First Nations Research Conference
Doing Research Our Way
Celebrating 10 Years of RHS
Conference Highlights

November 13 - 15, 2005
Government Conference Centre, Ottawa

Conference Highlights

- ***Release of the First Nations Regional Longitudinal Health Survey (RHS) results on the health of Children, Youth and Adults***
- ***National and Regional Reports***
- ***Showcasing Community-based Research/Health Initiatives***
- ***Understanding and Implementing Ownership, Control, Access, and Possession (OCAP)***
- ***Understanding Self-Determination in Research, Cultural Frameworks***
- ***How to become a Data Warrior!***

For more information and copies of reports and presentations please visit the RHS website at www.naho.ca/fnc.rhs

Sunday, November 13,2005

Conference Opening

The Conference opened with a prayer by **Elder Ernie Benedict** from the Mohawk Community of Akwesasne. Elder Benedict opened the conference with an address in which he gave thanksgiving to all of Creation including mother earth, the waters, plants, animals, moon, sun and stars and the Creator.

Ceal Tournier, RHS FNIGC Co-chair welcomed participants to the Second Wave of the only national First Nations survey – Regional Health Survey (RHS). She recounted that they were told the RHS process would not succeed, but that this had been proven wrong. Ms. Tournier mentioned many challenges that arose throughout the process. According to her, it is about "info jurisdiction and data sovereignty" and the only limitations lie within our vision. Ms. Tournier closed by saying that the RHS was only possible through the commitment and dedication of all who were part of it – "the little engine that could!"

Valerie Gideon, FNIGC Co-chair said the RHS is a team and a family. She acknowledged the dedication and sacrifice of all involved. It happened that the RHS team did not know where cheques were coming from but that they managed to do research "on our own terms."

Honorable Minister of State , Carolyn Bennett said that we are beginning to listen and learn from the teachings and wisdom of living on the land and staying healthy which we are trying to get the rest of the country to catch up to. She said health status is the accountant of a people.

The Minister said Prime Minister Paul Martin hopes to close the gap through discussions at the PM tables on Health. Minister Bennett said the RHS is a cause to celebrate and the government respects the community based approach characteristic of the RHS. She said it is immensely gratifying to see the kind of productive collaboration in the collection and use of health information because it is being done in a way that respects cultural values and develops research and data capacity within First Nation communities.

Bennett said she is obsessed with "evidence based practice" but that she was equally obsessed with "practice based evidence". The ultimate goal is closing the gap in health status for First Nation peoples and in order to accomplish

this we must begin with trusted data in which we are actually measuring what matters. She said it is important that we begin to think of interventions and best practices in a way that really is about measuring what works and measuring what doesn't work. Between 2001 and 2005, Health Canada provided more than 8 million dollars for the second round of the RHS and which is now targeting 28,000 First Nations citizens with about an 80% response rate.

She said this is an incredible response rate in any kind of research and one that speaks volumes about the care that went into the survey and the desire for First Nations to express themselves about health issues. The results from this first survey have been compelling and have formed an integral part of an overall body of research on First Nations and Inuit. This combined data has and will lead to concrete actions

These as well as other results have provided a much better picture of health among First Nations. These numbers are critical in helping us develop our policies and programs.

This is why it is so important to make sure, as is done with RHS, that surveys are based on science. However, the numbers are only useful if they lead to affirmative action. According to Minister Bennett, it has always been a simple equation, what gets measured gets noticed, what gets noticed gets done.

Minister Bennett highlighted that this is why it is so vital to the RHS stewardship of all aspects of the process. The RHS process is making the results, ensure that the results are meaningful to First Nations.

As a nation we aspire to be a country in which every person is as healthy as they can be physically, mentally, emotionally and spiritually. Minister Bennett believes that the success of the regional health survey has a lot to teach us about engaging citizens and communities. It is about taking the example and success of the RHS and moving that into mainstream initiatives

Ontario AFN Regional Chief Angus Toulouse addressed the Conference and congratulated all those involved for their hardwork and dedication to this ground-breaking initiative. The RHS is the only national First Nations research project. It is the only one that has total First Nations control and ownership, and involves all First Nations regions across the country.

Mr. Toulouse maintained that the RHS is visionary. It demonstrates how First Nations self-determination can be applied to research. It shows that First Nations have the ability and the drive to succeed in an area as complex as health research, despite historic barriers that have been placed before First Nation peoples.

First Nations are generally reluctant to participate in research due to issues relating to trust. In the past, research has been used against the First Nation population. First Nation peoples have not had much of a say as to how First Nations were portrayed in research.

Still today, there are little resources available to First Nations. It is very rare for national surveys to be dependent on year-to-year funding. Why is the RHS subject to this constraint? According to Regional Chief Toulouse, First Nations must be proud of what they have accomplished with the RHS. They have told their story. They have measured their progress and identified those areas where improvement needs to occur.

On November 24-25, Regional Chief Angus Toulouse will be travelling to Kelowna to attend the First Ministers Meeting on Aboriginal Issues. This is a critical event. The AFN has not been invited to a First Ministers Meeting since 1987.

At the FMM, delegates will be discussing key health determinants of self-government, health, education, housing and economic opportunities.

The FMM is aimed at closing the gap in quality of life between First Nations and other Canadians. Regional Chief Toulouse believes this can be achieved through recognizing and exercising First Nations jurisdiction, creating sustainable development opportunities, building institutional capacity, and through concentrated efforts on all of the determinants of health.

AFN has led the development of indicators to act as a baseline for the gaps that currently exist between First Nations and other Canadians. These indicators will also be used by federal, provincial, territorial and First Nation governments to measure progress on a 10-year challenge to eliminate poverty among First Nation peoples.

The AFN will be drawing on the RHS to measure some of these indicators. It is the preferred source of information. Also at the FMM, the National Chief will be endorsing a Blueprint on First Nations health. In this Blueprint, the AFN has obtained a commitment from the federal Government to seek funding

for First Nations to collect longitudinal data, and also to build their capacity through information centres and surveys.

It is the goal of First Nations leaders to ensure that communities and their technicians have the resources available to them to own, control, access and possess data on their populations – without depending upon universities, federal or provincial governments. First Nations wish to work in collaboration as equal partners in research.A

Gail MacDonald, former National Coordinator of the RHS spoke about the Beginning, Developments and Triumphs of RHS. She said she was proud to have worked for the RHS for 7 years. She said the concept began in 1995 when AFN was approached by Health Canada, after First Nations were left out of three national surveys, producing a large gap in First Nation information.

Gail said the RHS faced many challenges including First Nation people already having been "researched to death," little capacity for research, not enough funding, and having to create a protective environment for ethical, culturally sensitive research. She said as a group of "raggedy ass technicians" they got on with the task.

RHS was formalized in July 1996 with Chairpersons, a National Coordinator and AFN and Health Canada were asked to sit as ex-officio.

"The *gathering of information* and its subsequent use are inherently political. *Aboriginal people have not been consulted* about what information should be collected, who should gather that information, who should maintain it, and who should have access … RCAP 1996

She said tools were created, such as the *Code of Research Ethics* and they got help from research experts from across the country. They made sure they had sound research methods and developed questions that reflected First Nation realities. In 1998 the OCAP (Ownership, Control, Access and Possession) was developed. As the RHS team collected, cleaned, and analyzed data they learned a lot – mostly because they did it themselves. The first report was released in 1999.

Ms. McDonald said there were conflicts along the way – fighting for thier rightful place in data collection, protecting ownership of that information, creating a survey that was sound in its research methods while respecting community values and fighting over meagre funds with federal departments who did not support RHS.

Gail also spoke about the triumphs - creating awareness of privacy; producing ethical research; creating a capacity for data collection; advancing computer technologies and seeing this national initiative become the success that it is.

Gail concluded by saying RHS is about self determination, and now that First Nations have the data, its time to make use of it by making effective changes to improve the health of First Nations.

Current **National RHS Coordinator Jane Gray** spoke about the *Maintaining the Vision, & Growing with Resiliency*. Ms. Gray said she had been taught to always speak the truth and speak about what one knew. The origin of the term "Data Warrior" came from an elder at Nakoda Lodge in Alberta. As he opened the meeting he said that they were "warriors" and that their jobs were to defend First Nation rights to health. She professed to be proud to be called a data warrior and that today their were warriors across the country.

Ms. Gray said the First Nations Regional Longitudinal Health Survey is the "only national research initiative under complete First Nations control in Canada."

She stated that the first cycle started in 1997 and will end in 2014. 5.9% of First Nations citizens living in their communities were sampled. Ms. Gray said data warriors are those dedicated to protecting First Nations information and upholding the First Nations principles of Ownership, Control, Access, and Possession (O.C.A.P.)

Jane Gray said she was proud to replace Gail Macdonald whom she considers a mentor as well as a friend. The eagle feather Ms. MacDonald passed on to Ms. Gray helped her through difficult times. She said identity is important and it is critical to state that "RHS IS NOT THE NAHO SURVEY – RHS IS RHS!" Jane said the RHS has been housed at different organizations over the years and is currently housed at NAHO.

She said she is proud to be celebrating 10 years of RHS and thanked the FNIGC, political organizations, regional health organizations, regional coordinators and health directors in the different communities. She noted that 9 out of 10 regions support RHS.

Ms. Gray said RHS has broken new ground – with the OCAP principles, Code of Research, an RHS ethics process, license to use agreement, and a unique RHS cultural framework.

She proudly stated that the RHS team has presented twice at the United Nations. We have put the Royal Commission on Aboriginal Peoples (RCAP) recommendation quoted into action. The RHS report is divided into three sections, **Adult, Youth And Children** and is

presented as the **Good, The Bad and the Ugly**. Today we are releasing the RHS National report, the Peoples report, RHS at a Glance and RHS Fact Sheets.

