed that not every group was able to establish the same degree of community engagement and mutual support among PPLs; the degree of involvement was relative to the degree of coordination of outreach activities and creation of opportunities for collaboration. The Chinese RSHC group was most successful in organizing community outreach activities on a consistent basis because a small group of dedicated PPL volunteers managed to establish a ‘core organizational structure’ to guide and support the outreach activities.

The major hindering factor for the RSHC programs at the group/organizational level was a chronic ‘lack of adequate human and financial resources’. Since the RSHC programs in all three communities lacked stable operational funding, program coordination became an added responsibility for the staff in the partner agencies or a burden on the PPL volunteers themselves. The lack of a paid coordinator position compromised the ability for each community to carry out program outreach and train PPLs consistently. The lack of resources to pay honoraria to PPLs also limits the ability of the programs to recruit new PPLs, mobilize PPLs for community outreach or promote a sense of community, resulting in diminished opportunities for leadership development, and a higher turnover of PPL volunteers.

**Community level**

All three cases shared key factors that facilitated capacity building at the community level. As stated previously, the most crucial factor was ‘inter-sectoral and inter-professional partnerships’ in the community, which enabled service providers and community organizations to creatively identify strategies to cope with the lack of resources to facilitate community-wide outreach and promotion. This partnership development also generated ‘community coherence’ for collaborative efforts with TPH staff and various stakeholders in each community, based on shared visions of family sex education and support for immigrant parents. ‘Committed leadership’ was another crucial factor. The RSHC program in each community relied heavily on several committed leaders, who engaged actively in the community and who had great awareness of the issues facing their community. These leaders recognized the need to promote on-going dialogue about family sex education in the community and put significant effort into sustaining the community dialogue. However, ‘ongoing support from TPH’ in the form of consultation and technical support for the RSHC was critical to sustain the RSHC program in each community.

Another hindrance was the prevailing silence or ‘negative attitudes toward family sex education’ in the three communities. To varying degrees, all three RSHC programs encountered ongoing difficulties in recruiting parents to take part in community workshops. In some cases, the PPLs had to change the name of an RSHC workshop into a more generic parenting program when they advertised in the community. In addition, ‘internal diversity within the community’—in the form of sub-cultural groups, religious beliefs, class and family values about gender roles and attitudes towards parenting practices and sex education—posed challenges to the RSHC programs. This internal diversity required the programs and the PPLs to be responsive to the varying needs and viewpoints of community parents and stakeholders. Without a stable coordinating structure, as mentioned above, this has proved to be difficult.

**DISCUSSION**

**Capacity building as a multi-level, synergetic and ongoing process**

In this study, we were able to identify various overlapping push-and-pull forces that enhanced or impeded capacity building and/or the outcomes of the RSHC programs. Similar to other studies (Smith et al., 2004; Robinson et al., 2006; Raeburn et al., 2007; Carter et al., 2009), we found that the availability of funds and/or resources, the presence of committed leaders and volunteers and partnership development in the community were critical to the success of the RSHC programs.
Furthermore, we found that success in capacity building in RSHC was determined by multiple social systems that are not equally supportive (Joffres et al., 2004; Carter et al., 2009). This study illustrates that community capacity building involves multi-level and synergetic processes as defined in much of the literature (OPC, 2002; Smith et al., 2006; Simmons et al., 2011). It underscores the need to employ an ecological approach in both planning and evaluating community-based health promotion programs that employ a capacity building approach (Salis and Owen, 2002; Smith et al., 2004; Raeburn et al., 2007).

While RSHC programs in all the three communities, to varying degrees, were able to build long-lasting capacities at each of the three levels—individual, group/organizational and community—despite limited resources, our cross-case analysis also revealed that there is a strong association between each level, and that the most effective and sustainable community-wide capacity building is achieved only when the synergy of multi-level effects has taken place (McLaughlin et al., 1997; Crisp et al., 2000; Yeatman and Nove, 2002; Jackson et al., 2003). In the RSHC programs, structural capacity at the meso (i.e. group/organizational) level plays a particularly critical role in individual empowerment and capacity building, which in turn contributes to collective empowerment at the group and community levels. Thus, stable funding and ongoing technical support are needed to strengthen and sustain the program.

Our findings also suggest that the evaluation of community-based capacity building programs is a complex process. Since capacity building includes activities and interactions that are dynamic and occur at multiple levels, outcome evaluation needs to be an ongoing process that is mindful of the changing contexts and needs of the communities involved. For instance, the PPLs and community parents reported the benefits of the RSHC at the individual level, such as gaining knowledge and skills about human sexuality and parent–child communication, almost immediately upon joining the PPL training or community workshops. Yet, these positive personal outcomes were not only sustained, but also consolidated and expanded into broader areas as they continued to apply the RSHC principles to their everyday lives after 10 years.

