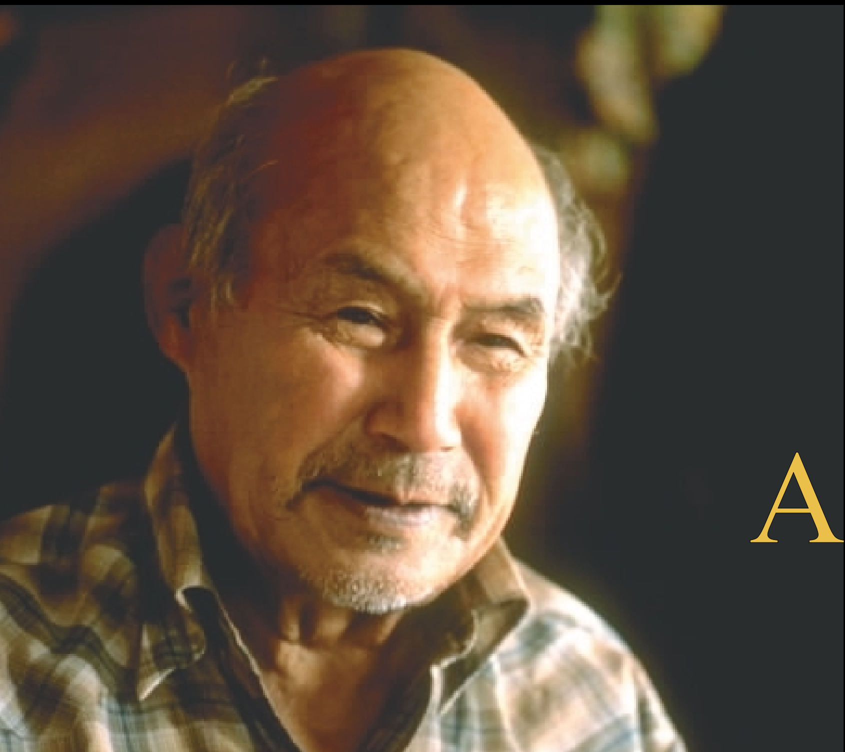
THE CANADIAN DIABETES STRATEGY



Aboriginal Diabetes Initiative

First Nations On-reserve and Inuit in Inuit Communities

Program Framework
July 5, 2000

Health Canada Santé Canada

Canada

ABORIGINAL DIABETES INITIATIVE

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Introduction

Aboriginal Diabetes Initiative

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The Aboriginal Diabetes Initiative (ADI) is one of four main components of the Canadian Diabetes Strategy (CDS) announced by the Government of Canada in 1999. The ADI has been allocated $58 million over five years to assist in meeting the needs of Aboriginal people dealing with the epidemic of type 2 diabetes in their communties.

The ADI program for First Nations living on-reserve and Inuit in Inuit communities will provide a range of diabetes care and treatment, diabetes prevention and health promotion, and lifestyle support services that are community-based, culturally appropriate, holistic in nature, and more accessible. The program will respond to the unique health and social needs of First Nations people living on-reserve and Inuit in their communities, and will take into account traditional practices and methods, wherever possible.

First Nations and Inuit Health Branch (FNIHB) regions will be responsible for establishing regional ADI work plans, in a collaborative process with First Nations and Inuit partners.
FNIHB is divided into the following regions:

- Pacific (British Columbia)
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- Atlantic (Newfoundland, New Brunswick, Nova Scotia, Prince Edward Island)
- Northern Secretariat (Yukon Territory, Northwest Territory, Nunavut)

A second component of the ADI program will deliver diabetes primary prevention and health promotion programs to Métis, off-reserve Aboriginal people, and urban Inuit. It will be delivered on a national basis, and is described in a separate framework document.

2 Target Population

The target populations for this program are:

2.1 First Nations[1] and Inuit of any age; and

2.2 Those who live on a First Nations reserve, or in an Inuit community, or in a First Nations community in the territories.

