First Nations and Inuit Regional Health Surveys, 1997

A Synthesis of the National and Regional Reports

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by the First Nations Centre at the National Aboriginal Health Organization

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The 1997 First Nations and Inuit Regional Health Surveys (RHS) broke new ground in Aboriginal research – not only in Canada, but internationally as well – as the first national survey to be designed, directed and implemented by First Nations and Inuit groups themselves. The survey was also the first to be conducted in accordance with the principles of First Nations and Inuit ownership, control, access, and possession of data. It produced important innovations in data-sharing protocols, research ethics, methodology, and culturally-appropriate questionnaire content. Most significantly, it built research capacity within First Nations and Inuit groups at community, regional and national levels. It also provided key information for use in planning, advocacy, policy development, and assessing communities' progress in health.

The survey was directed by a National Steering Committee made up of representatives from First Nations and Inuit organizations in each region, plus ex-officio representatives from the Assembly of First Nations and Health Canada. The Steering Committee co-ordinated all aspects of the survey process from developing a Code of Research Ethics to designing and testing the national questions. A Co-Principal Investigator's Group of experts provided advice and technical support. The survey took place in 1997 in 186 First Nations and Inuit communities with a sample of 9,870 adults and 4,138 children.

One of the most fundamental challenges for the RHS process was to strike a balance between national and regional objectives. The solution was to approach the RHS not as one national survey, but rather as a collection of region-level surveys designed to provide a certain amount of national-level information. Steering Committee members agreed that about 20 minutes worth of national core questions would be asked in every region. The remainder of the questionnaire was to be devoted to questions on region-specific priorities. This approach resulted in a basic set of national-level data and a wide range of different topics covered in the regional surveys. Some highlights of the national and regional results are as follows:

Children's Health

- Most parents considered First Nations and Inuit communities good places to raise children, although many communities lack recreational facilities.

- Many mothers continue to smoke while pregnant, but some stop drinking alcohol. Birth weights are average or high, but rates of breast-feeding are lower than the Canadian average at 50 per cent compared to 75 per cent across the country.

- 84 per cent of parents describe their child's health as very good or excellent. The most common concerns are ear problems, allergies, asthma, bronchitis, and overweight.

- Three-quarters of children get along well with their families. Only 17 per cent are said to have more behavioural problems than other children of comparable age.

Health of Youth (12 to 17 years)

- Nationally, 80 per cent of youth are reported in be in very good or excellent health. Frequently cited concerns are allergies, ear problems and asthma.

Ontario and Nova Scotia focused on youth in more detail. Subject to the caveat of small sample sizes, the results suggest that:

- Lifestyle habits of youth are not optimal. Eating habits and weight may need improvement while almost half of youth smoke and have tried alcohol and drugs.

- 45 to 60 per cent of youth say they participate in traditional activities and can speak an Aboriginal language.

- The majority of youth feel loved, get along with their families and have a positive outlook on life. But 10 to 15 per cent report family problems, depression and anxiety.

- Based on results from one region, significant proportions of youth have experienced physical (25 per cent) or sexual (14 to 28 per cent) abuse.

Health of Adults

- Adults report improvements in community infrastructure (housing, water), education, First Nations/Inuit control of services, and reviving some traditional practices. They are less likely to report improvement in employment opportunities. The findings on income adequacy indicate 28 per cent of

respondents in Labrador and 46 per cent in Manitoba said their households run out of money for food at least occasionally.

- Adults' lifestyle habits are not health enhancing. Based on results in various regions, 25 to 50 per cent of adults appear to be obese while 19 to 27 per cent report problems with alcohol. Nationally, smoking rates in First Nations and Inuit adults are double the average at 62 per cent.

- Rates of chronic conditions – such as diabetes, hypertension, heart disease, cancer, and arthritis/rheumatism – are higher than average. Nationally, 46 per cent of First Nations and Inuit adults report having one or more of these conditions. Rates of all of these diseases were higher than those reported to a 1991 survey.

- Based on information in some of the regional surveys, three-quarters of adults are usually happy and enjoy good self-esteem. However, 13 to 18 per cent met the criteria for major depression during the previous year and 15 per cent had attempted suicide at some time in their lives. Many adults reported having been physically (59 per cent) or sexually (34 per cent) abused when they were children.

Health of Adults Older Than 45

- First Nations and Inuit adults older than 45 have more chronic conditions (such as diabetes or heart disease) than other Canadians.

- One in four older adults is limited in his/her activities around the home. One in eight is housebound.

- Smoking rates among adults older than 45 are double the Canadian average.

Health Services

- Regional results suggest widespread support for making traditional healing programs available.

- Half of all adults said they think the health services provided to First Nations Peoples and Inuit are not as good as those received by other Canadians. Large proportions see a need for improvement in pediatric programs, prevention programs, continuing care, and mental health services.

Purpose

The 1997 First Nations and Inuit Regional Health Surveys (RHS) broke new ground in Aboriginal research – not only in Canada, but internationally as well – as the first national survey to be designed, directed and implemented by First Nations and Inuit groups themselves. The survey was also the first to be conducted in accordance with the principles of First Nations and Inuit ownership, control, access, and possession of data. It produced important innovations in data sharing protocols, research ethics, methodology, and culturally-appropriate questionnaire content. Most significantly, it built research capacity within First Nations and Inuit groups at community, regional and national levels. It also provided key information for use in planning, advocacy, policy development, and assessing communities' progress in health. In following this approach, the RHS has helped rebuild First Nations and Inuit trust in survey research. A second wave of the survey is taking place in 2002-2003 to continue the momentum.[1]

The 1997 RHS was organized as a collection of surveys that focused on topics of interest to each specific region (province). It also included a common core of questions that were identical across the country. The result was detailed information in each region with national-level information on a subset of the questions. The RHS results were published in a national report that analyzed the common core questions and in region-level reports (in all regions except Alberta) that analyzed both the core results for that region and the region-specific content. In addition, a report focusing on the health of youth was prepared in 2002.

Although the national report was widely distributed, the regional reports had more limited circulation. Their results tend to be known only within the originating region. This is unfortunate because many of the regional topics are likely to be of interest to a wider audience and some of the material is ground-breaking. To remedy this situation, Gail McDonald – then Director of the First Nations Centre at the National Aboriginal Health Organization and for many years the moving force behind the RHS – concluded that it would be useful to synthesize the national and regional reports into a single source. The result is this document, which summarizes the national and regional material and the associated information on methodology.

[1] Information on the progress of the 2002-2003 survey can be found on the NAHO Web site at http://www.naho.ca/firstnations/english/regional_health.php.

This report is based solely on published documents. It does not introduce any new material or draw from any documents produced for sub-provincial areas such as Tribal Councils or individual communities. Nor does it necessarily follow the format of the original source materials. Instead, it attempts to group information on an incredibly diverse range of topics in some coherent fashion to give the reader a picture of all the issues the RHS touched.

Most chapters are a composite of national and regional material. Wherever possible, for all core questions, national-level material is presented since this is based on the largest sample. Readers are cautioned that information from regional reports is of course based on smaller samples than the national results, therefore, the rates and percentages will be less precise.

This report was written with health staff, policy analysts and decision-makers in mind. For readers with less technical background in health issues, or simply less time, a companion series of Fact Sheets is available on the First Nations Centre section of the NAHO Web site at www.naho.ca/firstnations/english/first_survey_facts_sheets.php.

About the First Nations and Inuit Regional Health Surveys

Origin of the RHS

The 1997 RHS was the first national health survey in Canada to be carried out and controlled by First Nations and Inuit groups themselves. The initial push for the survey came 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 reserves and the number of off-reserve Aboriginal 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 Aboriginal groups.

Officials in Health Canada and other ministries recognized the need to have comparable information for Aboriginal Peoples. In 1994, they hired John O'Neil of the Northern Health Studies Unit at the University of Manitoba to investigate the feasibility of developing a National Longitudinal Aboriginal Survey. O'Neil and his colleagues held a series of workshops across the country and consulted with about 150 Aboriginal technical staff working in the fields of health, child development, education, and economic development. The objective was to answer the question:

> What kind of national longitudinal study would be acceptable to First Nation, Inuit and Métis people at the community level, while at the same time meeting the information needs of First Nations, Inuit and Métis organisations at the community, regional and national levels, and other levels of government? (O'Neil, 1998a)

The workshops made it clear that many Aboriginal Peoples were deeply sceptical of a national survey initiated by government. Four primary themes emerged:

1. *Power and Knowledge* – The participants felt that many research projects served only to perpetuate existing power imbalances and provided little or no tangible benefit to the community being studied.

2. *Community Participation* – Workshop participants were deeply convinced that research should be relevant to the needs of local communities and questioned the appropriateness of a quantitative approach.

3. *Research Capacity* – Participants wanted to develop research capacity among Aboriginal Peoples.

4. *Self-Government and Control Over Research* – The participants wanted Aboriginal Peoples to control the decisions about the survey including funding allocations. There was little appetite for Aboriginal advisory committees within federal ministries. Further, they preferred that control be at the local or regional (provincial) level.

Over time, the survey evolved to focus on health issues for people living in First Nations communities and the Inuit communities of Labrador. It also became de facto cross-sectional, although the long-term objective of securing ongoing funding for a longitudinal process remained. A National Steering Committee was formed to manage the process. It consisted of representatives from a First Nations or Inuit political organization in each province. At first, the Steering Committee was co-ordinated by Health Canada. However, serious tension developed between the timeframes and structures of Health Canada and those of the regions involved. This eventually resulted in the Steering Committee taking control of the entire process with Health Canada assuming a "backseat" role of providing funding and advice on request.

A Balance Between National and Regional Objectives

One of the most fundamental challenges for the RHS process was to strike a balance between national and regional objectives, between questions that would provide comparability with existing surveys and questions adapted to the priorities and perspectives of local communities. A balance also had to be struck between control at the national level and the local control that communities considered so important. The solution was to approach the RHS not as one national survey, but rather as a collection of regional surveys designed to provide a certain amount of national-level information. Steering Committee members agreed that about 20 minutes worth of national core questions would be asked in every region. The remainder of the questionnaire was to be devoted to questions on region-specific priorities. Each region would prepare its own report based on its own content. The core questions would be compiled into a national dataset and a national report would be based on them. This approach allowed for a maximum of regional flexibility.

In practice, the decentralized approach adopted for this first survey had strengths and weaknesses. It ensured regional control of the process and increased the acceptability of

the survey in the eyes of a highly sceptical population. It allowed for regional priorities to be addressed and produced a feeling of ownership of the results and an interest in the findings. All of these things helped maximize use of the data – which was the fundamental objective of the survey. This being said, it is clear that this first Aboriginal-controlled survey involved a learning process that happened at unequal speed across the different regions. The result was variability in approach, sample representativeness and data quality from region to region that inevitably had some impact on the coherence of the national dataset. Nonetheless, most of the RHS results are reasonably consistent with those of previous studies.

Management of the National Process

The National Steering Committee co-ordinated all aspects of the survey process from developing a Code of Research Ethics to designing and testing the national core questions. A Co-Principal Investigator's Group of experts provided advice and technical support. The survey took place in 1997 in 186 First Nations and Inuit communities. The national core segment of the questionnaire covered seven areas: children's health; residential schools and elders' health; chronic diseases; non-traditional use of tobacco; activity limitations and disability; wellness; and health and dental services.

The Northern Health Research Unit at the University of Manitoba compiled the core results from each region into a single national database and edited and weighted the data file. Each member of the Co-Principal Investigator's Group picked one or more of the seven national themes and analyzed the results. Preliminary analyses were presented to the first National Aboriginal Information and Research Conference held in Ottawa March 28 to 31, 1998. The final reports on all seven themes were compiled into a single volume, the First Nations and Inuit Regional Health Survey: National Report, 1999.[2]

Management of the Regional Processes

Most regions adopted an approach similar to the national one for managing their surveys by forming regional Steering Committees. Arrangements for technical support varied from region to region. Some hired outside experts to help with part or all of the process. Others developed ongoing relationships with university research groups.