Ms Gray said the RHS contains the evidence needed to make "evidence based decisions." The RHS team hopes it will be a catalyst for change and used to improve the lives of First Nations. There is a new "Red Standard" for First Nations community based research.

Valerie Gideon, AFN Health Director spoke of the AFN Blueprint for First Nations Health. She said it is an agenda for restoring and improving First Nations health. It will provide equitable access to Canadian health care improvement in a Ten-Year Plan with a strategy to clarify roles and responsibilities. She said Chiefs provided a mandate in 2004. First Nation Provincial and Territorial Organizations and Treaty Organizations received funding to support to develop Regional/Treaty-specific First Nation blueprint contributions. The Chiefs Committee on Health, with support from the National First Nation Health Technicians Network, developed a National FIRST NATIONS Blueprint contribution.

She said the purpose of the Health Blueprint is to propose an agenda for transformative change in all areas of health service delivery and to develop a process for ongoing collaboration among First Nation and Federal, Provincial, Territorial governments.

The conditions for success include the recognition of Treaty and Inherent rights, including Treaty right to health, and fiduciary responsibility of the Crown to the delivery of health services to First Nations. It includes a Recognition of First Nations jurisdiction in health, portability of rights, and the rejection of a pan-Aboriginal approach.

Valerie said the blueprint is intended to promote health and well-being through a First Nations wholistic health strategy including complementary traditional and western approaches, flexible funding arrangements, linkages with non-medical health determinants She said there is a special emphasis on mental wellness and addictions/harm reduction, chronic diseases and diabetes, maternal, child and youth programming, family violence, communicable diseases.

She said there are still some outstanding issues including Aboriginal language, no concrete federal funding commitments yet confirmed and implementation must occur at a regional/sub-regional level which will require immediate infusion of First Nation capacity dollars under First Nation control.

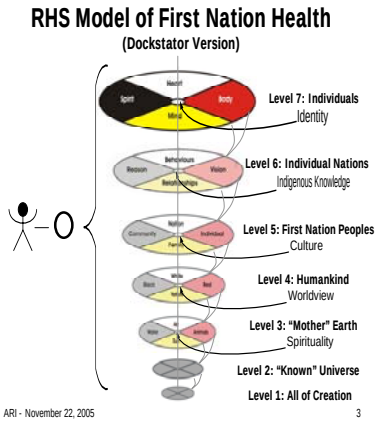
During lunch **Jane Gray** presented hand drawn caricatures as gifts to members of the FNIGC and RHS regional coordinators and workers in appreciation for their hard work and dedication.

Jane thanked CEAL TOURNIER - Saskatoon Tribal Council, VALERIE GIDEON - AFN Health Director- Co-chair, LORI MECKELBORG - BC Chiefs Health Committee, JAY LAMBERT - BC Chiefs Health KATHI AVERY KINEW - Assembly of Manitoba Chiefs, NANCY GROS LOUIS-MCHUGH - First Nations of Quebec and Labrador Health and Social Services Committee, SALLY JOHNSON - Union of Nova Scotia Indians, WENDY PAUL ROSENRAUCH - Union of New Brunswick Indians, LORI DUNCAN - Yukon First Nations JACKIE OKA -Treaty 7 Health is not here today, TRACY ANTONE - Chiefs of Ontario - she is unfortunately absent, LINDA KAY PETERS - BC Chiefs Committee on Health, MONICA CHIEF MOON - Alberta's First Nations Health Education Council, MARTIN PAUL - Federation of Saskatchewan Indian Nations, DONNA LOFT - Chiefs of Ontario, HELEN STAPPERS - Yukon First Nations, NIGEL JOHNSON - Nova Scotia – Absent,

Others acknowledged for their hard work included:

GAIL MCDONALD, BRIAN SCHNARCH - The RHS national team, PRAT HA - The RHS National team, JULIAN ROBBINS, COLLEEN TOULOUSE: - Communication Officer at the First Nations Centre, ODESSA BELANGER: our Admin Support at the FNC.

Developing a First Nations Cultural Framework and Research Model. Mark Dockstator from the Aboriginal Research Institute presented a First Nations perspective and framework for health and wellness. He said this was his version that was a result of what he had learned. He asked how do we interpret data coming in and what is a First Nations perspective of health. He answered that it was a connection to the natural world as demonstrated by the diagram below:



Mr. Dockstator said that individuals start through the Seven Levels with creation and the known universe, then proceed though mother earth/turtle island (spirituality), humankind (worldview), first nations peoples (culture), then individual nations (indigenous knowledge) and finally the individual, where identity rests.

He said the levels represent heart, mind, body and spirit and that we are trying to achieve balance within and between each level. He said the western approach is differrent - they look at separate indices, but the First Nations model is integrated and wholistic. The spectrum represents choice from a First Nations wellness model to the western health model but its "not all or nothing" – you can choose from both sides. He said our states are always changing and that this model is but one interpretation - "one size does not fit all."

Willie Ermine spoke about **Ethical Space**. He said when two entities come together ethical space is created. The value structure of First Nation communities applies to research. He presented a broad historical overview from 1492. He said that First Nations went through periods of engagement and disengagement. First Nations were engaged during the fur trade and disengaged during the rupture of it, engaged during the treaties but disengaged with their breach. He said now is the time to step back and identify the parties to the engagement and the rules for engagement - "what do we believe in and what is our knowledge system?"

Mr. Ermine said the treaty symbol represented a meeting of human cultures in an equal partnership with an agreement to co-exist.

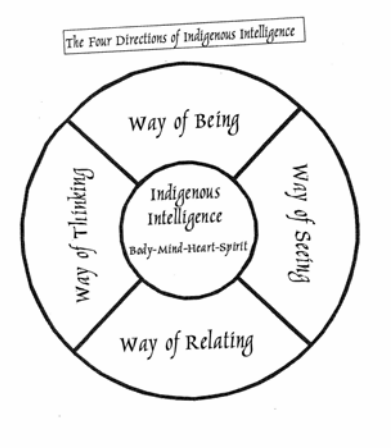
Mr. Ermine said every time First Nations engage they lose something of their identity. There is an undercurrent of established consciousness which is based on the western model of society which is not indigenous. It is supported by the Canadian state and recreated by its systems and institutions. They then tell indigenous peoples how they should view themselves and tell them how unhealthy they are based on their world view.

He said there is an indigenous experience based on community, and First Nation worldviews, traditions, philosophies and ways of knowing. Our elders are scientists of the natural world. The First Nation knowledge system is the basis of health and one must ask oneself whose knowledge system is one feeding? The RHS feeds back to First Nation communities, feeding First Nation knowledge systems.

When cultures, worldviews, knowledge systems and jurisdictions meet there is a meeting of ethos, histories and realities. It creates a space of dialogue and relationship building. When they come to First Nation communities there is knowledge space they cross and when they cross cultures they reach the level of their own incompetence. It is driven by human passion, not systems. It is the language of possibility.

Elder Jim Dumont spoke of Indigenous Intelligence. He recalled the recent celebrations by some people of the 500th anniversary of the arrival of Columbus. He suggested at the time that First Nations should celebrate the year 1491 – the year before he arrived, when First Nations were at the height of thier own systems. He said he noticed later that the National Geographic magazine had used his idea.

Jim said indigenous intelligence is the basis for what First Nations do and that intelligence tests indigenous peoples were put through were off -course. Westerners would fail First Nations intelligence tests. Indigenous beneficial knowledge is the use of wise and exemplary knowledge in a good way – "indigenosity". He said First Nations have to connect body, mind, heart and spirit. It includes future generations, and the living past and is beyond the 5 senses. The circle includes 4 quadrants – Being, Vision (seeing), Relating and Knowing/Thinking.



Elder Dumont said First Nations have to just do it and live that way – First Nations have to validate their own paradigms. Dumont said a healthy culture is a determinant to judge individual communities. If the family structure is still in place that is a determinant of family and social harmony. Dumont said First Nations have to use their own standards to measure thier health. What are the highest standards of health? We have to ask the people or they won't own the process. RHS is a culture based approach determined from each culture area.

He said First Nations have to develop ways of determining their standards for health and well-being, such as having a useful and productive life from childhood to old age. It may include physical wellness, as well as a long active life, self directed and creative learning, guided by elders. It could also include cultural connectivity – active living connected to ones culture. On the emotional level it is connection to family, extended family and community. Dumont concluded by saying sovereignty is the health of First Nation communities and having control over the forces affecting ones life.

RHS Adult Findings – the Good, the Bad, the Ugly spoke about Physical Activity, Body Mass Index, and Nutrition Among First Nations Adults - Christine Cameron said the Good news is that there are Three Key Preventative factors – diet, physical activity and avoidance of tobacco. Sufficient physical activity and nutritious diet are linked to excellent health, social support and balance of mind, spirit, heart and body. Physical activity reduces chronic diseases.

The Bad news is that over 63% of First Nations are not always eating a balanced and nutritious diet and only 21.3% have sufficient physical activity to meet the recommended guidelines of 30 minutes per day.

The Ugly news is that compared to the overall Canadian population First Nations have consistently higher rates of being overweight and obesity linked to chronic conditions, such as diabetes, and this was particularly apparent for Aboriginal women, who are more likely to report chronic diseases such as heart disease and stroke.

