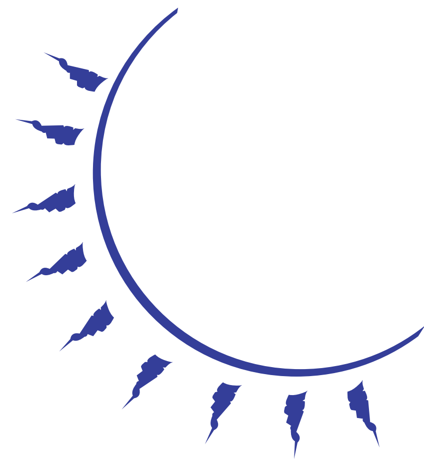
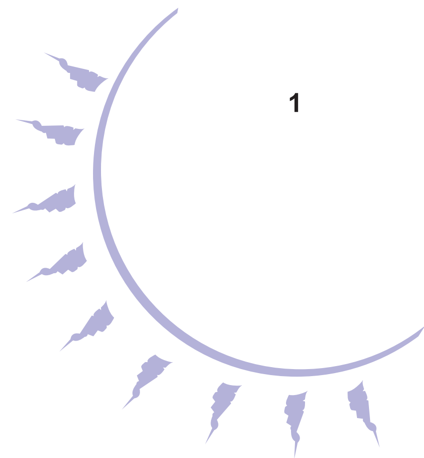


Using a Population Health Promotion Approach: Lessons Learned from the Population Health Promotion Demonstration Sites for Primary Prevention of Type 2 Diabetes

July 2003



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EXECUTIVE SUMMARY

The purposes of the Population Health Promotion Demonstration Initiative for the Primary Prevention of Type 2 Diabetes (PHP demonstration sites) were to:

1. Create social and physical environments that support healthier choices,
2. Enhance the ability of communities, families and individuals to take action, and
3. Reduce the risk conditions that contribute to the development of type 2 diabetes.

Seven demonstration sites covering more than half of the health districts in Saskatchewan were funded. The initiative provided an opportunity for individuals, organizations and communities to increase their knowledge and skills in using population health promotion approaches to address health issues. Using diabetes prevention as an entry point, demonstration sites worked with a number of inter-sectoral partners to create healthier communities by reducing or removing barriers that prevented people from making healthier choices. The demonstration sites supported changes to reduce the risks and root causes of developing type 2 diabetes. For example, physical inactivity and poor eating are risk factors but some of the root causes of these risk factors may be low incomes and lack of social supports.

Creating the conditions that supported healthy choices was the key. Demonstration sites worked collaboratively with their partners to improve the social and economic conditions and physical environments that contribute to type 2 diabetes and, ultimately, other chronic diseases. Developing partnerships with other sectors was essential because issues affecting health are too large and complex to be addressed by a single sector. Partners initiated a wide range of activities such as changes to school policies on physical activity and nutrition, serving healthier foods at feast days, and story telling by elders in Cree, Dene and English.

This evaluation summary focuses on several cornerstones of population health promotion. It describes and discusses the experiences of the demonstration sites in relation to:

- reducing barriers to health
- strengthening the community's ability to take action on issues
- creating environments that support healthy choices
- developing and implementing healthy public policies
- engaging and sustaining intersectoral partnerships
- creating changes in communities that last beyond the life of a demonstration project.

The evaluation also describes the nature and impact of central support provided by Saskatchewan Health staff to demonstration sites and to all health districts during the course of the initiative.

This report summarizes findings from the period April 1, 1999 to March 31, 2002, the end of funding of the initial proposals.

HIGHLIGHTS OF LESSONS LEARNED

Improving access to healthy foods and increasing opportunities for regular, enjoyable physical activity were the most common approaches. Sites used a number of creative strategies to reduce some of the barriers to healthy physical activity and good nutrition.

An early lesson was that using a population health promotion approach took some adjustments for health professionals who had been trained to independently assess the problems and then develop and deliver programs. Population health promotion requires working with communities to decide what is needed and how it will be done. It is also complex so a single strategy or approach is not enough to bring about meaningful change.

Strengthening a community's ability to take action first involved discussion with and involvement of community members. Community members could see that what seemed like obvious solutions to outside professionals might not work or there might be better ways of working. Stimulating community action was far more difficult without consistent leadership or a specific proposal around which people could coalesce. The community development process needs to be balanced with people's desire to see action and progress.

Creating supportive environments required understanding that people's actions are determined by the situations in which they live. What people knew was often far less important in determining action than the opportunities they had to make choices, the influence of friends and family, etc. Some of the changes resulted in long term policies being implemented.

Developing healthy public policies was often the most difficult strategy. It required that the community be involved and that the environment be supportive before a policy that was used could be implemented. It took time for people to understand what public policy is and how they could affect it. Local policies such as what was served at health district meetings or whether the school gymnasium was open to community members resulted in important changes.

Partnerships were an essential part of this initiative because they increased the expertise, the impact and the resources available to tackle quite complex issues. At the beginning potential partners needed to discuss how the goals of their own organizations fit with the proposals so they could decide what commitment to make. At every stage, communication within a partnership was the most important factor in the partnership's ability to deliver programs. Having a broad base of support and achieving results that partners believed was important were critical to keeping a partnership active. Partnerships do take a considerable amount of time, energy and commitment.

Another focus of this review was to look at the support provided by Saskatchewan Health staff. This included workshops, conferences, regular personal contact and financial and print resources to develop and build on existing skills. The expectations for collaboration, reporting and communication, evaluation and skill development were made as clear as possible before funding applications were developed. As the initiative progressed, however, additional needs were found and addressed.

The ability to put population health promotion theory into action, applying the underlying principles and values to everyday practice, is critical to improving health and well-being. As communities increase their skills in using population health promotion approaches, they can use that knowledge to effectively address issues as they arise. A population health promotion approach can create changes that make it easier for everyone in a community to make healthier choices.

SECTION 1: INITIATIVE DESCRIPTION

The Population Health Promotion Demonstration Initiative for the Primary Prevention of Type 2 Diabetes (PHP demonstration sites) focused on applying the Population Health Promotion (PHP) Model so it was easier for people to make healthier choices where they lived, worked and played.

The demonstration sites supported changes to reduce the risks and root causes of developing type 2 diabetes. For example, physical inactivity and poor eating are risk factors but some of the root causes of these risk factors may be low incomes and lack of social supports. [1,2]

The stated purposes of the PHP demonstration sites initiative were to:

1. Create social and physical environments that enhance healthier choices,
2. Enhance the ability of communities, families and individuals to take action, and
3. Reduce the risk conditions that contribute to the development of type 2 diabetes.

Much of this report is grouped under themes related to how community change was achieved:

1. Reducing the barriers related to the root causes of ill health (such as low income, education and social support) can be reduced; this was an underlying theme in all the projects.
2. Building on existing skills or developing new expertise to create healthier communities; the strategies included strengthening community action, creating supportive environments and building healthy public policies.
3. Working with intersectoral partnerships was key because no one group could make the lasting changes that were necessary.

The program was initiated by inviting health districts and some of their partners to a workshop to explain how they could submit proposals. The Getting Started Workshop outlined requirements in three broad areas:

1. partnerships,
2. strategies, and
3. planning and evaluation. Proposals needed to include workplans and basic evaluation outlines.

Applicants were asked to focus their proposals on:

- the broad community-based settings in which people live, work and play (for example, schools, recreation facilities, community and health district functions and programs, grocery stores, etc.);
- reducing the barriers created by certain determinants of health such as income and social support networks;
- using evidence about what works whether from the literature or community experience;
- empowering practice that supports community members in taking action;
- capacity building so community members would have more skills in working together to improve health;
- community participation in decision making;
- partnerships with several sectors, including those outside health, and;
- multiple strategies, including at least two of strengthening community action, creating supportive environments and building healthy public policies were required.

While diabetes provided the focus for collaboration by health districts, Aboriginal groups, community groups and other sectors, the underlying purpose was to help communities make changes that would improve health for all.

Diabetes was an entry point that mobilized many communities. The conditions and risk factors that contribute to the rising rates of diabetes are shared by many other health problems. By using a population health promotion approach to reduce the impact of barriers due to low income, education and social support, communities become healthier. Residents are at lower risk of developing diabetes and a number of other chronic illnesses. Those who already had diabetes also found there were more healthy choices available to them.

First Nations and Métis people are at higher risk of developing diabetes so this issue was particularly appealing to some communities. One proposal, for example, pointed out that the incidence of diabetes had doubled among First Nations people from 1980 to 1990 and doubled again by 1998-99. Rates among Métis people were similar. [1] In northern Saskatchewan, the population is about 50 per cent First Nations and 30 per cent Métis.

SEVEN DEMONSTRATION SITE PROJECTS

Communities Hand in Hand

The partners involved in this project included the Battlefords, Twin Rivers, Northwest and Lloydminster health districts, Canadian Diabetes Association, Lloydminster Native Friendship Centre, Meadow Lake community schools, Meadow Lake Tribal Council, Leadership Saskatchewan and a number of municipal parks and recreation departments.

The project goals were to:

1. improve physical activity and nutrition in six communities; and
2. build a stronger sense of community by involving many groups in project initiatives.

This was a multi-site project with all initiatives focusing on increasing physical activity and/or facilitating healthy food choices. A central steering committee of partners supported projects in six communities including Turtleford/Thunderchild, Maidstone, Loon Lake, Meadow Lake, Lloydminster and North Battleford. Some initiatives included promoting the use of walking trails, increasing healthy food choices at community events, organizing yoga and aerobics classes and developing an educational kit on diabetes prevention. A core of leaders from each of the community sites received training through the Leadership Saskatchewan Program.

Defeat Diabetes Team

The Defeat Diabetes Team project involved a number of partnerships including the Touchwood Qu'Appelle and Pipestone health districts, Carry the Kettle First Nation, Lipton School, Montmartre School, Pasqua First Nation, File Hills Qu'Appelle Tribal Council, Medical Services Branch (Health Canada), Lipton Parks and Recreation and the Canadian Diabetes Association.

This peer-centred, school-based project was working to:

1. empower youth through education to act as effective change agents; and
2. create environments that were supportive and conducive to healthy choices and lifestyles.

Peer teams in each of the four participating schools developed action plans and conducted activities such as walking clubs, healthy snack sales and street hockey tournaments. Teams also worked to influence their communities to practice healthier lifestyles and create community environments that supported healthy choices.

Linking Community Voices in the Promotion of Health

The partnerships involved in this project included the Regina Health District, University of Regina, Four Directions Community Health Centre, Rainbow Youth Centre, Regina Early Learning Centre, Regina Education & Action on Child Hunger (REACH), Regina and District Food Bank Inc., Scott Collegiate, Kitchener School, Herchmer School, Sacred Heart School, Albert School, O'Neill High School, North Central Community Society, Regina Indian Community Awareness Inc., Regina Public Library and City of Regina Community Services, Parks and Recreation.

