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

Report on Urban First Nations Living Outside Communities

Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador

First Nation of Quebec and Labrador Health and Social Services Commission

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Preamble

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

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

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

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

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

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

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

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

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

We hope you enjoy your reading!

Acknowledgments

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

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

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

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

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

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

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

Nancy Gros-Louis Mchugh
Research Technical Coordinator

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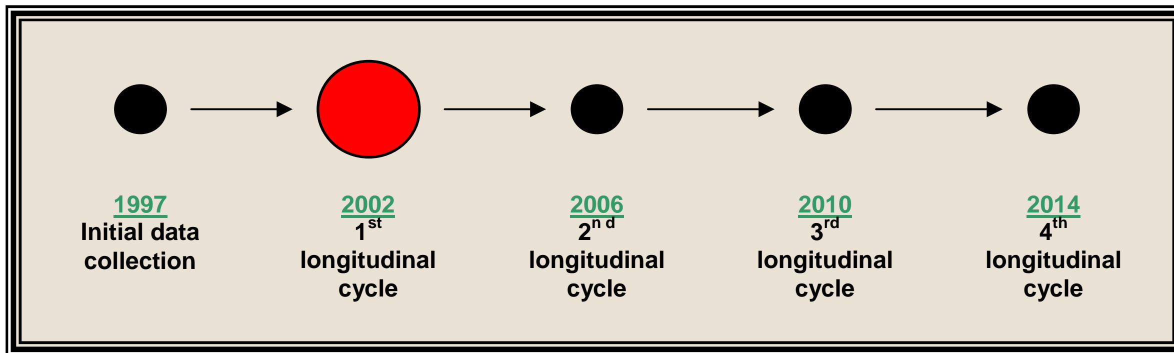
Section 1: Introduction

Introduction

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

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

Graph 1: Longitudinal evolution of the FNRLHS



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

1.1 Survey Objectives

The three questionnaires created for the survey (one each for adults, adolescents and children) were designed based on specific objectives:

- "Obtain information on the demographic characteristics that could affect the state of health of First Nations members living in Quebec.
- Obtain information regarding the state of physical health of First Nations members living in Quebec.
- Obtain information regarding the well-being of First Nations members living in Quebec.
- Obtain information regarding the lifestyle habits of First Nations members living in Quebec.
- Obtain information regarding the perceptions of health services by First Nations members living in Quebec."[1]
- Obtain the most relevant information possible regarding the various problems encountered in the communities of First Nations members living in Quebec.

[1] FNQLHSSC, 1999, p. 4.

- Achieve all of the above objectives for each age group identified for purposes of this research, i.e., children, adolescents and adults.

1.2 Principles of Ownership, Control, Access and Possession (OCAP)

This project is based on the principles of OCAP (Ownership, Control, Access and Possession), as implemented by the First Nations in Canada. The first three principles were developed by the FNRLHS steering committee in 1998, with 'Possession' added at a later date. This set of ethical rules constitutes the expression of First Nations' self-determination in research and information creation and management. The following definitions set out these concepts more clearly:

"Ownership

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

Control

The aspirations and rights of First Nations Peoples to maintain and regain control of all aspects of their 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.

Access

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

Possession

While ownership identifies the relationship between 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 breech or misuse. This is particularly important when trust is lacking between the owner and possessor.

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

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

A national ethics review concluded that the survey respects the privacy of the respondents. Also, the use of consent forms contributed a great deal to the principle of voluntary participation. All aspects related to the

[2] NAHO, 2004

data protection protocols are based on agreements and methods specific to First Nations. Publication of the FNRLHS data aims for maximum dissemination to ensure that First Nations can make the greatest possible use of it, while at the same time protecting each community's information. Lastly, all publications are subject to the approval of First Nations authorities at all three national, regional and local levels.

1.3 Methodology

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

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

1.3.1 Total Population of the Survey

The total population is defined as the entire survey population. For the purpose of the FNRLHS, it includes all Quebec First Nations members living in urban centers. The majority of respondents were selected in Native Friendship Centres, which probably influenced the validity of the results. A census conducted by Indian and Northern Affairs Canada (INAC) in 2001 established that there were 19,041 First Nations members living off-community in urban settings. However, it is difficult to estimate the proportion of individuals who do business with Native Friendship Centres.

1.3.2 Designated Population - Sample

Since the population of this survey includes First Nations members living off-community in urban centres, the sample of the survey is composed uniquely of respondents living in this setting. Three urban centres were chosen for the construction of the sample: the metropolitan areas of Quebec City and Montreal as well as the agglomeration of Val d'Or. These three urban centres were chosen because they have a high population count of First Nations members and they all have Native Friendship Centres, thus facilitating the contacts with First Nations members and the data collection. The sample created is a voluntary, non-probabilistic sample. Altogether, 268 adults, 36 adolescents and 64 children form the final sample.

Remember that, considering the non-probabilistic nature of the sample, the results obtained cannot be generalized to all the First Nations members living off-community.

1.4 Data Collection

1.4.1 Selection and training of interviewers

As mentioned earlier in this report, the FNRLHS stands out from other surveys due in particular to the involvement of First Nations members in every stage. In keeping with this principle of involvement, the FNQLHSSC gave priority to using First Nations members as interviewers. The FNQLHSSC asked the Montreal and Val d'Or Native friendship centres to recruit potential interviewers, while it took over the recruitment for Quebec City.

All of the selected interviewers had to sign an oath of secrecy before a commissioner of oaths and attend three days of training. This training, provided by the FNQLHSSC and held in all three urban centres, covered the following topics:

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

1.4.2 Data collection, processing and analysis tools

All of the interviews conducted for FNRLHS 2002-2003 in the Quebec region were computer-assisted. Each interviewer was provided with a laptop computer containing the child, adolescent and adult questionnaires. These computerized questionnaires were created on Lotus Notes under the supervision of the FNC (NAHO). All the questionnaires completed by the interviewers were automatically encrypted and inaccessible to any person, thereby ensuring the confidentiality of the respondents' answers. After each day's work, the interviewers uploaded the completed interviews from their laptops to the regional server of the FNQLHSSC. After all of the interviews were completed, the regional data were decrypted and transferred to a Microsoft Excel file, under the supervision of the FNQLHSSC, in order to serve as a raw database. This database was put onto a CD-ROM and sent to the FNC for standardization with the databases sent by the other regions (a step necessary for the national analysis) and for cleaning with SAS (Statistic Analysis System) and SPSS (Statistical Package for Social Sciences) softwares. When these steps were completed, the FNC sent the cleaned data to the different regions. The FNQLHSSC's research sector then carried out the data analysis using SPSS and Microsoft Excel.

1.4.3 Questionnaires

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

Questionnaire for children (0 to 11 years old)

The children's questionnaire was completed in the form of a structured interview. The interviewer spoke to the parent or guardian, selected on a random basis, who answered by proxy for their children. The questionnaire took about 35 minutes to complete and was made up of questions on the following topics:

- Household/family composition
- Parental education
- Education – level, performance, Head Start
- Height, weight – at birth and current

- Breastfeeding history
- Smoking – second-hand smoke exposure (pre & post natal)
- Language – comprehension, use, interest
- Food and nutrition
- Activities – physical, social, after school
- Health conditions, duration, treatment, effects
- Injuries
- Disabilities, limitations
- Health services access – Non-Insured Health Benefits
- Dental health, baby bottle tooth decay
- Traditional culture – importance, learning
- Emotional and social well-being
- Childcare- babysitting
- Residential school (parents, grandparents)

Questionnaire for adolescents (aged 12 to 17 years old)

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

National component

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

Regional Component

- Education, career goals and dreams for the future

Questionnaire for adults (18 years old and up)

The adult questionnaire was administered as a structured interview in which the respondents answered questions asked by the interviewer who guided them throughout the process (approximately one hour). Some questions were modified in order to make them relevant and consistent with the urban environment. The adult questionnaire covered the following topics:

National component

- Demographics
- Languages - comprehension, use
- Education
- Employment
- Income and sources
- Household-composition and income
- Housing - condition, crowding, mould
- Water quality
- Services - phone, water, smoke detector, internet etc.
- Height, weight
- Health conditions (duration, treatment, effects)
- Diabetes-type, treatment, effects
- Physical injuries
- Dental care
- Disability, limitations
- Physical activities
- Food and nutrition
- Home care - use, need
- Health services - use, access, Non-InsuredHealth Benefits
- Traditional medicines, healers
- Smoking, alcohol, drugs - use, cessation, treatment
- HIV/AIDS, STDs and sexuality
- Pregnancy, fertility
- Preventative health practices
- Well-being, supports & mental health
- Suicidal ideation and attempts
- Residential schools-impacts
- Culture, spirituality, religion

Regional Component

- Education
- Means of transportation and security
- Lifestyle and social problems
- Games of chance, lotteries

Important Notes for Readers

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

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

The sign (-) refers to a null value.

The comparison with the 1997 survey refers only to Montreal respondents, totalizing 201 individuals.

1.5 Research limitations

A survey of the scope of the FNRLHS is not immune from constraints, obstacles and bias that can alter the validity of the results and the general progress of the research. Fully aware of these actual and potential sources of errors, the research team who conducted the FNRLHS in the Quebec Region took them

into account in the results analysis and interpretation, as well as in the production of this report. The Quebec Region, and all of the regions who took part in the FNRLHS at the national level, have had to respond to common and specific challenges at each major phase of the Survey. This Section aims to document the bias and potential sources of errors inherent to the research context specific to the Survey[34] for each major phase, which are: the sampling, data collection, and analysis of the information collected.

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

1.5.1 Sampling method of the part on off-community urban First Nations members

Although the FNRLHS did not plan any data collection among off-community urban First Nations members, the FNQLHSSC, in charge of the FNRLHS in the Quebec Region, chose to document the health of off-community members through a parallel survey financed from the survey budgets. The results of this survey are presented in the report entitled "Report on off-community urban First Nations". The selection of off-community urban respondents was made based on a non-probability sampling, an imperative given the fact that, for financial reasons essentially, it was impossible to calculate the probability of each off-community member to be included in the sample. The single task of identifying the number of members living off-community and their localization would have necessitated almost all of the reduced resources allotted to that part of the survey. It is important to remember that the survey among that group was exploratory and carried out with funding from the budgets for the survey on First Nations members living on community.

Off-community urban First Nations members were mainly approached through the Native friendship centres of three urban centres: Quebec City, Montreal and Val-d'Or. The haphazard sampling method was privileged to contact most of the 268 adults, 36 adolescents and 54 children whose information was provided off community. Some of these informants were also reached outside friendship centres by "snowball" methods, or "through contacts". It goes without saying that the results obtained for these off-community respondents can in no case be inferred to those of all First Nations living off community, or even to those living in one of the three urban centres, because, among other things, a non negligible portion of these respondents shares an important characteristic: they go to a Native Friendship centre. These centres offer assistance and support services to First Nations members living off community and are particularly intended for those who are the most in need. Respondents reached in these centres could therefore have profiles that are not representative of the majority of off-community urban First Nations members. As such, the results presented in the report on that target group can only apply to them, at the time when the data was collected.

In addition, the survey report on off-community urban First Nations members includes several comparisons with First Nations members living in communities. Since the scope of the survey is essentially descriptive and exploratory, no hypothesis test was conducted to determine if the proportions presented in parallel for both groups can really be compared. These comparisons are only there as indications and can in no way bear witness to statistically verified distinctions. Furthermore, it is possible to state that the, sometimes significant, differences between the proportions of First Nations members living in communities and those living off community in urban settings are due to the significant differences between the populations under study, as well as to the distinct nature of the sampling.

[3] For a summary of the research methodology, please refer to the « Methodology » section of this report. For a detailed description of the FNRLHS methodology, please consult the "Methodology Report".
[4] In addition to the process review conducted internally by the FNQLHSSC research team, this section is based on the Harvard Project on American Indian Economic Development Report mandated by the First Nations Information and Governance Committee, a Standing Committee of the Chiefs Committee on Health and the First Nations Centre in the National Aboriginal Health Organization.

1.5.2 Data collection

1.5.2.1 Language and translation

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

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

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

1.5.2.2 Interviewer turnover

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

1.5.2.3 Errors due to the respondent

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

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

1.5.2.4 Errors due to the questionnaire

Although they were developed with thoroughness and a true concern to be adapted to the multiple situations experienced by first Nations members, the questions developed for the FNRLHS entail errors that might have biased the answers. Essentially these errors are choices of answers with non-mutually exclusive categories or incomplete choices of answers that did not cover the range of possible answers.

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

1.5.3 Data analysis and reports

1.5.3.1 Training

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

1.5.3.2 Turnover

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

Important

Remember that, considering the restricted number of respondents and the non-probabilistic nature of the sample, the results obtained cannot be generalized to all the First Nations members living in urban centres. These results must be interpreted with great caution.

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

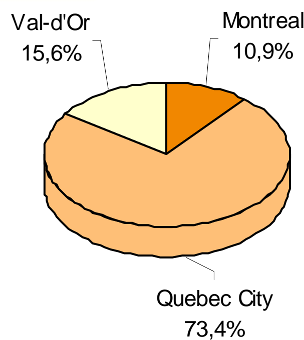
Children's health (0 to 11)

2.1 Demographic Profile

2.1.1 Sex, age and place of residence

The sample of children aged 0 to 11 is made up of 54.7% girls and 45.3% boys. Among these children, 25.1% are aged two or younger, 28.1% are aged three to five, and 46.8% are aged six to 11. The average age is 5.2.

Graph 2: Distribution of children, by place of residence

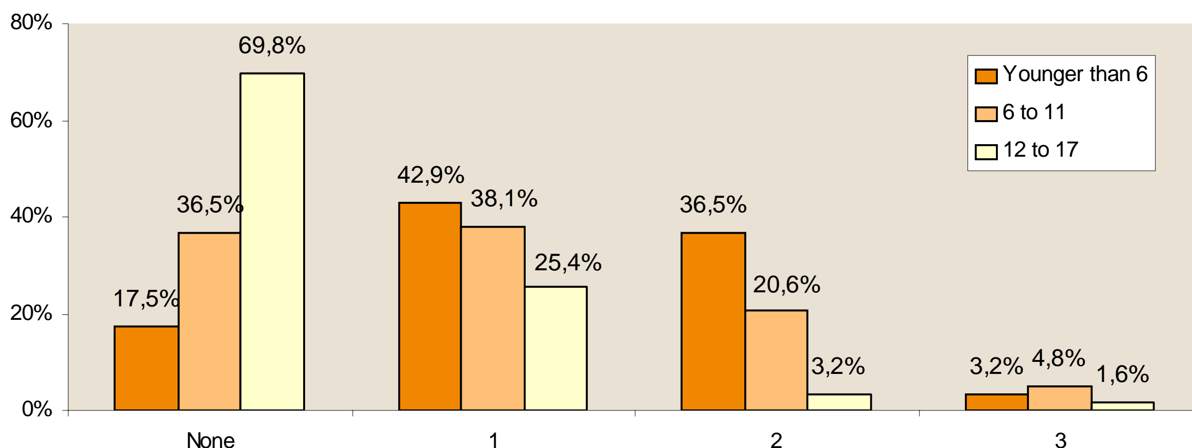


2.1.2 Information on households

2.1.2.1 Number of persons living on households

One quarter of all households have one child (aged 0 to 17), while close to one third have two children, and just under one in five have three children, all in the same age range. 59.4% of children live with their biological brothers and sisters, while 14.1% are mostly with their step-brothers and step-sisters.

Graph 3: Number of children at home, by age group



According to surveyed parents or guardians, 81.0% of children live in a household with two adults, while 17.5% live in a household with just one adult. No Elders aged 65 or older were reported.

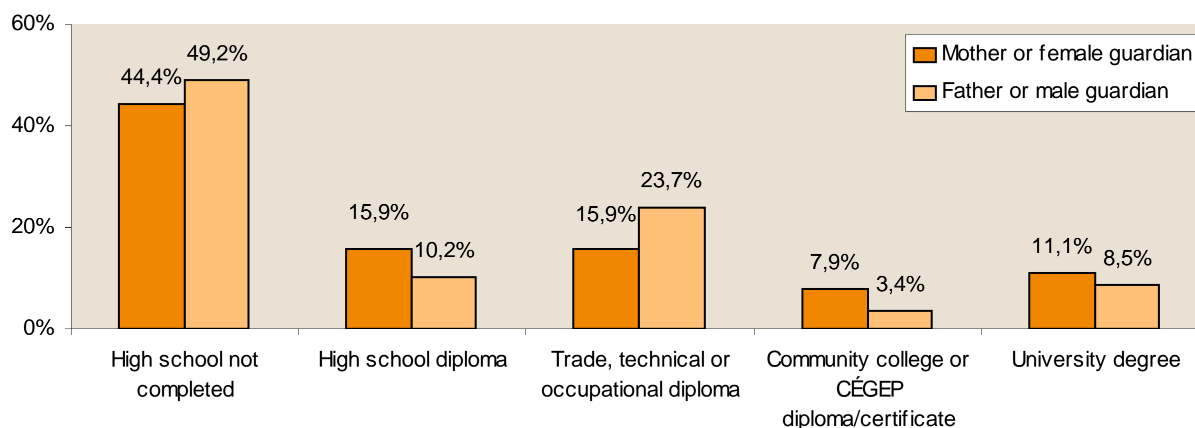
37.5% of children live with their two biological parents, 34.3% live with their biological mother only, and 20.3% live in stepfamilies with just one of their biological parents.

2.1.2.2 Housing

Residences in which children live have between 3 and 11 rooms (excluding bathroom, laundry room and garage or shed), for an average of 5.6 rooms. About income, 62.8% of the surveyed households had a total net income in 2001 of less than $25,000, and 45.3% were living below the poverty line.[5]

2.1.2.3 Schooling level of parents and children

Graph 4: Schooling level of parents



56.3% of parents or guardians interviewed have indicated that the child attends school and 80.6% of children have taken part in a First Nations Head Start (FNHS) program. At the time of the survey, 14.7% of children were attending an FNHS program and 26.6% were too young to go to school.

