National Aboriginal Diabetes Association

EVALUATING NADA'S PROGRAM And SERVICES

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Produced by

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CHAPTER ONE
BACKGROUND AND METHODOLOGY

I) BACKGROUND:[i]

The **National Aboriginal Diabetes Association** (NADA) is funded by the **First Nations Inuit Health Branch** (FNIHB) of **Health Canada.** In 2014 it undertook an evaluation of its national program and services. **Kaplan Research Associates Inc.** was engaged to design and administer this evaluation. A broad range of stakeholders were encouraged to participate in this evaluation process. These included NADA's membership; Tribal Council representatives; partner organizations such as the Heart and Stroke Foundation, the Kidney Foundation and the Canadian Diabetes Association; government representatives; and its own Board members.

NADA has been in operation since 1995. Its vision is that it will be an open, independent grassroots organization that is the driving force in:

- Raising awareness about diabetes and among Aboriginal and non-Aboriginal peoples in Canada
- Advocating for program and services for Aboriginal peoples affected by diabetes
- Promoting healthy lifestyles to prevent the onset or complications of diabetes for all Aboriginal peoples

Accordingly, the objectives of NADA are to:

1) Support individuals, families and communities to access resources for diabetes prevention, education, research and surveillance
2) Establish and nurture working relationships with those committed to persons affected by diabetes
3) Inspire communities to develop and enhance their ability to reduce the incidence and prevalence of diabetes
4) Be the driving force ensuring that diabetes and Aboriginal people remain at the forefront of Canada's health agenda

Its operational objective is to:

5) Manage and operate NADA in effective and efficient ways.

Its program and services are predicated on the following values:

- We respect the diversity, culture and traditions of the people we work with
- We honour and validate the experiences, wisdom and knowledge around us, and cultural differences, in building relationships
- We approach people, families and Aboriginal communities with caring and sharing
- Integrity guides us as we strive for excellence and quality in the work we do
- We are accountable in taking responsibility for all that we do, in building efficient operations and in promoting a holistic approach in our activities
- Aboriginal communities and families are at the centre of what we do as we connect NADA with its members and their Aboriginal communities
- We value the freedom to represent the best interests of diabetes and Aboriginal peoples.

The majority of NADA's members develop and/or provide diabetes prevention services in communities across Canada. NADA seeks to support these service providers to:

- Enhance their education

- Attain new knowledge and skills related to diabetes prevention and the promotion of healthy diets and lifestyles
- Provide them with information and materials that they can distribute to the people they serve in the communities in which they live.
- Learn about successful strategies and programs that others in this field, in other jurisdictions, have implemented
- Network with colleagues in their communities and across the country
- Learn how to manage their own diabetes, or that of a friend or relative affected by diabetes, if applicable

One of the prominent means by which NADA seeks to address the needs of its members and others supporting Aboriginal people with diabetes is through a national diabetes conference that it sponsors approximately every two years. It also publishes a bi-monthly newsletter, provides programmatic and educational materials on-line through its website or at other conferences and tradeshows, and is a repository of Health Canada reports. Both members and non-members can order NADA's free resources, such as posters.

II) THE EVALUATION METHODOLOGY:

The current evaluation was carried out through a questionnaire-based process, including the use of quantitative and qualitative (open-ended) questions. The specific areas of inquiry were developed in conjunction with NADA. Questions were placed into an online questionnaire format. NADA sent out links to the questionnaire to all of its members, ADI workers, its partner organizations. NADA's Board members and other stakeholders across Canada. Several reminders were sent out in September 2014.

2.1) The Evaluation's Areas Of Inquiry:

The areas of inquiry of this evaluation included:

- A description of the respondents to this study:
  - Their roles in diabetes prevention
  - Where they live in Canada
  - Their associations with NADA
  - Their years of experience in this field and with their current employers
  - Their years of association with NADA
  - Their ancestry
  - Their personal diabetes histories (having diabetes themselves and/or having family members with diabetes

- Their association with NADA:
  - Whether they have ever accessed resources or information from NADA and how they accessed them
  - The types of resources or information they accessed
  - How they used the resources and information they accessed
  - Whether they attended the 7th National Aboriginal Diabetes Conference and Strategic Planning Process held in 2013
  - How often they visit NADA's website over the course of a month
  - Whether there are other resources or information, not currently available through NADA that they would like to receive, and what they are

- Their evaluation of NADA:
  - Whether they feel that they, and their organizations, benefit from their association with NADA
  - The extent to which NADA helped them achieve their objectives for being members of the organization

- The extent to which they believe that NADA has successfully achieved its own objectives
- The changes they would make to NADA, if they could (as an open-ended question)
- Their future intentions regarding NADA, including whether they plan to continue their association with the organization and recommend that their colleagues join NADA as well

- An evaluation of the 7th National Aboriginal Diabetes Conference and Strategic Planning Process, excerpted from the text of the conference evaluation report:[ii]
  - Attendees' reasons for attending the conference
  - Whether their reasons for attending were achieved
  - Whether attending the conference was a good use of participants' time
  - Their intentions regarding attending a future conference, or recommending that their colleagues attend
  - Their ideas for improving future conferences (as an open-ended question)

- Board members evaluating NADA:
  - Evaluating the organization's responsiveness to its membership; members' perceived familiarity with its services, resources and events; and perceptions regarding whether members feel they benefit through their association with NADA

2.2) Data Collection And Analysis:

All data were collected online and stored in an Excel platform by NADA. These data were then imported into the ***Statistical Package for the Social Sciences*** (SPSS) for data processing and analysis. All open-ended questions were subjected to a ***content analysis***, with ***verbatim comments*** being included where applicable. In total **216 completed questionnaires** were received by NADA. This reflects the most comprehensive rate of return experienced by the organization. The preliminary evaluation results were shared with NADA's Board members at an October 21st meeting as a ***PowerPoint*** presentation. Some comments and corrections noted at that time have been incorporated into this document.

2.3) Technical Notes Related To This Study:

2.3.1) Descriptive Statistics:

Descriptive statistics constitute a primary basis of analysis. They include frequency counts and percentage breakdown; along with the mean and median responses; and standard deviation (sd).

- The ***mean* (average)** is a measure of central tendency for continuous variables calculated as the sum of all scores in a distribution, divided by the number of scores.
- The ***median*** is the value or score that exactly divides an ordered frequency distribution into equal halves: the outcome associated with the ***50th percentile***.
- ***Standard Deviation*** is a measure of the degree to which the range of scores either clusters around the mean, or is more widely ***dispersed***, or spread, along a given scale.

2.3.2) Chi-Square:

Chi-Square (χ^2) is used when comparing ***nominal variables.*** Examples of nominal variables include gender, age categories, and so on. **Chi-Square** itself is defined as a test of statistical significance based on a comparison of the observed cell frequencies of a ***cross-tabulation***, or ***contingency table***, with frequencies that would be expected under the ***null hypothesis*** of no relationship. Where the resulting data conform to the ***expected distribution*** of cases across the cells of the contingency table, it is assumed that there is no statistical relationship between the variables being examined. That is, that one variable is not seen to affect the other. Where the actual distribution of cases varies from the expected distribution of cases across this table, a relationship between the variables under review is assumed.

In order to test whether there is a ***significant*** statistical relationship between the variables under review, two additional factors must be examined. These include the ***Degrees of Freedom*** (df) associated with the ***contingency tables***, and its ***level of probability*** (p). **Degrees of freedom** is a factor of the construction of the contingency table. It is derived by calculating the number of rows in the table (minus 1) by the number of columns in that table (minus 1). The formula then reads df=(R-1)(C-1). A two-by-two contingency table would have 1 degree of freedom (2-1)(2-1). A four by five contingency table would have 12 degrees of freedom (4-1)(5-1). Degrees of freedom is an important element in this analysis, in that it refers to the potential for cell entries to vary freely, given a fixed set of marginal totals (i.e. column and row marginals).

Probability asks the question: how ***likely*** is it that the relationship observed in the sample data could be obtained from a population in which there was no relationship between the two variables? If it can be shown that this probability is very high within the general population then, even though a relationship exists in that larger sample, it is concluded that the two variables are not related. Only if the probability that the relationship being examined could have been created by sampling a population in which no relationship exists were small, would it be concluded that a ***statistically significant*** relationship exists.

As a minimal standard, probability must be at least **.05** or less (P <.05) in order for there to be a finding of significant difference. That is, in order for the data to be found significant, it would be expected that the results would be found within the general population less than five times out of a hundred.

2.4) Establishing Study Benchmarks:

Benchmarks are standards that facilitate the objective assessment of evaluation findings. They help to determine which findings are considered positive, overall; which findings are considered moderately positive; and which findings indicate the need for change. The benchmarks for this study, established by the organization, are:

Primary Benchmark *(Overall Positive Findings)*	75.0%+ of respondents indicating positive responses *(i.e., 'Very Good' + 'Good,' 'Very Much' + 'Somewhat,' and so on)*
Secondary Benchmark *(Moderately Positive Findings)*	60.0% to 74.9% of respondents indicating positive responses
Tertiary Benchmark *(Areas Requiring Attention and/or Remediation)*	<60.0% of respondents indicating positive responses

CHAPTER TWO
RESPONDENTS' CHARACTERISTICS

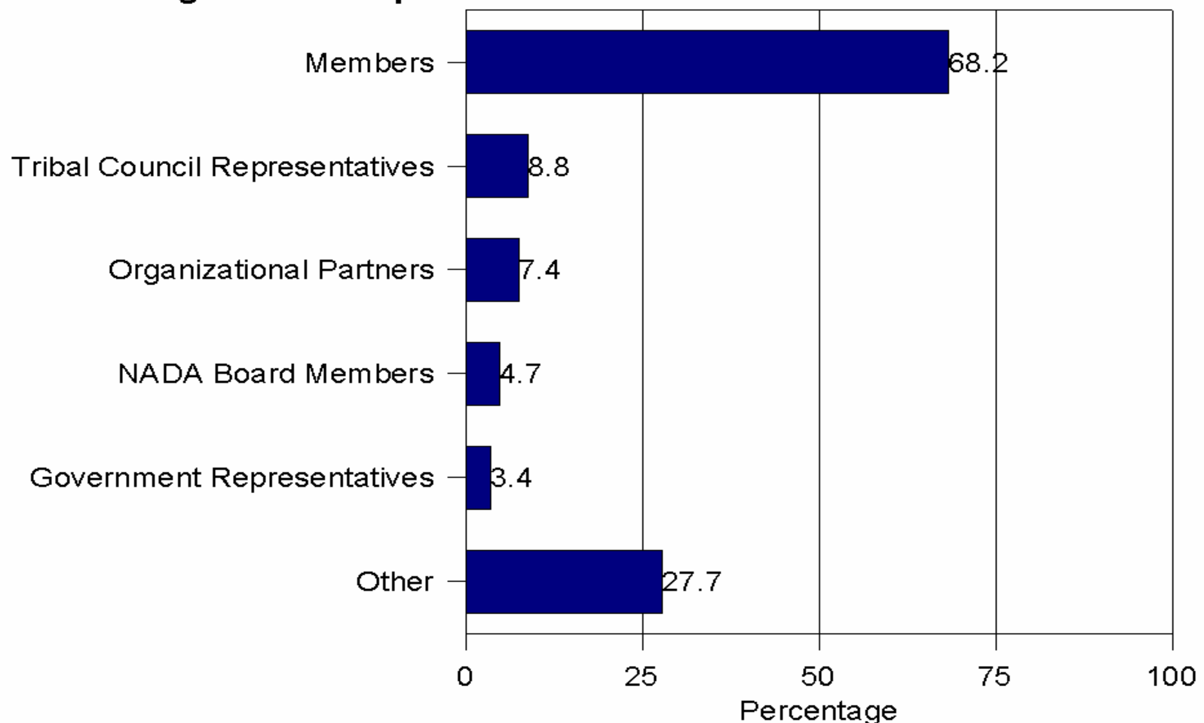
This chapter explores respondents' characteristics and roles in the diabetes prevention field. All related findings are analyzed in the aggregate, with several questions being analyzed by secondary independent variables.

I) THE RESPONDENTS TO THIS EVALUATION:

1.1) Their Associations With NADA:

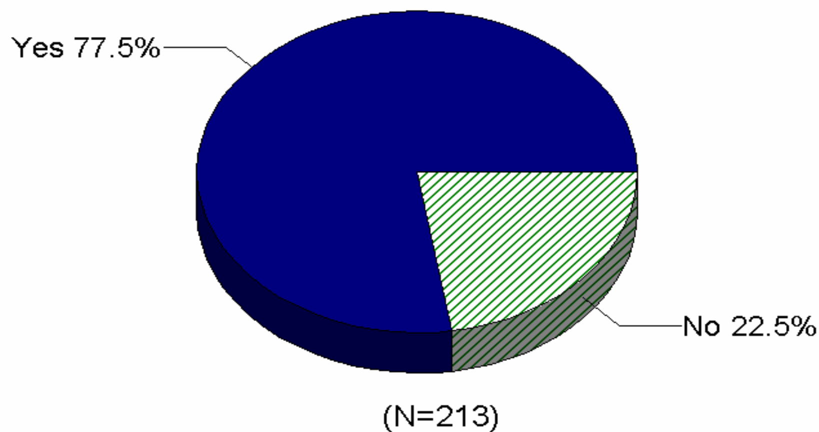
The largest percentage of respondents were NADA members (68.2%, n=101), followed by those with other relationships to NADA (27.7%, n=41), representatives of Tribal Councils (8.8%, n=13), organizational partners (7.4%, n=11), NADA Board members (4.7%, n=7), and representatives of government departments (3.4%, n=5) (Figure 1). Multiple responses were allowed for this question. Of the 47 respondents who indicated other associations with NADA, these included:

- 22 people employed in the healthcare sector (registered nurses, community health nurses, pharmacists, dietitians, health managers and other healthcare staff)
- 10 representatives from Aboriginal organizations and communities (Band Councils, Friendship Centres, and an Aboriginal women's association)
- 9 active Diabetes Prevention Workers (assumedly not also members of NADA)
- 6 representatives of programs supporting the ADI workers, including grant providers, those providing other resources, and presenters of related topics at workshops and conferences
- 4 representatives of affiliated or advocacy-based organizations
- 2 diabetes researchers
- 2 people with lived experience with diabetes
- 2 NADA staff



1.2) Their Roles In Diabetes Prevention:

Just over three quarters of all respondents (77.5%) were involved in diabetes prevention (Figure 2). This represents 165 individuals.



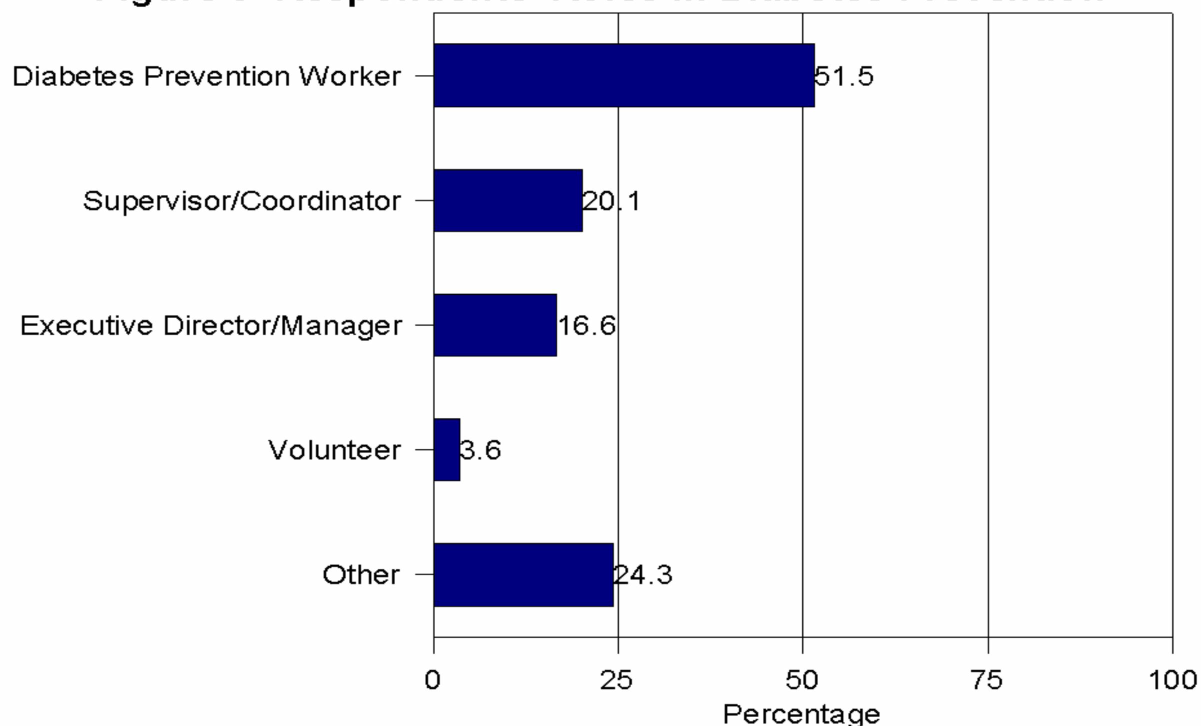
Of these, just over half (51.5%) were Diabetes Prevention Workers, 20.1% were program supervisors or coordinators, 16.6% were executive directors or managers, 3.6% were volunteers, and 24.3% reported some other role (Figure 3). This was a multiple response question.

Some respondents working in the field of diabetes prevention and the promotion of healthy living held a single position in their organizations, while several held multiple positions. In terms of the former, this included those working solely:

- As Diabetes Prevention Workers (n=69)
- As Supervisors or Program Coordinators (n=19)
- As Executive Directors or Senior Managers (n=24)
- As Volunteers (n=2)
- In "other" positions (n=33)

In addition, 22 respondents worked in multiple positions, including:

- 11 respondents who were both Diabetes Prevention Workers and Program Supervisors or Coordinators
- 3 respondents who were both Diabetes Prevention Workers and in other positions
- 1 respondent each who was:
  - A Diabetes Prevention Worker and Executive Director or Senior Manager
  - A Program Supervisor or Coordinator and Executive Director or Senior Manager
  - A Program Supervisor or Coordinator and a Volunteer
  - In another position and a Volunteer



- A Diabetes Prevention Worker, Executive Director or Senior Manager, and in another position
- A Program Supervisor or Coordinator, Executive Director or Senior Manager, and in another position
- A Diabetes Prevention Worker, Program Supervisor or Coordinator and in another position
- A Diabetes Prevention Worker, Program Supervisor or Coordinator, Executive Director or Senior Manager, and in another position

1.3) Respondents' Years Of Experience:

Respondents were quite experienced in their related fields and their years working with their current organizations (Figure 4). In terms of the former, respondents reported working an average of 10.0 years in their current fields, with a median of 8.0 (sd=8.31). Responses ranged from a minimum of 0.1 year (just over one month) to a maximum of 44.0 years. In terms of the latter, respondents reported working with their current organizations for an average of 10.2 years, and a median of 8.0 years (sd=8.33). The least amount of related experience was 0.2 years, with a maximum of 42.0 years.

1.4) Respondents' Years Of Association With NADA:

On average, each respondent reported being associated with NADA for 5.0 years, with a median of 3.0 (sd=4.71) (Figure 5). In this case the range of responses went from 0.1 years to a maximum of 20 years. Twenty years constitutes the full length of time that NADA has been in operation.

1.5) Respondents' Ancestry:

In the aggregate, over two-thirds of all respondents reported being of First Nations ancestry, with Treaty rights (68.4%) (Figure 6). Of the remainder 20.3% were non-Aboriginal, 5.7% were Métis, 3.3% were First Nations (non-Status), and 2.4% were Inuit. Analyzing respondents' ancestry by their roles in diabetes prevention, the largest percentage of Aboriginal individuals were Diabetes Prevention Workers (90.8%), or worked as volunteers (83.3%) (Table 1). Slightly smaller percentages of the

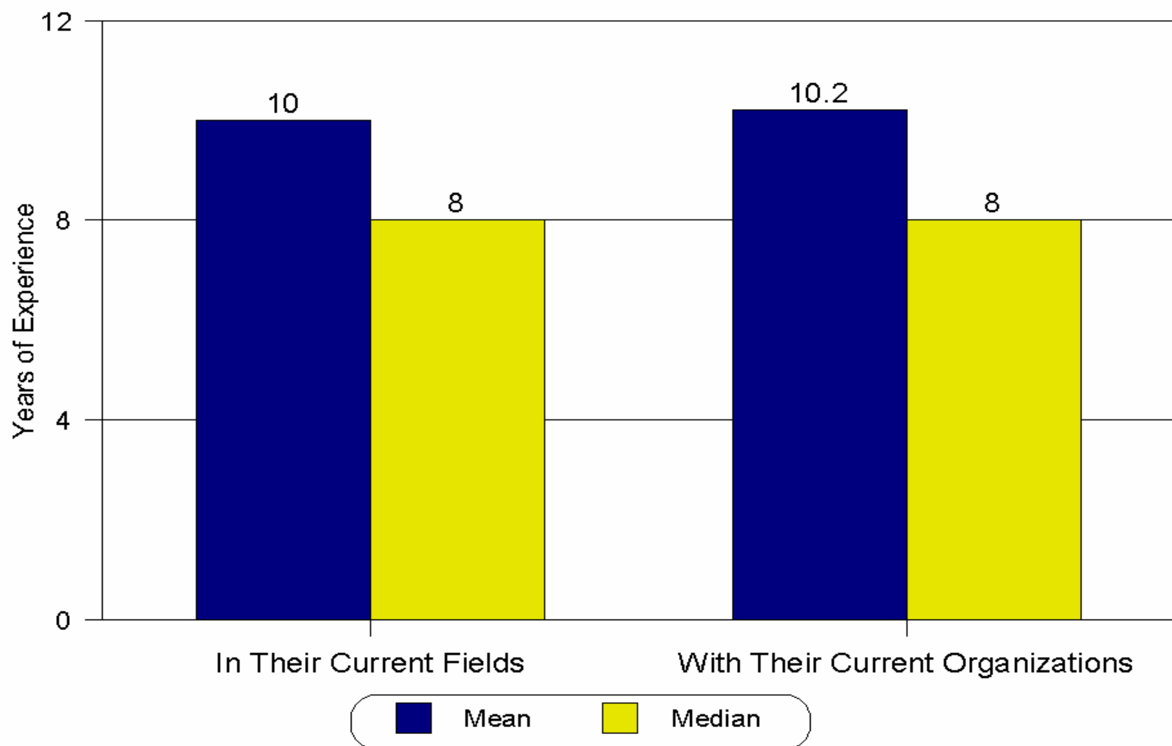


Figure 4 Respondents' Years Of Experience:
12
8
4
0
Years of Experience
10
8
10.2
8
In Their Current Fields
With Their Current Organizations
Mean
Median
(N=171, 174. Adjusted to exclude missing data.)

