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Aboriginal Diabetes Initiative

Program Framework 2010-2015

Canada 

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1.0 Why was the Aboriginal Diabetes Initiative (ADI) Created?

The Government of Canada is committed to working with Aboriginal people, provinces and territories to improve health outcomes and reduce health inequalities between First Nations and Inuit, and other Canadians. Health Canada's First Nations and Inuit Health Branch (FNIHB) works in collaboration with partners to:

- Ensure the availability and access to health services for First Nations and Inuit communities;
- Assist First Nations and Inuit communities to address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and
- Build strong partnerships with First Nations and Inuit to improve the health system.

Type 2 diabetes is a health concern among Canada's First Nations and Inuit. The risk of developing eye, kidney, nerve, circulatory and cardiovascular complications increases when diabetes is undiagnosed, untreated, or poorly managed. First Nations on reserve have a rate of diabetes three to five times higher than that of other Canadians. Rates of diabetes among the Inuit are expected to rise significantly in the future given that risk factors such as obesity, physical inactivity, and unhealthy eating patterns are high.

The Aboriginal Diabetes Initiative (ADI) was created in 1999 to help improve the health status of First Nations, Inuit and Métis individuals, families, and communities through actions aimed at reducing the prevalence (rate) and incidence (reported new cases) of diabetes and its risk factors.

2.0 What is the History of the Aboriginal Diabetes Initiative?

ADI Phase 1 (1999-2004)

In 1999, the Canadian Diabetes Strategy (CDS) was funded at \$115 million over five years and included the Aboriginal Diabetes Initiative as a key component. Given the magnitude of the problem among First Nations, the ADI was allocated \$58M of the total Canadian Diabetes Strategy funding. This funding allowed for a foundation of awareness to be built in order to implement health promotion and primary prevention programming in Aboriginal communities.

As part of the Canadian Diabetes Strategy, the ADI aimed to increase awareness of type 2 diabetes, and reduce the prevalence and incidence of diabetes and its complications among First Nations, Inuit and Métis.

ADI Phase 2 (2005-2010)

Budget 2005 provided \$190 million over five years for the ADI to strengthen community-based health promotion and diabetes prevention activities, increase the number of

health service providers, and improve screening and treatment services. This funding was separate from the CDS funding. Phase 2 of the ADI included four key components:

- Health promotion and primary prevention;
- Screening and treatment;
- Capacity building and training; and
- Research, surveillance, evaluation and monitoring.

Health promotion and primary prevention

A wide range of community-led, culturally relevant health promotion and primary prevention activities were offered in over 600 First Nations and Inuit communities to promote diabetes awareness, healthy eating and physical activity in support of healthy lifestyles.

Screening and treatment

The screening and treatment component of the ADI provided increased support for regular screening for the early diagnosis of diabetes complications, and provided education and support for people living with diabetes and their families. In four regions (Alberta, British Columbia, Manitoba and Quebec), screening for limbs, eye, cardiovascular, and kidney complications of diabetes were delivered through mobile complications screening initiatives in rural and remote areas. In other regions, screening was carried out through local health care providers. Several communities also formed partnerships with neighboring provincial healthcare services to increase screening opportunities.

Capacity building and training

Through capacity building and training, the ADI supported training for over 330 community diabetes prevention workers (CDPWs) who played a key role in diabetes prevention activities, and worked in partnership with healthcare professionals and other members of their community. Continuing education supported health professionals and para-professionals working with communities in diabetes awareness, health promotion and foot care. In addition, regional multi-disciplinary teams provided subject-matter expertise to communities on diabetes, physical activity and nutrition.

Research, surveillance, evaluation and monitoring

The key priorities under the research, surveillance, evaluation and monitoring component included:

- Establishing partnerships with appropriate research agencies and organizations to jointly fund priority research;
- Supporting the Canadian First Nations Diabetes Clinical Management Epidemiologic (CIRCLE) Study to determine the quality of diabetes healthcare in 19 First Nations communities; and

- Supporting evaluation studies and monitoring of programming at the local, regional and national levels.

