COMMUNITY MATTERS TORONTO
neighbours helping neighbours

Healthy Living in St. James Town
Program Evaluation

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Healthy Living In St. James Town

Project Evaluation

Contents

List of Tables and Appendices

Executive Summary

Healthy Living in St. James Town is a community-based, health promotion initiative led by trained residents of the community and supported by local health professionals. Through participation in community-led activities, residents would experience measurable health improvements in their lifestyle.

Specifically, the project aimed to mitigate the exceptionally high risk of diabetes, cardio-vascular disease and certain cancers within the South East Asian and African populations living in the St James Town and surrounding neighbourhoods of downtown Toronto. St. James Town is primarily a newcomer community of over 35000 residents living in 18 large apartment buildings in an area of less than one square kilometre.

Our initiative was centered around two primary areas of programming:

- Provide residents with opportunities to serve as Community Assistants, a role which saw them mentor, train others and act as role models in a variety of health promotion activities.
- Through the leadership of the Community Assistants, provide a wide range of culturally appropriate activities, at convenient times and in accessible locations focused on recreation, education and socialization.

These key activities provided a pathway to improved knowledge, access and support in understanding and addressing personal health risks and the mitigating activities in the community.

Healthy Living in St. James Town took an inclusive approach beginning by gaining participants trust and then providing services and answers to the wide range of newcomers needs all within the context of establishing and maintaining a healthy lifestyle.

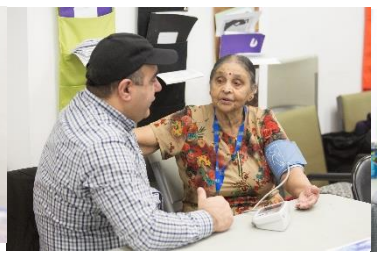
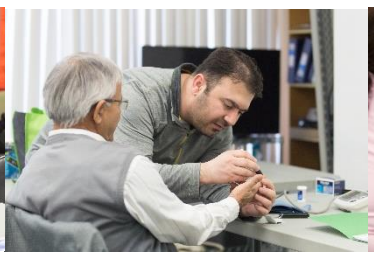
The long-term outcome for the project envisioned residents taking increased responsibility in maintaining a healthy lifestyle and reducing the health risks identified by the project.

The purpose of this evaluation is to assess the impact of the work of Community Assistants in mitigating the risk of diabetes, certain cancers and cardiovascular disease experienced by newcomers living in the surrounding neighbourhoods.

The project succeeded in establishing a well-trained group of residents capable of combining established Canadian practices with culturally appropriate approaches and spiritual customs to support participants in changing their health habits. We demonstrated that residents could achieve sustainable behaviour changes in their health habits. These results were in the context of maintaining multiple physical and emotional entry points to the participants journey, engaging neighbours in their own surroundings, and using familiar, comfortable methods not traditionally identified with health promotion and prevention activities.

Although not considered in the original program design, the existence of stress proved to be a significant obstacle to overcome prior to engaging in mitigation of the programs risk factors. The underlying causes of stress need to be noted as a contributing factor to poor health practices including overeating, drug, alcohol and tobacco usage. Going forward we would recommend the consideration of stress related health concerns and how to mitigate them as part of the over-all strategy.

In conclusion, the project established a cost-effective, alternative approach to improving long-term health practices through health promotion activities.


1.0 Evaluation Purpose

The purpose of the evaluation is to assess the impact of the work of St. James Town residents in mitigating the risk of diabetes, certain cancers and cardiovascular disease experienced by newcomers living in the surrounding neighbourhoods.

2.0 Program Description

2.1 Program Context

Healthy Living in St. James Town is a program within the Public Health of Canada's **Multi-Sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease**. Based on the premise that, using a population health approach, including multi-sectoral action and social innovation, can have a positive impact on health equity by improving health for all, the purpose of this stream is to advance innovative, multi-sectoral approaches to promote healthy living and prevent chronic disease[1].

The South Asian and African populations of Canada experience significantly higher risks of diabetes, cancer and cardiovascular disease than established Canadians[2]. In addition, the reported indicators of health established by the City of Toronto for the St. James Town neighbourhood were well below those of the rest of the city. [3]

Figure 1 Families participate together and are encouraged to form goals which change household health habits

Researchers and policymakers now recognize the prominent part neighbourhoods play in shaping individual and population health. Healthy Living in St. James Town proposed to place residents of the neighbourhood, identified as Community Assistants (CAs) as the centre of a process which would mitigate the risks of diabetes, cancer and cardiovascular disease amongst the South Asian and African population living in the community. The objective was to address the health behaviours which led to the figures reported by the City of Toronto.

The community-based approach positions the CAs at the centre of the process and places their knowledge of cultural and spiritual customs, awareness of their own neighbourhood and their proximity to each other as equal contributors to solutions. The community-based approach is distinctive: neighbours are served, not clients, responses are to community patterns and behaviours not business models or political will, methods are based on reciprocity and network building rather than from silos or case management models.[5]

[1] https://www.canada.ca/en/public-health/services/funding-opportunities/multi-sectoral-partnerships-promote-healthy-living-prevent-chronic-disease.html

[2] https://www.toronto.ca/legdocs/mmis/2013/hl/bgrd/backgroundfile-62904.pdf

[3] Appendix 3

[5] Appendix 8

The St. James Town neighbourhood is particularly well suited to the project. Estimates are that up to 35,000 residents live in 18 traditional apartment buildings in less than one square kilometer. With no through roads, few retail outlets and minimum community services there is ample opportunity for residents to meet others when picking up children from school, grocery shopping and at festivals and celebrations created by residents themselves.

The project invested heavily in the CAs. The major St. James Town cultures include Nepali, Pakistani, Hindi, Filipino, Chinese, Arab, and African. These cultures were represented through CAs and volunteers.

Figure 2 Dr Chandy talks dental health in front of a school mural created by students, program participants and Community Assistants

St. James Town neighbours were at the heart of this endeavour. Staff, known as Community Assistants (CAs), were chosen from our neighbours, often first volunteering in the program. The functions and training of staff and volunteers was the same. However, responsibility for program delivery remained with the CAs, volunteerism was a way to introduce neighbours to the team, the program and the methodology.

In most cases, the CAs had experience with health and community development work from their country of origin. CAs were hired on the basis that this would be their first Canadian employment opportunity. It was expected that CAs would use this opportunity as one step in finding permanent, meaningful employment. Training was established assuming that there would be a steady stream of new CAs and volunteers each year.

Program participants were St. James Town and surrounding vicinity neighbours.

The project was set up to be dynamic in nature responding to changing demographics and program and service responses. Mitigation of the health risks was to be broadly achieved by an interconnected series of activities which provided knowledge, access and opportunities to participate.

The primary concerns of newcomers are employment, access to good schools, language barriers and housing. In order to improve awareness of the health issues facing the community, programs and services were first designed as a form of engagement which served the newcomers immediate needs and provided the opportunity to open a dialogue. Access to supports around language, employment, technology, citizenship programs, and the opportunity for celebration encouraged participants to join in. Program curriculum

Figure 3 A weekend diabetes and blood pressure screening administered by a Community Assistant in a common room in St. James Town

included health subject matter: language classes presented health terminology, employment programs discussed the importance of mental health and physical fitness in a job search, computer programs taught search engine techniques for seeking information on health issues. Having first met the residents needs and earned trust, more direct health programing was integrated.

Feedback mechanisms including work-shop evaluations, discussions and weekly CAs reviews provided the opportunity to regularly adjust program and services and introduce new initiatives.

Figure 4 Adult swim lessons and aqua fit with men and women representing the cultures of St. James Town

2.2 Program Profile

The prevalence of risk factors is high in Ontario, especially for populations that face health inequities, such as those with low socioeconomic status and poor mental health [6]. The lack of access to culturally appropriate recreation, nutrition, social and mental health programs and facilities and the lack of support in taking positive steps towards a healthier lifestyle are all contributing risk factors. Healthy Living in St. James Town was designed to mitigate this risk by providing knowledge, access and opportunities to participate in preventive activities. The long-term goal was for St. James Town residents to consistently demonstrate healthy habits which mitigate the risks of chronic health conditions

Employing a neighbourhood-based approach, CAs were placed at the centre of a process designed to encourage residents to improve their health habits. The unique position of CAs as part of the community, establish a physical presence and share knowledge of their culture and health practices from their country of origin was enhanced by training from and collaboration with local partners: The Regent Park Community Health Centre, The Immigrant Women's Mobile Health Clinic, Cancer Care Ontario, The Wellesley Community Centre and Toronto Public Health.

Figure 5 A Balcony Herb Planting workshop conducted by a Community Assistant as a means of entering a broader nutrition discussion.

A dynamic, culturally appropriate set of interconnected programs, services, workshops and events covering topics like nutrition, diabetes awareness, physical activity, and disease screening were provided each day of the week during times and in locations identified as suitable for residents. Organized and led by the CAs, the activities were conducted in familiar spaces. Over

[6] The Burden of Chronic Diseases in Ontario: Key estimates to support efforts in prevention July 2019, Cancer Care Ontario and Public Health Ontario

the course of this programming, residents were encouraged to develop their own goals and a plan to incorporate healthy habits into their lives. The CA connected with residents through attendance at programs and events, telephone, social media and casual meetings in the neighbourhood.

A tiered outreach strategy was put in place to reach the entire community of over 35000. Social media (Facebook, WhatsApp), and regular community events allowed CAs to reach the majority of the community and provide them with information on activities being offered in the community, and local resources. A smaller group was more active and participated in our recreational and information programs and workshops where they tracked a number of their own health indicators and participated in health assessments. In conjunction with the CA, an additional group set a health plan with objectives and short-term goals to meet those objectives.

As our project participants are from cultures that primarily exchange information orally, unique data gathering tools and methods have been developed to track progress towards objectives and support decisions on new programs, directions and training. These tools include a unique data base developed in the community to capture storytelling and record information from the circles of care taking place in each program. Unique assessment tools including a Health Planner/Passport were used to gather health information over time through conversation and interaction.

Table 1: Overview of Funding Stages

Stage 1	Healthy Living in St. James Town: Mitigation of risk factors for diabetes, cancer and cardiovascular disease	December 2014 - March 2020	$ 528,665
Stage 2	Newcomer Dental Health Prevention	July 2016 – March 2020	$ 265,000
Stage 3	Mobile Intervention	October 2017 – March 2021	$ 90,000
Stage 4	Healthy Living in St. James Town including smoking cessation	March 2020 – March 2021	$ 160,000
			$ 1,043,665

Funding was matched by private companies, foundations and individuals in the form of cash and in-kind contributions.

2.3 Logic Model and Narrative

The long-term outcome for Healthy Living in St. James Town was for St. James Town residents to independently demonstrate healthy living and chronic disease prevention practices. The project places the CA at the center of a network of residents, partners with expertise in established Canadian health practices, local service agencies and businesses in a reciprocal approach to improving knowledge, access and participation in positive health practices. The activity areas, outputs, immediate and intermediate outcomes to achieve this final outcome are described below.

Figure 6 Building health screening into a community celebration

Outputs and Immediate Outcomes

A group of residents (often trained health care professionals in their home countries) were trained to provide empathetic and non-judgemental support to St James Town residents in a safe environment with access to holistic healthy living supports including information on employment, education, health, language, mental health, finances, and housing. Conditions were created to mirror those aspects which allowed newcomers to maintain healthy behaviours in their home countries.

With support of the CAs, residents engaged with a number of behaviour change practices using a cluster of self-regulatory techniques (goal setting) prompting self-monitoring, providing feedback on performance and goal review.

Figure 7 Special relationships with Community Assistants opens doors, creates safety and sets the conditions for screening procedures never before experienced.

The project created an opportunity for residents at risk of diabetes, cardiovascular disease or cancer to routinely participate in physical activity, nutrition programs and/or self-help support groups in a variety of locations within the community. As part of this participation, residents utilized multiple assessment tools for diabetes (CanRisk) and cancer screening (Mobile Health Bus).

In the short-term, St. James Town residents gained access to a range of health promotion activities, chronic disease prevention, and early disease detection and support resources. In the medium-term, residents increased their social networks and local activities which support healthy living and chronic disease prevention. In the long-term St. James Town residents took more personal responsibility for the maintenance of their own health.

3.0 Evaluation Description

3.1 Evaluation Scope, Approach and Design

The goal of the evaluation plan is to determine the effectiveness of the project activities in reaching the two primary objectives:

1) The establishment of a cross-sector group of organizations to improve health self-efficacy and decision-making of the St. James Town community including:

   a. Activities grounded in local resources and support systems such as internationally educated health care professionals
   b. Established cultural practices
   c. Local healthy eating and food security initiatives
   d. Physical activity to mitigate the critical risk factors for diabetes and cancer over a five-year period

2) A comprehensive knowledge transfer and exchange plan whereby project partners provide tools and project process information in support of other organizations who wish to undertake similar projects in the future.

Figure 8 Friendships built over time, residents knowing that there is always a neighbour to be there for them

Figure 9 Professional choirmasters create a unique opportunity to build a local choir drawing children, youth and parents into program through respect for and celebration of the arts as part of the community fabric

The evaluation plan, tools and measurement techniques were developed in consultation an independent evaluator with the input of participants, partners, CAs and volunteers using processes of **Community-based Participatory Research (CBPR).** Regular meetings, as well as mechanisms to elicit feedback from partners were put in place to ensure the evaluation plan, as well as tools and methodologies were appropriate throughout the project.

3.2 Evaluation Methods

To match our goals and the needs of the community, the program evaluation method needed to be agile, as the type of programming discussed does not reflect a “one-size fits all” approach to evaluating its processes. Our goal was to enact system-level change to attempt to reframe existing and future processes in the community and to provide residents with the knowledge and resources to take their health into their own hands.

To meet this goal, we required an approach that valued the "great changes [that] can emerge from small actions" (Patton, 2011, p. 5) and capture the social innovations and community-based adaptations that emerge in complex settings (Ibid, p.5). The evaluation was conducted in the context of a dynamic, complex community setting; that is, a setting that has deep root causes of health inequities, involves multiple stakeholders with diverse values and perspectives, and is constantly evolving (Cabaj, 2009 cited in Patton, 2011, p. 9). Our approach was to capture the changing conditions and needs of the project participants over the course of the initiative and reflect on lessons learned throughout the project's life (Patton, 2011, p.4).

This approach draws heavily from Michael Quinn Patton's comprehensive work on the field of developmental evaluation and also draws upon Dozois' et al (2010) "A Practitioner's Guide to Developmental Evaluation" which too draws heavily on Patton's work. Defined, developmental evaluation is an approach which "supports innovation development to guide adaptation to emergent and dynamic realities in complex environments… [it] supports social innovation and adaptive management…[and] informs ongoing decision making and adaptations" (Patton, 2011, p. 1).

This is not to say that summative decisions weren't identified, and scalable recommendations weren't developed. Rather, they were established within the context that conditions in the community changed frequently, we learned lessons along the way, and new needs emerged throughout the project (Ibid, p.4).

An important element to our approach was to reflect on feedback in a timely manner and redirect as needed to support learning and action in the community. CAs and program participants were integral members of the evaluation process and were highly engaged in "change efforts" (Ibid, p. 25). Data collection methods were integrated into the program plan and were collected at multiple time points throughout the initiative. Evaluation activities were designed to measure:

1) Improvements in access to resources

2) Improvements in the availability and quality of information, and increase in knowledge and awareness of the critical risk factors for diabetes and cancer

3) The changes in health behaviours through participation in activities and choices in food selection

4) The effectiveness of planned project activities

5) Stronger and more connected social networks for St. James Town residents and service providers

Figure 10 Multiple community opportunities to meet and encourage participants and listen to their stories

Quantitative and qualitative data were collected through registration forms, attendance records, pre and post participation surveys, web data collection and one on one and group resident and participant interviews. When necessary, data was collected using the language of the participant.

Evaluation information was distributed regularly to the community through presentations to partners, Community Matters CAs, at community meetings, newsletters, community video screens in high traffic areas (including apartment lobbies and elevators) and a project web site. A final report, which includes all components of the evaluation, will be created with input from the community and distributed widely.

4.0 Findings

4.1 Continued Need for Program

Going Forward: The Future

We will continue to foster individual and collective community health. The evolving role of the CA and the precise impact of their actions will result in a multiplier effect on community health.

Originally envisioned as positive contributors through their cultural connections, the CAs knowledge of health practices from back home and the training they received through this project revealed their impact on behaviour change through their position as influencers and central participants in various community networks. Going forward, through this broader understanding of their place in and impact on the community, we will introduce multiplier health improvement strategies into the community.

Figure 11: Mobile Health Clinic set in the middle of St. James Town providing access to women's health screening

Our project began with a community health systems model to develop effective health promotion strategies for newcomers living in a densely populated urban area. We used public health strategies enhanced by the benefit our community based CAs. We provided knowledge, access and support through linkage of our partners, creating process flow, health messages and programs and traditional referring out to professionals. Although a variation of sorts, our 'bottom up" method, like a "top down" approach implied some measure or control from an outside source.

