National Aboriginal Diabetes Association

Growing Your Program

Your Toolkit to Program Success

Getting started by giving thanks

Before we begin, let us take time to honour our community members, Elders, mothers and fathers, brothers and sisters, care givers, teachers, health care workers, program staff members, Chief and Council and all program partners who come together to help us pull together in the same direction – to a better life, health and happiness.

Let us keep working on the same path today, tomorrow and in the future. And as we work together, let us remember that every word is a prayer and every day is a celebration. Come take my hand and we will be fearless together.

Contents

Executive Summary

In November 2013 the National Aboriginal Diabetes Association (NADA) hosted the 7th National Aboriginal Diabetes Conference and Strategic Planning Session – *Celebrating Success: Building Healthier Pathways.* This event was well attended by Aboriginal Diabetes Initiative workers (ADI), health care professionals, researchers, sponsors, artisans, people with diabetes, the general public and various service providers and interest groups.

These conference participants contributed stories, best practices, challenges, and solutions, on various topics covered at the Strategic Planning Session. Participants were able to identify many successful programs, initiatives, collaborations and partnerships, all aimed at helping people with diabetes manage their disease and to encourage healthy living across the country. Many of these best practices, challenges and success stories will be highlighted throughout this document. These stories are presented here as an expression of gratitude for the sharing of knowledge and so that others may gather the information; reflect on it, and introduce it into community programming in order to strengthen that which needs strengthening.

Growing Your Program Toolkit, is a primer for building capacity in community programming and will introduce concepts of Asset Mapping, Capacity Building, Policy Development, and Evaluation. Resources will be provided to help you in this endeavour and for this reason; this document can be regarded as a toolkit for building capacity in your ADI program.

Are we on the right path?

ADI was established in 1999. The goal of the ADI is to reduce type 2 diabetes among Aboriginal people by supporting health promotion and primary prevention activities and services delivered by trained community diabetes workers and health service providers. Using local knowledge, First Nations and Inuit communities have responded by developing innovative, culturally relevant approaches aimed at increasing community wellness and ultimately reducing the burden of type 2 diabetes. Community activities vary from one community to another, and include walking clubs, weight-loss groups, diabetes workshops, fitness classes, community kitchens, community gardens and healthy school food policies. Some examples of other traditional activities include traditional food harvesting and preparation, canoeing, drumming, dancing, and traditional games.

The ADI has transitioned through 3 phases of funding/renewal processes. Each renewal process gathered information via consultation processes designed to gather information, report and build on this information and to steer the direction and growth of the ADI. Soon, the ADI will experience another transition year as Phase 3 funding sunsets and Phase 4 funding is considered.

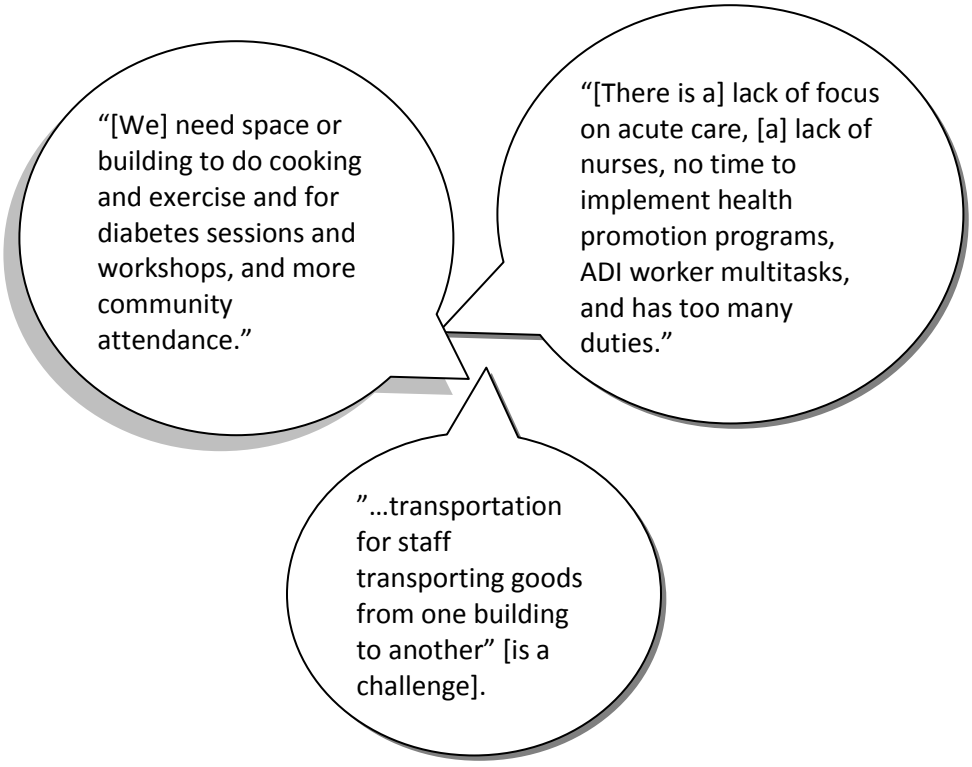
The purpose of this toolkit is to not only strengthen your community ADI program but also to strengthen the Aboriginal Diabetes Initiative.

What are the Issues?

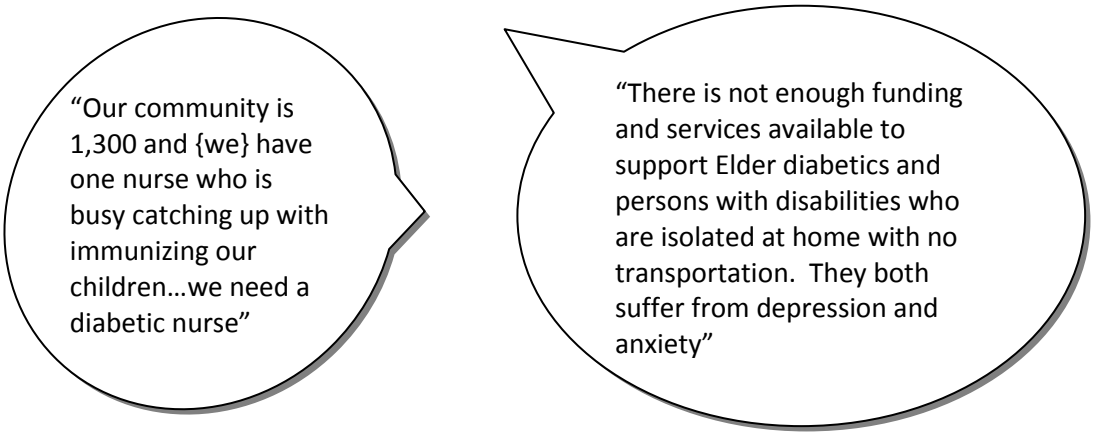
As an Aboriginal Diabetes Initiative worker (ADI) you may find yourself struggling with keeping up with the work load, visiting clients, doing paperwork and reports. You may be facing many program challenges, such as a sufficient complement of staff members or a lack of program resources, funding levels, few professionals in your communities with whom to network/partner with, difficulties coordinating essential services, feeling or being isolated, or problems with "no shows" for your weekly programs. Other challenges might be community-based where an apparent lack of communication exists between departments and organizations or there is a lack of knowledge about other programs in the community or surrounding area.

