Chronic Disease Prevention

Evidence Table

First Nations and Inuit Health

Health Canada Santé Canada

Canada

Introduction and Background

The Aboriginal Diabetes Initiative (ADI) subcommittee has identified the need *"to implement preventative awareness programs based on key findings."* A resource has subsequently been developed to share the evidence that supports chronic disease prevention activities.

What are evidence based activities?
They are interventions (i.e., experiences and practices) which, through different kinds of evaluation, have been proven to be effective in a population and/or setting in which they were studied.

Why do we want to use evidence based activities?
Chronic conditions such as diabetes, heart disease, obesity, cancer and respiratory diseases are responsible for 46% of the world's burden of disease. Almost 50% of all the global risks to poor health are related to inadequate nutrition and physical inactivity. Together, these risk factors, along with the non-traditional use of tobacco, play a key role in the development of chronic diseases. There is good evidence that interventions which aim to improve nutrition, physical activity and tobacco control, can reduce the burden of these risk factors and consequently the burden of chronic disease. *(Reference: 8)*

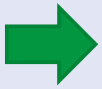
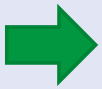
When developing comprehensive approaches to chronic disease prevention, program planners are encouraged to use evidence based interventions. These interventions are highly promoted because they have already been proven to work in the population in which they were first implemented, and in addition, they are more likely to lead to successful chronic disease prevention programs. Evidence based activities, compared to activities that haven't been proven to work, strengthen the likelihood of improving the health of your community.

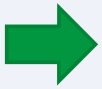
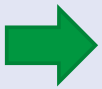
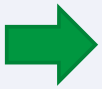
Who can use this resource?
The Chronic Disease Prevention Evidence Table was created for all health program planners and decision makers to use e.g., nurses, health directors, health promoters, dietitians, community health representatives, etc.

How does this resource work?

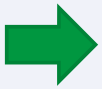
1. Decide on a **Risk Factor** (1st column) e.g., poor nutrition, physical inactivity, tobacco misuse, that you want to target based on the need of the community i.e., refer back to your community's Needs Assessment if available. Think about what your community is already doing about this risk factor.
2. Decide **who** you want to **Target** (2nd column) the intervention towards e.g., youth in schools, seniors or the community as a whole.
3. Choose a **Program Activity**(ies) (3rd column) that best suits your community's structure, values, priorities, traditions and resources. It is important to remember that these interventions are not one size fits all and they must be adapted to fit your community's needs as well as the capacity of your organization (**see Appendix A – How to Adapt Activities to your Community**). Some activities may not be feasible for all communities to implement, however, don't let this discourage you. Even choosing one evidence based activity will benefit your community.
4. Take note if the activity is **Recommended** based on the symbols in the 4th column. The  symbol represents activities that have been proven to be effective and therefore are recommended and should be given priority for implementation. The  symbol represents activities that require more evaluation to determine their effectiveness. Program activities that require further evaluation are not necessarily ineffective; rather there is not enough information to recommend implementation. Refer to the legend at the bottom of every page to guide you.
5. The **Comments** section, (5th column) provides references, any additional information that should be considered when implementing a program activity, as well as any websites that include resources and tools to guide the implementation of an intervention. It is essential that you refer to the references that correspond to the program activities you have chosen. They will provide you with more details on the intervention and will help you plan your program activities. Refer to the **References** section that is located at the back of the resource.

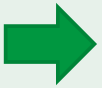
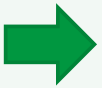
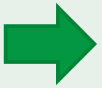
THANK YOU to the advisory group members who provided guidance with the development of this resource!

