Building social capital as a pathway to success: community development practices of an early childhood intervention program in Canada

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SUMMARY

In the last three decades, various concepts and strategies have been developed to address social determinants of health. This paper brings together the different focuses of health promotion, and demonstrates that effective health intervention programs need to be conducted at multiple levels and fronts. Specifically, based on the evaluation of KidsFirst, an early childhood intervention program in Saskatchewan, Canada, this paper presents the program practices effective in enhancing the social capital and social cohesion at the community and institutional levels. The findings fall into three interconnected areas: strengthening community fabric; building institutional social capital and bonding, linking and bridging. KidsFirst has brought the community together through conducting broad and targeted community consultations, and developing partnerships and collaborative relationships in an open and transparent manner. It has also developed institutional social capital through hiring locally and encouraging staff to deepen connections with the communities. Additionally, it has endeavoured to create conditions that enable vulnerable families to enhance connectedness among themselves, link them to services and integrate them to the larger community. The program's success, however, depends not only on the program's local practices, but also on the government's central policy framework and commitment. In particular, the program's focus on children's healthy development easily resonated with local communities. Its endorsement of local and intersectoral leadership has facilitated mobilizing community resources and knowledge. Further, its commitment to local ownership of the program and structural flexibility has also determined the extent to which the program could fit into the histories of local communities.

Key words: community development; social capital; evaluation research; intervention program

INTRODUCTION

Following the Ottawa Charter for Health Promotion, various community-based concepts and strategies have been developed in population health to address social determinants of health (e.g. Ziglio *et al.*, 2000; Wise and Signal, 2000; Labonte, 2004). Concomitant with the traditional community concepts, such as community development, community empowerment and community capacity, there have emerged a number of social concepts including social

capital, social cohesion and social inclusion/ exclusion. If the community-based notions have shifted the focus of health promotion from individuals to the community environments, the social concepts may have been instrumental in directing attention to the higher orders of political systems and perhaps give us another reason to attend to the community (Labonte, 2004). Corresponding to the conceptual expansion, the past three decades have witnessed the emergence of ever more proactive health promotion strategies, ranging from community capacity building (e.g. Crisp *et al.*, 2000; Laverack, 2003) to building alliances and intersectoral partnerships (e.g. Gillies, 1998; Jones and Barry, 2011), as well as advocacy (Carlisle, 2000). Specific to the Aboriginal people, a most vulnerable population, whose health is disproportionately impacted by cultural disruption, institutionalized racism, colonialism and long-term social marginalization (St Denis, 2007; King, 2009), decolonizing approaches (Mundel and Chapman, 2010) have also been proposed to promote health in culturally relevant manners. Echoing the expansive interests of health promotion practices, the Global Health Promotion Conference in Nairobi 2009 (Lin *et al.*, 2009) also proposed that health promotion strategy should address not only individual empowerment, but also community empowerment, health systems strengthening, intersectoral action, as well as building institutional and organizational capacity for health promotion.

This paper demonstrates that effective health intervention needs to be conducted at multiple institutional and societal levels and fronts. Specifically, it presents a range of effective health promotion practices reported in our evaluation of *KidsFirst*, an early childhood intervention program serving vulnerable families in targeted areas in Saskatchewan, Canada. In the study, research participants repeatedly emphasized 'relationship building' as a fundamental pathway for the program to evolve and thrive. With this observation, we organize our findings as they are related to enhancing social capital building at both the institutional and community levels. The rest of the paper is divided into five sections. The first section focuses on the conception of social capital that informed our data analysis. The second and third sections introduce the *KidsFirst* program and the evaluation methods, respectively. The fourth section presents the research findings and the last is a discussion of the limitations and implications of the findings.

