DIABETES CANADA

DIABETES CANADA PRESENTS:

WESTERN CANADA DIABETES HEALTH EQUITY SUMMIT

Conference Report

MARCH 21, 2024 • CALGARY, ALBERTA

Acknowledgements

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Sustaining Momentum in Implementing the Diabetes Framework (SMIDF) Team

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Supporters and Conference Organization

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Presenters for the Diabetes Canada Western Health Equity Summit supported fundamental learnings in the intersection of diabetes care and health equity. Presenters dedicated their time, energy, and resources to sharing their knowledge and experiences with summit attendees to further equitable diabetes care. In presenting order, we thank and acknowledge the following individuals for their contributions:

Katrina Plamondon, RN, MSc, PhD
Barbara MacDonald, RN, BSN, MS-DEDM, CDE
Roman Bhangoo, BSc, MBA
Bukola Salami, RN, MN, PhD
Meera Kaur, PhD, RD, CDE
Saania Tariq, MSc
Tucker Reed, BSc
David JT Campbell, MD, PhD
Natalie Riediger, PhD, MSc

Note on Indigenous Engagement and a National Diabetes Framework

In respect to Reconciliation and in recognition of Indigenous autonomy, self-determination, and sovereignty, the Public Health Agency of Canada has provided independent funding to the National Indigenous Diabetes Association (NIDA). NIDA is engaging with various Indigenous peoples, nations and organizations across Canada to develop an Indigenous Diabetes Framework. Through supporting open dialogue, NIDA sits on the Diabetes Canada/SMIDF's Pan-Canadian Action for Diabetes committee to promote mutual knowledge exchange and collaboration. For more information about NIDA, please visit www.nada.ca

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1.0 Executive Summary

On March 21st, 2024, Diabetes Canada, with support from the Public Health Agency of Canada, held the first ever Western Canada Diabetes Health Equity Summit, in Calgary, Alberta. With emphasis on supporting momentum for the Diabetes Framework in Canada, the event aimed to bring the principle of health equity to the forefront of conversations around diabetes care, prevention, access, and management. Approximately 25 participants from across Saskatchewan, Alberta, Manitoba, and British Columbia attended the summit, including stakeholders from the following sectors:

- healthcare professionals;
- diabetes researchers;
- health equity researchers/advocates;
- non-governmental organizations (NGOs);
- crown corporations.

In addition to supporting knowledge sharing around the Framework for Diabetes in Canada, the event aimed to support attendees in engaging with topics in health equity and diabetes by:

- Providing a space for multi-sectoral stakeholders to share their successes and challenges in applying the principles of health equity to their work in the healthcare and diabetes care sector
- Exploring barriers to understanding, diagnoses, prevention and care in Social Determinants of Health-impacted and health-equity deserving communities
- Highlighting the knowledge base around successful approaches to equitable diabetes care
- Discussing next steps to applying a health equity systems level approach to all diabetes initiatives and programs

Presentations from multi-sectoral attendees explored the role of nutrition policy in diabetes care, culturally competent diabetes care, the impact of diabetes on people experiencing homelessness, supporting equitable diabetes care for Black and South Asian communities in Canada, and more.

Findings from the conference highlighted the facilitators, barriers, and next steps for supporting equitable diabetes care in Western Canada. Attendees overwhelmingly shared the need for consistent funding, investment in community and spaces, and involvement from government to support equitable diabetes care in their work and in their province. Continued networking, ongoing conversations, and opportunities to connect were also highlighted as necessary to support the Framework's goal of applying the cross-cutting principle of health equity to diabetes care initiatives.

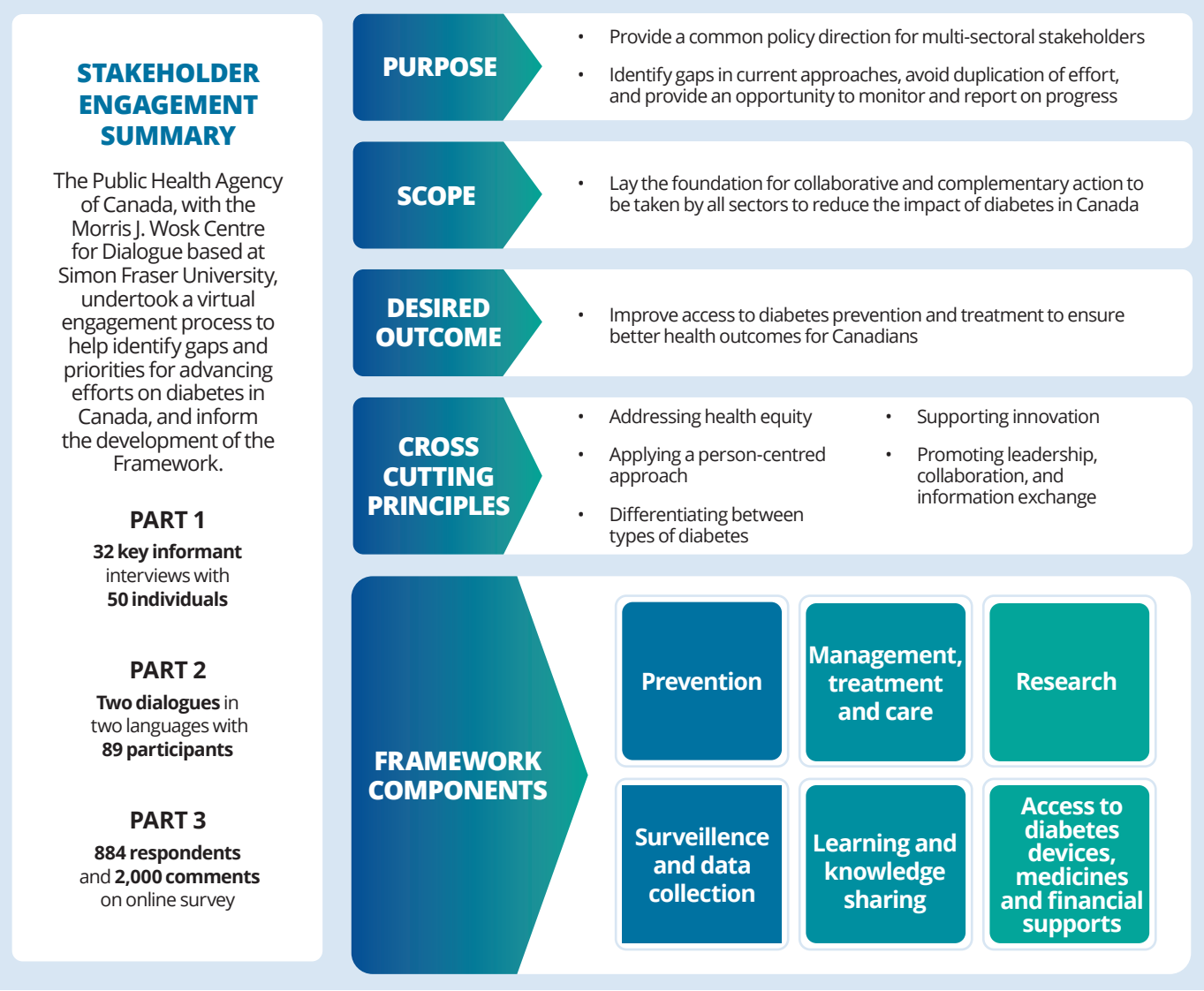
2.0 The Framework for Diabetes in Canada and SMIDF Overview

