MAMOW AHYAMOWEN

Northern Ontario Indigenous Health Information Partnership

SUMMER 2017, ISSUE 3

WELCOMING NEW PARTNERS

We continue to be excited by the enthusiasm we encounter when people hear about our partnership. We are particularly pleased to be able to welcome two new partners to Mamow Ahyamowen (meaning *Everyone's Voices*).

Matawa First Nations Management (MFNM) is a tribal council established in 1988 and serves nine Ojibway and Cree First Nations. The word Matawa means the *mouth of river* in recognition of the teachings of the elders that the rivers were the lifeline of their existence. Member First Nations include Aroland First Nation, Constance Lake First Nation, Eabametoong First Nation, Ginoogaming First Nation, Long Lake #58 First Nation, Marten Falls First Nation, Neskantaga First Nation, Nibinamik First Nation, and Webequie First Nation.

Keewaytinook Okimakanak (KO) means *Northern Chiefs* in Oji-Cree. KO is a non-political Chiefs Council serving six Northern Ontario First Nations.

(Continued on page 2…)

INSIDE THIS ISSUE

1 **Welcoming New Partners.** Our voices are getting stronger.

2 **Progress Updates.** Highlights from the last couple of months. **Definitions.** Common terms used in mortality analysis.

3 **Choosing Our First Analysis.** How did we decide to start with a mortality analysis?

4 **What Do We Know About Why Our People Are Dying?** An overview of mortality data from other analyses.

5 **Looking Forward** and **Community Approval**. How we will confirm community support.

The First Nations KO serves are Deer Lake, Fort Severn, Keewaywin, McDowell Lake, North Spirit Lake, and Poplar Hill First Nations.

Kenora Chiefs Advisory (KCA) is also pleased to welcome a ninth community to their organization. Northwest Angle 37 is KCA's newest member.

Together these new partners bring the total number of First Nations communities served by Mamow Ahyamowen to 73 and increases the number of partners to nine. We welcome MFNM, KO, and Northwest Angle 37 and we are thrilled that their voices will further strengthen our partnership.

Definitions

Mortality: Another word for death. **All-cause mortality** is all the deaths that occur while **cause-specific mortality** is the deaths due to a single cause (eg deaths due to cancer or deaths due to accidents).

Morbidity: Another term for illness. One person can have more than one illness at a time and we call these **co-morbidities**. When our people die they often have illnesses that were not the direct cause of death. For example, somebody could die in a fire in their house and the cause of death would be listed as an accident. If that person had Alzheimer's or dementia and forgot to turn off the stove before they went to bed then we might find we could prevent such accidents by improving the way we provide home care for our elders.

Mortality Rate: The number of people who die in a defined population over a specific period of time. For example, the number of First Nations people (the population) who die per year (a specific period of time). We often calculate rates as the number of deaths per 100,000 people. For example, if there were 3 deaths due to suicides in a community of 1,000 people in one year then we would say the mortality rate due to suicides in that community was 300 per 100,000 people. When we calculate rates for a population of 100,000 people we can compare mortality rates between communities of different sizes.

Cause of Death: When somebody dies in Ontario a death certificate is completed. On that death certificate a cause of death is recorded and a physician signs the death certificate to confirm the information is correct. Some causes of death (such as accidents) undergo further review to make sure the cause of death is correct.

Progress Updates

It has been a busy summer in Northern Ontario with several communities either evacuated or threatened by forest fires. Mamow Ahyamowen has continued to make progress even as Steering Committee members have dealt with these and other urgent challenges. Since our last newsletter our Steering Committee has:

- Learned about mortality analyses and what we can learn from them
- Decided to focus our first analysis on mortality and chronic diseases present at the time of death
- Used community input and feedback to develop an analysis plan
- Decided to submit an Applied Health Research Question (AHRQ) request to the Institute for Clinical Evaluative Sciences (ICES) to formalize our interest in analyzing First Nations mortality data
- Begun the process of seeking community approvals to determine which communities would like to participate in this analysis

This work prepares us well for a busy autumn with several Annual General Meetings where we look forward to further discussion of this work with our communities.

CHOOSING OUR FIRST ANALYSIS

Our partnership was formed to provide First Nations with the data needed to make better decisions about health in our communities. As we began to think about where to start we realized that our first analysis together needed to meet some important criteria including:

- Relevance: the data we analyze has to teach us about a well-defined health outcome that our communities value.
- Coverage: the data must exist for all or most Mamow Ahyamowen communities.
- Quality: there must be consistent ways for the data to be collected and the data must be reasonably complete (eg not too much missing data).
- Sample size: it will be challenging to provide data for communities particularly for our smaller communities. This means that the health outcome we measure has to occur frequently enough that we can actually provide some data to communities.

After considering all of these criteria we decided that the best starting point for our partnership is an analysis of the reasons that our people are dying (mortality) and what was making them sick when they died (morbidity).

We decided to start here because death is a very well-defined outcome that is experienced in all of our communities. The data is very high quality, quite complete, and deaths occur frequently enough that we should be able to provide some useful data to our communities.

