Diabetes in Canada

An Environmental Scan of Diabetes Strategies and Initiatives at the Federal, Provincial and Territorial Level

2011
# Table of Contents

Summary of Abbreviations.................................................................................................................................................4

Summary of Strategies and Initiatives by Jurisdiction

**Federal**
- Overview........................................................................................................................................................................5
- Strategies..........................................................................................................................................................................5
- Initiatives/Programs.......................................................................................................................................................6
- Aboriginal Strategies/Initiatives.................................................................................................................................7

**British Columbia**
- Overview.........................................................................................................................................................................8
- Strategies..........................................................................................................................................................................8
- Initiatives/Programs.......................................................................................................................................................9
- Aboriginal Strategies/Initiatives.................................................................................................................................10

**Alberta**
- Overview.........................................................................................................................................................................11
- Strategies..........................................................................................................................................................................11
- Initiatives/Programs.......................................................................................................................................................12
- Aboriginal Strategies/Initiatives.................................................................................................................................13

**Saskatchewan**
- Overview.........................................................................................................................................................................14
- Strategies..........................................................................................................................................................................14
- Initiatives/Programs.......................................................................................................................................................15
- Aboriginal Strategies/Initiatives.................................................................................................................................16

**Manitoba**
- Overview.........................................................................................................................................................................17
- Strategies..........................................................................................................................................................................18
- Initiatives/Programs.......................................................................................................................................................18
- Aboriginal Strategies/Initiatives.................................................................................................................................19

**Ontario**
- Overview.........................................................................................................................................................................21
- Strategies..........................................................................................................................................................................21
- Initiatives/Programs.......................................................................................................................................................22
- Aboriginal Strategies/Initiatives.................................................................................................................................23

**Quebec**
- Overview.........................................................................................................................................................................24
- Strategies..........................................................................................................................................................................25
- Initiatives/Programs.......................................................................................................................................................25
- Aboriginal Strategies/Initiatives.................................................................................................................................25

**Newfoundland and Labrador**
- Overview.........................................................................................................................................................................25
- Strategies..........................................................................................................................................................................26
- Initiatives/Programs.......................................................................................................................................................26
- Aboriginal Strategies/Initiatives.................................................................................................................................26
New Brunswick
Overview...........................................................................................................................26
Strategies..........................................................................................................................27
Initiatives/Programs..........................................................................................................27
Aboriginal Strategies/Initiatives.......................................................................................27

Nova Scotia
Overview...........................................................................................................................28
Strategies..........................................................................................................................28
Initiatives/Programs..........................................................................................................29
Aboriginal Strategies/Initiatives.......................................................................................30

Prince Edward Island
Overview...........................................................................................................................30
Strategies..........................................................................................................................31
Initiatives/Programs..........................................................................................................31
Aboriginal Strategies/Initiatives.......................................................................................31

Yukon
Overview...........................................................................................................................32
Strategies..........................................................................................................................32
Initiatives/Programs..........................................................................................................33
Aboriginal Strategies/Initiatives.......................................................................................33

Northwest Territories
Overview...........................................................................................................................33
Strategies..........................................................................................................................33
Initiatives/Programs..........................................................................................................34
Aboriginal Strategies/Initiatives.......................................................................................34

Nunavut
Strategies..........................................................................................................................34
Initiatives/Programs..........................................................................................................35
Aboriginal Strategies/Initiatives.......................................................................................35

References........................................................................................................................36

Appendix A: Prevalence of Diabetes and Pre-diabetes in Canada by Province and Territory in 2010

Appendix B: Estimated total costs for diabetes and out-of-pocket expenses for type 2 diabetes in 2010
Summary of Abbreviations

ADAPT - Aboriginal Diabetes Awareness, Prevention and Teaching
ADI - Aboriginal Diabetes Initiative
ADP - Assistive Devices Program
ADSS - Alberta Diabetes Surveillance System
AHRN-YT - Arctic Health Research Network
AMFH - The Alberta Monitoring for Health Program
ASRA – Aboriginal Sport and Recreation Association of British Columbia
BCHC – British Columbia Healthy Communities
BCHLA – British Columbia Healthy Living Alliance
BDDI - Baseline Diabetes Dataset Initiative
CAAWS - Canadian Association for the Advancement of Women and Sport and Physical Activity
CDA - Canadian Diabetes Association
CDEPP – Community Diabetes Education Prevention Program
CDM – Chronic Disease Management
CDMP - Chronic Disease Management Program
CDPI - Chronic Disease Prevention Initiative
CDS - Canadian Diabetes Strategy
CIHR – Canadian Institute of Health Research
COPD – Chronic Obstructive Pulmonary Disease
CPOP - Community Pharmacy Outreach Program
DASH - Directorate of Agencies for School Health
DCPNS – Diabetes Care Program of Nova Scotia
DISC - Diabetes Information and Support Centre
CPrA – Canadian Parks and Recreation Association
DPPS - Diabetes Prevention Program in Schizophrenia
GBT - Get Better Together! Manitoba
HESY – Healthy Eating is in Store for You™
HCM - Healthy Child Manitoba
HYHC – Honour Your Health Challenge
MDSi - Mobile Diabetes Screening Initiative
MICH - Manitoba Institute of Child Health
MRS – Medication Review Service
NADA - National Aboriginal Diabetes Association
NDSS - National Diabetes Surveillance System
NHFI - Northern Healthy Foods Initiative
NSDAP – Nova Scotia Diabetes Assistance Program
NSFPP – Nova Scotia Family Pharmacare Program
RHA – Regional Health Authorities
SOADI - Southern Ontario Aboriginal Diabetes Initiative
WHIC - Western Health Information Collaborative
Summary of Federal Government Strategies and Initiatives

Federal Overview

2006 – 2007:\(^1\)

**Occurrence:** 2 million Canadians aged 1 and older (6.2%) living with diagnosed diabetes.

**Gender:** 5.9% of girls/women and 6.6% of boys/men

**Prevalence:** Higher in the Maritimes (NL, NS, NB) and Manitoba; lower in the west (AB, BC, SK). Ontario has a higher rate than the national average, while Quebec’s prevalence rate is lower than the national average.

**2012 Projections:** 2.8 million people living with diagnosed diabetes.

**Costs:** $13.2 billion annually\(^2\).

Federal Strategies

**Canadian Diabetes Strategy (CDS):**

**Overview:** Began in 1999 with a $115 million pledge over five years to develop a Canadian Diabetes Strategy, including provincial, territorial and Aboriginal participation\(^3\). Was enhanced in 2005 and incorporated as part of the Healthy Living and Chronic Disease Initiative; provided an additional $90 million over 5 years to enhance strategy\(^4\). The aboriginal diabetes strategy was also enhanced, increasing to $25 million to 2005 and $55 million in 2010\(^4\).

**Four Inter-Related Components:** Aboriginal Diabetes Initiative (ADI), Prevention and Promotion National Diabetes Surveillance System (NDSS), National Coordination\(^5\).

**Expanded Strategy (2005)**\(^6\):

**NDSS (National Diabetes Surveillance System):** Reports provincial, territorial and national surveillance information on diabetes. Supported by
the Public Health Agency of Canada, the NDSS summarizes data about patients with diabetes using the health care system. The minimum requirement is 1 hospitalization or 2 physician claims with a diabetes-specific code over a two-year period\(^1\).

