



# First Nations Regional Health Survey (RHS)

2008/10



## Alberta Report 2012

Deborah Pace, Ph.D. &  
Anita E. Konczi, B.Sc.(Hons), M.A.



The Alberta First Nations  
Information Governance Centre

### Regional Advisory Committee:

Cora Voyageur, PhD

Diana Steinhauer, PhD

### Edited by:

Mary Collins

Amelia Crowshoe, BCC

Bonnie Healy, RN

Anita E. Konczi, B.Sc. (Hons), M.A.

Connie LeGrande, B.A. (Native Studies)

Melanie Parsons, BC (Applied) Public Relations

### Design and Artwork by:

Michal Waissmann

### Photography by:

Nadya Kwandibens

Melanie Parsons, BC (Applied) Public Relations

Blaire Russell



The Alberta First Nations  
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3848 Individuals  
22 Communities

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Empowering the community voice for change

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Okí  
Tánsí  
Ábá wáthtech  
Dánít'ada  
Dánít'eh



Oki,

It is important that our people are included in research projects like the Regional Health Survey (RHS), and that our overall well-being is considered throughout the process. From the beginning to the end of any research project, our people must be consulted in a meaningful and ethical way. It is important to incorporate traditional First Nations methods and processes of information-sharing that align with our traditional oral history.



**ELDER REG CROWSHOE**

In order to better serve the health needs of First Nations in Alberta, the need for accurate information is key. We cannot shy away from research due to poor experiences in the past. First Nations must enforce our right to be consulted before taking part in any project and ensure that we are entering into a mutually beneficial relationship. The Alberta First Nations Information Governance Centre (AFNIGC) has been working hard to engage more respectfully with First Nation communities by considering the way in which partnerships are formed within each community, Chief and Council Chambers, Elders, and most importantly, those members sharing their stories.

Our people continue to operate within the dominant Western paradigm while seeing life through a First Nations lens. Western society focuses heavily on written practices, relying on validation of information and knowledge through paper such as licenses, permits, and certificates. First Nations, however, continue to value traditional oral systems, which validate information between generations through stories, songs, and language protocols.

The RHS collects information that is a true reflection of the people living in our communities because it is self-reported and collected voluntarily. It is important that all research done in our communities recognizes the vital role culture plays in our daily lives and ways of sharing information. The AFNIGC sees that the inclusion and support of traditional knowledge keepers, such as Elders, is of the utmost importance. By working with Elders in our communities, the AFNIGC is trying to create an ethical space that is respectful and validated by those keepers. When working with First Nations it is crucial that program development, services offered, and information-gathering processes are culturally literate and align with our traditional oral history.

In order to approach communities in an ethical manner and to create that ethical space for Elders to provide cultural content, workable parallels that facilitate both the traditional practices of First Nations People and the Western system in which our society operates must be in place. Working together to promote enhanced systems of health in our community is reliant on inclusion of protocols that enhance the quality of information needed to support effective and superior health services among First Nations.

A handwritten signature in black ink, likely belonging to Elder Reg Crowshoe.



**CHIEF CHARLES  
WEASELHEAD**

Oki,

I am very honoured to introduce results of the First Nations Regional Health Survey (RHS) Alberta Report 2012 for adults, youth and children living on reserve in Alberta. The RHS is a process that promotes the exercise of First Nations jurisdiction and governance over our data, information and traditional knowledge; this is fundamental to the First Nations Principles of OCAP™ (Ownership, Control, Access, and Possession).

Thank you to all the elders, families, communities, and the many individuals who have the leadership, vision and commitment to move this important work forward with honour and respect for the health and well-being of our people.

Despite many health improvements in Canada, First Nations people are more likely to live in poverty and suffer from higher incidences of various illnesses than non-First Nations. Access to health services for First Nations is an overwhelming challenge and there is an urgent need for primary health care and public health reform to replace the current system of treatment and crisis management.

As data drives policy, the RHS's broad process helps to understand the unique determinants of health and issues related to First Nations care. Such research – conducted ethically under OCAP™ principles – provides an opportunity for Alberta First Nations and other interested groups to get an important updated insight into how our communities feel about their wellness, while exploring underlying factors that relate to the Social Determinants of Health.

The Alberta First Nations Information Governance Centre (AFNIGC) has been working hard – in conjunction with the First Nations Information Governance Centre (FNIGC) - to implement OCAP™ principles towards: rebuilding community trust in research; more democratic (participatory) methods for higher participation rates; promotion of First Nations analyses and perspectives that minimize biases and misinterpretations; contributions to community empowerment, self-determination, and encouragement of meaningful capacity development; and production of more relevant and useful health data results, which can lead to transformational change and promote ethical research practices.



The AFNIGC is committed to helping First Nations improve how research is conducted in First Nations communities in Alberta. The importance of defining health indicators and measuring progress on First Nation individual, family, and community health and well-being enables service providers and leadership the ability to develop and negotiate improved health care programs and services.

The study and analyses of the 34 health and wellness indicators of the RHS process reflect the overall well-being in First Nations communities. These indicators are not confined to only measuring illness, access and disability rates, but can also measure positive outcomes such as culture and language at the community level, education levels, and sport/recreation participation levels.

The information in this report is necessary for understanding how interventions can be best designed and delivered to reduce the enormous health disparities experienced by First Nations people. The results will support the planning, policy and strategic efforts of many organizations in moving forward to breathe life into our vision for healthy, self-determining First Nations children, families and communities.

I would like to thank the AFNIGC for their hard work and vital contributions to the promotion and protection of First Nations research, in particular in their capacity as data providers.

I wish to thank each and every First Nation who participated in the RHS process, the communities, the RHS Coordinators and to the National FNIGC for its continued guidance and support. Please accept my gratitude. I am deeply honoured for this opportunity and encourage leadership and communities to continue working together in the spirit of collaboration and partnership...to good health. Thank you.

Respectfully,



Treaty 7 Grand Chief Charles WeaselHead (Blood Tribe)  
Former member of FNIGC Board of Directors

**GREGG SMITH**

**Oki,**

Welcome to the First Nations Regional Health Survey's (RHS) Phase II Report. As Chair of the Alberta First Nations Information Governance Centre (AFNIGC), it gives me great pleasure to introduce this report to share important information; inspire implementation of ideas; help First Nations communities make informed decisions and to evoke change in policy, cultural safety, and socio-economic conditions. In short, using data as a tool for change to improve the health and well being of our People and Communities.

It is said that our people are “studied to death” and that there is a lot of confusion with all the organizations out there proclaiming to address First Nations Health Information and Research. When a comparison between our communities and non-First Nations’ is made, First Nations still have an extreme disadvantage. That is why we have to strive for real change, not just improving the status quo when it comes to improving the health and well being of First Nations Peoples.

My hope is that the results will be used to advocate for better access to programs, services, and treatments. Using this data, gaps in health and wellness can be identified and we can begin to make sense of our data while exercising jurisdiction over our information through the principles of OCAP™ (Ownership, Control, Access, and Possession).

Ownership, Control, Access, and Possession of Our Data, Our Information, and Our Traditional Knowledge is critical to evoking change and raising awareness and understanding of who we are and how we move forward. Using data as a tool for change can allow positive shifts in public opinion and can facilitate effective national conversations about First Nations health issues.

Establishing trust and respect is vital to any solution. First Nations have had varied and disappointing engagement with governments and it is critical that we be engaged as equals in a transparent and decision-making capacity. The work completed by the AFNIGC is an excellent example of building trust and using data as a tool for change. The development of the AFNIGC was necessary for First Nations in Alberta to continue to support the exercise of First Nations jurisdiction over information. This way we can obtain and use culturally valid First Nations data to make informed decisions about the health, social wellness, and impacts in our First Nation communities. Possessing culturally valid, credible information facilitates responsible, effective communications and information-sharing with federal, provincial and territorial governments and agencies.



I want to thank the AFNIGC Board, Chiefs Senate, and Staff for the important work they are doing to ensure that nothing is done without us. We must also seek to negotiate and develop cultural interpretation and ethical research practices; looking at a process for developing ethical engagement where the process or practice of First Nations principles of OCAP™ can be developed by the AFNIGC, respecting the role of the National FNIGC and regional processes...breathing life into OCAP™.

I would encourage Alberta First Nations Leadership to assist with interpreting the results and developing plans to improve health care access in the province. Let's use this data to advocate for changes to healthcare provisions and better access to treatments. The main problem with chronic health conditions in our First Nations communities is related to access to care and treatment. The non-insured health benefits program provided by the First Nations & Inuit Health Branch (FNIHB) also has limited approval and access rules are more restrictive, compared to non-First Nations. This results in First Nations patients not having the same opportunity to experience optimal treatments and outcomes. The goal of this RHS research is to advocate for change, including equal access to medications and equitable outcomes.

Thank you,

A handwritten signature in black ink, appearing to read 'Gregg Smith', with a stylized, cursive script.

Gregg Smith, AFNIGC Chair



**DEBORAH PACE, Ph.D.**

**Oki,**

It has been a long-time vision to actually witness and be a part of history in the making with the creation and development of First Nations research by the people for the people! I am very honoured to have been appointed by our Grand Chief, Charles Weaselhead, to sit on the Alberta First Nations Information Governance Board of Directors (AFNIGC). The process was, from inception of the research itself and throughout its journey, carefully and diligently led by Bonnie Healy and a wonderful team of First Nations researchers. I thank this team for their tenacity and hard work in blazing new paths for future First Nations research. They did a tireless task, from designing and collecting the data to developing the end product. Bonnie was always ten steps ahead and never lost sight of the end goal. We cannot thank you enough for the work you and your team carried out!

I especially thank Gregg Smith, AFNIGC Board Chairman, for his leadership role on the AFNIGC Board and for guiding us safely through murky waters. I have learned so much from Mr. Smith and it was an honour to work with a political icon. I thank the AFNIGC Board members for the support, great wisdom, and insight they shared throughout our meetings. There are many great people from Treaty No. 6, Treaty No. 7, Treaty No. 8 - too numerous to name individually - who contributed to the success of the Regional Health Survey (RHS) research in Alberta. Finally, I would like to thank my family and friends who continue to offer their support and encouragement.

The RHS research will serve to improve the lives of the First Nation communities in Alberta and for the children who have not yet arrived. With the confidence and ability that we all have, we will be able to see our communities flourish and thrive in the near future. From our ancestral teachings we have learned that we are strong and wise when we work together to achieve common good. This is an example of what we are capable of achieving! As we continue to strive to reach our potential, we will develop healthy families and healthy communities for our children. They will have hope in the knowledge that scientific research, through our cultural ways, benefits and teaches us that we will all have the opportunity to tell our stories which, in turn, will effect change and empower every individual.

Finally, I would like to encourage you to take part in research. I always pay tribute to my first research mentors, Dr. Roland Chrisjohn and Dr. Shelagh Towson, who have shown me the value of research. My first research dissertation was like baking a soufflé for the first time! I look forward to seeing new and upcoming researchers from the community and post-secondary institutions take an active part in research. We need you.

Thank you!

**LORRAINE MUSKWA**

## Tansi,

On behalf of Bigstone Health Commission, I would like to acknowledge the Alberta First Nations Information Governance Centre for coordinating the Regional Health Survey in Alberta. The data that we have received, through an agreement with Bigstone Cree Nation Chief and Council, has been a great source of information for the community and our program managers. We see this information as a vital element for planning and decision-making processes.

The Alberta First Nations Information Governance Centre has been very helpful throughout the survey process. Our relationship with the Centre's staff has been a positive one. They have been helpful in explaining the Regional Health Survey process. The Centre's Regional Health Survey Coordinator and Statistical Analyst presented us with Bigstone Cree Nation's data at our office, which was extremely helpful as they took their time to review the data and explain the tables and how the information can be useful to us. The ability to train our staff and to have them understand the importance of the data and methods of collecting data was a great way to increase capacity within our community.

We believe it is crucial that communities are aware of the Alberta First Nations Information Governance Centre's work and welcome their field workers. By participating in training and completing our surveys correctly, we can expect to see improved data sets, which are beneficial in short and long-term community planning. We assure that we will continue to be supportive in promoting the Centre's surveys in providing Bigstone Cree Nation with comparative data and a way to measure the community's progress.

We will continue building our positive relationship with the Alberta First Nations Information Governance Centre and ensuring the participation of Bigstone Cree Nation in future research.

A handwritten signature in black ink, appearing to read 'L. Muskwa'.

Lorraine Muskwa,  
COO, Bigstone Health Commission





**TINA YELLOWDIRT  
&  
ELAINE CHALIFOUX**

## Tansi,

As members of Treaty No. 6 and Treaty No. 8, we believe in being a part of something that has the ability to help First Nations build healthier communities and improve the lives of its members.

Our involvement with the Alberta First Nations Information Governance Centre (AFNIGC) and the Regional Health Survey (RHS) has been an amazing learning experience! We were given the opportunity to visit communities in the Treaty areas of Alberta and meeting with community members was highly rewarding despite being challenging at times.

Prior to interviewing members, AFNIGC acquired permission through a respectful agreement with Chief and Council. The community was made aware of the RHS with the help of Administration and Health staff who greatly assisted in the collection of data. We worked together to produce posters, pamphlets and other materials to advertise RHS. These were handed out at events in an effort to notify and inform members.

While most communities were welcoming of the RHS and field workers, some were apprehensive in agreeing to participate in yet another survey. Questions as to how their names were chosen, where does the information go, how is it going to be used, and who has access to the information were some of their concerns. We did our best to prepare our field workers to answer these questions. It was also helpful sharing the important fact that the RHS is a survey created for First Nations by First Nations and respects the privacy rights of communities and their members.

The information shared in this report is valuable to First Nations and we thank our dedicated fieldworkers and RHS Coordinators for their hard work in collecting the information in the pages that follow.

Elaine Chalifoux & Tina Yellowdirt

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke extending to the right.

# Chapter 01:

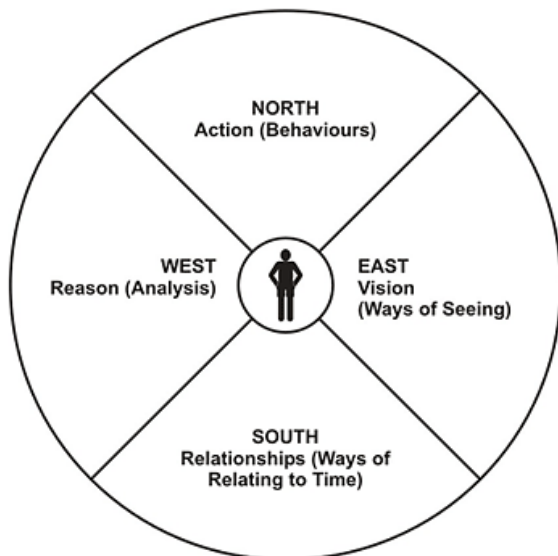
## INTRODUCTION

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The First Nations Regional Health Survey (RHS) is a First Nations initiative, led by First Nations. The purpose of the RHS is to support First Nations research capacity and control, and provide scientifically and culturally validated information to support decision-making, planning, programming and advocacy with the ultimate goal of improving First Nations health. It is based on a Cultural Framework, which was developed for the First Nations Information Governance Committee (now the First Nations Information Governance Centre or FNIGC) in 2002 for RHS Phase 1. This model “encompasses the total health of the total person within the total environment” (FNIGC, 2012).

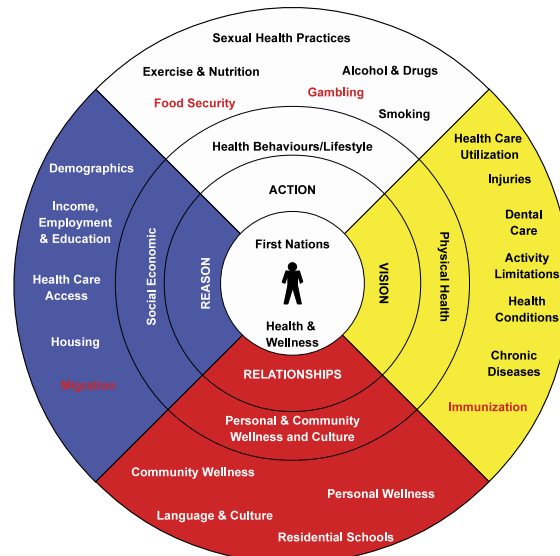
The RHS Phase 2 was initiated in 2008 and completed in the fall of 2010 (FNIGC, 2009). The information contained in this document is a breakdown of data for the participating communities in the Alberta region. While the RHS is best interpreted on a large-sample, national level, the information has been broken down to the regional level in all participating regions.

## 1.2 RHS CULTURAL FRAMEWORK



The goal of the RHS Cultural Framework is to assist in achieving a culturally informed interpretation process that can be presented back to communities in a way that is usable and that reinforces their ways of seeing, relating, knowing and being. A cultural framework will assist in providing a more accurate interpretation of the information shared by First Nations children, youth and adults. Simply stated, the RHS Cultural Framework encompasses the total health of the total person within the total environment (FNIGC, 2012)

The First Nations Information Governance Centre (FNIGC) commissioned the development of the RHS Cultural Framework for the RHS 2002/2003 to assist in making sure the RHS was a culturally-relevant study that would satisfy the need for scientific research while maintaining a First Nations Worldview. There is an “underlying science behind the cultural framework” ... that “has been handed down through generations of First Nations people as a cumulated body of knowledge and beliefs.” (FNIGC, 2012). A complete treatise on the cultural framework can be found in the FNIGC National Report, “First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities.” on pages 3 through 11, although we will make an effort to summarize this important tool for you here.



The cultural framework consists of four major sections, each related to a cultural paradigm based on First Nations’ connection with the natural world.

Various Western concepts can be linked to this paradigm through an Indigenous Knowledge perspective and each section of the RHS data belongs in one of the four sections, which are: Vision, Relationships, Reason and Action.

The following summaries are taken directly from FNIGC, 2012 as the explanations stand on their own merits.

### 1.2.1 **VISION (WAYS OF SEEING) – PHYSICAL HEALTH**

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

### 1.2.2 **RELATIONSHIPS (TIME/ WAYS OF RELATING) – PERSONAL AND COMMUNITY WELLNESS AND CULTURE**

Refers to the experiences that one encounters as a result of relationships built over time and examines how we relate to people. It provides an opportunity to gain an understanding of the attitudes and awareness that exist at this particular point of time, regarding the individual, community and national wellness issues.

### 1.2.3 **REASON (ANALYSIS/ REASON) – SOCIAL ECONOMIC**

Also referred to as learned knowledge, reason is where one becomes reflective, meditative and self-evaluative. It is in this direction, that the broader determinants of health are examined.

### 1.2.4 **ACTION (BEHAVIOURS) – HEALTH BEHAVIOURS & LIFESTYLES**

Also referred to as movement and represents strength, action explores what has been done about previously identified barriers and how to nurture us as First Nations. This component is important in that it activates positive change to improve the program so that it better achieves the vision (expectations) of First Nations resulting in the healthy development of their children, families and communities.

## 1.3 FIRST NATIONS PRINCIPLES OF OCAP™

The RHS infrastructure and system for information governance is based on the First Nations principles of Ownership, Control, Access and Possession or OCAP™ for short (FNIGC, 2012).

Ownership, Control, Access, and Possession (OCAP™) are principles that were developed by the FNIGC (formerly the First Nations Information Governance Committee) as an expression of self-determination in research. OCAP™ principles are continually being developed and used by First Nations to rebuild trust, improve research quality and relevance, foster capacity development within First Nation communities, and promote positive change.

### 1.3.1 OWNERSHIP:

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

### 1.3.2 CONTROL:

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

### 1.3.3 ACCESS:

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

### 1.3.4 POSSESSION:

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



You can learn more about the principles of OCAP™ by visiting our website at: [afnigc.ca](http://afnigc.ca) or the national (FNIGC) website at: [fnigc.ca](http://fnigc.ca)



# Chapter 02:

## METHODOLOGY

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RHS Phase 2 (2008/10) included three self-reported surveys specifically designed for adults (ages 18 and over); youth (ages 12-17 years); and child (age 0-11 years, completed by primary care giver). A customized Computer Assisted Personal Interviewing (CAPI) package was developed. Adults were either interviewed directly or used the computer to complete the survey themselves; children were interviewed via their primary caregiver. Youth completed the survey themselves although interviewers remained on hand to assist with any queries about the questions in the survey.

In addition to this there was a household survey piloted at one of the larger communities.

Copies of the surveys are available on the FNIGC website ([fnigc.ca](http://fnigc.ca)) in the downloads section under: RHS Phase 2 (2008/2010) – Core Questionnaires. Details about the RHS methodology are contained in the national report.

## 2.1 BASIC METHODOLOGY

The RHS Phase 2 built on strengths and lessons learned from the Pilot Phase and Phase 1. The Phase 1 questionnaires were reviewed and revised and new themes were added. The target sample for Phase 2 was 30,000 First Nations individuals in 250 First Nations communities in the 10 participating regions across Canada. Overall, 72.5% of the target was achieved, and 21,757 surveys were completed in 216 First Nations communities. Preliminary analysis of the national data was published in 2011 (The First Nations Information Governance Centre, 2011).

Our portion of the survey had a target sample of 3848 First Nations individuals in 22 communities. A list of alternate communities was also provided in case a community did not wish to participate. A total of 21 communities (some of which were on our list of alternates) participated. Of these, 16 had a large enough response rate to be included in the final analysis. We achieved a total of 1418 surveys from the 16 communities which are listed in Appendix I.

This report is commissioned by the Alberta Region partner of the First Nations Information Governance Centre; The Alberta First Nations Information Governance Centre (AFNIGC). It is based on the RHS data that was collected in Alberta.

The analysis was done using IBM SPSS Statistics, version 21, a powerful statistical software program used in a multitude of disciplines. Complex Samples analyses (frequencies and cross tabulations) were performed using a plan file derived by FNIGC.

Some of the questions in the survey were open-ended – meaning that respondents were able to put in their own textual information in an “other” category. Wherever possible these responses were put through the process of systematic content analysis for narrative data and, in some cases (for example type of employment and sources of water) we were able to place the responses back into pre-existing categories.

Content Analysis involves the development of categories, or what are sometimes referred to as coding schemes (matrices), that can be used to both describe the original narrative and reduce or synthesize the information presented into smaller, manageable quantitative units that can ultimately be subjected to numerical analysis.

The process involves an in-depth review of narrative data and the creation of groupings or categories of prominent themes. Once these categories have been defined (and refined) to certain criteria (see below) they can, in turn, be used to quantify the respondents’ original narratives, thereby turning them into nominal level data.

For our purposes, standard principles of developing categories and testing the reliability of coding or categorical assignment were employed (Krippendorff, 1980). The major requirements for any content categories were:

- Categories were exhaustive, so that any relevant response could be placed in a category.
- Categories were mutually exclusive, so that no response could be coded in more than one category.
- Categories were developed by “thematic grouping”, meaning that each category contained individual items from the original responses that were similar in information, content or theme.

For the purposes of this report only a synthesis of the content analytic procedures employed has been provided, and it is by no means comprehensive. The concept and practice of content analysis is in itself an exhaustive science and beyond the scope of this work to define. The reader would be best directed to reference material (Reynolds, 1977) for further information. Suffice to say that acceptable and best practices were employed in developing the coding scheme used to transform the qualitative data into quantitative data. In addition, a measure of inter-rater reliability of 97% (between 4 content coders/raters) was achieved, indicating a high degree of precision (concordance) in both the definition of categories and the assignment of participant responses to chosen categories.



## 2.2 LIMITATIONS AND APPLICATION

Information contained in this report can be used to assist communities in identifying possible service needs, and in some cases – when used in conjunction with other information sources – add weight to program funding proposals.

Due to the relatively small response rate for some of the questions you will find missing categories in some of the charts. This indicates either a low cell count (i.e. less than 5 respondents) or a Coefficient of Variation  $\geq 0.33$  which means we must suppress that cell. You will see an F either above or beside these categories.

Values with an “E” above or beside them are to be interpreted with caution due to a Coefficient of Variation that is  $\geq 0.166$  but  $< 0.33$  (items with I--- E ---I above them in a chart indicate that the entire group of values is to be interpreted with caution). The Coefficient of Variation is a measure of how reliable and/or precise your result is (how close an individual value is to the average of all the values in the data set for that particular question). The higher the Coefficient of Variation, the farther you are away from the average and therefore the bigger likelihood that the value is not as representative of your population as you may like. The larger the sample size the greater the likelihood that the data are representative of the population. It is for this reason that we hope to encourage increased participation for the next phase of RHS, which will be coming up in 2014.

We remind everyone that the RHS is a self-reporting survey tool – i.e. relies on individuals to provide subjective information. We encourage each community to use supporting direct measurement reports such as the First Nations Health Status Report – Alberta Region 2011–12 (produced by the Medical Officer of Health’s Office, First Nations and Inuit Health Branch, Health Canada–Alberta Region). We also encourage you to request additional information on your community that is readily available through Health Canada and the Province of Alberta.

## 2.3 PRIVACY AND CONFIDENTIALITY

Each respondent who participated in the 2008/10 RHS shared his/her personal information based on a standard consent form. Interviewers read the Statement of Participation to each respondent before they were asked to sign the form. This consent form assures that personal identity is kept confidential. More specifically, it prevents AFNIGC from disclosing “personal-identifying” information about respondents to anyone.

The AFNIGC is legally and ethically bound to respect limitations contained within the signed consent form, therefore individual or record level data is never released. This is in keeping with the principles of OCAP™ referenced earlier.













# Chapter 03:

## SECTION SUMMARIES

## 3.1 VISION – PHYSICAL HEALTH

### 3.1.1 HEALTH STATUS

- 48.5% of First Nation adults reported that their health was excellent or very good ("thriving"); of the remainder, who reported only good, fair or poor health ("non-thriving") 80.9% were over the age of 55
- a dangerous trend seems to be emerging in the child population; 49.4% qualify as obese (caveat - this is a self-reported survey and we did NOT weigh or measure the height of each person directly)
- 68.4% of youth and 85.3% of children were thriving
- adults are aware of the factors that make them healthy; good diet, good social supports, good sleep/proper rest, happiness, and exercise were endorsed by a minimum of 63.6%
- youth do not seem to perceive the same factors contributing to their good health as adults do – they believed good diet, regular exercise, and good sleep were the main factors while social supports, reduced stress, and being in balance were not really on their radar

### 3.1.2 HEALTH CONDITIONS & CHRONIC DISEASES

- most common long-term health conditions in adults (all at less than 25%)
  - arthritis – 22.1%
  - allergies – 20.6%
  - chronic back pain – 20.7%
  - high blood pressure – 18.9%
  - diabetes – 13.6%
  - asthma – 11.8%
  - stomach and intestinal problems – 11.2%
- most common long-term health conditions in youth (all at less than 25%)
  - allergies – 20.3%
  - asthma – 15.2%
  - dermatitis/atopic eczema – 11.2%
- most common long-term health conditions in children (all at less than 10%)
  - allergies – 9.9%
  - dermatitis/atopic eczema – 9.9%
  - asthma – 9.4%

### 3.1.3 DIABETES

- 13.6% of adults have been diagnosed with diabetes; 76.8% of these adults with Type 2 (adult onset)
- 84.6% of those diagnosed with Type 2 diabetes stated that their condition prompted them to adopt a healthier lifestyle

### 3.1.4 INJURIES

- 20.4% of adults, 29.7% of youth & 12.4% of children suffered some form of injury in the 12 months preceding the survey
- treatment occurred at a hospital emergency room for the majority in all three groups
- adult and child injuries mostly occurred at home whereas for youth it was at sports fields/facilities of schools

### 3.1.5 DISABILITIES/QUALITY OF LIFE

- 28.4% of adults reported that they had a physical or mental health problem that limited the kind or amount of activity they could do at home, work or otherwise
- The three most common disabilities were the inability to:
  - see or read newsprint even with glasses or contact lenses (22.7%)
  - lift or carry 10 lbs. (19.8%)
  - climb a flight of stairs without resting (16.7%)

### 3.1.6 HEALTH CARE UTILIZATION

- just under half (48%) said that they use traditional medicines
- a total of 56.4% of adults believed that they had access to the same level of health care as Canadians in general; 31.2% that they had less access, and 12.5% that they had better access to health care than Canadians in general
- 30.8% of adults had consulted a traditional healer
- over one quarter of youth (26.1%) remember having consulted a traditional healer at some point in their lives (54.7% had never consulted one)
- a total of 94.0% of the children had received their routine vaccinations/immunizations

### 3.1.7 DENTAL CARE

- only 52.5% of adults had received any dental care in the year prior to the interview – lack of care related to cost in 15% of the cases for those not receiving dental care
- more youth (77.5%) had received dental care in the year prior to the interview than adults had
- about two thirds (65.7%) of children had received dental care in the year prior to the interview



## 3.2 RELATIONSHIPS – PERSONAL AND COMMUNITY WELLNESS AND CULTURE

### 3.2.1 MENTAL HEALTH, PERSONAL WELLNESS AND SUPPORT AMONG FIRST NATIONS

#### ADULTS

- about 32.2% of adults said that they experienced physical aggression, and 52.2% verbal aggression in the past 12 months; only 25.9% of those who experienced aggression actually sought help to deal with it
- over 80% of adults believed that traditional spirituality was either very important (54.7%) or somewhat important (30.6%) in their lives
- about 70% of all adults felt in balance either all the time or most of the time in the four aspects of their lives: physical, emotional, mental, and spiritual
- a good proportion of adults believed that mental and emotional supports would be available to them when they would need them
- when asked who they turn to when emotional or mental health supports are needed, the most common responses were:
  - immediate family members (61.4%)
  - friends (61.1%)
  - other family members (49.2%)
  - the most common external supports mentioned were:
    - family doctors (35.7%)
    - traditional healers (27.3%)
- despite the fact that 43.6% of adults stated that they had personally experienced instances of racism in the past 12 months, over two thirds (66.5%) of them felt that racism had little to no effect on their level of self-esteem
- about 80% of the adults feel they are in control over their lives
- up to 24% of adults stated that they had symptoms of depression either all or most of the time

#### YOUTH

- approximately 30% of youth participated in activities outside of school hours (even if it was less than once per week)
- over 80% of youth had a positive self-image and either strongly agreed or agreed that they liked the way they were; that they had a lot to be proud of; that a lot of things about them were good; and that they were doing things well
- as with adults, roughly 80% of youth feel they are in control over their lives
- 14.7% of youth felt that they were currently being bullied
- of those being bullied, 37.7% have felt sad, blue or depressed for 2 weeks or more in a row during the preceding 12 months
- most youth (71.6%) felt in balance either all the time or most of the time in the physical aspect of their lives
- when asked about their feelings:
  - 52.3% of youth did not feel lonely at all
  - 85.4% felt loved either "A lot" or "Quite a bit"
  - 38.6% did not feel at all stressed
  - even more so than adults, a good proportion of youth (roughly 80%) believe that they have access to supports all or most of the time, if needed
- 27.2% of the general youth population responded that they have had a time during the past 12 months when they felt sad, blue or depressed for 2 weeks or more in a row



### 3.2.1 MENTAL HEALTH, PERSONAL WELLNESS AND SUPPORT AMONG FIRST NATIONS (CONT'D)

#### CHILDREN

- at a minimum, over 20% of children participated in activities outside of school hours (even if it was less than once per week). As with youth, sports activities were the most popular
- almost all parents/guardians (97.8%) believed that their children got along very well or quite well with the rest of their families

### 3.2.2 SUICIDE

- some adults (13.1%) and youth (15.5%) knew of a close friend or a family member who had committed suicide in the 12 months preceding the survey
- more in-depth analyses show that of those adults who had ever thought about committing suicide 55.0% had actually made an attempt
- 22.1% of adults and 15.6% of youth said that they had, at some point in their lives, thought about committing suicide
- most adults (84.8%) had not thought of committing suicide in the 12 months preceding the survey but 52.2% of youth had

### 3.2.3 RESIDENTIAL SCHOOLS

- just over one quarter (25.4%) of adults attended residential school with slightly more males (27.8%) than females (22.9%) attending. Over sixty percent of their parents, and approximately two thirds of their grandparents combined also attended residential school
- caregivers for the children were also asked whether their parents and/or grandparents had attended residential school. Of the caregivers who answered on behalf of the children (88.6% of whom were one of the child's birth parents) 25.8% said that at least one of the child's parents had attended residential school and 90.6% said that at least one of the child's grandparents had attended
- youth were also asked whether their parents and/or grandparents had attended residential school. Of the youth who answered 33.8% said that at least one of their parents had attended residential school and 91.4% said that at least one of their grandparents had attended
- most adults (61.7%) believed that residential school impacted them in a negative way

### 3.2.4 LANGUAGE AND CULTURE

- the languages adults used most in daily life were English (93.7%) and a First Nation language (33.8%)
- among adults, 71.9% can speak or understand a First Nation language. The number drops to 59.3% in youth and 41.9% in children
- over 90% of youth thought that it was important to participate in traditional cultural events as did 87.6% of the children's caregivers
- almost all youth (99.0%) used English in their daily life, and 13.0% a First Nation language.
- children were roughly the same with 99.1% using English and 15.1% using a First Nation language

### 3.2.5 COMMUNITY WELLNESS

- adults and youth generally felt that there had been little or no progress on most community issues in the past 12 months
- just over one third of adults felt there had been some to good progress or change in only three areas – Education and training opportunities (38.4%), Culture (38.3%) and Health (34.5%)
- the top three community strengths identified by adults and youth included:
  - family values (55.6% of adults and 59.4% of youth)
  - traditional ceremonial activities (55.1% of adults and 54.3% of youth)
  - elders (43.3% of adults and 37.9% of youth)
- one third or more of youth who responded felt that there had been some to good progress or change in five areas – culture (50.4%), education and training opportunities (48.3%), employment/number of jobs (38.0%), housing quality (35.2%) and health (33.7%)

### 3.2.6 MIGRATION

- almost two thirds (63.1%) of adults had lived outside of their First Nations community at some point in their lives
- most frequently selected reasons for moving away from First Nations communities (overall):
  - employment (cited by 28.0% of adults who had left their communities)
  - education (26.3%)
  - housing (15.7%)
- most frequent reasons for returning to the community:
  - family (cited by 53.0% of adults who returned to their communities)
  - connection to community/home (22.6%)
  - housing became available (17.2%)
- gender breakdown tells a different story:
  - men moved for employment (44.1%) and education (21.9%)
  - women tended to leave their communities because of education (30.5%) and housing (21.8%)

## 3.3 REASON – SOCIAL ECONOMIC

### 3.3.1 MENTAL HEALTH, PERSONAL WELLNESS AND SUPPORT AMONG FIRST NATIONS

#### ADULTS

- just over one quarter of adults (27.7%) reported that they had graduated from high school
- it is notable that lack of high school graduation did not necessarily predict whether someone went on to higher education of some sort
- for example, 41.0% of those who received a diploma or certificate from either a trade, technical or vocational school or a community college, CEGEP or university had not graduated from high school
- adult women were slightly more likely than men to have completed high school (55.3% as compared to 44.7%)
- adult women were 27% more likely to have a community college or undergraduate university degree (63.5% as compared to 36.5%)
- adult men were more likely to have completed a diploma or certificate from a trade, technical or vocational school

#### YOUTH

- at the time of the survey most youth (82.5%) were still attending school and, overall, they liked school to some extent (79.0%)

#### CHILDREN

- two thirds of children (66.7%) were also attending school at the time of the survey. Almost half of them (41.7%) had attended an Aboriginal Head Start program

### 3.3.2 EMPLOYMENT

- almost half (48.1%) of adults worked for pay (including wages, salary, and self-employment) at the time of the interview
- of those who were not working, 48.2% were looking for work

### 3.3.3 RESIDENTIAL SCHOOLS

- the majority of adults (85.5%) had some source of personal income
- individual adults' sources of income were from 4 major sources:
  - paid employment (57.5%)
  - Social Assistance (41.5%)
  - Child Tax Benefits (37.1%)
  - education or training allowance (14.1%)

### 3.3.4 FAMILY AND HOUSEHOLD STRUCTURES

- more children live with their biological parents than do youth
- the incidence of living with an aunt, uncle or cousins is more than double in the children's households than in that of the youth's households
- a majority of adults stated that their household was able to meet the basic living requirements of:
  - food - 49.4%
  - shelter - 82.3%
  - utilities (heat, electricity) – 68.0%
  - clothing – 73.6%
  - transportation – 56.0%
  - childcare – 81.8%
- almost half the youth (48.4%) stated that their biological parents were separated or not living together
- just over one third (36.5%) stated that their biological parents were indeed living together (whether married – 16.7% or not – 19.8%)

### 3.3.5 HOUSING AND LIVING CONDITIONS

- more than three quarters (83.3%) of adults stated that they live in band-owned housing
- Based on the adult survey 64.8% of homes were overcrowded and based on the child survey 50.1% of homes were overcrowded
- over half (52.8%) reported that there had been mould or mildew in their home in the 12 months preceding the survey
- most adults (79.1%) reported that they do not use any other sources of drinking water. Of those who do use other sources, bottled water (74.1%), and boiled tap water (8.0% E) were the two main sources
- the number of rooms in the home (including kitchen, bedroom, living room, and finished basement rooms) ranged from 1 to 13, with an average of 5.85 rooms per home
- over three quarters (76.1%) of adults felt that their home was in need of repair; either minor (30.1%) or major (46.0%)
- just over half of the adults (59.6%) said that the main water supply in their home was safe for drinking year round

## 3.4 ACTION – HEALTH BEHAVIOURS & LIFESTYLES

### 3.4.1 SMOKING

#### ADULTS

- well over half of the adults smoked either daily (49.2%) or occasionally (15.9%)
- despite being smokers, 60.7% of adults said that they had a smoke free home
- of the current 34.9% of adult non-smokers, 52.5% had never smoked in the past

#### YOUTH

- 70.9% of youth said they did not smoke at all
- just under half of the youth (48.4%) live in a smoke-free home

### 3.4.2 ALCOHOL AND DRUG USE

#### ADULTS

- over half of adults (61.7%) said that they drank beer, wine, liquor or other alcoholic beverages in the 12 months preceding the survey
- almost two thirds (63.8%) of those adults who do drink qualify as heavy drinkers (5 or more alcoholic drinks on a single occasion at least once per month)
- 62.1% of adults reported that they had never used any substances in the 12 months preceding the survey

#### YOUTH

- almost two thirds of youth (61.2%) said that they had NOT had any beer, wine, liquor or other alcoholic beverages in the 12 months preceding the survey
- less than half (47.6%) of those youth who drink qualify as heavy drinkers (5 or more alcoholic drinks on a single occasion at least once per month)
- among youth, non-users of various substances were at 97% and higher

### 3.4.3 GAMBLING

- 71.3% of adults had gambled at least once in their lives
- almost one quarter of adults (23.4%) had borrowed money to gamble

- one quarter (25.0%) reported that they had bet more money than they could afford to lose
- 15.0% (E) went on to report that their gambling had caused financial problems for them or their families

### 3.4.4 PHYSICAL ACTIVITY

#### ADULTS

- 14.1% of adults said that they were rarely active
- 19.7% said that they did at least 30 minutes of physical activity at least once a week
- 28.3% said that they did at least 35 to 59 minutes a day of walking or other moderate physical activity
- 37.9% said that their day involves at least 60 minutes of walking or other moderate physical activity every day
- most common activities listed by adults:
  - walking (83.7%)
  - gardening & yard work (38.9%)
  - running or jogging (32.1%)
  - weights or exercise equipment (31.5%)
  - swimming (29.6%)
  - berry picking & food gathering (28.3%)
  - dancing (25.7%)
  - golf (25.5%)

#### YOUTH

- 11.6% of youth said that they were rarely active
- 29.8% said that they did at least 30 minutes of physical activity at least once a week
- 28.6% said that they did at least 35 to 59 minutes a day of walking or other moderate physical activity
- 30.0% said that their day involves at least 60 minutes of walking or other moderate physical activity every day
- most common activities listed by youth:
  - walking (87.2%)
  - running or jogging (72.0%)
  - swimming (52.3%)
  - competitive or team sports (53.1%)
  - weights or exercise equipment (46.7%)
  - bicycle riding or mountain biking (41.1%)
  - skating (31.6%)
  - berry picking & food gathering (25.8%)
  - dancing (25.1%)

#### CHILDREN

- most common activities listed for children:
  - walking (80.9%)
  - swimming (66.3%)
  - running or jogging (61.9%)
  - bicycle riding or mountain biking (46.3%)
  - dancing (36.2%)
  - berry picking & food gathering (35.5%)
  - skating (26.7%)

### 3.4.5 NUTRITION

#### ADULTS

- about one third (32.9%) of adults believe that they always, or almost always eat a nutritious balanced diet

#### YOUTH

- about one third (30.2%) of youth believe that they always or almost always eat a nutritious balanced diet

#### CHILDREN

- about two thirds (65.5%) of the children's caregivers believe that the child always or almost always eats a nutritious balanced diet



### 3.4.6 FOOD SECURITY

- almost half (47.6%) of adults said that they couldn't afford to eat balanced meals
- More than one third of adults (38.3%) revealed that in the 12 months preceding the survey it was often (9.4% E) or sometimes (28.9%) true that they were not able to feed their children a balanced meal because they could not afford it
- over half (54.1%) said that the statement "The food we bought just didn't last and we didn't have any money to get more" was either often (14.4%) or sometimes (40.7%) true
- over one quarter (29.2%) of adults felt that in the 12 months preceding the survey their children were often (5.1% E) or sometimes (24.1%) not eating enough because they (the primary caregiver) could not afford enough food

### 3.4.7 SEXUAL HEALTH PRACTICES

#### ADULTS

- over three quarters (76.1%) of the adults interviewed were sexually active
- almost half of the adults (47.7%) had been tested for sexually transmitted diseases (STDs) or sexually transmitted infections (STIs) and over one third (38.5%) for HIV/AIDS
- 25.4% of them said they do not use any birth control or protection methods
- adults were also asked if they identify as being homosexual (gay or lesbian), bisexual or two-spirited. Most (95.8%) answered the question and of those who did, 4.9% (E) fell into this category

#### YOUTH

- almost once quarter (24.8%) of youth declared that they were sexually active at the time of the interview
- most sexually active youth use condoms (81.1%) as a birth control method







# Chapter 04:

## VISION – PHYSICAL HEALTH

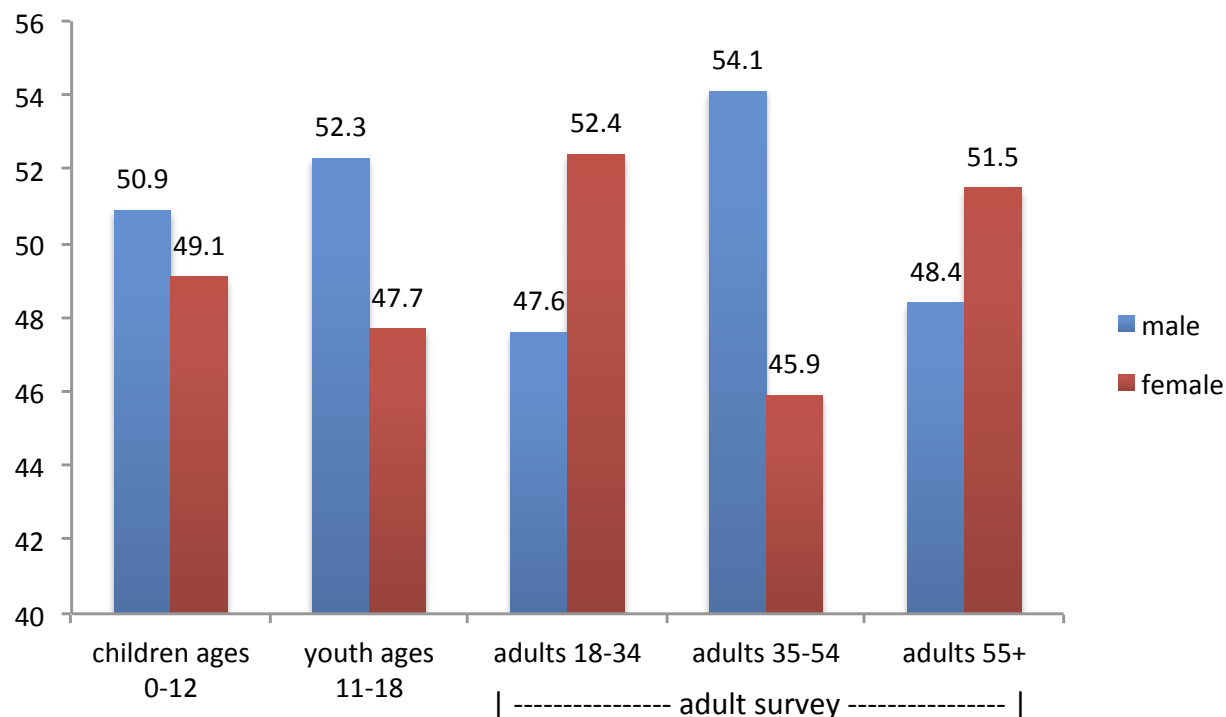
## 4.1 DEMOGRAPHICS

The total target sample for Alberta was 3848 surveys. Twenty one (21) of the 22 First Nations communities selected for the survey participated. There were 16 communities with a large enough response rate to be included in the final results. These communities are indicated by a star on the Alberta map located on the following page. Overall there were 1418 survey results (36.9% of our target sample) for us to use.

