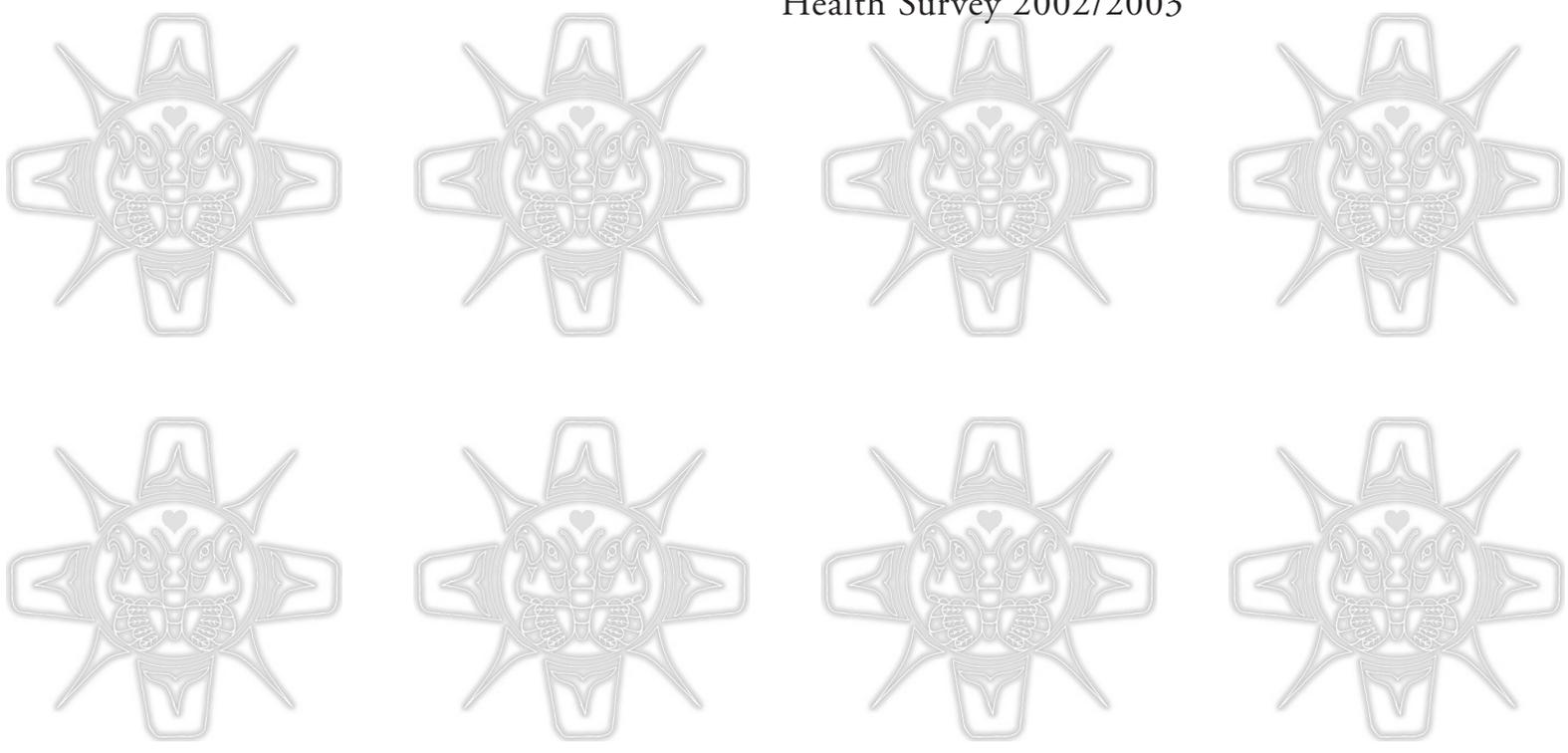


HEALTHY CHILDREN,
HEALTHY FAMILIES,
HEALTHY
COMMUNITIES:
THE ROAD TO
WELLNESS

BC First Nations Regional Longitudinal
Health Survey 2002/2003





Logo design by Terry Canute, Duncan, BC

“Well I drew this design on paper in pen first then scanned it onto a computer and edited it some of the photo editor adding the red shadings to the edges. This logo includes a Sun which represents

spirit and warmth to the community also the sun provides people with vitamin D and that adds onto the health part in a way. The transformation of the caterpillar to a

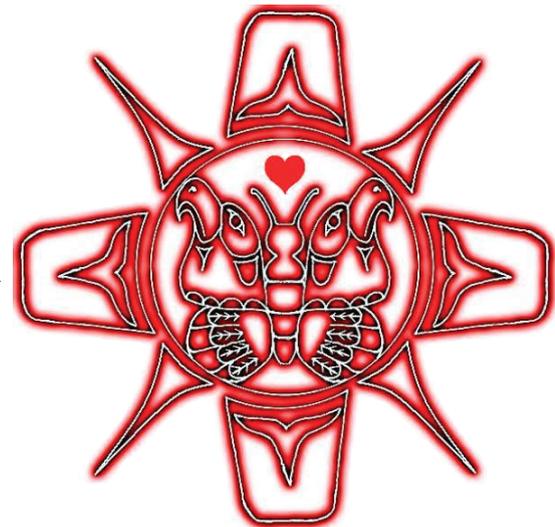
butterfly is a thing of beauty and is interesting to people of all ages and is similar to the birth of a healthy child. The two eagle heads on the wings of the

butterfly can symbolize parents and protection to the

young butterfly. To tie the drawing all in is a heart

near the center which draws out emotions and thought

about the logo.”



GREETINGS

As is customary with our cultures, before all other words are written, we extend greetings and words of thanks and appreciation to our community members.

Kleco kleco Mussi cho Doe neh nee
Kwelechsi siya:m el siya:ye Kukstcecmc Kukstselp
 Halakasla Hoychap siya:m el siya:ye
Howa
 Galakasla Hadih Lim Limpt
Ah jetch Xwut Ki'su'k Kyukyit Wai
 Cheh che ha thetch Meduh
?éx k? n? hén? 3é? k? ném? k? uk? stéyp

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Osoyoos Indian Band	Skway First Nation	
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EXECUTIVE SUMMARY

Three Canadian longitudinal studies were conducted in 1994 which examined issues related to general health, child development/wellness and economic well-being of the overall Canadian population. Although these studies appeared to be exhaustive, they failed to examine the realities and cultural differences among our First Nations people. As a result of this shortfall, our public health experts created the First Nations Regional Longitudinal Health Survey (RHS). This survey was developed, administered and analyzed by First Nations people for First Nations people, in providing culturally appropriate, community-based research.

In British Columbia, the RHS has been implemented by the First Nations Summit Society operating through the First Nations Chiefs' Health Committee (CHC). The CHC has been involved with the RHS since 1997 and have elected a regional committee known as the First Nations Health Research Committee to ensure that respect, equity and the Ownership, Control, Access and Possession (OCAP) principles are upheld throughout the RHS process. This report provides a written summary of some of the results and findings of the 2002/2003 BC First Nations Regional Longitudinal Health Survey.

The three national survey instruments addressed a comprehensive range of health status, wellness and health determinants measures. Nationwide, data from 22,602 surveys was collected over a 12 month period, in 238 First Nations communities. In British Columbia, 1,944 surveys were collected and the total sample was broken down as follows: 712 from adults, 566 from youth and 666 from children.

The model, or framework, used to interpret the information collected as part of the RHS is based on a holistic perspective of health, involving the different components of mind, body, spirit and moral/emotional well-being - each contributing to a structure that serves to strengthen our understanding of health.

MIND: In this realm we consider socioeconomic issues and look to the cognitive or thinking aspects imbedded in the data, showing how we think about our lives and how we exist. We further see how we can be educated or learn from the data as a means of improving our lives. We know the basic values and things we need to exist as healthy humans such a food, shelter, and a connection to our communities and people to help sustain us and we are able to see this reflected in the data. Areas examined include:

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

BODY: This quadrant represents the physical body, where we discuss issues related to the impacts on our physical health and level of activity. There are many indicators used in contemporary research to describe health, or the physical attributes of health, and in this section we focus on presenting these findings that are meaningful or most relevant, to our First Nations peoples. These categories are:

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

SPIRIT: Lifestyle choices impact our health. The lifestyle choices that we make can have direct impact on our health and well-being. The way in which we choose to live impacts us as spiritual beings. All of these individual choices make up who we are and contribute to our sense of spiritual health. Lifestyle issues include:

- Smoking
 - Drugs
 - Sexual Health Practices
 - Drinking
 - Exercise

MORAL AND EMOTIONAL WELL-BEING: In this section we look at how the data represents some of the most personal aspects of our lives, mainly our moral and emotional well-being and the impacts it has on our personal relationships. In essence, from a First Nations perspective, we are discussing the most basic elements of who we are as a people. Here the report looks at the survey and how our relationships with friends, family, and community, and also relationships with ourselves it impacts our sense of personal and community well-being. The key categories within this paradigm include:

- Mental Health, Personal Wellness and Support Among First Nations Adults, Youth and Children
 - Residential School Impacts
 - Languages and Cultures
 - Community Wellness

The initial phase of the RHS, while being very comprehensive, serves as our benchmark or baseline. The RHS will provide measures over time, as the research will be repeated over the course of several years. This allows us to examine the data to see if change occurs and to see, for instance, if policy and programming changes can be deemed effective or not.

The next data collection stage is scheduled to start in 2006 and before then we will reflect on the current process engaged in. The current First Nations interpretive framework will be used and improved upon with each successive data gathering cycle. The researchers are committed to the development and evolution of a First Nations research framework that allows us to collect and analyze data in a distinctly First Nations fashion while maintaining and ensuring scientific rigor.

CHAPTER 1: INTRODUCTION

Background

In 1994 three Canadian longitudinal studies were conducted to examine issues related to general health, child development/wellness and economic well-being of the overall Canadian population. Unfortunately only superficial attention was paid to First Nations matters. The three studies were:

- The National Population Health Survey,
- The National Longitudinal Survey of Children and Youth (NLSCY), and
- The Survey of Labor and Income Dynamics.

Although these studies appeared to be comprehensive, they neglected to look at the realities and subtle differences that occur among our First Nations people. More specifically, the surveys failed to identify and explain issues directly related to on-reserve and off-reserve First Nations people. The analysis of these surveys did not offer data, or plausible conclusions, that could be of use to our people and consequently increased the demographic and public health information divide that exists between our people and the general Canadian population. The recognition of this shortfall by our public health experts led to the creation of the First Nations Regional Longitudinal Health Survey (RHS). This survey was developed, administered and analyzed by First Nations people for First Nations people.

In British Columbia, the RHS has been implemented by the First Nations Summit Society operating through the First Nations Chiefs' Health Committee (CHC). The CHC has been involved with the RHS since 1997 and have appointed a regional committee known as the First Nations Health Research Committee to ensure that respect, equity and the Ownership, Control, Access and Possession (OCAP) principles are upheld throughout the RHS process. The Health Research Committee has provided guidance for the RHS project since 2000. For more information on the OCAP principles please see www.fnchc.ca

1997 RHS (FIRST NATIONS AND INUIT REGIONAL LONGITUDINAL HEALTH SURVEY)

In 1997, the first phase of the RHS was based on a collection of regional surveys where results were pooled together to provide a national outlook. There were nine regional areas included in the survey, which included both First Nations and Inuit samples. There were in total 14,008 participants (9,870 adults and 4,138 children) and the resulting data and analysis was used to inform and direct a considerable amount of findings, articles, literature and policy.

2002/2003 RHS (FIRST NATIONS REGIONAL LONGITUDINAL HEALTH SURVEY)

The second phase of the RHS was greatly improved upon and was informed by the experience of phase one. For this phase, between August 2002 and November 2003, there were 22,000 surveys completed with over 18,000 completed in British Columbia alone. The instrument design was more rigorous and required the concerted effort of many First Nation researchers. The design phase lasted two years and resulted in a larger sample size that used more targeted questions in a standardized fashion that increased the validity and reliability of the results. In addition, there was the opportunity for regions to include more specific components to their surveys to address their particular needs. In the first survey, only children and adults were surveyed, but not youth. However, in phase two the unique circumstances and challenges of our youth resulted in a survey dedicated exclusively to First Nations youth.

SURVEY THEMES

The three national survey instruments address a comprehensive range of health status, wellness and health determinants measures. For purposes of comparability across age groups, the same questions were used in all three surveys where possible. The following table provides an overview of the Survey Themes and topics addressed:

Adult (18+ years) Survey Themes

Demographics	28 Health Conditions- duration, treatment, effects	Smoking, alcohol, drugs – Use, cessation, treatment
Languages- comprehension, use	Diabetes – type, treatment, effects	HIV/AIDS, STD's and sexuality
Education	Physical Injuries	Pregnancy, fertility
Employment	Dental Care	Preventative Health practices
Income and sources	Disabilities, limitations	Wellness, supports, and mental health
Household-composition, income	Physical activity	Suicidal ideation and attempts
Housing-condition, crowding, mold	Food and Nutrition	Residential School- impacts
Water quality	Home care-use, need	Community wellness
Services	Health services-use, access, NIHB	Culture, spirituality, religion
Height, weight	Traditional medicines, healers	Community development

Youth (12-17 years) Survey Themes

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

Children's (0-11 years) Survey Themes

Household/family composition	Language-comprehension, use, interest	Health service access-NIHB
Parental Education	Food and nutrition	Dental, BBTD
Education	Activities-physical, social, after school	Traditional culture-importance, learning
Height, weight-at birth, current	19 Health conditions-duration, treatment, effects	Emotional and social well-being
Breastfeeding history	Injuries	Childcare-babysitting
Smoking-pre and post natal	Disabilities	Residential School

Data Collection Procedure

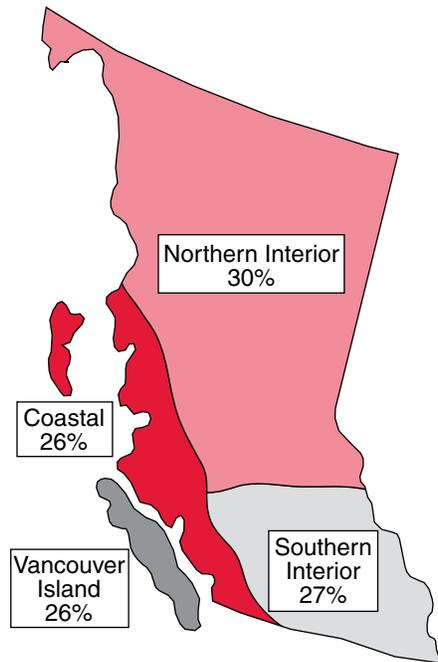
Data collection was completed in a standardized and comprehensive fashion using standard research procedures. Interviewers, selected by the community, were trained to administer the instrument using a contemporary computerized software package known as Computer Assisted Personal Interviewing (CAPI). They conducted face-to-face interviews using laptop computers. Adults were surveyed directly while children had someone, usually their mother or father, assist them during the interview process. Due to the sensitive nature of some of the information provided by youth, they were allowed to answer components of their surveys privately while a test administrator sat nearby if their assistance was required.

The First Nations Chiefs' Health Committee, under the direction of the BC First Nations Health Research Committee, carried out analysis of the data. All results have been statistically weighted to represent the First Nations population distribution.

COVERAGE

Nationwide, following 12 months of data collection and processing, a total of 22,602 surveys in 238 First Nations communities were available for analysis. In British Columbia, 1,944 surveys were collected and the total sample was broken down as follows: 712 from adults, 566 from youth and 666 from children. This represents 3.6% of the First Nation population living on reserve in BC reserve communities. Communities were categorized by region and size. From these categories 39 out of 198

communities were selected at random (stratified random sample) to ensure adequate representation of the four geographic regions as illustrated below: Northern Interior; Southern Interior; Vancouver Island; Coastal BC and community size: Small (population under 300); Medium (300-1499); Large (population 1500 and up).