**Knowledge Development and Exchange for Diabetes Prevention and Management:** Translates science-based research into effective policies and programs, including clinical practice guidelines\(^6\).

**Diabetes Community-Based Promotion and Programming:** To promote a positive shift in health status in high-risk populations\(^6\).

**Diabetes Coordination:** Within the federal government and with diabetes partners including provinces, territories and stakeholders to maximize effectiveness\(^6\).

**Diabetes Public Information:** Furthering awareness in at-risk populations; increasing integration of the messages of non-governmental organizations, public health units and other health-delivery partners\(^6\).

### Federal Initiatives/Programs

**Canadian Diabetes Association (CDA):** The National Association leading the fight against diabetes. Active in more than 150 Canadian communities and supports people living with diabetes through research, advocacy, education and services\(^7\).

**CDS Community-Based Program:** Provides time-limited project funding to non-profit based groups\(^8\). Regional priorities are determined through provincial/territorial consultations with key stakeholders.\(^1\)

**Community Pharmacy Outreach Program (CPOP):** Pharmacies partnered with the Canadian Diabetes Association throughout the country and are committed to providing knowledgeable staff, latest information, and diabetes supplies\(^9\).

**The Coordinating Committee for the National Diabetes Strategy**\(^5\): Formed in 2001, its mandate is to develop a national diabetes strategy and oversee its implementation\(^10\).

**Healthy Eating is in Store for You (HESY) ™:** Supported by CDS and the Dieticians of Canada to provide information on choosing a healthy diet through better use of the nutrition information on the label of packaged foods\(^11\).

**The Integrated Pan-Canadian Healthy Living Strategy**\(^12\): A conceptual framework for sustained action based on a population health approach. The goals of the Strategy are to improve overall health outcomes and reduce health disparities.

Federal Aboriginal Strategies/Initiatives

Aboriginal Diabetes Initiative (ADI):

Phase 1 (1999 – 2004): $58 million of the total $115 million in the CDS budget given to the ADI, intended to increase diabetes awareness.

Four Key Components:
1. Primary Prevention and Health Promotion – Relevant activities offered in over 600 First Nations and Inuit communities
2. Screening and Treatment – There are currently mobile diabetes screening initiatives in place in four regions (BC, AB, MB, QC)
4. Research, Surveillance, Evaluation, Monitoring

Several priorities:
- Establish partnerships with research agencies and organizations to jointly fund priority research;
- Support the Canadian First Nations Diabetes Clinical Management Epidemiologic (CIRCLE) Study to determine the quality of diabetes healthcare in 19 First Nation communities
- Support evaluation studies and monitor the programming at local, regional and national levels.

Phase 3 (2010 – 2012): Build on past successes
Renewed ADI focuses on:
- Initiatives for children, youth, parents and families;
- Diabetes in pre-pregnancy and pregnancy;
- Community-led food security plans to improve access to healthy foods, including traditional foods; and,
- Enhanced training for home and community care nurses on clinical practice guidelines and chronic disease management strategies.

Other Initiatives:
Aboriginal Sport Circle: Canada’s national voice for Aboriginal sport. Created in 1995 in response to the need for more accessible and equitable sport and recreation opportunities for Aboriginal peoples.
Everybody Gets to Play™: Led by the Canadian Parks and Recreation Association (CPRA) to make recreation more accessible for low-income children and their families.

National Aboriginal Diabetes Association (NADA): A not-for-profit, members-led organization established in 1995 as a result of the rising rates of diabetes in Aboriginal communities. NADA raises awareness, advocates programs and services, and promotes healthy lifestyles for all Aboriginal peoples.

Summary of Government Strategies and Initiatives in British Columbia

<table>
<thead>
<tr>
<th>British Columbia Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010</strong></td>
</tr>
<tr>
<td>338,000 people with diabetes</td>
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<tr>
<td>7.4% prevalence</td>
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<td>Cost: $1.3 billion</td>
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<th>British Columbia Strategies</th>
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<tr>
<td><strong>Strategy (2002)</strong></td>
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<tr>
<td>Collaboration and Partnership: With other health authorities, government and non-government agencies to enhance individual and organizational capacity for sustained chronic disease prevention and management.</td>
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<tr>
<td>Focus on Aboriginal Health: Putting in place processes to ensure that priority Aboriginal issues like diabetes are addressed.</td>
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<tr>
<td>Prevention and Wellness: Prevent type 2 diabetes occurrences through various initiatives including promotion of physical activity, nutrition, tobacco prevention and other public health programs.</td>
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<tr>
<td>Chronic Disease Management: Diagnosing diabetes early; preventing, delaying, managing, minimizing the impacts of the complications of diabetes.</td>
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Tracking Progress on Diabetes: By working with other health authorities and partners to assess and report on the performance of the health services system in responding to the care needs of people with diabetes.18

Also addressed in the Prevention and Wellness Strategy and the Chronic Disease Management Strategy.18

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**British Columbia Initiatives/Programs**

2010 Legacies Now™: Aimed to strengthen sport and recreation, healthy living, literacy, accessibility and volunteerism as a result of hosting the 2010 Olympic games.19

Act Now: A healthy living initiative focused on healthy eating, physical activity, healthy body weight and living tobacco-free to reduce chronic diseases.17

Action Schools! BC: Helps BC children become more physically active with the ultimate aim of primary prevention.20

BC Healthy Communities (BCHC): Addresses multiple determinants of health, builds capacities to create healthy communities and focuses on community involvement, political commitment, inter-sectoral partnerships and healthy public policy as building blocks for healthy communities.21

BC Healthy Living Alliance (BCHLA): Formed in 2003, the BCLA is a group of organizations which come together with a mission to improve the health of those living in BC through leadership and collaboration.22 Programs include Healthy Food and Beverages at School, Work and Play, Farm to School Salad Bar, Food Skills for Families, and Sip Smart!20

Brand Name Foods List: Rates packaged and franchised foods and beverages to promote a healthy food environment.23

Canadian Association for the Advancement of Women and Sport and Physical Activity (CAAWS): Provides leadership and education and builds capacity to foster support, opportunities and positive experiences for girls and women in sport and physical activity.24

Diabetes Information and Support Centre (DISC): Trained volunteers provide up-to-date information, resources, referrals and support. Also available in Chinese dialects.25

Fresh Choice Kitchens: Works to create opportunities for people to cook together and focuses on food and health.26

Healthy Heart Society of BC: A catalyst for change in health care in British Columbia. It provides knowledge and support for improved prevention and management of chronic conditions.27
Hearts in Motion Walking Club™: Encourages people to participate in regular physical activity by walking.

Making it Happen – Healthy Eating at School: Promotes healthy eating in schools through various tools and initiatives.

School Meal Programs – Directorate of Agencies for School Health (DASH): Helps inspire school communities to adopt a comprehensive school health approach. This approach offers a practical framework for teachers, students, families, schools and communities to work together to create plans that will enhance student health and learning.

Tobacco Strategy: BC has a well-established, comprehensive tobacco-control program.