Although we blanketed the St. James Town community, at large, with health messages, outreach posters and programs we observed a healthier neighbourhood emerging from smaller networks of influence driven by CAs or other residents. These networks exercised more, encouraged their family and friends to eat better and overcame their shyness/reserve in talking about their personal issues. We saw these as Natural Helping Networks – people already in the community and part of a natural neighbourhood network. They observed and learned from the program and turned what was relevant to them back into their network. Studies on social distance report significant associations between a person's social distance and/or connection to others and the impact on their drinking, happiness, loneliness, weight, smoking and sleep[7]. In the future we will

[7] Social Contagion Theory Examining Dynamic Social Networks and Human Behaviour. Christakis, N.and Fowler J. Sat Med 2013 Feb 20:32(4) doi:101002/sim.5408, p26

encourage, build and support microenvironments, organically supporting the transmission of healthy behaviours amplifying patterns of positive interactions, increasing neighbours' capacity to deal with their own and their families health.

In this project the CA worked up a learning ladder developing knowledge and adding new skills. They gained the ability to define the aggregate community issue, identify the community health implications and respond by enhancing resources, networks and other coping mechanisms of neighbours and local groups. Going forward the CA will work to identify formal and informal neighbourhood associations, other community influencers and central participants. They will build networks to reduce social isolation and maintain behaviour change support over time. They will:

- Reinforce existing community patterns
- Create healthy microenvironments
    - Strengthen neighbourhood connections
    - Broaden networks beyond culture
- Increase positive social contagion
- Reinforce positive habits and networks from back home
- Celebrate

Figure 12: Health Fair set in a converted alleyway between buildings with a mural created by a St. James Town artist

4.2 Alignment with PHAC Priorities

Healthy Living in St. James Town is a program within the Public Health of Canada's **Multi-Sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease** whereby the Public Health Agency of Canada seeks to:

- Advance innovative, multi-sectoral approaches to promote healthy living and prevent chronic disease
- Active engagement and partnerships with the private sector, not-for-profit sector, organizations within and outside the health sector, and other levels of government.[8]

Healthy Living in St. James Town succeeded in engaging the private and public sectors. Within those sectors, the project engaged educators, health promoters, community services including the public library, health agencies, community centres, private businesses including technology and real estate private foundations and private individuals. In addition, all three levels of government supported the project financially although these contributions were not matched under the established guidelines.

The partnerships (Appendix 5) were created to be reciprocal in nature. Typically, partners were seeking to establish more direct rapport with the community while Community Matters sought specific guidance and funding. In most cases mutual outcomes were agreed upon.

[8] https://www.canada.ca/en/public-health/services/funding-opportunities/multi-sectoral-partnerships-promote-healthy-living-prevent-chronic-disease.html

In the project CAs participated in the natural community patterns/system as neighbours. As part of the pattern the CA expanded the notion of personal health to a more prominent role and in so doing changed the neighbourhood pattern/system.

Outreach was not practiced in the traditional sense. Practices to improve personal health came from within the established community patterns. The CA participated in and helped to establish these patterns by their presence in the community.

Many newcomers bring established cultural patterns with them in which the primary influencers are often male figures, parents and senior family members. In our program, this pattern was a significant contributor to women who had not had a cervical screening (pap test) or mammogram. By establishing trust not only with the women of the family but the entire family, the CA became an influencer within the family unit. This position within the family contributed to changes in the family's attitudes towards screening for women resulting in the highest levels of one day screening in the Mobile Health Clinic achieved in the City of Toronto.

The establishment of community Walking Groups came from a CA inserting themselves into the pattern of parents and grandparents dropping children off at school and then returning home to a sedentary lifestyle. The CA established the first Walking Group as a physical activity prior to this return home after the school drop off. As an enhancement she introduced health topics for discussion on the walk which in turn led to increased participation by family members in nutrition and other recreational activities. Other Walking Groups and Stair Climbing groups followed independent of Community Matters. Rather than creating a program and then performing outreach to attract participants, the activity came from a respected leader in the community persuading others to join her in a recreational activity.

4.3 Achievement of Expected Outcomes (Effectiveness)

Our project was a learning process encouraging trial and error in developing activities which would deliver successful outcomes. As such we relied heavily on the feedback and response of our participants and the neighbourhood at large. In so doing the participants not only contributed through their attendance, participation in screening and setting and achieving health goals, but also by providing steady feedback which helped craft the evolving design of the project. By so doing they felt ownership of the project and in turn proposed valuable additions to the project. Participants were encouraged to enter into the project through a variety of gateways including participation in programs, volunteering, being part of feedback groups and forwarding social media messages.

The performance indicator data reported for each outcome was gathered from attendance and participant reports, self-reported pre and post program check lists, screening interviews conducted with CAs, self-reported pre and post goal achievement and personal interviews.

Training residents as Community Assistants

Objective 1	To increase community capacity to support residents at risk of diabetes, cancer and heart disease by **training** 6 residents (e.g. internationally educated health professionals) annually to provide empathetic and non-judgemental support to residents of St. James Town
Outcome 1 (a)	Access: St. James Town residents use health promotion, chronic disease, prevention, early detection and support resources created and delivered in the community
Outcome 1 (b)	Knowledge: Residents will learn of the risk factors and their mitigation from their own cultural perspective

Outcome 1 (c)	Social Support: Conditions and safe space will be created for residents to participate in their own health management
Primary Activities	Continuous training of residents as CAs. Subject training ranged from 1 to 8 workshops. A complete list of training workshops is provided in Table 3. The broad training categories included i) Mitigation of the risks for diabetes, cancer and cardio vascular disease, ii) Communication, including mobile intervention and networking, iii) Front line community health worker, iv) Program planning and delivery, v) Data gathering, management and interpretation, vi) Program evaluation and vii) Cultural outreach. *"When I come back from work I usually used to sit and watch TV, now it has been six months since I started this volleyball program. I am physically active and mentally alert. Above all I meet with people from all walks of life and chat with them. That really helped me to exercise my English as well." (PT004M)* CAs engaged participants during programs and workshops, developing health conversations at the pace of the participant. Participants were encouraged to complete a variety of screening tools including the Can Risk diabetes assessment and the Health Planner/Passport developed at Community Matters. Using the data from the Health Planner/Passport CAs worked with the participants to set progressive health goals, set a plan of steps to meet those goals and measure goal attainment. In addition, the data gathered from the Health Planner/Passport was used as an indicator of new program needs within the community and helped to identify emerging needs over the course of the project. The CAs recorded progress towards the goal and individual qualitative data in the online data base developed by Community Matters. CAs met regularly with participants on an informal basis at community events, chance meetings within the community and at various religious and community celebrations. CAs set up and managed community space on an apartment ground floor to hold program workshops, meetings, events and to exercise together. A schedule was established for room use every day of the week during the day and in the evenings. The room was made available for general community meetings, off site meetings between parents and the school for such issues as introduction of the sex education curriculum. Weekly CAs meetings were a tool to clarify previous workshop lessons, review individual data and community trends and decide on action to maintain the quality of programs
Target Population	Residents of St. James Town who will be trained as Community Assistants

Budget	$ 104,012 (Average annual budget over six years)
Partners	The Regent Park Community Health Centre, The Mobile Women's Bus, Cancer Care Ontario, Toronto Public Health, Centre for Addiction and Mental Health and WoodGreen Community Services
Staffing	Community Assistants, Trainers Program Leaders trained in specific disciplines (Yoga)
Evaluation Period	January 2015 – March 2019

	Target	**Actual**
Performance Indicators	6 residents will complete training annually	Sample Size 32 Community Assistants attended 512 training sessions over 6 years The average improvement in skills and knowledge using a 7-point scale was 2.9 Period of Collection January 2016 to February 2021 Change in skills level 4.2 to 6.8 on a 7 point scale The work-shop training was supplemented with training review and application discussions weekly where training knowledge and skills were reinforced
	Diabetes, Heart and Cancer screening will take place among St James Town residents	1215 residents were screened for cancer, diabetes and cardiovascular disease.
	St James Town residents will participate in physical activities, nutritional programs and support groups provided by this project	A total of 54 hours of formal activities were offered over the seven days of each week. 385 Residents completed the Community Matters Health Planner/Passport
	Participants will use electronic and health manual health management tools	385 residents completed the Can Risk Assessment 430 women were screened through the Mobile Health Bus

Reflection

Assessment

Training residents from a variety of cultural and economic backgrounds to support their neighbours was the program's primary premise. 73% of the project budget was invested in the CAs and their training.

During the project we employed 32 CAs. The original plan was to hire residents for a year, train them and provide workplace experience for them to then move on to fully paid employment appropriate to their skills. Over the course of the project, a few CAs stayed with the program in its entirety, some moved out of the community and others gained meaningful employment. The group was generally a mix of established and new CAs.

Most of the CAs came to the project with a degree from their home countries, usually health related, and quite often with extensive practical experience in community development. Their culture, newcomer background, language and society and confidence inspired trust throughout the St. James Town community. Some connections were almost immediate while in others, residents became involved over a longer period of time and continued their association with the CAs.

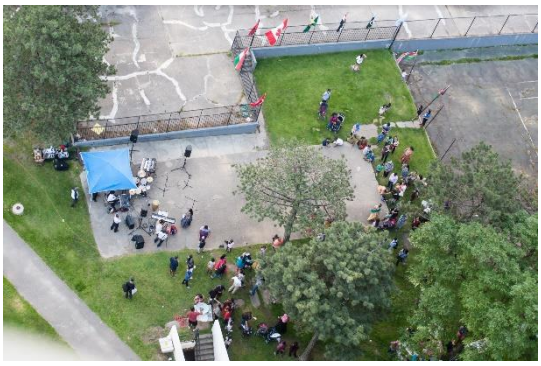


Figure 13: Annual Health Fair/Cultural Collage reopening abandoned recreation facilities in the middle of the neighbourhood surrounded by the flags of the nations in the community

In order to engage in conversations about health with the community, we needed to first meet the needs of the participants. CA's assisted residents with completing forms, helping with housing dealing with landlord issues, schooling for children, or helping bring a relative here from back home. The process of helping with those issues created strong connections and trust with the participants.

The trust that was gained provided a smooth entry into gathering health data. The data was gathered over a period of time where the CA would later record a conversation and complete the Health Passport/Planner based on information from a general conversation. At the outset, the participants understood that we were collecting information from our conversations and gave their verbal consent which CAs noted. Participants' concerns were not that we were gathering their data but that we would be paid for the data we collected which is a common practice in the community. This practice can have a negative impact on the accuracy of the data and reinforces the benefit of gathering information over a period of time while in conversation. With this knowledge of the participants health, CAs were gradually able to introduce progressive health goals and agree on steps to achieve those goals.

Recommendations

- A network of trained residents supported by service professionals experienced in community service delivery has a meaningful impact on engaging residents in improving their lifestyles and reducing the risks of disease.

- The project worked well with a mix of cultures, languages, education and income levels. It is best to have a steady rotation of residents trained as CAs with a range of experience within the group. All CAs were encouraged to leverage their experience gained and eventually move on to other opportunities.

- It was important to allow the CAs to take the lead in establishing the program, the method of delivery, and to support their efforts over an extended period of time. The CAs knew the community well and were able to anticipate how the residents would respond to programming. Imposing outcomes in a particular format, data gathering and time frames to reach outcomes was not considered to be effective, and as such, CAs were given broad program parameters and were empowered to work within them.

- The CAs reported that compensation was not a primary factor in their work. Several were drawn to the leadership opportunity and the ability to practice the skills they developed in their own careers and as new residents in St. James Town. Community Matters provided simple tools and the opportunity for them to do this work and observed it to be a continuation of a lifestyle established in their countries of origin.

> *"To give them love and respect. This is the way"*
>
> *Community Assistant*

- As most of the CAs are strongly motivated to learn, it is helpful to create a learning environment where they see that there is the opportunity to learn specific job-related skills and experience Canadian employment practices.

Links

Community Assistant Level 1 Training Slides
http://communitymatterstoronto.org/wp-content/uploads/2018/04/CA-Level-1-Training-Slides-V9-Jan-27_14.pptx

Community Assistants Training Module Sample
http://communitymatterstoronto.org/wp-content/uploads/2018/04/CA-Level-1-Training-Module.docx

Community Assistant Skills Check List: Program development
http://communitymatterstoronto.org/wp-content/uploads/2018/04/Skills-checklist-program-development-CA-summary-of-pretests-2017.pdf




Table 2

Community Assistant Courses and Workshops

Level	Course Title	Created By	Delivered By	Number and Length of training	Comments
	Health Promotion Skills				
2	Diabetes Prevention	Regent Park Community Health Centre	Regent Park Community Health Centre		
2	Cancer Prevention	Toronto Central Regional Cancer			
2	Mobility Device for Seniors	Consultant	Consultant		
2	Alzheimer's Workshop	Alzheimer Society of Toronto	Alzheimer Society of Toronto	1 – 2hour workshop	
2	Cholesterol	Regent Park Community Health Centre	Regent Park Community Health Centre		
2	New Canadian Food Guide	Regent Park Community Health Centre	Regent Park Community Health Centre		
2	Colon Cancer	Toronto Central Regional Cancer Program	Toronto Central Regional Cancer Program		
2	Breast Cancer				
2	Cervical Cancer				
2	Mammogram Training				
3	Food Care for Seniors				
2	Mental Health	CAMH, Toronto Public Health	CAMH, Toronto Public Health		
2	High Five Training for Seniors	High Five	CAs		CAs are certified High 5 trainers
2	Heart and Stroke	WoodGreen Community Services	WoodGreen Community Services		
2	Fall Prevention and Exercise	Toronto Public Health	Toronto Public Health, U. of Western	2 – 6 Hour Workshops	
2	Food Handling	In House	CMT Coordination		
3	Gardening	Toronto Garden Club/In House	Toronto Garden Club and CAs		
2	Fundamental Movement	High 5	In House High 5 Qualified CAs	8 -2 Hour Workshops	
3	Self Defense				
4	Dental Training	TPH, U. of T faculty of Dentistry	TPH, U. of T faculty of Dentistry	4 – 2 Hour workshops	2 separate events
4	Dental For Seniors	In House / IEHP	In House / IEHP		
	City Shelter System				
	Community Development Skills				
1	CA Training Level 1	In House	Executive Director& external resources	CA Training Level 1 20	In House
1	Public Speaking	External trainer	External trainer		
2	Cert in Health Prom.	Executive Director and external	Executive Director and Guest Speakers	8 -2 Hour Workshops	
1	CPR	Outside First Aid Provider	Outside First Aid Provider	1 – 6 hour workshop	Certificate Course provided annually
1	Advocacy Training	Executive Director and external	Executive Director and Guest Speakers	5 – 2 hours workshops	Provided 3 times
2	Self Help Group	Executive Director	Executive Director	Workshop	
2	Conflict Resolution	Executive Director and external	Executive Director and external resource		
2	Circle	In House	Consultant and CAs	8 – 2 hour workshops	Provided on 4 different occasions
2	Communication Skills	In House	Executive Director	4 – 2 hour workshops	
2	CA Health Promotion	Executive Director and external	Executive Director and external resource	4 – 2 hour workshops	
3	Outreach & Engagement	Executive Director and CAs	Executive Director and CAs	Workshop	

4	Newcomer Settlement	Executive Director and CAs	Executive Director and CAs	Workshop	
2	Housing	Executive Director and CAs	Executive Director and CAs	Workshop	
	Organizational Skills				
3	Program Planning and	Executive Director and external	Executive Director	5 – 2 hours workshops	http://communitymatterstoronto.org/progra
4	Evidence Based Practice	Executive Director and external	Executive Director	3 – 2 hours workshops	
4	Mobile Intervention	Consultant	Consultant	5 – 2 hour workshops	
4	Network Development	Executive Director and CAs	Executive Director and CAs	4 – 2 Hour workshops	
5.	Cochrane Best Practices	Executive Director	Executive Director	4 – 2 Hour workshops	
2	Health Planner Admin	Executive Director	Executive Director	2 – 2 Hour workshops	
Training was progressive building on skills developed from previous levels					

Findings

Achievement of Expected Outcomes (Continued)

Resident Participation

Objective	To create sustainable opportunities for residents at risk of diabetes, cancer or heart disease to **participate** in physical activities, nutrition programs and/or self-help support groups
Outcome: Access	St. James Town residents participated in a variety of physical activity, nutrition, and self-help support groups created in the community and delivered by qualified neighbours.
Primary Activities	Activities were offered each day of the week at times and in places convenient for the participants. Physical activities included swimming, walking, Bollywood dance, yoga, tai chi, stair climbing, volleyball, fitness classes and extreme cardio. Nutrition programs included: Healthy Eating, Cultural Cooking, food handlers' courses, and courses on developing small food businesses. Self-help support groups included: Life Through Art, Dental-Screening, I Feel Good Today, Seniors Socials, Weekly Health Check In, Quarterly Health Fairs, Monthly Community Events and one on one check ins.
Target Population	St. James Town residents at risk of diabetes, cancer or heart disease
Budget	$ 13,342 (Average of 6-year grant)
Partners	TDSB Wellesley Parliament Square Residents Regent Park Community Health Centre Toronto Central Region Cancer Program The Mobile Health Bus City of Toronto Wellesley Community Centre
Staffing	Community Assistants Program Leaders trained in specific disciplines (yoga)
Evaluation Period	January 2015 – March 2019

Another participant said he had his cholesterol dropped and motivated to come to the volleyball game. So far he lost 7 kg of his weight. He further said the game motivated more and more young people as well including their children. (PT005M).