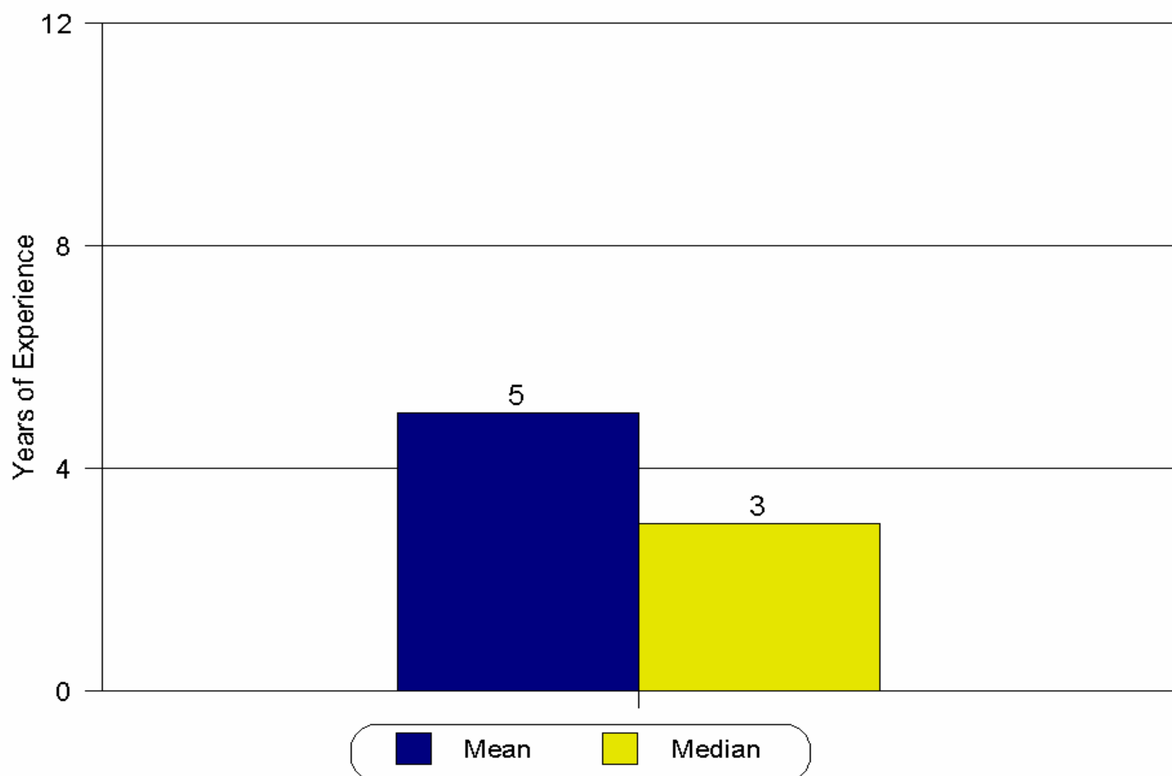
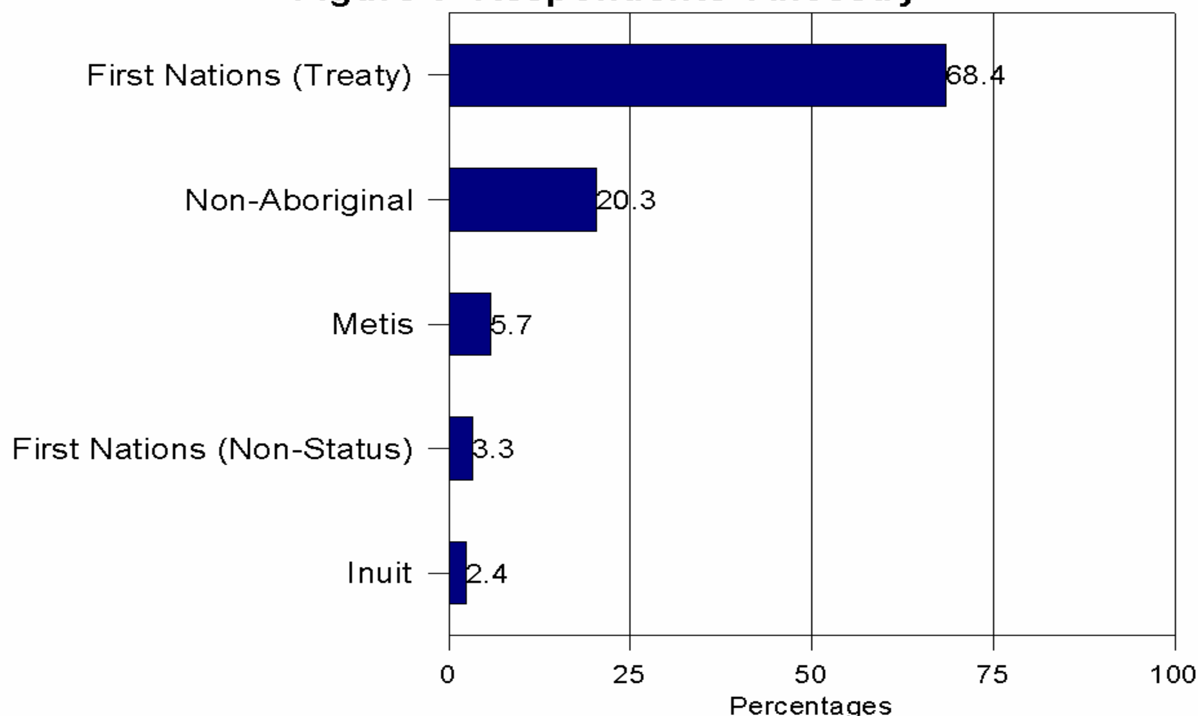


Figure 5 Respondents' Years Of Association With NADA
12
8
4
0
Years of Experience
5
3
Mean
Median
(N=128. Adjusted to exclude missing data.)



Aboriginal respondents were employed as executive directors or managers (75.0%), as supervisors or program coordinators (69.7%), or in other roles (68.3%). Given that multiple responses were allowed regarding respondents' roles, statistical significance was not measured.

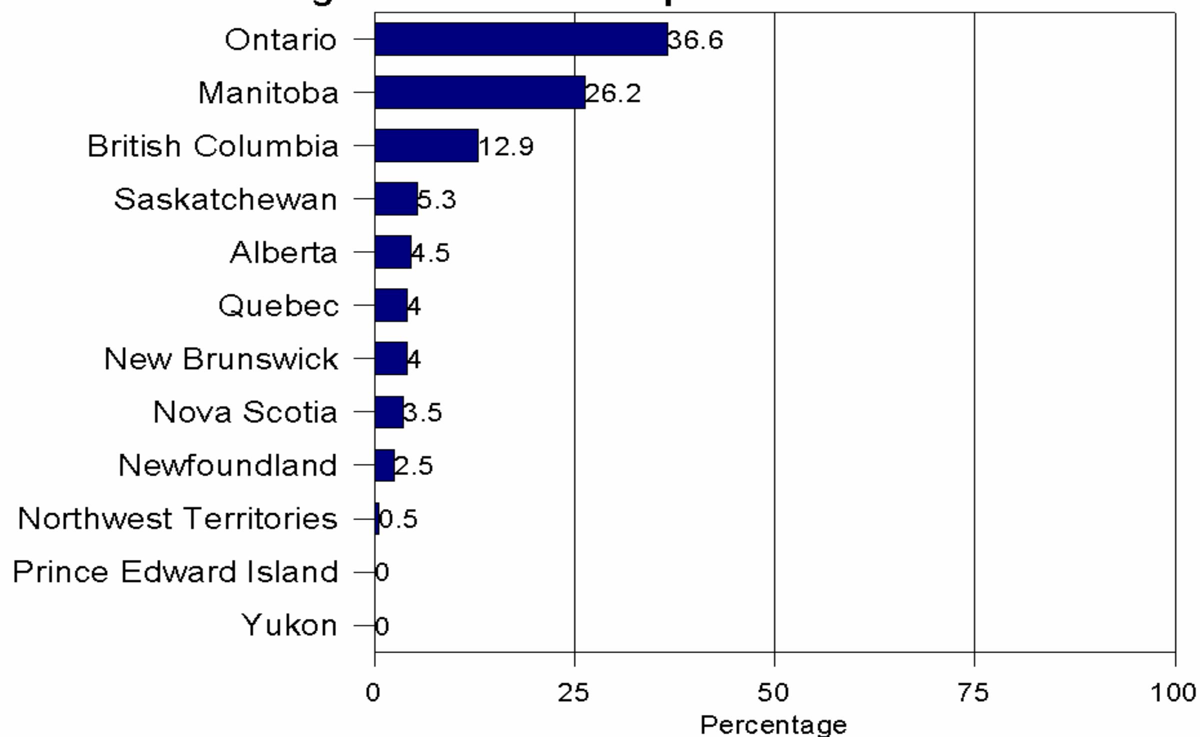
Table 1) Respondents' Roles In Diabetes Prevention Services By Ancestry

Positions or Role(s)*	First Nations (Treaty)		First Nations (Non-Status)		Métis		Inuit		Non-Aboriginal	
	%	N	%	N	%	N	%	N	%	N
Diabetes Prevention Workers	79.3%	69	4.6%	4	2.3%	2	4.6%	4	9.2%	8
Supervisors/Coordinators	69.7	23	-	-	-	-	-	-	30.3	10
Executive Directors/Managers	57.1	16	-	-	17.9	5	-	-	25.0	7
Volunteers	83.3	5	-	-	-	-	-	-	16.7	1
Other Roles	53.7	22	4.9	2	7.3	3	2.4	1	31.7	13

*Multiple responses were allowed for respondents' positions or roles.

1.5) Where Respondents Resided:

Based on the first three digits of respondents' Postal Codes, respondents represent almost all provinces and one territory of Canada (Figure 7). The exceptions included Prince Edward Island and the Yukon Territory.[iii] The province with the largest percentage of respondents was Ontario (36.6%, n=74). They were followed by those from Manitoba (26.2%, n=53); and British Columbia (12.9%, n=26). The remaining provinces or territories reflected in this study were: Saskatchewan (5.1%, n=11); Alberta (4.5%, n=9); Quebec (4.0%, n=8); New Brunswick (4.0%, n=8), Nova Scotia (3.5%, n=7); Newfound-land and Labrador (2.5%, n=5); and the Northwest Territories (0.5%, n=1).



1.7) Respondents' Lived Experiences With Diabetes:

Diabetes is recognized as being an epidemic within Aboriginal communities. It touches the lives of the people living with diabetes, and those who have family members with this disease. Accordingly, respondents were asked two questions regarding their lived experiences with diabetes: did they have diabetes themselves and did they have family members with diabetes?

1.7.1) The Aggregate Findings:

In the aggregate, 27.3% of all respondents have diabetes themselves (Figure 8). In addition, almost two-thirds of all respondents (66.2%) have family members who have diabetes.

1.7.2) By Ancestry:

Aboriginal respondents were significantly more likely than non-Aboriginal respondents to have diabetes (Figure 9). This applied to 32.5% of the Aboriginal respondents compared with 7.0% of the non-Aboriginal respondents (N=212, χ^2=11.28, df=1, p=.0008). Aboriginal respondents were also significantly more likely than their non-Aboriginal counterparts to have family members with diabetes: 73.4% compare with 44.2% (N=212, χ^2=13.3, df=1, p=.0003).

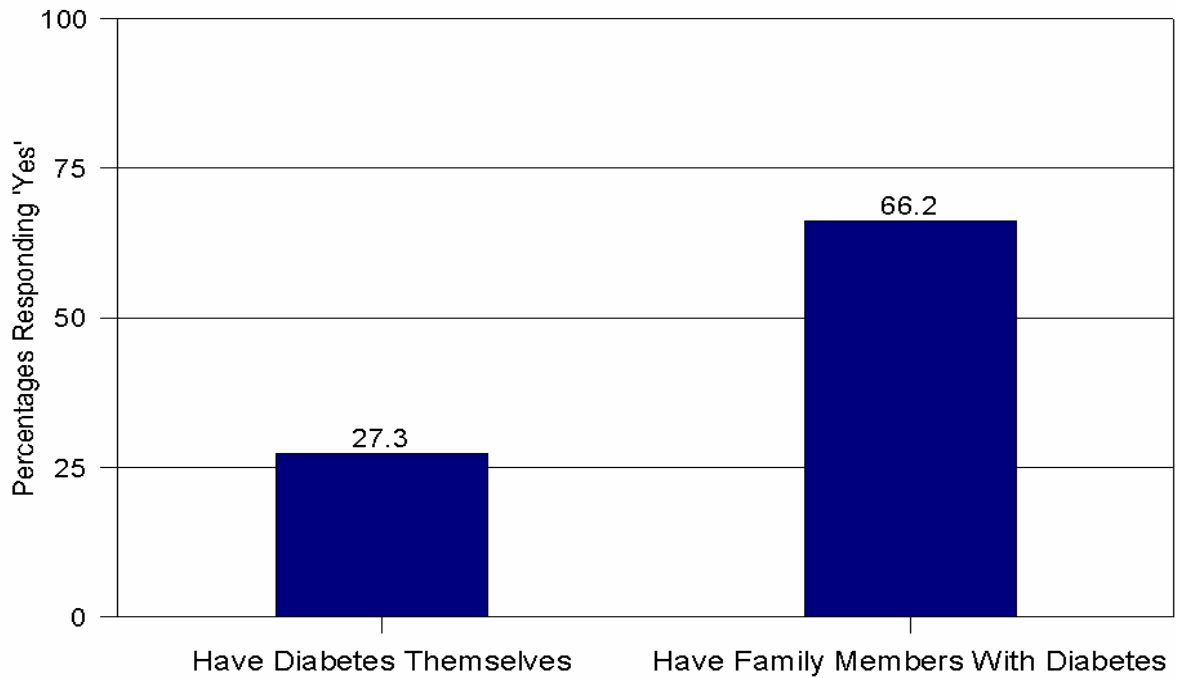


Figure 8 Respondents' Personal Experiences
With Diabetes, Aggregate
100
75
50
25
0
Percentages Responding 'Yes'
27.3
66.2
Have Diabetes Themselves
Have Family Members With Diabetes
(N=216, 216)

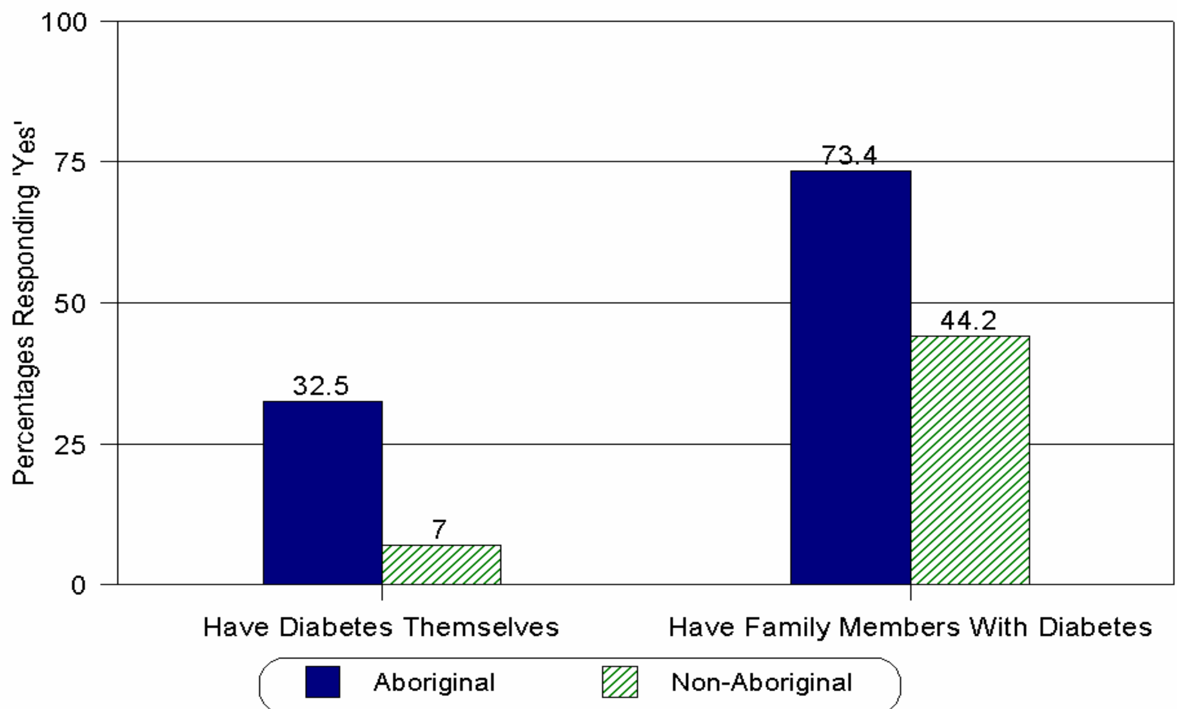
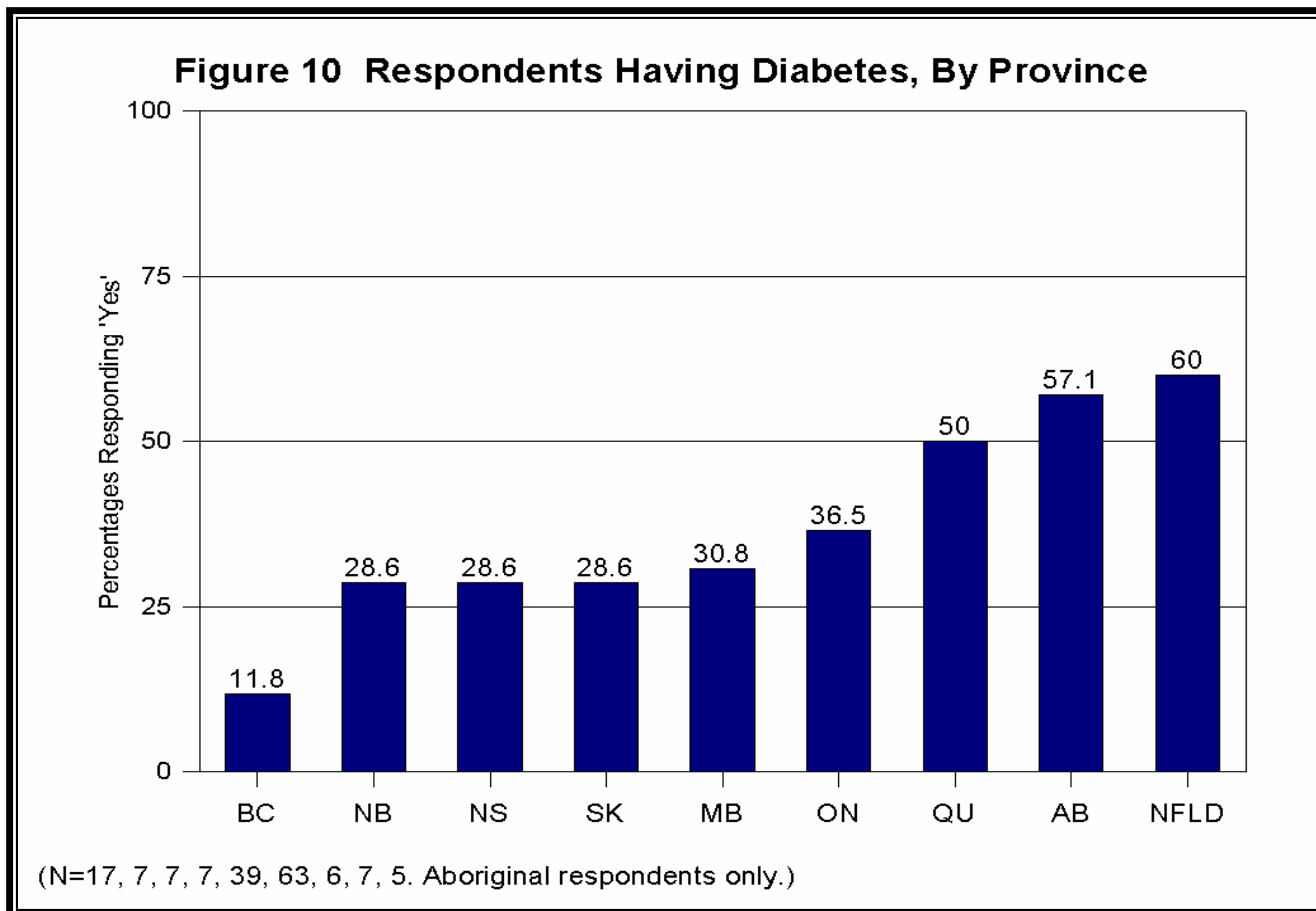


Figure 9 Respondents' Personal Experiences
With Diabetes, By Ancestry
100
75
50
25
0
Percentages Responding 'Yes'
32.5
7
73.4
44.2
Have Diabetes Themselves
Have Family Members With Diabetes
Aboriginal
Non-Aboriginal
(N=169/43, 169/43. Adjusted to exclude missing data regarding ancestry.)

1.7.3) By Province Of Residency:

There were no significant variations in the percentage of Aboriginal respondents with diabetes, based on their residency (Figure 10) (N=158, χ^2=8.28, df=8, p=.407). The highest percentage of respondents with diabetes lived in Newfoundland or Labrador (60.0%, n=5), Alberta (57.1%, n=7), or Quebec (50.0%, n=6). With the exception of British Columbia, between 28.6% and 36.5% of the respondents from the remaining provinces live with diabetes. Due to the small number of respondents living in some provinces, these findings are provided solely for interest. These data relate solely to Aboriginal respondents.



Similar findings emerged regarding the percentage of Aboriginal respondents who have family members with diabetes (Figure 11) (N=158, χ^2=10.45, df=8, p=.235). The highest percentage of respondents reporting this resided in Ontario (79.4%, n=63), Manitoba (74.4%, n=39), Alberta (71.4%, n=7), and Nova Scotia (71.4%, n=7). The smallest percentage of respondents with family members with diabetes resided in Newfoundland or Labrador (20.0%, n=5).