Diabetes Canada is a national health charity representing more than four million people in Canada living with diabetes. Diabetes Canada leads the fight by helping those affected by diabetes live healthy lives and addressing the onset and consequences of diabetes. In partnership with the Public Health Agency of Canada (PHAC), Diabetes Canada is engaging in a three-year project, Sustaining Momentum to Implement the Diabetes Framework (SMIDF). The Diabetes Framework, officially referred to as the Framework for Diabetes in Canada, was presented by the Government of Canada in 2022. The Diabetes Framework aims to support prevention and treatment for all types of diabetes and provides a common policy direction to address diabetes in Canada (PHAC, 2022). The Diabetes Framework also supports the identification of gaps in current diabetes care approaches, promotes reducing duplication of effort, and provides the federal government an opportunity to monitor and report on progress (PHAC, 2022). The Diabetes Framework is comprised of six interdependent and interconnected components of diabetes efforts including:

- Prevention,
- Management, treatment, and care,
- Research,
- Surveillance and data collection,
- Learning and knowledge sharing, and,
- Access to diabetes devices, medicines, and financial support.

A summary of the Framework for Diabetes in Canada is provided in Figure 1.

Figure 1: Visual of the Framework for Diabetes in Canada (PHAC, 2022)



The SMIDF teams foci relates to regional engagement initiatives with the Diabetes Framework and the creation of an inventory of successful diabetes programs, interventions, and projects across Canada. The creation of the inventory will also involve the dissemination of findings for adoption and scaling to identify and share best practices for addressing diabetes, including the identification of actions to reduce barriers to diabetes care in health-equity deserving communities.

3.0 About the Conference

A cross-cutting principle of the Diabetes Framework is addressing health equity in relation to diabetes care and management. Health equity is recognized as a state where all individuals are able to reach their full health potential, with fair and just opportunities to access healthcare resources (CDC, 2022). To achieve health equity, significant work is necessary at the systems level to critically analyze, understand, and remove barriers to care. This includes addressing the root causes of the social determinants of health, rather than focusing solely on mitigating the effects (Hill-Briggs et al., 2021). For diabetes care, this means reducing the impact of poor socioeconomic status, neighborhood and physical environments, food environments, healthcare, and social contexts, on diabetes outcomes (Hill-Briggs et al., 2021). Deeply rooted discriminatory policies, practices, and services embedded throughout our healthcare system can exacerbate risks and symptoms associated with diabetes. Therefore, an approach to diabetes care and management that recognizes the intersections of marginalization and inequity across Canada, and directly targets the root causes of the social determinants of health, is necessary to support patient-centered change that is available and accessible to all.

As a systems-level problem, discussions around health equity and inequity require insight, advocacy, and collaboration from all sectors that passively or actively engage with the healthcare system (Glasgow et al., 1999). Factors that support and interfere with diabetes care management and treatment include, but are not limited to, personal influence, access to healthcare providers/systems, and regulations and policies at the government level (Glasgow et al., 1999). Thus, meaningful discussion around change and action for the state of diabetes care in Canada requires multi-sectoral engagement and collaboration. The **Western Canada Diabetes Health Equity Summit**, held on March 21st, 2024, in Calgary, Alberta, aimed to support this objective. Approximately 25 participants attended the summit, including stakeholders from the following sectors:

- healthcare professionals;
- diabetes researchers;
- health equity researchers/advocates;
- non-governmental organizations (NGOs);
- crown corporations;
- advocates/individuals with lived experience;

Additionally, the conference team reached out to individuals in government across the four Western provinces to support provincial representation; however, time constraints and inclement weather limited participation overall.

