

SACRED AND STRONG: UPHOLDING OUR MATRIARCHAL ROLES

THE HEALTH AND WELLNESS JOURNEYS OF BC FIRST NATIONS WOMEN AND GIRLS





We acknowledge with respect the territories on which much of this work took place, including those of the Esquimalt and Songhees Nations (ləkʷəŋən peoples) and W̱SÁNEĆ peoples in Victoria, BC, as well as the Sḵw̱w̱ú7mesh (Squamish), xʷməθkʷəy̓əm (Musqueam), and səliilwətaʔ4 (Tseil-Waututh) Nations in Vancouver, BC. We also gratefully recognize Métis Chartered Communities and the respective territories of all those who contributed stories to this work.



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INTRODUCTION

Sacred and Strong: Upholding Our Matriarchal Roles is a report on the health and wellness of First Nations women and girls in BC— from conception to Elderhood. Featuring both quantitative and qualitative data, this report carries the voices of over 120 women and girls who have shared their stories and lived experiences to speak as the people behind the numbers. Created in partnership between the First Nations Health Authority and the Office of the Provincial Health Officer, *Sacred and Strong* is grounded in the First Nations perspective of wholistic wellness. It celebrates the many ways that First Nations women and girls in BC are flourishing and brings to light where systemic barriers continue to negatively impact their health and self-determination.

This Technical Supplement serves as a companion to the main *Sacred and Strong* report published in July 2021. It includes detailed figures for quantitative data referenced throughout the main report that are not publicly available in other reports. A short statement of interpretation is presented alongside each figure to guide the reader through the data analyses. Page references linking the data analyses and the main report are also provided for each chart. Adapted text from the main report, seen in rounded text boxes, helps to ground readers in important concepts pertaining to topics covered in each chapter. Please refer to the main report for personal narratives, teachings, and other First Nations perspectives that provide important context to the data presented here.

CONSIDERATIONS

The data presented in this Technical Supplement are ordered by life phase, mirroring the structure of the *Sacred and Strong* report, with chapters dedicated to exploring wellness from conception through infancy, during childhood, youth, adulthood, and Elderhood.

Various populations of analysis are featured in this report. Survey results and other data sources are frequently disaggregated by gender, Indigeneity (e.g., Status First Nations, self-reported Indigenous), and age group. For specific definitions of populations of analysis, please refer to the Data Sources and Methodology chapter.

CHART LEGEND

The charts in this technical supplement use the following general colour scheme throughout. Each chart indicates the specific populations represented in the chart.

First Nations women and girls or Indigenous women and girls

First Nations men and boys or Indigenous men and boys

First Nations or Indigenous data that are not disaggregated by gender

Other Resident women and girls or non-Indigenous women and girls

Other Resident men and boys or non-Indigenous men and boys

Other Resident or non-Indigenous data that are not disaggregated by gender



DATA SOURCES AND METHODOLOGY

This chapter summarizes the data sources and methodology used in the charts presented in the *Sacred and Strong: Technical Supplement*. The *Sacred and Strong: Technical Supplement* serves as a companion to the main *Sacred and Strong: Upholding our Matriarchal Roles* report. It includes detailed figures for quantitative data referenced throughout the main report that are not publicly available in other reports.

DATA SOURCES

DATA GOVERNANCE AND LIMITATIONS

It is imperative to honour every data point included in the *Sacred and Strong: Technical Supplement*, as each one represents a unique individual who is a beloved member of a family, community, and a proud Nation. The First Nations Health Authority (FNHA) and the BC Office of the Provincial Health Officer are committed to upholding First Nations data governance principles and advancing First Nations' inherent right to control their own data. While self-determination of First Nations data is our ultimate goal, it should be noted that the data sets used in this report are BC-wide and not held by any one Nation, with most sources being external to the FNHA and the BC Ministry of Health.

This report presents data in a distinctions-based manner by specifying whether the data are from individuals who are Status First Nations or those who identify as Indigenous. We recognize that there are limitations to the data presented in this report, one being that the data may not reflect the diversity of First Nations individuals and their social identities (such as their gender). Most of the data reflect only binary sex categories (male/female), and not a full spectrum of gender identities. In most surveys, there is no differentiation between an individual's biologically determined sex and their gender (how a person self-identifies). This report includes almost exclusively provincial-level data and, on one occasion, data by regional health authority. However, the report fails to reflect the significant diversity across the more than 200 distinct and self-determining BC First Nations communities; the differences between urban, rural, and remote communities; and the differences between individuals living on reserve compared to away-from-home.

Finally, it should be noted that many of the data included in this report are dated and do not reflect the many social, cultural, economic, political, and legal changes that have occurred over the past decade. Furthermore, they do not fully account for the impacts of the ongoing public health emergencies in BC, such as the toxic drug crisis and the COVID-19 pandemic.

Please refer to the main report—*Sacred and Strong: Upholding our Matriarchal Roles*—for further comments on the full limitations of the data for this project.



FIRST NATIONS DATA AND WISDOM

First Nations have shared knowledge and history for thousands of years through oral storytelling.^b The *Sacred and Strong: Technical Supplement* honours this established way of knowing by including the histories and lived experiences of First Nations in BC throughout this report. These voices and histories are forms of First Nations data and wisdom that are held up as equally important to the quantitative, population health data primarily presented in this technical supplement.

REVIEWS, SURVEYS, AND CENSUS

The *Sacred and Strong: Technical Supplement* reports on data that have been collected and analyzed by other groups. This section summarizes these data sources and links the reader to published information on the reviews, surveys, and Census.


In Plain Sight Data Report

The Addressing Racism Review was an independent investigation into Indigenous-specific racism in the BC health care system, launched on July 9, 2020. The results of this investigation are presented in the report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, released by the BC Minister of Health and Hon. Dr. M.E. Turpel-Lafond (Aki-Kwe) on November 30, 2020 ([Full Report](#)) and February 4, 2021 ([Data Report](#)). The full report and its companion data report include data collected from almost 9,000 people in BC. These reports analyze health sector data via information solicited from the Addressing Racism Review (e.g., key informant interviews, emails) as well as data from other surveys and health administrative databases. A significant portion of the quantitative data used to populate *In Plain Sight* was provided by the FNHA. Some of the data reported in this technical supplement are sourced from the *In Plain Sight Data Report*.

First Nations Regional Health Survey

The [First Nations Regional Health Survey](#) (RHS) is part of a national health survey conducted by and for First Nations. It captures a snapshot of the health and wellness of First Nations people living on-reserve across Canada. The FNHA is responsible for gathering and sharing the knowledge from the BC survey on behalf of First Nations in BC. This technical supplement presents data from the first three phases of the RHS ([Phase 1 in 2002–03](#), [Phase 2 in 2008–10](#), and [Phase 3 in 2015–17](#)). The RHS includes questions specific to BC, many of which are analyzed and presented in this supplement.

Some RHS questions had response categories with numbers too small to report in this technical supplement. These numbers were rounded; therefore, the sum of responses across all categories might not add up to 100%.



The First Nations principles of OCAP^{®a}: ownership, control, access, and possession, are intended to be used as a tool to facilitate conversations between First Nations and those who hold First Nations data about how that information is collected, managed and shared.

OWNERSHIP: A community or group owns their information collectively, like an individual owns their personal information.

CONTROL: First Nations are within their rights to seek control over any aspects of research or information gathering that impacts them.

ACCESS: First Nations must have access to information and data about themselves and their communities regardless of where it is held.

POSSESSION: Ownership is asserted and protected by the physical control of the data. This may be implemented with stewardship agreements if physical possession is too costly or unwanted by a First Nation.

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.4)

a First Nations Information Governance Centre. The First Nations principles of OCAP [Internet]. Akwesasne, ON: First Nations Information Governance Centre. Available from: <https://fnigc.ca/ocap-training/>.

b Marshall M, Marshall A, Bartlett C. Two-eyed seeing in medicine. In: Greenwood M, de Leeuw S, Lindsay N, editors. Determinants of Indigenous peoples' health: beyond the social. 2nd ed. Toronto, ON: Canadian Scholars Press; 2015. pp. 44–53.

Early Years Development Instrument

The [Early Years Development Instrument](#) is an annual survey conducted by the [Human Early Learning Partnership](#) (HELP) research network at the University of British Columbia. In February, this survey is disseminated to kindergarten teachers who respond to the survey questions for each student in their class. The questions are focused on the following areas: physical health and well-being, language and cognitive development, social competence, emotional maturity, and communication skills and general knowledge. Together, the data collected using the Early Years Development Instrument can be strong predictors of adult health, education, and social outcomes. Participation is open to all schools in BC, including public, independent, and on-reserve schools. The data are collected in waves that aggregate results from several consecutive school years. This technical supplement reports on Wave 2 (2004–2007) through Wave 7 (2016–2019). Please refer to the [Early Development Instrument Interpretation Toolkit](#) for more information on the survey and its methods.

Middle Years Development Instrument

The [Middle Years Development Instrument](#) is an annual survey conducted by the [HELP](#) research network at the University of British Columbia. There are two questionnaires, one for children in grades 4–5, and another longer questionnaire for children in grades 6–8. The questions relate to five areas of development: physical health and well-being, connectedness, social and emotional development, school experiences, and use of after-school time. Participation is open to all schools in BC, including public, independent, and on-reserve schools. This technical supplement reports on surveys from the 2013/14 school year through the 2017/18 school year. At the recommendation of the HELP team, the data presented in this supplement are disaggregated by the two grade cohorts due to the unique experiences of the two cohorts across the various indicators. Please refer to [A Companion Guide to the Middle Years Development Instrument \(MDI\)](#) for more information on the survey and its methods.

Adolescent Health Survey

The [BC Adolescent Health Survey \(AHS\)](#) is conducted by the [McCreary Centre Society](#) every five years for youth in grades 7 to 12. The AHS reports on physical and emotional health, as well as factors that could impact youth health. The AHS is administered in public schools only and excludes, for example, schools on-reserve and independent schools. This technical supplement includes AHS data from 2003, 2008, and 2013.

Canadian Census

The Census Program, conducted by Statistics Canada, occurs every five years and includes the entire Canadian population: citizens, landed immigrants, as well as non-permanent residents and their households living with them in Canada. Foreign residents who are temporarily visiting or representing a foreign government are not included. The Census collects demographic, social, and economic information in two parts: a short Census survey administered to all households, and



a long-form survey (National Household Survey) administered to a subset of Census participants. This technical supplement reports on results from the 2016 Census and uses population data from the 2016 National Household Survey. In addition, the 2011 Census population is used as the standard population for age-standardized rates in this report, as explained in the Methodology section.

BC COVID-19 Survey on Population Experiences, Action and Knowledge

The BC COVID-19 Survey on Population Experiences, Action and Knowledge (SPEAK) was funded by the BCCDC Foundation for Public Health. The SPEAK data are publicly accessible in an [online dashboard](#), and additional details are published in a [technical guide](#). This technical supplement reports on SPEAK Round 1 only.

Patient Reported Experience Measures Acute Inpatient Survey

The Patient Reported Experience Measures Acute Inpatient Survey is led by the [BC Office of Patient-centred Measurement](#), and is part of a provincial strategy to measure and improve patient experiences and outcomes. This technical supplement presents data from the 2016/17 Acute Inpatient Survey, asking whether respondents felt that their care providers were respectful of their culture and traditions during their hospital stay in acute inpatient care. Responses reported from this survey are unweighted.



ADMINISTRATIVE HEALTH DATA

First Nations Client File

The First Nations Client File (FNCF) is a cohort of First Nations people who (a) are BC residents; (b) have health records that could be linked through their BC Personal Health Number; and (c) are either registered under the federal *Indian Act*, or descendants of registered individuals determined to be eligible under the *Indian Act*. While the FNCF is the best available cohort of Status First Nations people living in BC, there are some limitations; specifically, the number of infants has been underrepresented in the FNCF since 2012.

To conduct population data analysis for the *Sacred and Strong: Technical Supplement*, the FNCF was linked with administrative health databases including the following: BC Client Roster, BC Perinatal Data Registry, BC Vital Statistics Agency (Births), Medical Services Plan (MSP) Database, Hospital Discharge Records / Discharge Abstract Database, and the Chronic Disease Registry.

BC Client Roster

This BC Ministry of Health database is a roster of everyone who interacts with the BC health system. For this technical supplement, denominators for rates are sourced from the BC Client Roster when the numerator is based on administrative health data. The denominators are based on mid-year populations of people who live, or have lived, in BC and have registered for a Personal Health Number. Every person in the FNCF is also in the BC Client Roster.



BC Perinatal Data Registry

The [BC Perinatal Data Registry](#) captures data on almost all births in BC from over 60 hospitals, as well as births at home attended by registered midwives. In addition, this registry captures data on maternal postpartum readmissions up to 42 days post-delivery, as well as baby transfers and readmissions up to 28 days after birth. The registry sources data from obstetrical and neonatal medical records. This technical supplement reports from an extract of this data registry as of January 2018.

BC Vital Statistics Agency, Births

The [BC Vital Statistics Agency](#) registers births, marriages, deaths, and changes of name in BC. This technical supplement reports on [birth data](#) available from the Vital Statistics Agency up to December 2017, including birth weights, gestational age of baby at birth, as well as rates of pregnancies and abortions.

Medical Services Plan Database

This BC Ministry of Health database contains records of health services eligible to be billed to the BC Medical Services Plan (MSP). This includes all medically required services from general practitioners and specialists, as well as laboratory services and diagnostic procedures including x-rays and ultrasound examinations. Dental and oral surgery are included when performed in hospital. Some supplementary health care benefits (e.g., chiropractic, massage therapy, naturopathy, physiotherapy, non-surgical podiatry, and acupuncture services) are also provided through the MSP for specific eligibility groups.

Hospital Discharge Records / Discharge Abstract Database

This BC Ministry of Health database contains records of patients who are admitted to hospitals. Each record follows a patient in a facility from admission to discharge, transfer, or death. Patients who are transferred have a new record at the next facility. Records include International Classification of Diseases and Related Health Problems 10th Revision, Canada (ICD-10-CA) diagnosis codes that identify the causes, types, and locations of injury.

Chronic Disease Registry

The Chronic Disease Registry is created by the Office of the Provincial Health Officer using other BC Ministry of Health databases—specifically the Discharge Abstract Database, Pharmacy Dispenses database, and MSP database—to identify people living with specific chronic conditions. Membership in these registries is not based on medical diagnosis, but instead determined based on whether their use of the health care system matches the case definitions for that condition. The Chronic Disease Registry data as well as data notes are published in an [online dashboard](#).

HEALTH SURVEILLANCE DATA

Human Papillomavirus Immunization

The BC Centre for Disease Control and Vancouver Coastal Health Authority provide data on the Human Papillomavirus (HPV) immunization series. The *Sacred and Strong: Technical Supplement* reports on the percentage of young women who have completed the HPV immunization series prior to their 16th birthday.

Sexually Transmitted Infections

This technical supplement reports on the crude rate of sexually transmitted infections. This rate is provided by the BC Centre for Disease Control.

OTHER BC GOVERNMENT DATA

BC Ministry of Children and Family Development

The *Sacred and Strong: Technical Supplement* reports on two datasets provided by the BC Ministry of Children and Family Development. The first dataset reports the rates of youth in custody of the Provincial Corrections system from the Ministry's Specialized Intervention and Youth Justice Branch, using data from the BC Corrections Operations Network (CORNET). The second dataset reports the rates of children in care from the Ministry's Integrated Case Management System.

BC Ministry of Education

This technical supplement reports on two datasets provided by the BC Ministry of Education. The first is the Eight Year Completion Rate and the second is the annual School Satisfaction Survey for years 2010/11 to 2014/15. The School Satisfaction Survey has been renamed the [Student Learning Survey](#).

BC Ministry of Advanced Education and Skills Training

This technical supplement reports on two datasets provided by the BC Ministry of Advanced Education and Skills Training. The first dataset is the [Student Transitions Project](#), which provides data on the paths of BC students from high school to public post-secondary school in the province. The second dataset is the [Baccalaureate Graduate Survey](#). This survey asks graduates from baccalaureate programs about their financial, employment, and educational outcomes, as well as their evaluation of, and satisfaction with, their post-secondary education programs. Graduates are surveyed two years after graduation. This technical supplement reports on the surveys from 2014, 2015, and 2016 (for graduates completing programs in 2012, 2013, and 2014, respectively).

BC Ministry of Public Safety and the Solicitor General and BC Corrections

The BC Ministry of Public Safety and Solicitor General provided data on women in custody via the BC Corrections Operations Network (CORNET). This technical supplement reports on the rate of Indigenous women in custody.



METHODOLOGY

SURVEY DATA: WEIGHTING AND PERCENTAGES

The *Sacred and Strong: Technical Supplement* reports data from multiple survey sources. Unless otherwise stated in the chart notes or in this chapter, reported survey responses are weighted to align the surveyed population with the study population. Therefore, the percentages responding with a given survey answer represent the study population, not the survey population. This technical supplement also reports all response options for a survey, unless otherwise stated. Finally, in some cases, the sum of percentages across reported response options may not equal 100% due to rounding or omission of some response categories.

RATES

This technical supplement reports on several epidemiological rates—measures of the frequency of reported events in a specific population over a specific period of time. Unless otherwise stated, this technical supplement reports rates for a given calendar or fiscal year, so rates are often represented as a number of events per number of people in the study population (e.g., “10 per 100,000 population”). The following describes the types of rates reported in this work.

Crude Rate (e.g., Age-specific Rate)

A crude rate is an unadjusted rate where the numerator is the number of events, and the denominator is the size of the study population. Age-specific rates are an example of crude rates reported in this technical supplement and refer to crude rates for each age group. Crude rates represent the true frequency of events in the study population and can be used to determine the burden of a disease or condition in that population. They also account for the population size. However, if two populations have different age structures, it would not be meaningful to directly compare the crude rates, as differences in rates could be a result of differences in population ages rather than in the occurrence of the disease or condition.

Age-standardized Rate

An age-standardized rate is a rate adjusted to account for different age structures in addition to different population sizes. The adjustment is often made so that each reported rate is aligned with the age structure of a standard population. This technical supplement reports age-standardized rates using the 2011 Canadian population as the standard population. While age-standardized rates allow for comparison of frequency between two populations adjusting for both size and age, the absolute value of these rates does not have a real-world meaning. Age-standardized rates should not be used to infer an actual burden or magnitude of event frequency.

To calculate the age-standardized rate, first calculate the age-specific rates for each age group in the study population. Then, multiply these rates by the percentage of the standard population within the age group of that age-specific rate. Finally, sum these numbers. In other words, the age-standardized rate is calculated as a weighted average of the age-specific rates for the study population, where the weights are the percentage of the standard population within the age group for the corresponding age-specific rate.

PREVALENCE

Prevalence is the proportion of people within a population who are living with a specific condition. This technical supplement reports prevalence of certain conditions from the BC Chronic Disease Registry (see above). This includes age-specific prevalence of these conditions for a specified time period, as well as age-standardized prevalence of these conditions over a number of years. The latter is reported to compare the prevalence by sex and by First Nations identity. Prevalence is reported per 100 residents (i.e., a percentage).



PERINATAL AND INFANT WELLNESS



The perinatal period is an especially important time in the lives of First Nations women, during which their communities specifically honour them for their roles as life givers and celebrate births as sacred events. Each Nation has unique teachings, knowledge, and ceremonies around pregnancy, childbirth, and mothering, which are taught to girls and young women by the matriarchs in the community. While colonialism has privileged the Western biomedical approach to pregnancy, childbirth, and mothering with the intention of extinguishing First Nations ways of knowing, First Nations women are resilient; they are both maintaining and reclaiming their traditional protocols and ceremonies. The extended support of mothers, grandmothers, and aunts promotes and protects healthy child development and ensures the strength and continuity of future generations.¹

This chapter provides detailed charts for the findings presented in the Perinatal and Infant Wellness chapter of the report, *Sacred and Strong: Upholding our Matriarchal Roles*. The chapter focuses on the health and wellness of First Nations women throughout their pregnancy journeys and the birth of their newborns. It considers the sacred role that mothers and other matriarchs play in passing on First Nations knowledge, ceremonies, and wisdom, and reflects on the various systems that support women during this critical time. Please refer to the main report—[*Sacred and Strong: Upholding our Matriarchal Roles*](#)—for further interpretation of the data presented here.

HEALTHY, SELF-DETERMINING WOMEN, INFANTS & COMMUNITIES – ROOTS OF WELLNESS

Women are revered in First Nations communities and, in some Nations, they are seen as a bridge between the Spirit World and Earth, with childbirth being a sacred occasion connecting the two.² Connection to the land, water, and territory brings communities together to nurture the health and wellness of the expectant mother and unborn baby,³ and childbirth strengthens this connection to nature.⁴ The impacts of colonization, including environmental degradation and forced relocation, negatively impact First Nations women's wellness by disrupting the traditions, customs, and ceremonies which are vital for their reproductive health and self-determination.^{5,6,7,8,9,10}

Many First Nations communities are reclaiming cultural teachings, practices, and protocols around birth, pregnancy, and mothering. There is a growing desire to bring birth closer to home where these protocols and ceremonies can be honoured.^{11,12}

This section of *Sacred and Strong: Upholding our Matriarchal Roles* does not contain original chart-based data, so no charts are presented here. Please refer to the main report for more information about this topic.

This ability for First Nations women, mothers, and communities to pursue and participate in their own cultural practices at all points in their life, but particularly during pregnancy and childbirth, is a vital aspect of their self-determination.¹³ These practices and ways of knowing around life giving and childbirth are also considered fundamental to shaping the health and well-being of the community.¹⁴

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.8)



SUPPORTIVE SYSTEMS

First Nations traditions and protocols for pregnancy and childbearing embrace the physical, mental, emotional, and spiritual needs of women and their babies. These protocols have been excluded and undermined by the Western biomedical approach that emphasizes the physical aspects of childbirth.⁵ The ongoing intergenerational legacy of colonization and related policies, behaviours, and practices have resulted in frequent occurrences of anti-Indigenous racism during pregnancy and birth, which prevent many First Nations women from seeking and receiving safe prenatal and postpartum care.^{15,16} First Nations women have inherent rights to supportive systems, respectful relationships, and environments that prioritize culturally safe and trauma-informed care, to empower them to be self-determining when it comes to their pregnancy journeys.¹⁷

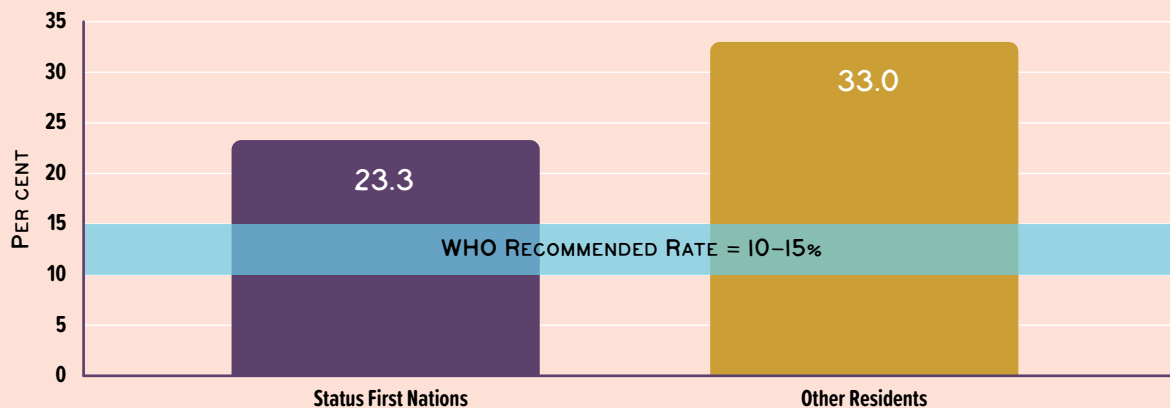
Refer to this page in the [Sacred and Strong](#) main report.



CAESAREAN SECTIONS

p.12

FIG 1.1 PERCENTAGE OF BIRTHS THAT WERE DELIVERED BY CAESAREAN SECTION, STATUS FIRST NATIONS AND OTHER RESIDENTS, BC, 2017/18



Notes: World Health Organization (WHO) has recommended a Caesarean section rate of 10% to 15%.

Source: Turpel-Lafond ME (Aki-Kwe). *In plain sight: addressing Indigenous-specific racism and discrimination in B.C. health care*. Data report. Victoria, BC: Addressing Racism Review; 2020. p.110.

The World Health Organization's (WHO) international recommendations for Caesarean sections consider an ideal rate to be between 10 and 15%.¹⁸ Based on data from *In Plain Sight* (2020), the percentage of Status First Nations births delivered by Caesarean section in 2017/18 (23.3%) was closer to this recommendation than the percentage of Other Resident births (33.0%). First Nations communities view birth as a celebration and are reclaiming birthing practices that rely on minimal medical interventions when it is safe for the mother and baby. First Nations identity is connected to the lands and waters of a given Nation; giving birth and being born in community is central to First Nations identity and wellness.¹⁹

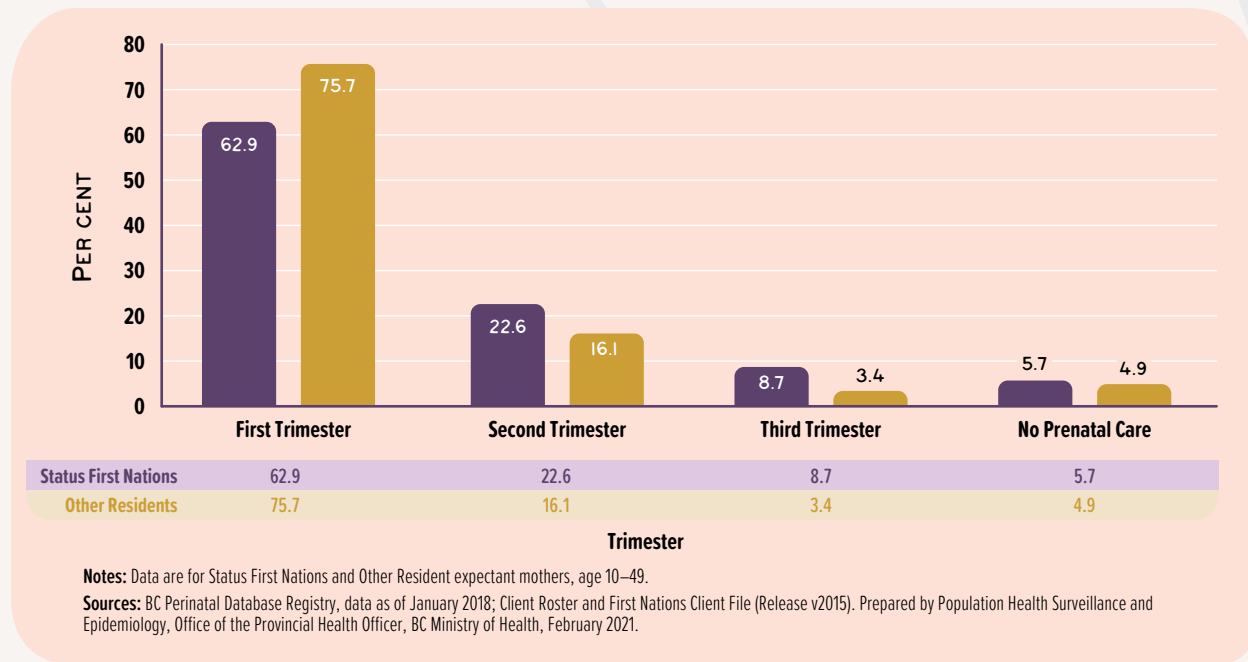




PRENATAL CARE

p.12

FIG I.2 PERCENTAGE BY TIMING OF FIRST PRENATAL VISIT AMONG EXPECTANT MOTHERS, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 10–49, BC, 2015



BC Perinatal Database Registry data indicated that in 2015, Status First Nations expectant mothers age 10–49 were less likely than Other Resident expectant mothers in the same age group to receive prenatal care for the first time in their first trimester. Status First Nations expectant mothers were more likely than Other Resident expectant mothers to receive prenatal care for the first time in their second and third trimesters, or to not receive prenatal care at any time during their pregnancy. First Nations women may face multiple barriers in accessing timely, adequate, and culturally safe prenatal care, especially in remote and rural communities where there may be fewer local providers.^{10,20,21}

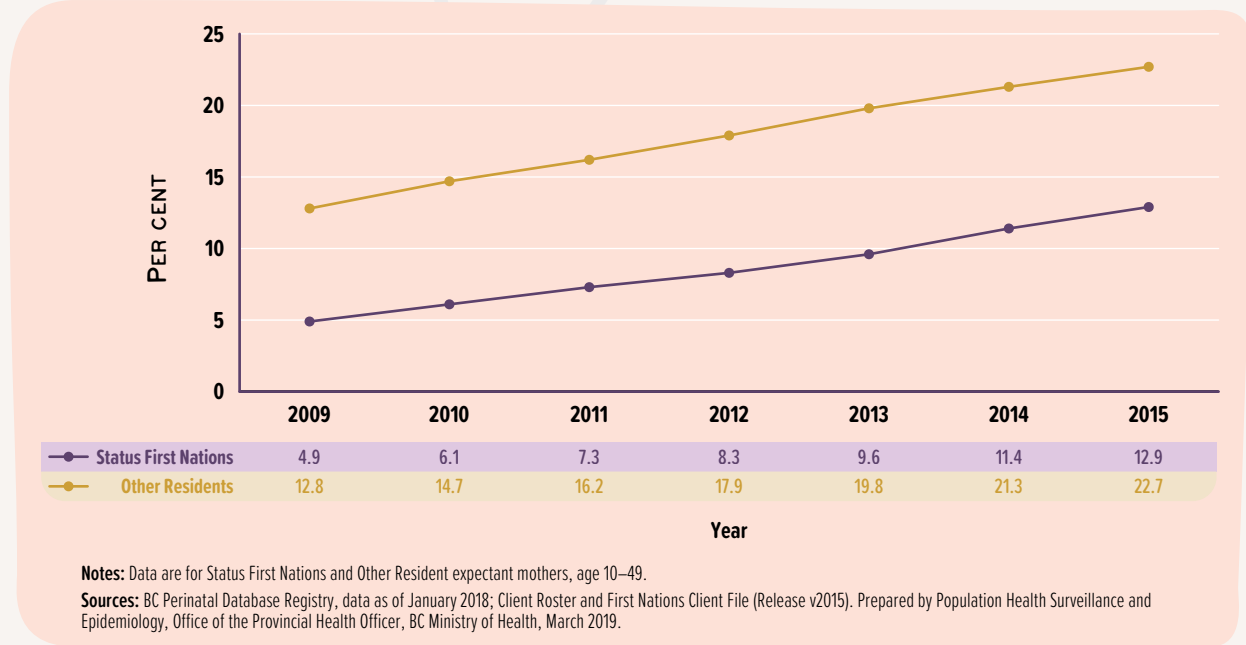




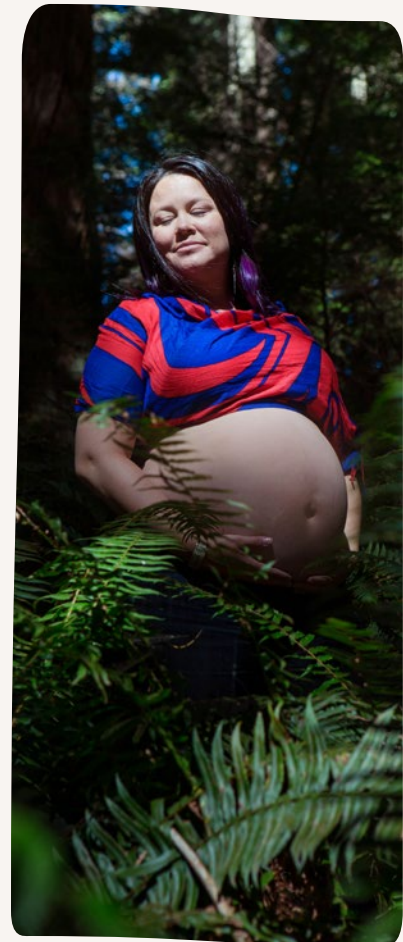
MIDWIVES

p.15

FIG I.3 PERCENTAGE OF EXPECTANT MOTHERS WITH MIDWIFE AS PRIMARY CARE PROVIDER DURING PREGNANCY, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 10–49, BC, 2009 TO 2015



BC Perinatal Database Registry data indicated that the percentage of Status First Nations expectant mothers age 10–49 with a midwife as their primary health care provider increased from 4.9% in 2009 to 12.9% in 2015. A lower percentage of Status First Nations expectant mothers had a midwife as their primary health care provider during pregnancy, compared to Other Resident expectant mothers, every year from 2009 to 2015. Midwives are the traditional birthing attendants in First Nations communities who assist with the physical and ceremonial aspects of childbirth throughout the perinatal and postpartum period.^{9,14,22,23} There has recently been a resurgence of First Nations midwives in Canada who are helping First Nations communities reclaim childbirth, and support families in bringing childbirth closer to home for rural and remote communities.¹⁴ However, Indigenous or First Nations-specific midwifery services may not be readily available or offered across the province, and may be especially difficult to access in rural and remote communities.^{23,24}



HEALTHY BODIES, MINDS AND SPIRITS

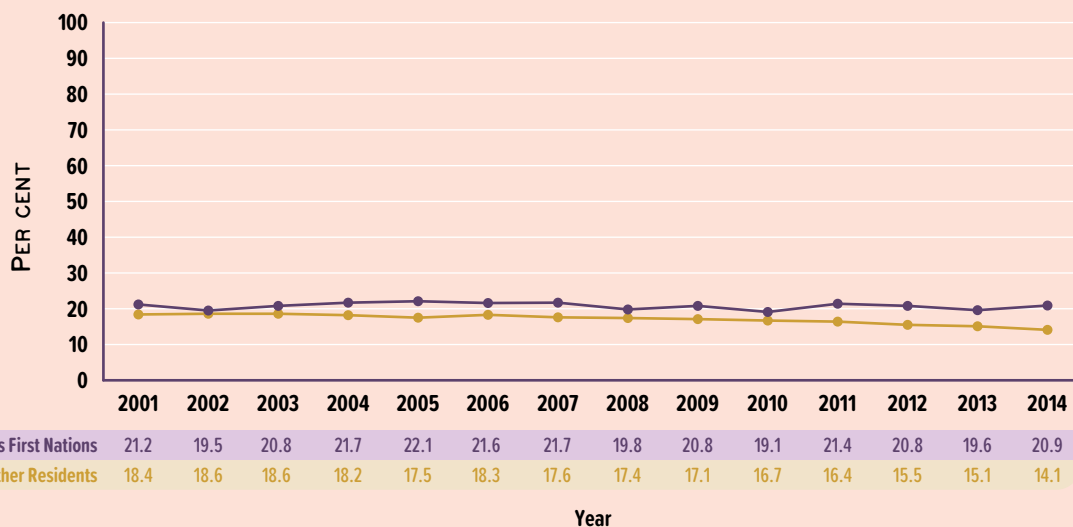


First Nations approaches to pregnancy place an emphasis on the physical, mental, emotional, and spiritual well-being of both the mother and unborn baby.⁸ The legacy and contemporary negative impacts of colonialism, attempted genocide, racism, and ongoing intergenerational traumas put undue stress on childbirth and create barriers for pregnant First Nations women to seek or access many of the wholistic traditional teachings critical to perinatal wellness. To address this, First Nations communities take a wholistic approach to supporting expectant mothers by guiding them in healthy practices and grounding them in traditional teachings.²⁴ Pregnant women are encouraged to surround themselves with positive relationships, reconnect with their culture to find strength and resilience, and strive for balance in all aspects of life.⁸

POSTPARTUM DEPRESSION

p-20

FIG 1.4 PERCENTAGE OF MOTHERS WHO RECEIVED HEALTH SERVICES FOR POSTPARTUM DEPRESSION, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 10–49, BC, 2001 TO 2014



Notes: Data are for Status First Nations and Other Resident mothers, age 10–49.

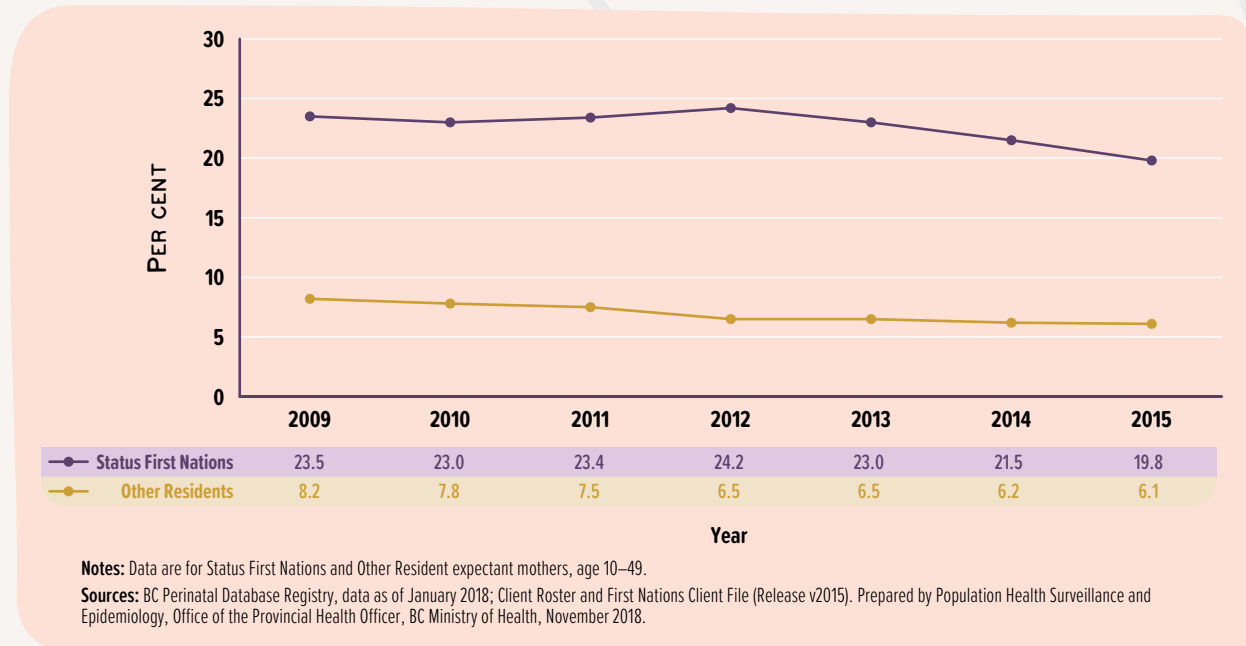
Sources: BC Vital Statistics Agency, data as of December 2017; Medical Services Plan, Client Roster and First Nations Client File (Release v2015). Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, March 2019.

From Medical Services Plan data, the percentage of Status First Nations mothers age 10–49 who received health services for postpartum depression (PPD) remained relatively stable from 2001 (21.2%) to 2014 (20.9%). A higher percentage of Status First Nations mothers received health services for PPD, compared to Other Resident mothers, every year from 2001 to 2014. In addition to receiving medical care for PPD, First Nations mothers may also find strength and resilience in their culture, identity, and relationship with the Creator when seeking to overcome PPD.^{24,25,26,27}

SMOKING COMMERCIAL TOBACCO DURING PREGNANCY

p.21

FIG 1.5 PERCENTAGE OF EXPECTANT MOTHERS WHO SMOKED DURING PREGNANCY, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 10–49, BC, 2009 TO 2015



From the BC Perinatal Database Registry, the percentage of Status First Nations expectant mothers age 10–49 who smoked during pregnancy decreased from 23.5% in 2009 to 19.8% in 2015. A higher percentage of Status First Nations expectant mothers smoked during pregnancy, compared to Other Resident expectant mothers, every year from 2009 to 2015.

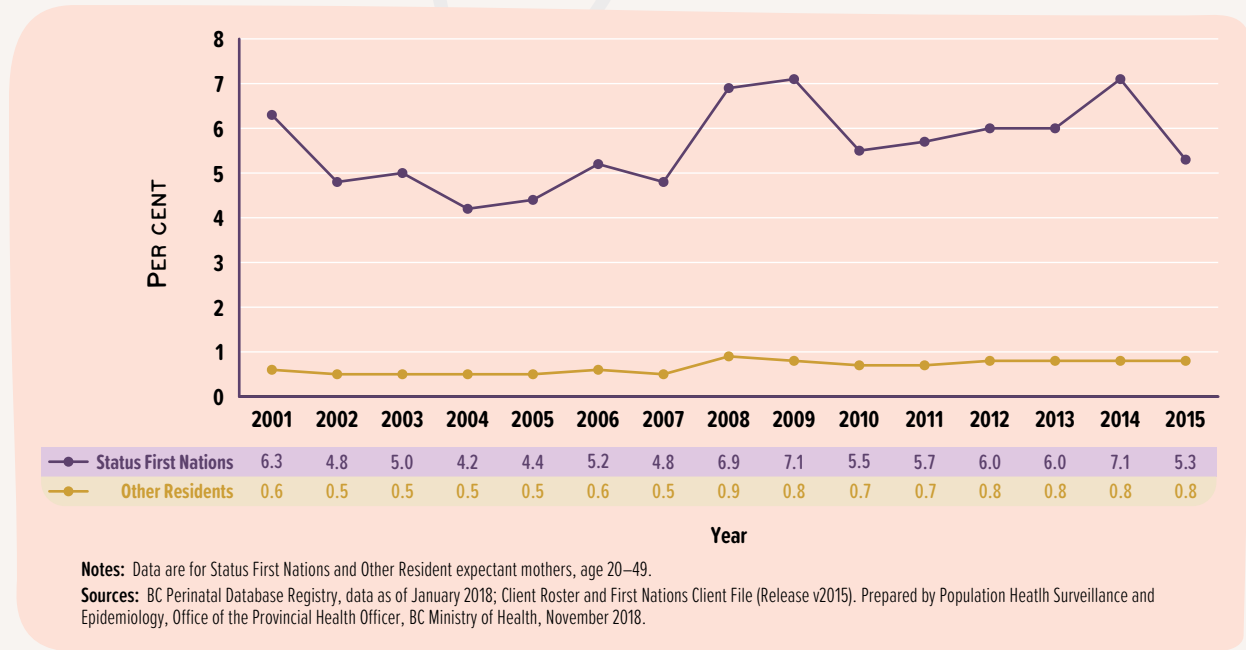
First Nations teachings encourage women to be mindful of what they are putting into their body, even before becoming pregnant. Historically, in some communities, pregnant First Nations women and even their partners were expected to refrain from using substances such as alcohol and drugs during the pregnancy period.²⁸

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.21)

ALCOHOL USE DURING PREGNANCY

p.21

FIG I.6 PERCENTAGE OF EXPECTANT MOTHERS WHO USED ALCOHOL DURING PREGNANCY, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 20–49, BC, 2001 TO 2015

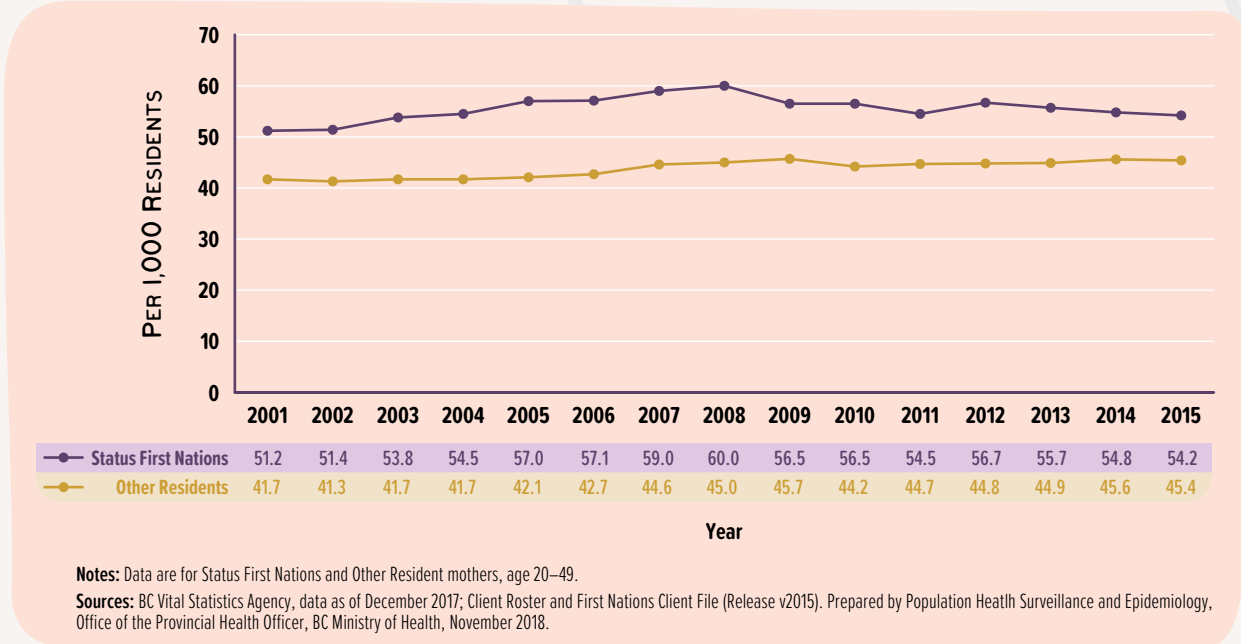


From the BC Perinatal Database Registry, the percentage of Status First Nations expectant mothers age 20–49 who used alcohol during pregnancy fluctuated from 2001 (6.3%) to 2015 (5.3%), reaching highs of 7.1% in 2009 and 2014, and a low of 4.2% in 2004. For some, substance use can provide a way of coping and living with the pain, trauma, loss, and intergenerational effects that are a direct result of racism and colonial systems and practices (e.g., residential school system, Sixties Scoop).²⁹ Pregnancy can be a time of healing for First Nations women, and some use it as an opportunity to step away from substances and focus on other coping methods. However, there may be barriers for First Nations women to seek support and access culturally appropriate services.^{30,31,32}

LIVE BIRTH RATES

p.24

FIG I.7 LIVE BIRTH RATE AMONG STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 20–49, BC, 2001 TO 2015



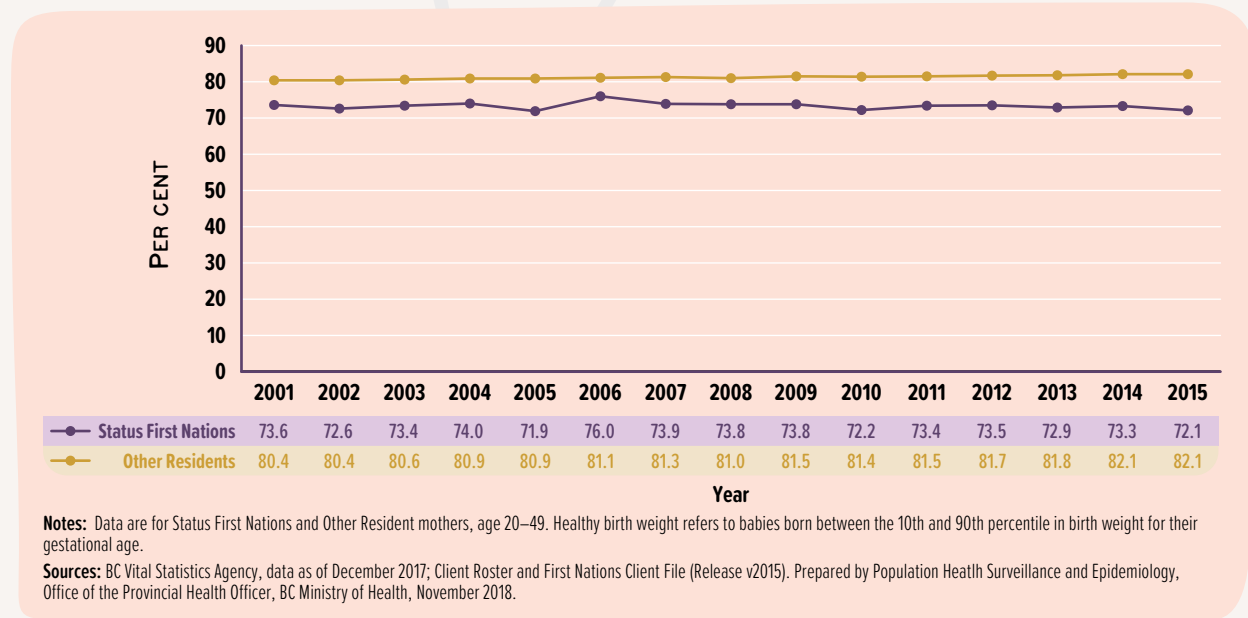
From the BC Vital Statistics Agency, the live birth rate among Status First Nations women age 20–49 increased from 51.2 per 1,000 residents in 2001 to 54.2 per 1,000 residents in 2015. The live birth rate was higher for Status First Nations women every year from 2001 to 2015, compared to the live birth rate for Other Resident women. This is a non-standardized way to capture fertility rate and population growth, but this finding indicates a higher population growth among Status First Nations in BC compared to Other Residents.



HEALTHY BIRTH WEIGHTS

p.24

FIG I.8 PERCENTAGE OF LIVE BIRTHS WITH HEALTHY BIRTH WEIGHTS, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 20–49, BC, 2001 TO 2015

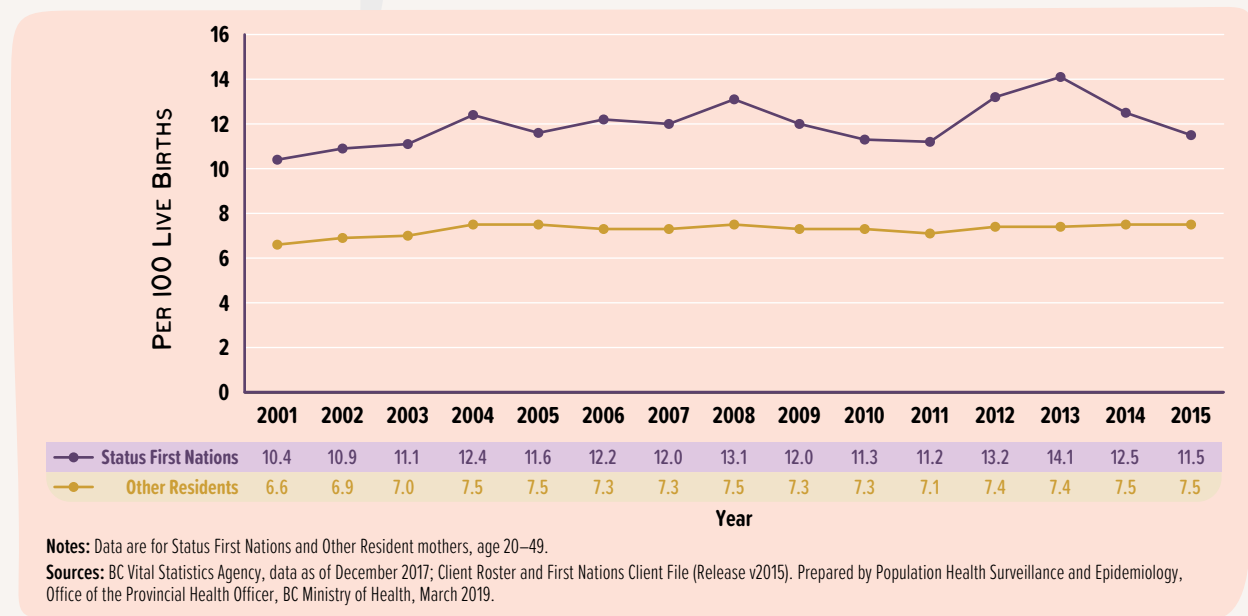


From the BC Vital Statistics Agency, the percentage of live births that were of healthy birth weight among Status First Nations mothers age 20–49 remained relatively stable from 2001 (73.6%) to 2015 (72.1%). This percentage was lower for Status First Nations births, compared to Other Resident births, every year from 2001 to 2015.