SOCIAL CAPITAL AS A DETERMINANT OF HEALTH

Social capital is a notion that has recently been introduced to population health (Kawachi and Berkman, 2003; Szreter and Woolcock, 2004). It is a multilevel and multi-component concept generally defined as a relational resource, such as personal and community networks, sense of belonging, civic engagement, norms of reciprocity and trust, which determines the quality of life, including our well-being and good health (e.g. Coleman, 1988; Putnam, 2000; Lin, 2001; Szreter and Woolcock, 2004). While the term, social capital, became well known through Coleman and Putnam's work much earlier, our paper is directly informed by the writings of Wakefield and Poland (Wakefield and Poland, 2005) and Mignone and O'Neil (Mignone and O'Neil, 2005).

Wakefield and Poland (Wakefield and Poland, 2005) have argued that social capital cannot be conceived in isolation from social, economic and political structuring of inequality. They have identified three constructs of social capital. The first, communitarian social capital, which follows Putnam's tradition, refers to the norms and social trust and ties that facilitate cooperation for mutual benefits (Putnam, 2000). The second is institutional social capital. Woolcock and Narayan (2000) referred to institutional social capital as the quality of formal institutions, including their 'internal coherence, credibility competence and external accountability to civil society'. Wakefield and Poland (Wakefield and Poland, 2005) further emphasized the importance of 'scaling up' individual social ties program staff possess and use these for organizational and community development purposes. The third is Bourdieu's critical construct (Bourdieu, 1979, 1986), which sees social capital as resources accrued to the socially and economically privileged individuals and groups. According to Bourdieu, differences in access to and control of social capital may explain why the same amount of economic and cultural capital may mean different degrees of profit, powers and influence for different actors. Wakefield and Poland (Wakefield and Poland, 2005) thus suggest that community developers consider the duality (inclusivity and exclusivity) of social capital and consciously engage in transformative practices.

Building on Woolcock and Narayan's work (2000), Mignone and O'Neil (Mignone and O'Neil, 2005) see three dimensions to social

capital that are particularly relevant to Aboriginal communities: bridging, bonding and linkage. The notions of bonding and bridging originated with Putnam (Putnam, 2000), who maintained that among all of the dimensions of social capital, the distinction between bridging and bonding is the most important. Bonding refers to the inward-looking social ties that reinforce and strengthen group identity and bridging to the outward-looking ties that overcome social cleavages. Woolcock and Narayan (2000) further pointed out that any entity, be it organizations, communities or state institutions, alone do not possess all of the resources for change; therefore, it is important for these entities to be linked and synergized. For Aboriginal people, Mignone and O'Neil (Mignone and O'Neil, 2005) define bonding as relations within individual Aboriginal communities, bridging as the horizontal links between Aboriginal communities and other communities, and linkage as the connections between Aboriginal communities and state institutions and private/public corporations.

The above review shows that social capital is a relational resource within and between groups that can be cultivated, mobilized and transformed for the wellbeing of a community. As well, social capital is not solely about shared values and norms; it is also about social and economic privileges and entitlements that are often unevenly distributed. Further, social institutions play an important role in mediating the distribution and production of social capital. With this understanding of social capital in place, we now turn to the *KidsFirst* program.

KidsFirst

KidsFirst is a provincial government initiated, community-based early childhood intervention program implemented in nine sites with high community needs in Saskatchewan, Canada. The vision of the program is that vulnerable children enjoy a good start in life and be nurtured and supported by caring families and communities. The aim of the program is to enhance existing services, fill service gaps and support front-line staff working with high-risk families (Saskatchewan Education, Health, Intergovernmental and Aboriginal Affairs & Social Services, 2001).

At its inception, each site formed a program management committee with senior-level representatives from human service sectors such as the health region, school divisions, social services and Aboriginal or Métis organizations. For each site, a community accountable partner, usually the health region or the school board, was designated. The program management committee and the community partner then hired a program manager to coordinate the development of the program in each site. Working with the management committee, program managers consulted with individuals and organizations to identify community needs and service gaps. They then formed partnerships with other organizations, particularly service providers, by funding and supplementing existing services for vulnerable families, such as home visitation, mental health and addictions counselling and early learning and childcare.