	Target	Actual
Performance Indicators		Sample Size 4463 residents participated in measured programs (This includes residents who may have participated in several programs a year over several years
	6 Physical fitness programs will be offered in the community annually	Period of Collection January 2016 to February 2021 Change in skills level 3.2 to 5.5 on a 7 point scale 11 Physical fitness programs were offered in the community annually
	6 Nutrition programs will be offered in the community annually	7 Nutrition programs were offered in the community annually
	3 Self-help groups will be provided in the community on an ongoing basis	4 Self-help groups were provided in the community on an ongoing basis. There was continuous one on one support throughout the community In addition, 3 Social events were held weekly, 8 community events and 4 Health Fairs annually
	There will be an 80 % participation rate by St James Town residents in these programs	There was a 90 % participation rate by St James Town residents in these programs
	REFLECTION	
Program Reflections	Over the life of the project, attendance grew steadily in these activities. On average, the pre and post skills and knowledge questionnaires showed improvement with an average improvement of 2.5 points on a 7-point scale.	

There were similar programs offered in the community and time was needed to explain that participation also required the completion of the Health Planner/Passports (described in the Health Tracking Tools section below) and discussion of healthy living habits. Neighbours were at first reluctant to participate in the healthy living discussion however, due to the persistence of the CAs, the help they were provided outside of the programs and because of the culturally appropriate approaches by the CAs, neighbours gradually came seeking health advice and had a desire to report their progress.

"I am a working single mom, my son is six years old is on the afterschool program and actively involved in the swimming program ,he is learning to swim now and really enjoy the program." (PT006F)

All programs had their ebbs and flows. It was important to review performance each week and proactively react through changes in approaches to boost attendance.

Using a COMBO approach, we adjusted program times, locations, context (indoors/outdoors), number of times offered and offered additional programming as needed (e.g., dental program). As an example, volleyball grew from a single one-hour session weekly to 3, three-hour sessions on three different days of the week.

By locating the programs close to home, in the community, and at times convenient to the neighbours we were able to grow the number of participants, the number of programs offered, and the hours in which they were offered. Making programs available on evenings and weekends at times and in local locations convenient for residents improved participation. After moving from the community some participants continued to attend physical activity programs.

An extensive array of interconnected programs increased the appeal to a wider group of residents in the community. The broader range of programs demonstrated to participants that any daily activity has a health component and is an opportunity to improve behaviours and overall health.

Recommendations

- By having programs led by trained neighbours of the same culture and having a second CAs member available to discuss health habits residents were more willing to enter into conversation which led to improved skills and knowledge and more openness to discuss their health and set health goals.
- Residents showed more sustained participation when CAs adopted programs to include more socializing, celebration, recognizing religious practices and holidays, and encouraged social friendships and connections.

Links: Project videos created by Community Assistants

What is Program Planning
http://communitymatterstoronto.org/programs/
Seniors Exercise Program
https://www.youtube.com/watch?time_continue=645&v=GVlrlyXnvN0&feature=emb_logo
Fundamental Movement
https://www.youtube.com/watch?time_continue=102&v=EvHPfou-0LM&feature=emb_logo
Swimming Program
https://www.youtube.com/watch?time_continue=20&v=BRfSWTrupuY&feature=emb_logo
Volleyball
https://www.youtube.com/watch?v=nsJXilcbZW4
Health Check In
https://www.youtube.com/watch?v=1sj77YNmV8k
Health Library
http://communitymatterstoronto.org/healthy-living/healthy-library/
CMT Healthy Minute: Simple Exercises
https://www.youtube.com/watch?v=gl53NgDuV2k&feature=emb_logo
CMT Healthy Minute: Your Smile Matters
https://www.youtube.com/watch?time_continue=9&v=NRHUtivquzs&feature=emb_logo
CMT Healthy Minute: Cancer Prevention
https://www.youtube.com/watch?v=GpQn3hdI48o&feature=emb_logo
CMT Healthy Minute: Spring Allergies and Food
https://www.youtube.com/watch?v=_KjFwbOzSDI&feature=emb_logo
CMT Healthy Minute: Health Benefits of a Balanced Diet
https://www.youtube.com/watch?time_continue=3&v=CQbwI-_nfso&feature=emb_logo
CMT Health Minute: Spring Allergies
https://www.youtube.com/watch?v=uFlpgIKj7jE&feature=emb_logo
CMT Healthy Minute: Choose Healthy Foods
https://www.youtube.com/watch?v=k8j4Gk-fDBM&feature=emb_logo
CMT Healthy Minute: Spike – Volleyball in St. James Town
https://www.youtube.com/watch?time_continue=5&v=vyxlS-YZ1Tk&feature=emb_logo

Table 3

Sample Program/Service Schedule

SCHEDULE Winter						
PROGRAM	**Comment**	**DAY(S)**	**DATE**	**TIME(S)**	**LOCATION**	**CONTACTS**
CHILDREN						
After School	JK to Grade 4	School Days	4-Jan-16	3:30 - 6:00 p.m.	Rose Avenue School	Shabana
Swim Lessons	Register	Thursdays	7-Jan-16	5:00 p.m. - 7:00 p.m.	Jarvis CI Pool	Yasotha
Gymnastics	Register	Saturdays	9-Jan-16	10:00 a.m. - noon	109-240 Wellesley St. E.	Hanan
ADULTS						
Job Club	One on One	Weekdays	Ongoing	10 a.m. - 4 p.m.	102-260 Wellesley St. E.	Mariam, Leena, Maltia
Job Club: Health Professionals	Register	Mondays	21-Sep-15	2 p.m. - 5 p.m.	109-240 Wellesley St. E.	Chris, Maltia
Training:						
Computer Basic	Register	Tuesdays	22-Sep-15	1:00 p.m. - 3:00 p.m.	Parliament Street Resource Centre	Mariam, Leena, Maltia
Computer Intermediate	Register	Tuesdays	10-Nov-15	9:30 a.m. - 11:30 a.m	Parliament Street Resource Centre	Mariam, Leena, Maltia
Public Speaking Level 1 & 2	Register	Tuesdays	22-Sep-15	1:00 p.m. - 3:00 p.m.	102-260 Wellesley St. E.	Mariam, Leena, Maltia
Child Minding	Register	Fridays	25-Sep-15	1:00 p.m. - 3:00 p.m.	102-260 Wellesley St. E.	Mariam, Leena, Maltia
Community Assistant	Register	Tuesdays	10-Nov-15	1:00 p.m. - 3:00 p.m.	102-260 Wellesley St. E.	Mariam, Leena, Maltia
Tutoring (7 Weeks)	Register	Tuesdays	06-Oct-15	1:00 p.m. - 3:00 p.m.	102-260 Wellesley St. E.	Shabana
Healthy Living:						
Community Walking Groups	Drop In	Daily	Ongoing	(:00 a.m. start	Rose Avenue School Yard	Surabhi
Self-help groups	Register	Fridays	8-Jan-16	1:00 p.m. - 3:00 p.m.	109-240 Wellesley St. E.	Bhavana
Stress Management	Register	Wednesdays	6-Jan-16	10:00 a.m. - noon	109-240 Wellesley St. E.	Surabhi
Diabetes Sessions	Once per month	Thursday	7-Jan-16	10:00 a.m. - noon	109-240 Wellesley St. E.	Surabhi
Diabetes Management	Once per month	Thursday	7-Jan-16	noon - 1:00 p.m.	109-240 Wellesley St. E.	Surabhi
Diabetes Adults Plus	Once per month	Thursday	7-Jan-16	1:00 p.m. - 3:00 p.m.	109-240 Wellesley St. E.	Surabhi
Cancer Screening	Register	Fridays	8-Jan-16	10:00 a.m. - noon	109-240 Wellesley St. E.	Surabhi
Adult Nutrition (6 wks.)	Register	Thursday	7-Jan-16	10:00 a.m. - noon	Wellesley Community Centre	Surabhi
Food Handling (6 wks.)	Register	Tuesdays	5-Jan-16	10:00 a.m. - 1:00 p.m	Wellesley Community Centre	Surabhi
Food Share Bus	Drop In	Mondays	ongoing	4:30 p.m. - 6:30 p.m.	102-260 Wellesley St. E.	Surabhi
Cross Cultural Cooking (6	Register	Tuesdays	5-Jan-16	1:00 p.m. - 3:00 p.m.	109-240 Wellesley St. E.	Surabhi
Meditation	Register	Tuesdays	ongoing	4:30 p.m. - 5:30 p.m.	109-240 Wellesley St. E.	Surabhi
Belly Dancing	Register	Saturday	9-Jan-16	10:00 a.m. - noon	109-240 Wellesley St. E.	Surabhi
Yoga	Register	Fridays	ongoing	11:00 a.m. - noon	Wellesley Community Centre	Surabhi
Bollywood Dance	Register	Saturday	ongoing	11:00 a.m. - noon	Rose Avenue School	Surabhi
Zumba	Register	Saturday	ongoing	10:00 a.m. -11:00 a.m	Rose Avenue School	Surabhi
Adult Volleyball	Register	Tuesday	5-Jan-16	7:00 p.m.-9:00 p.,m.	Rose Avenue School	Said
Adult Volleyball	Register	Thursday	7-Jan-16	7:00 p.m.-9:00 p.,m.	Rose Avenue School	Said
Adult Volleyball	Register	Saturday	9-Jan-16	2:00 p.m.-4:00 p.,m.	Rose Avenue School	Said
Swimming: Adults	Register	Thursday	7-Jan-16	7:00 p.m. - 9 p.m.	Jarvis CI Pool	Yasotha
Swimming: Adults/Family	Register	Sunday	7-Jan-16	10:00 a.m. - 4 p.m.	Jarvis CI Pool	Yasotha
Tai Chi	Register	Wednesdays	ongoing	6:00 p.m. - 7:00 p.m.	109-240 Wellesley St. E.	Surabhi
Adult + Home Visits		Please contact us at 416 944 9697 or visit us at 260 Wellesley St Unit 102 to set up appointment				Bawani
Adult + Thursday Social	Drop In	Thursday	ongoing	1:00 p.m. - 3:00 p.m.	109-240 Wellesley St. E.	Aruna
Home Management				Please contact us at 416 944 9697 or visit us at 260 Welle		Surabhi
English: Cafe	Register	Tuesdays	15-Sep-15	10:00 a.m. - 11:30 a.m	102-260 Wellesley St. E.	Sarah
English: Basic		Please contact us at 416 944 9697 or visit us at 260 Wellesley St Unit 102 to set up appointment				Angela
Citizenship and CIC Test Prep		Please contact us at 416 944 9697 or visit us at 260 Wellesley St Unit 102 to set up appointment				Angela

Findings

Achievement of Expected Outcomes (Continued)

Development of Health Tracking Tools

Objective	To create sustainable opportunities for residents at risk of diabetes, cancer or heart disease to participate in their own health management through the **development and provision of health tracking tools** during the first year of the project.
Outcome 3 Access:	Residents gained access to internet based and manual health tracking tools. We worked with our partner Self-Care Catalysts to develop an application unique to St. James Town which could electronically gather the information gathered manually through the Health Planner/Passport, provide health messages, link participants, and measure progress towards health goals.
Primary Activities	In consultation with CAs and neighbours a Health Planner/Passport was created which asked questions on health subjects identified by City of Toronto health indicators. The Health Planner/Passport was revised twice. First, to allow for written descriptions and tracking of personal health goals and the steps to be taken to achieve those goals. The second revision was to include more detailed questions regarding smoking. ***Apart from personal use at home the food handling trainings helped some interviewees to get employment opportunities in commercial kitchens.(PKI002F)*** We developed our own in-house database and registration form which gathered all health-related data, tracked goals, and told stories of participant progress. The database was available online through computer or telephone for ease of access and was available to participants. We adopted the Patient Activation Scale[9] created as part of the development of the Patient Activation Measure (PAM) to both measure participants' progress towards sustainable health habits through behaviour change and as a basis for receiving feedback and designing relevant programming. We set up WhatsApp groups for each program and service.
Target Population	Residents at risk of diabetes, cancer or heart disease living in St. James Town
Budget	$ 23,963 (Average of 6-year grant)

[9] Patient Activation Scale. Development of the Patient Activation Measure (PAM). Conceptualizing and Measuring Activation in Patients and Consumers.www.ncbi.nlm.nih.gov/pmc/articles/PMC1361231/

Partners	Health Care Catalyst
CAs	Community Assistants Program Leaders trained in specific disciplines (Yoga)
Evaluation Period	January 2015 – March 2019

	Target	**Actual**
Performance Indicators	A pilot agreement will be signed with MYOSCAR or similar electronic health management system	The electronic management system was designed however was not accepted by the community. A manual Health Planner/Passport/Planner was developed and used by the participants An electronic participant data base was developed internally to be used with participants to track their progress
	6 residents will be trained to support their neighbours in the use of health management system.	8 residents were trained annually to support their neighbours in the use of health management system. Sample Size 4463 residents participated in measured programs (This includes residents who may have participated in several programs a year over several years Period of Collection January 2016 to February 2021 Change in skills level 3.2 to 5.5 on a 7 point scale

REFLECTION	
Program Reflection	The external electronic management system was not accepted by CAs or the community. As an organization we were unable to achieve the level of design we needed as the program modifications to the partners standard technology became too expensive.

The users were reluctant to accept the app. At the time, the platform was not available on Android devices and, in the opinion of neighbours used too much of their data plan.

"We usually use Canadian food guide to help participants understand the proportion of food that they need to consume in a day and the amount of fruits and vegetables that they need to use in every meal." (PKI002F)

We adjusted and created our own manual Health Planner/Passport to collect data. Table 5 is a sample of the passport. The passport was completed over time in conversation with the CAs who would complete the document with the neighbour.

The Patient Activation Scale (Table 6) proved to be a unique tool to both gather data, monitor participants behaviour change, and establish a feedback mechanism for program design.

We gathered data on PAM through our Health Planner. Predictably, most participants were aware of the importance of exercise and good nutrition in improving their personal health. This was not only a reflection of our program but also of others working in the neighbourhood as well as messaging from all levels of government. However, few programs address long-term outcomes such as having the confidence to take action, taking action and ultimately staying the course.

The CAs role changed at each step and required different programming and different methods of support. In addition, we began to identify community assets which could support this behaviour.

It became clear that the CAs would need to develop competency in motivational techniques and supporting behaviour change.

"When I first come to this program I was eating what is available to me. I usually eat lots of rice and curry. Now I know what healthier serving size is. I reduce the rice and put more salad and fruits in my plate." (PT009F)

The Patient Activation Scale became a simple and effective tool to assess where the participant is on the spectrum of behaviour change, to delineate the kinds of approaches required at each level, and as a way of classifying participants stages on their journey to a lifestyle to sustain healthy practices.

We progressed to developing our own online data base which gathered all data collected and also acted as the program enrollment form. The data base could be accessed by phone, resulting in information being added to a neighbours file during formal programs, meetings in the neighbourhood, and visits to homes.

The database was developed by a team of newcomer technicians living in the community who were either directly involved with the program or whose spouses and children were participants. The

Recommendations

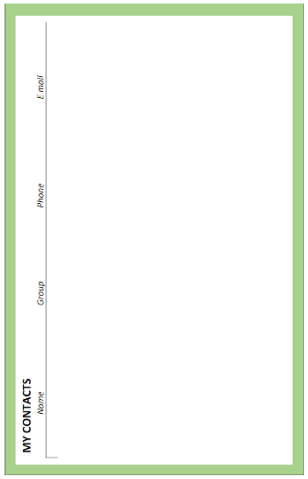
majority of the designing and coding was done on a volunteer basis, as their contribution to their community and to Community Matters.

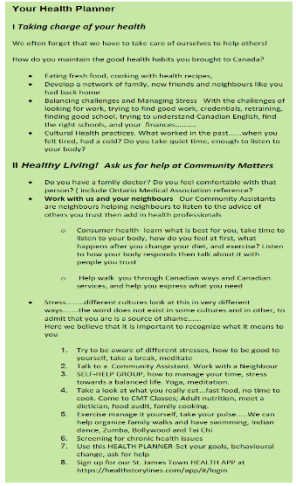
- The discipline of data collection and gathering in orally based cultures is challenging. Data collection was sporadic depending on the skill and desire of the CA as well as their attitude towards its necessity. We overcame these challenges by setting aside review time in each weekly CAs meeting discussing one neighbours file each week and by having the CAs participate in the design of the manual Health Planner/Passport.

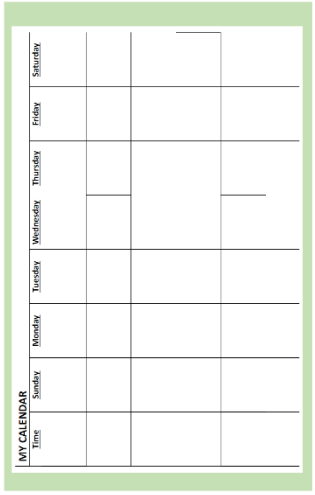
- We presented results of the work graphically to the CAs and used it as a learning opportunity to train on data interpretation and design of new programs.