Although the ADI's main objective was to support First Nations and Inuit residing in traditional communities, Phase 2 of the ADI also provided limited support for Métis, Off-reserve Aboriginal and Urban Inuit Promotion and Prevention (MOAUIPP) projects. MOAUIPP provided time-limited, proposal-based funding for culturally relevant health promotion and diabetes prevention projects. Over 60 projects were funded involving over 55,000 participants.

3.0 ADI Phase 3 (2010-2015)

In an effort to reduce the prevalence and incidence of diabetes and its risk factors, the Government of Canada committed \$275 million over five years (2010-2015) for the Aboriginal Diabetes Initiative to continue supporting health promotion and diabetes prevention activities and services. Phase 3 of the ADI features four areas of enhanced focus, including:

- Initiatives for children, youth, parents and families;
- Diabetes in pre-pregnancy and pregnancy;
- Community-led food security planning to improve access to healthy foods, including traditional and market foods; and
- Enhanced training for health professionals on clinical practice guidelines and chronic disease management strategies.

Details regarding the enhanced areas of focus are incorporated into the ADI components described in Section 7 of this program framework.

4.0 What Population does the Aboriginal Diabetes Initiative Serve?

The ADI's main objective is to support First Nations residing in traditional First Nations communities, and Inuit residing in traditional Inuit communities.

Time-limited funds also support:

- First Nations residing outside of traditional First Nations communities;
- Inuit residing outside of traditional Inuit communities; and
- Métis residing anywhere in Canada.

The ADI targets Aboriginal people of all ages, including children, youth, adults, parents and Elders and supports broader initiatives focused on families and communities.

5.0 What are the Objectives of the Aboriginal Diabetes Initiative?

The goal of the ADI is to reduce type 2 diabetes among Aboriginal people by supporting health promotion and primary prevention activities and services delivered by trained community diabetes workers and health service providers.

The objectives of the ADI include:

- Creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy food and promotion of healthy eating, physical activity, and healthy body weights;
- Increasing awareness of diabetes, diabetes risk factors and complications, and approaches to prevent diabetes and associated complications among all Aboriginal people;
- Increasing the early detection and screening for complications of diabetes in First Nations and Inuit communities;
- Increasing community ownership of diabetes programs and capacity to prevent, delay and manage diabetes;
- Increasing knowledge development and information sharing to inform community-led, evidence-based activities in Aboriginal communities; and
- Developing partnerships to maximize the reach and impact of primary prevention and health promotion activities.

6.0 What are the Guiding Principles of the Aboriginal Diabetes Initiative?

The principles used to guide the implementation of the ADI include:

- Evidence-based practices;
- Community-based and community-led approaches to prevent, delay and manage diabetes;
- Culturally appropriate activities;
- Consideration for varying levels of community-readiness;
- Increasing First Nations, Inuit and Métis capacity to deliver health promotion and primary prevention activities;
- Collaboration and development of partnerships; and
- Innovative approaches to prevent diabetes and support healthy living practices.

7.0 What are the Main Components of the Aboriginal Diabetes Initiative?

The ADI will achieve its objectives through activities in four component areas:

1) **Community-based Health Promotion and Primary Prevention**

Activities that focus on promoting health and preventing diabetes by creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy food; promotion of healthy eating, physical activity, and healthy body weights; and diabetes awareness.

2) **Screening and Management**

Activities that support the early detection of diabetes and related complications before they are apparent and maintain the appropriate management to improve health outcomes.

3) **Capacity Building and Training**

Activities to enhance community worker and health professional capacity to deliver effective health promotion and diabetes prevention programming.

4) **Knowledge Mobilization**

Activities that will improve and promote knowledge sharing on what works to promote health, and prevent diabetes and associated risk factors.

Each component builds on one another to provide a comprehensive approach to improving the health status of First Nations, Inuit and Métis individuals, families and communities. Implementation of the program components is shared by the community and the ADI regional and national levels in order to focus activities where the greatest benefit can be achieved.

