Pacific Community
Communauté du Pacifique

# Guidelines for the Development and Strengthening of National Diabetes Associations

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# Contents

# Preface

A recent Pacific Community (SPC) survey on the status of diabetes associations in the Pacific revealed a general lack of good governance, weak management structures and limited sustainable funding mechanisms, shortcomings echoed during the 2017 Inaugural Pacific Diabetes Associations Meeting in Fiji. The recognised need for support to diabetes associations in the Pacific prompted development of these guidelines in order to assist community groups and health care workers both to **strengthen existing diabetes associations** and to **establish and manage new diabetes associations** in the Pacific. These guidelines are only intended as a framework. As the cultures and political and economic systems vary throughout the islands, the guidelines should be tailored to each unique context and culture, enabling users to extract only that material relevant to them. Where possible, diabetes associations in the Pacific recognised for their exemplary organisational structure and governance are used as examples of good practise in this document.

***What is an Association?***
*In general, an association is a group of people (known as the association members) who are motivated by a common purpose. Drawing on a common vision, they come together voluntarily, to share their resources, skills and experience and to provide services to the association members and their respective communities.*

# Acknowledgements

These guidelines have benefited significantly from discussions with, and information provided by, Pacific Island country representatives who attended the Inaugural Pacific Diabetes Associations Meeting convened by SPC in 2017. Special acknowledgement is given to Diabetes Fiji, Kwajalein Diabetes Coalition, Guam Diabetes Control Coalition and Bougainville Diabetes Association for sharing copies of their documents, which are used as examples throughout these guidelines. Information is also drawn from diabetes associations further afield, including Diabetes Australia, Diabetes New Zealand (NZ), Diabetes UK, Diabetes Canada and Diabetes USA.

Acknowledgement is also due to SPC for the initiative and support in development of these guidelines. Special thanks go to Dr Si Thu Win Tin, Non-Communicable Diseases (NCD) team leader, and to Ms 'Elisiva Na'ati, Ms Karen Fukofuka and Ms Solene Bertrand, members of the NCD team, for their commitment to a Pacific free of diabetes.

# 1. Introduction

Diabetes is the face of Non-Communicable Diseases (NCD) in the Pacific where most residents know at least one person living with the disease. The human face is an important part of identity through which facial expressions often reveal underlying concerns. Similarly, diabetes can be the first expression of issues related to NCD that are otherwise hidden. By managing diabetes, other NCD are also managed.

NCD remain the number one health and socio-economic challenge facing the Pacific territories with diabetes, which has been described as a major socio-economic development challenge of this century, leading all NCD in the Pacific. This translates into a significant social and economic burden for many Pacific families. Amputations, blindness, stroke and kidney failure are common complications of diabetes in Pacific communities. Unemployment or inability to work in the garden and absences from school in order for children to care for their sick parents each demonstrate the impact diabetes has on the lives of Pacific individuals and families. These realities are consequences of socio-economic, environmental and political factors that exceed the capacities of individual families.

A holistic approach is required, including mobilisation and engagement of key stakeholders. This includes diabetes associations, which have great potential to support and make a difference in the lives of people with diabetes.

# 2. Purpose of diabetes associations

Diabetes associations are typically formed in response to unmet needs in the community that neither the government nor private sector is addressing. Such associations represent the social capital of a community, bringing out the goodwill, fellowship and sympathy that allow people to trust each other and to work together.

Diabetes is often assumed to fall under the responsibility of the government (department of health, clinics and hospitals), similar to other diseases. As a chronic condition associated with lifestyle choices and environmental conditions, however, diabetes calls for community engagement.

Although Type 2 diabetes is preventable, when it arises, it requires early detection and daily management. While doctors play a central role in diagnosis and treatment, diabetes associations can play an important role in prevention of Type 2 diabetes and control of both Type 1 and Type 2 diabetes, as members of the community share the same challenges in their daily lives. Family, friends and people with diabetes from the same communities can be mobilised through diabetes associations to share experiences and support one another. Further, the association can form a partnership with local clinical teams as well as other sectors beyond health to support people with diabetes and foster better health outcomes.

Diabetes associations can advocate for people with diabetes at different levels of the society – from the government to the community. They can form and support a valuable partnership with medical and hospital services ensuring the needs of people with diabetes are appropriately addressed.

**General considerations for establishment of diabetes associations:**

- Type 2 diabetes is preventable but requires team efforts for early detection and prevention.
- Type 2 diabetes prevention and control are directly related to lifestyle choices that are largely driven by socio-cultural, environmental and economic factors.
- Self-care is a critical component of diabetes and patients must be supported to manage their condition daily.
- Diabetes associations can play a very important role in prevention and control through advocacy efforts, including by providing a voice for people with diabetes at different social and political levels of the society.
- Diabetes associations can build strong partnerships with clinical teams ensuring people with diabetes are at the centre of diabetes services.

