

First Nations Regional Longitudinal
Health Survey (RHS) 2002/03



The Peoples' Report



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Special thanks to Health Canada for its continued support for the RHS process.
Les versions françaises de cette publication sont disponibles sur demande.

Wel'liog
 Tansi Yowitz Siigaay laas Haluukafi
 Hadih Danach'e 'a
 Kwai kwai Tunngasugit Sge:nox
 Klahowya
 Hello Dánän ts'in huyàjáél
 Kwei Tân'si Wâciye
 Oki
 Kwaay Nenànkäk nätäydëk häjit shò tri'nlay
 Kii-te-daas a

Before all other words are spoken or actions taken, we extend our greetings and thanks to all of Creation and to those who make up the heart of this report.... the First Nations participants who so willingly shared their time and life histories with us.

Se'kon Wa'tkwanowera:ton
 Aganna
 Tu ough qua no u Waachiyaa Gitana Mikagõm
 Yeytk
 Kwe kwe Asujutidli See-a
 Ainngai Etlanete'
 Wa-é ák-wé
 Yaw Boozhoo Bonjour
 Aanii Sheko:li

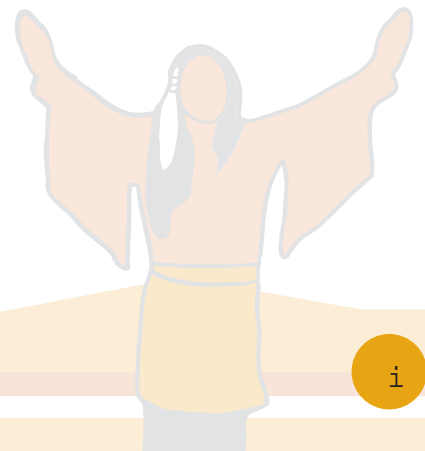


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ACKNOWLEDGEMENTS

The First Nations Regional Longitudinal Health Survey known simply as RHS is celebrating 10 years of existence. It is an event worth celebrating and a time to acknowledge the hardwork and commitment of First Nations across Canada to this process. RHS is designed as a longitudinal survey, with cycles every four years. We are pleased to be releasing the results of our survey for 2002/03. The RHS process is responsible for bringing the First Nations Principles of OCAP (Ownership, Control, Access and Possession) to the forefront in the area of research. The principles are now widely used, adopted and implemented by First Nations. RHS is viewed by many as being on the cutting edge in First Nations research and is widely considered the “Red Standard for Community Based Research”.

It has been a difficult struggle to change how research is done in First Nations communities in Canada. The RHS has lead the way as Data Warriors, asserting self-determination in the area of research. The path has not been easy but very rewarding. It is though First Nations dedication and determination from the community, regional and national levels, that has brought us this far in our journey.

The well-being of our First Nations communities has always been at the heart of this initiative. Doing “what is best for our communities” is deeply-rooted in all of our work. We believe that the information from the survey will be used to help improve the lives of our children, youth, adults and our elders in our communities.

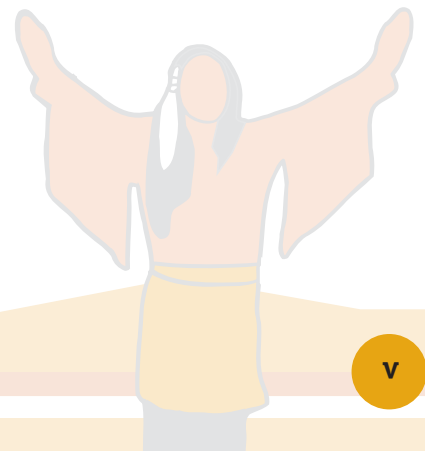
We wish to thank all First Nations who participated directly or indirectly in the RHS process, First Nations communities, RHS Regional Coordinators and the First Nations Information Governance Committee (FNIGC) for their continued support and guidance to RHS.

Without your belief, support and confidence in this process, we would not be celebrating 10 years of RHS!

Welalin,



Jane Gray, RN BSCN
National Coordinator
First Nations Regional Longitudinal
Health Survey (RHS)
March 2006





Executive Summary

The First Nations Regional Longitudinal Health Survey (RHS) 2002/03 is a First Nations initiative, led by First Nations. The RHS was coordinated by First Nations through the First Nations Centre (FNC) at the National Aboriginal Health Organization (NAHO). The Survey was conducted between August 2002 and November 2003, and asked questions about those areas of life that relate to the health of First Nations Peoples.

The purpose of the RHS is to support First Nations research capacity and control and provide scientifically and culturally validated information to support decision-making, planning, programming and advocacy with the ultimate goal of improving First Nations health. The Survey is a research project designed to collect information and document the changing nature of First Nations health over a 12-year period. This will be accomplished by conducting three more surveys, with the last one being administered in the year 2014.

The objective of this report is to provide an overview of the information collected in this, the first of four surveys to be administered over a four-year cycle. As a summary document, this report is not designed to be a comprehensive and detailed account of all the information collected. This report acts as only one part of a series of reports prepared on the information gathered by the RHS 2002/03.

As a First Nations initiative, this report is designed and presented from a First Nations perspective. There are many different First Nations, languages and ways to explain and understand a First Nations approach to health. The report outlines the development and explanation of the following First Nations perspective on health and wellness.

Flowing from this First Nations approach to understanding health, the summary of information collected by the RHS is presented. The information is grouped into four quadrants, with each quadrant representing a number of topics covered in the Survey. Information from the adults, youth and children surveys are integrated into this holistic framework and presented under the topics explored by the Survey.

The Survey collected vast amounts of information on First Nations health. Over 22,000 First Nations people were surveyed (adult, children and youth) from 238 First Nations communities across Canada. We now present some of highlights of the information collected and encourage everyone to read further, to find out more about First Nations health.

RHS Highlights

The highlights of the Survey are summarized under the following headings: Vision, Relationship, Reason, and Action which correspond to the chapters in the report.

VISION—WHEN WE LOOK AT THE HEALTH OF FIRST NATIONS PEOPLES, WHAT DO WE SEE?

This section of the report looks at the physical health of First Nations by summarizing information on:

- Health Conditions and Chronic Diseases
- Diabetes
- Injuries
- Dental Care

Health Conditions and Chronic Diseases: Particular health conditions and certain chronic illnesses are common in our communities. We report findings from the RHS 2002/03 on the most common health conditions; heart disease, hypertension, arthritis/rheumatism, asthma, cancer; and diabetes.

- First Nations adults have a higher rate of hypertension than Canadian adults.
- First Nations boys (children) are more severely affected by asthma than girls.
- For all age groups and genders, smoking is approximately twice that found in the Canadian population.
- Approximately one in ten of our children and one in five of our First Nations youth suffer from chronic ear infections.
- Over half of our First Nations children and less than half of our First Nations youth are overweight or obese.

Diabetes:

- The average age of diagnosis of diabetes in our First Nations youth is 11 years.
- Diabetes among our people is often linked with being overweight and obese.
- Prevalence of heart disease and hypertension among First Nations adults with diabetes is four times higher than that found in First Nations adults without diabetes.
- The majority of First Nations adults diagnosed with diabetes are undergoing treatment.

Injuries Among First Nations People:

- Our First Nations adults report injuries at a rate of almost three times the Canadian average.
- Almost one-third of our First Nations adults reported injuries requiring treatment—twice the Canadian average.
- One in twenty First Nations adults reported that they had suffered at least one instance of violence in the previous year.

Access to Dental Care and Treatments Needs of First Nations People:

- Just under half of First Nations adults who reported they needed urgent dental treatment, said they had difficulties accessing Non-Insured Health Benefits (NIHB).



- First Nations youth often access dental care for emergency purposes rather than preventative care.
- Although our First Nations children have a high level of dental care use, this has not reduced the need for treatment services, such as fillings.
- Baby Bottle Tooth Decay is a serious problem with our First Nations children.

RELATIONSHIPS—WHAT TYPE OF RELATIONSHIPS HAVE WE ESTABLISHED TO LIVE A BALANCED LIFE?

In this section of the report, we summarize the information that relates to the establishment of relationships by looking at:

- Personal Wellness and Mental Health
- Residential Schools
- Language and Culture

Mental Health, Personal Wellness and Support among First Nations:

- A majority of First Nations adults feel in balance physically, emotionally, mentally, and spiritually.
- One in ten First Nations adults report having suicidal thoughts and 50% of those people report suicide attempts over their lifetime.
- First Nations adults who feel healthy are less likely to experience suicidal thoughts as those with fair or poor health.
- First Nations youth do not access traditional supports or mental health services, despite reporting that they

are not feeling emotionally or mentally balanced.

- First Nations people felt strongly that their community was not progressing in relation to reducing alcohol and drug abuse.

The Impacts of Residential Schools on the Health and Well-Being of First Nations:

- A majority of First Nations residential school attendees witnessed the abuse of others or experienced it themselves.
- First Nations adults believe that their parents' attendance at residential school negatively affected the parenting they received.
- Although many First Nations youth do not speak their language, it is still very important to them that they are able to speak their language.
- Almost 60% of our First Nations children have one or more grandparents who attended residential schools.

Languages and Cultures:

- Only 13.9% of our First Nations youth use a First Nations language on a daily basis.
- Cree, Ojibway and Oji-Cree were the most frequently spoken language by First Nations youth on a daily basis.
- Most First Nations parents and grandparents believe that it is important for their children to learn traditional cultural events and a First Nations language.

- First Nations parents who have more formal education are more likely to be involved with the traditional cultural socialization of their child.

REASON—HOW DO WE LIVE A GOOD LIFE...IN WHAT WAYS CAN WE ACHIEVE AN ACCEPTABLE LIFESTYLE?

How do we live a good life...in what ways can we achieve an acceptable lifestyle? In this section of the report, we summarize the information relating to the ability and opportunity for First Nations People to achieve an adequate and appropriate lifestyle by looking at:

- Demographics, Employment, Income and Education
- Housing
- Health Care Access

Overview of Demographics, Employment, Education, and Income in First Nations Peoples:

- First Nations people who have paid employment report better health than those who do not have paid employment.
- Approximately 1/3 of First Nations children, who lived with one or more parents, also had other adults including grandparents, aunts, uncles, and/or cousins living with them.
- More than half of the First Nations children in childcare settings were cared for by relatives in home environments.

First Nations Housing and Living Conditions:

- Overcrowding is an issue in our communities.
- Approximately half of our homes are smoke free.

- First Nations are concerned about the presence of mould, unsafe drinking water and overcrowding.

First Nation Access to Primary Health Care Measures:

- Approximately half of First Nations adults have participated in health screening tests.
- First Nations women report significantly more difficulties in accessing NIHB than our men.

ACTION—WHAT TYPE OF LIFE DO WE LIVE?

This section of the report looks at the lifestyle habits of First Nations People by summarizing information on:

- Smoking
- Alcohol and Drugs
- Exercise and Nutrition
- Sexual Health Practices

First Nations Adults and Youth and Non-Traditional Tobacco Use:

- Just over half of the First Nations pregnant women at the time of the Survey were smokers.
- Most First Nations adults quit smoking out of a desire for a healthier life
- First Nations adults who do not smoke report the highest level of balance in their lives.
- First Nations youth who smoke, drink or use marijuana are not as healthy as abstainers.

Alcohol and Drug Use among First Nations People:





- More First Nations adults abstain from drinking alcohol than the general Canadian population.
- Most First Nations adults who do drink alcohol are moderate drinkers.
- The proportion of heavy drinkers in the First Nations adults is higher than the general Canadian population.
- First Nations non drug-users reported higher levels of social supports available to them.

Nutrition and Physical Activity in First Nations People and Their Relationship to Health:

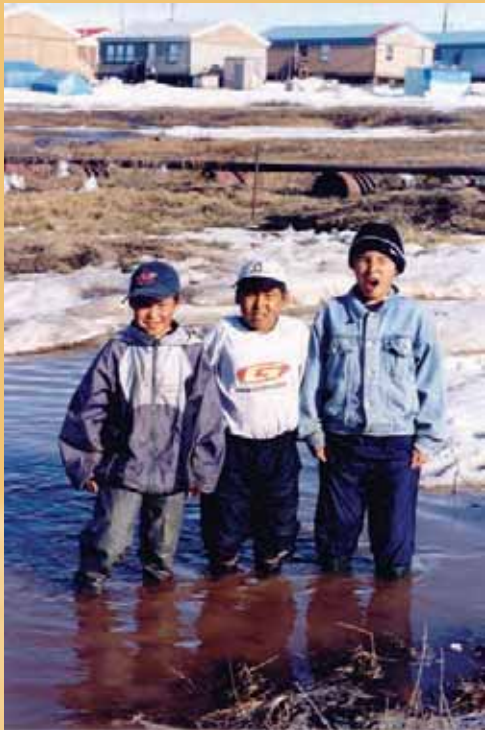
- Walking is the most frequently reported physical activity for First Nations adults, youth and children.
- The proportion of adults who are usually eating a nutritious and balanced diet increases with age, education and personal income.
- First Nations youth who are satisfied with their weight have a tendency to be more active.
- A large proportion of First Nations adults are considered overweight and obese.

- First Nations youth and children make up one-third of our population, therefore the high rates of overweight and obese children signals serious future chronic health problems.
- Over 60% of our First Nations infants were breastfed.

Sexual Health Practices among First Nations People:

- Across all age groups people thought they were safe and did not need to use a condom when they were with a steady partner.
- The most common age of first pregnancy or fathering a child was 16 years among First Nations.
- Among First Nations youth, 81% reported using condoms.

It is our hope that this research will contribute to the understanding and further development of more First Nations approaches to Health and Wellness, with the ultimate goal of increasing the chances of First Nations Peoples to achieve the balance in their lives based on a much expanded spectrum of health services.



CHAPTER 1: INTRODUCTION

THE PEOPLES' REPORT...WHY A PEOPLES REPORT?

There is a teaching amongst First Nations Peoples,¹ that life is both a gift and a sacrifice.

*A gift for the things you receive
A sacrifice for the things you give
It is a reciprocal relationship of receipt and giving.*

The First Nations Regional Longitudinal Health Survey (RHS) 2002/03 was coordinated by First Nations through the First Nations Centre (FNC) at the National Aboriginal Health Organization (NAHO), and asked questions about all areas of life that relate to health. The RHS was conducted between August 2002 and November 2003. In this report, which summarizes the information collected in the RHS 2002/03, we are attempting to honour our teachings.

In the reciprocal relationship of life, of giving and receiving back, we have received a great deal. All those who participated in this Survey, more than 22,000 First Nations community members, made a sacrifice by donating their time and most importantly, sharing with us the information of their lives. In return, it is now our responsibility to give back to the People in the form of a report that attempts to summarize all of the information collected.

We view our responsibility as more than producing a report filled with numbers and charts, of incomprehensible language and statistical calculations that would boggle

the mind of the best medical doctors and university researchers. We view our responsibility as producing a report that can be used by those who are intended to use the report...the People who contributed the information. Thus in our attempt to fulfill our responsibilities, we have produced this report—The Peoples' Report.



It is our hope that our analysis of the information that has been shared with us can be used by all Peoples and in this way, lead to the improved health for all First Nations Peoples in Canada and beyond.

THE ORGANIZATION OF THE RHS REPORTING SERIES

If we are to give effect to both the words and intent, that this report is meant to proceed from a First Nations perspective, then it must be expected that there will be some differences...differences from the majority of reports on First Nations Peoples that are prepared and presented from a non-First Nations perspective.



A major difference is in how the information is presented—the form, order, organization, presentation and use of language.² In this report, for example, the objective is to provide an overview of the information collected from the main survey. This report is not designed to comprehensively account for all the information collected. As such, this report acts as only one part of a series of reports prepared on the information gathered by the RHS.

Depending on the level of detail required by the reader, it is possible to access much more RHS information than contained in this report. There are three levels of detail that can be accessed by the reader, as follows:

- 1) The Peoples' Report is a summary document that presents an overview of the information collected in the Survey. The information is presented in the context of a culturally appropriate First Nations interpretive framework. This report is widely distributed and is available in both French and English.

In this report we have greatly reduced the number of charts, levels of statistical analysis, mathematical calculations, technical questions of methodology and academic/technical language.



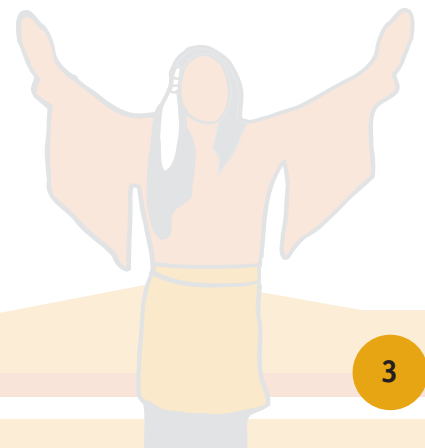
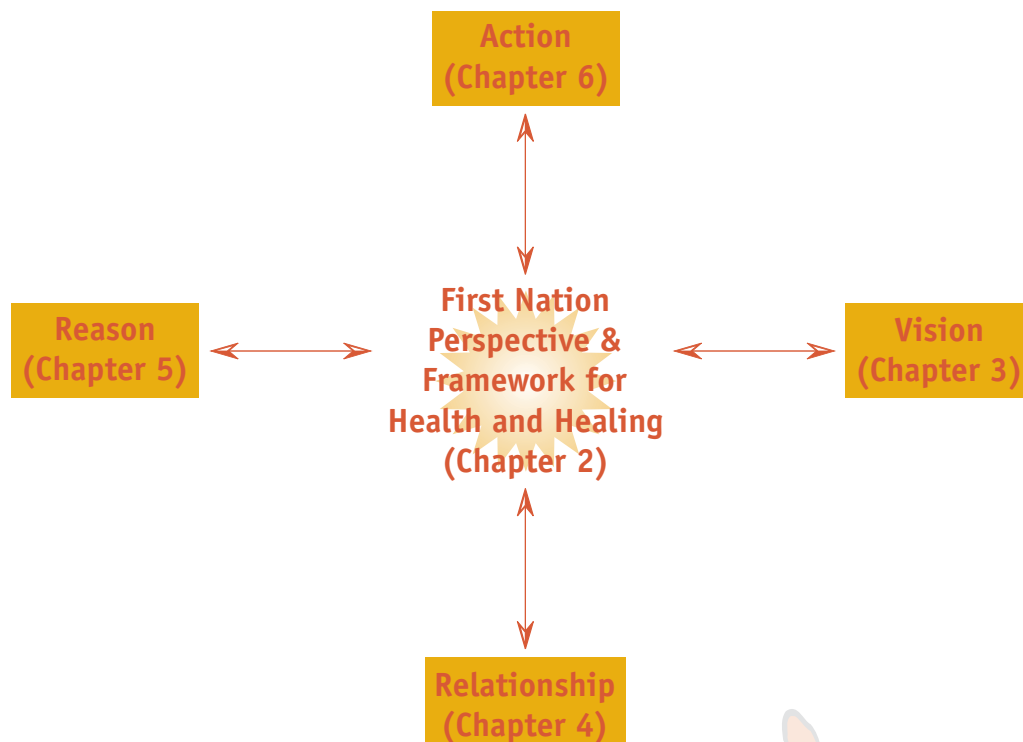
- 2) The RHS technical report, entitled "First Nations Regional Longitudinal Health Survey (RHS) 2002/03: Results for Adults, Youth and Children Living in First Nations Communities" is an extensive document which contains 34 detailed chapters on selected health issues from the RHS. The various chapters have been written by a number of experts³ in the field of health research. The technical report presents information according to the three main RHS categories of adult, youth and children.
- 3) The RHS Database is housed by the FNC at NAHO. Selected data is available upon request through an approval process that is overseen by the First Nations Information Governance Committee.

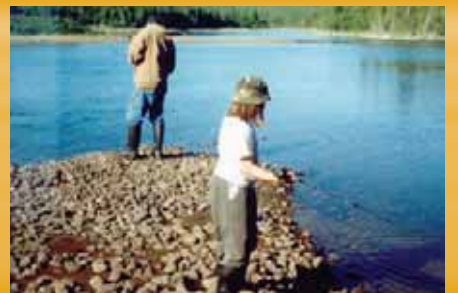
For those seeking additional details on the information on the First Nations Regional Longitudinal Health Survey, the reader can go to http://www.naho.ca/firstnations/english/regional_health.php

THE ORGANIZATION OF THE PEOPLES' REPORT

In this report, there are four main chapters (Chapters 3–6) that present the information collected in the RHS. These four chapters are arranged around a central component of the report, namely, the development of a First Nations perspective toward health and healing (Chapter 2). Together these four chapters form a holistic approach to the presentation of information and hopefully, in the future, will form the foundation toward a greater understanding of the information collected in the RHS research process.

As a central component to this report, the second chapter is entitled the “Centre”, and takes the reader through an explanation of how the First Nations perspective for this report was developed. The next four chapters flow from the development of this First Nations perspective, which can also be referred to as an interpretive framework. The four chapters are named Vision, Relationships, Reason, and Action, with each chapter presenting a summary of selected topics covered by the RHS. The organization of this report can be illustrated as follows:





CHAPTER 2: THE CENTRE—A FIRST NATIONS PERSPECTIVE AND FRAMEWORK FOR HEALTH AND WELLNESS

WHAT IS A FIRST NATIONS PERSPECTIVE OF HEALTH?

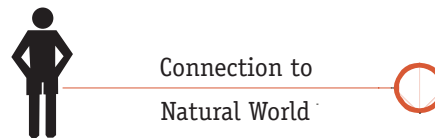
To respond to this question we start at the beginning...with the First Nations of Canada and the many different belief systems of the First Nations Peoples.

There are many different groups of First Nations, many different societies, different languages and ways to explain and understand all that is around us. There are also many commonalities...a fundamental one being the First Nations connection to the natural world.

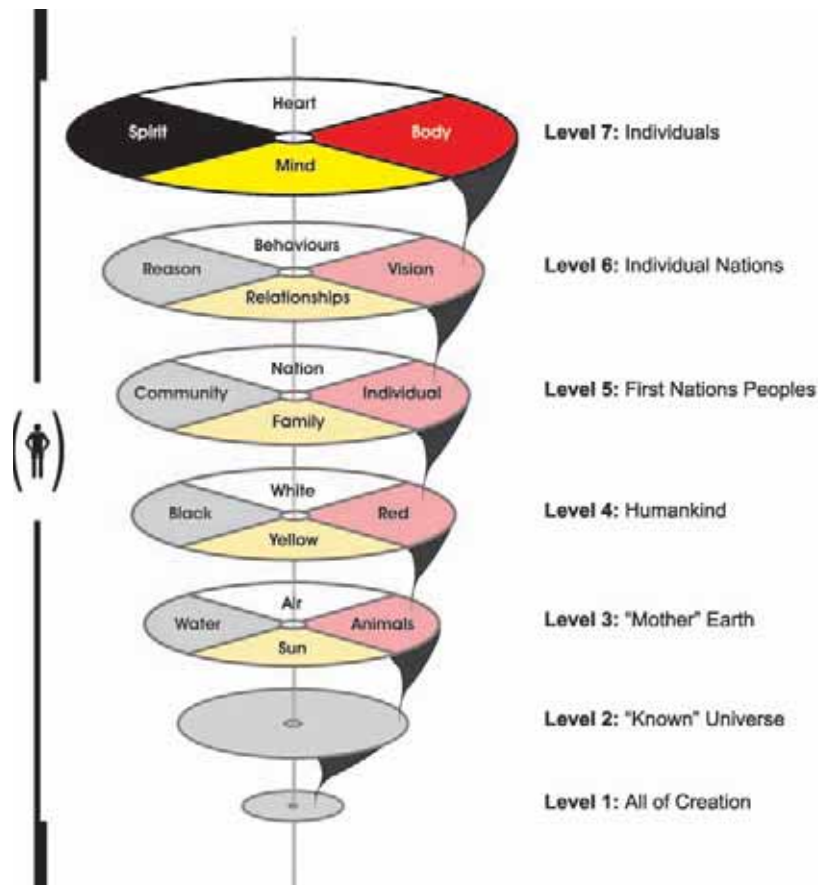
The natural world, or nature, is represented as a circle.

Why?

Because everything in nature is round or moves in a circle.⁴



Of course, a system so complex as the natural world and the human connections to these environments includes many different levels of understanding.⁵ A limited and simplified representation of these levels of understanding can be illustrated as follows:





There are many different ways, in the diverse First Nations languages, and unique First Nations belief systems, to describe the different levels of how humankind is connected to the natural world.

The following is one way⁶ that is used to explain the First Nations' approach to health.⁷

From this perspective of First Nations health, human beings are connected to the natural world, and thus to Creation through many different levels, or layers, of understanding. Each level represents only a small portion of the preceding one. All levels are interconnected.