According to the survey's respondents, 52.9% of children who go to school have average grades, compared to all the children in their class. 20.6% are slightly below average, while 14.7% are above average. Despite respondents' perceptions of their children's school performance, 23.5% of the children have had to repeat a school year.

2.1.3 First Nations languages and traditional culture

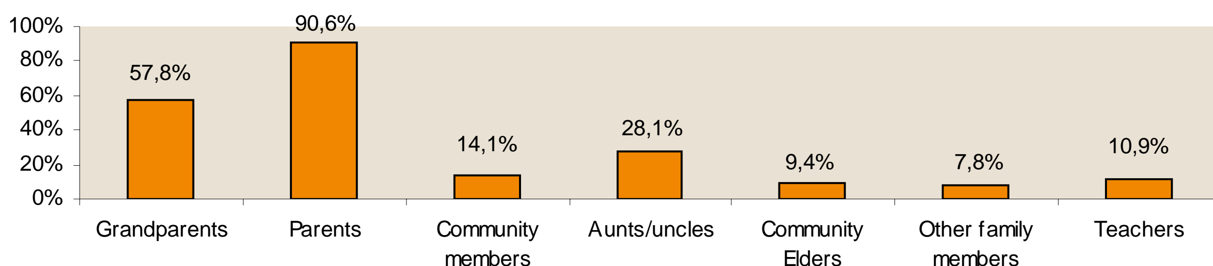
73.4% of respondents feel it is very important that their children learn a First Nations language, and 14.1% feel it is relatively important. Yet 66.7% of surveyed children do not understand any Aboriginal language and 73.3% do not speak one. It should be noted that 30.2% of the children are too young to fully express themselves orally. Nevertheless, 30.1% of respondents are satisfied or very satisfied with their children's level of mastery over a First Nations language, while 28.6% are dissatisfied or very dissatisfied.

71.9% of surveyed children understand French with ease, while 12.3% understand French relatively well. (Here, we should note that nearly three quarters of the respondents live in Quebec City.) 45.5% of the children do not understand English and 35.1% understand only a few English words.

Turning to their use of these two languages, we note that 56.7% of the children do not speak English and that 31.7% can pronounce only a few English words. 68.3% speak French with ease and 10.0% speak French relatively well. But it should be noted here that 39.7% of surveyed children are 3 or younger).

[5] "Quebec has defined the poverty line for its own purposes. It has been temporarily set at $15,500 for a single-parent family with one child, at $18,200 for a single-parent family with two children and for a couple with one child, at $22,000 for a single-parent family with three or more children and for a couple with two children, and at $24,500 for a family with more than three children" (translated from: Lévesque, K. and Chouinard, T., *Le Devoir,* Monday, November 10, 2003).

Graph 5: Individuals helping children understand the traditional culture



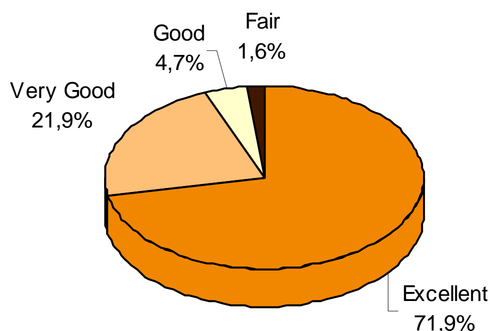
68.3% of respondents consider traditional cultural events to be very important in the life of their children; 20.6% consider them to be relatively important; and 10.9% do not consider them to be very important.

2.2 Health status

53.1% of parents or guardians interviewed indicated that the child had been breastfed. According to the respondents, 53.1% of their mothers did not smoke during pregnancy. However, 39.1% smoked throughout pregnancy, while 7.8% quit smoking during pregnancy. Among the women who smoked during pregnancy, 33.3% smoked occasionally, and 66.7% smoked every day. Among the latter, 60.6% smoked ten cigarettes or more each day.

Half of the respondents reported that another household member smoked during the mother's pregnancy, and 43.8% of households were reported not to be smoke-free environment.

Graph 6: Perceptions of children's overall health



2.2.1 Medical problems and physical injuries

Allergies and asthma are the most common medical problems among off-community children living in urban centres. According to our sample, 9.4% of the children have allergies and 18.8% have asthma. Among the children with asthma, 72.7% are receiving treatment, and 41.7% had an attack in the 12 months preceding the survey.

Finally, in the 12 months preceding the survey, there were few physical injuries requiring the intervention of a health professional. However, among the children who have had an injury, cuts and fractures were the most common ones reported.

2.2.2 Access to healthcare services

Nearly one third of parents or guardians interviewed experienced one or more obstacles in having the child receive healthcare services in the 12 months preceding the survey. The obstacles encountered by the parents or guardians who have encountered accessibility difficulties.

Table 1: Obstacles to accessing healthcare services for children

Obstacles*	% of parents or guardians
Waiting list too long	57.1%
Could not find transportation	28.6%
Not covered by the Non-Insured Health Benefits (NIHB) program	19.0%
Could not pay childcare service costs	19.0%
Could not pay direct costs for care/services	19.0%
Could not pay transportation costs	14.3%
Service not available in the region	9.5%
Felt that healthcare services were not culturally adapted	5.0%
Felt that healthcare services were inadequate	4.8%
No doctor or nurse in the region	4.8%
No health centre in the region	4.8%
Difficulty in receiving traditional care	4.8%
Refused authorization for services under the NIHB program	4.8%

* among the parents or guardians who have indicated encountering one or more obstacles.

2.2.3 Dental care

The *Ordre des dentistes du Québec* (ODQ) recommends that people see a dentist every six months. In our sample, 30.2% of children have visited a dentist in the 6 months preceding the survey. However, 34.9% last visited a dentist between six months and a year preceding the survey, and 34.9% (children aged 5 and younger) have never gone to a dentist. Half of the surveyed parents or guardians stated that the child required dental care. The main cares needed are presented in the following table.

Table 2: Proportion of parents or guardians who indicate that the child needs various types of dental care among the children who need care

Dental care	% of parents or guardians
Maintenance	93.5%
Fluoride treatment	35.5%
Filling or restoration	29.0%
Orthodontic treatment	6.5%

2.3 Lifestyle

2.3.1 Food and nutrition

78.1% of respondents reported that their children's diet is always or almost always balanced and nutritious. The rest feel their children's diet is sometimes balanced and nutritious. The following tables present the frequencies of consumption of various junk food and traditional food.

Table 3: Frequency of consumption of various junk food by children (12 months preceding the survey)

Junk food	Never / Almost never	Less than once a week	A few times a week	Once a day
Soft drinks	57.8%	20.3%	18.8%	3.1%
Fast food	42.2%	32.8%	25.0%	-
Cake, pie, cookies, candy, chocolate	32.8%	23.4%	31.3%	12.5%
French fries, potato chips, pretzels, fried bread	35.9%	39.1%	23.4%	1.6%
Added salt	85.9%	4.7%	4.7%	4.7%
Added sugar	71.9%	6.3%	9.4%	12.5%

Table 4: Frequency of consumption of traditional food (12 months preceding the survey)

Traditional food	Never	Sometimes	Often
Freshwater fish	26.6%	45.3%	25.0%
Wild berries or other fruits	23.4%	54.7%	18.8%
Bannock	26.6%	51.6%	18.8%
Big game	37.5%	42.2%	17.2%
Saltwater fish	48.4%	35.9%	12.5%
Other freshwater/saltwater foods	56.3%	34.4%	6.3%
Small game	46.9%	43.8%	6.3%
Corn soup	64.1%	28.1%	4.7%
Wildfowl	45.3%	48.4%	3.1%
Marine mammals	95.3%	1.6%	1.6%

In the 12 months preceding the survey, 18.0% of respondents indicated that their family often ate traditional food that another person shared with them, 63.9% sometimes and 18.0% never.

2.3.2 Physical activities and sedentary activities

2.3.2.1 Physical activities

The graph below shows that the majority of surveyed children regularly engage in physical or sports activities. Since 23.9% of the children are aged two or younger, one can presume this group accounts for most of the children who never engage in physical or sports activities or who do so less than once a week.

Graph 7: Children's participation in physical activities (outside class hours)

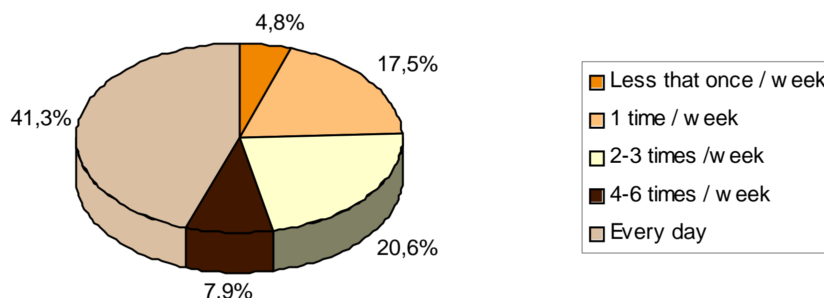


Table 5 lists the various physical activities that the surveyed children take part in according to the respondent. The five most popular activities are the same as the ones reported for the children living on community.

Table 5: Proportion of children involved in physical activities (12 months preceding the survey)

Physical activities	% of children
Walking	82.5%
Bicycling	66.7%
Swimming	44.4%
Ice skating	34.9%
Running	30.2%
Group or competitive sports	25.4%
Hiking	22.2%
In-line skating	17.5%
Dancing	12.7%
Berry gathering	12.7%

Physical activities	% of children
Aerobic gymnastics / workout	6.3%
Skateboarding	6.3%
Canoeing	4.8%
Hunting / trapping	3.2%
Fishing	3.2%
Martial arts	3.2%
Bowling	3.2%
Snowshoeing	1.6%
Skiing	1.6%

2.3.2.2 Programs and recreation

Outside of school hours, 90.0% of surveyed children do not take courses in art or music or participate in a music or art group, and 92.5% do not take courses in traditional singing or dance or participate in a traditional singing or dance group.

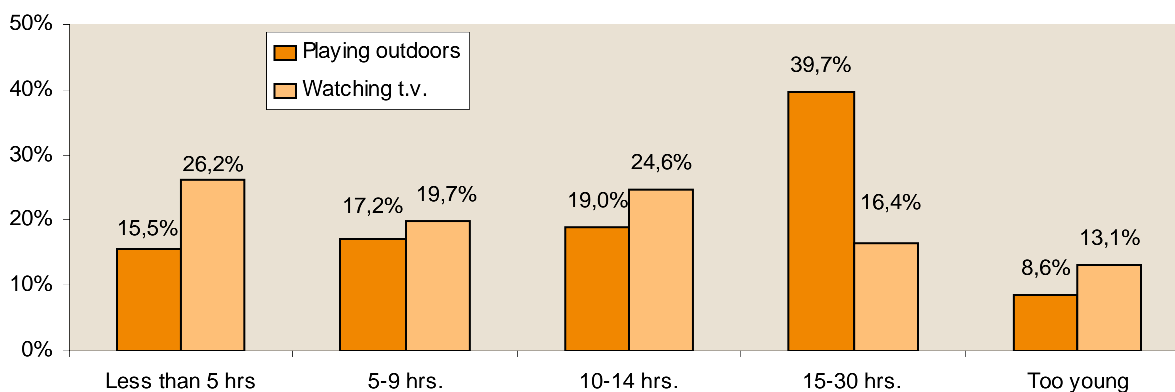
63.4% of surveyed children have never been involved in a team sport or program, while 24.4% are involved in a team sport or program one to three times a week.

2.3.2.3 Sedentary activities

A) Watching television and playing outdoors

Overall, Graph 8 shows that children spend more time playing outdoors than watching television. However, a significant proportion of children watch television several hours per week.

Graph 8: Number of hours spent each week watching television and playing outdoors



B) Video games

54.2% of parents or guardians interviewed reported that their child is too young to play video games. However, among the children who play video games, 23.7% play two hours or less each week, while 22.2% play video games between 10 and 20 hours a week.

C) Computer

57.1% of parents or guardians interviewed reported that their child is too young to use computers. However, among the children who use a computer, one quarter use it two hours or less a week, and one in twenty do so between 10 and 14 hours a week.

D) Household chores

31.3% of children do not do household chores because their parent or guardian considers them as being too young to do some. However, among the children who do household chores, 53.8% spend one hour a week on them, while 25.6% spend two to seven hours a week.

E) Reading

57.8% of children read or are read to every day, 17.2% a few times a week and 15.6% almost never.

2.3.3 Emotional and social well-being

In the 6 months preceding the survey, 88.9% of surveyed parents or guardians indicated that the child got along well with the rest of their family members and reported no problems. However, 6.3% had many family problems. Finally, 93.3% of parents or guardians indicated that their child did not have any more emotional or behavioural problems than other children the same age.

2.3.4 Childcare

40.6% of children receive childcare services when their parents or guardians are at work or at school; 45.3% of these children go primarily to a daycare centre (which may be in a private residence) or to a before-school and after-school daycare service.

Among these children, 30.8% receive childcare services of for eight hours or less a week, 26.9% between ten and 17 hours a week, and 38.5% between 20 and 40 hours a week.

Answers to the question “What other problems affect the well-being of your children?” included the following: 14.4% of respondents brought up the issue of their children’s education (first language teaching in particular), while one in ten mentioned issues related to alcohol and drugs.

2.4 Conclusion: Children’s health (0 to 11)

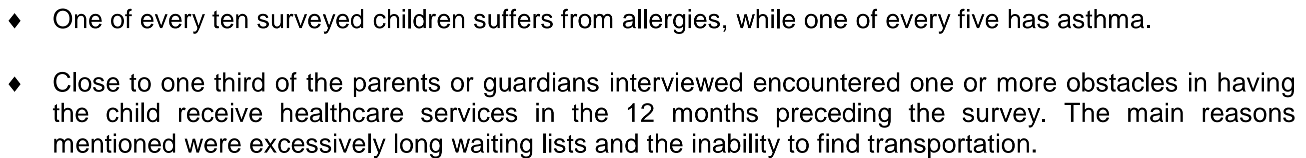
- Just over half of the children of the sample are aged five or less. Consequently, just over half are attending school. Nearly one quarter of all children attending school have had to repeat a year.

- According to surveyed parents or guardians, 45.3% of children in the sample live below the poverty line.

- Nearly three quarters of parents or guardians interviewed feel it is very important that their children learn a First Nations language, and more than two thirds consider traditional cultural events to be a very important part of their children’s lives.

Health status

- Slightly more than half of the parents or guardians interviewed indicated the child had been breastfed. 93.8% of respondents consider their children’s health to be excellent or very good.



- One of every ten surveyed children suffers from allergies, while one of every five has asthma.
- Close to one third of the parents or guardians interviewed encountered one or more obstacles in having the child receive healthcare services in the 12 months preceding the survey. The main reasons mentioned were excessively long waiting lists and the inability to find transportation.

Lifestyle

- 78.1% of respondents indicated that their children's diets are always or almost always balanced and nutritious. This perception is confirmed in general by the observations we made concerning the frequency of junk food consumption by the children, which is relatively low.
- The majority of surveyed children regularly practice physical activities or sports (41.3% do so every day). The children in the sample spend more time playing outdoors than watching television.
- 40.6% of children receive childcare services when their parents or guardians are at work or at school, with 38.5% of these children receiving such services between 20 and 40 hours a week.
- Finally, according to surveyed parents or guardians, 88.9% of surveyed children get along very well with the other members of their families, while 6.3% have had many family problems.

Section 3:
Adolescents' health (12 to 17)

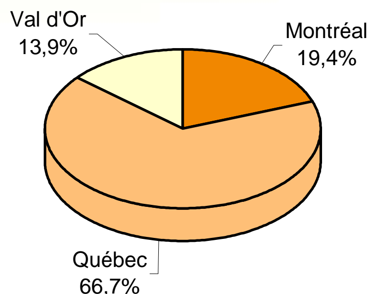
Adolescents' health (12 to 17)

3.1 Demographic Profile

3.1.1 Sex, age and place of residence

Our sample of adolescents aged 12 to 17 is made up of 55.6% girls and 44.4% boys. The average age is 14.7. The following graph gives the distribution of respondents by the three places of residence surveyed.

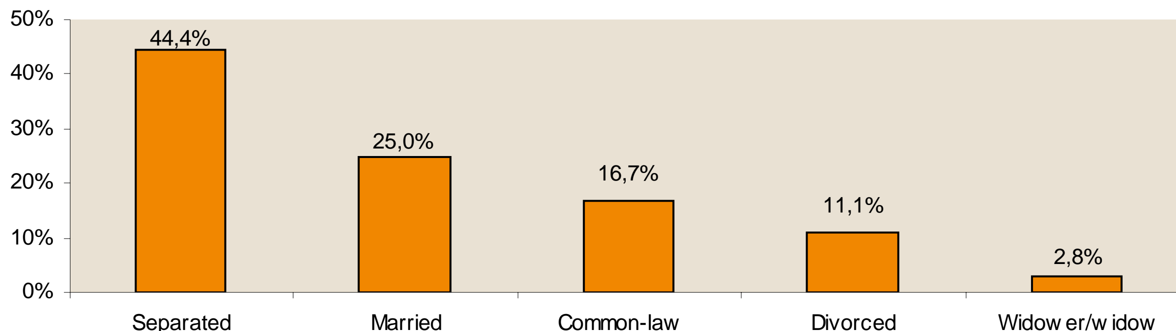
Graph 9: Distribution of adolescents, by place of residence



3.1.2 Information on households

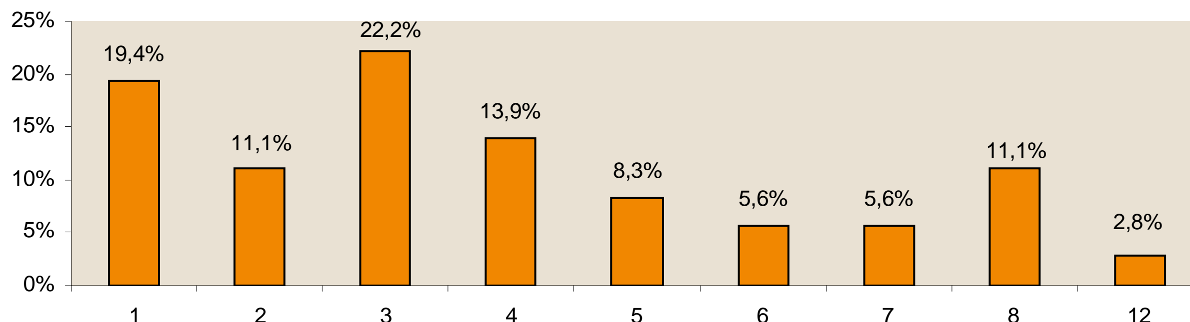
38.9% of surveyed adolescents live with their two biological parents, 16.7% live in a stepfamily, 11.1% live with their biological mother only, and 2.8% live with their biological father only. Finally, 2.8% live with their grandparents and the same percentage live with a partner in a cohabitational relationship or with a friend.