3 Program Purpose

The First Nations on-reserve and Inuit in Inuit communities program of the ADI is intended to create diabetes care and treatment, prevention and promotion, and lifestyle support services for First Nations living on-reserve or in communities in the territories, and Inuit living in their communities.

Type 2 diabetes is at epidemic levels among First Nations people, and this program will begin to address the problem. The program intends to create awareness of diabetes and its risk factors, look at viable community-based care and treatment services, link to other health care programs running in communities (such as First Nations and Inuit Home and Community Care) and establish lifestyle support services.

The level of diabetes among the Inuit is not as severe as it is in First Nations communities, making it an opportune time to create diabetes prevention and awareness programs. The Inuit have indicated that their priority will be on diabetes prevention and health promotion.

1 Innu are included in this definition

4 Program Objectives

The ADI program for First Nations on-reserve and Inuit in Inuit communities will begin to address the high rates of diabetes and its complications, and provide First Nations and Inuit communities with opportunities to design, develop, and participate in projects to address diabetes within their communities.

Specific program objectives are to:

4.1 Raise awareness of diabetes, its risk factors, and the value of healthy lifestyle practices;

4.2 Support the development of a culturally appropriate approach to care and treatment, diabetes prevention and health promotion programs, and lifestyle support programs;

4.3 Build capacity, linkages and infrastructure for all components of the ADI in First Nation and Inuit communities;

4.4 Promote self-management;

4.5 Coordinate with other community-based programming, specifically the First Nations and Inuit Home and Community Care program.

5 Program Elements

There are three essential elements of the First Nations on-reserve and Inuit in Inuit communities program:

- Care and Treatment
- Prevention and Promotion
- Lifestyle Supports

These elements will be based on the following principles and approaches:

- community-based to build/strengthen capacity within the community;
- establish self-management as a key goal of diabetes treatment;
- culturally specific and relevant;
- respect traditional wisdom, knowledge, healing methods and approaches;
- incorporate a systematic approach to the management of diabetes.

Care and Treatment services will begin to address the needs of First Nations and Inuit people already diagnosed with diabetes by providing them with direct services to help monitor their diabetes status, screen for and prevent further complications from developing, and provide diabetes education to clients to encourage self-management. Creative ways to remove service barriers should be examined and linkages with the First Nations and Inuit Home and Community Care program will be established to help ensure that the fullest continuum of care services may be realized.

Prevention and Health Promotion activities should target the entire population, to increase awareness of diabetes and its complications, create awareness of the benefits of healthy eating, active living, and encourage the integration of traditional methods and practices with western-based approaches. Diabetes prevention and health promotion activities that focus on the need to educate youth will decrease the likelihood of the next generation suffering from diabetes.

Lifestyle Support Services should provide support to people living with diabetes and their families/care providers, in coping with the consequences of having a chronic, potentially debilitating/life threatening disease. Lifestyle supports may enhance community capacity to provide holistic approaches to the realities of living with diabetes. Activities may include peer support groups, sharing circles, drop-in programs for people with diabetes and their family members, or youth programs. These activities may provide an opportunity to share feelings, and discuss issues, problems and solutions.

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The distribution of projects between the three elements will be related to the identified needs in each region, but all three elements must be addressed, either in separate projects, or as integrated parts of an overall project. Examples of projects or activities that may be established could include, but are not limited to those that:

- increase awareness of diabetes as a serious health risk;
- increase awareness of the signs and symptoms of diabetes and its complications;
- increase awareness of the importance of healthy lifestyles (such as healthy eating, weight management, physical activity);
- reduce the complications of diabetes;
- include the family and community as part of the program.

6 Program Delivery Model

In response to the consultation feedback, information sharing, and planning sessions with First Nations and Inuit in regions, **the program delivery model chosen for this component of the ADI is that of Targeted Strategic Investments.** Within the context of this ADI program, Targeted Strategic Investments will refer to regional 'blueprints' that include a variety of activities supporting the identified priorities within each region.