1.7.4) The Range Of Respondents' Experiences With Diabetes:

There were four types of experiences that respondents could have with diabetes: no experiences at all, experiences solely as a person living with diabetes, experiences solely as a person with a family member with diabetes, and someone who experiences both.

i) The Aggregated Findings:

In the aggregate the largest percentage of respondents had a family member with diabetes but did not live with this disease themselves (51.4%) (Figure 12). Of the remainder, 21.0% reported having no direct or family experience with diabetes, 15.4% experienced both associations with diabetes, and 12.1% lived with diabetes but had no family members who did so.

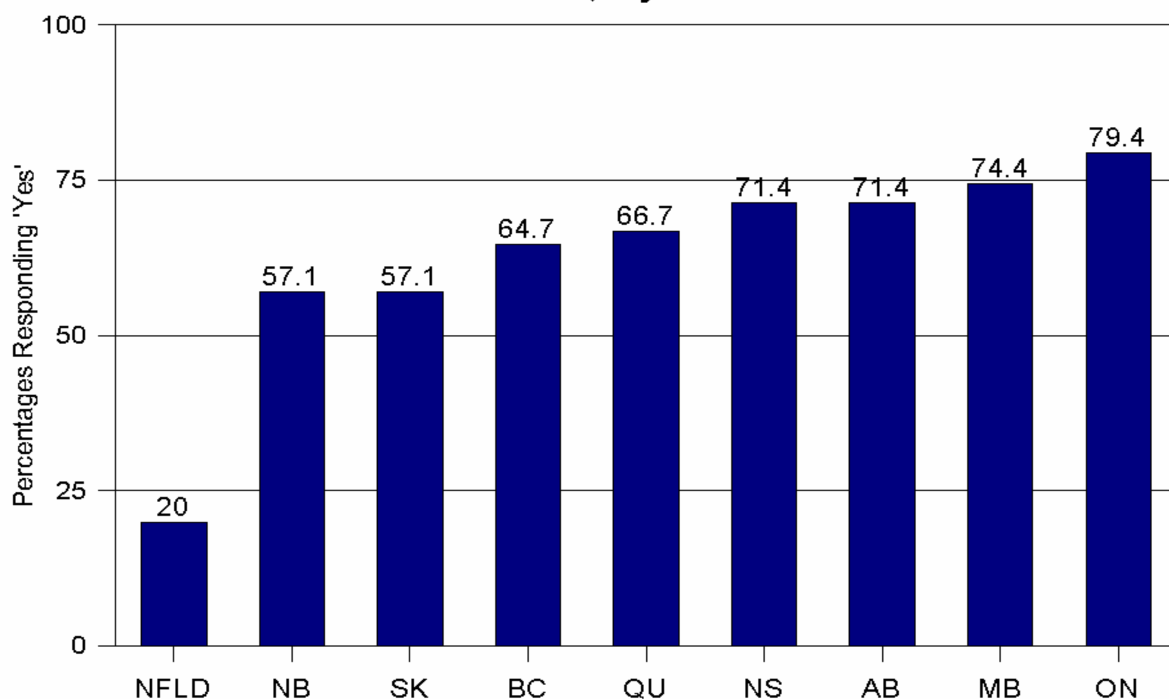


Figure 11 Respondents With Family Members
With Diabetes, By Province
Percentages Responding 'Yes'
100
75
50
25
0
20
57.1
57.1
64.7
66.7
71.4
71.4
74.4
79.4
NFLD
NB
SK
BC
QU
NS
AB
MB
ON
(N=5, 7, 7, 17, 6, 7, 7, 39, 63. Aboriginal respondents only.)

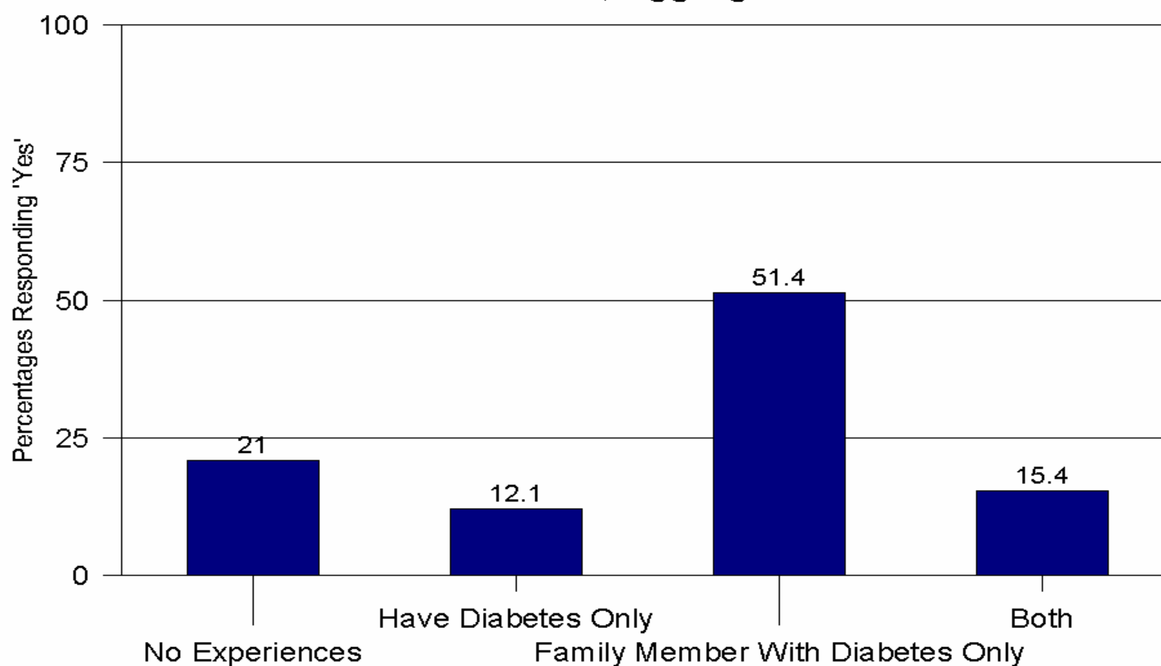
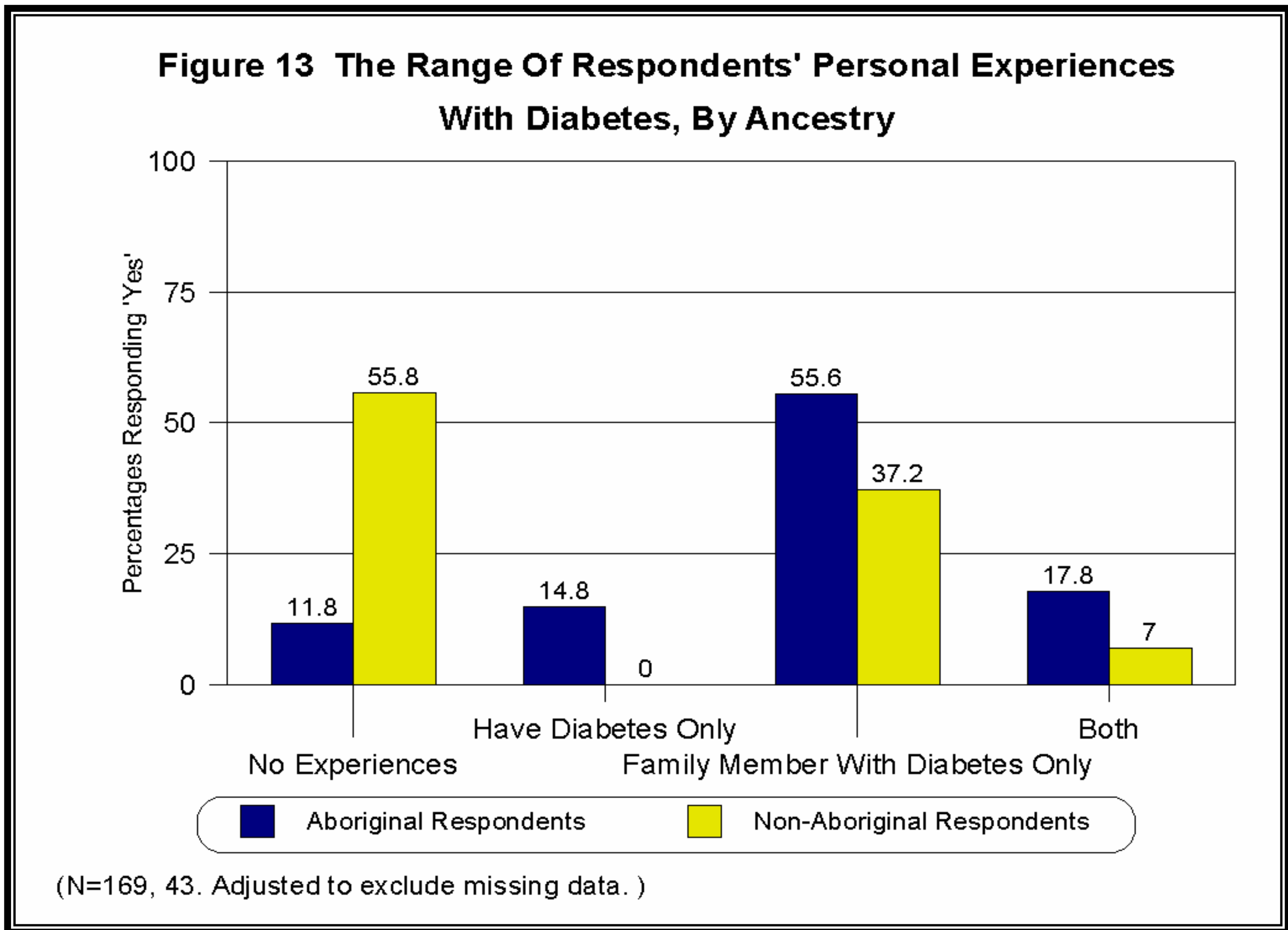


Figure 12 The Range Of Respondents' Personal Experiences
With Diabetes, Aggregate
Percentages Responding 'Yes'
100
75
50
25
0
21
12.1
51.4
15.4
No Experiences
Have Diabetes Only
Family Member With Diabetes Only
Both
(N=214. Adjusted to exclude missing data.)

ii) By Ancestry:

When these data were analyzed by respondents' ancestry, highly significant variations emerged (Figure 13) (N=212, χ^2=43.10, df=3, p<.00001). The majority of non-Aboriginal respondents had no associations with diabetes, either personally or through family members (55.8%), while 37.2% had family members with diabetes but were not living with diabetes themselves. Three respondents (7.0%) reported both living with diabetes and having family members who did so.

Of the Aboriginal respondents in this study, 11.8% had no direct or familial connections with diabetes, 55.6% reported having family members with diabetes but not living with diabetes themselves, 14.8% reported living with diabetes themselves but having no family members who did so, and 17.8% reported both living with diabetes themselves and having family members with diabetes.



CHAPTER THREE
RESPONDENTS' UTILIZATION OF NADA'S RESOURCES AND INFORMATION

I) BACKGROUND:

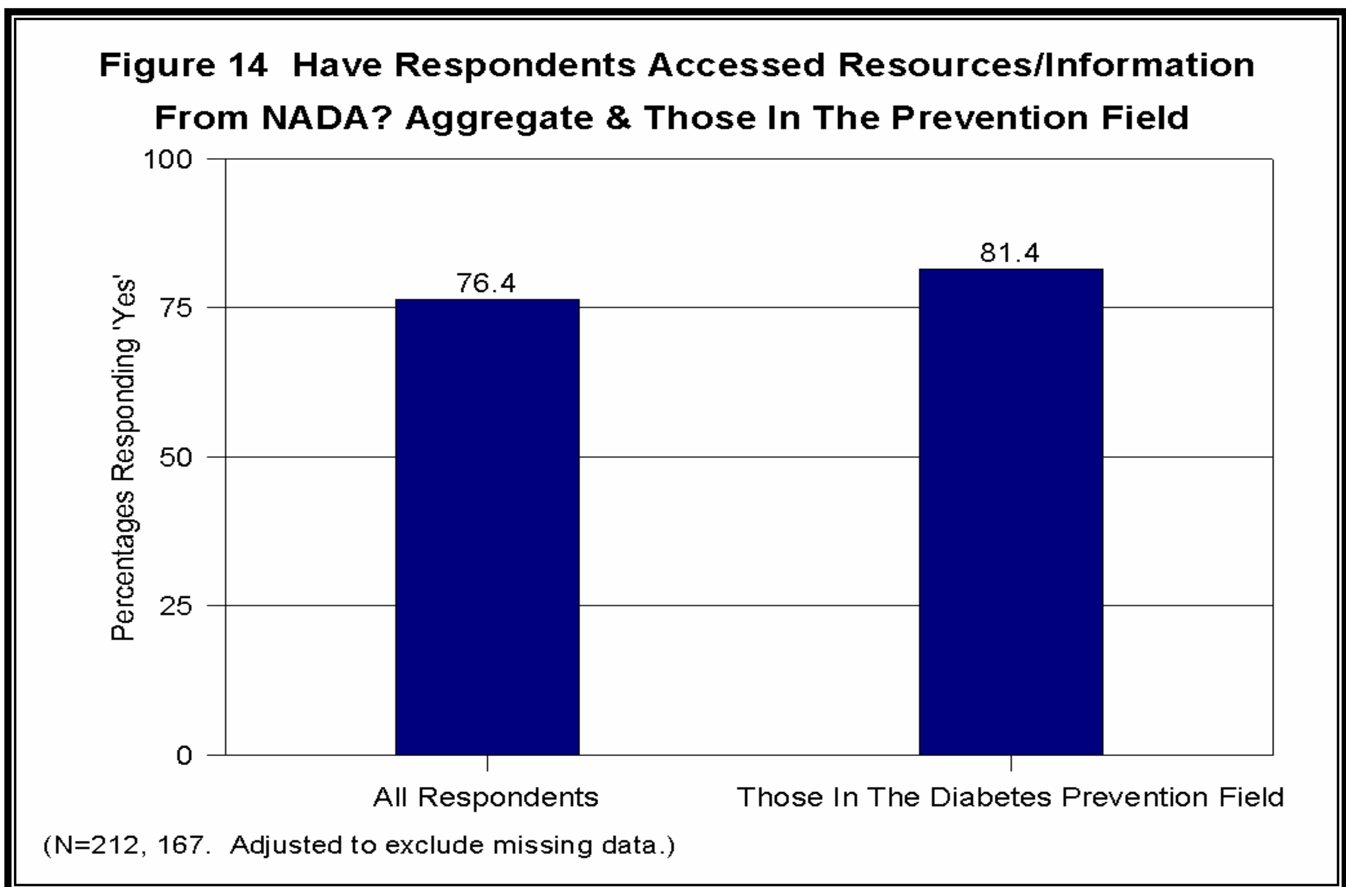
This chapter explores the extent to which respondents accessed NADA's resources and information; how they were accessed; the types of resources and information they accessed; how they were used; how often respondents visit NADA's website; and whether there were other resources or information they would like NADA to provide and what they are. This chapter also explores whether respondents had attended the 7th NADA conference held in Winnipeg in November 2013. All of the related findings are presented in the aggregate (as a single group), and responses from the Diabetes Prevention Workers in this study.

II) PREVALENCE AND NATURE OF RERESPONDENTS' USE OF NADA'S RESOURCES AND INFORMATION:

2.1) Respondents Accessing Resources And Information:

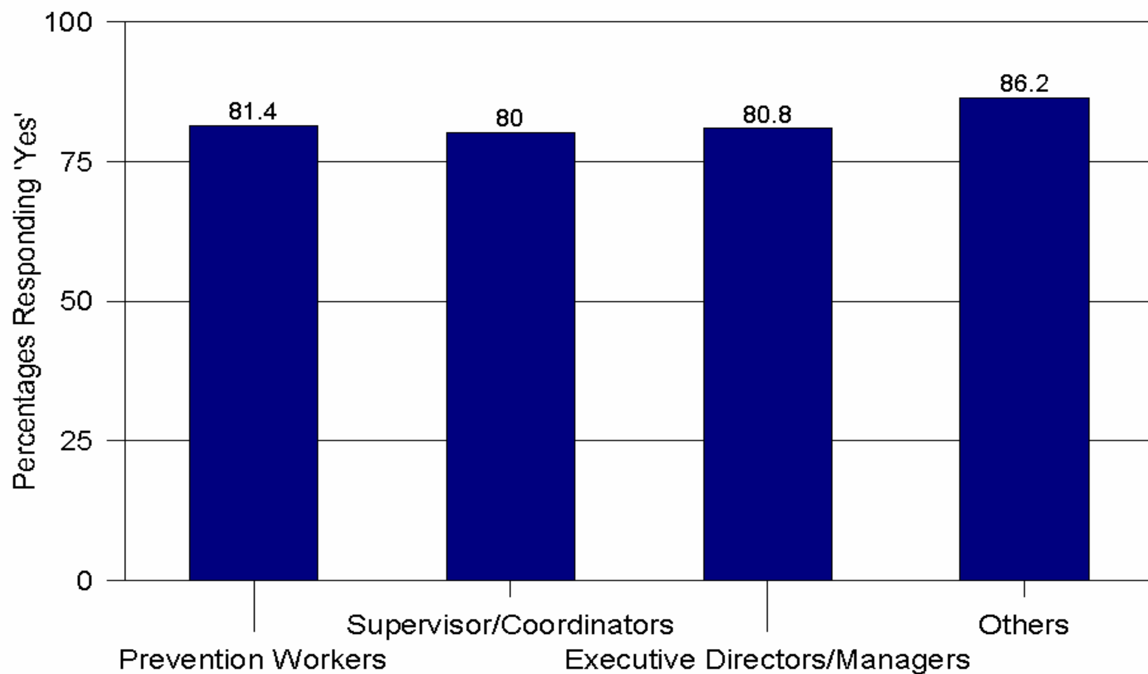
2.1.1) The Aggregate Findings:

In the aggregate 76.4% of all respondents have accessed resources or information from NADA (Figure 14). A somewhat larger percentage of the respondents working in the Diabetes Prevention and Health Promotion field (81.4%) had accessed resources or information from NADA.



2.1.2) By Position:

The percentages of respondents who accessed NADA's resources and information did not vary significantly based on their positions (Figure 15) (N=166, χ^2=7.74, df=8, p=.459). This ranged from a relative low of 80.0% for supervisors and coordinators to a high of 86.2% of respondents in other positions.



2.2) Respondents Attending NADA's Recent National Conference:

In the aggregate 42.5% of all respondents to this evaluation had attended the 7th National Diabetes Association Conference and Strategic Planning Process, held in Winnipeg in November 2013 (Figure 16). This figure represents 90 respondents. Diabetes Prevention Workers were more likely to have attended the 2013 National Conference and Strategic Planning Process (58.8%).

2.3) How Respondents Accessed NADA's Resources And Information:

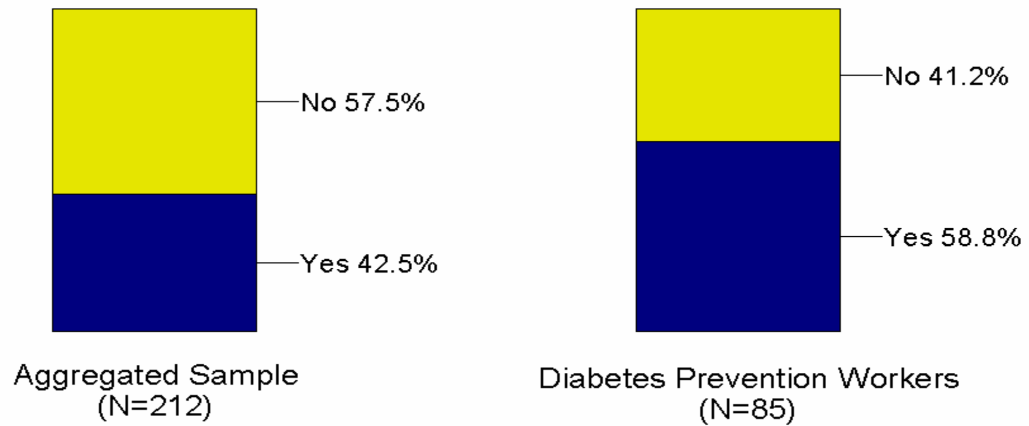
2.3.1) In The Aggregate:

Respondents were provided with a list of eight possible ways in which these resources and information could be accessed, and were asked to select those that applied to them. In the aggregate the two most frequent ways that they were accessed were through NADA's website (71.8%) or at a conference (63.2%) (Figure 17). Other less frequent means of accessing new resources and information included at health fairs (17.2%), at NADA's offices (12.9%), on Facebook (7.4%), at a tradeshow (5.5%), on Twitter (1.8%), or in some other way (8.6%).

2.3.2) Reported By Diabetes Prevention Workers:

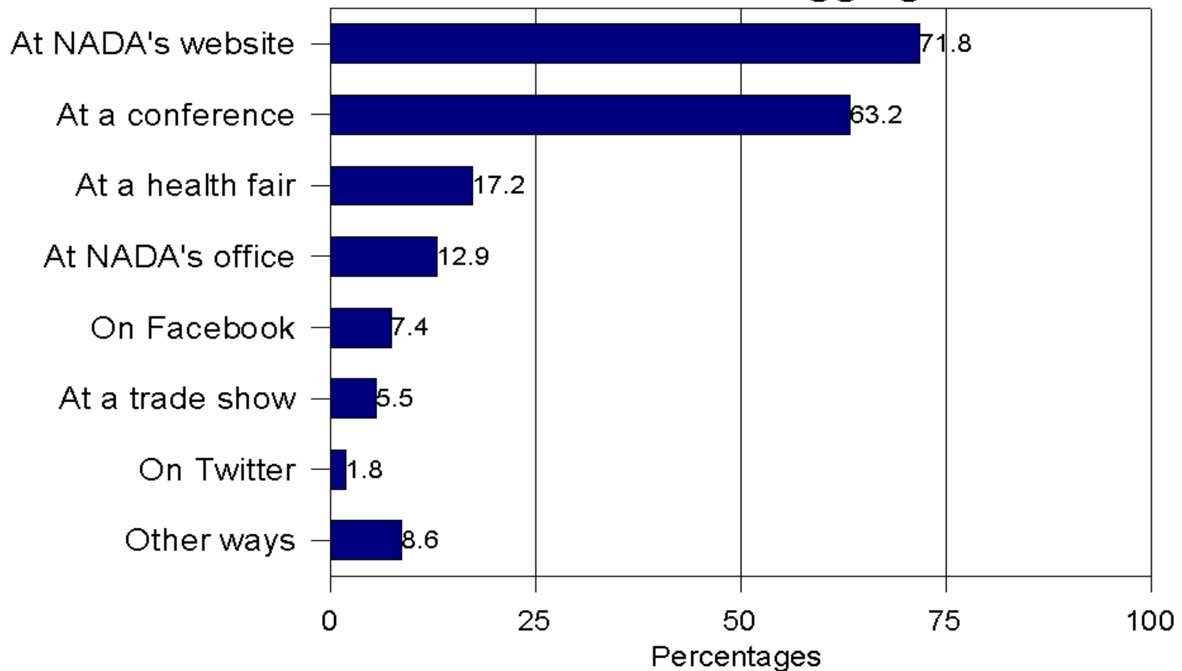
When these findings were analyzed solely for the Diabetes Prevention Workers in this study, a larger percentage reported accessing NADA's resources and information at a conference or through NADA's website (81.7% and 74.6%, respectively) (Figure 18).

