

Inuit Diabetes Network Bulletin



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INUIT TAPIIRIT KANATAMI

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The Aboriginal Diabetes Initiative is designed to provide a more comprehensive, collaborative and integrated approach to decreasing diabetes and its complications among Aboriginal peoples. The program is overseen by a national steering committee with representation from the national Aboriginal representative organizations (Assembly of First Nations, Inuit Tapiriit Kanatami, Métis National Council, Congress of Aboriginal Peoples, Native Women's Association of Canada) as well as the National Aboriginal Diabetes Association.(Health Canada, First Nations and Inuit Health Branch)

Since 2004 Inuit Tapiriit Kanatami (ITK) has acted as the facilitator for the Aboriginal Diabetes Initiative (ADI) with the Inuit regions and national Inuit organizations. Together this group forms the Inuit Diabetes Network (IDN). A summary of ITK activities related to diabetes and the IDN diabetes activities are provided in this section of the IDN bulletin.

YOUTH HEALTH SCREENING ON BAFFIN ISLAND, PANGNIRTUNG, NUNAVUT

A health screening study was coordinated by McGill University, Centre for Indigenous Peoples' Nutrition and Environment (CINE), with the Attagoyuk High School youth of Pangnirtung in May 2006. The study revealed that the youth are eating traditional foods well and few youth were overweight, although youth are drinking too much soda pop today. These results were reported back to the school and youth in November. To assist the project in addressing the results, two job opportunities were created: Health Promotion Coordinator and Communications Technician. The project is led by a steering committee with the cooperation of the Municipality of Pangnirtung, local Elders Society, the local Youth Committee and Attagoyuk High School.

HEALTH SCREENING ON BAFFIN ISLAND, PANGNIRTUNG, NUNAVUT

In collaboration with McGill, CINE, the community of Pangnirtung and ITK have worked with a screening project for three years. Of 52 community volunteers, five had been pre-diagnosed with diabetes, no new cases were found. Obesity rates among the women were observed. Men are in good health fortunately. Traditional foods are being consumed in high amounts. Less intake of saturated fats and sugars are encouraged. The community is encouraged to keep active and positive as best as possible.

Later, interviews with elders were conducted on traditional foods, traditional medicines, plants and climate change. CD's were produced, and once final editing is completed they will be broadcast through the community radio. A DVD production will also be developed in the community in early spring 2008 to demonstrate the highlights of the health screening project. Dr. Grace Egeland is the Principle Investigator of the project. The steering community members are: Jonah Kilabuk, Johnny Kuluguktuk, Selina Kisa of Pangnirtung and Looee Okalik of ITK.

ADI JOINT MEETING IN MONCTON, NB

Health Canada, First Nations and Inuit Health Branch (FNIHB), Assembly of First Nations (AFN), and ITK held an Aboriginal Diabetes Initiative Joint Meeting in Moncton for two days. IDN Chair, Francene Ross of Inuvialuit Regional Corporation (IRC) delivered the presentation on Inuit diabetes-related activities and reiterated that Inuit-specific activities and Inuit involvement are key to successful collaborations and activities.

ADI RESEARCH AGENDA WORKSHOP, TORONTO

ITK and IDN members participated at the ADI Research Agenda Workshop in Toronto for two days in September, 2006. Research is newly introduced into the ADI envelope. Researchers, project coordinators and advisors provided suggestions as to how to enhance the ADI program incorporating a research stream.

HEALTH SCREENING ON BAFFIN ISLAND STORYTELLING PRESENTATION AT CANADIAN DIABETES ASSOCIATION (CDA), TORONTO, ON

Health Screening on Baffin Island in Pangnirtung included a storytelling component led by Susan Bird. Inuit with diabetes shared their experiences on how it is to be an Inuk with diabetes. Inuit with diabetes indicated that traditional foods help them to maintain their diabetes, that they require more information in Inuktitut on diabetes, that food security is an issue, and that educating youth is crucial to prevent diabetes. The study results were presented by McGill, CINE project lead, Susan Bird and ITK project coordinator, Looee Okalik to Canadian Diabetes Association conference in Toronto, October 2006.



Abel Tingmiak of Inuvik demonstrating a blanket toss at the Healing Our Spirit Worldwide Conference in Edmonton, AB in August 2006.