# 3. Roles and responsibilities of diabetes associations

The major role and responsibility of a diabetes association is to support and serve the needs of people with diabetes. Specific functions that are common to diabetes associations worldwide are outlined below.

- **Advocacy:** Ensure the perspectives of people with diabetes are heard at the government level as well as in societies, churches and communities.
- **Awareness-raising:** Foster improved understanding of diabetes causes and consequences through provision of information about the disease, and encourage public support.
- **Community Engagement:** Engage the community to be a part of the solution to diabetes.
- **Education/Training:** Provide education and training for people with diabetes, and their families and carers, for health professionals, and for the community as a whole.
- **Fundraising:** Fundraise to ensure independence and sustainability of the association.
- **Research:** Promote and support intervention research on diabetes to inform good practise.

**Table 1: Examples of roles and responsibilities of diabetes associations**

| Name of association | Role and responsibility of the association |
|---|---|
| Guam Diabetes Control Coalition | • Advocate and promote training of medical professionals on diabetes prevention and curative services.<br>• Organise and run community awareness campaigns on the risk factors for diabetes.<br>• Advocate for sustainable funding of diabetes programmes.<br>• Promote a healthy social environment for healthy living.<br>• Facilitate and support community education and training on diabetes care and management. |
| Diabetes Fiji | • Promote and share information on diabetes causes, treatment and management.<br>• Work with media (*e.g.* radio, newspaper, television) to educate communities through dissemination of information on diabetes.<br>• Support availability of suitable food products for people with diabetes.<br>• Facilitate and establish outreach programmes for people with diabetes.<br>• Organise and provide screening opportunities for those at high risk of diabetes.<br>• Undertake fundraising events. |
| Diabetes UK | • Provide care and support to help people manage their diabetes effectively and confidently.<br>• Conduct campaigns for and with people with diabetes to improve health services.<br>• Undertake research on prevention and care of diabetes.<br>• Create a knowledge-sharing network to help improve the lives of people with diabetes.<br>• Involve people affected by, and at risk of, diabetes to help shape the services available. |

# 4. Assessment of diabetes associations

This short assessment checklist is designed to help identify areas where strengthening may be needed. It is also useful when developing a new national diabetes association.

**Table 2: Checklist to identify status of diabetes associations**

| Description | Yes | No | Comments |
|---|---|---|---|
| 1. An association is established (indicate date formed) | | | |
| 2. Board/governance officials and members are selected | | | |
| 3. A management team serves the association full time | | | |
| 4. The management team serves voluntarily | | | |
| 5. Constitution/bylaws are written | | | |
| 6. Membership registration is obtained | | | |
| 7. Regular meetings are held as per constitution/bylaws | | | |
| 8. A work plan is drafted and ongoing activities are held | | | |
| 9. Fundraising events are held regularly as per work plan | | | |
| 10. Annual budget is prepared to implement work plan | | | |
| 11. Ministry of health contributes to the annual budget | | | |
| 12. Other funding sources are available | | | |

# 5. Forming a diabetes association

Although forming an association may seem easy, maintaining one is challenging and requires specific measures from the start:

- **Step 1: Initiate an informal discussion.** Bring together a group of people with similar interests in combatting diabetes in the Pacific and, together, explore the possibility of forming a diabetes association.
- **Step 2: Initiate a formal meeting.** Identify and recruit individuals who possess the skills, experience and availability necessary to manage the association.
- **Step 3: Form a committee.** Form an organising committee to help establish the association.

- **Step 4: Establish the board of governance.** Establish a board and management team to oversee the association and its management.
- **Step 5: Develop a constitution.** Articulate the association's vision and develop governing documents, including a constitution, reflecting this vision.

## Step 1: Initiate an informal discussion

Hold an informal discussion with friends and colleagues with whom you share an interest in diabetes. Present the idea of forming a diabetes association, and begin planning a formal meeting to discuss the prospect of such an association.

## Step 2: Initiate a formal meeting

Call a meeting inviting a broad spectrum of community members, including recognised leaders, with the aim to gather widespread support for the association and to create a core group that will become the organising committee for the association. Ensure those chosen are able to commit their time to the association. Designate a volunteer among the group to act as chairperson and another to record notes of preliminary and ongoing discussions. The initial formal meeting should focus on one agenda item (*e.g.* recruiting and identifying individuals who are both capable and willing to serve on the organising committee). Determine the number of people needed to form the organising committee. A group of 5 to 7 people may be considered initially, with the understanding that the committee size may grow, if necessary, as people learn of the committee. Aim not to exceed 15 committee members.

## Step 3: Form a committee

The committee will set in motion the process of forming the association. At this stage, it can be useful to invite and request support from individuals and groups with particular expertise or experience, including those from the community, ministry of health, legal and economic advisers, retired individuals and individuals who work elsewhere but would be willing to volunteer their time and expertise to the cause.