Some challenges or barriers to helping people better manage their diabetes include Food Insecurity, Finding and retaining motivated participants, resource issues, difficulty accessing health care, engaging youth in programming, policy issues,

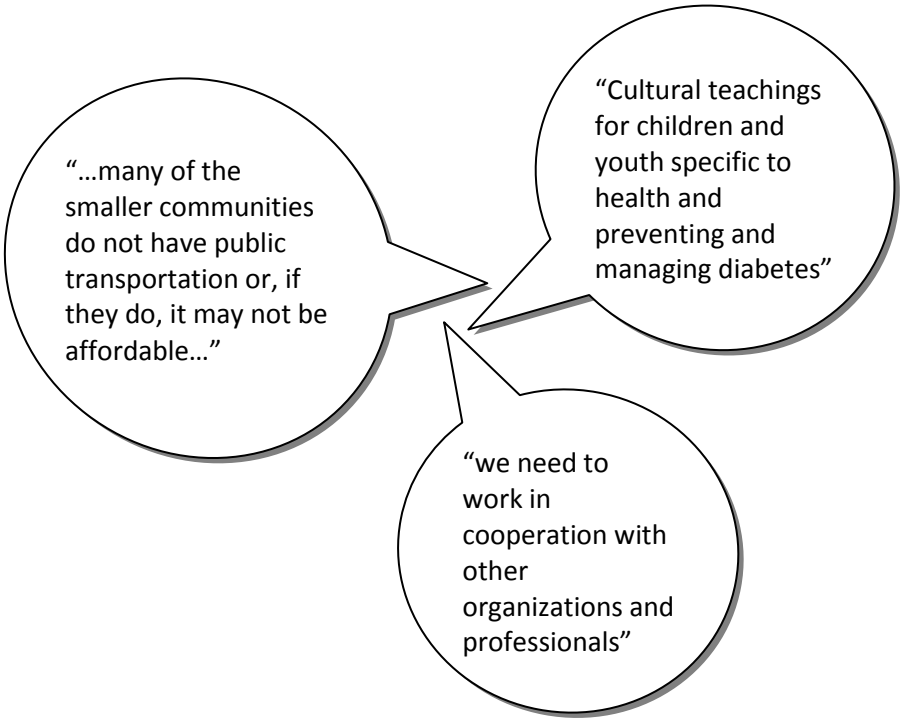
Many ADI workers have identified their program and community challenges during the 7th National Aboriginal Diabetes Conference and Strategic Planning Engagement Session and samples are presented below.



Other challenges or barriers were shared in the area of 'healthy behaviour change' and included the following thoughts: resource issues regarding facility usage, transportation, and lack of program resources, food insecurity, mental health and emotional health concerns.



In the area of creating healthier communities, the following nominal lists of challenges were shared: a lack of functional partnerships/collaborations, environmental issues, usage of Traditional approaches, distances to travel, and not reaching specific populations.



Most of the ADI workers who attended the Strategic Planning Engagement Session identified similar challenges or barriers to diabetes management and health living. Of all identified challenges or barriers, six major themes emerged as the most prominent. They are listed below:

1. Problems finding and retaining motivated program participants
2. Resource issues
3. Lack of accessible and affordable health food
4. Effects of stigma and denial
5. Programs being unable to reach youth, men in their communities
6. Mental health and emotional health concerns

Just as there are many challenges or barriers to diabetes management and healthy living, there are many solutions to explore and experiment with in order to lessen the burden of stress, isolation and staff burn-out. Some solutions might be obvious and others not so obvious. And some solutions might have short term effects while others have long term effects. The whole idea is to minimize the burden and to plug some of the gaps or holes in programming. Part of this process is planning and exploring how to "plug the gaps" and one way to do this is to look at the program's needs, problems and deficiencies and advocate for solutions from external sources. Another way is to take charge of the process by discovering and mobilizing the resources or assets to be found in every program, even in the most challenged communities.

Financial aid is frequently cited as the equalizer or solution to all challenges or barriers. This may be part of community development and engagement but there are personnel, community, and external assets that contribute to strengthening programs and communities. It is necessary to discover what other assets will improve the community and strengthen the program.

Provide funding to enable us to provide programs

Increase km payment

Funding and supports for Elders and persons with disabilities

Offer the meal more than once a month

Lack of staffing and finances

Not enough funds to hold classes and [provide] incentives

The following worksheets or questionnaires will help you to become aware of your program and community assets, how to identify new partnerships and how to engage the community or residents into your program.

Worksheet # 1 RELATIONSHIPS will highlight your connection with community residents, Associations, and Physical Space. See worksheet #1 on the following page.

WORKSHEET #1 **RELATIONSHIPS**

This questionnaire is designed to assess your connection and utility of all the resources found around you. This is an important step because **sustainable projects** have strong connections to community and community assets[i]. This will demonstrate how the relationships work, how they are involved and how to make them stronger. It is like a star blanket that is interwoven with different fabrics and patterns.

A 5-point scale appears below, where a value of 1 = Not at all, a value of 3 = Some, and a value of 5 = A Great Deal. Circle the response that most describes your project/community.

RELATIONSHIPS	Not at All		Some		A Great Deal
Our project uses the gifts and skills of our community members	1	2	3	4	5
Our project helps enhance the gifts and skills or our community members	1	2	3	4	5
Our community members help define our project objectives	1	2	3	4	5
Our project has strong relationships with volunteers	1	2	3	4	5
Our project has strong relationships with Youth Groups	1	2	3	4	5
Our project has strong relationships with the local store	1	2	3	4	5
Our project has strong relationships with local leadership	1	2	3	4	5
Our project has strong relationships with local artists	1	2	3	4	5
Our project has strong relationships with our community Elders	1	2	3	4	5
Our project has strong relationships with the local school	1	2	3	4	5
Our project has strong relationships with the Recreation Centre	1	2	3	4	5
Our project has strong relationships with the Nursing Station	1	2	3	4	5
Our project has strong relationships with the Highways Dept	1	2	3	4	5
Our project has strong relationships with the Fire Dept	1	2	3	4	5
Our project has strong relationships with other community businesses	1	2	3	4	5
Our project has strong relationships with other non-profit organizations	1	2	3	4	5
Our project uses the local physical spaces, such as baseball diamond, etc	1	2	3	4	5
Our project not only uses but improves our community's public spaces	1	2	3	4	5
Our project identifies and uses the job-related skills of local community members. E.g. Elders, artists, crafts, etc	1	2	3	4	5
Our project develops relationships with external institutions, such as:					
Foundations, businesses, other funding bodies	1	2	3	4	5
Government	1	2	3	4	5

Worksheet #2 INTERACTIONS will highlight how the relationships with community members and community assets interact with your program. For example, an empty lot or field may represent an opportunity for a local initiative to develop a child's playground or to build community garden spaces. Worksheet #2 can be found on the following page.