The RHS 2002/2003 Process and Methods Report provides details on the sampling design. It is available at http://www.naho.ca/firstnations/english/regional_health.php

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

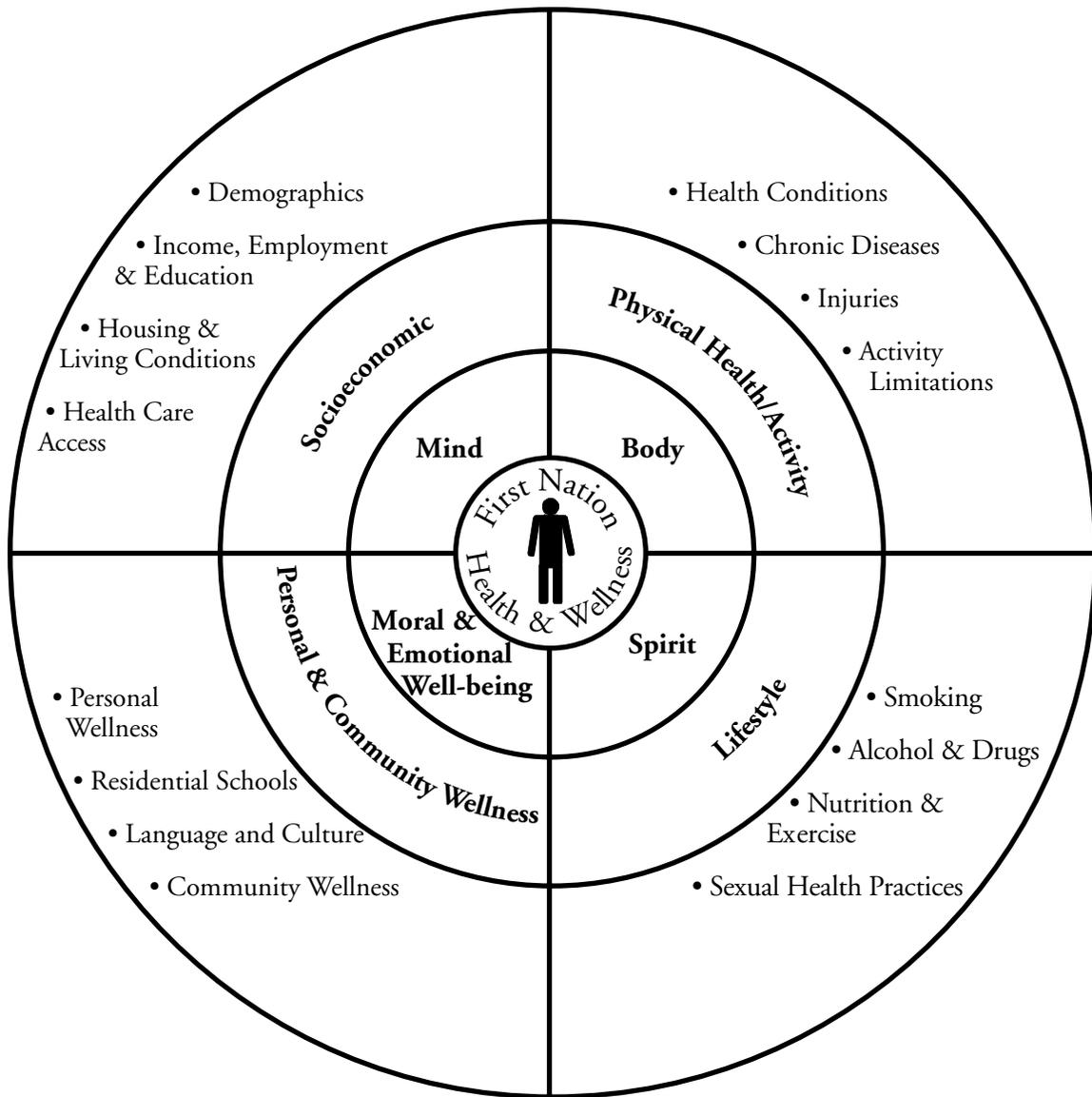
We begin this report with the question...how do we think about health? In other words how do we, as First Nation Peoples in British Columbia, conceptualize “health” and how do we explain these concepts?

Not a simple question and certainly the answer is anything but simple. However, despite the fact that all of us may, whether as individuals or as Nations, have different ideas of what constitutes “health”, we do share one common understanding. We all agree that when seeking guidance on very complex issues in life, a good starting point is to ask the Elders.

So it is with this report. We began by seeking guidance on the very difficult question of how we, as First Nations in British Columbia think about health...by asking the Elders. From the Elders Focus Group Session that was convened to ask our Elders their views about health, we begin this report with following quote from Elder Sarah Modeste:

“We need to teach children how to be healthy in mind, body and spirit and to look after mother earth as in return she will look after us. The spirit is the whole base of our life. Take care of our spirit and teach our children how to respect that. We all have the power to self heal as we have lived for 1000’s of years; the culture has been in us for 1000’s of years. It takes care of us. We are all medicine to one another”

This particular quote was chosen as it represents many of the other thoughts, insights and comments provided by our Elders. It is from this quote that we embarked on the next task, that of translating these words into a model, or framework, to guide the writing of this report.



To explain the diagram we begin in the centre.

The representation of a person at the centre, surrounded by the words “First Nation Health and Wellness”, refers to the words spoken by Elder Modest when she reminded us that we are “all medicine to one another”. If we begin to conceptualize health as beginning with us, as both individuals and as members of all the various First Nations in British Columbia, then we begin by placing ourselves at the centre.

By placing both ourselves and our concepts of what constitutes First Nation Health and Wellness at the centre, then we give recognition to the fact that we – and our beliefs and our ways of knowing, form the central tenants of how we can all be “medicine to one another” and thus have the “power to self heal”.

In the centre of the diagram, a circle surrounds both the person and words. The circle that surrounds us all is both our cultures and our spirit as a People. The circle is a representation of the words spoken by Elder Modest when she stated that:

“The spirit is the whole base of our life.

...the culture has been in us for 1000's of years. It takes care of us. We are all medicine to one another.”

From these words and from other similar teachings by Elders, we form the foundation of our model. As represented at the centre of the model, our understanding of “health” proceeds from the central tenant that our culture and spirit as a People lie at the core of how we perceive the health of an individual, community, Nation or Nations of Peoples.

Moving outward from the centre, the next level of the model is divided into four quadrants. From the Elders Focus Group Session, the Elders reminded us that it is important to remember that a total perspective of health involves the different components of mind, body, spirit and moral or emotional well-being. Accordingly each of the model quadrants is representative of these various components of health.

When viewed as a whole, each of these four quadrants operate like the spokes of a wheel. Moving outward from the hub, the spokes of a wheel provide both structure and strength, allowing the wheel to become functional. From this perspective of First Nations health, each of the “mind, body, spirit and moral/emotional well-being” components of health all work together like the spokes of a wheel, with each contributing to a structure that serves to strengthen our understanding of health.

In the next two levels of the model we begin to relate these core understandings of health, “mind, body, spirit and moral/emotional well-being”, to the categories used in the RHS survey. For example, the core understanding of “body” is translated to encompass those RHS categories that relate to “Physical health and Physical activity”, such as “health conditions, chronic diseases, injuries and activity limitations”. The data

from each of these RHS categories relates to and therefore impacts on the physical health of our body.

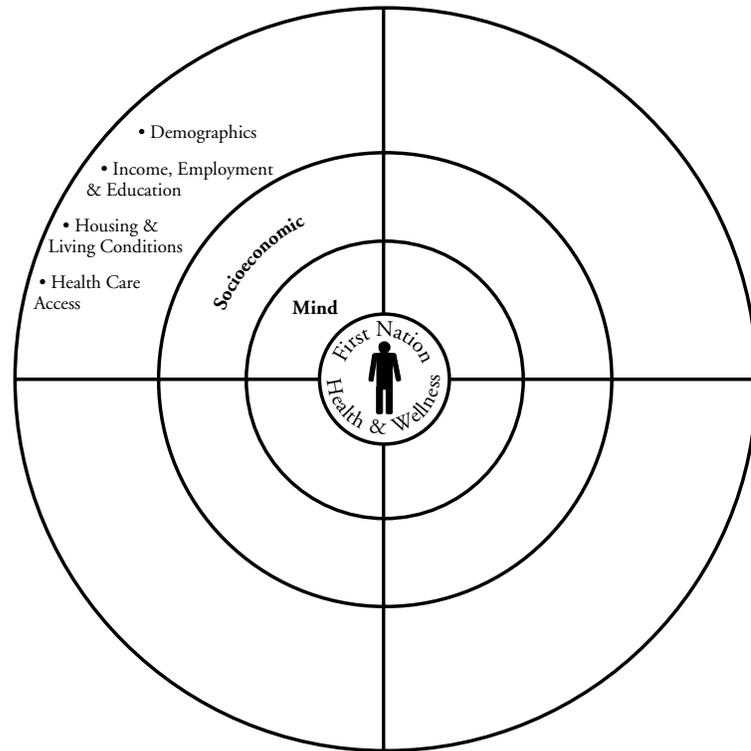
It was from these principles, which are contained in the guidance received from Elders, that we developed the model to guide the writing of this report. Before proceeding into an analysis of the RHS data collected, it is interesting to note the following two points.

First, when we look at the model as a whole, there are four concentric circles. Each successive circle merely represents the fact that all originate from a common, singular point. All represent an expansion of the core understanding, or basis for a First Nation understanding of health, which is that “we are all medicine to one another”. Like a pebble dropped into water, there is no difference between the circles...each successive circle only serves to repeat the original message sent out from the core.

Second, and again when we look at the model as a whole, there are four equal quadrants or sections. Although separate, each of the quadrants represent the various elements of health that are ultimately holistic, or in other words, are connected and operate together. Each of these quadrants, like the spokes of a wheel, combine to give both structure and strength to our understanding of health.

It is with starting point, with one interpretation of how we as First Nations in British Columbia view health, that we now proceed into an analysis of the data collected in the RHS process.

CHAPTER 3: MIND (SOCIO ECONOMIC CONSIDERATIONS)



The pictorial presented above shows how most things in First Nations life are seen to be naturally cyclical. Of course, in this case, as the pictorial shows, the same remains true for our approach to the research. It shows how we structure our research and how it fits into a frame of reference that suits how First Nations people view the world and how all things both animate and inanimate are interconnected. The four directions are also important to First Nations people and we, as First Nations in British Columbia, naturally realize the importance that these directions play in our day-to-day lives. For this exploration we focus on the West, for it is in this direction that our Minds are engaged, which helps to guide and direct our existence.

The research process follows this same premise as we view the data from the West, engaging our Minds, to interpret or see what the data means to us as First Nations people. We know that in this direction we look to the cognitive or thinking aspects imbedded in the data, showing how we think about our lives and how we exist. We

further see how we can be educated or learn from the data as a means of improving our lives. We know the basic values and things we need to exist as healthy humans such a food, shelter, and a connection to our communities and people to help sustain us and we are able to see this reflected in the data. Following the pictorial, we see how our Minds, being in the Western direction, also connect and assist our deliberation about our means of sustaining our families and ourselves. Here we explore, through the data, how we earn a living and how this impacts our Minds by creating environments in which we are able to exist. Here we will see how our examination of the data highlights the positive and negative experiences we encounter in making a living and how it impacts us as a people. Areas examined include:

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

Demographics

In general, more than half (52%) of all First Nations respondents rated their health as very good or excellent. In addition, another 33% rated their health as good. A total of 14% rated their health as fair (11%) or poor (3%). Older adults (35 to 54 and 55 and above) were more likely to rate their health as fair or poor than their younger counterparts. Men are more likely than women to rate their health as excellent or very good.

Though these numbers seem good, it should be stated that our people still do not rate their health as highly as do people in the general population. In the 2003 Canadian Community Health Survey, 60% of British Columbians aged 12 years or over stated that they were in excellent or very good health⁶.

Income, Employment and Education

INCOME AND EMPLOYMENT

Only 51% of our First Nations adults are working for pay, compared to the 65% labour force participation rate among all BC adults in the 2001 Census. The numbers for our First Nations adults are about the same as the National First Nations average.

More than a third of all First Nations adults in British Columbia (37.2%) had a personal income in the past year of less than \$10,000, compared to 28.1% of all adults in British Columbia in the 2001 Census.

Only 8.8% of our First Nations adults had a personal income in the past year of more than \$40,000, compared to 30.1% of all adults in British Columbia in the 2001 Census.

The average family income was \$28,398, compared to \$64,821 for the rest of British Columbia based on the 2001 Census.

Poverty during childhood is a strong predictor of poorer health later in life. The ways in which these factors influence health are complex. In general, the more resources, support and control over personal life circumstances and living conditions that a person has, the greater the chance of maintaining good health.



EDUCATION

The highest level of education attained by almost 50% of our First Nations adults is high school. In the general population of British Columbia, the number is 24%. Nationally, almost half of First Nations adults have graduated from high school.

The RHS indicates that 3.5% of our First Nations adults have obtained a university degree, compared with 17.6% of adults in the general population of British Columbia.

Among our First Nations mothers, 41% have obtained high school (no diploma) or less while 3% have a university degree. For our First Nations fathers, 49% have obtained high school (no diploma) or less while 3% have a university degree.

FAMILY AND HOUSEHOLD STRUCTURES

Housing and crowding are part of the very personal physical environment of the child, which impacts not only the child but also the family and other household members. On average, 21% of our people live in crowded living conditions.

More than half (55%) of our children live with both their biological parents, and 39% live with at least one. Only 6% of our children live with neither of their biological parents. In addition, 64% of our children live with two parents, 30% live with one parent and only 5% of our children live with no parents at all.

The RHS showed that 71% of childcare arrangements involved a relative caring for the child, either at the child's house or at someone else's house. Less than one-third of our children were cared for by: daycare centres; after school programs; nursery schools, or sitters that were unrelated to the child (29%). The average number of hours spent in childcare is 16.3 per week.

Housing and Living Conditions

DRINKING WATER SUPPLY

More than one quarter (27%) of the First Nations adult respondents considered our household water to be unsafe to drink. About 82% of households have piped water as their main supply. Of First Nations households surveyed, 14% get their water from a well and 2% get their water themselves from a river, lake or pond.



There are some regional variations. On the Coast, 90% of households get their water piped in, while 8% are on a well. In the Northern Interior, 85% of homes get their water piped in, 8% are on a well, and 5% collect their water from a river, lake or pond. In the Southern Interior 74% of households have their water piped in and 24% are on a well. On

Vancouver Island, 85% of households have their water piped in and 7% of homes are on a well.

As mentioned previously, more than a quarter of our adults think that their water supply is unsafe for drinking, though only one in ten drink boiled tap water. On the Coast, 26% of people consider their water supply to be unsafe, yet only 9% drink boiled tap water. In the Northern Interior, 37% think their water is unsafe and 17% drink boiled tap water. In the South Interior, 22% believe their water is not safe for drinking and 8% drink boiled tap water. On Vancouver Island 21% believe their water is unsafe and only 3% drink boiled tap water.