This project worked to affect risk factors of type 2 diabetes by:

1. linking existing community resources and removing identified barriers to physical activity and healthy food;
2. improving community access and use of existing programs such as Good Food Boxes; and
3. supporting and enhancing the community's

capacity to identify and solve problems around factors that affected its ability to obtain equity in health.

Project activities included cooking classes at the Food Bank, teaching kitchens, increased use of the Good Food Box program, free adult volleyball at local schools, a puppet show on diabetes produced and performed by two youth groups, development of the Story Sacs literacy program, and support for community leadership and healthy school policies.

Pathways to Well-Being

This project included partners from Saskatoon District Health, Canadian Diabetes Association, Child Hunger and Education Program (CHEP), Saskatoon Tribal Council Family Centre, Saskatoon Indian Métis Friendship Centre and Saskatoon Community Clinic.

The goals of the project were to:

1. improve the knowledge of children and youth about healthy food choices;
2. raise awareness within the Aboriginal community that type 2 diabetes may be prevented; and
3. involve more Aboriginal families in the Good Food Box Program.

Project activities included expansion of the Good Food Box Program, cooking classes with Aboriginal families using the Good Food Box, KidsCan school-based nutrition and cooking program, and adult cooking classes held and funded by the Community Clinic.

Primary Prevention of Diabetes Project

The partnerships involved in this project included the North East, North Central and Pasquia health districts, Melfort School Division, Northeast Regional Intersectoral Committee, Red Earth First Nation, Aboriginal Women's Council, Food for All Coalition, Kinistin Saulteaux First Nation, Métis Heritage Corporation, Métis Nation of Saskatchewan Eastern Region II, North East Recreation and Parks Association, North-East Early Childhood Intervention Program, Prince Albert Grand Council, Saskatoon Tribal Council, Shoal Lake First Nation and Yellow Quill First Nation.

The goal of the project was to work with Aboriginal and non-Aboriginal communities to increase physical activity and healthy eating. Forums were held in various communities to increase awareness about primary prevention of type 2 diabetes and assess community assets and needs. Interested communities had an opportunity to apply for project grants. A community development worker worked with communities to plan projects and submit proposals for grants, as well as assisted funded projects to implement and evaluate their initiatives.

Putting Prevention into Action

The project involved a long list of partners including the Assiniboine Valley, East Central and North Valley health districts, Yorkton Tribal Council, Métis Nation of Saskatchewan Eastern Region II, Gloria Hayden Community Centre, Regional Intersectoral Committee, Sports Council, Chief Gabriel Cote Education Complex, M.C. Knoll School, Keeseekoose First Nation, Key First Nation, Cote First Nation, Yorkton Métis Women's Group, Kamsack Family Resource Centre, Yorkton Friendship Centre and Canora Community Services.

The goals of the project were to:

1. build healthy public policy related to access to physical activity and nutrition in schools and recreation facilities;
2. facilitate the implementation and delivery of culturally-appropriate primary prevention of type 2 diabetes programs with Aboriginal groups; and
3. create resource kits focusing on the primary prevention of diabetes for use by schools and community organizations.

Project initiatives included work by the Public Policy Committee, development of a community grant program and development of a resource kit for schools and food security sites.

Working Together for a Brighter Tomorrow

The coalition of partners included the Keewatin Yatthé and Mamawetan Churchill River health districts and Athabasca Health Authority, Missinippi Broadcasting Corporation, Northern Inter-Tribal Health Authority, Prince Albert Grand Council, Northern Recreation Co-ordinating Committee, Northern Medical Services, Canadian Diabetes Association, Northern Lights School Division, Ile a la Crosse School Division, Métis Nations of Northern Saskatchewan, Peter Ballantyne Cree Nation, Meadow Lake Tribal Council, Lac La Ronge Indian Band, Social Services, Northern Human Services Partnership, the Department of Culture, Youth and Recreation, and University of Saskatchewan. More than 50 communities across the north were involved in initiatives.

The objectives were:

1. Co-ordination of action. To establish a northern diabetes prevention coalition to co-ordinate action on north-wide strategies, and to assist and respond to communities in the development of multiple community based, multi-sector strategies to increase physical activity and improve healthy eating practices.
2. Awareness and communication. To increase awareness that type 2 diabetes is potentially preventable and the awareness of the benefits of community action to increase physical activity and improve healthy eating practices.
3. Community support, capacity and action. To build capacity of northern communities to develop community-specific strategies aimed at the prevention of type 2 diabetes through increased physical activity and improved eating habits.

Some initiatives included work on healthy public policies in schools and rinks, production and broadcast of 15 radio spots in Cree, Dene and English, development of videos, and community workshops.

SUPPORT FOR ALL HEALTH DISTRICTS

Throughout the initiative there was an ongoing commitment from Saskatchewan Health to provide additional training and support. At times this was specific to the demonstration site partners, and at other times support was open to all health districts and their partners. Details about the workshops, conference and print materials appear later in this report.

SECTION 2: THE EVALUATION FOCUS WAS ON AN APPLICATION OF THE POPULATION HEALTH PROMOTION MODEL

This initiative was a new way of working for both the demonstration sites and Saskatchewan Health. Key ideas were selected from the PHP Model to develop a way of working that would deal with complex issues in a way that would maximize sustainable community change for better health.[2] (See Appendix 1: Population Health Promotion Model.) The principles that emerged have been outlined previously in this document.

In practice, the key themes were:
1. **Reducing the barriers** created by certain determinants of health such as income and social support networks.
2. **Creating healthier communities** (supportive environments). To do this, citizens needed to have the skills, ability and will to take action. This could lead to implementation of healthy public policies or to different norms or "ways of living" within the community.
3. **Working with partners,** including many outside the health field. By working together, organizations and citizens can accomplish far more than anyone working alone.
4. **Using evidence** about what works whether it comes from the literature or community experience.

This report highlights how these principles and some related issues such as sustainability of the work and the partnerships were applied.

WHAT THIS REPORT IS NOT

This report is not an evaluation of changes in rates of diabetes or its risk factors, physical inactivity and poor nutrition. Because the approach was "upstream" primary prevention with an emphasis on sustainable, long-term community change, the rates of type 2 diabetes and other chronic diseases could not be expected to fall over the relatively short duration of the initiative. (Upstream approaches are primary prevention and health promotion initiatives that reduce the risk of a condition ever developing.) The benefits of improved health will be seen over many years.

INFORMATION SOURCES

This report drew on written reports from the projects, interviews with key partners from each project, workshop evaluations, statistical analysis of two partnership surveys, the literature, telephone interviews about the role of Saskatchewan Health and ongoing discussion and observation throughout the project. The report summarizes information from the period April 1, 1999 to March 31, 2002, the end of the funding of the initial proposals.

The interview transcripts that appear in a number of places in this report have been edited for length and clarity but, as much as possible, are in the interviewees' own words. Portions that could identify which project or area was being described were removed. Quotations from the transcripts begin with

✷ They are also indented and in a different typeface.

SECTION 3: WHAT WAS DONE

The bulk of this report provides examples of what was done and what was learned. Sections 3 and 4 are organized under the headings:

- Reducing the barriers
- Creating healthier communities
- Working with partners

Lesson learned: It is important to note that there are many interconnections among these headings so it is sometimes difficult to place an activity in just one category. Separating a project into its components may also be misleading because some might think they could choose to do just one small part and that would be a population health promotion program. In fact, it takes many elements to make a program. Each project was required to include multiple strategies.

Another note is that while the approach made sense to most, the terminology was a barrier to understanding at times. The interconnections among some of the principles of the approach were also confusing for those trying to sort activities into different categories.

REDUCING THE BARRIERS

All of the projects were required to address barriers in the community that prevented people from making healthier choices the easier choices. Examples of such barriers included time, cost, place and geography. Projects were required to work on more than one of the following determinants of health:

- Income and social status
- Social support networks
- Education
- Employment and working conditions
- Physical environments
- Healthy child development.

The determinants of health provide insights into some of the barriers to achieving healthy levels of physical activity and nutrition, both risk factors for developing type 2 diabetes. [1,2,3] Sometimes it is necessary to look at several layers of barriers. For example, cost, having transportation and feeling comfortable, affected grocery store and recreation centre choice and use.

In practice, reducing barriers became the "background" for this initiative. This theme was woven throughout the activities and the report, rather than being separated out into a particular section.

Successful applicants identified many strengths as well as barriers in their communities and then presented a plan to reduce those barriers. One project, for example, in looking at barriers that needed to be addressed, said that the average household income in the selected area was slightly more than half of that for the area as a whole and many families were living below the poverty line. There were waiting lists at agencies that provided upgrading for grades 10 to 12 and work preparation. Unemployment was high so there was reliance on social assistance. Social support networks were disrupted when people moved to the city, away from families. The homes in the area were older and most were rented rather than occupied by homeowners. There was limited access to recreation facilities, and safety concerns kept residents from going for walks in the evenings. There were a number of programs for high risk children, indicating both a need and the potential for improvement. There was no major grocery store in the area, so residents relied on convenience stores or had to find transportation to larger stores with more selection and better prices. The plan was to bring together community agencies to address the issues.

Lesson learned: People may be overwhelmed and discouraged if they believe that they have to solve poverty, low education levels and many other hurdles before they can improve health. They were much more comfortable when they realized that these are long-term goals and, in the short-term, the requirement is to work towards reducing

the effects of these barriers. Identifying some of the barriers to good health led to many practical approaches to reducing their effects, apparent throughout each of the project descriptions.

CREATING HEALTHIER COMMUNITIES

Each project was required to use at least two of the following strategies:
- Create supportive environments
- Strengthen community action
- Implement healthy public policy.

Lesson learned: In practice, activities often fit more than one type of strategy and the three strategies are interdependent. A general observation was that supportive environments and community action were necessary first steps in order to implement healthy public policies. Developing healthy public policies that were actually used was sometimes the most difficult of the strategies. For example, a school could pass a policy but if the students, teachers and parents didn't support it or didn't have the skills to implement it, it would be left "on the shelf". Policies were more likely to be used if there was community support and the environment made it fairly easy. Some of these were informal "lived" policies rather than formal, written policies.