Figure 16 Had Respondents Attended The 7th Annual Diabetes Conference And Strategic Planning Session?

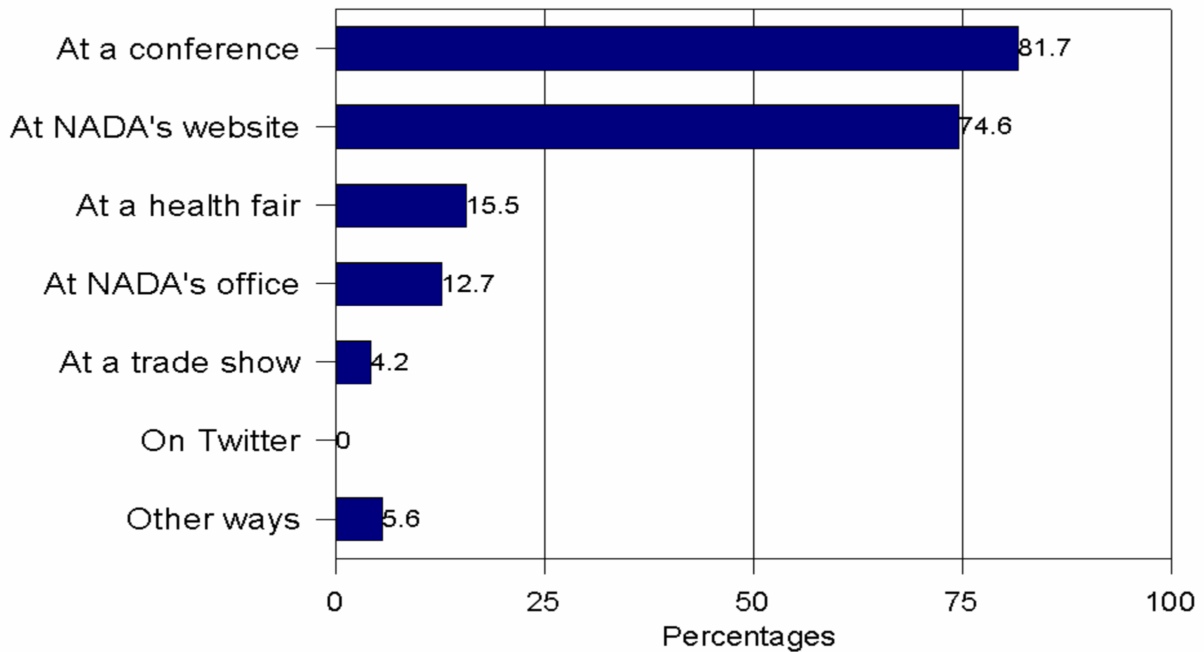


(Adjusted to exclude missing data.)

Figure 17 How Had Respondents Accessed Resources Or Information From NADA? Aggregate



(N=163. Multiple responses are allowed. Adjusted to exclude missing data.)



2.4) Frequency Of Respondents Visiting NADA's Website:

2.4.1) In The Aggregate:

The majority of respondents (53.7%) visited NADA's website one or two times in an average month (Figure 19). This equals an average of about 12 to 24 visits per year per person. Just under one-quarter (22.7%) never visited the website, and the remaining respondents visited it, on average, three or more times per month. This equals an average of at least 36 visits per year per person.

2.4.2) Reported By Diabetes Prevention Workers:

The Diabetes Prevention Workers visited NADA's website more often that the aggregate sample. Only 16.9% of these respondents never visited the website in an average month, about half visited it on average one to two times per month, and almost one-third visited it three or more times per month.

2.5) Resources And Information Respondents Accessed From NADA:

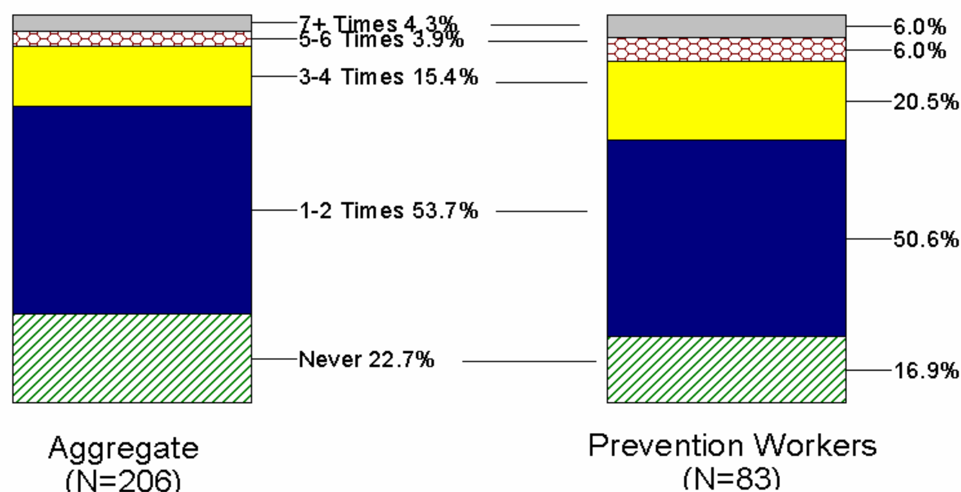
2.5.1) The Aggregated Findings:

Overall, respondents, who accessed NADA resources or information, were most likely to access articles about diabetes (69.8%), related newsletters (57.1%), and information about upcoming events (52.7%) (Figure 20). Other accessed resources and information included posters (42.9%), links to other websites (33.5%) and reports (30.1%).

2.5.2) Reported By Diabetes Prevention Workers:

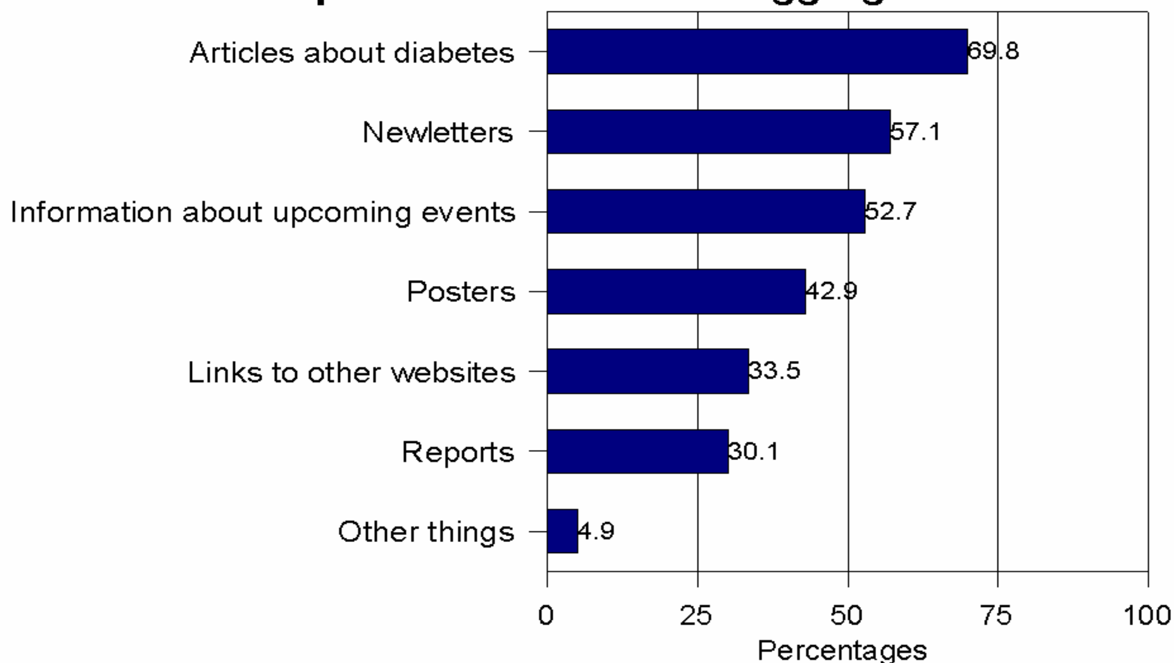
Diabetes Prevention Workers were also most likely to access articles about diabetes (75.0%), diabetes-related newsletters (61.3%), information about upcoming events (58.8%), and posters (47.5%) (Figure 21).

Figure 19 How Often On Average, Per Month, Did Respondents Visit The NADA Website?

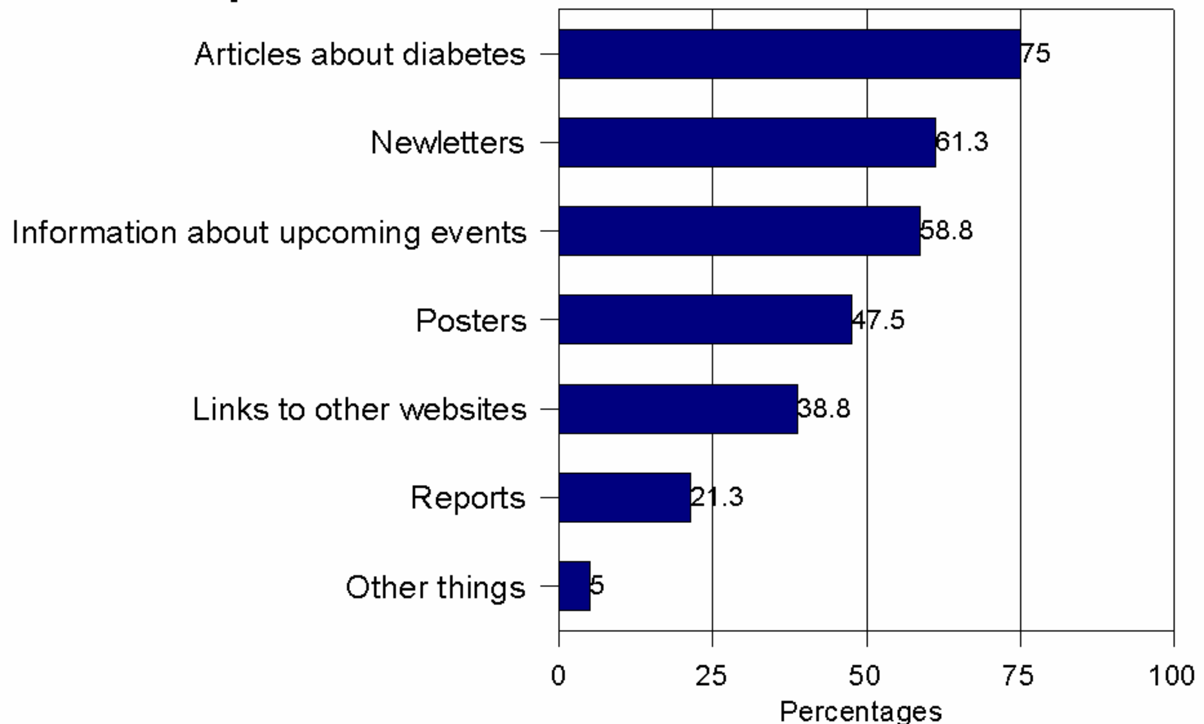


(Adjusted to exclude missing data.)

Figure 20 What Resources And Information Had These Respondents Accessed? Aggregate



(N=182. Multiple responses are allowed. Adjusted to exclude missing data.)



2.6) Respondents' Reasons For Accessing Resources And Information From NADA:

2.6.1) The Aggregated Findings:

In the aggregate respondents were most likely to access resources and information from NADA for their own educational purposes (60.6%), to distribute to their larger communities (55.9%), to get ideas for healthy eating initiatives (55.9%), to distribute to their clients or program participants (54.3%), for the benefit of someone else with diabetes (51.6%), or to get ideas for community development initiatives (44.7%) (Figure 22). The less frequent reasons to access resources and information included: to network with their colleagues (29.3%), to facilitate or support community networking (24.5%), to get ideas for related to community capacity building (23.4%), to get ideas for mental health initiatives (22.3%), for their own benefit related to healthier living or diabetes management (21.3%), to make new connections (16.0%), and/or as part of a course that they were taking (5.3%). Only 3.2% of all respondents (n=6) were not able to make use of the resources or information they received from NADA.

2.6.2) Reported By Diabetes Prevention Workers:

The Diabetes Prevention Workers in this study were notably more likely than the aggregated sample to make use of the resources or information provided by NADA for program development purposes (Figure 23). This included: distributing the resources or information to their larger communities (71.8%), distributing the resources or information to their clients or program participants (70.5%), to get ideas for healthy eating initiatives (69.2%), to get ideas for community development initiatives (56.4%), and/or to get ideas for mental health initiatives (34.6%).

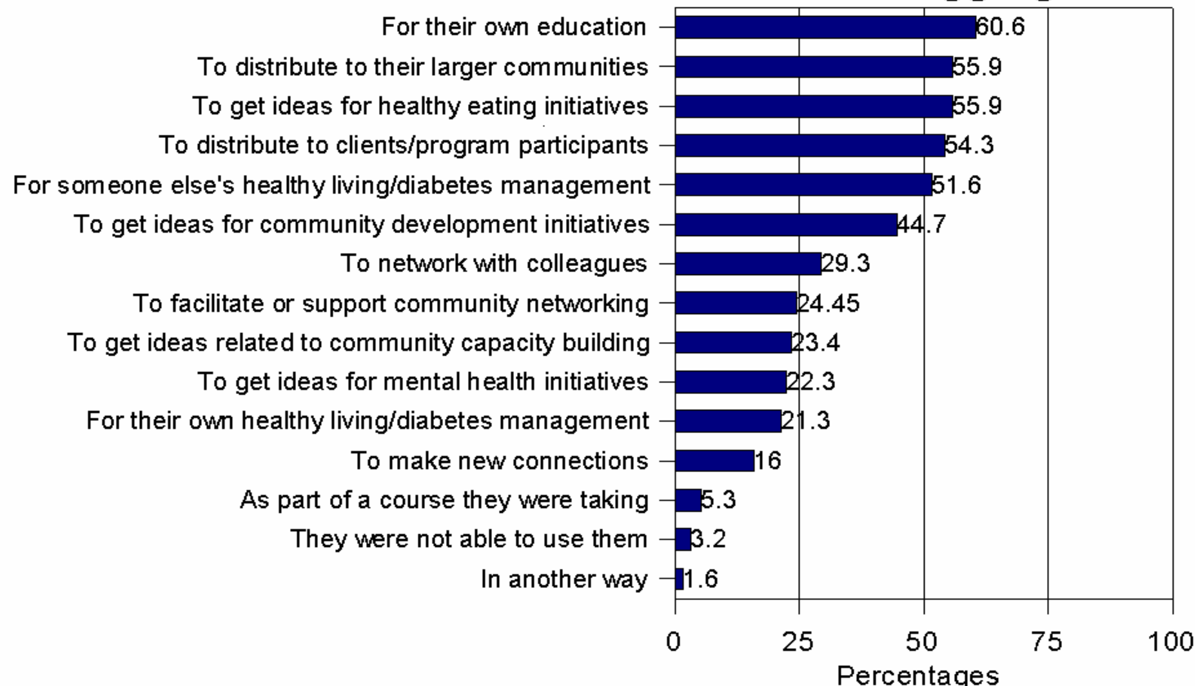


Figure 22 How Had Respondents Used The Resources And Information Accessed From NADA? Aggregate
For their own education
To distribute to their larger communities
To get ideas for healthy eating initiatives
To distribute to clients/program participants
For someone else's healthy living/diabetes management
To get ideas for community development initiatives
To network with colleagues
To facilitate or support community networking
To get ideas related to community capacity building
To get ideas for mental health initiatives
For their own healthy living/diabetes management
To make new connections
As part of a course they were taking
They were not able to use them
In another way
60.6
55.9
55.9
54.3
51.6
44.7
29.3
24.45
23.4
22.3
21.3
16
5.3
3.2
1.6
0
25
50
75
100
Percentages
(N=188. Multiple responses are allowed. Adjusted to exclude missing data.)

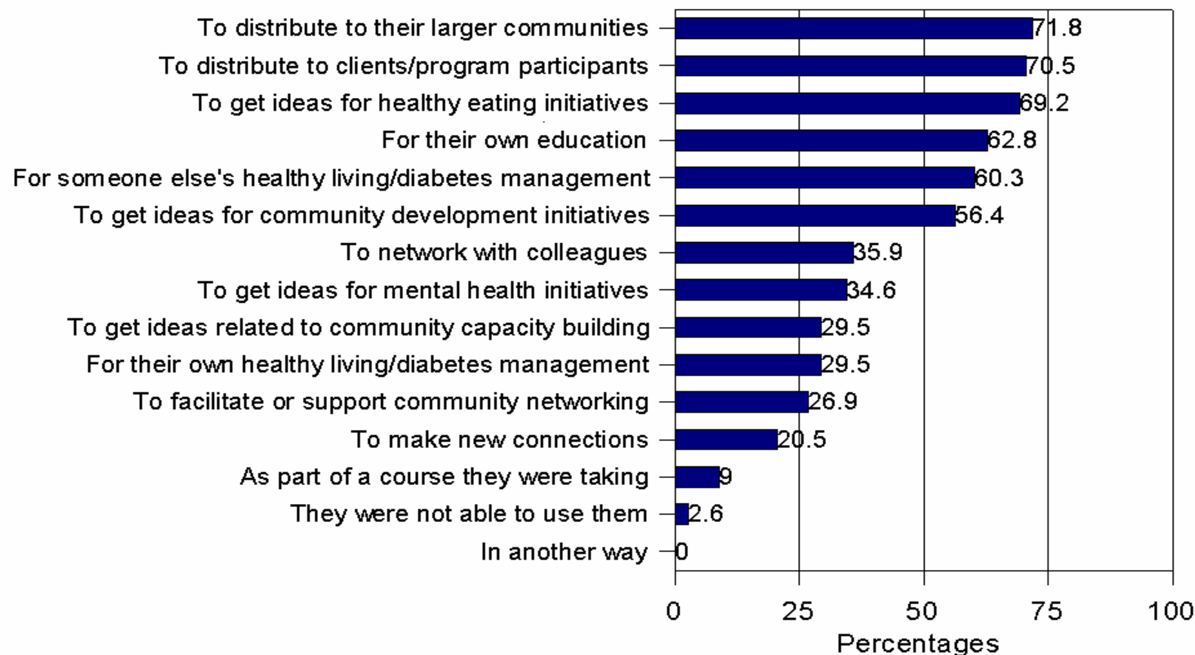
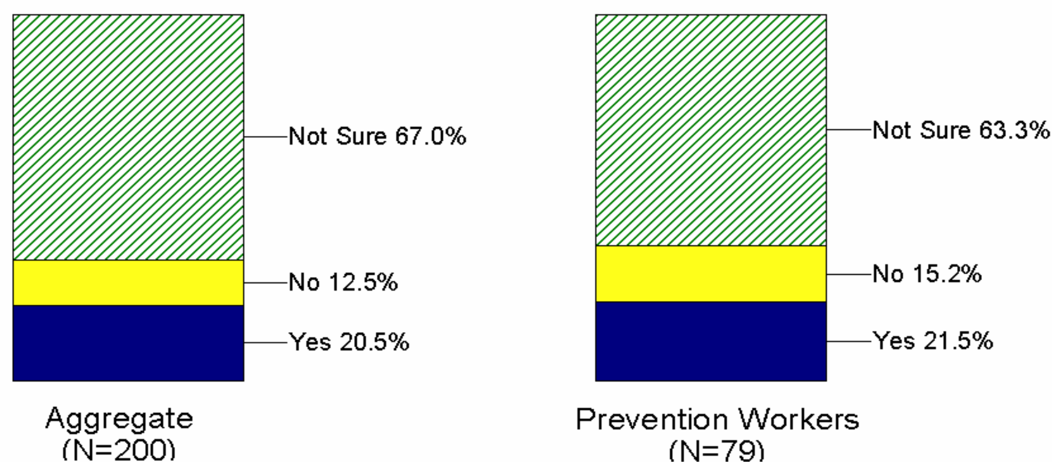


Figure 23 How Had Respondents Used Resources And Information Accessed From NADA? Prevention Workers
To distribute to their larger communities
To distribute to clients/program participants
To get ideas for healthy eating initiatives
For their own education
For someone else's healthy living/diabetes management
To get ideas for community development initiatives
To network with colleagues
To get ideas for mental health initiatives
To get ideas related to community capacity building
For their own healthy living/diabetes management
To facilitate or support community networking
To make new connections
As part of a course they were taking
They were not able to use them
In another way
71.8
70.5
69.2
62.8
60.3
56.4
35.9
34.6
29.5
29.5
26.9
20.5
9
2.6
0
0
25
50
75
100
Percentages
(N=78. Multiple responses are allowed. Adjusted to exclude missing data.)

2.7) Respondents Wanting Other Resources Or Information From NADA:

One in five respondents (20.5%) reported that there were additional resources or supports that they would like NADA to provide (Figure 24). This represents 41 respondents. Of the Diabetes Prevention Workers in this study, 21.5% reported wanting additional resources or information from NADA (n=15).