- a total of 714 Adult surveys were completed. Of all respondents, 50.5% were male and 49.5% were female, with their ages ranging from 18 to 93.
- 319 First Nations Youth completed the survey; 52.3% male and 47.7% female from ages 11 to 18.
- 385 guardians of children responded to the survey questions on behalf of children aged 0 to 12. Information was provided mainly by birth parents (88.6%) and grandparents (8.8%). Female parents/guardians were in the vast majority at 82.2%.

Figure 4.1a

### Gender of Respondents by Survey





### Treaty 8

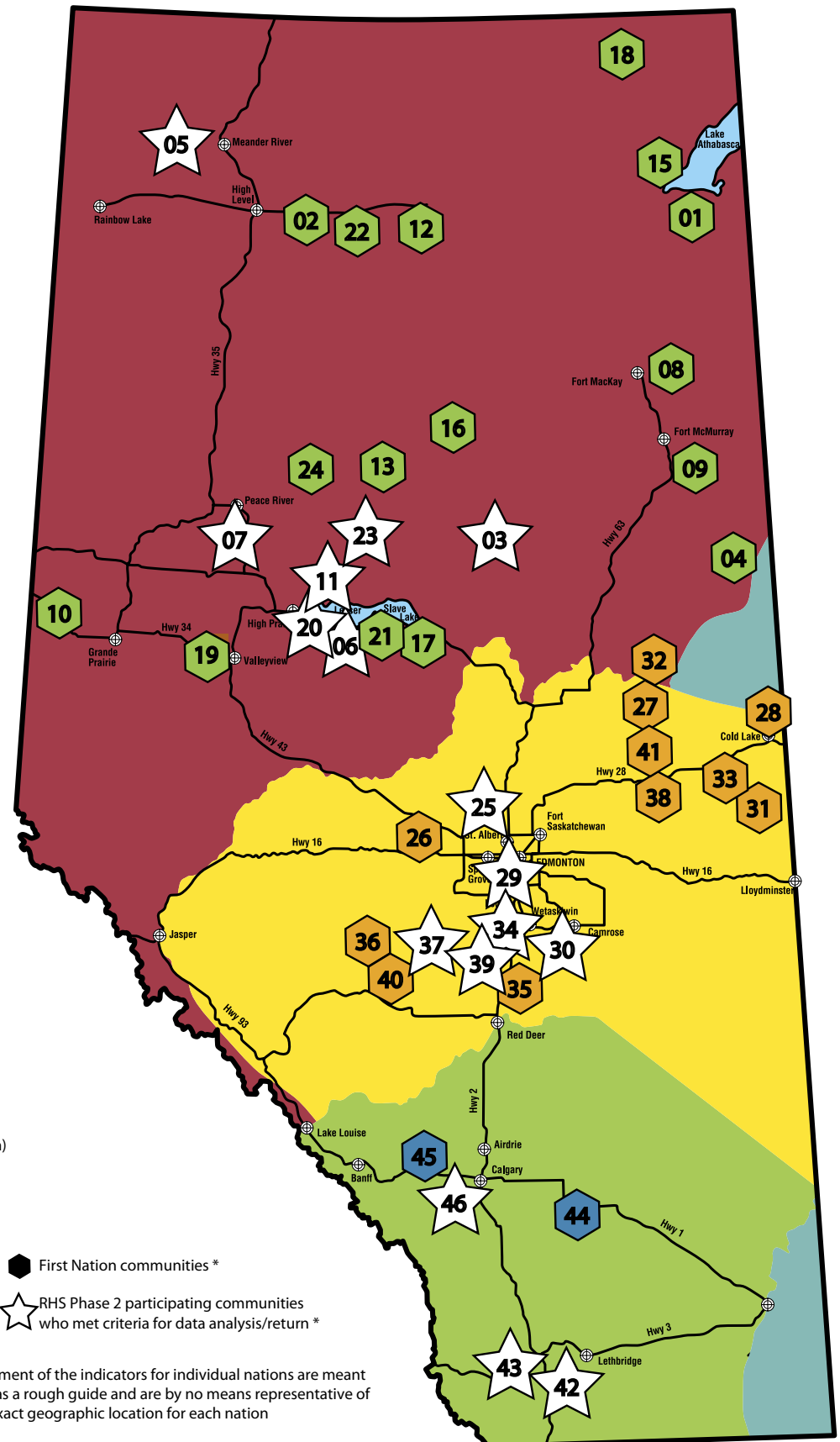
- 01 Athabasca Chipewyan First Nation
- 02 Beaver First Nation
- 03 Bigstone Cree Nation
- 04 Chipewyan Prairie First Nation
- 05 Dene Tha' First Nation
- 06 Driftpile First Nation
- 07 Duncan's First Nation
- 08 Fort McKay First Nation
- 09 Fort McMurray First Nation
- 10 Horse Lake First Nation
- 11 Kapawe'no First Nation
- 12 Little Red River Cree Nation
- 13 Loon River First Nation
- 14 Lubicon Lake Nation (No Reserve)
- 15 Mikisew Cree First Nation
- 16 Peerless Trout First Nation
- 17 Sawridge First Nation
- 18 Smith's Landing First Nation
- 19 Sturgeon Lake First Nation
- 20 Sucker Creek First Nation
- 21 Swan River First Nation
- 22 Tallcree First Nation
- 23 Whitefish Lake First Nation (Atikameg)
- 24 Woodland Cree First Nation

### Treaty 6

- 25 Alexander First Nation
- 26 Alexis Nakota Sioux Nation
- 27 Beaver Lake Cree Nation
- 28 Cold Lake First Nation
- 29 Enoch Cree Nation
- 30 Ermineskin Cree Nation
- 31 Frog Lake First Nation
- 32 Heart Lake First Nation
- 33 Kehewin Cree Nation
- 34 Louis Bull Tribe
- 35 Montana First Nation
- 36 O'Chiese First Nation
- 37 Paul First Nation
- 38 Saddle Lake Cree Nation
- 39 Samson Cree Nation
- 40 Suncild First Nation
- 41 Whitefish Lake First Nation #128 (Goodfish)

### Treaty 7

- 42 Blood Tribe
- 43 Piikani Nation
- 44 Siksika Nation
- 45 Nakoda Nations (Stoney)
  - Bearspaw Nakoda Nation
  - Chiniki Nakoda Nation
  - Wesley Nakoda Nation
- 46 Tsuu T'ina Nation



Map adapted from the First Nations of Alberta Report, 2013, pg 3

Aboriginal Affairs and Northern Development

[http://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-AB/STAGING/texte-text/fnamarch11\\_1315587933961\\_eng.pdf](http://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-AB/STAGING/texte-text/fnamarch11_1315587933961_eng.pdf)

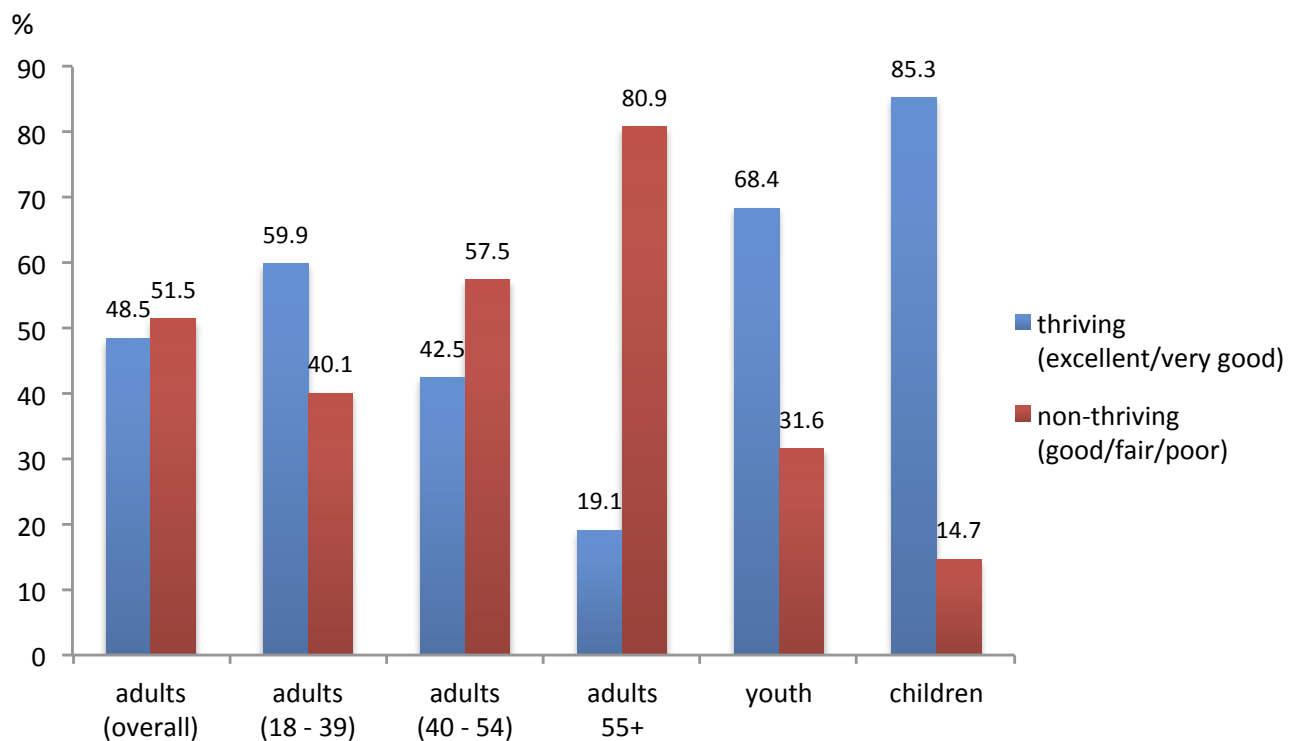
## 4.2 HEALTH STATUS

When asked about their general health 48.5% of First Nation adults in Alberta reported that their health was excellent or very good (i.e. “thriving”) and 51.5% reported that their health was “non-thriving” (good/fair/poor). This was further broken down within adults to see who was thriving and who was not. As expected, the older adults were more likely to be in the “non-thriving” group than the younger adults.

In the youth survey 68.4% fit into the thriving health status category and 69.4% also rated their mental health as excellent or very good.

According to their parents/guardians, 85.3% of the children were thriving (very good to excellent health). The calculated BMI-for-Age, based on the parent/guardian’s report of the child’s height and weight, indicates that only 28.0% of children are at a healthy weight while 49.4% of children are obese and 15.7% are overweight (again, this last value is to be interpreted with caution).

Figure 4.2a – Overall health status (adults, youth and children)



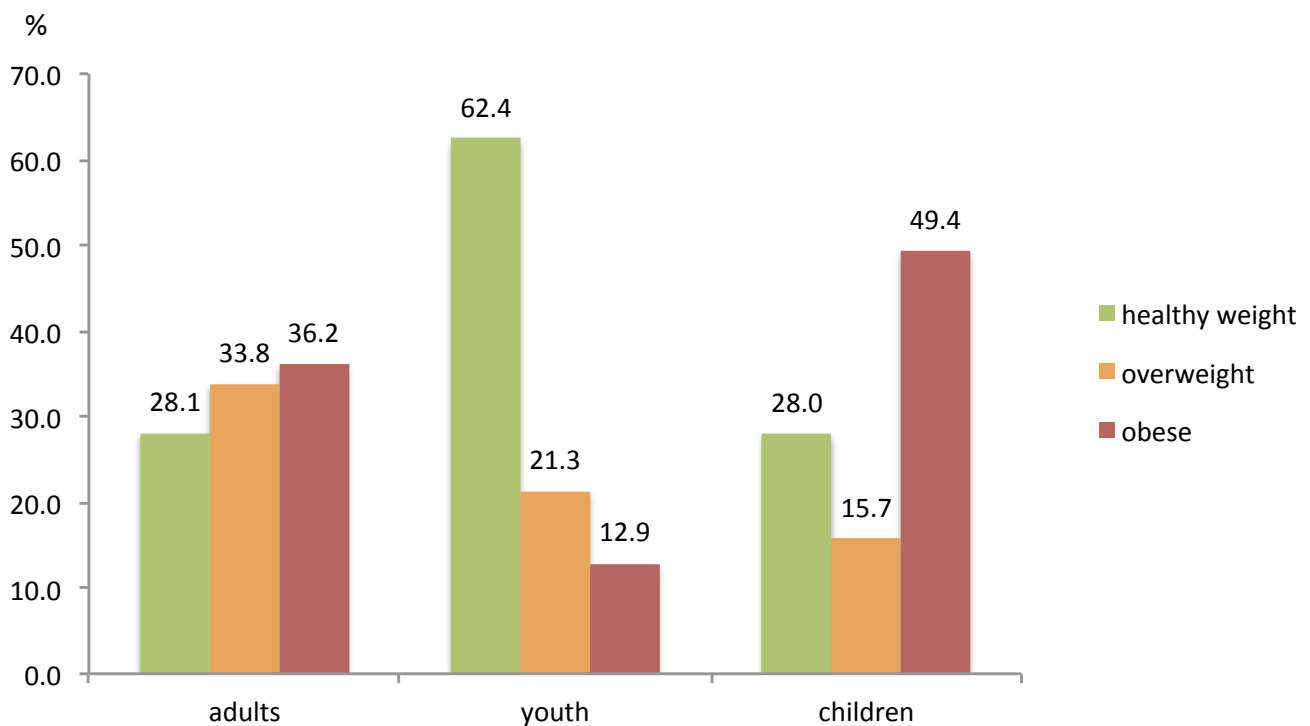


Body Mass Indices for adults were calculated using the CDC's (Centre for Disease Control) formulas. Two formulas were used as the BMI applies only to those 20 and over. BMI-for-Age was used for the 18 and 19-year olds. The end categories for both types of analyses are the same and so are comparable overall. Twenty eight point one percent (28.1%) of adults fit into the healthy weight category while 33.8% were overweight and 36.2% were obese.

When asked about satisfaction with their weight 68.8% of youth indicated that they were somewhat to very satisfied. Sixty two point four percent (62.4%) of youth were at a healthy weight, 21.3% were overweight and 12.9% were obese (although this last number is to be interpreted with caution).

The calculated BMI-for-Age, based on the parent/guardian's report of the child's height and weight, indicates that only 28.0% of children are at a healthy weight while 49.4% of children are obese and 15.7% are overweight (again, this last value is to be interpreted with caution).

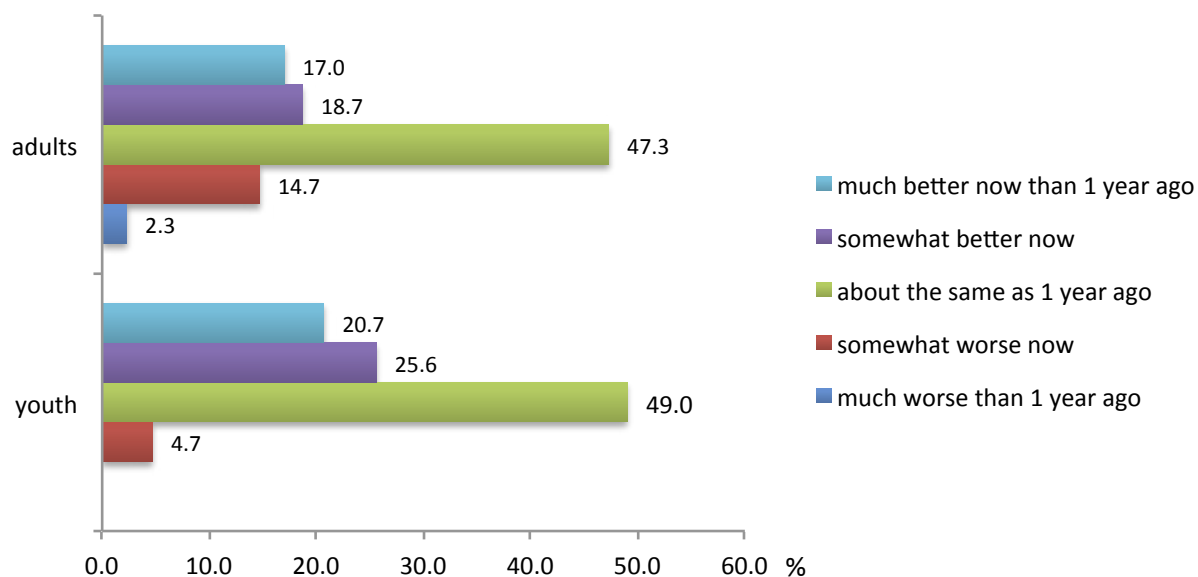
Figure 4.2b – BMI and BMI-for-Age (adults, youth and children)



Almost half of the adults (47.3%) stated that their health was about the same as it was in the previous year, 35.7% perceived that their health had improved and 17% that it had deteriorated.

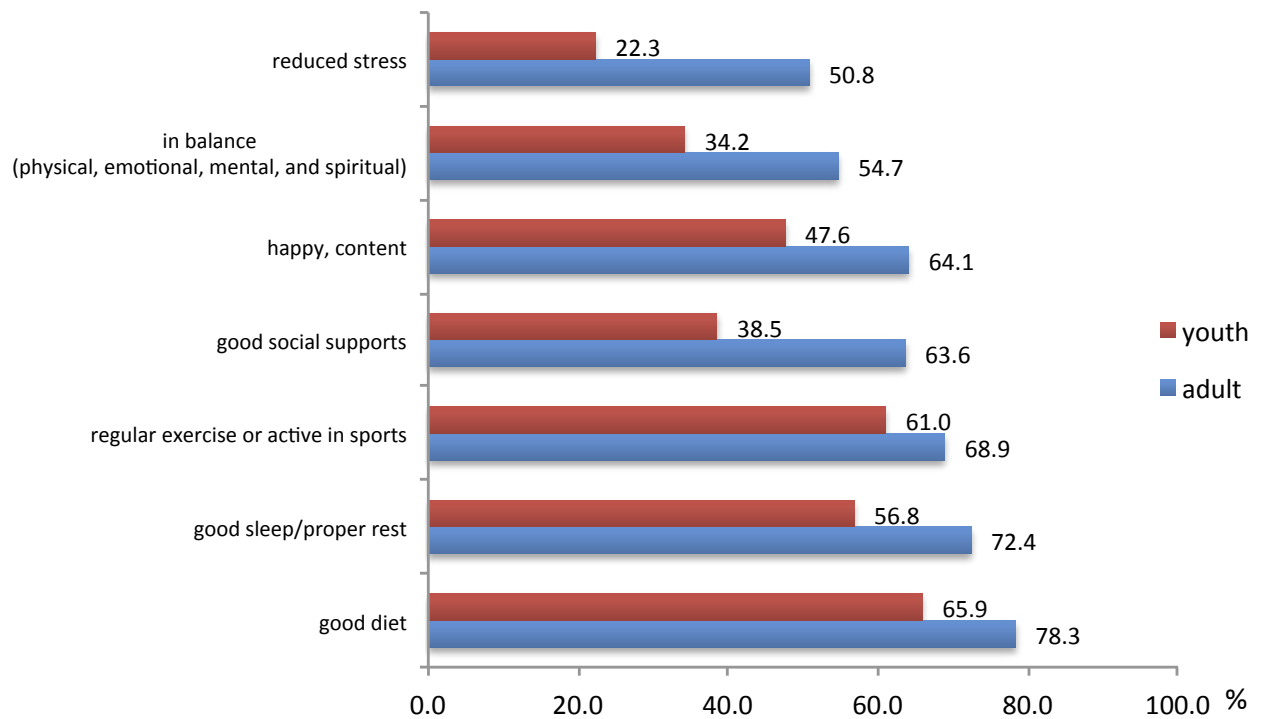
Only a small percentage (4.7%) of youth believed that their health had deteriorated to any extent over the past year; 46.3% believed that it was somewhat or much better than in the previous year.

Figure 4.2c – Current self-assessed health status compared to previous year (adults and youth)



When adults and youth were asked to list the things that made them healthy, good diet, good social supports, good sleep/proper rest, happiness, and exercise were all mentioned by at least 63.6% of the adults (63.6% being good social supports and the highest being good diet at 78.3%). In general we can say that the adults are aware of what factors contribute to good health.

Figure 4.2d – Perceived factors that make adults and youth healthy



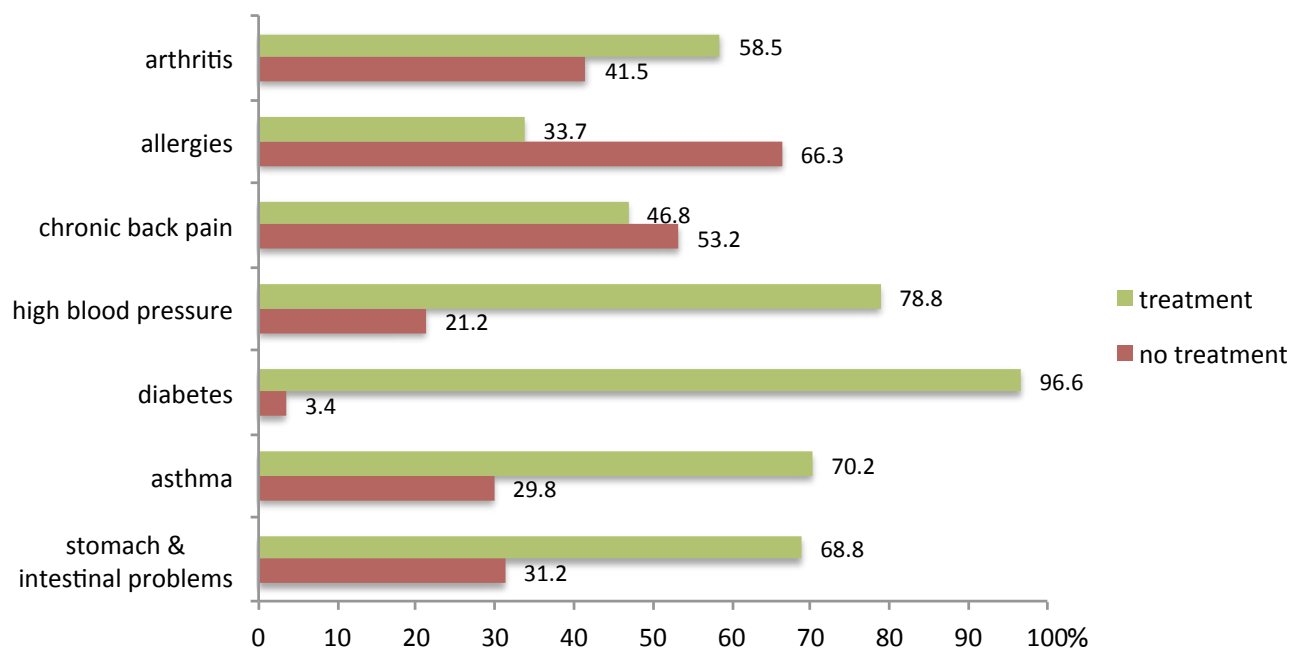
Youth believed that different things were responsible for their good health. Good diet (65.9%), regular exercise or active in sports (61%) and good sleep/proper rest (56.8%) were the three items rated most highly by youth. Reducing stress and being in balance (physical, emotional, mental, and spiritual) were listed by 50.8% and 54.7% of adults respectively but only by 22.3% and 34.2% of youth. Youth do not seem to perceive the same factors contributing to their good health as adults do.

## 4.3 HEALTH CONDITIONS AND CHRONIC DISEASES

### 4.3.1 HEALTH CONDITIONS AND CHRONIC DISEASES - ADULTS

The most common long-term health conditions faced by First Nations adults were arthritis (22.1% of adults), allergies (20.6%), chronic back pain (20.7%), high blood pressure (18.9%), diabetes (13.6%), asthma (11.8%) and stomach problems & intestinal problems (11.2%).

Figure 4.3a – **Most common health conditions faced by at least 10% of Adults and whether they are receiving treatment or not**



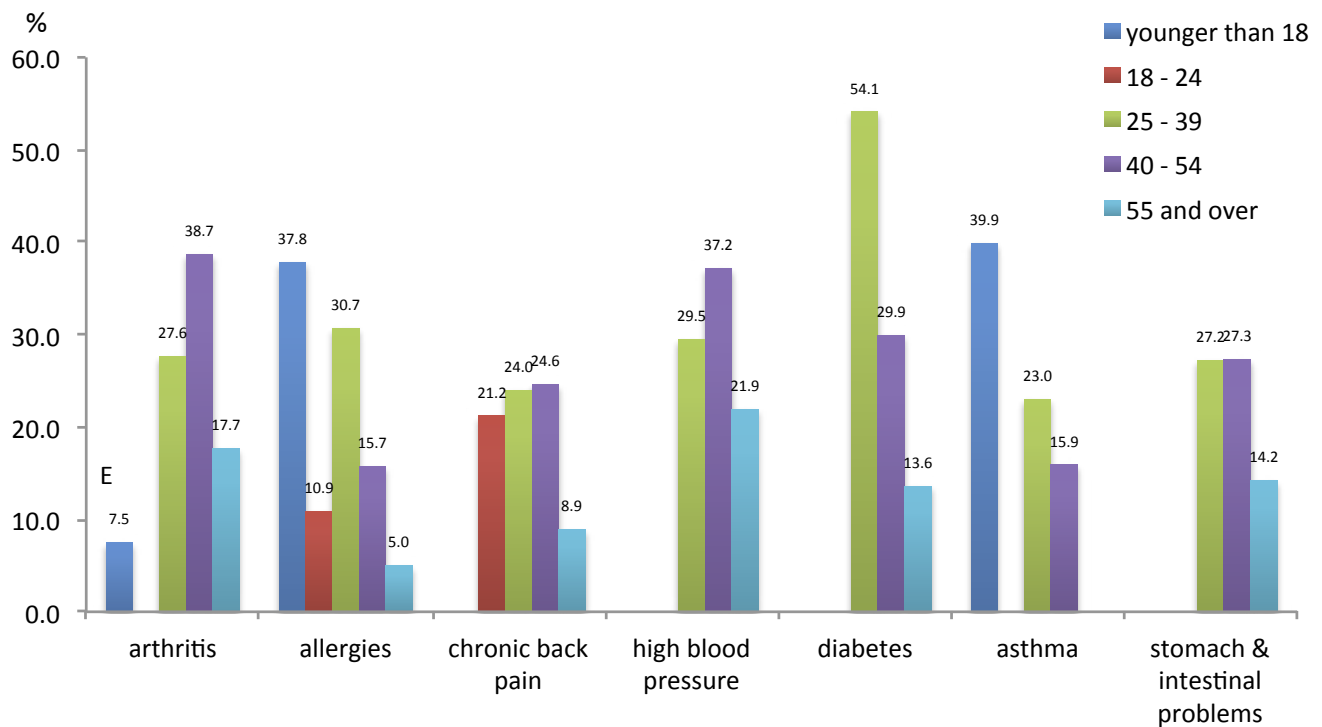
Asthma and allergies were present at an early age; 37.8% of adults were diagnosed before the age of 18.

Most cases of arthritis (56.4%) were diagnosed at the age of 40 and older.

Chronic back pain was diagnosed at a relatively early age: 66.5% of all cases were diagnosed before the age of 40.

Most diabetics (54.1%) were diagnosed between the ages of 25 & 39; the second biggest age category was between 40 & 54 (29.9%) and those diagnosed over the age of 55 accounted for 13.6%.

Figure 4.3b – Age of diagnosis for the most common health conditions faced by at least 10% of Adults



- Missing categories in the chart above indicate either a low cell count (i.e. less than 5 respondents) or a Coefficient of Variation  $\geq 0.33$
- Those values with an "E" above them are to be interpreted with caution due to a Coefficient of Variation that is  $\geq 0.166$  but  $< 0.33$  (items with |---- E ----| above them indicate that the entire group of values is to be interpreted with caution).

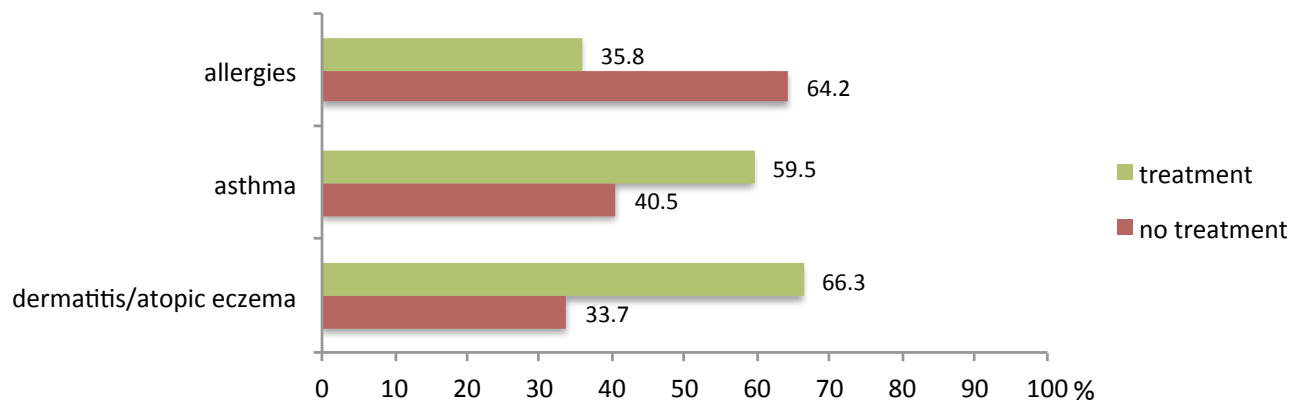
### 4.3.2 HEALTH CONDITIONS AND CHRONIC DISEASES – YOUTH

The most common health conditions experienced by youth were allergies (20.3%), asthma (15.2%), and dermatitis/atopic eczema (7.4%). All other conditions were at 4.2% or less and had too high of a Coefficient of Variation to provide usable results.

Asthma, dermatitis, and allergies started at a young age: 43.9% of asthma cases, 31.2% of dermatitis/atopic eczema, and 28.6% of allergies were diagnosed during the first 2 years of life.

At the time of the survey, 59.5% of the youth who had been diagnosed with asthma were receiving treatment for asthma. Of those with allergies 35.8% were receiving treatment and 66.3% of those with dermatitis/atopic eczema were also receiving treatment.

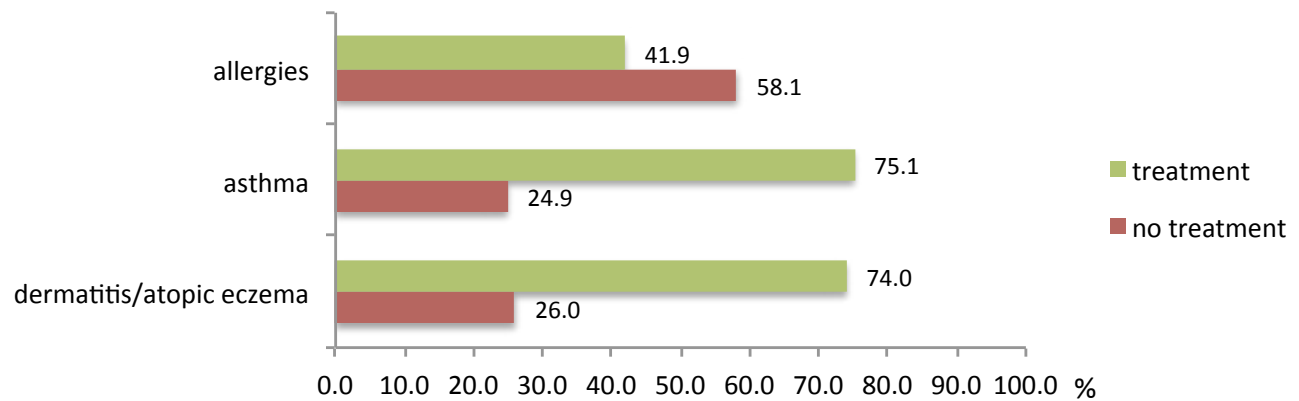
Figure 4.3c – **Most common health conditions faced by at least 7% of Youth and whether or not they are receiving treatment**





### 4.3.3 HEALTH CONDITIONS AND CHRONIC DISEASES – CHILDREN

Figure 4.3d – Most common health conditions faced by at least 9% of children and whether or not they are receiving treatment



The most common health conditions experienced by children were allergies (9.9%), dermatitis/atopic eczema (9.9%) and asthma (9.4%).

Asthma, dermatitis and allergies started at a young age: 68.4% of allergies, 65.6% of asthma cases, and 64.1% of dermatitis/atopic eczema were diagnosed during the first 2 years of life.

Over half of the children (56%) had experienced an ear infection at some point in their lives and 45.6% had experienced at least one in the preceding 12 months.

At the time of the survey, 12% of the children were taking asthma drugs (inhalers, puffers or Ventolin), 16.7% were taking antibiotics, and 30.3% took vitamins (79.4% of them once a day).

## 4.4 DIABETES

At the time of the survey 13.6% of adults had been diagnosed with diabetes. Of those, 76.8% had type 2 diabetes.

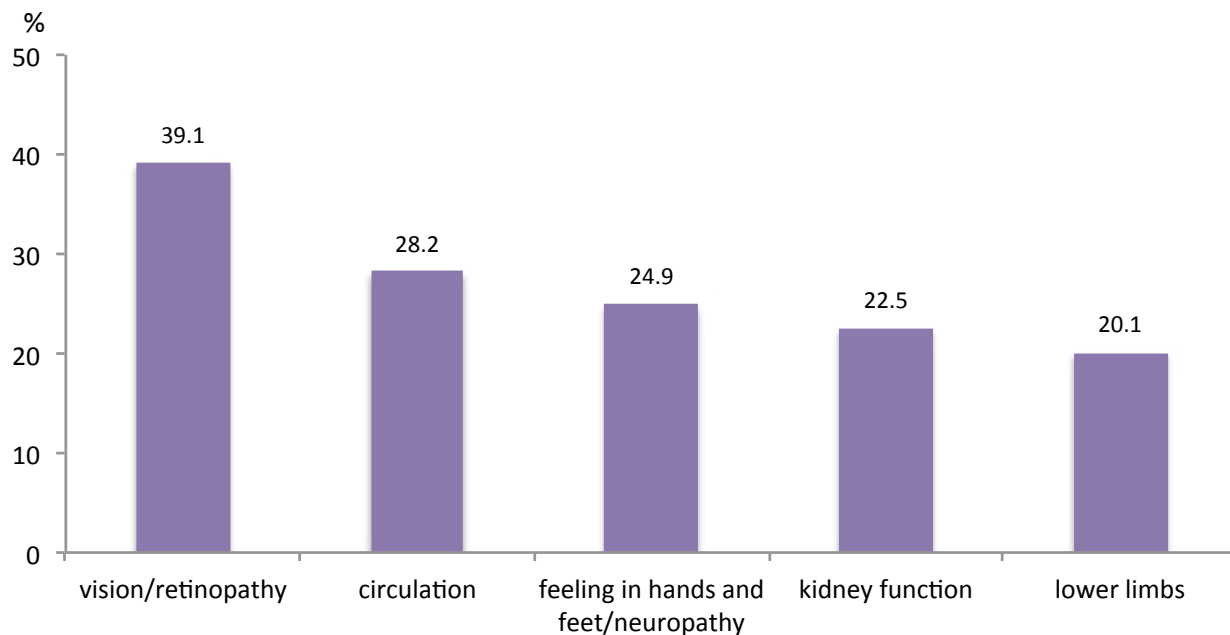
Treatment for diabetes included diet (67.7%), exercise (42.1%), insulin injections (30.1%), pills (73.1%), and traditional medicine (18.0%).

When asked how often they had checked their blood sugar level in the past 2 weeks, 58.3% of diabetic adults had checked once a day or more often while 22.4% hadn't checked it all.

