



THE HEALTH STATUS OF CANADA'S FIRST NATIONS, MÉTIS AND INUIT PEOPLES

A background paper to accompany
Health Care Renewal in Canada: Accelerating Change
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Table of Contents

	Page
Executive Summary.....	4
1. Foreword.....	10
2. Introduction.....	11
3. Demographic profile of Canada's Aboriginal population.....	14
4. The health status of the First Nations, Inuit and Métis – what is known	17
5. Health indicators.....	22
6. Determinants of health.....	23
7. Where are the gaps in information on health status?.....	32
8. Aboriginal Health Reporting Framework – update.....	34
9. Next steps.....	37
Conclusion & recommendations.....	38
Best practices: Eskasoni primary care project	40
Appendices.....	42
References.....	75

Executive Summary

The intent of this report is to present a detailed account of the current health status of the First Nations, Inuit and Métis peoples in Canada. Information to develop this report was gleaned from various federal/provincial/territorial sources, as identified in section four of the report. However, due to the varied ways that information is collected, or not collected in some instances, an accurate assessment of the health status of Aboriginal peoples remains beyond reach at the present time.

Métis, First Nation[s] and Inuit Peoples are distinct from each other and each has a unique history. There is also significant intra-group diversity. Most of the existing Canadian data on Aboriginal Peoples are derived from the Registered Indian population. This can present significant challenges in trying to understand the overall health of Aboriginal Peoples in Canada (CIHI 2004).

In spite of this hindering fact, however, health data that have been collected at the national and provincial/territorial levels indicate that the health status of First Nations, Inuit and Métis is well below that of the rest of Canadians.

Aboriginal peoples in Canada were in good health upon the arrival of the Europeans, as confirmed in various historical documents. A “special” relationship was established between Aboriginal peoples and the Crown concerning the provision of health care. This relationship was confirmed through the signing of specific treaties which, for Aboriginal peoples, signifies their ongoing “right” to health care. However, some treaties, such as Treaty 6 (the “Medicine Chest Clause”), have created ambiguity around responsibility for the health needs of Aboriginal peoples.

The effects of colonization and other policies, like the residential school and Indian Act, have, over the years, eroded the traditional way of life for many Aboriginal persons. This erosion has had a negative impact on the health and well-being of individuals, their families and communities.

In section three, a demographic profile of the Aboriginal peoples in Canada is presented. The information in this section was obtained primarily from the most recent census data and from Indian and Northern Affairs Canada and specifies the current number of First Nations, Inuit and Métis people living in Canada. A brief description of each group is provided in this section including their place of residency and population age distribution, which is dissimilar to that of the general Canadian population. The First Nations, Inuit and Métis populations are

much younger than the Canadian population as a whole – a fact to be considered when making health forecasts and program planning.

Section four is the focal point of this report. Health information on the health status of Aboriginal people is gathered from various sources. These include the National Aboriginal Health Organization, federal government departments such as Health Canada, Indian and Northern Affairs Canada and Statistics Canada, as well as some provinces and territories. However, information is mainly collected on the “status” First Nations and the Inuit with very little data specific to the Métis population.

As noted by federal sources, some of the impediments to reviewing First Nations and Inuit data have been that:

- In many cases, Aboriginal peoples access health care services from hospitals or private practice physicians under provincial jurisdiction; the data relating to these services do not necessarily identify the clients as either First Nations or Inuit;
- With the exception of communicable disease data,¹ between 1993 and 1999, information about the health status of the First Nations and Inuit was not compiled at the national level;
- The collection of vital statistics, and the reporting of these to Health Canada, varies across the country:
 - The Atlantic Canada, Quebec and Ontario jurisdictions do not provide vital statistics reports to Health Canada. In these areas, statistics are generally obtained from the community health nurses² where coverage of statistical information for the Aboriginal population ranges from 90% for Atlantic Canada to 50% for Quebec;
 - Nunavut is unable to provide Inuit-specific data – as the vital statistics system is not yet developed;
 - The Yukon and Northwest Territories provide vital statistics to Statistics Canada on the whole population and not on specific populations like the First Nations, Inuit and/or Métis;
- Immunization rates for the on-reserve First Nations population are provided annually to Health Canada. For the off-reserve population, this

¹ Federal case report forms for tuberculosis and AIDS cases were used during this time period in all provinces and indicated the Aboriginal ancestry of the person - Status Indian, Inuit or Métis. For tuberculosis, the report forms also indicated if the (Status Indian) person resided on or off-reserve (Health Canada, 2003b).

² Community health nurses are the primary health care providers in most First Nations communities.

- information is managed at the provincial level, may not reflect First Nation status, and is inaccessible to Health Canada;
- In most regions in Canada, community health nurses provide reportable diseases information to regional offices of the First Nations and Inuit Health Branch (FNIHB) . In Manitoba, the provincial public health department monitors First Nations reportable diseases information. Such information is unavailable for the First Nations who live off-reserve;
 - Three provinces – British Columbia, Alberta and Manitoba – can, to some extent, distinguish and analyse First Nations health information by way of their hospital databases. At present, only the Pacific regional office of FNIHB publishes First Nations hospital utilization reports on a regular basis (Health Canada 2003b).

Health Canada also indicates that very little health information outside of Non-Insured Health Benefit records is collected for the Inuit population. Neither Health Canada nor Indian and Northern Affairs collects health information on the Métis population.

Some provinces and territories collect health statistics on the Aboriginal population but their methods, including specific health indicators, differ. Those provinces and territories that have provided health statistics on the Aboriginal population indicate, in most instances, that the health status of the Aboriginal peoples in their respective jurisdictions is below their provincial and territorial counterparts.

Based on the list of comparable health status indicators approved by the Conference of Deputy Ministers of Health in 2004, the health of Aboriginal people is well below that of the rest of Canadians.

- Life expectancy for First Nations and Inuit is lower compared to their Canadian counterparts at the national, provincial and territorial level.
- First Nations' infant mortality rates are higher compared to national and provincial rates and are even higher for the Inuit in Nunavik, Nunavut and the Northwest Territories.
- Based on national information, the incidence of infants with low birth weight is increasing in the First Nations population compared to the rest of Canada. The highest incidence is among Inuit populations.
- The crude mortality rate for First Nations is higher compared to the Canadian and available provincial rates. The four leading causes of death in the First Nations are: injury and poisoning, circulatory diseases, cancer,

and respiratory diseases. The mortality rate of the residents of all territories is expected to rise between 2000 and 2006 unless conditions change.

- ❑ Lung cancer is the most common type of cancer for all Aboriginal peoples, followed by prostate and colorectal cancer for men and breast and colorectal for women.
- ❑ Ischemic heart disease is the primary cause of death for First Nations people 45 years of age and older, according to national statistics, and is cited as the number one cause in British Columbia and Saskatchewan.
- ❑ Suicide is the leading cause of potential years of life lost in both the First Nations and Inuit populations.
- ❑ Tuberculosis is still evident in the First Nations and Inuit populations; it is six times higher and 17 times higher, respectively, than in the rest of Canada.
- ❑ Sexually-transmitted infections like genital chlamydia and HIV are higher in the First Nations and Inuit populations as reported at the national and provincial/territorial levels.
- ❑ Diabetes is steadily rising in the First Nations and Inuit population but is much higher in the former group. The Métis diabetes rate is similar to the First Nations rate.
- ❑ More First Nations, Inuit and Métis smoke; the teenage smoking rate is also higher than the Canadian average.
- ❑ Residents of NWT tend to be more active than the rest of the Canadian population. The Inuit of Nunavut have an activity level that is similar to the rest of Canadians.
- ❑ According to the National Aboriginal Health Organization, major depression is a problem in the First Nations.
- ❑ Inuit Tapiriit Kanatami has named mental health and suicide prevention as the number one health concern for Inuit.
- ❑ Obesity rates in First Nations are twice as high in comparison to the rest of Canadians.
- ❑ Many older First Nations and Inuit adults do not receive needed home care services.

To address these disparities, the Health Council of Canada suggests that a population health approach be adopted to plan for improvements to the health status of Aboriginal peoples. The underlying philosophy of the population health approach takes the broader determinants of health into account. It is highly supportive of the Aboriginal belief that to be healthy one must achieve balance in all spheres – the spiritual, mental, emotional, physical and social. The approach is predicated on the principles that:

- Health is determined by the complex interactions between individual characteristics, social and economic factors and physical environments;
- The health of a population is closely linked to the distribution of wealth across the population;
- Strategies to improve the health of a population must address the entire range of factors that determine health;
- Important health gains can be achieved by focusing interventions on the health of the entire population (or significant sub-populations) rather than individuals; and,
- Improving health is a shared responsibility that requires the development of healthy public policies in areas outside the traditional system.

The Council also advises that systems be put into place to provide the necessary information to accurately assess the current health status of the First Nations, Inuit and Métis.

The Council advocates the implementation of the following measures to overcome inter-jurisdictional and infrastructural challenges to address the health disparities that are common to First Nations, Inuit and Métis populations:

1. Enable, expect and respect First Nations, Inuit and Métis as full partners with federal, provincial and territorial jurisdictions in developing and implementing the Aboriginal Health Reporting Framework. Enable Aboriginal populations to collect health information which establishes an accurate baseline; permits the comparison and monitoring of their health status within and between their populations and with the rest of Canadians; meets the information needs of community leaders; and reflects the unique realities of Aboriginal peoples.
2. Adopt a population health model to address the health disparities of the First Nations, Inuit and Métis population. Enable and require all federal, provincial and territorial departments/agencies to work in partnership with Aboriginal organizations that oversee, manage or advise on programs and

services, in order to address the determinants of health which have an impact the Inuit, Métis and First Nations populations.

3. In partnership with the various levels of government, identify the resource requirements to address the particular health needs of First Nations, Inuit and Métis who live in rural, remote or/and socio-economically challenged communities. Address, as a priority, the current and ongoing shortage of health care service providers available to these groups, especially nurses. Ensure that the necessary resources are devoted to implement educational programs that will increase the number of Inuit, Métis, and First Nations health care service providers – in the short, medium and longer terms. Recognize that resources have to be available and accessible. Barriers, such as those created through the use of standardized program or funding templates, should be avoided so that resources can be allocated and utilized.

Despite the challenges, there are several communities where the Aboriginal people have successfully improved their health status. The Eskasoni First Nations is one such community where partnerships have been developed with federal and provincial agencies to deliver health programs and services that are culturally-specific and appropriate, and are tailored to the needs of the Eskasoni First Nations residents. It appears that this effort has resulted in positive health outcomes for the Eskasoni population. A brief description of this particular project is included in this report.

1. Foreword

1.1 History

By way of the 2003 Health Accord, the federal/provincial/territorial governments agreed to work in partnership with each other, with health care providers and with Canadians to renew and/or reform the current public health care system. For details on the 2003 Health Accord see Appendix A. For details on the Health Council of Canada see Appendix B.

The Health Accord specifically mentions Aboriginal³ peoples and the particular efforts required by all stakeholders to address and improve their overall health status. Consequently, the federal government has committed to increasing its funding to improve the status quo and to work in collaboration with other jurisdictions as well as with Aboriginal peoples to meet the Health Accord's objectives. These include the three priorities of the Health Reform Fund: primary health care, home care, and catastrophic drug coverage. Further, First Ministers are directing Health Ministers to consult with Aboriginal peoples in order to develop a comparable Aboriginal Health Reporting Framework, to consult on the use of comparable indicators and to develop the necessary data infrastructure. This will serve to establish a baseline against which progress and key outcomes can be measured.

The following guiding principle was adopted in preparation for this background paper:

The health of Canadians depends on our ability to effectively deal with disparities of people most at risk, in particular:

- ❑ ***First Nations, Inuit and Métis;***
- ❑ ***Children and youth;***
- ❑ ***Elderly; and,***
- ❑ ***Mentally challenged people.***

This report focuses on the health of the First Nations, Inuit and Métis. Based on available information about the health of these groups, the report will indicate:

- ❑ What is known;
- ❑ Where are the gaps;
- ❑ What information must be collected to provide a proper framework for reporting for these communities; and

³ In reference to First Nations, Inuit and Métis peoples.

- What is needed to address a key commitment of the Accord: to develop an Aboriginal Health Reporting Framework; and
- What future actions are recommended.

2. Introduction

Currently, Aboriginal people have a health status that is well below the national average. Their socio-economic conditions are often cited as being similar to those in developing countries. This was not always so. At the time of contact with Europeans, Aboriginal people were in good health – a fact that is well documented in historical documents and through the findings of paleo-biology efforts (Royal Commission on Aboriginal Peoples, 1996). After the contact period, however, many Aboriginal people became ill and died from infectious diseases that were foreign to them, such as influenza, polio, measles, smallpox and diphtheria (ibid.).