## Step 4: Establish the board of governance

This is a critical step in the development of an association, regardless of whether it is new or has been in operation for some time. It is important to adhere to the principles of good governance with respect to the decision-making process and implementation (or not). There are eight characteristics of good governance (listed below) for consideration whilst setting up a board of governance and management team. Details of good governance are provided in **Appendix 1.**

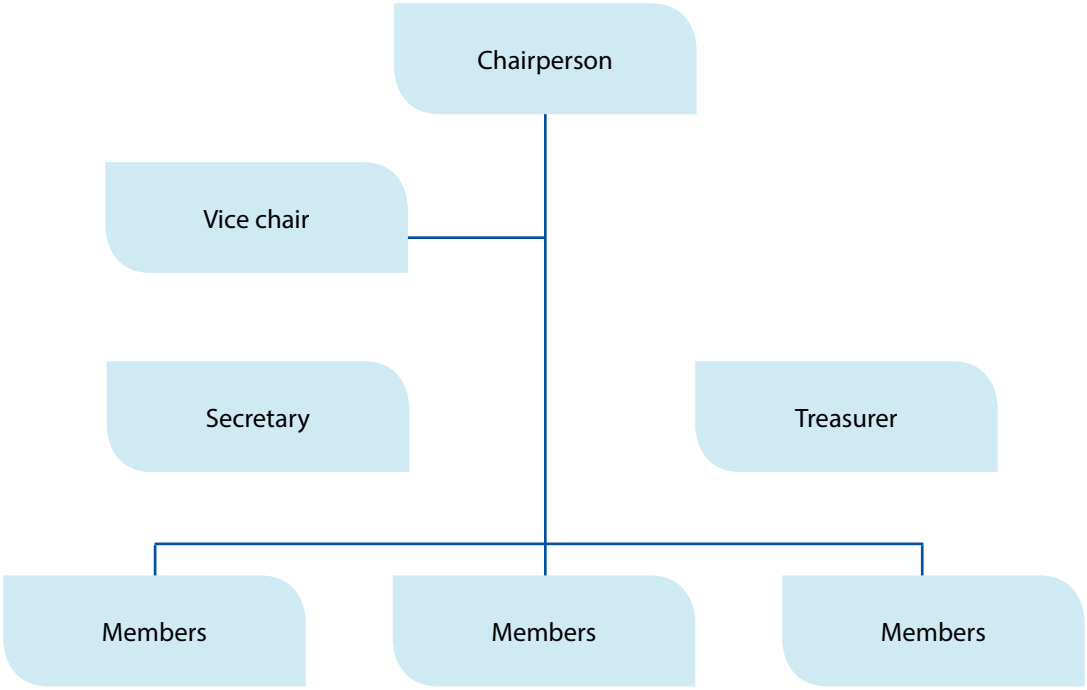
- Participatory
- Consensus oriented
- Accountable
- Responsive
- Transparent
- Effective and efficient
- Equitable and inclusive
- Follows the rule of law

The organising committee may wish to call a meeting to select members to the board and to establish a team responsible for managing the affairs of the association. Board members of other local associations may provide useful advice and support. Local knowledge is particularly critical with respect to lessons learned and to best practises relevant to the purpose and mission of the diabetes association. As the association becomes formalised, these proceedings will be included in the bylaws or constitution. It may be helpful to explore a structure for the association to take.

**a) Board of governance**

The executive members of the board of governance include the Chairperson, Vice-chair, Secretary and Treasurer. In addition to the board of governance, there will be at least 3 other board members.

An example of a traditional structure for a board is provided below.




**i. Executive responsibilities**

General responsibilities expected of association executives are outlined below. These responsibilities should be adapted to the unique circumstances of each association.

**Chairperson:**

- Report and be accountable to the board
- Chair all board meetings
- Review and sign minutes of board meetings
- Manage and provide leadership to the board
- Liaise between the board and management team

- Develop and set agendas for meetings of the board
- Assess and make annual recommendations regarding the work of the board
- Call special meetings of the board, where appropriate

**Vice chair:**

- Assist the chairperson with all association duties and responsibilities
- Act as chairperson, assuming all chair responsibilities when the chairperson is absent

**Secretary:**

- Call meetings of the association
- Prepare meeting notices and agendas in consultation with the chairperson
- Take minutes during all meetings
- Maintain copies of all correspondences and documents related to the association
- Maintain the register of association members

**Treasurer:**

- Manage cash flow, reconcile bank statements and manage investments
- Facilitate preparation of annual budget
- Prepare financial reports for the board and those required by banks and government agencies
- Support board members by translating financial concepts and information relevant to the country's laws

### ii. Role of the board

The following are general guidelines for functions of the board. Associations can improve upon these guidelines and adjust them to suit their own unique situations.