Regions varied immensely in how they approached the region-specific portion of the study. Each region adopted the approach best suited to its specific needs. Some developed general health questionnaires. While Nova Scotia and Ontario chose to focus on children, Alberta asked only the national core questions. British Columbia complemented its questionnaire with a large series of focus groups. Target populations and sampling methods also varied from region to region.[3]

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[2] As of December 2002, the complete report is posted on the Assembly of First Nations Web site, at www.afn.ca/assembly_of_first_nations.htm.

[3] A more complete description of the sampling methods and approach for each region is included in the Methods chapter.

In reaction to past research projects that failed to share their results with the research subjects, most regions viewed returning the results to the individual communities as a priority. In fact, Labrador's Steering Committee made an explicit commitment that its communities would be the first to hear the results. Distribution took a variety of forms in the different regions from newsletters and plain-language flyers, to interviews on community radio, to holding community meetings to discuss the results. The majority of regions also published a more formal, region-level report on their findings. These regional reports are summarized here along with the results of the national core analysis and the relevant technical material.

Methods

Participating Regions

The RHS included First Nations Peoples living on-reserve across all of southern Canada plus the Inuit population of Labrador. All provinces participated except Prince Edward Island and Newfoundland, which together have only three formally recognized reserves. The survey omitted the James Bay Cree communities and the Mohawk and Inuit communities of Quebec, all of which had recently participated in other health surveys. It also excluded the Yukon and Northwest Territories. Face-to-face interviews were used in all regions with the interviewers being trained Aboriginal Peoples, usually from the community itself. With the exception of Alberta, each regional survey covered both adults and children, although the age ranges varied slightly from region to region. Interviews with children were done by proxy, meaning that the most knowledgeable adult – usually the mother – answered on the child's behalf. Ontario region included an additional focus on youth age 12 to17 who answered the survey for themselves.

Topics Included in the Survey

Because the largest part of the survey was region-specific content, the RHS touched on a vast array of topics in different areas of the country. In some cases, regional surveys added depth to the national core questions. More frequently, they examined additional topics that could not be included in the national core. A summary list of the topics covered in the national and regional surveys is included in Appendix 1.

For children, the national core questions asked about birth weight, breast-feeding, health problems, knowledge of First Nations/Inuit culture, emotional and behavioural problems, and injuries. Regional surveys most frequently supplemented this with material on children's nutrition, leisure activities, language and culture, or additional depth on emotional health. Two regions focused more specifically on youth, adding questions dealing with sexual health, addictions, mental health, victimization, and self-esteem.

Among adults, the national core portion of the survey covered demographic and socio-economic variables, attendance at residential schools, tobacco use, chronic conditions, dental health, opinions about community wellness, and use and perceptions of

health services. Many regions supplemented this with considerably more information about mental and emotional health, residential schools, and social support. Addictions, particularly alcohol abuse, were also a major component of the regional material. Other common additions were information on sexual health, nutrition and traditional healing.

Sampling

Consistent with the principles of regional autonomy, each region independently identified its target population and developed a sample design. Different designs emerged to meet local objectives, accommodate differences in political and cultural realities, and respect protocols for community participation in each region. Table 2-1 summarizes the information on target populations and sample designs.

Table 2-1: Target Population and Sample Design by Region

Region	Target population	Sample design				
		Oppor-tunistic	Simple random	Stratified by geo-political area	Stratified by age-sex	Proxy interview for children
British Columbia	Age 15+			●		●
Alberta	Age 18+ in treaties 6, 7, 8	●				
Saskatchewan	Age 18+	●	●			●
Manitoba	Age 18+			●		●
Ontario	Child under 12 Youth 12 to 17 Adult 18+			●	●	●
Quebec	27 communities Age 18+			●		●
New Brunswick	Age 18+		●			●
Nova Scotia	Age 18+				●	●
Labrador	All coastal communities	●				●

Source: First Nations and Inuit Health Survey National Steering Committee, undated.

Individual response rates were high, generally more than 85 per cent. Nationally, the final sample totalled 9,870 adults and 4,138 children living in 186 communities. This represented five per cent of the adult target population and four per cent of the children. As with many surveys, youth and the elderly tended to be under-represented in the sample while female respondents were over-represented in many cases. Nationally, the male:female ratio among adult respondents was 45:55 with regional variations up to a high of 30:70 in Ontario. The ratios among children were generally much closer to 50:50.

Table 2-2: Sample Sizes by Region				
	Adults			Children
Region	**Target population (adults)**	**Sample size (adults)**	**Per cent of adult population sampled**	**Per cent of child population sampled**
British Columbia	32,869	1,984	6%	5%
Alberta	27,782	709	3%	-
Saskatchewan	26,298	869	3%	3%
Manitoba	32,813	1,948	6%	3%
Ontario	45,714	1,088	2%	2%
Quebec	25,285	1,875	7%	5%
New Brunswick	3,252	357	11%	4%
Nova Scotia	4,067	523	13%	7%
Labrador	1,920	517	27%	27%
National	**200,000**	**9,870**	**5%**	**4%**

Based on information from First Nations and Inuit Health Survey National Steering Committee, undated.

Description of the Approach in Each Region

British Columbia Region

In British Columbia, the target population was First Nations Peoples age 15 and older living on-reserve (36,219 people). British Columbia stratified its 197 communities by region (north, south and coast), then stratified by community size within each region (population less than 350, 350 to 700 and more than 700). This created nine different strata. Of the communities that agreed to participate, two were then selected from each stratum. In these communities, five per cent of individuals older than 15 were randomly selected from band lists. The primary caregiver in each participating household randomly selected one child for proxy interview.

Alberta Region

The target population was all First Nations Peoples aged 18 years and older living on-reserve in the Treaty 6, 7 and 8 areas. Sampling was opportunistic. Thirteen communities volunteered to participate. In these communities, all adults were invited to respond. For cultural reasons, Alberta's Steering Committee chose not to conduct any interviews with children.

Saskatchewan Region

Prior to developing its questionnaire, Saskatchewan held interviews with caregivers, health service providers and some community members. They were asked what issues keep First Nations Peoples from improving their health status. The issues identified were arranged into a cause-and-effect diagram (a sage tree). A panel of knowledgeable people was asked to rate the importance of each item. The results were used to determine what questions to include on the survey.

The target population was all 7,986 First Nations households in Saskatchewan's 70 communities. Sampling was opportunistic – that is it relied on communities volunteering to participate instead of choosing specific communities as part of a definite sampling plan. Since 67 of the 70 communities decided to participate, this approached worked well in practice. The resulting sample probably represents all First Nations communities in Saskatchewan well. Within communities, interviewers randomly selected 10 per cent of all households. If the community had fewer than 50 households, a minimum of five were selected. One child was selected for a proxy interview in each participating household with information provided by the primary caregiver.

Manitoba Region

The target population was all First Nations Peoples age 18 or older living on-reserve. Manitoba stratified its sample according to its eight Tribal Council Regions.[4] Within each Tribal Council, two communities (one large and one small) were selected, plus alternatives, for a final sample of 17 communities (three communities were selected from the largest Tribal Council). In the designated communities, interviewers randomly selected 20 per cent of households with a minimum sample of 100 people set for the smaller communities. All adults in the selected households were eligible to participate and one child per household was randomly chosen for the proxy interview.

Ontario Region

The target population was all First Nations communities in Ontario. That region used a two-stage stratified cluster sample. First, communities were stratified by geographic isolation (urban, rural, remote, or special access) and selected in proportion to the number of communities in the strata. Lists of community residents were further stratified by sex and age (children younger than 12, youth 12 to 17 and adults 18 and older). Individuals were randomly selected from each age-sex group. The person who knew most about the children (usually the mother) answered both the adult and child sections of the survey.

Quebec Region

Three groupings in Quebec (consisting of Cree, Mohawk and Inuit communities) chose not to participate in the RHS because they had recently been involved with other health surveys. The target population therefore consisted of people living in the remaining 27 First Nations communities. These were stratified according to four characteristics: size, isolation, non-Aboriginal language used (English/French), and primary emphasis of the community's health facility (prevention/treatment). Fourteen communities were selected of which 13 agreed to participate. Respondents were randomly selected within these communities. One child per household was randomly selected for a proxy interview. The final sample consisted of 1,875 adults and 707 children. In addition, Quebec included a non-random sample of 200 people from the Montreal area. (These Montreal respondents were excluded from the national database).

[4] A Tribal Council is a political grouping of communities located within the same geographic area.

New Brunswick Region

The target population was all First Nations communities in New Brunswick. A random sample of 150 households was drawn from these communities with all adults in these households eligible to participate. One child proxy interview was conducted in each household.

Nova Scotia Region

The target population was 11 Mi'kmaq communities in Nova Scotia. Unfortunately, results from St Mary's and Tobique were received too late to be incorporated into the national data, so the final results are based on the remaining nine communities. Nova Scotia stratified its sample by age and sex using band membership lists. This was followed by a random sample of 10 per cent of the population (15 per cent in smaller communities). Separate surveys were designed for children, youth and adults[5] with the primary caregiver answering on behalf of the children.

Labrador Region

The target population was all members of the Labrador Inuit Association[6] in the five coastal communities (Nain, Hopedale, Makkovik, Postville, and Rigolet), all of which participated. Interviews were held with the head of the household. One child per household was selected for a proxy interview.

Creation of the National Dataset

The National Steering Committee hired the Northern Health Research Unit at the University of Manitoba to compile the national core database. Each region submitted a data file of the responses to its national core questions. University staff combined the regional files and carried out a final edit of the data. Regions varied in the amount of editing they were able to do before the national roll-up resulting in significant numbers of missing values and unanswered questions. This reduced the possibilities for imputation as part of the editing process. (Imputation is a process of filling in missing information based on other information that is provided for a particular respondent. The more information that is missing, the more difficult this is to do.) University staff assessed how each region collected its data so as to take into account sampling and data quality issues and weighted the sample accordingly. Weights were calculated within age-sex strata based on information from the Indian Register maintained by Indian and Northern Affairs Canada and from the membership file maintained by the Labrador Inuit Association. The adult and child samples were weighted separately.

In addition to editing and weighting the national database, university staff added a set of ecological variables – that is, information on community characteristics – to each record. These variables included isolation (measured in terms of the community's

[5] As a result of this approach, the adult responses cannot be directly linked to those for children and youth.
[6] Because membership in the Labrador Inuit Association determines eligibility for benefits under Labrador's land claim settlement, this approach would include almost all Inuit in the area.

distance from health services), community size, health transfer status,[7] housing conditions, water and sewer facilities, fire protection, and other measures of community infrastructure. The data were drawn primarily from information provided by federal government ministries and the Labrador Inuit Association. After adding the ecological variables, individual and community identifiers were stripped from the file.

The final step in the process was to add information that would permit comparisons over time and comparisons to the non-Aboriginal population. Statistics Canada provided copies of the files from three relevant surveys: the 1991 Aboriginal Peoples Survey, the 1994 National Longitudinal Survey of Children and Youth, and the 1994 National Population Health Survey. Extracts from these three files were added to the RHS national database. Copies of the final dataset were sent to each participating region for its own analysis and use while members of the Co-Principal Investigators Group analyzed the core data at the national level.

[7] Health transfer status refers to whether a community has assumed direct control over its own health services or whether these are being provided by provincial or federal health departments.

Children's Health

The Environment

Before considering children's health status, it is of interest to consider the environment in which they are growing up and the behaviours that could affect their health. Several regional surveys asked about problems in the community. Ontario asked more specifically about relationships between community members and about the community as a good environment for children.

