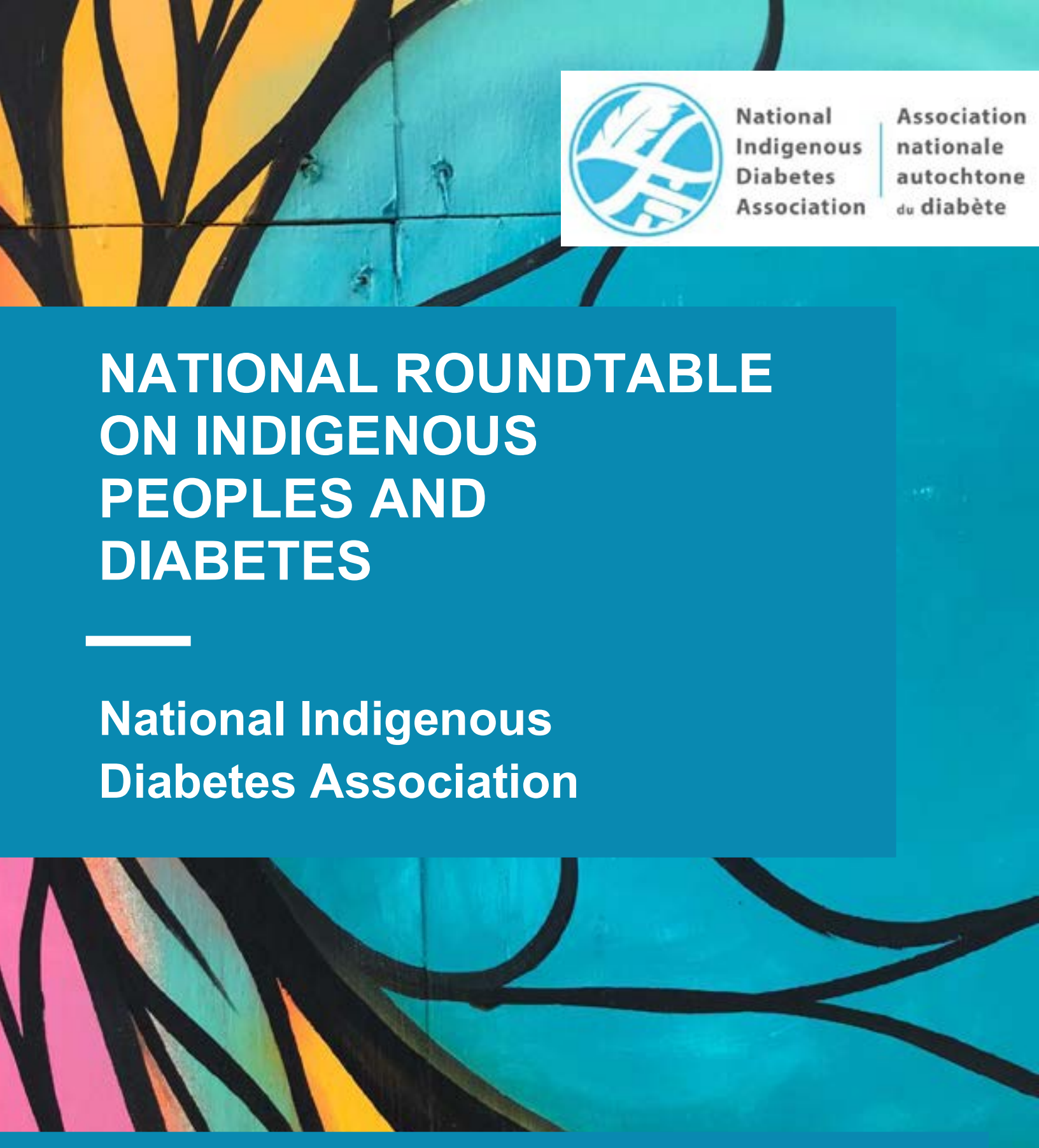

National Indigenous Diabetes Association | Association nationale autochtone du diabète

NATIONAL ROUNDTABLE ON INDIGENOUS PEOPLES AND DIABETES

National Indigenous Diabetes Association

November 14-15, 2019
Grey Eagle Resort and Casino
Calgary, Alberta

National Indigenous Diabetes Association | Association nationale autochtone du diabète

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Executive Summary:

Approximately 20 delegates, speakers, Indigenous government representatives, Indigenous Regional Diabetes Organizations, researchers and Diabetes / Health Care practitioners attended the NIDA National Roundtable Discussion on Indigenous Peoples and Diabetes two-day gathering. Discussions focused on challenges, potential investments and strategies to improve food sovereignty, reconciliation and potential initiatives "Beyond the Pill" including, the focus on the potential construct of a National Diabetes Strategy Framework.

The purpose of the roundtable was to canvas a broader yet focused group of Indigenous Health Care participants to develop a critical path forward to a National Indigenous Diabetes Strategy:

- To focus on opportunities and threats to a national strategy,
- To identify risk mitigation and to document the proceedings
- To assist in decision-making on a path forward with regards to the development of a National Strategy with Indigenous Peoples in the area of Diabetes prevention through NIDA.

The secondary, yet, equally important rationale for the gathering was to mobilize Indigenous leaders in Diabetes prevention to circumvent Diabetes Canada from developing their own National Strategy, outside of existing National Indigenous Organizational structures, for Indigenous Peoples—thereby, jeopardizing reconciliation by bypassing National Indigenous constructs.

The welcoming was conducted by Elder **Leonard Bastien, Pikani Nation** who offered words of encouragement and recognition of the diverse protocols for an inclusive and collective approach to the two-day event and discussions. As a former Chief and family man with a professional background in Child and Family Services, he understood the need to obtain diverse opinions and to reconcile a collective approach to Indigenous issues such as diabetes that has plagued most of our communities and families.