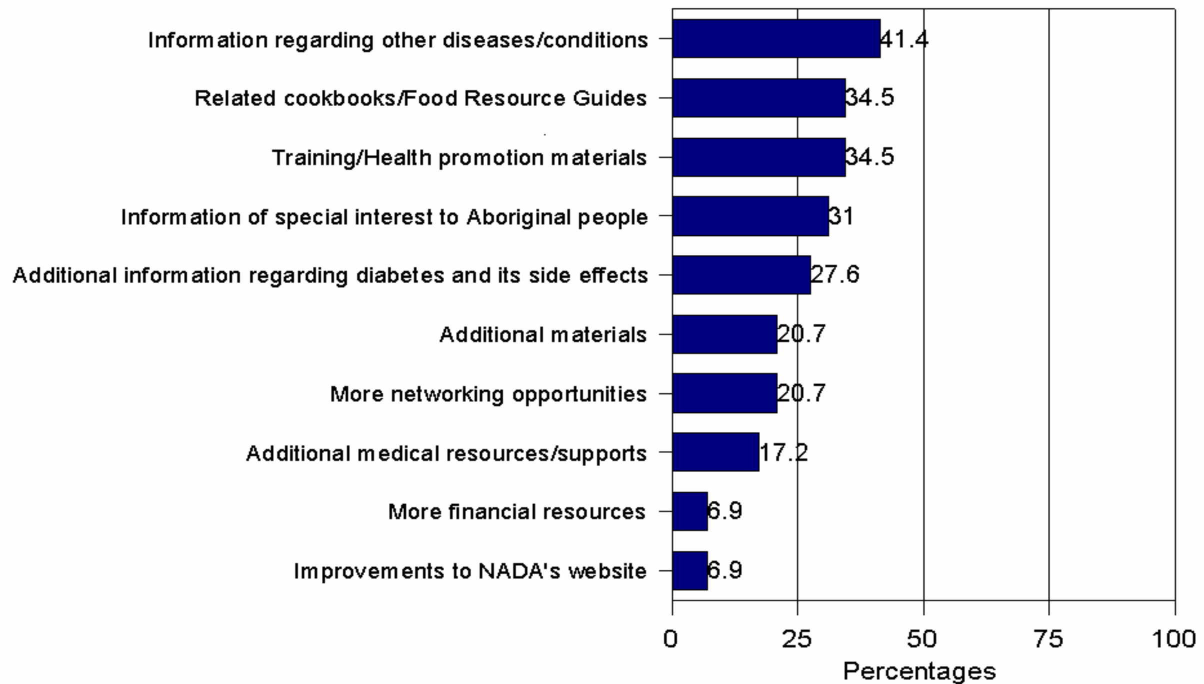
Figure 24 Are There Other Resources Or Information Respondents Would Like NADA To Provide?



(Adjusted to exclude missing data.)

2.8) Desired Additional Resources Or Supports Identified By Respondents:

Following-up from the preceding question, respondents were asked to identify additional resources or supports they would like NADA to provide. This was an open-ended question allowing for the widest range of responses. The four most frequently desired resources or information included: information regarding other (ancillary) diseases or conditions associated with diabetes (41.4% of the respondents who provided a comment), cookbooks or food resource guides (34.5%), training and health promotion materials (34.5%), information that would be of special interest to Aboriginal people (31.0%), and additional information regarding diabetes and its side-effects (27.6%) (Figure 25). Suggestions that were provided less frequently included: additional (generic) materials (20.7%), more networking opportunities (20.7%), additional medical resources and supports (17.2%), more financial supports for NADA to provide more services (6.9%), and improvements to NADA's websites.



2.8.1) Related Verbatim Comments:

Verbatim comments associated with this question are provided below and on the following pages:

__Information On Other Diseases/Medical Conditions__:

More on foot care and courses to attend…

Kidney health and Aboriginal People

[Information regarding] chronic diseases

Sciatic nerve problems

Heart and stroke

Arthritis

Cancer

Menopause in Men/Women

Elders' medications and falls

Mental health and Aboriginal people

Prevention of GDM

How to lose weight

__Cookbooks And Food Resource Guides For Diabetics:__

[Information regarding] how healthy maple syrup is to a Diabetic

Cookbooks for diabetics (x2)

Healthy eating as a family

Breastfeeding and diabetes prevention

What foods increase blood sugar

Traditional foods

Nutrition facts

Healthy recipes

Offer nutrition

Training/Health Promotion Materials:

Short videos to show to elementary and secondary aged children for prevention

Resources for family members to support a diabetic family member

Ways to recruit for health promotion (X2)

Posters including those promoting exercise (x2)

Material for presentations

Training and education

Healthy living

Information Of Special Interest To Aboriginal People:

Type I diabetes especially with First Nations children

Resources on what is available for Aboriginal diabetes clients

Funding to draft a local food guide for local traditional foods & medicinal plants

[It would] be cool to see NADA as the CDA arm for aboriginal people

A template of resources to print in own language

Cultural resources for Ontario

More teachings from Elders about healthy living

Traditional medicine information

Complementary medicine

Additional Information Regarding Diabetes And Side Effects:

Information on Type 1 diabetes and trial testing information for cures on this

More statistics regarding people with type 2 diabetes in each province if possible

More graphic pictures in a book to show other complications when having Diabetes

Update on recent diabetes resources for diabetics

Online access to education sessions for HCP and clientele

Education Information

Training initiatives

Articles about diabetes

Additional Materials:

Newsletter (x2)

Pamphlets

Magazine

Handouts

Additional resources

More Networking Opportunities

Facilitator contacts

Networking with public health (x2)

More contact with community workers

Visitations to communities by NADA & support initiatives

[More] community announcements

Additional Medical Resources/Supports:

Seeing a specialist in Vancouver for diabetes from our small community

Care plans for diabetics so we're all on the same level

More involvement with health care institutions

Telehealth

Forms already made up for monitoring

More Financial Resources For NADA:

Money to attend yearly conferences

Funding for a full time diabetes coordinator

Improvements To NADA Website:

It is sometimes difficult finding sites and I end up pressing assorted buttons

[More] easy access for list of activities

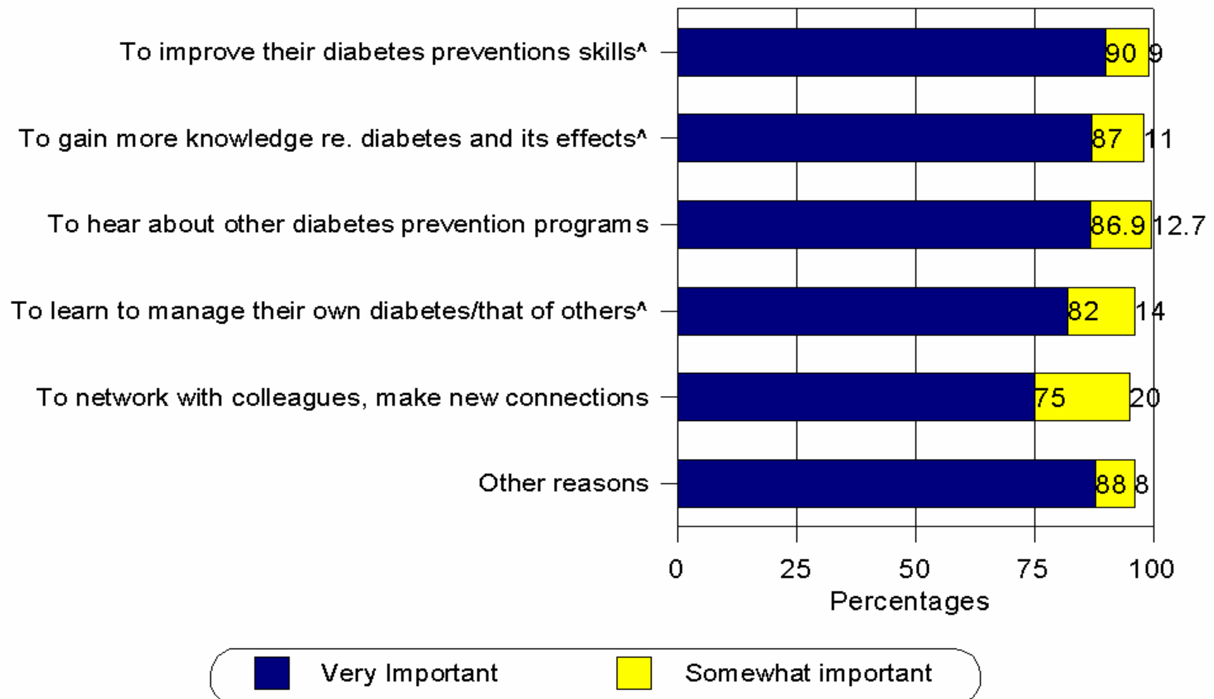
III) CONFERENCE PARTICIPANTS EVALUATING THEIR EXPERIENCES AT THE 2013 NATIONAL DIABETES PREVENTION CONFERENCE AND PLANNING SESSION:[iv]

A highlight of NADA's activities is the provision of its National Aboriginal Diabetes Prevention Conference. The most recent conference was held in November 2013 with an evaluation report being released in early 2014. Given the conference's prominence, selected excerpts from that evaluation report are being included in this global evaluation of NADA.

3.1) Participants' Reasons For Attending The Conference:

Respondents to the conference evaluation were asked to indicate the importance of six reasons for them to attend the conference in 2013. Based on the benchmarks assigned to this evaluation, each of these objectives was deemed to be important (far-exceeding the ***Primary Benchmark***) (Figure 26). The percentages who reported that each reason for attending the conference was important or very important to them included:

- To hear about other diabetes prevention programs (99.6%)
- To improve their diabetes prevention skills (99.0%)
- To gain more knowledge regarding diabetes and its effects (98.0%)
- To learn to manage their own diabetes, or diabetes of other family members, if applicable (96.0%)
- To network with colleagues and/or to make new connections (95.0%)



3.2) Respondents Achieving Their Reasons For Attending The 2013 Conference:

While virtually all respondents who attended this conference felt that its formal objectives were important to them, they equally felt that they were able to achieve these objectives (Figure 27). Again, responses to each objective far-exceeded the **Primary Benchmark**. The percentages reporting that each reason to attend was somewhat or very much achieved by them included:

- To hear about other diabetes prevention programs (100%)
- To improve their diabetes prevention skills (98.8%)
- To gain more knowledge regarding diabetes and its effects (96.3%)
- To learn to manage their own diabetes, or diabetes of other family members, if applicable (96.0%)
- To network with colleagues and/or to make new connections (94.0%)

3.3) Respondents' Global Evaluations Of The 2013 Conference:

Conference participants were asked four global questions to measure their overall satisfaction with it. In each instance virtually all of these respondents provided positive or very positive responses (far-exceeding the **Primary Benchmark**) (Figure 28). The percentages responding with somewhat or very much for each area of enquiry included:

- Feeling that attending the conference was a good or very good use of their time? (99.4%)
- Feeling that the conference provided them with new, relevant, effective, and current infor-mation and ideas (99.4%)
- Being satisfied or very satisfied with the topics offered at the conference (98.8%)
- Feeling supported in their diabetes prevention and health promotion activities as a result of attending the conference (98.5%)

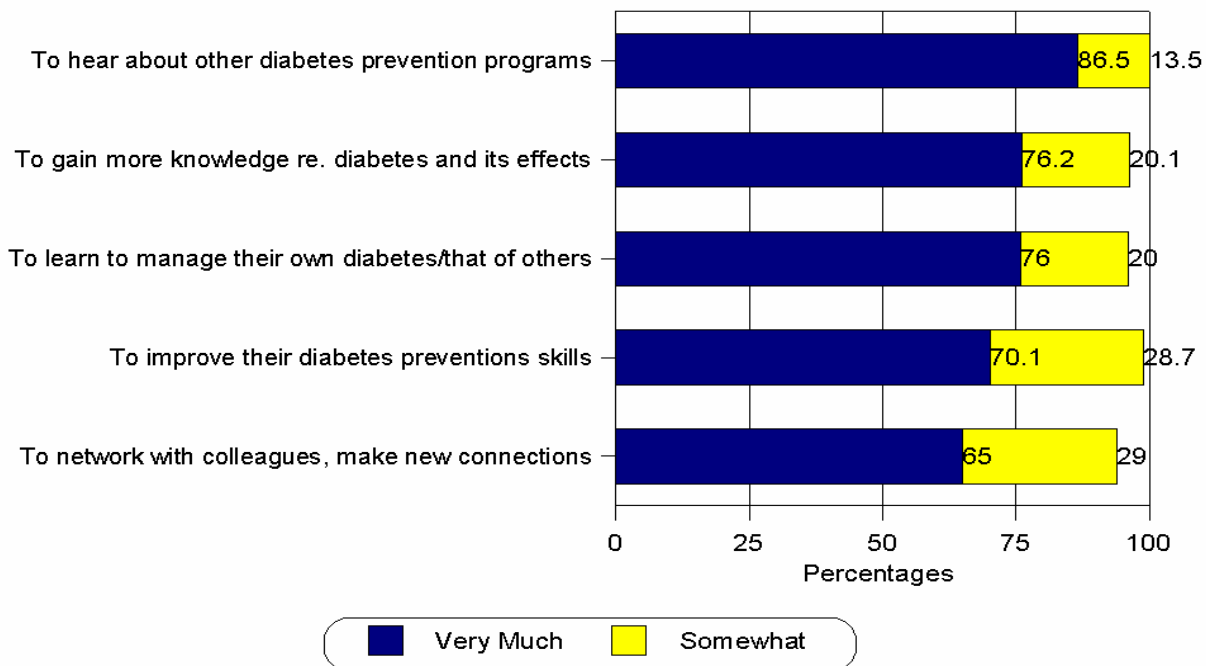


Figure 27 Were Participants' Reasons For Attending The
2013 National Diabetes Prevention Conference Achieved?
To hear about other diabetes prevention programs
86.5
13.5
To gain more knowledge re. diabetes and its effects
76.2
20.1
To learn to manage their own diabetes/that of others
76
20
To improve their diabetes preventions skills
70.1
28.7
To network with colleagues, make new connections
65
29
0
25
50
75
100
Percentages
Very Much
Somewhat
(N=163, 164, 117, 164, 162. Adjusted to exclude missing data.)

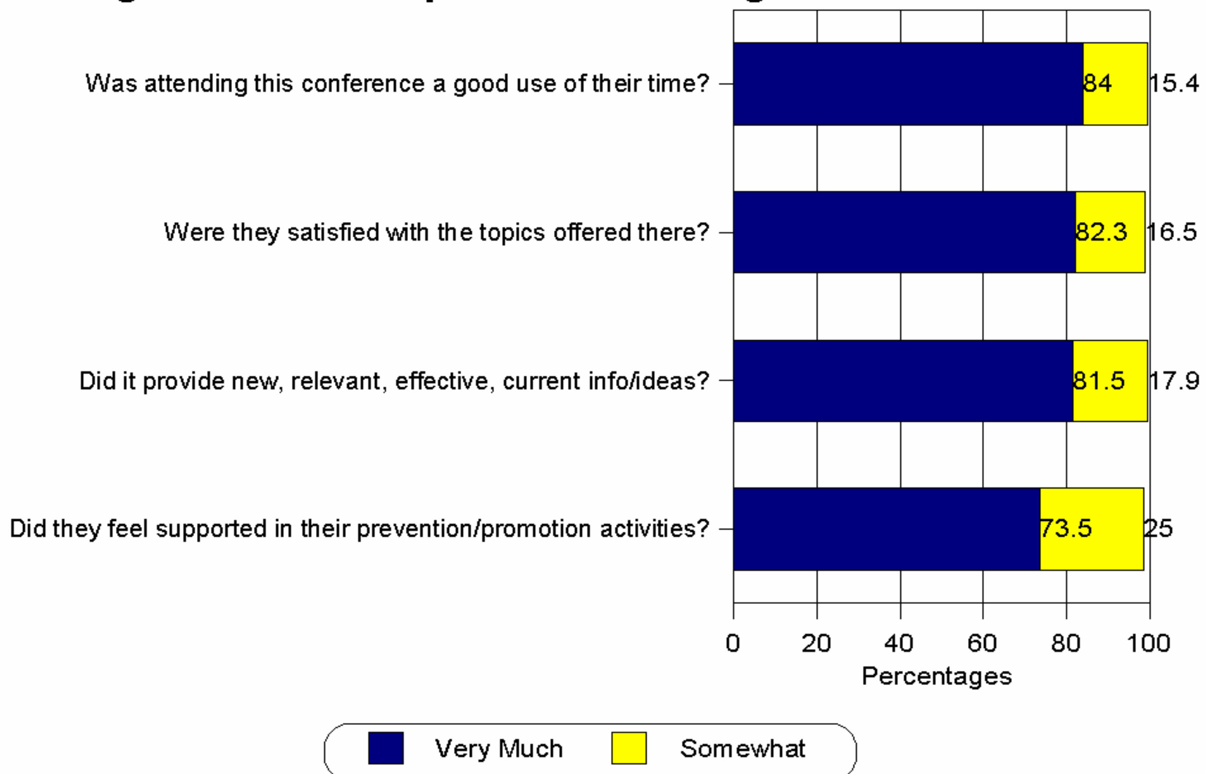
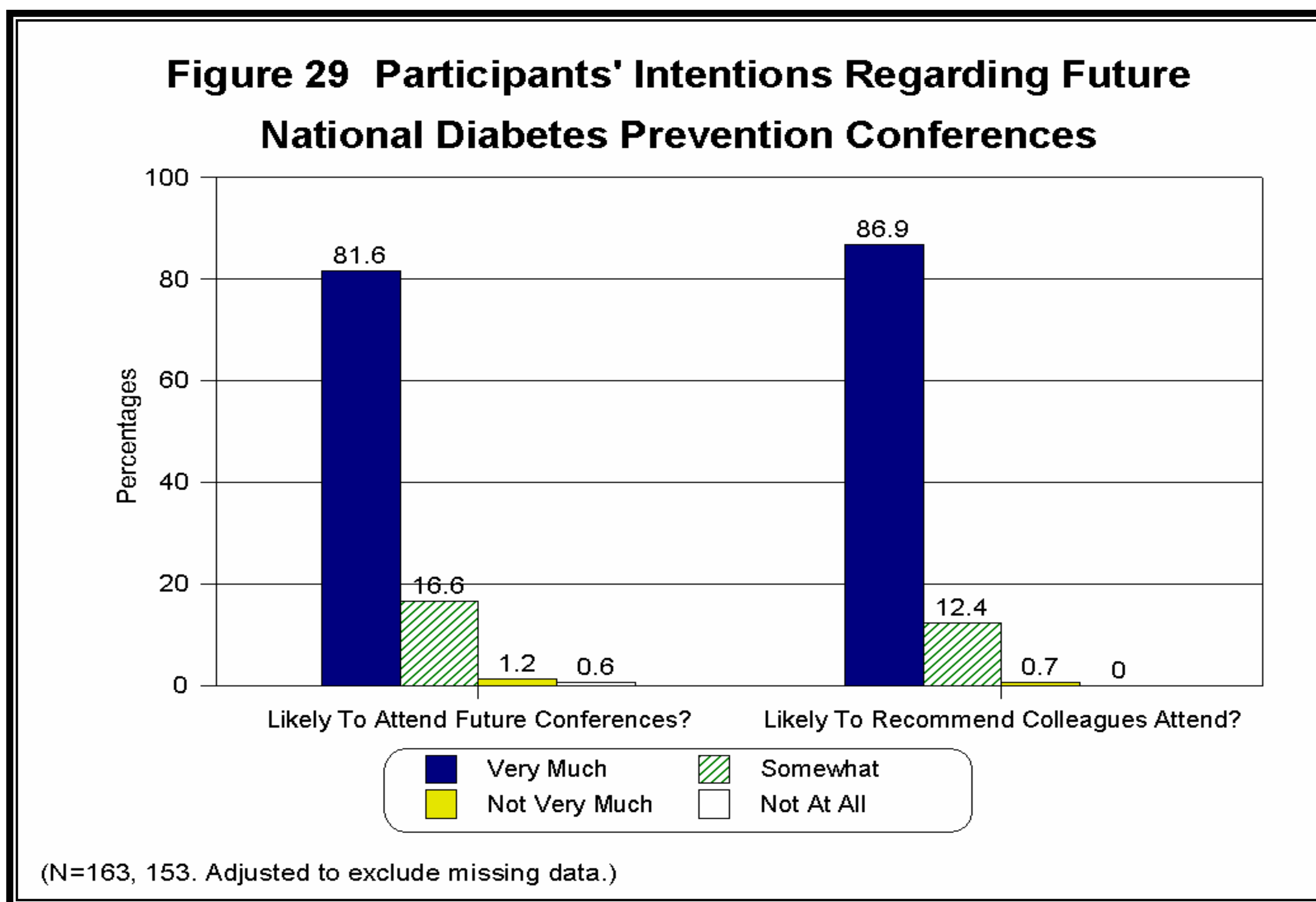


Figure 28 Participants Evaluating The Conference
Was attending this conference a good use of their time?
84
15.4
Were they satisfied with the topics offered there?
82.3
16.5
Did it provide new, relevant, effective, current info/ideas?
81.5
17.9
Did they feel supported in their prevention/promotion activities?
73.5
25
0
20
40
60
80
100
Percentages
Very Much
Somewhat
(N=162, 164, 162, 164. Adjusted to exclude missing data.)

3.4) Evaluating Conference Participants' Intentions Regarding Future Conferences:

These respondents were asked two questions regarding their intentions related to future NADA conferences; their likelihood of attending future conferences, and the likelihood of recommending future NADA conferences to their colleagues. In terms of the former, and consistent with the preceding findings, virtually all of these respondents were likely to attend future conferences held by NADA (Figure 29). This included 81.6% who said that they were very likely to do so and 16.6% who were at least somewhat likely to do so, for a total of 98.2%.