PRETERM BIRTHS

p.24

FIG I.9 CRUDE PRETERM BIRTH RATE, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 20–49, BC, 2001 TO 2015



From the BC Vital Statistics Agency, the crude preterm birth rate among Status First Nations mothers age 20–49 fluctuated from 10.4 per 100 live births in 2001 to 11.5 per 100 live births in 2015, reaching a high of 14.1 in 2013 and a low of 10.4 in 2001. The crude preterm birth rate was higher for Status First Nations mothers every year from 2001 to 2015, compared to the crude preterm birth rate for Other Resident mothers.



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CHILD WELLNESS



Children are considered sacred gifts from the Creator, and their health and happiness reflect the well-being of the community.^{1,2} Childhood is an important time in life when First Nations girls establish social and familial connections, are shaped by their environments, and nourish their bodies in a way that impacts their future health outcomes.³ BC First Nations believe there is a collective responsibility to care for, educate, and mentor their children.⁴ However, the racist systems, institutions, and policies of settler colonialism have attempted to break the vital networks of support around First Nations girls, and disrupted the rituals, cultural practices, and passage of teachings.^{4,5} Racist, sexist, and misogynist policies and practices across the health, education, and child welfare systems create barriers for First Nations girls, but they have learned from their matriarchs, mothers, aunts, and grandmothers to be resilient and to assert their rights to health and wellness.

This chapter provides detailed charts for findings presented in the Child Wellness chapter of the report *Sacred and Strong: Upholding our Matriarchal Roles*. The chapter focuses on the health and wellness of First Nations girls. It demonstrates how young First Nations children flourish when connected to culture and community, and it speaks to the various support systems needed to ensure healthy development throughout their childhood years. Please refer to the main report—[*Sacred and Strong: Upholding our Matriarchal Roles*](#)—for further interpretation of the data presented here.

HEALTHY, SELF-DETERMINING CHILDREN & COMMUNITIES – ROOTS OF WELLNESS

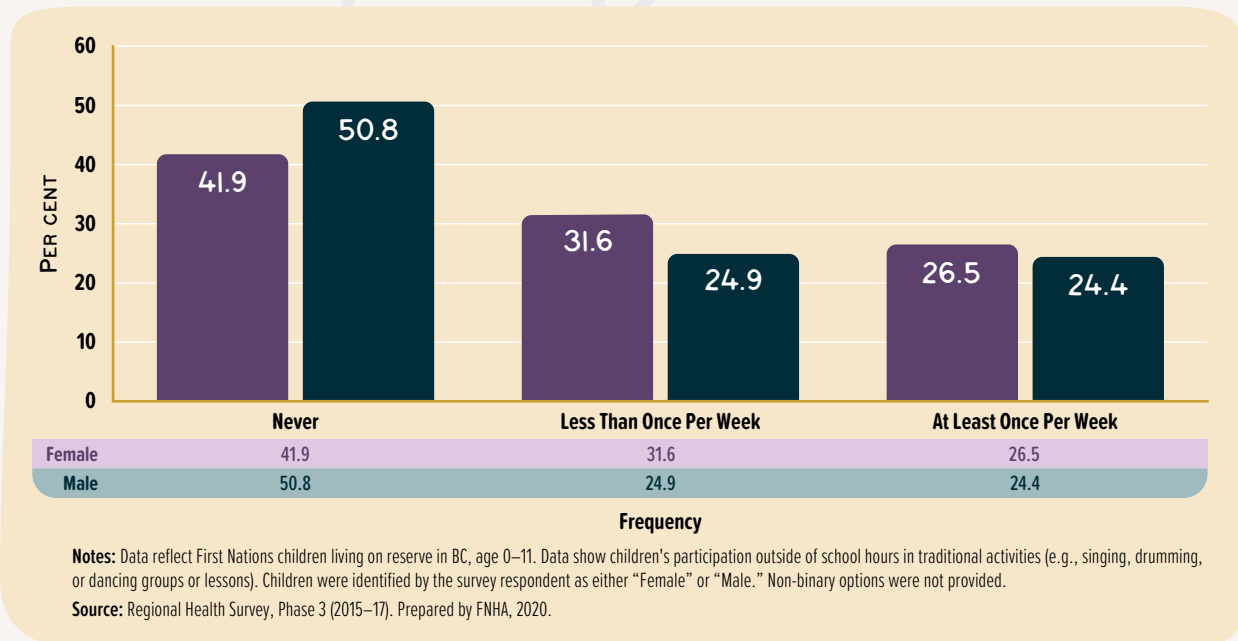


Childhood is a pivotal time when the roots of wellness are established. Developing strong connections to the land, community, and culture during the early years forms a foundation for health and well-being throughout life. Families and communities play a vital role in providing First Nations girls with unique teachings and ceremonies to empower them with knowledge about ways of being in the world, how to respect and care for themselves, as well as their roles and responsibilities in the community.⁶

PARTICIPATION IN CULTURAL EVENTS

p-29

FIG 2.1 PERCENTAGE WHO REPORTED PARTICIPATION IN CULTURAL EVENTS IN THEIR LOCAL COMMUNITY, FIRST NATIONS CHILDREN, AGE 0–11, BY SEX, BC, 2015–17

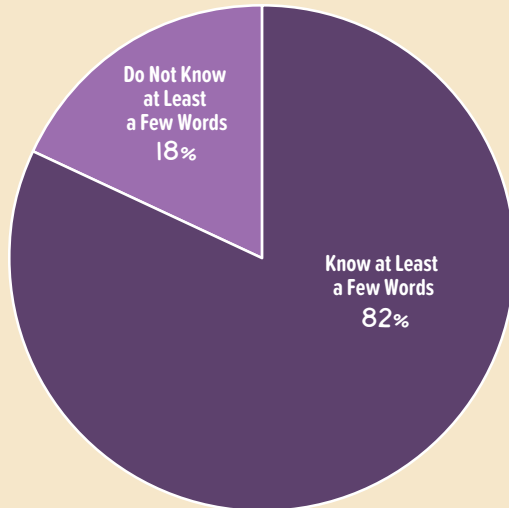


From Regional Health Survey, Phase 3 (RHS3; 2015–17), more than half (58.1%) of First Nations girls age 0–11 participated in cultural activities including singing, drumming, or dancing: 26.5% participated at least once per week, and 31.6% participated less than once per week. First Nations girls were more likely than First Nations boys in the same age group to participate in cultural activities less than once per week (31.6% vs. 24.9%) and at least once per week (26.5% vs. 24.4%). Participation in cultural activities, rituals, and ceremonies grounds First Nations girls in their culture at a young age.⁷ Cultural activities range from beading, drumming, dancing, and the potlatch, to being out on the land gathering and preparing food, to learning their language from their Elders.⁷

FIRST NATIONS LANGUAGE

p.29

FIG 2.2 FIRST NATIONS GIRLS WHO REPORTED KNOWING AT LEAST A FEW WORDS OF THEIR NATION'S LANGUAGE, AGE 0–11, BC, 2015–17



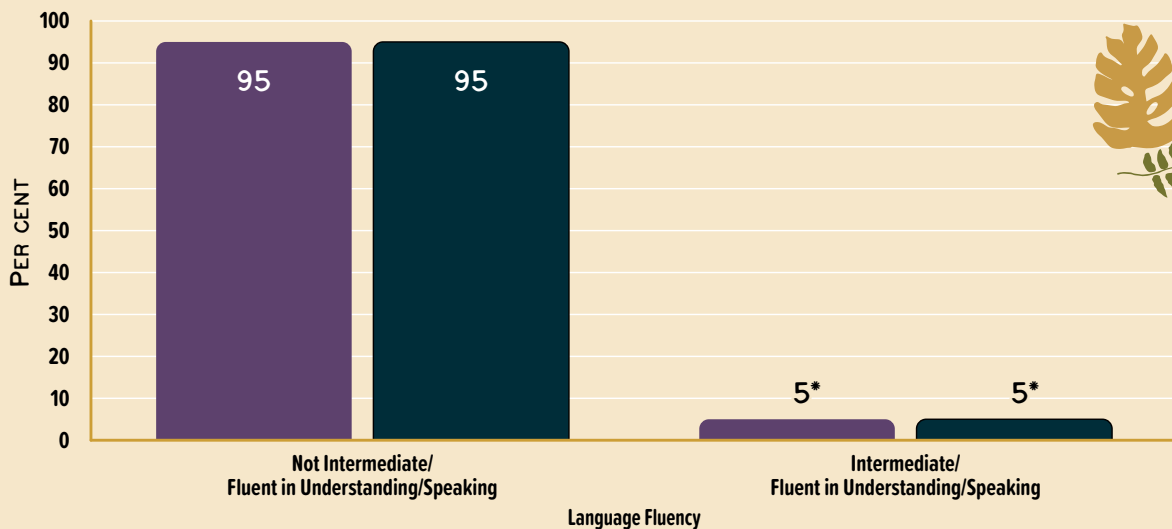
Notes: Data reflect First Nations girls living on reserve in BC, age 0–11, who reported being able to speak at least a few words of their Nation's language. Children were identified by the survey respondent as "Female." Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

An increasing number of First Nations people in BC are learning their traditional language, the majority being children and youth under the age of 25.⁸ From RHS3 (2015–17), 82% of First Nations girls age 0–11 knew at least a few words of their Nation's language. Some First Nations individuals take part in language nests and immersion programs provided by communities and spend about three hours a day immersed in their traditional language.⁸

p.29

FIG 2.3 LANGUAGE FLUENCY AMONG FIRST NATIONS CHILDREN WHO REPORTED KNOWING AT LEAST A FEW WORDS OF THEIR NATION'S LANGUAGE, AGE 0–11, BY SEX, BC, 2015–17



Notes: "*" means the percentage should be interpreted with caution due to a high coefficient of variation ($0.333 \geq CV \geq 0.166$). Data reflect First Nations children living on reserve in BC, age 0–11, who reported being able to speak at least a few words of their Nation's language. Children were identified by the survey respondent as "Female" or "Male." Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

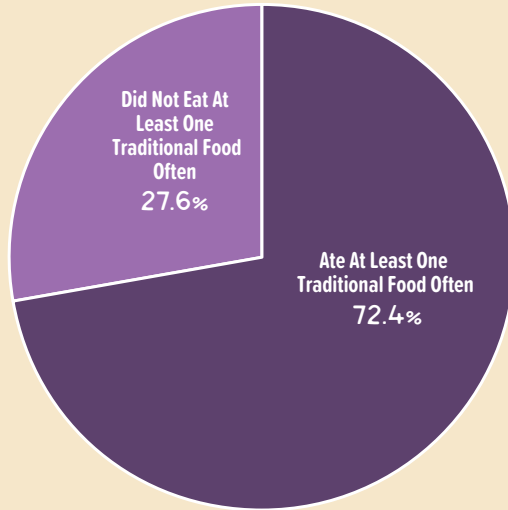
From RHS3 (2015–17), of the First Nations girls age 0–11 who knew at least a few words of their Nation's language, 5% were intermediate or fluent in speaking *and* understanding the language.



FIRST NATIONS FOODS

p.29

FIG 2.4 FIRST NATIONS GIRLS WHO REPORTED EATING TRADITIONAL FOODS (NOT INCLUDING BANNOCK) "OFTEN" IN THE PAST YEAR, AGE 0–11, BC, 2015–17



Notes: Data reflect First Nations girls living on reserve in BC, age 0–11, who reported eating at least one type of traditional food (not including bannock) “often” in the past 12 months. Children were identified by the survey respondent as “Female.” Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

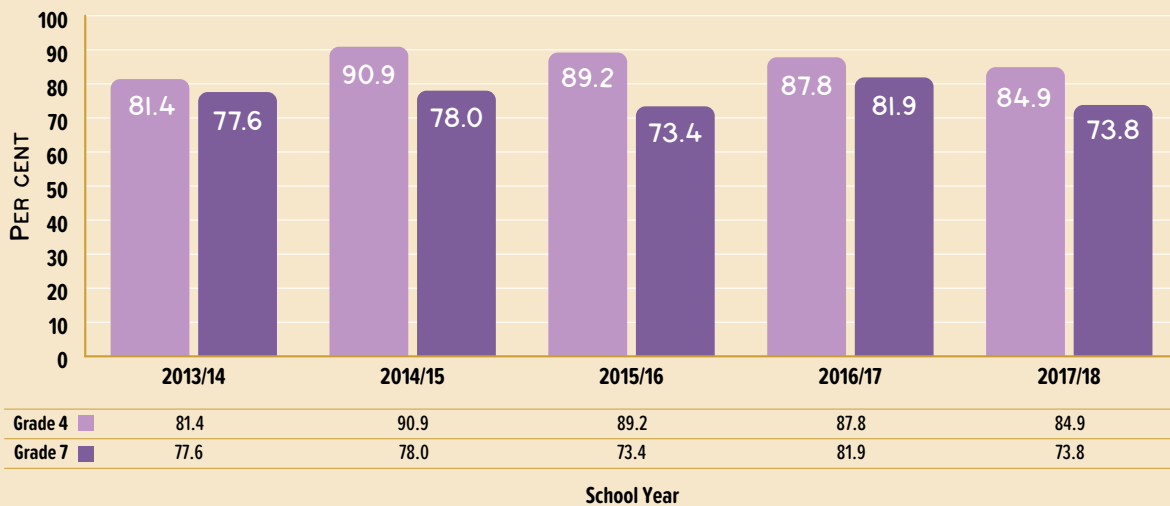
From RHS3 (2015–17), 72.4% of First Nations girls age 0–11 ate at least one traditional food (other than bannock) “often” in the past year. Land-based education initiatives, such as the Aboriginal Head Start On Reserve program,⁹ promote access to traditional foods by allowing First Nations children to take part in hunting, gathering, and food preparation activities.



CARING ADULTS

p.29

FIG 2.5 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED “MEDIUM” OR “HIGH” SCORES ON THE ADULT RELATIONSHIPS ASSET, BY GRADE, BC, 2013/14 TO 2017/18



Notes: Data reflect responses from students in grades 4 and 7, attending school in BC, who self-identified as Indigenous and “Female.” Non-binary options were not provided. “High” scores reflect that on average, responses were “Pretty Much True” or “Very Much True,” and “Medium” scores reflect that on average, responses were “A Little True” or a mix of positive and negative responses.

Source: Human Early Learning Partnership, Middle Years Development Instrument, 2013/14 to 2017/18. Prepared by FNHA.

Many of the charts in this chapter use data from the [Early Years Development Instrument \(EDI\)](#) or the [Middle Years Development Instrument \(MDI\)](#). These are surveys conducted by the [Human Early Learning Partnership](#) research network at the University of British Columbia.

To see how EDI and MDI data in this report compare with trends in the general population, please refer to the [EDI BC 2019 Provincial Report](#) and [MDI Data Highlights and Trends 2019–20](#).

For more information on these surveys, please refer to the “Data Sources and Methodology” chapter of this technical supplement. Interpretation guides are also available:

[EDI Interpretation Toolkit](#)

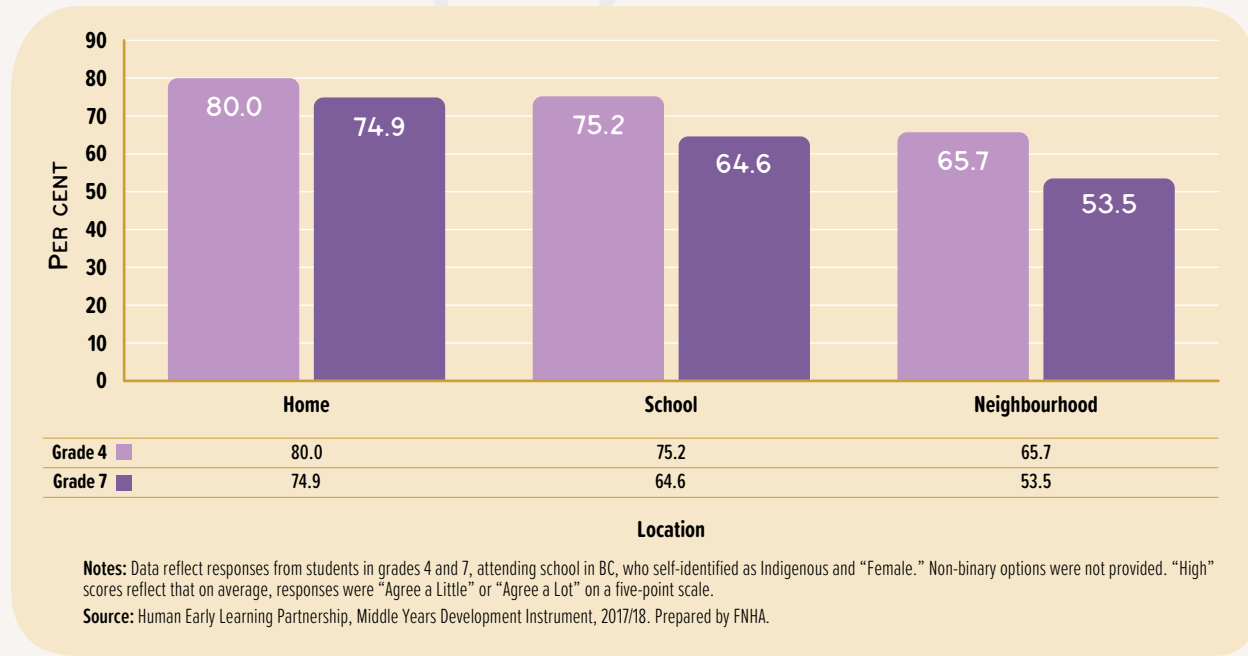
[MDI Companion Guide](#)

Having strong connections to adults in the community allows First Nations girls to feel a sense of belonging. These attachments are critical to the growth and development of First Nations girls and can have significant positive impacts on their lives.⁵ For each school year from 2013/14 through 2017/18, data from the Middle Years Development Instrument (MDI) showed that Indigenous girls in grade 4 were more likely to report average responses of “a little true” or higher on the Adult Relationships asset than Indigenous girls in grade 7. The Adult Relationships asset includes three measures of adult relationships—in the school, home, and community—and includes statements such as “At my school there is an adult who really cares about me,” and “In my home there is a parent or another adult who believes I will be a success.”



p.29

FIG 2.6 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED THAT THEY HAD SUPPORTIVE RELATIONSHIPS WITH CARING ADULTS, BY GRADE AND LOCATION, BC, 2017/18



Data from the 2017/18 MDI showed that a greater proportion of Indigenous girls in grade 4 than grade 7 had “high” scores in the Connectedness dimension, on statements like “At my school there is an adult who really cares about me,” and “In my neighbourhood/community (not from your school or family), there is an adult who believes that I will be a success.”

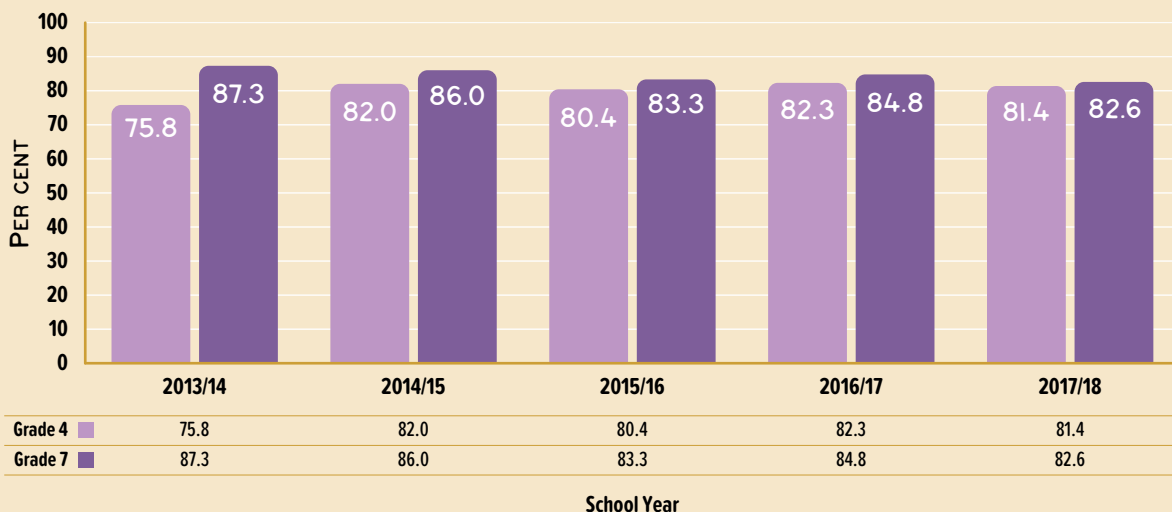




MEALS AT HOME WITH ADULTS

p.29

FIG 2.7 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED HAVING MEALS AT HOME WITH ADULTS AT LEAST THREE TIMES PER WEEK, BY GRADE, BC, 2013/14 TO 2017/18



Notes: Data reflect responses from students in grades 4 and 7, attending school in BC, who self-identified as Indigenous and “Female.” Non-binary options were not provided. Data reflect the proportion of respondents who reported eating meals at home either “3–4 Times a Week” or “5 or More Times a Week.”

Source: Human Early Learning Partnership, Middle Years Development Instrument, 2013/14 to 2017/18. Prepared by FNHA, 2020.



For each school year from 2013/14 through 2017/18, MDI data showed that a higher proportion of Indigenous girls in grade 7 than grade 4 reported having had meals with adults at home at least three times per week. Having meals at home can strengthen family bonds, as it provides time for parents and caregivers to connect and provide support to the children. Children who regularly eat meals with their family have higher self-esteem, hold a more positive view of the future, and are more likely to possess social resistance skills used to combat peer pressure.¹⁰



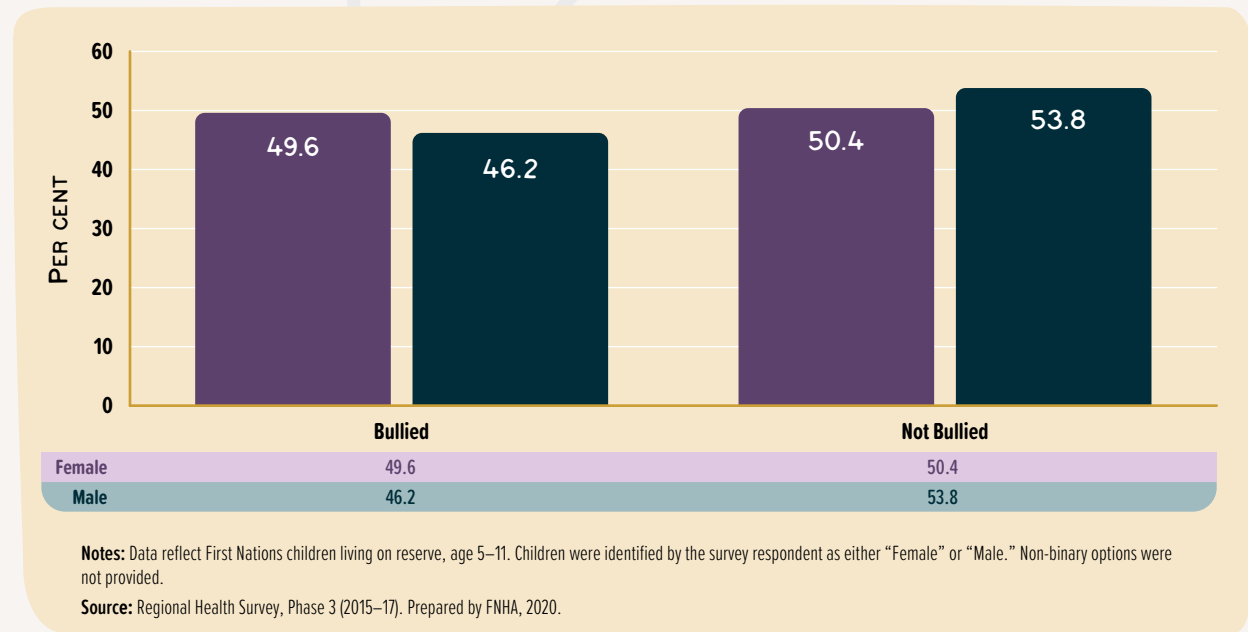
SUPPORTIVE SYSTEMS

Children are the heart of First Nations families, communities, and Nations. Childhood is a formative time for First Nations girls, and it is the community’s responsibility to provide them with guidance, support, and cultural practices that enable them to flourish. However, many of the anti-Indigenous, racist policies and practices that First Nations girls interact with in the education, health care, and housing systems remain deeply rooted in settler colonialism.^{11,12} Elders and matriarchs lead the way forward, continue to assert their inherent rights, and advocate for the dismantling of systems that undermine the health and wellness of their children, promoting supportive systems that enable First Nations girls to thrive and live up to their potential.

BULLYING

p.32

FIG 2.8 PERCENTAGE OF FIRST NATIONS CHILDREN WHO REPORTED BEING BULLIED OR NOT BULLIED IN THE PAST YEAR, AGE 5–11, BY SEX, BC, 2015–17



From RHS3 (2015–17), a higher percentage of First Nations girls age 5–11 were bullied in the past year compared to First Nations boys (49.6% vs. 46.2%). First Nations girls have incredible strength that has been learned and inherited from previous generations of matriarchs. Unfortunately, many continue to be subjected to emotional, physical, spiritual, and psychological traumas due to persistent settler colonial oppression and targeted anti-Indigenous racism, which is often compounded by sexism and misogyny.¹³

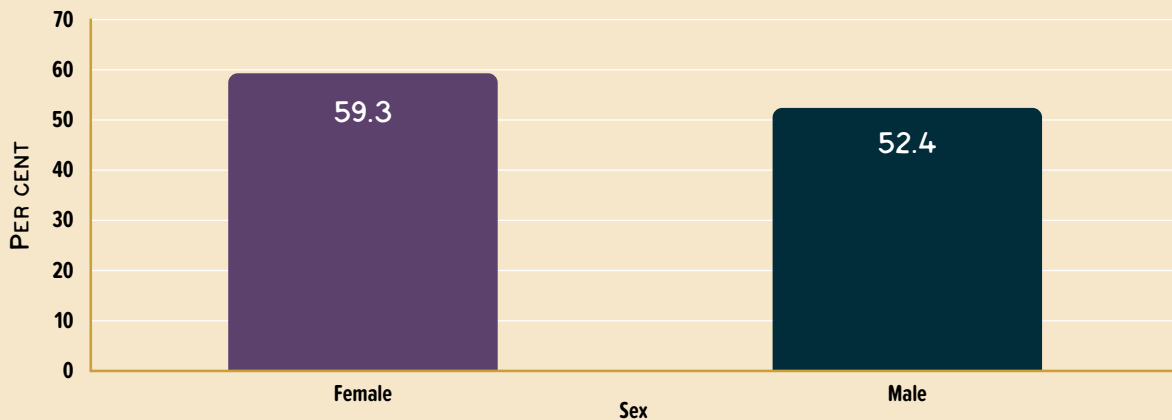




ABORIGINAL HEAD START ON RESERVE

p.33

FIG 2.9 PERCENTAGE OF FIRST NATIONS CHILDREN WHO HAD EVER ATTENDED AN ABORIGINAL HEAD START ON RESERVE PROGRAM, AGE 0–11, BY SEX, BC, 2015–17



Notes: Data reflect First Nations children living on reserve, age 0–11. Children were identified by the survey respondent as either “Female” or “Male.” Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

From RHS3 (2015–17), a higher percentage of First Nations girls age 0–11 had attended—at some point—an Aboriginal Head Start On Reserve program, compared to First Nations boys (59.3% vs. 52.4%). First Nations cultures view learning as a wholistic, experiential process embedded not only in the mainstream classroom setting, but in all aspects of life. First Nations children are exposed to teachings grounded in land, culture, and language.¹⁴

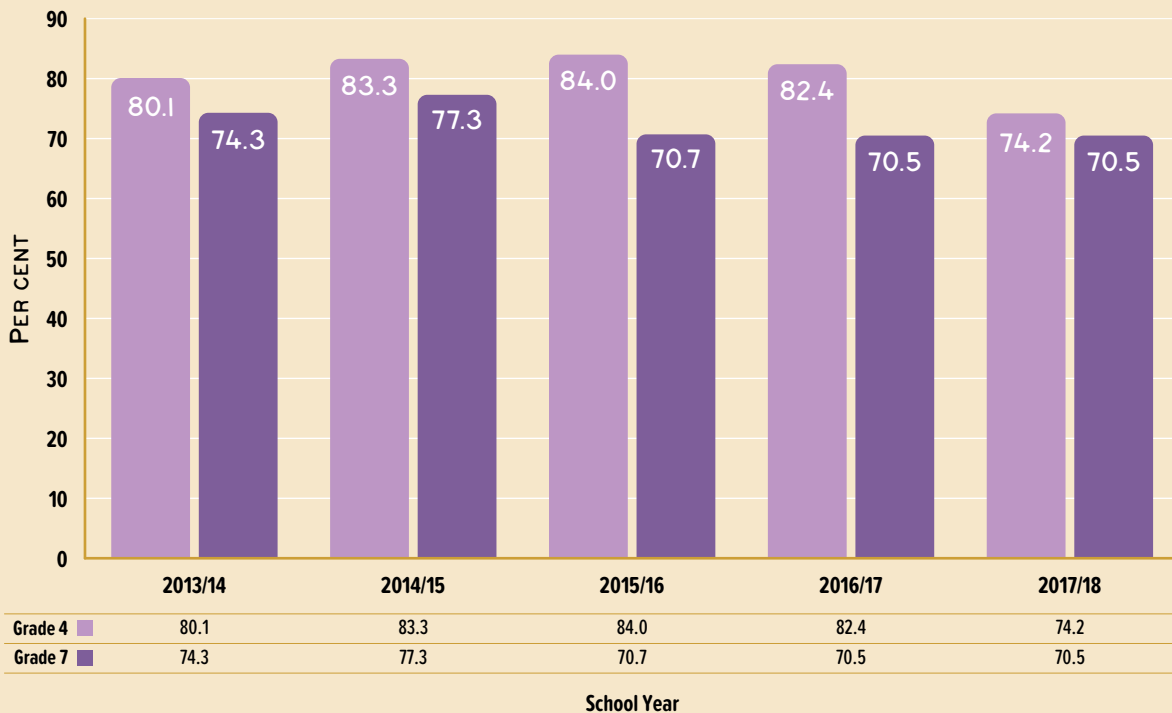




ACADEMIC SELF-CONCEPT

p.33

FIG 2.10 PERCENTAGE OF INDIGENOUS GIRLS WHO HAD “HIGH” SCORES ON THE ACADEMIC SELF-CONCEPT MEASURE, BY GRADE, BC, 2013/14 TO 2017/18



Notes: Data reflect responses from students in grades 4 and 7, attending school in BC, who self-identified as Indigenous and “Female.” Non-binary options were not provided. “High” level of confidence reflects children whose average responses were “Agree a Little” or “Agree a Lot” on a five-point scale, across three elements.

Source: Human Early Learning Partnership, Middle Years Development Instrument, 2013/14 to 2017/18. Prepared by FNHA, 2020.



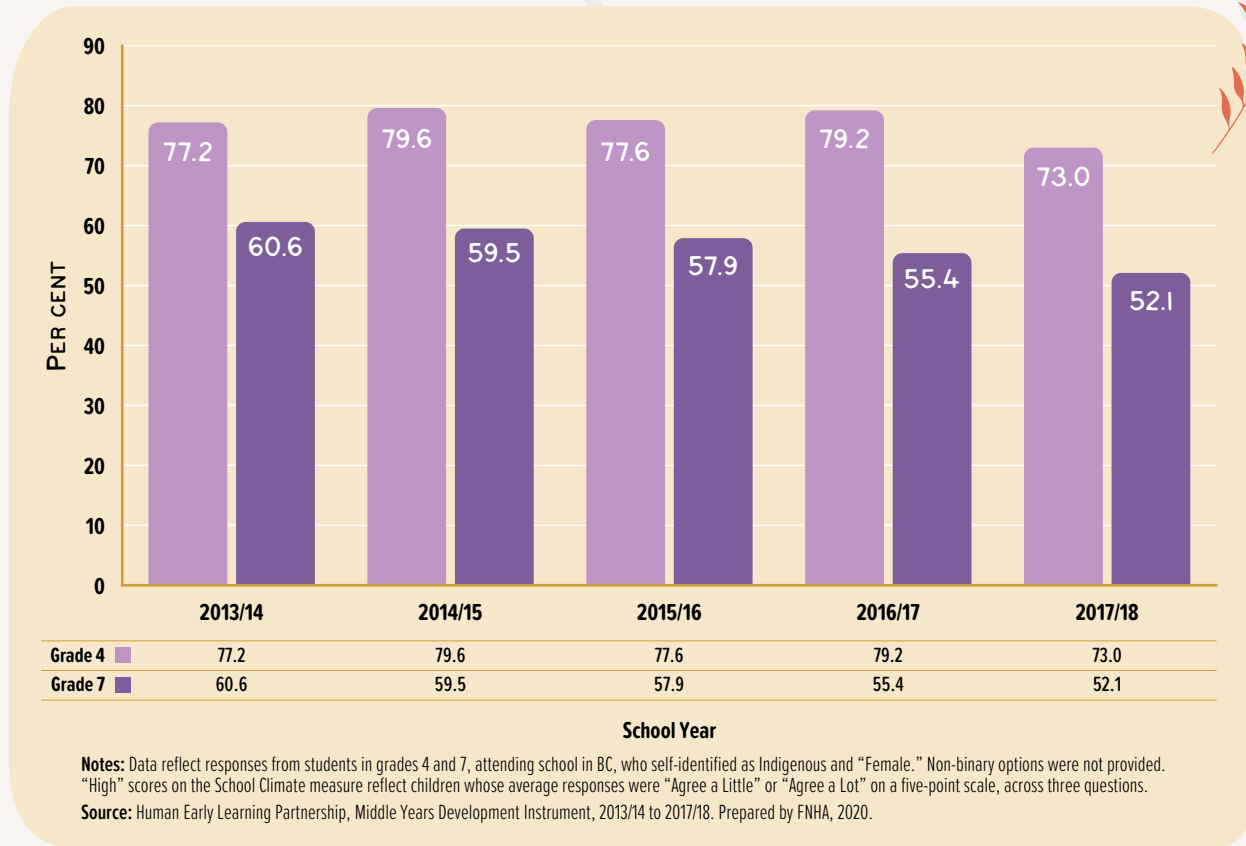
In each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 had “high” scores on the Academic Self-concept measure, on statements like “I am certain I can learn the skills taught in school this year,” and “If I have enough time, I can do a good job on all my school work.” The development of emotional, physical, intellectual, and spiritual capacities in the first six years of life is crucial to the development of a child’s identity and sense of self, as this is when the foundation for self-esteem and pride in community and culture is established.¹⁵ It is important to ensure that First Nations children have opportunities in the mainstream settler colonial education system to learn about their cultures and history prior to contact, as well as to restore First Nations self-determination in education.¹⁶



SCHOOL SUPPORT AND BELONGING

p.34

FIG 2.II PERCENTAGE OF INDIGENOUS GIRLS WHO HAD “HIGH” SCORES ON THE SCHOOL CLIMATE MEASURE, BY GRADE, BC, 2013/14 TO 2017/18



Children are best able to learn in environments where they feel safe, cared for, and supported.¹⁷ For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 had “high” scores on the School Climate measure of the School Experiences dimension, on statements like “Teachers and students treat each other with respect in this school,” and “People care about each other in this school.” This difference in reported “high” scores between Indigenous girls in grade 4 and grade 7 is concerning, and further information is needed to understand the root causes. The necessary work ahead to ensure that Indigenous girls continue to feel safe, accepted, and cared for throughout their school years will require committed partners working with intention and accountability.

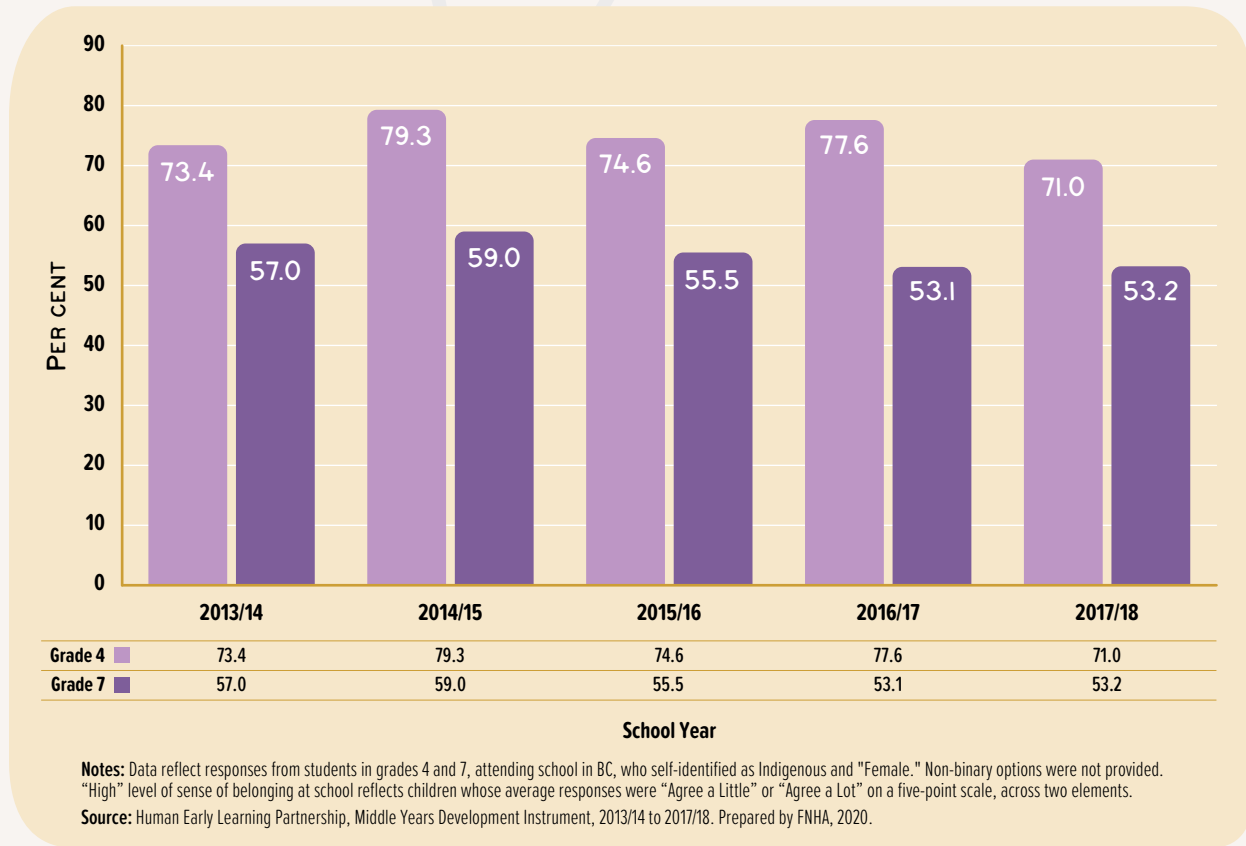




STRONG SENSE OF BELONGING AT SCHOOL

p.34

FIG 2.12 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED FEELING A STRONG SENSE OF BELONGING AT SCHOOL, BY GRADE, BC, 2013/14 TO 2017/18



For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 had “high” scores on the School Belonging measure of the School Experiences dimension, on statements like “I feel like I belong in this school,” and “I feel like I am important to this school.” This trend is consistent across school years and is of significant concern. More work is needed to understand why results for school belonging are consistently lower for Indigenous girls in grade 7 than in grade 4. It is especially important to address this trend early on, as school belonging is associated with better academic motivation and competence, higher self-esteem, lower emotional distress, and the likelihood of completing high school.¹⁸

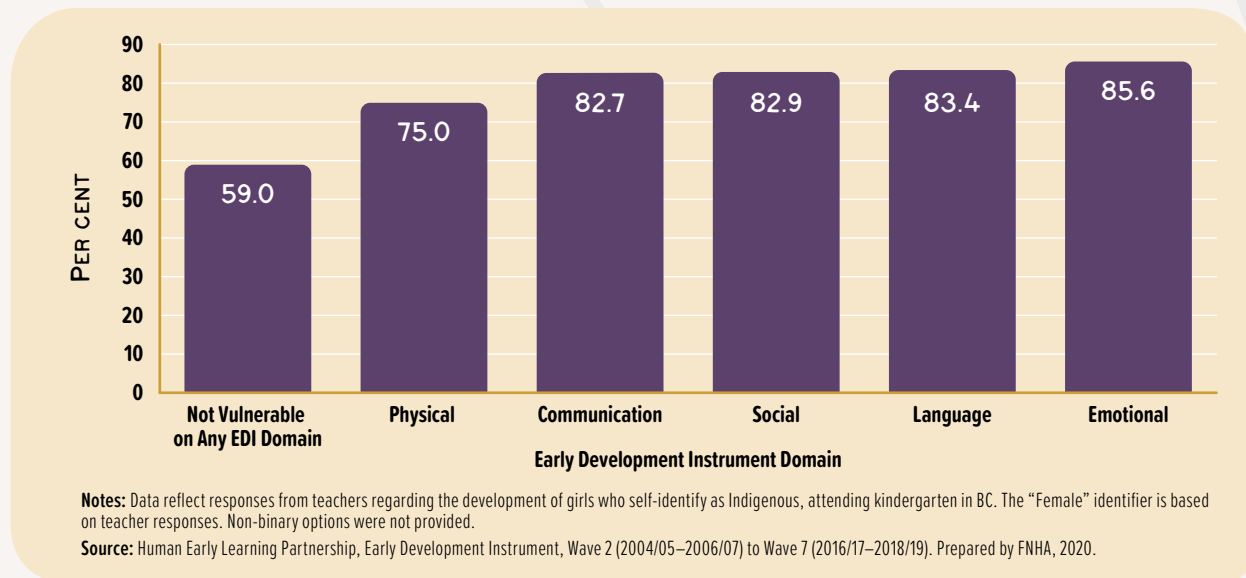




STARTING SCHOOL

p.34

FIG 2.13 PERCENTAGE OF INDIGENOUS GIRLS WITH NO VULNERABILITIES ACROSS THE EARLY DEVELOPMENT INSTRUMENT, AGE 5–6, BY DOMAIN, BC, WAVE 2 (2004/05–2006/07) TO WAVE 7 (2016/17–2018/19)

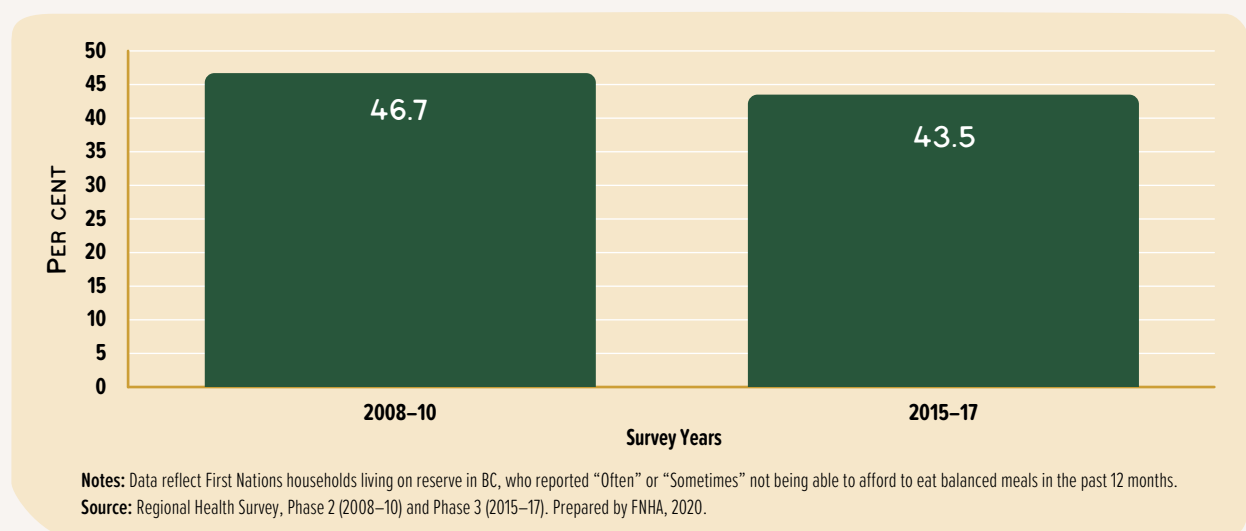


For each of the Early Development Instrument (EDI) domains—Physical, Communication, Social, Language, and Emotional—across Wave 2 (2004/05–2006/07) through Wave 7 (2016/17–2018/19), the majority of Indigenous girls age 5–6 were reported to have no vulnerabilities. In addition, 59.0% were reported to have no vulnerabilities across any of the EDI domains.

AFFORDING BALANCED MEALS

p.35

FIG 2.14 PERCENTAGE OF FIRST NATIONS HOUSEHOLDS THAT COULD NOT AFFORD TO EAT A BALANCED MEAL IN THE PAST 12 MONTHS, BC, 2008–10 AND 2015–17



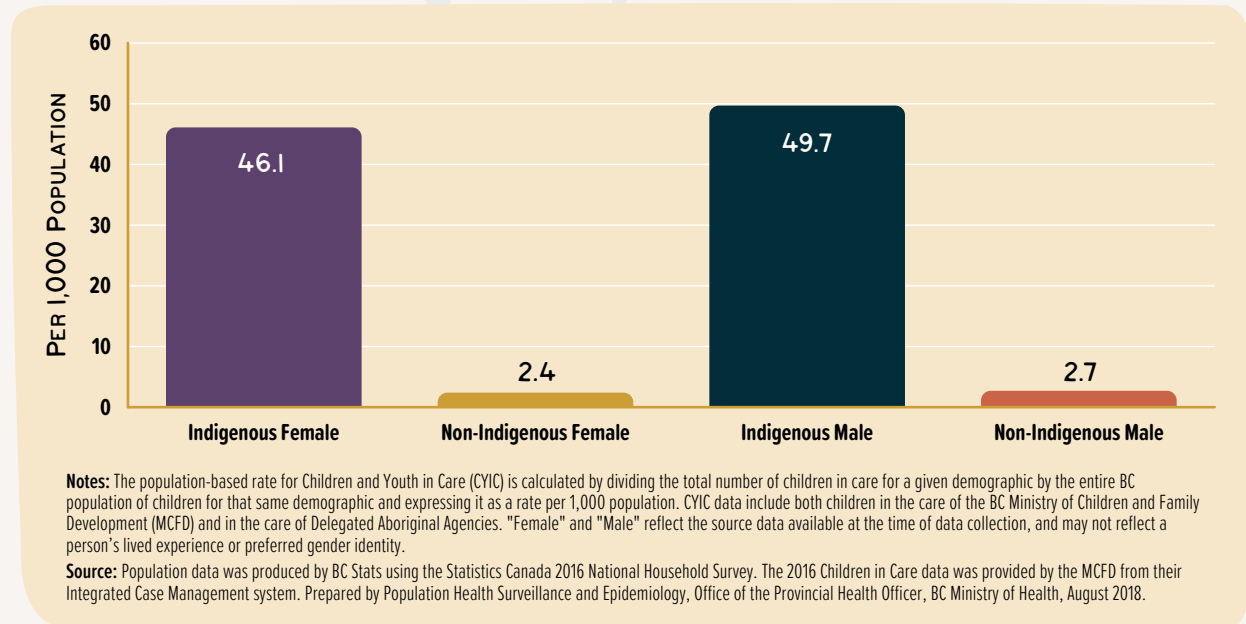
From RHS2 (2008–10) to RHS3 (2015–17), the proportion of First Nations households reporting they could not afford to eat a balanced meal in the past 12 months decreased 3.2 percentage points, from 46.7% to 43.5%. The historical and ongoing impacts of settler colonialism, as well as racist policies and systems that result in manufactured poverty and inequitable service provision, have economically disadvantaged First Nations people.¹⁹ These inequities particularly impact First Nations children, who experience higher rates of poverty than any other population in Canada.²⁰



GOVERNMENT CARE

p.38

FIG 2.15 RATE OF INDIGENOUS AND NON-INDIGENOUS CHILDREN IN CARE, AGE 0–9, BY SEX, BC, 2016



Data from the BC Ministry of Children and Family Development showed that Indigenous girls age 0–9 (46.1 per 1,000) were over 19 times more likely to be in government care than non-Indigenous girls (2.4 per 1,000).

“There is a tendency to codify poverty as neglect, which is why so many Indigenous children end up in care ... it’s not that their families don’t care about them – it’s because they didn’t have and couldn’t access the resources needed to care for them. Therefore, child welfare codifies discrimination and colonization as personal or family deficits instead of tackling the underlying problems.”