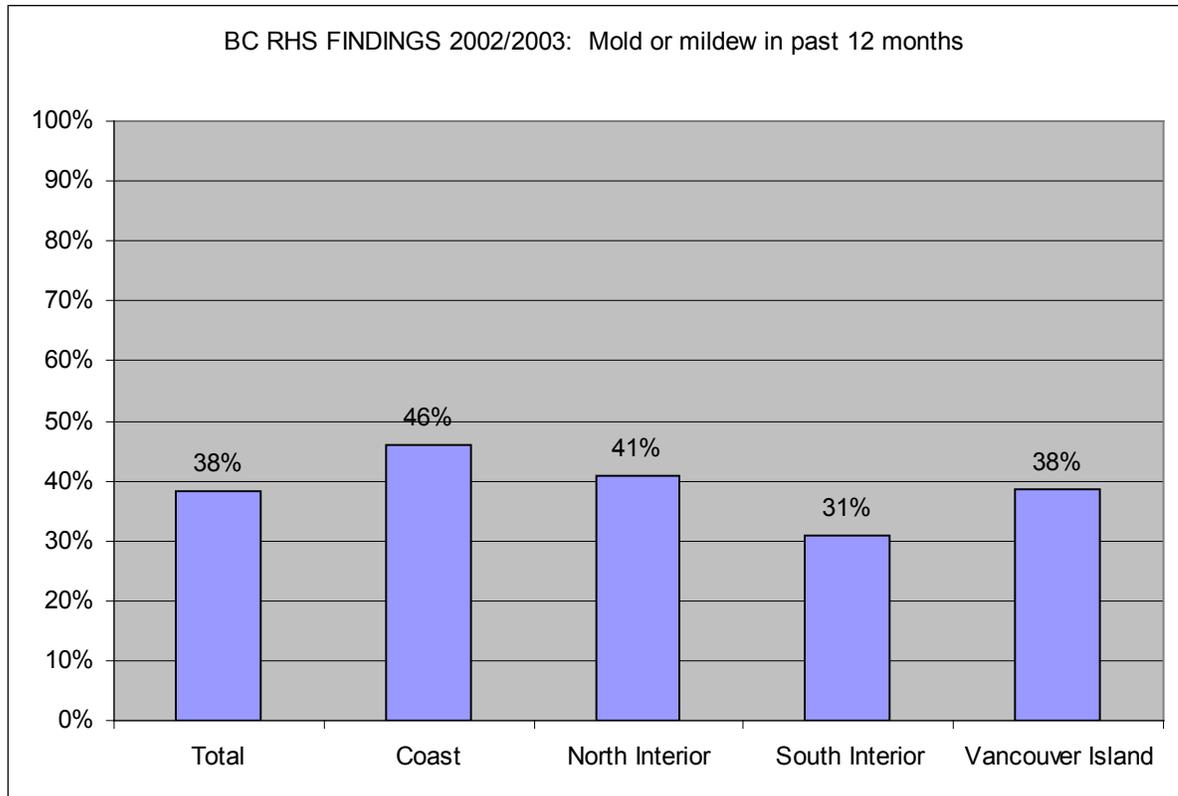
HOUSEHOLD MOLD

Toxic molds thrive in houses that are in poor condition or have a moisture problem and are a special concern of First Nations as they can cause serious health problems. These molds live in, or on, the structure of the building itself.



More than one third (38%) of homes reported the existence of mold or mildew in the past year. Regionally this breaks down to: the Coast (46%), the Northern Interior (41%), Vancouver Island (38%), and the Southern Interior (31%). We can relate these numbers

to the high incidence of allergies and asthma to our people. The RHS found that 13% of our adults, 13% of our youth, and 13% of our children have asthma. Further, 27% of our adults, 21% of our youth, and 19% of our children have allergies. It is interesting to note that among children and youth, the numbers of sufferers of asthma, chronic bronchitis, and allergies are considerably higher on the Coast, where almost half the homes report mold or mildew in the past year.



Health Care Access

Overall, 36% of First Nations adults in British Columbia rate their access to health care as being the same as that of other Canadians. An additional 16% rate their access as being better, whereas 28% rated their access as being poorer than other Canadians. This section of the report examines indicators of access to preventive primary health care measures, including access to health care, barriers to accessing health care, and access to Non-Insured Health Benefits (NIHB).

SCREENING PREVENTION

Of the major screening tests available, our First Nations men are consistently less likely to have undergone testing in the past 12 months, when compared to First Nations women.

The data shows that, in general, the rate of physical examinations increases in

older age groups, starting off at 30% for those 18-34 years of age to 52% for those 55 and older. Overall, 37% of our adults reported having a physical in the past year. A similar trend is seen among all major screening tests.

A blood sugar test screens for diabetes mellitus. A majority of First Nations adults over the age of 55 (59%) have undergone a blood sugar test in the past 12 months. Overall, 40% of our adults have been tested in the past year.

Regular vision or eye exams can also help detect the development of conditions such as high blood pressure or diabetes in their early stages. The RHS found that 61% of adults over 55 years of age and more than half (52%) of adults 35 to 54 years of age report having an eye exam in the past year. Overall, almost half of our First Nations adults (49%) report having an eye exam in the past 12 months.

One half of adults 55 years of age and one quarter of adults 35 to 54 years of age reported that they had a cholesterol test done in the past 12 months. Overall, one quarter of adults have undergone this test in the 2002/2003 study period.

The most frequent test that is undertaken by First Nations adults is a blood pressure test. Of all First Nations adults in British Columbia, 57% have taken this test in the past year. In adults aged 55 years and over the figure is 75%. The BC Health Guide recommends that healthy adults have their blood pressure re-checked at least every one to two years⁷. According to the 2000/2001 Canadian Community Health Survey, in British Columbia, these numbers are much higher among the general population.



More than half of First Nations women perform breast self-examinations. The RHS found that 37% of the women perform them 2 to 3 months or more. The Canadian Task Force on Preventive Health Care says that for women aged 40 to 69 years, there is fair evidence to recommend that routine teaching of breast self-examination be excluded from the periodic health examination⁸.

Among women aged 55 years or older, 45% had a mammogram within the past 3 years. In comparison, according to the 2003 Canadian Community Health Survey, among women in the general population of British Columbia aged 50 to 69 years, 52.1% had a mammogram within the past 2 years. The Canadian Task Force on Preventive Health Care states that there is good evidence for screening women aged 50 to 69 years by clinical examination and mammography. The best available data support screening every one or two years⁹.

Among women, 71% had a Pap smear within the past 3 years. In comparison with the general population, 74.5% had a Pap smear within the past 3 years. The recommended frequency is annual screening at age 18 or at the initiation of sexual intercourse, then, after 2 normal tests, screening every 3 years until age 69. The high mortality rate First Nations women experience as a result of cervical cancer makes more systematic screening advisable. This test can detect lesions on the cervix before they become cancerous, or in the very early stages of cancer. Early detection is a key issue for women.

BARRIERS TO ACCESSING CARE

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

- The waiting list was too long;
- Could not afford direct cost of care or service;
- Transportation issues;
- Felt health care was inadequate;
- Unavailability of doctor or nurse or service;
- Could not afford childcare;
- Difficulty in accessing traditional care;
- Difficulty in attaining approval from NIHB; and
- Encountering culturally inappropriate service.

All of these barriers rated high in the percentages for both men and women. However, it should be noted that in almost all barriers, save coverage by NIHB, the Northern Interior was considerably higher than other regions.

Summary of RHS findings

If we look to the learning environment in which we live, which greatly influences our opportunities to experience an adequate and healthy lifestyle, we see the following:

- More than half of all First Nations adults report that they are in excellent or very good health. Though this number is high, this is still lower than the general population of British Columbia.
- More than one third of our First Nation adults recorded a personal income of less than \$10,000.
- Overcrowding is a major issue among First Nations people. There is an average of 4.8 persons per household, almost twice the 2.5 person average in the general population of the province.
- Almost one third of First Nations adults live in homes that need repair.
- 38% of First Nations homes have mold. On the Coast, this number is 46%.
- Overall, 37% of First Nations adults received a physical within the past year.
- Almost 60% of our Elders received a diabetes test within the past year.
- Over half of First Nations adults had a blood pressure test. For our Elders this number is 75%.
- Many First Nations people experience barriers when trying to access services through NIHB. These barriers include: long waiting lists, immediate costs of service, transportation issues, inadequate health care, and the unavailability of a doctor or nurse.
- Almost half of First Nations people experience barriers when trying to access dental care through NHIB.

Context of Findings



We were always kept busy; we would have to go to the water early in the morning, we tanned hides, worked in the fields, went to the sweathouse, ate properly, helped in the gardens which most people grew. There was no end to the work and there was no boredom.

Elders

Elder Cultural Interpretation
Session

At the Adult, Elder and Youth Cultural Interpretation sessions many of the participants provided insight and cultural context that speaks to the Western direction, which helps to guide and direct our existence; it is the direction in which our Minds are engaged. The socio-economic components of our lives today are impacting the health of our people. One Adult participant said, “Health is influenced by ...poverty and economic level. Not very many people are going to be able to afford 4-5 servings of fruit and vegetables every day.” This is the stark reality of our existence for all too often we have the knowledge to live better but can’t reasonably afford it.

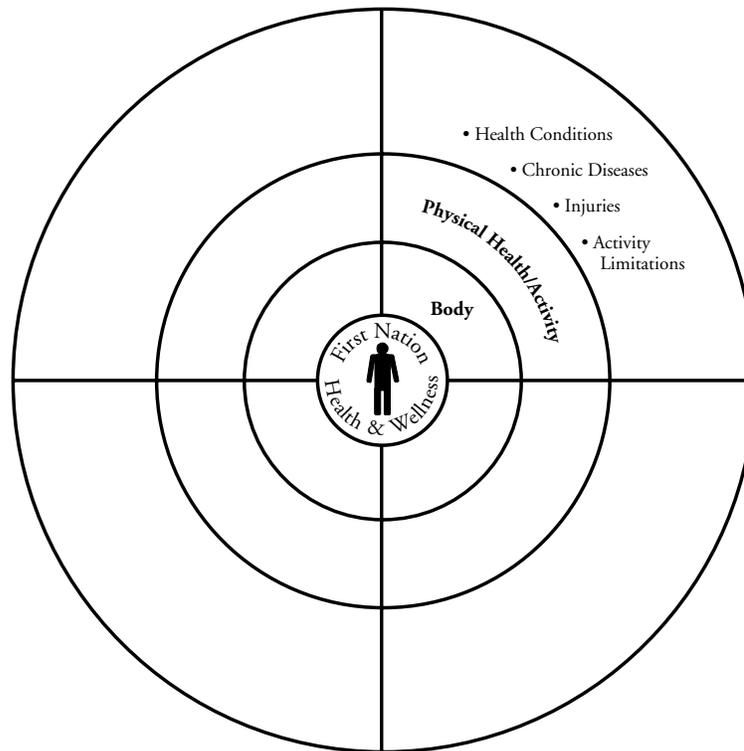
The socio-economic conditions today are a bleak comparison to the traditional ways of our Elders. At the Elders Cultural Interpretation session, “the Elder’s correlated good health to living a traditional lifestyle rich in culture, having spiritual harmony and exercising a relationship with the land.” So in effect our conceptualizations of what constitutes a good life have changed. One Adult participant added, “Berries, crabapples, baked fish. Elders had a good idea about a balanced diet.” This belies the fact that in spite of our technological advances the ways of the Elders still ring true. In the past, the land provided our food, and

food was our medicine. We relied on Mother Earth. As one Elder commented, “We’ve lost our traditional culture and our health goes with it.”

There is an ever-increasing gap between the knowledge of our Elders and the reality of life among our Youth. One Elder suggested “bringing Youth and Elder’s groups together to work with one another as a means of information sharing and to learn what each group has to offer. He indicated that ‘the youth do not know what we know and we do not know what they know’.” This is representative of the divide that exists between the generations. We need to get back to our traditional culture more than ever.



CHAPTER 4: BODY (PHYSICAL HEALTH / ACTIVITY)



It is common knowledge that our people, since first contact, have experienced health related problems that can be associated with the effects of colonialism. It is in the Northern direction, which represents the physical body, that we discuss issues related to these impacts on our physical health. There are many indicators used in contemporary research to describe health, or the physical attributes of health, and in this section we focus on presenting these findings that are meaningful or most relevant, to our First Nations peoples¹⁰. These categories are:

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

Health Conditions and Chronic Diseases

CHRONIC CONDITIONS: ADULT

Chronic health conditions are those that are long-term and are often related to the aging process or environmental causation. For First Nations people, too often the causes can be related to low economic status and substandard living conditions¹¹. For our people we have unusually high rates of arthritis, chronic back pain, asthma and high blood pressure all of which can be linked to environmental conditions.

Many First Nations people are affected by arthritis, which is a condition that limits mobility and causes joint pain and discomfort. It has a range of impacts on the body and comes in various forms. It can be as mild as joint pain and as severe as Rheumatoid arthritis, which is an autoimmune disease that causes chronic inflammation around the joints and surrounding tissue as well as affecting internal organs. Autoimmune diseases, such as Rheumatoid arthritis, occur when the body's own immune systems attacks its own tissues resulting in joint disintegration and severely limited mobility¹². The causes are also varied and range from genetics, infections and improper metabolism (gout). There is also literature that links arthritis to diet, stress and living accommodations, all of which have implications for First Nations people¹³.

Another disease that affects high numbers of First Nations people, and is also highly impacted by our environment, is asthma. Asthma is a chronic disease that impacts a persons breathing due to restricted airways¹⁴. It can be caused or triggered by many environmental agents such as: smoke, pollutants, and can also be triggered by stress and exercise. It is normally treatable and controllable but it can place restriction on people and their mobility.

As a result of the many environmental factors related to our economic and living conditions, our First Nations people often suffer from hypertension or high blood pressure. This also has many environmental linkages that are all too often present in our First Nations communities. High blood pressure is an elevated amount of tension on the walls of the arteries which can have a varied of effects on the body ranging from heart disease, stroke, artererioscoris and eye damage¹⁵.

First Nations people have high rates of heart disease. Heart disease directly affects the heart muscle and includes such conditions as: angina; arrhythmia; congenital heart disease; coronary artery disease; dilated cardiomyopathy; heart attack (myocardial infarction); heart failure; hypertrophic cardiomyopathy; mitral regurgitation; mitral valve prolapse; and pulmonary stenosis¹⁶. Risk factors include age, heredity, gender (male sex), tobacco smoke, high blood pressure, physical inactivity, obesity, diabetes, stress and excess alcohol consumption¹⁷. Many of the environmental and socioeconomic difficulties First Nations people experience are associated with risk factors for heart disease.

Among First Nations adults, 5% had heart disease while 11% had high blood pressure. As expected, these conditions were more likely within the 45 years and older age range. Compared to the general population, the prevalence of high blood pressure among older First Nations adults was about the same, even a little lower than expected. Women reported a slightly higher incidence of high blood pressure than men.

LONG-TERM CONDITIONS IN YOUTH (12 TO 17 YEARS)

The most common chronic disease affecting First Nations youth in British Columbia is allergies (21%). This is much higher than the national average for First Nations youth, which is 15.1% (RHS). These allergies are particularly high in the Coastal region and Southern Interior, areas which have reported more mold in their homes and a higher presence of cigarette smoking. In this category, more male (22%) than female (20%) youth have reported experiencing allergies. Close behind allergies is asthma (13%), which is on par with the First Nations national average (13.6%) (RHS). First Nations youth are more likely to have asthma than youth in the general population (9.5%)¹⁸.

Some youth respondents have hearing impairment (2%), vision problems (4%) or chronic ear infections (5%). Female youth report higher than male youth in each one of these conditions.

Finally, some youth respondents report having mental disabilities (1.3%), ADD/ADHD (2.3%), or a learning disability (5%). Interestingly, male youth are more than twice as likely to report having these conditions. Also, those youth from the South Interior report these conditions twice and sometimes three times as often as First Nations youth from other areas.

LONG-TERM CONDITIONS IN CHILDREN (0-11 YEARS)

In general, First Nations children are free from the serious conditions facing their adult counterparts.

Allergies are the most common occurrence among the First Nations children of British Columbia (19%). It should be pointed out that the national average among First Nations children is 12.2% and the national average in the general population is 16.4%. Once again, there is a high incidence of allergies in the Coastal region (33%) and in the Southern Interior (20%). Male children (20%) report slightly higher numbers than female children (17%) in this category.

Asthma is also a common condition (13%). This is slightly lower than the national First Nations average (14.6%) and higher than the average for the general population (8.8%). The Coastal region continues to report high numbers for this condition (21%). As well, male children (15%) continue to report slightly higher than female children (12%).