Youth on It: Addresses the issues young people with diabetes face through a guide targeted to 16 to 24-year olds.

British Columbia Aboriginal Strategies/Initiatives

Aboriginal Diabetes Awareness, Prevention and Teaching (ADAPT): Provides culturally, and community, appropriate diabetes prevention programs, including fitness, nutrition, awareness, herb and medicine workshops, support groups and community kitchens and gardening.

Aboriginal Head Start on Reserves: Designed to prepare young First Nations children for their school years by meeting emotional, social, health, nutritional and psychological needs.

Aboriginal Sports and Recreation Association of BC (ASRA): Provides leadership, guidance and support to Aboriginals in BC through sport, physical activities and recreation.

Active Communities™: Mobilizes and collaborates communities, local governments, First Nations and partner organizations to promote lifestyles choices, increase accessibility to physical activity and build supportive community environments.

Dial-a-Dietician: Provides free nutrition information via telephone.

Food Skills for Families Aboriginal-Canadian Diabetes Association BC Region: Six session cooking program that teaches healthy eating, shopping and cooking skills to at-risk populations.

HIGH FIVE®: Consists of training, resource and tools to support the safety, well-being and development of children in sport and recreation settings.
Honour Your Health Challenge (HYHC): Province-wide, community-based health initiative program which mobilizes and individuals and communities to live active, healthy and strong lifestyles.

Provincial Aboriginal Health Services Strategy: Developed in 2001 to improve the health of Aboriginal people and decrease health disparities with other British Columbians.

Rural and Remote Health Initiative: Through the Canadian Institutes of Health Research (CIHR), the government of Canada invested approximately $10.4 million in 2004/2005 in research on rural and remote health across Canada.

Summary of Government Strategies and Initiatives in Alberta

<table>
<thead>
<tr>
<th>Alberta Overview</th>
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<tbody>
<tr>
<td>2010:</td>
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<tr>
<td>217,000 people with diabetes</td>
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<tr>
<td>5.8% prevalence</td>
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<tr>
<td>Cost: $1.1 billion</td>
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<th>Alberta Strategies</th>
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<tr>
<td>Primary Prevention of Type 2 Diabetes:</td>
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<tr>
<td>1. Increase programs and services aimed at strengthening healthy living practices.</td>
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<tr>
<td>2. Enhance public awareness and education about healthy living.</td>
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<tr>
<td>3. Address the impact of low income and education on diabetes prevention.</td>
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4. Strengthen professional knowledge, skills and practices in diabetes primary prevention\textsuperscript{39}.

5. Address diabetes primary prevention needs of the aboriginal population\textsuperscript{39}.

**Secondary and Tertiary Prevention of Diabetes**\textsuperscript{39}:

6. Strengthen professional knowledge, skills and practices in the education and management of diabetes\textsuperscript{39}.

7. Implement appropriate screening, education, management and support services for those with diabetes\textsuperscript{39}.

8. Address management of diabetes in the Aboriginal population\textsuperscript{39}.

**Evaluation, Research and Surveillance**\textsuperscript{39}:

9. Facilitate and support diabetes evaluation, research and surveillance initiatives\textsuperscript{39}.

### Alberta Initiatives/Programs

**Alberta Diabetes Surveillance System:** A five-year project, led by the Institute of Health Economics, to help facilitate dissemination of diabetes surveillance information (incidence, prevalence and service utilization) to regional health authorities and other stakeholders\textsuperscript{40}. Two out of three diabetes atlases were published in 2007 and 2009\textsuperscript{41}.

**Alberta Health and Wellness:** Disseminated province-wide type 2 diabetes prevention messages in 2004-2006\textsuperscript{40}.

**The Alberta Monitoring for Health Program (AMFH):** Administered by the CDA, provides support to assist in the purchase of some diabetes supplies for low income Albertans without insurance\textsuperscript{42}.

**Healthy Alberta Communities Project:** Helps change diet and physical activity at an individual and community level. The project is part of the demonstration project for the World Health Organization’s Countrywide Integrated Non-Communicable Disease Intervention (CINDI), which involves internationally recognized researchers on obesity, healthy living, and chronic disease prevention\textsuperscript{40}.

**The WHIC Chronic Disease Project:** Alberta participated with Saskatchewan, Manitoba, and British Columbia on the Western Health Information Collaborative (WHIC) Chronic Disease Management Project. This project aimed to link information systems across health care providers\textsuperscript{43}.
Alberta Aboriginal Strategies/Initiatives

Specific Strategies:\nAlberta Health and Wellness, Health Canada, Regional Health Authorities, Provincial Pharmacy Associations, Canadian Diabetes Association, Alberta Learning and Education Sector, Lifestyle: Collaborate with First Nations and Métis, Health Canada, other provincial ministries, regional health authorities and other community and provincial organizations in the development, implementation, and evaluation of diabetes prevention programs and services for Aboriginal peoples.\\n
Promote and support holistic, community-based prevention strategies, incorporating traditional and current approaches, to prevent diabetes and reduce barriers to healthy living. Support Aboriginal media organizations to develop mass media products that focus on healthy eating and active living using appropriate language with translation when required. Encourage Aboriginal peoples to pursue careers in the health professions.

Initiatives:
**Aboriginal Diabetes Prevention and Management Program**: Focuses on awareness, prevention, early detection, education, self-care management and complication prevention.

**Aboriginal Diabetes Wellness Program**: Uses traditional aspects to promote health and wellness; provides diabetes education and support to the community and health care professionals. Includes nutritional, school diabetes programs, awareness promotion and glucose monitoring.

**Aboriginal Head Start on Reserves**: Designed to prepare young First Nations children for their school years by meeting emotional, social, health, nutritional and psychological needs.

**Aboriginal Urban Diabetes Initiative (AUDI)**: Teaches type 2 diabetes prevention strategies and traditional culture through summer camp experiences for children and youth.

**Alberta Diabetes Prevention and Management Program**: Focuses on awareness, prevention, early detection, education, self-care management and complication prevention. Different subgroups exist across varying communities.

**The Alberta First Nations Project to Screen for Limbs, Eyes, Cardiovascular and Kidney Complications of Diabetes Using Mobile Clinics (2001-2003)**: Deployed mobile unites containing all the necessary equipment for screening test complications to all 44 AB First Nations communities.

**BRAID Diabetes Research Group (BDRG)**: Operates out of the University of Alberta a number of diabetes research projects, including the
Mobile Diabetes Screening Initiative⁴⁶.

Mobile Diabetes Screening Initiative (MDSi): A traveling health care service that provides testing and education for diabetes and cardiovascular risk in Alberta’s off-reserve and remote communities⁴⁷.

Primary Health Care Diabetes Project: Provide chronic condition management and education programs in several communities⁴⁴.

Summary of Government Strategies and Initiatives in Saskatchewan

Saskatchewan Overview

2010⁵⁰:

- 75,000 people with diabetes
- 7.0% prevalence
- Cost: $419 million

Saskatchewan Strategies

Strategy (2002 – 2012)⁴⁸:

Primary Prevention of Type 2 Diabetes⁴⁸:
1. Create an environment that empowers people to increase control over their health⁴⁸.
2. Strengthen the skills and capacities of individuals, groups, organizations, communities to take action on their health⁴⁸.
3. Promote and support healthy living activities⁴⁸.