- Dr. Cindy Blackstock, Gitksan First Nation
- *Sacred and Strong: Upholding our Matriarchal Roles* (p.37)

The *Act respecting First Nations, Inuit and Métis children, youth and families* (also called *Bill C-92*) came into force on January 1, 2020 and recognizes Indigenous peoples’ jurisdiction over child and family services as part of their right to self-governance. The Act also establishes principles for governing child welfare to ensure that when determining the best interests of an Indigenous child, primary consideration is given to the child’s physical, emotional and psychological safety, security and well-being. The Act emphasizes the need for the system to shift from apprehension to prevention, with priority given to services that promote preventative care to support families. It also establishes protocols to preserve a child’s connection to their family, community, and culture.²¹

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.37)

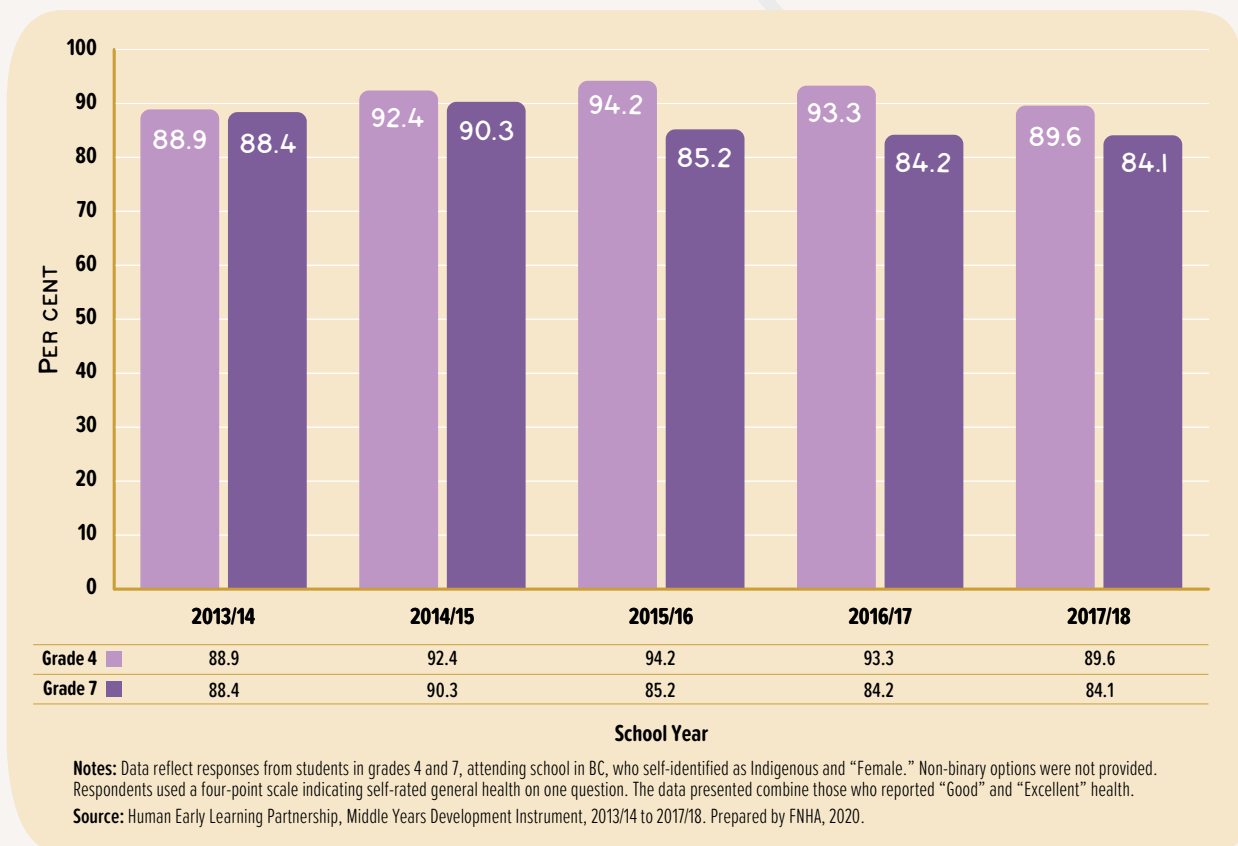
HEALTHY BODIES, MINDS AND SPIRITS

The health and wellness of First Nations children are shaped by their physical and social environments, and strengthened by identity, culture, and kinship ties that form their cultural values.²² BC First Nations have specific laws, customs, and teachings that create nurturing environments for First Nations girls to thrive and flourish.

GENERAL HEALTH

p.40

FIG 2.16 PERCENTAGE OF INDIGENOUS GIRLS WHO RATED THEMSELVES IN “GOOD” OR “EXCELLENT” HEALTH, BY GRADE, BC, 2013/14 TO 2017/18

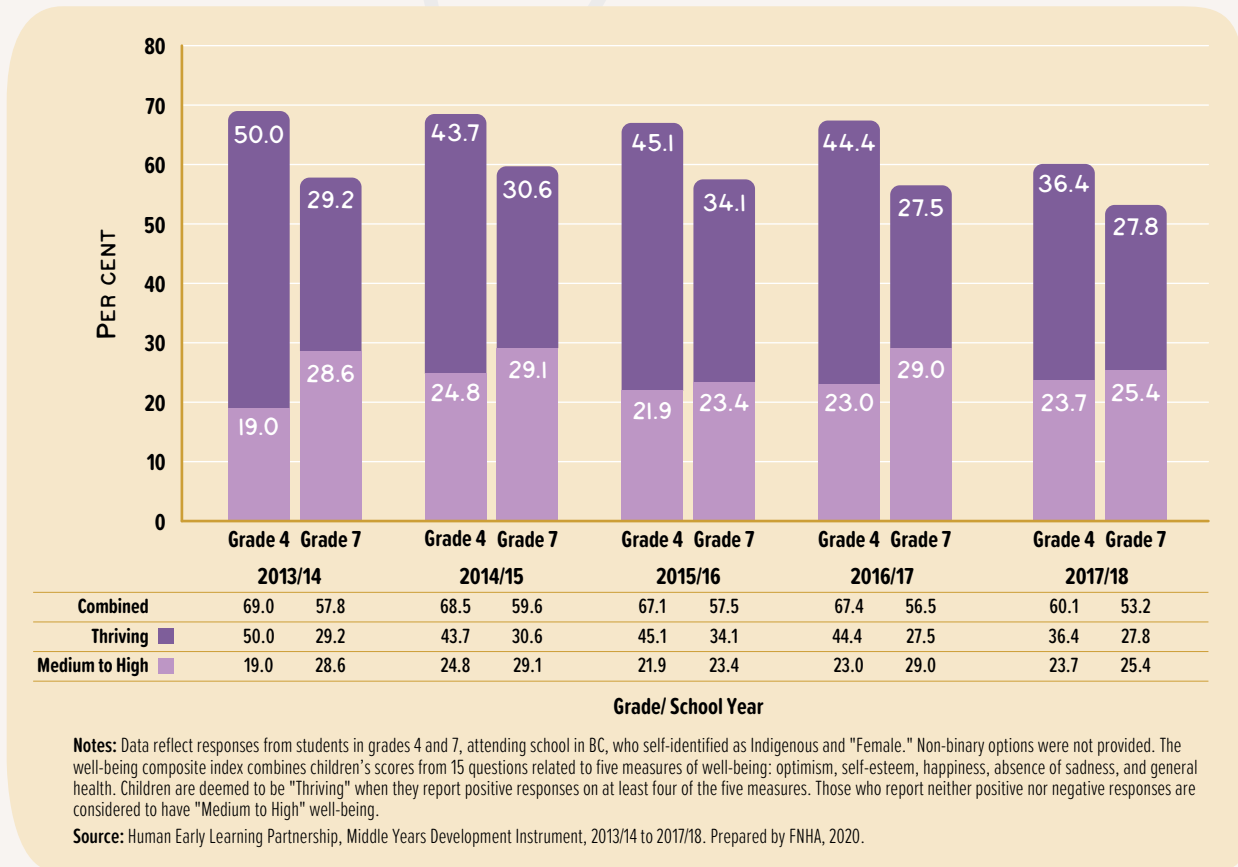


For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 reported being in “good” or “excellent” health.

WELL-BEING COMPOSITE INDEX

p.40

FIG 2.17 PERCENTAGE OF INDIGENOUS GIRLS WHO HAD “THRIVING” OR “MEDIUM TO HIGH” SCORES ON THE MDI WELL-BEING INDEX, BY GRADE, BC, 2013/14 TO 2017/18

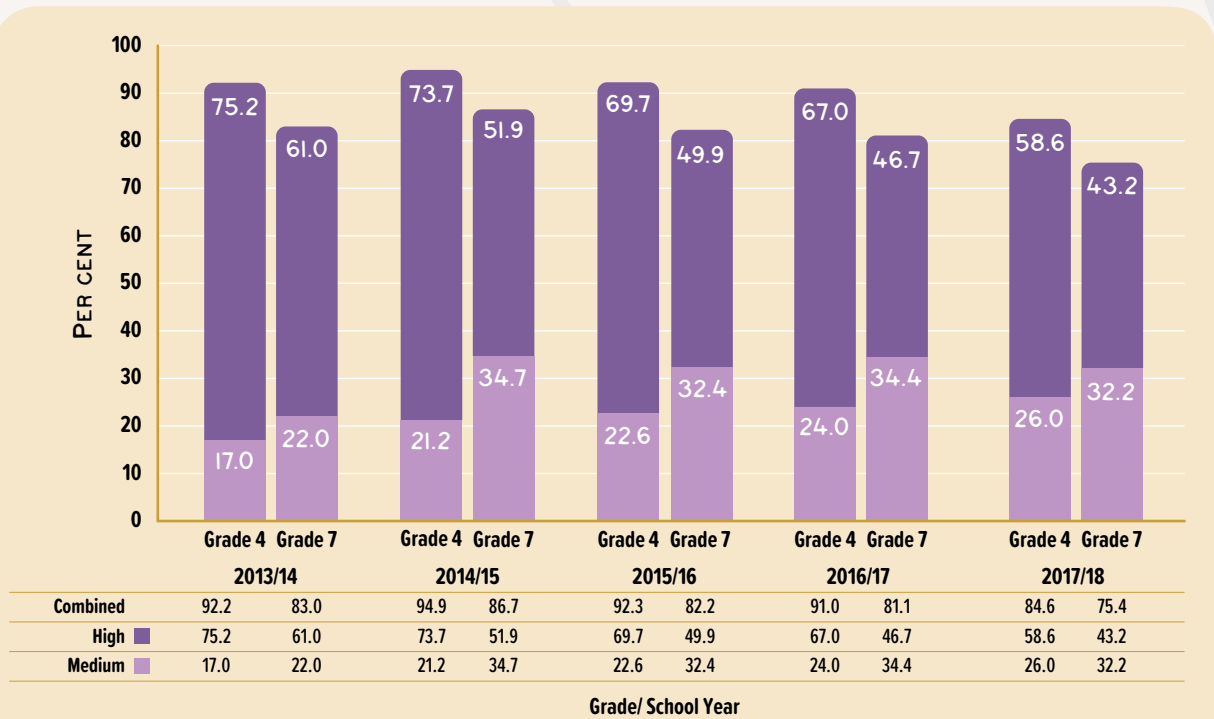


For each school year from 2013/14 through 2017/18, MDI data showed that Indigenous girls in grade 4 had a higher overall score on the Well-being Index across the “thriving” and “medium to high” categories, compared to Indigenous grade 7 girls. Wellness is achieved when there is a balance of mental, emotional, spiritual, and physical health. First Nations girls experience this balance when they feel a sense of purpose, have hope for the future, and a sense of belonging and connectedness with their family, community, and culture.²³

OPTIMISM AND FUTURE GOALS

p.42

FIG 2.18 PERCENTAGE OF INDIGENOUS GIRLS WHO HAD “HIGH” OR “MEDIUM” SCORES ON THE OPTIMISM MEASURE, BY GRADE, BC, 2013/14 TO 2017/18



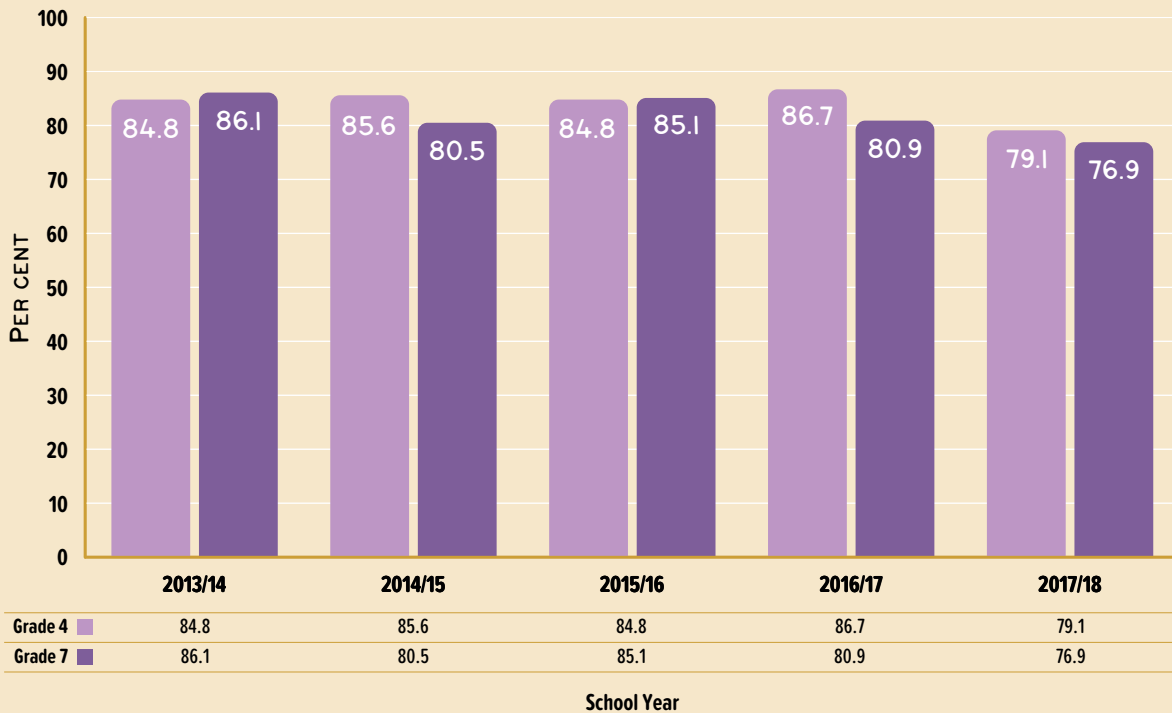
Notes: Data reflect responses from students in grades 4 and 7, attending school in BC, who self-identified as Indigenous and “Female.” Non-binary options were not provided. “High” level of optimism reflects children whose average responses were “Agree a Little” or “Agree a Lot” on a five-point scale, across three elements. “Medium” level of optimism reflects children whose average responses were “Don’t Agree or Disagree” and those who reported a mix of positive and negative responses.

Source: Human Early Learning Partnership, Middle Years Development Instrument, 2013/14 to 2017/18. Prepared by FNHA, 2020.



Supporting First Nations girls to achieve and maintain mental wellness helps them realize their own potential and more easily cope with the stresses of life.²⁴ For each school year from 2013/14 through 2017/18, MDI data showed that a higher proportion of Indigenous girls in grade 4 than grade 7 reported “high” scores for the Optimism measure on the Social and Emotional Development dimension. A higher proportion of Indigenous grade 7 girls had “medium” scores on the same measure for each school year. Across the survey years, there appears to be a downward trend of Indigenous girls in both grades 4 and 7 reporting “high” levels of optimism and, in turn, an increase in the proportion of girls reporting “medium” levels of optimism. Further analysis is needed to confirm the statistical significance of this finding.

FIG 2.19 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED HAVING PLANS FOR THE FUTURE, BY GRADE, BC, 2013/14 TO 2017/18



Notes: Data reflect responses from students in grades 4 and 7, attending school in BC, who self-identified as Indigenous and “Female.” Non-binary options were not provided.
Source: Human Early Learning Partnership, Middle Years Development Instrument, 2013/14 to 2017/18. Prepared by FNHA, 2020.



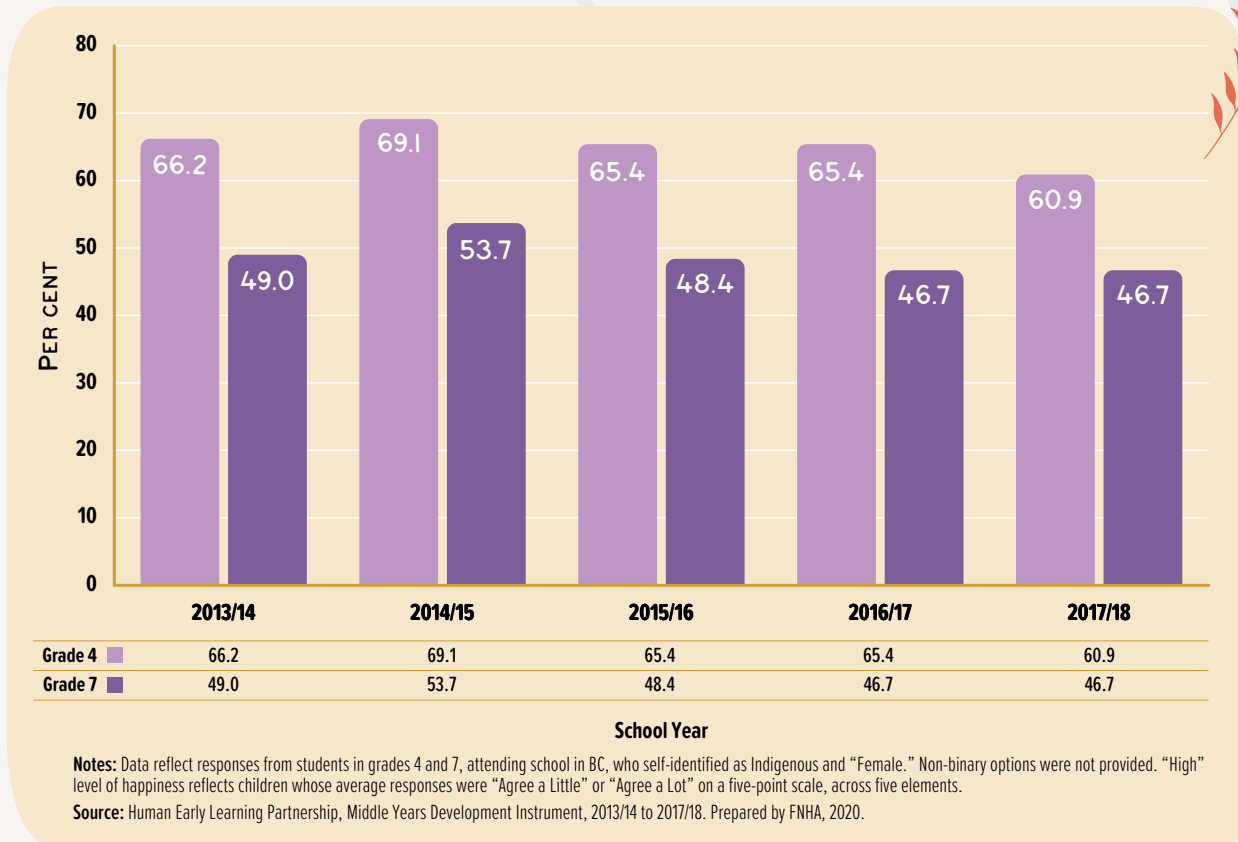
For each school year from 2013/14 through 2017/18, MDI data showed that the proportions of Indigenous girls in grades 4 and 7 were comparable when measuring agreement on the statement “When I grow up, I have goals and plans for the future,” within the Future Goals measure.



HAPPINESS

p.42

FIG 2.20 PERCENTAGE OF INDIGENOUS GIRLS WHO HAD “HIGH” SCORES ON THE HAPPINESS MEASURE, BY GRADE, BC, 2013/14 TO 2017/18

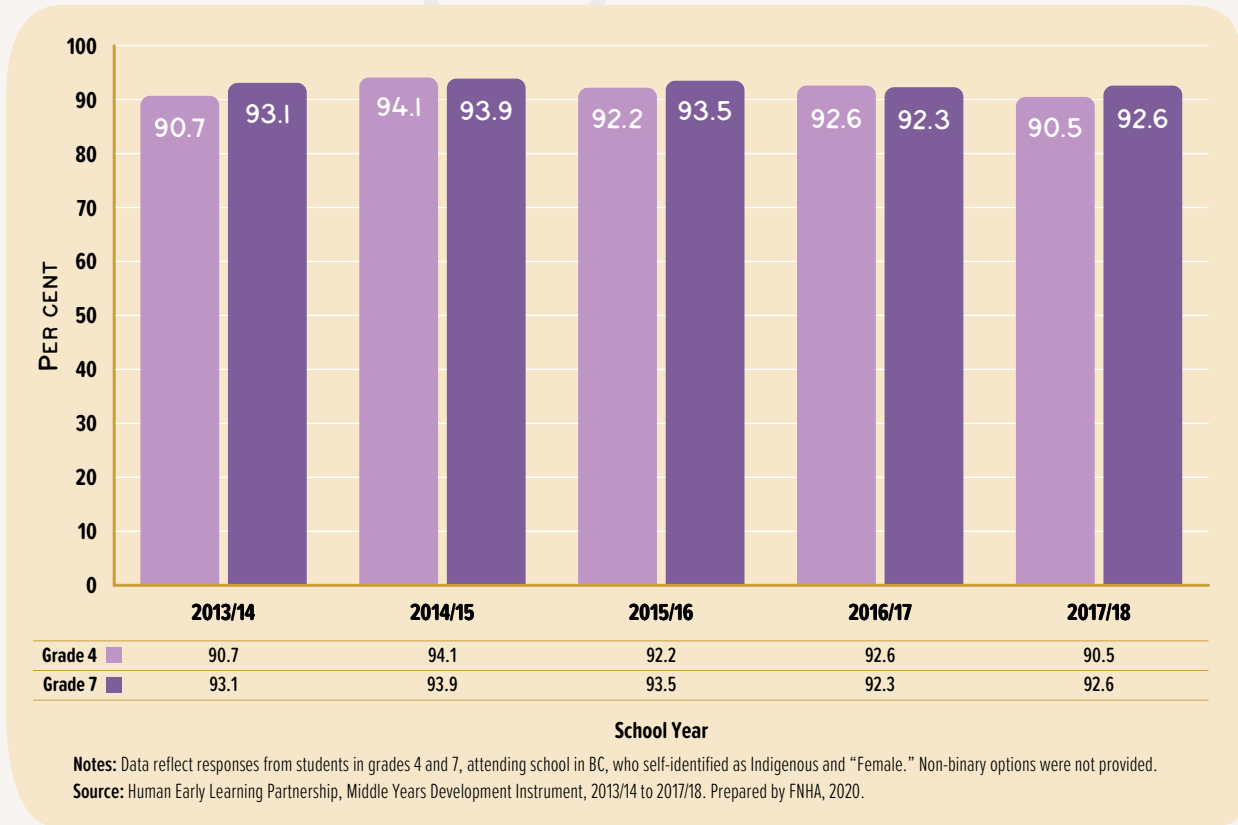


First Nations have always valued emotional and social development during childhood, as it sets a path for mental wellness later in life.²⁵ Each child enters the world with special gifts to share with their family and community.²⁶ For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 reported “high” scores on the Happiness measure of the Social and Emotional Development dimension. An example of a statement assessed in the Happiness measure is “The things in my life are excellent.”

PEER RELATIONSHIPS – CLOSE FRIENDSHIPS

p.42

FIG 2.21 PERCENTAGE OF INDIGENOUS GIRLS WHO HAD “HIGH” OR “MEDIUM” SCORES ON THE FRIENDSHIP INTIMACY MEASURE, BY GRADE, BC, 2013/14 TO 2017/18



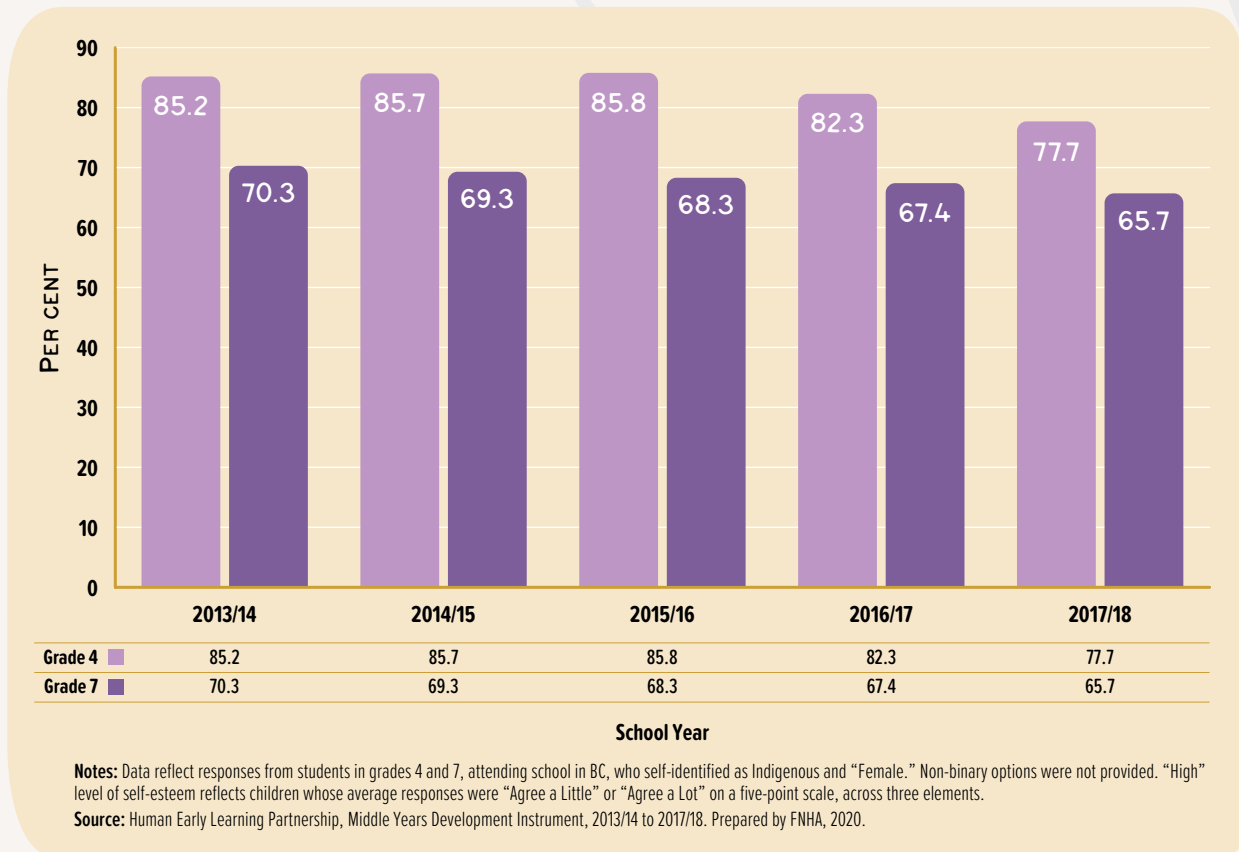
For each school year from 2013/14 through 2017/18, MDI data showed that more than 90% of Indigenous girls in grades 4 and 7 reported having “medium” to “high” scores on the Friendship Intimacy measure of the Connectedness dimension. This means that over 90% of Indigenous girls across grades 4 and 7 agreed with statements such as “I have a friend I can tell everything to,” and “I have at least one really good friend I can talk to when something is bothering me.”



SELF-ESTEEM

p.42

FIG 2.22 PERCENTAGE OF INDIGENOUS GIRLS WHO HAD “HIGH” SCORES ON THE SELF-ESTEEM MEASURE, BY GRADE, BC, 2013/14 TO 2017/18



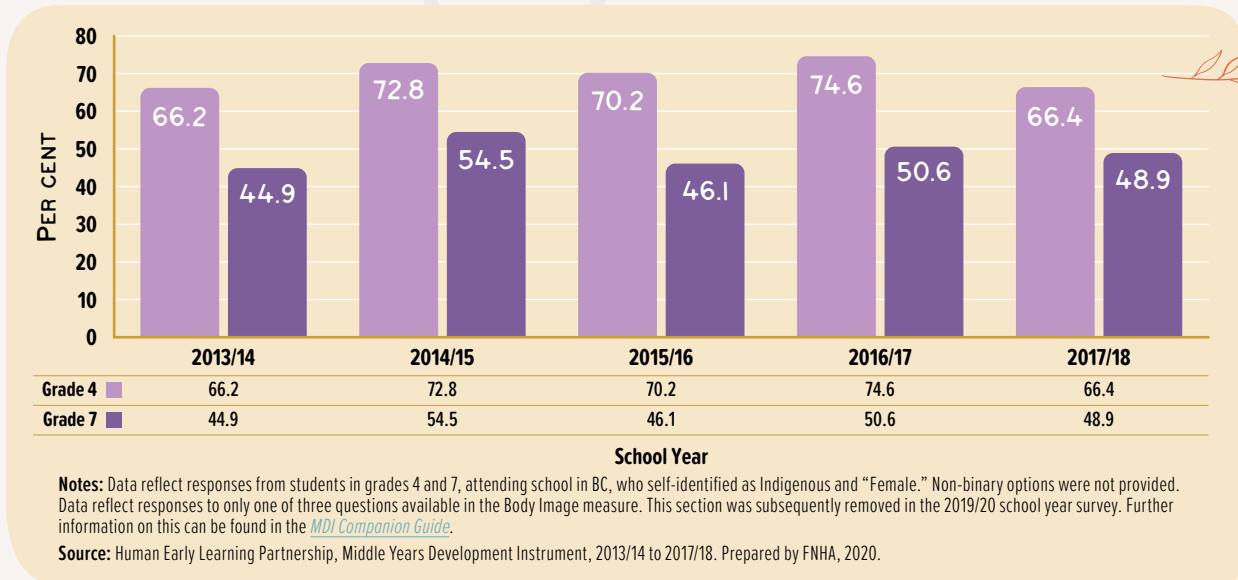
For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 scored “high” on the Self-esteem measure within the Social and Emotional Development dimension. This means that most Indigenous girls in grade 4 agreed with statements like “A lot of things about me are good,” and “Overall, I have a lot to be proud of.” The differences seen between grade 4 and 7 Indigenous girls are important to understand, especially in the context of what we can do to better support Indigenous girls through their adolescent years; this is a call to action for us and all our partners. It is imperative to enhance our understanding of these findings and assess whether this trend is also seen among non-Indigenous girls. Racist anti-Indigenous policies have deliberately disrupted First Nations knowledge and practices that nurture and promote mental wellness, and have created inequalities in the social determinants of health for many First Nations families.^{27,28,29} These inequities and disruptions of culture can negatively impact First Nations girls’ sense of belonging and mental wellness.³⁰ BC First Nations continue to assert their inherent rights, and communities are advocating and working to re-establish the circles of connectedness around their children.⁷



POSITIVE BODY IMAGE

p-42

FIG 2.23 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED THEY “OFTEN” OR “ALWAYS” LIKED THE WAY THEY LOOKED ON THE BODY IMAGE MEASURE, BY GRADE, BC, 2013/14 TO 2017/18

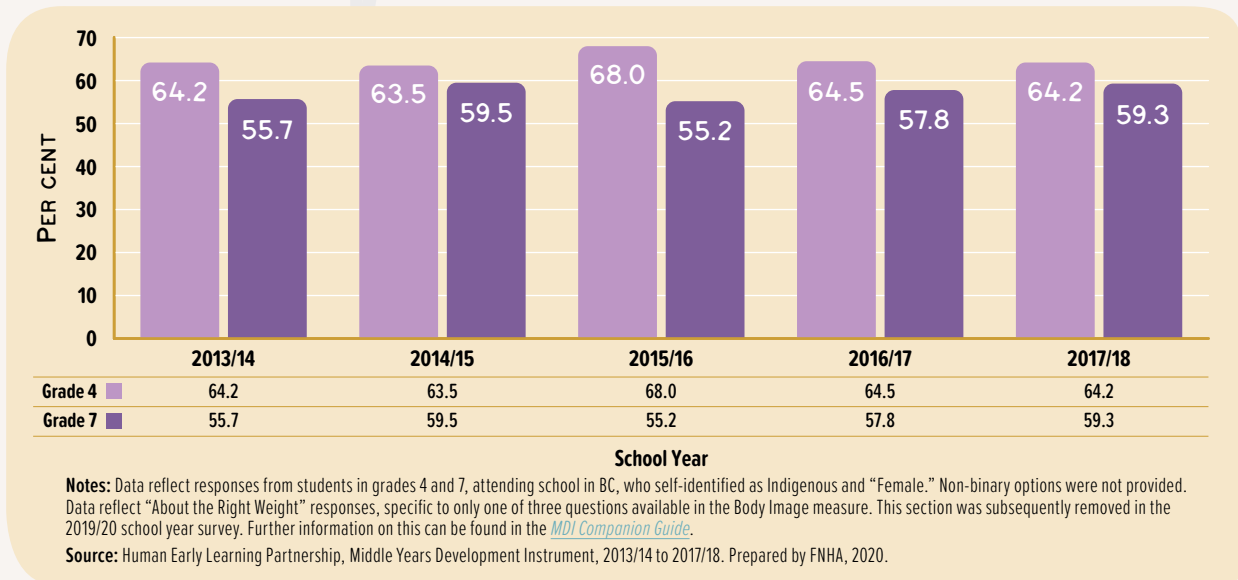


For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 reported “often” or “always” liking the way they looked. This is a single indicator within the broader Body Image measure of the Physical Health and Well-being dimension.

SELF-RATED BODY WEIGHT

p-44

FIG 2.24 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED HAVING A BODY WEIGHT THAT WAS “ABOUT RIGHT,” BY GRADE, BC, 2013/14 TO 2017/18

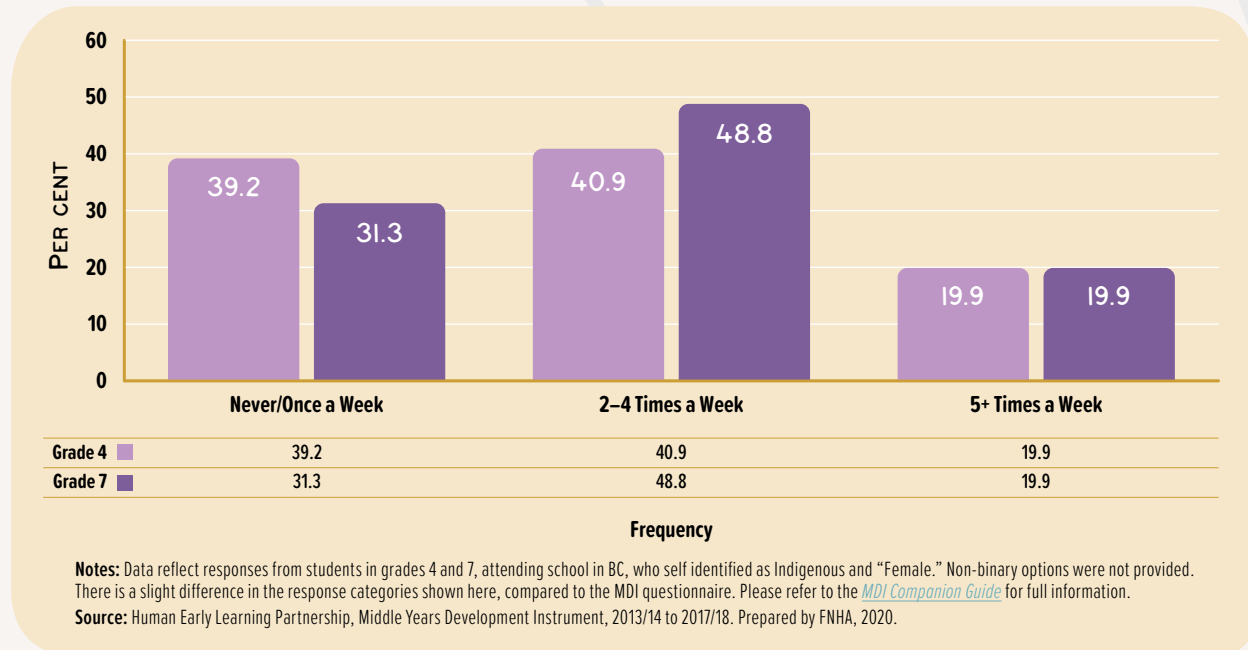


For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 rated their body weight “about right.” This is a single indicator within the broader Body Image measure of the Physical Health and Well-being dimension. Feeling dissatisfied with one’s body image during childhood can have a negative impact on self-esteem and increase self-consciousness.^{10,31} Unfortunately, many First Nations girls are exposed to, and socialized by, distorted and unhealthy Western values and norms about women’s bodies.^{32,33}

HEALTHY EATING

p.43

FIG 2.25 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED EATING JUNK FOOD (E.G., CHIPS, CANDY, POP), BY GRADE AND FREQUENCY, BC, 2017/18



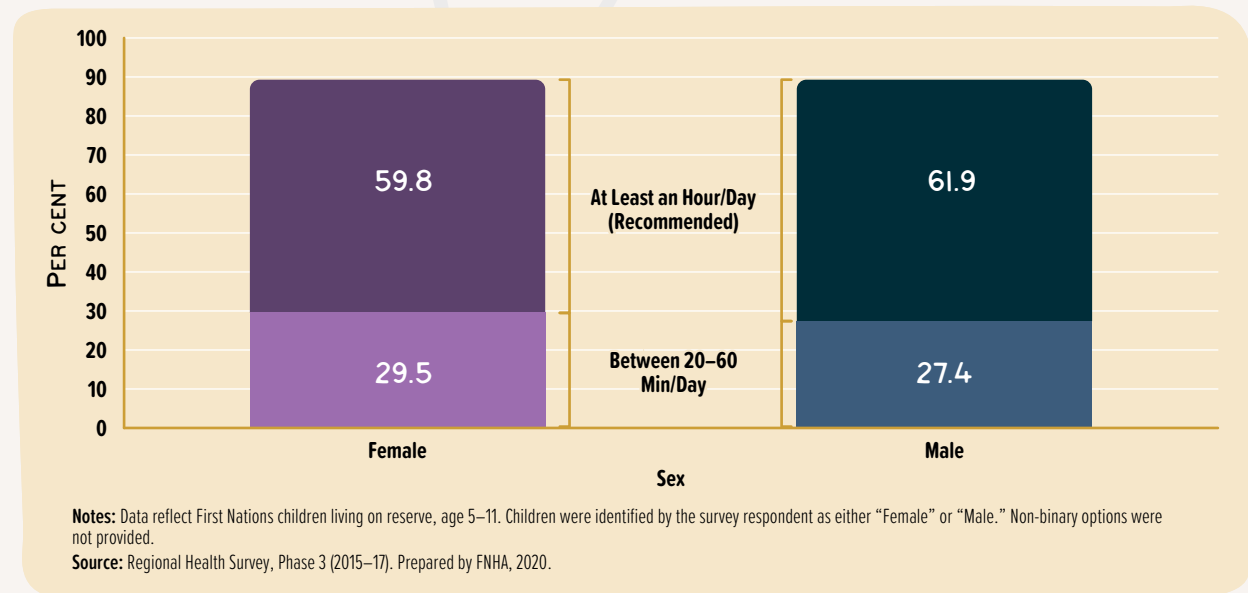
MDI data from 2017/18 showed that a greater proportion of Indigenous girls in grade 4 (39.2%) than grade 7 (31.3%) reported eating junk food “never” or “once a week.” Almost half (48.8%) of Indigenous girls in grade 7 reported eating junk food “2–4 times a week,” compared to 40.9% of Indigenous girls in grade 4. One in five (19.9%) Indigenous girls in both grades 4 and 7 ate junk food “5 times or more a week.” The MDI questionnaire did not include questions on the reason for eating junk food. Traditional food gathering and preparation activities such as berry picking, fishing, and canning provide First Nations girls with opportunities to connect with their families and communities; these activities can also help to build a sense of purpose and belonging.³⁴



PHYSICAL ACTIVITY

p.44

FIG 2.26 PERCENTAGE OF FIRST NATIONS CHILDREN'S PARTICIPATION IN PHYSICAL ACTIVITY IN A TYPICAL WEEK, AGE 5–11, BY SEX AND AMOUNT OF TIME, BC, 2015–17

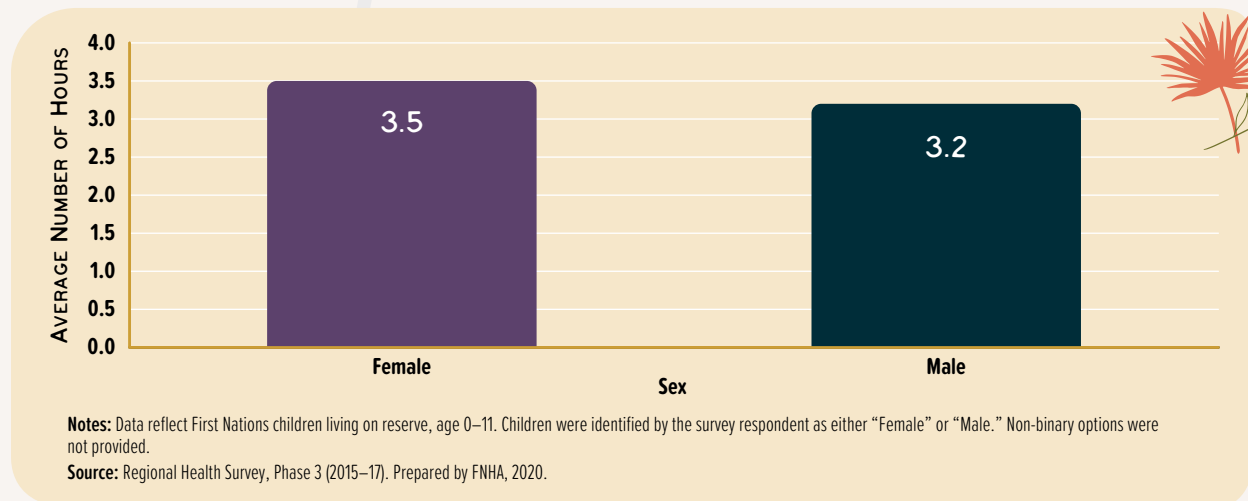


From RHS3 (2015–17), a slightly lower percentage of First Nations girls age 5–11 (59.8%) participated in physical activity for the recommended amount of “at least an hour/day,” compared to First Nations boys in the same age group (61.9%). Being active during childhood is vital to First Nations girls’ development; it can have a positive impact on their confidence, self-esteem, strength, and coordination.³⁵ Activities that take place outdoors also allow children to be on, and connect with, the land.

SCREEN TIME

p.44

FIG 2.27 FIRST NATIONS CHILDREN'S REPORTED AVERAGE HOURS OF SCREEN TIME PER DAY, AGE 0–11, BY SEX, BC, 2015–17

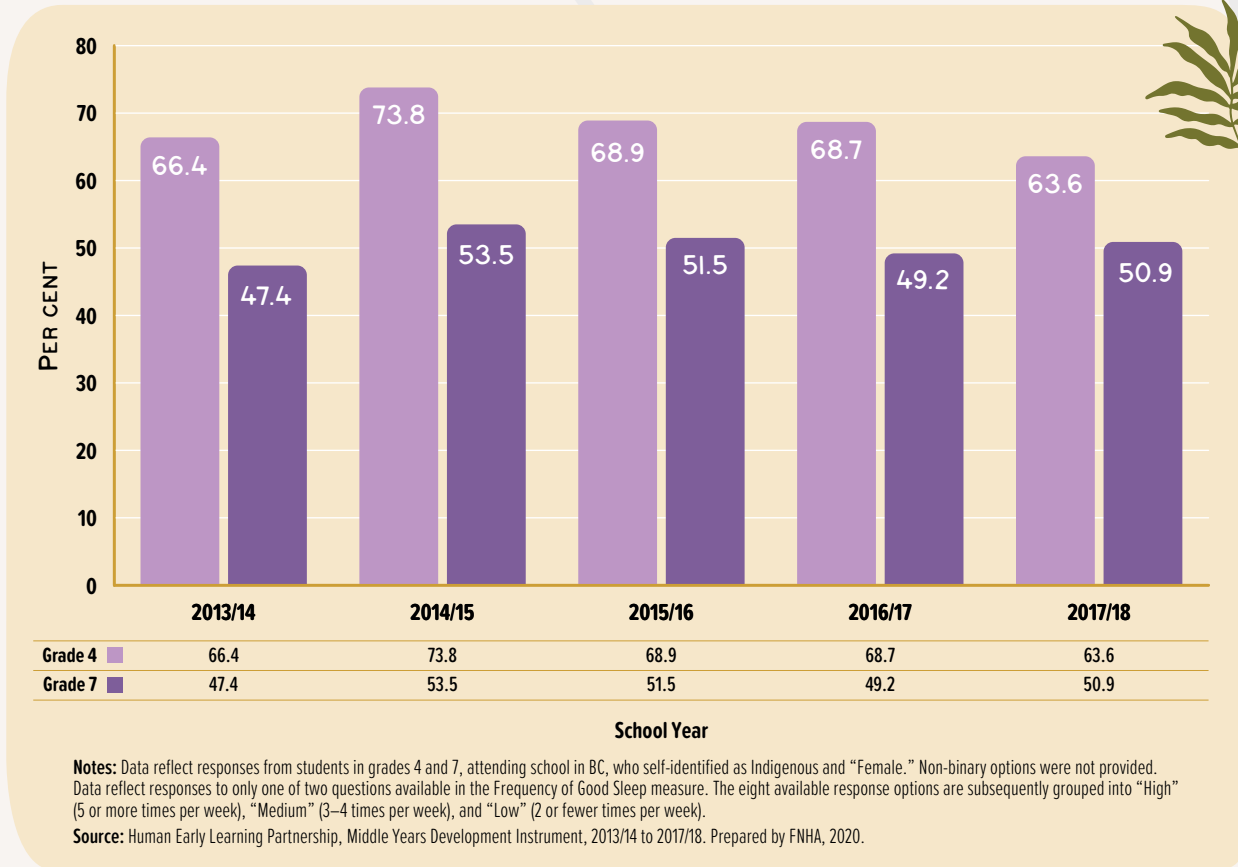


Establishing an active and healthy lifestyle in childhood that finds a balance between physical activity, more sedentary activities, as well as rest, is important for developing lifelong behaviours that contribute to health and wellness.³⁶ From RHS3 (2015–17), First Nations girls age 0–11 spent an average of 3.5 hours on daily screen time, whereas First Nations boys in the same age group spent an average of 3.2 hours.

SLEEP

p.44

FIG 2.28 PERCENTAGE OF INDIGENOUS GIRLS WHO HAD "HIGH" SCORES ON THE FREQUENCY OF SLEEP MEASURE, BY GRADE, BC, 2013/14 TO 2017/18



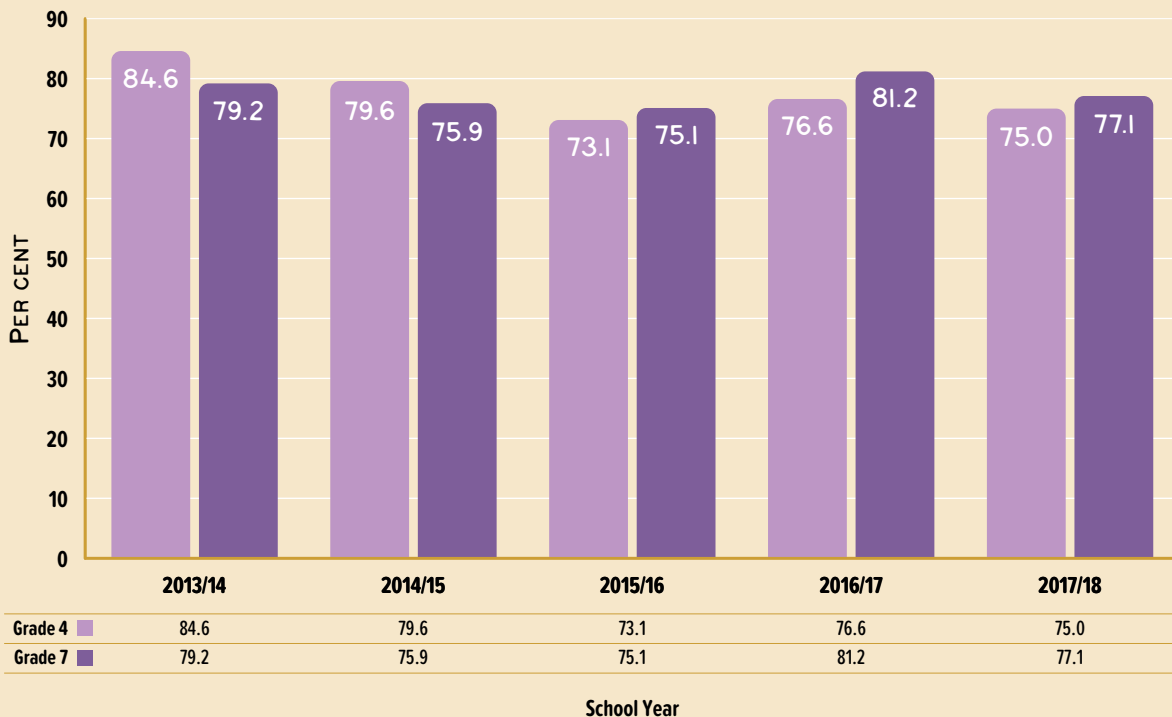
For each school year from 2013/14 through 2017/18, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 had "high" scores for the "Frequency of Good Sleep" measure within the Physical Health and Well-being dimension. For each school year, more than 60% of Indigenous girls in grade 4 had five or more nights of good sleep per week.



PHYSICAL CONDITION / ILLNESS

p.45

FIG 2.29 PERCENTAGE OF INDIGENOUS GIRLS WHO REPORTED HAVING NO PHYSICAL OR HEALTH CONDITIONS ON THE BODY IMAGE MEASURE, BY GRADE, BC, 2013/14 TO 2017/18



Notes: Data reflect responses from students in grades 4 and 7, attending school in BC, who self-identified as Indigenous and “Female.” Non-binary options were not provided. Data reflect the proportion of respondents who indicated “No Health Condition” where the health conditions assessed included a physical disability, a long-term illness, being overweight, or another respondent-specified condition. The Body Image measure was subsequently removed in the 2019/20 school year survey. Further information on this can be found in the [MDI Companion Guide](#).

Source: Human Early Learning Partnership, Middle Years Development Instrument, 2013/14 to 2017/18. Prepared by FNHA, 2020.

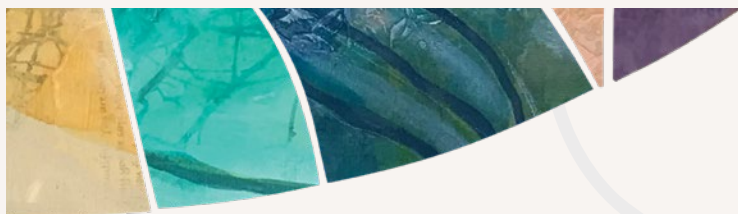
For school years 2013/14 through 2014/15, MDI data showed that a greater proportion of Indigenous girls in grade 4 than grade 7 reported having no physical or health condition that kept them from doing things that other kids their age do. Indigenous girls in grade 7 had a greater proportion on the same indicator from 2015/16 though 2017/18.



“Some of my earliest memories as a youth are from the summer and fall, when everyone in my community would be smoking salmon and jarring it – and being put on fish-gutting duty. At the time, I didn’t think it was so awesome, but now I know how valuable it is and it was teaching me respect. It’s just like when I went to Wet’suwet’en culture camps, and we butchered moose meat. I remember all those teachings we learned there. The culture in my community is strong and it’s definitely helped me a lot in growing up and being proud of being Wet’suwet’en. I remember there was a time when I wasn’t proud and that was really hard for me to get through. I think it can be difficult for the youth still – being proud of who you are when we’ve received so much discrimination and racism as Indigenous people. It’s a big part of your wellness, your mental wellness, to be proud of your culture and your identity.”

- Michelle Buchholz, Wet’suwet’en Nation

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.44)



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YOUTH WELLNESS



First Nations youth represent the future, and their health and wellness reflect the overall well-being of First Nations families and communities. Since time immemorial, First Nations have recognized adolescence as a critical period of development and celebrate this transformative time through rites of passage such as coming-of-age ceremonies where Elders, matriarchs, and community members share their wisdom about adulthood. The sharing of wisdom between generations is an important process for youth to affirm their responsibilities in the community and strengthen their connection to their culture as they transition to adulthood and begin to create their own roles within their families and communities.¹

This chapter provides detailed charts for findings presented in the Youth Wellness chapter of the report, *Sacred and Strong: Upholding our Matriarchal Roles*. The chapter focuses on the health and wellness of young First Nations women. It considers how they establish their roles within their communities and begin to chart their own paths forward into adulthood. This chapter highlights many of the ways in which young First Nations women flourish, and the impacts of various systems needed to empower young First Nations women in BC during this time of transition. Please refer to the main report—[*Sacred and Strong: Upholding our Matriarchal Roles*](#)—for further interpretation of the data presented here.