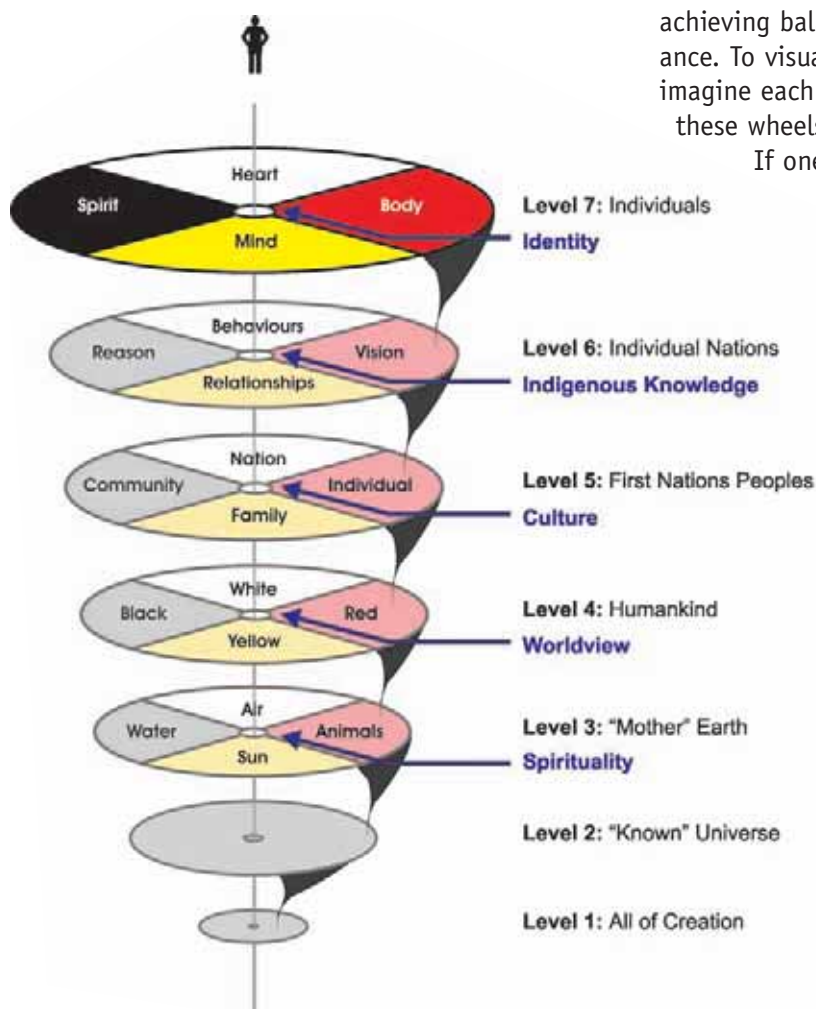
This approach to health and wellness is based on BALANCE...of seeking balance, of achieving balance and of maintaining balance. To visualize this model of health, imagine each level as a wheel, with each of these wheels rotating on a common axis.

If one wheel is out of balance, it will affect the balance of the other wheels and also the overall balance of the system.

When we speak of First Nations health, we are referring to the BALANCE of this system.

The seven levels of this system can be described using the following words:⁸

Level 1—Represents Creation, the act of Creation and the Creator...the beginning of all beginnings and therefore the basis from which All is derived and receives meaning. The straight line moving upwards from level 1 through the centre of all other levels represents the belief that the Creator represents the centre



of all else that is created. If all subsequent levels resemble spinning wheels, the act of Creation and the Creator are the hub around which all else revolves.

Level 2–Represents the known universe, that is, all that is known and understood by humankind ... which represents only a small part of the totality of Creation.

Level 3–When the earth was created, as one small part of the total known universe, so too were humans. At the centre of level 3, we as humans are connected to Creation through our spirituality. It is from our different belief systems, however they are expressed, that we are directly connected to Creation (both the act of Creation and the Creator – however many ways they are expressed and named by the different First Nations cultures and societies).

Level 4–As a small part of all living things that were created on Mother Earth, different races of humankind were created. Each of the different races created their own different worldviews, that is, how we as humans understand our world. First Nations Peoples are connected to and express their worldview through their spirituality, which in turn connects us back to Creation.

Level 5–As First Nations Peoples we are connected to Creation through our cultures, which are expressions of our worldview, which then connect us to our spirituality and so to Creation.

Level 6–As individuals we all possess an Indigenous Intelligence that when combined, such as by Nations, forms Indigenous Knowledge systems. These different knowledge systems (they are not the same for all

First Nations Peoples) are connected to our cultures, which are integrated into our worldviews, which are expressions of our spirituality.

Level 7–As First Nations individuals we all develop our own identity, which is formed by that which we know (Indigenous knowledge), which in turn is connected to our culture, which is an expression of our worldview and spirituality. ...all of which connects us to Creation.



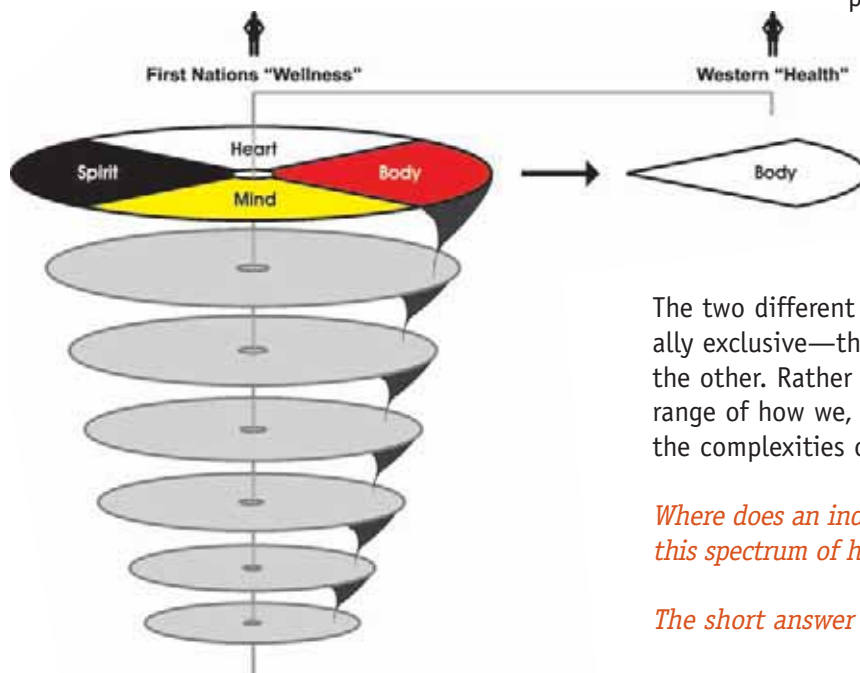
From this model, which visually illustrates a First Nations approach to understanding health, it becomes clear that when we speak of First Nations health, we speak of such things as Indigenous Knowledge, Identity, Culture, Worldview and Spirituality as indicators of “health”.

These indicators are core⁹ to an understanding of how we, as a People, keep ourselves “balanced” and therefore “healthy”.

We can also use this model to illustrate other approaches to health...such as the conventional Western¹⁰ approach, that is, the approach to health we experience in Canadian society. Using the same model, we



can visualize these two different approaches in the following way.



Both approaches deal with the health of individuals. In order to avoid confusion, we have identified the First Nations' approach as a system of "Wellness" and the Western approach as one of "Health".

As illustrated in the model, although different, each are connected and form the opposite ends of a "spectrum" that help us to understand the concept of human health. The First Nations approach places an emphasis on the various levels of understanding, of connections and interconnections within

these levels and maintaining a balance in the overall system. The Western approach places more of an emphasis on the physical body...isolating the body and studying the various elements and components of the physical self, namely, the human anatomy and maintaining a balance of these physical systems.

The two different approaches are not mutually exclusive—that is, it is not just one or the other. Rather they form a spectrum or range of how we, as humans, can understand the complexities of human health.

Where does an individual person fit within this spectrum of human health?

The short answer is everyone is different.

The two different approaches show us only two ends of a spectrum. There are many more combinations of these systems that exist for each individual. For example, just because a person is First Nations does not mean they believe only in Wellness and not Health (Western medicine). Alternatively, a person in Canadian society does not necessarily believe only in Health (Western medicine) to the exclusion of their connection to Creation or their understanding of personal Wellness.

The basis for the First Nations approach to Wellness is the concept of Balance. Every

person, just as in the natural world, is in a constant state of change. The spinning wheels of the First Nations approach to Wellness illustrate this concept of constant change...of motion, of attempting to maintain a Balance in a constantly shifting world.

As things change, a person may find him or herself at one end of the spectrum...to meet the specific circumstances of the moment. Then, at another time, they may find themselves at the other end—or somewhere in between. Whether First Nations or Western, the goal is to find a Balance.

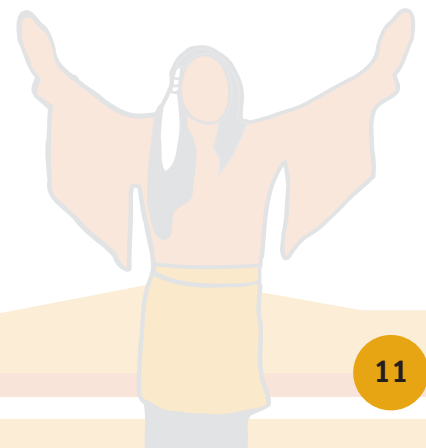
A problem for First Nations Peoples to this point in time has been the lack of choice. The primary choice for health care and available health systems has been only those based on the Western model. With the emergence and recognition of increasing numbers and First Nations health programs, based on the First Nations concept of Wellness and Health, the spectrum of choice for First Nations Peoples has begun to increase.

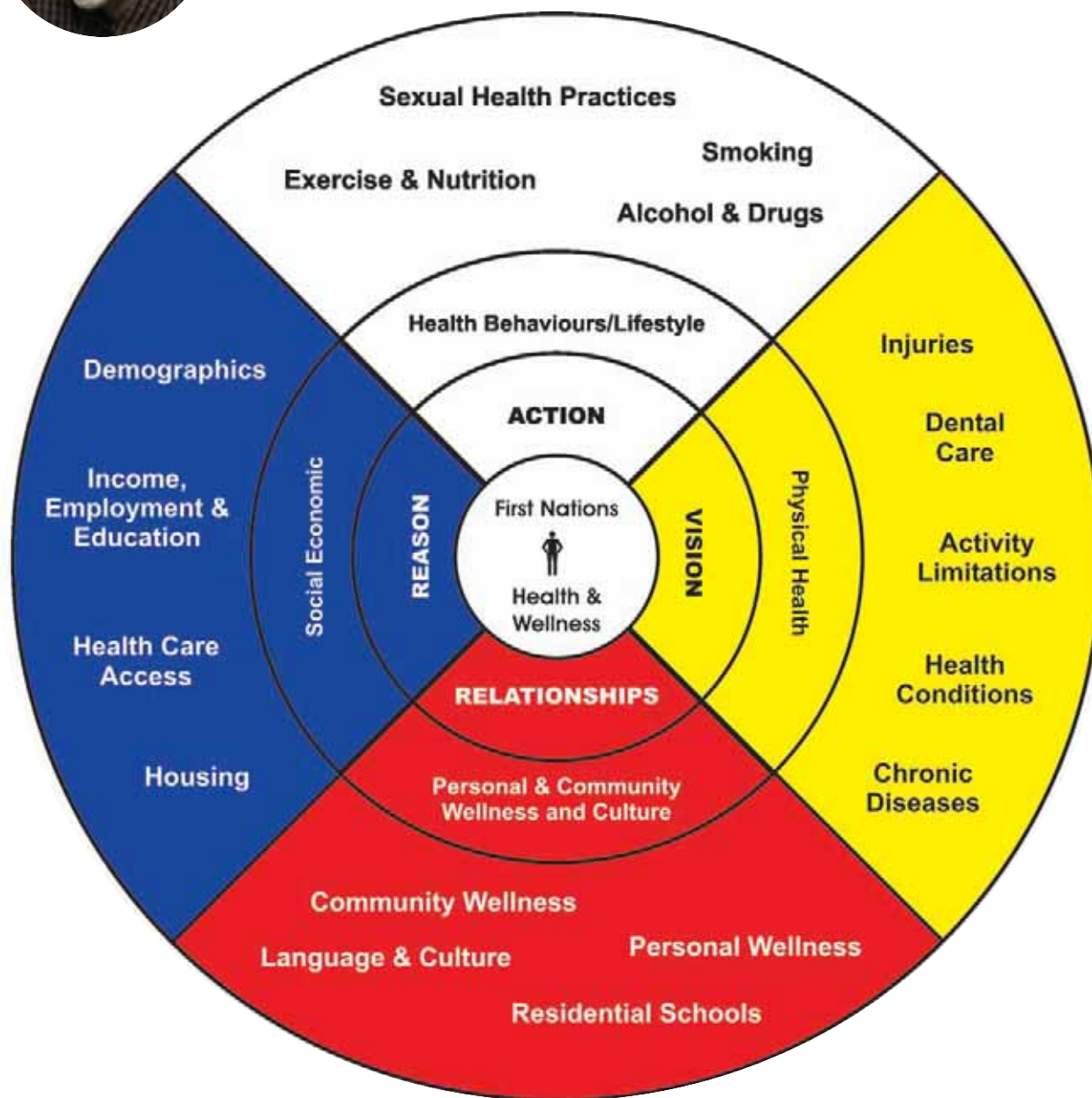
A specific objective of this study is to document the changing nature of First Nations health over the next 12 years. It is our hope that this research will contribute to the understanding and further development of more First Nations approaches to Wellness and Health. It is also hoped to increase the chances for First Nations Peoples to achieve the Balance in their lives based on a much expanded spectrum of health services.

SUMMARIZING THE AVAILABLE INFORMATION

The RHS 2002/03 collected vast amounts of information regarding the health of First Nations Peoples. How can we begin to summarize all this information?

To answer this question we begin with the First Nations framework established in the previous chapter—this is the Centre, or foundation for all the work in this report. If we simplify the framework, by compressing the seven levels of understanding into one and overlay all the questions asked in the RHS,¹¹ then we can illustrate the information collected in the following way:¹²

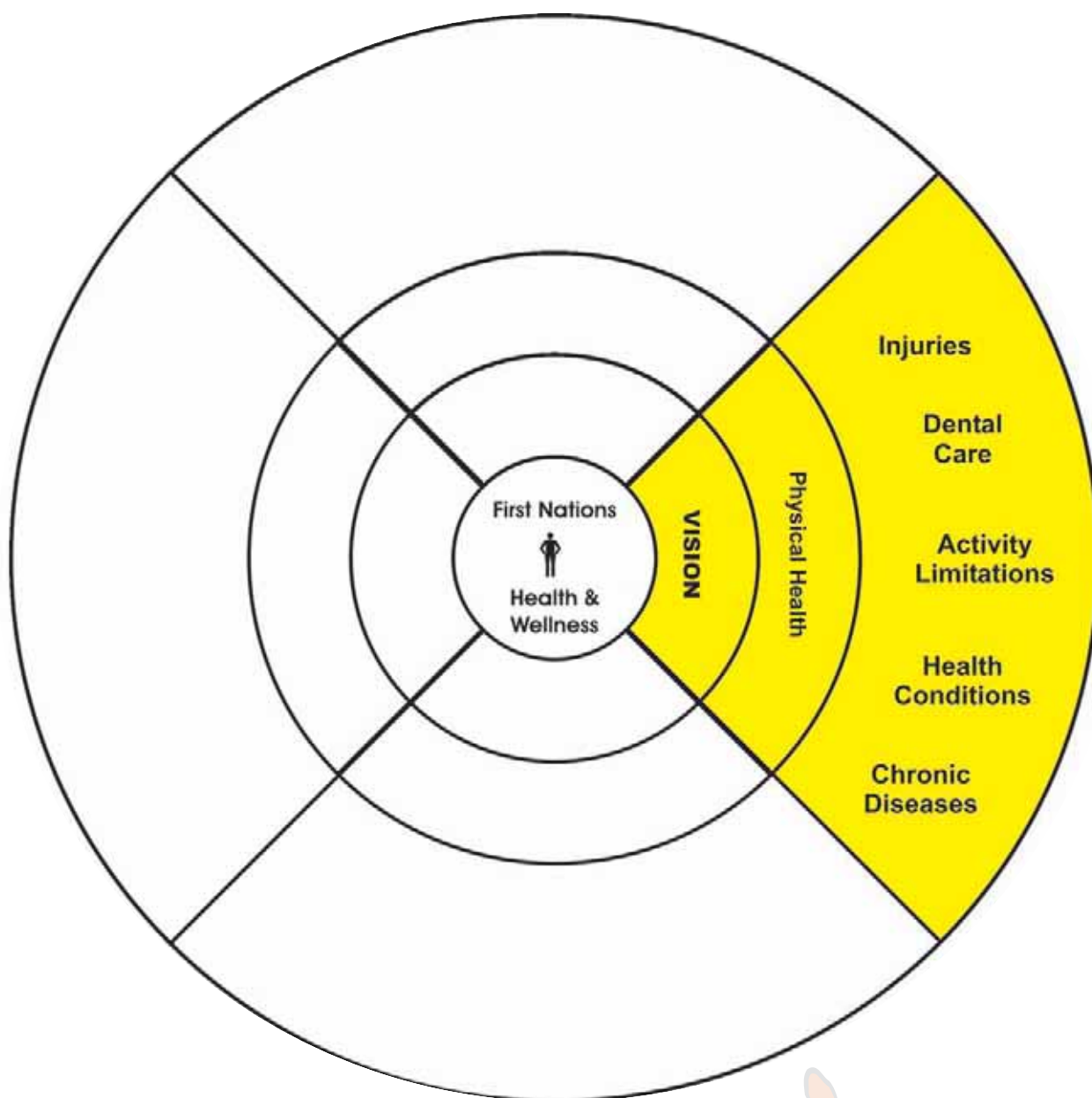




In this approach, the RHS 2002/03 information is grouped into four quadrants, with each quadrant representing a number of topics covered in the Survey. To begin our summary of the information collected, we begin in the eastern direction.



CHAPTER 3: VISION



WHY BEGIN IN THE EAST?

The framework established in the previous chapter, which represents a First Nations approach to collecting and summarizing the RHS information, is a reflection of the natural cycles found in the world around us. At

the beginning of each day as the sun rises in the east, it clears away the darkness and helps us to “see”. Accordingly, when speaking of vision our summary begins in the east, with information to help clear away the darkness surrounding our understanding of current First Nations health conditions.



The summary of information proceeds clockwise, through the southern, western, and northern quadrants, to return, once again, in the eastern quadrant vision.

The eastern direction represents our external vision, that is, looking around us to see the health conditions of others. So, if we begin at the Centre and look out at the health conditions of the First Nations around us, what is it that we see?

Usually what we see first are the physical attributes of health—the physical body, those who are sick or injured. Of course there are many ways to observe or measure the physical wellness of individuals.¹³ However, in this section we summarize only those diseases or health conditions that were found to be most common, or can be described as more serious than other health conditions. These categories are:

- Health Conditions and Chronic Diseases
- Diabetes
- Injuries
- Disabilities
- Dental Care

HEALTH CONDITIONS AND CHRONIC DISEASES

Chronic Health Conditions: Adult

The most common long-term health conditions facing First Nations adults are arthritis/rheumatism, chronic back pain, allergies



and high blood pressure. These are also leading long-term health conditions in the general adult population in Canada. Overall, First Nations women are more likely than their male counterparts to report at least one of the long-term health conditions explored and are more likely to be dealing with multiple conditions. In addition, arthritis, high blood pressure, asthma and heart disease are more prevalent among First Nations adults than in the general adult population in Canada.

Arthritis/rheumatism is a joint disorder featuring inflammation and is often accompanied by joint pain. Forms of arthritis range from those related to wear and tear of cartilage (such as osteoarthritis) to those associated with inflammation resulting from an over-active immune system (such as rheumatoid arthritis). Causes depend on the form of arthritis and include injury, abnormal metabolism (such as gout), hereditary susceptibility, infections and reasons that remain unclear.¹⁴ Rheumatoid arthritis is an autoimmune disease that causes chronic

inflammation of the joints and that can also cause inflammation of the tissue around the joints, as well as other organs in the body. Autoimmune diseases are illnesses that occur when the body's immune system mistakenly attacks its own tissues. Rheumatoid arthritis is typically a progressive illness that has the potential to cause joint destruction and functional disability.¹⁵ The research grouped RHS respondents who had arthritis or rheumatism.

High blood pressure or hypertension means high pressure (tension) in the arteries. An elevation of the blood pressure increases the risk of developing heart disease, kidney disease, hardening of the arteries, eye damage and stroke (brain damage). Risk factors include excess salt intake, age, obesity, hereditary susceptibility and kidney failure (renal insufficiency).¹⁶

Asthma is a chronic inflammation of the airways that causes swelling and narrowing of the airways, resulting in difficulty breathing. The bronchial narrowing is usually either totally or at least partially reversible with treatments. Triggers include allergens and irritants (respiratory infections, tobacco smoke, smog and other pollutants, Aspirin, other nonsteroidal anti-inflammatory drugs, physical exercise and various other environmental, emotional and hormonal factors).¹⁷

Heart disease includes any disorder that affects the heart. Sometimes the term is used narrowly and incorrectly as a synonym for coronary artery disease. Heart disease is synonymous with cardiac disease but not with cardiovascular disease which is any disease of the heart or blood vessels. Heart disease includes conditions such as: angina; arrhythmia; congenital heart disease; coronary artery disease; dilated cardiomyopathy;

heart attack (myocardial infarction); heart failure; hypertrophic cardiomyopathy; mitral regurgitation; mitral valve prolapse; and pulmonary stenosis.¹⁸ Risk factors include age, heredity, gender (male sex), tobacco smoke, high blood cholesterol, high blood pressure, physical inactivity, obesity, diabetes, stress and excess alcohol consumption.¹⁹

Arthritis/rheumatism affects a greater proportion of First Nations adults than adults in the general Canadian population (25.3% compared with 19.1% respectively). High

Arthritis/rheumatism and heart disease are more common in First Nations adults than the general Canadian population.

blood pressure is somewhat more prevalent among First Nations adults overall when comparing with the general population (20.4% compared with 16.4%). Overall, there is a slightly higher prevalence of asthma among First Nations adults than in the general adult population in Canada (10.6% compared with 7.8%). The largest difference occurs among those 50 years and older.

Heart disease is more common overall among First Nations adults than in the general adult population (7.6% compared with 5.6%). This difference is most pronounced in the 50–59 age group where 11.5% of First Nations are affected compared to 5.5% in the general population.

First Nations women are more likely than women in the general population to report



asthma (13.2% compared with 8.7%). Similarly, First Nations women are affected by arthritis/rheumatism more often than women in the Canadian population (30.1% compared with 17.4%). This difference is most notable among women younger than 60 years.

High blood pressure is more common among First Nations women than other women (23.2% compared with 17.4%). Heart disease is more prevalent among First Nations women than other women in Canada (8% compared with 5.1%). The rate is higher among First Nations than other women 60 years and older (22.4% compared with 15.6%)

Long-Term Conditions in Youth

Allergies, asthma and chronic ear infections/ear problems are the most common of the conditions reported for First Nations youth. Chronic bronchitis is not so prevalent but presents serious health risks. Learning disability and Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder are fairly low in prevalence but can involve multiple challenges to academic performance and social integration that can persist into and throughout adulthood.

First Nations youth seem to be less susceptible to allergies than youth in general in Canada. Allergies affect 15.1% of First Nations youth. However, of First Nations youth with this condition, only 26.3% are receiving treatment for it.

The next-most common long-term condition among First Nations youth is asthma, affecting 13.6%. Here, First Nations youth seem to be at least as susceptible as youth in the



general population, among whom 12.4% have asthma. Some 31.2% of First Nations youth with this condition had an asthma attack in the reference year, compared with 42.7% of youths in the general population.

Chronic bronchitis would seem to be more common among First Nations youth than youth in the general population: 2.4% of First Nations youth have this condition compared with 1.4% of youths in general. Chronic bronchitis presents potentially serious long-term health risks. Only 16.5% of First Nations youth with this condition are receiving treatment for it.*

Allergies, asthma and chronic ear infections are the most common of the chronic conditions affecting First Nations youth. Levels of

* Owing to high sampling variability, that figure should be used with caution. At a 95% confidence interval the estimated proportion receiving treatment ranges between 10.2% and 25.8%.

treatment for allergies and ear problems are low, there are lesser occurring but more problematic conditions such as learning disability, Attention Deficit Hyperactivity Disorder and chronic bronchitis. It is fairly common for youth with disabilities to be affected by more than one long-term condition and to be disabled by more than one condition.

Long-Term Conditions in Children

In general, First Nations children are free from the more serious conditions facing their adult counterparts. Of those conditions surveyed, asthma, allergies and chronic ear infections/ear problems are the most common of the conditions reported for First Nations children.

Asthma, allergies, and chronic ear infections are the most common conditions our First Nations children

At 14.6%, the frequency of asthma among First Nations children is quite high given that the prevalence among children in the general population is 8.8%. Overall, close to two-thirds of First Nations children with asthma are being treated for this condition.

Allergies are quite common among First Nations children (12.2%) and among other children in Canada (16.4%). Of First Nations children with allergies, only one in five are being treated.

Chronic bronchitis is more common among First Nations children at 3.6% than among children in the general population, where the rate is only 1.4%.

Almost 1 in 10 (9.2%) of First Nations children have chronic ear infections/problems that are probably otitis media. The condition can cause ongoing damage to the middle ear and eardrum and there may be continuing drainage through a hole in the eardrum. Chronic otitis media often starts painlessly without fever. Sometimes a subtle loss of hearing can be due to chronic otitis media.²⁰ Only one in four First Nations children with this condition are receiving treatment for it.