Most adults with diabetes (84.6%) stated that the condition prompted them to adopt a healthier lifestyle, including a good diet and/or exercise.

While the results of this section are to be interpreted with caution (Coefficients of Variation were between 0.204 and 0.272), the major complications of diabetes experienced by adults were: affected vision/retinopathy (39.1%), affected circulation (28.2%), affected feelings in hands and feet/neuropathy (24.9%), affected kidney functions (22.5%) and affected lower limbs (20.1%).

Figure 4.4a – **Complications of diabetes experienced by adults**



More than half (56.6%) of adults with diabetes stated that they were attending a diabetes clinic or were seeing someone for diabetes education at the time of the survey. The most frequent reason for not attending was the belief that they no longer require diabetes education because they already have the information needed (66.2%).

## 4.5 INJURIES

### 4.5.1 INJURIES – ADULTS

A total of 20.4% of adults reported an injury in the past 12 months. The most common injuries were broken or fractured bones (in 47.7% of adult injuries); major sprain or strain (31.7% E); and minor cuts, scrapes or bruises (19.5% E). Areas most often injured were ankles (28.2% E), hands (22.3% E), arms (20.6% E), and knees (19.0% E).

Most injuries happened at home (49.7% E) or on the street, highway or sidewalk (19.8% E).

Injuries occurred while engaging in a leisure or hobby activity (32.4%), participating in sports or physical exercise (27.6%), while working at a job or business (15.3%) or doing unpaid work/chores around the house (11.9%). Due to the small sample size all of the preceding values are to be interpreted with caution (E).

The most common causes of injury were falls or trips (39.4%), accidental contacts with another person or an animal (21.0%) and a varied list of other injuries not named in the survey (16.7%). As above, all of the preceding values are to be interpreted with caution due to the small sample size.

Almost all adults who experienced an injury received medical treatment from a hospital emergency room (72.0%) or at the office of a medical doctor (26.1% E).

Over one quarter (29.2% E) of adults stated that they were under the influence of alcohol when their injury occurred.

### 4.5.2 INJURIES – YOUTH

A total of 29.7% of youth had been injured in the past 12 months. The most common injuries among youth were broken or fractured bones (44.3% E), minor cuts, scrapes or bruises (38.9% E), major sprains or strains (26.7% E).

As with adults, injuries most commonly affected ankles (28.8%), hands (19.2%), arms (27.5%), and knees (17.0%) but also included leg (28.4%), foot (26.2%), wrist (16.1%), and head injuries (13.0%). Injuries happened most often at sports fields/facilities of schools (42.3%), at home (36.7%), at school, college or university (20.1%) or on the street, highway or sidewalk (32.4%). As with adults, due to the small sample size all of the preceding values are to be interpreted with caution (E).

Almost three quarters of youth with an injury were engaged in sports or physical exercise (72.6%) at the time. The next largest group were those participating in a leisure or hobby activity (18.1% E). Falls or trips were the cause of 45.9% (E) of injuries. The other injury causes had too high of a Coefficient of Variation to be included (although a created category – sporting accident – came close at 25.1%)

Almost all youth who experienced an injury received medical treatment from a hospital emergency room (54.2%), a doctor's office (31.5% E), or at home (9.3% E).

### 4.5.3 INJURIES – CHILDREN

Parents/guardians reported that 12.4% of children had been injured in the past 12 months. The most frequent injuries were minor cuts/scrapes or bruises - experienced by 60.5% of children with injuries.

A large proportion of the injuries (79.2%) happened at home. Over half of the injuries (52.7%) occurred while the child was engaged in a leisure or hobby activity, and other injuries took place during sports or physical exercise (42.9% E). The causes of injury were a fall or trip (46.4% E) or miscellaneous “other” causes (39.5% E) not listed in the survey.

Most children received treatment for their injury at a hospital emergency room (55.1% E).

The values for injuries are mostly to be interpreted with caution due to the fact that there were very few injuries to begin with.

Figure 4.5a – Injuries experienced in the preceding 12 months

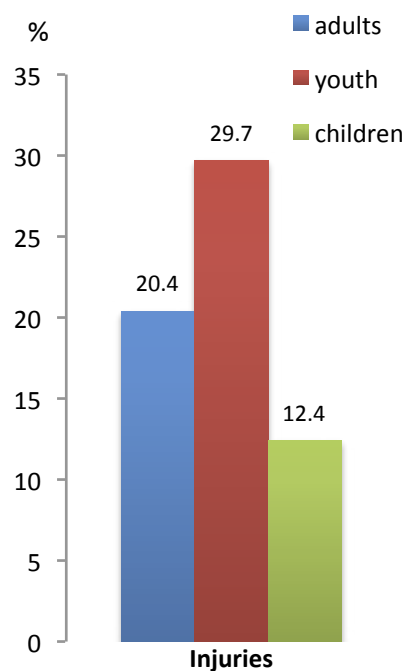


Figure 4.5b – Types of injury experienced

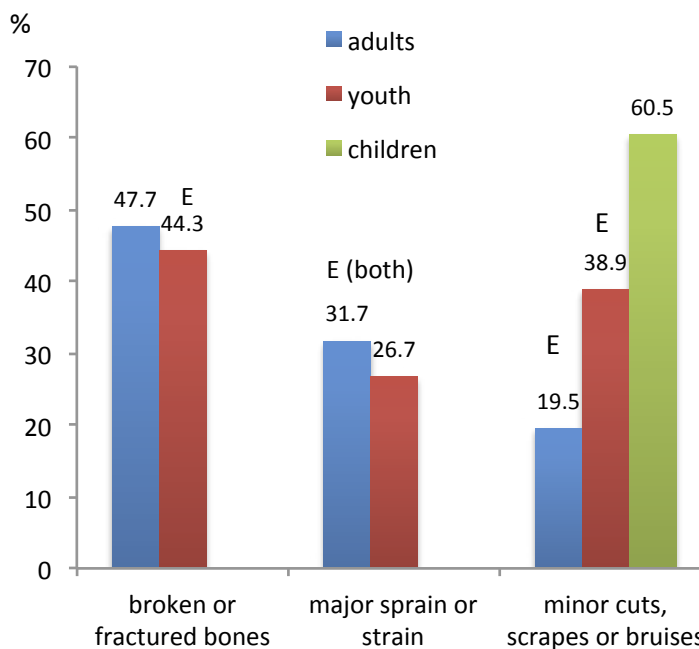


Figure 4.5c – Body parts most frequently injured

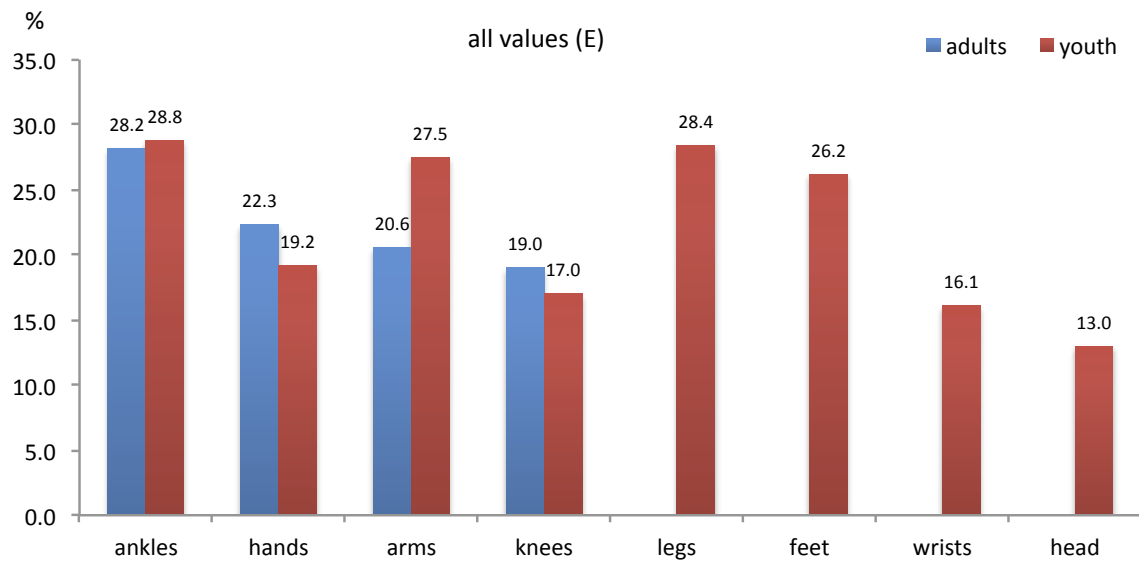


Figure 4.5d – Locations where injuries occurred

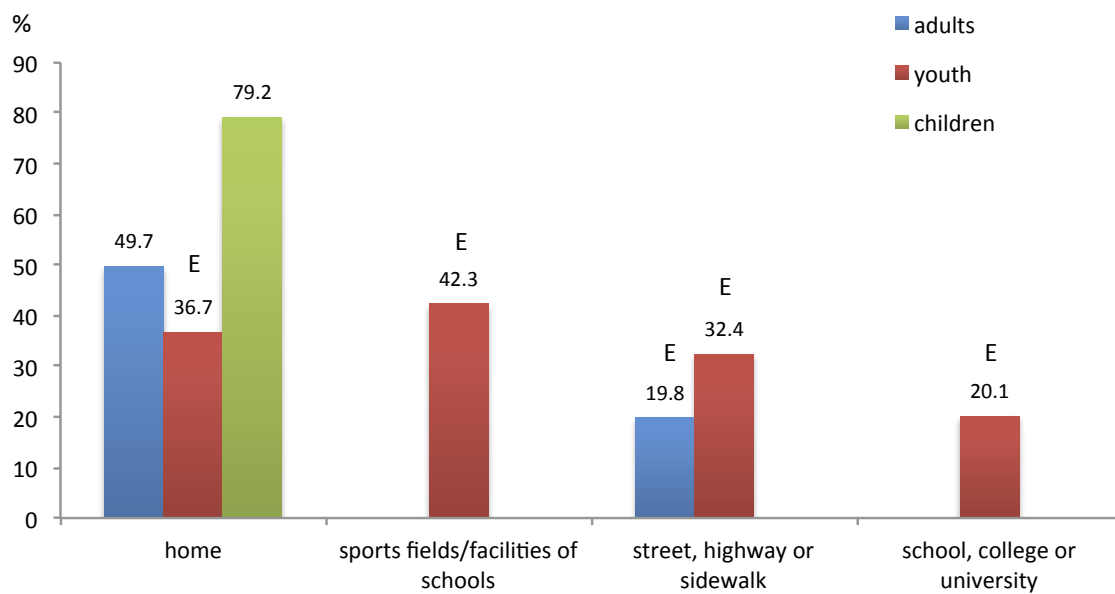


Figure 4.5e – Activities during which injuries occurred

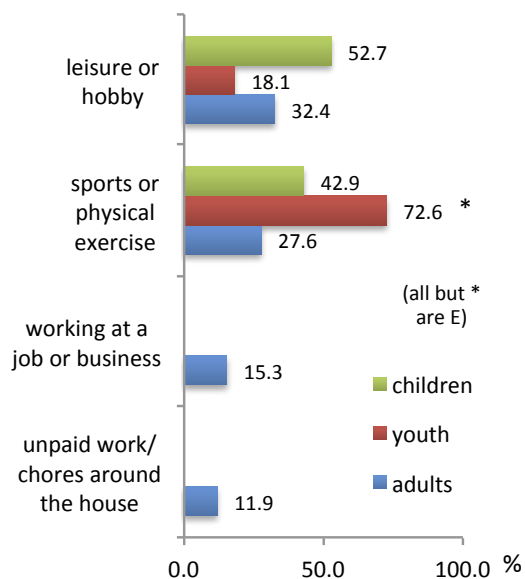


Figure 4.5f – Causes of injuries

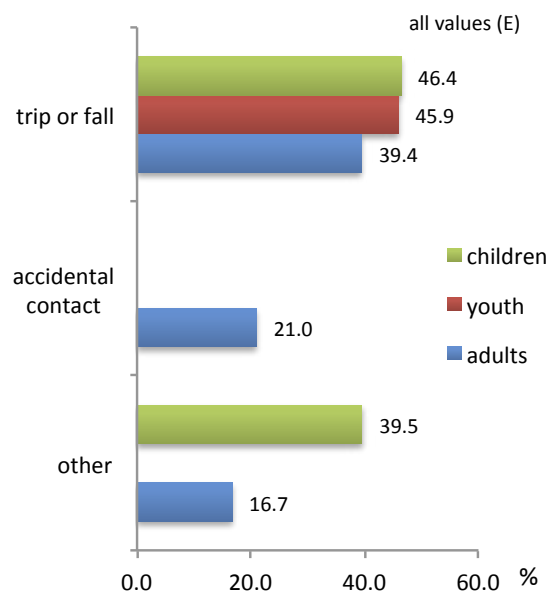
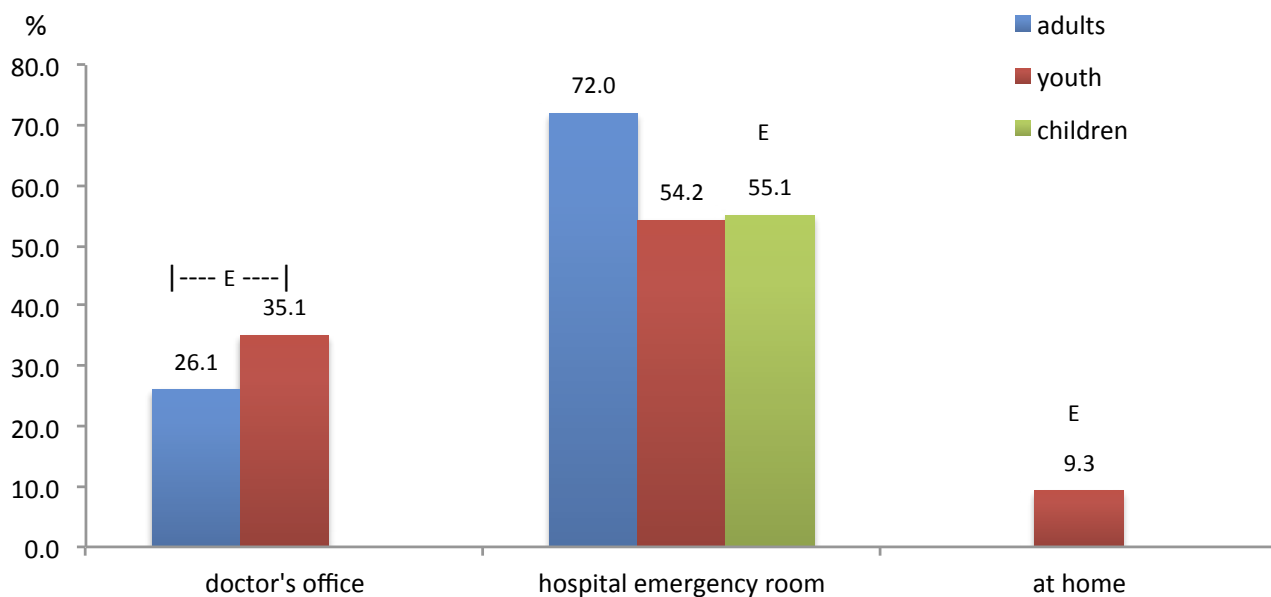


Figure 4.5g – Locations where injuries were treated



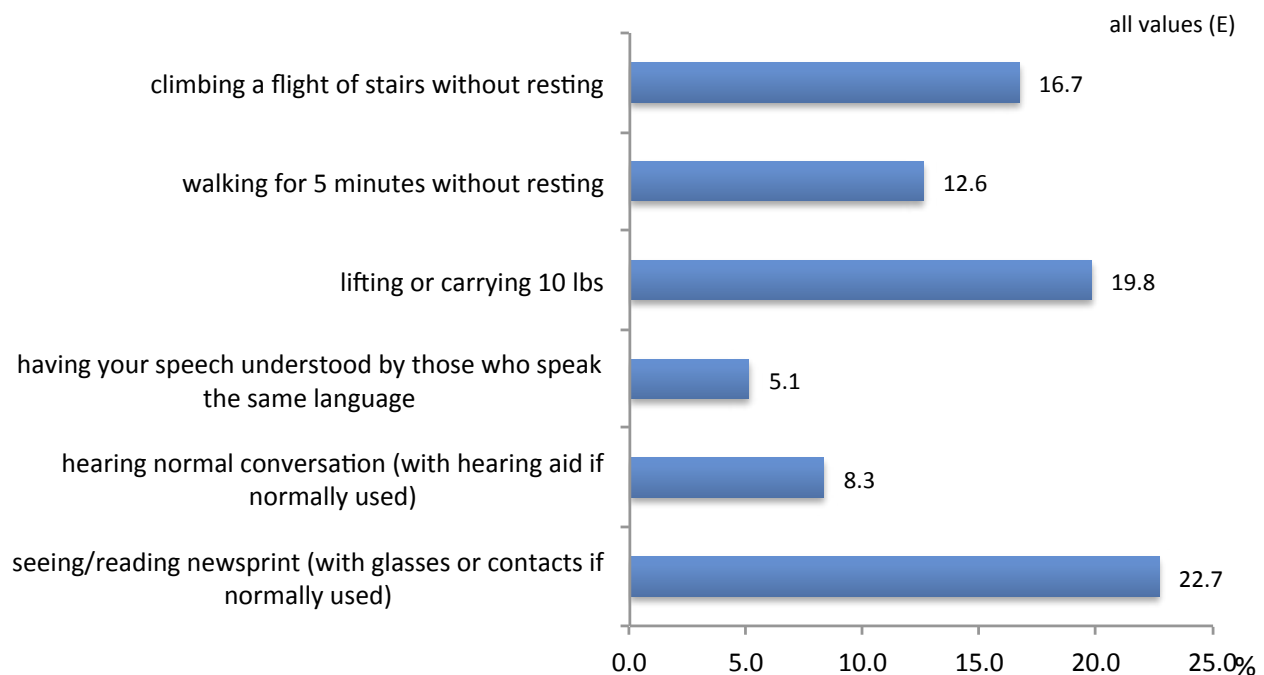


## 4.6 DISABILITIES/QUALITY OF LIFE

### 4.6.1 DISABILITIES

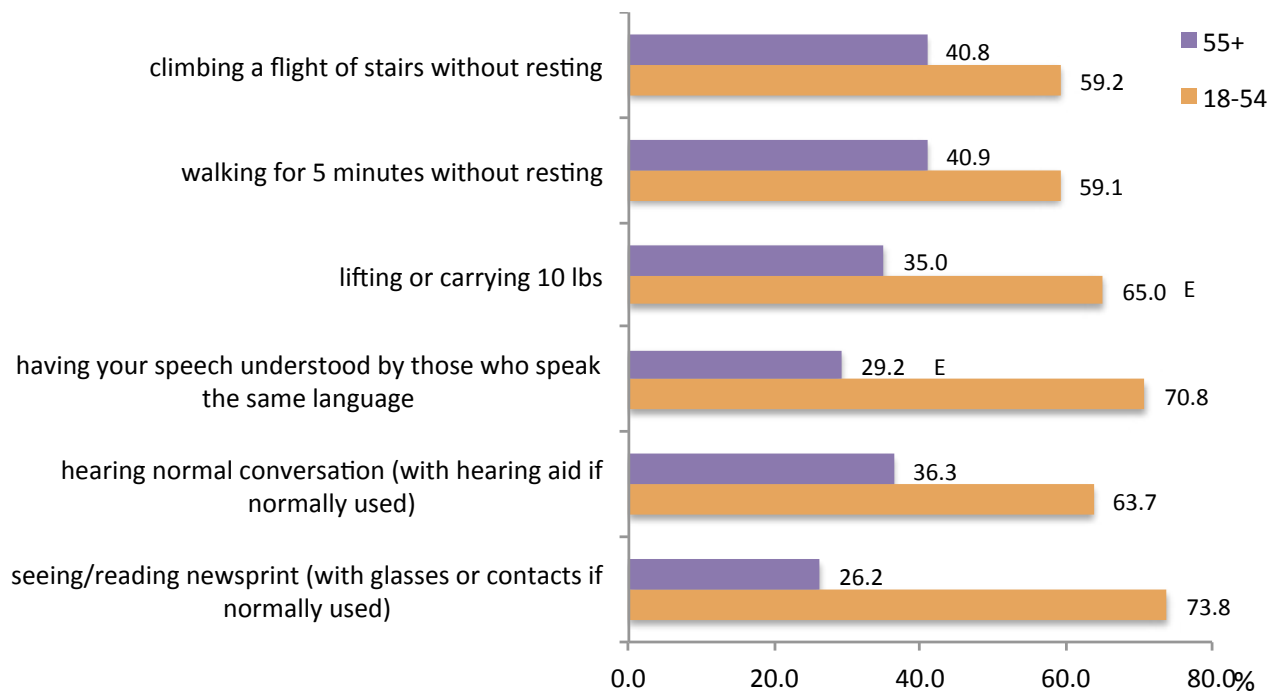
Over one quarter (28.4%) of adults reported that they had a physical or mental health problem that limited the kind or amount of activity they could do at home, work or otherwise. The three most common disabilities were the inability to: see or read newsprint even with glasses or contact lenses (22.7%), lift or carry 10 lbs (19.8%), and climb a flight of stairs without resting (16.7%). The values for the types of limitations fell within the “interpret with caution” range and are shown in the chart below.

Figure 4.6a – Prevalence of adults’ most frequent types of limitations or disabilities



While we might think that these disabilities would be age-related, those 55 and older account for only 30.1% of the adults who indicated a disability. The chart below shows the same categories split up into those 18-54 and those 55+. Those adults below age 55 years account for the majority in all cases.

Figure 4.6b – Prevalence of adults' most frequent types of disabilities – split into 2 age categories (18-54 and 55+)



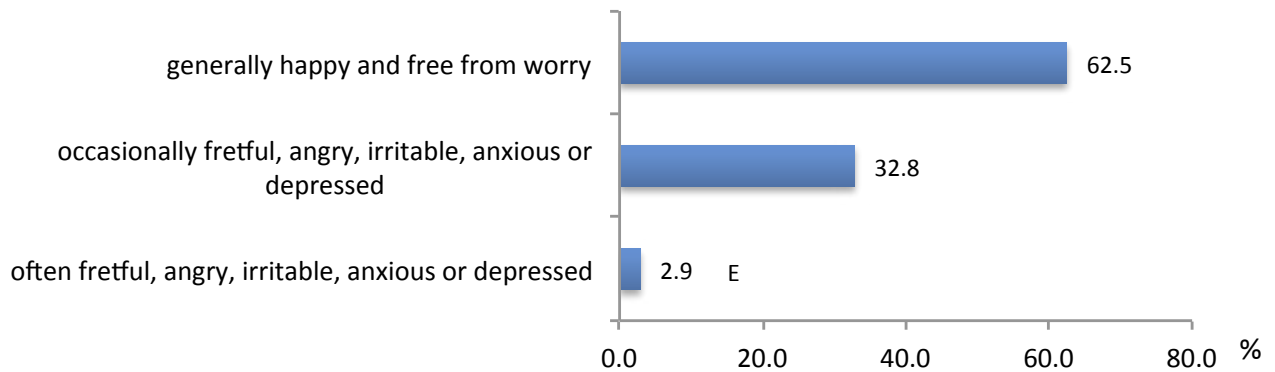
#### 4.6.2 HEALTH UTILITIES INDEX (HUI)

The Health Utilities Index (a series of questions developed by the Health Utilities Group at McMaster University) is “a measure of health-related quality of life”. In answer to this series of questions over half of the adults (51.5%) stated that their near vision was good enough to “read ordinary newsprint” without the help of glasses or contact lenses, and 43.6% thought their near vision was adequate with the help of glasses or contacts. A similar proportion (52.0%) indicated that their far vision was good enough to “recognize a friend on the other side of the street” without the help of glasses or contact lenses. A further 44.8% said their far vision was adequate with the help of glasses or contact lenses.

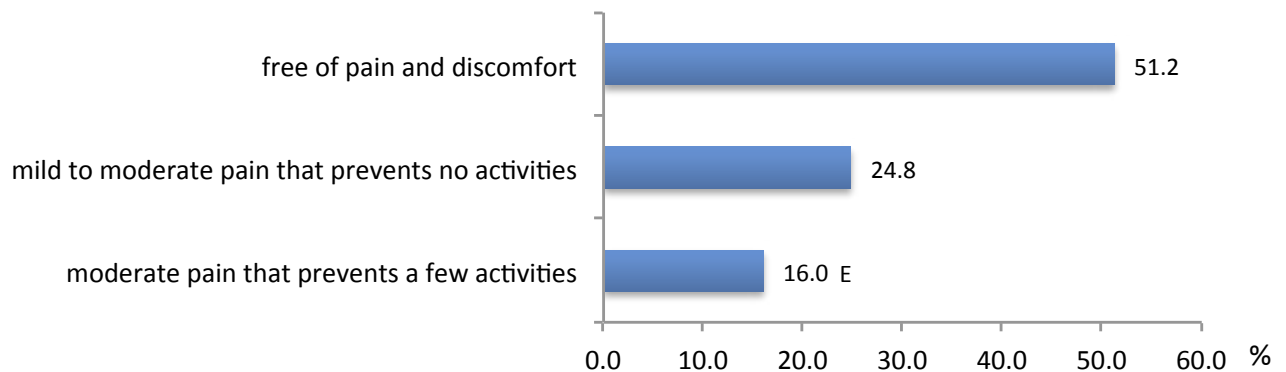
In terms of hearing, the percentage of adults who could hear properly without the help of a hearing aid in a group setting was 91.8% and 94.3% in a one-on-one conversation in a quiet place.

When speaking their own language, a large majority of adults believed that they were understood completely by people who knew them (92.3%) and by people who did not know them (84.6%).

Over 90% of adults usually felt happy and interested in life (64.8%), or somewhat happy (27.3% E). This goes hand-in-hand with their perceived emotional state where 62.5% of adults felt generally happy and free from worry, and 32.8% were occasionally fretful, angry, irritable, anxious or depressed.

Figure 4.6c – **Adults' perceived emotional state**

Just over 50% of adults (51.2%) stated that they were free of pain and discomfort. Pain was mild to moderate and did not prevent activities for 24.8% of adults while pain was moderate and prevented a few activities for 16% (E).

Figure 4.6d – **Adults' level of pain and discomfort**

Most adults had no difficulty in walking around their neighbourhood (92%) and 95.4% had full use of both their hands and all ten of their fingers.

Just over two thirds of adults (66.9%) felt that their memory was good; and 83.7% that they were able to think clearly and solve day-to-day problems.

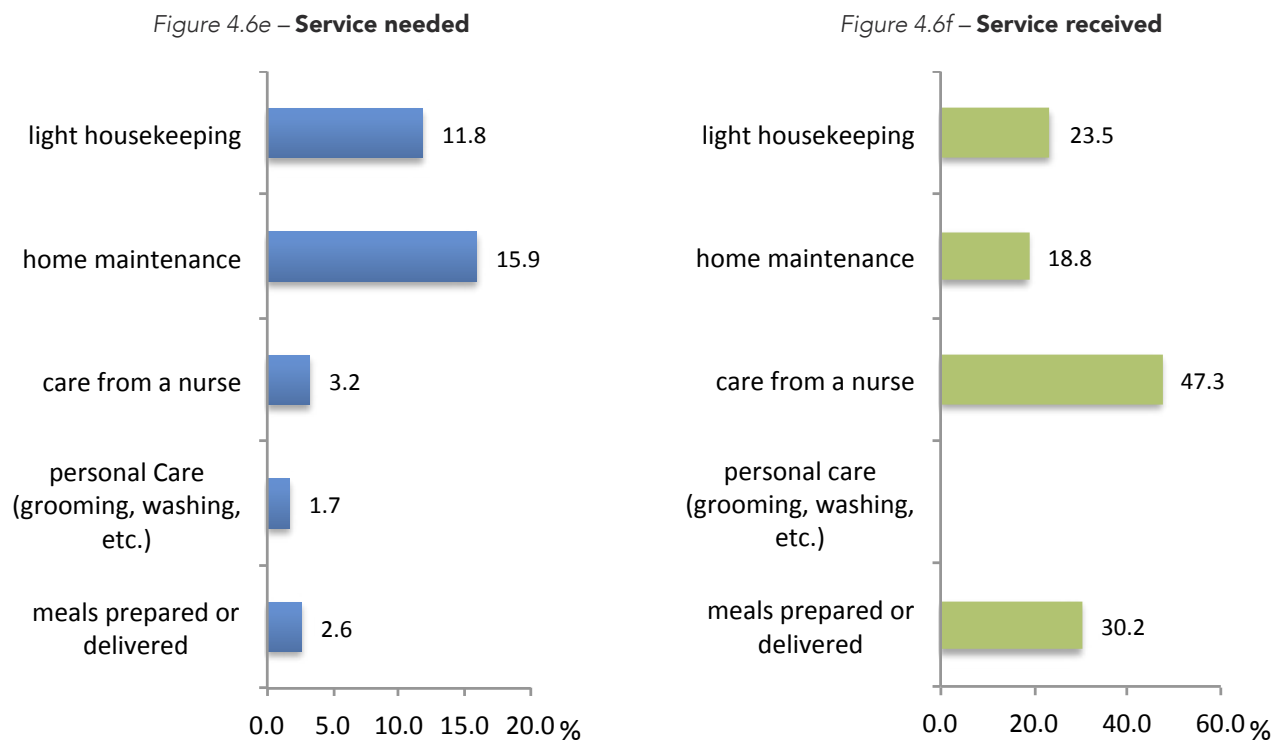
Almost all adults (97.4%) were able to eat, bathe, dress, and use the toilet normally.

### 4.6.3 HOME HEALTH CARE

#### 4.6.3.1 NEEDS

In terms of Home Health Care needs, 11.8% (E) of adults felt that they needed help with light housekeeping and 15.9% with home maintenance because of their physical condition or health problems. Of these individuals only 23.5% actually received housekeeping services and even less (18.8%) received home maintenance services.

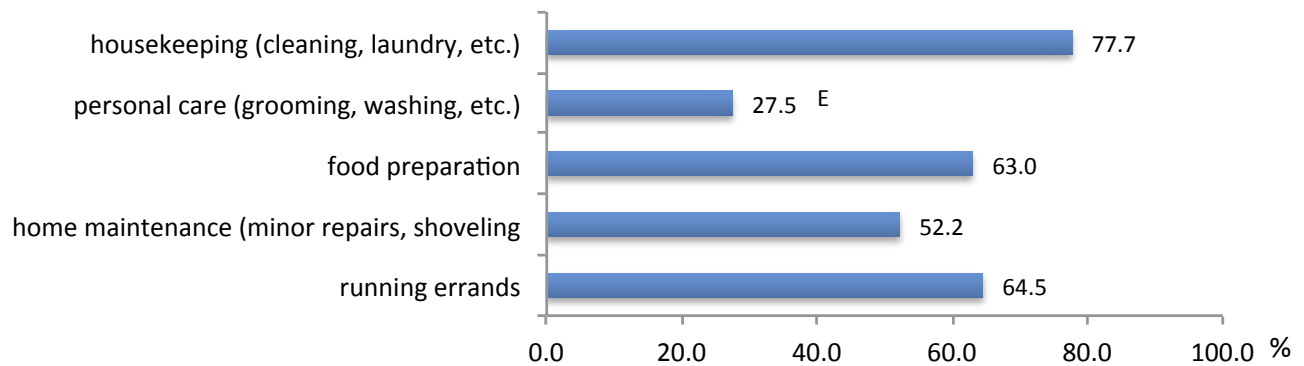
Figures 4.6e and 4.6f - Home Health Care needs and whether services are received - all values (E)



#### 4.6.3.2 PROVISION

About 23% of adults stated that they helped a family member or a friend with home care because of their chronic condition or disability. The type of help most often provided was housekeeping, running errands, food preparation, and home maintenance. Almost two thirds (61.6%) of those who helped someone with home care spent an average of 1 to 10 hours a week helping.

Figure 4.6g – Types of home care provided for family members or friends due to a chronic condition or disability



Twelve point eight percent of adults had an immediate family member who had been placed in a long-term care facility located outside of their community. Almost one quarter (24%) were placed in long-term care at the age or 80 years or older (E). We were unable to determine the actual reasons for placement due to a low response rate (94.2% did not provide a reason for why their family member is in the long-term care facility).

## 4.7 HEALTH CARE UTILIZATION

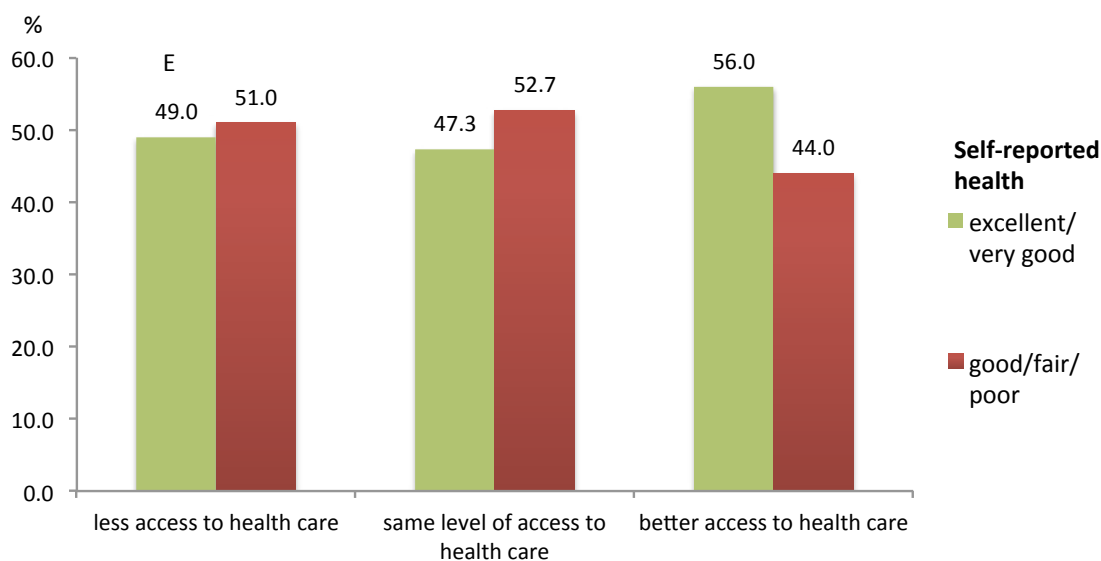
### 4.7.1 ACCESS TO HEALTH CARE - ADULTS

Adults were asked whether they use traditional medicines. Just under half (48%) said that they do. The vast majority (85.9%) stated that they have no difficulties in accessing these medicines. Of the 14.1% who did experience some difficulty, the major concerns were that they did not know where to get them (5.0% E) or that it was too far to travel to get access to the medicines (4.6% E).

Adults were asked to rate the level of access to health services available to them compared to Canadians generally. A total of 56.4% of adults believed that they had access to the same level of health care as Canadians in general; 31.2% that they had less access, and 12.5% that they had better access to health care than Canadians in general.

Adults who rated their health as "Good/Fair/Poor" were slightly more likely to state that they had the same level of access to services (52.7%) as all Canadians. Those who rated their health as "Excellent/Very Good" felt that they had better access than Canadians in general (56%) and those who felt the level of access was less were split almost evenly (51.0% vs. 49.0%).

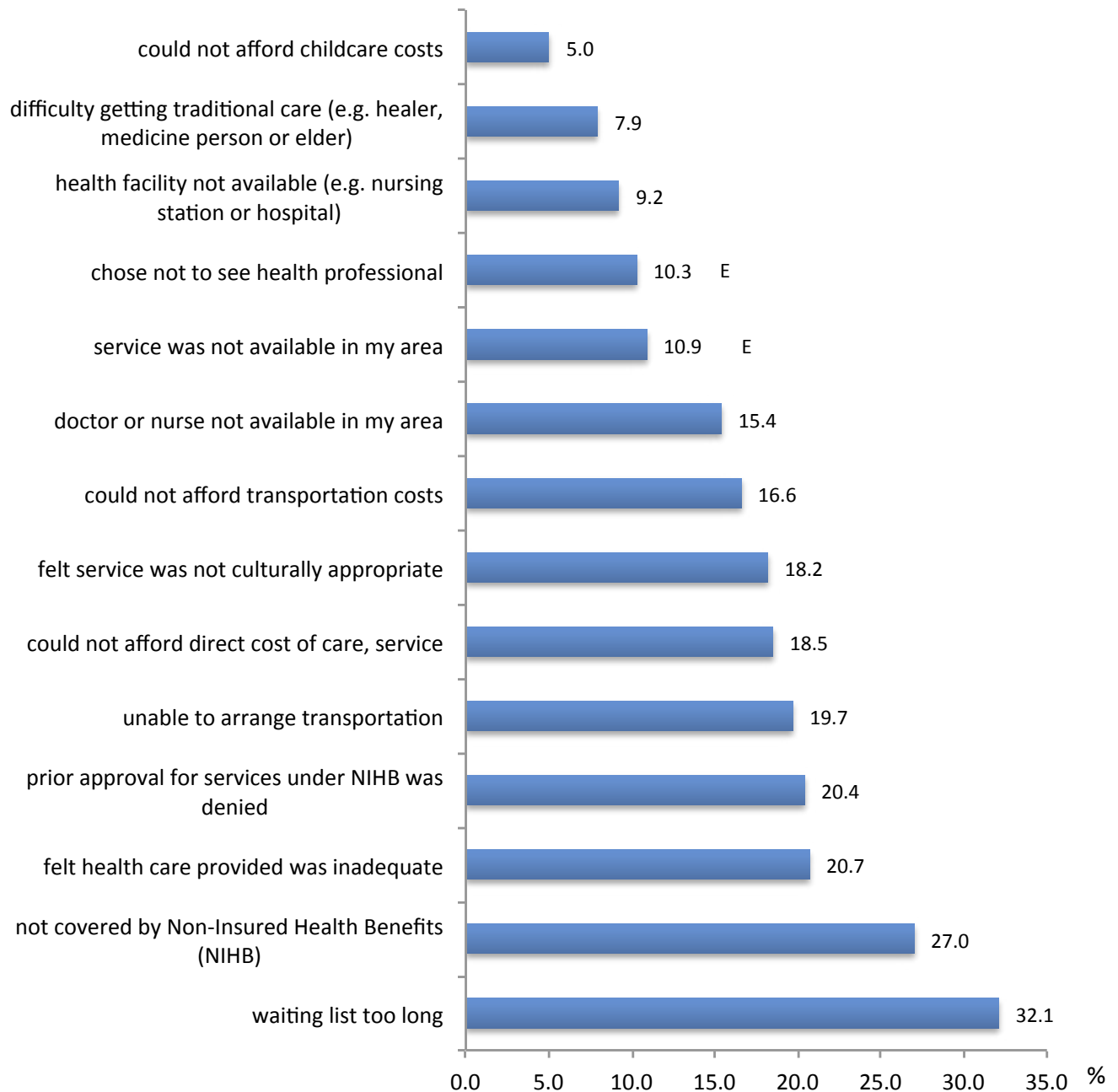
Figure 4.7a – Level of access to health care (as compared to Canadians generally) in relation to self-reported health



The top 4 (20% or higher) barriers to health care were: long waiting lists (32.1%), services not covered by Non-Insured Health Benefits (27.0%), felt that health care provided was inadequate (20.7%) and prior approval for services under NIHB was denied (20.4%).



Figure 4.7b – Barriers to health care access – adults only



Sixty percent (60%) of adults stated that they have no difficulties accessing NIHB services. Of those who did have difficulties, medication was the most often quoted at 19.0%, dental care difficulties at 16.8%, and vision care at 8.6% (E). All other difficulties accessing NIHB services had a lower than 5% response rate.

## 4.7.2 PREVENTATIVE HEALTH CARE - ADULTS

In the year prior to the RHS, 30.8% of adults had consulted a traditional healer while 42.2% had never consulted one.

In terms of Western medicine, 66.7% of the adults had their blood pressure checked, 55.9% had a vision or eye exam, 51.8% had their blood sugar checked, 39.8% had a complete physical examination, and 35.8% had their cholesterol tested.

A total of 57.7% of the adult women stated that they perform breast self-examinations (25.4% do it once a month), 38.8% of them have had at least one mammogram in their lives, and 91.9% have had at least one Pap smear in their lives. The majority of women (73.9%) had their last Pap smear within the last 3 years prior to the survey.