- Develop and endorse appropriate vision, mission, cultural value and practise
- Develop constitution and board rules
- Appoint CEO and management team
- Approve association's business and development plans
- Monitor progress against plan
- Establish a strategy, allocate resources and evaluate the association's processes

### iii. Board member selection and term of office

- Select an odd number of board members for voting purposes
- Prioritise members who are recognised and vocal in the community, where possible
- Make sure the board members represent the diversity of the community
- Prioritise those who have the time and, where possible, personal experience with diabetes
- Specify the term length and limits in the association constitution. (Board members typically serve for 2-3 years and may renew their term of service for a second term, lending to a maximum of six years.)

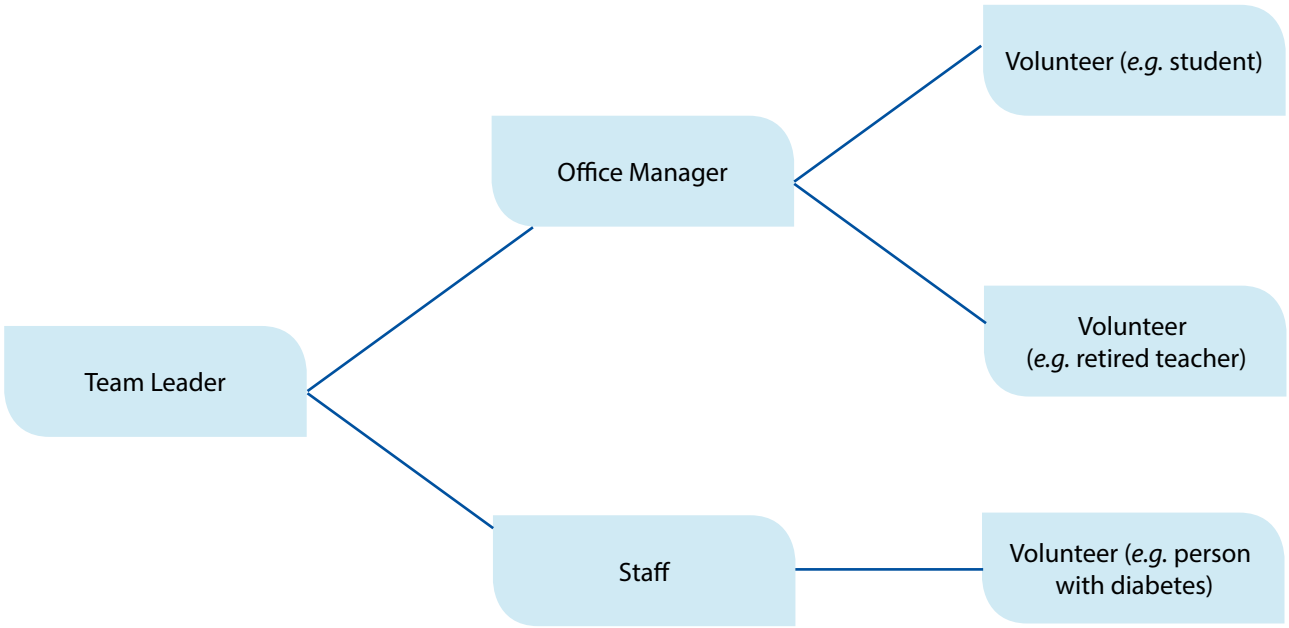
## b) Management team

The management team will manage the day-to-day activities of the association. The number of management team members will depend on the size of the association and the amount of work and resources available. Nonetheless, a management team should be comprised of, at least, three members.

### i. Management structure

An example of the management structure of an association is provided below:

- Team Leader
- Office Manager
- Staff (communication/fundraising)



### ii. Functions of the management team

- Serve as a liaison to the board
- Help clarify and implement the strategic plan
- Develop and maintain key relationships with:
  - association members and individuals living with diabetes;
  - community;
  - funders;
  - health providers; and
  - partners
- Oversee the association budget and manage its finances
- Ensure other duties as directed by the board

Once the structure of the association is in place, a method of management must be selected. There are many options, each with its own advantages and disadvantages. Volunteers tend to run most diabetes associations in the Pacific, often working full-time with local ministries of health or other government ministries. Associations may start with volunteers, offering the advantage of immediate and personal understanding of the needs and issues of the association as a result of the volunteer's individual interest and motivation. However, given volunteers are unlikely to be able to commit the time needed, it is recommended that management teams be comprised of paid positions, even if the initial management team commences voluntarily.

### iii. Selection of the management team

Selection of the management team is the responsibility of the board. A proper recruitment process (including qualifications, duration of contracts, evaluations, renewals and terminations, etc.) needs to be put in place, regardless of whether or not the management team is remunerated. A similar system should be put in place for all individuals, including volunteers, working on behalf of the association.

