Exploring sustainability among community-based health interventions in Nunavut communities

A Case Study.

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Introduction

In 2009, the Qaujigiartiit Health Research Centre project entitled 'Child and Youth Health and Wellness Research, Intervention and Community Advocacy Project' was funded by the Public Health Agency of Canada's Innovation Strategy.

The original research project was designed to address the mental health needs of children and youth by targeting specific demographics and services. Specifically:

- Development, piloting and evaluation of an evidence-based camp program for 10-14 year olds
- Development, piloting and evaluation of an evidence-based parenting support program based on the needs identified by Nunavut parents

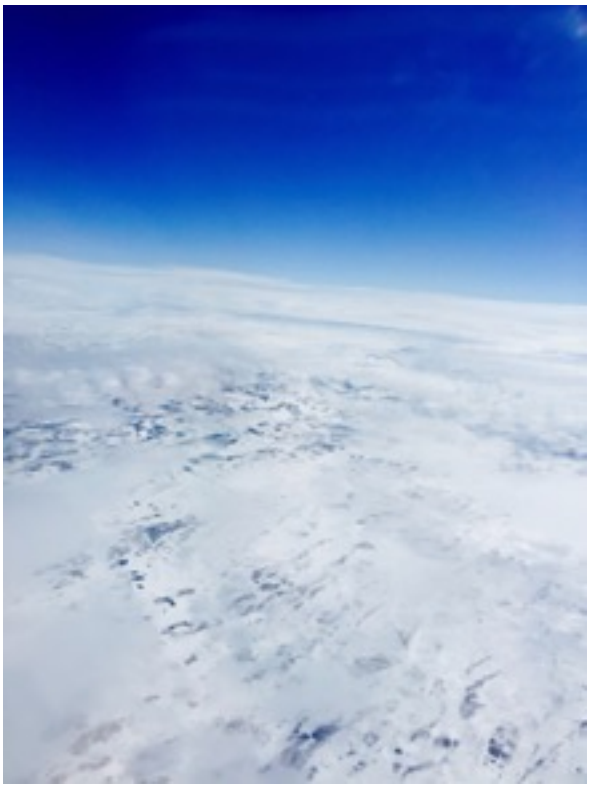
The 2 evidence-based interventions were developed, piloted and evaluated with great success. Despite the evidence base which supported these programs, and the degree to which they met the mandate of programs and services that should be delivered by the Government of Nunavut, the Qaujigiartiit Health Research Centre experienced challenges to the sustainable uptake and delivery of these programs within the health system.

Having discussed these challenges with other community-based organizations in the territory, we discovered that this challenge was not unique, and was a common experience among community-based agencies with a health and wellness-related mandate.

This case study was undertaken to explore and document the barriers and facilitators to sustainability and scale-up of community-based health and wellness interventions in northern communities.

Objective

To conduct a case study analysis of barriers and facilitators to obtaining an adequate level of sustainability for mental health promotion interventions in northern communities, particularly those based on indigenous worldviews.



Qikiqtaaluk (Baffin Island), March 2016.
Photo Credit: Gwen Healey

This study is timely, as the recent Truth and Reconciliation Commission Calls to Action, identified the need for:

- *(22) change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.*
- *(66) federal government to establish multiyear funding for community-based youth organizations to deliver programs on reconciliation, and establish a national network to share information and best practices.*

The content of the case study includes: a background and contextual review; description of the characteristics of the organizations and their current funding sources; facilitators and barriers to sustained community-based wellness programs; discussion of the findings in comparison with the literature; lessons learned/recommendations/ opportunities for improvement.

Background

This case study is nestled within a larger field of the public health literature related to 'implementation science' [1]. Implementation science is a newer term, which is being applied to the use of strategies for adopting and integrating evidence-based health interventions and changing health practice patterns in specific settings. Research on implementation addresses the level to which health interventions are successfully delivered within public health and clinical service systems.