HEALTHY, SELF-DETERMINING YOUTH & COMMUNITIES – ROOTS OF WELLNESS

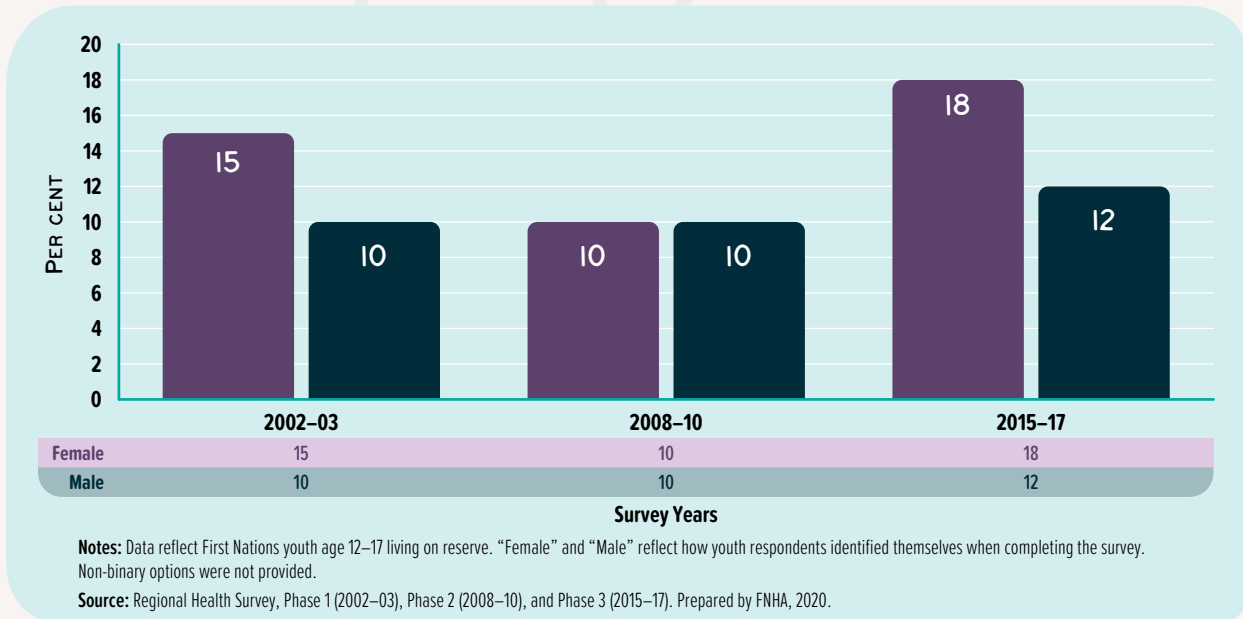


The roots of wellness for First Nations centre on forging a strong connection to their culture, land, and community. These connections support their self-determination and help them to explore and affirm their identity in society, which is especially important during the adolescent period.²

PARTICIPATION IN CULTURAL ACTIVITIES

p.48

FIG 3.1 PERCENTAGE WHO REPORTED PARTICIPATION IN CULTURAL EVENTS IN THEIR LOCAL COMMUNITY, FIRST NATIONS YOUTH, AGE 12–17, BY SEX, BC, 2002–03, 2008–10, AND 2015–17



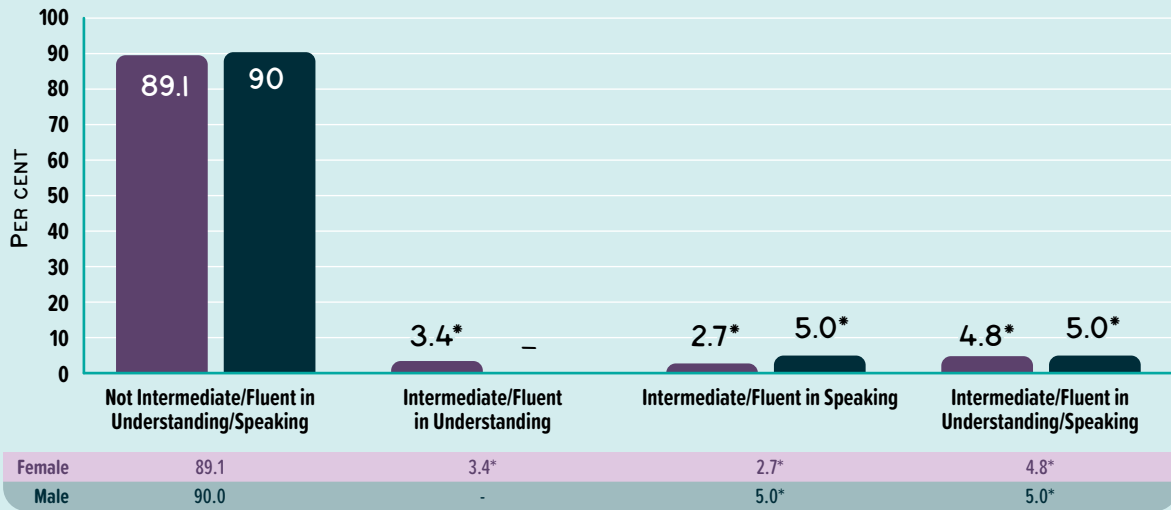
Participation in cultural events can cultivate a sense of purpose and belonging among First Nations youth and boost their confidence and pride.³ Between Regional Health Survey Phase 1 (RHS1; 2002–03) and Regional Health Survey Phase 3 (RHS3; 2015–17) the percentage of young First Nations women age 12–17 who reported participating in cultural events in their community at least once a week increased three percentage points, from 15% to 18%.



FIRST NATIONS LANGUAGE

p-48

FIG 3.2 LANGUAGE FLUENCY AMONG FIRST NATIONS YOUTH WHO REPORTED KNOWING AT LEAST A FEW WORDS OF THEIR NATION'S LANGUAGE, AGE 12–17, BC, 2015–17



Notes: Notes: “*” means that the value should be interpreted with caution as $0.333 \geq CV \geq 0.166$. “-” means that the value has been suppressed due to $CV > 0.333$ or cell count < 10 . Data reflect First Nations youth age 12–17 living on reserve in BC. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

BC is home to 34 First Nations languages, accounting for 60% of First Nations languages in Canada. As of 2018, the First Peoples Cultural Council reported that 78.1% of learners of First Nations languages in BC were under the age of 24.⁴ RHS3 (2015–17) showed that, among respondents who knew at least a few words of their Nation’s language, 4.8% of young First Nations women age 12–17 were intermediate or fluent in understanding *and* speaking their Nation’s language, while 2.7% were intermediate or fluent in speaking and 3.4% were intermediate or fluent in understanding their Nation’s language.



FIRST NATIONS FOODS

p.49

FIG 3.3 PERCENTAGE OF FIRST NATIONS YOUTH WHO REPORTED EATING TRADITIONAL FOODS (NOT INCLUDING BANNOCK) "OFTEN" IN THE PAST YEAR, AGE 12–17, BY SEX, BC, 2002–03, 2008–10, AND 2015–17



Notes: Data reflect First Nations youth age 12–17 living on reserve. “Female” and “Male” reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 1 (2002–03), Phase 2 (2008–10), and Phase 3 (2015–17). Prepared by FNHA, 2020.



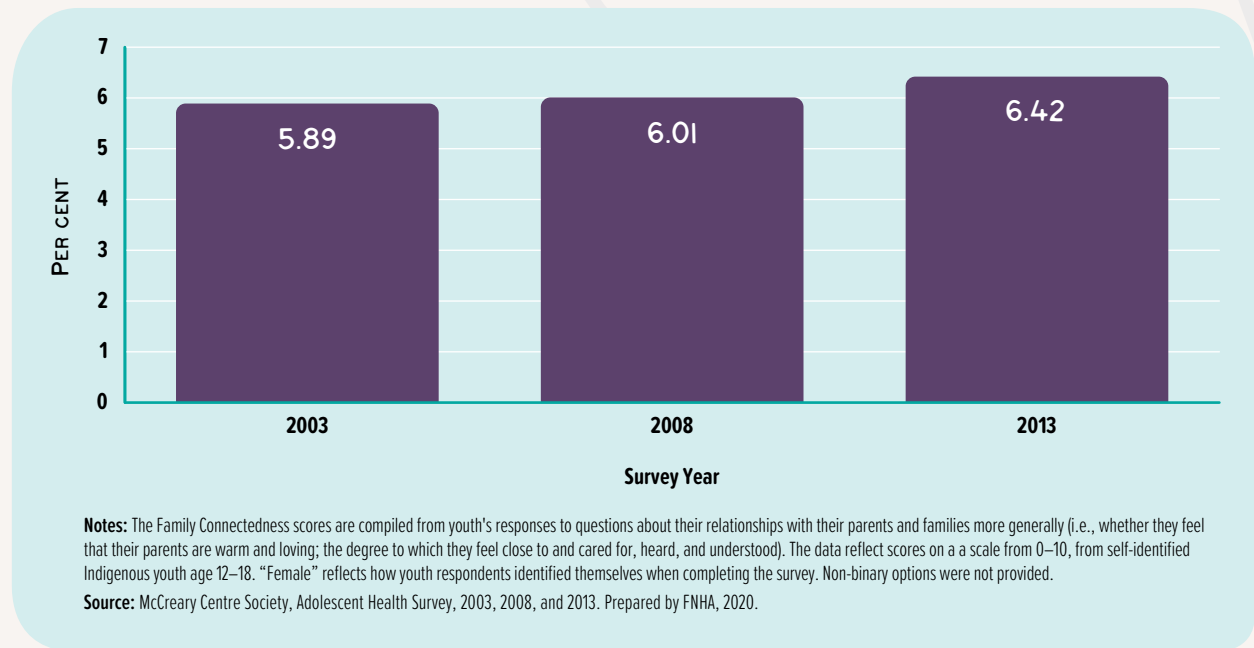
Between RHS1 (2002–03) and RHS3 (2015–17), the percentage of young First Nations women age 12–17 who reported eating traditional foods (not including bannock) “often” in the past year decreased slightly (from 66.3% to 62.7%), with a decrease of 12.1 percentage points in RHS2 (2008–10). The trend was similar for young First Nations men age 12–17. Eating traditional foods provides First Nations youth with a diet rich in nutrients and encourages them to see how the sustainability of the lands, waters, and natural systems is fundamental to wellness.⁵



FAMILY CONNECTEDNESS

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FIG 3.4 FAMILY CONNECTEDNESS SCORES OF YOUNG INDIGENOUS WOMEN, AGE 12–18, BC, 2003, 2008, AND 2013



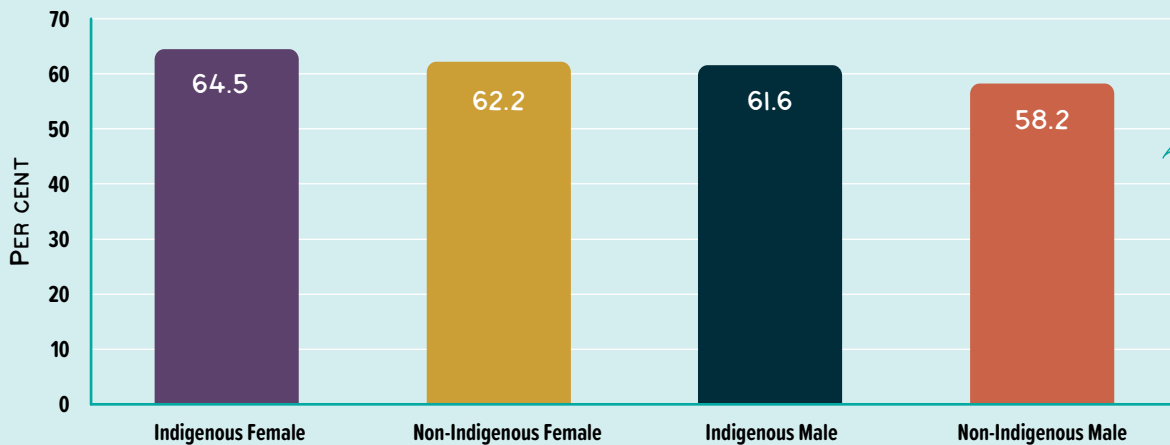
From 2003 to 2013, young Indigenous women age 12–18 reported an increase in their family connectedness score from 5.89 to 6.42, on a scale of 0–10, in McCreary Centre Society's Adolescent Health Survey (AHS). Fostering close connections with family and community provides First Nations youth with support as they face the changes and challenges in the transition to adulthood; having their family's love and support is essential to their wellness journey.^{6,7}



CARING ADULTS

p.50

FIG 3.5 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED THAT THEY HAD ADULTS IN THEIR COMMUNITY WHO REALLY CARED ABOUT THEM, AGE 12–18, BC, 2013



Notes: The data reflect responses from self-identified Indigenous youth and other youth age 12–18. “Female” and “Male” reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: McCreary Centre Society, Adolescent Health Survey, 2013. Prepared by FNHA, 2020.

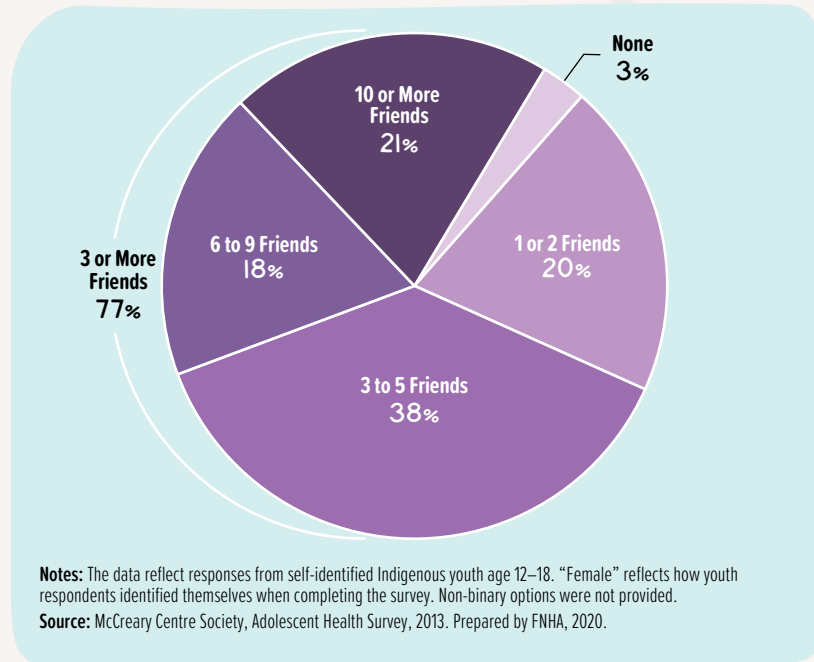


In 2013, the AHS showed that 64.5% of young Indigenous women age 12–18 felt they had an adult in their community who really cared about them, the highest proportion as compared to young Indigenous men (61.6%) and young non-Indigenous women (62.2%) and men (58.2%) in the same age group. Young First Nations women rely on their mothers, aunts, matriarchs, and Elders to help them navigate the changes that come during adolescence; these supportive relationships help ground youth in their culture and affirm their belonging in the community.⁶

PEER SUPPORTS – NUMBER OF CLOSE FRIENDS

p.51

FIG 3.6 NUMBER OF CLOSE FRIENDS IN THEIR SCHOOL OR NEIGHBOURHOOD REPORTED BY YOUNG INDIGENOUS WOMEN, AGE 12–18, BC, 2013



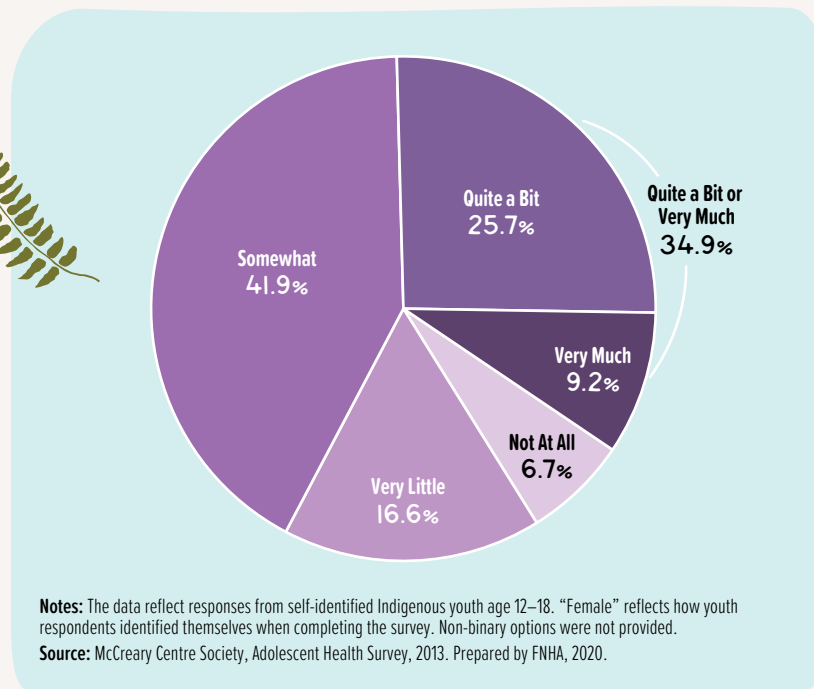
In 2013, 77% of young Indigenous women age 12–18 reported having three or more close friends in their school or neighbourhood.



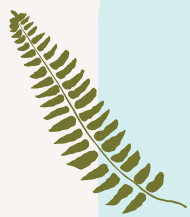
COMMUNITY CONNECTEDNESS

p.51

FIG 3.7 DEGREE OF CONNECTION TO THEIR COMMUNITY REPORTED BY YOUNG INDIGENOUS WOMEN, AGE 12–18, BC, 2013



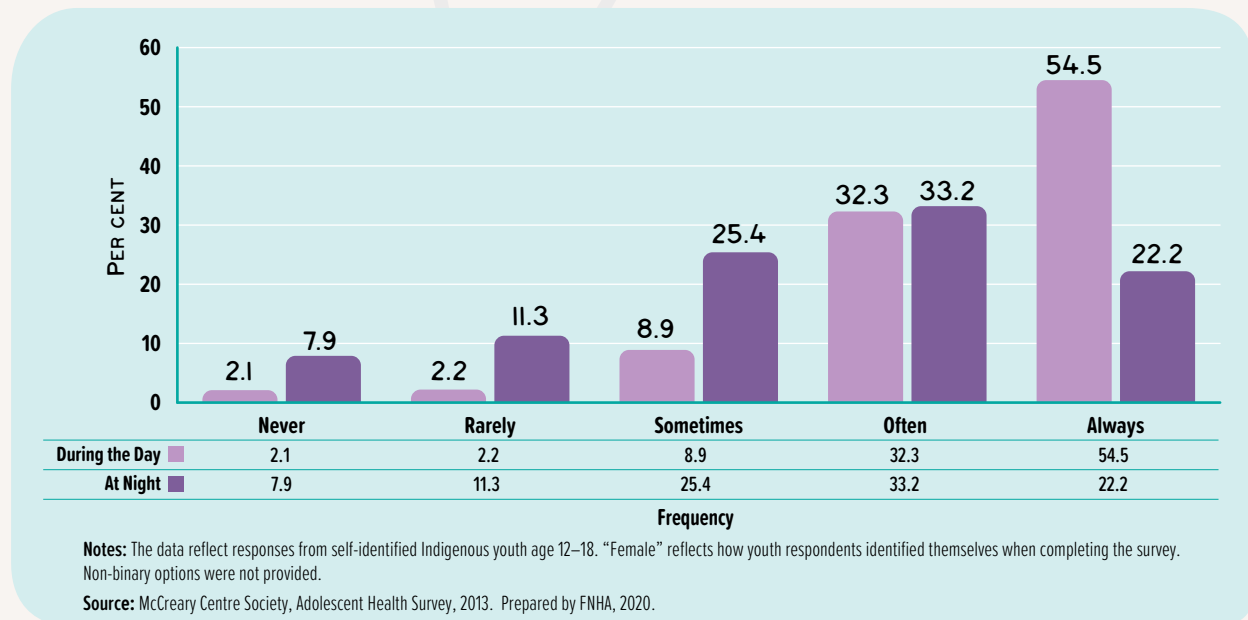
The AHS (2013) showed that 34.9% of young Indigenous women age 12–18 reported feeling “quite a bit” or “very much” a part of their community. Youth may belong to various social networks, in addition to the community where they grew up, by participating in cultural events, at school, and through shared interests or gender identity.⁸



FEELING SAFE

p.51

FIG 3.8 PERCENTAGE OF YOUNG INDIGENOUS WOMEN WHO REPORTED FEELING SAFE IN THEIR NEIGHBOURHOOD, AGE 12–18, BY TIME OF DAY, BC, 2013



The AHS (2013) showed that 86.8% of young Indigenous women age 12–18 “always” (54.5%) or “often” (32.3%) felt safe in their neighbourhood during the day. A smaller proportion (55.4%) “always” (22.2%) or “often” (33.2%) felt safe in their neighbourhood at night. Intergenerational trauma, as well as past experiences, may impact youth’s perception of safety in their neighbourhood.^{9,10} However, the close connections that youth develop with friends, family, and caring adults in their community provide them with reassurance that they will be supported, recognizing that many young Indigenous women continue to be subjected to violence.^{11,12}



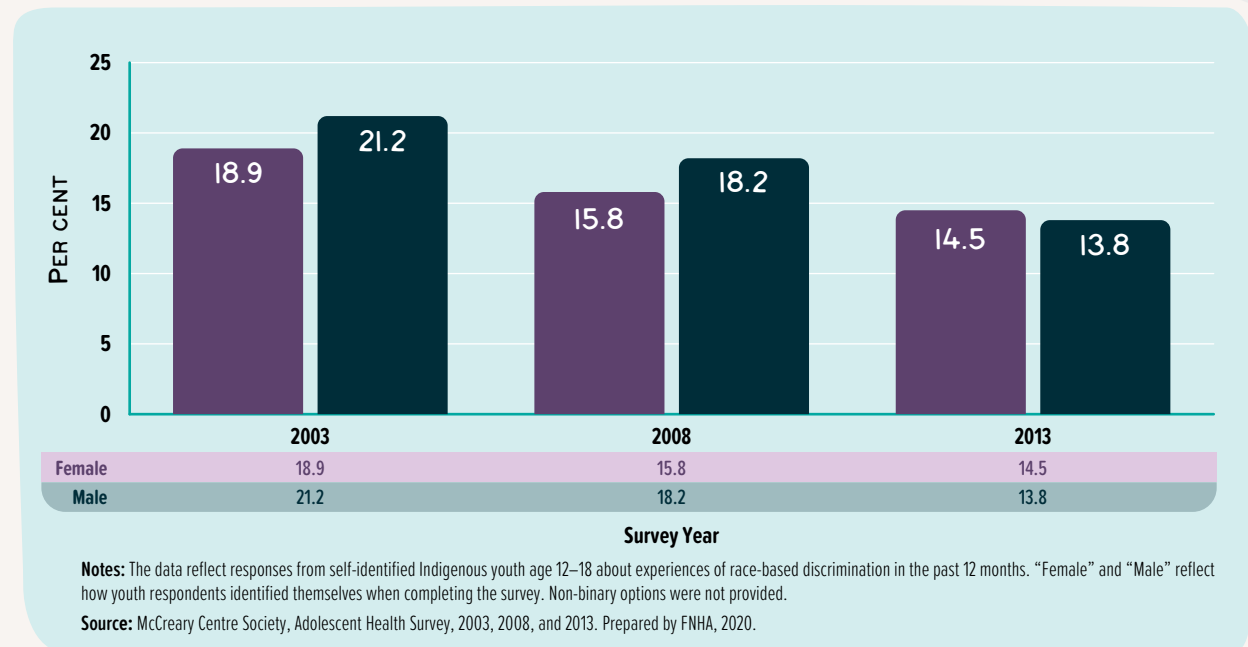
SUPPORTIVE SYSTEMS

First Nations youth regularly interact with systems for education, health care, housing, transportation, and justice. These Western systems are rooted in colonialism and continue to marginalize and discriminate against First Nations people.^{13,14,15} Young First Nations women also experience the additional and compounded impacts of sexism and other socially constructed biases, leading to disproportionate levels of risk compared to their non-Indigenous peers.¹³ The wellness of young First Nations women is shaped by self-determination, a sense of belonging, and a connection to their culture.³

RACE-BASED DISCRIMINATION

p-52

FIG 3.9 PERCENTAGE OF INDIGENOUS YOUTH WHO REPORTED HAVING EXPERIENCED DISCRIMINATION BECAUSE OF RACE OR ETHNICITY IN THE PAST YEAR, AGE 12–18, BY SEX, BC, 2003, 2008, AND 2013



In the AHS (2013), 14.5% of young Indigenous women and 13.8% of young Indigenous men age 12–18 reported experiencing discrimination based on race or ethnicity in the past year. For young Indigenous women, there has been a declining trend of 4.4 percentage points, with the 2013 value (14.5%) being the lowest reported since 2003 (18.9%). Although there has been a decline in reported experiences of racism and discrimination among First Nations youth, racist stereotypes and biases in Western society continue to affect how young First Nations women are treated and often lead to barriers when trying to access culturally appropriate services.¹⁴

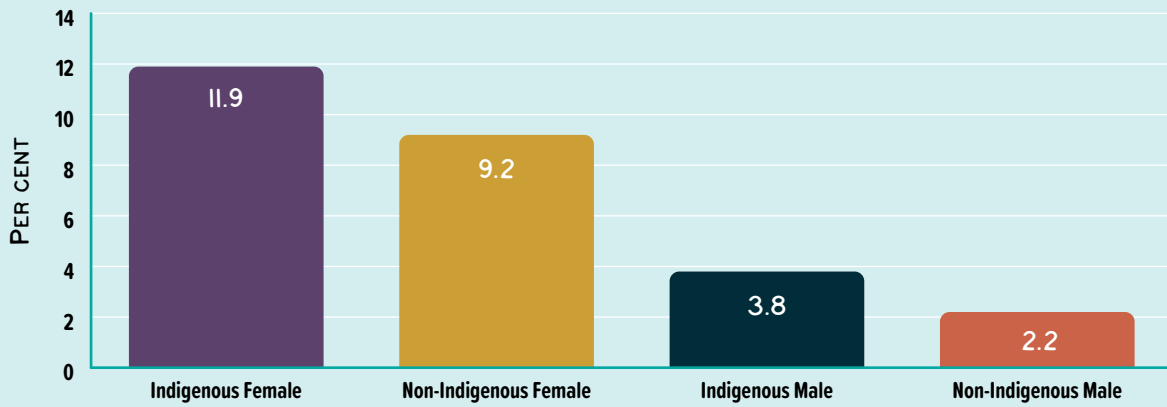




SEX- AND GENDER-BASED DISCRIMINATION

p.52

FIG 3.10 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED HAVING EXPERIENCED DISCRIMINATION BECAUSE OF SEX OR GENDER IN THE PAST YEAR, AGE 12-18, BY SEX, BC, 2013



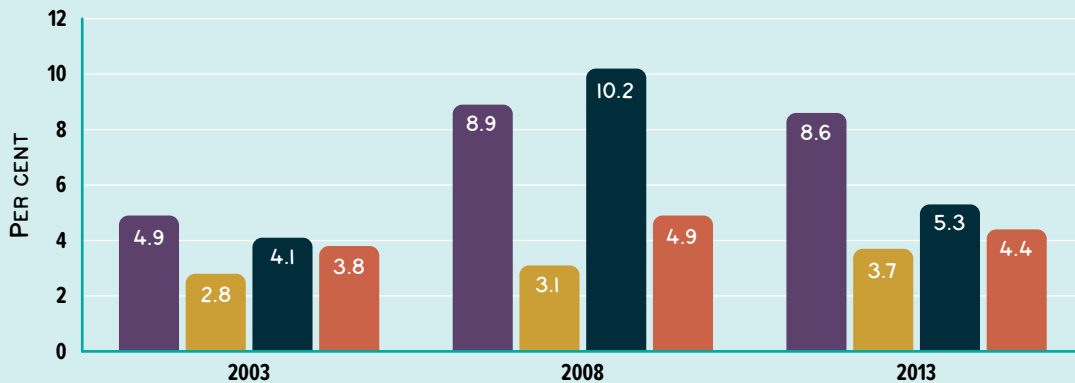
Notes: The data reflect responses from self-identified Indigenous youth and other youth age 12-18 about experiences of gender/sex-based discrimination in the past 12 months. "Female" and "Male" reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: McCreary Centre Society, Adolescent Health Survey, 2013. Prepared by FNHA, 2020.

The AHS (2013) showed that young Indigenous women age 12-18 experienced more discrimination based on their gender or sex in the past year (11.9%) than young non-Indigenous women in the same age group (9.2%). Both experienced significantly more discrimination than young Indigenous (3.8%) and non-Indigenous (2.2%) men age 12-18.

p.52

FIG 3.11 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED HAVING EXPERIENCED DISCRIMINATION BECAUSE OF THEIR SEXUAL ORIENTATION IN THE PAST YEAR, AGE 12-18, BY SEX, BC, 2003, 2008, AND 2013



	2003	2008	2013
Indigenous Female	4.9	8.9	8.6
Non-Indigenous Female	2.8	3.1	3.7
Indigenous Male	4.1	10.2	5.3
Non-Indigenous Male	3.8	4.9	4.4

Survey Year

Notes: The data reflect responses from self-identified Indigenous youth and other youth age 12-18 about experiences of discrimination based on sexual orientation in the past 12 months. "Female" and "Male" reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: McCreary Centre Society, Adolescent Health Survey, 2003, 2008, and 2013. Prepared by FNHA, 2020.

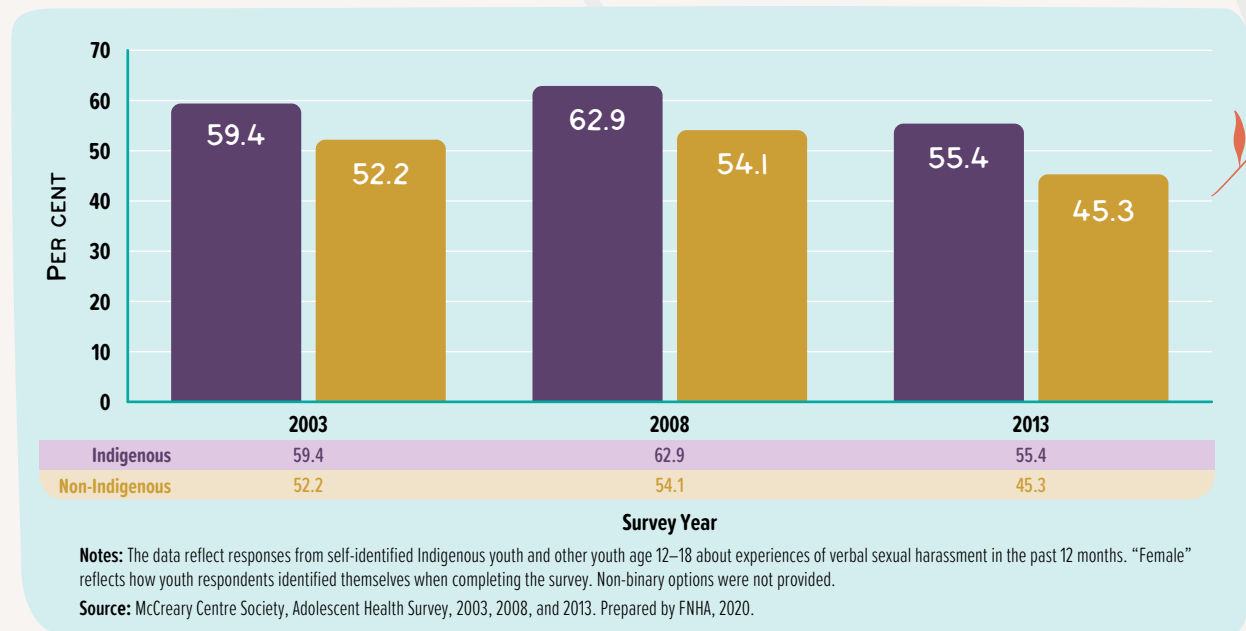
From 2003 (4.9%) to 2013 (8.6%), the AHS showed an increase of 3.7 percentage points in the proportion of young Indigenous women age 12-18 experiencing discrimination based on sexual orientation. During adolescence, young adults who are beginning to discover and explore their sexual orientation may lack the support and guidance needed as they navigate societal pressures and norms. For Indigenous youth, it is especially important that they have Indigenous role models and allies who can share their own experiences of overcoming hardships.¹⁶



SEXUAL HARASSMENT: VERBAL AND PHYSICAL

p.53

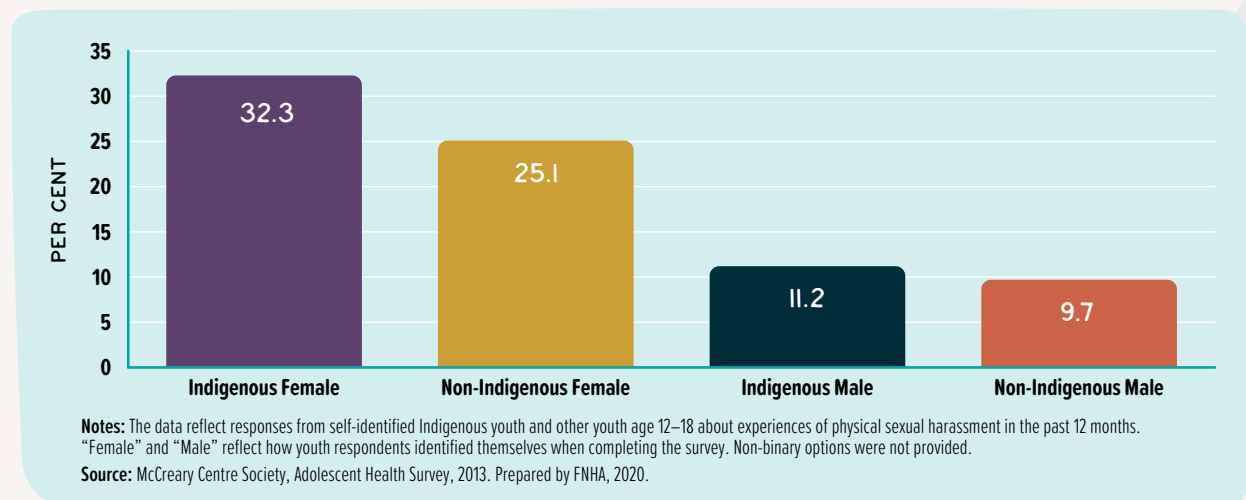
FIG 3.12 PERCENTAGE OF YOUNG INDIGENOUS AND NON-INDIGENOUS WOMEN WHO REPORTED EXPERIENCING VERBAL SEXUAL HARASSMENT IN THE PAST YEAR, AGE 12-18, BC, 2003, 2008, AND 2013



In the AHS (2013), 55.4% of young Indigenous women age 12–18 reported experiencing verbal sexual harassment in the past year. This is a four-percentage point decrease from 2003. Young Indigenous women were more likely than young non-Indigenous women to have experienced verbal sexual harassment during each survey year. First Nations have ceremonies and rituals that affirm women as sacred and protected but, for many Nations, these protocols have been eroded due to colonization. In Western society, Indigenous women are often blamed for the violence inflicted on them (verbal, sexual, and physical); this has created a culture of impunity around the violence.¹⁷ First Nations are reclaiming the ceremonies, protocols, and teachings that affirm young women as sacred and respected members of their communities.

p.53

FIG 3.13 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED EXPERIENCING PHYSICAL SEXUAL HARASSMENT IN THE PAST YEAR, AGE 12-18, BY SEX, BC, 2013



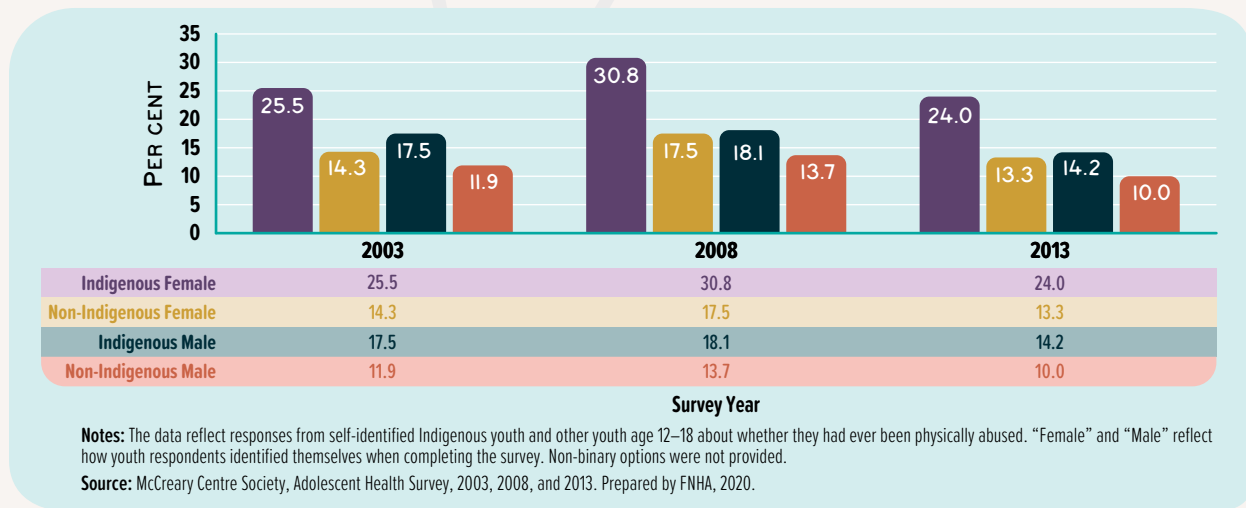
The AHS (2013) showed a nearly three-fold difference between young Indigenous women (32.3%) and young Indigenous men (11.2%) age 12–18 among those who reported experiencing physical sexual harassment in the past year.



ABUSE

p-53

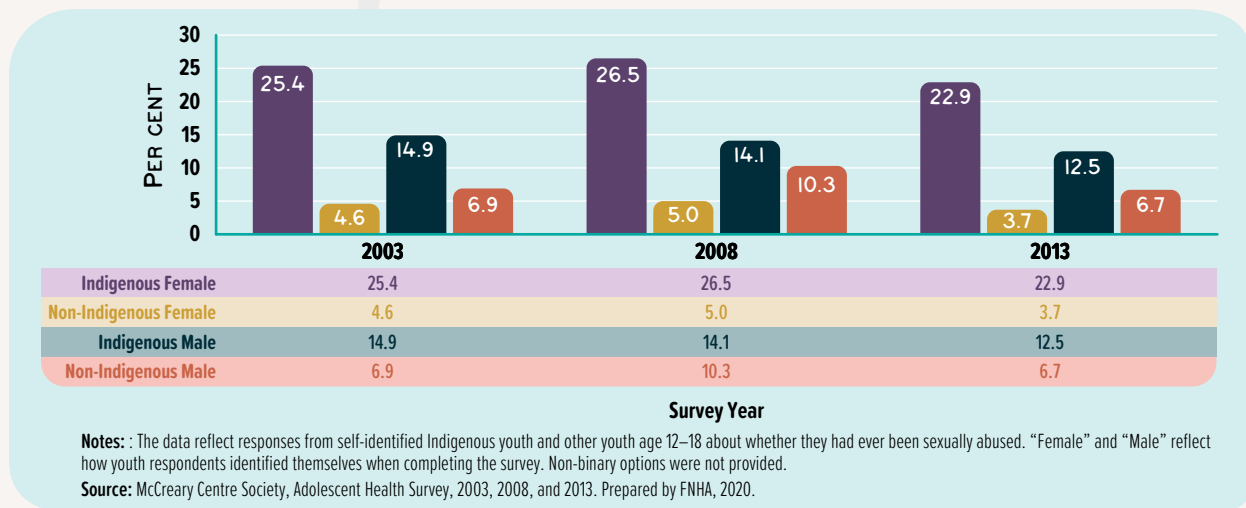
FIG 3.14 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED EXPERIENCING PHYSICAL ABUSE IN THE PAST YEAR, AGE 12–18, BY SEX, BC, 2003, 2008, AND 2013



The AHS (2013) showed that 24.0% of young Indigenous women age 12–18 reported experiencing physical abuse in the past year, a 6.8 percentage point decline from 2008 (30.8%). However, in all AHS years, young Indigenous women consistently remained the highest in reporting experiencing physical abuse, as compared to other groups. The National Inquiry into Missing and Murdered Indigenous Women and Girls confirmed that there has been and continues to be a genocide of Indigenous Peoples, with Indigenous women, girls, and 2SLGBTQQIA+^a peoples being specifically targeted.^{13,17} These human and Indigenous rights violations are caused by colonial structures and policies instilled in society. BC First Nations stand strong against this culture of violence through community support and the amplifying of each other’s voices.

p-53

FIG 3.15 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED EXPERIENCING SEXUAL ABUSE IN THE PAST YEAR, AGE 12–18, BY SEX, BC, 2003, 2008, AND 2013

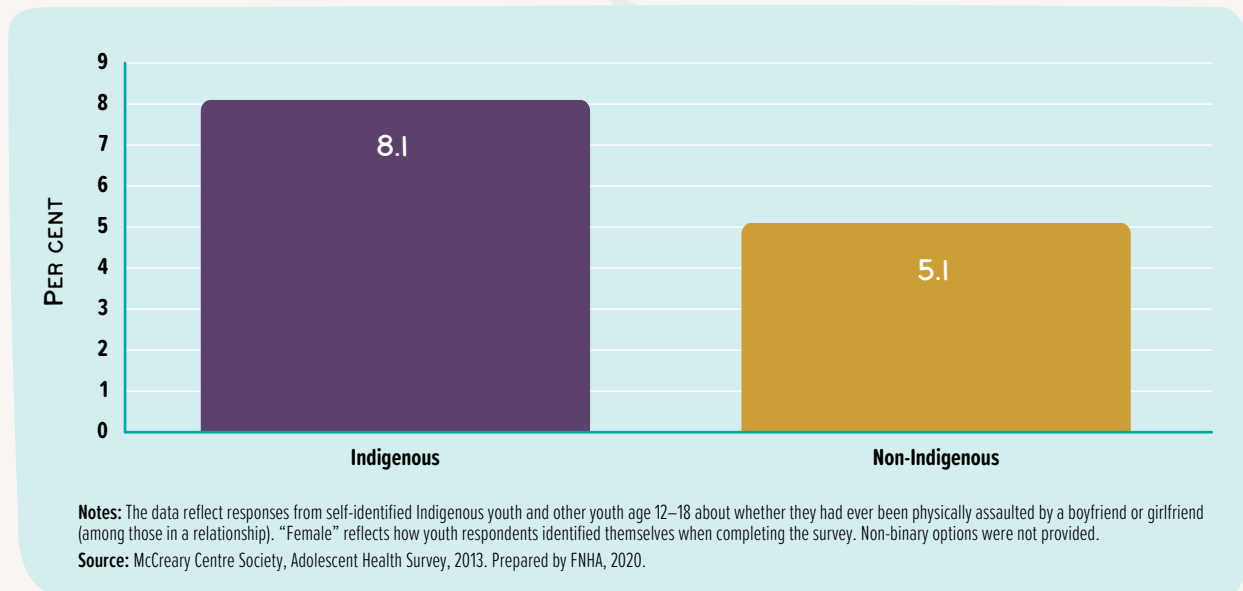


The AHS (2013) showed that 22.9% of young Indigenous women age 12–18 reported experiencing sexual abuse in the past year, remaining relatively consistent across all years reported here, with a decline of 3.6 percentage points since 2008. Young Indigenous women consistently reported the highest rates of sexual abuse, compared to other groups, across all survey years.

a 2SLGBTQQIA+ stands for Two-Spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex, and asexual. The plus sign acknowledges the many sexual and gender minority peoples who don’t see themselves in the umbrella acronym.



FIG 3.16 PERCENTAGE OF YOUNG INDIGENOUS AND NON-INDIGENOUS WOMEN WHO REPORTED THAT THEY HAD BEEN ASSAULTED BY A BOYFRIEND/GIRLFRIEND IN THE PAST YEAR, AMONG YOUNG WOMEN IN RELATIONSHIPS, AGE 12-18, BC, 2013



The AHS (2013) showed that 8.1% of young Indigenous women age 12–18 in relationships reported being physically assaulted by an intimate partner in the past year.

The everyday realities of young First Nations women are shaped by the pervasive threat of violence that has been created and maintained by colonialism. At the same time, for as long as violence has been inflicted against First Nations women and girls, there has been resistance against it. This ceaseless resistance is apparent in everyday individual acts of resistance of young First Nations women coming together, supporting each other, and speaking out against the violence.

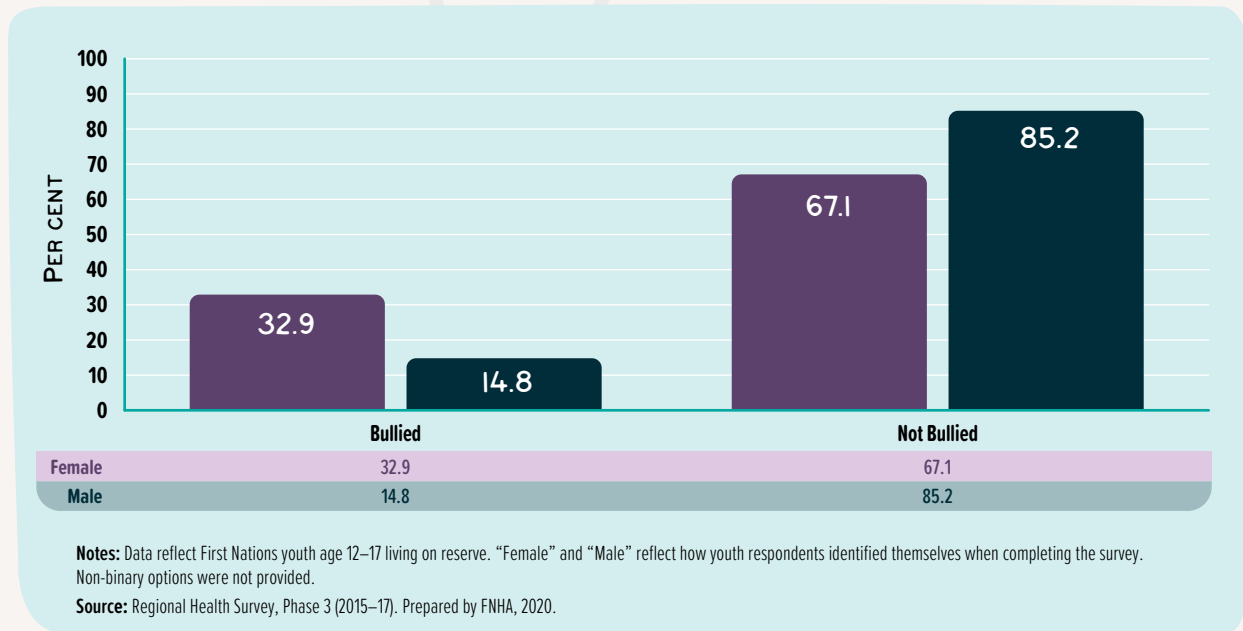
- Sacred and Strong: Upholding our Matriarchal Roles (p.53)



BULLYING

p.55

FIG 3.17 PERCENTAGE OF FIRST NATIONS YOUTH WHO REPORTED BEING BULLIED OR NOT BULLIED IN THE PAST YEAR, AGE 12–17, BY SEX, BC, 2015–17



RHS3 (2015–17) showed that 32.9% of young First Nations women age 12–17 reported being bullied in the past year, just over twice that of young First Nations men in the same age group (14.8%). Young First Nations women may be more likely to experience bullying due to colonial institutions, policies, and practices that have served to marginalize them in society. Additionally, they may experience lateral violence as a result of the traumas and violence inflicted on First Nations communities. Lateral kindness is an approach to counteract these behaviours; it aims to create an environment based on kindness and respect.¹⁸

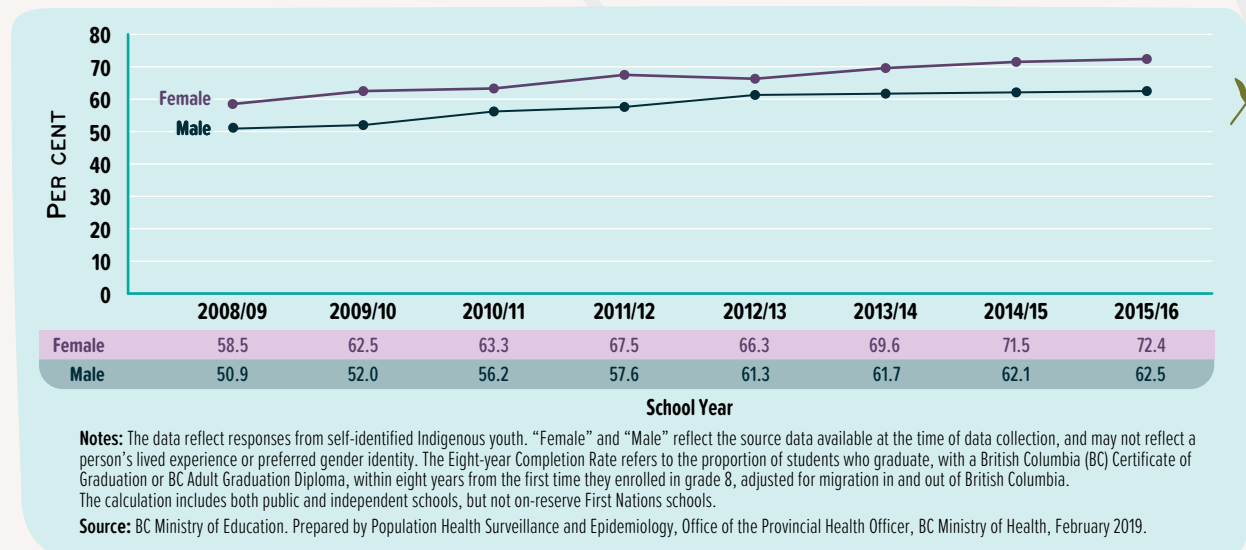




SCHOOL COMPLETION RATES

p-56

FIG 3.18 EIGHT-YEAR SCHOOL COMPLETION RATES AMONG INDIGENOUS YOUTH, BY SEX, BC, 2008/09 TO 2015/16

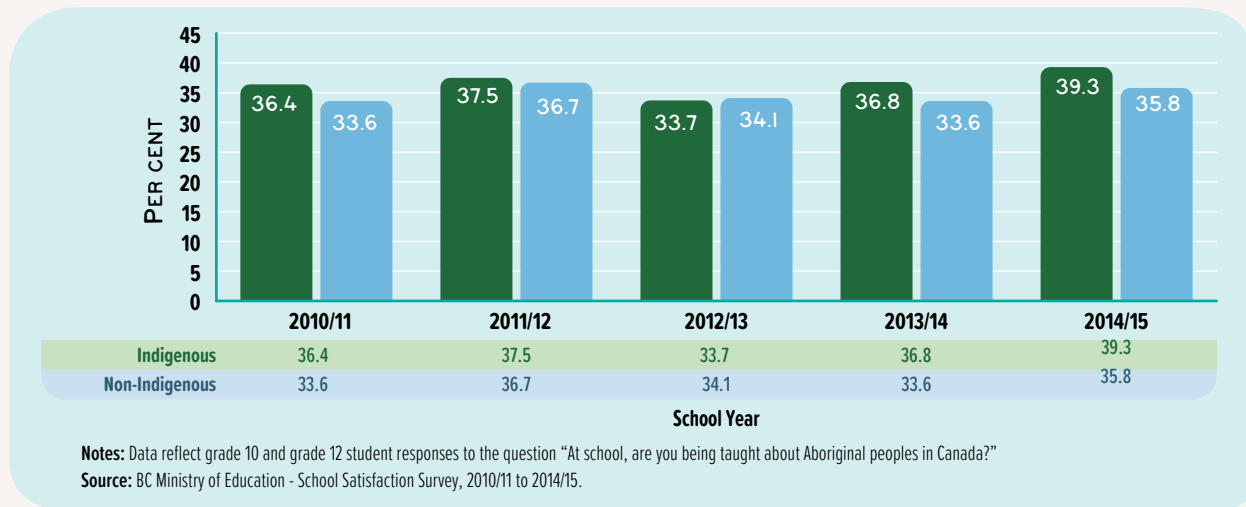


BC Ministry of Education data showed an increase of 13.9 percentage points among young Indigenous women graduating from 2008/2009 (58.5%) to 2015/2016 (72.4%). A similar trend was seen among young Indigenous men. While there have been efforts to integrate Indigenous perspectives and knowledges into BC’s education curriculum, these two streams of learning remain separate for many First Nations youth. There remains much work to do to create culturally safe learning environments for First Nations youth.^{19,20}

INDIGENOUS CONTENT IN BC PUBLIC SCHOOLS

p-56

FIG 3.19 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS STUDENTS IN GRADES 10 AND 12 WHO REPORTED THAT THEY WERE “ALWAYS” OR “MANY TIMES” TAUGHT ABOUT INDIGENOUS PEOPLES IN CANADA, BC, 2010/11 TO 2014/15



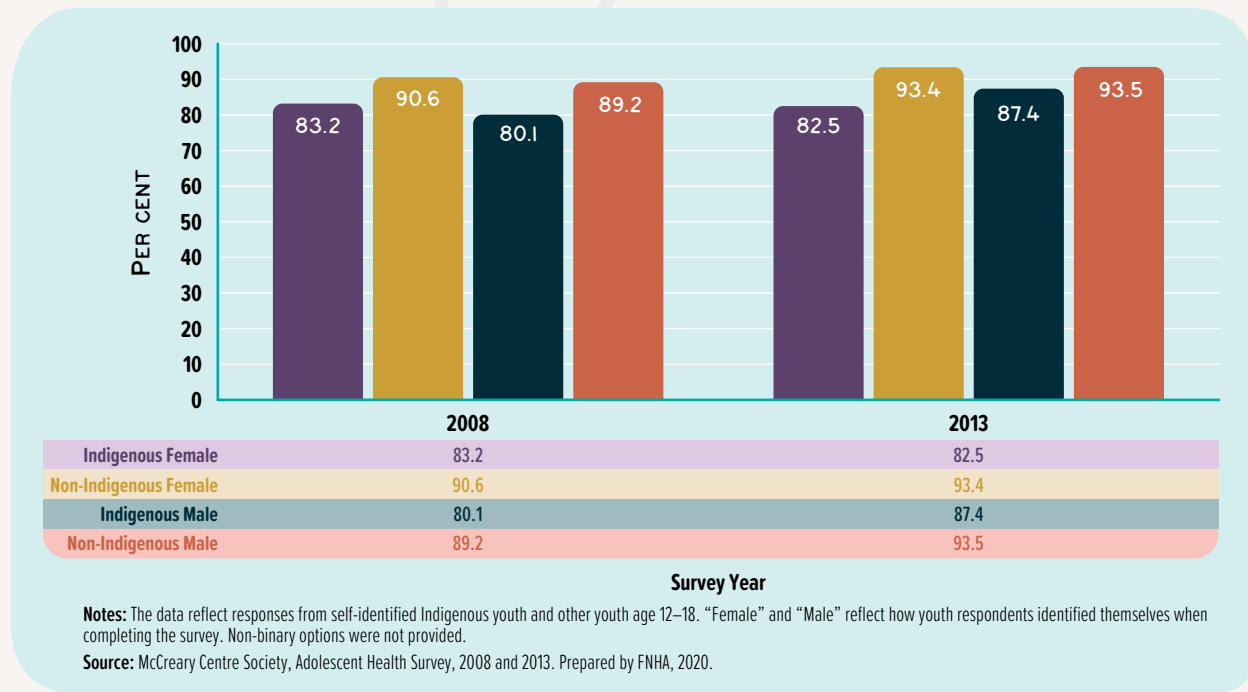
In 2014/2015, 39.3% of Indigenous students in grades 10 and 12 reported being taught about Indigenous peoples in Canada “always” or “many times,” as compared to 35.8% of non-Indigenous students.



