

# Quebec Region First Nations Regional Longitudinal Health Survey **2002**



Report on First Nations  
Living in Communities





**COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX  
DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR**  
**FIRST NATION OF QUEBEC AND LABRADOR  
HEALTH AND SOCIAL SERVICES COMMISSION**

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## Preamble

The FNQLHSSC research team is proud to present its report on First Nations living on community as part of the *First Nations Regional Longitudinal Health Survey 2002*.

Planning for this second wave of the survey began in 2000 in all ten Canadian provinces. The data collection finally got underway in 2002, after several years of planning and negotiations with regard to funding. Twenty-three communities in the Quebec region, along with three urban centres (Montreal, Quebec City and Val-d'Or) took part in the survey. More than 4,000 survey interviews were held with children, adolescent and adult respondents.

Following the completion of the data collection phase in 2003, the FNQLHSSC research team began working on the regional report. Three years full of challenges and enriching experiences spanned the time between the end of the data collection in the communities in the Quebec region and the publication of the regional report.

As you will note, three reports have resulted from this research project. The first focuses on the health and well-being of the First Nations members who live in the communities. The second concentrates on those who live in urban centres away from the communities, while the third deals with smoking among First Nations.

The FNQLHSSC was very pleased with the interest and enthusiasm demonstrated by the members of the communities. We achieved an outstanding participation rate of 85.5% of the target population! This result may be explained, in part, by the uniqueness of the survey, which was conducted in its entirety by the First Nations through a holistic approach encompassing many health determinants.

This survey is also longitudinal in nature. In other words, it is conducted at specific intervals every few years over a defined period of time to track the changes that affect the health and well-being of the members of the participating First Nations.

The FNQLHSSC strongly hopes that the experience gained through the second wave of this unique survey will usher in a new era for community research among First Nations. Indeed, it has opened up new vistas in the research sector and as such, constitutes a model for First Nations control of research which allows for the demonstration of scientifically and culturally validated data.

This regional report is a source of valuable information which will help us better understand the overall state of health of Quebec First Nations members and identify the priorities that we must focus on in the months ahead in order to improve the health and well-being of individuals, families, communities and Nations.

In the following pages, you will find a portrait describing the health of our First Nations members in 2002. The FNQLHSSC believes that a more in-depth examination which integrates a cultural approach covering all the results presented here is necessary if we are to accurately target and guide future interventions. The FNQLHSSC therefore recommends to the leaders and decision-makers at the community and regional levels that such an exercise be undertaken to broaden the interpretation of the results presented here. This report is not an end in itself, but rather a tool that provides a window into the health and well-being of our First Nations brothers and sisters in the Quebec region (excluding the Cree and the Inuit).

We hope you enjoy your reading!





## Acknowledgements

The FNQLHSSC expresses its gratitude to all the Chiefs who, on behalf of their communities, accepted the invitation to participate in this survey. Special thanks go to the communities' health Directors for taking up this challenge with us and for their trust and collaboration throughout the survey, as well as to the managers of the health facilities who opened their doors to us for the collection of data.

We also wish to thank all the survey interviewers – our ambassadors who played a front-line role in the survey – and all the community members who gave their time to take part in the survey.

The members of the Quebec First Nations Regional Research Committee also come in for special praise. We are grateful to them for the guidance and advice they gave us throughout the project.

Our thanks also go to the First Nations organizations which, along with the Quebec City Native Friendship Centre, collaborated with us in the preparation and conduct of the survey.

We gratefully acknowledge the assistance we received from the research team at the First Nations Centre of the National Aboriginal Health Organization. Its members helped us develop our regional methodology and procedures for the survey, and shared their knowledge with the FNQLHSSC research team.

Finally, we wish to thank the FNQLHSSC staff and research team for their invaluable support and expertise, which have ensured the successful completion of this vast project.

To one and all, megwetch for the support, trust and understanding you have shown throughout the project.

Nancy Gros-Louis Mchugh  
Research Technical Coordinator



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## Section 1: Introduction

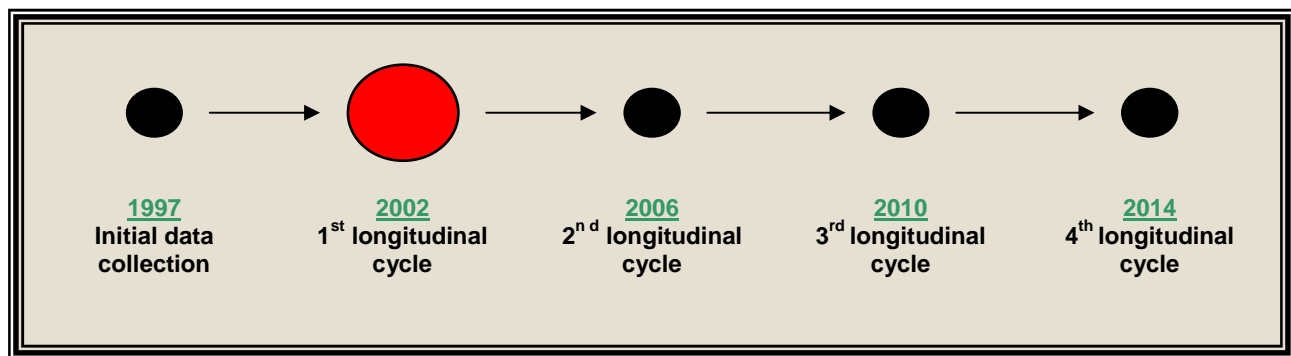


## Introduction

Rooted in a holistic vision, the First Nations Regional Longitudinal Health Survey (FNRLHS) for the Quebec region provides an overall portrait of Quebec First Nations' health, including descriptive and statistical information about the various health issues and the specific socio-cultural context of these groups. The survey's results accordingly identify problems and progress in holistic health. This survey marks the second phase of a First Nations health research project for which the governance, research methodology and coordination come for the first time under the full responsibility of First Nations authorities.

In 1997, the Chiefs Health Committee and the Assembly of First Nations (AFN) decided, in response to the need for information on First Nations health, to make the FNRLHS a quadrennial survey, i.e., one based on four-year cycles running until 2014, as illustrated by the following graph:

**Graph 1: Longitudinal evolution of the FNRLHS**



The 2002 wave of the FNRLHS was coordinated nationally by the First Nations Centre (FNC) at the National Aboriginal Health Organization (NAHO). Ten regional First Nations organizations conducted and supervised all aspects of the survey for their respective regions. The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) oversaw the survey in the Quebec region.

### 1.1 Survey Objectives


The three questionnaires created for the survey (one each for adults, adolescents and children) were designed to meet specific objectives, which are to:

- “Obtain information on the demographic characteristics that could affect the state of health of First Nations members living in Quebec.
- Obtain information regarding the state of physical health of First Nations members living in Quebec.
- Obtain information regarding the well-being of First Nations members living in Quebec.
- Obtain information regarding the lifestyle habits of First Nations members living in Quebec.
- Obtain information regarding the perceptions of health services by First Nations members living in Quebec.”<sup>1</sup>
- Obtain the most relevant information possible regarding the various problems encountered in the communities of First Nations members living in Quebec.
- Achieve all of the above objectives for each age group identified for the purpose of this research, i.e., children, adolescents and adults.

### 1.2 Ownership, Control, Access and Possession (OCAP)

This project is based on the principles of OCAP. Implemented by the First Nations of Canada, the principles of Ownership, Control and Access were first developed by the FNRLHS Steering Committee in 1998, with the

<sup>1</sup> FNQLHSSC, 1999, p. 4.



'Possession' principle added at a later date. This set of ethical rules constitutes the expression of First Nations' self-determination in research and information creation and management. The following definitions set out these concepts more clearly:

### **“Ownership**

Ownership refers to the relationship of a First Nations community to its cultural knowledge/data/information. The principle states that a community or group owns information collectively in the same way that an individual owns his personal information. It is distinct from stewardship. The stewardship or care taking of data or information by an institution that is accountable to the group is a mechanism through which ownership may be asserted.

### **Control**

The aspirations and rights of First Nations Peoples to maintain and regain control of all aspects of their life and institutions extend to research, information and data. The principle of control asserts that First Nations Peoples, their communities and representative bodies are within their rights in seeking to control all aspects of research and information management processes which impact them. First Nations control of research can include all stages of a particular research project – from conception to completion. The principle extends to the control of resources and review processes, the formulation of conceptual frameworks, data management and so on.

### **Access**

First Nations Peoples must have access to information and data about themselves and their communities, regardless of where it is currently held. The principle also refers to the right of First Nations communities and organizations to manage the information that concerns them as a group and make decisions regarding access to their collective information. This may be achieved, in practice, through standardized, formal protocols.

### **Possession**

While ownership identifies the relationship between people and their data in principle, possession or stewardship is more literal. Although not a condition of ownership per se, possession (of data) is a mechanism by which ownership can be asserted and protected. When data owned by one party is in the possession of another, there is a risk of breach or misuse. This is particularly important when trust is lacking between the owner and possessor.

Most importantly, OCAP is forward-looking and pro-active. It opens up new avenues for the expression of self-determination and self-governance in the areas of research and information and provides a measure of hope for positive change.<sup>2</sup>

It is the application of OCAP that primarily distinguishes the FNRLHS from other First Nations surveys. In doing so, it is the first research project on First Nations health for which the governance, methodological design and coordination come fully under the responsibility of the First Nations authorities.

A national ethics review concluded that the survey respects the privacy of the respondents. Also, the use of consent forms contributed a great deal to the principle of voluntary participation. All aspects related to the data protection protocols are based on agreements and methods specific to First Nations. Publication of the FNRLHS data aims for maximum dissemination to ensure that First Nations can make the greatest possible use of it, while at the same time protecting each community's information. Lastly, any publication is subject to the approval of First Nations authorities at each level (national, regional and local).

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<sup>2</sup> NAHO, 2004



### 1.3 Methodology

Descriptive in nature, the survey consists in studying a representative sample of the population by means of a written questionnaire in electronic format administered in the form of a structured interview. This method was chosen for the following budgetary, technical and ethical reasons:

- Modest costs because the survey is based on a sample, not on the entire population under study
- Respect of respondents' confidentiality and gathering of information on certain subjects that cannot be directly observed for ethical reasons
- Rapid and easy to administer
- Possibility of standardizing information, thus making analyses and comparisons easier

#### 1.3.1 Total Population

The total population is defined as the entire population in the survey. For the purpose of the FNRLHS, it includes all Quebec First Nations members living in the Quebec region. A census conducted by Indian and Northern Affairs Canada (INAC) in 2001 established that there were 63,315 First Nations members living in ten different Nations in Quebec. Of that number, 44,274 were living on-community, while 19,041 were living off-community.

#### 1.3.2 Designated Population

The designated population is made up of the members of the total population who present certain characteristics. For the FNRLHS, the designated population includes all on-community First Nations members, excluding the Cree, the Inuit, and the Mohawks of Kahnawake, who did not participate in the survey.<sup>3</sup> The rule stipulating that only on-community persons were to be included in the designated population did not apply in the case of the Malécites of Viger. In 2001 only two members of this Nation lived on-community. The designated population thus includes off-community Malécites. On the basis of the total population that was established, a designated population of 27,330 First Nations members living in the communities of nine Nations was identified.

#### 1.3.3 Designated Sample

A two-stage sample was constructed for the FNRLHS in the Quebec region. The first stage involved the use of cluster sampling to select the participating communities for each Nation. The second stage involved carrying out non-proportional stratified sampling for each cluster that was established.

#### 1.3.4 Cluster Sampling

To produce a representative sample of the participating communities, we categorized them according to demographic size, as follows: large (1,500 inhabitants or more), medium (301 to 1,499 inhabitants) and small (300 inhabitants or less).

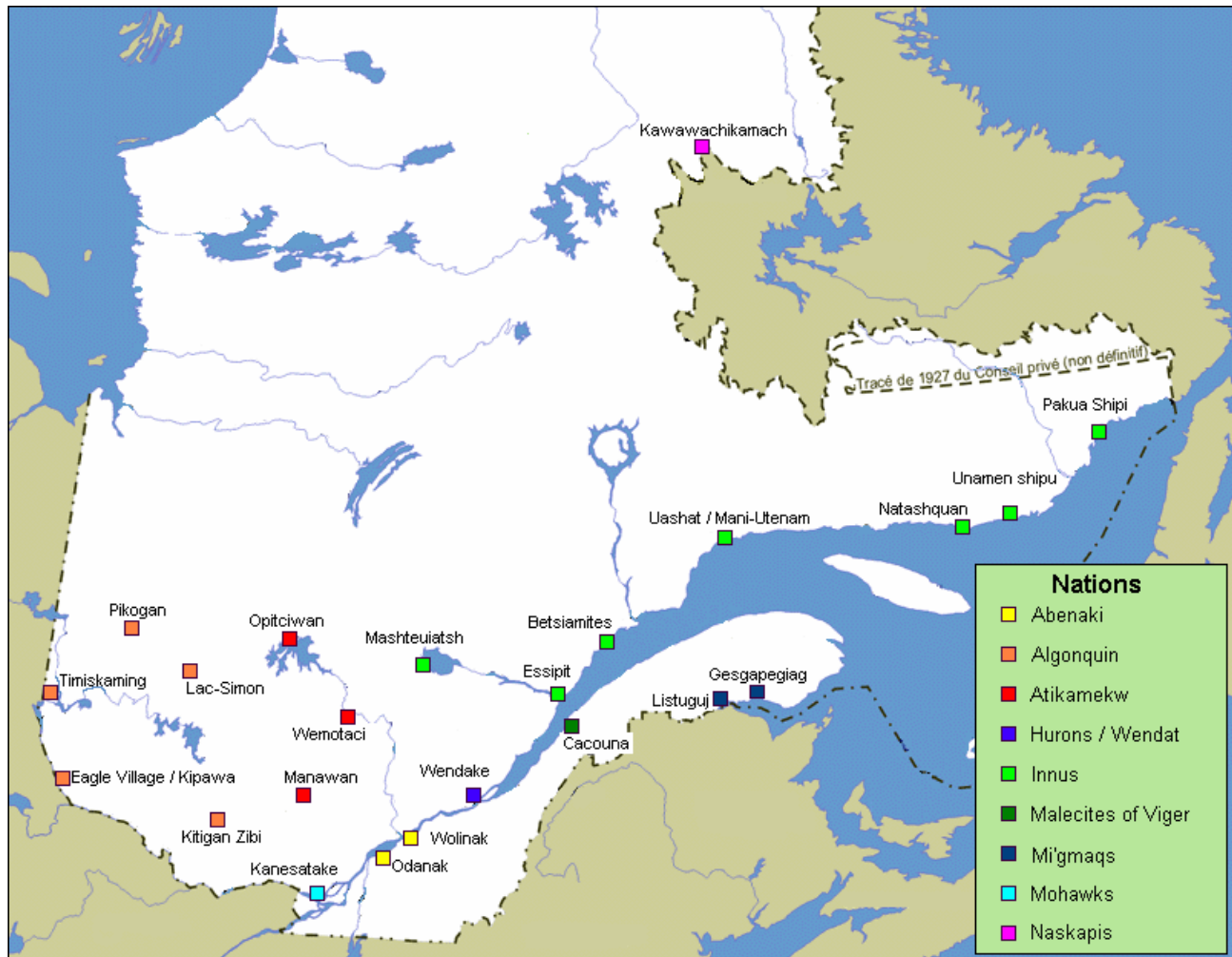
The initial selection of participating communities was carried out by means of cluster sampling, with one community considered the equivalent of one cluster. All of the large communities were automatically included in the sample. The medium and small communities were then randomly selected. Any communities that declined to take part in the survey were replaced by ones that were not part of the initial selection. The following table describes the selection of the participating communities and the map below shows the distribution of the Nations and communities that are participating in the FNRLHS.

<sup>3</sup> The results for the Mohawk Nation are for Kanesatake only because Kahnawake decided not to take part in the survey and Akwesasne is in Ontario region.

Table 1: Selection of participating communities

Nation	Community	Part of initial selection	Replacement community	Final selection
Abenaki	Odanak	X		X
	Wôlinak	X		X
Algonquin	Barriere Lake		X	
	Eagle Village-Kipawa	X		X
	Kitigan Zibi	X		X
	Lac Simon	X		X
	Long Point		X	
	Pikogan	X		X
	Timiskaming		X	X
Atikamekw	Manawan	X		X
	Opitciwan	X		X
	Wemotaci		X	X
Huron/Wendat	Wendake	X		X
	Betsiamites	X		X
Innu	Ekuanitshit		X	
	Essipit		X	X
	Mashteuiatsh	X		X
	Matimekush		X	
	Natashquan		X	X
	Pakua Shipi	X		X
	Uashat Mak Mani-Utenam	X		X
	Unamen Shipu	X		X
Malécite				X
Mi'gmaq	Gesgapegiag	X		X
	Listuguj	X		X
Mohawk	Kanesatake	X		X
	Kahnawake	X		
Naskapi	Kawawachikamach	X		X


Map 1: Nations participating in the 2002 wave of the FNRLHS: Quebec region



### 1.3.5 Stratified Sample

Initially, a non-proportional stratified sample according to age group and sex was constructed for each selected community in order to represent the designated population. The sample was designed in such a way as to ensure that each of these strata met the following criteria:

- A confidence level of 95%: Confidence level is an indicator of the level of certainty in arriving at an estimate that encompasses the average value for the population stratum.
- A proportion of 20%: Proportion in the sample is an unbiased estimator of a real proportion in the population. For the FNRLHS, this means that if we observe a phenomenon in 20% of the persons making up a sample stratum, we must be able to say without bias that this phenomenon is present in 20% of the population stratum.
- A coefficient of variation not exceeding 40%: Coefficient of variation is a percentage measure of the distribution of observations around the average value of the sample.
- A margin of error ranging from + 8% to – 8%: Margin of error refers to the margin by which the true result in the population may vary from the sample result. For example, if 40% of persons in a stratum are seen to live in apartments, with a margin of error at plus or minus 8%, the proportion for this population can vary between 32% and 48%.



Unfortunately, the sampling plan that was established proved too costly for the available funding. The scope was therefore adjusted by applying the above-mentioned characteristics to a sample that was stratified according to Nation, community size, age group and sex. Despite these efforts to rectify the situation, the representativeness of the revised strata still suffered. Thus, to obtain an acceptable level of representativeness for the smaller communities, they were combined with the medium ones. The population is therefore stratified into two sizes (large and medium/small) rather than three (large, medium and small).

Respondents were selected from lists of members of the participating communities. From these lists, a sample and a list of replacement respondents were created for each stratum, in simple random manner. Persons who were selected but declined to take part were replaced by persons on the replacement list.

#### 1.3.6 Final Sample

Although a designated sample is relatively easy to construct, very rarely will all of the persons included in it agree to participate in the survey. Thus, the final sample for a survey almost never includes as many participants as were in the designated sample that was initially established. A total of 1,949 adults, 798 teenagers and 1,038 children made up the final sample for the FNRLHS.

As we saw earlier, standards were set for our sample, i.e., confidence level of 95% and proportion of 20%. The confidence interval for the children's sample was 2.3%.

### 1.4 Data Collection

#### 1.4.1 Selection and training of interviewers

As mentioned above, the FNRLHS stands out from other surveys, due in particular to the involvement of First Nations members in every stage of its completion. In keeping with this principle of involvement, the FNQLHSSC gave priority to using First Nations members as interviewers. The FNQLHSSC first asked the Directors of health centres or clinics in each participating community to recruit potential interviewers. It then hired, on a contract basis, the persons who had been recommended and were considered as being the most competent for fulfilling the various duties necessary for conducting the interviews. Hiring First Nations members living in the communities presented certain advantages – each interviewer's knowledge of the community and its language of use was invaluable for ensuring better quality in the data obtained. Their knowledge helped limit problems in interpretation and in respondents' understanding of certain concepts that were difficult to translate. It is important also to note here that respondents demonstrate more trust when a person from their own community administers a questionnaire than when it is administered by a non-Aboriginal person whom they have never met before.

All of the selected interviewers signed an oath of secrecy before a commissioner of oaths and attended three days of training, which was held in Quebec City from September 30 to October 2, 2002. This training, provided by the FNQLHSSC, covered the following topics:

- History of the FNRLHS
- Sampling
- Consent to divulge information and data protection
- Interview techniques
- Methods for dealing with various situations that could arise during interviews
- Use of laptop computers to administer computerized questionnaires
- Record-keeping, sending of material and production of short reports

When required, training was given in the participating communities to new interviewers who had been hired to replace ones who resigned during the data collection process.

#### 1.4.2 Data entry, processing and analysis tools

All of the interviews conducted for FNRLHS 2002 in the Quebec region were computer-assisted. Each interviewer was provided with a laptop computer containing the child, adolescent and adult questionnaires. These computerized questionnaires were created on Lotus Notes under the supervision of the FNC (NAHO). Every questionnaire completed by the interviewers was automatically encrypted and inaccessible to any person, thereby ensuring the confidentiality of the respondents' answers. After each day's work, the interviewers uploaded the completed interviews from their laptops to the regional server of the FNQLHSSC. After all of the interviews were completed, the regional data were decrypted and transferred to a Microsoft Excel file, under the supervision of the FNQLHSSC, in order to serve as a raw database. This database was put onto a CD-ROM and sent to the FNC for standardization with the databases sent by the other regions (a step necessary for the National analysis) and for cleaning with SAS (Statistic Analysis System) and SPSS (Statistical Package for Social Sciences) software. When these steps were completed, the FNC sent the cleaned data to the regions. In the Quebec Region, the FNQLHSSC's research sector carried out the data analysis using SPSS and Microsoft Excel.

#### 1.4.3 Interpretation sessions by third parties

The FNQLHSSC held an interpretation session on June 15, 2005 at the Clarion Hotel in Quebec City. The purpose of this exercise was primarily to discuss the preliminary results with persons delegated by the health centres in all of the participating Nations. These persons were required to be familiar with the health problems in their communities. The meeting was held as a roundtable discussion during which the participants gave their opinions and ideas concerning the various problems raised by the survey. The main themes covered were:

- Traditional medicine
- Health care (overall)
- Nutrition
- Medical illnesses and problems
- Homecare
- Non-Insured Health Benefits (NIHB)
- Foetal alcohol syndrome/Foetal alcohol effect (FAS/FAE)
- Women's health
- Obesity
- Birth rate
- Holistic health
- Traditional cultural events
- Spirituality
- Religion
- Aboriginal languages

The interpretation session proved to be highly constructive by giving the communities an opportunity to contribute to the results interpretation stage of the FNRLHS. Its other benefits included allowing the FNQLHSSC research team to consider, from various perspectives, several problems that had not been explored. Lastly, it clearly showed that working in collaboration with the communities is an important step for ensuring the success of the survey.

##### 1.4.3.1 Questionnaires

The questionnaires were designed using a holistic approach that covered not just the health of First Nations members but also all aspects that can influence it. Further to dealing with health overall, the survey's questionnaires were elaborated to take account of the First Nations' cultural context and priorities. The Quebec region added a regional component for the adolescent and adult questionnaires. As mentioned previously, the three questionnaires were computerized to facilitate the work of the interviewers.

### **A) Questionnaire for children (0 to 11)**

The children's questionnaire was completed in the form of a guided interview. Interviewers spoke to parents or guardians, selected on a random basis, who answered by proxy for their children. Child respondents were designated in random fashion. The questionnaire took about 35 minutes to complete and was made up of questions on the following topics:

- Household/family composition
- Parental education
- Child's education – level, performance, Aboriginal Head Start
- Height, weight – at birth and currently
- Breastfeeding
- Smoking – exposure to second-hand smoke (foetal, at home)
- Language – comprehension, use, interest
- Food and nutrition
- Activities – physical, social, after school
- Health conditions, illnesses (length of treatment and effects)
- Injuries
- Disabilities, limitations
- Health care access – Non-Insured Health Benefits
- Dental health, baby bottle tooth decay
- Traditional culture – importance, learning
- Emotional and social well-being
- Child care
- Residential school (parents, grandparents)

### **B) Questionnaire for adolescents (12 to 17)**

The adolescent questionnaire was self-administered, i.e., it was completed directly by the respondents. They answered the questions on a laptop computer and were assisted by the interviewers, who gave clarifications as needed. The questionnaire, which took approximately 35 to 45 minutes to complete, covered the following topics:

#### **National Component**

- Household/family composition
- Education – level, performance, personal goals
- Language – comprehension, use
- Food and nutrition
- Activities – physical, social
- Height, weight, satisfaction level
- Diabetes – type, treatment
- Condition of health, illnesses (duration, treatment, effects)
- Injuries
- Dental care
- Smoking, alcohol, drugs
- Sexuality
- Preventative health practices
- Personal well-being, support and mental health
- Suicidal ideation, attempts
- After-school activities
- Traditional culture – importance, learning
- Residential schools (parents, grandparents)

## Regional Component

- Education, career goals and dreams for the future

## C) Adult Questionnaire (18 and older)

The adult questionnaire was administered as a structured interview in which the respondent answered questions asked by the interviewer who guided them throughout the process (approximately one hour). The adult questionnaire covered the following topics:

### National Component

- Demographics
- Languages – comprehension, use
- Education
- Employment
- Income and income sources
- Household – composition and income
- Housing – condition, crowding, mould
- Water quality
- Services – telephone, water, smoke detector, Internet, etc.
- Height, weight
- Condition of health, illnesses (duration, treatment, effects)
- Diabetes – type, treatment, effects
- Physical injuries
- Dental care
- Disabilities, limitations
- Physical activity
- Food and nutrition
- Homecare – use, needs
- Health services – use, access, Non-Insured Health Benefits
- Traditional medicine, healers
- Smoking, alcohol, drugs – use, cessation, treatment
- HIV/AIDS, STDs and sexuality
- Pregnancy, fertility
- Preventative health practices
- Wellness, support and mental health
- Suicidal ideation and attempts
- Residential schools – impacts
- Community well-being
- Culture, spirituality and religion
- Community development

### Regional Component

- Education
- Means of transportation and security
- Lifestyle and social problems
- Gambling and lotteries



## 1.5 Research limitations

A survey of the magnitude of the FNRLHS is not immune from constraints, obstacles and bias that can alter the validity of the results and the general progress of the research. Fully aware of these actual and potential sources of errors, the research team who conducted the FNRLHS in the Quebec Region took them into account in the results analysis and interpretation, as well as in the production of this report. The Quebec Region, and all of the regions who took part in the FNRLHS at the national level, have had to respond to common and specific challenges at each major phase of the Survey. This Section aims to document the bias and potential sources of errors inherent to the research context specific to the Survey<sup>45</sup> for each major phase, which are: the sampling, data collection and analysis of the information collected.

Publishing this section on the FNRLHS limitations bears witness to a concern for transparency throughout the whole research process, but mostly for a desire to share the knowledge acquired and the know-how developed in the course of the survey. The FNRLHS' next waves and the future research work will benefit from this tool to improve the emergent process of research by and for First Nations.

### 1.5.1 Sampling

The Survey's sampling plan for First Nations members living on community was developed based on the parameters for the production of probability samplings. The quantity of informants to be included in the various sampling strata (Nation, community size, age group and sex) was calculated based on the 1999 Indian Register, a register maintained by the Department of Indian and Northern Affairs Canada. This register establishes the number of First Nations members living in Indian reserves or on Crown land. The persons who can eventually be selected in the sample have been selected on a random basis in each stratum based on the community band lists.

The sampling plan developed<sup>6</sup> for the data collection included obtaining valid statistical data for each participating community. However, this sampling plan turned out to be too costly for the funding available. Adjustments were therefore made in order to have specific characteristics of the sample (level of trust, proportion in the sample, coefficient of variation and margin of error<sup>7</sup>) apply to a stratified sample based on the Nation, community size, age group and sex. Despite these efforts to rectify the situation, the representativeness of the revised strata was problematic and had to be readjusted<sup>8</sup>.

In addition to these constraints, as it is the case with a significant proportion of statistical surveys on Aboriginal populations<sup>9</sup>, the final sample does not correspond to the target sample in two out of the three age groups. Notwithstanding the additional interviews conducted in certain strata of the final sample, the Quebec Region achieved 85.5% of its initial objective in terms of sampling, which means responses from 1,949 adults, 798 adolescents and 1,038 children. However, if one considers the number of additional interviews carried out with adults, the total participation rate reaches 113.2%. Among the causes that explain the gap between the target sample and the final sample among children and adolescents, the significant turnover of interviewers in the communities during the data collection that lasted 15 months was identified. This turnover resulted in less time devoted to the data collection in communities, mainly because each new interviewer had to be trained for data collection within the context of this survey. The acquisition of experience and, therefore, the interviewers' efficiency were limited by the significant turnover. Moreover, the respondents in various strata of the sample could, in some cases, be difficult to reach if very few people corresponded to the respondent profile targeted in the communities or if there was a high rate of people who refused to participate.

<sup>4</sup> For a summary of the research methodology, please refer to the « Methodology » section of this report. For a detailed description of the FNRLHS methodology, please consult the "Methodology Report".

<sup>5</sup> In addition to the process review conducted internally by the FNQLHSSC research team, this section is based on the Harvard Project on American Indian Economic Development Report mandated by the First Nations Information and Governance Committee, a Standing Committee of the Chiefs Committee on Health and the First Nations Centre in the National Aboriginal Health Organization.

<sup>6</sup> For details, please consult the Methodology Report

<sup>7</sup> For details, please consult the Methodology Report

<sup>8</sup> For details, please consult the Methodology Report

<sup>9</sup> Please consult the report quoted in Note 2



## 1.5.2 Data collection

### 1.5.2.1 Language and translation

Because of limited funding, the consent forms in English and in French that were systematically used could not be provided to potential respondents in their mother language. However, all the interviewers selected were fluent in the First Nations language used in the community where they were affected, in addition to being fluent in English or French. Therefore they could help the respondents understand the forms. However, it is possible that consent forms were misunderstood or misinterpreted by some informants, which might have made them refuse to participate or resulted in forms being signed without a complete understanding of the content.

The management and handling of consent forms also had an impact on the number of informants whose responses could be included in the analysis. Several forms that were not filled correctly or included irregularities had to be rejected as well as the interviews with those respondents.

Another linguistic obstacle – once again caused by limited funding – occurred with the survey questionnaires, which were only available in French or in English. A question to respondents allowed us to calculate the proportion of those for whom a translation was necessary: 27.9% of respondents indicated that a translation of the questions was necessary. The interviewer acted as translator in almost all cases. The necessity to translate, the various ways of translating or the difficulty to translate certain concepts into an Aboriginal language might have influenced the way questions were understood, or might have resulted in non-responses to certain questions or even the refusal to answer the questionnaire.

### 1.5.2.2 Interviewer turnover

The turnover of interviewers also resulted in a multiplication of the ways to conduct the interview, which may have generated variations in the quality of the data collection. On these two last points, however, one should note that the cultural context in which the survey took place favoured the use of interviewers from the same community as the interviewee. It is important to remember that hiring contractual First Nations staff living in the community under study offers two advantages. First, the knowledge of the environment and the language used may limit the interpretation and comprehension problems of certain concepts that are difficult to translate. Second, the respondents' level of trust may also be higher when the questionnaire is administered by a member of the same community than by a non-Aboriginal stranger. However, hiring this staff may have as disadvantages that respondents are concerned about a potential breach of privacy because of the close links between community members and the interpretation of the respondent's answers based on the knowledge the interviewer has of the respondent. The situation involving the least risks was therefore privileged, which was to hire local interviewers.


### 1.5.2.3 Errors due to the respondent

Regarding the errors due to the respondent, it is possible that some respondents might have skewed some answers either voluntarily or not. A number of factors may explain this. The questionnaire included questions that might have induced some errors due to the social desirability, which consists in giving answers that one believes to be "good" on the social level (those "expected" socially). These errors usually occur in the case of questions that address more sensitive issues. The questionnaire used for this survey includes several of these questions, which is hard to avoid when a survey aims to document various items related to the health of individuals in a holistic approach.

Errors due to the non-response also occurred during the course of the survey process. In several cases, respondents gave incomplete answers or simply did not answer, which inevitably skews the results.

### 1.5.2.4 Errors due to the questionnaire

Although they were developed with thoroughness and a true concern to be adapted to the multiple situations experienced by first Nations members, the questions developed for the FNRLHS entail errors that might have



biased the answers. Essentially these errors are choices of answers with non-mutually exclusive categories or incomplete choices of answers that did not cover the range of possible answers.

Furthermore, some questions in the questionnaire are open to interpretation and may therefore influence the respondent's answers. For example, in one question, respondents are asked whether they had ever "thought about suicide". In addition to being a sensitive issue, "thought about suicide" probably does not mean the same thing for each respondent. One can assume that for some people, thinking about suicide means to "reflect upon the suicide issue", while for others it means to "have suicidal thoughts". Answers might therefore have been inspired by the respondents' various perceptions of the vocabulary used to address this issue. Moreover, when questions were not clearly understood, the interviewer could give additional explanations. However, the interviewers' training did not include assimilating clear and consistent indications to be transmitted to the informants concerning each question.

### 1.5.3 Data analysis and reports

#### 1.5.3.1 Training

The FNQLHSSC research team took over the analysis of the data stemming from the First Nations of the Quebec Region as well as the production of the various reports corresponding to the region. The innovative nature of the survey and the specificity of the survey population involved significant methodology and conceptual innovations to carry out the FNRLHS. Although the FNQLHSSC research team is comprised of staff trained in social research, additional training of the staff on the research issues, survey methods as well as various health indicators specific to First Nations would have facilitated the results analysis and interpretation. But the limited financial context did not allow the FNQLHSSC research team's various analysts and writers to access occasional and additional training that remain rare and expensive.

#### 1.5.3.2 Turnover

The FNQLHSSC research team grew at the same time as this cycle of the FNRLHS was carried out. The hiring of staff was therefore adapted to the needs identified over the months and years during which the 2002 Survey was conducted. As with the situation that prevailed among interviewers, the turnover of staff, particularly the research assistants, had a certain impact on the conduct of the survey. In addition to slowing down the production of various reports, this turnover also might have hindered the follow-up of certain important files and tasks in the context of this survey. It should be noted, for example, that files were transferred from one employee to another, who in turn lacked resources to invest the required amount of time.

## 1.6 Important Notes for Readers

Statistics followed by an asterisk (\*) have a high sampling variability (coefficient of variation between 16.6% and 33.3%). They must be interpreted with caution.

Statistics followed by the number sign (#) were not included because of a too high sampling variability (coefficient of variation at 33.3% or higher).

The sampling variability for the Malécite Nation was too high, making it impossible to perform even the slightest cross-tabulation involving Malécites. This explains why they are not included in the tables and graphs presenting the results per Nation.

The expression “First Nations population” is used in this report to indicate the designated First Nations population in Quebec, excluding the Crees, the Inuit, the Innus of Labrador, and the Mohawks (apart from members living in Kanasatake, which is included).

### **Community geographic zones**

The following system was developed by INAC to categorize First Nations communities’ levels of geographical remoteness:

- Zone 1: Located within 50 km of the nearest service centre<sup>10</sup> with year-round access
- Zone 2: Located between 50 km and 350 km from the nearest service centre with year-round access
- Zone 3: Located over 350 km from the nearest service centre with year-round access
- Zone 4: No year-round access to a service centre

### **Community size**

- Small: Between 0 and 300 inhabitants:
- Medium: Between 301 and 1,499 inhabitants
- Large: 1,500 inhabitants or more

The results for small and medium communities, as well as those for zone 3 and 4 communities, have been combined, because taken individually they do not provide statistically significant results.

Lastly, all results were cross-tabulated according to age, sex, Nation, and community size and zone. Influences exerted by education, most commonly used language, civil status and income were also studied when their cross-tabulation appeared to be of value. Results providing no statistically valid differences are excluded from this report, and to shorten the text we exclude all cross-tabulations that do not present statistical value.

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<sup>10</sup> Nearest community providing access to suppliers, banks and government services.



## Section 2: Children's health (aged 0 to 11)



## Children's health (aged 0 to 11)

### 2.1 Highlights

#### 2.1.1 Social characteristics

##### 2.1.1.1 Information on households

The majority of children (52.5%) lived in families that had 2 or 3 minors (aged 0 to 17). We also note that a higher proportion of children living in large families (4 or more children) were found in zone 2 communities<sup>11</sup> (33.3% compared to 13.1%\* in zone 1 communities and 26.3% in zone 3 and 4 communities). The majority of children (60.9%) lived with 2 adults. However, this proportion varied among the nations; it ranged from 48.5% among the Atikamekw to 81.1% among the Huron/Wendat.

##### 2.1.1.2 First Nations languages and traditional culture

More than half the children spoke and understood a First Nations language fluently or relatively well. The parents or guardians of children in the Algonquin, Mi'kmak, Innu, Atikamekw and Naskapi Nations felt it was very important for their children to learn a First Nations language, while those in the Abenaki and the Huron/Wendat felt it was less important. This observation was in keeping with the fact that almost all the members of the latter Nations did not use Abenaki or Huron in their daily life. We also note a correlation between community isolation and the ability to speak a First Nations language fluently or relatively well; 86.7% of children in zones 3 and 4 understood a First Nations language, compared to 72.8% in zone 2 and 32.8% in zone 1. Finally, the majority of parents or guardians considered traditional cultural events to be important in their children's life. This was especially so in large communities, where the majority of parents or guardians (51.1%) placed a great deal of importance on these events, compared to 45.5% in small or medium-sized communities.

##### 2.1.1.3 Education

Nearly three quarters (73.1%) of children were attending elementary school or the First Nations Head Start (FNHS) program at the time of the survey. Nearly half (46.9%) the children was taking part or had taken part in the FNHS program. In addition, 10.1% of children had repeated a grade, with a higher proportion of boys than girls. As for the schooling level of parents and guardians, it was found that the majority of them had not completed high school; more than one half of fathers (53.1%) and mothers (50.6%) did not have a high school diploma. Finally, we found that higher proportions of parents in small and medium-sized communities than in large communities had not completed high school.

<sup>11</sup> Zoning system developed by Indian and Northern Affairs Canada to categorize the level of geographical isolation of the communities

- Zone 1: Located within 50 km of the nearest service centre\* with year-round road access.
- Zone 2: Located between 50 km and 350 km from the nearest service centre with year-round road access.
- Zone 3: Located more than 350 km from the nearest service centre with year-round road access.
- Zone 4: No year-round road access to a service centre.

\* Nearest community providing access to suppliers, banks and government services.



## 2.1.2 Health status

### 2.1.2.1 Overall health

The vast majority of parents and guardians surveyed were very satisfied with their children's health; 44.3% considered their children to be in excellent health, while a combined total of 51.8% considered their children to be in very good or good health. However, a significant number of parents and guardians (46.6%) reported that their children had health problems; the most common ones were breathing problems, visual or hearing problems, and allergies. Furthermore, significant proportions of children were obese (40.1%) or overweight (12.2%). The results also indicate a higher prevalence of obesity and overweight among children in zones 3 and 4 than in zones 1 and 2.

More than one third (38.7%) of all children were breastfed. But this proportion varied among the zones. The highest proportions of breastfed children were in zone 1 (46.1%) and zone 2 (39.7%), while 16.3% of children in zones 3 and 4 were breastfed. The proportion of children who were breastfed increased with the mothers' schooling level; it rose from 31.3% for mothers who did not complete high school to 69.4% for those who had attended university. Finally, no cases of diabetes among children were found; this result was surprising given the prevalence of overweight and obesity. But it may be explained by the low percentage of children (7.4%) who had been tested for diabetes.

### 2.1.2.2 Dental care

In general, the majority of children had access to dental care. More than two thirds of them received dental care during the 12 months preceding the survey. Four of every five children (80.2%) who required dental care at the time of the survey needed maintenance, while more than one third (35.8%) required fillings or restoration work. Finally, the survey revealed that baby bottle syndrome had affected 14.8% of children.

## 2.1.3 Lifestyle

### 2.1.3.1 Food and nutrition

More than two thirds of parents and guardians surveyed felt that their children's diet was always or almost always balanced and nutritious. The survey also revealed that the 0-5 year-olds had more balanced and nutritious diets than the 6-11 year-olds. Finally, consumption of traditional food was low among all the children. It was, however, higher in zones 3 and 4.

### 2.1.3.2 Physical activity

Overall, boys seemed to be more physically active than girls. More than one third (32.1%) of boys had physical activity one to three times a week, compared to one quarter (26.6%) of girls. In addition, a higher proportion of children in zone 1 than in the other zones participated in organized physical activity, perhaps because the infrastructures and activities programs in zone 1 were more highly developed. Finally, the majority (58.3%) of children played outdoors at least two hours a day.



### 2.1.3.3 Sedentary activities

A significant proportion of children spent several hours a week in sedentary activities (watching television, playing video games, etc.). One quarter (24.3%) of them watched television 5 to 9 hours a week, while another one quarter (25.9%) did so 10 to 14 hours a week, and more than one third watched television 15 hours a week or more. Finally, nearly two thirds of boys played video games 10 hours a week or more, while half the girls played video games less than 4 hours a week.

### 2.1.3.4 Smoking among mothers

Just over half (50.5%) of parents and guardians surveyed indicated that the children's mothers smoked while pregnant. The vast majority of these mothers smoked every day (85.2%) and/or throughout the nine months of their pregnancy (83.8%). We found that the mothers' smoking rates vary among the zones. The results show that more women smoked during pregnancy in zones 3 and 4 (62.2%) than in zone 1 (40.6%) and zone 2 (59.1%). Furthermore, more than half the parents and guardians indicated that at least one other household member smoked during the mother's pregnancy. Finally, close to half the households did not provide smoke-free environments for the children.

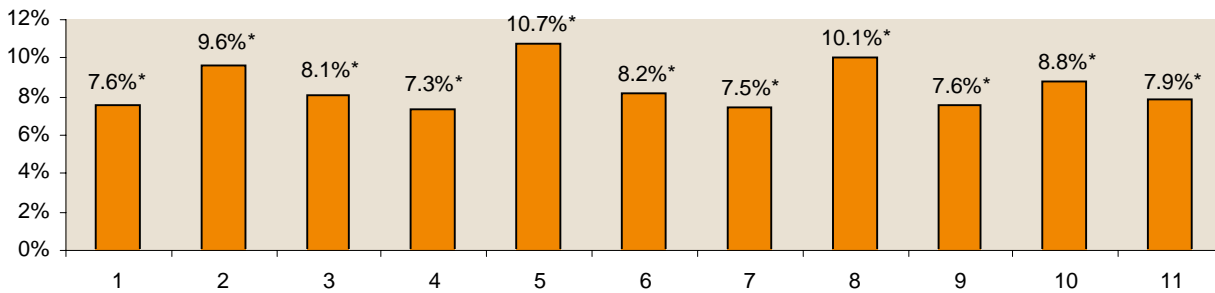
## 2.2 Demographic Profile

### 2.2.1 Age, sex and place of residence

#### 2.2.1.1 Age

The following Graph shows the age curve of the children. The average age is 5.8.

**Graph 2: Age of children**



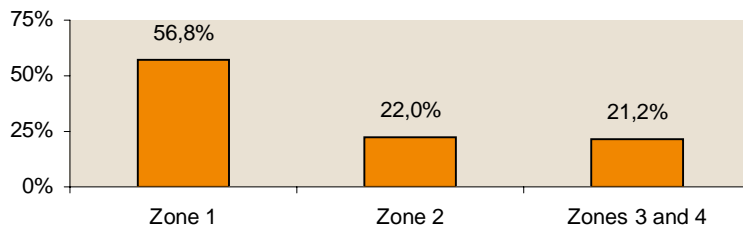
#### 2.2.1.2 Sex

The proportion of boys (51.0%) and girls (49.0%) is similar for the entire First Nations population. However, in zone 3 and 4 communities, there is a larger proportion of girls (53.3%) than of boys (46.7%). We see similar statistics for the small and medium communities, where the proportion of girls is 52.9%. The opposite holds for the Atikamekw Nation, where the proportion of boys is 52.5%.

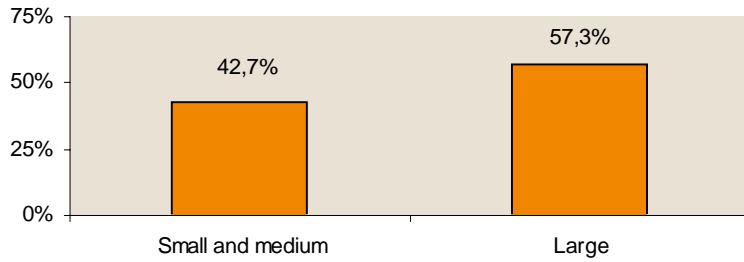
#### 2.2.1.3 Place of residence

As illustrated by the following graphs, more than half of the children live in zone 1 and in large communities (56.8% and 57.3% respectively). Moreover, zone 2 accounts for 22.0% of the children, and zones 3 and 4 for 21.2%. Most of the children thus live in communities relatively close to urban centres. The fact that more people live in these communities probably explains why the proportion of children is higher.

**Graph 3: Distribution of children by geographic zone**



**Graph 4: Distribution of children, by community size**



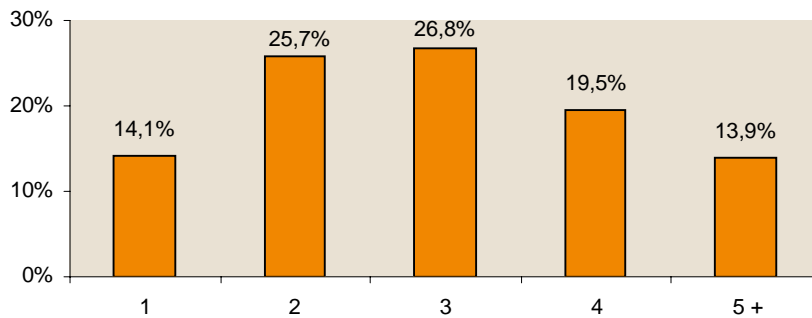
2.2.2 Information on the household

2.2.2.1 Number of minors (0-17) at home

More than half of the children live in households that have two or three children between the age of 0 and 17 at home. One child out of three lives in a household composed of at least four children (see Graph 5).

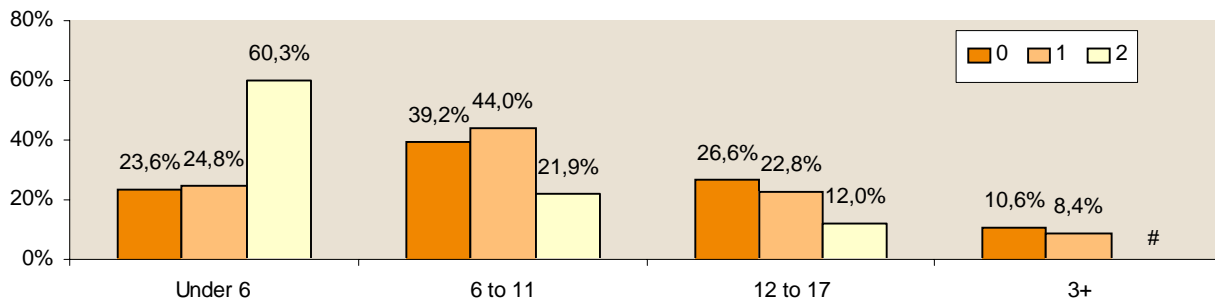
There is a direct link between community zone and the children living in households with at least four minors, rising from 13.1%\* in zone 1 to 26.3% in zones 3 and 4. Zone 2 is significant with a third of the children living in households that have five minors or more.

**Graph 5: Number of children, by household (aged 0 to 17)**



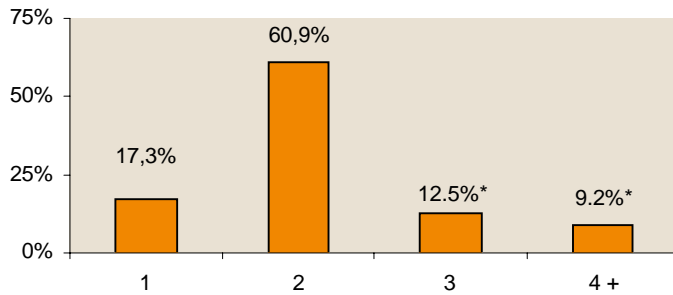
Graph 6 presents the number of children at home by age group. These children are not all necessarily brothers and sisters. Exceptionally for this section on children's health, the question covered adolescents as well. Finally, the children population is more numerous than the adolescents population.

**Graph 6: Number of children at home, by age group (0 to 17 years old)**



2.2.2.2 Number of adults in households

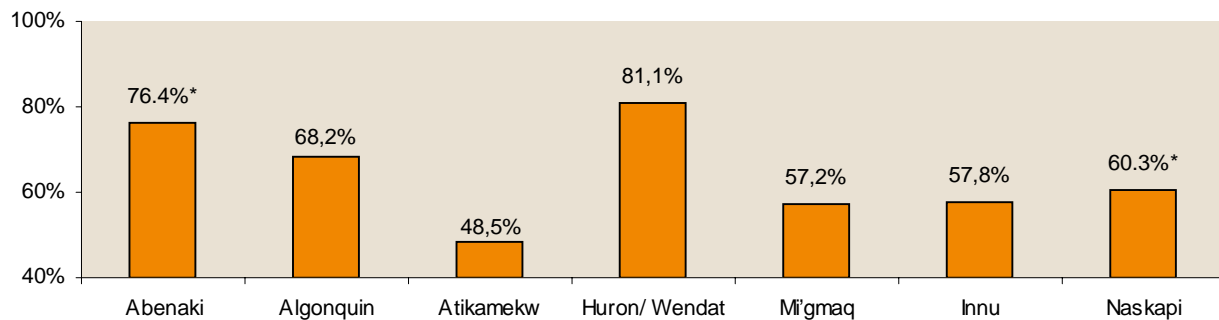
**Graph 7: Number of adults in households**



60.9% of children live in households made up of two adults. 96.2% of households surveyed for the adult/child report had no adults aged 65 or over.

Graph 8 presents, by Nation, the percentage of children living in households made up of two adults. The Western standard of a couple with their children seems to match most of these households, apart from the Atikamekw, where nearly one of every five households with children has three adults. One of every five Innu households is a single-parent family, and this proportion rises to one third among the Mi'gmaq.

**Graph 8: Proportion of children living in a household with two adults, by Nation**



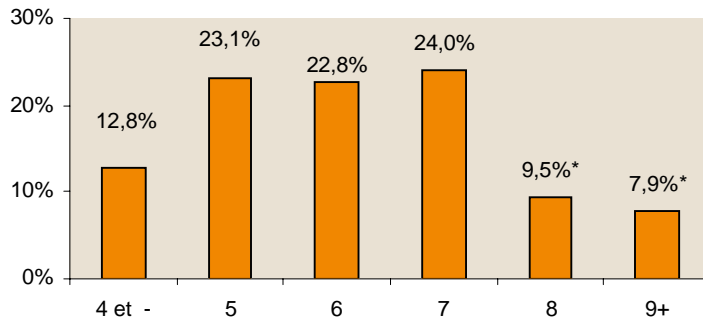
Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

67.8% of zone 1 children come from households made up of two adults compared to 56.0% in the other zones.

In the large communities, more than one child out of five is living in a single-parent family, compared to 15.6%\* in small and medium communities. More than two thirds of children in small and medium communities come from households made up of two adults, compared to 56.8% in large community households.

### 2.2.2.3 Size of the housing

**Graph 9: Number of rooms in the residence**



There are an average of 6.2 rooms per residence (not counting bathroom, entranceway, laundry room and adjacent shed).

Table 2 presents the number of rooms per residence compared to the number of children in the household.

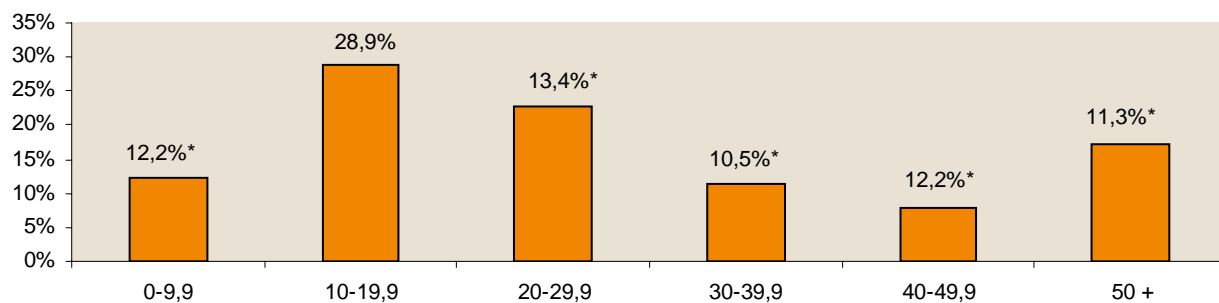
**Table 2: Number of rooms per residence compared to the number of children (0-17 years)**

Number of rooms	Number of children in the household				
	1	2	3	4	5 +
4 or fewer	31.4%	15.8%*	#	#	#
5	19.4%*	20.7%*	30.7%	21.6%*	18.8%*
6	#	23.8%	23.6%	31.8%	#
7	20.1%*	21.2%*	23.2%	21.0%*	38.3%
8	#	#	#	#	#
9 or more	#	#	#	#	18.7%*

### 2.2.2.4 Household annual income

The average annual income of households with children is \$22,500 (total net income of all household members). The Quebec government has provisionally set poverty levels at \$18,200 for a couple with one child and \$24,500 for families with three or more children.<sup>12</sup>

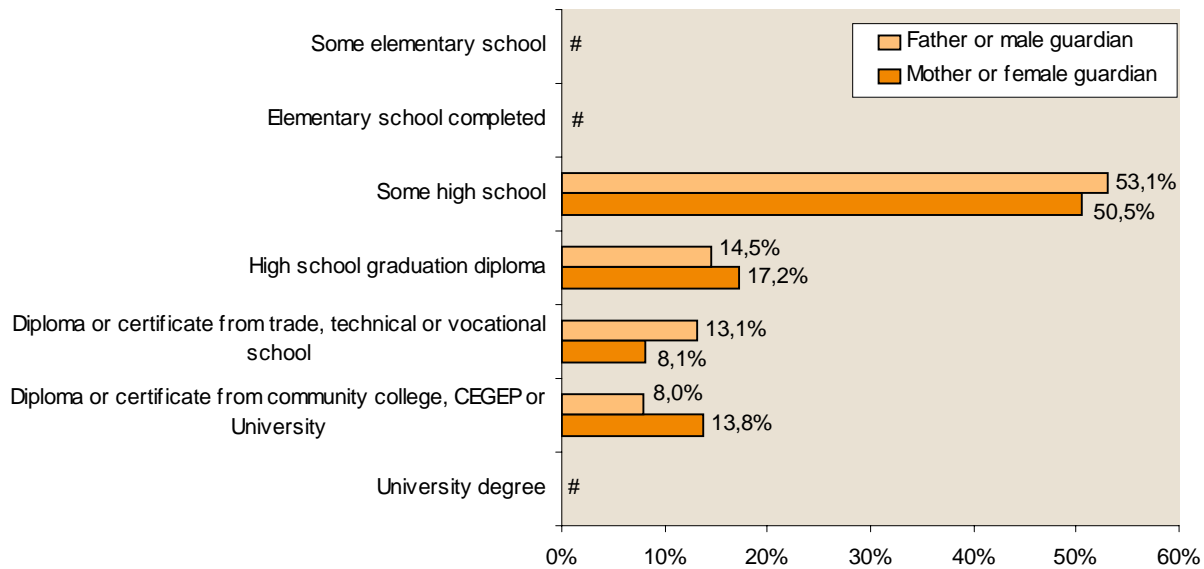
**Graph 10: Proportion of households with children based on annual income (in thousands of dollars)**



<sup>12</sup> Lévesque, K. and Chouinard, T., *Le Devoir*, Monday, November 10, 2003

## 2.2.2.5 Schooling level of parents or guardians

**Graph 11: Schooling level of parents/guardians**



One third of the mothers or female guardians in zone 1 have not completed high school studies, versus two thirds in the other zones. The proportions are similar for fathers and male guardians, although in zone 1, more of these men (39.6%) than women have not completed high school studies.

The results also differ significantly by community size. Parents or guardians are generally more educated in large communities, as shown in Table 3.

**Table 3: Schooling level of parents/guardians, by community size**

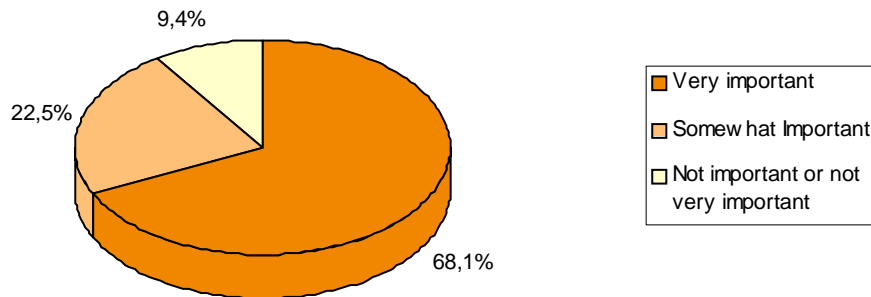
Education	Community size			
	Small and average		Large	
	Mother/female guardian	Father/male guardian	Mother/female guardian	Father/male guardian
High school not completed	48,1%	51,5%	37,3%	47,9%
High school diploma	17,0%*	16,3%*	23,8%	18,1%
Trade, technical or vocational diploma	#	12,7%*	10,7%*	13,4%*
Community college or CEGEP diploma or certificate	15,4%*	#	17,5%	10,2%*

## 2.2.3 First Nations languages and traditional culture

### 2.2.3.1 Languages understood and languages spoken

Graph 12 shows that a large majority of parents or guardians feel it is very important that a First Nations language be part of their children's life.

**Graph 12: Level of importance for parents or guardians of having their child learn a First Nations language**



58.4% of children understand one or more First Nations languages fluently or relatively well and 50.6% of them speak one or more First Nations languages fluently or relatively well.

More than one third of parents or guardians say they are very satisfied with their children’s knowledge of their First Nations language. One third report being satisfied, while 17.8% are dissatisfied or very dissatisfied.

More than two thirds of the Abenaki and half of the Huron-Wendat believe it is not important at all or not very important that their children learn a First Nations language, compared to nearly half of the Algonquin and Mi’gmaq who consider it to be very important, as do 79.7% of the Innu, 84.5% of the Atikamekw and 96.5% of the Naskapi. These perceptions directly influence children’s understanding and use of one or more First Nations languages, as shown in the table below.

**Table 4: Proportion of children capable of understanding or speaking a First Nations language fluently or relatively well, by Nation**

Understanding or speaking of a First Nation language	Nations					
	Abenaki	Algonquin	Atikamekw	Mi’gmaq	Innu	Naskapi
Understands one or more First Nations languages	#	40.8%	84.3%	22.4%*	66.7%	92.5%
Speaks one or more First Nations languages	0.0%	21.8%*	78.9%	#	61.8%	87.3%

Note: The Huron/Wendat, the Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

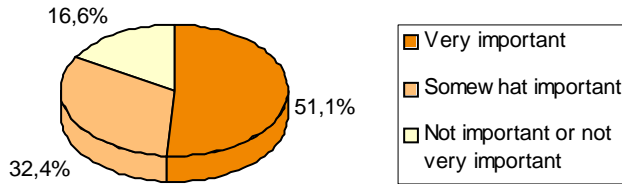
The community’s level of remoteness is associated with the individuals’ perception of the importance of having children learn a First Nations language. Less than half (47.2%) of the parents in zone 1 find it very important, versus two thirds of the people in zone 2 and 94.6% in zones 3 and 4. Finally, 18.7% of parents living in zone 1 consider it is not important or not very important for their child to learn a First Nations language.

Consequently, 86.7% of children in zones 3 and 4 understand one or more First Nations languages fluently or relatively well, compared to 72.8% in zone 2 and one third in zone 1. Furthermore, 81.0% of children living in zones 3 and 4 speak one or more First Nations languages, versus 71.6% in zone 2 and 21.7% in zone 1. We see the same trend for parents who are very satisfied with their children’s knowledge of a First Nations language, with the proportions rising from 15.8%\* in zone 1 to 69.7% in zones 3 and 4.

Finally, more than half of parents in small and medium communities and more than two thirds in large ones feel it is very important for their children to learn a First Nations language.

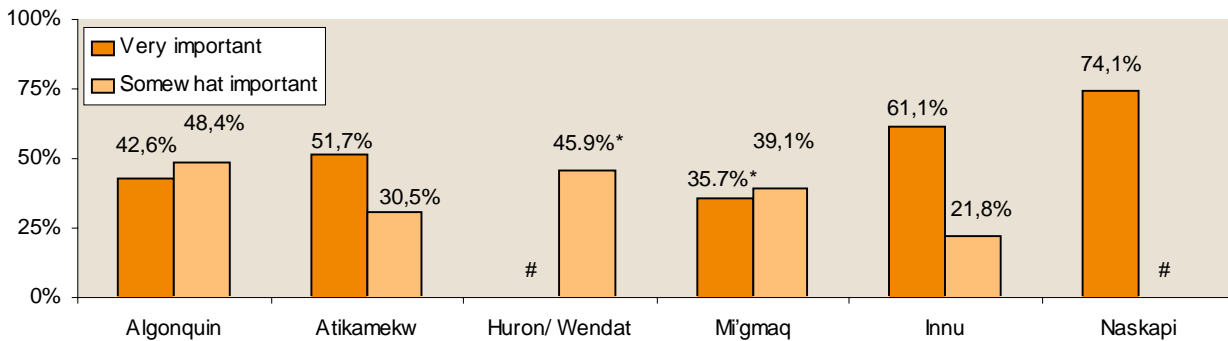
2.2.3.2 Traditional culture

Graph 13: Level of importance of traditional cultural events in children's life



The majority of parents or guardians consider traditional cultural events to be important in their children's life. The proportions of individuals by Nation who consider traditional cultural events to be very important or somewhat important in the life of children are presented in the following graph.

Graph 14: Level of importance of traditional cultural events in children's life, by Nation

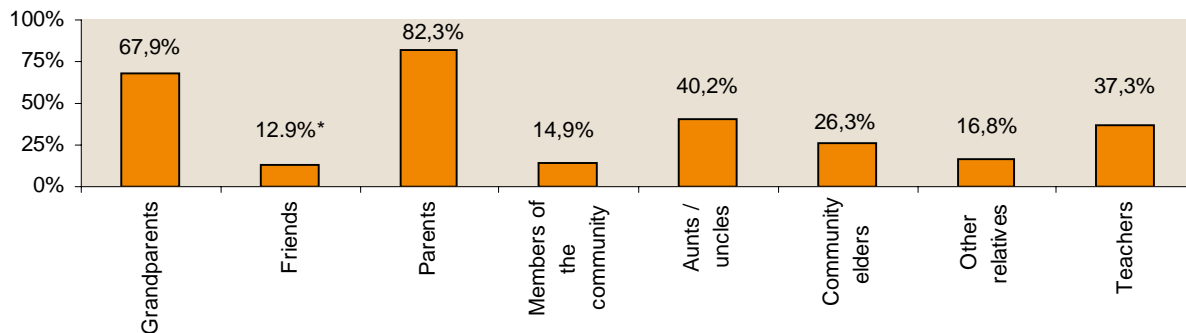


Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

About one fourth (25%\*) of Mi'gmaq persons feel that traditional cultural events are not important at all or not very important in their children's life, versus 17.4%\* of Atikamekw and Innu persons.

Graph 15 presents the persons who, according to the parents or guardians interviewed, help children understand their culture. Various family members share this role, which is mainly played by the parents and grandparents. One can see that the role of teachers is relatively low, which may be explained by the fact that most teachers are non-Aboriginal.

Graph 15: Origin of the help given to children to understand their culture





Parents or guardians are the primary resources for helping their children understand their culture, except among the Naskapi and the Mi'gmaq, where grandparents fulfil this role. Grandparents play a secondary role among the other Nations, while Elders play a preponderant role among the Atikamekw.

**Table 5: Origin of the assistance provided to children to help them understand their culture, by Nation**

Who helps children?	Nations						
	Abenaki	Algonquin	Atikamekw	Huron/Wendat	Mi'gmaq	Innu	Naskapi
Grandparents	#	62.9%	79.2%	35.6%*	52.3%	72.8%	83.6%
Friends	#	#	22.0%*	#	#	12.1%*	#
Parents	81.5%	81.5%	88.4%	83.8%	43.0%	89.1%	56.7%*
Community members	#	17.9%*	29.3%	#	#	#	#
Aunts/uncles	#	35.6%	65.4%	#	25.1%*	35.5%	#
Community Elders	#	#	50.3%	#	#	27.9%	#
Other relatives	0.0%	#	32.5%	#	#	11.8%*	#
Teachers	#	51.2%	35.0%	#	46.5%	33.3%	#

Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

Because culture is intrinsically related to language, the importance parents give to one is reflected in the importance given to the other. Nevertheless, language was seen to take precedence over traditional cultural events. In zone 1, 42.4% of parents believe traditional cultural events are very important for their children, while 47.2% believe language is important. The corresponding proportions in zones 3 and 4 are two thirds (traditional cultural events) and 94.6% (language). Finally, 17.1% of parents in zone 1 see traditional cultural events as not important or not very important.

The same finding holds when we look at the community size versus the importance of traditional cultural events and speaking First Nations languages, as shown in Table 6.

**Table 6: Proportion of parents/guardians who consider traditional cultural events and use of First Nations languages to be very important, by community size**

Parents who consider as very important	Community size	
	Small and medium	Large
Traditional cultural events	45.5%	51.1%
Speaking First Nations languages	55.8%	68.5%

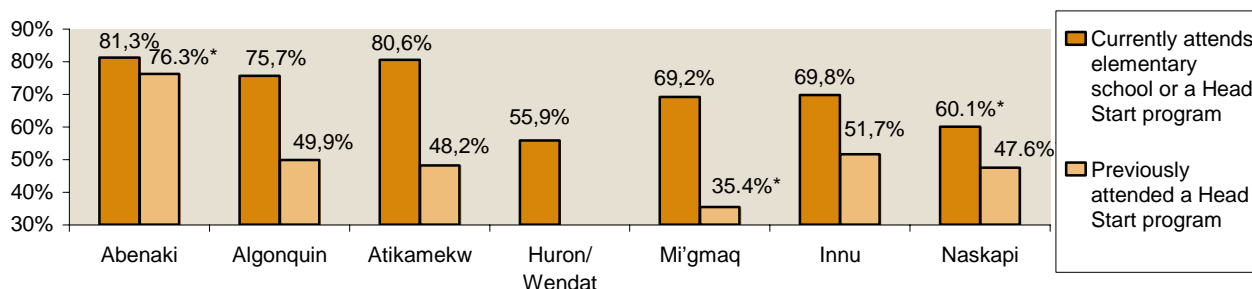
## 2.2.4 Education

73.1% of the children were attending elementary school or the Aboriginal Head Start program (AHS) at the time of the survey. 46.9% of the children had previously participated in the AHS program.

Parents and guardians always tend to think very highly of their own children, and this tendency was revealed when they were asked to evaluate how well their children were doing. According to parents or guardians, 27.4% of the children were considered to be above average, while 24.3% to be slightly above average. However, the survey shows that 10.1% of children have already repeated a grade.

The boys' school performances were rated lower than the girls: nearly one quarter of them (22.5%) were considered to be above average, versus one third of girls. A larger proportion of boys are thus considered as being average (44.6%), compared to one third of girls. Lastly, 13.4%\* of the boys have repeated a grade, versus a non-significant proportion of girls.

**Graph 16: Proportion of children attending or having attended school or Head Start attendance, by Nation**



Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

The absence of significant statistics for the Huron/Wendat may seem surprising. It should be noted that Head Start can be delivered to the community in various forms: home visits, in a facility or through other infrastructures such as childcare services. At the time of the survey, funding for this program was used to offer several activities, e.g., information sessions, parent activities, cultural events at the childcare service, etc. A facility-based program has been offered in Wendake only since 2003-2004, which follows the period covered by this survey.

## 2.3 Health Status

### 2.3.1 Overall Health Status

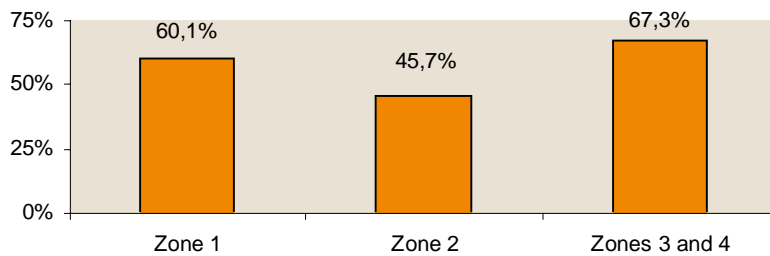
The parents and guardians of the children generally have a positive view of their children's state of health; 44.3% feel their children are in excellent health, and 51.8% feel their children are in very good or good health. We note, however, that a significant proportion of parents or guardians say that the mother smoked during pregnancy (50.5%), that a significant number of children are not breastfed (61.3%) and that a significant proportion of children are obese (40.1%).

#### 2.3.1.1 Tobacco use of mothers during pregnancy

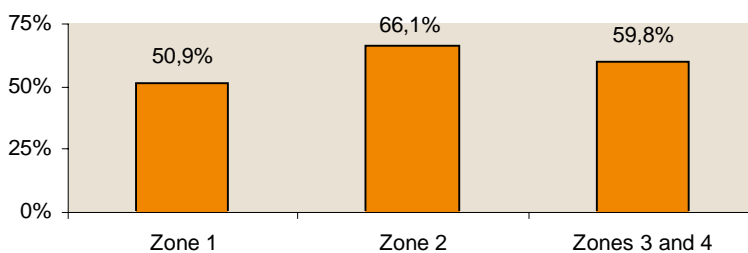
Concerning tobacco use by pregnant women (50.5% of mothers), 38.0% of them acknowledge that they smoked during the entire pregnancy, and 6.8% said they quit smoking during the first trimester. Among women who smoked throughout their pregnancy, 76.1% smoked every day. Furthermore, 59.0% of the parents and guardians acknowledged that another family member smoked when the mother was pregnant, and 44.5% said that their homes do not provide their children with a smoke-free environment.

The proportion of mothers who smoked when pregnant is lower in zone 1. However, women who smoked during pregnancy smoked more in zones 1 and 2, where proportions of pregnant smokers who smoked daily were respectively 76.5% (zone 1) and 79.9% (zone 2), versus 60.9% in zones 3 and 4. Zone 2 shows the largest proportion of children who have been exposed to second-hand smoke, with 66.1% of parents or guardians reporting that another family member smoked during the mother's pregnancy and with less than half (45.7%) reporting that they provided their children with a smoke-free environment.

**Graph 17: Proportion of parents/guardians with smoke-free residences, by geographic zone**



**Graph 18: Proportion of respondents who indicated that at least one other family member smoked during the mother's pregnancy, by geographic zone**



### 2.3.1.2 Weight, overweight and obesity

The results show that 40.1% of children are obese which is almost identical to the percentage of normal weight children as shown in Table 7. It is important to note that 12.2% of children are overweight.

**Table 7: Distribution of children aged 2 and over<sup>13</sup> per body mass index (BMI)<sup>14</sup>**

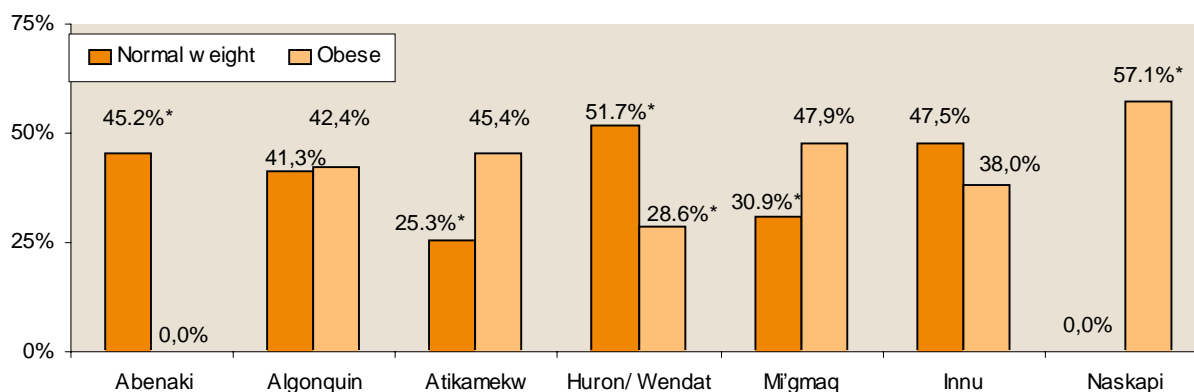
BMI weight categories	% of children
Underweight	#
Normal weight	40,3%
Overweight	12,2%*
Obese	40,1%

Zone 3 and 4 communities have especially high infantile obesity rates, with 65.6% of children considered obese, versus 37.1% in zone 1. We did not find significant rates of overweight and obese children in zone 2, so we cannot compare it with the other zones. We note, however, that the Algonquin and the Atikamekw Nations, who have several communities in zone 2, have high obesity rates, at 42.4% and 45.4% respectively. But among the different Nations, the Naskapi show the highest rate, with more than half of their children considered obese (57.1%), followed by the Mi'gmaq at 47.9% and the Innu Nation at 38.0%.