Elder Bastien expressed how the introduction of electricity, televisions, residential schools, and a sedentary lifestyle moved us away from our traditional food sources, our lands, responsibilities and balance. He also

expressed that many of his own family members have been impacted by the disease and he commended the work being done by this group.

The Elder acknowledged the Blackfoot Pikani territories and gave gratitude for the medicine bundle that the Creator provides us. Then he followed-up by singing a traditional song and thereby, opened the meeting. The sponsors were thanked for bringing experts together to talk about this important topic.

2. **Introduction:**

The National Indigenous Diabetes Association (NIDA), formerly known as, the National Aboriginal Diabetes Association (NADA) was established in 1995 to educate Indigenous Peoples about the treatment and prevention of diabetes, which is much higher among Indigenous Peoples than mainstream Canadians. For example, currently over 17 per cent of First Nations living on reserve have Type 2 diabetes which is directly related to poverty, diet, and lifestyle.

NIDA, in partnership with Boehringer Ingelheim and the Indigenous Health Policy Framework (IHPF) invited health Care delegates from government, research agencies, regional and national organizations to partake in a face to face gathering to provide a robust discussion on the following topics:

- Determinants of Type-2 and gestational diabetes among Indigenous Peoples,
- Paths forward in reducing the burden of diabetes in Indigenous communities,
- and, the interest and suitability in the development of a National Indigenous Diabetes Strategies.

This meeting was a follow-up to a pan-Canadian policy roundtable on diabetes in Indigenous populations in Canada that took place in November 2017. The delegates were invited as Indigenous community leaders in diabetes prevention from across Canada, to share stories and insight into issues and successes in diabetes care in Indigenous communities with an overall aim to influence policy conversations at a national level.

Key areas of discussion / presentations:

- Tabitha Martens shared information on her work with NIDA's Food Sovereignty Bundle research and community consultation.
- Nancy Perkins, from Sunnybrook Research Institute, substituted Dr. Sheldon Tobe, and gave a briefing on a family owned pharmaceutical Boehringer-Ingelheim's Dream Global 2 program and also presented the initial outcomes for the program that supports community driven initiatives in Indigenous Diabetes Health.
- Raven Indigenous Impact Foundation shared information about their work with Anishininew communities of the Island Lakes territories in Manitoba regarding Indigenous Solutions Lab, also referred to as, a Social Innovation Lab on Diabetes Reduction a unique innovative social capital investments structure and approach to sustainable health outcomes and development.
- Lastly, the roundtable discussions took place regarding the feasibility of developing a National Indigenous Diabetes Strategy that is focused on food sovereignty, Indigenous governance of health data and an equity framework.

Day 1—Presentation 1: Introducing our Indigenous Food Sovereignty Bundle by Tabitha Martens, Fisher River Cree Nation.

On the first day of the National Roundtable, Tabitha Martens, from the Fisher Cree First Nation, Manitoba, gave a virtual presentation on her work with the NIDA's Food Sovereignty Bundle research and Indigenous community consultation **which set the tone for the roundtable discussions.** She has worked in food sovereignty for the past 10 years as a "reluctant academic" and land-based activist.

She explained that the Food Sovereignty Bundle project **created an assessment tool and framework document** (adapted from a US food sovereignty assessment tool) to identify what food sovereignty looks like. This is more reflective of Canada and the Indigenous experience in Canada due to geographic diversity and food insecurity as a result of high costs, lack of access, government policies, changes to the land, and broken connections to families. This is all a result **of colonization**, the

desire for Indigenous lands by newcomers, and the residential school experience designed to eliminate Indigenous Peoples.

She also explained how the history of Canada gave rise to increased incidents for diabetes in our communities which resulted from the loss of land, food security, and our natural habitat. **Food was used as a weapon against our people**.

Tabitha stated that food insecurity has more to do with **power relationships**. Therefore, Indigenous food insecurity is deeply rooted in the past and related to colonial government policies, **shame, grief, racism** and **trauma**. And, that government polices continue to impact our food security which resulted from colonized food systems. In her work she opens conversations about food in terms of shame and trauma – because **it is not** and **never was** our fault that we were not able to properly feed ourselves. Therefore, food sovereignty is about:

- Restorative power
- It's holistic
- Activism (people need to active in food systems)
- Self-determination,
- Grounded in Nationhood, history and geography

She addressed the question, "Why Indigenous food sovereignty (Concept)"? Because it relates to production, consumption and **restores power** inherent in food systems.

Therefore, the driving force in **food sovereignty is rooted in self-determination.** Food sovereignty is one's ability to determine one's own food source, its local traditions and values rooted in nationhood, geography and language.

Tabitha also explained that based on feedback from the Indigenous communities—the Food Sovereignty Bundle research **assessment tool adaptation** was modified to decolonize the tool and adapted to create a tool that reflected more Indigenous a way of knowing and doing.

The tool captures Indigenous stories followed by an assessment of how they make you feel, followed by reflective Q & A's.

- Elements of the Food Sovereignty Bundle framework included chapters or rather themed stories. They are as follows:
  - Land
  - Family,
  - Diabetes (reclaiming self-determination, changing lifestyle and wellness to better manage diabetes)
  - Community Planning (power/control)
  - Food waste management – defined as a choice (responsibility and accountability)
  - Sharing
  - Process

- Tabitha explained that the framework is also grounding in the 4 r's: Respect, Reciprocity, Relational accountability, and Rights—the rights of the researched (Wilson, 2008).
  - The research and framework are also made by, for, and with Indigenous communities.