INTERACTIONS

Working together and pulling in the same direction is better than working alone. By working together, the work load is shared, a common interest is addressed, and more resources become available. It just makes sense to work together!

A new rating scale will be used in this questionnaire to highlight how each community resource interacts with your program. You might be surprised to find out that some of the community resources are not involved in your program. If so, this represents a key opportunity to connect and discover partnerships or program activities.

Check the most appropriate answer for your situation.

INTERACTIONS The following groups of people participate in our program as:	Recipients	Information sources	Participants	In control
Elders	☐	☐	☐	☐
Our community members will act as	☐	☐	☐	☐
Community members with disabilities	☐	☐	☐	☐
Youth	☐	☐	☐	☐
School personnel	☐	☐	☐	☐
Artists	☐	☐	☐	☐
Crafters	☐	☐	☐	☐
Volunteers	☐	☐	☐	☐
Tribal Council leadership	☐	☐	☐	☐
Recreation Centre	☐	☐	☐	☐
Local Fire Department	☐	☐	☐	☐
School Library	☐	☐	☐	☐
Local Transportation Department	☐	☐	☐	☐
Nursing Station	☐	☐	☐	☐
Community businesses	☐	☐	☐	☐
Other community programs	☐	☐	☐	☐
Other non-profit organizations	☐	☐	☐	☐
School Groups	☐	☐	☐	☐
Outdoor groups	☐	☐	☐	☐
Trappers & Fishermen	☐	☐	☐	☐
Others, please add them here:				
	☐	☐	☐	☐
	☐	☐	☐	☐

Worksheet #3 USES will highlight how your community assets can benefit your program by either sharing or providing in-kind contributions in the area of Personnel Expertise, Space & Equipment, Participants, Connectivity, or Other. The rating scale will highlight how each community resource can contribute to your program. Worksheet #3 is located on the following page.

Check the most appropriate answer for your situation.

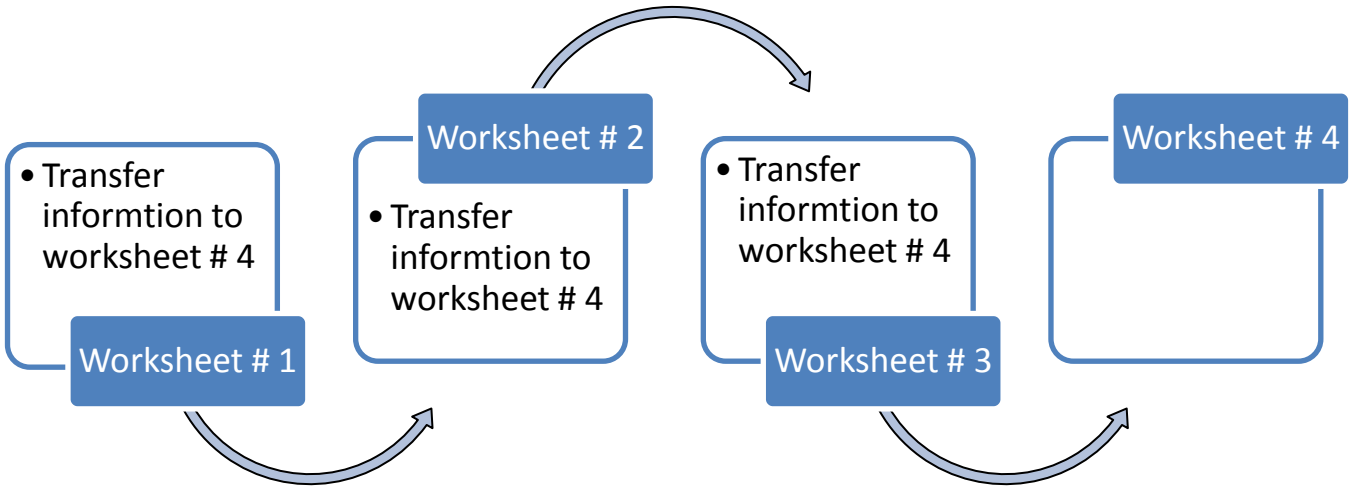
USES My project uses the following community assets for:	Personnel/ Expertise	Space & Equipment	Participants	Connectivity
Elders	☐	☐	☐	☐
School	☐	☐	☐	☐
School Library	☐	☐	☐	☐
Youth	☐	☐	☐	☐
School personnel	☐	☐	☐	☐
Artists	☐	☐	☐	☐
Crafters	☐	☐	☐	☐
Volunteers	☐	☐	☐	☐
Tribal Council leadership	☐	☐	☐	☐
Recreation Centre	☐	☐	☐	☐
Local Fire Department	☐	☐	☐	☐
Local Transportation Department	☐	☐	☐	☐
Nursing Station	☐	☐	☐	☐
Community businesses	☐	☐	☐	☐
Other community programs	☐	☐	☐	☐
Other non-profit organizations	☐	☐	☐	☐
School Groups	☐	☐	☐	☐
Outdoor groups	☐	☐	☐	☐
Trappers & Fishermen	☐	☐	☐	☐
Others, please add them here:				
	☐	☐	☐	☐
	☐	☐	☐	☐

"Coming together is a beginning; keeping together is progress; working together is success." Henry Ford

Worksheet # 4 COMMUNITY MAP is a special chart for you to collect all your information on programming and community assets in one centralized spot.

Your answers from worksheets # 1-3 will be transferred onto this collection sheet and will assist in organizing your material. This will provide you with an eagle-eye view of your community needs, problems, deficiencies and strengths. This is your community map.

Worksheet # 4 can be found on the following page.



Worksheet #4

COMMUNITY MAP

You collected information about people, programs, and relationships in the above worksheets. That information can be added into the following diagram. A few examples have been provided to get you started. Use this worksheet to create your own Community Map.