Home visitation is the core component of *KidsFirst*. Home visitors support families by meeting their basic needs, sharing prenatal and parenting knowledge with them and linking them to services and to their communities. Most home visitors are hired from the local community, and many are mothers who have at one time faced similar struggles as *KidsFirst* parents. All home visitors undergo standard program training, which is facilitated by the Provincial Early Childhood Development Unit (ECDU) of the Ministry of Education, the government unit overseeing the program.

KidsFirst is a voluntary program for parents with children from prenatal to age 5. Program participants are primarily identified through in-hospital birth screenings. Some are referred by existing *KidsFirst* parents or social service providers. Program eligibility is assessed based on the presence of risk factors, including low maternal education level, maternal substance abuse, mental health issues, low infant birth weight and financial or social instability. The program targets at-risk families of all cultural backgrounds, including women with Aboriginal heritage. Aboriginal people share with the general population some common determinants of health, such as income, education, employment, social support and access to health services. Owing to colonialism and long-term marginalization, they also face some Aboriginal specific health factors (Kendall, 2001; St Denis, 2007; King, 2009). Among others, the residential school system in Canada, has not only disrupted family and community lives, but also led to the loss of Aboriginal languages, knowledge and traditions as well as devaluation of

Aboriginal identities (Kirmayer *et al.*, 2003; Aboriginal Healing Foundation, 2012). As a result, compared with other populations, Aboriginal families and children may be more likely to suffer from serious health issues that are challenging to redress.

RESEARCH METHODS

Mixed methods research was conducted to determine how the program has met its goals and objectives (see Muhajarine *et al.*, 2007); the quantitative study was conducted to measure the short-term impacts *KidsFirst* has had on participating parents and children, while the qualitative study was designed to capture the program impacts that could not be captured by numbers, and identify ways in which the program has taken effect. Research questions were derived from the Evaluation Framework (see Muhajarine *et al.*, 2007), which the research team developed collaboratively with the program staff and policy makers. Specifically, the qualitative study asked what impacts the program has had on parents, children and the communities, and what program policies and practices contributed to the program outcomes (Muhajarine *et al*., 2010).

For the field research, researchers travelled to all nine sites between May and October 2009 to conduct interviews and focus groups, make observations and take field notes. As shown in

Table 1: Interview and focus group participants

Interviews	Focus groups
9 Program Manager interviews	10 staff focus groups (2 in the North) consisting of home visitors, home visitor supervisors and support staff
31 parent interviews	7 supporting agency focus groups
1 Aboriginal Elder interview	7 management committee focus groups
15 home visitor supervisor interviews	2 combined supporting agency/ management committee focus groups
28 home visitor interviews	1 Early Childhood Development Unit (ECDU) focus group
Total number of interviews: 84	Total number of focus groups: 27
Total number of interview participants: 87	Total number of focus group participants: 155

Table 1, semi-structured interviews were conducted with 28 home visitors, 15 home visitor supervisors, each of the 9 program managers, 34 *KidsFirst* clients and 1 Aboriginal Elder who worked with the program. Additionally, 10 staff focus groups were conducted with home visitors, supervisors and supporting staff, 7 with management committees and 2 with a combination of management committee and supporting agencies. A focus group was also conducted with members of ECDU. Focus groups not only enabled us to learn about the program from the perspectives of various stakeholders efficiently, but also allowed us to observe the dynamics of different groups across sites. All research participants had been involved in the program for at least 6 months at the time of the interviews. With the exception of the ECDU focus group, research participants were identified from a contact list provided by program managers.

In the study, research participants were asked to relay their experiences with the program, and potential areas for program improvement, and to identify changes in parenting practices and community collaboration that have come about as a result of the program. A separate interview guide was used for *KidsFirst* parents, home visitors, home visitor supervisors and program managers. A separate focus group guide was used for *KidsFirst* staff, management committees, supporting agencies and ECDU (see Muhajarine *et al*., 2010). The diversity of our study participants allowed us to capture different experiences and perspectives as well as to enhance the reliability of the research findings.

