EXECUTIVE SUMMARY

In 1996, the Assembly of First Nations Chiefs Committee on Health (CCOH) mandated that a First Nations health survey be implemented every four years across Canada. This resulted in the creation of the First Nations and Inuit Regional Longitudinal Health Survey (RHS). Considered an important stepping-stone in First Nations control over research, it is often referred to as the "First Nations Survey of Choice." The Regional Health Survey (RHS) is designed to be a longitudinal study and produce consistent data for First Nations across the country. Since the RHS data will be collected and interpreted by First Nations, the interpretations will be well-informed by First Nations culture and settings, thus eliminating risks of misinterpretations. In so doing, the RHS will serve as a useful and realistic model for culturally appropriate, community-based research. In choosing a longitudinal study the objective is to develop baseline data during the initial phases. The baseline data then sets the foundation against which comparisons can be made in later years.

The issue of First Nations ownership over information was at the forefront since the inception of the RHS, leading to the formulation of the First Nations principles of Ownership, Control, Access and Possession (OCAP). As such, the RHS is the first national survey to respect the First Nations principles of Ownership, Control, Access and Possession (OCAP). This report provides a written summary of some of the findings of the 2003 Ontario First Nations Regional Health Survey. The database will establish baseline data against which further data collection will be compared to.

Three national survey instruments were developed for 2002-03 addressing a comprehensive range of health status, wellness and health determinants measures. Chiefs of Ontario participated in the design and approval of the survey in a partnership role. The questions were refined over two years and validated scientifically for and by First Nations. They provide some comparability with content in Canadian surveys (e.g. CCHS, NLSCY) while addressing First Nations priorities within a cultural and holistic framework. RHS data collection was conducted between August 2002 and November 2003 in 29 First Nations communities across Ontario. A total of 1701 surveys were administered. Three age-specific questionnaires were completed by 680 adults, 18 years of age and over, 413 adolescents, 12 to 17 years of age and 608 children, 0 to 11 years of age (the parent or guardian responded).

The RHS mandate is to achieve the "collective empowerment of Aboriginal individuals and communities in matters of health". In so doing, the RHS is working towards developing an effective and workable cultural framework that will provide the means for appropriately interpreting the information collected and presenting it back to the communities in ways that are usable and that engender "collective empowerment". This collective empowerment would ideally lead to community-based approaches to improve and strengthen Aboriginal

health and wellness. An additional task that is important to consider, is that of making such a framework applicable to the present way in which data was collected. This is important in order to ensure that data collected is useful to the presentation of information, knowledge of health and well-being while remaining meaningful to Aboriginal peoples and communities.

In addition, in the context of Aboriginal issues, the key to understanding the future is to have a deep and detailed appreciation of the past. However, providing a singular interpretation of history is a challenging task when confronted by the complexity of the relationship between Aboriginal Peoples and Federal government relations and the negative impact it has had on the health and wellness of Aboriginal people. A detailed overview of the historical context is provided in Chapter 2.

To provide a clear focus for interpretation of data, health related topics could be thematically grouped according to health indicators. This would in turn provide an approach for the interpretation of data. The interpretation of findings for the Ontario Regional Health Survey will be presented within a medicine wheel framework, using the following four quadrants of discussion: Vision, Relationship, Reason and Action.

VISION: Within an Aboriginal cultural paradigm, vision is considered the most fundamental of principles. Visioning First Nations' well-being involves examining the complete picture of health including, physical, mental, emotional and spiritual health issues. Research shows that Aboriginal people suffer from poor health. They do not access mainstream (Non –Aboriginal) social systems, such as health care services (i.e. hospitals and community health programs and services). It is impossible to cover all of the health conditions within the survey in this report so Aboriginal Research Institute (ARI) have limited our analysis to address the most common **Health Conditions and Chronic Diseases** which include Heart Disease, Hypertension, Arthritis/Rheumatism, Asthma, Cancer. In addition, the report looks extensively at **Diabetes**, the 5th leading cause of death amongst the Aboriginal population as well as contributing to secondary health complications also leading to death. The medical category of **Injury** and poisoning includes all causes of death not attributable to disease (Manitoba Aboriginal and Northern Affairs, 2000). In fact, for First Nations people between the ages of one and 45 years, injury and poisoning are by far the main causes of death. The injury and poisoning death rate for First Nations nationally is 3.8 times the rate for non-Aboriginal Canadians. Finally, the last category within this paradigm to be examined in detail is **Disability** in adults. It is important to understand the impact of disability on adults because many adults with disabilities are not fully included in all aspects of society.

RELATIONSHIP: Refers to the experiences that one encounters as a result of relationships built over time and examines how we relate to people. The key categories within this paradigm include **Mental Health, Personal Wellness and Support Among First Nations Adults, Youth and Children.** In addition, **Suicidal Thoughts and**

Attempts data were alarming and warrant attention. The experienced instances of **Racism** and the resulting impact on self esteem are examined. **Emotional Wellness** was also examined to ascertain if there was any link to depression or suicide attempts and the data report no correlation. However, it is important to note that The **Availability of Personal Support** is an important factor to consider, specifically the availability of mental support which is reported as low availability for Youth and Adults. Another critically important category that is examined is the **Residential School Impacts.** Residential schools were often located in isolated areas and the children were allowed little or no contact with their families and communities. In addition, there was a regime of strict discipline and constant surveillance over every aspect of their lives including cultural expressions through language, dress, food, or beliefs. Suppression of culture was a mandate of the schools. Finally, the importance of **Language and Culture** cannot be overlooked. Language embodies all values, attitudes, beliefs and truths and consequently has historically played a significant role in the lives of Aboriginal Peoples.

REASON: Also referred to as learned knowledge. It is where we become reflective, meditative and self-evaluate. It is in this direction, that the broader determinants of health are examined, such as demographics, income, education, family structure, housing and living conditions as well as health care access. **Demographics, Housing and Living Conditions** are important determinants to consider when reviewing the status of Aboriginal health. Equally important are the level of **Income** and **Education** attained, both of which contribute to overall health. **Family Structure** data indicates that the majority of Youth are cared for by immediate family followed by extended family. Finally, **Access to Health Care** is an important category as it reports on selected indicators of access to preventive primary health care measures, including respondents' rating of their access to health care in comparison to other Canadians, access to screening and preventive measures, barriers to accessing health care, and access to Non-Insured Health Benefits (NIHB).

ACTION: Also referred to as movement and represents strength. This direction explores what has been done about previously identified barriers and how to nurture us as Aboriginal people. **Non-Traditional Tobacco Use** will describe some of the ways in how smokers and non-smokers are living their lives with their families and in their communities in relation to non-traditional tobacco use. Specifically, tobacco use during pregnancy, initiation, cessation, current and former use as well as consumption amounts are reviewed. The proportion of **Alcohol Use** by various demographic variables and community size is examined and of note is a consistent decrease in drinking with age. Frequency and type of **Drug Use** is also examined. The number of obese and morbidly obese respondents in all age categories is a concern for health issues as indicated in the **Nutrition, Physical Activity** and **Body Mass Index** data. Of particular concern is the difference between perception of good health and the Body mass Index results.

CHAPTER 1

INTRODUCTION AND METHODOLOGY

CHAPTER 1: INTRODUCTION AND METHODOLOGY

The Ontario Longitudinal RHS is designed to compare the health and wellness of First Nation to First Nation over time. The findings from the 2002-03 RHS provide a baseline of information. Ontario First Nations can now compare changes with the same respondents over time – each time you repeat the study. Although the findings of the 2002-03 RHS provide valuable information to track changes over time, the sample is limited for making comparisons to Canadian societal changes.

While there will be no restrictions to adding respondents in the next RHS, that will mean that Ontario First Nations will also be establishing a new baseline. The National RHS provides comparisons with Canadian society.

1.1. PURPOSE OF THE REPORT

Significant gaps persist in the amount and quality of information available on First Nations and Inuit health and health systems. Current major sources of data on First Nations health are the census, Vital Statistics, disease registries, health care insurance claims, and health surveys. These data sources are fragmented and often must be combined to obtain a portrait of health services accessed in and outside the First Nation community.

The Regional Health Survey (RHS) is designed to be a longitudinal study and produce consistent data for First Nations across the country. Since the RHS data will be collected and interpreted by First Nations, the interpretations will be well-informed by First Nations culture and settings, thus eliminating risks of misinterpretations. In so doing, the RHS will serve as a useful and realistic model for culturally appropriate, community-based research. In choosing a longitudinal study the objective is to develop baseline data during the initial

phases. The baseline data then sets the foundation against which comparisons can be made in later years.

This report provides a written summary of some of the findings from the snapshot provided through the 2003 Ontario First Nations Regional Health Survey. This snapshot is not designed to provide comparisons to other data sets; rather it is intended to establish baseline data against which further Ontario First Nations RHS data collection will be compared to.

1.2 STRUCTURE AND CONTENT OF THE REPORT

The Ontario First Nations Regional Health Survey provides an account of the background to and purpose of the RHS, a description of the process used by Ontario First Nations in implementing the survey, and an overview of key findings of the process.

The report is structured as follows:

Chapter 1: Introduction – providing an overview of the purpose of the report, the First Nations Regional Longitudinal Health Survey 2002-03; Methodology, and Study Limitations.

Chapter 2: Historical Context and cultural interpretation – a description of the relationship between historical actions and present health conditions, as well as the Aboriginal approach taken with the presentation of findings.

Chapter 3: Findings – have been broken down into four main categories: Physical health, Healing and Wellness, Social-demographic determinants, and health promotion.

Chapter 4: Summary – a summary and recommendations put forward by the Chiefs of Ontario RHS Technical Advisory Committee.

1.3 OVERVIEW OF THE FIRST NATIONS REGIONAL LONGITUDINAL HEALTH SURVEY (RHS) 2002-03

In 1996, the Assembly of First Nations Chiefs Committee on Health (CCOH) mandated that a First Nations health survey be implemented every four years across Canada. This resulted in the creation of the First Nations and Inuit Regional Longitudinal Health Survey (RHS). Considered an important stepping-stone in First Nations control over research, it is often referred to as the "First Nations Survey of Choice."

The issue of First Nations ownership over information was at the forefront since the inception of the RHS, leading to the formulation of the First Nations principles of Ownership, Control, Access and Possession (OCAP). As such, the RHS is the first national

survey to respect the First Nations principles of Ownership, Control, Access and Possession (OCAP). This, in itself, is a reflection of the growing awareness of the importance of information and the inherent right of First Nations to exercise self-determination and governance in the area of research.

The mandate of the First Nations Information Governance Committee (FNIGC), conferred by the CCOH, relates to research and information management. The FNIGC's role is to ensure First Nations accountability, respect and ethics. The Committee defines and upholds the principles of OCAP in the development of the First Nations Health Infrastructure and within various federal initiatives. The FNIGC is composed of First Nations representatives from the ten regions that participated in the 2002-03 RHS. The member-organizations also coordinate and act as data stewards in their respective regions.

Consistent with its mission, the First Nations Centre (FNC) at the National Aboriginal Health Organization (NAHO) was named by the Chiefs Committee on Health of the Assembly of First Nations, as the national coordinator and data steward for the second iteration of the RHS. While the FNC coordinates survey implementation nationally, the Assembly of First Nations coordinates and provides secretariat functions for the FNIGC. The FNIGC, which is advisory to the Chiefs Committee, oversees the survey and, provides overall direction to the FNC.

Ontario First Nations Regional Health Survey 2002-03

RHS 2002/03 – QUESTIONNAIRE THEMES

Three national survey instruments were developed for 2002-03 addressing a comprehensive range of health status, wellness and health determinants measures. Chiefs of Ontario participated in the design and approval of the survey in a partnership role.

The questions were refined over two years and validated scientifically for and by First Nations. They provide some comparability with content in Canadian surveys (e.g. CCHS, NLSCY) while addressing First Nations priorities within a cultural and holistic framework. The following themes specific to each age group were addressed in the survey instrument:

Table 1
Adult (18+ years. Computer-assisted interview. ~44 minutes*)

Demographics	28 Health conditions—duration, treatment, effects	Smoking, alcohol, drugs—use, cessation, treatment
Languages—comprehension, use	Diabetes—type, treatment, effects	HIV/AIDS, STD's and sexuality
Education	Physical injuries	Pregnancy, fertility
Employment	Dental care	Preventative health practices
Income and sources	Disability, limitation	Wellness, supports & mental health
Household— composition, income	Physical activity	Suicidal ideation and attempts

* *Mean time to complete survey, based on surveys uploaded to December 29, 2002.*

Housing—condition, crowding, mold	Food and Nutrition	Residential schools—impacts
Water quality	Home care—use, need	Community wellness
Services (phone, water, smoke detector, internet etc.)	Health services—use, access, NIHB	Culture, spirituality, religion
Height, weight	Traditional medicines, healers	Community development

Table 2

Adolescent **(12-17 years. Computer-assisted self-administered. ~35 minutes*)**

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

Table 3

Child **(0-11 years. Computer-assisted by proxy. ~24 minutes*)**

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

1.4 METHODOLOGY

RHS data collection was conducted between August 2002 and November 2003 in 29 First Nations communities across Ontario. A total of 1701 surveys were administered. Three age-specific questionnaires were completed by:

- 680 adults, 18 years of age and over,
- 413 adolescents, 12 to 17 years of age and
- 608 children, 0 to 11 years of age (the parent or guardian responded).

First Nations reserves and other First Nations communities were selected to represent all regions, sub-regions (e.g. Nations, Tribal Councils) and communities. Only those communities that agreed to participate were surveyed. The Ontario sample represents 2.88% of First Nations children, 4.29% of First Nations adolescents and 1.35% of First Nations adults living in the Ontario First Nations communities that participated in the 2002-03 RHS longitudinal study. Ontario represents 2.1% of the total number of 2002-03 surveys collected in Canada.

Interviews were coordinated by the Chiefs of Ontario Regional Coordinator and administered by trained First Nations interviewers selected by their respective First Nations using laptop computers. Training was provided in sampling, interviewing skills and techniques, handling situations, data collection, uploading data collection and basic computing skills. Chiefs of Ontario employed a Northern Data Supervisor and a Southern Data Supervisor to provide support to the First Nations interviewers. Data were encrypted and uploaded directly from the communities to secure servers. The interviews were conducted August 1 – October 31, 2003. The three questionnaires address a wide range of health and other priorities from a holistic perspective.

The Sample of Individuals

Goss Gilroy and Associates were responsible for providing Chiefs of Ontario with a compiled list of First Nations with on-reserve populations' statistics organized by Provincial Territorial Organizations and Independent First Nations to draw a representative sample for Ontario.

Table 4 presents the list of the First Nation communities that were selected to participate in the Ontario RHS and the corresponding predicted sample size (still to be added)

Table 4

First Nation Randomly Selected by Goss Gilroy for 2003 RHS	Participated in 2003 RHS	Did Not Participate in 2003 RHS
AIAI: (4)		
Moravian of the Thames	*	
Batchewana	*	
Mohawks of the Bay of Quinte	*	
Onyota'a'ka		*
Grand Council Treaty # 3 (8):		
Eagle Lake	*	
Lac la Croix		*
Northwest Angle #33		*
Wabigoon Lake	*	
Whitefish Bay	*	
Lac Seul	*	
Grassy Narrows	*	
Couchiching	*	
Independent First Nations (8):		
Mohawks of Akwesasne		
Six Nations of the Grand River	*	
Temagami	*	
Iskatewizaagegan #39		*
Wabeseemong		*
Big Trout Lake		*
Chippewas of Saugeen	*	
Bkejwanong		*
Nishnawbe-Aski Nation (11)		
Kee-Way-Win	*	
Chapleau Cree		*
Ginoogaming	*	
Sachigo Lake	*	
Deer Lake		*

Kasabonika		*
Eabametoong		*
Attawapiskat		*
Sandy Lake	*	
Albany		*
Pikangikum		*
Union of Ontario Indians (12):		
Moose Deer Point		*
Ojibways of Sucker Creek	*	
Chippewas of Kettle & Stony Point	*	
Whitefish Lake		*
Wasauksing	*	
Ojibways of Pic River	*	
Chippewas of Mnjikaning	*	
Chippewas of the Thames	*	
Whitefish River	*	
Sagamok Anishnawbek	*	
Wikwemikong		*

Table 5: Final Total Ontario Sample Size

Gender	Adult		Youth		Child	
	Count	Percent	Count	Percent	Count	Percent
Male	322	47.4	195	47.2	83	13.7
Female	358	52.6	218	52.8	525	86.3
Total	680	100.0	413	100.0	608	100.0

Table 6: Final Total PTO/IFN Sample Size

Ontario Provincial Territorial Organization	Adult		Youth		Child		
	Male	Female	Male	Female	Male	Female	Total
Association of Iroquois & Allied Indians	80	80	47	56	23	133	419
Grand Council Treaty #3	44	52	14	16	6	51	183
Independent First Nations	110	121	57	69	22	179	558
Nishnawbe-Aski Nation	27	34	22	20	19	45	167
Union of Ontario Indians	61	71	55	57	13	117	374
Total	322	358	195	218	83	525	1701

Table 7: Final Sample Size by First Nation

First Nation Name	Adult Survey		Youth Survey		Child Survey		Total		
	Male	Female	Male	Female	Male	Female	Male	Female	Total
Batchewana First Nation	13	14	10	8	4	18	27	40	**67**
Chippewas of Kettle and Stony	8	8	8	8	0	16	16	32	**48**
Chippewas of Mnjikaning	9	9	8	8	2	14	19	31	**50**
Chippewas of the Thames	4	9	2	4	1	11	7	24	**31**
Couchiching First Nation	7	8	1	1	0	8	8	17	**25**
Eabamotoong First Nation	6	7	4	3	7	7	17	17	**34**
Eagle Lake	8	9	8	7	2	16	18	32	**50**
Ginoogaming First Nation	3	5	1	0	2	6	6	11	**17**
Grassy Narrows First Nation	12	11	4	2	1	0	17	13	**30**
Kee-Way-Win	3	5	0	4	4	4	7	13	**20**
Lac Seul	9	15	21	20	1	16	31	51	**82**
Mohawks of the Bay of Quinte	25	20	5	7	8	41	38	68	**106**
Moravian of the Thames	12	13	0	2	0	24	12	39	**51**
Naotkamegwanning	5	4	0	1	0	1	5	6	**11**
Ojibways of Pic River	5	7	1	4	1	1	7	12	**19**
Ojibways of Sucker Creek	5	6	5	5	1	11	11	22	**33**
Oneida Nation of the Thames	24	28	9	16	2	10	35	54	**89**
Sachigo Lake	9	9	9	9	8	43	26	61	**87**
Sagamok Anishnawbek	6	6	8	7	3	15	17	28	**45**
Sandy Lake	6	8	8	8	2	13	16	29	**45**
Saugeen	4	4	0	4	3	13	7	21	**28**
Temagami First Nation	1	2	1	1	1	8	3	11	**14**
Upper Mohawk: Six Nations	93	97	47	62	18	158	158	317	**475**
Wabigoon Lake Ojibway	3	5	1	1	1	10	5	16	**21**
Wahta Mohawks	6	5	2	3	3	6	11	14	**25**
Walpole Island	12	18	9	2	3	13	24	33	**57**
Wasauksing First Nation	9	8	6	5	1	13	16	26	**42**
White Fish Lake (ONT)	9	9	8	8	2	14	19	31	**50**
Whitefish River	6	9	9	8	2	15	17	32	**49**
Total	**322**	**358**	**195**	**218**	**83**	**525**	600	1,101	**1,701**

Table 8: Weighted Sample

FIRST NATION	Adult Weight		Youth Weight		Child Weight	
	Male	Female	Male	Female	Male	Female
Batchewana First Nation	13.00	14.00	10.00	8.00	4.00	18.00
Chippewas of Kettle and Stony	8.00	8.00	8.00	8.00	0.00	16.00
Chippewas of Mnjikaning	9.00	9.00	8.00	8.00	2.00	14.00
Chippewas of the Thames	4.00	9.00	2.00	4.00	1.00	11.00
Couchiching First Nation	7.00	8.00	1.00	1.00	0.00	8.00
Eabamotoong First Nation	6.00	7.00	4.00	3.00	7.00	7.00
Eagle Lake	8.00	9.00	8.00	7.00	2.00	16.00
Ginoogaming First Nation	3.00	5.00	1.00	0.00	2.00	6.00
Grassy Narrows First Nations	12.00	11.00	4.00	2.00	1.00	0.00
Kee-Way-Win	3.00	5.00	0.00	4.00	4.00	4.00
Lac Seul	9.00	15.00	21.00	20.00	1.00	16.00
Mohawks of the Bay of Quinte	25.00	20.00	5.00	7.00	8.00	41.00
Moravian of the Thames	12.00	13.00	0.00	2.00	0.00	24.00
Naotkamegwanning	5.00	4.00	0.00	1.00	0.00	1.00
Ojibways of Pic River	5.00	7.00	1.00	4.00	1.00	1.00
Ojibways of Sucker Creek	5.00	6.00	5.00	5.00	1.00	11.00
Oneida Nation of the Thames	24.00	28.00	9.00	16.00	2.00	10.00
Sachigo Lake	9.00	9.00	9.00	9.00	8.00	43.00
Sagamok Anishnawbek	6.00	6.00	8.00	7.00	3.00	15.00
Sandy Lake	6.00	8.00	8.00	8.00	2.00	13.00
Saugeen	4.00	4.00	0.00	4.00	3.00	13.00
Temagami First Nation	1.00	2.00	1.00	1.00	1.00	8.00
Upper Mohawk: Six Nations (plus)	93.00	97.00	47.00	62.00	18.00	158.00
Wabigoon Lake Ojibway	3.00	5.00	1.00	1.00	1.00	10.00
Wahta Mohawks	6.00	5.00	2.00	3.00	3.00	6.00
Walpole Island	12.00	18.00	9.00	2.00	3.00	13.00
Wasauksing First Nation	9.00	8.00	6.00	5.00	1.00	13.00
White Fish Lake (ONT)	9.00	9.00	8.00	8.00	2.00	14.00
Whitefish River	6.00	9.00	9.00	8.00	2.00	15.00

Interpretation and analysis

INTERPRETATION

Interpretation is the transformation of numbers or statistics into a well-defined or more understandable picture. In the case of the RHS, interpretation brings into focus certain health-related issues addressed in the survey. The process of interpretation must first identify the main or intended beneficiary of the research. This will determine how to approach the data and assist in bringing meaning to the numbers.

TARGET GROUPS

The information arising from the Ontario RHS could benefit a number of individuals, organizations and governments. These target groups are being kept in mind during the interpretation process in order to produce information that will be useful and beneficial to them. Some target groups to keep in mind for the RHS are as follows:

- First Nations communities
- Individual community members
- First Nations Provincial Territorial organizations/Independent First Nations
- Aboriginal organizations

1.5 STUDY LIMITATIONS

Due to the small sample size of the Ontario survey, it will not be statistically valid to provide analysis of the data by Provincial Territorial Organization/Independent First Nations in the Ontario RHS report. Where socially significant, findings will be presented in accordance to remoteness factors or community size.

The findings presented in this report are un-weighted counts. A weight is the amount by which you "blow up" each person in the sample to represent the actual population. For example, if you interview 20 out of 100 people, each person would have a weight of 5. Technically, weighting provides more accurate estimates and confidence intervals. However, no weighting scheme can improve the confidence level of a sample size too small to begin with. Therefore, in this report, most findings will represent the actual number of respondents who answered particular questions.

There were two criteria for determining whether differences were significant – social and statistical. There were times when the differences were socially significant but the sample sizes were too small to yield statistical significance. These differences would not usually be reported in accord with western statistical standards. However, socially significant differences are subjective and focus on whether the differences count within the Aboriginal

community. Differences of about 10% from one group to another were usually considered socially significant. Readers may have different criteria than the authors. Statistically significant differences are mathematically derived and have to do with the accuracy of the estimates. Estimates of percentages and means that are based on samples are not exactly transferable to the populations that the samples represent. Each estimate comes with a range of values around it (a confidence interval) that describes all the possible values that the percentage or mean can take in the population. Due to the small sample size, the authors were often unable to produce findings that were statistically significant (small confidence intervals). Therefore, the findings described in this report do not purport to represent findings for all First Nations in Ontario however, they are weighted to reflect a more accurate estimate of the population for each participating community.

Where percentages are provided in this report, they will be the weighted percentage derived through a two step process: 1) Individuals weighted to the age/sex group within the community and 2) Weights adjusted by the ratio of the sub-region/ community size/ age/gender group's population for all communities over the same population but only for sampled communities.

CHALLENGES

The Chiefs of Ontario RHS Technical Advisory Committee acknowledges that the 2003 RHS resulted in a relatively small sample size due to a number of constraining financial issues. The proportional sample size is different from other small population provinces. Ontario First Nations have a large population spread out over a diverse geography, and it is not felt that they received an appropriate proportional funding allocation to meet this challenge and secure a larger sample.

However, the purpose of the Ontario Longitudinal RHS is to study changes over time for First Nation "A". Upon the completion of the subsequent rounds of the RHS, that is when analysis can take place to see what impacts different approaches to improving Aboriginal health have made on this population. For example, have education campaigns reduced the number of women who smoke during pregnancy. This is the true nature of a longitudinal study. Thus, this report presents a snapshot of the baseline data established in the 2002-03 Ontario RHS.

Furthermore, the Chiefs of Ontario RHS Technical Advisory Committee recognizes that other surveys and studies already exist for larger comparison of Aboriginal health issues to other groups such as Canadian society. The intent of this longitudinal study is not to simply repeat other studies, but to document something unique – that is, the impact that health approaches within a holistic framework, are having on improving First Nations health and well-being. This sample size also affords Ontario the opportunity to augment their data with other qualitative methodologies to delve more thoroughly and appropriately into some of the questions raised through the baseline quantitative data.

CHAPTER 2

Historical Context and Cultural Approach

Therefore, the Chiefs of Ontario RHS Technical Advisory Committee is confident of its ability to replicate the data over time (in accordance with the principles of the longitudinal study) and is committed to increasing the sample size with the next round of surveys.

CHAPTER 2: HISTORICAL CONTEXT AND CULTURAL APPROACH

2.1 HISTORICAL CONTEXT

The analysis of information begins by presenting, in chapter 2, a historical model of interaction that covers the last 500+ years of Aboriginal – Western (Canadian) societal relations. The model attempts to build a solid historical foundation by presenting both an Aboriginal and Non-Aboriginal (Western) perspective of the historical interaction. This is followed by a consideration of the historical past into an analysis of the present, by presenting the major events that occurred in the last 35 years.

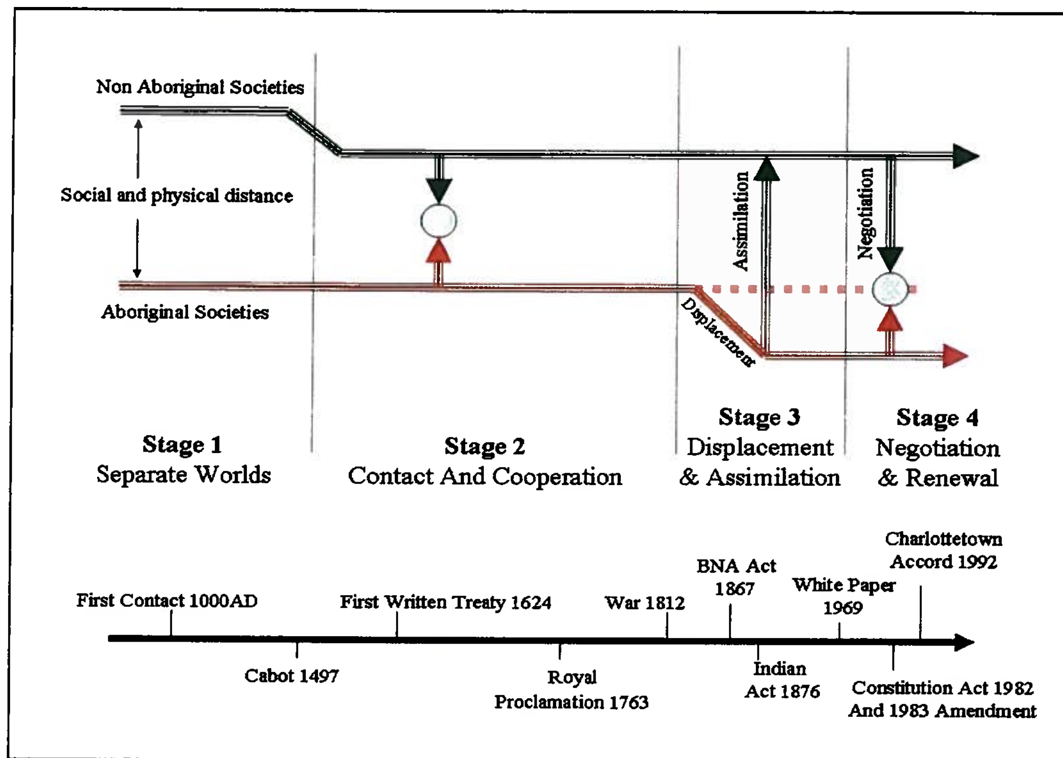
BACKGROUND

In the context of Aboriginal issues, the key to understanding the future is to have a deep and detailed appreciation of the past. However, providing a singular interpretation of history is a challenging task when confronted by the complexity of the relationship between Aboriginal Peoples and Federal government relations and the negative impact it has had on the health and wellness of Aboriginal people.

For the purposes of this report, ARI chose to begin with a model of Aboriginal – Government relations that have already met with a general level of acceptance, as a foundation for the interpretation of history. This model of societal interaction developed by Dr. Dockstator, an author of this report, was also used as the historical foundation for the Royal Commission on Aboriginal Peoples (RCAP, 1996) report.[1]

Diagram 1:

The Historical Model of Societal Interaction: Stages in Government – Aboriginal Relationship



Source: Mark Dockstator: "Towards an Understanding of Aboriginal Self-Government: A Proposed Theoretical Model and Illustrative Factual Analysis", doctor of jurisprudence thesis, York University, Toronto: June 1993, as cited in RCAP, Volume 1, 1996

In the above model, the totality of Aboriginal – Governmental relations is represented as passing through four distinct stages.

However, what is of particular interest is the fact that the model represents two very different interpretations of history. To the extent that the historical record can be reduced to two very general "streams" of events, the model incorporates both a "Western" and "Aboriginal" perspective of history. Due to the importance of the historical record for Aboriginal – Government relations, the following section will examine in more detail the different interpretations of history represented in the societal interaction model.

The chapter will proceed by presenting a brief historical background overview followed by the Aboriginal perspective of history followed by the Western view of the historical record. To accomplish this goal the model presented in the diagram will be reduced into its two constituent elements. That is, if we "take apart" the societal interaction model, the result will be two separate models…one representing an Aboriginal perspective and the other, a representation of the Non-Aboriginal ("Western") perspective of how the historical interaction can be interpreted.