DIABETES

Diabetes is an epidemic in our communities. Here we look at how it affects our people, different types of diabetes and how it may be impacted by multiple health conditions (MHC). The major risks of heart disease and obesity are also considered. We look as well at how diet, activity, community remoteness and other factors may affect our rates of diabetes.

The occurrence of diabetes in First Nations adults is much higher than that of the Canadian population in all age groups with rates for our females being higher than our males.

Four types of diabetes are found in our people:

Type 1: The person has no insulin producing cells, and requires insulin from an external source (usually by injection or infusion) in order to maintain a normal level of glucose (sugar) in the blood.



Type 2: The body produces some insulin, but not enough to maintain normal blood glucose levels, which may be controlled by diet, exercise and oral medication that increase insulin secretion from remaining insulin-producing cells. Type 2 diabetes is given special attention as it has been shown to be high (two to three times higher) in First Nations communities compared to non-First Nation communities.²¹

Pre-diabetes: Some impairment in the body's ability to handle glucose load, and also includes higher than normal fasting blood glucose, but not high enough to be considered diabetes. These individuals are at high risk to progress to overt diabetes.

Gestational diabetes: Occurs during pregnancy and results in a state of glucose intolerance. This type of diabetes can be controlled by diet and exercise, but may also require insulin therapy. Uncontrolled gestational diabetes in mothers may increase the prevalence of pre-diabetes in their children.

The occurrence of diabetes in First Nations adults (14.5%) is much higher than that of the Canadian population in all age groups. Moreover, this age related gap appears to have widened between First Nations adults and the general population, particularly among adults aged 45–54 and 55–64 years.²²

Among our adults with diabetes, 78.2% have Type 2 diabetes, 9.9% have Type 1 diabetes and 9.8% are in the pre-diabetic

The average age of diagnosis of diabetes in our youth is 11 years. Early onset of Type 2 diabetes leads to serious health consequences for youth as they age.

stage. One in eight First Nations women (11.9%) reported having gestational diabetes. The frequency of diabetes is lowest among 18–29 year-olds (3%) and significantly increases to a high of about one in three adults among those 55 years and older (36.4% among those 55–64 years and 35.2% among those 65 years and older).

Diabetes among our people is often linked with being overweight and obese.

There were no significant differences between genders.

Type 2 diabetes usually occurs after age 30 but has been a problem in First Nations children for some time now.²³ The average age of diagnosis of diabetes in our youth is 11 years. Two-thirds of youth with diabetes are receiving treatment while a small proportion report that they have limited activity levels because of their diabetes.

Just over a quarter (28.6%) of adult diabetics report activity limitation, while many

(88.7%) report one or more adverse consequences related to their diabetes, including: problems with feeling in hands or feet (37.1%), vision problems (36.8%), circulation problems (21.6%), problems with legs and feet (20.9%), kidney function (15.9%), infections (14.7%), and heart problems (11.3%).

Occurance of heart disease and hypertension among First Nations adults with diabetes is four times higher than that found in First Nations adults without diabetes.

Diabetes is often linked with being overweight or obese. Most First Nations adults without diabetes are classified as being of a healthy weight or overweight, while most adults with diabetes are classified as being obese. One in twenty (6.6%) First Nations adults with diabetes have a healthy weight, compared to almost one in three adults (29.7%) without diabetes.

There is a higher rate of First Nations adults diagnosed with diabetes who rate their health as 'poor', 'fair' or 'good' than do other adults (85.0% versus 55.9% respectively). The prevalence of heart disease and hypertension among First Nations adults with diabetes is four times higher than that found in First Nations adults without diabetes.

Four in ten diabetics (41.3%) are currently attending a diabetes clinic or seeing someone for diabetes education. About 20% of adults state that access is the main reason for not receiving education, and this was seen among those living in isolated commu-

nities (47.2%) and among those understanding or speaking a First Nations language compared to those who did not. Adults with diabetes more often indicated a lack of NIHB (27.0% compared to 18.7%), noting it was particularly difficult in accessing medication, other medical supplies and hearing aids.

Compared to those without diabetes, a higher percentage of adults diagnosed with diabetes report that lack of and denial of approval for services under NIHB limit access to health care (21.2% compared to 15.2%). Other reasons for not attending a clinic or seeing someone for diabetes education are cost (6.2%), insufficient information available (4.7%), and culturally inappropriate or inadequate services (3.3%).

The majority (89.8%) of First Nations adults diagnosed with diabetes are undergoing treatment. The majority are taking pills (68.0%) and watching their diet (65.5%). Other forms of treatment include exercise (52.9%) taking insulin (16.7%) traditional medicines (12.9%) and seeing a traditional healer or taking part in traditional ceremonies (6.0%).

The majority of First Nations Adults diagnosed with diabetes are undergoing treatment.

Of the four different types of diabetes, individuals with Type 2 diabetes are most likely to undergo treatment compared to the other types of diabetes. Type 2 diabetes was the type of diabetes reported by 60.9% of diabetic individuals 18–29 years, increasing to over 80% of the diabetic population over 60 years old.



Eating a nutritious balanced diet occurs more regularly with age. The 18–29 group ate a nutritious balanced diet the least and this is a risk factor for diabetes. The percentage of those that eat a balanced diet increased with each age grouping, with the 60+ age group achieving this goal 53.9% of the time.

INJURIES AMONG FIRST NATIONS

Injury is one of our leading causes of death, and is responsible for approximately one quarter of all deaths and over half the potential years of life lost.²⁴

Injuries can be split into two categories, whether they are intentional or unintentional. Unintentional injuries are those for which there is no intent to harm, either from the victim or someone else (fall or car crash). Within the “intentional” category, injuries may be self-inflicted injuries (suicide) or received by another person (assault).

Research indicates that in addition to death and disability, injuries (including those resulting from sexual violence) can lead to a variety of other health problems including depression, alcohol and substance abuse, eating and sleeping disorders, and HIV and other sexually transmitted diseases.²⁵

Injuries are caused by a variety of factors that include low socio-economic status, cultural norms that support violence to resolve conflict and rigid gender norms.²⁶ At the

individual level, there is evidence to suggest that injury risk is linked to income and education as well as alcohol and substance abuse.²⁷

In the year preceding the Survey, 28.8% First Nations adults reported injuries requiring treatment; a rate two times the Canadian average. The most commonly-reported types of injuries were major cuts, scrapes, or bruises; major sprains; and broken bones or fractures. The most common cause of injuries among our adults included falls, sports injuries, incidents with motor vehicles (cars, snowmobiles, ATVs), and violence (family violence or other assault).

A total of 17.5% of the First Nations children included in the RHS had experienced at least one injury serious enough to need medical attention in the year prior to the Survey. The most common types of injuries that First Nations children reported were major cuts, scrapes, or bruises; fractures; and major sprains or strains. There was no significant difference in injuries between boys and girls, however older children were more likely to suffer injuries than younger children.

Almost one-third of our First Nations adults reported injuries requiring treatment — twice the national average.

Men are at much higher risk than females. Men were significantly more likely than women to have an injury caused by sports, bicycle accidents, or environmental factors (such as insect stings or frostbite). Younger men, (18–34 year olds) are at significantly greater risk almost half (42.8%) reported some type of injury in the previous year.

The RHS revealed that lower-income First Nations people are at greater risk of injury: 30.9% of people in the lower-income households reported injury, where only 23.4% of those in higher-income households reported having been injured in some way. Injury rates were higher in our people who had used illegal drugs in the previous year; who are frequent, heavy drinkers; who had been depressed, or had ever considered suicide; and in people who had had a close friend or family member commit suicide in the previous year.

Injury rates did not seem to be associated with a community's size, whereas the community's level of isolation did seem to have an effect; the more isolated communities reported higher injury rates compared to non-isolated communities.

Fall and Trips

Falls were the most common injury reported among First Nations adults. The incident of falls was higher in young adults 18–34 than in adults aged 35–54 years. Higher rates in young adults can be linked to more risk-taking behaviour, higher levels of participation in sport, and perhaps more use of alcohol. There are no gender differences in the incidents of falls. Falls and trips were the most frequently reported cause of injury to children in the RHS: 7.6% of children had had at least one fall that required medical attention during the year. Falls are most common in younger children.



Sports Injuries

Sports injuries are common among our First Nations adults. The RHS reported 6.2% of adults indicated at least one injury due to sports in the year before the survey. Sports injuries are far more likely to happen to men than women (9.3% vs. 3.0% respectively). Younger adults are more likely to incur sports injuries 10.8% of adults age 18–34 had a sports injury, compared to just 2.7% of the people age 35–54.

Cycling

Bicycles were the second most commonly-reported cause of First Nations children's injury in the RHS, with 2.8% of all children having had a bicycle accident in the preceding year, and another 1.1% having experienced some type of collision between a bicycle and a motor vehicle. This was followed by sports-related injuries to children.

Motor Vehicle Crashes

In the RHS, 5.4% of our First Nations adults reported they were involved in one or more accidents involving a motor vehicle in the previous year. Men were more likely than



women to have been injured in a motor vehicle crash (6.8% vs. 3.9%). Few children were reported to have been injured as passengers in motor vehicles.

Violence

Violence in this analysis included both family violence and other types of assault—although both types are likely to be under-reported in a survey. Among our First Nations adults, 4.8% reported that they had suffered at least one instance of violence in the preceding year. Gender did not appear to play a role in the incidence of this type of injury. It can be speculated that the lack of a gender difference is because, although women suffer more domestic violence, men are more likely to suffer other types of assault such as fights and brawls.

One in twenty First Nations adults reported that they had suffered at least one instance of violence in the previous year.

DISABILITIES

Disability in Adults

For the RHS the research defines respondents 18 years and older as having a disability if they said that, because of a physical or mental condition or health problem, they are limited in the kinds or amount of activity they can do at home, work, school or in other activities such as leisure or travelling.

Prevalence of age-adjusted disability among First Nations and other adults in Canada, by gender

Gender	First Nations (RHS)	Canada (CCHS)	Canada (NPHS General file)*
Male	25.7%	23.2%	18.3%
Female	31.3%	28.2%	20.3%
Total	28.4%	25.8%	19.3%

Nearly one in three First Nations adults (28.4%) reported a disability as defined above. Nearly one in three First Nations women have disabilities compared with one in four men. Disability becomes more common as people age. For example, roughly half of First Nations people over 60 years of age group have a disability,** compared with 13.1% in the 18– 29 age group. This increase of disability with age can be explained, in part, to increased exposure to factors that place people at risk of disability across the lifespan, such as accidents, the natural aging process, illnesses and other conditions (e.g., arthritis, heart conditions, progressive hearing loss).

First Nations adults with disabilities are less likely to be single (and never previously married) than their able bodied counterparts (27.5% compared with 40%). In part this finding is likely due to the fact that the onset of disability tends to occur in adulthood for many people, i.e., sometime after people have a chance to enter into a long-term relationship with a spouse or partner.

* CCHS - Canadian Community Health Survey. NPHS - National Population Health Survey.

** That estimate is likely conservative. Unpublished data received from ODI based on the Census of 2001 indicates disability prevalence of 60.3% among First Nations seniors 65 years and older and 54.4% among Inuit seniors in this age group.

Having a disability did not affect the ability of First Nations youth and children to attend school.

First Nations women with disabilities are more likely to be widowed: 1 in 6 compared to 1 in 23 of all First Nations adults taken together. There is little evidence of educational disparity between able bodied and disabled First Nations adults. For example, First Nations adults with disabilities are about as likely as their non-disabled counterparts to have less than high school graduation.

First Nations adults with disabilities have less personal income on average than their non-disabled counterparts. Some 58.6% of First Nations people with disabilities had personal incomes of less than \$15,000 or no

First Nations adults with a disability are less likely to be employed than their able-bodied counterparts.

income in the year before the RHS was conducted. First Nations adults with disabilities are 1.7 times more likely to have incomes less than \$15,000 or no income at all. However, First Nations adults with disabilities are less likely to be employed than their non-disabled counterparts (37.3% compared with 52.2%).

Disability in Youth and Children

In general, First Nations youth and children are significantly less likely to report having a disability than their older, adult counter-

parts. 7.7% of First Nations youth can be classified as having disabilities. Another 8.1% of First Nations children reported having a disability (based on limitations due to long-term health conditions). Taking the NPHS figure as a benchmark and the corresponding data from the RHS for comparison,* childhood disability may be as much as 1.8 times higher among First Nations children.

Having a disability did not present a barrier for school attendance among First Nations youth (compared to able-bodied youth). However, youth with disabilities are more likely to report having learning problems at school than their able-bodied counterparts: 59.2% versus 42.3%. Likewise, First Nations children with disabilities are about as likely as their counterparts without disabilities to be attending school and to have attended an Aboriginal Head Start program.

ACCESS TO DENTAL CARE AND TREATMENT NEEDS OF FIRST NATIONS ADULTS

Almost 60% of our First Nations adults had received dental care in the previous year. However, the results also indicate that untreated cavities, periodontal and prosthetic treatment needs are on the rise. First Nations adults who self-reported themselves to be in better overall health were more likely to have accessed dental care in the past year.

Dental service use is largely determined by the ability to pay for services and dental care increased with household income and employment status. According to the NIHB program policy, dental coverage is not comprehensive, which may explain why more complex types of dental treatment among

* The estimate is based on an approach to identifying disability similar to that used in the NPHS, which yields a 4.4% prevalence of childhood disability in the general population; $7.8 \div 4.4 = 1.8$.



older adults are sometimes neglected. Overall, 17.6% of the adults said they were denied prior approval for dental services under NIHB. But more of a concern is the fact that among those who reported the

Just under half of First Nations adults who reported they needed urgent dental treatment, said they had difficulties accessing NIHB.

need for urgent dental treatment, just under half said they had difficulties accessing NIHB for dental services.

Historically, it has been difficult to attract general dentists and specialists to the more remote and isolated First Nations communities in Canada. There are also wide variations in relative dentist supply between provinces, and within regions in the provinces.²⁸

The findings that dental treatment needs were associated with diabetes and obesity have far reaching public health implications that should be noted. In addition obesity and diabetes is more prevalent among our

Youth more often access dental care for emergency purposes rather than preventative care.

adults.^{29, 30} Greater rates of smoking and alcohol consumption have also been reported among us, which impact dental health.³¹ The burden of oral diseases and tooth injury is increasing and the need for further research into these risk factors, with the goal of designing appropriate intervention programs should be a priority.

The majority of our First Nations youth have received dental care. However, dental care is accessed for emergency rather than preventative reasons. Our youth need restorations, maintenance care for their teeth, and tooth extractions. Nearly 20% of our youth have



dental pain, an indicator of the need for urgent care and a good predictor of tooth loss. Extractions of permanent teeth begin during the early teens as a result of tooth decay and continue into adulthood, when periodontal (gum) disease becomes the major indicator for tooth extraction. Our youth who live in remote communities were not able to readily access dental care in the preceding year and many need fillings.

In remote or isolated communities the variety and availability of nutritional foods can often be limited, with youth eating too much junk food and consuming soft drinks. In fact, soft drink consumption remains one of the major risk factors for tooth decay in children residing in First Nations communities and their dietary choices as children are very likely to influence their choices as youth.³²

Although our children have a high level of dental care use, this has not reduced the need for treatment services, such as fillings.

Two-thirds of our First Nations children have received dental care in the past year. Dental care is tied to age and the parents' education, and the size and isolation status of the community. Children with less educated parents or from remote or isolated communities are significantly less likely to have had dental treatment in the past year. While there is a high level of dental care use among our children, we do not see a reduction in treatment needs. One-quarter of our children need dental fillings and nearly half reported the need for dental check-ups or teeth cleaning. Some children need fillings as early as age one and the number of pre-school children requiring fillings was found to be the same as that of school age children. Baby Bottle Tooth Decay (BBTD) affected 30 % of children 3 to 5 years while

Baby Bottle Tooth Decay affected 30% of children 3 to 5 years.

approximately 30% of those affected remain untreated.

Preventive care and oral health promotion for our children should be examined. Community-based initiatives may help to reduce problems before they arise. Initiatives to teach prenatal women, new mothers, grandparents or other relatives who take care of children to provide good oral hygiene care will result in cavity reductions. School-based programs produce similar results and help raise awareness of risks of oral-facial injuries. Creation of safe environments at childcare and sports facilities may also help to reduce these injuries.

SUMMARY OF THE RHS DATA:

If we are to look around us and observe the health conditions of First Nations Peoples, this is what we see:

- First Nations adults have a higher rate of arthritis/rheumatism than Canadian adults.
- For all age groups and genders smoking is approximately twice that found in the Canadian population.
- Obesity for our First Nations women is approximately three times that of the Canadian female population.
- The occurrence of diabetes in First Nations adults is much higher than that of the Canadian population in all age groups with rates for our females being higher than our males.
- The average age of diagnosis of diabetes in our youth is 11 years. Early onset of Type 2 diabetes leads to serious health consequences for youth as they age.

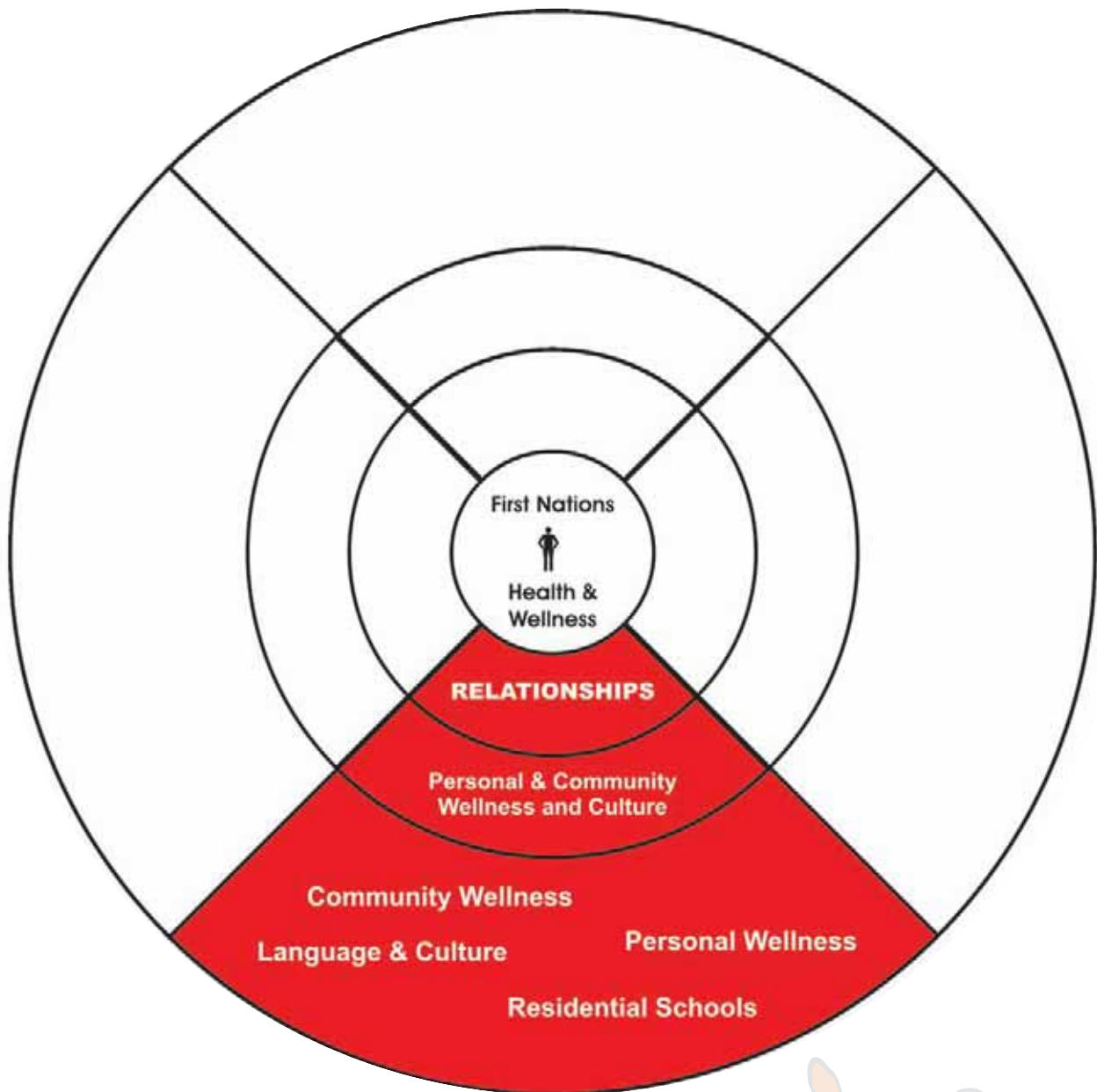


- Diabetes among our First Nations people is often linked with being overweight and obese.
- Frequency of heart disease and hypertension among First Nations adults with diabetes is four times higher than that found in First Nations adults without diabetes.
- The majority of First Nations adults diagnosed with diabetes are undergoing treatment.
- Approximately 1 in 10 of our First Nations children and 1 in 5 of our youth suffer from chronic ear infections.
- Over half of our children and less than half of our youth are overweight or obese.
- Our First Nations adults report injuries at a rate of almost three times the Canadian average.
- Almost one-third of our First Nations adults reported injuries requiring treatment – twice the Canadian average.
- One in twenty First Nations adults reported that they had suffered at least one instance of violence in the previous year.
- Just under half of First Nations adults who reported they needed urgent dental treatment, said they had difficulties accessing NIHB.
- First Nations youth more often access dental care for emergency purposes rather than preventative care.
- Although our children have a high level of dental care use, this has not reduced the need for treatment services, such as fillings.
- Baby Bottle Tooth Decay is a serious problem with our First Nations children.





CHAPTER 4: RELATIONSHIPS



Relationships develop over time.

As human beings, we all establish relationships and all these relationships develop, whether in a positive or negative way, over time. There are relationships with friends, family and community, and also relationships with ourselves...for example, how we view ourselves and our own sense of personal wellness.



From the First Nations framework established in Chapter 2 it was illustrated why these relationships are important measurements of overall health. Values such as culture, identity and traditional knowledge are considered to be core indicators of health. The underlying principle of Balance, which can also be expressed in terms of relationships, becomes vital to any measurement of overall health for First Nations Peoples.

In this section we summarize the information collected by the RHS which deals with the issue of relationships in a variety of ways. The general topics covered in this section are:

- Personal Health
- Residential Schools
- Culture and Language
- Community Wellness

MENTAL HEALTH, PERSONAL WELLNESS AND SUPPORT AMONG FIRST NATIONS ADULTS, YOUTH AND CHILDREN

Being in balance is a vital aspect of health for our people. Adult respondents felt in balance in the four aspects of their lives: 70.9% felt in balance physically, 71.0% emotionally, approximately 74.8% felt in balance mentally, and about 68.4% felt in balance spiritually. Despite this finding of perceived sense of balance, 30.1% of our adults have also experienced a time when they felt sad, blue or depressed for two weeks or more in a row to the high levels of perceived balance among our adults. In

A majority of First Nations people feel in balance physically, emotionally, mentally and spiritually.

addition, 37.9% have experienced instances of racism in the past 12 months.

First Nations adults' perception of supports also impacts mental health. Unfortunately, our mental health can be very unstable at times with alarming rates of suicidal thoughts and attempts, contradicting the notion that our people are in balance. Overall, one in ten of the adults reported having suicidal thoughts over their lifetime. About half who had thoughts of suicide reported an attempt during their lifetime. There were no gender differences reported in thoughts of suicide, however, women reported attempting suicide at a higher rate than men.

The majority of the adults feel they always have someone to show them love and affection. Over half of First Nations adults felt they always have someone who will take them to a doctor, or someone to do some-

One in ten First Nations adults report having suicidal thoughts and 50% of those people report suicide attempts over their lifetime.

First Nations youth do not access traditional supports or mental health services, despite reporting that they are not feeling emotionally or mentally balanced.