Some examples of implementation science research can include, but is not limited to [1]:

- Comparisons of multiple evidence-based interventions
- Identification of strategies to encourage provision and use of effective health services
- Identification of strategies to promote the integration of evidence into policy and program decisions.
- Appropriate adaptation of interventions according to population and setting
- Identification of approaches to scale-up effective interventions
- Development of innovative approaches to improve healthcare delivery
- Setting up an impact evaluation for a population based intervention

Intervention strategies usually target high-risk individuals or populations by a variety of means, such as strengthening protective factors or eliminating risk factors, to achieve positive outcomes. In recent decades, there has been an increasing movement in public health and prevention science to study the cultural adaptation of interventions and their implementation [2-4].

Among the literature about mental health programs developed for First Nations, Inuit and Metis peoples, accounts of the cultural adaptation process tend to begin with the identification of an intervention designed for a specific population, which is then adapted to be inclusive of socio-cultural expectations or language of the target First Nations, Inuit, and/or Metis audience.

However, much of the implementation of such interventions occurred at the community-level, and

Aqsarniit (northern lights) near Iqaluit, Nunavut. Photo Credit: Jimmy Noble Jr. 2016

community members have had a heightened awareness of the numerous cultural and contextual factors that often contribute to a misalignment between these 'adapted programs' and the values, goals, and activities that are needed in community-based wellness programs. In other words, community members have often had trouble implementing programs designed using this model.

As a result, many community organizations have attempted to reverse this process by, instead, focusing on the development, implementation, and evaluation of interventions designed by and for Inuit in Nunavut – and measuring them. These interventions are embedded in the social context, language, and values of the population for whom they are designed.

At the time of this case study, this innovative and responsive approach to community wellness programming has not been sustained by current funding models or policies. This compromises several critical aspects of implementation particularly related to promoting innovation and scale-up in northern communities

The purpose of this case study was to explore some of the barriers and facilitators to the implementation and sustainability of community-based wellness programs in Nunavut.

Method

This exploratory case study was conducted within an Indigenous knowledge framework with a focus on Inuit ways of knowing, specifically, the *Piliriqatigiinniq* Partnership Community Health Research Model [5]. The model highlights five Inuit concepts, which informed the research approach: *Piliriqatigiinniq* (the concept of working together for the common good); *Pittiarniq* (the concept of being good or kind); *Inuuqatigiittiarniq* (the concept of being respectful of others); *Unikkaaqatigiinniq* (the philosophy of storytelling and/or the power and meaning of story); and *Iqqaumaqatigiinniq* (the concept that ideas or thoughts may come into 'one').

The study was designed to respond to a community request, and was implemented collaboratively with community wellness centres, emulating the concepts of *Piliriqatigiinniq* and *Inuuqatigiitsiarniq*.

A purposive sampling strategy was used to invite 4 directors or staff of 3 regionally distinct community-based organizations in Nunavut to participate in this case study.

Narratives were collected in telephone interviews from staff at organizations with a mandate to develop and/or deliver community-based health and wellness programs in the territory. Interviews were conducted in English. They were not recorded, although notes were taken with permission. With respect for the concept of *Unikkaqqatigiiniq*, participants were asked open-ended questions about their experiences implementing community-based wellness programs and achieving sustainability for those programs in the community.

An analytical approach building on the concept of *Iqqaumaqatigiiniq* (all knowing coming into one), "immersion and crystallization," was used to identify elements in the data related to community-based programming, barriers and facilitators to implementing innovative responsive programming, and solutions to some of the challenges [5, 6]. Through a process of reviewing notes, reports, statistics, and discussing various topics, key themes crystalized in the data.

A rigourous, respectful, and mindful process was followed for the data analysis, which included: the comparison of findings to the known literature on the topic [7]; reflexivity and bracketing of researcher perspectives before and during the study ([8]; and discussion of findings with colleagues [9].