7.1 Community-Based Health Promotion and Primary Prevention

The community-based health promotion¹ and primary prevention² component funds communities and organizations to provide a range of community-based, culturally appropriate activities. These activities promote health and prevent diabetes by creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy food; promotion of healthy eating, physical activity, and healthy body weights; and diabetes awareness. Activities focus on a combination of approaches designed to enhance awareness, increase motivation, build skills and create environments that make positive health practices an easier choice.

Community-based health promotion and primary prevention is provided via two streams:

- First Nations and Inuit Community-Based funding; and
- Urban First Nations, Inuit and Métis Diabetes Prevention funding.

¹ Health Promotion is the process of enabling people to increase control over, and to improve their health.

² Primary Prevention aims to prevent or delay the onset of health problems by promoting health and reducing risk factors.

7.1.1 First Nations and Inuit Community-Based Funding

Over the last ten years, communities have been instrumental in communicating the importance of healthy living to prevent or delay type 2 diabetes. Through the ADI, communities will continue to build on and intensify community action to support individuals, families and communities in adopting healthy practices that will improve health and lead to fewer new cases of diabetes.

Community-based change can be supported in a number of ways including:

Planning: A well articulated, comprehensive and integrated plan that targets activities in each of the key areas (e.g. increasing access to healthy food; promoting healthy eating, physical activity, and achieving healthy weights; and diabetes awareness) and includes actions aimed at individuals, families and communities;

Leadership: A strong leader or community champion to engage community members, lead the development of the plan, mobilize community actions and support individuals, families and the community; and

Engagement: An approach where the broader community is involved in developing and implementing the plan to mobilize and coordinate efforts across sectors (e.g. health, social services, justice, education, etc).

Phase 3 of the ADI will build on progress made in communities. The focus will be on refining and implementing plans to intensify activities to support healthy living, strengthen multi-sectoral partnerships, and build community-wide involvement and conditions to respond to the needs and priorities identified by the community.

These activities will continue to be supported by community workers, often called Community Diabetes Prevention Workers (CDPWs). Although the job title and responsibilities of community workers can vary among communities, their main function is to carry out community-based planning and implement activities and services that focus on health promotion and diabetes prevention.

Community workers further contribute to their communities by being healthy living role models, and they are encouraged to work in partnership with other community and regional health service providers. Community workers are supported by a regionally-based multi-disciplinary team, which is available as a resource to support improved access to healthy food, healthy eating, physical activity, achieving healthy weights and diabetes awareness activities.

Phase 3 of the ADI will also emphasize community-led approaches to enhance health promotion and diabetes prevention initiatives for children, youth, parents and families as a way to encourage and support healthy living practices at a young age.

The key community-based health promotion and primary prevention initiatives supported by Phase 3 of the ADI include food security and improved access to healthy food, healthy eating, physical activity, and diabetes awareness and are described below.

Food Security and Improved Access to Healthy Food

Food security “exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life.”³ Having access to healthy, affordable food is important to support healthy eating and promote overall health. For First Nations and Inuit, food security includes traditional or country foods, and market foods.

A variety of approaches can be taken to address food security issues. The ADI has helped support several community actions such as community kitchens and gardens, healthy food box programs, store-based education and skill development activities, and traditional food harvesting, preparation and preservation. Such activities will continue to be an important part of Phase 3 of the ADI. Community-led food security planning is emphasized to build on this work, to promote a more comprehensive approach to addressing food security and enhance the capacity of communities to shape their food systems and improve access to healthy food.

As part of a food security planning process, communities are encouraged to:

- Come together to talk about local food issues, and identify current community assets and resources;
- Engage community leadership to create a vision about what improved access to healthy foods would look like in their community;
- Identify priorities and actions to reach this vision, based on local strengths and partnerships that can be created;
- Include Elders and youth when possible; and,
- Create opportunities to share successes and learn from other communities.

Regional-level food security plans will help guide community-led initiatives and promote evidence-based approaches. Partnerships between communities, regions and different sectors (such as various levels of government, agriculture, environment, retail and universities) will help facilitate the implementation and evaluation of culturally appropriate, sustainable activities, and link community activities to other initiatives.