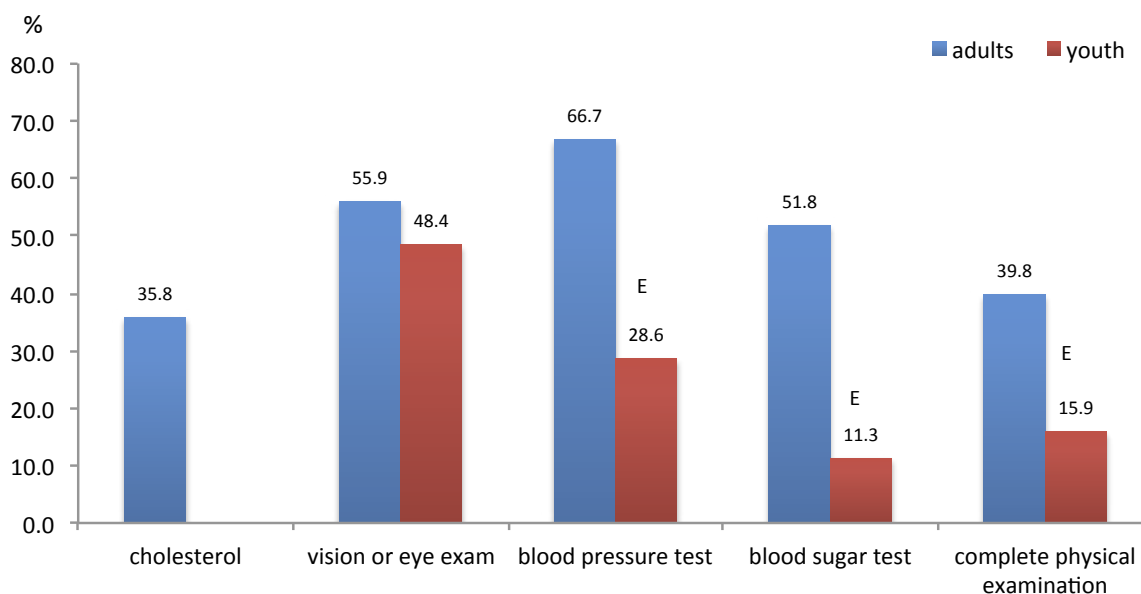
## 4.7.3 ACCESS TO HEALTH CARE – YOUTH

Over one quarter of youth (26.1%) remember having consulted a traditional healer at some point in their lives while 54.7% had never consulted one.

Alternatively, 63.3% had visited a doctor or community health nurse within the 12 months preceding the survey. Most youth (72.5%) have never accessed counselling, psychological testing or other mental health services in their lifetime.

About half of the youth (48.4%) have had an eye/vision exam in their life; 28.6% (E) had their blood pressure tested, 11.3% had their blood sugar tested, and 15.9% (E) had a complete physical examination.

Figure 4.7c – Health tests or examinations for adults and youth

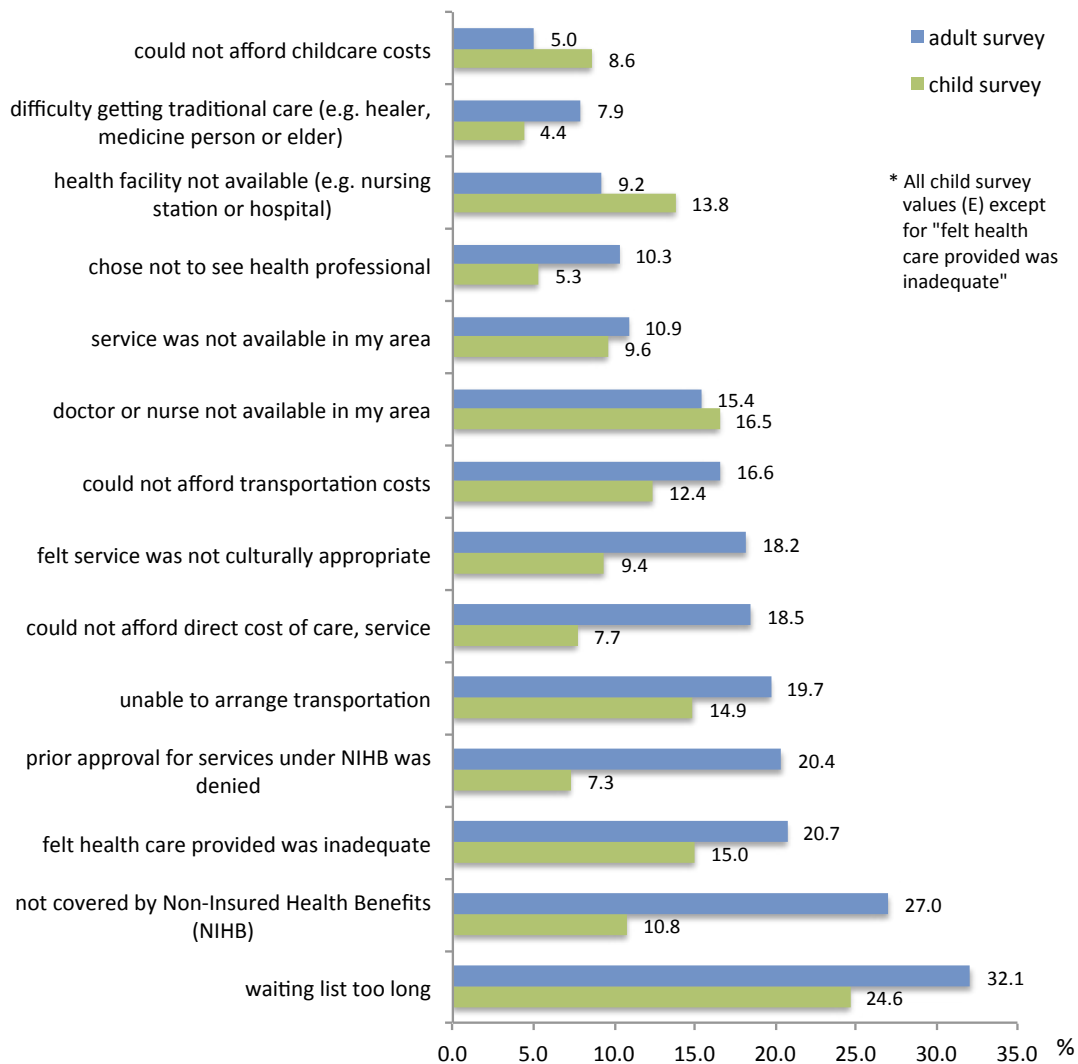


Of the female youth, 91.0% stated that they had never had a PAP smear in their life; and 19.7% that they had received the HPV vaccine.

#### 4.7.4 ACCESS TO HEALTH CARE

As with the adult survey the parents/guardians stated that the largest barrier to health care was the long waiting lists (24.6% E). The other top two (15% or more) reasons were that doctors or nurses were not available in their areas (16.5% E), and the feeling that the health care provided was inadequate (15% E). A comparison chart of the adult and children surveys outlines the similarities and differences.

Figure 4.7d – Barriers to health care access – adult survey compared to parents/guardians from children's survey



A total of 94.0% of the children had received their routine vaccinations/immunizations. For those who did not, the most common reason was that the parents forgot/failed to remember (E). The Coefficient of Variation for all other response options was over 0.33 and therefore the values had to be suppressed (F).

## 4.8 TRADITIONAL HEALER AND TRADITIONAL MEDICINE

Adults were asked when they had last consulted a traditional healer. More than one third (42.2%) of adults had never consulted one, 30.8% had done so during the 12 months preceding the survey and the remainder had done so more than a year ago or couldn't remember.

Less than half of the adults (48.0%) use traditional medicine. While most (85.9%) had no difficulty accessing traditional medicine a small percentage said that they did not know where to get these medicines (5.0% E) or it was too far to travel (4.6% E).

## 4.9 DENTAL CARE

### 4.9.1 DENTAL CARE - ADULTS

Only 52.5% of adults had received any dental care in the year prior to the interview. Most adults (90.3%) still had at least 1 of their own permanent adult teeth, and 26.8% wore full or partial dentures, false teeth, bridges or dental plates to replace missing permanent teeth.

When asked why they did not access dental care, the most common reasons (15% or over) were related to cost: services not covered by NIHB (25.9%), prior approval for services under NIHB was denied (23.4%), direct cost of dental care (17.0% E). The length of the waiting list was also mentioned by 20.6% of adults, as was the inadequacy of services (18.4% E).

Only 19.5% of adults stated that they did not need any dental care. The most needed services were maintenance (check-up and cleaning) (53.2% of adults) and cavities filled or other restorative work (42.9%).

### 4.9.2 DENTAL CARE - YOUTH

More youth (77.5%) had received dental care in the year prior to the interview than adults. Just over one quarter (26.9% E) had experienced problems with their teeth or dental pain in the month preceding the survey.

The dental care needs of youth were similar to those of adults. Only 25.0% of youth stated that they did not need any dental care. The most needed services were maintenance (check-up and cleaning) (60.0%) and cavities filled or other restorative work (41.1%).

### 4.9.3 DENTAL CARE - CHILDREN

About two thirds (65.7%) of children had received dental care in the year prior to the interview.

The dental care needs of children were similar to those of both adults and youth. Only 34.0% of caregivers stated that the child did not need any dental care. The most needed services were maintenance (check-up and cleaning) (61.2%) and cavities filled or other restorative work (31.5%).

Caregivers were also asked about issues relating to breast-feeding vs. being fed with a bottle.

Almost two thirds (65.3%) of children had been breast-fed for anywhere from 1 to 60 months with the average age of weaning at just over 8 ½ months.

Most children (89.6%) had been bottle-fed at some point. Almost one third (30.8%) of children had teeth that had been affected by Baby Bottle Tooth Decay. Of these children 77.8% had received treatment.

Caregivers listed the contents of the baby bottle with the most popular being: milk (64.4%), iron fortified formula (62.2%), water (57.3%), 100% fruit juices (46.9%), and regular formula (35.6%).









A black and white photograph of a Native American powwow. In the foreground, several folding chairs are visible, some with hats resting on them. In the background, a large group of people, mostly women, are dressed in traditional regalia, including feathered headdresses and beaded dresses. They are standing in a line, possibly performing a dance. The scene is outdoors, with a large, dark, curved structure, possibly a roof or a large tent, visible in the background. A large, solid red diagonal shape overlays the right side of the image, extending from the top right corner towards the bottom left.

# Chapter 05:

## **RELATIONSHIPS – PERSONAL AND COMMUNITY WELLNESS AND CULTURE**

## 5.1 MENTAL HEALTH, PERSONAL WELLNESS AND SUPPORT AMONG FIRST NATIONS

### 5.1.1 PERSONAL SAFETY - ADULTS

About 32.2% of adults said that they experienced physical aggression, and 52.2% verbal aggression in the past 12 months. Only 25.9% of those who experienced aggression actually sought help to deal with it.

### 5.1.2 PERSONAL WELLNESS - ADULTS

Over 80% of adults believed that traditional spirituality was either very important (54.7%) or somewhat important (30.6%) in their lives. Religion was also very important (33.8%) or somewhat important (35.2%) for most adults.

About 70% of all adults felt in balance either all the time or most of the time in the four aspects of their lives: physical, emotional, mental, and spiritual.


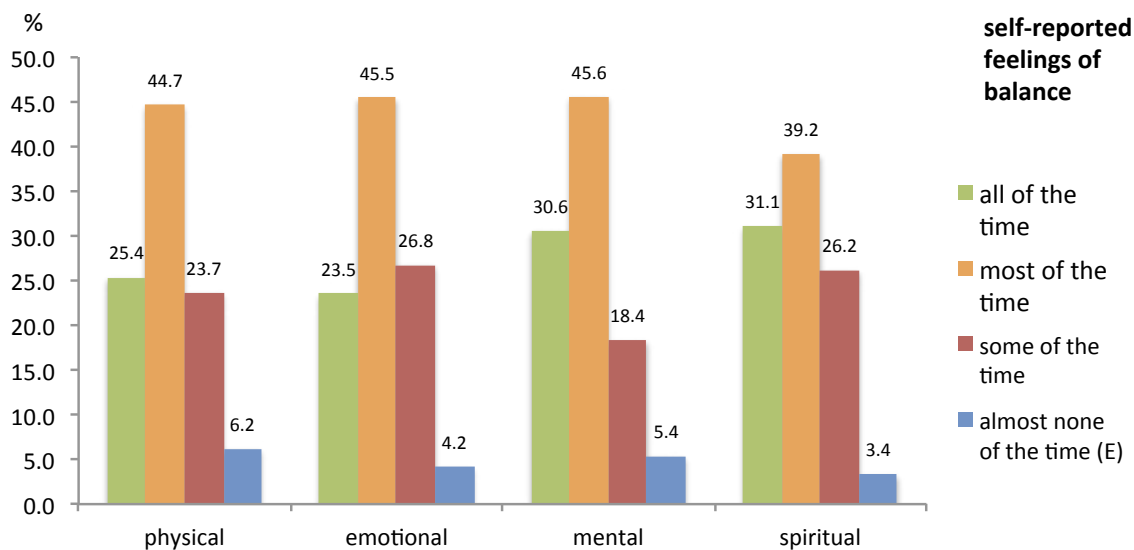


Figure 5.1a – Adults' perception of feeling in physical, emotional, mental and, spiritual balance



Despite the fact that 43.6% of adults stated that they had personally experienced instances of racism in the past 12 months, over two thirds (66.5%) of them felt that racism had little to no effect on their level of self-esteem.

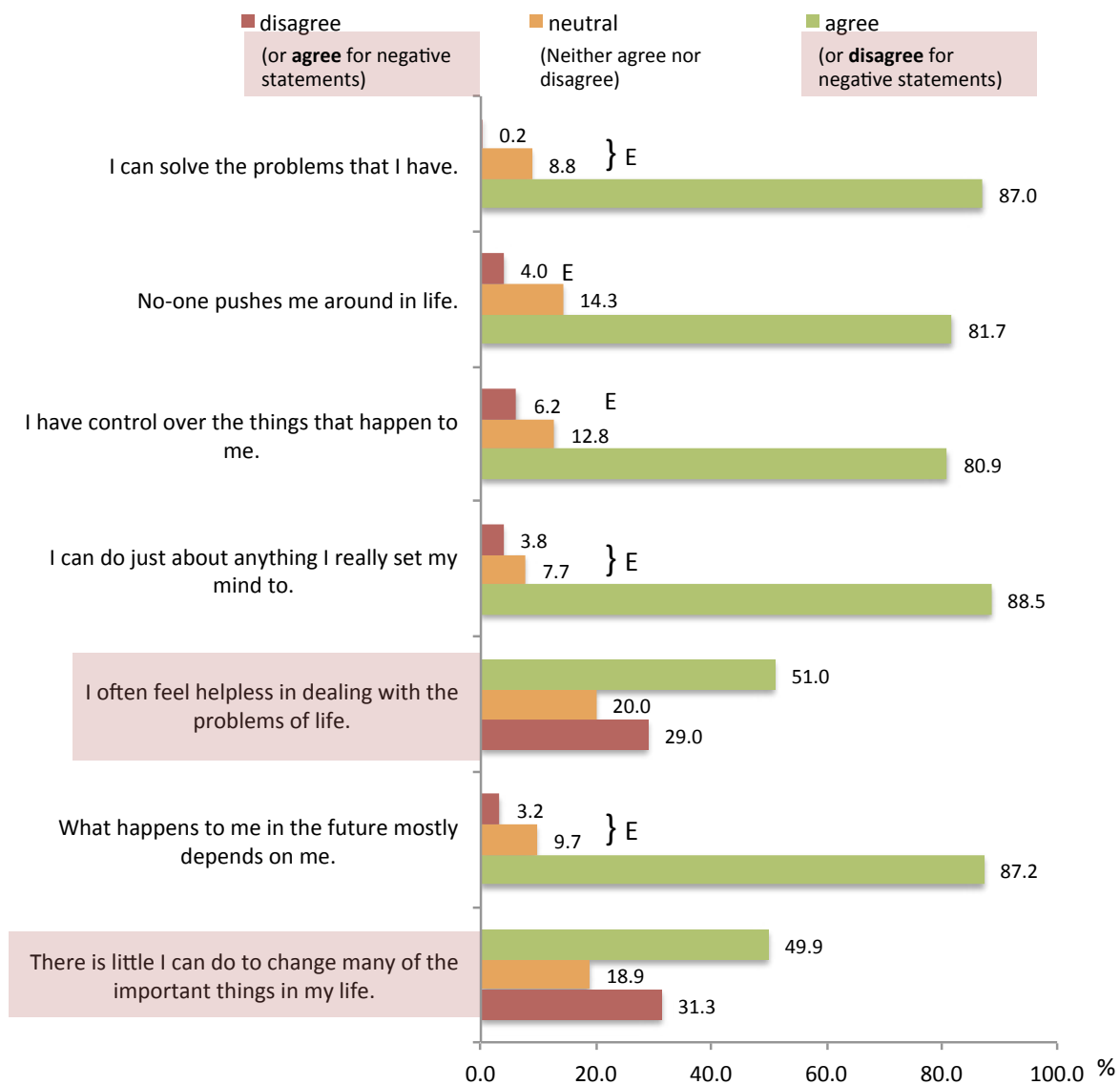
About 80% of the adults feel they are in control over their lives: i.e. either agree or strongly agree with the positive, empowering statements:

- "I can solve the problems that I have." (87.0%)
- "No-one pushes me around in life." (81.7%)
- "I have control over the things that happen to me." (80.9%)
- "I can do just about anything I set my mind to." (88.6%)
- "What happens to me in the future mostly depends on me." (87.2%)

Alternatively, the more negative, fatalistic statements:

- "I often feel helpless in dealing with the problems of life." (only 51.0% disagreed to some level)
- "There is little I can do to change many of the important things in my life." (only 49.9% disagreement) had a lower level of disagreement than what would be expected from the high positive response to the empowering statements.

Figure 5.1b – How strongly do you agree or disagree with: (the following statements)

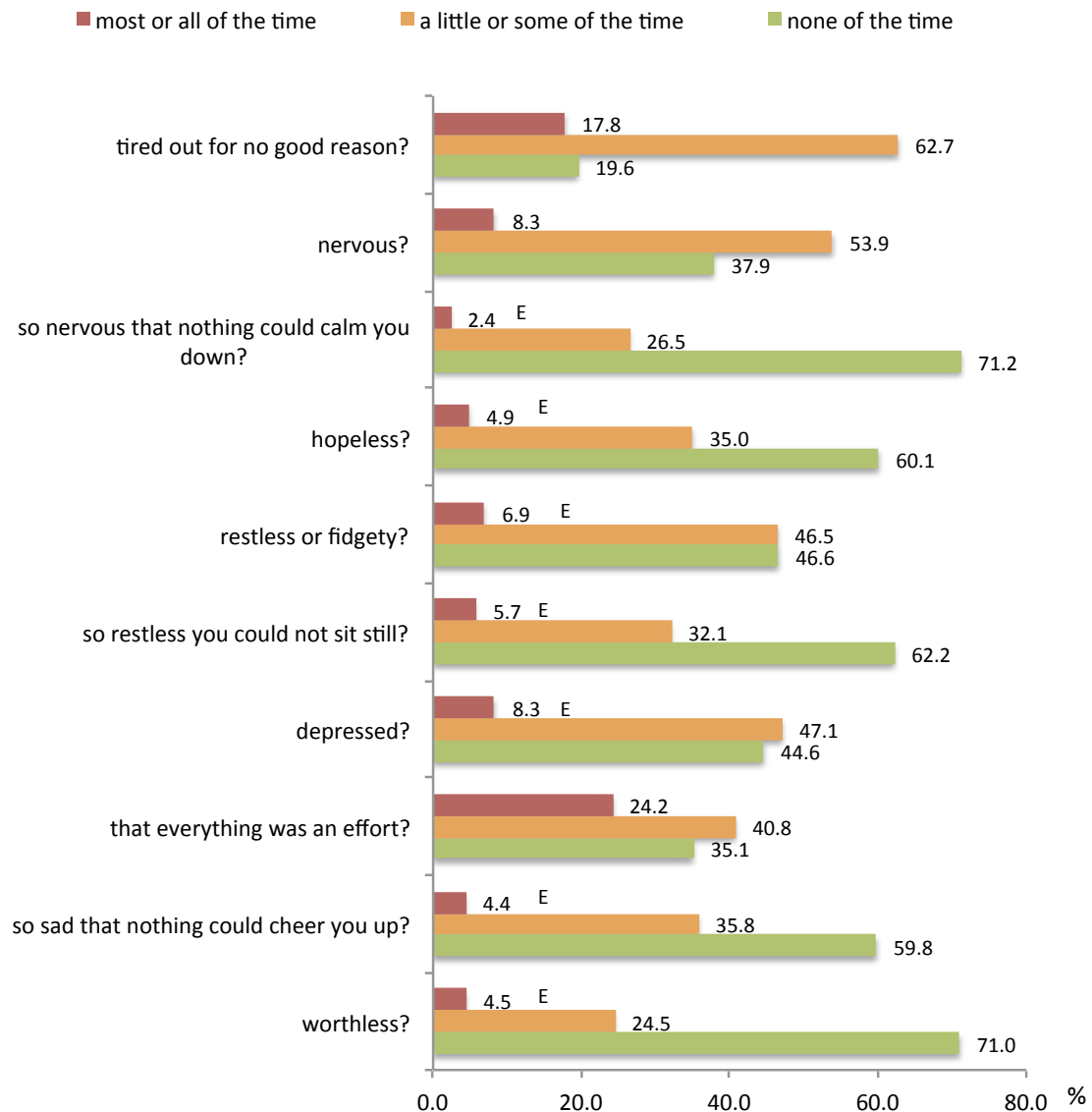


When asked to whom they turn when emotional or mental health supports are needed, the 3 most common responses were: immediate family members (61.4%), friends (61.1%), and other family members (49.2%). Family doctors (35.7%) and traditional healers (27.3%) were the most common external supports mentioned. All other supports were at a response rate of about 15% or less.

### 5.1.3 DEPRESSION - ADULTS

When asked about symptoms of depression in the month before the survey, up to 24% of adults stated that they had those symptoms either all or most of the time (depending on the question).

Figure 5.1c – In the past month how often did you feel:



### 5.1.4 SUICIDE - ADULTS

When asked about suicide 13.1% (E) of adults knew of a close friend or family member who had committed suicide in the 12 months preceding the survey.

When asked about their thoughts on suicide almost one quarter (22.1%) of adults had, at some point in their lives, thought about committing suicide. Most adults (84.8%) had not thought of this in the year preceding the survey.

Most adults who had thought of committing suicide did so either when already an adult (42.2%) or as an adolescent (53.6%). Overall, there were 14.4% of adults who had attempted suicide at some point in their lives; about half (52.1%) as an adult and about half (54.5%) as an adolescent. Based on the preceding two percentages a small number of adults had made multiple attempts.

More in-depth analyses show that of those adults who had thought about committing suicide, 55.0% had made an attempt. Any further breakdowns were not possible due to increasingly smaller sample sizes.

Figures 5.1d and 5.1e – Suicidal ideation and suicide attempts

Figure 5.1d – Thoughts of committing suicide

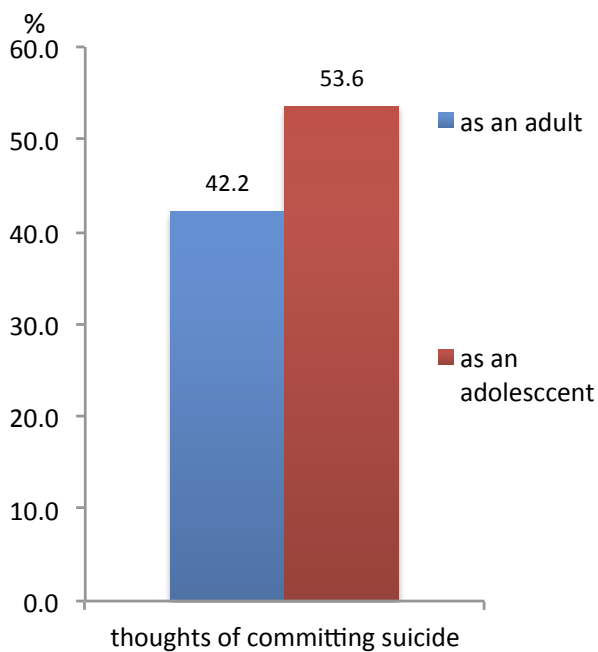
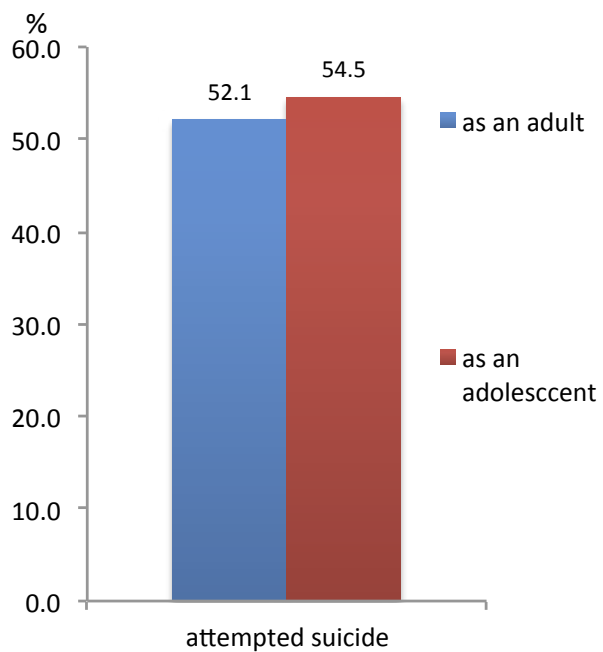


Figure 5.1e – Attempted suicide

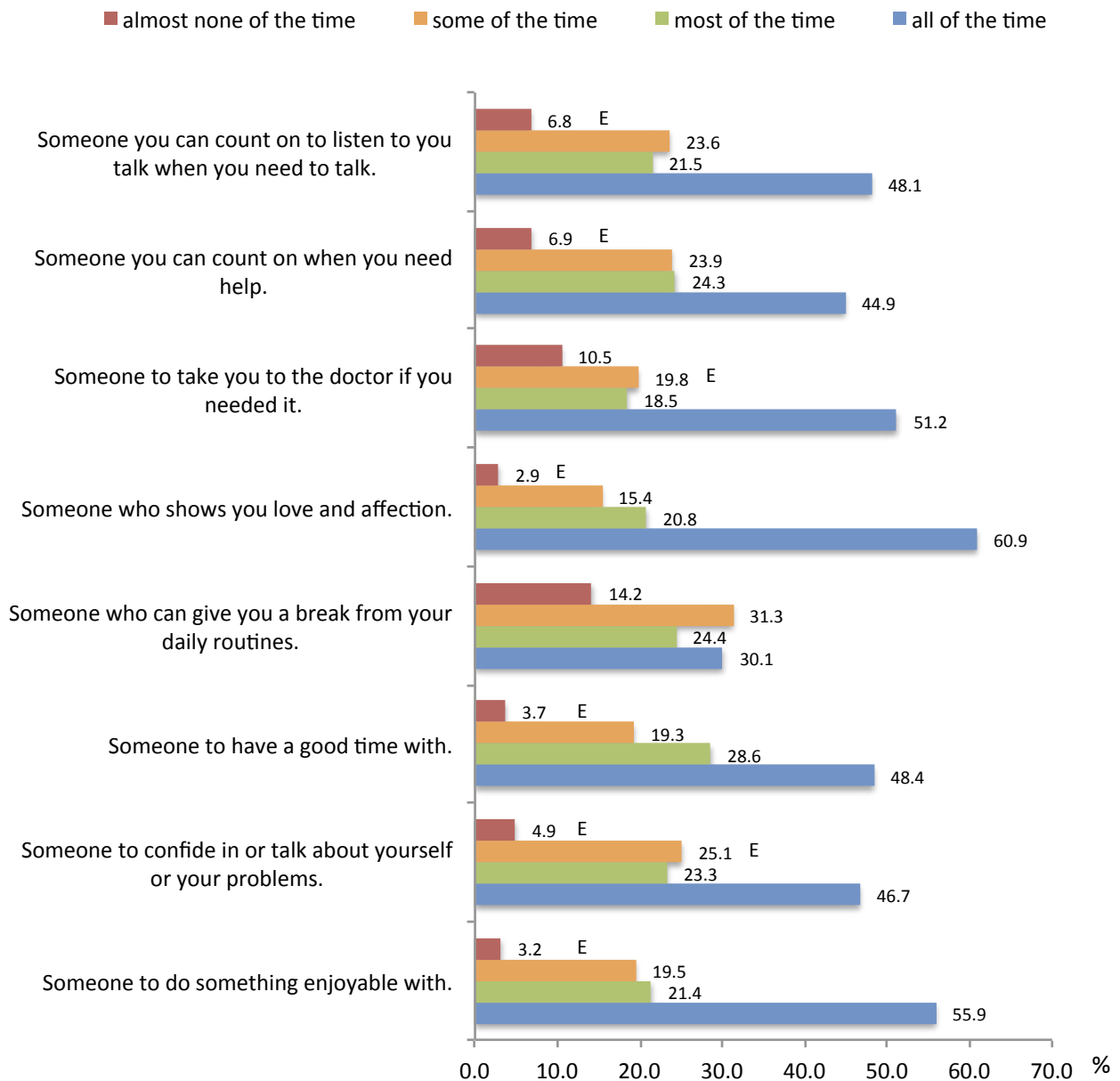




### 5.1.5 MENTAL HEALTH AND EMOTIONAL SUPPORTS - ADULTS

A good proportion of adults believed that mental and emotional supports would be available to them when they would need them.

Figure 5.1f – Available Support



## 5.2.1 PERSONAL WELLNESS - YOUTH

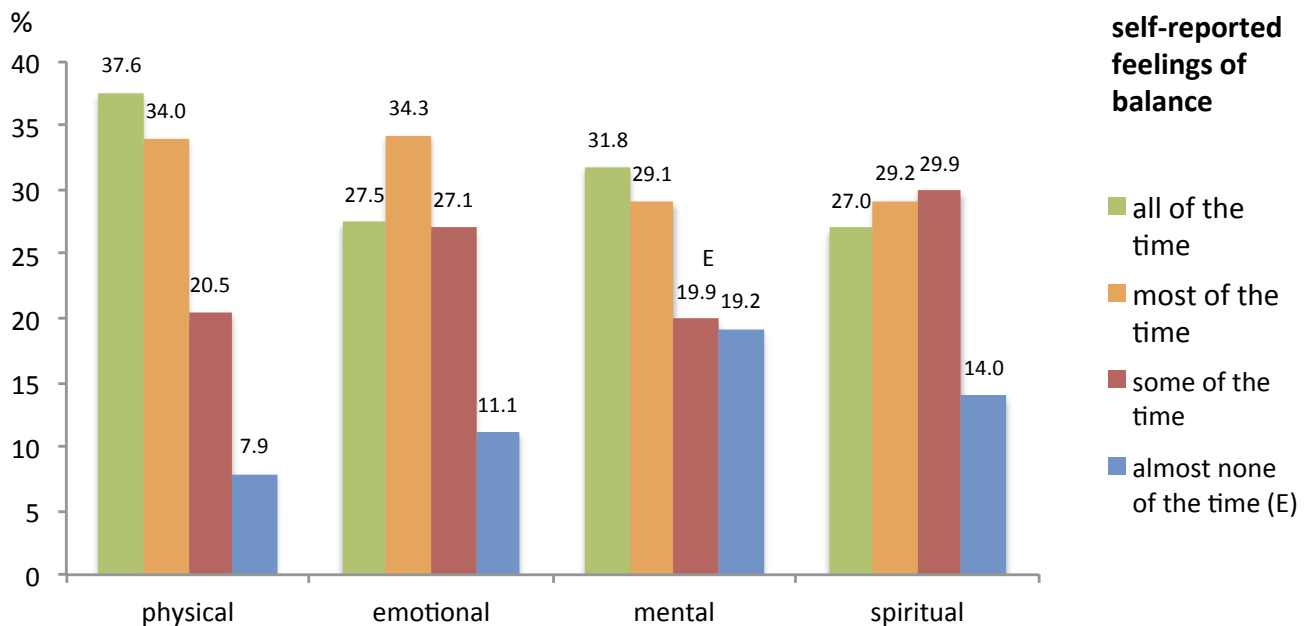
### 5.2.1.1 ACTIVITIES/OUTSIDE INTERESTS - YOUTH

Approximately 30% of youth participated in activities outside of school hours (even if it was less than once per week). Sports activities were the most popular, as indicated below:

- Take part in sports teams or lessons (61.2%)
- Take part in art or music groups or lessons (30.2%)
- Take part in traditional singing, drumming, or dancing groups or lessons (28.7%)
- Have a job such as baby-sitting, working at a store, tutoring (45.0%)

As with the adults, most youth (71.6%) felt in balance either all the time or most of the time in the physical aspect of their lives. A smaller percentage felt in balance either all the time or most of the time in the other 3 aspects: emotional (61.8%), mental (60.9%), and spiritual (56.2%)

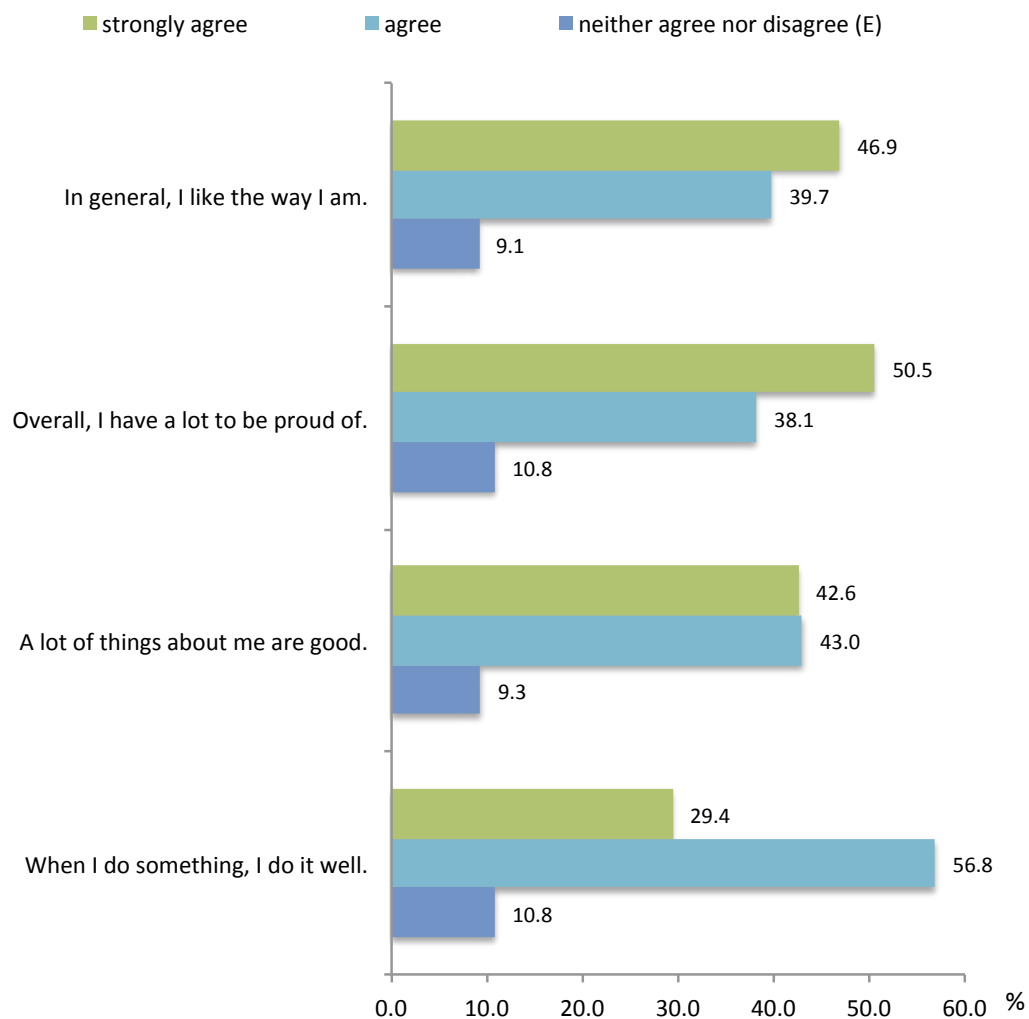
Figure 5.2a – Youth's perception of feeling in physical, emotional, mental, and spiritual balance



### 5.2.1.2 SELF-IMAGE - YOUTH

Over 80% of youth had a positive self-image and either strongly agreed or agreed that they liked the way they were; that they had a lot to be proud of; that a lot of things about them were good; and that they were doing things well. So few disagreed or strongly disagreed that the Coefficients of Variation were over 0.33 (the suppression cut-off), therefore only the "Strongly Agree", "Agree" and "Neither Agree nor Disagree" categories are shown in the following chart.

Figure 5.2b – Youth's perceived self-image



### 5.2.1.3 FEELINGS & EMOTIONS - YOUTH

When asked about their feelings, 52.3% of youth did not feel lonely at all, 85.4% felt loved either "A lot" or "Quite a bit" and 38.6% did not feel at all stressed.

Figure 5.2c – Do you feel loved?

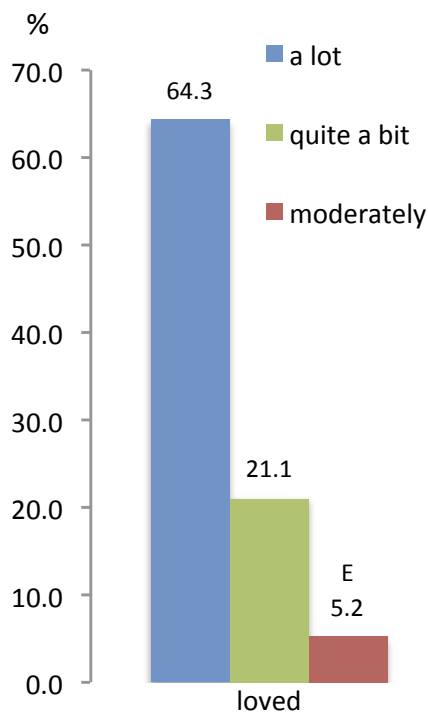


Figure 5.2d – Do you feel lonely?

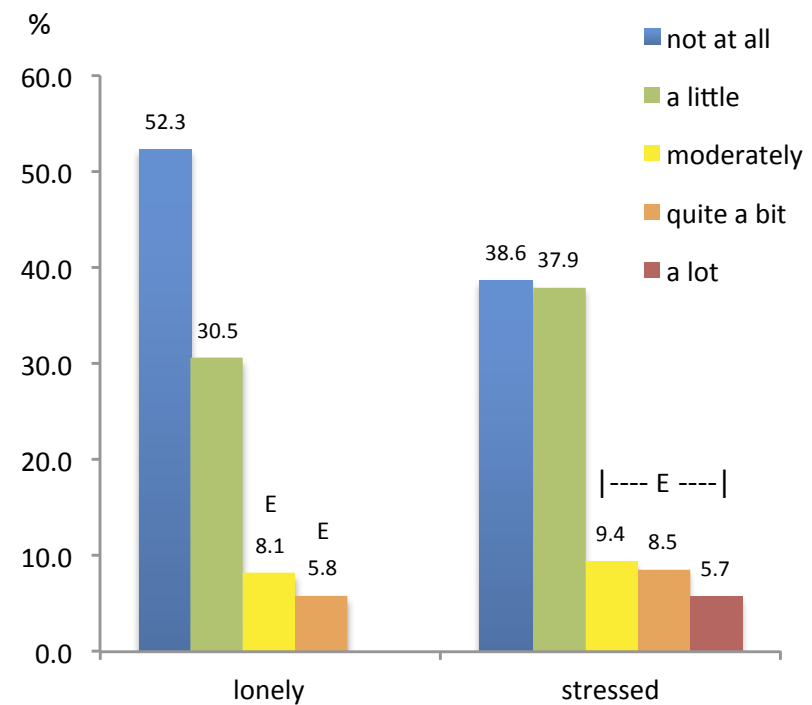


Figure 5.2e – Do you feel stressed?