INUIT DIABETES NETWORK MEETING, GOOSE BAY

IDN members met for two days in Goose Bay, in February 2007 to share their diabetes related activities, address the gaps and challenges in their work field, and to strengthen their activities in the areas of communication. Sophie Pamak, Home Care Nurse of Hopedale is the new chair of IDN.

GLOBAL VILLAGES MEETING IN BELLAGIO, ITALY

ITK is a part of the 12 Global Villages project led by Dr. Harriet Kuhnlein of McGill, Centre for Indigenous Peoples' Nutrition and Environment (CINE). We met in Bellagio, Italy in February 2007 to present our health intervention projects, how to impact policy with our work, and discuss the definition of indigenous peoples. It was interesting to see how our projects and approaches had so much commonality with one another even with our diversities, and that the cultural teachings are continually invaluable.

IDN PRESENTATION AT NATIONAL INUIT ELDERS AND YOUTH SUMMIT, BAKER LAKE

IDN Chair, Sophie Pamak delivered a presentation at the National Inuit Elders and Youth Summit in March 2007. The presentation highlighted the IDN, their promising activities, challenges to address, and the work scope ahead. With elders being our guides and knowledge keepers, and youth being future leaders, this is an opportune time to engage their perspectives into the IDN diabetes agenda.

HEALTH CANADA, FNIHB

IDN members are assisting Health Canada, FNIHB in the development of ADI resources: Inuit Guide, Action Plan, Capacity Building and Diabetes Prevention Resources.

2ND INTERNATIONAL DIABETES IN INDIGENOUS PEOPLES FORUM, VANCOUVER, BC, Nov. 2008

ITK and IDN members are preparing to participate at the 2nd International Diabetes in Indigenous Peoples' Forum in Vancouver, BC, Nov. 17-19, 2008. An Inuit Elder, Alicee Joamie will join other aboriginal and indigenous elders in having a role at the forum. ITK President, Mary Simon has received an invitation to join the other national aboriginal leaders in delivering opening remarks in Vancouver. The call for Abstracts submission deadline was April 16, 2008. For additional information on the forum, visit: www.ipconf@interchange.ubc.ca.

For more information on any of these meetings, activities, or for a CD copy of the Storytelling Presentation of the Health Screening on Baffin Island research project, contact Ms. Looee Okalik by phoning ITK's toll free number, 1-866-262-8181 extension 222 or e-mail okalik@itk.ca





Back Row: Robert Ladouceur, Middle Row: Amelia MacGregor, Heidi Langille, Francene Ross, Sharon Mulcahy, Shirley Flowers, Jean Crane, Bottom Row: Cynthia Tischer, Christine Lund, Looee Okalik, Renee Bowers

INUIT REGIONS UPDATES

The Inuit regions are as designated by the Land Claimant Organizations: Inuvialuit Regional Corporation (IRC); Nunavut Tunngavik Incorporated (NTI); Nunavik Regional Board of Health and Social Services (NRBHSS); Nunatsiavut Government (NG) and, the National Inuit Youth Council. IDN has observer seats for Pauktuutit, Inuit Women of Canada and, Tungasuvvingat Inuit.

ITK represents the four Inuit regions with a population of approximately 55,000 in 53 communities with a separate agreement to oversee the Inuit in Ottawa. Other urban centers have the opportunity to submit proposals to serve Inuit in other cities.



IRC Update

By Francine Ross

Education

Aklavik - Grades K-12

Table at local stores

Community driven events such as community dance & community feast

Youth and Elder Traditional Cooking

In school cooking classes

Gathering of diabetics

Partners

Beaufort Delta Regional Health Authority, Inuvik, NT

Gwich'in Tribal Council

Municipal Government

Various Government departments depending on program

Territorial and Federal Government

Best Practices

Youth and Elder Traditional Cooking Program

Education in all grades

Prevention

Holistic approach

Community Driven Initiatives

Gaps and challenges

8 month delays in receiving funding for a 1 year project

Northern food integration not holistic in approach

NTI Update

By Looee Arreak

In the year 2001-2002, it was estimated that 1.72% of the Nunavut population had Type 2 Diabetes. The prevalence in Canada is estimated at 4.8%.

The annual incidence rate of diabetes in Nunavut (number of newly diagnosed cases) has remained stable over the period 1997-2002, and on average, 41 new diabetes cases were diagnosed each year in Nunavut. Diabetes is a chronic disease; therefore, the prevalence of diabetes (total number of people with diabetes) has increased steadily.