Objectives of the Western Canada Diabetes Health Equity Summit included:

- Bringing the principles of health equity to the forefront of discussions around diabetes through information-sharing and relationship-building with experts in the field of diabetes and/or health equity
- Providing a space for multi-sectoral stakeholders to share their successes and challenges in applying the principles of health equity to their work in the healthcare and diabetes care sector
- Discussing and creating actionable next steps for applying a health equity systems level approach to all diabetes initiatives and programs as related to the Framework

4.0 Conference Presentations

To support the objectives of the Western Canada Diabetes Health Equity Summit, invitations for attendance also included requests for presenters. All potential attendees were invited to present their findings or experiences working on or developing a health-equity approach to diabetes care management, or access. Additionally, attendees were provided with the opportunity to prepare or share a case study of a diabetes intervention or initiative that would benefit from a health-equity and/or Diabetes Framework targeted review, insight, or feedback from other stakeholders at the summit. After the presentations, attendees broke out into smaller groups for case-study discussions. The summit ended with individual personal reflections shared through a digital brainstorming platform, MentiMeter. Outcomes and reflections from the small group discussions and reflections are explored in Section 5. An outline of the summit presentations is provided:

Presentation Topic	Presenter
Overview of the Framework for Diabetes in Canada*	Adria Cehovin, MSc
Five core equity practices to use anywhere, anytime	Katrina Plamondon, RN, MSc, PhD
An Approach to Equitable Diabetes Care – IDEA Diabetes	Barbara MacDonald, RN, BSN, MS-DEDM, CDE
South Asian Health Institute (SAHI)	Roman Bhangoo, BSc, MBA
The Intersection of Black Health and Diabetes Care	Bukola Salami, RN, MN, PhD and Aloysius Maduforo, PhD, RDN
The Intersection of Culture, Nutrition Equity, and Diabetes Care	Meera Kaur, PhD, RD, CDE
The Intersection of Diabetes and Homelessness	Saania Tariq, MSc, Tucker Reed, MSc, and David JT Campbell, MD, PhD
The Intersection of Diabetes and Nutrition Policy	Natalie Riediger, PhD, MSc

*Adria Cehovin provided summit attendees with a comprehensive overview of the Framework for Diabetes in Canada, as well as details on the outreach and engagement efforts of the SMIDF team across Canada. An overview of the Framework is available in Section 2.

4.1 Katrina Plamondon – Five Core Equity Practices to Use Anywhere, Anytime

To support a baseline understanding of health equity practices amongst the summit attendees, Katrina Plamondon was invited to share her knowledge and expertise in the field of equity science. Using the Systematic Equity Action (SEA) Framework created by Plamondon et al., she shared five core equity practices "applicable anywhere, anytime". The SEA framework, as outlined by Plamondon, applies a social systems and structures approach, emphasizing the relationship between health, equity, and structures we maintain and shape through our ideas, organizations, and knowledge (Plamondon et al., 2023; Plamondon & Shahram, 2024). The five core equity practices, in context with equitable diabetes care, include:

1. **Recognize your role and responsibility**

    - Supporting health equity work starts with self-reflection. Who are you? Where do you come from? Why do you want to engage in health equity work? These questions are important in understanding our position in society and the ways in which our day-to-day habits shape the world around us
    - It is important that we recognize that we are the structures and systems, that we so often describe in passing

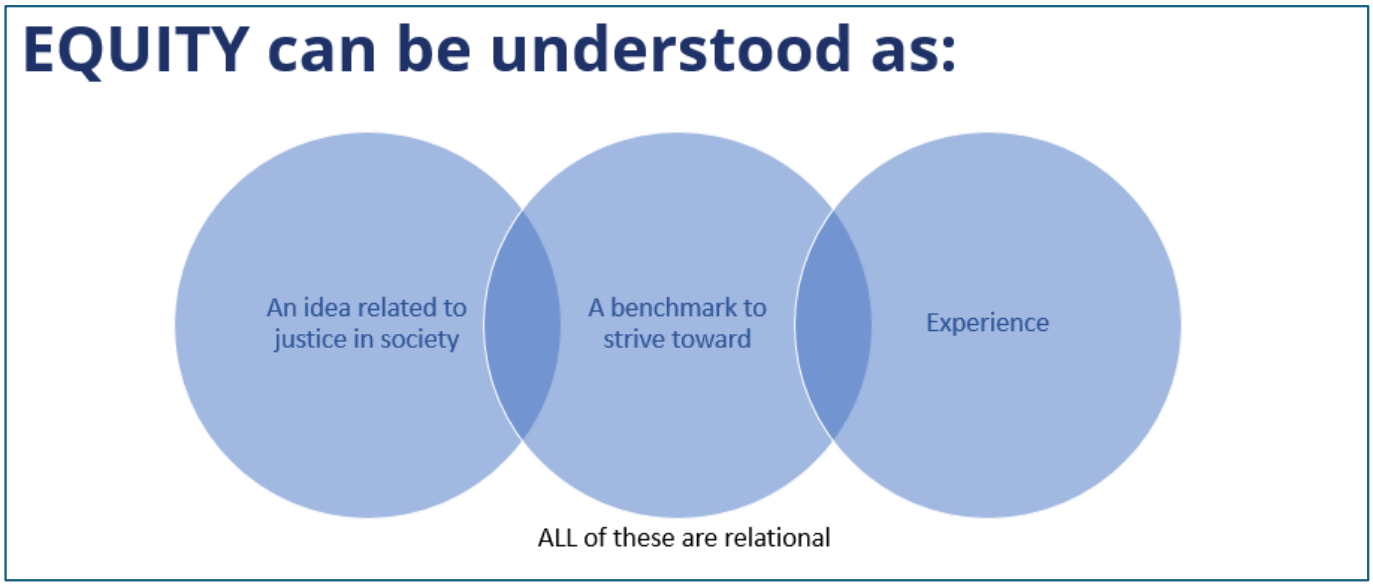
2. **Unpack influential worldview(s)**

    - Influential worldviews determine our ideas of health and wellness, history, and the "goodness" of our healthcare system – unpacking these ideas will help us understand why and how systems function (or fail to function) for different groups of people

3. **Get clear about definitions and determinants of equity**

    - Health inequities are predictable, systematic differences in health. Evidence shows that they are caused by the distribution of power, money, and resources.
    - Equity can be understood in three ways, each of which is relational (shown in Figure 2).