The next steps:

  - Publication: the framework is to be housed in the Manitoba First Nations Education Resource Centre, printed/electronic shared, to be continually shaped and shared overtime.

The presentation was followed by Q&A.

Day 1—Presentation 2: Raven—The Indigenous Solutions Lab on Diabetes Reduction, presented by Paul Lacerte, Raven Indigenous Impact Foundation (RIIF)

Paul Lacerte, presented on behalf of the Raven Indigenous Impact Foundation (RIIF). Paul is a member of the Nadleh Whuten Band and belongs to the Carrier First Nation in northern BC. Paul is a Managing Partner with Raven Indigenous Capital Partners (the first Indigenous financial intermediary in Canada) and served in a senior capacity on the BC Association of Aboriginal Friendship Centres for 20 years. In 2011, Paul and his daughter Raven created a grassroots movement of Aboriginal and non-Aboriginal men who are standing up against violence towards women and children; through the Moose Hide campaign.

Paul presented the RIIF concept and construct. He explained that RIIF is raising capital to combat Type-2 diabetes through private capital. RIIF is a foundation group which also has a private capital corporate structure. Today, they raised 11 million in Equity based investment funding.

RIFF also offers equity-based investments/funding to entrepreneurs between $250,000 to $1.2 million. They offer Impact Investing (investments in social and environmental cost-benefits) with Indigenous entrepreneurs. RIIF is an Indigenous owned and operated financial intermediary and a registered charity with a corporate structure arm. They are also rooted in Indigenous epistemology.

The Lab aims to define a business case for a $20M-$25M Diabetes Reduction Outcomes Contract. There is potential Indigenous economy to grow impact investment in the diabetes space. He introduced a pilot fund to address diabetes in an innovated way—The Solution Lab.

- Paul presented the RIIF Business Model:
    - Outcomes Finance Model— A Social Innovation Solutions Lab around diabetes.

Paul walked participants through a chronology of this co-created solutions lab development and their process of community engagements.

- He explained how they conducted 50 focus groups, and engaged several groups including: Government of Canada, Lawson

Foundation, Aki Foods, Four Arrows Regional Health Authority, and Mi'kmaq Confederation of PEI.

- The outcomes were a Financial Model that could fund diabetes prevention measures/projects (interventions) through pilot investments. A demonstration of how the model could work was conducted: the example used was a "Health Food Lunch Box" program. By offering healthy lunches to folks at no cost to the organization, well-being would be measured.
    - Early letters of investment and interest from both federal and provincial governments, and other private companies, that are based on Outcome Performance model into solutions led, measured by, and in the Indigenous communities.
    - These were co-created in the Indigenous Lab: outcomes could be reduction in diabetes, job creation, skills training, and new social enterprises, etc. Equal to "Diabetes Bonds to fund solutions innovations. Institutions and governments (i.e.: Canada Diabetes) can buy social outcomes. Metrics still need to be developed. The outcomes are: Cost savings/ proven savings—until we prove reduction in indicators (over 5 years).
    - The pay for performance arrangement model—has been modeled from a Clean Energy Bond. Concept has been proven in the commodities sector of development and is now being transferable to health care solutions.
    - It's not a retail product. There will be a set of investors.

Following the presentation, a robust open discussion ensured. The following highlights some of comments and questions that were raised by the participants:

- Participants had difficulty to see how one would measure performance outcomes of diabetes (medical records, privacy issues, ethics, etc.) , especially, within a short 5-year period. Baselines would need to be established, etc. Improvements take time to materialize…as do complications from diabetes (this can take years).
- I understand the model is a private and public investments from FED and Prov to reduce diabetes in the form of outcome purchases. What would this look like?

    - Example: In one FN's community after the installation of a Geo-thermal systems metrics were measured that proved savings for governments (9 years of savings based on meter readings).
- This is fascinating. We have a Universal Health Care system in Canada, where profit isn't the focus. Therefore, the challenge with this model is that it focuses on Profit for investors based on the reduction in the delta in investments that government makes and how the savings can be used in another area. How will this be done in diabetes complications which manifest over a long period of time; not 5 years? It was explained that the model will address prevention only. Measurements and metrics are complex and not yet determined for this process. This will be the challenge. You will have to be very primary prevention focused. You will need strong ethical practices and buy-in by the communities.
- Participants reaction to the model was interested yet skeptical about buy-in from patients and health care systems—And, ethics.
- What about a Situational example: reduction of amputees to save on housing rehabilitation?

Adjournment of Day 1: 9:00 pm

Day 2- Opening remarks, reflections from previous day and overview of agenda:

Bimaadzwin facilitator, Isadore Day, reviewed the agenda for Day Two and conducted a re-cap of the previous day's discussions and added some reflections on why the work in diabetes is important in First Nation communities. Regarding Type Two diabetes— the discussions raised awareness that many of our people are slowly dying from complications with diabetes. He recognized the gravity of this chronic disease and all the hard work that the folks in the room do to combat this disease. He recognized the polarities between local First Nations and federal government and provinces who have regulatory measures and a Health Accord within the Universal Health Care systems. First Nations do not get to exercise health care within their jurisdictions; even though we are in a transformative period of reconciliation with governments.

This is why first nations need to assert jurisdiction and ensure our children's right to good health, even if it means starting with by-laws that prohibit the sale of candies in vending machines in our communities. This is a First Nations right. And it is also our right to find innovative solutions to chronic diseases that plague our communities; innovation like Raven investments, or the food sovereignty bundle research. We need to find collective and individual solutions to manage better health outcomes. Therefore, we need to:

- Look at research
- Put resources into sovereignty
- And, find alternative ways to prevent and manage chronic diseases.