As with adults, roughly 80% of youth feel they are in control over their lives: i.e. either agree or strongly agree with the positive, empowering statements:

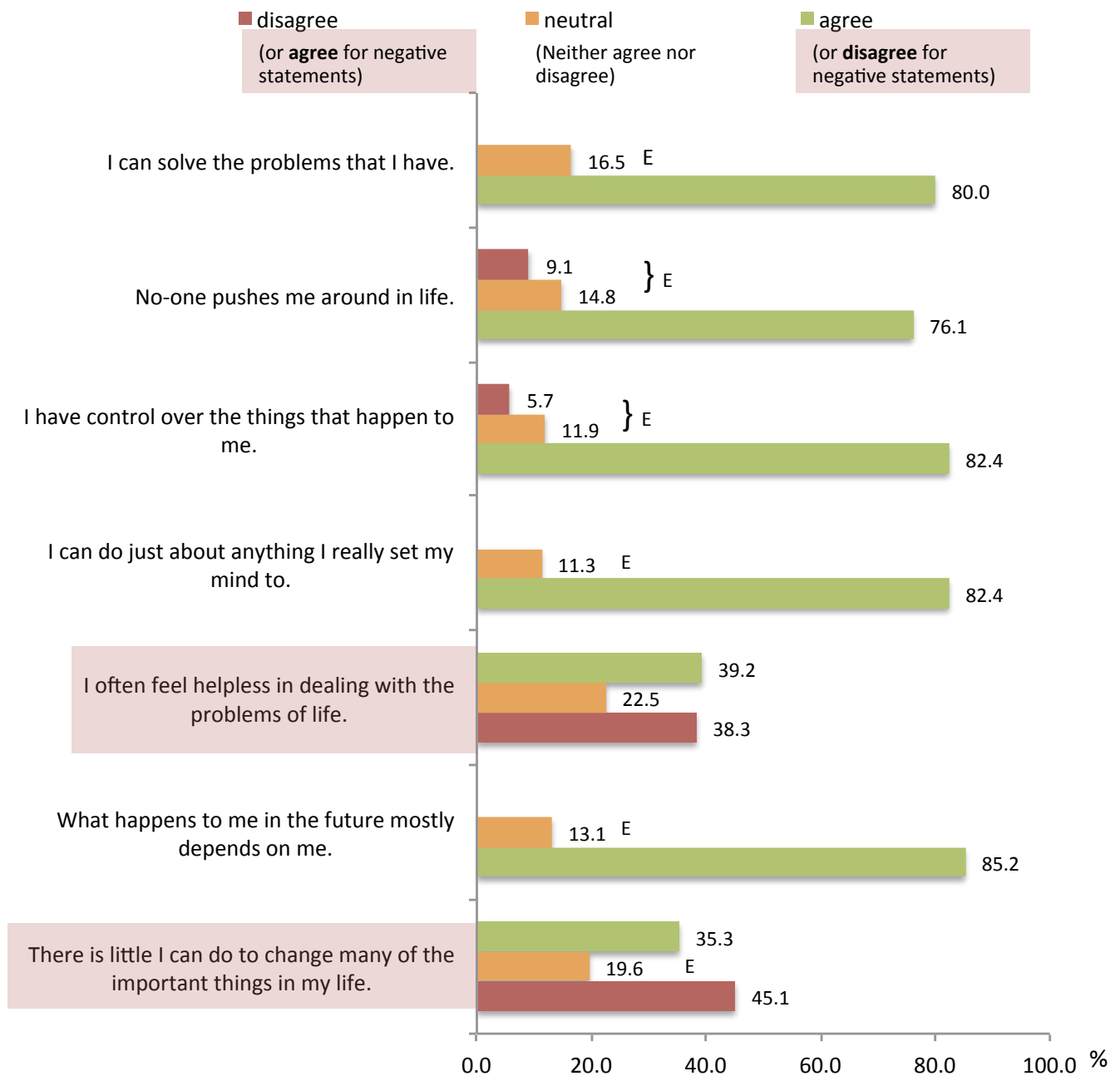
- I can solve the problems that I have (80.0%)
- No-one pushes me around in life (76.1%)
- I have control over the things that happen to me (82.4%)
- I can do just about anything I set my mind to (82.4%)
- What happens to me in the future mostly depends on me (85.2%)

Again, as with adults, the more negative, fatalistic statements:

- I often feel helpless in dealing with the problems of life (only 39.2% disagreed to some level)
- There is little I can do to change many of the important things in my life (only 35.3% disagreement)

had a lower level of disagreement than what would be expected from the high positive response to the empowering statements. As a matter of fact, the level of disagreement was even lower than that found in the adult survey

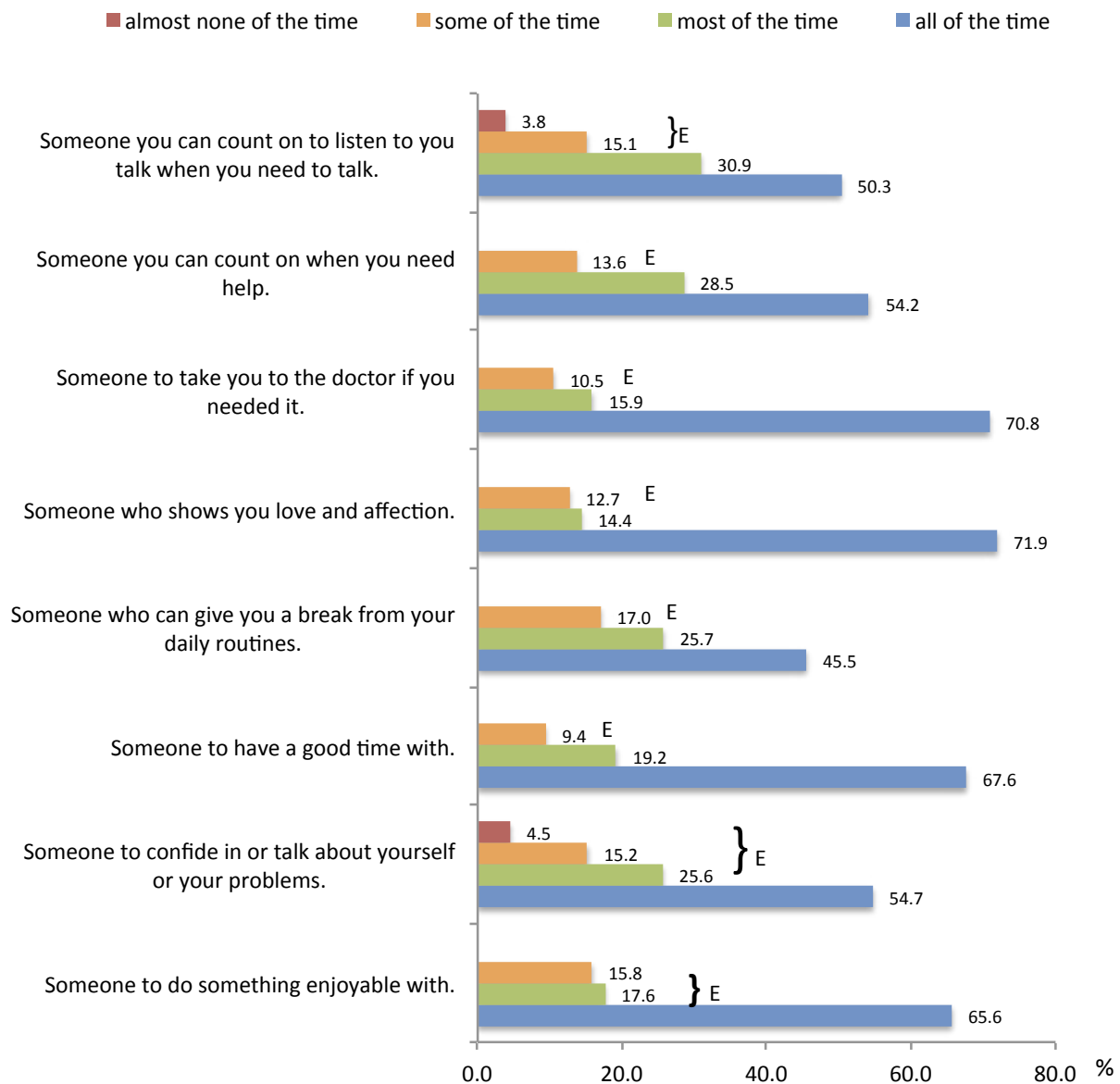
Figure 5.2f – How strongly do you agree or disagree with: (the following statements)



### 5.2.1.4 MENTAL HEALTH AND EMOTIONAL SUPPORTS - YOUTH

Even more so than adults, a good proportion of youth (roughly 80%) believe that they have access to supports all or most of the time, if needed.

Figure 5.2g – Available support



When asked to whom they would turn first for various problems, parent/guardian was the most common support mentioned for:

- Family problems (48.7%)
- Financial problems (71.7%)
- Drugs or alcohol (51.7%)
- Anger or feeling out of control (49.6%)
- Depression (51.1%)
- Problems with friends (50.7%)
- Sexual or physical assault (66.4%)
- STDs (48.8%)
- Birth control (58.0%)
- Pregnancy (60.3%)

with “Friends my age” being the second most favoured response (except for with financial problems).

“Friends my age” are, however, the first ones youth would go to for help with relationship problems regarding a boyfriend or girlfriend (44.5%).

A surprising number of youth said that they would go to no-one for:

- Relationships with a boyfriend or girlfriend (16.3% E)
- Financial problems (16.1% E)
- Drugs or alcohol (10.1% E)
- Anger or feeling out of control (8.3% E)
- Depression (8.2% E)
- Problems with friends (9.0% E)
- Sexual or physical assault (11.5% E)
- STDs (11.0% E)
- Birth control (9.7% E)
- Pregnancy (9.0% E)

### 5.2.1.5 BULLYING AND FEELINGS OF DEPRESSION - YOUTH

Data showed that 14.7% of youth felt that they were currently being bullied, and 27.2% responded that they have had a time during the past 12 months when they felt sad, blue or depressed for 2 weeks or more in a row. Of those being bullied, 37.7% have felt sad, blue or depressed for 2 weeks or more in a row during the preceding 12 months.

### 5.2.1.6 SUICIDE - YOUTH

Some youth (15.5%) knew of a close friend or a family member who had committed suicide in the 12 months preceding the survey.

When asked about their thoughts on suicide 15.6% of youth said that they had, at some point in their lives, thought about committing. Most youth (52.2%) had thought of doing this in the 12 months preceding the survey. There were very few attempts in the youth survey and therefore no further analyses could be done.



## 5.3 PERSONAL WELLNESS - CHILDREN

### 5.3.1 ACTIVITIES/OUTSIDE INTERESTS - CHILDREN

At minimum, over 20% of children participated in activities outside of school hours (even if it was less than once per week). As with youth, sports activities were the most popular as indicated below:

- Take part in sports teams or lessons (39.1%)
- Take part in art or music groups or lessons (21.7%)
- Take part in traditional singing, drumming, or dancing groups or lessons (33.9%)

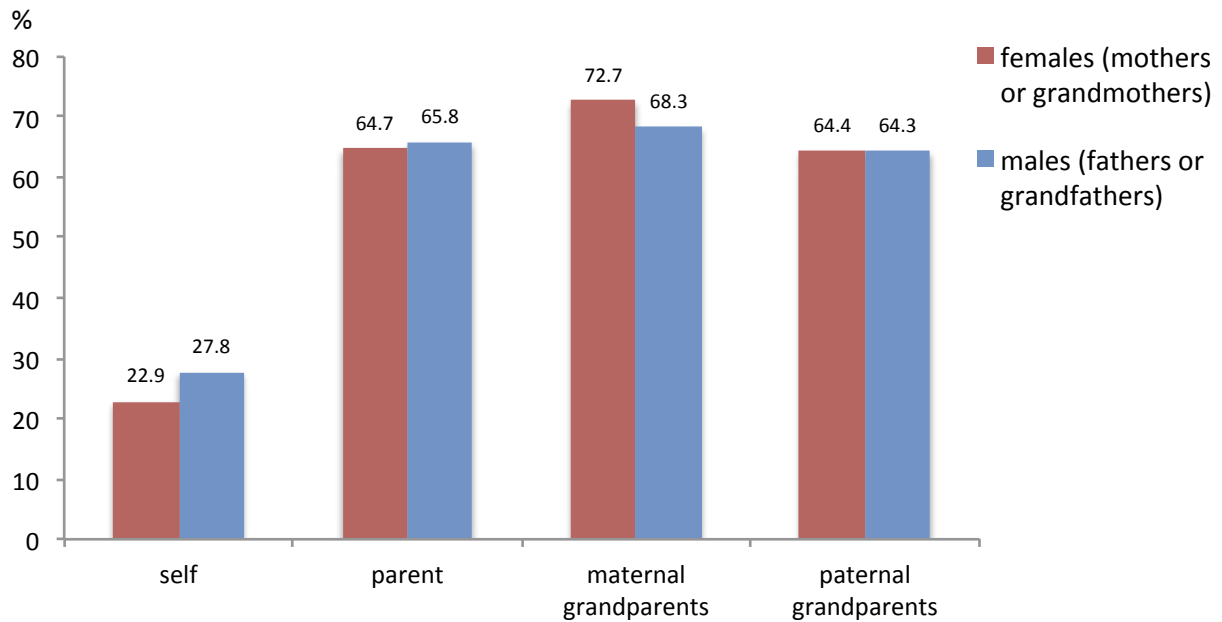
Almost all parents/guardians (97.8%) believed that their children got along very well or quite well with the rest of their families. Despite this, 13% felt that during the 6 months preceding the survey, their child had more emotional or behavioural problems than other boys or girls (E).



## 5.4 IMPACT OF RESIDENTIAL SCHOOLS

Just over one quarter (25.4%) of adults attended residential school with slightly more males (27.8%) than females (22.9%) attending. Over sixty percent of their parents and approximately two thirds of their grandparents combined also attended residential school.

Figure 5.4a – Residential school attendance – adult survey



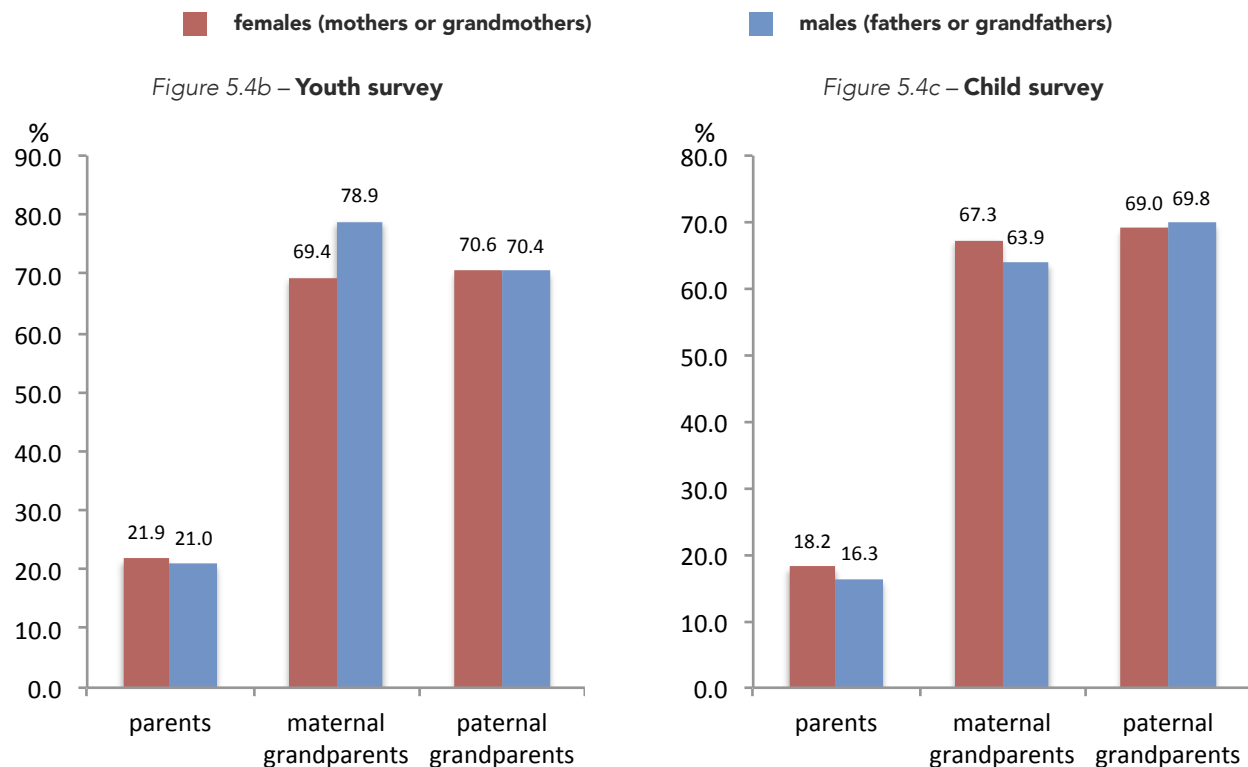
The majority of adults (73.0%) who attended residential school started attendance between the ages of 5 and 10 years. Most left residential school between the age of 11 and 17 (62.9%). Almost one quarter (24.6%) left between the ages of 5 and 10 years and 12.6% left at 18 years of age or older.

It is interesting to note that of those who started residential school between the ages of 5 & 10 years, 60.7% stayed on until between 11 & 17 years of age but 32.0% left while still between the ages of 5 & 10.

Youth were also asked whether their parents and/or grandparents had attended residential school. Of the youth who answered 33.8% said that at least one of their parents had attended residential school and 91.4% said that at least one of their grandparents had attended.

Caregivers for the children were also asked whether their parents and/or grandparents had attended residential school. Of the caregivers who answered on behalf of the children (88.6% of whom were one of the child's birth parents) 25.8% said that at least one of the child's parents had attended residential school and 90.6% said that at least one of the child's grandparents had attended.

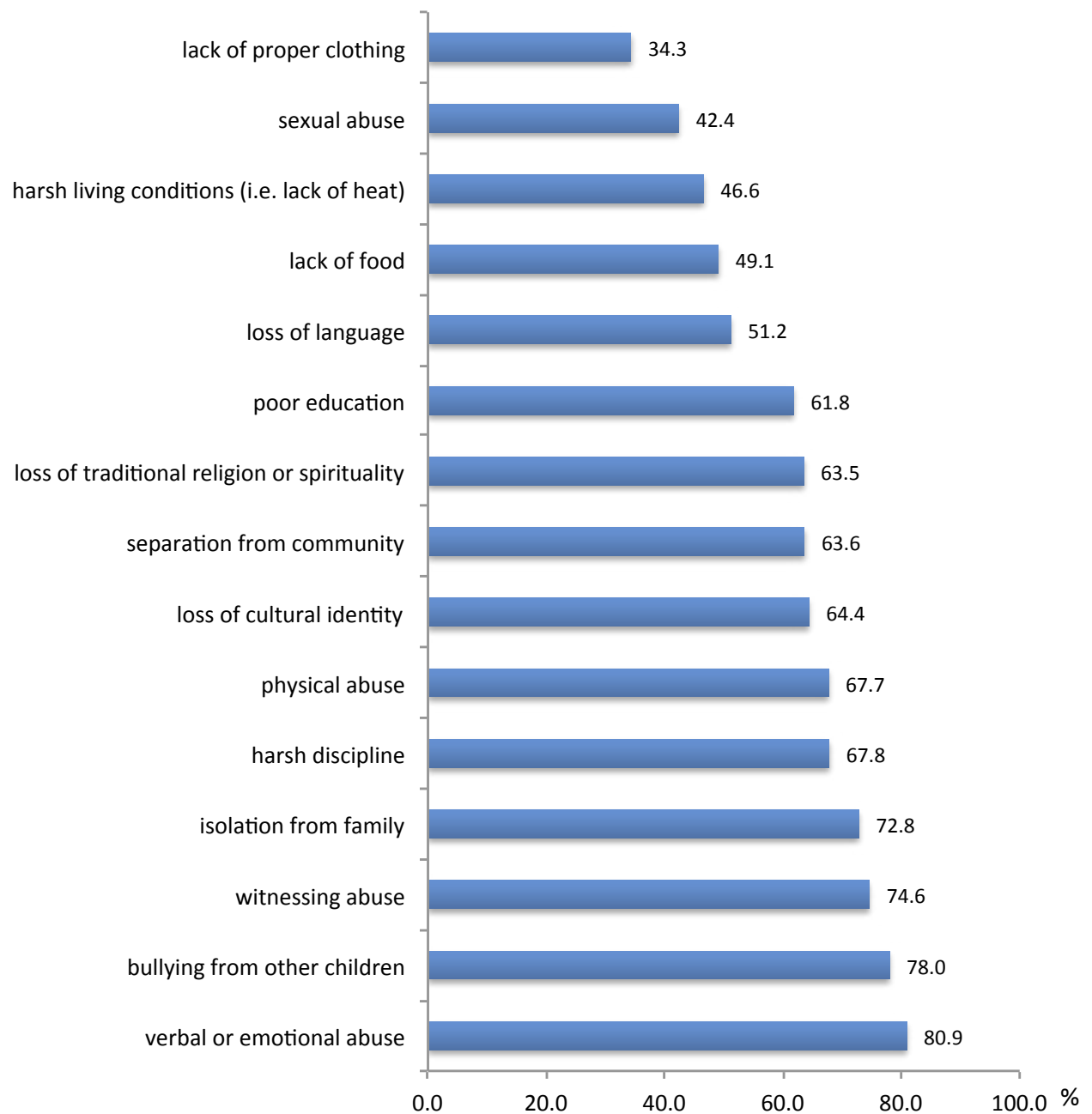
Figures 5.4b and 5.4c - **Parents' and grandparents' residential school attendance**



Most adults (61.7%) believed that residential school impacted them in a negative way, 12.9% that it had a positive impact, and 25.4% that it had no impact.

Of those adults who felt that residential schools negatively affected their health and well-being, the top 4 factors (identified by 70% or more of adults) included: verbal or emotional abuse, bullying from other children, witnessing abuse, and isolation from family.

Figure 5.4d – Residential school attendance’s negative impact on health and wellbeing because of:

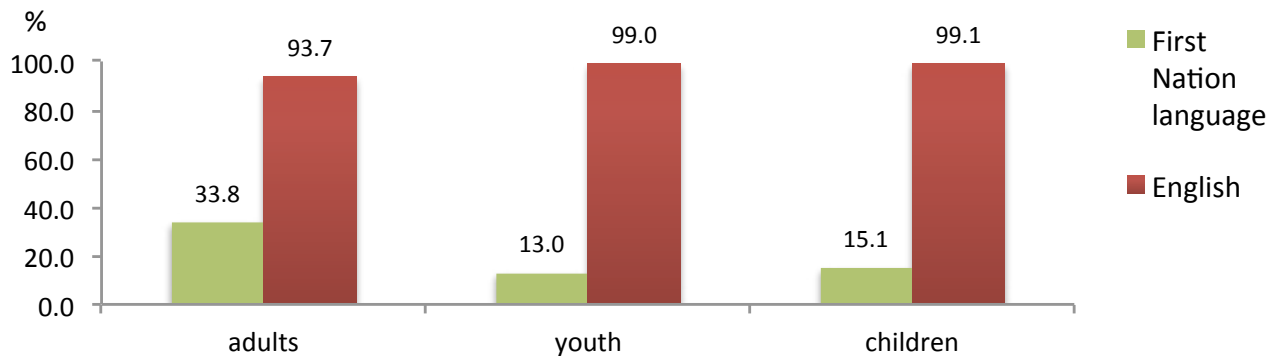


## 5.5 LANGUAGE AND CULTURE

### 5.5.1 LANGUAGE

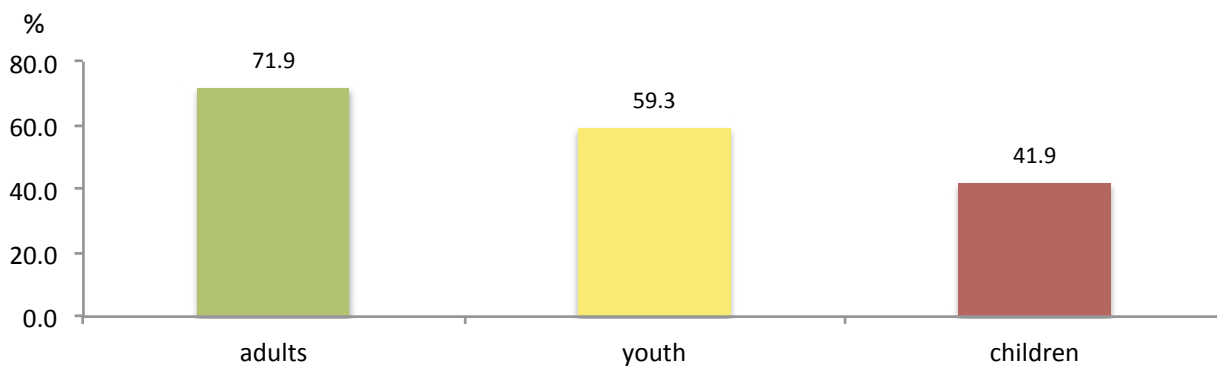
The languages adults used most in daily life were English (93.7%) and a First Nation language (33.8%). Almost all youth (99.0%) used English in their daily life, and 13.0% a First Nation language. Children were roughly the same with 99.1% using English and 15.1% using a First Nation language.

Figure 5.5a – Languages used in daily life



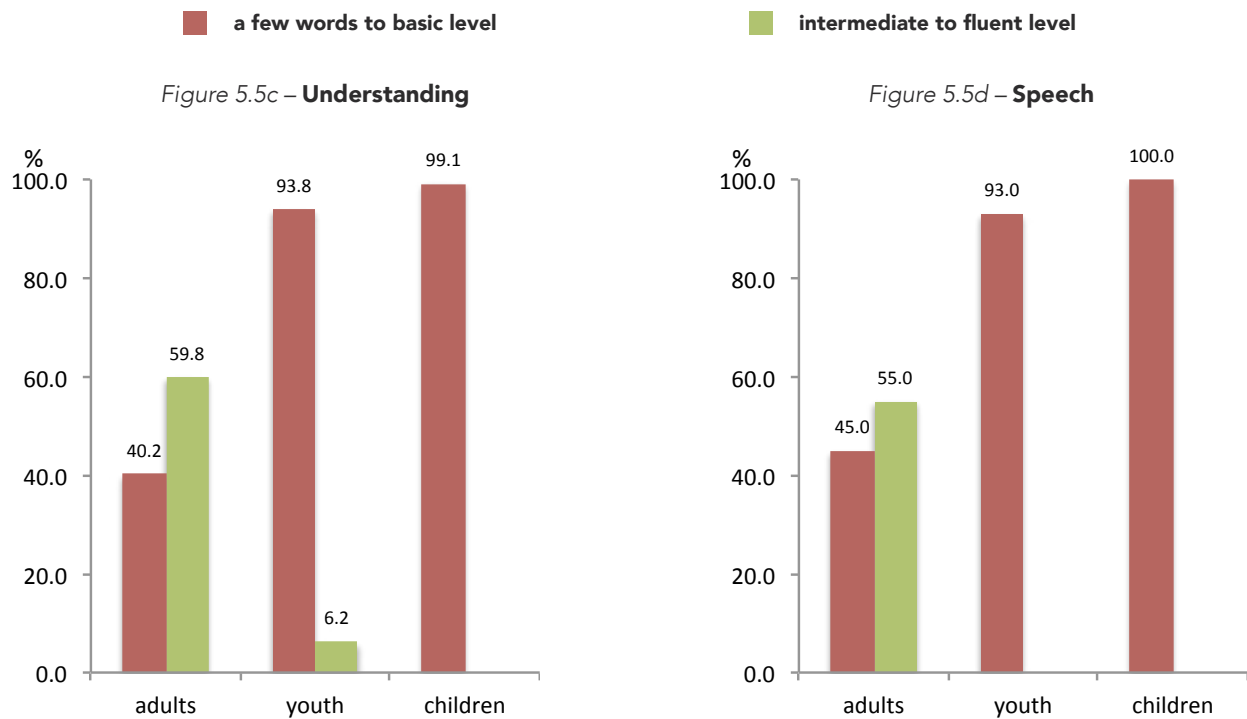
Among adults, 71.9% can speak or understand a First Nation language. The number decreases to 59.3% in youth and 41.9% in children. Languages most often spoken or understood by adults, youth, and children alike were Cree and Blackfoot.

Figure 5.5b – Language ability – can speak or understand a First Nation language (at even a minimal level)



In terms of language fluency, 59.8% of adults were able to understand one or more First Nation languages intermediately or fluently. Among youth 93.8% had a basic understanding or at least the ability to understand a few words. The same level of ability applied to 99.1% of children. Speech was more difficult for all groups. Just over half (55.0%) of adults were at an intermediate or fluent level in their speech while the majority of youth (93.0%) were mostly able to speak a few words or were at a basic level of speech. All children were at a basic level of speech or were able to say a few words.

Figures 5.5c and 5.5d - **Fluency in a First Nation language**



The majority of caregivers responded that it is very important (66.8%) for the child to learn a First Nation language. Youth were more divided on the issue with 45.9% responding that it is very important for them to learn a First Nation language, 40.6% responding that it is somewhat important, 11.1% responding that it is not very important, and 2.5% responding that it is not important.

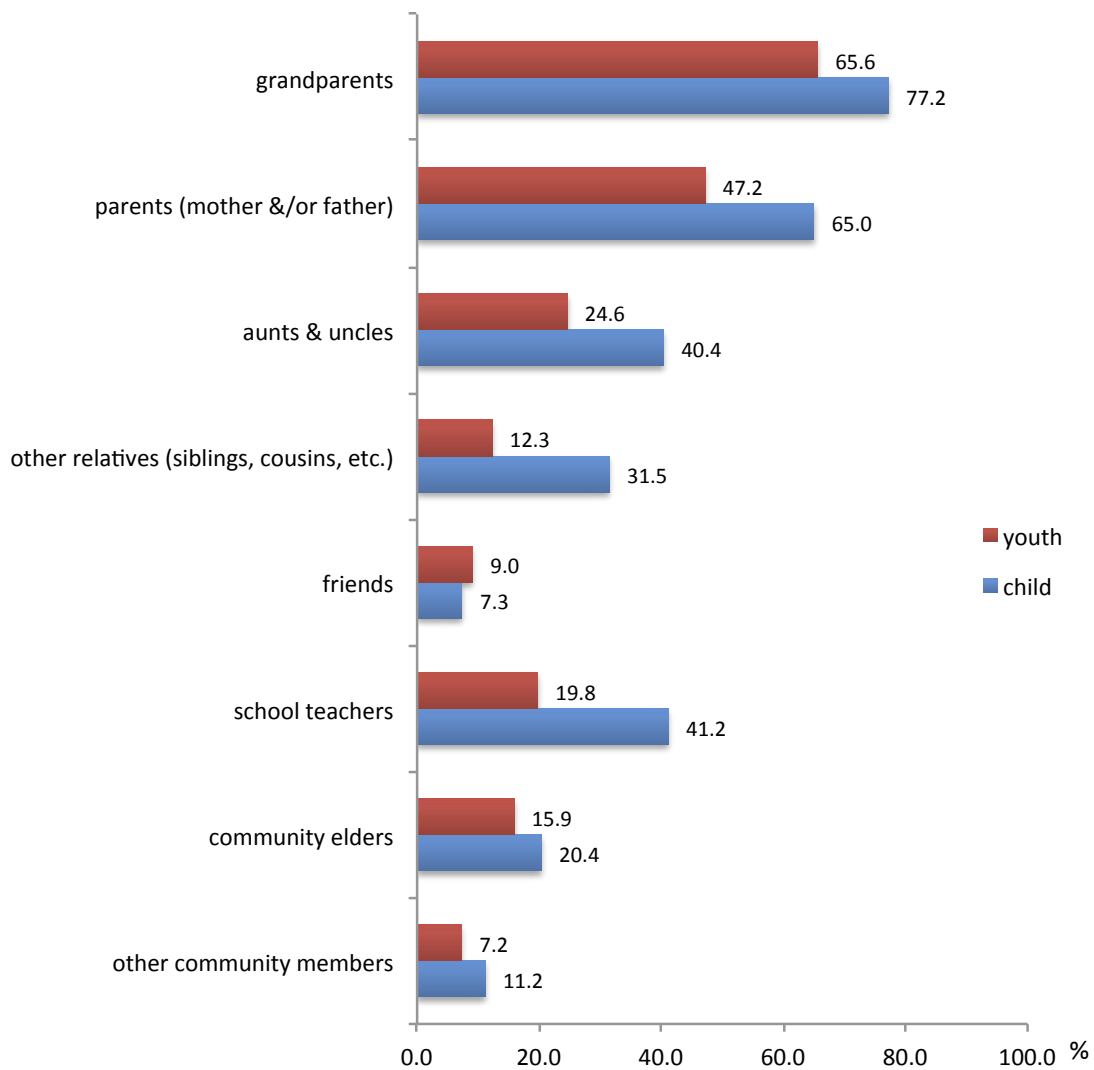


## 5.5.2 CULTURE

Over 90% of youth thought that it was important to participate in traditional cultural events as did 87.6% of the children's caregivers.

In terms of who helps with the understanding of culture, youth's opinions varied from those of children's caregivers although grandparents and parents were the top two choices for both groups.

Figure 5.5e – Who helps with the understanding of culture?



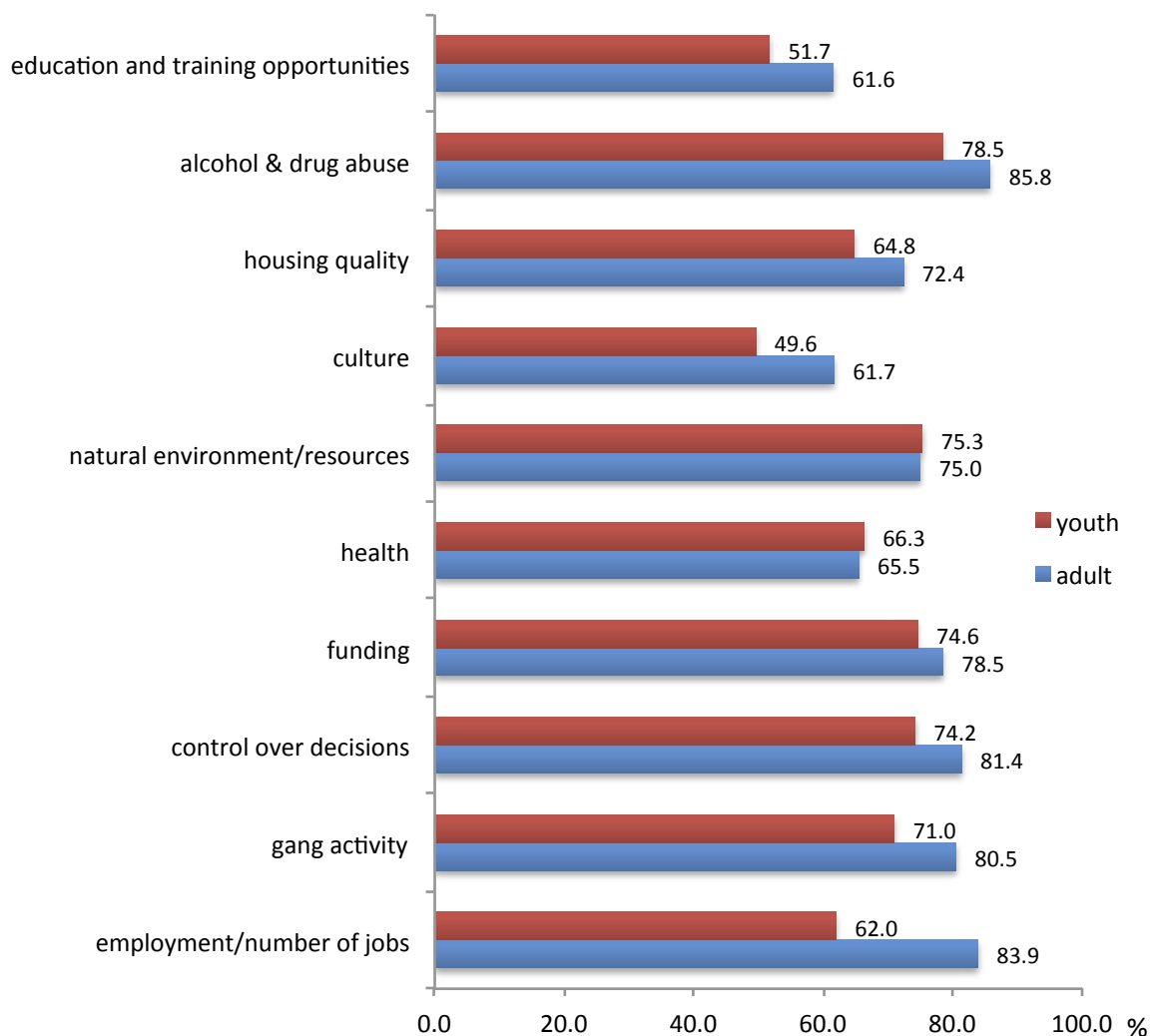
## 5.6 COMMUNITY WELLNESS

### 5.6.1 COMMUNITY CHALLENGES, PROGRESS AND STRENGTHS

#### 5.6.1.1 COMMUNITY CHALLENGES

Adults and youth responded differently to the “Community Issues” questions asked of them. The top 2 concerns they agreed upon were: Alcohol and drug abuse (87.3% of adults and 71.2% of youth) and Housing (77.1% of adults and 58.5% of youth).

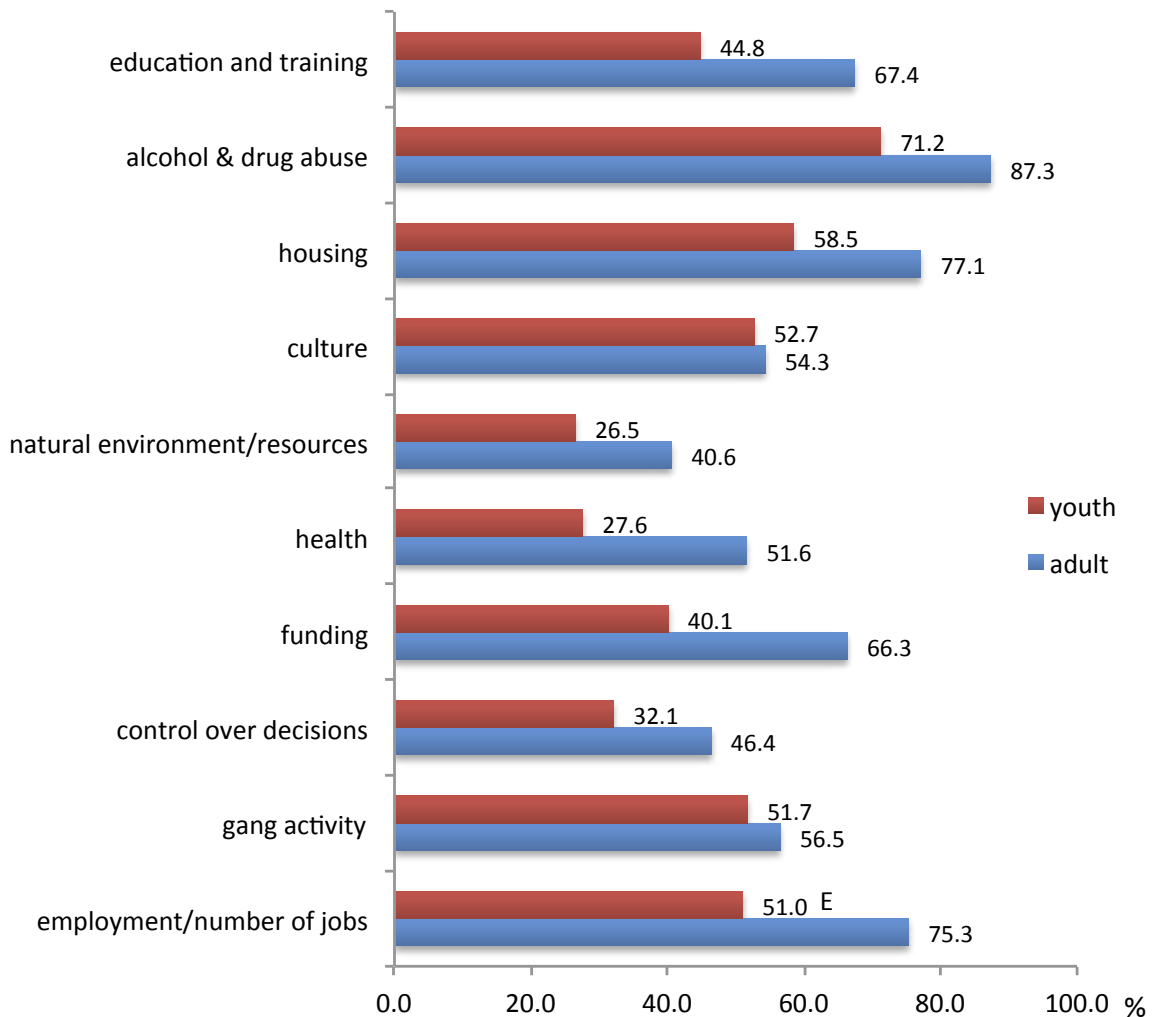
Figure 5.6a – Main challenges (issues) faced by First Nations communities, according to adults and youth



### 5.6.1.2 PROGRESS ON COMMUNITY CHALLENGES

While both adults and youth generally felt that there had been little or no progress on most community issues in the past 12 months, adults were more pessimistic than youth. Just over one third of adults felt there had been some to good progress or change in three areas: education and training opportunities (38.4%), culture (38.3%) and health (34.5%). Many youth declined to answer this section of the questionnaire but, of those who did, most responded with more optimism than adults. One third or more of youth who responded felt that there had been some to good progress or change in five areas: culture (50.4%), education and training opportunities (48.3%), employment/number of jobs (38.0%), housing quality (35.2%) and health (33.7%).