Making Palaugaaq (bannock). Makimautiksat Camp in Cambridge Bay. March 2016. Photo Credit: Moriah Sallaffie

Findings

The findings are presented below under 4 sub-headings:

- The characteristics of the organizations
- Funding sources for community-based health and wellness programming in Nunavut
- Perceived barriers to sustained community-based mental health and wellness programs
- Perceived facilitators to sustained community-based mental health and wellness programs

Characteristics of the organizations

Four community-based health and wellness centres were included in this case study from 3 regionally distinct regions in Nunavut.

- The organizations had all been in existence in some form for 10 years or more.
- They provided employment to between 15 and 100 people in various jobs, full- and part-time in the communities they serve.

Figure 1. This word cloud was developed from the content of the interviews with participants in this case study. The larger the word, the greater the frequency with which it was used in the discussion.

- The organizations deliver programs targeted toward community wellness, which can include, but is not limited to:
    - Canadian Prenatal Nutrition Program
    - land-based programs (elders/youth, healing, harvesting, etc.)
    - support for new parents and parents of young children
    - skill-building, such as qamutik-building, sewing, and crafting
    - talking/healing circles
    - youth camps
    - men's groups
    - cooking and nutrition-related programs
    - healing/counselling support
- None of the organizations had, at any time, received core operational funding from any source. They have operated on proposal-based funding, primarily on 1 year contribution agreements and, on some occasions, 3 or 5 year contribution agreements with funders.
- All of the organizations had participated in various evaluations of their programming over the years and have evidence to support the success of their programs.
- Two of the organizations had their funds managed by the Hamlet office and the other 2 operated as independent societies under the Nunavut Societies Act and had independent financial management.

Funding sources for community-based health & wellness programming in Nunavut

The organizations identified several funding sources to which they apply for funding for various initiatives at their organizations:

Local-level funding from the Hamlet or from a community group, such as the food bank, soup kitchen, or volunteer group

Proposal-based territorial-level funding from the Government of Nunavut such as Community Cluster Program Funding (territorial funding administered by hamlet councils); or Food Security Coalition Funding (new in 2016)

Proposal-based federal-level funding such as PHAC Sexual Health Program; PHAC Injury Prevention Funding; Health Canada funding for counselling services

Foundation funding such as Aboriginal Healing Foundation (now closed); Movember Foundation; and Canadian Women's Foundation.

University and researcher partnerships to access CIHR or SSHRC funding for program pilots or videovoice/documentary research about Inuit health

Crowd-sourcing for specific items, such as camping gear, equipment, or airfare.

Perceived Barriers to Program Sustainability and Scale-up

Gatekeepers. Gatekeepers were perceived as individuals working in the system, such as the municipal, territorial, or federal funding systems, who have the power/capacity to ensure a project is funded, or to remove funding entirely. In a small region, such as Nunavut, where funding processes can be dependent on the activities of one individual, gatekeepers can be the difference between a program be offered or canceled in any given year.

"Often, a single person holds the access to the money you want to get at. Personal agendas can play a role. A lot of it boils down to actual people making decisions and their agendas and biases. It matters whether you get along with [a contact] at the dept. you are trying to get funding from. They will advocate for you or not. They will route it [the application] to the right places or they won't."

Gatekeepers were not only viewed as crucial in obtaining funding in the system, but also as individuals in crucial supervisory roles, who either supported staff to deliver programs that best addressed the needs of the community or, if employed elsewhere in the community, to contribute their expertise to the successful implementation of community wellness programs. An example was given of a gatekeeper in a supervisory role who removed a staff member from actively implementing a successful multi-year community-based program without cause or explanation. Such actions are not uncommon among gatekeepers, and are punitive, controlling, and counter to the overall goals of the system, which are to provide care and services to the communities.

Political interference/influence - municipal, territorial, federal. In one example provided in an interview, a successful program, which had demonstrated excellent outcomes for several years, lost its funding because the political leadership at the territorial level felt that the mechanism that was being used to deliver the health programming was no longer of interest and they wished to see funds diverted elsewhere. An example of municipal-level political interference resulted in the same outcome for another program. Therefore, two successful programs with demonstrated health outcomes for the target population were canceled because of what might be characterized as political influence on funding allocations. This is a significant vulnerability in the current system and a real barrier for the community-based programs.

