The Manitoba First Nation Diabetes Strategy

A Call to Action - updated March 2017

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Executive Summary

This is the revised Manitoba First Nation Diabetes Strategy. It was developed by representatives from First Nation communities and tribal councils at the request of the Assembly of Manitoba Chiefs. The original Call to Action document was created to assist First Nation communities in developing community-based diabetes implementation plans and initiatives. It was the aim of the original strategy to identify needs and use existing strengths to deal with diabetes in Manitoba First Nation communities, tribal councils and regional levels to address this public health epidemic. This updated strategy continues to focus on identified priorities.

Beginning in 2010, the Manitoba First Nation Diabetes Committee (MFNDC) initiated an evaluation of the Call to Action-1999 Version. The scope of the evaluation covers progress from April 1, 2010 to March 31, 2014 and includes the activities of communities and their application of the Call to Action-1999 Version. The final evaluation report was prepared in March 2015. There were several recommendations to these documents that related to updating the Strategy to ensure:

- A new and shared Vision was developed;
- Greater clarity and a more comprehensive Vision and Mission Statement;
- A Change Management Component that ensure the strategy would be a more responsive tool for First Nation communities;
- Develop a plan to ensure ongoing monitoring and evaluation of the strategy to ensure relevance and to identify successes and challenges;
- Include a protocol to allow flexibility of the Strategic Plan, and;
- A regular orientation process for new users of the Strategy that is inclusive and capitalizes on new perspectives and skills

The committee was formally known as the Manitoba First Nation Diabetes Committee (MFNDC), in consultation with an Elder, the committee name was changed in February 2016 to the Manitoba First Nation Diabetes Leadership Council (MFNDLC).

A process was begun by the Manitoba First Nation Diabetes Leadership Council (MFNDLC) in June 2016 to address the above recommendations because First Nation communities have expressed they want:

- A consistent and collaborative approach to developing strategies and tools to address diabetes
- Approaches to be clearly defined in purpose and in line with community priorities and capacity

Preamble

Mission Statement

Through a holistic approach and based on the "Call to Action Strategy", the Manitoba First Nations Diabetes Leadership Council provides leadership through building capacity and relationships, case management, and care of mind, body and spirit to decrease the impact of diabetes in First Nation Communities.

Vision Statement

Reclaiming Healthy Living through indigenous knowledge and quality care.

As noted within the original Call to Action-1999 Version, Manitoba had the highest percentage of First Nations people with diabetes in the entire country (BOBET-1998). The prevalence of diabetes is almost five-fold higher in First Nations woman, and three-fold higher in First Nations Men than in the general population in Manitoba.

As of 2017, the prevalence of diabetes continues to be significantly higher in First Nations in Manitoba. According to the 2013 Canadian Diabetes Association (CDA), First Nations people have an earlier age of diagnosis as well as higher incidents and prevalence rates of Type 2 diabetes (CDA-CPG 2013). According to the 2013 Diabetes Canada Clinical Practice Guidelines, Aboriginal woman in Canada experience Gestational Diabetes rates 2 to 3 times higher than others (CDA-CPG 2013).

Further to the goals and activities listed in the Call to Action-1999 Version, there have been several activities implemented and accomplishments achieved at the community, tribal council, and regional level. This is evident within the Diabetes Education & Environmental Scan (Appendix E). To further enhance diabetes related programming amongst the First Nation communities, MFNDLC took part in a strategic planning session in June 2016 to update the diabetes strategy.

Determinants of Health

Mental Wellness

- language barrier, loss of identity, coping, addictions, counselling services available

Education

- literacy, learning skills; how can someone be taught if they can't comprehend the English language

Emotional

- social behaviour (upbringing), residential school impact; the body might not be able to fight off disease if someone is not emotionally stable.

Environmental Health

- Housing shortage/condition, geographical locations, flooding and community displacement. water quality and overcrowding increases stress levels which is one of the risk factors for diabetes.

Physical

- nutritional status, food security, vision status, hearing status, other chronic conditions, co-infections

Health Services

- professional education & awareness, medical transportation, various jurisdictions involved (CFS, PTOs), communication strategy is down, screening & contact tracing ↓

Spiritual

- Guidance, traditional/western, sharing circle; Religion is strong in our communities, how we need to help one another has yet to occur

Income & social welfare status

- Poverty, food insecurity, and unemployment can all contribute to diabetes and its complications.

Leadership

- key stakeholders, policy decision makers, ownership, control, access & possession of health data

5 Strategy Components

The chart below identifies the priorities and activities congruent with the following 5 components:

1. **Prevention and Promotion**
   This section deals mostly with primary prevention of diabetes within First Nation communities. it also includes human resource training needs required for community-based workers.