HISTORICAL BACKGROUND

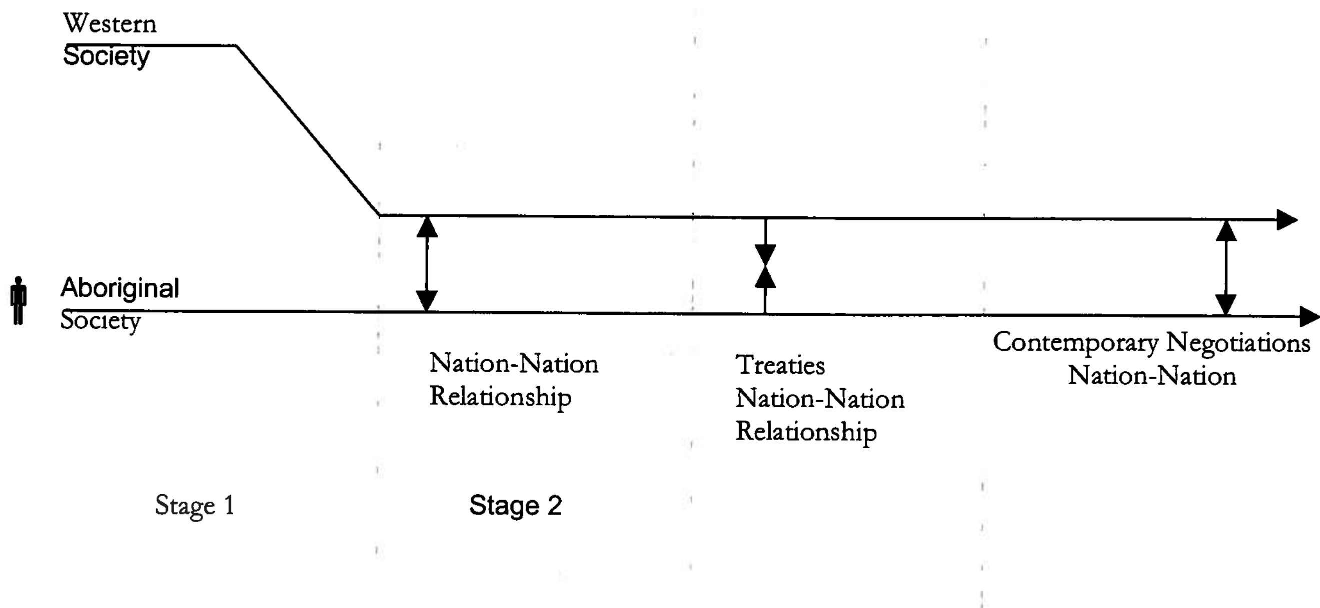
The historical relationship between Aboriginal and non-Aboriginal Peoples across Canada is as diverse as the land itself. Contact and the level of impact that resulted have been experienced differently by the Aboriginal and Non-Aboriginal Peoples of the diverse regions. Generally, the past 500 years has sustained a consistent and increasing presence of non-Aboriginal Peoples for the eastern and central regions of Canada whereas the northern Inuit and Pacific regions experienced settlement more recently. (RCAP, 1996) In an attempt to summarize and interpret the relationship and interactions between Aboriginal and non-Aboriginal Peoples, Dr. Mark S. Dockstator, divides his account of the historical relationship into four stages, as illustrated in Diagram 1.

The stages follow each other with some regularity, but they overlap and occur at different times in different regions.

Aboriginal Perspective

The Aboriginal perspective of the last 500+ years will briefly be explained using the following diagram.

Diagram 2: Aboriginal Perspectives Isolated



Stage 1

The Aboriginal perspective begins from the line entitled "Aboriginal Society" and proceeds to the point where Western Society arrives on the shores of North America, thus marking the beginning of stage 2 – contact in North America between Aboriginal and Non-Aboriginal society. From an Aboriginal holistic perspective, the differences between themselves and the newcomers were acknowledged as a result of an act of creation whereby everything and everyone has a specific purpose. These differences are an expression of the Creator.

Stage 2

At the point of contact, Aboriginal society recognizes that these newcomers to North America have their own history, cultural institutions and legal existence. The solid line is indicative of the fact that, although separated by the Atlantic Ocean in stage 1, when contact is made Aboriginal society treats them on an equal or "nation-to-nation" basis.

It was a period when Aboriginal People provided assistance to the newcomers which was crucial to the survival of the newcomers in the new and unfamiliar environment. This stage is marked by the two cultures remaining distinct and autonomous but meeting at mutually beneficial junctures such as, cooperation in areas of trade and military alliances as well as intermarriage. This stage is also where the Aboriginal population is ravaged by the exposure to the diseases brought by the newcomers.

Stage 3

The equality of the societal relationship continues through to stage 3. There are various agreements, such as treaties, which serve to acknowledge and reinforce the initial nation-to-nation nature and overall equality of the relationship established at contact.

However, at the same time, assimilation policies imposed upon Aboriginal Peoples are at their peak during this period. Policies such as relocation of communities from their homelands, removal of children from their families and communities to industrial and residential schools and outlawing spiritual expression occurred. Despite attempts to assimilate the Aboriginal Peoples into non-Aboriginal society, Aboriginal Peoples did not lose their distinctiveness or their social values.

Stage 4

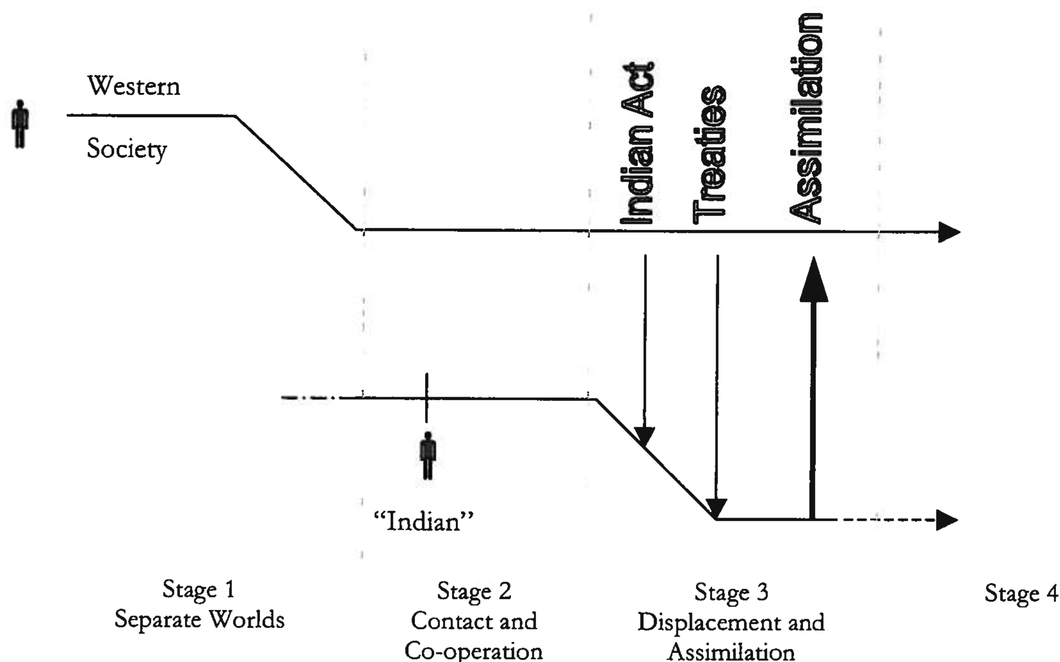
The fundamental nature of the societal relationship does not change through to the present. From this perspective, the overall goal of contemporary negotiations, whether related to specifics such as land claims or self-government, is to have the fundamental nature of the initial equal, or nation-to-nation societal relationship recognized and the "balance" between the two societies restored.

The Aboriginal perspective remains consistent, with the primary objective being to regain control over their own affairs by removal of interventionist non-Aboriginal government. Aboriginal People recognize that part of this process is the healing that must take place within the communities caused by generational domination by non-Aboriginal colonial policies.

Western Perspective

From a second perspective contained within the societal interaction model there is another, very different perception of history. This perspective is referred to in the following diagram as a "Western" perspective, representative of "Western society", that is, those cultures which arrived on the shores of North America from Western Europe.

Diagram 3: Western Perspective Isolated



Stage 1
Separate Worlds

Stage 2
Contact and
Co-operation

Stage 3
Displacement and
Assimilation

Stage 4

Stage 1

The perspective begins from the line entitled "Western Society" and proceeds in a downward direction through stage 1, representing the journey of these Peoples across the Atlantic Ocean to the shores of North America...thus marking the beginning of stage 2 – contact in North America between Aboriginal and Non-Aboriginal society.

Aboriginal and non-Aboriginal societies remained for the most part in isolation of one another. Both groups were respectful of the others traditions of governance and social environments and interacted accordingly.

Stage 2

At the point of contact, Western society collectively refers to Aboriginal Peoples as "Indians". As represented by the dotted line going back into stage 1, Western society allocates to the "Indians" a very limited form of legal recognition and sense of history (i.e. the history of North America begins with the arrival of European society). However, there is a de facto recognition of the economic and military importance of "Indians", thus stage 2 is categorized by a solid line running parallel to Western society, indicating the relative equality afforded "Indians" due to their strategic, military and economic importance to the newly forming colonies in North America.

Stage 3

When "Indians" lose their strategic, military and economic importance to Western society, they are displaced to the margins of society, indicated by the downward sloping line in stage 3. The displacement is accomplished through a number of means, illustrated in the diagram are the Indian Act and Treaties, which establish a "reserve" system of lands and societal organization. Non-Aboriginal society was no longer respectful of the distinctiveness of Aboriginal society which is reflected in the colonial policies directed at the Aboriginal population across Canada.

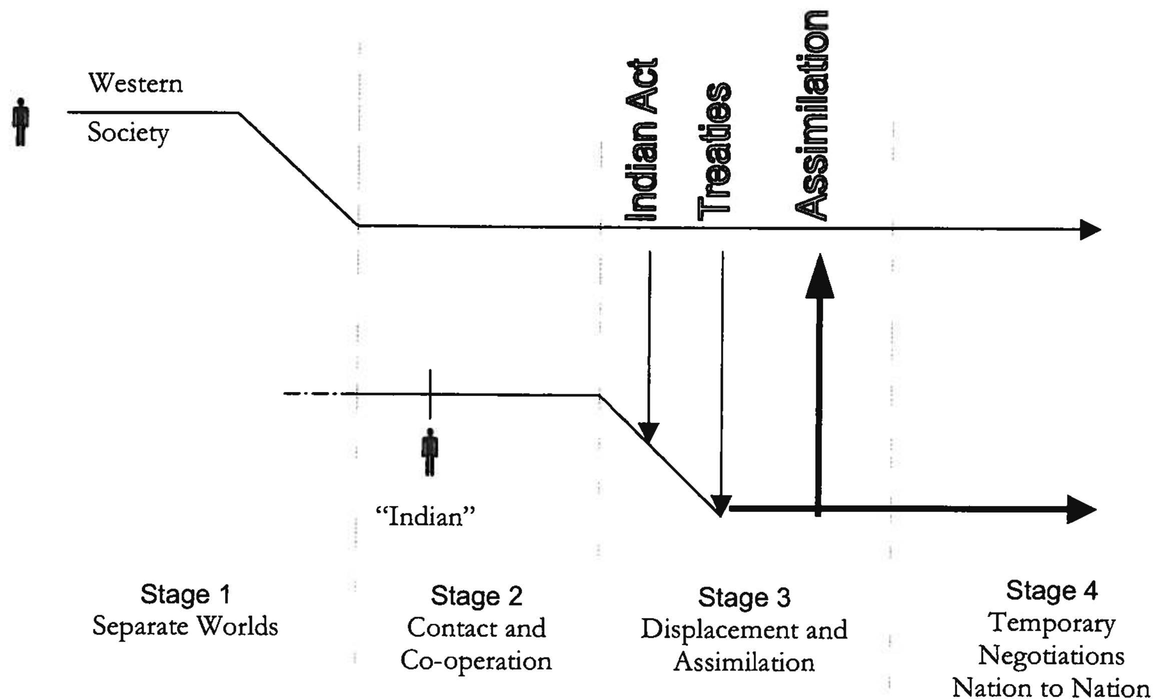
It was anticipated, and this diagram attempts to illustrate the "expectations" of this interpretation of history... that the displacement of "Indians" was only a temporary measure. As indicated by the line moving upward into the mainstream of society entitled "assimilation", there was an expectation that "Indians" would at some point assimilate back into the mainstream of Western society.

Stage 4

With the full assimilation of "Indians" which marks the beginning of stage 4, there would be no more distinct and separate existence of "Indians". This is indicated in the diagram with the disappearance of the bottom line. At this point in history there would be no further need for the Indian Act, treaties would be significant only as historical footnotes, "reserves" would disappear, thus there would be no need for further Government oversight and administration of Indian Affairs.

The line representing "Indians" in Stage 4 consists only of a few dotted lines, as it was anticipated that the Government responsibility for "Indians" would, after a period of time, no longer exist. However, history did not occur as anticipated. As represented in Diagram 4, "Indians" DID NOT give up their identity in order to integrate into the mainstream of society. In this revised diagram, stage 4 is characterized by a solid line continuing throughout stage 4, representing the continued marginalization of "Indians" in society. As "Indians" did not assimilate and therefore disappear, there still exists a system of reserves and Federal government responsibilities for oversight and administration.

Diagram 4: "Actual" Aboriginal Perspective Isolated

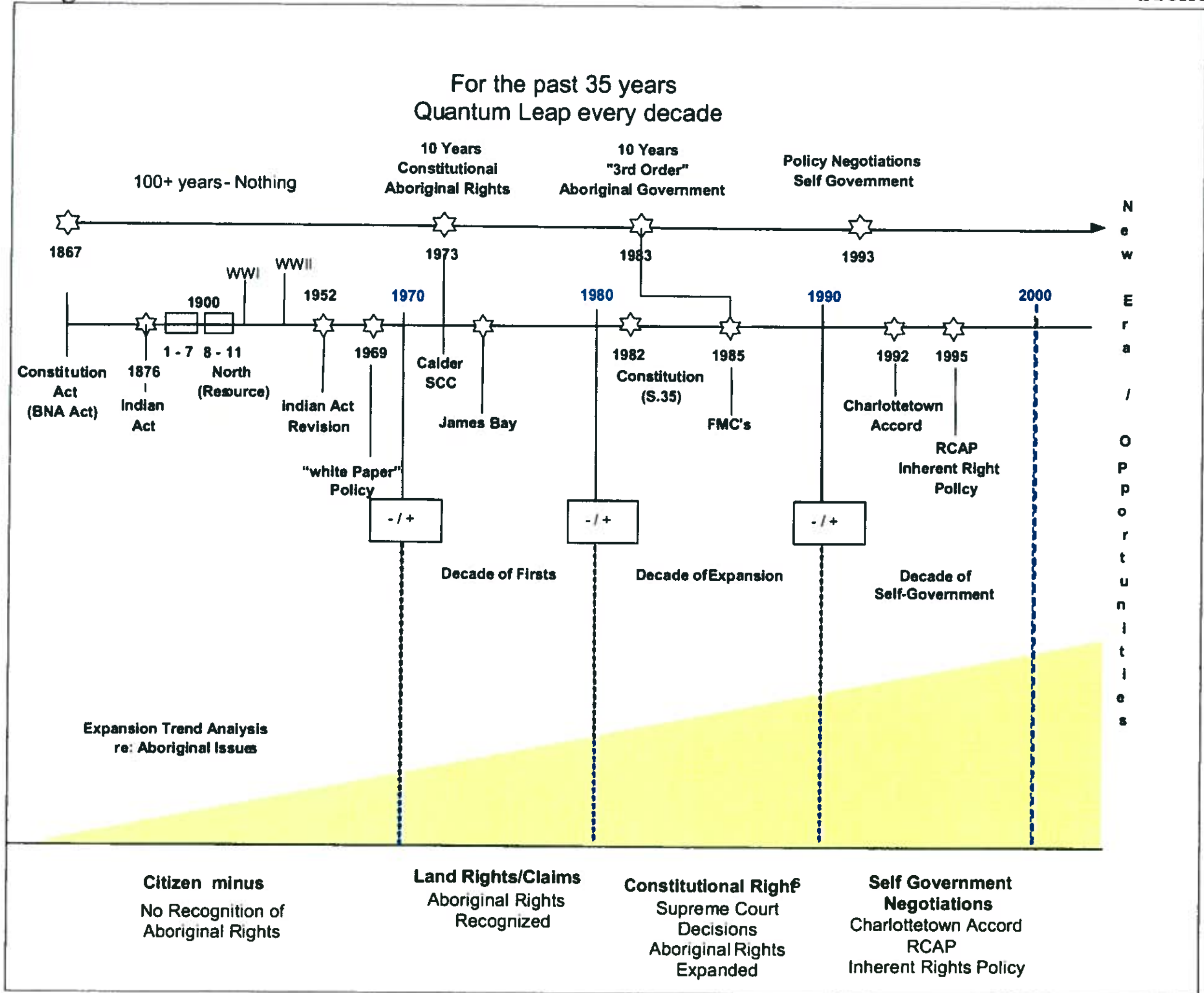


Two Perspectives – One "Official" View of History

As with any two perspectives, there is a tendency for one to dominate. In the context of Aboriginal – Federal Government relations, it is the Western version of history that dominates. As stressed in the RCAP reports (1996a, 1996b and 2000), it is vital to understand the historical interaction from both perspectives…not just one. If one views the historical interaction from the lens of a single perspective, this serves to distort the picture rather than give an accurate portrayal of how the relationship has developed and further, how the relationship will develop in the future.

A brief overview of the major trends that have occurred in the recent past (defined as the last 35 years) is illustrated in Diagram 5.

Diagram 5: Overall Trends



Within the last 35 years starting in 1970, there has been an explosion of Aboriginal issues that have served to impact, in various ways, on the actions of the Federal government. Diagram 5 illustrates an overall trend that became evident through an examination of a great deal of information relating to the past 35 years. There have been three major periods where the nature of Aboriginal issues and their impact on the Federal government have dramatically expanded. In each of the following three decades 1970 to 1980, 1980 to 1990 and from 1990 to 2000 there has been what may be termed "quantum leaps" in regards to the expansion of Aboriginal issues.

The following section briefly examines each of the three "decades of change" illustrated in Diagram 5.

1970 – 1980: The Decade of Firsts

The period begins with the introduction of the Federal government "White Paper", which outlined a proposed Federal government policy to guide the nature of future Federal government – "Indian" relations.

With reference to the model of historical interaction, the proposed policy was an exact reflection of the Western perspective of history as represented in Diagram 3. In this version of history it was anticipated that, at some point in time, the distinct and separate legal existence of "Indians" would be eliminated. Accordingly, there would be no further need for the Indian Act, "reserves" would disappear, Treaties would be significant only as historical footnotes and there would be no need for further Government oversight and administration of Indian Affairs. In so doing, these actions would pave the way for the full integration of "Indians" into the mainstream of society. This version of history was, in essence, the philosophy behind the proposed White Paper policy.

The White Paper proposal totally ignored any and all elements of the Aboriginal perspective of history. The result was a quantum leap increase in Aboriginal issues over the next ten years as Aboriginal groups organized nationally in response to the proposal. In essence, the proposed White Paper policy achieved the exact opposite reaction than was originally anticipated.

1980 – 1990: The Decade of Expansion

This is a decade of Aboriginal issues expansion and it begins with the process designed to "repatriate" the Canadian Constitution. Again the period begins with the approach of the Federal government to minimize or ignore the nature of Aboriginal issues. Prior to the ratification of the Constitution, there were various attempts to exclude, ignore or minimize the inclusion and/or scope of Aboriginal issues to be included in the Constitution.

In reference to the societal interaction model, the various policies of the Federal government very closely mirror the philosophy contained within the Western perspective of history (see Diagram 3). In this version of history Aboriginal Peoples occupy a permanently marginal

role in society not, as contemplated by the inclusion in the Constitution, a central role in the formation of Canadian society.

As with the previous decade, the federal approach, which ignored the Aboriginal perspective of history, accomplished the exact opposite of what was intended. The nature, scope and complexity of Aboriginal issues over the next ten years resulted in the third quantum leap in terms of the impact on the operations of the Federal government.

1990 – 2000: The Decade of Self Government

The period begins with the action, or in this case, inaction by the Federal government. There are a number of important events to consider, such as various Supreme Court of Canada decisions or the Meech Lake Accord. However, it is the events at Oka that serve to define the next ten years. The Federal government continued to minimize, or in some instances, ignore the nature, scope and impacts of land claims which had the overall effect of once again resulting in the exact opposite action over the next decade.

As with the two preceding decades, the approach that minimized the Aboriginal perspective of history, accomplished the exact opposite of what was intended. The next ten years resulted in another quantum leap in the nature, scope and complexity of Aboriginal issues that then impacted on the relationship with the Federal government.

2000 - 2005

Moving forward, several government policy initiatives such as RCAP and the Government of Canada's Approach to Implementation of the Inherent Right and the Negotiation of Aboriginal Self-Government Policy (Inherent Right Policy) in the mid 1990's have lead to a more "natural" or incremental growth of Aboriginal issues at the turn of the century. This as opposed to the massive or "quantum leaps" of uncontrolled growth experienced in the preceding three decades.

Certainly there have been many more initiatives by the Federal government during the 1990's that have, in different ways, recognized and acknowledged the existence of an Aboriginal perspective to history. For instance, RCAP not only recognized the existence but also expanded on how these principles of a separate Aboriginal perspective of history could be integrated into governmental and larger societal initiatives. The principles covered in the proposed Charlottetown Accord, the Inherent Right Policy and the Statement of Reconciliation all recognized and to some extent operationalized the principles contained in an Aboriginal approach to history.

In reviewing the time line of the past 500 years, it is clear that the nature of the Aboriginal – Federal Government relationship is complex.

An illustration of the cumulative nature of Aboriginal issues, growth and expansion is reflected in the fact that over the last thirty years issues such as health have traveled from very little recognition to a highly complex and challenging agenda item for both the Federal

government and Aboriginal Peoples, for example, diabetes, suicide, mental health. Healing and Wellness issues are experiencing an incredible growth rate both in terms of scale and complexity. These issues are not going away in the near future and, in all likelihood, will continue to expand rather than diminish. The Regional Health Survey is an example of Aboriginal People taking a proactive approach to addressing the issues rather than a reactive approach.

2.2 CULTURAL APPROACH

Jim Dumont, Traditional Teacher, prepared a research document to assist in developing a cultural interpretative framework. Within this paper, he defines the meaning of Aboriginal health and well-being in its broadest cultural perception, as: ***"The total (Aboriginal) health of the total (Aboriginal) person within the total (Aboriginal) environment".*** [2]

Total Health is all aspects and components of health and well-being seen as integrally interconnected with one another within an inclusive and inter-related and interactive web of life and living.

Total Person is inclusive of all levels of personhood – understood to be body, mind, heart and spirit:

- physical health, mental health, emotional health, spiritual health;

- healthy behaviour and life style, healthy mental function, cultural continuity with the past, as well as future opportunity;

- healthy connection to culture, healthy home life, community life, extended family connection, and, a healthy spirituality as an Aboriginal person.

Total Environment means a healthy connection and relationship with the living environment – this being constituted of the land, natural environment, cultural environment, context of activity, community, family, and the everyday living environment. [3]

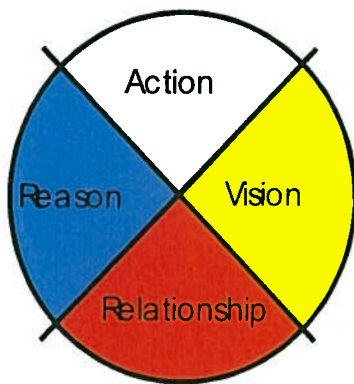
The RHS mandate is to achieve the "collective empowerment of Aboriginal individuals and communities in matters of health". In so doing, the RHS is working towards developing an effective and workable cultural framework that will provide the means for appropriately interpreting the information collected and presenting it back to the communities in ways that are usable and that engender "collective empowerment". This collective empowerment would ideally lead to community-based approaches to improve and strengthen Aboriginal health and wellness. An additional task that is important to consider, is that of making such a framework applicable to the present way in which data was collected. This is important in

order to ensure that data collected is useful to the presentation of information, knowledge of health and well-being while remaining meaningful to Aboriginal peoples and communities.

The Chiefs of Ontario RHS Technical Advisory Committee began by examining the survey instruments to determine the best approach for organizing data for interpretation. The RHS consists of three survey instruments: Adult, Adolescent and Children (by proxy). Parental permission was required for youth participation and parents completed the survey on behalf of their child. Each of these instruments consists of a variety of health-related topics ranging from health determinants, such as education or income to actual health conditions.

The topics are comprehensive and cover a wide range of health issues. To provide a clear focus for interpretation of data, health related topics could be thematically grouped according to health indicators. This would in turn provide an approach for the interpretation of data.

The interpretation of findings for the Ontario Regional Health Survey will be presented within a medicine wheel framework, using the following four quadrants of discussion: Vision, Relationship, Reason and Action. Some of the traditional understanding of the meanings of those values and directions are provided below[4].



VISION: Within an Aboriginal cultural paradigm, vision is considered the most fundamental of principles. Visioning First Nations' well-being involves examining the complete picture of health including, physical, mental, emotional and spiritual health issues. From an Indigenous Knowledge perspective, visioning will examine what is the ideal state of First Nations health and wellness (what was the standard in the past and what is the desirable/achievable in the future). In order to envision First Nations' health and wellness, it is imperative to establish a baseline of the extent and causes of the current situation. It is from that baseline that First Nation communities and stakeholders can move forward towards the ideal vision.

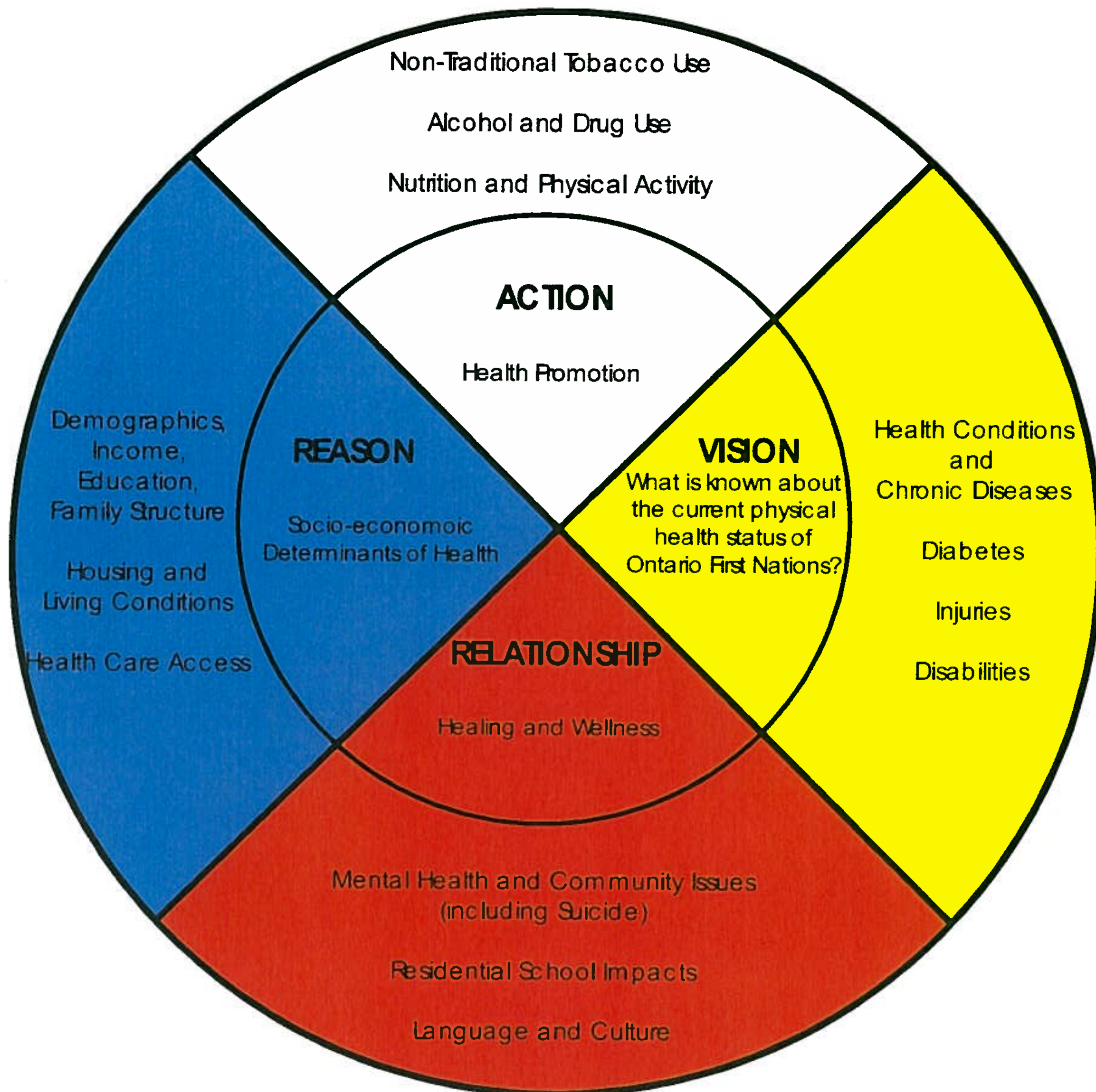
In this quadrant, baseline information will be presented related primarily to the physical health of the First Nation participants in the 2003 Ontario RHS survey.

RELATIONSHIP: Refers to the experiences that one encounters as a result of relationships built over time and examines how we relate to people. It provides an opportunity to gain an understanding of the attitudes and awareness that exist at this particular point of time, regarding the individual, community and national wellness issues, including language and culture, residential school impacts, emotional and mental issues, as well as availability of community supports.

REASON: Also referred to as learned knowledge. It is where we become reflective, meditative and self-evaluate. It is in this direction, that the broader determinants of health are examined, such as demographics, income, education, family structure, housing and living conditions as well as health care access. These health indicators provide a larger context for understanding and addressing First Nations health issues.

ACTION: Also referred to as movement and represents strength. This direction explores what has been done about previously identified barriers and how to nurture us as Aboriginal people. This component is important in that it activates positive change to improve the program so that it better achieves the vision (expectations) of the Aboriginal community. Resulting in the healthy development of their children, families and communities. Within this quadrant, this report will present findings related to Smoking, Alcohol, Drug Use, Nutrition and Physical Activity which are commonly known as promotional/preventative indicators of health.

To summarize, for the purposes of this report, the following groupings were identified by the Chiefs of Ontario RHS Technical Advisory Committee:

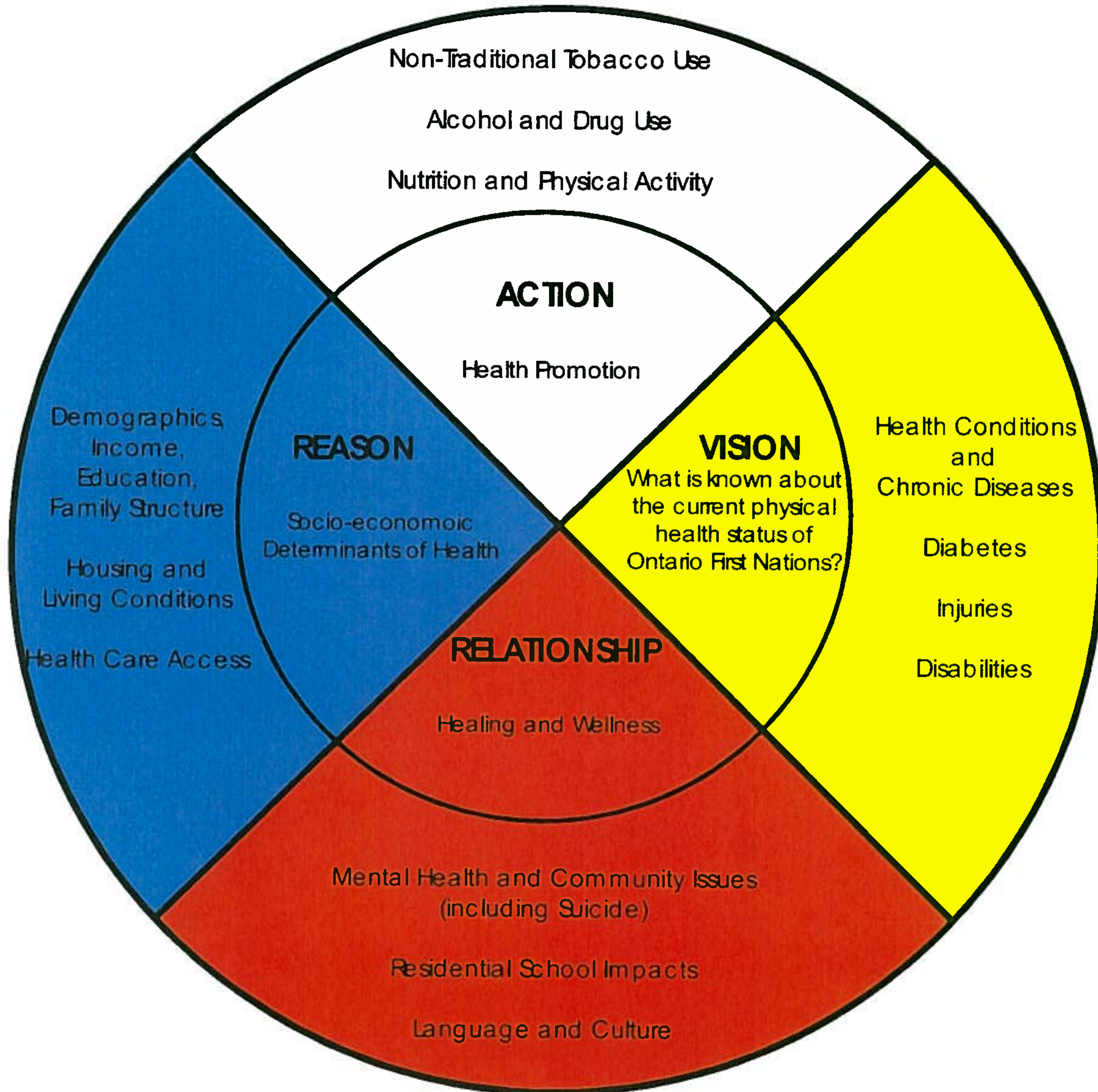


In keeping with the holistic approach identified by the Chiefs of Ontario RHS Technical Advisory Committee, each topic area will include discussion related to the life cycle (ages and stages of life) and will integrate findings from the three survey tools where appropriate.