Isadore commented that we as First Nations, "we have the aptitude and desire to tackle this problem, we have health authority models, and we have the responsibility to identify an alternative critical path forward. There is a lot of work to do. Together we will put a strategy in place "made for you and by you". On Day 2, participants were asked to continue to look at alternative investments in research and models to move the dial forward and to build a clear path forward within a national strategy.

Day 2—Presentation 3: DG2 and Supports for Community Driven Initiatives in Indigenous Diabetes—presented by Nancy Perkins (in place of Dr. Sheldon Tobe) -- both from the Sunnybrook Research Institute (SRI).

On Day Two of the roundtable discussions, Nancy Perkins, from Sunnybrook Research Institute, presented on behalf of Dr. Sheldon Tobe who is also from SRI. She presented on the family owned pharmaceutical Boehringer-Ingelheim's Dream Global (DG) 1 and 2 programs and its ties to Indigenous communities to improving outcomes in peoples managing diabetes.

Nancy gave a chronology of events that led to the current Dream Global 2 (DG2) research project. She explained that the **DREAM story began over 20 years ago in 1998** and later became DREAM Global in 2013, onwards and up to todays DG2 . She shared both the positive outcomes and the important lessons learned. She also provided statistics on hypertension and how it affects more than 1 billion people worldwide and is disproportionately prevalent in most Indigenous communities.

- DREAM GLOBAL-2 stands for the following:
  The Diabetes Reduction and Management Guidelines Lowering of Blood Pressure Achieved by Learning

- Nancy further explained what the long project title means: She stated that, "we believe that it is through learning and education, we can give knowledge to those communities to maintain better health outcomes". All of this entails long-term sustainability.

The objective of Nancy's presentation was as follows:

- To provide an overview of the **DREAM studies which were primarily focused on hypertension and diabetes** in the list of communities they worked with (approximately 10 communities).
- With a focus on GD2; the latest study—an education tool to better help manage and prevent serious complications of diabetes.
- She talked about DG2:

- Partnerships (Local champions are critical/ in community, expertise in research, identify the team to communicate with members. Grey Box is our tech partner
  (the teaching tool, InfoClin- software company that adaptations data collection tools that works with EMR;s)
- Goals,
- Anticipated impacts,
- *I-research* (a two-way communication tool)
- Most importantly, the evaluation and assessment processes
- And, of course, Ethical consideration (respect for traditions and local protocols)

- She talked about the origins of Dream Global coming directly from C-Change-Canadian Cardiovascular Harmonized National—Guidelines Endeavour Clinical Practice Guidelines across Canada. (Guideline for family doctors (best practices) that guides how they interact with patients and preventions. Hypertension and diabetes are integrated together to ensure better care. Guidelines for Indigenous communities is based on studies (more narrative tools).

The following is a list of past and current DREAM projects—The Dream studies included the following research and actions:

- D.R.E.A.M. 1 -1998.
  Community wide screening. To screen for diabetes and kidney disease via protein in urine screening. **Problem**: With Dialysis treatment patients' lives are diminished / families are separated because patients must leave the communities.
  Social determinate factors/barriers include: Can't get travel to clinic (2 months in/out), pharmacy, medical doctor; patient, communication, trust factors and community experiences.
  The need came from the northern First Nation communities in Saskatchewan (10 reserves involved). **Solution**: screening helped with prevention. **Results**: 101 patients; 99 completed the study, 85 positive results showed sustained improvements in blood pressure. Homecare nurses were trained and delivered the program. DR. Tobe developed algorithms and provided medication to Homecare nurses to administer (closely followed

by 12 physicians). **Outputs**: DR. Tobe was invited to continue with research due to positive outcomes. This was the motivation for other Dream studies.

- D.R.E.A.M. 2 1999-2000.
  Physician protocol with HC Nurse follow up visits.

- D.R.E.A.M. 3 2001-04.
  Nurse administered medication algorithm.

- D.R.E.A.M. Follow-up 2003-05.
  Follow clients after completing off D.R.E.A.M.

- D.R.E.A.M.-Tel 2006-2008 **The problem:** Patients need to better manage glucose testing at home via telecommunication. There were some positive results but the main lesson learned—communities lack of technology. These were the early days of technology investments. **Test group:** There were 25 patients in study. Patients self-tested blood sugars that was sent via Bluetooth. The data was updated to central server to document results. **Results**: Showed improvements in blood sugar controls.

- DREAM GLOBAL 2013- 2015 (Tanzania and Atlantic provinces) Use technology to manage blood pressure. They recruited 6 communities in Canada to participate in the study. **Results** were positive once again. Blood pressure monitors through technology. Another successful intervention.

Nancy provided other examples of working with Eel River Bar First Nation; a community of 350 with a study group of 65 participants. Barriers to good health outcomes include: Geography/ isolation and access to endo-chronologist and home are nurses.

In total, 52 visits were made on-reserve; this allowed for greater understanding of community protocols an opportunity to create trust and manage risks and ensure better outcomes. Dr. Tobe was involved throughout the process.

During DREAM Global 2, hypertension (HTN) has been identified as the leading cause of morbidity and mortality. Disparities in the social determinants of health, health care availability, utilization and outcomes, related to race and geography contribute to poorer blood pressure control rates and increased risk of stroke.

DREAM Global 2 is a Call to Action: Indigenous communities have identified the need for programs to prevent diabetes and hypertension as well as manage these conditions.

The Goals of DREAM Global 2:

- To prevent the new onset of diabetes and hypertension in Indigenous people at high risk for these conditions by applying evidence-based recommendations from clinical practice guidelines
- To improve the awareness, treatment and control of diabetes and hypertension in study communities
- To improve personal and community wellness through changes in personal outlook, community capacity development.