Access To Screening And Preventive Measures (Mostly Provincial Services); Barriers To Accessing Health Care and Access to Non-Insured Health Benefits (NIHB). **Jose Lavoie**, Manitoba First Nations Centre for Aboriginal Health Research presented highlights of her findings focusing on respondents' ratings of their access to health care in comparison to Canadians:

On overall access to Health care services 40.8% of FIRST NATIONS respondents rate their access to health services as being the same as Canadians (34.0% in the 1997 RHS, different questions); 23.6% of First Nation respondents rate their access to health services as being better; 35.6% rate their access to health services as being less than Canadians and 37.6% of First Nation women rate their access to health services as being less than Canadians. She said one startling finding is that the rate of Diabetes Mellitus is more then 3 times that of Canadians (1994 NPHS) and the age of onset of diabetes for First Nations First is dropping (Young et al, 1997). The average age of diagnosis is now 24. First Nations on reserve are at a higher risk for heart attacks with a rate of 72.7 per 100,000 compared to 52.1 per 100,000 Canadians.

Lavoie said that mortality from cervical cancer was 4 to 6 times higher in BC FIRST NATIONS women. Mortality from breast cancer among First Nations is half the Canadian rate. The mortality rate associated with prostate cancer is 29.7 per 100,000 for First Nations compared to 26.9 per 100,000 for Canadians; Mortality associated with colorectal cancer is 16.1 per 100,000 for First Nations compared to 18.4 per 100,000 for all Canadians.

She found that many First Nations citizens surveyed reported barriers to accessing health care services (economic, systemic, geographic and First Nations specific). Lavoie said that current rules of access to NIHB appear to go counter to the program's stated goal, which is to provide more equitable access to services. Lavoie recommended the next RHS cover access to comprehensive primary health care services, distinguishing between on and off-reserve services.

Nancy Gros-Louis Mchugh Coordonnatrice technique à la recherché Research - Technical Coordinator, presented the Quebec Region Adult Preliminary results. McHugh reported that they surveyed 23 communities including 3 urban communities and 9 First Nations. Thirteen percent of the target population was surveyed. Key findings included 52.0% of the community adult population indicated that their household was smoke-free. 39.0% of adults report having considered suicide and 18.4% reported having attempted suicide. She found the most

frequent medical conditions were diseases resulting in physical impairment: cancer, neurological and cognitive disorders, musculosketal problems and diabetes.

McHugh reported the good news - 59.2% of First Nations households have at least one child between 0 and 18 years of age. The Bad - 49% had not completed high school, 35.8% had mold in their homes and 28.2% had unsuitable water. The Ugly news was that 51% were unemployed and 62.8% had at least one medical condition. 21.0% of the adult population reported having a family member who received assistance for pathological gambling.

Martin Paul from Lake Manitoba, Saskatchewan presented for Andrea Johnson on Population Patterns and Personal Resources of Adults. He reported the Good news, that First Nations are supporting a significant portion of First Nations youth and children – our future leaders. First Nations communities have significantly more children and youth than adults.

First Nations citizens living outside of First Nations communities are similar to the general Canadian population – there is less of a contrast between children and youth when compared to adults. Paul said these patterns have powerful implications for the education system and the supply of health care for young children and youth living in First Nations communities, in the near future and subsequently, for adults and seniors.

He noted that higher education attainment has been on the rise over the past couple of decades among adults living in First Nations communities. The Bad news is that significantly fewer adults living in First Nations communities achieve formal education post high-school, when compared to Canadians

The ugly news is that the ultimate impact of gender, age, and educational attainment is on income level. The median personal income of RHS adults was $15,667. The 2001 Census showed that employed Canadians earned 1.6 times more than those with Aboriginal identity ($22,120 to $13,525).

Paul said so much is riding on income - standard of living, access to health care, housing, home repair and maintenance, access to healthy foods, mobility, etc. and that real solutions are needed to increase the higher educational attainment of First Nations adults. These findings suggest bi-cultural understanding may increase higher learning.

Malcolm King, Education Director of the Mississaugas of New Credit First Nation presented the Good, Bad and Ugly on School Education and Health. King said that the 3 major contributing factors are diet, physical activity and being a non-smoker. School performance is linked to aspirations, attendance, repeating grades, and to learning problems. Liking school is linked to diet, use of alcohol, smoking, sexual activity, health limitations and involvement in sports.

King reported the good news – those students reporting eating a balanced nutritious diet reported good health, lower rates of grade repetition, fewer learning problems and higher rates of liking and attending school. Those reporting participation in sports, and attending cultural events liked and attended school more.

The Bad news was that those with one or more health conditions reported an increase in learning problems and those students with a parent who attended residential school had higher rates of repeating grades and learning problems. Interestingly, those who spoke an aboriginal language and attended cultural events reported more learning problems in school.

The Ugly news was that those students who smoked daily, had frequent alcohol consumption, increased sexual activity reported more frequency of grade repetition and lower school attendance

The following is a **Summary of Community Workshops** held during the first day of the conference.

Workshop A – Dr. Jay Wortman spoke about Traditional Diet and Diabetes. Wortman said the traditional or pre-contact diet of First Nations peoples consisted of fish, meat, wild plants and berries. The present-day diet contains many foods rich in starch and sugar which were not part of the traditional diet. This rapid change in diet has contributed to the epidemic of serious health problems such as type 2 diabetes.

He said there is evidence that a diet program that uses selected modern foods in groupings similar to what people ate before contact can reverse these problems. Recent research shows that this kind of diet can prevent and treat obesity, metabolic syndrome and type 2 diabetes. The scientific evidence supporting this diet approach was discussed.

Dr. Wortman discussed the genetic pre-disposition of First Nations to obesity – the thrifty gene that allowed native peoples to store fat in times of scarce food, and now that food is everywhere First Nations are still storing those reserves. With a major lifestyle change First Nations activity level has dropped dramatically (living off the land) and this creates a

condition for being overweight – through reduced activity, can lead to diabetes.

He stressed diet and exercise as treatments against the risks of the extreme effects of diabetes such as amputations and blindness. First Nations pre-contact diets, depending on different geography and culture, consisted of game, fish, seafood, and a variety of seasonal plants, all with a very low glycemic value. Traditional diets were consistently "low-carb."

Dr. Wortman said the modern diet of First Nations people is very high in sugar and other refined carbohydrates. The simplicity of a low-carb/traditional diet approach may lead to greater compliance and effectiveness. He said the Atkins diet comes closest to being the modern equivalent of a traditional Aboriginal diet.

Workshop B – Nancy MacLeod, First Nations Centre spoke about How to Use Data for Effective Community Health Planning. She and Brian Snarch presented an overview of the 3 –day data warrior training session including ways of knowing, how health research is grounded, different approaches to studying health in your community, why health information is important to First Nations and using the internet to access health information to create a health information plan for your community.

The Principles of O.C.A.P. (Ownership, Control, Access and Possession), and the OCAP simulation game were discussed as well as the need for community health information and resources to develop capacity.

Workshop C - British Columbia RHS Regional Workshop was presented by Lori Meckelborg and Linda Kay Peters. The focus of the workshop was on the interpretation process and how data can become meaningful while utilizing community expertise. It examined the structure, decision making process, community input/feedback and lessens learned during the process. Questions were raised if the data was truly reflective of reality and what the "findings" really mean? The workshop also discussed how to involve elders in the process and how to get youth to open up.

The Manitoba First Nations Regional Longitudinal Health Survey: Locating Theory and Pragmatism was presented by Garry Munro and Dr. Brenda Elias. The 2002-3 survey addressed the social determinants of health in Manitoba First Nations communities, with team members redesigning the survey so that it critically addressed some of the social, cultural, and spiritual determinants of health. The second wave used revised questions to address some of the community needs such as a Children's resiliency survey and Governance and accountability (OCAP) challenges.

Workshop D: The Good, The Bad & The Ugly: Further Elaboration RHS Adult Findings - was not attended.

Workshop E - Personal Empowerment and Diabetes Prevention was presented by Alex McComber and Cynthia White from Kahnawake. Participants discussed the importance of role modeling healthy lifestyles for diabetes prevention, examining their lifestyle patterns and activities, perceptions about health and wellness in relation to diabetes prevention; and understanding that the change process begins with the individual making positive choices. The workshop discussed the development of a "personal empowerment plan" to create a personalized vision, identify goals, and start with small steps "to begin your walk and celebrate your successes.

"If we are out of balance, we are the only ones who can take action to put ourselves back in balance."

Questions were raised about how to develop a personal plan if other health conditions existed. Building a supportive health network was emphasized which includes a nurse, doctor and , Community Health Representative (CHR).

Workshop F: Revisiting the Kahnawake Schools Diabetes Prevention Project (KSDPP) Code of Research Ethics was presented by Dr. Anne MacAulay. The Kahnawake Schools Diabetes Prevention Project (KSDPP) Code of Ethics was developed 10 years ago based on Mohawk and Haudenosaunee philosophy including the Great Law of Peace, the Seven Generations Principle and the consensual decision making process. This philosophy has guided the community-based participatory research project in Kahnawake. Together, through respect, consultation and collaboration, community members and researchers developed the original Code which has served the community and Project well. The goal of the KSDPP was to prevent type 2 diabetes for future generations.

It was realized that the Code needed further elaboration to encompass changing ideas on research (OCAP), community participation and the realization that revisiting of the Code served to strengthen the Project and its outcomes.

Discussions focused on the process of revisiting the Code itself, and on knowledge transfer and who has the ultimate authority for students' research. Advice was provided to participants not to wait 10 years to update research protocol.

Workshop G: Weigh In Weigh Out: Meeting the needs of Aboriginal Women through Healthy Eating and Physical Activity was presented by Ruth Ann Cyr, Program Coordinator, Native Canadian Centre of Toronto and Carol Seto, Health Promotion Consultant. The program began with a concern for women's health as a preventative initiative to address weight gain. The program developed with 27 aboriginal women participants and with well-being and lifestyle support. Participants had medical conditions, mostly diabetes and hyper-tension.