Although the strategies were necessarily interconnected, projects were asked how they used each in order to help explain them as components of an overall approach. Project partners who were interviewed were asked a series of questions regarding what they understood about each of the three strategies at the beginning of the program and what had changed. These questions were difficult for many interviewees to answer. For a few who had had extensive experience in population health promotion there was good understanding. But for anyone relatively new to the Population Health Promotion Model, the concepts were difficult, particularly at the beginning of the project. From the answers, it wasn't clear that everyone understood the concepts by the time the interviews were conducted near the end of the funding. Several said that the terminology and the concepts were difficult so they found simpler explanations. Here is what some said:

- ✷ From the beginning, I understood nothing. And the concern I had about the project was for people from the outside. A lot of terminology that may have made sense to the health people didn't mean anything to me. I think there was an overemphasis on some of the terminology. That was extremely difficult for outsiders to grab on to quickly. It took awhile to understand what it was all about and what they meant in real practice. It had to be translated into an everyday concept.
- ✷ I think I had a fairly good understanding. Being a population health promotion facilitator, I learned on the job. This has been a particularly useful reference book. (Holding up *A Population Health Promotion Framework for Saskatchewan Health Districts.*) [4] So, I think I understood the concept but it's so much harder to put into practice than it is in theory.

Creating supportive environments

Creating supportive environments is based on the principle that the multi-faceted environments in which people live affect their well-being. [3] This includes the physical, social, economic, cultural and spiritual environments. The aim is to generate living, working and playing conditions that are safe, stimulating, satisfying and enjoyable.

Examples from the demonstration sites:
- Changes were made so it was easier for community members to use school gyms and community recreation facilities.
- Grants to Aboriginal organizations resulted in development of projects such as safe trails and connecting youth and elders in traditional activities that included physical activity.
- Eighteen restaurants in one project area indicated interest in changing their menus and

providing non-smoking environments.

- Good Food Box programs are non-profit buying clubs that sell boxes of nutritious foods such as fresh fruit and vegetables, usually once or twice a month. The number of Good Food Boxes sold in several locations increased significantly.
- A number of partner organizations changed their workplans or their staff job descriptions to include diabetes prevention. Some partners applied for other grants to increase physical activity and healthy eating.

Interviewees gave a number of examples of how they had grown in their understanding of creating supportive environments.

✷ Many of us were trained to fix the problem for somebody else. So what is the facilitator's role so people take on their own work in diabetes prevention? We need to ask community people to participate in that process. We started the radio spots, raising awareness that diabetes was largely preventable. Because it was such a big picture it's very hard to translate that down into community action. We had to create a supportive environment within our own structures. Strategies build on one another. You can't separate one without crumbling some of the others.

✷ Communities have a lot of strengths that can be supported by a project such as this; it is the communities themselves that can create better places to live.

✷ In areas where people are dealing with many crises such as abuse and violence, even when there is money for health promotion, the immediate solutions proposed are sometimes short term such as, "Let's have a conference and spend the money." It's hard to get commitment to long term solutions when the funding is short term.

✷ Even when a solution seems obvious, there may be barriers that can be found only by talking with those involved. For example, transportation was arranged to a grocery store so people could buy a wider variety of food but no one came because they weren't used to shopping at that store.

✷ The Good Food Box is a small program with big effect. Now you suddenly have people eating more nutritious foods. They are getting a better understanding of what health is about. All of that is building supportive environments.

In areas where they use the medicine wheel model, the spiritual, emotional and mental approaches are as important as the physical approach.

✷ Although the spiritual, emotional and mental aspects weren't the main focus, they are a part of creating supportive environments. All of those things are in addition to just saying how you could eat better and what you need to do to be more physically active. So in each community they know better than we do what their resources are. They know about the resources, what the barriers are, what the challenges are, what they can do, who to involve. Those are the strengths the communities have and they're very strong.

Strengthening community action

Strengthening community action involves the empowerment of individuals and communities to participate in and take action on issues that affect their health and the health of others. [3] It draws on existing human and material resources in the community to enhance self-help and social support. It develops flexible systems for strengthening public participation and directing health matters. At the heart is the empowerment of communities, and their ownership and control of their own work and destinies. Community development approaches are a tool to achieving this action. As well, social involvement and participation can themselves be significant psychosocial factors in improving health status.

[5] Partnerships with many sectors are essential to achieving the necessary level of community action.

Another aspect of building the ability for communities to take action is their self-confidence. People need to feel competent to take responsibility for their community.

✷ The word here that gets used over and over is 'repower' as opposed to 'empower'. People have the power and once they believe in themselves they can choose their own direction and go like gangbusters. Anybody can do it. Our job is to create that environment that allows that to happen.

Examples of strengthening community action summarized from the demonstration site reports:

- Communities are willing to take action now that they understand that type 2 diabetes can be prevented or delayed. They used to think it was inevitable and nothing could be done. (Note that unlike many other chronic diseases, the research on how to prevent type 2 diabetes was quite new when this program was initiated.)
- Working relationships among groups were strengthened so they will continue to work together on other initiatives. For example, health district employees and First Nations and Métis groups in some areas worked together more closely. Another reported that knowing about the knowledge, skills and resources of other partners translated into more focused community action.
- To motivate action and lend credibility, one project used Cree and Dene as well as English messages and had elders share stories in their own languages about changes they had made.
- Community school co-ordinators from public and separate schools began to meet and work together and share resources.
- Regional capacity-building workshops showed that participants and planners were ready, willing and excited about change.
- One organization incorporated more physical activity and diabetes promotion into its regular food and nutrition programs. It has formed a partnership with a large physical activity program. They are continuing to work together so there is more physical activity in the nutrition program and there is increased adaptation of the physical activity program to address the barriers to healthy choices for all residents.
- One site extended the number of teaching kitchens and some participants went on to train to be community kitchen leaders.
- Community school co-ordinators began holding orientation sessions on how to use the equipment at a local recreation facility. They also distributed discount passes.
- A youth theatre group developed a puppet play, *Fantastic Fred and the Fabulous Food Frenzy,* about diabetes prevention.
- Even small grants of a few hundred dollars were enough to enable some communities that had had few opportunities to choose their own course of action in the past. Activities included cooking classes, working with local stores, walking trails and increasing access to gyms and halls. Some went on to apply for grants from other sources, too.

If the goal is to strengthen community action, it is helpful to pick some partners who are experienced in mobilizing and working with communities or who have good connections.

✷ You need to have the right players at the table and know who they can reach and who they can partner with because the partnerships extend outside of your little group. It's a continuous link….
The most effective programs were those chosen by the community. It was easier to identify community needs as we worked more closely with residents. This also led to generous in-kind contributions from the community and businesses.

✷ How to put the philosophy into reality is what I've learned. Traditionally a lot of our

public health programming was to identify the need and we created the program and we took it to them and we fixed the problem. We found that having people be part of the process is a good change. It works well but it's very time consuming.

There were some reported instances where some of the partners were drawn to the project because they wanted services for people with diabetes even though it wasn't the focus of this initiative. Funding requirements to focus on primary prevention and these interests were compatible in some cases but not in others.

✷ There were people with diabetes in the area who couldn't get service. Now staff from the health district diabetes clinic come out once a month. That might not have happened without this project.

Communities differed in their readiness to take action. In one, participants were largely enthusiastic from the beginning because so much of what they were dealing with was negative - crime, abuse and illness - whereas this initiative was positive. In others it took some time to get communities to the point where they saw that they could take action.

✷ A couple of the first meetings we went to, the big demand was for facilities. "We don't have facilities." Second time we'd go back it was, "We have the facilities but we don't have the programs. We need programs." And the next time you'd come back and talk about it… "We do have lots of programs. We don't have parent support, community support, volunteer support. We need to co-ordinate together." Then they were ready to begin.

Facilitating action through community development takes many skills. Community action was more difficult without consistent leadership or specific activities around which people could coalesce. Some were not comfortable with the time it would take to use a community development approach. "The general public wants to see results. If you spend too much time on groundwork, you lose people." In some areas there were also difficulties with changes among the leaders or with the need for further leadership training in the communities. In some communities, there weren't enough people to do what they planned. Interviewees from one site said that it would have been better if they had hired a co-ordinator. On the other hand, if the partner organizations weren't able to make the necessary long-term changes it is likely that having a staff person could have actually reduced the partner agencies' commitment to hands-on work. [6]

Lesson learned: It is necessary to allow time for the process of developing the program but this must be balanced with people's need to see some action and progress.

Community development timelines weren't always compatible with those required by a project funded to do specific work.

✷ At times it felt as if the demonstration project timelines rather than community development and consensus building drove the project. The external pressure for speed may have left some behind. One community in our area wasn't ready initially but did participate in a grant project later.

A fundamental principle of health promotion is "to start where people are". [5] Beginning with community-felt needs rather than a personal or agency-dictated agenda is far more likely to experience success in the change process.

Even those with previous experience with community development encountered interesting challenges from which we can learn.

✷ We found that each community undertakes community development in a

different way. When we did the project proposal we had this idea that community committees would be established to work along with the co-ordinator at the community level. We thought this would probably play out much the same way in each of the three or four communities. In reality how that happened in each community was quite different and the success that they had at the community level was quite different.

Lack of time and resources in communities may be a further source of frustration.

- It's much more difficult than we thought. It's hard enough as a community to get staff together and actually have the time commitment to get involved. There are so many demands. In the communities, if the local leaders call a meeting then that's priority and it really doesn't matter what else is happening. This falls by the wayside. I've learned from personal experience that one of the difficulties of getting some community people involved is that they are used to being paid to attend these meetings.

- I was a volunteer but I'm not sure that I could have justified my involvement as an employee of another sector. There is a lot of work to be done to develop a commitment to collaboration, a commitment to working together, commitment to understanding each other's involvement in community. Health districts have a strong commitment to having staff involved.

Lesson learned: Some had difficulty providing examples of what led to community action beyond educating people about the dangers of diabetes. Education may be a component of strengthening community action but stimulating action requires far more than telling people there is a problem. Particularly for partners with little experience in population health promotion, it would have been helpful to have additional means of supporting their growing understanding of assessing community readiness and mobilizing community action.

Implementing healthy public policy

Healthy public policy is any policy that creates and encourages a setting for health. [3] Policies shape how money, resources and power flow through society and affect health as a result. Health promoting policies can include organizational change, legislation, regulations and guidelines at local, provincial or federal levels. They can be formal policy changes or less formal changes in the usual ways that people live, work and play.

Examples from the demonstration sites:

- Policies for schools regarding food choices and physical activity were developed and implemented. One project worked with school boards and public health to change the foods served in schools. In another project three templates or sample policies for healthy eating in schools, in rinks and in recreation centres and any other organization were developed so they can be adapted by others.
- One school district implemented a healthy lifestyles core goal. Community schools found ways to implement healthy food choices in canteens, in fund-raising events and in school food programs. Some schools began offering fruit and vegetables and banned junk food. Teachers noticed that students were more able to concentrate, and parents and children were more interested in healthy food.
- The only major supermarket in one area moved. There were no city buses going to the new location. Residents did not want to go to other stores just outside the area. Through work with partners, the city extended its bus route to include the new location of the preferred store.
- One project supported co-ordination of a food cost survey to show the impact of particularly high transportation costs in the area, as part of

a province-wide initiative. They are working towards developing solutions.