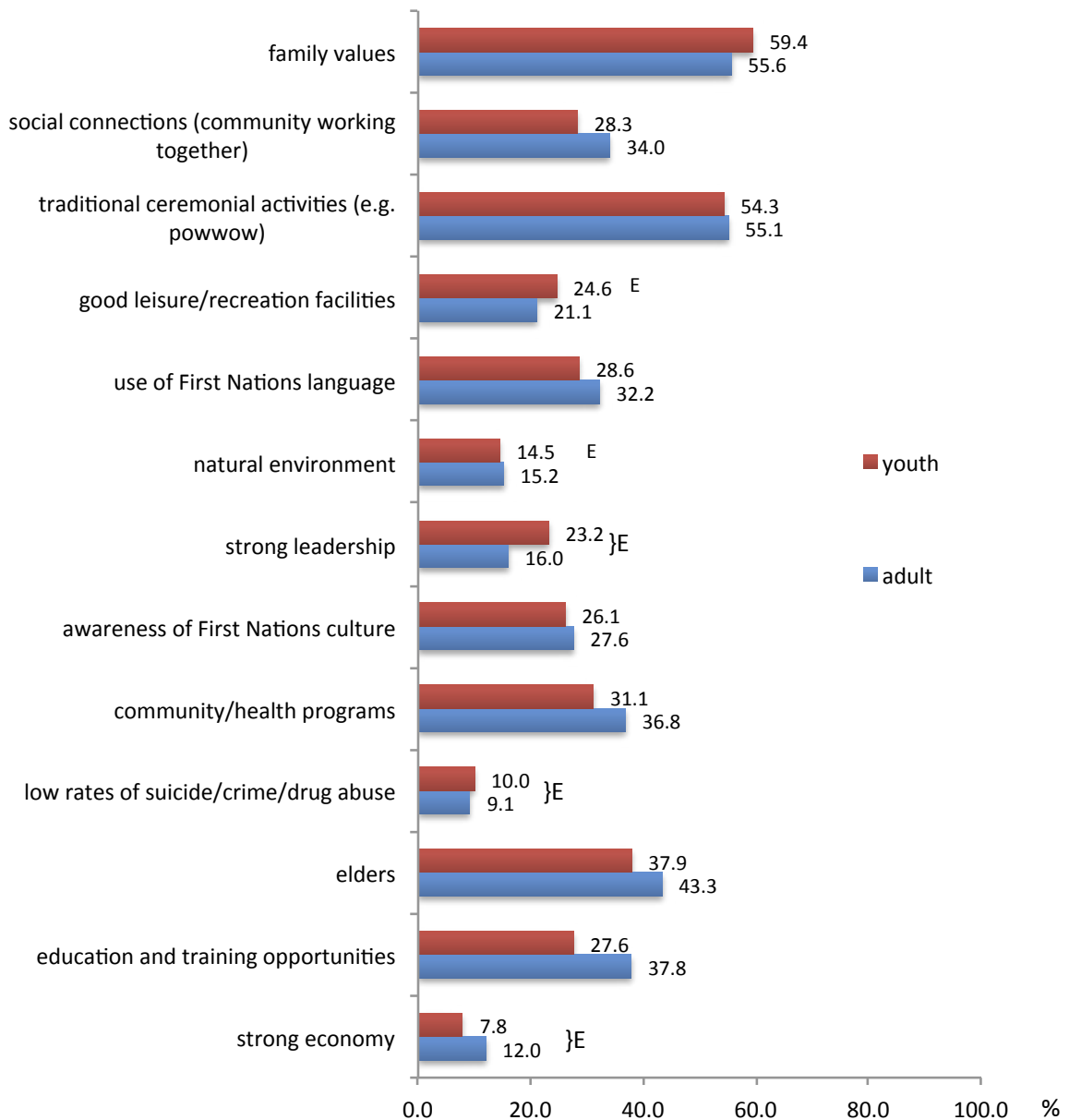
Figure 5.6b – Progress on challenges faced by First Nations communities according to adults and youth (no progress/change to worsening)



### 5.6.1.3 COMMUNITY STRENGTHS

The top three community strengths identified by adults and youth included: family values (55.6% of adults and 59.4% of youth), traditional ceremonial activities (55.1% of adults and 54.3% of youth), and Elders (43.3% of adults and 37.9% of youth).

Figure 5.6c – Community strengths as rated by adults and youth



## 5.6.2 MIGRATION

Almost two thirds (63.1%) of adults had lived outside of their First Nations community at some point in their lives. Of those who had lived away from their community, 35.6% had been away for more than 5 years, 38.3% for 1 to 5 years, and the rest for less than a year. The majority (76.3%) stayed in the same province (59.2% in the city and 17.1% in a small town or rural area) while away.

Overall, employment (cited by 28.0% of adults who had left their communities), education (26.3%), and housing (15.7%) were the most frequently selected reasons for moving away from their communities.

When analysed by gender the migration information tells a somewhat different story. Men's most common motives for moving away were employment (44.1%), and education (21.9%), while women tended to leave their communities because of education (30.5%), and housing (21.8% E).

The most frequent reasons for returning to the community were: family (cited by 53.0% of adults who returned to their communities), connection to community/home (22.6%), and housing became available (17.2%). Once again, females were more interested in housing than males were.

Figures 5.6d and 5.6e – Migration – leaving and returning to First Nation communities

Figure 5.6d – Reasons for moving away

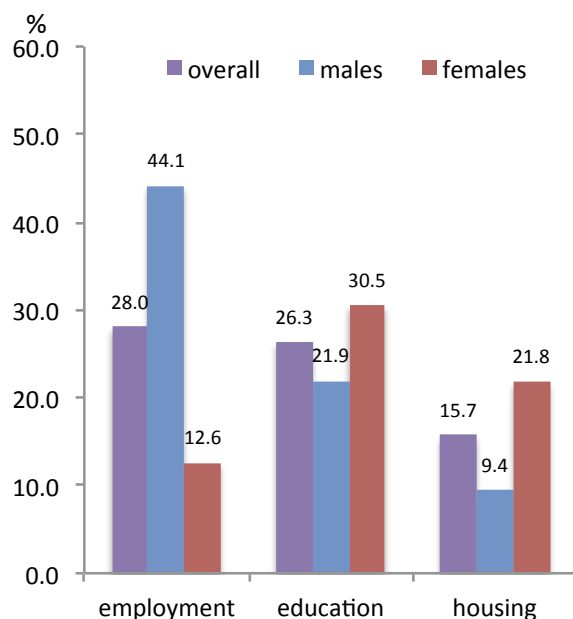
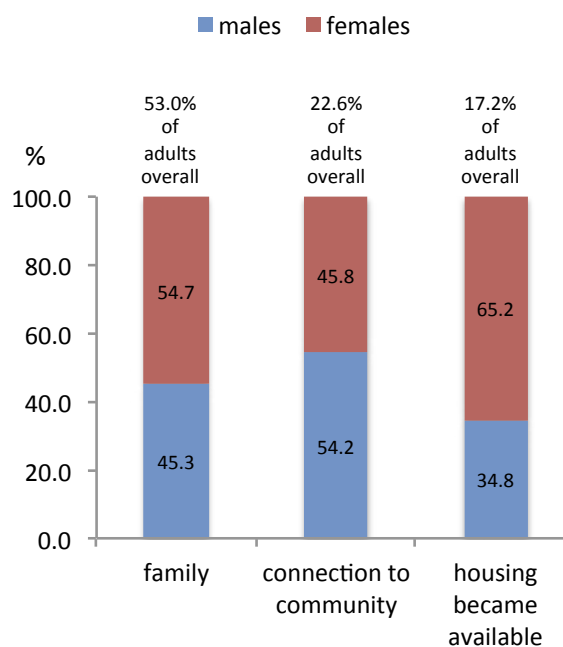
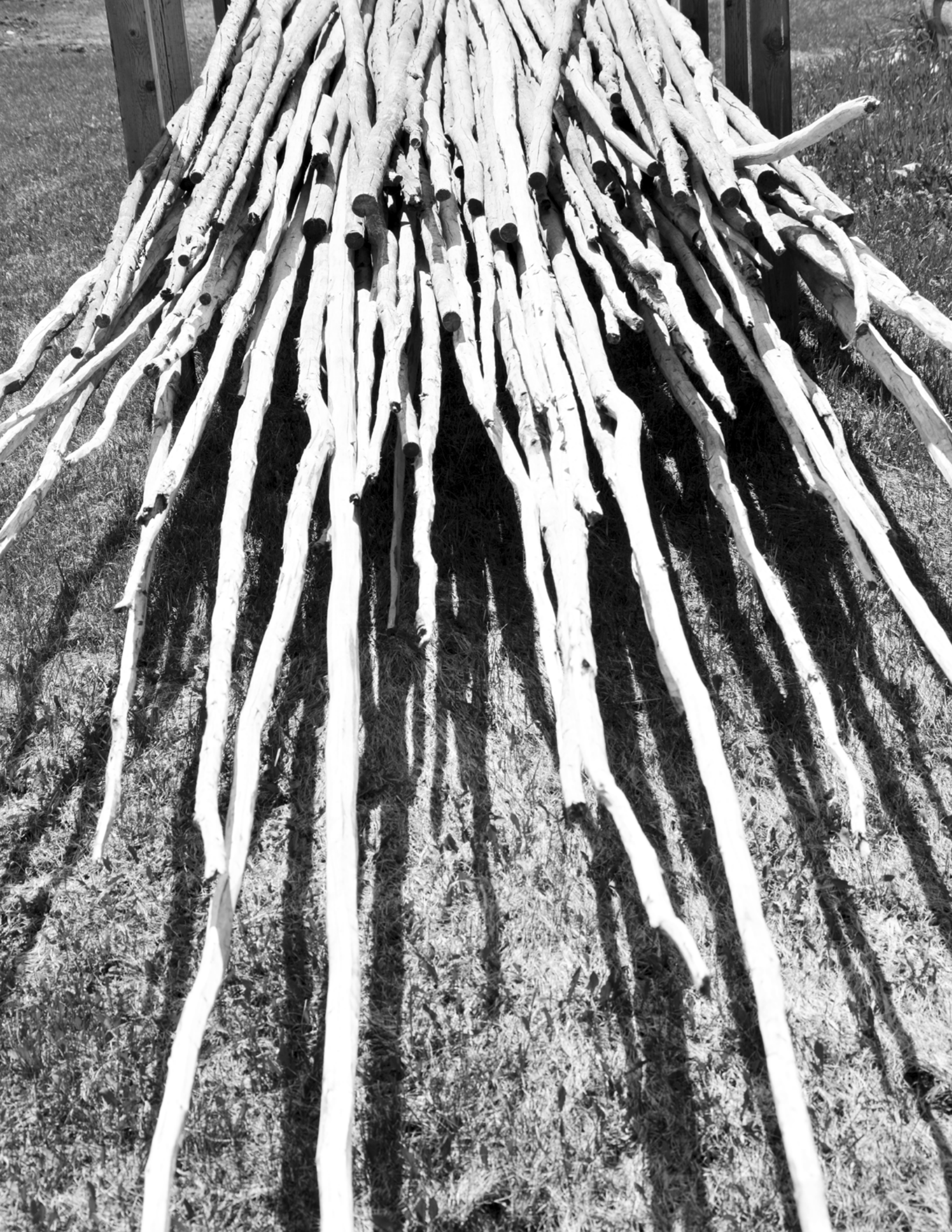


Figure 5.6e – Reasons for returning



Just over half of the adults (53.0%) who had moved from their community stated that they received services from their First Nations communities (such as health and education) while away. Over one third (39.7%) of adults stated that they had voted in their First Nations elections while living outside of their community.











# Chapter 06:

**REASON –  
SOCIAL ECONOMIC**

## 6.1 EDUCATION

### 6.1.1 EDUCATION - ADULT SURVEY

Just over one quarter of adults (27.7%) reported that they had graduated from high school. Despite this there are a number of adults who have completed some trade, technical or vocational education (18.8%), some community college (16.2%), and some university (6.3% E). Others have received diplomas or certificates from: a trade, technical or vocational school (12.5%) or a community college, CEGEP or university (15.8%). Completing some education did not necessarily mean that the individual actually went on to receive a diploma or certificate. Less than 16% went on to do so.

Figures 6.1a and 6.1b – Education and completion

Figure 6.1a – Some education completed in:

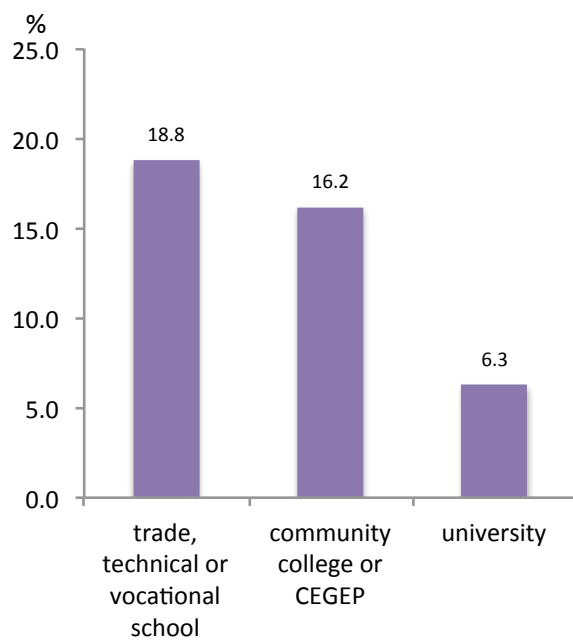
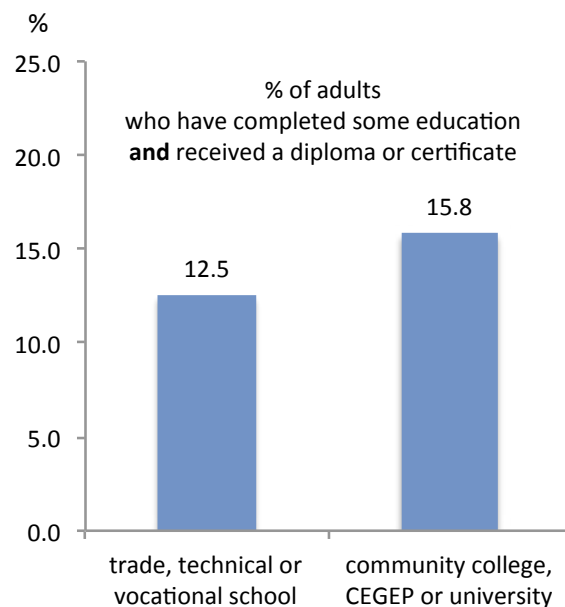


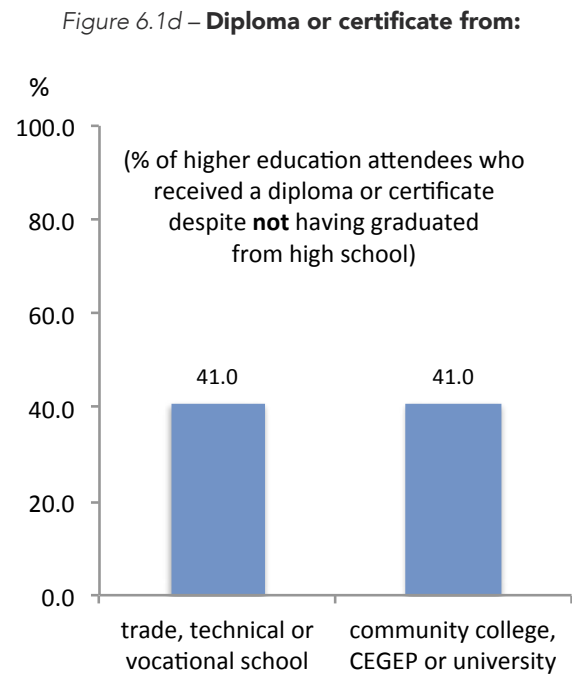
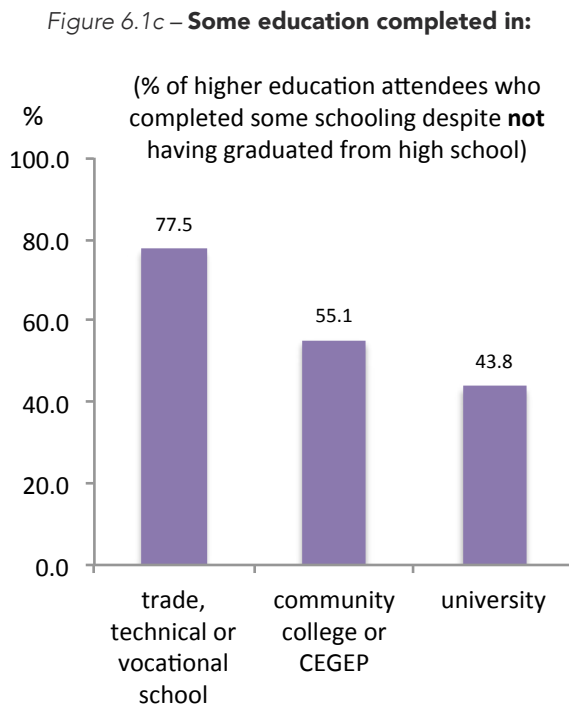
Figure 6.1b – Diploma or certificate from:



It is notable that lack of high school graduation did not necessarily predict whether someone went on to higher education of some sort. For example, 41.0% of those who received a diploma or certificate from either a trade, technical or vocational school or a community college, CEGEP or university had not graduated from high school. Not graduating from high school did, however, effect whether or not an individual received a university, professional or other degree.

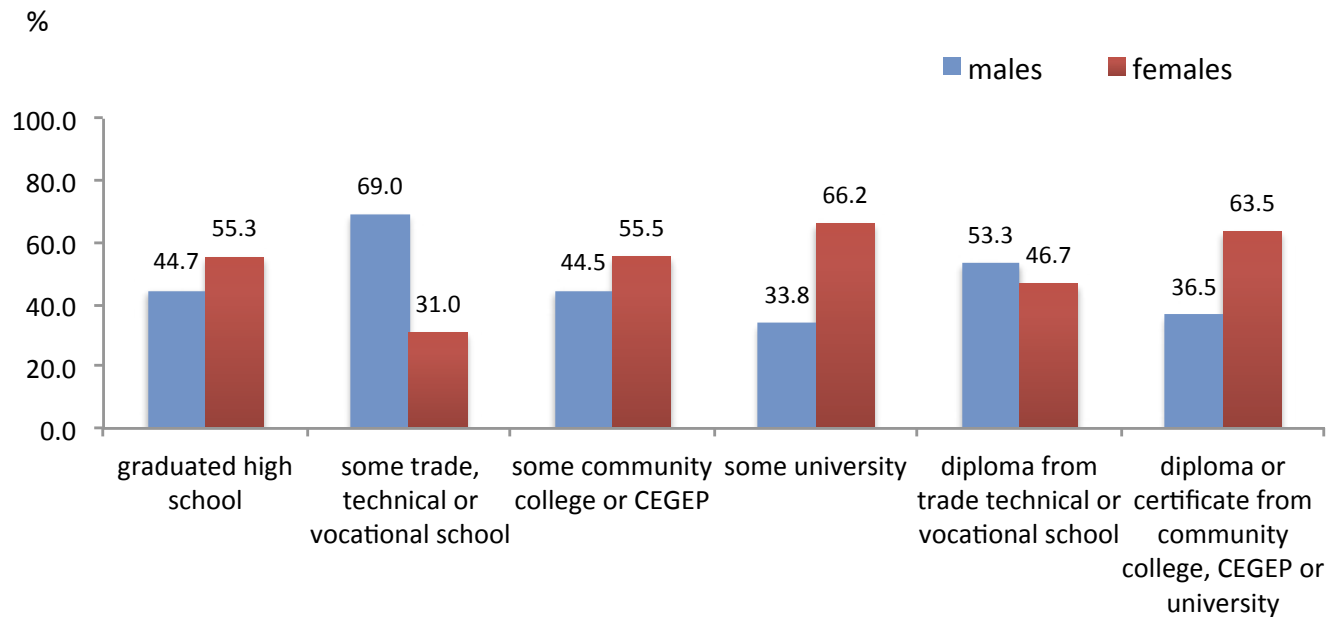
Of those who completed some trade, technical or vocational school, 77.5% had not graduated from high school. Of those who completed some community college or CEGEP, 55.1% had not graduated from high school, and of those who completed some university, 43.8% had not graduated from high school.

Figures 6.1c and 6.1d – **Percentage of high school NON-graduates in various types of higher education**



In terms of overall education, adult women were slightly more likely than men to have completed high school (55.3% as compared to 44.7%) and 27% more likely to have a community college or undergraduate university degree (63.5% as compared to 36.5%). Adult men were more likely to have completed a diploma or certificate from a trade, technical or vocational school.

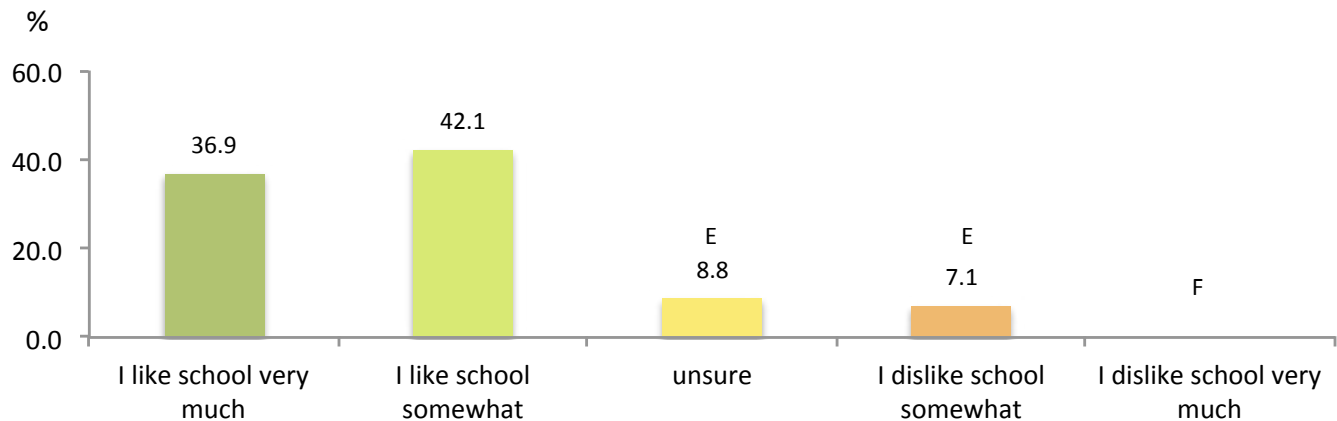
Figure 6.1e – Education by gender



## 6.1.2 EDUCATION - YOUTH AND CHILD SURVEY

At the time of the survey most youth (82.5%) were still attending school and, overall, they liked school to some extent (79.0%).

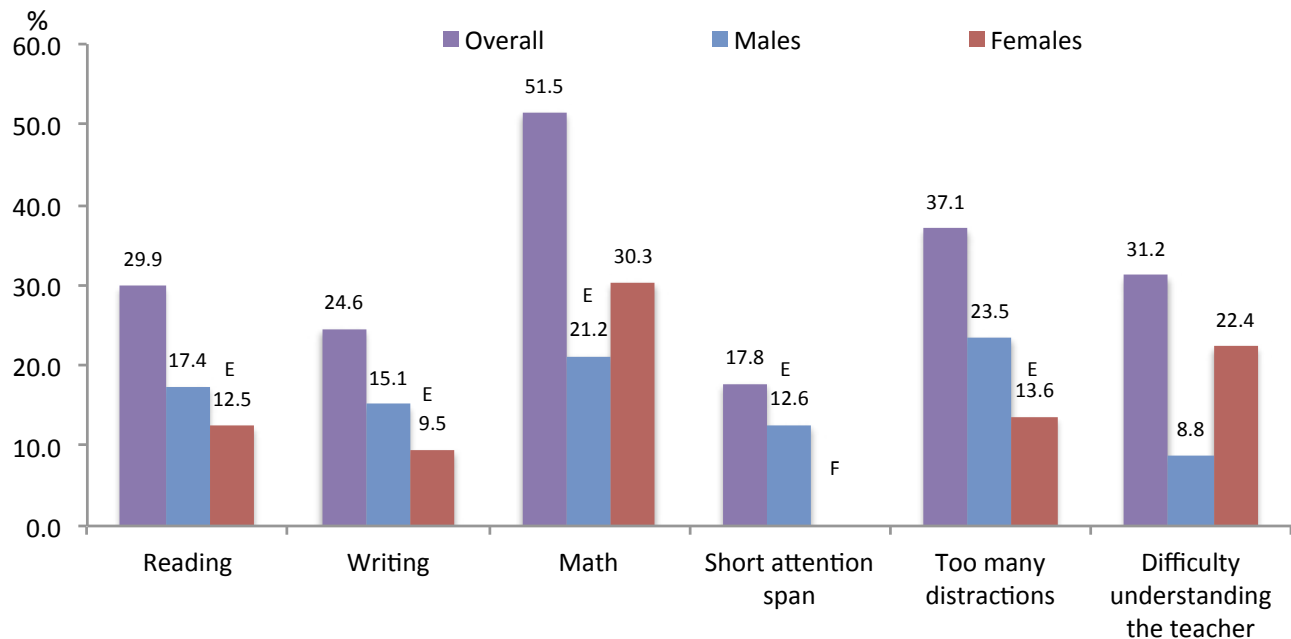
Figure 6.1f – How youth feel about school



Two thirds of children (66.7%) were also attending school at the time of the survey. Almost half of them (41.7%) had attended an Aboriginal Head Start program. Seven percent (7.0% E) of the children, and 34.5% of youth had repeated a grade at some time while 16.0% (E) of youth had skipped or advanced a grade as a result of academic performance.

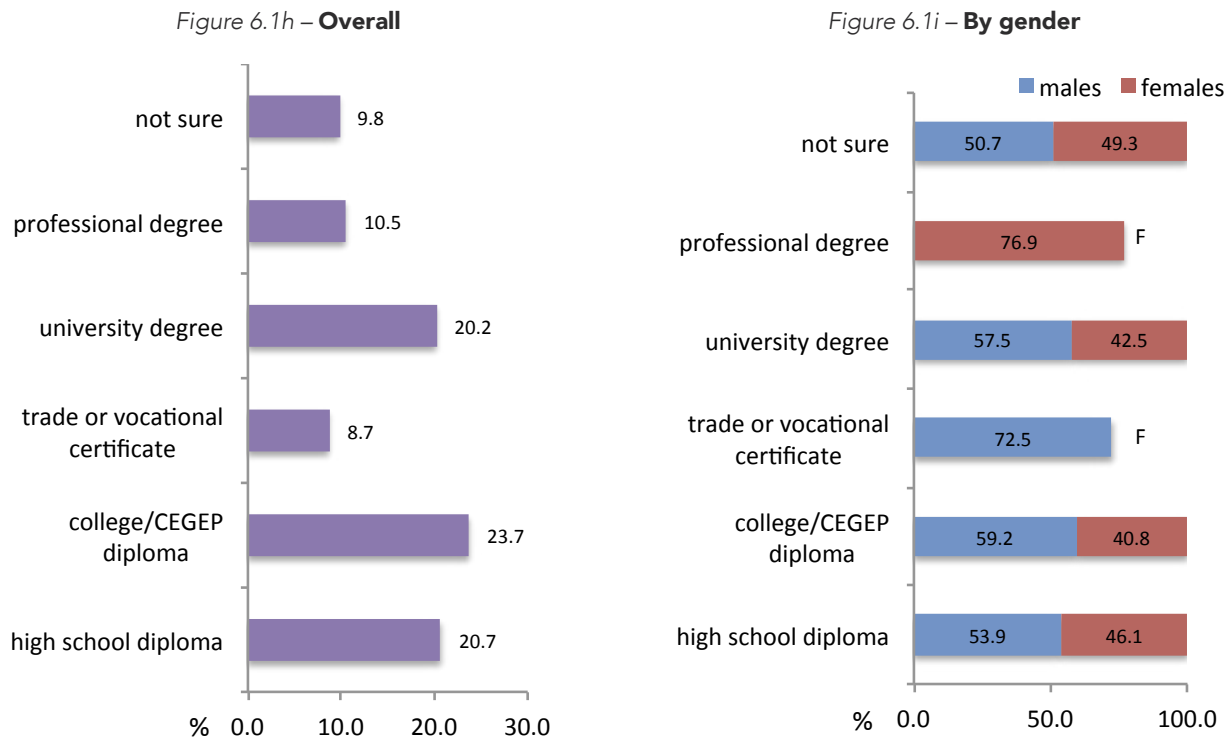
Just over one third of youth (35.2%) revealed that they had problems learning at school; over half of those youth (51.5%) citing math as a problem. Males and females had differing problems.

Figure 6.1g – Problems youth have at school



When asked what the highest level of school is that they would like to complete only 20.7% of youth said they would just like to complete their high school diploma. An additional 9.8% were not sure of what their aspirations were but the remainder would like to achieve some level of higher education. Males tended toward trade or vocational certificates and college diplomas while females were more inclined toward university and professional degrees.

Figures 6.1h and 6.1i – Highest level of education youth would like to achieve



When the youth were asked about the highest level of education of their parents, the greatest proportion stated that their mother or female guardian's highest level of education was "Some high school" (47.9%) with the same applying to their fathers or male guardians (57.7%). Similar proportions exist for the child survey with the majority of both parents having completed "Some high school" (mothers or female guardians at 55.4% and fathers or male guardians at 64.0%).

As with the adult survey, of those who did continue on to higher education, the males tended toward a diploma from a trade or vocational school (9.5% in the youth survey and 11.2% in the child survey) while the females tended more toward college and university (13.3% in the youth survey and 16.6% in the child survey).



## 6.2 EMPLOYMENT

Almost half (48.1%) of adults worked for pay (including wages, salary, and self-employment) at the time of the interview. Of those who were not working, 48.2% were looking for work.

The most common reasons for not working included: poor health or disability (21.3%), being a student (21.2%), being a stay-at-home parent (20.9%), and being retired or a seasonal worker (both at 13.2%).

The majority of all the working adults (83.4%) had employment in their own First Nations community.

The top 4 job sectors (over 10%) adults worked in were: construction (18.2%), health care and social assistance (15.3%), professional, scientific and technical services (11.4% E), and public administration (10.5% E).

## 6.3 INCOME

Adults were asked to provide an amount for their personal income from all sources, before deductions. The majority of individuals (85.5%) had some source of personal income.

Household incomes were generally higher with one quarter (24.7%) of households at the \$50,000 and over range. Less than half the percentage of households (6.6% E) had no income at all as compared to individuals – 14.2% (E) of whom reported having no income.

Figure 6.3a – Adults' total personal income and total household income





Individual adults' sources of income were from 4 major sources:

- paid employment (57.5%)
- Social Assistance (41.5%)
- Child Tax Benefits (37.1%)
- education or training allowance (14.1%)

The remaining income sources were at below 14% and had a high Coefficient of Variation.

The majority of individuals received income from a total of one (38.5%), two (33.5%) or three (13.2%) sources. Income from government sources made up the bulk (83.8%) of these.

The vast majority of those who were working worked from between 30 and 40+ hours per week (95.8%). Those who worked 40+ hours made up the majority of that total, contributing 74.0%.

Almost half of the households (45.1%) have 2 or 3 members receiving an income of any source. One quarter (25.4%) of the households depended on a single household member's source of income.

Guardians of children interviewed were asked to think of the children's total household income in the past 12 months. Almost one third of the respondents (31.1%) did not know or did not answer that question. As in the adult survey there was a wide range of income reported.

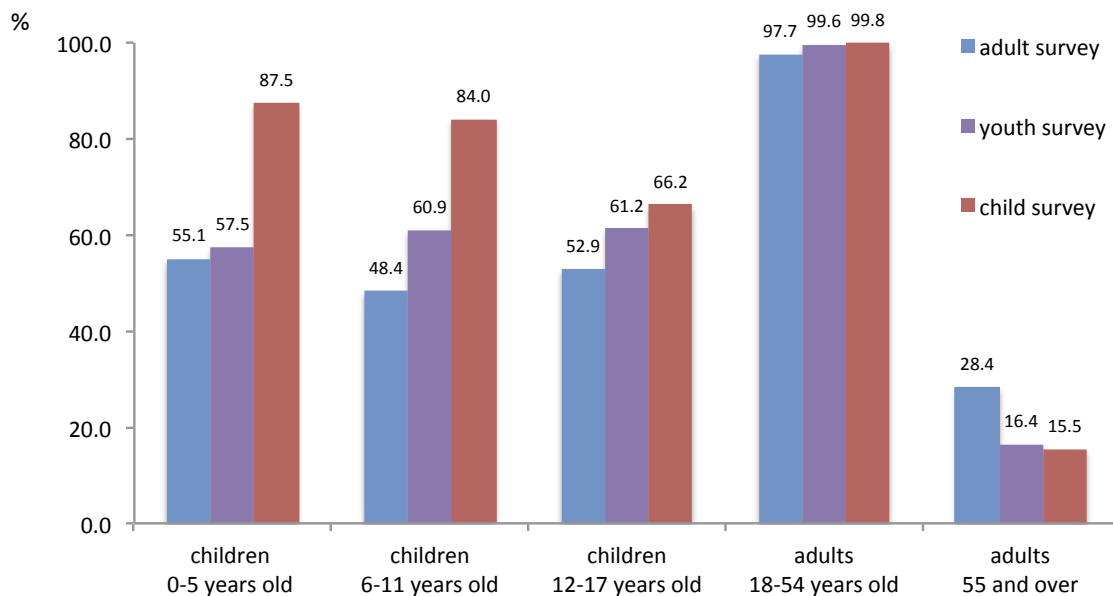
Figure 6.3b – Household income reported on child survey



## 6.4 FAMILY AND HOUSEHOLD STRUCTURES

All three surveys asked who lived in the household and in what numbers. The chart below shows the percentage of households who have residents of each age group living in their households.

Figure 6.4a – Age groups in the household



When youth were asked who they lived with most of the time they answered the following:

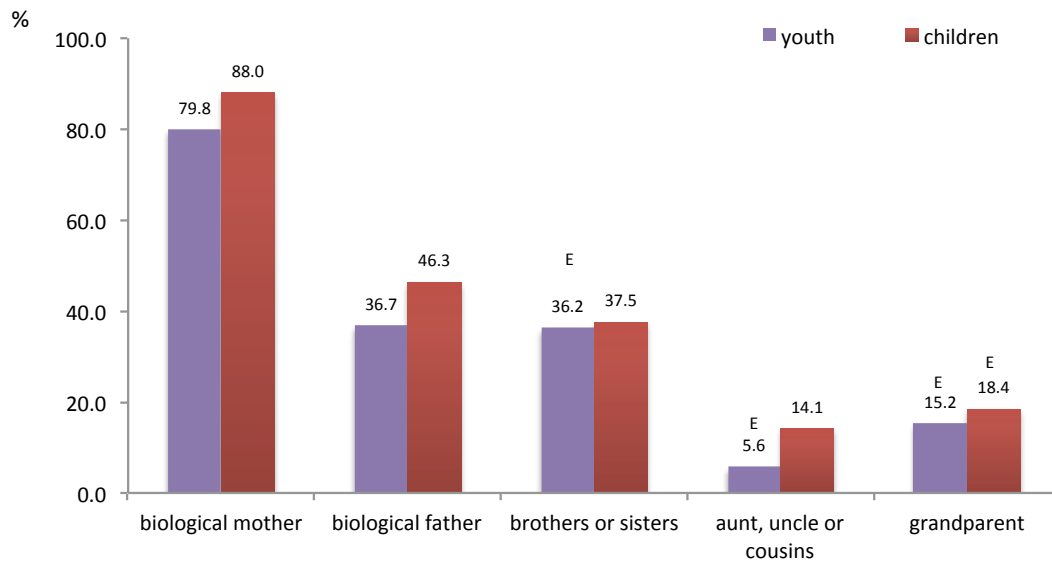
- biological mother (79.8%)
- biological father (36.7%)
- brothers or sisters (36.2% E)
- aunt, uncle or cousins (5.6% E)
- grandparent (15.2%)

Caretakers for the children were asked the same question with some different results.

- biological mother (88.0%)
- biological father (46.3%)
- brothers or sisters (37.5%)
- aunt, uncle or cousins (14.1% E)
- grandparent (18.4% E)

More children live with their biological parents than youth do and the incidence of living with an aunt, uncle or cousins is more than double in the children's households than in that of the youth.

Figure 6.4b – Who children and youth live with



Almost half the youth (48.4%) stated that their biological parents were separated or not living together while over one third (36.5%) stated that they were living together (whether married – 16.7% or not – 19.8%).

Just over one quarter (27.3%) of children received childcare of some sort and most (88.8%) spent more than 30 hours a week there. The main provider of childcare was a daycare centre (45.5%).

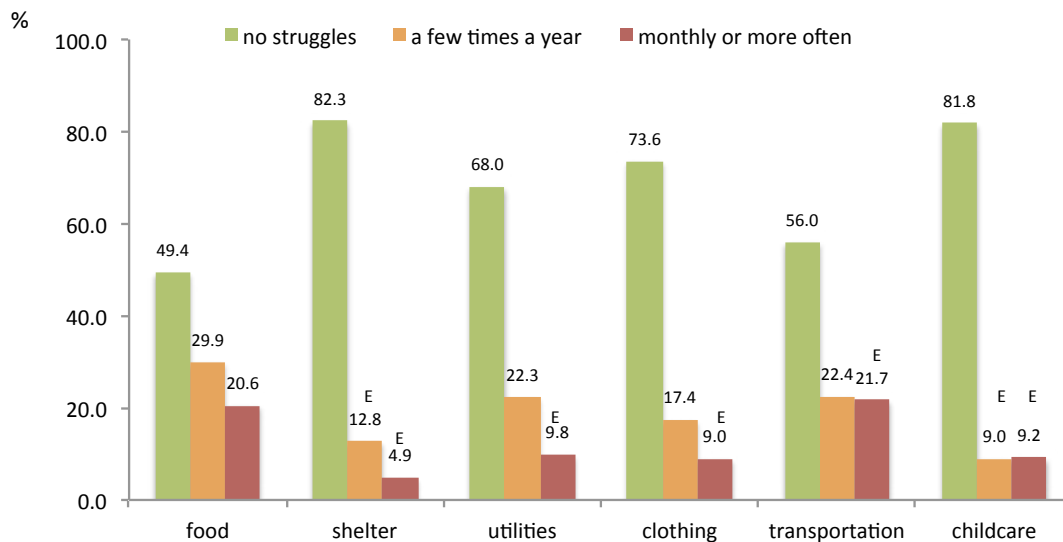
Only 19% of youth reported that their birth parents were married and living together, and another 22% that their birth parents were living together but were not married.

A majority of adults stated that their household was able to meet the basic living requirements of:

- food - 49.4%
- shelter - 82.3%
- utilities (heat, electricity) – 68.0%
- clothing – 73.6%
- transportation – 56.0%
- childcare – 81.8%

Struggles were still quite common, especially in the areas of food, transportation, and utilities. Many households struggled monthly or more often.