Skeletal remains of unquestionably pre-Columbian date... are, barring a few exceptions, remarkably free from disease. Whole important scourges [affecting Europeans during the colonial period] were wholly unknown... There was no plague, cholera, typhus, smallpox or measles. Cancer was rare, and even fractures were infrequent... There were, apparently, no nevi [skin tumours]. There were no troubles with the feet, such as fallen arches. And judging from later acquired knowledge, there was a much greater scarcity than in the white population of... most mental disorders, and of other serious conditions (RCAP, 1996).

Various factors (health determinants) directly influence the health of a person or population. However, the disparities in the health status of the Aboriginal peoples can also be linked or traced back to the beginning of the colonization period.

As far back as the 18th and 19th centuries, agreements with representatives of the British Crown were initiated and sought by Aboriginal leaders to address the worsening health status of their people brought on by “new” infectious diseases and poverty. Many treaties⁴ – Treaty 6 (1876), Treaty 8 (1899), Treaty 10 (1906); and Treaty 11 (1921) – were signed by both the federal government and First Nations, stating that the Crown would provide health care to the First Nations people to reimburse them for the use of their land and resources. First Nations

⁴ Treaties between Aboriginal and European nations were negotiated and concluded through a treaty-making process that had roots in the traditions of both societies. These were the means by which Europeans reached a political accommodation with the Aboriginal nations to live in peaceful co-existence and to share the land and resource of what is now Canada (RCAP, Vol. 1, 1996).

people hold to the view that health care is a treaty right that was affirmed in the treaty-signing process and, as such, is legally binding to this day. Furthermore, because of the special relationship that was established through these agreements, Aboriginal people believe that the provision of health care falls under federal jurisdiction as opposed to being a provincial/territorial matter.

Further, many First Nations people agreed to live on land “set aside” for them by the Crown – these land bases are known as reserves and still exist to this day (RCAP, 1996). As a result of being confined to a limited land base, resources such as food and clothing materials, normally acquired by hunting, trapping and fishing and used for trading/bartering purposes, quickly shrunk. As access to and availability of these resources declined, major lifestyle, livelihood and diet changes occurred that affected the health status and well-being of the Aboriginal people. Conditions such as diabetes, which is considered to be epidemic in some communities, various forms of cancer, and other “newer” infectious diseases such as HIV/AIDS and hepatitis C are steadily increasing in the Aboriginal population and can be linked to unhealthy diet and lifestyle choices/habits, poverty and the loss of their traditional diet and lifestyles.

By the early 1900s, the health and social conditions of Aboriginal people were so appalling that the government appointed a physician to help improve the health status of the First Nations, Inuit and Métis peoples (RCAP, 1996). From that time forward, health care services were provided by various agents/agencies, such as RCMP officers, missionaries and officers who were later replaced by nurses and physicians. By 1950, Health and Welfare Canada had assumed this responsibility and over the years has established nursing stations, health centres and small regional hospitals throughout Canada to address the health needs of “registered” Indians and Inuit. However, such services from the federal government have remained unavailable for the most part for the Métis and non-status population.

Inuit have knowledge and practices to protect and preserve their own health and recognize that the total environment influences health and well-being. Since the 1950s, Canadian Inuit have experienced significant change, both positive and negative, as a result of federal government actions taken to respond to outbreaks of starvation and infectious disease in some regions of the Arctic, and to protect Canadian sovereignty in the Arctic. Inuit are a culture in transition, actively engaged to protect and preserve tradition while adapting tools of the modern world to their own uses.

Other events in the past 100 years have added to the present-day dilemma of Aboriginal people. Most notable are those linked to the residential school experience. Throughout the past century, many First Nations, Inuit and Métis children were forcibly taken from their families and placed in residential schools. It has been reported that 35% of Aboriginal adults over the age of 45 attended a

residential school and remained in these institutions for an average of six years. Many of those who attended are of the opinion that their health and well-being were and continue to be affected by this experience (National Aboriginal Health Organization 2004b).

The government-imposed relocation of Aboriginal people has also had an impact on their health and well-being. In the 1950s, many Inuit from northern Quebec were forcibly moved to the High Arctic to create new communities where the climate and living conditions were much harsher and the food sources different. Other Aboriginal people from Manitoba and Labrador were also forced to relocate from their traditional land bases by various government bodies and/or agencies (NAHO 2004b). Without a doubt, these imposed policies have had and continue to have a negative impact on the people directly involved as well as on their descendants.

In 1978, a new policy on First Nations health was put forward by the federal government which encouraged more involvement of Aboriginal people in the planning and delivery of health care services within their communities. This became known as the “transfer of health services” to First Nations control; however, for the federal government this meant only the transfer of administrative control and not full control as anticipated by the First Nations. In 1982, a five-year Community Health Demonstration Program was implemented to test the notion of transfer (RCAP, 1996). Presently, nearly half of all First Nations in Canada have opted for transfer, while those who have not continue to receive health services primarily from Health Canada.

Other situations exist where Aboriginal governing bodies have entered into agreements with provincial governments to provide various health services to their people. Among these notable exceptions are the Kateri Memorial Hospital Centre in Kahnawake, the James Bay and Northern Quebec Agreement, Labrador Independent Health Commission, the Alberta Indian Health Commission, and Anishnabe Health in Toronto (RCAP, 1996). Each of these agencies has negotiated with the provincial government in its region to provide health care services to First Nations, and to Inuit as well as Métis peoples on reserve and/or off-reserve.

3. Demographic profile of Canada's Aboriginal population

According to Section 35 of the 1982 Canadian Constitution, Aboriginal peoples are recognized as being of First Nations, Inuit and Métis ancestry, acknowledging the various indigenous languages, cultures and traditions (CIHI 2004, Health Canada 2003a). In 2001, 3.3% of the total Canadian population identified as Aboriginal compared to 2.8% in 1996 (Statistics Canada 2003a).

In the 2003 Census report, 976,305 people indicated they were of Aboriginal ancestry. Of this total number, 608,850 (62%) identified as North American Indian,⁵ 292,310 (30%) as Métis, and 45,070 (5%) as Inuit. The remaining 3% are Aboriginal persons who identified with more than one (Aboriginal) group or who may be registered Indians or band members who would not identify themselves as Aboriginal (Statistics Canada 2003a).

3.1 First Nations

First Nations is the term now commonly used to replace the word Indian and refers to both status and non-status persons of First Nations ancestry (Health Canada, 2003a). First Nations can be officially recognized as a registered or status Indian according to rules set out in the Indian Act and are recorded as such in an Indian Register that is maintained by Indian and Northern Affairs Canada. (CIHI 2004).

According to Indian and Northern Affairs Canada (INAC),⁶ 690,101 people were recorded as registered or status Indians in 2001 (INAC, 2003). It is projected that this number will reach 939,666 by 2021.

In 2002, the majority of First Nations people (57.5%) resided on-reserve; however, since 1981, the number of First Nations people living off-reserve has steadily increased. In 2001, 42.5% lived off-reserve compared to 29.7% in 1981 (ibid.). Census information indicates that most North American Indians living off-reserve are located in: Winnipeg (22,955), Vancouver (22,700), Edmonton (18,260), Toronto (13,785) and Saskatoon (11,290) (Statistics Canada 2003a).

More people migrate to Indian reserves than leave, with most arriving from rural non-reserve areas. In 2000, there was a net gain of 3,100 people moving to reserve communities while the 27 census metropolitan areas received a net gain

⁵ Statistics Canada refers to First Nations (status/treaty and non-status Indians) as North American Indians.

⁶ Data for First Nations has been obtained from Indian and Northern Affairs Canada which is considered to be more accurate because Statistics Canada has indicated that "undercoverage in the 2001 Census was considerably higher among Aboriginal people... due to the fact that enumeration was not permitted, or was interrupted before it could be completed, on 30 Indian reserves and settlements," (Statistics Canada, 2003).

of 1,145 Aboriginal persons. In summary, both the larger urban centres and reserves (First Nations communities) are experiencing net increases in the Aboriginal population which is reflective of a trend that began in 1981 (Statistics Canada 2003a).

The median age for First Nations populations is younger than for the non-Aboriginal population with the median age 23.5 years compared to 37.7 for the latter group. In 2001, 50% of the total North American Indian population was less than 23.5 years of age. Further, some 213,530 or 35% of the North American Indian children were less than 14 years of age in comparison to 19% for the non-Aboriginal population (Statistics Canada 2003a).

Even though the First Nations populations are young, the number of people reaching and living beyond 65 years is steadily increasing. Since 1996, the number of North American Indians to reach 65 years of age and/or older has increased by 31%, with more than half (53%) living on-reserve (ibid.).

3.2 The Métis

Of mixed First Nations and European lineage, the Métis have their own language and culture and are distinct from the two other Aboriginal peoples. They account for about 30% of the total Aboriginal population in Canada and had the greatest population gain of all Aboriginal groups between 1996 and 2001; the Métis population grew by 43% during this period (Statistics Canada 2003a).

The majority or 68% of the Métis population live in cities while the remainder (29%) reside in rural areas. A proportion of Métis (7,315) live on-reserves and this doubled between 1996 and 2001. Most of the urban-dwelling Métis live in Winnipeg (31,395), Edmonton (21,065), Vancouver (12,505), Calgary (10,575) and Saskatoon (8,305) (ibid.).

The median age of the Métis is 27 compared to 37.7 years for the non-Aboriginal population. The median age of the Métis is about 3 years older than that of the North American Indian population and about six years older than the median age of the Inuit. Métis youth and children aged 14 and younger account for 29% of the population compared to 19% in the mainstream Canadian population. Since 1996, young people between 15 and 24 still account for 18% of the total Métis population. About half (49%) of the Métis are between 25 and 64 years of age, representing an increase of 3% since 1996. Métis seniors account for 4% of the total population, unchanged since 1996, compared to 13% of seniors in the general Canadian population (ibid.).

3.3 Inuit

Inuit are the Aboriginal people from Arctic Canada who share a common language and generally live in 53 communities located in one of the following four (Inuit) regions: Nunavut, Inuvialuit (Western Arctic), Nunavik (Northern Quebec) and Nunatsiavut (Northern Labrador). About one-half of the Inuit population lives in Nunavut with the remainder residing in Inuvialuit (9%), in Nunavik (21%) and in Nunatsiavut (10%) (Statistics Canada 2003a). It must be recognized that census data does not reflect the full numbers of Inuit in Canada due to undercounting in some Inuit regions, most notably the Northwest Territories.

Between 1996 and 2001, the Inuit population experienced a growth rate of 12% compared to a 3.4% growth rate for the non-Aboriginal group; this has been attributed to an increase in fertility rates and life expectancy. The Inuit birth rate is two times that of the mainstream population (ibid.).

The Inuit population is younger than the First Nations and the Métis with the exception of the First Nations population in Saskatchewan (Statistics Canada 2003a). In 2001, the median age of the Inuit was 20.6 years, which is 17 years below the median age of the mainstream population. Children aged 14 years and younger account for 39% of the total Inuit population compared to 19% for the non-Aboriginal population. The number of Inuit in the working-age category (25 to 64 years) accounts for 40% of the total population – only 1% higher than the proportion of children in their population. Only 3% of the Inuit population is 65 years of age or older; however, this shows an increase of 38% for the period 1996 – 2001 (ibid.).

Inuit are distinct from the two other Aboriginal groups. Noting this difference and the realization that a pan-Aboriginal approach is ineffective to address their specific concerns and needs, the Inuit have entered into discussions with the federal government to develop a new partnership that has culminated in the development of an Inuit Action Plan. Phase I of this major undertaking was completed in 2001. In Phase II of this process, Inuit-specific policies, programs and services will be developed and delivered to the Inuit in their respective regions (Inuit Tapiriit Kanatami, n.d.)

4. The health status of the First Nations, Inuit and Métis – what is known

The following information is based on current available data on the three Aboriginal groups; however, little information has been collected or is available for the Métis population (Lamouche 2002; CIHI 2004).

Historically, Health Canada has been responsible for providing health care services to the First Nations and Inuit populations who live on-reserves and/or in Inuit communities (Health Canada 2003a). Public health services and health promotion and disease prevention activities are carried out by the First Nations and Inuit Health Branch (FNIHB) of Health Canada with the exception of those First Nations and Inuit communities that have opted for transfer of health services. By way of transfer, communities can assume control over community-based health programs that were formerly managed by FNIHB. Non-insured health benefits such as medications and dental services are made available to the status Indian and eligible Inuit populations regardless of where they reside – on or off-reserve (Health Canada 2003a).

The Métis are not eligible for FNIHB health care programs and services. They must obtain health care services from provincial or territorial sources. However, Health Canada, through the Population and Public Health Branch (now the Public Health Agency of Canada), offers several programs targeted specifically for the three Aboriginal groups such as the Head Start Program, Community Action Program for Children and the Canada Prenatal Nutrition Program (ibid.).