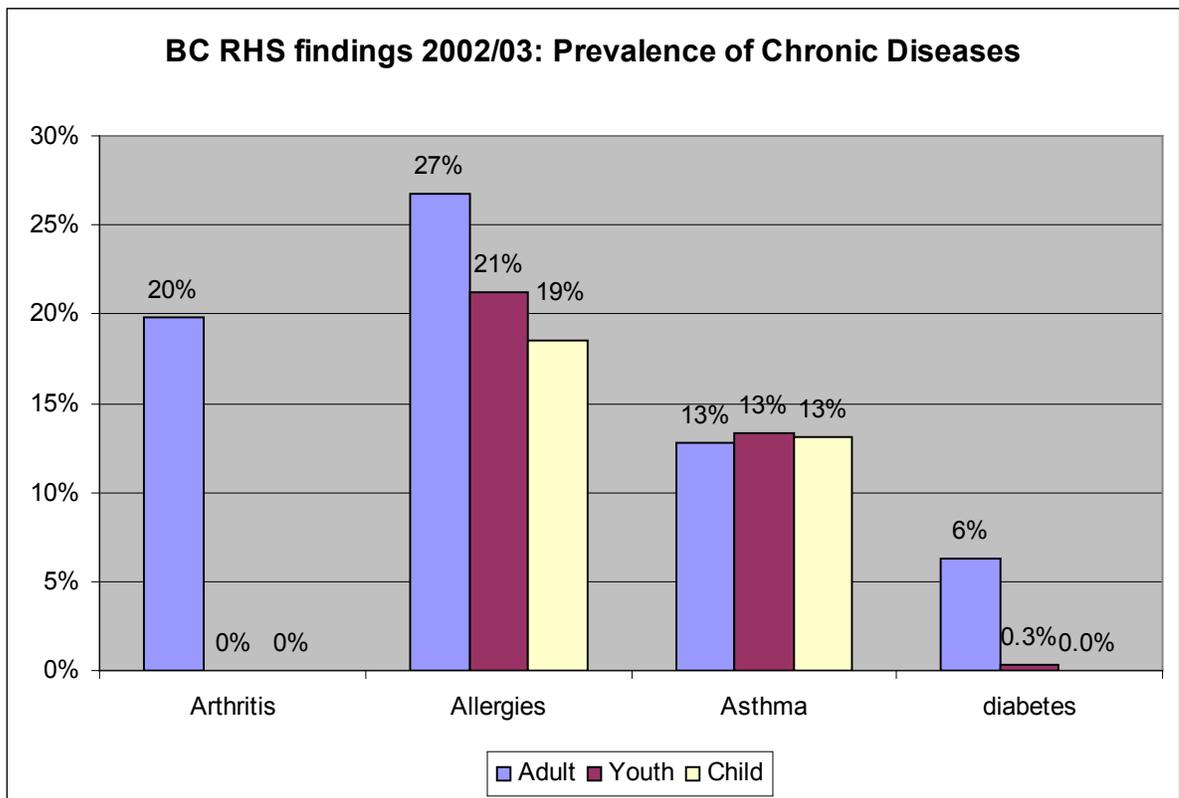
First Nations children also suffer from chronic ear infections (8%). This is less than the national First Nations average, which is 9.2%. These chronic ear infections are probably otitis media, which can cause ongoing damage to the middle ear and eardrum and there may be continuing drainage through a hole in the eardrum. Chronic otitis-media often starts painlessly without fever.



Sometimes a subtle loss of hearing can be due to chronic otitis media¹⁹. In British Columbia, 3% of First Nations children report hearing impairment.

Children also reported conditions of mental disability (2%), ADD/ADHD (2%), and learning disability (5%). With the exception of mental disability (Females – 3%, Males – 1%), males were twice as likely to report these conditions than their female counterparts.

Another disturbing number among First Nations children is the incidence of heart condition (4%). This is twice as likely among female children (6%) than male children (3%) and is extremely high in the Coastal Interior (10%).



Diabetes

First Nations people are facing an epidemic with diabetes. Rates of diabetes, in the near future, will increase in our communities as our people age - we must find ways to grapple with this health issue. The focus of this section looks at the affects diabetes has on our people and the variety of types of diabetes that affect our people. Unfortunately diabetes is often accompanied by another health complication, like heart disease and obesity, as many of our people are impacted by multiple health conditions (MHC). In addition, many environmental factors such as diet, stress and where we live geographically may impact our rates of diabetes. The types of diabetes found among our people include:

Type 1: requires insulin from an external source (usually by injection or infusion) as the person has no insulin producing cells in order to maintain a normal level of glucose (sugar) in the blood. **Type 2:** not enough insulin

is produced naturally to maintain normal blood glucose levels. This type of diabetes may be controlled by diet, exercise, and oral medication that increases insulin secretion from remaining insulin-producing cells. First Nations people are highly susceptible to Type 2 diabetes as it has been shown to be high (two to three times higher) in First Nations communities compared to non-First Nations communities²⁰. **Pre-diabetes:** The body's ability to handle glucose is reduced, and also includes higher than normal fasting blood glucose, which is not high enough to be considered diabetes. These individuals need to be closely monitored as they are at high risk to progress to develop diabetes. **Gestational diabetes:** Occurs during pregnancy as a result of glucose intolerance. Generally it can be controlled by diet and exercise yet on occasion may require insulin therapy. Rates of pre-diabetes in children has been shown when their mothers have had uncontrolled gestational diabetes.

Overall, 6% of First Nation adults report having diabetes. Among the older First Nations adult respondents in British Columbia, the prevalence of diabetes was higher than expected (45+ - 11%). Previous Health surveys had reported that of the First Nations adults in British Columbia, 7.1% of adults aged 45 to 64 years and 12.6% of adults aged 65 years and older had diabetes.

Of the adult respondents, most used oral medication without insulin (57%). Only some used insulin (18%) and some respondents used neither (25%). Well over half the respondents opted to tackle diabetes through diet modification (65%) and exercise (60%). Some respondents also used traditional medicines (11%) and ceremonies (5%) to deal with diabetes. In total, 39% of First Nations adults were currently receiving diabetes education.

Diabetes can complicate or lead to many other illnesses. The adult First Nations respondents of British Columbia felt that diabetes had led to other health issues. This is shown by the fact that all respondents who stated that they have diabetes also reported at least one diabetes connected complication. Many stated that diabetes had led to problems, including: problems with feeling in their hands or feet (40%), problems with circulation (23%), heart problems (10%), kidney problems (17%), lower limb problems (31%), vision problems (36%), and problems with infection (11%). There were, however, no reports of diabetes-related amputations.

Compared to the general population of Canada, the prevalence of diabetes among First Nations youth (aged 12 to 17 years) was the same (0.3%). In children, ages 0-11, the rate is 0%. This reflects the fact that the diabetes most prevalent among the First Nations is almost entirely of the Type 2 variety, which sets in later on in life.

Injuries Among First Nations

Injuries are either intentional or unintentional. Intentional injuries are those that are considered to be self-inflicted injuries (suicide) or received by another person (assault). Unintentional injuries are often considered accidents where there was no intent to harm by anyone involved in the incident.

First Nations people are prone to injury and it is one of our leading causes of death. It is recognized as the means of death for approximately one quarter of all victims and results in over half the potential years of life lost among our people²¹. In addition, the literature shows that beside death and disability, injuries (including those resulting from sexual violence) can lead to an array of other health problems including depression, alcohol and substance abuse, eating and sleeping disorders, and HIV and other sexually transmitted diseases²².

For First Nation people, there is support that shows that injury risk is related to income and education as well as alcohol and substance abuse²³. Low socio-economic status along with a culture that often supports conflict resolution through violent means, including strict gender norms, also contribute to these elevated rates²⁴.

For the most part, among all types of age groups, commonly reported types of injuries are cuts or scrapes, major sprains, and broken bones or fractures.

Among adults, injuries of major sprains (15%), major cuts, scrapes or bruises (13%), and broken or fracture bones (8%) were reported. With the exception of broken bones (Females - 9% and Males – 8%), men reported 5% higher in each

injury. As expected, there was a much higher occurrence of injury among the 18-24 years of age category than any other age grouping.

The causes of these injuries, among adults, were most frequently falls (12%), sports (6%) and motor vehicle collisions as the driver or a passenger (5%). As well, 6% of adults stated that they had sustained an injury related to alcohol or drugs. With the exception of collisions, which is even among all age groups, the 18-24 years of age category was much more likely to report being injured by falls (20%), sports (13%) and alcohol and drug related incidents (11%). This 11% of this category of respondents reported that they had been injured by physical assault, as well as 8% by poisoning. Many of these injuries in the young adult category could be related to alcohol and drug-use.

Among youth (12-17), the most frequent injuries were major cuts, scrapes or bruises (32%), major sprains (25%), broken bones (18%) and burns (16%). Generally speaking, these injuries were more common among male youth than female youth. As well, youth in the Coastal region and the Southern Interior were well above the average in every injury category.

The causes of these injuries were most frequently, sports (25%), falls (21%) bicycle accidents (12%), scalding by hot liquid or food (7%) and natural environmental factors (7%). Once again, these injuries affect male youth more than female youth by a significant margin. 4% of youth reported injuries relating to alcohol and drugs.

Among children (0-11 years of age) the most frequent injuries were major cuts, scrapes or bruises (14%), broken bones (5%), and sprains (4%). These injuries were sustained most frequently by falls (12%), bicycle accidents (5%) and sports (4%). Children's parents and/or guardians reported 2% of these injuries are alcohol or drug related injuries.

Disabilities

DISABILITY IN ADULTS

An adult disability is defined as someone over the age of 18 years as having a disability if, because of a physical or mental condition or health problem, they are restricted in the types or amount of activity they can do at home, work, school or in other activities such as leisure or traveling.

In total, 20% of the First Nations respondents of British Columbia reported being limited in their activity at home, 17% reported being limited in their leisure activities or traveling and 16% reported being limited in their activities at work or in school. Women were more likely to report being limited in their activities in some manner.

The activity of respondents is limited most frequently by arthritis (12%), chronic back pain (12%), asthma (6%), and allergies (6%). This tends to affect the respondents aged 45 years and older the most.

Access to Dental Care and Treatment Needs of First Nations

ACCESS TO DENTAL CARE FOR ADULTS

57% of our adult First Nations of British Columbia received dental care in the past year. More women (63%) than men (51%) have received dental care within the past year.

The BC Health Guide recommends that adults receive dental care (including examination by a dentist, and scaling and topical fluoride application by a dental hygienist) once or twice per year²⁵.



There are many existing barriers to dental care. First Nations adults encountered the following problems: Could not afford it (31%), the needed service was not covered by Health Canada's Non-insured Health Benefits program (28%), there was a direct cost of care (25%), approval for care was sought under NIHB but it was denied (21%), felt dental care was inadequate (21%), transportation costs (20%), a long waiting list (18%), services were not available in their area (13%), childcare costs (11%) and other costs (8%).

Many of these barriers relate to the cost of dental care, as dental service is largely determined by the ability to pay for services. According to the NIHB program policy, dental coverage is not comprehensive, which may explain why more complex types of dental treatment among older adults are sometimes neglected.

When asked to identify their current dental care needs, 56% of First Nations adults stated that they needed maintenance, 45% needed cavities filled, 20% needed fluoride treatment, 16% needed prosthetics (dentures, including repair and maintenance), 12% needed extractions, 8% needed urgent care (problems requiring immediate attention), and 5% needed orthodontic work.

ACCESS TO DENTAL CARE FOR CHILDREN

The majority of our First Nations children in British Columbia have received dental care within the last year (78%). This is 64% of children age 5 or less and 87% of children aged 6 to 11 years. The BC Ministry of Health and the Canadian Dental Association recommend that children have their first visit to a dentist about six months after the first tooth arrives (between 6 and 12 months)²⁶. After this, if there are no problems, children should go to the dentist once or twice a year. If infants are excluded from our numbers, among children aged 1 to 5, 70% were receiving the dental care that they needed while 30% were not.

The First Nations children's needs, according to their parents and/or guardians, are: maintenance (teeth cleaning and check-ups) (56%), no treatment needed (26%), cavities filled or other restorative work (29%), fluoride treatment (23%), orthodontic work (11%), extractions (6%), and urgent care (3%). It is interesting that 26% of parents believed that their children needed no dental work, as 96.5% of the children in the survey were at least one year old and standard expectations are that children require dental care at least once a year.

“Baby Bottle Tooth Decay” refers to tooth decay in a toddler caused by prolonged or continuous contact with any fluid containing sugars. This affected 27% of First Nations children in British Columbia, which is below the national First Nations average of 30%. Of the 27% of children affected, 84% had received treatment for it.



BC RHS FINDINGS 2002/2003: Dental health and care (Children)

	Total	Females	Males	0 to 5 years	6 to 11 years	Coast	North Interior	South Interior	Vancouver Island
Last time had any dental care									
Less than 6 mo ago	49%	45%	52%	39%	56%	49%	48%	51%	44%
6 to 12 mo ago	29%	32%	26%	25%	31%	32%	23%	28%	35%
1 to 2 yrs ago	8%	6%	10%	7%	9%	5%	11%	9%	5%
More than 2 yrs ago	2%	2%	3%	1%	4%	2%	2%	3%	2%
Never	12%	15%	9%	28%	0%	11%	16%	9%	14%
Has Baby Bottle Tooth Decay	27%	27%	27%	29%	27%	23%	27%	32%	23%
If yes:									
Been treated for Baby Bottle Tooth Decay	84%	77%	89%	74%	91%	90%	78%	84%	84%

Summary of RHS findings

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

- First Nations adults have high levels of arthritis, allergies and asthma.
- First Nations youth and children suffer from high levels of allergies and asthma, particularly in those regions that report a large presence of mold in their homes.
- Diabetes affects more than 1 in 10 of our older adults.
- The majority of our adults have stated that diabetes has resulted in or complicated other medical conditions.
- Our First Nations youth has a rate of diabetes that is on par with the Canadian national average.
- The majority of First Nations adults diagnosed with diabetes are undergoing treatment.
- Over one-third of our First Nations adults reported injuries requiring treatment – twice the Canadian average
- One in twenty First Nations adults reported that they had suffered at least one instance of violence in the previous year.
- One in five First Nations adults report being limited in their activity in the home.
- Over half of our First Nations adults reported that they needed urgent dental care.
- First Nations adults have encountered many barriers to dental services. Over one in five were denied coverage by NIHB and over one quarter stated that their needed service was not covered by NIHB.
- Almost one third of First Nations children are not receiving the dental care they need.
- More than one quarter of First Nations children suffer from Baby Bottle Tooth Decay.

Context Of Findings



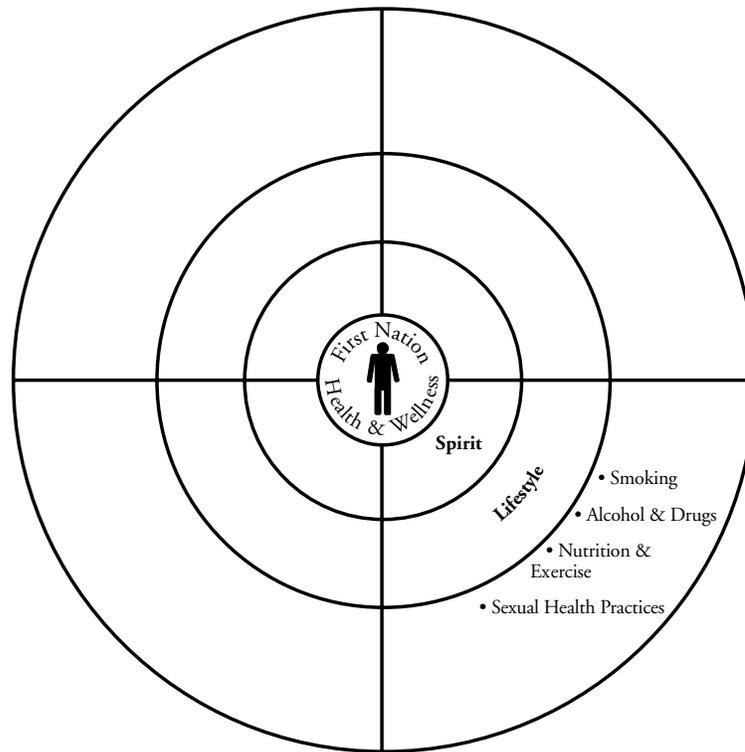
A long time ago we didn't think in terms of health, we took care of each other. People knew the traditional methods of taking care of themselves with the use of plants, roots and going to the land for food and medicines.