³ Agriculture and Agri-Food Canada. *Canada's Action Plan for Food Security: A Response to the World Food Summit*. Ottawa: Agriculture and Agri-Food Canada, 1998. Available at: www.agr.gc.ca/misb/fsec-seca/pdf/action_e.pdf

Healthy Eating

Healthy eating is an important way to lower the risk of diabetes and its many complications. Communities can build on the strong foundation of nutrition activities already in place to develop skills and increase knowledge about healthy eating. Communities can also work with other community-based programs that target specific populations, such as the Canada Prenatal Nutrition Program (CPNP), to enhance healthy eating activities.

Activities to promote healthy eating could include:

- Offering awareness and education sessions on healthy eating and how to use *Eating Well with Canada's Food Guide - First Nations, Inuit and Métis*⁴;
- Organizing grocery store tours, cooking classes and community workshops on planning and preparing healthy meals and snacks for individuals and families;
- Hosting sharing sessions with Elders about the role of traditional or country foods as part of a healthy way of eating;
- Arranging on the land activities to share knowledge and skills related to traditional food harvesting, preparation and preservation;
- Coordinating gardening initiatives, *Good Food Boxes* and food vouchers;
- Creating or leading support groups to achieve and/or maintain healthy weights;
- Delivering school-based feeding programs that promote healthy food choices;
- Developing health promotion campaigns through radio shows or public service announcements, resource materials and displays to support community workers in providing information to enhance knowledge and skills about healthy eating; and
- Working with community leaders and partners to establish policies to better support healthy food choices in daycares, schools, workplaces, and other shared community areas.

Physical Activity

Regular physical activity contributes to reducing rates of obesity, a major risk factor of diabetes. Phase 3 of the ADI will continue to support First Nations and Inuit communities to increase physical activity participation rates and promote regular physical activity, as outlined in the Canadian Society for Exercise Physiology (CSEP)'s physical activity guidelines⁵.

⁴ Eating Well with Canada's Food Guide - First Nations, Inuit and Métis: <http://www.hc-sc.gc.ca/fn-an/pubs/fnim-pnim/index-eng.php>

⁵ Canadian Society for Exercise Physiology. Canadian Physical Activity Guidelines, 2011: <http://www.csep.ca/english/view.asp?x=804>

Activities to promote physical activity and create supportive environments could include:

- Offering awareness and education sessions to learn ways to achieve and maintain healthy body weights, meet physical activity targets and engage in safe physical activity practices;
- Improving access to activities through community centres, gyms and schools;
- Organizing/hosting family-oriented physical activity events and traditional activities such as snowshoeing, dancing and outdoor survival skills;
- Coordinating regular sport and physical activity clubs;
- Increasing community outreach in an effort to increase participation across the community (e.g. youth, families, etc.); and
- Working with partners to establish policies to promote and support physical activity in daycares, schools, workplaces, and other shared community areas.

Key strategies for successfully engaging children and youth in physical activity could include:

- Increasing community leadership by involving youth groups or a youth council to support the development and implementation of sustainable physical activity and supportive environment initiatives;
- Supporting the development of youth leaders;
- Engaging role models to inspire and motivate youth to take action; and
- Supporting youth exchange of information and knowledge development.

Diabetes Awareness

Increasing awareness of diabetes can help prevent or delay the disease and its associated complications. Phase 3 of the ADI will continue supporting First Nations and Inuit communities to implement innovative, culturally-relevant approaches aimed at increasing awareness of diabetes and its risk factors and complications.

Activities to promote diabetes awareness could include:

- Organizing community workshops to provide information on diabetes and its risk factors and complications;
- Promoting the benefits of regular screening for pre-diabetes and diabetes;
- Organizing community events, such as diabetes bingo and diabetes walks, to raise awareness of diabetes; and
- Engaging Elders in Talking Circles to provide community-based diabetes education.

7.1.2 Urban First Nations, Inuit and Métis Diabetes Prevention (UFNIMDP) Funding

Health services for First Nations and Inuit living outside their traditional communities and Métis are typically delivered by provincial or territorial governments. Federal health departments and agencies play a limited role, typically providing time-limited support for culturally appropriate projects.

