South West Local Health Integration Network

Aboriginal Diabetes in South West Ontario
Winning the Fight Against Diabetes

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1. EXECUTIVE SUMMARY

Aboriginal populations have much higher rates of diabetes, complications from diabetes, and diabetes-related mortality than the general Canadian population. The Southwest Local Health Integration Network (SWLHIN) developed nine priorities to strengthen the diabetes outreach, education and management programs for the local Aboriginal populations. These priorities focus on understanding the historical and psychosocial causes of high diabetes in the Aboriginal populations, and then managing diabetes and its complications using robust data collection, culturally-sensitive models of care, examples from other LHINs and coordinated government services.

This report brings together some current best practices of treating, managing, and preventing diabetes in Aboriginal populations to inform the SWLHIN Aboriginal Health Committee in their effort. It does this by presenting academic and grey literature on the topic and cross references it with primary data collected in interviews and focus groups with local residents and service providers (See Table 1). The findings are brought to life in a case study of an individual diabetic respondent and a case study of the Chippewas of the Thames Site. These case studies show the interrelations of the various sociocultural aspects of health and provide some insight into how one should start addressing them.

Primary Data Findings

Respondents were asked about their knowledge of diabetes, awareness of local diabetes services, and suggestions to improve diabetes support in the area. Respondents were generally aware of the risk factors of diabetes and its complications, such as genetics, diet, exercise, and weight control. However, at diagnosis, they reported feeling frightened and helplessness in the face of their genetic predisposition, and often fell into a cycle of denial, guilt, hopelessness, and inaction. They reported that their diagnosis consultations rarely gave them the information and tools to cope with diabetes and address the sociocultural roots of the disease. Conversely, existing diabetes education programs have been plagued with low participation with service providers unsure on how to encourage patients into accessing them, given the host of competing health and social issues the patients face. Finances remain a barrier to program accessibility (lack of transport) and to living a healthy life with diabetes (buy quality foods).

The focus group participants suggested that the key to success is educating patients on the fact that they can prevent complications by controlling diabetes, and then motivating them on making healthy lifestyle choices and accessing supportive health services. Many reported being able to find support groups and make lifestyle changes since diagnosis (See Table 2). They were satisfied with the services and supports that they accessed and pointed to the importance of staying positive. Patients shared that good services lifted their spirits, gave them positive energy and a zest for life, and supported the entire community. However, respondents noted the importance of tailoring services to individual patients. They preferred on-reserve services because the providers off-reserve were not trained in Aboriginal culture.

Service concerns shared by the respondents included the following:

1- Poor patient surveillance and follow-up. The lack of follow-up with diabetics in the community was particularly problematic since the patients who were reluctant to access programs and services were at the greatest risk of developing complications of diabetes.

2- Lack of information around transportation support. Information and communications packages that correspond to the literacy needs of the target population needed to be developed.

3- Services offered do not address the needs of the population. For example, respondents stated the need for after-hour services, connecting with services from other communities on or off-reserve. In addition, the current structure of mainstream diabetes service and support provision support the physical and mental aspects of the medicine wheel, but do not as yet embody the emotional and spiritual aspects. However, there has been some slow change in this area (See Figure 5).

Literature Review

The literature review provides several examples of nutritional food programs and prevention programs that are tailored for Aboriginal communities. The literature highlights the importance of health services being holistic and multi-faceted so as to promote healthy lifestyle for whole families and communities and understand the broad range of stressors and barriers to health in Aboriginal societies. Health services also need to be flexible and relevant to the Aboriginal approach to health in all areas of programming, from the design phase to program development and implementation. They should follow mainstream clinical practice guidelines in terms of sensitivity to language, culture, traditional beliefs, medicines, and geographic issues.

The grey literature provided many creative ideas and recommendations. For example, in one community, Early Childhood Educators supported community healthy eating and exercise programs. The AFN suggested placing the community at the center of the programs—having community-based screening programs, primary prevention located in the community, and access to community wellness centres. Also, integrating with western medicines was encouraged, with suggestions to review and update the NIHB formulary to enable access to the best treatments.

However, the literature also pointed issues faced by existing diabetes programs. These include the absence of federal plan aimed at improving diabetes surveillance for Aboriginal peoples. It was suggested that the uneven provincial/territorial database information for Aboriginal peoples limits the ability to develop a national surveillance plan.

Recommendations

The most important recommendations from the interview respondents and focus group participants related to community outreach, improving health services, and providing access to nutritious food, transport, and training. Some of the recommendations are summarized below:

1. Strengthen surveillance, screening, and follow-up, specifically with the socially isolated who may be at risk of developing complications of diabetes. Start regular screening at age 10.
2. Disseminate diabetes information around the community that responds to the community's literacy rates, mitigates stigma, and clears diabetes misconceptions. Sensitize the community leadership on the extent and impact of the issue in the community. Ensure that patients get personal support from doctors in a way that they understand.
3. Support a holistic approach to service provision that responds to the need for emotional and spiritual supports for clients. Provide after-hour services such as a telephone hotline.
4. Address the lack of access to healthy nutritious food by supporting community gardens, community markets, and by supporting partnerships with local farmers and food co-ops.
5. Address the transportation barriers community members face and explore locally based alternatives.
6. Provide ongoing training to health care providers to support the provision of unbiased and supportive health care by hospitals and non-Aboriginal health care providers.

2. GLOSSARY OF TERMS

Aboriginal – The term "Aboriginal" refers to the first inhabitants of Canada, and includes First Nations, Inuit, and Métis peoples. When used in Canada, however, it is generally understood to refer to Aboriginal peoples in a Canadian context. http://indigenousfoundations.arts.ubc.ca/home/identity/terminology.html

Diabetes Education Program – (DEP) A network of community and hospital based diabetes education teams consisting of a registered nurse and dietician who provide information and assistance to clients to support them to self-manage their condition. The teams work collaboratively with primary care physicians and diabetes specialists. http://www.southwesthealthline.ca/listServices.aspx?id=10891

Indigenous – Indigenous is a term used to encompass a variety of Aboriginal groups. It is most frequently used in an international, transnational, or global context. In the UN, "Indigenous" is used to refer broadly to peoples of long settlement and connection to specific lands who have been adversely affected by incursions by industrial economies, displacement, and settlement of their traditional territories by others. http://indigenousfoundations.arts.ubc.ca/home/identity/terminology.html

Local Health Integration Network (LHIN) – Local organizations that plan, integrate and fund local health care, improving access and patient experience. There are 14 LHINs in Ontario. http://www.lhins.on.ca/

Non-Insured Health Benefits – (NIHB) Health Canada program that provides registered First Nations people and Inuit with access to health services and supports not covered under the provincial or regional health care system. Included are prescription drugs, medical transportation, dental and eye care, medical supplies and equipment, mental health services. http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php

Regional Coordination Centre (RCC) – Established in each of the LHINs to organize and coordinate the network of regional diabetes programs and services. The RCCs work collaboratively with regional and local hospitals and community based health service providers to improve access to diabetes programs and services. http://news.ontario.ca/mohltc/en/2009/11/ontario-diabetes-strategy.html

Southwest Ontario Aboriginal Health Access Centre (SOAHAC) – Provides holistic and culturally based primary health care, health promotion and social services to Aboriginal people living in southwest Ontario, both on and off reserve. Health clinics are located in Windsor, London, Chippewas of the Thames First Nation and Owen Sound. First Nation communities served by SOAHAC include Cape Croker, Saugeen, Muncey-Delaware, Chippewas of the Thames, Oneida and Moravian. www.soahac.on.ca