General statements about problems in the community elicited a somewhat negative picture. In Quebec, 34 per cent of adults felt that violence was a problem in the community. In Manitoba, 14 per cent reported domestic violence as a problem in the household. When asked about a list of problems, from 50 to 80 per cent of adults in Ontario said alcohol abuse, unemployment, tobacco use, drug use, and diabetes were issues in their community. Responses to the questions about non-traditional use of tobacco show that smoking occurred in 57 per cent of households across the country, with the consequent exposure of children, elders and other adults to second-hand smoke.

Responses to questions about community cohesion in Ontario, although generally positive, compared unfavourably to those obtained for the Canadian population as a whole (see Table 3-1).

There are also some more positive views. A majority (85 per cent) of the Ontario respondents considered their community as an average or better-than-average place to bring up children. The proportion of people (77 per cent) who felt it was safe to walk alone after dark was comparable to the Canadian average. More than 89 per cent said it was safe for children to play outside during the day – a slightly higher proportion than in the rest of Canada. What tended to be seen as lacking were recreational facilities for children. Only 33 per cent of parents agreed there were good parks, playgrounds or play spaces in the community, a much lower proportion than the 77 per cent in the rest of Canada. Fewer than 50 per cent of First Nations parents in Ontario reported any sports facilities for children or other activities such as dancing. More than 70 per cent reported their community needed facilities for children such as a drop-in centre, swimming pool, or playground equipment. Results from Saskatchewan were similar with 94 per cent of

adults wishing their community had a swimming pool, 79 per cent parks or playgrounds, and 72 per cent an indoor rink.

Table 3-1:
Relations Between Community Members
Ontario First Nations (1997) and Canada (NPHS 1994)

Per cent who agree or strongly agree that…	Ontario First Nations	Canada
If there is a problem around here, the neighbours/ community members get together to deal with it	41%	68%
There are adults in the neighbourhood/community that children can look up to	77%	81%
People around here are willing to help their neighbours/ community members	70%	87%
You can count on adults in this neighbourhood/ community to watch out that children are safe and don't get into trouble	66%	84%
When I'm away from home, I know that my neighbours will keep their eyes open for possible trouble	69%	87%

Prenatal and Infant Health

A few regions asked about women's health habits during pregnancy that might affect the health of the infant. Significant proportions of women continued to smoke throughout their pregnancies, which increases the risk of stillbirths and low birth weight. In Nova Scotia, 52 per cent reported smoking during their pregnancies, double the Canadian average. The figures for alcohol use during pregnancy were lower. In Manitoba, 81 per cent of women reported they refrained from drinking during their last pregnancy. In fact, of the women who had ever quit drinking for a period of time in their lives, 32 per cent said they had quit because they were pregnant. The comparable figures in Nova Scotia were even higher at 51 per cent.

Despite possible concerns about smoking during pregnancy, the national RHS results suggest that First Nations and Inuit infants were no more likely than average to be of low birth weight. In fact, high birth weight is more of a concern with almost a fifth of all infants weighing more than four kilograms at birth.

Breast-feeding rates were somewhat lower than average for First Nations and Inuit infants: 50 per cent as compared to 75 per cent in the rest of Canada. However, the mothers who did breast-feed tended to continue for a longer period of time. Half breast-fed for more than six months, whereas only a quarter of all Canadian babies are breast-fed for that length of time. Analysis in Quebec suggested breast-feeding rates tended to increase with the mother's education and were higher in communities located close to large cities. As well, the Quebec results suggested breast-feeding rates had increased over the past six years. Forty-three per cent of the babies born in the two years prior to the

survey had been breast-fed compared to just 17 per cent of those born between 1991 and 1993.

Figure 3-1

Health-Related Behaviours

Nova Scotia's survey asked about children's health-related behaviours such as leisure activities, diet and substance use. It found that 98 per cent of children watched television each week for an average of 2.9 hours each day while 72 per cent played video or computer games. Eighty per cent read for pleasure at least once a week and 45 per cent did so every day while 56 per cent engaged in sports at least once a week.

Nova Scotia also asked about diet. Parents reported that about three-quarters of children always ate breakfast and 63 per cent ate healthy foods at lunch. However, there was room for improvement in snacks as the majority of children were snacking on pastry, cookies and chips.

Finally, according to reports by parents in Manitoba, 19 per cent of all children under the age of 18 smoked cigarettes, seven per cent drank alcohol, and five per cent had used illegal drugs. The national results from adult respondents may also shed some light on smoking behaviour. Among adult smokers, the peak age for starting smoking was 16, with many beginning as young as 11. In the absence of information from the children themselves, it seems reasonable to suppose that today's children are starting at least as young.

Physical Health of Children

The national RHS asked parents to provide a global rating of their child's health and about specific illnesses. The vast majority (84 per cent) of parents reported that their child's health was good or excellent. Fewer than five per cent of parents reported that their child had had major diseases such as tuberculosis or diabetes, or serious injuries such as deep burns, frostbite, hypothermia, or instances of near-drowning (FNIRHS National Steering Committee, 1999).

Figure 3-2

The RHS also asked about a list of common health conditions. Of these, the most frequently reported were ear problems (15 per cent of children), followed by allergies (13 per cent), asthma (12 per cent), bronchitis (seven per cent), and overweight (seven per cent). Bronchitis and asthma were reported more frequently for the younger children, while overweight was more common at older ages. Several of these conditions are respiratory in nature, particularly since ear infections tend to be a consequence of upper respiratory infections. Respiratory infections are common for children throughout Canada, but First Nations and Inuit children may be unusually subject to them because of inadequate nutrition, crowded housing and exposure to wood smoke and second-hand cigarette smoke.

Thirteen per cent of children had suffered a fracture at some time in their lives. Of the children age 12 and older, 20 per cent had had a fracture at some point. Rates of fractures were equal for boys and girls. Other types of major injury – such as serious burns – were

rare. Because the RHS question asked about lifetime prevalence of injuries, whereas most other surveys ask about injuries over a specified time period, it is difficult to compare the RHS results to those for non-Aboriginal children. However, Nova Scotia asked specifically about injuries in the year prior to the survey. The results showed that 11 per cent of children had had some type of injury during the year, usually cuts/scrapes/bruises (7.6 per cent), burns (1.3 per cent), sprains or strains (1.3 per cent), or fractures (0.5 per cent). These figures were not radically different from those obtained for Canadian children in general.

Figure 3-3

Emotional/Social Health

The national RHS included several questions for parents about how much their child knew about Aboriginal culture, how well he/she got along with family and whether he/she had behavioural or emotional problems. The results showed that more than two-thirds of parents were satisfied with their child's knowledge of Aboriginal culture. Parents who themselves spoke an Aboriginal language on a daily basis were especially likely to be satisfied with their child's knowledge. Three-quarters of all children were said to get along well with their families.

The survey also asked parents if in the previous six months their child had had more behavioural or emotional problems than other children of the same age. About 17 per

cent of parents said their child had had such problems. Parents of older children were more likely to say this. About a quarter of the children 12 and older – both boys and girls – were reported to have more emotional or behavioural problems than their peers. Analysis in Quebec suggested that emotional problems were related to family structure with two-parent families less likely to report problems (see Figure 3-5).

Figure 3-4

Figure 3-5

Ontario's survey explored emotional and social problems in children in much greater depth using the same scales for conduct disorder, hyperactivity and emotional disorder as the 1994 National Longitudinal Survey of Children and Youth (NLSCY). Using these measures, it appeared that conduct disorders (physical aggression, indirect aggression and damage to property) were somewhat more frequent for First Nations children than for other children in Canada. Indicators of hyperactivity, in contrast, were generally lower in First Nations children while emotional disorders (seeming unhappy, crying a lot and being tense) were somewhat higher than average for First Nations boys, but about average for girls (see Table 3-2).

Table 3-2: Scales of Emotional and Mental Health for Children Age 4 to 11 Ontario First Nations (RHS 1997) Compared to Canada (NLSCY 1994)

	Conduct Disorder		Hyperactivity		Emotional Disorder		One or More Disorders	
	FN	Can	FN	Can	FN	Can	FN	Can
Boys	16.8%	11.0%	10.0%	14.0%	12.4%	9.0%	29.0%	24.0%
Girls	15.1%	8.3%	3.6%	6.4%	8.3%	8.6%	21.9%	17.4%
Both	16.1%	9.6%	7.2%	10.3%	10.6%	8.8%	25.9%	20.7%

Summary

The RHS found many expectant mothers avoid alcohol during their pregnancy, although fewer give up smoking. Despite this, birthweights were average or high, not low. Rates of breast-feeding were lower than average, but infants were breast-fed for longer durations.

Although people identified many problems in First Nations and Inuit communities, most parents nevertheless considered them good places in which to raise children. There were, however, concerns about the availability of recreational facilities and play spaces. The vast majority of First Nations and Inuit children were reported to be healthy. Many of the existing health problems were respiratory in nature. The most commonly reported conditions among children were ear problems, allergies, asthma, bronchitis, and overweight. Most children also got along with their families and had no more emotional or behavioural problems than other children of similar age. Information from Ontario suggested that the prevalence of conduct disorders might be higher than average in First Nations children and that rates of emotional disorder were somewhat high in boys. Conversely, First Nations children in Ontario were somewhat less likely than average to exhibit symptoms of hyperactivity.

The Health of Youth

According to the 1996 Census, children and youth (birth to 19 years) represent about 44 per cent of the Aboriginal population, a much larger proportion than in the rest of Canada where they make up only 28 per cent. Because of this high proportion and the higher birthrates in First Nations and Inuit communities, the concerns of youth will become increasingly significant over time. The RHS findings about the health of youth have already been touched upon under the broader heading of child health. However, Nova Scotia and Ontario also included a special focus on youth[8] in their surveys. Thus, they were able to cover topics of particular relevance to adolescents such as cultural identity, substance use, emotional health, and hopes for the future. This chapter summarizes the results from those surveys based in large part on a report by MacMillan et al. entitled *Aboriginal Youth* (2001). The numbers should be interpreted with caution because they are based on relatively small samples. The Nova Scotia survey included proxy responses for 87 youth. The Ontario survey included 173 parents who provided information on youth and 232 youth who were interviewed in person. In addition, the Ontario youth completed a written questionnaire on victimization, which they placed in a sealed envelope and mailed back to the interviewer.

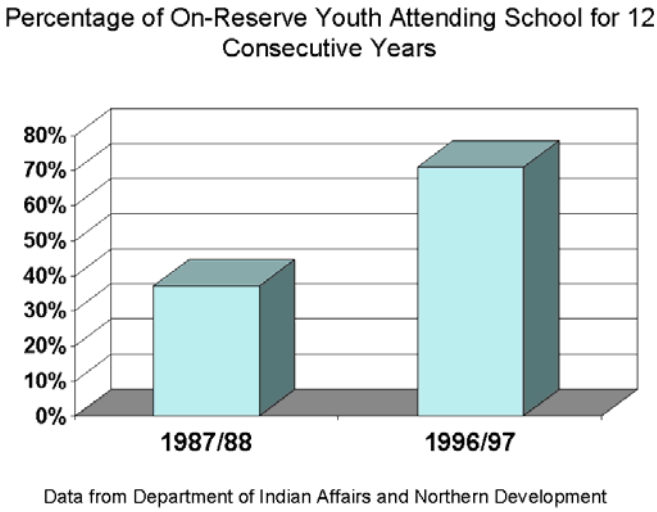
The Determinants of Health

The environment in which today's youth are growing up is influenced both by historical factors and by the current socio-economic context of First Nations and Inuit communities. The type of parenting they receive may have been affected by historical events such as the residential schools policy and the "Sixties Scoop" in which large proportions of Aboriginal children were removed from their birth families and placed in

[8] Nova Scotia defined youth as ages 12 to 18 while Ontario defined it as 12 to 17 years. Results from the national core questions that are included in this chapter use the 12 to 17 year range.

foster care. Many First Nations youth are also growing up in economically disadvantaged situations – their unemployment rate was double the Canadian average in 1996 and their families were three times more likely to live in homes with multiple problems such as crowding and lack of repair. However, their educational achievement has improved dramatically in recent years. Over the 1987/88 to 1996/97 period, the proportion of on-reserve youth remaining in school for 12 consecutive years rose from 37 per cent to 71 per cent while the number of youth enrolled in post-secondary institutions rose from 14,000 to 27,000 (MacMillan et al., 2001).