Graph 10: Proportion of adolescents, by civil status of biological parents



55.6% of adolescents live with at least one brother or sister, for an average of four children per household. Three quarters of households do not have a child younger than six, half do not have any children aged 6 to 11, and one quarter have three adolescents aged 12 to 17.

Graph 11: Number of children per household



63.9% of households have two adults and 16.7% have one. 94.4% of households do not have any Elders aged 65 or more.

Residences have between 2 and 12 rooms, for an average of 6.9 rooms (excluding bathroom, laundry room and garage or shed).

3.1.3 First Nations languages and traditional culture

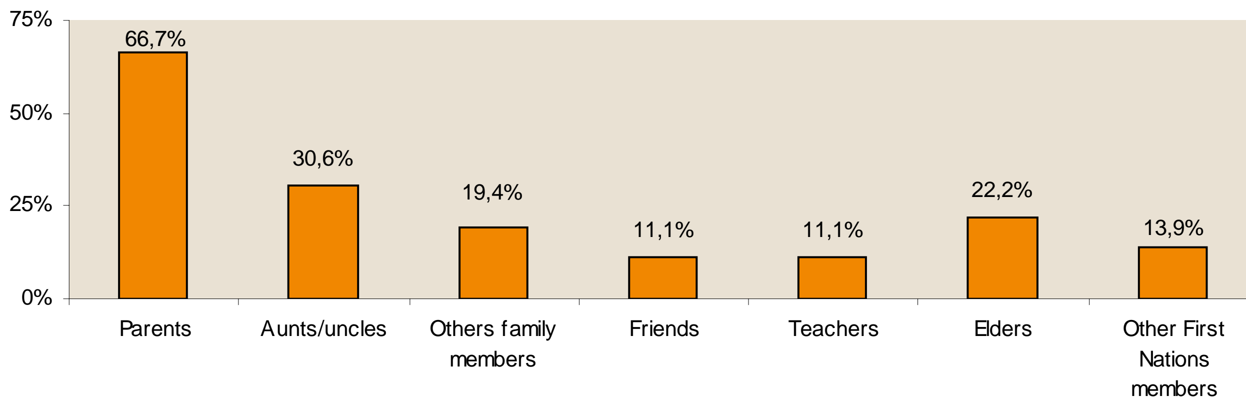
Regarding the language used most often by respondents, 86.1% of respondents use French (we note here that two thirds of all respondents live in Quebec City), 5.6% use English and 5.6% use Innu. Despite these figures, 97.2% of respondents understand French with ease and 27.8% understand English with ease. Finally, 30.6% understand English relatively well.

44.4% of respondents indicated that they speak two languages with ease, 94.4% that they speak French with ease, 27.8% speak English with ease, and 22.2% speak English relatively well.

52.9% of adolescents feel it is very important to speak their First Nation language, while 41.2% feel it is relatively important. However, 52.8% do not understand a First Nation language and 55.6% do not speak one.

71.4% of surveyed adolescents consider traditional cultural events to be a very important part of their lives, while 25.7% do not feel they are very important.

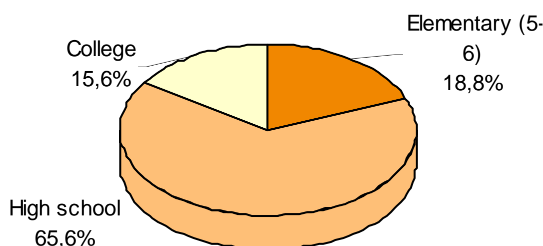
Graph 12: Proportion of adolescents who receive help from various individuals to understand the traditional culture



3.1.4 Education

91.7% of surveyed adolescents were going to school at the time of the survey.

Graph 13: Schooling level of adolescents



36.4% of adolescents indicated that they like school very much, 33.3% that they like school somewhat and 18.2% that they do not like school very much.

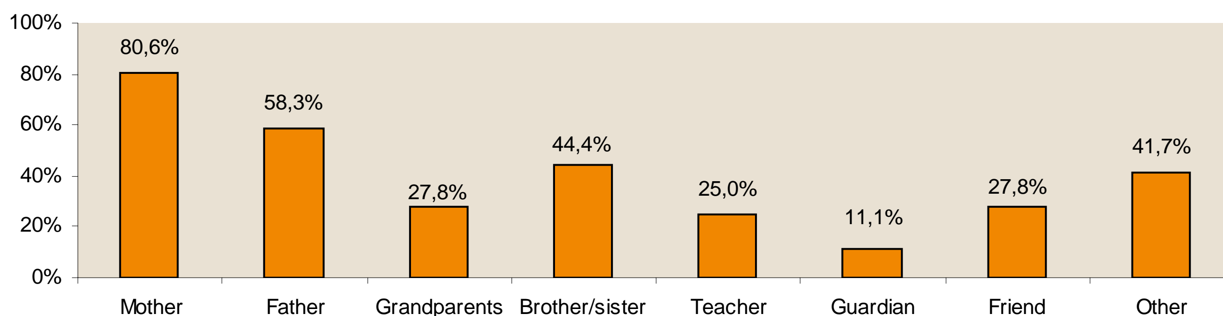
33.3% of adolescents reported that they have had learning difficulties at school. Moreover, 38.9% have had to repeat a year. Despite these problems, 38.2% of adolescents want to obtain a university degree.

Conversely, 8.3% have skipped a year because of their good grades. Table 6 lists the main learning difficulties encountered and Graph 14 shows the proportion of adolescents receiving help from various individuals to continue their studies.

Table 6: Proportion of adolescents who have indicated various learning difficulties at school among adolescents who have had difficulties

Learning difficulties	% of adolescents
Difficulty concentrating	83.3%
Difficulty understanding the teacher	83.3%
Mathematics	66.7%
Too many distractions	66.7%
Reading	50.0%
Writing	41.7%

Graph 14: Proportion of adolescents who receive help from various individuals to continue their studies



3.2 Health status

3.2.1 Overall health

The surveyed adolescents clearly have a very good perception of their overall health status. The results concerning their diet and physical activities, both covered in the next chapter, will show whether these perceptions are accurate or whether adolescents instead have short-term or medium-term health problems that must be dealt with.

Graph 15: Adolescents' perceptions of their overall health

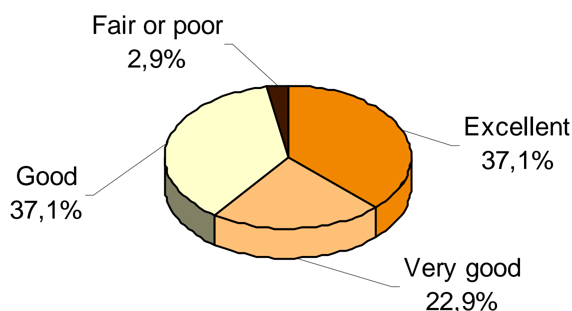


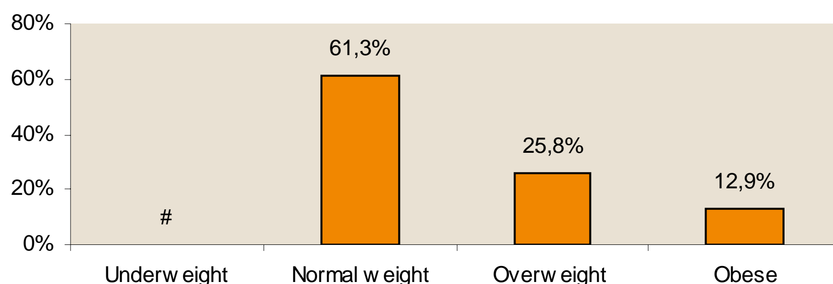
Table 7 presents some reasons that justify a good state of health according to surveyed adolescents. It is important to note that just over half of all adolescents (52.8%) answered these questions regarding the reasons that justify being in very good or excellent health.

Table 7: Reasons that justify being in very good or excellent health among adolescents

Reasons	% of adolescents
Happy/satisfied in life	89.5%
Regular exercise/practice of a sport	89.5%
Well-balanced life	89.5%
Healthy diet	84.2%
Little stress	84.2%
Good social support	84.2%
Sleep well/get plenty of rest	84.2%

The height of surveyed adolescents varies between 144.8 cm and 180.3 cm, for an average of 166.8 cm. Their weight varies from 35.4 kg to 120 kg, for an average of 63.3 kg. From those results, the Body Mass Index (BMI) was calculated for every respondent. The results are presented in the following graph.

Graph 16: Proportion of adolescents, by Body Mass Index (BMI)[6] categories



58.3% of surveyed adolescents say they are very satisfied with their weight, while 13.9% are somewhat or very dissatisfied.

3.2.2 Medical problems and physical injuries

In our sample, we found no cases of chronic bronchitis, vision difficulties, HIV/AIDS, tuberculosis, epilepsy, psychological or nervous disorders, mental disabilities, cerebral palsy, physical disabilities, liver disorders (including hepatitis), kidney disease or diabetes. Our sample did find the following illnesses:

- 13.9% have asthma
- 11.1% have learning difficulties
- 8.3% have allergies
- 8.3% have chronic ear problems or infections

During the year preceding the survey, one quarter of surveyed adolescents had one or more physical injuries that required attention from a health professional. Table 8 gives the distribution of these injuries.

Table 8: Types of injuries incurred (12 months preceding the survey)

Types of injuries	% of adolescents
Cuts, scrapes or bruises	44.4%
Fracture	33.3%
Burn	22.2%
Sprain	22.2%
Concussion	11.1%
Broken tooth	11.1%

3.2.3 Use of health and dental care services

In the 12 months preceding the survey, 55.6% of respondents had an eye examintion and 13.9% had a full medical check-up. 17.1% of respondents have previously consulted a traditional healer. Finally, 20.6% have previously made use of a counselling service, psychological testing or other mental health services.

3.2.4 Dental care

The *Ordre des dentistes du Québec* (ODQ) recommends that people see a dentist every six months. 61.1% of surveyed adolescents indicated that they are following this recommendation, whereas 25.0% last visited a dentist between six months and a year before the survey. 69.7% of surveyed adolescents required one or more dental care in the 12 months preceding the survey, as described in Table 9 below.

[6] These categories are based on the Body Mass Index (BMI) as follows: lower than 20 (underweight), 20-24.9 (satisfactory weight), 25-26.9 (a bit overweight) and 27 or higher (overweight). The BMI is a tool used to determine the healthy weight of individuals. It is obtained by dividing weight (kg) by height squared (metres).

Table 9: Proportion of adolescents who need various types of dental care among adolescents who indicate they need dental care

Dental care	% of adolescents
Maintenance	57.6%
Filling, restoration	27.3%
Fluoride treatment	12.1%
Extraction	3.0%
Periodontal treatment	3.0%

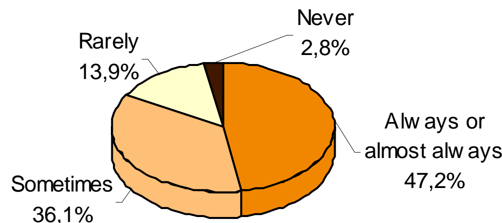
Finally, 30.6% of adolescents had dental problems or pain during the 12 months preceding the survey.

3.3 Lifestyle

3.3.1 Nutrition

Almost half of surveyed adolescents feel they always or almost always have a balanced and nutritious diet. But as Graph 17 shows, many of them eat properly only sometimes and a sizeable number rarely do so.

Graph 17: Frequency of balanced and nutritious diet



Adolescents eat a significant amount of junk food, as seen in Table 10. One can note the consumption of soft drinks, fast food, cake, pie and other sweets, French fries and potato chips varies from a few times a week to several times a day for more than half of the adolescents in our sample. Table 11 presents the frequency of traditional food among adolescents.

Table 10: Frequency of consumption of various junk food

Junk food	Never or almost never	Less than once a week	A few times a week	Once a day	Several times a day
Coffee or tea	61.1%	8.3%	8.3%	11.1%	11.1%
Soft drinks	22.2%	16.7%	41.7%	11.1%	8.3%
Fast food	13.9%	33.3%	50.0%	-	2.8%
Cake, pie, cookies, candy, chocolate	19.4%	16.7%	27.8%	22.2%	13.9%
French fries, potato chips, pretzels, bannock	11.1%	16.7%	58.3%	8.3%	5.6%
Added salt	44.4%	8.3%	16.7%	8.3%	22.2%
Added sugar	41.7%	11.1%	19.4%	16.7%	11.1%

Table 11: Frequency of consumption of traditional food

Traditional foods	Often	Sometimes	Never
Wild berries or other fruits	31.4%	54.3%	14.3%
Big game	27.8%	52.8%	19.4%
Bannock	25.0%	66.7%	8.3%
Freshwater fish	16.7%	52.8%	30.6%
Saltwater fish	14.3%	34.3%	51.4%
Wildfowl	11.1%	55.6%	33.3%
Small game	11.1%	44.4%	44.4%
Other freshwater/saltwater foods	8.3%	33.3%	58.3%
Corn soup	2.8%	27.8%	69.4%

Finally, in the 12 months preceding the survey, three quarters of adolescents sometimes ate traditional food that other persons shared with their family, while 14.7% reported doing so more frequently.

3.3.2 Physical activities and sedentary activities

3.3.2.1 Physical activities

42.9% of adolescents indicated that they spend between one and five hours a week in physical activity that increases their heart and breathing rates. 20.0% spend between 11 and 20 hours in physical activity, while 8.6% do not get any physical activity. The following graph presents the frequency of participation to such activities, and table 12 presents the physical activities practiced by adolescents.

Graph 18: Frequency of participation in physical activities that increase heart and breathing rates

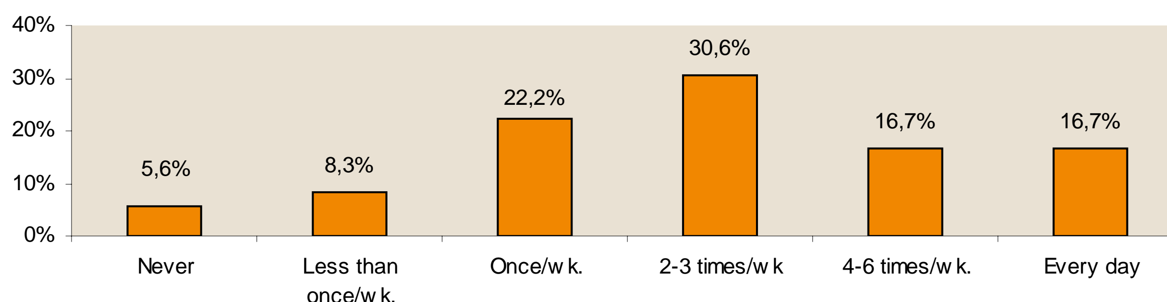


Table 12: Proportion of adolescents who practice various physical activities (12 months preceding the survey)

Physical activities	% of adolescents
Walking	94.4%
Bicycling	75.0%
Running	66.7%
Competitive or group sport	66.7%
Hiking	38.9%
Swimming	36.1%
Canoeing	33.3%
Ice skating	33.3%
Hunting, trapping	27.8%
Dancing	25.0%
Rollerblading	25.0%

Physical activities	% of adolescents
Weightlifting/exercise equipment	25.0%
Fishing	22.2%
Aerobic gymnastics	19.4%
Bowling	19.4%
Skiing	16.7%
Skateboarding	16.7%
Snowshoeing	13.9%
Gathering berries or other foods	13.9%
Golf	8.3%
Martial arts	8.3%

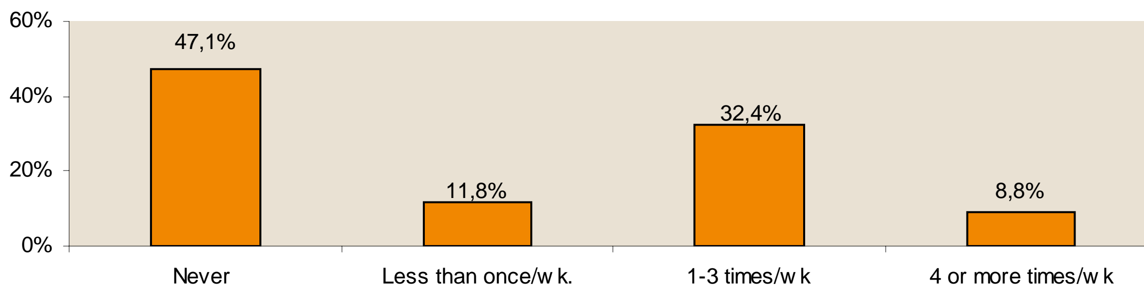
3.3.2.2 Programs and recreation

Outside of class hours:

- 86.2% of respondents do not take courses in art or music or participate in a musical or art group;
- 93.1% do not take courses in traditional singing or dance or participate in traditional singing or dance groups;
- 86.2% do not babysit, work in a store or give courses.

