Empowerment through Community Building: *Diabetes Today* in the Pacific

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The goal of *Diabetes Today*, a program of the Centers for Disease Control and Prevention (CDC), is to develop coalitions and train coalition members in assessment, planning, and evaluation to address diabetes in their communities. CDC established the *Pacific Diabetes Today* Resource Center (PDTRC) in 1998 to tailor the program for Pacific Islander communities in Hawaii, American Samoa, Guam, the Commonwealth of the Northern Marianas Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and Palau. PDTRC's work is guided by the principles of community building and the goal of empowering coalitions to take action around diabetes. Culturally appropriate strategies are used to gain access to the community, transfer knowledge and skills, build coalitions, and provide technical assistance. Evidence of empowerment is seen in increased individual competence, enhanced community capacity, reduced barriers, and improved supports to address diabetes. To maintain the gains of community building in the Pacific, three factors appear critical: an engaged leader, a host agency for the coalition, and continuing access to technical assistance.

KEY WORDS: American Samoa, cultural competence, Hawaii, Micronesia, technical assistance

In the United States, Native Hawaiians and Pacific Islanders are four to seven times as likely as Caucasians to develop diabetes and are more likely to develop secondary complications from the disease and to die prematurely than are other major racial and ethnic groups.[1] The *Pacific Diabetes Today* Resource Center (PDTRC) was established in 1998 through a contract from the Centers for Disease Control and Prevention (CDC) as a *Diabetes Today* training center for Pacific Islander communities in Hawaii, American Samoa, Guam, the Commonwealth of the Northern Marianas Islands (CNMI), the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and Palau. *Diabetes Today*, a program of the Division of Diabetes Translation (DDT) at CDC, aims to enhance the skills of community coalitions to plan, implement, and evaluate their own diabetes prevention and control programs.[2]

The United States–associated Pacific region includes more than 2,000 small islands and atolls within 4 million square miles of ocean. It takes 12 hours of air travel to cross this vast region—from Hawaii on the eastern

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edge of the region to Palau on the western edge. Although the jurisdictions have unique cultures and languages, they share a history of colonization and have economic and political relationships with the United States: Hawaii is a state, American Samoa and Guam are U.S.-unincorporated territories, the CNMI is a U.S. commonwealth, and the FSM, RMI, and Palau are independent nations with signed agreements allowing the U.S. military access in return for economic aid.[3,4] In addition, Pacific people belong to oral–aural cultures, where face-to-face interactions and hands-on demonstrations are preferred over written or electronic communication.[5] Pacific cultures tend to be collectivistic, rather than individualistic, and reciprocity and helpfulness are central to this orientation.[6]

In the Pacific, increased mortality and morbidity from diabetes are attributed to drastic changes in lifestyle over the past 50 years. Traditional Native Hawaiian and Pacific Islander lifestyles were active, and diets consisted primarily of low-fat, high-fiber foods from the land and sea.[7] Today, most islanders have sedentary lifestyles and their diets are high in calories, salt, fat, and refined foods.[5] As the incidence and prevalence of chronic diseases (e.g., diabetes) have risen, jurisdictional governments have spent increasingly larger portions of their health budgets on secondary and tertiary care, leaving increasingly limited resources for chronic disease prevention and control.[1,5] To help address diabetes prevention and control, DDT policy makers felt that community coalitions could help expand awareness and relevant activities among Native Hawaiians and Pacific Islanders and established PDTRC in 1998.

PDTRC's work is guided by the principles of community building. In community building, agents of change help individuals and communities get involved in, gain skills regarding, and take action about an issue of importance to them.[8,9] The desired outcome of community building is empowerment or increased capacity to identify and resolve problems.[8–11] We outline the community-building steps used by PDTRC: gaining access to the community,[9,12–16] transferring knowledge and skills,[13,15] building coalitions,[9–12,14,17] and providing technical assistance.[15,18,19] We also describe how PDTRC promotes empowerment by helping increase individuals' competence, enhance community capacity, reduce barriers, and improve supports for diabetes prevention and control in the Pacific.[10,11,17] Factors necessary to maintain the gains of community building in the Pacific are discussed as well.