South West Local Health Integration Network (SWLHIN) – One of 14 Local Health Integration Networks in Ontario that are responsible for funding, planning and coordination of health services within their region. www.swlhin.on.ca

Southern Ontario Aboriginal Diabetes Initiative (SOADI) – Provides information and support services including prevention, self-care and foot care, to Aboriginal people and organizations in southern Ontario. www.soadi.ca

3. INTRODUCTION

In April 2013, the Ministry of Health and Long Term Care transferred responsibility for local coordination of diabetes management from the Regional Coordination Centre to the Local Health Integration Networks (LHINs) located across the province. As a result, the Southwest Local Health Integration Network (SWLHIN) assumed responsibility for nine Diabetes Education Programs (DEPs) located in their area. In addition to these DEPs, diabetes education and management programs and services were delivered by a number of other service providers in the SWLHIN including:

- community and primary care providers (South West Ontario Aboriginal Health Access Centre (SOAHAC), community health centers' chronic disease programs, family health teams, primary care physicians);
- tertiary and specialist care providers (St. Joseph's Health Care's Diabetes Education Centre, 14 endocrinologists); and
- other health care providers (individual and community pharmacists).

The DEPs have sought to develop program and outreach models to support their local populations, however there are inconsistencies across the programs including models of care, referral processes, and the percentage of people with diabetes being served by the various programs. Primary care physicians have indicated that many of their peers are either unaware that DEPs exist or are not confident that DEPs provide the needed services for their patients.

To act on the LHIN's mandate for coordination of diabetes management, a priority issue is to ensure coordinated access to regional diabetes management and education services for all people in their area. As part of the SWLHIN's efforts to respond to the needs of First Nation and Aboriginal people, they have further identified specific priorities for this group. They are:

1. Building a fuller-body of medicine: e.g., traditional medicines, understanding what health approaches are effective within First Nations
2. Preventing the secondary complications related to diabetes
3. Understanding the emotional and mental health aspects of diabetes
4. Healing from trauma as a leading prevention practice (e.g., Kiikeewanniikaan, Southwest Regional Healing Lodge and the Southern Ontario Aboriginal Diabetes Initiative (SOADI))
5. Exploring new models of care: e.g., identifying diabetes education programs as resources
6. Contacting other LHINs that have a robust vision of diabetes health for Aboriginal people, e.g., Wellington and Waterloo LHIN
7. Collecting data on health service surveys that include diabetes care (i.e., SOAHAC)
8. Understanding why diabetes is so prevalent among Aboriginal people
9. Inter-ministerial and multi-sectoral collaboration towards ending Type 2 diabetes

This report aims to build on the current body of knowledge of diabetes among Aboriginal people by identifying current best practices in treatment, prevention and management of diabetes in the local communities and identifying options and needs aimed at minimizing the extent of complications from diabetes experienced by the local communities. It is anticipated that this report will act to inform future recommendations generated through the SWLHIN Aboriginal Health Committee to support the SWLHIN and SOAHAC to provide appropriate diabetes services and supports to local Aboriginal communities in response to identified local issues, needs and priorities.

Diabetes is a rapidly growing epidemic across the world that is affecting populations in both developed and developing countries. Issues behind this increase are related to an aging population and to a more sedentary lifestyle and rising levels of obesity (Wild et al., 2004). Within the Canadian context, diabetes among First Nations members living on-reserve has reached levels that far exceed the prevalence among the general population and there is growing evidence that First Nations people are more affected by the complications of diabetes (vision loss, amputations, and renal disease) than the general population. First Nations people are also experiencing higher mortality rates from diabetes compared to the general population. Data from the 2008-2010 First Nations Regional Longitudinal Health Survey phase 2, indicates that the crude rate of prevalence of diabetes among First Nations people living on-reserve is two and a half times greater than that of the non-Aboriginal population. When this data is age-standardized, the rate increases to over three times that of the general population. Among First Nations people living off-reserve, the prevalence of diabetes is higher than the general population but lower than that of individuals living on-reserve. In this case, the crude rate of prevalence between the general population and the off-reserve First Nation population is 6% vs 8.7%, and jumps to 5% vs 10.3% when the data is age-standardized (PHAC, 2011).

4. METHODOLOGY

The findings reported are largely based from information documented during a primary data collection process which collected in-person interview data as well as focus group data in four areas within the Southwest Local Health Integration Network jurisdiction that offered some form of diabetes programming. The four locations which offered diabetes related programming included Muncey-Delaware Nation, Saugeen First Nation, and Chippewas of Nawash First Nation and M'Wikwedong Native Cultural Resource Centre. A secondary review of data involved the meta-analysis of published as well as grey literature and other documents and reports pertaining to diabetes and First Nations peoples. These secondary data are utilized to complement or show contrasts to the primary data collected and analyzed.

The 15 participants involved in the interview process included those who do not have diabetes, those with diabetes and those whose family members have diabetes. They were asked to describe their own experience and knowledge of diabetes in their community or those of their family members, and to share the strategies and approaches they use or have knowledge of, that serve to support people with diabetes from developing complications. They were also asked to describe their impressions of the effectiveness of the services and their suggestions for effective approaches aimed at supporting individuals to manage their diabetes and minimize the complications related to the disease.

Focus groups were hosted by each of the four diabetes related programs and comprised of service providers, program managers and coordinators who work directly with the a population which is susceptible to or engaged in fighting against diabetes. In each focus groups, the participants were asked to describe how diabetes manifests itself within the community and their experience of people they know encountering diabetes, the strategies currently being used to reduce the onset of secondary complications of diabetes and issues regarding access and availability of services for diabetics in their community. The table on the nest page summarizes participation in the study group and focus group process.

Table 1: Summary of Interview/Focus Group Participation

Methodology	Community				
	Muncey-Delaware	Saugeen	Cape Croker	M'Wikwedong	Total
Focus Group	8 participants including: 2 Physicians 1 Nurse Practitioner 2 Diabetes Educators 1 Physiotherapist 1 Registered Practical Nurse 1 Administrator	4 participants including: 1 Nurse Case Manager for Home and Community Care 1 CE certified Diabetic Educator, 1 Community Health Nurse 1 Health Director	1 participant: Diabetes Educator	2 participants including: Executive Director Life Long Care Program Coordinator	15
Study Participant - Group A – with diabetes	Nil	1	2	1	4
Study Participant – Group B – family members with diabetes	Nil	2	1	3	6
Study Participant – Group C – do not have diabetes	1	1	3	Nil	5

5. FINDINGS

5.1 PATIENT FOCUSED

Each sub-section summarizes a certain aspect discussed by the interviewees as to the needs to be addressed; the title of the sub-section capture the main theme the sub-section discusses.

5.1.1 Patients generally know what constitute right and wrong health behaviours.

Survey respondents are knowledgeable of the role that lifestyle plays in diabetes. Survey respondents pointed to diet, exercise and weight control as the main risk factors associated with diabetes, and that these are the areas that need to be controlled in order to effectively manage the condition and to help avoid complications such as amputations, vision loss and kidney failure. Some of the comments heard from participants illustrate the disparity between ideas of healthy eating and poor choices in food consumption. Regardless of their actual eating habits all respondents knew what constituted a poor eating choice and what made-up a healthy diet.