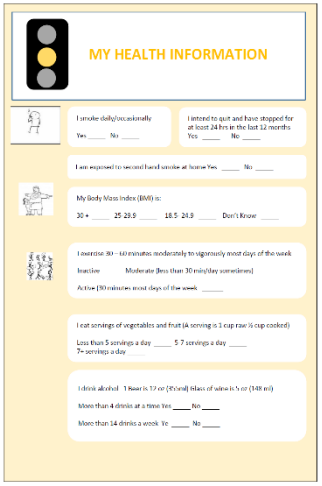
Table 4

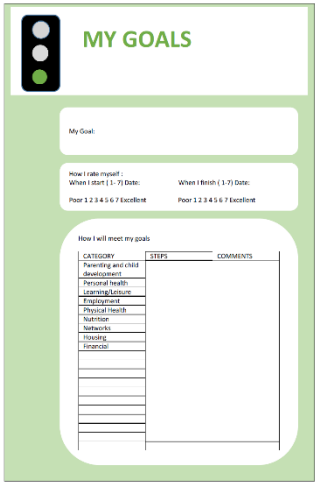
Health Planner

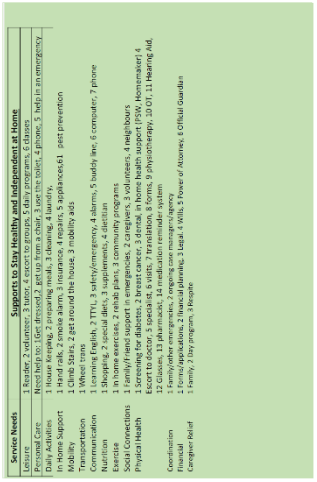


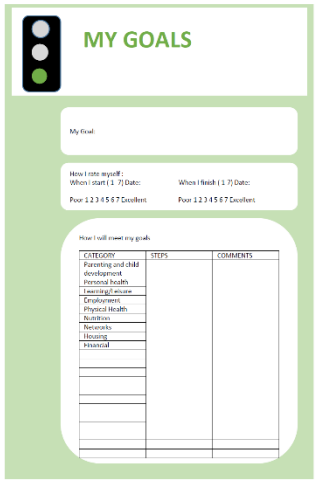


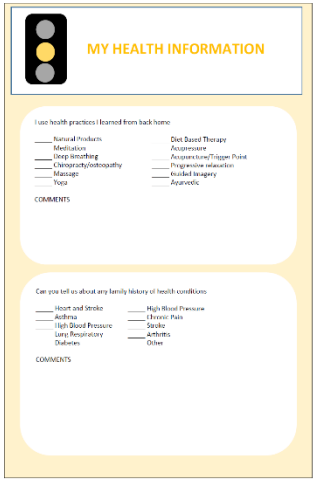


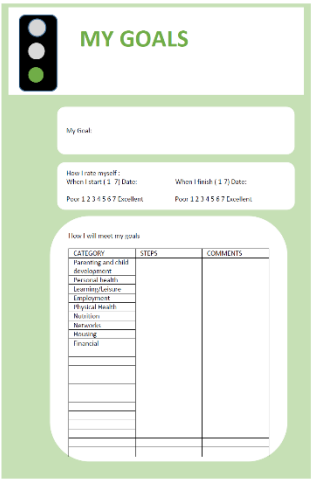












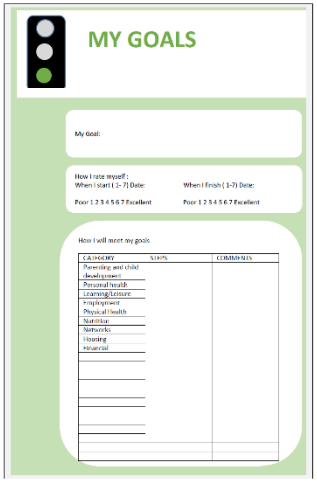


Table 5

The Patient Activation Scale[10]

Four Stages of Activation (PAM Category)	Community Assistant Role	Community Participation
Believes Active Role is Important	• Meet a neighbour at home • Accompany neighbours • Bring neighbour to a program • Stay with the neighbour in times of crisis	**BRONZE:** Residents we meet in the community and who would attend our groups, social events, fairs and the occasional CMT program.
Has Confidence and Knowledge to Take Action	• Sets up a "Buddy System" with a volunteer/friend to support each other's participation	**SILVER:** Neighbours who attend programs, completed screenings and assessments, and participated in health conversations
Takes Action		
Stays the Course Under Stress	• Follows up regularly to help the participant maintain their progress, deal with stresses that arise and develop other networks, personal strengths and resources	**GOLD:** Those who took the next step and worked with us individually or in a group to achieve, maintain and set new health goals.

[10] Patient Activation Scale. Development of the Patient Activation Measure (PAM). Conceptualizing and Measuring Activation in Patients and Consumers. www.ncbi.nlm.nih.gov/pmc/articles/PMC1361231/

Table 6

Program registration page containing health questions

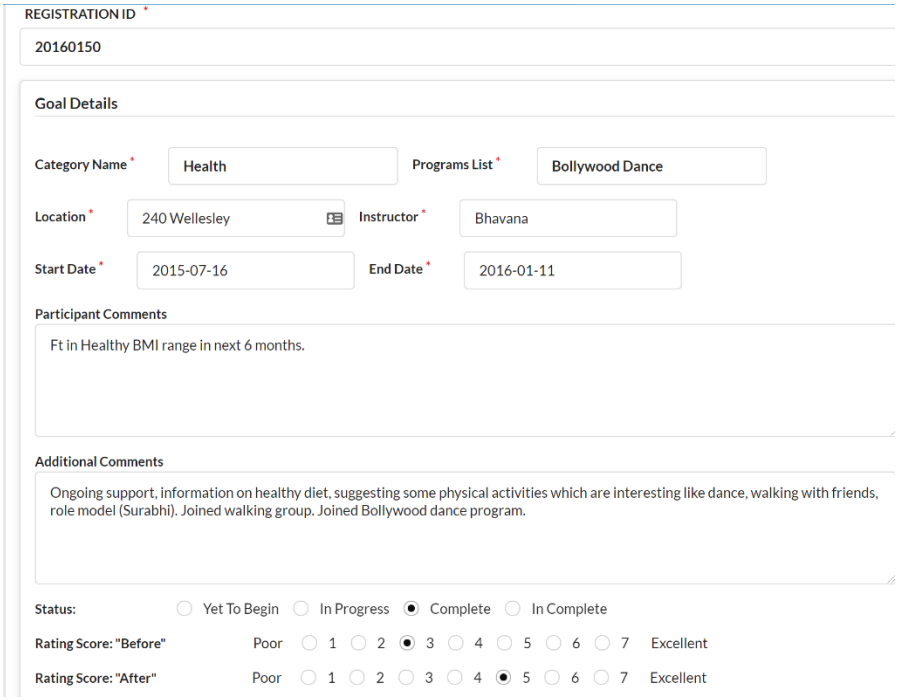
Member details - Answer all

(Please Select accordingly)

Overall I think my health is:	○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
My satisfaction with my life is:	○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
My social networks of family and friends are:	○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
My level of connection with my community is:	○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
My level of stress is:	○ High ○ Quite a lot ○ Depends ○ Manageable ○ Low
I can talk to others about my personal health issues:	○ Never ○ When it is urgent ○ If I am upset ○ Sometimes ○ All the time
Do you have a family doctor?	○ Yes ○ No
Number of times each year I visit	Family Doctor ☐ Walk in Clinic ☐ Emergency Room ☐ Hospital ☐
I am aware of the risk factors for diabetes, cancer and cardiovascular disease	○ Yes ○ No
I am aware of facilities, programs, parks, playgrounds within community for healthy living and physical activity	○ Yes ○ No
I am physically active (exercise atleast 3 times a week for 1 hour)	○ Yes ○ No

Table 7

Sample of Goal Form in Participants Database of Participants



REGISTRATION ID *

20160150

Goal Details

Category Name * Health

Programs List * Bollywood Dance

Location * 240 Wellesley

Instructor * Bhavana

Start Date * 2015-07-16

End Date * 2016-01-11

Participant Comments

Ft in Healthy BMI range in next 6 months.

Additional Comments

Ongoing support, information on healthy diet, suggesting some physical activities which are interesting like dance, walking with friends, role model (Surabhi). Joined walking group. Joined Bollywood dance program.

Status: ○ Yet To Begin ○ In Progress ◉ Complete ○ In Complete

Rating Score: "Before" Poor ○ 1 ○ 2 ◉ 3 ○ 4 ○ 5 ○ 6 ○ 7 Excellent

Rating Score: "After" Poor ○ 1 ○ 2 ○ 3 ○ 4 ◉ 5 ○ 6 ○ 7 Excellent

Findings

Achievement of Expected Outcomes (Continued)

Health Risk Screening: Participants use of health assessment tools

Objective	To create sustainable opportunities for residents at risk of diabetes, cancer or heart disease to participate in the use of health assessment tools including CanRisk and cancer screening
Outcome 4 (a)	Access St James Town residents used health assessment tools for their personal health awareness and health management.
Outcome 4 (b)	Support Trained St. James Town residents encouraged and assisted their neighbours in using health assessment tools for diabetes, cancer and heart health.
Outcome 4 (c)	Knowledge Residents understood the benefit, access to and ease of use of health assessment tools and were encouraged to use them to manage their family's health. Residents improved their knowledge of their own health through the direct communications methods available with the health management tools.
Primary Activities	CAs would complete the assessment tools with the resident while they were attending a program. As an example, while attending a Zumba class one CA would take a participant aside and complete an assessment tool such as CanRisk or the Health Planner/Passport. CAs would work with participants creating health goals based on information coming from the assessment(s). The participants would rate themselves on their confidence in achieving their goal at the beginning and at the end of the program (e.g. a 16-week set of Zumba classes). CAs met with residents and talked about their health and progress towards their health goals, referring them to our social media pages and our web-based health library. Individual follow up took place to encourage follow through on advice received from family doctors and other health professionals.
Target Population	Residents at risk of diabetes, cancer or heart disease
Budget	$ 13,342 (Annual average of 6 year grant)

"I reduced weight ,I learned about eating healthy and avoid junky food. I started to eat balanced diet such as protein ,carbohydrate, and vitamins." (PT0010F)

Partners	TDSB Wellesley Parliament Square Residents Regent Park Community Health Centre Toronto Central Region Cancer Program The Mobile Health Bus City of Toronto Wellesley Community Centre
CAsing	Community Assistants
Evaluation Period	January 2015 – March 2019

	Target	Actual
Performance Indicators	400 residents will complete the CanRisk diabetes assessment tool	**450** Residents completed the Can-Risk assessment tool
	200 residents will utilize cancer screening tools	**385** Used Cancer Screening Tools and 900 residents were screened
	Explanatory information (videos, slide presentations) will be published online and on community electronic notice boards	A Social Media Calendar (Appendix 6) was developed each year which included 3 relevant Facebook posts each week. The posts included posters, links, and videos. We created our own health library posted on our web site with a variety of videos, presentations and written information
	6 trained residents will accompany neighbours to screening appointments	An average of 8 residents were trained each year and accompanied their neighbours.

REFLECTION

Assessment

Our objective was to introduce participants to the use of screening tools to identify potential health risks. CAs worked with their neighbours to provide information and support on health care and health promotion as the basis for a plan to address those risks.

The process of screening and developing tools evolved over the duration of the project. Initially screening, although based in the community, was done by issue. We created processes to separately screen for cervical and breast cancer, heart and stroke, diabetes, and later for dental.

At the same time our programs were managed at a senior level. CAs could be assigned or participate in different programs, not specifically identifying with a program or the participants of that program.

The next step was to assign CAs to a specific program. Relationships between the CAs and participants progressed positively and the CAs took ownership of “their program” and “their participants”, completing health passports and helping participants to set health goals. At the same time all CAs were aware of who each CA was working with and determined how best to support them.

As we progressed and gathered data, programs were refined – the Health Bus was introduced, we engaged more partners such as Food Share, additional programs were developed and offered, the in-house database was developed and the trends identified through analysis were used to support decision regarding new programs, program times and providing additional information. The Patient Activation Measure was introduced and monitored.

"At any given time there are 20 to 30 participants are coming for our program of food handling. This program benefits participants on how to handle food at home and offer them with job opportunities for many." (PKI002F)

Screening tools provided "real time" information and assisted CA's to create personal health goals and plans with program participants.

With a goal of integrating discussions about health into the daily routine of our neighbours, we identified 3 categories of participation:

- Bronze were residents we would meet in the community. They would attend social events, fairs and the occasional program
- Silver were residents that attended programs, completed screenings and assessments, and participated in health conversations
- Gold were residents that took the next step and worked with us to use their screening information to set health goals.

It was sometimes challenging to introduce the assessments in a natural way during routine programming (e.g., Zumba, dance, local fairs, etc.). Nonetheless, the CAs were familiar to the residents, the classes/events were based in the community, events/classes were free and taught by skilled leaders, and as such, most participants were willing to take the time to complete the assessments. Some assessments were done over several sessions so as not to turn participants away from the process.

The CAs needed to acquire good communication skills to have this be effective information gathering. With consistent attendance by our CAs and a consistent message, over time, residents became more willing to enter into the discussions with some eventually prepared to set and work at health goals.

With goals set, we then used the information available to us through our library, online resources, including our own Facebook page to add to residents' knowledge.

We became innovative in our delivery approach with health-focused videos during our food markets, and PowerPoint presentations available at local spas where women were receiving facials, having their nails done, haircuts, and receiving massage treatments.

The Mobile Health Bus (a cancer screening service for women) was incorporated into a health fair which included, food, music, dance,

children's events and children and adult games. The social mix through the fair brought residents in, leading to less reluctance to be screened at the bus. This approach led to the highest numbers screened at any one session in the city.

We further recognized that we could have even more impact by influencing the neighbourhood systems to create better conditions for personal health.

As these changes took place over the period of the project, participants demonstrated through conversation an increased awareness of the risk factors for diabetes, cancer and cardio-vascular disease including the risks from lack of exercise, poor nutrition and not participating in screening.

Recommendations

- Health screening was a new skill for most of our CAs and participants. They required training on the correct use of screening documentation, how to lead health discussions with participants, goal setting, and follow up. The training in this area needs to be thorough and include regular knowledge and skill evaluation.

- The time for weekly group staff reviews of progress with selected participants needs to be increased to at least 3 hours. The reviews were done as a group as each Community Assistant had different experiences and brought different, proven ideas to the discussion. As the participant attended several different programs led by different CAs were able to see the contribution of each activity to the overall goal of improved health.

- The internal design of some of the screening tools helped in their completion.

- Although there is more organization and coordination required, the introduction of screening into regular community activities such as the Mobile Health Bus had very positive effects on the number and willingness of neighbours to participate.

Table 8: Sample of Participants Goals

Participants Comment/Goal	Community Assistant's additional comments	Measurement	
		Pre	Post
achieve healthy BMI weight along with socialization in next 3mnths and improve English	Insisted her to come regularly for Bollywood to get socialize, gave her information about other CMT programs but she is working….coming for Zumba as it is on weekends. Reminder messages for the physical exercise programs. For English, gave her information about English Cafe and connected her with Neighbourhood Net	1	4
Weight reduction.	April 2019: Susmita is a very energetic participant. She scores her progress before joining the program as 2 and after as 5. She feels like she is progressing but she has not reached her ideal weight which is 62 Kg. (Dastan June 6, 2019)	2	5
Increase in stamina (e.g.: currently able to cover 3/4 of the pool width).	April 2019: she scores her progress before as 2 and after as 6. She believes that she has to build more stamina. (Dastan June 6, 2019)	2	6
Improve my health. April 4th, 2019: She is overall better. She now has a wound on her Right leg that makes walking difficult for her. Scoring after is (5)	XXX is a participant in our Health Check-In and she has been accessing our services and resources for few years. She is 82 years old, she lives with her spouse. She does not smoke or drink, has confidence and knowledge to act alone. She eats fruits and vegetables daily. She has a complex health condition (mostly affecting her cardio-vascular system), she has her own family physician and specialist that she visits and follow up with them on regular basis. My role as a CA is to screen her blood pressure and blood sugar weekly, interpret the results and advice her from a community worker's perspective. XXX health condition is chronic in nature. Her blood pressure over the summer was reading low. Over the course of few months, her blood pressure reading shifted to normal.	4	6
Her first Goal- To perform cardio workout and burn out calories with an aim to remain fit; to relieve stress. She would like to attend more classes realted to physical activity and menatl health. Her specific goal is on Health to maintain her weight. She would also interested in Nutrition to leraning seving size. She is very much concern for Health.	She is living in this community almost two years. She lives in 240. She is my friend and i told her about CMT programs. She was looking some phiysical activity on weekend then I told her about Zumba program on Saturday. It helps to reduce weight and minimize stress. then she got encouraged to attend our zumba program. So I had registered in the program. She is our regular participant in Zumba. She is giving feedback after each class. I'm followup with her on regular basis. I'm planning to do with her Health planner soon.	2	In Progress
His goal is to get rid off stress; reduce his high blood pressure and high diabetic levels	With the help of CMT, the participant started to attend our programs like volley ball and meditation. Furthermore, he walks at least one hour every day and has changed unhealthy eating habits from junk to health food by purchasing fresh fruits and vegetables from Food Share every Mondays. After almost 8 month, his stress is normalized; his blood pressure and sugar levels have been reduced satisfactorily, according to his family doctor's report.	1	4
o look a good Dentist for her Son (2yrs old) in next 1 month	Did ask her to do a dental screening with our Your Smile Matters. Suggested some of the Dentist in neighborhood. She got one who is ready to treat her son. After 1 month her son got extraction of some teeth. Now following Dentist's instructions.	2	6
	Overall Per Cent Improvement		280 %