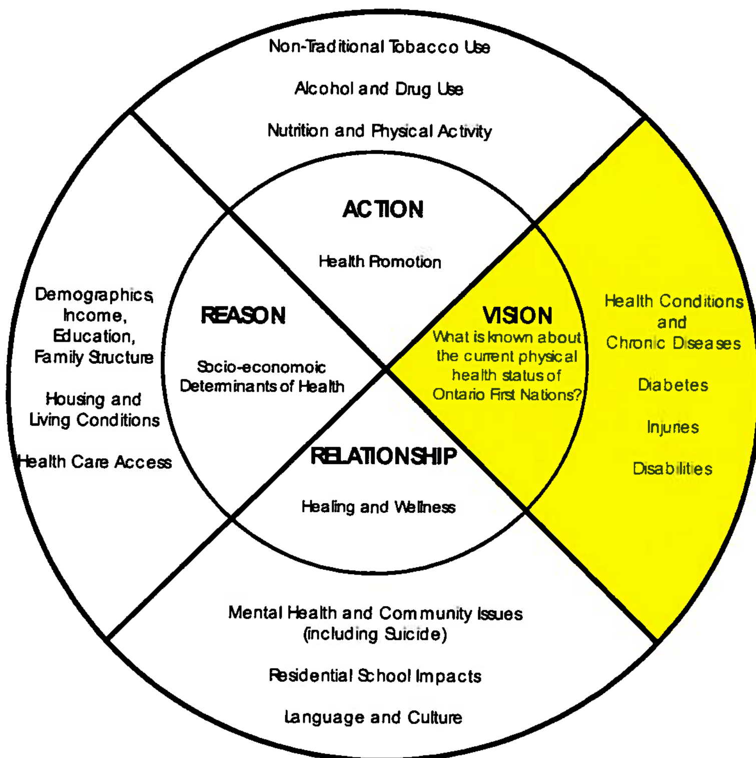
Chapter 3

Findings

CHAPTER 3: FINDINGS



3.1 VISION



Within an Aboriginal cultural paradigm, vision is considered the most fundamental of principles. Visioning First Nations' well-being involves examining the complete picture of health including, physical, mental, emotional and spiritual health issues. From an Indigenous Knowledge perspective, visioning will examine what is the ideal state of First Nations health and wellness (what was the standard in the past and what is the desirable/achievable in the future). In order to envision First Nations' health and wellness, it is imperative to establish a baseline of the extent and causes of the current situation. It is from that baseline that First Nation communities and stakeholders can move forward towards the ideal vision.

Research shows that Aboriginal people suffer from poor health. They do not access mainstream (Non –Aboriginal) social systems, such as health care services (i.e. hospitals and community health programs and services).[5] As a result, Aboriginal people tolerate poor health longer than necessary and thus, when they do access the health care system, the health problems are more complex with a high level of chronicity or co-morbidities that need to be managed.

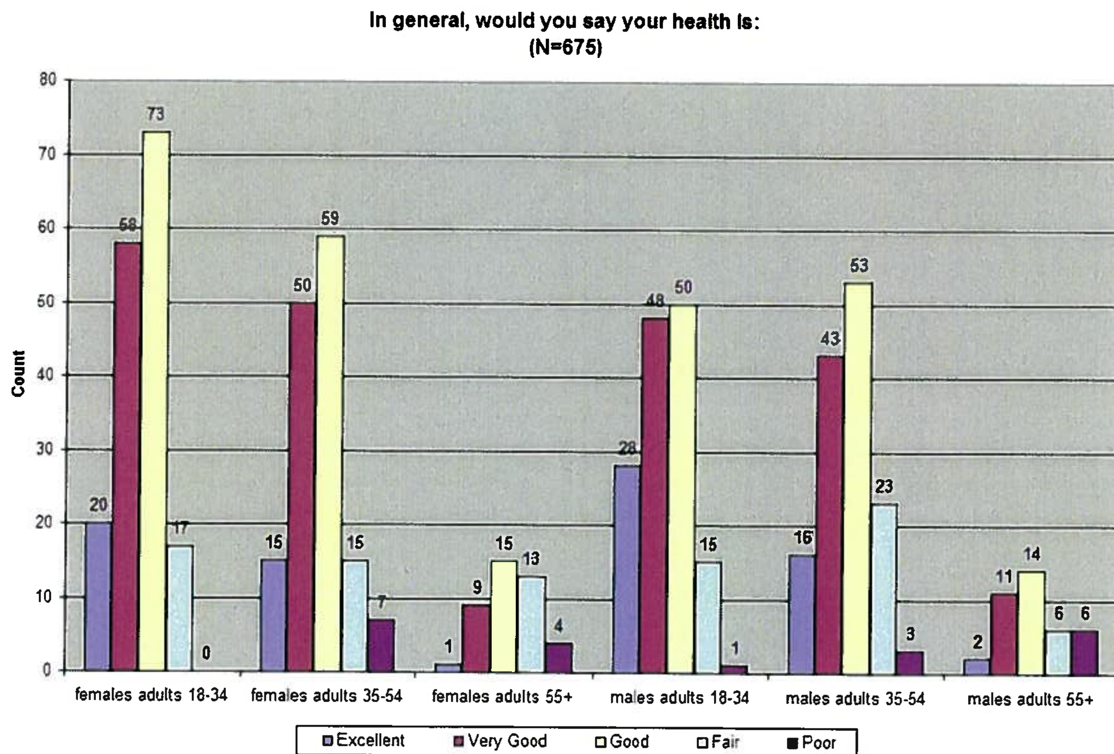
The 2002-03 RHS questioned participants on 28 health conditions. It is impossible to cover all of the health conditions within the survey in this report so we have limited our analysis to address the most common health conditions. Chronic diseases extract a significant burden on affected individuals, their families and the communities they live in.

In this quadrant, baseline information will be presented related primarily to the physical health of the First Nation participants in the 2003 Ontario RHS survey.

HEALTH CONDITIONS AND CHRONIC DISEASES

Chart 1 shows the range of responses to a general question asking First Nation adults how they would rate their health. Of the adult population surveyed, only 12.1% rated their health as excellent. However, when the categories of excellent, very good and good were collapsed together, 565 of the 675 adults or 83.6% indicated that their health was good or better. It is important to note however, that 16.3% of the adult population surveyed described their health as either fair or poor.

Chart 1 – Health by Age Group



Heart Disease

Heart conditions such as hypertension are reported to be an issue of increasing concern among the Aboriginal population nationally and provincially. In Ontario there was a two-fold increase in breathing and heart problems, and a two-fold increase in ischemic heart disease

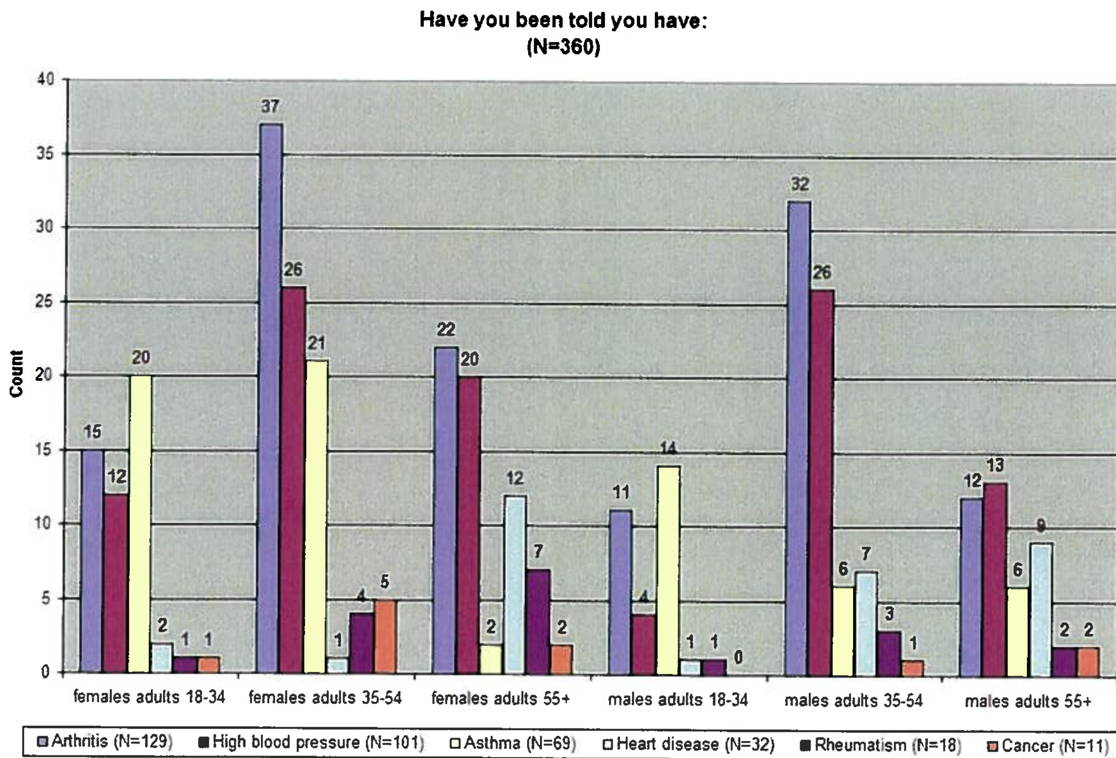
among this population when compared to rates of these conditions in the non-First Nations Ontario population.[6] Moreover, a recent comprehensive review of all hospital admissions in Ontario from 1981 to 1997 for ischemic heart disease (IHD) has suggested, "that IM is of increasing significance among the Native population".[7]

The increasing prevalence of heart disease among First Nations Peoples within Canada is especially alarming since this is the major cause of death among non-First Nations peoples in Canada, contributing to 37% of annual deaths nationally (Canadian Public Health Association, 1999: 21). First Nations Peoples also are at a higher risk of death from heart disease due to increased rates of cigarette smoking, obesity, lack of exercise, loss of traditional diet and existence of complementary diseases such as diabetes.[8]

Of the 669 adult respondents, 32 reported having been told by a health care professional that they have heart disease.

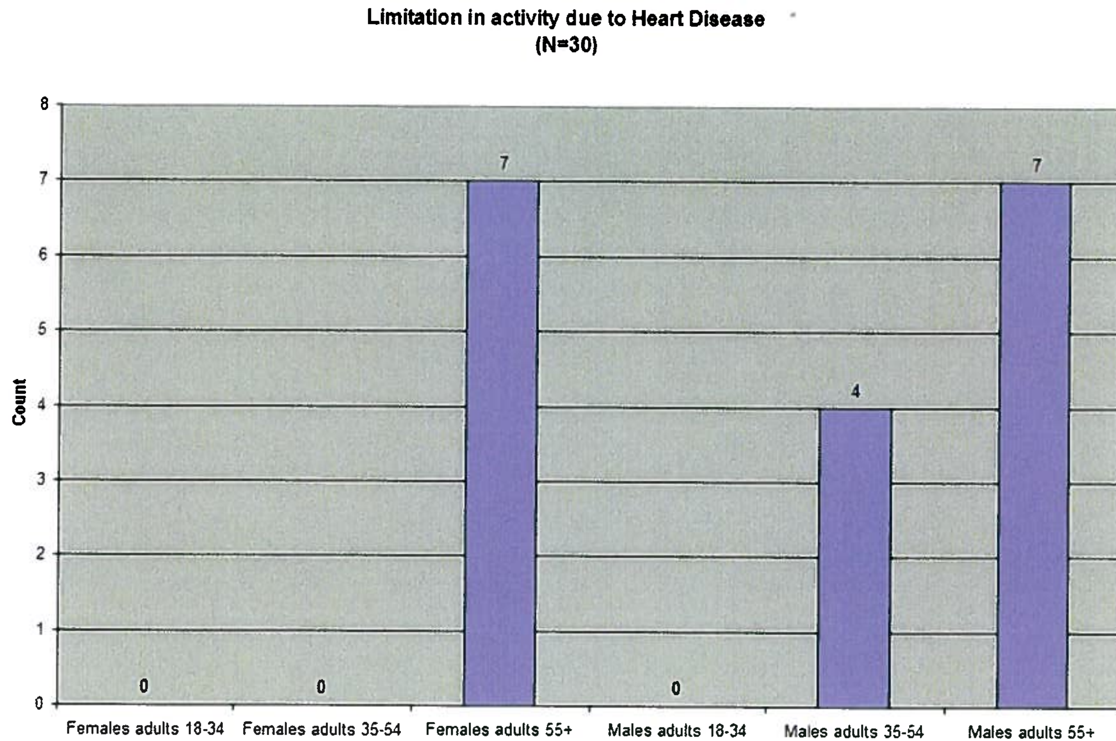
In Chart 2 the age and gender stratified prevalence of heart disease is presented. The data suggests that the occurrence of heart disease varies minimally by age and gender. Male adults between the ages of 35-54, however, reported a notably higher number of cases of heart disease, at 7 respondents, than women of the same age bracket, with only 1 respondent reporting to have been told by a health care professional that they have heart disease.

Chart 2 – Adult Diagnosed Illnesses



Of the respondents who reported having heart disease, 18 respondents reported resulting activity limitations. While both female and male adults aged 55+ expressed the same amount of limitation in activity due to heart disease (7 respondents respectively), no females between the ages of 35-54 expressed activity limitations, while 4 First Nation men reported limited activity within the same age bracket.

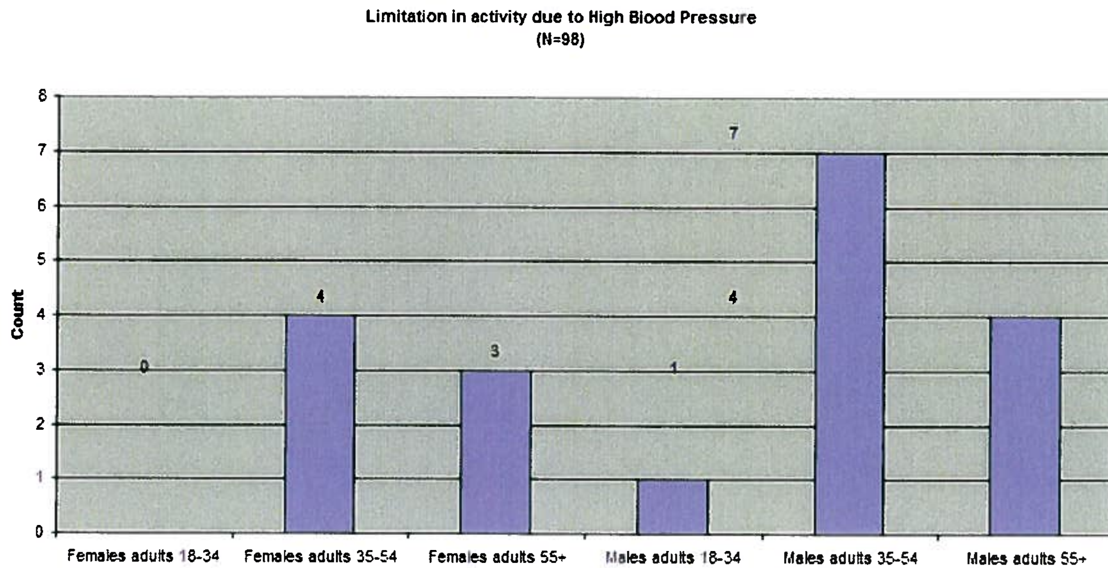
Chart 3 – Activity Limitation due to Heart Disease



Hypertension

Hypertension for First Nations adults is notably prevalent in the 35-54 age bracket, with 52 of the 101 respondents or 42.9% occurring within this age group.

Chart 4 – Activity Limitation due to High Blood Pressure

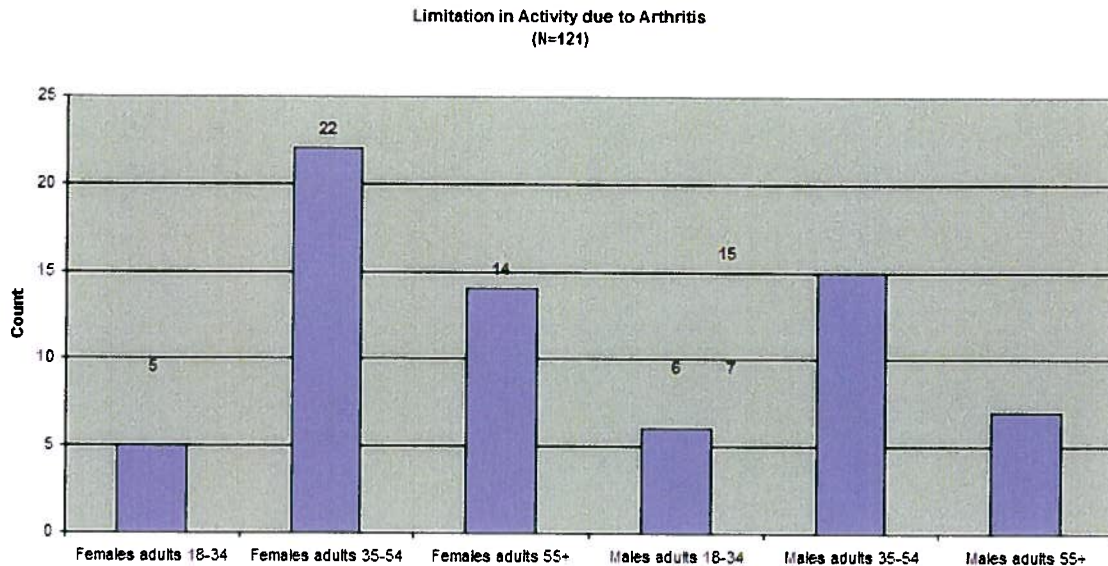


Limitation in activity due to hypertension is evident in the adults 35-54 and 55+ age groups. Only 1 adult, a male, reported limitation in activity in the 18-34 age group. Further, of the First Nation adult respondents who reported having been told that they have hypertension, 62.7% of the respondents reported undergoing treatment for this condition.

Arthritis/Rheumatism

Adult respondents were surveyed to determine the prevalence of arthritis and rheumatism in the First Nations population. Of the 670 respondents, 129 reported that they have arthritis. Further, 18 of the 669 respondents reported having been told that they have rheumatism. Trends in the data from this survey suggest that females among all age groups suffer from arthritis and rheumatism in slightly higher proportions than First Nations males.

Chart 5 – Activity Limitation due to Arthritis

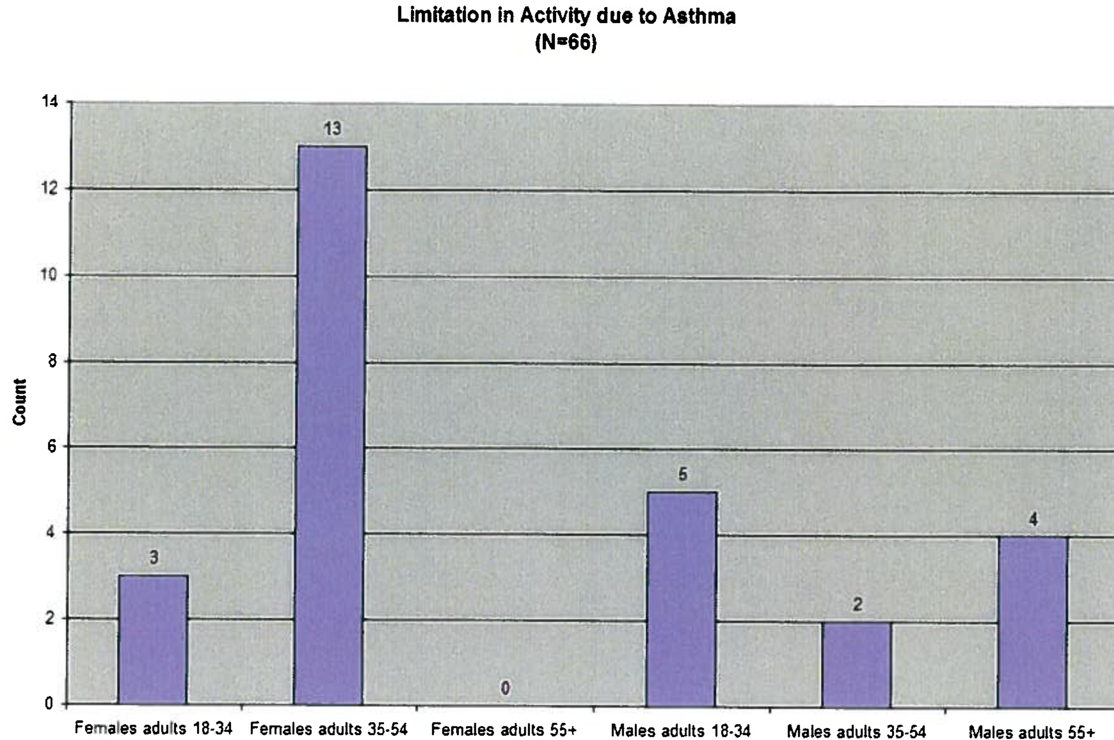


Activity limitations due to arthritis are slightly higher in females than in males, primarily in the 35-54 and 55+ age groups. Activity limitations due to rheumatism are high at 59.9% (12 of 17 respondents) suggesting the severity of the condition for those diagnosed. Just over half (8 of the 15 respondents) report undergoing treatment for rheumatism, while the proportion of respondents claiming to seek treatment for arthritis is slightly less at 58.2%.

Asthma

Of the 672 First Nation adult respondents, 69 reported that they have been told by a health care professional that they suffer from asthma, of which the majority were female (43 representing approximately 62.9%). Of these asthma sufferers, 47 reported undergoing treatment for this chronic health condition, and 24 reported having had an asthma attack in the past twelve months. The highest prevalence of asthma among the First Nations adult population occurs before the age of 54.

Chart 6 – Activity Limitation due to Asthma



First Nations females with asthma, 59.2% are more likely to report limitations in activity than First Nations men, 40.7%. Notably, 13 of the respondents or 48.1% of the adult females who reported limitation in activity due to asthma fall between the ages of 35-54.

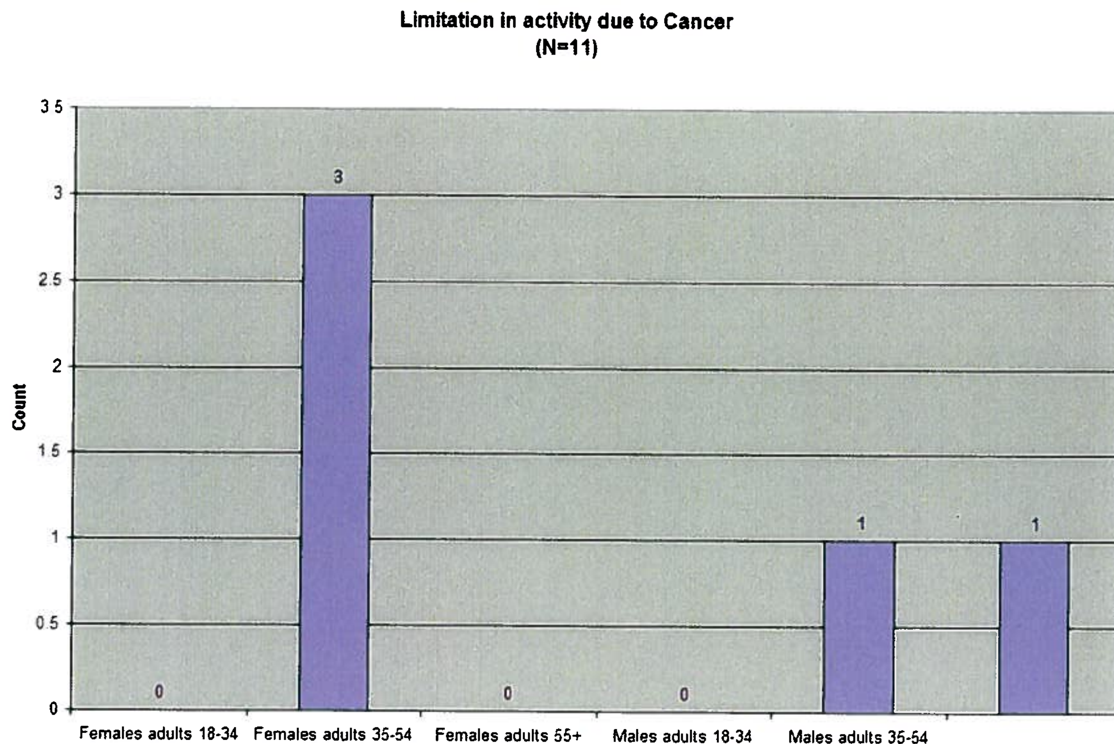
Of the 395 youth respondents, 71 reported having been told that they have asthma. In 35 of these cases, the youths report undergoing treatment for the condition. Further, 15 of the respondents report having had an asthma attack in the past 12 months. Only 15 of the youth asthma sufferers report limitations in activity as a result of asthma.

Surveying of children under the age of 11 revealed that 111 of 597 respondents suffer from asthma, with a slight predominance of asthma in male First Nation children (65 of 111).

Cancer

Of the 680 First Nation adults who participated in the survey, 11 reported having been told by a health care professional that they have cancer, of which 5 are females between the ages of 35 and 54. Of the different types of cancer, breast cancer, cervix cancer and lymphoma were the types of cancer which more than one respondent reported suffering from. Further, 5 of the 11 adults reported to suffer from cancer report undergoing treatment for the condition.

Chart 7 – Activity Limitation due to Cancer



Activity limitations due to cancer were reported by 5 of the respondents, 3 of which are females in the 35-54 age bracket.

DIABETES

Diabetes is a serious health burden in Ontario. It contributes to premature death, and often leads to long-term complications including heart disease, stroke, kidney failure, limb amputation, and blindness. In Ontario, people with diabetes are two to six times more likely to have cardiovascular problems, and 21% will develop heart disease or suffer a stroke (compared to four percent without diabetes). It requires a substantial portion of resources for hospitalization and treatment. The risk of developing diabetes increases with age. Given Ontario's growing and aging population, the prevalence of diabetes is likely to increase.[9]

The fifth leading cause of death among Aboriginal Peoples is due to the increasing presence of two diseases among the Aboriginal population, diabetes and AIDS (classified as endocrine and immune disorders), both of which are affecting individuals in epidemic proportions. Diabetes is characterized as the body's inability to produce insulin (type 1) or to use insulin effectively (type 2), and is a disease that affects the entire Aboriginal population, regardless of age and sex.[10] Diabetes is the seventh leading cause of death for Canada in general with roughly one million Canadians having diabetes, however the prevalence rates among the First Nations population are three to five times higher per capita than the general Canadian

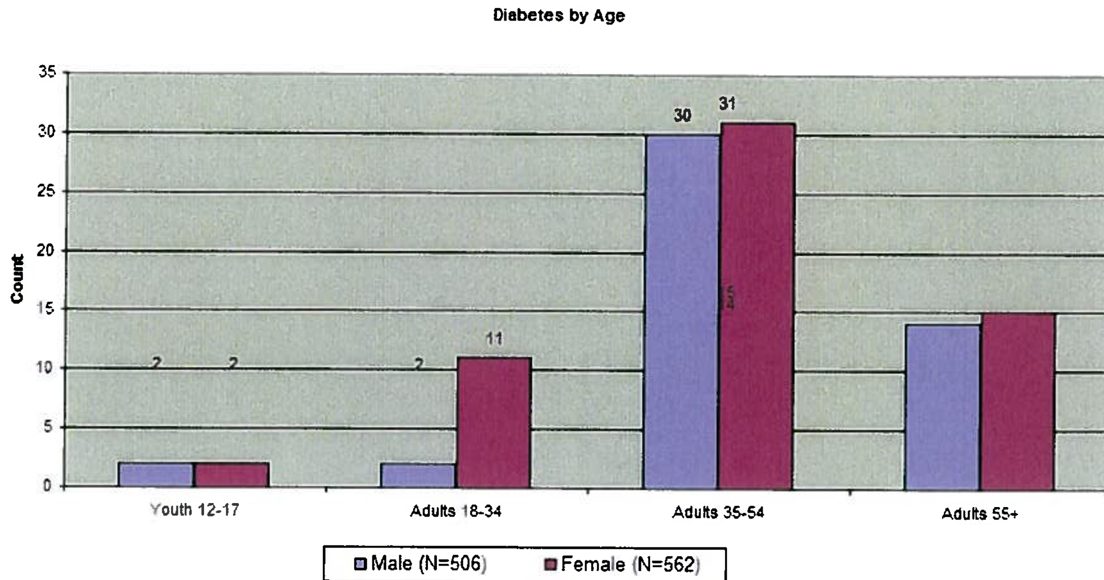
population. [11] More frequently, the high prevalence of diabetes within this population is due to the growing rate of Type 2 diabetes, which is increasingly being diagnosed among children as young as years of age.[12] Currently, among Aboriginal Peoples in Canada "10 percent of the population aged 15 and over, and 23 percent of the population 65 and older have been diagnosed with diabetes".[13]

Equally concerning is the knowledge that the current rates of diabetes among the First Nations population show little sign of slowing, as current projections estimate that 27% of Aboriginal Peoples will acquire diabetes within the next 20 years.[14] Furthermore, since diabetes is still an evolving epidemic among the First Nations population, "the full impact of this disease will likely not be seen in the morbidity and mortality rates for some time".[15]

Diabetes within the Aboriginal population is daunting in its capacity to contribute to death, in addition to indirectly causing it.[16] This is largely because for people aged 35 to 64 with diabetes, there is a six-fold greater risk of heart disease and stroke than for people without diabetes.[17] As with many diseases, major risk factors for diabetes include obesity, poor eating habits and physical inactivity all of which "are prevalent in the Aboriginal population primarily as a result of the lifestyle transition that has been imposed on Aboriginal peoples".[18]

Of the 663 adult respondents, 103 reported having been told by a health care professional that they have diabetes. For First Nations adults, diabetes is notably prevalent in the 35-54 age bracket with 49.3% of respondents falling into this age group. There were little gender differences related to diabetes. Of the diabetic First Nations adults surveyed, 8 reported having been diagnosed with Type 1 diabetes, 73 reported suffering from Type 2 diabetes, 15 respondents report being pre-diabetic, and 11 report being diagnosed with gestational diabetes.