How the DG2 tool works: It is a combination of DIET and PHYSICAL Activity that can help to reduce the risk for diabetes, hypertension and their complications- using technology (cell phones) to motivate and monitor results. Plug and play. The tools have been better adapted based on a community participatory approach; with feedback from community members.

A new publication is available (by Dr. Mars) on GD that address the DREAM study successes, challenges, the process, the communications, the important outcomes and lessons learned.

Facilitator Isadore Day provided additional comments on Bimaadzwin's work with Dream Global 2 and where the project is going next to improve health outcomes in hypertension and diabetes. Isadore provided some context on Bimaadzwin's work with DG2 and how we are facilitating in the development of an Indigenous Health Policy Framework through roundtable discussions like this group to close the

gap on fragmented collaborations with Indigenous Peoples. There is a critical need to create measures that go "Beyond the Pill" that are actionable (not just a study that sits on a shelf). The IHPF is intended to ensure better relational accountability and culturally appropriate applications. These efforts will ensure that BI investments are collaborative and focused on Indigenous Health issues. BI has been a silent champion for Indigenous Peoples and our steering committee of Indigenous health experts are collaborating to ensure their guidelines are culturally appropriate.

The presentation was followed by Q&A. Some questions included:

- Where did the idea for a National Diabetes Strategy?
- Who would this IHPF be for?
- How does it differ from a NIDA National Strategy?
- Are we using the same check list?
- National organizations are changing and are evolving?
- NIDA has access to Health Care practitioners.
- DISC is changing this can create competition for financial resources.
- Most of the push for a national strategy s coming from Diabetes Canada (around since 1960's—nationally there's been a disconnect. Not comfortable with DC steering a National Strategy for Indigenous Peoples as there has been a disconnect with this organization especially, in the area of diabetes.
- NIDA sees the need to be more inclusive, to get perspectives from the north/ across Canada to develop a national lens to our work. Not sure it can be done? This is the purpose of the Roundtables can a national strategy be done and how can it be operationalized. We hope this is the beginning of the process.
- There is incredible value in the gathering of community value and cross-sectorial views to see if a National Strategy will be beneficial to our community members and what it will look like. We will come back for roundtable discussions like this.
- NIDA has a small budget 240 k— for smoking strategy, salaries (1.5 person years), so couldn't do a national strategy with this structure and with such limited resources. Thee discussion are more exploratory.

Day 2–Presentation 4: CHIR Initiatives: The Canadian Institutes of Health Research (CIHR) Initiatives in Indigenous Wellness- Community Perspectives on Research needs.

Dr. Norm Rosenblum, Scientific Director of CIHR Institute of Nutrition, Metabolism and Diabetes and Dr. Earl Nowgesic, Assistant Scientific Director, CIHR Institute of Indigenous Peoples' Health, presented on a new initiative. CIHR was established in 2000, there are now 13 institutes and they are evolving. In this spirit, they were pleased to announce a NEW funding initiative referred to as the Network Environment Indigenous Health Research (NEIHR). The announcement was followed by the first roundtable discussions.

The NEIHR research program is a $100.8 million investment over a 16-year period that entailed the following grants:

1. Twenty-four (24) one-year development grants—valued at $75,000 each; this is already launched
2. Nine (9) Full network grants valued at $700,000 annually from 2019-20 to 2023-35
3. One (1) consortium grant annually from 2019-20 to 2034-35 to support a NEIHR Coordinating Centre for the (9) individual NEIHR grants (an overseer of the larger long-term grants.

The partnership goals of CIHR are:

- Discovery
- Delivery

The partnership objectives:

- First Nation wellness and reliance
- And, treatment linked to community values and Indigenous led

Some key stakeholders: Diabetes Canada and Chronic Kidney Disease.

The proposed National Network Centres (NNoC) focused on capacity development, research, and knowledge translation centred on Indigenous Peoples (First Nation, Inuit, and Metis).

They shared an important fact in diabetes medicine and history—2021 will mark the 100-year anniversary in the discovery of insulin (Fredrick

Banting and JJR Macleod won the Nobel Prize (circa,1923). Life expectancy prior to the discovery was 1 year. Today, folks like Ted Ryder survived 76 years living with diabetes.

The CIHR roundtable discussions were convened to gauge key stakeholders' perceptions on the strengths, weaknesses, opportunities and threats to the development of research funding around Indigenuos Peoples and diabetes to be delivered by NIDA and researcher guidelines. Participants were guided by **three questions** per discussions table and facilitated by Bimaadzwin. This method was employed to ensure an inclusive and targeted participatory process and 360-degree feedback. The following highlights the 360 feedback from the discussion tables:

Some Highlights from CIRH RoundTable Discussions:

- Poverty is a dominant condition for Indigenous communities; this connects with food security/healthy eating and diabetes. Thus, research must address how to mitigate these interacting factors. There are examples of programs aimed to do this. Are these programs effective? Other programs that could be developed?
- Food sovereignty is a critically important issue.
- Mental health/suicide/diabetes – important interactions and critical to address within a resilience theme.
- Disease trajectory is not uniform among individuals with diabetes. What is the source of this heterogeneity? What can be done with such information?
- The governance/policy structure of the Indigenous community and how this affects issues e.g. food, connection to land, etc., and diabetes.

Discussion questions:

1. How is diabetes viewed in the broader context of wellness and resilience in Indigenous communities?
2. Are there research questions that, if answered, could improve wellness in relation to diabetes in Indigenous communities?
3. What would be helpful to support communities to lead their own research projects?