- The job description for a person involved in food security expanded to include some diabetes prevention education.
- Many mayors and chiefs in one project area adopted a policy on offering healthy choices at their own meetings. They are now interested in advocating for policies that will affect the availability of nutritious food at lower cost in areas where transportation costs are prohibitive.
- The foods served at feast days in a community centre changed so there were fresh vegetables and fruit and salad dressing was served separately.

Policy changes can occur at many levels: within organizations, communities, regions, provinces and nations.

✷ Maybe I can't change the Saskatchewan policy, but maybe I can influence what's in our canteen.

✷ Healthy public policy is creating a healthy choice, an easy choice. I think that's the part that's just starting to catch on. You have no idea the difference that suggesting something other than doughnuts and coffee at meetings can make. Something as simple as adding bananas, muffins or carrots is a big change. For the health district themselves to say, "We're going to do this and we're going to suggest the staff do the same; that's a big change. And people love it. Having diet pop or juice or water in a pop machine is a major, major change - and having it show up in the stores! Storeowners are more interested too. We've had some say, "We have to look at some more issues. We provide food for the community. We want to do better." It's an option now. At the schools, there are really good examples of schools and principals who want to see change. They want to have better nutrition and physical activity. For example, a local school used to provide lunch for students. Now, what they do is have the kids come down and make their own lunches. They make sure that they have good ingredients. Those kids are learning to have better nutrition and physical activity. That's a policy change. Another school is looking at the policy template. What they were looking at was policies and they have implemented that.

✷ I think the change that occurred was our thoughts on how easily it could happen in some levels and how difficult it is at others. Sometimes within a half hour meeting you can have a school policy develop. At the same time we underestimated the work to consistently make change. In terms of building healthy public policy, the time constraints are enormous. We may not have the same timelines as communities have.

Implementing policies can be very beneficial, but how do you ensure that they are maintained over time?

✷ Our project is here for a short time but it is important that changes are longer term. If a child comes to a vending machine, does he have a choice of six kinds of pop or something else? One of the principals in an elementary school said, "Look, our staff turn over quickly. We believe in a healthy public policy. We passed it. But you know what I need to do? I need to put it in the teachers' handbook. So that every year they see that these are the healthy policies." And that's true. It had to be continuous. A fact of life here is the huge turnover in schools. So if you set a policy it isn't good enough to be done once and forgotten.

Policy change was not the major goal with most projects. Some said that their communities weren't ready yet. The community really needs to

buy into it. Some said that they wished they had spent more time on policy. Others said that policy development would have been a good topic for a Saskatchewan Health workshop because it is a difficult concept for many people to understand. "It's a maze. You need someone to steer you through it." If learning opportunities were developed, they could fit under the heading of community mobilization rather than policy implementation. That would allow a broader approach and might be more appealing.

- ✷ I think that we identified that policy was something that we would like to see happen but I don't think we're there yet. It takes the strength within the community that's working on the issue to really buy into it. You might make a healthy food policy in the school or a physical education policy. I don't think our group is quite there yet. I think they could be given time. I think we need advocates.

What would have encouraged projects to be more involved in public policy?

It can take time for people to begin to understand what public policy is and how they can affect it in their own settings. They needed to see examples that were working. When others saw what was happening in one school they were more willing to make changes in their own schools. When people saw that having healthy choices in the classroom, at breaks and school functions was popular, there was far less concern that students would not be interested or that costs would be too high. In one site there were monthly healthy snack sales that both the parents and students wanted more often. Fruit and Yoghurt Smoothies were a real hit.

It can be an empowering process for people to know they can change the larger society as well as at the local level, but it can also be confusing. Some of those interviewed said they weren't experienced in policy development so they needed to learn what it was themselves.

Policy change doesn't happen overnight.

Integration of the three strategies

Some talked about the integration of the strategies with one building on another. "You have to create the foundation, a certain awareness. Get the community or the school to buy in. To do the groundwork first before you get to the policy stage." Implementing healthy public policies is often the most difficult strategy.

- ✷ You can certainly create a supportive environment, which will be helpful for individuals but if you're really going to have a big influence, you also have to really mobilize the community. Then for sustainability you need to go on to policy change.
- ✷ If we were going to really focus on healthy public policy, we probably would have done the application for the project differently. And to me it almost seems like you're building on layers. You start with a supportive environment and then the community action and then public policy. They build on each other. So if you start at one end or the other, like you start in supportive environments, then sometimes maybe you don't get to healthy public policy.

Which was the easiest strategy to implement?

- ✷ I think probably strengthening community action is easiest. I really enjoy being part of the coalition and coming to meetings and being able to see all the people that I work with.
- ✷ I see our meetings as community action- having representatives who keep coming to meetings and getting involved in projects. And then they take it back to the community members. We work with community representatives rather than the community at large.

Some skill in community development was an asset whichever strategy was being applied.

- There is a need for ongoing learning about community development processes, including the methods, the time and energy that they take.
- The community development process works differently in each community. It may be a function of the trust and the relationship with the community development worker as well as whether there are key people to take the lead roles in organizations.
- Our analysis is that this is only the beginning of a long-term process that may result in many more changes. The impact has already been noted by many communities in the increased opportunities to form groups like walking clubs, healthier foods available in schools and people are beginning to talk with more hope about prevention for the future. This is a change from the view that diabetes is inevitable and nothing can be done.

Another observation was that it was helpful to have the same services and messages available on and off reserve because it strengthened the belief that the programs were universal, not divided along jurisdictional lines.

SECTION 4: WORKING WITH PARTNERS

Each demonstration site was guided by a partnership that included partners outside the health sector. Information about each partnership was obtained in two ways:

1. by detailed personal interviews, and
2. by two mailed surveys. [7]

The information was collected from those individuals involved in the ongoing work of each partnership.

Working in partnerships was an integral part of implementing the strategies. There was a relationship between the effectiveness of the partnerships and projects' ability to mobilize communities. "One area of personal growth during the whole exercise is a much better understanding of the relationship of partnerships and community actions."

INTERVIEW RESPONSES TO QUESTIONS ABOUT PARTNERSHIPS

Partnerships are time consuming but they increase expertise, impact and resources.

- We saw that what one organization could not achieve on its own can be achieved by working together to find solutions.
- If we hadn't partnered with other organizations, they might not have been committed to work together to continue what we started.
- While it's harder to work in partnership, the impact is broader.
- Coalition partners contributed significant time but the analysis was that it was worth it because it led to positive change at the community level.
- It's not easy to get so many people together from different groups in a partnership but they were involved from day one and we accomplished our goals.

One site estimated that in-kind contributions from partners were valued at approximately twice the amount of funding dollars received from Saskatchewan Health.

Each of the projects had a variety of partners with different roles. How did they choose whom to approach? Some projects identified front line workers, such as community school co-ordinators, who could play specific roles in the project's work. Métis and First Nations organizations were a high priority at many sites. Projects looked for stakeholders who were located in or near the area where they were working. One used the phone book as a starting point. Another developed a grid. Sometimes a broad net was cast to find anyone with an interest and commitment to the subject. Sometimes people were missed because the letters didn't go to the right people at the right time. One project had meetings and those who attended were asked to participate. In smaller communities there were a limited number of potential partners so anyone who was interested was invited. Another partnership was composed of a subgroup of a larger group focused on a wider range of issues related to diabetes, particularly treatment and screening.

How were people engaged or involved? Several sites provided small grants to community organizations and they then became partners. In some cases the participants found the meetings so valuable for their day-to-day work that it continued to draw them to meetings. Some projects were able to build on previous working relationships with potential partners; there was already a level of trust developed. When people saw that their suggestions were being used as the program developed, they were encouraged to stay involved. One partner who had diabetes said, "I'm here to help figure out how to prevent my grandkids from getting diabetes."

The list of barriers to participation in a partnership is long. Sometimes there were individual citizens who were very interested but their employers or

the organizations to which they belonged didn't see this as a priority. Travel was a problem when there was no money to pay mileage or honorariums. Some of the committed partners left their organizations and weren't replaced. Partners were at different stages of understanding community development; some were used to a "top down" approach. Partners who joined midway through a project were sometimes overwhelmed and intimidated. The "small p" politics made it harder. Having one group represent another group or organization didn't work well in some cases. It was difficult for some representatives to get information to others in their organizations. Some organizations didn't think these projects were at a high enough level to appoint a representative. There was a concern among some potential partners that if they became involved in this project it would jeopardize their opportunities to apply for federal funding. Some people were interested in specific activities but not in the development of the overall project. Some wanted to do screening or treatment and didn't support primary prevention as a priority.

✷ Some communities or potential partners needed time or experience in order to participate in this type of partnership initiative but that wasn't always feasible. As an outsider I saw struggles. I think our systems are not always consistent with their expectations. On one hand they're saying, "use partnerships, use community development." At the same time the requirement is, "it's got to be done in this time frame; it's got to be done this way." So, there were some growing pains. Using this kind of model in communities, which are maybe not attuned to using this kind of model is hard. Trying to use a new model in a system that hasn't quite caught up to it yet.

Understandably, everyone was trying to meet his or her own agencies' needs. It is often difficult for representatives of different groups to focus first on the shared needs of all the partners and the communities rather than their own agencies. This is particularly true when resources are involved. It may be necessary to make working agreements and contributions of partners very clear, perhaps in the form of contracts. It also took time and trust to build relationships so that everyone at the table felt equal whether their organizations contributed or received resources or not. Even for members from within the same organization, such as a health district, it took time to find common ground.

Partnerships, like any complex relationship, involve people with different views, needs and styles. This can lead to disagreements and conflict. If not resolved, partners may leave or whole partnerships may dissolve.

✷ At some points our partnership just didn't feel right. People were feeling frustrated but we hadn't taken the time to talk about what was going on. We had to get our feelings out on the table. If something like that is happening you really need to take the time to address it.

Some potential partners did not participate. In some cases interested but inactive partners or nonpartners were kept up to date with the work, but they didn't come as partners to the table. Sometimes the size of the partnership would have been prohibitively large if all potential partners had been invited to sit at one table. In other small communities, as mentioned already, there were so few potential partners that it was essential to involve all. There were times when it was best to involve a group for specific activities but not on an ongoing basis.

It was difficult to involve some community members as partners. They may not have been used to going to meetings or to speaking in a group. It was necessary to be sure that everyone was comfortable and felt respected in the groups. Some people didn't have childcare or transportation. Some interviewees said they would have liked to bring even more Aboriginal people to the table.

Another issue is that it is difficult for an individual to represent a number of groups.

