

**Action on Wellness**  
***“Building a Healthier Tomorrow Together”***

**Health Promotion for Diabetes Prevention in  
an Aboriginal Community:  
The Kahnawake Schools Diabetes Prevention  
Project**

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an Aboriginal Community:  
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Kahnawake Schools Diabetes Prevention Project

Kahnawake, Mohawk Territory

# Kahnawake (by the rapids) Quebec



# Kahnawake (by the rapids) Quebec



# My grandparents (1940's)







## The 1990 Oka Crisis



In the pines at Kanehsatake



Kahnawake Support for Oka





## **Health Promotion and community control over conditions of health**

“Health promotion is the process of enabling people to increase control over, and to improve, their health.” (Ottawa Charter for Health Promotion, 1986)

“Aboriginal people told us that control will permit them to redesign health and social programs to more fully reflect their values and diverse cultures.” (Royal Commission on Aboriginal Peoples, 1996)



**The Kahnawake Schools Diabetes Prevention  
Project (KSDPP)**

# Kahnawake Schools Diabetes Prevention Project - KSDPP

**17 year, ongoing community directed intervention and research project in the Mohawk community of Kahnawake**

1984 - 1994    Community diagnosis of health issue: type 2  
Diabetes

→ 1994 - 1997    KSDPP Intervention & Evaluation (NHRDP)

1997 - 1998    Community supported only intervention

1998 - 2000    Continue Intervention & Evaluation

2001 - 2006    Centre for Research & Training (CIHR)

2007 - present    Intervention, Training & Knowledge Translation

# Kahnawake Schools Diabetes Prevention Project - KSDPP

- *Essentially KSDPP was designed as an Obesity Prevention program*
- *Diabetes Prevention was the health issue that held meaning for Kahnawake*