Meals were provided based on class teachings (functional food, portion, use of humour and music). Privacy was needed during weigh-in to create a casual safe environment. Participants were tested pre and post study and then followed for 3 – 6 months.

The presenters gave an overview of the process taken and results found emphasizing the importance of cultural sensitivity and the role of tradition in increasing participants' comfort level.

Workshop H: Antecedents and Social Consequences of Type 2 Diabetes Among Urban First Nations People of Eastern Ontario: Western Science and Indigenous Perceptions. Scheduled Presenter was Hasu Ghosh, Recent Carleton University Graduate. The workshop was designed to present an Anthropological investigation of the perception and management of Type 2 diabetes among Urban First Nations of eastern Ontario. Semi-structure interviews are conducted among the people with and without diabetes, health care professionals, caregivers to understand and document each group's experiences, disease perceptions and coping mechanisms. Attempts are made to explain the experiences and perceptions with existing theoretical insights. Shared social, cultural and historical circumstances that have contributed to the emergence of diabetes among First Nations people are also examined.

No participants for this workshop.

Workshop I: Voices and Values Saving Lives: Inuit Traditional Lives
In the past, death from suicide among Inuit youth traditionally did not occur. Values and beliefs stressing endurance, connectedness, survival and modeling of coping mechanisms and attitudes were passed on to the young. Marginalization of traditional teachers resulted from another culture assuming authority over peoples' lives, which disrupted the transmission of this vital knowledge and failed to recognize its importance. An oral presentation will look at traditional values and beliefs historically held by the Inuit and compare and contrast present youth attitudes and behaviours.
This workshop was cancelled.

Workshop J: Health Information and Tobacco Reduction in Unamaki (Cape Breton) Presenters: Michelle Michael, We'koqma'q First Nation and Angela Paul, Membertou First Nation. Presenters explained that Unamaki is a tribal district that includes 5 Mi'kma'q communities. They provided a summary of what has taken place in the 5 communities of Unamaki with regards to health information and tobacco use.

The Tui'kn Initiative was described as a journey to renew primary health care so that it is wholistic, comprehensive and leads to improved health and quality of life. It involved collaborative planning around tobacco reduction in the five communities, comparison of surveys that had already been done and the development of a common survey for all five communities and other strategies for reduction of non-traditional use of tobacco.

The Tui'kn Initiative recognized the need to train their own Mi'kma'q people to collect and gather their own health data with the purpose of determining their own communities' health needs. Future plans include developing a culturally appropriate school-based tobacco program (prevention & cessation), developing an awareness campaign for the five communities and developing extra curricular activities for the five communities that emphasize "no-smoking".

Workshop K: Partnering with Métis Settlements in Alberta to Screen for Diabetes and Cardiovascular Risk presented by Shannon McEwen, Jerry LaRose and Dr. Brenda Elias.
Métis health councils throughout Alberta have enthusiastically endorsed a mobile diabetes screening project, with strong support from community members and leadership. The project aims to reduce the burden of diabetes in Métis settlements. The data collected establishes a risk profile for Métis people. The mobile format has been effective at mediating health-care accessibility barriers. The project meets the Canadian Diabetes Association's recommendation of establishing community based screening programs in Aboriginal communities, and is consistent with "best practices" guidelines.
No one attended.

Monday November 14, 2005

Roberta Jamieson, President & CEO, National Aboriginal Achievement Foundation gave the Keynote Address. Ms. Jamieson spoke about the significance of the building where the conference was being held when in 1982 a commitment was given to meet on

aboriginal issues. Then, as today, leadership was concerned about First Nation health issues. She said hope was felt that day and that this promise is yet to be realized.

Jamieson said she saw many talented people but also so much un-realized potential of children, youth and elders. She said we have been placed on the sideline through colonialism, racism and dependence. Poor health holds the entire nation hostage. We have to build momentum to change that picture by linking potential with achievement. We can't let our people fail due to lack of funding. But funding isn't enough – we also have to change homes and way people are educated.

Jamieson said she wanted to work with people in the room to support the upcoming scholars, scientists, performers, traditional healers. She said she would like to see a tidal wave of change in the health of our people. She spoke about the importance of role models and recognized RHS as role models.

Jamieson said the NAAF will give over $3 million in scholarships, many in the field of health, and she emphasized that you can get funding even if you get money from your band. She said Awards are only one part of what we do – also hold career fairs, including those upcoming in Winnipeg and Vancouver. She said we have to focus on those dropping out because we can't fill the employment needs with only 30% of our students graduating. Jamieson said she would like to see an International Centre For Indigenous Health in Kanata. She said there is a lot of work to do and we need to be comprehensive.

Jamieson issued a challenge to the conference for achieving and measuring results in the next 10 years. Given what we've read what are we expecting for 2015? She asked what change is needed, what needs to be done and "what will be your role in changing the statistics?" She issued a plea for partnerships, to work across jurisdictions to create change.

Jamieson said the time had come to create an independent Parliamentary Committee on First Nation Issues to measure progress on the promises. She saluted the work done by RHS and said she stands ready to work with RHS to change the picture.

Tina Keeper gave a presentation on **Suicide Prevention: A Community Driven Approach.** Keeper said she works with the Assembly of Manitoba Chiefs youth secretariat. She said almost everyone has been touched by the issue of Suicide. She experienced it when a cast member of North of 60 committed suicide during the 5th season.

Keeper said she lives a clean and sober life and speaks to communities across Canada but because of this issue she almost stopped going to communities. The Manitoba First Nations Suicide Prevention Project suicide prevention project started in 1998 and she was surprised to find no resources available. She also said she found a chasm exists in research and that it isn't impacting on the community level. She said what is available is either not relevant of not used.

Keeper said they have worked with the Calgary and Winnipeg RCMP suicide units. The Manitoba First Nations Suicide Prevention Project was undertaken to develop a Manitoba First Nations Strategy and multi-year work plan that would impact on the lives of First Nations people so that suicide is not an option. It is hoped it will also transform attitudes, policies and services to this aim as a collaborative effort between governments, organizations, and individuals to develop prevention, intervention, and postvention models for First Nations people.

She said most of the current research speaks to the elevated risk and contributing factors of suicide within the First Nations population and many make specific recommendations. However, there continues to be a serious lack of appropriate resources to address this issue either at a regional or local level. Keeper noted that neither Canada nor Manitoba has a federal or provincial policy to address the issue of suicide. She has concluded that due to the elevated level of risk, First Nations require specialized resources and expertise on prevention, intervention and post-intervention.

Keeper said the *Jicarilla Apache Nation Mental Health and Social Services Program* model was chosen as it has been recognized as a "recommended program" in two recent Canadian reports; Some of their key success factors include:

- A sustained effort
- Multiple prevention and intervention strategies
- Full-time program staff
- Focus on community education
- Focus on heightened screening
- Crisis response team 24-7
- Inter-agency protocol supported by tribal law
- Surveillance of at-risk individuals supported by tribal law
- Emphasis on cultural values & traditions

Keeper said that elders have taught her that suicide is not our tradition. She said it is connected to colonization. Elements of the Manitoba Strategy includes eestablishing a First Nations Wellness Resource Centre to address suicide prevention, to promote awareness on suicide prevention as a critical issue in First Nation communities, to develop mechanisms to secure resources for

the suicide prevention strategy and to increase the availability of resources on suicide prevention relevant to First Nations.

The Devastating Impact of Crystal Meth: Prevention, Awareness and Community Education (P.A.C.E.) Program
Cherylee Highway, Saskatchewan Indian Institute of Technologies gave a disturbing and effective presentation. Highway showed graphic images of the effects of Crystal Meth and introduced the PACE program to deal with it. She said the danger of the drug is that it is so easy to make with everyday products bought in the local store. There is no profile for the drug – it is used by all ages, cultures, races and geographies. Over 65% of users have children in their homes. The ultimate impact is wide, affecting the individual, their families, the community and their environment.

She said it comes in many forms including powder and rocks and is being sold to the young in fancy packaging. It can be smoked, ingested or injected. When ingested it is often wrapped in bread because of the caustic material it is made from (Draino, lye). She said 6 months of using crystal meth has the same effect as 20 years of alcoholism.

Highway said the effects include loss of memory, paranoia, heart attacks, strokes, aggression and weight loss. Addicts have in some cases gone 21 days without food. It can also cause massive sores which can become infected. She said their program is training 400 workers in Saskatchewan and trying to train 40 specialists in each region of Canada.

OCAP Presentation: **Ceal Tournier, FNIGC Co-Chair spoke about the spider-web path to OCAP.** She said Governments and other interest groups gather, analyze, interpret & report data without First Nation *consent*, review or input. Subjects are chosen that reflect personal or academic interest rather than First Nations priorities. Individuals or communities feel pressured to participate or fear loss of services or funding if they don't.

Tournier said results are often interpreted and presented in language and formats that are inaccessible or inappropriate. First Nations' ways of knowing (data collection or processes) are not considered "valid". Non-First Nation university based researchers are seen as the experts on First Nations, effectively displacing the true experts ("Whose system are we feeding?).

She also noted that First Nations have difficulty influencing the research agenda even when they "are" in fact, the research agenda! Tournier said that OCAP arose out of the sorry history or research relations and as a cry for self determination and First Nation research capacity.

She said First Nations aspirations and rights to self determination includes information management and data sovereignty as a fundamental capacity and that possession (stewardship) is a mechanism to assert ownership.