Community-Building Steps

Gaining access to the community

To successfully access Pacific communities, PDTRC first needed to gain the trust of jurisdiction leaders. PDTRC staff approached their contacts in the Pacific to obtain support for PDTRC's mission. These contacts attested to PDTRC's legitimacy, which increased the willingness of jurisdictional leaders (e.g., community leaders, health professionals, and persons with diabetes and their family members) to meet with PDTRC staff to share their perceptions of diabetes and its control. In being asked for their opinions, many leaders realized their interest in diabetes and agreed to form coalitions to learn how to plan, implement, and evaluate solutions. PDTRC staff thus gained the trust of the leaders by demonstrating respect for their cultural protocol and an ability to listen, share resources, and follow through on commitments.

Transferring knowledge and skills

To help the nascent coalitions gel and expand and to teach coalition members the skills to carry out diabetes-related activities, PDTRC offered *Diabetes Today* training in each Pacific jurisdiction. With the help of jurisdictional leaders, PDTRC staff adapted *Diabetes Today* and renamed it *Pacific Diabetes Today*. *Pacific Diabetes Today* featured simplified wording, enlarged print, and graphics, photos, and case studies that reflect Pacific Island cultures, situations, and peoples. To accommodate local preferences for face-to-face interactions and hands-on demonstrations the training including structured opportunities for community members to share stories, work in small groups, and practice new skills during the training. Training coordinators at each site were required to cofacilitate *Pacific Diabetes Today* training so they could improve their own teaching and leadership skills. PDTRC also encouraged persons with natural training abilities to help PDTRC staff deliver training in other jurisdictions.

Building coalitions

Coalition membership invariably increased following *Pacific Diabetes Today* trainings. As coalitions developed, one or two local persons stepped into leadership roles. Sometimes staff from the jurisdiction's CDC Diabetes Prevention and Control Program (DPCP) or from a local hospital or clinic assumed leadership; community members with diabetes, elected officials, and civic club members also took on this role. Ideas for local interventions to address diabetes prevention and control emerged from the community coalitions. PDTRC helped them determine the priority of and put

into practice their ideas, but the coalitions directed their own activities.

Providing technical assistance

PDTRC staff offered to each coalition technical assistance, such as help finalizing an action plan and linking coalitions to organizations outside the community to broaden networks, build alliances, and secure resources. Coalitions were encouraged to use local volunteers and health programs, seek local donations, and sponsor fundraisers. PDTRC also let coalitions know about each other's work through the PDTRC newsletter and website, at annual meetings, and in telephone conversations.

Evidence of empowerment

The logic model in Figure 1 represents the relationship between community building, empowerment-related outcomes, and the ultimate goal of PDTRC of decreasing the burden of diabetes in the Pacific. Data to track achievements were collected through pre- and posttraining questionnaires, training portfolios (notebooks of completed training exercises and action plans prepared for each site), telephone interviews, and annual site reports. In this section, we show how PDTRC helped increase the competence of individuals in the Pacific Islands, enhance community capacity reduce barriers, and improve supports.

Increasing competence

By the end of PDTRC's fourth year, approximately 450 persons had participated in *Pacific Diabetes Today* training, more than 1,000 had participated as coalition members, and more than 3,000 had participated in coalition-sponsored activities. Many persons demonstrated how their participation improved their personal abilities. Trainees learned and practiced public health skills.