Phase 3 of the ADI will continue supporting health promotion and diabetes prevention projects for First Nations and Inuit living outside their traditional communities and Métis through the Urban First Nations, Inuit and Métis Diabetes Prevention (UFNIMDP) Stream. A continued effort to strengthen linkages and better integrate with federal/provincial/territorial and First Nations, Inuit and Métis partners will also be emphasized to enhance health promotion and diabetes prevention activities.

Activities will focus on the following areas:

Health Promotion and Primary Prevention Projects

The ADI will fund time-limited culturally appropriate health promotion and diabetes prevention projects for First Nations and Inuit living outside their traditional communities and Métis. The focus is on strategies to create supportive environments and increase the practice of healthy behaviours through improved access to healthy food; promotion of healthy eating, physical activity, and healthy body weights; and diabetes awareness.

Projects will be selected using a request for applications (RFA) and peer review process.

Demonstration Projects

ADI-funded demonstration projects will build evidence on the effectiveness of promising practices focused on health promotion and diabetes prevention among First Nations and Inuit living outside their traditional communities and Métis. These projects will help build First Nations, Inuit and Métis organizations' capacity to evaluate promising practices and disseminate new knowledge. A strong evaluation and dissemination component is required for each project.

Drawing from previous MOAUIPP projects supported under Phase 2 of the ADI (2005-2010), and based on performance and innovations, a number of First Nations, Inuit and Métis organizations will be invited to submit proposals for demonstration projects.

7.2 Screening and Management

The early detection of diabetes and related complications (before they are apparent), and support for effective diabetes management practices are essential to address diabetes in First Nations and Inuit communities. In Phase 3 of the ADI, screening and

diabetes management activities will continue to focus on secondary⁶ and tertiary prevention⁷.

Secondary Prevention

The ADI will facilitate access to diabetes screening to support the early diagnosis of pre-diabetes, and referral to prevention, education and support services to stop or delay disease progression. In addition, the ADI will continue supporting initiatives to help First Nations people and Inuit learn the signs and symptoms of diabetes and have access to information from health care professionals before the onset of diabetes.

This can be achieved through a variety of ways, including:

- Ensuring that community members are aware of the importance of regular screening, and promoting attendance at screening sessions;
- Creating diabetes support groups to share successes, challenges and concerns; and
- Training health professionals, including home and community care nurses, working in First Nations and Inuit communities on clinical practice guidelines for diabetes screening and treatment in high-risk populations.

A key area of focus under Phase 3 of the ADI is enhancing efforts around diabetes in pre-pregnancy and pregnancy. Activities in support of this area could include:

- Strengthening collaboration and coordination among programs, such as the Canada Prenatal Nutrition Program (CPNP), and health providers involved with prenatal care by developing policies, protocols and tools of mutual benefit;
- Developing and distributing public education materials for health professionals and women at risk;
- Increasing training on gestational diabetes for community workers, including Community Diabetes Prevention Workers (CDPWs), and health professionals to enhance knowledge/practice; and
- Developing knowledge and sharing promising practices in the prevention and management of gestational diabetes.

Tertiary Prevention

The ADI will support those currently living with diabetes to:

- Improve the management of diabetes;
- Reduce or delay diabetes related complications; and
- Improve the quality of life.

⁶ Secondary Prevention involves detecting disease before it is apparent and treating it to improve outcomes.

⁷ Tertiary Prevention is directed at reducing the progression of a disease and its complications, and improving the quality of life for those with chronic disease.

Key strategies will vary across regions and communities and can target individuals, families, communities and health professionals.

Activities for individuals and families could include:

- Providing diabetes education and support to increase self-management of diabetes; and,
- Supporting family members who are caring for people with diabetes.

Activities for communities could include:

- Implementing diabetes complications screening clinics, where appropriate, to support screening for diabetes-related limb, eye, cardiovascular and kidney complications;
- Providing access to diabetes health care teams that provide a range of services including screening and care;
- Developing links with provinces and territories to improve coordination of services for people accessing diabetes care outside their community; and
- Exploring options to use new health technologies such as e-health and videoconferencing to increase efficiency and access to customized diabetes services in communities.