## Step 5: Develop a constitution

Together with board members and the management team, the association's vision, purpose, mission and constitution or bylaws should be put in place to guide the association's activities.

### a) Reasons for a formal constitution

**It is important to write the association rules into a formal constitution in order to:**

- Provide clear guidelines as to how the association will work
- Safeguard the interests of members against each other and ensure ongoing success
- Provide a record of terms to which association members have agreed
- Allow new members to know and understand what is expected of them

- Help resolve disagreements as to how the association should be managed.
- Protect against members committing the association to any contract or expense beyond the constitution.

## b) General components of a constitution

### i. Name of association

The name of the association should reflect the national identity and purpose of the association enabling everyone to understand its general location and purpose. Existing diabetes association names include the following: Diabetes Fiji; Guam Diabetes Control Coalition; and Bougainville Diabetes Association.

### ii. Objectives

This clause expresses the purpose and mission of the organisation.

The **Purpose** should consist of a one-line statement of the reason the association is needed and its vision. Examples of association purposes are provided below.

- People of Guam are diabetes free (Guam).
- People with and at risk of diabetes lead a healthy and productive life (Fiji).
- Prevent diabetes and its complications (Kwajalein Atoll, Marshall Islands).
- A world where diabetes can do no harm (UK).

The **Mission** should consist of one or two sentences) and be "feasible, motivating, and distinctive," as exemplified in the mission statements provided below.

- Diabetes free through collaboration, innovation, commitment and trust. (Guam)
- Better health outcomes through better care, healthier environments and education for people with or at risk of diabetes. (Fiji)
- Promote policy, advocate for better access to care and treatment for people at risk of developing diabetes. (Kwajalein)
- Know diabetes. Fight diabetes. (UK)

### iii. Powers

This clause sets out what the association is permitted to do in pursuit of its objects. For example, an association has the power to:

- schedule annual general meetings and extraordinary general meetings in order for all members to meet regularly;
- make decisions that require the vote of all members at these meetings;

- promote, encourage, carry out or commission research, surveys, studies or other work to be disseminated upon completion;
- provide services for people with diabetes and those who care for them; and
- employ paid or unpaid agents, employees and professional or other advisors, subject to the association's constitution.

### iv. Membership

This clause describes the type of individual or organisation eligible to apply for membership, including:

- categories and qualifications;
- application and resignation procedures; and
- membership privileges.

For example, Diabetes UK includes two kinds of membership: 1) supporting membership (*e.g.* non-health care professionals, people with diabetes, etc.); and 2) professional membership.

### v. Board of governance and management team

This clause describes how the board of governance and management team will manage the organisation and, in particular, the following:

- the board size;
- qualifications expected of board officers;
- duties and terms of office for each of the board officers; and
- the method to elect the first and subsequent board of directors.

For example, the board of governance and management team of Diabetes Fiji include the parameters outlined below.

- Board size: minimum of 4 board officers.
- Board officer qualifications: Individuals must be of high standing in the community and fully support the aim and objectives of the association.
- Duties:
  - Ensure all objectives of Diabetes Fiji are achieved.
  - Scrutinise and ensure strategies are implemented.
  - Hire and fire paid staff in consultation with the board of management.
  - Scrutinise and comment on management's quarterly report.
  - Act as arbiter in all disputes within the operation of Diabetes Fiji.
  - Scrutinise the annual audited financial report.
- Term of office: Each board officer shall serve for a period of three years and be eligible for re-election at the end of this tenure.

### vi. General meetings

This clause states when the annual general meeting will be held and what business is to be discussed.

- Annual reports
- Finance report/auditor appointment
- Election of board members and the committee
- Provisions for extraordinary or special general meetings

### vii. Rules and procedures for all meetings

The rules and procedures should state:

- who chairs the meetings in the absence of the chairperson;
- if the chairperson is to have a second or casting vote;
- which board member will keep the minutes of all meetings;
- description of standing committees;
- nomination and election procedures;
- procedures for filling vacancies;
- procedures for amending bylaws;
- indemnification of board and officers; and
- procedures for dissolution of the association.

### viii. Finances

This clause should make clear that the funds of the association can only be used to further the objectives of the association. It will also state if the accounts of the association are to be audited or independently examined.

### ix. Amendments to the constitution

Only members may alter a constitution, and any such alterations must only be made during special general meetings or annual general meetings. Advanced notice of such meetings and anticipated changes to the constitution must be given to all members.

### x. Dissolution

A clause must be included on dissolution, outlining what happens if the association ceases to function and, in particular, what will be done with any funds or assets remaining after all liabilities have been met.