✷ I think it was unrealistic to have one person represent one to five distinct, diverse communities because in essence they only represent themselves and their own community. I'm not sure how we might have done that differently.

In fact, it is difficult for an individual to represent a whole group or community because there will inevitably be diverse needs and opinions.

PARTNERSHIP SURVEYS

Written surveys were sent after approximately one year of operation (wave one) and again after year two (wave two). The survey was adapted from a similar instrument that was developed to assess partnership practices and outcomes, including partnership initiation and development, program implementation, sustainability, communication, conflict resolution/problem solving and decision-making. [7]

Survey responses from each project were grouped. The results, including lists of the questions that received particularly high and low scores, were sent to contacts for each project so they could see how their partners thought they were operating. Responses were generally very positive in both survey waves and were somewhat higher after two years than after one year. Examples of questions used to assess key categories in partnerships are shown in Table 1.

Table 1: Examples of partnership survey questions. Respondents were asked to indicate which were true, more true than false, more false than true, and false.

Communication The partnership has regular, structured meetings. Members of the group listen to each other without interrupting.
Conflict Resolution/Problem Solving Differing opinions are expressed and considered. Members are willing to let go of an idea for one that appears to have more merit.
Decision Making Members have agreed on what decisions will be made by the partnership. We have an effective decision-making process.
Initiation of Partnership Our membership is not dominated by one group or sector. The work we are engaged in is likely to have a real impact on the problem.
Partnership Development Our group has set ground rules about how we will work together. We have concrete, measurable objectives to judge the success of our partnership.
Program Implementation Members are willing to devote whatever effort is necessary to achieve the goals for the partnership. Our group is effective in obtaining the resources it needs to accomplish its objectives.
Sustainability of Partnership and Its Work The benefits of being a member outweigh the costs. The number of members has stayed the same or increased in the past year.

High scores for program implementation and for sustainability were desirable outcomes in these surveys. Program implementation questions were

developed to reflect a partnership's ability to develop and deliver a program. Sustainability questions, on the other hand, were developed to show the partnership's ability to continue its programs and partnership over time. Results from all of the sites were analyzed to see what practices were linked to program implementation and sustainability scores.

For both waves of the survey, communication was the most important factor for predicting implementation scores. In other words, communication was the most important factor in partnerships' ability to deliver programs. Decision-making may also have made a modest contribution but its role was much weaker than that of communication.

When looking at sustainability as the outcome, there were differences between the results for surveys done after a year and those after two years. In wave one, initiation practices were important. Questions regarding initiation asked about belief that the work would make a difference and whether the partnerships had a broad base of support extending beyond the health sector. Implementation and communication practices were also associated with sustainability scores.

In the second survey, after two years, scores for initiation were the single most important predictor of sustainability scores. It appears that these factors became more important for sustainability over time. Since sustainability is usually a characteristic of a more mature partnership, the results for wave two carried more weight than those of wave one.

Lesson learned: To summarize results of the partnership survey, there are many important practices for partnerships. In order to implement a program, communication was the most critical component for these groups. For sustainability, having a broad base of support beyond the health sector and achieving results that the partners believed were important were the most critical.

SECTION 5: SKILLS AND STRENGTHS OF PARTNERS AND COMMUNITIES

Since implementing a PHP approach takes different skills from those for conventional lifestyle education programs, what knowledge and experience among partners were particularly useful? What skills were strengthened or developed?

- ✷ There is a difference between health promotion for individuals versus the population health promotion approach. This was a real opportunity to look at the big picture and plan accordingly. Usually you are told to do what's in your job description and there is limited opportunity for creativity.
- ✷ People and communities have a heart, a knowledge and we need to be able to work with that.

There was a wide range of skills among members, which was not surprising. What was interesting was what some of the useful skills were. For example, someone mentioned that it was helpful to understand Aboriginal legends well and how to attract and involve community members, particularly among First Nations and Métis communities. Another said marketing skills were an unexpected asset. Another project was able to make good use of theatre skills.

Other useful talents included being able to develop networks and partnerships. Being able to work with a consensus way of reaching decisions takes time but it was more consistent with First Nations' ways of working. Communication, whether it was within the group or with others, was key. In spite of having diverse groups, some were able to create an understanding about population health promotion. Being able to write proposals and do evaluation were also useful. "You can start out with grandiose ideas but when you see them in the evaluation plan, you realize that you need to be more realistic." Some technical skills in nutrition and physical activity and risk factors for diabetes were essential.

Someone said that you needed a lot of patience to be involved in this type of work. There were many barriers such as distance, weather and misunderstandings that had to be worked out.

Having diverse backgrounds was a help.

- ✷ You can't have all of the same type of people and expect to get very far.

Leadership skills, particularly having some consistent leadership, and facilitation skills were critical if the groups were going to stay active.

Many abilities were developed or strengthened during the projects. The support of Saskatchewan Health was acknowledged although it was external to the demonstration site partnerships. The Department's role in providing training and support strengthened the skill sets of partners. This will be covered in more detail in a later section of this report.

Understanding how type 2 diabetes could be prevented was an important step for some partners and their communities. Working closely with Aboriginal communities was a learning opportunity for some.

Evaluation appeared to be a struggle for a number of projects.

- ✷ I have a better appreciation of some of the processes around goals and objectives and evaluation. The processes we used and the time were too high for the value. I grew in appreciation in measuring outcomes and have used that elsewhere.

Another interviewee expressed concern with her/his group's ability to involve the community, particularly Aboriginal members, in the evaluation

in any meaningful way. It was also difficult to find anyone who was able to evaluate the population health promotion approach and/or a community development approach. How do you measure if you have made a difference in the community?

People have different resources and different levels of commitment.

- It's relatively easy to begin a coalition and develop partnerships initially but it's a real challenge to be able to support them for the long term.
- We need time and energy to help communities that are at the precontemplation stage or are blaming others for their situations. Some communities were ready and we could support them but there are others at the precontemplation stage where we couldn't focus on diabetes prevention.

SECTION 6: APPLYING THE POPULATION HEALTH PROMOTION MODEL IN OTHER SITUATIONS

Participants were asked to talk about how they would apply the PHP Model if they were to develop another program.

- We would continue to analyze where the barriers were. Is it transportation or childcare? If it's education, we'd be sure materials are easy to read and have graphics.
- If this was to be done again, we need professionals trained in community development to work with communities. You could not reproduce this and be cost effective.
- Seeing what some of the conditions like diabetes, cancer and heart disease had in common was an "ah-ha."

In almost every interview, someone said that they wouldn't mention the PHP model itself, although they were using its principles.

- We kept the Model behind the scenes for the planners rather than talking about it much with the community groups. We don't have time for it. We've got to get going.

Others tried to create a more user-friendly version but maintain the critical components.

- They don't want to know that they've created healthy environments. They just want to know that they've done something to help someone else.
- Initially there was concern about working with a system level (such as the school system) in population health promotion. We're probably going to have more impact working at a system level than simply being a little snack program in the school.
- Economic development experts see the need for communities to take action. Health can't do it by itself. I don't think that other people see they have a role to play in health. Health is struggling with it.
- I think we'd do it much the same. Now we're trying to move from a disease specific focus to a broader, action-oriented focus.
- There is excitement now. We're looking at sustainability now. What do we need to consider as we look at the time, the energy and the philosophy for the next steps? We need to remember though that communities are at different stages. Some are strong and others are not. We have to be careful in our attention to the keen communities versus the others. Where we see action, we can share success. A couple communities can be left behind. We can actually increase inequalities. If the work ended now it would be really bad for the slower communities.
- The community understands action better than we did.
- I've already used a short version of the model to develop two completely different groups. (Care providers and a discipline group.)
- I am really encouraged by the process we took in involving the partners. To take the partners to the conferences and to identify what should be done together. Creating an environment in the community, to create the changes, is certainly transferable.

WHAT WOULD YOU DO DIFFERENTLY IF YOU WERE DOING THIS AGAIN?

- It would have been better to have more time to work with groups. It was excellent to take people through the population health promotion approach but it does take time. With more time we could have

done more skill development.

- We had to work out a way of spending our money that was community focused. This took a lot of trust. The money was focused on the community and it was for all. In the past money was raised and was divided. With our partners not everyone had money to put into the pot. Many, many organizations put in time. We had to get beyond the feeling that there's a dividing line between who got the money and who has money to spend. The money wasn't given so one organization had more staff. That took a lot of trust. But I think that trust is so important in a coalition or partnership. For people to feel that they are equally able to take part by offering their knowledge, by offering their expertise is more important. In fact, we have had partners say, 'We've done so much and we haven't spent as much money as we thought we would.'
- We purposely separated from treatment. There were more disagreements then. We stayed out of the treatment discussions. There were federal and provincial jurisdictional issues on the horizon so we stayed away. It was like crabs in the pot or wolves around the meat. Ideally there would be more integration with treatment.

Although there were many First Nations and Métis people involved, it would have been good to have more Aboriginal representation in some projects.

- We needed to have more effective ways of getting community representation rather than thinking that one person could do it. Or maybe we needed to limit the number of communities we worked with so there was good representation. There were also some issues related to suspicion and financial issues because of who held the money. There were issues related to federal, provincial and local jurisdictions. It will be tough slugging until jurisdictions are settled.
- We need to commit the time to get local buy-in. It really would have been a community project as opposed to a health district/tribal council project. You have to have someone that's got the time to be out working in that community. Talking to the principals, talking to… Too often when people know something is a health program, they sit back because they expect health will develop and deliver the services. That's what they're used to.

Ongoing commitment from the heads of some of the organizations, including the health districts, would have helped in some cases. Individuals, but not always agencies, were committed so if the individual left, the organization didn't always replace her or him. Within the health sector some administrators didn't see the value of this type of work and limited employee involvement. There needed to be a commitment from administration, or population health promotion principles were sacrificed. One respondent said she wasn't sure she would do this again. It took so much of her time and it wasn't visible enough for her employer.

Evaluating a PHP approach meant breaking some new ground. The programs needed to be multi-faceted and the outcomes were not easily measured, especially in a short timeframe. The evaluations were a great source of satisfaction for some.

- When we received the first evaluations from some of the First Nations communities and saw what they were doing to make a difference in the lives of the people on the reserves, that was a real encouragement.

For others, doing the evaluation was very hard. People prefer to "get the money and run" with their projects rather than spend a lot of time on evaluation.

- Evaluation was a problem. It would have been better if Saskatchewan Health had

kept the money and had done the evaluation. Another project (a research project that was not one of the demonstration sites) has hired full-time evaluators.

Something else that projects talked about doing differently related to administrative practicalities.