Optimum Care and Prevention of Diabetes Complications⁴⁸:
1. To ensure every person with diabetes in Saskatchewan has:
- Timely access to quality diabetes care that is client-centered.
- Access to specialized services, as needed, in the diagnosis and management of diabetes and its related complications and associated conditions.
- The necessary supports to achieve self-management to the best of his/her ability with inclusion of the family and support network.
- Culturally appropriate care, including self-management education, and support.

2. To ensure early detection of diabetes and its predisposing conditions and initiation of appropriate on-going care.
3. To reduce the impact of the human and financial costs for persons with diabetes, their families and communities.

**Progress (2007):** Saskatchewan Health provided copies of the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada to each regional health authority.

Saskatchewan Health participated with Manitoba, Alberta and British Columbia on the Western Health Information Collaborative (WHIC) Chronic Disease Management Project. This project aimed to link information systems across health care providers.

**Education for Care Providers:**
1. To ensure practicing health care providers are knowledgeable regarding diabetes care and prevention.
2. To improve access to diabetes education and continuing education activities.
3. To improve access to quality diabetes care that is client-centred and culturally appropriate.

**Progress:** See Education for Care Providers in initiatives.

**Diabetes Surveillance:**
1. Establish and conduct ongoing and comprehensive surveillance of diabetes and associated conditions in Saskatchewan.
2. To provide a mechanism to use data and support decision-making.
3. To establish an electronic mechanism to support the delivery of team-based services.

**Progress:** Utilization of the NDSS towards the development of the Saskatchewan Diabetes Profile 2002/2003 to 2006/2007.

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**Saskatchewan Initiatives/Programs**

**Chronic Disease Network and Access Program:** Collaborates with all organizations, care providers and agencies working with chronic disease prevention and management to improve quality of life for Northern residents, many of whom are First Nations.
Clinical Practice Guidelines for the Prevention and Management of Diabetes Foot Complications\textsuperscript{50}: Developed in 2008.

Diabetes Toolkit/Clinical Flow Sheet: As part of its Chronic Disease Management and Collaborative on diabetes to enhance the care and health of people living with coronary artery disease and diabetes (2005)\textsuperscript{50}.

Dress Down for Diabetes: Campaigns are held three times annually in November, February and June. Participation helps over 50,000 children, adults and seniors living with diabetes in Saskatchewan\textsuperscript{52}.

Education for Care Providers: Two diabetes education programs were developed in 2003 from funding provided to the Saskatchewan Institute of Applied Science and Technology (SIAST). The Basic’ and Advanced Diabetes Education for Health Care Providers’ are currently being offered by distance education\textsuperscript{43}.

Healthier Places to Live, Work and Play: A health promotion strategy developed by Saskatchewan Health provides a framework for population health at the local, regional and provincial levels\textsuperscript{43}.

Kids First Program: A targeted, community-based program to support vulnerable families in developing the capacity to nurture their children. The program focuses on children prenatal to age five and their families who are most vulnerable due to their social and economic circumstances\textsuperscript{48}.

A Physically Active Saskatchewan! A Strategy To Get Saskatchewan People In Motion\textsuperscript{49}: Supports the provincial/territorial target of reducing physical inactivity by 10\% by 2010\textsuperscript{45}.

School\textsuperscript{Plus}: Ensures that all Saskatchewan children and young people have the supports they need for well-being, learning and life\textsuperscript{48}.

Travelling Diabetes Resource Program (TDRP): Provides people with access to the same programs and services offered in urban areas by utilizing mobile assistance. In 2009/10 the program connected with more than 10,000 people in rural and remote areas of Saskatchewan\textsuperscript{53}.

**Saskatchewan Aboriginal Strategies/Initiatives**

Epidemiologic Studies: A University of Saskatchewan conducted a 20 year study and published their results in the February 2010 issue of the Canadian Medical Association Journal. The study widened the current understanding of the demographic differences between First Nations and non-First Nations people across Canada. The study points to high rates in obesity, and not the commonly quoted genetics, as a reason for high Aboriginal diabetes rates\textsuperscript{54}.
Strategies:
- Development of a coordinated diabetes awareness campaign.
- Workshops on healthy living.
- Developing a Diabetes Mentorship program in partnership with the province to teach care providers how to provide support to those living with diabetes.
- Assisting communities in developing prevention programs such as safe walking paths, 100-mile club, increased access to fitness equipment, community kitchens, and exercise clubs.
- Developing a set of Diabetes Program Guidelines.
- Developing a portable display Cost of Diabetes that can travel to each community.
- Developing earlier access to screening for diabetes, and complications screening.
- School education programs, workshops, logo contests, healthy snack programs, no junk food days, healthy eating policies.
- Intersectoral work to foster acceptance and adherence to the CDA Clinical Practice Guidelines for diabetes.

Initiatives:
Aboriginal Head Start on Reserves: Designed to prepare young First Nations children for their school years by meeting emotional, social, health, nutritional and psychological needs.

Diabetes Program (On-Reserve)

Summary of Government Strategies and Initiatives in Manitoba

Manitoba Overview

2010:

- 94,000 people with diabetes
- 7.6% prevalence
- Cost: $498 million
## Manitoba Strategies

**Strategy**<sup>57</sup> (1998):

**Prevention:** Developing community-based Diabetes Primary Prevention and Screening Programs, focusing specifically on seniors and Aboriginal people<sup>57</sup>.

**Education:** Establish Standardized Multi-level Diabetes Education Programs to expand the pool of qualified diabetes educators from community to specialist levels<sup>57</sup>.

**Care:** Developed Manitoba Diabetes Care Recommendations that are consistent with evidence-based Canadian Diabetes Association Clinical Practice Guidelines<sup>57</sup> (published in 2010)<sup>58</sup>.

**Research:** Develop a Manitoba Diabetes Surveillance System that provides data on an ongoing basis to monitor and evaluate interventions and initiatives related to diabetes<sup>57</sup>.

**Support:** Address the inequities of Access to Support Services across the province and provide a network of support services for those people with diabetes and its complications<sup>57</sup>.

## Manitoba Initiatives/Programs

### 1. Advance Policies, Programs and Systems<sup>59</sup>:

**Housing and Health:** Identifies and reviews existing house-related policies, programs and services and to propose enhancements or alternatives to improve the housing and health outcomes for seniors and individuals with mental health and homelessness issues<sup>59</sup>.

**Healthy Child Manitoba (HCM):** Aims to help all Manitoba children and youth be physically and emotionally healthy. HCM focuses on evidence-based programs and policies that support positive parenting, nutrition and physical health, literacy and learning, and community capacity-building<sup>59</sup>.

**Northern Healthy Foods Initiative (NHFI):** Increases nutritional options and support informed healthy food choices for Northern Manitobans. The NHFI assists communities in developing capacity to increase local food production, increase the availability of nutritional foods, implement strategies to lower the cost of healthy food increase awareness on healthy eating, etc<sup>59</sup>.

**Manitoba Institute of Child Health – University of Manitoba (MICH):** Improves the health of children and youth by creating an environment that fosters excellence in research and the development and application of treatments and cures<sup>59</sup>. 