Charlotte & Jimmy Williams, Elders

It is the Northern direction that relates to the physical body. The Adult, Elder and Youth Cultural Interpretation sessions discussed many of the issues related to our physical health. Our poor overall health is reflected in the high numbers of reported health conditions and chronic diseases and the prevalence of diabetes. This is the result of not following our traditional ways. At the Elders Cultural Interpretation session, the Elders asserted it seemed there was longevity for Elders in past decades compared to now, as Elder's recalled people lived to be much older. The discussion continued as they discussion how "longevity was linked to healthy living, they did not hear of heart attacks, diabetes, high blood pressure, HIV, AIDS or cancer as people died of old age not cancer". The Elders went so far as to say "people did not get sick, everyone was well." Our physical bodies respond to the way in which we chose to live our lives and our contemporary choices have not been good ones.

The Adults Cultural Interpretation session focused on the impacts of our choices on dental health, as one participant stated, "decaying of teeth is relatively new." There is a lack of parental education about baby bottle tooth decay and there is little focus on the prevention of tooth decay. Poor preventative measures together with limited dental care access results in poor dental health among many of our people.

CHAPTER 5: SPIRIT (LIFESTYLE)



Lifestyle choices impact our health. The lifestyle choices that we make can have direct impact on our health and well-being. For instance, it is our individual choice as to whether we eat well or exercise. However, there may be other factors that impact our decisions like socioeconomic and education variables.

Lifestyle issues include our habits and patterns of behaviours that include smoking, drugs, sexual health practices, drinking and exercise. The way in which we choose to live impacts us as spiritual beings. All of these individual choices make up who we are and contribute to our sense of spiritual health.

Non-Traditional Tobacco Use

Smoking, in this context, includes non-traditional use, recreational use, as well as the misuse and abuse of tobacco.

Over a half of our First Nations adults (53.3%) are tobacco smokers. The majority of these are daily consumers - the remainder are occasional consumers. Almost one quarter of our youth (24.3%) are non-traditional tobacco smokers. Almost one third (32.2%) of our Elders are smokers, a high majority of them daily consumers. The rates of smoking are much higher among women than men.

In comparison with the general population of British Columbia, First Nations numbers are much higher. According to the Canadian Community Health Survey of 2003, the prevalence of daily or occasional smoking among British Columbians aged 12 years and older was just 18.3%. Overall, First Nations smoking, daily and occasional, in British Columbia is 36.2%.

More than one quarter (25.7%) of our Elders stated that they had never smoked. Among our adults this number is cut in half (13.1%). This indicates that the lower rate of smoking among Elders is about two thirds due to never having started and about one third due to quitting as they grew older.

Regionally, smoking is more prevalent in the Northern Interior and Coastal sub regions and less in the Southern Interior and Vancouver Island sub regions.

Cigarette smoking is arguably the single most significant contributor to premature death and preventable illness among Canadians today. It causes cancer, atherosclerotic diseases of the heart and blood vessels, and chronic obstructive lung diseases (which are quite prevalent among our First Nation people: chronic bronchitis, emphysema and chronic asthma). The following table provides a summary of findings on smoking from the 2002/2003 BC RHS.

	Smoke-free home*	Smoked cigarettes	Currently smoke		Number of cigarettes per day**	Age smoking started***
	Yes %	Never %	Occasionally %	Daily %	Mean	Mean
Total	73.3	9.2	13.4	21.8	3.4	14.9
Females	70.5	8.5	15.9	22.3	3.4	15.4
Males	75.7	9.9	11.1	21.3	3.3	14.4
0-11 years	79.3		0.5			
12-17 years	50.0		8.5	15.3	1.3	12.8
18-54 years	76.7	13.1	20.8	32.5	3.9	14.7
55+ years	73.3	25.7	8.8	23.4	2.6	18.1
Coast	76.9	7.4	10.8	26.6	4.2	14.7
North Interior	74.6	9.4	16.4	26.5	4.1	15.2
South Interior	70.3	10.8	12.1	19.2	2.7	14.3
Vancouver Island	73.9	7.8	15.0	13.5	2.3	15.7

Notes:

* Among current non-smokers

** Currently, includes non-smokers who smoke zero cigarettes per day.

*** Among current and former smokers,

SMOKING AND PREGNANCY

Almost three quarters (70%) of First Nations children surveyed were born to mothers who did not smoke cigarettes at all during their pregnancies. However, 16% of children were born to mothers who smoked throughout the pregnancy and 11% to mothers who quit during their pregnancy.

Smoking by pregnant women increases the risk of premature birth and babies with low birth weights. Only 14% of women who quit smoking listed pregnancy as a reason. More awareness, of the harmful consequences and risks of cigarette smoking, is needed.

FORMER SMOKERS

Almost half of those First Nations adults surveyed do not smoke. Women were less likely to have never smoked than their male counterparts.

WHEN PEOPLE BEGIN TO SMOKE

Women (15 years of age) started smoking later than men (14 years of age), though only by one year. Youth smokers reported starting smoking around the ages of 12 or 13, while Elders who smoked reported starting around the age of 18.

CURRENT SMOKERS

53.3% of our First Nations adults are current smokers. The average number of cigarettes consumed by current smokers is 3.9, though this number includes the non-smokers who smoke zero cigarettes a day. Women consume more cigarettes per day, on average, than men.

STOPPING SMOKING

In the past year, more than half of our First Nations youth (67.4%) and adult (57.9%) current smokers have tried to quit, at least once. The majority of the youth and adult who attempted to quit did so once or twice. Interestingly, less than half of our Elders (46.4%) have tried to quit in the last year. The majority who tried to quit also did so once or twice. Significantly fewer smokers have tried to quite 3 to 4 times in the past year and only a few have tried to quit more than 5 times. It should be noted that this trend holds true for all but our youth. Many of our youth (11.4%) have attempted to quit smoking more than 5 times this year, in comparison to 3 to 4 times (10.6%).

The most common reason for quitting smoking, for both adults and youth, was a desire for a healthier lifestyle (57%). Other important reasons were: having a greater awareness (34%), respect for loved ones (27%), and a health condition (21%). Interestingly, it was our First Nations men who were affected significantly by respect for the cultural and traditional significance of tobacco, a healthier lifestyle, health conditions, and greater awareness. Our First Nations women were much lower in these areas and were more likely than men to cite: doctor's orders, peer pressure, respect for loved ones and pregnancy.

The most common method for quitting smoking was, by far, 'cold turkey' (91.3%). Other popular methods include: help from spirituality (8.9%) and assistance from family (8.3%). None of the listed aids, such as the patch, nicotine gum, Zyban, etc., were commonly used.

SMOKING IN THE HOME

Among current non-smokers, 73.3% of First Nations people surveyed live in a smoke-free home. This means that 26.7% of First Nations people live in an environment affected by smoking, though they are not smokers. The majority

of First Nations children (79.3%) live in a smoke free environment, compared to only 50% of First Nation youth. 76.7% of First Nations adults and 73.3% of First Nations Elders live in smoke free environments. The proportion of non-smokers in the general population of British Columbia who live in smoke-free homes is 94%.

Among infants, exposure to environmental tobacco smoke increases the risk of Sudden Infant Death Syndrome. Among young children, exposure to environmental tobacco smoke increases the risk of asthma.

Alcohol and Drug Use

Although anecdotal evidence as to the extent of First Nations issues with alcohol and drugs exists there remains a lack of comprehensive information on the abuse and impact of these substances²⁷. The significance of substances such as alcohol and drugs within the First Nations communities is immense. For example, drug induced deaths are three times higher than that of the general population while alcohol related deaths are six times higher²⁸.

ALCOHOL USE

Contrary to popular belief, our First Nations people, according to previously released studies, have a higher abstinence rate than that of the general population²⁹. Interestingly this is consistent with the findings in the current RHS. In 2002/2003, less than two thirds of our First Nations adults (64%) reported the use of alcohol, which is lower than the general Canadian population.

In fact, more than one third (39%) of First Nations adults aged 55 and over reported the use of alcohol, compared to 78% of those aged 18 to 34.

Among our First Nations youth, 44% of them reported alcohol use in the 12 month period (2002/2003). This number is higher among women (46%) than men (42%). More than half the youth in the Coastal region reported alcohol use (53%), Vancouver Island reported 47%, the Northern Interior reported 45% and the Southern Interior reported 36%.

FREQUENCY OF DRINKING AMONG ALCOHOL USERS

The frequency of alcohol use was moderate. Only 11% of First Nations adults stated that they used alcohol either daily or 2 to 3 times a week, compared to 44% in the general population. Males were almost twice as likely to report a weekly frequency, than their female counterparts.

HEAVY DRINKING

The problems associated with alcohol are with those who have problem drinking, rather than overall use of alcohol - specifically, the issue with the higher rates of alcohol dependence and substance abuse issues among heavy/binge drinkers³⁰. Heavy drinking (five or more drinks on one occasion) remains higher than that found in the general population.

If we exclude people who did not drink at all in the past year, 68% of adult current drinkers had a binge 12 or more times (once a month) and 16% of adult current drinkers had a binge 52 times or more (once a week) this past year. According to the 2003 Canadian Community Health Survey, among adult current drinkers in British Columbia, the prevalence of binge drinking 12 or more times a year was highest (29%) among those aged 20 to 34. For First Nations adults aged 18 to 34 this number was 80%. Among the general population of British Columbia aged 35 to 54 years the prevalence of binge drinking was 32%, compared to First Nations of the same age at 59%. Finally, adults 55 years and older in the general population have a binge drinking rate once a month or more of 15% while our Elders have a rate of 60%. In general, binge drinkers are much more likely to be male than female.

Though the above trends are disturbing, our heavy drinking rates among our youth are even more disturbing. Of the youth who are considered to be “current drinkers” (people who have had alcohol at least once in the past 12 months), 73% have had 5 or more drinks one or more times in the last year. There are 55% of our First Nations youth who have had 5 or more drinks once a month or more. Finally, 17% of our youth binge drink once a week or more. This number is higher than their adult counterparts. Though there are more male youth (57%) than female youth (52%) who binge drink once a month or more, the margin is not wide. The most disturbing data is that of the 17% of youth that binge drink once a week or more, 21% of these are women and 13% are men. In the Southern Interior, youth that binge drink once a week or more is 30%, while the rest of the regions hover around 12%.

DRUG USE

Currently, we find that about one quarter (24%) of First Nations adults have used marijuana over the past year. By far the highest frequency was among adults aged 18 to 34 years (37%).

In general, there was a low usage of illicit substances in the past year by our First Nations adults: .5% used PCP (angel dust), 1% used LSD, 1% used ecstasy, and 5% used cocaine. In addition, 11% of our adults used opiates (excluding heroin), 9% used chewing tobacco, and 1% used sedatives. None of our adults reported using solvents or heroin. Women are much more likely than men to use sedatives and opiates, while men are much more likely to use chewing tobacco, marijuana, cocaine, LSD, PCP and ecstasy.

In terms of regions, residents of the Northern Interior had the highest prevalence of drug use in the past 12 months.

Among our First Nations youth respondents fewer than 4% reported using illicit substances. It should be noted, however, that in most areas (PCP, LSD, ecstasy, inhaled solvents, sedatives, and heroine) usage was higher than among adults. Use of marijuana was quite high among our First Nations youth, 32%. It should also be noted that except for ecstasy and heroine, usage of all drugs was higher for women than men.

TREATMENT AND COMMUNITY RESPONSE

The impact of substance abuse can also be seen through the proportion of adults who sought treatment for their addiction. Treatment was most often sought for alcohol abuse (19%). A smaller proportion reported that they had sought treatment for drug abuse (8%). In addition, 1% reported they had sought treatment for solvent abuse. More men than women sought treatment for substance abuse. The prevalence of treatment was highest among those residents of the Northern Interior and lowest among residents of Vancouver Island. These rates may not reflect the extent of those requiring treatment or may reflect a lack of treatment resources.

Nutrition and Physical Activity

The literature clearly shows that plenty of exercise can prevent illness. It can help reduce the impacts and rates of chronic illnesses and physical conditions, including heart disease, hypertension, obesity, Type 2 diabetes, osteoporosis, certain cancers, and functional limitation with aging³¹. People who exercise and stay active are more likely to be mentally healthy, and have reduced anxiety, depression and tension. Exercise has positive effects on the emotional state of both young and old people alike³².

Overall being overweight and obese is reaching record levels in Canada³³. People are less likely to be active and are eating poor foods that are high in sugar, salt and saturated fats. In addition for First Nations people there has been a shift from traditional foods (hunting, fishing and trapping) that were historically available right up until the 1960's to a virtually complete westernized diet³⁴. It can be asserted that the increased reliance on governmental subsidies and store bought food for First Nations people resulted in the decrease in traditional physical activities and means of obtaining wild game³⁵. Nutrition data indicates that being overweight has increased through carbohydrate intake, particularly soft drink consumption³⁶. When people choose to change back to a traditional diet it helps reduce their weight, increases their energy balance and positively impacts their overall well-being.

Certain chronic diseases are caused in part by being overweight and obese. Chronic diseases are the major cause of death, representing 59% of deaths worldwide³⁷. Three preventative factors – diet, physical activity and avoidance of tobacco use – are important to reduce chronic disease³⁸. A person can control them in order to reduce the chance of developing chronic disease. Our First Nations youth have high rates of obesity and chronic conditions such as Type 2 diabetes.

PHYSICAL ACTIVITY

More than half of our First Nations adults participate in the traditional activities of fishing (54%) and berry picking (51%). Berry picking is done more by women (60%) than men (43%) and fishing is undertaken more by men (70%) than women (36%). Hunting and trapping is done by 32% of our adults, mostly by men. Hunting and trapping is done the most by adults aged 18 to 34, fishing is done more by adults aged 35 to 54 and berry picking is undertaken the most by our Elders.

The measure for sufficient activity was defined as reporting at least 30 minutes of moderate/vigorous activity (defined in the survey as physical activity "...that results in an increase in your heart rate and breathing") for four or more days of the week. Using this guideline, 40% of our First Nations adults participate in 5 or more hours per week of physical activity that increased their heart rate or breathing. They do this approximately 4.8 times a week. Women are more likely to be sedentary than men and men are more likely to meet the measure for sufficient activity as shown in the following table from the 2002/2003 BC RHS.

BC RHS FINDINGS 2002/2003: Physical Activity (Adults)

	Total	Females	Males	18-34 years	35-54 years	55+ years	Coast	North Interior	South Interior	Vancouver Island
Physical activity: Activity that increases heart rate or breathing										
0 hours per week	11%	13%	8%	4%	12%	27%	11%	11%	12%	6%
1 to 2 hours per week	26%	31%	20%	23%	30%	17%	30%	23%	21%	35%
3 to 4 hours per week	15%	13%	17%	18%	14%	10%	13%	17%	15%	17%
5 to 6 hours per week	14%	14%	13%	17%	12%	10%	13%	12%	13%	18%
7 to 10 hours per week	14%	11%	17%	12%	16%	11%	10%	12%	21%	8%
11 or more hours per week	12%	8%	16%	16%	10%	8%	13%	18%	11%	6%
Mean number of times per week	5%	5%	5%	5%	5%	4%	5%	6%	4%	4%

Almost half of our youth are likely to spend more than three hours a day watching television (47%). In addition, 28% of our youth spend more than three hours a day playing video games or using a computer (not for video games). Video game usage is three times as prevalent among teenage boys, than teenage girls.