Granular data for each question of CIHR roundtable:

1. **How is diabetes viewed in the broader context of wellness and resilience in Indigenous communities?**

- There is lots of blame of T2D, deficit-based. Social Determinants of Health (SDOH) plays a big role, and trauma also contributes to the broader context of wellness. Diabetes is a symptom of broader issue. We must continue amazing work happening on the ground, but need to focus on national level policies.
- How we view diabetes – how do we bring community concerns to the national levels? How can we bring it to communities? **Why, after 10 years of the Aboriginal Diabetes Initiative (ADI), are we still working on a plan?**
- Finally starting to look at food in schools, activity of kids, Elder activities.
- Issue of ceremony – imbalance happening.
- What are we going to do to move forward? Nurses are primary point of care; give nurses tools and resources to look at health promotion and disease prevention and treatment.
- TRC – non-Indigenous settler engagement – so many recommendations; working at cultural safety, knowledge keepers, and curriculum tools.
- Keyhole – same landscape – communities are under siege – small communities are resource challenged with so many issues. Working on theory of change, so much about healing, wellness, culture is such an important point.
- Not many apprentices for knowledge keepers. No traditional roles in communities (plays out in addictions) – must think about the ecosystem as it relates to diabetes. We are so far behind.
- One example provided was from an individual from a fasting culture.
- In healthcare providers – National Indigenous Diabetes Strategy. Schools of nursing need to address prevention for both

Indigenous and non-Indigenous. There are conflicting practices in primary care. We need better communication between traditional and western approaches.

- **Consider SDOH and TRC – use for every decision.**
- People are just not getting basic needs met, hard to talk about getting people to check their sugars.
- Hard to talk about prevention when people are in crisis all the time. Always new problems on reserve.
- IT infrastructure is not in place – how did the DREAM2 people think their plan would work? Nurses always have to innovate.
- **Quebec has no time for prevention**. It is very much a focus on treatment – community health representatives could do it if they have one in the community.
- The Canada Food Guide is not realistic for many; canned foods and flour feed community. How to simplify to make it real for what people have.
- Liked presentation last night about food sovereignty; liked empowering people. It was more hopeful, like they have control over their lives. The mental wellness framework does that well.
- **Canada Post used to do a subsidy for shipping food, then it stopped.** We need healthy food bins – teaching financial literacy. National Indigenous Healthcare organization – nurses, social workers, social workers, NIOs

2. **Are there research questions that, if answered, could improve wellness in relation to diabetes in Indigenous communities?**

- TRC – research component – research collaborative agreements – Indigenous People are not getting sucked in – using OCAP principles.
- Non-Indigenous people are offended – a research battle – who owns it?
- There is already lots of research that happens.
- **We know what the issues are in diabetes.**

- Research needs to be qualified – looking for concrete solutions at the community level.
- Chronic disease has common factors. We need a model for holistic health living together – taking prevention generally will impact multiple chronic diseases.
- **An important research question may be to look at wellness of helpers (family support workers, nurses, NPs, etc). What happens quickly is a "martyr mentality" gets rewarded and community workers burn-out. So we need to improve resilience of helpers. It is hard to retain staff.**
- The biggest gap is Indigenous focus, led by Indigenous people.
- Some are sitting on research projects – research the safety

3. **What would be helpful to support communities to lead their own research projects?**

- Already the Indigenous Nurses Association is working with the Chief Public Health Officer (CPO), 24 Colleges, 14 organizations identified Indigenous health as a priority – Indigenous Working Group formed. **Huge gaps have been identified.**
- Working with CPO to develop principles of engagement with Indigenous Peoples, how to facilitate inclusion and engagement.
- Research on stigma, privilege and racism.
- It would be important to support communities in navigating through some academic stuff e.g., ethics – it would be so much better if autonomous, language doesn't make sense from an Indigenous perspective – TCPS 2 is a barrier.
- There is a perfect opportunity under Nursing Now initiative.
- Communities need time to think through ethics piece.
- Establish ownership.
- Capacity in many areas is lacking.
- PHAC sends things to AFN that excludes on-reserve population.
- **Indigenous Impact Framework is so under-valued because it's based on story telling – sometimes there is such a culture clash.**

- Participatory video demonstrates it is really different when young people tell stories.
- We need capacity-building for young people – determining priorities at community level.
- Allow communities to choose subject and method.

- Loss of traditional foods, over-fishing, commercial fishing, fish farms. Effects of climate change, environmental pollutants. Same with over hunting.
- **Mentorship is missing.**

General themes from Day 2-- Discussions

Theme 1- Addressing Trauma

- The importance of research addressing root causes of diabetes, such as trauma. Research addressing lifestyle change (diet/exercise) doesn't address the underlying reasons people may not make healthy lifestyle choices.
- Without addressing the root causes of diabetes, many communities may feel programs to change lifestyle are futile
- Residential schools left many without tools to cope and without models of healthy relationships, need to develop coping tools, but also ability to express love, respecting culture.
- Asking people to change their lifestyle without addressing trauma is asking people to fight their own bodies; messaging about lifestyle change can be interpreted as "shame and blame", which is not productive. There is a need for scientific rigour, but allow other types of knowledge.
- The idea that shame can lead to backsliding when you are trying to change your habits to a healthier lifestyle; the need for messaging/"safe places" to support people if/when they backslide as they try to deal with emotions
- Discussion about stigma, the need to address teasing and bullying (e.g. Garden Hill video for teens; KR note: Craig Settee showed this video at the INMD ECI Meeting)

Theme 2- Food and Culture

- The importance of food sovereignty (control of access to food) to food security, and relationship of food systems to colonization
- The idea that communities need to be rebuilt, aspects such as community food sharing were keys to survival in past, but there was the sense that broader community food sharing (beyond sharing with Elders) is not done now; the link between food and culture and community (e.g. bison)