Activities for health professionals could include:

- Training health professionals on clinical practice guidelines for the prevention and management of diabetes;
- Working with nursing and medical officers and the Home and Community Care Program to implement clinical practice guidelines, including foot care and treating wounds, in First Nations and Inuit communities; and
- Developing or adapting common administrative tools for use by health professionals in communities to support care.

7.3 Capacity Building and Training

This component supports community capacity by enhancing the knowledge and skills of community workers, often called Community Diabetes Prevention Workers (CDPWs), and health professionals to deliver effective health promotion and diabetes prevention programming. This is achieved through the training of CDPWs and health professionals, and the implementation of regionally-based multi-disciplinary teams.

CDPWs play a key role in mobilizing communities and creating supportive environments for individuals and families at risk of, affected by, or living with diabetes.

Training for Community Workers, including Community Diabetes Prevention Workers (CDPWs)

Activities may focus on:

- Providing access to training for new CDPWs to increase the quality of health promotion, and diabetes prevention and support services in First Nations and Inuit communities;
- Planning and implementing continuing education activities for community workers, including trained CDPWs, to build on existing knowledge and expertise and support workers in responding to emerging priorities such as diabetes in pre-pregnancy and pregnancy and food security; and,
- Supporting community mentoring opportunities and events to share promising practices across communities.

Activities supported by Phase 3 of the ADI will complement and link to the First Nations and Inuit Health Branch (FNIHB) Aboriginal Health Human Resources Initiative (AHHRI), which also supports training and development for community-based health workers in First Nations and Inuit communities.

Training for Health Professionals

The ADI supports access to diabetes-related training for health professionals such as foot care, nutrition, and cultural competency. Phase 3 of the ADI also supports training to those working with communities, including home and community care nurses, on clinical practice guidelines and chronic disease management strategies. This activity is managed by FNIHB's Home and Community Care program.

Multi-Disciplinary Teams

Phase 3 of the ADI will continue to support regionally-based multi-disciplinary health teams which provide subject matter expertise and support to community workers and health professionals implementing food security, healthy living, and diabetes education initiatives. Multi-disciplinary health teams provide expertise in the areas of nutrition, physical activity, and diabetes.

7.4 Knowledge Mobilization

Knowledge mobilization is an essential part of the ADI. It provides important information on what is working to support communities, develops knowledge on emerging issues, helps describe trends, and facilitates decision-making at the community, regional and national levels by providing information on the effectiveness of interventions.

Knowledge mobilization is led by the ADI national office, and is strongly supported by the work undertaken by regions and implemented by communities. Knowledge mobilization includes activities in the following areas:

- Knowledge development;
- Knowledge translation and exchange; and,
- Evaluation and monitoring.

Knowledge Development

Knowledge development involves supporting special studies, capturing community knowledge, informing research and surveillance agendas, analyzing data (e.g. surveillance), and documenting success stories and promising practices. In Phase 3, the ADI will continue working with First Nations and Inuit partners, communities, research agencies, academics and other partners to influence research and surveillance agendas and partner on priority research to support knowledge development in health promotion and diabetes prevention in Aboriginal populations.

Funding may support:

- Baseline data collection to inform interventions and evaluations;
- The development of indicators to monitor progress towards desired outcomes (e.g. food security and prevention of obesity in school-age children and adolescents);
- Increased collaboration with partners on research and surveillance;
- The assessment of promising and innovative community-based and regional initiatives;
- Pilot-testing of evidence-based, innovative approaches, methods or practices that help guide and inform health promotion and diabetes prevention activities in First Nations and Inuit communities/populations;
- Developing knowledge of effective approaches and potential barriers in partnership with communities to enhance diabetes prevention programming with First Nations, Inuit and Métis partners.

Knowledge Translation and Exchange

Knowledge translation and exchange activities help First Nations and Inuit communities adapt and share knowledge with other communities, researchers or other partners and help inform community-based program planning and delivery. Phase 3 of the ADI aims to strengthen the foundation of community activities by supporting:

- The adaptation and sharing of promising and evidence-based practices, and resource materials for use in communities;
- Public information opportunities that help mobilize communities and individuals to take action;
- Information exchange to increase understanding and awareness of the issues to support communities;

- The use of technology to share information (e.g. web-based networking tools, websites, etc.) to support community workers; and,
- Partnership development to exchange knowledge with regions, other Health Canada programs, other government departments and agencies, provinces and territories, national Aboriginal organizations, non-governmental organizations, international partners, and other stakeholders to raise the profile on key issues of mutual interest.