> *....I owe my current health to my family members, my mom was a good cook, so when I started learning about sugars, I stopped with the sweet tooth, I ate better....*
>
> *Women turn to eating for emotional stress, they want comfort foods.... I think they ate too much sugar, my mum always ate pastries, always was baking sweets, she put sugar in her scones and she was overweight as well...*
>
> *My nerves were shot and I wasn't eating properly, breakfast and lunch was pop.*

5.1.2 Upon diagnosis patients are frightened, lack coping skills and the roots of the health issue are not discussed or addressed within that first diagnosis consultation.

The diagnosis of diabetes is frightening. Words that survey respondents used to describe their feelings about diabetes included 'frightening, scary and denial'. A number of respondents pointed to their own unwillingness to accept the diagnosis at the beginning and to finding themselves in an initial state of denial regarding the condition. The individuals did come to accept the diagnosis and the need to change their personal habits in order to stay healthy. Many respondents spoke of their own experiences of seeing family and community members cope with the complications of diabetes and of seeing close ones lose limbs, experience kidney failure and vision problems. As one person said, '*my grandmother had an amputation so for me diabetes is a death sentence – injections, amputations and vision loss*'. Clients experience a deeply rooted fear at the thought of needing to use insulin; they see the needle as a last line of treatment. The fear was not so much of the needle itself, but rather directed at seeing the need to take insulin as a confirmation they have somehow 'failed' at this task and this is compounded with other failures they have experienced throughout their lives – this failure tends to feel like the icing on the cake – the last straw.

Respondents also describe the sense of hopelessness and complacency that many First Nations members feel concerning the diagnosis of diabetes and that this has a significant impact on how individuals respond to such news. The pressure of possibly failing, viewing diabetes as a test they are sure to fail, upon diagnosis these preconceptions and even myths put individuals into a state of shock. Individuals report they are left in this state of shock, without proper education, and sensitivity to their feelings. This

state of shock translates into an unwillingness to actively become engaged in their own health care, such as seeking-out information and taking advantage of services which are available.

While the respondents to this report were not involved in these fatalistic attitudes, since they are actively involved in support groups, they and the focus group members shared their observations of others about self-help and their reactions to a diagnosis of diabetes. Instead the study participants were currently accessing services and had already made their own lifestyle changes in response to their health conditions. Some of their reflections are noted next. For some people the reluctance to seek support arises out of a belief that being First Nations means that diabetes, 'is in my genetic make-up and therefore there is little a person can do about it'. As noted above, denial is often the initial reaction by clients when they hear the diagnosis, and it takes time to come around to accepting the condition and accepting the required changes in their daily routine. For others, their own experience of diabetes is that of severely reduced quality of living and the inevitability of future complications. Several respondents described seeing family and community members succumb to the complications of the condition, thus providing a bleak picture of the impact of the disease. As well, diabetes has not been an issue that has been easily discussed in the community in the past, shame and secrecy surrounding the disease continues, although some respondents spoke of a start in a change in this attitude. A survey respondent noted that despite the good services that are available, in her community, probably 50% of those with diabetes do not come out to the programs. For some, the fear of being labelled by others in the community as having somehow failed, or of being the focus of 'bad talk' may prevent them from taking action to address their condition. Diabetes is still seen by some as evidence of some sort of personal failure on the part of the individual, and, particularly for those individuals who are already burdened by other issues, the added 'stigma' of diabetes and the effort needed to learn how to manage it may not be beyond their ability to cope. Ability to cope is largely impacted by limited educational attainment, poverty (Raphael, , 2011: p. 225-226) and the intergenerational impacts of residential school in terms of the disruption of the functional of family and one's relationship to their environments (LHF, 2014: p6), as well as the process of 'cultural genocide' (TRCC, 2015" p1).

5.1.3 Motivation is thought to be the key to success, but little is known as to what could make / encourage / reform patients into accessing supportive health services.

Stress and depression is a factor among those with diabetes. Community workers spoke of the need to motivate people to go to community clinics and that low turn-out to programs is a common phenomenon. Kettle/Stony Point, for example, run a monthly support group but turn-out to the program is low. Clients don't come back to clinics for follow-up and there is no structure in place to enable the program leaders to do the outreach and communication with diabetics that could help to bring them out to the programs. Rather, the programs rely primarily on personal initiative (motivation) to seek help and support to live a healthier life. Those individuals who experience a sense of hopelessness surrounding diabetes are unable to take advantage of the programs and supports that are offered. Strong Helpers' Teachings, by Cyndy Baskin, under a Chapter titled, Values and Ethics, points to the need to move away from individualism. This narrative points to the need to phrase sickness within the context of the environment of the person. By phrasing it as an issue of personal initiative (motivation) service providers are making their job harder as well as that of the patients.

> *Within the profession of social work, individualism is often manifested in the ways that we choose to work with people. Perhaps we might choose to work with that individual on a one-on-one basis, but avoid actively engaging in community outreach and practice. We might have rigid guidelines about confidentiality. .. we are enforcing a condition of isolation…focusing on individual concerns we put the broader community*

> *at-risk…by looking at health conditions with a narrow view we are hurting ourselves and others…By not addressing the collective, we are missing out on many helpful possibilities, suggestions, and opportunities that might help us assist one another…[this is part and parcel to] social workers also working in isolation* (Baskin, 2014: p 92-93).

For too many First Nation people, the diagnosis of diabetes is another in a long line of personal issues that they are dealing with, and it is only adding to their already heavy burden of disadvantages including trauma, depression, substance abuse and family violence. Programs such as diabetes support groups and activities may not be suitable for those individuals who are already more socially isolated than others as a result of their personal and home life situation. The other issues they are experiencing, including personal, family and community stresses, may be more immediate and pressing than diabetes until the disease has progressed to the point of exhibiting complications. The impact of inter-generational trauma among First Nations people is described in the article, *Intergenerational Trauma: Convergence of Multiple Processes among First Nations peoples in Canada* (2009). These 2009 authors suggest that stressful events may predispose individuals to further stressors and to an increased response to these stressors. The report finds that stressful events can have an effect on coping mechanisms, on lifestyles, and on overall physical and mental health.

A 2011 study commissioned by Anishnawbe Health Toronto showed that the participants were aware of the importance of maintaining a positive outlook in order to manage their diabetes and that 61% of participants were somewhat, very much, or completely concerned about the impact that depression can have on their self-care (Lavallee & Howard: 2011). In a discussion about the effects of mental health stigma and myths, Forchuk et al (2011), concluded that current health system policies and support service practices fail to address the specific needs associated with housing, medical care, employment, and opportunities for community participation in actively addressing the staggering rate at which community members are becoming "sick" (p. 78-79). Basil Johnston, in Ojibway Heritage (1994: p 84-93) described a process by which any individual treated by a Mide would be initiated into the first order (of the Mide). This exemplifies a community approach to health care, where the system which guides the development of the next generations healers, encompasses a process by which all members of a society become active learners and participants within a system, among other things, supports the development of health conscious and therefore the growth of a health community membership (Aboriginal Healing Foundation, 2008).

5.1.4 Individualism guides health care service provision and personal motivation is required if one is to successfully access health services.