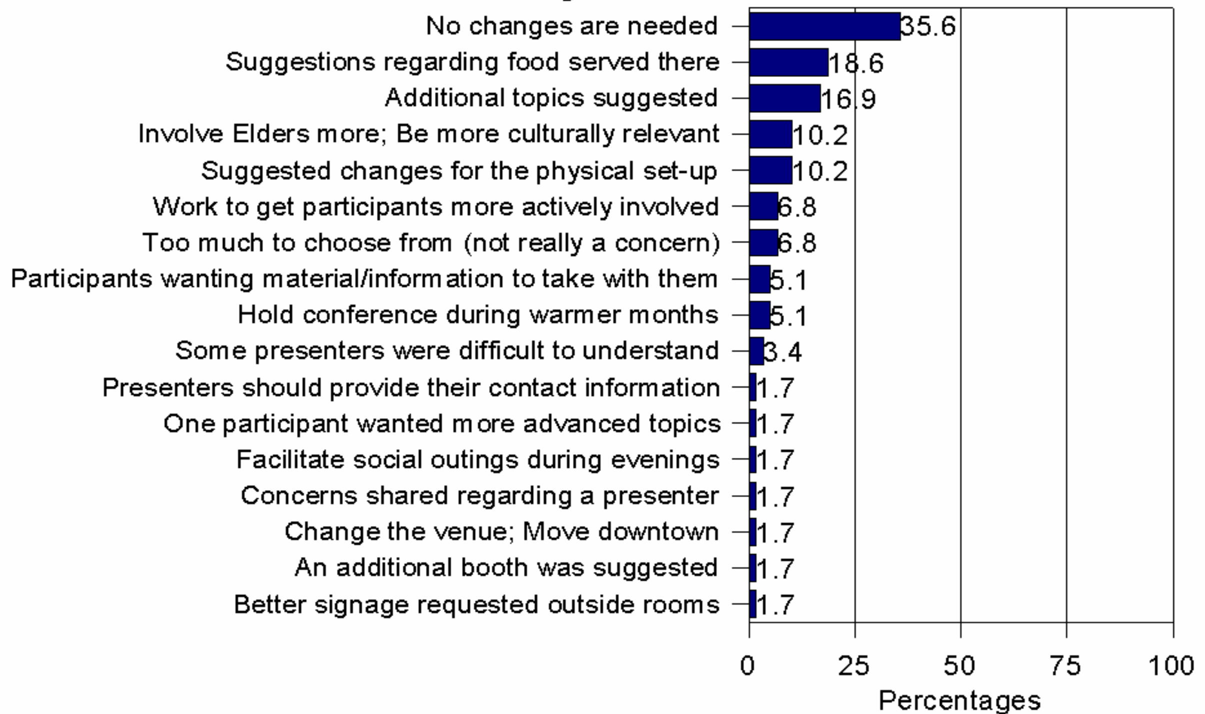
In terms of the latter, a similar percentage of respondents were likely to recommend that their colleagues attend future NADA conferences. This applied to 86.9% who were very likely to make this recommendation and another 12.4% who were at least somewhat likely to recommend it, for a total of 99.3%.



3.5) Changes Respondents Would Make To Future Conferences, If They Could:

The final question in the conference evaluation questionnaire asked respondents to share their suggestions to improve future conferences. Fifty-nine respondents wrote in a response (Figure 30). Seventeen themes emerged from their comments, with ten of these being shared by one to three respondents.

The most frequent comment was that no changes to future conferences were needed (35.6%). Other relatively frequent comments included suggestions about the food that was served during the conference, with the need for healthier choices (18.6%); some ideas for other topics they would like to see added for future conferences (16.9%); the involvement of more Elders during the conference or making the conference more culturally relevant for those attending (10.2%); and suggested changes to the physical set-up of the venue (10.2%). Selected verbatim comments are provided below and on the following pages.



The related verbatim comments from the conference evaluation can be found in the report: **7th National Aboriginal Diabetes Conference and Strategic Planning Engagement: Conference Evaluation Report**, Kaplan Research Associates Inc., February 2014, at:

http://www.nada.ca/download/2900/ on pages 35 to 39.

CHAPTER FOUR
RESPONDENTS EVALUATING THEIR ASSOCIATIONS WITH NADA

I) BACKGROUND:

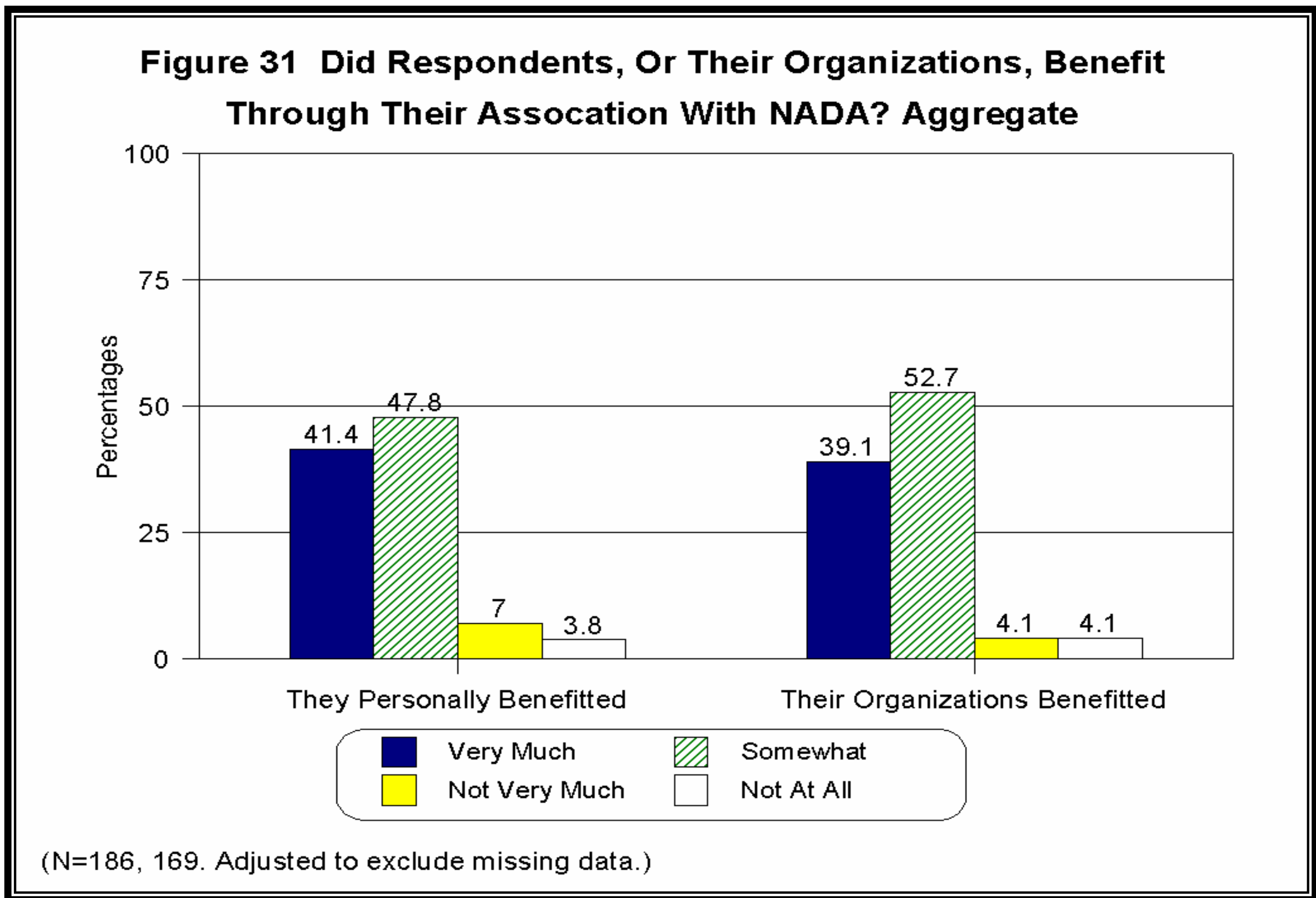
This chapter explores respondents' evaluation of their association with NADA. This includes the perceived benefits of their association with the organization, the objectives they have achieved through NADA, the degree to which they feel that NADA has successfully achieved its objectives, their future intentions regarding NADA, and any changes they would make to NADA, if they could.

II) THE RELATED STUDY FINDINGS:

2.1) Respondents Feeling That They Benefited Through Their Association With NADA:

2.1.1) The Aggregated Findings:

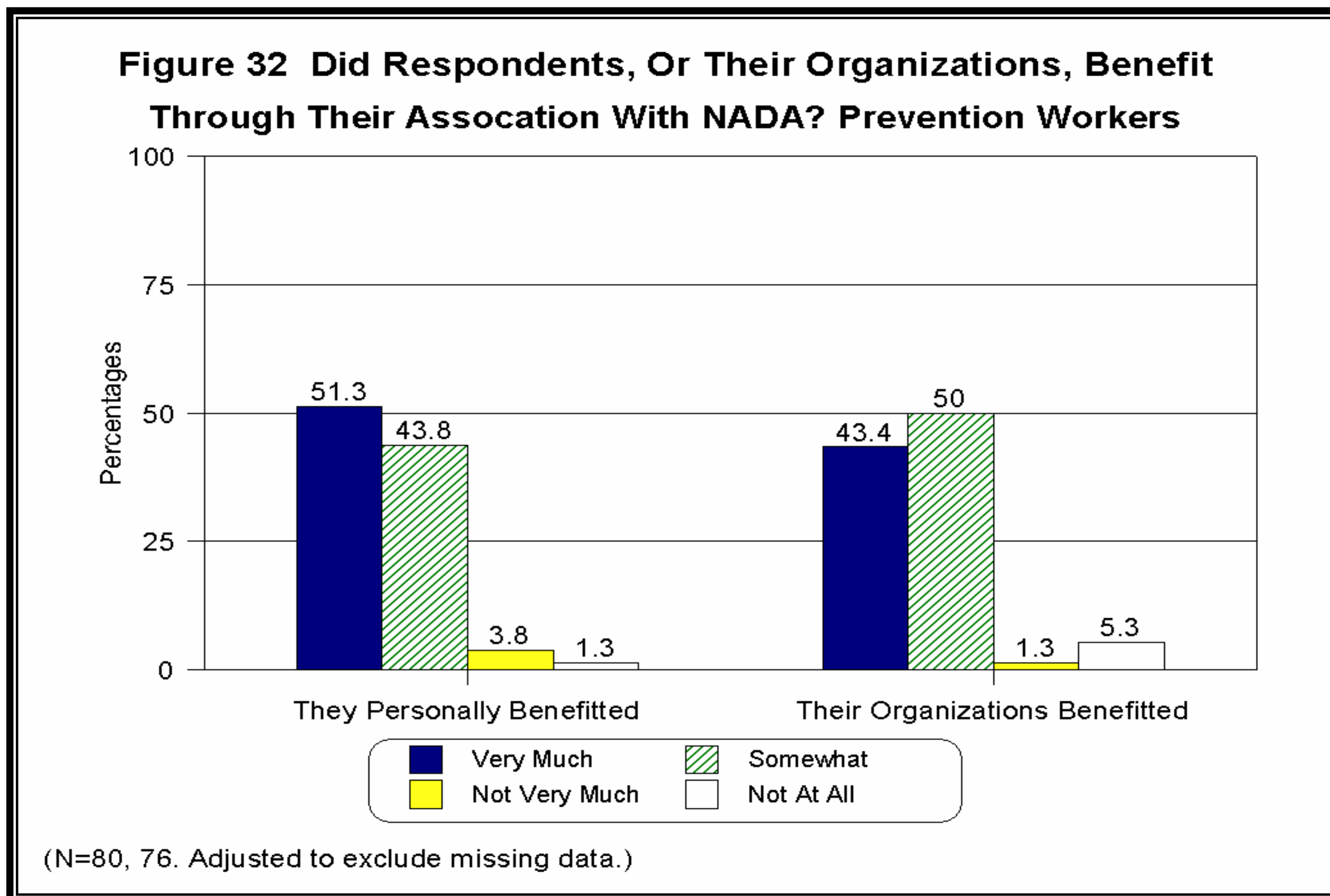
In the aggregate 89.2% of all respondents felt that they personally benefited through their association with NADA, with 41.4% feeling that they very much benefited (Figure 31). Of the remainder, 7.0% (n=13) felt that they did not really benefit as a result of their association with NADA, and 3.8% (n=6) felt that they did not benefit at all. When asked whether they felt that their organizations benefited as a result of their association with NADA, 91.8% reported that they had. Of these, 39.1% strongly believed this to be true. Of the remainder, 4.1% (n=7) felt that their organizations did not really benefit from their association with NADA and another 4.1% strongly believed this. Responses to both questions far-exceeded the study's **Primary Benchmark**.



2.1.2) Responses From Diabetes Prevention Workers:

Diabetes Prevention Workers were more likely than the aggregate to feel that both they and their organizations benefited through their association with NADA (Figure 32). On a personal level, 95.1% of these respondents felt that they benefited by being associated with NADA,

with 51.3% of these strongly believing this. Only 3.8% (n=3) did not feel that this was really true, and 1.3% (n=1) did not feel that this was true at all. When it came to their organizations benefiting by being associated with NADA, 93.4% believed that they had, with 43.4% strongly believing this. One respondent (1.3%) somewhat disagreed with this statement, while 5.3% (n=4) strongly disagreed with this. Responses to both of these questions again far-exceeded the **Primary Benchmark**.



2.2) Respondents Achieving Their Objectives For Being Associated With NADA:

2.2.1) The Aggregated Findings:

Respondents were provided with NADA's five objectives and were asked to describe the degree to which they felt that they had personally achieved each of these. In the aggregate almost all respondents reported that they felt that they had at least somewhat achieved each of these objectives, reaching or far-exceeding the **Primary Benchmark** (Figure 33). The percentages who had very much or somewhat achieved each objective included:

- Hearing about interesting diabetes prevention programs in other areas (93.0%)
- Gaining more knowledge about diabetes and its effects (89.0%)
- Improving their diabetes prevention skills (88.0%)
- Learning how to manage their diabetes and/or that of a relative or friend, if applicable (86.0%)
- Networking with colleagues in the field or making new connections (76.7%)

2.2.2) Responses From Diabetes Prevention Workers:

Virtually all Diabetes Prevention Workers were more likely than the aggregate to feel felt that they had achieved each of these objectives (Figure 34). These included:

- Learning how to manage their diabetes and/or that of a relative or friend, if applicable (95.0%)
- Hearing about interesting diabetes prevention programs in other areas (94.0%)

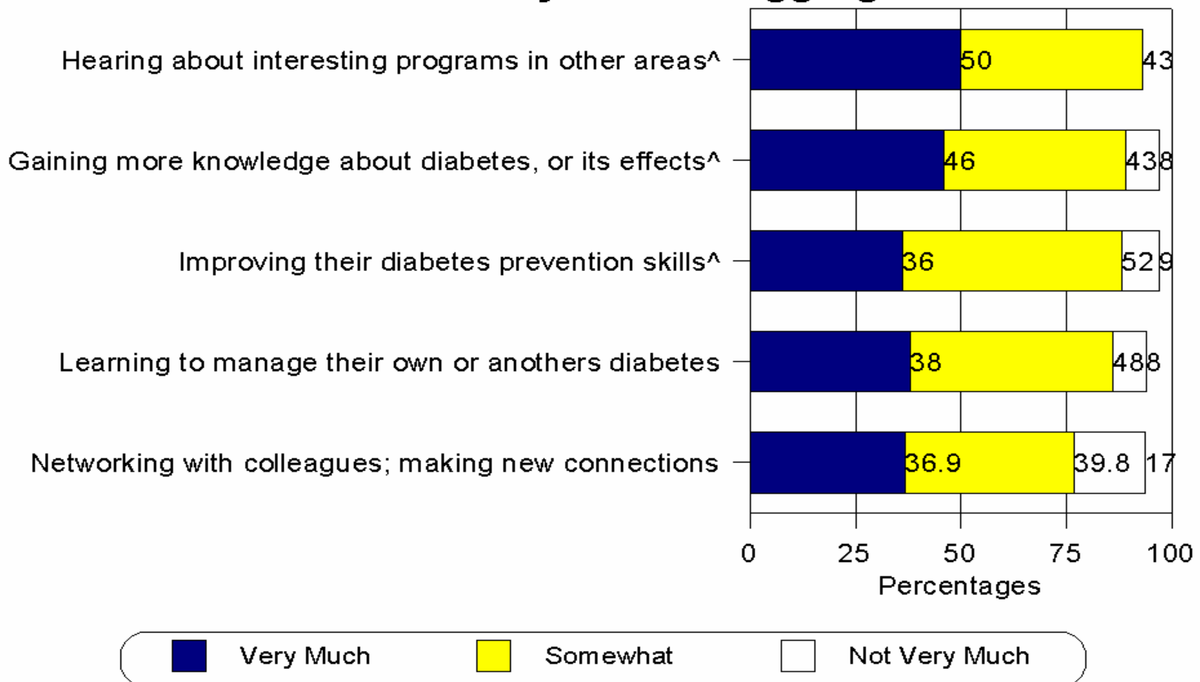


Figure 33 Has NADA Helped Respondents To Achieve Their Own Objectives? Aggregate
Hearing about interesting programs in other areas^
Gaining more knowledge about diabetes, or its effects^
Improving their diabetes prevention skills^
Learning to manage their own or anothers diabetes
Networking with colleagues; making new connections
50
43
46
43
8
36
52
9
38
48
8
36.9
39.8
17
0
25
50
75
100
Percentages
Very Much
Somewhat
Not Very Much
(N=186, 183, 170, 151, 176. ^Data rounded or truncated to increase legibility. Adjusted to exclude missing data.)

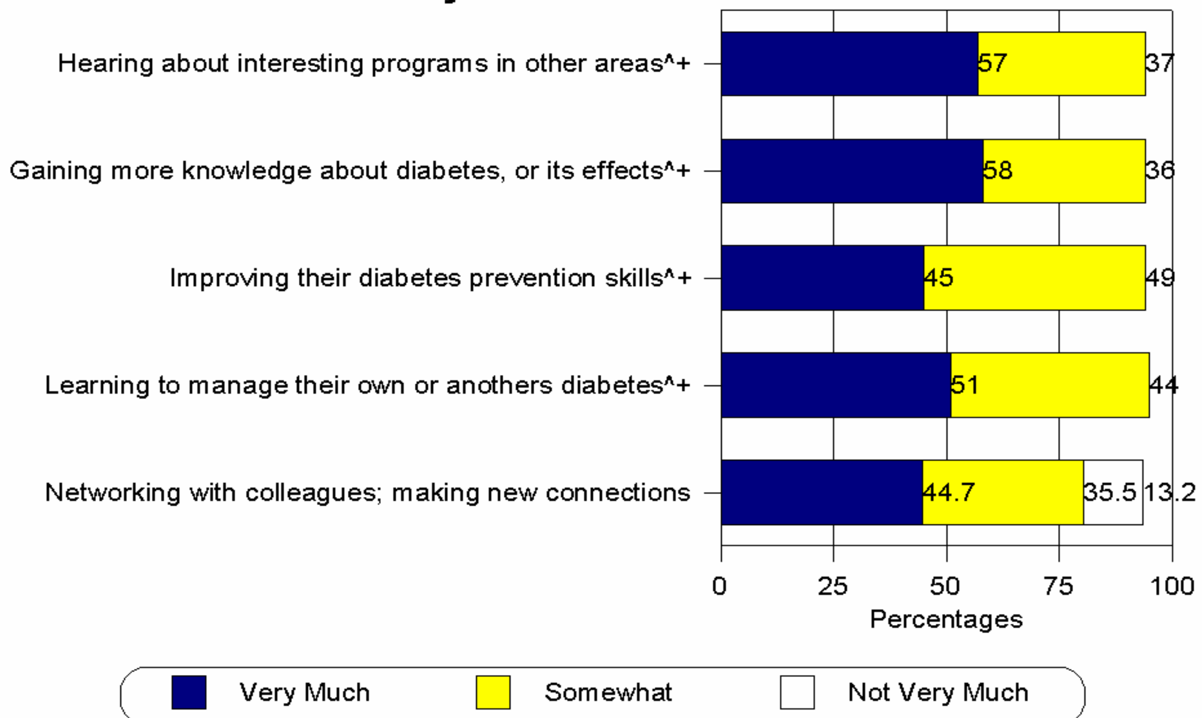


Figure 34 Has NADA Helped Respondents To Achieve Their Own Objectives? Prevention Workers
Hearing about interesting programs in other areas^+
Gaining more knowledge about diabetes, or its effects^+
Improving their diabetes prevention skills^+
Learning to manage their own or anothers diabetes^+
Networking with colleagues; making new connections
57
37
58
36
45
49
51
44
44.7
35.5
13.2
0
25
50
75
100
Percentages
Very Much
Somewhat
Not Very Much
(N=81, 81, 80, 69, 76. ^Data rounded to increase legibility. +Data truncated to increase legibility. Adjusted to exclude missing data.)