Figure 4-1



The RHS found some room for improvement in eating habits and obesity among First Nations and Inuit youth. Nationally, 10 per cent of parents said their children age 12 and older were overweight. Research in specific communities such as Sandy Lake has also found high rates of obesity, which were inversely related to the child's television viewing habits, fitness level, fibre intake, and consumption of junk foods (Harris et al., 1998 cited in MacMillan, 2001). The Nova Scotia survey shed further light on eating habits, finding that fewer than 40 per cent of youth always ate breakfast and that their reported choices of lunch and snacks emphasized less healthy foods such as hamburgers and soft drinks.

Both the Ontario and Nova Scotia surveys asked youth about drugs, alcohol and non-traditional[9] use of tobacco. The Ontario survey found that more than 60 per cent of youth had used alcohol at some time in their life. In Nova Scotia, 30 to 50 per cent had used it in the previous year. According to both surveys, more than half of all youth had used drugs at least once, with the drugs of choice being marijuana, followed by some type of inhalant. There is some suggestion in the Nova Scotia data that inhalant use declines among older youth. Numerous past studies have found high smoking rates in First Nations and Inuit adults so it is no surprise that youth smoking rates also appear to be

[9] Non-traditional refers to the use of tobacco for purposes other than its traditional role in ceremonies and spiritual practices – such as having a regular smoking habit.

high. In Nova Scotia, about two-thirds of youth had used tobacco in non-traditional ways at some point while 41 per cent of males and 48 per cent of females were smoking at the time of the survey. The results for Ontario youth were similar with smoking rates of 54 per cent in males and 48 per cent in females.

Figure 4-2

Community and Culture

Youth in Ontario were asked about the availability of sports and cultural facilities in their community. Just fewer than half reported their community had sports facilities for boys with somewhat lower proportions reporting facilities for girls. The next most frequently available activities were dancing and drumming while about a third of respondents indicated their community had a drop-in centre for youth. The most commonly cited needs were for a swimming pool in the community, followed by the need for playground equipment, arenas and drop-in centres (see Figure 4-3).

Youth also provided information about the extent of their participation in cultural activities and their hopes and dreams for the future. Results from both Ontario and Nova Scotia suggested considerable proportions of youth could speak their Aboriginal language and participated at least occasionally in traditional activities. In Ontario, 60 per cent of youth said they spoke a Native language sometimes or often. In Nova Scotia, 44 per cent could speak Mi'kmaq at least pretty well. In both regions, more than half reported some degree of participation in traditional activities. In Ontario, a majority said they prepared traditional foods, paddled a canoe or made traditional crafts at least occasionally. In Nova Scotia, 62 per cent had participated in a traditional event such as a powwow, smudging or sweetgrass ceremony in the previous year.

Figure 4-3

When asked about their hopes for the future, most Ontario youth wished for unspecified improvements in their communities. About a fifth hoped for increased prosperity or the maintenance of First Nations culture. Youth's hopes for their own futures centred primarily on education, employment and careers, followed by family and cultural concerns (see Figure 4-4).

Physical Health of Youth

The RHS found that the majority of First Nations and Inuit youth were in good physical health. Nationally, more than 80 per cent of the parents of youth age 12 to 17 reported that their child's health was very good or excellent. The most commonly reported problems in this age range were allergies, ear problems, asthma, and bronchitis, although most of these were less frequently reported for youth than for children.

Other studies on the topic of youth health suggest Aboriginal youth may be at higher than average risk for both diabetes and infectious diseases, possibly as a result of factors such as poverty and crowded housing, nutritional problems and exposure to environmental pollutants including tobacco smoke (RHS National Steering Committee, 1999). Injuries are typically among the main health concerns for youth. The RHS results show 42 per cent of youth had a fracture at some time in their life while four to five per cent each had experienced near-drowning, serious head injuries or burns.

Figure 4-4

Figure 4-5

Mental and Emotional Health

According to the report of the Royal Commission on Aboriginal People, many Aboriginal youth feel "strung between two cultures and psychologically at home in neither" (Royal Commission on Aboriginal Peoples, 1995, cited in MacMillan 2001). Thus, issues of identity and emotional health can be expected to be particularly important for them, although past studies have provided somewhat conflicting results. One national survey in the United States found that while most Aboriginal youth had good emotional health, eight to 14 per cent appeared to be at some risk for depression and hopelessness, while six per cent showed severe emotional distress (Blum, 1992 and Cummins, 1999, both cited in MacMillan, 2001). The literature suggests that contributing factors to good emotional health include perceived family caring, body pride, a sense of connectedness to school, parental expectations, and having a personal area of skill (Cummins, 1999).

Suicide has often been taken as one of the more obvious indicators of emotional health. Rates in First Nations youth are known to be from five to eight times higher than average (Canadian Institute of Child Health, 2000). The risk factors for suicide include psychiatric problems; use of alcohol, drugs or solvents; recent life events; friends or family who attempt/commit suicide; and sexual abuse. Conversely, a sense of connectedness with family and discussing problems with friends and family appear to be protective (Borowsky et al, 1999, cited in MacMillan). A recent study by M.J. Chandler has also demonstrated a strong link between the youth suicide rate and the presence of community characteristics indicative of cultural continuity such as seeking title to traditional lands; having control over health, education, police and fire services; and the presence of cultural facilities (Chandler, 1998 cited in MacMillan). To date, no program has been proven effective in preventing youth suicide, although a few deserve further evaluation (MacMillan, 2001).

Relationships with family and others are an important dimension for youth and have a bearing on their emotional health. The Ontario and Nova Scotia surveys found that, depending on the relationship considered, one to 14 per cent of First Nations youth had problems relating to family, friends/classmates or teachers. The majority of Ontario youth reported their parents "take care of me" (85 per cent) and "make me feel loved" (78 per cent). However, significant minorities also report that it often happens that their parents "don't care where I am" (21 per cent) or "call me things like stupid, lazy or ugly" (11 per cent).

Exposure to violence seemed to be a serious problem for a significant proportion of First Nations youth. According to the Ontario survey, 30 per cent of youth had seen a parent or step-parent hit another adult in their home on one or more occasions. A third of youth (both male and female) reported having been physically abused in some way. Parents were identified as the most common culprits, although strangers, siblings and other people were also implicated. Similarly, 25 per cent reported instances in which an adult "got so mad you thought you were going to get badly hurt or did get hurt." For 10 per cent, this was a repeated occurrence happening either sometimes or often. Sexual abuse was less frequently reported, but unlike physical abuse, showed a large gender difference. Twenty-eight per cent of female and 14 per cent of male youth in Ontario reported sexual abuse, much of it severe, with the majority of perpetrators being people from outside the family.

Table 4-1: Exposure to Violence as Reported by Youth in Ontario (Based on 232 samples or N = 232)		
Sometimes get hassled by other children		35%
Have seen a parent or step-parent hit another adult in the home	Rarely or sometimes	30%
	Often	3%
An adult got so mad you thought you were going to get badly hurt or you did get hurt	Happens rarely	15%
	Happens sometimes or often	10%
	Had to see a doctor as a result of the incident	8%
Physically abused	Males	33%
	Females	36%
Sexually abused	Males	14%
	Females	28%

Data from Centre for Studies of Children at Risk and Chiefs of Ontario, 1998, pp. 79-80. Rates of refused/missing responses for these items ranged between four to eight per cent depending on the question. Under-reporting is a possibility.

Ontario's survey also included a series of scales asking youth about symptoms of conduct disorder, emotional disorder, hyperactivity, prosocial behaviour, and attitude towards life. Depression and anxiety appeared to be the areas of concern with 15 per cent of youth reporting they often felt worried and seven per cent saying they had trouble enjoying themselves. In contrast, fewer than 10 per cent of youth endorsed any of the statements indicative of conduct disorders or hyperactivity while high proportions reported prosocial behaviours (such as helping others in difficulty) and agreed with statements indicative of problem-solving ability and feeling good about oneself. Overall, a majority of youth had positive perceptions of life, as shown in Table 4-2.

Table 4-2: Youth Attitudes Towards Life: Ontario First Nations Youth (Based on 232 samples or N = 232)					
	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**Refused**
In general, I am happy with how things are for me in my life now	2%	15%	67%	11%	6%
The future looks good to me	3%	9%	70%	13%	6%
I feel that my life has purpose and meaning	3%	7%	62%	22%	6%

Source: Centre for Studies of Children at Risk and Chiefs of Ontario (1998): p.68.

Summary

Many First Nations and Inuit youth are growing up in economically-disadvantaged circumstances, although a positive note is that education levels are increasing. Their eating habits and weight give cause for concern, while about half have tried alcohol and drugs and 40 to 50 per cent smoke. Significant proportions of youth are also exposed to violence, reporting instances of physical or sexual abuse.

Despite this, the physical health of the vast majority of youth is reported to be quite good with the primary concerns being allergies, ear problems and asthma. The proportions reporting symptoms of conduct or emotional disorders are generally below 10 per cent with the exception of depression and anxiety, which are more common. The great majority of youth get along well with their families and report their parents take care of them and make them feel loved. However, from 10 to 20 per cent of youth and parents report problems in these areas.

Between one-third and half of youth report their community has sports and cultural facilities. Between 45 and 60 per cent are able to speak their First Nations language and report participating in traditional activities. Youth's hopes for their communities include prosperity and the preservation of First Nations culture. Consistent with the figures showing major increases in school attendance, their hopes for their personal futures emphasize education, employment and a successful career.

The Health of Adults

The Community Environment

Questions on community wellness and conditions were included in the RHS because it was felt that the context in which a person lives provides the framework for their personal health and for how they perceive health issues. The socio-economic conditions of Aboriginal communities in Canada – low incomes, high unemployment, less formal education, and poor housing – have been thoroughly documented elsewhere. However, the RHS results provide some additional insight by documenting people's experience of these realities and their perceptions about community conditions.

Historical Factors

Among the historical factors that have affected First Nations and Inuit communities, two were singled out either in the national core portion of the survey or in particular regions: the experience of residential schools and forced relocations. Attendance at residential schools was of course higher among older adults. Nationally, 35 per cent of adults older than 45 had attended a residential school at some time in their lives and remained there for an average of six years. It was believed that this experience might have an effect on their health in later life. In fact, people who attended residential schools reported much poorer health over all. However, researchers believe the trend may be more related to the older age of residential school attendees than their actual attendance.

Nova Scotia, Manitoba, Saskatchewan, and British Columbia asked more specific questions about the impact of residential schools. In these regions, 10 to 25 per cent of all adults had attended residential schools – in most cases, under compulsion. Significant minorities felt the experience had affected their health or well-being. In Nova Scotia and Manitoba, between 20 and 44 per cent

Residential Schools – Results from British Columbia

- 25% attended, most (79%) not voluntarily
- Felt residential school had a negative impact on their:

Language	58%
Culture	62%
Current health	27%

felt it had negatively affected their lives or their communities. In Saskatchewan, only 30 per cent of those who had attended residential schools said it had been a bad experience, while 27 per cent described it as OK and 28 per cent as a good experience. British Columbia's results provide a more subtle picture suggesting people felt their language and culture had been affected more than their health.