# 6. Strategies and priority focus areas

To ensure the best results for association members and, in particular, people living with diabetes, it is important to remain focused on priority areas identified during the formation of the association. Although each association will have its own unique priority areas, most associations tend to focus on prevention of complications, diabetes care management, capacity building for caregivers, resource provision, healthy public policy development and research support. The following diabetes associations exemplify the diverse range of priority areas they may have:

- Diabetes Fiji prioritises foot care and addresses other aspects of diabetes care, prevention of complications and self-management practises;
- Diabetes UK focuses on diabetes research, prevention of obesity and type 2 diabetes, diabetes care and support; and
- Diabetes Canada focuses on development of healthy public policy, community-based health promotion programmes, accessible health services for prevention of diabetes in high-risk individuals, education, research and surveillance.

# 7. Potential collaborative initiatives and support

During the Inaugural Pacific Diabetes Associations Meeting in 2017, a number of development partners, academic institutions and Pacific associations expressed interest and willingness to form collaborative partnerships of knowledge sharing and resource mobilisation. Examples of collaborative partnerships and support offered by some of the agencies present are outlined below.

- **SPC:** policy development; advocacy; training; guidelines; health promotion resources; operational research; etc.
- **WHO:** guidelines; various resources (*e.g.* "PEN" package); etc.
- **UNDP:** policy support; etc.
- **Fred Hollows Foundation:** eye care service; training; etc.
- **FNU:** professional placement; research; etc.
- **Health Promotion Forum of NZ:** workforce capacity building; etc.
- **Otago University:** research; etc.
- **Diabetes NZ:** South-to-South collaboration; etc.
- **Diabetes Australia:** South-to-South collaboration; study tours from Pacific Island diabetes association; etc.
- **Diabetes Fiji:** training; workshops; diabetes resources; etc.
- **Guam diabetes control coalition:** community garden resources; train-the-trainers resources; etc.

Many diabetes associations have developed resources, covering various issues related to diabetes, for information and knowledge sharing with their members. Most are available electronically and can be accessed through the respective agency websites. **Appendix 2** provides examples of available resources from diabetes associations.

# 8. Financial support and fundraising for associations

An important determinant of an association's success is the sustainable funding mechanism. As stressed during the Inaugural Pacific Diabetes Associations Meeting, funding is a major barrier to the progress of all such associations.

Current funding is primarily provided by the respective ministries of health. However, to date, budgets have not been specifically allocated to diabetes associations. Additional funding support comes from development partners, which include the World Health Organization (WHO), SPC, International Diabetes Federation (IDF) and World Diabetes Foundation (WDF), as part of special events such as World Diabetes Day (14 November 2018).

Well-established associations make it a priority to be financially independent and employ a diverse array of strategies to facilitate access to a variety of funding sources. These strategies include:

- membership fees;
- grants and donations from government and donor agencies;
- public donations; and
- fundraising and charitable activities.

Many charitable organisations rely on donations from the public, as people respond favourably when the cause is noble and organised well. Pacific diabetes associations may also solicit public donations but need to be creative and utilise culturally appropriate ways of fundraising. It is common practise within Pacific cultures to give and share resources with those in need. Fundraising, thus, should be viewed as an empowering mechanism rather than an obligation forced upon the public. Different approaches should be employed providing an opportunity for everyone who is willing and able to engage meaningfully through their contribution to the cause.

To engage the public in financing diabetes care, a more systematic approach and strategic planning and management is essential. In-kind donations (time, technical expertise) are valuable resources that should be considered alongside cash donations. Volunteers are also critical resources that can be mobilised to support fundraising initiatives. A realistic budget should be carefully developed, and experts should be consulted unless an existing team member already possesses the skills/knowledge sought.

For the association to be successful, it is critical to identify specific priority focus areas alongside the resources needed to address them in a sustainable manner. Examples of diabetes association's funding sources and expenses are described in **Appendix 3.**

# 9. Tracking the progress of diabetes associations

It is critical to keep track of the progress as well as any shortcomings with respect to the objectives and achievements of the association in order to ensure the association is achieving what it set out to do and that members are held accountable for meeting these objectives. An accountability mechanism is, therefore, necessary to help keep the association in line with its mission.

Monitoring and evaluation allows associations to adjust or redirect their efforts in order to achieve desired outcomes. Monitoring and evaluation mechanisms should be established at the same time as the association is being developed. Instead of carrying out an evaluation only when an association is confronted by challenges, a monitoring and evaluation checklist will alert the management team and members to any shortcomings or particular successes, enabling the association to continuously learn and grow.