Chart 8 – Diabetes by Age

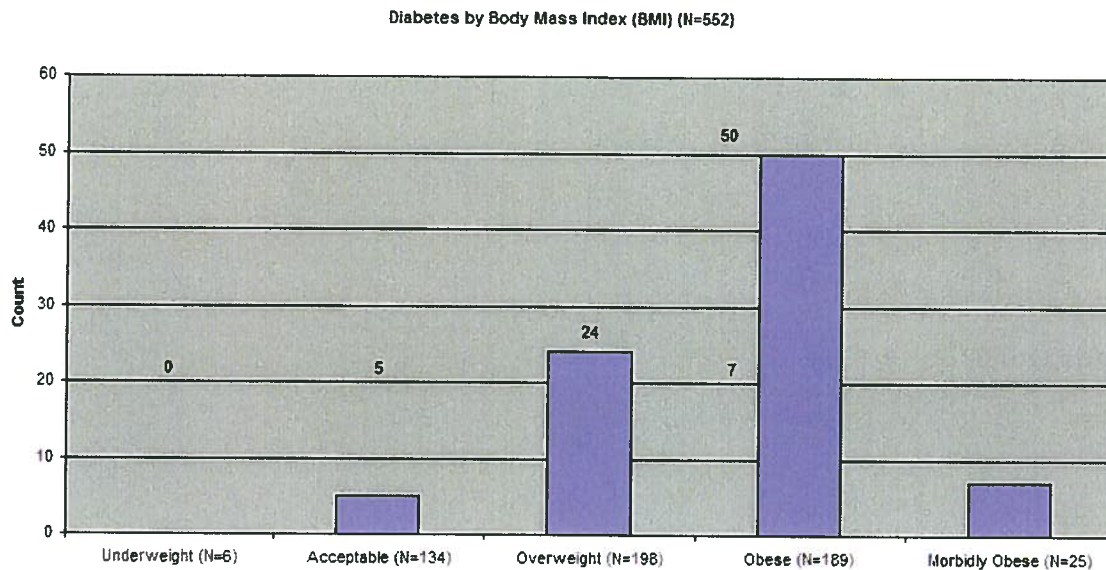


The number of diabetic respondents undergoing treatment is high with 71 adults reporting undergoing some form of treatment. The data further suggests that females are much more likely to attend a diabetes clinic than males. This trend was consistent across all age groups. When questioned on their reason for not attending clinics, 41 of the 57 respondents stated that they already have the information needed, and no longer require diabetes education.

The three most common effects of diabetes on adults reported were as follows: prompted to adopt a healthier lifestyle (75.5%), vision was affected (75.5%), and affected the feeling in the hands or feet (27.4%).

Various factors that may influence the development and prevalence of forms of diabetes, notably Type 2, were examined, including body mass index (BMI). Excluding pregnant females, adults participating in the survey were asked to rate their body mass index into one of the following categories: underweight, acceptable, overweight, obese, or morbidly obese. Of those surveyed, 5.9% had acceptable weights, while 26.4% were overweight, and 67.7% were either obese or morbidly obese.

Chart 9 – Diabetes by Body Mass Index (BMI)



Diabetes is closely related with the co-morbidities of heart disease and high blood pressure, which was reflected in the data from the survey. The principal secondary complications of diabetes reported were high blood pressure at 36.9%, and heart disease at 15.4%.

When youths and children were asked if they had been told by a health care professional that they have diabetes, 4 of 405 youth respondents, and 1 of 603 children, reported that they have. The most common forms of treatment for the youths surveyed were diet and exercise.

INJURIES

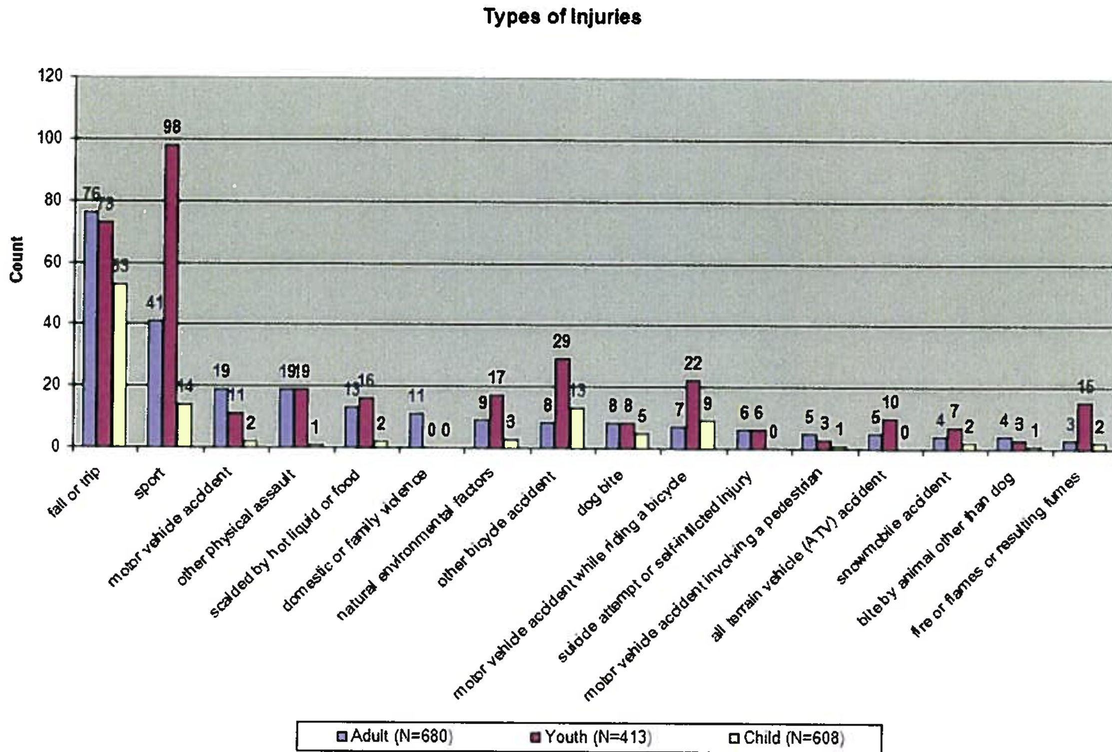
The medical category of injury and poisoning includes all causes of death not attributable to disease.[19] In fact, for First Nations people between the ages of one and 45 years, injury and poisoning are by far the main causes of death. The injury and poisoning death rate for First Nations nationally is 3.8 times the rate for non-Aboriginal Canadians, and there has been little change in this rate since the 1980's.[20] Among the Status Indian population, deaths due to injury and poisoning are more than twice as common among males than among females.[21]

As a whole, the category of injury and poisoning is generally divided into the following causes of death; motor vehicle accidents, suicide, poisoning and overdose, drowning, fire, falls, and deaths due to firearm use (accidental or homicide), and other (aircraft crash, suffocation, exposure, or industrial accident).[22]

The most common injury sustained by First Nations adults and children according to this survey was trips and falls, with 76 of 680 adults, and 53 of 608 children reporting suffering

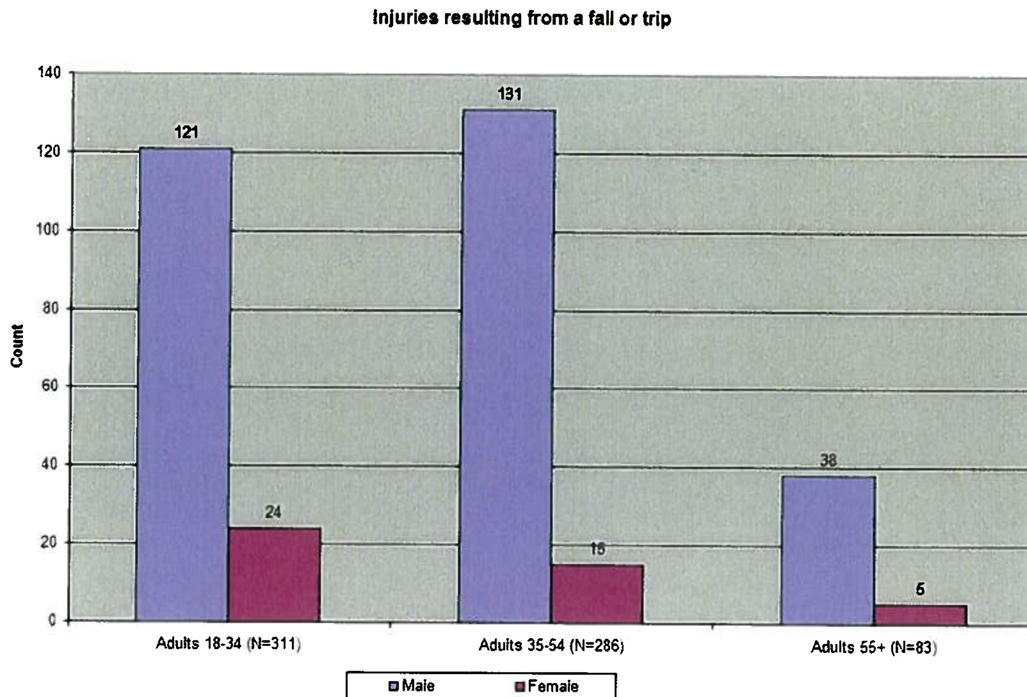
injury from this cause. While the number one cause of injury for youth was sport, with 98 of 413 reporting some form of sport related injury, youths also suffered a marked number of trips and falls (73 of the 413).

Chart 10 – Types of Injuries



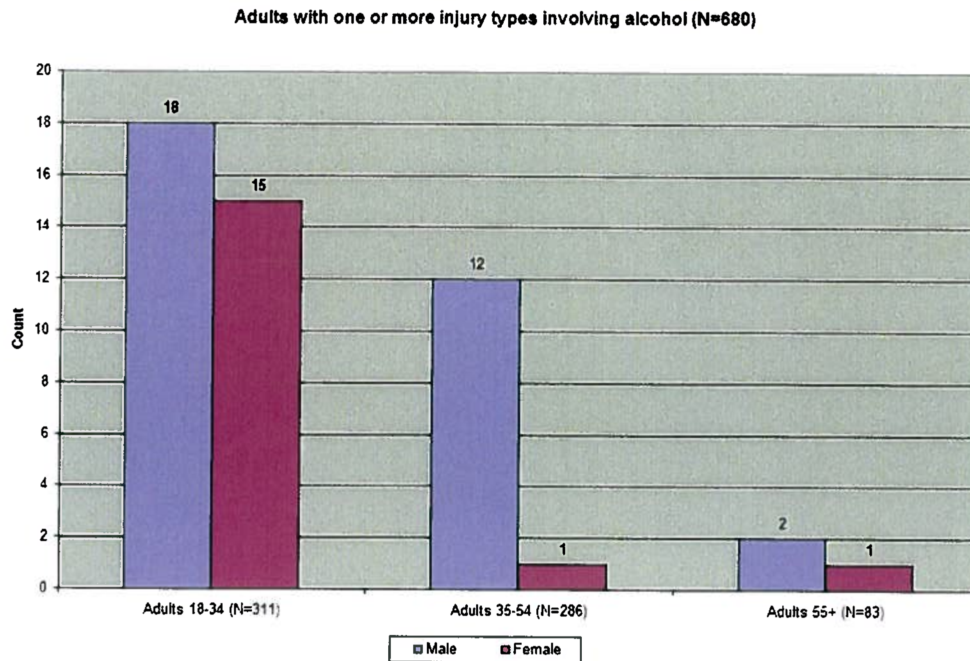
There is a notable difference in gender reporting of falls in First Nations adults, as well as a trend was noted with age. Specifically, the number of trips and falls decreased with age for both males and females.

Chart 11 – Injuries resulting from a Fall or Trip



First Nations adults report alcohol being involved in one or more injury types across all age groups, with alcohol involvement being most prevalent in the 18-34 age group. Within the 18-34 age group, 33 of the 311 respondents (18 male; 15 female) responded that alcohol was a factor in one or more injury types. In the 35-54 age group, 13 of the 286 adults surveyed responded to having alcohol involvement in one or more injury types, with all but one of these respondents being male. Only 8% of all reported injuries for adults involved alcohol.

Chart 12 – Injuries involving Alcohol



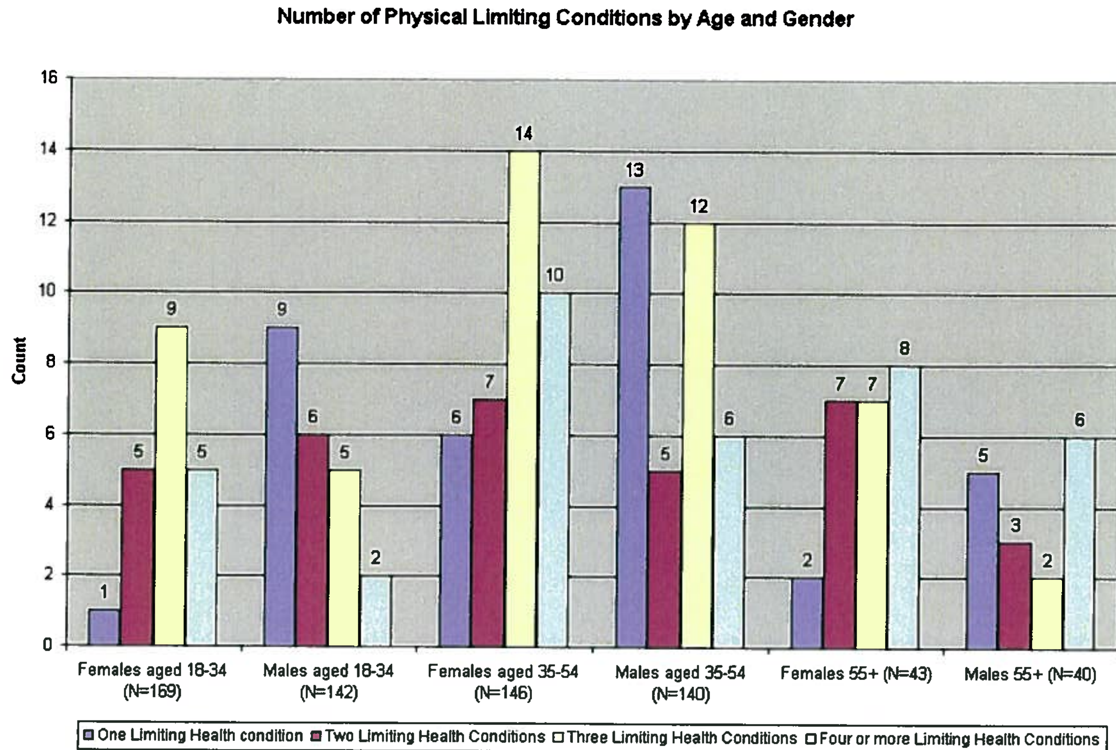
DISABILITIES

The RHS (2002-03) examined disability in adults as one of its components. It is important to understand the impact of disability on adults because many adults with disabilities are not fully included in all aspects of society.

Disability is defined in two ways in this study: a) being told by a health care professional that they have the diagnosis and b) having an activity limitation at home, at school/work; and in other situations such as at leisure or while traveling, due to physical or mental condition or health problem.

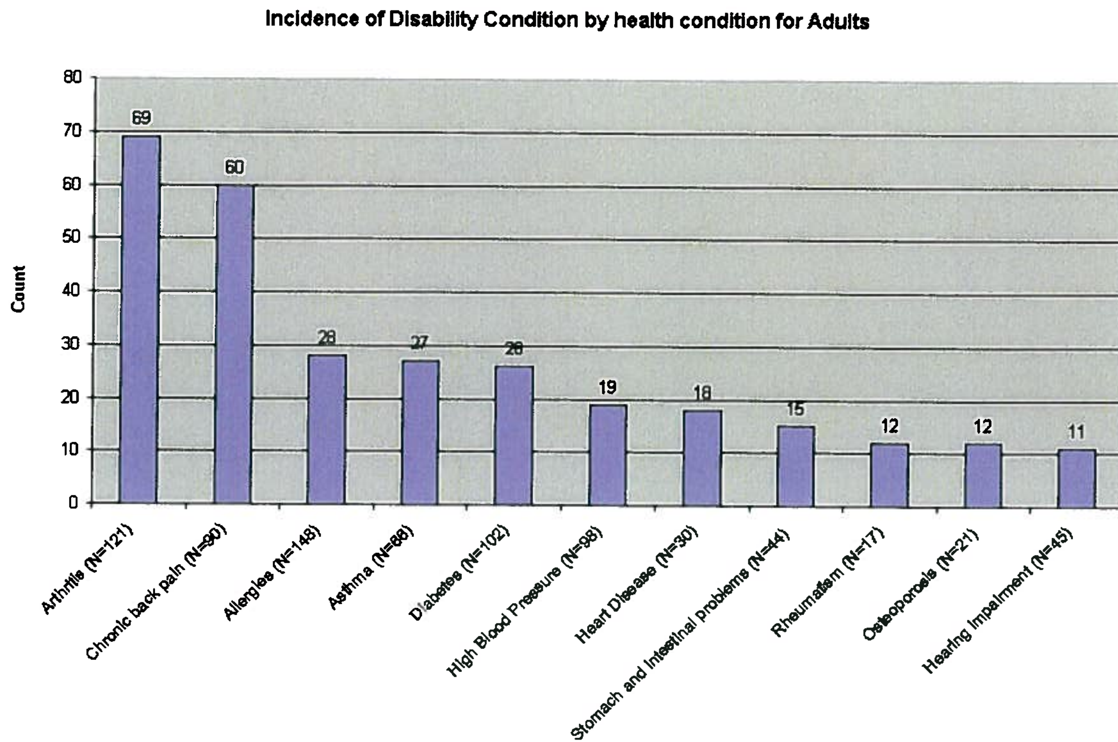
The following diagram provides a breakdown of the number of limitations per adult by age and gender.

Chart 13 – Number of Physical Limiting Conditions by Age and Gender



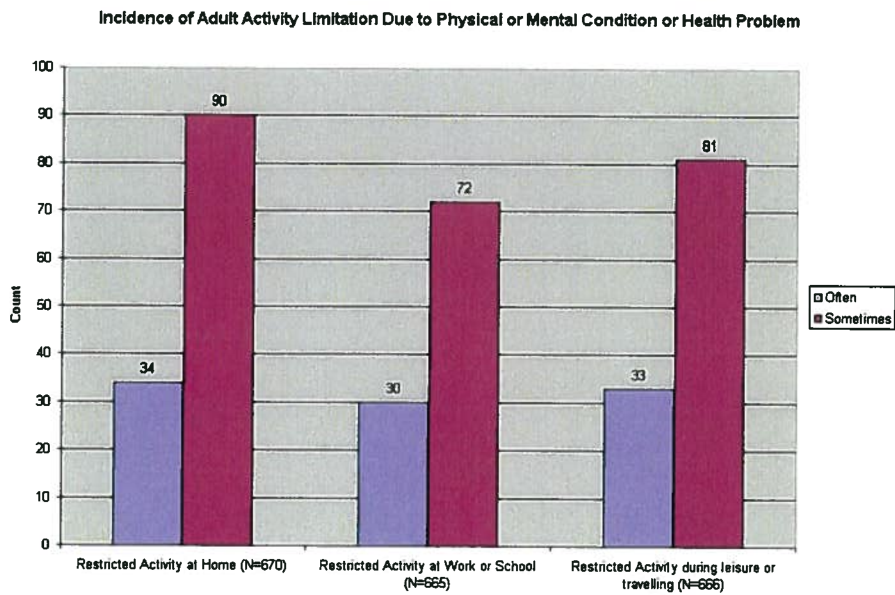
The incidence of disabilities is represented by health condition in Chart 13. The greatest frequency of health conditions contributing to disability or limited activities for Adults who participated in this survey is Arthritis. Chronic back pain is the next frequently mentioned health condition that limits the activities of Adults who participated in this survey.

Chart 14 – Incidence of Disability Condition by health condition for Adults



This chart indicates the degree of limitation experienced by Adults who indicated that they have a disability or limitation due to a physical or mental condition or a health problem.

Chart 15 – Adult Activity Limitation due to Physical, Mental or Health



Thirty-five of 667 Adult respondents indicated that they require modifications to their home to accommodate their disabilities. A total of 84 adults out of 661 respondents stated that a family member often or occasionally provides them with home care. The largest group to indicate that they receive assistance from family members is women over the age of 55 representing 20% whereas men over the age of 55 only represent 11% of those receiving assistance from family members.

In addition, respondents were asked about the type of home care services they need and currently receive. The following Tables 9 and 10 outline their responses.

Table 9:

Do you receive the following services:	Yes	No	Total
Light housekeeping (N=50)	27	23	50
Home maintenance (N=80)	24	56	80
Care from a nurse (N=11)	8	3	11
Personal care (N=11)	8	3	11
Meals prepared or delivered (N=8)	5	3	8
Palliative care (N=2)	0	2	2

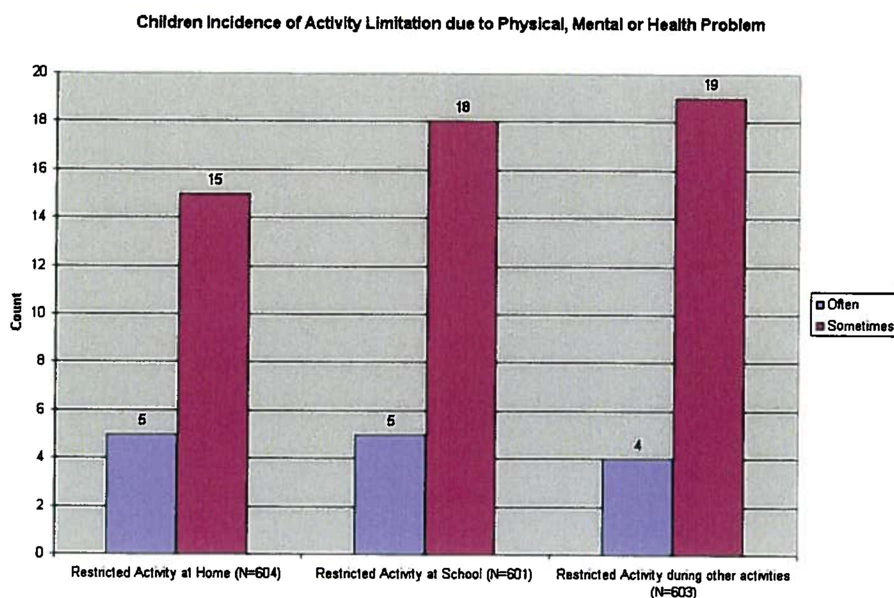
While some of the respondents indicate they are receiving home care services such as nursing care, personal care, light housekeeping and meal preparation, twice as many people indicate that they need similar service, including home maintenance.

Table 10:

Do you believe you need:	Yes	No	Total
Home maintenance (N=673)	82	591	673
Light housekeeping (N=673)	51	622	673
Care from a nurse (N=677)	11	666	677
Personal care (N=677)	11	666	677
Meals prepared or delivered (N=677)	8	669	677
Palliative care (N=678)	2	676	678

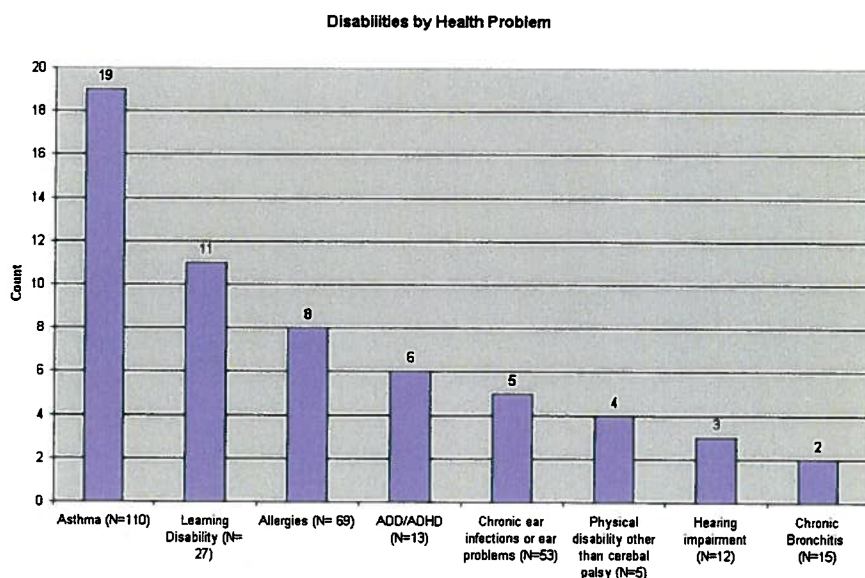
Children were asked the same three questions as adults regarding whether their health conditions result in limitations in activities, with approximately 3% indicating that they have activity limitations.

Chart 16 –Children Activity Limitation due to Physical, Mental or Health

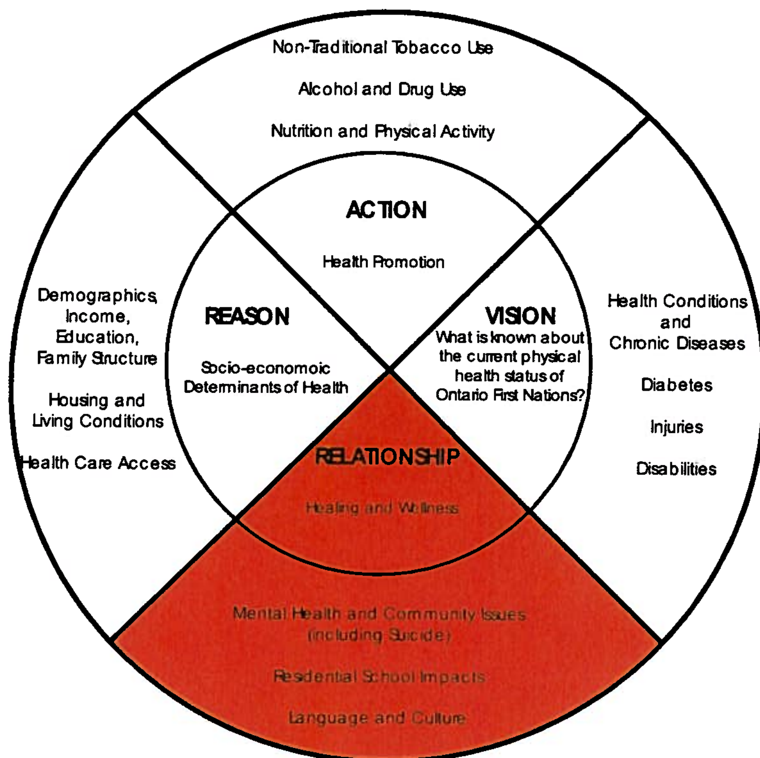


Similar to the adult responses, asthma and allergies were frequently identified as health conditions leading to restrictions in child physical activities. In addition, 11 children had learning disabilities.

Chart 17 – Disabilities by Health Problem



3.2 RELATIONSHIPS



Understanding and identifying the determinants of individual and community wellness is a complex task within the cultural framework discussed in Chapter 2. This section of the report refers to the experiences that one encounters as a result of relationships built over time and examines how we relate to people. By reporting on the Ontario First Nation responses in the 2003 RHS, allows for an opportunity to gain an understanding of the attitudes and awareness that exist at this particular point of time. In particular regarding individual, community and national wellness issues, which include emotional and mental well-being issues, availability of community supports, language and culture, as well as residential school impacts.

Jim Dumont offers the following examples[23]:

Mental Well Being

- Self-directed and creative learning
- Learning guided by elders, vision and creative learning
- Learning directly linked to survival and procurement of quality of life
- Cultural connectivity
- Continuity with cultural and historical past

- Culturally connected and meaningful/purposeful education and learning
- Community supported culture-based education

Emotional Well Being

- Emotions and feelings in balance with individual's life events
- Strong self-esteem related to strong cultural identity
- Pride in heritage
- Self-confidence and self-empowerment
- Community recognition at important stages of life path
- Community is empowered and encourages active community involvement
- Community support for youth involvement and youth achievement
- Community support for elder participation in community events

Culture

- Connection and continuity with the cultural past
- Healthy and vibrant Indigenous culture
- Continuity with the Indigenous historical past
- Meaningful/successful use of cultural healing practices in achieving health
- Significant and active cultural elder contingent
- Active cultural institutions and spiritual traditions
- Strength of language base/active retrieval of the language
- Respect for the land and environment, in keeping with cultural principles

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

Although the historical impacts affecting the mental health of Aboriginal communities have recently gained attention through various initiatives such as the Aboriginal Healing Foundation and the Aboriginal Healing and Wellness Strategy, there is still very little data documenting the state of mental health for this population.

Kirmayer, Bass and Tait acknowledge the consequences of assimilation policies on Aboriginal mental health in "The Mental Health of Aboriginal Peoples: Transformation, Identity and Community". The review indicates that policies implemented at contact such as superimposing a colonial governmental structure onto the Aboriginal population; the reserve system and residential schools, interfered with traditional values and lifestyle including connection to the land, which has had a significant impact on Aboriginal health. An important indicator that the current health service delivery model does not adequately meet the needs of the Aboriginal population is indicated in the fact that so few Aboriginal people seek treatment. As a result, it is difficult to provide an accurate estimation of the full degree of impact on mental health.

The Ontario RHS asked respondents to express how often they felt in balance in their lives relating to the four aspects of physical, emotional, mental and spiritual. More than 491 or 73% felt in balance physically at least most of the time. Similarly, 503 about 75% felt in balance emotionally. Approximately 542 or 78% felt in balance mentally and about 465 or 78% felt in balance spiritually at least most of the time. Despite these high levels of perceived balance among the respondents, 155 (N=652) have experienced a time when they felt sad, blue or depressed for 2 weeks or more in a row, which is indicative of depression.

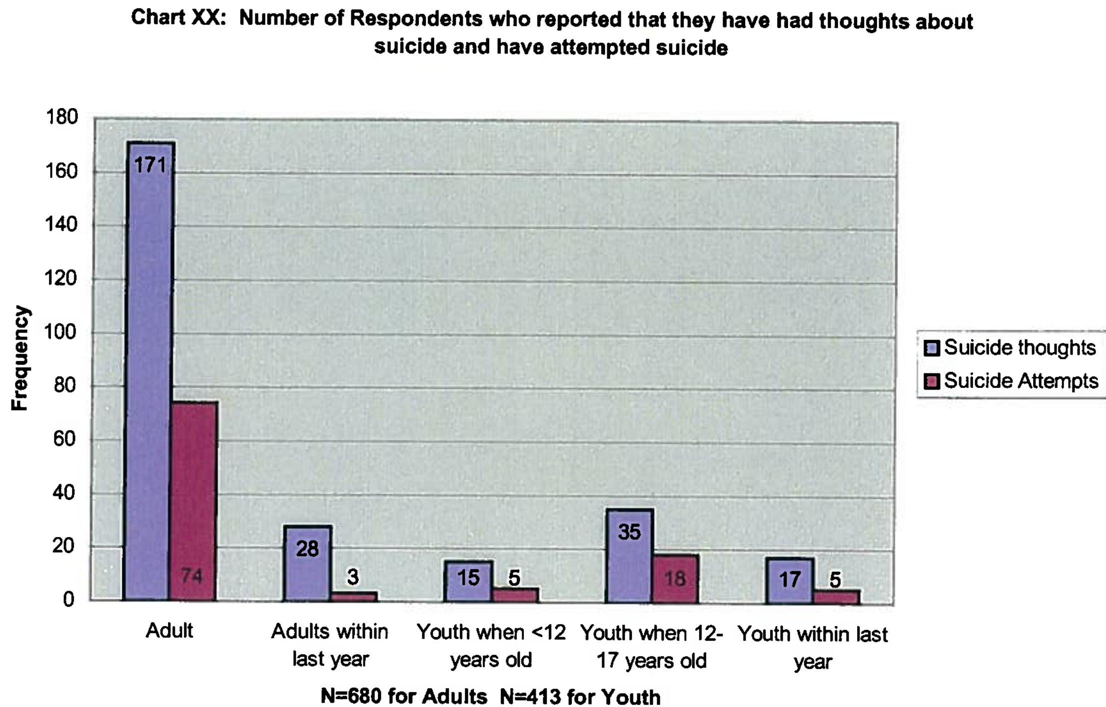
SUICIDE THOUGHTS AND ATTEMPTS

The retrospective data on suicidal thoughts and attempts were alarming and are presented in Chart 18. The results indicate that overall, 171 out of 630 **Adult** respondents (weighted % =29%) reported having had suicidal thoughts over their lifetime. There was relatively equal representation between male and female respondents with 102 women representing approximately 51%. The **Youth** respondents reported that 67 of the 413 respondents have thought about suicide. There were significantly more female youth who have experienced suicidal thoughts: 11/15 while under the age of 12; 28/35 while in the 12-17 age range.

Just under half of those Adults who had thoughts of suicide reported a suicide attempt over their lifetime (74 of the 171), with a higher proportion of female respondents (49 of the 74 respondents). Three adults attempted suicide in the past year, two of which were in the 17-29 age range and one was in the 30-39 age range.

The Youth survey findings reported that four of the five suicide attempts under 12 years of age were by females, and females account for 14 of the 18 attempts between the ages of 12-17 years. Three of the five suicide attempts by youth respondents in the previous year were attempts by females.