Figure 6.4c – Struggles with meeting the basic living requirements

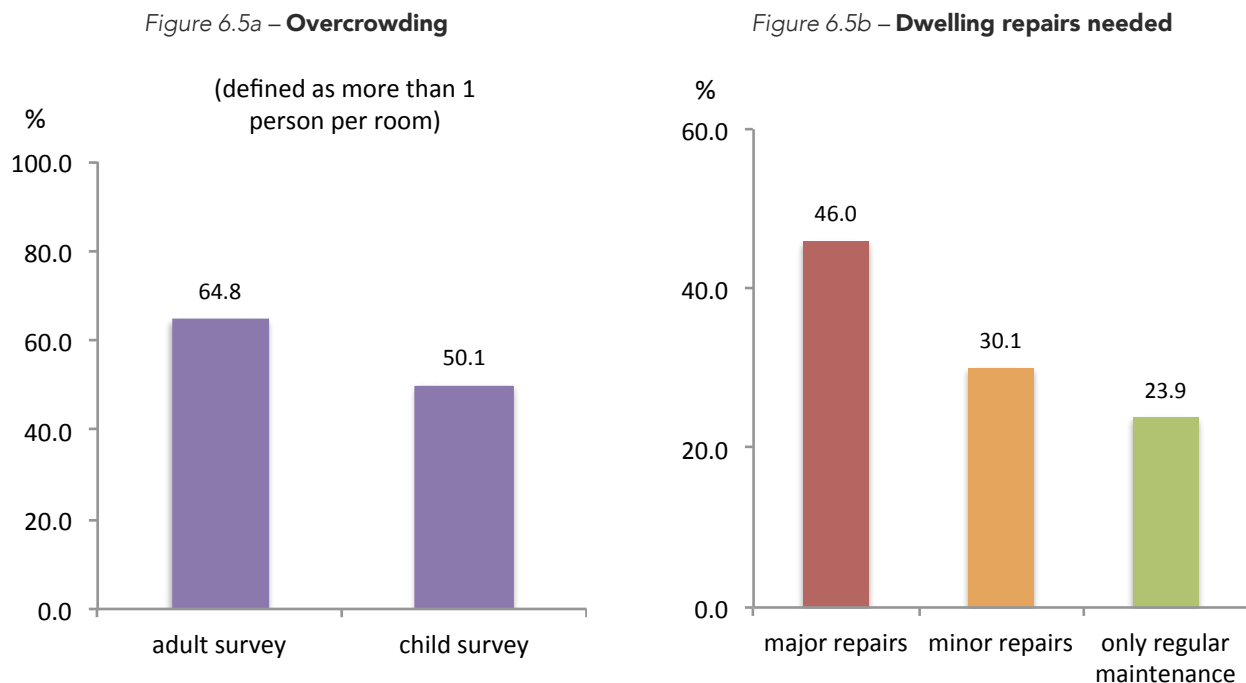


## 6.5 HOUSING AND LIVING CONDITIONS

More than three quarters (83.3%) of adults stated that they live in band-owned housing. The number of rooms in the home (including kitchen, bedroom, living room, and finished basement rooms) ranged from 1 to 13, with an average of 5.85 rooms per home.

The number of "persons per room" (PPR) was calculated to get an idea of overcrowding. The definition of overcrowding is varied (persons per room, persons per bedroom and average floor area per person are some examples) but a good proportion of the literature regarding North America refers to anything over 1.5 PPR as over-crowded (the World Health Organization uses a measure of 2.5 PPR). The RHS National Report uses a value of "more than one person per habitable room" as derived from the Canada Mortgage and Housing Corporation's (CMHC) guidelines. Based on the adult survey 64.8% of homes were overcrowded and based on the child survey 50.1% of homes were overcrowded.

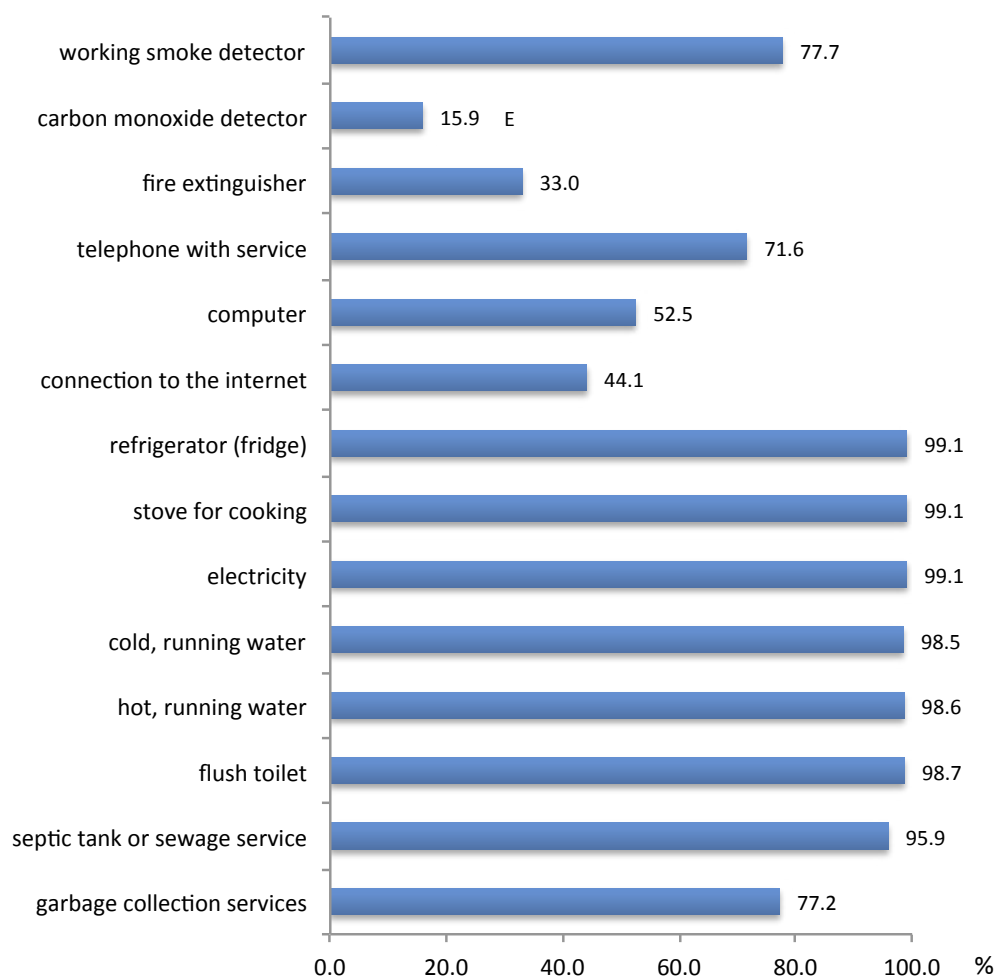
Figures 6.5a and 6.5b – Housing



Over three quarters (76.1%) of adults felt that their home was in need of repair; either minor (30.1%) or major (46.0%) and over half (52.8%) reported that there had been mould or mildew in their home in the 12 months preceding the survey.

When asked about the amenities in the home almost all the adults responded that they have: electricity (99.1%), a stove and a refrigerator (both 99.1%), flush toilets (98.7%), hot (98.6%) and cold running water (98.5%), and either a septic tank or sewage service (95.9%). Over three quarters (77.2%) had garbage collection services. Less than three quarters (71.6%) had a telephone with service. Just over half (52.5%) had a computer but only 44.1% had an Internet connection. While over three quarters (77.7%) of the homes had a working smoke detector, only 33.0% had a fire extinguisher in the home, and only 15.9% (E) had a carbon monoxide detector.

Figure 6.5c – Amenities in the home



When asked about the main source of water supply for their household, 48.9% of adults responded that the water was piped in, 26.0% (E) that it was trucked in, and 22.2% (E) that it came from a well (either individual or shared).

Just over half of the adults (59.6%) said that the main water supply in their home was safe for drinking year round. Most adults (79.1%) reported that they do not use any other sources of drinking water. Of those who do use other sources, bottled water (74.1%) and boiled tap water (8.0% E) were the two main sources.











# Chapter 07:

**ACTION –**  
HEALTH BEHAVIOURS  
& LIFESTYLES

## 7.1 SMOKING

### 7.1.1 SMOKING - ADULTS

Well over half of the adults smoked either daily (49.2%) or occasionally (15.9% E). Of the current 34.9% of non-smokers, 52.5% had never smoked in the past. Despite this, 60.7% of adults said that they had a smoke free home.

Over one third (36.8%) of adults smoked 1 to 5 cigarettes a day, 24.9% smoked 6 to 10 cigarettes a day, and 38.3% smoked 11 or more cigarettes a day. More than three quarters (76.0%) of the current smokers stated that they had never tried to quit smoking in the 12 months preceding the survey.

Adults started smoking early: 47.4% of current and 44.4% of ex-smokers started smoking before the age of 16. An additional 37.3% of current smokers and 36.8% of ex-smokers started smoking between the ages of 16 and 18.

Figures 7.1a and 7.1b – Smoking habits - Adults

Figure 7.1a – Current smoking frequency

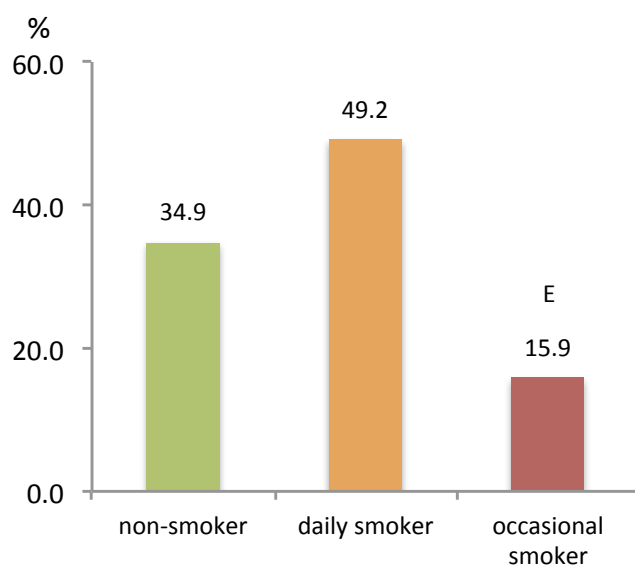
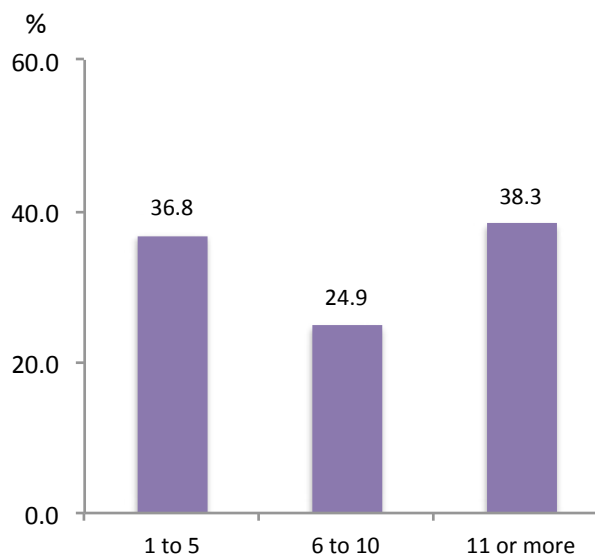


Figure 7.1b – Number of cigarettes smoked daily



Of those adults who had quit smoking, 23.4% (E) stopped before the age of 20 years old, 37.5% (E) between the ages of 21 and 30, 17.1% (E) between 31 and 40, and the remainder after the age of 41.

Figures 7.1c and 7.1d – **Smoking habits**

Figure 7.1c – **Age of starting smoking**

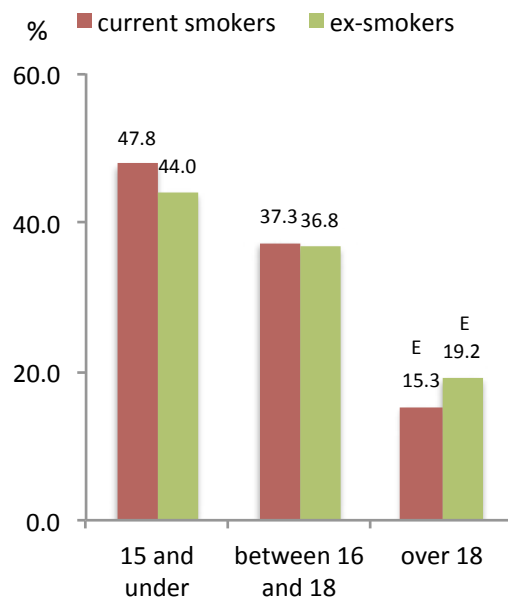
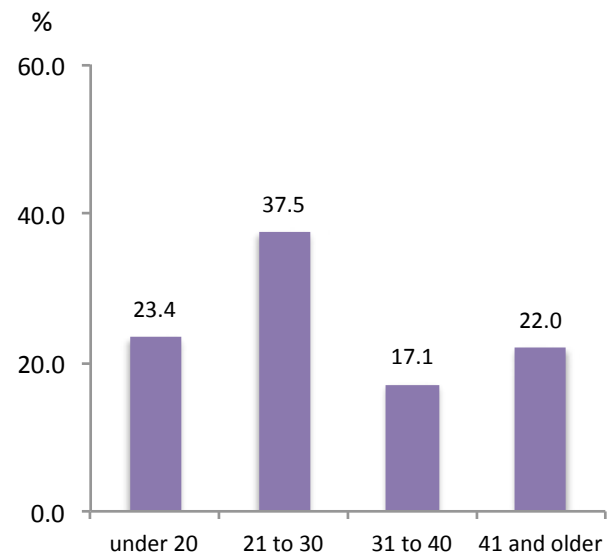


Figure 7.1d – **Age of quitting smoking (E)**



The main reasons for quitting were choosing a healthier lifestyle (59.1%), a health condition (18.5% E), a greater awareness of the ill effects of cigarettes (17.7% E) and respect for loved ones (11.1% E). Of adults who quit, 78.8% said that they quit cold turkey (will power alone).

## 7.1.2 SMOKING - YOUTH

Just under half of the youth (48.4%) live in a smoke-free home.

When asked whether they currently smoked, 70.9% of youth said they did not smoke at all, 15.7% (E) that they smoked daily, and 13.4% (E) that they smoked occasionally. When asked if they had ever smoked, 85.8% of current non-smokers said that they had never smoked.

Of those who do smoke, 63.6% smoke 1 to 5 cigarettes a day, 20.0% (E) smoke 6-10 cigarettes a day, and the remaining 16.4% (E) smoke 11 or more cigarettes a day.

Figures 7.1e and 7.1f – Smoking habits - Youth

Figure 7.1e – Current smoking frequency

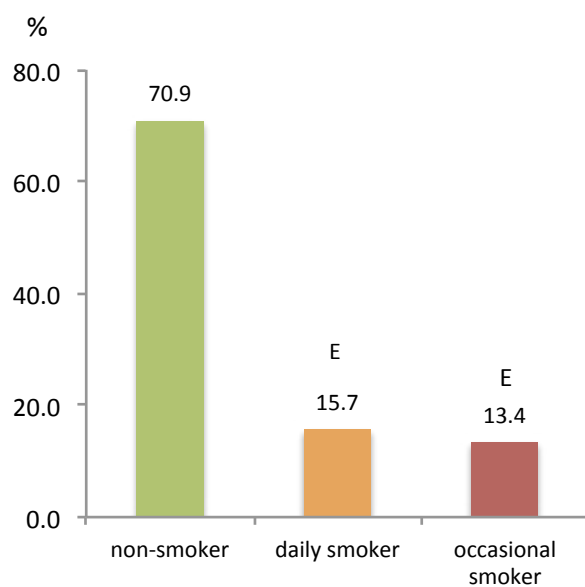
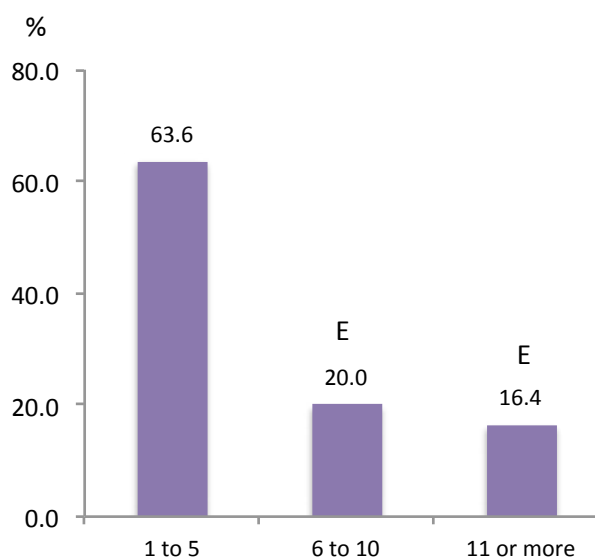


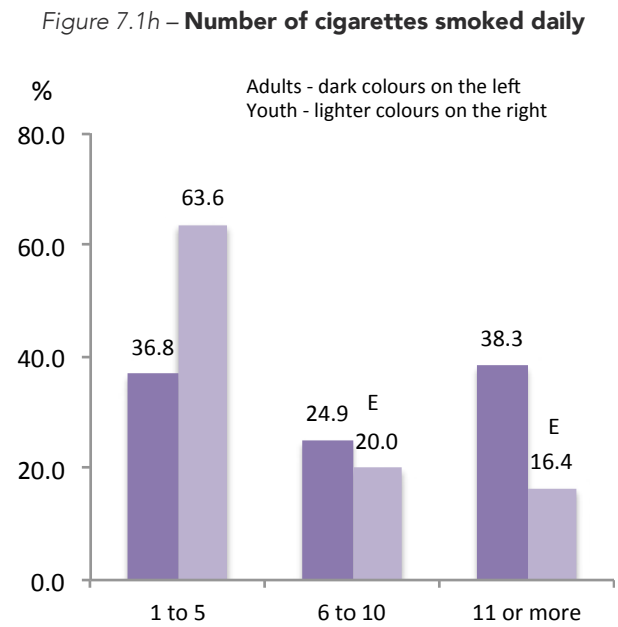
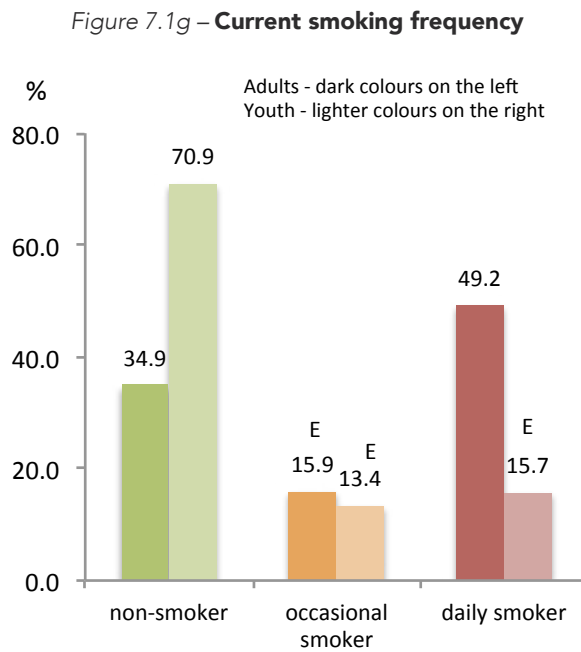
Figure 7.1f – Number of cigarettes smoked daily





### 7.1.3 **SMOKING** - COMPARISON CHARTS BETWEEN ADULTS AND YOUTH

Figures 7.1g and 7.1h – **Smoking habits – Adults & Youth**



## 7.2 ALCOHOL AND DRUG USE

### 7.2.1 ALCOHOL - ADULTS

Over half of adults (61.7%) said that they drank beer, wine, liquor or other alcoholic beverages in the 12 months preceding the survey. When asked about the frequency of drinking alcoholic beverages, 16.8% of adults said that they drank about 2–3 times a week (E), 36.3% said that they drank about 2–3 times a month, 23.1% about once a month, and 22.6% about 2–3 times a year (E).

Of those adults who do drink, a large proportion (85.8%) reported that they had been binge-drinking (5 or more alcoholic drinks on a single occasion), at least once in the 12 months preceding the survey. Of these individuals 22.0% did this less than once per month, 26.4% did this once per month, 24.5% did this 2–3 times per month, and the remainder once per week or more often. Almost two thirds (63.8%) of those adults who drink qualify as heavy drinkers (5 or more alcoholic drinks on a single occasion at least once per month).

Figures 7.2a and 7.2b – Drinking habits - Adults

Figure 7.2a – Drinking frequency in the 12 months preceding the survey

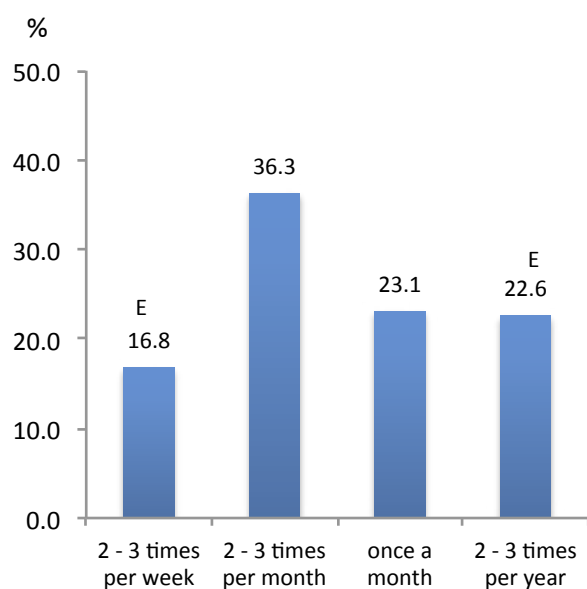
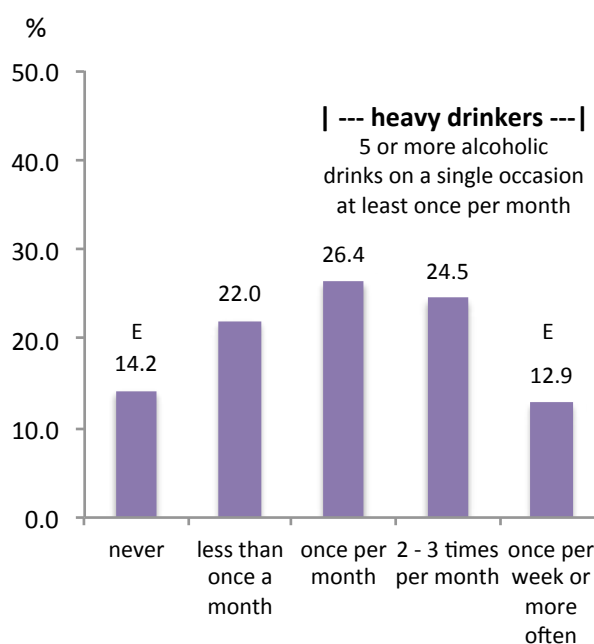


Figure 7.2b – Number of times drinkers had 5 or more alcoholic drinks on one occasion in the 12 months preceding the survey



## 7.2.2 ALCOHOL - YOUTH

Almost two thirds of youth (61.2%) said that they had not had any beer, wine, liquor or other alcoholic beverages in the 12 months preceding the survey. When the 38.8% of drinkers were asked about the frequency of drinking alcoholic beverages, 25.1% said that they drank about 2–3 times a month (E), 24.6% about once a month, and 43.3% about 2–3 times a year.

Of those youth who do drink, a large proportion (78.3%) reported that they had been binge-drinking (5 or more alcoholic drinks on one occasion) at least once in the 12 months preceding the survey. Of these individuals 30.7% did this less than once per month, 17.9% did this once per month, 25.4% did this 2–3 times per month, and the remainder once per week or more often. Less than half (47.6%) of those youth who drink qualify as heavy drinkers (5 or more alcoholic drinks on a single occasion at least once per month).

Figures 7.2c and 7.2d – Drinking habits - youth

Figure 7.2c – Drinking frequency in the 12 months preceding the survey

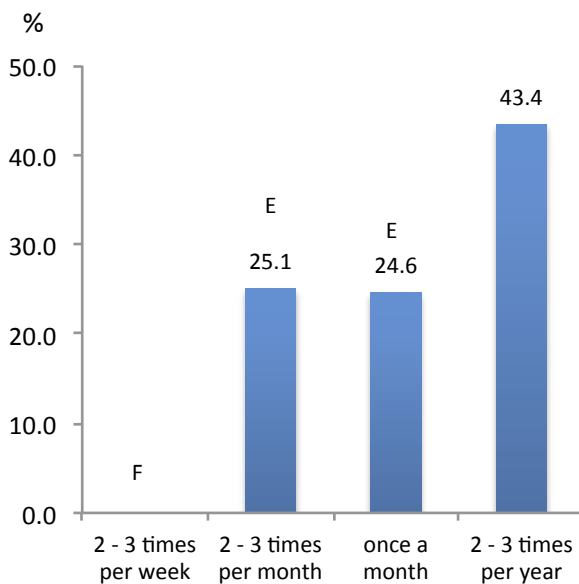
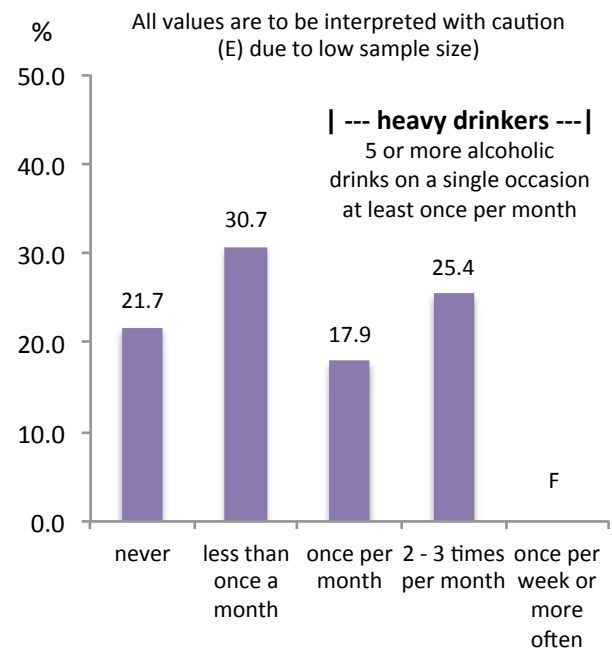


Figure 7.2d – Number of times drinkers had 5 or more alcoholic drinks on one occasion in the 12 months preceding the survey





### 7.2.3 DRUG USE - ADULTS

When adults were asked to report on which non-prescription drugs they had used in the past 12 months, 62.1% reported that they had never used any substances in the 12 months preceding the survey. Of the minority (37.9%) who did use, 33.8% responded that they had taken cannabis at least once, with 13.3% taken cannabis daily.

Other substances such as cocaine (such as coke or crack), amphetamine type stimulants (such as crystal meth, speed, and ecstasy), inhalants (such as solvents, glue, petrol, and paint thinner), sedatives or sleeping pills (such as Valium, Serapax, and Rohypnol), hallucinogens (such as LSD, acid, mushrooms, PCP, and Special K), and opioids (such as heroin, morphine, methadone, and codeine) were used far less frequently. The numbers were all below 6% and to be interpreted with caution or suppressed.

To get a better idea of the type of drug use in communities some additional calculations were made. When drug use was calculated overall, 62.1% had used some sort of substance at least once in the 12 months preceding the survey but, if cannabis is eliminated from the tally, then only 14.7% qualify as having used any substance in the 12 months preceding the survey (i.e. cocaine, inhalants, sedative or sleeping pills, hallucinogens, and opioids in any combination). Even so, over one fifth (21.4%) of adults had sought treatment for substance abuse/addiction at least once in their lives.

### 7.2.4 DRUG USE - YOUTH

When youth were asked to report on which non-prescription drugs they had used in the past 12 months, a high percentage reported that they had never used any substances in the 12 months preceding the survey. Once again the only drug that was mentioned more often than others is cannabis with 35.5% of youth responding that they had taken cannabis at least once (8.2% use cannabis daily – E).

All other substances such as cocaine (such as coke or crack), amphetamine type stimulants (such as crystal meth, speed, and ecstasy), inhalants (such as solvents, glue, petrol, and paint thinner), sedatives or sleeping pills (such as Valium, Serapax, and Rohypnol), hallucinogens (such as LSD, acid, mushrooms, PCP, and Special K), and opioids (such as heroin, morphine, methadone, and codeine) were used far less frequently. Non-users were at 97% and higher. The only other substance that registered at over a suppression level was amphetamine type stimulants (such as crystal meth, speed, and ecstasy) and even then only 2.5% of youth reported that they had used it once or twice.

Youth were asked about treatment for addictions in a little more depth than adults. They were separated out into alcohol abuse/addiction, drug abuse/addiction, and solvent abuse/addiction. There was only one question that had enough respondents for us to report on; i.e. 6.4% (E) of youth had sought treatment for alcohol abuse/addiction.

## 7.3 GAMBLING

Gambling was a common occurrence among adults: 71.3% had gambled at least once in their lives. Almost one quarter (23.4%) had borrowed money to gamble. One quarter (25.0%) reported that they had bet more money than they could afford to lose, and 15.0% (E) went on to report that their gambling had caused financial problems for them or their families.

## 7.4 PHYSICAL ACTIVITY

### 7.4.1 PHYSICAL ACTIVITY - ADULTS

When asked about their level of physical activity, 14.1% of adults said that they were rarely active, 19.7% that they did at least 30 minutes of physical activity at least once a week, 28.3% that they did at least 35 to 59 minutes a day of walking or other moderate physical activity, and 37.9% that their day involves at least 60 minutes of walking or other moderate physical activity every day.

Walking (83.7%), gardening & yard work (38.9%), running or jogging (32.1%), weights or exercise equipment (31.5%), swimming (29.6%), berry picking & food gathering (28.3%), dancing (25.7%), and golf (25.5%) were the most common physical activities listed by adults.

The number of physical activity types that adults participated in ranged from zero to 18 with the average number at around 4.

Figure 7.4a – Adults' level of physical activity

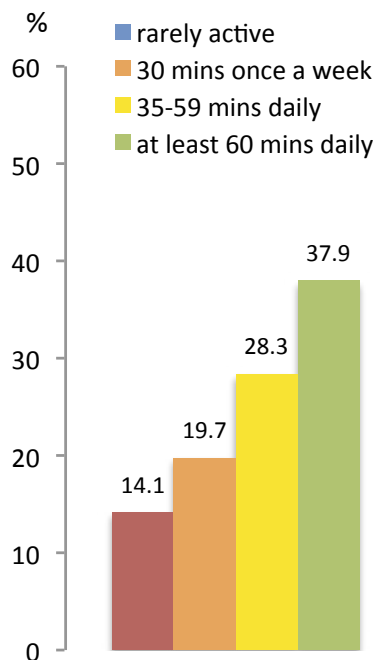


Figure 7.4b – Types of activity (listed by at least 25% of adults)

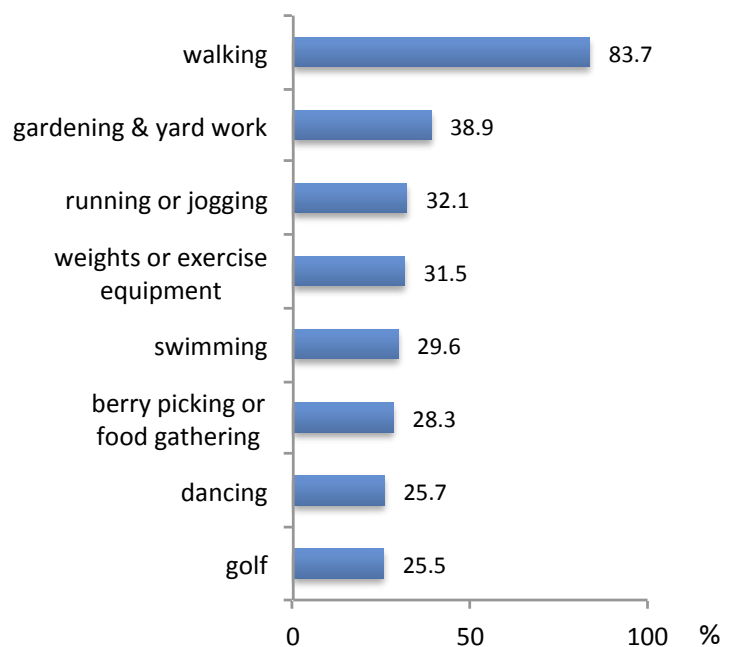
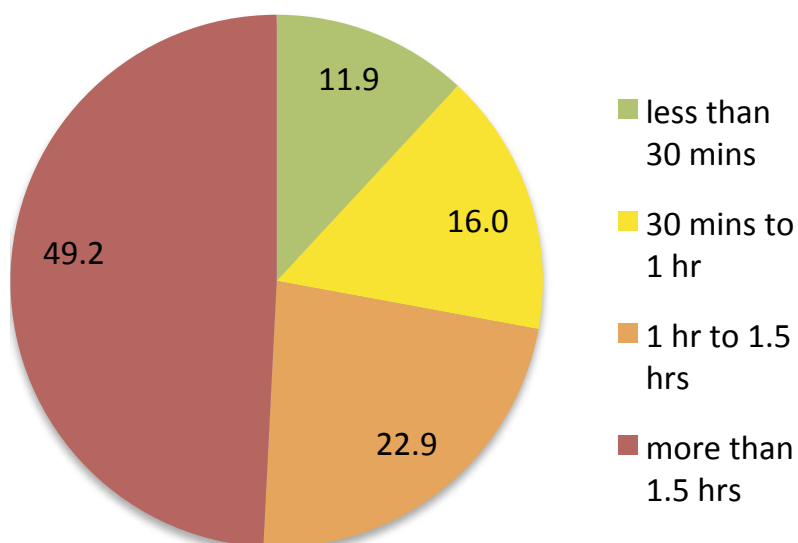


Figure 7.4c – Time adults spend in sedentary activities outside of work or school

Adults were also asked about their sedentary activities, i.e. "During the past week, how much time in an average day did you spend watching TV, reading, playing bingo/video games or working at your computer (outside of workday/school day)". Despite their physical activity level almost half of adults (49.2%) spent more than 1 ½ hours doing sedentary activities.



## 7.4.2 PHYSICAL ACTIVITY - YOUTH

As with adults, youth were asked about their level of physical activity, 11.6% of youth said that they were rarely active, 29.8% that they did at least 30 minutes of physical activity at least once a week, 28.6% that they did at least 35 to 59 minutes a day of moderate physical activity, and 30.0% that their day involves at least 60 minutes of moderate physical activity every day.

Youth differed from adults in the types of physical activities they participated in. Walking (87.2%), running or jogging (72.0%), swimming (52.3%), competitive or team sports (53.1%), weights or exercise equipment (46.7%), bicycle riding or mountain biking (41.1%), skating (31.6%), berry picking & food gathering (25.8%), and dancing (25.1%) were the most common physical activities listed by youth.

Figure 7.4d – Youth's level of physical activity

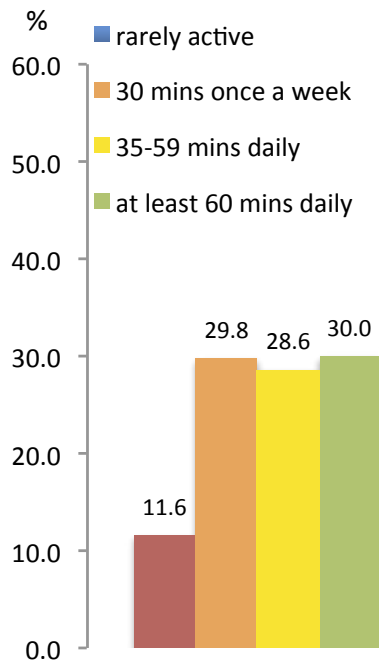
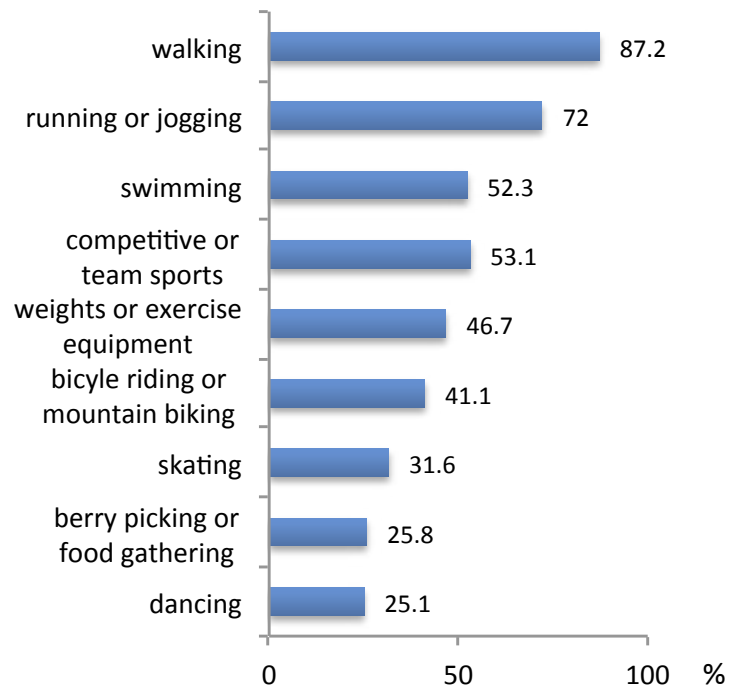


Figure 7.4e – Types of activity (listed by at least 25% of youth)



The number of physical activity types that youth participated in ranged from zero to 20 with the average number at around 6.

Figure 7.4f – Overall time youth spend in sedentary activities outside of work or school

As with adults, youth were also asked about their sedentary activities, i.e. “During the past week, how much time in an average day did you spend watching TV, reading, playing bingo/video games or working at your computer (outside of workday/school day)”. Despite their physical activity level almost two thirds (62.6%) of youth spent an hour or more at sedentary activities.

The youth sedentary activities were further broken down into 3 types of activities: working at a computer (40.9% spent less than 30 minutes daily), reading (44.9% spent less than 30 minutes daily), and playing video games (37.4% spent more than 1 1/2 hours daily).

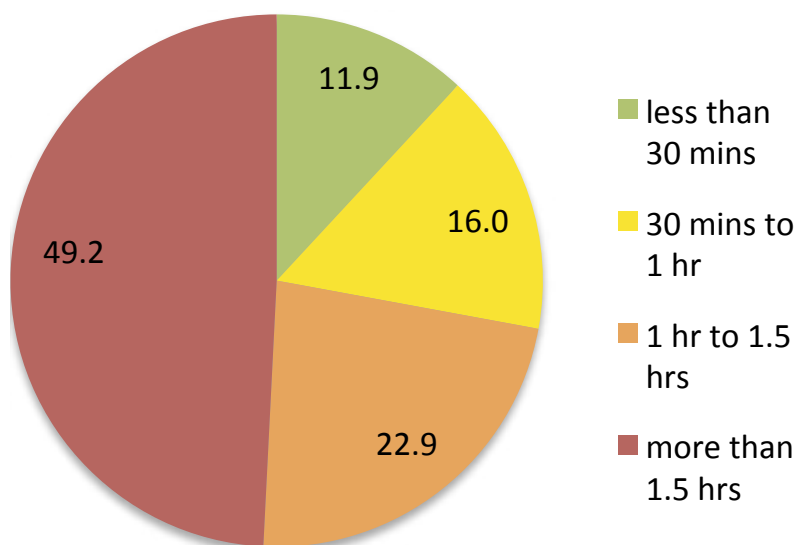
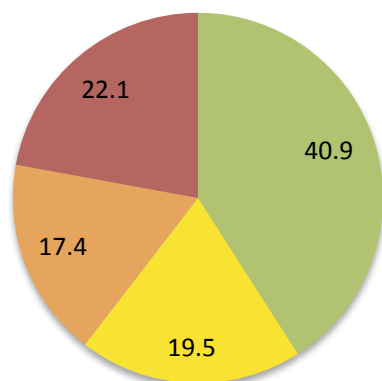


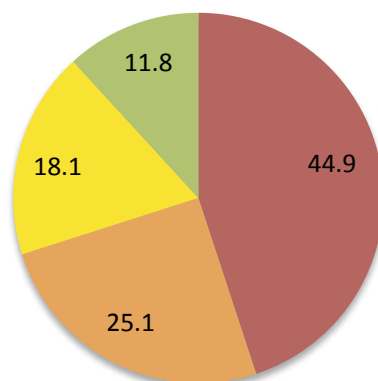
Figure 7.4g – Daily time youth spend working at a computer



■ less than 30 mins  
 ■ 30 mins to 1 hr  
 ■ 1 hr to 1.5 hrs  
 ■ more than 1.5 hrs

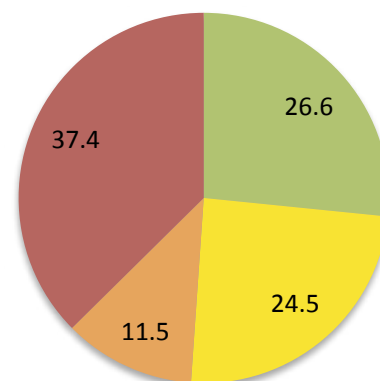
Figure 7.4h – Daily time youth spend reading

(note opposite colour scheme as reading is a desirable behaviour)



■ less than 30 mins  
 ■ 30 mins to 1 hr  
 ■ 1 hr to 1.5 hrs  
 ■ more than 1.5 hrs

Figure 7.4i – Daily time youth spend playing video games



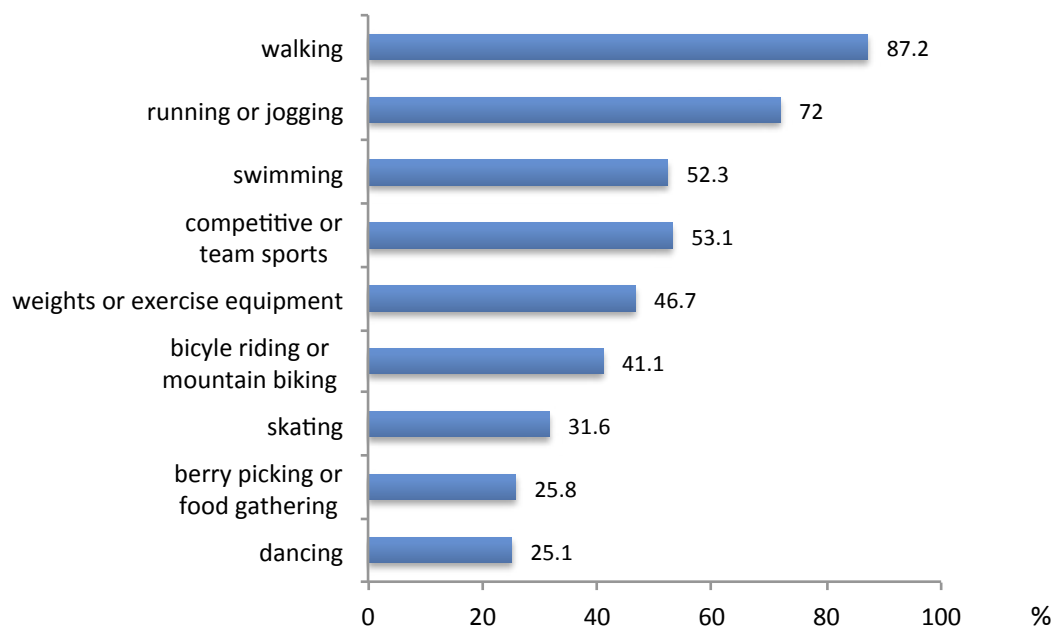
■ less than 30 mins  
 ■ 30 mins to 1 hr  
 ■ 1 hr to 1.5 hrs  
 ■ more than 1.5 hrs

### 7.4.3 PHYSICAL ACTIVITY - CHILDREN

Caregivers for children were asked about the types of physical activities the child participates in.