Evaluating the RSHC programs over a period of 10 years enabled us to recognize the characteristics of the holistic approach taken by the three communities. Laverack (2004) argues that top-down programs often fail because they tend to focus only on particular problems without addressing the social and economic factors surrounding the problem and the overall health of the community. Although the RSHC was a family sex education program led by a public health unit, not one that narrowly focused on preventing negative sexual problems such as STIs and unplanned pregnancy, it promoted the well-being and health of immigrant parents, families and communities by enabling them to develop transferable competencies, social support networks and infrastructures for community action. Furthermore, the RSHC program encouraged each community to be creative, flexible and culturally responsive to the needs of its members, which was a key contributing factor for the success and sustainability of the program (Joffres et al., 2004; Smith et al., 2004).

Using capacity building model in immigrant communities

The results of our cross-case analysis also raise a few cautionary points. First, the varied degrees of capacity building through the RSHC programs in the three communities posed a critical question about the ‘one-size-fits-all’ type program support provided by health units or government agencies. The RSHC programs used a bottom-up approach that valued and promoted each community’s self-determination, community ownership and self-reliance. However, putting all the responsibility on the shoulders of a handful of committed volunteers can set the stage for disillusionment. Our cross-case analysis indicated that the different histories of migration and settlement within the three communities shaped the current contexts of the communities, including the types and availability of community resources (e.g. media outlets, community agencies, community coalitions, volunteers), geographical dispersal, cultural and linguistic diversity, readiness to accept a family sex education program and so forth. In the context of this study, we found that the Chinese and Tamil communities have a relatively large number of ethno-specific settlements and community service organizations, while the Portuguese community has few community agencies and social resources, making it difficult to establish partnerships to enhance their RSHC outreach activities. Furthermore, community-based characteristics also influence the availability and participation patterns of volunteers (Fyfe and...
Milligan, 2003). It is thus important to take these differences into considerations when health units or government agencies allocate resources to support community health promotion programs in different immigrant communities.

Secondly, in addition to the diversity across communities, the diversity within a community also needs to be considered when designing and implementing culturally and linguistically appropriate intervention programs like the RSHC. The results of our cross-case analysis revealed that communities that share a common language do not always share similar cultural values, beliefs or practices. Gunaratnam (2003) has noted the relational nature of ethno-race labeling and identities; that is, the use of racial and ethnic categories is often deceptive and insufficient because they are ‘inflected and differentiated in the local,’ making them ‘appear as if they had unchanging, transcendent qualities and meanings’ (p. 42). In this study, we found that the shared experiences and social position of being immigrant parents contributed to a sense of cohesion in each of the RSHC programs. Furthermore, the participants in the RSHC program in each community seemed to be rather homogeneous in terms of class, gender, age, abilities and religious and family values. This finding suggests that the RSHC programs need to consider expanding their outreach to include parents of diverse family structures, such as extended families, solo parenting families and same sex families; and the hard to reach parents who are not affiliated with community health promotion programs.

Thirdly, voluntarism among community members contributes significantly to the sustainability of community-based health promotion programs. Volunteer efforts, however, especially among recent immigrants, who are experiencing migration- and settlement-related stress, and time and resource constraints, must be supported by a community infrastructure that provides moral and material support. In the context of this study, the small honorarium provided to the PPLs represented not only an attempt to reduce the additional resource burden (travel cost and time) imposed on the PPL volunteers, it also represented a recognition of their contributions to ‘Canadian’ society. The small honorarium provided the PPLs with a sense of accomplishment and hope as they accumulated the symbolic ‘Canadian experience’, which serves as an important stepping stone toward employment among many immigrants, given various barriers facing them to get into the labour market in Canada (Handy and Greenspan, 2009). Thus, community-based health promotion programs in immigrant communities must recognize the significant contributions of the volunteers and ensure that they support the volunteers to gain transferrable skills and integrate successfully into Canadian society.

Fourthly, the RSHC programs in the three communities demonstrate that creativity and flexibility are crucial to overcoming challenges such as resource constraints and cultural taboos against family sex education in the community. Nevertheless, it is also crucial for the RSHC programs to have a mechanism in place to evaluate whether the goals of the program need to be revised or maintained over time to ensure that contentious but critical components based on health equity and social justice (e.g. gender equality, anti-homophobia) are not lost in the process of linguistic and cultural translation. Investigating the balance between bottom-up and top-down approaches—, i.e. the idea of community self-determination versus the core social justice principles of the original RSHC curriculum—requires ongoing dialogue and evaluation.

CONCLUSION

The results of this study address the gaps in the literature on health promotion evaluation, particularly in the area of sustainable community capacity building, where evaluation is especially scarce (Raeburn et al., 2007). In addition, unlike many existing evaluations that measure capacity building at one specific level, this study used cross-case analysis to examine the inter-relationships of capacity building at the individual, group/organization and community levels. Our evaluation of the 10-year RSHC programs in three immigrant communities in Toronto enabled us to document both the processes and outcomes of capacity building through an ecological and synergetic mechanism to capture factors that promote or impede the collective empowerment and sustainability of community health promotion programs. We conclude that the successes and challenges identified in the RSHC programs provide lessons that can be used to guide the development of culturally and linguistically appropriate programs to promote family health in immigrant communities. Furthermore, insights gained from addressing the methodological challenges we encountered also
contribute to the field of evaluative research of health promotion programs.

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