Interviews and focus group discussions were tape recorded, transcribed verbatim and sent back to the research participants for checking. For data analysis, we adopted a basic interpretive qualitative approach, which is descriptive and inferential in nature, focusing on uncovering meaning from research participants' views (Merriam, 2002). With a basic interpretive qualitative approach, data were 'inductively analyzed to identify the recurring patterns or common themes that cut across the data' (Merriam, 2002). ATLAS.ti, a qualitative data analysis tool, was used for coding and analysis purposes.

Building social capital as a pathway to success: community development practices

In this section, from the lens of social capital building, we present *KidsFirst* policies and

practices that the research participants reported to be effective in improving the life circumstances of children. These practices are thematically summarized including strengthening the community fabric, building institutional social capital and bonding, linking and bridging. We also highlight the overall program framework and policy commitments that are essential to the success of the program, including the program's goals to advance children's health and wellbeing, intersectoral leadership and the program's commitment to community planning and structural flexibility.

Strengthening the community fabric

By strengthening the community fabric, we mean that *KidsFirst* has brought the community together, cultivated communitarian social capital and improved institutional and service environments. In this respect, the program has benefited from broad and targeted community consultation, and building partnership and collaborative relationship through transparent communications.

Conducting community consultation both broadly and in a targeted manner. To develop the program, *KidsFirst* has reached out to service agencies and other organizational and institutional bodies, as well as individual community members, which, to a certain extent, has served to bridge cleavages between *KidsFirst* families and other social groups across occupations, organizations and class lines. Through broad outreach, *KidsFirst* made the program known to the public, and raised the awareness of the community with regard to children's health; it has also gained support from different organizations such as local fire departments, doctor's offices, pharmaceutical manufacturers and business owners. These organizations pooled their efforts with *KidsFirst* by organizing fundraising events, donating medications, providing free services and spreading health information.

   KidsFirst also conducted targeted outreach. For instance, in some sites, it was able to build on existing interagency work where different service agencies had worked together to identify community needs. Reportedly, where the program succeeded in building on community momentum, it has benefited from the synergy, leadership, knowledge, trust and relationships

that had been cultivated over the years within the community.

> KidsFirst came to the tables [of the interagency group] looking for resources . . . everybody knew what the gaps were and . . . It is the process we have gone through to build trust amongst the agencies, . . . that had brought us to where [the program is].   (Management Committee Member)

Targeted outreach also refers to focused community consultation that *KidsFirst* conducted in some sites around particular issues.

> I called together people in the community who were experts in [specific areas] . . . when we were talking about mental health, I had mental health folks in the community come together and provide us some advice about what kind of model we wanted and [which organization] we might want to take that. And when we did the home visiting piece we had huge groups, . . . thirty people sitting around a table talking about what were our challenges and what were our strengths, and what might we do. And . . . we had families at those tables.   (Program Manager)

In focused community consultation, different stakeholders were involved in discussing specific issues and services. This practice has helped *KidsFirst* identify community needs and effective service delivery models, and reorient existing services by educating service providers about the needs of the community. For instance, some agencies were initially critical of *KidsFirst* parents for not keeping their appointments. When they learned from home visitors and/or family members the different factors inhibiting families from accessing services, they started to understand that the ways in which they provided services might be part of the problem. With this insight, some organizations changed their service delivery methods. In one site, an agency began transporting families to and from their appointments. In some other sites, community agencies have started providing childcare, food and transportation during their evening events and have since noted an increase in family attendance in their programs.

Building partnerships and collaborative relationships. To bridge gaps in services, *KidsFirst* forms partnerships and works collaboratively with service agencies, which may have helped improve the quality of institutional and service environments.   One   barrier   obstructing

inter-agency collaboration is territorialism (see Altman *et al.*, 1991). Some study participants suggested that service organizations may become territorial when they are put in a position to compete for the same pool of funding or when the policies, procedures and mandates of different institutions conflict.