Figure 2: Relational ideas of Equity Visual (Plamondon & Shahram, 2024)



- Understanding the relationship between equity and inequities can help us to understand what areas of our systems and structures we need to target to achieve specific health outcomes. A relational diagram of systems and health outcomes is shown in Figure 3.

4. Align intention with actions

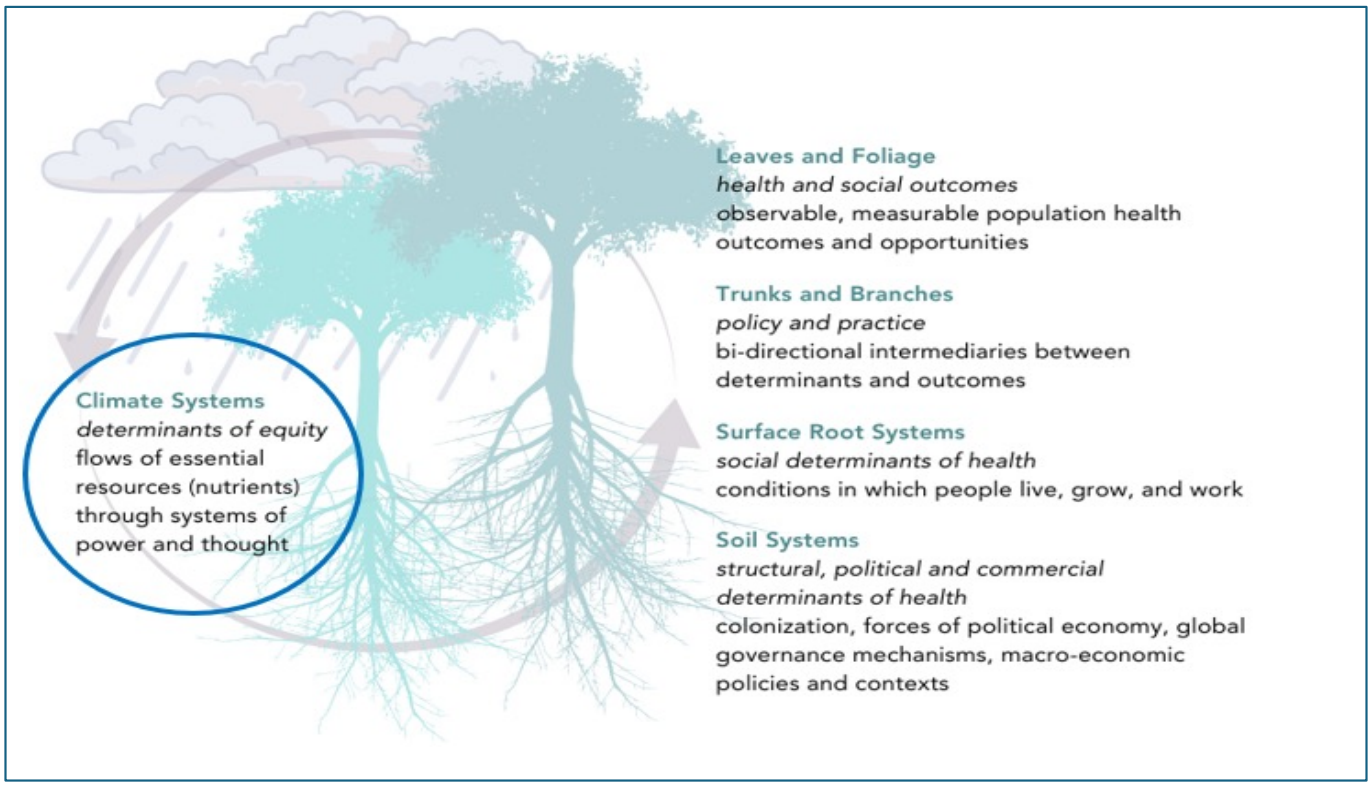
- Over-reliance on intentions and low awareness of the determinants of equity can risk misappropriating equity work
- Only a small portion of research addressing inequities focuses on known causes
- Often, health inequities are viewed as having no cause and no relation to issues of power in society; and responses to them focus on adjusting the behaviours of people burdened by inequities, instead of the systems and structures that create conditions of inequity

5. Align actions with evidence

- Designing actions that act on the determinants of equity and the structural, political, and commercial determinants of health, colonization, forces of political economy, and global governance mechanisms are key
- Work in diabetes program, planning and policy can play a pivotal role in advancing equity!

To learn more and access resources from the presentation: www.equityscience.ca

Figure 3: Relational diagram of systems and health outcomes (Plamondon & Shahram, 2024)



4.2 Barbara MacDonald – An Approach to Equitable Diabetes Care: IDEA

As the co-founder of IDEA Diabetes, Barbara MacDonald supports health empowerment for people with diabetes. By emphasizing the person with diabetes as the expert, IDEA Diabetes aims to support their ability to make informed decisions about diabetes self-management. At the summit, MacDonald shared three core principles integral to the work of IDEA diabetes: hope, power, and action.

"Everything we do is centered around hope and possibility."

IDEA Diabetes works to inspire hope by emphasizing a key aim in diabetes management: 'keep blood flowing now and several generations from now'. Blood vessel protection is well known in diabetes with the emphasis placed on maintaining microvascular and microvascular integrity (Liu et al, 2022). By emphasizing hope in keeping blood flowing, now and in the future, this approach to diabetes management focuses on the person and their blood vessels as a component of their quality of life. It emphasizes creating safer spaces for people with diabetes, with hope and desired future to work towards, supporting the individual's journey in deserving the best possibilities possible for themselves and their care. By supporting quality of life, MacDonald's team hopes to unlock hope and maintain a safer space for individuals with diabetes.