Theme 3- Integrating Tradition and Western Science

- need innovative approaches to reach youth including children and teens which includes traditional knowledge but also Western science (include Elders and dieticians, e.g. coloring book about traditional foods)
- The idea that activity is more than "exercise"; traditional community activities such as chopping down a tree and building a canoe, feasts, etc bring purpose to activity (and returning to Theme 1- links between culture/ceremony and recovery from trauma)
- Tribal point study: comparing groups with two interventions: (1) diet/exercise and (2) ceremony. Ceremony outcomes were better. (speaks to link between ceremony and recovery from trauma)

Theme 4- Community Led Research

- The feeling that there is a disconnect between interests of community and interests of researchers, and there is cynicism about the motivations of non-Indigenous researchers working in Indigenous communities. Communities need to have a stronger voice; researchers need to be open to researching what communities are interested in.
- Research too often doesn't address concerns of the community—the sense of fatigue at being researched "about" not "with". The sense that the things that need to be looked at are not being researched. The idea that the reason for the research is to get numbers to inform federal government policies is not good rationale for community research.

- The sense that rights of individuals could be violated by researchers; the need to respect the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Testing of pharmaceuticals should not be allowed.
- Lack of time and resources in communities makes it difficult for some communities to participate in requests for applications. Long application timelines, dissemination of opportunities, and advance notice of future opportunities to communities are needed. Some communities lack expertise and must hire consultants even to apply to a funding opportunity which is a barrier. Long and time-consuming forms like the Common CV (CCV) are a barrier.
- Things that are helpful and welcoming to community-led research: framing opportunity in terms of mobilizing the community; referencing UNDRIP in funding opportunity text; including the need to incorporate Indigenous paradigms in research (it's not just about including Indigenous people as part of the research team).

3. Day 2—Presentation 5: NIDA Roundtable on Indigenous Peoples and Diabetes Introduction, Jeff LaPlante, National Indigenous Diabetes Association

Jeff LaPlante, Executive Director of NIDA presented a history and chronology of NIDA's history and evolution –past, present and future endeavors including research, structural changes..

- Jeff examined the impact of Colonization, Supremacism and Capitalism on Indigenous Peoples that resulted in Trauma and lose of resources. He gave a chronology of racist government policies; to remove independence. What happened to our foods?
- Sugar and slavery went hand and hand for centuries dating back to 1440's
  as seen in Portugal. Racism create disparities in the social construct and are this underpinning of disease; creating chronic stress, trauma and chronic inflammation.

- Jeff provided many examples and explained that Indigenous Peoples also experienced the impacts of colonization, creating loss of lands, language and foods; and stated that this is how diabetes was manifested in Indigenous communities—and the Genocide continues
- Decolonizing medicine and diet can improve outcomes.
- He gave a historical chronology of racist government policies by Canada and the impact on Indigenous Peoples; dating back to 1755; governments through the decades historically starved Indigenous Peoples into compliancy and complacency.
- Today, NIDA advocates and provides diabetes related tools, resources to First Nations, Metis and Inuit, helps to build capacity and knowledge. He provided links to recent data and research (see power point presentation for links to data).
- Jeff presented a simple but impactful slide that showed historians found hunger at the root of contemporary Indigenous problems and the introduction of the poor diet in Indigenous communities. For example, in the 1940s, governments shared five gifts to combat food insecurity yet, it is these same five "gifts" that are at the base of a poor diet. They are; **flour, milk, butter, salt and sugar.**
  Educating our communities with simplistic messaging can influence changed lifestyles. The NIDA mission is to lead the promotion of healthy environments to prevent and manage diabetes by working collaboratively with Indigenous Peoples, communities, and organizations.

- Jeff was proud to announce a NEW exemplary training program, and certification partnership:

  - The Indigenous Diabetes Wellness Organization Program Granted Professional Certification Status.
  - The first certified Diabetes wellness worker recipient was honoured on November 14, 2019.
  - The Indigenous Diabetes Health Circle (IDHC) in Tyendinaga Mohawk Territory becomes the first diabetes organization to achieve training programs certification status by the Indigenous Certification Board of Canada (ICBOC)

NIDA continues to evolve and wants to learn more about this group perceptions and concerns about a National Diabetes Strategy in lieu an outside government organization taking on this role—as they are far removed from the culture and social construct. But, will leave this to the group to decide. That is the purpose of bringing health practitioner together to brainstorm possible social structures that will support food sovereignty and to eradicate health inequalities.

In terms of Urban native groups, Jeff stated that it is also evident that health service for Urban First Nations/Metis people cannot address existing health inequalities by simplistic application of pan-Aboriginal strategies in prevention services; and that a strategy that targets their particular lived-life is also needed.

4. Discussion Tables—Developing National Indigenous Diabetes Strategy

In order to explore the feasibility of developing a National Indigenous Diabetes Strategy that is focused on food sovereignty, Indigenous governance of health data and an equity framework participant were asked to engage in an open roundtable discussion.

In a larger group setting participants engaged in an open brainstorming session facilitated by Bimaadzwin (a 40-minute brainstorming activity). The intent was to garner input into answering **three key questions** on a designed approach to a National Strategy. The key questions are listed below. They are:

Discussion Questions:

1. **Can it be done?**
2. **What would it look like?**
3. **Addressing Trauma, Racism, Sovereignty and an Equity Framework**

Bimaadzwin encouraged the participants to reflect on the presentations and address how the issues presented thus far can be incorporated into a National Strategy. To stop looking at food as nutrient but rather as place, family, love, healing and from a decolonizing lens. Facilitator Isadore Day drew a diagram to facilitate the discussion and to incorporate the themes into the discussion table talks.

Diagram—A healing medicine wheel; how to restore one's balance of harmony and well-being –

An open discussion ensured and its was unanimous that a National Strategic can be done, the questions that followed outlined the how and highlighted other areas for consideration.