With regard to partnership formation, the study shows, when *KidsFirst* selects its service partners in a transparent manner, it reduces conflict and competition among service organizations. Below are some effective practices reported in one particular site:

> We picked our partners like an interview process. So they came to the table and we had sort of a little community panel and they presented what they thought they could bring to the program and the families, and that was how we made our decisions. It was very transparent in the community. We had very good agencies say things like '. . . I know exactly what you're looking for. You've been transparent about that. We are not a good fit but those folks that are applying are a good fit'. We didn't have fallout from the decisions.
> (Program Manager)

Of note, while interviewing typically accentuates power differences between the interviewer and the interviewees, and necessarily encourages competition, by using the format of a community panel, the program created an opportunity for *KidsFirst* and the community agencies to mutually assess needs and fits in an open and transparent manner. As a result, the program was able to reach partnerships with selected agencies, without hurting its community bases or relationship with other stakeholders.

Territorialism is an issue when *KidsFirst* staff worked together with other agencies and organizations whose institutional mandates conflicted with those of *KidsFirst,* as demonstrated in the following example:

> [Their services were] butting up against ours and vice versa, and I've met with them and said 'Look our programs are designed to be in conflict with each other so this is not a personality issues, it's a policy and procedural' . . . for example we encourage moms to spend that time after they have a baby to do the bonding and the attachment whereas [their] piece is they need to be moving forward . . . back into work or education at three months. We are designed to be in conflict.
> (Program Manager)

In order to work through mistrust and conflicts due to institutional differences, *KidsFirst* in this particular site convened community organizations to discuss issues and to produce common protocols. We noted that dialogue and open communications helped draw healthy work boundaries for different organizations, and foster mutual understanding among individual workers, which enabled them to work across institutional constraints.

Building institutional social capital

To integrate the program into local communities, *KidsFirst* puts great value on staff's personal ties with both parents and other organizations within the community. Staff's individual relationships with other members in their respective communities constitute a form of institutional social capital, an essential element for the success of the program.

Scaling up individual ties. Relationship building, according to many research participants, is crucial to the success of the program. Parent respondents especially valued their relationships with home visitors. Some referred to home visitors as 'friends', and some saw them as family members. Some parents indicated emotional investment when they decided to let in home visitors. One parent, for instance, felt hurt when she had to change home visitors.

> I kinda got shuffled around from three different home visitors the first while which was a little difficult 'cause you start opening up to one person, get used to her and then you gotta start opening up again with the next person. (Parent)

Home visitors are the program ambassadors who work directly with vulnerable families. To engage and retain parents, *KidsFirst* has made a point to match families with home visitors with whom they can connect at a personal level. It has also hired home visitors from the local communities; many of the home visitors had similar backgrounds as those of the parents on the program. Some sites also intentionally hired Cree speakers and elders to work with Aboriginal parents.

While the relationships and connections home visitors establish with parents are scaled up into institutional social capital, in the process, home visitors may run the risk of experiencing burnout. It is not uncommon for

KidsFirst families to call home visitors and show up at their homes for help outside of their working hours, which was reported to be a problem for a number of home visitors. As well, given the relational and emotional work home visitors conduct, and the extremely difficult circumstances they witness, some home visitors have also had traumatic experiences.

Another aspect of home visitors' relational work is to develop formal and informal social relations with other service providers while linking families to services. Through establishing these relationships, home visitors sometimes are able to make changes in how other service providers deliver services.

It should be noted that it is not only home visitors, but also *KidsFirst* staff at all levels who engage in relationship building within the community. In sites where the program is reported to be a success, research participants described good relationships between *KidsFirst* and other service organizations, and researchers observed rapport and healthy dynamics among the program staff who participated in focus group discussions.

Hiring staff locally and community development. When *KidsFirst* expands its institutional social capital through hiring staff locally, it directly contributes to community development. In particular, it opens up employment and other life opportunities for the hired staff.