<sup>13</sup> BMI cannot be calculated in children under 2 years of age.

<sup>14</sup>Body mass index (BMI) is a measurement used to determine the healthy weight of individuals. We obtain BMI by dividing their weight (in kg) by their height in metres squared. For children and teenagers, we apply this index to a growth chart that indicates the individual's weight category: underweight, normal weight, overweight, or obese.

**Graph 19: Proportion of normal-weight or obese children, by Nation**



Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

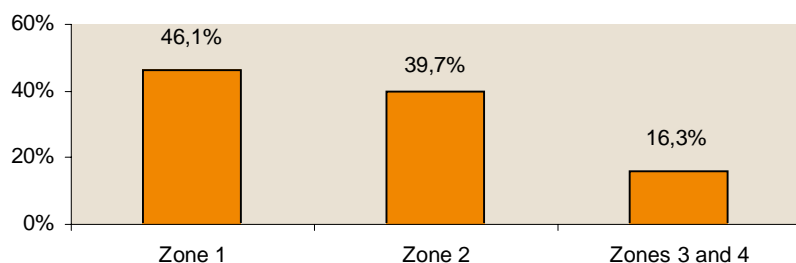
The high cost of fresh food in isolated communities may be one phenomenon that explains the high occurrence of BMI indicating overweight and obesity in children. In isolated communities, it is less expensive to buy chips and chocolate than fruits and vegetables. Food transport subsidies for the transportation of healthy and fresh food may be one solution to this problem. It was also mentioned that eating fruits and vegetables is not necessarily an easy thing to do in remote communities. This is reflected in the fact that some fruits and vegetables have no names in the local languages.

Turning to physical activity, we find that some communities have no sports facilities, while those that do lack the funding required to organize sports and leisure activities.

### 2.3.1.3 Breastfeeding

There is a significant correlation between the geographical location of communities and the proportions of children who have been breastfed or not. Zone 3 and 4 communities have the lowest rate of breastfed children, at 16.3%, versus 39.7% in zone 2 and 46.1% in zone 1.

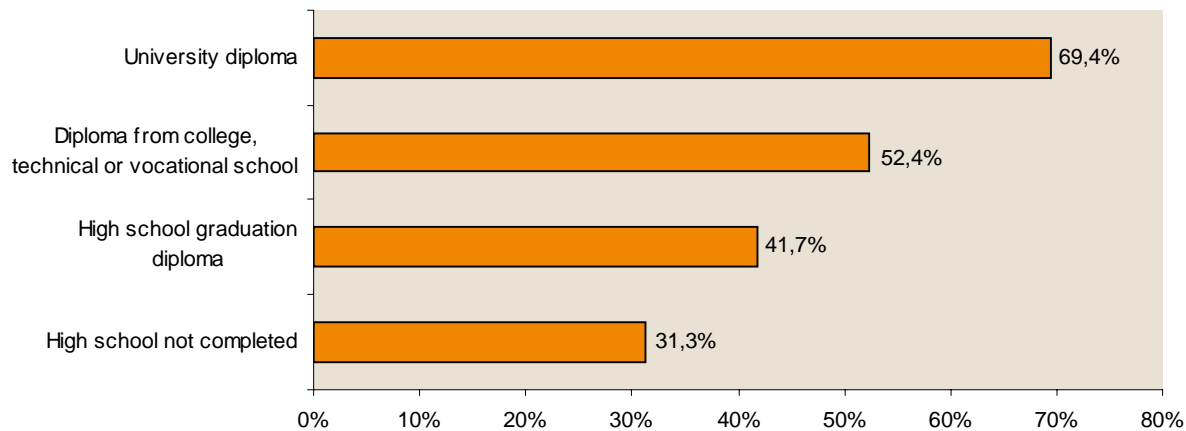
**Graph 20: Proportion of breastfeeding and breastfed children, by geographic zone**



The interpretation session participants had particularly eloquent comments on the factors related to the choice of breastfeeding or not: in zone 4, future mothers leave their community three weeks before giving birth and return after having spent one week in the hospital. Since help and support are crucial for breastfeeding success, many give it up. Zone 1 has more resources: breastfeeding support and follow-up that may last up to a year; the “Welcome Baby Basket” with information and supplies, the names of various organizations that support new mothers (e.g., La Leche League), etc.

A mother’s schooling level seems to be associated to whether or not she breastfeeds her baby. The breastfeeding rate increases as the schooling level rises. Household income has a lesser effect, although households earning \$40,000 or more a year have a significantly higher breastfeeding rate (53.3%) than do households earning less (between 35.0% and 40.0% for households with an annual income lower than \$40,000).

**Graph 21: Proportion of breastfed children by mothers' schooling level**



#### 2.3.1.4 Improvements and changes among mothers

We note changes regarding smoking by mothers, exposure to second-hand smoke and breastfeeding. 40.7% of mothers with children aged 6 to 11 smoked throughout their pregnancy, versus 35.0% of mothers with children aged 0 to 5. However, a majority of mothers who smoked throughout their pregnancy smoked every day. Finally, 49.2% of children aged 6 to 11 live in a smoke-free home, compared to 62.3% of children aged 0 to 5.

The most noticeable changes concern breastfeeding; 29.2% of children aged 6 to 11 were breastfed, versus 48.9% of children aged 0 to 5.

It is interesting to note that despite changes in smoking and breastfeeding behaviours, we do not see any change in parents' or guardians' perceptions of their children's health. Parents and guardians of children aged 6 to 11 and those of children aged 0 to 5 present almost identical proportions regarding their perceptions (excellent, very good, good, fair or bad) of their children's health status.

Lastly, we see that zone 3 and 4 communities have the highest proportions of parents and guardians who feel that their children are in excellent health (51.1%), although these communities are also the ones with the lowest breastfeeding rates and the highest obesity rates.

#### 2.3.2 Children's medical problems

A little less than half of the children (46.6%) have health conditions: 21.3% have respiratory problems, 20.2% have visual or hearing problems and 14.7% have allergies.

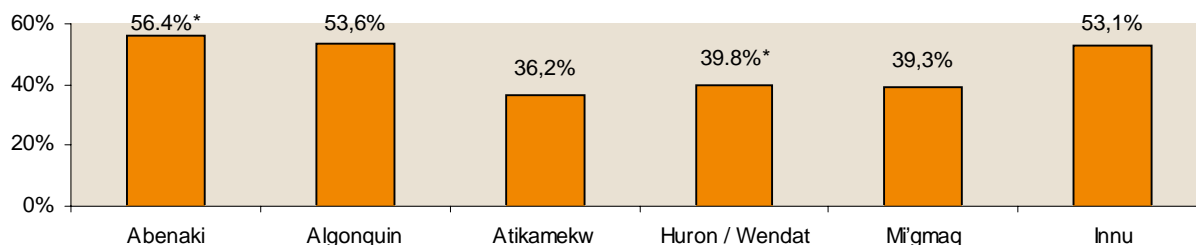
We did not observe any cases of diabetes among the children, which seems astonishing given the high obesity rate. Let it be noted that only 7.4% of the children have had a test to determine their blood sugar level. This test is usually administered only when there is some cause to suspect diabetes. According to a Health Canada report, it "is alarming that these young cases of type 2 diabetes are being diagnosed in First Nations children as young as 5 to 8 years of age in both northern Ontario and Manitoba, and the incidence appears to be increasing at a rapid rate."<sup>15</sup>

Regarding differences between Nations, one can see that more than half of the Abenaki, Algonquin and Innu children have health conditions. In the Algonquin communities, 28.9% of the children have respiratory problems, compared to 20.9% among the Atikamekw and 20.4% among the Innu. Children in zone 1 communities show a slightly higher proportion of health conditions than children in zone 3 and 4 communities.

<sup>15</sup> Health Canada, *Diabetes Among Aboriginal People in Canada: The Evidence*, March 2000, p. 11.

But the latter communities show slightly higher proportions of chronic ear problems and infections than communities in zone 1.

**Graph 22: Proportion of children with medical problems, by Nation (according to parents or guardians)**

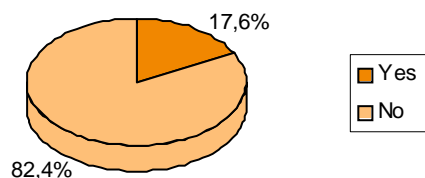


Note: The Malécites of Viger, the Mohawks and the Naskapi are not included in the graph because their results were statistically non significant.

### 2.3.2.1 Physical injuries

17.6% of the children surveyed suffered one or more injuries in the 12 months preceding the survey. Of these children, 46.6% had cuts, scrapes or bruises, 27.0% had broken bones and 13.7% had burns. In about half of the cases (48.5%), the injuries were due to falls or lack of attention, while 14.3% were caused by bicycle accidents not involving a motor vehicle.

**Graph 23: Occurrences of physical injuries among children (12 months preceding the survey)**



We find there is little difference in the injuries to 0-to-5-year-olds and 6-to-11-year-olds, other than that the older children had more broken bones over the 12 months preceding the survey, at 30.9% of 6-11 years old compared to 23.5% of 0-5 years old. The boys also suffered more injuries than the girls, with a proportion of cuts, scrapes and bruises at 55.1%, versus 34.7% of girls. The girls had slightly more broken bones than the boys (30.7% versus 24.4%).

### 2.3.2.2 Difficulties in accessing healthcare services for children

More than one third (36.7%) of the parents or guardians stated that they encountered one or more obstacles in trying to access healthcare for their children. The obstacles brought up most often in response to the questionnaire were: long waiting lists (39.9%), no doctor or nurse in the area (27.0%), services are not covered by Non-Insured Health Benefits - NIHB (26.2%), and difficulties getting traditional care (23.4%). The following table shows the complete list of difficulties mentioned by parents or guardians.

**Table 8: Obstacles encountered by parents or guardians in accessing healthcare services for their children**

Obstacles encountered*	% of parents of guardians
Waiting list too long	39.9%
Doctor or nurse not available in my area	27.0%
Not covered by NIHB	26.2%
Difficulty getting traditional care	23.4%
Chose not to see a health professional	20.4%
Service not available in my region	19.4%*
Felt health care provided was inadequate	18.8%*
Could not afford childcare costs	18.4%*
No health facility in my region	17.8%*
Felt service was not culturally appropriate	16.0%*
Prior approval for services under NIHB was denied	12.9%*
Unable to arrange transportation	12.7%*
Could not afford the direct costs of care	#
Could not afford transportation costs	#

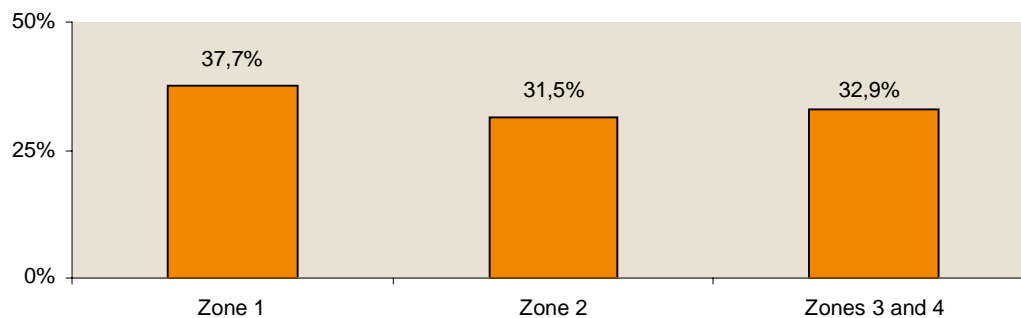
\* Among the parents or guardians who reported having encountered at least one obstacle

The Huron/Wendat, Naskapi and Mi'gmaq parents or guardians experience the fewest obstacles to accessing health care for their children, with over 80.0% of parents and guardians experiencing none at all. Next are the Atikamekw (71.4%), the Innu (60.0%), the Abenaki (59.3%) and the Algonquin (50.0%). The Innu and the Algonquin mentioned the most obstacles encountered. The case of the Innu is particular in that the main obstacles they mention are not the same as those mentioned by the other Nations.

While the main health care obstacle for other Nations is long waiting lists, only 25.5% of the Innu mentioned this obstacle, compared to an average of 50.0% and as much as 70.0% in some Nations. For the Innu, the main obstacle was the difficulty in getting traditional care (32.1%).

In addition, a higher proportion of parents and guardians in zone 1 mentioned one or more obstacles (37.7%) than in zone 2 (31.5%) or zones 3 and 4 (32.9%). The following graph illustrates this.

**Graph 24: Proportion of parents/guardians who encountered one or more obstacles in accessing healthcare for their children, by geographic zone**



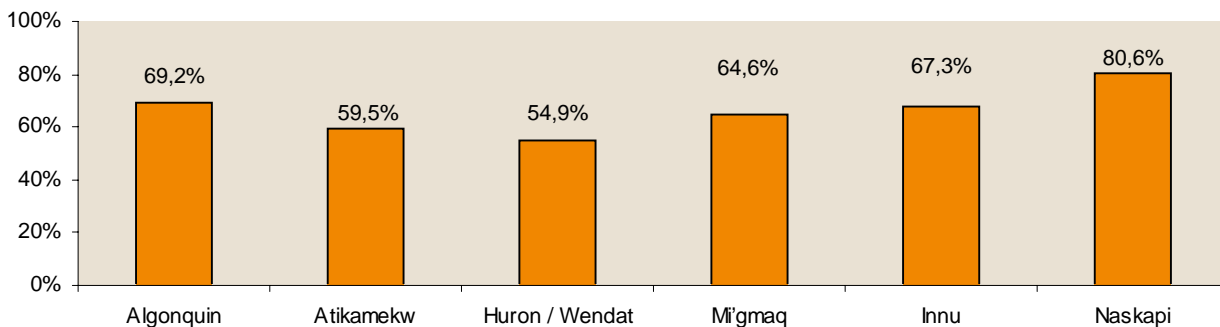
### 2.3.3 Dental Care

More than two thirds (71.2%) of the children received dental care in the year preceding the survey. Among the children who needed dental care, 80.2% needed maintenance, 35.8% needed a filling or other restorative work, 14.7% needed fluoride treatment, and 7.0% needed orthodontic treatment. We note few differences among the Nations, excluding the Naskapi, who had a higher proportion of children needing dental care, at 80.6% of children. Among the latter, 64.3% of the Naskapi children needed fillings or other restorative work, which is a higher proportion than among the other Nations.

The Naskapi children's greater need for dental care does not seem to be linked to their diet. We did not find significant differences in the consumption of junk food among the Nations. At the interpretation session, one participant said that the Naskapi were slightly behind in terms of dental care and that could explain why their children have a greater need for dental care.

The Algonquins and the Innus come next regarding children's need for dental care. 69.2% of Algonquin children and 67.3% of Innu children required dental care at the time of the survey. These children require more maintenance (48.9%) than fillings or restorative work (31.1%). The Naskapis and the Algonquins also had higher proportions of children who had baby bottle tooth decay than the other Nations, at 20.5% and 22.3% respectively, compared to 15.0% and for the other Nations. Algonquin children with this problem are more likely to have received treatment than Naskapi children. The percentage of children who received treatment in the two Nations is 88.1% among Algonquin and 80.8% among Naskapis.

**Graph 25: Proportion of children who need dental care, by Nation**

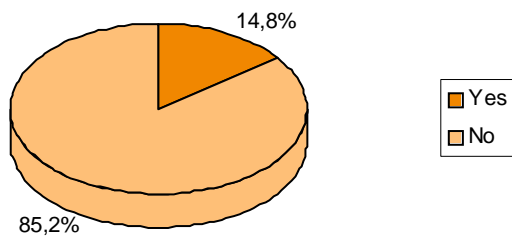


Note: The Abenakis, the Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

The survey revealed that 14.8% of the children have or have had baby bottle tooth decay. Of these, 84.0% received treatment. We note a slight decrease in baby bottle tooth decay since 16.8% of children aged 6 to 11 had this condition, compared to 12.5% of children aged 0 to 5. We also observe that while similar proportions of boys and girls are affected by bay bottle tooth decay, the boys are more likely to receive treatment (87.7%) than the girls (81.0%). Furthermore, a larger proportion of children in large communities have received treatment for baby bottle tooth decay than those in small communities, despite presenting similar proportions of children with this condition.



**Graph 26: Proportion of children with baby bottle tooth decay**



## 2.4 Lifestyle

### 2.4.1 Nutrition

#### 2.4.1.1 Consumption of junk food

Nearly two thirds of parents or guardians perceive their children’s diet to be always or almost always balanced and nutritious, while the remaining third feel their children’s diet is balanced and nutritious sometimes.

According to parents or guardians, 68.3% of the children aged 0 to 5 have a diet that is always or almost always balanced and nutritious, compared to 57.3% of the 6-to-11-year-olds. One can suppose this gap could be even greater between those two groups when we consider the following:

- 21.9% of children aged 0 to 5 years old consume soft drinks a few times a week, versus half (50.2%) of the 6-11 year-olds
- Less than one third (31.2%) of the 0-to-5-year-olds eat fast food a few times a week, versus more than half (54.2%) of the 6-to-11-year-olds
- 46.9% of the 0-to-5-year-olds eat cake, cookies and candies a few times a week, versus 57.9% of the 6-to-11-year-olds
- Less than half of the 0-to-5-year-olds (45.3%) eat French fries and potato chips a few times a week, versus two thirds (66.4%) of the 6-to-11-year-olds
- More than three quarters (76.4%) of the 0-to-5-year-olds never or almost never add salt to their food, versus 57.3% of the 6 to 11-year-olds.
- Two thirds (63.1%) of the 0-to-5-year-olds never or almost never add sugar to their food, versus 38.7% of the 6-to-11-year-olds.

In view of the above, one can see that the perceptions of parents or guardians concerning their children’s state of health are probably higher than reality. Let it be reminded that 40.1% of the children are obese and 12.2%\* are overweight. Diet is clearly not the only factor that influences health and fitness; physical activity is also a determining factor (section 1.3.2). Finally, in section 2: Adolescents’ health (12-17), we will see what are the main factors that justify being in excellent or very good health among First Nation adolescents. This will allow us to better understand how First Nation members define excellent or very good health.

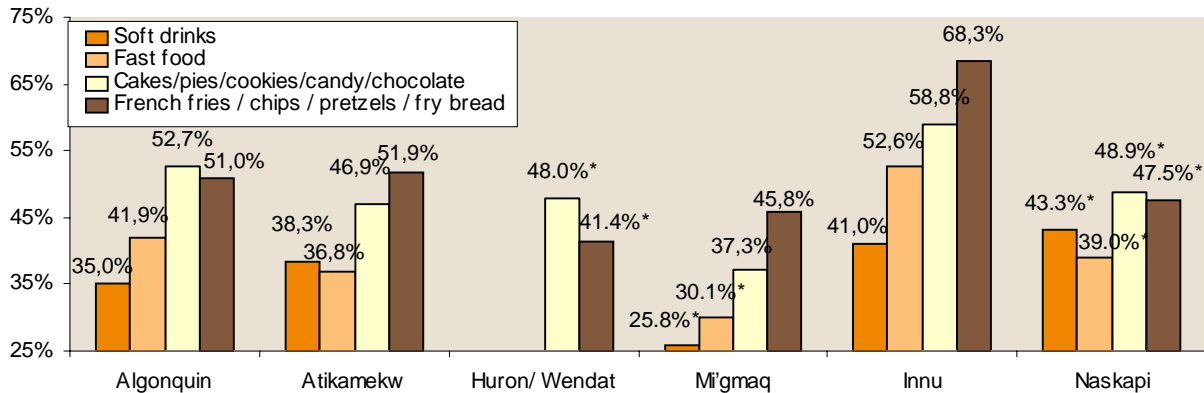
Table 9 presents the frequencies of consumption of various food by children. We can see that, apart from the addition of sugar and salt, those junk food are eaten a few times a week.

Table 9: Frequency of consumption of various food by children

Junk food	Frequency of consumption			
	Never/almost never	Less than once a week	A few times a week	Once a day
Fast food	16,8%	38,8%	43,1%	#
Cakes, pies, cookies, candy, chocolate	14,2%	21,4%	52,6%	9,7%*
French fries, chips, pretzels, fried bread	13,6%	26,2%	56,3%	#
Added salt	66,4%	9,8%*	11,9%*	9,1%*
Added sugar	50,4%	16,5%	21,4%	8,6%*

Finally, although 31.5% of the children never or almost never drink soft drinks, 36.6% do so a few times a week, and 7.2%\* do so several times a day. The only significant difference between the sexes is that more boys than girls eat fast food a few times a week. The following graph shows the consumption of various junk food a few times a week by Nation.

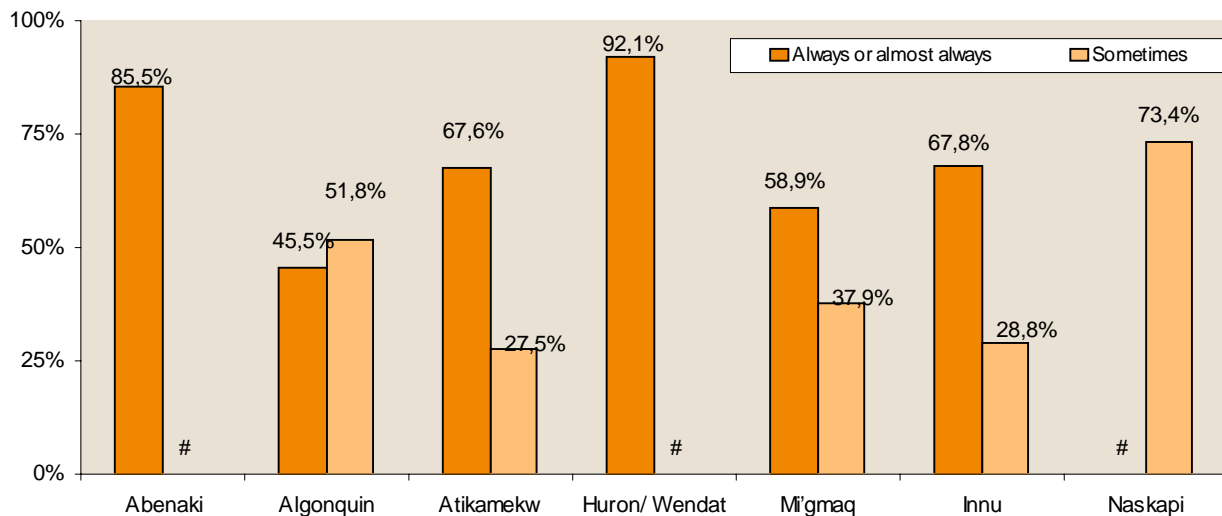
Graph 27: Proportion of children who eat various junk food a few times a week, by Nation



Note: The Abenakis, the Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

In the above graph, Innu children present the highest rates concerning consumption of the above foods a few times a week, excluding soft drinks, which they drink in roughly the same proportions than the Naskapi and Atikamekw children do. Furthermore, 15.5%\* of Innu children eat cakes, cookies, candies and chocolate at least once a day, and 11.1% add salt to their food at least once a day. Still, the following graph shows that 67.8% of Innu parents or guardians consider their children's diet to be always or almost always nutritious and balanced (Graph 28).

**Graph 28: Perceptions of parents or tutors of whether their children’s diet are balanced and nutritious, by Nation**



Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

Although two third of parents assess that their children's diet is balanced, the previous data prove this perception to be slightly wrong. Some hypotheses can explain the difference between the perception of the children’s diet and the reality.

- For some people, a balance diet is to eat three meals a day without any concern with the nutritional value of the food.
- People eat the right food, but with lots of empty food.
- Portions are too big.
- The way of preparing and cooking food is perhaps at fault: many people use butter and fat.

Children’s consumption of tea and coffee seems to be related to their community’s level of remoteness; 94.1% of zone 1 children never or almost never consume these beverages; the proportion drops to 70.3% in zones 3 and 4. As for other foods, no general trends were discerned, other than that children systematically add more sugar to their food in zones 2, 3 and 4 than in zone 1.

Regarding the difference between various sizes of communities, more than half of the parents in small and medium communities (54.4%) consider their children’s diet to be always or almost always balanced and nutritious, with this proportion climbing to 67.2% in large communities.

Finally, children in small and medium communities drink more tea and coffee, eat more cake and other sweets, and add more salt and sugar to food than the children in large communities, who for their part eat more French fries and potato chips.

## 2.4.1.2 Consumption of traditional food

Table 10: Frequency of consumption of traditional food by children (12 months preceding the survey)

Traditional food	Frequency of consumption		
	Not at all	Sometimes	Often
Large game	24,4%	56,4%	19,1%
Small game	41,3%	52,8%	#
Wildfowl	40,4%	52,0%	7,6%*
Freshwater fish	35,4%	51,2%	13,4%
Saltwater fish	74,2%	22,3%	#
Other freshwater/saltwater foods	83,6%	14,0%	#
Marine mammals	99,5%	#	#
Wild berries and fruits	22,7%	63,4%	14,0%
Bannock / Fried bread	18,7%	53,8%	27,5%
Corn soup	89,2%	9,4%*	#

Regarding the consumption of traditional food, the only significant differences between the sexes are as follows:

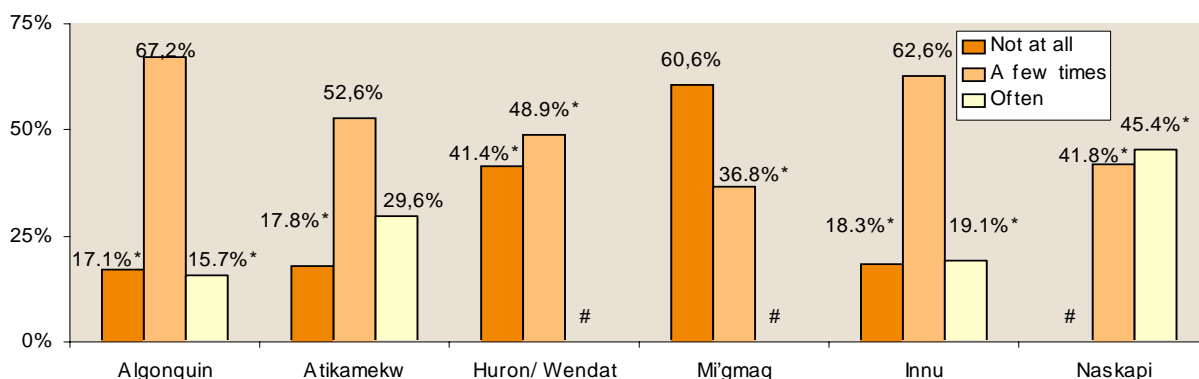
- Wildfowl: eaten by 55.7% of girls sometimes, compared to 48.4% of boys.
- Wild berries and fruits: eaten by 68.2% of girls sometimes, compared to 58.7% of boys.

On the statistical level, the significant differences between the age and the consumption of traditional food also involve these two food types and bannock:

- Wildfowl: not eaten by 37.8% of children aged 6 to 11, compared to 43.1% of those aged 0 to 5.
- Wild berries and fruits: eaten by 68.3% of children aged 6 to 11 sometimes, compared to 58.0% of those aged 0 to 5.
- Bannock: eaten often by almost two thirds of children aged 6 to 11, compared to less than one quarter of those aged 0 to 5.

There are significant differences between Nations in terms of traditional food consumption. For most traditional food, the Algonquin and Innu Nations show the greatest proportions of children who eat them “sometimes,” varying between half and two thirds, while the Atikamekw are frequently found among Nations with the highest proportions of children who eat traditional food often. Graphs 29 to 33 show the differences between Nations in terms of traditional food consumption.

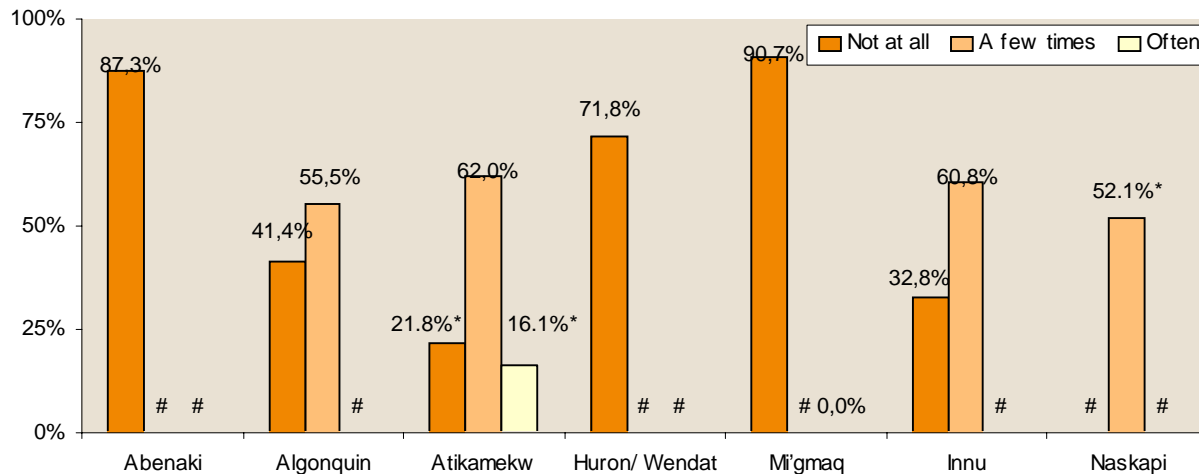
Graph 29: Frequency of consumption of large game, by Nation



Note: The Abenakis, the Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

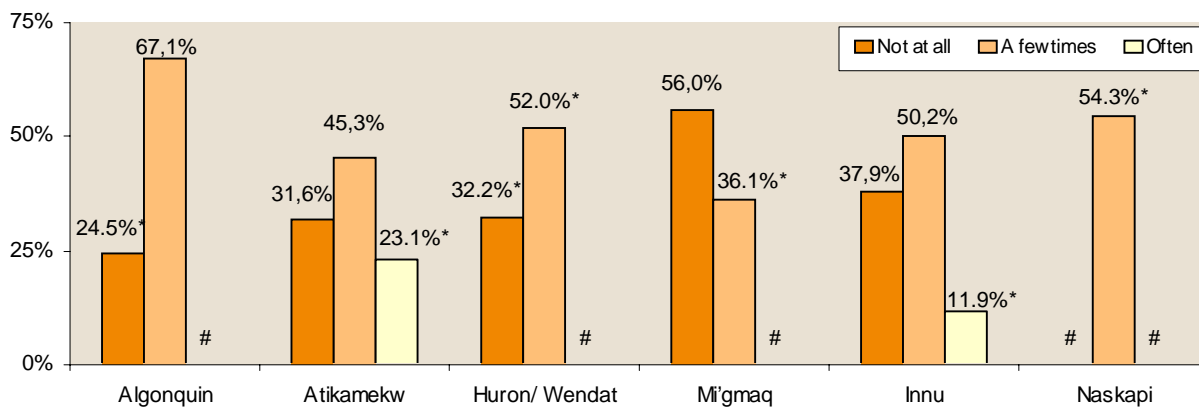
The consumption of small game is less frequent than large game among children: 90.9% of Abenaki and Mi'gmaq children do not eat small game at all, nor do 79.7% of Huron/Wendat and Naskapi children. Half of Algonquin children and over two thirds of Atikamekw and Innu children eat small game sometimes. Let it be noted that the varying accessibility of traditional foods depending on the Nation clearly plays a role in these numbers.

**Graph 30: Frequency of consumption of wildfowl, by Nation**



Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

**Graph 31: Frequency of consumption of freshwater fish, by Nation**

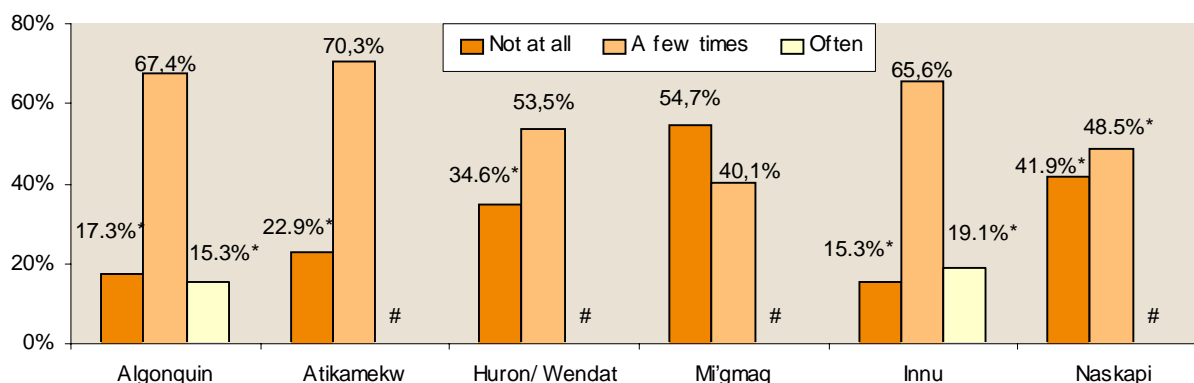


Note: The Abenakis, the Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

Saltwater fish is clearly less popular than freshwater fish, probably because it is less easily accessed in several communities. 91.5% of Algonquin, Atikamekw and Naskapi children never eat saltwater fish. The Hurons/Wendat are the biggest consumers of saltwater fish, with 43.0% eating it sometimes, as do more than one third of the Abenakis, the Innus and the Mi'gmaqs.

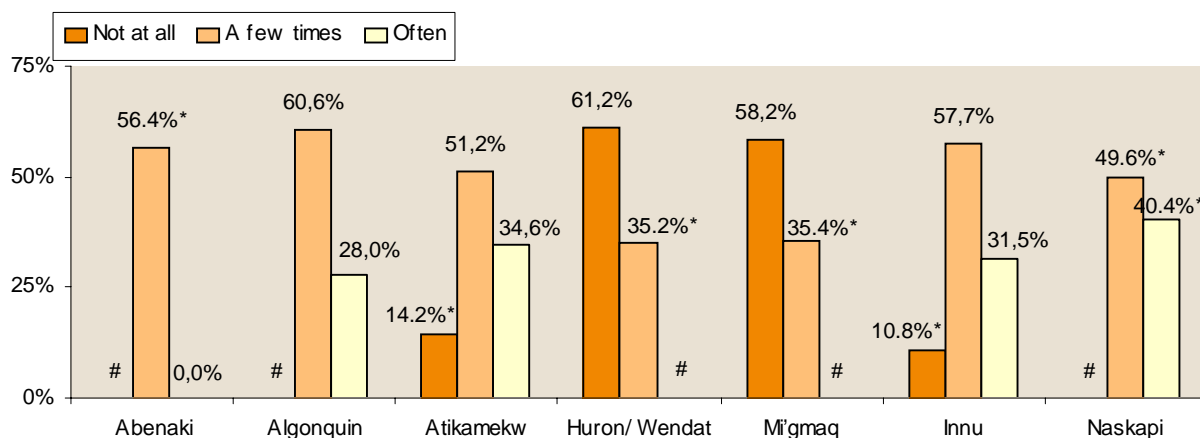
The consumption of other saltwater/freshwater food is even lower, with proportions of children who never eat them varying between 83.6% (Abenaki) and 95.6% (Naskapi). Nearly one quarter of the Mi'gmaqs and almost one Innu in five eat these food sometimes.

**Graph 32: Frequency of consumption of wild berries and fruits, by Nation**



Note: The Abenakis, the Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

**Graph 33: Frequency of consumption of bannock, by Nation**



Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

Finally, let it be noted that corn soup is not frequently eaten by children: 85.0% to 94.4% of them never eat it, although it is slightly more popular among the Abenaki children, where the rate of those who never eat it drops to 76.4%\*. We note here that the cultivation of corn was limited to the St. Lawrence Valley, mainly among the Huron/Wendat and the Mohawks Nations.

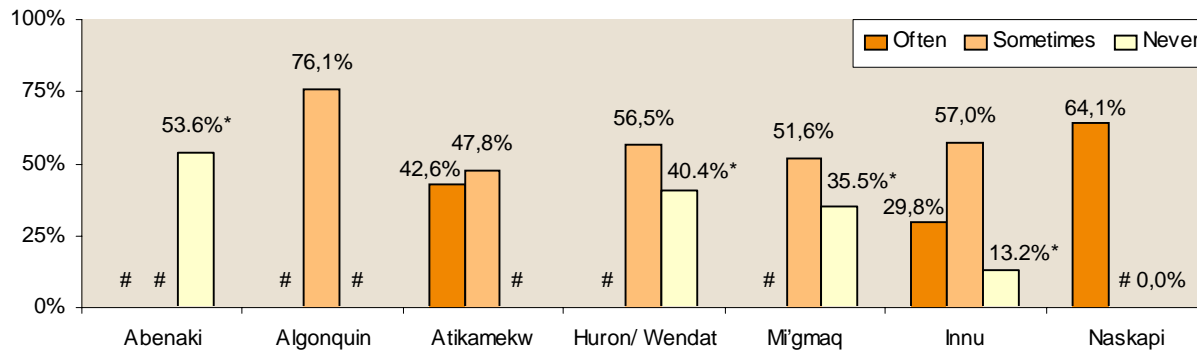
The frequency of consumption of traditional food by children living in zone 1 is lower than in the other zones, excluding saltwater fish and other freshwater/saltwater foods, for which they show the highest frequency of consumption. Access to supermarkets and lower prices may explain the fact that children in zone 1 communities eat more of it. Only the consumption of berries (sometimes) and bannock (often) seems to be associated with the community's level of remoteness.

Concerning the size of the communities, one can see that systematically larger proportions of children in small and medium communities eat traditional food sometimes, compared to children in large communities. The only exception is saltwater fish, where the numbers are reversed. Finally, let it be noted that for other saltwater/freshwater food and bannock, there are no significant differences from a statistical point of view.

Also, greater proportions of children whose parents or guardians consider traditional cultural events to be very important eat traditional foods such as wildfowl, small game, and wild berries and fruits sometimes. The proportions diminish progressively based on the importance given by parents to traditional cultural events for their children. The children whose parents or tutors consider traditional cultural events as not important are the ones who eat large game most often.

We conclude this section by looking at the survey question “How often did someone share traditional food with your household?” 27.0% of respondents said often, 57.6% sometimes and 15.4% never. We also note strong differences among the Nations, as illustrated in the graph below.

**Graph 34: Frequency of sharing of traditional food, by Nation**



Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

We note that the sharing of traditional food tends to increase with the communities’ level of remoteness. The proportion of children living in households that frequently share traditional food rises from 12.7%\* in zone 1 to 50.6% in zones 3 and 4. One quarter of children living in zone 1 households have never shared traditional food.

## 2.4.2 Physical activities and sedentary activities

### 2.4.2.1 Physical activities

According to the American National Association for Sports and Physical Education:

- Toddlers should take part in structured physical activities<sup>16</sup> for at least 30 minutes a day, and pre-schoolers for at least 60 minutes.
- Toddlers and pre-schoolers should take part in non-structured physical activities<sup>17</sup> for at least 60 minutes and up to several hours a day and should not be sedentary for more than 60 minutes at a time, except when sleeping.<sup>18</sup>

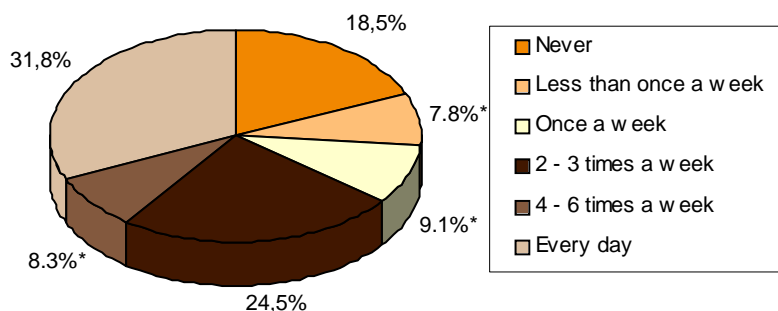
In light of this information, Graph 35 bears witness to a flagrant lack of physical activity among First Nations children, revealing that less than one third of them participate in physical activities every day.

<sup>16</sup> Including games and directed activities in which an adult participates with the child.

<sup>17</sup> In which children participate freely, alone or with others, under supervision.

<sup>18</sup> From *Early Childhood Sector Bulletin*, April 2005, FNQLHSSC, p. 6. The Public Health Agency of Canada states that the “disease process leading to osteoporosis, diabetes, hypertension, high cholesterol and other cardiovascular disease begins in childhood if physical activity levels are insufficient” ([http://www.phac-aspc.gc.ca/pau-uap/paguide/child\\_youth/media/qa.html#5](http://www.phac-aspc.gc.ca/pau-uap/paguide/child_youth/media/qa.html#5)).

Graph 35: Frequency of children's participation in physical activities (outside class hours)



There are no statistical differences between ages in daily participation in physical activities (other than at school) according to age. However, 35.5% of boys participate in physical activities every day, compared to 27.9% of girls.

One quarter of the children in zone 1 participate in physical activities every day, compared to a little more than one third of the children in the other zones. During the interpretation session, workers mentioned that having sports or recreational facilities is not enough: there must also be structured programs and organized activities. But with the wide range of other problems in the communities, recreational activities are more often than not relegated to the bottom of the list of priorities.

The table below presents the physical activities that the children took part in during the 12 months preceding the survey, in order of frequency, first for all children and then by sex and age. We indicate only the significant differences between the sexes.

Table 11: Physical activities children participated in during the 12 months preceding the survey

Physical activities	Children	Boys	Girls	0 – 5 years	6 years +
Walking	85,9%	86,2%	85,6%	78,5%	92,7%
Cycling	74,8%	75,1%	74,4%	55,3%	92,4%
Swimming	51,4%	53,3%	49,4%	37,7%	63,7%
Running	45,9%	48,7%	42,8%	33,9%	56,7%
Ice skating	45,1%	45,3%	45,0%	23,4%	64,7%
Berry gathering	42,6%	38,4%	46,9%	31,8%	52,2%
Fishing	33,2%	42,2%	23,8%	20,0%	45,1%
Hiking	26,7%	29,7%	23,5%	16,4%*	35,9%
Competitive or group sports	26,7%	33,7%	19,3%	#	43,6%
Rollerblading	25,5%	29,3%	21,6%	#	41,5%
Dancing	24,8%	17,7%	32,3%	22,1%	27,3%
Canoeing	20,1%	24,4%	15,6%*	15,6%*	24,2%
Hunting/trapping	18,5%	25,1%	11,6%*	11,8%*	24,6%
Aerobics or fitness class	16,2%	15,4%*	17,0%*	#	25,5%
Skateboarding	10,2%*	17,4%*	#	#	16,8%*
Snowshoeing	10,1%*	12,4%*	#	#	15,6%*
Bowling	9,8%*	10,1%*	9,6%*	#	16,3%*

Gathering of wild berries and fruits and dancing are the only two activities that the girls do more than the boys. It is no great surprise to find that greater proportions of children aged 6 to 11 are systematically involved in various physical activities than those aged 0 to 5.



No general trends emerge that would enable us to associate the communities' level of remoteness and the children's level of physical activity. We note, however, that communities in zone 1 show the lowest proportions of children who participate in the more traditional physical activities, such as hunting and trapping, snowshoeing, canoeing and gathering of wild berries and fruits, but they come well ahead of the others in cycling, swimming, bowling and hiking.

Finally, it was found that hunting and fishing are more common among children whose parents or guardians consider traditional cultural events to be very important.

### **Frequency of structured sports activities (outside school hours)**

Less than one third of the children (29.4%) participate between one and three times a week in a sports program or belong to a sports team, and more than half (56.6%) had not done so in the six months preceding the survey.

More boys than girls participate in sports activities: 32.1% of boys get involved between one and three times a week, compared to 26.6% of girls. A larger proportion of girls (59.7%) did not participate in a sports activity in the six months preceding the survey than of boys (53.6%). Finally, children aged 6 to 11 are obviously much more likely to take part in these activities than children aged 0 to 5.

More than one third of the children in zone 1 participate between one and three times a week in a sports program or belong to a sports team, while in the other zones the numbers vary between one child in four and one child in five. These results are the opposite of the picture revealed in the physical activity section, where we found that only one quarter of zone 1 children get physical activity every day, compared to a little over one third of children in the other zones. This contrast suggests a more formal structuring of sports activities in zone 1 or more (and adequate) infrastructures for sports activities in that zone.

Finally, less than half of the children in small and medium communities did not participate in any sports programs, compared to nearly two thirds of the children in large communities.

Here are various observations on the physical activities practised by children, by Nation:

- Hunting or trapping: Here, the Innu children stand out, with one quarter (25.4%) participating. Among other Nations, the proportions of children who participate in this activity range from 3.6% (Abenaki) to 16.7% (Algonquin).
- Fishing: 39.8% of Innu children fished during the 12 months preceding the survey, as did over one third (34.2) of the Atikamekw, 29.1% of the Algonquin, less than one quarter (22.2%) of the Mi'gmaq and 16.9% of Naskapi children.
- Canoeing: One of every five (20.7%) Innu children practices canoeing. The children of other Nations practice canoeing in proportions between 1.5% and 10.5%.
- Walking: 77.2% of Atikamekw children and 88.7% of Algonquin children walk; this proportion reaches 98.5% among Naskapi children.
- Swimming: There is a wide variability here, ranging from 37.7% among the Atikamekw to 79.6% among the Naskapi children.
- Dancing: 51.8% of Naskapi children dance; this proportion varies between 16.2% and 35.3% among the other Nations.
- Running: Three quarters (74.8%) of Algonquin and 77.4% of Naskapi children run, as do over half (53.3%) of the Mi'gmaq, 43.9% of the Atikamekw and less than one third (32.2%) of the Huron/Wendat and Innu children(30.6%).
- Hiking: While proportions range from one quarter to one third for most Nations, one in every ten Mi'gmaq children hikes.
- Snowshoeing: Only 10.1% of children snowshoe. Abenaki and Atikamekw children have the highest rates with 16.4% and 15.4% respectively.
- Gathering of wild berries or fruits: Participation here ranges from near one quarter to one third of children, but the proportion rises to half among the Atikamekw and the Innu children.
- Competitive or group sports: About one quarter of children in all Nations participate in competitive or group sports, except the Algonquin children, who have a participation rate of over one third.

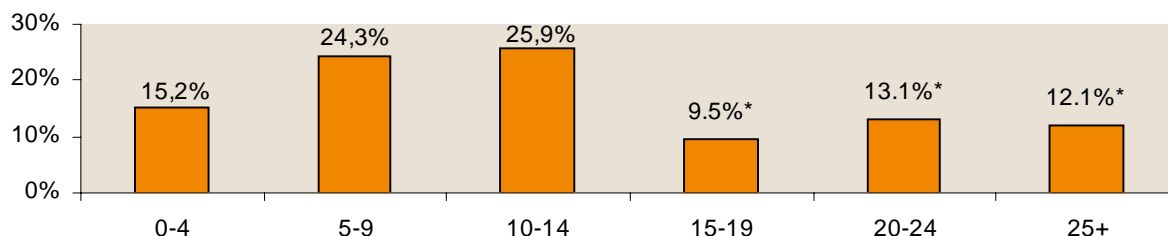
- Bowling: the Abenaki, the Mi'gmaq and the Huron/Wendat children, who all live near urban centres, practise this activity.

#### 2.4.2.2 Sedentary activities

The survey reveals that several children participate in sedentary activities several hours a week. A deeper examination of these activities allows us to provide a portrait of the children's physical inactivity.

### B) Watching television

**Graph 36: Number of hours spent weekly watching television**

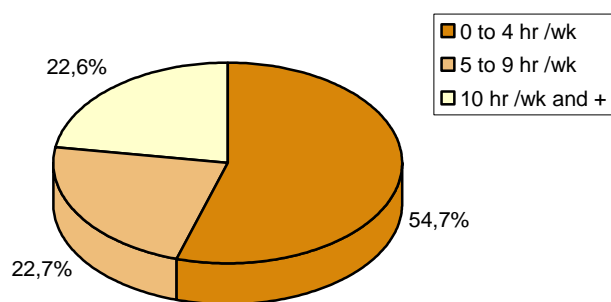


The significant observations retained in terms of children's age versus the average hours spent watching television are as follow:

- more than one out of five 0-to-5-year-olds watch television between 0 and 4 hours a week, compared to one out of ten 6-to-11-year-olds
- nearly one out of five of 0-to-5-year-olds watch television between 10 and 14 hours a week, compared to 30.6% of 6-to-11-year-olds.

### B) Video games

**Graph 37: Number of hours spent weekly playing video games**



Boys clearly play video games more often than girls do. Nearly one quarter of boys play between 5 and 9 hours a week, compared to one out of five girls. While nearly two thirds of boys play 10 hours a week or more, half of the girls play 4 hours a week or less.

Statistically, the same proportion of 0-to-5-year-olds and 6-to-11-year-olds play over 10 hours a week (approximately one out of five).

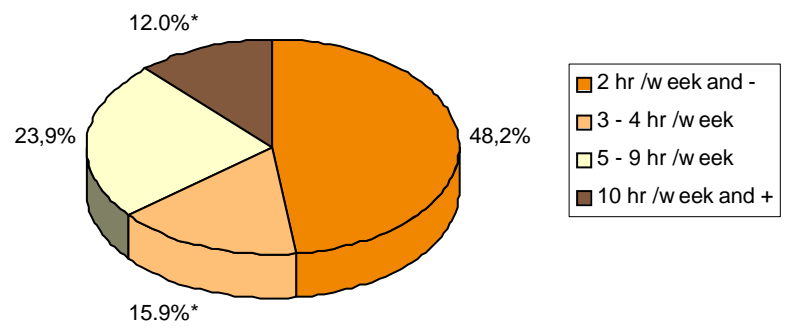
From the data for each Nation, we see that 20.0%\* of the Innu children play video games 10 hours a week or more, compared to 25.6% of the Algonquin and 29.9%\* of the Atikamekw children.

The number of hours spent playing video games seems to be related to the communities' level of remoteness. Children in zones 3 and 4 spend the most time playing video games, followed by children in zone 2 and then zone 1.

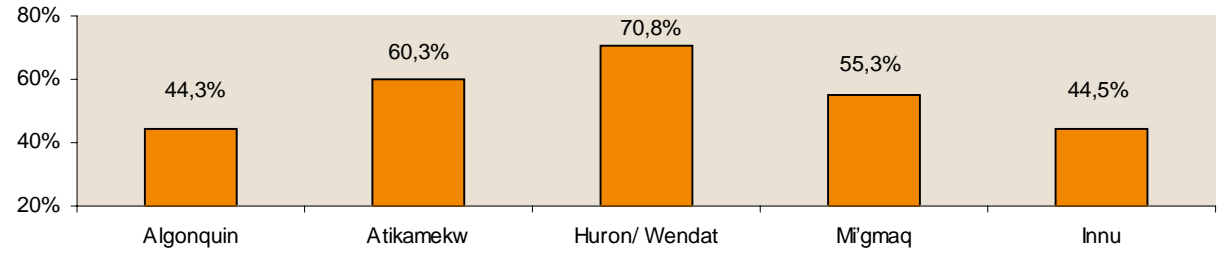
Finally, one can see that children whose mothers who did not complete high school spend more time per week playing video games than children whose mother completed high school. While half of the former spend 0 to 4 hours per week on video games, two thirds of the children of the latter do the same.

**C) Computer use**

**Graph 38: Number of hours spent weekly using the computer**



**Graph 39: Proportion of children using a computer two hours or less per week, by Nation**



Note: Abenaki, Malécites of Viger, Mohawk and Naskapi children are not included because their proportions are not statistically significant.

55.4% of children in the small and medium communities use a computer two hours a week or less, versus 47.7% in the large communities.

Finally, 30.7% of the children who eat fast food a few times a week use a computer 5 to 9 hours a week, and 16.4%\* of them use a computer 10 hours a week or more.

## 2.4.3 Emotional and social well-being

### 2.4.3.1 Activities and hobbies

#### A) Artistic or musical activities (outside school hours)

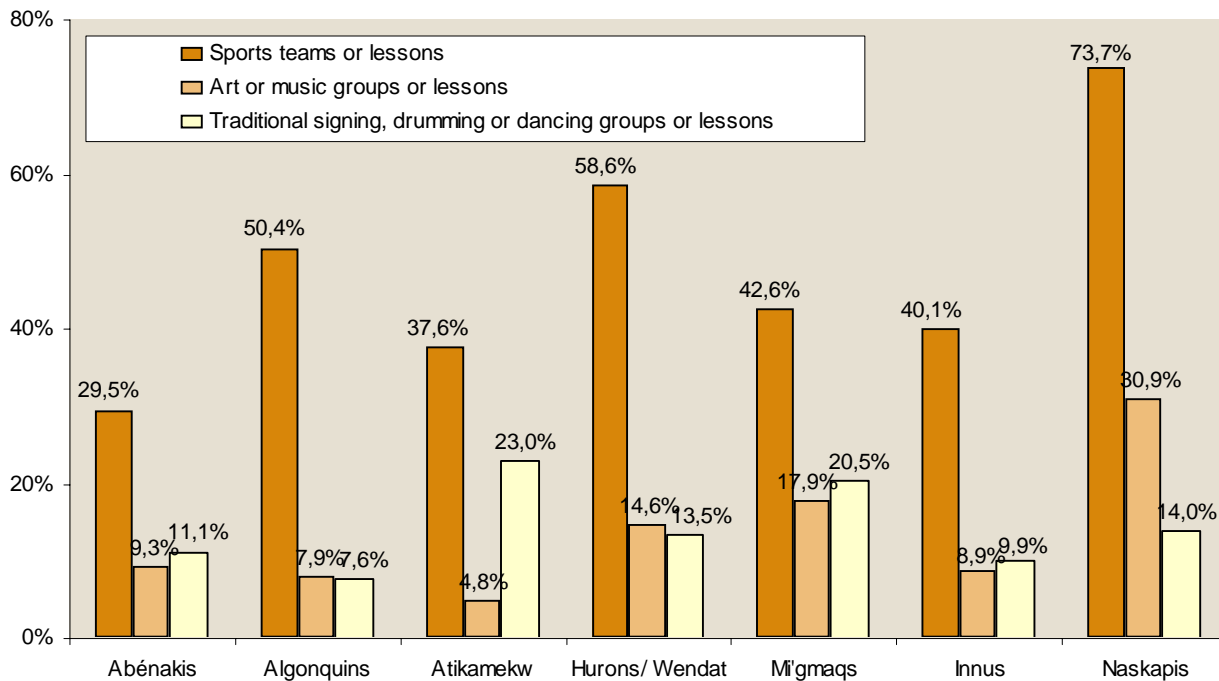
90.6% of the children did not take any art or music lessons or never were members of an art or music group.

Once again, the 6-to-11-year-olds are more likely to take part in art or music activities than the 0-to-5-year-olds.

#### B) Traditional activities (outside school hours)

86.1% of the children did not take any traditional singing, drumming or dancing lessons. Larger proportions of children aged 6 to 11 participate than of children aged 0 to 5. The following graph shows the differences between Nations in terms of the participation in certain types of activities.

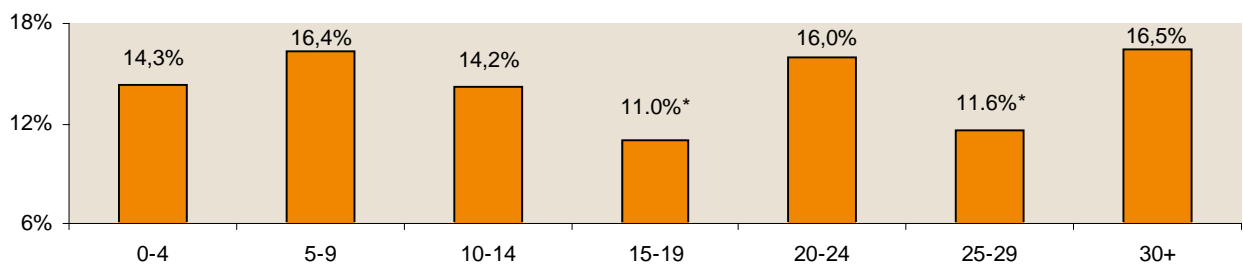
**Graph 40: Proportion of children participating in activities outside class hours, by Nation (6 months preceding the survey)**



Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

### C) Outdoor games

Graph 41: Number of hours spent weekly playing outdoors

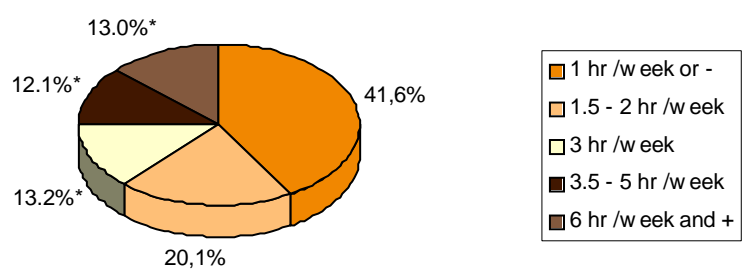


This graph shows that 55.1% of children spend an average of 15 hours or more weekly playing outdoors.

There is no significant difference from the statistical point of view between normal-weight children or obese children and the number of hours spent weekly playing outdoors.

### D) Help with household chores

Graph 42: Number of hours spent weekly doing household chores

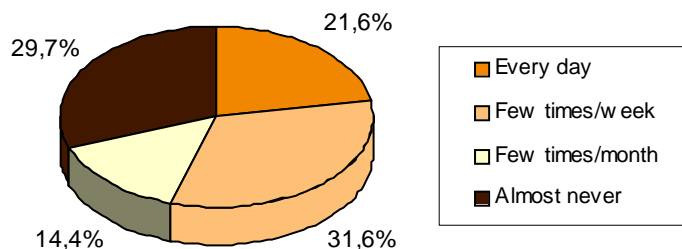


47.0% of the boys help with household chores for an hour or less every week, compared to 36.8% of the girls. On the other hand, 43.5% of the girls help with household chores for 3 hours a week or more.

71.7% of Huron/Wendat children help with household chores for an hour a week or less, as do two thirds of Abenaki children. Among the other Nations, the proportion varies from 34.6%\* to 43.3%, except among the Naskapis, where the proportion is not valid on the statistical level to be considered.

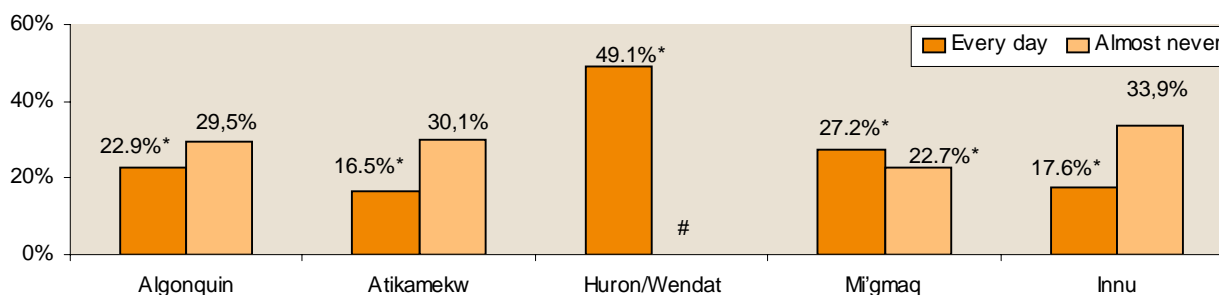
## E) Reading

Graph 43: Number of hours spent weekly reading



Results show that girls read more than boys do. Nearly one quarter of the girls read every day, versus only 16.9%\* of the boys. Nearly one third of the boys almost never read, versus 26.2% of the girls.

Graph 44: Frequency of reading by children, by Nation



Note: Abenaki, Malécites of Viger, Mohawk and Naskapi children are not included in the graph because their results were statistically non significant.

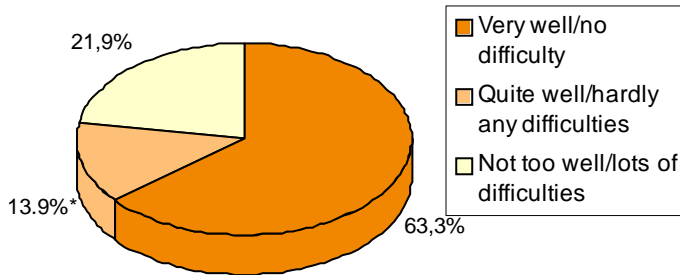
The biggest readers live in zone 1; more than one quarter of the children there read every day, compared to 17.3% in the other zones. Nearly a quarter of zone 1 children almost never read, compared to over one third of those in other zones. We can assume that in the zone 1 communities, greater accessibility of libraries and bookstores greatly facilitates reading among children. The Huron/Wendat children, located in zone 1, post the highest proportion of readers.

Children in large communities read on average more than those in small and medium communities.

The proportion of children who almost never read seems to be related to the schooling level of the mother or female guardian. More than one third of children whose mother or female guardian did not complete high school studies almost never read, compared to less than a quarter of those whose mother have trade, technical or vocational diplomas. The same is true for fathers or male guardians: 16.2%\* of children whose father or male guardian did not graduate from high school read every day, versus 23.8%\* of children whose father or male guardian graduated from high school and 34.8%\* from college.

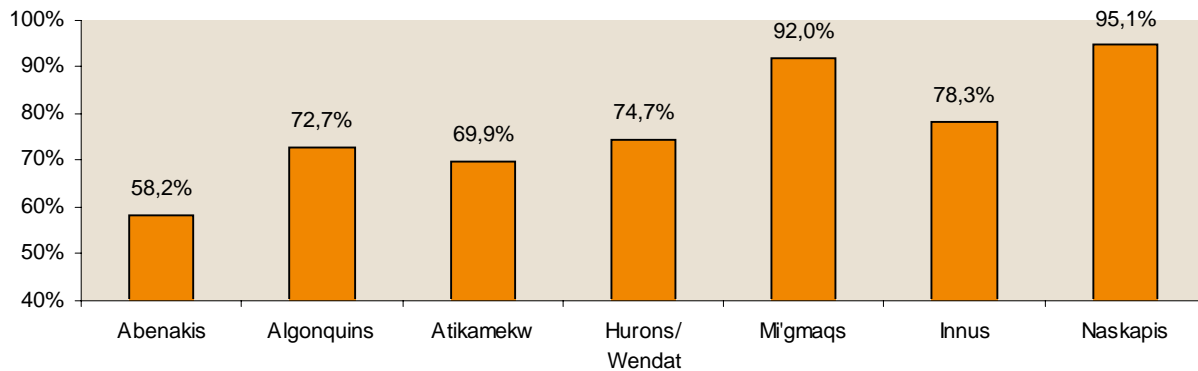
2.4.3.2 Relationship with the family

**Graph 45: Perceptions of parents or guardians of the children’s relationship with the family (6 months preceding the survey)**



According to parents or guardians, the 0-to-5-year-olds clearly have a better relationship with their family than do the 6-to-11-year-olds. 67.8% of the 0-to-5 year-olds had no problems, compared to 59.1% of the 6-11-year-olds. However, nearly one quarter (24.7%) of the latter had many problems, compared to 18.9% of 0-to-5-year-olds.

**Graph 46: Proportion of parents or guardians who consider the children’s relationship with the family as good or very good, by Nation (6 months preceding the survey)**




Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

40.2% of children living in zone 2 communities do not get along very well or not at all with their family. The proportion is 22% in zone 1 and 16% in zones 3 and 4.

Finally, 29.4% of the children in small communities do not get along very well or not at all with their family, compared to 28.9% in the medium and 13.0% in the large communities.

2.4.3.3 Emotional and behaviour disorders

16.5% of the parents or guardians consider their children to have had more emotional or behavioural problems than other children their age in the six months preceding the survey. 12% of the 0-to-5-year-olds had more emotional or behavioural problems than other children their age, compared to 20.6% of the 6-to-11-year-olds.



20.2% of the Atikamekw children have had more emotional or behaviour disorders than other children their age. For the Abenaki, the Algonquin, the Huron/Wendat and the Mig'maq children, the proportions vary between 11.1% and 15.7%. Finally, the proportion is 7.1% for the Naskapi.

Mirroring the family relations situation, zone 2 has the highest proportion of children with more emotional or behaviour disorders than other children their age: 27.9% of children in zone 2 compared to 14.5%\* in zone 1 and a statistically non-significant proportion in zones 3 and 4.

The questionnaire ended with the following question: "Are there other issues affecting the well-being of children in this community that should be asked about?" Among the answers we received, only one demonstrated any statistical significance: use of drugs, volatile substances and alcohol (15.6%).

Following are answers that did not obtain statistically significant proportions:

- Activities for children
- Parental support
- Sexual abuse
- Recreational infrastructure and activities
- Crime and violence
- Traditional knowledge and activities
- General well-being
- Community safety
- Safety from stray dogs (high number of stray dogs)
- Bullying, rudeness and disrespect among children at school
- Education at school and from parents
- Neglect
- Social support

#### 2.4.4 Residential Schools<sup>19</sup>

A low proportion of children have at least one parent who has attended a residential school (16.1%). However, a little over half (53.1%) have one or more grandparents who attended one. Of these, we noted a higher proportion of maternal grandmothers who attended a residential school (37.8%). Zone 2 communities have the highest numbers of children whose grandparents attended a residential school. The Atikamekw and the Algonquin are the Nations with the most communities in zone 2.

#### 2.4.5 Child Care Arrangements

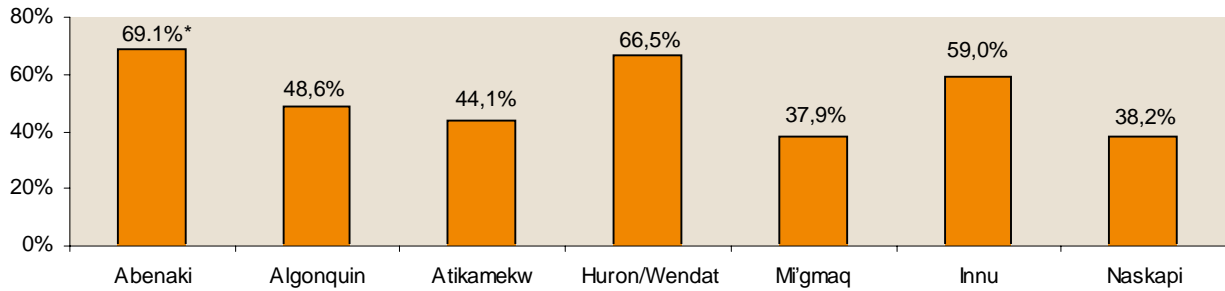
Other persons care for 50.7% of the children when their parents or guardians are at work or school. Of that proportion, 34.3% go to a daycare service, 25.2% are taken care of by relatives and 21.6% are taken care of at home by a brother or sister. The Abenakis, the Hurons/Wendat and the Innus have the highest proportions of children requiring child care, at 69.1%, 66.5% and 59.0% respectively, compared to about 50.0% for all the other Nations.

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<sup>19</sup> The residential schools are the institutions exploited by the federal government or of the religious communities where many Aboriginal children from across Canada lived between 1860 and 1974.



**Graph 47: Proportion of children requiring childcare services when the parents or guardians are at work or at school, by Nation**

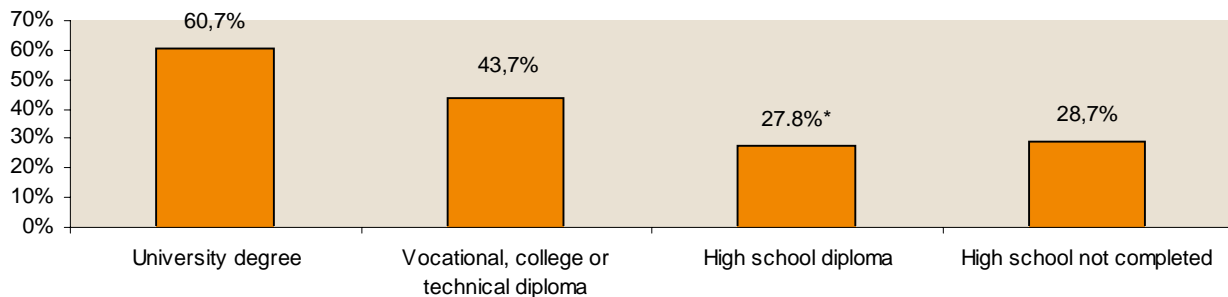


Note: The Malécites of Viger and the Mohawks are not included in the graph because their results were statistically non significant.

A higher proportion of Abenaki and Huron/Wendat children go to a daycare service, 60.5% and 51.3% respectively. This could be related to the fact that all of their communities are in zone 1, because the Innus, even though they also have one of the highest proportions of children requiring child care, present different results. Of the Innu children requiring child care, 25.7% go to daycare, 25.7% are taken care of at home by a brother or sister, and 29.9% are taken care of in someone else's home by a relative. The Naskapi, who are also in a remote region, show a particularly high number of children being taken care of in someone else's home by a relative (66.1%).

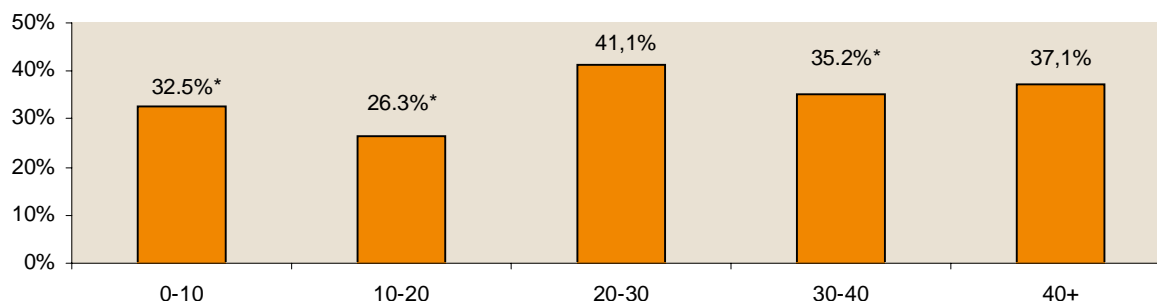
We have difficulty correlating child care arrangements with household income and level of education of the mother or female guardian, since much of the data is statistically non significant. We did note, however, a marked difference in terms of daycare use between mothers or female guardians with the least education and those with the most. Daycare is used by 28.7% of mothers and female guardians who did not graduate from high school, compared to 27.8% of those who did, and compared to 43.8% of women with technical, vocational or college diplomas and 60.7% of women who obtained a university degree.

**Graph 48: Proportion of children in daycare, by mother's or guardian's schooling level**



We also note that households with incomes between \$10,000 and \$19,999 use daycare at a lower proportion, 26.3%, compared to proportions of 30.0% and higher for other income brackets. Households with annual incomes between \$20,000 and \$29,999 and those with an annual income above \$40,000 show the highest proportions of daycare use, at 41.1% and 37.1% respectively.

Graph 49: Proportion of children in daycare, by household income (in thousands of dollars)



Finally, higher percentages of 6-11 year-olds are taken care of in someone else's home by a relative or at home by a brother or sister compared to 0-5 year-olds who attend daycare centres in a proportion of 48.3%.

## 2.5 Conclusion: Children's Health (0 – 11)

### 2.5.1 Demographic Profile

More than half of the children live near an urban centre, i.e., in zone 1. We note that the Naskapi in particular have a large proportion of children (more than 75%) in the 6 to 11 year-old group. Households located in zones 3 and 4 have more children than those in zone 1, and more than one out of five households in zone 1 is a single-parent family.

A high percentage of families with three or more children live under the poverty line. One third of the mothers in zone 1 have not completed high school studies, and this proportion climbs to two thirds of mothers in the other zones.