Examples of federal-level political 'interference' were related to priority swings, for example the priorities of one federal health minister might be related to mental health and the next minister might prioritize family violence prevention, and funding opportunities swing with the priorities. Although, this was viewed as both a barrier to sustainability (if funding is diverted to another priority area) and as a facilitator in cases where an organization was

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"[It seems] the system is designed to protect the financial status of the Government of Nunavut. Funds are handed out on an annual basis. Because their processes are so slow, the funding doesn't arrive until half-way through the year. We are expected to cash-manage, with no other sources of income, or our programming lapses while we wait for funds to arrive.…We are required to provide multiple financial reports. In some cases, financial reports are requested from us before the funds even arrive. The processes are ridiculous. In cases where the funds are devolved from the territory to the hamlet or town council, the process is even longer. We have to do this every year. These long, arduous, resource-consuming processes do nothing to improve community wellness. They are designed to protect the government's financial system.…What if they took more chances and gave more long-term, guaranteed funding to communities for health and wellness programming? What would that look like? … Has anyone bothered to look at a systems-level change that would put funds in the hands of community organizations that affect change, instead of in the hands of managers and finance clerks who turn over every year?" - Case study participant

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seeking opportunities to branch into other topic or program areas. In addition, the example of the elimination of Aboriginal Healing Foundation funding for community-based programs was highlighted as a federal-level funding decision which had a significant impact on the sustainability of community-based mental health and healing programs in Nunavut.

Systemic funding blocks. The way in which funds are allocated and distributed within the system was viewed as a barrier to sustainability. For example, the requirement to re-submit proposals for on-going programming such as cooking clubs or youth and elders groups on an annual basis was viewed as a significant systemic funding block. One case study participant stated,

"Managing the risk of a community organization mis-spending funds has become more important than managing the risk of a young person dying by suicide - because the programs that help youth and families can't access the funding to implement supportive programs in a timely and consistent way."

In addition, multiple layers of review and program management at the territorial level were viewed as prohibitive to the timely and successful implementation of community-based wellness programs.

Disconnect between program and financial mechanisms at the territorial level. Program staff may make commitments in support of community-based program implementation, which finance staff will not support. In the words of one case study participant,

"There is a systemic something happening in the Government that creates a cyclic short-sightedness."

An example was given of an organization entering into a funding agreement with a specific health program to deliver training, which included a clause for a percentage of the funding to be provided in advance to help the small organization to cash-manage the project. The finance clerk refused to execute the clause and allow the funding to be provided in advance. This is another example of vulnerabilities in system implementation that prohibit the actions needed to support community-based wellness program implementation and sustainability.

High-turnover of management and admin staff. The Government of Nunavut experiences a high rate of employee turnover. Community organizations are acutely affected by this turnover, particularly with regards to developing meaningful partnerships and relationships which are required for implementing innovative programming or scaling-up. It also exacerbates the issue related to gatekeepers by placing greater reliance on few individuals in the system with the responsibility to process contribution agreements or payments. This can inadvertently allocate more power to gatekeepers whose beliefs or behaviours do not align with community-based programs. In one example, a community-based organization was in the process of entering into a contribution agreement with a territorial department, when the staff member overseeing the agreement resigned. The agreement was never processed as a result because no other staff member was assigned to see it through. This happened on two occasions to the same organization within the last 3 years. In both cases, the projects never received the funding and the programs were not delivered.

In resource-limited community organizations, the time spent developing proposals is wasted when the proposal does not get to the contribution agreement stage. It is viewed as a significant draw on time and energy that could be spent on meaningful community health programs. In the words of one participant,

"Fifty percent of [my] time is spent asking for money, 25% of time [my] running programs that may not be our primary focus, but generate the revenue that pays the rent. The rest of the time, I work on the programs that I know our community wants and needs. Time spent searching for core funding could be spent implementing the programs - imagine what that would look like."