> Well . . . one of the things that we didn't expect to happen . . . was [that] we've had a huge impact on our home visitors and their families . . . As they're being trained, they're learning all kinds of new information. So I think we're seeing a ripple [effect], which is very good . . . Many of the home visitors come from the neighbourhoods that we're [serving],. . . from a community development perspective, that's been a really unanticipated goodie. Many of our home visitors who leave the program are leaving to go back to school. We've got several in faculty of education, [and] in faculty of social work . . .   (Program Manager)

While the program provides personal growth opportunities to its staff, the day-to-day work does not come without challenge for the home visitors, especially those without formal training in social services. For instance, some home visitors reported difficulty in filling out paper work and entering information on the computerized information management system. Some also found it a challenge to deal with extremely high-risk families. These findings call for additional customized training programs to better meet the needs of the staff.

Bonding, linking and bridging

Families play a central role in shaping children's development. Parents' access to services, social networks and opportunities for social and community participation are all key determinants of health (e.g. Lynch, 2000). *KidsFirst* has provided families with assistance ranging from meeting their basic needs, to a greater degree of integration within the community. From the perspective of social capital development, the program has played a significant role in creating bonding relationships among the families, linking them to services and bridging them more broadly to the community at large. While creating bonding, linking and bridging conditions is important for all *KidsFirst* families, it may be particularly relevant for the Aboriginal families whose 'stock' of social capital has been negatively affected by social, cultural, and political marginalization and economic deprivation throughout history (e.g. Mignone and O'Neil, 2005).

Creating bonding opportunities. KidsFirst across sites has created opportunities for the families to develop relationships and support networks with other families. One parent said:

> KidsFirst also gave us . . . another social network because there were other families in the program that you went with your children . . . now these families are people who are friends of ours.
>   (Parent)

When engaging Aboriginal families, *KidsFirst* has also provided culturally relevant programs and services. For instance, in *KidsFirst* North, which serves a predominantly Aboriginal population, the program has been working to re-establish the parenting knowledge lost due to the residential school system. It has organized cultural activities such as retreats for parents and families where elders reconnect the young parents with land- and lake-based activities. During these gatherings, parents learn traditional and holistic approaches to family life and parenting. Great-grandparents who have witnessed the disruption of language transmission to their grandchildren teach Cree and Dené at these

events and within their extended family homes. In other sites, the program has also made conscious efforts to integrate culturally specific programming to make *KidsFirst* more relevant to clients with Aboriginal backgrounds. One home visitor reported using Aboriginal prenatal calendars when working with Aboriginal women. In some communities, home visitation services are also offered in Cree or Dené, which has helped a number of families overcome language barriers, and supported the use of these languages in the community. Through such activities, the program works to encourage cultural continuity for Aboriginal people, which may strengthen their cultural identity and sense of community.

Linking families to services. The study revealed that many *KidsFirst* parents do not trust state institutions and lack the means, knowledge and confidence to seek out help on their own. *KidsFirst* has played a central role in linking parents with health and other services. It has provided referrals and arranged transportation and childcare so that parents can keep their appointments. Home visitors also accompanied parents when they accessed services and modelled ways of self-advocacy vis-à-vis institutions. This is the type of support that Vygotsky termed as 'scaffolding' (Vygotsky, 1978), where home visitors support families to use different services and then, when parents feel more confident using services on their own, gradually withdraw support.

A parent described the support she received this way:

> I [didn't] trust doctors with me ... [then] my home visitor came with me and held my hand through it all. I'm able to go on my own now.   (Parent)

While linking families to services brings us back to the reality that *KidsFirst*, a government-funded project, represents a state apparatus after all, the ways in which *KidsFirst* builds linkages between the individual and the institutional suggests an orientation towards community development. Instead of subjecting families to institutional management, the program strives to develop families' confidence to independently use, navigate and negotiate within the service system.

> [The home visitor has helped me stand up for myself] ... [I]f I ever had to take my daughter [to the doctor's],... and I knew there was something

wrong,... [If I was told], '... there's nothing wrong', I [would] just stick to [my] guns and make sure things [get] checked out.   (Parent)

On the other hand, *KidsFirst* has also combated social marginalization through advocating for the families within governmental institutions. The program has influenced the ways in which other services agencies work with the families through informing, if not educating, them of the reality of *KidsFirst* families. In some other cases, the program has directly influenced the policies and practices of governmental departments. For instance, housing safety was identified as a concern for families. In response, in one site, *KidsFirst* brought housing concerns to the local municipality's attention. At another site, involvement from *KidsFirst* and other local agencies led to the development of a bylaw to regulate property standards within the local municipality. Such advocacy work is significant in challenging the structural exclusion that parents may experience.