Parents' or guardians' perception of how important it is for their children to learn a First Nations language seems to be associated to the level of remoteness of their community: the more remote the community, the more they feel it is important. In general, parents and guardians are very satisfied or satisfied with their children's knowledge of their first language. Overall, they also consider traditional cultural events to be important in the life of their children. One can see that family members are the persons who play the biggest role in helping children understand their culture.

Turning to education, we note that one of every ten children has repeated a year at school and boys are doing less well at school than girls. The Huron/Wendat and Mi'gmaq communities make the least use of Head Start programs at the time of the survey.

### 2.5.2 State of Health and Lifestyle

The main conclusions concerning the children's state of health include that high proportions of women smoked during pregnancy, high rates of children are not breastfed and a significant percentage of children are obese. More than one third of women who smoked while they were pregnant acknowledge having smoked during the entire pregnancy.

In looking at breastfeeding and infantile obesity, we note significant differences among the geographic zones. Zones 3 and 4 have the lowest proportion of breastfeeding mothers and the highest proportion of obese children. It should be pointed out that since the first phase of the survey in 1997, there has been a marked increase in the proportion of children who were breastfed.

Just under half of the children have health conditions. The most widespread health conditions are, in order of incidence, respiratory problems, vision or hearing problems, and allergies. Asthma is the problem that requires the most treatment and causes the most limitations to children's activities.

The most important obstacle that parents and guardians encounter in trying to access health care for their children is long waiting lists. The situation among the Innus is unique; their main obstacle is the difficulty in accessing traditional care.

Most of the children received their last dental treatment within the 12 months preceding the survey and were in need of dental maintenance. There are few differences among the Nations, although we find a greater proportion of Naskapi children requiring dental care.

Regarding the diet of children, we note that a high proportion of children eat fast food, cakes, French fries, etc., a few times a week. Furthermore, even though the overall proportion of children who drink tea or coffee is quite low, the survey revealed that nearly one third of the children in zones 3 and 4 drink these beverages.

About half of the children eat traditional food sometimes. However, there are important differences among the Nations. The Nations where children eat the most traditional food are the Atikamekw and the Naskapi, followed by the Algonquin and the Innu children. The Mi'gmaq children eat traditional food the least often.

Finally, according to the physical activity guidelines published by the American National Association for Sports and Physical Education, First Nations children suffer from a flagrant lack of physical activity. Boys get more physical activity than girls, and the children in zones 2, 3 and 4 get more physical activity than those in zone 1. However, a few more children in zone 1 participate in sports programs or team sports.

Most of the children did not take art or music lessons or participate in traditional activities such as singing, drumming and dancing outside of class hours in the 12 months preceding the survey.

### 2.5.3 Emotional and Social Well-Being

Nearly one quarter of the 6-11 year-olds have had many family difficulties. However, most of the parents and guardians feel that their children do not have more emotional or behavioural problems than other children. We find that zone 2 has the highest proportion of children with more problems than other children.

As for child care arrangements, half of the children receive care from other persons while their parents or guardians are at school or work. Of these, one third goes to daycare and one quarter are cared for by a relative. The Abenaki, Huron/Wendat and Innu children post the highest proportions of children requiring childcare services.



## Section 3: Adolescents' health (aged 12 to 17)



## Adolescents' health (aged 12 to 17)

### 3.1 Highlights

#### 3.1.1 Social characteristics

##### 3.1.1.1 Information on households

Survey results indicate that more than half (57.6%) of adolescents lived with two adults. Half the adolescents (51.7%) lived with their two biological parents, while nearly one quarter (24.1%) lived only with their biological mother. Close to one half (45.7%) of adolescents reported that their biological parents were married or common-law and living together, whereas more than one quarter (28.8%) reported that their parents were not married and not living together. We also observed differences among the zones<sup>20</sup> regarding the marital status of parents. More adolescents in zone 2 (59.1%), zones 3 and 4 (66.6%) had parents who were married or common-law and living together than in zone 1 (35.2%).

##### 3.1.1.2 First Nations languages and traditional culture

The survey shows that nearly one half (48.9%) of adolescents felt it was important to speak a First Nation language. This is reflected by the fact that the majority of them understood (62.4%) and spoke (55.7%) a First Nations language. However, opinions seemed to be divided regarding the importance of traditional cultural events. Nearly half (44.3%) of adolescents felt they were very important, while more than half (52.1%) felt they were not very important or not important at all. Lastly, adolescents in zones furthest away from urban centres (zones 2, 3 and 4) placed more importance on the ability to speak a First Nations language than adolescents in the areas closest to urban centres (zone 1). The same observation holds for the importance given to traditional cultural events.

##### 3.1.1.3 Education

The majority of adolescents seemed to have difficulties in their education. Half the adolescents (50.4%) had repeated a school year and two out of five (41.0%) reported that they had learning difficulties. We also note that a high proportion of adolescents like school somewhat. 86.3% of adolescents reported that their mother encourages them in their studies, while 69.6% indicated that they received encouragement in their studies from their father.

#### 3.1.2 Health

##### 3.1.2.1 Overall health

Nearly two thirds of adolescents felt they were in excellent or very good health. The main reason they gave for being in excellent or very good health was getting regular physical activity (70.8%). However, many adolescents had health problems, which were more prevalent in zone 1, at 45.1%, compared to 29.5% in zone 2 and 25.8% in zones 3 and 4. Although the majority (56.0%) of adolescents had a normal weight, 20.3% were overweight and 21.7% were obese. Finally, the proportion of adolescents with a normal weight seemed to decrease as the level of community isolation increased (62.7% in zone 1 compared to 50.7% in zone 2 and 42.6%\* in zones 3 and 4).

<sup>20</sup> Zoning system developed by Indian and Northern Affairs Canada to categorize the level of geographical isolation of the communities

- Zone 1: Located within 50 km of the nearest service centre\* with year-round road access.
- Zone 2: Located between 50 km and 350 km from the nearest service centre with year-round road access.
- Zone 3: Located more than 350 km from the nearest service centre with year-round road access.
- Zone 4: No year-round road access to a service centre.

\* Nearest community providing access to suppliers, banks and government services.



### 3.1.2.2 Dental care

The majority (85.5%) of adolescents had received dental care in the 12 months preceding the survey. Nevertheless, it was found that a high proportion (69.8%) of them required dental care. Among these, three quarters (75.9%) required maintenance and nearly one half (48.5%) required fillings or restoration work.

### 3.1.2.3 Sexual health

More than two of every five adolescents were sexually active. Among these, condoms were the most popular contraceptive method; they were used by a strong majority (86.6%) of sexually-active adolescents. The main reasons given for using condoms were to prevent pregnancy and to receive protection from sexually-transmitted diseases (STDs).

### 3.1.2.4 Physical, emotional, mental and spiritual well-being

With regard to their well-being, the majority of (57.8%) of adolescents felt they enjoyed an average level of balance. Adolescents' levels of balance were established according to the extent to which they agreed with certain statements about life in general. In addition, nearly three quarters of adolescents had high self-esteem (slightly higher among boys, at 79.6%, than among girls, at 67.4%). A self-determination index was used to determine the extent to which adolescents felt they had control over their life; 61.9% of boys and 56.1% of girls scored high on this index. However, the strong majority of adolescents felt they received poor social support, i.e., they felt there were few persons whom they trusted to speak with about their emotional or mental health. Only a minority of adolescents indicated that they always had someone whom they trusted to speak with about their problems (47.5% in zone 1, 35.4% in zone 2 and 28.6% in zones 3 and 4). Social support also varied among the zones; it diminished as the community's level of isolation increased. 47.5% of adolescents in zone 1 felt they always had someone whom they could trust to speak with about their problems, compared to 35.4% in zone 2 and 28.6% in zones 3 and 4. Finally, psychological distress is a problem which clearly affected a significant number of adolescents. The survey revealed that 46.5% of girls and 23.6% of boys had considered committing suicide at some point in their life, and two of every five had been depressed for a period of two consecutive weeks or more in the 12 months preceding the survey.

### 3.1.2.5 Physical injuries

According to the survey's results, a significant proportion of adolescents (55.0%) had physical injuries in the 12 months preceding the surveys. The most common ones were cuts, scrapes and bruises (50.7%), sprains or strains (41.9%), broken bones (34.9%) and burns (25.9%). The main causes of injuries were as follows: sports (50.1%) and falls or trips (43.6%).

## 3.1.3 Lifestyle

### 3.1.3.1 Food and nutrition

Survey results indicate that the majority of adolescents had diets that were sometimes balanced and nutritious. Furthermore, the diet of younger adolescents was healthier than the diet of older adolescents; 57.8% of 12-14 year-olds eat junk food once a day or more, compared to 65.2% of 15-17 year-olds. We also noted that the girls' diet was healthier than the boys' diet. The latter consumed more coffee or tea, soft drinks and cake than the girls. Consumption of traditional food was relatively low in all the geographical zones, but it was found to be higher in large communities than in smaller communities.

### 3.1.3.2 Physical activity

The information obtained through the survey shows that adolescents were relatively active. Half (43.0%) had physical activity four times a week or more, while 21.0% did so four to six times a week and 22.0% did so every day. Walking and cycling were the two most common physical activities. We also found that one third (33.1%) of adolescents played outdoors three to five hours a day, while close to one third (30.5%) did so one to two hours a day.



### 3.1.3.3 Sedentary activities

A significant number of adolescents took part in sedentary activities (watching television, playing video games, etc.) several hours a day. Nearly half (45.0%) watched television one to two hours a day, while more than one third watched television three to five hours a day. Video games were also popular among adolescents, boys in particular (70.6%). Nearly half (45.6%) the boys who play video games did so one to two hours a day, and one quarter (25.0%) did so three or more hours a day. Finally, two of every five (39.9%) adolescents spent one to two hours a day at the computer.

### 3.1.3.4 Smoking

There was a high smoking rate among First Nations adolescents. More than half smoked (51.2%). The majority (66.8%) of adolescent smokers were aged 15 to 17, while one third (33.2%) were aged 12 to 14. In addition, two thirds of adolescent smokers (66.0%) smoked every day. We note that adolescents began smoking at very young ages; three quarters (76.5%) indicated that they began smoking before they were 13. Finally, half of them indicated that they did not live in smoke-free households.

### 3.1.3.5 Alcohol consumption

Consumption of alcohol increased considerably during adolescence. One third of 12-14 year-olds drank beer, wine, spirits or other alcoholic beverages in the 12 months preceding the survey, compared to three quarters (75.9%) of 15-17 year-olds.

### 3.1.3.6 Drug and solvent consumption

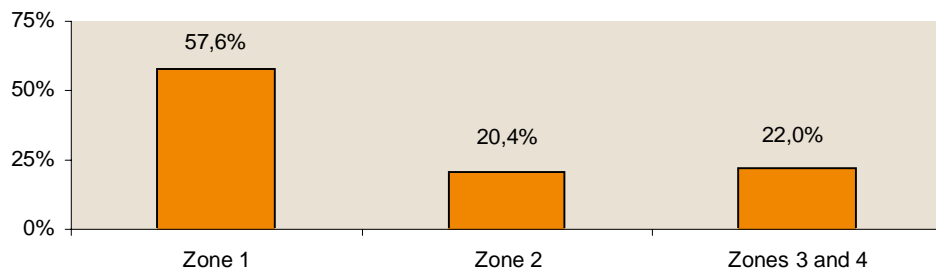
The results show that more than two of every five adolescents (44.2%) used drugs or solvents in the 12 months preceding the survey. The proportions were slightly higher for girls (45.9%) than for boys (42.6%). Marijuana was the drug used most frequently by adolescents; a vast majority of them (92.1%) used it in the 12 months preceding the survey.

## 3.2 Demographic profile

### 3.2.1 Age, sex and place of residence

Youth aged 12 to 17 make up the survey's adolescent group. Quebec's First Nations are home to slightly more 15-17 year-olds than 12-14 year-olds (54.2% and 45.8% respectively). There are as many girls as boys. More than half of all adolescents live in zone 1 (57.6%) and more than half live in large communities (56.6%). The proportion of adolescents is approximately 20.0% in the other geographic zones. Finally, 43.4% of adolescents live in small and medium-sized communities.

**Graph 50: Distribution of adolescents by geographic zone**



Note: Zones 3 and 4 are merged for reasons of statistical validity.

### 3.2.2 Information on household

80.9% of all adolescents live with one or two other adolescents, 41.6% with one or two children aged 6 to 11, and 32.4% with one or two children aged 0 to 5 (it must be noted that adolescents and children are not necessarily biological brothers and sisters). More than half of adolescents (57.6%) live with two adults, while 7.0% live with one or more adults aged 65 or older. About half (51.7%) live with their biological parents (with higher proportions in zones 2, 3 and 4). It is important to note that 24.1% of adolescents live with their biological mother only, which indicates a high proportion of single-parent families.

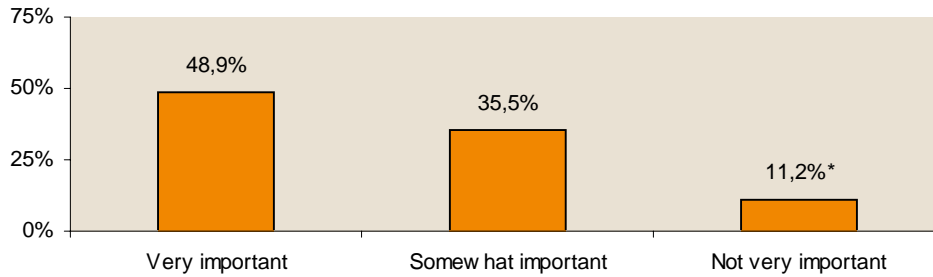
Slightly under half of all adolescents (45.7%) indicated that their biological parents are married, and 28.8% stated that their biological parents do not live together. The biological parents of adolescents in zone 1 present the lowest proportion of married couples, at 35.2%, versus 59.1% in zone 2 and 66.6% in zones 3 and 4. We also note fewer married couples in large communities than in small and medium-sized ones.

### 3.2.3 First Nations languages and traditional culture

#### 3.2.3.1 Languages understood and languages spoken

Almost half of all adolescents (48.9%) believe it is very important to speak a First Nations language, while 35.5% believe it is somewhat important, and 11.2% believe it is not important. 62.4% understand one or several First Nations languages fluently or adequately, and 55.7% speak one or several First Nations languages fluently or adequately. Slightly more girls than boys understand and speak one or several First Nations languages.

**Graph 51: Level of importance given to speaking a First Nations language**



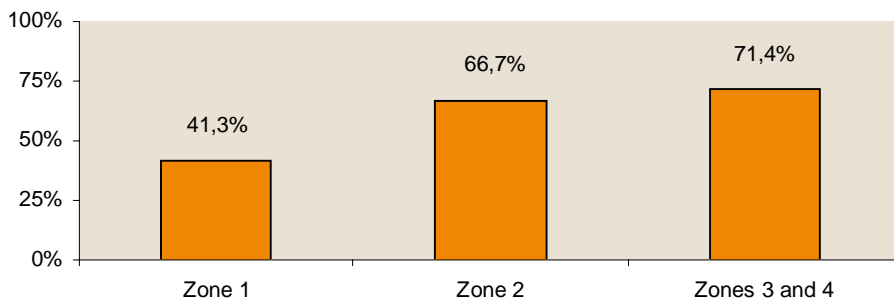
More adolescents understand and speak French fluently than English. 38.7% of adolescents understand English fluently and 38.2% speak English fluently, compared to 50.5% of all adolescents who understand French fluently and 47.6% who speak French fluently. The 15-17 year-old adolescents understand and speak English slightly more than do the 12-14 year-olds. The Cree and Inuit, whose communities are all English-speaking, did not participate in the survey. These results are therefore explained by the fact that there are more French-speaking Nations than English ones in the survey.

Adolescents appear to be divided in their opinions concerning traditional cultural events. 44.3% believe they are very important, versus 52.1% who feel they are not very important or not important. More girls (47.9%) than boys (40.6%) feel that traditional cultural events are very important.

More than half of all adolescents mentioned that their grandparents and parents help them understand their culture (53.9% and 52.7% respectively), while 29.7% mentioned their aunts and uncles. For help in this regard from persons outside the family, 24.1% mentioned teachers and 31.9% mentioned the community's Elders.

We clearly see that more adolescents living in zone 2 (66.7%) and zones 3 and 4 (71.4%) find it important to speak their First Nations languages than do adolescents in zone 1 (41.3%). Also, over 85.0% of adolescents in zones 2, 3 and 4 understand and speak one or several First Nations languages fluently or adequately. In zone 1, 42.6% understand and 35.2% speak one or several First Nations languages. There seems to be a correlation between the level of remoteness and these statistics because the need to speak one or several First Nations languages is greater in the remote regions.

**Graph 52: Level of importance given to the ability to speak one or several First Nations languages, by geographic zone**



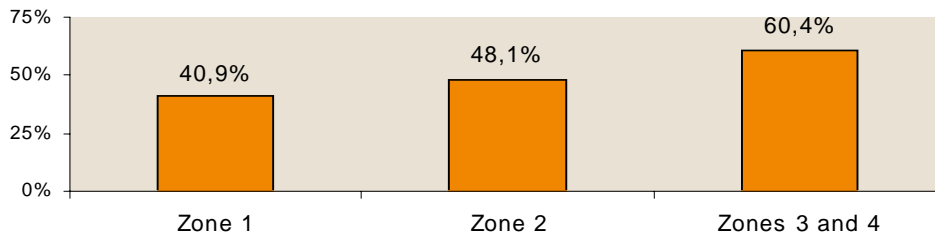
Note: Zones 3 and 4 are merged for reasons of statistical validity.

It is difficult to compare the geographical zones regarding the use and understanding of French and English because several proportions are not statistically significant. However, adolescents in large communities understand and speak English more fluently than do their counterparts in small and medium-sized communities. Conversely, adolescents in the latter communities understand and speak French more fluently.

### 3.2.3.2 Traditional culture

More adolescents in zone 2, and zones 3 and 4 (48.1% and 60.4% respectively) believe that traditional cultural events are very important, versus 40.9% in zone 1. Over 70.0% of adolescents in zones 2, 3 and 4 indicated that their grandparents help them understand their culture, versus 40.9% in zone 1. Help from Elders is also mentioned more often in zones 2, 3 and 4, whereas in zone 1, help from teachers is more important. Indeed, 26.5% of adolescents in zone 1 receive help in understanding their culture from teachers, versus 13.1% in zone 2 and 7.7% in zones 3 and 4.

**Graph 53: Proportion of adolescents who consider cultural events as very important, by geographic zone**

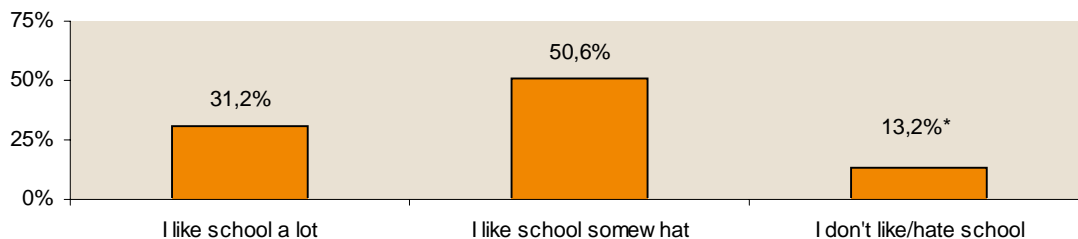


Note: Zones 3 and 4 are merged for reasons of statistical validity.

### 3.2.4 Education

A majority of adolescents attended school at the time of the survey (92.7%). Half of them report liking school somewhat, 31.2% like school very much and 13.2% do not like or hate school (Graph 54). A majority (90.3%) have never skipped a grade. But half (50.4%) have repeated a year and 41.0% reported having had learning difficulties. One third (32.0%) would like to obtain a college, vocational or technical diploma, while 29.5% would like to get a university degree and 17.1% only want to finish high school.

**Graph 54: Appreciation level of school**



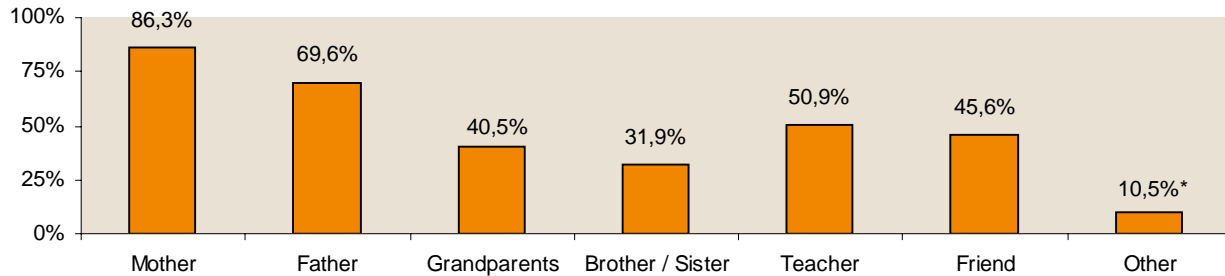
Practically equal proportions of boys and girls have learning difficulties. However, more girls consider having reading problems (69.8%) and writing problems (81.3%) than boys, for whom the comparative respective figures are 59.2% and 61.3%. However, 54.3% of boys have repeated a year, versus 46.3% of girls.

Some differences seem to be age-related. The 12-14 year-olds have more problems understanding teachers and are more easily distracted in class than the 15-17 year-olds. However, a much larger percentage of adolescents in the older age group (60.7%) have repeated a year, than the 12 to 14 year-old adolescents (38.3%).

Turning to differences among geographical zones, adolescents in zone 2 like school the most. More than half of them like school very much, compared to 22.9% in zone 1 and 34.7% in zones 3 and 4. Adolescents in zone 2 are also the ones who most want to obtain a university degree (39.0% versus 29.0% in zone 1 and 28.9% in zones 3 and 4).

There are no differences in the proportions of adolescents with learning difficulties by geographic zone. But a particularly high proportion of adolescents in zones 3 and 4 (88.9%) have difficulties concentrating, compared to 69.9% in zone 1 and 62.4% in zone 2. Also, distraction problems are more prevalent among adolescents in zone 2 (87.5%) and zones 3 and 4 (88.9%) than in zone 1 (74.5%). We also see a slightly lower proportion of adolescents in zone 1 who repeated a year (49.3%), compared to zone 2 (61.1%) and zones 3 and 4 (66.9%).

**Graph 55: Proportion of adolescents who are encouraged to continue their studies by various persons**



The previous graph shows that mothers are the main sources of encouragement for the pursuit of studies by adolescents.

Regarding the differences between girls and boys in terms of sources of encouragement, the only significant differences according to sex are:

- 35.2% of girls are encouraged by brothers or sisters, versus 28.8% of boys;
- 54.8% of girls are encouraged by a friend, versus 36.7% of boys.

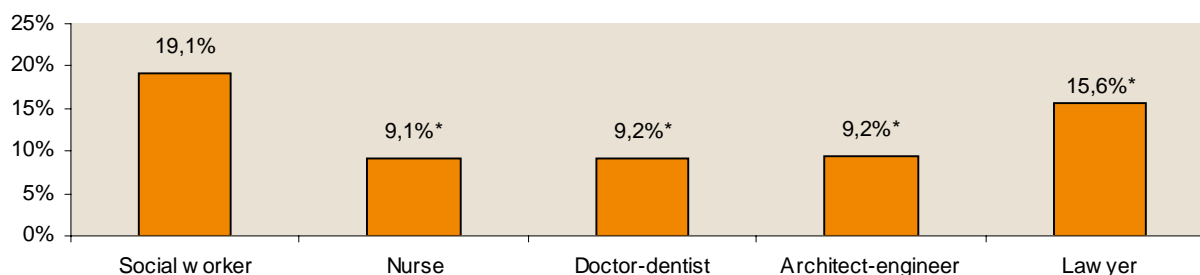
Finally, regarding the age group differences, the survey reveals that younger adolescents (12-14) receive more encouragement from adults, while the older ones (15-17) receive more encouragement from adolescents the same age as them, as shown in the following table.

**Table 12: Proportion of adolescents who receive encouragement from various people to continue their studies, per age group**

Persons who encourage adolescents	Age groups	
	12-14	15-17
Grandparents	45,1%	36,6%
Brother or sister	28,4%	35,0%
Teacher	55,7%	46,8%
Friend	40,4%	50,0%

Finally, adolescents were interviewed on the profession they would like to have as adults. The following graph shows the professions most often mentioned by adolescents.

**Graph 56: Main professions aimed by adolescents**

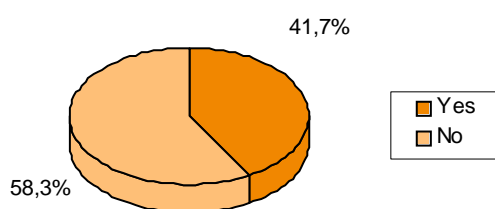


Regarding the sex-related differences, one can see that a higher proportion of girls than boys would like to be nurses, lawyers and hairdressers. More boys would like to be social workers, architects, engineers, cabinet-makers, carpenters, truck drivers, electricians or plumbers.

### 3.3 Health status

#### 3.3.1 Overall Health

**Graph 57: Proportion of adolescents with or without medical problems**



Graph 57 shows that 41.7% of adolescents indicated that they have medical problems. Among them, 20.1% have respiratory problems, 18.7% have allergies, 16.1% have neurological or cognitive problems and 13.9% have visual or hearing problems.

More 15-17 year-olds report having medical problems than 12-14 year-olds (46.8% versus 35.8%). They also have more respiratory problems (25.5% versus 14.0%). Boys also have slightly more health problems than girls (44.8% versus 38.4%). Also, 23.6% of boys with health problems have respiratory problems, compared to 16.5% of girls.

Zone 1 is where we find the highest rate of health problems among adolescents, at 45.1%, versus 29.5% in zone 2 and 25.8% in zones 3 and 4. The explanation for this difference might be that adolescents in zone 1 are more diagnosed than are adolescents in the remoter regions. Adolescents who are overweight or obese also have more medical problems (48.9%, 44.3% compared to 37.4%) than do those with a normal weight. Weight, overweight and obesity are themes presented in the following section.

Lastly, we see that adolescents feel positive about their health status; 62.2% feel they are in excellent or very good health. Only 9.5% feel their health is passable or poor. Physical exercise heads the reasons given for being in excellent or very good health, according to 70.8% of respondents. Next come sleeping well (60.7%), being happy and satisfied (59.5%) and having good social support (55.6%). Diet is more important for girls (56.3%) than for boys (45.5%); physical exercise is more important for boys (79.0%) than for girls (62.0%).

Table 13: Reasons given to justify being in very good or excellent health

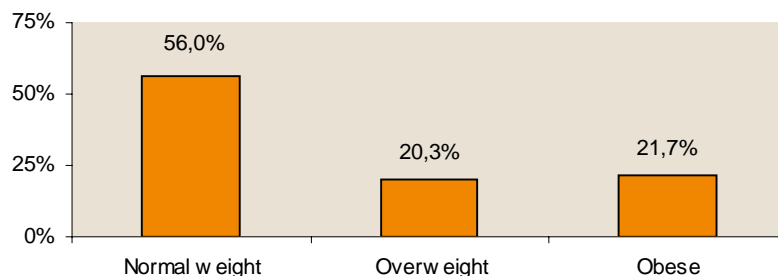
Causes	% of adolescents
Regular exercise / sports	70.8%
Proper sleep and rest	60.7%
Happy / satisfied	59.5%
Good social support	55.6%
Healthy diet	50.7%
Well-balanced life	43.8%
Little stress	31.0%

Concerning life balance, one can see that it is slightly more important for boys, but we see a marked difference between the 12-14 year-olds and 15-17 year-olds. Half of the 15-17 age group believes that a well-balanced life is important, versus 38.2% in the 12-14 age group. The concept of a well-balanced life may have more meaning for the older group, hence the difference here.

The 15-17 year-olds also indicate physical exercise, social support and little stress as being more important reasons for feeling they are in excellent or very good health than they are for 12 to 14 year-olds. As with a well-balanced life, social support and stress may be concepts better understood by the 15 to 17 year-old group than by the 12-14 year-olds.

### 3.3.2 Weight, overweight and obesity

Graph 58: Distribution of adolescents based on body mass index (BMI)<sup>21</sup>

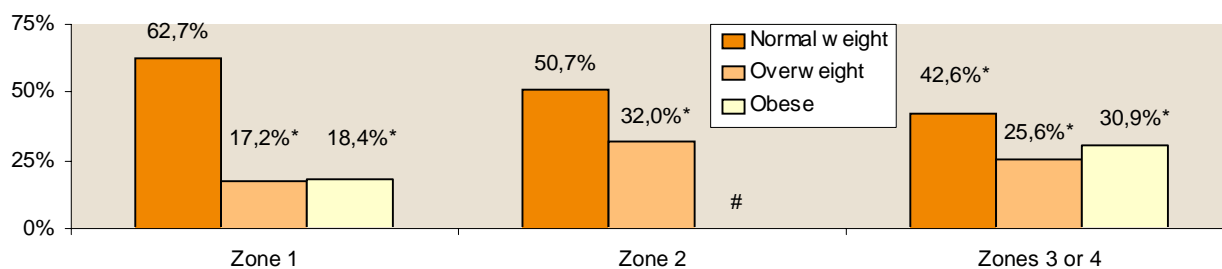


More than half of all adolescents have a normal weight (56.0%) However, 20.3% are overweight and 21.7% are obese (Graph 58). But just under one third (31.5%) are very satisfied with their weight and a similar amount (30.5%) are satisfied, while 18.1% are neither satisfied nor dissatisfied and 20.3% are a little or very dissatisfied.

More boys (26.1%) are obese than girls (15.9%). Also, the proportion of adolescents with a normal weight decreases as remoteness of the community increases. The proportion of adolescents with a normal weight reaches 62.7% in zone 1, versus 50.7% in zone 2 and 42.6% in zones 3 and 4. The following graph illustrates these results.

<sup>21</sup> Body mass index (BMI) is a measurement used to determine the healthy weight of individuals. We obtain BMI by dividing their weight (in kg) by their height in metres squared. For children and teenagers, we apply this index to a growth chart that indicates the individual's weight category: underweight, normal weight, overweight, or obese.

**Graph 59: Proportion of adolescents based on body mass index (BMI) categories, by geographic zone**



Note: Zones 3 and 4 are merged for reasons of statistical validity

### 3.3.3 Physical injuries

Among the 55.0% of adolescents who indicated having suffered from injuries in the 12 months preceding the survey, the main injuries cited are cuts, scrapes and bruises (50.7%), sprains (41.9%), broken bones (34.9%) and burns (25.9%). These injuries are due primarily to sports accidents (50.1%), falls or lack of attention (43.6%) and bicycle accidents not involving a motor vehicle (24.7%).

**Table 14: Types of physical injuries incurred by adolescents (12 months preceding the survey)**

Types of injuries	% of adolescents
Cuts, scrapes, bruises	50.7%
Sprains	41.9%
Broken bones	34.9%*
Burns	25.9%*

53.3% of boys and 36.4% of girls indicated that they have suffered some injuries during the 12 months preceding the survey. In both cases, the main injuries were cuts, scrapes and bruises, sprains, broken bones and burns.

### 3.3.4 Use of health services

77.0% have never used or do not remember using traditional medicine and 77.3% have never used counselling, psychological testing or other mental health services.

We note few significant differences in terms of geographical zone or community size. However, higher proportion (36.6%) of adolescents in zones 3 and 4 use traditional medicine, versus 27.8% in zone 1 and 29.1% in zone 2. Also, fewer adolescents in zones 3 and 4 received dental health services in the 12 months preceding the survey, 74.1% in zone 3 and 4 versus 87.2% in zone 1 and 85.8% in zone 2. One can therefore suppose that access to dental care is slightly more difficult in zones 3 and 4. Additional data on dental care is presented in the following section.

More than half of all adolescents (56.9%) had an eye examination during the 12 months preceding the survey. Furthermore, 16.7% had a glycemia (blood sugar level) test, 11.5% had a hearing test, and 11.5% had a complete physical check-up. The 12-14 year-olds had the most hearing tests, while the 15-17 year-olds had the most glycemia tests. More girls than boys had eye examinations and glycemia tests.



Table 15: Adolescents' medical examinations (12 months preceding the survey)

Types of medical examinations	% of adolescents
Eye examination	56.4%
Blood sugar level (glycemia)	16.7%*
Hearing test	11.5%*
Complete physical check-up	11.5%*
Cholesterol	#

### 3.3.5 Dental care

85.5% of all adolescents had a dental check-up in the 12 months preceding the survey, and 8.7% had one between one and two years before the survey. 69.8% required dental care. Of that number, 75.9% were for maintenance, 48.5% for filling or restoration and 12.0% for fluoride treatment. The 15-17 year-olds needed more dental care than the 12-14 year-olds (73.6% vs 65.1%).

Table 16: Dental care required by adolescents who report requiring dental care

Types of dental care	% of adolescents
Maintenance	75.9%
Filling, restoration	48.5%
Fluoride treatment	12.0%*
Extraction	#
Periodontal treatment	#

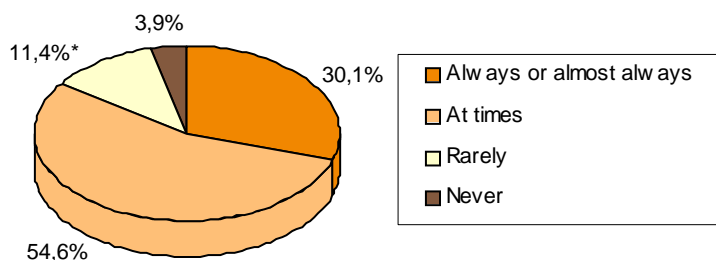
Lastly, adolescents in zone 2 had more eye examinations (65.5%) than those in zone 1 (56.6%) and zones 3 and 4 (51.4%).

### 3.4 Lifestyle

#### 3.4.1 Nutrition

##### 3.4.1.1 Consumption of junk food

**Graph 60: Balance level of adolescents' diet**



More than one third of 12-14 year-olds feel they always or almost always have a balanced, nutritious diet, versus one quarter of 15-17 year-olds.

57.8% of 12-14 year-olds eat junk food at least once a day or more, versus 65.2% of 15-17 year-olds. Older adolescents eat less well than younger adolescents.

61.8% of adolescents reported that they eat junk food one or more times a day (67.2% for boys and 56.2% for girls).

A community's level of remoteness is not linked to adolescents' perception of their diet or consumption of junk food. The perceptions and consumption of junk food of adolescents living in zones 1, 3 and 4 are similar, while adolescents living in zone 2 seem to have a better perception of their diet and a less frequent consumption of junk food.

**Table 17: Frequency of consumption of various food**

Junk food	Consumption frequencies		
	A few times a week	Once a day	Several times a day
Soft drinks	40,4%	18,9%	15,6%*
Fast food	50,0%	#	#
Cake, pie, ,cookies, candy, chocolate	43,8%	14,1%*	#
Fries, chips, pretzels, bannock, fried bread	48,5%	11,6%*	#
Extra salt	25,9%	17,1%*	11,3%*
Extra sugar	23,8%	15,1%*	10,4%*

In general, girls eat better than boys. Fewer girls than boys consume coffee, tea, soft drinks and cake once a day or more. More boys eat fast food a few times a week and boys add more salt to their food than girls. The 12-14 year-olds eat better than the 15-17 year-olds.

Adolescents' consumption of coffee or tea seems to be related to their community's level of remoteness. The number of those who drink coffee or tea at least once a day increases from 13.6%\* in zone 1 to 30.7%\* in zones 3 and 4. Also, the number of those who add sugar to their food increases from 23.4%\* in zone 1 to 44.6% in zones 3 and 4. More adolescents in zones 1 and 2 (31.7%) never or almost never add salt to their food than in zones 3 and 4 (23.9%\*).

58.3% of adolescents living in small and medium-sized communities eat junk food at least once a day, versus 67.3% in the large communities. 22.9%\* of adolescents in large communities eat cake, pie and other sweets at least once a day, versus 15.7%\* in small and medium-sized communities.

### 3.4.1.2 Consumption of traditional food

Table 18: Frequency of consumption of traditional food

Traditional food	Consumption frequencies		
	Never	Sometimes	Often
Big game	18,7%	55,8%	25,5%
Small game	44,5%	45,0%	10,4%*
Wildfowl	40,2%	46,7%	13,0%*
Freshwater fish	38,2%	46,7%	15,1%*
Saltwater fish	72,5%	24,6%	#
Other freshwater / saltwater foods	78,9%	17,6%	#
Marine mammals	97,5%	#	#
Wild berries and fruits	23,7%	51,3%	25,0%
Bannock/fried bread	14,3%*	53,6%	32,1%
Corn soup	67,4%	25,4%	#

In general, adolescents in small and medium-sized communities eat more traditional foods than do the youth in the larger communities.

More than 25% of all households indicated that during the 12 months preceding the survey, another person often shared traditional foods with them, versus 60.4% (occasionally) and 13.3%\* (never).

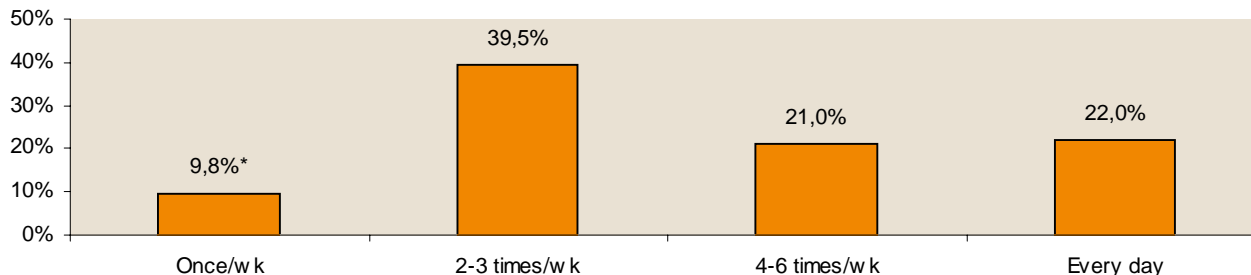
Communities' level of remoteness is also a factor here : 25.4% of adolescents in zone 1 often shared traditional food, versus 39.4% in zones 3 and 4. As for community size, we note more sharing of traditional food in the larger communities (32.5%) than in the small and medium-sized ones (25.7%\*).

### 3.4.2 Physical activities and sedentary activities

#### 3.4.2.1 Physical activities

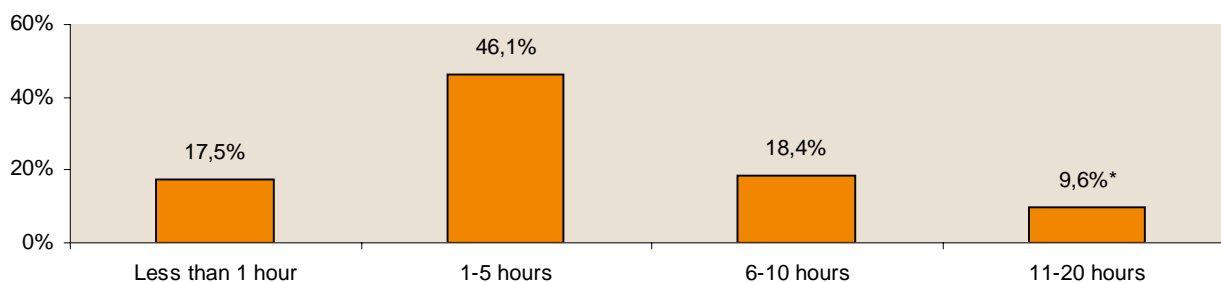
The following graphs show that 39.5% of adolescents get physical activity two or three times a week, versus 22.0% (every day), 21.0% (four to six times a week) and 9.8% (once a week). The following graph presents these results.

**Graph 61: Frequency of participation in physical activities**



Moreover, 46.1% of adolescents participate one to five hours every week in a physical activity that increases their cardiovascular rate, versus 18.4% (six to ten hours a week) and 17.5% (less than one hour a week). These results are presented in the following graph.

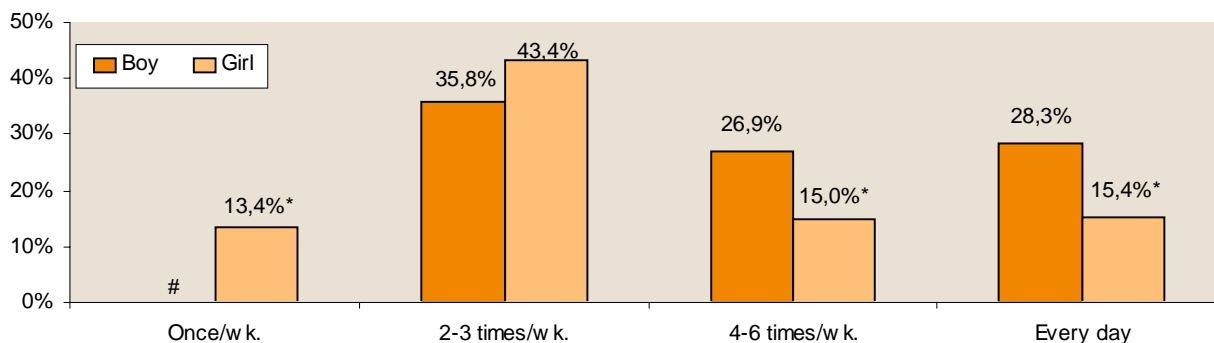
**Graph 62: Number of hours spent weekly in one or several physical activities that increase the cardiovascular rate**



More precisely, 38.3%\* of the boys spend six hours a week or more doing activities that increase their cardiovascular rate, compared to 23.9% of girls. The 12-14 year-olds also spend less time on such activities: 21.0%\* do so less than one hour a week, versus 14.5%\* of 15-17 year-olds.

The following table shows that boys get involved in a physical activity more often than girls do.

**Graph 63: Frequency of participation in physical activities, by sex**



Walking and bicycling are the physical activities that adolescents get involved in most often, at 85.4% and 74.0% respectively. A large proportion of these activities seem to be related to the need to get somewhere rather than organized. They are followed by competitive or group sports (60.5%) and running (57.3%) as activities most frequently practised. Compared to adults, adolescents participate less in traditional activities such as hunting, fishing and berry gathering. The following table presents the various activities practised by adolescents.

Table 19: Physical activities practised by adolescents (12 months preceding the survey)

Physical activities	% of adolescents	Physical activities	% of adolescents
Walking	86,4%	Gathering of berries or other foods	27,1%
Bicycling	74,0%	Bowling	24,2%
Competitive or group sports	60,5%	Canoeing	23,6%
Running	57,3%	Dancing	23,2%
Swimming	40,9%	Skiing	22,5%
Ice-skating	40,8%	Snowshoeing	21,3%
Fishing	38,2%	Aerobic gymnastics	20,8%
Rollerblading	36,0%	Snowboarding	16,6%*
Weightlifting	35,2%	Golf	10,9%*
Hiking	27,8%	Martial arts	#
Hunting, trapping	27,2%		

Only walking and dancing are practised more frequently by girls. Most of the other activities are practised more by boys, which emphasizes the fact that boys are more active than girls.

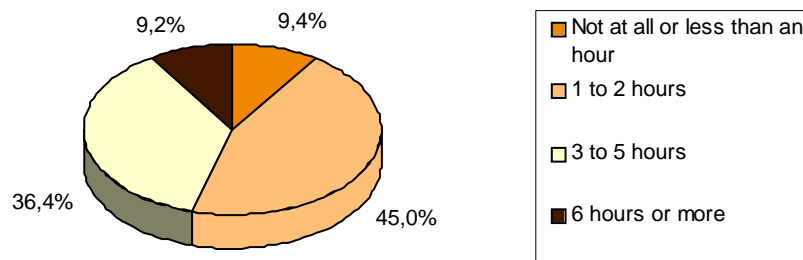
Lastly, the 12-14 year-olds participate more in competitive or group sports and ice-skating than do the 15-17 year-olds. But the latter participate in weightlifting and gathering of berries or other foods more often.

### 3.4.2.2 Sedentary activities

This section examines how frequently a number of sedentary activities are practised. We note that a significant proportion of adolescents spend several hours a day watching television, playing video games and using a computer.

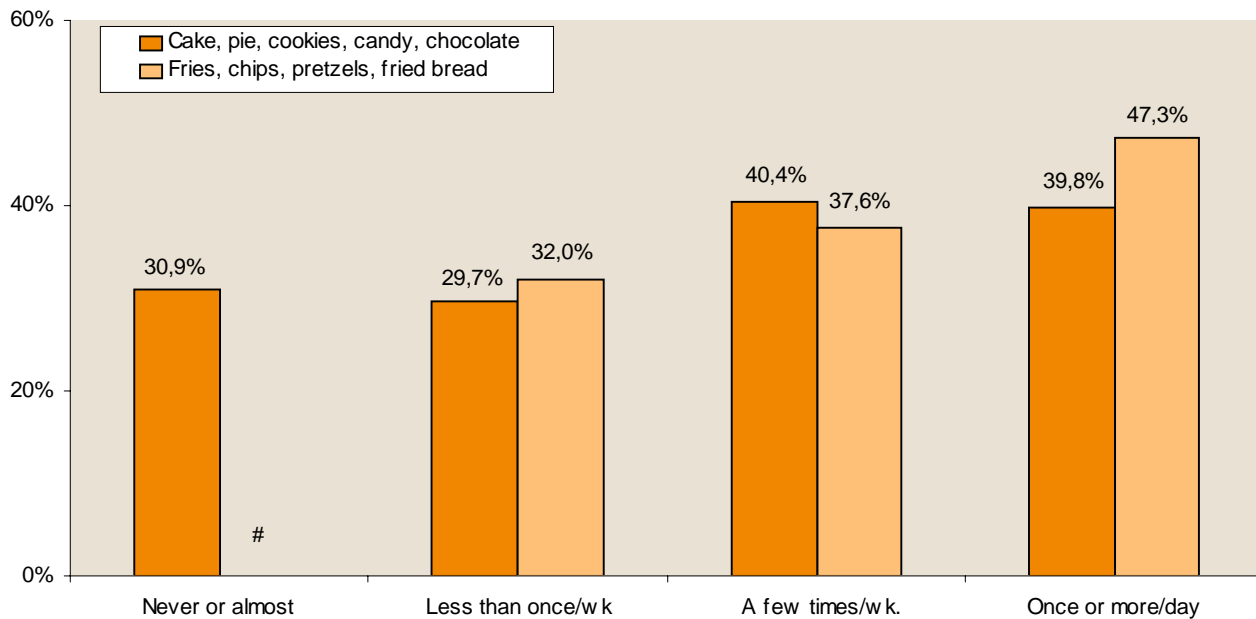
#### A) Watching television

Graph 64: Number of hours spent daily watching television



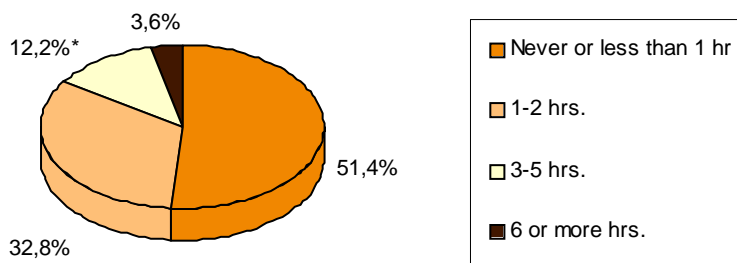
48.7% of boys watch television one to two hours a day, versus 41.3% of girls. Over 50% of adolescents in zones 2, 3 and 4 watch television one to two hours a day, versus 38.8% in zone 1. However, more adolescents in zone 1 (39.9%) and zone 2 (35.0%) watch television three to five hours a day than do adolescents in zones 3 and 4 (29.1%). The following graph shows that there is a slight relationship between the consumption of various junk food and watching television several hours per day.

**Graph 65: Consumption of various junk food by adolescents who watch television 3 to 5 hours a day**



**B) Video games**

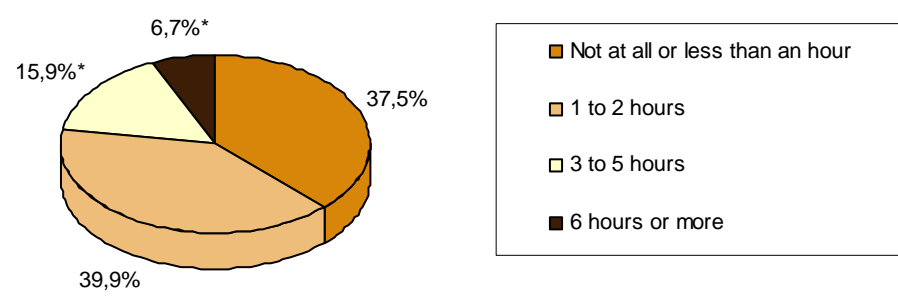
**Graph 66: Number of hours spent daily playing video games**



While 70.6% of boys play video games, only 26.3% of girls do so. 45.6% of boys play these games one to two hours a day, 18.2% do so 3 to 5 hours a week and 6.8% play six hours or more a day.

### C) Computers

**Graph 67: Number of hours spent daily at the computer**



42.6% of girls spend one to two hours a day using a computer, versus 37.2% of boys. Adolescents in the remotest regions use the computer the least. 43.7% in zones 3 and 4 never use one, versus 48.1% in zone 2 and 33.3% in zone 1.

#### 3.4.3 Lifestyle habits

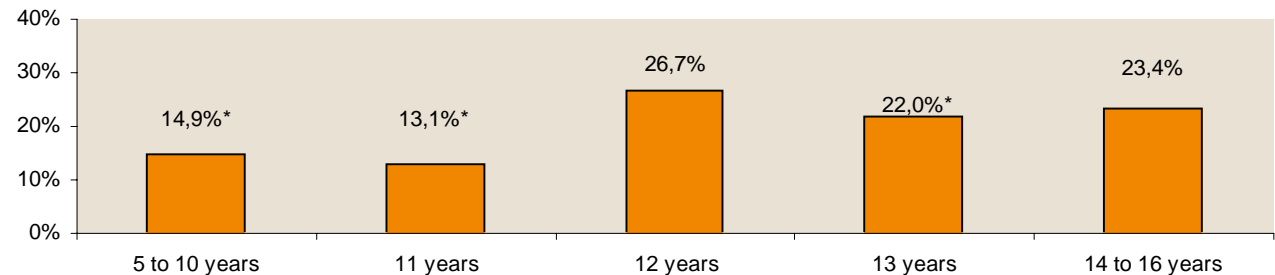
##### 3.4.3.1 Smoking

More than half of adolescents smoke (51.2%). Per age group, 37.5% of 12-14 year-olds smoke and this percentage rises to 62.5% of 15-17 year-olds. Two thirds of smokers smoke every day, while one third smokes occasionally. Girls smoke more than boys (56.7% vs 45.7%). Moreover, the proportion of girls who smoke daily is higher than that of boys; respectively 68.7% and 62.8%.

The prevalence of tobacco use among adolescents seems to be associated with a community's level of remoteness. The proportion of smokers increases from 46.4% in zone 1 to 56.3% in zone 2 to 71.4% in zones 3 and 4.

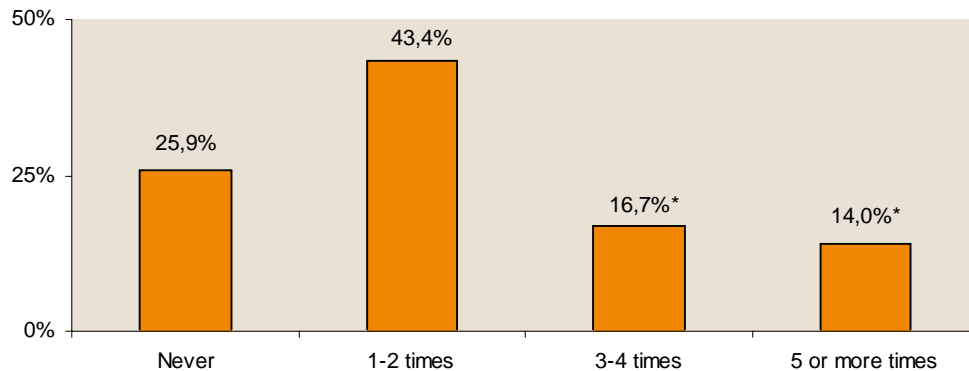
One quarter (25.1%) of adolescents who smoke daily smoke an average of ten cigarettes or more a day, and one third (33.7%) smokes between five and nine cigarettes a day. However, 41.2% smoke less than five cigarettes a day (i.e., half of the 12-14 year-old smokers and just over one third of the 15-17 year-old smokers). The following graph presents the age when adolescents began smoking.

**Graph 68: Age at the beginning of tobacco use**



31.8% of boys began smoking at the age of twelve, while 22.4% of girls began at twelve. In zone 1, 25.0%\* began at twelve, versus 35.4% in zones 3 and 4.

Graph 69: Number of attempts by adolescents to stop smoking (12 months preceding the survey)



71.0% of adolescents who smoke tried to quit during the 12 months preceding the survey. Nearly one third tried at least three times. Moreover, 46.8% of girls tried once or twice, versus 39.1% of boys. The survey collected data on smokers and non-smokers. Here are the results:

- 15.0%\* of non-smokers at the time of the survey used to smoke regularly (every day)
- Among ex-smokers:
  - 53.6% began smoking between the ages of 5 and 12, and 46.6%\* between 13 and 16;
  - 48.1%\* quit smoking between the ages of 9 and 13, the rest between 14 and 17;
  - One 15-17 year-old adolescent ex-smoker smoked every day;
  - Two thirds of non-smoking girls who previously smoked every day had begun smoking between the ages of 5 and 12, versus 44.4%\* of boys;
  - Nearly two thirds of girls quit smoking between the ages of 9 and 13; the same proportion of boys stopped between the ages of 14 and 17.
- Adolescent ex-smokers began smoking at a later age in isolated zones. 66.7%\* in zones 3 and 4 began between the ages of 13 and 16; while 58.3%\* in zone 1 and 70.4%\* in zone 2 started between the ages of 5 and 12.
- The main motivation for trying to quit smoking is the desire to adopt a healthier lifestyle. 36.3% of adolescents who have tried to quit gave this as their reason.
- One adolescent out of ten appears to be influenced by awareness campaigns.
- More adolescents in large communities than in small and medium-sized communities have tried to quit smoking.

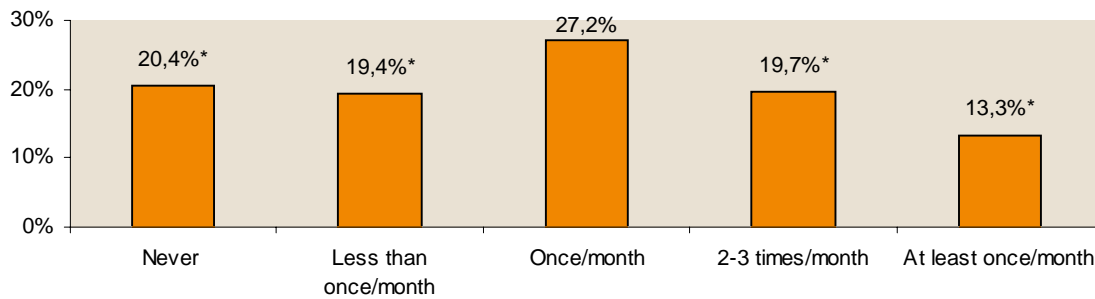
Let it be noted that whether they smoke or not, almost half of all households where adolescents live (48.1%) provide a smoke-free environment.

#### 3.4.3.2 Alcohol consumption

In the 12 months preceding the survey, 37.5% of 12-14 year-olds drank beer, wine, spirits or other alcoholic beverages, and this percentage rises to 75.9% of 15-17 year-olds. More girls (66.3%) drink alcohol than boys (50.6%).



**Graph 70: Frequency of consumption of 5 or more glasses of alcohol on a single occasion (12 months preceding the survey)**



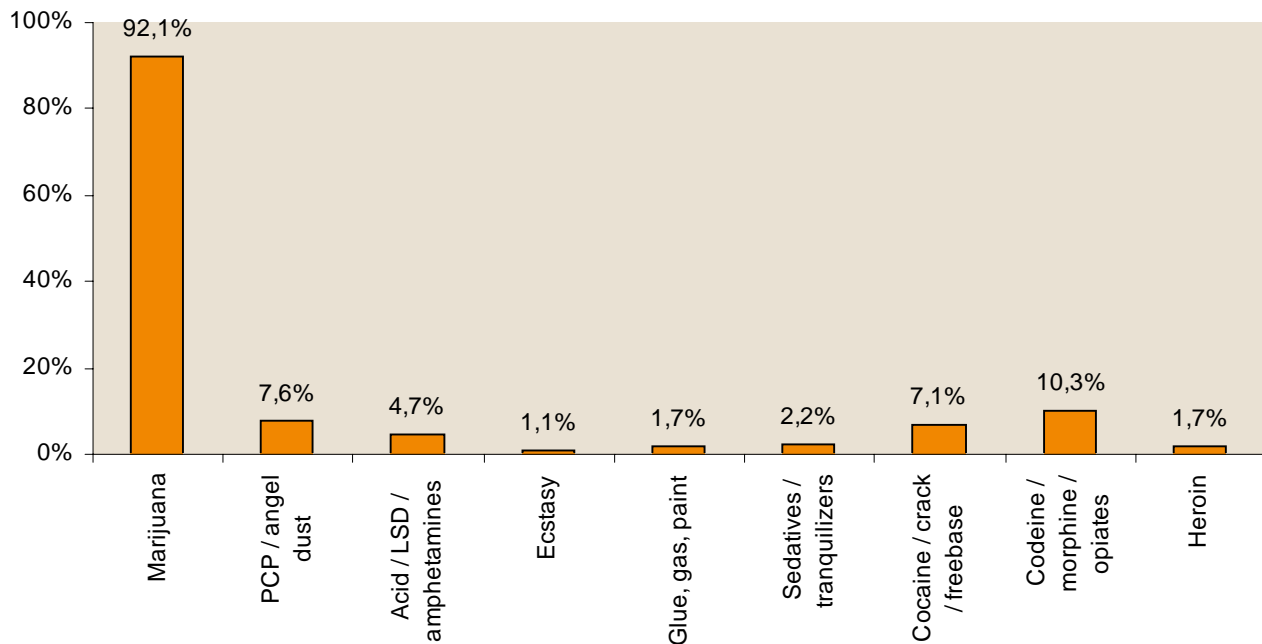
In the 12 months preceding the survey, 27.1%\* of 12-14 year-olds drank five or more glasses of alcohol on a single occasion. Moreover, 27.5%\* of adolescents in zones 3 and 4 drink five or more glasses of alcohol on a single occasion at least once a week.

Finally, 68.5% of adolescents in zone 2 drank alcoholic beverages in the 12 months before the survey, versus 60.2% in zone 1 and 54.3% in zones 3 and 4.

### 3.4.3.3 Drugs and volatile substances

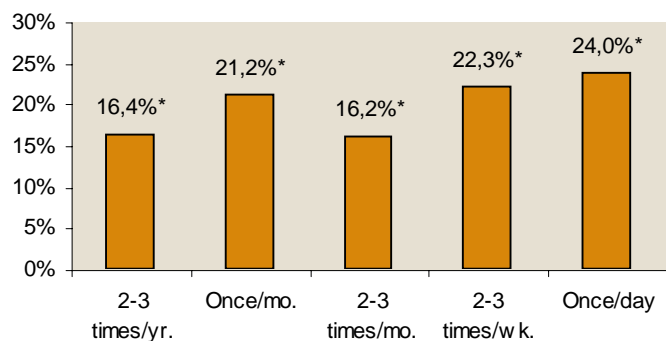
44.2% of adolescents used drugs or volatile substances during the 12 months preceding the survey. Among the 12-14 age group, 27.1% used drugs versus 58.4% in the 15-17 age group. 42.6% of boys and 45.9% of girls indicated that they had used drugs in the 12 months preceding the survey.

**Graph 71: Drugs used among adolescents users (12 months preceding the survey)**



Graph 71 shows that marijuana is the drug adolescents use most. 92.1% of drug users say they used marijuana during the 12 months preceding the survey. Far behind, opiates (except heroin) (10.3%) arrive in second place, followed by PCP at 7.6% and cocaine and its derivatives with 7.1%. The following graph presents the marijuana consumption frequencies among drug users.

**Graph 72: Frequency of consumption among marijuana users**



We saw earlier that adolescents in zone 2 drink more alcoholic beverages than do adolescents in the other zones. However, they use less drugs and volatile substances (36.6%\* versus 44.9% in zones 1, 3 and 4).

#### 3.4.3.4 Sexual health – Contraception and sexually-transmitted diseases (STDs)

42.9% of adolescents reported that they were sexually active during the 12 months preceding the survey. 41.7% of boys and 44.2% of girls indicated being sexually active. Moreover, 20.3% of the 12-14 age group had sexual relations during the year preceding the survey, versus 62.6% of the 15-17 age group. Finally, 66.5% of sexually-active adolescents had one or two partners (61.1% boys, 71.4% girls) whereas 21.8% had three or four partners.

The communities' level of remoteness seems to be related to the proportion of adolescents who had sexual relations in the 12 months preceding the survey; it increases from 40.3% in zone 1 to 55.1% in zones 3 and 4.

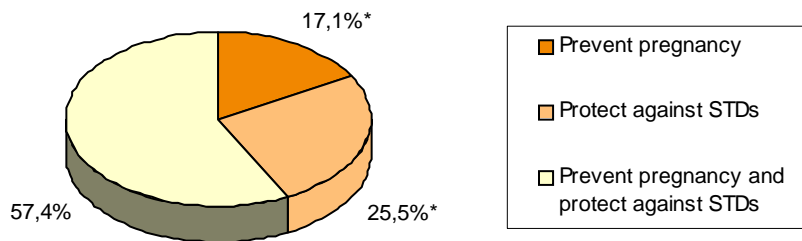
**Table 20: Contraceptive means used by adolescents who have been sexually active (12 months preceding the survey)**

Contraceptive means	% of adolescents
Condom	86.6%
Oral contraceptive	18.7%*
Depo-Provera	#
None	#
Coitus interruptus	#
Rhythm method	#
Diaphragm	#
Foam	#
Contraceptive implant	#
IUD	0.0%
Sponge	0.0%

94.3% of 12-14 year-olds who were sexually active in the 12 months preceding the survey use condoms for contraception, versus 84.7% of 15-17 year-olds.

Among the adolescents who were sexually active during the 12 months preceding the survey, 93.9% of boys report using a condom for contraception, versus 79.4% of girls. Also, 29.9%\* of girls use oral contraceptives, with more than twice doing so in zone 1 and 2 communities (19.5% and 18.1% respectively) than in zone 3 and 4 communities (9.3%).

**Graph 73: Reasons for using contraceptives among adolescents**



94.3% of adolescents answered no to the question “Have you ever been pregnant or gotten someone pregnant?” Of the small proportion who answered yes, 38.8%\* were 16 when they got pregnant, while 40.0%\* were pregnant at the age of 14 or 15. Moreover, 60.7% had an abortion or lost the baby, while 39.3%\* had their baby.

According to some participants at our interpretation session, the number of abortions has increased compared to five years ago. Some participants expressed their concerns regarding the lack of information available for letting young girls know about the consequences of abortion (physical and psychological). Some of them are concerned that abortion could become a contraceptive means for adolescents.

Moreover, 76.6% of sexually-active 12-14 year-olds reported that they always use a condom for protection against STDs, versus 63.2% of 15-17 year-olds. 17.2%\* in the latter group reported occasional or no condom use at all. 78.4% of boys always use condoms to prevent STDs, while only 54.6% of girls demand that their partners use one. Nearly one quarter of girls demand the use of a condom sometimes or simply never. However, we did not obtain any statistically significant results concerning adolescents’ reasons for using condoms, apart from that of being with a regular partner.

Here are the main reasons mentioned by adolescents for not using a condom, although these results are not valid statistically:

- I have a regular partner.
- I didn’t have a condom at the time.
- I was under the influence of alcohol or drugs.
- My partner didn’t want to use one.
- I couldn’t get one at the place where I was.
- I didn’t think there was any danger.
- I didn’t want to use one.

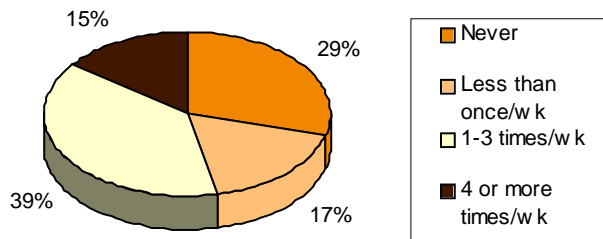
### 3.4.4 Personal and social well-being

#### 3.4.4.1 Activities and hobbies

##### **A) Physical activities**

Kino-Québec’s science committee recommends that “all children and adolescents should be physically active every day or almost every day and should get physical activity of average or higher intensity three or more times a week, for at least 20 minutes at a time.” The following graph shows how frequently adolescents participate in physical activities.

**Graph 74: Adolescents' participation in a sports program or team (outside class hours)**



The above graph clearly shows that only 15.0% of all adolescents participate in sufficient physical activity.

**B) Artistic and musical activities**

Three quarters of adolescents never take a course or participate in an artistic or musical group outside school hours. Nearly one adolescent in ten participates in artistic or musical activities less than once a week, while approximately one in ten does so one to three times a week.

**C) Traditional activities**

86.5% of teenagers never take courses in traditional activities outside school hours or participate in traditional singing or dance groups. About 10% do so up to three times a week.

**D) Paid employment**

More than 2/3 of teenagers have never worked in a store, given courses or babysat outside school hours. 15.9%\* work in these jobs less than one day a week and 16.4%\* do so one day or more a week.

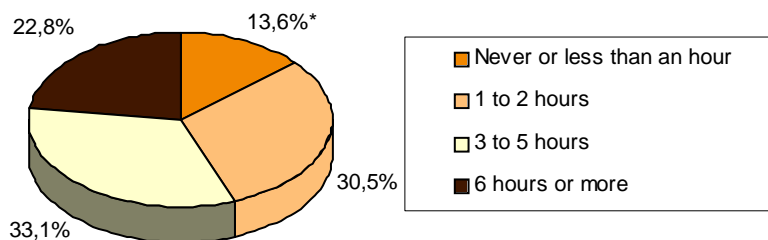
More girls than boys have a paid job. 49.5% of girls either work in a store, give classes or babysit children, versus 20.5% of boys.

We also note that teenagers living in the remotest zones work the least in these jobs; 19.8% of adolescents living in zones 3 and 4 never work, versus 27.4% in zone 2 and 39.5% in zone 1.

**E) Outdoor activities**

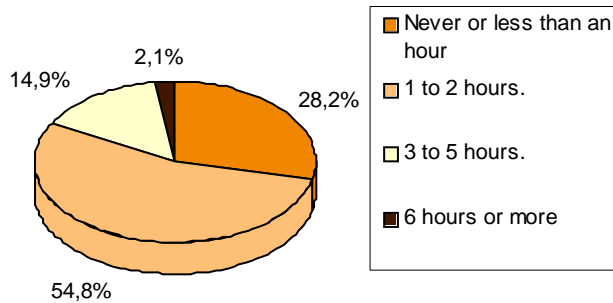
36.5% of 12-14 year-olds spend three to five hours outdoors every day, versus 30.2% of 15-17 year-olds. Boys spend much more time in outdoor activities than girls. 31.0% of boys spend six hours or more outdoors daily, versus 14.5%\* of girls.

**Graph 75: Number of hours spent daily in outdoor activities**



## F) Housework

**Graph 76:** Number of hours spent daily on household chores

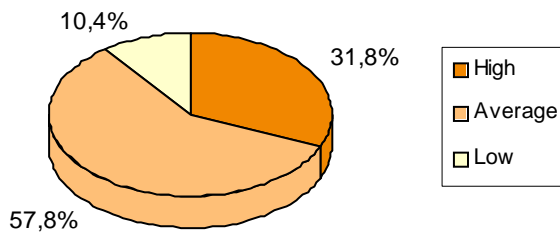


Girls spend more time on household chores than boys. 85% of girls do so one hour or more a day, versus 59.7% of boys.

### 3.4.4.2 Physical, emotional, mental and spiritual well-being

In this section, we calculated adolescents' balance levels by combining the four types of balance mentioned in the questionnaire: physical, emotional, mental and spiritual. Based on the adolescents' answers to those four questions, we determined an index for balance levels broken down into three categories: low, average and high. The following graph presents the results.

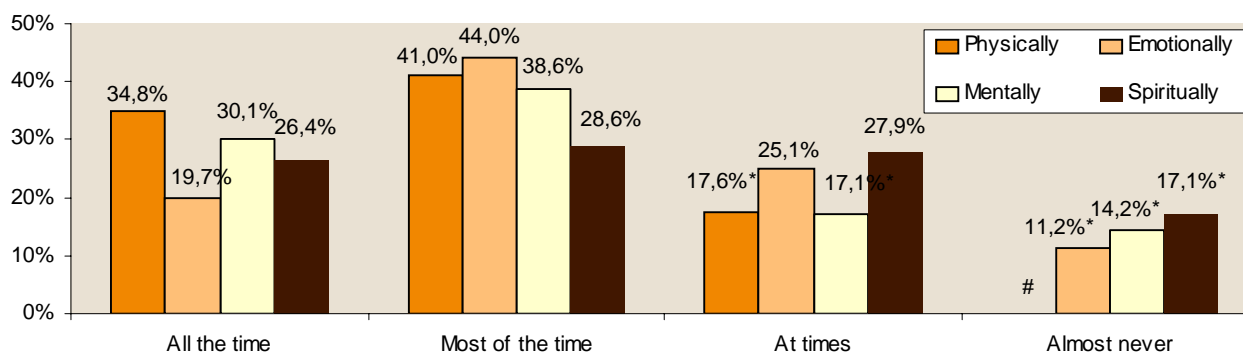
**Graph 77:** Global level of adolescents' physical, emotional, mental and spiritual balance



More boys (34.5%) than girls (29.1%) felt they had high balance levels. More girls (61.5%) than boys (54.2%) felt they had an average level. Moreover, we see similar proportions in the different age groups.

We also note that adolescents living in zones 3 and 4 generally have lower balance levels than those living in zones 1 and 2. Indeed, 65.6% of adolescents living in zones 3 and 4 feel they have an average level, versus 50.6% in zone 1 and 55.0% in zone 2. Also, the proportion of adolescents who feel they always enjoy good physical or mental balance is lower in zones 3 and 4.

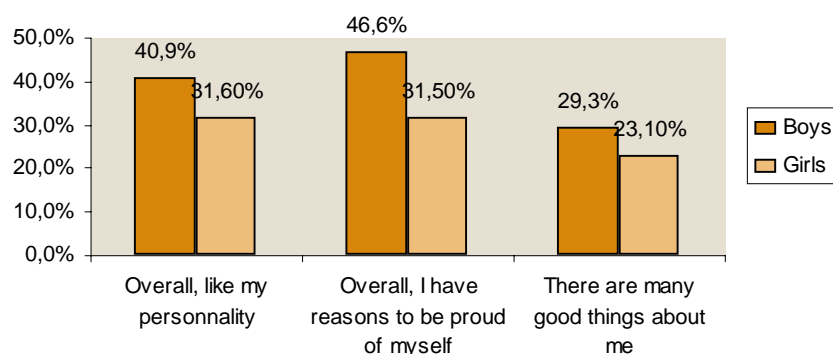
**Graph 78: Individual level of balance, based on four dimensions of well-being**



More than three quarters of all adolescents have high self-esteem, and one quarter have average self-esteem. Boys have higher self-esteem (79.6%) than girls (67.4%).

Among the questions concerning on which aspect adolescents have a high level of self-esteem, boys always presented higher percentages than girls, as shown in the following graph:

**Graph 79: Proportion of adolescents who strongly agree with three statements concerning self-esteem, by sex**



### 3.4.4.3 Self-determination index

This arbitrary index evaluates the level of control that individuals have over their life. A very low index means that an individual has little control over his/her life, while a very high one means control over several aspects of one's life. The self-determination index was elaborated based on the level of agreement (strongly agree, agree, neutral, disagree, strongly disagree) with the following statements:

- I can solve my problems.
- No one bothers me in my life.
- I can cope with events that happen in my life.
- I can do almost anything I decide to do.
- I often feel helpless in facing life's problems.<sup>22</sup>
- What happens to me in the future depends mostly on me.
- There's not much I can do to change many of the important things in my life.