This approach has been selected based on the feedback received from First Nations and Inuit in regional discussions which recognized that the ADI funding is insufficient to support universal programming to all communities. Therefore, regions will be collaborating with First Nations and Inuit to ensure that projects and activities are shared between communities wherever possible, and that every community has access to at least one of the three elements of this ADI program.

To promote innovation and allow for program flexibility, each region will, in collaboration with its First Nation and Inuit partners, determine the most appropriate approach for establishing the program in that region. This includes targeted investments (such as shared diabetes workers among several communities, or a joint project with the province to set up a diabetes centre of excellence) and may include solicited proposals based on regionally defined priorities.

Communities are encouraged to think of ways to partner to share resources, develop the most cost effective program possible, and take advantage of linkages to the First Nations and Inuit Home and Community Care program for care and treatments activities.

In all cases, projects must be culturally appropriate, holistic in nature, and designed and delivered either by, or in partnership with, First Nations and/or Inuit. The program will recognize and address the unique health and social needs of First Nations people living on-reserve and Inuit in their communities, and will take into account traditional practices and methods, wherever possible.

Care and treatment programs should be delivered by trained diabetes care workers and integrated with the First Nations and Inuit Home and Community Care program wherever possible. The creation of linkages and partnering in programming (i.e. shared diabetes workers) is encouraged to make the most effective use of resources. Programs must be based on needs identified by the community or in combination with other communities/Tribal Councils/Inuit regions.

Diabetes prevention and health promotion programs may take a number of formats, depending on the needs of the communities. Programs that focus on education and primary prevention for youth in communities may be a priority; a theme highlighted often during the consultation process.

Issues of sustainability and capacity building must be addressed at the outset of the program. Rigorous evaluation frameworks will be required for all projects to ensure accountability of the program.

Diabetes programs may include separate activities for care and treatment, diabetes prevention and health promotion or lifestyle support, or be integrated, depending on the needs of the communities.
For example, a diabetes educator usually delivers diabetes prevention and health promotion information along with care and treatment, and often offers support to the family as well. Examples of diabetes programs that could be delivered through this initiative may include but are not limited to:

- community, Tribal Council or regional level trained/certified diabetes workers/educators;
- Centres of Excellence that partner with provincial programs to deliver a full continuum of diabetes care services;
- school-based education programs;
- nutritional counseling programs;
- diabetes awareness programs;
- development of active living health promotion programs;
- screening programs;
- diabetes care clinics;
- diabetes support services.

7 Program Funding

Program funding for First Nations on-reserve and Inuit in Inuit communities care and treatment, diabetes prevention and health promotion and lifestyle support services will flow through the First Nations and Inuit Health Branch agreements as outlined in the: Contribution for National Indian and Inuit Time Limited Special Initiatives.

Given the amount of funding available to the ADI over the five years of the strategy, and the breakdown per year ($2 M, $11 M, $15 M, $15 M, $15 M), it is clear that **the program does not permit each First Nation or Inuit community in a region to receive a base amount of funding.**

7.1 Funding formula

Based on feedback from the consultations and regional implementation planning sessions, the factors considered in the funding formula to allocate resources out to regions were:

- First Nations on-reserve and Inuit population;
- remoteness of communities; and
- capacity within the community/region to deliver services.

The number of people with diabetes in a community/region was also considered as a factor in funding, but due to the current lack of accurate data, it was not possible to factor in this element during these first few years of ADI programming.

Although most of the funding will be regionally allocated for programs, a small portion of funding will be retained at the national level for projects such as a national Aboriginal diabetes resource centre.

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7.2 Elements that will not be funded:

The ADI will not:

- provide any major capital or construction funding;
- fund research projects;
- provide services that fall under provincial/territorial jurisdiction, such as dialysis;
- fund operational activities not directly related to the ADI projects;
- duplicate services provided through the First Nations and Inuit Home and Community Care program.

8 Program Criteria and Implementation

8.1 Program criteria

As there are limited resources for the ADI program, each community in a region will not be able to run a full complement of care and treatment, prevention and promotion and lifestyle support services.