The reasons our people are dying will let us start to quantify several of the challenges that our communities have been telling us are important. For example, we will be able to see the number of deaths due to suicides, chronic diseases (such as diabetes), infectious diseases, cancer, etc. When we look at what was making people sick when they died we will get an even better understanding of why our people are dying.

With this information we anticipate that our communities will feel more confident when they prioritize and plan their health services, apply for funding, advocate for their health needs, and evaluate their successes. We thank the communities and Health Directors who provided feedback to help us plan this analysis. We are now in the process of reaching out to communities again to confirm which communities would like to be part of this analysis.

WHAT DO WE KNOW ABOUT WHY OUR PEOPLE ARE DYING?

Many of us have a good sense of why our people are dying. We have a suicide crisis in our Northern First Nations. Far too often we hear about opioid addictions and overdoses. Tragic accidents like fires or car accidents affect our loved ones. We know a lot about why our people are dying.

What we often do not have available are the numbers and statistics that we need to help us decide if we should prioritize programs to prevent diabetes or to prevent accidents in our communities. We often do not have the comparison's we need to really tell our stories—we believe that we have a lot of people dying of chronic disease in our communities but how does that compare with the rest of Ontario?

We can get some insights from data that other people have analyzed. For example, a recent analysis of deaths in the United States found that the number of deaths in the total population was decreasing over time but the number of deaths among American First Nations and Alaska Natives has actually been increasing over the same period of time.[1]

Back in 2001/2002 an analysis of deaths among First Nations people in Atlantic and Western Canada (Ontario was not included) found that deaths among First Nations people were occurring about twice as often as the general population and infant mortality in BC and Manitoba First Nations was occurring about twice as often as Canada's overall population.[2]

Statistics Canada looked across Canada at avoidable causes of death between 1991 and 2006. They compared First Nations deaths with the general population and found that First Nations adults had more than twice the risk of dying from avoidable causes as non-aboriginal adults.[3]

Each of these examples might cause us to wonder what the data look like in Northern Ontario. Back in 1983 an analysis was done to look at First Nations deaths in Northwestern Ontario between 1972 and 1981. It found First Nations people had a higher risk of dying of injuries and poisonings, respiratory diseases, and infectious and parasitic diseases than the rest of Canada. They did not see a difference for cancers and stroke.[4]

Mamow Ahyamowen's first analysis will provide communities with their mortality data and the comparisons they need to make our voices stronger and tell our stories more clearly.

> "Closing the gap in the quality of life between First Nations and Canada has to be our National priority"
>
> –Assembly of First Nations National Chief Perry Bellegarde

LOOKING FORWARD

Over the coming months our partnership will focus on the community approval process. We hope that many of our communities will choose to participate in our first mortality analysis. We will continue to plan and prepare for the analysis so that we are ready to begin once we know which communities would like their data included. We are planning our second annual face to face meeting for November and will be busy making sure that we have an engaging agenda that continues to build and strengthen our partnership. We will be starting to explore sustainability planning over the coming months. Our current funding ends March 31, 2018 and we recognize it takes time to review progress, revise or set priorities, and secure new funds.

COMMUNITY APPROVAL

We were excited to hear from communities about the questions they would like answered in our first analysis. Now that their feedback has defined the questions we are seeking to answer we are going back to communities to confirm which communities would like to participate in an analysis of mortality data. This is an important step in our commitment to respecting the principles of OCAP.

While we hope that communities will choose to participate we recognize that some communities might not want to be part of this analysis. Each of our partners has established mechanisms by which they are accountable to the communities they serve. Some partners have Boards comprised of community representatives, others hold Annual General Meetings, while others choose to seek out Band Council Resolutions to document community decision making.

Over the next couple of months our partners will be engaging their communities to determine which communities would like to participate in our first mortality analysis. We hope to have strong participation and look forward to the next steps of our journey together.

REFERENCES

[1] Shiels MS, Chernyavskiy P, Anderson WF, Best AF, Haozous EA, Hartge P, Rosenberg PS, Thomas D, Freedman ND, Berrington de Gonzalez A. Trends in premature mortality in the USA by sex, race, and ethnicity from 1999 to 2014: an analysis of death certificate data. The Lancet 2017; http://dx.doi.org/10.1016/s0140-6736(1730187-3

[2] Available at: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/aborig-autoch/stats-profil-atlant/vital-statistics-eng.pdf

[3] Available at: http://www.statcan.gc.ca/pub/82-003-x/2015008/article/14216-eng.pdf

[4] Available at: Kue Young T. Mortality Pattern of Isolated Indians in Northwestern Ontario: A 10-Year Review. Public Health Reports. 1983; 98:5 pp 467-475 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1424479/pdf/pubhealthrep00109-0061.pdf

FOR QUESTIONS, COMMENTS, AND SUGGESTIONS PLEASE CONTACT:

Stephen Moore,
Mamaw Ahyamowen Project Manager
Stevemoore2011@gmail.com
76 ½ Lake Street, Sioux Lookout,
Ontario, P8T 1E6
Tel: (647) 205-2095