1. Can it be done?

The output from the Group Discussion were as follows:

- Acknowledge that there are many different perspectives.
- We also need to acknowledge all the different types of interests.
- Yes, it can be done.
- Examine different existing models / best practices (i.e.: C-pack) and utilize model.
- The Metis/Inuit nations did something similar: optimistic NIDA can too.
- They will need guiding principles and inclusion.
- Refresh what's been done in mainstream.
- Address Pan Canadian /Pan Indigenous organizational interests.
- What will be the community impact?
- How can we strengthen our capacity?

2. What could it look like?

The Opportunity— Some responses and question identified were as follows:

- To decolonize the mainstream processes; as it relates to Indigenous populations
- To use strengths in regions—on the ground
- There is a need to clearly determine rationale
- To determine what will happen with the strategy?
- To examine the current mandate of NIDA—
    - For example: what are the authorities and obligations to develop a strategy?
    - What are the timelines? What will be regulated?
    - What will be the Design?
    - Is there a renewed mandate?
    - What will the board do to establish objectives and relationships?

- Federal governments can support with financial and expertise capacity building.

NIDA can and should drive the National Strategies mandate / renewal: They will need to consider the following:

- Serving community specific objectives
- Member driven associations
- Diabetes prevention programs –and, conduct a 360-degree review
- Examine historically—who are the supports?
- Relational accountability- Conduct an environmental scan and a 360-degree review of Diabetes Canada.
- Clarifying setting in place the Indigenous voice.
- Is ADI involved and in what capacity?
- Focused investments and representation.
- Coordination of the networks and supports for Indigenous Diabetes program(s).
- Consider legislation and regulatory measures.
- There is a need for tech and research support.
- Communication is imperative for new strategies,
- We need to include 5 pillars of a strategy:
    - Regulatory measures,
    - Training,
    - Expert Advocacy,
    - Ongoing Communication,
    - Plus, design a delivery mechanism,

- Take the strategy to CIHR for funding. Core funding is required.
- Expert advisory support.
- Reports, plans, priorities.

3. Addressing Trauma, Racism, Sovereignty and an Equity Framework:

- Include TRC, UNDRIP, WHO measures for Indigenous reconciliation to address improved health outcomes
- The strategy will need to be focused and pro-active.
- Include other associations such as MNC/ITK
- Formal Indigenous collaborations?

Other questions included: What IS the strategy and what IT IS NOT?
The following highlights some of the responses. The strategy will:

- Mobilize and clarify mandate.
- Allow for inclusion of Elders and youth.
- Emphasize decolonization and healing—as central principals.
- Provide a distinction-based Health Legislation.

NIDA provided some historical information on the development and evolution of NIDA ; in terms of connectivity to Indigenous groups and populations:

- In 1995, NIDA was established in Winnipeg, MB and was first established by a group of women concerned with the rise of Diabetes and the complications associated with the disease and the impact on their community and family members. The demanded resources to combat the disease and provide education for prevention.

5. Facilitator's Comments

The overall discussion among the NIDA roundtable on diabetes was very engaging. The models and perspectives about what can be done to combat the disease and to also live a quality of life with managed diabetes, was an important focal point for two of the main themes; research ideas and consideration of a national strategy.

The Canadian Institutes of Health Research provided a very clear set of questions concerned with Indigenous Health Research. This group participated in sessions aimed at answering CIHR's questions on research design and selection of projects awarded over the next several years. This is an opportunity that should be followed up on as individual efforts; but also, NIDA could become instrumental as a means to assist in providing guidance, support and access to a cast of networks in all NIDA's catchment regions, making a wider use of its mandate as a national association. A follow-up is warranted and further strategic action between NIDA and CIHR would greatly benefit the important endeavour to combat diabetes.

It is evident that the sentiment on creating a national strategy through NIDA on Indigenous Diabetes was positive, it should be underscored that this group is representative of a minimal voices and mandates. This is clearly a strong preliminary to determining the next steps in NIDA moving forward on a national strategy. The following considerations are being recommended for follow-up with the group in attendance, and further with NIDA as an association and its board of directors:

1) Outreach to NIDA's association members updating them on this report and posing the questions in the two day session should be issued for response over the next three months. Once conclusive, and more wide spread input can be achieved, a supplementary report can be made with respect to the central questions regarding a National Strategy.

2) Document review and primary research on 'organizational' responses to diabetes should validate the specifics on where there has been success, progress and shortfalls in addressing diabetes in Indigenous communities. This document review could also include mandates, funded initiatives of a national or regional scope that focused on diabetes response, and resolutions that have supported and guided the national response to diabetes.

3) Establishing a modernized framework that takes into account the most recent and pressing policy issues and perspectives of Indigenous Diabetes in Canada. For example, addressing diabetes from the perspective of de-colonizing the spaces and places where diabetes manifests; whether it's home, community, public spaces, healthcare systems, etc. The policy issues surrounding solutions and prevention models are vast and promising - only if coordination can be the harness that brings focus and strategic options. Another modernization component of the strategy could also look at bringing the full Indigenous catchment into a optional model of participation; this would provide NIDA with a very important responsibility to establish inroads, engagement opportunities, and partnership goals that would strengthen a response to Diabetes across a wider cross section of Indigenous populations.

A follow-up meeting should be expedited with the association members and mandates organizations that affiliate with NIDA and its goals.

Note: These are the key recommendations from Bimaadzwin, and should be considered as non-exhaustive to the two day dialogue session. It will be important that this work continues to find conclusive steps forward and a definitive action plan based on the two days.

The session was essential, useful and a solid starting point to move forward on a national strategy; of which NIDA can take a key role in facilitating.

Laurie Ann Nicolas: closed the meeting with a traditional traveling song.

Adjournment: 3 pm