The survey reveals that more than two thirds of adolescents (67.7%) believe their level of self-determination is high, while 32.1% believe it is neutral or low.

<sup>22</sup> Disagreeing with the statements are positive responses as self-determination indices.

Finally, we asked adolescents to evaluate their level of self-determination based on certain statements for which they had to indicate their perceptions on a graduated scale from strongly agree to strongly disagree. The following table shows the proportion of adolescents for each of the statements.

**Table 21: Perceptions of adolescents concerning their self-determination in light of various statements**

Statements	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I can solve my problems.	29.1%	51.2%	14.5%*	#	#
No one bothers me in my life.	25.5%	39.3%	24.1%	9.3%*	#
I can cope with events that happen in my life.	18.5%	53.0%	23.2%	#	#
I can do almost anything I decide to do.	26.0%	51.8%	15.8%*	#	#
I often feel helpless in facing life's problems.	#	24.3%	27.3%	34.6%	#
What happens to me in the future depends mostly on me.	36.5%	47.7%	11.0%*	#	#
There's not much I can do to change many of the important things in my life.	11.3%*	32.9%	21.6%	28.2%	6%*

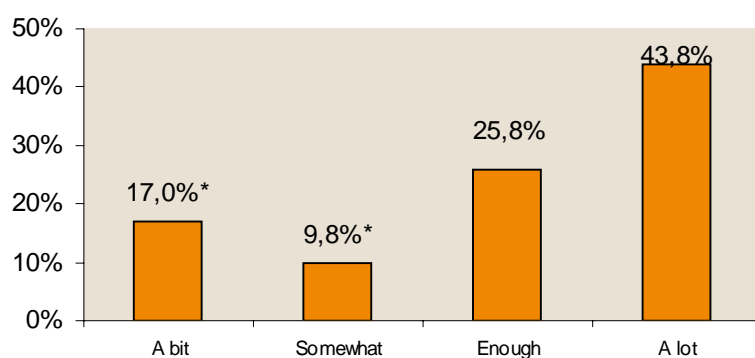
A slightly higher proportion of boys (61.9%) than girls (56.1%) believe their self-determination level is high. Boys also show higher proportions concerning all statements in the above table, apart from the last two which are “What happens to me in the future depends mostly on me” and “There’s not much I can do to change many of the most important things in my life”.

Adolescents in zones 3 and 4 have lower levels of self-determination than do adolescents in zones 1 and 2. We find that 43.2% in zones 3 and 4 feel they have a high level, versus 64.1% in zone 2 and 60.9% in zone 1.

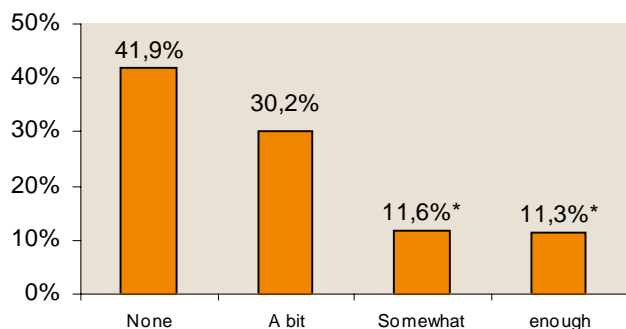
#### 3.4.4.4 Loneliness and social support

52.2% of adolescents say they do not feel alone, while 36.9% say they feel a bit or somewhat alone and 10.8% who feel very much alone. A higher proportion of girls than boys say they feel alone and/or loved. Girls also seem more stressed by life than boys since 34.9% of girls feel no stress at all, versus 48.7% of boys.

**Graph 80: Perceptions of the degree to which adolescents feel loved**



**Graph 81: Perceptions of the degree to which adolescents feel stressed**



Adolescents in zones 3 and 4 feel more alone and less loved than do adolescents in zones 1 and 2. Less of them never feel alone compared to adolescents in other zones (39.0% in zones 3 and 4, compared to 58.1% in zone 1 and 59.6% in zone 2). Less of them feel very much loved, compared to adolescents in other zones (35.5% feel very much loved in zones 3 and 4, compared to 49.4% in zone 1 and 49.2% in zone 2). However, adolescents in zone 2 feel they have the most stress, at 53.8%, compared to 41.3% in zone 1 and 43.3% in zones 3 and 4.

27.3% of adolescents turn to a health professional or social worker to talk about their emotional or mental health. Family members and friends appear to be the preferred confidants of most adolescents with 75.3% turning to them when they need emotional or mental support.

**Table 22: Proportion of adolescents having confided in various people concerning their mental or emotional health (12 months preceding the survey)**

Confidants	% of adolescents
Friend	63.90%
Immediate family member	51.10%
Other family member	36.30%
Social worker	15.8%*
Psychologist	11.7%*
Family doctor	11.2%*
Community health representative	#
Counsellor	#
Traditional healer	#
Psychiatrist	#
Telephone help line	#
Nurse	16.2%*

More girls than boys talk about their emotional or mental health. 53.8% of boys said they never spoke to others about their emotional or mental health in the 12 months preceding the survey, versus 18.1% of girls.

Adolescents in zone 1 confide less in others about their mental and emotional health than do adolescents in the other geographical zones; 76.1% have not spoken to a health professional in this regard and 75.8% have not consulted a mental health professional or social worker, compared to proportions close to 65.0% of adolescents in other geographic zones. Concerning the family, close to two thirds of adolescents living in zone 2 (65.8%) talk about their emotional and mental health to an immediate family member.

The following table presents the frequency of the social support adolescents believe they have access to or not.



Table 23: Frequency of the social support's availability for adolescents

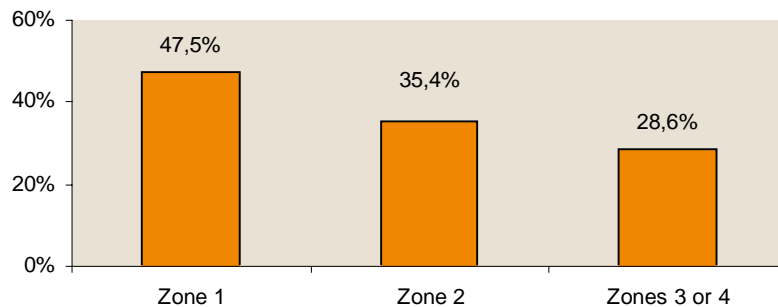
Social support available	Always	Most of the time	Sometimes	Almost never
Someone you can trust when you need to talk	40.9%	32.0%	17.7%	9.3%*
Someone you can trust when you need help	43.3%	32.2%	18.0%	#
Someone who can take you to the doctor	45.1%	25.2%	15.6%*	14.0%*
Someone who shows you love and affection	52.7%	23.4%	15.1%*	#
Someone with whom you can take a break from your daily routine	22.5%	29.1%	30.2%	18.3%
Someone with whom you can socialize	52.6%	29.4%	11.9%*	#
Confidant you can talk to about yourself or tell your problems to	41.0%	30.1%	18.9%	10.0%*
Someone with whom you can do enjoyable things	50.8%	30.1%	14.7%*	#

It should be noted that more girls than boys feel they always have access to these kinds of support, excluding when they need someone who can take them to the doctor, which gives similar proportions.

The remoter the region, the less the above-mentioned kinds of support are available to adolescents. Results are much higher for zone 1 adolescents than for zone 2, 3 and 4 adolescents concerning availability of persons they can trust when they need help, of persons who can take them to the doctor, and of persons with whom they do enjoyable things.

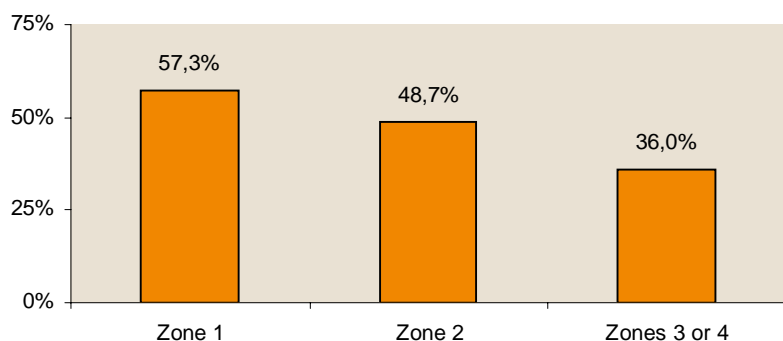
More than half of adolescents in zones 1 and 2 reported that they receive love and affection from others (56.5% in zone 1 and 54.1% in zone 2), versus 32.1% in zones 3 and 4. Availability of persons with whom they can socialize or confide in about themselves or their problems decreases as remoteness of the region increases, as indicated by the following graphs:

Graph 82: Proportion of adolescents who report always having a confidant to talk to, by geographic zone



Note: Zones 3 and 4 are merged for reasons of statistical validity.

**Graph 83: Proportion of adolescents who report always having someone to socialize with, by zone**



As the following table shows, most adolescents will see a parent or guardian when they have personal problems, excluding love relationships and family problems, for which they turn instead to a friend of the same age. For problems of anger and loss of temper, and problems with friends, the proportions are equal between parents/guardians and friends of the same age.

Adolescents in zones 3 and 4 generally turn less frequently to their parents or guardians to resolve certain problems compared to adolescents in zones 1 and 2. For example, adolescents in zones 3 and 4 will more readily see their health professionals than parents or guardians concerning contraception issues and STDs. The opposite holds for adolescents in zones 1 and 2.

**Table 24: People to whom adolescents would turn to for help if they had various personal problems**

Personal problems	Parent/guardian	Friend of same age	Nobody
Family problems	28.2%	35.4%	#
Love relationship problems	20.1%	55.7%	9.9%*
Financial problems	65.1%	#	14%*
Problems with drugs/alcohol	34.9%	27.8%	11.7%*
Anger, loss of control	34.2%	34.6%	10.1%
Depression	39.1%	21.5%	14.0%*
Problems with friends	34.6%	30.5%	13.0%*
Physical/sexual abuse	54.8%	17.3%*	#
STD	35.2%	13.1%*	#
Contraception problems	37.8%	15.7%*	12.9%*
Pregnancy	44.3%	#	17.3%*

#### 3.4.4.5 Suicide

One of every ten adolescents had suicidal thoughts at the age of 12 or younger, and nearly twice as many (20%) have had suicidal thoughts between the ages of 12 and 17. More girls than boys have thought about suicide: 46.5% of girls have had suicidal thoughts, versus 23.6% of boys.

More than 12.4%\* of adolescents have attempted suicide at one point in their life (this percentage only applies to the unsuccessful attempts because a research by questionnaire cannot take in account the suicide attempts that succeeded). In the 12 months before the survey, 22.2% of adolescents had a friend or family member who committed suicide.

Also, 39.3% of adolescents suffered from depression for at least two weeks or more in the 12 months preceding the survey. More girls than boys reported depression over the 12 months preceding the survey (48.2% vs 30.7%).

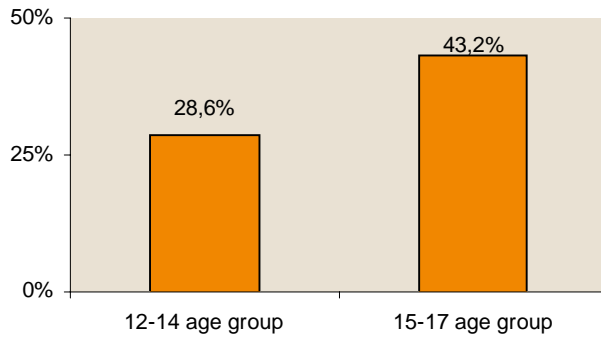
Regarding differences among the geographical zones, several proportions are not statistically significant. However, we note that more adolescents in zones 2, 3 and 4 have had suicidal thoughts than have adolescents in zone 1.

We also see a marked difference according to geographic zone among adolescents who indicated that a friend or family member had committed suicide in the 12 months preceding the survey. Indeed, 56.9% of adolescents living in zone 2 reported having a friend or family member who committed suicide in the 12 months preceding the survey, compared to 33.5% in zones 3 and 4 and 13.0%\* in zone 1.

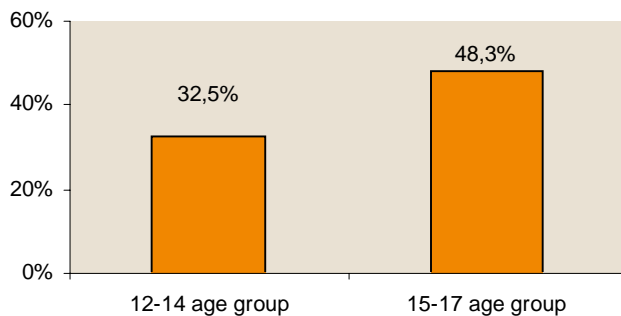
#### 3.4.4.6 Residential Schools

Neither parent of nearly two thirds (63.6%) of adolescents went to a residential school, nor did either grandparent of 59.4%. Proportions are higher for the 15-17 year-olds than for the 12-14 year-olds. The following graphs present the differences between both age groups.

**Graph 84:** Proportion of adolescents with one or several parents who attended a residential school, by age group

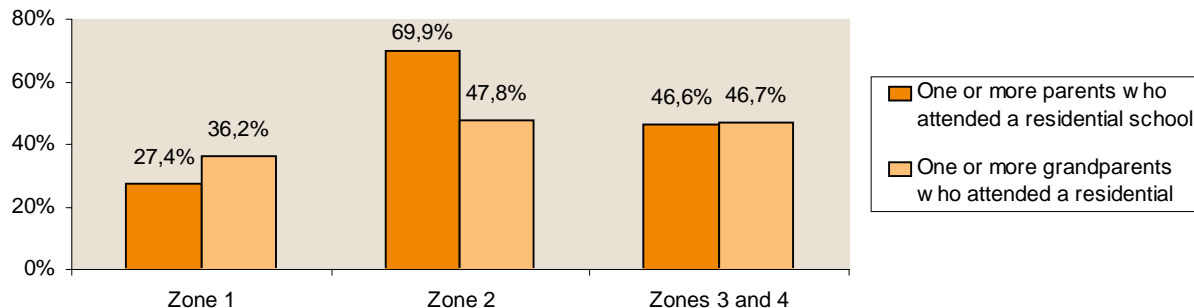


**Graph 85:** Proportion of adolescents with one or several grand-parents who attended a residential school, by age group



We also note certain differences among the geographical zones. Zone 2, which is occupied primarily by the Algonquin and Atikamekw Nations, shows the highest proportion of adolescents with one or more parents who went to a residential school (69.9%), followed by zones 3 and 4 (46.6%) and zone 1 (27.4%). The proportions of adolescents with one or more grandparents who attended residential schools are much the same for zones 2, 3 and 4, with zone 1 again showing the lowest proportion.

**Graph 86: Proportion of adolescents with one or several parents or grand-parents who attended a residential school, by geographic zone**



Note: Zones 3 and 4 are merged for reasons of statistical validity

### 3.5 Conclusion: Adolescents' health (12 – 17)

This survey is a continuation of the First Nations health survey of 1997. However, it is difficult to compare some of its results directly with the 1997 survey's results because some questions were not presented the same way both times.

Today, the majority of on-community adolescents live in zone 1, thus less than 50 kilometres from an urban centre. Most of them live in households with other minors (0-17). A low proportion of adolescents in zone 1 report that their biological parents are married compared to a much higher percentage in zones 2, 3 and 4.

In the Quebec Region, French is the language used most by First Nations adolescents who participated in this survey. Just over half of them believe it is important to speak a First Nations language. We clearly see that zones 2, 3 and 4 have the highest proportion of adolescents who believe it is important to speak their First Nations language. Also, even though adolescents are ambivalent regarding cultural events, such events are still clearly more important to adolescents in zones 3 and 4 than to those living closer to urban centres.

In zones 2, 3 and 4, Elders are the persons who most often help adolescents understand their culture, compared to a higher percentage of teachers who take on that role in zone 1. One can suppose this has an impact on the transmission of culture since a significant proportion of teachers are not First Nations members.

#### 3.5.1 Health status and lifestyle

The main health problems of adolescents are, in decreasing proportions, respiratory problems, allergies, neurological or cognitive problems, and visual or hearing problems. Furthermore, nearly 50.0% of adolescents are either overweight or obese.

We note that a higher proportion of boys than girls are obese. Boys do not eat as well as girls do and they eat more junk food. However, girls are less active. The only activities that they practice more than boys are walking and dancing. Girls also get less hours of physical activities each week that increase their cardiovascular rate.

In general, adolescents participate in physical activities two or three times a week; the activities most practised being walking and bicycling. Furthermore, they spend 1 to 5 hours a week in physical activities that increase their cardiovascular rate. Regarding their diet, although they generally have a positive view of their eating habits, we note that boys often consume soft drinks, fast food, cakes and French fries.

The highest obesity prevalence is in zones 3 and 4; the proportion of adolescents who have a normal weight tends to decrease as remoteness of the community increases. Adolescents living in remote zones (3 and 4)

are less likely to have a normal weight. The survey also reveals that adolescents in remoter regions use more sugar and salt in their food.

Turning to adolescents' use of the healthcare system, we find that very few use traditional medicine or the counselling and mental health services available to them. We also note that more girls than boys go for medical tests.

Lastly, most adolescents received dental care in the 12 months preceding the survey, but with the lowest proportion in zones 3 and 4.

### 3.5.2 Lifestyle Habits

More than one third of 12-14 year-olds smoke, versus two thirds of 15-17 year-olds, which are high proportions. The survey reveals that a certain percentage of adolescents began smoking between the ages of 5 and 10, with more having done so in zone 1 than in zones 2, 3 and 4. Finally, at the time of the survey, more girls smoked than boys.

Girls also drink more alcohol than boys do. In general, the 15-17 year-olds drink significantly more and more often than the 12-14 year-olds. Adolescents in zone 2 drank more alcoholic beverages in the 12 months preceding the survey than did adolescents in the other zones.

Just under half of all adolescents use drugs or volatile substances. The most common drug is marijuana. A more significant proportion of 15-17 year-olds use marijuana, but a strong percentage of 12-14 year-olds also use it. We note that a higher proportion of girls than boys use marijuana. However, more boys than girls use marijuana daily. We note that adolescents in zone 1 drink more alcohol than those in zones 2, 3 and 4, but use less drugs and volatile substances.

Concerning sexual relations, the communities' level of remoteness seems to be related to the fact of having had sexual relations in the 12 months preceding the survey. Adolescents in zones 3 and 4 are more sexually active than adolescents in zones 1 and 2. It also appears that contraceptive habits differ – more adolescents in zones 1 and 2 use oral contraceptives than do adolescents in zones 3 and 4. A large proportion of adolescents also use condoms. Among adolescents who do not use condoms, the majority report that it is because they have a regular partner.


### 3.5.3 Personal and social well-being

With regard to this component, the survey brings out marked differences between adolescents in zones 3 and 4 and those in zones 1 and 2, and differences between the sexes. Adolescents in zones 3 and 4 generally have significantly lower levels of physical, emotional, mental and spiritual balance than do adolescents in zones 1 and 2. We also find that boys have higher levels of balance and self-esteem than girls do.

In general, adolescents feel they have a good level of self-determination, which was evaluated according to the control they have over their life. More than half feel their level of self-determination is high. But we note that adolescents in zone 3 and 4 feel they have less self-determination than do adolescents in zones 1 and 2. Also, a slightly higher proportion of boys than girls feel they have control over their life.

Concerning suicide and potentially related feelings such as loneliness, feeling of not being loved, feeling of being stressed, we see that girls feel more alone and more stressed than boys do. However, more girls than boys feel loved. They also find support more easily and talk more frequently about their mental health than boys.

The survey reveals that adolescents in zones 3 and 4 feel more alone and less loved. We saw in conjunction with this finding that the various kinds of support are less available in the remoter regions. However, adolescents in zone 1 confide less in others about their mental health than do adolescents in the other zones.



Lastly, more than one third of adolescents have had suicidal thoughts, and among them girls outnumber boys. More girls than boys felt depressed during 2 weeks or more. Finally, nearly one quarter of all adolescents had a friend who committed suicide during the 12 months preceding the survey.

## Section 4: Adults' health (aged 18 and older)





## Adults' health (aged 18 and older)

### 4.1 Highlights

#### 4.1.1 Social characteristics

##### 4.1.1.1 Demographic profile

The First Nations adult population is relatively young; more than one half (54.5%) of adults were between the ages of 18 and 39. Of that figure, 29.5% were in the 18-29 age group and 25.0% were in the 30-39 age group. We also note that the adult population of small communities is older than in the medium and large communities. In terms of civil status, nearly one third (31.6%) of adults were married and over one third were single (34.7%). About one adult in five (19.2%) was living in a common-law relationship (unmarried spouse).

##### 4.1.1.2 First Nations languages and traditional culture

The survey revealed that 38.5% of adults used a First Nation language as their main language. Just as many of them, however, could not understand (39.2%) or speak (42.7%) a First Nations language.<sup>23</sup> The use of First Nations languages was more prevalent among adults in the more isolated communities.<sup>23</sup> The proportions of adults who used First Nations languages were 78.6%, 83.7% and 94.1% in zones 2, 3 and 4 respectively, compared to 17.2% in zone 1 communities.

##### 4.1.1.3 Education

In general, the level of education was poor in First Nations communities. Nearly half (49.0%) the adults had not completed high school. However, 14.9% had a high school diploma, 29.9% had a college, technical or vocational diploma, and 6.1%\* had earned a university degree.

##### 4.1.1.4 Employment and income

Nearly half the adults had jobs at the time of the survey. We note that the proportion of adults with paid jobs varied according to community size: 64.9% of adults were working in the small communities, compared to 46.3% in the large communities. With regard to annual income, the survey demonstrates that one adult in five (20.2%) was receiving employment insurance (EI) benefits and that a slightly higher percentage (23.7%) were receiving employment assistance (social assistance).

##### 4.1.1.5 Housing

In First Nations communities overall, nearly half (47.7%) of the adults lived in a home they owned (or that was owned by another member of their household). Responses to the survey questions concerning housing quality indicate that 28.2% of adults did not consider the water from their main water supply to be safe for drinking. In addition, over one third of adults indicated the presence of mould in their homes in the 12 months preceding the survey. Finally, one quarter of adults felt that their home required major repairs. With regard to fire safety, we note that 84.9% of homes had a smoke detector and 56.7% had a fire extinguisher.

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<sup>23</sup> Zoning system developed by Indian and Northern Affairs Canada to categorize the level of geographical isolation of the communities

- Zone 1: Located within 50 km of the nearest service centre\* with year-round road access.
- Zone 2: Located between 50 km and 350 km from the nearest service centre with year-round road access.
- Zone 3: Located more than 350 km from the nearest service centre with year-round road access.
- Zone 4: No year-round road access to a service centre.

\* Nearest community providing access to suppliers, banks and government services



## 4.1.2 Health

### 4.1.2.1 Overall health

Half the adults felt they were in excellent or very good health. In contrast, the survey revealed that certain chronic illnesses, such as diabetes and respiratory problems, had increased since the last cycle of the survey, which was held in 1997. In addition, nearly two thirds (63.0%) of adults indicated that they suffered from health problems. Among these, the most common problems were musculoskeletal (23.3%) and cardiovascular (21.8%). Furthermore, level of community isolation, age, socio-economic status and access to health care services were determinants that influenced the health conditions of the adult population. The main reasons given by adult respondents for being in excellent or very good health were being happy/content, getting good sleep/proper rest and having good social support. The survey also showed that more than two thirds (67.0%) of adults were overweight or obese and that just over one quarter (26.4%) were of normal weight. Finally, about 14.5% of adults had diabetes. More women were affected (16.4%) than men (12.5%). We note that the prevalence of diabetes in the non-Aboriginal population of Quebec was 7.0%.

### 4.1.2.2 Physical injuries

Physical injuries appeared to occur frequently among First Nations adults. More than one adult in five suffered one or more injuries in the 12 months preceding the survey. The most common injuries were sprains and strains; cuts, scrapes and bruises; and fractures. Falls and trips were responsible for almost one half (42.1%) of these. It is important to note here that nearly one injured person in five (17.9%) stated that the cause of the injury was related to drug or alcohol consumption.

### 4.1.2.3 Dental care

Nearly two thirds of adults had received dental care in the 12 months preceding the survey. In addition, nearly three quarters felt they needed dental care. The most frequently mentioned types of care were maintenance (69.9%) and fillings or other restoration work (36.2%). We note that the older the adults become, the less likely they were to feel they needed dental care: 77.8% of those aged 18 to 29 reported needing dental care, compared to only 61.7% of those aged 60 or over. Finally, the survey showed that adults living in small communities were less likely to consult a dentist than those living in large communities. We note that twice as many adults in zones 3 and 4 encountered one or more obstacles in receiving dental care (41.2%\*) than did adults living in zone 1 (20.5%\*) and zone 2 (25.1%\*).

## 4.1.3 Lifestyle

### 4.1.3.1 Food and nutrition

Although nearly half the adults considered their diet to be balanced and nutritious, the majority of them (94.6%) consumed junk food several times a week. The survey revealed that young adults (aged 18 to 34) consumed more junk food than older adults (aged 35 and older).

The frequency of consumption of traditional food by adults seemed to be related to the geographic location of the communities. Adults in the zone 4 communities had traditional food most often.

### 4.1.3.2 Physical activity

On average, First Nations adults had physical activity twice a week (i.e., they spent a total of three and a half hours each week in activities that increased their heart and breathing rate). However, 13.0% of adults did not get any physical activity at all. The most common physical activities observed in the entire adult population were walking, hunting and fishing, cycling, and berry picking or other food gathering.

The survey revealed that adults aged 18 to 29 were more active than adults in the other age groups. The same holds true for men compared to women. Adults in zone 4 communities and those with a university degree were among the most physically active.

#### 4.1.3.3 Smoking

More than half the adults smoked and the majority of these (79.4%) smoked every day. Exposure to second-hand smoke in the home was also common. Indeed, 48.0% of homes were smoking environments. In addition, the survey revealed that smokers living in a smoking environment smoked more cigarettes daily than those who lived in a smoke-free environment.

More than one quarter (28.4%) of adults were ex-smokers. The main reasons ex-smokers gave for quitting were the desire for a healthier lifestyle (60.7%) and the need to do so for their health (38.1%).

We note that a greater proportion of 18-to-34-year-olds smoked than adults in other age groups. In addition, the 18-to-34-year-olds generally began smoking at a younger age. Non-graduate adults smoke in greater numbers than graduate adults (all levels of education taken together). However, the survey did not reveal any differences in the smoking rate between the employed and the unemployed. Likewise, no differences were found between the proportions of male and female smokers, although a higher proportion of men smoked daily.

#### 4.1.3.4 Alcohol consumption

In the year preceding the survey, 74.3% of adults drank alcohol. While 22.3% drank once or several times a week, 21.0% did so every day. We note that 20.3% of drinkers never had 5 or more drinks on a single occasion in the 12 months preceding the survey. The survey also revealed that adults who completed high school and those who had jobs drank more often than adults who did not complete high school and those who were unemployed. Finally, 15.5% of adults had been treated for alcohol abuse.

#### 4.1.3.5 Drug and solvent use

More than one third (36.2%) of adults used drugs or solvents in the 12 months preceding the survey. In the adult population overall, the most frequently consumed drugs were marijuana (26.6%), cocaine, crack or freebase (11.0%), codeine, morphine and opiates (8.6%). Finally, 10.2% of adults had been treated for drug or solvent abuse.


The 18-to-34-year-olds were the biggest users of drugs and solvents. In addition, we note that the proportion of consumers appeared to be higher in the medium and large communities. However, some adult users in the small communities may not have reported that they used drugs due to the close-knit nature of the communities or other confidentiality concerns.

The survey revealed a link between schooling level and drug and solvent use. Fewer adults with the highest schooling levels (high school, college, technical or vocational diploma, or university diploma) use drugs than those who had not finished elementary or high school. Finally, there seemed to be a link between emotional and/or mental health and drug use: 50.4% of adults who had considered suicide at some point in their life and 55.1% of adults who had attempted suicide had used drugs and/or solvents in the 12 months preceding the survey.

#### 4.1.3.6 Preventive health care

Blood pressure tests (63.7%), eye exams (60.3%) and blood sugar tests (53.0%) were the medical examinations taken by the largest proportion of adults. We note that more women than men had had medical examinations. Likewise, older adults had more medical tests than younger adults, with the exception of eye exams. Although the adults living in small communities had more medical tests and analyses than those living in medium and large communities, adults in zone 4 had the fewest of all. Finally, survey results demonstrated that only 30.1% of men and 42.7% of women had had an HIV screening test.

With regard to women's health, 43.4% of women had never performed breast self-examinations and 60.6% had never had a mammogram. These proportions stood at 37.4% and 33.6% respectively among women aged 40 and over, the highest-risk group for the development of breast cancer. Women in remote communities (zones 3 and 4) were less likely to perform breast self-examinations but more likely to have had



a mammography. Finally, we note that 6.5%\* of women had never had Pap smears (vaginal examination with tissue sample), and that nearly half (49.3%) had had one in the 12 months preceding the survey.

#### 4.1.3.7 Residential schools

17.0% of all adults attended a residential school. Of these, 36.3% felt that their health and well-being had been negatively affected by their experience. The impacts most frequently cited were verbal or emotional abuse (69.9%), isolation from one's family (69.0%) and harsh discipline (68.9%). Loss of cultural identity and loss of language were mentioned respectively by 64.3% and 61.1% of adults who stated that their self-esteem was negatively affected by their residential school experience.

#### 4.1.4 Personal and social well-being

The vast majority of adults felt they were in physical, emotional, mental or spiritual balance "all of the time" or "most of the time." However, about 16.0% of adults felt they were in balance "sometimes." The highest proportion of adults in this latter category lived in zone 4.

The survey revealed that more than half (56.5%) the adults felt they had very little control over their life, while one third reported having a good level of control. These results were obtained by measuring the respondents' level of agreement with seven statements used to develop the self-determination index for the survey. We note that people who had not finished high school felt they had less control over their life compared with graduate adult (high school, college, vocational or technical diploma, or university degrees). Furthermore, adults living in small communities generally felt they had better control over their life than those who lived in medium and large communities. We also noticed differences among the geographic zones, with the adults in zone 3 stating that they had the least control over their life.

##### 4.1.4.1 Social problems

Adults were asked about the occurrence of various social problems in their life and in their families. They were also asked to specify whether they felt that these problems were minor or major. The most prevalent social problems were alcoholism, drug and medication abuse, and verbal and psychological abuse. The survey revealed that adults living in small communities perceived fewer social problems than those living in medium and large communities. Likewise, the adults who did not finish high school were more likely to identify problems in their own life or in their families and social circles. Finally, we note that 18.7% of men and 20.2% of women had someone in their family with serious alcohol problems.

##### 4.1.4.2 Social support

In general, First Nations adults felt they had a good social network to support them in times of need. Women were more likely than men to have access to this support. It also appears to be easier to get support in the small communities. Finally, the support available appears to be related to the community's level of isolation; a greater proportion of adults in zone 1 (52.7%) than in zone 4 (29.6%) always had someone they can count on to listen to them when they need to talk.

##### 4.1.4.3 Suicide

The survey revealed that 39.0% of adults had considered committing suicide at some point in their life, and that 18.4% had attempted suicide. The highest proportions of adults who had considered suicide were found in zone 2 (49.1%) and zone 3 (53.9%). The rates were also higher in large communities. Finally, there appears to be a link between language most often used and suicidal thoughts.

##### 4.1.4.4 Racism

The survey results show that 28.3% of adults experienced racism in the 12 months preceding the survey. Men were more likely to be victims of racism than women (30.7% compared to 25.9%). In addition, more 18-to-34-year-olds experienced racism than did older adults. On the other hand, young adults appear to have

suffered fewer effects in terms of their self-esteem than the older adults. Finally, the proportion of adults who experienced racism decreased as community isolation increased, dropping from 29.2% in zone 1 to 15.2%\* in zone 4.

#### 4.1.4.5 Gambling

In the 12 months preceding the survey, 8.4%\* of adults participated in gambling activities in which they lost more money than they could afford. We note that with the exception of bingo, men were more likely than women to be in a situation in which they lose more money than they can afford.

#### 4.1.4.6 Support agents

Nearly one third (32.9%) of adults felt depressed for a period of two consecutive weeks or more in the 12 months preceding the survey. Friends, immediate family members and other family members were the people that adults preferred to confide in concerning their emotional and mental health. Health professionals (family doctor, nurse, social workers, etc.) were consulted less often. The survey also revealed that men turned to fewer support agents than women did. We note that older adults turned more to health professionals for support regarding their emotional and mental health, while young adults (18 to 34 years old) were more likely to turn to a friend or family member. Finally, adults in small communities generally consulted fewer support agents than those in large communities.

### 4.1.5 Community well-being and traditional culture

#### 4.1.5.1 Community and cultural progress

Adults were asked questions about different areas in which they felt that the community might have made progress. Twice as many adults noticed significant progress in the 1997 survey than in the 2002 survey. This points to a decreased level of satisfaction with community progress between 1997 and 2002. Among the areas for which a large percentage of adults felt that no progress had been made, reduction of alcohol and drug abuse came first, at 66.4%, followed by community police services, at 50.8%.

With regard to cultural progress, 50.8% of adults felt that no progress had been made in traditional approaches to healing, while 46.9% saw no progress in the renewed relationship with the land, and 45.5% saw none in the renewal of First Nations/Inuit spirituality.

The areas in which the greatest progress was felt to be made were water and sewage facilities (26.1%), access to education and training opportunities (16.5%), and use of First Nations languages (13.2%). We must note, however, that while these were the highest proportions recorded in this survey, they were still much lower than the proportions obtained in 1997.

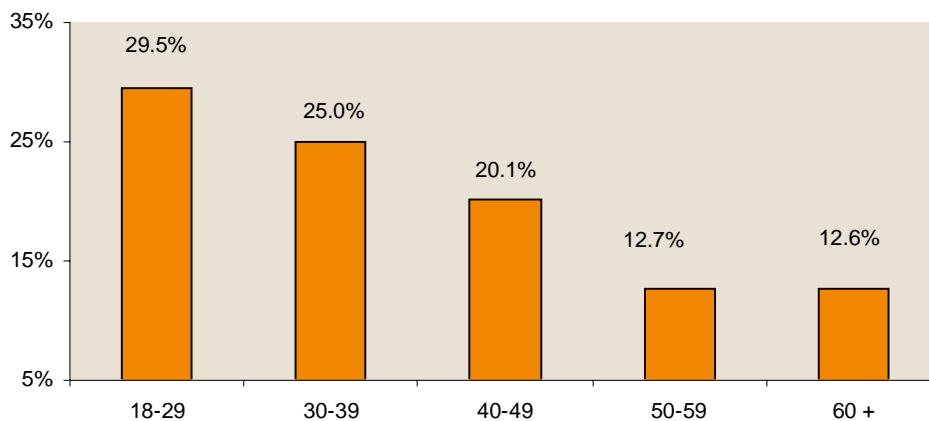
## 4.2 Demographic profile

### 4.2.1 Age, sex and place of residence

#### 4.2.1.1 Age

Among First Nations adults having participated in the survey, the 18-29 age group accounts for the largest number of adults (29.5%). As the age increases, the proportion of adult decreases. The average age of adults living in the communities is 40.2, which is an increase compared to the first phase of the survey in 1997 (38.0). The proportion of adults younger than 45 is 65.3%, versus nearly 73.0% in 1997.

**Graph 87: Age of adults**

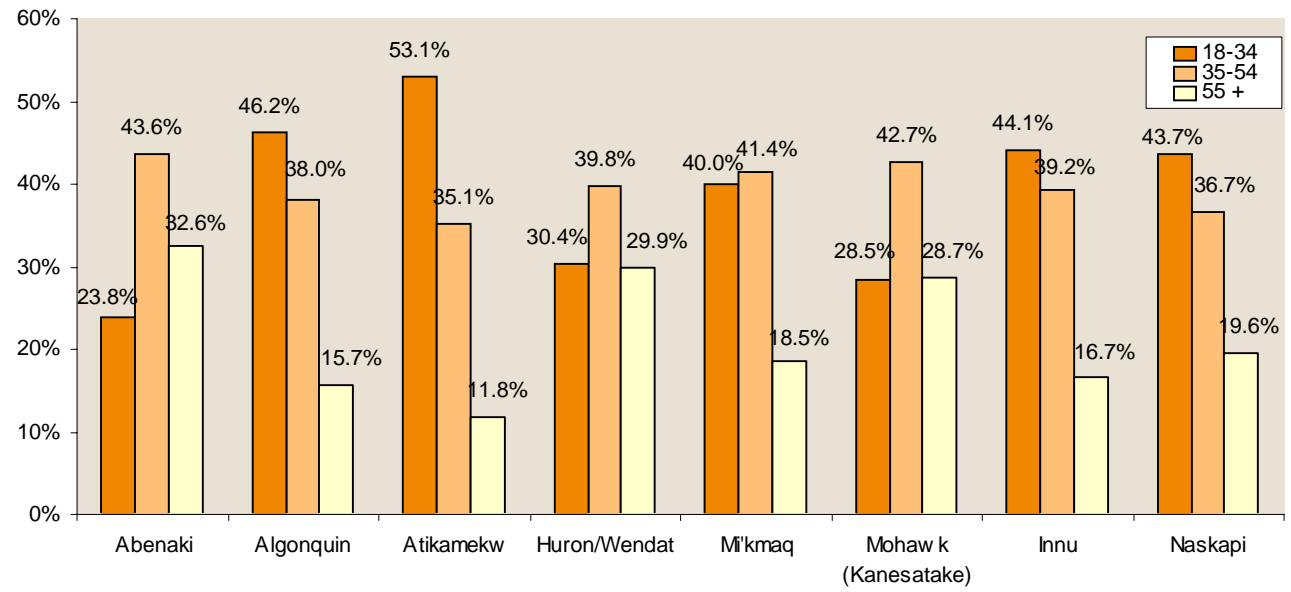


The population is older in small communities than in medium and large communities. Table 25 shows that small communities have less adults aged 18-34 and more adults aged 55 and older than do the medium and large communities.

**Table 25: Age of adults, by community size**

Age groups	Small	Medium	Large
18-34	36.1%	42.7%	43.5%
35-54	39.7%	37.4%	39.7%
55 +	24.1%*	19.9%	16.8%

**Graph 88: Proportion of adults per age group, by Nation**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

The Atikamekw Nation is the youngest Nation. It presents the highest percentage of young adults and the lowest percentage of Elders, in addition to an average age of 36.6. Conversely, the Abenaki and Huron/Wendat Nations, followed by the Mohawk community of Kanesatake, present the lowest proportions of young adults and the highest proportions of Elders, with average ages ranging from 44.4 to 45.9. These three First Nations are all situated in zone 1, where proximity to an urban centre very likely promotes the exodus of young adults from the community to the city.

4.2.1.2 Sex

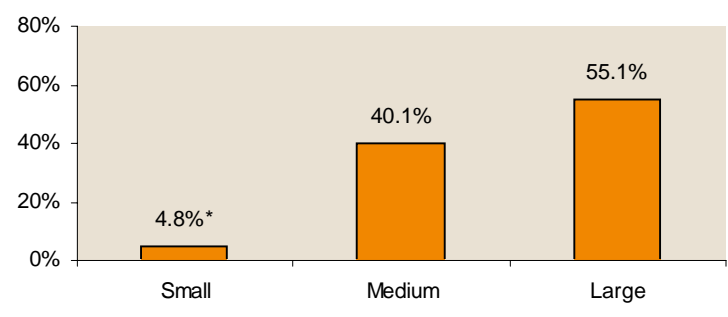
The Atikamekw and Naskapi Nations have slightly higher percentages of men (52.5%) than of women (47.5%), while the Abenaki and the Mohawks of Kanesatake have more women (56.4% and 55.3% respectively) than men (43.6% and 44.7% respectively).

Regarding schooling levels, a higher percentage of men (33.0%) have diplomas at the college, technical or vocational level than do women (27.0%).

4.2.1.3 Place of residence

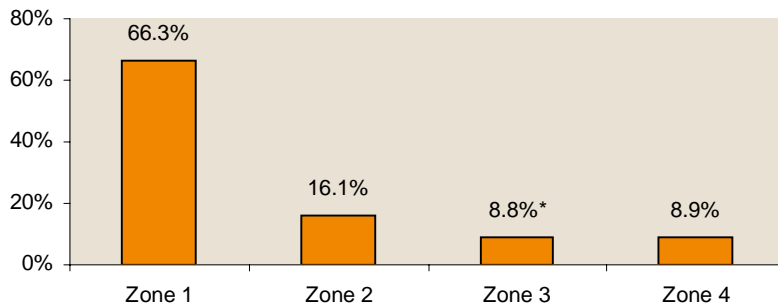
Just over half of the communities that participated in the survey are large, while close to one in 20 are small (Graph 89). Two thirds of the communities are located in zone 1 (Graph 90).

**Graph 89: Proportion of adults, by community size**





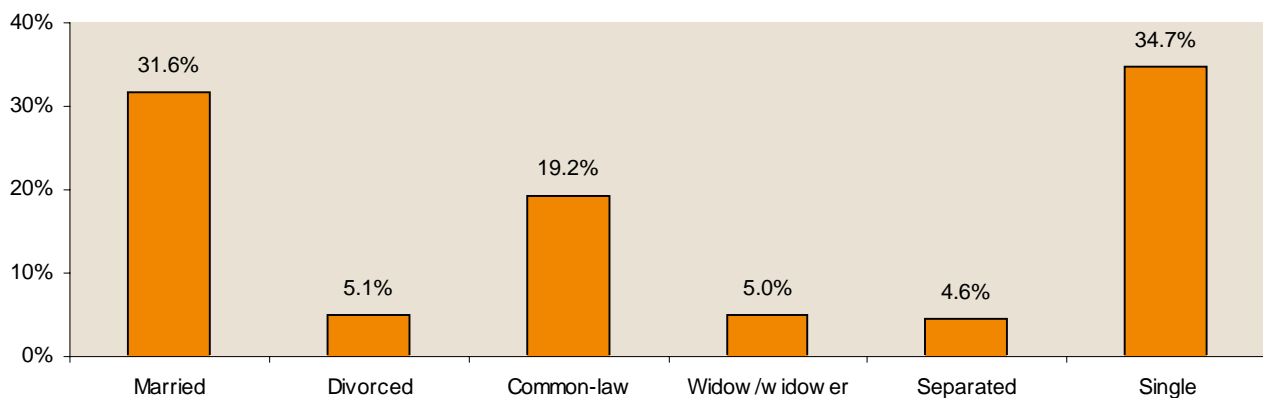
Graph 90: Proportion of adults, by geographic zone



#### 4.2.1.4 Marital status

There are almost as many married persons (31.6%) as single persons (34.7%). The number of common-law relationships (19.2%) has increased since 1997, when the percentage of married couples was 35.1%, while that of common-law couples was 15.4%. The average age of married persons is 47, which is a much higher figure than the average age of persons in common-law relationships (33.0). One can suppose that the discrimination against women by the *Indian Act*, the Christianizing zeal which remains strong in the communities and the limited choice of partners in zone 4 or smaller communities are factors that have influenced the evolution in the marital status of First Nations members.

Graph 91: Marital status



About one third of adults in small and medium communities are married (33.4% and 33.5% respectively) and less than one third are single (31.9% and 31.4% respectively). In the large communities, 29.6% of adults are married and 31.7% are single. The reasons for this difference may include the fact that the average age in large communities is lower. In considering percentages of single adults according to communities' level of isolation, we note that the situation has reversed since 1997, when zone 4 communities had the lowest proportion of single adults (barely 25.0%). In 2002, they had the highest proportion, at 38.8%, versus 34.6% in zone 1, 27.4% in zone 2 and 23.5%\* in zone 3.

#### 4.2.2 First Nations languages and traditional culture

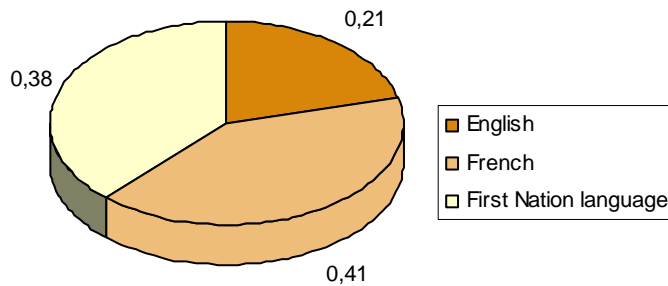
##### 4.2.2.1 Languages understood and languages spoken

25.2% of adults asked for a translation of the survey's questions into their First Nations language. In 91.6% of these cases, the interviewer translated for them. The 60 and older age group obviously presented the largest proportion of persons who used the translation service (43.8%). But 22.4% of the 18-29 year-olds used it as

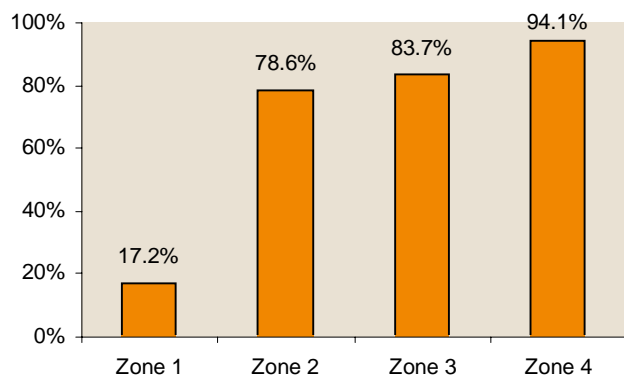


well. We did not find any major differences among age groups according to understanding or use of a First Nations language.

**Graph 92: Most often used language**



**Graph 93: Proportion of adults who use a First Nations language the most often, by geographic zone**



Although 38.5% of adults use their First Nations language the most often (a reduction compared to nearly 45.0% in 1997), a similar percentage do not know a First Nations language (39.2%) and more do not speak one (42.7% versus 33.3% in 1997).

A community's level of remoteness seems to be related to the more frequent use of a First Nations language, as seen in Graph 93. The use of English and French is more concentrated in zone 1 communities, where 51.9% speak French and 30.9% speak English. (N.B.: The Cree, who mostly speak English, did not participate in the survey.) Consequently, understanding and use of a First Nations language tends to increase as isolation increases (see Table 26).

Table 26: Proportion of adults who understand and speak a First Nations language fluently or relatively well, by geographical zone

Understanding and speaking an Aboriginal languages fluently or relatively well	Zone 1	Zone 2	Zone 3	Zone 4
Understand one or several Aboriginal languages	43.1%	85.8%	97.7%	94.7%
Speak one or several Aboriginal languages	38.7%	85.2%	97.0%	94.9%

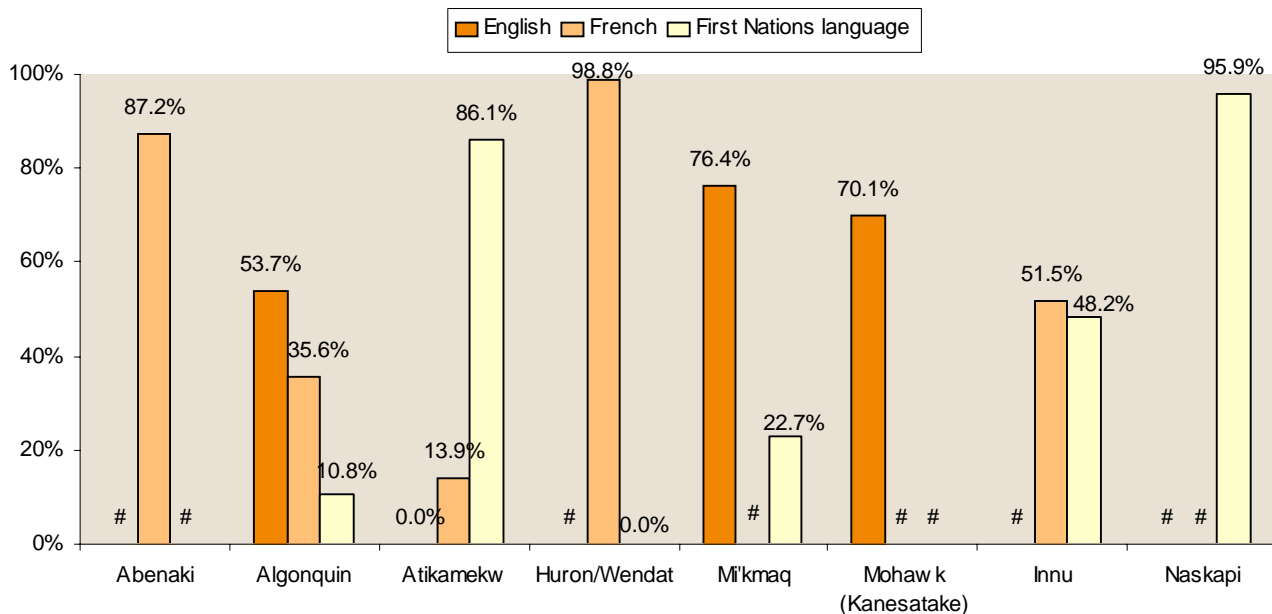
The percentage of adults who use French the most often decreases as the community size increases (76.4% in small communities, 39.7% in medium communities and 25.5% in large communities). Adults living in large communities also use First Nations languages more (47.6%). Furthermore, the highest proportion of English speakers is found in large communities, at 26.9% (23.0% in medium-size communities). Table 27 describes the ability to understand or speak a First Nations language according to the community size.

Table 27: Proportion of adults who understand or speak a First Nations language fluently or relatively well, by community size

Ability to understand or speak a First Nations language	Small	Medium	Large
Understand one or several Aboriginal languages	13.5%	58.0%	72.1%
Speak one or several Aboriginal languages	12.3%	54.9%	67.4%

Graph 94 illustrates the level of use of First Nations languages among the adults having participated in the survey.

Graph 94: Most often used language, by Nation



Note: The Malécites of Viger are excluded because their results were not statistically significant.

We note an increase in the number of Atikamekw members who use their language, at 86.1% compared to 79.3% in 1997. The same observation holds for Algonquin speakers (10.8% compared to 2.9% in 1997). The number of Innu language users dropped from 74.4% in 1997 to 48.2% in 2002.

A low use rate does not necessarily mean poor understanding of the language. Table 28 gives a more accurate picture of the linguistic reality.

Table 28: Proportion of adults who understand or speak a First Nations language, by Nation

Understanding or speaking a First Nations language	Algonquin	Atikamekw	Mi'kmaq	Mohawk (Kanesatake)	Innu	Naskapi
Understand one or several Aboriginal languages	48.6%	97.0%	65.8%	46.1%	67.1%	96.1%
Speak one or several Aboriginal languages	46.9%	96.7%	53.1%	35.1%	63.9%	96.1%

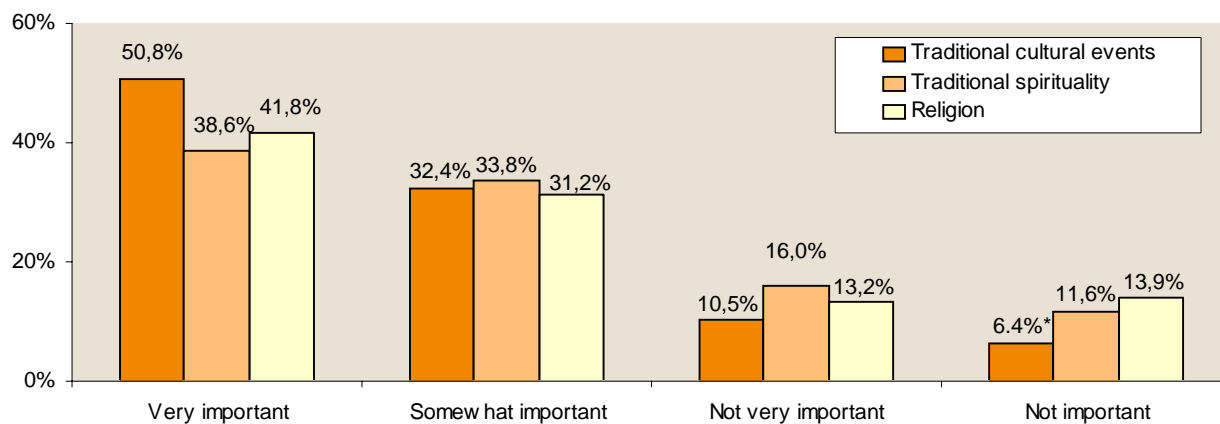
Note: The Abenaki, the Huron/Wendat and the Malécites of Viger are excluded for reasons of statistical validity.

#### 4.2.2.2 Traditional culture

This section of the questionnaire sought to evaluate the importance of cultural events, traditional spirituality and religion in the life of First Nations members. Section 3.3.7 (Community well-being and traditional culture) deals with these issues from the point of view of progress observed within the communities over the 12 months preceding the survey.

Graph 95 shows that a vast majority of people consider traditional cultural events, traditional spirituality and religion to be important.

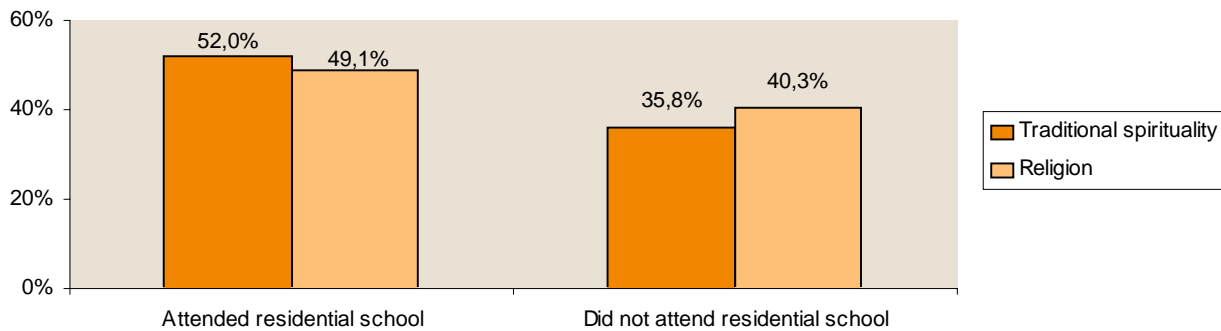
Graph 95: Perceptions of the level of importance of cultural and traditional events, traditional spirituality and religion



Half of all men and women said they consider traditional cultural events to be very important; only 6.4%\* said they are not important. 38.6% feel traditional spirituality is very important, while one in ten feels it is unimportant. As for religion, women clearly make more room for it in their life, as 48.6% of them said they consider it to be very important, versus only 34.8% of men. Only 9.2%\* of women said they consider it to be unimportant, versus 18.6% of men.

46.7% of 18-to-34-year-olds reported that traditional cultural events are very important to them. This proportion rises to 50.0% of adults 35 and older. About 10% of 18-to-34-year-olds and 35-to-54-year-olds do not consider traditional spirituality to be important, versus 16.9%\* of adults 55 and older. Finally, we note that the importance of religion increases with age; 31.4% of 18-to-34-year-olds said they feel religion is very important, versus higher percentages of 43.5% of 35-54 year-olds and 61.6% of adults 55 and older.

**Graph 96: Proportion of adults who consider spirituality and religion to be very important, by attendance of residential school**



Nearly two thirds of the former residential school residents who said the experience had negative impacts on their overall health and well-being consider traditional spirituality to be very important, as do more than three quarters of former residents who indicated a loss of cultural identity. Among the former residents who mentioned loss of religion or traditional spirituality as a result of their experience, 72.7% consider traditional spirituality to be very important, versus 60.8% of those who did not feel this religious or spiritual loss.

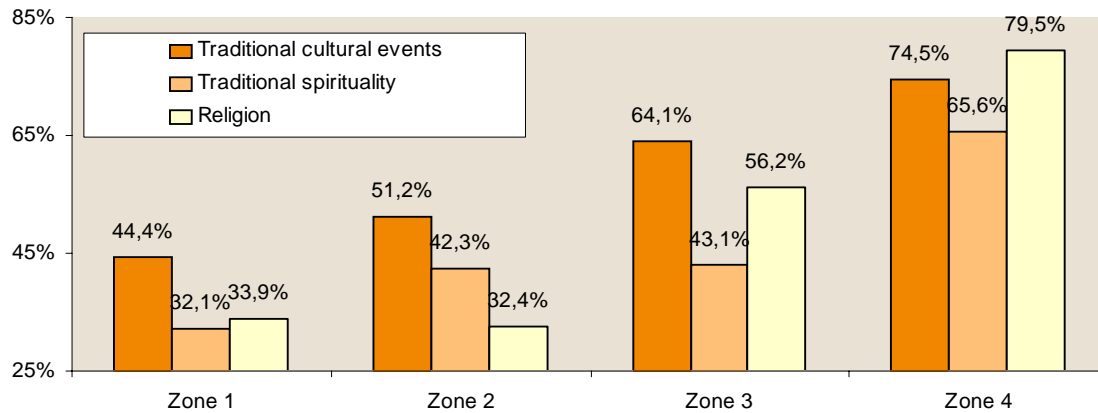
We note an inverse trend in terms of the importance placed on religion in relation to these same impacts. 45.3% of former residents who reported that the experience had negative impacts on their overall health consider religion to be very important, versus 51.6% of former residents who did not feel these impacts.

The same goes for loss of cultural identity: 38.6% of former residents who report having lost their cultural identity consider religion to be very important, versus 54.9% of those who did not experience this loss. Finally, among former residents who experienced a loss of traditional spirituality or religion, 36.7%\* consider religion to be very important, versus 52.1% of those who did not experience this religious or spiritual loss.

We therefore find that among former residents, those who consider religion to be very important indicated fewer negative impacts arising from their experience than those who consider religion to be less important. Furthermore, contrary to those who consider religion to be very important, former residents who consider traditional spirituality to be very important say they felt more negative impacts related to traditional spirituality than those for whom traditional spirituality is less important.

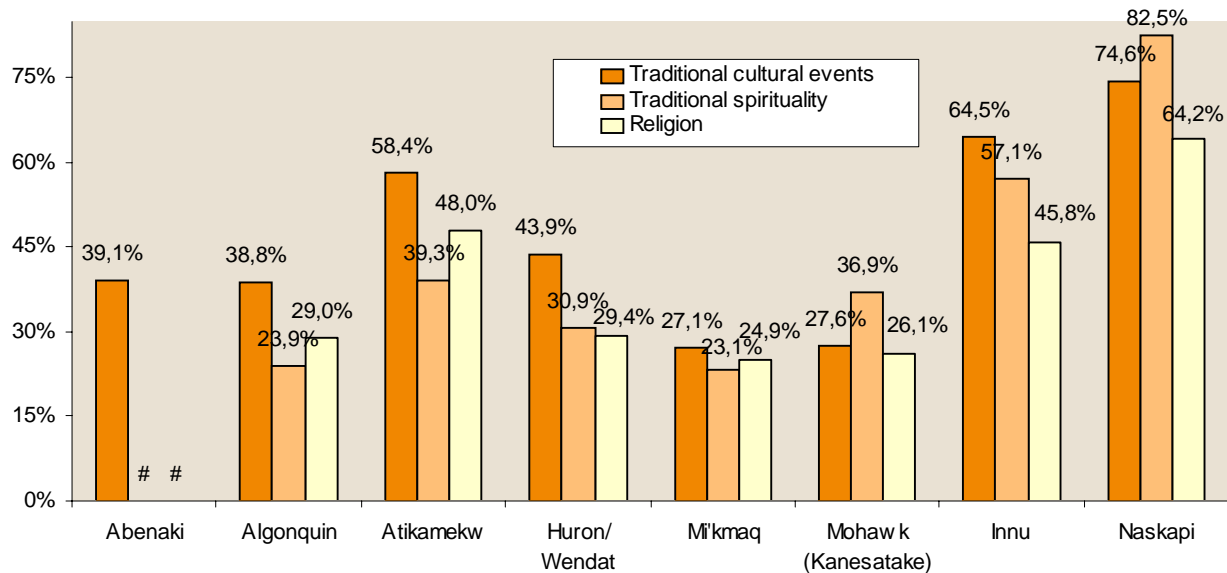
The perception of the importance of traditional cultural events, traditional spirituality and religion seems to be related to community isolation, as shown in Graph 97. We note that 13.4% of individuals in zone 1 and 17.4%\* of those in zone 3 do not consider traditional spirituality to be important, while 17.4% in zone 1 and by 21.9% in zone 2 do not consider religion to be important.

**Graph 97: Proportion of adults who consider traditional cultural events, spirituality and religion to be very important, by geographic zone**



The community size seems to be related to the proportion of people who consider traditional cultural events to be very important; it rises from 43.0% in small communities to 52.7% in large communities. The same holds for traditional spirituality; 33.3%\* of individuals in small communities consider it to be very important, versus 41.7% in large communities. This trend continues with religion; 34.7%\* of people in small communities consider it to be very important, versus 41.5% of those in large communities.

**Graph 98: Proportion of adults who consider traditional cultural events, spirituality and religion to be very important, by Nation**

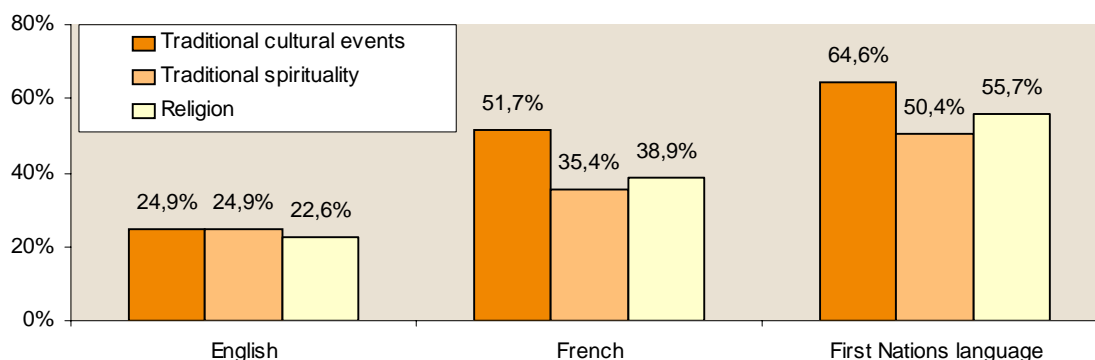


Note: The Malécites of Viger are excluded because their results were not statistically significant.

27.6% of the Mohawks of Kanesatake and 27.1% of the Mi'gmaqs do not consider traditional cultural events to be very important. Traditional spirituality is somewhat important to 38.8%\* of the Abenaki, while 27.1%\* of the Huron/Wendat, 14.9%\* of the Mi'gmaqs and 11.8%\* of the Innus do not consider it to be important at all. As for religion, nearly one third of the Huron/Wendat, nearly one Mohawk (Kanesatake) in five, one Mi'kmaq in five, and one Atikamekw in five do not consider it to be important.

The importance of cultural events and traditional spirituality appears to be related to the most often used language, as demonstrated in Graph 99.

**Graph 99: Proportion of adults who consider traditional cultural events, spirituality and religion to be very important, by most often used language**



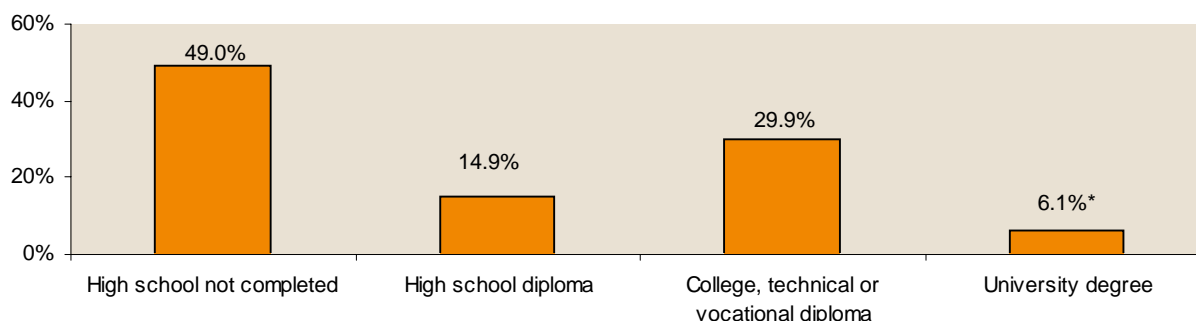
While just over half of individuals, notwithstanding their schooling level, consider traditional cultural events to be very important, only 36.2% of high school graduates consider them to be important. The same goes for traditional spirituality: 40.0% of individuals, again, notwithstanding their schooling level, consider it to be very important, versus just 27.9% of high school graduates. An opposite trend emerges regarding religion; it is very important for nearly one third of all individuals (regardless of education), versus 51.9% of individuals without a high school diploma.

#### 4.2.3 Education

Nearly half of all adults do not have a high school diploma. A significant enough proportion of them attended a residential school, an environment that often does not foster academic success or the development of the desire to learn (section 3.3.5 'Residential schools' in 'Lifestyle habits' chapter expands on these ideas).

The only statistically significant difference between men and women is that 33.0% of men have a college, technical or vocational diploma, versus 27.0% of women. Moreover, 6.4%\* of women have a university degree, versus a percentage of men too small to be statistically valid.

**Graph 100: Schooling level of adults**



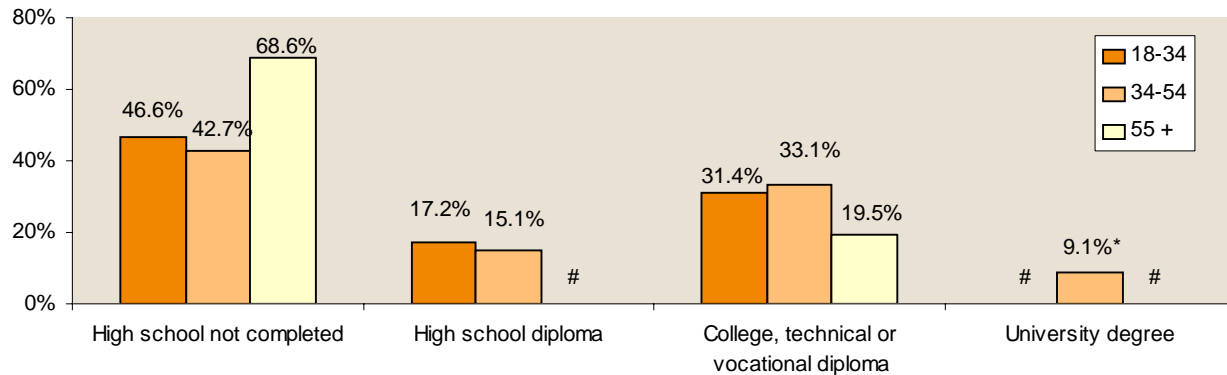
A community's size and level of remoteness appear to be related to the schooling level of adults. The proportion of adults who did not complete their high school studies tends to increase with community size (ranging from 38.0% in small communities to 47.4% in large ones). A similar trend holds with regard to the obtention of college, technical or vocational diplomas; a higher proportion of adults in small communities (39.1%) have obtained a diploma than in large ones (31.0%).

We also note a correlation between community size and employment rates. Thus, the employment rate is 64.9% in small communities, 51.8% in medium communities and 46.3% in large communities. One can also

note a correlation between geographical remoteness and employment rates. The more isolated the community, the fewer the workers. Employment opportunities are likely scarcer in zones 3 and 4.

Graph 101 presents schooling levels by age group. It is surprising to see that a higher proportion of 18-34 year-olds have not completed their high school studies than 35-54 year-olds. Dropping out of school therefore seems to be increasingly present.

**Graph 101: Proportion of adults per schooling level, by age group**



Among the 11.4% of adults attending school at the time of the survey, 48.5% were aged between 18 and 24, 16.0% between 25 and 29, and 9.9% between 30 and 34.

#### 4.2.4 Employment and income

##### 4.2.4.1 Employment

Among the 49.0% of adults who had jobs at the time of the survey, 44.2% were working full-time. We find the highest proportion of workers in the 30-39 age group (59.2%) and the 40-49 age group (66.7%), while less than half of adults in the youngest age group (18-29) and older adults (50-59) have paid jobs (46.1% and 44.8% respectively). Slightly more men (51.1%) than women work (47.0%). They also have more full-time jobs (47.2%) than women (41.3%).

The percentage of adults with paid jobs decreases as community size increases, ranging from 64.9% in small communities to 46.3% in large communities. The proportion of full-time workers follows the same trend, going from 60.5% in small communities to 42.7% in large ones.

Consistent with the hypothesis that employment prospects are better in zone 1 communities than in zone 4 communities, one can see that 54.0% of adults in zone 1 communities have jobs, versus 45.9% in zone 4 communities.

Proportions of workers by Nation range from 44.8% to 59.4%, with the Huron/Wendat Nation standing out at 67.9% of the adult population who has a paid job.

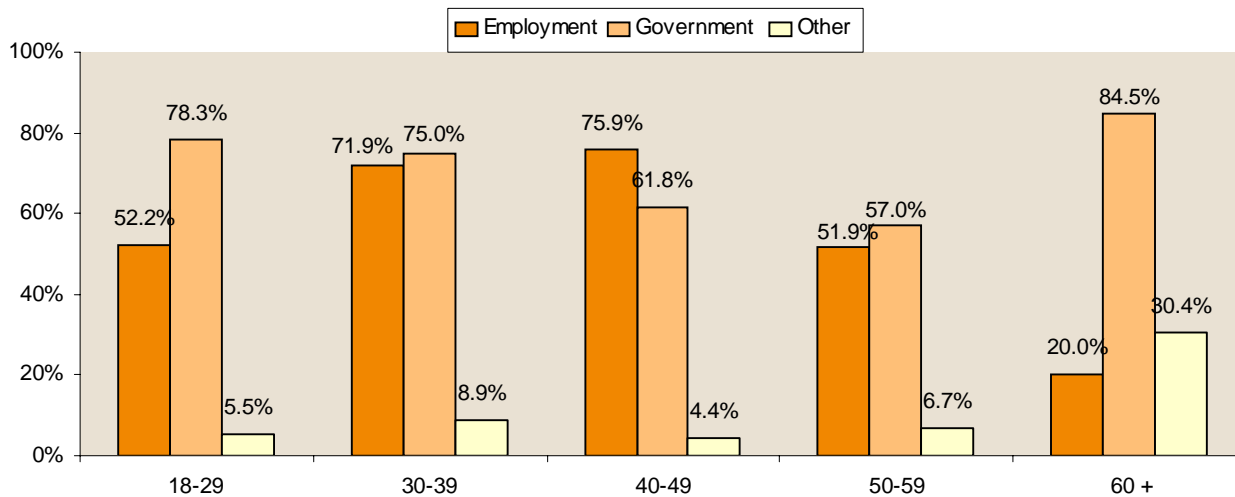
##### 4.2.4.2 Sources of income

At the time of the survey, 55.0% of adults were receiving employment income (versus 31.6% in 1997) and 46.4% were receiving government-source income<sup>24</sup> (of whom 22.7% were receiving two or more forms of such income). 9.4% were receiving one or two forms of income that did not come from either employment or a government source. It must be specified that 20.2% of adults were receiving employment insurance (unemployed), double the figure in 1997, and 23.7% of adults were receiving employment assistance (social

<sup>24</sup> Employment insurance; income security; basic old age security; Canada or Quebec pension plan benefits; veteran's pension; child tax benefit; worker's compensation; disability, education or training allowance.

assistance). Readers should note that a certain number of workers have seasonal jobs, related, for example, to forestry or fishing.

**Graph 102: Income sources, by age group**

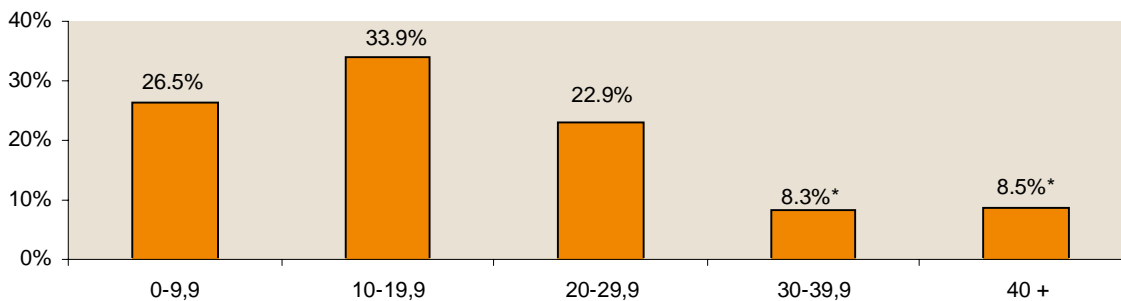


More men (63.7%) than women (52.0%) receive employment income, while 80.9% of women receive income from a government source, versus 60.3% of men. Various reasons may explain this, such as the fact that child care (including daycare) is usually provided by women. 12.8% of women receive income from sources other than employment or the government, versus a statistically non-significant proportion of men.