Personal motivation is a key factor to keeping healthy. From the comments provided by the interview and focus group respondents, the effectiveness of available services is dependent on having a high degree of personal motivation on the part of participants. Individuals cited the difficulty in getting people into exercise programs and of motivating people to take an active role in their health. Giving people the information they need about diabetes and what they need to do to stay healthy and telling them how to avoid complications was seen as messaging which failed to resonate with patients who lack personal motivation. As stated earlier, many First Nations members are already dealing with trauma and the added burden of a diabetic regime and the attendant lifestyle changes diabetes required in order to manage it, can overload people and cause them to turn away or to ignore available supports. The onset of trauma was primarily from the implementation of an individualistic regime within the residential school system, when children were told they could not see their families, practice their culture, and their very being and self-worth was archaic and barbaric.

5.1.5 Finances remain a barrier to program accessibility and to living a healthy life with diabetes.

Availability of transportation to services is a barrier for many clients to access services and to participate in support programs and groups. Clients without a vehicle or without easy access to one are limited in terms of their ability to attend clinics and activities. Problems with transportation funding from Non-Insured Health Benefits (NIHB) were cited as a specific issue, including the uncertainty regarding the policies and availability of travel support from NIHB, to make appointments. The need for a vehicle to transport people to programs was cited as a way to address these issues.

Finances were also cited as a major barrier to healthy living in terms of being able to buy the quality foods and fresh fruits and vegetables that are needed to support the health of people with diabetes. The local stores on-reserve don't carry the quality food diabetics need and the options to access quality foods include driving to another community to buy food or to take advantage of local food banks and markets if available.

5.2 Programs and Services

Three major discussions are presented next. These include current programs and services / supports available within the four communities we held data collection activities. As well as, concerns regarding these services, and integrating cultural knowledge in the design and delivery of health services.

5.2.1 Current Programs and Services and Supports

Respondents were generally satisfied with the services and supports that they access and point to the importance of staying positive and of taking advantage of the services that are available. The majority prefer to access services on-reserve but a few expressed interest in using other off-reserve services that would suit their needs. Some concerns were expressed regarding the attitudes of doctors who automatically assume that because they are Aboriginal that they have diabetes, while in hospital settings, there are still problems with staff who are not culturally sensitive to Aboriginal peoples. One individual noted that some people would prefer to go to the hospital for additional services, rather than access the services from a community based non-Aboriginal service provider.

Participants' described the positive aspects of the programs and services they access, including the opportunity for social interaction, access to quality foods, cooking and sharing healthy meals together, the workshops, exercising as a group, receiving rewards for reaching good health behavior goals, having easy access to foot care, foot massage, and full body massage. Effects of good services, expressed by patients, included lifting one's spirits, sharing their zest for life and positive energy, and the supports with provide to the entire community. One patient spoke about the Southern Ontario Aboriginal Diabetes Initiative (SOADI) as working with youth in the community, using hip hop as an activity for the youth to talk (rap) about health foods, what to eat and not eat, in addition to SOADI demonstrating how much sugar is in a can of pop and how big that looks when you have a pop everyday over a year.

Table 2 below identifies the programs and services that were identified through the survey and focus group process.

Table 2: Programs and Services Identified by Primary Data Collection Participants.

Community	Program	Description	Comments
Chippewas of Nawash First Nation	Walking to Wellness Diabetes Support Group	Exercise program	Helpful in motivating participants to see a doctor
Chippewas of Nawash First Nation	Nutrition in a Bag program	Ingredients for a healthy meal are provided to families *	Promotes family cooking
Chippewas of Nawash First Nation	Community market	Provides access to healthy economically priced fresh foods	Brings community together
Chippewas of Nawash First Nation	Rewards Program	Diabetes support group members agree to a specific goal and are receive a reward upon successful completion (multiple challenges and rewards are undertaken per year)	Helpful in motivating participants to engage in healthy activities and decision making. Also integral to participation in programming
M'Wikwedong Native Cultural Resource Centre	Life Long Care Program	Social program combined with nutritious meal, transportation, friendly visiting, information, referrals, accessing traditional healers,	Provides an opportunity for specialist foot care
M'Wikwedong Native Cultural Resource Centre	Good Food Box program	Fresh fruits and vegetables available at reduced cost	Diabetics and first Nations people receive subsidy
M'Wikwedong Native Cultural Resource Centre	Gardening Program	Supplies fresh vegetables for program participants	Opportunity to learn to garden
M'Wikwedong Native Cultural Resource Centre	Walking Program	Opportunity to do physical activity as a group	Physical activity
Saugeen First Nation	Fitness Program	3 month membership at local gym running group, volleyball, basketball, baseball	Focus is on fun
Saugeen First Nation	Good Food Box program	Fresh fruits and vegetables available at reduced cost	Diabetics and first Nations people receive subsidy
Saugeen First Nation	Lunch and Learn	Share nutritious meal and hear speakers	Coupled with diabetes screening
Saugeen First Nation	Walking Club	30-45 minute group walk or poling club	Meets twice a week
Saugeen First Nation	The Mide Challenge	Weight loss challenge for couples - $20 entry fee and prize money	Was not well attended

5.2.2 Concerns Regarding Services and Supports

Service concerns revolved around: patient surveillance and follow-up; after-hour clinics and services; clarification of policy regarding transportation support; and accessing services from other communities (on/off reserve).

Respondents identified the need for improvements in the outreach and follow-up provided to clients to better track their condition and to maintain contact with diabetics in the community, including those who are reluctant to access programs and services and may be at greater risk of developing complications of diabetes. Community wide screening for diabetes should be incorporated into community health services that target all community members starting from age 10 and regardless of the individual's perceived level of risk. Patients were generally very positive about community service quality but there were some concerns with bias on the part of outside health care providers. Cultural training of health professionals to reduce bias and increase comfort level of First Nations patients is still needed. Patients also need access to understandable information regarding diabetes management from their health care professional, and information and communications packages need to be developed that correspond to the literacy needs of the target population. Patient navigators are important to assist clients to better understand doctor's communications and follow-up care instructions.

Service providers in the London area described their efforts to bring the primary care team and the diabetes team together to work as a group and are considering starting a clinic one day a week. Currently the London primary care team goes out to the SOAHAC located in Muncey and relies on the local community workers to bring the clients into the clinics. The dieticians spend much of their time visiting the First Nations located around the London-area but their ability to visit all First Nations is hampered by staffing. One diabetes professional for example, currently runs 10 different programs which leaves little time to focus on new or emerging issues. It is a challenge to get patients out to the clinics and incentives have been offered in the London area as a way to bring people out; while these are successful they cannot be offered each time. Chippewas of Nawash First Nation utilizes a reward / challenge program to increase participation and improve patient outcomes: "*I always make it fun and exciting, never boring; they do not know what we are up to*.", said the Diabetes Educator. One event involved a foot care bingo using monopoly money. Surveillance is a major challenge for the service providers and better screening is expected to help identify and monitor patients with diabetes. Another challenge involved the patients being provided a set of verbal visual description of a number of specific supermarket items and the patients tasked with finding these items in the supermarket and recording the nutrition information and calculating how they could work these food products into their diet regime and which items would lead to potential secondary complications with diabetes. Nawash diabetes support group members are even challenged to a weight loss goal contest with rewards they are excited to win – the Diabetes Educator reported that many had indeed lost weight during these challenges. The London area group identified concerns with the availability of local recreational facilities and the under-resourcing they experience that hampers their ability to do outreach to patients for follow-up care and better monitor their care needs.