A majority of our youth report spending more than 3 hours a day outdoors (62%), while 13% reported spending three hours or more a day doing household chores. Teenage boys spent more time outside than teenage girls, while more than twice as many teenage girls spent more time doing chores than teenage boys.

Inactivity is somewhat of a concern for our youth, as almost a quarter of them do not participate in sport teams or lessons after school. Males are more likely to be involved in these activities than their female counterparts. Regionally, our youth in the Northern Interior are very involved in outdoor activities and sports teams or lessons.

More than one third of our youth participate in physical activity for 6 hours or more a week (37%). Males are more likely than females, on average, to undertake physical activity for more than 11 hours a week. However, females are slightly more likely than males to exercise 6 to 10 hours a week. Though, females are more than twice as likely not exercise at all or less than 1 hour a week.

BC RHS FINDINGS 2002/2003: Physical Activity (youth, age 12 to 17 years)

	Total	Females	Males	Coast	North Interior	South Interior	Vancouver Island
Activity that increases heart rate or breathing							
None	4%	4%	4%	4%	5%	3%	4%
Less than 1 hour per week	11%	17%	5%	15%	12%	7%	11%
1-5 hours per week	35%	30%	40%	33%	35%	34%	42%
6-10 hours per week	19%	20%	19%	16%	23%	22%	12%
11-20 hours per week	12%	10%	14%	14%	6%	16%	10%
More than 20 hours per week	6%	2%	9%	8%	9%	3%	6%
Don't know	12%	16%	9%	9%	9%	15%	14%

Some of our youth report participation in traditional food gathering activities: 42% of our youth participate in fishing, 39% participate in berry picking, and 19% participate in hunting or trapping.

Our First Nations children are quite active: 63% of them participate in physical activity either almost every day or every day. Only 10% of them do not participate in any physical activity or undertake it less than once a week. More than half of our children participate in sports teams or lessons outside of school (54%). These youth are more likely to be boys than girls. Our children spend about 13.3 hours a week, on average, watching television and an average of 8 hours a week playing video games or using a computer. Our First Nations children spend about 15.2 hours a week outside playing and about 3.7 hours a week helping with household chores. Boys are more likely to spend time playing video games and playing outside, while girls are more likely to spend time on the computer and assisting in chores. Regionally, all of these numbers are highest on the Coast, so while these children spend slightly more time than others watching television and playing video games, they also spend more time outside and helping around the house.

BC RHS FINDINGS 2003/2003: Physical Activity (children, age 11 years or less)

	Total	Females	Males	0-5 years	6-11 years	Coast	North Interior
Any kind of physical activity							
Never	5%	4%	5%	6%	3%	4%	5%
Less than once a week	5%	7%	3%	4%	4%	3%	5%
Once a week	7%	6%	7%	3%	10%	13%	7%
2-3 times a week	20%	16%	23%	20%	20%	15%	21%
4-6 times a week	15%	17%	13%	8%	20%	18%	14%
Every day	48%	48%	47%	58%	41%	45%	44%

NUTRITION

Our First Nations adults consume foods that are not nutritious quite frequently. More than one quarter (27%) of our adults drink pop at least once a day and eat fast food at least once a week (29%). Almost one third of our adults consume sweets at least once a week (30%). One third of the adults surveyed reported that they added salt (33%) and sugar (34%) several times a day. Fried starch was eaten more than once a week by 36% of our First Nations adults and 44% of them consume coffee or tea several times a day. With the exception of coffee or tea and soft drinks, men consume more of these non-nutritive foods than women, but only by a slim margin.

On the other hand, at least a third of our First Nations adults consumed traditional protein-based foods such as game and fish. The same proportion also consumed berries and other wild vegetation often in the past year. However, 37% also ate bannock or fry bread often in the past 12 months as well. This consumption is similar across all age groups. Men are more likely to consume our protein-based traditional foods more often than women. Regionally, those areas that have more of a particular traditional food are more likely to consume it. For instance, 61% of adults in the Northern Interior consume large land mammals often, compared to 8% of residents of the Coast.

Among our First Nations youth, consumption of high starch and fatty foods was very common. Almost a third of our youth consume soft drinks once a day (32%) and almost half consume fast food once a week (43%). However, more than half eat sweets (53%) and fried starch (58%) more than once a week. Very

few add salt or sugar to their foods and a low number drink tea or coffee. Our teenage boys are more likely to consume these fatty foods than our teenage girls. Regionally, these numbers are higher in the Northern Interior and on Vancouver Island.

In regards to our traditional foods, our youth consume them less regularly than our adults. Less than a third of our youth state that they have eaten large land mammals (29%), and fresh water fish (30%) often in the past 12 months. Our youth are more likely to have eaten berries and other vegetation (35%) and fry bread (46%) often in the past year than our protein-based traditional foods. The numbers for our teenage boys and girls are similar, with more women consuming berries and fry bread. Regionally, the patterns reflected are similar for the youth and the adults, with a few notable exceptions: More youth on the Coast and in the Southern Interior are likely to have eaten large land mammals in the past year than their adult counterparts; On Vancouver Island, our youth are eating land mammals almost a third less frequently than our adults of the same region; and our youth of the Northern and Southern Interior are eating more berries and eating corn soup much more frequently than the adults of those areas.

Our First Nations children consume fatty and starchy foods at a very high rate. Almost half of our children consume sweets (48%), fried starch (44%) and soft drinks (43%) more than once a week. Almost one in five of our children eat fast food more than once a week. A low percentage of our children add sugar or salt to their food several times a day. However, 13% of our children drink coffee or tea once a week or more. These numbers are for children aged 0 to 5 and children ages 6 to 11. The consumption rate is much higher in the latter category. In this category, a half or more of our children are consuming sweets (57%), fried starch (50%) and soft drinks (53%) more than once a week. These numbers are relatively the same across genders. Regionally, we can say that our children in the North Interior are consuming the most non-nutritive foods overall. However, our children on the Coast are consuming sweets and fried starch in the highest percentages.

Our children consume traditional foods at a higher rate than our youth, closer to that of our adults. About one third of our children have eaten large land mammals, fresh water fish and berries often in the past 12 months. 39% have

eaten bannock often in the past year. These numbers are higher for boys for our protein-based traditional foods, with the exception of salt-water fish. Girls eat more berries and other vegetation but only by a slim margin. Regionally, patterns are similar to the adults and the youth.

BODY MASS INDEX

A large proportion of First Nations adults are considered overweight and obese. A smaller proportion is considered morbidly obese (BMI above 40), which increases the risk for developing health problems. Our First Nations adults have a higher acceptable BMI than the national First Nations average and slightly less are overweight; however, more of our First Nations adults are morbidly obese than the national First Nations average. In total: 1% of our adults are underweight, 30% are of acceptable weight, 36% are overweight, 26% are obese, and 6% are morbidly obese. It should be stated that our men are more likely to be of acceptable weight or overweight than our women, while women are more likely to be obese or morbidly obese. In fact, the rate of morbid obesity among our First Nations women is three times that of our men and twice the national First Nations average. Our Elders are more likely to be obese while our adults 35 to 54 are more likely to be morbidly obese. Regionally, our adults on the Coast and on Vancouver Island are more likely to be overweight, obese and morbidly obese.

The majority of our First Nations youth are of an acceptable weight or underweight (70%). However, this means that almost one third of our youth are overweight (21%) or obese (9%). In general, our teenage girls are much more likely to be overweight than our teenage boys but it is our teenage boys that are more likely to be obese. Regionally, it is on the Coast where more than a third of our youth (35%) are overweight and obese.

Less than half of our First Nations children (48%) are either of an acceptable weight or underweight. 52% of our children are either overweight or obese. Once again, our girls were more likely to be overweight, while our boys were more likely to be obese. The rate of obesity is 32% in children ages 0 to 5 years old and it drops to 20% in the 6 to 11 year old age range. The overweight rate almost doubles from 18% in the range of 0 to 5 years old, to 33% of children ages 6 to 11. Regionally, 56% of First Nations children from Vancouver Island are overweight or obese.

It is clear that there is a serious epidemic of obesity among First Nations adults and that this begins with excess weight in childhood. Because of its contributing role to a variety of common and serious diseases, obesity has a strong impact on population health. Promoting healthy body weights should be included as a key component of a health strategy for our First Nations people.

Obesity is the result of interaction between environmental factors and a person's genetic tendency to gain weight, rather than the lack of will power or self-control. Loss of traditional diet, loss of the physical exertion associated with traditional food gathering, replacement with an easy and constant supply of processed convenience foods high in fat and sugar, sedentary pastimes such as watching television are all examples of environmental factors that affect obesity. Returning to a more traditional diet and lifestyle could be part of the solution to this epidemic.

As well, there is a need to address the socio-economic differences between our people and the rest of Canada. Low income means insecurity and lack of control over one's living conditions and is quite stressful. People with low income have limited opportunities for enjoyable recreation and fatty foods are readily available and inexpensive. As in the First Nations population, low-income non-First Nations peoples also show high rates of obesity. Poverty reduction is not usually the mandate for health authorities but perhaps it should be.

Infant Health Measures

Infants are often at risk when they live in unhealthy social, economic, and environmental conditions. Infant health measures, such as infant mortality and low birth weight, are firmly linked to health conditions related to adequate food supply, adequate housing, employment, education level, and environmental exposures. These measures are seen as a core reflection of the health of a community.

In this section our examination will centre on infant health, birth weight, and two important health behaviours of mothers; smoking during pregnancy and breastfeeding. Further, factors of health from pregnancy, birth, to the childhood years of life are explored.

BIRTH WEIGHT

Nine out of ten First Nations babies are born of a healthy birth weight, 2.5 to 3.5 kg (90%). Only 6% of our babies are born underweight and 4% are born with a high birth weight (more than 4.5 kg). The average birth weight is 3.5 kilograms. This was slightly higher for boys than girls. The prevalence of low birth-weight among First Nations babies is similar to that among the general population of British Columbia.



BREASTFEEDING

We found that 77% of our children are breastfed (82% of children less than five years old and 74% of children ages 6 to 11 years old). Regionally, children on Vancouver Island had high rates of breastfeeding, 90%. While only 59% of the children of the Northern Interior were breastfed. On average, breastfeeding lasted for about 8.6 months (this number also includes those women that do not breastfeed). On Vancouver Island this number is 10.5 months, while in the Northern Interior it is 6.2 months. Although breastfeeding by mothers of First Nations infants appears to be increasing, the frequency is still less than the general population. Among women in the general population of British Columbia who had babies in the previous 5 years, 93.3% breastfed their infants.

SMOKING DURING PREGNANCY

Overall, 27% of our children were exposed to some maternal cigarette use. In addition, while our First Nations women were pregnant, 30% lived with another household member that smoked.

Sexual Health Practices

First Nations adult males report that they are more sexually active than females. Of those who reported they were sexually active over the past year, the majority stated that it was with one or two partners. Almost all First Nations women (94%) that were sexually active in the past year were sexually active with one or two partners, compared with 75% of First Nations men. First Nations men were more likely to report engaging in sexual activity with multiple partners. As well, 18 to 34 year olds were more likely to report having multiple partners than any other age group.

The majority of our First Nations youth do not report being sexually active within the past 12 months (72%). Of the 28% of our youth who were sexually active within the past year, more than half was with one or two partners (16%) while 6% reported 3 to 4 partners. More men reported being sexually active than women. However, it was more likely that our teenage boys reported being with one or two partners than our teenage girls. They were more likely than the boys to report 3 to 4 partners. Regionally, the youth on the Coast are more sexually active than our youth of other regions.

PATTERNS OF BIRTH CONTROL PROTECTION

One of the most effective means of curtailing Sexually Transmitted Infections/ Human Immunodeficiency Virus transmission, besides abstinence, is the use of a condom. However, despite efforts to educate our people, condom use across all age groups of First Nations people is low. In fact, more than half of our sexually active First Nations adults stated they never use condoms and only 31% stated that they always do. The reason for not always using condoms was that many First Nations people were with a steady partner (65%). Among our First Nations women, this number was 74%. Overall, 6% stated that they did not use a condom because either they or their partner did not want to. Many more people aged 18 to 34, cited being under the influence of drugs or alcohol as the reason why they did not choose to use a condom, than all other age groups. In addition, those 55 years of age and over frequently chose not use a condom because they thought they were safe (9%) and because they did not want to (28%).

When asked about birth control methods the majority chose “none” (39%), just over one third chose condoms (36%), and less than one in five (16%) chose the birth control pill. Condom use and the use of the birth control pill were highest among the 18 to 34 year olds and lowest among the 35 to 54 year olds. Usage of these contraceptives increased among our Elders. The use of no contraceptives reflects this pattern as one in five 18 to 34 year old chose no contraceptives, over half (57%) of 35 to 54 year olds chose no contraceptives, and just over one third of our Elders chose none (35%). Interestingly, according to the 2002/2003 BC RHS findings illustrated below, our First Nations women are much more likely to use no contraceptives than our First Nations men.

BC RHS FINDINGS 2003/2003: Sexual Activity (Adults)

	Total	Females	Males	18-34 years	35-54 years	55+ years	Coast	North Interior	South Interior	Vancouver Island
Birth control or protection methods used (by self or partner):										
withdrawal	4%	3%	5%	7%	2%	0%	8%	7%	1%	0%
condom	36%	28%	43%	56%	19%	33%	29%	49%	32%	35%
birth control pills	16%	20%	13%	27%	6%	18%	10%	18%	16%	23%
diaphragm	1%	0%	1%	0%	1%	0%	0%	1%	0%	1%
sponges	4%	1%	6%	1%	6%	7%	4%	4%	5%	1%
Depo Provera	8%	11%	6%	13%	3%	13%	10%	9%	8%	4%
foam	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%
rhythm	0%	0%	1%	0%	1%	0%	0%	0%	1%	0%
IUD	2%	2%	2%	2%	3%	0%	0%	2%	4%	2%
none	39%	42%	37%	21%	57%	35%	41%	33%	37%	52%
Hysterectomy/tubal ligation/vasectomy	9%	10%	7%	6%	12%	2%	11%	5%	12%	6%

Half of our First Nations women and almost one third of men (29%) have been tested for HIV in their lifetime.

Our First Nations youth who are sexually active overwhelmingly use condoms (85%) and the birth control pill (26%). Only 8% state that they use no contraceptives at all. Generally speaking, the reasons our youth chose for using birth control methods were to avoid pregnancy and for protection against sexually transmitted infections (STIs). A large majority of our youth choose to use condoms to protect against STIs either always or most of the time (89%). Only 5% choose never to use condoms for this reason, though among our teenage girls this number is 10%.

When our youth was asked their reason for not always using a condom, many stated that it was due to a presence of a steady partner (29%). This number was slightly higher among our teenage boys than teenage girls. Overall, our youth also stated that they did not have a condom at the time (15%), they were under the influence of

drugs or alcohol (13%), and their partner did not have HIV (9%). Our teenage girls were more likely than teenage boys to state that their partner did not want to use a condom (11%), that they did not want to use a condom (8%), that they did not have HIV (2%), they did not think of using one (4%), they thought they were safe (6%), they wanted to get pregnant (2%), they could not afford to buy them (3%) or they were too embarrassed to get condoms (2%). Our teenage boys were more likely than girls to state that they did not have one at the time (19%), and that their partner did not have HIV (10%). Our teenage boys gave the reason that they were under the influence of drugs or alcohol almost three times as much as girls (21%).

PATTERNS OF PREGNANCY OR FATHERING A CHILD

The average number of children that our First Nations adults have given birth to or fathered is 2.4. Among women it is 2.8 and among men it is 2.0. The birth rate appears to be declining when the age-groupings of adults is compared. Our Elders (55+) report giving birth to or fathering an average of 4.7 children; adults between the ages of 34-54 report an average of 2.7 children and young adults between the age of 18-34 report giving birth to or fathering an average of 1.8 children.