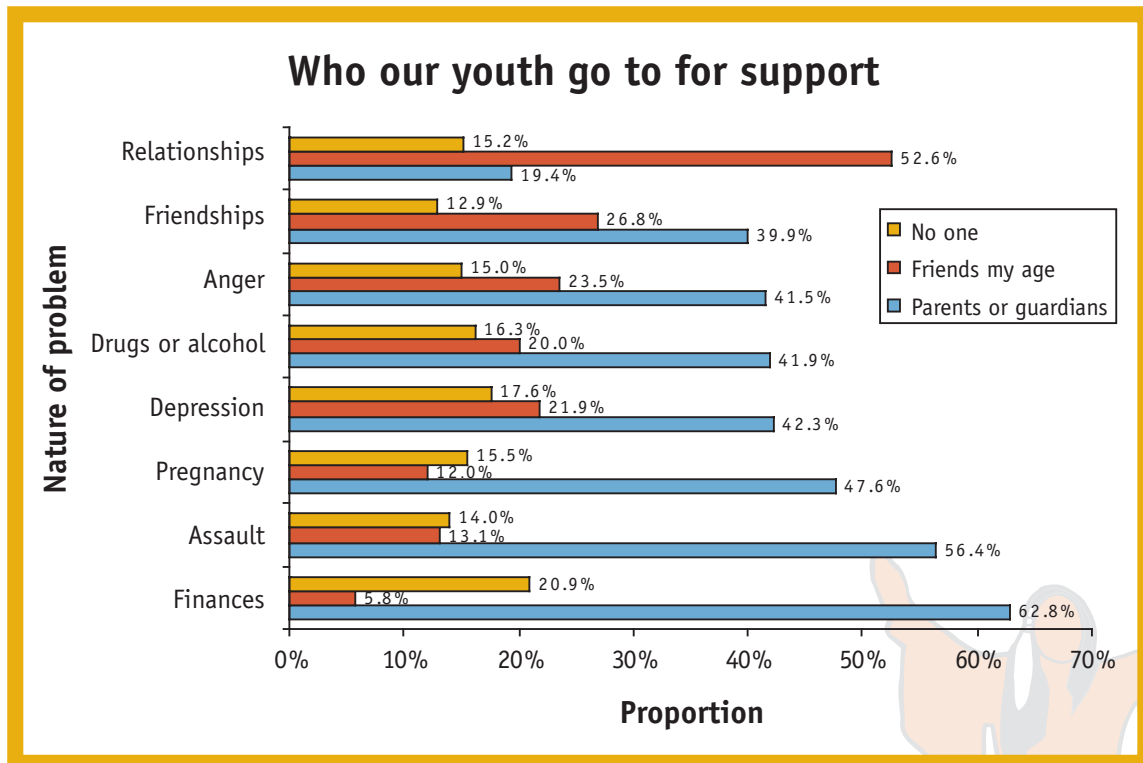
thing enjoyable with. The availability of someone who can always give them a break from their daily routines was quite low. Emotional or mental health support is usually found among family and friends.

Similar to the findings reported by First Nations adults, the majority of our youth report being in a state of physical, emotional, mental, and spiritual balance. Physical balance was most often reported, respectively followed by emotional balance, mental balance and spiritual balance. However,

those that live in isolated communities were most likely to report feeling emotional or mental balance almost more frequently than those in non-isolated communities.

Our First Nations youth tend to seek emotional help from friends and immediate family members. Females are more likely to seek these individuals for help than males. Traditional healers, counsellors, psychological testing or any other mental health services were generally not sought out by our youth. The majority of youth in remote isolated communities reported never consulting a traditional healer. Age and health transfer status of communities made no difference to this finding.

When First Nations youth are dealing with problems, there is a consistent small group of people that the majority will turn to for assistance. Most will turn to a parent or





guardian; then they will turn to friends their own age. Youth seek assistance over various issues from parents/guardians; friends their own age; and no one. One of the most alarming reports are the percentage of youth that will turn to no one when dealing with factors that have high contribution levels to suicide such as relationships; substance use; depression; and physical or sexual assault.



Parents or guardians are the most popular choice when First Nations youth are dealing with all of the listed problems except boyfriend/girlfriend relationships. Friends their own age are the most popular choice when dealing with such relationships, and second most popular choice for everything else with the exception of financial problems and assault. The only time doctors/nurses/health care aides are sought is in dealing with STDs, birth control and pregnancy. Males and females will seek advice of their parent/guardians for help. Males are more likely to deal with things

themselves while females are more likely to go to friends their own age.

Employment

The percentage of First Nations respondents who thought about suicide during their lifetime was similar between those working for pay and those who were not. However, 42.3% of those who work are more likely to have experienced racism, which is higher than those who do not currently work for pay (33.5%).

Perceived Health Status

Those in poorer health are much more likely (approximately 33% more) to have thought about suicide in their lifetime than those in better health.

Self-Esteem

Self-esteem is the confidence and satisfaction one has in him or herself. Two-thirds of First Nations adults who experienced racism also reported that their self-esteem was negatively affected. Moreover, these individuals were also more likely to have thought about suicide in the past year.

Racism

Those First Nations who feel strongly (very or somewhat) about the importance of cultural events and spirituality report higher numbers of racism than those who report that cultural events and spirituality are unimportant.



Residential School

Residential school attendance has been repeatedly cited to have adversely influenced the health and well-being of First Nations peoples. There were no differences in rates of suicide attempts or thoughts between attendees and non-attendees.

Personal Support

First Nations adults who feel sad, blue or depressed ranked mental health and social professionals as their main source of support, while other adults who did not feel sad, blue or depressed ranked their family and friends as their main supports. Those who are depressed say they have low levels of supports available for their emotional and mental health needs from family, friends,

First Nations felt strongly that their community was not progressing in relation to reducing alcohol and drug abuse.

and health practitioners. They were also less likely to have a high sense of self-determination.

Community Progress

First Nations felt strongly that their community was not progressing in relation to reducing alcohol and drug abuse. Two areas in First Nations communities where our people saw some progress with water and sewage facilities and with education and training opportunities.

THE IMPACTS OF RESIDENTIAL SCHOOLS ON THE HEALTH AND WELL-BEING OF FIRST NATIONS

In this section, we examine the impacts of residential schools on the health and well-being of our adults, youth and children.

Residential School Impacts on Adults

One in five of First Nations adults (20.3%) attended residential schools for average of five years. On average our people usually started school at about nine years old and finished when they were fourteen years old.

Today First Nations survivors of residential school are 40 years old and over. Residential schools were closed between the 1950s and 1990s. Half the First Nations adults who attended residential school said their health and well-being was negatively affected. The experience had long-lasting mental and health effects. The three most noted effects are: isolation from their family, verbal or emotional abuse and loss of cultural identity. At least 18% of attendees have attempted suicide in their lifetime, and 30% have used one or more non-prescription drugs in the past year.³³



The majority of attendees (71.5%) witnessed the abuse of others. Residential school attendees reported experiencing the following types of abuse as a student themselves: sexual abuse 32.6%, physical abuse 79.2%, and verbal or emotional abuse 79.3%. Other impacts include harsh living conditions (43.7%), lack of proper clothing (40.5%), bullying from other children (61.5%), loss of language (71.1%) and loss of traditional religion or spirituality (67.4%).

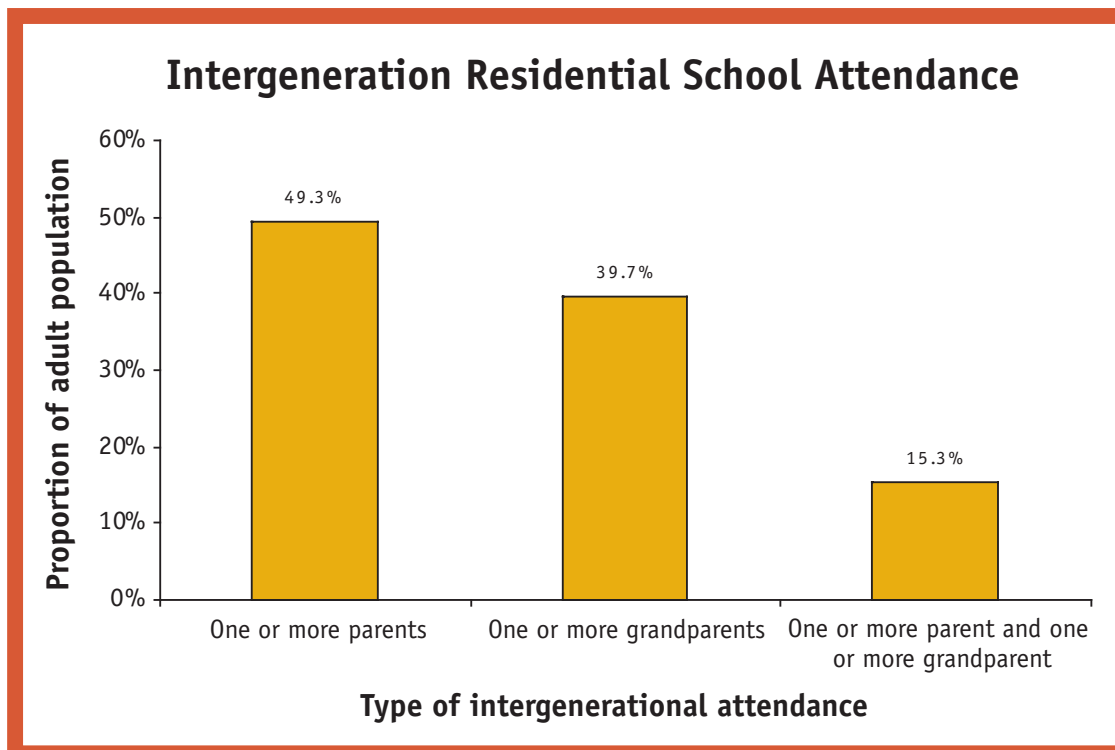
While more than 90% can speak and understand English fluently or relatively well, half of our First Nations adults do not under-

A majority of First Nations residential school attendees witnessed the abuse of others or experienced it themselves.

stand a First Nations language. Just less than half of our adults (43.9%) are able to speak one or more First Nations languages fluently or relatively well.

Our First Nations adults believe that their parents' attendance at residential schools negatively affected the parenting they received as children. The majority of adults also believe that their grandparents' atten-

Proportion of adults who had parents, grandparents or both parents and grandparents attend residential schools:



dance at residential schools negatively affected the parenting that their own parents had received when they were children.

In addition to suffering from mental health effects such as depression and substance abuse, First Nations adults were also likely to think about suicide. Further to this, those adults having at least one parent attending residential school were more likely to have thought about committing suicide in their lifetime: 37.2% compared to 25.7% of those adults who did not have parent(s) who attended residential school. Furthermore, 20.4% of adults who had grandparent(s) who attended residential schools also had attempted suicide during their lifetime, in comparison to 13.1% (of adults who did not have grandparent(s) who attended residential schools).

First Nations adults believe that their parents' attendance at residential school negatively affected the parenting they received.

Attendees are more likely to suffer from tuberculosis, diabetes, arthritis, and allergies as well.

Over half of our First Nations adults said that traditional cultural events and traditional spirituality are somewhat or very important in their lives. Additionally, 70.3% say that religion is somewhat or very important in their lives. For residential school attendees who have gone on to lead well-adjusted lives, religious beliefs and spirituality are frequently cited as reasons for their current well-being.³⁴ This is shown in the RHS where residential school atten-

dees were more likely than non-attendees to say that traditional cultural events, traditional spirituality, and religion were important in their lives. Our spiritual traditions help former attendees, reclaim their own identity and meaning in their lives.

Residential School Impacts on First Nations Youth

The residential schools that operated from the mid-19th century to the late 20th century continue to have indirect effects on our youth today. The effects of residential schools on cultural identity, health and well-being and the ongoing tensions between the values of First Nations Peoples and mainstream society complicate the efforts of our youth to form identities and find their ways in the world.

First Nations youth (12–17 years) are more likely than children (under 12) to have had parents and/or grandparents who have attended residential schools. About one in three youth today have one or more parents and about two-thirds have one or more grandparents who attended residential schools. This suggests our youth are at a greater risk to experience the indirect effects of residential schools than are children under the age of 12 years.

With several generations of children having grown up in a setting where expressions of First Nations identity was criticized and devalued, it is not surprising that the cultures and languages of so many communities

Almost 60% of our First Nations children have one or more grandparents who attended residential schools.



are in danger of being lost. The loss of language, the ability to speak and understand any of our languages by youth is devastating.³⁵ Although youth have experienced the loss of their language, youth still believe that it is very important to them that they be able to speak their language.

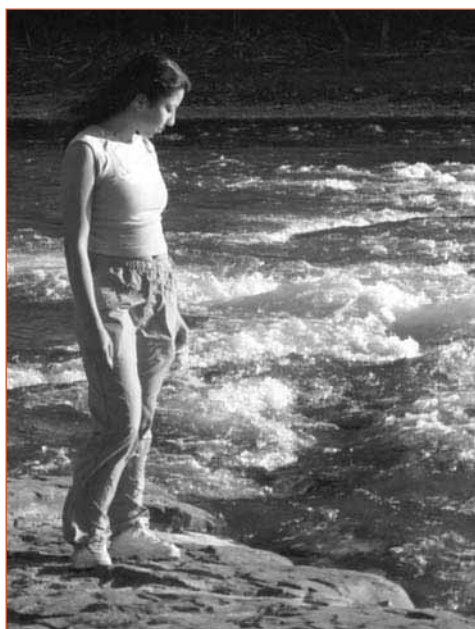
About half of our First Nations youth who have a parent or grandparent who attended a residential school, stated that it was very important to them that they speak their own language. For youth who had one or more parents who attended a residential school, over half of them believe that cultural events are important in their life.

The residential school experience can lead to an early death³⁶ due to high incidences of suicide among other risk factors. In cases where one or more parent attended residential school, youth were more likely to have thought about or attempted suicide at least once in their lifetime. The same situation exists for youth with one or more grandparents attending residential school.

Residential School Impacts on Children

One of every six of our First Nations children has one or more parents who attended residential schools. Furthermore, almost 60% of our children have one or more grandparents who attended residential schools.

The residential school experience has had lasting impacts on their succeeding familial generations and communities. For those who attended residential schools, the mental,



physical, emotional and spiritual impacts are profound. In turn, our children are at some risk for experiencing the indirect effects of the residential school experiences of their parents and grandparents. The impacts on our children are seen in our loss of language, and traditional cultural events.³⁷

Almost all parents felt that it was important for their child to learn a First Nations language. Residential school attendees were slightly more likely to feel this way than non-attendees.

There is little difference in terms of understanding or speaking one or more languages fluently or relatively well for children of those who did or did not attend residential school. Parents who attended residential

school were more likely to have children who could speak their language than non-attendees: 22.6% versus 16.4%.

Just over half of parents who attended residential school stated that traditional cultural events are very important in their child's life, in comparison to 42.3% of those parents who did not attend residential school.

LANGUAGES AND CULTURES

The following section will look at the influences of language and culture on First Nations health.

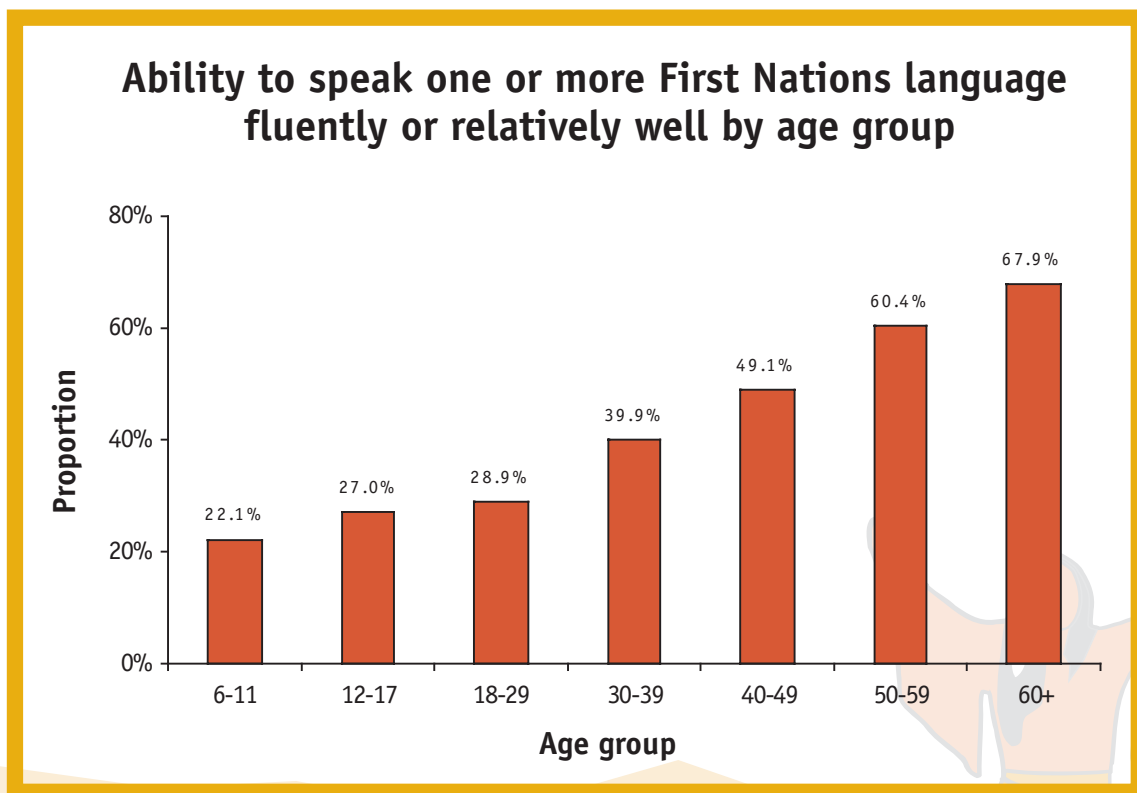
Overall, we see that the older the age group the stronger the emphasis and importance placed on traditional culture. Traditional spirituality and ceremony are both very important for both First Nations males and females of all ages.

Barriers to Health: Language and Culture

First Nations health needs have to be seen within a culturally appropriate framework that is respectful of First Nations. It is important to see the barriers that are in place, namely, cultural interpretation, language and prior notions of First Nations health.

Certain barriers may limit the ability of our adults to access health services, such as: not being able to describe the symptoms, language translation, physical access to health services, the cultural context in which they are experiencing health concerns and the use of traditional medicine. Such factors reflect the research regarding community progress in relation to traditional approaches to healing.

Both First Nations men and women, in all age groups of fluent speakers believed traditional approaches to healing are very impor-





Only 13.9% of our First Nations youth use a First Nations language on a daily basis.

tant contributors to community progress. There is little doubt of the strong ties between culture and community/individual health, where traditional healing is viewed as important in the overall health.

Our First Nations youth (ages 12 through 17) have a special relationship to their traditional culture. The people from whom they learn their language and culture are their family and community and these connections are vital.

Over 80% of our youth believe that speaking their language is important. Traditional cultural events in one's life are considered important by about half of our youth.

Unfortunately, the actual use of language by our youth lags behind the sense of importance for language expressed. Only 13.9% named a First Nations language as a daily use language. Of these youth (12.4%) spoke their language exclusively in daily use. In contrast, 87.6% named English, French or sign language as a daily use language in their daily activities (85.4% English; 2.4% French).

The use of our First Nations languages can be seen in the context of the number of languages in daily use by our youth. The

majority (96.0%) indicated the use of one language in daily life, that being English. The First Nations languages in daily use that were cited most often were Cree, Montagnais, Attikamekw, Stoney, Oji-Cree, Mi'kmaq, Ojibway and Dene.

Daily use of First Nations languages – youth

Using First Nations language	13.9%
FN language only	12.4%
Using English, French or sign	87.6%
English	85.4%
French	2.4%

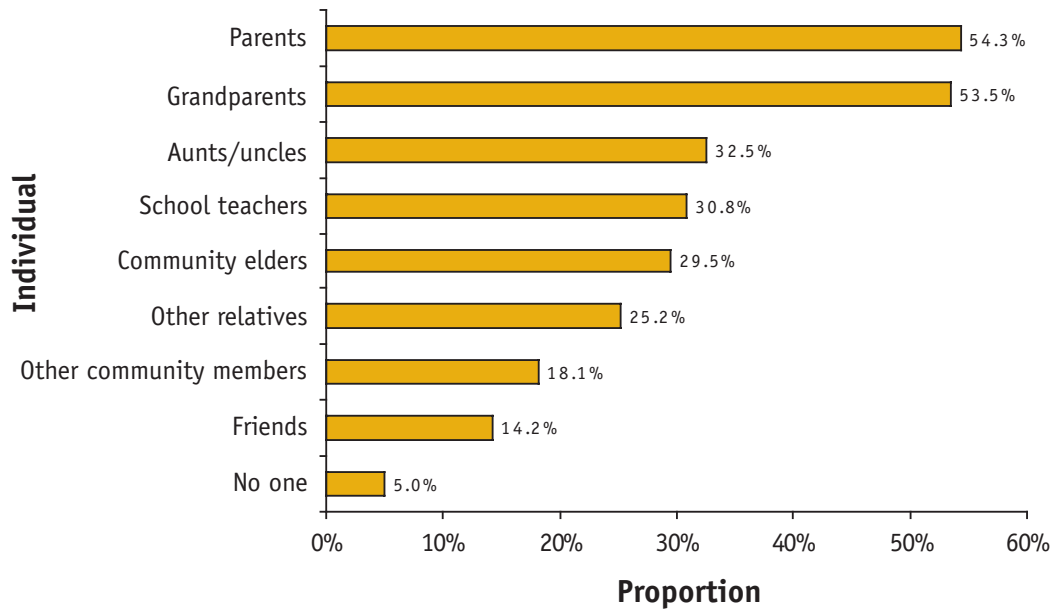
Number of daily use languages

1	96.0%
2	3.0%
3	0.2%

Of the 32 First Nations languages captured in the RHS, First Nations youth were asked about how well they understand and spoke their own language. As anticipated, understanding comes before being able to speak. The questions asked the extent to which each language could be understood: fluently, relatively well, a few words, or not at all. About one in three of our youth are able to

Cree, Ojibway and Oji-Cree were the most frequently spoken language by First Nations youth on a daily basis.

Who helps our youth learn their culture and language



understand their language and one in four can speak a First Nations language fluently or relatively well.

Cree, Ojibway and Oji-Cree, were the most cited First Nations languages for the majority of the youth with any understanding or speaking ability of a First Nations language. Other languages that are understood fluently or relatively well by youth were Naskapi, Stoney, Mohawk, Mi'kmaq, Attikamekw and Salteaux. About 85% of youth spoke English fluently and 4% spoke French fluently.

Many people within our communities help youth understand their language and culture, with grandparents and parents mentioned most often. Aunts/uncles and community Elders as well as school teachers, the parents and grandparents also support

youth. Other people mentioned who also support a youth's understanding of his or her language and culture were other relatives, community members and friends. About 5% of our youth have no one helping them with their language and cultural understanding. Research shows the more available sources for learning a language, the more likely youth are to speak and understand their language.³⁸ In general, the more people youth can turn to for cultural teachings the more likely they can understand or speak our languages. In fact, there is a significant difference even if the youth only have one person to teach them as opposed to no one.

Traditional cultural events and learning a First Nations language are considered important by most children's parents and grandparents.



Children's actual knowledge of our languages is less than their parents'/grandparents' sense of importance of such learning. Only 28.9% of our children (6–11 years) understand their language, and one in five can actually speak their language. For children (3–5 years) one in five understand and one in seven can speak their language. Almost 60% of parents were satisfied with their child's understanding of their First Nations language.

Most First Nations parents and grandparents believe that it is important for their children to learn traditional cultural events and a First Nations language.

Family and Community Sources for Understanding Culture

First Nations children and youth learn about their culture primarily from their parents and grandparents. Understanding is also gained from extended family members (aunts, uncles) and through school teachers. Community Elders, relatives, community members and friends are also important.

Some children have up to eight sources of help for cultural understanding. Generally speaking, the number of sources related to understanding or speaking our languages shifts, depending on who is involved with the children, as they get older. Relatives are as likely to be involved in helping the

children understand their culture at all ages, but community members are more and more involved as the children get older.

In addition to expected age differences, other things impact our children's language and cultural experiences. Parents' education and community characteristics are two of the major factors.

First Nations parents who are formally educated³⁹ are more likely to be involved with the traditional cultural socialization of the child, especially in the area of language. More parents were cited as involved in their children's understanding of their culture when the mothers had some post-secondary education. A similar but not as pronounced trend is seen with the educational attainment of fathers.

Community Characteristics

Valuing and learning our languages and culture are tied to family and housing situations, community size and relative isolation.

First Nations children in larger communities were much more likely to be able to under-

First Nations parents who have more formal education are more likely to be involved with the traditional cultural socialization of their child.

stand and speak a First Nations language than those in smaller communities.

Remote and isolated communities placed more importance on children learning their language, and stressed the importance of learning traditional culture from traditional sources as might be expected by those with the least exposure to Western influences.

COMMUNITY WELLNESS: JOURNEYING FORWARD

The RHS asked First Nations to rate the progress of their communities towards community wellness by responding to a number of indicators:

Renewal of First Nations Spirituality

One indicator of community wellness is the amount of language used in our communities. Approximately 75% of our First Nations adults report that English is the language that they use most often in daily life. First Nations adults reported that there were few efforts to enhance improvement in language acquisition in the community.

Concerns were expressed about the current status of culture and health. Over half our First Nations adults felt that communities were making some or good progress in renewing a relationship with the land. There were similar views expressed when asked to report on community progress towards “renewal of spirituality”.

Reduction in Alcohol and Drug Abuse

Community wellness is dependent on some form of sobriety. Unfortunately, only one-third (36.4%) of our adults felt that there was progress in reducing the amount of alcohol and drug abuse in their community.



The remaining two-thirds felt that there was no progress at all. Literature suggests that substance abuse is a coping mechanism for the social disintegration experienced by many First Nations communities.⁴⁰

Traditional Approaches to Medicine

There is a relationship between respondents' level of education and their beliefs regarding the revitalization of traditional healing practices. Those First Nations with post-secondary vocational training are more likely than those who did not graduate from high school to state that some progress has been made regarding the revitalization of traditional healing practices.