Bridging families to the community life. Given long-term poverty, social isolation and in some instances, mental health and addiction issues, as well as associated low self-confidence and self-efficacy, many *KidsFirst* families do not participate in community activities and affairs. *KidsFirst* has contributed to breaking this cycle by enabling their voices, and expanding their social opportunities in the community.

In some sites, it has systematically involved families in program development, which has enabled them to participate in the decision-making process within the community.

> With the community development work ... there's [a] focus ... on ... strategizing and thinking about tapping into the voice of actual community members; of families who've been [an] influence for their children, to be that voice ... [We use] focus groups, and we use a model called Developmental Assets, which is a positive framework for families in communities to look at how children are thriving in your community. And it's strength-based. (Management Committee Member)

KidsFirst not only involves families in the initial program consultation process, but also encourages them to be part of the program in many other capacities. For instance, in one site, some families were invited to sit on hiring committees. In another site, some families were

involved in streamlining services. In yet another site, because the program has been open and welcoming to families' voices, some family members have reportedly developed a sense of ownership over the program.

> They're phoning . . . to make a suggestion,. . . they phone with 'Have you ever thought' and . . . it's because we've provided that kind of welcoming . . . 'It's your program' right . . . so 'What kind of program will work for you?' We've had families who've actually influenced some of our practice.
>
> (Program Manager)

While what is presented here is from the management perspective, it does suggest that the management recognizes the significance of having parents driving the development of the program.

While encouraging voices from participating families in the community, *KidsFirst* has also worked to bridge families to the community beyond the program. For instance, through measures such as providing transportation, it has encouraged and enabled *KidsFirst* families to join family-centred and community-based social activities where they had new opportunities to socialize and connect. Through participating in these activities, some families were able to expand their own social networks. Some also started giving back to the community by volunteering in different programs. A few even took on leadership roles within their community. In some cases, *KidsFirst* has also played an instrumental role in helping parents return to school and to the labour market. What needs to be emphasized is that expanding the social capital at the community level is not a one-way street. Instead, the program in some sites has also undertaken community education and cultural training to break down racial stereotypes about Aboriginal populations, and to explore some underlying causes of poverty and poor health associated with these populations.

Program framework and policy commitment

The success of *KidsFirst* depends not only on the program's local practices, but also on the overall program framework and policy commitment. The study showed that the program's focus on children's health, its intersectoral leadership framework, and its commitment to local planning and flexibility constituted structural conditions for the success of the program.

Community development programs planned and implemented from above often encounter resistance because they may conflict with agendas and interests of the community (Carlisle, 2010). *KidsFirst* staff across sites reported that it was easy to find allies within the community because partners could easily support the program's focus on children's wellbeing. Intersectoral leadership was also emphasized as an important success factor; it facilitated *KidsFirst* tapping into and mobilizing the expertise and resources from key sectors within the community. In sites where management staff from different organizations are involved in *KidsFirst*'s management committee, reportedly, information and messages from *KidsFirst* get communicated efficiently to other organizations, and this could lead to relatively quick feedback, actions and changes. One drawback of intersectoral leadership, however, as some of the research participants mentioned, is that it may have added layers of accountability that at times unnecessarily prolonged the decision-making process for the program.

Policy commitment to local planning and flexibility in program structure also determines the extent to which *KidsFirst* integrates into the history and realities of local communities. Many research participants believed that the strength of the program is that while the government sets the major guidelines, it has left open the opportunity for communities to shape their program to suit their local histories and contexts. As a result, the program has evolved differently from site to site, which reflects the particular needs, local resources, history and leadership in different communities.