Table 9 : Sample of one participants progress through goal setting

Participants Comment/Goal	Community Assistant's additional comments	Measurement	
		Pre	Post
1. To improve English in next 3 months. Has basic English knowledge but not comfortable in talking.	She is very new to Canada. Started to come to Social support as one friend told her about the program. In this program she told me (Bhavana) her interest towards English speaking. Connected with Sarah's English café, Buddy (Sulekha). Started to go to Sarah's English speaking regularly and improved her confidence in talking.	3	5
2. Ft in Healthy BMI range in next 6 months.	Ongoing support, information on healthy diet, suggesting some physical activities which are interesting like dance, walking with friends, role model (Surabhi). Joined walking group. Joined Bollywood dance program.	3	5
3. Increase veg/fruits intake – 5/day in next 3 months. Being South Asian I have more intake of Carbohydrates. I want to change that habit.	Reminding her to eat more fruits and vegetables almost every day...set a reminder for it, had a discussion of benefits from vegetables and fruits in a social support group. Suggested her to join Surabhi's Adult Nutrition and Food Handling. Initially the goal was for 3 months but we continued it untill she achieves her goal of having intake for 7/day. Meanwhile she got pregnant so I encouraged her to eat more veggies and fruits for a healthy baby.	2	6
4. Improving knowledge about healthy pregnancy pre and post. It is second pregnancy but for first pregnancy she was in India so got more support and that is why does not know how to handle this change.	Connected with Growing Together's Pre and Post natal program from October, exchanging information in social support group, Buddy (N.B.)	1	6
5. getting support after delivery and get confidence in handling a baby for next 1 month.	Talked to her friends and made a schedule for some days to take care of her food and her daughters. Home visits to support her mentally and sharing knowledge. Motivate and encourage her to re-join Growing Together's post-natal program for more information and Social support to reduce stress. After one month I felt that she is pretty confident in handling a baby and the situation around her and her daughters.	3	5
6. participation in the outdoor banner contest before deadline.	Told her about Canada150 and outdoor banner contest. She was not confident initially but I encouraged her and my other participants from Life through Art for trying and participating in this contest by telling that it wont's hurt if we will try. Worse will happen that they will not select your paintings but there is no harm to participate. Finally she made one painting and I connected her to Nicole. Met to Nicole and SUBMITTED a painting.	3	5
7. Need food handling certificate for the Job. She is registered for the Food handling course at CMT. Program is design for the six week.	Earned certificate and gained a job	3	5
		2.5	5.2
	Per Cent Improvement		208 %

The pre and post measurement assesses the participant's confidence level in achieving the defined goal. For all goals set the confidence level of achieving a healthy outcome for the health goal increased from 2. To 4.6 on the seven point scale.

Findings

Achievement of Expected Outcomes (Continued)

Dissemination of Health Information

Objective	To create an understanding in the community of St. James Town of the critical risk factors for diabetes, cancer and heart disease and their mitigation through the ongoing delivery of a multi-pronged approach to disseminate relevant health information
Outcome 5 (a)	Access Information concerning the chronic disease critical risk factors and their mitigation was made available to the residents of St. James Town through a variety of culturally appropriate means.
Outcome 5 (b)	Support Residents were supported to combine healthy living practices from their country of origin with those commonly practiced in Canada.
Outcome 4 (c)	Knowledge Residents improved their knowledge of critical risk factors and mitigation strategies and applied this knowledge to their personal and family health management.
Primary Activities	Disseminated frequent health messaging through multiple methods and platforms, as informed by feedback and acceptance by neighbours. Coordinated messaging with Rose Avenue Public School and incorporated information into school curriculum, after school programs, and shared health fairs. Built health messages into all program curriculum at Community Matters including recreational, language, training and after school programs, as well as fairs, cultural and monthly community events.
Target Population	St. James Town residents
Budget	
Partners	Rose Avenue Junior Public School The Wellesley Community Centre Wellesley Parliament Residences (Landlord)
CAs	Community Assistants and Volunteers
Evaluation Period	January 2015 – March 2019

	Target	Actual
Performance Indicators	2 Health information work-shops will be held in partnership with Rose Avenue School Parent Council annually	2 Health Workshops were held in partnership with Rose Avenue School Parent Council annually

	Health information will be an element of every program offered by Community Matters	Health information was an element of every program offered by Community Matters including After School and Language classes
	Health information will be an element of programming at the Wellesley Community Centre and part of curriculum at Rose Avenue Public School	Health information was an element of programming at the Wellesley Community Centre and part of curriculum at Rose Avenue Public School including Yoga classes and After School programs
	Health information videos and slide shows will be posted on a web site and on 4 community electronic billboards	Health information videos and slide shows are posted on a web site. 3 posts were completed each week for the full period of the program in accordance with our media calendar. Electronic community billboards were not set up due to cost
	Healthy information will be distributed in local grocery stores monthly	Healthy information was distributed in local grocery stores intermittently
	Health information will be distributed in a welcome package to new tenants of the 16 apartment buildings in St James Town	Health Information was distributed directly to tenants through lobby events in 5 apartment buildings
	Health information and assessments will be conducted at community events and festivals	Health information and assessments was conducted at community events and festivals

REFLECTION

Assessment

The most effective way to share any information in St. James Town is orally and through conversation. The use of flyers, informational pamphlets and multi-media is far less effective. Our objective was to effectively separate this information from all the other information our newcomer neighbours are being bombarded with.

All Community Matters programs are structured to provide an opportunity for learning through conversation. As adult learners, CAs, volunteers and residents are anxious to contribute their own learning, points of view and experience to an issue.

> *"One of the reasons that seniors came to our program was for food and that food was usually starch, sugar based cakes and creams and that type of thing. And over a two year period that food now is fresh vegetables it's much more related to a healthy diet and that group actively seeks that kind of food."(PKI001F)*

Community Matters programs and workshops all include health and lifestyle subjects in the curriculum with the provision for extended conversation. As an example, when learning how to search for

information online, we asked participants to search for pages which discuss the risk factors of diabetes. The results were then shared with the group, and agreement was reached on which page had the most reliable content. In those discussions, personal health strategies were discussed, and we encouraged conversation about practices from their home countries.

Our fairs, cultural occasions and monthly events are also set up in an environment that encourages lifestyle conversation. Our annual "Cultural Collage" festival celebration of Canadian newcomers includes the replication of living rooms complete with couches, mats, tables and serving tea. Neighbours are encouraged to visit, sit and engage in conversation which includes the steps and activities they are taking on to improve their lifestyle.

The repetition of the same messages by all CAs and volunteers in all discussions has had a positive impact on neighbours' knowledge and their willingness to change their lifestyle. Over time, we found residents would naturally weave conversations about health into program discussions; for example, the healthy snacks they would be eating at the break.

Throughout the grant, we changed our approach slightly in response to feedback from residents. For example, we decided that covering each apartment building with flyers was too time consuming and did not provide the opportunity to enter into conversations with residents. We replaced this with pop-up mini health fairs. in the lobbies of the apartments where we had the most connection. In most cases flyers delivered to homes are treated as "junk mail" and thrown out before reading. The pop-up mini health fair gave us the chance to engage with residents as they waited for elevators which could be up to twenty minutes during rush hours. Each week, we would be in the lobby at the same time with a consistent message and engaged residents as they waited for the elevators.

> *"I learned that I have cancer, I have two children both of them are married and live their lives. They are not around. Thanks to CMT I joined Zumba and yoga clubs. This helped me a lot to relax myself." (PT0013F)*

Beyond Community Matters and a few partners (Rose Avenue School, apartment building landlords), willingness to display health messages was less consistent. Grocery stores and the recreation centre, both of whom deal with many different organizations with different agendas, were more reluctant to participate. The reason provided was that they did not want to appear to be supporting one initiative at the expense of another.

Recommendations

- Creating opportunities for open ended conversations provides the most effective venue for residents to talk about their lifestyle.

- Weaving discussions about health into the program and service curricula is a subtle and effective method of introducing key concepts.

- Take time to develop agreements that establish clear expectations with project partners.

Findings

Achievement of Expected Outcomes (Continued)

Creating a Culturally Appropriate Environment

Objective	To create a safe, culturally appropriate environment in which residents can learn and participate in their health management	
Outcome 6 (a)	Access Residents gained access to the use of services (e.g. disease screening tools) to help mitigate critical health risk factors.	
Outcome 6 (b)	Support Residents accepted and participated in practices (e.g. disease screening) to contribute to the mitigation of critical health risk factors.	
Outcome 6 (c)	Knowledge Residents enhanced culturally accepted health knowledge and practices with those available in Canada.	
Primary Activities	Established permanent, safe space within the community to offer programs and services. Established spaces within shared program facilities where residents can engage in personal discussions. Held regular events in program spaces to demonstrate a welcoming, safe environment.	
Target Population	Residents at risk of diabetes, cancer or heart disease	
Budget		
Partners	TDSB, Wellesley Parliament Residences	
CAs	Community Assistants and volunteers	
Evaluation Period	January 2015 – March 2019	
Performance Indicators	**Target**	**Actual**
	Residents will participate in support groups addressing mental health, diabetes, cancer and heart health	Between 1 and 3 support groups took place each week of the program
	Residents will participate in cancer and diabetes screening services	Screening took place regularly through workshops, health fair and one on one
	Residents will be supported in their own health management	385 neighbours completed Health Planner/Passports and engaged in lifestyle goal setting.
Assessment	**REFLECTION**	
	Our premise was that newcomers would be more prepared to be screened, receive information, discuss, and take part in health conversations if those conversations took place in a safe familiar environment with neighbours they know and trust.	

St. James Town is geographically small (less than 1 sq. km) and the availability of public space is extremely limited, and even more so for space that is not shared with other groups and organizations. The contribution of our partners and landlord to provide space free of charge in the middle of the community was invaluable.

We were given a large open commercial space with storage and meeting space, and created a warm environment putting in a new floor which could be used for activities such as dance and yoga, a small washroom, and a small kitchen. The space opened out onto a large pedestrian pathway which we used for festivals, events and to grow plants. We decorated the walls and covered them with health messages.

We also made the space available free of charge to neighbours for their events such as birthday parties. We made access easy and the space quickly became known as a place where the community could gather. Over time, this created positive memories of community events, meetings and gatherings.

> *"whenever we come to CMT we chat, discuss and gossip on various issues, and this is a very good platform for us to release /vent our stress, learn about nutrition and do some physical exercise like Zumba and Bollywood dances."(PT0011F)*

In addition to our own activities it also became a neutral space to discuss issues which carried strong and differing points of view. As an example, the space was used to gather the community and the school together to discuss the implementation of the new sexual education curriculum. There were strong opinions on various sides of this issue, yet the meeting resulted in all parties accepting a way forward. This was in part due to the mutual respect among the group and, we feel, because they were in a familiar community space which provided them with safety to openly explore solutions.

In this environment, newcomer residents were more willing to discuss sensitive topics and expand their personal approach to a healthy lifestyle. Over time, neighbours entered this space to discuss very difficult personal issues which included domestic abuse and depression.

This was the primary setting where residents used disease screening tools, learned about health issues, and set and met their personal goals.

Recommendations

- In combination with neighbours supporting one another, the establishment and maintenance of a safe space within the community is a significant contributor to the support of residents changing their lifestyle.
- Broadening the use of the space to a range of community activities and meetings serves to broaden the appeal of the space to more residents within the community.

- Because of proximity to the landlord's office and CAs, the property owners could see the immediate benefits of the use of the space.

Development of Knowledge Transfer Tools

Objective	To develop and provide knowledge transfer tools, over the life of the project, to partners and organization who may be considering similar initiatives.	
Outcome 6 (a)	<u>Knowledge</u> Similar projects will benefit from the tools and lessons learned from the implementation of this project	
Primary Activities	Develop hard copy and online resources for use by other organizations Create a searchable web page for project documentation	
Target Population	Organizations who wish to use a community-based approach to improve lifestyles amongst newcomers	
Budget **Partners**	Computer and web technicians	
CAs	Web design and web-based data base consultants, Community Assistants creating content	
Evaluation Period	January 2015 – March 2019	
Performance Indicators	**Target**	**Actual**
	Similar projects will use the Knowledge Transfer tools in the development of their projects	Web based Health Library completed and on-line covering 13 categories with 298 culturally appropriate links and videos Web based program tools with 8 separate categories populated by training videos and templates Attendance and invitation to present at Tamarack Conference Screening for Newcomers Conference with Toronto Central Regional Cancer Program
Assessment	**REFLECTION**	
	Our commitment was to make ourselves available to other organizations for mentorship and advice, and to provide clear, concise tools in the form of program plans, electronic data bases, forms, and poster templates. The need to provide useable online tools ensured that our documentation was complete, understandable and easily navigable by others. Some of the web-based material such as the written documentation and videos is immediately available without modification. We have used the Mobile Intervention application as a basis to provide an online program planning workshop which would be easily adapted to any other program. Mobile Intervention is the use of	

telephony by trained CAs to initiate behavioural change and lifestyle interventions.

As we are primarily focused on the work necessary to support our neighbours, we have never committed resources to publication of our work or our achievements beyond the maintenance of our website. We have a passive approach preferring interested parties to contact us.

In retrospect our approach is similar to the Friendship Bench model established in Zimbabwe. In that case, an operating manual has been made available online and new groups are invited to be part of an email communication group where new tools are added periodically.

Over the course of the project we have connected with WoodGreen Community Services and were influential in designing their project to support small grass roots organizations in their catchment area. Elements of our program are now part of their project.

"I am 70 years of age .I have diabetes type II ,I regularly check the status and apply doctor's advices ,I eat less sugar, regularly exercise and now my sugar level dropped amazingly. " (PT0012M)

We have also presented at the Tamarack Conference and the Screening for Newcomers Conference with Toronto Central Regional Cancer Program. There is continuing interest in our approach to successfully reach vulnerable and isolated members of the community.

We have successfully made our documents available online and will continue to maintain and update this information. Nearing the completion of our project our data and materials are finalized and can be used by other groups. This would include access to our online data base which could be adapted to other organizations for tracking and reporting purposes. We now need to put more attention into engaging additional organizations who could benefit from these infrastructure tools.

Recommendations

- Without demonstrated measurable success it would not be appropriate to share the concept or the tools.
- Organizations must be proactive in sharing information either online, through video-conferencing or direct contact through the duration of their projects.
- A budget line with corresponding expertise and resources would have placed more focus on this activity to ensure the gains and successes were not lost and there is a concerted effort to promote the community-based approach.

Links to Program Tools:

http://communitymatterstoronto.org/program-tools/

5.0 Conclusion

Healthy Living in St. James Town demonstrated that a neighbour-led approach could have a positive effect on resident's personal health, equaling or bettering levels of advancement reported through established health improvement methodology.

The project was designed as a learning ladder and encouraged experimentation, risk and adaptability to changing conditions. Learning from success and failure along the way, we supported the neighbourhood and its residents to create conditions which support sustainable personal health habits.

Vital to the process is the CAs role as an influencer in the community. By establishing trust, the CA became an influencer within the family unit. This position contributed to changes in the family's attitudes towards screening for women resulting in the highest levels of one day screening in the Mobile Health Clinic achieved in the City of Toronto. The CAs influenced and changed neighbourhood patterns by contributing to immediate neighbourhood and individual challenges, establishing personal health as priorities in the neighbourhood, and organizing solutions for residents. This approach negated the need for traditional outreach activities which are imposed on a community, are well worn and treated with suspicion and replaces that with resident driven motivation, demands and actions.

Having established resident driven action, the Patient Activation Measure (PAM) strongly contributed to enabling the community to not only possess an abundance of readily available knowledge, but to sustain healthy living practices in their daily lives. The use of the scale identified where the participant was on the continuum and motivated the CAs to develop new and creative methods to encourage sustainable action by participants. Networks, motivation, communication, buddy systems, small groups, and expanded and novel programming were all used as support tools to encourage sustainable behaviour change.

In most cases CAs were trained and had experience in various health sectors in their home countries. In addition to their training they were encouraged to express their natural sense of caring, compassion and spirituality, and to blend traditional cultural values into their approaches, establishing these factors as equal in importance to the technical aspects of their work.

As they became seen as community leaders, they began to influence the neighbourhood patterns, establishing personal health as a priority in the lives of the community and creating patterns and physical structures which supported healthy personal lifestyles.

Honouring who the CA is and what they uniquely bring to the community creates a sense of purpose and determination for them to bring those personal traits to their work and the community.

These three key factors, participation in and changing neighbourhood patterns, using the Patient Activation Measure and placing the CA at the centre of the process brought out the underlying social norms in the community and supported the transmission of healthy behaviours throughout the neighbourhood.