Isolation appears to have an effect on individuals' source or sources of income. 63.2% of adults in zone 1 reported receiving employment income. This percentage decreases in the more isolated communities (zone 2- 48.1%, zone 3- 58.1%, zone 4- 44.7%). Percentages of persons receiving government-source incomes are as follows: zone 1- 68.8%, zone 2- 80.3%, zone 3- 67.1%, and zone 4- 77.7%.

Finally, it is possible that in the year preceding the survey, some individuals received income from employment and from one or several government sources.

**Graph 103: Annual individual income (in thousands of dollars) (2001)<sup>25</sup>**



<sup>25</sup> "Quebec has defined the poverty line for its own purposes. It has been set temporarily at \$10,800 for single persons, at \$15,500 for couples without children and single-parent families with one child, at \$18,200 for single-parent families with two children and couples with one child, at \$22,000 for single-parent families with three or more children and couples with two children, and at \$24,500 for families with more than three children" (translated from: Lévesque, K. and Chouinard, T., *Le Devoir*, Monday, November 10, 2003).

We believe, as common sense would dictate, that the poverty line for individuals living in isolated communities should be significantly higher, to reflect the higher costs there of services and transportation. The poverty line is thus a sensitive indicator that varies from one region to the next.

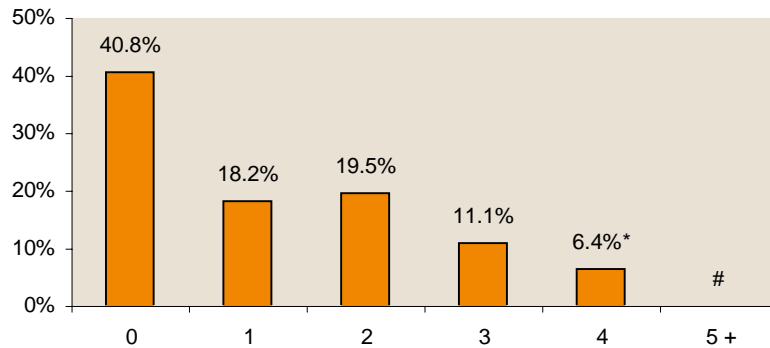


Regarding individual income, we note that at least one of every five First Nations members is living below the poverty line.

#### 4.2.5 Information on household

##### 4.2.5.1 Number of children at home

**Graph 104: Distribution of the number of children (0-17) per household**

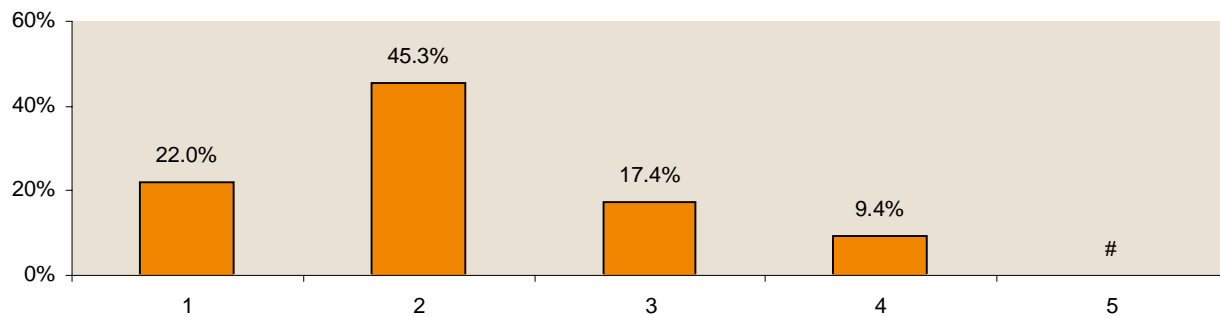


At the preliminary results interpretation session, some participants mentioned that 20 years ago, girls were becoming pregnant at the age of 14 or 15, whereas today, with contraception and abortion, full-term pregnancies generally do not occur until they are about 20. Still, it is not rare in some communities for girls aged 12 or 13 to become pregnant.

Small community households have an average of 0.78 minors, versus 1.52 in large communities. 58.4% of adults in small communities live in households with no children, versus 35.7% in large communities. Zone 4 communities have a higher average of children per household (1.96) than that of communities in zone 1 (1.08). Zone 2 communities have the highest average, at 2.48 children per household.

##### 4.2.5.2 Number of adults at home

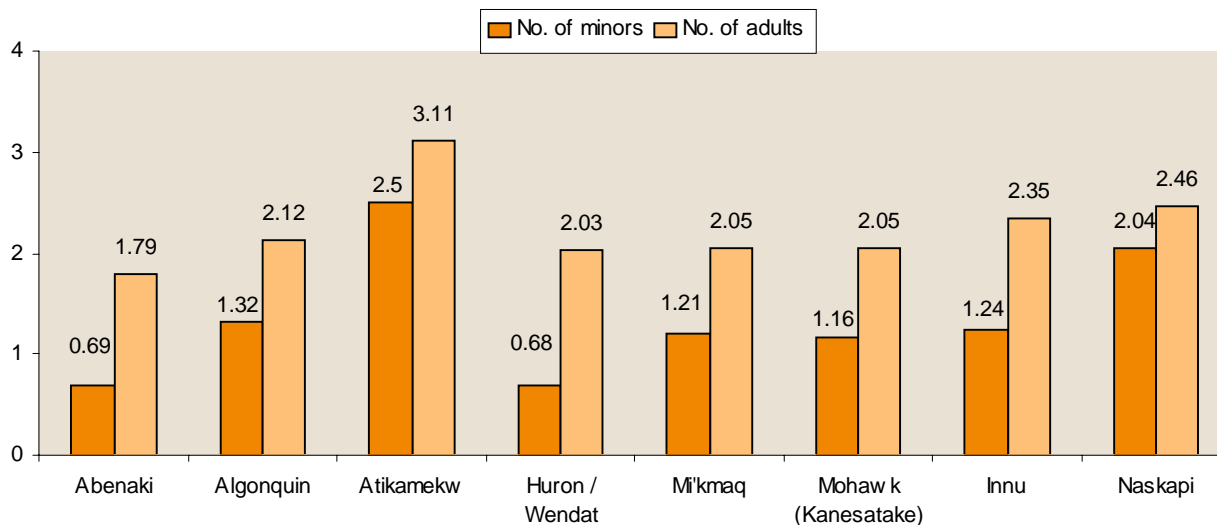
**Graph 105: Distribution of the number of adults per household**



50.8% of adults are married or living common-law. The limited and insufficient number of housing units available in the communities, overcrowded conditions and housing costs may explain why 34.7% of single persons do not live alone. This situation is considered more closely in the Children's Health section of this report, where we ascertain the persons with whom children live most of the time (biological parents, grandparents, aunts, etc.).

The percentage of households with just two adults decreases as community isolation increases, going from 49.0% in zone 1 to 40.8% in zone 4. The opposite trend holds for households with three adults, where the percentage increases from 15.5% in zone 1 to 20.3%\* in zone 4 communities.

**Graph 106: Average number of minors (0-17) and adults per household, by Nation**

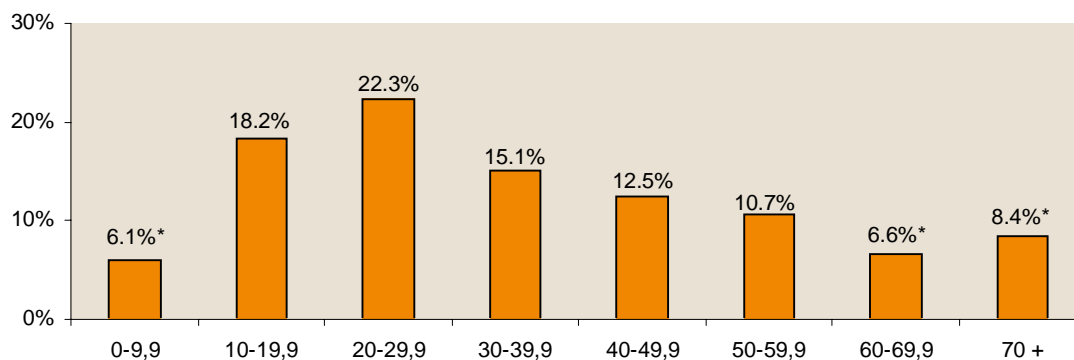


Note: The Malécites of Viger are excluded because their results were not statistically significant.

#### 4.2.5.3 Annual income of household

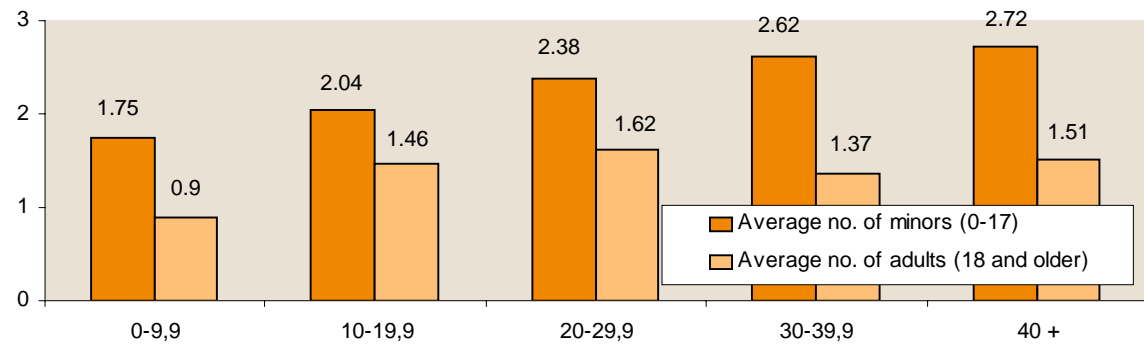
Household income includes all types of income received by individuals in the household, as presented by Graph 107. In Graph 108, we see how household income increases in direct correlation to the number of adults in the household.

**Graph 107: Annual household income, in thousands of dollars (2001)**



The poverty line is \$18,200 for a single parent with two children or a couple with one child, \$22,000 for a single parent with three or more children or a couple with two children, and \$24,500 for families with more than three children.

**Graph 108: Average number of minors (0-17) and adults (18 or older) per household, by household income (in thousands of dollars) (2001)**

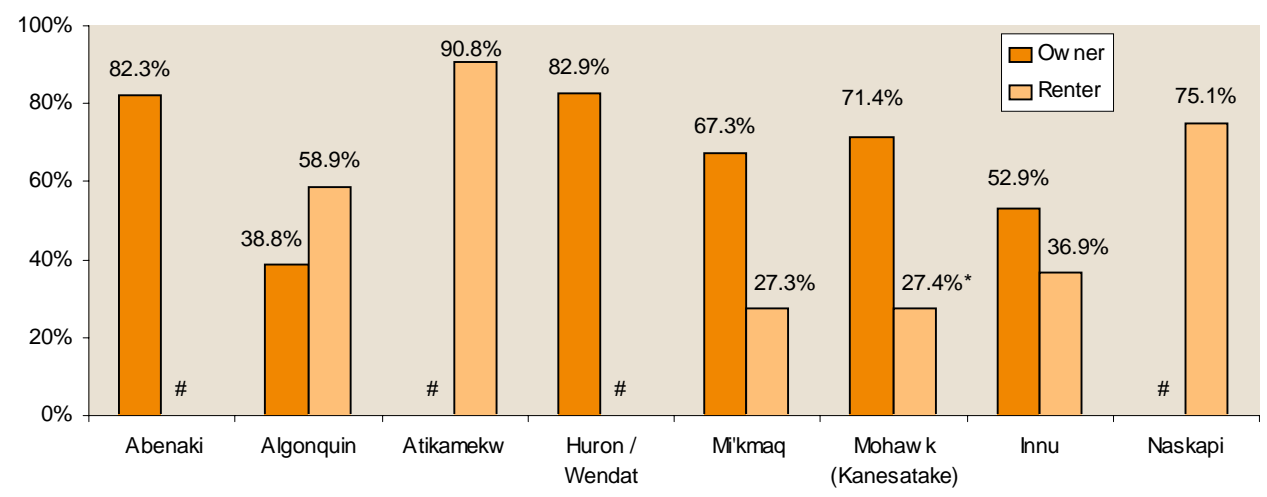


4.2.6 Housing

47.7% of individuals live in a dwelling owned by them or another household member. The percentage of persons living in private dwellings increases according to age group, as follows: 39.0% of 18-29 year-olds, to 53.7% of 40-49 year-olds, and 59.4% of persons aged 60 and older.

Small communities have a higher percentage (70.0%) of persons in private dwellings, versus an average of 43.8% in other communities (58.7% in zone 1 and 30.0% in zone 4). The percentage for zone 2 communities is just 11.7%\*, while the rate for zone 3 is not statistically significant. 34.5% of individuals in zone 1 live in a house owned by the band council; this percentage is clearly higher in the other zones as follows: zone 2 (87.6%), zone 3 (95.7%) and zone 4 (91.4%).

**Graph 109: Status of housing, by Nation**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

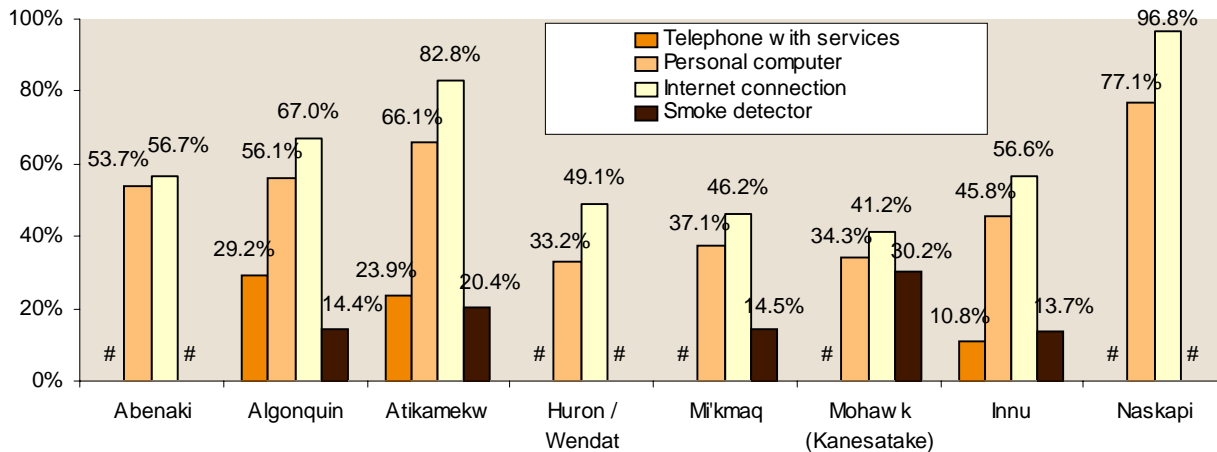
With regard to various household equipment and facilities:

- 99.1% of First Nations members have running water and electricity.
- 94.9% reported having flush toilets, septic tanks or sewer service, and waste collection service.
- 99.3% have refrigerators and stoves.
- 84.9% have smoke detectors and 56.7% have fire extinguishers.
- 85.8% have telephone lines and 39.2% have Internet connections.

Table 29: Proportion of adults who have access to various household equipment and services, by geographic zone

Household equipment and services	Community geographic zone			
	Zone 1	Zone 2	Zone 3	Zone 4
Smoke detector	86.4%	77.0%	84.0%	88.4%
Carbon monoxide detector	10.3%	14.1%	8.1%	2.0%
Fire extinguisher	53.9%	84.6%	62.5%	66.9%
Telephone with services	86.7%	70.3%	79.9%	81.7%
Computer	55.1%	32.6%	35.2%	30.7%
Internet connection	45.3%	12.3%	28.3%	14.2%
Refrigerator	99.5%	100.0%	100.0%	100.0%
Stove	99.7%	100.0%	100.0%	100.0%
Electricity	99.7%	99.5%	100.0%	100.0%
Cold running water	99.8%	99.5%	100.0%	100.0%
Hot running water	99.5%	99.5%	99.6%	100.0%
Flush toilet	99.9%	99.5%	100.0%	100.0%
Septic tank or sewage service	97.5%	96.4%	99.1%	87.8%
Garbage collection service	99.4%	97.1%	98.7%	95.1%

Graph 110: Households without access to certain facilities/equipment, by Nation



Note: The Malécites of Viger are excluded because their results were not statistically significant.

For 88.4% of people, running water is the main source of water for the household, while 10.8% have individual or shared wells. 28.2% of individuals do not consider the water provided by their main source as being drinkable. Elders aged 60 and over are more severe; 36.8% do not feel their water is drinkable. The younger age groups agree in proportions varying from 24.9% to 28.9%.

99.7% of households in small communities rely on local or community-supplied running water, versus 88.5% in medium and large communities. Conversely, 29.1% of the Algonquin and 74.8% of the Mohawks of Kanesatake get their running water from wells. Finally, although 92.8% of Naskapi members use local water, 82.8% feel the water from this source is not drinkable.

Finally, for housing to be adequate, it must meet three conditions:<sup>26</sup>

<sup>26</sup> CMHC, September 2002, "Special Studies on 1996 Census Data: Housing Conditions of North American Indian Métis and Inuit Households in Canada," *Research Highlights*, Canada, no. 55-10, p. 1.

- Appropriate quality (does not require major renovations)
- Appropriate size (has a sufficient number of rooms)
- Affordable cost (housing costs are less than 30% of household income before taxes).

Let us now examine what is the status of these three conditions in the communities that participated in the survey.

#### 4.2.6.1 Quality of housing

25.1% of First Nations members reported the need for major repairs. We can thus assume that approximately one of every four dwellings does not meet quality standards. Also, at the time of the survey, 29.7% of adults reported the need for minor repairs and 35.1% reported the need for regular maintenance, whereas just 10.0% of adults felt no repairs were necessary. Moreover, 35.8% of individuals indicated the presence of mould in their dwellings in the 12 months preceding the survey. This situation could be affecting their overall health to a significant extent.

21.5% of adults living in zone 1 reported that their dwelling required major repairs; this proportion climbs to 46.9% in zone 4 communities. There are also similar gaps regarding the need for regular maintenance: 37.7% of adults living in zone indicated that their dwelling requires regular maintenance, compared to 15.3%\* in zone 4. The presence of mould follows the same trend, rising from 31.0% in zone 1 to 54.6% in zone 4.

Lastly, let it be noted that the Nations that stand out in terms of major repairs are the Naskapi (58.3%) and the Mohawks from Kanasatake (36.8%).

#### 4.2.6.2 Size of housing

Dwellings have an average of six rooms, excluding bathroom, entranceway, laundry room and shed or garage. On the basis of a ratio of one person per room,<sup>27</sup> 9.7% of dwellings are overcrowded.

Regarding the differences between Nations, one can see that nearly one third of Atikamekw dwellings are overcrowded, versus one of every eight Naskapi dwellings. We did not obtain statistically-significant percentages for the other Nations. However, we do see that 31.6% of zone 2 dwellings and 27.3% of zone 3 dwellings are overcrowded. For comparison purposes, 4.6% of zone 1 dwellings and 12.7% of zone 4 dwellings are overcrowded.

Finally, one of every ten dwellings in medium and large communities is overcrowded.

#### 4.2.6.3 Cost

Since the survey did not document the average cost of housing, we cannot explore this issue.

### 4.3 Health status

#### 4.3.1 Overall health

We assessed the state of health of First Nations members using a series of questions on illnesses, dental hygiene, physical injuries, disabilities and activity limitations, as well as perceptions and use of health services. Half of the population feels it is in excellent or very good health (compared to 60.7% of the population aged 15 and older in the Quebec population overall.)<sup>28</sup> But the prevalence of some chronic

<sup>27</sup> "According to the National Occupancy Standard, 'enough bedrooms' means one bedroom for each cohabitating adult couple; unattached household member 18 years of age and over; same-sex pair of children under age 18; and additional boy or girl in the family, unless there are two opposite sex siblings under 5 years of age, in which case they are expected to share a bedroom. A household of one individual can occupy a bachelor unit (i.e., a unit with no bedroom)." (<http://www.cmhc-schl.gc.ca/en/obloca/ablo2004/#31>).

The reader will understand that we could not go into such detail to establish the actual occupancy of dwellings.

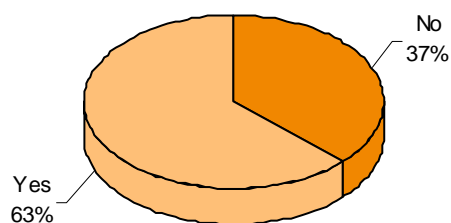
<sup>28</sup> Institut de la statistique du Québec, *Canadian Community Health Survey 2000-2001*, p. 55. ([http://www.stat.gouv.qc.ca/publications/conditions/pdf2005/donn\\_sociale05c3.pdf](http://www.stat.gouv.qc.ca/publications/conditions/pdf2005/donn_sociale05c3.pdf)).

In 2003, this proportion fell to 56.6%.

illnesses such as diabetes and respiratory problems has increased in comparison to the results in the analysis and interpretation report on the 1997 regional longitudinal health survey. When compared to the 1997 survey, the health of First Nations members is not improving. For our survey, well over half of all First Nations members (63.0%) reported having health problems.

#### 4.3.1.1 Medical problems

**Graph 111: Proportion of adults who report various health problems**



The highest prevalence of health problems mentioned by adults was for musculoskeletal and cardiovascular problems, as illustrated in the following table.

**Table 30: Proportion of adults who report various medical problems**

Medical problems	% of adults
Musculoskeletal problems	23.3%
Cardiovascular problems	21.8%
Allergies	18.6%
Respiratory problems	15.0%
Diabetes	14.5%
Visual and auditory problems	13.0%
Digestive system problems	11.7%
Thyroid gland problems	7.1%
Neurological and cognitive problems	5.9% *

For First Nations members, being happy and satisfied is the main criteria for being in good health, followed closely by sleeping well, resting and having good social support. For the 18-29 year-olds, being happy and satisfied is the main criteria, while good social support is the most important criteria for persons aged 60 and over.

In general, the reasons given by First Nations members for being in good health, such as healthy diet, balanced lifestyle, etc., are more important for women than for men. But exercising regularly is clearly more important for 61.3% of men than for 46.9% of women.

Persons with diplomas appear, like women, to be more aware of the reasons that people are in good health. They consider a greater number of aspects that influence their health. Let it be noted that the only factor for excellent or very good health that is important for persons without diplomas is to have little stress in their life.

This section presents our analysis on the most common illnesses among First Nations. Some new and rare illnesses, such as osteogenesis imperfecta and lupus, are not included. It will eventually be necessary to

study the causes of these new illnesses in First Nations, to prevent their development. But given their very low prevalence, they will require research techniques other than the ones we have used to date.

Illnesses and health problems, such as diabetes and cardiovascular problems, are a threat to the future and a burden regarding health costs, because they often limit the activities of the persons they afflict and increase the need for health and homecare services. They can also lead to other health problems. For example, diabetes can lead to blindness, heart disease, amputations, nerve damage and strokes. Here we note also that high blood pressure is a diabetes risk factor.

#### 4.3.1.2 Risk factors and general findings

Overall, the prevalence of illnesses and health problems increases with age. On the other hand, respiratory problems and allergies are frequently diagnosed in younger adults, compared to other illnesses. Also, the 18-29 year-olds have more allergies than the 50-59 year-olds. This leads us to assume that there are new risk factors related to these illnesses, for example environmental risks (housing, leisure and work facilities, and overall pollution, etc.).

In general, women have more health problems than men do, excluding visual and hearing problems. These results are based on chronic illnesses reported at the time of the survey. We can hypothesize that men present a lower prevalence of illnesses and health problems because they see health professionals less often.<sup>29</sup> Furthermore, women's average lifespan is longer than men's. This could explain in part why women present a higher proportion of health problems.<sup>30</sup>

**Table 31: Proportion of adults who report various medical problems, by sex**

Health problems	Men	Women
Health problems in general	59.2%	66.2%
Musculoskeletal problems	22.9%	23.7%
Respiratory problems	14.2%	15.7%
Visual and auditory problems	15.0%	11.0%*
Neurological and cognitive problems	#	6.8%*
Cardiovascular problems	21.2%	22.3%
Digestive system problems	9.3%	14.0%
Allergies	15.2%	22.0%
Thyroid gland problems	#	10.2%*
Diabetes	12.5%	16.4%

There appears to be a correlation between geographical zone and the number of persons with health problems, which decreases from 65.0% in zone 1 to 50.0% in zone 4. Musculoskeletal, respiratory, cardiovascular and digestive system problems present marked differences according to communities' level of isolation. The proportion of these problems is higher in zone 1 than in zone 4.

We will see later that zone 3 and zone 4 present the highest proportion of adults who indicated that the lack of doctors or nurses is a major obstacle to accessing health services: 35.5% of adults in zone 3 and 30.9% of adults in zone 4. As for non-availability of health services, zone 3 again stands out with a proportion of adults of 49.7%. Finally, 22.8% of individuals in zone 4 criticized the lack of healthcare facilities.

<sup>29</sup> "In Quebec, more women than men go to the doctor, across all age groups, excluding the 65 and older age group, for which the gap between the sexes is not statistically significant (90% of women vs. 88% of men)." (Institut de la statistique du Québec, *Canadian Community Health Survey 2000-2001*, p. 60).

[http://www.stat.gouv.qc.ca/publications/conditions/pdf2005/donn\\_sociale05c3.pdf](http://www.stat.gouv.qc.ca/publications/conditions/pdf2005/donn_sociale05c3.pdf).

<sup>30</sup> In 2001-2003, the life expectancy of Quebec women aged 65 was 25% higher than that of Quebec men aged 65. Women can thus expect to live 3.8 years longer than men. (Institut de la statistique du Québec, 2005, *Résultats sociaux du Québec*, p. 44).

[http://www.stat.gouv.qc.ca/publications/conditions/pdf2005/donn\\_sociale05c2.pdf](http://www.stat.gouv.qc.ca/publications/conditions/pdf2005/donn_sociale05c2.pdf).

Although individual income does not appear to have a predominant effect on health problems, some interesting facts emerge. For example, persons with an income between \$10,000 and \$19,000, i.e., near the poverty line, have the most illnesses, while persons below the poverty line (income between \$0 and \$9,999) have the fewest illnesses. Persons with income between \$10,000 and \$19,000 and those with income of \$40,000 or more obtain the highest rates of cardiovascular problems and diabetes.

**Table 32: Proportion of adults who report various medical problems, by annual individual income (in thousands of dollars)**

Medical problems	0 – 9.9	10 – 19.9	20 – 29.9	30 – 39.9	40 +
Health problems in general	60.6%	65.6%	63.6%	63.8%	63.8%
Musculoskeletal problems	25.6%	23.6%	22.1%	24.9%*	16.4%*
Respiratory problems	15.6%*	17.7%	14.5%*	#	#
Visual and auditory problems	11.8%*	17.3%	13.7%*	#	#
Cardiovascular problems	17.7%	24.5%	21.7%	19.2%*	27.3%*
Digestive system problems	13.1%*	14.2%*	10.4%*	#	#
Allergies	16.3%	19.4%	19.8%	19.8%*	23.2%*
Thyroid gland problems	#	8.5%*	#	#	#
Diabetes	14.1%*	17.4%	11.7%*	11.7%*	15.5%*

In conclusion, it is important to mention that respondents who indicated they did not have jobs seem to have more diseases and medical problems than those with a paid job. Indeed, 67.3% of people without a job have medical problems, versus 58.4% of persons with jobs.

#### 4.3.1.3 Weight, overweight and obesity

The tables below summarize the results for adults' height and weight by sex.

**Table 33: Average height and weight of adults, by sex**

	Men	Women
Height (cm)	175.5	162.3
Weight (kg)	87.7	76.2

**Table 34: Proportion of adults by body mass index (BMI)<sup>31</sup> categories, by sex**

BMI categories	Men	Women	Total
Underweight	#	#	1.4%
Normal weight	25.5%	27.4%	26.4%
Overweight	41.2%	32.2%	36.9%
Obese	27.7%	32.7%	30.1%

Although one in five adults has a normal weight, more than two thirds of the adult population is overweight or obese. In comparing adults' weight according to the schooling level, we find that adults who did not complete high school studies present the highest proportion of obesity (33.3% versus 24.6% of high school graduates) and the lowest proportion of persons having normal weights (22.8% versus 31.7% of high school graduates).

The proportion of adults with obesity in zone 4 communities is 43.3%, compared to a much lower 27.3% in zone 1 communities. However, the proportion of overweight persons is the reverse, at 27.5% in zone 4, versus 38.5% in zone 1. 27.9% of adults in zone 1 communities have a normal weight, while the percentage

<sup>31</sup> Body mass index (BMI) is a measurement used to determine the healthy weight of individuals. It is obtained by dividing weight (kg) by height squared (metres): underweight ( $\leq 18.5$ ), normal weight ( $= 18.5$  to  $< 24.999$ ), overweight ( $= 25$  to  $< 29.999$ ), obesity ( $= 30$  to  $< 39.999$ ), and morbid obesity ( $= 40$  and higher).



for this category in zone 4 communities is too small to be statistically valid. Less than one third of adults in small and medium communities are obese, versus over one third in large communities.

The 18-29 year-olds stand out positively from the other age groups. They present the highest percentage of adults with normal weights (38.1%) and the lowest percentage of overweight (30.9%) and obese (25.5%) adults. By comparison, the percentages for the other age groups range from 15.8% to 26.4% for normal-weight adults, from 36.3% to 44.2% for overweight adults and from 29.6% to 32.6% for obese adults. Nevertheless, 56.4% of the 18-29 year-olds do not have a normal weight.

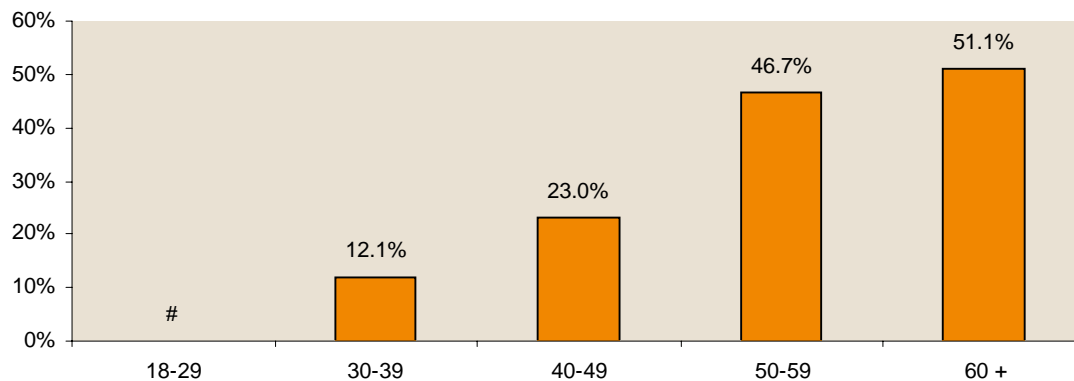
We note that the proportion of normal-weight adults decreases constantly as income increases, dropping from 30.4% for adults with income of under \$10,000 to 19.4% for those with an income of \$40,000 or more.

Finally, we must specify that certain factors such as education and income are often related, although we interpret them separately. Let it be noted that health is influenced by several factors (education, income, environment, housing, genetics, etc.) and that the overall situation of an individual influences his/her health and weight.

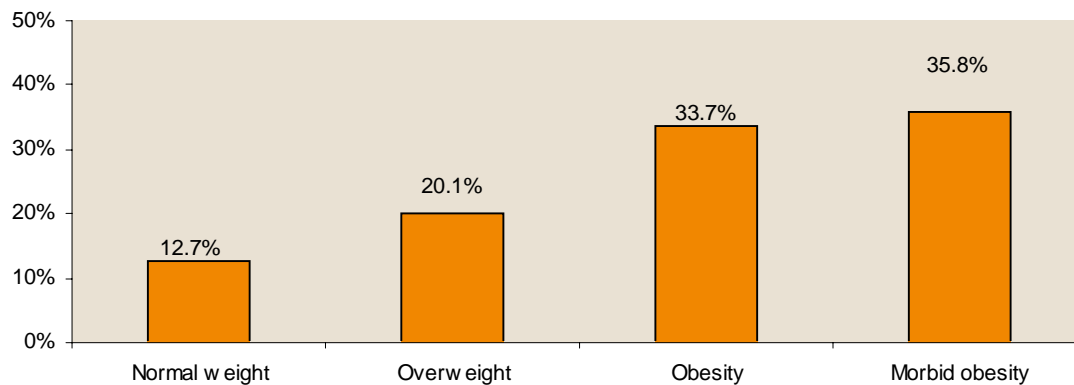
#### 4.3.1.4 Cardiovascular problems

Cardiovascular problems, diseases that affect several First Nations members, include strokes, high blood pressure and heart problems. The proportion of individuals with these illnesses increases with age and weight (BMI) of individuals, as demonstrated in the two following graphs.

**Graph 112: Proportion of adults with cardiovascular problems, by age group**



**Graph 113: Proportion of adults with cardiovascular problems, by body mass index (BMI)**

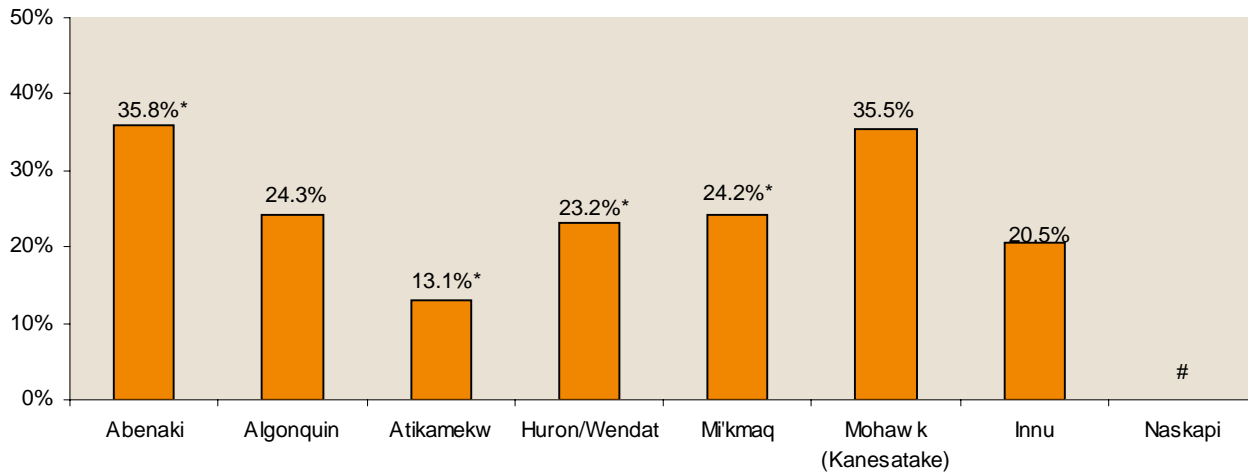


Other risk factors must be taken into consideration to understand the factors that influence the state of health of individuals. Persons without jobs are more affected by cardiovascular illnesses than those with jobs: 25.1%

versus 18.6%. Persons without diplomas are also more affected than those with diplomas. Obviously, these two factors are often linked, because individuals with jobs usually have more education.

Concerning the study of risk factors related to the social environment's influence on health, the case of the Abenaki and the Mohawks of Kanesatake is particularly interesting. They have the highest prevalence of cardiovascular disease among all Nations, as shown in the following graph.

**Graph 114: Proportion of adults with cardiovascular problems, by Nation**



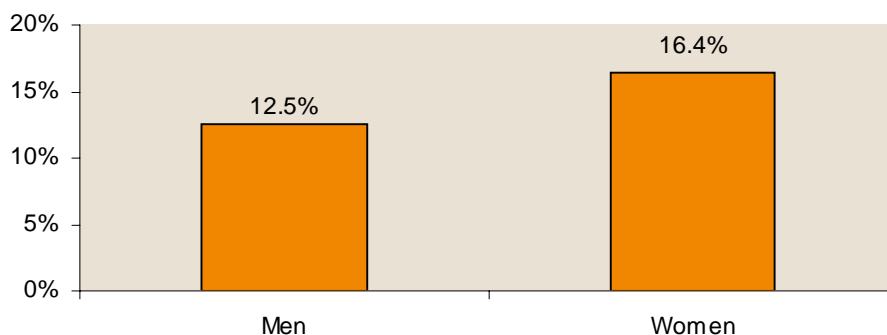
Note: The Malécites of Viger are excluded because their results were not statistically significant.

The Abenaki Nation has the oldest population and this factor must be taken into account. Obviously, this Nation's older population influences its rate of cardiovascular diseases.

#### 4.3.1.5 Diabetes

"Diabetes Québec estimates that close to 500,000 Quebecers, or 7% of the population, live with diabetes. Of that number 200,000 are not aware that they have the illness."<sup>32</sup> In the Quebec First Nations, diabetes affects at least 14.5% of the adult population (16.4% of women and 12.5% of men).

**Graph 115: Proportion of adults with diabetes, by sex**



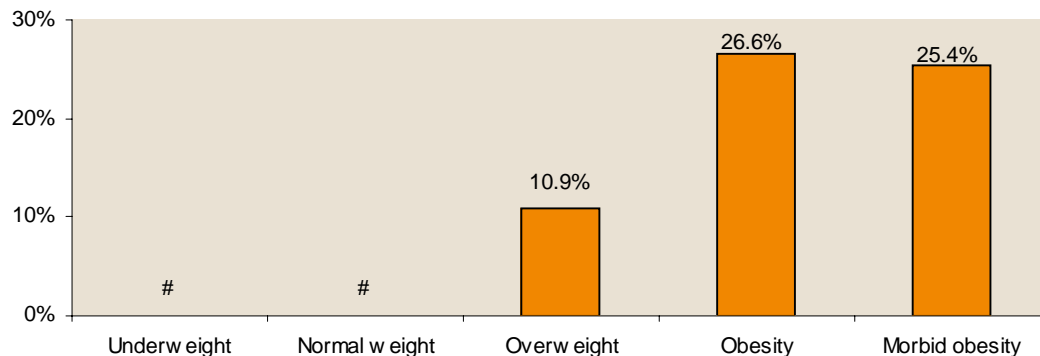
Diabetes is an illness that can have several effects on the state of health of adults affected, therefore leading to numerous health complications. The problems reported by First Nations adults with diabetes (all types

<sup>32</sup> [http://www.diabete.qc.ca/html/salle\\_de\\_presse/diabete\\_chiffres.html](http://www.diabete.qc.ca/html/salle_de_presse/diabete_chiffres.html)

combined<sup>33</sup>) as being related to their condition include, with corresponding percentages: problems with hands and feet (over 35.9%), visual problems (29.7%), problems with lower limbs (24.8%), blood circulation problems (21.5%). Men with diabetes seem to suffer more complications than women do. Furthermore, persons in large communities are also more affected by the physical problems that diabetes can lead to.

Body mass index (BMI) is an important risk factor for diabetes. The risk of diabetes increases as BMI increases. The percentage of diabetics also increases significantly with age and reaches its peak among people in their fifties. Type 2 diabetes accounts for 73.3% of cases in men, versus 76.1% of cases in women. 7.9% of women have or have had gestational diabetes.

**Graph 116: Proportion of adults with diabetes, by body mass index (BMI) categories**



It is important to remember that 14.5% of First Nations adults have diabetes. Among the latter, 96.1% report treating their diabetes. Over half of the persons (51.1%) who treat their condition indicated that they paid more attention to their diet. The most common treatment, however, remains the use of drugs (other than insulin) for 69.8% of people affected. Other forms are: physical activity (43.3%), use of insulin (25.5%) and traditional medicine (11.9%).

**Table 35: Proportion of adults who have received various treatments to control diabetes**

Types of treatment	% of diabetics
Pills	69.8%
Diet	51.1%
Exercise	43.3%
Insulin	25.5%
Traditional medicine	11.9%*

79.6% of diabetics reported that their condition prompted them to adopt a healthier lifestyle. 62.1% of 18-34 year-olds treating their condition pay attention to, among other things, their diet, while 56.0% of 35-54 year-olds focus on getting more physical activity. Persons 55 or older present the highest proportion of treatment using insulin or pills.

More than three quarters (76.2%) of diabetics have type 2 diabetes. This proportion increases with age, but we still note that 45.3% of diabetics in the 18-34 age group have type 2 diabetes. This percentage is alarming because type 2 diabetes normally affects older people.

Over 61.8% of diabetics attend or have attended a diabetes clinic. The most common reason given by diabetics who have not consulted a diabetes clinic is that they already have enough information on diabetes. More women (58.0%) than men (52.6%) feel they are well informed. This slight difference may be due to the

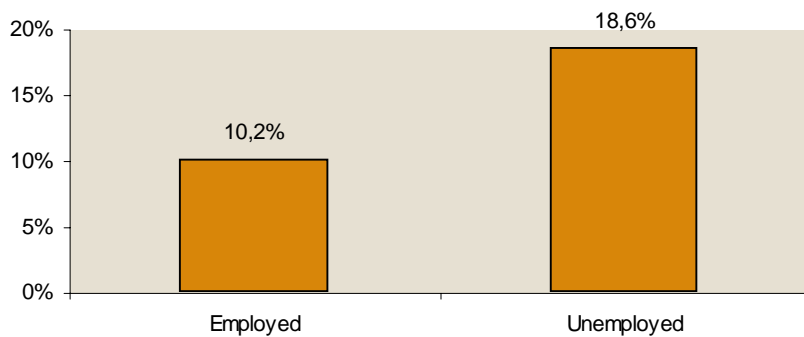
<sup>33</sup> Includes type 1 diabetes (previously called insulin-dependent diabetes mellitus), type 2 diabetes (previously called non-insulin dependent diabetes mellitus), gestational diabetes (pregnancy-related only) and pre-diabetes (which includes glucose tolerance and glucose intolerance).

fact that women are more likely to be responsible for preparing meals for the family and one can assume that they are more concerned about their health than men are.

Use of diabetes clinics and frequency in checking blood sugar levels increase with age. 39.8% of diabetics aged 18 to 34 said they did not check their blood sugar levels during the two weeks preceding the survey, while 40.8% of 35-54 year-olds and 41.9% of persons 55 and older said they checked their blood sugar levels once a day in the two weeks preceding the survey.

Zone 3 communities present the highest proportion of diabetics who did not check their blood sugar levels. Let it be noted that zone 3 communities have a larger proportion of 18-34 year-olds. However, zone 4 communities also have a relatively high proportion of 18-34 year-olds and a higher proportion of persons who checked their blood sugar levels once or several times a day in the 12 months preceding the survey (57.2%). The following graph shows the difference between the prevalence of diabetes among the persons who have a job and those who do not.

**Graph 117: Proportion of adults with diabetes, by employment status**



Finally, persons without jobs presented a higher rate of diabetes than persons with jobs. Also, we note a higher rate of diabetes among persons without high school diplomas than those with a high school, college, technical, or vocational diploma or university degree.

#### 4.3.1.6 Musculoskeletal problems

Musculoskeletal problems include arthritis, chronic back pain, rheumatism and osteoporosis, which all tend to increase in frequency with age. But chronic back pain is being diagnosed in a relatively young population at an average age of 32.

Musculoskeletal problems primarily affect the 40-49 year-olds. They are also the second biggest health problem among the 50-59 year-olds, after cardiovascular illnesses. Persons without diplomas or degrees are more affected by them than are persons with diplomas or degrees.

Eating habits and physical activity are also important factors regarding musculoskeletal problems. 36.2% of adults who reported never having a balanced diet are affected by these problems.

#### 4.3.1.7 Respiratory problems

Respiratory problems include asthma, chronic bronchitis, emphysema and tuberculosis. They affect a large number of 18-29 year-olds and in comparison to other health problems are seen more in this group than in the 30-49 year-olds. Respiratory problems are being diagnosed in persons at younger ages.

Respiratory problems appear to be more prevalent among obese persons and persons who reported mould in their dwellings.

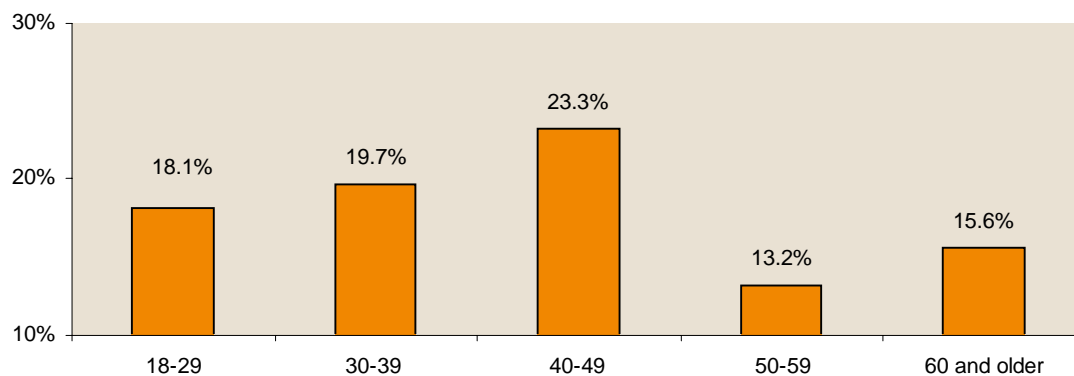
#### 4.3.1.8 Allergies

Allergies today affect a large number of people. This relatively new and important development is not restricted to First Nations members.

Like respiratory illnesses, allergies affect a high percentage of 18-29 year-olds. Their occurrence tends to increase with age, but this pattern appears to end with adults 50 and older, who present the lowest proportion of allergies. This fact is interesting because it suggests that certain changes in lifestyles or living environments could impact the prevalence of allergies and respiratory problems and could represent new risk factors. For example, changes in eating habits and lifestyle could have an influence on the increase of allergies and respiratory problems among First Nations adults.

For instance, young persons have rapidly adopted the use of new products arriving in the communities, while older persons use them less or not at all. Furthermore, it has been shown that children who were breastfed develop fewer allergies.<sup>34</sup> According to the survey, 61.3% of First Nations children have not been breastfed.

**Graph 118: Proportion of adults with allergies, by age group**



Women are more affected by allergies than men (22.0% versus 15.2%). Finally, the rate of allergies increases as body mass index (BMI) increases.

#### 4.3.1.9 Visual and hearing problems

These problems include hearing impairments, cataracts, blindness and glaucoma. They increase with age and are found at particularly high rates among the 50-59 year-olds.

Men are more affected by these problems than women (15.0% versus 11.0%), possibly because of the types of activities they engage in. For example, they participate more in outdoor activities, such as hunting and fishing, which may expose them more to the sun's harmful effects on the eyes. It is also possible that the frequent temperature changes (going from warm interior to cold outside) can lead to certain problems for the ears, such as otitis.

It is also relevant to mention that diabetes, a common illness in the First Nations, can cause visual problems, such as blindness.

#### 4.3.1.10 Digestive system problems

These problems include stomach, intestinal and liver problems. The survey reveals that women are more affected by them than men in a proportion of 14.0% versus 9.3%.

<sup>34</sup>Kull I, Wickman M, Lilja G, Nordvall SL, Pershagen G. Department of Environmental Health, Stockholm County Council, Stockholm, Sweden, in *Arch Dis Child*, December 2002, vol. 87 (no. 6): 478-81.

#### 4.3.1.11 Cancer, thyroid gland disorders and neurological and cognitive problems

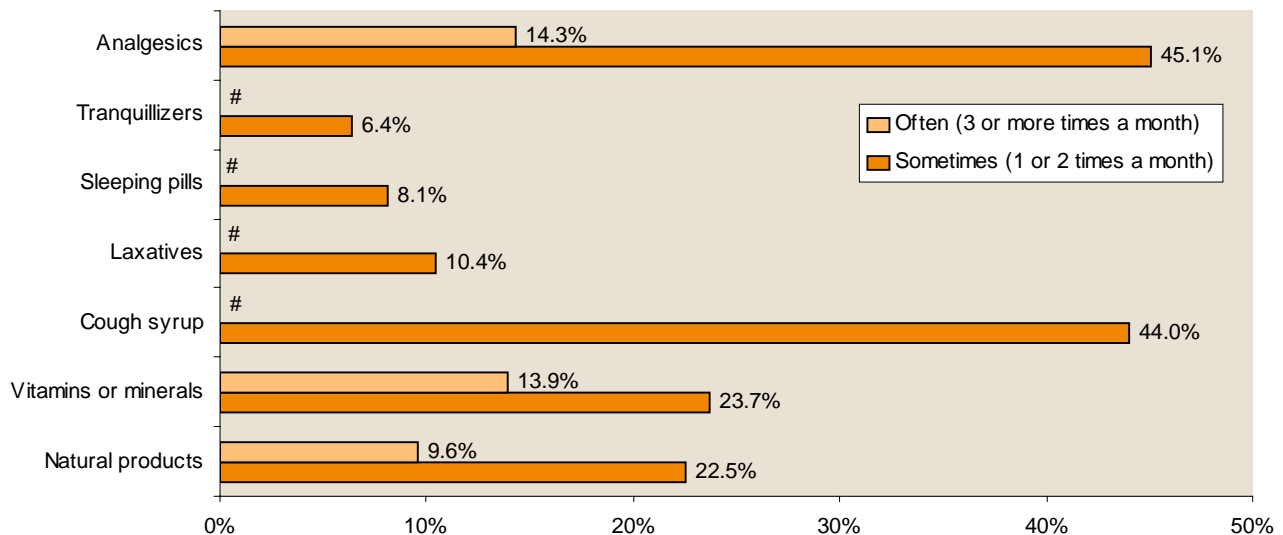
A low percentage of First Nations members have these health problems (7.1% for thyroid gland disorders, 5.9% for neurological and cognitive problems and 2.5%\* for various types of cancer). Persons with cancer indicated the greatest need for homecare services.

Thyroid gland problems are more common among persons 60 and older and obese persons. Furthermore, persons with hypothyroidism can experience weight gains.

#### 4.3.1.12 Use of non-prescription drugs

As indicated by the results of the 1997 survey, the use of drugs increases with age. Women appear to use more pharmaceutical products than men (in 1997, only the consumption of vitamins or minerals presented statistically significant differences). We can link this finding to the hypothesis that women use medication more for preventive purposes, while men use them more for curative purposes. In general, adults in zone 1 communities also use medication more than adults in zone 4 communities, which had also been noted in the 1997 survey.

**Graph 119: Proportion of adults who have used various non-prescription drugs (6 months preceding the survey)**



In 1997, analgesics and vitamins or minerals were the medications used most often by First Nations adults. Five years later, we can add natural products and, to a lesser extent, cough syrup. Use of non-prescription drugs seems to have increased since 1997, depending on the type of medication.

Table 36: Comparison of the non-prescription drug consumption between the First Nations Regional Longitudinal Health Survey (FNRLHS) of 1997 and 2002

Non-prescription drug	FNRLHS 1997	FNRLHS 2002
Analgesics	45.0%	59.4%
Cough syrup	35.8%	44.0%
Vitamins or minerals	25.7%	37.6%
Laxatives	5.7%	10.4%
Sleeping pills	6.2%	8.1%
Tranquilizers	4.7%	6.4%

#### a) Analgesics

Use of analgesics increases with age, with once or twice monthly use standing at 40.1% of 18-19 year-olds and rising to 48.7% for adults 60 and older. We see the same trend for use three or more times a month: 9.9%\* of 18-29 year-olds versus 18.8%\* of adults 60 or older. The use of analgesics tends to decrease as community size increases, going from 49.2% of adults living in small communities who use them sometimes, to 43.7% in large communities.

#### B) Tranquilizers

Although these results must be used with caution, the survey reveals that the use of tranquilizers seems to vary with age. A greater proportion of adults aged 60 and over (13.7%\*) used them at least once in the 6 months preceding the survey, compared to 4.4%\* of 18-19 year-olds. The biggest users of tranquilizers appear to be the 50-59 year-olds, with close to 13.7%\* of them using them once or twice a month. Furthermore, the survey reveals that a greater proportion of women than men use tranquilizers. 11.1%\* of women used a tranquilizer at least once in the 6 months preceding the survey, compared to 5.8% of men.

#### C) Sleeping pills

The use of sleeping pills increases with age. 4.9%\* of 18-29 year-olds used them at least once in the 6 months preceding the survey; this proportion climbs to 12.6%\* of 50-59 year-olds and 23.9% of the 60 and over age group.

11.3% of individuals in zone 1 communities used sleeping pills at least once in the six months preceding the survey; proportions vary from 5.0% to 7.0% in zones 2, 3 and 4.

#### D) Laxatives

The use of laxatives also tends to increase with age. 6.7% of 18-29 year-olds used them in the 6 months preceding the survey. The percentage rises steadily to stand at 13.0% of 50-59 year-olds and 27.9% of adults 60 and older.

#### E) Cough syrup

About 44.5% of adults used cough syrup once or twice a month in the 6 months preceding the survey. The 50-59 year-olds stood out with a lower rate of 36.3%.

Higher proportions of adults who never used cough syrup in the 6 months preceding the survey were found in isolated communities (52.4% in zone 3 and 58.5% in zone 4) than in non-isolated communities (45.9% in zone 1 and 48.2% in zone 2).

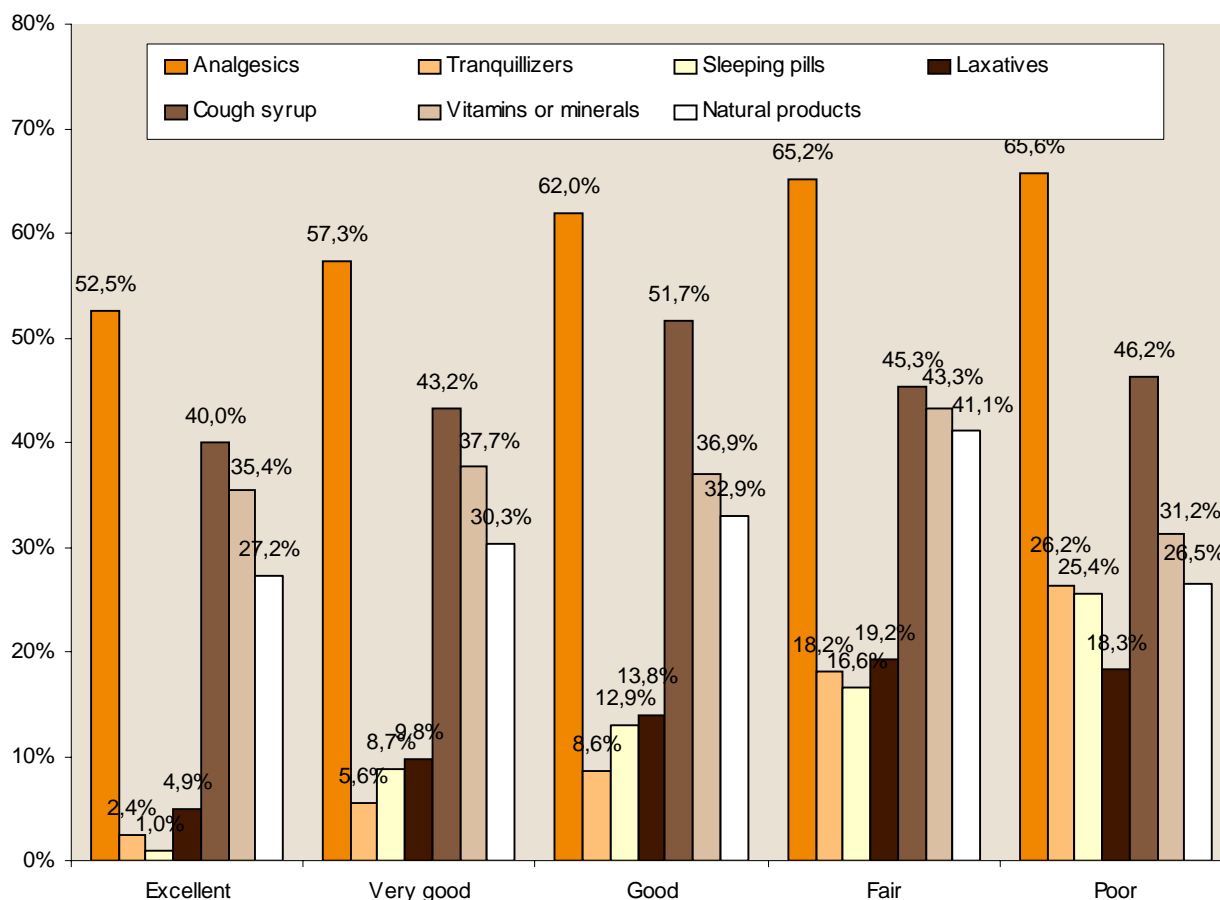
## F) Vitamins or minerals

Use of supplements in the 6 months preceding the survey was seen to increase with age, rising from 32.8% of 18-29 year-olds to 41.9% of adults 60 or older.

## G) Natural products

Fewer men (29.3%) than women (34.9%) used natural products in the 6 months preceding the survey.

**Graph 120: Proportion of adults who have used certain drugs according to their reported state of health (6 months preceding the survey)**



The use of tranquilizers, sleeping pills, laxatives and analgesics follows a trend we might expect, i.e., a much greater number of people in poor health use them than do people in good health. We also found less use of vitamins, minerals and natural products by people who reported that their health was poor.

### 4.3.2 Physical injuries

22.0% of the population reported having had one or more injuries in the 12 months preceding the survey. Among those who were injured, 17.9% said the cause was related to the use of alcohol or drugs. The most common injuries were as follows: sprains or strains; cuts, scrapes, or bruises; and broken bones.

Falls or slips caused 42.1% of injuries, followed by sports accidents (15.7%), physical assault (10.9%), and all-terrain-vehicle (ATV) accidents (5.4%). Alcohol or drug abuse played a major role; 38.4% of injuries from ATV accidents, 15.7% of injuries from falls or slips, and 55.0% of injuries from physical assaults would be related to the use of alcohol or drugs.



Table 37: Main causes of injuries

Causes of injuries	% of injuries
Fall or slip	42.1%
Sport	15.7%*
Physical abuse	10.9%*
ATV accident	5.4%

Table 38: Proportion of injuries in which alcohol or drugs were involved, by various causes of injuries

Cause of injuries	% of injuries involving alcohol or drugs
Physical abuse	55.0%
ATV accident	38.4%
Fall or slip	15.7%
Sport	#

Men overall and 18-29 year-olds reported the most injuries, due probably to the frequency and types of activities they engage in. Men had more injuries related to sports and physical assault, while women showed a high percentage of injuries due to falls and slips.

Finally, we have examined the cases of physical injuries compared to the perception of the state of health. We note that 26.9% of persons who felt their health was fair or poor had one or several physical injuries in the 12 months preceding the survey, versus 16.8% of persons who felt their health was excellent.

#### 4.3.3 Disabilities and activity limitation

More than 71.5% of adults with health problems reported not being limited in their activities. However, nearly half of individuals with cancer or neurological problems said they were sometimes or often limited by their conditions. Moreover, nearly half of the persons with musculoskeletal problems (44.0%) and visual and auditory problems (42.2%) are sometimes or often limited by their condition. One quarter (25.3%) of cancer victims indicated they were often limited in their activities.

Neurological problems led the way in causing limitations of work or education-related activities, followed by musculoskeletal problems. Persons with these problems (38.6% and 32.8% respectively) reported being often or sometimes limited by their state of health. It also appears that diabetes is a problem for work or school; 13.2% of diabetics indicated they are often limited in these activities.

Finally, a higher number of people with neurological problems (38.5%), cancer (37.4%) and musculoskeletal problems (36.7%) have indicated that they are sometimes or often limited in their leisure activities. Finally, 15.2% of diabetics have indicated they are often limited by their condition.

#### 4.3.4 Homecare

12.8% of the overall population indicated the need for one or several types of homecare (including services), with the most common types being nursing care, light housekeeping and home maintenance (minor repairs, etc.).

The need for homecare increases significantly with age. 40.2% of persons aged 55 or older indicated a need for one or more types of homecare, compared to 10.1% of people aged 35 to 54.

Table 39: Proportion of adults who consider they need homecare, by age group

Type of care required	18-34	35-54	55+
Nursing care	#	#	18.2%
Home maintenance	#	7.2%*	31.7%
Light housekeeping	1.8%	4.4%	27.9%

A greater proportion of women (15.2%) than men (10.5%) need homecare. The needs include home maintenance and light housekeeping in particular.

48.7% of persons indicating the need for one or several types of homecare services reported they were not receiving these services. Another troubling fact is that over 73.7% of 35-54 year-olds and 66.7% of 18-34 year-olds said they were not receiving the services they needed, versus 31.8% of persons aged 55 or older. We note here that chronic illnesses are increasing and are affecting a younger population. It may therefore be necessary to modify the ways in which resources are adapted to deal with these problems.

Furthermore, 33.3%\* of the 18-34 year-olds who indicated requiring homecare said they were getting the services they needed, versus 26.3%\* of the 35-54 year-olds and 68.2% of adults 55 and older.

Women who judge they need homecare do not receive them in a greater proportion than men: 54.1% of women versus 40.9% of men. The reason for this may be that women live longer than men and generally have more illnesses than men.

We found that small communities and zone 1 communities presented the highest proportions of persons who received the care they needed.

Moreover, we wanted to know if persons requiring care because of a physical condition or health problem were receiving assistance from family members and if these conditions or problems required modifications to their dwellings. 10% of persons requiring care said they were receiving homecare assistance from family members and 7.2% said their physical condition or health problem required modifications to their dwellings.

Finally, a higher proportion of women overall and persons 55 or older requiring care because of health problems said that family members provided them with homecare assistance and that their dwellings required modifications.

#### 4.3.5 Access to healthcare services

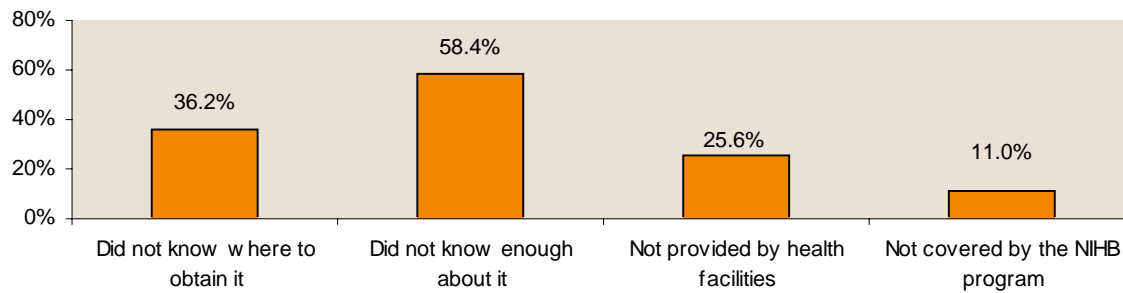
This section covers in particular the frequency of use of traditional medicine and individuals' satisfaction concerning access to healthcare services. We will also present the barriers they encounter in seeking access to healthcare services and traditional medicine.

##### 4.3.5.1 Traditional medicine

Use of traditional medicine rises as community isolation increases. 68.8% of persons in zone 3 and 67.4% in zone 4 use traditional medicine, versus lower rates of 57.0% in zone 2 and 26.8% in zone 1. 43.3% of the overall population reported encountering one or several problems in trying to access traditional medicine. The main problem mentioned was not having enough information on this type of medicine; 58.4% of persons encountering one or more barriers to accessing traditional medicine reported this as a problem.

No knowing where to access traditional medicine is a problem, as well as the fact that it is not provided in health facilities. Over 36.2% of First Nations members who experienced difficulties in accessing traditional medicine did not know where to obtain it and 25.6% considered its unavailability in healthcare facilities as a barrier.

**Graph 121: Proportion of adults who have encountered various difficulties among the adults who have encountered difficulties in accessing traditional medicine**



A smaller proportion (11.0%) of individuals who encountered one or more barriers to accessing traditional medicine said the fact this medicine is not covered by Health Canada's Non-Insured Health Benefits (NIHB) program was a barrier to accessing it. On the other hand, not being able to pay the costs of this medicine was not a significant barrier for the population overall.

Elders' loss of traditional knowledge and their hesitation to transmit this valuable information for fear of its commercialization or the fact that it is being ignored by younger persons are also factors reducing access to traditional medicine.

#### 4.3.5.2 Accessibility to healthcare services

45.0% of First Nations members report the same level of access to healthcare services that all Canadians enjoy. Moreover, 33.4% report better access and 21.5% report less access. People in zone 4 communities are particularly satisfied with the level of access to health services; 59.3% report that they enjoy better access to healthcare services than the Canadian population in general.

#### **A) Obstacles in accessing health services**

More than 46.5% of First Nations members reported encountering one or several barriers to healthcare in the 12 months preceding the survey. Of these members, 55.6% mentioned that waiting lists were too long.

Table 40 presents the barriers to healthcare services, as identified in the questionnaire, according to First Nations members' evaluations of the level of access to those services. In general, the highest proportions of persons experiencing barriers were obtained by those who felt they had less access than Canadians overall.

Table 40: Proportion of adults who have encountered various difficulties among adults who reported having encountered difficulties in accessing healthcare services (12 months preceding the survey)

Difficulties encountered	% of adults
Waiting list too long	55.6%
Not covered by the NIHB program	33.4%
Doctor or nurse not available in my area	29.9%
Services not available in my area	24.7%
Denied prior approval under the NIHB program	24.0%
Difficulty in obtaining traditional care	23.5%
Felt health care provided was not culturally appropriate	20.9%
Felt health care provided was inadequate	19.8%
Could not afford direct cost of services	15.9%
Unable to arrange transportation	13.3%
No health facility in my area	11.6%
Could not afford transportation costs	10.2%*
Could not afford childcare costs	8.2%*
Chose not to see a health professional	7.6%*

### B) Costs

A high percentage of barriers to healthcare services involved costs. 33.4% of individuals who experienced difficulties said it was because the required care was not covered by the NIHB program. Furthermore, 24.0% of the problems encountered involved refusal of approval for services under this program. 15.9% of persons who encountered barriers said they could not pay the direct costs of health services/care, 10.2% could not pay transportation costs, and 8.2% could not pay childcare costs for their children when they need to leave to receive health care.

Zone 3 communities mentioned the problem of costs the most often, followed by zone 1 communities. In zone 3, 57.2% of persons encountering barriers to healthcare services indicated that the required care was not covered by their insurance, 36.4% were denied approval of services under the NIHB program, and 24.2% could not pay the direct costs of care/services.

### C) Resources

Resources constitute another important problem in accessing health services. More than 29.3% of individuals who encountered one or several barriers to healthcare services said there were no nurses or doctors in their areas, 24.7% said services were not available in their areas, 11.6% said there were no healthcare facilities in their areas, and 13.3% said they could not arrange transportation to get to their medical appointment.

Zone 3 communities present the highest percentage of persons who indicated a lack of doctors or nurses, at 35.5%, followed by zone 4 communities, at 30.9%. The community's remoteness appears to have an influence on the lack of doctors and nurses. 49.7% of individuals in zone 3 indicating that the required services were not available in their areas. 22.8% of individuals in zone 4 mentioned the absence of healthcare facilities.

## D) Healthcare quality

Healthcare quality may also be a problem for First Nations members. More than 19.8% of individuals who encountered one or several difficulties in accessing healthcare services felt the available services were inadequate, and 20.9% felt the available services were not adapted to their culture. Zone 2 communities present the highest proportion of adults who consider health services to be inadequate, while zone 3 communities present the highest proportion of adults who feel services are not adapted to their culture, followed by zone 1 communities.

Zone 3 is occupied primarily by the Atikamekw Nation, which is among the Nations where the use of a First Nations language is widespread with a rate of 86.1% of adults. Atikamekw members' extensive use of their Aboriginal language could partly explain why they feel services are not adapted to their culture, even though they may speak a second language such as French.

### 4.3.5.3 Accessibility to the Non-Insured Health Benefits (NIHB) program

The majority of First Nations adults (71.4%) did not encounter problems in accessing healthcare services offered by Health Canada through the NIHB program.<sup>35</sup> Among the 28.6% of individuals who encountered certain problems, the most common problem was access to medications, which was mentioned by 61.1% of persons who had difficulty accessing the program.

Other accessibility problems were encountered in accessing dental care and eye care. Over 30.2% of individuals who had one or more difficulties in accessing NIHB services mentioned dental care as one of those services, while 27.8% mentioned eye care. The following table presents the various difficulties encountered.

**Table 41: Proportion of adults who have encountered various difficulties among adults who reported having encountered difficulties in accessing healthcare services under the NIHB program (12 months preceding the survey)**

Services for which difficulties were encountered	% of adults
Medication	61.1%
Dental care	30.2%
Vision care	27.8%
Transportation services or costs	18.2%
Medical supplies	16.8%
Travel escort	15.7%*
Hearing aid	#

### 4.3.6 Dental care

At the time of the survey, 64.1% of First Nations members reported that they went to the dentist within the 12 months preceding the survey, versus just under 60.0% in 1997. The following table presents how long it has been since the last dental care.

<sup>35</sup> This result must be interpreted with caution, because although 71.4% of First Nations members reported not having problems in accessing NIHB services, there was no survey question making it possible to establish the proportion of the population that *tried to or genuinely needed to* access these services.

Table 42: Time that has elapsed since the most recent dental care received (at the time of the survey)

Time that has elapsed	% of adults
Less than 6 months	39.3%
Between 6 months and 1 year	24.9%
Between 1 and 2 years	15.2%
Between 2 and 5 years	7.6%*
More than 5 years	12.0%
Has never received dental care	1.1%*

As in 1997, more young adults than older ones go to the dentist. In the 12 months preceding the survey, 71.1% of 18-29 year-olds and 76.5% of 30-39 year-olds went to the dentist. However, only 64.8% of 40-49 year-olds, 49.8% of 50-59 year-olds and 36.0%\* of persons 60 and older went to the dentist.

Because young adults see dentists more often than Elders do, more of them report requiring dental treatment. The proportion of adults who feel they need dental care decreases with age, going from 77.8% of 18-29 year-olds to 61.7% of persons 60 and older, following the same trend seen in 1997. One can assume that many older persons have dentures, which require less dental care.

Also following the trend seen in 1997, but in greater proportions, adults in small communities tend to go less often to the dentist (61.8% in the 12 months preceding our survey, compared to 52.2% in 1997) than adults in large communities (66.7% compared to 60.6% in 1997).

Although the level of remoteness does not appear to influence the frequency of visits, zone 3 and 4 communities have the least access to dentists. In these zones, 41.2%\* of individuals who encountered barriers to obtaining dental care mentioned the lack of nearby services as the cause, versus 20.5%\* in zone 1 and 25.1%\* in zone 2.

#### 4.3.6.1 Obstacles encountered in receiving dental care

19.5% of individuals encountered obstacles in receiving dental care. Table 43 presents these obstacles. The percentages in this section concern only persons who encountered barriers, i.e., approximately one of every five persons.