5.2.3 Using the Medicine Wheel as a Model for Diabetes Support

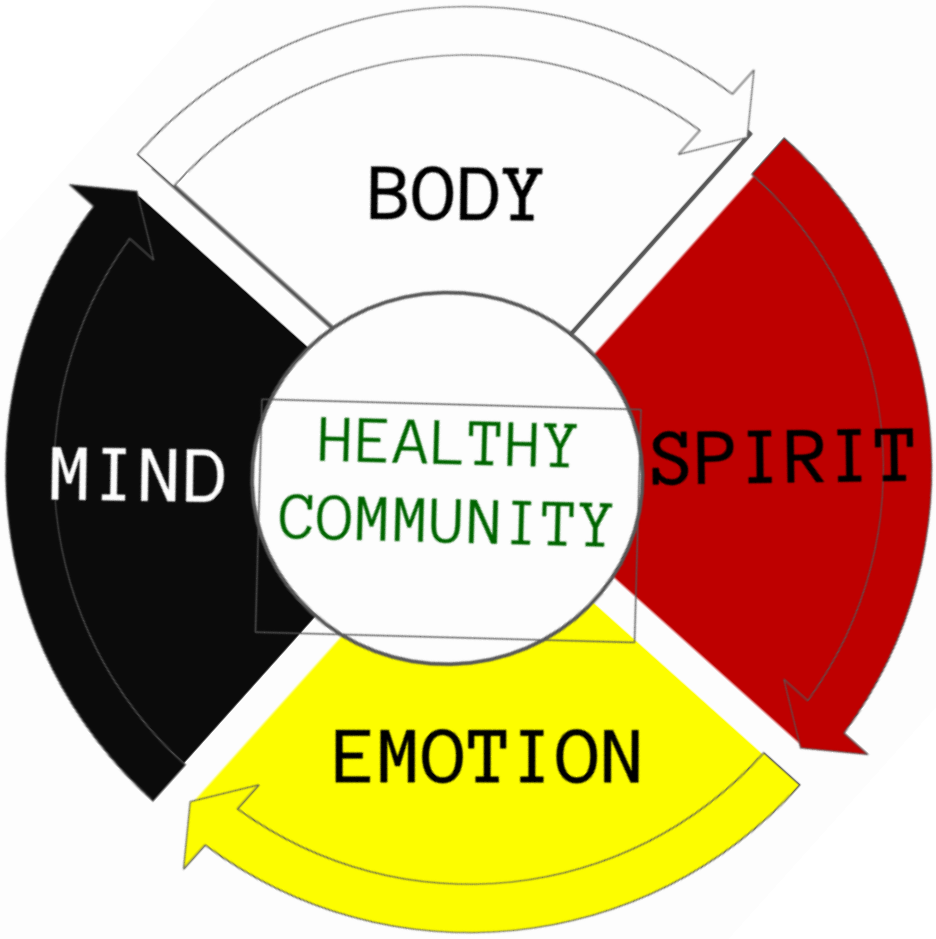
The current array of diabetes services and supports support the physical and mental aspects of the medicine wheel, but the emotional and spiritual aspects as they relate to personal health care may not as yet be fully embodied within the current structure of mainstream diabetes service and support provision. Several survey participants discussed the ways they take care of their spiritual side. "I try to drink lots of water. I see water as sacred and say my prayers to water." The need for balance was effectively

described by a respondent who spoke of the impact this had on her mother's health. '..she didn't have a handle on being a balanced individual, some of that anger resentment definitely had an impact on her health, including her diabetes'.

Community services are using a variety of approaches to connect to the spiritual and emotional supports needed by clients. In one community the four quadrants are incorporated 'softly' into their work with clients. Spiritual teachings that incorporate the need for balance as a condition for optimal health are used with both adults and youth. Traditional teachings are complemented by teachings from eastern philosophies that incorporate yoga, relaxation techniques, brain imagery and meditation for example. Activities that focus on the emotions help the clients to self-reflect and the emotional response is followed up with support from other members of the group.

'They need to get this out and need to go back and have fun and relax and learn to enjoy things again'. Other communities see the value of one-on-one discussions to provide an opportunity to talk about personal motivation and to respond to the individual's whole situation and the impact it has on self-care. Issues such as early childhood trauma and the affect it has on people's ability to change habits are supported through techniques such as hypnosis that can respond to the emotional issues individuals face.

Figure 3: Medicine Wheel Model of Individual and Relationship to Community



This Ojibwe medicine wheel, was depicted in the brochure for Biidaaban, the Mnjikaning Community Healing Model. This model speaks to the importance of the need to include community within a health and healing model of care. The following passage from the community healing model framework

explains the meaning of healthy community in the centre of the medicine wheel. In the context of diabetes, it is about including a community process when patients are diagnosed with diabetes. As evidenced in the previous sections of this report, diagnosis is a shocking and traumatic point and taking a community consultation process is a step in the right direction to harnessing that negative energy and transforming it into a positive perspective where the patients does not feel alone and is never left alone in living with this disease which is at the heart of it a disease of the community. As well, the following passage provides insights into what constitutes spirituality and the need to live in balance across all four domains of self and one's community.

Figure 4: Excerpt from the Biidaaban: The Mnjikaning Community Healing Model

> Christine Douglas recalled a community healing circle, held for a 10-year-old boy who had fired a pellet gun and hit the back window of a taxi going past his house. The driver called the police and they found the child. It was suggested that he attend a community gathering. The cab driver wasn't able to attend, but the taxi's owner came. Said Douglas, "He talked about how terrified the taxi driver had been when it had happened because he thought that he was going to be killed; he didn't know it was just a pellet gun. He talked about the fact that now the cab driver might be afraid to come to the community. And this child's mother relied on cabs because she had no car. So he was really able to see the impact of his behavior. His family was there, and we also were able to talk about all of the good things that this child is doing. It worked really well even though the child was only 10 years old. And nothing would've happened otherwise, because he was too young to charge."
>
> Asked if they felt that the Biidaaban process derives from traditional Aboriginal justice practice, Leanne Douglas said she thought it did, "because people took responsibility for their behavior and it was the community that tried to set them on the right path. If somebody was acting out and not behaving properly, it meant that they were out of balance and that they needed to be brought back into balance. When we talk about balance and harmony within the community I think it comes from that." Added Christine Douglas, "It's a consensus model and I think that's very much an Ojibwe model."
>
> About the tie between justice and spirituality, Leanne Douglas said, "We incorporate spirituality in everything we do—in our gatherings, in the work with individuals. It's a part of our teachings—using the medicine wheel [a Native symbol used in healing and other ceremonies] to help the people we work with understand about their whole self. We look at their spirit, their heart, the mind and the body, trying to keep that in balance and having them understand that they need to work in those four areas."
>
> All healing circles open with a spiritual observance. "If you're a traditional person we open with a smudge [a spiritual purification using smoke from a burning bundle of sage or other sacred herbs] and a prayer; if you're Catholic or Pentecostal or whatever it may be, we do an opening that's right for those people. There's no discrimination about beliefs," said Douglas.

For the First Nations in which primary data were gathered for this report, an explanation if offered for each of the four parts of self from a context of diabetes.

Figure 5: Medicine Wheel Components of Self Fighting Diabetes

Physical: Health promotion services and supports that are aimed at keeping people healthy. Examples include opportunities for physical activity, community screening for diabetes, access to health care providers and health services, availability of foot care clinics and vision screening, access to healthy foods, learning about healthy cooking.

Mental: Opportunities to gain knowledge about diabetes, about the impact of lifestyle on diabetes, healthy eating, exercise and obesity, providing access to information about maintaining good health while living with diabetes, learning about self-care. Community leadership take an active role in bringing the issue forward to the community and to speak openly and objectively about the condition.