Relocations have also been a reality for some First Nations communities due to circumstances such as flooding of traditional lands, epidemics, or various government initiatives. Both the Labrador and Manitoba surveys asked about relocations. The results are strikingly similar. In these regions, 10 to 11 per cent of adults had been relocated. In both cases a majority – 62 per cent – said they or their families were negatively affected by the move. The results a generation later were less negative. Of the Labrador adults whose parents or grandparents had been moved, most felt the moves had had no effect. Those who did perceive an effect were divided as to whether the impact was positive or negative.

Table 5-1: Forced Relocations in Labrador and Manitoba

	Labrador	Manitoba
Per cent relocated	10%	11%
Per cent who felt relocation had negative impact	62%	62%
Per cent whose parents/grandparents were relocated	36%	12%
Impact of parents' relocation: Negative	15%	
Positive	20%	
No effect	38%	
Uncertain	27%	

Income Adequacy

Income and employment rates are known to be low in many First Nations and Inuit communities (see for example Indian and Northern Affairs Canada, 2002). The Labrador and Manitoba surveys specifically asked about whether incomes were adequate to meet basic needs such as food. The results are disconcerting. In Manitoba, 40 per cent of adults said their household income was insufficient to meet basic needs. A further 27 per cent said it was only sufficient sometimes. Running out of money for food at least occasionally was a problem for 46 per cent of households in Manitoba and 28 per cent of those in Labrador.

Not having enough to eat

Running out of money for food/not having enough to eat is a problem for

- 46% of households in Manitoba
- 28% of households in Labrador

This happens:

- "At least once a month" for 31% of households in Manitoba
- "Often" for 7% of households in Labrador

Problems in the Community

The RHS devoted considerable attention to people's perceptions of the problems in their communities and households and to whether these problems had improved during

the two years prior to the survey. Nationally, large proportions of people reported there had been progress in community infrastructure (water, sewage, and housing), education, First Nations/Inuit control of services, and some traditional practices. Both national and regional results suggest a wide consensus that housing conditions, in particular, have improved in recent years. Alcohol and drug abuse led the list of problems that people did not think had improved, followed by employment opportunities and the availability of First Nations/Inuit health professionals (see Figure 5-1). An interesting finding in Quebec was that these improvements varied with community size. Medium and large communities were most likely to have seen improvements in First Nations control of services and Aboriginal culture programs in the schools. Small communities cited major improvements in the use of Aboriginal language, the role of Elders and infrastructure.

Figure 5-1

Besides asking about problems in the community, Labrador and Manitoba asked people more specifically about problems in their own households. Problems such as drinking, drugs, gambling, overcrowding, and communication among family members led the list of household problems. Few respondents reported any improvement over the previous two years.

Problems in the Household	
Labrador	**Manitoba**
Main problems: Drinking Communication between family members Overcrowding Gambling Other frequently mentioned problems: Unemployment Inadequate household income Inadequate housing	Problems cited: Drinking 38% Gambling 33% Drug use 23% Overcrowding 20% Domestic violence 14%

Wellness and Tradition

Many First Nations and Inuit traditions interpret health in the context of the individual's relationship with the family, community, environment, and spiritual world. Language, tradition and culture may be central to a person's concept of who they are and are believed to play a role in mental and emotional health by giving people a feeling of being connected to their past, present and future (Labrador Inuit Health Commission, 1999g).

Nationally, more than 80 per cent of RHS respondents believed a return to traditional ways was a good idea for promoting wellness in the community. The people most likely to think so were those who believed the health services presently available were inferior to those provided to other Canadians; those who spoke a non-Aboriginal language at home; and those who had attended residential schools. Given that the existing health systems in most First Nations and Inuit communities are based on the western medical model rather than the traditional view, this raises questions about what type of system First Nations People/Inuit desire and whether the current frameworks for transferring health services to community control allow them to implement the type of system they want (RHS National Steering Committee, 1999). However, people living in communities that were actively considering taking control of their own health services were somewhat less likely than others to advocate a return to traditional ways.

The importance many people place on reviving tradition is clearly demonstrated in Ontario's survey. Overall, 91 per cent of Ontario respondents agreed there was a need to revive and preserve Native language and culture. When asked why, the response was most frequently to prevent loss, followed by for the children.

Nationally, as seen in the preceding section, many First Nations Peoples and Inuit said there had been good progress in returning to traditions over the past several years. More specifically, people reported good progress in certain areas – such as the use of Elders, traditional ceremonies, use of language, and cultural education programs in schools – and less progress in areas such as returning to traditional gender roles and increased personal responsibility for healing. Several regions asked about personal participation in traditional events and use of Aboriginal language. The results suggest considerable cultural retention, but with large variations from region to region.

Figure 5-2

Language and Tradition: Some Responses in Different Regions

In Ontario…

- 62% seek assistance from Elders
- 54% receive spiritual guidance at least some of the time when they need it

but

- 41% report understanding Native culture very little or not at all
- the preferred way to teach children an Aboriginal language is through school programs rather than in the family

In Nova Scotia…

- 67% understand Mi'kmaq quite well
- more than 50% participate in traditional activities such as powwows, smudging, sweetgrass, pipe, or sweatlodge ceremonies

In Saskatchewan…

- 51% participate in traditional activities
- 48% use an Aboriginal language or a mixture of English and an Aboriginal language at home
- 70% say their child knows Native culture
- a large majority indicate the child is learning culture from parents, grandparents, or other family members

Hopes for the Future

The Ontario survey provided some information, not only on current conditions in the communities, but also on people's hopes and dreams for the future. Respondents tended to hope for health, happiness and self-sufficiency for themselves and their families. In contrast, their hopes for their community suggest the importance that many First Nations and Inuit traditions place on relationships with community cohesiveness chosen far more often than topics such as health or employment.

Figure 5-3

Health-Related Behaviours

Nutrition, Weight and Exercise

The RHS questions on nutrition dealt not only with weight and eating habits, but also with traditional foods. Wild meat is an important source of several key nutrients. It may play a role in preventing heart disease and cancer as well as in protecting the body from the harmful effects of some contaminants (Labrador Inuit Health Commission, 1999c). Several regions asked people about their consumption of traditional foods. The results suggest that most First Nations Peoples and Inuit consume wild food, but there are large regional differences in the proportions who do so regularly. For example, 94 per cent of respondents in Manitoba said they ate wild food, but only 18 per cent did so at least once a week. Results from Quebec showed 25 per cent frequently ate fish or game. The more isolated the community, the more likely people were to eat wild meat and the less likely

they were to eat fruit and vegetables. This probably reflects issues of supply and price (First Nations of Quebec and Labrador Health and Social Services Commission, 1999). The highest proportions reported were in Labrador where 70 to 85 per cent of the population reported they fish, hunt or pick berries and 76 per cent of adults obtained half or more of their meat, fish and birds from hunting and fishing.

Figure 5-4

Figure 5-5

Fewer regions collected information on the quality of people's western diet. An exception was Nova Scotia, which found that adults reported fairly healthy food choices, far better than those made by youth. Almost half of adults in Nova Scotia considered healthy eating to be very important. More than half indicated they generally choose a sandwich rather than a burger for lunch. Quebec's survey also asked people about their consumption of junk food and found that younger adults eat fast foods more than older adults. Labrador, interestingly, asked people about their reasons for using fast foods. The most common responses were that these foods are quick to prepare, they look good to eat and children love them.

Consistent with past surveys, obesity appeared to be common in First Nations and Inuit adults. Using reported height and weight to calculate Body Mass Index, Nova Scotia found that 33 per cent of men and 42 per cent of women were obese. Another 22 per cent of adults were overweight. Manitoba found that 50 per cent of adults were overweight or obese. Labrador found 26 to36 per cent of respondents to be obese with women more likely than men to fall into this category.

Several regions also asked people if they were making any changes to improve their health. The results were enormously variable ranging from nine per cent in New Brunswick who had actually succeeded in improving their eating habits in the previous year to 50 to 80 per cent in Manitoba and Labrador who said they were trying to improve their diets.

New Brunswick and Saskatchewan also asked about exercise habits. In New Brunswick, three-quarters of respondents had participated in some form of physical activity in the previous three months, most often walking, bicycling, gardening or dancing. The proportions in Saskatchewan were somewhat lower. Only 56 per cent reported participating in any form of physical activity in the previous three months. Asked how often they exercised in a typical week, 17 per cent of Saskatchewan respondents reported exercising more than five times a week, while the largest proportion (31 per cent) said they exercised once or twice a week and 25 per cent said they never exercised. The most common forms of exercise in Saskatchewan were walking, dancing, jogging, and hunting/fishing. People's choices of recreational activity should be interpreted in the context of the facilities available to them in the community. In Saskatchewan, 70 to 94 per cent of respondents indicated they would like their community to have facilities such as a swimming pool, park or playground, gym, or indoor rink.

Figure 5-6

Sexual Health

Numerous regions asked questions about women's preventive health practices – Pap smears and mammograms. Three regions also asked about HIV and safe sex. The results for both Pap smears and mammograms were quite variable across regions. Depending on the region, 59 to 94 per cent of women reported ever having had a Pap smear with women in Ontario and Labrador being particularly likely to have had one. Depending on the region, anywhere from a third to three-quarters of all women had had a Pap smear in the year or two preceding the survey (see Table 5-2).

Table 5-2: Women Who Had a Pap Smear…

	At some point	In the past year or two
Labrador	94%	78% (past 2 years)
New Brunswick	59%	35% (past year)
Quebec	68%	46% (past year)
Ontario	88%	64% (past year)
Manitoba	76%	

The results for mammograms are harder to interpret because regions used different age ranges. Canadian guidelines recommend annual mammograms for women age 50 to 69. Only Labrador measured this particular age, finding that 15 per cent of women age 50 and older had had a mammogram. Quebec found that 13 per cent of all adult women had had a mammogram at some point, a proportion similar to the Quebec average. Ontario found that 23 per cent of women had had one, which was low compared to Ontario and

Canadian averages, although some of this may be because more of the First Nations women are young.

Three regions asked about safe sex practices. In Nova Scotia, 31 per cent reported they did not always practice safe sex. A third of these were youth under the age of 19. In Manitoba, although 84 per cent said more education on HIV/AIDS was required, nearly half felt HIV was not likely to become a problem in First Nations communities. Most adults in Manitoba (72 per cent) believed they personally were not at risk of HIV/AIDS while 61 per cent did not practice safe sex.

Saskatchewan focused on how much people knew about HIV and where they were getting their information. Eighty-six per cent of respondents knew what AIDS was, 21 per cent had been tested for it at some point and 14 per cent knew someone with HIV/AIDS. The main sources of information on HIV/AIDS was the popular media: 93 per cent obtained their information from television and 81 per cent from newspapers, magazines or newsletters. Much lower proportions obtained their information from health professionals such as nurses or community health representatives.

Alcohol

Many regions included questions about alcohol consumption in their surveys. As previously mentioned, large proportions of people described alcohol as a problem, both in their communities and in their own households. In Quebec, 74 per cent said alcohol and drug abuse was a problem in their community. In Manitoba, 47 per cent reported alcohol consumption was a problem in their household, while in Labrador, 33 per cent said a family member had alcohol problems.

As for personal drinking habits, in Manitoba 25 per cent said they themselves had a drinking problem. In Saskatchewan, 19 per cent said they had had a desire for alcohol that they could not resist sometime during the previous year. Despite this, in the regions that asked about daily and weekly alcohol consumption, the pattern was remarkably consistent. The proportions of First Nations Peoples who had consumed alcohol in the previous week, month or year were lower than the Canadian average. The concern appears to be not with frequency of drinking, but with binge drinking. For instance, in Nova Scotia, 80 per cent of the people who drank reported instances when they had five or more drinks on one occasion. Twenty to 39 per cent of them reported having binged 10 or more times a year. These proportions of binge drinkers were far higher than the provincial average.