It needs to be raised that the program framework may not always be facilitative of the development of the program locally. Prior to the launching of *KidsFirst,* collective inter-agency work had existed in some sites. Reportedly, when the program framework was aligned with the existing capacity, infrastructure and community momentum in particular sites, it gained a strong head start in program implementation. In contrast, where the program mandate contradicted what the local community believed to be the most effective strategies, it had a hard time gathering community support, and the establishment of the program was delayed. For example, in one site, the local community was planning to build additional facilities to serve all families. This measure did not fit within the *KidsFirst* framework, which does not typically allow

stand-alone projects independent of existing services. In this case, the local people involved in the program planning process felt that their priorities were not taken into account, and as a result, lost interest in engaging further with *KidsFirst*. It took the program a long time to remedy the damage done.

CONCLUSION, LIMITATIONS AND IMPLICATIONS

Through the lens of social capital building, in this paper, we presented a set of effective community development policies and practices reported by the research participants in our evaluation of *KidsFirst*. The notion of social capital was not in the original evaluation framework. Yet, in the study, 'relationship building' was a recurring theme in the interview data collected. Program staff believed that relationship building with parents, with community organizations and with community members at large was most challenging, and yet it was an essential pathway to the success of the program. While some *KidsFirst* participants joined the program for tangible benefits such as food coupons and free transportation, many highly cherished the personal relationship they were able to build through the program. Further, although the evaluation focused on the short-term impacts of *KidsFirst,* particularly in relation to children's developmental outcomes, we would suggest that the long-term impact of the program is contingent on how the program is able to enhance social capital at the individual, community and institutional levels.

The findings presented are not without their limitations. First, not all the practices illustrated are evident across all nine *KidsFirst* sites. We elicited best practices from the research participants, but did not explore if the same practices were employed across sites, or if there was consensus among research participants regarding the effectiveness of particular practices. Secondly, given that this paper focuses on the program policies and practices*, KidsFirst* staff who provided us with detailed descriptions of the program have had more of a presence and voice than the parents. Despite the limitations, this paper has significant implications for health promotion programs in other settings. To start with, echoing WHO's call for multidimensional action, we suggest that effective health promotional practices need to be implemented at

different levels and fronts. In the study, effective practices are not only about empowering individual parents in vulnerable families, they are also about building social cohesion among the community members, building partnerships and intersectoral collaboration at the institutional levels, advocating for the disempowered, as well as providing culturally relevant services. These health promotion strategies are not parallel or discrete practices. Rather, they interconnect and coalesce around building capacity and social capital among individuals, institutions and communities. We therefore hope to sensitize community developers and researchers to the significance of the everyday activity of relationship and social capital building.

To enable the vulnerable individuals to develop social capital, it is important for health promotion programs to recognize both their basic needs and their needs for social connection and space. Further, when programs help enlarge the social space for marginalized populations, they embark on a project that is not solely about social cohesion. Given the uneven distribution of social capital, which often serves to exclude, health promotion programs may also need to tackle fundamental inequalities in people's access to information, resources, services and community membership. Should the programs manage to advocate for the marginalized and engage the larger community in this project, they would be working to enhance the social capital at the community level, and contributing to the common well-being of the community. To build social capital in communities where Aboriginal people are involved, it is also important for the program to be culturally relevant and to explicitly take on a decolonizing approach. In the case of *KidsFirst*, conscious efforts have been made to re-engage and reconnect Aboriginal families with Aboriginal languages and traditions, which may have helped affirm the cultural identities of these families.

The study also notes that for a community-based program directed from above, building institutional social capital through scaling up individual staff's local connections may be instrumental for the program's success and longer term sustainability in the local community. Hiring local community members and encouraging all staff to develop relationships in the community therefore are of strategic importance. Management, however, needs to recognize that additional workload and worker

burnout may result due to the blurring of private and public lives for the staff. Specialized training may need to be provided to effectively support staff. Finally, we reiterate that social capital is a crucial determinant as well as mediator of health that can be addressed through multi-pronged health intervention programs. We consider this paper one among many that are needed to deepen our understanding of community-based interventions to promote health equity through enhancing social capital at multiple and intersecting levels—individual, institutional and community.

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