Although the following graph shows that almost half of adolescents have never participated in a team sport or a sports program, we nevertheless note that half of them participate in physical or sports activities (Graph 18 and Table 12).

Graph 19: Frequency of participation in a sports team or program (outside of class hours)



3.3.2.3 Sedentary activities

This section takes a closer look to the frequency of adolescents' participation in various sedentary activities. One can note that an important proportion of adolescents spend many hours daily watching television, playing video games or using a computer.

A) Television

44.4% of surveyed adolescents spend 1 to 2 hours daily watching television and the same proportion spends 3 to 5 hours daily watching television.

B) Video games

50.0% of respondents play video games less than one hour a day or not at all, 27.8% play video games one to two hours a day and 22.2% play video games three to five hours a day.

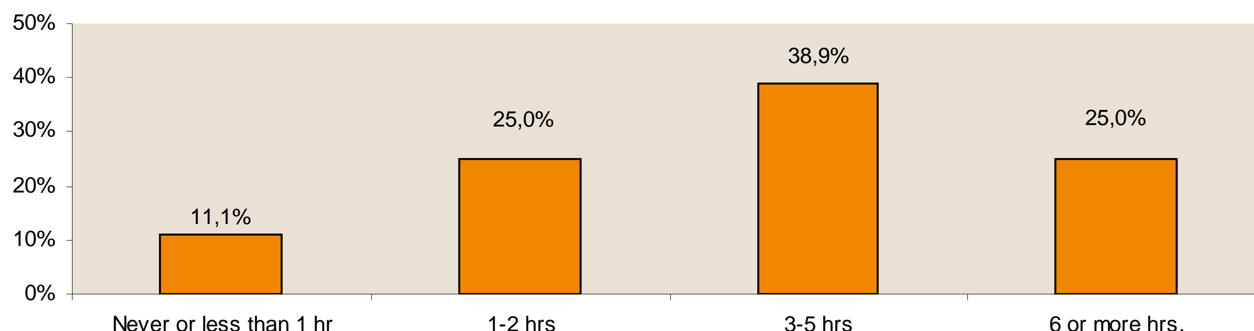
C) Computer

56.6% of adolescents surveyed spend 1 to 2 hours daily using the computer, 19.4% use it 3 to 5 hours whereas 22.2% spend one hour or less daily using the computer or no time at all.

D) Outdoor activities

Although half of the surveyed adolescents are not involved in a team sport or program, most respondents spend a great deal of time outdoors (Graph 20). During those hours, they practice walking, bicycling, running, and other physical or sports activities, as presented in Table 12.

Graph 20: Number of hours spent daily on outdoor activities



E) Household chores

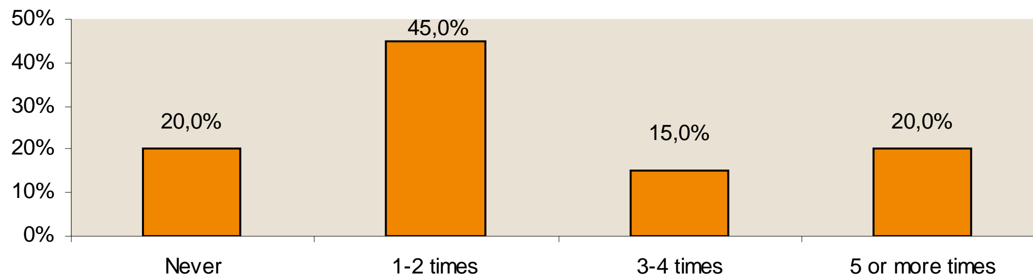
61.1% of surveyed adolescents spent 1 to 2 hours daily on household chores, while 30.6% never did so or did it less than an hour a day.

3.3.3 Lifestyle

3.3.3.1 Smoking

58.3% of surveyed adolescents smoke and 90.5% of smokers do so every day. Among smokers, 42.9% began smoking under the age of 12 and smoke ten cigarettes or more every day. Finally, 52.8% of respondents' homes do not offer a smoke-free environment.

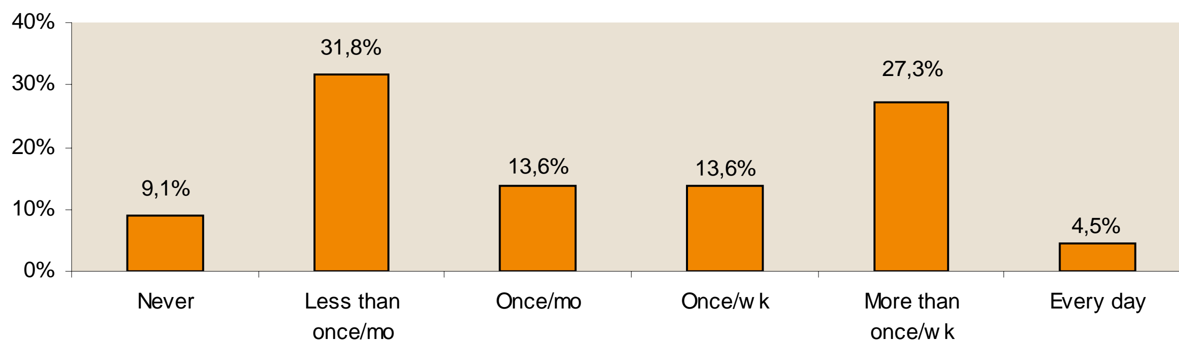
Graph 21: Proportion of adolescents who smoke and have tried to quit smoking, by number of attempts (12 months preceding the survey)



3.3.3.2 Alcohol consumption

63.9% of surveyed adolescents drank beer, wine, spirits or other alcoholic beverages in the 12 months preceding the survey. Among them, a certain number have consumed 5 glasses or more of alcohol on a single occasion, as presented in the following graph.

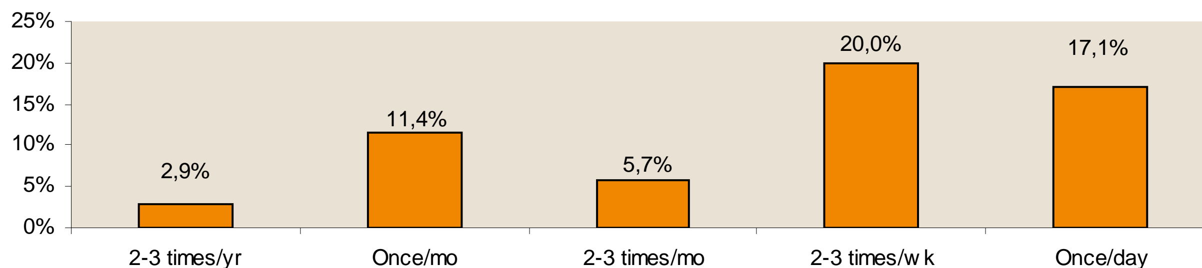
Graph 22: Frequency of consumption of 5 glasses or more of alcohol on a single occasion among adolescents who drank alcohol (12 months preceding the survey)



3.3.3.3 Drugs and inhalants consumption

57.1% of surveyed adolescents used drugs or inhalants in the 12 months preceding the survey and all of the latter smoked marijuana. The following graph presents the frequency of consumption of marijuana among users.

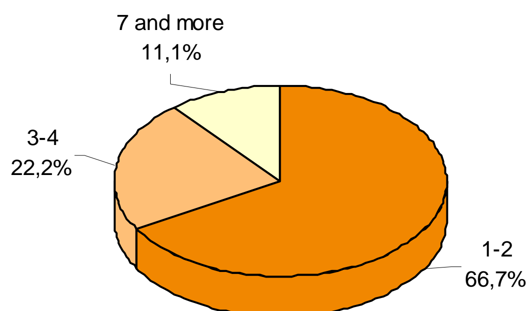
Graph 23: Frequency of consumption of marijuana among users (12 months preceding the survey)



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

55.6% of surveyed adolescents are sexually active, and 90.0% of sexually active teens had sexual relations in the 12 months preceding the survey. Graph 24 shows the number of sexual partners of sexually-active adolescents.

Graph 24: Number of sexual partners among sexually-active adolescents (12 months preceding the survey)



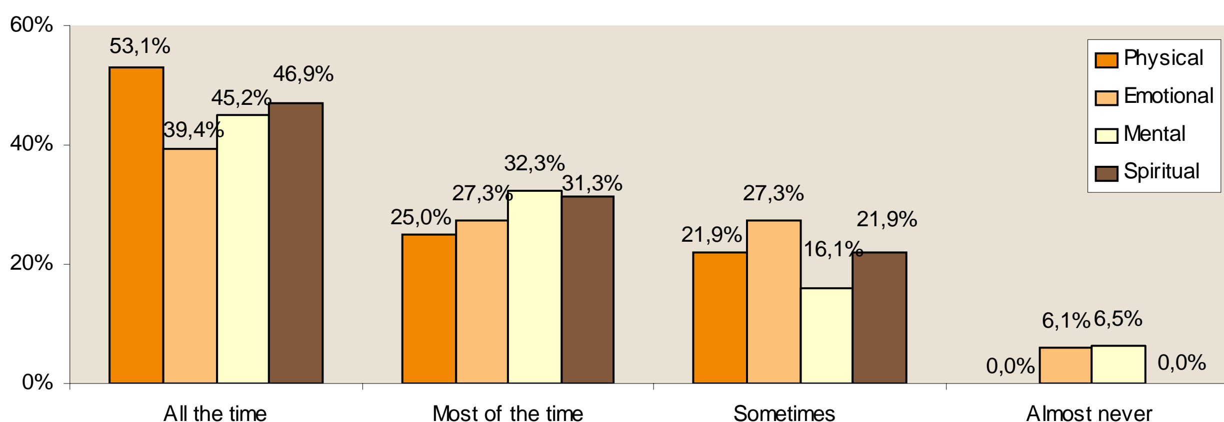
94.4% of sexually active adolescents use condoms as their contraception method. 82.4% of the latter use condoms for protection against sexually transmitted diseases (STDs). Among them, 61.1% reported that they always use condoms for protection against STDs, while 27.8% do so most of the time. Finally, the fact of having a regular partner and the fact of not having a condom at the time of the sexual relation are the two main reasons reported for not using condoms.

3.3.4 Personal and social well-being

3.3.4.1 Physical, emotional, mental and spiritual well-being

50.0% of the surveyed adolescents indicated a high level of balance in the four dimensions of well-being (physical, emotional, mental and spiritual), while 46.7% indicated an average level. The following graph presents these results:

Graph 25: Perception of balance by four dimensions of well-being



3.3.4.2 Self-esteem and self-determination indicators

69.4% of respondents obtained a very high level of self-esteem, while 22.2% obtained a high level. This scale was established in accordance with respondents' answers to the questions given in Table 13 below.

Table 13: Adolescents' perceptions regarding various statements on self-esteem

Statements	Strongly agree	Agree	Neither agree nor disagree	Disagree
In general, I like my personality.	47.2%	44.4%	5.6%	2.8%
Overall, I have reasons to be proud of myself.	44.4%	41.7%	13.9%	-
There are many good things about me.	47.1%	41.2%	8.8%	2.9%
When I do something, I do it well.	36.1%	55.6%	8.3%	-

30.6% of adolescents reported that they feel somewhat lonely, while 63.9% do not feel lonely at all. 52.8% say that they feel very much loved, 16.7% feel adequately loved and 22.2% feel moderately loved. Finally, 47.2% do not feel any stress, 27.8% feel somewhat stressed and 13.9% feel moderately stressed. Table 14 gives respondents' opinions concerning certain general statements about life.

Table 14: Adolescents' perception regarding various statements on self-determination

Statements on self-determination	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I can solve my problems.	36.1%	50.0%	13.9%	-	-
No-one bothers me in my life.	36.1%	36.1%	16.7%	11.1%	-
I have control over the things that happen to me.	27.8%	61.1%	5.6%	5.6%	-
I can do just about anything once I set my mind to it.	22.9%	62.9%	14.3%	-	-
I often feel helpless in facing life's problems.	3.1%	12.5%	25.0%	46.9%	12.5%
What happens to me in the future depends mostly on me.	31.4%	60.0%	2.9%	5.7%	-
There's not much I can do to change the important things in my life.	12.1%	42.4%	9.1%	24.2%	12.1%

3.3.5 Agents of support

3.3.5.1 Social support

Family members and friends are the persons adolescents turn to the most for support, followed by various social caregivers. Health professionals arrived in last. Table 15 presents the persons in whom adolescents confided regarding their emotional and mental health in the 12 months preceding the survey.

Table 15: Confidants regarding emotional or mental health (12 months preceding the survey)

Confidant	% of adolescents
Friend	74.3%
Member of the immediate family	65.7%
Other family member	34.3%
Psychologist	20.0%
Social worker	20.0%
Family doctor	11.4%
Traditional healer	8.6%
Nurse	8.6%
Psychiatrist	5.7%
Counsellor	2.9%
Community health representative	2.9%

No adolescent used a telephone help line in the 12 months preceding the survey. The following table suggests that most adolescents have access to social support when needed.

Table 16: Frequency of social support available for adolescents

Social support available	Always	Most of the time	Sometimes	Almost never
Someone I can trust when I need to talk.	66.7%	22.2%	5.6%	5.6%
Someone I can trust when I need help.	75.0%	13.9%	11.1%	-
Someone who can take me to the doctor.	75.0%	11.1%	11.1%	2.8%
Someone who shows me love and affection.	83.3%	13.9%	2.8%	-
Someone with whom I can take a break from my daily routine.	55.6%	27.8%	11.1%	5.6%
Someone to have a good time with.	77.8%	13.9%	8.3%	-
Confidant I can talk to about myself or tell my problems to.	69.4%	19.4%	8.3%	2.8%
Someone with whom I can do enjoyable things.	72.2%	19.4%	5.6%	2.8%

The following table confirms that parents and friends are the agents of social support or confidants whom the majority of surveyed adolescents turn to for support concerning a various types of problems if they have or were to have any.

Table 17: Persons to whom adolescents would turn to for help if they had various personal problems

Personal problems	Parent / guardian	Other family member	Friend of the same age	Adult friend	Doctor / nurse	School principal, counsellor, teacher	Other	No one
Family problems	37.1%	22.9%	22.9%	8.6%	-	8.6%	-	-
Love relationship	23.5%	5.9%	47.1%	2.9%	-	-	20.6%	-
Drugs or alcohol problems	32.4%	2.9%	35.3%	5.9%	11.8%	2.9%	2.9%	2.9%
Anger, loss of control	25.0%	2.8%	33.3%	11.1%	5.6%	2.8%	2.8%	16.7%
Depression	38.2%	8.8%	20.6%	14.7%	11.8%	2.9%	-	-
Problems with friends	33.3%	2.8%	41.7%	11.1%	-	2.8%	5.6%	2.8%
Sexual / physical abuse	54.3%	2.9%	14.3%	2.9%	11.4%	2.9%	11.4%	-
STD	45.7%	2.9%	8.6%	-	40.0%	-	-	2.9%
Contraception methods	38.2%	5.9%	17.6%	2.9%	26.5%	-	2.9%	5.9%
Pregnancy	45.5%	15.2%	12.1%	6.1%	18.2%	-	-	3.0%

3.3.5.2 Suicide

One third of surveyed adolescents had a friend or family member who committed suicide in the 12 months preceding the survey.

30.6% of interviewed adolescents have previously thought about committing suicide between the ages of 12 and 17 and half of those who have thought about committing suicide have attempted to commit suicide.

29.4% of surveyed adolescents felt depressed for a period of two weeks or longer in the 12 months preceding the survey.

3.3.5.3 Residential schools

28.1% of surveyed adolescents had one or both parents who went to an Aboriginal residential school, and 16.0% of adolescents had one or more grandparents who went to an Aboriginal residential school.

Conclusion: Adolescents' health (12 to 17)

This survey continues the work begun by the 1997 survey on the health of off-community First Nations members living in urban centres. However, it is difficult to compare our results directly with the results of the 1997 survey because each survey approached many questions differently. Also, the sample for 1997 included only First Nations members living in Montreal whereas the 2002 phase includes respondents form Quebec City and Val-d'Or.

Demographic profile

- 91.7% of the adolescents surveyed in Montreal, Quebec City and Val-d'Or were attending school at the time of the survey, with two thirds of them in high school. Over three quarters of them reported various learning problems.

- More than half of surveyed adolescents feel it is very important to speak their First Nations language, and close to three quarters consider traditional cultural events to be an important part of their lives.

Health status

- 58.1% of surveyed adolescents have a normal body weight and 60.0% feel they are in excellent or very good health.

- 55.6% of respondents had an eye examination in the 12 months preceding the survey and 13.9% had a full medical check-up.

Lifestyle

- Although nearly half of all surveyed adolescents feel they always or almost always have a balanced and nutritious diet, they eat a significant amount of junk food. Half of the respondents engage in physical activity one to three times a week.

- 58.3% of adolescents smoke, with 90.5% of smokers doing so every day. Just under half of all smokers began smoking under the age of 12. Just over half of all respondents' residences do not offer a smoke-free environment.

- Nearly two thirds of respondents drank alcohol in the 12 months preceding the survey and more than one quarter drank more than once a week. 57.1% of adolescents used drugs or inhalants in the 12 months preceding the survey. Among the latter, all of them smoked marijuana, with 20.0% doing so two or three times a week and 17.1% every day.

- More than half of surveyed adolescents are sexually active; 94.4% use condoms as their contraception method and 82.4% use condoms to prevent sexually transmitted diseases.

- Finally, one third of surveyed adolescents had a friend or family member who committed suicide in the 12 months preceding the survey; 30.6% of respondents have previously thought about committing suicide and half of these respondents have previously attempted suicide.