Alcohol Consumption: Results From Saskatchewan	
In the past 12 months…	**Yes**
Did alcohol increase your chances of being hurt?	23%
Did alcohol affect your work, studies or employment?	15%

Labrador, Ontario and Manitoba also asked people whether they had ever cut down on their drinking or felt they needed to cut down. Large proportions (77 to 90 per cent) had cut down or quit drinking at some point in their lives. In Labrador, 27 per cent felt they needed to cut down at present. Ten per cent of the adults in Labrador had attended an alcohol treatment centre at some time. The reasons for cutting back were very consistent. In all three regions, the leading reasons were that drinking was interfering

with family relationships or that the person recognized that he/she had a drinking problem. Significant proportions also said they had cut back because their drinking was affecting their health or because they became pregnant.

Smoking

The national core of the RHS included questions about smoking and non-traditional use of tobacco. Smoking rates in First Nations adults were double the Canadian average, at 62 per cent. Rates were even higher at younger ages. Almost three-quarters of people in their early 20s smoked. These rates were essentially unchanged since 1991 when the Aboriginal Peoples Survey documented similar proportions. Most adults had begun smoking around age 16, some as early as 11, and a few as young as eight. Consistent with other research on smoking in Canada and the United States, few people had begun smoking after age 19. Most smokers reported smoking less than a pack a day.

Figure 5-7

Smokers rated their health lower than other people of comparable age. The higher the pack-day (a measure of duration and heaviness of smoking), the more likely they were to report poor health. Smokers were also more likely than other people of the same age to report having a chronic condition such as diabetes, hypertension or heart disease.

Exposure to second-hand smoke was also an issue since more than half the RHS respondents said someone smoked in their household. Three-quarters of non-smokers and more than a third of smokers reported they sometimes felt unpleasant effects from other people's tobacco smoke. Despite this, only a third said their communities place limits on where people could smoke.

Quitting Smoking:
Some Differing Results

- In Nova Scotia, 17% of smokers reported they were seriously considering quitting in the next six months.
- Of the former smokers in New Brunswick, roughly 20% each had quit before age 20, during their 20s, and during their 30s. About 30% had quit during their 40s, and after that the proportions declined: very few smokers quit after age 50.
- Results in Saskatchewan differed: although 25% of smokers had quit by age 25, the remainder quit throughout the entire life course, leading Saskatchewan's researchers to conclude that smoking-cessation programs should be directed to all adult age groups.

Physical Health of Adults

Nationally, the RHS asked about three aspects of adults' health: chronic conditions, activity limitations and dental health. Nova Scotia also asked about the prevalence of injuries.

Chronic Conditions

Chronic conditions such as diabetes, hypertension, heart disease, cancer, and arthritis/rheumatism are extremely common. About 46 per cent of all adults reported having been diagnosed with one or more of these conditions. Smokers were at even greater risk. In contrast to findings of previous research, the RHS results suggest all of these conditions are more prevalent among First Nations Peoples and Inuit than in the Canadian population as a whole. Age-standardized rates range from 1.5 to 5 times the national average.

Figure 5-8

Table 5-3: Ratio of First Nations/Inuit to Canadian Prevalence of Selected Chronic Conditions (based on age-standardized rates)	
Diabetes	3-5 times higher
Heart disease	3 times higher
Hypertension	2.5 times higher
Cancer	1.5-2 times higher
Arthritis/rheumatism	1.5 times higher

Chronic conditions tend to cluster with many people having more than one condition. For instance, 50 per cent of the people with diabetes also reported hypertension while 26 per cent had heart problems. Predictably, rates also increased with age. One implication is that this group will tend to have less formal education than others so health messages must be tailored to accommodate this reality.

Chronic conditions were associated with activity limitation such as being unable to take short trips or needing help with personal care. Depending on

Some degree of activity limitation was reported by…

- 24% of the people with hypertension
- 28% of those with diabetes
- 33% of those with arthritis
- 36% of those with heart disease
- 38% of those with cancer

the specific condition, 24 to 38 per cent of the people with chronic conditions reported some degree of activity limitation. Those with chronic conditions were also far more likely than others to rate their overall health as poor and to feel that there should be improvements in health care services such as more health staff, chronic care facilities, home care, education on medications, preventive education, and mental health services.

There has been concern in recent years that First Nations Peoples develop conditions such as diabetes at younger ages than other Canadians. Although the national report did not analyze the age of onset of chronic conditions, British Columbia's report did (see Table 5-4.

Table 5-4
Average Age at Time of First Diagnosis
First Nations Peoples in British Columbia, 1997

Arthritis	35 years
Cancer	36 years
Hypertension	36 years
Heart problems	37 years
Diabetes	42 years

The national RHS results suggest chronic conditions are becoming more frequent. Several conditions that were historically lower than average were high according to the RHS figures. All rates were higher than those reported to Statistics Canada's 1991 Aboriginal Peoples Survey.

- Diabetes, once almost unknown in First Nations communities, is known to have risen rapidly (see for example Health Canada, 2000). This was also true in the RHS results. Past research suggests that at least 90 per cent of the diabetes is Type 2. It is difficult for a survey to distinguish between Type 1, Type 2 and gestational diabetes, but a few regions attempted it. In Nova Scotia, 73 per cent of the people with diabetes said they had Type 2, while nine per cent did not know what type they had. Manitoba found that 46 per cent of the women with diabetes had previously been diagnosed with gestational diabetes during a pregnancy.
- Past research has concluded that rates of heart disease are lower than average in First Nations Peoples, but the RHS found high rates.
- Cancer rates were historically low in First Nations Peoples and Inuit, but some studies suggest that lung and cervical cancers are increasing. (Gillis, 1991; Irvine, 1991; and Band, 1992, cited in RHS National Steering Committee, 1999).

Injuries

Nova Scotia and New Brunswick asked respondents about their experience of injuries in the 12 months prior to the survey. In Nova Scotia, 16 per cent reported an injury. In New Brunswick, 10 per cent had had an injury serious enough to limit their normal activities. In both cases, the most common injuries were fractures, sprains and strains, and cuts, scrapes and bruises. Men were considerably more likely than women to report having been injured. The most frequent causes of injury were falls and sports.

Figure 5-9

Road Safety Habits – New Brunswick

Although the 1991 Aboriginal Peoples Survey found low rates of seatbelt use, New Brunswick's RHS in 1997 found that:

- 70% of drivers always insist their passengers use seatbelts or child car seats and 22% do so most of the time.
- Three-quarters drive at posted speed limits, although one-quarter seldom or never do so.
- Almost all drivers who go out with friends to drink report using taxis or designated drivers.

Activity Limitations

Chronic diseases or injuries can result in activity limitation. The RHS asked about limitations such as trouble taking trips, needing help with personal care such as grooming, or being housebound. The RHS questions were somewhat different from those used in the 1991 Aboriginal Peoples Survey. The resulting figures were quite different. Whereas the Aboriginal Peoples Survey found that 30 per cent of adults had an activity limitation, the RHS figure was 15 per cent. The proportion of people with a limitation increased with age. Single women with no children living at home reported more limitations than people living in other arrangements, possibly because these were older women. Providing care for people with activity limitations may be complicated by the fact that 30 per cent of them live in isolated communities and an additional 13 per cent live in remote communities (i.e., ones that lack year-round road access).

Figure 5-10

The RHS did not ask about the causes of the activity limitations that people reported, but it is likely that chronic conditions contributed since three-quarters of people with activity limitations reported having a chronic condition – a much higher proportion than in people of comparable age without limitations. Those with activity limitations were more likely than others to report they had heart problems (47 per cent), arthritis (45 per cent), respiratory problems (31 per cent), or diabetes (27 per cent). People with multiple chronic conditions were especially likely to report being limited in the activities they could do. Because rates of chronic disease are high in the First Nations Peoples and Inuit, and even some middle-aged people have more than one chronic condition, disability rates seem likely to increase in the future (RHS National Steering Committee, 1999).

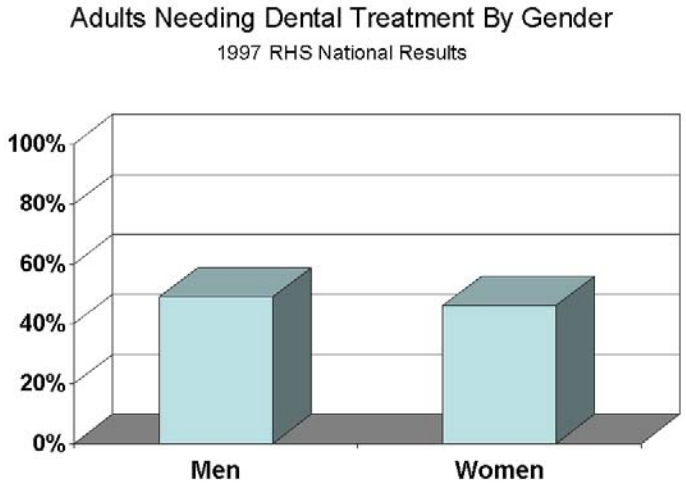
Less than a third of the people with activity limitations believed that First Nations Peoples and Inuit receive the same level of health care as other Canadians. When asked which of a list of health services needed improvement, they tended to emphasize continuing-care services such as seniors' homes and chronic care facilities, medication awareness programs, dialysis, and translation services.

DENTAL HEALTH

On a national level, the dental health of First Nations adults appears to be below average. However, more than half the population – especially women – had seen a dentist during the year prior to the survey. This suggests that the biggest need may be for better prevention of dental problems. Measures could include improved oral health habits and

possibly fluoridation of community water supplies or the use of individual fluoride supplements (RHS National Steering Committee, 1999). About 48 per cent of adults said they needed dental treatment. Almost a quarter had had dental pain or a dental problem during the previous month. These findings held constant across most communities no matter what their size, level of isolation, health transfer status, or language. Younger adults were particularly likely to need dental treatment and to have sought it during the previous year.

Figure 5-11



Mental Health

Positive mental health depends on individuals, families and communities feeling connected to each other, and to their culture and traditions. Also needed is a feeling of being connected to the past, present, and future.

Many people have lost their feeling of being connected to (…) traditions, language, and culture. They are caught in a "no-man's land" between traditional practices and the expectations of the "outside." As a result, the connection between the past, present, and future is not clear. Many historical factors have contributed to people having loss of control or power over decision making and their lives in general. This can lead to feelings of helplesness and hopelessness and an increase in mental health problems. (…)

There are many consequences of poor mental health. These include suicide, family violence and breakdown, child abuse and neglect, alcohol abuse, and crime.

Source: Labrador Inuit Health Commission, 1999g.

Although the RHS national core did not include questions on mental health, Labrador, Nova Scotia, Ontario, Manitoba, and Saskatchewan explored this topic. The Ontario survey, in particular, explored victimization in considerable detail. This was the first time a large survey with a representative sample explored such issues among First Nations Peoples.

Self-Esteem and Happiness

Labrador and Nova Scotia asked questions about what might be described as everyday emotional health – happiness, balance and self-esteem. In Labrador, 73 per cent of respondents described themselves as usually happy and interested in life. However, 24 per cent said they were only somewhat happy. Three per cent were somewhat or very unhappy. Similarly, in Nova Scotia, more than 75 per cent appeared to have good self-esteem according to one of the standard scales, agreeing with statements such as I like the way I am. Further, 55 per cent of adults in Nova Scotia reported the four aspects of their lives (physical, mental, emotional, and spiritual) were in balance most or all of the time.