Cultural identity plays a key role in the delivery of health care. Half of our First Nations adults had consulted a traditional healer within the past year. The use of traditional medicine by our people does not seem to be affected by age or gender. Not surprisingly, those who valued traditional



spirituality were more likely to have had consulted a traditional healer in the past year.

Housing Adequacy

Housing can play an important role in our health. We need adequate living space and homes in good repair with the basic amenities for health and safety. Many of us do not have these things.

Overcrowding on-reserve is much greater problem than for the Canadian population overall and is getting worse. The 2001 Census indicates that, nationally, there are 2.6 persons per household. The RHS figure is almost double at 4.2 persons per household. In 1991, the estimate for First Nations was 3.5 persons per household compared with 2.7 for Canadians overall according to the Census. While crowding is steadily declining in Canada, it is increasing rapidly in First Nations communities.

Overcrowding on-reserve is much greater problem than for the Canadian population overall and is getting worse.

In some instances the occupant density of our homes is much higher than this average: the RHS records up to 18 people in a house. We tend to have large families, with low income and live in houses that are too small. Our average household size is 5.5 people (children's survey).

Some First Nations households lack electricity, refrigeration, cooking stoves, running water, and flush toilets.

Of the First Nations adults surveyed in the regions, 63.3% reported that they live in band-owned housing. Lower income adults are more likely to be living in band-owned housing than adults with higher incomes.

One-third (33.6%) of First Nations homes need major repairs, up from one quarter cited in 1985 by the Neilson Task Force and four times the rate for Canada overall (8.2%).⁴¹ Adults with lower incomes are more likely to live in homes requiring major repairs.

More than 1 in 5 First Nations adults live in homes that lack access to garbage collection services and nearly 1 in 10 have neither a septic tank or sewage service. Although most (77.3%) have a working smoke detector, less than half have a fire extinguisher. In the 21st century, a small but important proportion of our people still live in homes lacking such basic amenities as electricity (0.5%), refrigerators (1.3%), cooking stoves (0.7%), cold (3.5%) or hot (3.7%) running water, and flush toilets (3.5%).

When asked about the community overall, 2 in 5 First Nations adults felt that there had been no progress in improving the quality of First Nations housing in the previous year.



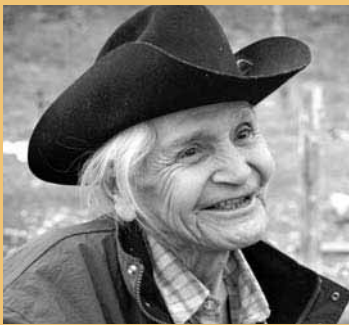
Recreation and Leisure Facilities

Traditionally our people have always placed importance on sport and recreation. Sport and recreation reinforce cultural practices, socialization and builds community ties. The use of traditional activities and games provides an excellent opportunity to enhance our language and culture in a fun and entertaining fashion. More than half of First Nations adults (54.5%) reported that some or good progress has been made in terms of improving recreation, leisure, and sports activities in their community.

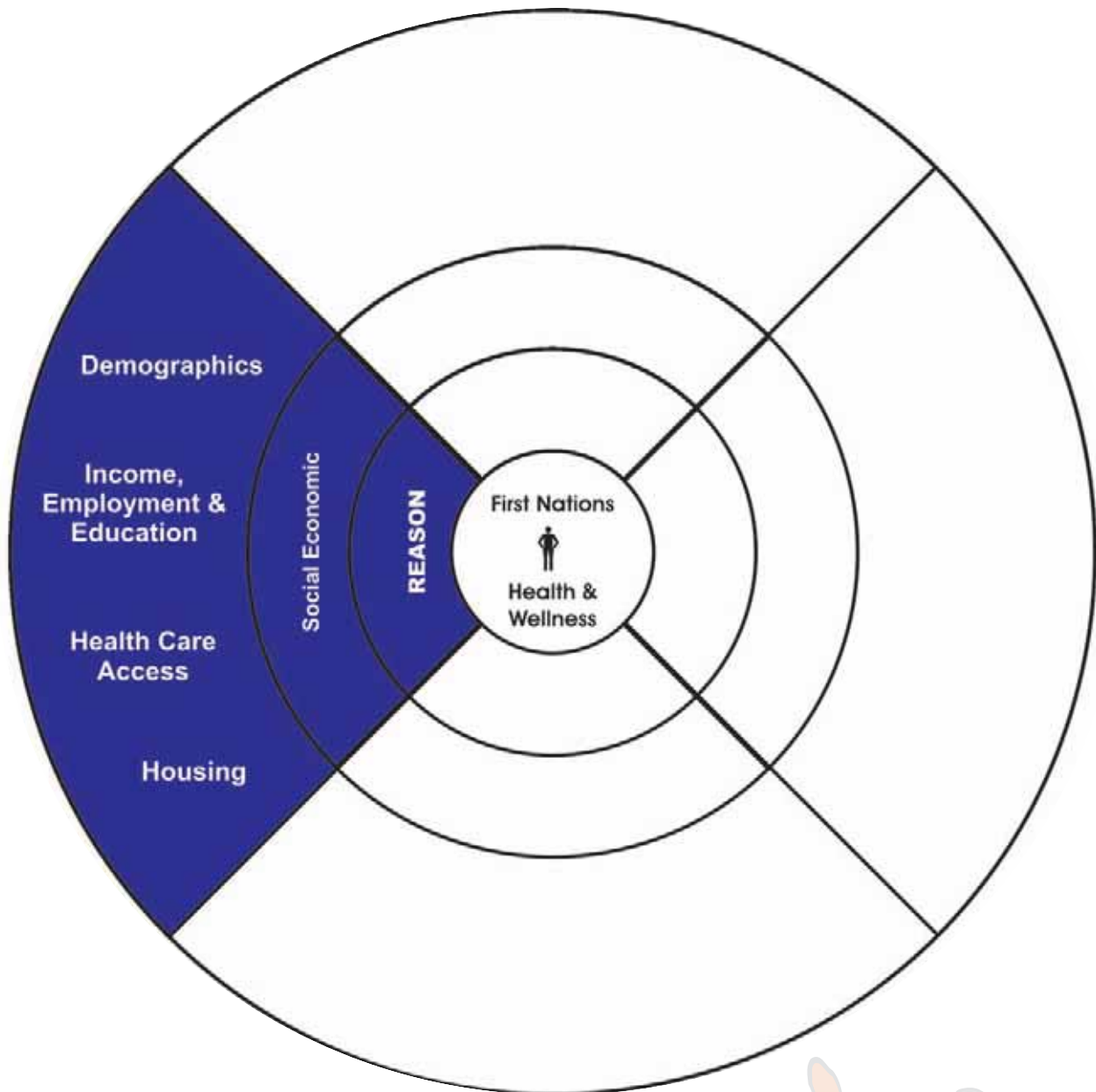
SUMMARY OF THE RHS DATA:

As we look around us and see the physical indicators of health, such as sickness and injury, we can also observe the relationships that we have established. It is our connections to self, others, and the overall environment that also give us information about our health. In this section we have seen that:

- A majority of First Nations people feel in balance physically, emotionally, mentally and spiritually.
- One in ten First Nations adults report having suicidal thoughts and 50% of those people report suicide attempts over their lifetime.
- First Nations youth do not access traditional supports or mental health services, despite reporting that they are not feeling emotionally or mentally balanced.
- First Nations adults who feel healthy are less likely to experience suicidal thoughts as those with fair or poor health.
- First Nations people felt strongly that their community was not progressing in relation to reducing alcohol and drug abuse.
- A majority of First Nations residential school attendees witnessed the abuse of others or experienced it themselves.
- First Nations adults believe that their parents' attendance at residential school negatively affected the parenting they received.
- Although many First Nations youth do not speak their language, it is still very important to them that they are able to speak their language.
- Almost 60% of our First Nations children have one or more grandparents who attended residential schools.
- Only 13.9% of our First Nations youth use a First Nations language on a daily basis.
- Cree, Ojibway and Oji-Cree were the most frequently spoken language by youth on a daily basis.
- Most First Nations parents and grandparents believe that it is important for their children to learn traditional cultural events and a First Nations language.
- First Nations parents who have more formal education are more likely to be involved with the traditional cultural socialization of their child.



CHAPTER 5: REASON



What does it mean to have “reason”, to reason something out... to be reasonable?

Generally speaking reason deals with the mental component of a human being. Reason is something of the mind... a process that takes place in the thinking part of the body. As a mental activity, reason represents all those elements of the mind that allow us to live, and to earn a living.

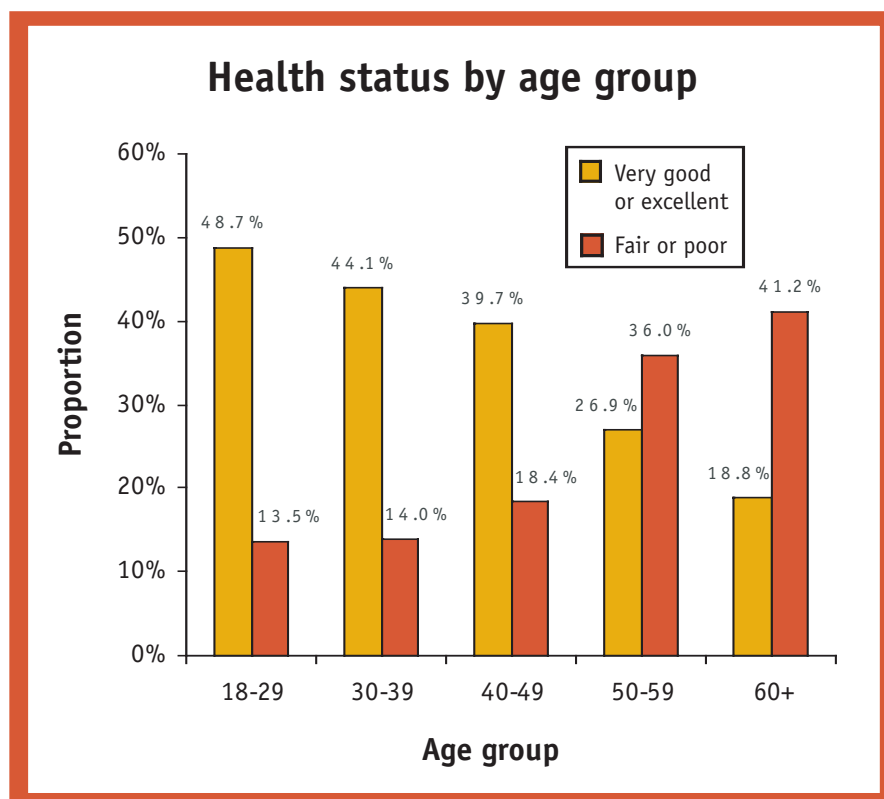


We need the basics of food, clothing, shelter and warmth to live. To obtain these basics of life we need an income, the size of which depends to an increasing degree on formal education. Education is in turn dependant on your living environment...do you have safe and adequate housing, healthy food and access to health care. Given the proper and appropriate living environment, combined with adequate educational opportunities, the chances to earn an adequate and healthy lifestyle increase.

Reason or learned knowledge, as representative of the thinking activities of the mind, allows us to live and to earn a living...to

supply not only the basics of life but also the opportunity to live a comfortable lifestyle. In this section of the report we focus on those areas of the Survey relating to Reason, the ability and opportunity for First Nations Peoples to achieve an adequate and appropriate lifestyle. The section looks at the information collected on the topics of:

- Demographics
- Income, Employment and Education
- Housing and Living Conditions
- Health Care Access



DEMOGRAPHICS

Almost 10% of our First Nations adults live in small communities (less than 300 people) while 34.2% live in communities with a population greater than 1,500 people. A small percentage of First Nations people live in remote, isolated communities (2.8%) while most First Nations adults (76.0%) live in non-isolated communities within 90 km road access of a physician. House sizes vary a great deal (four to seven rooms most common). Almost one in five adults (17.2%) are considered to be living in crowded conditions (more than one person per room). There was a wide range of First Nations adults who told us that their general health and wellness ranged from excellent (13.3%) to poor (4.1%). In general, younger adults (18–29 yrs and 30–39 yrs) reported much better health than did adults 50 years of age and older. Compared with Canadians in general, fewer First Nations people considered themselves in excellent health (13.3% vs. 21.9%), while more First Nations people reported their health as poor (4.1% vs. 2.9%).⁴²

INCOME, EMPLOYMENT AND EDUCATION

Employment

Employment, or the lack of it, is a major concern to many of our First Nations adults surveyed. Our total household income for First Nations adults showed the following profile:

Total household income	percentage
Less than \$10,000	11.7%
\$10,000–20,000	19.0%
\$20,000–30,000	19.5%
\$30,000–50,000	25.6%
More than \$50,000	24.2%

About half of adults in First Nations communities are working for pay and most of those are employed full time. More women worked part-time than full-time. Those adults between the ages of 30 and 59 years were more likely to be working for pay than younger adults (under 30 years) and older adults (60 years). The higher the education, the more likely those adults have paying jobs. First Nations adults aged 30–59 years have higher paying jobs than other adult age groups.

There was a relationship between paid employment and perception of health. For many of those First Nations adults currently working for pay, they felt themselves in

First Nations people who have paid employment report better health than those who do not have paid employment.

excellent or very good health, compared to those adults who were not working for pay. Those working for pay were more likely to be free of any medical conditions (49.3%) compared to those unemployed (43.0%). Moreover, adults who were employed were less likely to have physical limitations due to a medical condition: 21.7% versus 30.8%.

Education

Almost half of our First Nations adults surveyed in the RHS 2002/03 have graduated from high school. Just about one-quarter of these high school graduates (22.9%) have received a diploma from trade, technical, or vocational school, or had received a diploma from a community college or CEGEP, while a minority (5.1%) had obtained a bachelor's or master's degree or doctorate.



There were no differences in educational success between First Nations men and women. There were, however, differences by age. First Nations adults over 60 years had the highest rates of not completing high school. First Nations adults in the 18–29 year age category had not yet attained college or university education as frequently as adults in the 30–59 age category. Many of our parents are still in high school, and many adults return to school for post-secondary education after a break of some years.

Family and Household Structures

First Nations children are affected by the physical and social environments they live in. Here we look at their families and households, as the primary influences of their health and wellness, and balance of body, mind, heart, and spirit. Housing and crowding are part of the very personal physical environment of the child, which impacts not only the child but also the family and other household members.

Most of our First Nations children live in households with five or more people, usually family members. Most children live with more than two adults and more than three children and/or youth. The number of household members ranges from 2 to 22, adults living in the household ranged from 1 to 11, and the number of children and youth ranges from 1 to 17.

In First Nations children's households with one or more parents present, 37.9% had

Approximately one-third of First Nations children who lived with one or more parents, also had other adults including grandparents, aunts, uncles, and/or cousins living with them.

other adults living in the household. This was true for a larger number of households with one parent present than households with two parents. About half of the households with parents and other adults included grandparents, and about half included aunts, uncles or cousins. Half of those included both grandparents and other extended family at the same time.

Most of our First Nations children live in households with other children and/or youth.

- 12.7% of the children were the only child in the household.
- 24.0% live with one other child or youth.
- 46.0% live with two or three other children or youth.
- 17.3% live with four or more other children or youth.

When parents made childcare arrangements for their children, they were most often cared for by relatives, thereby remaining with family when the parents were away. Some children travelled outside their home for childcare, but a substantial portion did not leave their own homes.

About one-third of the First Nations children had childcare arrangements made for them. Of the children in childcare settings, over half were cared for by relatives in home settings. Of all the children with childcare arrangements, almost twice as many were cared for in homes (2 in 3) as were cared for in more formal settings (1 in 3). For those in homes, they were equally divided between their own homes and the homes of others, most of them cared for by relatives.

More than half of the First Nations children in childcare settings were cared for by relatives in home environments.

More First Nations children in small communities have parents with high school diplomas and higher, and had more space at home with fewer children in childcare situations. In large communities fewer children were in childcare or had parents with high school diplomas and higher while more children were in crowded homes. Mid-size communities resembled small communities in having less crowding in children's homes.

HOUSING AND LIVING CONDITIONS

Drinking Water Supply

Nearly one-third (32.2%) of First Nations consider our household water unsafe to drink. A 2004 study found that about the same proportion (almost a third) of drinking water treatment systems in our communities are at high risk of contamination.⁴³ As shown in Table 1 the majority (63.2%) have piped water as their main supply. About one in six get their water by truck or from a well. Other main sources of water include, collecting it themselves from rivers, lakes or ponds, from the water plant, and from a neighbour's house.

Aside from 'other' sources, the source that appears to inspire the least confidence is trucked water; more than four in ten (41%) of those receiving water by truck consider it unsafe. Well water and water collected personally from the plant are also relatively distrusted, with one in three considering those sources unsafe.

Seven in ten First Nations adults (70.8%) resorted to alternative sources for drinking water to supplement their main water sup-

Main water source and lack of confidence in the safety of the source

	Piped (local supply)	Trucked	Well (individual or shared)	Personally collected from river, lake, or pond	Personally collected from water plant	From neighbour's house	Other source	All sources
Main water supply	63.2%	15.9%	16.5%	0.9%	1.8%	0.7%	1.1%	100%
Consider that supply unsafe	28.6%	41.0%	36.6%	19.7%	34.4%	22.8%	63.4%	32.2%



ply. Among those who had indicated their water was unsafe, more than nine in ten (92.9%) did so. The most common alternate source of drinking water was bottled water, mentioned by 61.7% of all respondents. In comparison, 35% of Canadians reported drinking bottled water at least once a week.*

Household Mould

Toxic moulds, a contaminant of indoor air, are common in Canadian homes and a special concern of First Nations. These moulds live in, or on, the structure of the building itself. Rhinitis, asthma, alveolitis and other allergies are associated with them. Moulds thrive in houses that are in poor condition and have a moisture problem.

Almost half of First Nations adults with asthma have visible mould in their homes.

Almost one half (48.5%) of First Nations in band housing reported mould or mildew in their home (and two thirds of our people live in band houses). A lesser percentage (36.9%) of respondents in other types of accommodation reported mould or mildew.

Allergies and asthma are among the most common ailments among First Nations adults. Almost half (43.5%) of adults with asthma and 52.2% of those with chronic bronchitis are living with mould in their

homes. This further exacerbates the respiratory problems for these individuals.

HEALTH CARE ACCESS

Overall, 40.8% of First Nations adults rate their access to health care as being the same as that of other Canadians. An additional 23.6 % rate their access as being better, whereas 35.6% rated their access as being less than that of other Canadians. Here we look at indicators of access to preventive primary health care measures, including access to health care, barriers to accessing health care, and access to NIHB.

A number of factors affect how our First Nations adults rate their access to health care. Those who are in good to excellent health are most likely to state that their access to health care is better or the same as other Canadians. The rating of access to health care was not related to gender or age. First Nations adults in remote or isolat-

Approximately half of First Nations adults have participated in health screening tests.

ed communities were much more likely to report less access to health care than those from semi- or non-isolated communities. Interestingly, communities that are part of a multi-community transfer agreement are

* <http://pubs.nrc-cnrc.gc.ca/cwrj/cwrj30/cwrj300111.pdf>

more likely to say that they have less access to healthcare when compared to communities with only community transfer agreements.

Screening and Prevention

Of the major screening tests available, our First Nations men are consistently less likely to have undergone testing in the past 12 months, when compared to First Nations women. The only exception was for rectal examination, which is used to detect rectal cancer in both men and women, but is also used to detect prostate cancer in men over the age of 50 years of age.

The data shows that, in general, the rate of physical examinations increases in older age groups starting off at 34.3% for those 18–29 years of age to 61.2 for those 60 years old and over. A similar trend is seen among all major screening tests.

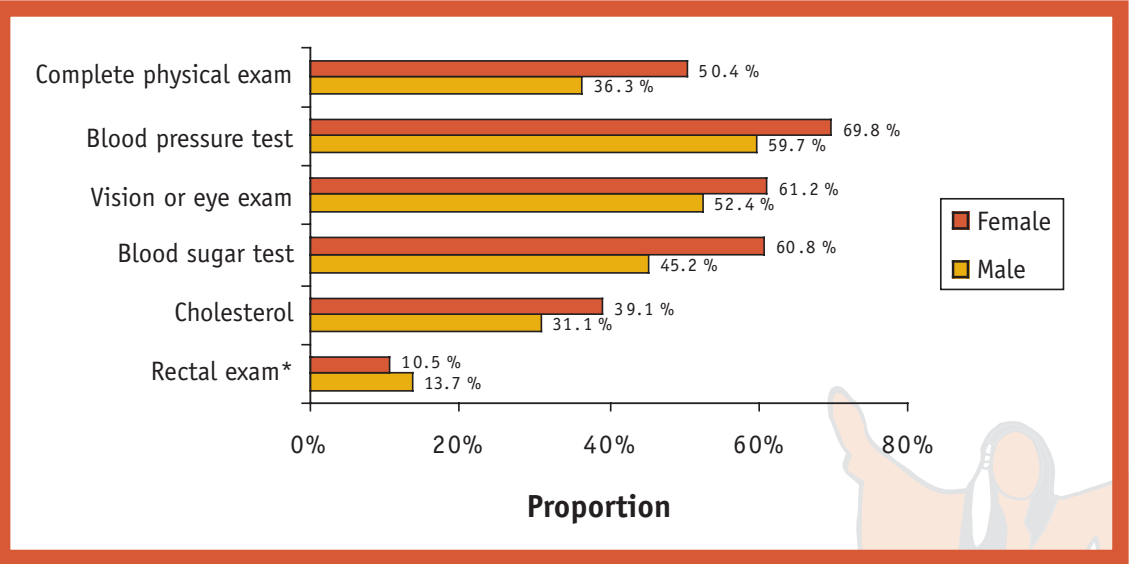
A blood sugar test is a key test in screening for diabetes mellitus. A majority of First

Nations adults over the age of 40 have undergone a blood sugar test in the past 12 months. Screening for diabetes needs to be expanded knowing the severity of this epidemic among our people.

Regular vision or eye exams not only ensure optimal vision, but can also help detect the development of conditions such as high blood pressure or diabetes in their early stages. More than 50% of First Nations adults over the age of 40 reported have undergone a vision or eye exam in the past 12 months.

There are a high number of First Nations women who have performed breast self-examinations (BSE). Repeated studies have shown that this method is not effective in reducing mortality from breast cancer, unless women are trained to detect abnormalities. Education in this area is required. The high mortality rate First Nations women experience as a result of cervical cancer, makes more systematic screening advisable.

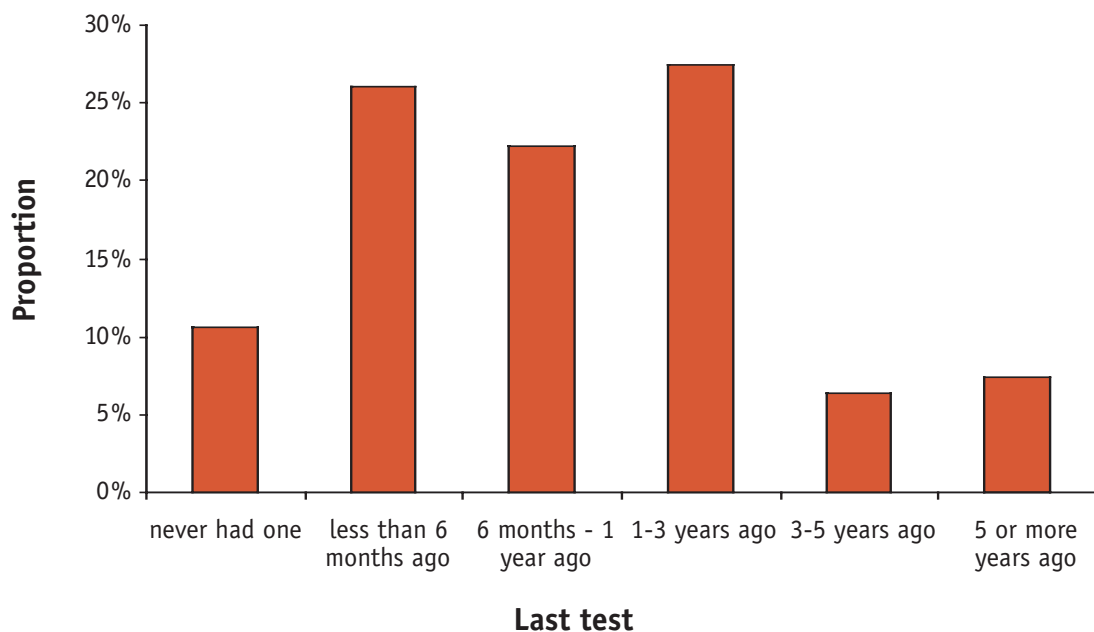
Proportion of respondents having received selected health screening tests by gender



*The number of respondents varied slightly in relation to each category.



Last instance of obtaining a pap smear test



This relatively simple test can detect lesions on the cervix before they become cancerous, or in the very early stage of cancer. Early detection is a key issue for women.

Barriers to Accessing Care

First Nations adult women reported having experienced barriers to care more often than men for the following reasons:

- unavailability of doctor or nurse or service;
- lengthy waiting lists;
- transportation issues (access and cost);

- difficulty accessing traditional care;
- difficulty attaining approval from NIHB;
- finding affordable childcare; and
- encountering culturally inappropriate service.