COMMUNITY ASSETS	OTHER PROGRAMS	INDIVIDUALS	PROGRAM ASSETS
School Baseball Diamond Recreation Centre	Brighter Futures NNADAP Aboriginal Head Start	Elder Artists Cooks	Meeting space Transportation Community Garden space

WORKSHEET #5A

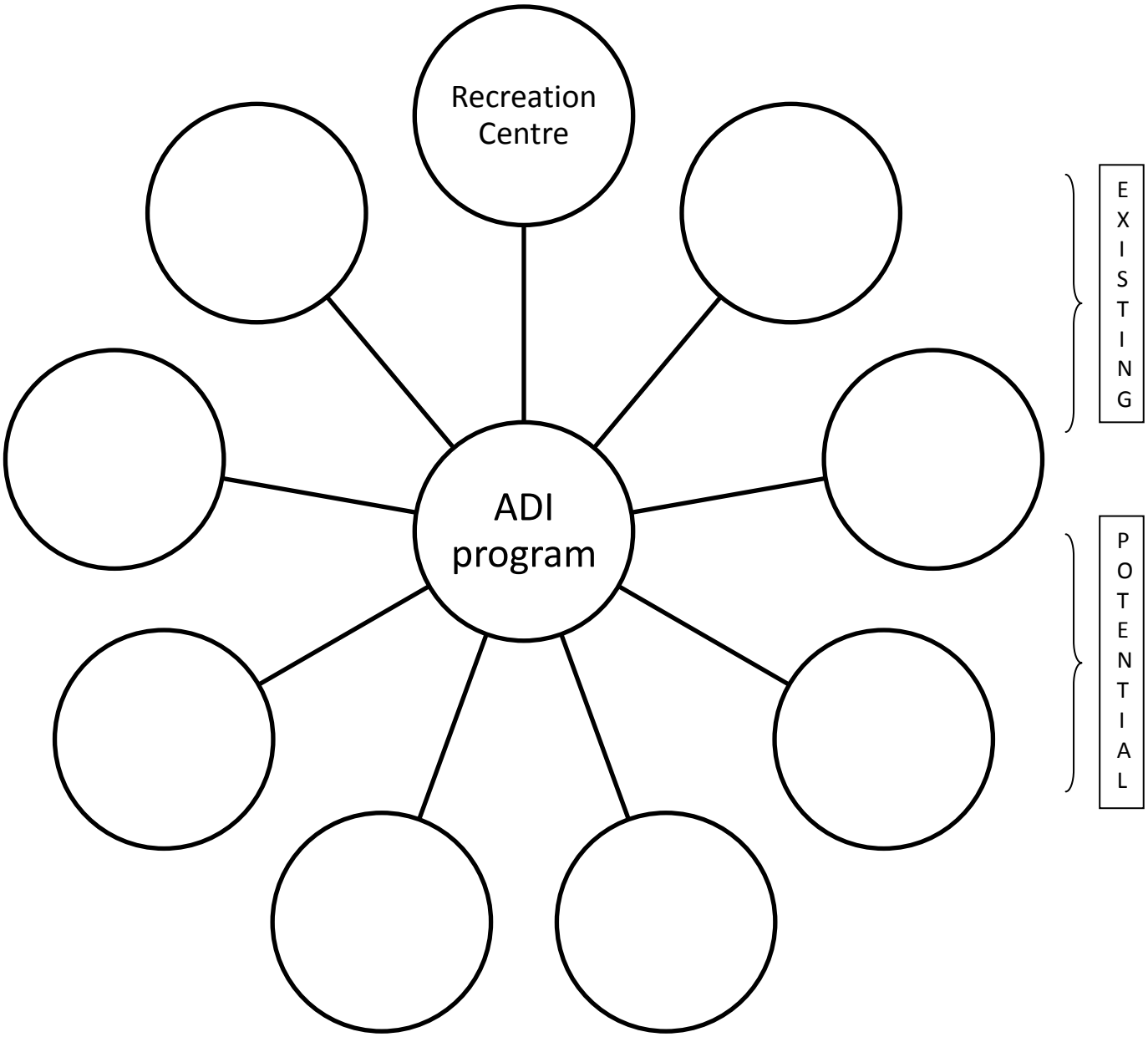
COMMUNITY MAP and YOUR PROGRAM

The following worksheet is an excellent opportunity to affirm how your community is linked to your program. This exercise highlights the true nature of your community relationships, while glimpsing at the gaps and deficiencies at the same time. This exercise will show you that there are several assets that can be used to strengthen your project.

COMMUNITY MAP and YOUR PROGRAM **Use this space to identify how your community resources are connected to your program. A brief example is provided for you.**	
Other programs: • AHS • • •	Your program: how will these assets be connected to your program? Cook, nutritionist, transportation, early childhood development, Elder, parent involvement
Community Assets: • Garden spots • • •	
Individuals: • Elders • • •	
Program Assets: • Computers, furniture, telephone • • •	

WORKSHEET #5B **COMMUNITY MAP AND YOUR PROGRAM**

Worksheet #5B is offered as an alternative tool for mapping your community assets. Use this format if you do not enjoy using a Table format, as in Worksheet 5A. The top circles are available for you to enter the names of your existing partners/resources and the bottom circles are available for you to enter the names of your potential or future partners/resources. The first one, or Recreation Centre, is provided as an example. This linkage might mean access to space, equipment, personnel that your program uses. Draw more circles if needed.



If you completed worksheets 1 – 5, you already have a good idea what your program strengths are and, of course, what your program weaknesses or challenges are.

Some comments from ADI workers, who participated in the Strategic Planning Engagement Session, shared the following challenges or barriers in First Nation and Inuit communities which were seen to inhibit greater collaboration and team work and included the following:

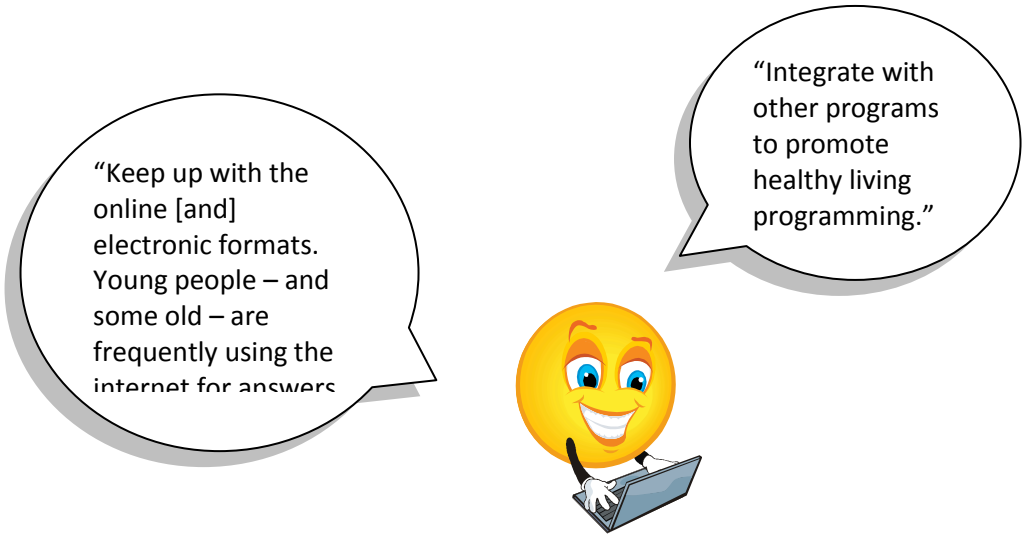
- Lack of staffing and finances
- Difficulties coordinating
- Feeling or being isolated and multitasking
- Few professionals in their communities with whom to network
- An apparent lack of communication between the organizations, agencies and departments in their communities

Other barriers for some programs related to a lack of resources while others cited a lack of facility space for educational programming and food preparation. Yet others focused on the lack of transportation, distances for travelling and difficulty accessing health care due to language/jurisdictional issues when services straddle geographic boundaries and wait times as opponents to service delivery and barriers to helping people manage their diabetes.