A monitoring and evaluation mechanism should include output and/or impact indicators to track progress and elicit particular shortcomings or successes. Examples of key output and impact indicators for diabetes associations are provided in **Appendix 4.**

## 10. Risk mitigation and sustainability

Successful diabetes associations are realistic in their objectives, identify potential risks, and have a mitigation plan in place. This enables diabetes associations to be sustainable in the long term. Common areas of concern include finances, strategies if income fails to meet projected targets or if associations lack the capacity needed to deliver as planned. Examples of potential risks and recommended solutions are provided in **Appendix 5.**

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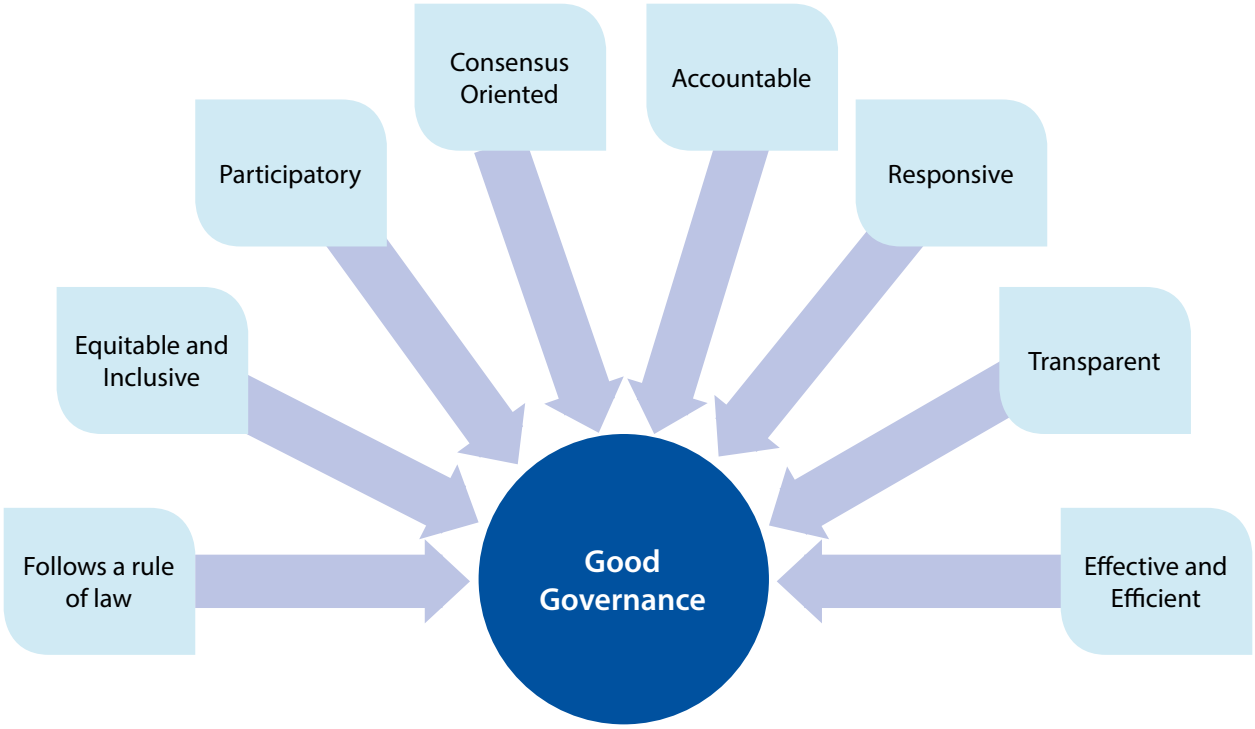
# Appendices

## Appendix 1: Characteristics of good governance (UNESCAP, 2018)




Good governance is defined by the United Nation as the process of decision-making and the process by which decisions are implemented (or not implemented). There are eight characteristics of good governance:

**(1) Participatory**: Participation is key and encouraged.

**(2) Consensus oriented**: Several actors and as many viewpoints are respected.

**(3) Accountable**: The association is accountable to those who will be affected by its decisions or actions.

**(4) Transparent**: Decisions taken and their enforcement follow rules and regulations. Information is freely available, accessible and easily understandable to those who will be affected by such decisions and their enforcement.

**(5) Responsive**: Institutions and processes aim to serve all stakeholders within a reasonable timeframe.

**(6) Effective and efficient**: Processes and institutions produce results that meet the needs of stakeholders while making the best use of resources at their disposal.

**(7) Equitable and inclusive**: All members, particularly the most vulnerable, feel that they have a stake in the association and do not feel excluded in any way.