Section 4:
Adults' health (18 and up)

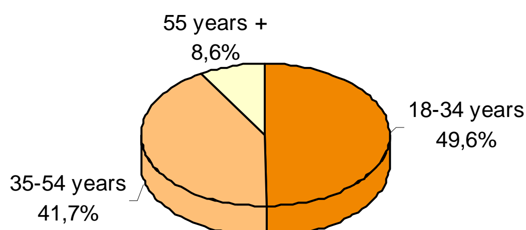
Adults' health (18 and up)

4.1 Demographic Profile

4.1.1 Sex, age and place of residence

The final sample of off-community First Nations adults living in urban centres is made up of 59.3% women (54.9% in Montreal, 63.2% in Quebec City and 62.9% in Val-d'Or) and of 40.7% men (47.4% in Montreal, 39.6% in Quebec City and 13.1% in Val-d'Or).

Graph 26: Distribution of adults by age groups



38.1% of women from the sample are aged 35 to 54, versus 47.2% of men. Half of the adult population of both sexes is between 18 and 34. The majority of persons 55 and older are women.

4.1.2 First Nations Languages

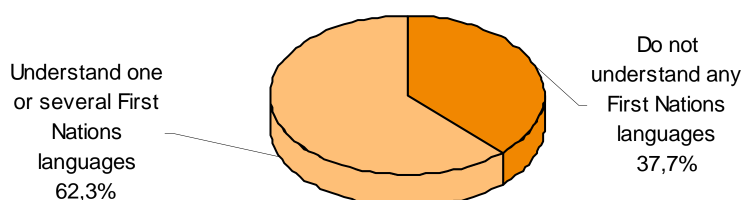
53.2% of off-community First Nations adults living in urban centres understand or speak two languages with ease, whereas 31.4% understand or speak only one language. Quebec City and Val-d'Or are French-speaking cities; we should therefore not be surprised to find that 58.6% of respondents report French as the language that they use most often. Although only 28.0% of respondents use English most often (in Montreal, which is a bilingual city), 73.1% understand English with ease and only 53.0% understand French with ease.

- In Montreal, 53.5% of First Nations adults use English the most often, compared to 70.0% of adults respondents in 1997. 74.8% understand French with ease and 49.6% speak French with ease.

- In Quebec City, although 85.8% of First Nations adults respondents use French the most often, 96.2% understand English with ease.

- 68.6% of First Nations adults living in Val-d'Or use French the most often and 82.9% understand English with ease.

Graph 27: Understanding of one or several First Nations languages

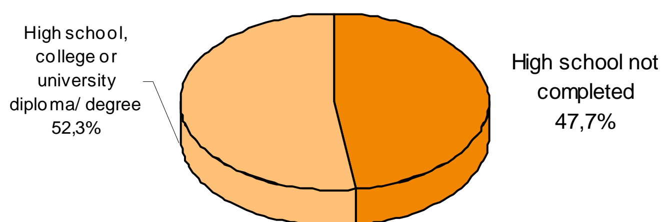


We find almost the same percentage of persons who understand one or more First Nations languages (62.3%) as we do of persons who can express themselves in these languages with ease or relative ease (60.4%).

Women appear to be more gifted in or at least more interested in languages; 57.7% understand two languages with ease, versus 48.6% of men, and 55.1% speak two languages with ease, versus 51.4% of men. Nevertheless, 67.3% of men understand one or several First Nations languages, versus 59.6% of women.

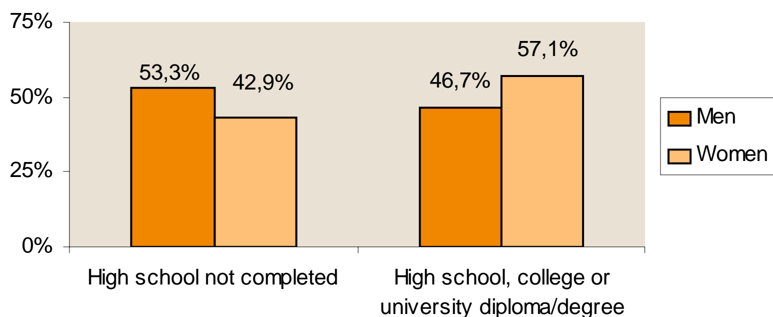
4.1.3 Education

Graph 28: Schooling level of adults



These results are similar to what we find among adults living in the communities, where 49.0% of the adults have not finished high school and 52.0% have a high school, college or university diploma.

Graph 29: Schooling level, by sex



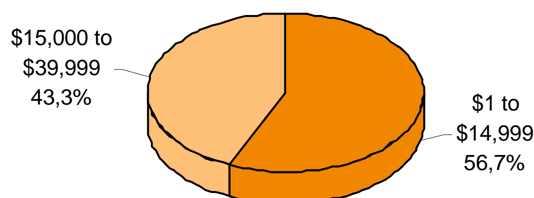
65.7% of Val-d'Or respondents do not have a high school diploma, compared to 59.8% of respondents in Montreal and 53.8% of respondents in Quebec City.

Finally, we note that at the time of the survey, more than one quarter of women and less than one quarter of men were attending school, which is more than twice the number of adults doing so in the communities. Their distribution by city is as follows: one third of Quebec City respondents, one quarter of Val-d'Or respondents and less than one in five of Montreal respondents.

4.1.4 Employment and income

Even if 46.4% of surveyed First Nations members were receiving income from one or more jobs (over two thirds were working 35 hours or more a week), 61.9% were unemployed. 62.6% of men were unemployed (versus 48.9% in the communities) and 60.9% of women were unemployed (compared to 53.0% in the communities). Finally, 65.2% of the 18-34 year-olds were unemployed, versus 55.0% of 35-54 year-olds and 73.9% of respondents aged 55 and older.

Graph 30: Gross annual income of individuals (2001)



Individuals' net income is calculated on an annual basis and may combine several sources. 43.3% of respondents indicated that they obtain their income from a single source, while 35.8% have two sources of income. 49.6% receive income from the government,[7] (similar proportion in communities). Among the latter, 40.1% receive income security (versus 23.7% in the communities).

58.2% of men have a net income of less than $15,000, versus 52.3% of women. 45.1% of women reported having an income of $15,000 or more.

The situation regarding household annual income appears to be more precarious than for households living in the communities: 40.9% of urban households have a net income of less than $20,000 (24.3% in the communities), and 59.1% have a net income of $20,000 or more (75.7% in the communities). 69.7% of First Nations' Quebec City households have an income of $20,000 or more, versus 51.5% in Montreal.

Table 18 gives the proportions of adults receiving various forms of income. This information allows us to assume that it is slightly easier to find work in Montreal, that one third of Val-d'Or respondents are living in Val-d'Or for educational or training purposes and that the largest proportion of children is in Quebec City.

Table 18: Source of income, by place of residence (2001)

Source of income (2001)	Montreal	Quebec City	Val-d'Or
Self-employment	10.3%	2.8%	2.9%
Income security	46.0%	32.1%	42.9%
Child tax benefit	9.6%	14.2%	54.3%
Education or training program	10.3%	24.5%	34.3%

4.1.5 Information on households

54.1% of respondents were single at the time of the survey, and 72.0% of single persons were aged 18 to 34, which is similar to the situation of 1997 when 56.0% of respondents in Montreal were single. Over one third of adults were married or living common-law (34.3%), which is an increase over the figure of the 1997 survey (25.0% of adults in Montreal) but a much smaller proportion than for adults living in the communities where one adult out of two is married or living common-law.

57.9% of men are single, versus 50.6% of women. 47.9% of households had two adults, 36.9% had just one adult, and 95.5% did not have any elder aged 65 or older.

60.1% of respondents had no children in their households, while 34.7% had 1 to 3 children. However, an average of 69.7% of women had previously given birth to children, as follows: 55.6% of women in Montreal, 73.1% of women in Quebec City and 91.7% of women in Val-d'Or. 7.4% of women were pregnant at the time of the survey. Finally, approximately one of every four couples with at least one child is living below the poverty line.[8]

[7] Employment insurance (unemployment assistance); income security (social assistance); basic old age security; Canada Pension Plan or Régime des rentes du Québec benefits; veteran's pension; child tax benefit; worker's compensation; disability, study or training allowance.

[8] "Quebec has defined the poverty line for its own purposes. It has been temporarily set at $15,500 for a single-parent family with one child, at $18,200 for a single-parent family with two children and for a couple with one child, at $22,000 for a single-parent family with

4.1.6 Housing

More than three quarters of residences are rented by respondents or other household members (versus slightly over half in the communities) as follows: 82.1% men and 73.0% women. 31.8% of these residences have three or fewer rooms and 43.1% have four or five rooms.

4.1.6.1 Concerning household equipment:

- 87.7% of residences have smoke detectors, 50.6% have fire extinguishers and 10.8% are equipped with carbon monoxide detectors.
- 97.3% have refrigerators and 97.7% have kitchen ranges (versus 99.3% in the communities).
- 99.6% have electricity, hot and cold running water, and flush toilets. 90.2% are connected to sewer systems and 95.1% receive garbage pick-up services.
- The main source of water for 97.3% of households is by way of public water supply line. Although 83.6% of respondents consider the water drinkable, 60.4% also use bottled water.

First Nations members living in the communities enjoy slightly higher percentages of technological or communication equipment. In fact, 46.1% of respondents have a computer at home (51.0% in the communities), and 35.3% have Internet service (versus 39.2% in the communities).

45.2% of residences need major or minor repairs, while 33.6% require regular maintenance. In the communities, 54.8% of residences need major or minor repairs. Finally, 32.9% of respondents reported the presence of mould in their residences in the 12 months preceding the survey (35.8% in the communities).

4.2 Health Status

4.2.1 Overall health

4.2.1.1 Weight, overweight and obesity

39.3% of off-community adults in urban centres are of normal weight, while 36.8% are overweight. Many women living off-community in urban centers appear to be morbidly obese. The average weight of women is indeed higher than that of men: 58.2% of women are overweight or obese, compared to 54.5% of men.[9]

Table 19: Average height and weight, by sex

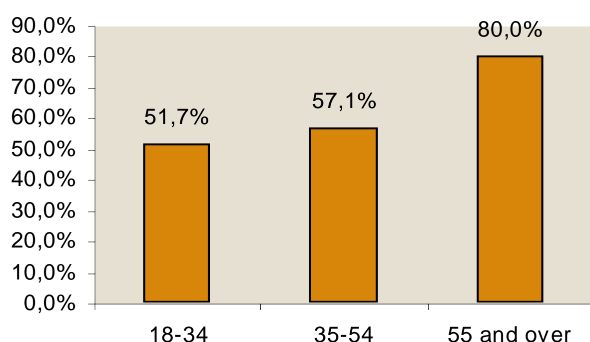
		Men	Women
Height (cm)	Off-community in urban centres	168.6	166.3
	In the communities	175.5	162.3
Weight (kg)	Off-community in urban centres	75.1	76.2
	In the communities	87.7	76.2

Graph 31 shows the influence of age on the percentage of overweight or obese persons, while Graph 32 presents the proportion of overweight and obese adults by place of residence.

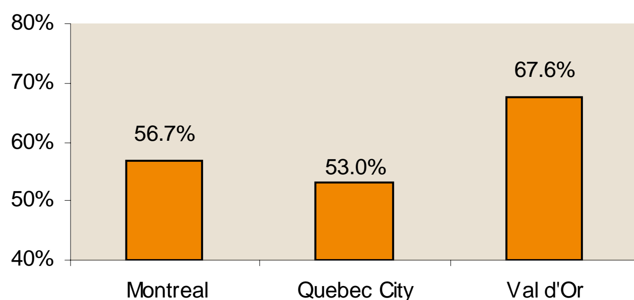
three or more children and for a couple with two children, and at $24,500 for a family with more than three children" (translated from: Lévesque, K. and Chouinard, T., *Le Devoir,* Monday, November 10, 2003).

[9] These categories are based on the body mass index (BMI): under 20 (underweight), 20-24.9 (acceptable weight), 25-26.9 (slightly overweight) and 27 or more (overweight). The BMI is a tool used to determine the healthy weight of individuals. It is obtained by dividing weight (kg) by height squared (metres.

Graph 31: Proportion of overweight and obese adults, by age group



Graph 32: Proportion of overweight and obese adults, by place of residence



47.8% of respondents said that in general their health was excellent or very good, while 36.6% said their health was good, for results similar to those in the communities. While 53.8% of women consider their health to be excellent or very good, 43.0% of men consider theirs to be good. Let it be noted that positive perceptions of the health status tend naturally to diminish with age. Finally, 44.2% of Montreal and Quebec City adults say their health is excellent or very good (56.2% in Montreal in 1997), versus 71.4% of Val-d'Or adults.

When asked about the reasons for being in good health, respondents gave the following answers:

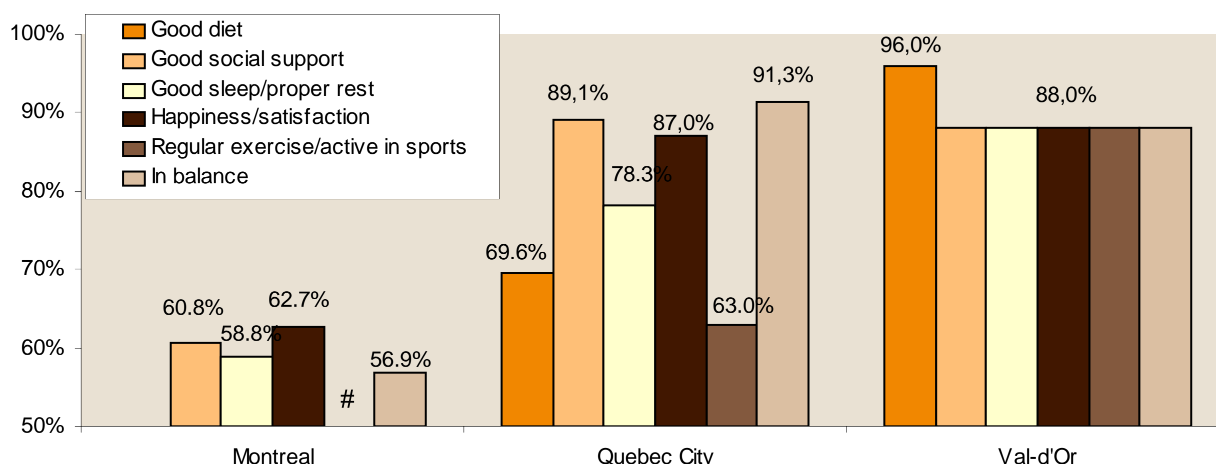
Table 20: Proportion of adults considering various reasons to justify being in very good or excellent health, by sex

Reasons justifying a very good or excellent health	Men	Women
Healthy diet	69.2%	68.8%
Little stress	56.4%	57.5%
Good social support	76.9%	78.8%
Proper sleep and rest	79.5%	67.5%
Happy/satisfied	71.8%	78.8%
Regular exercise/active in sports	69.2%	51.3%
Well-balanced life	82.1%	73.8%

The proportions of respondents who experience or integrate these elements into their lives tends to diminish with age, excepted for "Little stress" and "Proper sleep and rest" which are more frequently reported by people aged 35 to 54 than those aged 18 to 34.

Graph 33 presents the reasons justifying being in very good or excellent health by place of residence.

Graph 33: Proportion of adults considering various reasons to justify being in very good or excellent health, by place of residence



4.2.2 Medical problems

4.2.2.1 Medical problems

47.8% of respondents stated to have at least one medical problem. Of these, 64.8% suffer from one or two problems, and the others suffer from three problems or more.

77.1% of Val-d'Or respondents stated not to have any medical problems, versus 52.0% in Montreal and 44.3% in Quebec City. Among adults who stated to have at least one medical problem, the following table shows the most frequent medical problems.

Table 21: Proportion of adults with various medical problems

Medical problems	% of adults
Musculo-skeletal	16.0%
Respiratory	15.3%
Cardiovascular	12.3%
Visual or auditory	11.9%
Infectious disease	10.1%
Neurological or cognitive	7.8%

The proportion of respondents with medical problems tends naturally to rise with age and Montreal residents are the most affected, excluding respiratory problems, which Quebec City residents suffer from in the highest proportion.

Regarding the individual annual income, the sample revels that people who earn less than $15,000 per year are more likely to have medical problems than those who earn $15,000 or more, excluding musculo-skeletal and cardiovascular problems.

Table 22: Proportion of adults with a medical problem who have a physical limitation and are being treated

Medical problems	% of adults affected	% of adults with physical limitations	% of adults being treated for that problem
Allergies	19.8%	9.6%	24.5%
Asthma	13.8%	-	75.7%
High blood pressure (1)	9.4%	30.4%	84.0%
Stomach or intestinal problems	9.0%	29.2%	-
Tuberculosis	8.3%	4.8%	14.3%
Chronic back pain	8.2%	77.3%	-
Arthritis	7.1%	-	-
Hearing impairment	6.4%	-	11.8%
Diabetes	6.4%	-	-
Chronic bronchitis	4.2%	-	-
Thyroid problems	4.2%	-	90.9%
Liver disease (excluding hepatitis)	4.1%	-	9.1%
Psychological or nervous disorders	3.7%	-	-
Heart disease	3.4%	-	-
Cancer	3.0%	-	-
Learning disability	2.6%	-	14.3%
Osteoporosis	2.6%	-	-
Hepatitis	2.3%	-	-
HIV / AIDS	1.9%	-	-
Rheumatism	1.9%	-	-

(1) Some cases are pregnancy-related

The Survey revels that the proportions of respondents suffering from illness increases with age, with certain exceptions: chronic bronchitis is more common among those aged 35 to 54 (followed by those aged 55 and over). Learning disabilities follow a reverse trend, no case was found among adults aged 55 and over. This is probably because young people are more inclined to be in a learning situation (school, training, etc.).

The highest proportions of most illnesses are divided between Montreal and Quebec City respondents, except for chronic bronchitis, which is more common in Val-d'Or.