Food security and a lack of nutritious and affordable food were the most frequently cited barriers (ADI workers) to helping people better manage their diabetes. More funding and resources, both material and human resources, were often cited as the forerunner to increasing community diabetes programming, hence, success.

ADI workers also felt that additional funds would help their programs to teach more clients how to shop for healthy food, would allow them to provide programs that facilitated active living, would increase the participation of community Elders and people with disabilities, and increase staffing levels to adequately service the people they serve. Finally, several ADI workers wanted more funds to advertise their programs and services to reach a range of populations.

A fairly large number of ADI workers felt that they would be more successful at assisting their clients to manage their diabetes and live more active lives through the improved coordination of diabetes–related services and policies.



WORKSHEET #6

TOOLS – CREATING THE DIALOGUE

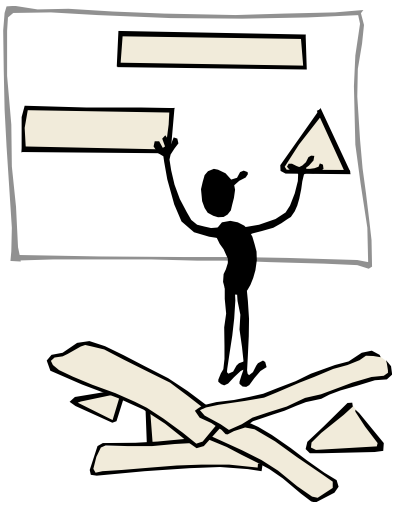
Worksheet 6 TOOLS – CREATING THE DIALOGUE will guide you in your introductions and conversations with potential program partners, guest presenters, volunteers, individuals, Elders, etc. This tool also has other uses, especially if advocating for additional program add-ons as in proposal writing. It will also highlight who is involved with your program and who isn't. Again, the deficiency becomes an opportunity to advocate for those needed resources, such as volunteers, youth participants, school personnel, etc.

TOOLS – CREATING THE DIALOGUE **This worksheet will help you approach and dialogue with community members, potential partners, other program members, community leaders, Elders, etc. This is intended to be a guide and it can be adapted to suit your style and community.**	
Gifts I can give my community:	NAME: Ph. :
Gifts of the Head (Things I know something about and would enjoy talking about with others, e.g. Art, birds, sacred medicines, etc.)	
Gifts of the Hands: (Things or skills I know how to do and would like to share with others, e.g. Sports, gardening, cooking, etc.)	
Gifts of the Heart (Things I care deeply about, e.g. Protection of the environment, children, etc.)	

Worksheet # 6 is a very dynamic tool for you to use. It has several applications – like a multipurpose tool. Here are just some of its uses:

- ✓ This tool can be used as an 'icebreaker' because it is a natural conversation opener
- ✓ This tool can help guide your conversations with others, so that you can remain on topic
- ✓ This tool can be adapted to meet your needs
- ✓ This tool can be used anywhere, such as Health Fairs, community events, bingo, etc.
- ✓ This tool can help build your confidence to meet new community members, leaders, other program personnel, potential partners, business owners, community groups, etc. to talk about your program and to ask how others might wish to participate
- ✓ This tool can help organize your thoughts, ideas, and opportunities for enhancing your program and this is how you build and strengthen your program.

You may photocopy worksheet # 6 many times so that you always have one available to use when meeting community members or others. Remember to be prepared to talk about your program highlights, such as program goals and activities and your interest in strengthening the program.



Next Steps: Worksheets 1 – 6 have been gathering tools, generally, information for you to ponder, connect to, and fit into your schema or program framework.

For example, if you discovered that your community members want to be information sources, then you can foster that relationship by inviting them to participate in FOCUS GROUPS or as HELPERS to fill in PROGRAM NEEDS SURVEYS. Other possibilities include, making a list of topics that the residents feel confident talking about, then inviting them to special program events to present on gardening, crafts, the environment, hunting, traditional medicines, etc. This presentation can be followed by a FOOTCARE session or DIABETES BINGO, the opportunities are limitless.

If, on the other hand, the community members want to be in control in programming then they might be perfect participants for your Focus Group, Advisory Committee or Steering Committee who contribute in GOAL SETTING, PLANNING AND IMPLEMENTATION.

FOCUS GROUPS

The purpose of using focus groups is to discuss the findings from Worksheets 1 to 5B (community mapping, collaborations, resources) with a sample of community members, partners, staff and key stakeholders and to elicit suggestions for improvement.

Focus groups are basically:

- ✓ Ways of listening to staff, community and partners and learning from them. For instance, if your community members stated that they wanted to "be in control" as depicted in Worksheet 2, then these are the individuals who make good candidates for Focus Groups, Advisory Committees, Steering Committees, etc. They want to have input into the program by sharing their ideas.
- ✓ A demonstration of commitment to a participative process
- ✓ An opportunity to prioritize the specific areas in which there is a need for action
- ✓ An opportunity to explore practical and workable improvements

BEFORE THE INVITATIONS ARE SENT OUT

The data gathered from Worksheets 1 to 5B should have highlighted a number of areas warranting further exploration. Therefore, it is advised to base the question set on these areas.

For example, you may have highlighted that you do not have strong relationships with Volunteers and Youth (Worksheet #1), and that Crafters and the Nursing Station did not participate in your program (Worksheet #2), and that Elders and School Groups were not used by your program (Worksheet #3), etc.