Emotional: Respond to the fear, anxiety, stigma and shame that can accompany a diagnosis of diabetes. Providing opportunities for community members to learn about diabetes in a non-threatening environment, for example at community events. Providing opportunities at gatherings and workshops for people to share their questions and fears about diabetes in a format that recognizes and responds to the emotional distress that diabetes can cause. Doing outreach to individuals who are socially isolated or dealing with multiple issues and are at risk of developing complications from diabetes.

Spiritual: Provide opportunities to keep the spirit healthy or to regain spiritual health by offering culturally based services such as access to elders and traditional healers and supporting alternative health care approaches including meditation. Integrating western and traditional approaches to health care to provide a link between the spiritual and the physical.

6. Case Studies

6.1 Personal Story

"I developed diabetes because my nerves were shot and I was eating all the wrong food. Breakfast and lunch was pop. Maybe eating badly probably started when I was young after my mum passed away. We didn't have a lot of money and so rather than worrying about what I ate, I focused on making sure my siblings ate well. There was diabetes on both sides of my family. My dad and his mother had diabetes, and most of my aunts and uncles, even on my mother's side. All I knew about diabetes when I was growing up was that it meant the needle and that my grandmother would say she needed to eat something sweet because her blood sugar was too low. I've had diabetes for 10 years, and for me, it means that I'm not as energetic as before, I feel more tired and sometimes I feel thirsty.

"When I first got diagnosed my doctor gave me information about diabetes and told me about a website I could go to. We both agreed that I should manage it with diet control. The diet control worked for me but at one point I 'feel off the wagon' and started to eat whatever I wanted the next thing I know I'm on medformin twice a day. I don't have any complications from diabetes and I'm happy with the services I receive from my physician.

"I think that what is needed is more education about diabetes and how it affects you and how to keep yourself healthy with the condition. I know that there is a program in the community, but I also hear that not many people go to it. I think people should come to the healthy living program at the health center and get information about how to eat properly. When I was on diet control for example, I ate my main meal at noontime and ate a light snack at dinnertime. I think that people should go to their doctor if they're not feeling well and get it checked out. Don't hide from it. I know what it's like to not look after yourself. I used to be like that. I don't know why people don't want to look after themselves. Maybe they're too busy."

6.2 Community Story: Chippewas of the Thames Site

The Chippewas of the Thames site provides diabetics and pre-diabetics in the community with information and supports to help them self-manage their condition, stay healthy and avoid complications. Nurses, foot care specialists and dieticians provide information, counselling and foot-care services for their clients. Clients may also access other services offered at the site, including primary health care and culturally based services from elders and traditional health providers.

Diabetic patients can access primary care services Monday to Friday and ½ day Saturday. Other services offered include foot care and physiotherapy. Clinic staff are willing to work with the Diabetes Education Team and see the value of being able to offer health services and diabetes education and support in one place and at the same time.

Clinic staff face the challenge of providing services to a client population that experiences barriers related to access to services, lack of transportation, poverty, social isolation, and for many, sense of hopelessness regarding self-care, particularly with those in their middle-age years. Staff describe a sense of fatalism among many community members that accompanies a diagnosis of diabetes. A staff member describes hearing a six-year old child saying, "I have to get the diabetes'.

When the primary care team goes to the communities to offer clinics, lunch is provided for participants but they are still reliant on the local community workers to do outreach to the community members and bring them to the clinics. Low participation in the diabetes support groups was described as an issue in other communities; Sarnia First Nation offers incentive gift cards to entice people to attend meetings. A reluctance to take advantage of the services that are available results in the health workers seeing patients who return to the clinic only when they experience a major health issue. Clinic staff would like to focus on providing patients with information about diabetes that could help clients understand that diabetes is manageable, however current resource make this difficult to do.

Staffing and resource issues were cited as barriers to doing more effective outreach to those with diabetes. Currently, the Centre does not have the capacity or structure to do follow-up with clients if they don't return for follow-ups. The diabetes program does not have administrative support to provide client follow-up and clinic staff are considering using the Electronic Medical Records system to identify diabetic patients who need follow-up.

Dieticians provide information about healthy eating to clients, but the Centre does not currently have an exercise program to complement the healthy eating component. Currently the Centre has only limited exercise facilities (i.e., one exercise bike) and no professional staff to oversee a community based exercise program. Those individuals who enjoy participating in team sports can play baseball in the summer, but there are no year-round opportunities and options for exercise in the communities. Staff note the difficulty of getting people into exercise programs and of the need for exercise programs that match the needs and preferences of individuals and of the importance of exercise becoming a social activity that engages the broader community.

Personal motivation is a complex issue that is difficult to address. Staff note that for many people, motivation to self-care comes from their desire to remain healthy for their children. Regardless of the source of motivation, staff understand that motivation is personal issue and that a variety of factors can affect an individual, including the presence of other stressors, i.e. financial issues, other health issues, experience of trauma, etc. Current discussions about more effective ways to reach the clients is aimed at reducing the number of diabetes patients who do not currently participate in diabetes programming and screening.

7. WAYS TRIED AND TRUE IN DIABETES PREVENTION

Taken from the literature a number of initiatives and research findings are revealed which are directed at diabetes prevention.

The *Food Skills for Families* program is an urban based health promotion program that consists of small groups (under 12) coming together once a week for 6 weeks to cook and share meals together while they learn about nutrition and healthy eating. Besides learning about food and its impact on health, the program helps build a social network of support among the participants (PHAC)**.** In its 2006 report, A First Nations Diabetes Report Card**,** the Assembly of First Nations (AFN) also supports participatory teaching programs such as community kitchens as a prevention tool. The importance of social support and a sense of community engagement was identified as one of the wellness enablers in an evaluation of Anishnawbe Health Toronto's diabetes prevention program, *Biim-Maa-Sii-Win*, that was conducted with community members. This program, which is achieving success in terms of making change in knowledge and behaviours, combines both western and traditional approaches to health. The evaluation also pointed to culture and spirituality as enablers of wellness and identified emotional health as a barrier to wellness. It appears that both the *Food Skills for Families* program and *Biim-Maa-Sii-Win* are having an impact in addressing some of the challenges people face when trying to eating better and exercising, including poverty, in particular for people who live in shelters, social isolation and depression (Lynn F. Lavallee Consulting, 2014). The *Food Mail Program* was identified as a good model in the 2006 AFN report because it helps reduce the cost of foods, provides information about healthy food choices and helps build capacity at the community level about health information.

The holistic approach that is the basis of Indigenous philosophy regarding health and well-being was articulated in Ontario back in 1994 when the province developed the Aboriginal Health Policy. That policy is based on several principles, one of which is the holistic medicine wheel approach. The Policy identifies the connection between individual, family and community and the need for all three to be empowered to make personal choices about physical health and lifestyle. At the same time, it includes the importance of the health system to being flexible and supporting the Aboriginal approach to health and that this is respected in all areas of programming, from the design phase, to program development and implementation. The policy identifies the need to empower the individual, the family and the community to understand all the factors that affect health so as to enable people to make personal choices about physical health and lifestyle (Ontario, 1994). The holistic approach is also noted in the AFN's 2006 Report Card, and spoke about the importance of recognizing language, culture and geographic diversity in program design.

Programs involving healthy living and lifestyle must involve the whole community and target the whole family. Community needs and preferences in terms of tradition, culture, language must be respected Interventions should be multi-faceted to promote healthy lifestyle for families and communities (Mi'kmaq Confederacy of PEI, 2014).