NEVER GOING TO BED HUNGRY

p.57

FIG 3.20 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED NEVER GOING TO BED HUNGRY DUE TO A LACK OF MONEY FOR FOOD, AGE 12-18, BY SEX, BC, 2008 AND 2013



The AHS (2013) showed that 82.5% of young Indigenous women age 12–18 reported never going to bed hungry due to lack of money for food. However, young Indigenous women experience the highest rate of hunger (17.5%) as compared to young Indigenous men (12.6%) and young non-Indigenous women (6.6%) and men (6.5%) in the same age group. In addition to income, having access to First Nations territories for hunting and gathering is an important component of food security and food sovereignty for First Nations.^{21,22}

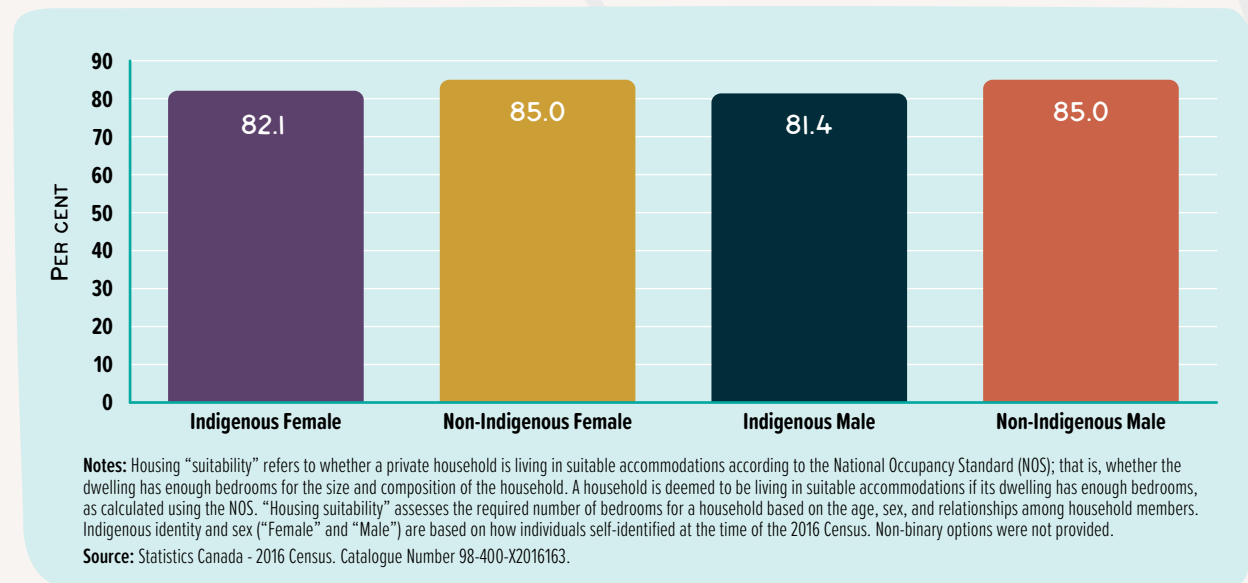




HOUSING

p.57

FIG 3.21 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH LIVING IN HOUSING CONSIDERED TO BE "SUITABLE," AGE 12-18, BY SEX, BC, 2016

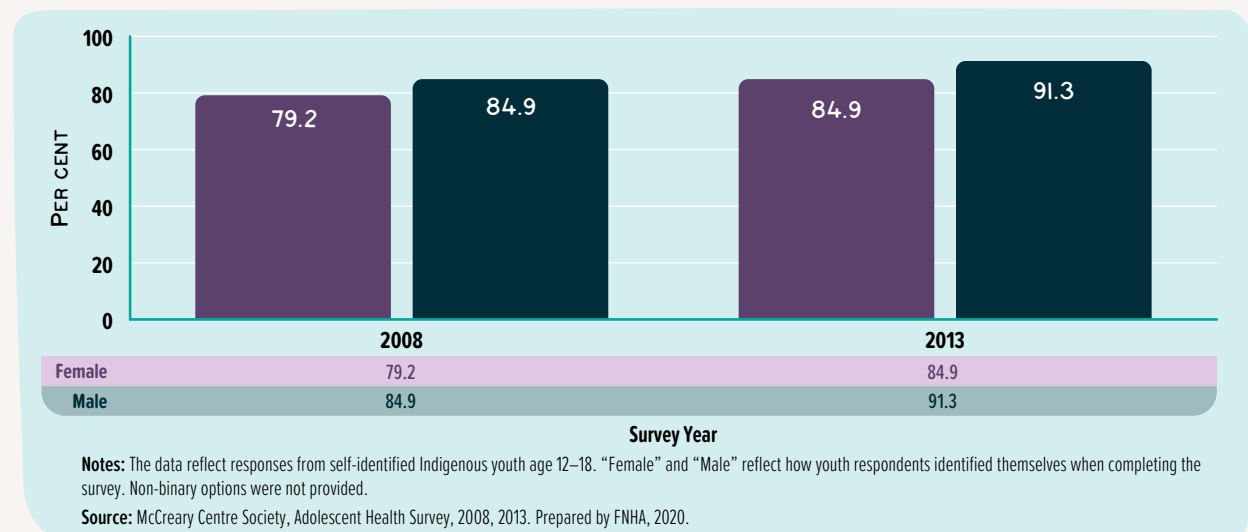


Statistics Canada reported in 2016 that 82.1% of young Indigenous women age 12–18 lived in “suitable” housing as compared to 85.0% of young non-Indigenous women, 81.4% of young Indigenous men, and 85.0% of young non-Indigenous men. Having a healthy and stable home environment contributes to the overall health and wellness of young First Nations women and may be protective against long-term mental health issues linked to high levels of stress.^{23,24}

SEEKING MEDICAL CARE WHEN NEEDED

FIG 3.22 PERCENTAGE OF INDIGENOUS YOUTH WHO EITHER DID NOT NEED MEDICAL HELP, OR GOT THE MEDICAL HELP THEY NEEDED, IN THE PAST YEAR, AGE 12-18, BY SEX, 2008 AND 2013

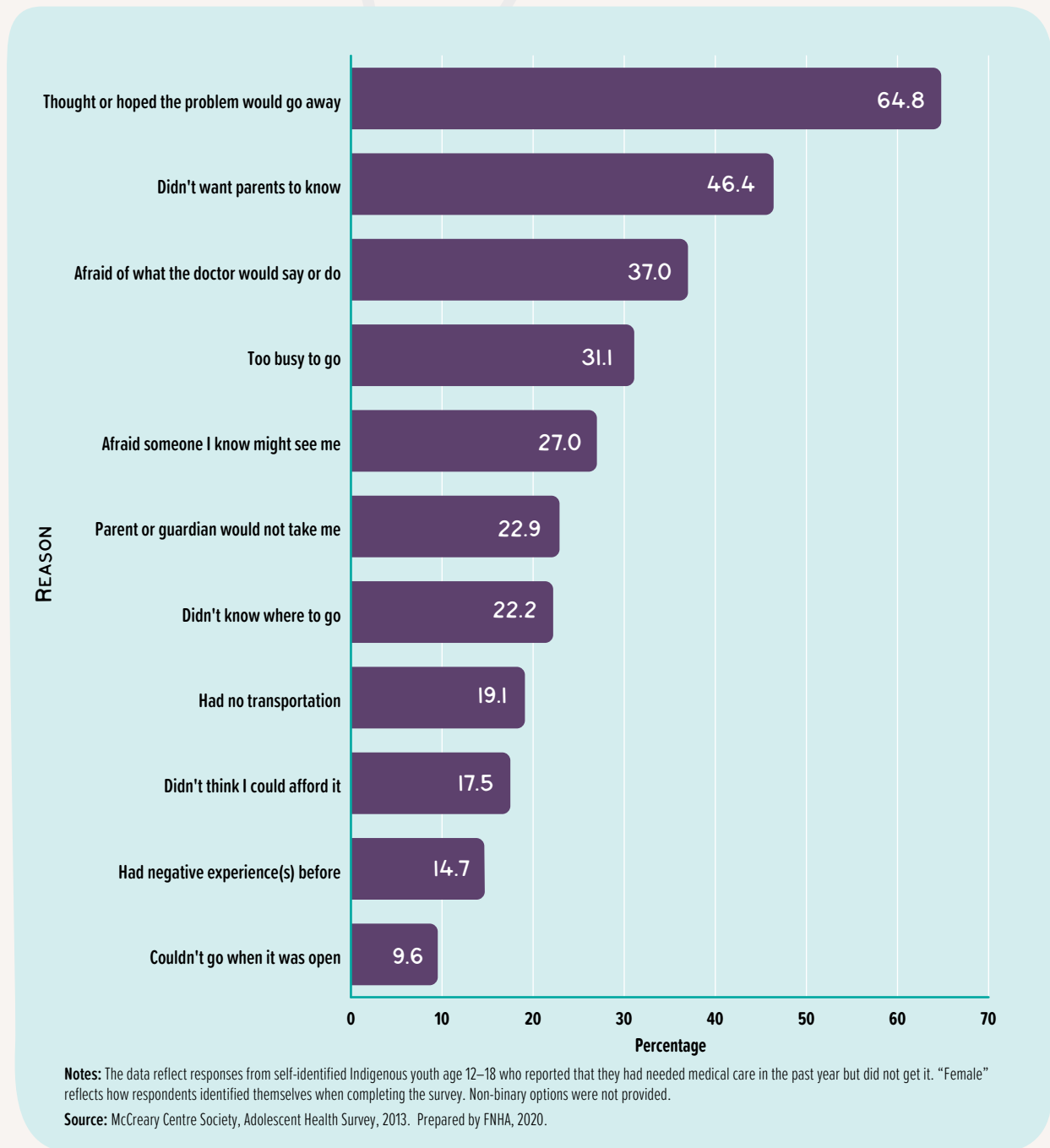
p.59



From 2008 to 2013, the AHS showed a 5.7 percentage point increase, from 79.2% to 84.9%, in the proportion of young Indigenous women age 12–18 who reported either “not needing medical help” or “getting the medical help they needed” in the past year. A similar increase was seen among young Indigenous men in the same age group, whose values were consistently higher across the two time periods. Embedding cultural safety and humility into the health care system creates environments where young First Nations women feel safe, supported, and respected, and where they are more likely to access health care services and social supports when needed.²⁵



FIG 3.23 PERCENTAGE OF REPORTED REASON FOR NOT ACCESSING CARE, AMONG YOUNG INDIGENOUS WOMEN WHO FELT THEY NEEDED MEDICAL HELP AND DID NOT ACCESS CARE, AGE 12–18, BC, 2013



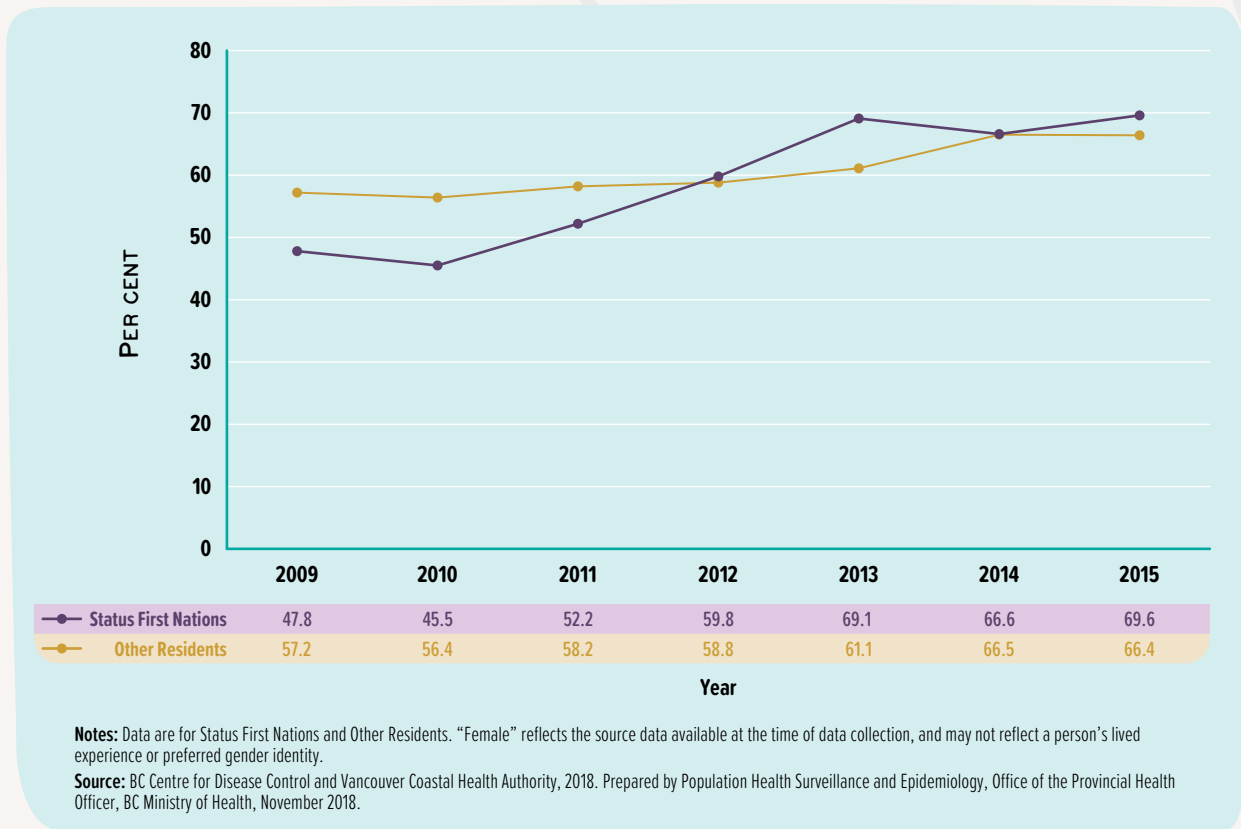
Adolescence is a time when youth are gaining independence and may be more reluctant to involve their parents or consult a health care provider for concerns, especially around topics such as substance use, emotional problems, reproductive issues, or gender and sexuality.^{26,27} The top three reasons reported in the AHS (2013) for young Indigenous women age 12–18 to forego medical help when needed were: thinking or hoping the problem would go away (64.8%), not wanting parents to know (46.4%), and fear of what the doctor would say or do (37.0%). Providers who approach care from a place of cultural humility, and who are sensitive to past traumas, may help to facilitate positive experiences that encourage young First Nations women to access the care they need.²⁸



HUMAN PAPILLOMAVIRUS IMMUNIZATION

p.60

FIG 3.24 PERCENTAGE OF YOUNG WOMEN WHO COMPLETED THE HPV IMMUNIZATION SERIES PRIOR TO THEIR 16TH BIRTHDAY, STATUS FIRST NATIONS AND OTHER RESIDENTS, BC, 2009 TO 2015



In 2015, 69.6% of young Status First Nations women completed the human papillomavirus (HPV) immunization series prior to their 16th birthday, an increasing trend of 21.8 percentage points from 2009. The completion rate was lower or the same among young Other Resident women from 2012 to 2015.

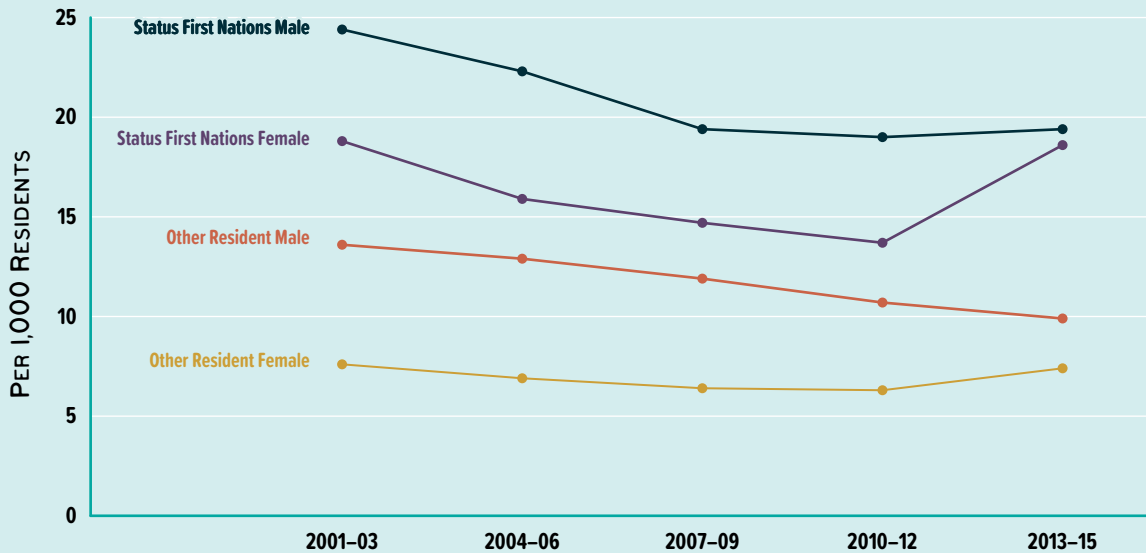




AVOIDABLE HOSPITALIZATIONS – INJURIES

p.60

FIG 3.25 AGE-STANDARDIZED HOSPITALIZATION RATES FOR INTENTIONAL AND NON-INTENTIONAL INJURIES AMONG STATUS FIRST NATIONS AND OTHER RESIDENT YOUTH, AGE 10–19, BY SEX, BC, 2001–03 TO 2013–15



	2001–03	2004–06	2007–09	2010–12	2013–15
Status First Nations Female	18.8	15.9	14.7	13.7	18.6
Other Resident Female	7.6	6.9	6.4	6.3	7.4
Status First Nations Male	24.4	22.3	19.4	19.0	19.4
Other Resident Male	13.6	12.9	11.9	10.7	9.9

Years

Notes: Data are for Status First Nations and Other Residents age 10–19, standardized to the Canada 2011 population. “Female” and “Male” reflect the source data available at the time of data collection, and may not reflect a person’s lived experience or preferred gender identity.

Source: Hospital Discharge Records, Client Roster and First Nations Client File (Release v2013–2015). Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, April 2019.



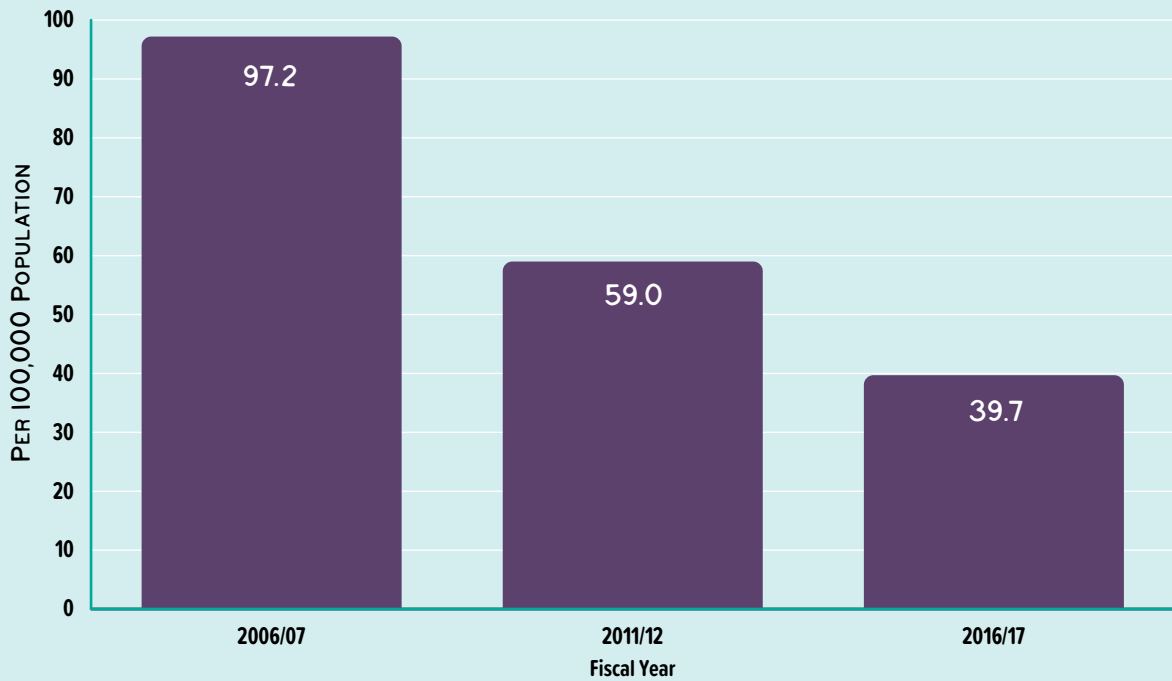
According to hospital discharge records, the age-standardized hospitalization rate for intentional and non-intentional injuries among young Status First Nations women age 10–19 remained consistently higher than for Other Residents in the same age group from 2001–03 to 2013–15. Rates for both young Status First Nations and Other Resident women showed a steady decline from 2001–03 to 2010–12 then, in 2013–15, returned to rates similar to those recorded for 2001–03.



YOUTH CUSTODY RATES

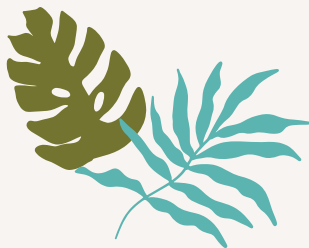
p.60

FIG 3.26 RATE OF YOUNG INDIGENOUS WOMEN IN PROVINCIAL YOUTH CUSTODY, AGE 12–17, BC, 2006/07, 2011/12, AND 2016/17



Notes: This analysis reports the BC population-based proportion (rate per 100,000 population) for youth of the female sex who were in custody (either open or secure custody) by Indigenous status, showing a comparison of data reported during the 2006/07, 2011/12, and 2016/17 fiscal years. The population-based rate is calculated by simply dividing the average number of individuals who were admitted into provincial custody by the number of Indigenous individuals in the total BC population. The Indigenous population includes Inuit, Métis, Native, First Nations, and Aboriginal designations. The age range is 12–17 at the time of the offence, but it should be noted that a youth could be held in youth custody at the age of 18, 19, or 20 on a youth sentence. “Female” reflects the source data available at the time of data collection, and may not reflect a person’s lived experience or preferred gender identity.

Source: Data provided by the Ministry of Children and Family Development, Specialized Intervention and Youth Justice Branch, CORNET system. The Statistics Canada population estimates, provided by BC Stats, are from the 2006, 2011, and 2016 census years representing Indigenous individuals age 12–17. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, April 2020.

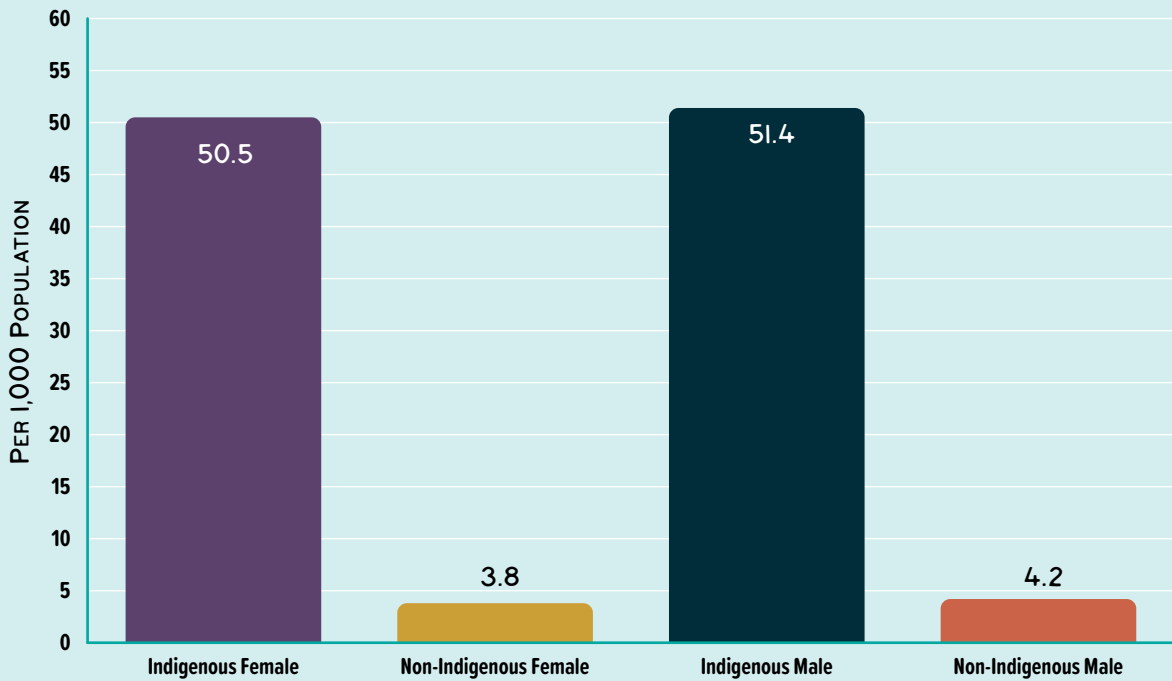


The BC Ministry of Children and Family Development reported a sharp, decreasing trend in the rate of young Indigenous women age 12–17 in provincial youth custody, from 97.2 per 100,000 (2006/07) to 39.7 per 100,000 (2016/17). These changes may be the result of recommendations, calls to action, and calls for justice from several inquiries and reports highlighting the colonial policies and approaches that have caused the over-representation of Indigenous youth in custody.^{29,30}



YOUTH IN CARE

FIG 3.27 RATE OF INDIGENOUS AND NON-INDIGENOUS YOUTH IN CARE, AGE 10–18, BY SEX, BC, 2016



Notes: The population-based rate for Youth in Care is calculated by simply dividing the total number of children age 10–18 in care for a given demographic by the entire BC population of children for that same demographic and expressing it as a rate per 1,000 population. Youth in care data include both youth in the care of BC Ministry of Children and Family Development (MCFD) and in the care of Delegated Aboriginal Agencies. “Female” and “Male” refers to the youth’s sex. This categorization reflects the source data available at the time of data collection, and may not reflect a person’s lived experience or preferred gender identity.

Source: Population data was produced by BC Stats using the Statistics Canada 2016 National Household Survey. The 2016 Children in Care data was provided by the MCFD from their Integrated Case Management system. This analysis was prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, August 2018.



In 2016, the BC Ministry of Children and Family Development reported the rate of young Indigenous women age 10–18 in care at 50.5 per 1,000, over 13 times that of the rate reported for young non-Indigenous women in the same age group. Similarly, the rate among young Indigenous men age 10–18 in care was 51.4 per 1,000, more than 12 times that of young non-Indigenous men. A growing number of First Nations communities are reclaiming control of their own child welfare services and reviving the systems of culture and knowledge that ensured the safe and effective protection of children and youth for thousands of years.³¹

HEALTHY BODIES, MINDS AND SPIRITS

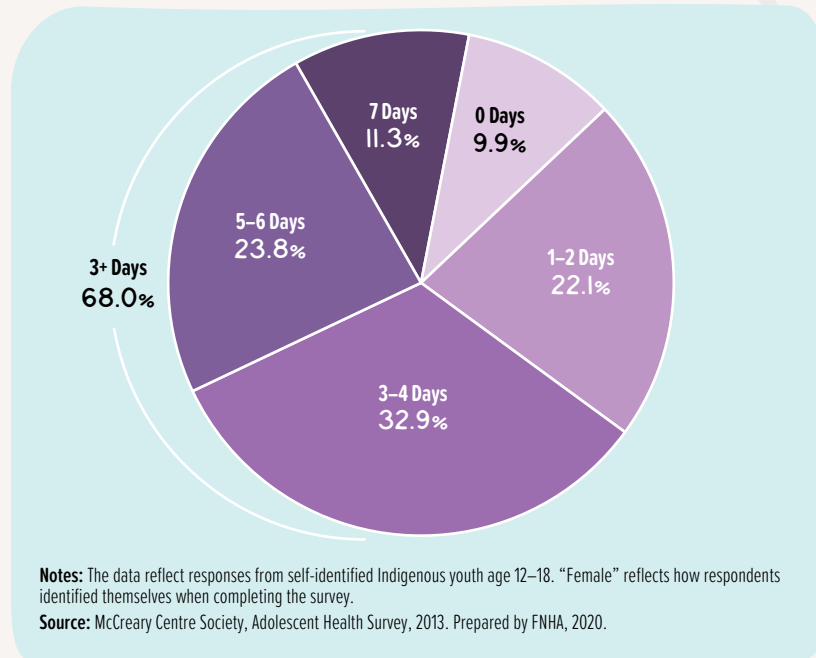


Young First Nations women who have well-nourished roots of wellness and supportive systems free of systemic barriers and racism will have the foundations necessary to flourish.

PHYSICAL ACTIVITY

p.62

FIG 3.28 NUMBER OF DAYS OF SELF-REPORTED MODERATE TO VIGOROUS PHYSICAL ACTIVITY AMONG YOUNG INDIGENOUS WOMEN, AGE 12–18, BC, 2013



First Nations teachings emphasize the benefits and importance of being active. From the AHS (2013), 68.0% of young Indigenous women age 12–18 reported moderate to vigorous physical activity at least three days a week.



Notes: The data reflect responses from self-identified Indigenous youth age 12–18. “Female” reflects how respondents identified themselves when completing the survey.

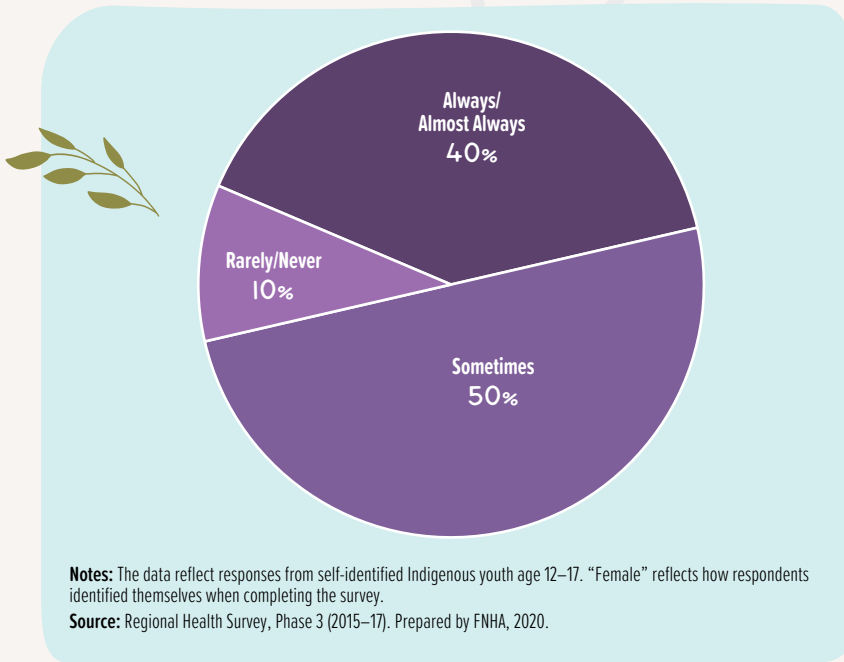
Source: McCreary Centre Society, Adolescent Health Survey, 2013. Prepared by FNHA, 2020.



EATING NUTRITIOUS MEALS

p.63

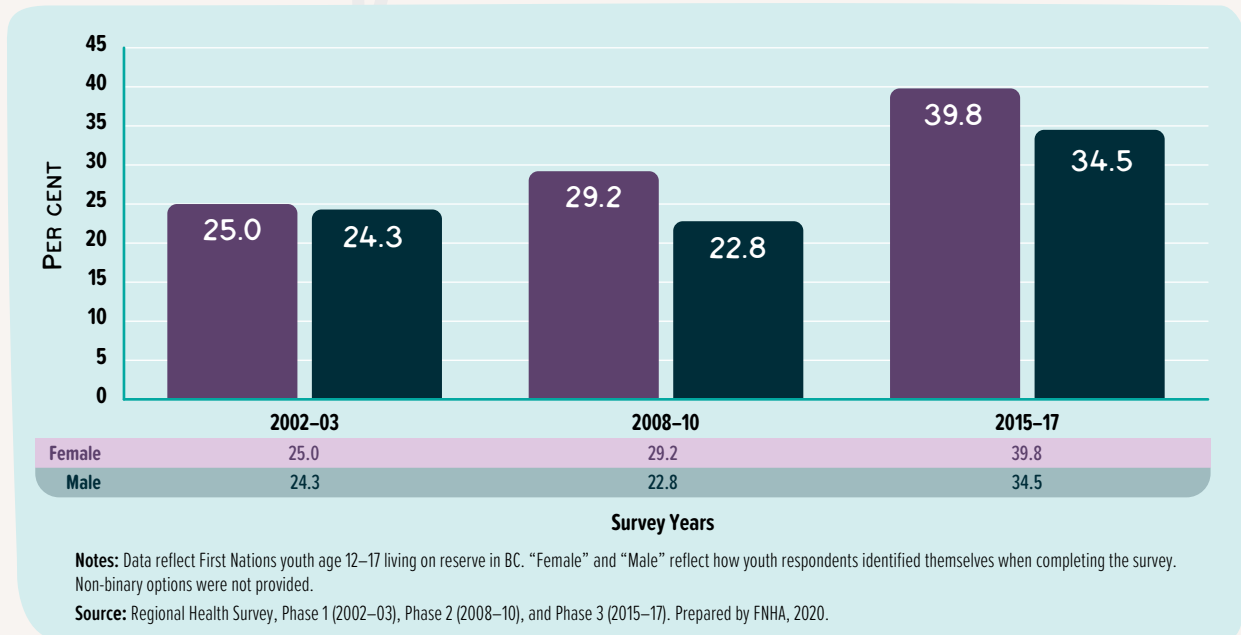
FIG 3.29 SELF-REPORTED FREQUENCY OF EATING NUTRITIOUS, BALANCED MEALS IN THE PAST YEAR AMONG YOUNG FIRST NATIONS WOMEN, AGE 12–17, BC, 2015–17



From RHS3 (2015–17), 40% of young First Nations women age 12–17 reported “always” or “almost always” eating nutritious, balanced meals in the past year. Half (50%) reported “sometimes” and 10% reported “rarely” or “never” eating nutritious, balanced meals in the past year. First Nations youth’s participation in the harvesting of food, and in the communal preparation and sharing of meals, is a key part of connecting with culture, family, community, and the land.³²

p.63

FIG 3.30 PERCENTAGE OF FIRST NATIONS YOUTH WHO REPORTED EATING NUTRITIOUS, BALANCED MEALS “ALWAYS” OR “ALMOST ALWAYS” IN THE PAST YEAR, AGE 12–17, BY SEX, BC, 2002–03, 2008–10, AND 2015–17

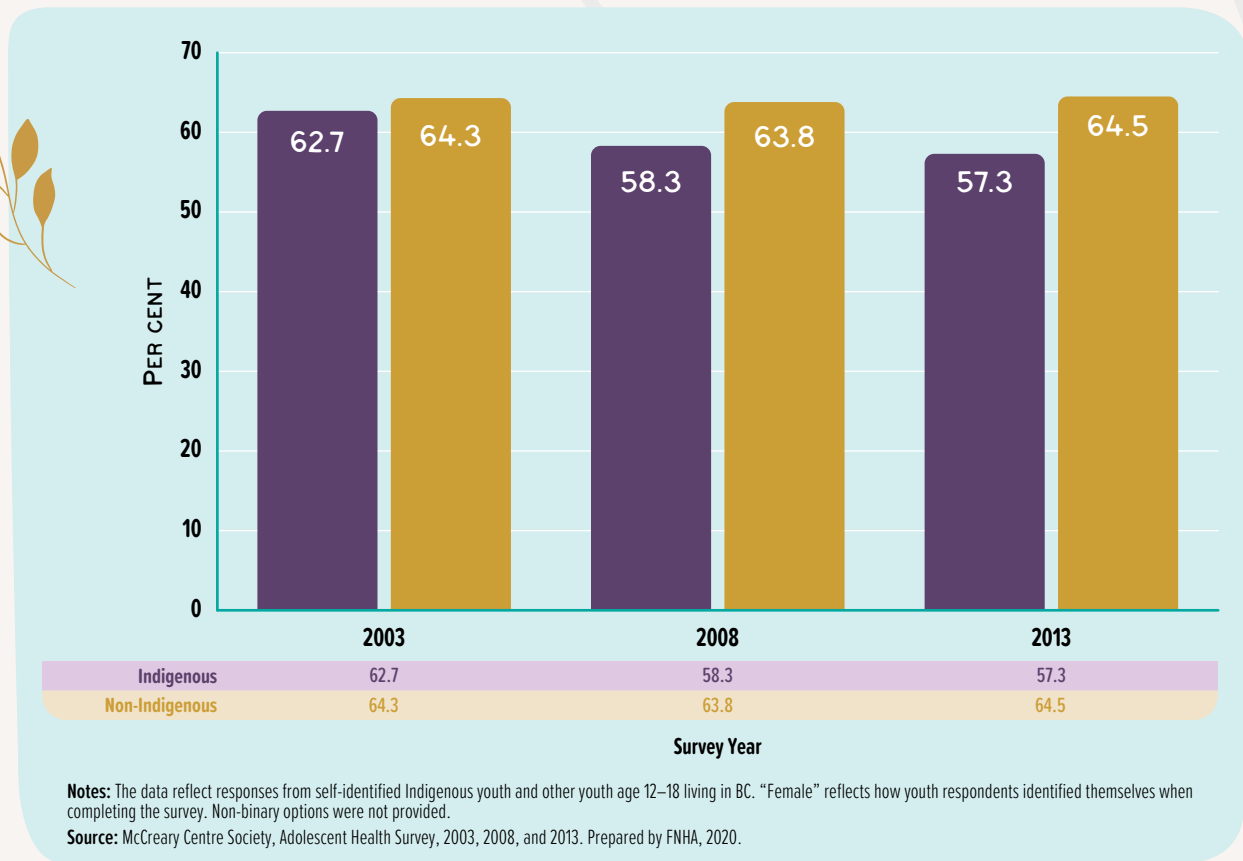


Comparing the three cycles of RHS, there was an increasing trend of 14.8 percentage points, from 25.0% (2002–03) to 39.8% (2015–17), among young First Nations women age 12–17 who reported “always” or “almost always” eating nutritious, balanced meals in the past year. A similar trend was seen among young First Nations men in the same age group, with an increase of 10.2 percentage points, from 24.3% (2002–03) to 34.5% (2015–17).

BODY WEIGHT

p.63

FIG 3.31 PERCENTAGE OF YOUNG INDIGENOUS AND NON-INDIGENOUS WOMEN WHO FELT THAT THEY WERE "ABOUT THE RIGHT WEIGHT," AGE 12-18, BC, 2003, 2008, AND 2013



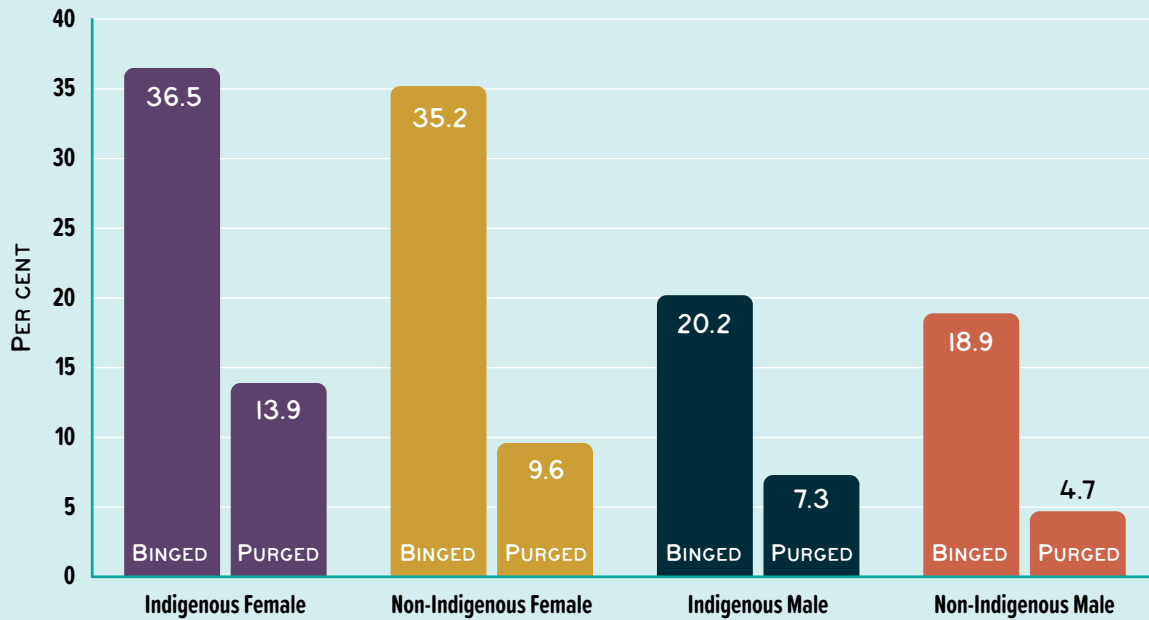
Comparing AHS cycles, there was a decreasing trend of 5.4 percentage points, from 62.7% (2003) to 57.3% (2013) in the proportion of young Indigenous women age 12–18 who felt they were “about the right weight.” Maintaining relationships with healthy First Nations women and Elders as role models and learning to gather and prepare healthy First Nations foods empowers young First Nations women, promoting the resilience to reject unhealthy mainstream social norms of beauty, body image, and objectification of women.^{33,34}



DISORDERED EATING

p.63

FIG 3.32 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO INDICATED THAT THEY ENGAGED IN BINGE-EATING/GORGING OR PURGING AT LEAST ONCE IN THE PAST YEAR, AGE 12-18, BY SEX, BC, 2013



Notes: The data reflect responses from self-identified Indigenous youth and other youth age 12–18 living in BC. “Female” and “Male” reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: McCreary Centre Society, Adolescent Health Survey, 2013. Prepared by FNHA, 2020.

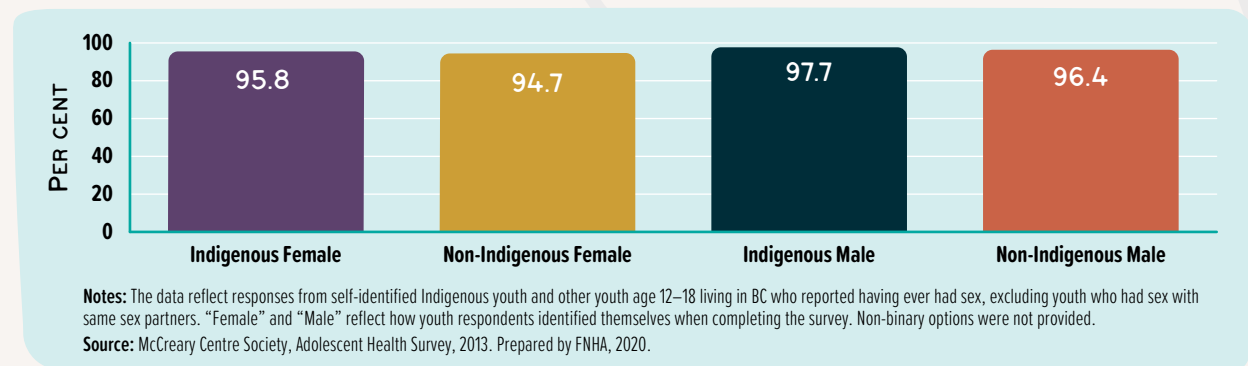


From the AHS (2013), both young Indigenous (36.5%) and non-Indigenous (35.2%) women age 12–18 engaged in binge-eating at much higher rates than young men in the same age group. Young Indigenous (13.9%) and non-Indigenous (9.6%) women also purged at higher rates than young men. Colonialism and racism are ever present factors that influence culture and identity for young First Nations women,^{33,35,36} and the introduction of Eurocentric ideals and body standards has negatively affected the health and wellness of many First Nations youth.^{33,37}

USE OF CONTRACEPTION

p.64

FIG 3.33 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO USED SOME FORM OF CONTRACEPTION THE LAST TIME THEY HAD SEX, AGE 12–18, BY SEX, BC, 2013

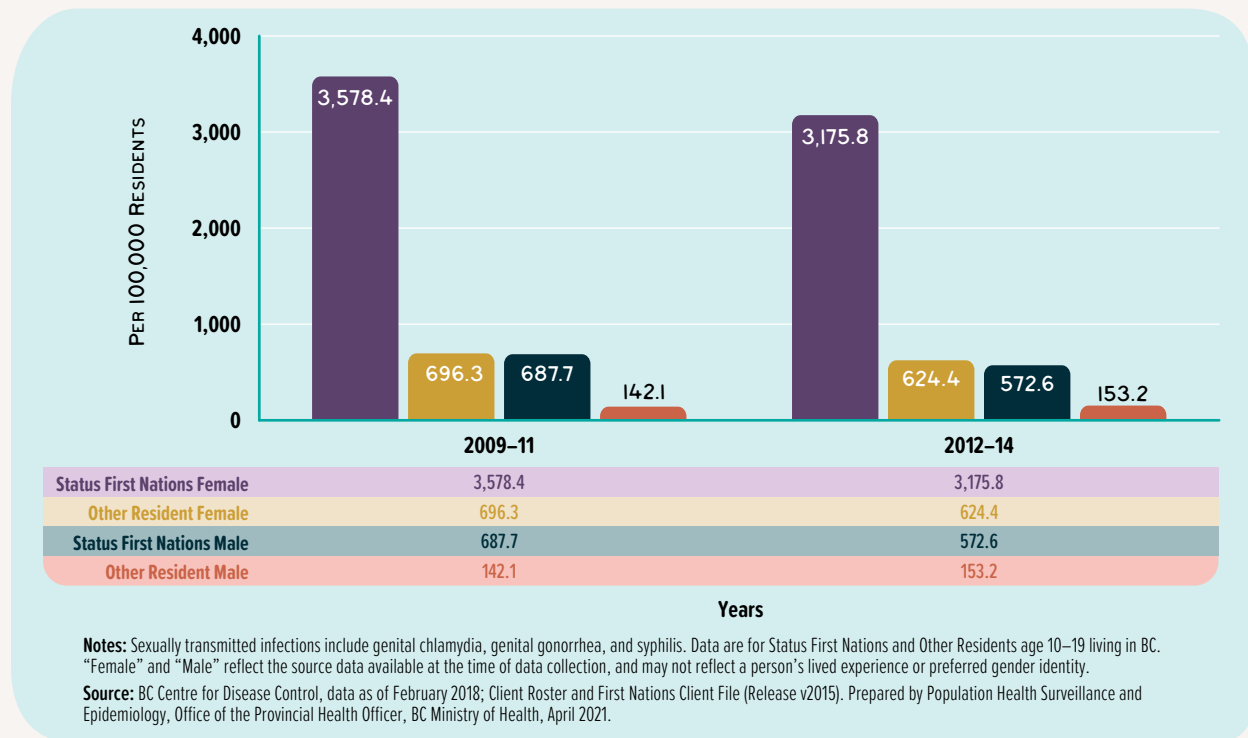


The AHS (2013) reported that 95.8% of young Indigenous women age 12–18 used some form of contraception the last time they had sex, which was similar to other comparison groups.