Socio-cultural awareness. One of the greatest challenges to implementing the health care system in Nunavut is the system's reliance on short-term health professionals, including health program managers and administrators. The challenges of providing programs in this context are further exacerbated by the fact that many of the staff in the system are not oriented to the Inuit historical context, cultural traditions, or societal values.

As a result, community-based organizations identified challenges related to miscommunication or misunderstandings due to language, and cultural barriers, such as not understanding societal values

related to relationship-building, crafting, caregiving, storytelling, justice, the role of the land in wellness, and the importance of artistic expression in mental health. This translated into barriers acquiring support and favourable reviews of projects, such as in the example, below,

"If [a gatekeeper] really likes a land-based program, for example, and gets it, they would be more likely to advocate for it in the review process. If they think 'oh, they are just trying to go camping', then they won't appreciate the importance of passing on that proposal."

Perceived Facilitators of Program Sustainability and Scale-up

Champions in the system. Champions were perceived as individuals working in the system, such as the municipal, territorial, or federal funding systems, who are the gatekeepers advocating for community organizations. They were viewed as individuals who were supportive of community-based programming and advocated for resources for community programs in different ways, for example, by advocating for funding proposals, by helping to write documents in support of community programs, by donating staff time in-kind to program implementation, or by advocating publicly in the media or on community radio. Shaw et al. (2012) argue that practice transformation requires a sustained improvement effort that is guided by a larger vision and commitment and assures that individual changes fit together into a meaningful whole. Change champions – both project and organizational change champions – are critical players in supporting both innovation-specific and transformative change efforts [10].

Community strengths and determination. The creation of Nunavut was about self-determination and self-governance. In Nunavut, community-based health programs are grounded in Inuit ways of knowing and understanding wellness. Such models are not only essential for public health, but they are also a critical part of on-going self-determination and decolonization processes for indigenous communities throughout the North and around the world. Participants identified that Nunavummiut have strengths, capacity, and capabilities which contribute positively to health. They also talked about their drive and dedication to ensure their programs continue in spite of the challenges.

Sunrise after the sun's return to Clyde River in late January. 2016. Photo Credit: Gwen Healey

"[We are] being creative, tenacious. It's our strategy… Write 5 proposals and hope one gets funded - that is the way we have been able to survive."

Community members know and understand the pathways to wellness that work for Nunavummiut, and we should build on them to implement health programs that can meaningfully address health outcomes.

Growing evidence-base to support work. There has been an increase in the number of publications in the peer-reviewed and grey literatures which highlight evaluation findings from community-based wellness programs. This information, which may have only rested with the funding agency previously, is increasingly being made public to share innovative approaches. These are very important contributions to the literature on the topics of community-developed interventions from indigenous communities, evaluation, and the diversity of methods that can be applied to improve health outcomes in northern communities [11-16]. This evidence base is useful for organizations that are advocating for meaningful funding agreements for programs that are proven to be making a difference in northern communities.

On-going training opportunities. Participants in this case study identified that there is often good support for new or on-going training in different community-based health initiatives, such as ASIST Suicide Intervention Training; Mental Health First Aid; nutrition, cooking and food safety courses; breastfeeding support; tobacco cessation, and specific training for community-based alcohol and

drug counsellors. However, it was also noted that the availability of training opportunities is usually attributed to the high rate of turnover in government-level positions, and the need for constantly re-training new staff. Communities make the most of this situation by participating in training opportunities when they become available.

Discussion

Several barriers to achieving sustainability of community health and wellness programs were identified in the case study. Systemic funding blocks; gatekeepers; political interference/influence; disconnect between program and financial mechanisms at the territorial level; high turnover of management and admin; and cultural awareness among senior program staff who turnover regularly. These are not new challenges to any health and wellness care system - however their constant and persistent presence in Nunavut is problematic. Systemic challenges must be addressed at all levels.

These challenges may arise from the fact that community-based wellness programs are not included as a meaningful component of the system design. Community organizations believe their programs and services are not valued or viewed as part of the continuum of health care services available in northern communities. However, community-based health and wellness programs provide essential services that are not available through the remainder of the system, particularly in communities that understaffed or under-resourced in other aspects of the health care system. As such, they should be core-funded, and not dismissed as annual or 2-3 community projects.