Children differed from both adults and youth in the types of physical activities they participated in. Walking (80.9%), swimming (66.3%), running or jogging (61.9%), bicycle riding or mountain biking (46.3%), dancing (36.2%), berry picking & food gathering (35.5%), and skating (26.7%), were the most common physical activities listed for children.

Figure 7.4j – Types of physical activity (listed for at least 25% of children)

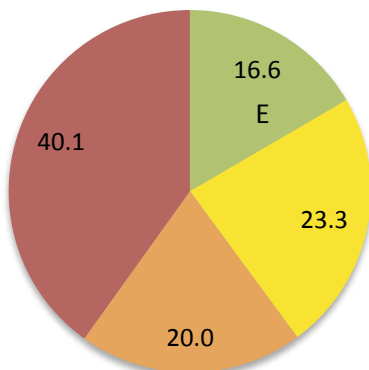


The number of physical activity types that children participated in ranged from zero to 18 with the average number at around 5.

Sedentary activities for children were broken down into 4 types: watching TV (only 16.6% spent less than 30 minutes daily), working at a computer (56.2% spent less than 30 minutes daily), reading (56.0% spent less than 30 minutes daily), and playing video games (56.0% spent less than 30 minutes daily).

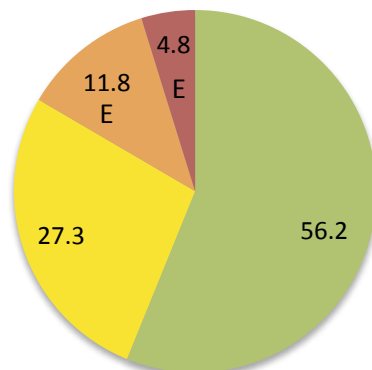
Figures 7.4k through 7.4n – Amount of time in an average day the child spends:

Figure 7.4k – **Watching TV**



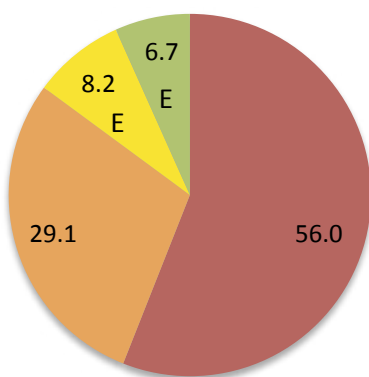
■ less than 30 mins    ■ 30 mins to 1 hr  
 ■ 1 hr to 1.5 hrs    ■ more than 1.5 hrs

Figure 7.4l – **Working at a computer**



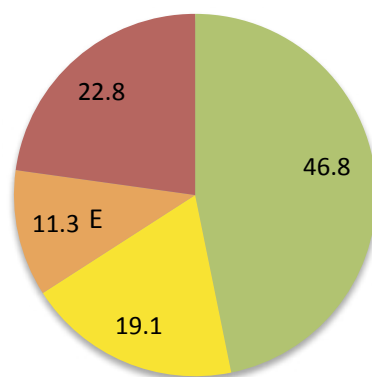
■ less than 30 mins    ■ 30 mins to 1 hr  
 ■ 1 hr to 1.5 hrs    ■ more than 1.5 hrs

Figure 7.4m – **Reading**  
 (note opposite colour scheme as reading is a desirable behaviour)



■ less than 30 mins    ■ 30 mins to 1 hr  
 ■ 1 hr to 1.5 hrs    ■ more than 1.5 hrs

Figure 7.4n – **Playing video games**



■ less than 30 mins    ■ 30 mins to 1 hr  
 ■ 1 hr to 1.5 hrs    ■ more than 1.5 hrs



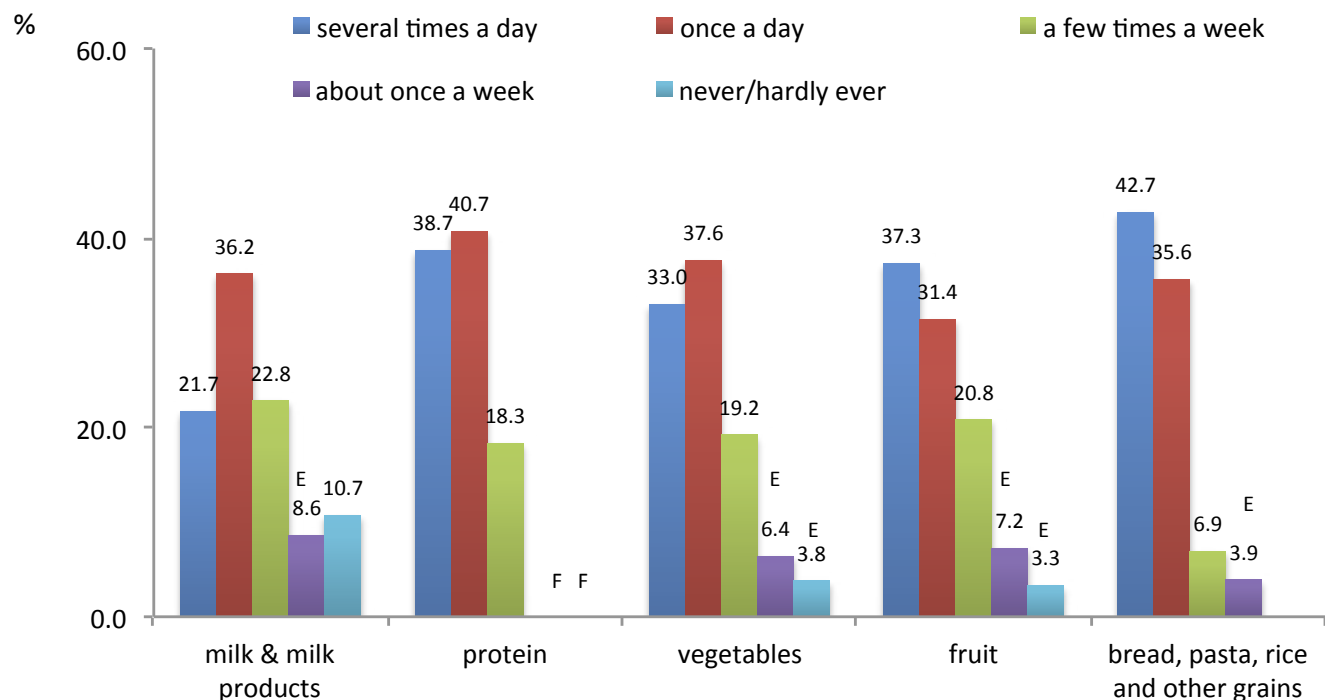
## 7.5 NUTRITION

### 7.5.1 NUTRITION - ADULTS

About one third (32.9%) of adults believe that they always or almost always eat a nutritious balanced diet; 49.5% say they sometimes do, and 17.7% say that they rarely or never eat a nutritious balanced diet.

Over half of adults have at least a daily intake of: milk and milk products (57.9%), protein (79.4%), vegetables (70.6%), fruit (68.7%) and bread, pasta, rice and other grains (78.3%). Almost three quarters (72.9%) of adults eat fast food at least once a week. A high proportion of adults drink pop (45.8%) at least once daily and an even higher proportion (63.3%) drink juice at least once a day. Most adults (93.7%) say they drink water once a day or more often.

Figure 7.5a – Types of food and quantities eaten by adults



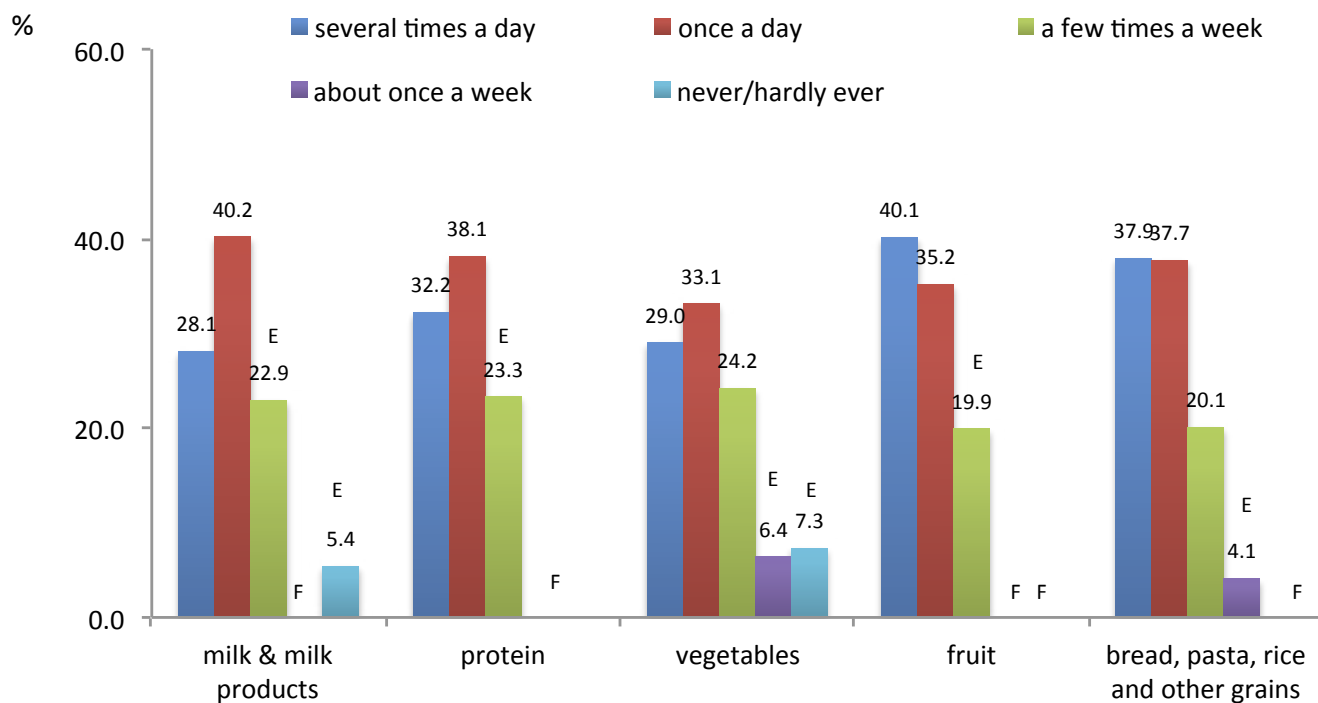
Adults were also asked about their consumption of traditional foods. The most common traditional foods eaten by First Nations adults in Alberta were bannock/fry bread (95.1%), land based animals (72.9%), berries or other wild vegetation (76.1%), and fresh water fish (49.2%). Adults acknowledged that someone shared traditional food with their household often (24.3%), or sometimes (60.8%).

## 7.5.2 NUTRITION - YOUTH

About one third (30.2%) of youth believe that they always or almost always eat a nutritious balanced diet; 45.7% say they sometimes do, and 24.0% say that they rarely or never eat a nutritious balanced diet.

Over half of the youth have at least a daily intake of: milk and milk products (68.3%), protein (70.3%), vegetables (59.1%), fruit (75.3%) and bread, pasta, rice and other grains (75.6%). Over three quarters (83.3%) of youth eat fast food at least once a week. Over half drink pop (55.5%) at least once daily, and an even higher proportion (82.5%) drink juice at least once a day. The same proportion of youth (93.7%) as in the adult survey, say they drink water once a day or more often.

Figure 7.5b – Types of food and quantities eaten by youth



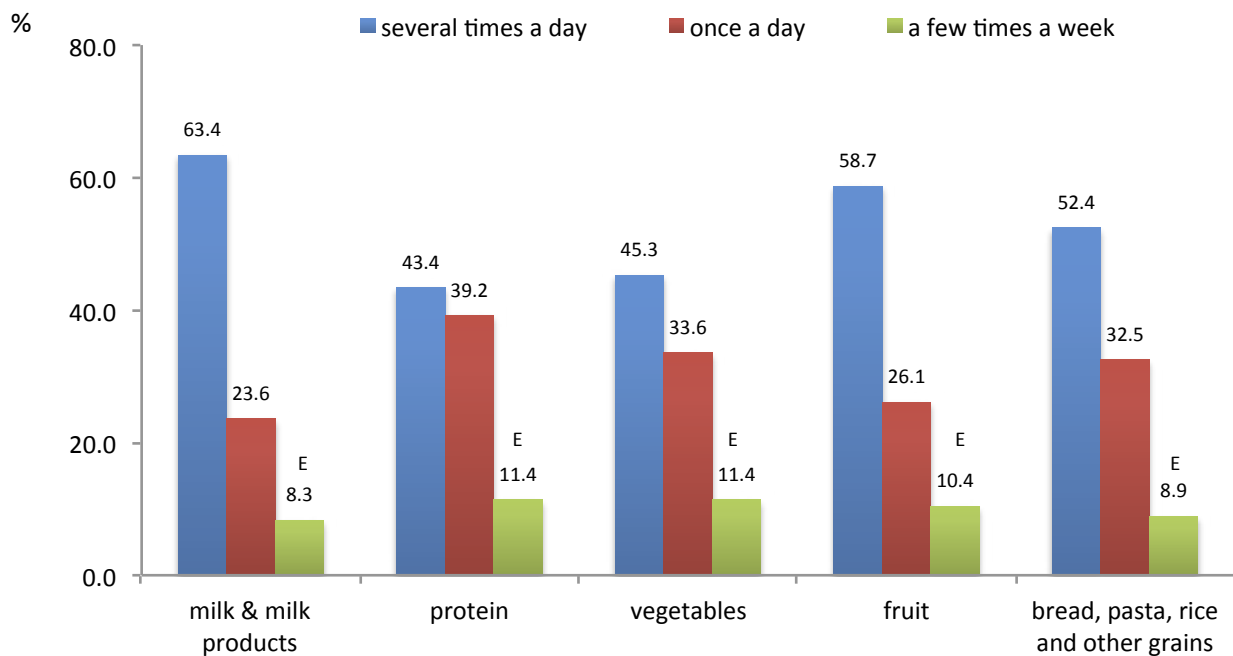
Youth were also asked about their consumption of traditional foods. The most common traditional foods eaten by First Nation youth in Alberta were bannock/fry bread (93.2%), land based animals (65.2%), berries or other wild vegetation (73.6%), and fresh water fish (33.2%). Youth acknowledged that someone shared traditional food with their household often (25.3%), or sometimes (64.5%).

### 7.5.3 NUTRITION - CHILDREN

About two thirds (65.5%) of the children's caregivers believe that the child always or almost always eats a nutritious balanced diet; 28.7% say they sometimes do, and only 4.0% say that they rarely eat a nutritious balanced diet.

Over three quarters of the children have at least a daily intake of: milk and milk products (87.0%), protein (82.6%), vegetables (78.9%), fruit (84.8%) and bread, pasta, rice and other grains (84.9%). Over three quarters (77.0%) of children eat fast food at least once a week. Over one quarter drink soft drinks/pop (15.9%) at least once daily while a much higher proportion (81.0%) drink juice at least once a day. A slightly smaller proportion of children (89.1%) than adults or youth (93.7%) drink water once a day or more often.

Figure 7.5c – Types of food and quantities eaten by children



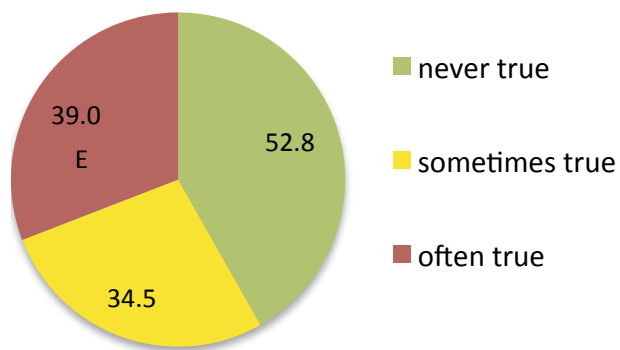
Caregivers were asked about the child's consumption of traditional foods. The most common traditional foods eaten by First Nation children in Alberta were bannock/fry bread (84.8%), berries or other wild vegetation (71.6%), land based animals (59.1%), wild rice (30.6%), and fresh water fish (29.3%). Someone shared traditional food with the child's household often (27.9%), or sometimes (59.8%).

## 7.6 FOOD SECURITY

Almost half (47.6%) of adults said that they couldn't afford to eat balanced meals, and over half (54.1%) said that the statement "The food we bought just didn't last and we didn't have any money to get more" was either often (14.4%) or sometimes (40.7%) true.

Nearly one quarter (24.8%) of adults (or other adults in their household) cut the size of their meals or skipped meals because there wasn't enough money for food. Of those who had to do this 39.5% had to do it almost every month, 45.9% had to do it some months, but not others, and 14.6% (E) had to do it for only one or two months.

Figure 7.6a – Reliance on low cost food



In the 12 months preceding the survey 18.0% were hungry but didn't eat because there wasn't enough money for food, and 26.6% ate less than they felt they should, again due to lack of money to buy food.

Almost half (47.2%) said that they had to rely on only a few kinds of low-cost food (such as macaroni and rice) to feed their children because they were running out of money to buy food in the 12 months preceding the survey.

More than one third of adults (38.3%) revealed that in the 12 months preceding the survey it was often (9.4% E) or sometimes (28.9%) true that they were not able to feed their children a balanced meal because they could not afford it.

Over one quarter (29.2%) of adults felt that in the 12 months preceding the survey their children were often (5.1% E) or sometimes (24.1%) not eating enough because they (the primary caregiver) could not afford enough food.

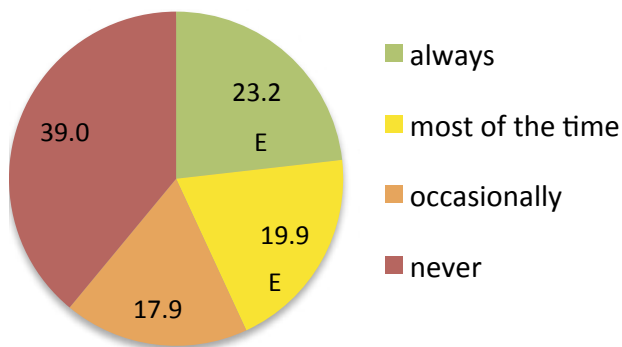
## 7.7 SEXUAL HEALTH PRACTICES

### 7.7.1 SEXUAL HEALTH PRACTICES - ADULTS

Over three quarters (76.1%) of the adults interviewed were sexually active. Of those who said they were sexually active 98.6% had sexual intercourse in the 12 months preceding the survey. The majority (74.6%) had 1 sexual partner in that time period, another 12.2% had 2 partners, and the remainder had 3 or more.

Of those adults who were sexually active, 25.4% said they do not use any birth control or protection methods. Of those who do use some method (or combination of methods), 44.5% used condoms, and 19.4% used birth control pills. A small percentage (10.8% E) had surgery (hysterectomy, vasectomy or tubal ligation). Depo Provera injections, withdrawal, and the rhythm (natural family planning) method were also provided as options but received minimal (less than 10%) endorsement.

Figure 7.7a – Adults' use of condoms



The reasons for using any of the methods listed above were for birth control (40.7%), protection from sexually transmitted diseases (13.7% E) or both (41.2%).

The use of condoms was varied, with 39.0% saying they never use them, 23.3% (E) saying they always use them, 19.9% (E) saying they use them most of the time, and 17.9% saying they use condoms occasionally.

Almost half of the adults (47.7%) had been tested for sexually transmitted diseases (STDs) or sexually transmitted infections (STIs), and over one third (38.5%) for HIV/AIDS.

About half of the adults (49.9%) listed the number of children they had given birth to, or fathered. Of those, 18.1% (E) indicated that they had not had any children, 37.9% said that they had 1 or 2 children, 28.9% said 3 or 4 children, and the remainder had 5 children or more. The age range for having the first child was from 13 to 39 with the largest group (44.4%) falling into the 17-19 year age range.

Adults were also asked if they identify as being homosexual (gay or lesbian), bisexual or two-spirited. Most (95.8%) answered the question, and of those who did, 4.9% (E) fell into this category.

## 7.7.2 **SEXUAL HEALTH PRACTICES - YOUTH**

Almost one quarter (24.8%) of youth declared that they were sexually active at the time of the interview. Of those who were sexually active, 86.7% said that they had sexual intercourse in the 12 months preceding the survey.

Of those who had sexual intercourse, 54.0% had one sexual partner only, 24.4% had 2 partners, and the remainder had 3 or more partners.

Most sexually active youth use condoms (81.1%) as a birth control method with the remaining types of methods (birth control pills, Depo Provera injections, withdrawal, and the rhythm/natural family planning method receiving less than 10% endorsement.

A high percentage of youth use condoms, with 61.6% saying they always use them, and 25.2% (E) saying they use them most of the time. There were not enough respondents to the question of: "What is the main reason for not always using condoms?" to draw any useable conclusions.

A large percentage of youth (85.4%) said that they had never been pregnant or had gotten anyone pregnant and so, once again, there were too few respondents to the questions of "How many children have you given birth to or fathered?", and "At what age did you have your first child?" to draw any useable conclusions.

As with the adult survey, youth were asked if they had been tested for sexually transmitted diseases (STDs) or sexually transmitted infections (STIs), and for HIV/AIDS. Less than 7% had been tested for either and therefore we do not have any useable information on these questions either.











# Chapter 08:

## DISCUSSION



## 8.1 GENERAL

The Regional Health Survey is a self-reported survey, meaning that we rely on the respondents to give us accurate information. While this is a very common and often-used method it is not without its limitations.

## 8.2 ADULTS

Adults were aware of the factors that contribute to their good health, namely good diet, good social supports, good sleep/proper rest, happiness, and exercise.

### 8.2.1 VISION - PHYSICAL HEALTH

Almost half of the adults in Alberta reported that their health was “thriving” (either excellent or very good) with the vast majority of those who were “non-thriving” being over the age of 55.

Adults were aware of the factors that contribute to their good health, namely good diet, good social supports, good sleep/proper rest, happiness, and exercise.

There were no clear-cut health conditions identified as to why adults, as a group, may not be thriving. The most commonly reported long-term health condition was arthritis but even that was below the 25% mark.

A smaller than expected proportion (13.6%) of adults reported being diagnosed with diabetes; just over  $\frac{3}{4}$  of them with Adult Onset (Type II) Diabetes. A large majority of diabetics stated that they have now adopted a healthier lifestyle due to their diagnosis. Since we have no baseline measures or case files we have no way of knowing as to whether the healthier lifestyle has improved the condition of these individuals.

Over one quarter of adults reported that they have a physical or mental health issue that limits the kind or amount of activity they are able to do at home, work, or otherwise. The most common limitation was related to the lack of proper vision.

Almost one third of adults had consulted a traditional healer at some point in their lives, and just under half said that they use traditional medicines. Over two thirds of adults believed that, in terms of Western medical care, they have the same or better access to health care than Canadians in general. Despite this, barely over half of the adults had received any dental care in the year prior to the survey, and 15% of them cited cost as the reason.

## 8.2.2 **RELATIONSHIPS – PERSONAL AND COMMUNITY WELLNESS AND CULTURE**

Adults' mental health was generally good, with over three quarters stating that they felt "in control" over their lives. Just under one quarter (24%), however, had symptoms of depression either all or most of the time, based on their responses to questions from the Kessler Psychological Distress Scale included in the survey. Most adults felt that they did have emotional or mental health supports available to them. These were mainly family and friends, but over one third also felt that their family doctors were there for them.

Aggression was a problem for many adults, with over half experiencing verbal aggression, and almost one third experiencing physical aggression in the 12 months preceding the survey. It is troubling to note that only one quarter of those who experienced any sort of aggression actually sought help in dealing with it.

Suicide was another area of concern, with almost one quarter of adults having thought of committing suicide at some point in their lives. More in-depth analyses of responses showed that of those adults who had thought of this, over half had actually made an attempt. The majority (almost 85%), however, had no suicidal thoughts in the 12 months preceding the survey.

Just over one quarter of adults had attended residential school themselves, and of these individuals over 60% felt they had been negatively impacted. Most parents (over 60%) and grandparents (66%) had also attended residential school.

Despite residential schooling, over 70% of adults can speak or understand a First Nation language, and over one third use that language in their daily lives.

When asked about the wellness of their community, adults generally felt that there had been little to no progress on most community issues in the past 12 months. They did, however, identify 3 top community strengths. These were: family values, traditional ceremonial activities, and the elders.

Migration is related to community wellness in many ways, and almost two thirds of adults had lived outside of their First Nation at some point in their lives. The most frequent reasons were employment, education, and housing. Men tended to leave their communities mainly for employment (a smaller number for educational opportunities) while women left for educational and housing opportunities. Reasons for returning to the community included family, connection to community/home, and housing became available.

### 8.2.3 **REASON – SOCIAL ECONOMIC**

In terms of the education they received, women were slightly more likely to have completed high school than men, and were also more likely to have a community college or undergraduate university degree. Men were more likely to have completed a diploma from a trade, technical or vocational school.

Just under half of the adults worked for pay at the time of the survey, and of those not working almost half were looking for work.

The majority of adults (just over 85%) did have some form of income. Over 40% reported getting Social Assistance. They were generally able to meet their shelter, childcare, clothing, and to some extent, utility needs (all above 65%) but were less able to meet the needs for transportation and food (both below 60%). Housing is overcrowded and in need of repairs, with over half reporting that they had issues with mould or mildew in their homes in the 12 months preceding the survey.

An area of concern regarding income is that 37% of adults surveyed reported Child Tax Benefits as a source of income. According to the Canada Revenue Agency, the Child Tax Benefit is a “tax-free monthly payment made to eligible families to help them with the cost of raising children under age 18”. The costs of raising a child are well beyond what the Child Tax Benefit, even in combination with the National Child Benefit Supplement, can cover.

### 8.2.4 **ACTION – HEALTH BEHAVIOURS AND LIFESTYLE**

Most adults reported some form of physical activity, with walking being the preferred choice by the vast majority (almost 84%). Adults’ perceived nutrition levels are less favourable, with only about one third claiming they always or almost always eat a nutritious, balanced diet. This could be due, in part, to the fact that almost half (48%) stated that they could not afford to eat balanced meals, and over half agreed that the statement: “The food we bought just didn’t last and we didn’t have any money to get more.” was either often or sometimes true. More than one third also revealed that they were not able to feed their children a balanced meal because they could not afford it, and over one quarter felt that their children were either often or sometimes not eating enough because they could not afford enough food.

Almost two thirds of adults smoke either daily or occasionally. Despite this, 61% of adults said they had a smoke free home. This demonstrates a trend that adults are becoming more aware of the dangers of second hand smoke in the home.

Over half of all adults drank beer, wine, liquor or other alcoholic beverages in the 12 months preceding the survey. As in the National Report, of those adults who do drink almost two thirds qualify as heavy drinkers.

Over 70% of adults reported that they had gambled at least once in their lives. Gambling was a problem for some of these adults, with almost one quarter of them having borrowed money in order to gamble. A full quarter of those adults who reported that they had gambled had bet more money than they could afford to lose. Gambling had caused financial problems for adults or their families in 15% of cases.

Over three quarters of adults reported some amount of sexual activity. Among these individuals almost half had been tested for sexually transmitted diseases (STDs) or sexually transmitted infections (STIs), and over one third for HIV/AIDS. Of the over 95% of individuals who answered the question, about 5% identified as being homosexual (gay or lesbian), bisexual or two-spirited.

## 8.3 YOUTH

### 8.3.1 VISION - PHYSICAL HEALTH

Over two thirds of the First Nation youth in Alberta reported that their health was “thriving” (either excellent or very good). Almost two thirds were at a healthy weight in accordance with BMI-for-Age calculations per the Centres for Disease Control (CDC) and, correspondingly, just over two thirds were somewhat to very satisfied with their weight.

Youth perceived physical factors, namely good diet, good sleep/proper rest, and exercise as being the main contributors to their good health. Unlike adults they seem to be unaware of the psychological factors such as good social supports, reduced stress, and being in balance as other important contributors.

Long-term health conditions in youth were few. Allergies topped the list at barely over 20%. Youth were more prone to acute conditions, namely injuries, which were the most likely to occur at sports fields or school facilities.

Youth were not asked as many questions regarding their health care utilization as adults were. We do know that just over one quarter of youth remember having consulted a traditional healer at some point in their lives. We also know that almost half again as many youth (78% vs. 53%) received dental care in the 12 months preceding the survey.

### 8.3.2 RELATIONSHIPS – PERSONAL AND COMMUNITY WELLNESS AND CULTURE

As with adults, the mental health of youth was generally good, with roughly 80% stating that they felt “in control” over their lives, and over 80% had a positive self-image - either agreeing or strongly agreeing that they liked the way they were; that they had a lot to be proud of; that a lot of things about them were good; and that they were doing things well.

About 30% of youth participated in extra-curricular activities to some extent.

Most youth (72%) felt in balance either all the time or most of the time in the physical aspect of their lives and, even more so than adults, a good proportion of youth (again, roughly 80%) believe that they have access to supports all or most of the time, if needed. Despite this, just over one quarter of youth responded that they have had a time during the past 12 months when they felt sad, blue or depressed for 2 weeks or more in a row.

Bullying was somewhat of a concern, with almost 15% of youth stating that they were currently being bullied. Of those being bullied, a higher percentage (almost 38%) have felt sad, blue or depressed for 2 weeks or more in a row during the preceding 12 months

Just over 15% of youth said that they had, at some point in their lives, thought about committing suicide; just over half of them in the 12 months preceding the survey.

One third of the youth had at least one parent who had attended residential school, and over 90% said that at least one of their grandparents had attended.

Over half the youth are able to speak or understand a First Nation language, with almost 15% of them using it daily. Most youth (over 90%) thought that it was important to participate in traditional cultural events.

As with adults, youth generally felt that there had been little to no progress on most community issues in the past 12 months. Youth identified the same top community strengths as adults (i.e. family values, traditional ceremonial activities, and elders).

### 8.3.3 **REASON – SOCIAL ECONOMIC**

At the time of the survey most youth (over 80%) were still attending school and, overall, they liked school to some extent (79%).

When asked about their household structures almost half the youth (48%) stated that their biological parents were separated or not living together.

### 8.3.4 **ACTION – HEALTH BEHAVIOURS AND LIFESTYLE**

Most youth reported quite a bit of physical activity. As with adults, walking was the main activity for the vast majority (just over 87%), but youth also ran or jogged (72%), swam (52%), and played competitive or team sports (53%).

As with adults, youth's perceived nutrition levels were not favourable. Less than one third claimed they always or almost always eat a nutritious, balanced diet.

Just over 70% of youth say they don't smoke at all, and just under half live in a smoke-free home. Almost two thirds of youth don't drink (or had not had any alcohol in the 12 months preceding the survey), and over 97% stated that they don't use drugs of any kind.

Almost one quarter of youth reported that they are sexually active and most of them use condoms as a birth control method.

## 8.4 **CHILD**

### 8.4.1 **VISION - PHYSICAL HEALTH**

Just over 85% of children were reported to be "thriving" (either excellent or very good health) by their caregivers. A sobering statistic was that, despite their good health, almost half of the children qualify as obese in accordance with BMI-for-Age calculations per the Centres for Disease Control (CDC).

As with youth, there were very few children with long-term health conditions. Allergies again topped the list, this time at 10%. Children had fewer injuries than adults or youth but when they did occur it was mostly at home.

Health care utilization among children was good, with 94% receiving their routine vaccinations and immunizations. This indicates that community health services are responding successfully in meeting the health needs of children.

Two thirds of children had received dental care in the year prior to the survey interview.

### 8.4.2 **RELATIONSHIPS – PERSONAL AND COMMUNITY WELLNESS AND CULTURE**

Just over 40% of children are able to speak or understand a First Nation language, with about 15% of them using it daily.



### 8.4.3 **REASON – SOCIAL ECONOMIC**

Two thirds of children (66.7%) were attending school at the time of the survey. Almost half of them (41.7%) had attended an Aboriginal Head Start program.

More children live with their biological parents than youth do, and the incidence of living with an aunt, uncle or cousins is more than double in the children's households than in that of the youth.

### 8.4.4 **ACTION – HEALTH BEHAVIOURS AND LIFESTYLE**

As with youth, caregivers for children reported quite a bit of physical activity. As with adults and youth, walking was the main activity for the vast majority (81%), swimming and running or jogging were also at over 60%.

Children's perceived nutrition levels were more favourable than for adults and youth, with about two thirds of caregivers saying the children always or almost always eat a nutritious, balanced diet.



# Conclusions and Recommendations

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The Regional Health Survey (RHS) is a self-reported survey, meaning that we rely on the respondents to give the most accurate information they can. While this is a very common and often-used method, it is not without its limitations.

These types of surveys are helpful in that they are practical and researchers can obtain large amounts of quantifiable information. Inherent in this type of research is the human factor - perceptions of those responding to the survey as well as over or under-reporting for various reasons. For example, under-reporting is possible with measures of dietary habits and drug or alcohol consumption. Researchers must rely on the perceptions of many different individuals and of different age groups. Younger people may have a more difficult time with questions pertaining to their physical and emotional well-being due, for example, to less experience with quantifying their feelings.

Overall, these types of surveys are very useful to begin to identify the trends in the issues under question and around the population being researched. From here, we can then propose starting points for other areas of research that are either separate from, or are used in conjunction with the current information.

There are some important next steps that need to be considered in the 2014 research. First, we must continue presenting the value and importance of research in 'telling our stories'. The process ought to continue emphasizing our traditional ways and work toward the benefit of community health through reliable data collection. The results of the data must be discussed, including limitations and suggestions for improving data collections from the

communities themselves. More importantly, we must focus on utilizing the RHS data for future follow up in respective First Nation communities.

For the first time in history First Nation communities in Treaty No. 6, Treaty No. 7, Treaty No. 8 have been presented with research data that has been developed and culturally validated by First Nations themselves. There will be an opportunity to begin follow-up, planning, and decision-making based on scientific evidence and facts. First Nations communities will be able to examine the trends in their communities as it relates to the RHS Cultural Framework with the intent to design holistic and culturally-fit programs to improve overall health.

The second recommendation is that First Nation communities in Alberta work collaboratively with their treaty area Health Secretariats to develop a working document that addresses both short and long-term goals based on the RHS data results. The RHS data is a powerful tool for affecting change within the community, as it relates to the total health of the total person within the total environment. Implementation of evidence-based practices based on collectively developed goals may be presented at an RHS Health Conference in the near future.

The final recommendation is, as research continues in "Indian Country", First Nation communities work jointly and develop partnerships with each other, government organizations and other agencies so that we maintain our vision of improving First Nations health.

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# References/ Bibliography

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Centers for Disease Control and Prevention. Healthy weight - it's not a diet, it's a lifestyle! Assessing your weight. About BMI for children and teens. Retrieved December 17, 2012, from Centers for Disease Control Web Site: [http://www.cdc.gov/healthyweight/assessing/bmi/childrens\\_bmi/about\\_childrens\\_bmi.html](http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html)

Econometrica, Inc. (2007). Measuring overcrowding in housing. U.S. Department of Housing and Urban Development Office of Policy Development and Research.

First Nations Information Governance Centre (FNIGC) (2012). First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities. Ottawa (ON): FNIGC.

Government of Canada, Canada Revenue Agency. Canada child tax benefit (CCTB). Retrieved July 23, 2013, from Canada Revenue Agency Web Site: <http://www.cra-arc.gc.ca/cctb/>

Helliwell, J., Layard, R. & Sachs, J. (Ed.). (2012). World happiness report. New York (NY): Earth Institute, Columbia University.

Kader, G.D. & Perry, M. (2007). Variability for categorical variables. *Journal of Statistics Education*, 15(2).

Knotsch, C. & Kinnon, D. (2011). If not now ... when? Addressing the ongoing Inuit housing crisis in Canada. National Aboriginal Health Organization.

Northrup, D.A. (1996). The problem of the self-report in survey research. *Institute for Social Research*. 12(1).

Paulhaus, D.L. & Vazire, S. (2007). The self-report method. In R.W. Robins, R.C. Fraley, & R.F. Krueger (Eds.), *Handbook of research methods in personality psychology* (pp. 224-39). New York: The Guilford Press.

Schacter, D. L. (1999). The seven sins of memory. *Insights from Psychology and Cognitive Neuroscience*. *American Psychologist*, 54(03), 182-203.

Sørensen, J.B. (2000). The Use and Misuse of the Coefficient of Variation in Organizational Demography Research. Sloan School of Management, Massachusetts Institute of Technology.

World Health Organization. Overcrowding. Retrieved March 18, 2013, from World Health Organization Web Site: <http://www.who.int/ceh/indicators/overcrowding.pdf>

Yu, C.H. (2010). Research and evaluation of web-based instruction. Reliability of self-report data. Retrieved April 23, 2013, from Creative Wisdom Web Site: <http://www.creative-wisdom.com/teaching/WBI/memory.shtml>

# Office Information

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## The Alberta First Nations Information Governance Centre

### **AFNIGC**

PO Box 640  
Morley, AB T0L 1N0

### **AFNIGC South Office**

Suite 111, 535-8 Avenue SE  
Calgary, Alberta T2G 5S9

### **AFNIGC North Office**

16310-100 Avenue  
Edmonton, Alberta T5P 4X5

403.539.5775

## AFNIGC Operations Manager:

Bonnie Healy  
Bhealy@afnigc.ca  
403.539.5775

## AFNIGC Officers:

### **Treaty 6 Representatives**

Alphonse Arcand - Secretary  
Brenda Joly

### **Treaty 7 Representatives**

Gregg Smith - Chairman  
Dr. Deborah Pace - Treasurer

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Chief Charles Weasel Head  
Chief Herb Arcand  
Chief Rose Laboucan

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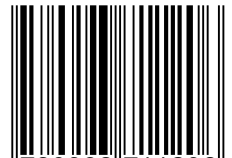




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