**Goal:** to prevent type 2 diabetes in future generations

**Objectives to:**

- improve diet
- increase physical activity
- promote a positive attitude

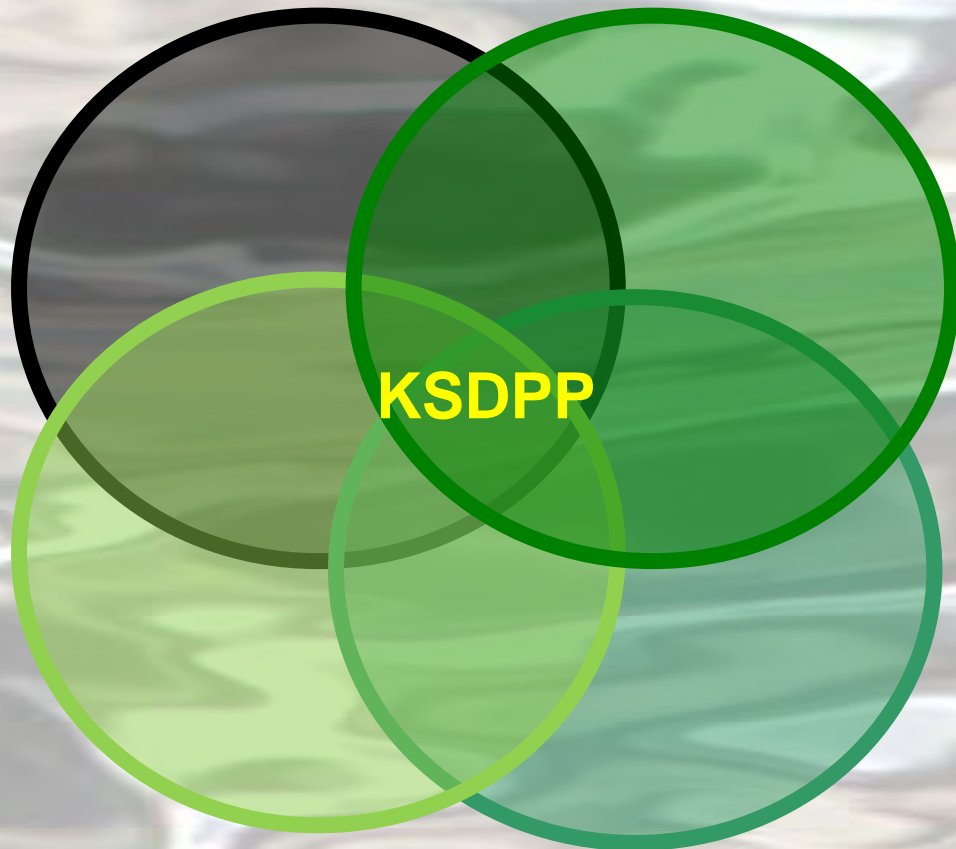


# Community-University Partnership

McGill University 1994

*Participatory  
Research at  
McGill 2006*

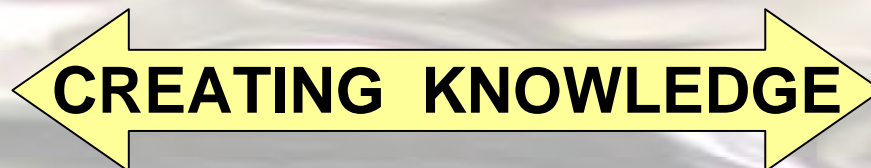
Kahnawake



Queens  
University

2002

Université de  
Montréal 1994



# **KSDPP Code of Research Ethics Policy statement**

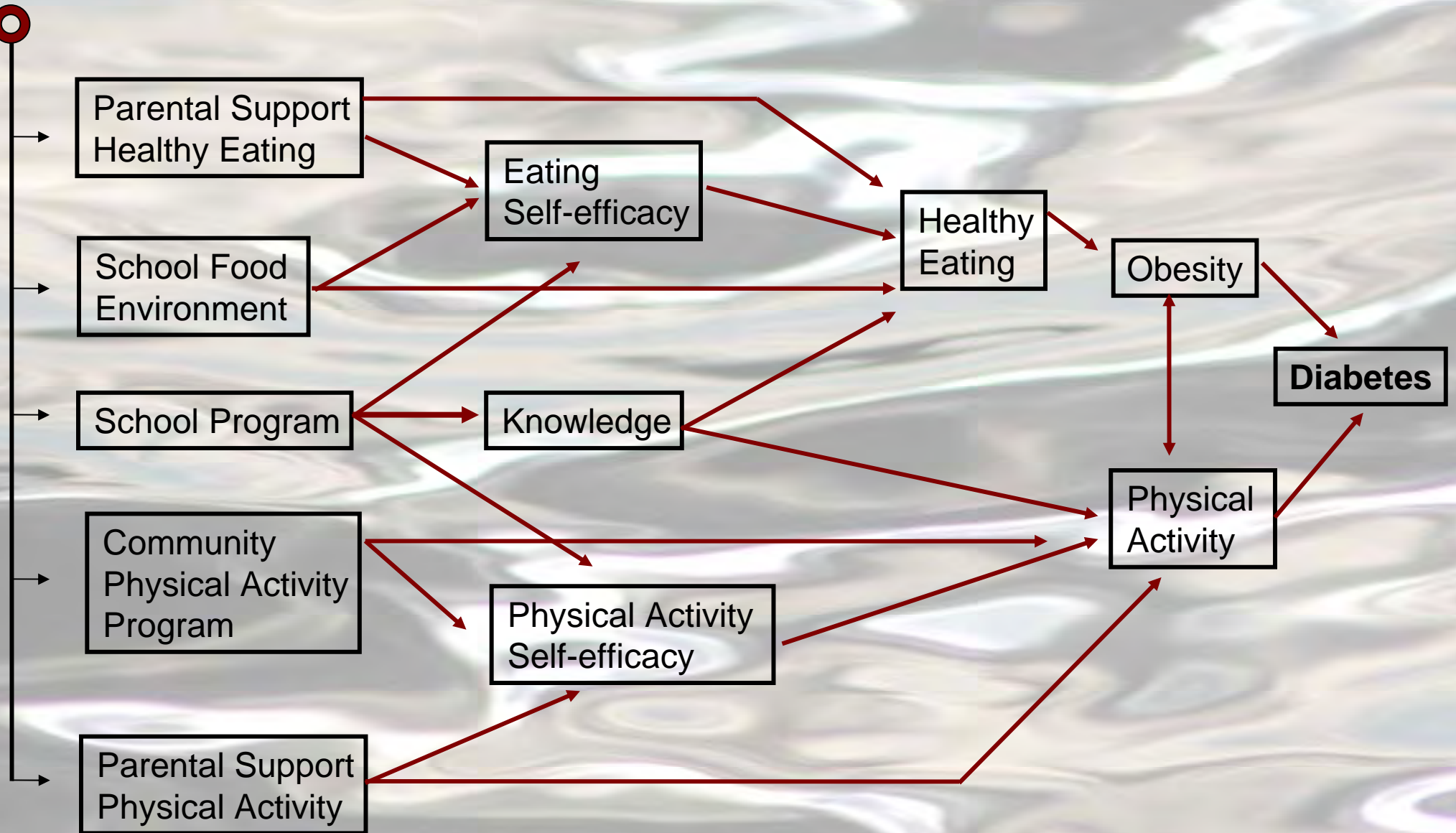
The self-determination of the Kanien'kehá:ka of Kahnawá:ke to make decisions about research is recognized and respected.