Evaluation Outcomes Summery			
Objective		**Performance Targets**	**Output Targets**
Training residents trained as Community Assistants	6 residents will complete training annually	Met	Met
	Diabetes, heart and cancer screening will take place among St James Town residents	Met	Met
	St James Town residents will participate in physical activities, nutritional programs and support groups provided by this project	Met	Met
	Participants will use electronic and health manual health management tools	Met	Partially Met
Resident Participation	6 physical fitness programs will be offered in the community annually	Met	Met
	6 nutrition programs will be offered in the community annually	Met	Met
	3 self-help groups will be provided in the community on an ongoing basis	Met	Met
	There will be an 80 % participation rate by St James Town residents in these programs	Exceeded	Met
Development of Health Tracking Tools	A pilot agreement will be signed with MYOSCAR or similar electronic health management system	Not Met	Not Met
	6 residents will be trained to support their neighbours in the use of health management system.	Met	Met
Participants Use Health Tracking Tools	400 residents will complete the CanRisk diabetes assessment tool	Exceeded	Met
	200 residents will utilize cancer screening tools	Exceeded	Met
	Explanatory information (videos, slide presentations) will be published online and on community electronic notice boards	Partially Met	Partially Met
	6 trained residents will accompany neighbours to screening appointments	Met	Met
Dissemination of Health Information	2 health information workshops will be held in partnership with Rose Avenue School Parent Council annually	Met	Met
	Health information will be an element of every program offered by Community Matters	Met	Met
	Health information will be an element of programming at the Wellesley Community Centre and part of curriculum at Rose Avenue Public School	Met Partially	Met Partially
	Health information videos and slide shows will be posted on a web site and on 4 community electronic billboards	Met Partially	Met Partially
	Healthy information will be distributed in local grocery stores monthly	Not Met	Not Met
	Health information will be distributed in a welcome package to new tenants of the 16 apartment buildings in St James Town	Not Met	Not Met
	Assessments will be conducted at community events and festivals	Met	Met
Creating a Culturally Appropriate Environment	Residents will participate in support groups addressing mental health, diabetes, cancer and heart health	Met	Met
	Residents will participate in cancer and diabetes screening services	Met	Met
	Residents will be supported in their own health management	Met	Met

6.0 Recommendations

Impact

Recommendations affecting the overall impact of the project are detailed in the Achievement of Expected Outcomes section of the evaluation.

Resources

The project benefited from the multi-sectoral approach to resources and funding. In some cases, clear benefits were gained by the development of mutually beneficial relationships such as was achieved with the landlord. Not only did the project gain valuable free space but also the relationship addressed some social issues experienced by individuals and groups of tenants which ultimately resulted in improved landlord-tenant relations. Eventually the landlord joined with the project to investigate ways to address the mental health and stress issues experienced in the community.

A more formal structure could be established in developing mutually beneficial relationships defining specific outcomes prior to entering into the formal partnership, including:

- Specific outcomes defined for each partner which lead to meeting the projects long term objective.
- Identifying multi-sectoral partners for each outcome.
- Creating targets for introducing new partners throughout the project.
- Establishing long-term shared outcomes for the partners.

Throughout the project there was increased in-kind contributions from a variety of sources including volunteer time in specific disciplines (e.g., art, materials, communications support). The project did not adequately record or value these contributions in part as these acts were considered normal with no need for recognition. The result was an undervaluing of the community contribution. Going forward, our recommendations include:

- Establishing a simple system for recording and valuing contributions.
- Include a documentation area for contributions in the individual program plans.
- Train the CAs to identify, record and recognize these contributions.
- Establish an agenda item on the periodic program reviews.

Planning

Designed as a Learning Ladder, the project established regular reviews to provide the opportunity to discuss experiences of implementation and to propose program changes. It is felt that, although changes did take place and additions were added these could have taken place more smoothly and more immediately. This was in part because the very discipline of project review was new to most of the CAs. Within the broad guidelines of the project new ideas were implemented often because of the previous experience from a CA, or a new idea emerged from participants. Beyond these sources, changes were slow to implement. While the implemented changes contributed strongly, the project could have gone further.

This became increasingly evident as we gathered information from our database which was identifying clusters of needs (stress, lack of familiarity with the existing health care system, reluctance to enter into activities, influence from the larger extended family). Some new ideas needed more focused attention to effectively implemented, including:

- A senior team member with some experience in data analysis leading to program implementation should be part of the team.
- More training in combining data analysis and response with traditional methods of identifying needs should be implemented.

Evaluation

Traditional evaluation methods and techniques were new concepts to the majority of the CAs and participants. The participants and CAs also came from orally based cultures and communities and were unfamiliar with gathering and reporting data, how to read this data, and the benefits of the evaluation.

In addition, interpreting answers to questions required an in depth understanding of the participants. Often participants came to the program believing that if they did not answer a question in a certain way, they would not be able to participate in the program. Others believed that the questionnaire was being used as a method of compensation for the organization (i.e. the organization would be paid for each questionnaire submitted to the funder). Over time, techniques were developed to mitigate these issues however data gathering was somewhat compromised. Going forward, our recommendations include:

- More up-front training is required in the theory of evaluation and the practice, design and implementation of the evaluation plan.
- Data and information review should be built into regular team meetings.
- Program amendments proposed by CAs and participants should include data analysis.

Table 10 Project Logic Model			
Objectives	**Expected Results (Outcomes)**	**Indicators**	**Data Collection Tools**
Capacity To increase community capacity to support residents at risk of diabetes, cancer and heart disease by training 6 residents (e.g. foreign trained health care professionals) annually to provide empathetic and non-judgemental support to residents of St. James Town	Access St. James Town residents use health promotion, chronic disease, prevention, early detection and support resources created and delivered in the community Knowledge Residents will learn of the risk factors and their mitigation from their own cultural perspective Social Support Conditions and safe space will be created for residents to participate in their own health management	Note: This objective is designed to support the success of the projects other objectives and will primarily be measured by the indicators of those objectives. A resident training manual will be published 6 residents will complete training annually Diabetes and Cancer screening will take place among St James Town residents St James Town residents will participate in physical activities, nutritional programs and support groups provided by this project Participants will use electronic and health manual health management tools	Semi-structured pre/post interviews with project participants and partners Training work-shop attendance sheets Pre and Post skills check lists Participant interviews Participant assessment of training Pre and post quantitative surveys Trainer interviews and assessment of participants Interviews with St James town residents
Participation: To create sustainable opportunities for residents at risk of diabetes, cancer or heart disease to participate in physical activities, nutrition programs and/or self-help support groups	Access St. James Town residents will participate in a variety of physical, nutrition and self-help support groups created in the community and delivered by qualified neighbours	6 Physical fitness programs will be offered in the community annually 6 Nutrition programs will be offered in the community annually 3 Self-help groups will be provided in the community on an ongoing basis There will be an 80 % participation rate by St James Town residents in these programs	Attendance records Program Calendars Certificates of completion Pre and Post skills check lists Program delivery assessments Participant interviews Program CAs interviews

Table 10 Project Logic Model

Objectives	Expected Results (Outcomes)	Indicators	Data Collection Tools
Participation To create sustainable opportunities for residents at risk of diabetes, cancer or heart disease to participate in their own health management through the development and provision of health tracking tools during the first year of this project	Access Residents will have access to and use internet based and manual health tracking tools Knowledge Residents will have knowledge of the availability, methods of access and appropriate use of health management tools	A pilot agreement will be signed with MYOSCAR or similar electronic health management system 6 residents will be trained to support their neighbours in the use of health management system.	Enrollment in Electronic health management system Enrollment in manual self-tracking health management system Participant interviews Participant questionnaires Document analysis, benchmarking activities Support CAs interviews Support CAs questionnaires
Participation To create sustainable opportunities for residents at risk of diabetes, cancer or heart disease to participate in the use of health assessment tools including CanRisk and cancer screening	Access St James Town residents will use health assessment tools as part of their personal health awareness and health management Support Trained St. James Town residents will encourage and assist where necessary their neighbours in using health assessment tools for diabetes, cancer and heart health Knowledge Residents will understand the benefit, access to and ease of use of health assessment tools and will be more encouraged to use them in management of their family health Residents will improve their knowledge of their own health through the direct communications methods available with the health management tools	400 residents will complete the CanRisk diabetes assessment tool 200 residents will utilize cancer screening tools Explanatory information (videos, slide presentations) will be published online and on community electronic notice boards 6 trained residents will accompany neighbours to screening appointments	Frequency of use statistics Completed CanRisk assessments Published videos Published slide presentations Participant interviews Trained resident interviews

Table 10 Project Logic Model			
Objectives	**Expected Results (Outcomes)**	**Indicators**	**Data Collection Tools**
Knowledge To create an understanding in the community of St. James Town of the critical risk factors for diabetes, cancer and heart disease and their mitigation through the on-going delivery of a multi-pronged approach to disseminate relevant health information	Access Information concerning the chronic disease critical risk factors and their mitigation will be made available to the residents of St. James Town through a variety of culturally appropriate means Support Residents will be supported in combining healthy living practices from their countries of origin with those practiced in Canada. Knowledge Residents will have an improved knowledge of critical risk factors and their mitigation and apply this knowledge to their personal and family health management	2 Health information workshops will be held in partnership with Rose Avenue School Parent Council annually Health information will be an element of every program offered by Community Matters Health information will be an element of programming at the Wellesley Community Centre and part of curriculum at Rose Avenue Public School Health information videos and slide shows will be posted on a web site and on 4 community electronic billboards Healthy information will be distributed in local grocery stores monthly Health information will be distributed in a welcome package to new tenants of the 16 apartment buildings in St James Town Health information and assessments will be conducted at community events and festivals	Work-shop curriculum and attendance sheets Workshop pre and post questionnaires Community Matters program curriculum Community Matters pre and post questionnaires Program and class curriculum Programming on electronic billboards Web site page hits Number of welcome packages delivered Health assessments completed at community events Resident questionnaires
Access To create a safe, culturally appropriate environment in which residents can learn and participate in their health management	Access Residents will gain access to the use of services (e.g. screening) which will mitigate critical health risk factors Support Residents will accept and participate in practices (e.g. screening) which will contribute to the mitigation of critical health risk factors Knowledge Residents will enhance culturally accepted health knowledge and practices with those available in Canada	Residents will participate in support groups addressing mental health, diabetes, cancer and heart health Residents will participate in cancer and diabetes screening services Residents will be supported in their own health management	Schedule of support groups Attendance at support groups Participant interviews Diabetes screening records Cancer screening attendance Attendance at physical health and nutritional work-shops and events Support group coordinator interviews

Table 10 Project Logic Model			
Objectives	**Expected Results (Outcomes)**	**Indicators**	**Data Collection Tools**
Knowledge Transfer To develop and provide knowledge transfer tools, over the life of the project, to partners and organization who may be considering similar initiatives.	Knowledge Similar projects will benefit from the tools and lessons learned from the implementation of this project	Similar projects will use the Knowledge Transfer tools in the development of their projects	Other projects will report benefits from the use of tools and communication with residents, CAs and partners of this project Stakeholder/Network Mapping Exercise

Community Results Compared to the City of Toronto Measures

	City %	St. James Town %
Perceived health, very good or excellent	60.9	43
Perceived health, fair or poor	9.5	12
Perceived mental health, very good or excellent	72.9	
Perceived mental health, fair or poor	5.6	
Life satisfaction, satisfied or very satisfied	91.6	49
Perceived life stress, quite a lot (15 years and over)	24.0	4
Mood disorder	5.9	
Arthritis	13.6	
Diabetes	5.7	23
Asthma	6.4	9
High blood pressure	15.4	33
Chronic obstructive pulmonary disease (COPD)	2.1	3
Pain or discomfort by severity, moderate or severe	11.4	4
Pain or discomfort that prevents activities	13.5	3
Current smoker, daily or occasional	16.8	2
Current smoker, daily	11.8	2
Exposure to second-hand smoke at home	4.1	2
Exposure to second-hand smoke in the past month, in vehicles and/or public places	15.9	2
Exposure to second-hand smoke in the past month, in vehicles	4.6	2
Exposure to second-hand smoke in the past month, in public places	13.6	
5 or more drinks on one occasion, at least once a month in the past year	13.7	4
Fruit and vegetable consumption, 5 times or more per day	40.0	5
Physical activity during leisure-time, moderately active or active	49.2	52
Physical activity during leisure-time, inactive	50.8	13
Body mass index, self-reported, adult (18 years and over), overweight or obese	47.3	20
Body mass index, self-reported, adult (18 years and over), overweight	32.6	28
Body mass index, self-reported, adult (18 years and over), obese	14.7	20
Body mass index, self-reported, youth (12 to 17 years old), overweight or obese	19.4	28
Sense of belonging to local community, somewhat strong or very strong	66.8	39
Has a regular medical doctor	91.1	86
Influenza immunization, less than one year ago	29.1	

This data was collected at registration and is included in the worksheet of raw data which we gathered off our data base plus a few registrations which were not in the data base.

The sample size is 1556 and was gathered as noted above from May 2016 continuing until spring of 2020 There were only a few registrations in 2020 due to the pandemic and program cancellation.

Programming Principles

- Attach Community Assistants to their participants
- Integrate programming and Services in with a COMBO approach, adjusting programming content, time and context based on the feedback from participants and results from Health Planner and other screening tool summaries

COMMUNITY MATTERS TORONTO
neighbours helping neighbours

Healthy Living - MEDIA CALENDAR_2018 (1)						
Prepared by:	**Bhavana (Media Lead), Surabhi Khare (Program Lead)**					
	MONTH					
	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
THEME	WINTER READINESS	MENTAL HEALTH	NUTRITION MONTH, GLAUCOMA, & TB	IBS, DENTAL, & FND	BLADDER CANCER, BRAIN TUMOUR, HYPERTENSION, & VISION	THYROID & BRAIN INJURY MONTH
WEEK# 1 MONDAY WED FRIDAY	NUTRITION CONSUMER LITERACY WINTER READINESS (One post each)	FOOD & CANCER CONSUMER LITERACY MENTAL HEALTH (One post each)	NUTRITION CONSUMER LITERACY NUTRITION DEFICIENCY DISEASES (one post each)	NUTRITION AUTISM LITERACY IBS (One post each)	NUTRITION CONSUMER LITERACY BLADDER CANCER (One post each)	NUTRITION CONSUMER LITERACY THYROID HEALTH (One post each)
WEEK # 2 MONDAY WED FRIDAY	NUTRITION AND WINTER CONSUMER LITERACY WINTER READINESS (One post each)	NUTRITION CONSUMER LITERACY MENTAL HEALTH (One post each)	NUTRITION CONSUMER LITERACY NUTRITION DEFICIENCY DISEASES(One post each)	NUTRITION CONSUMER LITERACY ORAL HEALTH (One post each)	NUTRITION CONSUMER LITERACY BRAIN TUMOUR (One post each)	NUTRITION CONSUMER LITERACY MEN'S HEALTH (One post each)
WEEK # 3 MONDAY WED FRIDAY	NUTRITION AND WINTER CONSUMER LITERACY WINTER READINESS (One post each)	NUTRITION CONSUMER LITERACY MENTAL HEALTH (One post each)	NUTRITION CONSUMER LITERACY GLAUCOMA (One post each)	NUTRITION CONSUMER LITERACY Functional Neurological Disorder (One post each)	NUTRITION CONSUMER LITERACY HYPERTENSION (One post each)	NUTRITION CONSUMER LITERACY BRAIN INJURY (One post each)
WEEK # 4 MONDAY WED FRIDAY	NUTRITION & WINTER CONSUMER LITERACY WINTER READINESS (One post each)	NUTRITION CONSUMER LITERACY MENTAL HEALTH (One post each)	NUTRITION CONSUMER LITERACY TUBERCULOSIS (One post each)	NUTRITION CONSUMER LITERACY ROSACEA MONTH (One post each)	NUTRITION CONSUMER LITERACY VISION HEALTH (One post each)	NUTRITION CONSUMER LITERACY THYROID HEALTH (One post each)
RESPONSIBILITY (For Content)	Bhavana & Surabhi	Bhavana & Surabhi	Bhavana & Surabhi	Bhavana & Surabhi	Bhavana & Surabhi	Bhavana & Surabhi

COMMUNITY WORK

SERVICE AGENCY

Community Based Approaches

Community Based PARTICIPATION

- Increased participation in civic/civil life
- Increased involvement and influence of local residents in wider-governance arrangements
- Changes in who takes decisions on resource allocation and/or local priorities
- Increased numbers of formerly marginalised groups engaged with the decision making process
- Increased understanding of the difficult trade-offs required when making decisions about local service provision, and therefore increased perceptions of fairness

- Improved appreciation of the needs of others in the community
- Improved understanding of the issues surrounding resource allocation

- Efficient use of community resources and in terms of obtaining more sustainable and lasting benefits for the community
- Reduction in unit cost of services
- Reallocation of resources to better reflect the wishes of citizens
- Reallocation of resources in favour of those with greatest need
- Improved health and well-being of local residents

Community Based EMPOWERMENT

- Enhanced skills and confidence,
- Expanded social networks, specialist policy knowledge
- Enhanced perception that residents can influence their local place and services
- Enhanced capacity to engage in local issues

Feeling of personal control

- Is magnified when supported by a group
- Is multiplied through group action

- Effective decisions are made in less time than in the past or more decisions taken using the same resources
- Better quality decisions, such as fewer reversals of previous decisions

- communities are able to exercise more influence on decision making
- a sustained shift in power towards communities and, in particular, previously excluded groups
- Increased social capital (including trust in each other and service providers)
- Increased community cohesion
- More people involved in local decision making

REPRESENTATION

- Speak for Individuals and Small Groups
- Service delivery
- Speak with the Community as a whole

METHOD

- Case management
- Business Plans
- Silos
- Reciprocity
- Networks
- Self-Examined Life

FRAMEWORK

- Business Plan/Model
- Neighbourhood

TERMINOLOGY

- Clients
- Patients
- Customers
- Business Plan
- Business Model
- Neighbours
- Friends
- People
- Family
- Community
- Citizens

RESPOND TO

- Political Will
- Community patterns and behaviours

Community based DEVELOPMENT

Community Based SOCIAL CHANGE

COMMUNITY MATTERS TORONTO
neighbours helping neighbours

Public Health Agency of Canada | Agence de la santé publique du Canada

Community Assistants: Community Leaders

With our focus on “NEIGHBOURS HELPING NEIGHBOURS” we developed the idea of Community Assistants familiar and trusted community residents from many cultures trained to help their neighbours and to respond to questions raised in the community.