Overall the prevalence of diabetes in Nunavut was significantly higher in non-Inuit (4.5%) than in Inuit (0.9%).



Overweight, obesity, physical activity and poor nutrition are considered risk factors for the development of diabetes. Although the prevalence of Diabetes in Nunavut is lower than that of Canada, there are concerns with these risk factors in Nunavut. In 2000, 30.7% of residents of Nunavut were overweight and 23% were obese. Nearly 50% of Nunavut residents were physically inactive.

Although Inuit in Nunavut don't have high rate of diabetes, it is critical that we work on intervention and prevention programs and that the funding is critical, we should not wait until it's too late.

Nunavik Update

By Robert Ladouceur

The Following resources are available from NBBHSS in Kuujjuaq, Nunavik:

- Training for diabetes patient (english - french - inuktitut)
- Pamphlet for the client (english - french - inuktitut)
- Nunavik Food guide (english - french - inuktitut)
- Meal planning for diabetic patient (english - french - inuktitut)
- Inuk to Inuk knowledge (Puvirnituaq - Inukjuak)
- Inuk to Inuk knowledge (DVD)
- Training center in Puvirnituaq
- Training for Community Health Worker in Kuujjuaq
- Gestational Diabetes protocol
- Nunavik prevention and control guide

Nunatsiavut

Dept of Health & Social Development

By Sharon Mulcahy/Sophie Pamak in collaboration with the Nunatsiavut Home & Community Care Nurses

Introduction

Within the Nunatsiavut Department of Health & Social Development (DHSD) all ADI monies are integrated into the Home & Community Care Program (HCCP) because the Home Care Nurses (HCN) are responsible for the case management of all Nunatsiavut clients with diabetes. The total caseload is approximately 76 clients: Nain-22; Hopedale-8; Makkovik-7; Postville-11 and Rigolet-28.

Education

Prevention

Schools/Youth: the HCN's provide educational sessions using age appropriate and culturally adapted tools such as a "Jeopardy" game and "Who Wants to be a Millionaire". The Kahnawake school curriculum is also being utilized in the elementary and junior high in some of the communities. Presentations are also done in the evenings for youth groups. Usually, when presenting the above sessions, the HCN will supply health snacks.



General Community:

- Health Fairs- the HCN's offer screening and educational information
- Radio Spots- (oral tradition) general health information and information specific to diabetes.
- Monthly newsletter covering various health related topics.

Consultation: the HCN's provide current information to the Community Health Worker (CHW) to ensure they are providing accurate information to the clients. They also provide information, informally, to any staff that might "drop by" with concerns or a request to have a blood glucose test or a blood pressure measurement done.

Screening

The HCN's also manage pre-diabetes screening with a mandate to assess and educate clients with impaired fasting glucose (IFG). This education focuses mainly on lifestyle changes e.g. diet and exercise and is proving to be quite successful.

Care

Clients with Diabetes are seen by all the HCN's on a regular basis from every second week to a minimum of every 3 months as per the Canadian Diabetes Association 2003 Clinical Practice Guidelines. These clients receive monitoring of all the clinical parameters e.g. weights, blood pressure, BMI's and blood work for A1C , blood glucose levels and lipids. Education is ongoing and is focused on promoting self-management.

Support Groups are just starting to be established in some communities and one aspect of this will be preparing and serving a healthy meal.