4.1 Information sources

While there is more health data on the First Nations and the Inuit, -- collected primarily by Health Canada from sources such the census, vital statistics, communicable disease reports, and Indian and Northern Affairs -- it remains that, “the multi-jurisdictional complexity of health services to First Nations and Inuit challenges the ability to gather comprehensive health information” (Health Canada, 2003b). Less health information is readily available for the Métis population. The Métis are concerned about how they have been defined and enumerated in the census and the Aboriginal Peoples Survey; they must, nonetheless, rely on these two sources at the present time (Lamouche 2002).

4.1.1 National Aboriginal Health Organization (NAHO)

In 2000, the National Aboriginal Health Organization (NAHO) was established by the five national Aboriginal organizations: the Assembly of First Nations, the Métis National Council of Canada, the Inuit Tapiriit Kanatami, the Congress of Aboriginal Peoples, and the Native Women's Association of Canada. Its primary purpose is to "influence and advance the health and well-being of Aboriginal Peoples through carrying out knowledge-based strategies." Three centres within NAHO have been created. The First Nations, Ajunnginiq and Métis centres oversee activities specific to each group, especially in the area of health research and in the sharing of knowledge (NAHO 2004a).

The First Nations Centre of NAHO produced a synthesis report of the findings of the First Nations and Inuit Regional Health Survey carried out in 1997 (NAHO 2004b). A second Regional Health Survey (RHS) was completed in 2002/2003 for the on-reserve First Nations population and is entitled *The First Nations Longitudinal Regional Health Survey (FNL RHS)*. The Inuit have chosen to carry out their own Inuit-specific research, and thus, will not be included in this second endeavour (NAHO 2004c). Preliminary findings of the second FNL RHS have been released with the complete report scheduled for release in 2005.

In 2002, the First Nations Centre carried out its first national public opinion telephone poll about First Nations health issues. The first of its kind, the poll surveyed the opinion and perceptions of First Nations vis-à-vis their health and health care (NAHO 2004d). The findings of the NAHO surveys/polls have been included in this report.

4.1.2 Federal government

Health Canada and Indian and Northern Affairs are the two primary federal government departments that collect health and demographic data on the First Nations and Inuit populations. Statistics Canada gathers information on all three Aboriginal groups but in varying degrees. The various reports are subject to limitations and should be considered accordingly.

Listed below are the limitations of the most recent report put out by the First Nations and Inuit Health Branch, Health Canada – *A Statistical Profile on the Health of First Nations in Canada*. These limitations prevent or hinder accurate reporting on the health status of the First Nations and Inuit:

- First Nations access health care services from hospitals or private practice physicians under provincial jurisdiction;

- The data are held in provincial or territorial databases and in many provinces there is no system in place to identify if the clients are either First Nations or Inuit;
- Between 1993 and 1999, information about the health status of the First Nations and Inuit, with the exception of communicable disease data,⁷ was not compiled at the national level;
- Atlantic Canada, Quebec and Ontario do not provide vital statistics reports to Health Canada. Statistics are generally obtained from the community health nurses where coverage of statistical information for the Aboriginal population ranges from 90% for Atlantic Canada to 50% for Quebec;
- Nunavut is unable to provide Inuit-specific data – as the vital statistics system is not yet developed;
- The Yukon and Northwest Territories provide vital statistics to Statistics Canada on the whole population and not on specific populations such as the First Nations, Inuit or Métis;
- Immunization rates for the on-reserve First Nations population are provided annually to Health Canada. For the off-reserve population this information is managed at the provincial level and is inaccessible or unavailable to Health Canada;
- Community health nurses provide information on reportable diseases to FNIHB regional offices from most regions in Canada. In Manitoba, the provincial public health department monitors First Nations reportable diseases information. Such information is unavailable for the First Nations who live off-reserve;
- Three provinces – British Columbia, Alberta and Manitoba – can, to some extent, distinguish and analyse First Nations health information in their hospital databases. At present, only the Pacific regional office of FNIHB publishes First Nations hospital utilization reports on a regular basis (Health Canada 2003b).

Health Canada states that the three major limitations to consider when examining its health statistics report on First Nations and Inuit are:

1. *The report uses 1999 calendar year data for the First Nations on-reserve population only (with the exception of British Columbia, which reports on First Nations people born and resident in that province and Alberta, which can only report vital statistics for Alberta First Nations people on and off-reserve combined). Information was supplemented with published data for Inuit where available.*

⁷ Federal case report forms for tuberculosis and AIDS cases were used during this time period in all provinces and indicated the Aboriginal ancestry of the person - Status Indian, Inuit or Métis. For tuberculosis, the report forms also indicated if the (Status Indian) person resided on or off-reserve (Health Canada, 2003b).

2. *Most regions have some degree of underreporting for several or all of the indicators used. Every effort has been made to clearly identify these reporting limitations for each table or figure, as data completeness can vary with each indicator. Specific regional limitations, which are noted throughout the text, are outlined as follows:*

- ❑ *The Atlantic region used health data only from those bands where information was available.*
- ❑ *The Ontario region used the First Nations and Inuit Health Information System, which is voluntary. Communities not participating in First Nations and Inuit Health Information System were asked to provide data on indicators. Mortality data in this report are primarily available from one zone where codes for International Classification of Disease, Version 9 (ICD-9) causes of death were available.*
- ❑ *Vital statistics from the Pacific region included the entire Status First Nations population of British Columbia, both on and off-reserve.*
- ❑ *Vital statistics from the Alberta region represent Alberta First Nations in that province, both on and off-reserve.*
- ❑ *Vital statistics were not available for 111 of the 144 First Nations communities in the Ontario region and for 29 of the 41 First Nations communities in the Quebec region.*
- ❑ *Notifiable disease data include only on-reserve communities in the Pacific region. These data do not include 47 of the 144 First Nations communities in the Quebec region.*
- ❑ *In general, communicable disease rates will be underreported if patients do not indicate their address as on-reserve.*

3. *Currently, there is little Inuit-specific health information, and with the exception of Non-Insured Health Benefits records, no health data are routinely collected and forwarded to Health Canada. The only data available are from special surveys (e.g. Statistics Canada 1991 Aboriginal Peoples Survey) and sporadic university-based research conducted in communities. A major issue in health information is the lack of consistent identifiers across the regions for the collection of Inuit health data⁸ (Health Canada 2003b).*

⁸ Some Inuit health data, although limited, was presented in “A Statistical Profile on the Health of First Nations in Canada” and will be included in this report.

Indian and Inuit Affairs Canada (INAC) also publishes a Basic Departmental Data report each year on the conditions of First Nations including demographics, health, education, social conditions, housing, and governance, as well as a separate section for the North. However, these data are also somewhat limited (INAC 2003).

In addition to the federal sources described above, information was obtained from the 2001 Census when deemed applicable (Statistics Canada 2003a).

4.1.3 Provincial/territorial sources

Information on the health of Aboriginal peoples is available from various provincial/territorial sources, but the type and extent of data collected differs from region to region.

The Health Council of Canada identified a contact person from each province and territory, with the exception of Quebec and New Brunswick, to obtain information on health-related topics. Consequently, data on the First Nations, Inuit and Métis peoples' health status, which is included in this report, was obtained from the following regions: British Columbia, Manitoba, Saskatchewan, the Northwest Territories, and Nunavut. Information will be forthcoming from Newfoundland/Labrador and Ontario but was not received in time to be included in this report. The contact persons from Alberta, Nova Scotia and Yukon indicated that information on Aboriginal populations is not presently collected and the Prince Edward Island contact person did not reply to this information request, as of this report.

5. Health indicators

Health indicators are defined as *variables, susceptible to direct measurement that reflect the state of health of persons in a community*. (Last 2001:83 as cited in NAHO briefing note FNC03-024).

Indicators on the health status of Aboriginal people are often lacking or incomplete when compared to indicators for the population as a whole. The National Aboriginal Health Organization (NAHO) has been working hard to develop and track a number of relevant indicators. Information on the health status of Aboriginal people has been collected, when available, according to the comparable health indicators that were approved by the Conference of Deputy Ministers of Health in June 2004. These indicators, under the heading Canadian Indicators, along with NAHO indicators, are presented in Appendix C.

For a list of comparable health indicators currently unavailable for the First Nations, Inuit and Métis population, see Appendix D.

6. Determinants of health

The health condition of a person or group is influenced by several factors known as determinants of health (Health Canada 1998; Health Canada 2003a; Health Canada n.d.). The determinants of health are presented below including geography, which is now also being considered as a factor in determining health outcomes.

Key determinants	Underlying premises	Aboriginal conditions
<p>1. Income and social status</p>	<p>Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.</p>	<p>Aboriginal people are the poorest of all minority groups in Canada. According to 1996 Census data, the income level of First Nations on-reserve was half that of the rest of Canadians (Armstrong as cited in Health Canada 2003b). 40% of First Nations, over the age of 15, 24% of Inuit and 28% of the Métis, were in a low income bracket in 2000 compared to 16% for other Canadians (CIHI 2004). Many Aboriginal children do not eat breakfast every day, which may indicate a lack of money to buy food. 72% of Inuit children 6 – 14 years of age ate breakfast every day compared to 82% for the North American Indian children and 78% of Métis children (Statistics Canada 2004).</p>
<p>2. Social support networks</p>	<p>Support from families, friends and communities is associated with better health. The importance of effective responses to stress and having the support of family and friends provides a caring and supportive relationship that seems to act as a buffer against</p>	<p>Currently, there are approximately 90,000 direct and indirect residential school survivors. Many of them have been unable to establish effective relationship with families and friends as a result of being taken away at an early age from their families and communities, thus, the usual parenting, role modeling and</p>

	health problems.	social bonds that occur with family members, friends and community members were severely and permanently damaged as a result of the residential school legacy and through the colonization process (CIHI 2004; Kirmayer et al. 2000). Thus, this buffer against health problems is unavailable for many of the direct, as well as the indirect, survivors of residential schools.
3. Education	Health status improves with level of education. Education increases opportunities for income and job security, and equips people with a sense of control over life circumstances – key factors that influence health.	Aboriginal peoples on the whole are less educated than their non-Aboriginal counterparts. In spite of some progress in the education attainment of Aboriginal people, their education levels remain low. In 2001, 48% of First Nations, Inuit and Métis had completed high school – an increase of 4% since 1996. About 37% of non-reserve Aboriginal people had finished post-secondary studies – this proportion remains lower than the Canadian average of 58%. Common reasons for not completing their post-secondary education are, for women, family responsibilities (34%) and, for men, financial reasons (24%) (Statistics Canada 2003b).
4. Employment/ working conditions	Unemployment, underemployment and stressful work are associated with poorer health. People who have more control over their work circumstances and less job-related stress are healthier and often live longer than those in more stressful	Overall, fewer Aboriginal people are in the workforce. Due to their lower educational attainment, Aboriginal people tend to be employed in menial or clerical/support/ labour positions where they have little control over their work conditions. Unemployment rates are higher for First Nations, Inuit and Métis with rates of 22%, 22% and 14%

	or riskier employment settings.	respectively compared to an unemployment rate of 7% for the general Canadian population (based on 2001 Census– CIHI 2004).
5. Social environment	The array of values and norms of a society influence in varying ways the health and well-being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Studies have shown that low availability of emotional support and low social participation have a negative impact on health and well-being.	The effects of colonization and various policies like the Indian Act continue to destroy indigenous cultures (Miller 2000; Richardson 1993 as cited in Kirmayer 2000). The Indian Act controls all aspects of a First Nations person from birth onwards, including the definition of who can be identified as an Aboriginal person, i.e. status versus non-status. The goal of Aboriginal governments (First Nations, Inuit and Métis) is self-determination/governance in all areas that affect their health and well-being. Communities with active programs related to self-governance have lower youth suicide rates. (Chandler and Lalonde 1998)
6. Physical environments	Physical factors in the natural environmental (e.g., air, water quality) are key influences on health. Factors in the human-built environment such as housing, workplace safety, community and road design are also important influences.	Aboriginal people are more likely than any other segment of the Canadian population to live in environments that have a negative impact on their health and well-being. They are more likely to live in over-crowded dwellings – in 2001 about 17% of non-reserve Aboriginal people lived in crowded conditions compared to 7% for the rest of Canadians. In the Canadian Arctic, the situation is worse – more than half of the Inuit (53%) lived in overcrowded conditions. Sixty-five First Nations and Inuit communities were under a “boil