Our idea began in 1999 when two mothers volunteered in a program which identified hearing, speech, vision and behavioural issues in pre-school children. These first 'Parent Assistants' helped prepare snack and maintained the space and supplies. It quickly became clear that they had far more to offer through their cultural understanding, familiarity with participants and the neighbourhood and their personal desire to learn and make a meaningful contribution.

They then provided translation, helped families understand and use the professionals' recommendations about speech, behavioural and social issues. They identified families who would not have come to the attention of schools and other services and lobbied in the neighbourhood to help families understand what 'assessments' and 'special needs' meant and how Canadian services could help their children.

Links:

http://communitymatterstoronto.org/community-assistants/

https://www.youtube.com/watch?time_continue=5&v=5TD7w-Jc15w&feature=emb_logo

The Parent Assistants identified areas where they required increased knowledge. In 2004, training was arranged, and another newcomers helped to expand the idea in our Job Club, using 'Employment Assistants'

As local neighbours increasingly participated in our programs, the quality improved. We now use the term Community Assistant to refer to those neighbours who are key to the delivery of all our neighbourhood programs. Training is provided to enhance existing skills and continues when issues and new programs are identified. Community Assistants volunteer a considerable amount of their time and are paid a small stipend reflecting their contribution.

Today, all Community Matters programs are run by Community Assistants. They identify a need in the community, participate in the design of the program response and often in budget preparation and fund raising. They deliver the program and participate in its evaluation. Over 500 newcomer families annually are assisted with housing, financial and social assistance, employment assistance, citizenship classes, language assistance, parent workshops, an autism support group, a music program, homework club, tutoring, a summer literacy camp, as well as helping families and preschool children with developmental issues.

The Community Assistant idea is based on the belief and our experience in St James Town, that the majority (80%) of the knowledge and resources required to resolve an issue exist in the community. The remaining 20% is provided by working with professionals and services to obtain specialized knowledge, services, training and consultation.

Neighbours helping neighbours strengthen and build the confidence of both individuals and the community as a whole. The Community Assistant role has expanded beyond that of providing translation and outreach to program planning, delivery, administration and fund raising.

The community is listened to by Community Assistants who have similar cultural backgrounds as well as knowledge of the support available in Canada. They are a conduit, able to “interpret” the issue, the suggested course of action, and the necessary follow through. They are readily available with practical suggestions. Based in their neighbourhood, Community Assistants work is precise and relevant, reducing the demand for already limited resources and improving the quality of local programs.

Multi-Sectoral Partnerships

The Geoffrey H. Wood Foundation	Private	Funding
The Tippet Foundation	Private	Funding
Manulife Financial	Private	Funding
The Weston Foundation	Private	Funding
Parliament Square Residences	Private	Space
Mr. T Goldspink	Private	Funding
Self-Care Catalysts	Private	Technology
Sofco	Private	Technology
The Regent Park Community Health Centre	Public	Training and Mentorship
The Toronto Public Library	Public	Health Resources
Toronto Central Regional Cancer Program	Public	Training and Mentorship
Food Share	Public	Fruits and Vegetables
Building Roots	Public	Fruits and Vegetables
Immigrant Women's Health Centre	Public	Screening Services
Ontario Ministry of Tourism, Culture and Sport	Public	Funding
Invest In Neighbourhoods (City of Toronto)	Public	Funding
Rose Avenue Junior Public School (TDSB)	Public	Shared Programming
Centre for Addiction and Mental Health (CAMH)	Public	Training and Mentorship

CMT CA Certificate in Health Promotion Training Background/Rationale

As a community-based organization, Community Matters Toronto (CMT) provides programs and activities that support people to live healthy lives in St. James Town.

Over the years, our programs have evolved to cover employment, education and healthy living. A key component of our programs is that they are connected and often overlap to provide support to new Canadians. For example, our After-School Program enables parents to work while their children enjoy a program focused on nutrition and physical activity. Our job club and training programs support people looking for work and our healthy living programs support people to be healthy as they either look for work, participate in the workforce or look after their families.

We have continued to refine our focus and have identified a need to support new Canadians to stay healthy long after their arrival in Canada. In addition to our Community Assistants, we now have a team of Healthy Living Community Assistants whose role will be to run our Healthy Living programs at an even deeper level than before and to train our other CAs on many aspects of health programming.

This training provides the Healthy Living CAs with the background, knowledge and skill to run our Healthy Living Programs and to train other CAs.

Training Name:	**CMT CA Certificate in Health Promotion: Overall Strtegy and Objectives**
Capacity:	10
Length:	2 hours 8-9 sessions
Logistics:	**Dates:** **Time:** **Location:**
Description:	Community Matters Toronto (CMT) is about Neighbours Helping Neighbours. The CMT CA Certificate in Health Promotion is designed to provide residents who have a health background with the knowledge and skills to work as a CMT Healthy Living Community Assistant. Each 2-hour session will cover a different topic including: understanding the Healthy Immigrant Effect, Using the CMT Health Planner, Designing health related training, working in our Drop In program, conducting outreach, working with social media, evaluating health apps, self-help groups and health screening.
Learning Objectives:	**By the end of the training, participants will:** • Understand the components that go into being a HL CA • Demonstrate the knowledge and skills to perform HL CA roles • Be able to design and deliver training sessions to other CAs and also use these with the community • Work towards earing a CMT CA Certificate in Health Promotion • Have increased confidence in speaking about HL topics

Training Name:	**CMT CA Certificate in Health Promotion: Overall Strtegy and Objectives**
	• Have had an opportunity to build connections between the HL CAs (networking) and learn together.
Who Should Attend:	Participants with a health background who are part of the CMT Healthy Living Program.
Other Considerations:	Participants must be committed to attending all sessions.
Pre-Work:	TBD

The complete work-shop outline and resources for all 8 sessions are on-line at:

.

Best Practices Resources (Part 1)

Evidence	Methods	Application in Healthy Living in St. James Town
1. Community		
		Training and benchmark their skill levels
		Links to Regent Park and Public Health for training and best practices; add new skills and training leading to a manual
A targeted after school programme aerobic dance programme, Weight Winners, also had high programme satisfaction and highlights the importance of group leaders' participation in providing empathetic and non-judgemental programme leaders[11]. The latter is a factor that may be particularly important for female participants	Use of community assistants and internationally trained health professionals living in St JT	Document the addition of other partners and their contributions: PH: screening, nutrition, healthy babies, diabetes, school, stakeholder group: HP, drugstore, landlord, link to CHC and diabetes education and support groups
		Number and in-kind contributions of established and emerging partners
Community targets for interventions: School, parenting centre and apartments; Junior and Senior Kindergarten students.	Take the 200 families in JK and SK at Rose Avenue	Ongoing use of HIS to track increasing adoption of health practices
Schools were found to be a critical setting for programming where health status indicators, such as body composition, chronic disease risk factors and fitness, can all be positively impacted.	Cross reference with postal codes to focus on the 2-3 apartments where the majority live.	Bayesian model, program and process evaluations rather RCT: iterative interventions: design the array of nutrition, exercise and self-help, test review and redesign

[11] Hoerr SM. The prevalence and treatment of obesity in adolescence.[PhD]. Nutritional Sciences, University of Illinois: Urbana-Champaign, 1985.

Evidence	Methods	Application in Healthy Living in St. James Town
Involvement of family is reported as one of the lessons learned by the multidimensional, school-based Pathways programme ([12],[13]), which identified that to be successful, childhood obesity prevention programmes likely need to address environmental and socioeconomic factors that go beyond the school setting ([14]).		
Communications Strategy	Health messages in newsletter, television ads at the school, apartments, and groceries	Website, health infomercial, videos, Number of site visists, surveys General groups, in grocery store, community centre Target new tenants in designated apartments At Registration and screening: how did you hear about this?
Food Strategy		Partner with Loblaws, Metro and/or Sobeys-fresh fruit and vegetables
Increased access to a culturally appropriate variety, accessible and affordable	Advocate for bulk foods, regular food audits	Increase local vendors capacity
Obesogenic environment, no programmes were identified that specifically targeted their potentially specialized needs (e.g. different food supply in a new country)		Increased access to bulk food shopping

[12] Stevens J, Story M, Ring K, Murray DM, Cornell CE, Juhaeri, Gittelsohn J. The impact of the Pathways intervention on psychosocial variables related to diet and physical activity in American Indian schoolchildren. *Prev Med* 2003; **37**(6 Pt 2): S70–S79.

[13] Gittelsohn J, Davis SM, Steckler AB, Ethelbah B, Clay TE, Metcalfe L, Rock BH. Pathways: lessons learned and future directions for school-based interventions among American Indians. *Prev Med* 2003; **37**: S107– S112.

[14] Davis SM. Editorial. *Prev Med* 2003; **37**: S1–S2.

Evidence	Methods	Application in Healthy Living in St. James Town
		Improved food audit ratings
One American programme, designed to increase fruit and vegetable intakes, involved local grocery stores to enhance promotion of fruit and vegetables at 'point of purchase' ([15]). The grocers staged extra activities to promote fruit and vegetables for primary school children and their families		
2. Cultural Integration		
A complete lack of programming to address and understand the specific needs of immigrants new to industrialized countries was identified in this review. This indicates that such families make the difficult transition from their traditional diet and physical activity patterns to those that prevail in the host country without opportunity and education to ensure this changeover is healthy. Children and adolescents within new immigrant families tend to become socially integrated more quickly than their parents and as such are likely to be particularly vulnerable to an obesogenic environment ([16]).	Programmes addressing the issue of unfamiliarity recognize that immigrants are in the process of adapting to a new lifestyle and may not be aware of the health practices and perceptions in their new community and country. For example, a diet high in fat and fast food is often associated with prestige and prosperity in certain immigrant populations ([19], [20], [21]).	Learn from the Healthy Immigrant effect Intervene as residents sign leases. Integrate Cochrane best practices with findings from Alternative Best Health practices: Johns Hopkins, then Use Internationally trained health professionals as coaches to identify and maintain healthy practices from back home, educate about effects of immigration and Canadian junk food
The increasing prevalence of overweight identified among first generation to third generation adolescent immigrants to the USA		

[15] Baranowski T, Davis M, Resnicow K, Baranowski J, Doyle C, Lin L, Smith M, Wang DT. Gimme 5 fruit, juice, and vegetables for fun and health: outcome evaluation. *Health Educ Behav* 2000; **27**: 96–111.

[16] *Sobal J. Commentary: globalization and the epidemiology of obesity. Int J Epidemiol 2001; 30: 1136–1137.* 50, *Perez CE. Health Status and Health Behaviour Among Immigrants. Statistics Canada: Ottawa, ON, 2002. Catalogue 82-003.*

[19] Teufel NI, Ritenbaugh C. Development of a primary prevention program: insight gained in the Zuni diabetes prevention program. *Clin Pediatr* 1998; **37**: 131–141.

[20] Hyman I, Guruge S, Makarchuk M, Cameron J, Micevski V. Promotion of healthy eating among new immigrant women in Ontario. *Can J Diet Pract Res* 2002; **63**: 125–129.

[21] Greaves et al. BMC Public Health 2011, 11:119. http://www.biomedcentral.com/1471-2458/11/119

Evidence	Methods	Application in Healthy Living in St. James Town
bears testament to this vulnerability ([17]). The prevalence of chronic diseases associated with obesity also increases among immigrants with time living in an industrialized host country ([18]).		Define the cultural best practices and reinforce them with a health practitioner from back home Support new Canadians through social isolation by using self-help group/Circle approach to mimic the extended family and its benefits
3. Holistic Support and Care		
Establish a safe environment with access to a holistic approach (jobs, education, health, language, mental health, financial and housing help)		Individuals at risk for diabetes need a "place to go" where they can receive a continuum of adequate, reliable, behavioural care[22] Start the Health Planner/Passport process (Oscar) at the onset, track use of other community supports (CMT database)
4. Screening in Context		
Screening in context rather that mass, one off events	Offer screening to individuals, in a screening group and/or lifestyle group (self-help, nutrition and exercise)	Screening rates in St. JT as good as the rest of the city Measure the degree to which the screening rates approach the Toronto norm (TPH table)

[17] Popkin BM, Udry RJ. Adolescent obesity increases significantly in second and third generation US immigrants: the national longitudinal study of adolescent health. *J Nutr* 1998; **128**: 701–706.

[18] Perez CE. *Health Status and Health Behaviour Among Immigrants.* Statistics Canada: Ottawa, ON, 2002. Catalogue 82-003.

[22] (Elizabeth M. Venditti, PhD, Diabetes Prevention Program Outcomes Study).

Evidence	Methods	Application in Healthy Living in St. James Town
5. Consumer Driven		
Track progress and utilization with a consumer driven HIS	OSCAR	St JT cohort successively approaches the Toronto Health indicator profile by census metropolitan area, two-year period estimates Audit use of OSCAR as a health tracking tool and its usefulness with different cultures and literacy levels. Over five years introduce new ways to introduce OSCAR (coaching, group workshops, trouble shooting, follow up)
6. Interventions Looking at Root Causes		
Several chronic diseases with common risk factors can be addressed simultaneously. For example, a programme that integrates the three main healthy living strategies (diet, physical activity and mental health) has the ability to address cardiovascular disease, Type 2 diabetes and cancer simultaneously ([23], [24]).	Multiple reinforcing effects of interventions that cover all the setting where people live work and play (school community and shops home and clinic).	Enter on Oscar from point of screening Follow up and track them: Health indicator profile by census metropolitan area, two-year period estimates (Toronto (Ont.) Appendix attached
Compelling arguments for integration concern the optimization of scarce resources, congruent messages to the public and potential to enhance access for marginalized populations (see footnotes 11 and 12 for references).	Focus on lifestyle weightwatchers self help groups Families and adults	• Health Planner/Passport • Diet • Exercise • Self help • Access

[23] Health Canada. *The Population Health Template: Key Elements and Actions that Define a Population Health Approach, Draft July, Health Canada Population and Public Health Branch, Strategic Policy Directorate.* Author: Ottawa, 2001.
[24] Health Canada. Integrated Pan-Canadian Healthy Living Strategy. Health Canada. Available at: http://www.hc-sc.gc.ca/English/lifestyles/healthyliving/index.html, 2003.