Power is another principle integral to the work of IDEA diabetes. This includes working on the power of language (i.e. moving away from "diabetics" to "people/persons with diabetes", and when providing care using language such as "you should..." to "lets figure this out together,"), as well as strengths-based care—which emphasizes what one is trying to achieve in diabetes care rather than what we they are trying to avoid.

Finally, the group pillars action. MacDonald emphasized the opportunity that exists with the Diabetes Framework to make a real difference by focusing on action with purpose—an approach that begins with the end in mind. A vision for the future of diabetes must take stock of the current state of diabetes care, understand what is working, visualize outcomes we are trying to achieve, then create actions and strategies that will support this new vision of diabetes care. Using a combination of hope, power, and action, IDEA Diabetes has been able to support equitable diabetes care at the individual, group, community, regional, and national level.

To learn more about IDEA Diabetes, visit www.idea-diabetes.com

4.3 Roman Bhangoo – South Asian Health Institute (SAHI)

As leader of the South Asian Health Institute (SAHI), Roman Bhangoo supports the community-based health promotion program in its efforts to foster culturally appropriate health promotion and prevention activities for South Asian communities. Established in 2013, SAHI is a unique community health initiative that prioritizes empowerment and engagement in South Asian communities to advance health and wellness. Through its community engagement efforts and culturally tailored care approach, SAHI is able to identify population-specific health disparities, and provide targeted health promotion and system navigation support to build community capacity.

A combination of individual, social, environmental, and genetic factors lead to an increased risk of developing type 2 diabetes for South Asians—with the prevalence of diabetes among South Asians being 8.1 times higher than prevalence amongst white adults in Canada (Diabetes Canada, 2022). To support diabetes education, care, management, and treatment amongst the South Asian population in the Fraser Health region, SAHI prioritizes community partnerships (through places of worship, non-profits, community groups, independent schools, etc.) and community engagement activities. Past activities have included: educational sessions, outreach information booths, culturally relevant resources and tools, and providing a cultural framework to programs, community tables, and working groups.

Through their leadership and engagement with South Asian communities, Bhangoo and her team have recognized a variety of barriers to accessing care, including:

- Language barriers for care services provided,
- Difficulty navigating the Canadian health care system,
- Fear of how accessing healthcare will impact immigration status,
- Barriers to attending appointments (including lack of transportation and long waiting times), and
- Limited one-on-one time with healthcare professionals to discuss health concerns.

Through their work, SAHI has also identified facilitators to community care that support the health of their target population, including:

- Providing language-specific programming and services while ensuring translations reflect the original messaging
- Supporting both individualist and collectivist approaches to care by acknowledging the patient's preferences, culture, and values, without treating the community as a monolith
- Approaching patient care with a holistic understanding of their individual lifestyles, which may include family dynamics and the role of family in health management

Bhangoo concluded by sharing that SAHI has been able to form strong relationships and support health prevention and management of type 2 diabetes in the community by:

- Maintaining an active presence and fostering relationships directly with community leaders and members
- Framing individual health and healthcare access through a cultural framework
- Having community representation in the team through staff/volunteers who bring lived experiences into their role
- Allocating resources to support translation services

To learn more about SAHI, visit www.fraserhealth.ca/sahi

4.4 Bukola Salami – The Intersection of Black Health and Diabetes

Bukola Salami, a professor at the Cumming School of Medicine (University of Calgary), and an expert on policies and practices shaping Immigrant health and Black people's health, provided an overview of the racial disparities in both the incidence of diabetes, and inequities in diabetes care for Black Canadians. With over 300 ethnic and cultural origins identified amongst the community, Black Canadians make up a large and diverse racial group. As well, with over 1.5 million Canadian's identifying as Black in 2021, Black Canadians make up 4.3% of the total population (Statistics Canada, 2024). Black Canadians are also reported to face one of the poorest health outcomes and experience the greatest health inequities and disparities amongst all other racial and ethnic groups in Canada (Abdillahi & Shaw, 2020). As Salami outlines, a combination of anti-Black racism through historical practices of slavery and immigration bans, as well as present-day practices of racism in almost all sectors of work and life, has had large consequential impacts on the lives of Black Canadians—especially in relation to health and wellness.

Health inequities for Black Canadians are seen in the incidence of diabetes and the level of care provided. The prevalence of diabetes among Black Canadian adults is 2.1 times the rate amongst White Canadians (Abdillahi & Shaw, 2020). As well, Black individuals typically develop diabetes at younger ages, leading to increased risks for other health complications and co-morbidities (Lipman, 2012). One reason for this may be the lack of tailored preventative strategies in place for assessing risk in Black communities. While Body Mass Index (BMI) is often used as a predictive factor for diabetes risk, the cutoff value for predicting diabetes is often not adjusted for different ethnic groups (Lipman, 2012). A lack of inclusive diabetes management programs may also impact prevalence, highlighting the need for culturally tailored programs that support patient engagement and effective care coordination (Veenstra & Patterson, 2015). Additional factors impacting prevalence in Black communities are shown in Figure 4.