They need to correspond to local community resources and infrastructures. Culturally appropriate primary prevention programs for Aboriginal children and adults should be initiated by Aboriginal communities with support from community leaders, health care professionals, the health systems(s) and partnered with local funders/agencies. Appropriate dialogue, respect and planning are required in developing programs. Risk factors must be considered when developing programs, e.g., geographic and cultural barriers, food insecurity, psychological stress, insufficient infrastructure, settings that aren't conducive to physical activity. Partnerships need to incorporate culture in order to build trust and capacity and increased local knowledge. Environmental change needs to be promoted. Efforts to

prevent diabetes should focus on all diabetes risk factors, including prevention of childhood, adolescent, adult and pre-pregnancy obesity. Youth-targeted programs need to focus on decreasing the consumption of sugar beverages, providing knowledge about diabetes risk factors, and supporting youth oriented fitness facilities (Harris et al., 2013). Programs need to be fun and engaging, promote culture and traditions, engage the community by using volunteers, invite outside groups into the community, i.e. Hip Hop dance. Enthusiastic role models are important and programs can also provide leadership development opportunities. Participation in programs should be inclusive and not competitive (Johnston Research Inc., 2011).

The AFN places the community at the center, for example having community-based screening programs and primary prevention located in the community, along with access to community wellness centres. School diabetes prevention programs are specifically noted, including providing access to healthy foods and exercise (Johnston Research Inc., 2011). The 2014 report *Strengthening Partnerships and Taking Action Toward Healthy Weights in Children* recommends that the community be part of consultation on healthy eating policies at schools.

Diet and exercise are two areas of diabetes prevention. The principles of a traditional diet, including removing sugars and refined carbohydrates, is supported by a growing body of literature on the effectiveness of carbohydrate-restricted diets in assisting with weight loss and improved diabetes management, and is identified as an approach in the First Nation Regional Health Survey report 2008-10 (FNIGC, 2012). The Regional Health Survey includes the clear need for more educational efforts to be directed at reducing the consumption of caloric beverages and sugar in the First Nations population at large, and notes the need for an overall reduction in fructose consumption as a logical target. The report by Harris et al (2013), *Clinical Practice Guidelines: Type 2 Diabetes in Aboriginal Peoples*, identifies promoting traditional activities and foods. Other food related activities include community gardens and exploring the use of food production projects to create economic development opportunities. Active living initiatives must involve the whole family (Mi'kmaq Confederacy of PEI, 2014), and adults need access to recreational opportunities such as walking (AFN, 2006).

Early detection and screening are identified as prevention activities (AFN Diabetes Report Card, FN Regional Health Survey 2008-10). Screening for Aboriginal children and adults should follow guidelines for high risk populations. Also, starting in early childhood, Aboriginal people should be evaluated for modifiable risk factors (e.g., obesity, lack of physical activity, unhealthy eating habits, pre-diabetes, metabolic syndrome. Programs to detect pre-gestational and gestational diabetes, provide optimal management of diabetes in pregnancy and timely post-partum checkup should be instituted for all Aboriginal women to improve perinatal outcomes and reduce type 2 diabetes rates in their children. Aboriginal women should attempt to reach a healthy body weight prior to conception to reduce their risk for gestational diabetes, and breastfeeding should be promoted for the first year of life (Harris et al, 2013).

The 2013 Spring Auditor General's Report found that there is limited collaboration between Health Canada and the Public Health Agency of Canada to improve the limited surveillance information that exists on Aboriginal people and that Health Canada gathers limited performance information on the results of its Aboriginal Diabetes Initiative projects. Specific issues include the absence of federal plan aimed at improving diabetes surveillance for Aboriginal peoples and the uneven provincial/territorial database information for Aboriginal peoples that limits the ability to develop a national surveillance plan. Challenges in Aboriginal surveillance, including privacy, access to provincial and territorial data, and First Nations data governance. In response, the federal government agency and department

committed to developing and implementing an Aboriginal diabetes surveillance plan by 2014 in collaboration with the First Nations, Métis and Inuit (FNMI) partners.

The Harris et al. (2013) report recommend that routine medical care for Aboriginal peoples of all ages should include identification of modifiable risk factors such as obesity, abnormal waist circumference or body mass index, physical inactivity, smoking and unhealthy eating habits. Additionally, screening for diabetes with a fasting plasma glucose test or an oral glucose tolerance test should be considered every 1-2 years in individuals with one or more risk factors. Children from age 10 with one or more risk factors, including exposure to in utero diabetes, should be screened every 2 years, and children who are very obese should have regular screening and follow-up.

8. Ways Tried and True Interventions

Taken from the literature a number of initiatives and research findings are revealed which are directed as diabetes interventions.

8.1 Diabetes Education – Helping People to Understand the Condition

The principles of holism, the medicine wheel approach, respect for culture, language, partnership, geographic diversity, information about traditional foods and providing basic food literacy are key elements in providing diabetes education for Aboriginal people (Mi'kmaq Confederacy of PEI, 2014). AFN's 2006 Diabetes Report Card speaks about diabetes education programs that are grounded in First Nation teachings and Harris et al (2013) identifies the need for programs to be community directed. The 1994 Aboriginal Health Policy identifies the need for broad community based understandings of the factors that affect health and about the importance of partnership, cross-cultural respect, and of the need for understanding of the impact of language and culture on access to programs.

Specific programs such as *Biim-Maa-Sii-Win* and the *Food Skills for Families Program* mentioned above are effective in providing people with knowledge and are having an impact on behavioural and attitudinal change. The diabetes workshops provided by *Biim-Maa-Sii-Win* are showing an impact in terms of increased coping skills, positive thoughts, motivation and determination (Lynn F. Lavallee Consulting, 2014).

Efforts to support community healthy eating and exercise programs can be strengthened by providing training capacity among Early Childhood Educators (Mi'kmaq Confederacy of PEI, 2014). Issues such as providing access to traditional healers, providing transportation to programs need to be included in program design (Ontario, 1994). The Anishnawbe Health Toronto (AHT) evaluation showed that most people prefer to get their information from community programs, then friends/family and also on their own. This is consistent with the findings that the social aspect of community programs can help address the emotional issues that can affect people with diabetes, such as depression, and is especially important when individuals are socially isolated (Lynn F. Lavallee Consulting, 2014).

The 2013 Spring Auditor General's Report noted that the Aboriginal Diabetes Initiative Evaluation indicted that the programs are having an impact on increased awareness and knowledge related to lifestyle management of diabetes and are helping to change behaviour, however the absence of surveillance databases hinders the ability to assess the impact on Aboriginal people's health.

8.2 Diabetes Treatment – Helping People to Manage the Condition

Health programs should be holistic, grounded in the principles of healing and wellness and guided by Aboriginal beliefs, values, customs, languages, traditions, and geographic diversity. Management of diabetes and pre-diabetes should follow the same clinical practice guidelines as for the general population with sensitivity to language, culture, traditional beliefs, medicines, geographic issues and adopt a holistic approach to health that address the broad range of stressors shared by Aboriginal peoples (Harris et al., 2013. The Information needs to be provided not only to the individual but also to the community and families so that they have the information and ability to make choices. Aboriginal health workers need to be recruited and training to provide services and barriers to access (e.g., transportation) must be addressed when considering diabetes treatment. A provider team that includes western and

traditional based approaches (community health providers, healers, medicine people, elders, ceremony), similar to the *Biim-Maa-Sii-Win* model, is recommended. AFNs Diabetes Report Card and the FN Regional Health Survey support this integrated model. This approach requires that system barriers and rigid role definitions be removed to improve the ability of all providers to work together to support a healing network, or circle of care (Ontario, 1994). As an alternative therapy, the Canadian College of Naturopathic Medicine reports that the clinic at Anishnawbe Health Toronto is achieving positive outcomes and addressing specific health issues.