SEXUALLY TRANSMITTED INFECTION RATES

p.64

FIG 3.34 CRUDE RATE OF SEXUALLY TRANSMITTED INFECTIONS AMONG STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 10–19, BY SEX, BC, 2009–11 AND 2012–14



Data from the BC Centre for Disease Control showed a decrease from 3,578.4 per 100,000 (2009–2011) to 3,175.8 per 100,000 (2012–2014) in the crude rate of sexually transmitted infections among young Status First Nations women age 10–19. However, this rate has remained higher than all other comparison groups across the two time periods. Intergenerational traumas, experiences of abuse and sexualized violence, and traumatic practices such as coerced and forced sterilizations have contributed to the ongoing mistrust and fear that some First Nations women feel when accessing sexual health services. These barriers, in addition to the anti-Indigenous racism that is pervasive across the health care system, persist in the present reality for First Nations women seeking sexual health services.^{38,39}

TEENAGE PREGNANCIES

p.65

FIG 3.35 CRUDE RATE OF PREGNANCIES, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 10–19, BC, 2001–03 TO 2013–15

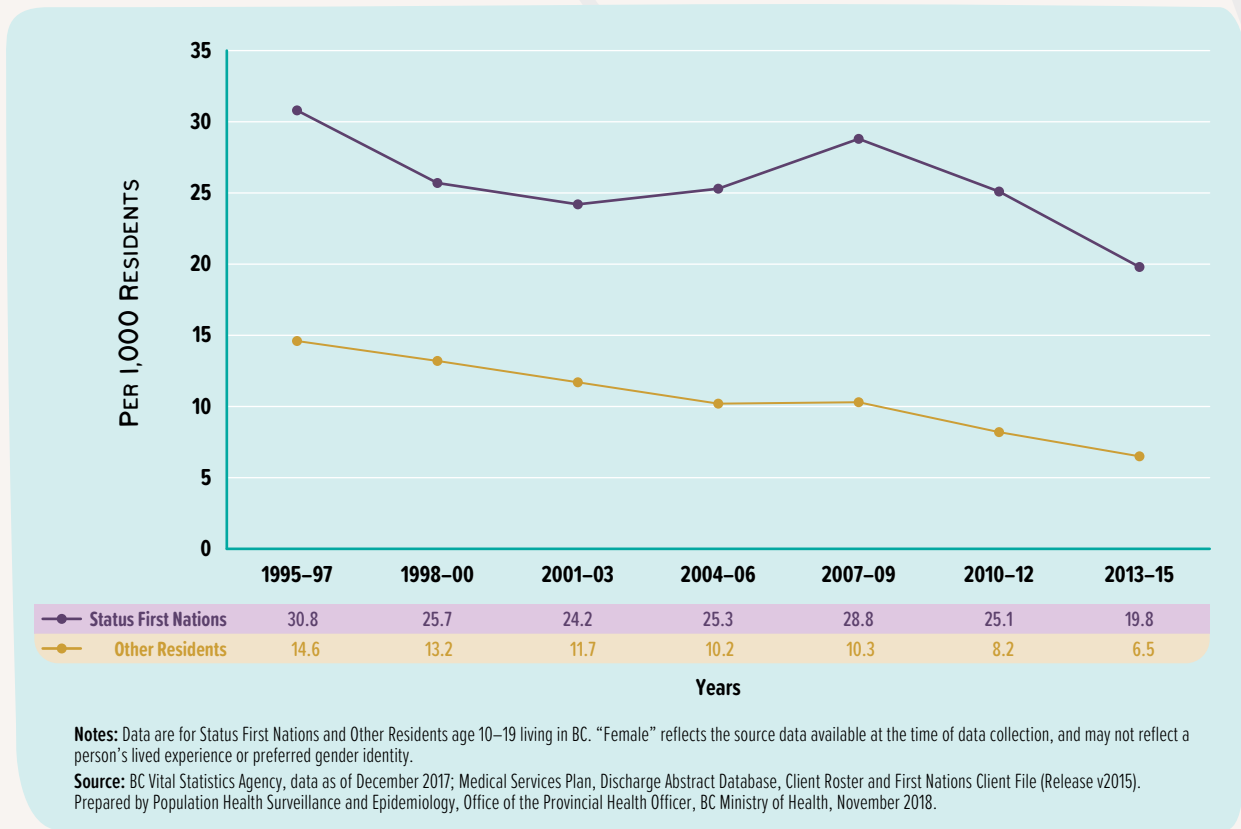


BC Vital Statistics Agency data showed that the pregnancy rate of young Status First Nations women age 10–19 has declined from 61.2 per 1,000 (2001–2003) to 47.4 per 1,000 (2013–2015). These rates have been consistently higher than those of Other Residents in the same age group. Many young First Nations mothers receive extensive support from their immediate and extended families, as well as through culturally interrelated systems of care that are common in First Nations communities.⁴⁰

ABORTION

p.65

FIG 3.36 CRUDE RATE OF ABORTIONS, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 10–19, BC, 1995–97 TO 2013–15



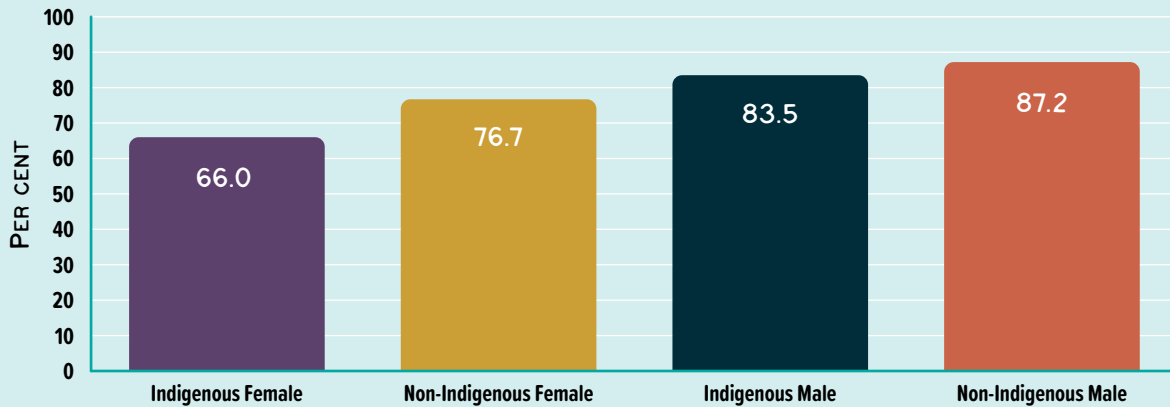
BC Vital Statistics Agency data showed that the abortion rate among young Status First Nations women age 10–19 has declined from 30.8 per 1,000 (1995–97) to 19.8 per 1,000 (2013–15). These rates were consistently higher than those of Other Residents in the same age group. A decreasing trend was also seen among Other Residents.



SELF-RATED MENTAL HEALTH

p.66

FIG 3.37 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO RATED THEMSELVES AS BEING IN EITHER "GOOD" OR "EXCELLENT" MENTAL HEALTH, AGE 12-18, BY SEX, BC, 2013



Notes: The data reflect responses from self-identified Indigenous youth and other youth age 12-18 living in BC. "Female" and "Male" reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: McCreary Centre Society, Adolescent Health Survey, 2013. Prepared by FNHA, 2020.

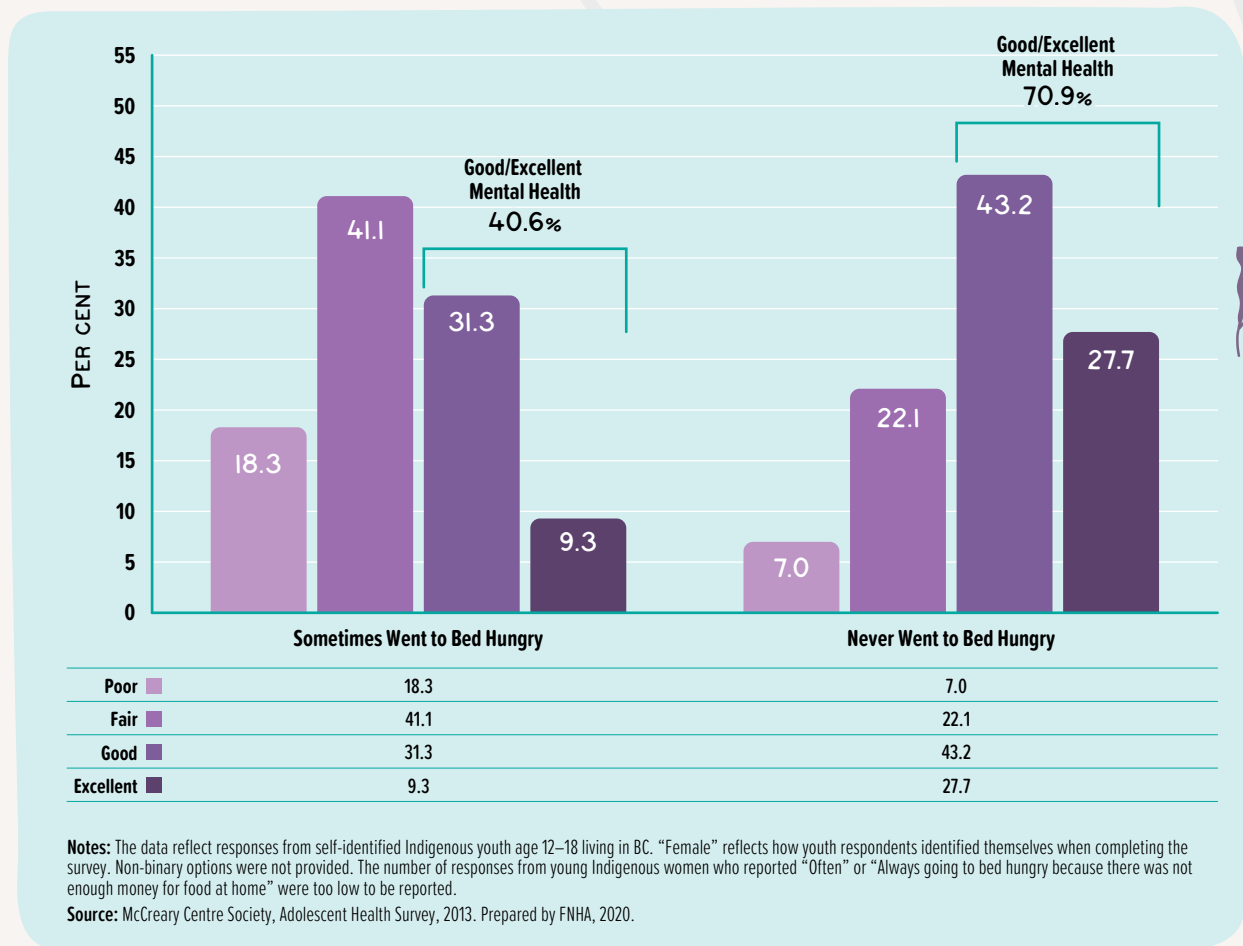


The AHS (2013) showed that 66.0% of young Indigenous women age 12-18 reported "good" or "excellent" self-rated mental health. This was the lowest proportion compared to young non-Indigenous women (76.7%), as well as young Indigenous (83.5%) and non-Indigenous (87.2%) men in the same age group.

Many young First Nations women living across BC are happy and thriving in connection with their communities and the land. But for some, intergenerational trauma and socio-economic inequities related to the effects of systemic discrimination, colonization, residential schools, land appropriation, Indian hospitals, and child welfare intrusion have caused significant harms and stresses. Young women impacted by these adverse experiences either directly or indirectly face greater barriers when it comes to establishing and maintaining balance in their lives. They are also more susceptible to problems associated with their mental wellness.⁷

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.65)

FIG 3.38 PERCENTAGE OF SELF-RATED MENTAL HEALTH OF YOUNG INDIGENOUS WOMEN, AGE 12–18, BY HOW OFTEN THEY WENT TO BED HUNGRY, BC, 2013



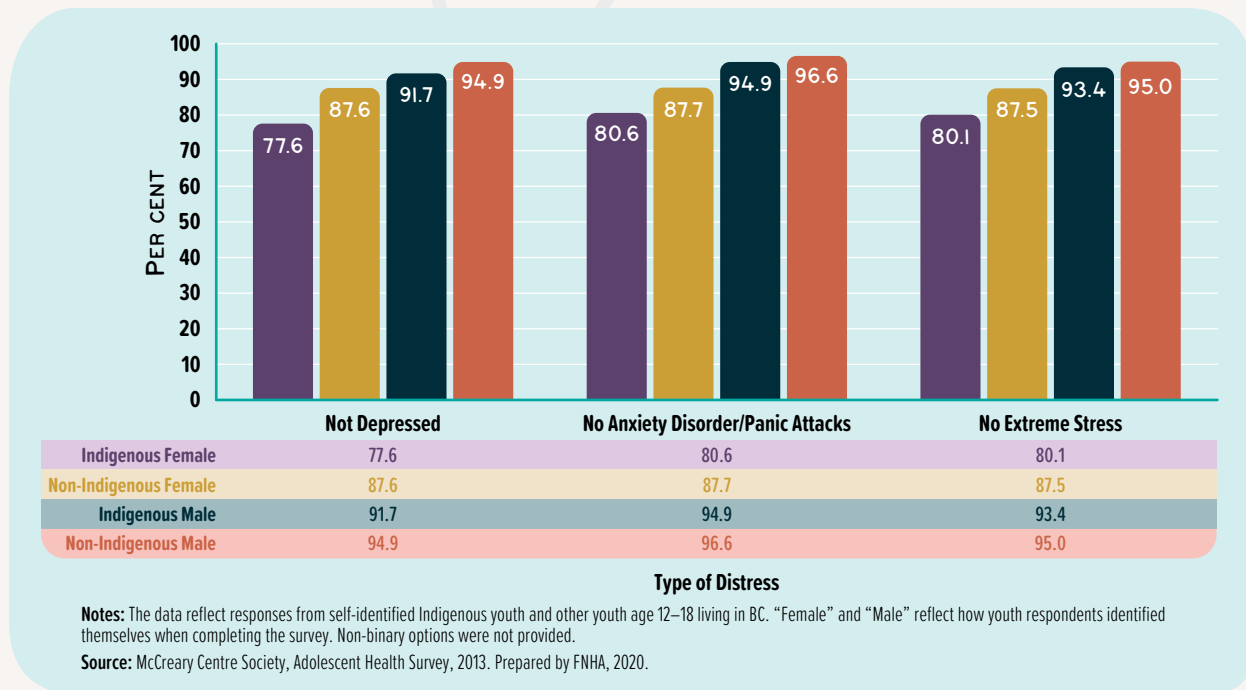
The AHS (2013) showed that, among young Indigenous women age 12–18 who never went to bed hungry, 70.9% rated themselves as being in either “good” or “excellent” mental health, in comparison with 40.6% of those who sometimes went to bed hungry. First Nations teachings affirm that “food is medicine” and that it has healing qualities for First Nations people’s physical, mental, spiritual, and emotional health.⁴¹ Providing First Nations people with access to healthy, traditional foods is especially important for improving their mental health; these foods are nutrient-dense and ground First Nations people to the land and their ancestors.⁴¹



STRESS, DEPRESSION, AND ANXIETY

p.66

FIG 3.39 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED HAVING NO FEELINGS OF MENTAL HEALTH DISTRESS IN THE PAST 30 DAYS, AGE 12–18, BY TYPE OF DISTRESS, BC, 2013



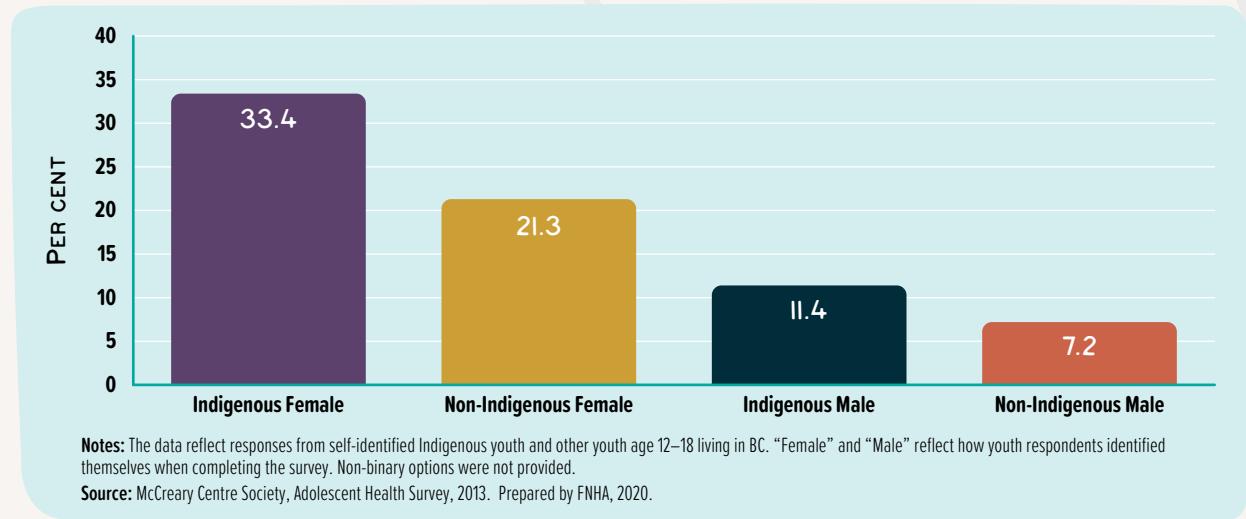
The AHS (2013) showed that in the past 30 days, 77.6% of young Indigenous women age 12–18 were not depressed, 80.6% reported no anxiety disorder or panic attacks, and 80.1% reported no extreme stress. However, these data also indicate that young Indigenous women have the highest reported proportion feeling depressed, having anxiety disorders or panic attacks, and feeling extremely stressed as compared to other groups surveyed.



SELF-HARM

p.66

FIG 3.40 PERCENTAGE OF INDIGENOUS AND NON-INDIGENOUS YOUTH WHO REPORTED THAT THEY HAD PURPOSELY CUT OR INJURED THEMSELVES AT LEAST ONCE IN THE PAST YEAR, AGE 12–18, BY SEX, BC, 2013

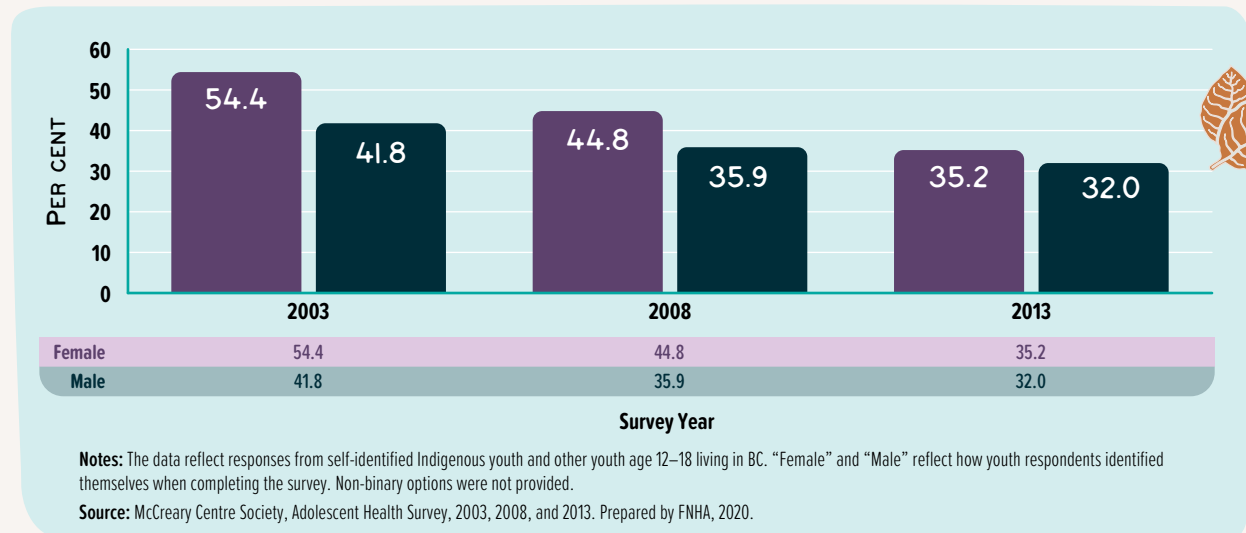


The AHS (2013) showed that 33.4% of young Indigenous women age 12–18 reported having purposely cut or injured themselves at least once in the past year, the highest proportion compared to other groups surveyed. Adolescence is a period of heightened stress for many young people, and these stresses can be particularly acute for First Nations youth who may also be experiencing disconnections with family, schooling, and their culture due to the ongoing legacy of colonization and social marginalization.⁴²

SMOKING

p.67

FIG 3.41 PERCENTAGE OF INDIGENOUS YOUTH WHO HAD EVER TRIED SMOKING COMMERCIAL CIGARETTES, AGE 12–18, BY SEX, BC, 2003, 2008, AND 2013

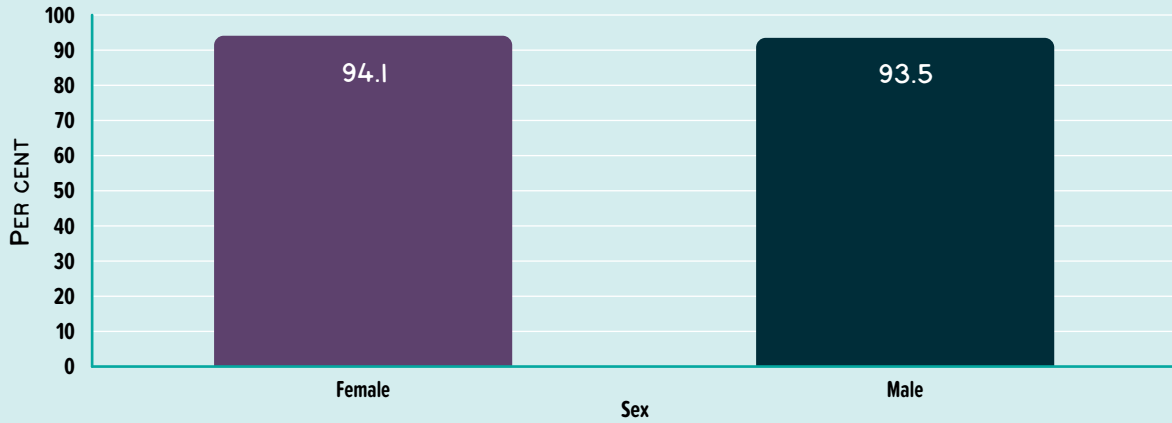


There was a decreasing trend of 19.2 percentage points among young Indigenous women age 12–18 who reported ever trying commercial cigarettes, from 54.4% (2003) to 35.2% (2013) across three cycles of the AHS. There was a similar trend among young Indigenous men in the same age group, from 41.8% (2003) to 32.0% (2013). Many First Nations use tobacco as an integral part of ritual, ceremony, and prayer. First Nations youth have demonstrated strong leadership in restoring respect around the use of tobacco and reducing rates of youth smoking.⁴³

ALCOHOL AND OTHER SUBSTANCE USE

p.68

FIG 3.42 PERCENTAGE OF FIRST NATIONS YOUTH WHO REPORTED THAT THEY ABSTAINED FROM USING ANY SUBSTANCES IN THE PAST YEAR, AGE 12–17, BY SEX, BC, 2015–17



Notes: Data reflect First Nations youth living on reserve in BC age 12–17. “Female” and “Male” reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided. Data reflect any use of the following: cocaine, amphetamines, methamphetamine, ecstasy, hallucinogens, heroin, and other specified substances (reported by respondent). Data exclude use of cannabis, inhalants, and salvia.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

RHS3 (2015–17) showed that 94.1% of young First Nations women age 12–17 abstained from using substances including cocaine, amphetamines, methamphetamine, ecstasy, hallucinogens, heroin, and other specified substances in the past year. In 2016, BC declared the toxic drug crisis to be a public health emergency, one in which First Nations people are staggeringly overrepresented in the number of toxic drug events and deaths.⁴⁴

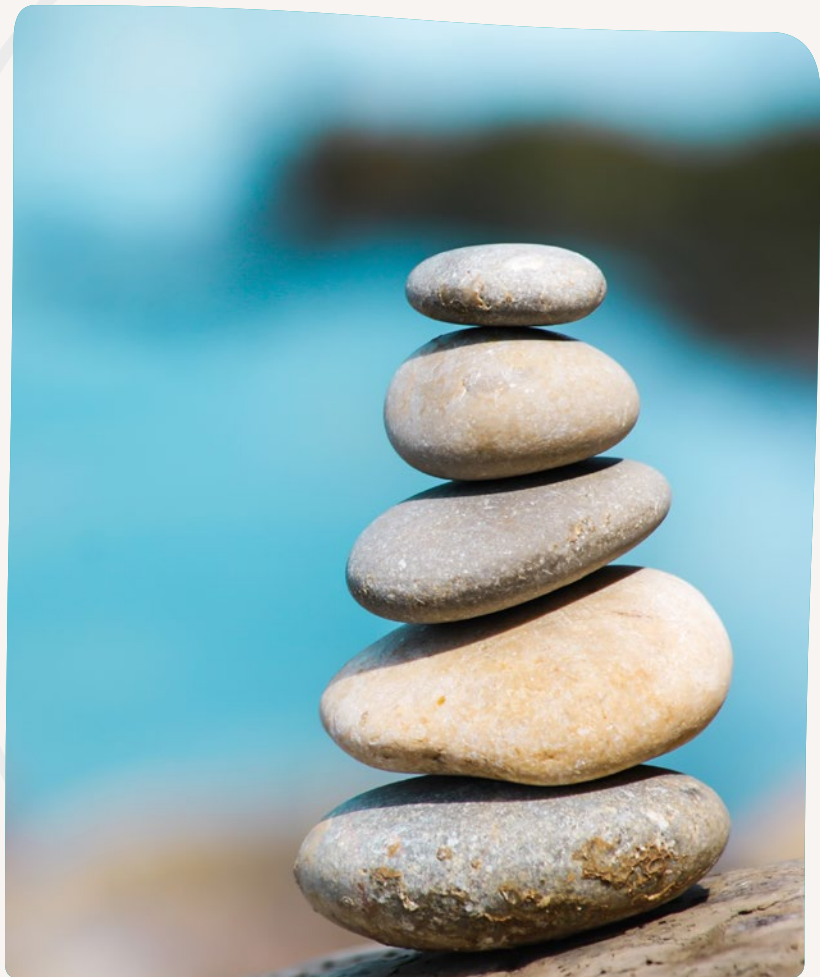
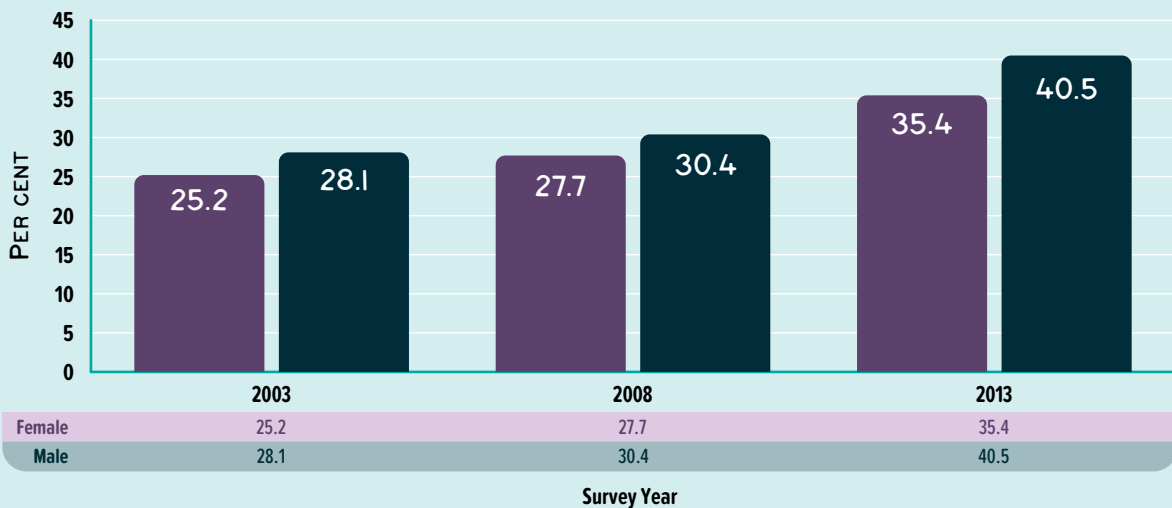


FIG 3.43 PERCENTAGE OF INDIGENOUS YOUTH WHO REPORTED THAT THEY ABSTAINED FROM USING ALCOHOL AND OTHER SUBSTANCES IN THE PAST YEAR, AGE 12–18, BY SEX, BC, 2003, 2008, AND 2013



Notes: The data reflect responses from self-identified Indigenous youth and other youth age 12–18 living in BC. “Female” and “Male” reflect how youth respondents identified themselves when completing the survey. Non-binary options were not provided. While this question was asked on each iteration of the survey, the response options were not consistent between survey cycles.

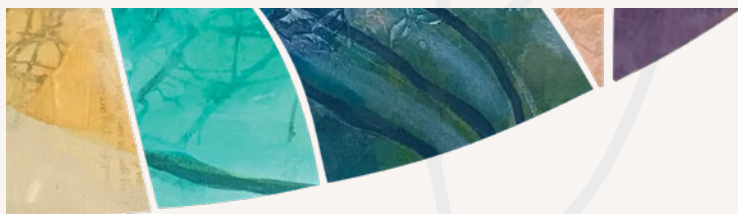
Source: McCreary Centre Society, Adolescent Health Survey, 2003, 2008, and 2013. Prepared by FNHA, 2020.

Across three cycles of the AHS, there was an increasing trend of 10.2 percentage points among young Indigenous women age 12–18 who reported abstaining from using alcohol and other substances in the past year, from 25.2% (2003) to 35.4% (2013). Higher proportions were reported among young Indigenous men, following the same increasing trend over time. Indigenous youth use alcohol and other substances for a wide variety of reasons.⁶ Youth living with trauma and intergenerational trauma may use substances to try and numb the pain they feel and temporarily relieve emotional distress;⁴⁵ however, having a supportive adult in their lives helps protect youth from harms related to substance use.^{6,46,47}

“I was really struggling with a bad addiction to alcohol and I was using some other types of drugs. I went down to the fire pit and talked to an Elder and we’re talking for a bit and she told me to keep on going in life. Just talking to an Elder will help you to go on the right pathway and sometimes life gets hard, but you keep on going and don’t give up because everybody cares about you and you’re a warrior, you should stay strong. Talk to an Elder, or a teacher, or somebody that really cares, ‘cause I matter, you matter, we matter.”

- Mary Modeste, Coast Salish, Quwut’sun (Cowichan) Territory

- Sacred and Strong: Upholding our Matriarchal Roles (p.68)



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ADULTHOOD



Women are respected as matriarchs in First Nations cultures and as leaders of their communities.^{1,2} Many Nations are traditionally matrilineal, meaning that people’s identities, including their clans and roles, are passed down through their mothers.³ While many First Nations matriarchs continue to thrive and hold positions of leadership in their communities,⁴ the ongoing structures, policies, and attitudes of colonialism have had devastating effects on the lives, relationships, and health of many First Nations women, which have impacted the strength and balance of families and communities.⁵

This chapter provides detailed charts for findings presented in the Adulthood chapter of the report, *Sacred and Strong: Upholding our Matriarchal Roles*. The chapter focuses on the health and wellness of First Nations women age 18–54 (and up to 65 for some data), and celebrates First Nations women’s resilience and their ability to adapt and thrive amidst ongoing challenges stemming from colonial structures and systems. Please refer to the main report—[*Sacred and Strong: Upholding our Matriarchal Roles*](#)—for further interpretation of the data presented here.

HEALTHY, SELF-DETERMINING WOMEN & COMMUNITIES – ROOTS OF WELLNESS

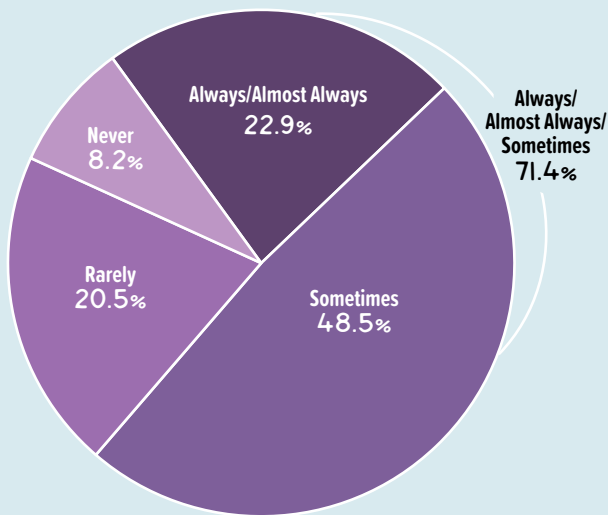


The health and wellness of First Nations women are grounded in their roots of wellness, such as their connections to culture, identity, the land, family, and community. Families, communities, and Nations continue to actively resist colonization and exercise their self-determination to maintain their distinct ways of knowing and being.⁶ As matriarchs of their communities, First Nations women preserve their culture by passing on language, teachings, and protocols to children and grandchildren.³

PARTICIPATION IN CULTURAL EVENTS

p.72

FIG 4.1 REPORTED DEGREE OF PARTICIPATION IN CULTURAL EVENTS IN THEIR LOCAL COMMUNITY AMONG FIRST NATIONS WOMEN, AGE 18–54, BC, 2015–17



First Nations women play a key role in leading, preserving, and revitalizing cultural activities and ceremonies,⁷ presiding over feasts, and leading ceremonies to mark key life transitions.⁴ Regional Health Survey, Phase 3 (RHS3; 2015–17) showed that nearly three quarters (71.4%) of First Nations women age 18–54 reported “sometimes” or “always/almost always” participating in cultural events in their local community.

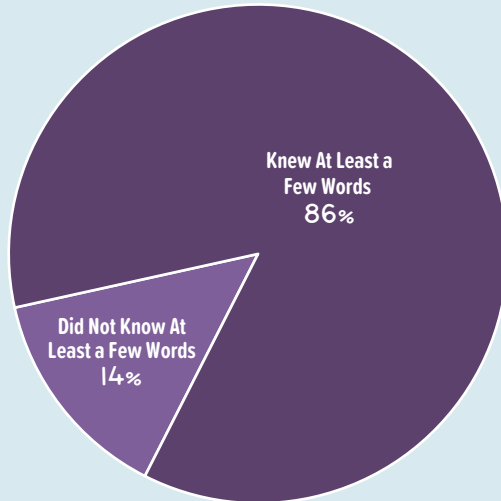
Notes: Data reflect responses from First Nations women age 18–54 living on reserve in BC. “Female” reflects how respondents identified themselves when completing the survey. Non-binary options were not provided.
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.



FIRST NATIONS LANGUAGE

p.72

FIG 4.2 FIRST NATIONS WOMEN WHO REPORTED KNOWING AT LEAST A FEW WORDS OF THEIR NATION'S LANGUAGE, AGE 18–54, BC, 2015–17



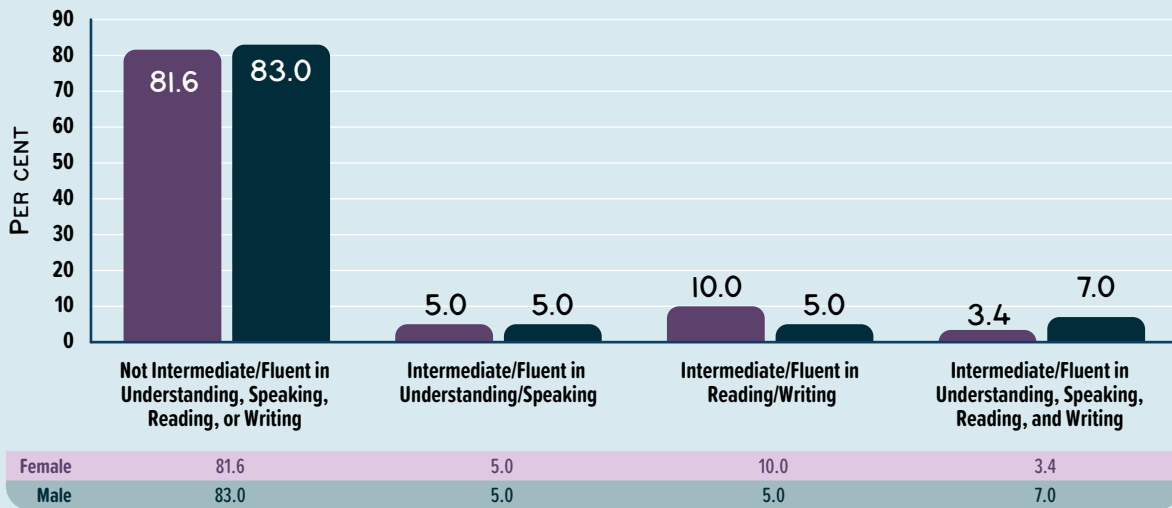
Notes: Data reflect responses from First Nations women age 18–54 living on reserve in BC. “Female” reflects how respondents identified themselves when completing the survey. Non-binary options were not provided.
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

From RHS3 (2015–17), 86% of First Nations women age 18–54 reported knowing at least a few words in their Nation’s language. Connecting to culture and language is a core aspect of wellness and identity for First Nations women, and a powerful way to break the cycle of trauma.⁸ A growing number of First Nations parents are taking action to learn their language to be able to pass it on to their children.⁹



p.72

FIG 4.3 LANGUAGE FLUENCY AMONG FIRST NATIONS ADULTS WHO REPORTED KNOWING AT LEAST A FEW WORDS OF THEIR NATION'S LANGUAGE, AGE 18–54, BY SEX, BC, 2015–17



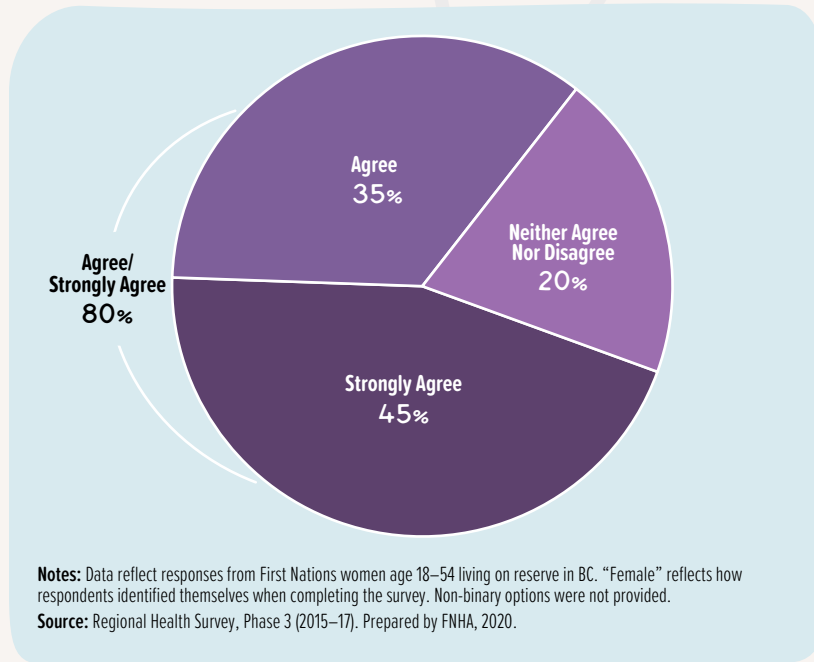
Notes: Data reflect responses from First Nations adults living on reserve in BC, age 18–54. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

From RHS3 (2015–17), among First Nations women age 18–54 who reported knowing at least a few words in their Nation’s language, 5.0% identified their language fluency as intermediate or fluent in speaking *and* understanding, 10.0% identified as being intermediate or fluent in reading *and* writing the language, and 3.4% identified as being intermediate or fluent in understanding, speaking, reading, *and* writing the language.

IMPORTANCE OF SPIRITUALITY

p.72

FIG 4.4 LEVEL OF AGREEMENT ON THE IMPORTANCE OF TRADITIONAL SPIRITUALITY AMONG FIRST NATIONS WOMEN, AGE 18–54, BC, 2015–17

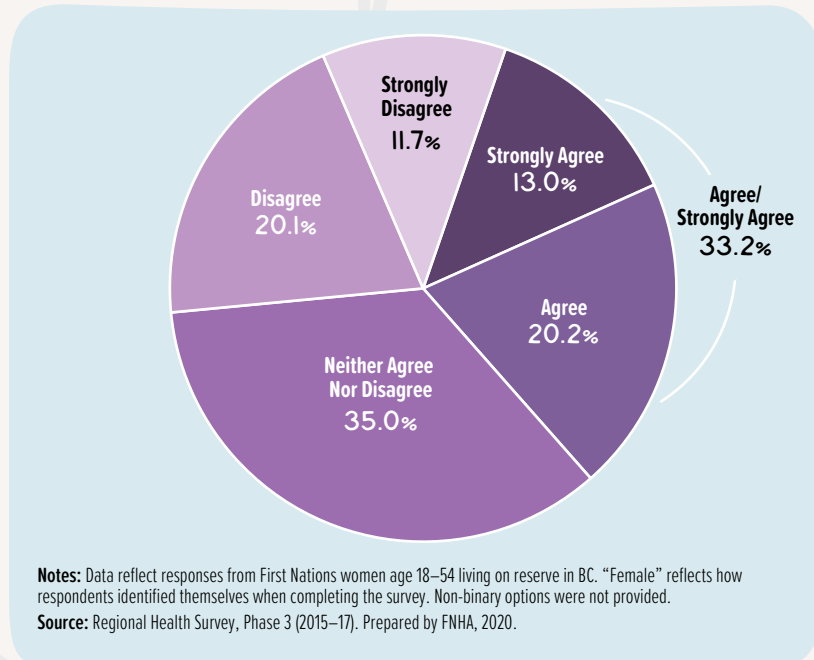


RHS3 (2015–17) data showed that 80% of First Nations women age 18–54 strongly agreed or agreed that traditional First Nations spirituality is important to them.



p.72

FIG 4.5 LEVEL OF AGREEMENT ON THE IMPORTANCE OF ORGANIZED RELIGION AMONG FIRST NATIONS WOMEN, AGE 18–54, BC, 2015–17

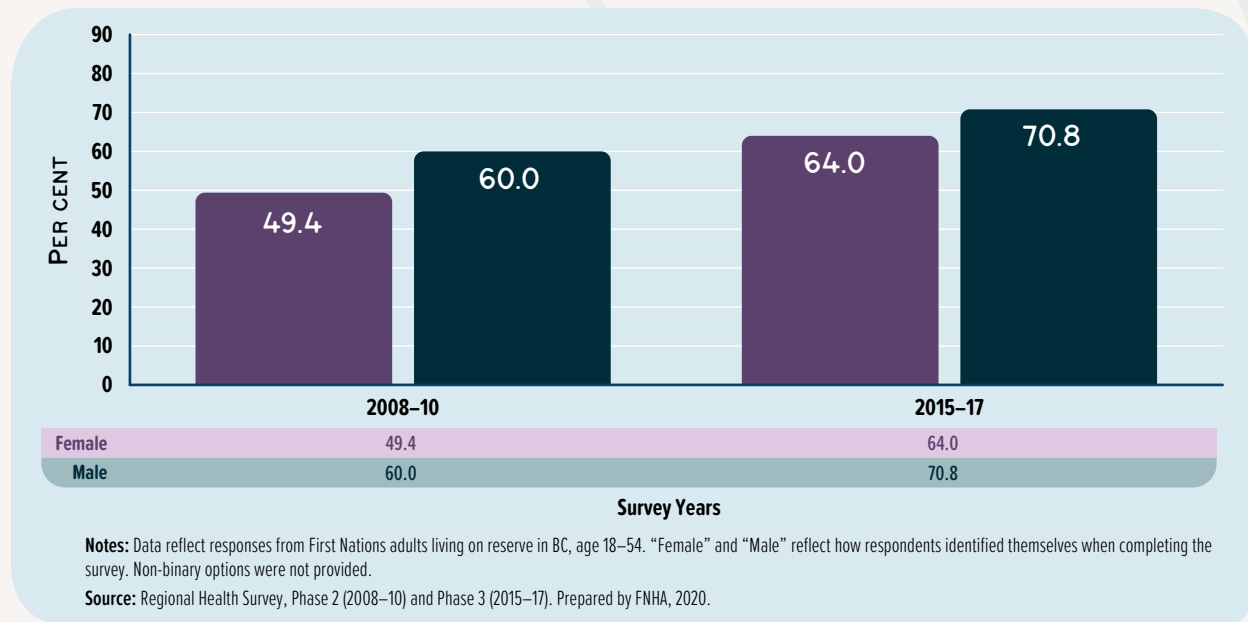


RHS3 (2015–17) data showed that 33.2% of First Nations women age 18–54 strongly agreed or agreed that organized religion (e.g., Christianity, Buddhism, Islam) was important to them.

FIRST NATIONS FOODS

p-72

FIG 4.6 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED EATING TRADITIONAL FOODS (NOT INCLUDING BANNOCK) "OFTEN" IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17

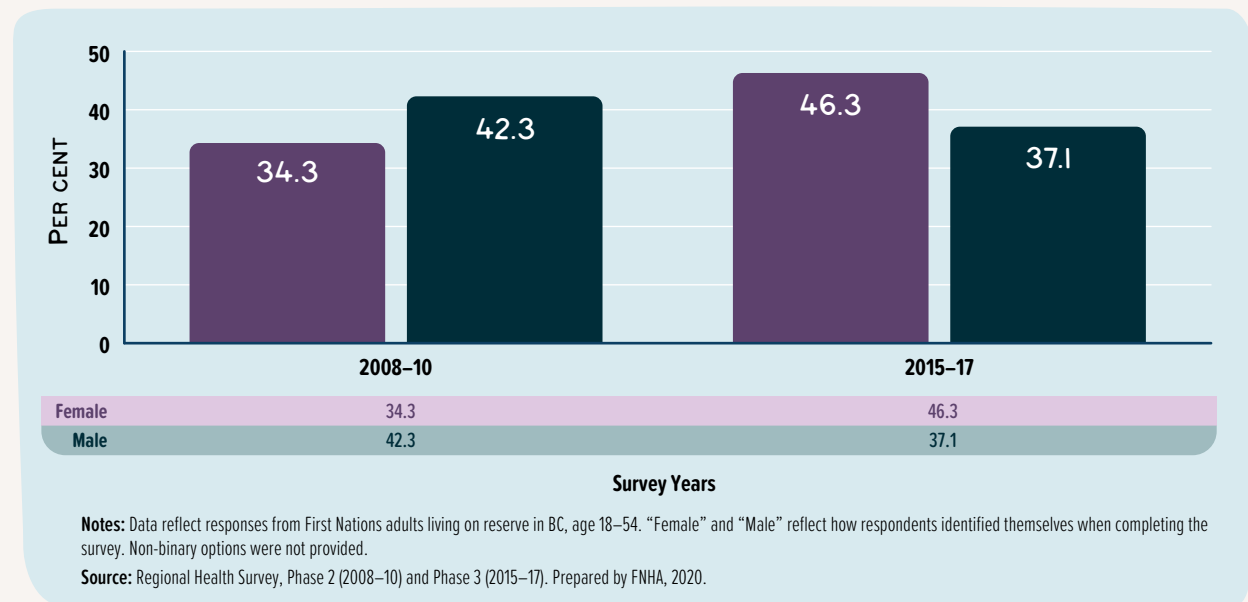


From RHS3 (2015–17), 64.0% of First Nations women age 18–54 reported eating traditional foods (not including bannock) “often” in the past year, an increase of 14.6 percentage points from 2008–10 (49.4%). Traditional foods and medicines are essential components of healing and maintaining wellness for First Nations women.¹⁰

TRADITIONAL MEDICINE

p-73

FIG 4.7 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING USED TRADITIONAL MEDICINE IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17

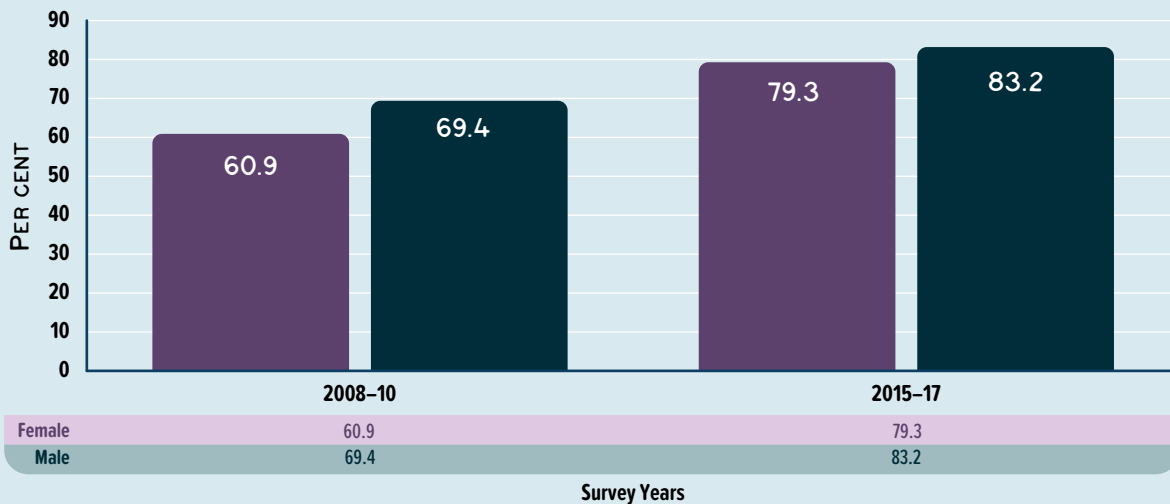


From RHS2 (2008–10) to RHS3 (2015–17), the percentage of First Nations women age 18–54 who reported having used traditional medicine in the past year increased 12.0 percentage points, from 34.3% to 46.3%.