Evidence	Methods	Application in Healthy Living in St. James Town
The degree of integration in addressing chronic disease prevention scoring had two parts: (i) integration of healthy living strategies and (ii) integration in targeting chronic disease ([25]). Integration of healthy living strategies was assessed on three key elements (healthy eating, active living and mental health) common to the chronic conditions – diabetes, cardiovascular disease and cancer that are associated with obesity. Ranking for integration in targeting chronic disease was derived from a count of the number of the three chronic diseases (cardiovascular disease, diabetes and cancer) specifically targeted by the programme under review. *Available at* *http://www.calgaryhealthregion.ca/childobesity/synthesis_research.htm*	Screening across 3 disease conditions Integration from interview with a TPH professional; social support and goal setting Communication, behaviour, peer educators, high risk screening	Target; The development of type 2 diabetes is strongly associated with being overweight, obese or physically inactive. Large randomised controlled trials (RCTs) have shown that relatively modest changes in lifestyle (increasing fibre (15 g/1000 kcal), reducing total fat(< 30% of energy consumed) and saturated fat (< 10% of energy consumed), engaging in moderate physical activity (30 mins/day), weight reduction (5%)) can reduce the risk of progression to type 2 diabetes in adults with impaired glucose regulation (also known as pre-diabetes) by around 50% [3-7]. In one study, achieving four or more of the above targets led to zero incidence of type 2 diabetes up to seven years later. DPP website (http://www.bsc.gwu.edu/dpp/manuals.htmlvdoc)
American Heart Association **On the prevention of heart disease in adults aged over 18, which recommend the use of motivational interviewing as well as goal setting, self-monitoring and a high contact frequency.**	**Interventions** targeting both diet and physical activity, mobilising social support and the use of well described/established behaviour change techniques. Using a cluster of self-regulatory techniques (goal setting, prompting self-monitoring, providing feedback on performance, goal review [62,64]), and providing a higher contact time or frequency of contacts.	Self-report and actual measures: Outcome indicators (obesity study) outcomes that were directly measured (e.g. changes in body composition, chronic disease risk factors and physical fitness) compared with those indirectly assessed (e.g. dietary intakes, physical activity levels and self-esteem) or those that were indicative of behaviour change (e.g. improvement in knowledge). For presentation of results the former were categorized as status indicators of chronic disease risk, while the latter were categorized as intermediary indicators of chronic disease risk.
US Association of Diabetes Educators also recommends goal setting, problem solving (relapse prevention) and self-monitoring of plans (self-regulation) for supporting healthy eating and increased physical activity in people with Type 2 Diabetes.		
Interventions can be delivered successfully by a wide range of providers in a wide range of settings, in group or individual or	CAs and Internationally trained HP	Literature on ethnicity-specific health interventions shows that programmes must be targeted to specific

[25] Flynn MA, McNeil DA, Maloff B, Wu M, Mutasingwa D, Ford C, Tough SC. Web supplement for reducing obesity and related chronic disease risk in children and youth: a synthesis of evidence with 'best practice' recommendations. Calgary Health Region, 2005. Available at: http://www.calgaryhealthregion.ca/childobesity/synthesis_research.htm

Evidence	Methods	Application in Healthy Living in St. James Town
combined modes, and can be effective for a wide range of ethnic and age groups.	Track for 5 years: difficult to maintain gains	populations. Thus, in developing programmes that are appropriate for a specific immigrant sub-population, research is necessary to identify whether a given cultural element is supportive, neutral, or opposes the desired outcome (e.g. healthy eating, increased physical activity) ([26]). Cultural preferences may reflect different concepts of recreation and the tendency to engage in different activities. Therefore, to be effective, recommendations for recreation should be realistic and consideration given to cultural acceptability and preference ([27])
What are the triggers of behaviour change? Effects of social support and attention	Numbers invited versus numbers completing programme	Chronic disease risk factors/markers associated with obesity (blood pressure, blood glucose and insulin levels, blood lipids levels, leptin levels, other
What maintains behaviour change over time, what intensity of coaching, follow up makes a difference?	Mental Health, self-help: circle, lifestyle groups and meditation	v Risk factors for obesity (exercise/activity levels, fitness, dietary habits/food choice, psychosocial factors, e.g. body image/self-esteem, anxiety, depression, other
Nutrition: Adult Nutrition, food audit, food handling, cross cultural and family cooking	Descriptions of individuals or community groups participating	Use of fundamental movement skills methodology to track improvements in basic movement skills
Exercise programs: swimming, yoga, circuit training, YMCA memberships, belly dancing and Bollywood, walking and participation in other exercise programs		

[26] Michielutte R, Sharp PC, Dignan MB, Blinson K. Cultural issues in the development of cancer control programs for American Indian populations. *J Health Care Poor Underserved* 1994; **5**: 280–296.
[27] *Michielutte R, Sharp PC, Dignan MB, Blinson K. Cultural issues in the development of cancer control programs for American Indian populations. J Health Care Poor Underserved 1994; 5: 280–296. 75: Wang CY, Abbot LJ. Development of a community based diabetes and hypertension preventive program. Public Health Nurs 2001; 15: 406–414.*

Evidence	Methods	Application in Healthy Living in St. James Town
Process indicators: Other information evaluating how programme was proceeding (acceptability/popularity, access, other Greaves et al)		Evaluate the methodology (outreach, curriculum and teaching approaches; individual coaching, groups) used to deliver the program What are the effects of incentives? (Completion of one program entitles participants to a YMCA membership) Videos, testimonials Blogging the process, partners, flow charts, challenges

The Healthy Living In St. James Town Project Model
Best Practices Resources Part 2
(Diabetes Management, Community Navigation, Behavior Change, Alternative Medicine)

Evidence	Methods and Application in St. James Town
A. Diabetes Management and Prevention	
As research suggests, primary approaches to prevent diabetes include programs, targeting high risk subgroups of population like high risk ethnic groups, such as those designed to promote physical activity and healthy eating in adults and children [28]. Adverse neighbourhoods and housing conditions may affect the development of DM (Diabetes Mellitus) through their influence of development of other health conditions of residents. These include obesity, hypertension and other co-morbid conditions.	Researchers and healthcare providers need to extend their understanding beyond lifestyle impacts /changes and seek different explanations and solutions. Dennis argues that service providers and researchers should take into consideration social determinants such as peoples' social economic status and start "asking different questions to the

[28] *Best practices on Diabetes education for people from diverse cultures with emphasis on south-east Asians, Africans and Latin Americans. Presented by: Dr Amina Chaudhary (M.B.B.S.)*

Evidence	Methods and Application in St. James Town
Primary prevention strategies like using best diabetes education practices will aim to empower people to take charge of their own health by gaining control over the determinants of health. Of interest for researchers is the possibility of prevention of DM. Prevention in turn can improve the quality of life of an individual and reduce health care costs. Health promotion moves beyond prevention and management of chronic disease to community development, health education, citizen participation and advocacy of health. It is believed that, type 2 diabetes has reached an alarming "epidemic" level; over 2 Million Canadians have diabetes. Diabetes has been ranked the 7th leading cause of death in Canada due to high morbidity and mortality associated with its chronic complications.	causes of its incidence and factors effecting its management". Dennis states that for many low-income people, there are other pressuring societal issues such as poverty, unemployment etc. that makes the recommended lifestyle change a difficult task to achieve.
Key Components in Diabetes Education/Prevention in Canada for newcomer populations 1. **Culturally tailored diabetes interventions** 2. **Group-based counselling for improved coping** 3. **Supplying information through extensive audio and video formats for individuals with low health literacy skills** 4. **Using community health workers (CA's) to deliver patient education that is culturally and linguistically appropriate.** 5. **Develop patient skills and build confidence to enable them to make informed decisions about their diabetes self-care.** 6. **Diabetes prevention education including physical activity, weight management, weight loss, meal planning and capacity building**	**Approaches** which would work in this densely populated community are following: • Teaching of didactic content, cooking demonstrations and group support. • Content on stress and stress management, heredity and culture • Peer educators support played a key role in success of this intervention.
Evidence that a comprehensive lifestyle behaviour change program targeting eating and physical activity, and ultimately weight loss, can alter the course of diabetes progression is growing. State-of-the-art behaviour change programs for weight control in general, and diabetes prevention in particular, commence by imparting a core,	Getting participants off to a good start through regular contact and solid behavioural teaching is critical. Studies of combination methods and use of the Internet also show promise, but it appears that results are most optimal when a face-to-face

Evidence	Methods and Application in St. James Town
instrumental knowledge base in three areas: nutrition, physical activity, and behaviour modification **In addition to the core behavioural change curriculum, the proposed program will:** • **Use of population health approach to continue to *refine targeted outreach efforts*** • ***Trained peer counsellors from representative cultures* in St James Town to develop individual and family Health Planner/Passports and monitor their progress.** • ***Cross cultural nutrition and exercise* programs** • **The use of *local foreign trained health professionals to adapt residents' cultural beliefs and health practices* and communicate Diabetes Best Practices[29].**	behavioural treatment context is already established.
Established Behaviour Change Techniques	
NICE Obesity guidance **This guidance document comprises a summary (and expansion) of reviews by Shaw et al. McTigue et al., Avenell et al. and Smith et al. Definitions vary by analysis but typically include cue avoidance, self-monitoring, stimulus control, social support, planning problem solving, cognitive restructuring, modifying thoughts, relapse prevention, reinforcement of change, coping strategies, coping imagery, goal setting, social assertion, reinforcement techniques for enhancing motivation** ***Nutrition recommendations and interventions for diabetes*** 1. **Diabetes medical nutrition therapy and counselling provided by a registered dietician**	Adults and families with information and support to understand and live with the implications of their condition. We focus on the community of St JT where the wide range of linguistic and cultural approaches to chronic health conditions influence the way people perceive and live with their conditions. ***A core curriculum*** for behaviour change with regular follow up: 'All individuals at risk for diabetes need a "place to go" where they can receive a continuum of

[29] *Support for weight loss programs Efficacy of Lifestyle Behavior Change Programs in Diabetes, Elizabeth M. Venditti, PhD*

Evidence	Methods and Application in St. James Town
2. **Modest weight loss for overweight or obese individuals via lifestyle changes (education, physical activity, dietary changes, regular contact) (Weight loss medications and bariatric surgery may be considered, as appropriate)** 3. **Nutritional interventions for primary prevention of diabetes, including moderate weight loss, physical activity, and recommended fibre intake** 4. **Nutritional interventions for secondary prevention of complications, including appropriate intake of carbohydrates, fat and cholesterol, protein, alcohol, and micronutrients** 5. **Consideration of special populations, including those with type 1 or type 2 diabetes, pregnant and lactating women, and older adults** 6. **Nutritional interventions for controlling complications (tertiary prevention), including reduction of protein (micro vascular complications) and sodium (cardiovascular disease)** 7. **Nutritional interventions for acute complications and special considerations for patients with comorbidities in acute and chronic care facilities**	adequate, reliable, behavioural care that is engineered for effective outcomes" (Vendetti E. et al, 2007). However, a number of newcomers from 67+ different cultures live in St James Town. They typify the health and policy challenge presented by those at moderate to high risk of diabetes and other chronic health conditions clustered in Canada's urban centres. Newcomers and longer-term immigrants were both significantly more likely than Canadian-born residents to be physically inactive (Toronto's Health Status Indicators). The prevalence of diabetes of South Asians in St James Town is more than twice that of other areas in Ontario (CASSA, 2010) So, in addition to the core behavioural change curriculum, the proposed program will: - Use of population health approach to continue to *refine targeted outreach efforts* - *Trained peer counsellors from representative cultures* in St James Town to develop individual and family Health Planner/Passports and monitor their progress.

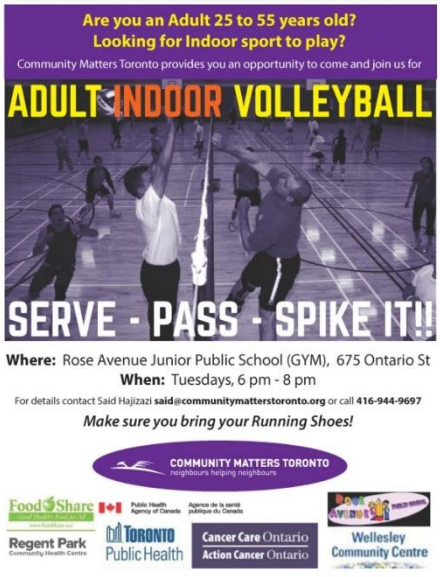
Evidence	Methods and Application in St. James Town
	- *Cross cultural nutrition and exercise* programs - The use of *local foreign trained health professionals to adapt residents' cultural beliefs and health practices* and communicate Diabetes Best Practices.
Community/Patient Navigation	
Promotoras were a critical link between clinical CAs and patients. Promotoras identified, engaged, and motivated patients with type 2 diabetes who had not seen their primary care provider for routine care in the past four months. They were mentors, teachers and advocates for patients with type 2 diabetes[30]. **Health Navigators are part buddy, part outreach worker, part coach. They work with doctors, social workers, lawyers, and a variety of community-based organizations to get their clients the services they need to be healthy and happy. It's not just about stopping HIV. It is about community, pride, hope, and care[31].** **Patient navigation in cancer care refers to individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care. Cancer patient navigation works with a patient from pre-diagnosis through all phases of the cancer experience[32].**	This project is hoping to have a long-term impact in the St. James Town community and to effectively work on health planning with families and residents of the neighbourhood. We intend to do this in a community-based way that is inclusive, equitable and accessible for all using methods that borrow from existing community and patient navigation models.

[30] http://diabetesnpo.im.wustl.edu/programs/DIHHC.html

[31] http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_wel_wellness_navproject

[32] http://www.cancerpatientnavigation.org/resources.html

Evidence	Methods and Application in St. James Town
Complimentary and Alternative Medicine	
• **Newcomers often prefer alternative medicine to mainstream Western options because they are unfamiliar with western concepts and terminology of illness and diseases, as well as of modern diagnostic techniques or treatments.** • **Some newcomers cannot afford to pay for conventional biomedical services and find traditional medicines and practitioners affordable and accessible.** • **In developing countries (and in ethnic enclaves in industrialized countries), the affordability, availability, and cultural familiarity of traditional medicine, as well as family influence, contribute to the continued use of traditional medical providers and medicines.** • **Alternatively, some studies found that use of Complimentary and Alternative Medicine (CAM) was associated with female gender, high income and high levels of education.** • **Traditional knowledge of medicinal plants acquired in the home country is continuously diminishing, with its composition influenced by urbanization and ongoing globalization processes and challenged by shifts from traditional healing practices to modern healthcare facilities.**	Western drugs and medication are important however we cannot discount the role of alternative medicine. Complimentary and Alternative Medicine is everything other than allopathic medicine. On use of alternative/complimentary medicine: it depends on what you believe in. for example, Nepalese people would rather use alternative medicine and change behavior than use mainstream medication. What needs to be done to maintain the healthy immigrant effect? To maintain the healthy immigrant effect you need to change belief systems. It is not an individual approach but rather a whole community and system approach where the proper supports need to be in place and accessible to new Canadians.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• Childcare
• Getting around Toronto
• Improving your English
Community Matters Toronto invites all newcomers and refugees to a series of sessions to orient you to St James Town and Toronto.
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Time: 6-7:30PM
Where: 240 Wellesley St E, Unit #109
(main floor just beside the elevators)
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Phone 416 944 9697 Email info@communitymatterstoronto.org
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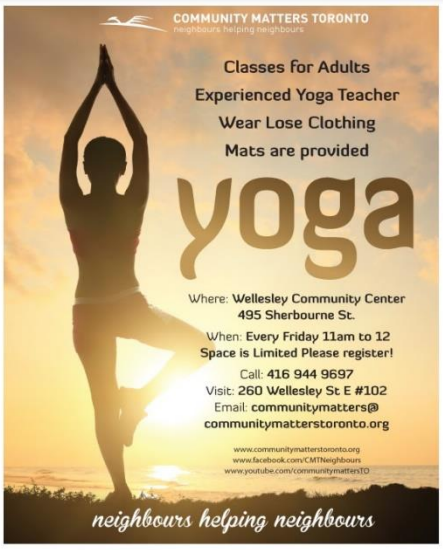
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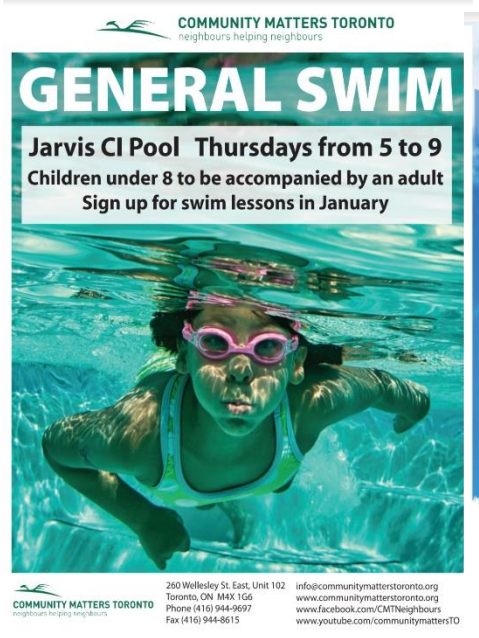
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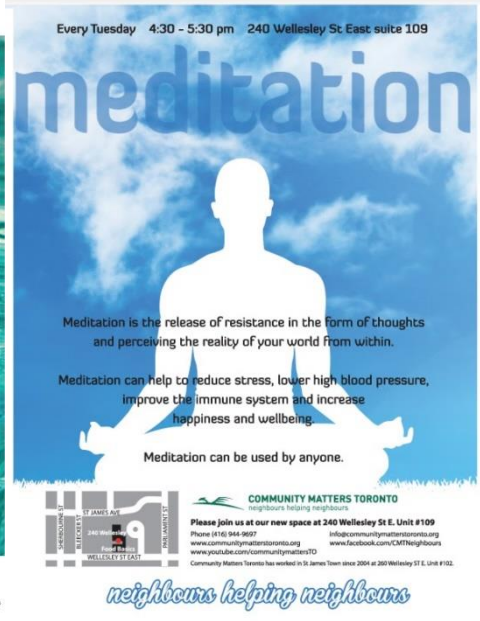
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Community Matters Toronto has worked in St James Town since 2004 at 260 Wellesley ST E. Unit #102.
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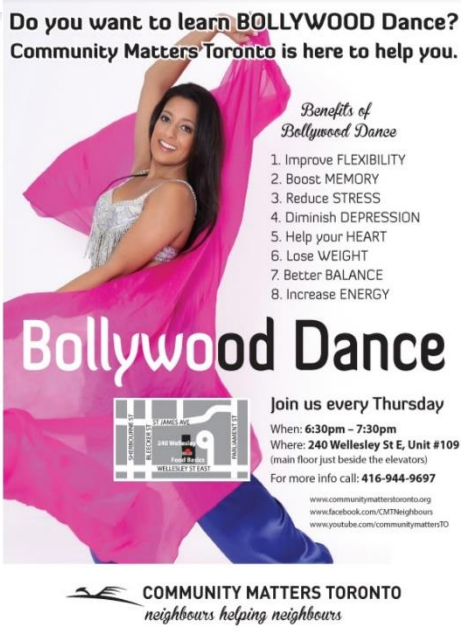
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(main floor just beside the elevators)
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