Harnessing the strengths of communities is one of the key components to moving forward and achieving sustainability. Encouraging people in gatekeeping positions to be champions is easy and important first step. Recognizing and building on community strengths and determination, and the growing body of evidence to support the work being done, is also an important step in advancing scale-up and sustainability opportunities. Continued and on-going learning opportunities are also important to implement, as the state of community health is dynamic, not static, and new learning opportunities are always needed.

Youth and Elder games at Makimautiksat Camp, Cambridge Bay, NU. 2016. Photo credit: Moriah Sallaffie

The findings from this small case study echo a larger body of literature on health funding structures, healthcare innovation, health systems for Canada's indigenous peoples, and and the science of implementation in Canada. These topics are discussed further, below.

1) Funding system based on risk/probability of fund mis-use

One of the systems-level challenges identified by some of the participants in this case study, included how the community wellness funding system is implemented to mitigate financial risk of the funder.

Similarly, Naylor et al. (2015) also discuss the 'risk-averse culture' of the Canadian healthcare system in a Report of the Advisory Panel on Healthcare Innovations (pp.19):

"A risk-averse culture: It is unsurprising that healthcare delivery systems are risk-averse. Mistakes can be fatal. However, some stakeholders argued that the precautionary principle in clinical care had pervaded the organization and finance of the system as a whole, contributing to stasis and impeding the spread of innovation. Until a change in culture is signalled … leaders in the system may be reluctant to confront those who have a vested interest in the status quo… "

When combined with the challenges of gatekeeping and ebb-and-sway of political priorities for funding, this challenge appears insurmountable to community organizations.

2) Health innovations suffer in a fragmented, risk-averse health care system

In Canada, the discourse on healthcare innovations spans from systemic and financial innovations to frontline care delivery to public health programming and health promotion to applications of health technology, design, and architecture.

Some challenges that are apparent at the national level are felt at the territorial and community-level as well. In particular, the Report of the Advisory Panel of Healthcare Innovations identified several elements causing fractures and delays in optimal healthcare system implementation [17]. Of particular relevance to Nunavut are the challenges of operating within a fragmented system; the lack of effective use of digital technologies; and inadequate focus on understanding and optimizing innovation.

System fragmentation: The system appears to be burdened by a lack of integration which effectively stifles innovation, particularly the spread of innovation between organizations and across jurisdictions. Managers and professionals acknowledged that patients and families lose the most in a poorly-coordinated system. Lack of integration was identified as the single most important barrier to innovation.

Lack of effective deployment of digital technology: Nunavut is very far behind in terms of harnessing the power of digital technology for telehealth, public health, training, chronic disease management. Much of this can be attributed to the lack of investment in Northern Canada's tele-communications infrastructure, which was recently highlighted in a hearing of the Canadian Radio and Telecommunications Commission on northern telecommunications [18]. Canada is also behind in the deployment and meaningful use of electronic medical and health records. These factors underpin the lag in health data generation and information management capacity, and reduces the responsiveness of our healthcare systems, including public health and community-based health programs, to timely action and innovation. In Nunavut, an electronic records management has been slow to be piloted and implemented on a wider scale.

Inadequate focus on understanding and optimizing innovative practices that benefit the health of communities: The Report of the Advisory Panel on Healthcare Innovation reports that healthcare systems leaders make decisions that are "short-term and politicized" [17] (pp.19). In this report, a lack of overarching vision for Canada's healthcare systems was noted, and the authors called for greater clarity of objectives and firmer follow-through on priorities for innovation, architectural changes to the system, and rules of engagement for participation by innovators from the public and private sectors. The authors also noted a lack of both mechanisms and the political will to spread, scale up, and sustain high-potential innovations, which were also challenges identified in this case study.