ACCESS TO SAFE DRINKING WATER

p.73

FIG 4.8 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING SAFE DRINKING WATER ALL YEAR ROUND, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17



Notes: Data reflect First Nations adults living on reserve in BC, age 18–54. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

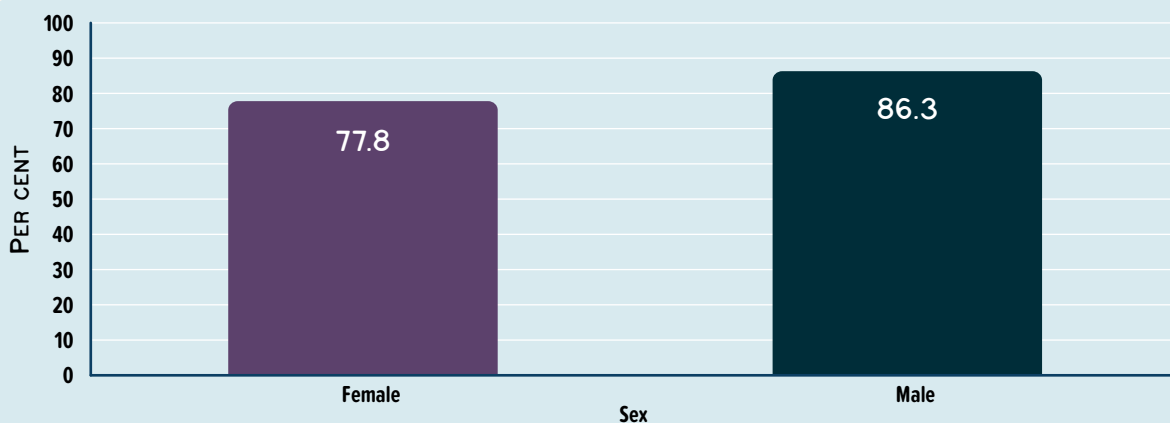
Source: Regional Health Survey, Phase 2 (2008–10) and Phase 3 (2015–17). Prepared by FNHA, 2020.

The percentage of First Nations women age 18–54 who reported having safe drinking water all year round increased by 18.4 percentage points, from 60.9% in RHS2 (2008–10) to 79.3% in RHS3 (2015–17). First Nations recognize that connections to land, water, and territory are foundational to wellness. Colonialism continues to disrupt First Nations’ rights and access to water resources, including safe and clean drinking water, through the Indian reservation system, ecological destruction, and contamination.¹¹

SENSE OF BELONGING

p.73

FIG 4.9 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING A STRONG SENSE OF BELONGING TO THEIR LOCAL COMMUNITY, AGE 18–54, BY SEX, BC, 2015–17



Notes: Data reflect responses from First Nations adults living on reserve in BC, age 18–54, to the question: “How would you describe your sense of belonging to your local community: strong or weak?” “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

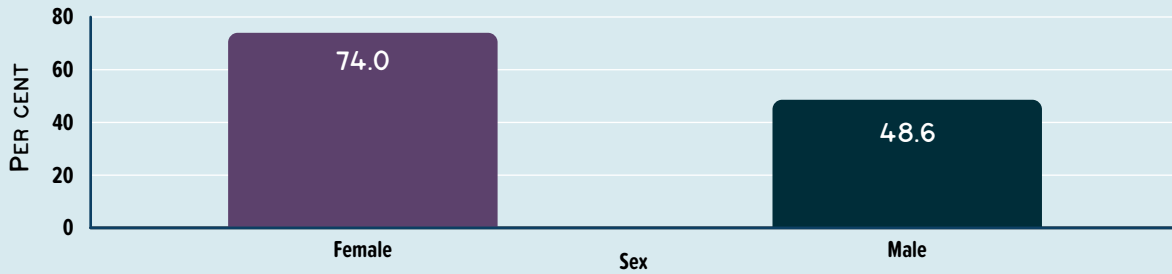
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

The relationships that First Nations women have with their families, communities, and Nations shape their health and identities. These relationships serve as anchoring points that foster a sense of being loved and supported.^{12,13} From RHS3 (2015–17), 77.8% of First Nations women age 18–54 reported having a strong sense of belonging to their local community.

SOCIAL SUPPORTS

p.73

FIG 4.10 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED THAT THEY HAD SPOKEN TO SOMEONE ABOUT THEIR MENTAL AND/OR EMOTIONAL HEALTH IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2015–17



Notes: Data reflect responses from First Nations adults living on reserve in BC, age 18–54. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

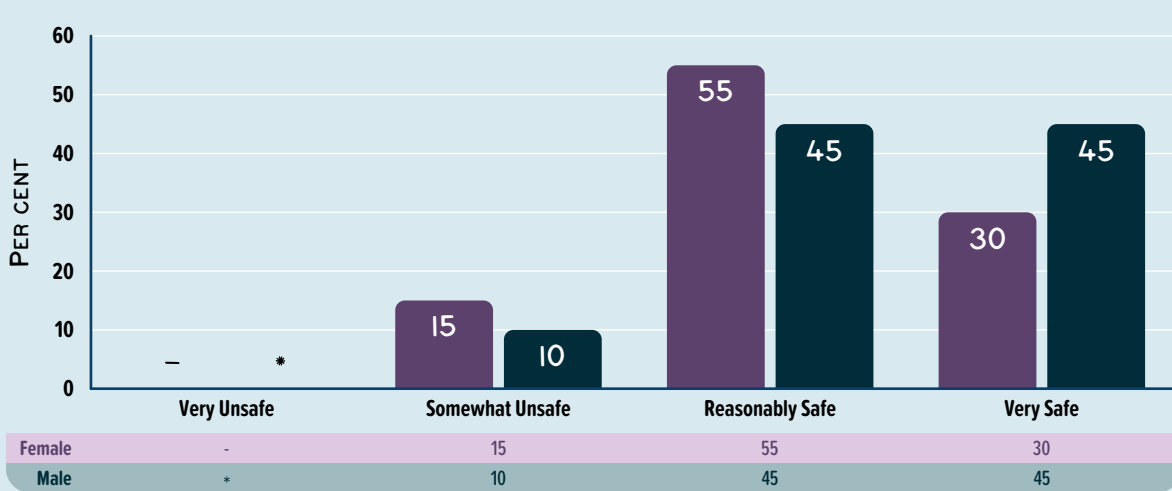
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

From RHS3 (2015–17), 74.0% of First Nations women age 18–54 reported having spoken to someone about their mental and/or emotional health in the past year.

FEELING SAFE

p.73

FIG 4.11 PERCENTAGE REPORTED FEELINGS OF SAFETY IN THEIR COMMUNITY AMONG FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2015–17



Notes: “-” means that the percentage has been suppressed due to co-efficient of variation > 0.333. “*” means that the percentage has been suppressed as it is based on a cell count <10. Data reflect responses from First Nations adults living on reserve in BC, age 18–54. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

RHS3 (2015–17) data showed that 30% of First Nations women age 18–54 felt “very safe,” 55% felt “reasonably safe,” and 15% felt “somewhat unsafe” in their community. The important role that women play in their communities as matriarchs contributes to their sense of belonging and safety.¹⁴ However, a greater proportion of First Nations men felt “very safe” (45%) in their community compared to First Nations women (30%). *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* documented how First Nations women and girls and 2SLGBTQQIA+^a peoples continue to be subjected to more violence than others.¹⁴

a 2SLGBTQQIA+ stands for Two-Spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex, and asexual. The plus sign acknowledges the many sexual and gender minority peoples who don’t see themselves in the umbrella acronym.

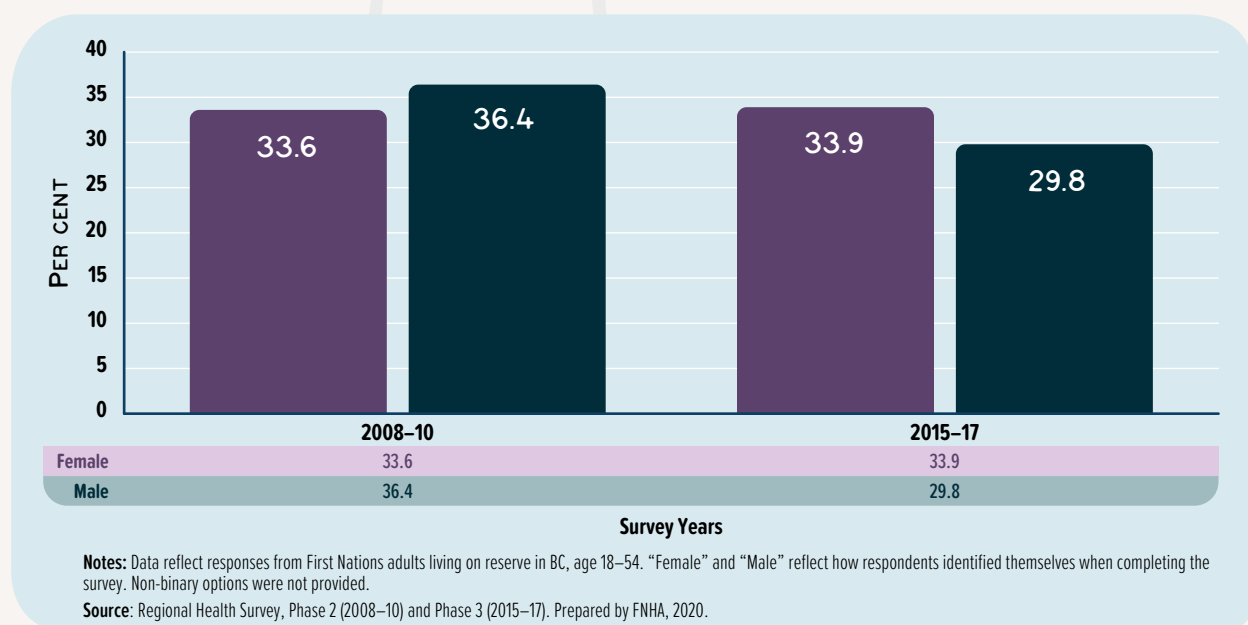
SUPPORTIVE SYSTEMS

The health and wellness of First Nations women are shaped by interconnected systems and structures rooted in Canada’s colonial history. As a result, many First Nations women continue to be subjected to social, economic, cultural, and political exclusion.¹⁴ First Nations women are leading the important work to decolonize the systems and institutions that create systemic barriers leading to health inequities.⁴

RACISM

p.75

FIG 4.12 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING PERSONALLY EXPERIENCED INSTANCES OF RACISM IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17



From RHS2 (2008–10) to RHS3 (2015–17), the percentage of First Nations women age 18–54 who reported having personally experienced instances of racism in the past year remained consistent (33.6% between 2008–10 and 33.9% between 2015–17).

Racism and discrimination are embedded in the everyday lives of First Nations women. In mainstream society, the values are so deeply entrenched that those holding them do not see them as discriminatory. Racism and discrimination [that] manifest at the individual level and the structural level, through systems, institutions, laws, and policies and structures as well as interpersonal relationships – result in stereotyping, marginalization, stigmatization, and violence.¹⁴ Racism compounds other forms of social exclusion based on intersections such as gender, sexual orientation, age, class and ability, causing further injustice and harm.¹⁴ The pain and trauma resulting from racism and discrimination affects First Nations women and their children and communities in countless ways.¹⁵

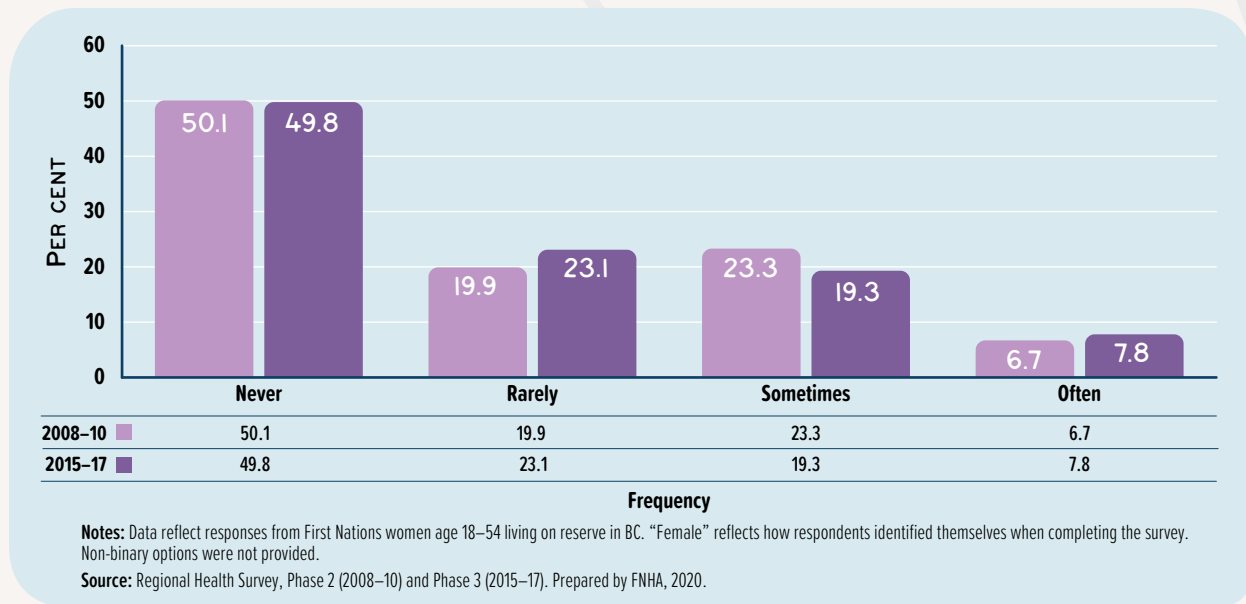
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VIOLENCE AND ABUSE

p.76

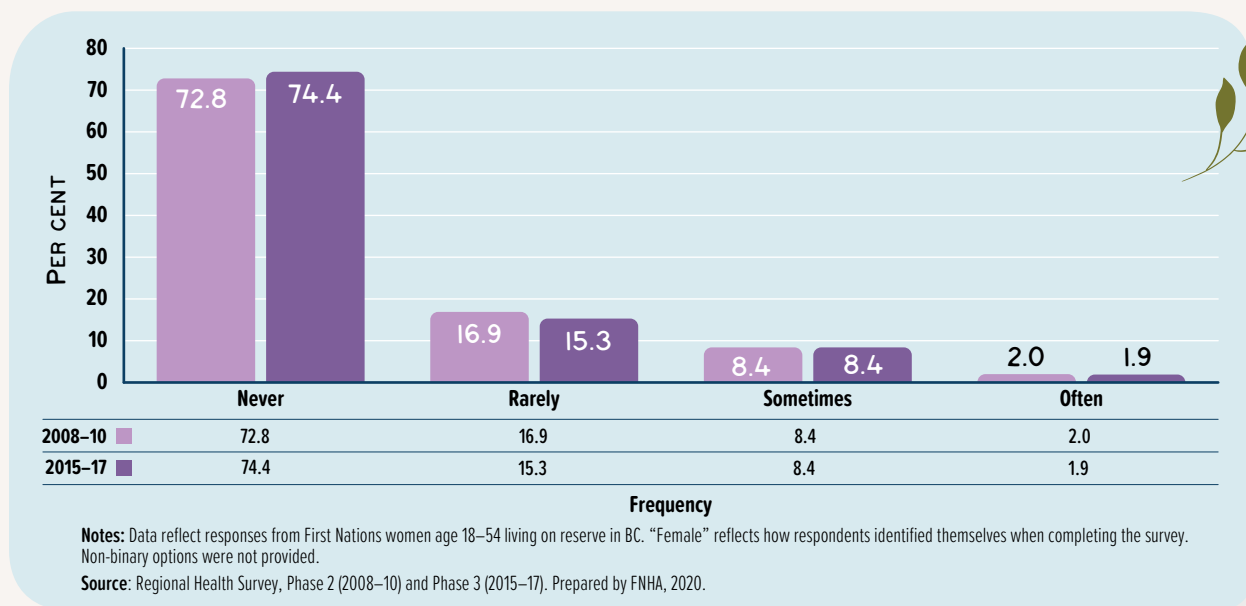
FIG 4.13 PERCENTAGE OF FIRST NATIONS WOMEN WHO REPORTED HAVING EXPERIENCED VERBAL AGGRESSION TOWARDS THEM IN THE PAST YEAR, AGE 18–54, BC, 2008–10 AND 2015–17



First Nations women experience disproportionate levels of violence and aggression due to historical and ongoing impacts of colonialism compounded by misogyny and racism.¹⁴ From RHS2 (2008–10) to RHS3 (2015–17), reported experiences of verbal aggression remained consistent with approximately half (50.2%) of First Nations women age 18–54 experiencing verbal aggression towards them. This result is calculated by adding the 2015–17 results for response categories “rarely” (23.1%), “sometimes” (19.3%), and “often” (7.8%).

p.76

FIG 4.14 PERCENTAGE OF FIRST NATIONS WOMEN WHO REPORTED HAVING EXPERIENCED PHYSICAL AGGRESSION TOWARDS THEM IN THE PAST YEAR, AGE 18–54, BC, 2008–10 AND 2015–17

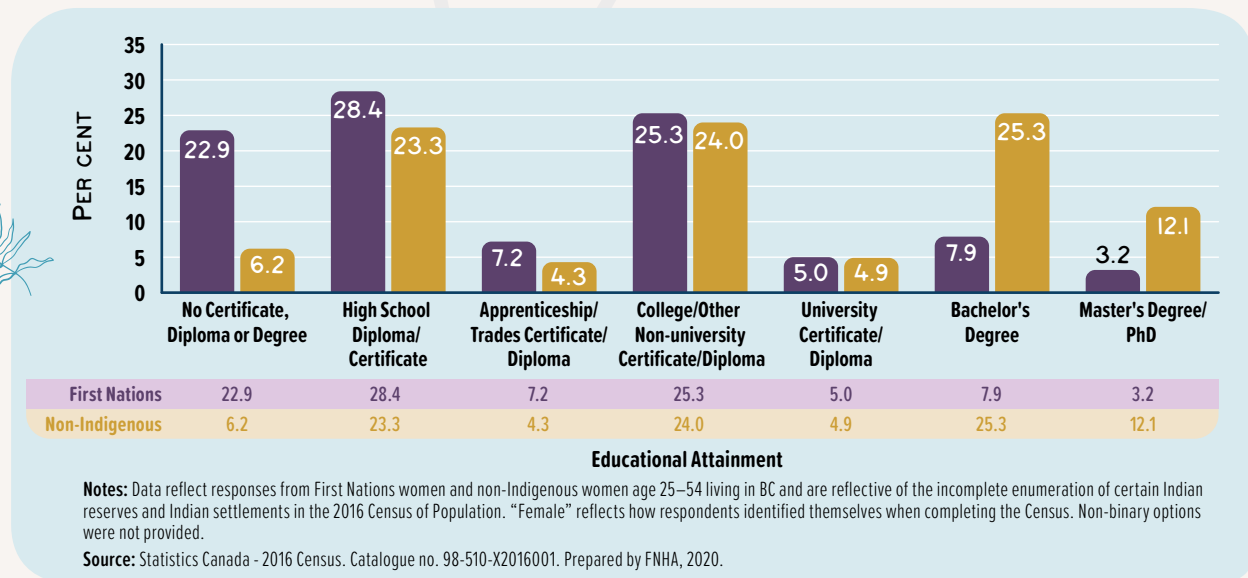


From RHS2 (2008–10) to RHS3 (2015–17), the proportion of First Nations women age 18–54 who reported experiencing physical aggression towards them in the past year remained relatively consistent across each response category. The majority of First Nations women across both time points (72.8% in 2008–10 and 74.4% in 2015–17) reported “never” experiencing physical aggression towards them.

POST-SECONDARY EDUCATION

p-77

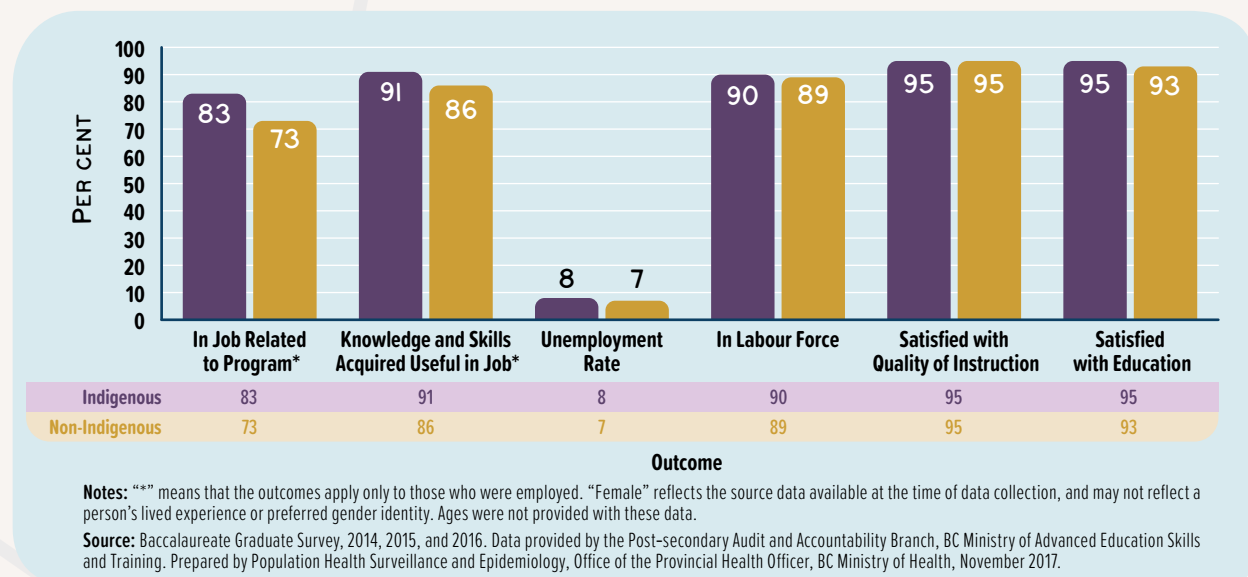
FIG 4.15 PERCENTAGE OF EDUCATIONAL ATTAINMENT AMONG FIRST NATIONS AND NON-INDIGENOUS WOMEN, AGE 25–54, BC, 2016



In 2016, Statistics Canada reported that 48.6% of First Nations women in BC age 25–54 had some level of post-secondary training or education, and 28.4% had a high school diploma or certificate. The mainstream education systems experienced by many First Nations children and youth are grounded in colonialist perspectives, values, and assumptions that perpetuate racism and harm. Post-secondary education institutions continue to be culturally unsafe for First Nations students.^{16,17} Since the *Truth and Reconciliation Commission of Canada: Calls to Action* report was released in 2015, acknowledgements and commitments have been made to increase the relevance of post-secondary programs for Indigenous learners^{18,19} by better integrating Indigenous perspectives, knowledge, and teaching methods into the curriculum.

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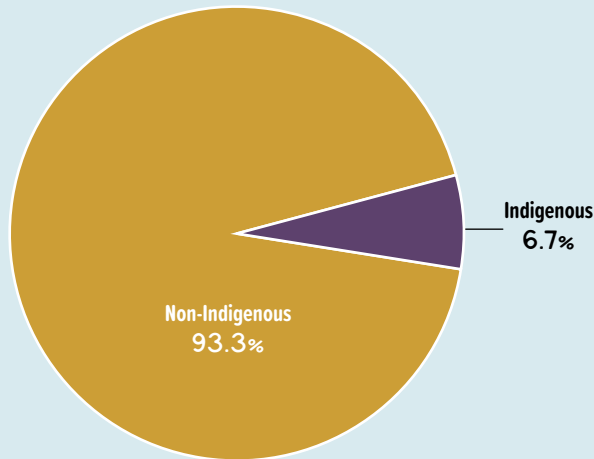
FIG 4.16 STUDENT OUTCOMES FOR BACCALAUREATE GRADUATES AMONG INDIGENOUS AND NON-INDIGENOUS WOMEN, BC, 2014–2016



Results from the 2014–2016 Baccalaureate Graduate Survey showed that 83% of female Indigenous graduates were employed related to their program of study, as compared to only 73% of female non-Indigenous graduates.

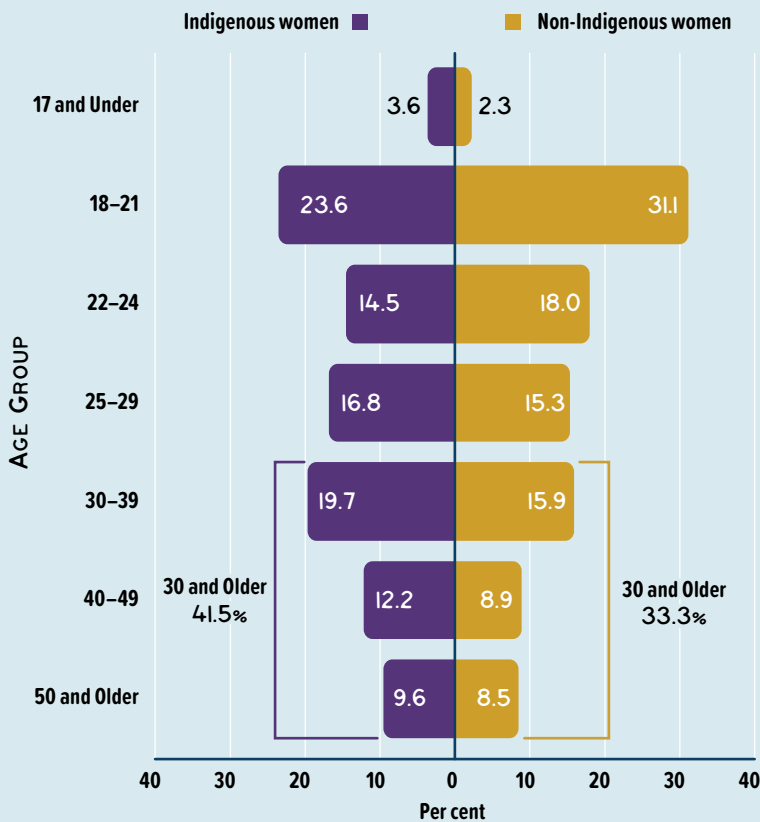


FIG 4.17 PROPORTION OF SELF-IDENTIFIED INDIGENOUS WOMEN AMONG WOMEN ENROLLED IN POST-SECONDARY INSTITUTIONS, BC, 2018



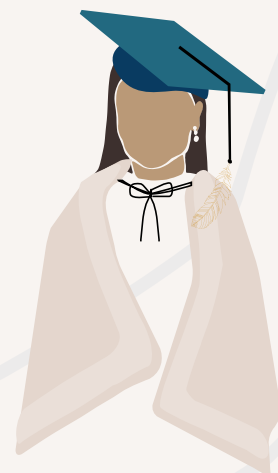
Source: BC Ministry of Advanced Education Skills and Training; Student Transitions Project - Fall 2018 Data Submission. Prepared by FNHA, 2020.

FIG 4.18 PERCENTAGE ENROLLMENT IN POST-SECONDARY INSTITUTIONS AMONG INDIGENOUS AND NON-INDIGENOUS WOMEN, BY AGE GROUP, BC, 2018



Source: BC Ministry of Advanced Education Skills and Training; Student Transitions Project - Fall 2018 Data Submission. Prepared by FNHA, 2020.

In Figure 4.17, data from the Student Transitions Project (2018) indicated that 6.7% of all women enrolled in post-secondary institutions across BC identified as Indigenous. Figure 4.18 shows that, among Indigenous women enrolled in post-secondary institutions, 41.5% were age 30 and older. In comparison, among all non-Indigenous women enrolled in post-secondary institutions, 33.3% were age 30 and older. There are many different reasons why First Nations women might delay enrollment in post-secondary institutions, including prioritizing family responsibilities, cultural responsibilities, and community leadership roles. Post-secondary institutions inflict racism on First Nations learners, and some First Nations women may choose to delay entry to develop greater resilience to endure the culturally unsafe spaces created by mainstream post-secondary institutions. Colonialism and manufactured poverty create financial barriers to accessing post-secondary education, and First Nations women may require more time to persist and overcome these barriers.¹⁶

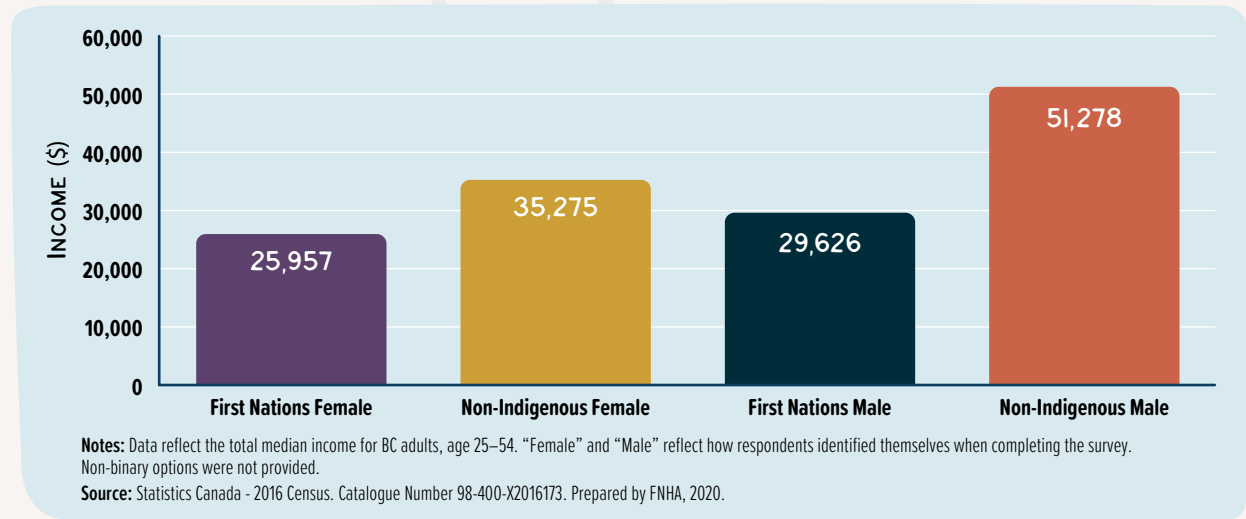




INCOME

p-78

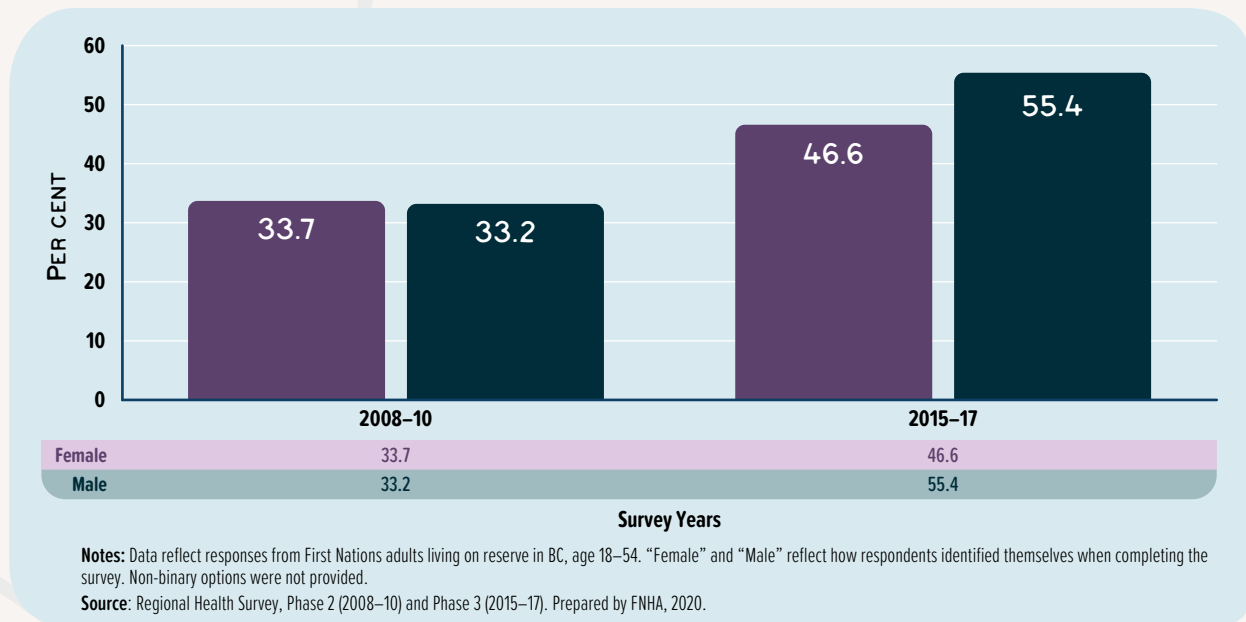
FIG 4.19 MEDIAN TOTAL INCOME AMONG FIRST NATIONS AND NON-INDIGENOUS POPULATIONS, AGE 25–54, BY SEX, BC, 2016



Racist laws and policies continue to benefit settler Canadians by limiting First Nations’ inherent rights, including preventing access to their ancestral lands, resources, and employment opportunities, thereby perpetuating socioeconomic disadvantage among First Nations women and their communities.²⁰ These racist laws and policies result in First Nations people being disproportionately marginalized when it comes to meeting their basic needs and the needs of their families.²⁰ In 2016, Statistics Canada reported that the median total income among First Nations women age 25–54 was \$25,957 per year, the lowest in comparison to non-Indigenous women (\$35,275), First Nations men (\$29,626), and non-Indigenous men (\$51,278) in the same age group.

p-78

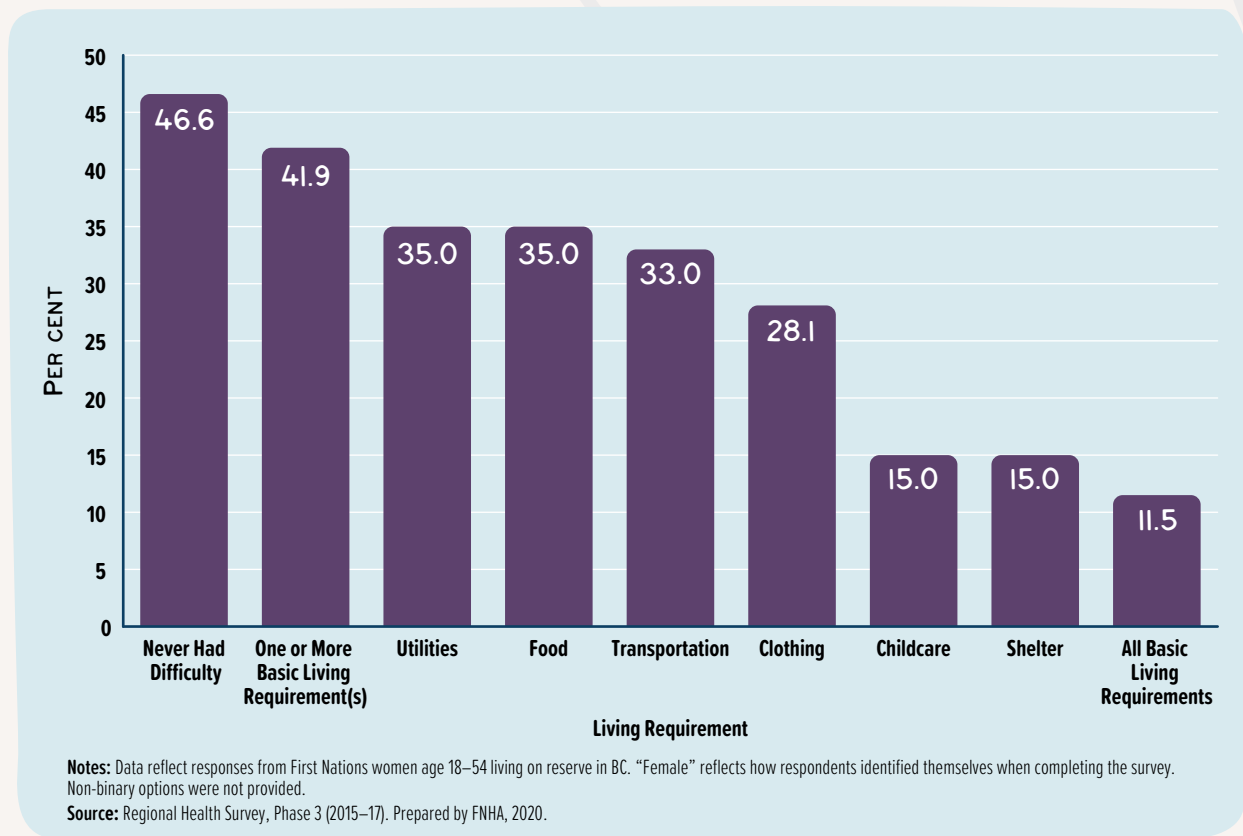
FIG 4.20 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED THAT THEY NEVER HAD DIFFICULTY MEETING THEIR BASIC NEEDS IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17



From RHS2 (2008–10) to RHS3 (2015–17), the proportion of First Nations women age 18–54 who reported that they never had difficulty meeting their basic needs in the past year increased 12.9 percentage points, from 33.7% to 46.6%.



FIG 4.21 PERCENTAGE OF FIRST NATIONS WOMEN WHO REPORTED THAT THEY STRUGGLED AT LEAST A FEW TIMES PER YEAR TO COVER THE COSTS OF BASIC LIVING REQUIREMENTS, AGE 18–54, BC, 2015–17



From RHS3 (2015–17), 41.9% of First Nations women age 18–54 reported struggling at least a few times per year to cover the costs of at least one basic living requirement (i.e., utilities, food, transportation, clothing, childcare, or shelter), while 11.5% reported struggling to cover all basic living requirements at least a few times per year. In comparison, 46.6% reported never having difficulty covering the costs of any basic living requirements.



Poverty can force women to make difficult choices between things that many families take for granted such as putting food on the table, paying for medicine, enrolling their children in sports or dance classes, or buying gifts.²¹ It can force them into situations where they are more vulnerable and/or unsafe—and compel their dependence on male partners and precarious work.²² At times, the circumstances of living in poverty are perceived as neglect. Far too many First Nations women are placed in positions of having to make impossible decisions, such as whether to remain in an abusive relationship or face poverty and homelessness.²³

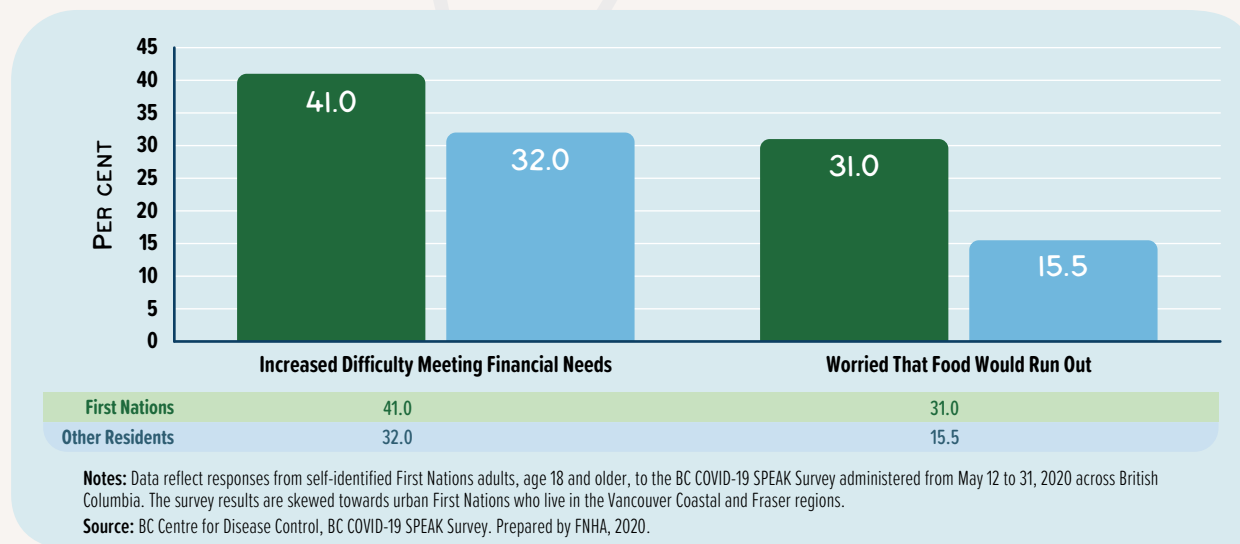
- Sacred and Strong: Upholding our Matriarchal Roles (p.78)



BASIC NEEDS

p-78

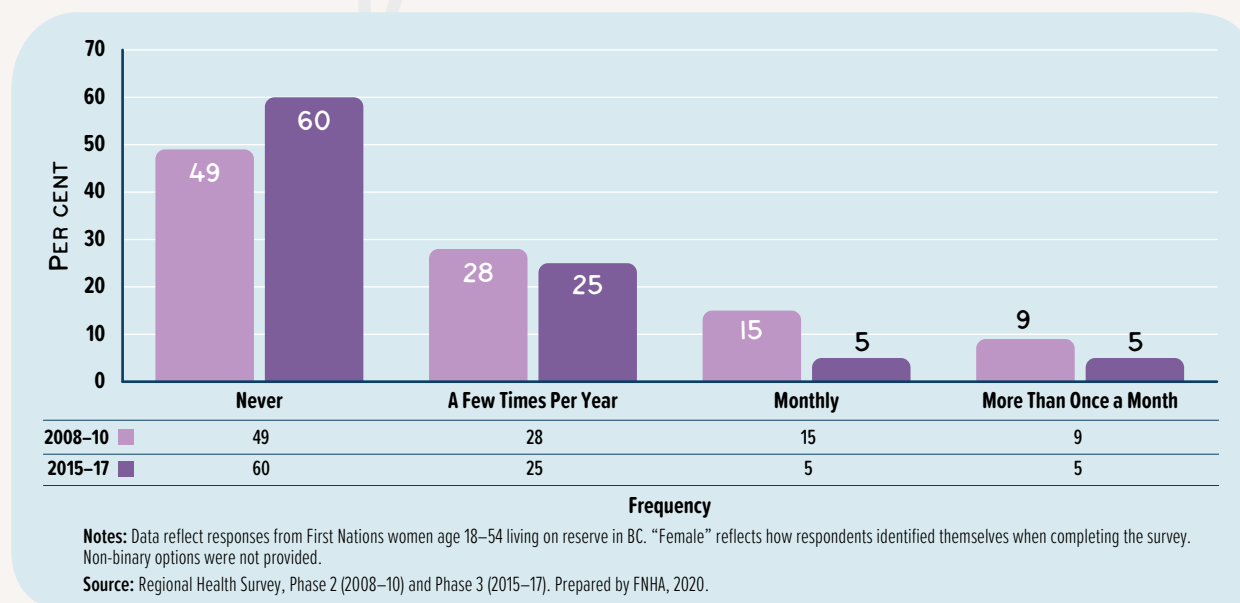
FIG 4.22 PERCENTAGE OF FIRST NATIONS AND OTHER RESIDENTS WHO REPORTED DIFFICULTY MEETING BASIC NEEDS DUE TO THE COVID-19 PANDEMIC, AGE 18 AND OLDER, BC, MAY 2020



The BC COVID-19 SPEAK (2020) showed that 41.0% of First Nations adults age 18 and older experienced increased difficulty meeting their household financial needs due to the COVID-19 pandemic, as compared to 32.0% of Other Residents. Similarly, due to the pandemic, 31.0% of First Nations adults—twice the percentage of Other Residents (15.5%)—reported that they worried that food would run out before they had money to buy more.

p-79

FIG 4.23 PERCENTAGE OF FIRST NATIONS WOMEN WHO REPORTED STRUGGLING TO COVER THE COSTS OF FOOD IN THE PAST YEAR, AGE 18–54, BY FREQUENCY, BC, 2008–10 AND 2015–17



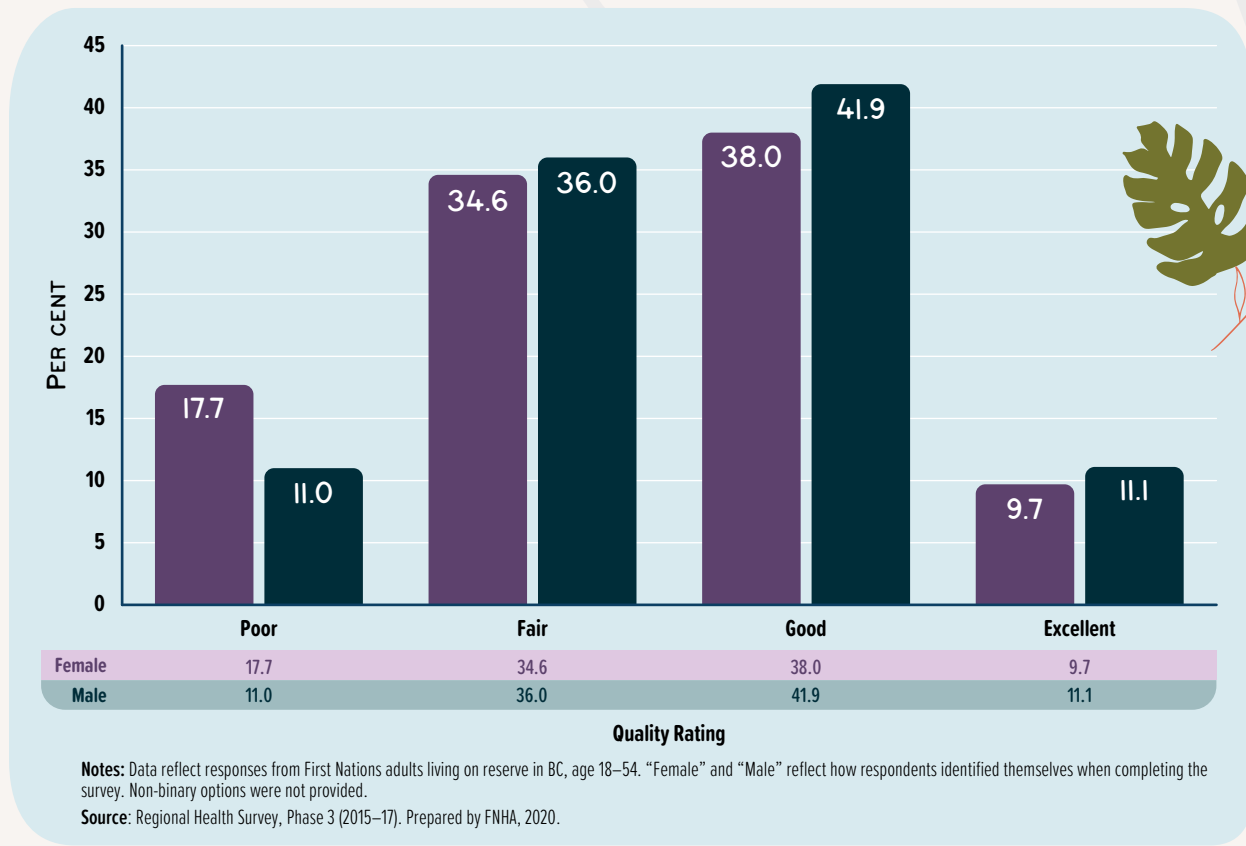
From RHS3 (2015–17), the majority of First Nations women age 18–54 (60%) never struggled to cover the costs of food in the past year. This is an increase of 11 percentage points from RHS2 (2008–10). In comparison, 35% reported struggling at least a few times per year to cover the costs of food. This result is calculated by adding the response categories “a few times per year” (25%), “monthly” (5%), and “more than once a month” (5%) for RHS3 (2015-17). Accessing affordable and fresh food is more challenging in lower-income, rural, and remote areas.²⁴ Many First Nations women and communities are regaining control of their own food practices by starting community gardens and reinitiating traditional hunting and harvesting practices.^{25,26}



QUALITY OF AVAILABLE HEALTH SERVICES

p.80

FIG 4.24 PERCENTAGE REPORTED QUALITY RATINGS OF THE HEALTH CARE SERVICES IN THEIR COMMUNITY BY FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2015–17



RHS3 (2015–17) data showed that 9.7% of First Nations women age 18–54 rated their community health care services as “excellent” and 38.0% as “good.” However, fewer First Nations women than men rated their health care services as “excellent,” “good,” or “fair.” *In Plain Sight* clearly indicated that BC’s health care system inflicts disproportionate anti-Indigenous racism on First Nations women that results in lower quality health care being provided;⁵ this is especially true for First Nations people who are gender-diverse and experience compounded stereotypes and biases in the health care system.²⁷

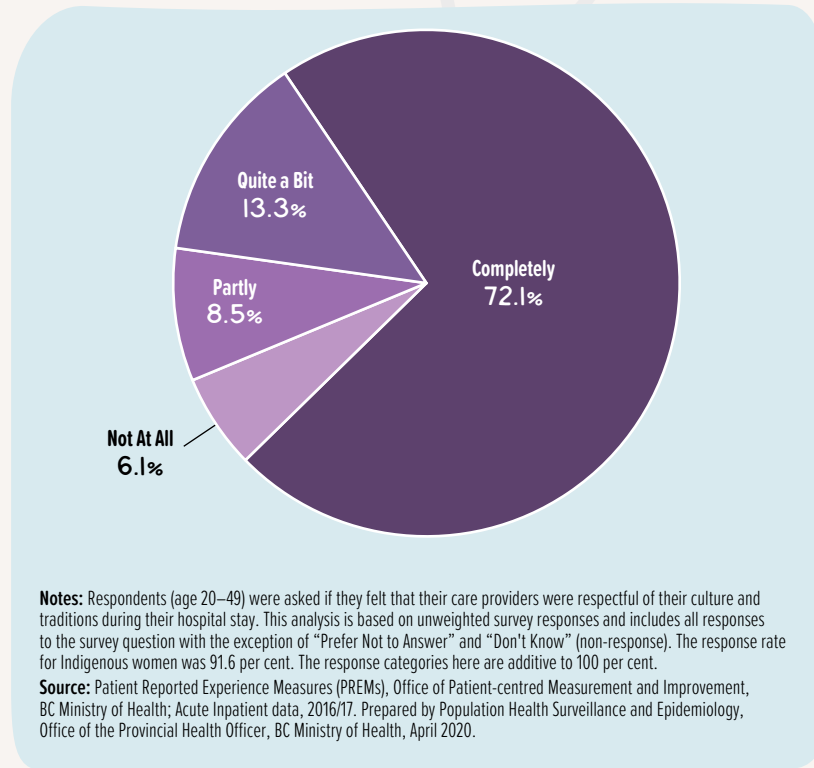




RECEIVING CULTURALLY SAFE CARE

p.80

FIG 4.25 REPORTED DEGREE TO WHICH HEALTH CARE PROVIDERS WERE RESPECTFUL OF INDIGENOUS WOMEN'S CULTURE AND TRADITIONS DURING THEIR HOSPITAL STAY, AGE 20–49, BC, 2016/17



From the 2016/17 Patient Reported Experience Measures Acute Inpatient Survey, 72.1% of Indigenous women age 20–49 reported that health care providers were “completely” respectful of their culture and traditions during their hospital stay. These results are not aligned with the disproportionate anti-Indigenous racism documented in *In Plain Sight*, including the findings that Indigenous respondents were significantly less likely to make complaints and significantly more likely to cite barriers to filing a complaint when they had the grounds to do so.⁵ Additionally, Indigenous women were less likely to make complaints compared to Indigenous men.⁵ As such, this chart must be interpreted with caution. Providing First Nations women with culturally safe care is key to both preventing and reducing the severity or impact of various health issues, as having positive experiences will encourage them to seek out health services when needed in the future.⁵ Increasing health care providers’ competency and confidence in providing culturally safe care through training is fundamental in improving the health and wellness of First Nations women.