Evaluation and Monitoring

Evaluation is a critical part of the ADI. Nationally-led evaluations, special assessments and studies are carried out to provide detailed information on target areas and program outcomes, and inform and guide future policy and program decisions. An evaluation framework guides the process, which is developed in partnership with First Nations and Inuit partner organizations.

Consideration is given to ensure that evaluations use culturally appropriate tools and methodologies and do not place unnecessary burdens on communities.

To monitor project performance, communities and First Nations and Inuit organizations that have received funding from the ADI through contribution agreements are requested to complete a Community-Based Reporting Template. The template consolidates and reduces the reporting burden that was placed on recipients in past years by eliminating the need for individual program reports.

8.0 How is the Aboriginal Diabetes Initiative Implemented?

First Nations and Inuit Health (FNIH) regions are responsible for preparing regional work plans or health plans in a collaborative way with First Nations and Inuit partners. There are eight Health Canada-FNIH regions:

- Pacific (British Columbia)
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- Atlantic (Newfoundland and Labrador, New Brunswick, Nova Scotia and Prince Edward Island)
- North (Yukon, Northwest Territories, and Nunavut)

Communities and organizations are encouraged to address their specific needs, build on strengths, and draw on traditions to help community members lead healthy lives, prevent or delay diabetes where possible and offer support to manage the condition effectively if it occurs. They are also encouraged to be innovative in their approaches to tackling diabetes, form strong partnerships where needed, employ local knowledge, and work together to reduce the burden of diabetes.

To ensure community-based activities (as identified within the components of the ADI) support the ADI objectives, First Nations or Inuit communities and organizations seeking to develop and carry out ADI activities need to submit the type of plan required for their funding agreement (e.g. a work plan is required for set and flexible agreements and a health plan is required for block agreements) to their ADI regional office. These agreements vary in terms of level of control, flexibility, authority, reporting requirements and accountability depending on community capacity.

Communities are encouraged to consider the following when preparing their plans:

- ADI objectives;
- ADI components;
- ADI guiding principles;
- The needs of the target population;
- How community members will be engaged in the design, development, planning and implementation of the project;
- How partnerships will be developed to help achieve the objectives of the plan and implement the actions in the plan; and
- How data collection and evaluation needs are being incorporated in community-based planning and activities.

Additionally, communities and organizations are encouraged to consider undertaking new projects or expanding on existing projects that address one or more of the new areas of focus under Phase 3 of the ADI:

- Healthy living initiatives for children, youth, parents and families;
- Diabetes in pre-pregnancy and pregnancy;
- Community-led food security planning; and,
- Enhanced training for health professionals on clinical practice guidelines and chronic disease management strategies.

FNIH regions review and approve community plans, and use the information from those plans to inform regional work plans, which are then submitted to the national office. Contribution agreements with First Nations and Inuit communities and/or organizations are created or amended by FNIH regional offices prior to funding being released.

Additionally, the national office plays a leadership role in the following areas:

- Working with National Aboriginal Organizations and other stakeholders to move forward on common areas of interest;
- Developing partnerships with national organizations that have expertise in specific health-related areas such as diabetes;
- National coordination, facilitating regular communication among regions and with the national office and knowledge mobilization functions; and,

- Policy work at a national level related to healthy living and disease prevention (e.g. improving access to healthy food; promoting healthy eating, physical activity and achieving healthy body weights; and increasing diabetes awareness).

The national office also supports time-limited health promotion and primary prevention projects for First Nations and Inuit living outside their traditional communities and Métis.

9.0 How does the Aboriginal Diabetes Initiative Work with Partners?

Phase 3 of the ADI will continue developing and maintaining partnerships with other federal departments and agencies, provincial/territorial governments and First Nations, Inuit and Métis organizations. Instrumental partnerships have also been established with the Assembly of First Nations and Inuit Tapiriit Kanatami to inform and support the work being delivered with First Nations and Inuit communities, respectively.