Chronic Disease Risk Factor	Target	Program Activities	Recommend?	Comments
Poor Nutrition	Children and Youth	Increase vegetable and fruit intake* and decrease fat intake in children and youth by implementing one or more of the following activities: • **classroom lessons and activities;** • **school menu changes** (healthier options); • **family involvement** e.g., parent programs that encourage and support behaviour change such as completing home assignments with children, family nights, parent-teacher meetings; • **point-of-purchase education** e.g., display of information on how to prepare certain low cost vegetables in the produce section of the grocery store; • **media marketing** e.g., posters, displays, public service announcements. **Factors for success:** interventions that have multiple components should include a combination of an environmental (e.g., school menu changes), classroom and family or community components; interventions should focus on behaviour change rather than knowledge gain only; increased chance of change with longer duration interventions.		*References: 4, 2, 6* Additional research needed to determine effects on reducing obesity. *Recommended Vegetables and Fruit servings/day: Children 2-3 yrs: 4; Children 4-13 yrs: 5-6; Teens: 7-8. *http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html* Communities and Schools Promoting Health. Provides links to research, reports, how-to manuals, planning and assessment tools, lesson plans and student webquests. *http://www.safehealthyschools.org* Alberta Nutrition Guidelines for Children and Youth *www.healthyalberta.ca*
Poor Nutrition	Community	Increase healthy food choices by implementing one or more of the following activities: • **family activities** e.g., community wide dinners including nutrition education; • **education sessions;** • **changing workplace policies;** • **improving access to healthy foods** in the community.		*References: 2* The Community Toolbox. Information on skills for building healthy communities. *http://ctb.ku.edu/en/Default.htm*
Poor Nutrition	Seniors	Increase healthy food choices by implementing one or more of the following activities: • **self-assessment** and **goal setting;** • **food preparation and tasting;** • **nutrition & gardening education;** • **print material** e.g., tip sheets; • **empowering clients** through **enhancement of social support** • **enhancing choices of food;** • **home visits** to encourage healthy foods, social interaction.		*References: 2*

Poor Nutrition	Workplace	Increase vegetable, fruit and fibre intake and decrease fat intake in adults by implementing one or more of the following activities: • **education** e.g., skill-building sessions and demonstrations; • **cafeteria menu changes** (healthier options), healthy vending machines; • **family involvement** e.g., participation of family members in meal planning, grocery shopping, family festivals and newsletters; • **media marketing;** • **individualized counselling.**		*References: 2*
Poor Nutrition	Policy	Decrease unhealthy food consumption and increase healthy food consumption by implementing one or more of the following policies: • **school and workplace food policies** such as **cafeteria menu changes** (healthier options) and **nutrition education;** • **vending machine policies;** • **tax increase on unhealthy foods;** • **lowering the price of healthy foods.**		*References: 2* School Nutrition Handbook – Feeding the Future. *http://www.calgaryhealthregion.ca/hecomm/nal/ProgramsServices/SchoolNutritionProgram/SchoolNut.htm*
Poor Nutrition	Aboriginal	**Pathways Study** Expected outcome: aims to reduce/prevent obesity in a young population at risk for type II diabetes. Children in the Pathways intervention benefited from the following program activities: • **classroom curriculum** on healthy eating and physical activity • **changes to physical education curriculum** • **family support** e.g., family events and challenges • **changes to school food service program** (healthier options) **Pima Pride Study** Expected outcome: aims to reduce risk factors in a population at risk for type II diabetes. Adults in the Pima Pride intervention participated in the following activities: • **self-directed learning** facilitated by an appreciation of local culture • **small group discussions, monthly** • **printed handouts** on healthy eating and physical activity • **newsletters** with contributions from community members		*References: 2, 3* ***Note: the evidence provided is based on Aboriginal populations which may include First Nations people.*** *Pathways.* (1999). *http://hsc.unm.edu/pathways/* for further information on details of intervention and curriculum. Narayan, KM. et al. (1998) Randomized clinical trial of lifestyle interventions in Pima Indians: a pilot study. *Diabetic Medicine.* Jan; 15(1), 66-72.

 = Recommended  = More evaluation is needed to determine effectiveness of program activity