© Canadian Pharmacists Association, 2011.
Maestro Project: Transition support for diabetes young adults transitioning from pediatric to adult care services.  

2. Promote Healthy Choices in Every Setting:  
Breastfeeding in Manitoba Provincial Strategy and Framework: Reinforces the importance of breastfeeding for optimal health and development.  

Chronic Disease Prevention Initiative (CDPI): A five-year demonstration project currently implemented in 10 regional health authorities (RHAs) in Manitoba involving 83 communities, including 21 First Nations and seven Métis which aims to reduce modifiable risk factors for diabetes and other chronic diseases.  

Healthy Buddies™: A comprehensive health education and promotion program that aims to empower students to live healthier lives using a peer-led and mentorship approach.  

Healthy Schools Initiative: Includes a website, targeted provincial campaigns and community resources that promote healthy living choice and behaviours.  

Manitoba in Motion: A province-wide strategy to help Manitobans make physical activity part of their daily lives for health and enjoyment. Manitoba has initiated Healthy Schools in motion, Communities in motion and Workplaces in motion.  

Manitoba School Nutrition Policy: Ensures healthier foods are available in school cafeterias and vending machines.  

Type 2 Diabetes Prevention Campaign: Manitoba Health and Healthy Living has developed a province-wide public education campaign for people at risk of developing type 2 diabetes. The campaign includes television advertising and a website.  

3. Identify, Screen and Address Risk Factors:  
Diabetes Integration Project: A mobile diabetes care and treatment services program developed by the Manitoba First Nations Diabetes Committee to improve health status. Objectives include raising awareness of diabetes and risk factors, building capacity and linkages, promoting self-management and coordinating services with other.  

Pre-diabetes Initiative: A 15-month project which began in 2008, the project developed and delivered community-based pre-diabetes screening and interventions to Manitobans aged 20 to 74.
Regional Diabetes Program: Initiated in 2004 to enhance the existing Diabetes Education Resource Program. Components include the provision of periodic assessments for at risk people and an annual complication assessment for patients with diabetes59.

Risk Assessment Tool: Located on the Manitoba Healthy Living website, this tool helps Manitobans assess and learn about their risk for type 2 diabetes59.

4. Detect Disease and Establish Therapeutic Strategies59:
Manitoba Diabetes Care Recommendations: Updated in 2009 to reflect the current national practice guidelines59.

Manitoba Retinal Screening Vision Program: Provides mobile retinal screening, vision assessment, diagnosis and treatment for people at risk for diabetic retinopathy in northern and remote communities59.

Manitoba Renal Program: Provides a holistic approach to caring for people with kidney disease, their families and communities using an interdisciplinary team of health care professionals59.

5. Enable a Comprehensive Approach for Services and Programs59:
Advanced Access to Health Care Services: 16 primary and specialty clinics throughout Manitoba are implementing Advanced Access so that patients, many of whom have a chronic disease, can see a physician or other care practitioner at a time and date that is convenient for them59.

Physician Integrated Network: Involves the collection and measurement of care in a primary setting for people living with diabetes and other chronic diseases59.

TeleCare Manitoba: A telephone-based program that helps Manitobans with heart failure or type 2 diabetes manage their condition. Health care providers called patients on an individualized call monitoring schedule60.

6. Cultivate Quality of Life59:
Get Better Together! Manitoba (GBT): A chronic disease self-management program licensed through Stanford University. This program assists participants with diabetes and chronic disease to increase activity levels, improve food choices, quality of life and health status through regular peed-led sessions59.

Manitoba Aboriginal Strategies/Initiatives

Aboriginal and Northern Affairs Recreation Funding: Funding is available for either a full-time recreation director or part-time recreation programming59.
Aboriginal Head Start on Reserves: Designed to prepare young First Nations children for their school years by meeting emotional, social, health, nutritional and psychological needs.  

Brighter Futures: Delivers community-based aid to First Nations children in their school years by meeting emotional, social, health, nutritional and psychological needs. Provides health promotion and ill-health prevention for First Nations and Inuit communities.  

First Nations Wait Time Guarantee: An 18-month project initiated in 2007 to reduce the impact of foot ulcers and amputations in Manitoba First Nation communities by establishing and implementing a wait-time guarantee for the prevention, treatment and care of diabetic foot ulcers.  

Provincial Dialysis Program: Includes health promotion and prevention of disease by education of public and health care professionals. Also involves the identification of high risk individuals for renal disease within Manitoba.

Summary of Government Strategies and Initiatives in Ontario

<table>
<thead>
<tr>
<th>Ontario Overview</th>
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<tbody>
<tr>
<td>2010:</td>
</tr>
<tr>
<td>1,160,000 people with diabetes</td>
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<tr>
<td>8.3% prevalence</td>
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<tr>
<td>Cost: $4.9 billion</td>
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<table>
<thead>
<tr>
<th>Ontario Strategies</th>
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<tbody>
<tr>
<td>Ontario Diabetes Strategy (2008 -2012):</td>
</tr>
<tr>
<td>Increasing Access to Team-Based Care: Investing $290 million to expand current programs, align care and fund new programs. By mapping the prevalence of diabetes across the province, service gaps can be addressed.</td>
</tr>
</tbody>
</table>
Diabetes Prevention: Education campaigns to raise awareness of risk factors of type 2 diabetes, including physical inactivity, poor nutrition and obesity. These campaigns will focus on high-risk groups.

Diabetes Registry: All Ontarians with diabetes will be entered into an electronic registry that will provide people with diabetes instant access to electronic information and educational tools to help manage their care. Physicians will be able to use the system to check patient records and access information.

Insulin Pump Therapy: In December 2006, children and youth aged 18 and under were provided funding for insulin therapy and the program was expanded in September 2008 to all adults with type 1 diabetes.

Chronic Kidney Disease Services: Ontario is investing $220 million to expand its Chronic Kidney Disease Program. This includes improved access, increase dialysis service, and increased availability of home renal replacement therapies.

Bariatric Centres of Excellence: Enhanced capacity for bariatric surgery in the province by providing bariatric education for health care providers and establishing pre and post bariatric surgery programs that will be linked to surgical problems.

Targets:
- Ensure all people with diabetes have access to a primary health care provider.
- Ensure that 80% of people with diabetes have all three diabetes tests (cholesterol, retinal eye exam and HbA1C test).
- Have 35% of dialysis patients receive their dialysis at home.
- Ensure that Insulin Pumps and Supplies Program for Adults meets its target of 1,342 new approved applicants for funding for insulin and supplies.
- Increase the number of annual bariatric surgeries to 2,085 a year by 2011/2012.
- Provide education to the public about diabetes and prevention.
- Support patients managing their disease.
- Increase the adoption of practice guidelines for proven care and treatment.
- Continually improve local health coordination.

Ontario Initiatives/Programs

Assistive Devices Program (ADP): Provides insulin pump therapy to children and adults with type 1 diabetes.

Baseline Diabetes Dataset Initiative (BDDI): Matches patients with diabetes to primary care providers and provides care providers with Patient Lists and Testing Reports containing the most recent dates for the three key tests for diabetes. It also indicates the percentage of patients
whose tests are within recommended guidelines\(^{66}\).