Capacity Building

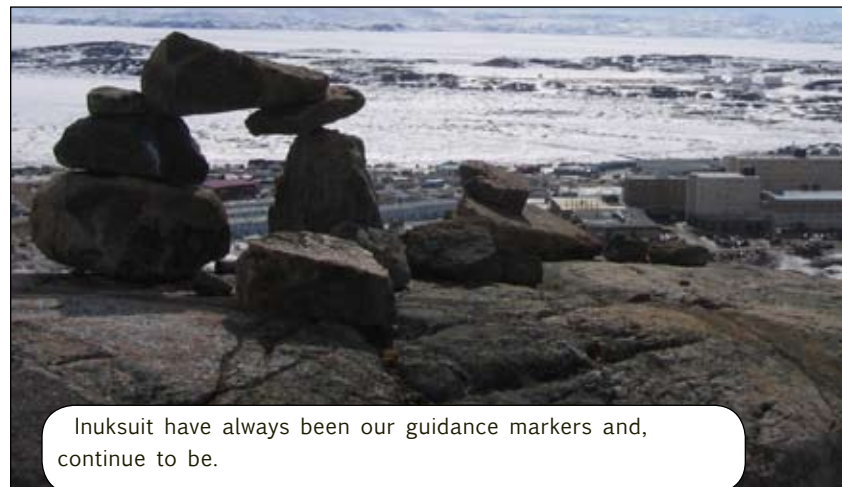
Standardized Resources: in an effort to ensure all the communities are building on the work of the Regional Diabetes Nurse Educator (RDNE) and to ensure continuity of care, a significant investment was made in standardized equipment and supplies for each community. This was done in consultation with the RDNE and the HCN's. The decision to buy mainly "hands on" items, rather than just printed materials, was also based on the Inuit oral tradition of sharing knowledge and information i.e. oral and "hands on" are more effective.

Standardized Education: significant investments have also been made in continuing education for the HCN's. A number of Teleconferences and face-to-face workshops have been offered including sessions with the RDNE and the provincial dietitian to provide more consistent follow up when the clients return to their respective communities.

(There is a great need for continued funding for ongoing education to ensure existing staff remain current with advances in treatment/management/best practices and also to ensure any new staff receives appropriate baseline training.)

Foot care- all HCN's are trained in advanced foot care.

The organization as a whole is learning to make small changes for events where food is served such as serving healthier choices, using traditional foods and adapting recipes.



Partnerships

Prevention/screening

Partnerships have been developed with a number of local organizations e.g. with the post office to put pamphlets, with a contact number, in all the mailboxes, with various retail businesses to set up booths and poster displays, and with the schools to provide educational sessions or to offer walking programs etc.

Capacity Building

Committee Membership:

1. Inuit Tapiriit Kanatami (ITK) Inuit Diabetes Network (IDN) – the HCN from Hopedale, who also happens to be bilingual in Inuttitut, sits on this committee. She attended the AGM in Inuvik NWT from Feb 22-23, 2006. This HCN has also been working with Lynda Brown, Manager, Community & Healthy Living, Pauktuutit Inuit Women of Canada on the Lawson Diabetes Project: “Inuk Living with Diabetes-Inuk to Inuk Knowledge Transfer”. This HCN also collaborated with the Tungasuvvingat Inuit Diabetes coordinator Christine Lund to provide Inuttitut translations for a set of 7 posters on diabetes.
2. Aboriginal Ad Hoc committee a sub-group for a Provincial Diabetes strategy committee-the HCN from Makkovik sits on this committee.

Collaborative Practice: in addition to the very effective day-to-day collaborative practice with the provincial nurses who work in the acute care settings, the HCN’s have also been involved in a Primary Health Care Initiative of the provincial Government. This involved using and piloting a provincial Diabetes Collaborative flow sheet that is being developed “to enhance the quality and continuity of care for clients living with diabetes”.

Best Practices

Screening/Care

1. The Nunatsiavut HCN (in a pilot community) is assuming full responsibility for all Blood Work (BW) with all clients (Inuit and non-Inuit) with Diabetes Mellitus.

The Canadian Diabetes Association 2003 Clinical Practice Guidelines states (pg S18) complications of diabetes mellitus can be reduced with tight glycemic control and recommends (pg S22) glycosylated hemoglobin [A1C] should be measured approximately every 3 months to ensure that glycemic goals are being met or maintained.

Previously the provincial clinical staff were responsible for all the BW but due to time constraint were not always able to ensure clients were regularly done every 3 months

Since the HCN took on the responsibility as part of her overall case management the clients are being seen regularly, a minimum of every 3 months and are being managed more effectively by both the HCN and the physician. For example when BW is being drawn other related activities such a teaching or foot care may be done during the same visit. An added bonus is that any other BW, unrelated to the diabetes, is drawn at the same time so the client only has to have one puncture.

2. Diabetes Home Care Project, established in 1999/2000, in Rigolet, which was funded by ADI monies.

This project that embraced a primary health care model and utilized all 3 levels of prevention has had a far reaching impact with anecdotal evidence for positive changes in many client indicators- reduced cholesterol levels, lowered blood pressure, lowered stabilized HBA1C levels, increased smoking cessation and an overall awareness within the community of Diabetes and the lifestyle changes necessary to prevent occurrence



and morbidity. The HCN's in Rigolet are presently undertaking a retrospective analysis to establish empirical evidence for these improved health outcomes, with a view to presenting at the upcoming 2nd International Diabetes in Indigenous Peoples' Forum in Vancouver, BC, Nov. 2008.