The level of frustration with waiting lists is common among our people. Barriers associated with geography (lack of local services), economics (lack of transportation and the cost of services) however affects our people more so. Interestingly, men are less likely to seek out care, and may imply that as a

result they are not aware of the barriers to care.

Access to Non-Insured Health Benefits

Access to Non-Insured Health Benefits (NIHB) can be difficult. First Nations women report significantly more difficulties in accessing NIHB for medication, vision care, hearing aids, other medical supplies, and escort travel than men.

Access to NIHB was not affected by factors such as income, education or community size. Community remoteness factors had varying influence on difficulties in accessing NIHB. For example, adults from remote isolated communities were much more likely to report difficulties in accessing NIHB for transportation services or costs than those in isolated or non-isolated communities.

First Nations women report significantly more difficulties in accessing NIHB than men.

SUMMARY OF RHS DATA:

As we look around and see our physical health and the relationships we have established, we also observe the conditions under which we exist. If we look to the “human-made” environment in which we live, which greatly influences our opportunities to experience an adequate and healthy lifestyle, we see the following:

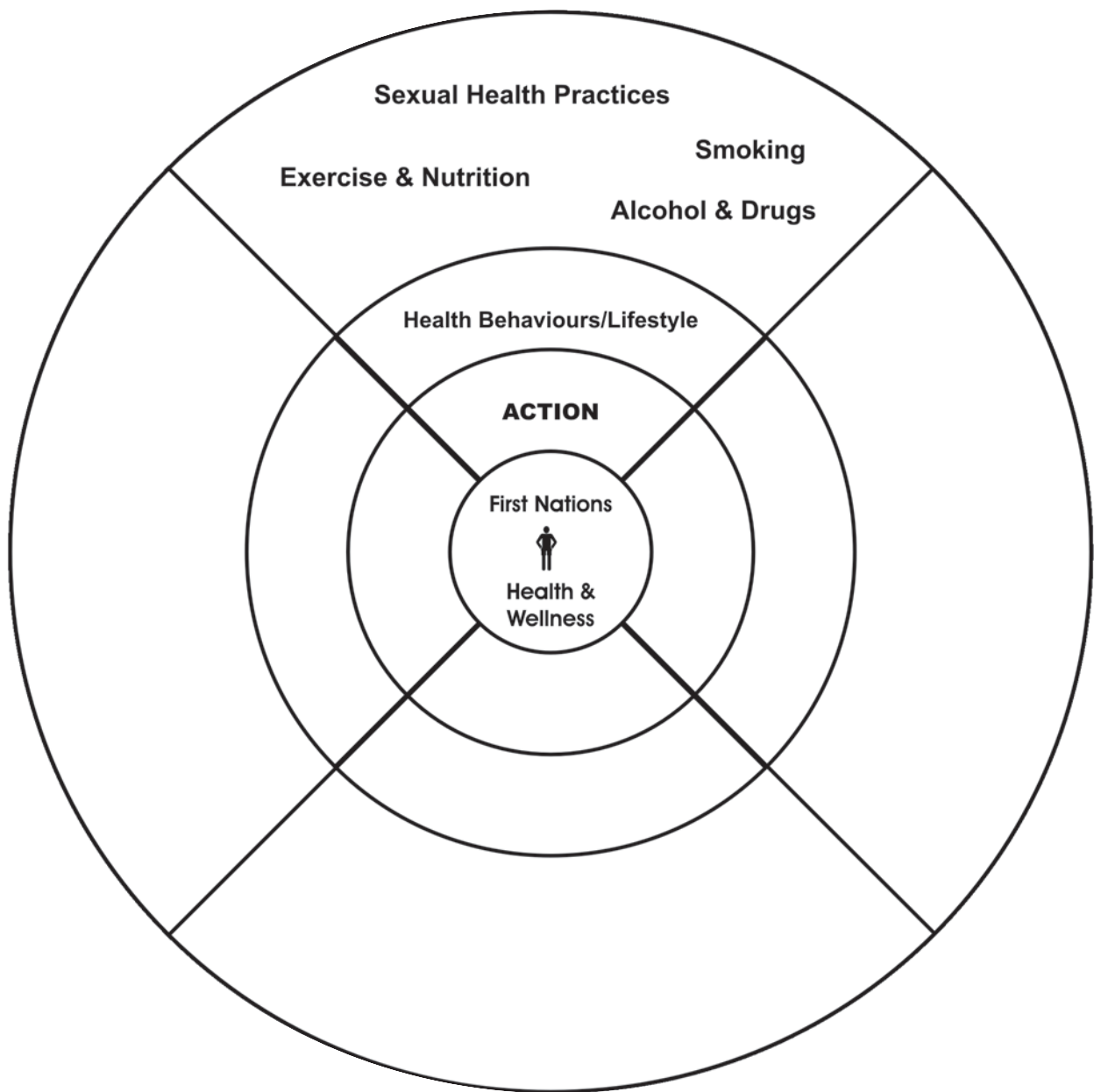
- A majority of First Nations people feel in balance physically, emotionally, mentally and spiritually.
- One in ten First Nations adults report having suicidal thoughts and 50% of

those people report suicide attempts over their lifetime.

- First Nations youth do not access traditional supports or mental health services, despite reporting that they are not feeling emotionally or mentally balanced.
- First Nations adults who feel healthy are less likely to experience suicidal thoughts as those with fair or poor health.
- First Nations people felt strongly that their community was not progressing in relation to reducing alcohol and drug abuse.
- A majority of First Nations residential school attendees witnessed the abuse of others or experienced it themselves.
- First Nations adults believe that their parents’ attendance at residential school negatively affected the parenting they received.
- Although many First Nations youth do not speak their language, it is still very important to them that they are able to speak their language.
- Almost 60% of First Nations children have one or more grandparents who attended residential schools.
- Only 13.9% of First Nations youth use a First Nations language on a daily basis.
- Cree, Ojibway and Oji-Cree were the most frequently spoken language by First Nations youth on a daily basis.
- Most First Nations parents and grandparents believe that it is important for their children to learn traditional cultural events and a First Nations language.
- First Nations parents who have more formal education are more likely to be involved with the traditional cultural socialization of their child.



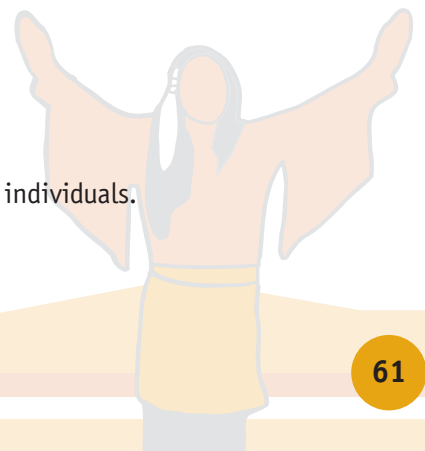
CHAPTER 6: ACTION



We all act or behave in a certain way.

As individuals we all adopt a particular lifestyle.

All of us adopt habits and develop routines that serve to define us as individuals.





In this section of the report we look at those actions or behaviours that have a significant potential to impact on our health. Some would refer to these behaviours as “bad habits” and others as “good habits”, depending on how they are exercised. We refer to them as lifestyle issues, that is, our habits and patterns involving smoking, drugs, sexual health practices, drinking and exercise.

NON-TRADITIONAL TOBACCO USE

Non-traditional use, recreational use, tobacco abuse and the misuse of tobacco are all part of the attempt to describe smoking in the First Nations context.

Over half of First Nations adults are tobacco smokers. The majority of smokers are daily consumers and the remainder are occasional consumers. The rates of tobacco smoking among our youth vary considerably. Just over one-third of our youth are non-traditional tobacco smokers. The number of youth smoking increases with age, and the rates among female teenagers is much higher than for boys.

Just over half of First Nations pregnant women at the time of the survey were smokers.

Pregnancy

Just over half of First Nations pregnant women at the time of the RHS were smokers. More pregnant women fell into the former smoker category than those who were not pregnant. A large proportion of women who were pregnant at the time of the RHS were former smokers.

Non-smoking First Nations Youth

First Nations former smokers who quit did so to lead a healthier lifestyle and out of respect for a loved one. Non-smoking youth are more likely to live in a smoke-free home, live in a household with his or her parents and in a non-isolated community. These youth enjoy school very much and a high

The majority of First Nations former smokers began smoking cigarettes between 13 and 16 years old.

number rank their health as excellent or very good. Specifically, these youth place importance on eating well, having reduced stress, good social supports, good sleep, being happy, having regular exercise and being in balance physically, emotionally, mentally, and spiritually.

Former Smokers

Half of those First Nations adults surveyed do not smoke. About half of the adult non-smokers are former smokers and the other half has never smoked cigarettes. Most for-

mer smokers were daily consumers and few were occasional smokers. Men and women evenly represent non-smokers.

Starting to Smoke

Females started smoking later in life (after 20 years of age) more often than men. More former smoking men reported initiating before the age of 13 years than did former female smokers. Current smokers tend to have started before the age of 16.

In comparing the age of initiation of current smokers to former smokers, current smokers initiate slightly earlier than those who have quit smoking. Interestingly, more former smokers started at sixteen years of age, however more current smokers reported beginning to smoke before the age of sixteen. This finding suggests that the earlier

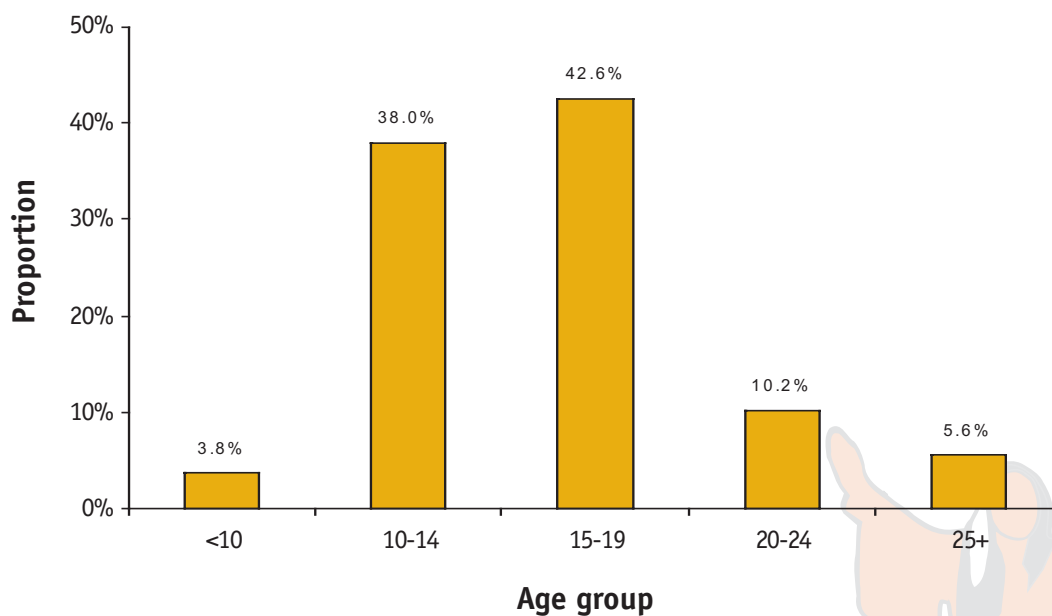
age that you start to smoke, the less likely you are to quit.

Current Smokers

Nearly six in ten First Nations adults (58.8%) are current smokers. The average daily number of cigarettes consumed by current smokers is 10. This rate of consumption is lower than the Canadian average of about 15 cigarettes a day. First Nations young men between 18 and 29 years old consume about two and a half more cigarettes a day than young women of the same age. Men consume about one cigarette a day more than women. Cigarette consumption for men and women evens out among those 30 and over.

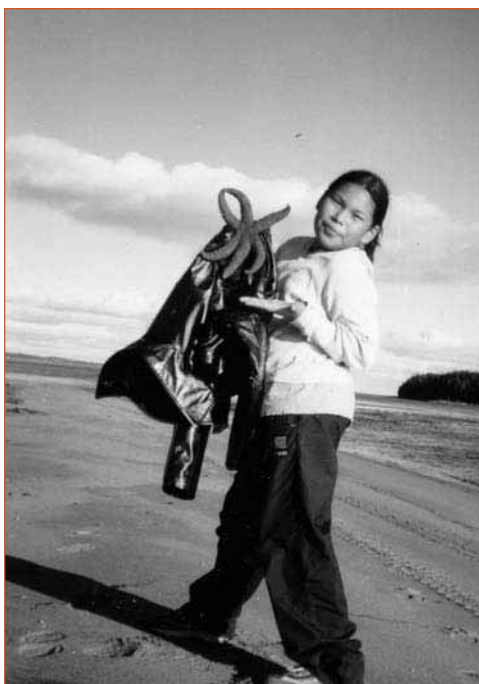
More than half of First Nations current smokers have made at least one attempt at quitting smoking in the past year. The majority of those who have made attempts

Reported age of starting to smoke by former smokers





have only done so once or twice. Just under half of the smoking population has yet to make their first quitting attempt.



For First Nations youth, the average age of starting was 12 years old and the average age for quitting among former smokers was 14 years old. These youth quit smoking for a variety of reasons with the most often cited reason being that they want a healthier lifestyle. Others quit out of respect for loved ones or they gain greater awareness or education on the ill effects of tobacco on health. Other reasons include health condition; respect for the cultural and traditional significance of tobacco; pregnancy; peer

Most First Nations adults quit smoking out of a desire for a healthier life.

pressure from friends or co-workers; and doctor's orders. First Nations youth reported smoking an average of six cigarettes a day. Among current smokers, over 70% had tried to quit smoking at least once in the past year; nearly half of these youth tried over three times.

Quitting Smoking

On average all First Nations former smokers quit smoking by 32 years old. The desire for a healthier lifestyle was overwhelmingly the main reason given by former smokers. Other important reasons for quitting smoking included having greater awareness, having a health condition, closely followed by respect for loved ones. For women, a large proportion (22.2%) reported pregnancy as one of the reasons for quitting smoking, and a few men also reported pregnancy as a reason (mostly likely that of their partner).

'Cold turkey' was by far the most common method used to quit smoking by smokers. Other popularly reported methods to quit smoking included: help from spirituality, and assistance from family, followed by the "patch".

General Health and Smoking

First Nations smokers did not see their health as being fair or poor compared to

non-smokers. Smokers and former smokers who responded that their health was either excellent or very good were further asked to disclose those things that made them so healthy. Both reported that a healthy being was achieved through healthy eating and feeling in physical, emotional, mental, and spiritual balance.

First Nations youth, who smoke tobacco, drink alcohol and use cannabis more than two times a week, are not as healthy compared to non-smokers/users/drinkers. The largest difference in responses was seen when comparing the tobacco smokers to the non-smokers. Non-tobacco smokers consistently ranked each category higher compared to the smokers. The most often cited

First Nations youth who smoke, drink or use marijuana are not as healthy as abstainers.

reason for having good health was regular exercise or participation in sports, good sleep, being happy and eating well. Heavy consumers of tobacco and cannabis tended to be less satisfied with their weight than their abstaining counterparts.

First Nations alcohol users were more than twice as likely to be smokers compared to non-users: 81.2% versus 37.4%. Similarly, alcohol users were significantly more likely to be marijuana users as well: 62.6% versus 11.9%.

Second hand smoke is a health issue for our people. Nearly half of First Nations youth (44.2%) are exposed to cigarette smoke in their homes.

Housing

About half of all our homes are smoke free, and current smokers have a slightly higher number of children living in one household. According to the First Nations adult survey, more current smokers are living in an overcrowded housing situation. The majority have a working smoke detector in their home. One in five First Nations adults said they did not have a working smoke detector in their home.

Adults who do not smoke report the highest level of balance in their lives.

Personal Wellness

Smoking or non-smoking did not seem to make any difference to the importance people place on cultural events. Current smokers responded more favourably to traditional spirituality than did the non-smoking population. Non-smokers were more likely to have a higher level of balance in their lives.

First Nations youth tobacco smokers spend more time working at a job compared to the non-smokers. With regards to time spent traditional singing, drumming or dancing groups or lessons, all youth (despite usages) responded similarly.

First Nations youth spend the same amount of time using a computer whether they were smokers/users/drinkers or not. Most youth feel 'in balance', regardless of their usage across each response (physical balance, emotional balance, mental balance and spiritual balance) the tobacco smokers replied differently compared to the non-smokers; non-smokers consistently felt in balance



more than smokers. In general, non-smoking youth felt more often in balance (physical, emotional, mental, and spiritual) than their smoking counterparts. Overall, however, most youth felt in balance most of the time. Non-smokers were also more like than smokers to feel that they were in control of their lives, reported that they liked themselves and also reported a high level of self-worth.

Health Conditions

Generally, smoking has impacts for health and chronic illness/disease such as chronic bronchitis; emphysema; psychological or nervous disorder; cognitive or mental disability; cancer; liver disease (excluding Hepatitis); and tuberculosis.

Nutrition

People who quit smoking often become overweight. The impact of smoking on diet is great where non-smokers tend to eat nutritious, balanced diet on a regular basis.

Alcohol and Non-prescription Drugs

First Nations adult non-smokers are less likely to drink alcoholic beverages 2 to 3 times a month. It seems that if people don't smoke they are less likely to have problems with alcohol consumption. Non-



smokers are more likely to abstain from any alcohol consumption. Non-smokers are also more likely to report any incidence of binge drinking in the past year. Smokers are more likely to need treatment for alcohol and drug abuse. Smokers are also more likely to use drugs more often than non-smokers.

Employment and Income

An equal proportion of adult smokers and non-smokers are working part-time. Smokers had a slightly higher rate of unemployment than non-smokers. Household income and low income are not suitable indicators in the probability of smokers.

Education

When our First Nations youth report they like school they are more likely to report never smoking cannabis or tobacco, and not drinking over the past 12 months.

ALCOHOL AND DRUG USE

Although issues around alcohol and drug use continue to be identified as a concern by many of our communities, there remains a lack of comprehensive information on the abuse and impact of these substances.⁴⁴ To better understand the nature and context of these results, a discussion of relevant literature is provided.

The impact of alcohol and drugs on First Nations communities is great—alcohol-related deaths were six times higher and drug induced deaths were more than three times that of the general population rate.⁴⁵

Alcohol Use

Previous studies actually indicate that our people overall have a higher abstinence rate than that of the general population⁴⁶ and the current RHS results are consistent with this occurrence. Over the past twelve months, two-thirds of First Nations adults reported the use of alcohol, which is lower than the general Canadian population.⁴⁷ There is a notable decrease in drinking with age. In fact, only one third of 60+ reported the use of alcohol compared to 82.9% of those 18 to 29 years old. Males were more likely to report alcohol use than females and

More First Nations adults abstain from drinking alcohol than the general Canadian population.

the highest rates were found among younger males aged 18–29.

Past year drinkers were more likely to report having one or more medical conditions than

non-drinkers, but were also more likely to state they had a higher status of health. Drinkers were also more likely to have sought non-traditional care, with over half noting that they had consulted a traditional healer. Rates of alcohol use were also available for a number of community indicators.

Most First Nations adults who do drink alcohol are moderate drinkers.

Rates did not vary significantly by community size; however, a higher proportion of users were found in remote communities compared to semi and non-isolated communities.

Frequency of Drinking among Alcohol Users

The frequency of alcohol use was mostly moderate and did vary somewhat by a number of demographic characteristics. This data is also consistent with abstinence rates, with a lower frequency of use being reported by First Nations than the general population. Only 17.8% of First Nations adults stated that they used alcohol on a weekly/daily basis compared to 44% in the general population.⁴⁸ Males were about twice as likely as females to be weekly drinkers. First Nations younger males (aged 18–39) showed the highest reported rates, while the older men's usage had the lowest rate.

About 40% of our First Nations youth report drinking beer, wine, liquor or any other alcoholic beverage during the past 12 months. Females between 15 and 17 years of age reported the highest rate of usage (65.4%), followed by males in the same age



group (56.8%). Younger teens (12–14) were much less likely to have had any drink at all in the past year; 20.4% overall. Moreover, older teenage alcohol users were more likely to have binged on alcohol at least once in the past year (83.1% versus 56.5%) with one in five reporting that they engage in binge drinking 2 to 3 times a month.

Heavy Drinking

The impact of alcohol is connected with problem drinking, rather than overall usage. Previous work has found higher rates of alcohol dependence and substance abuse issues among heavy/binge drinkers.⁴⁹

Although lower abstinence and drinking frequency rates is a positive sign for communities, the proportion of heavy drinkers (five or more drinks on one occasion) remains higher than that found in the general population. More than double the proportion of adults reported heavy drinking on a weekly basis than in the general population.⁵⁰

The proportion of heavy drinkers in the First Nations adults is higher than the general Canadian population.

Males appear to be at highest risk of reporting heavy drinking on a weekly basis, compared to only a small proportion of females.

Drug Use

Currently we find that about one quarter of First Nations had used marijuana over the

Non drug-users reported higher levels of social supports available to them.

past year. By far, the highest frequency user was males aged 18 to 29. Of which a significant proportion (29.1%) reported the use of marijuana on a daily basis. The use of prescription drugs, including codeine, morphine and opiates was the next most frequent response. Very few people reported the use of sedatives.

There is relatively low frequency of use among illicit substances. The use of any of five illicit (illegal) substances⁵¹ was found to be low (7.3%) over the past year. However, this is more than double that of similar statistics found among the general population, in which past year use was reported to be only 3% (excluding inhalants).⁵² The reported use of these substances declined with education.

With respect to illicit drug use, the vast majority of First Nations youth are non-users. Fewer than 4% of our youth reported ever using PCP, acid/LSD/amphetamines, ecstasy, inhalants, sedatives or downers, cocaine/crack/freebase and codeine/morphine/opiates. However, marijuana use was quite prevalent: 32.7% overall. It should be taken into consideration that First Nations may be reluctant to report use of illicit drugs. Older youth were more likely to be

marijuana users as well as being more frequent users.

Consistently higher proportions of non-users reported higher levels of various levels of social support. The impact of the use of illicit substances is of concern to communities. Illicit drug use is connected with alcohol dependence, as well as co-morbid dependence of other substances, with cocaine and marijuana acting as a 'base drug'.⁵³

Treatment and Community Response

The impact of substance abuse can also be seen through the proportion of adults who sought treatment for their addiction. Treatment was most often sought for alcohol abuse. A small proportion reported that they had sought treatment for drug abuse. These rates may not reflect the extent of those requiring treatment or may reflect a lack of treatment resources. Other characteristics were identified among treatment seekers. For example, those seeking treatment for alcohol abuse were more likely to report one or more medical conditions than those not seeking treatment. Those seeking treatment for alcohol abuse were more likely to indicate that there was progress in community in the reduction of alcohol and drug abuse.

NUTRITION AND PHYSICAL ACTIVITY

Regular physical activity is recognized for its role in preventing several chronic and physical conditions, including heart disease, hypertension, obesity, Type 2 diabetes, osteoporosis, certain cancers such as colon cancer, and functional limitation with aging.⁵⁴ Exercise and being active also plays an important role in mental health as well,



such as reducing anxiety, depression and tension, and having positive effects on the emotional state of both young and old people.⁵⁵

Unfortunately, lack of physical activity has caused escalating rates of overweight and obesity in Canada.⁵⁶ It may be due to eating foods that may have replaced more nutritional choices that were historically more common.⁵⁷ In some communities in Canada, traditional First Nations activities (hunting, trapping, fishing) were apparent through to the 1960s. Then, a combination of decreased reliance on traditional food and

Diet, physical activity and avoidance of tobacco use are three prevention factors that are important to reduce chronic disease.



increased reliance on governmental subsidies resulted in decreases in traditional physical activities and store bought foods becoming the norm in food supply.⁵⁸ Also there has been a major shift to sedentary lifestyles. Nutrition data is limited for our adults; existing data indicates that being overweight has increased through carbohydrate intake, particularly soft drink consumption.⁵⁹ People are saying that when they change back to a traditional diet it helps normalize the energy balance and reduce the frequency of being overweight.

Certain chronic diseases are caused in part by being overweight and obese. Chronic diseases are the major cause of death, representing 59% of deaths worldwide.⁶⁰ Three preventive factors—diet, physical activity and avoidance of tobacco use—are important to reduce chronic disease.⁶¹ A person can control them in order to reduce the chance of developing chronic disease. Our First Nations youth have high rates of obesity and chronic conditions such as Type 2 diabetes.

Physical Activity

Walking is cited as the most frequently reported physical activity in which adults participated over the year. Other frequently cited activities include fishing, swimming, berry picking or other food gathering, bicycling, and hunting or trapping. Roughly one in four adults reported running or jogging, using weights or exercise equipment, forms of dancing, competitive, group or team sports and hiking.

Walking is the most frequently reported physical activity for First Nations adults, youth and children.

Gender differences appear for certain physical activities. Women are more likely than men to report participating in walking, berry picking or other food gathering activities, aerobics or fitness classes, and dancing. Men, however, are more likely than women to cite participation in most other activities, including: fishing and hunting; bicycling; weight training; running; competitive or team sports. Participation in other physical activities is generally lower in older age groups.