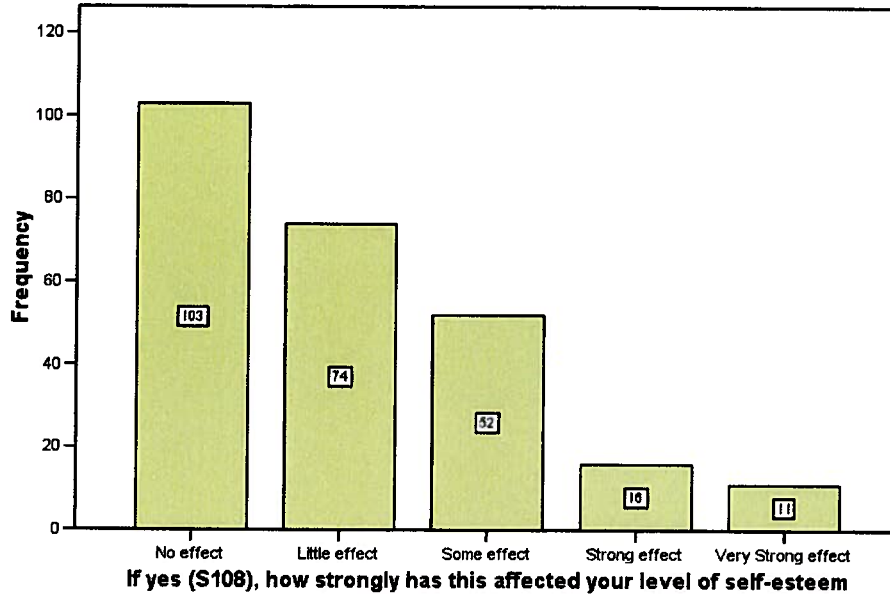
Chart 18 – Reported Suicide Thoughts and Attempts for Youth and Adults



RACISM

Respondents were asked if they have experienced instances of racism in the past 12 months. Of the 646 people who answered this question, 274 responded affirmatively (weighted % = 36.4%). Respondents went on to identify what impact it has on their self esteem as indication in Chart 19:

Chart 19 – Impact of Racism on Self Esteem on Adults



EMOTIONAL WELLNESS

Adult and Youth respondents were asked to respond to a series of questions regarding control over their lives. There was no significant correlation between these responses and depression or suicide attempts.

Chart 20 – Adult Emotional Wellness

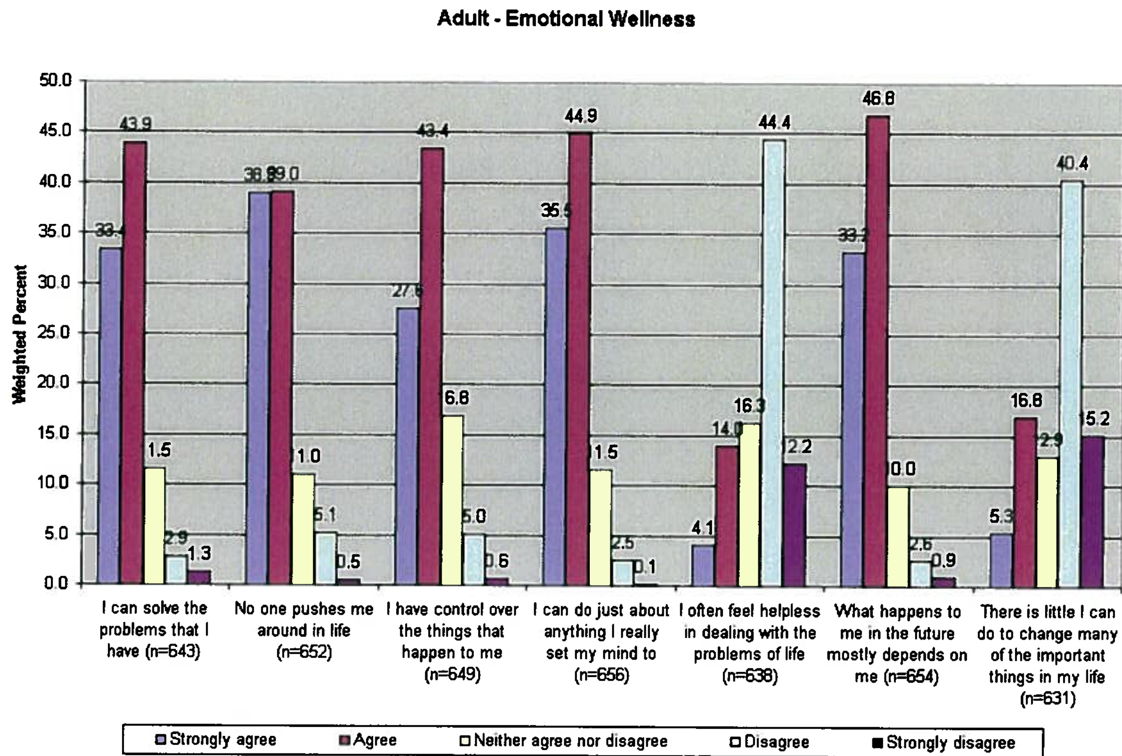
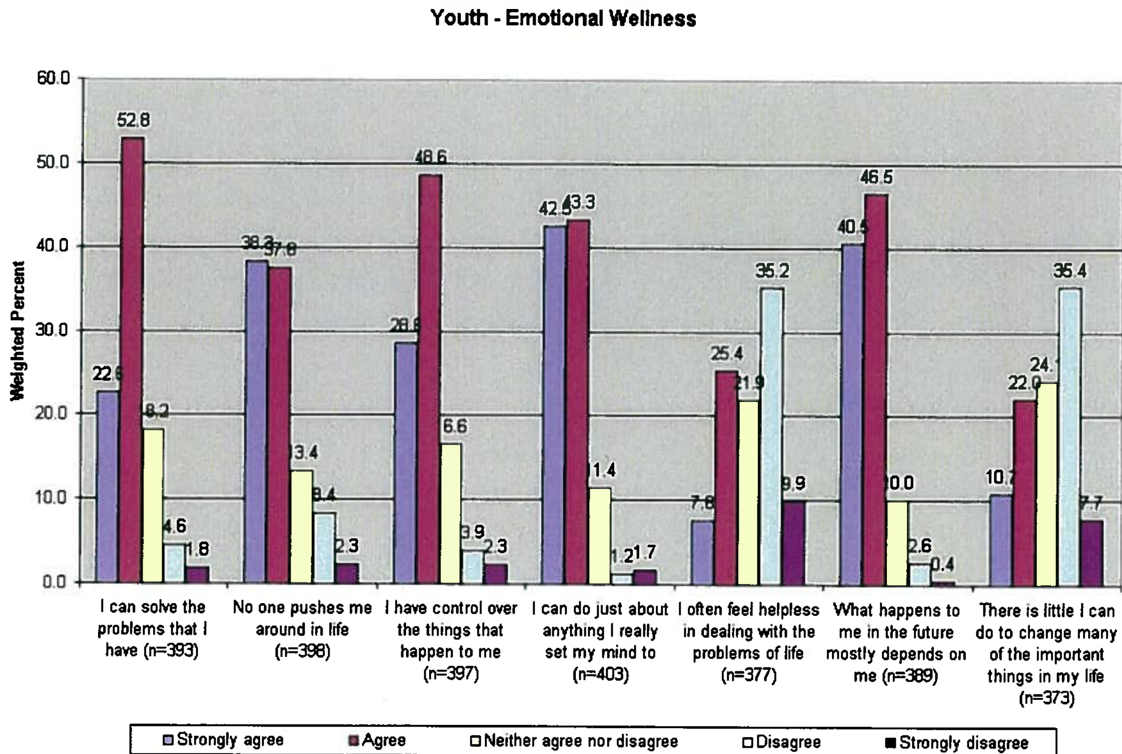


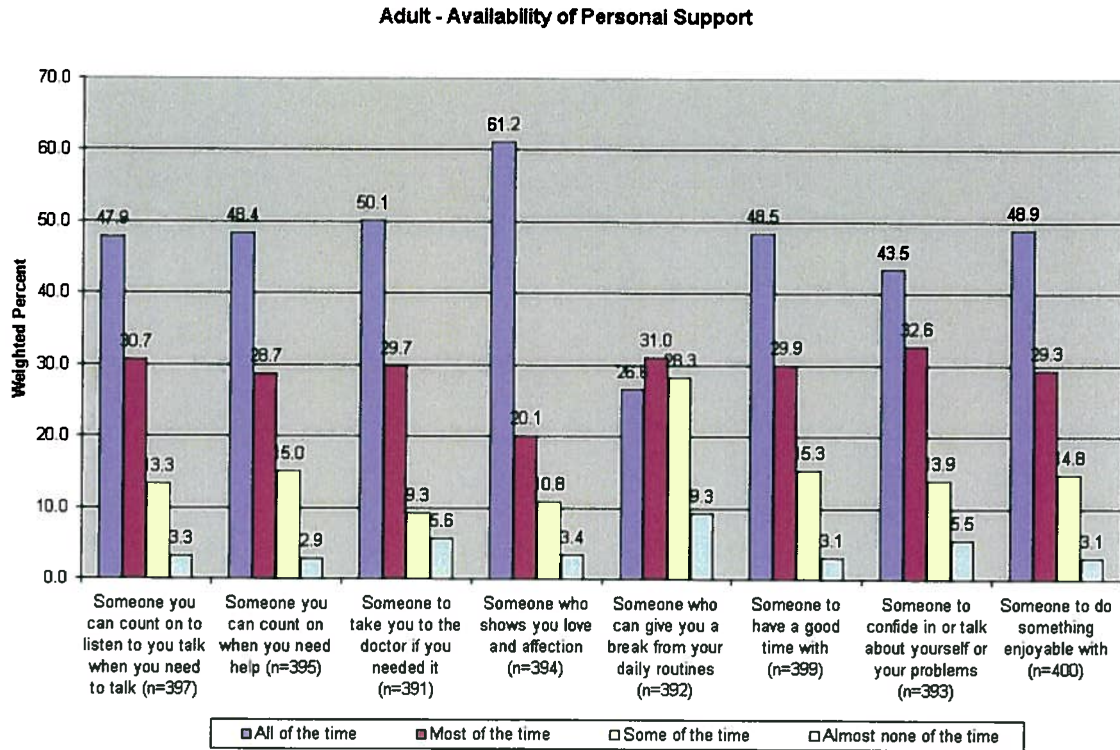
Chart 21 – Youth Emotional Wellness



PERSONAL SUPPORT

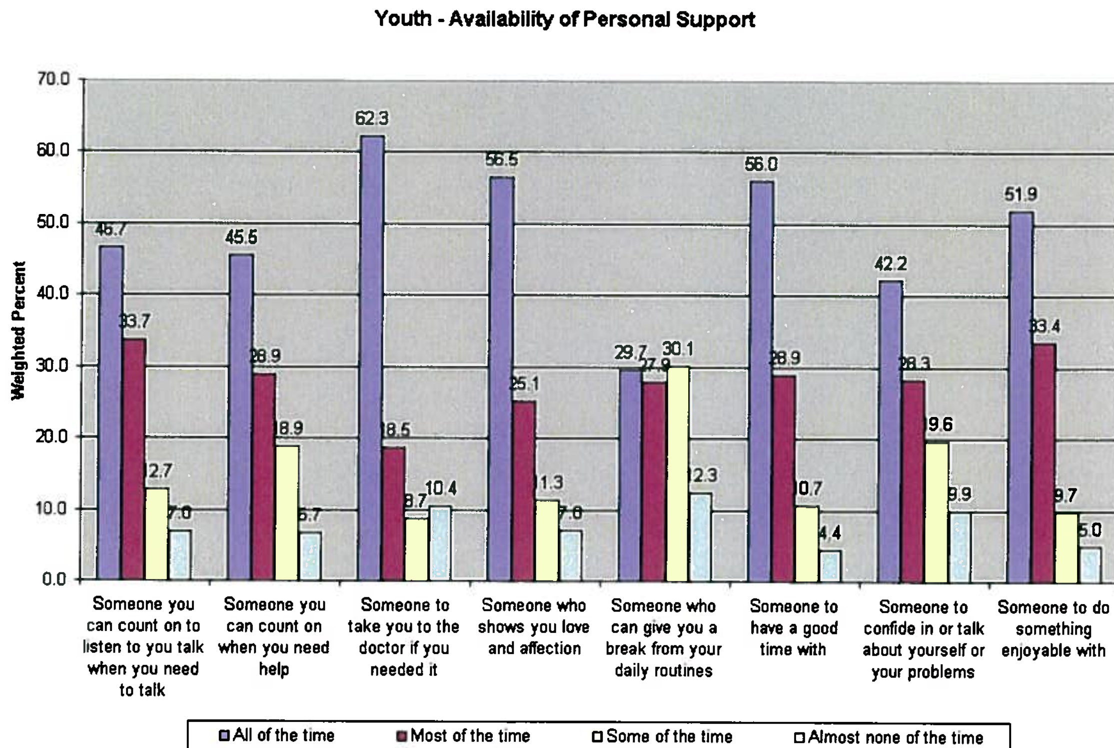
The availability of personal support was asked to survey respondents. For **Adults**, approximately 61% felt they always have someone to show them love and affection. About half of the respondents, representing 49%, felt they always have someone who will take them to a doctor, or someone to do something enjoyable with. The availability of someone who can always give them a break from their daily routines was quite low at 26%.

Chart 22 – Adult Availability of Personal Support



For **Youth** respondents, approximately 56% felt they always have someone to show them love and affection. More than half of the respondents, representing about 62%, felt they always have someone who will take them to a doctor and 52% reported having someone to do something enjoyable with. The availability of someone who can always give them a break from their daily routines was quite low at 29%.

Chart 23 – Youth Availability of Personal Support



When asked about the use of emotional or mental health support, the respondents demonstrated that the majority of their support was sought from family and friends (Chart 23). **Adult** respondents reported more than one source of support, approximately 23.3% used emotional or mental health support from their family doctor, about 12.5% reported the use of traditional healers, and about 3.5% sought support from a psychiatrist and/or psychologist, while roughly 1.8% received support from a crisis line worker.

The Youth respondents also sought more than one source of support with approximately 7% used emotional or mental health support from their family doctor, about 4.7% reported the use of traditional healers, about 3.5% sought support from a psychiatrist and/or psychologist, while roughly 1.2% received support from a crisis line worker.

CHILDREN

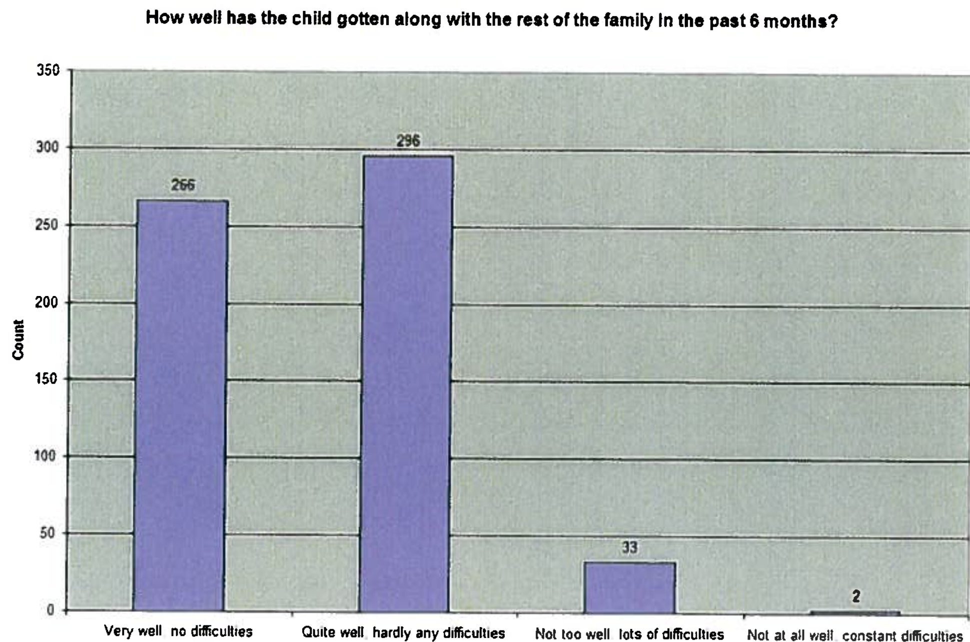
Reading to children and encouraging reading by children has often been cited as a determinant in healthy childhood development. Reading activities have been praised for the developmental benefits, relationship building and emotional connectedness that it fosters. As such, the emotional and well-being component of the RHS Children's survey asked parents how often their child read for fun or was read to (outside of school).

Table 11:

		Sub region final				
		Assoc. of Iroquois & Allied	Grand Council Treaty #3	Independent First Nations	Nishnawbe-Aski Nation	Union of Ontario Indians
How often does the child read for fun or is read to	Every day	66	18	93	13	59
	A few times a week	54	18	65	18	45
	Once a week	12	10	14	10	6
	A few times a month	7	4	5	6	5
	Less than once a month	4	2	4	4	2
	Almost never	11	5	16	12	12

Family connectedness and how children relate to and get along with their families is also an important consideration in their emotional and social well being. The role that social environments and support networks play with respect to the emotional and physical well-being of children has been widely recognized as important. One of the essential elements of this social environment is the family. The RHS measured this through one survey question which asked respondents how well the child has gotten along with the rest of their family over a given period of time.

Chart 24 – Child getting along with family in the past 6 months



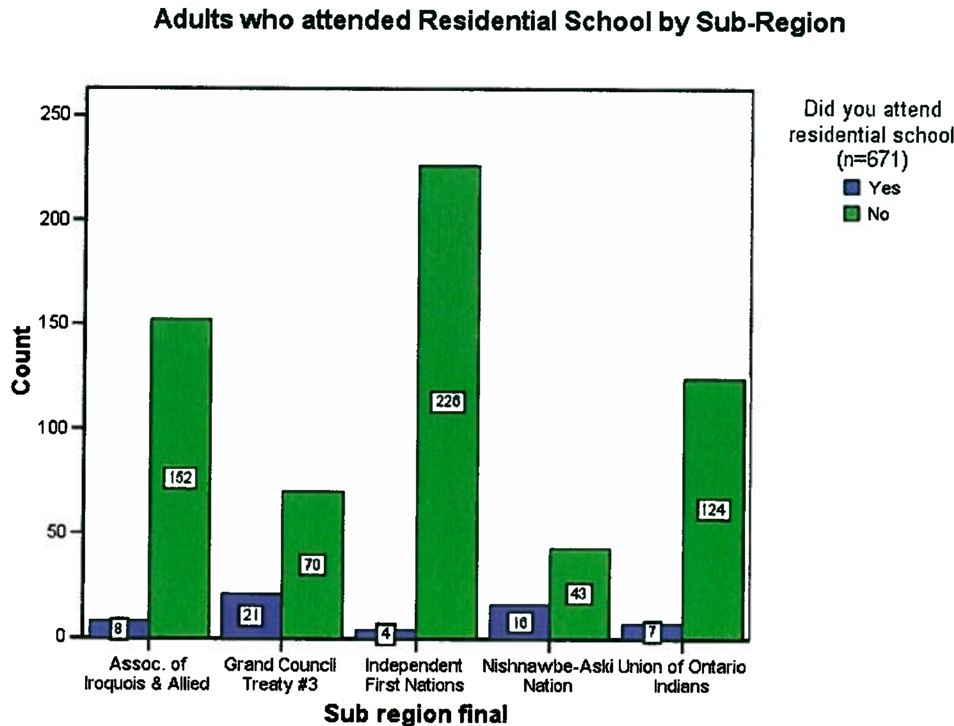
When asked how the child has gotten along with family in the past six months, 266 out of 597 children or 43 %, indicated very well with no difficulties, 296 or 50% said quite well with hardly any difficulties and 33 or 4.6% said not too well with lots of difficulties. About 2 or 0.4% of the respondents indicated that the child was not getting along at all well with constant difficulties. Chart 24 presents the descriptive results for how well child got along with family in the past six months.

RESIDENTIAL SCHOOL IMPACTS

Of the **Adults** interviewed, 56 of the 680 respondents, approximately 10%, reported that they attended residential schools and spent an average of approximately 5 years at residential school. The average age that adults started attending residential school was about 10 years old and they left the schools when they were 15 years old. Similar findings were indicated in a 1991 survey of on-reserve Aboriginal Peoples across Canada whereby results reported that 39% of First Nations people (45+) had attended a residential school and had stayed for an average of six years.

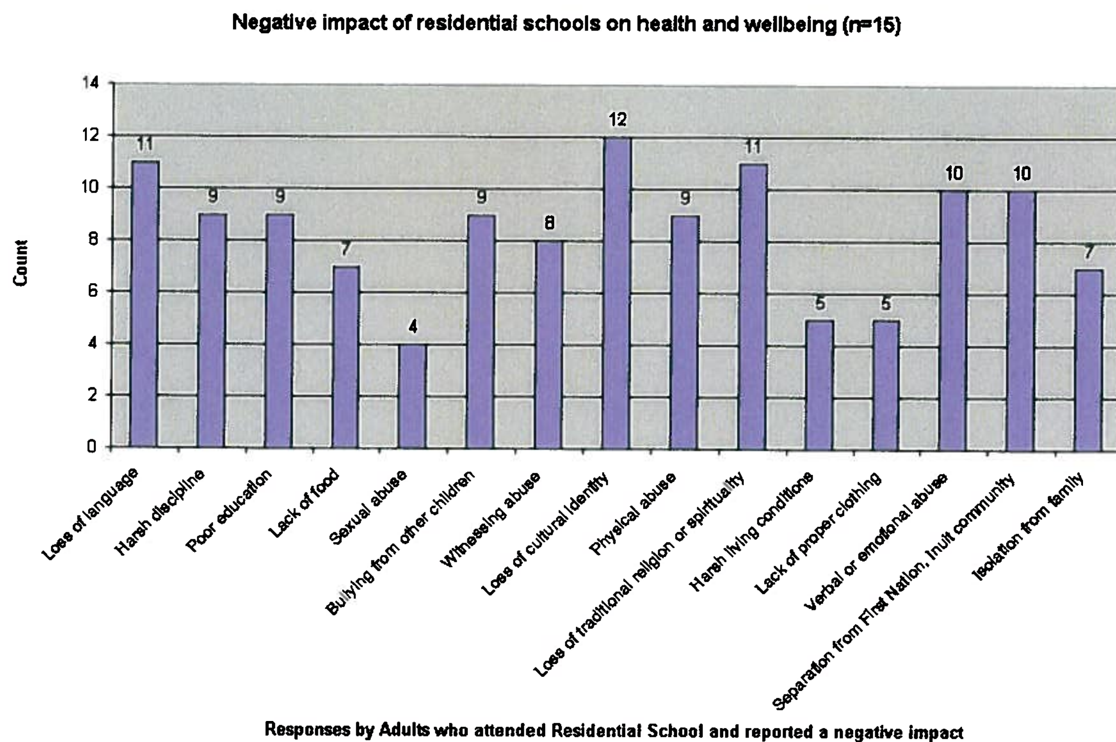
There was an equal distribution of adults who attended residential schools across the age range. This is in contrast to what was expected, which was that the proportion of First Nations and Inuit adults who attended residential schools would generally increase with age—a reflection of the gradual disappearance of residential schools between the 1950's and 1990's. This result may be a reflection of residential schools remaining open in Grand Council Treaty #3 and Nishnawbe Aski Nation until well into the 1990's (see Chart 25).

Chart 25 – Adults who attended Residential School by Sub-Region



Residential schools were often located in isolated areas and the children were allowed little or no contact with their families and communities. In addition, there was a regime of strict discipline and constant surveillance over every aspect of their lives including cultural expressions through language, dress, food, or beliefs. Suppression of culture was a mandate of the schools. Seventeen of the 56 Adults reported that their overall health and well-being has been negatively affected due to their attendance at residential school. Responses of the fifteen adults who reported specifically on how their health and well-being was impacted by their residential school experience are represented in Chart 26.

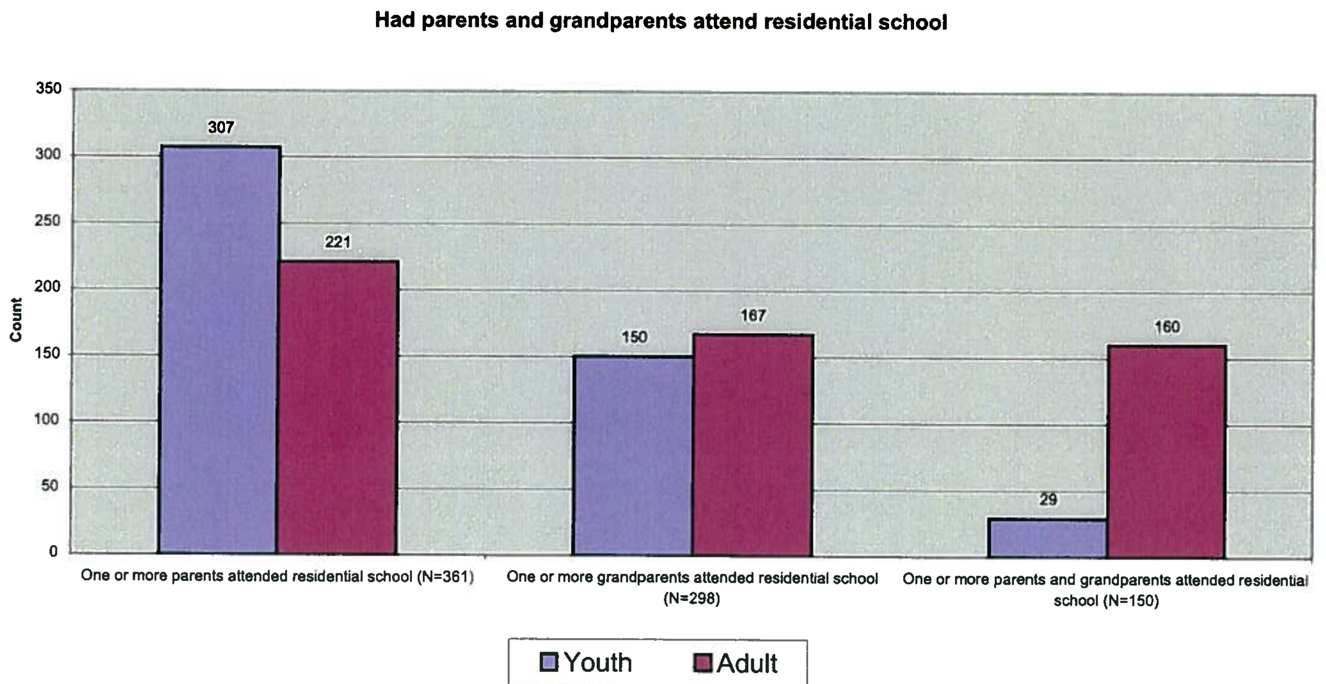
Chart 26 – Negative impact of residential school on health and wellbeing



INTERGENERATIONAL IMPACTS OF ATTENDANCE AT RESIDENTIAL SCHOOL

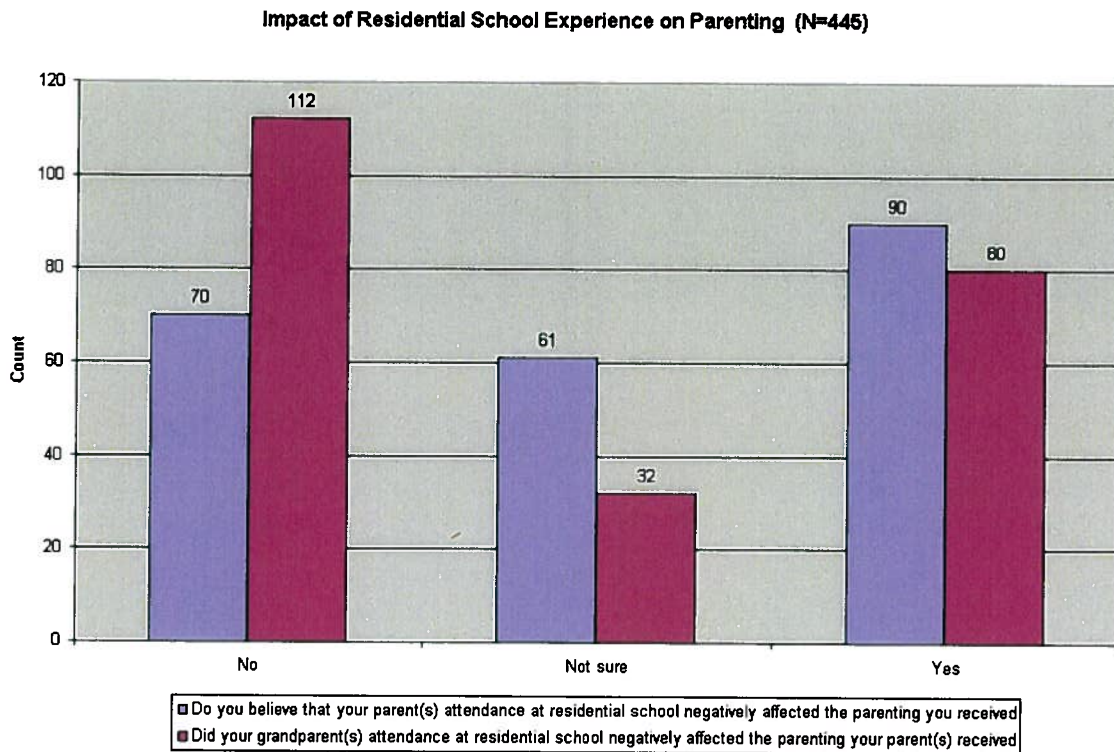
The Royal Commission on Aboriginal Peoples (RCAP), 1991 is one of many residential school studies which indicate that many of today's Aboriginal parents and grandparents who went through the residential school system were denied role models from which they could learn proper parenting skills. This resulted in leaving them ill-equipped to become parents with healthy parenting skills in their own right. Chart 27 summarizes intergenerational attendance at residential schools.

Chart 27 – Parents or Grandparents who attended Residential School



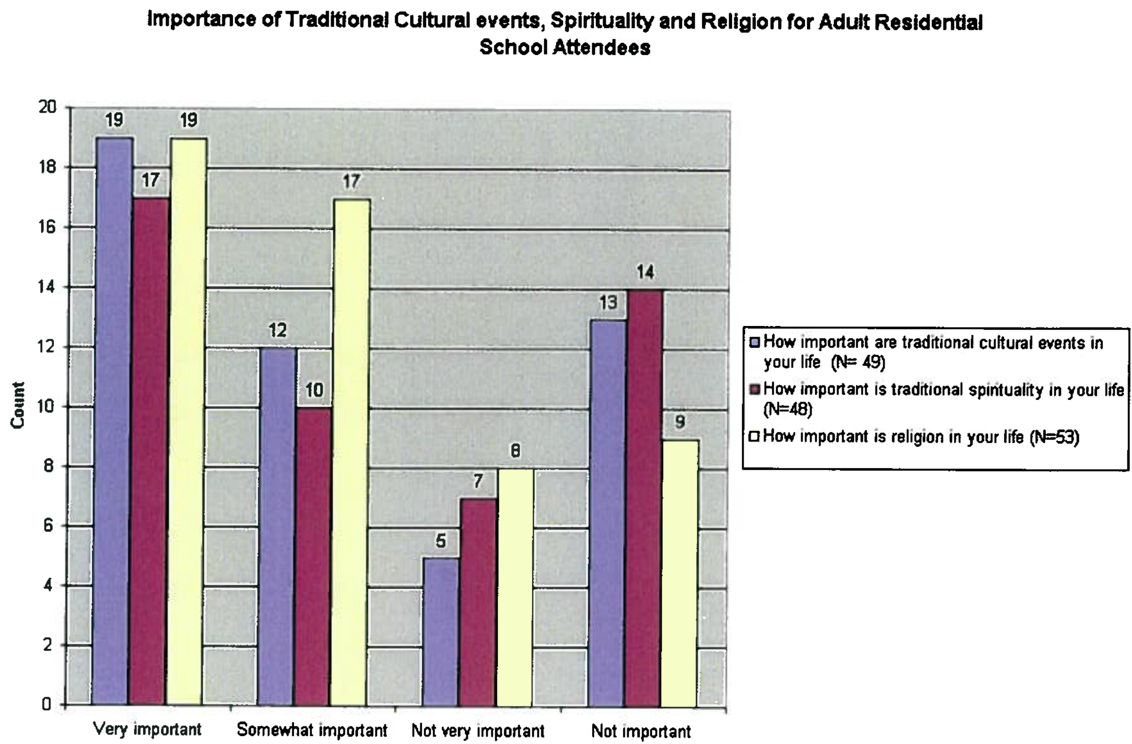
Almost one third or 35% of the adults interviewed believe that their parents' attendance at residential schools negatively affected the parenting that they received as children. The majority of adults, 67%, also believe that their grandparents' attendance at residential schools negatively affected the parenting that their own parents had received when they were children.