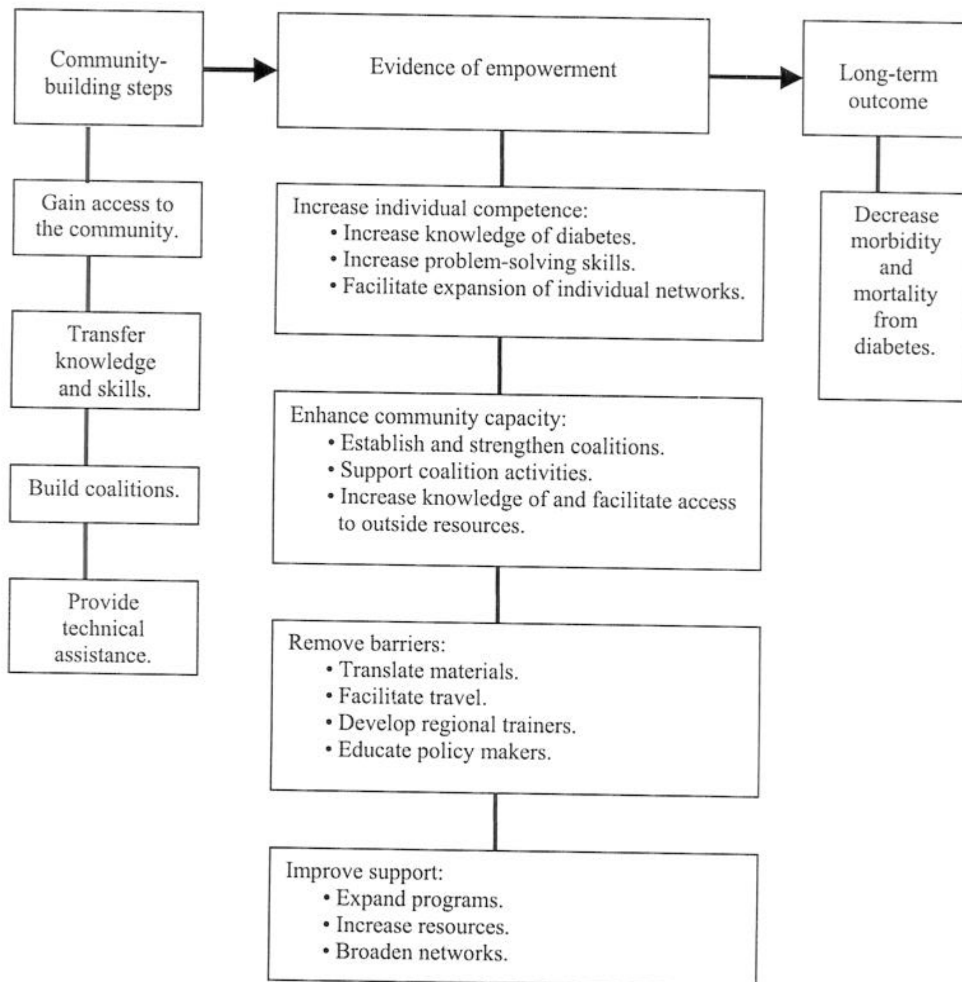

FIGURE 1. PDTRC: Community-building steps and evidence of empowerment.

Although some coalitions were more formal or active than others, each continued to meet and sponsored at least one diabetes-related activity per year since its formation.

For example, the Maui site coordinator applied skills learned through *Pacific Diabetes Today* training to facilitate a strategic planning process for her parent agency. Coalition members wrote proposals and implemented projects related to diabetes prevention and control, and coalition leaders demonstrated stronger relationships with health professionals in other Pacific communities and on the U.S. mainland. Coalition members from the CNMI, Kosrae (FSM), Marshall Islands, Maui, Palau, and Pohnpei (FSM) traveled with PDTRC staff to other jurisdictions to help lead *Pacific Diabetes Today* training. The Marshall Islands DPCP coordinator cofacilitated the training in Majuro and then independently led trainings on Ebeye Island and Jaluit Atoll.

Enhancing community capacity

By the end of PDTRC's fourth year, 11 Pacific communities had formed coalitions. Although some coalitions were more formal or active than others, each continued to meet and sponsored at least one diabetes-related activity per year since its formation. Coalitions in American Samoa and Maui filed 501(c)(3) papers to obtain nonprofit status, and the Kosrae group filed for chartering status. The Chuuk (FSM) coalition established an outreach program for diabetes education and added a breast cancer component to their outreach program. The Guam coalition applied promotional strategies from the *Pacific Diabetes Today* training to advertise Guam's annual diabetes conference, thereby increasing attendance to 1,300; this coalition also wrote for grants and secured a large donation from a California-based pharmaceutical company to support the cost of the conference. A Palau coalition member adapted the *Pacific Diabetes Today* curriculum to help solve problems regarding the broader issues of lifestyle and chronic diseases.