To support culturally appropriate diabetes care for Black Communities in Canada, Salami makes the following recommendations:

- Consider the influence of anti-Black racism and how it reinforces and reproduces social determinants of health, including income inequity
- Customization of care is essential, as there is no one-size-fits-all approach to diabetes management—Black communities are diverse, and differences exist in beliefs, practices, and dietary habits amongst different communities
- Use simple language, visuals, and teach-back methods to help ensure patients understand their care plans, treatment options, and medication beliefs
- Healthcare providers must understand cultural food practices, provide education materials in multiple languages, and offer culturally sensitive nutrition counselling
- Must go beyond 'self' management; family involvement and social support are significant factors in diabetes management, requiring healthcare providers to understand the role of family and address social norms

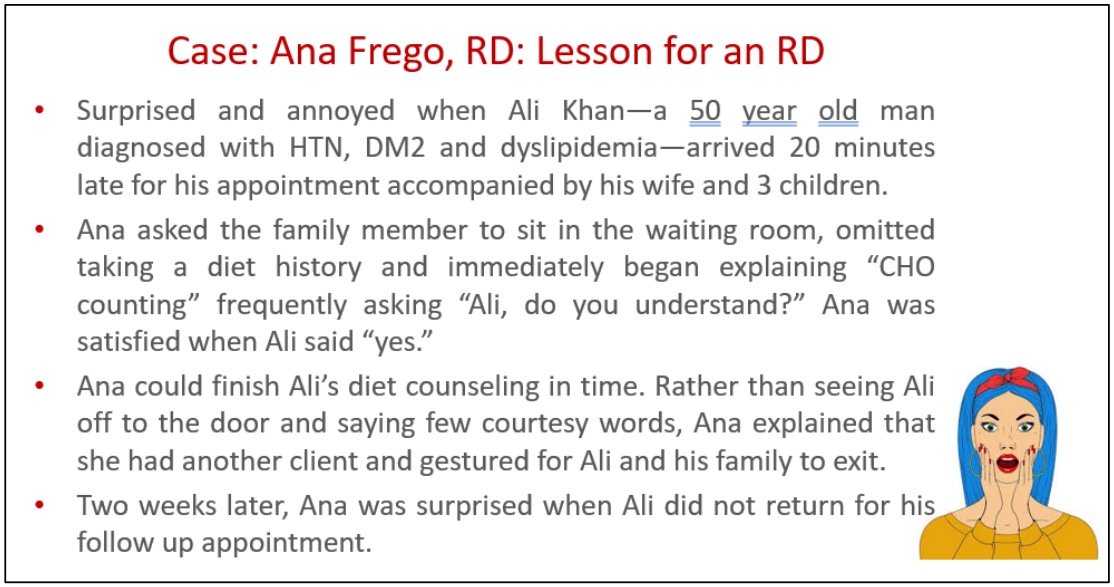
To learn more about Bukola Salami's research, visit profiles.ucalgary.ca/bukola-salami

Figure 4: Factors impacting diabetes prevalence in Black communities in Canada

4.5 Meera Kaur – The Intersection of Culture, Nutrition Equity, and Diabetes Care

Highlighting the mosaic of cultures, ethnicities, and languages that make up the diversity of individuals and communities across the country, Meera Kaur provided summit attendees with the ways in which culture, nutrition equity, and diabetes care intersect in Canada. Kaur emphasized that culture, which includes shared beliefs, values, customs, traditions, social behaviors, and more, shape societies, social cohesion and belongingness. When focusing on the intersection of culture and diabetes, it is important to understand the ways in which diabetes care should approach the individual— addressing systemic barriers and disparities faced, while also promoting fairness, inclusivity, and empowering self-management. By treating diabetes care with the intersection of culture in mind, Kaur emphasized that we can support the prevention of type 2 diabetes while also promoting equitable care for people living with diabetes. Kaur then explored case studies of diabetes care experiences, with a focus on how cultural competency (or incompetency) may impact care. The case, Ana Frego, RD: Lessons for an RD, is shown in Figure 5.

Figure 5: Case Study – Ana Frego, RD: Lessons for an RD (Registered Dietitian)



Here, Kaur highlighted the role in which behaviors and attitudes can impact the success of care provided. Current diabetes literature focused on lifestyle interventions often poses patients as 'non-compliant' when they do not follow an intervention set out for them. However, Kaur suggests that it is the job of the culturally competent dietitian to realize that when educating their patients about lifestyle interventions, consideration needs to be given to cultural values, health beliefs, typical ethnic diets, and health-related dietary practices. To support equitable and culturally appropriate diabetes care, Kaur highlighted key recommendations for the attendees to carry in their own work and beyond. Some of the recommendations include:

- Encourage training and education for cultural competency and make cultural competency required for all healthcare professionals
- Provide culturally tailored nutrition education, develop/translate resources and services in languages other than English
- Focus on applied research through the development of resources (ex. nutrition guides) that support the inclusion of nutritious and ethnic/culturally specific foods that are available locally and at a low-cost (i.e. bannock, paratha, corn-based African foods)

To learn more about Meera Kaur's research, visit home.cc.umanitoba.ca/~kaur/

4.6 Saania Tariq and Tucker Reed – The Intersection of Diabetes and Homelessness

The Calgary Diabetes Advocacy Committee (CDAC), led by Principal Investigator and Endocrinologist Dr. David Campbell and supported by research students and presenters, Saania Tariq and Tucker Reed, takes a community-based participatory research (CBPR) approach to understand and positively impact the lived experiences of people with diabetes, who have also experienced homelessness. In CBPR, community members are considered to be co-researchers, rather than study participants, and involve them throughout the entire research process, from study design to knowledge dissemination. The CDAC's collaboration with community members has allowed them to address topics important to the community and get to the heart of the issues impacting these individuals in their day-to-day lives.

People living with diabetes who are also experiencing homelessness or have a history of homelessness are at greater risk for complications associated with diabetes in comparison to the general population. A study led by Campbell found that the rate of macrovascular complications for individuals with diabetes who have experienced homelessness was 85% higher compared to the population that did not have a history of homelessness. As well, there was a 5x increase of hospitalization for glycemic emergencies and a 3x increase in skin/soft tissue infections for individuals with diabetes that had a history of homelessness in comparison to the population without a history of homelessness. This study highlighted the significant health outcome disparities that exist for individuals living with diabetes who have also experienced homelessness.