We were not able to establish a link between asthma, chronic bronchitis, allergies, heart disease or high blood pressure and the presence of mould in the house, tobacco use or the effects of second-hand smoke.

4.2.2.2 Diabetes

In contrast to the situation of adults living in the communities, men are more likely to suffer from diabetes than women, at a rate of nearly one man in ten compared to nearly one woman in twenty.

88.2% of diabetics have had no infections or amputations resulting from their disease. In the communities, more than one third of diabetics state that they have problems resulting from their illness.

21.4% of diabetics rely on physical activities to control their disease (versus 43.3% in the communities), whereas one diabetic in five states to be adopting a healthier lifestyle (versus over three quarters in the

communities) and one in seven uses traditional ceremonies or the help of a traditional healer (versus one in ten in the communities).

4.2.2.3 Use of non-prescription drugs

Women are generally more likely to use non-prescription drugs, like their counterparts who live in the communities.

Table 23: Use of non-prescription drugs, by place of residence

Non-prescription drug	Off-community living in urban centres	In the communities
Analgesic	53.4%	59.4%
Vitamins or minerals	46.2%	37.6%
Natural products	42.6%	32.2%
Syrup (cough)	32.9%	46.2%
Tranquillizers	22.0%	8.4%
Sleeping pills	11.6%	10.5%
Laxatives	5.2%	11.9%

In general, Montreal residents are more likely to use non-prescription drugs, excluding natural products and tranquilizers. Lastly, consumption of sleeping pills and laxatives seems to increase with age (as it does in the communities).

4.2.3 Physical injuries

In the 12 months preceding the survey, one of every ten off-community First Nations adults living in an urban centre had at least one injury that required the care of a health professional (this proportion doubles among adults living in the communities). For Montreal, the proportion was one quarter of all respondents. Table 24 presents a list of these injuries. The proportions concern only the total number of respondents who had at least one injury in the 12 months preceding the survey.

Table 24: Proportion of adults who have had various types of physical injuries (12 months preceding the survey)

Types of injuries	% of adults
Cuts, scrapes or bruises (major)	43.4%
Sprain or strain (major)	26.4%
Fracture	22.6%
Concussion	13.5%
Tooth injured by accident	13.2%
Burns or scalds	9.4%
Dislocation	9.4%
Injury to an internal organ	-

Barely one woman in twenty suffered a burn in the 12 months preceding the survey, versus nearly one man in five. One man in ten and less than one third of the women had a serious strain or sprain.

Montreal presented the highest percentages of fractures, burns, dislocations, strains/sprains and concussions, followed by Quebec City and then Val-d'Or. No residents of the latter two cities suffered any burns or concussions in the 12 months preceding the survey.

The number of injuries tends to increase with age, although the results should be interpreted carefully for those aged 55 or more, since the results for four or more types of injuries have a high sample variability. For adults living in the communities, the results show that people between the ages of 18 and 29 suffer the most physical injuries.

Finally, we note that 88.9% of physical assaults are related to the consumption of alcohol or drugs, compared to 55.0% of physical assaults occurred in the communities.

4.2.4 Disabilities and activity limitation

More than one of every five individuals experiences limitations due to mental or physical health problems. Nearly one quarter of all Montreal residents and less than one person in five in Val-d'Or have a physical disability. Age seems to be related to disabilities and physical limitations: more than one person in five among 18-to-34 year old group experiences limitations, versus over one quarter of those aged 34 to 54 and nearly half of those aged 55 or more.

Nearly one man in five and one woman in ten indicate they need home care and homecare services. One of every 20 urban respondents say they need one or more types of home care, compared to 12.8% in the communities. Age seems to influence the need for home care: no-one aged 18 to 34 in our sample required home care, compared to fewer than one in ten people aged 35 to 54 and more than one in five aged 55 or older.

4.2.5 Access to healthcare services

4.2.5.1 Traditional medicine

38.1% of off-community First Nations adults living in urban centres use traditional medicine (37.8% in the communities), which is one third of men and 41.0% of women. However, many people encounter problems in trying to access traditional care, as presented in the following table.

Table 25: Obstacles encountered among the adults who have encountered difficulties in accessing traditional medicine

Obstacles in accessing traditional medicine	% of adults
Not available at the health centre	28.7%
Not covered by NIBH (Health Canada)	25.0%
Do not know enough about it	22.2%
Do not know where to find this type of care	18.1%
Too far to travel	13.9%
Can't afford it	9.3%

It appears to be more difficult to access traditional medicine in Montreal than in Val-d'Or: one quarter of Montreal residents do not know where to find traditional medical care, compared to just over one resident in twenty in Val-d'Or. Incidentally, more than one Montreal resident in five say they have to travel too far to access traditional medical care, versus one Quebec City resident in ten and less than one Val-d'Or resident in twenty.

In general, young adults encounter more problems accessing traditional medicine than their elders. About one in five of the 18-54 year old do not know where to find traditional medical care, versus one in ten of adults aged 55 or over. More than one third of 18-to-34-year-olds feel it is an obstacle that traditional medicine is not offered in healthcare institutions, versus one in five of 35-to-54 year old and one in twenty of adults aged 55 and older.

4.2.5.2 Accessibility to healthcare services

In general, 48.3% of respondents feel that they have the same level of access to health care as the Canadian population, a similar result to that found in the communities (45.0%). More than one quarter feel they have better access (one third of adults living in the communities are of the same opinion), while less than one quarter believe that health care is less accessible to them than it is to the general population. 57.7% of off-community First Nations adults respondents living in urban centres met at least one obstacle to receiving health care in the 12 months preceding the survey, compared to 46.5% living in the communities. These results suggest that it is easier to obtain healthcare services in the communities than in the cities.

Table 26: Obstacles encountered by adults who have indicated problems in accessing healthcare services (12 months preceding the survey)

Obstacles encountered	% of adults
Waiting list too long	56.1%
Not covered by NIHB	35.1%
Difficulty in receiving traditional care	33.8%
Felt service was not culturally appropriate	26.8%
Unable to arrange transportation	19.9%
Could not afford the direct costs of care/service	19.7%
Prior approval for services under NIHB was denied	18.1%
Chose not to see a health professional	17.8%
Felt health care provided was inadequate	17.0%
Could not afford transportation costs	10.2%
Service not available in my area	9.6%
Doctor or nurse not available in my area	5.1%

Although men and women show similar proportions in experiencing obstacles (56.4% of men and 58.4% of women), we identified more women in general than men for each of the points in Table 26. The 18-to-34 year old are the most likely to have encountered at least one obstacle, apart from the inability to arrange transportation or to afford the direct costs of care or the failure to secure prior approval for services under the non-insured health benefits (NIHB) program.

58.2% of Montreal residents have encountered at least one obstacle to receiving health care, compared to 51.0% of Quebec City residents and 76.5% of Val-d'Or residents.

4.2.5.3 Non-Insured Health Benefits (NIHB)

33.6% of respondents have had trouble accessing the NIHB Program, compared to 28.6% in the communities. Age seems to influence this percentage, going from 70.5% of 18-34 year old having no trouble accessing the program to just over half of those aged 55 or over.

Table 27: Health care or services where adults have encountered obstacles in accessing NIHB services among the adults who have indicated problems (12 months preceding the survey)

Health care or services	% of adults
Medication	66.3%
Dental care	36.1%
Vision care	19.3%
Transportation services or costs	13.3%
Escort for travel	10.8%
Medical supplies/equipment	4.8%

In general, women are more likely to have had problems, excluding medications, for which 69.7% of men had problems, versus 64.6% of women. The proportion of adults who encountered problems increases with age, other than dental and vision care, where those aged 55 or more were the least likely to have encountered difficulties.

4.2.6 Dental care

At the time of the survey, 33.0% of off-community First Nations respondents living in urban centres received dental care within the previous six months (39.3% of adults living in the communities). Like their counterparts in the communities, nearly one respondent in five encountered obstacles in receiving dental care; over one woman in ten and over one man in five. Nearly one third of respondents in Montreal and over one respondent in twenty in Val-d'Or have encountered difficulties. The following table shows the main obstacles to access encountered by adults who have indicated difficulties.

Table 28: Obstacles to accessing dental care among adults who have had difficulties in receiving dental care

Obstacles in accessing dental care	% of adults
Services not covered by NIHB	62.2%
Cannot afford direct cost of care	33.3%
Prior approval for services under NIHB Program was denied	28.3%
Waiting list too long	22.0%
Felt dental services were inadequate	14.0%
Dental services not offered in my area	10.0%
Could not afford transportation costs	7.8%

74.0% of off-community First Nations adults living in urban centres need dental care, which represents the same proportion as in the communities. The dental care required among adults who have indicated they require them are presented in Table 29. Graph 34 suggests that the need for dental care rises with age. Montreal residents are generally more likely to need the various kinds of dental care listed in Table 29.

Graph 34: Adults who need dental care, by age group

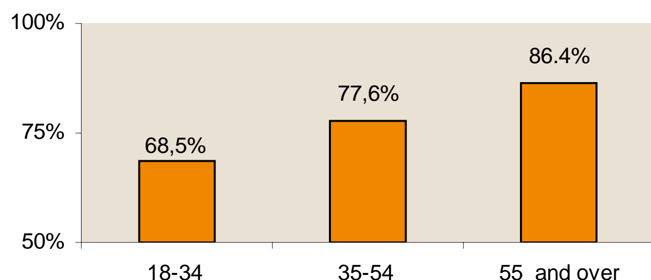


Table 29: Adults who need various types of dental care among the adults who have indicated they need care

Types of dental care	% of adults
Maintenance	81.7% (1)
Filling or restorative work	38.7%
Prosthetic	19.9%
Extraction	16.2%
Periodontal work	7.9%
Emergency	6.8%
Fluoride treatment	6.8%
Orthodontic work	2.1%

(1) Approximately two thirds (66.6%) in the communities

The dental care needed by most women is maintenance and fluoride and periodontal treatments, while a higher number of men need the other kinds of dental care. Respondents aged 55 or more need more dental care, but they are less likely to need fluoride treatment, orthodontic work or fillings than do younger adults.

4.2.7 Women's health

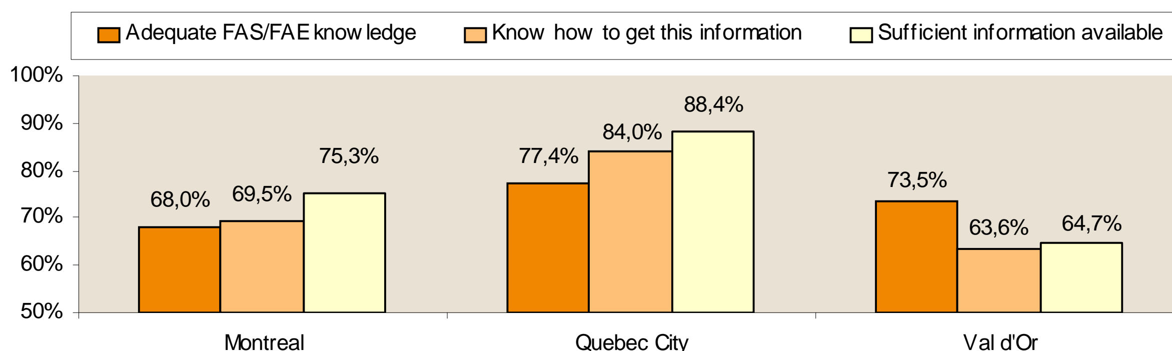
4.2.7.1 Foetal alcohol syndrome (FAS) and Foetal alcohol effect (FAE)

69.7% of adult women interviewed have already had a child. 57.4% of them did not drink alcoholic beverages, beer or wine during their pregnancy. 69.8% of those who drank did so less than once a month.

72.8% of women feel they have adequate knowledge about FAS/FAE. Moreover, 75.0% know how to get information about these problems and 79.4% feel that the necessary information is available in their city.

Women appear to be slightly better informed about FAS/FAE than men are. Accordingly, 71.1% of men feel they have adequate information about FAS/FAE, versus 74.6% of women. 71.1% of men know how to get this information, versus 77.6% of women. The following graph presents the data by place of residence.

Graph 35: Women's perceptions of FAS/FAE, by place of residence



4.3 Lifestyle

4.3.1 Nutrition

4.3.1.1 Consumption of junk food

44.0% of off-community adults living in urban centres consider their diet to be always or almost always balanced and nutritious, whereas 41.4% say it is sometimes. These perceptions, which are almost identical to those of adults living in the communities, appear realistic when we consider consumption of junk food, as reflected by the following data:

- 35.4% drink coffee or tea several times a day (42.8% in the communities);
- 35.1% eat french fries, potato chips, and pretzels, etc., at least once a week (28.0% in the communities); 39.9% eat them a few times a week (49.8% in the communities);
- 35.8% eat less than one fast-food meal per week (similar proportion in the communities); 32.5% eat fast-food a few times a week, versus 40.7% in the communities;
- 39.2% never or almost never eat cake, pie, cookies, candy and chocolate (23.0% in the communities);
- 36.6% never or almost never add sugar (32.1% in the communities); 40.7% do so one to several times a day (45.1% in the communities);
- 37.7% never or almost never add salt to their food (35.5% in the communities).

This comparison between off-community individuals living in urban centres and individuals living in the communities shows a slightly higher proportion of city dwellers make better dietary choices.

4.3.1.2 Consumption of traditional food

Table 30: Proportion of adults, by frequency of consumption of traditional foods

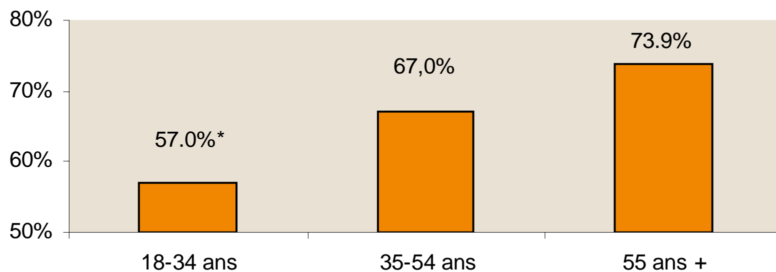
Traditional foods	Never	A few times a week
Large game	25.1%	57.7%
Small game	49.1%	43.1%
Wildfowl	38.2%	52.1%
Freshwater fish	23.6%	58.8%
Saltwater fish	38.0%	49.2%
Other freshwater/saltwater foods	45.3%	46.0%
Sea products (seafood)	88.0%	10.1%
Wild berries or other fruits	21.6%	54.1%
Bannock	19.8%	52.2%
Corn soup	63.7%	30.0%

The survey shows that women generally eat more traditional food than men, with the exception of wild berries or other fruits, which 57.0% of men eat a few times a week, versus 51.9% of women. Consumption of game (small, large and wildfowl) a few times a week is lowest among adults in Montreal and highest in Val-d'Or. Saltwater fish, bannock and wild berries or other fruits are more likely to be eaten in Quebec City. Finally, adults aged 18 to 34 generally eat less of the traditional food listed in the above Table.

A comparison of the consumption frequency of traditional food among adults living in the communities shows that urban respondents eat more saltwater fish, sea-based animals and corn soup than do adults in the communities. Consumption of large game is basically the same.

In the 12 months preceding the survey, 62.6% of households sometimes received traditional food from a third party who shared it with them. This sharing of traditional food is more frequent among women (66.4%) than among men (55.2%). The following Graph shows the proportion of adults who have received traditional food from a third party, by age group. One can see that the sharing of traditional food increases with the age, as observed among adults living in the communities.

Graph 36: Adults who have sometimes received traditional food from a third party, by age group



4.3.1.3 Meat and fish preparation methods

The methods used to cook or prepare meat and fish can, in a certain extent, reflect the eating habits that may be harmful or beneficial to health. Here are the frequencies of the various meat and fish preparation methods.

Table 31: Frequency of various meat and fish preparation methods

Methods of preparation	Often (1 meal in 2)	Sometimes (1 meal in 4)	Never
Margarine	35.5%	36.3%	13.9%
Steam or oven	33.2%	36.4%	8.0%
Vegetable oil	23.7%	37.3%	16.5%
Butter	21.2%	36.0%	21.6%
Broth	27.1%	32.7%	17.9%
Grease (Crisco, lard)	8.8%	25.2%	43.2%
Smoked	2.0%	14.0%	66.8%
Dried	1.6%	10.0%	69.9%
Cooking spray (PAM)	5.3%	8.5%	70.9%
Animal fat (goose, seal)	3.2%	6.8%	75.3%
Raw	7.2%	6.0%	77.7%

Montreal residents are most likely to use traditional methods to prepare their meat and fish: more than half of them smoke or dry these foods, and more than one third eat them raw or use animal fat. More than one third also uses cooking spray. Val-d'Or residents are the second most likely to use traditional methods to prepare their meat and fish, in proportions varying between one quarter and one-fifth. Quebec City residents are least likely to do so (in proportions varying from one in five to one in ten). The 35-to-54-years-old is the age group that uses traditional preparation methods the most.

The consumption of raw meat and fish appears to be higher among urban adults than among adults living in the communities. Nearly one quarter of off-community adults eat raw meat or fish compared to one in twenty of adults living in the communities. Lastly, the use of animal fat and vegetable cooking spray is similar off community and in the communities.

4.3.2 Physical activities

Off-community surveyed adults living in urban centres appear to be less active than those living in the communities; 66.5% of the latter participate in four types of physical activity, versus only 50.5% of urban respondents.

Women seem more likely to vary their physical activities, with 58.3% participating in four or more types of physical activities, while 60.7% of the men are involved in one to three. With the exception of walking, running and dancing, more women participate in the physical activities listed in Table 32.

Concerning the differences between the age groups, 60.6% of the 18-to-34-year-olds take part in four or more types of physical activity, while 55.9% of the 35-54 year-olds make do with one to three. A higher number of young adults are involved in every activity presented in Table 32, with the exception of fishing, canoeing and snow-shoeing, for which the 55 and older age group shows the highest proportions.