- Gaining more knowledge about diabetes and its effects (94.0%)
- Improving their diabetes prevention skills (94.0%)
- Networking with colleagues in the field or making new connections (80.2%)

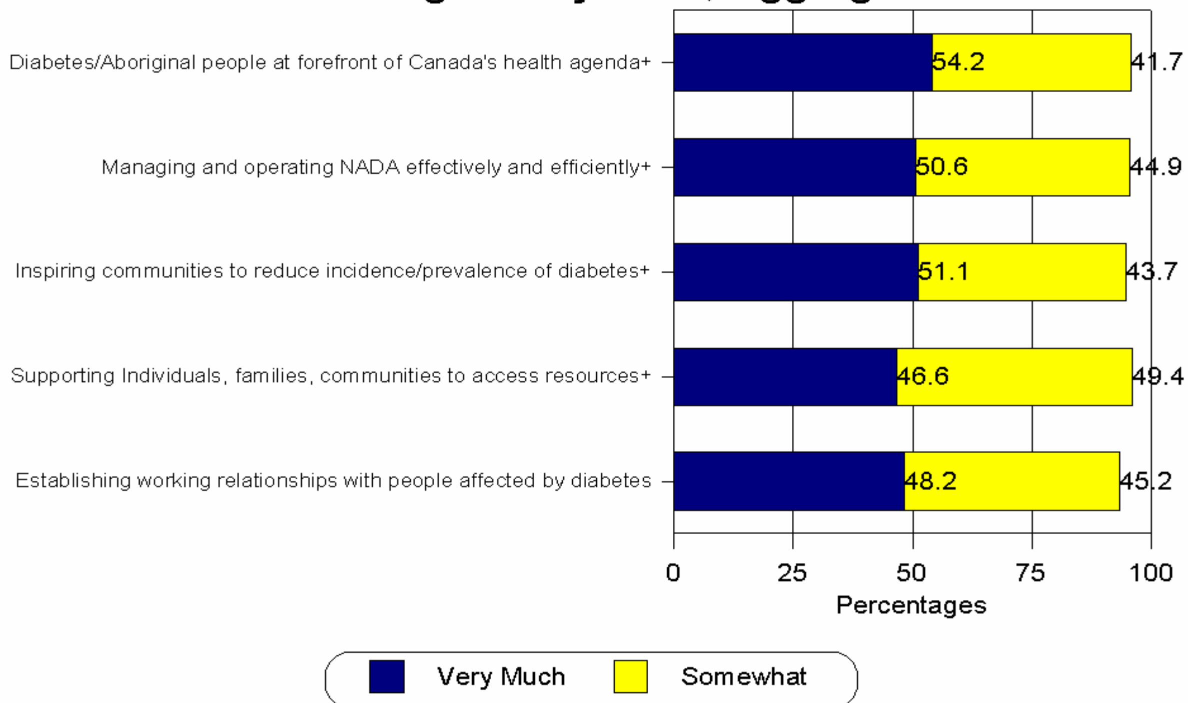
2.3) Respondents Evaluating Whether NADA Had Achieved Its Objectives:

2.3.1) The Aggregated Findings:

Respondents then evaluated the degree to which they felt that NADA had achieved its own organizational objectives. In the aggregate, the percentage of respondents who felt that NADA was able to achieve its organizational objectives far-exceeded the **Primary Benchmark** (Figure 35). The percentages responding very much or somewhat to each question included:

- Supporting individuals, families and communities to access resources for diabetes prevention, education, research and surveillance (96.0%)
- Being the driving force in ensuring that diabetes and Aboriginal people remain at the forefront of Canada's health agenda (95.9%)
- Managing and operating NADA effectively and efficiently (95.5%)
- Inspiring communities to develop and enhance their ability to reduce the incidence and prevalence of diabetes (94.8%)
- Establishing and nurturing working relationships with those committed to persons affected by diabetes (93.4%)

Figure 35 Respondents Evaluating Whether NADA Is Achieving Its Objective, Aggregate

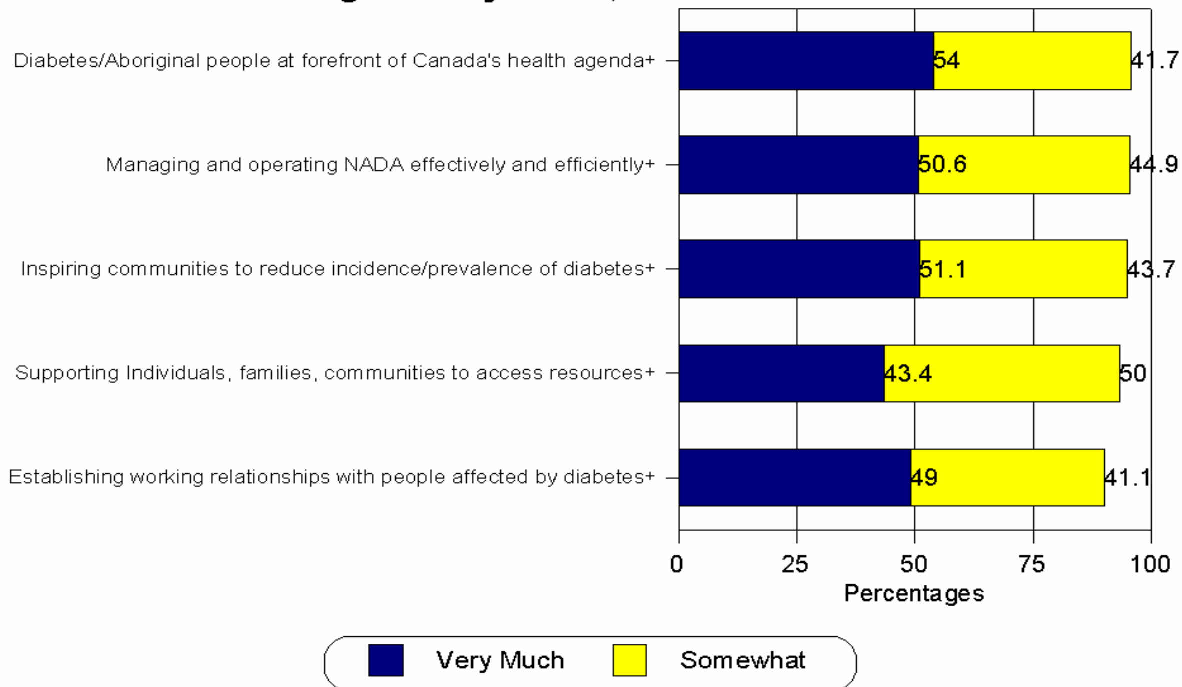


(N=168, 156, 174, 174, 168. +Data truncated to increase legibility. Adjusted to exclude missing data.)

2.3.2) Responses From Diabetes Prevention Workers:

Responses to these questions from the Diabetes Prevention Workers were very similar to those of the aggregated sample (Figure 36), as follows:

- NADA being the driving force in ensuring that diabetes and Aboriginal people remain at the forefront of Canada's health agenda (95.7%)
- Managing and operating NADA effectively and efficiently (95.5%)
- Inspiring communities to develop and enhance their ability to reduce the incidence and prevalence of diabetes (94.8%)
- Supporting individuals, families and communities to access resources for diabetes prevention, education, research and surveillance (93.4%)
- Establishing and nurturing working relationships with those committed to persons affected by diabetes (90.1%)



2.4) Respondents' Future Intentions Regarding NADA:

2.4.1) The Aggregated Findings:

Respondents were asked two questions regarding their future intentions related to NADA: the likelihood of continuing their membership with it, and the likelihood of them recommending that their colleagues join NADA. In the aggregate virtually all respondents (96.8%) were likely to continue their membership with NADA into the future, with 73.8% being very likely to do so (Figure 37). In addition, 92.2% were likely to recommend that a colleague in the field also join NADA, with 61.5% being very likely to make this recommendation. Responses to both of these questions far-exceeded the study's **Primary Benchmark**.

2.4.2) Responses From Diabetes Prevention Workers:

All of the Diabetes Prevention Workers who responded to this question (100%) were likely to continue their memberships with NADA, with 76.3% being very likely to do so (Figure 38). As well, 96.2% of these respondents were likely to recommend that their colleagues join NADA as well, with 62.8% being very likely to make this recommendation. Clearly the results to both of these questions also far-exceeded the **Primary Benchmark**.

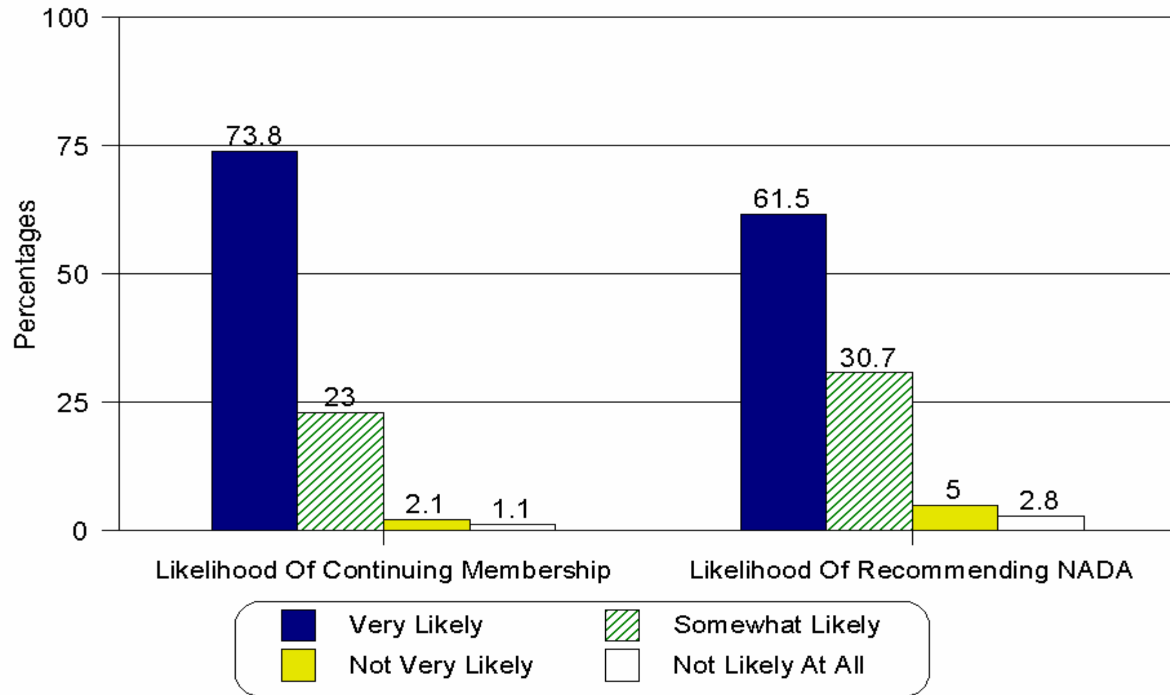


Figure 37 Evaluating Respondents' Future
Intentions Regarding NADA, Aggregate
100
75
50
25
0
Percentages
73.8
23
2.1
1.1
61.5
30.7
5
2.8
Likelihood Of Continuing Membership
Likelihood Of Recommending NADA
Very Likely
Somewhat Likely
Not Very Likely
Not Likely At All
(N=187, 179. Adjusted to exclude missing data.)

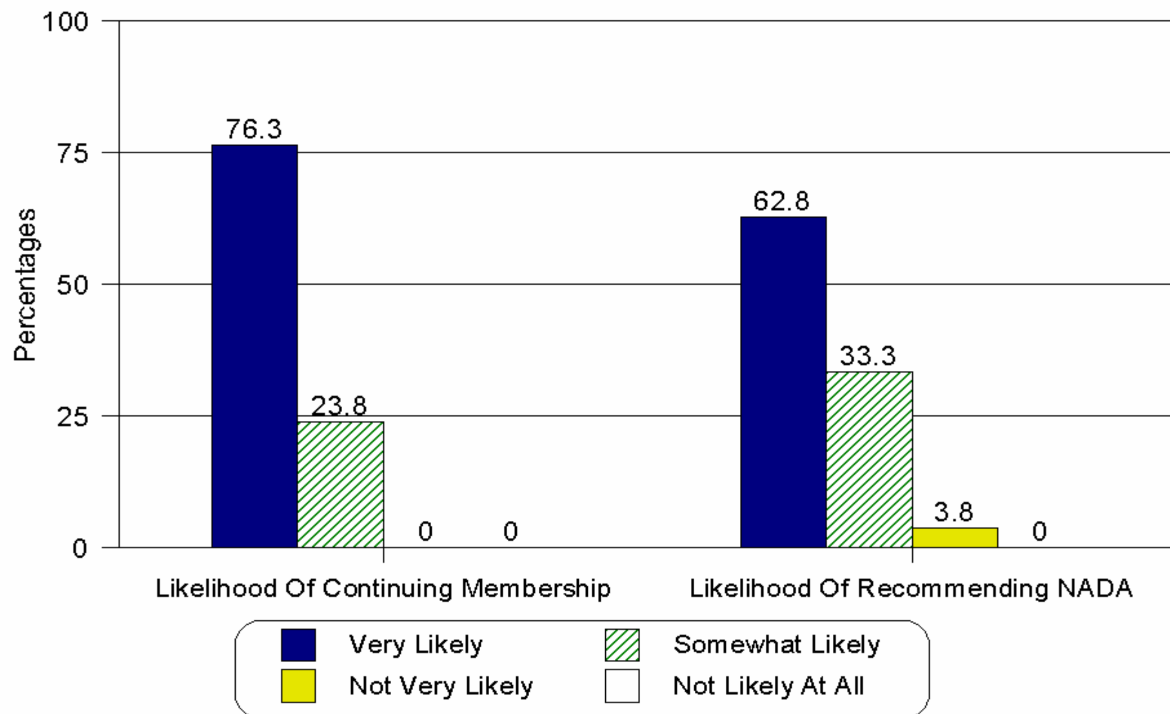
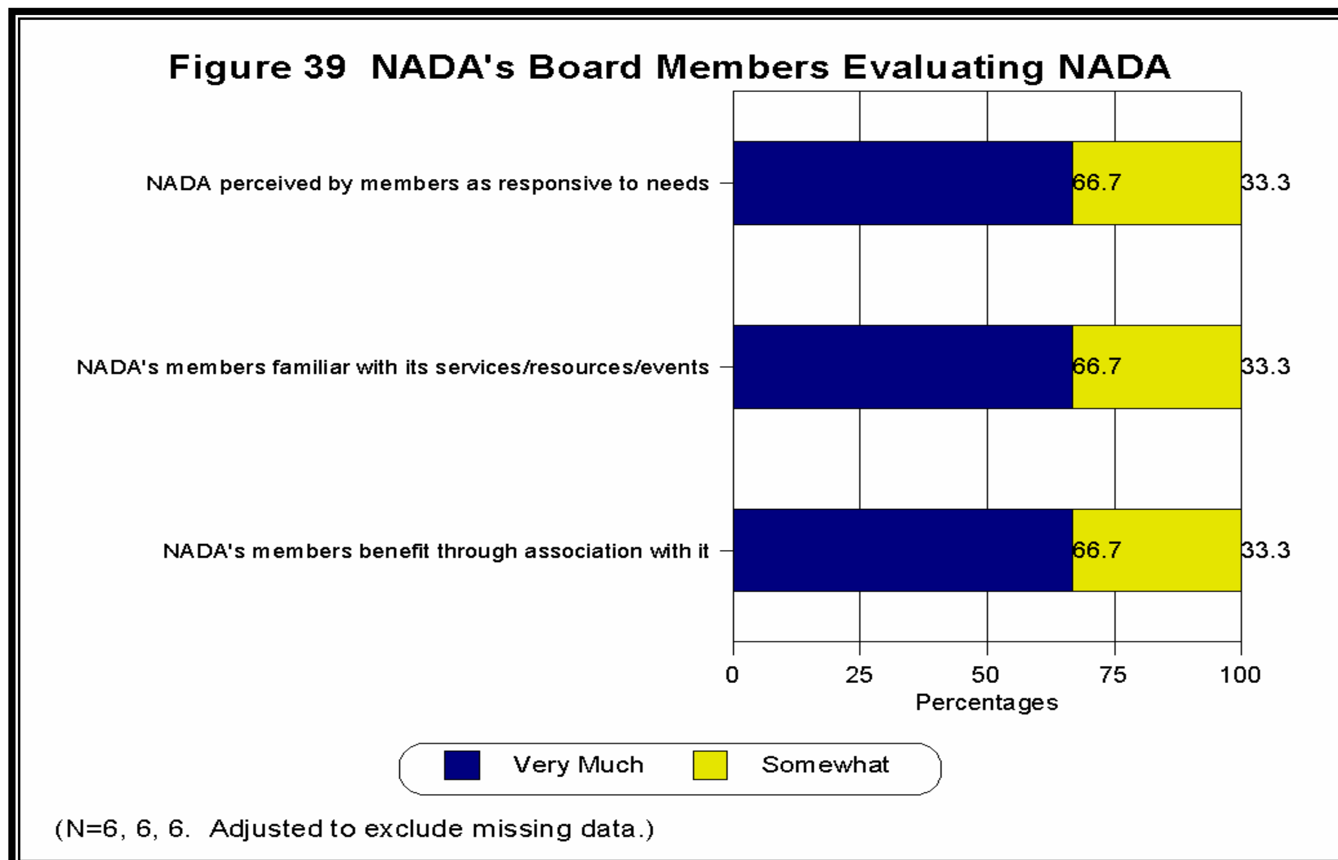


Figure 38 Evaluating Respondents Future
Intentions Regarding NADA, Prevention Workers
100
75
50
25
0
Percentages
76.3
23.8
0
0
62.8
33.3
3.8
0
Likelihood Of Continuing Membership
Likelihood Of Recommending NADA
Very Likely
Somewhat Likely
Not Very Likely
Not Likely At All
(N=80, 78. Adjusted to exclude missing data.)

2.5) NADA's Board Members' Assessment Of NADA:

NADA's board members were asked three questions regarding the perceived benefits that its membership received from the organization, and their familiarity with its services, resources and events. Six of the seven board members who completed a questionnaire answered these questions. From the data (Figure 39) all of these board members at least somewhat believed that:

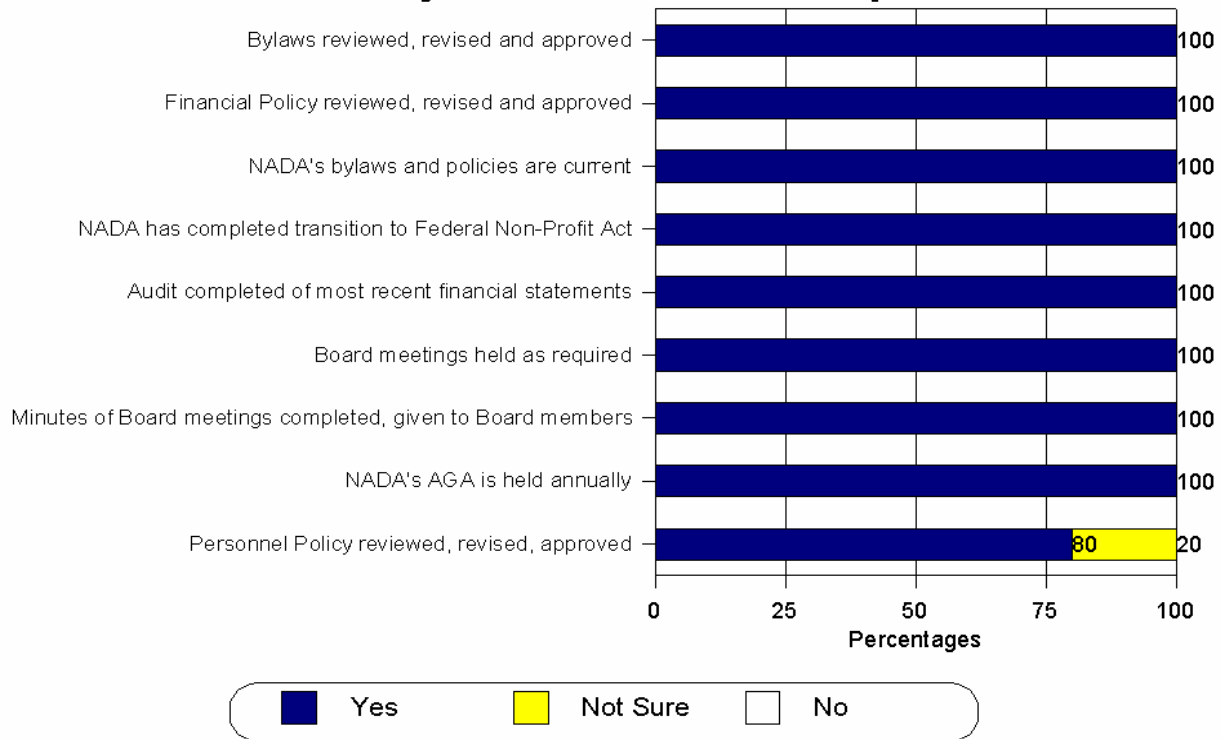
- NADA is perceived by its members as being responsive to the needs of Aboriginal people with diabetes (100%)
- NADA's members are familiar with its services, resources and events (100%)
- NADA's members benefit through their association with NADA (100%)



A second question answered solely by NADA's board members related to the organization meeting its policy and governance requirements. Five of the seven board members in this study answered these questions (Figure 40). In all but one instance, all of these board members felt that NADA was in compliance. This included:

- Bylaws have been reviewed, revised and approved (100%)
- The Financial Policy has been reviewed, revised and approved (100%)
- NADA's bylaws and policies are current (100%)
- NADA has completed the transition to the Federal Non-Profit Act (100%)
- There has been an audit of its most recent financial statements (100%)
- NADA's board meetings are held as required by its bylaws and constitution (100%)
- Minutes of NADA's board meetings are completed and provided to board members in a
- timely manner (100%)
- NADA's Annual General Assembly is held annually (100%)

Four of the five board members (80.0%) felt that NADA's Personnel Policy has been reviewed, revised and approved, with one being unsure about this.

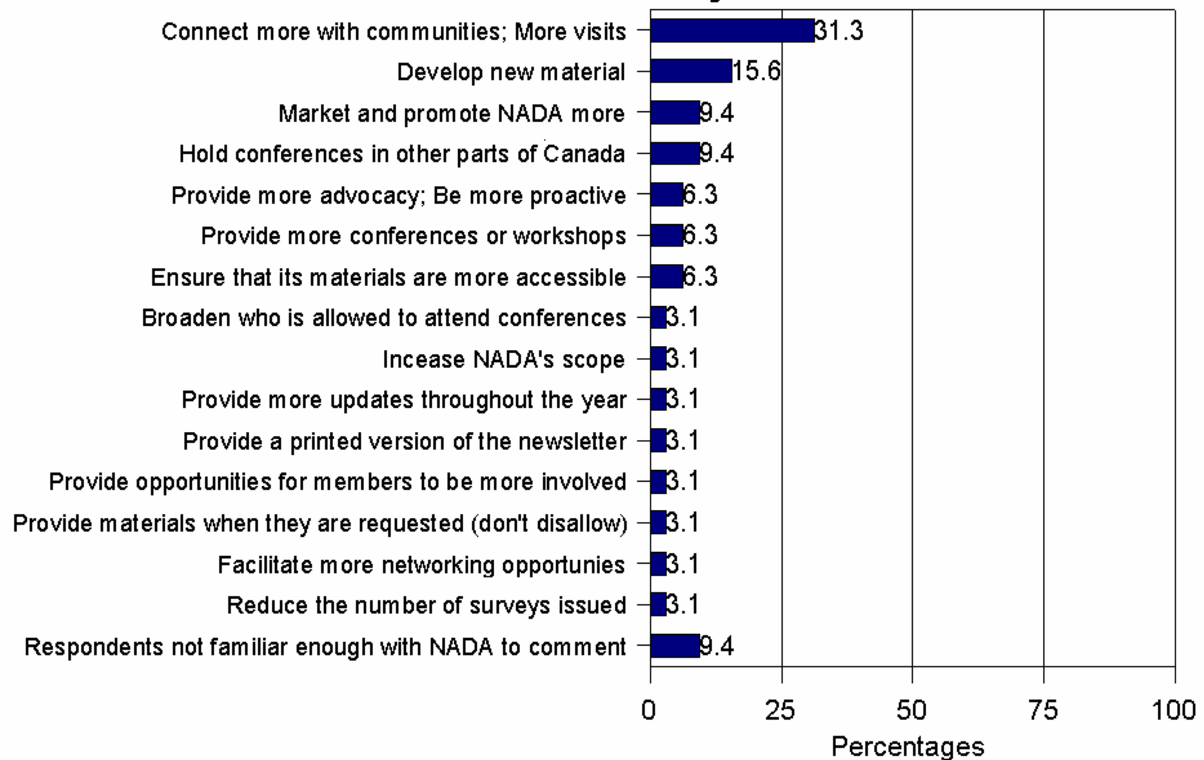


2.6) Changes That Respondents Would Make To NADA, If They Could:

Respondents were given the opportunity to suggest changes that they would make to NADA, if they could. This was an open-ended question. Of the 216 individuals who completed a questionnaire, only 32 (14.8%) provided a suggested change. Sixteen themes emerged from their responses, with most of these suggesting the need for more or different types of resources or information being provided by the organization (Figure 41). Many suggestions were provided by one or two respondents, indicating that there were few systemic issues that arose from this question.