2. **Care and Treatment**
   This portion addresses the care and support of those First Nation community members and their families affected by diabetes. This section also addresses secondary and tertiary prevention.

3. **Gestational Diabetes**
   Though many of the methods required to help address gestational diabetes are discussed throughout the diabetes strategy, this form of diabetes that affects both mother and child requires its own category. Issues surrounding this prevalent and serious condition are discussed in this section.

4. **Surveillance, Research and Evaluation**
   Surveillance monitors the proportion of diabetes in the population, and helps to identify those at risk. Research is the information gathered regarding the many issues surrounding diabetes and its complications. Finally, evaluation concentrates on measuring the effectiveness of planning and actions.

5. **Policy and Infrastructure**
   This section talks about the organizational and infrastructure necessary to deal with diabetes at the community, tribal council, and regional levels.

Programs that improve mental well-being	**Standardized foot care in every community**	**Full time sustainment ADI workers per community**	**Case management system to improve client care**
Fitness leaders in every community; recreational facilities on-reserve; clubs (arts & crafts, + mentoring; involve elders); greater supportive programming	Foot care nurse in each tribal council per community Full time foot care nurse in communities Foot care in all	Greater ADI funding Long term ADI (retaining workers) Full time ADI worker (health promotion) Full time ADI position	Case conferences; case management system (HR, forms, referral process) Circle of Care (CFS, NNADAP, ADI) working together for care plan; strategy for hard to reach

(addictions, mental health, & smoking); club (youth/elder, leadership, volunteering); recreational facilities; child care to support programs and fitness; family support groups; accessible sports programs; family focused recreation programs; mental health professionals in every community; mental health; mental health screening; physical activity (sports, hunting)	communities' stand-alone foot care program in each health facility		diabetics; data tracking to monitor progress through health care system Myth-busting of diabetes as inevitable; EMR; medical transportation (day rooms, escort, foot care, food, wait time, GDM, DM registry; Care base on CPGs Need proper D/C planning; All HCP work together (MD, Nurse, CHR, ADI etc.) Medical trans (not going by doctor's recommendations)
Access to a dietitian	**Moving forward, looking back: Practicing our traditional culture**	**Greater access to indigenous Doctors & Nurses**	**Health promotion in schools**
Full time dietitian in communities Nutritionist/Dietitian in each tribal council Dietitian (include elder and education)	Traditional support; Traditional teachers per tribal council ie. hunting, fishing, trapping, medicines, and summer camps; Incorporate traditional health and healing Promotion of traditional diets (living off land using what the Creator put there); spiritual	Trained indigenous diabetes Doctors Full time Nurse Practitioner/Physician MDs in all First Nations On-reserve access to Pharmacy/labs	School meal programs are healthy; Healthy living programs-holistic medicine wheel approach; Promoting physical activity and nutrition in basic health curriculum; Screening in children;

	support Greater access to traditional medicines/healer Elder involved in all aspects (nurse, doctor, dietitian) Greater breastfeeding; creating healthy babies, healthy families (self-care); positive lifestyle changes for young moms and couples.		Diabetes a part of school curriculum; Cooking skill programs in school; Elder teachings; Policy influence ie. energy drinks; Leadership involvement (chips, drinks); land-based classes
Improving access to specialized Diabetes care	**Accessible Diabetes complications screening**	**Improving food & water security**	**Quality care closer to home**
Specialized diabetes Nurse in every community; Full time Nurse focus on Diabetes; Nurse educator in FN; GDM educator access right away; Greater gestational Diabetes education classes Care & treatment services in every community; Specialty Diabetes groups;	One stop shop; nutritionist; CDE; Foot care; Clinical support, screening, initial education; Initial education sessions at diagnosis (series of classes) TDC model to provide services as DIP services at TC level Screening Kidney Screening Retinal screening Heart health	Freight lowering strategy for grocery in remote communities; more food security coordinators/TC; Clean water in every community; Food security promotion of drinking water; no sports energy drinks Affordable food Social determinants of health; Diabetic resources More gardening programs; Farmer markets on-reserve Board homes – server healthy foods	More dialysis units in more communities Dialysis closer to or in First Nations

TDC to become CDE certified CDE in every community	Sexual health	Traditional food in hosp./PCH Traditional food co-op Education on budgeting	

The 3-6 month goals for each of the 1-year goals are as follows:

Programs that improve mental well-being	Standardized Foot Care in every community	Full time sustainable ADI workers per community	Case management system to improve client care
Networking closer with the Mental Health workers within our communities; working together for client care	Workers to touch base with their diabetic clients to assess foot care health; foot care grab and go kits distributed	Advocate for this to be included in the 2017 management operation plan	Contact Nelson House and get the model of care distributed to the committee – to promote the case management conferencing
Access to a Dietitian	Moving forward, looking back: Practicing our traditional culture	Greater access to indigenous Doctors & Nurses	Health promotions in school
Start lobbying FNIHB for a dietitian for each TC to service each area	Discuss this issue with MFNERC as to how this could be incorporated by involving elders in the schools	Tribal Councils to be part of the orientation for physicians and nurses going into communities	Discuss strategy and ideas with MFNERC
Improving access to specialized Diabetes care	Accessible Diabetes complications screening	Improving food & water security	Quality care closer to home
Fran to look into actioning this step in terms of funds	Develop a proposal to submit for a MOP request	We would like more Food Security Coordinators	Manitoba renal program – meeting them to talk about where they are at with this program (background), networking and exploring how we can partner with them – they can

			present at our next meeting

The 1-year goals are as follows:

Programs that improve mental well-being	Standardized foot care in every community	Full time sustainable ADI workers per community	Case management system to improve client care
• All ADI workers to take the following training; a) Mental health first aid. b) Coping skills, and c) Motivational interviewing	• Support DIP's foot care proposal • Ongoing foot care training for Nurses • Basic foot care training for ADI workers	• advocate for increased community-based funding to FNIHB for full time ADI workers • Ongoing enrolment for the community Diabetes prevention worker certificate	• Develop Circle of Care case conferencing (look at offering training for the Circle of Care model) • TDC's to network with regional diabetes programs
Access to Dietitian	Moving forward, looking back: Practicing our traditional culture	Greater access to indigenous Doctors & Nurses	Health promotion in schools
• Partnering with RHA for telehealth • Lobbying for tribal council Dietitian	• Promoting traditional food • Providing education from elders on traditional medicines and practices • To encourage elder participation in all aspects	• Network with ACCESS programs and their advisors • To increase practicum positions in FN communities for physicians, nurses, and pharmacy Dr. Lavallee and Dr. Cook	• Network with MFNERC and Frontier SD to do more health curriculum in class • Working with the schools to ban energy drinks in the building
Improving access to specialized Diabetes care	Accessible diabetes complications screening	Improving food & water security	Quality care closer to home
• Network with Nursing schools or FNIHB Nurses to provide basic foot care training as	• Teams based out of the TC do a proposal to get funds to have a team in the TC that does Kidney Screening, retinal	• To increase funds for a food security position • with that position, there would be more teaching	• Community case managers to work keep clients closer to home

part of their core training • Access funds to flow thru TC's for all Nurses to take the CDE exam	screening and to cover their areas • Sub-Committee to explore how to do that	about purifying water and other surviving skills for credit • work with MFNERC about teaching gardening skills	• main focus on the prevention of dialysis

Working Groups

MFNDLC members are divided into 3 working groups:

1. Prevention & Promotion
2. Care & Treatment
3. Surveillance, Research, & Evaluation

These working groups will work toward achieving the following, but not limited to, priorities listed below:

Prevention and Promotion

- Programs that improve mental wellbeing
- Full Time ADI workers per community
- Moving Forward, Looking Back: Practising our Traditional Culture
- Health Promotion in Schools
- Improving food and water security
- Increasing awareness of Gestational Diabetes Mellitus and Diabetes in pregnancy.

Care and Treatment

- Standardized Foot Care in every community
- Case Management system to improve client care
- Access to a Dietitian
- Greater access to indigenous Doctors & Nurses
- Improving access to specialized Diabetes Care
- Accessible Diabetes Complications Screening
- Quality Care Closer to Home
- Screening and treatment of Gestational Diabetes Mellitus and Diabetes in pregnancy.

Surveillance, Research and Evaluation

- Lobbying for increased funding and resources.
- Advocating for continuation and/or enhancement of resources and services
- Providing input and advocacy toward policy development and implementation
- Ensuring cultural competency and safety within diabetes care
- Ensuring ongoing organizational infrastructure
- Ensuring that standards exist and are followed
- Networking with various sectors to ensure collaboration is ongoing in order to support a holistic approach

Conclusion

Through increased awareness and education, it is anticipated that we will see increased rates of diabetes however this should not undermine the successes. Numerous activities and accomplishments have been achieved at the community, tribal council, and regional levels such as local ADI workers, Tribal Diabetes Coordinators, Provincial Food Security Coordinators, and the Diabetes Integration Project (DIP).

Despite the many achievements such as increasing knowledge and awareness, screening, and networking; there clearly needs to be ongoing programming and support. With ongoing efforts, we will one day see a decreased level in the diabetes rates and its impacts on the First Nations population, particularly in children and adolescents. This will require collaboration amongst several sectors leading to living well as an individual, family, and community.