Chart 28 – Impact of Residential School Experience on Parenting



Former residential school students responded to questions regarding the importance of traditional cultural events and spirituality for this study. Nineteen of the 49 residential school attendees or 39.5%, indicated that traditional cultural events are very important in their lives with an equal number indicating that this is not very important to their lives. Seventeen respondents or 31.7% stated that traditional spirituality is very important in their lives. However, an equivalent number of respondents indicated that traditional cultural events and traditional spirituality are not important to in their lives. Additionally, 19 of 53 respondents or 34.3% who attended residential school say that religion is very important in their lives (Chart 29).

Chart 29 – Importance of Traditional Cultural Events for Adult Residential School Attendees



LANGUAGE AND CULTURE

Aboriginal languages are like the many streams that surge through the land to form one mighty river which flows through souls nourishing their identity, traditions and way of life and carrying their hopes, dreams and desires into the everyday world of human existence. (Dockstator, 2004)

It is the belief of many Aboriginal teachings that languages have been given by the Creator as an integral part of life and as a means of establishing a relationship with the Creator. Language embodies all values, attitudes, beliefs and truths and consequently has historically played a significant role in the lives of Aboriginal Peoples. However, as Aboriginal Peoples came into contact with western society, an incredible amount of inward pressure was exerted through policies and residential schools that served to extinguish Aboriginal languages and cultures.

The participants in the 2004 Task Force on Aboriginal Languages and Cultures National Consultations eloquently and passionately shared a richness of knowledge through teachings and personal testimonials of the negative impact of historical events, including Indian Act regulations, treaties and residential school experiences. A common theme that Task Force on Aboriginal Languages and Cultures participants spoke about was the loss of language through residential schools and colonization.[24] A great number of the participants were residential school survivors. Some have survived with their language intact and some are struggling to regain their former fluency. In residential schools, Aboriginal children were beaten and shamed if they spoke their own language.

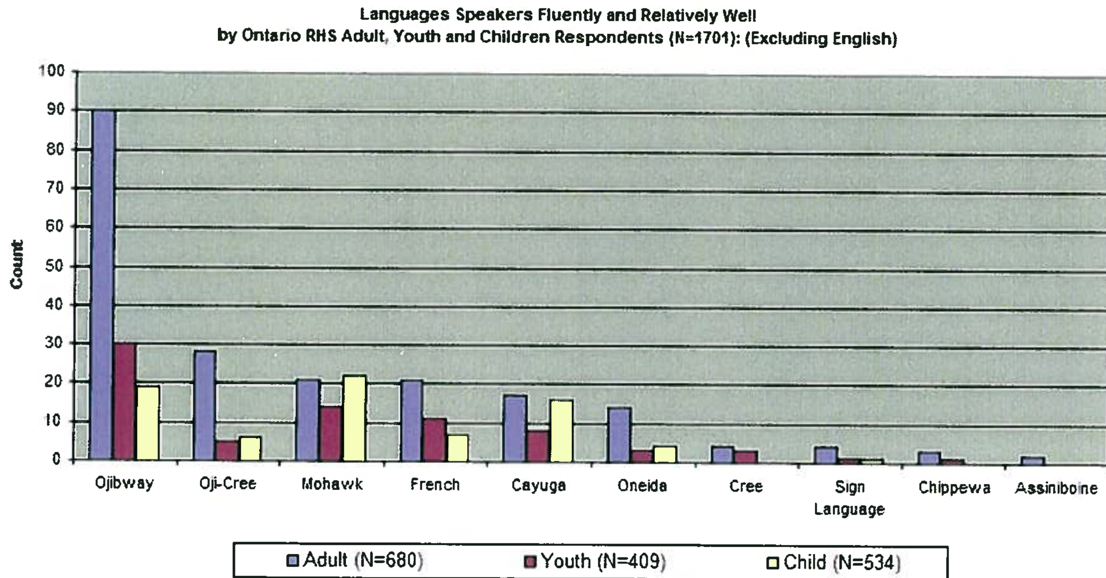
The participants emphasized the importance of rectifying this loss and again restoring languages to the appropriate balance in Aboriginal Peoples' lives. The participants spoke about their different experiences with the language. There were those participants who had learned their language from birth, those who had lost it through residential schools and colonization, and those who were not raised with the language and were only beginning their journey to learn it. Aboriginal languages are much more than words that are spoken. "Languages are the breath of life", as one participant eloquently stated. "They connect you to the Creator, to Mother Earth, to the community, to your family and to yourself." [25]

As part of these language consultations, Aboriginal people across the country discussed the connection that language provides to culture, spirit and the community, insisting that language and culture cannot be separated from each other. If they are, the language becomes only a tool and the spirit that lives within the language is diminished. An important theme of revitalizing the languages is not solely about becoming fluent in Aboriginal languages but it is also about becoming fluent in Aboriginal cultures and histories themselves. One of the responsibilities Aboriginal peoples have to the Creator, according to the consultations, is to ensure that the language is passed to forthcoming generations. The youth of today are the leaders of tomorrow and it is through them that many wounds will be healed. Hopefully, with each successive generation the language will grow and the impacts of colonization will diminish.

LANGUAGE

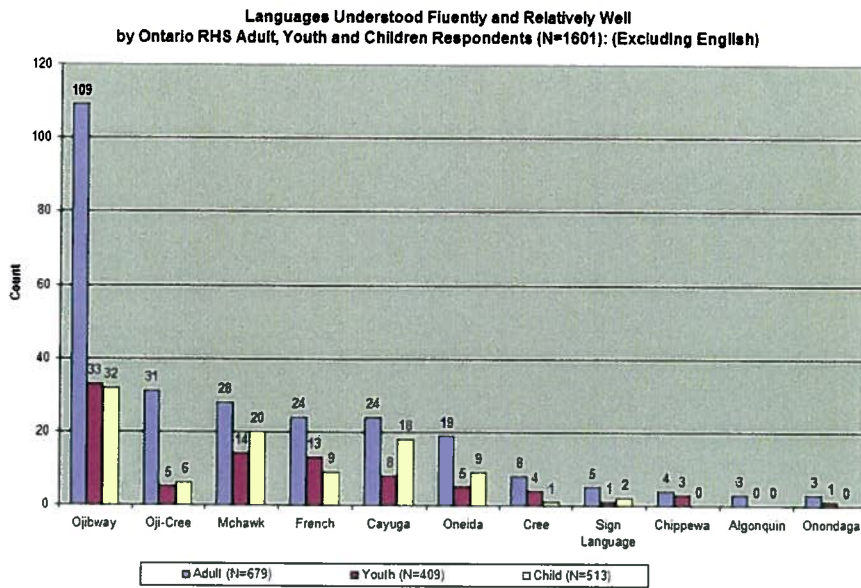
Respondents were asked questions about their ability to speak and understand Aboriginal language, with the following responses available: fluently, relatively well, a few words, or no understanding. For the purposes of this discussion, fluently and relatively well responses were combined. As demonstrated in the Charts 30 and 31 below, Ojibway is the most widely fluently spoken and understood language by the respondents who took part in this study with Oji-Cree and Mohawk completing the top three languages fluently spoken by the sample group. It is clear from this chart that fluency decreases by age category of Adult, Youth and Children.

Chart 30 – Languages Spoken by Adult, Youth and Children



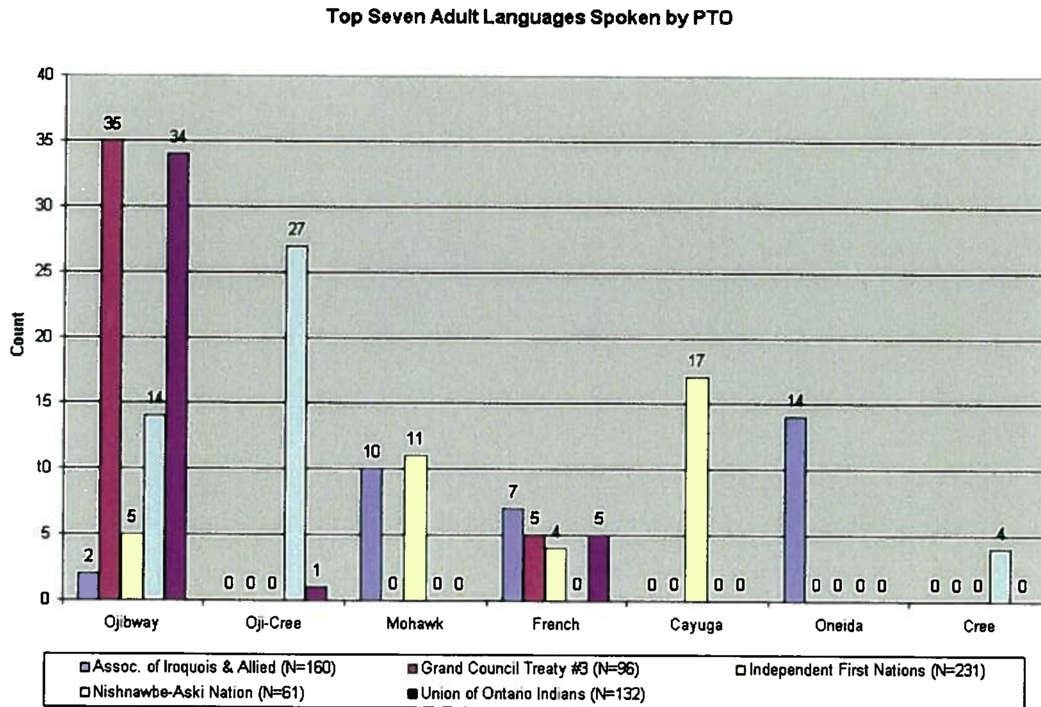
As expected, the number of First Nations people who understand their language fluently and relatively well is slightly larger than the number of people who speak their language. (Charts 30 and 31)

Chart 31 – Languages Understood by Adult, Youth and Children



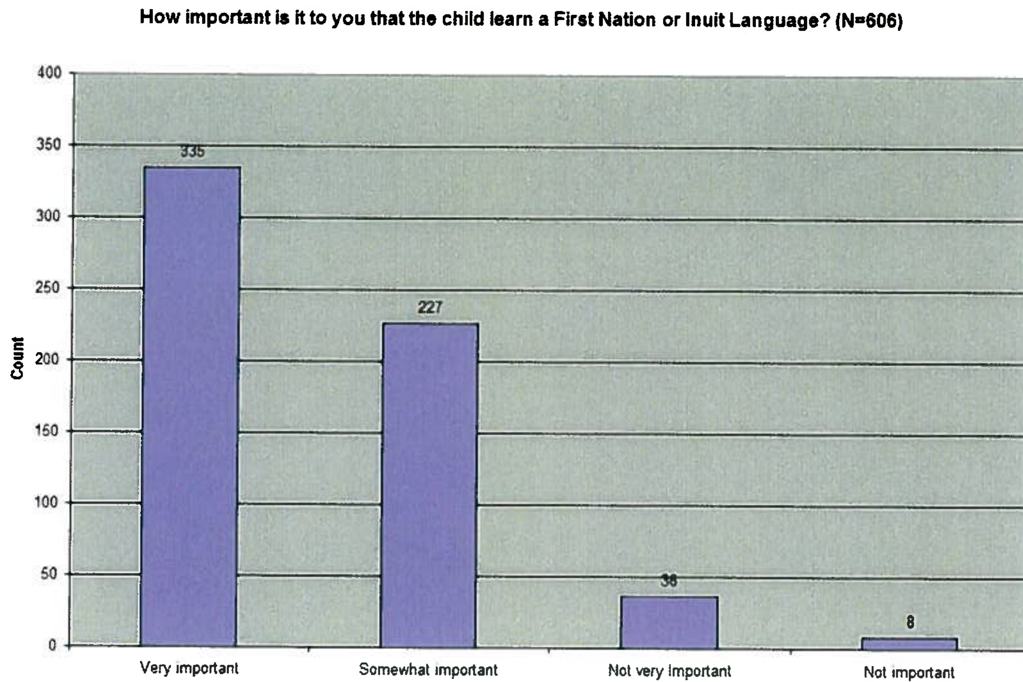
The following Chart 32 provides a further breakdown of Adult fluent speakers by Provincial Territorial Organization/Independent First Nations.

Chart 32 – Top Seven Adult Languages Spoken by PTO



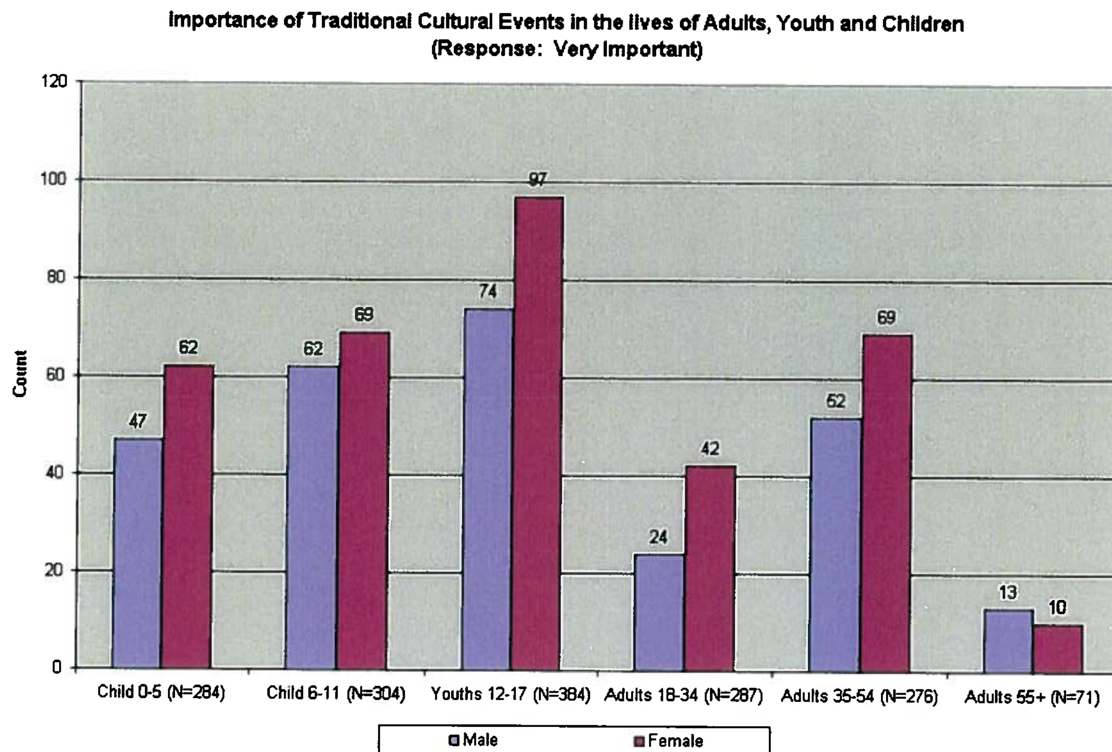
In addition to identifying the fluency or ability to understand Aboriginal languages, parents were asked to share how important is it to them that their children learn a First Nation language. Chart 33 demonstrates the high importance placed on learning a language in contrast to the low numbers of children and youth who actually speak or understand a First Nation language.

Chart 33 – Importance of Children learning First Nation or Inuit Language



CULTURE

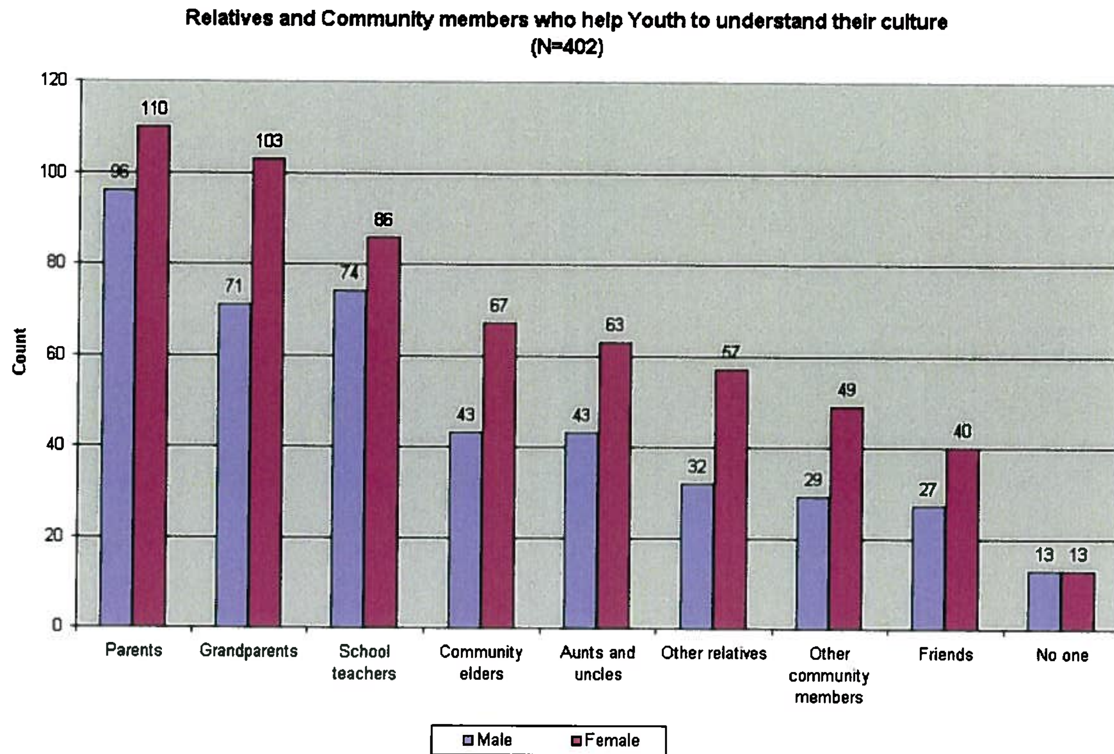
Chart 34 – Importance of Traditional Cultural Events for Adults, Youth and Children



As discussed earlier, many Aboriginal people believe in the link between language, culture and the connection with the Creator, to Mother Earth, to the community, to family and to self. A number of questions were directed towards the importance of traditional cultural events in the Ontario RHS respondents' lives. Chart 34 presents a summary of responses for Adults, Youth and Children who stated that traditional cultural events were "very important" in their lives. As illustrated in the chart, slightly more females than males attached a high level of importance to traditional cultural events in their lives, across all age groups.

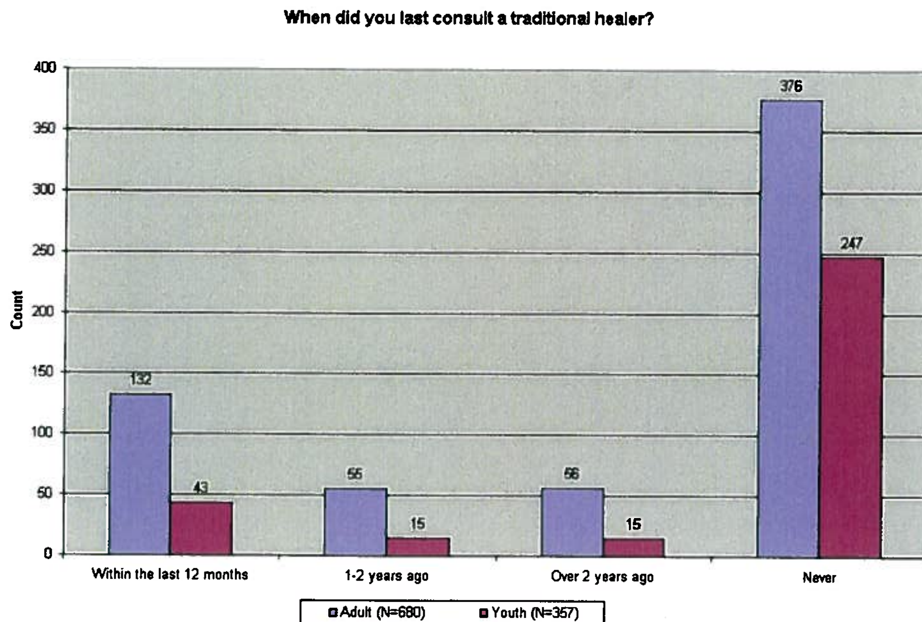
The importance of passing Aboriginal language and culture on to future generations has been a consistent priority for Aboriginal Peoples. In the RHS, youth were asked who had helped them to understand their culture and overwhelmingly they identified that their immediate family members, parents and grandparents were there initial source of Indigenous knowledge, followed by school teachers and community Elders.

Chart 35 – Relatives and Community Members who help Youth understand their culture



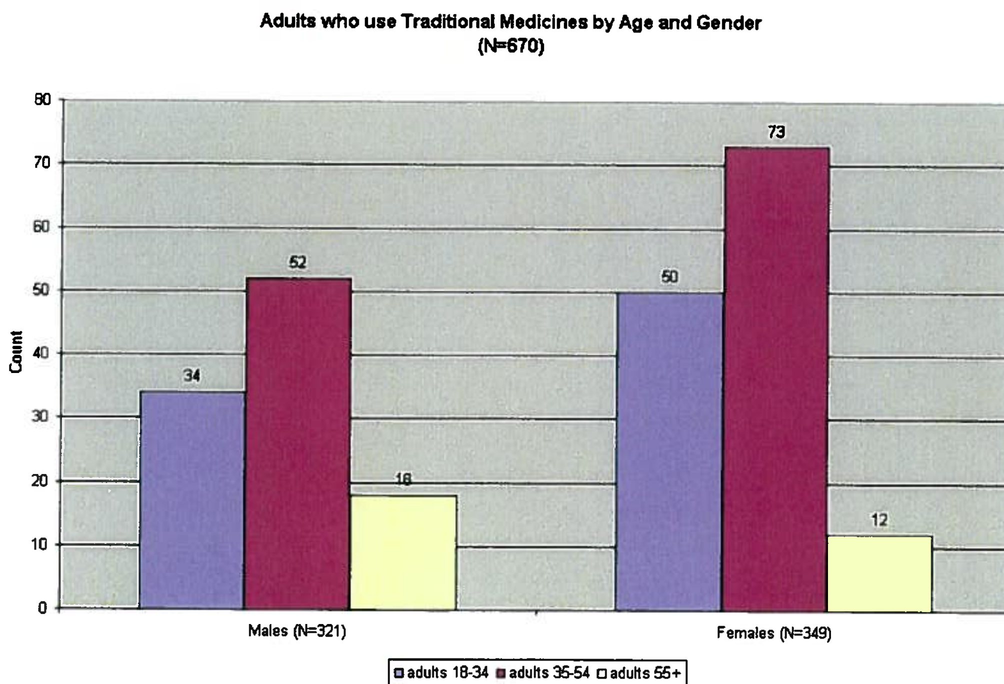
The RHS asked Adult and Youth participants when they last consulted a traditional healer. Chart 36 demonstrates that more adult respondents access a traditional healer than youth, however, 66% of the Adults and 69% of the Youth have never accessed a traditional healer.

Chart 36 – When Adults and Youth last consulted a traditional healer



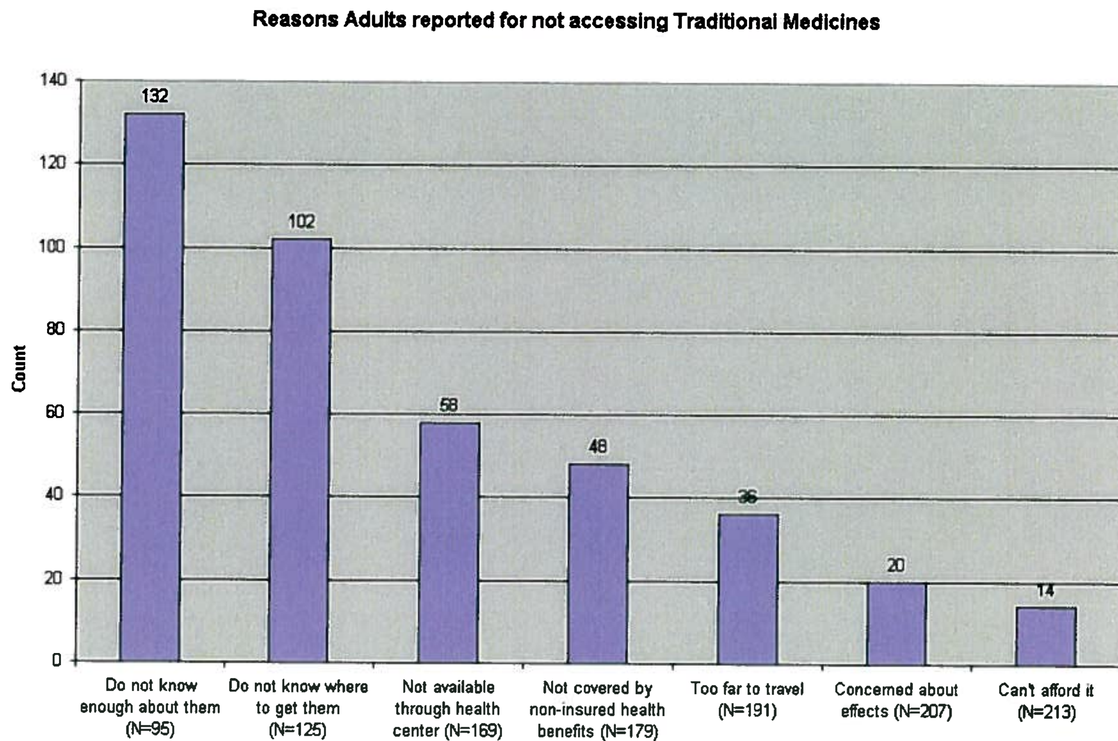
In addition, the RHS asked two questions about the use and access of traditional medicines, (see Chart 37). A total of 239 people out of the 680 respondents or 36% responded affirmatively. While there is some use in early adulthood, females aged 35-54, reported that they used traditional medicine more often than men or other age groups.

Chart 37 – Adults who use Traditional Medicines by Age and Gender



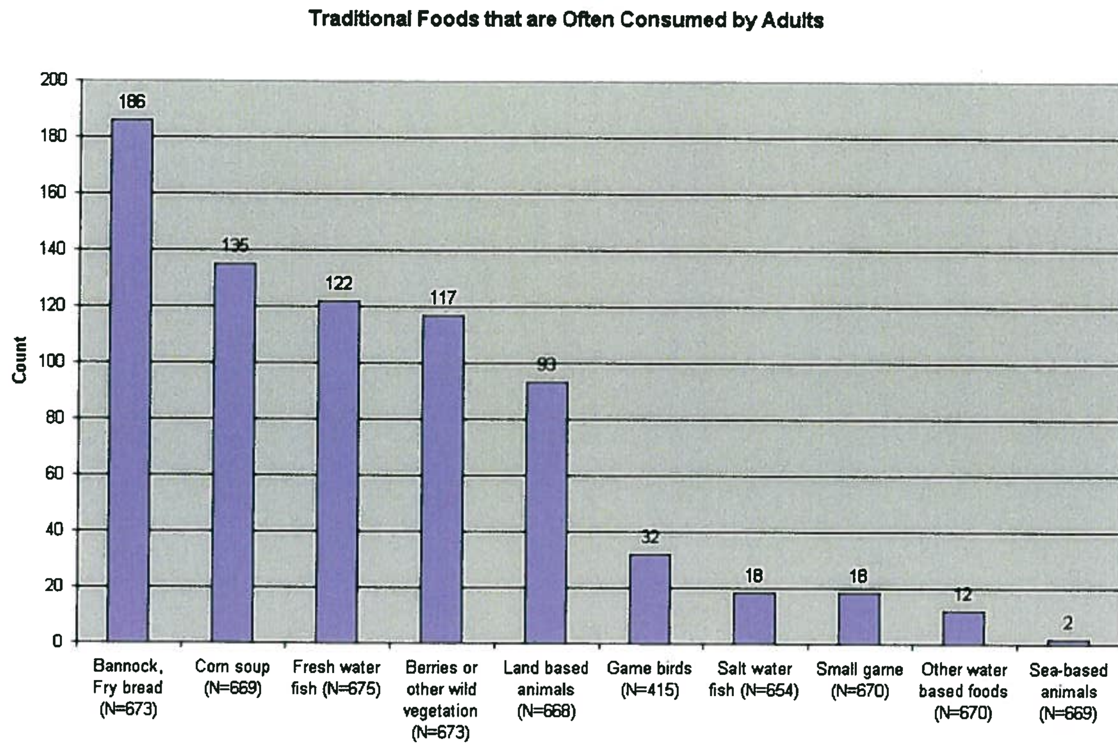
In order to learn more about why respondents did not use traditional medicines, the RHS further probed the 431 respondents about possible explanations why not. The following reasons were provided by the Adults who indicated that they had difficulty accessing medicines, with lack of information or knowledge as the predominant response.

Chart 38 – Reasons Adults reported for not accessing Traditional Medicines



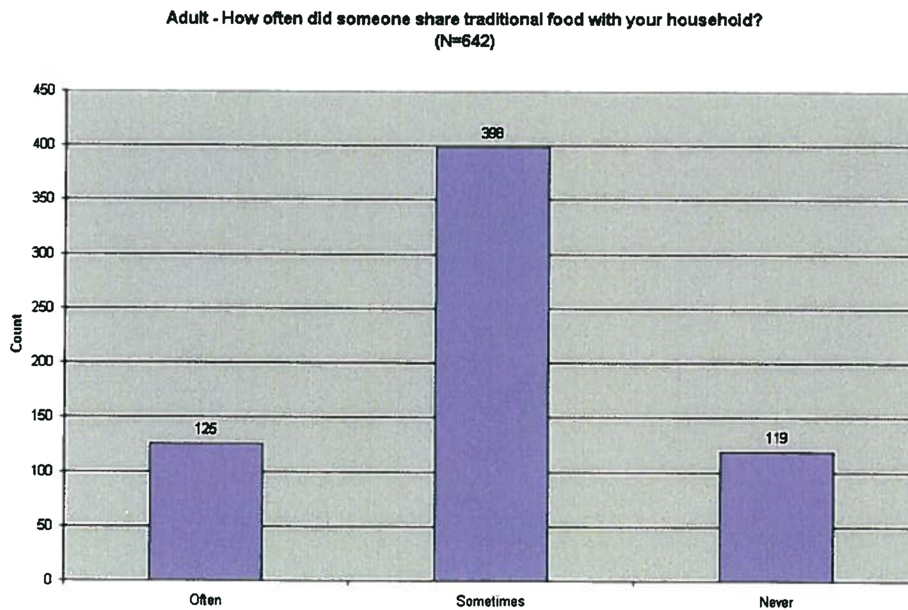
Patterns surrounding the use and sharing of traditional foods could also be interpreted as an indicator of cultural wellness. The following two charts illustrate some of the habits surrounding traditional food consumption and sharing of traditional foods.

Chart 39 – Traditional Foods that are Often Consumed by Adults

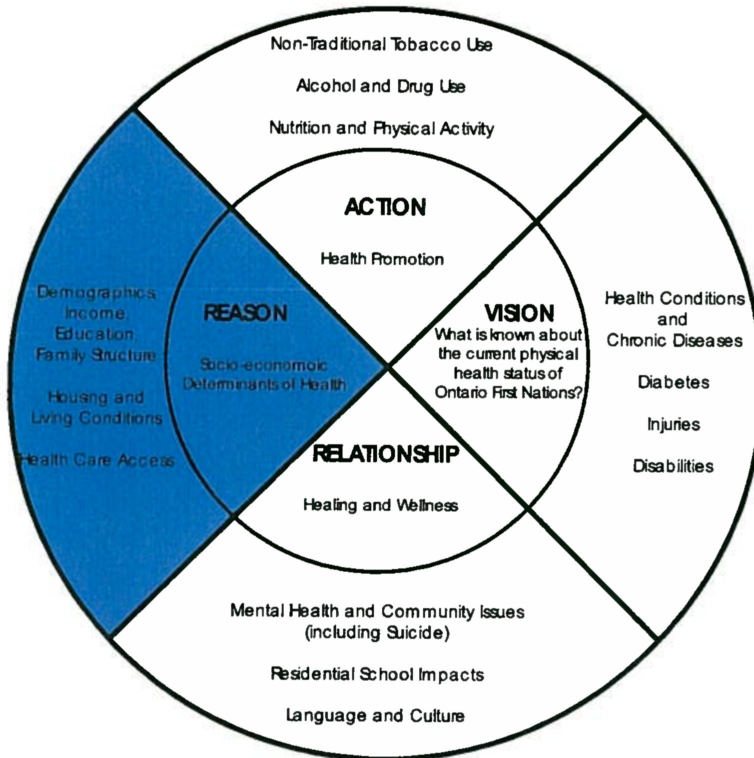


A large number of Adult respondents indicated that they sometimes have shared in or received traditional food from other community members.