Table 43: Obstacles encountered by adults who have had difficulty obtaining dental care

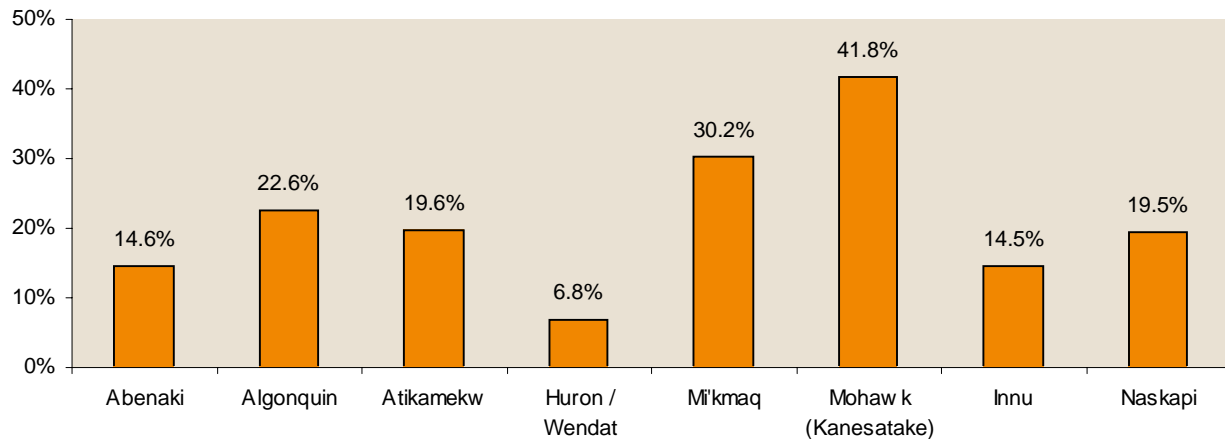
Obstacles	% of adults
Service not covered by the NIHB program	36.6%
Denied prior approval for services under the NIHB program	35.5%
Could not afford the cost	31.2%
Waiting list too long	27.4%
Service not available in my area	26.0%
Could not pay direct cost of care	21.7%
Felt services were inadequate	20.8%
Could not afford transportation costs	14.9%*
Could not afford childcare costs	10.4%*
Other costs	#

32.2% of men who encountered barriers reported long waiting lists for obtaining dental care, versus 23.3%\* of women. The latter reportedly have more difficulties in paying the costs (33.3%) than men (29.0%), in paying the direct costs of care (28.0% of women, versus 14.6%\* of men), and in paying transportation costs (18.2%\* of women, versus a statistically insignificant percentage of men).

Finally, among individuals who encountered obstacles to dental care, more women (22.8%\*) than men (18.5%\*) felt services were inadequate. Furthermore, 30.1% of 18-34 year-olds mentioned long waiting lists, versus 26.0%\* of 35-54 year-olds and 24.3%\* of persons 55 or older.

89.5% of individuals in small communities did not encounter any obstacles to dental care, versus 78.7% in medium communities and 79.3% in large communities.

**Graph 122: Proportion of adults who have encountered one or more difficulties in receiving dental care, by Nation**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

Among the adults who reported having encountered obstacles in accessing dental care, 37.0% of the Algonquin indicated lack of dental services in their area, followed by the Innu (29.9%\*) and the Atikamekw (27.3%\*). Moreover, 70.0%\* of the Naskapi who encountered obstacles in accessing dental care mentioned long waiting lists, as did 46.4% of the Mi'kmaq members and close to 33.0%\* of the Atikamekw and the Innu.

More than half of Mi'gmaqs (55.7%) and of Mohawks in Kanesatake (54.1%) who encountered difficulties in accessing dental care said the required services were not covered by the NIHB program, versus 38.9% of the Algonquin and 26.0%\* of the Innu.

Nearly 33.0%\* of Algonquin, Atikamekw and Innu members who encountered barriers to dental care indicated they were due to, among other reasons, refusal of approval for services under the NIHB program. This proportion rises to 43.4%\* of the Mohawks of Kanesatake, 51.1% of the Mi'gmaqs and 64.6%\* of the Huron/Wendat.

Finally, let it be noted that between 68.7% (Atikamekw) and 90.2% (Abenaki) of adults having encountered difficulties in accessing dental care did not feel services were inadequate.

#### 4.3.6.2 Dental care needs

At the time of the survey, 74.6% of First Nations members reported that they required dental care. Table 44 lists the types of dental care required that they feel they need. As in the previous section, the percentages given here cover only persons who needed dental care (i.e., nearly three quarters of the population).

**Table 44: Proportion of adults requiring various types of dental care among adults who reported requiring dental care**

Dental care required	% of adults
Maintenance	69.9%
Filling or restoration	36.2%
Dentures	18.8%
Extraction	9.9%*
Fluoride treatment	7.7%*
Periodontal care	#
Orthodontic care	#
Emergency care	#

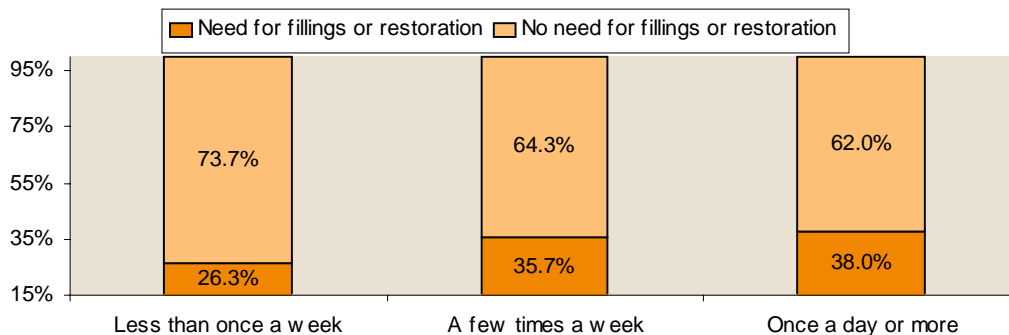
The need for fillings or restoration decreases with age. 42.8% of 18-29 year-olds and 46.5% of 30-39 year-olds reported this need, versus 34.2% of 40-49 year-olds, 18.2%\* of 50-59 year-olds and 16.1%\* of persons 60 or older. The same finding holds regarding dental maintenance, which drops from 74.5% of 18-29 year-olds to 50.7% of persons 60 and older.

The need for dentures obviously increases with age. Statistically significant percentages concerning this need are as follows: 40-49 year-olds (25.7%), 50-59 year-olds (41.6%) and persons 60 or older (54.6%).

One can see that more men require fillings or restoration than women (41.2% and 31.1% respectively). The same holds for maintenance (72.5% of men and 67.2% of women). But the results are the opposite regarding dentures; 16.5% of men need dentures versus 21.1% of women.

Among the adults who report requiring dental care, the needs for fillings or restoration tend to increase as community remoteness increases, going from 38.0% in zone 1 to 52.8% in zone 4. However, zone 3 resists this trend (34.2%). We find that the needs for dentures are slightly higher in zone 1 and 2 communities than in zone 3 and 4 communities. Finally, greater proportions of individuals requiring fillings or restoration consume soft drinks once or more a day than do individuals without these dental needs (37.9% versus 28.5%). Similarly, 30.6% of individuals requiring this dental care add sugar to their food more than once a day.

**Graph 123: Proportion of adults who need fillings or restoration according to soft drink consumption**



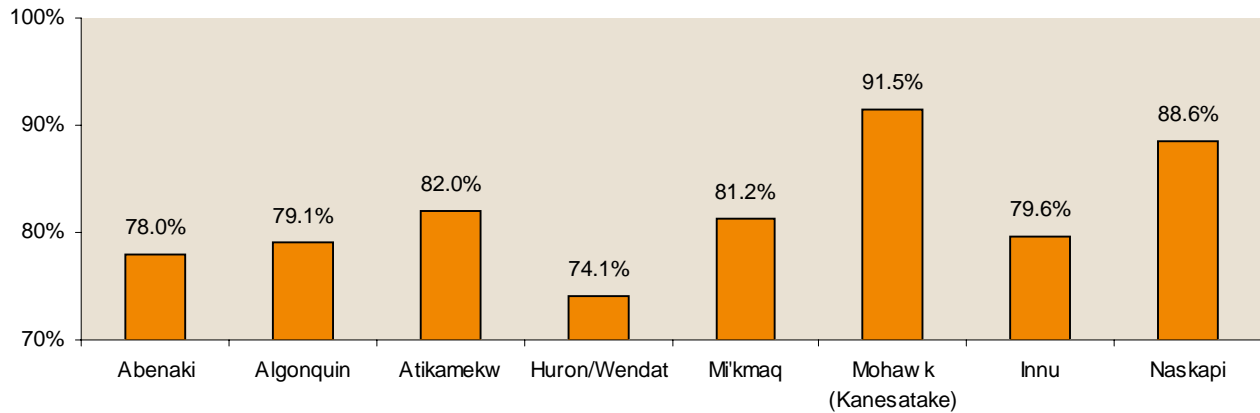
The above graph shows that the need for fillings or restoration increases with the consumption of soft drinks.



#### 4.3.7 Women's health

##### 4.3.7.1 Consumption of alcoholic beverages during pregnancy

**Graph 124: Proportion of women who have had children, by Nation**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

80.3% of women surveyed had given birth (69.0% of 18-34 year-olds, 90.1% of 35-54 year-olds and 84.4% of women 55 or older). Among them, 29.6% of them drank beer, wine or other alcoholic beverages during pregnancy. Among the pregnant women who drank alcohol, 62.2% drank alcohol less than once a week during pregnancy, and 18.1%\* drank alcohol once a month.

On these occasions, 31.7% had from one half to a full glass of beer, wine or other alcoholic beverage, while 35.7% had four drinks. Among women who drank these alcoholic beverages during pregnancy, 33.9% of 18-29 year-olds, 32.5% of 30-39 year-olds, 37.9% of 40-49 year-olds, 59.4% of 50-59 year-olds and 13.8% of women 60 or older had more than four glasses on a single occasion.

Community size appears to be related to the number of drinks taken on a single occasion. Regarding the consumption of 4 drinks or more on a single occasion, the proportion goes from a statistically non-valid figure in small communities to 34.9%\* in medium communities and 44.0% in large communities.

#### **A) Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Effect (FAE)<sup>36</sup>**

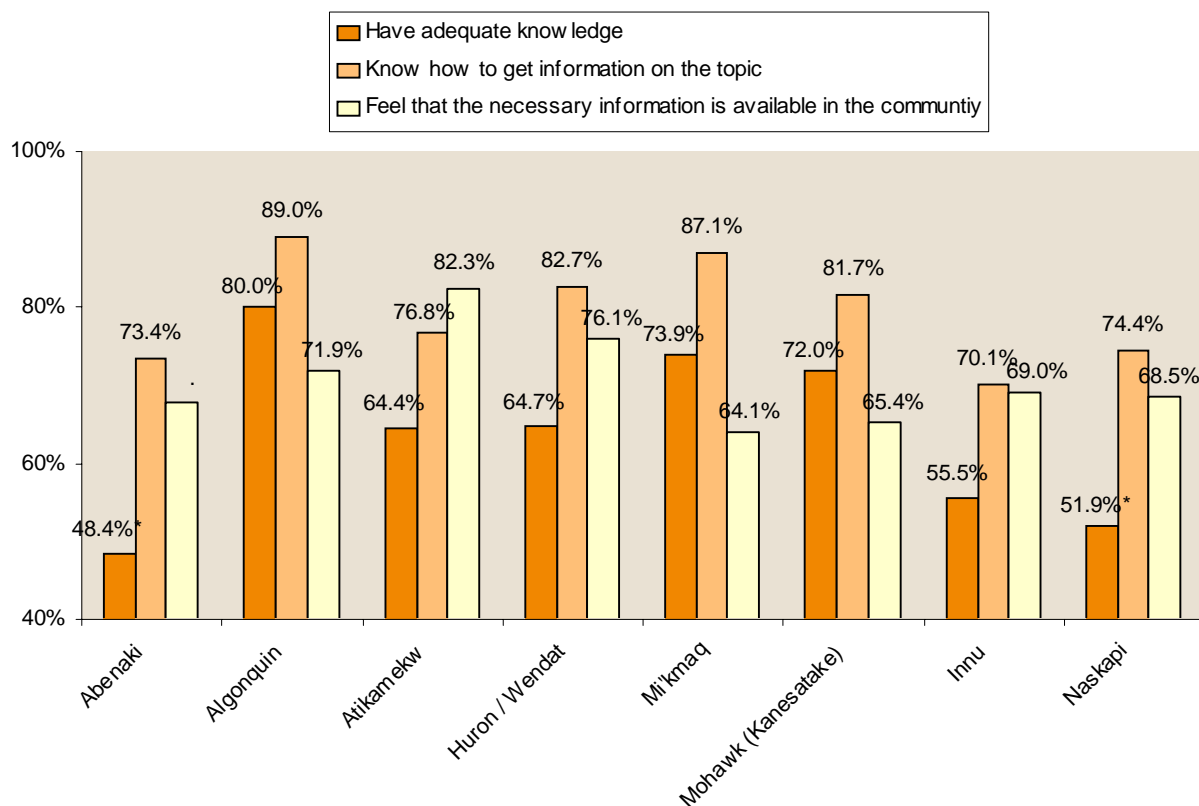
62.9% of women feel they have adequate knowledge about FAS/FAE. Moreover, 76.3% reported knowing how to obtain information about these problems, and 70.1% feel their community has the necessary information about them. In zone 4, less than half of the women (44.8%) say they have adequate knowledge about FAS/FAE. The percentage in the other zones varies from 55.4% to 62.8%. The ability to obtain information appears to be related to the community's level of remoteness; percentages of women who say they know how to obtain information range from 66.3% in zone 4 to 78.6% in zone 1. Finally, 37.1% of women in zone 4 feel the information in their community is insufficient, compared to 30.7% in zone 1 and 21.8%\* in zone 2.

Communication appears to be more effective in small communities, where 84.1% of women know how to obtain information on FAS/FAE. This proportion decreases to 74.5% in medium and large communities. However, a smaller proportion of women in small communities (53.2%) feel they have adequate knowledge than do women in large communities (62.2%).

<sup>36</sup> FASD (Fetal Alcohol Spectrum Disorder) is the term now used to cover both FAS and FAE.

In most Nations, less than one third of women feel they are poorly informed. However, nearly half of Abenaki, Innu and Naskapi women report not having adequate knowledge about FAS/FAE. Graph 125 gives the percentages per Nation of women who feel they have adequate knowledge about FAS/FAE, of women who know how to obtain this information in their community and of women who feel the available information is adequate.

**Graph 125: Perception of women concerning FAS/FAE, by Nation**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

Adequate knowledge of FAS/FAE appears to be related to the schooling level. 53.3% of women who did not complete their high school studies have adequate knowledge, versus 68.5% of women who completed high school, 69.5% of women with a professional, technical or college diploma and 96.2% of women with a university degree. The same holds for ability to obtain information on FAS/FAE: 67.4% of women who did not complete high school can do so; this proportion rises to 83.3% of women with a diploma (professional, technical, college) and 95.4% of women with a university degree.

Women who use English appear to be better informed (78.6%) than women who use French (57.8%) or a First Nations language (60.4%). Following the same trend, 89.9% of Anglophones know how to get information on FAS/FAE, versus 74.4% of Francophones and 70.8% of women who use First Nations languages.

These figures may explain in part why First Nations language users represent the highest proportion of women who drank during pregnancy (over one third versus one quarter of Anglophones and Francophones). More of them (49.3%) also drank 4 glasses of alcohol on a single occasion while pregnant, versus 6.9% of Anglophones and 30.3% of Francophones.

#### 4.3.7.2 Consumption of tobacco during pregnancy

21.9%\* of women said they quit smoking when they learned they were pregnant, but this figure must be interpreted with caution. The percentages decrease as age increases. Furthermore, 44.0%\* of women pregnant at the time of the survey said they were smoking.

#### 4.3.7.3 Medical examinations

In 1997, 74.2% of women had never undergone a mammography in their life, versus 60.6% in 2002. However, the proportion of women who had one in the 12 months preceding the survey is almost unchanged between 1997 (13.0%) and 2002 (14.5%). Finally, in 1997, 56.2% of women aged 45 to 64 had previously undergone mammographies (the highest proportion of all age groups). This proportion climbed to 76.5% in 2002.

**Table 45: Proportion of women based on frequency of breast self-examination**

Self-examination frequency	% of women
Never	43.4%
About once a month	31.0%
About 2-3 times a month	10.4%*
Less than 2-3 times a month	15.2%

**Table 46: Time that has elapsed since the last mammography**

Time that has elapsed	% of women
Never	60.6%
Less than 6 months	6.6%*
Between 6 months and 1 year	7.9%*
Between 1 and 3 years	14.9%
Between 3 and 5 years	#
5 years or more	6.7%*

About 37.4% of women 40 or older never perform breast self-examination, while 33.6% do so once a month. 30.1% of women 40 or older have never had a mammography, while 10.6% last had one 5 or more years before the survey.

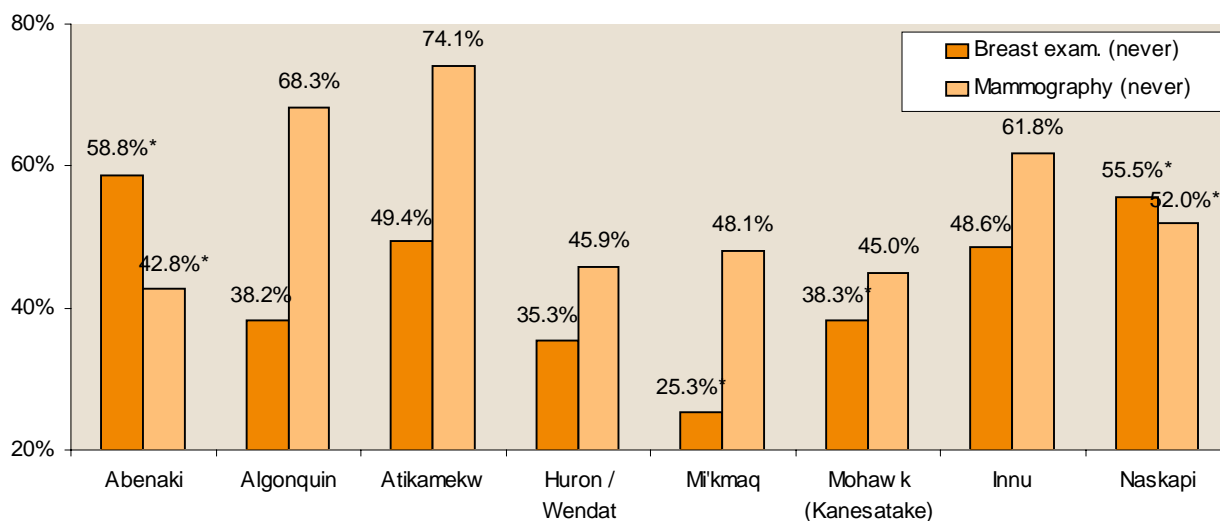
52.9% of women in small communities never performed breast self-examination, compared to 39.5% of women in large communities. The reverse trend emerges regarding mammographies; 51.8% of women in small communities have never undergone one, compared to 64.0% in large communities. The latter results, although high, indicate an improvement compared to the 1997 survey, when 69.9% of women in small communities reported never having undergone mammographies, compared to 75.9% in large communities.

54.8% of women in zone 4 communities never perform breast self-examination, compared to 41.4% in zone 1, while 63.3% of women in zone 4 have never undergone mammographies, versus 56.4% in zone 1, 73.2% in zone 2 and 70.3% in zone 3. Nevertheless, we see an improvement compared to 1997, when 81.4% of women in isolated communities (zones 3 and 4) had never undergone mammographies, versus 69.3% in non-isolated communities (zones 1 and 2).

These results may be explained in part by the fact that women in zone 1 communities form an older population than in the other zones and are thus maybe better informed about breast cancer.

Graph 126 gives the percentages of women who have never had certain medical examinations, by Nation. We see that almost half or more than half of women in the Abenaki, Atikamekw, Innu and Naskapi Nations never perform breast self-examination and have never undergone mammographies.

Graph 126: Proportion of women who have never had certain medical examinations by Nation



Note: The Malécites of Viger are excluded because their results were not statistically significant.

50.1% of women who did not finish their high school studies never perform breast self-examination; this proportion decreases to 38.8% of high school graduates and 37.3% of women with a professional, technical or college diploma. The schooling level therefore appears to be related to breast self-examination.

In 1997, 68.4% of women had undergone cytology tests<sup>37</sup> at some point in their life, this proportion climbs to 93.5% in 2002. These results are specified in the following table.

Table 47: Time that has elapsed since the last cytology test

Time that has elapsed	% of women
Has never had a cytology	6.5%*
Less than 6 months	25.9%
Between 6 mo. And 1 year	23.4%
Between 1-3 years	27.4%
Between 3-5 years	6.8%*
5 years or more	9.9%*

As Table 48 shows, the younger women are, the more likely they are to be aware or informed of the importance of vaginal smear tests (cytology).

Table 48: Time that has elapsed since the last cytology test, by age group

Last cytology test	18-29	30-39	40-49	50-59	60 +
Less than 6 months	38.6%	33.6%	16.8%*	#	#
Between 6 months and 1 year	22.7%	28.1%	31.0%	#	#
Between 1-3 years	25.1%	27.2%	29.6%	28.6%*	28.5%*
5 years or more	#	#	#	25.7%*	27.5%*

In 1997, a much higher percentage of women in small communities (90.4%) had undergone cytology tests than women in medium ones (69.9%) and large ones (63.5%). But these differences fade and become statistically non significant in 2002, with an average of 93.8%.

In 1997, the highest percentages of women who underwent vaginal smears were in non-isolated communities (74.9% versus 53.0% in isolated communities). This trend continued in 2002 but the gap is less important

<sup>37</sup> Vaginal smear test.

despite the fact that the proportions are higher. An average of 94.3% of women in zones 1 and 2 had undergone cytology tests, versus an average of 87.9% in zones 3 and 4.

#### 4.4 Lifestyle

##### 4.4.1 Nutrition

In this section, we will discuss eating habits regarding consumption of traditional food and junk food, such as fast food, sweets, French fries, etc. Overall, First Nations adults have a positive perception of their diet: 43.3% of adults consider their diet to be always or almost always balanced and nutritious, and 47.0% consider their diet to be sometimes balanced and nutritious.

Still, over 94.6% of individuals said they eat junk food several times a week. One can notice though that the consumption of junk food decreases slightly as positive perceptions of diet increase. But the consumption of junk food by adults who say they always or almost always have a balanced diet remains high.

**Table 49: Proportion of adults who eat junk food several times a week, according to perceptions of diet**

Consumption of junk food several times a week	Perception that one's diet is:		
	Always or almost always balanced	Sometimes balanced	Rarely or never balanced
Consumption of soft drinks	57.7%	72.0%	73.5%
Consumption of fast food	34.2%	50.7%	66.1%
Consumption of sweets, cookies, etc.	48.8%	51.5%	54.9%
Consumption of fries, chips, etc.	51.1%	61.2%	70.5%
Added salt	48.2%	64.9%	62.5%
Added sugar	55.3%	65.4%	62.2%

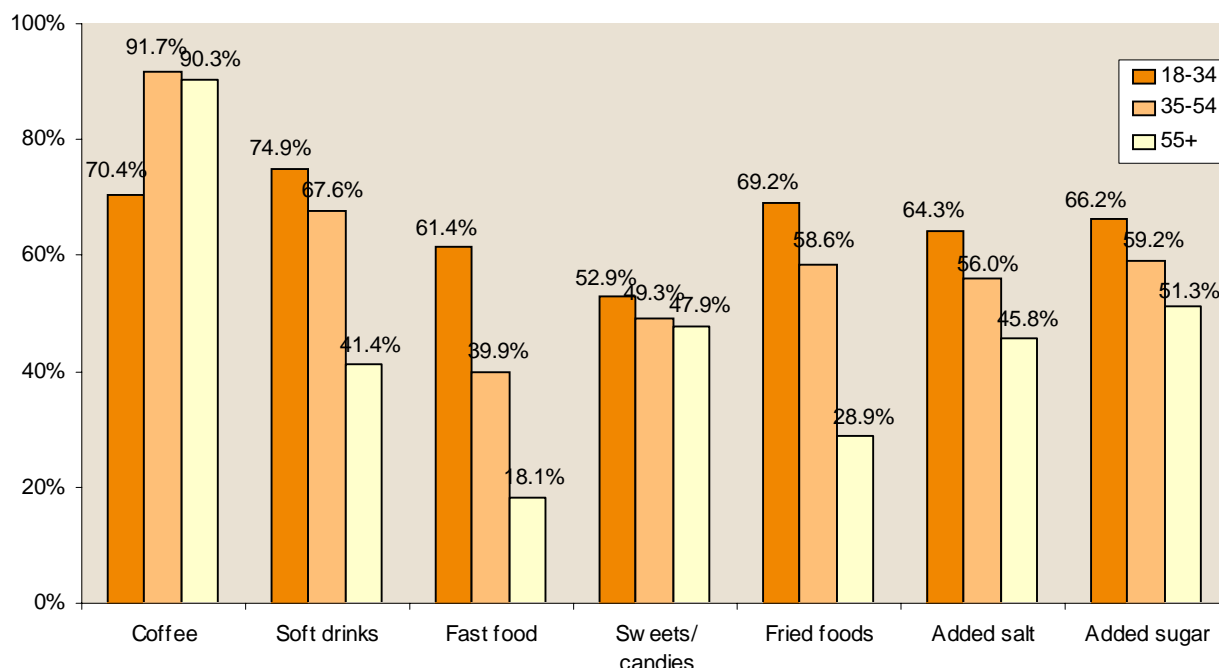
We note that perceptions of a balanced diet do not necessarily mean a truly balanced and nutritious diet. Another finding is that persons with cardiovascular problems and diabetes have a more positive perception of their diet than do persons without these illnesses.

Finally, the participants at an interpretation session formulated certain hypotheses regarding the gap between adults' perceptions of a balanced and nutritious diet and their actual diet. First, they may feel that a healthy and balanced diet refers more to satisfying their hunger than to eating healthy foods. Next, although adults eat nutritious food, there are many extras (snacks, etc.) that they do not take into account. Also, the size of the portions may be questionable for those who eat excessively.

##### 4.4.1.1 Consumption of junk food

The age of the population appears to be linked with the consumption of junk food; 18-34 year-olds eat the most junk food such as fries, soft drinks, fast food, etc. However, the consumption of coffee and tea is higher among 34-54 year-olds and 55 year-olds and over.

Graph 127: Proportion of adults who eat various junk food several times a week, by age group



More men than women eat junk food. We also noted that women place more importance on adopting diets for better health than men do.

The 1997 survey also showed that 18-29 year-olds consumed the most salt, sugar, fast food and fatty foods, although its questions were not identical to the ones in our survey. It also showed that more men ate red meat, fish, wild game, salt, fatty food and fast food than women did. We see the same trends in our survey.

We find the highest junk food consumption indicator<sup>38</sup> in zone 2, followed closely by zone 4. These geographic zones have the highest percentage of 18-34 year-olds, which might influence these results. Also, the limited variety of healthy food available in zone 4 communities and the higher cost of such foods may lead people there to eat more junk food.

Individuals without high school diplomas eat more junk food than do individuals with high school diplomas. Level of schooling may thus have an effect on the adoption of healthy eating habits.

#### 4.4.1.2 Consumption of traditional food

Age plays a less important role in consumption of traditional food. We note, however, that 18-34 year-olds obtain a slightly lower average of consumption than the other age groups.

The consumption of traditional food appears to be related to the geographical location. Adults living in zone 4 communities are the biggest consumers, especially of game, fish and bannock. Innu, Naskapi and Atikamekw members eat and share traditional food the most often. Finally, bannock, big game, freshwater fish, and berries and other wild fruits are the traditional food eaten the most often.

<sup>38</sup> The junk food consumption indicator is calculated according to frequency of consumption (never or almost never, less than once a week, a few times a week, once a day, several times a day) of the following foods: soft drinks, fast food, cake, pie, cookies, chocolates, fries, chips, bannock, added salt and added sugar.

Table 50: Level of consumption of traditional food, by geographic zone<sup>39</sup>

Level of consumption of traditional food	Community geographic zone			
	Zone 1	Zone 2	Zone 3	Zone 4
Very low	49.9%	34.0%	22.0%*	16.0%*
Low	40.9%	53.0%	63.8%	55.8%
Average	8.1%*	11.9%*	#	20.3%*
High or very high	#	#	#	#

Slightly more men than women eat traditional food, but the actual differences depend on the types of food consumed. Women eat more wild berries and bannock, while men eat more wild game and fish.

Individuals with university degrees eat more traditional food than do those without degrees. They also share traditional food more often with others and, as we saw, eat less junk food. Their knowledge about or different relationship to traditions and eating may partly explain these observations.

Finally, underweight or normal-weight persons eat less traditional food than overweight, obese or morbidly obese persons. Morbidly obese persons form the group that shares traditional food the most often. We cannot conclude that the consumption of traditional food is a direct cause of overweight and obesity. However, it is possible that a link exists between consumption of traditional food and a more sedentary lifestyle, which contributes to putting weight on.

#### 4.4.1.3 Meat and fish preparation methods

Meat and fish preparation methods can provide indicators about eating habits that may be harmful or beneficial to health. We therefore analyzed several meat and fish cooking methods and the different types of fat used (animal or vegetable).

We found that margarine and butter are the most often-used fats and that First Nations adults prefer most of the time to steam, oven-cook or boil their meat and fish. In general, vegetable oils are used more often than animal fat. Animal fat (seal, goose, etc.) is used very little; 77.0% of individuals never use it. The same goes for vegetable cooking sprays; 71.4% of individuals never use them.

<sup>39</sup> Frequency of consumption of traditional food (very low, low, average, high or very high) serves to categorize the traditional food consumption indicator. This indicator is calculated according to frequency of consumption (never, sometimes, often) of the following foods: large game, freshwater fish, saltwater fish, other water-based foods, sea-based animals, game birds, small game, berries and other wild fruits, bannock, and corn soup.

Table 51: Meat and fish preparation methods

Preparation methods	Often (1 of 2 meals)	Sometimes (1 of 4 meals)	Rarely (1 of 10 meals)	Never
Steam or oven	29.0%	43.8%	17.8%	9.4%
Boiled	26.0%	41.3%	18.4%	14.3%
Vegetable oil	23.0%	43.4%	19.7%	13.9%
Animal fat (goose, seal)	#	6.9%*	13.9%	77.0%
Shortening (Crisco, lard)	13.9%	28.8%	22.6%	34.7%
Margarine	31.6%	36.2%	13.2%	19.0%
Butter	29.6%	31.0%	17.2%	22.2%
Vegetable cooking spray	5.0%*	10.6%	13.1%	71.4%
Smoked	#	15.9%	18.1%	63.1%
Dry	#	10.9%	13.5%	72.7%
Raw	#	#	#	94.1%

The proportion of persons who eat raw meat or fish is not statistically significant (this is more an Inuit custom than a First Nations custom) since over 94.1% of the population never eat raw meat or fish. A low proportion eats smoked or dried meat and fish; 15.9% of adults eat smoked meat or fish sometimes (one in four meals) and 10.9% eat dried meat or fish sometimes.

Men tend to use more fat in meat and fish preparation than women do. They obtain the highest proportions for use of animal and vegetable fat and for consumption of smoked or dried meat and fish. However, higher proportions of women use steam, oven-cooking and boiling methods, and they use vegetable cooking spray (e.g., PAM) more often.

There are no significant generational differences apart from the fact that 18-39 year-olds use more animal fat and butter, while 40-49 year-olds represent a particularly high proportion for margarine consumption. Individuals in zone 3 and 4 communities are the biggest consumers of smoked and dried meat and fish, and of margarine, butter and animal fat. Consumption of vegetable oil and shortening such as Crisco or lard is more widespread in zones 2 and 3.

Finally, overweight or obese persons present the highest proportions for all categories, excluding consumption of butter. Indeed, underweight persons are the biggest consumers of butter. Morbidly obese persons obtain greater percentages than overweight or obese persons for consumption of dried meat and fish, margarine, and steam-cooked, oven-cooked and boiled meat and fish.

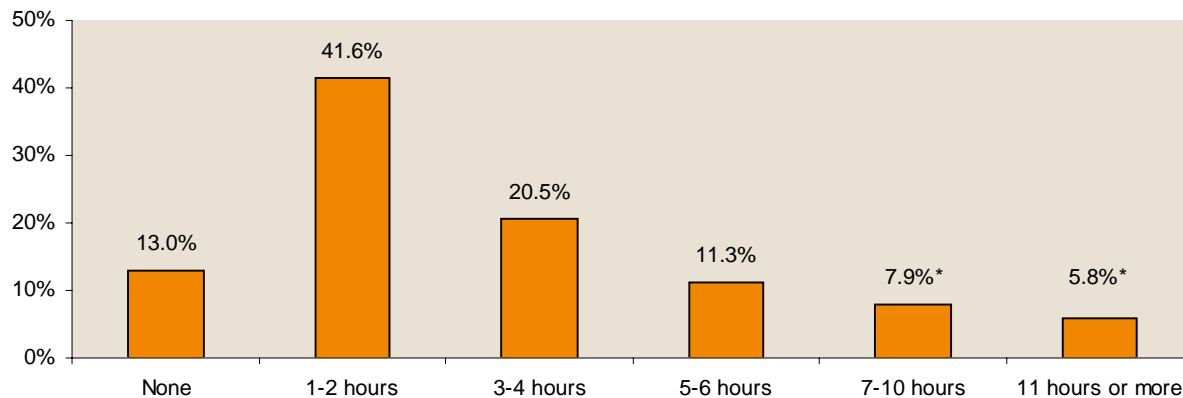
#### 4.4.2 Physical activities

This section deals primarily with the frequency of First Nations adults' involvement in physical activities, in particular those that increase heart and breathing rates. We have also sought to determine the types of activities they practised most.

First, we found that First Nations members practise an average of two physical activities per week and spend an average of three and a half hours a week on activities that increase their heart and breathing rates. But, as Graph 128 shows, a majority of individuals spend one to two hours a week on physical activities that increase their heart and breathing rates.



**Graph 128: Number of hours spent weekly on activities that usually increase heart and breathing rates**



Walking is by far the most common physical activity since it is practised by 89.0% of adults, followed by hunting and fishing, bicycling and berry gathering. Hiking, canoeing and swimming are practised by about one third of the population, while other activities such as dancing, gymnastics, competitive sports and martial arts are only practised by a small proportion of adults.

The 18-29 year-olds practise, on average, more physical activities and spend more time on activities that increase their heart and breathing rates than adults of other age groups. However, men are more active than women in a majority of activities, excluding walking, swimming, dance and berry gathering. Overall, they also spend more time each week practising physical activities than women.

Men practise an average of 6.07 different physical activities a week, versus 4.42 for women. In addition, men engage in physical activity about four times a week, versus about three times a week for women.

The geographical zone does not appear to influence the number of physical activities practised by individuals. However, people in zone 4 spend, on average, more hours per week on physical activities that increase their heart and breathing rates. Also, most activities practised by First Nations adults are related to their traditional way of life (e.g., hunting and fishing). Let it be noted that these activities called traditional are more frequently practised by adults living in zone 4.

Changes in the First Nations' ways of life may thus have led to sedentariness among their members. Furthermore, prevention and promotion programs involving physical activity must allow people time to adapt to new habits, including new kinds of physical activity.

We also found that individuals' perceptions of their state of health appears to be related to the frequency of physical activity. The more negative the perception of health, the less the weekly involvement in physical activities, including those that increase heart and breathing rates.

This is an important factor for prevention and promotion efforts regarding physical activity, because persons who feel their health is poor are those who get the least exercise. Of course, some physical conditions can limit physical activity. For example, the number of activities that can be practised goes down slightly as body mass increases. Individuals with higher body masses participate in a smaller number of physical activities. However, weekly frequency of physical activities changes little or not at all. We note that intensity and duration of physical activities are more specific aspects which could create more differences, but they are not dealt with by this survey.

Finally, we note that adults with university degrees practise more different physical activities than those without degrees. But again, the frequency of physical activities practised changes little. Schools and recreational centres could provide opportunities for learning about various physical activities, seeing

especially that a high proportion of the population feels no progress was made in this regard in their communities during the 12 months preceding the survey.

#### 4.4.3 Lifestyle habits

##### 4.4.3.1 Tobacco

Smoking is an important problem in the First Nations. More than half the population smokes today and more than one quarter (28.4%) of individuals are ex-smokers. Second-hand smoke is also a problem since 48.0% of adults report that their home is not smoke-free. This is an important fact, especially regarding the impact of second-hand smoke on health and the influence of environment on health. We found that smokers living in smoke-free homes smoke an average of 9 cigarettes a day, while smokers living in homes that are not smoke-free smoke an average of 14 cigarettes a day. Smoke-free homes have an average of 1.46 children, and homes that are not smoke-free have an average of 1.36 children. Finally, 44.0%\* of women who were pregnant at the time of the survey were smoking.

Regarding consumption habits of smokers, 20.6% of smokers smoke occasionally while 79.4% smoke every day. Furthermore, 22.1% smoke 5 or less cigarettes a day and 26.3% smoke between 10 and 14 cigarettes a day. We also found a relatively high percentage of persons who smoke 25 cigarettes or more a day (15.9%). 65.9% of ex-smokers smoked every day.

**Table 52: Average number of cigarettes smoked daily by smokers**

Number of cigarettes smoked	% of smokers
Less than 5	22.1%
Between 5 and 9	16.4%
Between 10 and 14	26.3%
Between 15 and 19	11.6%
Between 20 and 24	7.8%*
25 or more	15.9%

41.4% of smokers have never tried to quit, while 39.8% have tried once or twice. As Table 53 shows, the main reason given for trying to quit is to adopt a healthier lifestyle, which indicates that some awareness has been built regarding the effects of smoking on health. However, 38.1% of smokers mentioned that health problems had motivated them to quit smoking. We saw that ex-smokers with respiratory ailments quit smoking, on average, six years later than the others. It therefore appears that the number of years spent smoking is a determining factor in the appearance of such illnesses. Finally, 52.6% of persons with health problems smoke.

**Table 53: Reasons given by ex-smokers for quitting**

Reasons given for quitting smoking	% of ex-smokers
Healthier lifestyle	60.7%
Health condition	38.1%
Respect of loved ones	22.1%
Awareness	19.9%
Pregnancy	11.6%*
Doctor's order	10.0%*
Pressure from friends and work colleagues	#
Respect for traditional significance of tobacco	#

There seems to be a correlation between smoking and the perception of the state of health: adults with a positive perception of their health quit smoking at a younger age. The more negative the perception of health, the older the age at which people quit smoking.

82.6% of smokers who tried to quit have used the cold-turkey method, while 7.3% of ex-smokers have used a nicotine patch.

The 18-34 year-olds began smoking at younger ages than did the 35-54 year-olds and adults 55 or older. We can thus hypothesize that smokers start to smoke at a younger age than in the past (at the age of 14 for the 18-34 year-olds, versus 15 or 16 for the 35-54 year-olds and 16 or 17 for adults 55 or older).

The proportion of smokers decreases as age increases. We thus find the highest percentage of smokers among 18-34 year-olds. But the persons who smoke the most often and the most are adults 55 and older, 89.8% of whom smoke every day, versus about 78.0% of 18-34 year-olds and 35-54 year-olds.

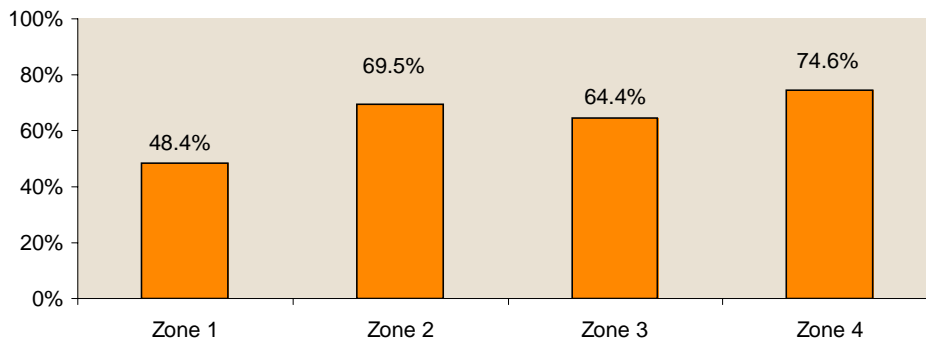
23.6% of smokers in the 35-54 age group and 21.0% of smokers 55 or older smoke more than 25 cigarettes a day, versus 9.1% of 18-34 year-olds. The latter age group appears to be more informed about the benefits of adopting a healthier lifestyle. It presents the highest percentage of individuals who quit smoking for this reason.

Similar proportions of women (56.1%) and men (53.9%) smoke. However, 19.6% of men smoke 25 or more cigarettes a day, versus 12.3% of women. Also, more men (42.0%) quit smoking for health reasons than do women (33.8%).

A greater proportion of single persons (61.6%) smoke, followed closely by persons in common-law relationships (60.6%) and persons who have separated from their partners (59.3%). Moreover, 63.1% of persons without diplomas smoke, compared to 45.5% of persons who have completed high school. We see little differences between the percentages of smokers that have a job and those of unemployed persons. However, 18.8% of persons with jobs smoke 25 or more cigarettes a day, compared to 13.3% of persons without jobs.

As Graph 129 illustrates, zone 4 communities have the highest proportion of smokers, at 74.6% of adults, but smokers in zone 1 communities smoke the most. Smokers in zone 3 communities smoke the lowest average number of cigarettes a day. Zone 3 communities also present the highest percentages of occasional smokers and of smokers living in smoke-free homes.

**Graph 129: Proportion of smokers, by geographic zone**



Some Nations stand out sharply regarding smoking statistics. For example, Abenaki smokers smoke an average of 21.5 cigarettes a day, which is much higher than the average in other Nations, which varies from 9 to 16 cigarettes a day. But the Naskapi Nation has the greatest proportion of smokers (73.9%), followed closely by the Atikamekw Nation (69.0%). The Huron/Wendat Nation had the smallest proportion by far, at 32.1%.

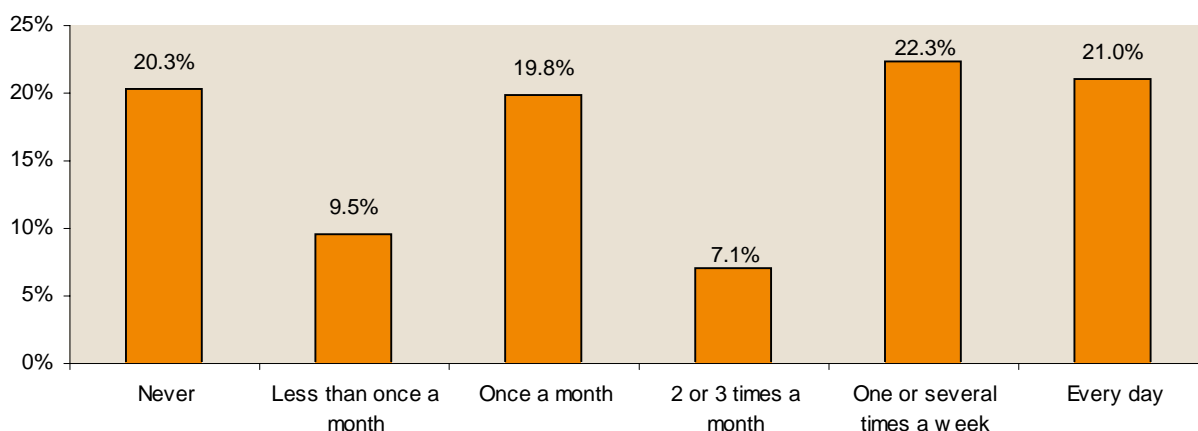
In 1997, 83.0% of First Nations members reported using or having used tobacco. In 2002, the proportion is similar, at 83.4%. However, the percentage of smokers at the time of the survey has decreased from 62.0% in 1997 to 55.0% in 2002. The proportion of regular smokers has also dropped. In 1997, 61.8% of First Nations adults were regular smokers, versus 43.6% in 2002. Finally, in 2002, the average number of cigarettes smoked each day was 12.2, versus 14.3 in 1997.

The average age at which men and women started smoking is 15. According to the 1997 survey, men and women who quit smoking did so around the age of 32. In 2002, the majority of adults who quit smoking did so around the age of 34.

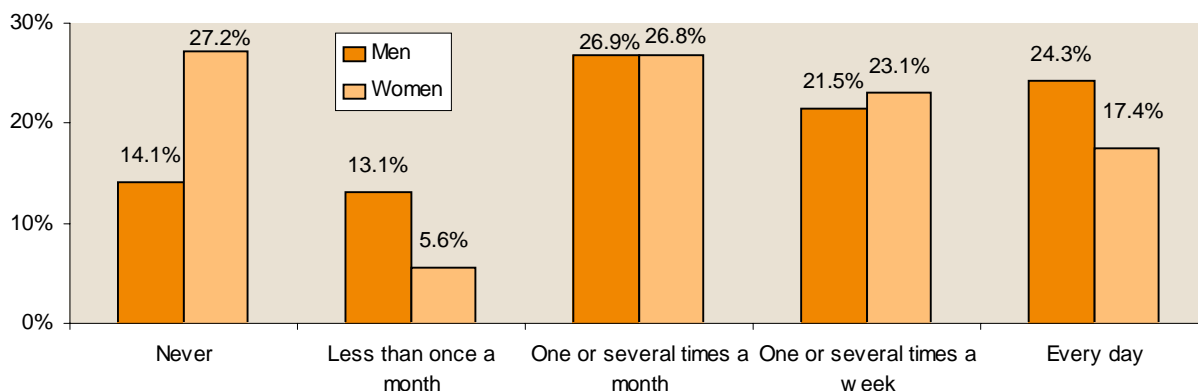
#### 4.4.3.2 Alcohol

Among First Nations adults, 18-34 year-olds are the main consumers of alcohol; 86.9% of them drank in the twelve months preceding the survey, versus 68.3% of 35-54 year-olds and 57.3% of adults 55 and older. Moreover, 78.3% of men said they drank in the 12 months preceding the survey, compared to 70.3% of women. 20.3% of all members said they never drank a minimum of 5 glasses of alcohol on a single occasion during the year preceding the survey, while 21.0% said they did so every day. Higher percentages of men than women drank 5 or more glasses of alcohol on a single occasion. Younger adults and men overall consume alcohol more often and in greater quantities on a single occasion.

**Graph 130:** Frequency of consumption of 5 or more glasses of alcohol on a single occasion (12 months preceding the survey)



**Graph 131:** Frequency of consumption of 5 or more glasses of alcohol on a single occasion, by sex (12 months preceding the survey)



More than 15.5% of First Nations members have been treated previously for alcohol abuse. 32.0% of individuals who reported that a member of their family received help for severe alcoholism indicated that they themselves drink five or more glasses of alcohol every day. One can suppose that alcohol abuse problems are transmitted from generation to generation or are recurring in certain family environments.

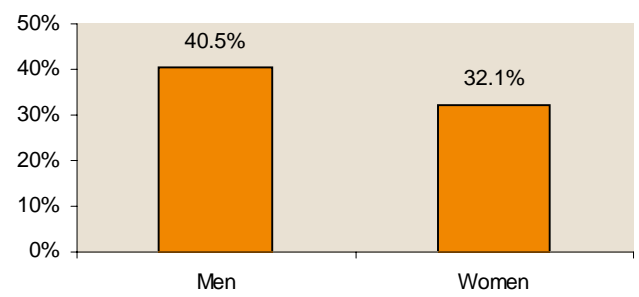
The survey reveals that employed persons drink more than unemployed persons. 78.7% of the former drank in the year preceding the survey, versus 69.9% of the latter. Finally, 83.7% of high school graduates drank in the 12 months preceding the survey, versus 68.9% of people without high school diplomas.

4.4.3.3 Use of drugs and volatile substances

More than 36.2% of First Nations members indicated that they used drugs in the 12 months preceding the survey. In the overall population, 26.6% used marijuana, 11.0% used cocaine, crack or freebase, 8.6% used codeine, morphine or opiates, and 4.6% used PCP or angel dust.

10.2% of First Nations adults have previously received treatment for drug abuse; more men (12.2%) than women (8.2%). Moreover, 40.5% of men reported using drugs, versus 32.1% of women (see Graph 132).

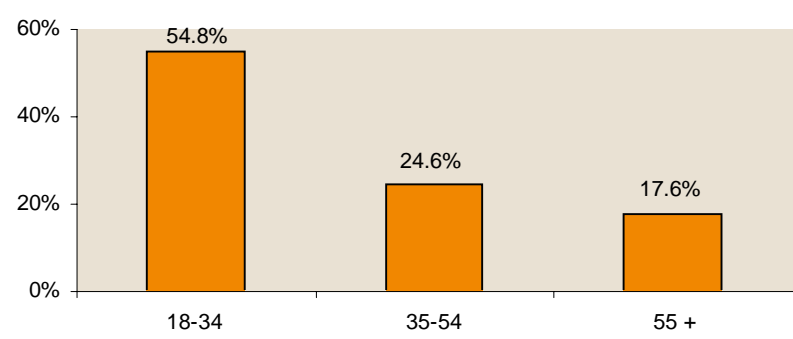
**Graph 132: Proportion of adults who have used drugs and/or other inhalants, by sex (12 months preceding the survey)**



More than 54.8% of 18-34 year-olds used drugs and/or volatile substances in the 12 months preceding the survey, versus 24.6% of 35-54 year-olds and 17.6% of adults 55 and older. We also note that drug and/or volatile substances use rates are lower in smaller communities than in medium and large ones, and that the higher the educational attainment level, the less the tendency to drugs and/or volatile substances.

We can hypothesize that adults in small communities are less likely to report using drugs, due to concerns about confidentiality. They live in closer proximity to others and probably know each other better than people do in medium and large communities.

**Graph 133: Proportion of adults who have used drugs and/or other inhalants, by age group (12 months preceding the survey)**



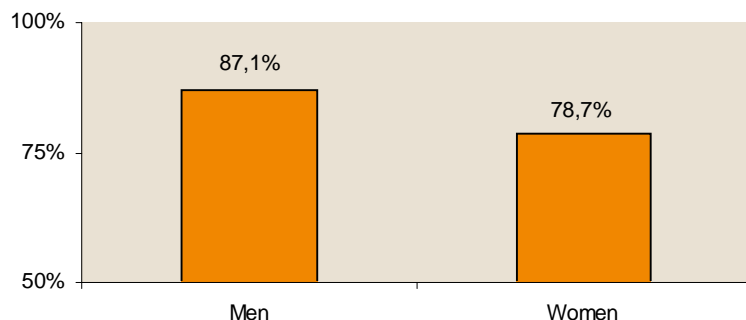
Finally, we note that 50.4% of adults who have previously considered suicide and 55.1% of adults who have attempted suicide use non-prescription drugs and/or volatile substances. (The results for suicide attempts cover only failed attempts because the survey questionnaire could not take account of successful attempts.) At our interpretation session, one participant said that people who attempt suicide are often under the influence of alcohol or drugs when they attempt to commit suicide. Furthermore, 47.5% of the community

members who report a low physical, mental, emotional and spiritual balance say that they also use drugs and/or volatile substances.

#### 4.4.3.4 Sexual health – Contraception and sexually transmitted diseases (STDs)

82.9% of individuals had sexual relations in the 12 months preceding the survey. However, this percentage drops as age increases. 87.1% of men indicated that they had sexual relations in the 12 months before the survey, versus 78.7% of women.

**Graph 134: Proportion of adults who reported being sexually active, by sex (12 months preceding the survey)**



Most (85.7%) First Nations members had one or two sexual partners in the 12 months preceding the survey. The percentage of those who had more than two partners during this same period is low. However, 13.5% of 18-to-29-year-olds stated that they had 3 or 4 different partners in the 12 months preceding the survey, while 10.5% stated that they had 5 or more partners. We note here that as individuals get older, the number of their sexual partners declines.

We found that single persons present, as do the 18-29 year-olds, slightly higher proportions in terms of number of partners, with 18.0% of them reporting 3 or 4 partners and 11.7% reporting 5 or more partners. Men also tend to have had more partners than women do.

Condoms are the most widely used method of contraception, at 42.2% of sexually-active adults. Next come oral contraceptives, at 15.7% of sexually-active adults. More than one third of individuals said they never use any method of contraception (31.7%) and 5.6% use the withdrawal method. As Table 54 shows, 41.8% use a contraceptive method to prevent conception. 37.9% also said they use these methods as protection against sexually transmitted diseases (STDs).

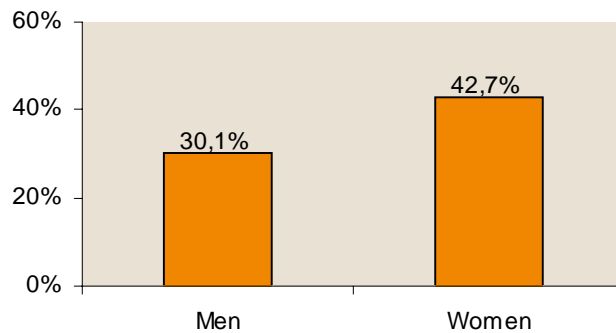
**Table 54: Proportion of adults having indicated various reasons for using contraceptive methods**

Reasons given for using contraceptive methods	% of adults
Birth control	41.8%
Birth control and protection against STDs	37.9%
Protection against STDs	17.8%
Other reasons	2.5%*

We clearly see that the older people get, the less likely they are to use contraception and the less likely they are to use condoms as protection against STDs. The 40-to-59-year-olds use condoms the least, their main reason being that they have regular sexual partners. Having a regular partner also influences whether or not people protect themselves from STDs. Single people clearly use condoms more often to protect themselves from STDs, in a proportion of 44.8%, compared to 12.8% of married people. 31.7% of people who were sexually active in the 12 months preceding the survey used no contraception and 51.6% said they never use condoms for protection against STDs. Of these, 68.3% said they do not use condoms because they have regular partners, 10.8% because they or their partners did not want to use them, and 6.3% because they did not believe there was any danger. Let it be noted that men report having had more partners than women in the 12 months preceding the survey.

The following graph shows that a greater proportion of women have had an HIV test, versus 30.1% of men.

**Graph 135: Proportion of adults who have been tested for HIV, by sex**



Finally, married people present the smallest proportion for HIV testing, followed by single people. Persons most likely to have been tested for HIV are those who are separated, living common law or divorced.

### Community size and geographic zone

Regarding the community size and the geographic zone, the proportions of sexually-active adults are basically the same. Furthermore, the average number of sexual partners is two. But we observe some differences in behaviour regarding the use of contraception.

For example, people in small communities are less likely to use condoms, but they present a higher rate of oral contraceptive use. Small communities also use more contraceptive methods primarily for birth control, not for protection against STDs. The larger communities present a higher rate of condom use and also have the highest number of individuals who mentioned using condoms for protection against STDs.

**Table 55: Contraceptive method used by adults, by community size**

Contraceptive method	Small	Medium	Large
Withdrawal	#	#	7.4%*
Condom	29.4%*	41.2%	42.7%
Oral contraceptives	21.1%*	15.6%*	16.6%
None	34.8%*	31.9%	31.5%

Communities in zone 1 have the highest proportion of people who have been tested for HIV and the lowest proportion of condom use. We also note that the more isolated the zone, the less likely it is for the inhabitants to have been tested for HIV.

#### 4.4.4 Preventive health care

This section deals with the preventive healthcare measures taken by First Nations members, including medical tests and examinations and the use of traditional medicine. 76.7% of First Nations members said they have never consulted a traditional healer. Only 9.9% consulted one in the 12 months preceding the survey. Although this percentage is low, it is higher than the figure reported in the 1997 study. At that time, only 5.1% of individuals had consulted a traditional healer in the 12 months preceding the survey.

Among the medical tests and examinations taken in the 12 months preceding the survey, blood pressure tests, eye examinations and blood sugar level tests obtained the highest percentages, as demonstrated in the following table.



Table 56: Proportion of adults having undergone various medical examinations (12 months preceding survey)

Medical examinations	% of adults
Blood pressure test	63.7%
Eye examination	60.3%
Blood sugar test	53.0%
Cholesterol	47.7%
Complete physical check-up	44.0%
Rectal exam (men only)	17.9%

As adults advance in age, they undergo more medical tests or examinations. Eye examinations are slightly more frequent, however, among 18-29 year-olds (53.5%) than among 30-39 year-olds (51.9%). With regard to the various medical tests and examinations that apply to men and women alike, the women always post higher rates than the men.

Table 57: Proportion of adults having undergone various medical examinations, by sex (12 months preceding survey)

Medical examinations	Men	Women
Blood pressure test	57.1%	70.3%
Eye exam	58.6%	62.0%
Blood sugar test	44.2%	61.5%
Cholesterol	41.0%	54.4%
Complete physical examination	40.0%	47.9%
Rectal exam (men only)	17.9%	---

First Nations members living in small communities generally undergo more medical tests and examinations than those living in medium and large communities, excluding eye examinations, for which they obtain slightly lower percentages than other communities. Finally, adults living in zone 4 communities undergo the fewest medical tests and examinations; individuals living in zone 1 undergo the most.

#### 4.4.5 Residential schools<sup>40</sup>

In this section, we seek to determine the impacts the residential schools have had on the different generations of First Nations people. A total of 17.0% of adults attended a residential school. Of these, 36.3% said they feel the experience had a negative impact on their health and well-being. Among the negative impacts examined, verbal abuse and isolation from family were cited the most often. But as the table below shows, physical abuse was also mentioned by 56.5% of the residents who were negatively affected and witnessing abuse was mentioned by 43.5%. Loss of language and cultural identity also presented high proportions.

<sup>40</sup> Residential schools were federal government or church-run institutions that many First Nations children throughout Canada lived in from 1860 to 1974.



Table 58: Proportion of adults having experienced various difficulties among adults who have reported that residential schools had negative impacts on their health

Difficulties experienced	% of adults
Verbal or emotional abuse	69.9%
Isolation from family	69.0%
Harsh discipline	68.9%
Loss of cultural identity	64.3%
Loss of language	61.1%
Physical abuse	56.5%
Loss of traditional religion/spirituality	49.0%
Witnessing abuse	43.5%
Sexual abuse	28.6%*
Lack of proper clothing	25.2%*
Poor education	17.3%*
Separation from First Nation community	#
Harsh living conditions	#
Lack of food	#
Bullying from other children	#

A very small percentage of 18-34 year-olds attended residential school. This is probably because these institutions began to close down in the 1970s. However, 24.9% of 35-to-54-year-olds and 24.8% of adults 55 and older attended residential schools. Of these, 40.2% of 35-to-54-year-olds and 42.8% of adults 55 and older said that the experience had negative impacts on their health and well-being.

The 18-to-34-year-olds presented the greatest proportion (49.4%) of persons reporting that one or both parents had attended a residential school. A small percentage of the adult population (8.5%) said that one or several of their grandparents attended a residential school.

We note that the age at which people entered the residential schools varies much more than the age at which they left them. In general, people left their residential schools at the age of 14 or 15. The 18-to-34-year-olds began attending around the age of 12, while the 35-to-54-year-olds and those 55 and older entered, on average, at the age of 10. We assume therefore that people over 35 stayed in their residential schools for longer periods.

It also appears that people from less isolated communities entered the residential school at younger ages and stayed longer. Individuals from zone 1 and 2 communities entered at around the age of 9 and left when they were about 14, while those from zone 3 and 4 communities, on average, entered at the age of 13 and left when they were 15.

We note some cases of people who entered the residential schools at younger ages. The Algonquin, for example, started at the average age of 7 and left when they were about 11. The Mi'gmaq entered around the age of 6 and left at 13 or 14, which means they spent more time in residential schools than members of other Nations, i.e., an average of 7 compared to the other Nations' average of 4 years.

#### 4.4.5.1 Negative impacts of residential schools

The proportion of men who said that the residential schools had negative impacts on their health and well-being is slightly higher than the percentage of women (39.9% versus 32.8%). Regarding sexual abuse, only the men posted a significant percentage, at 34.0% of them having experienced sexual abuse. But a higher proportion of women witnessed abuse (47.7%). The men also obtained higher percentages concerning the impacts of physical and verbal abuse and loss of their mother tongue. A greater proportion of women mentioned being isolated from their families and harsh discipline as negative impacts. A higher percentage of men felt that their parents' attendance of the residential schools had a negative impact on their upbringing.

The 35-to-54-year-olds presented the greatest proportion concerning the number of negative impacts that residential schooling had on their health and well-being, closely followed by adults 55 and older. We note, however, that the negative impacts do not fall in the same order in each group. Adults 55 and older presented the greatest proportion of sexual abuse cases, while the 34-to-54-year-olds presented particularly high percentages for physical and verbal abuse, isolation from family and harsh discipline. For the 18-to-34-year-olds, only the loss of their mother tongue and the isolation from family presented proportions statistically significant.

**Table 59: Negative impacts of residential schools on the health of adults among those who have reported negative impacts, by age group**

Negative impacts of residential schools	18-34 years old	35-54 years old	55 and up
Loss of the language	62.5%*	63.1%	56.7%
Loss of cultural identity	#	71.0%	56.0%
Physical abuse	0.0%	62.2%	56.0%
Loss of traditional religion/spirituality	#	58.4%	32.4%*
Lack of proper clothing	0.0%	26.4%*	#
Verbal or emotional abuse	#	72.4%	68.0%
Isolation from family	62.5%*	73.3%	61.4%
Harsh discipline	#	74.2%	66.2%
Sexual abuse	0.0%	29.6%*	32.1%*
Witnessing abuse	0.0%	43.8%	51.2%

Not only do the 35-to-54-year-olds represent high proportions concerning the negative impacts that residential schools have had on their parents, and indirectly on the parental education they received, but even more of them (72.6%) mentioned that the fact that their grandparents' attendance of the residential schools had a negative impact on their parents' upbringing.

We note that the larger the community, the greater the proportion of people who attended residential school and the greater the proportion of negative impacts. Zone 2 communities presented the highest percentages of negative impacts due to the residential schools on the health and well-being. However, the communities with the greatest proportion of adults who have attended residential schools located in zone 3.

Finally, among the Algonquin who indicated that the residential schools had a negative impact on their health, 51.2% said they were sexually abused. The Algonquin also reported the most negative impacts, followed by the Innus and the Atikamekw.

#### 4.4.6 Personal and social well-being

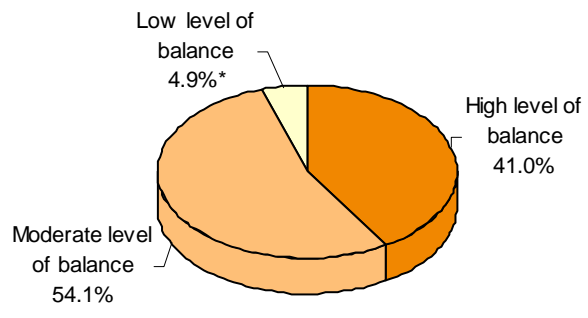
##### 4.4.6.1 Perceptions of physical, emotional, mental and spiritual well-being

This section seeks to determine individuals' perceptions of the level of balance of their life based on the four dimensions of balance (physical, emotional, mental and spiritual).

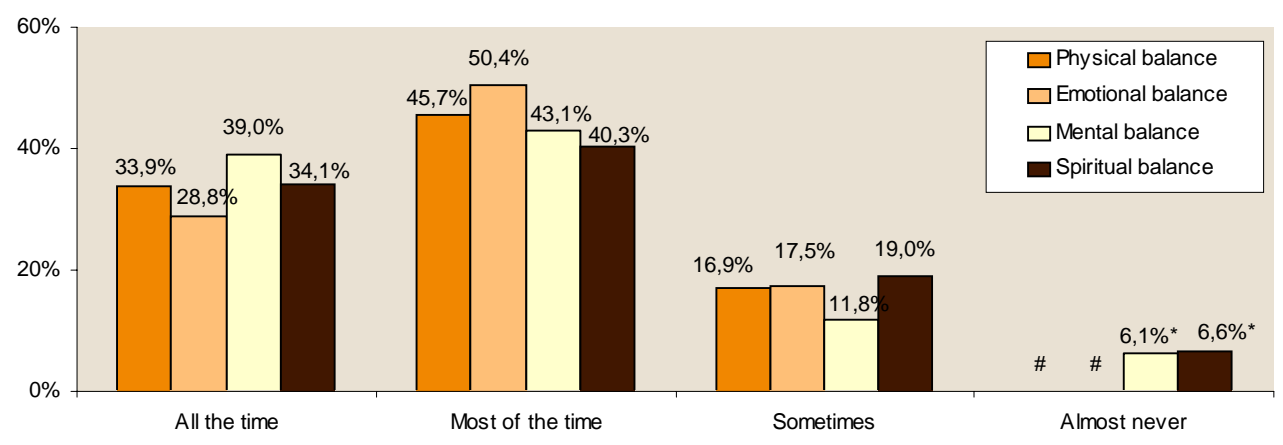
We will see in the following section ('Self-determination indicator') that despite the fact that several adults present a strong level of balance, the level of control that adult have over their life is, in most cases, very low (56.5%). Only one third feel that they have strong personal control over their life.

Graph 136 shows that 59.0% of individuals feel that they have a low or moderate level of balance based on the various dimensions of balance (physical, emotional, mental and spiritual). 45.7% of men report a high level of life balance, versus 36.4% of the women, while moderate balance is achieved by 49.3% of the men and 58.9% of the women. Level of life balance includes physical, emotional, mental and spiritual balance.

**Graph 136: Perceptions of adults on the balance level in their life**

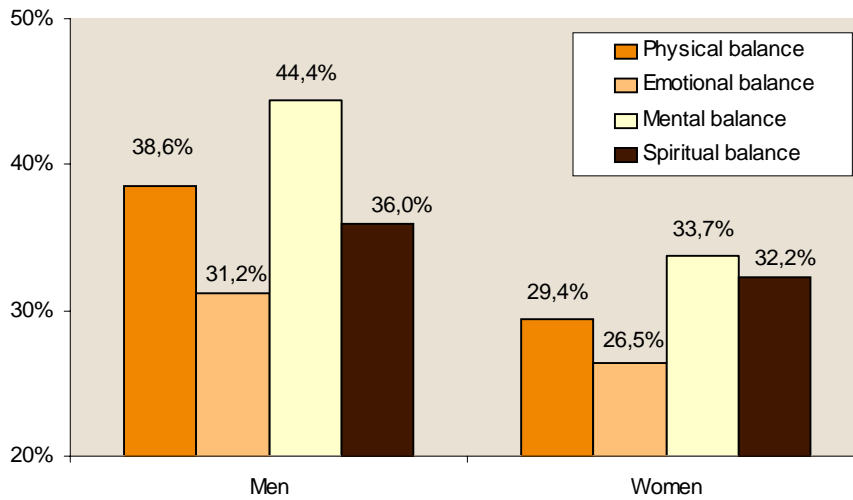


**Graph 137: Frequency of achievement of the various dimensions of balance**



The survey reveals that 38.6% of men and 29.4% of women feel they are always in physical balance, while 3.1% and 3.8% respectively almost never do. The percentages are similar for emotional balance; 31.2% of men and 29.4% of women state that they are always in emotional balance, while 4.0% and 2.6% respectively say that they almost never are in a state of emotional balance. 44.4% of men and 33.7% of women feel they are always in mental balance, while 5.7% of men and 6.4% of women almost never are. Finally, 36.0% of men and 32.2% of women reported that they feel they are always in spiritual balance, while 7.1% and 6.2% respectively said that they almost never are in spiritual balance. Graph 138 shows the percentages of people who indicated that they are always in physical, emotional, mental and spiritual balance, by sex.

**Graph 138: Proportion of adults who always feel balanced based on the 4 dimensions of balance, by sex**

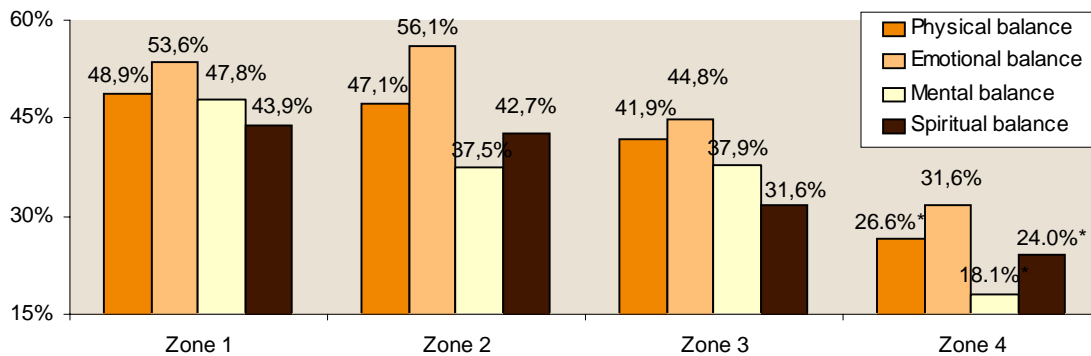


The percentages of individuals who feel they are always in balance generally increase with age, with the exception of physical balance, which exhibits an inverse trend. Significant differences regarding physical balance were noted only with regard to individuals who reported that they were in physical balance “most of the time;” the response rate for this category drops from 48.1% of 18-to-34-year-olds to 41.8% of adults 55 and older. However, the percentage of individuals who are always in emotional balance increases with age, going from 26.5% of 18-to-34-year-olds to 33.3% of adults 55 and older. The same trend is seen regarding mental balance; the proportion going from 37.7% of 18-29 year-olds to 46.0% of adults 60 or older. Finally, 9.0%\* of 18-to-29-year-olds are almost never feel in mental balance. We see a marked difference between 40-49 year-olds and adults 60 and older regarding percentages of individuals who achieve mental balance most of the time (47.3% of the former versus 35.5% of the latter).

Spiritual balance appears to be related to age; the percentage of individuals always in spiritual balance rises from 27.9% of 18-to-29-year-olds to 46.2% of adults 60 and older. 9.7%\* of 18-to-29-year-olds feel they are almost never in spiritual balance.

The proportion of adults who consider their life balance to be moderate appears to be related to the community’s level of remoteness; it decreases from 58.4% of adults in zone 1 to 50.6% of adults in zone 4. As Graph 139 shows, remote communities (zones 3 and 4) generally present smaller proportions of adults who feel in balance most of the time than do non-remote communities (zones 1 and 2).

**Graph 139: Proportion of adults who feel balanced most of the time based on the 4 dimensions of balance, by geographic zone**



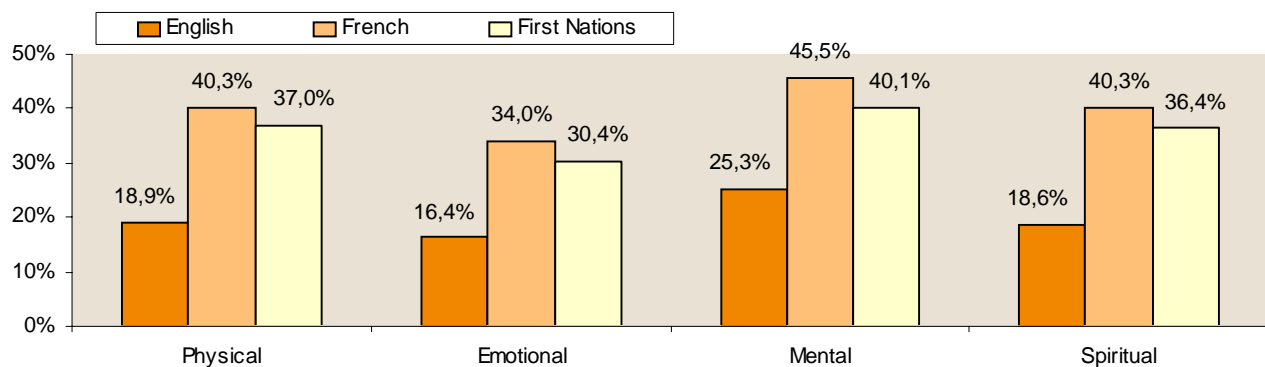
18.4%\* of individuals in zone 4 are almost never in physical balance, 17.4%\* are almost never in emotional balance, 42.2% are almost never in mental balance and 23.0%\* are almost never in spiritual balance. The percentages for these categories in the other zones range between 3.0% and 10.0%. Zone 4 has the lowest percentages of graduates and adults with jobs.

Adults living in smaller communities obtain the highest percentage of individuals (56.1%) with a high level of life balance, followed by adults living in large communities (39.6%) and those living in medium communities (31.3%).

28.2%\* of the Naskapi consider their level of balance to be low; at the other extreme, 65.5% of the Huron/Wendat consider theirs to be high. About half of the individuals in the Nations feel they are moderately balanced; the percentages here range from about one third of the Mohawks of Kanésatake to 70.2% of the Mi'gmaq and 75.2% of the Algonquin.

51.3% of the Naskapi said they are almost never in mental balance, while, again at the other extreme, 66.8% of Huron/Wendat feel they are always in mental balance. The Huron/Wendat also represent the highest proportion of adults always in spiritual balance (57.9%).

**Graph 140: Proportion of adults who always feel balanced, by language mainly used**



Adults who use French the most often present the highest proportion of having a high level of life balance (48.7%), followed by adults who mainly use a First Nations language (42.4%), while only 23.9% of adults who use English have a high level of life balance. Moreover, 7.6%\* of individuals who use a First Nations language feel they have a low level of life balance.