Chronic Disease Risk Factor	Target	Program Activities	Recommend?	Comments
Poor Nutrition	Aboriginal	Decrease unhealthy food consumption and increase healthy food consumption by implementing one or more of the following activities: • **social marketing initiatives** to increase awareness about nutrition including **media campaigns** about healthy eating practices and regulation of advertising unhealthy foods; • **store-based interventions** (e.g., point of purchase education) along with **providing information** to increase purchase of healthy foods; • **nutrition labelling and nutrition information** in cafeterias, worksites, grocery stores and restaurant menus to increase healthy food choices made; • **changes to school food service program** (healthier options); • **classroom curriculum;** • **family involvement** with youth to demonstrate positive role modeling e.g., family challenges, family event, involving youth in purchase and preparation of meals; **Factors for success:** community involvement, cultural appropriateness, suitable program design e.g., holistic view, multiple activities within an intervention, capacity building (empowering community), data collection and evaluation.		*References: 3* ***Note: the evidence provided is based on Aboriginal populations which may include First Nations people.***
Poor Nutrition & Physical Inactivity	Aboriginal	**Obesity Prevention Plus Parenting Support** study included education to mothers (with infants) on lifestyle behaviours and parenting skills, home visits, and parental support. Expected outcome: aims to reduce the prevalence of obesity in high-risk Aboriginal preschool children. **Kahnawake Schools Diabetes Prevention Project** provided health education for grades 1-6, support program for parents on healthy lifestyles and a Community Advisory Board to support project efforts. Expected outcome: to prevent diabetes among Aboriginal children. **Sandy Lake Health & Diabetes Project** consisted of classroom education for grades 3-5, family support through radio shows, information booths, newsletters etc., peer role models and school food policies. Expected outcome: aims to prevent type II diabetes in a young, high-risk population. **Zuni Diabetes Project – High school** consisted of a Teen Wellness Centre (fitness centre) located in the school, school food policies, vending machine policies, changes to create healthier school lunches, changes in curriculum that incorporated nutrition information, diabetes prevention and orientation to the Teen Wellness Centre. Expected outcome: aims to prevent type II diabetes in a young, high risk population.		*References: 2* **Note: the evidence provided is based on Aboriginal populations which may include First Nations people.** Harvey-Berino, J. et al (2003). Obesity prevention in preschool Native American children: a pilot study using home visiting. *Obesity Research,* 11, 606-611. Kahnawake Schools Diabetes Prevention Project. (2005). *www.ksdpp.org* Sandy Lake Health Diabetes Project. (2006). *www.sandylakediabetes.com* Ritenbaugh, C et al. (2003). A lifestyle intervention improves plasma insulin levels among Native American high school youth. *Preventive Medicine,* 36 (3), 309-319.

Physical Inactivity	Children and Youth	Increase physical activity and physical fitness by implementing one or more of the following activities: • **enhanced physical education (PE) classes in schools:** **~ longer PE classes; increased vigorous physical activity vs. moderate intensity** • **additional classroom physical activity and curriculum;** • **goal setting;** • **family involvement programs** e.g., family activities, newsletters, homework to be completed with parents.		*References: 2, 6* Effective across diverse racial, ethnic, and socioeconomic groups, females, males, all school year ages, urban and rural settings.
		• **classroom based health education** specifically focused on reducing television viewing and video game playing and providing information.		*References: 6*
Physical Inactivity	Community	Increase physical activity levels in adults by implementing one or more of the following activities: • **point of decision prompts** (signs at elevators or escalators encouraging the use of stairs); • **community wide campaigns** delivering messages through TV, radio, newspapers e.g., messages around the benefits of physical activity in combination with **individual efforts** such as **support groups, education, and community events or policy changes;** • **community based social support** e.g., walking or other groups such as 'buddy systems'; • **individually adapted health behaviour change programs** delivered in a group setting e.g., teaching individuals how to incorporate physical activity into a daily routine; • **follow up with clients** e.g., telephone follow up; • **creation of enhanced access to places for physical activity** combined with **informational outreach activities** e.g., training on fitness equipment, seminars, health forums, counselling.		*References: 2, 6* Important to create interventions that are flexible and suitable for any stage of change. Canada's Physical Activity Guide *http://www.phac-aspc.gc.ca/pau-uap/paguide/index.html* Transtheoretical Model (stages of change) defined: *http://en.wikipedia.org/wiki/Transtheoretical_Model*
		• **mass media campaigns implemented alone** that are not directed at a specific audience using newspapers, radio, TV, billboards*; • **family based social support** e.g., goal setting and problem solving as a family.		*References: 6* ***Mass media campaigns** differ from **community wide campaigns** (see recommended activities above) in that they do not include other components such as support groups, education, community events etc.
Physical Inactivity	Seniors	Increase physical activity levels by implementing one or more of the following activities: • **educational workshops** including exercise demonstrations; • **exercise programs;** • **individual counselling;** • **motivational telephone contact.** **Factors for success:** delivering activities in groups; tailoring activities to individual preferences; encourage self monitoring.		*References: 2* Provide professional guidance about starting an exercise program and support. Base interventions on readiness to change and recommend higher intensity activity.