Reducing barriers

PDTRC was successful in helping communities reduce social and environmental barriers to diabetes control. Originally, appropriate educational materials in the Pacific to accommodate the large number of languages were lacking; PDTRC supported translation of *Pacific Diabetes Today* and other educational materials in the Marshall Islands and in three FSM states (Kosrae, Chuuk, and Pohnpei). In addition, because transportation is a major barrier in the Pacific, PDTRC helped coalition members travel to meetings and trainings. To reduce feelings of isolation among the jurisdictions, PDTRC helped coalitions learn about PDTRC and non-PDTRC initiatives throughout the region, including Guam's "Get Up and Move" policy that allowed state employees to participate in physical activity programs during the workday, a Hawaii-American Samoa collaboration to promote traditional diets, and Pohnpei's attempt to raise taxes on imported foods to encourage citizens to eat local produce and fish.

Another barrier was lack of awareness about diabetes at the policy level. Most communities were successful in attracting policy makers to training sessions, and several policy makers joined the coalitions. Coalitions developed links to the Pacific Islanders Health Officers Association, a regional health policy consortium, which agreed to endorse PDTRC. Coalitions in Pohnpei, Kosrae, and Palau were co-facilitated by public health physicians, thereby increasing attention to diabetes within public health departments in these jurisdictions. The Kosrae Pacific Diabetes Today group supported two of its members in their bid for public office; both were elected to state-level public office, and one was named chair of the health committee. A member of the Guam coalition sought and was appointed to an international diabetes association.

Improving supports

Coalitions established or strengthened through partnership with PDTRC were successful in increasing diabetes-related activities and resources in their communities and in expanding their organizational networks (Table 1). Almost all coalitions produced diabetes awareness materials in their languages and sponsored community education events; many also sponsored walks, volleyball games, athletic contests, and diet programs. In American Samoa the coalition coordinated diabetes education and screening in the villages and, because of community interest in diet, it set out to develop a Samoan diet and exercise program. To learn how to develop such a program, the coalition members traveled to Hawaii to learn firsthand about a successful diet and exercise program targeting Native Hawaiians. After the coalition attained nonprofit status, it applied for and received a $25,000 grant from the American Samoa Government to implement the program.

PDTRC also helped coalitions expand their networks and secure resources. Coalitions in almost every jurisdiction were successful in tapping local businesses for financial and in-kind supports, and relationships with DPCP programs were strengthened. Coalition

TABLE 1 ● Accomplishments and partnerships of trained groups, 2000–2002

Group and year of initial PDTRC training	Accomplishments	Type of partners*
American Samoa Diabetes Association (2000)	• Obtained nonprofit status • Received a $25,000 grant • Sponsored diabetes awareness, education, and screening • Collaborated with business leaders	LBJ Tropical Medical Center DPCP Hui No Ke Ola Pono (Hawaii) Star Kist Tuna Blue Sky Communications
CNMI Diabetes Today (2001)	• Sponsored diabetes awareness activities, cooking demonstrations, health screening, health walks, and a diabetes documentary	Northern Mariana College DPCP Public Health Nurses
FSM–Kosrae Diabetes Today (2000)	• Sponsored nutrition workshops, fun walks, and volleyball tournaments	Kosrae Association of Businesses Kosrae Women's Center Local and national DPCP representatives
FSM–Pohnpei Lipaiere (2000)	• Translated educational materials • Sponsored health walks	Lions Club of Pohnpei Local and national DPCP representatives
FSM–Chuuk Women's Advisory Council (2002)	• Sponsored outreach, training on outer islands, and other education programs	FSM Department of Health Local and national DPCP representatives
Guam Diabetes Association (2002)	• Sponsored diabetes conference and "Family Fun Run/Walk for Diabetes"	DPCP Guam Lions Association Guam America
Republic of the Marshall Islands: Majuro, Ebeye, and Jaluit Groups (2001)	• Translated materials • Sponsored training on outer islands, gardening project, sports tournaments, and community fundraising	DPCP Salvation Army Rita Youth Group Missionary Ventures Marshall Islands
Republic of Palau, Ulkerreuil a Kelngar (2000)	• Established the "Active Community Lifestyle" program • Used PDT curriculum for training in other chronic diseases	Palau Resource Institute DPCP Palau Community Action Agency Bureau of Women's Interest Religious organizations
Hawaii–Halau Ola O Mimiko No Waianae (2000)	• Sponsored diabetes workshops and support groups in several communities	Ke Ola Mamo Ko'olauloa Community Wellness Center Kahuku Hospital Drug Free Hawaii Queen Lili'uokalani Trust Brigham Young University of Hawaii
Hawai'i—Maui Native Hawaiian Diabetes Coalition (2001)	• Sponsored health fairs and workshops	Hui No Ke Ola Pono American Diabetes Association of Hawaii
Hawai'i–Molokai Diabetes Task Force (2002)	• Sponsored health fair, screening, and support groups	Lamalama Ka 'Ili Public Health Nurses Dialysis Patient's Support Group, National Kidney Foundation—Hawaii Hawaii Association of Diabetes Educators