**Diabetes Complications Prevention Strategy:** Provides basic level diabetes education programs in southern Ontario. As well as promoting self-care, educations develop individualized management plans for each patient\(^{65}\).

**EatRightOntario:** Provides Ontarians with access to nutrition information from Registered Dieticians through both a telephone and a web-based service\(^{65}\).

**HealthyOntario:** Provides residents with a wide range of information on health, disease prevention and health care services\(^{65}\).

**MedsCheck Program for Ontarians Living with Diabetes:** Community pharmacists in Ontario may perform annual medication reviews for patients living with type 1 or type 2 diabetes\(^{100}\).

**Northern Diabetes Health Network:** Funds 39 adult diabetes education programs in large and small northern communities, helping to ensure that people with diabetes and their families are given tools to manage their condition and improve quality of life\(^{65}\).

**Ontario Monitoring for Health Program:** Designed to help people with diabetes afford testing supplies. The program helps 3,000 Ontarians annually\(^{67}\).

**Pediatric Diabetes Initiative:** Established in 2001. Supports children with type 1 diabetes and their families through diabetes education, treatment and help with ongoing management of the illness through 34 regional programs across Ontario. More than 90% of children with diabetes receive services from this network\(^{65}\).

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### Ontario Aboriginal Strategies/Initiatives

**Ontario Aboriginal Diabetes Strategy\(^ {68}\):**

**Prevention:** Decrease the cross-generational incidence of type 2 diabetes in all Aboriginal communities in Ontario by addressing the unique needs of Aboriginal people and the diverse circumstances of Ontario’s Aboriginal communities\(^ {68}\).

**Care and Treatment:** Establish holistic, community-based, Aboriginal-specific diabetes programs and services that will help Aboriginal people to manage their diabetes, prevent complications, and promote good health and well-being\(^ {68}\).

**Education:** To establish holistic, community-based Aboriginal diabetes education models that reflect Aboriginal culture, are designed by Aboriginal people to meet their communities’ needs and are accessible to all Aboriginal communities in
Ontario\textsuperscript{68}.

**Research:** To support and promote research that increases Aboriginal peoples’ knowledge of diabetes as well as the impact of diabetes prevention, care and treatment on health outcomes\textsuperscript{68}.

**Coordination:** To improve integration, collaboration and partnerships in Aboriginal diabetes policy, programs and services, and enhance Ontario’s capacity to deliver comprehensive, quality programs and services for Aboriginal people and communities\textsuperscript{68}.

**Initiatives:**

**The Aboriginal Diabetes Education and Health Promotion/Prevention Program:** Provides funding to 8 Aboriginal organizations and the independent First Nations Health Liaison to support Aboriginal-specific diabetes education and care programs\textsuperscript{69}.

**Aboriginal Head Start on Reserves:** Designed to prepare young First Nations children for their school years by meeting emotional, social, health, nutritional and psychological needs\textsuperscript{69}.

**Diabetes Prevention Program in Schizophrenia (DPPS), Central South Ontario:** This program is both service and research-oriented, aimed at the prevention of type-2 diabetes among mentally ill people with pre-diabetes, and brokering of diabetes services for the mentally ill\textsuperscript{69}.

**Healing Trail Diabetes Education and Prevention Program:** Offers diabetes education and prevention programs to urban aboriginals\textsuperscript{69}.

**The Southern Ontario Aboriginal Diabetes Initiative (SOADI):** Provides diabetes education, prevention and management in on- and off-reserve Aboriginal communities in southern Ontario\textsuperscript{69}.

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**Summary of Government Strategies and Initiatives in Quebec**

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<tr>
<th>Quebec Overview</th>
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2010\textsuperscript{103}:
<table>
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<tr>
<th>563,000 people with diabetes</th>
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<tbody>
<tr>
<td>7.2% prevalence</td>
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<tr>
<td><strong>Cost:</strong> $9.2 billion</td>
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### Quebec Strategies
No Provincial Strategies were identified at this time.

### Quebec Initiatives/Programs
**Diabetes Québec**\(^7\): Coordinates more than 45 affiliated associations in Quebec to help health professionals improve their care for patients with diabetes. Provides: education for health professionals (academic publications), services for patients such as an InfoDiabetes Hotline and Diabétaide Centres, funding for diabetes research, and government relations to lobby for the rights of individuals with diabetes.

### Quebec Aboriginal Strategies/Initiatives
**First Nations of Quebec and Labrador Health and Social Services Commission**\(^74,75\): Receives funding from the Aboriginal Diabetes Initiative (ADI) to implement services for 54 communities in Quebec including: 31 First Nations, 9 Cree communities and 14 Inuit communities. Also provides training for individuals to become community diabetes prevention workers.

### Summary of Government Strategies and Initiatives in Newfoundland and Labrador

<table>
<thead>
<tr>
<th>Newfoundland and Labrador Overview</th>
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<tbody>
<tr>
<td><strong>2010</strong>(^76):</td>
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<tr>
<td>47,000 people with diabetes</td>
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<tr>
<td>9.3% prevalence</td>
</tr>
<tr>
<td><strong>Cost:</strong> $254 million</td>
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</table>
# Newfoundland and Labrador Strategies

**Lack of province-wide strategy**[^76]: Due to this, the four Regional Health Authorities (RHAs) across the province are in the process of developing their own programs. Western RHA appears to have accomplished the most: received provincial funding to implement the Stanford Chronic Disease Self Management Program, developed the regional Chronic Disease Prevention and Management Plan.

## Newfoundland and Labrador Initiatives/Programs

**Funding for diabetic supplies**[^76]: From 2007-2010, $1.4 million was allotted for insulin pumps and supplies for qualified individuals under age of 18. In March 2010, coverage was expanded to include individuals aged 18-25, providing an additional $797,000 in the 2010-2011 budget.

**Diabetes Practices**[^76]: 36 practices established in 4 RHAs across the province. These include 9 primary health care site practices, 8 diabetes education centers and 19 other local collaborative practices. All RHAs have nurses, diabetes educators, dieticians and clinicians.

## Newfoundland and Labrador Aboriginal Strategies/Initiatives

**Diabetes Prevention Program**[^77]: Began in 2001 by the Federation of Newfoundland Indians using funding from the Aboriginal Diabetes Initiative. Offers education on diabetes prevention to off-reserve aboriginal people on the island portion of Newfoundland. Goal: provide people with information needed to prevent or delay type 2 diabetes.