To support the target population, Dr. Campbell engaged people with diabetes who have also experienced homelessness (i.e., co-researchers) through focus groups and interviews to form the CDAC. Through ongoing roundtable discussions with co-researchers, the CDAC explored possible barriers to diabetes management while experiencing homelessness, depicted in Figure 6. Diabetes awareness, access to medications in shelters, and lack of safe spaces were considered to be the highest rated barriers.

Figure 6: Barriers to diabetes management amongst populations facing homelessness

To explore and address issues of community importance, CDAC undertook a participatory filmmaking project, to conceptualize and create a visual media piece on the lived experiences of people living with diabetes who face homelessness. The short narrative film, LOW, available through private screenings, has engaged over 1600 audience members to date. Pre- and post-surveys assessed audience members' knowledge, attitudes, and beliefs towards topics intersecting diabetes and homelessness, with results highlighted in Table 1. Notable results show that there was a significant increase in familiarity with diabetes, diabetes stigma, and barriers to medication storage and access in shelters for audience members post-screening. Moving forward, the group plans to continue screening the film through private forums to support continuous discussion and build meaningful dialogue surrounding issues impacting individuals with diabetes experiencing homelessness. As well, the group is hoping to continue to support populations across Calgary by providing mobile diabetes care for diabetes and related complications.

To learn more about CDAC and register for a future virtual screening, visit www.low-film.com

Table 1: Pre-and post-survey results for LOW film screenings

	Pre-Survey Score	Pre-Survey Mean	Post-Survey Score	Post-Survey Mean
How familiar are you with medication storage and access in shelters?	342	1.6930	514	2.5445
How familiar are you with diabetes stigma?	518	2.5517	666	3.2970

4.7 Natalie Riediger –The Intersection of Diabetes and Nutrition Policy

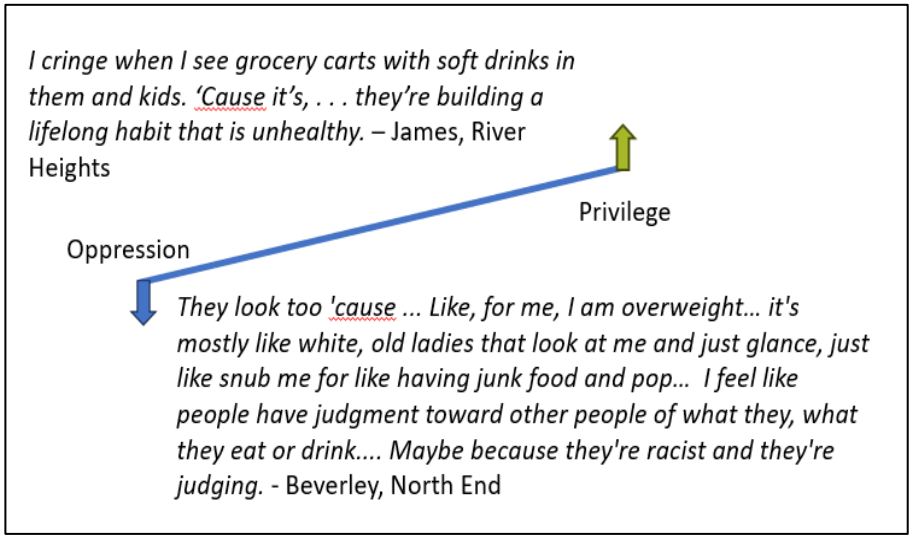
Through a social constructionist lens, Natalie Riediger's research explores the intersection between health and food equity. This theory of knowledge, focusing on the ways in which the systems we live in create and maintain the status quo, supports Riediger's decolonizing approach to understanding the power structures, spatial structures, and social narratives that shape our food systems and associated health inequities. Riediger's research focuses on the ways in which our knowledge systems, economic systems, food systems, legal systems, and taxation systems (as power structures) maintain control over land and food resources—while shifting responsibility for health, and by extension, stigma, onto the individual. Riediger's applied research focuses on sugar-sweetened beverages (SSB) taxes, as she highlights the ways in which taxation systems can further perpetuate stigma and "responsibilization," where responsibilities to support public health shift from the government to the individual (Bommel & Hoffken, 2021). SSB taxation has been discussed and proposed throughout Canada and has recently taken affect in Newfoundland and Labrador and (Waugh et al., 2022). Qualitative interviews conducted in River Heights, Manitoba, a population that generally reflects the affluent, liberal, and majority white, dominant group of Canadian society, as well as with several Indigenous communities, explored perceptions around SSB – including their consumption and health implications of said consumption (Waugh et al., 2022). Riediger provided a brief overview of the findings from this study, emphasizing the presence of both privilege and oppression in the ways individuals view SSB and associated taxation, and their perception of those who consume SSB. Riediger shared two quotes from her group's research, highlighting the stigma and judgement in both the individual speaking from a place of privilege and the individual speaking from a place of oppression.

Riediger also highlighted the manner by which weight stigma intersects with perceptions of SSB and SSB taxation, and the parallels of common stigmatization of class, race, weight, and parenting that is also seen in diabetes stigma. She presented some of her research regarding how stigmatizing narratives of 'non-compliant' individuals with type 2 diabetes are present in academic literature, i.e. knowledge systems, a critical power structure

As Riediger continues to explore health and food equity in her work, she shares that key areas of discussion and research will include exploring literacy as a social determinant of health, and social media as a site of circulating narratives regarding diet, health, and bodies.