The measure for sufficient activity was defined as reporting at least 30 minutes of moderate/vigorous activity (defined in the survey as physical activity "...that results in an increase in your heart rate and breathing") for four or more days of the week. Using this measure, a small proportion (21.3%) of adults perform sufficient physical activity to meet these guidelines. Men are more likely than women to report sufficient activity to meet these guidelines. These gender differences are most apparent among younger adults and those 60+.

Walking is the most frequently reported physical activity in which our First Nations youth participate. Gender differences are



apparent for certain physical activities. Our female youth are more likely than males to participate in walking, dancing, and berry picking or other types of food gathering. Males are more likely to participate in running, bicycling, skating, rollerblading, skateboarding, snowshoeing, golf, weight training or exercise equipment, hiking or traditional activities.

Over half of our First Nations youth spend three or more hours watching television daily. Another 41.2% spend one to two hours in front of the TV. In addition, one in five of youth play video games or use computers for more than three hours a day. Video game usage is more prevalent among our teenage boys.

Nine in ten First Nations youth reported spending more than an hour in outdoor activities daily while one in five spent more than three hours daily doing chores. Males spend a greater amount of time outdoors while females are more likely to spend a greater time assisting in household chores.

Inactivity is a problem for our First Nations youth as 29.4% say they don't participate in

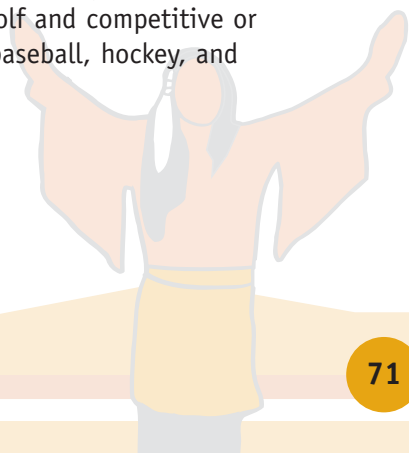
sport teams or lessons after school. Males are more likely to be involved in these in an after school activity and participate in them more frequently. This seems to get worse with age as older youth are more likely to state that they never partake in sport teams or lessons outside of school.

On a positive note, over 80% of our First Nations youth participate in physical activity at least twice a week. Once again,

teenage males are shown to be more active than their female counterparts. There are no differences in frequency of participation concerning age.

Further to this, 45.1% of our First Nations youth exercise heavily for 30 minutes most days of the week. Males are more likely than females to exercise to meet these guidelines. However, for the most part youth were sufficiently active overall and this does not vary by the age of the youth.

Walking is the most frequently reported physical activity among First Nations children. Other popular activities include running, swimming, bicycling, and competitive sports. Gender differences are apparent for certain physical activities. For example, girls are more likely than boys to participate in dancing, and aerobics or fitness classes. Boys, however, are more likely than girls to participate in fishing, hunting, rollerblading, skateboarding, golf and competitive or team sports such as baseball, hockey, and lacrosse.





Nutrition

One-third of First Nations adults report that they usually eat a nutritious and balanced diet, whereas just over half only do sometimes. The remainder either rarely or never

The proportion of First Nations adults who are usually eating a nutritious and balanced diet increases with age, education and personal income.

eats a balanced and nutritious diet. The proportion of adults who are usually eating a nutritious and balanced diet increases with age, education and personal income.

In terms of the consumption of traditional food items, over half of First Nations adults often consume protein-based foods, such as game and fish, whereas a smaller proportion state that they often consume berries and other types of vegetation. Two out of five adults often eat other First Nation foods such as fry bread, bannock or corn soup. There are, however, no gender, age, income, or education related differences in the consumption of traditional or First Nation foods. Adults in small communities (<300 residents) are more likely than residents in larger communities (>1,500 residents) to consume: protein-based traditional foods, and berries and other vegetation.

About 1 in 5 First Nations youth always eat well while another 1 in 5 rarely or never eat a nutritious diet. Boys were more likely to consume fast foods and soft drink. Males are also more likely to consume traditional protein based foods such as wild game or fish.

Our First Nations youth who are active report that they eat a nutritious or balanced diet, and are more likely to state that they often consuming berries and wild vegetation more often, and other such cultural food such as fried bread, bannock, and corn soup. Youth who are satisfied with their weight have a tendency to be more active.

First Nations youth who are satisfied with their weight have a tendency to be more active.

About 71.5% of active youth who have a good diet do not smoke. Active youth who eat well are almost twice as likely to report that they feel that they are in balance physically, mentally, and spiritually all of the time. They are also more likely to have never thought about suicide.

Over half of our First Nations children usually eat a balanced, nutritious diet and this is higher among children who are active daily compared to those occasionally active. Just

A large proportion of First Nations adults are considered overweight and obese.

over one-third of children are obese. Children who are active daily or who usually eat a balanced diet are more likely to cite excellent health.

Body Mass Index

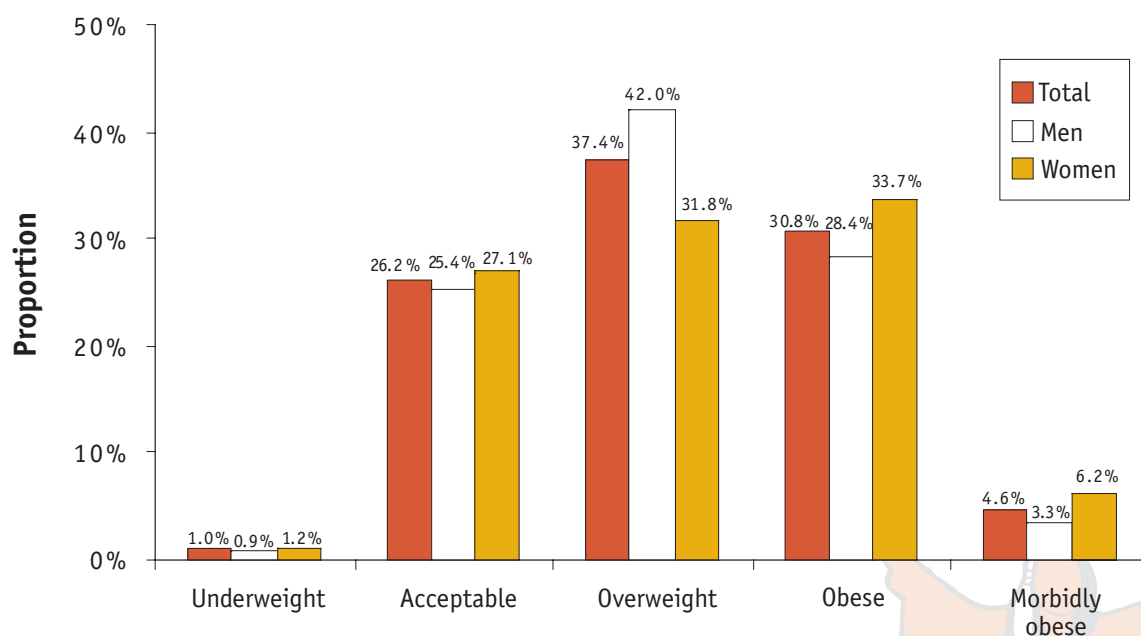
A large proportion of First Nations adults are considered overweight and obese. A smaller proportion is considered morbidly obese (BMI above 40), which increases the risk for developing health problems.

Overall, men are more likely than women to be overweight whereas women are more likely than men to be obese and morbidly obese.

Generally speaking, younger adults (18 to 29 years) are less likely than adults older than 30 to be obese or morbidly obese.

Just over half of First Nations youth are considered to be acceptable or underweight. However, 28.1% of our youth are considered overweight. Unfortunately, 14.1% are deemed obese. Female youth are more likely than males to be categorized with normal or underweight. There are no age-related differences for classification of body mass, however, younger youth (age 12–14) are

Distribution of body mass index by gender (adults)



For more information on BMI, go to <http://www.hc-sc.gc.ca/fn-an/nutrition/weights-poids/guide-ld-adult/gr.pub>



One-third of our First Nations youth and children are overweight.

more likely than older youth (age 15–17) to be very satisfied with their weight.

Just over one-third of our First Nations children are considered to be obese and a further 22.3% are considered overweight. Only 41.5% have a normal weight or are underweight. There were no differences between boys and girls.

Physical Activity, Nutrition and Body Weight

First Nations adults who are underweight are the least likely to report consuming a nutritious, balanced diet on a regular basis. There are no differences in body weight for those who consume traditional First Nations foods as compared to those who do not.

Adults who usually eat a balanced diet are more likely than those who do not to be in very good or excellent health. Almost two out of five adults who usually eat a nutritious diet also smoke on a daily basis. However, there are more adults smoking among those who less frequently eat a nutritious diet. Adults who mostly eat a nutritious diet are less likely to have cardiovascular health conditions than those who rarely do. Moreover, individuals who usually eat a nutritious diet are more likely to report being in physical, emotional, mental and spiritual balance.

Those who are underweight or acceptable weight are more likely to be also non-smokers. No differences appear between adults of different body weight with respect to social support, that is having someone to talk to or confide in, someone to count on when they need help, someone to take them to the doctor, and so on. Similarly, no relationships exist in perceptions of community

First Nations youth and children make up one-third of our population, therefore the high rates of overweight and obese children signals serious future chronic health problems.

progress to control over health services in the community, the availability of recreation or leisure facilities or traditional ceremony activity.

Our First Nations youth eat too much junk food and watch too much television. A healthy living strategy can provide protection from obesity and helps our youth get more exercise. Our programs need to involve school, community, and family to develop healthy eating and activity for our youth. This study found that when dealing with family problems, differences exist for those who consume healthy diets and those who do not. Those who do, tend to find support in parents whereas those who do not find support in friends. This suggests that influencing peer behaviours and using peer role models may be an important means of influ-

encing certain segments of youth. A cultural framework is essential in promotional strategies and understanding barriers relevant to our people.

First Nations children who usually eat a balanced diet are more likely to cite excellent health.

Given that children make up one-third of the First Nations population,⁶² the high rates of overweight and obesity is of great concern as this translates into increased risk of health problems among First Nation children. Immediate consequences of childhood obesity may include diabetes, asthma, gallstone development, hepatitis, obstructive sleep apnea, orthopedic problems (bowing of the legs as an example), menstrual abnormalities and neurological conditions.⁶³ In addition, social and emotional problems may result from overweight and obesity, where obese children have lower body image, lower academic achievement, and self-esteem.



An Early Start to Good Health

Infant health measures are very much considered to be a core reflection of the health of a community. Measures such as infant mortality and low birth weight have been firmly linked to health conditions related to

Over 60% of our First Nations infants were breastfed.

adequate food supply, adequate housing, employment, education level, and environmental exposures. Infants are vulnerable to bad social, economic, and environmental conditions.

Here we will focus on infant health, birth weight, and two important health behaviours, smoking during pregnancy and breastfeeding. In addition, factors of health from pregnancy, birth, to the childhood years of life are examined.

Birth Weight

Of the First Nations children surveyed, 5.5% were low birth weight babies (<2.5 kg) while 21.0% were high birth weight babies (>4.0 kg). One in five males had a high birth weight compared to one in six females. No associations were observed between low birth weight and maternal age, maternal education, residential schooling status, or community healthcare transfer status.

Breastfeeding

The RHS found that over 60% of our First Nations children are or have been breastfed. Over 40% of these children were breastfed for more than six months. Breast feeding was more prevalent for better educated mothers, higher family incomes, and children residing in remote communities.

Smoking During Pregnancy

Overall, 36.6% of our First Nations children were exposed to some maternal cigarette use. The rates for daily smoking of cigarettes is 19.4% for 1 to 9 cigarettes per



day; 14.3% for 10 to 19 cigarettes per day; and 2.1% for 20 or more cigarettes per day. The rate of babies exposed to smoking during the third trimester was 32.2%. The rate of household second-hand smoke was 48.2%.

There were no connections between maternal smoking and residential schooling status, household crowding, community isolation status or health care transfer status.

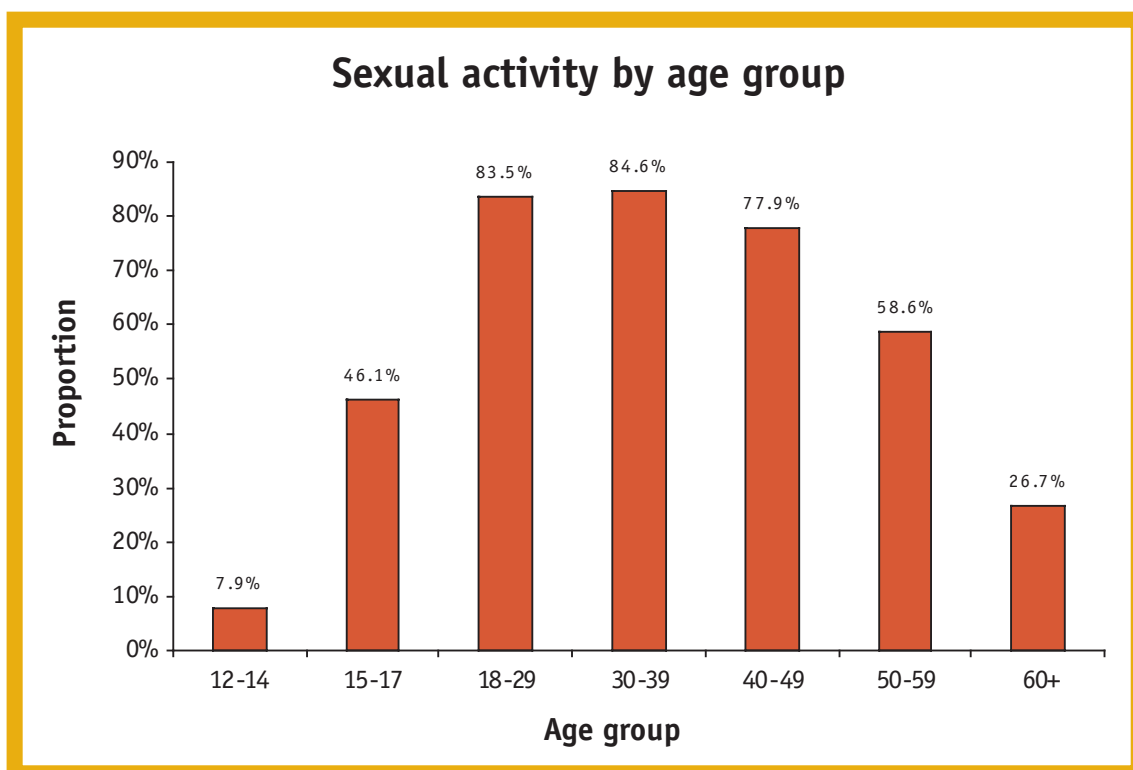
SEXUAL HEALTH PRACTICES

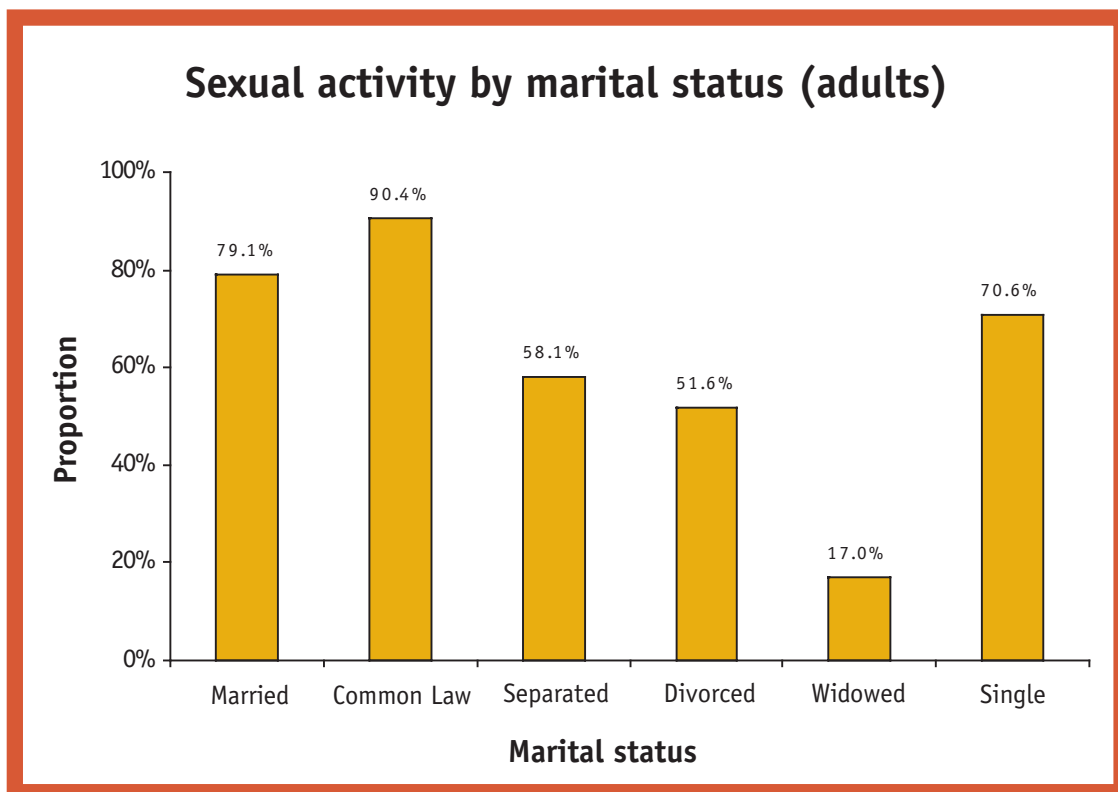
The sexual activity (number of sexual partners, condom use, and HIV testing by age,

gender, and/or marital status) is presented in this chart.

First Nations people are sexually active throughout their lifespan, although sexual activity declines with age. This suggests that attaining optimal sexual health practices within communities requires education for people of all ages and backgrounds.

Approximately one in ten of our First Nations youth are sexually active. Almost one-third (30.9%) of our youth indicated having sexual intercourse in the last 12 months. There are fewer youth in the 12–14 age group who are sexually active; whereas nearly half of the youth 15–17 years are sexually active. Our youth's sexually activity





increases with age; and the majority of individuals are sexually active at 17 years old. There were no gender differences in terms of being sexually active.

First Nations adult males reported being more sexually active than females. The majority of males were sexually active while fewer females reported being sexually active. Adults were asked questions about their marital status and sexual activity. Sexual activity decreases by marital status in the following order: common law, married, single, separated, divorced, and widowed.

Multiple sexual partners over the previous year was a finding across age groups—with the largest number of sexual partners found in the 18–19 years of age group.

According to marital status, single people were most likely to have more than one or two sexual partners.

Patterns of Birth Control Protection

Condom use has been strongly advocated as a means of STIs/HIV prevention, and yet, across all age groups they stated that they do not always use condoms citing the main reason as having a steady partner. This was also cited as the main reason among all marital groups, including those who were married, divorced, common law, widowed, separated, or single. Many First Nations adults between the ages of 18 and 29 stated that they did not always use condoms because they were under the influence of alcohol; however, as age increased, people were less likely to cite alcohol use as the reason for not using condoms.



Birth control protection falls under the two main categories: attempting to avoid pregnancy, and protection to avoid sexually transmitted infections (STIs). Fully 81.0% of First Nations youth report using condoms and 19.2% report using birth control pills, while 10.9% report using no form of birth control protection. The majority of First Nations youth use birth control protection methods to avoid both pregnancy and protection from STIs. The use of birth control methods increases slightly with age. The use of birth control pills as a contraceptive is mainly among those 15–17 years of age. Two-thirds of our First Nations youth report always using a condom to protect them from STIs. Males are more likely to use condoms than females.

If a condom was not used, the three main reasons cited by First Nations youth for not using a condom include: under the influence of alcohol, with a steady partner, and, not having a condom at the time.

According to the First Nations adult survey, despite the reasons cited for not using condoms, younger adults were the most likely to receive HIV testing, while HIV testing begins to decline with age. Females were more likely to get tested for HIV than males.

Patterns of Pregnancy or Fathering a Child

Less than 5% of our First Nations youth report ever having been pregnant or being responsible for getting someone pregnant. Females were more likely to report to have

The most common age of first pregnancy or fathering a child was 16 years.

been pregnant than males reporting to have fathered a child. The number of youth, who report being pregnant or having gotten someone pregnant, increases with age, with the majority being between the ages of 15–17 years. Early teen pregnancy is often “accompanied by early school drop out rates, high rates of unemployment, low levels of education, and increased reliance on social assistance”.⁶⁴ The Aboriginal Roundtable on Sexual and Reproductive Health (1999) acknowledges the early onset of parenthood as common in traditional First Nations societies and cites a “breakdown in traditional support structures and values” as responsible for the poor health and social problems that teenage parents and their families often experience.⁶⁵

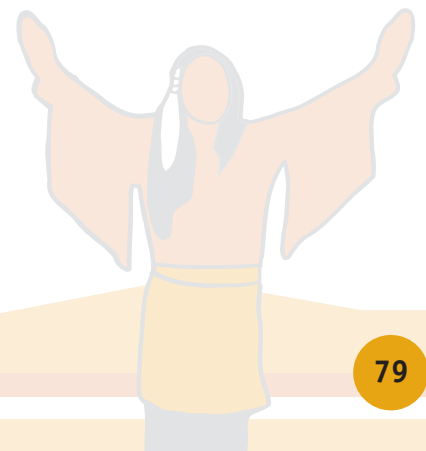
Factors Affecting Sexual Activity and Sexual Health

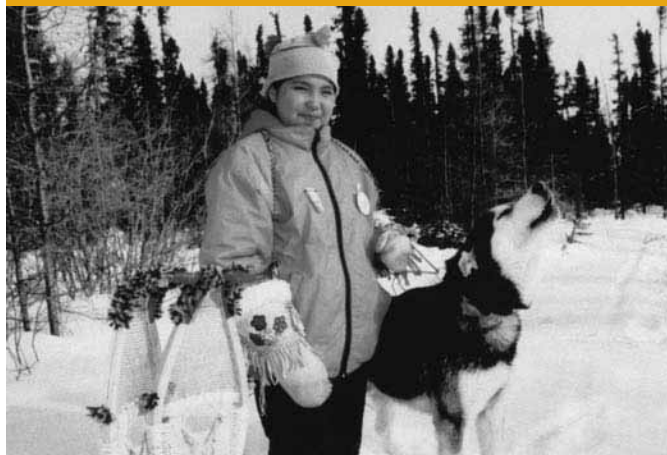
Gender is considered to be significant in relation to the sexual health and sexual activity of First Nations youth. Females tend to report lower rates of condom use than our males; females are at an increased risk for the complications associated with unprotected sexual activity. Alcohol and drugs are also believed to have significant effects on the sexual activities and sexual health of youth.

SUMMARY OF THE RHS DATA:

As we observe our physical health, the relationships that we have established and the conditions under which we live, we also look to habits and routines that we have adopted. Collectively our lifestyle choices define our behaviour, who we are and the choices we make on a daily basis to live our lives. In this chapter we have seen that:

- Just over half of First Nations pregnant women at the time of the RHS were smokers.
- Most First Nations adults quit smoking out of a desire for a healthier life.
- First Nations youth who smoke, drink or use marijuana are not as healthy as abstainers.
- First Nations adults who do not smoke report the highest level of balance in their lives.
- More First Nations adults abstain from drinking alcohol than the general Canadian population.
- Most First Nations adults who do drink alcohol are moderate drinkers.
- The proportion of heavy drinkers in the First Nations adults is higher than the general Canadian population.
- First Nations non drug-users reported higher levels of social supports available to them.
- Diet, physical activity and avoidance of tobacco use are three prevention factors that are important to reduce chronic disease.
- Walking is the most frequently reported physical activity for First Nations adults, youth and children.
- The proportion of First Nations adults who are usually eating a nutritious and balanced diet increases with age, education and personal income.
- First Nations youth who are satisfied with their weight have a tendency to be more active.
- A large proportion of First Nations adults are considered overweight and obese.
- First Nations youth and children make up one third of our population, therefore the high rates of overweight and obese children signals serious future chronic health problems.
- Over 60% of our First Nations infants were breastfed.
- Across all First Nations age groups people thought they were safe and did not need to use a condom if they had a steady partner.
- The most common age of first pregnancy or fathering a child was 16 years.
- Among First Nations youth, 81% reported using condoms.





CHAPTER 7: RETURNING TO VISION—LOOKING TO THE PAST

According to the RHS model of health developed for this report, we now return to the eastern direction and Vision. Having completed a full circle of summarizing some of the information collected by the Survey, the next step is to look both into the future, and the past, to determine the next steps of the process.

Before we look into the future, in the next chapter, we first need to look to the past to see where we came from in order to see where we are going.

BACKGROUND

The First Nations Regional Longitudinal Health Survey (RHS) was the first national health survey in Canada to be carried out and controlled by First Nations themselves. This initiative was conceived in 1994 when several large longitudinal surveys were introduced for the Canadian population as a whole: the National Population Health Survey; the National Longitudinal Survey of Children and Youth (NLSCY); and the Survey of Labour and Income Dynamics. Collectively, these three surveys were designed to provide a wealth of information on health, child development, and labour market dynamics. However, none of them included First Nations Peoples living on-reserve and the number of off-reserve First Nation Peoples included was generally too small to permit reliable conclusions. The effect was to widen the gap between the amount of information available for the Canadian population in general and the amount available for First Nation groups.