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## Summary of Government Strategies and Initiatives in New Brunswick

### New Brunswick Overview

**2010[^103]:**

- 67,000 people with diabetes
- 8.8% prevalence
- **Cost:** $298 million
New Brunswick Strategies

A Comprehensive Diabetes Strategy for New Brunswickers 2011-2015:

Strategic Area #1: Capacity Building – establish a New Brunswick chronic disease prevention and management unit

Strategic Area #2: Prevention – support action across government on the social determinants of health and develop strategies for at-risk individuals

Strategic Area #3: Detection – implement screening programs that target vulnerable populations and at-risk individuals

Strategic Area #4: Management – improve provision of risk-factor control and early detection of complications, secondary and tertiary care support to persons with diabetes, access to tools that enable self-management and access to necessary and affordable medications, supplies and devices

New Brunswick Initiatives/Programs

DM² New Brunswick: A research initiative designed to improve the health of New Brunswick patient participants with Type 2 diabetes via a multi-system disease management model. Provides 2 new tools to physicians to manage type 2 diabetes:

1) Electronic patient management tool software with latest treatment guidelines pertaining to type 2 diabetes across all organ spectrums
2) Multidisciplinary clinic consisting of a core group of pharmacist, nurse, social worker, dietician, several specialists including cardiologist, nephrologist, general internist and endocrinologist

River Valley Health Diabetes Program: An integrated network of hospitals, health centers, and specialty care programs in New Brunswick, servicing 21.7% of the province’s population. Services for individuals with diabetes include:

1. Individual assessment and follow up with nurse, dietician and other health professionals
2. Diabetes education classes (type 1, type 2, pre-diabetes)
3. Specialty clinics (gestational diabetes, pediatric clinic, insulin pump therapy)

Community-based diabetes services

New Brunswick Aboriginal Strategies/Initiatives

Community Diabetes Education and Prevention Program (CDEPP): A diabetes prevention and health promotion program organized under...
the New Brunswick Aboriginal Peoples Council targeted to off reserve aboriginal people. Program began in 2003 and funded until November 2009 by the Aboriginal Diabetes Initiative (ADI). Emphasizes holistic wellness, type 2 diabetes prevention and promotion of healthy lifestyle activities. Objectives are to:

- Increase awareness of diabetes, diabetes risk factors, complications and of the strategies to prevent diabetes and diabetes complications among Aboriginal people;
- Increase practice of healthy eating and active living behaviours among First Nation/inuit and Metis; and
- Increase ownership and capacity to combat the disease.

**Diabetes Program for First Nationals People and their Communities at River Valley Health**: River Valley Health is an integrated network of hospitals, health centers, and specialty care programs in New Brunswick, servicing 21.7% of the province’s population. Services include:

- Individual assessment and follow up with a nurse
- Diabetes education classes (Type 1, Type 2, Pre-diabetes)
- Specialty clinics (gestational diabetes, pediatric clinic, insulin pump therapy)
- Community-based diabetes services
- No fee for patients with current Medicare coverage

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**Summary of Government Strategies and Initiatives in Nova Scotia**

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<tr>
<th>Nova Scotia Overview</th>
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<tr>
<td><strong>2010</strong>&lt;sup&gt;104&lt;/sup&gt;:</td>
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87,000 people with diabetes
8.9% prevalence
**Cost**: $383 million

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<tr>
<th>Nova Scotia Strategies</th>
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<tbody>
<tr>
<td>Diabetes Care Program of Nova Scotia (DCPNS) Strategic Plan 2008-2012&lt;sup&gt;103&lt;/sup&gt;:</td>
</tr>
</tbody>
</table>
Key aims are to:

a. Forge new and strengthen existing partnerships in the development of an integrated system of chronic disease prevention

b. Collaborate in the development, implementation and evaluation of comprehensive standards and guidelines for diabetes care, education and service delivery

c. Use complete, accurate and accessible local and provincial data, to set targets, make informed decisions and take action to improve diabetes in NS

d. Promote self management in individuals living with, affected by, or at risk of developing diabetes.

e. Reduce the incidence of diabetes through strategic, collaborative partnerships aimed at health promotion and prevention

### Nova Scotia Initiatives/Programs

**Diabetes Care Program of Nova Scotia (DCPNS)**: Implemented in 1991 and funded by the Nova Scotia Department of Health and Wellness. Provides diabetes expertise such as program planning and evaluation (i.e. diabetes centers), standardized documentation, guidelines for special populations and specific complications/co-morbidities, DCPNS registry with access to local and regional data on diabetes in NS, provides provincial policy and procedures for insulin dose adjustments

**Diabetes Centers**: Provides programs and services to people with diabetes and their family members. There are currently 39 full and part-time DCs in the province. All DCs staffed with specialized nurse and dietician diabetes educators and medical advisors. Pharmacist may be included to provide the following:
- Individual assessment
- Individual and group education
- Motivational counseling
- Promoting and facilitating adherence to recommended clinical practice guidelines
- Adjusting insulin
- Foot assessments
- Prediabetes programming
- Linkage to available community programs and services

**Nova Scotia Diabetes Assistance Program (NSDAP)**: Implemented January 2006. A provincial drug plan that helps pay for certain prescribed medications and supplies used to manage diabetes. As of April 1, 2010, new beneficiaries no longer accepted; existing beneficiaries required to
e-register by April 1 each year in order to remain in the program.

**Nova Scotia Family Pharmacare Program (NSFPP)**: Replaces the NSDAP and became effective on February 2011. The goal is to assist Nova Scotians who do not have drug coverage or are experiencing high drug costs not covered by their private insurance (including anti-diabetic medications and supplies). Permanent NS residents who have a NS health card, and not already covered by other public coverage programs are eligible.

**Medication Review Service (MRS)**: An insured service under the Nova Scotia Seniors’ Pharmacare Program. Pharmacies are reimbursed for providing a MRS to patients who have one of the following chronic diseases (as well as fulfilling other criteria): asthma, hypertension, congestive heart failure, arthritis, **diabetes**, hyperlipidemia, Chronic Obstructive Pulmonary Disease (COPD).

**Family Physician Chronic Disease Management (CDM) Incentive Program**: Implemented in 2009. Eligible family physicians are paid base incentives per year to manage an annual cycle of care and address the required indicators/risk factors for patients who have either or both diabetes and ischemic heart disease. These patients must be seen at least twice per year by a licensed health care provider, including at least 1 visit with the family physician who is claiming the CDM fee.

**Nova Scotia Aboriginal Strategies/Initiatives**

**Aboriginal Diabetes Awareness Program (ADAP)**: Initiated under the Native Council of Nova Scotia. Its goal is to raise awareness and educate all off reserve and non-status Native People throughout the province regarding diabetes prevention. Diabetes facilitators conduct Wellness Sessions and Participation Sessions on various diabetes prevention-related topics. Also provides a library that lends DVDs, cookbooks and other resource guidebooks about diabetes. The Diabetes Elder and Youth Conference is held annually in order to maintain connections between these two age groups as it relates to diabetes education.

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**Summary of Government Strategies and Initiatives in Prince Edward Island**

**Prince Edward Island Overview**

2010.
12000 people with diabetes  
8.0% prevalence  
**Cost:** $61 million

### Prince Edward Island Strategies
No Provincial Strategies were identified at this time.

### Prince Edward Island Initiatives/Programs

**Provincial Diabetes Program**[^90]: Provides diabetes education and management advice to clients and families, and promotes diabetes awareness and prevention by educating health professionals and the public on practices and standards for diabetes care.