 = Recommended  = More evaluation is needed to determine effectiveness of program activity

Chronic Disease Risk Factor	Target	Program Activities	Recommend?	Comments
Physical Inactivity	Workplace	Increase physical activity levels in the workplace by implementing one or more of the following activities: • **information sessions;** • **print materials* and displays;** • **onsite exercise programs with** professional guidance and support to join; • **health screening** e.g., find out health status and learn about good health practices; • **media marketing** including newsletters, health fairs and contests.		*References: 2* *Print materials based on stages of change (readiness to change) and focus on lifestyle activity rather than exercise.
Physical Inactivity	Policy	Increase physical activity and decrease sedentary behaviours by implementing one or more of the following policies: • **creating access to places for physical activity** such as building walking trails or facilities; • **school physical education policies such as increasing the number of PE classes per week, physical activity opportunities outside of PE class, increasing the number of PE specialists to teach PE class, increasing the number of PE courses in which students can enrol;** • **workplace policies** e.g., free use of onsite exercise program; • **point of decision prompts** e.g., signs at elevators or escalators encouraging use of stairs.		*References: 2, 6* Physical Activity Resource Centre's (PARC) online toolkit for influencing physical activity policy: *http://www.ophea.net/parc/policy.cfm*
Physical Inactivity	Aboriginal	Also see section: Poor Nutrition/Aboriginal for program activities in the Pathways and Pima Pride Studies. Increase physical activity level by implementing one or more of the following activities: • **support** from family, coworkers and community; • **social networks** including buddy systems, walking groups; • **participating in traditional community events;** • **family-friendly programs and workplace programs;** • **accessible and affordable activities, programs and recreational facilities;** • **access to safe places to exercise;** • **community wide informational campaigns;** • **point of decision prompts** e.g., signs at elevators or escalators encouraging use of stairs; • **equipment and facilities close to home** for youth; • **encouraging physical activity to be part of daily routine.** **Factors for success:** community involvement, cultural appropriateness, suitable program design e.g., holistic view, multiple activities within an intervention, capacity building (empowering community), data collection and evaluation.		*References: 2, 3* ***Note: the evidence provided is based on Aboriginal populations which may include First Nations people.*** Physical Activity and Nutrition Initiatives in Aboriginal Communities Resource Guide: *www.niichro.com/2004/pdf/cmc-eng-binder.pdf*

Tobacco Misuse	Children and Youth	To prevent initiation of tobacco misuse in youth, implement one or more of the following activities: • **classroom education;** • **telephone and mail contact;** • **mass media marketing** through radio and TV; • **parent and school principal groups** e.g., to develop school policies. **Factors for success:** including peers in the development and implementation of programs, focusing on multiple risk factors and not just tobacco, focus on higher grade levels, sustaining interventions until the end of adolescence, adaptable and acceptable in different communities, ensuring community activities are reaching youth, including multiple activities that address different factors of smoking behaviour.		*References: 2* Evaluation Springboard. A guide to developing and implementing evaluations: *http://www.evaluationspringboard.org/getstrt-2.html*
Tobacco Misuse	Community	To increase tobacco cessation among adults implement one or more of the following activities: • **mass media campaigns** to inform and motivate individuals to remain tobacco free e.g., TV, radio, billboards etc. when combined with other interventions (also to reduce tobacco use initiation); • **multicomponent interventions with ongoing contact, including client telephone contact*;** • **healthcare provider reminder systems** e.g., prompts or reminders such as stickers on patients charts to counsel their patients on quitting tobacco use; • **healthcare provider reminder systems with provider education** (so they can help their patients quit) **with or without patient education;** • **self help materials and manuals** (cessation); To prevent initiation of tobacco misuse among children and youth implement one or more of the following activities: • **restricting minors' access** to tobacco products by **community mobilization** (building the capacity of the community to work together) **when combined with additional interventions** (stronger local laws directed at retailers, active enforcement of retailer sales laws, retailer education with reinforcement)**		*References: 2, 6* *Telephone contact may be *proactive* e.g., provider initiates contact or user initiates contact with provider follow-up or *reactive* e.g., tobacco user initiates contact **These activities are implemented community-wide to focus public attention on the issue of youth access to tobacco products and to generate and mobilize community support for additional efforts to reduce that access. Health Canada Tobacco Resources provides numerous resources on best practices and developing policies etc: *http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/res/index_e.html*

 = Recommended  = More evaluation is needed to determine effectiveness of program activity