Table 32: Proportion of adults who practice various physical activities, by place of residence

Physical activities	Off-community in urban centres	In the communities
Walking	93.2%	89.4%
Bicycling	42.6%	41.0%
Swimming	33.6%	30.1%
Hiking	27.2%	36.4%
Fishing	25.7%	51.3%
Gathering berries or other foods	24.9%	40.6%
Dancing	23.0%	17.4%
Running	22.3%	11.7%
Hunting/trapping	20.8%	40.2%
Competitive or group sports	20.4%	21.8%
Canoeing	19.2%	29.2%
Skating	17.0%	18.5%
Bowling	15.1%	15.8%
Aerobics/fitness	14.3%	13.5%
In-line skating	13.6%	8.4%
Weightlifting/exercise equipment	12.5%	19.7%
Snowshoeing	10.2%	21.1%
Skiing	9.8%	7.3%
Golfing	5.7%	10.9%
Martial arts	4.9%	3.0%
Skateboarding	1.9%	1.1%

A greater proportion of off-community adults living in urban centres practices jogging and in-line skating. However, a higher number of adults living in the communities practices hunting, trapping, fishing and snowshoeing.

More Val-d'Or adults are involved in the activities listed above, excluding martial arts, fitness and running, for which Montreal adults show the highest proportions. Quebec City shows higher proportions of adults practicing cycling and swimming.

53.1% of respondents participate in physical activities that increase their heart rate one to three times a week (61.3% of women), while 36.2% take part in four or more. Based on this data, people living in the communities seem to be more active, as 42.9% of them participate in four or more of these activities every week. Furthermore, 41.6% of them spend one to two hours a day pursuing these activities, compared to 38.3% of urban adults.

The respondents who consider traditional cultural events to be very important in their lives are more likely to take part in hunting/trapping, fishing, and canoeing in a greater proportion. One can see that the proportion of adults who take part in hunting/trapping, fishing, and canoeing declines as the importance placed on traditional events decreases.

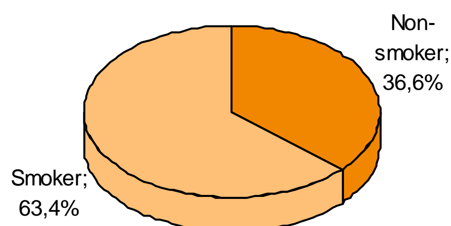
4.3.3 Lifestyle

4.3.3.1 Smoking

The proportion of smokers seems to be higher among off-community adults in urban centres (63.4%) than among adults living in the communities (55.0%). Furthermore, in contrast to what we found in the communities, slightly more men smoke than women (66.4% versus 62.2%). More men also smoke every day

(84.5% versus 78.4% of women) and smoke more cigarettes (54.9% of men smoke more than ten cigarettes a day, compared to 45.4% of women). We also note that while two thirds of the 18-34 years-old smoke, more than three quarters of adults aged 55 and over are non-smokers.

Graph 37: Proportion of smoking and non smoking adults



Half of all smokers smoke on average more than ten cigarettes a day (61.6% in the communities). 81.2% of them smoke every day (79.4% in the communities). Moreover, half tried to quit smoking in the 12 months preceding the survey, without success. Lastly, 47.1% began smoking between the ages of 7 and 13, while 40.8% began between the ages of 14 and 17.

Concerning the differences between the cities, 68.5% of Montreal respondents smoke, 78.2% of which smoke every day and 47.1% smoke more than ten cigarettes a day. In Quebec City, 56.6% of the respondents smoke, with 85.0% of smokers doing so every day and 58.3% smoking more than ten cigarettes a day. Finally, 65.7% of Val-d'Or respondents smoke. Among them, 82.6% smoke every day and 34.8% smoke more than ten cigarettes a day.

64.3% of non-smokers used to smoke and more than three quarters of these used to smoke every day (74.1% of men and 80.6% of women). Moreover, 53.4% of ex-smokers began smoking between the ages of 5 and 14, while 56.9% quit smoking between the ages of 13 and 30. Finally, 92.0% of male ex-smokers began smoking before they turned 18, compared to 71.4% of female ex-smokers.

Table 33: Proportion of ex-smokers having evoked various reasons for quitting smoking

Reasons for quitting smoking	% of ex-smokers
Chose a healthier lifestyle	57.6% (1)
Health reasons	54.2% (1)
Awareness campaigns	35.6%
Out of respect for loved ones	27.1%
Pregnancy	10.2%
Peer pressure from friends or co-workers	8.5%
Doctor's orders	6.8%
Respect for the traditional significance of tobacco	1.7%

(1) All women 55 years and older living in Quebec City

Less than one man in twenty mentioned pressure from friends and co-workers as a reason for quitting, compared to one woman in ten. Women were also more likely than men to quit out of respect for loved ones or on a doctor's orders. Nearly one of every ten adults in the 18-34 and the 55 or older age groups stopped on the orders of a doctor, compared to fewer than one in twenty among the 35-54 year-olds.

The reasons for quitting were cited in similar proportions of adults living both in and outside of the communities, but the latter were more likely to mention health reasons (54.2% off-community versus 38.1% in

the communities) and the influence of awareness campaigns (nearly one third of off-community adults in urban centres compared to one-fifth in the communities).

Table 34: Proportion of adults having used various methods to quit smoking

Methods to quit smoking	% of ex-smokers
Cold turkey	72.9%
With spiritual support	8.5%
With family support	6.8%
Nicotine replacement patch	6.8%
Nicotine replacement gum	5.1%
Traditional methods	5.1%
Support or self-help program	1.7%
Hypnosis	-
Acupuncture	-
Zyban	-
Other prescription drugs	-

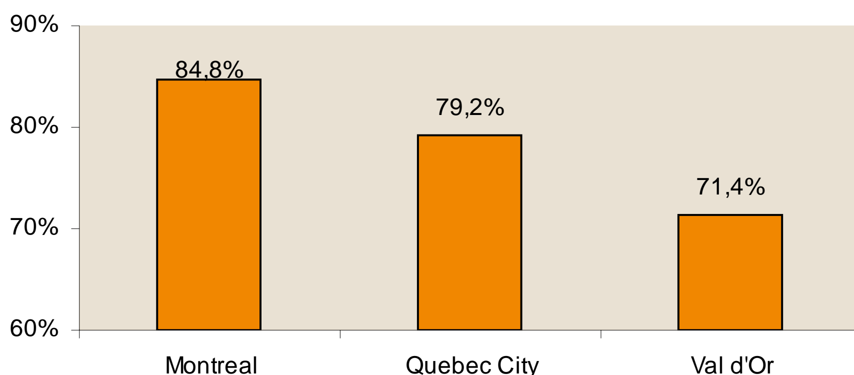
Family support was an important element for more women (nearly one in ten) than men (fewer than one in twenty), while nicotine replacement patches were more popular among men (over one man in ten) than among women (less than one woman in twenty).

Finally, 62.9% of households headed by men allow smoking (49.2% in the communities), versus 55.6% of households headed by women (46.8% in the communities). 63.9% Montreal households fail to offer a smoke-free environment, versus 56.6% of Quebec City households and less than half of Val-d'Or households.

4.3.3.2 Alcohol consumption

While 74.3% of adults in the communities drank beer, wine, spirits and other alcoholic beverages in the 12 months preceding the survey, 80.8% of off-community adults living in urban centres did so. More men (85.8%) than women (79.4%) drank beer, wine or spirits. Among the adults who drank alcohol, 47.7% drank one to three times a month (55.4% in the communities), while 39.2% drank at least two or three times a week (23.9% in the communities).

Graph 38: Adults who have used alcohol, by place of residence (12 months preceding the survey)



One quarter of respondents have been treated for alcohol abuse; one man in four and more than one woman in five. This proportion is higher than that of adults living in the communities where 15.5% of adults were treated for alcohol abuse.

4.3.3.3 Drug use

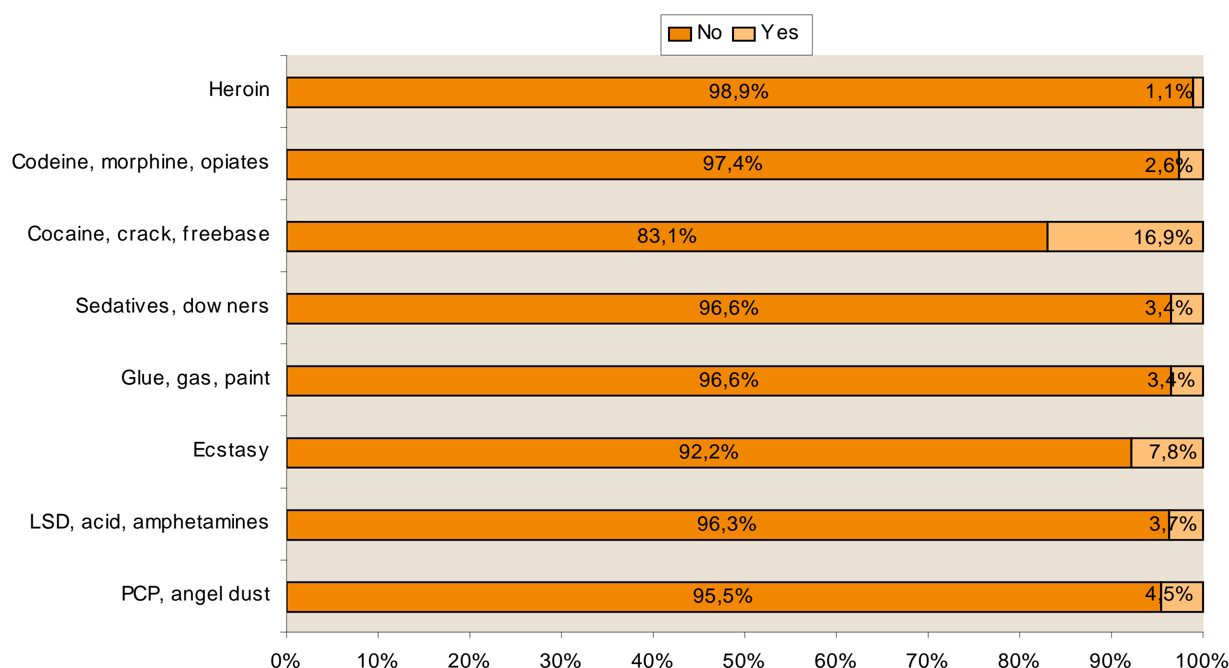
The study reveals that 57.8% of respondents used at least one non-prescription drug in the 12 months preceding the survey (excluding marijuana and chewing tobacco), which represents a proportion slightly inferior to that observed in the communities (62.3%).

The number of users declines significantly with age, dropping from 74.2% among 18-to-34-year-olds to 46.8% among 35-to-54-year-olds, and 13.0%* of adults aged 55 and. The proportion is also much higher in Montreal (71.7%) than in Quebec City or Val-d'Or (fewer than half of all respondents). Nevertheless, while one in five adults in Montreal and Quebec City has been treated for drug abuse, it is more than one in four adults in Val-d'Or who has been treated for drug abuse.

The study also reveals that 51.3% of respondents used marijuana in the 12 months preceding the survey, the proportion being 61.3% of men and 44.9% of women. This is double the rate of what is observed in the communities. Among the adults who have used drugs, 65.1% used marijuana in Montreal and 38.7% in Quebec City. Finally, 55.5% of adults who used marijuana smoked two to three times a week, which is a proportion similar to that observed in the communities (50.8%).

Graph 39 presents a portrait of drug and volatile substance consumption among off-community adults living in an urban centre. We note that nearly one adult in five (16.9%) used cocaine, crack or freebase in the 12 months preceding the survey.

Graph 39: Proportion of adults who have or have not used various types of drugs and inhalants

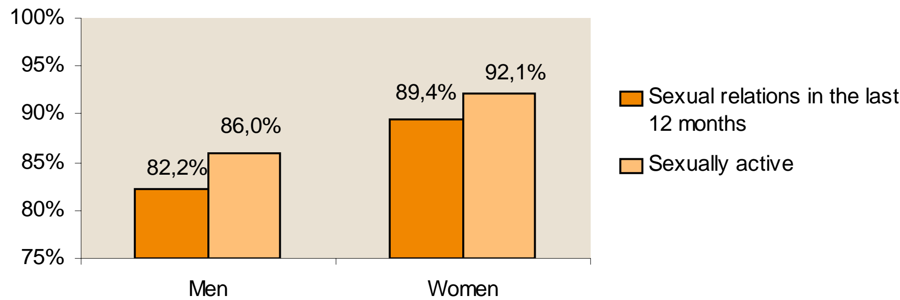


Apart from ecstasy, sedatives and codeine, more men generally use the drugs listed in the previous graph. The main difference between both sexes concerns cocaine: nearly one man drug user in four uses cocaine, versus less than one woman drug user in seven. Only a few respondents in Montreal used heroin or inhaled glue, gas or paint. More Montreal residents also used ecstasy, LSD and codeine. Finally, although less than one in five adults has received treatment for drug abuse, this figure is near double the figure for adults living in the communities.

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

Although 88.7% of adults were sexually active at the time of the survey, 85.6% had sexual relations in the 12 months preceding the survey, which represents proportions slightly higher than in the communities. Three quarters of adults who were sexually active in the year preceding the survey had had one or two partners, compared to 85.7% of adults living in the communities. Graph 40 shows that women seem to have a more active sex life than men.

Graph 40: Sexual activity, by sex



Men seem to have had more sexual partners than women since 71.6% of them had one or two partners, compared to 77.1% of women. The rate is not the same in every city, standing at 61.2% for Montreal residents and at 84.5% for Quebec City and Val-d'Or residents. Age seems to play a role in the number of partners; 67.3% of 18-to-34 year old had one or two partners, versus 83.9% of 35-to-54 year old and 91.7% of adults aged 55 or older.

The use of contraceptive means seem to be more frequent among off-community adults living in urban centres than in the communities. The most widely used method of contraception is the condom: 51.8% for urban adults versus 42.2% in the communities. To protect themselves from STDs, 48.6% use condoms most or all of the time, while 44.0% never do. To the question "What is the main reason for not always using a condom?" 67.9% indicated they had a regular partner, which is the same proportion as in the communities. Finally, 59.3% had taken an HIV screening test: 57.0% of men and 61.5% of women, figures well above the 30.1% of men and 42.7% of women in the communities.

Finally, let it be noted that one Montreal surveyed adult in seven uses no birth control, while no one in Quebec City or Val-d'Or falls into this category.

One-fifth of surveyed women use oral contraceptives. More specifically, one quarter of Quebec City surveyed women, one-fifth of Montreal surveyed women and only one Val-d'Or surveyed woman in ten do so. About one surveyed adults in twenty relies on coitus interruptus, depo provera or no birth control at all. 31.7% of surveyed adults living in the communities did not use birth control.

4.3.4 Preventive health care

4.3.4.1 Consultation of traditional healers

55.9% of off-community adults living in urban centres consulted a traditional healer in the 12 months preceding the survey. Let it be noted that only 9.9% of adults living in the communities say that they consulted a traditional healer in the 12 months preceding the survey.

4.3.4.2 Medical examinations

Table 35 presents the proportions of adults who underwent various types of medical examinations in the 12 months preceding the survey. Concerning examinations specific to each sex, we found that less than one man in five had a rectal examination. Moreover, 57.8% of women never had a mammogram, 46.6% say they

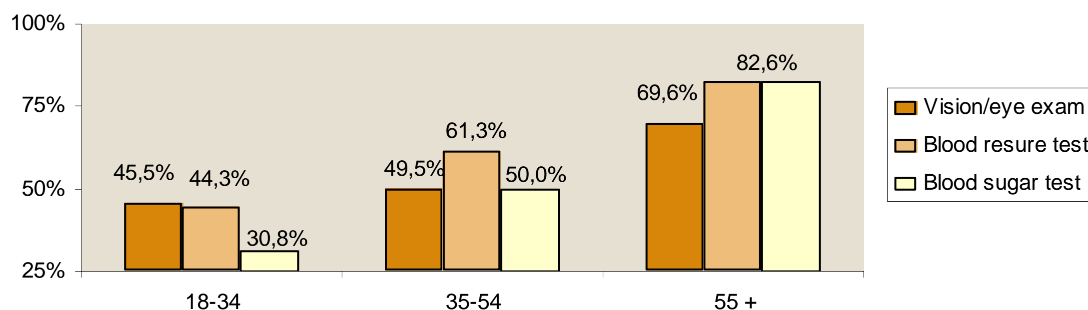
perform monthly breast self-examinations and 49.5% have had a Pap smear in the last year.[10] These proportions are similar to those in the communities.

Table 35: Proportion of adults having undergone various medical examinations, by place of residence (12 months preceding the survey)

Examinations	Off-community in urban centres	In the communities
Blood pressure test	54.7%	63.7%
Eye exam	49.6%	60.3%
Complete physical check-up	43.8%	44.0%
Blood sugar test	43.4%	53.0%
Cholesterol test	38.2%	47.7%

Apart from physical check-ups, people living in the communities are more likely to have various types of tests. The proportion of respondents who underwent examinations increases directly with age, as the graph below demonstrates:

Graph 41: Proportion of adults who have had various medical examinations, by age group (12 months preceding the survey)



Although more men (56.1%) than women (52.9%) had blood pressure tests, a greater proportion of women have undergone complete physical check-ups (46.5% of women compared to 39.3% of men).

4.3.5 Residential schools

Just under one of every five off-community adults living in urban centres attended a residential school; this proportion corresponds to the numbers found in the communities (17.0% of adults). 63.6% began attending residential schools when they were between 4 and 8, and 65.8% were 13 or older when they left. One third of 35-54 year-olds attended a residential school, versus one quarter of the same age group in the communities.

We note a significant difference among the cities: less than one in five Montreal and Quebec City residents attended residential school, compared to one quarter of Val-d'Or residents.