- It would have been good to have a co-ordinator hired at the very beginning. Having to go through the health district hiring process did slow this.
- It was a real challenge to try to do community development over a large geographical area but in a way this could have been an asset. They couldn't manage the community projects themselves; the ideas had to come from the communities. If you have just a small area you may want the power more. We think we know what their needs are in those communities but I think this way we were so non-hands-on except for our worker and she wasn't a health district employee. A lot of what health districts do may be called community development but it's more the health district saying what they think is needed in the community and trying to get buy-in later.

One project used a training program that required seven days of participants' time. People acquired some skills but that is a huge time commitment.

- Using a community development approach (in one area) meant that too little concrete was happening, so the groups lost potential. It didn't help that no one had designated time for the project, it was in addition to existing work.

SECTION 7: SUSTAINABILITY

Sustainability of the initiative is the ability to continue the work and benefits of the program beyond the initial funding period. It includes ongoing working relationships, changes to programs and policies and use of skills. It may not involve additional funding.

Sustainability was a relatively new concept in the project and program development literature. Although sustainability was not one of the criteria for funding, it became apparent about a year into the initiative that this would be an issue. A workshop was developed based on the literature and discussion. Demonstration site partners were invited to a workshop to develop sustainability plans. In the interviews and final reports they were asked for their observations about sustainability.

What changes or activities do you expect will continue after the funding ends?

There was clearly a legacy from each demonstration site. At the time the final reports were written it was not clear if additional funding would be available so the following sections reflect what was planned for sustainability without committed funding. Some of the plans included:

- The healthy public policy work initiated by Working Together for a Brighter Tomorrow is ongoing; it is a low cost item. Schools will continue to implement the core goal changes they made. School nutrition policies and programs will be maintained as the school districts have contributed long-term funding through their community schools project with Northern Lights School Division and many First Nations schools. Healthy snacks will still be offered. Recognition awards and reminders will help to sustain some of these programs. Awareness raising and motivating strategies will continue. (Several months after initial funding ended, one of the endeavours, *The Gift of Health: Prevention of Type 2 Diabetes in Northern Saskatchewan* premiered on Aboriginal People's Television Network. [8] The video features diabetes prevention, including the work of this demonstration site.) There was ongoing work with front line staff such as community health educators/representatives/wellness workers, and community health and public health nurses.
- In Linking Community Voices, partners have built the trust and links in their shared goals that will enable them to continue to work together to address other health issues such as heart disease. Community kitchens, the puppet show as well as the Story Sac literacy program will be ongoing. Partner organizations have included diabetes prevention in some of their job descriptions and this will be there beyond the life of the initiative. Concession booths at school events now offer more healthy choices and one of the core area schools has banned some fast food company products from the school; this applies to students and teachers. Because existing community groups developed and delivered the programs, a number of initiatives will stay after the project finishes. Community members who were supported in taking advantage of the Leadership Regina training program and the Fitness Leadership Certificate program will continue to use these skills.
- In Pathways to Well-Being, a partnership was developed with Saskatoon District Health's *in motion* program to maintain and expand the program to include more physical activity. Within the existing Child Hunger and Education Program that hosted much of the activity in the demonstration phase, there is more of an emphasis on diabetes prevention that will be ongoing.
- The Defeat Diabetes Project community co-ordinators will be responsible for keeping the teams going in the schools. Students will attend a fall workshop and develop action plans for their schools. A binder on how to create a team is being developed. (Funding from another source was secured so some of

the higher cost activities could continue at this site.)
- Communities Hand in Hand observed that successful activities such as walking paths, education kits, yoga, restaurant tent cards and the fitness centre will be the most sustainable. Each of the sites had a sustainability plan. Another long-term benefit is that communities are more aware of diabetes prevention.
- In Putting Prevention into Action, the diabetes prevention kit will still be used in a number of settings. There are plans to further develop and promote an orientation to the resource kit that was created. Work will continue with the school division on the development and implementation of a healthy food policy and policies related to physical activity. Third party grants initiatives, such as the Youth Circle Project to increase healthy food choices, are ongoing through other funding. A walking trail will be available year round in one area. First Nations youth have had more experience in applying their cultural heritage to be healthier. The response to the use of traditional Aboriginal story telling as a method of exploring an issue was very positive and will be used in other situations.

Five of the seven projects received some additional funding from Saskatchewan Health to expand the focus of their programs for nine months. A sixth project received three years of funding from Health Canada. Some community activities of the seventh were expected to continue without additional external funding.

Are there changes anticipated or are there programs that will stop when the PHP demonstration site funding ends?

Projects that had hired staff specifically for the project said that any ongoing work would need to be done in a different way. Without continued funding in one project they won't have a project co-ordinator, so partnership meetings won't be conducted in the same way. All the partners have full-time jobs and it won't be possible for one to take on all the co-ordination. They are looking at options to continue the monthly meetings and information sharing which they find very valuable. Membership probably won't continue to grow without formal leadership and coordination. Project workers in several sites have strong ties in the Aboriginal communities so their loss will decrease the links with Aboriginal participants in a variety of programs.

Grants to communities for special projects will stop although alternative funding may be available to continue in some locations.

Productions such as videos will stop but some low-cost media work may continue where alternative funding arrangements can be made.

Some specific activities will stop or be modified. For example, one project was demonstrating use of foods in a Good Food Box but that will be reduced. Community members won't have orientation to local recreation facilities. Healthy policy development in schools may not spread quickly to more schools.

Are there partnerships or working relationships that will continue after the project ends?

Six sites talked about continuing to work together and the seventh expects local relationships but not multi-community relationships to continue. Several will have a modified version of their existing partnerships, while others will be or are working together on other initiatives. Some working relationships will be formal while others will be more ad hoc.

Partners have become involved in other interagency meetings so they are part of the planning and implementation of a variety of initiatives. These are not just information sharing meetings.

✷ Since this project was a positive experience for all partners, it appears that partnering will occur on other projects in the future.

One partnership made a point of meeting in different agencies so members would feel comfortable in one another's organizations. There is a new spirit of co-operation rather than competitiveness. Partners have learned to look beyond their own agencies.

Networking among sectors has increased and the value has been recognized repeatedly.

Lesson learned: Partners have learned that communities generally know what they need and have a great deal to offer with regard to how things can realistically be accomplished. Communities have strengths and capacities that can be developed for community action.

COMMUNITY AND PROGRAM FACTORS AFFECTING SUSTAINABILITY

Holdner and Moore summarized a number of community and program factors that affect sustainability. [9] This framework was used both for the Sustainability Workshop with the demonstration sites and for the analysis that follows.

Community factors that support or hinder sustainability of an initiative: There were a number of observations that diabetes prevention was important to the community. Having the support of key leaders and using local staff or community members so the skills developed stayed in the community were also important. It is likely that some health districts did not apply for funding because diabetes prevention was not as high a priority as other work in their areas or because potential leaders were not able to make the necessary time available.

Characteristics of the programs themselves also affect their sustainability: The programs that changed the ways the partner agencies operated on an ongoing basis were building in sustainability. Policy changes such as nutrition and physical activity will endure, particularly when they are supported by print material or other means, even when staff are replaced. Working relationships that were developed through the demonstration sites will carry over into other situations. All projects will be able to continue at least part of their work whether or not they have additional funding. A wide variety of resources that have been used successfully in the community will continue to be used. Some will be adapted and produced or distributed by the health regions or other partners.

There are limiting, as well as enabling, factors for sustainability: These include lack of leadership, poor understanding of the vision and theoretical basis of a project, pre-existing hostilities, lack of local buy-in and failure to consider that the initiative is in competition with others for resources and attention. [9] The demonstration site partners observed that these factors had to be resolved throughout the projects or they could have limited long-term viability.

In this initiative and others, partners and staff have talked about becoming tired and sometimes overwhelmed with what needed to be done over an extended time. As a result, personal coping and renewal were added to the list of sustainability factors. Information about this subject was shared in a number of informal ways during the initiative and was discussed at the Sustainability Workshop for demonstration site partners.

Project partners were asked how they handled some of the heavy demands; there were observations about what seemed to be helpful and what was draining. People appeared energized when they were able to share their accomplishments with others and when they saw good things happening in the communities. Some made sure they celebrated their successes. Many made their work as much fun as possible. Many of the partnerships were also very supportive. On the other hand, writing reports seemed to be particularly draining for many partners.

The Saskatchewan Health demonstration site team also needed to develop ways of accommodating

the demands of this initiative. Like partners in most of the demonstration sites, all had a number of other responsibilities in addition to the PHP demonstration initiative. The Saskatchewan Health demonstration site team had very short meetings, usually twice a week, to discuss what needed to be done and decide who could do it. The atmosphere was co-operative and encouraging. No one person carried the load and the lead role changed from task to task. Power and responsibilities were shared. This was also an exciting opportunity to put into practice the principles of population health promotion that had been developing in the province for several years.

Demonstration sites also talked abut sharing work, power and regular communication. Sometimes this required overcoming large geographical areas that made face-to-face meetings difficult and it always seemed to involve very busy schedules. It seemed that the enthusiasm for the work and mutually supportive relationships helped to keep people involved in spite of the extra work that this type of initiative involved.

Ray suggests two other dimensions to consider when planning for sustainability. [6] First, embedding change in the standard way the partner organizations work is far more sustainable than operating a pilot project in parallel with existing programs. Changes such as foods served at meetings and in schools, and changes in job descriptions are examples of sustainable changes by the partners involved.

Ray's second point relates to whether to hire a co-ordinator and, if so, what the co-ordinator's duties should be. [6] Her experience is that hiring a co-ordinator puts sustainability in jeopardy if there is no way to do the work once the position is no longer funded. If the coordinator is responsible for distributing resources, mediating conflicts, calling people to remind them of meetings and initiating much of the work, that person becomes the one almost solely responsible. A co-ordinator should support partners who are trying to change the system, but the partners themselves must remain the primary workers of the project.

Understandably because of the volume of work involved, a number of those interviewed expressed relief at being able to turn much of the program delivery work over to a co-ordinator. Another project that did not have a co-ordinator said that this was a mistake. While having a co-ordinator is helpful in many ways, her or his job description should be carefully considered in light of sustainability. One interviewee said, "When there was a paid co-ordinator there was less volunteer involvement and less community action." Projects where the community participated and changed would be the most sustainable. Training programs for community members also created more supportive environments for future growth.

Another consideration related to hiring a co-ordinator that was mentioned several times was that having a staff member of Aboriginal descent or with direct experience of some of the conditions of program participants did open doors. There was a further benefit to sustainability of skills if someone hired to coordinate a project was able to use them in other employment.

SECTION 8: THE ROLE OF SASKATCHEWAN HEALTH

Saskatchewan Health's role in supporting this initiative included a series of workshops and a conference, regular contact with each site and financial and print resources. As much as possible, the population health promotion approach that was required of projects was modelled by Saskatchewan Health's demonstration site team.