Specific programs and services include:
- **At-risk class:** 3-hour class covers healthy living approaches to reduce risk factors for diabetes
- **Getting started class:** 3-hour class for people newly diagnosed with diabetes covering what is diabetes, blood glucose goals and meal planning.
- **Living well with diabetes class:** Content includes meal planning, cholesterol, complications/medications and diet
- **Individual assessment/counseling:** Delivered by certified diabetes educators
- **Follow-up for people with diabetes**
- **Drop-in blood glucose test clinic:** Available one day per month
- **Gestational Diabetes Clinic:** To provide diabetes education for those with gestational diabetes
- **Pediatric Diabetes Clinic:** Provides diabetes education and follow up to children and youth diagnosed with diabetes and their families/support persons

**Pre-Diabetes Screening Program**[^93]: Conducted from April 2007 to September 2008 at Four Neighborhoods Community Health Centre, Central Queens Family Health Centre and Gulf Shore Family Health Centre. Its goal is to develop a province-wide screening tool. Patients aged 40-74 not diagnosed with diabetes are recruited to see a family physician. They completed the 2-hour OGTT (oral glucose tolerance test) and CANRISK (Canadian Risk Assessment Screening Questionnaire) screening tool. Current status of this program is unknown.

### Prince Edward Island Aboriginal Strategies/Initiatives

**Native Council of Prince Edward Island**[^91]: Received funding from 2000 to 2009 from Health Canada. Objective is to raise awareness of diabetes, its risk factors and the value of healthy

[^90]: Reference number
[^91]: Reference number
[^93]: Reference number
Lifestyle practices.

Program activities include:
- Maintain and update resources for diabetes prevention, health promotion and everyday meals, cook books, etc.
- Set up information booths and make presentations during health events throughout the province
- Provide information on diabetes prevention lifestyle changes and the importance of screening for diabetes
- Home visits to members in urban areas passing out information on diabetes
- Food Co-op - Fruit and vegetables are bought from local growers and sold to native council members at no cost.

Summary of Government Strategies and Initiatives in Yukon

<table>
<thead>
<tr>
<th>Yukon Overview</th>
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<tr>
<td>2010⁷⁰:</td>
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<tr>
<td>5.5% prevalence</td>
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<table>
<thead>
<tr>
<th>Yukon Strategies</th>
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<tbody>
<tr>
<td>Informal Diabetes Strategy (2009 – 2012)⁷¹:</td>
</tr>
<tr>
<td><strong>Care and Treatment:</strong> Encourage self-care through a supportive network of professionals⁷¹.</td>
</tr>
<tr>
<td><strong>Health Promotion and Diabetes Prevention:</strong> Healthy eating, active living and stress management attitudes and behaviours need to be enforced⁷¹.</td>
</tr>
<tr>
<td><strong>Coordination and Support:</strong> Maximizes resources and enables an effective and comprehensive diabetes response. Coordination and support involves communication and information sharing, research and measurement, implementation of strategic actions, development and maintenance of partnerships and professional development⁷¹.</td>
</tr>
</tbody>
</table>
### Yukon Initiatives/Programs

**Arctic Health Research Network-Yukon (AHRN-YT):** Participants created strategies for their communities related to health issues.  

**Chronic Disease Management Program (CDMP):** Tracks and involves over 800 people living with diabetes in the Yukon. Health care professionals receive educational support and training through the program.  

**Diabetes Reference Group:** Provide networking opportunities, partnerships and resource sharing amongst those involved in diabetes prevention and care.  

**Healthy Living Programs and Initiatives:** Delivered by the Recreation and Parks Association of the Yukon, aim to promote health promotion and disease prevention through active living.

### Yukon Aboriginal Strategies/Initiatives

**Diabetes Prevention Program:** For Métis, off-reserve Aboriginals and urban Inuit.

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### Summary of Government Strategies and Initiatives in Northwest Territories

#### Northwest Territories Overview

2010:  
5.2% prevalence

#### Northwest Territories Strategies

**Northwest Territories Diabetes Strategy 2009-2010:** Created by the NWT Department of Health and Social Services. Goals are to reduce morbidity and premature mortality among NWT residents living with all types of diabetes mellitus, and facilitate health professionals to provide effective and efficient diabetes prevention, education, treatment and care within a chronic disease framework.
A Foundation for Change – Building a Healthy Future for the NWT 2009-2012: Their mission is to promote, protect and provide for the health and wellbeing of the people of NWT. 3 basic goals:
- **Wellness**: communities, families and individuals make healthy choices and are protected from disease
- **Accessibility**: People get the care they need, and know where and how to find it
- **Sustainability**: Resources are used effectively and innovatively to ensure the health and social services system will be sustained for future generations

Under ‘Accessibility’, a Chronic Disease Management Model will be created for 2009-2012 to decrease severity and incidence of a broad range of chronic diseases including diabetes, heart disease and cancers.

### Northwest Territories Initiatives/Programs

**Northwest Territories Health Care Plan**: NWT has one of the most extensive coverage programs for diabetes medications, devices and supplies in Canada. All permanent residents of NWT are eligible for coverage. Extended health benefits are eligible to non-native and Métis residents with a specified disease, two of which include diabetes insipidus and diabetes mellitus.

### Northwest Territories Aboriginal Strategies/Initiatives

No Provincial Strategies/Initiatives for Aboriginals were identified at this time.

### Summary of Government Strategies and Initiatives in Nunavut

**Nutrition in Nunavut – A Framework for Action**: Includes 10 goals in 4 areas:
- Overarching Nutrition Program
- Public Health Nutrition
- Clinical Nutrition Services
- Foodservice Management
Goal 8 emphasizes that all Nunavummiut diagnosed with nutritional health conditions requiring nutrition therapy (i.e. diabetes) will have timely access to the services of a Registered Dietician. All relevant Government of Nunavut facilities will be sufficiently staffed and supported by nutrition professionals. The objectives are to support all regions in having a referral system in place for diabetic patients, and to consistently refer people diagnosed with type 2 diabetes (and other conditions) to a Registered Dietician within 3 months of diagnosis.

**Nunavut Initiatives/Programs**

No Provincial Initiatives/Programs were identified at this time.

**Nunavut Aboriginal Strategies/Initiatives**

**Inuit Wellness Programs in Nunavut 2004-2005**[^99]: A Nunavut Aboriginal Diabetes Initiative. From 2004-2005, diabetes prevention projects occurred in 12 communities tailored to meet specific needs of residents. Territory-wide training courses were provided to health professionals related to diabetes care including foot-care workshops for home and community nurses, partnership with an online nutrition course from McGill University, and Drop-the-Pop campaign to help students choose healthier beverages instead of pop. Over half of all schools in Nunavut participated in this campaign.

[^99]: Source: [Aboriginal Diabetes Initiative](https://www.gov.nu.ca)
References


Appendix A: Prevalence of Diabetes and Pre-diabetes in Canada
by Province and Territory in 2010

Prevalence of Diabetes or Pre-diabetes (%)

Estimated diabetes prevalence
Estimated pre-diabetes prevalence
Appendix B: Estimated total costs for diabetes and out-of-pocket expenses for type 2 diabetes in 2010

Estimated costs for diabetes ($) or out-of-pocket expenses for type 2 diabetes (% of annual income)

- Estimated cost ($ in billions)
- Out of pocket expenses for type II (% of annual income)

[Chart showing estimated costs for diabetes and out-of-pocket expenses by province in 2010]
CONTACT INFORMATION

FOR MORE INFORMATION ON THE DIABETES STRATEGY FOR PHARMACISTS CONTACT:

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www.pharmacists.ca/diabetes