Tournier said when First Nations data is in the possession of others (e.g. government, academia), there is a risk of breech or misuse of information. Especially when trust is lacking between owner and possessor. Tournier said "Data Sovereignty**"** or self-determination applied to data holdings, information management and research is "the way forward.*"*

She called on everyone to recognize that OCAP and First Nations' aspirations will not "go away" and to work with First nations in their vision of research.

A humourous skit was performed demonstrating some of the issues encountered by data warriors and the Principles of OCAP

He who holds the data holds the gold!

Bernice Downey, CEO of NAHO spoke during the lunch hour about Indigenous Research Leadership and Opportunities. She congratulated the FNIGC, Coordinator and staff and stated NAHO's support of the First Nation Regional Longitudinal Health Survey.

Downey spoke about the work of NAHO. It was envisioned as an Aboriginal designed and controlled body, that would influence and advance the health and well-being of Aboriginal Peoples through carrying out knowledge-based strategies. An aboriginal health institute was planned that would be arms length from both government and national aboriginal organizations.

Downey said NAHO was the first organization with First Nation, Métis and Inuit peoples represented in its governance structure and mandate. A second 5 year mandate was recently received.

She said NAHO is committed to unity while respecting diversity. She said NAHO gathers, creates, interprets, disseminates and uses First Nations, Métis and Inuit traditional knowledge and western approaches and it views the community as thier primary focus.

Downey said there are three separate aboriginal health centres and over 60 partnerships have been formed with aboriginal, non-aboriginal health organizations, academic, research institutes and governments.
Downey said the research initiatives of the Inuit Centre include facilitation and promotion of Inuit-related research and Inuit research-capacity and environmental change

specifically related to dietary changes. The Research initiatives Métis Centre include culturally specific health research, including traditional health knowledge and healing practices and a Fellowship Program.

She said NAHO is doing international work with the International Indigenous Health Knowledge & Development (INIHKD), and other organizations to devise knowledge transfer strategies.

NAHO has developed an Information Centre on Aboriginal Health. (ICAH) It is a database of information on bibliographic and web-based resources, programs and services, health careers and scholarships and bursaries. The goal of ICAH is to provide information that supports NAHO'S objectives.

Downey said NAHO has also become the aboriginal affiliate of the Canadian Health Network or (CHN). Downey said this is an exciting opportunity to inform many areas of health which are currently lacking in First Nations, Inuit and Métis perspectives. Over the past year NAHO has been exploring the development of a Learning Institute on First Nations, Inuit and Métis Health. In addition to being a sustainability initiative for the organization, it will introduce specific and priority health issues of First Nations, Inuit and Métis to a wider audience of health professionals and policy makers.

In closing Downey said the title of the RHS conference, "Our Voice, Our Survey, Our Future" alludes to a collective outlook on First Nations health. NAHO looks forward to supporting the work of the RHS "as you look toward your next ten years and beyond"

RHS Youth Findings: "The Good, The Bad & The Ugly" Andrea L.K. Johnston, Director, Johnston Research Inc. presented on Language and Culture, Family and Household Structure, Housing Resources and Community Characteristics. Johnson said the Good news is that most First Nations youth (82.1%) considered speaking a First Nation or Inuit Language *important* and over half First Nations youth (54.8%) considered having cultural events in their lives *important*.

Johnston said the Bad news is almost half First Nations youth (45.2%) considered it *not very important* or *not important* to have cultural events in their lives. The Ugly news is that most First Nations youth (87.6%) named English, French or signing as a language of daily use and almost all First Nations youth (96%) used one language in daily life. While many youth value First Nations language, very few speak it daily. She said adequate supports are needed for learning the language and teaching the value of cultural events.

On household structure she said the Good News is that almost all First Nations youth (98%) lived in homes with their parents or other relatives and First Nations youth were well surrounded by family. Traditional household compositions included parents and other family who could pass on language and cultural knowledge.

She said the Ugly News was that while a large household composition is favoured in First Nations communities, most homes did not have an adequate number of rooms, by western standards. By western standards, over two-fifths of First Nations' households with youth (42.9%), were crowded

The Bad News, Johnston said, is the less isolated a First Nations community, the less likely a youth is to regard language as important and the less likely he/she knows or speaks a First Nation language.

Johnston said this look at First Nations youth shows that as we move into more non-isolated communities we gain education and economic opportunities, but we loose a sense of our ancestry. She said we will need a concerted effort to save cultures and more and better housing is needed.

Max King, Education Director, MNCFN, gave a presentation on a Framework for Our Youth. He said his brother made the distinction between health care and wellness awareness. It links to ideas raised by the previous day's speakers about a context and framework for cultural education – "where we are and where we want to be."

King said mainstream education systems have excluded indigenous knowledge, intelligence, values and beliefs. He said Roberta Jamieson spoke about achievements beginning with choices. "Well, we help frame those choices and it begins with children and youths. "

He quoted a newspaper article from Chief Stan Beardy who said: "Our desires are…safety and security, good health, a voice in our own affairs, enough to eat, a place to shelter out of the storm and to raise our children." King said we need governance based on our values, physical, mental health and full respect for our treaties. Roads will give us access to better quality and cheaper foods.

King said school performance can be predicted by attendance, diet and repetition of grades. He said there is a need for program focus on nutrition, cultural programs and healthy choices.

King reported the Good news from their survey – those students reporting eating a balanced nutritious diet, reported good health, lower rates of grade repetition, fewer learning problems and higher rates of liking and

attending school. Those reporting participation in sports, and attending cultural events liked and attended school more.

The Bad news was that those with one or more health conditions reported an increase in learning problems and those students with a parent who attended residential school had higher rates of repeat grades and learning problems. Interestingly those who spoke an aboriginal language and attended cultural events reported more learning problems in school.

King said the Ugly news was that those students who smoked daily, had frequent alcohol consumption, (higher grades) and increased sexual activity reported more frequency of grade repetition and lower school attendance. He read an email message from his brother Malcolm King (who participated in the RHS) who said "he hopes people will come away with a message for policy – we need to do more with these statistics than just bemoan them. They need to be used to set policy goals – where to put resources and who to bring together to deal with the issues."

Garry Munro, CNTHC – AMC-HIRC presented the Preliminary Report on Manitoba Findings.
He said they were celebrating the successful 1995 partnership with the university. Their study covers 63 First Nations, 7 tribal councils and 23 participating First Nations with a 70% sampling rate completion.

Munro said their survey breaks new ground in understanding youth resiliency. He said youth are involved in risky behaviours: Over 40% smoked, 20% smoke pot, 35% drank in a 12 month period. 18% drank 5 or more times per month and 33% were gambling.

He said our youth are struggling!
20% have thought about committing suicide, 10% have attempted suicide, nearly 50% feel lonely or stressed, about 30% reported a lack of meaningful participation in their families, school and community.

Munro said other findings tell another story. Over 60% are physically active, around 50% are full of energy, happy, relaxed, stress free, loved and feel appreciated, over 70% report having a lot to be proud of, over 70% feel good about who they are, Nearly 65% feel they have control over their lives, Nearly 65% feel that they can solve their own problems, Close to 70% view their life as interesting.

He said many have strong caring relationships among their peers and within their family, school and community In varying numbers, young people are engaged in their culture, individually, with family or friends, or at the community level. Many youth consider their spirituality as a source of strength and as a way to stay in balance.

Dr. Jay Wortman spoke about Physical Activity, Nutrition and Body Mass and its Relationship to Health. He said the research resonates with the validity of the past and traditional practices. Change is the root cause and the solution is to look to the past and learn those lessons. He said there was no infectious disease or use of alcohol. The change in nutrition and activity resulted from colonization. Activity levels changed and First Nations adopted a sedentary lifestyle. First Nations diet and nutrition levels have also changed. This has led to youth being overweight and obese.

Wortman said the effect of being overweight and obesity creates a much higher risk of diabetes and heart disease. Rates of these diseases are higher in the Aboriginal population. He said First Nations youth are at high risk for becoming obese. Although the disease process is slow, the problem is urgent.

Wortman said the Good new is that a large majority of First Nations youth are physically active. A physically active lifestyle delivers several short and long term benefits. These include: increased self-esteem and perceived physical competence, ability to cope with mental stress and greater chance of not smoking or consuming alcohol or drugs.

He said Youth who are sufficiently active and consume a balanced and nutritious diet are less likely to have suicidal thoughts. Normal weight youth are less likely to spend more than 6 hours a day watching television. Youth who eat a healthy diet report that they tend to turn to their parents for support.

The Not-So-Good news is that almost half of youth (46.4%) never participate in sports lessons after school or do so less than once a week. Only 45.1% of youth engage in sufficient physical activity (51% of boys, 38.6% of girls) and only 38.8% of boys and 31.0% of girls report consuming traditional protein-based foods.

The Bad news is that 49.2% of boys consumed fast foods a few times weekly. 90.3% consumed soft drinks at least once a week. Girls are only slightly behind at 41.9% and 86.6%.

Wortman said the Really Bad news is that only one in five youth always or almost always eat a nutritious balanced diet. 6.4% of girls and 3.6% of boys eat sweets several times a day

He said the Really Bad news is that almost half of First Nations youth are overweight or obese (42.2%). Being overweight in childhood increases the risk of diabetes and heart disease in adulthood and is associated with a number of other problems like asthma, gall-stones, hepatitis, and menstrual abnormalities. Wortman said fast

junk food is causing most of the problem.

Phil Fontaine, National Chief, AFN congratulated the First Nations Regional Health Survey for its ten-year anniversary as the only national research project under total First Nations control. He said First Nations have come from a state of freedom to economic dependence as a result of colonization. The results of this have included devastating cultural losses, family disruptions, suppression of spiritual practices, community upheavals, lack of opportunity, and grinding poverty.