Gaps

Screening

Screening is being done but is presently hit or miss. A limited amount of screening is being done by the HCN's at the health fairs. Any clients who are picked up during routine blood work, at the provincial clinics, are seen on a regular basis by the HCN's but the status of many/most of the Nunatsiavut population is still unknown. This is an area that needs further development e.g. need to have policy for protocols to ensure capacity to respond to screening results and to develop health indicators and baseline data to establish benchmarks so we will know if we are making a difference.

Challenges

- Lack of compliance due to clients having many social issues to deal with and therefore health is not always a priority.
- Lack of a regular physician that leads to inconsistency of care. Or lack of any physician at all which impacts the HCN ability to even provide care e.g. unable to get the necessary prescriptions written when changes are noted in blood work.
- Lack of easy access to specialists.
- Difficult to get the optometrist to perform dilating eye exams as per the CDA 2003 clinical guidelines. (HCN are encouraging clients to request this type of examination.)
- Ensuring all clients have blood work drawn every 3 months – the provincial clinics have been responsible for this and are not always able to do it due to time constraints etc.

This is being addressed in one community with the HCN doing all the blood work for all the clients with diabetes (Inuit and non-Inuit) and it is so successful that it is now being introduced in 3 of the other 4 communities. It would not work in the 4th community due to geography – the majority of the clients live in closer proximity to the clinic than the Nunatsiavut DHSD. (See Best Practices)

For additional information on the ADI Inuit updates, contact Ms. Looee Okalik, ITK Health Projects Coordinator, okalik@itk.ca or at 613.238.8181 ext. 222.

Métis, Off Reserve Aboriginal, Urban Inuit Prevention and Promotion (MOAUIPP)

Tungasuvvingat Inuit (TI)

The Urban Inuit Diabetes awareness and prevention program is national in scope. Many activities are developed and implemented locally by TI, and then introduced to representatives in urban cities across Canada in the hopes that the activities will be duplicated. Some of the activities that have been completed are:

Diabetes Brochures and Posters

There have been 2 posters produced with diabetes messaging, and 7 posters adapted from the Canadian Diabetes Association. All posters have been produced in Inuktitut (from varying regions) and English with national distribution.



Public Service Announcements

Along with the poster development there were three 60 second diabetes television public service announcements created. These PSA's promoting awareness of diabetes to Inuit in Inuktitut as well as English are still broadcast today across the north.

Inuit Diabetes Web-site

To facilitate the gathering of information on diabetes specific to Inuit an Inuit Diabetes web-site was created. The site incorporates culturally appropriate information about diabetes and diabetes prevention specific for Inuit from across Canada.

Community Gatherings

Locally a monthly Community Feast is held to promote community wellbeing. The feast features a healthy meal with contemporary foods as well as traditional foods, encourages an active and healthy lifestyle, and features a presentation/display about diabetes and Inuit.

There is diabetes programming and presentations continually being worked into the framework within TI, as well as with external organizations. The programming focuses on diabetes awareness and prevention.

Some activities that are completed to promote Inuit health are;

- The completion of the TI community Newsletter. This newsletter is a means to reach community members locally and nationally. The newsletter is intended to keep community members abreast of programs and services available at Tungasuvvingat Inuit, as well as the upcoming schedule of events. The newsletter also provides the diabetes program opportunity to insert tips and articles about prevention and awareness for community members who may not be able to attend scheduled events and programs.
- The development and upkeep of an additional website is also an activity completed to deliver up to date information to Inuit anywhere. The site features current activities, programs offered by our local organization, as well as general information about urban Inuit.

The Urban Inuit Diabetes Awareness & Prevention Program has been very successful in reaching the community locally as well as nationally.

A funding application was approved in November 2006 for TI to begin a new three year project for Urban Inuit Diabetes Awareness & Prevention Program. In the new project, we will continue to work with the local community in programming activities. The activities will be documented and a resource will be developed to assist in the outreach to other urban centres across Canada in the application and development of an Urban Inuit Diabetes Awareness & Prevention Program for their local population.