To learn more about Natalie Riediger's research, visit umanitoba.ca/agricultural-food-sciences/food-and-human-nutritional-sciences/natalie-riediger

Figure 7: Perceptions on sugar-sweetened beverage (SSB) taxes in River Heights, MB (Waugh et al., 2024)



5.0 Breakout Discussions

Breakout room discussions with summit attendees focused on supporting the following objectives of the summit:

- Explore barriers to understanding, diagnoses, prevention and care in Social Determinants of Health-impacted and health-equity seeking communities
- Discuss next steps to applying a health equity systems level approach to all diabetes initiatives and programs

Through the review of case studies highlighting diverse and unique experiences to diabetes care, access, management, and treatment, attendees were asked to discuss the current state of diabetes care in their province and actionable steps that can be taken to support equitable diabetes care. An example of a case study and discussion questions is provided below:

Case Study #1: Addressing Diet and Food Insecurity

Angie is a 45-year-old woman who has been recently diagnosed with type 2 diabetes. She is a single mother with two children, supporting her family on a single household income. Due to primary care shortages, she currently has no family doctor or dietitian to support her and instead relies on online interventions and resources to support herself. However, due to her many competing priorities and responsibilities, she has struggled to find the time, energy, and resources, to focus on the lifestyle interventions online diabetes management resources insist she makes. She is bombarded with resources that emphasize changing her diet to remove "bad foods" and incorporate "good healthy foods", which she finds to be opposed to her more intuitive form of eating. As well, while she would like to incorporate the "healthy" options into her diet, she has a limited budget which has only been further exacerbated due to rising food costs. Many of these online diabetes management resources also suggest she make a diet plan with her dietitian, which she does not have. Feeling like she is making 'bad' food choices, Angie struggles mentally with her chronic disease diagnosis and feels that she is doing a 'poor' job at her diabetes management, which has only been further enforced by criticisms on her diet from extended family.

Discussion Questions:

1. *How does the current state of diabetes care available in your province facilitate or limit/prevent meaningful diabetes healthcare for individuals who face one or all of the social determinants faced by (name of individual in case study)?*
2. *What actionable steps can be taken to support equitable diabetes care for individuals impacted by one or all of the social determinants of health outlined in this example? Consider tangible steps at the patient care and government level.*

Key reoccurring facilitators and barriers for diabetes care in Western Canada are highlighted in Table 2, as well as actionable next steps provided by summit attendees.

Table 2: Facilitators, barriers, and next steps for equitable diabetes care in Western Canada

Barriers
• Assumption that self-care and self-management is accessible and feasible for all • Limited primary care resources and/or quick and rushed interactions with medical staff • Lack of support in rural regions, including the cost to travel to urban centers for care • Need for better models for virtual care • Translation services are not supported, available, or ideal • Lack of cultural sensitivity and competency training provided • High barriers for accessing support that require knowledge and awareness of the intervention and the processes involved in accessing care • Income-testing is a barrier to care • Gaps in coverage, especially amongst low-income individuals
Facilitators
• Language services, when provided • Community engagement in diabetes care, management, and treatment • Education that focuses on equity, diversity, and inclusion • Coverage for glucose monitors • Financial support systems such as Assured Income for Severely Handicapped (AISH) in Alberta
Next Steps
• In the primary care environment: reduce shame, increase patient-centered care, and offer suggestions for treatment and management that are in line with patient realities • Government policy changes are needed to improve access for medication and supplies • Support increased internet access across the country to enable virtual care • Improve support for community-based services for older adults living with diabetes and other chronic conditions • Remove barriers to physical exercise facilities and spaces • Explore culturally competent practices in the primary care environment • When possible and applicable, apply a family-based approach to care • Support funding models for primary care that would allow for longer appointment times • Form policies that support all individuals with diabetes, in addition to providing targeted resources for those most in need, as current policies wait until low-risk individuals become high-risk to begin providing meaningful support • Support care providers in their ability to navigate and provide resources for patients • Shift our focus around chronic disease from the individual to system level influences

6.0 Reflections

At the end of the summit, attendees were asked to reflect on the presentations and discussions of the day. Using the online brainstorming tool, MentiMeter, attendees were asked to anonymously answer the following questions, with a select number of responses to each question provided below:

1. **Reflecting on the principles of health equity, how can we define a successful diabetes intervention?**

   "Not a universal definition as it will never encompass everything that it needs. It needs to respect the complexities while putting honus [sic] on system level changes that honor individuals."

   "Meaningful feedback and perception of care from patients as well as improved quality of life."

   "One which ensures that all benefit from the intervention, and especially those who face forms of social and structural disadvantage, thus narrowing the gap in outcomes achieved."

   "Health equity must be fundamental and overarching principle guiding all diabetes interventions. This requires population management and outcomes, data access, and analytics, as well as data acquired (including PREMS and PROMS) at point of care."

2. **What resources or supports do you need to move forward with equitable change in your own work?**

   - *Funding (including consistent funding and national funding)*
   - *Need to engage government*
   - *Continued networking, ongoing conversations, and opportunities to connect*
   - *Investment in Community*
   - *Resources for dialogue-based methods*
   - *Culturally competent education materials for patients*
   - *More training*

7.0 Next Steps

The Western Diabetes Health Equity Summit granted one of the first opportunities in Canada for individuals in the diabetes care and health equity space to connect, learn, share, and discuss next steps towards achieving equitable diabetes care. As Diabetes Canada and the SMIDF team prepare for the next Health Equity Summit, key feedback from the Western Summit will guide the planning and implementation of the event forward. A common theme for feedback from Western Summit attendees was the excitement and desire to discuss **action**. The SMIDF team hopes to expand their efforts to support equitable diabetes care across Canada, and advance discussions around actionable steps to preventing and removing the barriers to equitable diabetes care.

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