Fontaine said the PM acknowledges the shameful conditions of First Nations. As revealed in release of the First Nations Regional Health Survey at this Conference, the statistics are shocking

He said on November 24-25 in Kelowna, he will be calling on the First Ministers to commit with First Nations to a national goal – to eliminate the gap in quality of life between First Nations and Canadians. Beyond changes to programs and funding, what is required includes the ultimate recognition of First Nations' jurisdiction and our inherent right to govern ourselves.

The National Chief said First Nations have said many times that First Nations government must be defined by First Nations people according to their own understanding of natural law, based on their own customs, traditions and values, and these must also be equally recognized within the Canadian legal system.

Fontaine stated the First Nations Regional Health Survey (RHS) is a great example of a First Nations controlled initiative that is more efficient and effective than federal government initiatives. This survey is more beneficial to First Nations because they can be part of the research from the beginning to the end of the process. The RHS is First Nations self-government applied to research.

At the First Ministers Meeting, Fontaine noted, we will be tabling a Blueprint on First Nations health. In this Blueprint, we will be requesting multi-year funding to ensure the sustainability of First Nations research – and, of course, our flagship: *the First Nations Regional Health Survey*.

He said this is our Survey. Its numbers help First Nations to tell their story. It helps First Nations to understand the future of their Elders, their youth, their women and their children. As a result of this FMM, it is Fontaine's hope that First Nations will not have to face the same struggles in recognition of the RHS teams' excellent work and in seeking the necessary funding to support their goals. Fontaine said First Nations should also spend time talking about what they do well – their successes and achievements. He said there is genius in First Nation communities.

Youth Role Models and Health Promotion Strategies

Workshop presenters: Joyce Spence, NARMP Program Manager, Thomas Edwards, Role Model. A video was shown with interviews of current youth role models. The youth role model program was established by the National Native Alcohol and Drug Abuse Program in 1984. It was redesigned by NAHO to include Métis and Inuit and Indians.

The National Aboriginal Role Model Program highlights the accomplishments of First Nations, Inuit and Métis youth. It is designed to encourage Aboriginal youth to pursue their dreams. A youth working group designed it.

NARMP Goals and Objectives

- To facilitate availability of Aboriginal role models to Aboriginal youth and communities;
- To influence behaviours and attitudes of Aboriginal youth toward healthy lifestyles;
- To promote healthy self-esteem among Aboriginal peoples;
- To strengthen Aboriginal identity;
- To enhance a positive public image of Aboriginal people; and
- To foster Aboriginal inspired leadership

The Need for Role Model in Health Promotion Strategies - Health Careers NAHO's discussion paper entitled Aboriginal Health Human Resources, "A Pillar for the Future," concludes it is important to acknowledge the success stories—individual role models (Aboriginal nurses, doctors, dentists and other health care workers).

Healthy Living NIICHRO's Youth and Diabetes paper (www.niichro.com) says there are two main obstacles to successful diabetes control among Aboriginal children: lack of adult role models and widespread fear and misconceptions about diabetes as a disease. It suggests the need to provide role models (e.g. teachers, parents, Elders, older children, and other role models) for healthy eating. Role models can encourage more Aboriginal youth in lifelong sports, recreation and active living and education them on the benefits of these pursuits.

Spence said twelve new 12 Role models for 2005/06 will soon be announced. Nominations for 2006/07 Role model will begin in the new year of 2006. Encourage

your community to get involved. Honour your youth!

Community Workshop Summaries

Workshop A: Pilot Training for Assessment and Planning Tool Kit for Suicide Prevention in First Nations - Presenters: Tina Keeper and Nancy MacLeod

Discussions centered around the suicide toolkit developed by NAHO. Presenters asked for feedback and recommendations. Teena Keeper said that she had hoped that it would be a real toolkit that frontline workers could pick up and start using – "where's the tools?" It still needs a lot of work.

Other discussions spoke to the need for more networking, more support for frontline workers, who often feel isolated, greater access to data and coroners reports and more community based research and surveillance, Community protocols and need for more training.

Participants said documents need to give practical solutions helpful at the community level – the aim is to "provide service not to promote organizations." The group was informed that a National Strategy on Suicide Prevention had been developed by Canada and national aboriginal organizations. Some participants knew nothing about it.

Other discussions were about the need for more community supports to be in place, like psychiatrists: that First Nations should use their elders as a cultural component – suicide is not part of their traditions; some frontline workers are not equipped to deal with suicide; and the suggestion that First Nations should establish a Centre of Excellence, need for a 5 day training kit.

Another suggestion was that there should be a clearinghouse of information where all data can be shared across the country, the need for a communication strategy with other communities. Presenters indicated the Toolkit would be on the web-site and participants should provide their feedback.

Workshop B: D.R.E.A.M. Diabetes Risk Assessment and Microalbuminuria Presenter Vera Whitford In 1997 the Battlefords Tribal Council Home Care Program identified the need for better care and treatment for persons with diabetes. The three DREAM (Diabetes Risk Evaluation and Microalbuminuria) research projects were community driven initiatives born out of the need for improved care and services. Each project provided knowledge and understanding which led to changes in program and service strategies, increased support from leadership, and enhanced the capacity and confidence of the home care staff. (No Attendance)

Workshop C: Quebec & Saskatchewan RHS Regional Workshop

Presenters: Nancy Gros-Louis and Jules Picard, First Nations of Quebec and Labrador Research Protocol (FNQLHSSC) Martin Paul, RHS Regional Coordinator (SK) In order to express its position regarding research carried out among First Nations, The Assembly of First Nations of Quebec and Labrador (AFNQL) undertook the development of a research protocol to offer their communities a reference guide to better monitor the various activities and numerous demands related to the research carried out in their territories.

This protocol aims at promoting ethical, precise and well-informed research conducted in compliance with the will of the First Nations. It evolved as a Tool to support communities on the road towards their autonomy and in the reappropriation of control over community-based research. This protocol would apply to research, surveys, questionnaires and discussion groups conducted among individuals, individual communities or an individual First Nation.

Elements of the process include first contact, consultations, informed consent, confidentiality, consent form, right of control, primacy of aboriginal knowledge, benefit sharing and data processing.

The steps include project design, data collection, report production and dissemination of results. This reference guide is intended to enable communities to better frame research-related activities and requests carried out in their territories.

It also aims at promoting ethical, precise and well-informed research conducted in compliance with the will of the First Nations involved. It follows the OCAP Principles.

Questions raised during the workshop included how should First Nations implement the survey process throughout the province. The AFNQL was the answer provided.

Workshop D: Youth Role Model Program Presenter: Joyce Spence

The National Aboriginal Role Model Program highlights the accomplishments of First Nations, Inuit and Métis youth. It is designed to encourage Aboriginal youth to pursue their dreams.

The Objectives of the program are to facilitate availability of Aboriginal role models to Aboriginal youth and communities; To influence behaviours and attitudes of Aboriginal youth toward healthy lifestyles; To promote healthy self-esteem among Aboriginal peoples; To strengthen Aboriginal identity; To enhance a positive public image of Aboriginal people; and to foster Aboriginal inspired leadership.

Participants discussed how role models sharing their stories promote self-esteem. Questions raised included how one gets chosen, the age or role models, training and if they are alcohol and drug free?

Workshop F: Healing and Residential Schools: The Aboriginal Healing Foundation Final Report: 2006
Presenters: Gail Valaskakis, Director of Research, Aboriginal Healing Foundation

This session presented the research findings and the policy implications of the Aboriginal Healing Foundation, a ten-year timeframe; and a mandate to fund community-based healing projects that address the physical and sexual abuse in the residential school system, including intergenerational impacts.

With the funding for projects fully-allocated, the AHF has completed a three volume report on the activities, impact and future of Aboriginal healing.

The summary points of the Final Report will be presented in this session. Volume one of the AHF Final Report is a narrative overview of the AHF's development, impact, accomplishments and contribution to the healing movement and a discussion of future healing needs.

Volume two is an overview of AHF evaluation, including three national surveys, thirteen case studies, seven focus groups and twelve hundred individual participant questionnaires.

Volume three summarizes Best or Promising Healing Practices, highlighting what AHF has learned from funded projects through file search, surveys and a national gathering. The session will discuss the future requirements and policy implications with respect to healing the legacy of residential schools.

As of March 31, 2005 1,346 contribution agreements were signed for a total of $377,745,857 (audited). Funded projects included Legacy education, healing services, residential treatment and training.
Approximately 86,000* Survivors are alive today of which First Nations - 80%; Métis – 9%; Inuit – 5%* and non-status – 6%.

During workshop discussions a survivor wondered about the psychological and spiritual effects resulting from residential schools (most talk surrounds physical abuse). The presenter responded that there is recognition that psychological, spiritual and cultural are critical however the mandate focused on physical and sexual abuse. The survivor said that psychological abuse was just as detrimental as physical abuse.

Workshop G: Potential Pitfalls in Research Capacity Building: A Chapter in a Communities Story
Presenter: Andrea Colfer and Denis LeBlanc, B.Ps.,BSW, MSW Research Evaluation Coordinator/Consultant
Drawings on one community's experience with research, the presenter examined some of the pragmatic, ethical and epistemological issues tied to developing community-based research with First Nation communities.

Some of the issues addressed included Potentials and pitfalls of research capacity building with First Nations, Forces that hinder and support successful CBRs, OCAP and Participatory Action-Research: theory vs. practice, Voice appropriation and fostering legitimacy, Balancing rigor and relevance in CBR, and opportunities and recommendations for First Nation Research Granting Policies, Potential areas for best practices in research capacity building with First Nations.