Your question set must focus on the 'gaps' or challenges in your programming and service delivery. To ensure that you stay on track and keep the group focused on the task at hand; here are a few guidelines to follow:

1. Develop a question set
    a. The pre-prepared questions can help the facilitator to stay on track and on time
        i. Use introductory questions first. They should be open-ended. For example, "*what program events did you like the most"* is better than *"The Medicine Picking event was our best, do you agree?"*
        ii. Use transitional questions, so that the facilitator can move from one topic to the next related topic. For example: *earlier we discussed the fun activities of the program, now let's talk about …*

iii. Use key questions and follow-up questions which address the key issues. For example, *what is the most important issue facing the program? Then, what can we do about it?*

2. Prepare a statement on what will happen next. For example, *the results will be summarized, interpreted and reported…actions will be taken…timelines will be…*

3. Select the group
    a. The number of Focus Groups that you will host will depend on local circumstances, timing and sequencing of events and the issues that need to be addressed as identified by Worksheets 1 to 5
    b. Selecting the participants may be dependent on venue of the Focus Group, participation levels of the community and partner relationships. However, choose participants that will be comfortable with one another

4. Determine the size of the group
    a. A workable group size can range from 6 to 10 participants. This comfortable number of participants will enable participants to make their contributions

5. Select a facilitator and note taker
    a. This individual's main responsibility is to welcome the participants, set the scene, explain the purpose of the focus group, introduce the topics for discussion, keep the group on time and focused on the topics, encourage participation from all the group members, summarize the discussions from time to time, and ensure that all the key issues are addressed
    b. The note taker is responsible for scribing the comments, actionable items, and other discussions pieces. The notes will be re-formatted into meeting minutes for later distribution and reporting

6. Select the venue and time of the Focus Group

7. Send the invitations, calendar dates, poster reminders, etc.
    a. Send invitations, in advance, with a little note explaining the purpose of the Focus Group and how the results will be used, in this case, to support future program service delivery
    b. Ensure that you have a contact or call-back number for further information

8. Run the Focus Group
    a. Gather up your meeting supplies, such as, pens, pencils, name tags, flip chart paper, markers, Meeting agenda, etc.
    b. Prioritize the recommendations. Make a list of thing to do first, second, and third, etc.
    c. At the end of the session, have a Closing Circle so that the Focus Group participants can express their thoughts on their participation or the meeting process, etc.

9. Record the Results after the Focus Group
    a. Interpret and report the results in a report format. Translate the results into actionable items

10. Follow up
    a. Communicate with the Focus Group participants by sending them a copy of the report and how the recommendations will be acted on

You will find a sample Community Focus Group agenda and meeting notes template. You may find this template useful in organizing your Focus Groups. This template is adaptable to your needs.

WORKSHEET #7 **COMMUNITY FOCUS GROUP AGENDA AND MEETING NOTES FORM**

Agenda

Community Focus Group

Date
Time
Venue

Type of meeting:
Facilitator:
Note taker:

Attendees:

Agenda topics

15 minutes	Welcome	Meeting organizer
	Introduction of Participants	All
	Purpose of Focus Group	Facilitator
30 minutes each	Focus Group Topics	Facilitator
	Topic A	
	Topic B	
	Topic C	
	Topic D	
30	Meeting Summary and Wrap Up	Facilitator
15 minutes	Summary of Actionable Items	Facilitator
	Announcement of Next Steps	Facilitator
30	Closing Circle	All participants

Special notes:

Meeting Notes

Community Focus Group

Date
Time
Venue

Type of meeting:
Facilitator:
Note taker:

Attendees:

Agenda topics

	Welcome	Meeting organizer
Discussion:		
	Introduction of Participants	All
Discussion:		
	Purpose of Focus Group	Facilitator
Discussion:		
15 Minutes	Focus Group Topics Introduction	Facilitator
Discussion:		

30 minutes	Topic A	
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:

30 minutes	Topic B	
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:

30 minutes	Topic C	
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:

30 minutes	Topic D	
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:

30 Minutes	Meeting Summary and Wrap Up	Facilitator
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:

15 minutes	Summary of Actionable Items	Facilitator
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:

Announcement of Next Steps		Facilitator
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:
30 minutes Closing Circle		All participants
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:
Special notes:		

Worksheet # 7 will help you get organized for your meetings or Focus Groups. This is especially useful for staying focused on the task at hand and transitioning from one topic to another. Stay on time for each section, so that all topics are covered. The meeting notes will feature the discussion pieces and the decisions, recommendations and actionable items. These actionable items will be developed into a prioritized action plan.

SETTING PRIORITIES

Your Focus Group Report is a very important tool to help you set your priorities in a manageable fashion. You must identify the priorities by listing what items need to be addressed first, second, third, etc.

How you organize your priority list is as important as what is on the priority list.

For example, you may want to add services or partnerships to your program to enhance service delivery. To do so, you need to consider community variables with community directions. Some questions to ask when plotting priorities are:

1. What is easily within our reach?
2. What will take a long / short time to achieve?
3. Do we need external resources?
4. How much work is involved?

A comprehensive list of guiding questions is provided on the following page. See Worksheet # 8 ACTION PLAN CHART.

"Coming together is a beginning; keeping together is progress; working together is success." Henry Ford

ACTION PLAN CHART

Long Term Goal				
Short Term Goal				
	Resources	Responsibility	Timeline	Measurable Outcomes
Priority # 1				
Priority # 2				
Priority # 3				
Priority # 4				
Special Notes				

Instructions:

- Fill in the Long Term Goal: longer than 3+ years
- Fill in the Short Term Goal: less than 3 years
- Fill in the Priority lists, as determined by your Focus Group recommendations
- Identify the Resources required prior to implementation of the Priority
- Identify who or which groups of individuals will be assisting this work
- Identify the length of time needed to develop or implement the plan
- Identify the measurable outcomes for each priority. These outcomes identify the results of achieving your goals

Long Term Goal	ADI program by including early childhood development programming			
Short Term Goal				
	Resources	Responsibility	Timeline	Measurable Outcomes
Priority # 1 Develop child care centre	Child care standards	ECE manager Band Council ADI Manager	2015 – 2017	Feasibility Study completed by June 2015 Funding approved – June 2016
Priority # 2				
Priority # 3				
Priority # 4				
Special Notes				

WHAT IS WORKING WELL AND WHAT ARE SOME SUCCESSFUL APPROACHES?

Participants at the Strategic Planning and Engagement Session were able to identify many successful programs, initiatives, collaborations and partnerships, all aimed at helping people with diabetes manage their disease, and to encourage healthy living across the country. These best practices were grouped into 5 themes as follows:

1. Living Well with Diabetes
2. From Awareness to Change
3. Healthy Communities
4. Working Together
5. Mental Health and Emotional Support

Some of the ADI program best practices are recorded in Table 1. For a complete listing of "best practices" please visit: www.nada.ca and visit the Reports section or click here for the Diabetes Strategic Planning Session Report.