		<p>water” advisory averaging 183 days per affected community. Fifty communities were under boil advisories from six months to one year. Such information is unavailable for the three territories. The water for over one third (34%) of Inuit in the Arctic region was noted to be contaminated at some points during the year – in Nunavik 73% of the Inuit said their water was contaminated at some time throughout the year (Health Canada 2003b; Statistics Canada 2003b).</p> <p>Since 1992, INAC has been working with First Nations to deal with contaminated sites in 800 reserves located across Canada. Of the 2,500 contamination issues identified:</p> <ul style="list-style-type: none"> • 60% are related to hydrocarbon contamination soils caused by storage facilities’ leakages; • 25% are linked to waste including active and inactive waste disposal sites, and disposal of solid, liquid, and industrial waste; and, • 15% are associated with air and water pollution; asbestos, tires and other contaminants or factors (INAC 2003). <p>About 30.6% of First Nations households are in need of major repairs compared to 8.2% for Canada (NAHO 2004e).</p>
7. Personal health	Social environments that enable and support	Many Aboriginal communities do not have the infrastructures to

<p>practices and coping skills</p>	<p>healthy choices and lifestyles, as well as people’s knowledge, intentions, behaviours and coping skills for dealing with life in healthy ways, are key influences on health. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.</p>	<p>promote healthy lifestyle choices/behaviours. 48% of 1,209 respondents indicated that regular exercise was a precursor to good health and 43% indicated a balanced diet (NAHO 2004c). In Saskatchewan, 70 – 90% of 869 respondents stated they would like their community to have a swimming pool, park/playground, gym or indoor rink (NAHO 2004b). It is unlikely that many Aboriginal communities are equipped with infrastructures that will promote healthy lifestyle choices/behaviours.</p>
<p>8. Healthy child development</p>	<p>The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills and competence is very powerful. Children born in low-income families are more likely than those born to high-income families to have low birth weights, to eat less nutritious food and to have more difficulty in school.</p>	<p>Aboriginal children are less-advantaged than their non-Aboriginal counterparts and are more likely to be born in poverty, to grow up in lone-parent families, and to live in overcrowded dwellings. 18% of Aboriginal women are single mothers which represents 27% of all Aboriginal families (CERA 2002). In general, the health and bond between an infant and mother is enhanced through breast-feeding. The rate of breast-feeding for Aboriginal children 3 years of age and under was 73% compared to 82% for other Canadian children. Inuit children are less likely to eat breakfast every day (72% compared to 78% for Métis children and 82% for North American Indians.) Over half (53%) of Aboriginal children</p>

		6 – 14 years of age had attended an early childhood development program; the Inuit rate was lowest at 35% followed by the First Nations at 54% and the Métis at 57%. (Statistics Canada 2004).
9. Biology and genetic endowment	The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some instances genetic endowment appears to predispose certain individuals to particular diseases or health problems.	Data unavailable
10. Health services	Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health.	In general, there is a lack of health care service providers in Canada and even more so in Aboriginal communities. The current nursing shortage will peak in 2008 when Canada will be faced with a deficiency of 78,000 nurses. This deficiency will cause serious resource problems at the Aboriginal community level where health services are, in most instances, provided by nurses. The turnover rate for nurses varies from community to community but has been cited as every 1-2

		<p>years and as often as six months – the average community stay of a nurse is two years. With the current nursing shortage, health promotion and disease prevention activities have become secondary as treatment becomes the primary activity and concern of the health care providers – the nurses (A.N.A.C. 2002: A.N.A.C. 2003).</p> <p>In the recent NAHO survey, 12.9% of the respondents indicated that one or more of their home care service needs are not being met (NAHO 2004e). And more than a third (35.9%) said they had less access to health care services in comparison to their Canadian counterparts (ibid.).</p>
<p>11. Gender</p>	<p>Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes on a differential basis. “Gendered” norms influence the health system’s practices and priorities. Many health issues are a function of gender-based social status or roles. Women, for example, are more vulnerable to gender-based sexual or physical violence, low income, lone parenthood, gender-based causes of exposure to health risks</p>	<p>In a study conducted in 2002, the chief health concerns identified by Aboriginal females were family violence, diabetes, substance abuse and mental health issues. Aboriginal women are even poorer than their male counterparts. In 1996, 43% of women aged 15 years and over had an income level that was below the low income cutoff compared to 35% of Aboriginal men and 20% for non-Aboriginal women. For lone Aboriginal mothers, the situation was worse as 73% of them lived below the low income cutoff (CERA 2002).</p> <p>28% of women indicated their nutritional needs were not being met (Timmins 2001/2002). Similar issues are experienced by Inuit women in terms of</p>

	<p>and threats (e.g., accidents, STDs, suicide, smoking, substance abuse, prescription drugs, physical inactivity). Measures to address gender inequality and gender bias within and beyond the health system will improve population health.</p>	<p>poverty, violence against women and other gender-inequality issues (Pauktuutit 2000).</p>
<p>12. Culture</p>	<p>Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss of devaluation of language and culture and lack of access to culturally appropriate health care and services.</p>	<p>As a result of their poor socio-economic conditions, the health of Aboriginal peoples is lower than the norm for many health conditions affected by social and environmental factors. Their overall poor health status is compounded by the lack of culturally-appropriate programs and services as well as a shortage of culturally-sensitive health care workers. Further, many Aboriginal people, because of their cultural background, face racism and discrimination on a day-to-day basis. Cultural discontinuity including loss of indigenous languages has been associated with higher rates of depression, alcoholism, suicide and violence, and as having a greater impact on youth (Kirmayer et al. 2000). Inuit have a distinct culture, language and strong values of self-sufficiency, resilience and adaptability. Inuit have knowledge and practices to protect and preserve their own</p>

		health and recognize that the total environment influences health and well-being
13. Geography		The location of a community is related to health outcomes. All 55 Inuit communities are located in the northern most areas of Canada. Of the 396,688 on-reserve First Nations population in 2001, 44.6% lived in rural ⁹ settings, 3.7% in remote ¹⁰ areas of 16.9% live in special access ¹¹ centres. Consequently, health and other resources are more costly and harder to obtain for communities that are located a significant distance from urban centres.

⁹ Rural is defined as: A zone where a First Nation is located between 50 km and 350 km from the nearest service centre having year-round road access (INAC 2003).

¹⁰ Remote is defined as: A zone where a First Nation is located 350km from the nearest service centre having year-round road access (INAC 2003).

¹¹ Special Access is defined as: A zone where a First Nation has no year-round access to the nearest service centre and as a result, experiences higher cost of transportation.

7. Where are the gaps in information on health status?

Many gaps in the data limit the analysis of the health status of Aboriginal peoples in Canada and especially in comparison to the availability of health information on the general Canadian population (Lamouche 2003; Health Canada 2003a; CIHI 2004). The data gaps are most obvious for the Métis and Inuit populations although there is still a significant lack of information for First Nations as well. Further, the collection of data on the First Nations is incomplete and varies from region to region; data gathered by the census is also inaccurate because many First Nations communities refuse to participate in any statistical data gathering activities for political, historical and cultural reasons (Statistics Canada 2003a).

Undercoverage in the 2001 Census was considerably higher among Aboriginal people than among other segments of the population due to the fact that enumeration was not permitted, or was interrupted before it could be completed, on 30 Indian reserves and settlements. These geographic areas are called incompletely enumerated Indian reserves and settlements.

Data are not available for incompletely enumerated reserves and settlements, and these reserves and settlements are not included in tabulations. While the impact of the missing data tends to be small for national-level and most provincial-level statistics, it can be significant for some smaller areas (Statistics Canada 2003a).

In 2001, net undercoverage for Canada as a whole was 2.99%, compared to 8.11% for the Northwest Territories. This was the highest rate of net undercoverage among all provinces and territories in the country (Statistics Canada, 2001).

Information is not gathered distinctly for each group either; therefore, some information is available for one or two groups but not for others in a region. For nearly all the health indicators listed in this report, comprehensive data are unavailable for the First Nations and Inuit and are vastly lacking for the Métis population.

For example, the life expectancy of the Métis is unknown as are rates for infant mortality, low birth weight, and types of cancer that most commonly cause death in the Métis population. Other major mortality causes are unknown including suicide rates and potential years of life lost due to intentional or unintentional injuries. The rate and type of communicable diseases affecting the Métis are also unknown, with the exception of some data on HIV/AIDS. Self-reported health and well-being and physical activity information is also unavailable.

Thus, it is clear that there is an absence of reliable data and data sources to represent health indicators for the Métis population in Canada.

Even though there is more data to describe the health status of First Nations and the Nunavut Inuit , there remains a scarcity of information necessary to measure and compare their health status to that of the general Canadian population. Information about the prevalence of depression, physical activity, body mass index, teenage smoking rates as well as information on health indicators such as life expectancy rate by socio-economic status and/or five-year cancer survival rates are just some examples where information is lacking and/or is available for one of the groups, usually the First Nations, but not for the Inuit and Métis populations. It is important that this data be collected to contribute to health service planning and delivery.

In summary, there are many gaps that exist to properly determine the health status of the First Nations, Inuit and Métis populations in Canada. The data that are available are inadequate and do not accurately reflect the health of Aboriginal peoples in Canada.

8. Aboriginal Health Reporting Framework – update

As part of their mandate, the Healthy Canadians Working Group must report on the development of the Aboriginal Health Reporting Framework (AHRF),¹² although this activity falls under the responsibility of the F/P/T Advisory Committee on Governance and Accountability (ACGA).

In order to develop the AHRF, the F/P/T Advisory Committee on Governance and Accountability (ACGA) struck a task force which includes representation from the F/P/T governments and the six national Aboriginal organizations (NAOs) – Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapiriit Kanatami, Métis National Council, Native Women’s Association and Pauktuutit, and the Inuit Women’s Association. The co-chairs of the AHRF task group are Deborah Schwartz, Executive Director, Aboriginal Health, British Columbia Ministry of Health Planning and Katherine Stewart, Director General, Strategic Policy, Planning and Analysis Directorate, First Nations and Inuit Health Branch, Health Canada. The following briefly describes the activities that must be considered and completed for the development of the AHRF.

The key considerations of the AHRF are to:

- Reflect the 2003 First Ministers’ Accord;
- Provide a model to understand health disparities between Aboriginal people and non-Aboriginal people;
- Be inclusive and respectful of cultural needs/expectations;
- Be cognizant of OCAP¹³ principles;
- Incorporate tenets of prior agreements; and
- Integrate performance indicator expertise with community interests to establish a scientifically rigorous model.

The following are considerations for developing a framework of indicators:

- Consultation with Aboriginal groups will be a central part of activities;
- AHRF process will run parallel to the ACGA’s efforts to complete indicator definitions;
- AHRF will focus on comparability of indicators with those defined by ACGA (e.g., primary care, home care, catastrophic drug coverage, medical equipment, health human resources, etc.) but may not be identical; and

¹² Information on the AHRF process was obtained from a federal government official and a representative from a national Aboriginal organization.

¹³ Ownership, Control, Access and Possession (OCAP)

- Indicator sources will be primarily health and administrative databases in F/P/T jurisdictions.

The proposed process has two phases:

Phase I:

- Agreement on parameters of a framework;
- Support of Aboriginal capacity to participate; and
- Collection of national and international indicators

Phase II:

- A community dialogue, the parameters of which will be defined in Phase I, moving toward a consensus on content and process for an Aboriginal Health Reporting Framework.

The federal representative has stated that progress on the AHRF includes:

- Three face-to-face meetings among the F/P/T and NAOs since January 2004;
- Six teleconferences held since March 2004;
- The draft AHRF High Level Long Term Workplan approved by the Advisory Committee on Governance and Accountability (ACGA), and subsequently approved at the Conference of F/P/T Deputy Ministers (CDM) in June 2004;
- Three sub-committees established and finalizing the following materials:
 - **Discussion Document on the Technical Aspect of the AHRF** – reviews the technical aspects of the framework development and grounds them in the language of framework development.
 - **Standard Engagement Protocol for Orientation and Brainstorming Sessions** – outlines a common engagement process for brainstorming sessions across the country.
 - **Draft Sample Agenda for Orientation Sessions** – are designed to introduce participants to the AHRF Task Group process and to fundamental technical issues surrounding framework development to orient them toward the type of input required from them in the brainstorming sessions.
 - **Draft Sample Agenda for Brainstorming Sessions** – The brainstorming sessions will also have a brief introductory phase but will primarily focus on obtaining structured feedback on the draft indicator framework.

- **Communications Strategy for Orientation and Brainstorming Sessions**
- **PowerPoint Presentations for Orientation and Brainstorming Sessions**
- **Background on AHRF**
- **AHRF Q's and A's**
 - The Communications Strategy, PowerPoint Presentation, Background on AHRF and AHRF Q's and A's will be used for information and distribution to support the Orientation and Brainstorming sessions.
- Brainstorming sessions are scheduled to begin December 2004, after the CDM has reviewed and approved the material to be used during these sessions.