"Every time I go to a conference on research with First Nations, most of the experts are white…what does that say?"

Discussions during the workshop included forces that hinder and support PAR research and the untold challenges that researchers (university based) and community based face when trying to respect the principles of OCAP and an examination of power dynamics that underscore epistemological debates. Participants related their own experiences of "voice appropriation" and the politics that hinder community based self determination in research.

Workshop H: An Overview of the Health Status of First Nations in Manitoba and Canada
Presenter: Mark Sagan, Manager, Health Surveillance and Analysis, First Nations and Inuit Health Branch, Manitoba Region
This presentation provided an overview of the health status of First Nations in Manitoba on such indicators as birth rates, life expectancy, death rates, causes of death and hospital separations, where available, national comparisons are provided.

Determinants of Health – Shelter, Water and Sanitation
Shelter: Only 56.9% of homes in First Nations communities adequate (not needing repair or replacement) (1999/2000), Only 41.4% of First Nations communities reported at least 90% of homes connected to water treatment plant (1999/20), Only 33.6% of First Nations communities had at least 90% of homes connected to community sewage disposal system (1999/2000)

Implications for First Nations Health Status
The First Nations population in Manitoba is growing at a faster rate than the general population. The

remote and semi-remote nature of Manitoba First Nations communities presents logistical challenges to the delivery of, and access to, programs and services. Manitoba Centre for Health Policy study noted that remote communities are not necessarily less healthy. Infant mortality rates are higher for the On Reserve First Nations population. Although life expectancy has improved for the First Nations population, it is still less than the national average.

The leading cause of death for Manitoba First Nations individuals is injury. This prevalence is higher for males and on reserve. Certain health conditions and disease are more prevalent in the First Nations population, such as diabetes and tuberculosis. First Nations are playing a larger role in the collection, control, and use of health care data (OCAP). FNIHB is working jointly with the Assembly of Manitoba Chiefs, Manitoba First Nations Centre for Aboriginal Health Research, Manitoba Health, and INAC to develop a data sharing agreement that will improve the quality and quantity of First Nations health data in Manitoba

During discussions questions were raised about the timeline for the partnership with First Nations. It was explained that discussions were ongoing for 15 years. It was noted that data was presented within a medical model and more collaboration with First Nations is needed. It was observed that there is a lack of consistent First Nations identifiers in First Nations data collection.

Workshop K: Information Sharing Session on Hepatitis C and First Nation Communities
Presenter: Greg Brown, Health Advocate Developer for the Northeast Region Ontario Aboriginal Health Advocate Initiative
The workshop was developed to help counsellors, health professionals, community service and frontline workers set up guidance and direction for both the clients and themselves. There are also paths within the workshop for those who would like to start to heal themselves and create a healthier way of living within their own communities. This workshop follows an oral based and interactive style that is based on traditional ways of teaching.

Most of the teachings will be based on the old ways. As previously mentioned, the difference in this workshop from others is that it will have a strong oral based set of values and through oral teachings it is their wish to provide awareness on Hepatitis C to all the First Nations people.

This workshop will also help the First Nations people realize that they do have a choice; no matter what one does in life, it all comes down to one's choice and the outcome reflects one's chosen path. If First Nations could incorporate all these ancestral ways of teaching, it may just help the First Nations people realize the severity of Hepatitis C and ways to reduce the effect and spread of this disease throughout their communities.

Workshop L: Telling Our Own Stories in Our Own Ways: Urban Dakota and Dene Quality of Life Indicators Project Presenter: Keely Ten Fingers. This presentation provided an overview including research methodology and preliminary findings of the Urban Dakota and Dene Quality of Life Indicators Project. In December 2004, the Assembly of Manitoba Chiefs completed Phase one of two phases which involves engaging Dakota and Dene people living in Winnipeg to identify and develop meaningful and accurate quality of life indicators. These indicators are meant to assist technicians, organizations and decision-makers to ensure effective and appropriate policies, programs and services are developed to improve the quality of life of these populations.

Culturally appropriate, meaningful measures have been developed for urban Dakota though a participatory approach in Winnipeg. They are not "research participants" but "possessors" of knowledge. The process is the key, methods evolved en route. Discussions included a recognition that economic indicators (GDP) are not useful on reserves where there is little "economy". Conventional measures of quality of life ignore culture and were not developed through engagement with First Nations.

Preliminary Findings - Culture is an important and key theme of QOL for Dakota and Dene people living in Winnipeg. Dakota people in Winnipeg are doing well, with the exception of sustaining & strengthening their culture in the City. Dene people in Winnipeg face many challenges, including an overwhelming sense of disconnection from & lack of sense of belonging. Much needs to be done to improve their situation. Both Urban Dakota & Dene people turn to their own governments, institutions, and themselves, to improve their situation. Due to the unique cultures and cultural perspectives of Dakota and Dene people living in Winnipeg, it's important that separate & distinct QOL indicators are respected & maintained.

Workshop M: Innovative Use of Secondary databases to Study Community Characteristics and Birth Outcomes Among Canadian Aboriginal Women
Presenter: Zhong-Cheng LUO, Assistant Professor, Department of Obstetrics and Gynecology, Sainte Justine Hospital, University of Montreal
Workshop was about an ongoing research initiative to study community characteristics and birth

outcomes among Canadian aboriginal women, using secondary perinatal databases linked to census-based area-level socioeconomic characteristics. The study is funded by Institute of Aboriginal Peoples' Health, Canadian Institutes of Health Research.

Presenters noted that using available data the study will likely be able to demonstrate that differences in community level characteristics are important determinants that contribute substantially to disparities in birth outcomes particularly between First Nations and other Canadians.

Community characteristics being studied include rural vs. urban, low income families, education, distance to the hospital, size, north vs. south and single parent families.

Data analyses and reports will be done for each province separately. Aggregate reports or comparisons will be done for some outcomes where appropriate for the overall Study Report, where the aggregate analyses can be justified

Aboriginal Governance Consultations and Supports will be sought from relevant Aboriginal/First Nations research committees in each of the three provinces at the outset of the study, e.g., Assembly of Manitoba Chiefs Health Information Research Committee. The Study Team will establish an Aboriginal Advisory Council.

The Advisory Council will serve as an interface for communications between the study team members and local aboriginal health and governance stakeholders and review Research Proposal and Study Reports and make recommendations to the study team. It may recommend new research projects for further development to the study team in response to emerging needs of First Nations and Canadian Aboriginal communities

Expected Outcomes - The study will provide the first detailed profile of community characteristics in relation to Aboriginal birth outcomes in Canada. The information on the effects of community characteristics may be helpful to Aboriginal health stakeholders in formulating community-based programs and strategies to improve birth outcomes among Canadian Aboriginal women.

Unique OCAP Issues include: Use of annonomized secondary databases, without collection of new data from, or contact with any particular individual or community; The study team will not be able to have possession of the data, but need to request for access to the data (where they are housed); "National" in scope - covers all births in three Canadian provinces.

The RHS Conference held an **Evening Social** including a dinner and entertainment by David Maracle, Pollyanna McBain and Julie Bull.

Tuesday November 15,2005

RHS Independent Review – Report by Harvard University
Dr. Alyce Adams, Assistant Professor, Harvard Medical School Courtney Andrews, Research & Evaluation Specialist, School of Public Health, Saint Louis University; Dr. Miriam Jorgensen, Research Director, Harvard Project on American Indian Economic Development, Harvard University

Evaluators presented the Purpose of the Review - To review the sampling design, data collection, analysis and dissemination of the RHS with respect to accepted survey research standards and OCAP. They indicated it was an independent preliminary result.

Methods used for the review included a Technical Review; Examination of survey validity and quality; Comparative analysis; In-depth Interviews with RHS Regional Coordinators, Health Directors, RHS Staff and FNIGC Members, Statistics Canada and Health Canada.

The review was done by qualified staff – experts in health policy and evaluation. They weighed the RHS against accepted standards. They concluded that RHS is unique, though there is some comparable work in the USA and Australia. There were also 3 experts who reviewed their work.

The evaluators indicated they were impressed with the technical quality of the RHS. It was clear that lessons learned from the 1997 were used in the new survey. Standardizing affected the quality of data coming out.

The evaluators commented the RHS is on top of all surveys for level of reserve participation rate. Data collection was highly consistent with gold standards. The RHS use of computerization is the way to go and an advancement in the field because it reduces error rates.

The evaluators indicated that questionnaire design was highly consistent with gold standards. The field testing done improved quality. There were low error rates – paper surveys had higher error rates than CAPI (computer). Training was important as well as building a rapport with respondents by community interviewers.

The evaluators said interpretation is important and noted the questions came from First Nation perspectives yet still met high technical standards. The youth self administration of survey increased the quality of the data. Use of local interviewers stands out in comparison to other surveys because of the direct local input.

The RHS data not being publicly available distinguishes it from other surveys of other indigenous populations surveys (Australia, New Zealand, USA and Canada – APS).
The evaluators said the greatest strength of the RHS was the role of First Nations in the reporting process – "the cultural framework and OCAP are the true strengths of RHS."

The Harvard evaluators found that the RHS methods are consistent with established survey methods and it compared favorably with other surveys. There are however still some challenges including limited funding, high turnover of staff, small sample size, limited community analysis and balancing the Principles of OCAP – the Impact of community interviewers on bias and who is the ultimate consumer: community members, health directors, organizations?

Next steps

- the first draft of their review is in the hands of their expert panel.
- Completion of interviews with stakeholders is due in November.
- Assess key barriers & aids to RHS completion
- Review draft by readers
- Complete report and submit to funder

Aboriginal Women's Health and Healing Research Group
Linda Day, Executive Director, said the AWHHRG was created to strengthen research on women's' health. The Vision is to increase knowledge of Aboriginal women's health and healing through community driven, evidence based research broadly framed by social determinants of health.