Partnerships with other communities, or partnerships at a regional or Tribal Council level will be necessary to maximize program effectiveness.

Each ADI program activity will be required to submit a plan to an established regional review process for approval. The plan must meet the following criteria:

8.1.1 Identification of what diabetes services will be provided as a result of the program, the target population, and how the activities tie into the goals and objectives of the ADI;

8.1.2 Identification of how the program will be established, including any support services that will be required from the region;

8.1.3 Identification of how this program will help to build capacity within the community;

8.1.4 Identification of existing diabetes or home care programs operating in the community, and how the proposed program will link to those existing programs;

8.1.5 Identification of all linkages relevant to the ADI between and within communities, with Tribal Councils, other Inuit regions, provincial/territorial organizations, non-governmental organizations, and provinces/territories;

8.1.6 Identification of all the activities and related costs associated with the program;

8.1.7 Description of how the community is involved in the design, planning, operation and evaluation of the program;

8.1.8 Identification of how the information on the program activities will be disseminated back to communities;

8.1.9 Identification of the ongoing training and human resource development activities;

8.1.10 Identification of how the program will be evaluated and reported on, in accordance with the ADI evaluation framework (Fall 2000).

Each FNIHB region will determine, in collaboration with First Nations and Inuit, the exact approach to accessing funding. However, for the First Nations and Inuit component of the ADI, funding is limited to:

- First Nations on-reserve or Inuit Communities' health authorities or Band Councils, Tribal Councils, Provincial/Territorial Organisations, First Nation or Inuit Associations;
- Other First Nation or Inuit organisations deemed eligible under the terms and conditions of the above-mentioned agreements; (see section 7)
- Governments of the Territories, provided that funding is targeted to First Nations and Inuit in these Territories, and that First Nations and Inuit have demonstrated involvement, partnership and support in the development of diabetes programs in their communities;
- Other organizations provided that they have the demonstrated support of First Nations or Inuit to deliver the ADI program.

8.2 Program Implementation

The ADI First Nations on-reserve and Inuit in Inuit communities program will be composed of projects designed by communities, or organisations on behalf of communities. Each First Nation or Inuit organisation wishing to develop and implement a diabetes program is required to submit a program plan. The plan must:

- describe how they will deliver one or all of the essential elements of the ADI (see section 5);
- describe how program criteria (see 8.1) will be met.

All plans will be reviewed by a collaborative regional review process (some regions may already have established processes in place; others will need to establish processes) to ensure that program plans are complete, eligible , and adhere to the program criteria as outlined in section 4.

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This regional review process will also ensure that available ADI resources are distributed equitably, and that all communities have access to some ADI activities.

Once the regional review is completed, the Regional Director will approve the plan or ask for revisions prior to approval.

Regions will be required to demonstrate how they are working with First Nations and Inuit and what collaborative processes they are using (i.e. either existing or new groups established for this program). Regions must submit a plan to FNIHB headquarters, demonstrating clearly how they will implement the program in their region.

9 Program Monitoring and Evaluation

The accountability framework for the Canadian Diabetes Strategy will form the basis of the evaluation framework for the ADI programs. Interim reports will be prepared and presented by the Minister of Health to Cabinet in 2003. Formal evaluation will take place during the fifth year of the ADI (2004), which will permit the department to return to Cabinet with a report on the successes, gaps and future needs with respect to diabetes.

As a requirement for funding under the ADI, any program or project must contain an evaluation component and will clearly outline:

9.1 the principles and objectives of the evaluation in relation to the program goals, objectives and key results:

9.2 the roles and responsibilities for program evaluation at the community/program, regional and national levels;

9.3 the evaluation methodology that will be used;

9.4 the detailed questions and indicators to be used in annual local and regional evaluations and in the final evaluation of the ADI;

9.5 reporting and approval mechanisms for evaluation reports.

A final detailed report will be submitted to Treasury Board at the conclusion of the ADI (2004), reporting on whether and how the program met its identified objectives, and accounting for all ADI funding.