The results for depression were less favourable. In Nova Scotia, 22 per cent of men and 34 per cent of women had felt depressed for two weeks or more in the year prior to the survey. In Ontario, eight to10 per cent of respondents had felt that everything is an effort most or all of the time during the previous month. Thirteen per cent of male and 18 per cent of female respondents in Ontario met the criteria for major depression during the previous year, proportions which exceeded the Canadian average. Unusually high proportions of First Nations Peoples said the depression interfered significantly with their life and activities (see Table 5-5 and Figure 5-12).

Table 5-5: Mental Health
Ontario First Nations (1997) Compared to Canada (NPHS 1994)

	Men		Women		Total	
	FN	Can	FN	Can	FN	Can
Major depression	13.3%	5.4%	18.4%	9.4%	15.9%	7.5%
The depression interferes with activities "some" or "a lot"	24.5%	13.5%	27.2%	17.7%	25.8%	15.7%
Consulted professional about emotional health in past year	13.7%	5.5%	19.4%	10.5%	16.6%	8.1%

Figure 5-12

Parenting and Victimization During Childhood

The Ontario survey also explored childhood victimization in detail. About 870 adults filled out confidential questionnaires about their experiences during childhood. Although the majority reported their parents had usually taken care of them, protected them and made them feel loved, fairly high percentages reported their parents did not like them, didn't care where they were, frightened them, or called them things like stupid, lazy, or ugly (see Table 5-6).

Table 5-6:
Ontario First Nations Adults' Experience of Parenting During Their Childhood

My parents or step-parents…	Never/Sometimes	Often/Very Often
…took care of me.	13.9%	85.1%
…made me feel I was loved.	25.0%	74.3%
…protected me.	25.1%	74.1%
…didn't care where I was.	79.4%	19.0%
…called me things like stupid, ugly, or lazy.	90.7%	9.35
…said hurtful or mean things.	90%	9.1%
…didn't like me.	92.3%	6.4%
…really frightened me.	89.3%	9.9%

Reported rates of physical and sexual abuse during childhood were extremely high with 59 per cent reporting physical abuse, much of it severe. Men were considerably more likely than women to report physical abuse during their childhood. Parents were most frequently named as the abusers with 52 per cent of victims saying their mother physically abused them while 45 per cent said their father had done so. In addition to

physical abuse, 34 per cent of the respondents in Ontario reported sexual abuse during childhood, almost all of it severe. In contrast to physical abuse, respondents were more likely to name other people or other relatives than parents as being responsible for the sexual abuse (see Table 5-7).

Table 5-7: Ontario First Nations Adult Reports of Sexual Abuse During Childhood			
Did anyone ever do any of these things to you?	**Yes**	**No**	**N/A**
Exposed themselves to you more than once	16.7%	79.8%	3.6%
Threatened to have sex with you	15.3%	80.9%	3.8%
Touched the sex parts of your body	25.6%	71.4%	3.0%
Tried to have sex with you or sexually attacked you	24.9%	72.1%	3.0%

Maintaining Mental Health

Saskatchewan took a very different approach to the issue of mental health, asking respondents which factors they themselves felt were important in maintaining mental health. Interestingly, although people considered most of the choices on the list "very important," factors such as alcohol abuse, lack of trust, and acknowledging problems ranked slightly ahead of factors such as physical or sexual abuse (see figure 5-13).

Figure 5-13

Suicide

Suicide is one of the most dramatic indicators of mental health. Two regions specifically asked respondents about it. In Labrador, 22 per cent of adults had seriously considered suicide at some time in their lives. A quarter of them (about five per cent of the total adult population) had considered it in the previous year. About 15 per cent of people had actually attempted suicide at some point. Again, a quarter of them had done so in the year prior to the survey. The figures from Manitoba were remarkably similar: 28 per cent reported having felt suicidal at some time and 13 per cent had actually attempted suicide.

Some regions also asked people about whether help was available for their mental/emotional health problems and where they turned for help. Friends and family were the most common sources in both Labrador and Manitoba followed by health professionals. Discouragingly, 25 per cent of respondents in Manitoba – and 44 per cent of those who had felt suicidal – said they had no one to turn to for help. Availability of mental health professionals may be an issue. In Manitoba, only 10 per cent had ever consulted with a professional about their mental health. Proportions were higher in Nova Scotia where 12 to 15 per cent of the population reported having consulted someone about their mental health in the past year alone. Despite this, 20 to 27 per cent of respondents reported having trouble getting help for mental health issues.

Health Services

Use of Traditional Healing Methods

Most regions asked people about traditional healing methods with widely varying results. Nationally, more than 80 per cent of adult respondents agreed a return to traditional ways would be a good idea for promoting wellness in the community. In Manitoba, 58 per cent said they would like to see a traditional healing program incorporated into the community wellness plan.

Seen a Healer or Used Traditional Remedies in the Past Year	
Nova Scotia	34%
New Brunswick	5%
Quebec	5%
Ontario	19%

The proportions of people in Manitoba who were actually familiar with traditional methods or who used them themselves were somewhat lower, but still significant. Quebec found that use of traditional medicines was more common in isolated communities, a fact which may help to explain some of the variations in traditional healing reported across the country. For instance, in Labrador, 54 per cent of adults said they were familiar with plants or methods traditionally used for healing. In Manitoba, 37 per cent reported using plants for healing and 36 per cent had seen a healer at some point in their lives. In Saskatchewan, the equivalent figure was 19 per cent. Across the regions, five to 34 per cent had consulted a healer in the year prior to the survey.

A few regions noted that use of traditional methods was highest among adults in the middle age ranges and somewhat lower in the elderly. Results from Quebec suggest that

people may either use traditional methods regularly or not at all. While five per cent of adults had seen a healer in the past year, 90 per cent had never consulted one in their lives.

Figure 5-14

Use of Western Health Services

Information on the use and availability of western health services was somewhat contradictory. New Brunswick, Quebec and Ontario asked people what types of health practitioners they had consulted during the year prior to the survey. The results show that 50 per cent or more had consulted doctors while anywhere from nine to 60 per cent had consulted a nurse. The difference in the figures for nurses may be attributable to the fact that more isolated communities would typically have a health centre or station staffed by nurses whereas people in urban communities such as those in the Maritimes could visit doctors in the community itself or in nearby towns.

Table 5-8: Consultations with Health Professionals During the Past Year
Percentage of Respondents Who Had Consulted A…During the Previous Year

	GP/Family Doctor	Nurse	Medical specialist
New Brunswick	49%	9%	8%
Quebec	54%	60%	32%
Ontario	67%	30%	24%

However, availability of health care seemed to be an issue in some areas. In Ontario, eight per cent said they had been in need of health services that they had not received at some point during the year prior to the survey. In Manitoba, 18 per cent said this had happened at some time in their lives. Manitoba's results also showed most people

perceived the supply of health professionals to be inadequate. For instance, only 35 per cent believed there were enough nurses while even lower proportions felt there were enough doctors, dentists, interpreters, and specialists (see Figure 5-15).

Figure 5-15

Apart from sheer geographic availability, discrimination was also an issue in some cases and appeared to occur more frequently outside the community than within it (see Table 5-9).

Table 5-9: Discrimination in the Health Care System

Percentage of respondents in Manitoba who report discrimination from health care workers:	
Inside the community	16%
Outside the community	30%
Percentage of respondents in Labrador who were treated with respect by health care workers:	
Inside the community	96%
Outside the community	89%

Although people across the country reported the availability of First Nations/Inuit health professionals had improved over time, results from Saskatchewan showed there was still some room for progress as only 36 per cent of respondents had ever received services from a Native health professional. Of these, most reported the professional in question was a community health representative, followed by nurses and traditional or spiritual healers.

Opinions About the Quality of Health Services

Nationally, almost half the respondents to the RHS thought the health services provided to First Nations Peoples and Inuit were not equal to those provided to other Canadians. Only a third thought they were equal. French-speaking First Nations Peoples and Inuit were more likely to think health services were comparable. Groups that were particularly dissatisfied were those with chronic conditions, activity limitations, people living in small and isolated communities, and people in communities that were not engaged in health transfer. It is not clear whether this is because health transfer improves the services; because larger, developed communities are more likely to transfer; or a combination of the two.

Health Transfer: An Issue of Profile?

Manitoba asked respondents if health services in their community had been transferred to Band control. About 355 were unable to say, while 11% said yes, 175 partly, and 37% no.

In fact, at the time, 25% of communities in Manitoba had signed transfer agreements and another 495 were actively engaged in pre-transfer projects. Onlv 26% were not involved in transfer.

Those who felt that services were unequal were asked whether any of a list of services needed to be improved. About three-quarters of the respondents answered yes to all of the items indicating a desire for better services across the board. However, the top choices for improvement were:

- paediatric care
- preventive programs such as disease prevention, diabetes education, and medication awareness
- continuing care such as home care and homes for the elderly
- mental health programs

There was broad agreement on these priorities. In addition, people living in small communities and those who spoke an Aboriginal language emphasized the need for translation services. Those with poor health, activity limitations and chronic conditions placed special emphasis on home care, chronic care facilities and preventive education.

Table 5-10: Health Services in Need of Improvement: Percentage of People Who Feel Health Services are Unequal Who See a Need for Improvements In… National RHS results, 1997	
…paediatric services	86%
…disease prevention	84%
…medication awareness	83%
…diabetes awareness	82%
…homes for the elderly	82%
…home care	81%
…mental health services	81%
…more health staff	78%
…chronic care facilities	77%
…dental services	77%
…translation services	73%
…kidney dialysis	72%

Summary

The results for adult health suggest people are living in environments where incomes and employment levels are low and significant proportions of households have trouble meeting their basic needs. While aspects such as infrastructure (especially housing) and Aboriginal control of programs have improved, problems persist in terms of alcohol use (specifically binge drinking), employment and the availability of First Nations or Inuit health professionals.

The vast majority of respondents felt tradition was important. Most participated in traditional activities at least occasionally. However, some sense that part of the culture has been lost is suggested by the fact that children are learning Aboriginal languages through school programs rather than in the community and some adults report not understanding Aboriginal culture.

Information on diet is limited, but suggests adults have better dietary habits than youth. The survey also shows that in some regions wild food still constitutes a major part of people's diets. However, obesity is common. Smoking rates are also high, a fact that is of concern not only because of its impact on the health of the smokers themselves, but also because of the number of household members exposed to second-hand smoke.

Measures of health status give cause for concern. Rates of chronic conditions are higher than average and in many cases appear to be increasing over time. At least 15 per cent of adults have some degree of activity limitation and many of them live in isolated communities, a fact which affects the types of support services available to them. Many adults report dental problems despite recent visits to the dentist, suggesting a need for more preventive services.

While roughly three-quarters of adults appear to be reasonably happy and enjoy good self-esteem, information from Ontario suggests higher-than-average proportions suffer from major depression. Significant proportions of adults experienced physical or sexual

abuse during their childhood. In this context, the proportions reporting difficulty in accessing the help of a mental health professional are a serious concern.

With respect to health care, there is widespread support for making traditional healing services available, although smaller proportions of adults routinely use these services at present. People report concerns about the availability of the usual western health services. Most feel the services their community receives are not as good as those provided to other Canadians. Improvements are desired in many areas, but particularly in paediatric services, prevention programs, continuing care, and mental health services.

The Health of Older Adults

To date, few studies have focused on the health of older Aboriginal Peoples. What research there is comes from the United States. It suggests that older Native Americans have good networks of family and friends and are more likely than non-Aboriginal Americans to be living with their children and grandchildren. However, they usually live in poorer conditions, have difficulty accessing culturally-appropriate health services, develop health problems at younger ages than other Americans, and have lower life expectancy (Robert, 1991, and Cuellar, 1990, cited in RHS National Steering Committee, 1999). Because of this literature indicating Native Americans develop some of the diseases associated with aging at a younger age than average, the 1997 RHS analysis defined elder's health as that of people age 45 and older.