*Papa Ola Lokahi, the parent agency for PDTRC, was a partner for each site.

members learned about U.S. and international resources available to support diabetes-related projects. Finally, PDTRC helped strengthen their connections to regional, national, and international coalitions on diabetes and health.

Implications for Public Health

Through this project, PDTRC validated the importance of adhering to community-building principles to empower communities. Several elements appear critical

for maintaining the gains of community building in the Pacific: an engaged leader, a host agency for the coalition, and continuing access to technical assistance and program funds. Good leaders emerged from the public and private sectors, but coalition activities often lagged when a government-employed leader retired or was reassigned. Co-leadership is helpful in maintaining continuity if one leader should leave the coalition. The backing of a local host agency is crucial to the long-term success of a coalition. Various agencies have the resources and infrastructure to support coalitions on multiple levels (e.g., by providing meeting space and fiscal management services), and ideal host agencies will support a broad-based coalition and not try to control its agenda. Continuing access to technical assistance and resources also is critical. Technical assistance may be available locally (e.g., through a relationship with a college that can provide assistance with data collection and evaluation or a DPCP that can help with project implementation). We found that some coalitions were reluctant to ask for help, so efforts were made to talk regularly with coalition representatives about their needs and to suggest ways in which PDTRC could help.

Program funds are necessary to support coalition activities. Amounts needed are often modest but they are important, particularly in the Pacific, where the cost of office supplies can be double the cost in the continental United States. Traveling from one jurisdiction to the next—and even between islands within a jurisdiction—is expensive. In Chuuk, participants coming from the lagoon islands must take a 2-hour boat ride to the capital island; traveling between Majuro and Ebeye in the RMI requires a 40-minute plane ride followed by a 20-minute boat ride. In many Pacific jurisdictions, government and nongovernment agencies do not compensate for time off from work, even to attend training or coalition meetings, so activities must be scheduled for evenings and weekend or coalitions must be able to provide "sitting fees" to participants to compensate for time off. Some coalitions were successful in securing donations from local businesses, but Pacific communities have limited resources available to them. Thus, access to outside sources is important, and CDC and other U.S. federal programs should continue to support diabetes programming in the Pacific. In fact, DPCP in six jurisdictions included linkages with Diabetes Today coalitions in their 2003 applications to CDC for continued funding.

Community building proved to be valuable in guiding PDTRC's activities and it helped empower communities, as evidenced by increased competence of individuals, enhanced capacity for action, and fewer barriers and more supports to prevent and control diabetes in the Pacific. It is envisioned that the PDTRC's collective experiences in using culturally appropriate strategies of community building can serve as a framework for other organizations that want to successfully enter, train, and support Pacific communities in health-related activities. To help coalitions maintain their momentum and ultimately reduce the burden of diabetes in Pacific communities, future projects should pay particular attention to supporting local leaders and appropriate host agencies, linking coalitions with steady sources of technical assistance, and lobbying for continued financial backing from governmental and nongovernmental organizations that can fund diabetes programs.

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