The academic researchers' obligation to contribute to knowledge creation in their discipline is recognized and respected.

Research should support the empowerment of Kahnawá:ke to promote healthy lifestyles, wellness, self-esteem, and the Kanien'kehá:ka's responsibility of caring for the Seven Generations.

# KSDPP Intervention Framework

Social Learning Theory set within Ecological framework

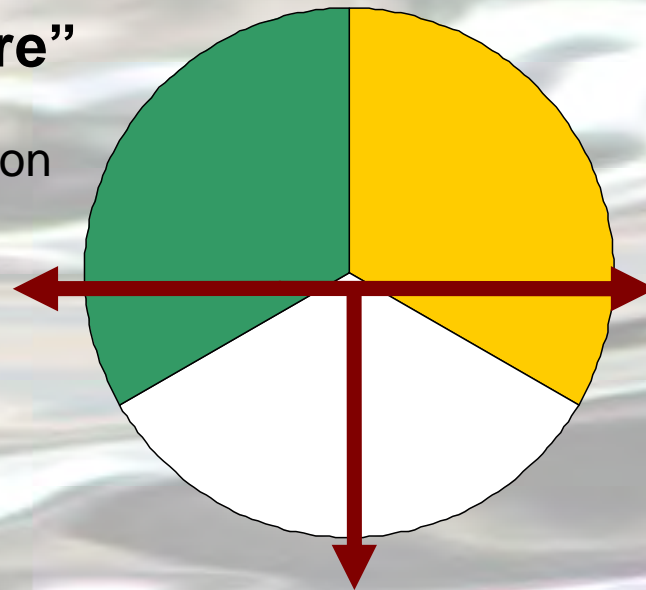


# Traditional Mohawk Decision Making Process

## “People across the Fire”

Consensus through Discussion

**Researchers**



## “Well Keepers”

Global input  
Develop the agenda

**KSDPP Staff**

## “Fire Keepers”

Confirm the decision of the  
two sides

**Community Advisory Board**

# KSDPP recipient of the CIHR Partnership award 2010





**KSDPP Research to better understand how social relationships shape well-being / health**

# **Indigenous Perspectives on Health and Wellness**

Wellness or health is wholistic involving the mind, body and spirit in balance or harmony.

Individual wellness or health is shaped by family (in extended sense) and community relationships.

# Limitations to current intervention theories

Outcomes focus on health behaviours of individuals (diet, physical activity, sedentariness)

Determinants of individual behaviours are examined separately and uni-directionally, their interactions are rarely studied

We can describe many determinants of health behaviours

We can not explain why certain behaviours of diet, physical activity or sedentariness become patterned in the first place.