Its mission is to create a supportive national context for Aboriginal women researchers and their community and academic partners to engage in health and healing research and policy advice. The Research focus is on Policy Advice, Network Building, Information Sharing and Organizational development. Day said they want to generate new knowledge on women's health and healing while upholding the OCAP principles.

A literature review was conducted last year to identify the gaps in existing research and aboriginal women's' community concerns.
13 research Themes have been identified including, among others, colonization and racism and unequal treatment of aboriginal women. 19 research gaps were also identified. Ongoing work include developing policy briefs on mental health, planning 3 regional workshops, production of a culturally relevant patient care video and the development of a strategic workplan.

RHS Children's Findings: The Good, The Bad & The Ugly
Andrea L.K. Johnston, Director, Johnston Research Inc.
Andrea indicated the study covered First Nations Children (ages 0-11) Families, Child Care Arrangements, Language, Culture, Pre-school and School, the Good findings are that Children are surrounded by family, even when in daycare; Parents and grandparents highly value their children's knowledge of First Nations languages, and experiences of traditional events; Family and community play a part in passing on traditional culture to children.

The bad news is that almost all homes with crowding (more than 1 person per room) had children.
For households with 6 or more children, 85% or more were 'crowded'.

The ugly news is that Parents education and incomes lag seriously behind the Canadian population.
30% of boys ages 9-11 had repeated a grade.
Other findings - 85% of houses were crowded. A high proportion of children were cared for by family members. 30% of boys repeated at least one grade. 64% of parents felt language and culture were important. 19.3% speak fluently or relatively well, 25.2% understand fluently or relatively well. For ages 9 through 11, it is 25.1% speaking and 31.2% understanding.

In summary, Children are well rooted in their families and communities. Families and communities help children with traditional culture. Families lag behind Canadian population in material and educational resources
Crowded homes are common
High proportion of children repeating grades.

Dr. Jay Wortman said Childhood obesity is a worldwide problem. Lack of physical activity in childhood is linked to sedentary behaviours in adulthood. The proportion of Canadian youth who have appropriate levels of physical activity is low. The prevalence of being overweight and obese among Canadian youth has increased dramatically in the past 20 years

Wortman asked what is causing the epidemic of childhood obesity? The answer is genetics, inactivity, not enough fruits and vegetables, Increasing consumption of carbohydrate calories, particularly soft-drinks.

He said activity levels among First Nations Children - Younger children are more active on a daily basis than older children (50.3% vs. 37.3%). The most common activities are walking 86.9%, running 73.3%, swimming 68.8% and bicycling 68.3%. Children in lower-income households are less active than those in higher income households.

Wortman said Children who are active daily are less likely to consume fast foods, soda drinks, baked goods, and snack foods; are more likely to consume a healthy diet; are more likely to consume traditional protein food, berries and wild plants; are more likely to spend time outdoors, watch fewer hours of television, and are more likely to report excellent health.

Wortman said First Nations children who live in small communities (<300) vs. larger communities (>1500) are:
twice as likely to consume traditional meat (44.8% vs. 23.3%) and eat berries and wild plants (33.7% vs. 17.8) and are less likely to be obese (25.7% vs. 44.2%).

Nancy Gros-Louis Mchugh, Quebec Regional RHS Coordinator, FNQLHSSC
McHugh said Québec RHS added 3 urban areas – Quebec City, Montreal and Valdor. 9 First Nations and 23 communities were included. The Québec region report will be available in 2006. 13% of target population interviewed (except for the Cree and Inuit Nations)

The good findings - The average of the total number of children aged between 0 - 17 years in the household is 3. The average of the total number people by household is 5. 68% of parents wanted their child to learn their aboriginal language,

People who help children in understanding their culture: Parents - 81.1%; Grandparents - 66.9%;
Aunts, Uncles - 39.6% 73.1% of the children attend the school or the First Nations Head start program.
46.9% of the children took part in a preschool program. 10.1% of children have repeated a year.
43.3% of the children take part in a sport program or sport team;
38.7% of the children were breastfed; 56,8% of the mothers nurse for a period of three months and less.
13.9% of the children take part in songs, drum or traditional dance groups. 9.4% of the children take part in artistic or musical groups.

The main health problems observed in children are: 17% - Asthma; 16.7% Ear infections or chronic problems; 14.7% Allergies; 7.3% Chronic Bronchitis. 52% of children over the age of 2 are either overweight or obese.

Ian Potter, Assistant Deputy Minister, Health Canada
Mr. Potter congratulated the FNIGC and the First Nation Centre at NAHO. He said the conference is a huge success and demonstrates how RHS can help though education, prevention programs and health care delivery. Potter said Health Canada and FNIHB was proud to have contributed to the RHS – between 2001 – 2005 an $8 million contribution.

He said the RHS broke new ground. It was organized and delivered by First Nations, capacity was built at the community level, it took a wholistic approach to health and created a research and practitioner partnership.

Potter said good data provides us with the ability to understand the problem, evaluate effectiveness of programs, monitor progress and ultimately improve health. He said "you can be proud of what you have accomplished with the RHS even though the path was difficult, you persevered and succeeded."

Potter concluded, "as the national chief said yesterday, it is important to focus not only on what needs to change but on what First Nation have accomplished, as individuals, as communities and First Nations. The RHS is one such accomplishment."

Bill Erasmus, AFN Vice-Chief
Gave thanks for the opportunity to provide closing remarks at this historic event: a ten-year celebration of the only national research initiative under complete First Nations control. He said, "I congratulate you for your dedication and success, and for your leadership in putting together this ground-breaking research."

Erasmus said this latest Regional Health Survey provides the information needed for the AFN's Chiefs Committee on Health to prove to the federal, provincial and territorial governments that there is need for urgent action to address the poor health and social conditions experienced in so many First Nations communities.

As demonstrated by the RHS, First Nations are champions in creating innovative health models. First Nations can lead the way in improving the overall Canadian health system.

This morning, the National Chief and Bill Erasmus told health ministers that the Chiefs endorsed moving forward in the FMM planning at the AFN Special Chiefs Assembly held in Regina. They did this with the caveat that all FMM processes must result in First Nations specific developments.

In closing, at the First Ministers Meeting, there are expectations to see major announcements and concrete commitments that will provide First Nations with the recognition and the resources needed to support their people and their communities to break the cycle of poverty and poor health.

During their lifetimes, all First Nations should finally be able to experience what most Canadians take for granted – what it is like to live in healthy, happy communities – what it is like to live in one of the most prosperous countries in the world.

Summary of Dialogue Circles: New Beginnings, Charting a New Course, Planning for Future Generations. Facilitator Harold Tarbell formed participants into discussion groups and asked then to identify **Priorities For The Next RHS** – Specifically What Questions Should Be Asked, The Process For Conducting The Survey And Application Of The Resulting Data?

Survey Questions to Ask For The Next RHS

- Registered under C-31 or 6.1/6.1
- more questions on First Nation indicators of quality of life – economic, health indicators
- whether children were involved in sports
- stay away from attitudinal questions.
- physical activity and attitudes
- do you believe your standard of living affects your lifestyle
- do you feel subjected to discrimination?
- do you have access off-reserve?
- How important is it to keep the Earth clean
- do you reside urban, rural or remote?
- are you concerned with the contamination of traditional foods/
- is the Canada food guide appropriate and are you aware of what is consists of?
- questions for youth – have you left the reserve in last 5 years or plan to?
- flesh out the difference between traditions and culture
- how much time have you lived off reserve and plans to return?
- the availability of fresh fruits and vegetables?
- did you know that bannock was not a traditional food?
- include two spirited people in survey
- questions on wellness and quality of life and environmental pollution affects on health
- more questions on chronic disease - cancer
- questions on family violence

Process For Conducting The Survey:

Include Off Reserve In The Next Survey

- Pay attention to regions and aggregates
- Be respectful of differences in regions
- community driven collective approach
- create a red standard
- Include urban, incarcerated, rural, remote in survey
- face to face interviews
- regions should form groups & develop questionnaire from grass roots.
- validate the process at the community level
- assessment at the local level
- sell RHS to chief and council
- focus on more positive well being - personal, community, nation strengths
- long-term stable increased funding
- increase community capacity
- involve community leaders – Band Council Resolutions

Application Of The Resulting Data – How do we Use it?

- have a regional dissemination prior to a national dissemination
- disseminate in First Nation languages
- use the results from the data
- produce 1 page fact sheets
- results should be given back to the community before any inclusion in publication – create a policy for this
- make available to youth
- transparency – pamphlets, web-site
- a broader dissemination of the report to participants and community members
- a communications strategy
- more user friendly – large tables and graphs – more easily read
- create more awareness - newsletter
- use maps and video

Wrap Up

Ceal Tournier provided closing remarks. She thanked the data warriors for their good work as well as conference coordinator Tuesday Johnson Macdonald, RHS Coordinator Jane Gray and the moderator Harold Tarbell. She thanked the hououred guests including Minister Bennett, NC Fontaine, Regional Chief Toulouse, Ian Potter and Roberta Jamieson.

Jane Gray thanked participants and said they will listen to participants' comments and do something with the next RHS.

Moderator **Harold Tarbell** closed by saying all the materials would be available on the web-site (**www.naho.ca/fnc.rhs**) . Some of the summaries would be available immediately and the PowerPoint and Conference Summary in a week or so, but would be made available as quickly as possible.

Elder Ernie Benedict from Akwesasne closed the meeting with a Thanksgiving Address.