The Assembly of First Nations (AFN) has raised concerns that aspects of the AHRF process limits its and other NAOs' input. These concerns include:

- Capacity issues;
- Timeframe;
- Ownership, Control, Access and Possession (OCAP) principles;
- Consultation;
- Pan-Aboriginal approach; and
- Community needs.

The concerns of the development of the AHRF are also clearly outlined in a Briefing Note put forth by the First Nations Centre of NAHO and are similar to those expressed by the AFN as listed above (NAHO 2003).

9. Next steps

The Health Council of Canada believes that crucial and urgent steps must be taken to understand and improve the comparatively poor health status of First Nations, Inuit and Métis peoples. The Council will monitor and report on Canada's progress in adopting the measures described in this report and evaluating their success.

The Council will:

- Report on the health of First Nations, Inuit and Métis elders, children and youth, and those who are mentally-challenged;
- Report on the development and adoption of an Aboriginal Health Reporting Framework, as a key commitment of the Health Accord;
- Highlight the gaps in health care provider availability in First Nations, Inuit and Métis communities across Canada;
- Identify and comment on innovative or best practices which appear to have positive impacts on Aboriginal health-related matters;
- Report on the disposition of the fund set up through the Accord to support the development of First Nations, Inuit and Métis health care; and
- Assess whether or not the Health Accord's objectives and priorities have addressed the specific needs of the First Nations, Inuit and Métis peoples.

Conclusion and recommendations

An accurate description of the actual health status of First Nations, Inuit and Métis cannot be presented yet, for the range of reasons cited in section four of this report. However, there are clear indications that the health of the First Nations, Inuit and Métis, well below the Canadian average, is disturbing and problematic. In spite of the many initiatives by the federal government and some provincial and territorial governments, the health status of Aboriginal peoples remains below the national norm, and in some respects appears to be getting worse. For example, rates of HIV infection and diabetes continue to increase in spite of special programs specifically for the Aboriginal population. Both conditions are steadily increasing at an alarming rate.

The health of Aboriginal people can be improved through the application of a population health approach which corresponds to and complements the holistic view of health held by many Aboriginal people. The involvement of Aboriginal people as full and responsible partners in the development and implementation of change is essential for success. A culturally appropriate application of the determinants of health model is essential.

Aboriginal people believe that for successful change to occur they must be treated as equal partners and that such partnerships, i.e., government to government, are solidly entrenched in the treaties, wampum belts, land claims agreements and the covenant chain (Ottawa, 2004). Further, the inherent right for self-government is enshrined in the Canadian Constitution (ibid.). First Nations, Inuit and Métis want to assert more control over all matters that affect them. According to a study carried out by the Harvard Project on American Indian Economic Development, the important underpinnings of self-determination are: genuine self-rule (empowerment), capable governing institutions (exercise power effectively, responsibly and reliably); and cultural match (the institutions that are created are reflective of the values and culture of the people for whom they were intended). (Cornell n.d.)

History has proven that there is little hope for positive outcomes without the complete involvement and participation of First Nations, Inuit and Métis in matters that affect them; thus, the fundamental principles of self-determination should be respected when applying the following recommendations.

The Council advocates the implementation of the following measures to overcome inter-jurisdictional and infrastructural challenges to address the health disparities common to First Nations, Inuit and Métis populations:

- 1- Enable, expect and respect First Nations, Inuit and Métis as full partners with federal, provincial and territorial jurisdictions in developing and implementing the Aboriginal Health Reporting Framework. Enable

- Aboriginal populations to collect health information which establishes an accurate baseline; permits the comparison and monitoring of their health status within and between their populations and with the rest of Canadians; meets the information needs of community leaders; and reflects the unique realities of Aboriginal peoples.
- 2- Adopt a population health model to address the health disparities of the First Nations, Inuit and Métis population. Enable and require all federal, provincial and territorial departments/agencies to work in partnership with Aboriginal organizations that oversee, manage or advise on programs and services, in order to address the determinants of health which have an impact the Inuit, Métis and First Nations populations.
 - 3- In partnership with the various levels of government, identify the resource requirements to address the particular health needs of First Nations, Inuit and Métis who live in rural, remote or/and socio-economically challenged communities. Address, as a priority, the current and ongoing shortage of health care service providers available to these groups, especially nurses. Ensure that the necessary resources are devoted to implement educational programs that will increase the number of Inuit, Métis, and First Nations health care service providers – in the short, medium and longer terms. Recognize that resources have to be available and accessible. Barriers, such as those created through the use of standardized funding and program templates, should be avoided so that resources can be allocated and utilized.

The present health status of Aboriginal peoples is unacceptable and must be urgently and critically addressed by all levels of government, in partnership with the First Nations, Inuit and Métis people. Improving the health of the First Nations, Inuit and Métis to a standard comparable to the rest of Canadians must be a national priority; otherwise their health will continue to lag or even worsen. The three recommendations above have been put forth as solutions to begin the process of improving the health status of the First Nations, Inuit and Métis.

Best practices

The identification and showcasing of best or successful practices can serve to encourage others to undertake similar activities to improve their health outcomes. Highlighted here is but one example of a best practice currently demonstrating positive outcomes in an Aboriginal community in Canada.

Eskasoni primary care project

This is a tri-partite approach that was put in place to develop a new model to deliver primary health care to the Eskasoni First Nations. This pilot project was initially funded by the Health Transition Fund, and was put in place to test the effectiveness of a tri-partite steering committee comprised of representatives from FNIHB, the provincial – Nova Scotia – government, and the Eskasoni First Nations.

The goals of the project are:

- To establish a mechanism through which a tri-partite steering committee can build a positive working relationship and function as the building block for this primary care project;
- To improve the health status of the residents of Eskasoni;
- To use health care resources more efficiently;
- To discourage inappropriate dependency on physicians and prescribed medications; and
- To remove overlaps in services, while at the same time addressing some deficiencies in the services that have to date been available in Eskasoni.

Among its key successes are:

- Visits by Eskasoni residents to the outpatient/emergency department at the regional hospital have declined by 40%.
- Frequency of visits by Eskasoni residents to family doctors has been reduced from a high of 11 patient visits per year to approximately four visits per year.
- Savings to the medical transportation budget have been achieved in the order of approximately \$200,000.
- 96% of all pregnancies were followed from prenatal care through delivery and post-natal care by an Eskasoni family doctor and community health nurse (70-80 births annually).
- Referrals from local family doctors to the team nutritionist/health educator for diabetic management have increased 850%.
- 73% of patients at the Eskasoni Health Centre report obtaining an appointment with their family doctor within 24 hours or less; 90% secure an appointment within 48 hours.
- 89% of patients believe that the quality of health services has improved compared to five years ago.
- Collaboration with Cape Breton regional hospital in several key program and service areas has been achieved.
- All primary care providers report satisfaction working in this model of primary care.

- Prescription of benzodiazepines over 24 months of study declined by 56%.
- A collaborative approach to patient care resulted in successful integration of a new service model.
- Collaboration among the five Cape Breton bands created a second successful primary care initiative.

Appendix A

2003 Health Accord

The First Ministers agreed to respect the five principles of the public health system: universality, accessibility, portability, comprehensiveness and public administration. Further, the First Ministers agreed to enhance the transparency and accountability of the health care system while at the same time guaranteeing that health care will remain affordable to all Canadians.

The Health Accord pledges that:

- All Canadians have timely access to health services on the basis of need, not ability to pay, regardless of where they live or move in Canada;
- The health care services available to Canadians are of high quality, effective, patient-centred and safe; and
- Our health care system is sustainable and affordable and will be here for Canadians and their children in the future.

The fundamental purpose of the Health Accord is to make sure that Canadians:

- Have access to a health care provider 24 hours a day, seven days a week;
- Have timely access to diagnostic procedures and treatments;
- Do not have to repeat their health histories or undergo the same tests for every provider they see;
- Have access to quality home and community care services;
- Have access to the drugs they need without undue financial hardship;
- Are able to access quality care no matter where they live; and
- See their health care system as efficient, responsive and adapting to their changing needs, and those of their families and communities now, and in the future.

The First Ministers have agreed to prepare an annual public report for their respective constituents on the three priority areas of the Health Accord – primary health care, home care, and catastrophic drug coverage. In addition, the First Ministers have agreed to use comparable indicators and develop the necessary data infrastructure to develop the annual public reports. By means of these reports, Canadians will be informed on the progress that is being made and of key outcomes of the Health Accord.

In order to monitor and oversee the implementation of the Health Accord, a Health Council has been established to ensure accountability and transparency of the complete process.

Appendix B

The Health Council of Canada

The establishment of the Health Council was formally sanctioned in the 2003 First Minister's Accord. Its primary purpose is: *to monitor and report on the progress of health care renewal with regard to the accountability and transparency provisions as set out in the Accord*. Twenty-seven health experts and other representatives from across Canada were appointed as Councillors of the Health Council. The Councillors will provide the needed direction and leadership to fulfill this mandate.

The First Ministers identified seven themes or priority areas for health reform, which should be addressed by the Health Council of Canada:

1. Framework for monitoring system progress;
2. Healthy Canadians (to include general population as well as Aboriginal health and early childhood development);
3. Wait times;
4. Primary care;
5. Health human resources;
6. Home care; and
7. Drug coverage.

Appendix C

Comparable Health Indicators

Canadian Indicators	NAHO ¹⁴ Indicators																														
5.1 Life expectancy	Perceived progress in community wellness:																														
Definition: The number of years a person would be expected to live, starting from birth or at age 65 on the basis of mortality statistics for a given observation period, typically a calendar year ¹⁵ .	Percentage seeing good progress in:																														
<p>First Nations:</p> <p>In 2001, life expectancy for First Nations males was 70.4 years and 75.5 years for females compared to 76.5 and 82.1 years for the non-Aboriginal male and female population (INAC 2003).</p> <p>British Columbia: During the period 1997-2001, status Indian males in BC had an average life expectancy rate of 69.9 years, which is eight years less than the non-Aboriginal male BC population, and status Indian females had a life expectancy rate of 75.4 years compared to other females in BC whose life expectancy was 82.0 years. (British Columbia 2002).</p> <p>Manitoba: The life expectancy for the “registered” First Nations population is less when compared to the rest of Manitobans (males: 68.4 years compared to 76.1 years and for females the rate is 73.2 years compared to 81.4 years) (Manitoba</p>	<table border="1"> <tbody> <tr> <td>Water/sewage:</td> <td>31%</td> </tr> <tr> <td>Use of Elders:</td> <td>24%</td> </tr> <tr> <td>Languages:</td> <td>23%</td> </tr> <tr> <td>Cultural Programs in School:</td> <td>23%</td> </tr> <tr> <td>Training Opportunities:</td> <td>23%</td> </tr> <tr> <td>Housing Quality:</td> <td>21%</td> </tr> <tr> <td>FN/I Controlled Programs:</td> <td>15%</td> </tr> <tr> <td>Relationship with Land:</td> <td>15%</td> </tr> <tr> <td>Networking:</td> <td>15%</td> </tr> <tr> <td>Training in Health:</td> <td>14%</td> </tr> <tr> <td>Return to Tradition:</td> <td>13%</td> </tr> <tr> <td>Commitment to Personal Healing:</td> <td>12%</td> </tr> <tr> <td>FN/I Health Professionals:</td> <td>11%</td> </tr> <tr> <td>Employment Opportunities:</td> <td>11%</td> </tr> <tr> <td>Alcohol/Drug Abuse:</td> <td>8%</td> </tr> </tbody> </table>	Water/sewage:	31%	Use of Elders:	24%	Languages:	23%	Cultural Programs in School:	23%	Training Opportunities:	23%	Housing Quality:	21%	FN/I Controlled Programs:	15%	Relationship with Land:	15%	Networking:	15%	Training in Health:	14%	Return to Tradition:	13%	Commitment to Personal Healing:	12%	FN/I Health Professionals:	11%	Employment Opportunities:	11%	Alcohol/Drug Abuse:	8%
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¹⁴ NAHO – National Aboriginal Health Organization – based on First Nations and Inuit Regional Health Surveys, 1997.