**Hungry Planet: What the world eats. (2005) by: Peter Menzel and Faith D'Aluisio**



Hungry Planet: What the world eats. (2005) by: Peter Menzel and Faith D'Aluisio

# Food Choice Practice Framework – how social context shapes food choice patterns

- Acknowledges that people creatively make food choices because they have agency.
- Choice is always socially structured by the norms, meanings and resources (materials, skills, authority) in the course of daily food choice activities.
- These 'Rules and Resources' are unequally distributed in society and can enable and constrain practice.
- Social structure is both the means and outcome of food choice practices.
- Food choice practices form patterns (routines) that endure through time.
- Changing food practices involves changing the social structures that reinforce certain patterns.

(Delormier, Frohlich & Potvin, 2009)

# Implications of the social structuring of social practices ( food, physical activity, sedentarity)

- Understanding Aboriginal communities as *social contexts* where distinct constellations of resources (material and authority) give rise to shared ways of doing things.
- Shift thinking from Individual behavior to '*Collective lifestyles*' - how social structures shape patterns of smoking behaviour for youth distinctly by neighbourhood.

(Frohlich, Potvin, Gauvin & Chabot, 2002)

# Implications of the social structuring of social practices (food, physical activity, sedentarity)

- Need to consider Aboriginal communities as unique social contexts whose histories, cultures, geographies, politics, economies generate the current context of health practices.
- Example: Variable rates of suicide in British Columbia exemplify distinct community contexts, where most suicides (90%) happened in a small proportion (<10%) of communities. (Chandler & Lalonde, 1998). Rates were associated with **community practices** which indicated **collective efforts** of **cultural continuity**.



**Addressing the social context of successful obesity prevention and treatment programming in Aboriginal communities.**

# KSDPP Training Program – Evaluation Research (Cargo, 2006)

What factors serve as barriers to the implementation of diabetes prevention efforts in Aboriginal communities?

20 participants (front-line workers/ administrators/ health professionals)

Four 1-week training sessions

The settings in which diabetes prevention were to be implemented

- a geographical Aboriginal community
- an urban centre serving Aboriginal peoples
- a region serving multiple Aboriginal communities

# Barriers to implementation identified from interviews

- |                                  |                                 |
|----------------------------------|---------------------------------|
| 1. Funding (19)                  | Human Resources                 |
| 2. Participant engagement (16)   | Physical Environment            |
| 3. Organizational Readiness (15) | Volunteerism                    |
| 4. Mental Health (11)            | Culture/language                |
| 5. Leadership (11)               | Inter-organisational networking |
|                                  | Social environment              |
|                                  | Socio-political environment     |

(n) number of barriers identified  
total n for study was 107 barriers

# Implications for Obesity Prevention Program Implementation

Rethink categorical implementation of health programs – (specific disease foci).

Refocus on community and organizational readiness to enable front-line workers to implement obesity/ type 2 diabetes prevention programs.

Engage stakeholders from relevant Aboriginal organizations to ensure knowledge translation.

# KSDPP Research - Understanding Diabetes Prevention in a community context

Purpose: to seek perspectives and experiences on the meanings of diabetes prevention.

- Participants were 16 community practitioners – diabetes prevention, holistic health promotion
- Sought perceptions on actions needed to ensure children will not develop diabetes in their future
- Information to inform Kahnawake and KSDPP on orienting future diabetes prevention from a disease focus toward one which is person and community centered in positive health and well being.

# Responses by theme characterized the social-relational conditions in which well-being is influenced

Theme 1: Relationship with self / being onkwehonwe (self esteem)

Theme 2: Family Relationships (nurturing, caring, connected)

Theme 3: Relationship with community - enabling/encouraging places (physical environment, opportunities)

Theme 4: Relationship with community – enabling/encouraging practices (collective cultural understandings, practices)

Theme 5: Relationships with each other in our community (working together, divisions...)

Theme 6: Relationships – the Others (colonization, racism...)

- We want to address the community understandings of social determinants of health in order to work collaboratively to prevent diabetes (obesity)
- *Social relational conditions* address how social determinants are experienced and understood in an Aboriginal community
- Is it useful for Kahnawake to expand the *disease prevention focus* to address maintaining, enhancing and promoting *holistic well-being*.



Nia:wen Ko:wa

Thank you