According to the RHS, 59 per cent of older adults are married. About 39 percent speak an Aboriginal language at home with the older they are, the more likely they are to speak an Aboriginal language. At least 39 per cent of the adults age 45 and older attended residential schools at some point in their lives and they remained there for an average of six years. As mentioned in the previous chapter, this did not have a measurable impact on their health, but many felt it had had a negative effect on their knowledge of their own culture and language. Few older adults finished high school. Many did not go as far as Grade 6. Of the people age 45 to 54, only 14 per cent had completed high school. In older groups, even fewer had done so. These facts suggest this group will continue to need translation services and health workers seeking to provide information to them will need to adapt their materials to accommodate differences in language and education levels.

Consistent with the American research, the RHS found that adults 45 and older reported far more chronic conditions – such as heart problems, hypertension, diabetes, or arthritis – than other Canadians of comparable age. At ages 45 to 64, one person in five had diabetes. After age 65, one in three was affected. Many diabetics also had high blood pressure or heart disease. Rates of these co-morbid conditions rose with increasing age.

Table 6-1: Chronic Health Problems Among Older Adults First Nations/Labrador Inuit and Canada (percentage)									
		45 to 54 years		55 to 64 years		65 years and older		Total 45 and older Age-adjusted	
		FN/I	Cdn	FN/I	Cdn	FN/I	Cdn	FN/I	Cdn
Heart problems	**M**	14%	4%	24%	8%	44%	18%	13%	4%
	F	10%	2%	24%	5%	30%	15%	10%	4%
Hypertension	**M**	29%	9%	36%	5%	49%	23%	22%	8%
	F	29%	10%	37%	22%	59%	32%	25%	10%
Diabetes	**M**	18%	3%	18%	7%	28%	11%	11%	3%
	F	22%	3%	34%	5%	32%	9%	16%	3%
Arthritis/	**M**	21%	10%	32%	21%	49%	33%	18%	10%
rheumatism	**F**	32%	18%	47%	33%	57%	47%	27%	18%

Figure 6-1

It was not possible to establish directly from the survey whether these chronic conditions caused activity limitations. What is known, however, is of the people age 45 and older, one in four was limited in his/her activities around the home; one in eight was unable to leave home and required help with personal care; and one in three had hearing problems.

Hearing Problems
Nationally, 38% of First Nations/Inuit men and 35% of women reported difficulty hearing what is said when having a conversation with another person. (Numbers are for the general adult respondents and not necessarily older adults.)

Older First Nations Peoples and Inuit were twice as likely as other Canadians to have a smoking habit. The smokers reported poorer health than non-smokers or ex-smokers and were more likely to have each of the chronic diseases that the survey asked about. The higher the pack-day (a measure of duration and heaviness of smoking), the more likely smokers were to report having asthma, breathing problems or hypertension. Exposure to second-hand smoke may also be an issue for older adults since 62 per cent of all First Nations and Inuit adults smoke. Elderly people and children are at increased risk for the negative health effects of second-hand smoke because of their smaller lung capacity.

Older adults were less likely than other First Nations Peoples and Inuit to report they needed dental care. It is not clear if these adults had more traditional diets for much of their lives and therefore enjoy better dental health or if on the contrary they need less dental treatment because they now have dentures.

Like younger respondents, about half of the older adults believed that First Nations Peoples and Inuit do not receive the same quality of health care as other Canadians. They thought almost all of the services mentioned to them needed improvement. They were particularly likely to want improvements in disease prevention, medication awareness, diabetes education, and paediatric care (almost everyone – no matter what their age – wanted improvement in paediatric services). However, older adults tended to be more satisfied with community progress in other areas. Besides seeing improvements in housing, many older adults felt there had been progress in returning to traditional ways, school programs to teach children about Aboriginal culture, the use of Aboriginal languages, and First Nations and Inuit control of programs. They were less likely to believe there had been progress in reducing the abuse of alcohol or drugs, employment opportunities or the availability of First Nations and Inuit health care workers.

Like most of the RHS respondents, 80 per cent of older adults agreed a return to traditional ways would improve community wellness. More than two-thirds said they had seen progress in areas such as traditional ceremonies, renewal of Native spirituality and traditional approaches to health. About half felt there had been progress in returning to the traditional roles of men and women.

Summary

Few previous studies have focused on the health needs of older adults. The RHS results contain some implications for the provision of health services. Chronic conditions are prevalent in this group. That suggests a need for secondary and tertiary prevention services to help people cope with these conditions and to delay or prevent complications of diseases such as diabetes. Those who have treatment such as surgery or dialysis will need programs to slow the progression of their disease and to improve their quality of life during and after treatment. Education may be a part of these efforts to minimize problems since many older adults indicated they wanted better education about medication, diabetes and disease prevention. These educational efforts will need to take into account that many older people have little formal education and many speak an Aboriginal language.

Besides prevention programs, older adults will need health services to treat their conditions. Because of their activity limitations, many are likely to need transportation, medical escorts and translation services to enable them to receive treatment. Supports such as home care services will also be needed to enable people to continue to live in their home community (RHS National Steering Committee, 1999).

Conclusion

Because of its regional focus and regionally-directed process, the 1997 RHS produced results on two levels: providing data and developing research capacity within First Nations/Inuit groups in each region. The regionally-driven process also resulted in wide distribution of the data to individual communities and tribal councils. The focus on regional priorities produced an incredible diversity in the topics covered, from regions that focused on youth, to those that asked batteries of questions on specific topics such as gambling, to the regions that complemented their surveys with extensive use of qualitative approaches. While this diversity limits the amount of national data that can be extracted, it provides at least a taste of information on many different topics.

Consistent with First Nations and Inuit traditions, many of the surveys adopted a more holistic view of health than is usually the case on national surveys. Thus, there is lots of material on mental and emotional health as well as on the larger context – issues of tradition, language, relationships between community members, and community conditions. Some of the material – in particular, the information about mental health, abuse and traditional healing – has never before been available for a large, representative sample.

The surveys found that most children were in good health. The major problems seemed to be respiratory conditions such as asthma, bronchitis, allergies, and ear infections. In older children, obesity was also an issue. Information from Ontario's survey suggests that First Nations children may be more likely than average to exhibit signs of conduct disorder (direct or indirect aggression, property damage, etc.), but less likely to have symptoms of hyperactivity. Nationally, however, most children were said to get along with their families and to have no more behavioural or emotional problems than other children their age. This was most likely to hold true for younger children with larger proportions of parents reporting problems after age 12.

The picture for youth (12 to 17 or 18 years) was less positive. Although physical health was generally good at this age, eating habits and weight were not optimal while substantial proportions smoked and had used alcohol and drugs. Community conditions may contribute to this picture as less than half of youth report their community has any sport or cultural facilities. Significant proportions of youth in Ontario reported instances of physical or sexual abuse. Ten to 20 per cent reported problems in their relationship with family. Some showed signs of depression and anxiety. Despite this, the majority of youth appear to get along well with their families and relatively few report symptoms of

conduct or emotional disorders. Most youth appear to be optimistic about the future and report hopes for education, employment and career success.

Adults reported health status declines most noticeably. Significant proportions of adults report their household income is insufficient to meet basic needs and although diet is better than in youth, obesity continues to be common. Smoking rates are high and clearly correlate with health problems. Reported rates of chronic conditions such as hypertension, heart disease or diabetes are considerably above national averages and appear to be rising. While the majority of adults report they are reasonably happy, significant proportions suffer from major depression and report having considered or attempted suicide at some time in their lives. Most adults agree that returning to traditional ways would promote community wellness, although smaller proportions report actually using traditional healing methods themselves. There are concerns about the existing health services: not only are there problems with availability of different types of services, but most adults also feel the services First Nations Peoples and Inuit receive are not as good as those provided to other Canadians. Large proportions would like to see improvements in preventive programs, continuing care and mental health services.

The results for older adults are similar. Older adults reported higher-than-average prevalence of chronic conditions. One in four was limited in his/her activities around the home with one in eight being completely housebound. Like younger adults, those 45 and older felt most health services needed improvement. They were particularly likely to want improvements in disease prevention, medication awareness and diabetes care. However, health care initiatives directed at this group will need to take into account that older adults tend to have less formal education and are more likely than others to speak an Aboriginal language.

The 1997 RHS produced valuable information on a very wide range of topics and permitted a focus on specific groups such as children, youth, adults, and older adults. With its broad scope – ranging from information about the determinants of health through to health status and the use of health care systems – the data will continue to be useful to First Nations and Inuit communities as they plan health programs, develop policy, advocate on behalf of their communities, and assess progress in health.

Appendix 1

National and Regional Topics Included in the 1997 RHS[10]

Children

National Core Topics for Children:

Sex
Birth weight
Breast-feeding
Health as rated by parents
Health problems
Lifetime experience of serious injuries
Emotional/behavioural problems
Relationship with family
Knowledge of Aboriginal culture

Regional Topics for Children:

	Lab	N.S.	N.B.	Que.	Ont.	Man.	Sask.	B.C.
Birth weight[11]	●							
Breast-feeding			●					
Mother's prenatal habits		●				●		
Developmental level	●							
Nutrition		●						
Weight		●						
Leisure habits		●			●			
Conduct disorder					●			
Hyperactivity					●			
Emotional disorder					●			
Injury		●						
Community facilities/ characteristics for children					●			
Tobacco/alcohol/substance use		●				●		
Leisure habits of school-age children		●						
Language and culture		●					●	

[10] Results are not included for Alberta because Alberta did not publish a regional report.
[11] Topics such as birth weight and breast-feeding, that also appear in the national core, are mentioned in the regional topics if the regional questions added some new dimension to the information.

Youth

National Core Topics for Youth:

National content for youth was the same as for children

Regional Content for Youth:

	N.S.	Ont
Leisure activities	●	
Nutrition and traditional foods	●	
Self-rated health	●	●
Health problems	●	
Injuries	●	
Dental health	●	
Smoking, alcohol, gambling, drugs	●	●
Sexual practices	●	
Mental health and self-esteem	●	●
Body image	●	
Hopes and dreams		●
Conduct disorder		●
Hyperactivity		●
Emotional disorder		●
Childhood victimization, parenting, abuse		●
Aboriginal language and culture	●	●

Adults

National Content for Adults:

Demographics (age, sex, marital status, family composition)
Languages
Education
Non-traditional use of tobacco
Chronic conditions
Dental health
Activity limitations
Residential schools attendance
Opinions about progress in community wellness
Opinions about health services in need of improvement

Regional Content for Adults:

	Lab.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	B.C.
Language, tradition, culture	●	●			●		●	
Socio-economic variables		●	●	●	●	●	●	●
Income and food sufficiency	●					●		
Mental health	●	●			●	●	●	
Use of mental health services		●			●	●		
Suicide	●					●		
Parenting, victimization, abuse during childhood					●			
Social support			●					
Residential schools		●				●	●	●
Addictions (alcohol, drugs, substances)	●	●			●	●	●	
Addiction services	●							
Gambling		●					●	
Tobacco control and quitting		●	●			●	●	
Sexual health: Pap smear, mammogram, breast self-exam	●		●	●	●	●		
Safe sex and HIV		●				●	●	
Leaving home for childbirth	●					●		
Nutrition and wild food	●	●	●	●		●		
Weight	●	●	●			●		
Exercise			●				●	
Other chronic conditions			●	●				
Diabetes – type		●				●		
Age at diagnosis of chronic conditions							●	●
Injuries and safety habits		●	●					
Relocation	●					●		
Community facilities					●		●	
Traditional healing	●	●	●	●	●	●	●	
Access to health care					●	●		
Racism in health care	●					●		
Native health professionals							●	
Health transfer						●		

Older Adults

National Core Topics for Older Adults:

National content for older adults was the same as for adults

Regional Content for Older Adults:

National content for older adults was the same as for adults

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