<p>2002).</p> <p>Northwest Territories¹⁶: In 1997, Aboriginal women in the NWT had a life expectancy rate of 75 years with Aboriginal men having a life expectancy rate of 70 years compared to 80 and 75 years for the non-Aboriginal NWT female and male population respectively (NWT 1999).</p> <p>Inuit: Life expectancy of the Inuit people is less than the First Nations. In Nunavut, in 1999, the life expectancy rate for the Inuit males was 67.7 years and 70.2 years for women (Health Canada 2003b). In Nunavik (Northern Quebec), for the period 1993 -1997, life expectancy was recorded as 69.3 years and 62.4 years for women and men, respectively (Pauktuutit, 2000).</p> <p>Métis: Data unavailable</p>	members																			
	Overcrowding	Drug use (23%																		
	Gambling	Overcrowding (20%)																		
	Unemployment	Domestic violence (14%)																		
	Inadequate household income																			
	Inadequate housing																			
<p>Reasons to revive and preserve Aboriginal language:</p> <table border="1"> <tr> <td>Prevent loss:</td> <td>35%</td> </tr> <tr> <td>For children:</td> <td>13%</td> </tr> <tr> <td>Show pride in culture:</td> <td>8%</td> </tr> <tr> <td>Able to speak:</td> <td>7%</td> </tr> <tr> <td>Survival of people:</td> <td>9%</td> </tr> <tr> <td>Enrich life:</td> <td>4%</td> </tr> <tr> <td>Educate children</td> <td>3%</td> </tr> <tr> <td>Way of life:</td> <td>2%</td> </tr> <tr> <td>Gain respect:</td> <td>1%</td> </tr> </table>			Prevent loss:	35%	For children:	13%	Show pride in culture:	8%	Able to speak:	7%	Survival of people:	9%	Enrich life:	4%	Educate children	3%	Way of life:	2%	Gain respect:	1%
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¹⁵ Definitions of indicators are taken from the “Plan for Reporting Comparable Health Indicators in November 2004” report submitted by: The Advisory Committee on Governance and Accountability (ACGA) and approved by the Conference of Deputy Ministers of Health.

¹⁶ Based on 1998 population estimates, more than 50% of the NWT population is Aboriginal of Dene, Métis and/or Inuit ancestry (NWT 1999).

<p>5.5. Infant mortality</p>	<p>Hopes and dreams for the community (Ontario results):</p>																									
<p>Definition: The number of infants who die in the first year of life, expressed as a rate (per 1,000 live births) for that year.</p>	<table border="1"> <tr><td>Cohesiveness</td><td>40%</td></tr> <tr><td>Self-sufficiency</td><td>12%</td></tr> <tr><td>Better people</td><td>10%</td></tr> <tr><td>Happiness</td><td>9%</td></tr> <tr><td>Community Growth</td><td>9%</td></tr> <tr><td>Health</td><td>7%</td></tr> <tr><td>Healing</td><td>8%</td></tr> <tr><td>Alcohol/drug free</td><td>7%</td></tr> <tr><td>Culture</td><td>8%</td></tr> <tr><td>Pride in what we are</td><td>8%</td></tr> <tr><td>More community service</td><td>5%</td></tr> <tr><td>Work/Job</td><td>4%</td></tr> </table>		Cohesiveness	40%	Self-sufficiency	12%	Better people	10%	Happiness	9%	Community Growth	9%	Health	7%	Healing	8%	Alcohol/drug free	7%	Culture	8%	Pride in what we are	8%	More community service	5%	Work/Job	4%
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<p>First Nations: The infant mortality rate was 8.0/1,000 live births in 1999 compared to 5.5/1,000 for Canada as a whole. The leading cause of infant mortality was Sudden Infant Death Syndrome (SIDS). In two studies conducted in the 1990s, the rate of SIDS in the First Nations population was 5 -10 times higher than the rates in the non-First Nations populations of British Columbia and Alberta respectively (Health Canada 2003b).</p>	<p>Amount of meat, fish and birds obtained by hunting and fishing (Labrador results):</p>																									
<p>British Columbia: In 2001, the Aboriginal infant mortality rate was 4.3/1,000 live births close to the provincial rate of 3.9/1,000 live births (British Columbia 2002).</p>	<table border="1"> <tr><td>All</td><td>31%</td></tr> <tr><td>Half to most</td><td>45%</td></tr> <tr><td>Less than half</td><td>23%</td></tr> <tr><td>None</td><td>1%</td></tr> </table>		All	31%	Half to most	45%	Less than half	23%	None	1%																
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<p>Northwest Territories: In 1998, the infant mortality rate was 6/1,000 live births which has remained similar to the Canadian rate since 1988 (NWT 1999).</p>	<p>Frequent consumption of fast foods by age (Quebec results):</p>																									
<p>Inuit: During 1990 and 1994, the infant mortality rate in Nunavik was 25.5/1,000 live births (Health Canada 2003b).</p>	<table border="1"> <tr><td>18 – 29 years</td><td>41%</td></tr> <tr><td>30 – 44 years</td><td>30%</td></tr> <tr><td>45 – 64 years</td><td>17%</td></tr> <tr><td>65+</td><td>5%</td></tr> </table>		18 – 29 years	41%	30 – 44 years	30%	45 – 64 years	17%	65+	5%																
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<p>Infant mortality in the North for 1999 was reported to be: 2.6/1,000 (Yukon); 16.7/1,000 (NWT) (INAC 2003).</p>																										
<p>Nunavut: In 1999, the infant mortality rate was 15/1,000 live births compared</p>																										

to 4.4/1,000 for the rest of Canada (Nunavut 2002a).	
Métis:	
Data unavailable	

Canadian Indicators	NAHO Indicators
5.6 Low birth weight	
Definition: The number of live births (birth weight known) with a birth weight less than 2500 grams and at least 500 grams.	
<p>First Nations:</p> <p>In 1999, 6.0% of the 8,125 First Nations births were classified as being low birth weight. This compares to 5.6% for the general Canadian population. There is an increase of low birth weight infants in the First Nations population. During 1989- 1993, the incidence of low birth weight for First Nations infants varied between 3% and 5%. (Low birth weight is considered a more serious issue than high birth weight in First Nations communities because low birth weight infants experience a higher mortality rate than high birth weight infants. Both low and high weight infants are linked to the rising rates of diabetes among Aboriginal people) (Health Canada 2003b)"</p> <p>Northwest Territories: The low birth weight for the NWT is similar to the rest of Canada at a rate of about 5/1,000 (NWT 1999).</p> <p>Inuit:</p>	

<p>Nunavut: About 35% more low birth weight infants are born in Nunavut compared to the rest of Canada. Low birth weight among the females is higher at 8/1,000 compared to 7/1,000 for infant males (Nunavut, 2002).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7 Mortality rates (Overall)</p>	
<p>Definition: The number of deaths of individuals where the underlying cause of death is one of those specified, per 100,000 population, that would be observed in the population if it had the same age composition as the reference or “standard” population.</p>	
<p>First Nations:</p> <p>In 1999, the First Nations crude mortality rate was determined to be 354.2/100,000 population. The four leading causes of death have been the same since 1991 and are: injury and poisoning, circulatory diseases, cancer and respiratory diseases. For Canada the three leading causes of mortality are: cardiovascular diseases, cancer and injuries. The crude death rate for First Nations males is 1.3 times higher than for females representing 382.3/100,000 compared to 293.3/100,000 in that order. During this period the causes of deaths differed between the males and females. The three chief causes of mortality for the males were injury and</p>	

poisoning, circulatory diseases and cancer. For females, the three primary diseases that led to death were circulatory diseases; injury and poisoning followed by cancer. The crude mortality rate attributed to suicide was 32.2/100,000 according to 1996 data (Health Canada 2003b).

British Columbia: In 2001, the mortality rate for status First Nations was 1.5 times the general population. The five leading causes of death for First Nations in BC are: ischemic heart disease, motor vehicle accidents, accidental poisoning, suicide and cerebrovascular disease (British Columbia 2002)

Manitoba: The premature mortality rate for registered First Nations is 6.6/1,000 compared to 3.3/1,000 for the rest of Manitobans. First Nations living in northern areas have a lower premature mortality rate in comparison to those First Nations living in southern areas (Manitoba 2002).

Northwest Territories: The leading cause of mortality for the residents of the NWT is cancer, which accounts for 25% of all deaths followed by injuries and poisoning (23%), and circulatory disease (23%) (NWT 1999).

Inuit:

Mortality rates for the North - Yukon, NWT and Nunavut - for 2001-2002 were 5.2/1,000; 3.9/1,000; and, 5.7/1,000 respectively. It is projected that the mortality rates from 2000 to 2006 will increase for all territories (INAC 2003).

<p>Injury has been cited as a leading cause of death in the Inuit population. In Nunavik, injuries were the cause in 55% of the male deaths and in 27% of the female deaths as reported by Hodgins in 1997 (Health Canada 2003b).</p> <p>Suicide amongst the Inuit, based on 1996 health information, was reported to be 79.0/100,000 compared to 13.2/100,000 for the mainstream population. During 1991 – 1995, Nunavik had a suicide rate of 82/100,000 population (Health Canada 2003b).</p> <p>Métis :</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.1 Mortality rate for lung cancer</p> <p>First Nations:</p> <p>In 1999, the crude rate of cancer-related deaths for First Nations males was 57.9/100,000 - lung cancer was the most common type. For females the crude death rate resulting from cancer was 59.8/100,000 with lung ranking as the second type to cause death (Health Canada 2003b).</p> <p>Northwest Territories: Trachea, bronchus and lung cancer were the most prevalent types of cancer to result in death in the male Dene population and accounted for 36% of all cancer-related deaths during 1990 – 1999.</p>	

For the female Dene population, this type of cancer ranked second and accounted for 20% of cancer-related deaths during this same time period (NWT 2003).

Inuit:

Trachea, bronchus and lung cancer were the leading types of cancer to cause death in the male and female NWT Inuit population and accounted for 39% and 36% respectively (NWT 2003).

Inuit women in the Nunavik region have the highest incidence of lung (and cervical) cancers. One in fourteen (1/14) deaths is linked to lung cancer. During the period 1987 – 1994, the lung cancer rate in Nunavik was 3.4 times higher than the Quebec rate (Pauktuutit 2000).

Nunavut: In 1999, the lung cancer mortality rate for men was 3.2 times and 5.3 times higher for females compared to the Canadian rate (Nunavut 2002a).

Métis:

In the NWT, in the “other” category, which includes the non-Aboriginal and Métis populations, trachea, bronchus and lung is the chief cause of cancer-related deaths in both the male and female groups and accounts for 38% and 27% respectively (NWT 2003).

Canadian Indicators	NAHO Indicators
<p>5.7.2 Mortality rate for prostate cancer</p> <p>First Nations:</p> <p>Prostate cancer was the second leading type of cancer to cause death in the First Nations male population in 1999 (Health Canada 2003b).</p> <p>Inuit:</p> <p>Data unavailable</p> <p>Métis:</p> <p>In NWT, in the population group that considers the Métis, prostate cancer accounts for 11% of cancer-related deaths and ranks as third leading type to cause death (NWT 2003).</p>	

Canadian Indicators	NAHO Indicators
<p>5.7.3 Mortality rate for breast cancer</p> <p>First Nations:</p> <p>Breast cancer was the leading cause of cancer-related deaths in the First Nations female population in 1999 (Health Canada 2003b).</p> <p>Northwest Territories: Breast cancer ranks as the third leading cause of cancer-related deaths in the female <u>Dene</u> population (NWT 2003).</p> <p>Inuit:</p>	

<p>Nunavut: Fewer women die of breast cancer in Nunavut. The breast cancer mortality rate is 11.9/100,000 compared to 25.2/100,000 for the rest of Canadian women (Nunavut 2002a).</p> <p>Métis:</p> <p>In the NWT, breast cancer ranked as the second leading cause of cancer-related death in the <u>general</u> female population, which includes the Métis (NWT 2003).</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.5 Mortality rate for acute myocardial infarctions (AMI)</p> <p>First Nations:</p> <p>In 1999, ischemic heart disease was the primary cause of death in the middle-age (45 – 65 years) and senior (65+) First Nations population and accounted for 17% and 29% of deaths respectively (Health Canada 2003b).</p> <p>British Columbia: Between 1991-2001, ischemic heart disease was the leading cause of death in the status First Nations population (British Columbia 2002).</p> <p>Northwest Territories: Diseases of the circulatory system were the second leading cause of death for NWT residents, with 44% of these deaths attributed to AMIs (NWT 1999).</p>	

<p>Saskatchewan: In 2001, the leading cause of death for males and females was diseases of the circulatory system which accounted for 21.3% of all deaths in the First Nations population (Saskatchewan 2001).</p> <p>Inuit:</p> <p>Nunavut: The mortality rate for AMI was 39/100,000 compared to 63.5/100,000 for the rest of Canadians during 1997 – 1999 (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.6 Mortality rate for stroke</p> <p>First Nations:</p> <p>Age-standardized death rates rank circulatory diseases as the leading cause of mortality for First Nations in 1999. Aboriginal women have higher mortality rates than the general non-Aboriginal female population for both heart disease and stroke (Health Canada 2003b).</p> <p>British Columbia: Cerebrovascular disease was the fifth cause of mortality in the status First Nations population during 1991 – 2001 (British Columbia 2002).</p> <p>Northwest Territories: Stroke was the cause of 17% of all circulatory-</p>	