Chart 40 – How often did someone share traditional foods with Adults



3.3 REASON

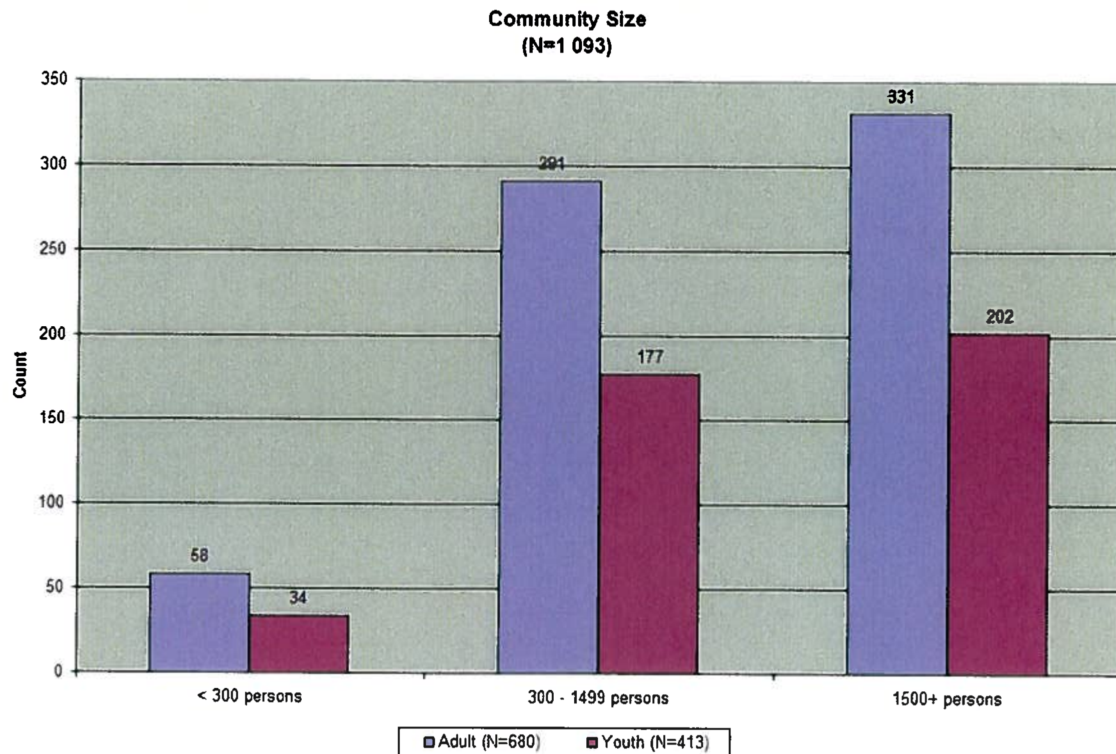


This quadrant refers to learned knowledge. It is where we become reflective, meditative and self-evaluate. It is in this direction, that the broader determinants of health are examined, such as demographics, income, education, family structure, housing and living conditions as well as health care access. These health indicators provide a larger context for understanding and addressing First Nations health issues.

DEMOGRAPHICS

For both Adults and Youth the majority of respondents lived in communities larger than 300 people. Of the 680 Adult respondents, 533 reported living in non-isolated communities that have road access and are less than 90 kilometres from a physician. As well, 332 Youth respondents indicated living in non-isolated communities of the 393 respondents.

Chart 41 - Community Size of Adults and Youth

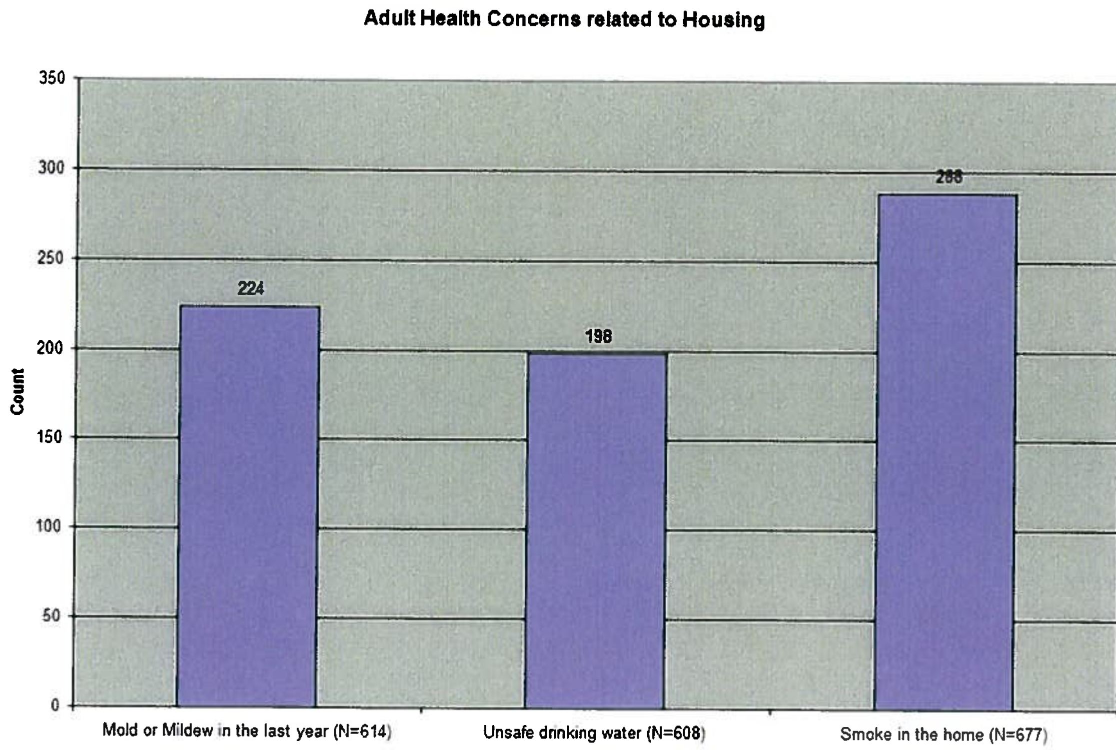


HOUSING AND LIVING CONDITIONS

A total of 80 (N=667) Adults were considered to be living in crowded conditions (more than one person per room). The majority of houses contained 4-7 rooms (73% for Adults and 67% for Youth). Approximately 97% of both Youth (N=413) and Adult (N=680) respondents lived in a community that was not part of a health transfer agreement.

There are numerous health concerns related to Adult housing, including the presence of mold or mildew in the last year as indicated by 40% of the respondents, unsafe drinking water in 28% of the housing and 39% reported not living in a smoke-free home. Of those people who reported that they had mold/mildew in their homes during the past twelve months, 25 people also reported having asthma and 58 people also experience allergies.

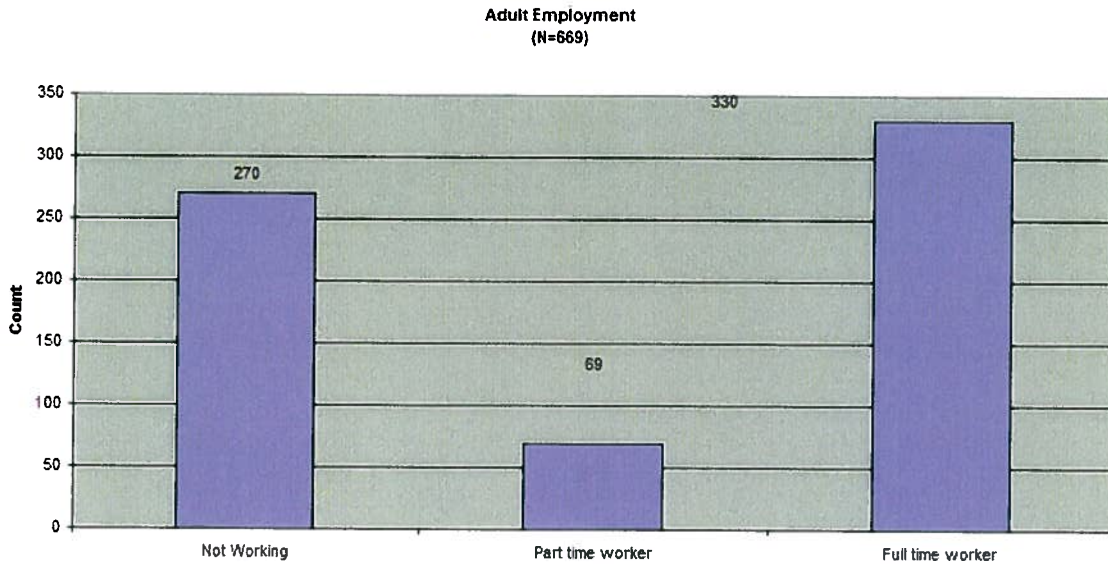
Chart 42 – Adult Health Concerns related to Housing



INCOME

The current unemployment of adult respondents is 42% and in 2001 36% did not receive income from paid or self-employment. Of the 399 Adults employed, 330 worked full-time and 69 worked part-time. The majority of those employed worked between 30-45 hours per week.

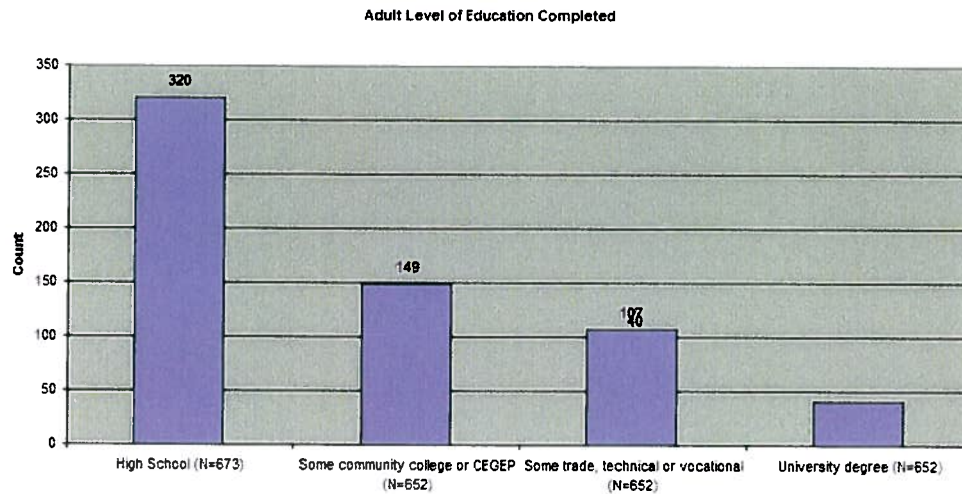
Chart 43 – Adult Employment



EDUCATION

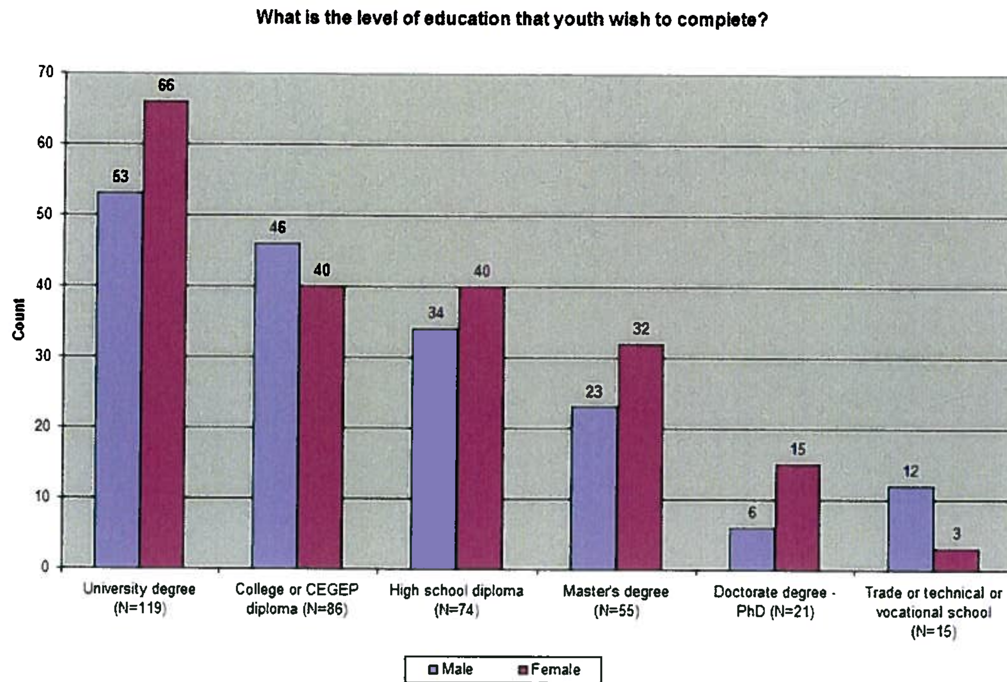
A large proportion of Adults, approximately 41%, had graduated from high school compared to 15% who had received some trade, technical or vocational training , 18% had some community college or CEGEP and 5% a university degree.

Chart 44 – Adult Level of Education Completed



Of the 411 Youth respondents, 384 indicated that they are currently attending school. Most Youth wanted to complete a university degree.

Chart 45 – Level of Education that Youth wish to complete

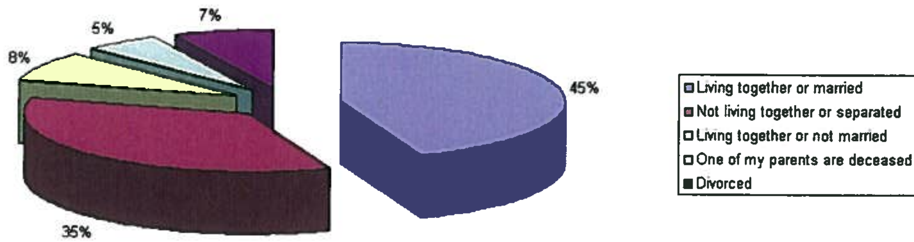


FAMILY STRUCTURE

The youth survey respondents reported on the marital status of their biological parents. The majority of their biological parents lived together (either married or not), while 43% of the biological parents of youth were separated or divorced.

Chart 46 – Marital Status of Youth's Biological Parents

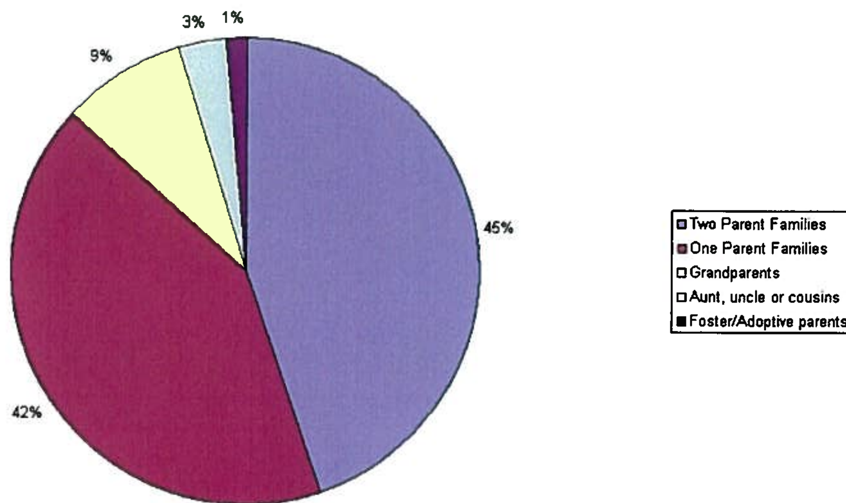
Marital status of Youth's Biological parents (N=402)



The following diagram illustrates the family caregivers for Youth respondents. A slight majority reside in two parent households, followed by one-parent families. Grandparents are the major caregivers for a further 9% of Youth.

Chart 47 – Parents, Other Relatives or Caretakers in Families of Youth

Parents or Other Relatives or Caretakers in Families of First Nations Youth (n=432)



ACCESS TO HEALTH CARE

This section reports on selected indicators of access to preventive primary health care measures, including respondents' rating of their access to health care in comparison to other Canadians, access to screening and preventive measures, barriers to accessing health care, and access to Non-Insured Health Benefits (NIHB).

OVERALL ACCESS TO SERVICES

Overall, 42% of respondents rate their access to health care as being the same as that of other Canadians. An additional 23 % rate their access as being better, whereas 34% rated their access as being less than that of other Canadians.

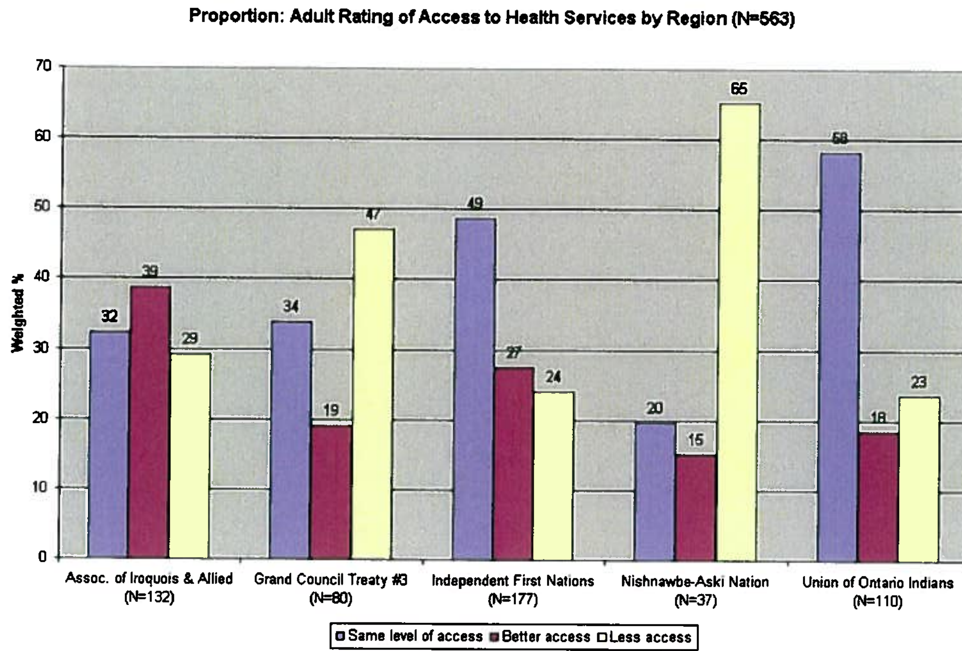
The following table provides a breakdown of self-rated health status by access to health care. A total of 81 of the 162 Adult respondents who rated their health as fair or poor also indicated that they have less access to primary health care services than other Canadians.

Table 12: Adult Survey: Rating of access to health care in relation to self-rated health status (N=533)

Weighted %	Excellent Health %	Very Good Health %	Good Health %	Fair Health%	Poor Health%
Same level of access	57	49	40	32	24
Better access	21	26	21	25	21
Less access	22	26	40	43	56
Total	100	100	100	100	100

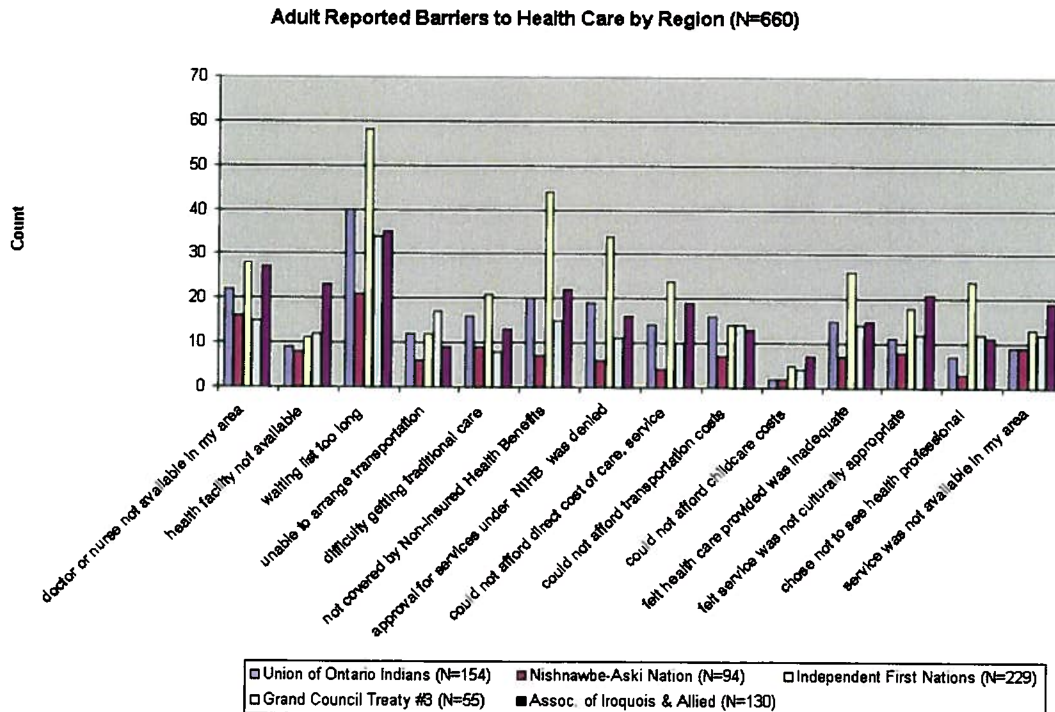
The following chart provides a breakdown of access to health care by region. The more northern and remote areas such as Nishnawbe Aski Nation and Grand Council Treaty #3 report less access to health care.

Chart 48 – Adult Rating of Access to Health Services by Region

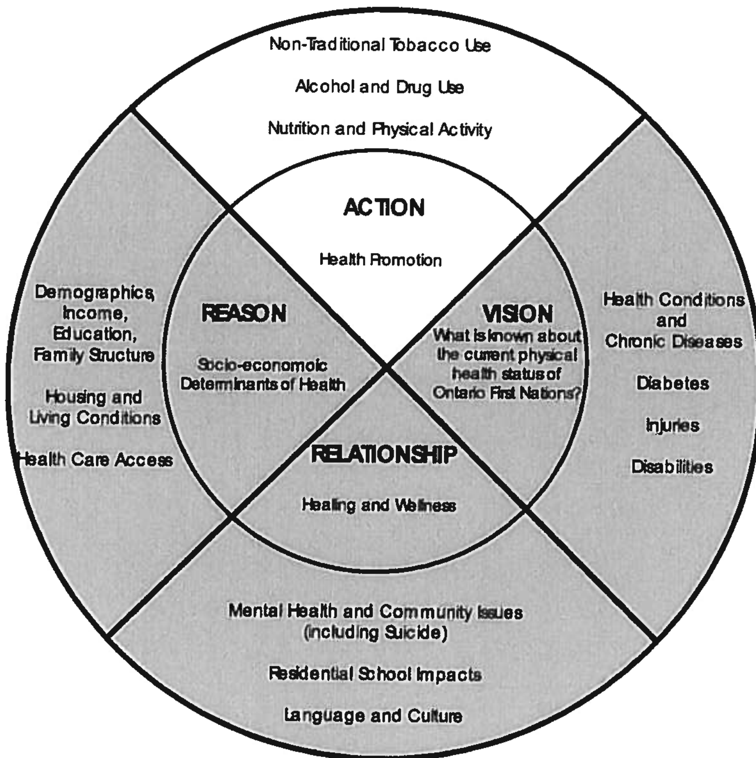


The following chart describes the barriers to health care by region as reported by Adult Survey respondents. Waiting lists and lack of coverage by Non-Insured Health Benefits were frequently cited reasons.

Chart 49 – Adult Reported Barriers to Health Care by Region



3.4 ACTION



This quadrant is referred to as movement and represents strength. This direction explores what has been done about previously identified barriers and how to nurture us as Aboriginal people. This component is important in that it activates positive change to improve the program so that it better achieves the vision (expectations) of the Aboriginal community for the healthy development of their children, families and communities. Within this quadrant, this report will present findings related Smoking, Drug and Alcohol use and Nutrition, Physical Activity, also commonly known as promotional/preventative indicators of health.

NON- TRADITIONAL TOBACCO USE

All First Nations come from a unique historical and ongoing indigenous way of life that includes an historical relationship with tobacco. This section will describe some of the ways in how smokers and non-smokers are living their lives with their families and in their communities in relation to non-traditional tobacco use.

A total of 82% of the Adult RHS respondents have smoked at one time in their lifetime (N=671). However, as demonstrated below, approximately 25% of the Adult sample group has since stopped smoking. A total of 37% of Youth respondents reported that they smoke

at this time. It is interesting to note that a total of 61% of the Adult respondents and 58% of the youth Respondents reported that they have a smoke free home.

Table 13: Current Adult and Youth smokers (n=1086) reporting daily or occasional non-traditional tobacco use.

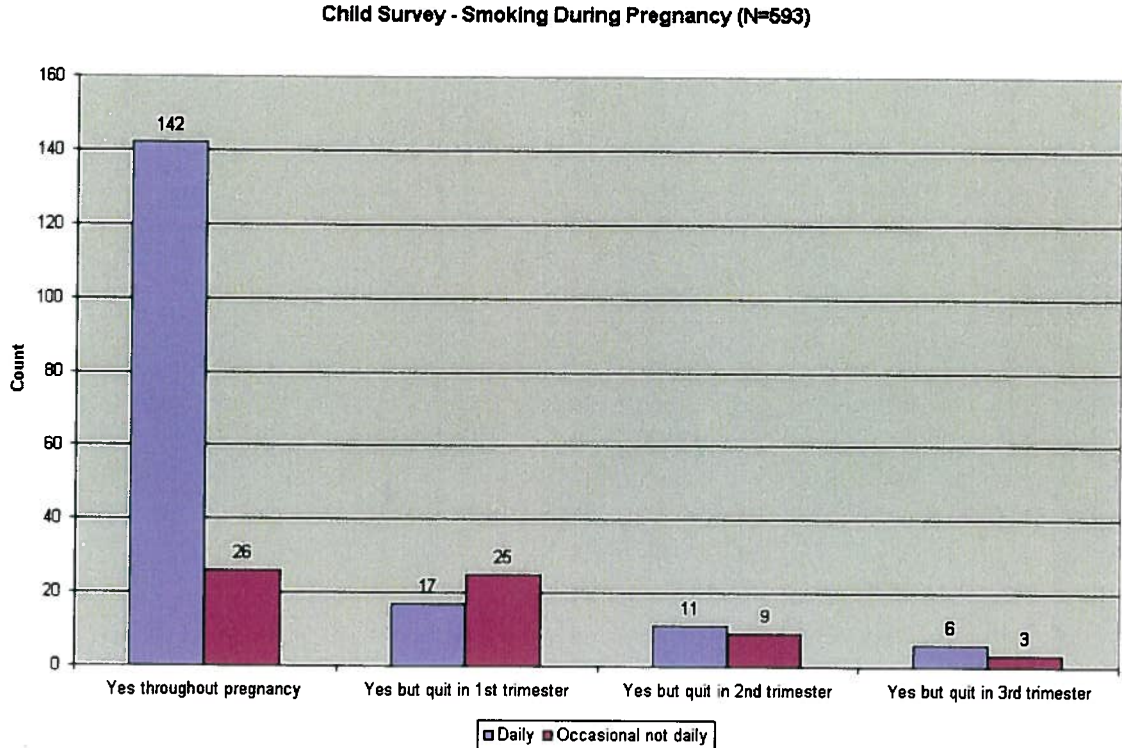
	Adult (N=676)	Youth (N=410)
Daily	279	96
Occasionally	90	34

PREGNANCY

A total of 8 First Nation women were pregnant at the time of the survey. Three of the women presently smoke daily, three smoke occasionally and two women do not smoke at all.

The Child survey also asked questions related to smoking during the pregnancy of the child respondent. Approximately 32% of the mothers did smoke throughout their pregnancy (N=593), and 73% did so on a daily basis. Parents were asked if anyone else smoked in the home during the pregnancy and approximately half the respondents replied yes. However 72% of the respondents to the child survey reported that their children now live in a smoke free home (N=601).

Chart 50 – Smoking During Pregnancy



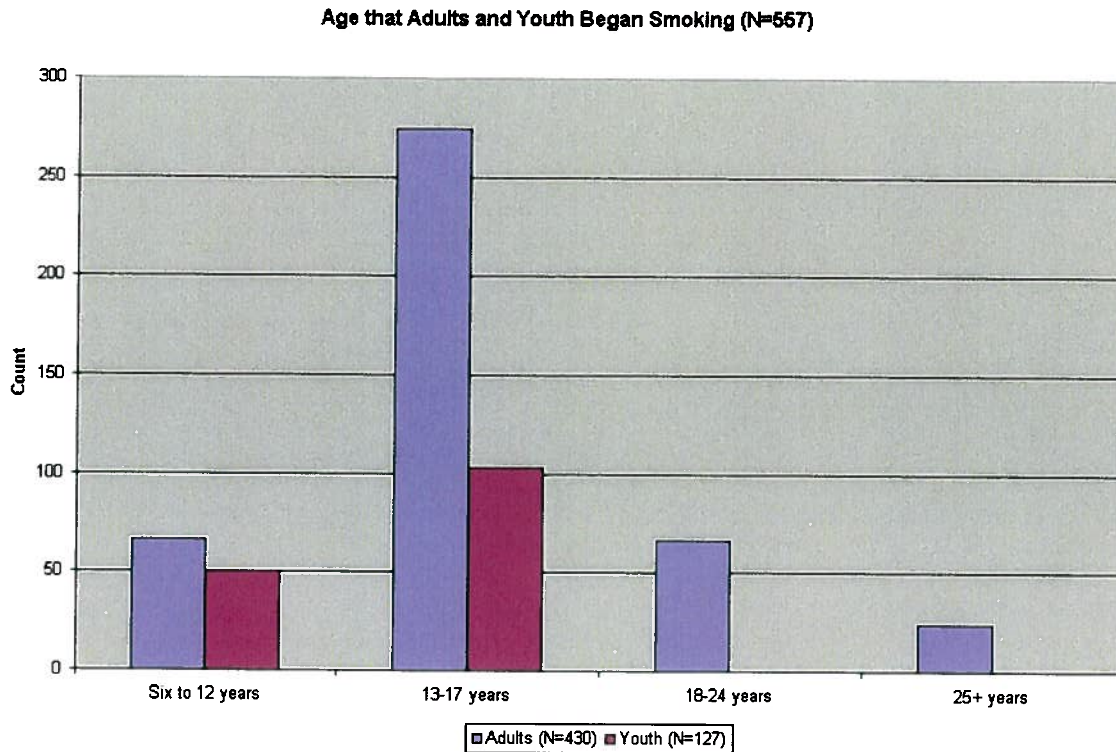
FORMER SMOKERS

A solid 18% of Adult respondents (135/676) sampled in this survey have never smoked cigarettes, another 25% of former Adult smokers (n=172/676) make up the population of non-smoking First Nations. Men and women equally represent non-smokers.

INITIATION

The age of smoking initiation for smokers ranged between six and forty-nine years of age. The overwhelming majority of the smokers began smoking cigarettes between 13 and 17 years old. On average the Adult First Nation smoker began smoking at 16 years old (mean= 15.85) (female mean=15.64) (male mean=16.10). For Youth, the average age for beginning to smoke was 12.81 and there was no difference between genders.