Chronic Disease Risk Factor	Target	Program Activities	Recommend?	Comments
Tobacco Misuse	Community	• **restricting minors' access to tobacco products by:** ~ sales laws directed at tobacco retailers to reduce illegal sales to minors, when implemented alone; ~ laws directed at minors' purchase, possession, or use of tobacco products, when implemented alone; ~ active enforcement of sales laws directed at retailers, when implemented alone; ~ retailer education with reinforcement and information on health consequences, when implemented alone; ~ retailer education without reinforcement, when implemented alone; ~ community education about minors' access to tobacco products, when implemented alone; • **mass media education** to recruit, inform and motivate tobacco product users to initiate and maintain cessation efforts; • **mass media education (cessation contests)** that encourages participation in a targeted quit date or period; • **healthcare provider education only** to increase their knowledge and change their attitudes and practice (see recommended activity healthcare provider reminder systems); • **community education to reduce exposure to environmental tobacco smoke** (second hand smoke) **in the home** e.g., mass media messages, educational materials, counselling provided outside the healthcare setting.		*References: 6* There is little evidence of effectiveness if these interventions are implemented alone.
Tobacco Misuse	Workplace	**Quit smoking programs** that include one or more of the following activities: • **self help materials** e.g., manual that provides a structured plan to cessation for individual completion; • **group counselling;** • **individual counselling;** • **telephone counselling;** • **buddy system for education and support.**		*References: 2*

Tobacco Misuse	Policy	To reduce tobacco prevalence, initiation, and consumption; and increasing cessation, implement one or more of the following policies: • **increasing the price of tobacco products;** • **increasing taxes on tobacco products;** • **banning tobacco marketing and promotion;** • **100% smoke free public places and workplaces;** • **ban all retail tobacco displays;** • **removing tobacco sales from pharmacies and health care facilities.**		*References: 1, 2, 6* Effective across various age groups and ethnicities.
Tobacco Misuse	Aboriginal	Limited research involving First Nations Populations – see above Recommended tobacco control strategies. **Activities should include information on tobacco misuse vs. the traditional and sacred use of tobacco.**		*References: 3* Tobacco misuse or the non traditional use of tobacco includes: smoking cigarettes, cigars, pipes, using smokeless tobacco (e.g., snuff, chewing tobacco) or exposure to environmental tobacco smoke (second hand smoke.)
		Alaska Native Medical Center Tobacco Cessation Program included behaviour modification classes, telephone follow up and medications to help quit. Expected outcomes: aims to reduce tobacco use in an Alaska Native population. **GAINS (Giving American Indians No-Smoking Strategies)** included clinician based smoking cessation counselling based on smoking status on patient charts, smoking and cessation information for staff and supportive telephone calls and counselling by outreach workers. Expected outcomes: aims to increase smoking cessation rates of urban Aboriginal people. **Tribal Tobacco Policy Project** consisted of regional workshops for tribal representatives on health risks associated with smoking and workbook provided, follow up meetings to work with key tribal members, telephone consultations between staff, tribal representatives and key members. Expected outcomes: aims to assist tribal councils to develop and approve tobacco policies.		*References: 2* ***Note: the evidence provided is based on Aboriginal populations which may include First Nations people.*** Hensel, M. R. et al (1995). Quit rates at one year follow-up of Alaska Native Medical Center Tobacco Cessation Program. *Alaska Medicine,* 37, 43-47. Johnson, K. M. et al (1997). The GAINS Project: outcome of smoking cessation strategies in four urban Native American clinics. *Addictive Behaviours,* 22, 207-218. Glasgow, R. E. et al (1995). The Tribal Tobacco Policy Project: working with Northwest Indian Tribes on smoking policies. *Preventive Medicine,* 24, 434-440.

 = Recommended  = More evaluation is needed to determine effectiveness of program activity

References

1. *Briefing note RE: Evidence Supporting Tobacco Control Policies.* Alberta Cancer Board. (2007). Retrieved December 6, 2007.
Website: *http://www.cancerboard.ab.ca/PS/Prevention/Tobacco/*

2. *Information Packages for Evidence-Informed Interventions: Nutrition, Physical Activity, Tobacco and Aboriginal.* Last modified May 24, 2007. Retrieved March 11, 2008, from Knowledge Exchange Network (KEN), Canadian Cancer Society, Manitoba Division.
Website: *http://www.cancer.ca/ccs/internet/standard/0,3182,3331_407538771_419967129_langId-en,00.html*

3. Jacobson P. M., McMurchy, D., Palmer, R. W.H. (2006). *Chronic Disease Prevention: A Review of the Effectiveness Literature.* Prepared for Health Canada. Toronto, ON. Jacobson Consulting Inc.