Overall, 5% of our youth report that they have had a pregnancy or have been responsible for someone becoming pregnant. Our teenage girls were more likely to report this than our teenage boys. Regionally, 10% of the youth on Vancouver Island have ever been pregnant or made someone pregnant. The majority of our youth have had no children (97%) and 3% have had one. On Vancouver Island, 5% of our youth have had one child and 1% have had two children.

There is a strong linkage between early teen pregnancy and “early school drop out rates, high rates of unemployment, low levels of education, and increased reliance on social assistance”³⁹. In addition, the Aboriginal Roundtable on Sexual and Reproductive Health (1999) recognizes that the early onset of parenthood, which is common in traditional First Nations societies, can contribute to the “breakdown in traditional support structures and values.” Although young families have been a historical reality the lack of traditional familial support structures may be a contributing factor responsible for the poor health and social problems that teenage parents and their families often experience⁴⁰.

Summary

As we observe our physical health, the relationships that we have established and the conditions under which we live, we also look to habits and routines that we have adopted. Collectively our lifestyle choices define who we are and impact on our sense of spiritual health.

In this chapter we have seen that:

- Over half of adults and almost one quarter of youth are smokers.
- 30% of First Nations children were born to mothers who smoked at some point during their pregnancies.
- More than half of First Nations youth and adult smokers have tried to quit at least once during the last year.
- 79% of children live in a smoke free home, however only 50% of youth inhabit a smoke free environment.
- Less than two thirds of adults used alcohol last year, which is much lower than the national average.
- Almost half of First Nations youth reported using alcohol.
- 68% of current adult drinkers report binge drinking once a month
- Almost one in five youth report binge drinking once a week, more than one in five of these youth are female.
- One quarter of First Nations adults and one third of First Nations youth used marijuana last year.
- Almost one in five First Nations adults is receiving treatment for alcohol abuse.
- More than half of First Nations adults' fish and berry pick while more than one third hunt.
- 40% of First Nations adults undertake physical activity for more than 5 hours a week.
- Almost half of our youth spend three hours a day watching television, however 62% spend three hours a day outside.

- More than one third of our youth are physically active for more than 6 hours a week
- 63% of children are physically active every day.
- One third of adults eat fried starch more than once a week, but at least one third eat some form of traditional protein.
- More than half of our youth eat sweets and fried starch more than once a week and they consume traditional foods less frequently.
- More than half of children ages 6 to 11 years of age eat sweets and fried starches, though they consume traditional foods at about the same rate as First Nations adults.
- A large number of First Nations people are overweight and obese. 36% are overweight, 26% are obese, and 6% are morbidly obese.
- Women are three times as likely as men to be morbidly obese.
- 70% of our youth are of an acceptable weight or underweight.
- 52% of our children are overweight or obese. The rate of obesity in children 0 to 5 years of age is 32%.
- 90% of our babies are born at healthy birth weights.
- 77% of our children were breast-fed and this number is increasing among children born in the past five years.
- More than half of First Nations adults do not use condoms and 39% use no birth control at all.
- The majority of youth use condoms.

Context of Findings



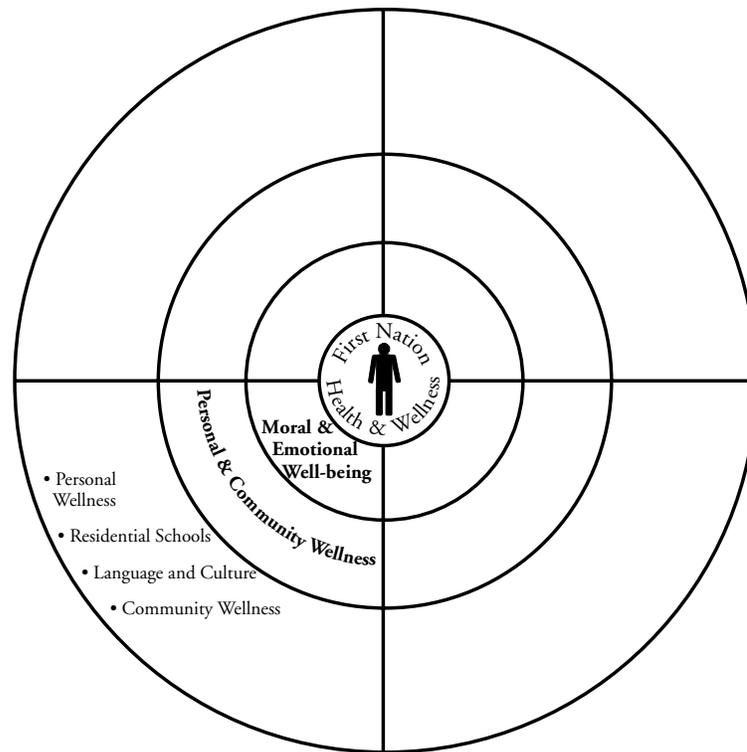
People walked, it kept people alive and a long time ago people were disciplined. People lived miles away from everything and we never saw doctors. Women had their babies at home. There were no doctors or hospitals. The mountains were called our cupboards, that is where we went for all of our needs.
Ethel Billy, Elder

The Eastern direction is related to our spiritual being, and is impacted by our lifestyle choices. As discussed by our Elders at the Cultural Interpretation session, “quality of health in the past was not an issue of survival but was dependant on active lifestyles which included a daily regiment of healthy eating, plenty of exercise, social interaction and exercising the relationship with the land.”

At the Adult, Elders and Youth Cultural Interpretations sessions, nutrition was discussed as an element that is affecting our spirit. Nutrition begins right from birth, as one Adult participant stated, “mental balance starts from mother’s breast,” emphasizing the importance of breastfeeding and our nutrition as “what mother eats, baby eats”. Our Elders are concerned about today’s commercialization of food, and the consumption of fast foods in our communities and the affect on individual long-term health. Youth equate fast food convenience as a solution for busy families. Whereas Adults discussed the lack of traditional teachings for parents on nutritional diets, and discussed how they can incorporate Elder’s teachings into cooking classes. A balanced nutritional diet and physical exercise contribute to good spiritual health. Physical activity is essential, and traditionally our people walked tremendous distances everyday collecting daily necessities. One Elder explained that “walking is a blood cleaner, we have to keep walking.” The Elders agree that there is a definite need for more exercise. Exercise is a part of our culture, traditionally daily activities ensured that we maintained physically fit.

It is important to remember the lessons of our Elders: “our bodies are allergic to sugar, that means we are allergic to alcohol.” It is important for us to realize that alcohol and other substances diminish our health and shorten our lives. Our youth reveal that substance abuse is a reality, and that drug use is on the rise.

CHAPTER 6: MORAL AND EMOTIONAL WELL-BEING



In this section we look at how the data represents some of the most personal aspects of our lives, mainly our moral and emotional well-being and the impacts it has on our personal relationships. In essence, from a First Nations perspective, we are discussing the most basic elements of who we are as a people. Our emotional well-being is often defined and impacted by the relationships we have. We are all members of a family, members of a community and members of a First Nation. We all have rights, duties and responsibilities and a sense of moral right and wrong.

Unfortunately many of the relationships we have are not positive for us and while it is important for most First Nations people to have balanced relationships it is a challenge to achieve and maintain such. Here the report looks at the survey and how our relationships with friends, family, and community, and also relationships with ourselves impact our sense of personal and community well-being.

ADULTS

Being in balance is important for the health of our people. Overall, 93% of adult respondents felt they were in a high (33%) or moderate (60%) degree of balance in the physical, mental, emotional and spiritual aspects of their lives. Despite this finding of balance, 29% of adults have also experienced a time when they felt sad, blue or depressed for two weeks or more in a row. These numbers are highest among women (36%) rather than men (23%). In addition, 45% of adults have experienced instances of racism within the past 12 months. This is higher than the national First Nations average of 37.9%.

First Nations adults' perceptions of supports also impacts mental health. There were unsettling rates of suicidal thoughts and attempts. Overall, 31% of respondents had thought about committing suicide in their lifetimes, slightly more women (34%) than men (29%). Of these, 17% had attempted suicide in their lifetime. In the past year, almost one in five adults had experienced the suicide of a close friend or family member.

There are a variety of emotional and mental health support resources available to people. These range from institutional-based, mainstream methods to informal resources. Overall, more than half of First Nations adults relied on a friend (59%) or an immediate family member (61%) for emotional help. The respondents also relied on other family members for help in large numbers (43%). The reliance upon these emotional networks was much greater among women than men.

The majority of First Nations adults in British Columbia feel they always have someone to show them love and affection. Over half of the respondents feel they will always have someone to take them to the doctor, do something enjoyable with, have a good time with, and someone to count on when they need help. As well, many adults felt they always had someone to listen to them and to confide in. However, there is not a high number of people who are available to give them a break (27%).

More than half of our First Nations adults stated that traditional cultural events (54%) and traditional spirituality (50%) were very important in their lives. Additionally, 26% of the adults surveyed stated that religion was very important.

YOUTH

Similar to our adults, the majority of our youth also report being in a high (37%) or moderate (52%) state of physical, emotional, mental, and spiritual balance. As well, the majority of youth report a high (66%) or moderate (33%) sense of self worth. Few of our youth report feeling lonely quite a bit (9%), feeling unloved (12%), and feeling a lot of stress (13%). Despite this, one in five youth state that they have felt sad, blue or depressed for two weeks or more in a row (21%). As well, one in five youth have contemplated suicide in their lifetimes (20%). Three times as many girls (31%) have thought of committing suicide than boys (11%). One in ten of these youth have attempted suicide in their lifetime (10%), four times as many girls (16%) than boys (4%). Similar to our adults, 18% of our youth have experienced the suicide of a close friend or family member in the past year.

Our youth tend to rely on the informal methods of emotional assistance as well. They rely on: friends (57%), immediate family members (47%) and other family members (35%). There were also quite a few youths who chose to speak to a counselor about their problems (21%). Like their adult counterparts, many more girls than boys take advantage of these emotional resources.

More than half of the youth respondents felt that there was always someone available to show them love and affection (66%), to take them to the doctor (64%), to do something enjoyable with (56%), to count on when they need help (55%), and to listen to them (51%). There were also many youth who felt they had someone who they could always confide in (46%). As in the adult survey, there were a low number of youth who felt someone was always available to give them a break (29%).

When asked whom they would turn to for help when they had problems with their family, boyfriend or girlfriend relationships, finances, friends, anger, drugs and alcohol, and depression, the majority of youth stated they would seek out their friends, parents or guardians, or family members.

CHILDREN

Over the past six months, 95% of the adults or guardians surveyed reported that their children had no difficulties (52%) or very few difficulties (43%) getting along with the rest of the family. 12% of children are reported to have more emotional or behavioural problems than other children of the same age.



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

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

ADULTS

One in four First Nations adults attended residential schools for an average of one year. On average our people usually started school at about nine years old and finished when they were fourteen years old.

Residential School survivors are 40 years of age and older, given the phasing out of the program during the 1970's and early 1980's. Over half of the First Nations adults who attended residential schools said their health and well-being were negatively affected. The most noted effects (40% of respondents or more) are: harsh discipline, verbal or emotional abuse, witnessing abuse, isolation from family, separation from community, physical abuse, loss of language, loss of cultural identity, and loss of traditional religion or spirituality. Respondents who are Residential school survivors also state that their health was affected negatively due to: bullying from other students (34%), harsh living conditions (32%), lack of food (30%), poor education (25%), lack of proper clothing (23%), and sexual abuse (17%). Of the respondents that believed residential school affected their well-being negatively, a large majority felt at least five of the above listed conditions contributed negatively to their overall well-being.

A large majority of our First Nations adults stated that one or more of their parents attended residential school (69%). Over half of these believe that residential schools negatively affected the parenting they received (54%).

Almost half of our First Nations adults stated that one or more of their grandparents attended residential school (48%). 63% of these respondents believe that this had a negative effect on the parenting that their own parents had received when they were children.

In the British Columbia regional survey, we did not have the numbers to make broad associations across the data, relating certain aspects of health and well-being to residential school attendance.

Languages and Cultures

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

The majority (92.2%) of First Nations people, adults, youth and children, use the English language most often. More than 90% of youth (96.7%), adults 18 to 34 years of age (96.1%), and adults 35 to 54 years of age (92%) speak English as their most frequently used language. For adults over 55 years of age, this number is lower (74.8%), yet still quite high.

BC RHS FINDINGS 2002/2003: Language Use

	Language most often used	First Nations language (fluently or relatively well)	
	English %	Understand %	Speak %
Total	92.2	24.7	18.4
0-11 years	.	14.8	9.7
12-17 years	96.7	21.9	17.0
18-34 years	96.1	19.7	13.2
35-54 years	92.0	27.5	20.3
55+ years	74.8	60.7	54.5
Coast	92.1	14.6	9.0
North Interior	90.2	34.9	25.6
South Interior	92.2	26.5	20.7
Vancouver Island	96.1	18.1	14.4

Among all respondents, 24.7% of people could understand a First Nations language and 18.4% could speak it relatively well. The ability to understand and speak one or more First Nations languages was highest in Elders as more than half of them could understand (60.7%) and speak (54.5%). What is also of interest is that the ability to understand and speak a First Nations language is higher among youth than it is among adults 18-34 years of age. This may suggest that recent school-based First Nations language programs are having an impact on the historical trend of language loss.

There are some regional variations as well. 14.6% of the people on the Coast can understand a First Nations language and 9% of them can speak it. On Vancouver Island, 18% of people can understand a First Nations language and 14% of them can speak it. In the Southern Interior, 26.5% of people can understand a First Nations language and 20.75% of them can speak it. Finally, in the Northern Interior, 34.9% of people can understand a First Nations language and 25.6% of them can speak it.

Community Wellness

In this section we look at how our First Nations people of British Columbia rate the progress of their communities as they work towards community wellness. British Columbia Regional Health Survey respondents were asked to respond to a number of cultural related indicators.

RENEWAL OF FIRST NATIONS SPIRITUALITY

One indicator of community wellness is the amount of language used in our communities. 67% of First Nations adults report that there is some progress or good progress being made toward the use of First Nations languages within the communities.

Concerns were expressed about the current status of culture and health. The RHS found that 47% of our adult respondents felt that there was some or good progress being made in the area of renewal of First Nations spirituality. Half of the respondents felt confident in the progress being made toward a renewed relationship with the land. In addition, a majority of respondents felt that there

was progress being made toward the revitalization of traditional ceremonial activity (61%) and cultural awareness in our schools (75%).

REDUCTION IN ALCOHOL AND DRUG ABUSE

Sobriety is an indicator of Community wellness. One-third (34%) of our adults felt that progress was made in reducing the amount of alcohol and drug abuse in their community.

TRADITIONAL APPROACHES TO MEDICINE

Cultural identity plays a key role in the delivery of health care. However, only one in five First Nations adults consulted a traditional healer in the past year. More men (23%) than women (18%) sought traditional healing in the past year. Half of all respondents stated that they had never consulted one, though 41% of adults stated that they use traditional medicines.

There are barriers associate with accessing traditional medicines. A majority said that they could not afford traditional medicines (58%). Some said that they did not know enough about them (31%), while other said they did not know where to get them (22%). However, it was also a concern that traditional medicines were not available through the health centre (15%), that they are not covered by Non-Insured Health Benefits (13%), that it is too far to travel to retrieve them (11%), and some are concerned about the effects (6%).

Almost half (49%) of the First Nations respondents of British Columbia feel that there is some or good progress being made toward traditional approaches to healing in their communities. In addition, more than half of our adults believe that progress is being made in the areas of availability of First Nations health professionals (52%) and First Nations control over health services (57%).