<p>related deaths in the NWT (NWT 1999).</p> <p>Manitoba. The age/sex adjusted hypertension rate among the registered First Nations aged 25 years and older was 221/1,000 compared to 202/1,000 to the rest of Manitobans. Higher hypertension rates were found among the on-reserve population in comparison to the off-reserve registered First Nations population (235 versus 199 per thousand) (Manitoba 2002).</p> <p>Inuit:</p> <p>Data unavailable</p> <p>Métis:</p> <p>Data unavailable</p>	
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<p>5.7.17 Potential years of life lost due to suicide</p>	
<p>Definition: Potential years of life lost (PYLL) due to suicide is the number of years of life “lost” from a suicide death, when a person dies “prematurely” – defined as dying before the age 75. A suicide at age 25, for example, has lost 50 potential years of life.</p>	
<p>First Nations:</p> <p>In 1999, suicide was attributed as the cause for 1,315.4 potential years of life lost (PYLL) per 100,000 First Nations. Suicide is among the leading causes of death for First Nations between 10 – 44 years of age (Health Canada 2003b).</p> <p>Inuit:</p> <p>The suicide rate for the Inuit population as a whole, in 2002, was 79.0/100,000 – PYLL unavailable (Health Canada 2003b).</p> <p>Nunavut: The PYLL in the male Inuit population is 8.5 times greater in comparison to the Canadian rate. Women in Nunavut had four times more PYLL compared to the general Canadian female population. In 1999, the PYLL for Inuit males was 6222.3/100,000 and for females this rate was 749.1/100,000 (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	

Canadian Indicators	NAHO Indicators										
<p>5.7.18 Potential years of life lost due to unintentional injury</p>	<p>Causes of injuries in Nova Scotia (1997 RHS Nova Scotia results). Percentage injured in previous 12 months due to:</p>										
<p>Definition: Potential years of life lost (PYLL) due to unintentional injury is the number of years of life “lost” when a person dies “prematurely” from an unintentional injury – defined as dying before age 75. A person dying at age 25, for example, has lost 50 potential years of life.</p>	<table border="1"> <tr> <td>Falls</td> <td>39%</td> </tr> <tr> <td>Sports</td> <td>31%</td> </tr> <tr> <td>Assault</td> <td>18%</td> </tr> <tr> <td>Motor vehicle</td> <td>17%</td> </tr> <tr> <td>Bicycle</td> <td>9%</td> </tr> </table>	Falls	39%	Sports	31%	Assault	18%	Motor vehicle	17%	Bicycle	9%
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<p>First Nations: For First Nations, the injury and poisoning category, which includes suicide, is the leading reason for PYLL. This category represented 4,909 years of potential life years lost per 100,000 population for First Nations in 1999 (INAC 2003; CIHI 2004)</p> <p>British Columbia: Injuries are the leading cause of death in the Aboriginal population of BC and include death from motor vehicle crashes, accidental poisoning (including drug overdose deaths), suicides, falls, fires and drowning (British Columbia 2002).</p> <p>Northwest Territories: Injuries account for approximately half of all premature deaths in the NWT with the average age of premature death to be 38 years. The PYLL for men in the NWT as a result of injury is twice that of the NWT female population – 50% versus 27% respectively (NWT 1999).</p> <p>Saskatchewan: In 2001, of the 9,335 PYLL, 4005 are attributed to external causes of morbidity and mortality and represents nearly half (42.9%) of all</p>											

<p>PYLL in the registered First Nations population living on and off-reserve (Saskatchewan 2001).</p> <p>Inuit:</p> <p>Nunavut: In 1999, the number of PYLL was 2594.2/100,000 for females and 3039/100,000 for males compared to 374.5/100,000 and 1036/100,000 for their Canadian counterparts respectively (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.20 Incidence rate for measles</p> <p>Definition: The rate of new cases reported by year. A confirmed case is defined as laboratory confirmation of infection in the absence of recent immunization with measles-containing vaccine: isolation of measles virus from an appropriate clinical specimen or significant rise in measles specific antibody titre between acute and convalescent sera or positive serologic test for measles IgM using a recommended assay or clinical case in a person who is epidemiologically linked to a laboratory confirmed case.</p> <p>First Nations:</p> <p>No reported cases of measles in the First Nations population in 1999 (Health Canada 2003b).</p> <p>Northwest Territories: During 1989 –</p>	

<p>1998, the rate of measles was 4.1/100,000 compared to 0.7/100,000 the Canadian rate (NWT 1999).</p> <p>Inuit:</p> <p>Nunavut: No reported cases of measles since 1991 (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.21 Incidence rate for Haemophilus influenza B (invasive) (Hib) disease</p>	
<p>Definition: The rate of new cases by year in children under 5. A confirmed case is defined as invasive disease with laboratory confirmation of infection in the absence of recent immunization with Hib-containing vaccine: isolation of H. influenzae type b from a normally sterile site or epiglottis in a person with epiglottitis, or demonstration of H. influenzae type b antigen in cerebrospinal fluid. Invasive disease includes meningitis, bacteraemia, epiglottitis, pneumonia, pericarditis, septic arthritis, or emphysema.</p>	
<p>First Nations:</p> <p>In 2001, five cases of invasive H. influenzae type B and one death among Aboriginal children from northern Canada were noted (Health</p>	

<p>Canada 2003b).</p> <p>Northwest Territories: During 1989 – 1998, the rate of H. influenza B was 4.1/100,000 compared to 0.7/100,000 the Canadian rate (NWT 2003).</p> <p>Inuit:</p> <p>Nunavut: One case reported in 2000 which represents a rate of 28.7/100,000 (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.22 Incidence rate for tuberculosis</p> <p>Definition: Rate of incident cases of infectious pulmonary tuberculosis reported by calendar year. Case definition for reporting to the Canadian Tuberculosis Reporting System (CTBRS) (all cases).</p> <p>Cases with mycobacterium complex (i.e. M. tuberculosis, M. bovis, excluding BCG strain or M. africanum) demonstrated on culture in the absence of bacteriological proof, cases clinically compatible with active tuberculosis that have for example:</p> <ul style="list-style-type: none"> - Chest x-ray changes compatible with active tuberculosis including idiopathic pleurisy with infusion; - Active extrapulmonary tuberculosis (meningeal, bone, kidney, peripheral lymph nodes, etc.); - Pathologic or post-mortem 	

evidence of active tuberculosis.

First Nations:

In 1999, the incidence of tuberculosis (TB) among the First Nations was 61.5/100,000 compared to 5.9/100,000 the Canadian rate. In 2000, the rate decreased to 34.0/100,000 for First Nations – the Canadian rate remained fairly steady at 5.5/100,000. The TB rate for First Nations is still six times the Canadian rate (INAC 2002; Health Canada 2003b).

Northwest Territories: During 1990 – 1998, the number of tuberculosis incidence rates for NWT was 54/100,000 compared to 7/100,000 for the rest of Canada. In 1994 – 1995 there were significant increases in the number of TB cases for both male and females but by 1998 this rate declined significantly to be more similar to the Canadian rate (NWT 1999).

Saskatchewan: In 2001, the rate of TB infection occurred at a rate of 0.64/1,000 population. 47% (16/34 cases) of TB were reported in children less than 10 years of age which reflects a TB infection rate of 1.15/1,000 for children in this age group. 161 children under the age of 15 were treated for TB (Saskatchewan 2001).

Inuit:

Nunavut: Tuberculosis rates are rising in Nunavut with the TB rate to be 17 times higher than the Canadian rate. The rate for TB was 101.1/100,000 compared to 5.9/100,000 for other Canadians (Nunavut 2002a).

Métis:	
Data unavailable	

Canadian Indicators	NAHO Indicators																			
<p>5.7.24 Incidence rate for chlamydia</p> <p>Definition: Incidence rate of reported genital infections, by calendar year. A confirmed case is defined as laboratory confirmation of infection – detection of C trachomatis by appropriate laboratory techniques in genitourinary specimens.</p>	<p>Women who had a Pap smear:</p> <table border="1" style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">At some point</th> <th style="text-align: center;">In the past year or two</th> </tr> </thead> <tbody> <tr> <td>Labrador</td> <td style="text-align: center;">94%</td> <td style="text-align: center;">78% (past 2 years)</td> </tr> <tr> <td>New Brunswick</td> <td style="text-align: center;">59%</td> <td style="text-align: center;">35% (past year)</td> </tr> <tr> <td>Quebec</td> <td style="text-align: center;">68%</td> <td style="text-align: center;">46% (past year)</td> </tr> <tr> <td>Ontario</td> <td style="text-align: center;">88%</td> <td style="text-align: center;">64% (past year)</td> </tr> <tr> <td>Manitoba</td> <td style="text-align: center;">76%</td> <td style="text-align: center;">64% (past year)</td> </tr> </tbody> </table>			At some point	In the past year or two	Labrador	94%	78% (past 2 years)	New Brunswick	59%	35% (past year)	Quebec	68%	46% (past year)	Ontario	88%	64% (past year)	Manitoba	76%	64% (past year)
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<p>First Nations:</p> <p>The rate of genital chlamydia in the First Nations population in 1999 was 947.0/100,000 compared to 138.2/100,000 for the rest of the Canadian population. Females between 15 –24 years accounted for 54% of the cases, where age and gender were determined, which is similar to the rate of chlamydia infection in the Canadian female population in this same age bracket (Health Canada 2003b).</p> <p>Northwest Territories: During 1989 – 1999, rates of chlamydia infection averaged 542/50,000 compared to 77/50,000 for the Canadian population (NWT 1999).</p> <p>Saskatchewan: In 2001, of the 672 reported cases of sexually-transmitted diseases, 478 (71%) were due to chlamydia and 55 (8.2%) had both</p>																				

<p>chlamydia and gonorrhoea (Saskatchewan 2001).</p> <p>Inuit:</p> <p>Nunavut: Chlamydia rates for women are 17 times higher and 18 times greater for men in Nunavut compared to the rest of Canada. The rate of chlamydia infection, in 2000, was 1577.3/100,000 versus 89.1/100,000 for males and 3623.4/100,000 compared to 211.8/100,000 for females in the Nunavut and Canadian populations respectively (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.25 Incidence rate for HIV</p>	
<p>Definition: Estimates of new diagnoses of HIV infection based on new positive HIV test reports.</p>	
<p>First Nations:</p> <p>During 1998 – 2001, 605 Aboriginal persons in Canada tested positive for HIV infection representing 25.9% of all reports with known ethnicity (Health Canada 2003b).</p> <p>HIV reports, from provinces reporting ethnicity (BC, Yukon Territory, Alberta,</p>	

<p>Saskatchewan, Manitoba, Prince Edward Island and Newfoundland and Labrador), indicate that new HIV diagnoses are rising: 19.2% in 1998; an average of 24.0% in 1999 to 2001; and climbing to 26.5% in the first half of 2002 (Centre for Infectious Disease Prevention and Control 2003).</p> <p>British Columbia: Aboriginal people account for 16% of those testing positive for HIV although Aboriginal people only account for 4% of BC's total population (British Columbia 2002).</p> <p>From 1987 – 1998, twenty cases of individuals testing positive for HIV were reported in the NWT (NWT 1999).</p> <p>Inuit:</p> <p>Nunavut: No new diagnoses of HIV infection for the past seven years (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators
<p>5.7.26 Prevalence of diabetes (Feature in 2004)</p>	<p>Diabetes was noted to be 3-5 times higher in the First Nations and Inuit population compared to the Canadian prevalence rate. This condition was ranked as the fifth most prevalent issue that was reported among the non-reserve Aboriginal population in the 2001 Aboriginal People's Survey and is diagnosed at a younger age (NAHO 2004b).</p>
<p>Definition: The prevalence of diagnosed diabetes among health service users per 100,000 population.</p>	
<p>First Nations:</p> <p>Diabetes is especially prevalent in the older Aboriginal women with one in</p>	

four, 65 years of age and older, indicating they were diagnosed as diabetic in comparison to one in 10 for the rest of Canada's senior female population. The rate for Aboriginal men was one in five compared to one in seven for the general Canadian male population (Statistics Canada 2003b).

Saskatchewan: The age-sex adjusted prevalence rates for diabetes in the First Nations population in Saskatchewan is about three times higher in comparison to the non-First Nations rate (Saskatchewan 2000).

Inuit:

According to the 1991 Aboriginal People's Survey (APS), the diabetes prevalence rate in the Inuit population was 1.9% and reached 2.3% in 2001. The rate was reported as 4% for the Inuit in Labrador as reported in the First Nations and Inuit Regional Health Survey (Statistics Canada 2003b; Health Canada 2003b).