1997 RHS (First Nations and Inuit Regional Longitudinal Health Survey)

The first round of the RHS took place in nine regions of Canada in 1997 and included both First Nations and Inuit. The approach of the first round of the RHS was not one national survey, but rather as a collection of regional surveys designed to provide a certain amount of national-level information. The final sample included 14,008 people (9,870 adults and 4,138 children). Numerous reports of findings were released as a result of this first round of data collection.

2002/03 RHS (First Nations Regional Longitudinal Health Survey)

The design phase of the second survey began in 2000 and was a First Nations specific survey. The instruments and methods were fine-tuned through an inclusive process that lasted over two years. Building upon the learning experiences of the 1997 RHS, the RHS 2002/03 was more harmonized than the first round with standardized sampling methods and a larger set of “core” questions. Regional processes provided the opportunity to include additional questions to capture community priorities. In addition to adult and children’s surveys used in the first round, it was decided that a separate and distinct youth survey was needed to reflect the unique issues facing First Nations youth. The data collection took place between August 2002 and November 2003 with adults, youth and children in First Nations communities throughout Canada. Over 22,000 surveys were collected.



Survey Themes

The three national survey instruments address a comprehensive range of health status, well-ness and health determinants measures. For purposes of comparability across age groups, the same questions were used in all three surveys where possible. The following tables provide an overview of the topics addressed:

Adult (18+ years) Survey Themes

Demographics	28 Health conditions—duration, treatment, effects	Smoking, alcohol, drugs—use, cessation, treatment
Languages—comprehension, use	Diabetes—type, treatment, effects	HIV/AIDS, STDs and sexuality
Education	Physical injuries	Pregnancy, fertility
Employment	Dental care	Preventative health practices
Income and sources	Disabilities, limitations	Wellness, supports & mental health
Household—composition, income	Physical activity	Suicidal ideation and attempts
Housing—condition, crowding, mold	Food and Nutrition	Residential schools—impacts
Water quality	Home care—use, need	Community wellness
Services (phone, water, smoke detector, internet etc.)	Health services—use, access, NIHB	Culture, spirituality, religion
Height, weight	Traditional medicines, healers	Community development

Youth (12–17 years) Survey Themes

Household/family composition	Diabetes—type, treatment	Preventative health practices
Education—level, performance, personal goals	19 Health conditions—duration, treatment, effects	Personal wellness, supports & mental health
Language—comprehension, use	Injuries	Suicidal ideation, attempts
Food and nutrition	Dental care	After school activities
Activities—physical, social	Smoking, alcohol, drugs	Traditional culture—importance, learning
Height, weight, satisfaction with	Sexuality	Residential school (parents, grandparents)

Children's (0–11 years) Survey Themes

Household/family composition	Language—comprehension, use, interest	Health service access—NIHB
Parental education	Food and nutrition	Dental, BBTD
Education—level, performance, Head Start	Activities—physical, social, after school	Traditional culture—importance, learning
Height, weight—at birth, current	19 Health conditions—duration, treatment, effects	Emotional & social well-being
Breastfeeding history	Injuries	Childcare—babysitting
Smoking, second hand smoke exposure—pre & post natal	Disabilities, limitations	Residential school (parents, grandparents)

Approach to Data Collection

In most cases, surveys were completed using laptop computers in the respondent's home. A customized Computer Assisted Personal Interviewing (CAPI) package was developed for laptop computers and fieldworkers were hired by each region to administer the surveys. The adults were interviewed directly. First Nations children were surveyed by proxy, with a person who knew them well, most often the mother or occasionally the father. First Nations youth normally completed the RHS themselves.

The decision to have the youth questions self-administered was intended to reduce the non-response rate and increase honest disclosure, especially on sensitive or private topics, such as sexuality and drug use. The fieldworker remained in the room positioned where she/he could not see the screen, and offered help as needed.

Following 15 months of collection and after processing, a total of 22,602 surveys in 238 communities are available for analysis. The RHS 2002/03 Process and Methods Report provides details on the sampling design. It is available at http://www.naho.ca/firstnations/english/regional_health.php

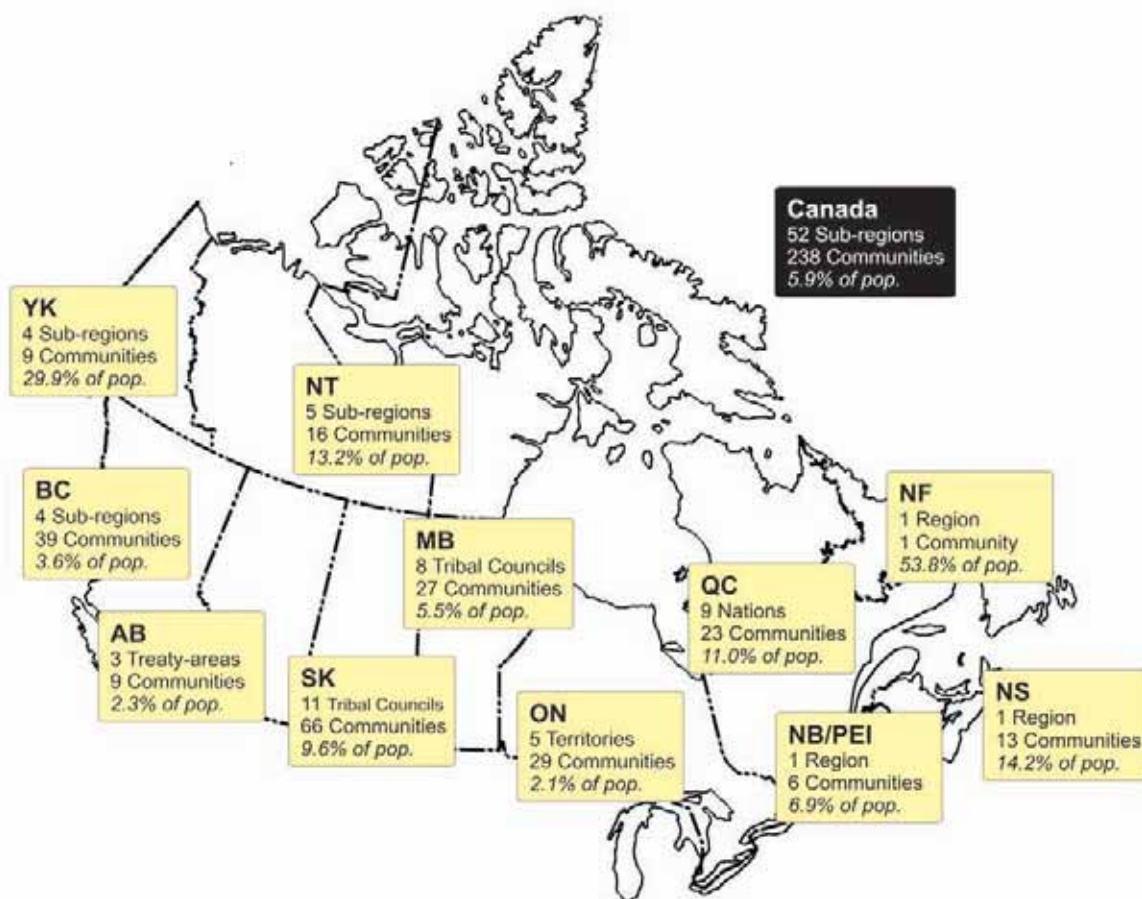
Coverage

With the exception of the James Bay Cree of Northern Quebec and the Innu of Labrador, all First Nations sub-regions were represented. Overall, the national sample represents 5.9% of First Nations living in First Nations communities (mostly reserves) in Canada. As shown in Figure 3, coverage rates ranged from 2.1 % in Ontario to 53.8% in Newfoundland.





OVERVIEW OF FINAL SAMPLE, BY REGION



Governance of RHS

The First Nations Information Governance Committee (FNIGC)—a standing committee of the national Chiefs Committee on Health has the mandate to oversee the First Nations Regional Longitudinal Health Survey (RHS). FNIGC provides guidance and direction to the overall RHS process. The FNIGC is composed of the survey partners.

The 2002-03 survey partners are:

National

Assembly of First Nations

First Nations Centre of the National Aboriginal Health Organization

Regional

Union of Nova Scotia Indians

Union of New Brunswick Indians

First Nation of Quebec and Labrador Health and Social Services Commission

Chiefs of Ontario

Assembly of Manitoba Chiefs

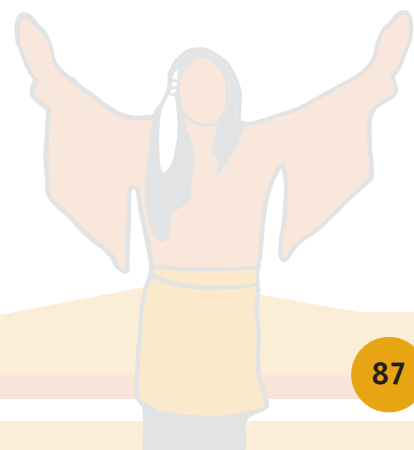
Federation of Saskatchewan Indian Nations

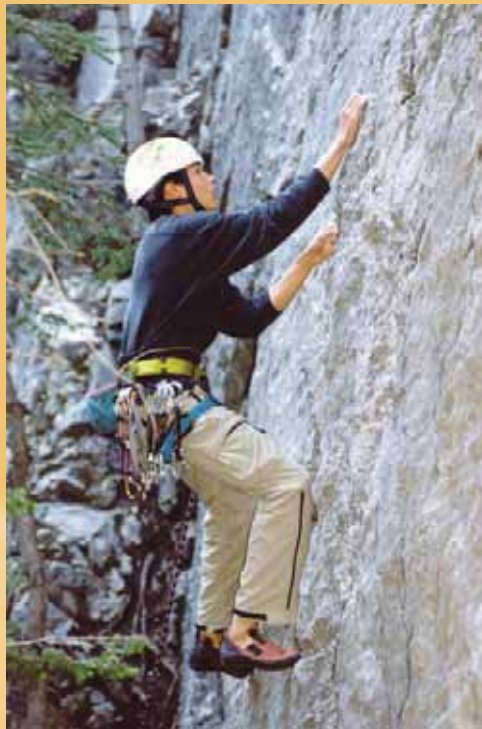
First Nations Adult and Higher Education Consortium

First Nations Chiefs' Health Committee (B.C.)

Dene National Office

Council of Yukon First Nations





CHAPTER 8: RETURNING TO VISION—LOOKING TO THE FUTURE

As we return to the east and vision, having examined past activities, we now look toward the future to determine the next steps in the RHS process.

As a research process, the RHS is designed as a longitudinal research project. This means that the same or similar survey will be repeated a number of times. The purpose of this type of research is to measure changes that occur over time. This is accomplished by establishing a baseline of information in the first survey. Any future changes that occur will be documented in subsequent surveys, then the extent of

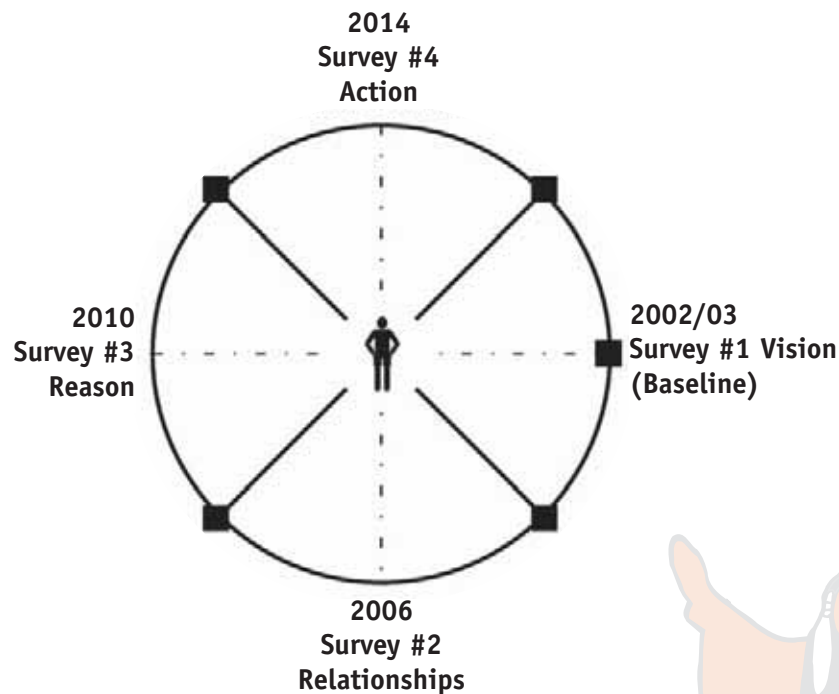
change measured by comparing them against the baseline of information established in the first survey.

In the case of the RHS, the survey will be conducted four times over 12 years, as follows:

Survey 1	2002/03	VISION (Baseline)
Survey 2	2006	RELATIONSHIPS
Survey 3	2010	REASON
Survey 4	2014	BEHAVIOURS/ACTION

This is also illustrated in the following diagram.

Holistic nature of RHS longitudinal study





The results of the first survey, conducted in 2002–03, are summarized in this report and available in more detail in the Technical Report. These results form the baseline of information against which to measure the extent of change that occurs in the health status of First Nations Peoples over the next 12-year period.

The next step in this research process is to revisit our vision, in light of the materials gathered and lessons learned, listen to the community and begin the process of improving the process for the next data gathering cycle, scheduled to begin in 2006.

With each data gathering cycle we repeat the process of summarizing the information using the interpretive framework developed in this report. As a reflection of the principles contained within the interpretive framework, our energies were focused in the eastern direction...on developing our vision.

We began to produce a culturally based approach to understanding the health of First Nations Peoples. In the next cycle of data collection we hope to focus on the southern direction, and spend more time in understanding the relationships that emerge between and within the different sets of data collected. By the third cycle we hope to have developed a better sense of the reasons and rationale that underlie the various relationships that emerge from the data. Lastly, by the fourth cycle, our intent is twofold: First, in the northern direction we hope to be able to more accurately assess reasons and rationale for various health actions; second, since it is the last cycle, the intent is to have a more holistic understanding of the changes that have occurred over time, and how these changes interact with and affect the overall balance of the health and wellness of First Nations Peoples.

Appendix A

Participating Communities

The following First Nations communities participated in the First Nations Regional Longitudinal Health Survey (RHS) 2002/03:

Alberta

Alexander First Nation
Driftpile First Nation
Kainai
Kapawe'no First Nation
Nakoda Bearspaw
Piikani First Nation
Siksika Nation
Sucker Creek First Nation
Swan River First Nation

British Columbia

Adams Lake Indian Band
Cambell River (We Wai Kum First Nation)
Canim Lake Indian Band
Columbia Lake Indian Band
Cowichan Tribes
Ehattesaht First Nation
Fort Nelson First Nation
Gitlakdamix Village Government (New Aiyansh)
Glen Vowell Indian Band
Gwa'sala-Nakwaxda'xw Nation
Heiltsuk Nation
Katzie First Nation
Kwadacha Band
Laxgalts'ap Village Government
Leq'a'mel First Nation
Malahat First Nation
Metlakatla Band
Mount Currie Band Council
Musqueam Indian Band
Nadleh Whuten Band (Nadleh Whuden)
Nanoose First Nation
Nee-Tahi-Buhn Band
N'Quat'qua Band
Okanagan Indian Band
Osoyoos Indian Band
Scowlitz First Nation
Seabird Island Band
Sechelt Indian Band
Skway First Nation
Sliammon
Soowahlie First Nation
Stone Indian Band (Yunesit'in)
Takla Lake First Nation
Tl'azt'en Nation (Tslasden)

Tsartlip First Nation
Tseshaht First Nation
Tzeachten First Nation
Westbank First Nation
Williams Lake Indian Band (Sugar Cane)

Manitoba*

Barren Lands
Bloodvein
Borkenhead Ojibway First Nations
Canupawakpa Dakota First Nation
Ebb and Flow
Fairford
Fisher River
Fort Alexander
Garden Hill First Nation
Grand Rapids First Nation
Hollow Water
Kinojeoshtegon First Nation
Little Black River
Long Plain
Mathias Colomb
Norway House First Nation
Opaskwayak Cree Nation
Pine Creek
Rolling River
Roseau River
Sayisi Dene First Nation
Sioux Valley Dakota Nation
Split Lake Cree, First Nation
St. Theresa Point
Waywayseecappo
Wuskwi Sipihk First Nation
York Factory First Nation

New Brunswick*

Big Cove
Eel Ground
Kingsclear
Madawaska Maliseet First Nation
Saint Mary's
Woodstock

Northwest Territories*

Dechi Laot'I First Nations
Deh Gah Gotie Dene Council
Deninu K'ue First Nation
Dog Rib Rae

Fort Good Hope
Gwich'ia Gwich'in
Hay River Dene
Jean Marie River First Nation
Liidii Kue First Nation
Lutsel K'e Dene
Pehdzeh Ki First Nation
Tetlit Gwich'in
Tulita Dene
Wha Ti First Nation
Yellowknives Fene First Nation

Nova Scotia/Newfoundland

Acadia
Afton (Paq'tnkek)
Annalopsis Valley
Bear River
Chapel Island First Nation (Potlotek)
Eskasoni
Horton
Membertou
Miawpukek
Millbrook
Pictou Landing
Shubenacadie
Wagmatcook
Waycocomagh (We'koqma'q)

Ontario

Aundeck Omni Kaning First Nation
Bkejwanong Territory (Walpole Island)
Chippewas of Kettle and Stony Point
Chippewas of Mnjikaning First Nation
Chippewas of the Thames First Nations
Couchiching First Nation
Delaware First Nation (Moravian of the Thames)
Eabametoong First Nation
Eagle Lake
Ginoogaming First Nation
Grassy Narrows First Nations
Kee-Way-Win
Lac Seul
Mohawks of the Bay of Quinte
Naotkamegwaning Anishinabe First Nation



Ojibways of Batchewana
Ojibways of Pic River First Nation
Oneida Nation of the Thames
Sachigo Lake
Sagamok Anishnawbek
Sandy Lake
Saugeen
Temagami First Nation
Upper Mohawk: Six Nations (plus
other 12 bands)
Wabigoon First Nation
Wahta Mohawks
Wasauksing First Nation
Whitefish Lake First Nation
Whitefish River

Québec

Betsiamites
Eagle Village - Kipawa
Essipit
Gesgapegiag
Kanesatake
Kawawachikamach
Kitigan Zibi
Lac Simon
Listuguj
Malécites de Viger
Manawan
Mashteuiatsh
Natashquan
Odanak
Opticiwan
Pakua Shipi
Pikogan
Timiskaming
Uashat Mak Mani-Utenam
Unamen Shipu
Wemotaci
Wendake
Wôlinak

Saskatchewan

Ahtahkakoop First Nation
Beardy's and Okemasis First Nation
Big River First Nation
Birch Narrows First Nation
Black Lake First Nation
Buffalo River Dene Nation
Canoe Lake First Nation
Carry The Kettle First Nation
Clearwater River Dene First Nation
Cote First Nation 366
Cowessess First Nation
Cumberland House Cree Nation
Day Star First Nation
English River First Nation
Fishing Lake First Nation
Flying Dust First Nation
Fond du Lac First Nation
Gordon First Nation
Hatchet Lake First Nation
Island Lake First Nation
James Smith First Nation
Kahkewistahaw First Nation
Kawacatoose First Nation
Keeseekoose First Nation
Key First Nation
La La Ronge First Nation
Little Black Bear First Nation
Little Pine First Nation
Makwa Sahgaiehc First Nation
Mistiwas First Nation
Montreal Lake First Nation
Moosomin First Nation
Mosquito-Grizzly Bear's Head First
Nation
Muscowpetung First Nation
Muskeg Lake First Nation
Muskoday First Nation
Muskowekwan First Nation
Nekaneet First Nation
Ocean Man First Nation

Ochapowace First Nation
Okanese First Nation
One Arrow First Nation
Onion Lake First Nation
Pasqua First Nation #79
Peepeekisis First Nation
Pelican Lake First Nation
Peter Ballantyne Cree Nation
Pheasant Rump Nakota First Nation
Piapot First Nation
Poundmaker First Nation
Red Earth First Nation
Red Pheasant First Nation
Sakimay First Nation
Saulteaux First Nation
Shoal Lake of The Cree Nation
Star Blanket First Nation
Sturgeon Lake First Nation
Sweetgrass First Nation
Thunderchild First Nation
Wahpeton Dakota Nation
Waterhen Lake First Nation
Whitebear First Nation
Whitecap Dakota/Sioux First Nation
Witchehan Lake First Nation
Wood Mountain First Nation
Yellow Quill First Nation

Yukon

Kluane First Nation
Kwanlin Dun First Nation
Little Salmon Carmacks First Nation
Ross River Dena Council
Selkirk First Nation
Teslin Tlingit Council
Tr'ondëk Hwëch'in
Vuntut Gwitchin First

**Community names are those used in the 2002 Indian Register maintained by Indian and Northern Affairs Canada and may not be the communities' preferred names/spellings.*

ENDNOTES

- ¹ The term "People" or "Peoples", as used in this report, is an acknowledgement of how we refer to ourselves in our own languages. In so many of our First Nations languages, the term or terms used to describe ourselves often refers to the fact that we are the "People" or "Original Peoples" or the "Peoples" of a particular geographic region.
- ² For example, there is a deliberate attempt to avoid technical or scientific language that would only serve to obscure the message being transmitted to a wider audience. For those readers with a desire for more technical language or application, they can access this form of information from the Summaries, Technical Reports or from the Database.
- ³ For a list of report contributors see the Technical Report (First Nations Regional Longitudinal Health Survey (RHS) 2002/03: Results for Adults, Youth and Children in First Nations Communities).
- ⁴ We are speaking here of the natural world at every level, not just the most visible to humans. For example, although a crystal may have straight edges, at the molecular level the constituent or elemental components of the crystal are round or move in circles.
- ⁵ There is an incredible breadth of spectrum and depth of complexity to the many First Nations teachings that can be used and applied to illustrate these concepts. In this representation, which is based on the authors experience, the model has been limited to 7 levels and is designed specifically for a health context. There are an infinite number of model variations possible, depending on the indigenous knowledge of individual First Nations Peoples. As such, this model is not meant to be in any way "universal" to all First Nations, that is, it is not meant to represent all First Nations knowledge or teachings. The model has been designed only to illustrate the most general of commonalities of First Nations approaches to health. Accordingly the model is designed to act only as a tool to assist in illustrating the underlying concepts. It is the intent that this generalized model will be used by First Nations and others and in that use, be modified to meet the particular needs, circumstances and knowledge requirements of each First Nation..
- ⁶ In many ways the RHS model is breaking new ground. With such limited space in the report to develop and explain the model, it is necessary to emphasize a few important points regarding the model.
The RHS model has been developed from First Nations teachings. On this topic there are three important points to make. The first regards ownership. The model belongs to all First Nations because it is based on First Nations teachings. It is intended that the model be used, and in that use, be modified to meet the needs of individual First Nations and their citizens. The second point regards the way in which the teachings are represented in this model. The designation after the model, "Dockstator Variation", refers to the fact that the author of this report has a responsibility to those teachings received and used in the derivation of this model. There is an element of interpretation and manipulation of oral and ceremonial based teachings, to design such a model and present it in a written/report format. As there are many ways to interpret and present these teachings, in addition to the fact that the model is meant to change, the designation of "Variation" allows for the model to be traced back to its' foundational teachings through the author/designer of the model. As others use and change the model, they too should state their name to identify their variation/interpretation of the model teachings. The third point relates to accreditation. There is a long line of individuals - Elders, Traditional

People and others, who have shared with the author those teachings that form the foundation for this model. From a traditional perspective these teachers state that they do not "own" the knowledge, but rather are responsible for its' transmission. It is this group of people and teachers who should be accredited with the derivation of this model. However they do not wish to be classified as "owners" of knowledge or acknowledged as such in footnotes. As such the author assumes the responsibility of accrediting these individuals, if so required and upon request. Accordingly the "Dockstator Variation" also refers to the responsibility assumed by the author, to trace the teachings used in this model and the people/teachers who have contributed to these teachings. If contacted and requested to do so the author may, with the permission of those involved, trace both the teachings used and those involved in the transmission of those teachings.

- ⁷ Although specifically designed to meet the requirements of a First Nations approach to health, the model is general enough in design to be further modified to explain the First Nations approach to other topics.
- ⁸ The choice of words is difficult when the translating from the oral to written context, blending different First Nations traditions and using the English language to express First Nations concepts in a limited space. Consequently there are many other ways to correctly express the same concepts.
- ⁹ These indicia of health are referred to as "core" as they exist at the centre of each level of understanding...at the centre of each circle. There are other indicators of health that surround and interact with each of these core values.
- ¹⁰ The term Western in this particular and specific context is used to refer generally to the institutions and structures of Canadian society.
- ¹¹ For a complete list of these questions please go to http://www.naho.ca/firstnations/english/regional_health.php
- ¹² We are using the FNC/NAHO model to organize the information—there are many other FN approaches that can be used to illustrate the information differently.
- ¹³ There are 28 in the survey— for more complete please go to http://www.naho.ca/firstnations/english/regional_health.php
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Prepared on behalf of the
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