Table 1 BEST PRACTICES

Living Well with Diabetes

1. Facilitating successful programs, services or events.
    a. Provision of information, education sessions and health fairs, peoples with diabetes sharing their stories, developing strategies to reduce risk factors, and the promotion of a health theme each month – "February is Heart Month"

2. Providing educational programming and opportunities to learn about healthy eating and proper food preparation
    a. How to prepare healthy foods through "whole food lunch programs" and tasting parties", preparing low-sodium dishes and harvesting vegetables, introduction of food boxes, use of vouchers for fresh fruit and vegetables, providing in-store healthy eating demos, providing winter activities, such as snowshoeing and hiking, offering door prizes, providing HEY Health Empowerment for You, Colour it Up, Healthy Eating For Diabetes cookbook

3. Working in partnership with other organizations and professionals
    a. Providing linkages to health care professionals, such as: dietitians, physicians, cardiac nurses, homecare nurses, diabetes educators, nurse practitioners, exercise therapists, foot care specialists, and dental hygienists, access to an online chronic disease self-management program though the University of Victoria, home care nursing staff doing basic diabetes self management and support, facilitation of home and community gardens

4. Tailoring programming for specific populations
    a. Introducing activity programs such as Yoga for children, hosting 'diabetes day' at school, hosting school-based healthy cooking classes and food preparations sessions called "Kids in the Kitchen", Eldercize Programs

Living Well with Diabetes Con't

5. Using Traditional approaches
    a. Teaching residents about traditional dietetic practices and healthier food preparation, teaching them how to live off the land, teaching children how to hunt for their food

6. Empowering their clients
    a. Using a 'strength-based approach, using strategies of Motivational Interviewing and Stages of Change, empowering clients to assume a leadership role in diabetes self-care by leading workshops, planning wellness events, running healthy cooking classes and physical activity groups, as well as providing group self management education options, called Diabetes M & M sessions (Meals, muscles, monitoring & Meds) every 2 months on each community

7. Incorporating new medical equipment/supplies
    a. Introduction of new blood-glucose meters and providing better access to supplies and equipment

From Awareness To Change

1. Providing programs aimed at diabetes prevention and healthy living
    a. Delivering programs that offer information, e.g. meal planning on a budget,
    b. Providing services such as foot care, good food boxes (see reference and resources at end of this manual), mobile diabetes clinics, health coaching and one-to-one visits, offering exercise focused activities, such as Nordic Pole Walking, cooking classes, gardening and walking programs

2. Hosting special events
    a. Hosting diabetes awareness programs, screening clinics and fitness challenges, e.g. "All FN schools in Nova Scotia participate in a month long walking challenge and have education sessions delivered on physical activity , healthy eating and diabetes and its prevention. This program is directed at grades 4,5,6…"

3. Providing educational opportunities, workshops or training
    a. Examples include hosting Elders' luncheons, diabetic workshops, and school-based presentations

4. Networking with other professionals in their communities
    a. This includes inter-professional collaboration, interagency meetings, partnerships between community health centres, schools, and other programs

5. Providing health promotion initiatives
    a. Initiatives included programs utilizing local radio/TV, lending skates program and nutrition newsletter

From Awareness To Change, Con't

6. Leading by example
    a. Being consistent and sincere when working within communities
    b. Supporting those making changes but at the same time allowing them to do it themselves, teach how to be independent
    c. Leaders in the community setting good example for others
    d. Serving healthy food and snacks at community meetings to reinforce healthy behaviour messaging

7. Focusing their initiatives on traditional ways
    a. "Trainers empowered to make change in community and teach members healthy eating, substance abuse moderation, exercise also included in modules is history and traditions of our people"

8. Encouraging policy changes
    a. Such as removal of vending machines in some schools and some workplaces and no smoking in public buildings and other healthy public policies

9. Celebrating success
    a. Each student receives a Certificate of Participation
    b. Celebration of each class's success is done in December with a fruit tray provided by the health centres and used for taste testing!
    c. The winning class of the Walking Challenge receives a trophy and water bottles

Healthy Communities

1. Facilitating programs and initiatives focusing on healthy foods, cooking
    a. Breast feeding support circles, diabetes support group, community meals, group-based weight loss initiatives, including Biggest Loser and Weight Watchers

2. Programs and initiatives focusing on active living
    a. Elder programming including walking poles, seated exercise classes, and Tae Chi, for children, before School Breakfast Program

3. Providing a range of medical services
    a. Medical services such as screening for complications, foot care, eye retinopathy, dietetics, flu shots, and diabetes education
    b. All departments in the community come together to plan events that promote,,, healthier lifestyles through coordination of exercise, meals, and educational sessions

4. Providing diabetes awareness activities
    a. Community members acting as peer facilitators, education at Parent – Teachers meetings, Social media and outreach using the phone, creating groups for people to engage and work to be healthy, prevention education in schools

Healthy Communities, Con't

5. Providing programs and initiatives promoting gardening and livestock
    a. Teaching community members to garden, offering space for community gardens, apple orchards – fruit share, building green houses, gardening contests, livestock programs

6. Focusing on traditional ways
    a. Returning to traditional ways by hosting cookouts, ice fishing, berry picking, hunting

7. Facilitating health-oriented policies
    a. Healthy policies are required to support healthy communities; such as, No Smoking in public buildings, nutritious food at large events and group programming, breakfast programs, removal of vending machines, mandatory Food Handler's Certificate

Working Together

1. Sharing their knowledge and expertise
    a. Chronic conditions support Program participates in Yukon Diabetes Reference Group, Lunch and Learn sessions, sessions offered that link diabetes, traditional health services, and mental health care, partnering with aquatic centre and cross trainers, linking food banks with dietitian and diabetes education, partnership with SOAHAC and youth centre

2. Developing partnerships across a range of topics
    a. Membertou FN Diabetes Working Group partners with school Fitness programs include weekly skating lessons, boot camp through the public school system, walking/running groups, Elder exercise, Zumba
    b. Committee development with multiple partners focused on healthy activity curriculum development

3. Developing partnerships specifically to increase community diabetes awareness
    a. Fundraisers, walks, weight loss challenges, monthly diabetic day clinics, diabetic kitchen events, breakfast programs, prenatal collaborations promoting breastfeeding and community health fairs

4. Providing joint team presentations and coordinated facilitation
    a. Diabetes team working in collaboration with dietitians and Youth focused community workshops such as conferences, or talent nights
    b. Nurses and health educators taking a team approach to service delivery and patient care

Working Together Con't

5. Expediting referrals to other health care providers
    a. Informing individuals of community resources and how to access them
    b. Coordinated service delivery allows clients to meet with different providers during one visit

6. Developing partnerships to improve clients' food choices
    a. Tribal Council nutritionist hosts one-on-one sessions for people with Diabetes
    b. Guest speakers present information on nutrition, diabetes, etc
    c. Cooking classes feature healthier foods
    d. Healthy alternatives offered as snacks

7. Sharing feedback and ideas with others in the field
    a. Feedback and information offered at gatherings, luncheons, asset mapping, staff/community meetings,

8. Developing positive relationships across fields
    a. Positive relations while working with community members, program partners is integral element for successful partnerships

9. Developing partnerships to facilitate networking
    a. Networking with partners such as North Bay Health Unit, Nipissing Health Centre provide information at our workshops, prevention and awareness week
    b. Having the Health Authority staff come to the community was seen as advantageous

10. Sharing costs and resources
    a. In–kind contributions such as event coordination and service provider time were seen as valuable outcomes of partnering

11. Facilitating joint training
    a. Creating partnerships allows for expanded education opportunities and more options for participants
    b. Shared event promotion and inviting partners to attend community events and share resources is of extreme value

12. Helping to arrange transportation for clients
    a. Partners providing transportation…"to groups and having set schedules and times has been working well."