HOUSING ADEQUACY

Overcrowding on-reserve is a much greater problem than for the Canadian population overall and is getting worse. The 2001 Census indicates that, nationally, there are 2.6 persons per household and 2.5 persons per household in British Columbia. The RHS figure is much larger at 4.2 persons per household and for First Nations in British Columbia the number is almost double the

provincial average at 4.8 persons per household. This is highest in Vancouver Island, where the residents' average 5.5 occupants per household and over one-quarter live in overcrowded conditions. On average, one in five First Nations adults in British Columbia live in overcrowded conditions. In 1991, the estimate for First Nations was 3.5 persons per household compared with 2.7 for Canadians overall according to the Census. While crowding is declining in Canada, it is increasing rapidly in First Nations communities.

Almost one third (30%) live in homes that require major repairs, particularly on the Coast (38%). This figure stands in comparison with the general population of British Columbia of whom only 9% had homes that required major repair. As well, more than a third lived in homes with mold or mildew over the past year (38%), particularly on the Coast (46%).

Basic fire safety equipment and sanitary services are far from universally present. Most homes (77%) have a working smoke detector, only slightly over half (55%) had a fire extinguisher, and only 12% had a carbon monoxide detector. Garbage collection occurs at 86% of the First Nations households. 95% of adults surveyed have a septic tank or a sewer system and 82% have piped-in water from a community system. However, only 73% of our adults consider their home water supply safe for drinking and one in ten drinks boiled tap water. In the Northern Interior, only 63% of adults surveyed considered their drinking water to be safe and almost one in 5 adults (17%) drank boiled tap water.

In the 21st century, access to modern communication and other basic amenities were much worse than for the general population of the province. Though 43% of households have a computer and 30% have an internet connection, 18% of households remain without a phone. In comparison, according to the Statistics Canada 2003 Survey of Household Spending, 95% of British Columbia households had a working telephone, 73% had a computer and 63% had an internet connection.

Given these statistics, it is important that our people feel that our communities are working toward improving these conditions. Over half of our First Nations adults (57%) feel that there is some progress or good progress being made on the

housing quality issue. On the Coast, however, only 44% of adults believe that there is progress on this matter. 65% of First Nations adults see some or good progress being made in regards to water and sewage facilities.

RECREATION AND LEISURE FACILITIES

Traditionally, our people have always placed importance on sport and recreation. More than half of First Nation adults (55%) reported that some or good progress has been made in terms of improving recreation, leisure, and sports activities in their community.

Summary

First Nations people place tremendous emphasis on their connections with the earth, their communities and their Nation. In order to fully appreciate how we define and think about our health and spiritual well-being we must look at all of these factors and how they impact us. This section spoke to the following areas:

- A majority of First Nations people feel in balance physically, emotionally, mentally and spiritually.
- One third of First Nations adults report having suicidal thoughts in their life time. Of these, one in five has attempted suicide.
- Almost half of First Nations adults has experienced racism in the past year.
- A high majority of all First Nations respondents relies on informal emotional and mental health supports.
- A majority of First Nations youth feel in balance physically, emotionally, mentally, and spiritually.
- One in five First Nations youth reported having suicidal thoughts in their lifetime, one third of which were girls. Of these, one in ten youth have attempted suicide.
- The majority of our First Nations people feel supported by the people around them.
- 69% of First Nations adults have one or more parents who attended Residential School. More than half of these respondents state that it has negatively affected the parenting they received.
- Only one quarter of all First Nations people understand a First Nations language and less than one in five speak a First Nations language well.
- Language comprehension and use is increasing among our youth.
- More than half of First Nations adults believe traditional cultural activities and traditional spirituality are important.

Context of Findings



We need to teach children how to be healthy in mind, body and spirit and to look after mother earth as in return she will look after us. The spirit is the whole base of our life. Take care of our spirit and teach our children how to respect that.

Sarah Modeste, Elder

Moral and emotional well-being are connected with the Southern direction. In the past, according to the Elders Cultural Interpretation session, “there was no such thing as depression,” our lifestyles then kept us busy. We must learn from this. The Elders identified that loss of identity was impacting our social health, and emphasized a need for adults and youth to be re-connected with their spiritual history. In addition, the residential school legacy has impacted our moral and emotional well-being. The impact of residential schools has deteriorated the use of our languages, which are our connection to the past. At the Adult Cultural Interpretation session participants claimed “we need to overcome our fear and insecurity in using our own language.” Language is the essence of our culture and identity. We need to rejuvenate the use of our language to improve our emotional well-being.

One of the major lessons learned from the Elders Cultural Interpretation Session was that morality was a key to health, and that one of the most important aspects of morality is forgiveness for without forgiveness there is no healing. One Elder stated, “forgiveness needs to be a part of health. How can you be well when you are holding on to bitterness and anger? Forgiveness is a virtue”.

At the Elders Cultural Interpretation sessions, the Elders spoke of raising awareness of the “old teachings that demonstrates the essence of life is in the quality of how we live and what we do.” The Adults emphasized that “teachings need to be incorporated into our health.”

CHAPTER 7: RETURNING TO THE CENTRE – LOOKING TO THE FUTURE

As we return to the centre, having examined the past data collected, we now look toward the future and the next steps in the RHS process.

The initial phase of the RHS, while being very comprehensive, serves as our benchmark or baseline. In addition, the RHS will provide measures over time as the research will be repeated over the course of several years. This allows us to examine the data to see if change occurs and to see, for instance, if policy and programming changes can be deemed effective or not. The RHS survey will be conducted four times over 12 years, as follows: Survey 1-2002/2003; Survey 2-2006; Survey 3 – 2010, and Survey 4 – 2014.

Over the course of a 12-year period First Nations Peoples of British Columbia will have the opportunity to compare the benchmark or baseline health status results from this first survey to others scheduled to take place.

The next data collection stage will be in 2006 and before then we will reflect on the current process engaged in. We will re-examine our vision and purpose and fine-tune our methods for data collection and the research process. We will consult with communities for their input and direction.

The current First Nations interpretive framework will be used and improved upon with each successive data gathering cycle. The researchers are committed to the development and evolution of a truly First Nations research framework that allows us to collect and analyze data in a distinctly First Nations fashion while maintaining and ensuring scientific rigor.

Best Practices

The RHS process has also served to highlight some promising practices that First Nations have put in place to support the health and well-being of their community members. In this section of the report, the First Nations Chiefs' Health Committee wishes to highlight a few examples they discovered in the course of their work.

COMMUNITY HEALTH PROGRAM FOR TOBACCO PLAINS INDIAN BAND

The community health advocate shared how they started a community garden two years ago and they are heading into their third season. They have slowly been getting community members – both young and old – involved in the project. The garden started out small but has now grown to three times the original size. Last year when they harvested the food, they made up boxes for each household on reserve. This included potatoes, onions, carrots, tomatoes, beets, lettuce, Swiss chard, spinach, peppers, cabbage, and beans. Unfortunately their corn never ripened. They also held a day where they made borscht with everything out of the garden and held a community lunch. Entering into the new season, they find that the community is starting to bring vegetables to plant and get involved in the program.

The community health program holds a Nutrition Kitchen at the end of every month. This is a healthy lunch. The recipe is handed out so people can make it at home. This is usually very well attended. They also hold a Step/Pedometer Challenge whereby participants are given a record sheet called My Own Sweet Time. It records their daily steps for eight weeks. To date there are 50 people on this small reserve and area taking part. They have weekly prize draws to keep the incentive going and conclude with a wind up dinner to see who walked the most.

WESTBANK FIRST NATION FAMILY SUPPORT HOUSE

One of the goals of the WFN Health Program is to empower families and encourage the growth of their capacity as members of the community. Building a sense of community and ownership of programs is something they continue to strive for.

Many of their young people starting families are without a strong support network. To help people meet each other, Baby Circle was started for parents of children one year and younger. They started by meeting once a week in a very informal setting. The community nurse made lunch and led a time of conversation and support. Sometimes they watched videos or learned about particular areas of interest. Mostly they talked and laughed and ate. As time went on and the babies became toddlers they still wanted to meet so we they added Toddler Time to their schedule.

They have moved into a larger facility – a two-bedroom duplex – and have an Elder in the role as house grandmother to the families. Since they have been meeting at Family Support House they have had presentations on interesting subjects, lots of conversation, time to play with the babies and toddlers, and have recently started a Walking Club called the Bannock Bellies. Parents have also contributed to cooking, cleaning and stocking the house. They have a few rules: no smoking or drinking, nutritious fresh food is served, everyone is welcome, everyone is respected and everyone has a contribution to make. It gives participants a chance to know each other, share their stories and skills, learn from each other and support each other in difficult times. It is an effective step in building a healthy community.

HEALTH INNOVATIONS IN THE FORT NELSON FIRST NATION COMMUNITY

The Fort Nelson First Nation (FNFN) is located in northeastern British Columbia, eight kilometers south of the town of Fort Nelson, and is home to more than 460 on-reserve residents. They are developing our own Environmental Health Department. With funding from the First Nations and Inuit Health Branch of Health Canada the FNFN started an air quality study, collecting air samples, monitoring industry emissions and open-burning in our area, and documenting our concerns by visiting sites, investigating the concerns, and taking photographs whenever possible.

Their air monitoring equipment runs every third-day for a 24-hour period. Also, in 2004 they undertook the responsibility of community drinking water testing, to ensure safe, clean water for their residents. They promote awareness of environmental health issues such as open-burning, West Nile Virus, indoor air

quality, and events like International Earth Day, and community clean-up. Together with their Community Health Department they promote smoke-free homes and lifestyles, and teach about the effects of Environmental Tobacco Smoke.

They are helping their community to think about their health, the health of their Mother Earth, and how they can build toward stronger, healthier futures for both.

NEW AIYANSH COMMUNITY TRIBAL SMOKEHOUSES



This is a cultural initiative located in the capital of the Nisga'a Nation. The main objective of this initiative is to promote healthy Nisga'a togetherness through cultural foods' preparation. The first smokehouse was completed in 2000 for the Frog tribe with the Wolf, Eagle and Killerwhale completed in 2001. The smokehouses are used for the preparation of all current seasonal Nisga'a foods such as the ooligans, tibun, spring salmon, and sockeye, preserving either by smoking, sun

drying, salting, freezing and jarring. The program is designed to alleviate undue hardships on those families without the resources to prepare all Nisga'a Foods. Youth participation is encouraged to learn how to prepare traditional foods with the assistance of Elders. The program also assists with community distribution to all low-income families, all community Elders for their Winter Food Supply and the Meals On Wheels Breakfast & Lunch Programs.

HELPFUL DOCUMENTS

For those readers that would like to follow up with best practices found in the literature, the technical review committee suggests exploring the following documents:

Two references for alcohol and drug best practices:

Loxley, W., Toumbourou, J., Stockwell, T.R., Haines, B., Scott, K., Godfrey, C., Waters E. and Patton, G. The prevention of substance use, risk and harm in Australia: A review of the evidence. Australian Government Department of Health and Ageing: Canberra. (downloadable from carbc website or www.ndri.curtin.edu.au)

Stockwell, T., P. Gruenewald, J. Toumbourou, and W. Loxley, (Eds.) Preventing harmful substance use: The evidence base for policy and practice. John Wiley & Sons. Order online: www.wileyurope.com Or email: cs-books@wiley.co.uk

Two good tobacco control best practices references:

Fiore MC, Bailey WC, Cohen SJ, Dorfman SF, Gritz ER, Heyman RB, Holbrook J, Jacn CR, Kottke TE, Lando HA, Mecklenbur R, Mullen PD, Nett LM, Robinson L, Stitzer M, Tommasello AC, Villejo I, Wesers ME. Treating tobacco use and dependence. Clinical practice guidelines. Rockville, MD: U.S. Department of Health and Human Services - Public Health Service 2000.

Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs-August 1999. Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999.

Youth Role Models

The First Nations Chiefs' Health Committee (CHC) wants to celebrate the importance of our Youth as our future leaders. To this end, the CHC wants to share the stories of two youth role models.

SUZANNE IDLE - GITXSAN NATION

Suzanne Idle is very proud of her Gitksan Nation ancestry. She has chosen to pursue a career in nutrition, as she feels it is a very important way that we can maintain our health. Suzanne completed a Bachelor of Science Degree majoring in dietetics at the University of British Columbia and went on to finish a dietetic internship program with the Yukon First Nations Comprehensive Internship Program in Whitehorse, Yukon. She was then able to become a registered dietitian and obtained employment as a casual dietitian at a hospital in Vancouver BC. This work experience in a variety of programs and inpatient units has provided her with the opportunity to learn a great deal in many different areas. In the future, she hopes to work towards a master's degree in population health so she can work in the community promoting healthy lifestyles and disease prevention. In her spare time, Suzanne loves to keep active and always be learning.



BEN MATTHEW – SIMPCW FIRST NATION

Ben Matthew is a proud Secwepemc youth. His home is the Simpcw First Nation community of Chu Chua, located north of Kamloops, B.C. He graduated from high school in 2001, at Barriere Secondary School, with honors standing. Ben then proceeded to Thompson Rivers University in Kamloops, B.C., where he completed a Bachelor of Science (Biology) in Spring 2005. Throughout these years Ben feels that he has benefited from and enjoyed an excellent education, provided by his teachers and professors.



Ben is now going into his first year of studies at the University of British Columbia Faculty of Medicine, Class of 2009. He is in the Northern Medical Program, which focuses on the health needs of rural communities in British Columbia. He looks forward to the rewards and challenges that will be up-coming with these studies. Ben has chosen a career as a physician because it will allow him to fill a role as someone who can make a difference in the lives of others, and at the same time challenge himself in a dynamic and diverse field.

Personally, Ben enjoys a variety of different activities such as participating in sports (golf, basketball, volleyball, and running), music, reading, cooking, hunting/fishing, and simply spending time with friends and family. He is grateful for the support and encouragement that he has received, and continues to receive, from his parents, his relatives and friends, and his community.

Summary

This report summarizes the findings of the B.C. Regional Health Survey 2002/2003. The survey was carried out by First Nations people and focused on the impact of health services and initiatives delivered to the First Nations community. Our Elders and community members added further context to the findings by discussing the results and adding cultural and community context to the findings. More detailed information on the findings from the RHS can be found in the technical report prepared by Dr Andrew Jin at www.fnchc.ca

ACKNOWLEDGEMENTS CONTINUED

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Matthew Louie	Youth Interpretation Session
Ginger Gosnell	Youth Interpretation Session
Marilyn Ota	Adult Interpretation Session
² Anne Cochran	Adult Interpretation Session

Elders: (Participants in Elders Health Session)				
³ Sarah Modeste	Dr. Mary Louie	Ethel Billy	Jimmy Williams	Charlotte Williams

Adult Interpretation Sessions		
Shirley Anderson	Marge Leidegarote	Fred Roland
Marilyn Camille	Earl Joe	Troy Patenaude
Joyce Cooper	Tania Moore	Linda N. George
Chief Doris Baptiste	Shawna Campbell	Frank George
Johnny D. Billy	Lorna Prette	Derryl Baker
H. Annette Jensen	Y. John	D. Nadine Charles
Martha Matthew	Peter John	Maryann Harril
Fay Michell	Lila Peters	Alfreda Page
Mike Hanson	Sadie McPhee	Christina Brazzoni
Michael Crawford	Kim Brooks	Illa Setah
Coyote Gottfriedson	Maggie Aronoff	Mary McCullough
Marion Lee	Dora Wilson	Lucy Dick
Jennifer Bobb	Charlotte Williams	Barb Mack
Dolores O'Donaghey	Eydie Pelkey	Mary McMilan
Brian Muth	Rebecca Campell Rice	E. Johnson
Phil Hall	Terry Sampson	Ken Johnson
Clarissa Mitchell	Patricia B. North	Arthur Dick
Judith Staples	Ben Clappis	Ron Johnson
Michelle Julian	Doreen Peter	Elizabeth (Lisa) Daniels
4 Brian Williams	Maureen Tommy	

Youth Interpretation Session		
Todd Alec	Joey Wesley	Leona Andrews
5 Gerren Henry	Emily Williams	Melody Andrews

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