Diet and exercise are important aspects of treatment and the FN Regional Health Survey states that more effort may need to be directed at encouraging the use of non-pharmaceutical therapies (diet/exercise) to manage diabetes and that a return to the principles of a traditional diet (low carb) could be a more important factor than exercise in improving the management of diabetes among First Nation adults Harris el a. (2013) suggest both lifestyle and metformin be initiated as treatment of pre-diabetes and that they be provided with regular screening, follow-up and surveillance.

Access to treatment are issues that need to be addressed in providing effective treatment. This includes providing access for aboriginal peoples in their communities to diabetes management programs that includes an inter-professional nurse-led team, diabetes registries and ongoing quality assurance and surveillance programs. Diabetes management includes access to Aboriginal health providers and health and wellness centres, but also to healthy foods and places where physical activity can be enjoyed. Regarding access to western medicines, the NIHB formulary needs to be reviewed and updated to enable access to the best treatments. (FN Regional Health Survey and AFN Diabetes Report Card).

Regarding western approaches to diabetes management, Harris et al (2013) recommend that services acknowledge local resources and challenges, including access to healthy foods, geographic isolation; that programs work within the context of local traditions, language and culture; that nurses' and community health workers scope of practice be expanded in diabetes care, that all health care workers are provided diabetes management training, that mobile screening and treatment units be provided and for the establishment of diabetes registries, recall systems, call plans and outreach services. Systematic and validated surveillance of the prevalence, incidence and morbidity and mortality rates due to type 2 diabetes in First Nation communities to improve quality of care.

The South West Regional Wound Care Program was created the support the delivery of best practice and better outcomes for clients receiving health services in hospitals, at community facilities and in long-term care facilities. The program has resulted in the sharing of exemplary best practices, knowledge transfer, and has worked to address care transition issues. Significant accomplishments to-date include the establishment of a Wound Care Program Team, identification of Wound Care Champions (WCC: n=130) and the creation of a Regional Wound Care Toolkit. The program is premised on a cross sectoral partnership model which supports: 1) collaborative networking in the creation of a cross sector WCC standardized CAWC/SWRWCP[1] foundation level skin and wound care training; and 2) knowledge transfer among the 130 and growing database of Wound Care Champions. The program anticipates engaging the First Nation community in the development of a Health Equity Impact Assessment and training of First Nations health professionals as Wound Care Champions (Memo: 2014).

The Southwest LHIN Vision Care Project (Southwest LHIN, 2015) builds on the Current State of Vision Care report to pursue the objectives of establishing a framework that encompasses access to service provision, application of best practice and clinical guidelines and improved continuity of care. This

[1] Canadian Association of Wound Care (CAWC) / South West Regional Wound Care Program (SWRWCP)

report is intended to build on the work done to develop the Current State of Vision Care report that was developed in July 2014. The SOAHAC is working with the SWLHIN to prepare a report that identifies unmet needs among Aboriginal people in the region and examine the application of best-practice within that context as part of its work to plan for the delivery of culturally appropriate services and models of service delivery (SWLHIN, 2015). Best practices highlighted in this report include the Eye See…Eye Learn whereby local Doctors perform eye exams with all junior kindergarten students with proof of Health Card and students in need of glasses befits from corporate donations up to $250 in value, instilling the idea of regular check-ups at an early age, and all children in the age category are screened. Similarly, the discussion on Diabetic Retinopathy requires professionals to take action in ensuring those with diabetes are regularly screened at the given intervals (e.g., those 15 years and older with type 1 diabetes require a professional screening annually starting five years after the onset of diabetes). However, there currently is no all-inclusive approach, as the Eye See…Eye Learn initiative which ensures that all individuals with diabetes are screened at the appropriate intervals. The future state recommendations are as follows:

> Future State Recommendation 2.1: Steps should be taken to reinforce and support the need for regular eye examinations by high risk groups to primary health care providers, in keeping with the recommendations of the Canadian Diabetes Association, the Canadian Ophthalmological Society and Health Quality Ontario.
>
> Future State Recommendation 2.2: Standard vision screening information and questions should be integrated into primary health care Electronic Medical Records (EMR) so determination of the need for vision screening and referral of high risk populations for eye vision examination can become a routine part of primary care practices.
>
> Future State Recommendation 2.3: In addition to high risk groups, promotion of vision screening of young children and all children before they begin school (Junior Kindergarten) should be a routine part of primary health care practices.

The 2013 Spring Auditor General's Report recommends that developing performance measures and surveillance information would enhance the programming funded under the Aboriginal Diabetes Initiative.

9. RECOMMENDATIONS

Community participants and service providers shared concrete suggestions for ways services and programs can better respond to the issue of diabetes among Aboriginal people and better support individuals and families.

9.1 OUTREACH TO COMMUNITY

1. Improve surveillance and outreach activities to clients to promote improvements in follow-up and participation in currently available services.
2. Conduct specific outreach to those who are socially isolated and may be at risk of developing complications of diabetes.
3. Respond to the literacy levels of the community by developing communications packages that respond to the literacy needs of the community.
4. Bring the community leadership on-side to understand the impact and extent of the issue in the community.
5. Provide diabetes information as a standard practice to the whole community at places other than health facilities. Make this information available at community events, through the school system, and from the community leadership.
6. Reduce the shame and stigma of diabetes by providing the opportunity for community members to discuss the condition openly and objectively. Address specific local misconceptions or misunderstandings about diabetes and the impact on the individual.

9.2 HEALTH SERVICES

7. Provide standardized regular screening of all community members, regardless of risk, and starting at age 10.
8. Provide after-hour services for clients on evenings and weekends and provide a telephone hotline where clients with questions can get immediate and culturally effective advice and information in response to diabetes specific health concerns.
9. Ensure that clients get the personal support they need when attending medical appointments to ensure they understand the communications provided by doctors and other health professionals.

9.3 HOLISTIC APPROACH

10. Support the holistic approach in service provision that responds to the need for emotional and spiritual supports for clients to help them with the significant personal adjustments they need to make. Support clients to break through the emotional barriers that can prevent them from seeking help.

9.4 SUPPORT COMMUNITIES TO GAIN ACCESS TO HEALTHY NUTRITIOUS LOW-COST FOODS

11. Address the immediate need for access to healthy nutritious food by supporting the expansion of community gardens and community markets in the communities to provide access to low cost fresh food.

12. Support communities to partner with local farmers, food co-ops and other non-mainstream food sources as a way to provide local communities with access to quality low cost nutritious food.
13. Communities should consider establishing an independent food co-op controlled by the community to increase access to quality low cost nutritious foods.

9.5 TRANSPORTATION

14. Address the transportation barriers community members face. Explore locally based alternative approaches to ensure that no client is prevented from attending clinics and services due to the lack of a car or access to one.

9.6 TRAINING FOR HEALTH PROVIDERS

15. Provide ongoing training to health care providers to support the provision of unbiased and supportive health care by hospitals and non-Aboriginal health care providers.

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