The following is largely excerpted from a report prepared by an external evaluator. [10] It summarizes the results of telephone interviews at the end of the projects with the primary contact from each of the sites.

Support is generally perceived as giving assistance, encouragement and approval to an individual or group. Saskatchewan Health provided continuous access to information and learning opportunities over several stages of the initiative. This central support was provided in the form of training workshops, print materials, newsletters and a conference. Central support targeted issues on: getting started (preparing the proposal), project evaluation, partnerships, sustaining the project and documentation/reports. Moreover, the central support modelled the essential ideas of population health promotion.

Saskatchewan Health organized the project environment to promote partnerships in communities. Patterns of work in a funded project over widespread geographical areas typically relied on conference calls. However, the workshops created the opportunity to bring together project members for a sustained period of time, which included time set aside for face-to-face project group work. Changing the pattern of how funded work was carried out had a self-reported significant impact on the project members. In addition, projects had more equal access to information, workshops, print materials and ongoing support whether they were in the northern corners of the province or in the largest urban centre in Saskatchewan.

Saskatchewan Health's demonstration site team members were assigned to a particular project for ongoing contact, involvement and support. This ongoing contact enhanced the ability of project members to take control of how the project unfolded and developed. This contact was achieved through electronic communication, telephone and meetings. The central support activities included regular communication, problem-solving, planning and educational support. In addition, all team members had contact with each project to some extent through workshops and conferences. The amount of contact and support did vary from project to project; there were instances where more support would have been beneficial.

Saskatchewan Health's demonstration site team members provided different types of functional support for the assigned projects: informational, practical and emotional. Support provided was positive and essential for the projects. The Saskatchewan Health demonstration site team members were also the same people who planned and conducted the workshops, and developed most of the print materials to support the demonstration site projects.

Throughout the demonstration site initiative process, Saskatchewan Health worked toward meaningful participation and giving the projects a voice in this process. Similarly, projects were given an open-ended opportunity to comment on the role of Saskatchewan Health staff in supporting the development and implementation of their projects.

Suggestions and conclusions from the demonstration sites about central support

This section summarizes the concerns and suggestions about Saskatchewan Health's role in different types of support. They will be of use if this type of initiative is undertaken again:

- Projects that had some preliminary partnerships in place before the Getting Started

workshop were better positioned than those that had to put together their proposals and then "pitch it" to community partners. If they didn't already have some ideas about what could be done, they weren't as able to take advantage of the workshop.
- It would have been helpful for funded projects to get together very early to discuss more of the details about what was expected.
- Projects were at different stages when they attended the evaluation workshop. Those that had already spent a lot of time on evaluation were initially confused but were able to work towards a more doable plan. For those with relatively little evaluation experience, this was a steep learning curve. Not everyone realized how much actual work would be done at the workshop so they didn't plan to attend or went to only part of it.
- Some projects felt they didn't have the experience, time or funds to do the evaluation. They felt under-supported by Saskatchewan Health and needed more help. (Comment: The PHP evaluation template developed during the project would have been helpful at the beginning.) A similar concern was expressed about the need for more direct one-on-one support for resolving partnership issues.
- The Partnerships: Building on Our Shared Experiences workshop, approximately nine months after proposals were approved, was helpful for those who were still building their partnerships but some had already established viable working relationships and would have liked more details about what to watch for as time went on.
- The Planning for Sustainability workshop was approximately a year before the end of funding. The content was viewed as valuable. For those projects where partners were able to meet on a regular basis, they viewed this workshop as a burden of time and travel. They felt they could have done this work at home. For those where meeting face-to-face was a challenge, this was a great opportunity. Everyone agreed that sharing information about other projects was helpful.
- The Build Better Tomorrows Conference was open to anyone in Saskatchewan and many came from other provinces. The visible Aboriginal focus, including the fact that a large proportion of attendees were of Aboriginal descent, brought home the idea of thinking holistically about communities and families. The main suggestion was to increase the focus on the determinants of health and help the presenters make a clearer link between the PHP Model and the project they were discussing.
- *Population Health Promotion Practice in the Primary Prevention of Type 2 Diabetes,* "the purple booklet," was a clear, concise, easily understood document used by all the sites. [2] It was suggested that it could be revised now to include more examples from the PHP Demonstration Sites.

✷ My booklet is full of scribbles, underlining and it is marked up so it is really helpful to us and we really use it and share it with others.

- The Evaluation Guide was also useful. [11] It would have been helpful if it had been available at the proposal writing stage and if it had included the PHP evaluation template that was used for the final report. (Appendix 2)
- The newsletters, particularly in electronic format, were distributed among partners but were not as important as the workshops. There was so much competing information that it would have been better if there were more pictures, lots of colour and professional desktop publishing.
- The overall processes used by the Saskatchewan Health demonstration site team received high marks for modelling the PHP approach that projects were, in turn, using with their communities. The approach was "breaking new ground." The frustrations expressed were that there was more evaluation required for the amount of money given than there was with acute care funding. There was

also some concern about the imbalance of power when health districts were required to take a lead role because of the funding arrangements; for some, having the health district hold the money created unequal relationships in their partnerships.

- ✷ We were doing all this work in addition to our full time jobs so we didn't seem to have enough time to learn or gain enough knowledge on this approach and hold it all together and get the work done.
- ✷ The requirement for the health district to hold the money for the projects created an unequal relationship right from the beginning of our partnership. It remained sensitive throughout the whole project.
- ✷ The process helped us learn how to apply theory in everyday work, decide what works, what doesn't and then make changes to improve. The best part was working and learning together.
- ✷ Saskatchewan Health gave us some ideas, some frameworks, some information and then let us make it meaningful in our communities. We never felt that we were going through the motions, we felt supported to do something meaningful and creative in our communities.

- The majority of the demonstration site partners described their perceptions of the involvement of Saskatchewan Health staff in their project as available, helpful and prompt. The ongoing support was more important than the workshops for some. Some suggested that it be made clearer at the outset what support the Saskatchewan Health team members would provide. Because partnerships were so complex and needed more emphasis, a team member could have been assigned to support partnership development in all seven projects.
- The reporting required was viewed as a "necessary punishment." Reporting was a problem particularly in projects with no staff assigned to do this type of work.

- ✷ Saskatchewan Health needs to spell out that these are the types of reports, and this is what needs to be done, and this is the time needed to do this. Then partners in the project could determine who will do what, when, and clearly understand what the time commitment is – in other words, everyone will know what they are signing on for and what they are getting themselves into. It takes time to take minutes, detail everything, collect the information, fill out the required reports, send them in, respond to requests for information. Who will take on these roles?

There were many positive summary comments about the role of Saskatchewan Health in supporting this initiative. Perhaps the most meaningful recognized the way the demonstration site team had consistently tried to support existing skills and build on them throughout the initiative. It wasn't enough for projects to submit a proposal and then a final report.

- ✷ If we do not have this kind of support we flounder around – as we do in many other projects.
- ✷ Saskatchewan Health has strengthened the capacity for partnerships in our community so that more work can be done in a collaborative way.

SECTION 9: LESSONS LEARNED – CONCLUSIONS AND RECOMMENDATIONS

The Population Health Promotion Demonstration Sites for Primary Prevention of Type 2 Diabetes Initiative was developed to address complex problems that could not be resolved with a single strategy or by the health sector alone. It required that a number of strategies, involving many partners, be implemented to reduce some of the barriers to good health. The focus was on community rather than individual change. While components of the initiative had been used elsewhere, this particular combination, based on the Population Health Promotion Model, had not been applied in any other jurisdiction in this way to the best of our knowledge. That provided both challenges and great opportunities.

The greatest achievement was that the demonstration sites were able to work in partnerships to create some changes that will be lasting in their communities. The approach achieved broader commitment and involvement than a focus on individual lifestyle behaviour change would have. It also placed higher emphasis on a population health promotion approach so more people are able to apply the skills in a variety of settings.

Quotations begin with
- ✷ They are also indented and in a different typeface.

There are lasting benefits from this initiative. Interviewees were asked, "When you look back at what you have accomplished, what has given you the most satisfaction?" Some of the responses to the question about lasting benefits were:
- ✷ The partnership was a great source of satisfaction. The coalition kept spreading to include others. After a meeting, people don't just leave. They are talking and making arrangements to share resources, etc. There are people who are truly interested in the project. Even if partners had differences they were usually able to overcome them because they had a common goal.
- ✷ There are many more people starting to understand prevention. There is a ripple effect in the community.
- ✷ People aren't just calling health workers for transportation slips. Workers are recognizing that there are more things they can do.

The PHP Model can be intimidating so demonstration sites and Saskatchewan Health needed to find ways to simplify it. Some talked about reducing the barriers due to low income, education and lack of social support. Some talked about needing to work with many partners to build the healthy communities people wanted for themselves and their families. For those with more experience, there were opportunities to go deeper into the meaning and application of the different facets of the PHP model.

- ✷ It was an opportunity to go through the population health promotion framework. It is complicated but it is less complicated now and we are really starting to understand it. I've incorporated it in other planning.

- ✷ The evidence base in the model is also a reminder that we need to look at the literature and people's experiences carefully in planning and implementing any program. Interestingly, there were times when we had to make decisions based on our experience and only later did we have time to support it with the literature.

Diabetes prevention was a mobilizing focus for some health districts and their partners, but not for all. A population health promotion approach requires that the issues being addressed have the commitment and interest of partners.

Building partnerships and good working relationships was an ongoing theme of this initiative. It takes time to develop trust and common understanding even among people who have worked together in different settings. It would have been preferable to allow more time for partnerships to develop before they needed to submit their initial proposals. There were projects that needed more support in developing their partnerships. The members of the partnerships in some projects were quite fluid; some left or were inactive for a time and then became active again. Rejoining was an option because all were kept informed in the interim through minutes and newsletters.

Long-term policy change, including less formal changes such as having more nutritious food available at meetings and feasts, will have lasting effects. The skills developed among partners and Saskatchewan Health staff are being used in many other settings.

As much sustainability planning as possible would be built into the initial proposals if a similar initiative was being developed now. Sustainability of a demonstration project is a relatively new concept in the literature. Holdner and Moore's summary of the supporting and restricting factors for sustainability of initiatives of this type was published in 2000 by which time the projects were already underway. [9] There are many tasks at the beginning of a program such as this, but keeping the sustainability factors in mind as proposal requirements are developed and programs begin would help.

Capacity to undertake population health promotion work is a critical issue. Both funding agencies and projects need to identify the leadership, funds, time, skills and other resources that are required.

Funding agencies need to be as clear as possible about all the expectations for collaboration, reporting and communication, evaluation and skill development before funding applications are developed. Sometimes when this information is provided, it may not be heard because applicants choose to minimize its importance due to their interest in the project. For this reason, it would be wise to outline the requirements in writing as well as through discussion. As much of the support material (such as manuals and guidelines) as possible should also be available at the outset. Again, new information and skills will be identified during any lengthy initiative so it is unlikely that everything will be in place before a project begins.