Finally, we note that adults who use a First Nations language the most often are the only ones who presented statistically significant proportions for almost never being in mental and spiritual balance (10.5%\* and 8.5%\* respectively).

The proportion of individuals with a high level of life balance tends to increase with level of education, rising from 39.8% of those who did not finish high school to 50.4% of university graduates.

35.1% of individuals who completed high school studies and 37.4% of those who did not complete high school stated that they achieve mental balance all of the time, versus 43.2% of those with a vocational, technical or college diploma and 44.7% of those with a university diploma. 9.3%\* of individuals without a high school diploma say they almost never feel in mental balance.

Married people present the greatest proportion of people who always feel in balance (32.4%), while divorced people represent the smallest proportion (20.3%\*).

Finally, 45.7% of widows and widowers are always in spiritual balance, followed by married persons (39.3%) and single persons (29.0%).

#### 4.4.6.2 Self-determination index

The self-determination index is an arbitrary index which evaluates the level of control that individuals exercise over their life. A very low rating on this index means little control, while a very high one suggests solid personal empowerment. The self-determination index was established according to respondents' answers (strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree) to the following statements:

- I can solve the problems I have.
- No one pushes me around in life.
- I have control over the things that happen to me.
- I can do just about anything I set my mind to.
- I often feel helpless in dealing with the problems of life.
- What happens to me in the future mostly depends on me.
- There is little I can do to change many of the important things in my life.

**Table 60: Proportion of adults based on the self-determination index**

Self-determination index	% of adults
Very low	56.5%
Low	#
Moderately low	#
Neutral	4.5%*
Moderately high	16.2%
High	15.9%
Very high	5.7%*

The above percentages do not include the responses “don’t know” and “refused.” We are led to ask certain questions regarding the 55.1% of respondents who chose these answers. Moreover, 56.5% of respondents score very low on the self-determination scale. Less than one third (32.1%) say they have some control and only 5.7%\* feel they have complete control of their life balance.

In our interpretation session, some participants offered the following remarks:

- Economic problems are the crux of the issue: when you do not have a job, you do not own your home and you are dependent on government hand-outs. Naturally, you feel you have little control over your life. This is why the drop-out rate is so important; young people see a bleak future ahead of them and they have no motivation.
- The concerns are not the same in the isolated communities, where the level of poverty is extremely high and the priority is often just to get enough to eat.
- One participant said that in her community, the women generally work year-round while the men have seasonal work. The men thus have lower self-esteem, which brings with it the problems of gambling, alcoholism, drug addiction and suicide.
- The creation of reserves, the residential school system, imposed acculturation, forced assimilation, infantilization on the part of governments, and political interference keep the people in a state of dependency. It thus becomes difficult for people to pass on the values of self-determination to their children when everything seems designed to destroy their own culture and identity.

The following table presents the statements that make up the self-determination indicator and gives the overall results for the adult population.

Table 61: Level of agreement with various statements regarding the level of control of adults over their life

General statements on life	Strongly agree or agree	Neutral	Disagree or strongly disagree
I can solve the problems I have.	86.9%	7.5%*	#
No one pushes me around in life.	80.6%	11.2%*	8.2%*
I have control over the things that happen to me.	77.2%	16.0%	6.8%*
I can do just about anything I set my mind to.	83.2%	12.5%*	#
I often feel helpless in dealing with the problems of life.	25.7%	20.4%	54.0%
What happens to me in the future mostly depends on me.	83.9%	11.0%*	#
There is little I can do to change many of the important things in my life.	25.3%	14.5%	60.2%

Note: It is important to keep in mind that about 55% of respondents did not answer these statements.

#### A) Self-determination index, by sex

Similar percentages of adult men and women stated that they strongly agree or agree with the general statements about life. But a slightly smaller proportion of women strongly agreed or agreed with the statement “No one pushes me around in life,” and a higher proportion of men strongly agreed or agreed with the statement “There is little I can do to change many of the important things in my life.”

#### B) Self-determination index, by age

With regard to age, we note that a higher proportion of adults 55 and older strongly agreed or agreed with the statement “I have control over the things that happen to me” than of 18-54 year-olds.

Concerning the statements “I often feel helpless in dealing with the problems of life,” “What happens to me in the future mostly depends on me,” and “There is little I can do to change many of the important things in my life,” adults 55 and older have a more negative outlook than 18-54 year-olds, as the following table shows:

Table 62: Proportion of adults who agree or strongly agree with various statements regarding the level of control of adults over their life, by age group

General statements on life	18-34	35-54	55+
I often feel helpless in dealing with the problems of life.	24.8%	25.4%	28.7%*
What happens to me in the future mostly depends on me.	85.0%	84.9%	78.4%
There is little I can do to change many of the important things in my life.	22.6%	24.4%	35.5%

These results may reflect the fact that adults 55 and older are more frequently ill or restricted in their activities than 18-54 year-olds. This undoubtedly increases their feelings of helplessness in dealing with life’s problems or their feelings of dependency on others.

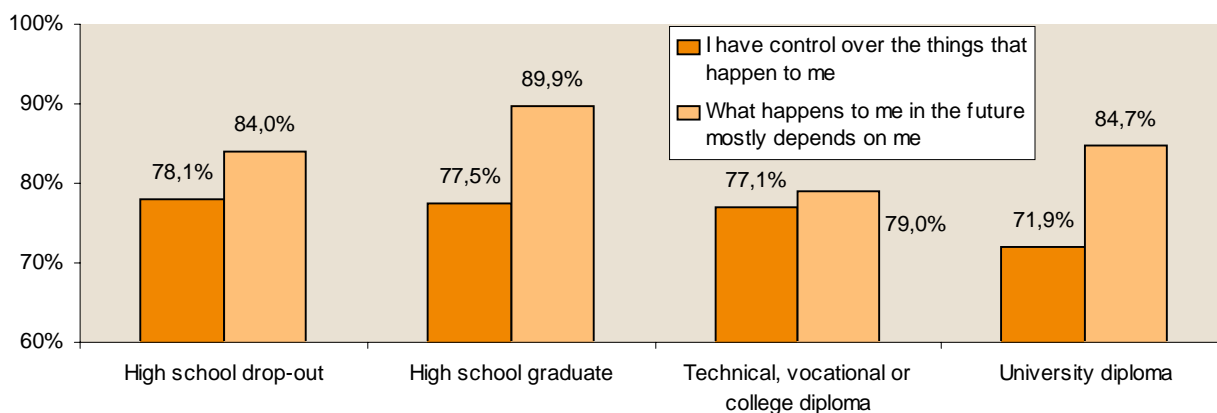


### C) Self-determination index, by schooling level

The schooling level appears to be related to the individuals' level of self-determination. Individuals who did not finish their high school studies had a more negative outlook, as seen in their answers to the general statements about life asked in the questionnaire, than did those with a high school diploma, a vocational, technical or college diploma or a university diploma. Lower proportions of people who did not finish their high school studies and of high school graduates strongly agreed or agreed with the statement "No one pushes me around in life" than did people with a technical, vocational or college diploma or degree.

We note two interesting exceptions, however. For the statement "I have control over the things that happen to me," the results were inverted; a smaller proportion of university graduates (71.9%) than of the rest of adults (77.6%) strongly agreed or agreed with this statement. In addition, a smaller proportion of people with vocational, technical or college diplomas (79.0%) than of adults in the other categories (average of 86.2%) agreed or strongly agreed with the statement "What happens to me in the future mostly depends on me."

**Graph 141:** Proportion of adults who agree or strongly agree with various propositions pertaining to the level of control of adults on their life, by schooling level



### D) Self-determination index, by community size

We note that individuals in small communities tend to have a more positive view concerning the questionnaire's general statements on life than people in medium and large communities. On the other hand, for certain statements such as "I have control over the things that happen to me" and "I can do just about anything I set my mind to," the proportions of adults are similar for all communities.

73.9% of adults of small communities stated that they disagree or strongly disagree with the statement "I often feel helpless in dealing with the problems of life," versus 56.3% of adults in large communities and 45.2% of adults in medium communities. In response to the statement "There is little I can do to change many of the important things in my life," 79.0% of adults of small communities said they disagree or strongly disagree with this statement, compared to 61.5% of adults in large communities and 47.5% in medium communities.

Finally, small and medium communities present similar proportions of adults who strongly agreed or agreed with the statement "What happens to me in the future mostly depends on me," at 88.5% and 89.5% respectively, versus 77.8% of adults in large communities.

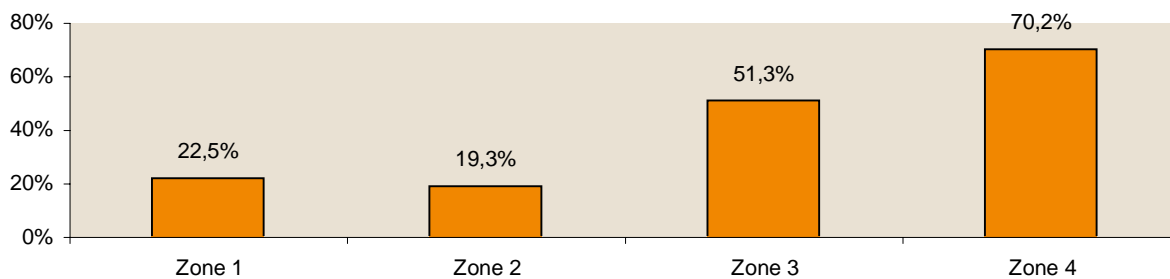


### E) Self-determination index, by geographic zone and Nation

We note that First Nations adults living in zone 3 generally have a more negative view of their level of self-determination. To the statement “I can do just about anything I really set my mind to,” 56.0% replied that they strongly agree or agree, versus 87.5% of First Nations adults in zones 1, 2 and 4. The Innus and the Atikamekw, who make up the Nations with the most communities in zone 3, obtained the lowest proportions of adults who strongly agree or agree with this statement.

Much higher proportions of individuals in zones 3 and 4 (51.3% and 70.2% respectively) strongly agreed or agreed with the statement “I often feel helpless in dealing with the problems of life” than people in zones 1 and 2 (22.5% and 19.3% respectively).

**Graph 142:** Proportion of adults who have indicated they strongly agreed or agreed with the statement “I often feel helpless in dealing with the problems of life,” by geographic zone



A much higher proportion of adults in zone 4 communities (72.7%) than of adults in other zones (average of 28.0%) strongly agreed or agreed with the statement “There is little I can do to change many of the important things in my life.”

These results may be related to the limitations caused by isolation. Indeed, the Naskapi present the highest proportions of individuals who strongly agreed or agreed with the statements “I often feel helpless in dealing with the problems of life” and “There is little I can do to change many of the important things in my life.”

Nevertheless, we would like to stress the fact that Huron/Wendats, who live in zone 1, presented the lowest proportions of people who strongly agreed or agreed with the statements “I have control over the things that happen to me” and “No one pushes me around in life”.

#### 4.4.6.3 Social problems of First Nations adults and/or their close ones

Table 63 presents various social problems that adults were asked to evaluate as being a major or minor problem or not a problem for their families in the 12 months preceding the survey. The following table presents these results.

Table 63: Proportion of adults who have experienced various social problems within their family (12 months preceding survey)

Social problems	Not a problem	Minor problem	Major problem
Gambling/lotteries	79.0%	14.0%	7.0%*
Alcoholism	59.1%	23.0%	17.9%
Drug or medication abuse	71.1%	15.8%	13.1%
Neglect of children	86.9%	9.8%	#
Domestic violence	83.7%	11.7%	#
Neglect of the Elderly	93.8%	#	#
Sexual abuse	93.7%	#	#
Verbal or psychological abuse	75.9%	18.4%	5.7%*
Overcrowding	85.9%	9.0%*	5.2%*
Family isolation	87.9%	9.7%	#
Lack of food	88.5%	9.8%	#

The age of individuals appears to be related to social problems. More adults 55 and older experience no problems within their family than 18-34 year-olds. The only exception to this trend is neglect of the Elderly; 88.9% of adults 60 and older – the people most concerned by this problem – feel this is not a problem, versus 94.6% of adults younger than 60. Finally, young adults present the highest proportions of individuals who mentioned problems of alcoholism, drug or medication abuse, and verbal or psychological abuse.

Based on the survey results, smaller communities generally have fewer social problems than medium and large ones, with an average difference of 14.0%. Following are the three main gaps observed:

1. The greatest difference is for alcoholism; 81.5% of adults in small communities indicated no problems with alcoholism within their family, compared to 58.5% of adults in medium communities and 52.8% in large ones.
2. 88.8% of people in small communities said that no members of their families had drug or medication abuse problems in the 12 months preceding the survey, compared to 68.3% in the medium and large communities.
3. While 7.0% and 5.3%, respectively, of people in medium and large communities acknowledged minor problems concerning verbal or psychological abuse within their families, only 1.4% of adults in small communities.

As for most-often used language, higher proportions of people who use English or French than of those who use a First Nations language felt that the social problems listed in Table 63 were not a problem in their families, with the exception of neglect of the Elderly, family isolation, and verbal or psychological abuse, where there were no significant differences between the groups.

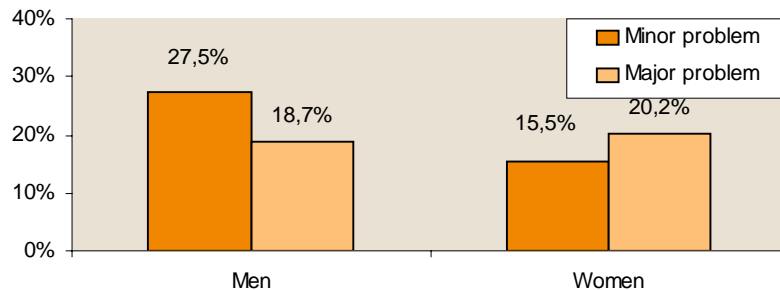
The schooling level appears to be related to social problems, since people who did not finish their high school studies generally identified more problems than high school graduates did, with the exception of verbal or psychological abuse, where there was no difference. Once again, the first three issues in the list – gambling, alcoholism and drug or medication abuse – differ from the other ones in that they seem related to the schooling level. The proportions of adults with the problems identified decrease as the number of years of education rises.

#### A) Family problems

More women (20.2%) than men (15.5%) said that someone in their family had a major problem related to alcoholism or received help to this effect. The opposite was true concerning those who declared having a

family member who had a minor problem related to alcoholism or received help to this effect (27.5% of men versus 18.7% of women).

**Graph 143: Proportion of adults who indicated they knew someone in their family who had a major or minor problem related to alcoholism, by sex**



Moreover, 8.1%\* of women consider that a major problem of verbal or psychological abuse occurred in their family in the 12 months preceding the survey. The percentage of men in the same situation is statistically non significant and therefore cannot be considered.

Finally, zone 1 and 4 communities generally obtained similar and greater proportions of adults than zone 2 and 3 communities, concerning almost all of the social problems listed in Table 63.

## B) Solitude

In general, less widows and widowers are able to find people at any time, around them, to provide them with social support, with the exception of someone to take them to the doctor. 25.2% more of Huron/Wendat members than of members from any other Nation can at all times count on someone to provide these types of support, while the Naskapi present the highest proportion of individuals who can count on someone most of the time (excluding having someone to take them to the doctor), excluding having someone to take them to the doctor. Individuals who use French the most often are the most likely to always have someone to count on (56.0%), while more English-speakers are able to count on someone most of the time (33.2%). Finally, the small communities obtained better results overall than the medium and large communities.

**Table 64: Availability of various sources of support**

Question	All the time	Most of the time	Sometimes	Almost never
Someone you can count on to listen to you when you need to talk	48.7%	29.4%	15.6%	6.2%*
Someone you can count on when you need help	48.9%	30.8%	15.7%	4.7%*
Someone to take you to the doctor	56.0%	22.1%	10.9%	10.9%
Someone who shows you love and affection	63.1%	20.9%	10.9%	5.1%*
Someone who can give you a break from your daily routines	34.3%	29.8%	23.3%	12.7%
Someone to have a good time with	52.4%	29.1%	14.1%	#
Someone to confide in or talk to about yourself or your problems	50.8%	27.5%	15.8%	5.9%*
Someone to do something enjoyable with	50.8%	29.3%	14.0%	5.9%*

A higher proportion of women than men have networks of people they can talk to. Half of the women always have access to someone they can count on to listen to them when they need to talk, compared to 46.8% of

men, and 53.8% of women always have someone they can confide in or talk to about themselves or their problems, compared to 47.7% of men.

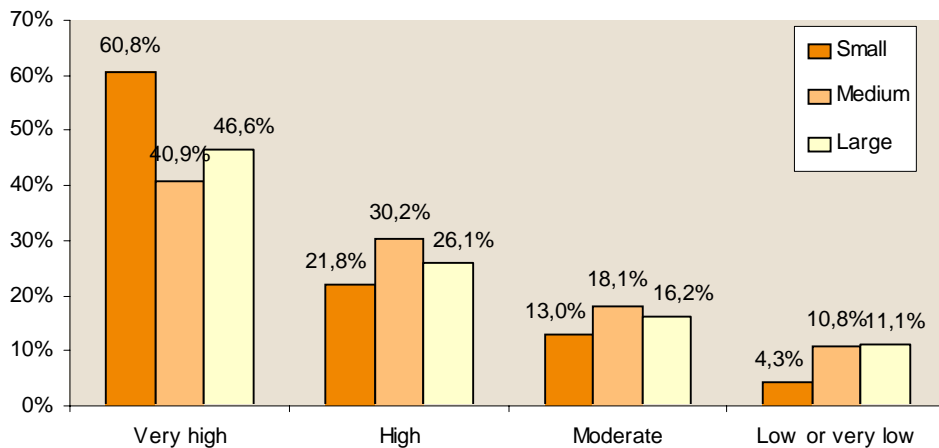
However, 54.9% of men and 50.0% of women reported always having someone to have a good time with. The proportions are similar for always having access to someone to do something enjoyable with (53.4% of men and 48.2% of women).

More than half (51.2%) of the of 18-to-34-year-olds always have access to someone they can confide in, this proportion decreases to 46.8% of adults 55 and older. Moreover, 53.6% of adults aged 18 to 54 always have someone to have a good time with, as well as 47.1% of adults 55 and older.

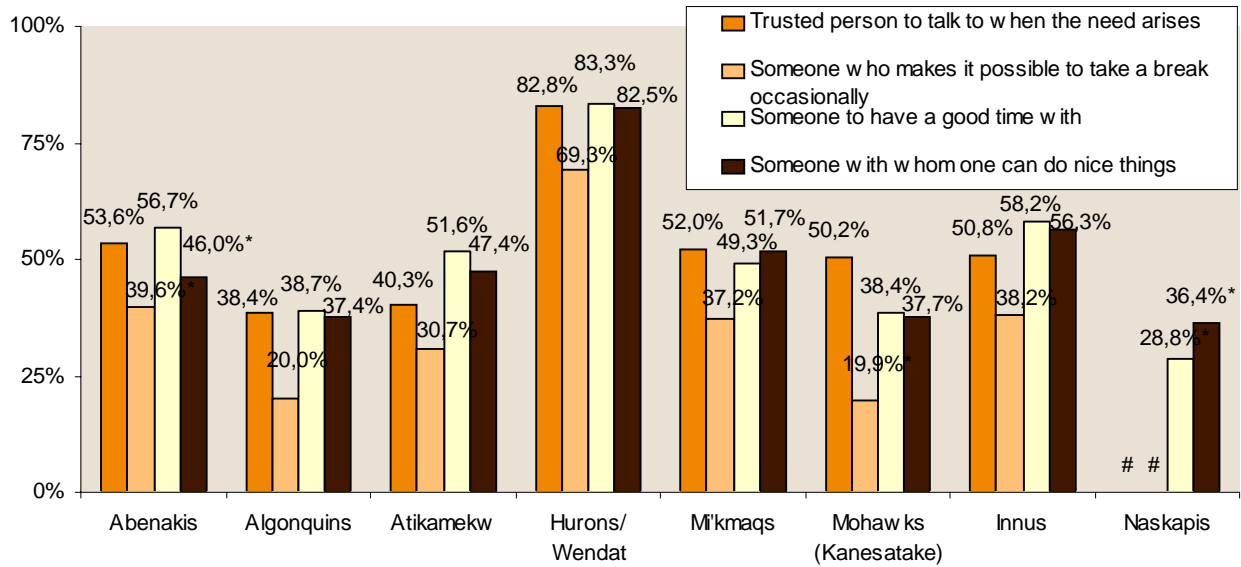
The available support appears to be related to the community's level of remoteness. A higher proportion of adults in zone 1 (52.7%) than in zone 4 (29.6%) reported always having someone to confide in. Similarly, a higher proportion in zone 1 (52.5%) than in zone 4 (29.9%) reported always having someone to count on when they need help. The same trend holds regarding proportions of adults who always have someone to show them love or affection (65.1% in zone 1 versus 49.5% in zone 4). Finally, the availability at all times of someone to confide in or talk to about themselves or their problems decreases from 53.0% in zone 1 to 32.7% in zone 4.

The information in Graph 144 indicates that it is easier to get support in small communities. However, the availability of support is relatively strong in all communities.

**Graph 144: Availability of various sources of support, by community size**



**Graph 145:** Proportion of adults who indicate they always have access to support from one or more people in various situation, by Nation

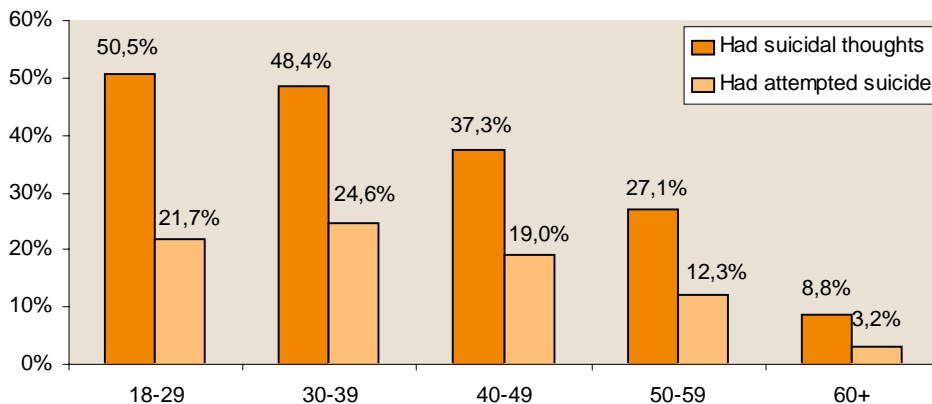


Note: The Malécites of Viger are excluded because their results are not statistically significant.

### C) Suicide

39.0% of adults reported that that they have considered committing suicide at some point in their life and 18.4% have attempted suicide. (The results for suicide attempts cover only failed attempts because the survey questionnaire could not take account of successful attempts.) Among the adults who have considered committing suicide, 5.8% have considered omitting suicide when they were aged less than 12, 38.9% between the ages of 12 and 17, and 56.9% when they were aged 18 and over. Let it be noted that 11.7% of adults who considered committing suicide, did so in the 12 months preceding the survey. Finally, among the people who attempted committing suicide, 37.7% did so when they were aged between 12 and 17 and 56.6% when they were aged 18 and over.

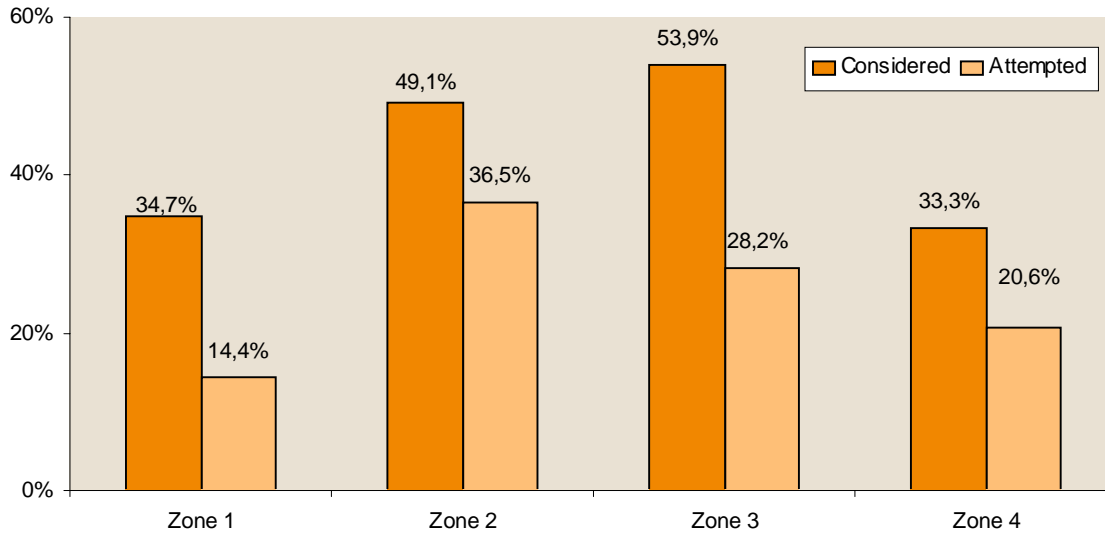
**Graph 146:** Proportion of adults who have considered or attempted committing suicide at some point in their life, by age group



Communities in zones 1 and 4 present the lowest proportion of individuals who have considered suicide (34.0%). The highest proportions are in zone 3 (53.9%) and zone 2 (49.1%). We note similar trends for adults who have attempted suicide, as presented in Graph 147. Finally, 13.4% of individuals in zone 1 have had a

friend or family member who committed suicide, versus 35.2% in zone 4 and an average of 48.7% in zones 2 and 3.

**Graph 147: Proportion of adults who have considered or attempted committing suicide, by geographic zone**



The community size appears to be related to an individual's likelihood of considering suicide, rising from 29.9%\* in small communities to 42.4% in large ones. The same is true for suicide attempts: less than one person in ten in the small communities has attempted committing suicide, compared to one in five in large communities.

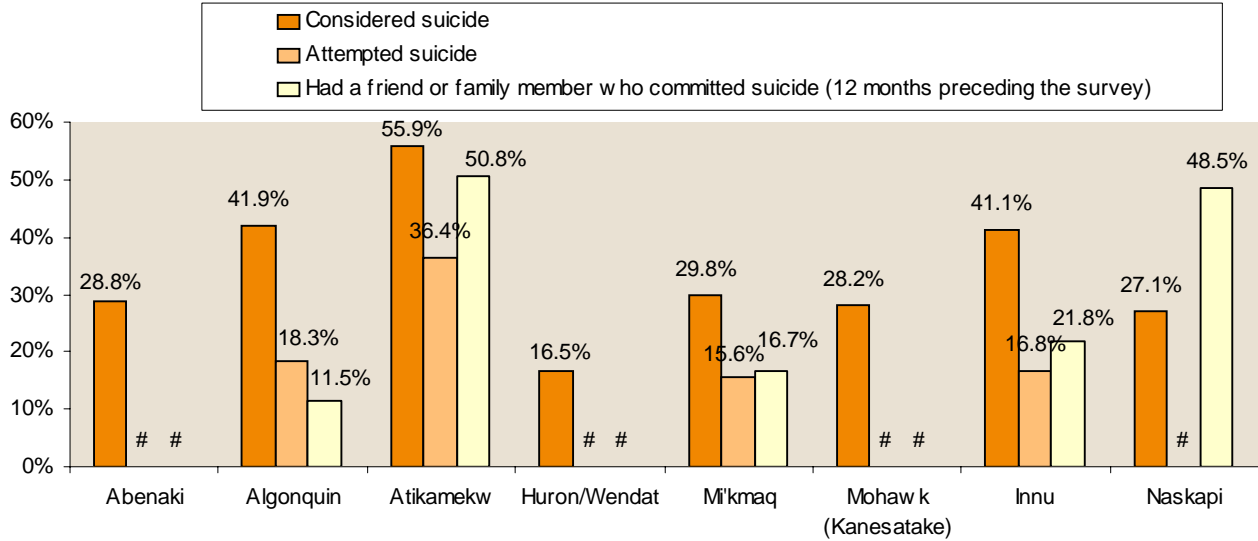
There seems to be a correlation between the language used and the occurrences of suicidal thoughts. 31.4% of English speakers and 37.7% of French speakers have had suicidal thoughts, while 45.0% of adults who mainly speak a First Nations language have considered committing suicide.

The proportions of adults who have had a friend or family member commit suicide in the 12 months preceding the survey reveal much greater differences, however, rising from 18.4% of French speakers to 32.0% of those who speak First Nations languages. The proportion is not statistically significant for English speakers. Let it be noted that an average of 21.6% of adults have reported that, in the 12 months preceding the survey, a friend or family member has committed suicide.

Finally, in 2002, the Coroner's Office reported that 33 First Nations members committed suicide in Quebec and 28 in 2003. It points out, however, that suicides committed in urban centres were not necessarily included in these numbers, unless the individuals were considered unequivocally, according to their names, to be Aboriginal.<sup>41</sup>

<sup>41</sup> Quebec Coroner's Office. Personal communication, January 2005.

**Graph 148: Proportion of adults who have had an experience related to suicide, by Nation**



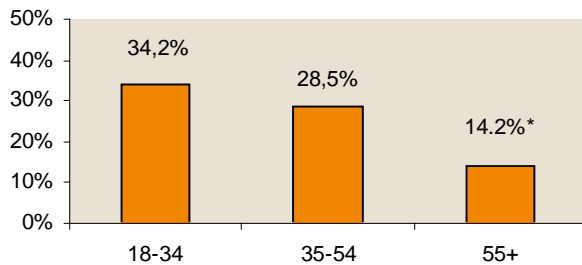
Note: The Malécites of Viger are excluded because their results were not statistically significant.

### C) Racism

In the 12 months preceding the survey, 28.3% of individuals experienced instances of racism. Of these, 36.5% said the experience had no effect on their self-esteem, while 24.2% said it had a little effect and 24.4% said it had some effect.

30.7% of men and 25.9% of women experienced an instance of racism in the 12 months preceding the survey. Women appear to be slightly more sensitive in this regard than men; 29.3% of them said the experience had some effect on their self-esteem, compared to 20.1%\* of men. 45.6% of men said that the racism they experienced had no effect on their self-esteem, compared to 26.0% of women. The following graph presents the adults who have experienced racism by age group.

**Graph 149: Proportion of adults who experienced instances of racism, by age group**



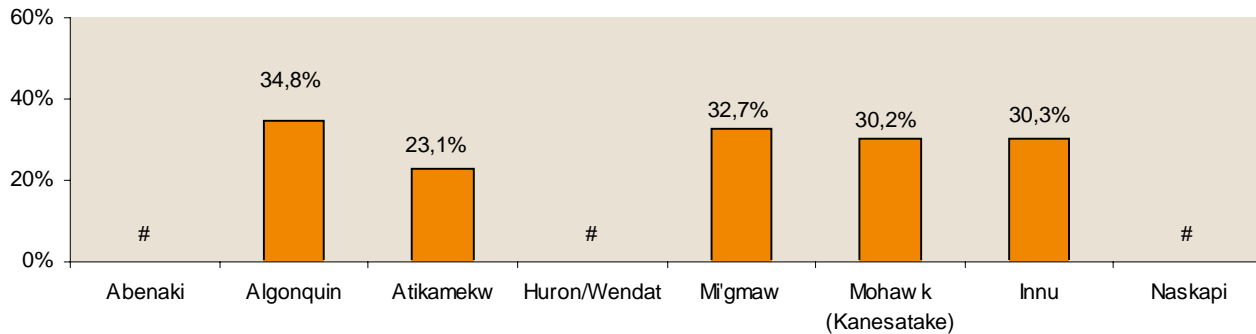
The age of people appears to be related to experiencing racism. 34.2% of 18-to-34-year-olds experienced instances of racism, versus 14.2%\* of adults 55 and older. However, young adults appear to be less affected by racism than older adults concerning the impact of racism on their self-esteem: 43.0% of 18-to-34-year-olds indicated their experience had no effect on their self-esteem, versus 26.6%\* of adults 55 and older.

The proportion of adults who experienced racism tends to decrease with the community's level of remoteness, going from 29.2% in zone 1 to 15.2%\* in zone 4. More than one of every five persons in zone 1 said racism has some effect on their self-esteem. We can hypothesize that people who live in less isolated regions (zones 1 and 2) are more likely to be subjected to racism, since they are in contact more often with people of other ethnic origins.

While one quarter of people in small and medium communities have experienced racism, nearly one third of those in the large communities. 52.3%\* of racism victims in small communities felt no effect on their self-esteem, but this percentage drops to 30.2% of racism victims in medium communities and 36.5% in large communities. Finally, 23.1% of racism victims in large communities stated that their experience had some effect on their self-esteem, as well as 29.3% of those in medium communities.

Nearly one third of the Algonquin, the Mi'gmaqs, the Mohawks of Kanesatake and the Innus experienced racism in the 12 months preceding the survey, as did about one quarter of the Abenaki and the Atikamekw, and 15.7% of the Huron/Wendat and the Naskapi. The Algonquin appear to be the most sensitive to the effects of racism on their self-esteem; 36.4% of them said they felt some negative effects. Half of the Abenaki and the Atikamekw were not affected in any way, versus 40.3% of the Innus and one third of the Mi'gmaqs and the Mohawks of Kanesatake.

**Graph 150: Proportion of adults who experienced instances of racism, by Nation**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

The schooling level completed does not reveal any trends in this regard, but the greatest proportion of adults who experienced racism (46.7%) involves university graduates, of whom 30.9%\* said they felt some effects. 39.7% of high school graduates experienced racism, versus 21.3% who did not finish their high school studies.

#### D) Gambling

During the 12 months preceding the survey, 8.4%\* of adults participated in gambling activities in which they lost more money than they could afford. The proportion of individuals who lost more money than they could afford decreases with age, dropping from 10.8% of 18-34 year-olds to 3.6% of adults 55 and older. There are no statistically significant differences by Nation. Graph 151 presents types of gambling activities in which players lost more money than they could afford, by sex. We note that a higher proportion of men lost more money than they could afford, apart from their participation in bingo.



**Graph 151: Proportion of adults who participated in gambling activities in which players lost more money than they could afford, by sex**

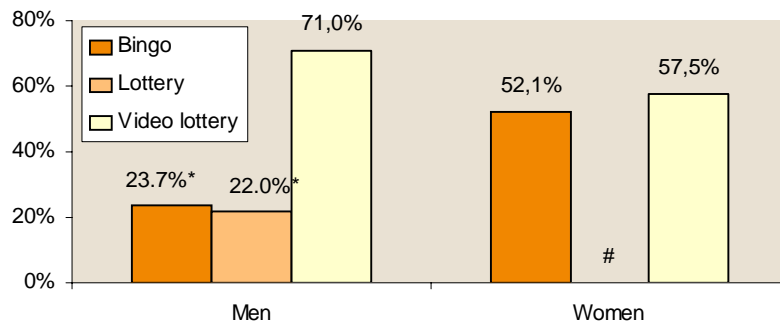


Table 65 presents gambling activities in which players lost more money than they could afford. Video lotteries constitute the activity with the highest proportion of persons in this situation (65.1%). The rates for private card games and sports betting have been omitted because they were not statistically significant.

**Table 65: Proportion of adults who participated in various gambling activities among adults who reported having lost more money than they could afford**

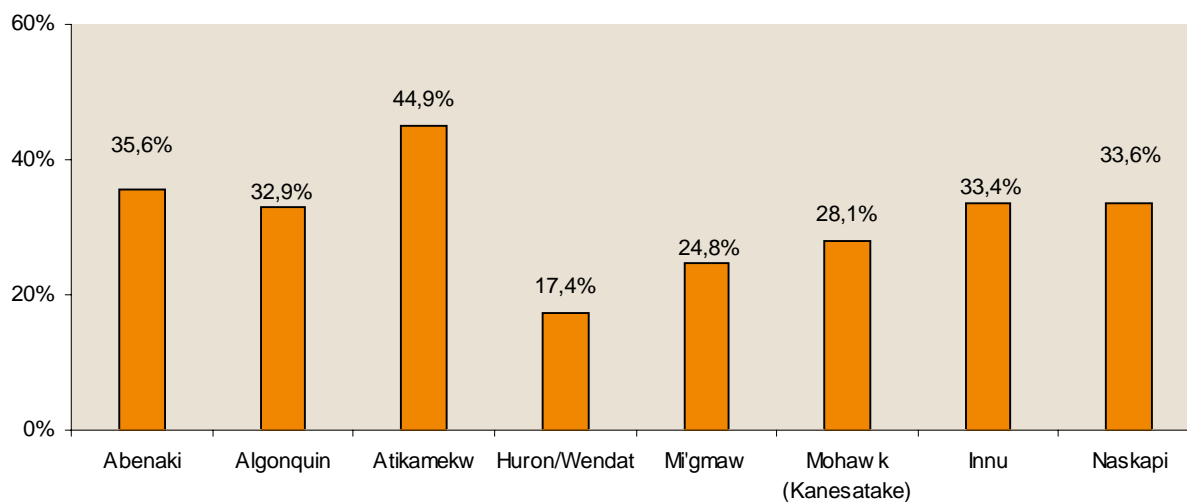
Gambling activities	% of adults
Video lotteries	65.1%
Bingo	36.1%
Lotteries	19.5%*
Casino	14.9%*
Private card games	#
Sports betting	#

#### 4.4.6.4 Agents of support

32.9% of adults felt depressed for two weeks or longer during the 12 months preceding the survey (27.9% of men and 37.8% of women). 18-to-34-year-olds were slightly more susceptible (35.0%) than adults 55 and older (30.0%). 29.5% of people who are married or living common law felt depressed, versus 46.7% of divorced adults and 49.5% of separated adults.

Community size appears to be related to the proportion of persons who experienced depression; it affected one quarter of individuals in small communities, compared to one third of adults living in medium or large communities. We note that slightly higher proportions of persons who use a First Nations language the most often (36.6%) felt depressed in the 12 months preceding the survey than of persons who use French (32.8%) or English (26.4%) most often. Finally, the percentage of persons who experienced depression tends to drop as the schooling levels rise; it increases from 35.0% of adults who did not complete high school to 28.3%\* of university graduates.

**Graph 152: Proportion of adults who felt depressed for 2 weeks or longer, by Nation (12 months preceding survey)**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

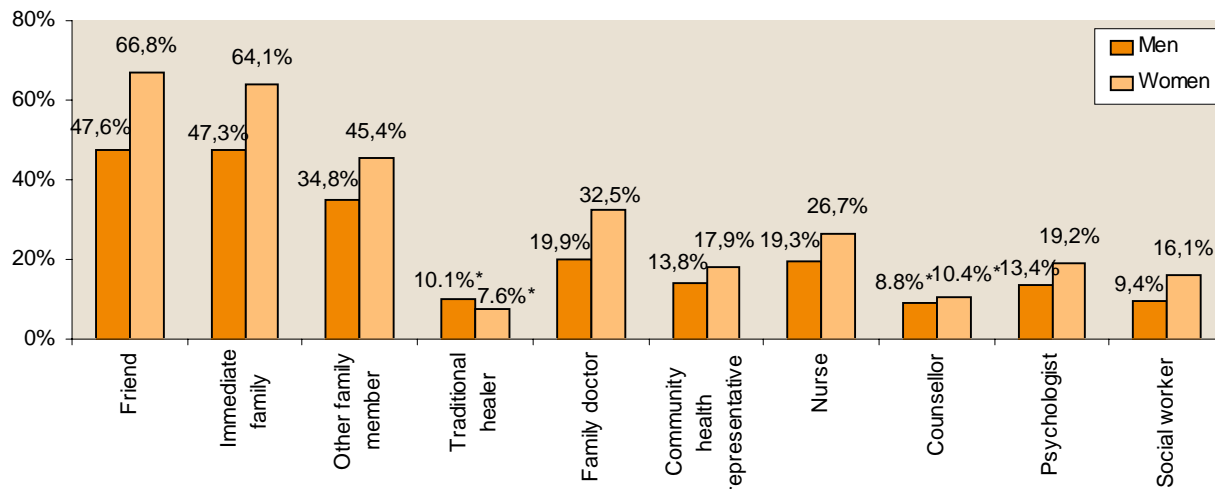
Table 66 presents the different agents of emotional or mental support, who are the people who provide adults with support in difficult times. It appears that adults prefer to confide in a friend or family member rather than in healthcare professionals, even though the latter must maintain professional confidentiality.

**Table 66: Agents of support to whom adults have confided regarding their mental or emotional health (12 months preceding survey)**

Agents of support	% of adults
Friend	57.3%
Immediate family member	55.8%
Other family member	40.2%
Family doctor	26.3%
Nurse	23.0%
Psychologist	16.4%
Community health representative (CHR)	15.9%
Social worker	12.8%
Counsellor	9.6%
Traditional healer	8.8%
Psychiatrist	5.1%*
Telephone help line	#

In general, men have fewer support providers than women do. Graph 153 presents the various support providers to whom men and women spoke regarding their emotional or mental health in the 12 months preceding the survey.

**Graph 153: Agents of support to whom adults spoke to regarding their emotional or mental health, by sex (12 months preceding survey)**



Consultation of friends or family members tends to decrease with age, while the opposite is seen regarding consultation of general healthcare professionals. It appears that social interveners (psychologist, social worker) constitute the least popular type of support provider and that the older individuals are, the less likely they are to consult these mental health professionals.

The same trend is seen with regard to speaking to a friend about one’s mental or emotional health in the 12 months preceding the survey. The younger the adults, the more they tend to have spoken to friends about their mental or emotional health in the 12 months before the survey, thus dropping from 68.3% of 18-34 year-olds to 43.8% of adults 55 and older.

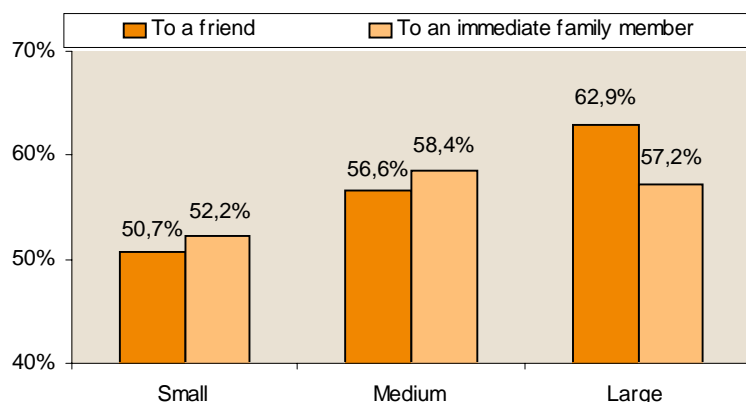
Proportions of individuals who turn to their family doctors for support increase with age; from 18.7% of 18-to-34-year-olds to 37.3% of adults 55 and older. Similarly, 18.9% of 18-to-34-year-olds confided in a nurse, compared to 30.7% of adults 55 and older. Following the same trend, but with a smaller gap, 13.3% of 18-to-34-year-olds sought support from a community health representative (CHR), compared to 19.6% of adults 55 and older. While 17.5% of 18-to-34-year-olds turned to a psychologist for support in the year preceding the survey, only 10.9%\* of adults 55 and older did so in the 12 months preceding the survey.

There is a smaller gap with regard to seeking support from other family members; 43.4% of 18-34 year-olds did so, compared to 38.3% of adults 35 and older.

Recourse to friends and families is clearly more frequent in zone 4 (71.1%) than in the other zones (average of 56.3%).

In general, adults in small communities turn less often to the various support providers for help – apart from family doctors, psychologists and help lines – than adults in larger communities. About half of them spoke about their mental or emotional health to a friend or family member in the 12 months preceding the survey, compared to an average of 60.5% in large communities.

**Graph 154: Proportion of adults who spoke about their emotional or mental health to a friend or immediate family member, by community size (12 months preceding survey)**



The Naskapi Nation stands out from the other Nations regarding the number of support providers available through their circle of friends or family members. Half of its members can count on at least three friends or family members as agents of social support, versus one third of the Algonquins and the Innus and about one quarter of adults of the other Nations.

74.1% of the Naskapi spoke about their mental or emotional health to a friend in the 12 months preceding the survey, while 73.3% spoke to an immediate family member. Among the other Nations, the percentage of individuals who spoke to a friend for support varies from 47.6% (Huron/Wendat) to 65.5% (Algonquin) and the percentage of individuals who spoke to a family member for support varies from 48.2%\* (Abenaki) to 65.8% (Algonquin). The same pattern holds with regard to turning to other family members for support: 63.9% of Naskapi did so in the 12 months preceding the survey, while the rate among other Nations varies from 35.2% (Mi'gmaqs) to 47.6% (Algonquin). We note, however, that 73.8% of the Abenaki and 71.7% of the Huron/Wendat did not confide in other family members.

An opposite picture emerges with regard to consulting general healthcare professionals; 71.7% of the Naskapi did not consult them in the 12 months preceding the survey, while the proportion among other Nations varies from 48.4% (Atikamekw) to 65.0% (Huron/Wendat).

The Atikamekw stand out with regard to seeking support from social workers; 41.4% of them do so, compared to a proportion in other Nations ranging from 14.0% (Mi'gmaq) to 28.9% (Innu). Finally, 6.2% of the Huron/Wendat used telephone help lines, versus an average of 1.4% for other Nations. Let it be noted that no telephone help lines specifically for First Nations are officially implemented in the Quebec region, although a project is currently being studied.

Individuals who use a First Nations language the most often were found to consult general healthcare professionals at a higher proportion: 47.3% of them compared to an average of 39.4% of adults who use English or French the most often. Furthermore, 32.8% of them turn to mental health support providers, compared to 27.8% of French speakers and 19.1% of English speakers.

A higher proportion of persons who use a First Nations language the most often also spoke to a traditional healer about their mental or emotional health in the 12 months preceding the survey (14.3% versus 8.6% of English speakers and 3.9% of French speakers).

Finally, separated adults consult psychologists and psychiatrists (29.8%\* and 16.3% respectively) the most often. The rates at which these professionals are consulted by persons in the other marital status categories are 11.2% and 4.1% respectively.

#### 4.4.7 Community well-being and traditional culture

##### 4.4.7.1 Community and cultural progress

Table 67 presents the perceptions of progress based on the situation of various community and cultural elements. We will elaborate on these perceptions, but we note first in particular that men are generally more positive in their evaluation than women. In addition, more progress is generally felt to have been made as community size and level of isolation increase. Also, the more education adults have, the greater the proportion of adults who perceive progress at the community level. Finally, adults who attended residential schools generally noticed greater progress regarding aspects of traditional culture than those who did not.

**Table 67: Comparison of the proportion of adults who have observed progress within their community or not between the First Nations Regional Longitudinal Health Survey of 1997 and 2002**

Areas of community progress observed	Good progress		Some progress		No progress	
	1997	2002	1997	2002	1997	2002
Traditional approaches to healing	9.8%	5.9%*	53.1%	43.4%	32.4%	50.8%
Renewal of First Nations spirituality	13.6%	6.0%*	53.6%	48.6%	28.5%	45.5%
Traditional ceremonial activity	n/a	9.3%*	n/a	52.7%	n/a	38.0%
Renewed relationship with the land	17.2%	7.6%*	35.7%	45.4%	34.2%	46.9%
Use of First Nations languages	33.8%	13.2%	33.5%	53.3%	23.7%	33.4%
Reduction in alcohol and drug abuse	11.4%	#	44.5%	29.4%	35.0%	66.4%
Availability of First Nations health professionals	n/a	10.4%	n/a	59.5%	n/a	30.1%
Cultural awareness in schools	25.2%	14.4%	42.9%	63.6%	19.6%	22.0%
Education and training opportunities	30.8%	16.5%	46.2%	57.2%	13.3%	26.2%
Housing quality	34.0%	13.4%	43.1%	52.2%	14.2%	34.4%
Water and sewage facilities	42.2%	26.1%	34.3%	50.3%	11.7%	23.7%
First Nations control over health services	n/a	13.6%	n/a	62.5%	n/a	24.0%
Recreation and leisure facilities	n/a	12.5%	n/a	47.9%	n/a	39.6%
Police services	n/a	5.9%*	n/a	43.4%	n/a	50.8%

First finding: Efforts to reduce drug and alcohol abuse should be continued and increased, because this problem shows the lowest proportion of responses indicating “some progress” and the highest proportion of responses indicating “no progress.”

Second finding: All elements covered by the 1997 survey obtain proportions of adults who have observed “good progress” nearly double the 2002 proportions. Moreover, the 2002 results reveal much higher proportions of adults who have not perceived any community progress in a majority of areas. This means that for all these aspects, we observe in general a serious decline in people’s positive perceptions of progress achieved in the 12 months preceding the survey.

##### 4.4.7.2 Spirituality and traditions

A greater proportion of adults who use traditional medicine noted some progress in traditional approaches to healing than people who do not use it (51.5 % versus 37.2%). Obviously, it is easier for people interested or involved in a particular area to observe progress in that area.

57.4% of people who felt that residential schooling had negative impacts on their traditional spirituality or religion said they noted some progress in the renewal of First Nations spirituality, compared to 43.8%\* of adults having attended residential schools who did not experience a negative impact. 10.4%\* of people who

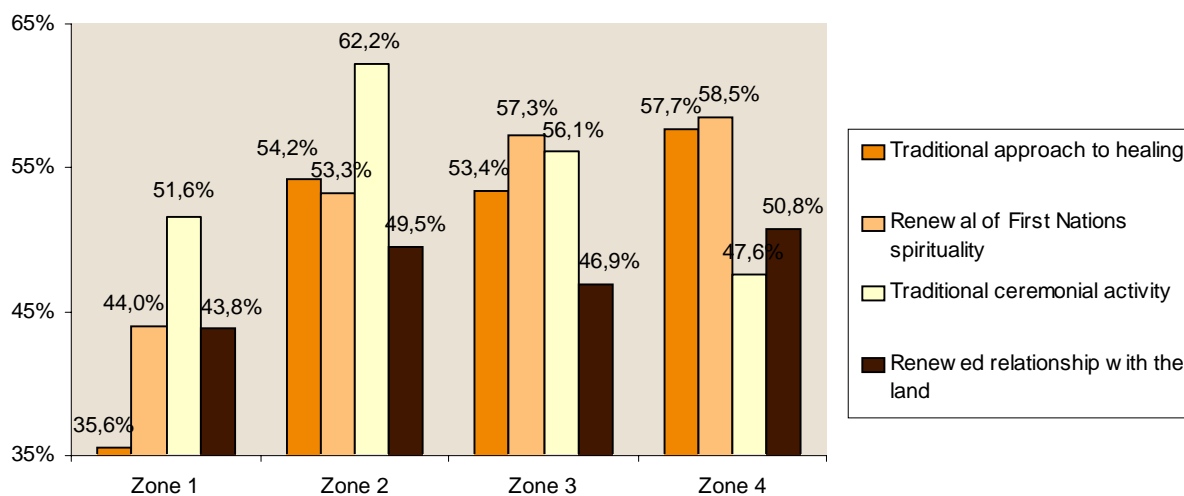
consider traditional spirituality to be very important see good progress in this area, while 52.6% see some progress.

The same trend can be observed based on perceptions of the importance of religion. 50.3% of people who consider it to be very important said they perceive some progress in the renewal of First Nations spirituality, compared to 47.0% of adults who feel it is not very important and 43.3% of those who feel it is not important.

Finally, 12.7%\* of adults who feel that traditional cultural events are very important see good progress in traditional ceremonial activity. The proportion of adults who see no community progress in traditional ceremonies increases as the importance placed on traditional cultural events decreases, rising from 33.7% (very important) to 49.3% (not very important) and to 66.7% (not important). The same direct correlation can be observed regarding perceptions of a renewed relationship with the land. Only people who consider traditional cultural events to be very important perceive significant progress in the renewal of the First Nations' relationship with the land (9.5%\*).

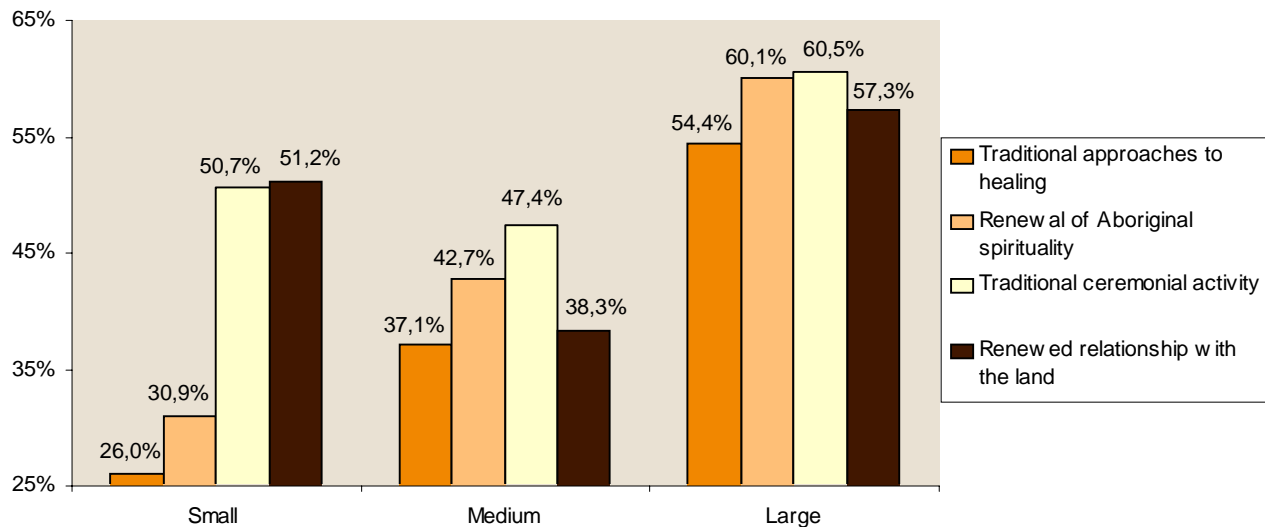
As in 1997, we note a general trend in which the proportion of adults who see some progress in spiritual issues increases with community isolation (Graph 155), with the exception of progress in traditional ceremonies. The increased use of First Nations languages in remote zones (94.1% in zone 4 and about 81.2% in zones 2 and 3, versus 17.2% in zone 1), the stronger feeling of nature's omnipresence in remote regions, and the presence of a younger population which seems clearly to be turning more to its spiritual heritage are all factors that could explain this trend. Finally, the following graph presents the community progress observed in the various Nations.

**Graph 155: Proportion of adults who perceived various progress in their community, by geographic zone**



We see the same general trend when we consider community size since the proportion of adults who perceive some progress in spiritual areas increases as community size increases (Graph 156). That fact that First Nations languages are used most often by nearly half of the people who live in large communities, compared to over one third in medium communities (37.4%) and a statistically insignificant proportion in small communities, also fosters the maintenance and tradition of the First Nations spiritual heritage. One can suppose that the increase of a community's size results in more adults likely being familiar with their Nations' spiritual and ceremonial traditions.

**Graph 156: Proportion of adults who perceived various progress in their community, by community size**



51.6% of men said they perceive some progress in the renewal of Aboriginal spirituality, versus 45.3% of women. The same percentage of men and women (9.3%\*) reported seeing good progress in terms of traditional ceremonial activity, while 55.0% of men and 50.4% of women saw some progress.

Regarding the differences between the age groups, nearly half of 18-to-34-year-olds noted some progress in the renewal of spirituality, compared to 40.7% of adults 55 and older. But a reverse trend appears concerning traditional ceremonies since 50.1% of 18-to-29-year-olds and 58.8% of adults 60 and older saw some progress, compared to 44.2% of 50-59 year-olds.

80.7% of the Mohawks of Kanesatake reported no progress in traditional approaches to healing, followed by 69.0% of the Abenaki and 67.4% of the Huron/Wendat. On the other hand, 60.6% of the Atikamekw, 54.3% of the Mi'gmaq and 50.6%\* of the Naskapi noted some progress, while the Innus and the Algonquin are somewhat divided on the issue.

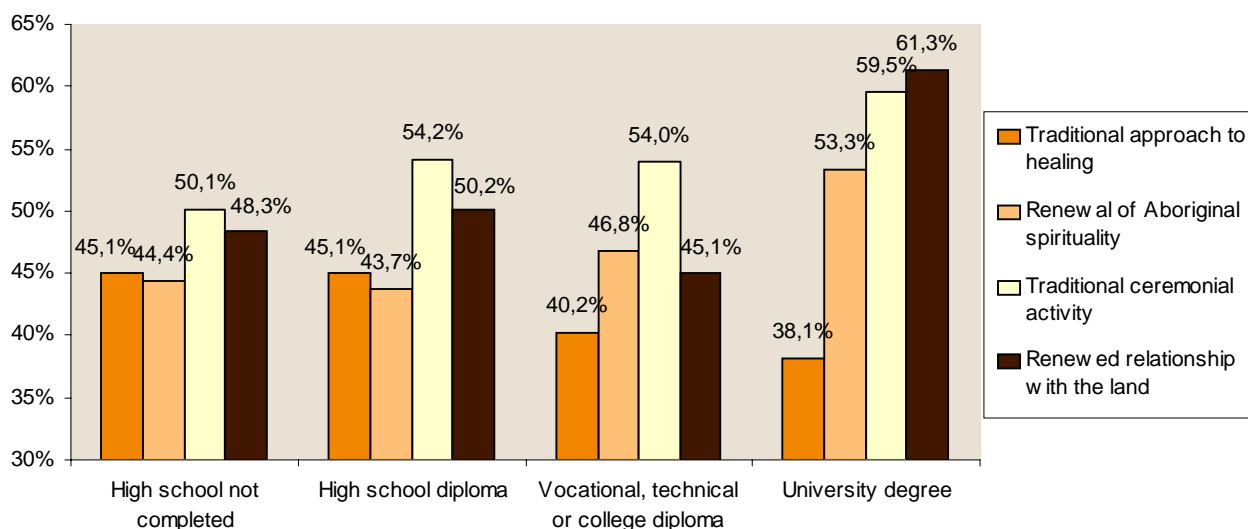
Members of the Abenaki Nation (77.5%) and the Mohawk community of Kanesatake (75.6%) were among the most numerous to indicate that no progress had been made in terms of the renewal of Aboriginal spirituality. The Mi'gmaq (65.9%) and the Atikamekw (62.8%) said they see some progress, while the other Nations are divided in their opinions.

21.8%\* of the Atikamekw felt that good progress has been made in terms of traditional ceremonial activity, while 61.8% reported some progress, as did 63.9% of Huron/Wendat and 61.1% of the Mi'gmaq. Opinions are divided in the other Nations, with the exception of the Mohawk community of Kanesatake, where two thirds reported no progress in traditional ceremonies.

Traditional spirituality and ceremonies appear to have been revitalized to some extent among the Atikamekw adults, 16.7%\* of whom reported good progress concerning a renewed relationship with the land, while 55.3% reported some progress, as did 56.1% of the Huron/Wendat. The other Nations are again divided in their opinions, although 79.8% of the Mohawks of Kanesatake said they see no progress in the renewed relationship with the land.



**Graph 157: Proportion of adults who perceived various progress in their communities, by schooling level**



#### 4.4.7.3 Use of First Nations languages

60.7% of individuals who attended residential schools, and who felt the experience led to a loss of their language, saw some progress in the use of First Nations languages, versus 46.7\* of those who did not feel they the experience led to a loss of their language. 48.0% of the latter group said they feel that no progress has been made regarding the use of First Nations languages.

48.8% of adults who use French the most often saw some progress in the use of Aboriginal languages; this proportion climbs to 54.2% among users of Aboriginal languages and to 60.1% of English speakers. 15.3\* of the latter group feel good progress has been made in this area, versus 20.2% of First Nations language users.

A higher proportion of individuals who understand one or more First Nations languages reported good progress in the use of these languages (16.0%) than of those who do not understand any (7.9\*%). The reverse situation holds regarding people who see no progress: 41.9% of individuals who do not understand any First Nations languages felt there had been no progress, versus 28.6% of those who understand at least one.

How can we explain this more positive view held by people who use a First Nations language as their main language? Is the circle of people they can talk to in their language increasing? Are children better able to understand them? Are news releases, newspapers and other written media becoming more bilingual?

The progress observed regarding language use diminishes with age, dropping from 55.7% of 18-to-34-year-olds citing some progress to 46.9% of those aged 55 and over.

Perceptions that progress has been made in the use of First Nations languages appears to be related to the community size, and therefore in direct proportion to the number of people who use Aboriginal languages the most often: 54.2% of people in small communities say there has been no progress, versus 40.0% in medium communities and 22.1% in large communities (where nearly half of the people use a First Nations language).

About two thirds of the people in isolated communities (zones 3 and 4) reported some progress in the use of First Nations languages, compared to just under half in non-isolated communities (zones 1 and 2).



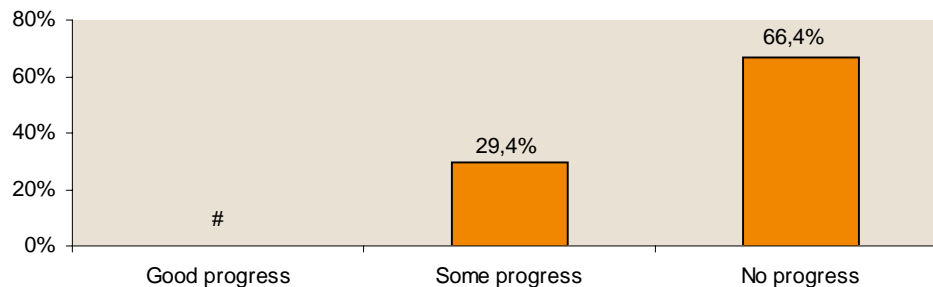
31.6% of the Atikamekw said they see good progress in the use of their language, as did 18.8%\* of the Mi'gmaq. In the other Nations, the proportion of adults who felt some progress had been made ranged from 46.4% (Algonquin) to 58.6% (Mohawks of Kanasatake). 70.5% of the Abenaki perceived no progress regarding the use of a First Nations language. Finally, 43.5% of the Huron/Wendat said they noted some progress in the use of First Nations languages.

The schooling level appears to be related to the perception that some progress has been made on the language front: 49.7% of non-graduates noted some progress; this proportion rises to 69.7% for university graduates.

#### 4.4.7.4 Reduction of alcohol and drug abuse

Graph 158 shows that a high percentage of First Nations members feel no progress was made in reducing alcohol and drug abuse in the communities during the 12 months preceding the survey.

**Graph 158: Individuals' perceptions concerning the reduction of alcohol and drug abuse in their community (12 months preceding survey)**



32.0% of men said they perceive some progress in this regard, as do 26.8% of women. The percentages decrease directly with age, going from 32.3% of 18-to-29-year-olds to 24.9%\* of adults 60 and older.

The level of remoteness appears to be related to the progress observed regarding the reduction of alcohol and drug abuse. 44.6% of adults in zones 3 and 4 said they see some progress in the reduction of alcohol and drug abuse, this percentage decreases to 30.8% in zones 1 and 2.

The Naskapi stand out regarding this issue since 55.2% of adults said that they see some progress, while the proportions of adults in other Nations who reported no progress ranges from 53.6% (Algonquin) to 75.4% (Innu).

#### 4.4.7.5 Availability of health professionals and health service administration

Adults who declared themselves to be in excellent health overall go less often to healthcare facilities; it follows that a higher proportion of them see some progress in the availability of healthcare professionals (62.2%) than of adults who said they are in poor health (48.2%). The same observation holds regarding First Nations' control of healthcare services; more adults in excellent health (67.1%) say they see some progress in this area than do those who are in poor health (48.8%).

A higher proportion (70.1%) of adults who feel they have better access to healthcare services in the communities than other Canadians felt some progress has been made in the availability of healthcare professionals than did people who felt their access to healthcare is similar to (57.3%) or worse than (49.9%) that of other Canadians. The same holds true for First Nations control over health services; 70.6% of people who feel they have a better level of access to healthcare services than the overall Canadian population reported some progress. Of adults who feel their access to healthcare services is similar to that of the Canadian population, 60.4% said they see some progress; this proportion drops to 55.3% of those who feel they have less access to health services than the rest of Canadians.

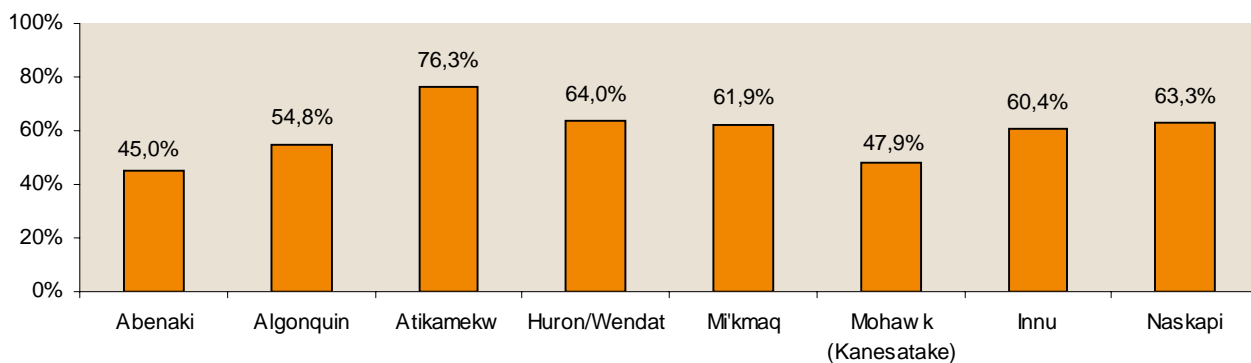
While 10.4%\* of both men and women see good progress in the availability of healthcare professionals, 62.5% of men and 56.5% of the women feel there has been some progress. 64.9% of men and 60.0% of women feel there has been some progress in First Nations control of health services.

Older people, who generally need more medical care, were more critical and less likely to say that they saw some progress. Still, 56.8% of adults 55 and older said they felt some progress had been made, compared to 61.4% of 18-34 year-olds. The same trend can be observed regarding the progress in First Nations administration of health services; 52.5% of adults 55 and older said they see some progress, compared to 66.4% of 18-to-34-year-olds.

The community's remoteness appears to be related to the perception of some progress in First Nations control of health services, rising from 63.3% in zones 1 and 2 to 72.2% in zones 3 and 4. A higher proportion of people in small communities (23.7%\*) see good progress than in medium (12.6%\*) and large communities (14.4%).

Most of the members of the various Nations felt some progress had been made in the availability of healthcare professionals, with percentages in the 50.0% range for the Abenaki, the Mohawks of Kanesatake, and the Algonquin. This proportion rises to about two thirds of adults for the Huron/Wendat, the Mi'kmaq, the Innus and the Naskapi, and to three quarters for the Atikamekw.

**Graph 159: Proportion of adults who felt some progress was made regarding availability of healthcare professionals, by Nation (12 months preceding survey)**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

Proportions similar to those presented in the graph above are found regarding First Nations control of health services; the only exception being the Algonquin, among whom 68.0% of adults see some progress. Finally, we note that 48.9% of the Mohawks of Kanesatake and 24.3%\* of the Huron/Wendat said they have seen no progress.

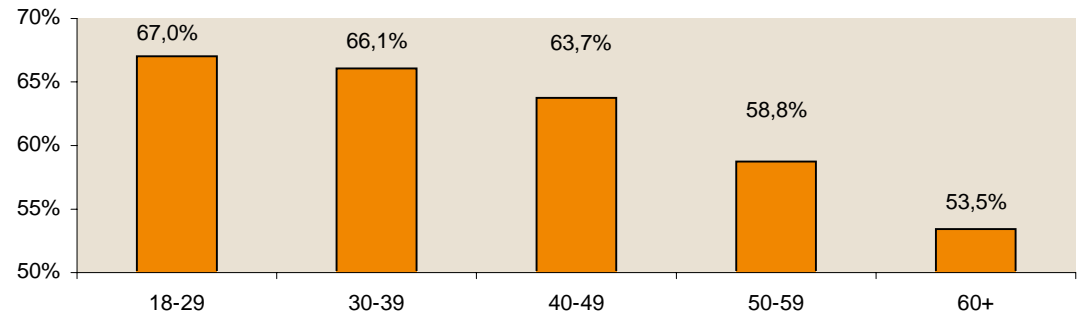
#### 4.4.7.6 Education

There were more people (64.2%) who feel that residential schools led to a loss of cultural identity in noting some progress in cultural awareness in schools than were people who reported no impact from residential schools on their cultural identity (58.9%). The same holds true for adults who had at least one parent attend a residential school: some progress was observed by 67.9% of them, compared to 62.1% of those whose parents did not attend a residential school. Conversely, 64.8% of adults whose grandparents did not attend residential schools noted some progress in cultural awareness in schools, versus 56.0% of adults with at least one grandparent who attended residential schools. However, a higher proportion of people in this last group (19.5%\*) saw good progress than did people in the other groups (12.3%).

Although the highest proportion of adults who noted good progress in cultural awareness in schools was found in adults 60 and older (20.0%\* compared to 12.4%\* of 18-to-29-year-olds), the proportion of adults who

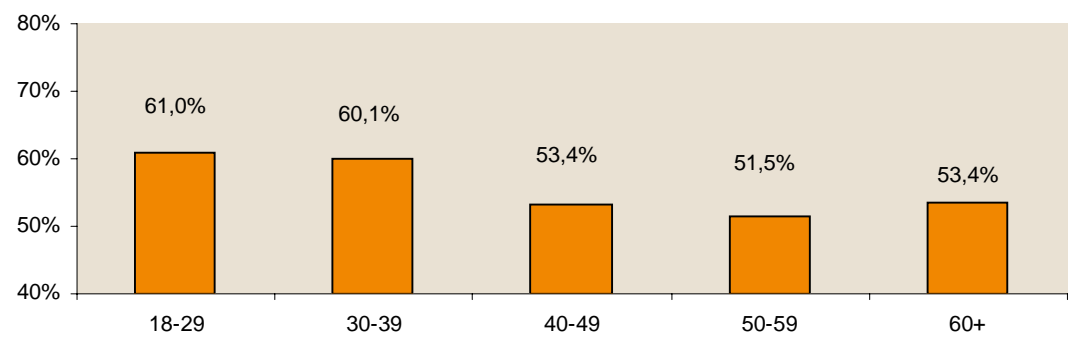
see some progress decreases as age increases, going from 67.0% of 18-29 year-olds to 53.5% of adults 60 and older, as illustrated in the following graph.

**Graph 160:** Proportion of adults who felt some progress was made regarding cultural awareness in schools, by age group (12 months preceding survey)



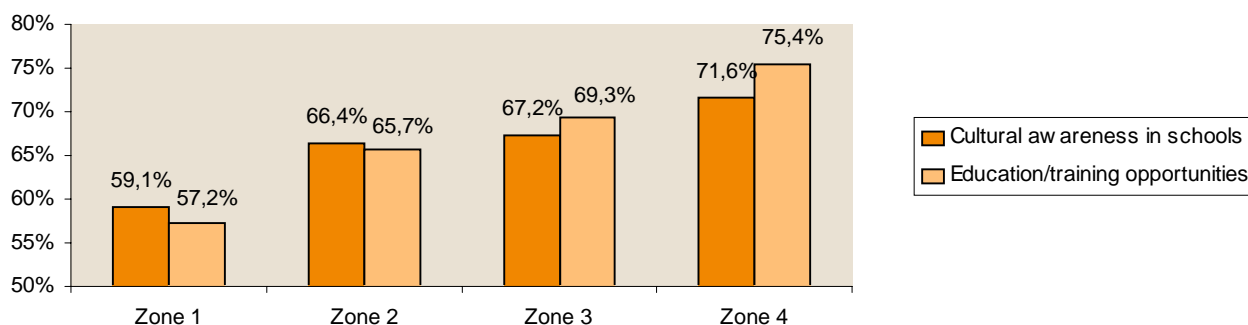
The same holds true regarding education and training opportunities; a higher proportion of adults 60 and over (21.0%\*) than of young adults (14.9%\* of 18-29 year-olds) believe good progress has been made in this area. However, a smaller proportion of adults 40 and older (about 53.0%) than of young adults (about 60.5% of 18-39 year-olds) feel there has been some progress.

**Graph 161:** Proportion of adults who felt some progress was made regarding access to education and training opportunities, by age group (12 months preceding survey)



There appears to be a correlation between community remoteness and the perception that some progress has been made regarding cultural awareness in schools and regarding education and training opportunities (Graph 162). Accessibility of education and training also appears to be related to community size, rising from 47.2% in small communities to 66.3% in large ones. 54.5% of the people in the large communities see some progress regarding education and training opportunities, compared to over two thirds of those in small and medium communities.