Also, one or both parents of 35.4% of adults attended a residential school (the mother of 25.0% of adults and the father of 20.0% of adults). These proportions are similar to those found in the communities, but there was a marked difference concerning grandparents: one or more grandparents of one urban respondent in five attended a residential school, but the proportion drops to fewer than one in ten in the communities. 69.6% of persons whose grandparent(s) attended a residential school felt that this experience had had negative impacts on the way their parents were raised. Let it be noted that 55.5% of the adults in the same situation in the communities are of the same opinion.

Just under half of adults who went to residential schools feel that being schooled in that environment had negative impacts on their overall health and general well-being. Just over one third of adults in the

[10] Vaginal exam with cervical smear.

communities feel the same. The following table summarizes these impacts and suggests that adults living in urban centres suffered more or had more problems coping with their experiences than adults who still live in their community. The main impact of residential schools is the loss of cultural identity.

Table 36: Proportion of adults who have experienced various negative impacts caused by residential schools

Impact	Off-community in urban centres	In the communities
Loss of cultural identity	94.7%	64.3%
Harsh discipline	84.2%	68.9%
Loss of one's language	78.9%	61.1%
Isolation from one's family	78.9%	69.0%
Verbal or emotional abuse	73.7%	69.9%
Physical abuse	63.2%	56.5%
Loss of traditional religion/spirituality	63.2%	49.0%
Witnessed abuse	47.4%	43.5%
Lack of proper clothing	47.4%	25.2%
Sexual abuse	31.6%	28.6%
Poor education	31.6%	17.3%

4.3.6 Personal and social well-being

4.3.6.1 Culture and traditional spirituality

The information in Table 37 shows that urban adults place greater importance on cultural events and traditional spirituality than the adults living in the communities. However, religion seems less important.

Table 37: Proportion of adults who consider various elements important or very important by place of residence

Elements	Off-community in urban centres	In the communities
Traditional cultural events	89.0%	83.2%
Traditional spirituality	79.7%	72.4%
Religion	63.0%	73.0%

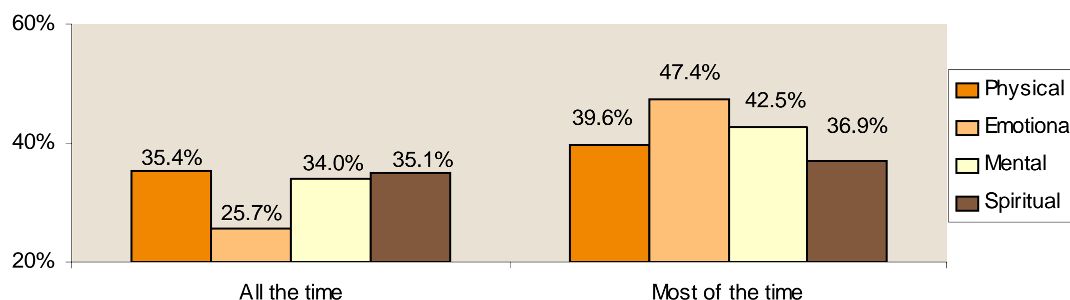
Traditional cultural events are very important for 53.7% of Montreal residents, versus 62.6% of Quebec City and Val-d'Or residents. This importance also tends to rise with age, going from 57.4% among 18-34 year-olds and 57.4% among 35-54 year-olds to 78.3% among adults aged 55 and over.

Traditional spirituality is very important for 54.9% of women, versus 48.1% of men. It is very important for 45.9% of Montreal residents and 57.5% of Quebec City residents.

4.3.6.2 Physical, emotional, mental and spiritual well-being

This section of the survey seeks to determine people's perception of the various dimensions of balance in their lives: physical, emotional, mental and spiritual. 39.6% of adults feel they have achieved a high level of balance, while 55.6% feel they have achieved moderate balance. These results are similar to those found in the communities. Graph 42 provides further details about these results, and the following section (self-determination indicator) shows that half of all adults feel they have very little control over their lives.

Graph 42: Frequency of balance achieved in its various dimensions



4.3.6.3 Self-determination indicator

The self-determination indicator is an arbitrary index that evaluates the level of control people feel they have over their lives, classified in the very low, low, average, high and very high categories. A "very low" index means that the individual exercises very little control over his or her life, while a "very high" index indicates a solid grip on life. The self-determination index was established according to answers to the following questions, which we will examine individually below:

- "I can solve my problems."
- "No-one bothers me in my life."
- "I have control over the things that happen to me."
- "I can do just about anything once I set my mind to it."
- "I often feel helpless in facing life's problems."
- "What happens to me in the future mostly depends on me."
- "There's not much I can do to change many of the important things in my life."

14.9% of respondents scored very high on the self-determination index, 32.1% scored high and 33.6% scored moderately. 15.7% had neutral scores and 3.7% had moderately low or low scores.

Table 38: Adults who strongly agree or agree with various statements regarding self-determination

Statements	% of adults who strongly agree / agree
I can solve my problems.	77.9%
No-one bothers me in my life.	75.5%
I have control over the things that happen to me.	73.5%
I can do just about anything once I set my mind to it.	79.6%
I often feel helpless in facing life's problems.[1]	27.2%
What happens to me in the future mostly depends on me.	79.3%
There's not much I can do to change the important things in my life.[1]	28.0%

(1) Disagreeing with this statement is a positive response for establishing the self-determination index

There was only one notable difference with adults living in the communities: 48.8% of them agree that they can solve their problems, compared to 39.6% of off-community adults living in urban centres.

4.3.6.4 Racism

39.6% of adults indicated they had experienced racism in the 12 months preceding the survey, versus 28.3% of adults living in the communities. Among the adults having experienced racism, 60.7% of them indicated it had little or no effect on their self-esteem, compared to half of the urban respondents.

Alike the situation in the communities, more men (43.3%) experience racism than women (38.4%). Racism is slightly more pronounced in Montreal (more than one person in three affected) than in Quebec City (less than one person in three affected).

4.3.6.5 Agents of support

32.8% of adults felt depressed for two or more weeks in the 12 months preceding the survey (39.2% in the communities). In contrast to the situation in the communities, the proportion of men is higher than that of women. More Montreal adults (a little over one third) are likely to have felt depressed than Quebec City adults (more than one quarter). Finally, one third of adults aged 18 to 34 felt depressed, versus less than one quarter of adults 55 or over.

The survey documented the various agents of support that adults turn to for support when they have personal problems. The main results show that:

- 82.1% of adults rely on friends or family members;
- 39.6% rely on general health care professionals;
- 42.5% rely on mental health or social services professionals.

Table 39 provides details on these results by presenting the various agents of support for urban adults and adults living in the communities. Urban adults rely on the following support persons, excluding the family doctor, nurse or community health representative, in significantly greater percentages than do adults in the communities.

Table 39: Adults who have access to agents of support, by place of residence (12 months preceding survey)

Agents of support	Off-community living in urban centre	In the community
Friend	70.3%	57.3%
Immediate family member	61.8%	55.8%
Other family member	48.5%	40.2%
Social worker	25.1%	12.8%
Psychologist	20.2%	16.4%
Family doctor	20.6%	26.3%
Counsellor	18.0%	9.6%
Traditional healer	16.2%	8.8%
Nurse	15.7%	23.0%
Community health representative	12.8%	15.9%
Psychiatrist	8.6%	5.1%
Help-line	7.5%	#

Moreover, results show that more men than women confide in people close to them (friends, family, family doctor), while more women turn to nurses, social workers, help-lines and traditional healers. We note that the tendency to seek support from traditional healers and nurses increases with age.

Finally, we note that Montreal residents are the least likely to confide in others and that Val-d'Or residents are the most likely to confide in others. The only exceptions are that Montreal residents consult nurses more often and that social workers and help-lines seem less popular in Quebec City than in the other two cities.

4.3.6.6 Suicide

59.4% of men and 51.6% of women living off-community in urban centres have previously contemplated suicide, which represents a significant difference from those in the communities (38.7% men and 39.2% women). Young adults are the most likely to have thought about suicide, at 62.3% of 18-to-34-year-olds (50.5% in the communities) and 48.6% of 35-to-54-year-olds (38.9% in the communities).

Nearly one adult in ten thought about suicide when they were younger than 12 (more than one man in ten compared to more than one woman in twenty). One third thought about suicide between the ages of 12 and 17 (42.5% of men and more than one quarter of women) and one quarter thought about suicide after the age of 17 (same proportion in both sexes).

The survey reveals that one quarter of adults have attempted suicide (nearly one third of men and nearly one quarter of women), whereas in the communities nearly one adult in five attempts suicide at some time in their lives. The proportions decrease with age, dropping from one third of those aged 18 to 34 to one in five of those aged 35 to 54 and to just over one in ten of those aged 55 or over. The same finding was true of those who considered committing suicide within the last year, ranging from one in ten of 18-to-34-year-olds to no elders at all.

In the 12 months preceding the survey, more than one adult in twenty thought about suicide (more women than men), while nearly one quarter of the adults had a friend or family member who committed suicide. Similar proportions were noted in First Nations communities.

63.4% of Montreal adults have considered committing suicide at some time in their lives, compared to 45.3% of Quebec City residents. About one resident of Montreal or Quebec City in twenty thought about committing suicide in the 12 months preceding the survey, in comparison to one Val-d'Or resident in ten.

Table 40 presents various sources of support available to respondents. It must be added that women are generally more likely to be able to count on these various types of support all the time, other than "Someone to have a good time with," a form of support that men use the most often. These percentages also tend to decrease with age. Quebec City scored highest regarding the proportion of adults who have access to support, followed by Val-d'Or adults and then Montreal adults.

Table 40: Frequency of sources of support available

Sources of support	All the time	Most of the time
Someone I can trust when I need to talk.	57.8%	22.4%
Someone I can trust when I need help	57.1%	22.0%
Someone who can take me to the doctor.	49.6%	23.1%
Someone who shows me love and affection.	55.2%	23.5%
Someone with whom I can take a break from my daily routine.	36.9%	21.6%
Someone to have a good time with.	51.1%	31.0%
Confidant I can talk to about myself or tell my problems to.	54.5%	24.6%
Someone with whom I can do enjoyable things.	46.3%	32.8%

Off-community adults living in urban centres are more likely than persons living in the communities to always be able to count on someone to listen to them when they need to talk or to help them when they need it. However, more people in the communities can always count on someone to take them to the doctor or to show them love and affection.

4.3.6.7 Social problems around the respondent

The respondents were asked to evaluate if various social problems were present in their family in the 12 months preceding the survey, and if so, if they were minor or major. Although very few of these results are valid from a statistical point of view, they show that adults living in the communities are generally less likely to see no problems at all than adults living in urban centres.

4.4 Conclusion: Adults (18 and up)

Within the context of this survey, we have continued the 1997 survey on the health of off-community First Nations members living in urban centres. However, it is difficult to directly compare the results of the two surveys because many of the questions were not approached the same way each time. Furthermore, the 1997 survey covered only First Nations members living in Montreal.

Demographic profile

- Half of the adults surveyed in Montreal, Quebec City and Val-d'Or are aged 18 to 34, and fewer than one tenth are 55 or older. Nearly two thirds understand one or more First Nations languages. There are slightly fewer of them than adults living in the communities who can speak one or more First Nations languages.

- More than half of the respondents were single at the time of the survey.

- Nearly half of the respondents did not complete high school, which is a proportion very similar to the one in the communities. We also note that First Nations members living in the communities are slightly better equipped in terms of telephone services, computers and Internet connections than are off-community adults living in urban centres.

- 61.9% of all adults were jobless at the time of the survey and 49.6% were receiving income from a government source. One of every four couples with at least one child was living under the poverty line.

Health status

- 58.2% of women are overweight or obese, versus 54.5% of men. 47.8% of respondents nevertheless declared their overall health to be excellent or very good, while 36.6% said their overall health was good.

- Nearly half of all respondents have at least one medical problem. Of these, more than one third are affected by three or more problems. Montreal residents are generally the most affected. Musculo-skeletal and respiratory problems are most common among adults with medical problems. More than one individual in five has limitations due to mental or physical health problems.

- Off-community First Nations women living in urban centres appear, like their counterparts in the communities, more likely to use non-prescription drugs (analgesics, vitamins, natural products, syrup, sleeping pills, etc.).

- 69.7% of the women have given birth to a child. 57.4% drank no beer or wine or other alcohol beverage during their pregnancy. About three quarters of all respondents feel they have adequate knowledge about foetal alcohol syndrome (FAS) and foetal alcohol effect (FAE) and know how to get information on the subject.

- It appears that persons who are separated from their community are more likely to try to make contact with various aspects of their culture: 55.9% of off-community adults living in urban centres consulted a traditional healer in the 12 months preceding the survey, versus 9.9% of adults living in the communities.

- Just under half of all respondents feel they have the same level of access to health care as Canadians in general, similar to the figure in the communities (45.0%). More than one quarter feel they have better access. Nevertheless, 57.7% of off-community First Nations adults living in urban centres encountered at least one obstacle to receiving health care in the 12 months preceding the survey. Long waiting lists figured highest on the list of obstacles most frequently mentioned.

- One third of respondents had difficulty accessing the healthcare services offered by Health Canada through the Non-Insured Health Benefits program (NIHB).

- Finally, individuals living in the communities are generally more likely to undergo various types of medical examinations, excluding full medical check-ups.

- 33.0% of respondents received dental care within the six months preceding the survey. As was found in the communities, nearly one person in five encountered obstacles to receiving dental care, with services not covered by the NIHB program and the inability to pay the direct costs of care being the two most reported obstacles.

- Three quarters of all surveyed adults required dental care, with more than four in five needing maintenance.

Lifestyle

- 44.0% of off-community adults living in urban centres consider their diet to be always or almost always balanced and nutritious, while 41.4% feel their diet is balanced and nutritious sometimes. A comparison of the results for the communities with the results for the urban centres reveals that urban residents make better dietary choices. The accessibility and cost of food products undoubtedly influence this behaviour.

- However, off-community adults are less active than those living in the communities; 66.5% of the latter participate in four or more types of physical activity, compared to 50.5% of adults living in urban centres. Women take part in a grater variety of physical activities. Young adults are proportionally more numerous in every activity other than fishing, canoeing and snowshoeing, for which persons 55 or older show the highest proportion. Finally, 53.1% of respondents take part in one to three physical activities a week that increase their heart rate.

- The respondents who consider traditional cultural activities to be very important in their lives take part in hunting/trapping, fishing and canoeing in higher proportions than those who do not consider them important.

Tobacco, alcohol and drugs

- The proportion of smokers is greater among adults living in urban centres (63.4%) than among adults living in the communities (55.0%). Two thirds of 18-54 year-olds smoke, while more than three quarters of adults aged 55 and over are non-smokers. Half of the smokers smoke an average of more than ten cigarettes per day, and 81.2% of smokers smoke every day (versus 79.4% in the communities). Half of them tried to quit smoking in the 12 months preceding the survey. Finally, 58.5% of residences allow smoking.

- 80.8% of all adults drank beer, wine, spirits or other alcoholic beverages in the 12 months preceding the survey. 39.2% drank at least two or three times a week. One quarter of respondents have previously been treated for alcohol abuse.

- 51.3% of respondents use marijuana in the 12 months preceding the survey, which is double the rate in the communities, and 57.8% used one or more non-prescription drugs, slightly less than in communities (62.3%). Although less than one of every five adults was treated for drug abuse, this rate is almost twice as much as the rate in the communities.

- Finally, 88.9% of physical assaults were related to alcohol or drugs, versus 55.0% in the communities.

Sexuality

- 78.9% of all adults were sexually active at the time of the survey, whereas 85.6% had sexual relations in the 12 months preceding the survey. These rates are slightly higher than those in the communities. The proportion of adults who use protection during intercourse is also higher among off-community adults living in urban centres than among those living in the communities. Condoms are the most common birth control methods (used by 51.8% of off-community adults, versus 42.2% of adults in the communities). 48.6% of off-community adults use condoms for protection against STDs always or most of the time, while 44.0% never do, with two thirds of the latter group indicating this is because they have a regular partner.

Residential schools

- Just under one of every five off-community adults living in urban centres attended a residential school; this proportion is similar to that found in the communities (17.0% of adults). We note also that off-community adults suffered more or had more trouble coping with the residential school experience than adults living in the communities. As we noted previously, off-community adults seem more likely to try to make contact with the various aspects of their culture. It is therefore not surprising that loss of cultural identity was almost universally considered to be the most important negative impact of the residential school experience. Off-community adults also place greater importance on cultural events and traditional spirituality than do adults living in the communities, and appear to be more critical of or less favourably inclined towards religion.

Agents of support

- The survey reveals that more men than women confide in persons close to them (friends, family members, family doctor). Women, on the other hand, are more likely to turn to nurses, social workers, help-lines and traditional healers.

- Moreover, 39.6% of adults experienced racism in the 12 months preceding the survey, compared to 28.3% in the communities.

- Finally, 59.4% of men and 51.6% of women living in urban centres have previously contemplated suicide at some point in their life, which is a significantly different than the situation in the communities (38.7% of men and 39.2% of women).

Final Note

The Report on the health of off-community urban First Nations members was carried out based on a sample of respondents recruited in the Native friendship centres of Quebec City, Montreal and Val-d'Or. Since the size of the sample was not large enough and the sampling was on a voluntary basis, the research results do not allow for a portrait that is representative of the health of off-community urban First Nations members. For these reasons, we cannot make recommendations that are applicable to all of the population under study.

Although the results give the overall situation of the Native friendship centres' recipients who participated in the survey, more in-depth and extended research work will have to be conducted in order to provide a general portrait of the health of off-community urban First Nations members.

In the course of this research work, it will be necessary to seek the most efficient methods to reach off-community members and not only limit the research to Native Friendship centres where a majority of recipients are applicants for psychosocial services, health services and other assistance services.

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