The most frequently provided suggested related to an interest to see NADA representatives connecting more with communities across Canada and, in particular, Aboriginal or First Nations communities (31.3%, n=10). Other suggestions included:

- NADA developing new materials on diabetes and diabetes awareness (15.6%, n=5)
- Doing more to market and promote NADA (9.4%, n=3)
- Holding conferences in other parts of Canada (9.4%)
- Doing more advocacy or being proactive across the various levels of government (6.3%, n=2)
- Providing more conferences or workshops (6.3%)
- Ensuring that NADA's materials are more accessible (i.e., written in French and English, or in plain English to be more "user-friendly") (6.3%)
- Broadening criteria for who can attend conferences (3.1%, n=1)
- Increasing NADA's scope regarding the services it provides (3.1%)
- Providing more updates throughout the year (3.1%)
- Providing hard copies of its newsletters (3.1%)
- Providing more opportunities for members to participate at the board level (3.1%)
- Providing materials that are requested (3.1%)



- Facilitating more networking opportunities, networking teams (3.1%)
- Reducing the number of surveys sent to members (3.1%)

Three respondents did not feel that they were familiar enough with NADA to offer suggested changes. This actually decreases the number of respondents who provided suggested changes to 29 (or 13.4% of the total study sample).

2.6.1) Related Verbatim Comments:

Selected verbatim responses are provided below and on the following pages.

Connect More With Communities:

No changes except to visit communities to help persuade individuals that it for their own health and to helping themselves to improve.

Conduct workshops by other organizations going to other communities and presenting their expertise to the members.

If they had more funds for more staff they could spread the word/resources to more people.

[Provide] NADA offices with at least one indigenous diabetes expert in each province [and] territory.

More community involvement nation-wide.

More champions per First Nation community.

Connect with First Nation communities.

More support and involvement to First Nation communities and events.

Develop And Provide New Materials:

Just the development of up-to-date videos to be used as clips as part of teaching resources.

[Provide] updated data.

I'd like to see NADA involved in a process that would develop and help promote, market and deliver a consistent educational process for educating/training different levels of "educators," and have a national accreditation process for Aboriginal Diabetes Workers.
My opinion of some of the resources is that they are bland and boring. Many of them are too wordy, and the only difference that makes them "Aboriginal," is that they have aboriginal type graphics on them. Sorry

[Provide] more on awareness

[Provide] more funding to run different programs in our communities.

Market And Promote NADA More:

NADA is doing a great job with its education on diabetes. I would love it if NADA could have a more visible role in Eastern Canada.

Greater visibility in Western Canada. Annual conference. Greater visibility at provincial [levels].

Give NADA a higher profile that would make it as important a go-to site for providers service to Aboriginal communities as CDA is to all providers. Most of our [service] providers are non-Aboriginal, and their first point of reference is non-Aboriginal resources, whereas I feel NADA could enhance the cultural appropriateness/safety of their services for our member communities.

Hold Conferences In Different Locations:

Move the conference around so it is not expensive to attend.

Perhaps, host the Conference in the Eastern part of Canada, (Montreal area) so that many of my neighboring communities [can attend].

A northwest First Nations diabetes conference so family members can attend.

Do More Advocacy:

Do more advocacy or make us more aware of all the advocacy that is being done so we can get involved... Have a bigger impact.

Be more proactive at all levels of government and communities.

More Conferences/Workshops:

More conference about diabetes and chronic diseases.

[More] workshops.

Materials Should Be More Accessible:

Availability of all materials [and the] web-site in French.

[Materials should be] more user friendly.

Broaden Who Can Attend Conferences:

Offer conferences [for] community workers, not just NADA workers and members.

Increase NADA's Scope:

Increased capacity to broaden scope of service.

More Updates Provided Throughout The Year:

More updates throughout the year… new links for First Nations.

Provide Printed Version Of The Newsletter:

I wish I still received the newsletter by print - i don't like reading on the computer, and don't seem to be able to find the time or interest, to access the computer. Everything I receive from NADA I forward to my work email. If I get time to read it I do .

Provide Opportunities For Members To Become More Involved With NADA:

[I want to] be a participant at a board level.

Provide Requested Materials:

I was disappointed that the one resource I asked to have mailed - albeit a very large one - was denied.

Facilitate More Networking:

Networking teams.

Cut Back On Surveys:

I would like these almost monthly surveys to stop. I don't have time.

Respondents Who Were Not Familiar Enough With NADA To Comment:

I don't know too much about what this offers.

Fairly new to the program, I have been in the field but have not had much time to devote to health-related issues due to other.

I am just now getting involved with NADA since our manager has left. I hope to gain a great working relationship with the organization.

CHAPTER FIVE
EVALUATION SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

I) BACKGROUND:

This evaluation was designed to elicit the perceptions and experiences of NADA's members and other stakeholders regarding the organization's services, program and the information. The original survey was developed by Kaplan Research Associates Inc. in conjunction with NADA staff. NADA staff converted the questions to an online format, and collected the data, which were subsequently provided to the evaluators for data processing and analysis. The survey was admini-stered in August and September 2014, with a link to the survey provided in a widely distributed email. Several reminders followed the initial email to elicit the best possible rate of return. Two hundred and sixteen surveys were completed. This is reportedly the best rate of return experienced by NADA for an evaluation of this nature.

The areas of inquiry for the evaluation included:

- The characteristics and associations of the evaluation respondents
- Respondents' length and types of associations with NADA
- The types of resources and information they received from NADA, how they accessed them, and how they used them
- Their evaluation of NADA's resources, services and activities, along with their assessment regarding NADA being able to achieve its objectives
- Excerpts from an evaluation of the 7th National Aboriginal Diabetes Conference and Strategic Planning Process, published in February 2014
- NADA board members evaluating NADA's ability to achieve its organization objectives

Evaluation findings were rated based on a three-point set of **benchmarks**. A description of these benchmarks can be found on page 10 of this report.

II) A SUMMARY OF THE EVALUATION FINDINGS:

2.1) Work Experience Of The Respondents To This Evaluation:

- Respondents to the evaluation reported a range of associations with NADA. The largest percent-tage were NADA members (68.2%), along with Tribal Council Representatives, partners repre-senting other allied associations, members of NADA's board, and government representatives. "Other" respondents primarily included healthcare providers and representatives of other Aboriginal organizations.
- Most respondents provided diabetes prevention services (77.5%), with the majority of these being Diabetes Prevention Workers, followed by Supervisors or Coordinators, and Executive Directors or Senior Managers. Twenty-two of these respondents held dual roles within their organizations.
- On average each respondent had worked in their current fields for 10.0 years, with a median of 8.0 years. They had worked with their current organizations an average of 10.2 years with a median of 8.0 years
- On average each respondent had been associated with NADA for 5.0 years, with a median of 3.0 years.

Conclusion One **NADA was successful in attaining the perceptions of people from a range of sectors and organizations, all dedicated at varying levels to diabetes prevention and/or the promotion of healthy living in Aboriginal communities. These respon-dents reported having many years or experience in their fields and being associated with NADA over at least several years. One respondent reported being associated with NADA since its inception, 20 years ago. They are therefore qualified to effectively judge the efficacy and value of the program, services and information provided by NADA.**

2.2) Other Characteristics Of The Evaluation Respondents:

- Approximately eighty percent of the respondents (79.7%) were Aboriginal. Just over two-thirds of these (68.4%) reported being First Nations with Treaty Status with the remainder being Métis, First Nations (non-Status) or Inuit.
- Geographically, ten provinces or territories were represented in the study sample. The largest percentage of respondents lived in Ontario (36.6%), Manitoba (26.2%) or British Columbia (12.9%). These three provinces accounted for 75.7% of all respondents.
- Just over one-quarter of all respondents (27.3%) reported having diabetes themselves. Just under two-thirds (66.2%) reported having family members with diabetes.
  - Aboriginal respondents were statistically significantly more likely than other respondents to both have diabetes themselves (32.5% compared with 7.0%), and to have family members with diabetes (73.4% compared with 44.2%).
  - While there were variations in the percentages of respondents with diabetes and with family members with diabetes based on their provinces or territories of residence, these variations were not statistically significant.
  - Aboriginal respondents were also significantly more likely than their non-Aboriginal counter-parts to have any experiences living with diabetes (88.2% compared with 44.2%, respect-tively).

Conclusion Two **It is notable that the large percentage of respondents reflected the communities they serve. This was true both with respect to their ancestry and to their lived experiences with diabetes themselves and with family members with diabetes.**

2.3) Respondents Using the Resources and Information Provided By NADA:

- In the aggregate 76.4% of all respondents had accessed resources or information provided by NADA.
  - For respondents providing diabetes prevention this did not vary significantly based on their positions: 81.4% of the prevention workers had accessed NADA's resources and information, as did 80.0% of the supervisors and coordinators, 80.8% of the executive directors and senior managers, and 86.2% of those in other positions.
- There are seven ways in which NADA shares its resources and information, with respondents using each of these. In the aggregate the most frequently reported methods used included through NADA's website (71.8%), at conferences (63.2%), at health fairs (17.2%), or at NADA's offices (12.9%).
  - Diabetes Prevention Workers were most likely to access NADA's resources and information at conferences (81.7%) or through its website (74.6%).
- In the aggregate 77.3% of all respondents accessed NADA's website on a monthly basis, while 83.1% of the Diabetes Prevention Workers did so. Almost one-quarter of all respondents (23.6%) access the website, an average three or more times per month. This applied to 32.5% of the Diabetes Prevention Workers in this study.
- In the aggregate a range of resources and supports were accessed by respondents. This most frequently included, in ranked order: articles about diabetes (69.8%), related newsletters (57.1%), information about upcoming events (52.7%), and related posters (42.9%). A somewhat higher percentage of Diabetes Prevention Workers accessed these materials and information.
- Respondents accessed these resources and information to meet a number of needs. In the aggregate these most frequently included: for their own education (60.6%), to distribute to their larger communities (55.9%), to get ideas for healthy eating initiatives (55.9%), to distribute to their clients or program participants (54.3%), for someone else's healthy living or diabetes manage-ment (51.6%), or to get ideas for community development initiatives (44.7%).

- Diabetes Prevention Workers were more likely than the aggregate to use these resources or information to distribute to their larger communities (71.8%), to distribute to their clients or program participants (70.5%), to get ideas for healthy eating initiatives (69.2%), for someone else's healthy living or diabetes management (60.3%), or to get ideas for community development initiatives (56.4%).

➢ Twenty percent of the aggregate sample reported that there were other resources or information they would like NADA to provide. This figure was similar for the Diabetes Prevention Workers.

- The desired additional resources or information most frequently included: information regarding other ancillary diseases or conditions (41.4%),[v] cookbooks or food resource guides for diabetics (34.5%), training or health promotion materials (34.5%), information of special interest for Aboriginal people (31.0%), and/or additional information regarding diabetes and its side effects (27.6%).

Conclusion Three: **NADA provides a wide range of resources and information related to diabetes prevention and management, and healthy eating and active living initiatives. It also makes these available to both its members and other stakeholders using a range of media and venues for access and distribution. Respondents reported using the full range of resources and information, from a wide range of media and venues, and for a broad range of purposes.**

The Diabetes Prevention Workers, in particular, seem to be accessing these materials for purposes related to their areas of practice.

Conclusion Four: **While the current resources and information appear to be frequently accessed and well-used, there were additional materials that one-fifth of the respondents requested from NADA.**

2.4) Responses Related To NADA's National Conferences:

➢ In addition to providing resources and information regarding diabetes prevention and healthy living, NADA also hosts national conferences on these topics. Forty-two percent of the respondents to the current evaluation had attended the most recent National Diabetes Conference and Strategic Planning Process in 2013.

➢ Based on findings from the evaluation of the 2013 Aboriginal Diabetes National Conference evaluation, virtually all respondents to that study attended the conference in order to achieve the following objectives:

- To hear about diabetes prevention programs being delivered in other jurisdictions (99.6%) [vi]
- To improve their diabetes prevention skills (99.0%)
- To gain more knowledge regarding diabetes and its effects (98.0%)
- To learn how to manage their own diabetes or the diabetes experienced by someone else, if applicable (96.0%)
- To network with colleagues or to make new connections in the field (95.0%)

➢ All, or virtually all, of the respondents to the conference evaluation said that their objectives for attending the 2013 conference had been at least somewhat achieved, with the majority saying that they had been very much achieved (with combined responses ranging from a relative low of 94.0% to a high of 100%).

➢ Respondents to the conference evaluation provided the following positive perceptions of the event:

- Attending the conference represented a good use of their time (99.4%)
- They were satisfied with the topics offered during the conference (98.8%)
- They reported that the conference provided them with new, relevant, effective and current information and ideas (99.4%)
- They felt supported in their diabetes prevention and/or health promotion activities as a result of attending the conference (98.5%)

- In terms of respondents' intentions regarding upcoming national Aboriginal diabetes conferences, virtually all were at least somewhat likely to attend a future conference (98.2%), and 99.3% were at least somewhat likely to recommend that their colleagues attend future conferences as well.
- When asked for suggestions to improve future conferences, as an open-ended question, the largest percentage (35.6%, n=21) commented that no changes were needed. Other relatively frequent suggestions included: making changes to the food provided at the conference (i.e., healthier choices, different choices) (18.6%, n=11), offering other topics (16.9%, n=10), involving more Elders in the conference, making it more culturally relevant (10.2%, n=6), changing the physical set-up of the venue (10.2%).

Conclusion Five: **Recapping from the original conference evaluation report (the *7th National Aboriginal Diabetes Conference and Strategic Planning Process Evaluation Report),* it is apparent that the 2013 national Aboriginal diabetes conference was very successful. Virtually all respondents to that study identified the five conference objectives as being important to them; virtually all of these respondents indicated that their objectives for attending the conference had been achieved; these respondents felt that attending the conference represented a good use of their time; they were satisfied with the topics covered; they felt that they received new, relevant, effective and current ideas and information there; and they felt supported in their diabetes prevention and health promotion activities.**

Virtually all of the conference respondents were likely to attend future conferences sponsored by NADA and to recommend that their colleagues do the same. Some potentially helpful suggestions to improve future conferences were put forward by small numbers of these respondents.

Conclusion Six: **NADA exists to provide its members and other stakeholders with resources and information related to diabetes prevention and health promotion through a range of media and events. A highlight of NADA's activities is its national conferences. Respondents to the current evaluation and the most recent conference were uniformly satisfied or very satisfied with the full range of services and supports they have received from NADA.**

2.5) Respondents Evaluating Their Associations With NADA.

- Consistent with the preceding findings, a very large percentage of all respondents (89.2%) felt that they had personally benefited through their association with NADA. In addition, a similar percentage (91.8%) felt that their organizations had benefited from this association as well.
- Diabetes Prevention Workers were somewhat more likely than the aggregate sample to feel that they, and their organizations, benefited from their association with NADA (95.1% and 93.4%, respectively).
  - The large majority of respondents, in the aggregate, felt that NADA had allowed them to achieve their own objectives for membership with the organization (achieving or far-exceeding the **Primary Benchmark**). The percentage of respondents who answered 'very much' or 'somewhat' to each question included:
  - Being able to hear about interesting diabetes prevention or health promotion programs taking place in other areas of Canada (93.0%)
  - Gaining more knowledge about diabetes and/or its effects (89.0%)
  - Being able to improve their diabetes prevention skills (88.0%)
  - Learning how to manage their own diabetes, or someone else's diabetes, if applicable (86.0%)
  - Being able to network with their colleagues or make new connections, through NADA (76.7%)

- The Diabetes Prevention Workers in this study were more likely to report that each of the preceding objectives for their membership with NADA had been achieved.
- Similarly, and consistent with the preceding findings, virtually all respondents, in the aggregate, felt that NADA had successfully achieved its own objectives. This included:
  - Being able to support individuals, families and communities to access the resources, related to diabetes, that they require (96.0%)
  - Ensuring that diabetes and Aboriginal people are at the forefront of Canada's health agenda (95.9%)
  - Being able to manage the organization both effectively and efficiently (95.5%)
  - Being able to inspire communities to reduce their incidence and prevalence of diabetes (94.8%)
  - Being able to establish working relationships with people who are affected by diabetes (93.4%)
- Responses from the Diabetes Prevention Workers in this study were very similar to those of the aggregate study sample.
- We've seen that respondents' future intentions regarding NADA's national conferences were overall very positive. The same can be said regarding their future intentions regarding an ongoing association with NADA. Specifically:
  - 96.8% of all respondents were likely to continue their associations with NADA, with 73.8% of these being very likely to do so.
  - 92.2% of all respondents were likely to recommend that their colleagues join NADA as well, with 61.5% being very likely to make this recommendation.
- Responses from the Diabetes Prevention Workers were somewhat more positive than those of the aggregate sample of respondents: 100% and 96.2%, respectively.
- The members of NADA's Board of Directors was equally positive in their evaluation of the organization's ability to meet the needs of their membership. This included:
  - NADA's ability to respond responsively to the needs of its members (100%)[vii]
  - The degree to which they perceive that NADA's members are familiar with its services, resources and the events it sponsors (100%)
  - The degree to which they perceive that NADA's members benefit through their association with the organization (100%)
- When board members were asked to evaluate whether NADA was in compliance with its policy and governance requirements, five of the seven members in this study provided a response. Of these, all (100%) reported that:
  - NADA's bylaws have been reviewed, revised and approved
  - The Financial Policy has been reviewed, revised and approved
  - NADA's bylaws and policies are current
  - NADA has completed the transition to the Federal Non-Profit Act
  - There has been an audit of its most recent financial statements
  - NADA's board meetings are held as required by its bylaws and constitution
  - Minutes of NADA's board meetings are completed and provided to board members in a
  - timely manner
  - NADA's Annual General Assembly is held annually

  - Four of the five board members (80.0%) reported that NADA's Personnel Policy has been reviewed, revised and approved, with one being unsure about this.
- When respondents were asked what they would change about NADA if they could, only 32 provided a response. This represents only 13.4% of the total study sample. Most suggestion were put forward by one or two respondents, indicating that they are not systemic issues. The most frequents suggestions included:

- NADA being more connected to the communities across Canada (31.3%, n=10)
- NADA developing new material related to diabetes prevention and health promotion (15.6%, n=5)
- NADA doing more to market and promote its services and information (9.4%, n=3)
- NADA holding conferences in other parts of Canada (9.4%)

Conclusion Seven: **The results of all aspects of this evaluation of NADA have been consistently positive. In every case the responses provided either achieved or, in most cases, exceeded the evaluation's Primary Benchmark. From the findings in this last section we have seen that virtually all respondents felt that both they, and their organizations, had benefited by being associated with NADA. They felt, overwhelmingly, that they had achieved their personal objectives for joining NADA, and that the organization had generally been overall successful in achieving its own organizational objectives. Its board members agreed with this latter observation as well.**

Conclusion Eight: **Consistent with the previous conclusion, when respondents were given the opportunity to provide suggestion to improve NADA, over 85% could not think of any ways to accomplish this; with the implication that NADA was fine the way it currently is. However, given the assumption that every organization has the capacity and need to seek ways to be as relevant as possible to its membership, that the organization review the verbatim comments provided in this report to assess their usefulness and relevance for the organization.**

III) RELATED RECOMMENDATIONS:

The following recommendations were based on the evaluation findings.

Recommendation One: ***Based on responses from this evaluation it is recommended that NADA endeavour to provide its members and other stakeholders with the following information and resources:***

- ***Additional information regarding diseases or conditions associated with diabetes***
- ***Cookbooks or food resource guides for persons with diabetes, or those seeking to eat healthier foods***
- ***Additional training and health promotion materials***
- ***Additional related information of special interest to Aboriginal people***
- ***Additional information regarding diabetes and its side-effects***
- ***Improvements to NADA's websites to make it easier to navigate***

Recommendation Two: ***As well as the new information or resources noted in Recommendation One, it is further recommended that NADA endeavour to provide its members with more networking opportunities. This would be a particular necessity for the Diabetes Prevention Workers and other stakeholders located in small and/or isolated communities, who have limited resources to their peers.***

Recommendation Three: ***When respondents were asked for ways to improve NADA,*** **the most fre-** ***quent suggestion was that NADA representatives should have more of a presence in their communities; particularly in Aboriginal and First Nations communities. It is recommended that the organization review its current travel budget to determine its capacity to meet this expressed need and to identify the related shortfall. Discussions with its funders regarding a commensurate increase to this aspect of NADA's budget, or a review of travel cost-sharing opportunities, should follow.***

Recommendation Four: ***That NADA endeavour to provide its resources and information in languages other than only English. This could include seeking financial support from government and other sources to translate its key resources into French, Cree and Ojibwe.***

Recommendation Five: ***Based on some of the suggestions to improve NADA that were put forward by respondents to this study, it is recommended that NADA seek to increase its budget for technology enhancements to facilitate better community engagement. Related projects could include the development of digital projects such as diabetes presentations made available via YouTube and PowerPoint, along with poster development on diabetes complications using Layar technology (similar to Blipar and barcode) which is very interactive with cell phone usage.***

Recommendation Six: ***That NADA seek to provide its National Diabetes Prevention Conferences on a bi-annual basis. In addition, it has been suggested that the organization attempt to provide some of these conferences in other centres outside of Winnipeg. It is recommended that the organization consult with Health Canada regarding a commensurate increase to its contribution agreement and fund raising strategy to support the implementation of this recommendation.***

ENDNOTES:

i) Much of the information contained in this section was cited from the 'About Us' page of NADA's website, at http://www.nada.ca/about/about-nada/ Some portions were adapted for this section.

ii) The ***7th National Aboriginal Diabetes Conference and Strategic Planning Process Evaluation Report***, Kaplan Research Associates Inc, February 2014.

iii) There were 14 respondents who did not provide their partial Postal Codes, so it is possible that these last two parts of Canada were reflected in the study sample.

iv) Cited from the ***Evaluation Report on the 7th National Aboriginal Diabetes Conference and Strategic Planning Process***, Kaplan Research Associates, February 2014

v) The percentage of respondents who provided an open-ended response.

vi) The percentage of respondents who said that each objective was very or at least somewhat important to them. Some of these data have been rounded to increase their legibility in the accompanying graphs.

vii) The percentage of respondents who answered 'very much' or 'somewhat' to each question (n=6).