Chart 51 – Age that Adults and Youth Began Smoking

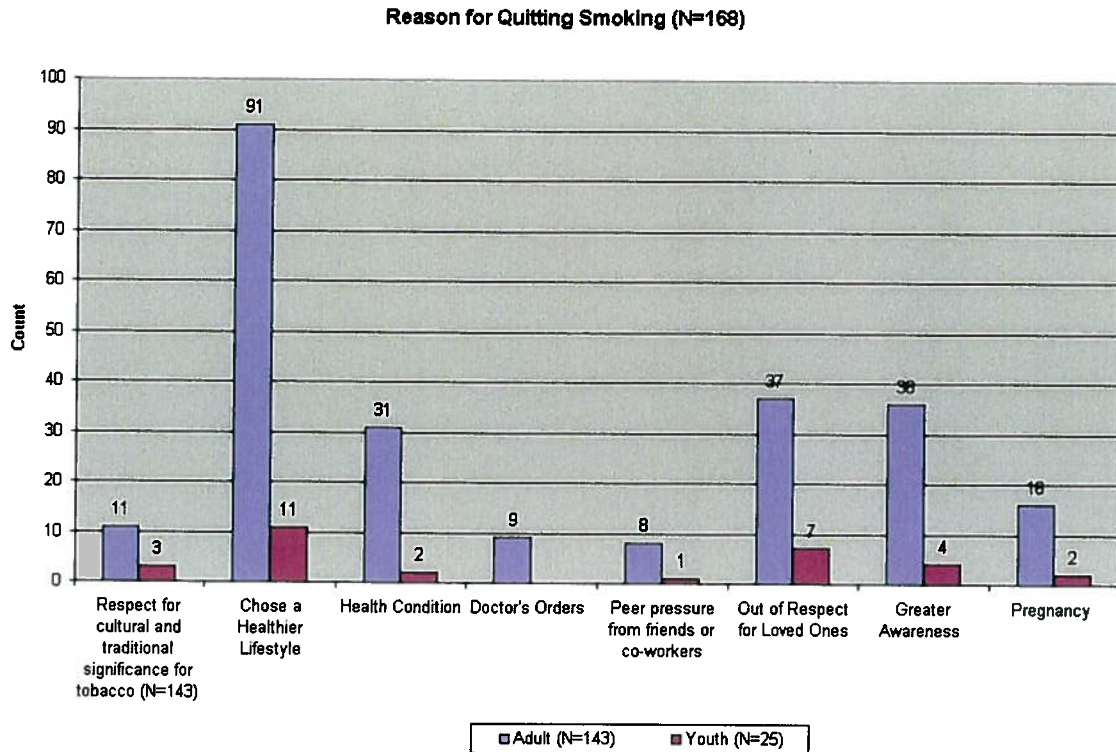


CESSATION

About one-third of Adult former smokers quit smoking by 24 years old, another third quit between 25 and 39 years old and the remaining third quit after their fortieth birthday. On average the former Adult First Nation smoker quit smoking at 32 years old, men quit most often following their 34th birthday (mean=34.3) and women quit just before their 32nd birthday (mean=31.68). Research proves that once a smoker quits smoking remarkable improvements are immediate improving both length and quality of life.

Former smokers were asked their reasons for quitting smoking. In the question, respondents were read a list of reasons from which they could select all the reasons that applied to him/her. Based on the responses, the desire for a healthier lifestyle was overwhelmingly the main reason given by former smokers. The second most reported reason for quitting smoking was a tie between the respondent having greater awareness and a health condition, closely followed by respect for loved ones.

Chart 52 – Reason for Quitting Smoking



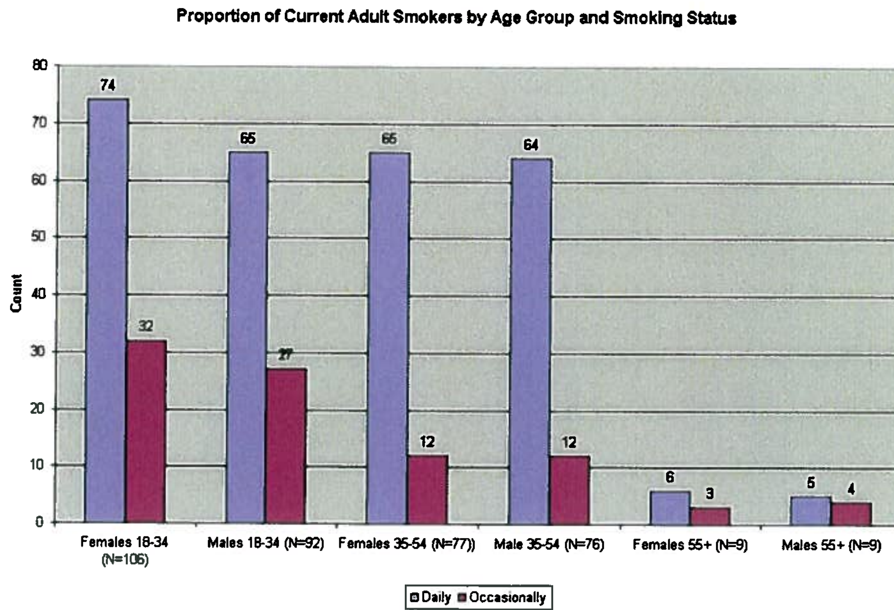
Former smokers were read a list of methods for quitting smoking. From this list the respondent selected methods that applied to him/her. Based on the responses, 90% reported 'cold turkey' as the predominant smoking cessation method that applied to former First Nation smokers. Other popularly reported methods for smoking cessation included: help from spirituality, and assistance from family. There was an extremely low use of pharmacotherapy as a cessation method – only 10 people out of 161 respondents to the question.

CURRENT SMOKERS

As described in Chart 53, fifty-eight percent of First Nations are currently smokers. This section will describe the age distribution, consumption patterns by age group and gender, and the number of quitting attempts.

The age distribution across current smoking status shows that as the population ages daily smoking behaviour remains constant for the age categories 18-54.

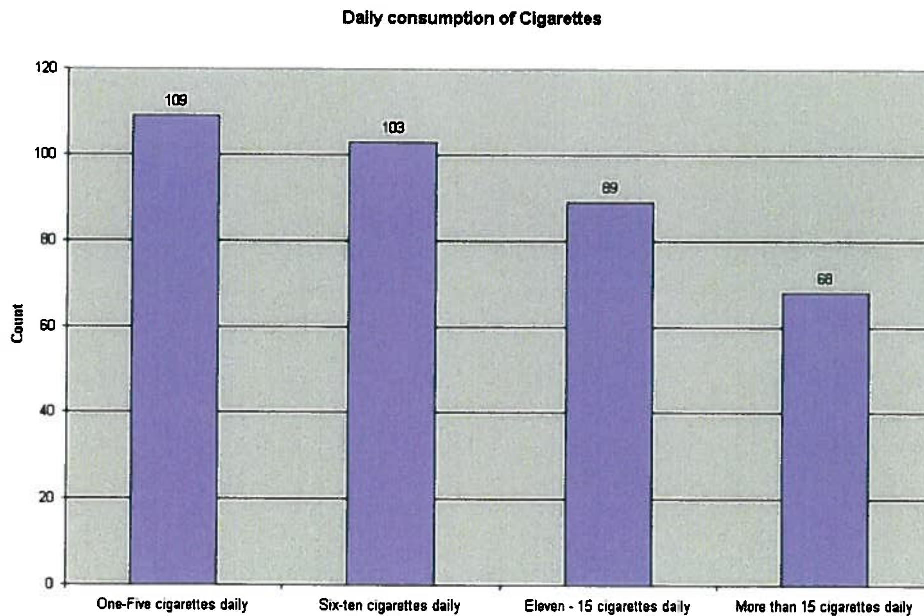
Chart 53 – Current Adult Smokers by Age Group and Smoking Status



CONSUMPTION OF CIGARETTES

The average number of cigarettes consumed by current smokers that includes daily and occasional smokers is 10.75. Men consume an average of 11.65 cigarettes a day whereas women consume an average of 9.9 cigarettes per day.

Chart 54 – Daily Consumption of Cigarettes



ALCOHOL USE

Over the past twelve months, slightly more than two-thirds or 69% of survey respondents reported the use of alcohol, compared to 79.3% of the general Canadian population[26]. The following charts compare the proportion of alcohol users by various demographic variables and community size. Of note is a consistent decrease in drinking with age. In fact, only 40% of RHS survey respondents over 55 years of ages reported the use of alcohol; less than half that of the rates found among Canadians aged 55 – 74.[27] Males and Females equally reported alcohol use and the highest rates of 90% were found among younger males aged 18 to 29, although the females were close behind at 80% of the respondents. Canadian data from the general population reflects comparable usage rates among younger males and also indicates that this group is more likely to have consumed alcohol over the past year.[28]

Chart 55 – Adults Reporting Alcohol Consumption over the Past Year by Age

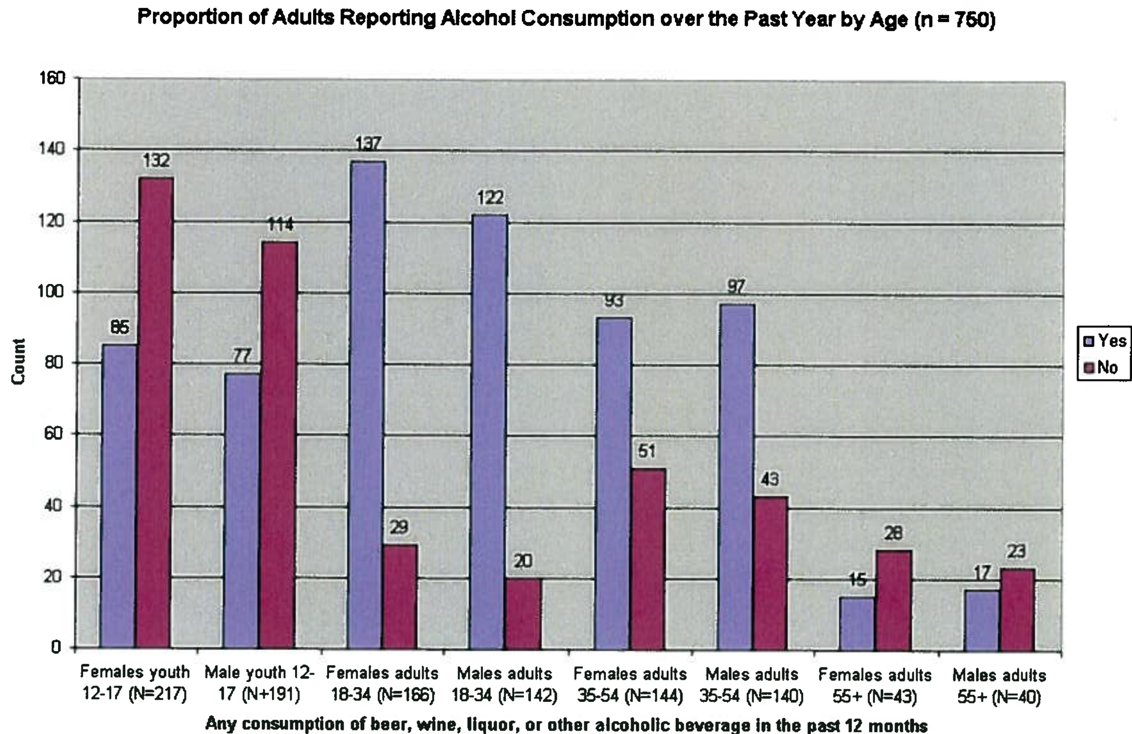


Chart 56 – Frequency of Adult Alcohol Consumption

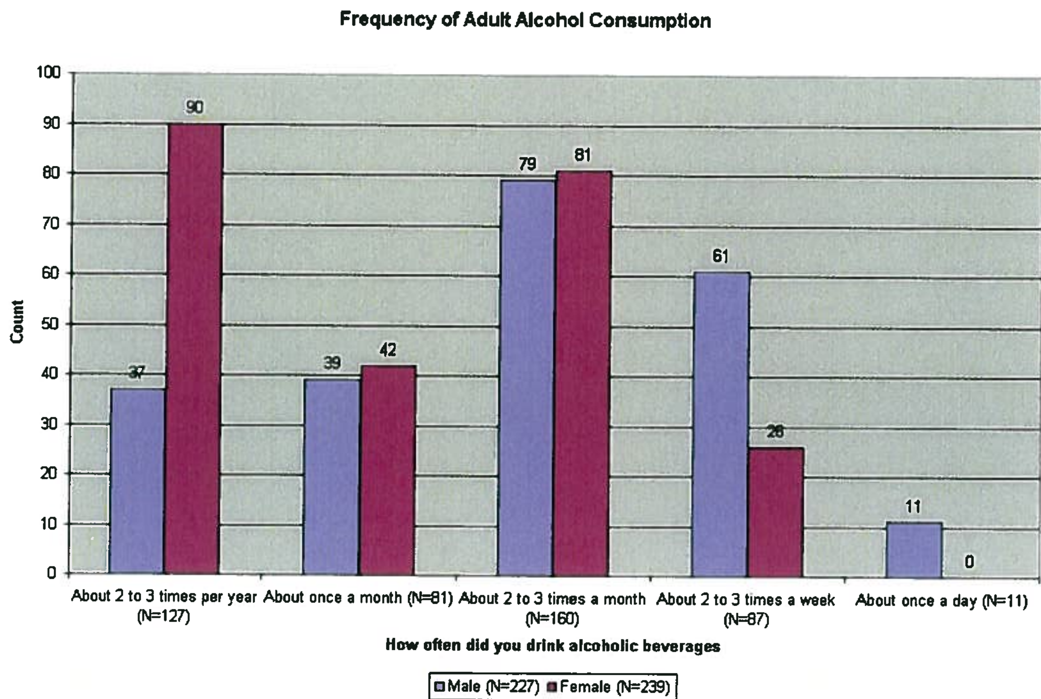
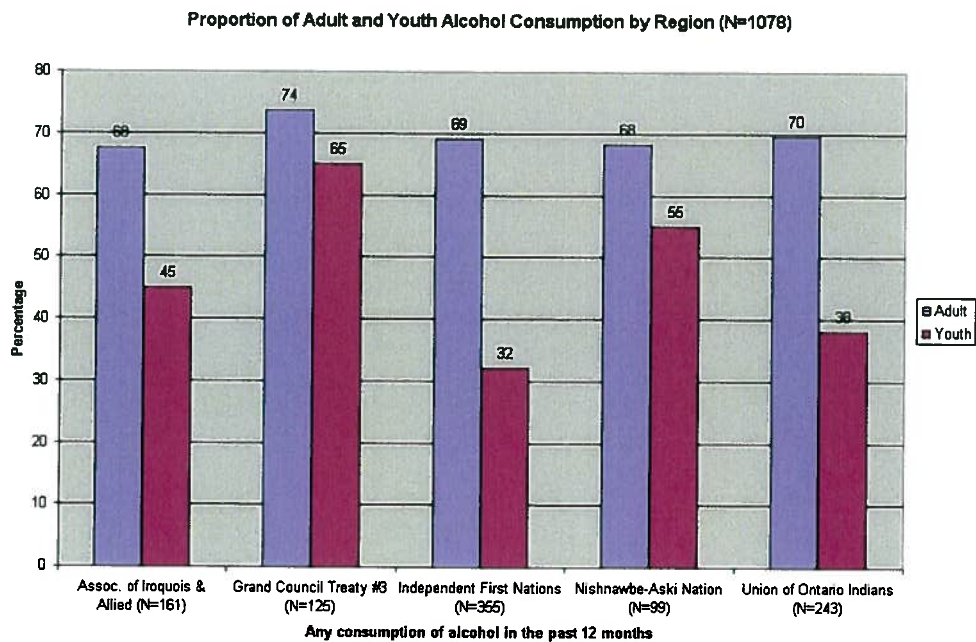


Chart 57- Adult and Youth Alcohol Consumption by Region



As seen in the preceding charts, the frequency of alcohol use was predominately moderate and did vary somewhat by a number of demographic characteristics.

Only 8% of respondents stated that they used of alcohol on a weekly/daily basis compared to 44% in the general population.[29] A further 23% reported that they used alcohol 2-3 times a month and 38% indicated that they consume alcohol once a month or less than once a month.

The role of culture as a mediating factor was also found. For example, infrequent drinkers (monthly or less) were more likely to have seen a traditional healer over the past year.

Lower abstinence and drinking frequency rates are a positive sign for communities, and the proportion of heavy drinkers is also similar to that found in the general population. Twice as many men as women drank heavily once per week, and 5 of the 6 daily heavy drinkers were also male, whereas twice as many women either never or once a month drank heavily in comparison to the men.

Table 14

How often have you had 5 or more drinks on one occasion				
	Adult Survey		**Youth Survey**	
	Frequency	Weighted %	Frequency	Weighted %
Never	84	21	42	22.8
Once per month	80	18	27	23.8
Once per week	39	7	14	7.6
Every day	6	1	1	0.3
Less than once per month	100	20	32	20.5
2 to 3 times per month	113	23	34	19.5
More than once per week	41	9	10	5.5
Total	463	100	160	100

DRUG USE

Both Adult and Youth were asked a question about drug use. The following table indicates the number of Adults who have sought treatment for substance abuse.

Table 15:

Adult Survey: Have you ever been treated for substance abuse:	Yes	No	Total
Alcohol	82	594	676
Drugs	44	633	677
Solvent abuse	6	670	676

As illustrated in the following two tables, the substance most frequently used by Adults and Youth is marijuana or hash. Adults also used cocaine, while Youth used codeine or morphine derivatives.

Chart 58 – Adult Non-Prescription Drug Use

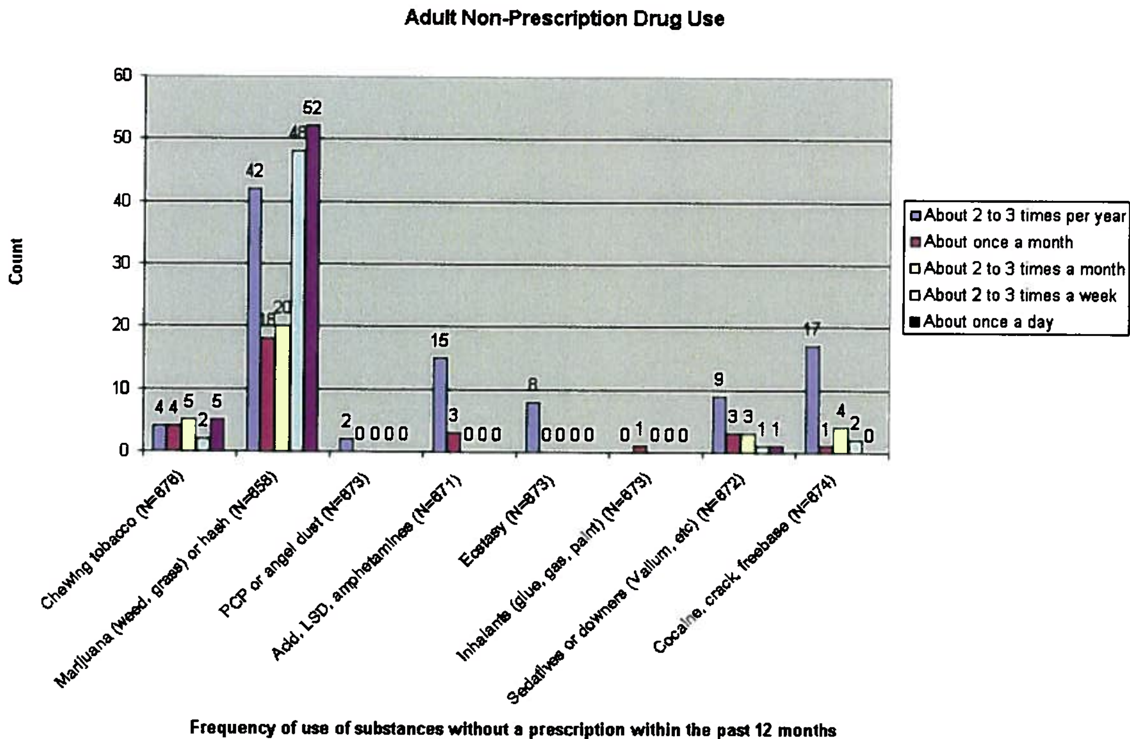
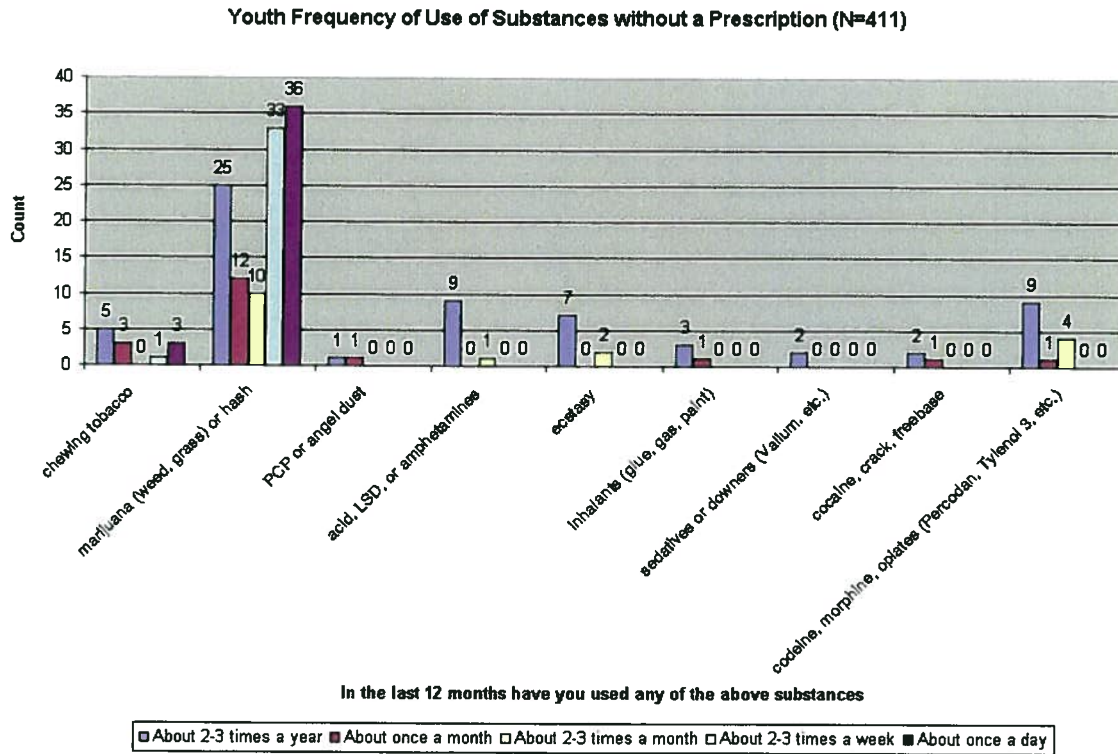


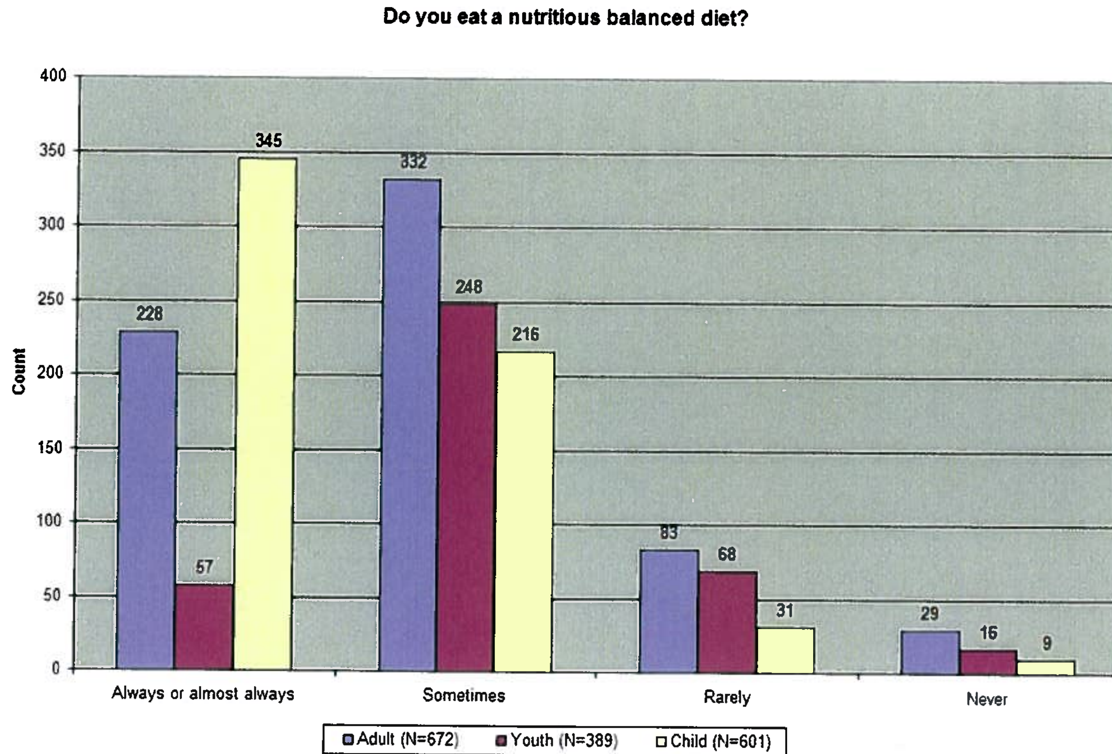
Chart 59 – Youth Non-Prescription Drug Use



NUTRITION

The following chart illustrates Adult, Youth and Child responses to the question "Do you eat a nutritious balanced diet?" According to their responses, children ate a balanced diet always or almost always whereas Youth report the least balanced diet overall. Half of adults reported sometimes eating a balanced diet with a third reported almost always eating a nutritious balanced diet.

Chart 60 – Do you eat a nutritious balanced diet?

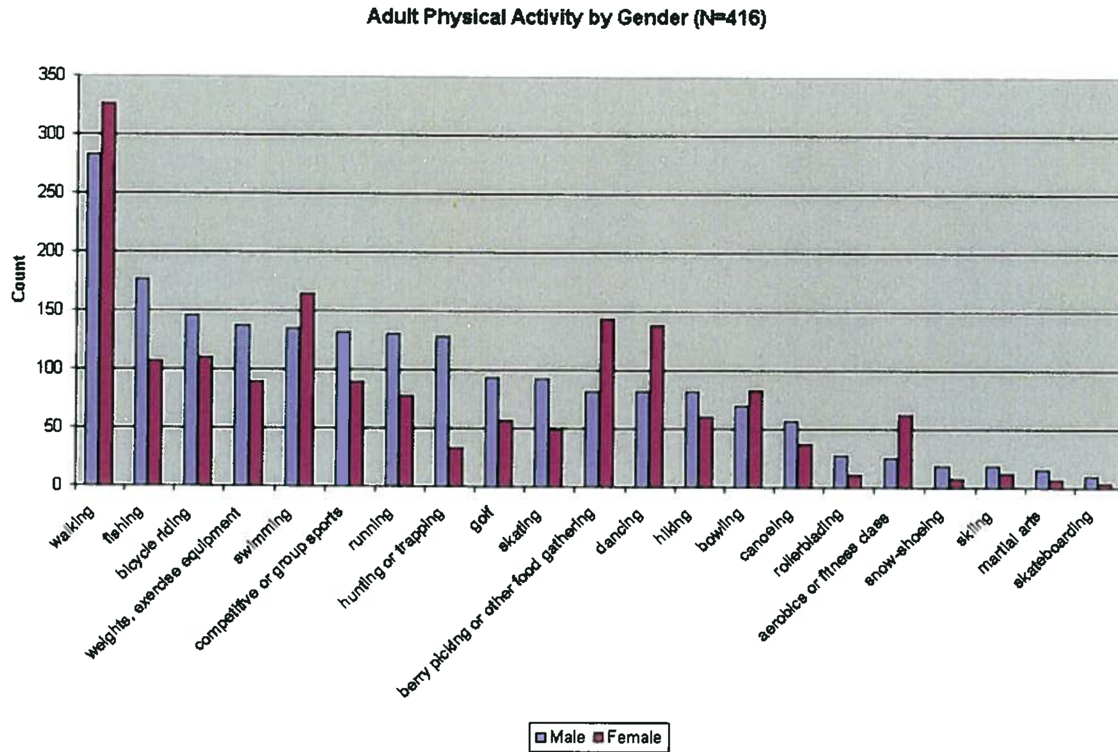


PHYSICAL ACTIVITY

Walking is cited as the most frequently reported physical activity in which First Nations Adults participated over the year prior to completing the survey. Other activities which followed included swimming, fishing, bicycling, and using weights or exercise equipment. Berry picking, sports, dancing, running and hunting or trapping were also cited as means of physical activity.

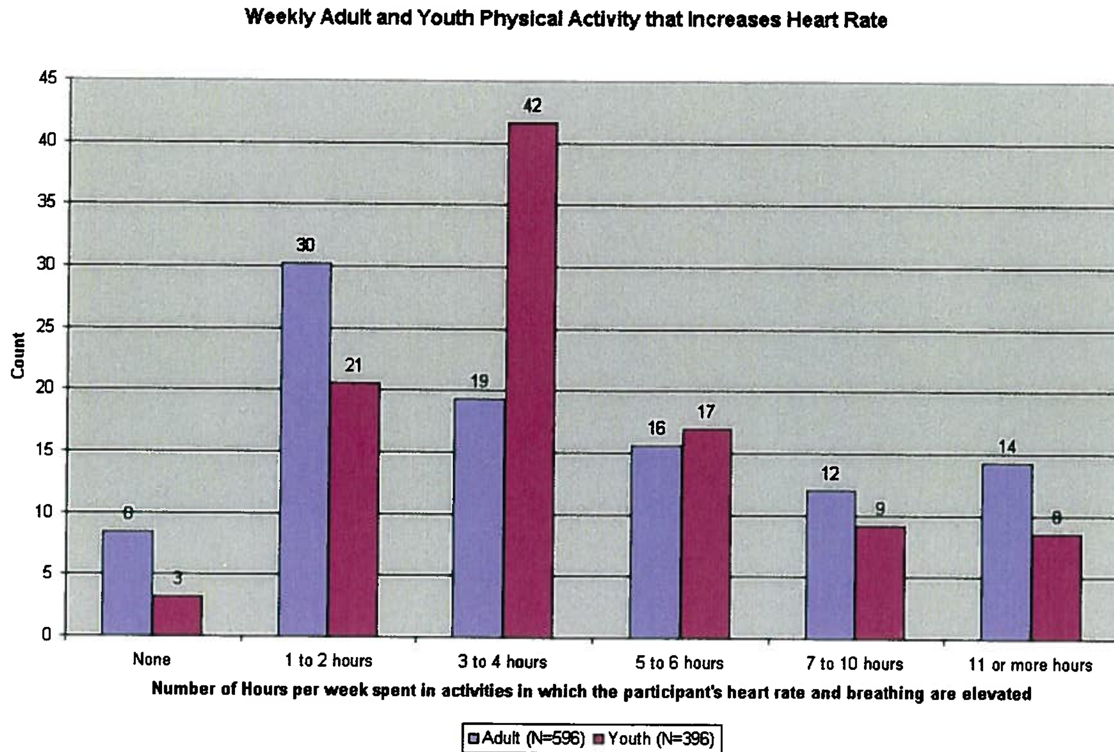
Gender differences appear for certain physical activities. Women are more likely than men to report participating in walking, berry picking or other food gathering activities, aerobics or fitness classes, and dancing. Men, however, are more likely than women to cite participation in most other activities, including: fishing and hunting; bicycling; weight training; running; competitive or team sports such as baseball, hockey, and lacrosse; hiking; rollerblading; skating; skateboarding; golfing; canoeing; martial arts; and skiing. Chart 61 summarizes the gender differences in reported physical activities.

Chart 61 – Adult Physical Activity by Gender



The following table indicates the frequency with which Adult and Youth respondents participate in intense physical activity.

Chart 62 – Weekly Adult and Youth Physical Activity that increases Heart Rate



BODY MASS INDEX

For the purposes of these analyses, body mass index (BMI) was classified according to Canadian guidelines. According to Canadian guidelines, 26% (CI 24.9-27.5) of adults are considered to be *normal* weight or having the least risk of developing health problems. The following chart illustrates that as the Ontario RHS there is a tendency for increased BMI as the respondents increased in age. However, the number of obese and morbidly obese respondents in all age categories is a concern for health issues.

Chart 63 – Adult and Youth Body Mass Index (BMI) by Age and Gender