In light of what was said by the demonstration sites and the literature, before hiring staff for any pilot project, it would be wise to discuss how staff can support the work without taking on so many roles that the work of the project cannot continue after funding ends.

The Getting Started Workshop may have been the most important training event. It was designed to increase understanding of what population health promotion is. It clearly outlined the expectations for proposals. It spread the word that we were in business.

There will probably always be challenges in identifying the needs and supporting skill development when there are people and projects at different stages of development. Learners also have different learning styles and preferences. It is tempting to look back and say, "I wish I'd known that at the beginning," but some things are best learned after there is some experience on which to build. Perhaps the answer is to strive to have as many resources as possible available at the beginning and then encourage participants to use them when they are ready. Face-to-face learning opportunities may be best used when interaction will significantly increase learning, when participants will learn best from discussion and sharing with each other, and when they need opportunities to get to know each other and form networks. Another reported benefit of funding attendance at workshops for front line staff who do not normally have these opportunities was that it

built commitment to the projects.

Although much of the focus of this initiative was on the seven demonstration sites, Saskatchewan Health also had a strong commitment to share what was being learned about population health promotion with all health districts. As a result, the Partnership Workshop and Build Better Tomorrows Conference as well as print materials, including the *Build Better Tomorrows Conference Proceedings* were available to other health districts and other interested individuals. Meeting the needs of this larger audience in addition to the demonstration sites is even more complex than assessing the needs of the seven demonstration sites alone. Something that still needs to be done is to seek opportunities to share more broadly what was learned from each of the demonstration sites.

The Build Better Tomorrows Conference attracted about 300 people, half of them First Nations and Métis participants. This was no doubt due, in large part, to ensuring that First Nations and Métis people were very active in planning the conference, and the conference program reflected this. It was very valuable to learn from the elders who were an important part of the program. Paying attention to the cultural and ceremonial needs of all participants was important. In fact, First Nations and Métis people were active partners throughout this initiative.

A workshop or resources on how to mobilize communities to make change would have been useful for some projects. De-mystifying policy development and implementation would be a key component because this was a sticking point for some projects.

Evaluation is a challenge for most initiatives, particularly those that are community-based. People who want to get on with delivering services are sometimes impatient with the need to report what they have done, even when they recognize that this could improve their work. Having an outline of what is expected, perhaps including a template, such as the PHP Evaluation Template found in Appendix 2, would be helpful. It was also suggested that Saskatchewan Health hire or assign someone with expertise in evaluation to work with each of the demonstration sites individually. Quick feedback to those who supply information so they can use it in their work is also useful.

In conclusion, a population health promotion approach can indeed create changes that make it easier for everyone in the community to make healthier choices. The demonstration site partners and Saskatchewan Health demonstration site team learned a great deal that is being used in a number of settings. The demonstration sites and others who participated in some of the learning opportunities have also said how helpful it was to have this experience.

Both communities and the Saskatchewan Health demonstration site team needed to work differently when implementing this type of approach.

The focus of the Population Health Promotion for Primary Prevention of Type 2 Diabetes initiative was to strengthen community members' ability to take action, so they could create environments or communities where it was easier to be healthy. Partners built healthy public policies that will have long-term effects. The projects used approaches that would reduce the effects of some of the barriers imposed by the determinants of health such as low income and lack of social support. Changes of this magnitude can be achieved only by working with partners in different sectors and in communities. The initiative was based on the values and principles of population health promotion. Research evidence and respect for the experience of those working in the field was crucial. There is a commitment to adding to and continuing to share this knowledge base about population health promotion.

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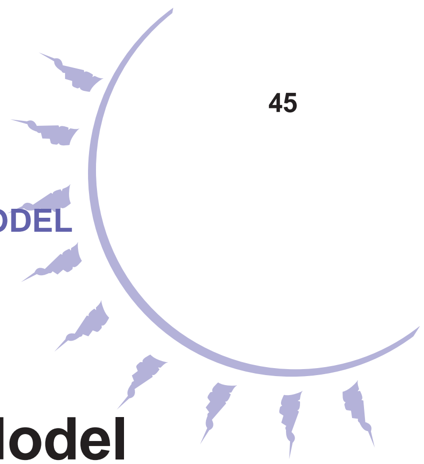


SECTION 11: APPENDICES

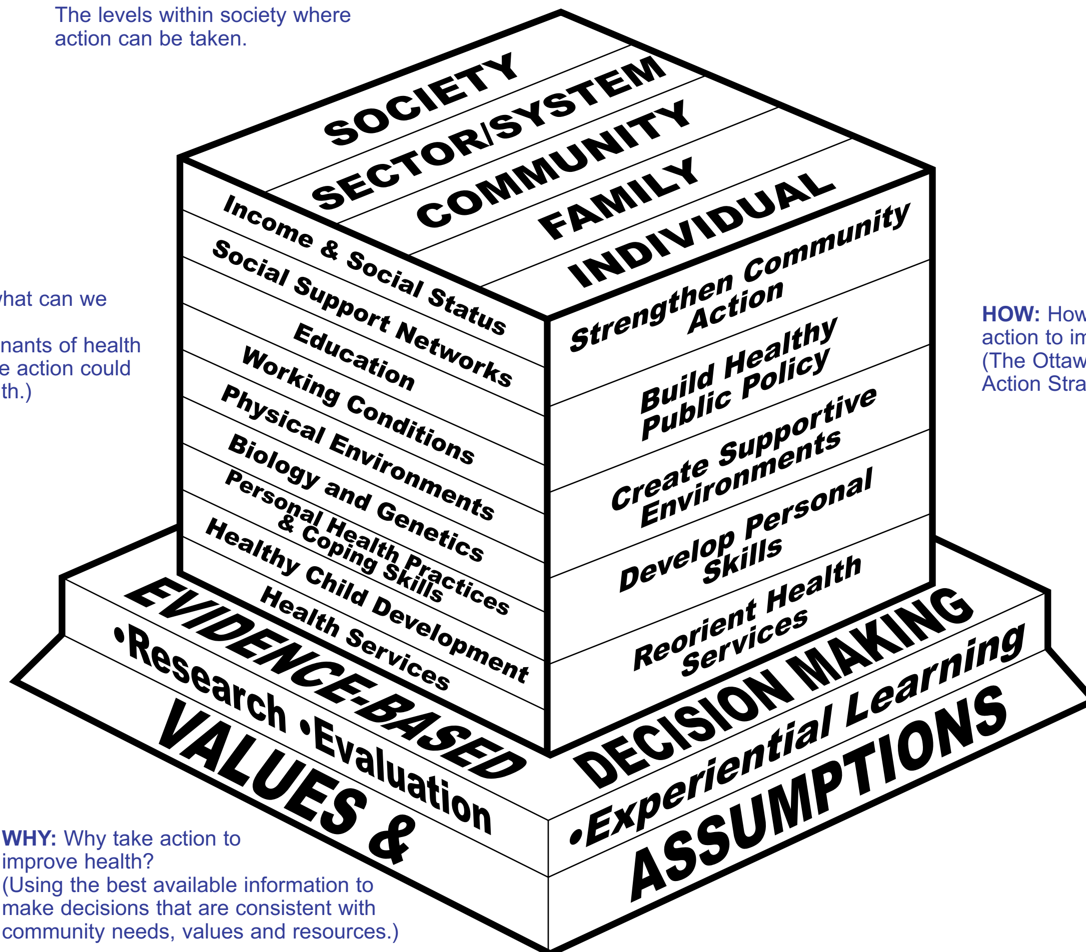
APPENDIX 1- POPULATION HEALTH PROMOTION MODEL

Population Health Promotion Model

WHO: With whom can we act?
The levels within society where action can be taken.

WHAT: On what can we take action?
(The determinants of health - areas where action could improve health.)

HOW: How can we take action to improve health?
(The Ottawa Charter Action Strategies)



WHY: Why take action to improve health?
(Using the best available information to make decisions that are consistent with community needs, values and resources.)

Nancy Hamilton & Tariq Bhatti
Health Promotion Development Division
Health Canada
February 1996

APPENDIX 2- POPULATION HEALTH PROMOTION EVALUATION TEMPLATE

SUMMARY TEMPLATE FOR APPLICATION OF PHP FRAMEWORK

What was done? How was it done? What was the outcome or impact?

The following information is being gathered from each demonstration site in order to give us a provincial picture of how the PHP model was applied in the Population Health Promotion for Primary Prevention of Type 2 Diabetes Program.

Name of PHP Demonstration Site Project:____

<table>
<tr>
<td>WHAT BARRIERS NEEDED TO BE ADDRESSED?

List barriers addressed and summarize information about each barrier. Include information such as:
• Number of people affected by the barrier and by the intervention
• Size of the barrier
• Seriousness of the barrier
• Importance to the community
• Feasibility of changing the barrier

Barriers of particular interest include:
• Income and social status
• Education
• Employment and working conditions
• Social support networks
• Physical environments
• Healthy child development</td>
<td>HOW WAS THE PROJECT DONE?

Summarize information about:
• creating supportive environments
• strengthening community action
• policies developed, adopted, changed and implemented

Under each heading, include a very brief description of strategies used, population group targeted and evidence of collective action. Some strategies will cover more than one type of action; use your judgement about where it fits best or create an all-inclusive category.</td>
<td>WHAT WAS THE OUTCOME/IMPACT?

Effects include:
• Outcomes, either products or processes, linked to the strategies
• Size of the impact
• Include unanticipated outcomes and modifications to the plan</td>
</tr>
<tr>
<td>**</td>
<td>**
Create supportive environments:
•

Strengthen community action:
•

Implement healthy public policy:</td>
<td>**
Create supportive environments:
•

Strengthen community action:
•

Implement healthy public policy:</td>
</tr>
</table>

Your conclusions and comments about how the barriers were addressed:	Your conclusions and comments about how the project was done: *If one of the action strategies was not used or was used infrequently, why was this the case?* *Has the project been able to take action at various levels?* ***Are there strategies on which no action could be taken?*** *Are there comments on the "degree of difficulty" - healthy public policy usually being most difficult or requiring work on the other areas first.*	Your conclusions and comments about the outcome or impact
Conclusions and comments on sustainability: **What changes or activities do you expect will continue after the funding ends on March 31, 2001?** **Are there changes or programs that will stop when the PHP demonstration site funding ends?** **Are there partnerships or working relationships that will continue after the project ends?** **Are there experiences that you believe partners will use in other projects after this project is completed?**		

**** indicates a section that should be completed by each project.**

Adapted from "Population Health Promotion Demonstration Site Summary Template" [12]

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