For primary prevention projects where programs and services are delivered to First Nations and Inuit living outside their traditional communities and Métis, partnerships have been established with:

- Assembly of First Nations⁸
- Inuit Tapiriit Kanatami⁸
- Congress of Aboriginal Peoples⁸; and
- Métis National Council⁸.

Through its advisory groups and committees, the ADI will continue ensuring strong and consistent linkages are developed and maintained with ADI regional coordinators, National Aboriginal Organizations, community member representatives and experts. Some examples include:

- First Nations Diabetes Working Group;
- Inuit Diabetes Network; and,
- The Chronic Disease and Injury Prevention Working Group.

Important links have also been made with organizations such as:

- Canadian Diabetes Strategy (Public Health Agency of Canada);
- National Aboriginal Diabetes Association; and
- Canadian Diabetes Association.

Communities and community workers are encouraged to continue the following activities:

- Sharing resources, promising practices and lessons learned;

⁸ For more information, please refer to the respective organization's website: Assembly of First Nations (www.afn.ca); Inuit Tapiriit Kanatami (www.itk.ca); Congress of Aboriginal Peoples (www.abo-peoples.org); and Métis National Council (www.metisnation.ca).

- Implementing evidence-based activities;
- Strengthening linkages with the First Nations and Inuit Home and Community Care program, the Office of Nursing Services and the First Nations Health Managers Association;
- Collaborating on shared areas of focus with the Community Programs Directorate's community-based programs, for example with the Canada Prenatal Nutrition Program to enhance diabetes in pregnancy activities and the National Aboriginal Youth Suicide Prevention Strategy to enhance physical activity; and,
- Working with other partners to maximize resources and delivery mechanisms.

10.0 Which Expenses are Eligible and Not Eligible?

10.1 Which Expenses are Eligible?

Community-based funds received through contribution agreements with the ADI should be expensed on items directly related to ADI objectives. The First Nations and Inuit Health Branch (FNIHB) has a generic list of expenses that fall under the Primary Health Care Authority which replaced the Community Programs Authority on April 1, 2011. Eligible expenses generally include:

- Administration of the program;
- Staff salaries and benefits;
- Contracts related to program planning, delivery and evaluation;
- Staff travel;
- Office supplies;
- Accommodation;
- Printing; and
- Staff training and development.

While these are the broad categories, considerations can be given to allow other expenses for cultural and traditional activities. Communities should refer to the program schedule within their contribution agreement which lists eligible expenses.

Administration costs must be consistent with current Health Canada FNIHB contribution agreement guidelines. Other expenditures may be considered eligible based on the work plan or health plan. These must be approved and reviewed by FNIH regions.

Minor capital expenditures for operational requirements are permitted only if the estimate is in the work plan or health plan and is approved by the FNIH regions. Some examples include:

- Office supplies such as computers, software, desks, filing cabinets;
- Equipment to promote physical activity; and
- Required equipment or material to promote and deliver healthy eating and food security initiatives.

10.2 Which Expenses are Not Eligible?

Expenses not eligible under the ADI include:

- Services that fall under provincial or territorial jurisdiction, such as dialysis;
- Financial support for operational activities not directly related to ADI projects;
- Funding for services provided through other community programs, such as the First Nations and Inuit Home and Community Care Program; and,
- Funding for major capital such as construction, buildings, vehicles and renovations as identified in the Treasury Board policy on capital.

11.0 How Can We Reach Our Goal?

Phase 3 of the ADI will support health promotion, prevention, screening and management initiatives that are community-based and culturally appropriate to enable First Nations and Inuit communities to continue building on past successes in more than 600 communities throughout Canada.

The ADI encourages communities to address their needs by building on their strengths and drawing on their traditions and culture, to help community members prevent or delay diabetes where possible and offer support to help manage the condition effectively when it occurs.

First Nations and Inuit communities continue to be innovative in their approaches to tackling diabetes, forming strong partnerships where needed, employing local knowledge and working together to promote health and reduce the burden of diabetes.