5-year old on first hunt for ptarmigan. 2015. Photo credit: Gwen Healey

3) Recommendations from the Truth and Reconciliation Commission Calls to Action regarding the healthcare system

Some of the barriers and facilitators described in this case study were also noted in the Truth and Reconciliation Commission's Calls To Action [19]. Specifically, the following recommendations are relevant to this discussion:

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field, ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities, iii. Provide cultural competency training for all healthcare professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

66. We call upon the federal government to establish multiyear funding for community-based youth organizations to deliver programs on reconciliation, and establish a national network to share information and best practices.

4) Integrating research findings into health care policy and practice - scaling up and the science of implementation

Returning to the beginning of this case study, this topic is relevant to the literature on the science of implementation and the use of strategies to integrate evidence-based health interventions in specific settings. Further to this concept is the idea of 'scaling-up' successful interventions. Scaling up in the health sector means "doing something in a big way to improve some aspect of a population's health" [20]. It can be applied to scaling up inputs; outputs (access, scope, quality, efficiency); outcomes (coverage, utilization) or impact (reducing morbidity or mortality).

Youth and elders in Gjoa Haven, NU playing the 'Atii Gameshow' - an evidence-based intervention developed by Inuit youth for Inuit children to promote health literacy, nutritious foods and physical activity. Photo Credit: Tracey Galloway.

While implementation science literature examines the methods to promote the integration of research findings and evidence into healthcare policy and practice, 'scale-up' literature examines the resources and systems which are necessary for successful scale-up of interventions. More resources are definitely necessary for scale-up, however, there are many other factors that also need to be addressed, including unsupportive laws, complex or outdated management systems or limited demand from the public.

According to the World Health Organization, 3 key factors are important to consider for successful scale-up of evidence-based interventions [20]:

- Scaling up generally involves a partnership of organizations working on service /program delivery, financing and/or stewardship (co-ordination, regulation etc.).
- Scaling up generally requires a highly committed group of individuals to push it along.
- Monitoring implementation of the scale-up is crucial for assessing progress relative to overall objectives and for identifying aspects of the scale-up which are not working well. In practice, this is often a neglected aspect of scaling up.

It seeks to understand the behaviour of healthcare professionals and other stakeholders as a key variable in the sustainable uptake, adoption, and implementation of evidence-based interventions. In the scale-up literature, the behaviour of individuals, working as a collective, are also an essential component in success.

In this case study, several barriers and facilitators to the sustainable uptake of interventions were identified. Many of the challenges will require a systemic shift in order to be addressed, however other barriers, particularly challenges which are embedded in the behaviours of gatekeepers in the system can be eliminated with training, awareness, and encouragement. In addition, the actions of the collective of community organizations that exist to advance health in their communities can and should be harnessed to ensure evidence-based interventions are implemented and scaled as needed/wanted.

Lessons Learned

Taking these findings into account, there are a number of important key messages:

- Community-based organizations/centres provide a core service to the community - particularly communities that are under-resourced in the health or social services sectors
- Community members need and deserve sustainable and reliable services/programs, which cannot be sustained by community organizations without core base funding.
- The territorial or federal governments often lack the human resources and local knowledge to implement programs/services effectively.
- A systems shift is needed to recognize community-based health services/programs as an essential part of the continuum of health services in Nunavut and to provide adequate funding for such.
- Barriers to the sustainability of community-based health services/programs that are embedded in the behaviours of gatekeepers in the system could be eliminated with training, awareness, and encouragement to find creative opportunities in the system to meet existing needs.
- Individual behaviours (e.g. gatekeepers or champions) and collective behaviours (e.g. committed interagency or multi-agency collaborations/advocacy) are important factors in scale-up and implementation of evidence-based public health interventions. Our individual and collective efforts as 'change champions' are critical in supporting both innovation-specific and transformative change efforts [10].

Grade 9 students in Iqaluit, NU participate in an arts-based workshop develop in Nunavut entitled Timiga Ikumajuq *("My Body, The Light Within"), which harnesses the storytelling power of Inuit performance arts and contemporary dramatic arts to engage youth in discussions and skits about important topics in sexual health and relationships. 2012. Photo Credit: Gwen Healey*

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