Nunavut: In 2001 – 2002, about 7.72% of the Nunavut population had Type 2 diabetes. The annual incidence of diabetes at 0.29% has remained stable over the period 1997 – 2002 and about 41 new diabetes cases are diagnosed each year. 65% of those diagnosed with diabetes are 20 – 59 years of age, compared to only 15% in this age group among the general Canadian population with diabetes (Nunavut 2002ab).

Métis:

The 2001 rate for diabetes among the

The rate of self-reported diabetes among First Nations adults, over the age of 20, is more than 3 times the Canadian rate (15.5% versus 4.7%) (NAHO 2004e). The comparison of diabetes rates for First Nations compared to other Canadians by age group is as follows:

Age group:	
20 – 34	3.5 times higher
35 – 54	5.6 times higher
55 +	5.6 times higher

<p>Métis climbed to 5.9% compared to 5.5% in 1991 (The Daily 2003).</p> <p>Saskatchewan: The age-standardized rate of diabetes in the Métis population is similar to the First Nations rate or three times higher than the non-Aboriginal people (Saskatchewan 2002).</p>	
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Canadian Indicators	NAHO Indicators																																				
<p>5.7.27 Exposure to second-hand smoke</p>	<p>Smoking rates by age (FNI versus the Canadian rate) (1997 RHS National Results):</p>																																				
<p>Definition: Proportion of the non-smoking population aged 12 and over regularly exposed to second-hand tobacco smoke at home, in private vehicles, and in public spaces.</p>	<table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th>Age</th> <th>FNI rate</th> <th>Canadian rate</th> </tr> </thead> <tbody> <tr><td>20 – 24</td><td>71%</td><td>33%</td></tr> <tr><td>25 – 29</td><td>70%</td><td>40%</td></tr> <tr><td>30 - 34</td><td>68%</td><td>38%</td></tr> <tr><td>35 - 39</td><td>60%</td><td>33%</td></tr> <tr><td>40 - 44</td><td>60%</td><td>32%</td></tr> <tr><td>45 - 49</td><td>59%</td><td>31%</td></tr> <tr><td>50 - 54</td><td>52%</td><td>29%</td></tr> <tr><td>55 - 59</td><td>48%</td><td>28%</td></tr> <tr><td>60 - 64</td><td>37%</td><td>27%</td></tr> <tr><td>65 - 74</td><td>32%</td><td>15%</td></tr> <tr><td>75+</td><td>21%</td><td>nil</td></tr> </tbody> </table>	Age	FNI rate	Canadian rate	20 – 24	71%	33%	25 – 29	70%	40%	30 - 34	68%	38%	35 - 39	60%	33%	40 - 44	60%	32%	45 - 49	59%	31%	50 - 54	52%	29%	55 - 59	48%	28%	60 - 64	37%	27%	65 - 74	32%	15%	75+	21%	nil
Age	FNI rate	Canadian rate																																			
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75+	21%	nil																																			
<p>First Nations:</p> <p>In 1997, 62% of the First Nations population smoked, double the Canadian average. More than half of respondents (9,870 adults and 4,138 children) to the 1997 First Nations and Inuit Health Surveys stated that someone in their household smoked. Three-quarters of non-smokers and more than a third of the smokers said they suffered unpleasant second-hand smoke effects (NAHO 2004b).</p> <p>British Columbia: In a BC study, exposure to second-hand smoke occurred in the home, work and other indoor settings. Aboriginal people were two times more likely than other British Columbians to be exposed to second-</p>	<p>Smoking rate by period (NAHO 2002-2003 results):</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th></th> <th>RHS 2002-2003</th> <th>RHS 1997</th> <th>APS 1991¹⁷</th> </tr> </thead> <tbody> <tr> <td>20+</td> <td>56.9%</td> <td>62%</td> <td>62%</td> </tr> </tbody> </table> <p>Based on the recent NAHO regional health survey 2002-2003 findings, the smoking rates for adults appear to be</p>		RHS 2002-2003	RHS 1997	APS 1991 ¹⁷	20+	56.9%	62%	62%																												
	RHS 2002-2003	RHS 1997	APS 1991 ¹⁷																																		
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¹⁷ APS – Aboriginal Peoples’ Survey 1991

<p>hand smoke at home (15% versus 6%) and at work (11% compared to 6%). Aboriginal children were more likely to be exposed to second-hand smoke in the home compared to other BC children (27% versus 15%) (Canadian Paediatric Society 1999).</p> <p>Northwest Territories: More NWT residents, 12 years of age and older, smoke compared to the national rate (45% compared to 30%). More Aboriginal people over the age of 15 smoke compared to the non-Aboriginal population (54% versus 30%) (NWT 1999).</p> <p>Inuit:</p> <p>The smoking prevalence rate of Inuit in Labrador was 65% (63% and 67% for men and women respectively) (Reading 1999 as cited in Health Canada 2003b).</p> <p>The Inuit have the highest smoking rate of 72% compared to the two other Aboriginal groups (Canadian Paediatric Society 1999).</p> <p>Métis:</p> <p>The Métis have a 57% smoking rate which is the second highest in the Aboriginal groups (Canadian Paediatric Society 1999).</p>	<p>declining though it still is twice that the Canadian rate (NAHO 2004e).</p>
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Canadian Indicators	NAHO Indicators
<p>5.7.28 Self-reported health (Feature in 2004)</p>	<p>Perceived personal health:</p> <p>Of the 1290 First Nations who were polled by NAHO, 13% rated their health</p>
<p>Definition: Percent of population aged</p>	

<p>12 and older who report that their health is very good or excellent.</p>	<p>as excellent and 27% rated it to be very good (NAHOb).</p>
<p>First Nations:</p> <p>British Columbia: In 2000 – 2001, 16.0% of Aboriginal people rated their health as being very good or excellent compared to 24.3 % for the rest of the BC population (British Columbia 2002).</p> <p>Inuit:</p> <p>Data unavailable</p> <p>Métis:</p> <p>Data unavailable</p>	<p>49% of those who rated their health to be excellent or very good indicated that regular exercise and a balanced diet contributed to their good health status (NAHOb).</p>

<p>Canadian Indicators</p>	<p>NAHO Indicators</p>
<p>5.7. 29 Teenage smoking rates (Feature in 2004)</p>	<p>About 50% of the 492 First Nations youth from Nova Scotia and Ontario (12 – 17 years of age), who were surveyed, indicated they were current smokers and according to Manitoba parents, 19% of children under 18 years of age smoke cigarettes (NAHO 2004b).</p>
<p>Definition: Percentage of population aged 12 – 19 (inclusive) reporting they are current smokers (current includes daily and occasional smokers) at the time of the interview, and percentage of population age 12 –19 (inclusive) reporting they are daily smokers at the time of the interview.</p>	
<p>First Nations:</p> <p>Over half (54%) of youth between 11 – 19 years of age smoke (Canadian Paediatric Society 1999).</p>	

<p>In a province-wide poll taken in 1997 in BC, it was found that 41% of youth between the ages of 12 – 18 smoked.</p> <p>Northwest Territories: More than half of the NWT residents older than 50 started to smoke between the ages of 15 – 19 years compared to 44% for the rest of Canadians (NWT 1999). By age 19, 63% of the Dene youth in the NWT were current or occasional smokers (Canadian Paediatric Society 1999).</p> <p>Inuit:</p> <p>In 1989, 71% of Inuit who reached 19 years of age were current or occasional smokers compared to 47% of the non-Aboriginal population of the same age (Canadian Paediatric Society 1999).</p> <p>Nunavut: Overall, teenage smoking rates are 2.5 times the Canadian rate. During 2000-2001, 50.5 % of females smoked compared to the Canadian teenage female rate of 19.8%. The rate of teenage smoking among Nunavut males was 42.1% compared to 17.6% for the rest of Canadian males (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	
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Canadian Indicators	NAHO Indicators	
5.7.32 Physical activity	Frequency of physical activity (Saskatchewan results for adults):	
Definition: a) Percentage of population aged 12 and over who report a physical activity index of “active”.	Never	25%
	1 – 2 times/week	32%
	3 – 4 times/week	14%
	5 – 6 times/week	3%

and over who report a physical activity index of "inactive".	Daily	14%		
	Other	12%		
<p>First Nations:</p> <p>Northwest Territories: 31% of NWT residents are considered physically active compared to 19% of the rest of Canadians (NWT 1999).</p> <p>Inuit:</p> <p>Nunavut: In 2000-2001, about half (47.2%) of the Nunavut residents are inactive with 19.3% reporting they are moderately active and 23.6% say they are active. These activity levels are similar to the rest of Canada (Nunavut 2002a).</p> <p>Métis:</p> <p>Data unavailable</p>	Activity limitations reported by age (1997 RHS National results):			
		15-29 years	30-54 years	55+ years
	Home activity limited by health problems	4%	10%	32%
	Unable to leave home	2%	2%	17%
	Difficulty taking short trips	4%	6%	27%
	Need help on short trips	4%	5%	30%
	Need help with personal care	1%	2%	16%

Canadian Indicators	NAHO Indicators
5.7.33 Body Mass Index (Feature in 2004)	Based on 9,124 adults and categorized according to standard international categories: underweight, normal weight, overweight and obese. Information below is for those in the overweight and obese categories:
Definition: Percent of adults who report a (computed) body mass index in specified categories, ranging	

<p>from overweight to obese.</p> <p>Body mass index (BMI) is based on self-reported height and weight, and calculated for persons 18 years of age and over, excluding pregnant women. Due to different rates of growth for individuals under 18 years of age, the standard BMI is not considered a suitable indicator for this group. BMI is calculated as weight (kilograms) divided by height (in metres) squared.</p>		Overweight (25 – 29.99)		Obese (> 30)	
	Age Group	RHS 2002/ 03	Canada	RHS 2002/ 03	Canada
	18-34	35.1%	25%	28.1%	14%
	34-54	38.1%	35.2%	43.5%	18.3%
	55+	37.2%	38.7%	42.9%	19.3%
	18+	36.7%	33.3%	36.6%	17.4%
	<p>The BMI for First Nations is especially higher in the “obese” category and is, in most instances, twice the Canadian obesity rate.</p>				

Canadian Indicators	NAHO Indicators						
5.7.35 Prevalence of depression	Mental health						
<p>Definition: Percent of population suffering from depression in the past 12 months</p>	<p>Definition: Positive mental health depends on individuals, families and communities feeling connected to each other, and to their culture and traditions. Also needed is a feeling of being connected to the past, present and future.</p>						
<p>Inuit:</p> <p>Date unavailable</p>	<p>Ontario First Nations (1997) compared to Canada (NPHS 1994):</p> <table border="1"> <thead> <tr> <th></th> <th>First Nations (men and women)</th> <th>Canadian</th> </tr> </thead> <tbody> <tr> <td>Major</td> <td>15.9%</td> <td>7.5%</td> </tr> </tbody> </table>		First Nations (men and women)	Canadian	Major	15.9%	7.5%
		First Nations (men and women)	Canadian				
Major	15.9%	7.5%					
<p>Métis:</p> <p>Data unavailable</p>							

	<p>depression: (the depression interferes with activities “some” or “a lot”).</p> <p>Consulted professional about emotional health in past year.</p>	16.6%	8.1%
<p>Factors considered very important to the difficulties in maintaining mental health (1997 RHS Saskatchewan Results):</p>			
Alcohol/drug abuse		68%	
Lack of trust		61%	
Acknowledging problems		60%	
Lack of First Nations staff		58%	
Lack of services		56%	
Lack of confidence		55%	
Family violence		54%	
Verbal abuse		54%	
Lack of role models		54%	
Reluctance to discuss emotions		54%	
Emotional abuse		54%	
Gambling addiction		52%	
Physical abuse		52%	
Elder abuse		50%	
Sexual abuse		50%	

Appendix D

Comparable Health Indicators Currently Unavailable for First Nations, Inuit and Métis populations

- 5.2 Life expectancy by socioeconomic status
- 5.3 Health-adjusted life expectancy (HALE) for overall population
- 5.4 Health-adjusted life expectancy (HALE) by socio-economic status
- 5.7.7 Five-year survival rates
 - 5.7.7.1 Five-year survival rate for lung cancer
 - 5.7.7.2 Five-year survival rate for prostate cancer
 - 5.7.7.3 Five-year survival rate for breast cancer
 - 5.7.7.4 Five-year survival rate for colorectal cancer
- 5.7.12 Incidence rate
 - 5.7.12.1 Incidence rate for lung cancer
 - 5.7.12.2 Incidence rate for prostate cancer
 - 5.7.12.3 Incidence rate for breast cancer
 - 5.7.12.4 Incidence rate for colorectal cancer
- 5.7.19 Incidence rates for invasive meningococcal disease
- 5.7.30 Teenage smoking rates: proportion current teenage smokers
- 5.7.31 Teenage smoking rates: proportion daily smokers
- 5.7.34 Immunization for influenza, aged 65 plus (“Flu shot”) (Feature in 2004)

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