Mental Health and Emotional Support

1. Referring their clients, with mental health concerns, to external related services providers
    a. Referral to Right Path Counseling and Prevention Program for clients needing mental health or emotional supports
    b. Referrals to local psychologists in private practice, to hospitals, to addiction services (NNADAP), to crisis response teams, and to chronic disease nurses
    c. Some programs screen for depression

2. Providing counseling services and supports through their own organizations
    a. …"we have a mental health liaison worker every Friday to see people from 11:00 am – 1:00 pm"
    b. We provide one-on-one counseling to deal with [their] depression or denial stage when they're diagnosed
    c. One to one counseling, going into homes to support victims, quarterly workshops on-going, and we do follow-ups

3. Using traditional ways and approaches to support these individuals
    a. [we use] a spiritual healing lodge and go on medicine walks
    b. …integrating a medicine wheel holistic approach
    c. Elders will help if offered tobacco
    d. Linkage with traditional approaches to address mental and emotional issues

4. Providing these individuals with information through workshops
    a. Support groups helps clients understand effects of high sugars and the stress of living with diabetes
    b. Invited Canadian Mental Health Association CMHA to talk about how depression, anxiety [and]stress can lead to addictions

5. Coordinating service delivery across several organizations
    a. Family therapist, NNADAP workers and ADI work together
    b. [We] partner with suicide prevention and present information on self-esteem, body image – for girls,
    c. We offer sharing circles and traditional healers

6. Delivering programs that focus on healthy eating, active living
    a. We offered cooking classes, preparation of and eating healthy breakfasts, recipe bingo, providing health food boxes, and the concept that food security can be linked ot improved mental health outcomes
    b. We offer walking programs, including Elders in Motion and Nordic walking, gym classes, and outings with a physical focus

Given that some ADI workers are based in small and isolated communities, the availability of other caring professionals MAY be difficult to foster. Notwithstanding this clear limitation, it seems that the ideal of interdisciplinary teams serving First Nations communities would be worth establishing as a medium-to long-term objective.

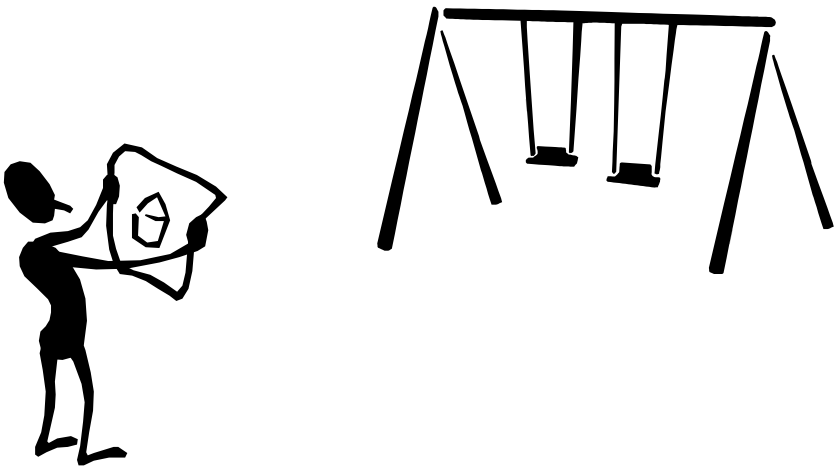
With the advent of technologies such as Skype, teleconferencing, webinars and Telehealth, and the availability of Internet access in almost all parts of Canada, it seems possible that virtual interdisciplinary teams may be a practical alternative for the time being.

Based on the comments derived through this strategic planning process, it is suggested that, to the extent possible, these teams should be comprised of the following disciplines and professions:

- ADI specialists
- Nurses
- Physicians
- Social workers
- Mental health therapists or counselors
- Nutritionists
- Podiatrists and other foot care specialists
- Occupational therapists
- Recreation specialists
- Community development specialists
- Elders and Traditional Healers

For information on how to start a Multidisciplinary virtual team, click on the following hyperlink: virtual team. Alternatively, you may find plenty of information on the Internet. If you are 'surfing the net' for your information, make sure that you visit safe and free sites.

DOES YOUR PLAN MATCH YOUR PRODUCTIVITY?



Worksheets 1 through 6 have helped you and your teams identify your community assets, such as buildings, human resources, participants as users of the service or contributors to the service, as well as networking opportunities. All of this information needs to be acted on in a thoughtful way so that your good intentions reflect consistent and quality programming.

As you can see in the above diagram, the organizer is monitoring progress of the plan but the plan did not evolve as expected. Instead of a home a playground was constructed. When things don't work out, you must wonder, why not or what went wrong? In reality, you must know what went wrong and how to correct the situation so that the wrong thing doesn't happen again.

So, in the previous pages, you performed your due diligence and surveyed the community, asked all the right questions, got people interested in the future programming changes or additions. This is all very good, but now you must review your program evaluation. Your program evaluation must answer the following questions:

- Did I do what I said I would do?
- What difference did it make?

Essentially, if your programming made a difference in your community, you should recognize the changes and then you should tell everyone about it. Tell community members, partners, and Tribal Council, key stakeholders and of course, your program funding body. Celebrate your successes and ponder your challenges.

It's okay to have program challenges and to talk about them to your staff, program participants, partners, key stakeholders and of course, your program funding body. But before you do this, have an idea about possible solutions to quash those challenges. You can easily find the solutions to the program challenges by hosting post-evaluation Focus Group or meeting with your Advisory Committee(s) . This is a brainstorming session and this type of approach helps you arrive at real solutions for your program challenges. This approach also enhances transparency with all.

Closing Circle

Growing Your Program, Your Toolkit to Program Success is dedicated to all ADI workers. Many thanks for your passion and dedication in delivering programs, services and inspiration in helping people manage their diabetes and living a healthier lifestyle.

... We are not meant to be perfect.
We are meant to be whole

APPENDICES

Example Icebreaker Exercise

Ask members to respond to the following questions about themselves. Make them share their responses with the rest of the group. You as a leader should respond and share as well.

1. What is an example of a life goal you aspire to accomplish in your career?
2. What are the characteristics of that life goal that inspire you?
3. In what way are such life goals fulfilling for you?
4. What have you learned from aspiring to this goal that you could share with others and help them develop?

REFERENCES AND RESOURCES

[i] Adapted from: Discovering Community Power: A guide to Mobilizing Local Assets and Your Organization's Capacity. John P. Kretzmann and John L. McKnight, Co-Directors with Sara Dobrowolski, Project Coordinator and Deborah Puntenney, Ph.D. 2005.

GOOD FOOD BOX
How to Start a Good Food Box Program, Click here.
Winnipeg, Click here.
Calgary, Click here
Victoria, Click here,
Toronto Click here,
Ottawa, Click here
Northern Healthy Communities, Click here
Shuswap Family Resource Centre, Click here.