**Graph 162: Proportion of adults who observed some progress in their community regarding cultural awareness in schools and access to education/training opportunities, by geographic zone**



Since 70.5% of the Abenaki perceive no progress in the use of First Nations languages, it is not surprising that 80.1% of them feel no progress has been made regarding cultural awareness in the schools, an opinion shared by one quarter of the Algonquin and the Huron/Wendat. However, 58.5% of the Algonquin and 69.3% of the Huron/Wendat see some progress, as do 71.8% of the Atikamekw, 71.5% of the Naskapi, 69.8% of the Innus and 68.0% of the Mohawks of Kanésatake. Finally, we note that 38.8% of the Mi'kmaq felt there has been good progress regarding cultural awareness in schools.

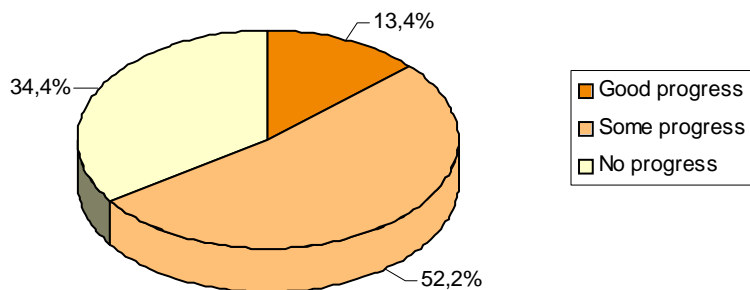
More than one third of the Mohawks of Kanésatake and the Innus feel no community progress has been made regarding access to education and training opportunities, while over one third of the Mi'gmaq and one quarter of the Algonquin see good progress. Finally, nearly three quarters of the Naskapi and the Atikamekw acknowledged some progress, versus 60.8% of the Abenaki.

As would be logically expected, a higher proportion of people with the most education saw some progress in access to education and training opportunities: 65.9% of university graduates compared to 54.7% of adults who did not finish high school.

#### 4.4.7.7 Quality of housing

We note that just over half (52.2%) of First Nations people feel some progress has been made in housing quality in their community. Just over one third (34.4%) of the population said no progress has been made regarding this issue.

**Graph 163: Perceptions of community progress concerning housing quality (12 months preceding survey)**



More women (38.0%) than men (30.8%) indicated that they see no progress in housing quality, as did about one third of the people in each age group, apart from the 50-59 age group, for which the figure is 43.6%.

The proportion of people who said they have seen some progress in housing quality tends to increase along with community isolation, going from 52.2% in zone 1 to 67.4% in zone 4, but with a drop to 43.7% in zone 2. However, 27.3% of adults living in zone 2 noted good progress.

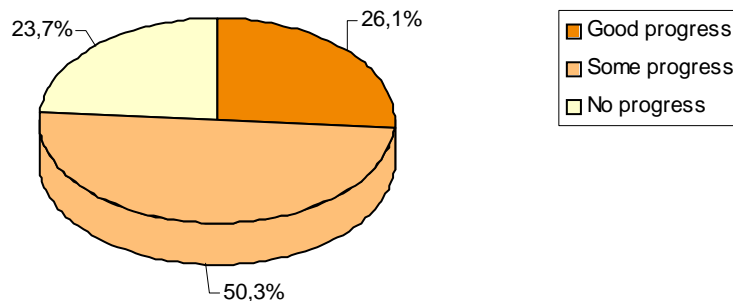
75.8% of the Mohawks of Kanésatake noted no progress in housing quality, as did 26.8% of the Algonquin. Yet 25.2% of the Algonquin said they see good progress, as did 23.8%\* of the Mi'gmaq. Most of the other Nations see some progress (from 49.2%\* of the Abenaki to 65.8% of the Huron/Wendat).

A higher proportion of adults with higher schooling levels saw some progress in the quality of housing (65.0% of university graduates compared to 50.8% of adults who have not finished their high school studies).

#### 4.4.7.8 Water and sewage facilities

Similar to what we saw regarding housing quality, half (50.3%) of First Nations members feel some progress was made in water and sewage facilities in the 12 months preceding the survey. But a somewhat smaller number of people feel there has been no progress in this area in their community.

**Graph 164: Perceptions of community progress concerning water and sewage facilities (12 months preceding survey)**



Men appear to be more positive in this regard than women: 28.2% see good progress regarding the water and sewage network, compared to 23.7% of the women.

31.0% of people in zone 1 and 40.1% in zone 2 see good progress in water and sewage facilities, and the percentage of people who see some progress appears to increase with community isolation, rising from 46.9% in zone 1 to 62.3% in zone 4 (but peaking at 75.4% in zone 3).

54.5% of people in small communities noted good progress, compared to 21.0% in medium communities and 26.7% in large communities. In contrast, the proportion of adults who said there has been some progress appears to be related to the increase in community size, rising from about 33.0%\* in small communities to 57.2% in large ones.

76.3% of the Mohawks of Kanésatake said there has been no progress in their water and sewage facilities. This opinion is shared by 25.3% of the Innus and 36.0%\* of the Naskapi, although 24.7% of the Innus said there has been good progress and 54.2% of the Naskapi reported some progress. Around one third of the Abenaki, Algonquin, Huron/Wendat and Mi'gmaq reported good progress, while over two thirds of the Atikamekw mentioned some progress.

#### 4.4.7.9 Sports and recreation facilities

The survey reveals that 46.1% of adults living in zone 1, 32.6% of adults living in zone 2 and 61.8% of adults living in zone 4 noted some progress concerning recreation and sports facilities.

Large communities appear to be better off regarding these facilities, because 16.1% of their residents said there has been good progress, compared to less than one person in ten in small and medium communities.

More than half of the adults living in large communities (53.9%) noted some progress, compared to less than half (44.7%) in the others.

About two thirds of the Abenaki, Huron/Wendat and Mohawks of Kanesatake felt no progress had been made regarding recreation and sports facilities, an opinion shared by over one third of the Algonquin, Atikamekw and Innu. 59.4% of the Mi'gmaq and 71.0% of the Naskapi felt there had been some progress.

#### 4.4.7.10 Police services

The proportion of adults who have noted some progress in the police services varies from one geographic zone to the other. Less adults in zone 1 communities have noted some progress has been made regarding police services (35.6% versus an average of 54.9% in the other zones). The perception of some progress appears to be related to community size; it rises from 26.0%\* of adults in small communities to 37.1% in medium communities and 54.4% in large communities.

Over two thirds of the Abenaki and the Huron/Wendat said they see no progress in police services in their community, versus a little over half of the Innus and the Algonquin and one third of the Atikamekw, the Mi'gmaq and the Naskapi. The highest percentage for this response is found among the Mohawks of Kanesatake (80.7%).

The proportion of adults who have perceived no progress increases with level of education, rising from 48.1% of those who did not finish their high school studies to 60.6% of university graduates.

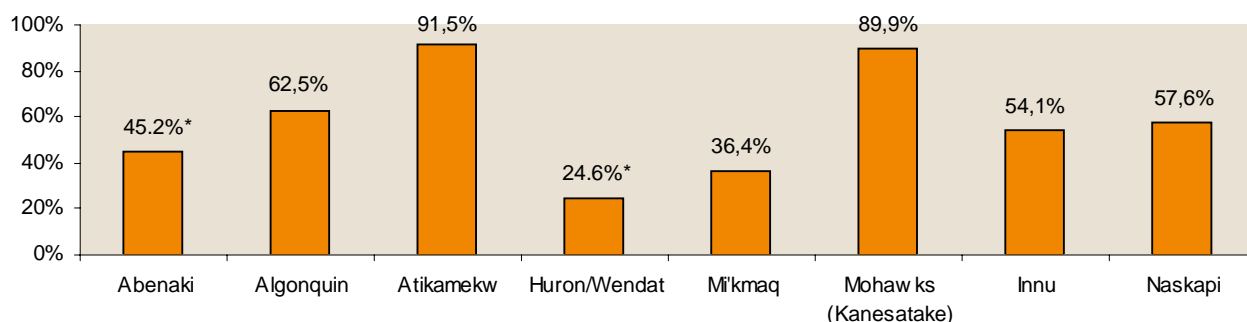
#### 4.4.8 Transportation means

33.5% of First Nations members drive all-terrain vehicles (ATVs), 36.1% drive snowmobiles and 52.6% use boats or canoes seasonally.

59.5% of adults said that the community authorities allow people to drive ATVs or snowmobiles on community roads.

Zone 2 and 3 communities appear to be much more permissive in this regard (95.4% and 89.8%). The percentage drops sharply to 69.0% in zone 4 and to 46.5% in zone 1. Furthermore, large communities are more permissive (62.2%) than small and medium communities (53.6%).

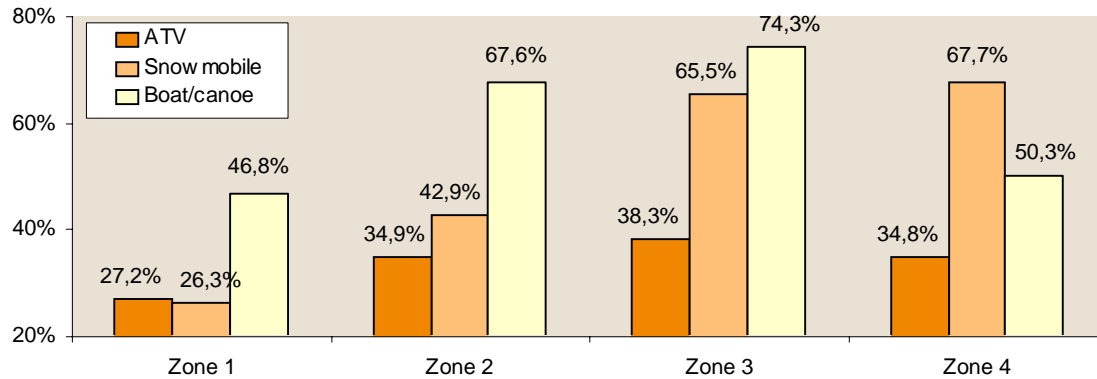
**Graph 165: Proportion of adults who had permission from community authorities to drive ATVs or snowmobiles on community roads, by Nation**



Note: The Malécites of Viger are excluded because their results were not statistically significant.

We note that geographic zone is directly related to the number of ATV and snowmobile users, which increases with community level of isolation.

**Graph 166: Proportion of ATV, snowmobile and watercraft users, by geographic zone**



Ability to swim does not appear to influence the proportion of adults who use watercrafts, since over one third of adults (37.8%) in zones 3 and 4 do not know how to swim, versus 23.7% in zones 1 and 2. Yet the highest proportion of watercraft users is in zone 3. Although the lowest proportion of watercraft users is in zone 4, 31.5%\* of zone 4 watercraft users go out on the water at least once a day.

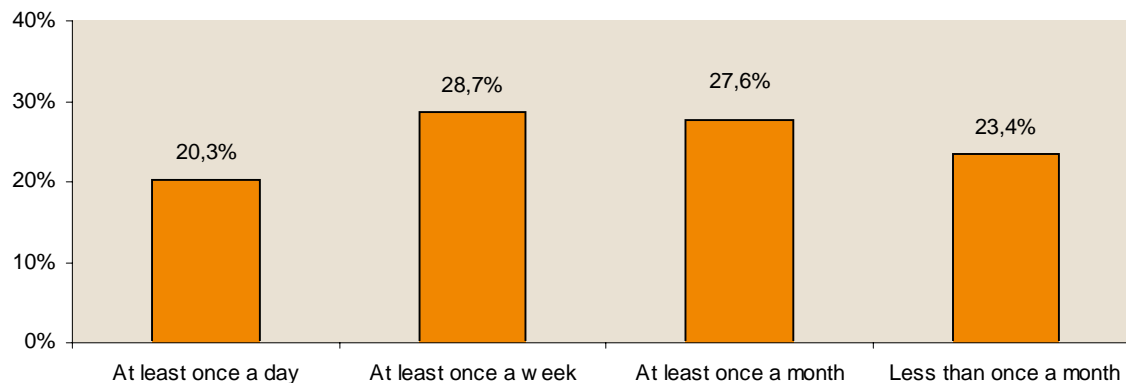
Not only are adult non-swimmers more numerous in zones 3 and 4, but they are also more likely to never wear a life jacket (52.9% in zone 4 compared to 26.0% in zone 1).

#### 4.4.8.1 All-terrain vehicles (ATVs)

41.5% of men and 25.7% of women drive ATVs. The percentage of users is related to the age, dropping from 44.4% of 18-to-29-year-olds to 34.9% of 30-39 year-olds to 39 and to 19.5%\* of adults 60 and older. However, daily use generally increases with age, going from 18.3%\* of 18-34 year-olds to 26.0%\* of adults 55 and older. Thus, fewer older people drive ATVs but those who do are the biggest daily users.

Daily ATV use appears to be related to the geographic zone of residence, varying from 15.0%\* in zone 1 to 49.0% in zone 4.

**Graph 167: Frequency of seasonal use of ATVs**



The Innus are the biggest ATV users (43.0%), followed by the Atikamekw (33.2%) and the Algonquin (32.5%), while 85.3% of the Huron/Wendat do not use this type of vehicle.

Among the one third of people who use ATVs, one third always wear a helmet and two thirds wear one occasionally. Moreover, 41.5% of men always wear a helmet, while 25.7% of women do the same. The proportion of adults who always wear a helmet diminishes with age (44.4% of 18-29 year-olds versus 19.5%\* of adults 60 and older), while a reverse trend is found among those who wear one sometimes (55.6% of 18-



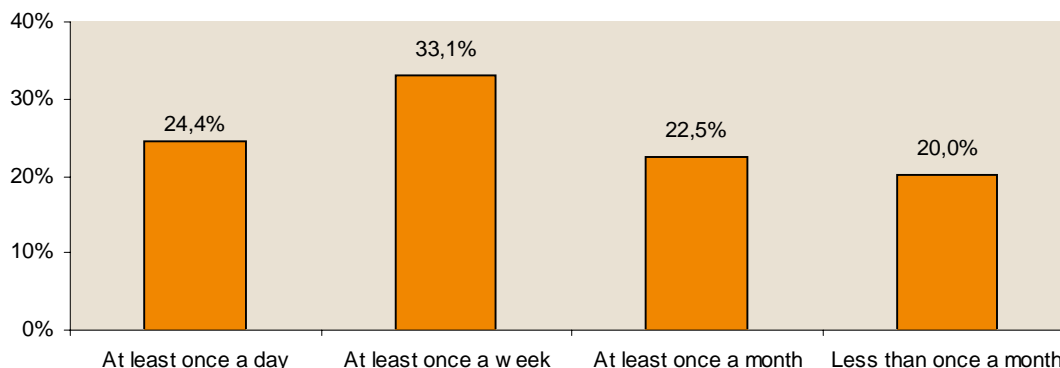
to-29-year-olds versus 80.5% of adults 60 and older). Safety awareness and promotion campaigns probably reach young adults more than older ones.

#### 4.4.8.2 Snowmobiles

43.5% of men and 29.0% of women drive snowmobiles. Among them, 46.4% always wear a safety helmet, 21.4% wear one sometimes and 28.1% rarely do. Moreover, 50.3% of men always wear a helmet and 25.6% rarely do, while women apparently take more risks since 40.5% always wear a helmet and 31.9% rarely do so.

In season, one quarter of snowmobilers use their vehicle at least once a day (24.4%), one third do so once a week (33.1%) and nearly one quarter do so less than once a month (22.5%). These results are presented in the following graph.

**Graph 168: Frequency of seasonal use of snowmobiles**



Snowmobile use declines directly with age, dropping from 47.4% of 18-to-29-year-olds to 17.1%\* of adults 60 and older. In contrast to ATVs, systematic use of a helmet tends to increase with age among snowmobilers, rising from 38.5% of 18-to-29-year-olds to 56.2% of adults 60 and over.

More than one of every three snowmobilers use theirs at least once a day in small communities, versus about one in five in medium and large communities. Moreover, the daily use increases according to the community's level of remoteness, rising from 11.9%\* of users in zone 1 to 46.1% in zone 4.

58.4% of the Naskapi, 52.1% of the Atikamekw, 43.5% of the Innus and 37.4% of the Algonquin form the category of persons who use snowmobiles the most often. The Nations with the lowest user proportions also present the highest proportions of people who always wear a helmet (79.3%\* of the Abenaki and 94.0% of the Mi'gmaq, apart from the Mohawks of Kanésatake, who stand in this regard at 44.9%\*). The Innus(32.6%) post a lower proportion of people who always wear a helmet.

Although the proportion of snowmobilers increases with the community level of isolation, the proportion of adults who always wear a helmet decreases at the same time, dropping from 63.7% in zone 1 to a statistically insignificant result in zone 4. In contrast, the number of users who rarely protect themselves rises from 15.4%\* in zone 1 to 37.4% in zone 4.

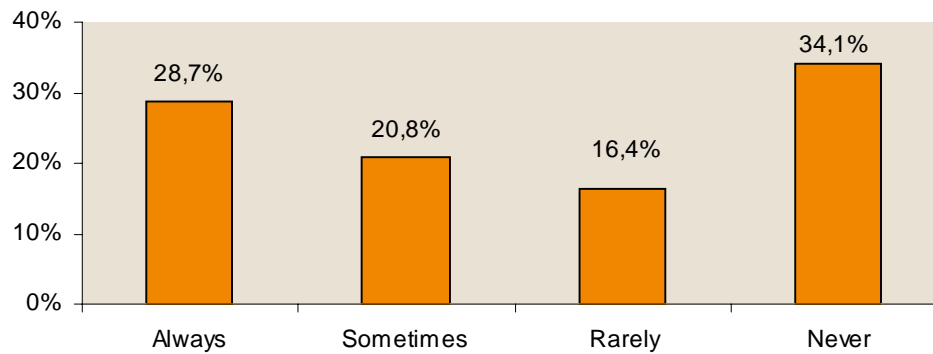
Finally, the use of a helmet tends to increase with level of education, rising from 37.2% of people who did not finish their high school studies to 56.6% of high-school and other graduates and 67.3% of university graduates. The importance of wearing a helmet therefore appears to be greater among people with more education.



### 4.4.8.3 Watercrafts

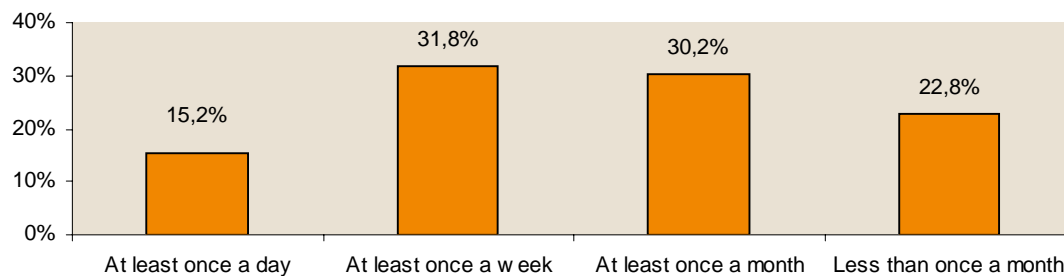
Among the 52.6% of adults who reported using boats or canoes, 28.7% always wear a lifejacket, 20.8% sometimes wear it, 16.4% rarely do and over one third never do (34.1%). These results are presented in the following graph.

**Graph 169: Frequency of use of lifejackets in boats among adults who use boats**



27.4% of the people do not know how to swim, and of these 25.2% never wear a lifejacket, while 23.4% rarely do. The proportion of adults who do not wear a lifejacket is fairly high, considering that 15.2% of First Nations people use these watercraft at least once a day during the season.

**Graph 170: Frequency of seasonal use of watercraft**

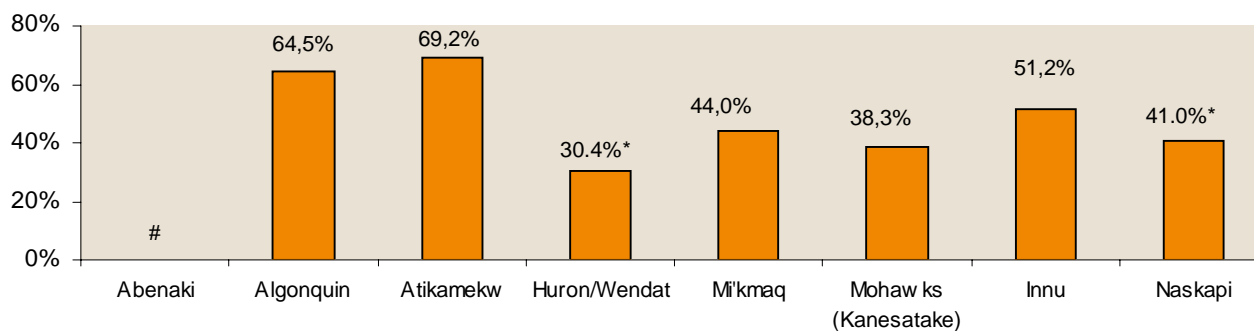


Once again, more men (63.8%) use watercrafts as transportation means than women (41.7%). Although 82.9% of men know how to swim (versus 62.5% of women), they are less careful than women. Indeed, only one quarter of them always wears a lifejacket, compared to one third of women. However, more men (22.7%) than women (18.1%) sometimes wear lifejackets. Finally, one third of both men and women never wear one.

Per age group, one can see that 55.2% of 18-to-29-year-olds use watercraft, as do 59.2% of 30-39 year-olds and 39.7% of adults 60 and older. Lifejacket use tends to rise with age, going from 20.6% of 18-to-29-year-olds to 40.7% of adults 60 and older. Let it be noted that 85.6% of 18-to-29-year-olds and 42.7% of adults 60 and over know how to swim.

The Atikamekw (69.2%) and the Algonquin (64.5%) are among the biggest users of watercraft, while the Abenaki (73.0%) and the Huron/Wendat (69.6%) are the smallest users. Despite the fact they are the biggest users, the Algonquin and Atikamekw, 50.0% and 28.9% respectively never wear a lifejacket, while 24.7% and 19.2%\* respectively always wear one.

Graph 171: Proportion of adults who use boats or canoes, by Nation



Note: The Malécites of Viger are excluded because their results were not statistically significant.

Lifejacket use, like snowmobile helmet use, tends to increase with level of education, rising from 23.8% of people who did not finish their high school studies to 33.9% of high school graduates and 37.4%\* of university graduates.

Finally, we note that persons who can swim tend to be the ones who wear lifejackets the most.

#### 4.5 Conclusion: Adults' health (18 and older)

##### 4.5.1 Demographic profile

The overall First Nations population includes more young adults aged 18 to 29 compared to all other age groups. Small communities and those in zone 1 have an older population than the medium and large communities and the more isolated ones. The Atikamekw Nation has the youngest population, while the Abenaki Nation has the oldest population, followed by the Mohawk community of Kanesatake and the Huron/Wendat Nation.

Although more than one third of the population often uses a First Nations language, this proportion has declined since 1997. There are also more people who cannot speak a First Nations language. It should be noted here that community level of isolation is one of the factors that appears to be related to the frequency of First Nations language use.

Nearly half of all adults do not have high school diplomas. We note further that a significant proportion of adults without high school diplomas attended a residential school. This gives us an insight into the harmful effects that residential schools have had on First Nations members who attended these schools, not to mention the effects on the population as a whole.

Finally, we see an improvement concerning employment. Indeed, over half of all adults received income from an employment source in the 12 months preceding the survey, versus just under one third in 1997.

##### 4.5.2 Overall health and lifestyle

In comparison to the report on the analysis and interpretation of the 1997 regional health survey, our assessment of the First Nations shows that their health is not improving. Some chronic diseases such as diabetes and respiratory problems are getting worse, and the incidence of high blood pressure and asthma is also on the rise. Finally, over half of the First Nations population reported having health problems.

We note that only one adult in four has an acceptable weight. Over two thirds of the population is overweight or obese. Since overweight and obesity are risk factors for several chronic diseases such as diabetes and cardiovascular problems, it will be very important to track this issue in the future.

As for lifestyle habits, we find that a high proportion of adults eat junk food, in particular the 18-34 year-olds and men overall. 18-34 year-old men do get more physical activity than women. On the other hand, women tend to eat better than men.

Turning to women's health, we note that just under one third of women who have had children drank alcohol while they were pregnant. A significant proportion of women feel they have adequate knowledge concerning FAS and FAE. But nearly half of Abenaki, Innus and Naskapi women said they do not have sufficient knowledge on the subject.

#### 4.5.3 Lifestyle habits

Tobacco use is also a serious problem among the First Nations and a major threat to their health. Over half of the adult population smokes, the majority of which smoke every day. More than one quarter of adults who do not smoke are ex-smokers. Furthermore, half of all adults report that their homes are not smoke-free. This is an important fact, especially when we consider the effect of second-hand smoke on health.

The greatest proportion of smokers is found among the 18-to-34 year-olds adult group, who also began smoking at the youngest age, compared to other age groups. Smokers aged 55 and over smoke more cigarettes on a daily basis, however.

Nearly one quarter of the entire adult population reported drinking five or more glasses of alcohol on a single occasion one or several times a week. As we saw regarding tobacco use, the 18-to-34-year-olds are the biggest consumers of alcohol. Furthermore, a high percentage of First Nations adults (15.5%) have been treated for alcohol abuse.

Drug and solvent use is most common among 18-to-34-year-olds and men overall. Marijuana is the drug used most frequently by First Nations members.

#### 4.5.4 Personal and community well-being

In general, First Nations adults have good perceptions of their level of life balance (physical, emotional, mental and spiritual well-being). Nevertheless, the degree of control they consider to have over their life (self-determination indicator) is very low for the majority of them.

Women have a lower perception of their life balance than men do and also consider their degree of self-determination to be lower. However, more women than men have a support network they can turn to when they need someone to talk with.

39.0% of adults have considered suicide at some point in their life and 18.4% have attempted suicide. Finally, one adult in five said that a friend or family member committed suicide in the 12 months preceding the survey, which is a particularly alarming statistic.

The most common social problems are, in order of importance, alcoholism, drug and medication abuse, verbal or psychological abuse, and gambling.

Community members' perceptions of community progress made in the 12 months preceding the survey have deteriorated since 1997. Finally, over two thirds of adults feel no progress was made concerning the reduction of alcohol and drug abuse, versus just over one third of individuals in 1997.



## Section 5: Elders' health (55 and older)



## Elders' Health (aged 55 and older)

### 5.1 Highlights

#### 5.1.1 Social characteristics

##### 5.1.1.1 Demographic profile and First Nations languages

Women accounted for 54.1% of Elders who participated in the survey. The survey's results revealed that 60.3% of all Elders understand one or several First Nations languages, while 35.5% used a First Nation language as their main language in daily life.

##### 5.1.1.2 Income

The survey revealed that 42.2% of Elders had individual annual incomes of \$10,000 to \$19,999 and that 29.8% earned less than \$9,999 per year.

##### 5.1.1.3 Education

More than two thirds (68.6%) of Elders had not completed high school.

#### 5.1.2 Health

The majority of the Elders surveyed were satisfied with their state of health. Indeed, 23.1% felt they were in excellent or very good health, while 40.8% felt they were in good health. However, 36.2% felt that their health was fair or poor.

84.9% of all Elders reported having health problems, the most common ones being cardiovascular problems (49.1%), musculoskeletal problems (44.2%), visual or hearing problems (35.9%) and diabetes (33.0%).

Finally, according to the body mass index (BMI) classification, 51.4% of Elders were overweight and 29.4% were obese.

##### 5.1.2.1 Physical injuries

14.6% of Elders had one or several injuries in the 12 months preceding the survey. The main injuries reported were falls or trips (responsible for 57.3% of all injuries).

##### 5.1.2.2 Homecare

Nearly one half (44.3%) of all Elders required one or several homecare services. Among these, 31.8% reported that they were not receiving the services they need. In addition, 30.1% of Elders requiring homecare received these services in part from family members.

##### 5.1.2.3 Accessibility of health care and preventive health services

More than half (59.1%) the Elders encountered obstacles to receiving health care services, with long waiting lists mentioned by them as being the main obstacle.

The majority of Elders had various medical tests or analyses during the 12 months preceding the survey; 87.9% had a blood pressure test, 83.3% had a blood sugar test, 80.7% had a cholesterol test, 77.3% had an eye exam, and 65.9% had a complete physical check-up. In addition, 45.7% of men had a rectal examination. As for the women, 14.2% of them had a mammogram less than six months before the survey, while 13.7% had one between six months and a year before the survey.



### 5.1.3 Lifestyle

#### 5.1.3.1 Physical activity

On average, the Elders spent 2.4 hours each week on physical activities that increased their heart and breathing rates. A significant number of Elders were involved in traditional activities; 40.3% gathered berries or other foods, 38.3% fish and 36.1% went hunting or trapping. However, walking was the most common physical activity among Elders (85.2%).

#### 5.1.3.2 Smoking

More than one third (39.6%) of Elders smoke. The majority of these (89.8%) smoked every day. Furthermore, 45.6% of Elders lived in a smoking environment.

### 5.1.4 Personal and social well-being

#### 5.1.4.1 Aboriginal residential schools

Nearly one quarter of Elders attended a residential school during their childhood or adolescence. Among these, 42.8% indicated that the experience had negative impacts on their health. The most frequently mentioned impacts were physical or verbal violence (68.1%), harsh discipline (66.3%) and isolation from one's family (61.5%).

#### 5.1.4.2 Social support

Overall, the Elders seemed to have strong social networks. One half of them had access to support agents among the members of their families. In addition, 51.8% spoke about their emotional or mental health to a family member or friend in the 12 months preceding the survey. Finally, the majority of Elders indicated that they always had access to a variety of persons who can support them and provide them with assistance when they require.

#### 5.1.4.3 Suicide and periods of depression

The survey showed that 13.2% of Elders had previously thought about committing suicide and that 6.2% had tried to commit suicide at some point in their life. In addition, 30.0% were depressed for a period of two consecutive weeks or more in the 12 months preceding the survey.

### 5.1.5 Community well-being and traditional culture

Overall, the Elders had a rather negative view concerning the progress that had been made in their communities. The majority of them felt that no progress had been made with regard to the reduction of alcohol and drug abuse (70.2%), the renewal of First Nations spirituality (54.8%), traditional approaches to healing (54.6%), police services (54.6%) and a renewed relationship with the land (51.7%).

However, the majority felt that good progress had been made with regard to cultural awareness in the schools (75.8%), education and training opportunities (75.3%) and the use of First Nations languages (61.9%).



## 5.2 Demographic profile

Among the 55 and over age group, 27.4% are 70 or older and 54.1% are women. This age group thus includes a much larger number of women than men.

Most Elders live in zone 1, thus near urban centres, for a proportion of 72.2%. Half of them (50.3%) live in large communities. Also, over 60.3% of Elders understand one or more First Nations languages, and 35.5% use a First Nations language as their main language.

Nearly half (48.3%) of all adults 55 or older are married, 21.6% are widowed, 11.2% are single and 11.1% are divorced. Moreover, 89.0% of Elders have an annual income under \$30,000, 42.2% live on between \$10,000 and \$19,999 a year, and 29.8% have an income between \$0 and \$9,999. More than 68.6% of Elders did not finish their high school studies.

## 5.3 Health status

In general, Elders have a more negative perception of their health than do adults younger than 55. Nevertheless, 23.1% said they are in excellent or very good health, and 40.8% said they are in good health. A little over one third (36.2%) reported that their health is fair or poor. When asked the reasons for their state of health, Elders in excellent or very good health cited the following as the main ones: having good social support, having a healthy diet, and being happy or satisfied.

**Table 68: Proportion of Elders who consider various reasons for being in excellent or very good health**

Reasons given for being healthy	% of Elders
Good social support	67.4%
Healthy diet	66.7%
Happy/satisfied	66.1%
Good sleep/proper rest	62.7%
Life in balance	59.5%
Regular exercise/active in sports	51.7%
Reduced stress	46.3%

The survey reveals that 84.9% of adults 55 and older have health problems. Furthermore, only 21.5% have normal weights, while 41.4% of Elders are overweight and 29.4% are obese. This situation undoubtedly leads to health problems, particularly cardiovascular ones, which affect 49.1% of Elders with health problems. Indeed, as we saw regarding other adults, the higher the body mass index, the greater the number of cardiovascular problems.

**Table 69: Proportion of Elders with various health problems**

Medical problems	% of Elders
Cardiovascular	49.1%
Musculoskeletal	44.2%
Visual and auditory	35.9%
Diabetes	33.0%
Respiratory	23.5%
Digestive system	20.7%
Allergies	15.9%*
Thyroid gland	12.7%*
Neurological and cognitive	#
Cancer	#

As Table 69 illustrates, 44.2% of adults 55 and older have musculoskeletal problems, 35.9% have visual or auditory problems, and 33.0% have diabetes. Of the latter, 80.6% have type-2 diabetes. Nearly all diabetics are receiving treatment (97.4%). It should also be noted that diabetes often triggers other health problems, including problems with hands and feet (45.2%), problems with lower limbs (35.0%) and visual problems (34.8%).

**Table 70: Proportion of Elders with complications due to diabetes**

Complications	% of diabetics Elders
Hand or foot problems (e.g., neuropathy)	45.2%*
Problems with lower limbs	35.0%*
Visual problems	34.8%*
Circulatory problems (not related to the heart)	28.0%*
Kidney problems	18.2%*
Heart problems	17.3%*

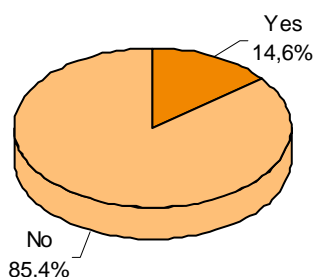
73.1% of diabetics are being treated with pills and 30.3% with insulin. Nevertheless, 73.4% of them said that being diagnosed with diabetes led them to adopt a healthier lifestyle. Indeed, 42.2% have changed their diet and 31.5% are exercising. A good number of diabetics (41.8%) check their blood sugar levels once a day or more, although 17.2% had not checked it in the two weeks preceding the survey.

Over 69.2% of diabetics have attended a diabetes clinic or consulted a resource person. Like other adults with diabetes, a proportion of 45.6% of those who did not attend a clinic indicated, as their main reason, the fact that they were already informed.

### 5.3.1 Physical injuries

A low percentage of Elders (14.6%) had one or several injuries in the 12 months preceding the survey. 93.4% of those who were injured said their injuries were not related to alcohol or drug use. Falls and slips were the main causes cited by Elders who were injured one or several times, in a proportion of 57.3%.

**Graph 172: Proportion of Elders who had injuries (12 months preceding the survey)**

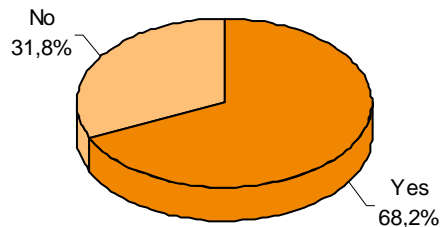


### 5.3.2 Activity limitation and homecare

44.3% of adults 55 and older said they are often or sometimes limited in their activities because of their physical condition or health problems. Fewer Elders work or study, so only 18.9% reported being limited in these activities. 34.4% said that they are often or sometimes limited in their recreation and travel activities by their physical condition or health problems.

40.2% of adults 55 and older indicated that they require one or more types of homecare (including services). Of these, over 31.8% said they do not receive the care they need and 30.1% said that a family member contributes to the care they receive at home.

**Graph 173: Proportion of Elders who feel they receive the homecare they need**



Of the types of homecare required, home maintenance (31.7%) and light housekeeping (27.9%) are those in greatest demand, followed by nursing care (18.2%), and preparation or delivery of meals (12.0%). Furthermore, 20.5% of Elders have had to make modifications to their homes because of their physical condition.

Among the 31.7% of Elders who feel they need home maintenance assistance, about half (52.8%) said they do not receive this service. But proportions for other services requested are lower. One third (33.0%) of Elders who said they need light housekeeping services do not receive this service, and 28.1% of those who feel they need nursing care do not receive it. However, 78.5% of those who require meal preparation assistance receive this service when they need it.

**Table 71: Proportion of Elders with various homecare needs**

Types of homecare	% of Elders
Home maintenance	31.7%
Light housekeeping	27.9%
Nursing care	18.2%*
Meal preparation or delivery	12.0%*

### 5.3.3 Accessibility of health care and dental care

Over 46.4% Elders feel they have the same level of access to healthcare services as other Canadians, while 30.3% feel they have better access. Moreover, 23.3% indicate that their access is not as good, and 43.9% reported that they have encountered one or more barriers to receiving health care.

Among the Elders who said they have had problems accessing health care, 59.1% mentioned that waiting lists were too long. Next come barriers related to cost. To this effect, 32.0% reported that they have had problems because certain services are not covered by the NIHB program and 28.3% said they were denied prior approval for services under the NIHB program. Finally, 19.2% said they could not afford the direct costs of the services.

The lack of healthcare resources may also be problematic. 26.6% of Elders reported that there are no doctors or nurses in their area, 23.8% said that certain services are not available in their area, and 18.0% indicated that they were unable to arrange medical transportation.

Healthcare quality is another factor that must also be considered. 25.4% of Elders feel that healthcare services are not culturally appropriate, and 21.8% feel that they are inadequate. Moreover, 14.9% reported that they have difficulty accessing traditional care.

**Table 72: Proportion of Elders having encountered various difficulties among Elders who reported having difficulties in accessing health care services**

Difficulties encountered	% of Elders
Waiting list too long	59.1%
Not covered by NIHB program	32.0%
Prior approval for services under NIHB denied	28.3%
Doctor or nurse not available in my area	26.6%*
Felt service was not culturally appropriate	25.4%*
Service not available in my area	23.8%*
Felt health care provided was inadequate	21.8%*
Could not afford direct cost of care/service	19.2%*
Unable to arrange transportation	18.0%*
Difficulty getting traditional care	14.9%*

38.9% of Elders use traditional care, but 37.9% said they have encountered one or more barriers to receiving traditional care. Of the latter, 47.6% indicated that they do not know enough about this type of health care, and 25.2% said that the fact it is not offered in healthcare facilities creates a barrier to its use. Furthermore, 23.8% do not know how to obtain traditional medicine.

Most adults 55 and older (71.5%) reported that they had no problems accessing healthcare services offered by Health Canada through the NIHB program. Of the 28.5% who did encounter one or more barriers, 62.6% indicated having difficulty obtaining medication through the program.

Next in severity are problems related to travel escorts (30.0%), dental care (29.3%), eye care (22.7%) and transportation services or costs (20.8%).

**Table 73: Proportion of Elders having encountered various difficulties among Elders who reported having difficulties in accessing NIHB services**

Services for which difficulties were encountered	% of Elders
Access to medication	62.6%
Travel escort	30.0%*
Dental care	29.3%
Eye care	22.7%*
Transportation services or costs	20.8%*

We note that 29.3% of Elders who had problems accessing NIHB services encountered difficulties in these care. Furthermore, 35.2% said they had not received any dental care in the 5 years preceding the survey.

In general, the dental care required by adults 55 and older includes maintenance (35.4%), prosthodontics (33.0%) and fillings or restoration (12.2%).

## 5.4 Lifestyle

### 5.4.1 Nutrition

Elders feel good about their diet in general; 54.9% feel their diet is always or almost always balanced. 36.0% report that their diet is sometimes balanced and nutritious, while only 9.1% say their diet is rarely or never balanced. Adults 55 and older eat less junk food than people in other age groups. On the other hand, they are big coffee and tea drinkers; over 78.8% drink one or more cups per day.

#### 5.4.1.1 Consumption of junk food

Soft drinks, candy and sweets obtain the highest junk food consumption proportions among Elders who eat junk food at frequencies ranging from a few times a week to several times a day (41.4% and 47.9% respectively). Moreover, 28.9% of Elders said they eat French fries, chips, pretzels etc. a few times a week or more, while 18.1% eat fast food a few times a week or more.

#### 5.4.1.2 Consumption of traditional food

When asked how often they eat traditional food, most Elders answered that they had done so a few times during the 12 months preceding the survey. The main traditional food eaten with this frequency were berries or other wild fruits (61.3%), freshwater fish (58.7%), large game (55.3%), bannock (52.4%), small game (48.9%) and game birds (47.0%). Moreover, 96.3% said they never eat sea-based animals and 75.7% said they never eat corn soup. Other water-based food and saltwater fish are also less popular. Finally, more than half of Elders (55.5%) sometimes share traditional food.

#### 5.4.1.3 Meat and fish preparation methods

Elders prefer most of the time to steam or oven-cook (79.6%) or boil (71.7%) their meat and fish. 69.1% use margarine, while 62.5% use vegetable oil.

Shortening (Crisco or lard) and butter are used less often; in proportions of 40.2% and 55.8% respectively of Elders use them often or sometimes. As for the use of animal fat (goose, seal, etc.) and cooking spray (PAM), most Elders never use them: 78.0% never use animal fat and 68.8% never use vegetable cooking spray.

Consumption of smoked, dried or raw meat and fish is low. More than 93.5% of Elders never eat raw meat or fish, 76.1% never eat dried meat or fish and 63.2% never eat smoked meat or fish.

#### 5.4.2 Physical activities

The types of physical activity practised by most adults 55 and older are closely linked to their traditional way of life. Indeed, with the exception of bowling (11.7%) and swimming (11.6%), activities such as competitive sports, golf, ice skating, dancing, weight training, etc., are almost not practised by the vast majority of Elders. They spend, on average, 2.4 hours a week in activities that raise their heart and breathing rates.

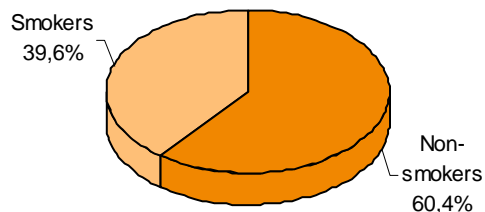
Walking is the most popular activity, with a proportion of 85.2%. Next come berry and other food gathering (40.3%), fishing (38.4%) and hunting and trapping (36.1%). Activities such as hiking, canoeing, cycling and snowshoeing are also practised, but in a lesser proportion. We find that the physical activities embraced by Elders are mostly outdoor activities, which is probably due, once again, to their traditional lifestyle.

#### 5.4.3 Lifestyle habits

##### 5.4.3.1 Tobacco

There are fewer smokers in the 55 and older age group than in other age groups. But they smoke more than people in the other age groups. Of the 39.6% of Elders who smoke, 89.8% smoke every day and 30.9% smoke an average of 10 to 14 cigarettes a day. Moreover, 39.0% of smokers have never tried to quit and 38.8% have tried once or twice. Smokers and ex-smokers alike started smoking around the age of 17.

Graph 174: Tobacco use among Elders



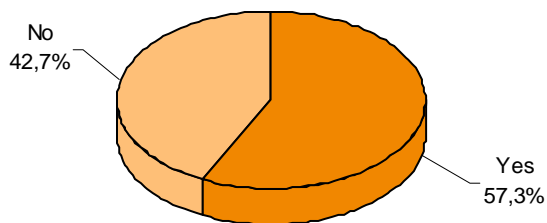
45.6% of Elders reported that their homes are not smoke-free. This might be among the factors affecting the frequency and severity of certain chronic illnesses.

Among non-smokers, 50.7% are ex-smokers who used to smoke every day. The main reasons cited for quitting are adopting a healthier lifestyle (55.1%), health reasons (48.5%), doctor's orders (22.7%) and respect for loved ones (17.8%). No particular means was used to quit smoking, but 86.0% of ex-smokers said they quit cold turkey.

#### 5.4.3.2 Alcohol and drug use

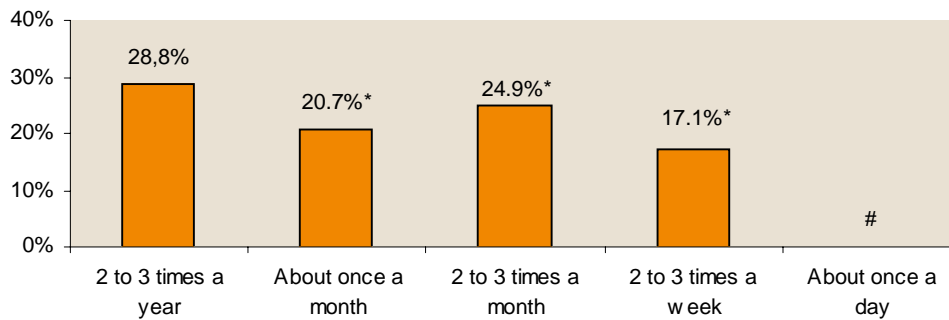
More than half of all Elders (57.3%) reported that they consumed alcohol during the 12 months preceding the survey.

Graph 175: Proportion of Elders who reported they used alcohol (12 months preceding survey)



Among Elders who used alcohol, 28.8% reported drinking only 2 or 3 times during the year, 20.7% once a month, 24.9% 2 or 3 times a month and 17.1% 2 or 3 times a week. Over 40.8% of Elders who drank said they never consumed more than 5 glasses of alcohol on a single occasion.

**Graph 176: Frequency of alcohol consumption by Elders among Elders who reported drinking alcohol (12 months preceding survey)**



17.1% of Elders who drank alcohol in the 12 months preceding the survey said that they consume 5 or more glasses of alcohol on a single occasion 2 or 3 times a week. Most of those who drank (i.e., 90.1%) said they have never been treated for alcohol abuse.

As for drug consumption, we estimate that 17.6% of adults 55 or older take drugs. However, 97.6% of them have never been treated for drug abuse and 98.3% have never been treated for solvent abuse.

#### 5.4.3.3 Sexual health

One third of adults 55 or older said that they are sexually active. Over 40.6% of this age group reported having had sexual relations in the 12 months preceding the survey. Among them, 98.6% had one or two partners. Although the survey questionnaire combined having one or two partners into a single category, our observations lead us to conclude that most Elders have one partner, not two. 78.6% of them never use condoms and 81.4% of these cited as their main reason for not using condoms the fact that they have regular partners. Finally, 82.3% of Elders have never undergone HIV testing.

#### 5.4.4 Preventive health care

With regard to preventive health care in the 12 months preceding the survey, the majority of people aged 55 and over had medical tests and examinations for cholesterol, vision, blood pressure or blood sugar level. The only exception is for rectal examination, which 45.7% of the men underwent. We also note that one third of Elders (34.1%) did not have a complete physical check-up in the 12 months preceding the survey.

**Table 74: Proportion of Elders who underwent various prevention tests (12 months preceding survey)**

Prevention tests	% of Elders
Blood pressure test	87.9%
Blood sugar test	83.3%
Cholesterol test	80.7%
Eye examination	77.3%
Complete physical check-up	65.9%
Rectal examination (men only)	45.7%

Concerning women, 34.2% of them have never performed breast self-examinations. Among those who performed breast self-examinations, 32.6% did so once a month. 40.9% of women reported that their last mammography was between 1 and 3 years before the survey, and 14.2% have never had one. 14.2% had a mammography less than 6 months before the survey and 13.7% did so between 6 months and 1 year before the survey. Finally, 29.8% said they had their last cytology test (vaginal smear test) between 1 and 3 years before the survey, versus 26.2% who had their last one 5 years or more before the survey.

#### 5.4.5 Residential schools

One quarter of the Elder population attended a residential school. Of these, 42.8% believe their experience had a negative impact on their health. The main negative impacts cited by these people are physical and verbal abuse (68.1%), harsh discipline (66.3%) and being isolated from their families (61.5%).

Loss of language (56.8%) and cultural identity (55.9%) are also widely felt negative impacts. 55.8% of former residents experienced physical abuse and 32.0% experienced sexual abuse. More than half of the Elders who attended a residential school said they witnessed these kinds of abuse.

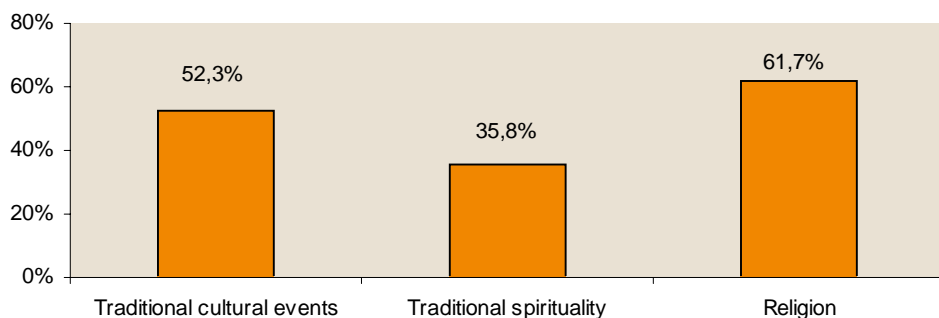
The age at which Elders began attending residential school varies a great deal, while the average age at the end is 14 to 15). Unlike persons in the other age groups, most adults 55 and older said their parents and grandparents did not attend residential schools, since residential schools did not exist at that time.

#### 5.4.6 Personal and social well-being

The personal well-being of adults 55 and older was evaluated using questions related to life balance and self-determination, as well as racism and suicide. We also analysed the various support networks that Elders have access to and their perceptions of traditional culture.

In this regard, we find that over half of all Elders confirmed that traditional events are very important to them. But traditional spirituality is less important to them. Religion obtained a significantly higher percentage; 61.7% of Elders said it was very important to them, while only 35.8% said that traditional spirituality was very important to them.

**Graph 177: Proportion of Elders who consider traditional cultural events, traditional spirituality and religion to be very important**



##### 5.4.6.1 Balance and self-determination

47.5% of Elders reported being in very good balance and 47.6% reported being moderately in balance. Indeed, Elders reported being in emotional, mental and spiritual balance always or almost always in proportions generally exceeding 80.0%. Regarding physical balance, there was a slight drop with a proportion of 76.5% of Elders who said they are always or almost always in physical balance, which could be related to a certain loss of autonomy.

The level of self-determination of adults 55 and older, i.e., the degree to which they feel they are free and in control over their life, is also positive overall. Over 80.0% of them said they strongly agree or agree with the fact that they can solve the problems they have, that no one pushes them around in life, that they have control over the things that happen to them, and that they can do just about anything they really set their minds to. Finally, 78.4% indicated that what happens to them in the future mostly depends on them.



#### 5.4.6.2 Social support

Most adults 55 and older turn to friends or family members as support providers; 46.6% said they have 2 or 3 support providers from these groups. Among them, 26.7% have 2 or 3 support providers chosen from among general healthcare practitioners (traditional healer, family doctor, community health representative and nurse), while over 77.8% indicated that they do not have any support providers who are mental health professionals or social workers (psychiatrist, psychologist, counsellor, social worker and telephone help line).

In the 12 months preceding the survey, Elders spoke more often about their emotional and mental health to immediate family members (51.8%) and friends (43.8%), who are followed by other family members (39.4%), family doctors (37.4%) and nurses (30.7%). Over 80.0% of Elders did not speak about their emotional and mental health to community health representatives, psychologists, psychiatrists, social workers, counsellors or traditional healers and have never used a telephone help line.

61.6% of Elders reported that, from among the types of support providers, they always have someone to show them love and affection, and 58.4% said they always have someone to take them to the doctor. About half said they always have someone they can count on to listen to them when they need to talk, someone who is there when they need help, someone to have a good time with, someone to do something enjoyable with, or someone to confide in.

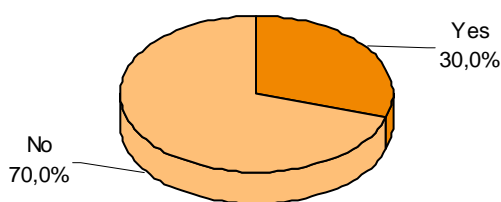
#### 5.4.6.3 Racism and suicide

In the 12 months preceding the survey, 14.2% of adults 55 and older said they had experienced instances of racism. Of these, 30.6% said the experience had some effect on their self-esteem.

Regarding suicide, 13.2% of Elders said they have thought about committing suicide at some point in their life. Furthermore, 6.2% said they have tried to commit suicide at some point in their life. (The results for suicide attempts cover only failed attempts because the survey questionnaire could not take account of successful attempts.)

Finally, 30.0% of adults 55 and older said they had felt depressed for a period of two weeks or longer in the 12 months preceding the survey.

**Graph 178: Proportion of Elders who felt depressed for a period of two weeks or longer (12 months preceding survey)**



#### 5.4.7 Community well-being and traditional culture

Community well-being and traditional culture were evaluated using a series of questions about the progress that adults 55 and older felt had been made in certain areas related to these two themes.

Of all the types of community issues dealt with by the survey, adults 55 and older seemed particularly dissatisfied with progress regarding the reduction of alcohol and drug consumption. 70.2% felt that no progress had been made in reducing alcohol and drug abuse in the 12 months preceding the survey. More than half of Elders also felt that no progress had been made regarding the renewal of First Nations spirituality (54.8%), traditional approaches to healing (54.6%), police services (54.6%) and renewed relationship with the land (51.7%). As for traditional ceremonial activity, 53.7% felt some progress had been made in this area in their community.

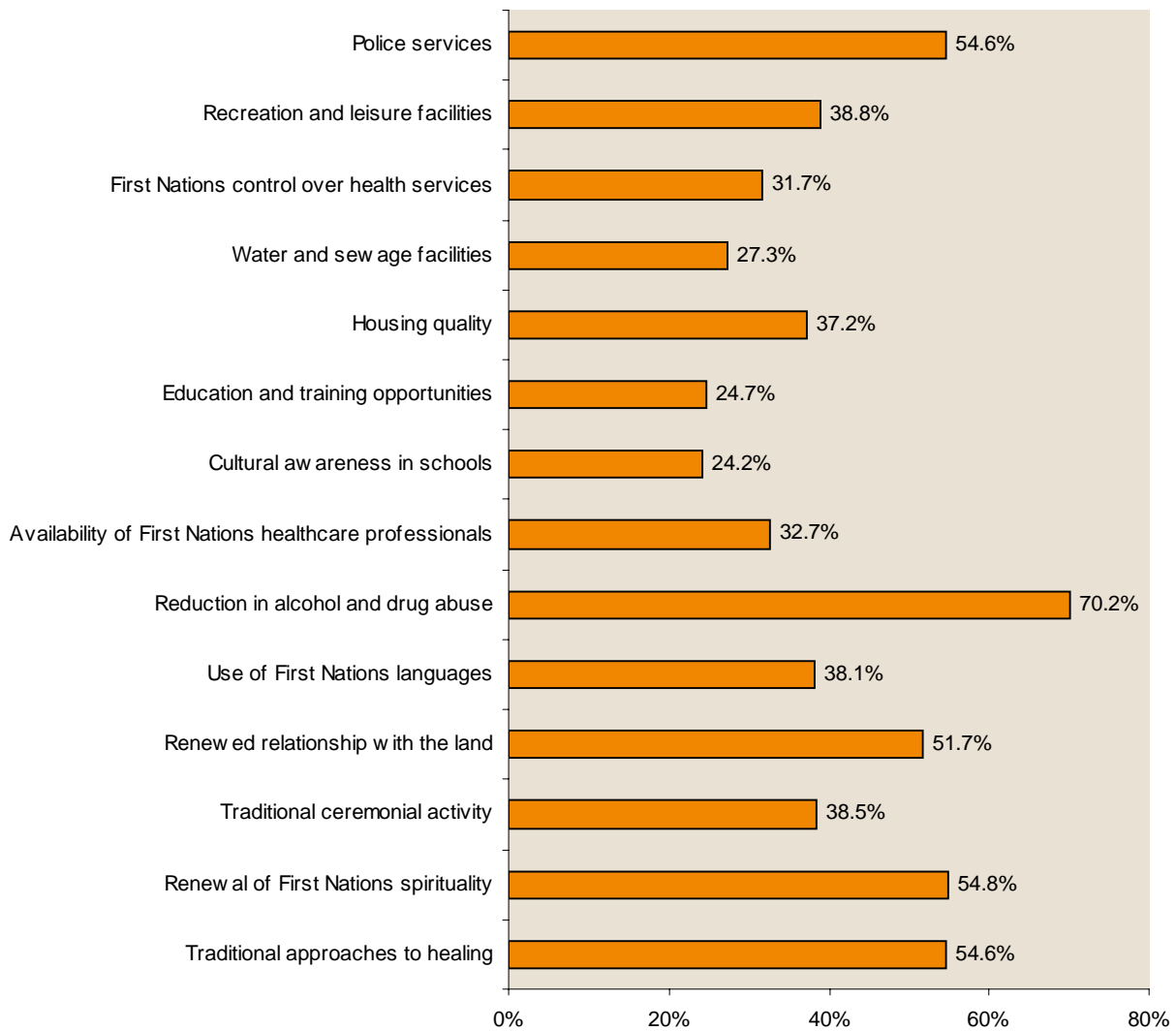
The types of progress that Elders were most satisfied with are found in education and improvements in the quality of their immediate environment (housing, water facilities, etc.). In looking at education, we note that over 75.8% of Elders said they felt that good or some progress had been made regarding cultural awareness in schools, while 75.3% and 61.9% respectively felt that good or some progress had been made regarding access to education and training opportunities, and the use of First Nations languages.

Improvements to water and sewage systems also posted a rate of 72.8%. Moreover, 62.8% of Elders felt that good or some progress had been made in the quality of housing and 50.5% expressed the same opinion concerning recreation and sports facilities.

Finally, Elders also saw progress in the area of health. 68.4% felt that good or some progress had been made concerning First Nations control of health care services, while 56.8% felt the same way regarding availability of First Nations healthcare professionals.

Graph 179 provides an overview of the types of community progress considered by Elders to have been least significant in the 12 months preceding the survey. This graph gives the percentages of Elders who said they felt no progress had been made in the various areas.

**Graph 179: Proportion of Elders who feel that no community progress has been made in certain areas (12 months preceding survey)**



## 5.5 Conclusion: Elders' health (55 and older)

Nearly two thirds of all adults 55 and older live in zone 1, thus closer to urban centres, while half of them live in large communities. Half of them understand one or more First Nations languages and more than one third use one regularly. In general, the annual income of First Nations Elders does not exceed \$19,000.

84.9% of Elders have health problems, and only 21.5% have normal weights. This trend is undoubtedly a contributing factor to health problems, in particular cardiovascular diseases, which affect nearly half of all Elders. Furthermore, Elders smoke less than individuals in other age groups. However, those who smoke do so more than smokers in other age groups. Moreover, Elders eat less junk food than individuals in the other age groups, but they drink more tea and coffee.

Finally, as a rule, Elders feel they are in very good or moderate emotional, mental and spiritual balance. We note, however, a slight decline in their perceptions of physical balance, which may be related to a certain loss of autonomy associated with ageing.



## Section 6: Recommendations



## Recommendations

Overall, the Report on the Health of First Nations Living on Community outlines the social and health conditions that prevail in the First Nations of the Quebec Region. This section presents the recommendations based on a number of highlights from the First Nations Regional Longitudinal Health Survey 2002: Quebec Region. It is important to note that the recommendations are not ranked in order of priority; they are all priorities for the improvement of the health and well-being of First Nations.

### 6.1 General recommendations:

The extent of the problems affecting the general state of health, life habits that do not favour the health and well-being, poverty and social exclusion, the lack of community resources, and the social problems, all reflect the **necessity to act upstream to improve the living conditions of First Nations**.

In order to pursue an in-depth reflection on the radical changes required in health and social services, **additional financial resources** and the **mobilization of all players**, at the community, regional and national levels, are essential.

The improvement of the health and well-being of First Nations will be possible if the various prevention, health promotion, health service and care programs are **developed, taken over and managed by the First Nations themselves**.

Finally, First Nations communities are the most competent to **adapt the various tools and programs based on their needs and cultural reality**.

### 6.2 Demographic profile

#### Living conditions:


Considering that children living in more remote communities grow up in conditions that are more difficult and less favourable to health (ex.: non drinkable running water, shortage of health professionals, etc.):

- *Measures should be implemented, maintained and reinforced in order to ensure that these children grow in better living conditions. This requires improving the quality and accessibility of services, supported by adequate resources.*

#### Poverty:

Considering that poverty is a determinant of health and well-being; that one out of five First Nations members lives under the poverty line, and that slightly less than half of the adults are unemployed in first Nations communities:

- *Community, regional and national strategies to combat poverty and social exclusion should be implemented, maintained and reinforced in order to break the vicious cycle of poverty;*
- *Additional resources must be invested in order to foster employment opportunities and to offer appropriate training in the communities;*
- *Community, regional and national skills development initiatives should also be implemented, maintained or reinforced.*



Considering that a high percentage of mothers have little education (50.6% of them did not complete their high school studies), have a low income (80.9% of women receive an income from the government) and that their children's overall state of health is less favourable:

- *Better training opportunities and better paid and sustained jobs will have to be offered to women and mothers in the communities;*
- *Community support during their pregnancy and after the birth of their child should be available for these women.*

#### **Education:**

Considering that one child out of ten has repeated a grade, that boys have more problems in school than girls, and that education is a determinant of health:

- *Additional financial resource must be invested in order to have resources to support these children and their parents. Services should also be better adapted to the needs of the communities and more qualified to supervise the children.*

Considering that almost half of the adults have not completed their high school studies and that the schooling level is a major determinant of health and well-being:

- *Vocational and general training should be implemented, maintained or reinforced at the community and regional levels in order for adults to have an opportunity to develop their skills, increase their income, improve their living conditions and increase their sense of control over their life;*
- *In order to ensure the success of these training opportunities, they should be offered directly in the communities. This requires additional and adequate financial resources.*

#### **Housing:**

Considering that nearly two adults out of five have noticed the presence of mould in their dwelling and that it can have adverse effects on health:

- *Community initiatives, supported by regional and national authorities, must be implemented, maintained and reinforced in order to clean up the living environments;*
- *Information sessions on the impacts of mould on health should be implemented, maintained and reinforced at the community level.*

### **6.3 State of health**

Considering the increase in the prevalence of chronic diseases, such as diabetes (affects 14.5% of adults), and respiratory problems (affect 12.1% of 30-39 year-olds, 23.0% of 40-49 year-olds and 46.7% of 50-59 year-olds):

- *Chronic disease prevention and health promotion strategies must be implemented, maintained and reinforced, as well as adequately financed.*

#### **Obesity:**

Considering the lack of physical activities and the high prevalence of overweight and obesity among First Nations children (12.2% and 40.1% respectively);

Considering that nearly half of the adolescents and over two thirds of the adults are overweight or obese;

And, considering that overweight and obesity are risk factors of a certain chronic diseases such as diabetes and cardiovascular diseases:

- *Community, regional and national initiatives for the promotion of physical activity and healthy eating must be implemented, maintained and reinforced;*



- Obesity prevention and healthy lifestyle habit measures should be implemented, maintained or reinforced at the community level. It is preferable to adopt a global approach and involve all the players from the community (school network, daycare centres, health centres, recreation centres, Band Councils, etc.);
- Communities should have access to additional resources in order to organize educational activities on healthy eating with adolescents and their parents, in order to provide healthy meals at school and in order to promote the benefits of physical activities;
- It is also advisable to evaluate the access to healthy food cost- and availability-wise and to eliminate these socioeconomic obstacles.

Considering that boys are more affected by overweight and obesity than girls (26.1% of boys compared to 15.9% of girls):

- Obesity prevention and healthy lifestyle habit promotion messages should be adapted in order to reach the target clientele more efficiently based on the gender.

Considering the high proportion of Elders who are overweight (41.4%) or obese (21.5%):

- *Adapted and supervised physical activities as well as workshops on healthy eating should be implemented, maintained and reinforced at the community level in order to allow Elders to adopt healthier lifestyle habits.*

#### **Physical injuries:**

Considering the high frequency of physical injuries that result from alcohol and/or drug use (17.9% of injuries):

- *Community injury prevention strategies, supported by regional and national authorities, should include a component on the risks associated to using alcohol and/or drugs.*

#### **Non-prescription drug use:**

Considering the increase in the use of non-prescription drugs and the fact that woman are the greatest users:

- *Culturally-adapted campaigns should be implemented, maintained and reinforced in order to inform people on a responsible and safe use of drugs.*

### **6.4 Lifestyle habits**

#### **Physical activities:**

Considering the relatively low level of physical activity for several adolescents in the communities (35.8% of boys and 43.4% of girls participate in physical activities 2 to 3 times a week):

- *Projects for the promotion of physical activity should accompany the building of sports facilities;*
- *School programs should include more sports and extracurricular activities;*

In order to do so, available financial resources must be improved.

#### **Nutrition:**

Considering the high consumption of junk food among adults, particularly among young adults (18-34 year-olds), and the low level of physical activity:

- Community, regional and national initiatives should be implemented, maintained and reinforced in order for healthy and active lifestyle habits to be the easiest and trendiest one to adopt.



## Smoking:

Considering the significant proportion of pregnant women who have smoked during their pregnancy (38.0% smoked during their whole pregnancy) or who have been exposed to second-hand smoke during their pregnancy (59.0% of parents or guardians interviewed indicated that another member of the household smoked during the mother's pregnancy):

- *Community initiatives, supported by regional and national authorities, for tobacco prevention and control, as well as healthy lifestyle habit promotion initiatives should be implemented, maintained and reinforced.*

Considering that more than half of the adults use tobacco and that the majority of them smoke every day (79.4%):

- *Community, regional and national initiatives should be implemented, maintained and reinforced;*
- *The First Nations & Inuit Tobacco Control Strategy must be maintained and reinforced in order to ensure that tobacco control is a priority for all;*
- *Additional and adequate financial resources must be invested in order to allow communities to implement initiatives themselves that meet their needs.*

Considering that 48.0% of households do not provide a smoke-free environment to their residents:

- *Educational initiatives on the benefits of smoke-free environments and the health risks of smoking environments should be implemented, maintained and reinforced at the community, regional and national levels;*
- *Additional and adequate financial resources will have to be invested to develop these initiatives.*

## Alcohol and drug use and gambling:

Considering that one third of 12 to 14 year-old adolescents and three quarters of 15 to 17 year-old adolescents have used alcohol and over two adolescents out of five have used drugs or volatile substances in the 12 months preceding the survey:

- *Community, regional and national initiatives promoting sobriety and/or responsible use should be implemented among youth;*
- *Discussion groups and other awareness methods aimed at parents and workers with youth should be implemented, maintained or reinforced in order for the latter to be able to support the youth and participate in the prevention of abuse;*
- *Community initiatives to supervise the youth (sports and cultural activities, training, etc.) should be implemented, maintained and reinforced in order for the youth to develop their social skills, self-esteem, self-confidence, etc.*

Considering that nearly one third of pregnant women have used alcohol during their pregnancy and there appears to be a link between the women's low schooling level and the lack of knowledge on the effects of alcohol during pregnancy:

- *Health education strategies should be designed for this specific population. It would be advisable to have action-oriented messages that are non blaming and disseminated directly in pregnant women's life environments;*
- *A longer and supervised personalized pregnancy follow-up would allow mothers to have access to relevant information on maternal health;*



- *Healthy lifestyle habit prevention and promotion strategies must be implemented at the community level, thus allowing reaching pregnant women directly in their life environment. Also, interactive workshops on the Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Effects (FAE) should be implemented, maintained and reinforced in all the communities;*
- *Efficient communication strategies should be implemented, maintained and reinforced in order to reach women who are less educated and/or illiterate and isolated women.*

Considering that more than one adult out of five has 5 alcoholic drinks or more per day and that a significant proportion of adults (66.4%) have observed no progress with regards to the reduction of alcohol and drug abuse in their community:

- *The National Native Alcohol and Drug Abuse Program (NNADAP) must be maintained and funded in order to meet the specific needs of communities;*
- *Additional human resources should be trained not only for intervention with people experiencing crisis, but also for alcohol, drug and other addictions prevention; Adequate funding is necessary in order to increase the number of workers, prevent staff turnover among NNADAP workers and ensure continued education for them;*
- *The current efforts must be maintained and reinforced at the community, regional and national levels. This requires additional and adequate funding as well as the involvement of all the players in the communities.*

Considering that one young adult (18 to 34 year old) out of ten has participated in gambling activities in which he/she has lost more money than he/she could afford; that there are no measure to treat gambling specifically in First Nations Treatment Centres of the Quebec Region, and that Health Canada does not fund treatment for addiction for gamblers:

- *Measures and services should be implemented, maintained and reinforced at the community level. In order to do so, additional and adequate financial resources are required;*
- *Prevention strategies should also reach people at risk;*
- *Training for workers on gambling prevention must be developed and funded adequately.*

### **Personal and social well-being:**

Considering the high number of adolescents who have had suicidal thoughts at one point in their life (46.5% of girls and 23.6% of boys) and/or have felt depressed for more than two weeks in the 12 months preceding the survey (39.3% of adolescents):


- *Community, regional and national initiatives should enable all these adolescents to get help in case of difficulty;*
- *Prevention, intervention, follow-up (psychological or psychosocial), postvention and mourning resolution actions should be implemented, maintained and reinforced based on community needs;*

In order to do so, additional financial resources must be invested.

Considering that the level of self-determination and physical, emotional, mental and spiritual balance is lower among adolescents in semi-isolated or isolated communities (zones 3 and 4) than among adolescents in urban or semi-urban settings (zones 1 and 2):

- *Programs developed by First Nations on empowerment, self-esteem and self-knowing should be implemented, maintained or reinforced in more isolated communities in order for their youth to fulfill themselves;*

Additional resources must be invested to support these workshops.



Considering that adolescents living in semi-isolated and isolated zones (zones 3 and 4) feel more lonely and less loved than adolescents in urban and semi-urban zones (zones 1 and 2):

- *Community, regional and national initiatives should be implemented and maintained to reinforce the family and social fabric as well as the youth's sense of belonging and self-esteem.*

Considering that more than one third of First Nations adults has had suicidal thoughts and that nearly one adult out of five has attempted to commit suicide:

- *Community, regional and national initiatives covering the complete range of services should be provided to prevent suicide. These initiatives must be maintained and funded more based on the community needs;*
- *Efficient suicide prevention requires accessibility to a complete range of services. These services should be developed and delivered by First Nations, should meet the specific needs of communities and should be developed based on a holistic approach.*

Considering that more than half of the adults have a very low level of control over their life (self-determination index):

- *Community, regional and national initiatives aiming the individuals' empowerment should be implemented, maintained and reinforced in order to encourage individuals to play a more active part in their life, the life of their family and in their community.*

Considering that more than one quarter of the adults have indicated they had experienced racism, and that a majority of them consider that it has had a negative impact on their self-esteem:

- *Regional and national anti-racism against Aboriginals initiatives should be implemented, maintained and reinforced in order to reduce the social exclusion and prejudice faced by First Nations members.*

#### **Sexual health:**

Considering that a significant proportion of adolescents are sexually active (42.9% were active in the 12 months preceding the survey):

- *Community, regional and national sexual health promotion initiatives must be implemented, maintained and reinforced in all the communities.*

#### **Residential schools:**

Considering that one quarter of the Elders has attended a residential school during their childhood and/or adolescence, and that nearly half of them (42.8%) deem that this experience has had a negative impact on their health (as do 36.3% of adults who have attended a residential school):

- *The Aboriginal Healing Foundation initiatives must be maintained and must reach all the communities where former boarders live.*

#### **Health service organization:**

Considering that nearly half of the people who require home care do not receive them:

- *Measures should be implemented, maintained and reinforced in order to improve the service delivery, to recruit and train human resources and to increase the funding of programs related to home care.*

Considering the various obstacles mentioned by adults in accessing health services:

- *Resource must be invested in order for all First Nations members to have fair access to services notwithstanding the community size and/or remoteness.*



Considering the decrease in the number of people who have undergone one or more screening tests since the 1997 survey (mammography, HIV, diabetes):

- *Community, regional and national strategies must be implemented in order to promote the benefits of undergoing screening tests and to ensure these tests remain accessible to everyone, notwithstanding the community size and/or remoteness. This would help prevent diseases and/or detect them as early as possible in order to treat them more efficiently and without any delay.*

Considering that more than half of the Elders deem they do not have the same level of access to health services than the general Canadian population:

- Financial and human resource must ensure a complete service delivery in all the First Nations communities.

### **Transportation safety:**

Considering the high number of adults who do not wear any life jacket when they are out on the water (34.1%), or who do not wear a helmet when riding a snowmobile (28.1% rarely wear one) or an ATV (two thirds wear one sometimes):

- *Adapted awareness campaigns should be developed in order to increase the use of these two safety equipments. A community could also decide to implement a community policy for helmets and life jackets*

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