**(8) Follows the rule of law**: Fair legal frameworks are in place and enforced impartially.

## Appendix 2: Examples of available resources from established diabetes associations

| Name of association | Available resources |
|---|---|
| Diabetes Australia | • Diabetes and self-management<br>• Diabetes and pregnancy<br>• Gestational diabetes<br>• Health and well-being<br>• Nutrition and exercise<br>• Older people with diabetes<br>• Young people with type 1 diabetes<br>• Aboriginal and Torres Strait Islander people<br>• People from culturally and linguistically diverse communities<br>• Carers for people with diabetes<br>• Professional resources: Best practise guidelines; tools and eLearning; reports on prevention, diagnosis and management of diabetes; and news on current diabetes research |
| Diabetes NZ | • Diabetes and how to care for your feet<br>• Diabetes and physical activity<br>• Pre-diabetes<br>• Healthy food choices<br>• Diabetes and insulin<br>• Staying well with type 2 diabetes<br>• Take control toolkit<br>• Diabetes wellness publication<br>• Resources for youth living with diabetes |
| Diabetes Canada | • Blood sugar and insulin, dental care, diet and nutrition, exercise, foot care, general tips, heart health and weight management<br>• Living with type 1 diabetes, type 2 diabetes, gestational diabetes, and pre-diabetes<br>• Complications of diabetes<br>• Taking charge of diabetes<br>• Recipes<br>• Kids, teens and diabetes<br>• Pregnancy and diabetes |

## Appendix 3: Examples of funding sources and expenses for diabetes associations

| Name of association | Funding source and expenses |
|---|---|
| Diabetes Australia | **Income:**<br>• Government grants and affiliations = 85%<br>• Donations = 11%<br>• Commercial partnership<br>• Fundraising = 2%<br><br>**Expenses:**<br>• Employee benefits = 7.3%<br>• Depreciation and amortisation<br>• National Diabetes Services Scheme = 67%<br>• Other expenses including fundraising = 14% |
| Diabetes NZ | **Income:**<br>• Revenue from exchange transactions = 31%<br>• Non-exchange transactions<br>• Donations = 6%<br>• Fundraising = 12%<br>• Rendering services – MoH = 10.8%<br>• Grants = 38%<br><br>**Expenses:**<br>• Revenue associated with revenue generation/fundraising = 38%<br>• Operating expenses = 62% |
| Diabetes UK | **Income:**<br>• Donations and legacies = 79%<br>• Other trading activities = 13%<br>• Income from investments = 0.8%<br>• Income from charitable activities = 6.8%<br><br>**Expenses:**<br>• Expenses on fundraising = 23%<br>• Research = 17%<br>• Managing diabetes = 19%<br>• Transforming care = 19%<br>• Prevention = 12% |

| Name of association | Funding source and expenses |
|---|---|
| Diabetes Canada | **Income:**<br>• Support from public = 64%<br>• Income from Diabetes Trust = 21%<br>• Income from other charitable events = 8%<br>• Income from camp services = 3%<br>• Education services = 3%<br><br>**Expenses:**<br>• Improving management and prevention = 37%<br>• Public relations and development = 26%<br>• Research = 12%<br>• Drive for excellence in diabetes care = 12%<br>• Helping type 1 diabetes = 8%<br>• Administration = 5% |

## Appendix 4: Examples of output and impact indicators for diabetes associations

| Name of association | Key output and impact indicators |
|---|---|
| Diabetes UK | • Approximately 6,427 people biked, ran or swam to take part in fundraising events (*e.g.* RideLondon, Great North Run, Swim22) for the association.<br>• More than 100,000 hours of volunteer time were dedicated to bucket collections or to assist diabetes children at school.<br>• 120 different research projects were funded across the UK on all types of diabetes, searching for more effective treatments and a cure.<br>• 8.4 million hits were reported on the website searching for information and support, a 40% increase from the previous year.<br>• More than 7,000 people joined the campaign to keep children with diabetes safe in school.<br>• £29 million were raised to ensure more people live confidently with diabetes and everyone is aware of the seriousness of the disease. |
| Diabetes Canada | • 54 research grants were awarded.<br>• 2.6 million people found vital diabetes resources and information on the website.<br>• Some 1,891 children and youth with type 1 diabetes attended camps.<br>• Approximately 300,000 Canadians with type 1 diabetes benefited from an improved application for tax credit.<br>• 20,000 people obtained responses to their diabetes-related calls and emails.<br>• 3.6 million Canadians with diabetes benefit from Diabetes Canada's world leading clinical practise guidelines.<br>• 80,000 people attended 1,400 Diabetes Canada programmes and educational events. |

## Appendix 5: Examples of potential risks and recommended solutions

| Name of Association | Potential risks | Recommended solutions |
|---|---|---|
| Diabetes UK | Income targets are not met. | Develop existing sources of funding (*e.g.* philanthropy and partnership funding). |
| | Capacity to deliver the strategy is limited. | Engage and upskill employees, and implement a new IT strategy to improve systems and ensure they are fit for purpose. |
| | Failure to protect the vulnerable people with whom Diabetes UK works. | Roll out an experienced safeguarding manager and training to staff and volunteers. |
| | Failure to observe due compliance. | Ensure staff and volunteers adhere to all guidance and legislation in these areas. |

SUSTAINABLE PACIFIC DEVELOPMENT THROUGH
SCIENCE, KNOWLEDGE AND INNOVATION

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