4. Micucci, S., Thomas, H., Vohra J. (2002). *The Effectiveness of School-Based Strategies for the Primary Prevention of Obesity and for Promoting Physical Activity and/or Nutrition, the Major Modifiable Risk Factors for Type 2 Diabetes: A Review of Reviews.* Retrieved December 6, 2007 from Public Health Research, Education and Development Program (PHRED) – Effective Public Health Practice Project.
Website: *http://old.hamilton.ca/phcs/ephpp/ReviewsPortal.asp*

5. Rabinowitz, P. (2007). *Chapter 19. Choosing and Adapting Community Interventions.* Retrieved December 7, 2007 from The Community Toolbox, University of Kansas.
Website: *http://ctb.ku.edu/en/tablecontents/chapter_1019.htm*

6. *The Community Guide: Topics Nutrition, Physical Activity, Tobacco.* Last Modified November 20, 2007. Retrieved December 7, 2007 from The Community Guide to Preventative Services, Centre for Disease Control.
Website: *www.thecommunityguide.org*

7. *Using What Works: Adapting Evidence-Based Programs to Fit your Needs.* National Cancer Institute. Retrieved December 7, 2007.
Website: *http://cancercontrol.cancer.gov/use_what_works/start.htm*

8. WHO's Chronic Disease Information Sheets. World Health Organization. Retrieved December 20, 2007.
Website: *http://www.who.int/dietphysicalactivity/publications/facts/riskfactors/en/index.html*

APPENDIX A - How to Adapt Activities to Your Community

(Sources: see references 2, 7, 8)

Evidence based activities are not one-size-fits-all; therefore, they need to be adapted to "fit" different populations and settings. Use the following principles and guidelines to successfully adapt your program activities.

Adaptation Guidelines

1. Determine the needs of your population (audience) and whether this program addresses those needs;
2. Review the program and its material with your population or a community representative for feedback;
3. Define the extent of adaptation needed and potential ways to implement the new program;
4. Develop a "revised" program;
5. Implement and monitor the need for further change;
6. Modify/revise program based on feedback;
7. Evaluate the effectiveness of your adapted program and products. Plan how to evaluate at the beginning of the program rather than leaving it to the end.

Program Adaptation Checklist

✓ **Objectives:** The program's objectives fit the needs of your population;
✓ **Approach Used:** The approach(es) used in the program are based on sound theory about how people behave or act, and will fit with your population;
✓ **Content:** The reading level, complexity, and amount of detail of information provided in the program are appropriate for your population. Have individuals from your population review the materials and provide you with feedback;
✓ **Level of Understanding:** The underlying beliefs/values of the program fit with the cultural background and understanding of your population;
✓ **Fit With Community Resources:** The program's activities are realistic and achievable given the resources in your community;
✓ **Media And Information Channels:** Your intended mode of delivery for the program will not diminish the effectiveness of the message(s), even if it is different from that of the original program;
✓ **Terminology:** You understand how your population interprets the key terms used in the program and review the terminology to ensure it will be understood by your audience;
✓ **Fit:** You seek feedback from your population regarding the cultural appropriateness of the program and make sure there is a good 'fit';
✓ **Intended Actions:** The desired/expected behaviours are consistent with your objectives and the needs of the population.

Monitoring the implementation of the adapted program is important (e.g. pilot testing), especially if:

1. Your population is significantly different from that of the original program;
2. You intend to deliver the program to your population using a different mode of delivery;
3. You do not intend to use the entire program and all its recommended products as implemented in the original setting – choosing some but not all of the program components or products to modify and use;
4. Your resources prevent you from implementing the program as it was intended;
5. You intend to translate the product into another language, as mere translation does not guarantee that the program's content will be culturally relevant.

For more information contact:

Aboriginal Diabetes Initiative, Alberta Region
First Nations and Inuit Health
Health Canada
730, 9700 Jasper Ave
Edmonton, Alberta T5J 4C3
Phone: (780) 495-8710
Fax: (780) 495-2687

For additional copies contact:

Program Resources, Alberta Region
First Nations and Inuit Health Branch
Health Canada
730, 9700 Jasper Ave
Edmonton, Alberta T5J 4C3
Phone: (780) 495-2699
Fax: (780) 495-8920

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