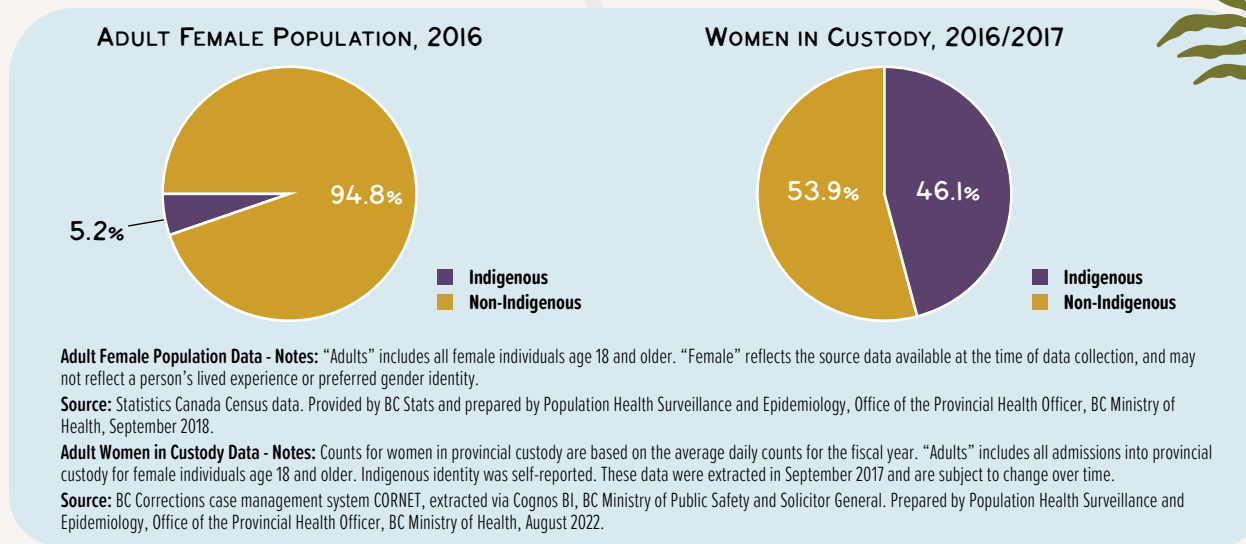




CUSTODY RATES

p.81

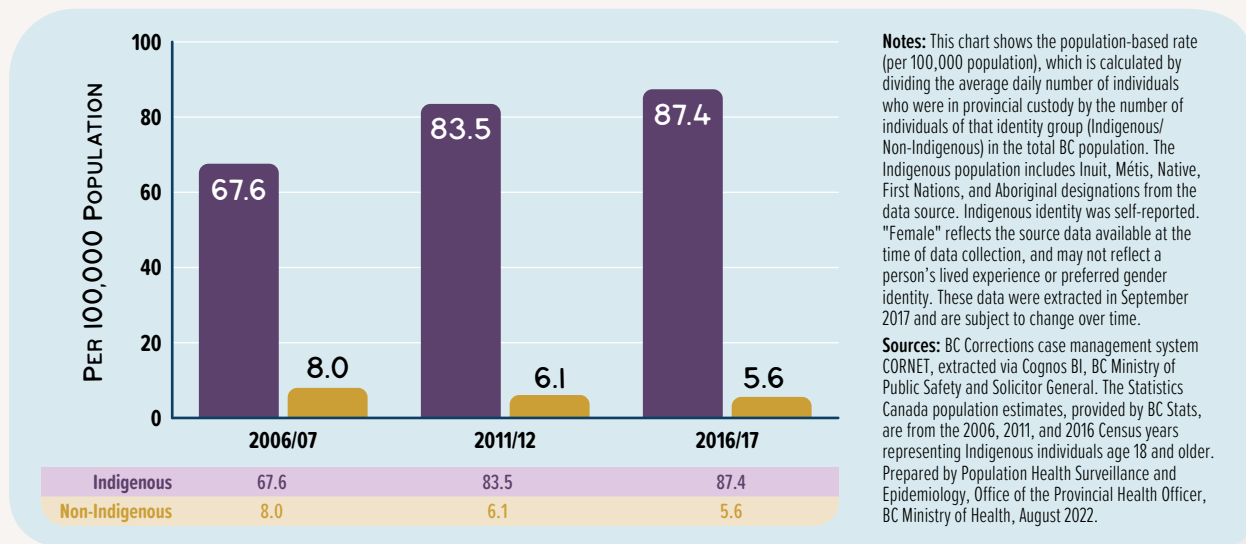
FIG 4.26 PROPORTION OF POPULATION AND AVERAGE POPULATION IN PROVINCIAL CUSTODY AMONG INDIGENOUS AND NON-INDIGENOUS WOMEN, AGE 18 AND OLDER, BC



Indigenous women are disproportionately criminalized and more likely to be incarcerated than non-Indigenous women due to racist laws and policies, manufactured poverty, impacts of intergenerational trauma, and for resisting the violence and destruction inflicted on their communities.¹² According to Census data, Indigenous women age 18 and older represented 5.2% of the adult female population in BC in 2016, but 46.1% of women in custody in 2016–17. This is a stark comparison to non-Indigenous women who represented 94.8% of the adult female population, but only 53.9% of women in custody. Indigenous women are targeted by law enforcement and criminalized for protecting themselves, their loved ones, and their land from violence.¹² To decrease custody rates among First Nations women, there is a need for reform to non-Indigenous enforcement practices.²⁸ In addition, there is a need for Indigenous-grounded, restorative justice programs and community-based law enforcement to restore power imbalances created by colonialism.

FIG 4.27 RATE OF INDIGENOUS AND NON-INDIGENOUS WOMEN IN PROVINCIAL CUSTODY, AGE 18 AND OLDER, BC, 2006/07, 2011/12, AND 2016/17

p.81



In the 10-year span from 2006/07 to 2016/17, the rate of Indigenous women age 18 and older in provincial custody increased from 67.6 per 100,000 to 87.4 per 100,000. However, BC Corrections has intentionally worked to improve the collection of Indigenous identity information during these years, so the increase is partly due to this change.

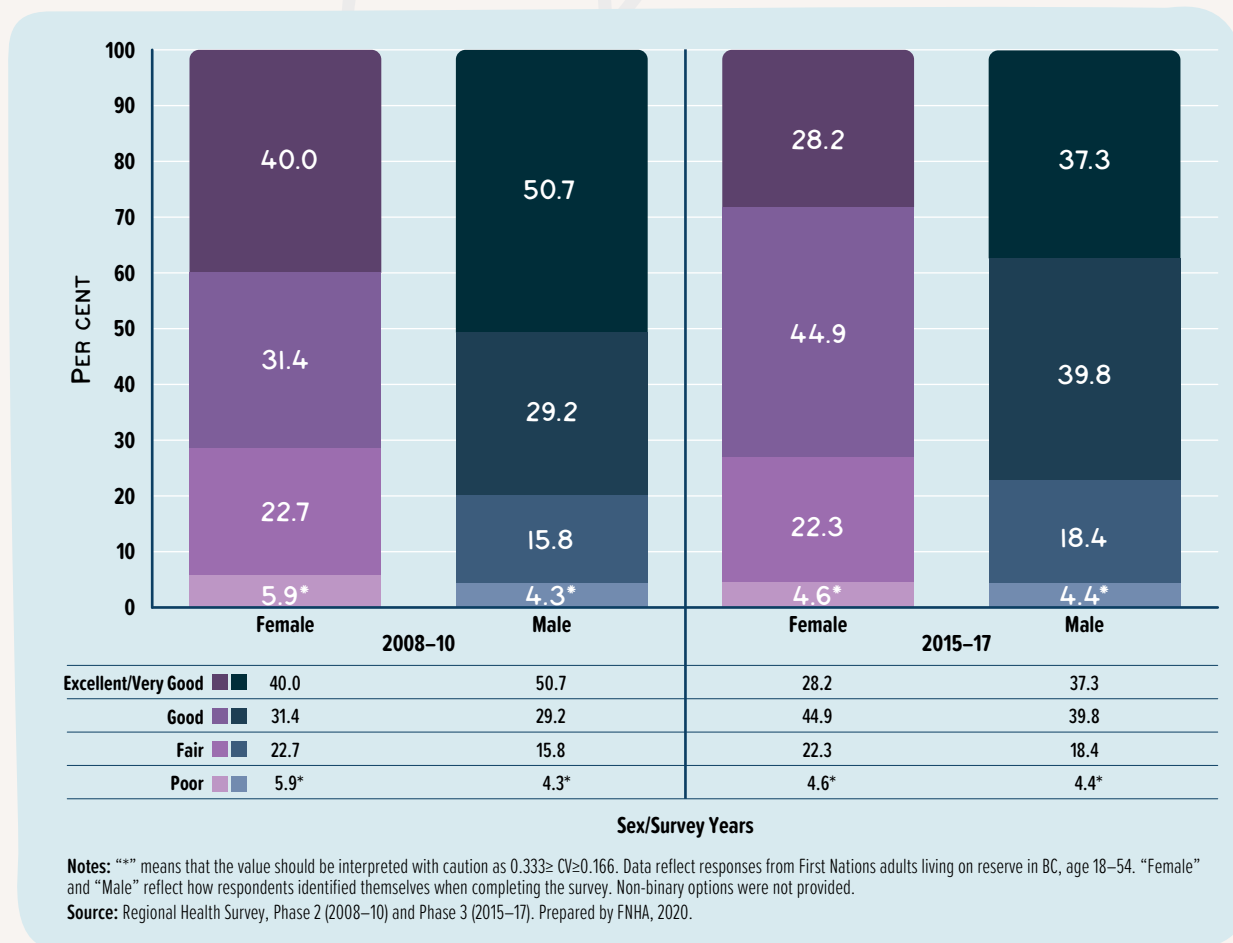
HEALTHY BODIES, MINDS AND SPIRITS

The connections First Nations women have with their culture, family, and community are essential to their health and wellness.^{29,30} Supportive systems are needed that respect First Nations cultural values and traditions, and that arrest racist policies and practices. Work must still be done to eradicate racist policies and practices that suppress the rights and self-determination of First Nations women. Restoring the inherent rights and self-determination of First Nations women will result in improved physical, mental, spiritual, and emotional health.

SELF-RATED HEALTH

p.82

FIG 4.28 PERCENTAGE SELF-RATED GENERAL HEALTH AMONG FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17

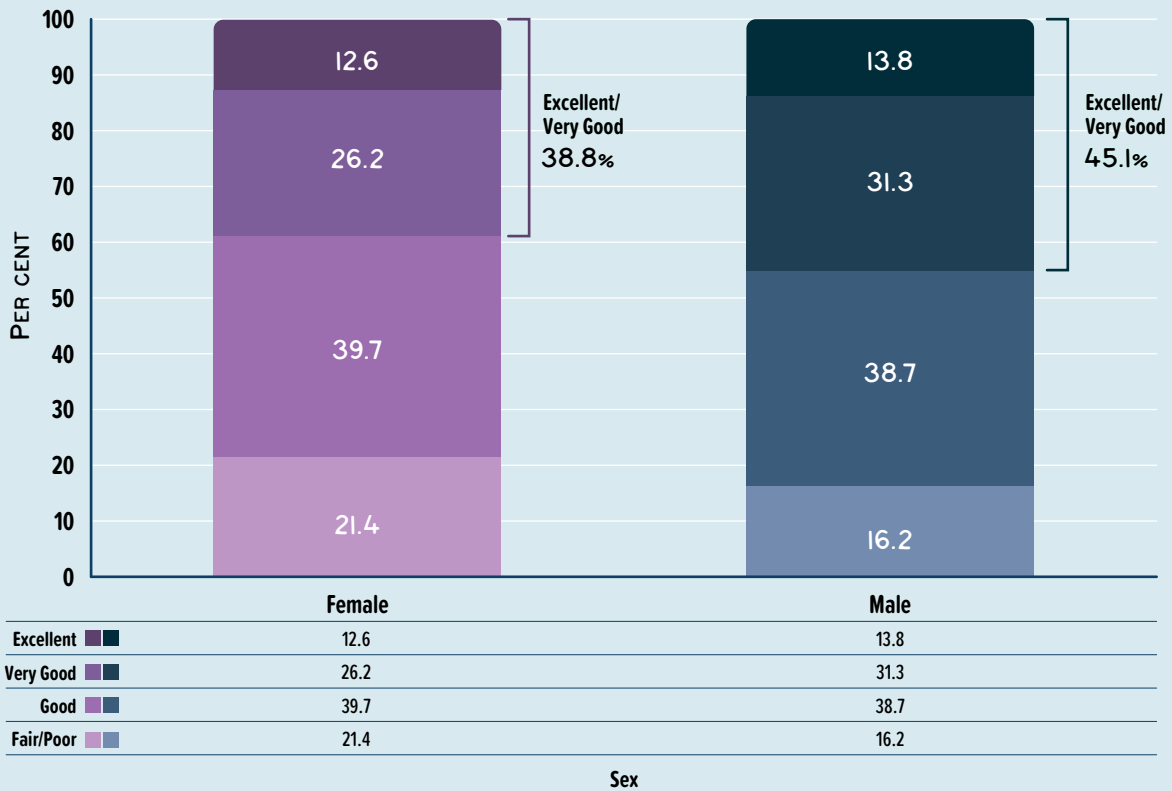


Balanced physical, mental, spiritual, and emotional health are all necessary components of health and wellness. First Nations women’s self-rated general health is centered on their feelings of connectedness to themselves, nature, their friends, family, community, and ancestors.³¹ RHS3 (2015–17) data showed that 28.2% of First Nations women rated their health as “excellent” or “very good,” while 44.9% rated their health as “good.” There was a decrease of 11.8 percentage points among First Nations women reporting “excellent” or “very good” health from RHS2 (2008–10) to RHS3 (2015–17).

SELF-RATED MENTAL HEALTH

p.83

FIG 4.29 PERCENTAGE SELF-RATED MENTAL HEALTH AMONG FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2015–17



Notes: Data reflect responses from First Nations adults living on reserve in BC, age 18–54. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

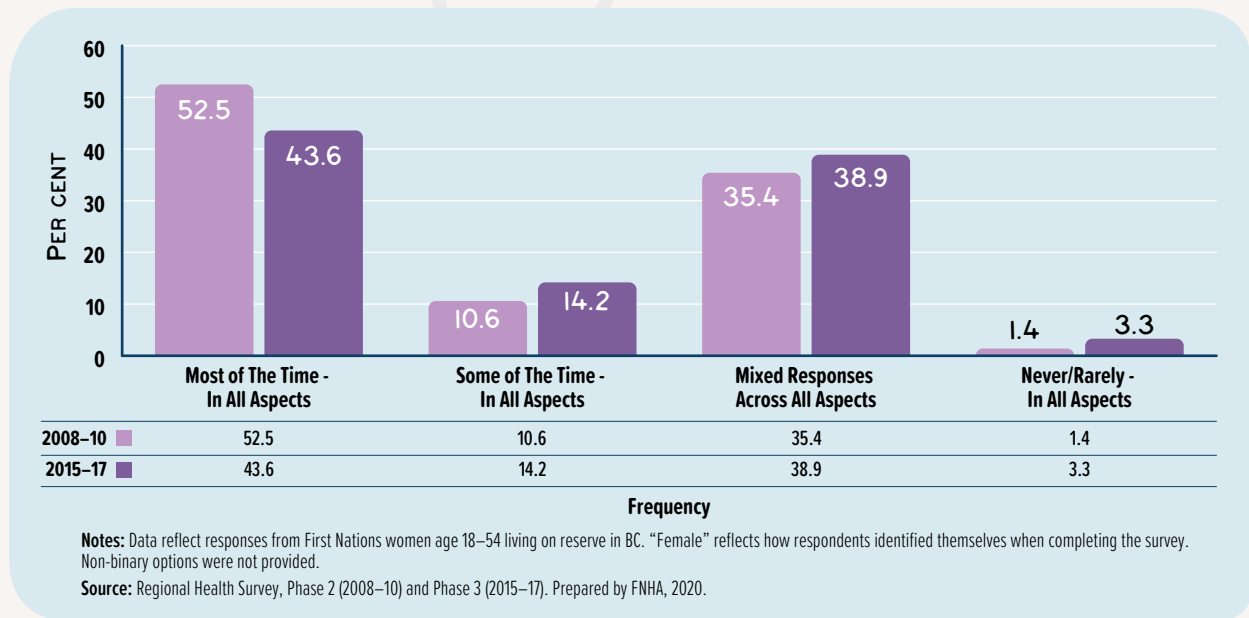
From RHS3 (2015–17), a lower percentage of First Nations women age 18–54 rated their mental health as “excellent” or “very good” compared to First Nations men in the same age group (38.8% vs. 45.1%). Research has consistently found a greater prevalence of anxiety and stress disorders among women than among men.³² First Nations women look to their traditions, customs, and culture to help them reclaim and maintain their strength and resilience in the face of racism, discrimination, and intergenerational trauma.³³



SENSE OF BALANCE

p.83

FIG 4.30 PERCENTAGE SELF-RATED FREQUENCY OF BALANCE IN WELLNESS ASPECTS OF LIFE (PHYSICAL, MENTAL, SPIRITUAL, AND EMOTIONAL) AMONG FIRST NATIONS WOMEN, AGE 18–54, BC, 2008–10 AND 2015–17



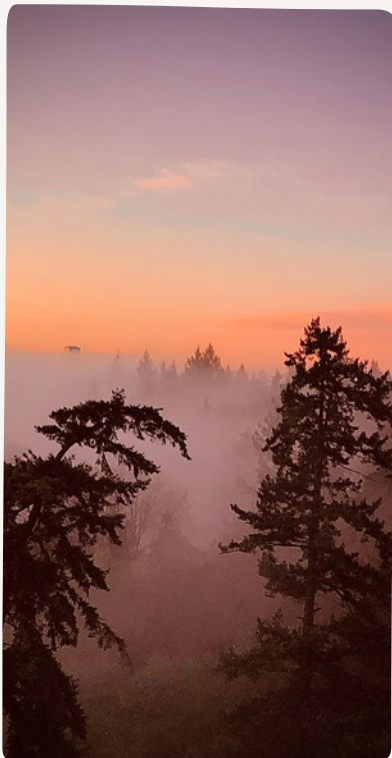
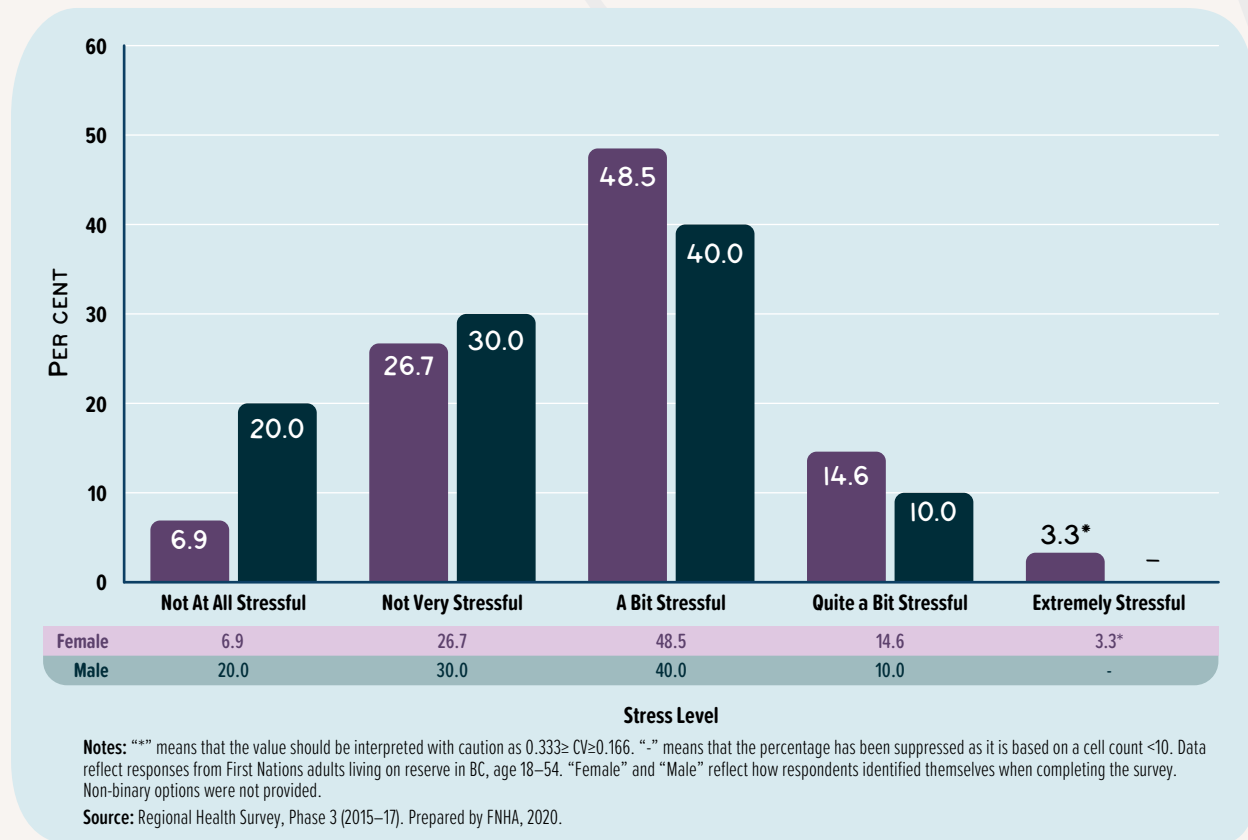
RHS3 (2015–17) data showed that 43.6% of First Nations women age 18–54 felt balanced “most of the time—in all aspects” of wellness, which is a decrease of 8.9 percentage points from RHS2 (2008–10). More First Nations women felt balanced “some of the time—in all aspects” in 2015–17 than in 2008–10 (14.2% vs. 10.6%). Being connected to the land, community, and family helps First Nations women to have balance in wellness.³⁴ First Nations women also value having avenues for communication to speak freely and openly about issues they might be facing.³⁵



LIFE STRESS

p.84

FIG 4.31 PERCENTAGE REPORTED STRESS LEVEL OF MOST DAYS AMONG FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2015–17



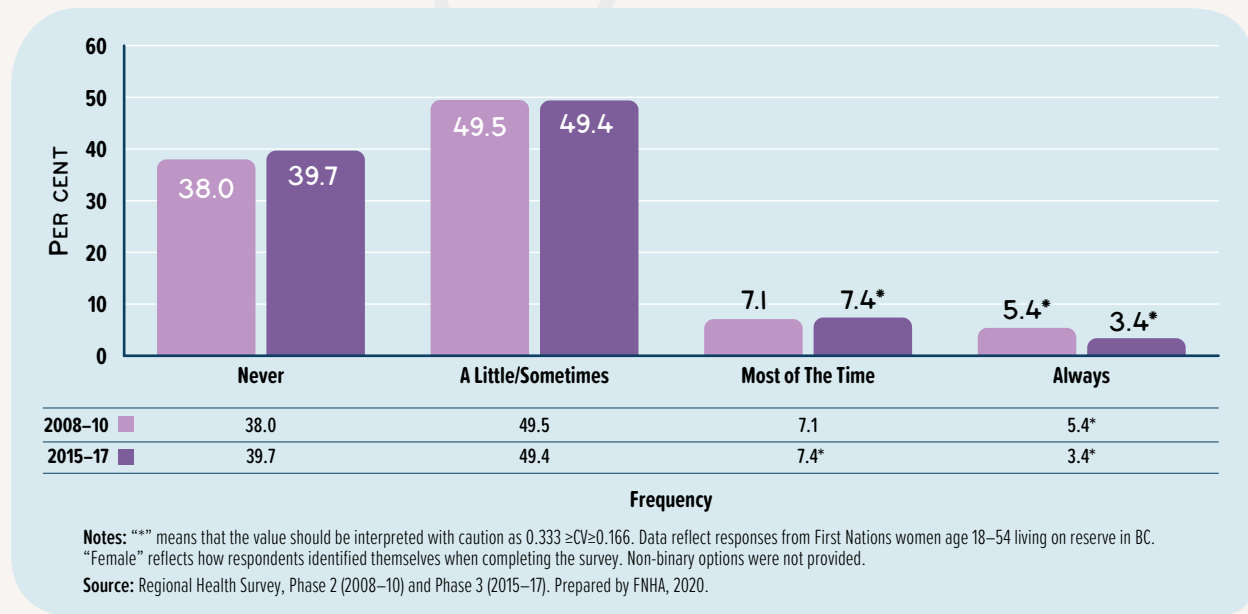
From RHS3 (2015–17), 48.5% of First Nations women age 18–54 reported that most days in life were “a bit stressful,” while 14.6% felt most days were “quite a bit stressful.” Only 33.6% of First Nations women felt that most days in life were “not at all stressful” (6.9%) or “not very stressful” (26.7%). First Nations women may experience higher levels of stress due to the impacts of interpersonal racism and racist laws and policies that have impacted their overall wellness and sense of balance.



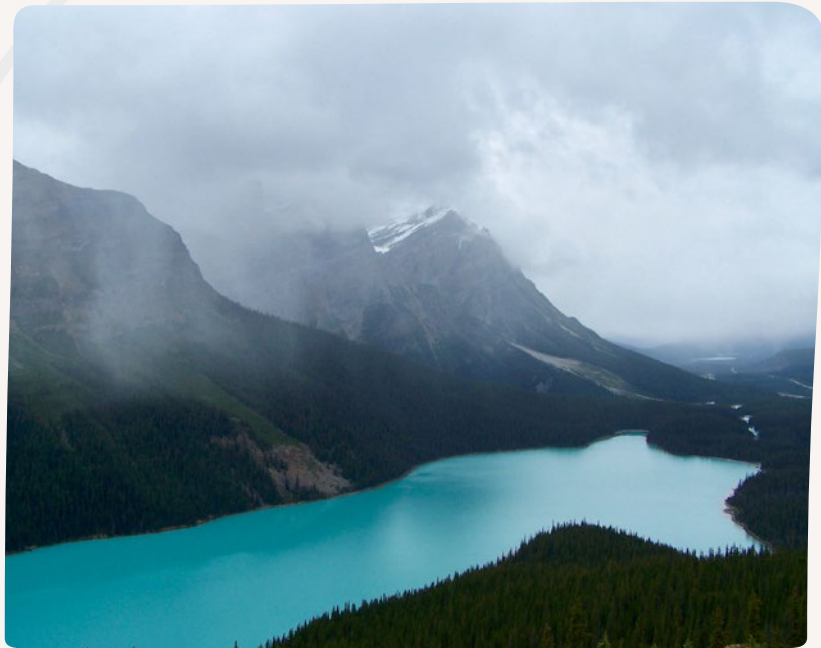
DEPRESSION

p.84

FIG 4.32 SELF-REPORTED FREQUENCY OF FEELINGS OF DEPRESSION IN THE PAST MONTH AMONG FIRST NATIONS WOMEN, AGE 18–54, BC, 2008–10 AND 2015–17



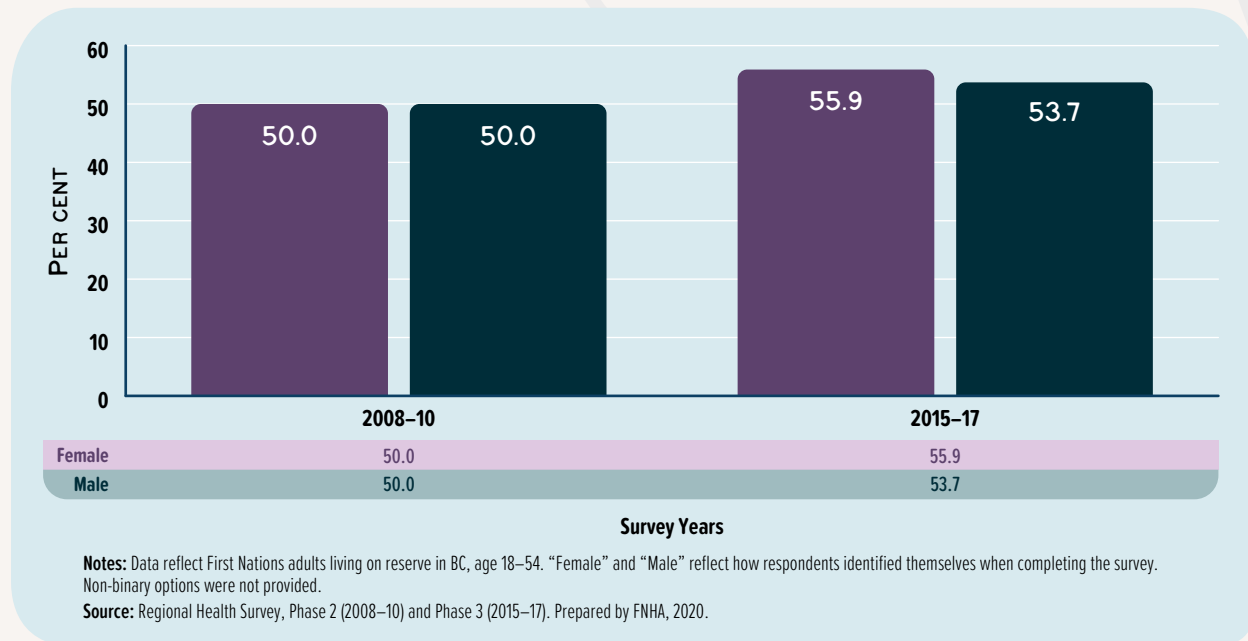
From RHS3 (2015–17), the majority (89.1%) of First Nations women age 18–54 either “never” (39.7%) or “a little/sometimes” (49.4%) experienced feelings of depression in the past month. First Nations women are two times more likely than First Nations men to experience depression or mood disorders.⁵ This gender difference is likely due to many complex factors, but the racist laws and policies that result in stereotyping, marginalization, stigmatization, and violence against First Nations women undoubtedly have an impact on their mental health.¹⁴



NON-SMOKING RATES

p.84

FIG 4.33 PERCENTAGE OF FIRST NATIONS ADULTS WHO WERE NON-SMOKERS AT TIME OF SURVEY, AGE 18-54, BY SEX, BC, 2008-10 AND 2015-17



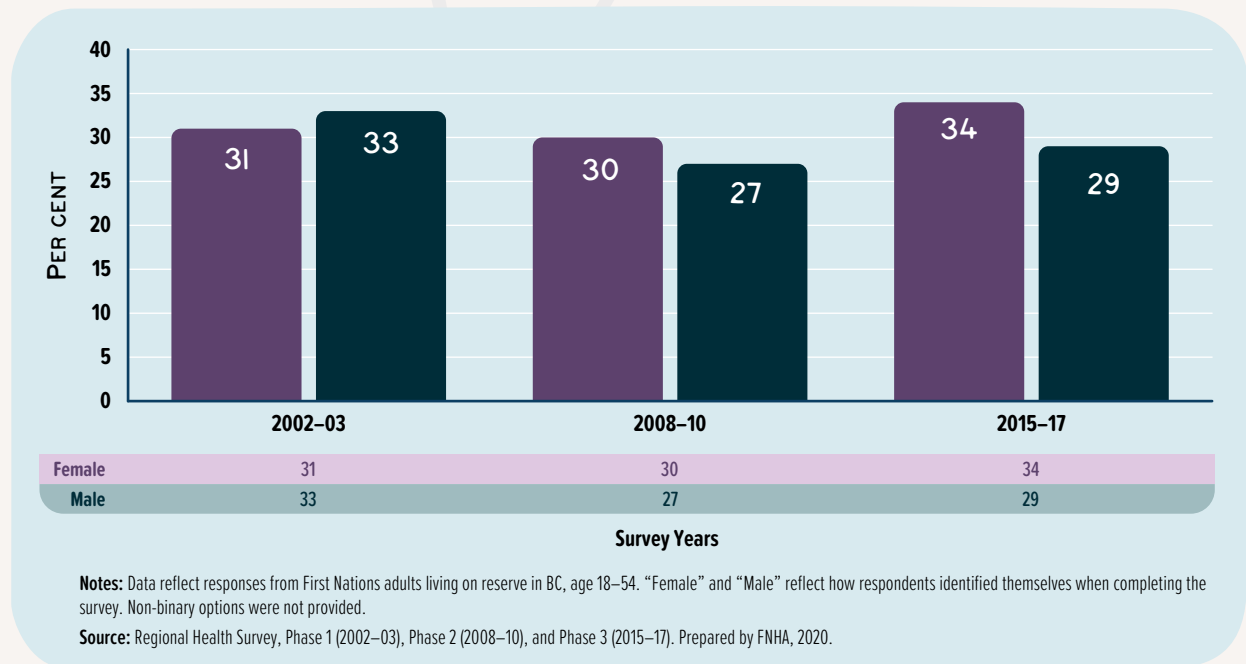
From RHS2 (2008-10) and RHS3 (2015-17), the percentage of First Nations women age 18-54 who did not smoke cigarettes increased by 5.9 percentage points from 50.0% to 55.9%. Broad awareness of the negative impacts of commercial tobacco use—including the impact of second-hand smoke on children and families—may be a factor in the reduction of commercial smoking among First Nations women.³⁶



ALCOHOL USE

p.85

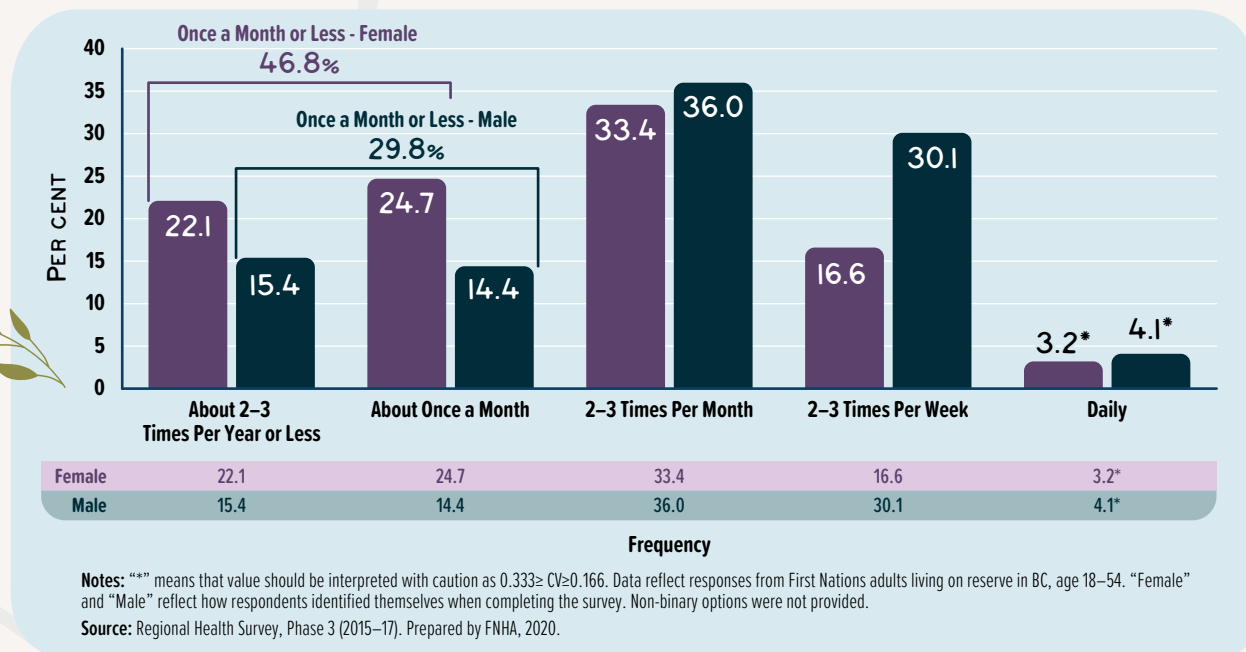
FIG 4.34 PERCENTAGE OF FIRST NATIONS ADULTS WHO DID NOT DRINK ALCOHOL IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2002–03, 2008–10, AND 2015–17



From RHS1 (2002–03), RHS2 (2008–10), and RHS3 (2015–17), the proportion of First Nations women age 18–54 who did not drink alcohol in the past year consistently remained at or over 30%. Many First Nations women have experienced significant traumas due to colonialism and have seen the impacts of alcohol use in their communities; however, they remain both resilient and strong.

p.85

FIG 4.35 PERCENTAGE REPORTED FREQUENCY OF ALCOHOL CONSUMPTION AMONG FIRST NATIONS ADULTS WHO DRANK ALCOHOL IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2015–17

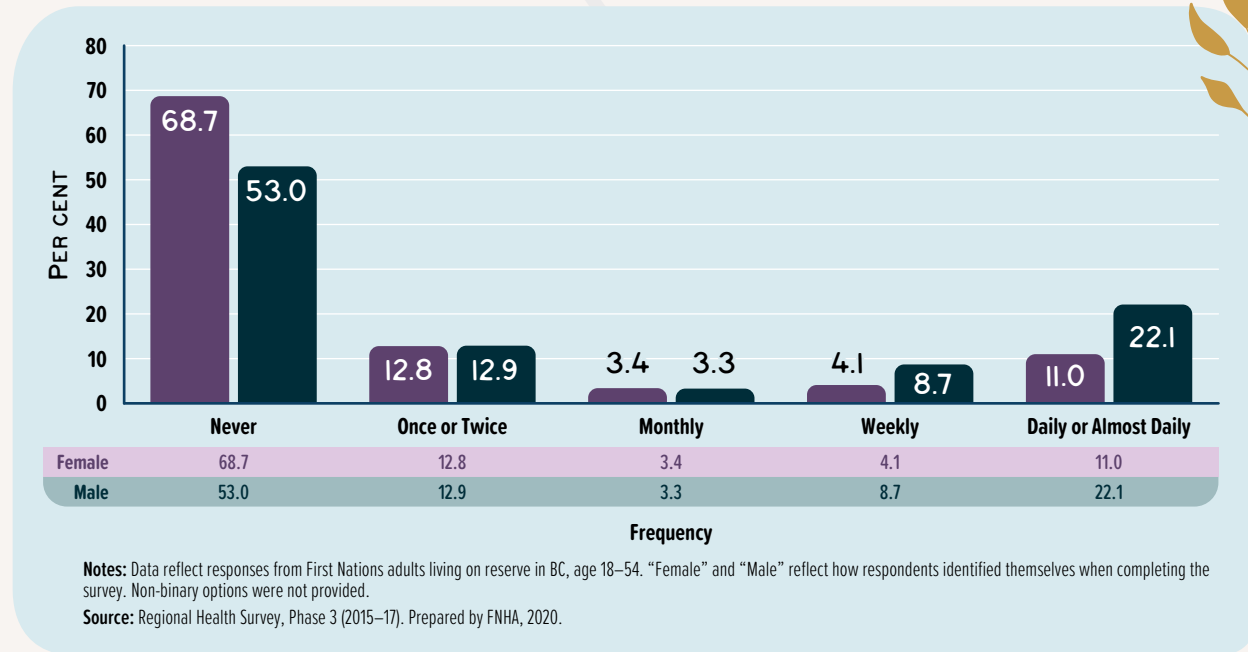


From RHS3 (2015–17), of the First Nations women age 18–54 who drank alcohol in the past year, 46.8% drank rarely—“about once a month” (24.7%) or “about 2–3 times per year or less” (22.1%).

CANNABIS USE

p.85

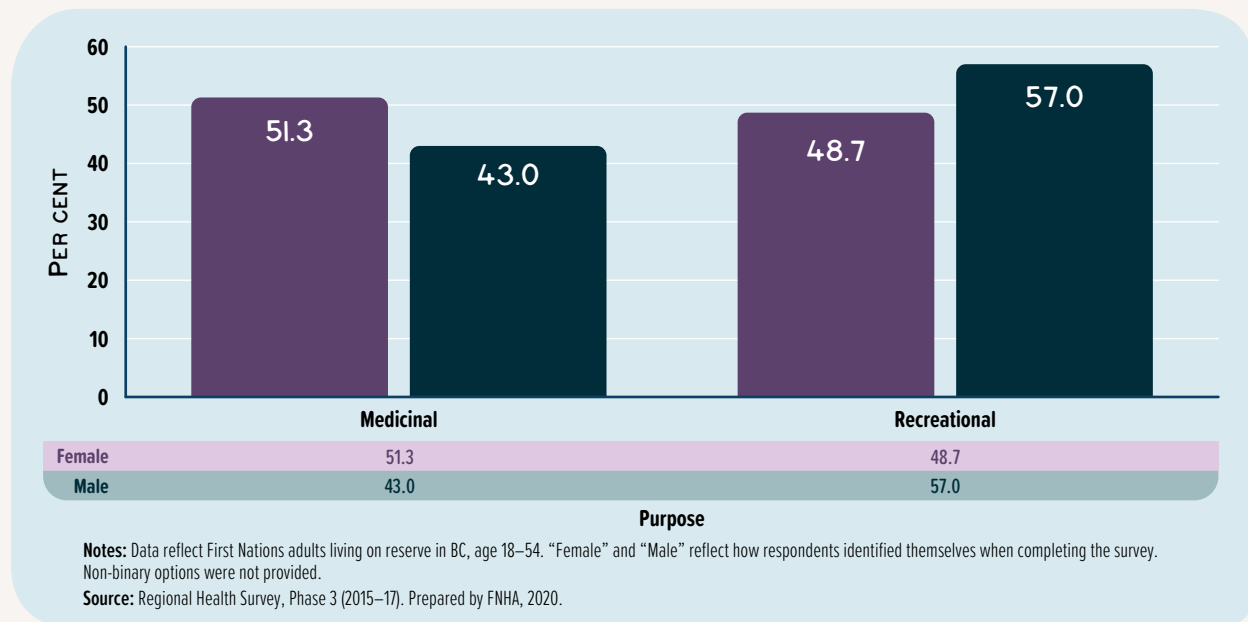
FIG 4.36 PERCENTAGE REPORTED FREQUENCY OF CANNABIS USE IN THE PAST YEAR AMONG FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2015–17



From RHS3 (2015–17), 31.3% of First Nations women age 18–54 used cannabis in the past year. Some First Nations women use cannabis recreationally or for medicinal purposes; however, it may also be used as a coping mechanism for intergenerational trauma, psychological distress, or racism.³⁷

p.85

FIG 4.37 PERCENTAGE REPORTED CANNABIS USE FOR MEDICINAL OR RECREATIONAL PURPOSES AMONG FIRST NATIONS ADULTS WHO USED CANNABIS IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2015–17

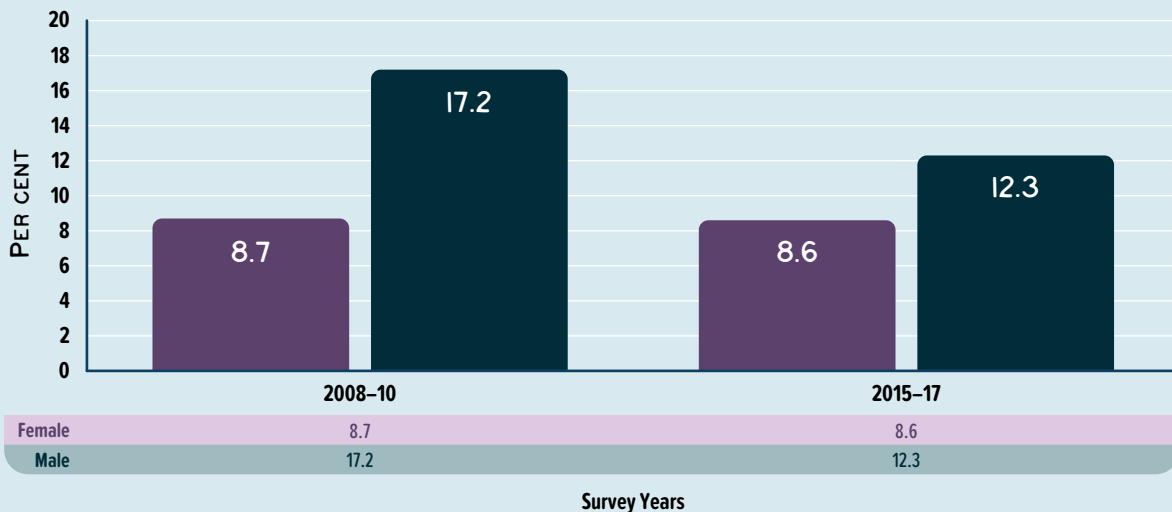


From RHS3 (2015–17), of First Nations women age 18–54 who used cannabis in the past year, 51.3% did so for medicinal purposes.

OTHER SUBSTANCE USE

p.86

FIG 4.38 PERCENTAGE REPORTED USE OF OTHER SUBSTANCES IN THE PAST YEAR AMONG FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17



Notes: Data reflect responses from First Nations adults living on reserve in BC, age 18–54. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided. Data reflect any use of the following: cocaine, amphetamines, methamphetamines, ecstasy, hallucinogens, heroin, or other specified substances (reported by respondents). Data exclude use of cannabis, inhalants, and salvia.

Source: Regional Health Survey, Phase 2 (2008–10) and Phase 3 (2015–17). Prepared by FNHA, 2020.

Across RHS2 (2008–10) and RHS3 (2015–17), less than 9% of First Nations women age 18–54 reported any use of substances in the past year, including cocaine, amphetamines, methamphetamine, ecstasy, hallucinogens, inhalants, heroin, salvia, opioids, sedatives, and other specified substances. Racism, intergenerational trauma, and attempted genocide harm First Nations women; however, First Nations women continue to actively resist the continued effects of colonialism and seek diverse ways of coping and healing, including relying on their culture and spirituality.³⁸

A harm reduction approach is about taking a compassionate, non-judgemental approach to alcohol and substance use: meeting people where they are at, accepting them, and understanding the complexities of substance use and addiction.³⁹

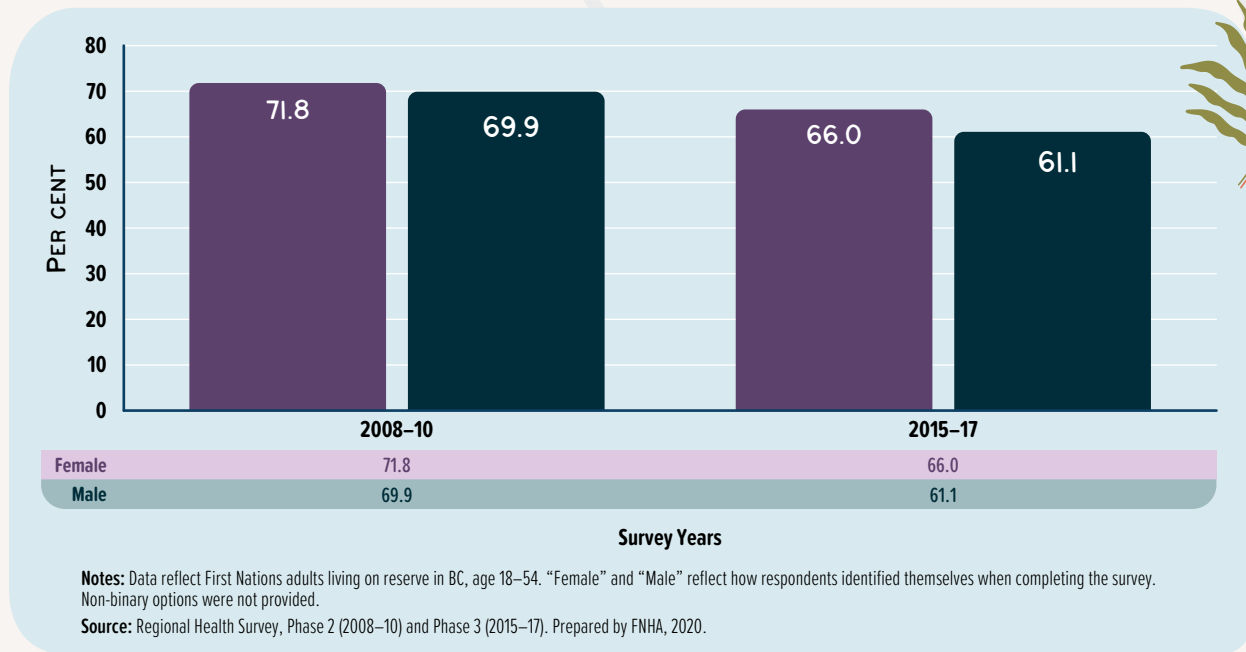
This approach focuses on building relationships based in trust to support individuals in reducing the harms associated with their substance use and finding safer ways of coping. These connections can be life-saving – and in response to the toxic drug crisis, many Nations have developed innovative and culturally relevant harm reduction and housing programs—often involving Elders—to strengthen supports and reduce the risks of overdoses.

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.85)

GAMBLING

p.86

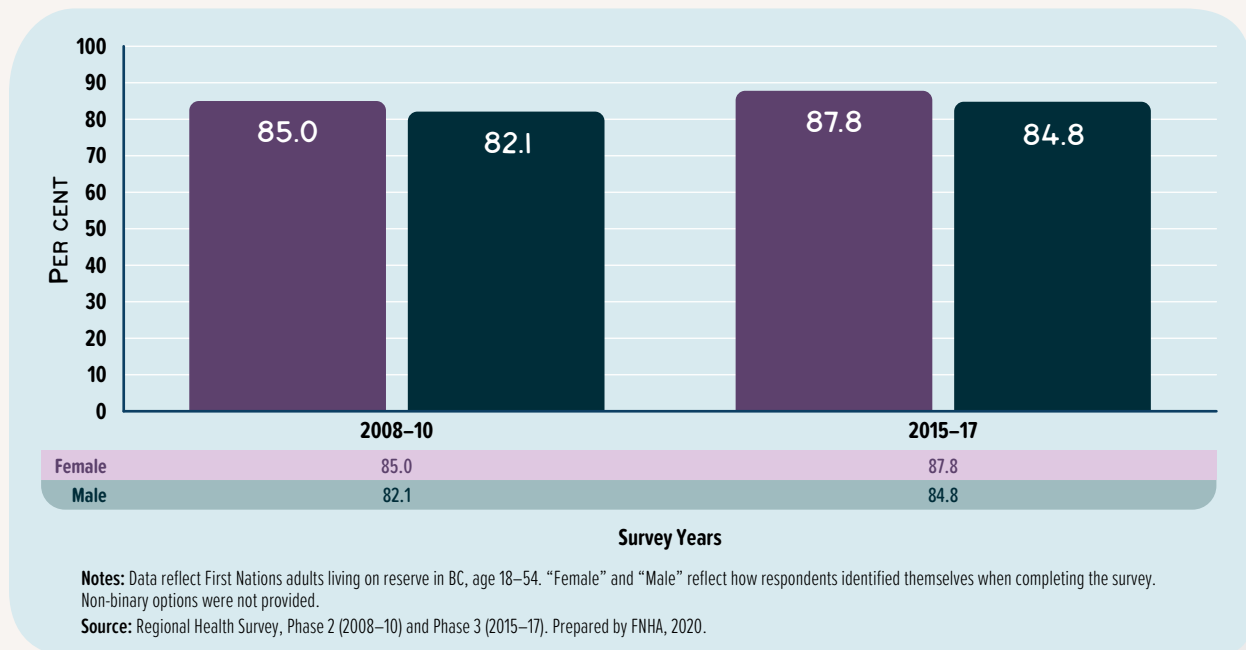
FIG 4.39 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED GAMBLING IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17



From RHS2 (2008–10) to RHS3 (2015–17), the percentage of First Nations women age 18–54 who reported gambling in the past year decreased by 5.8 percentage points, from 71.8% to 66.0%.

p.86

FIG 4.40 PERCENTAGE OF FIRST NATIONS ADULTS WHO NEVER BET MORE THAN THEY COULD AFFORD TO LOSE, AMONG THOSE WHO REPORTED GAMBLING IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17

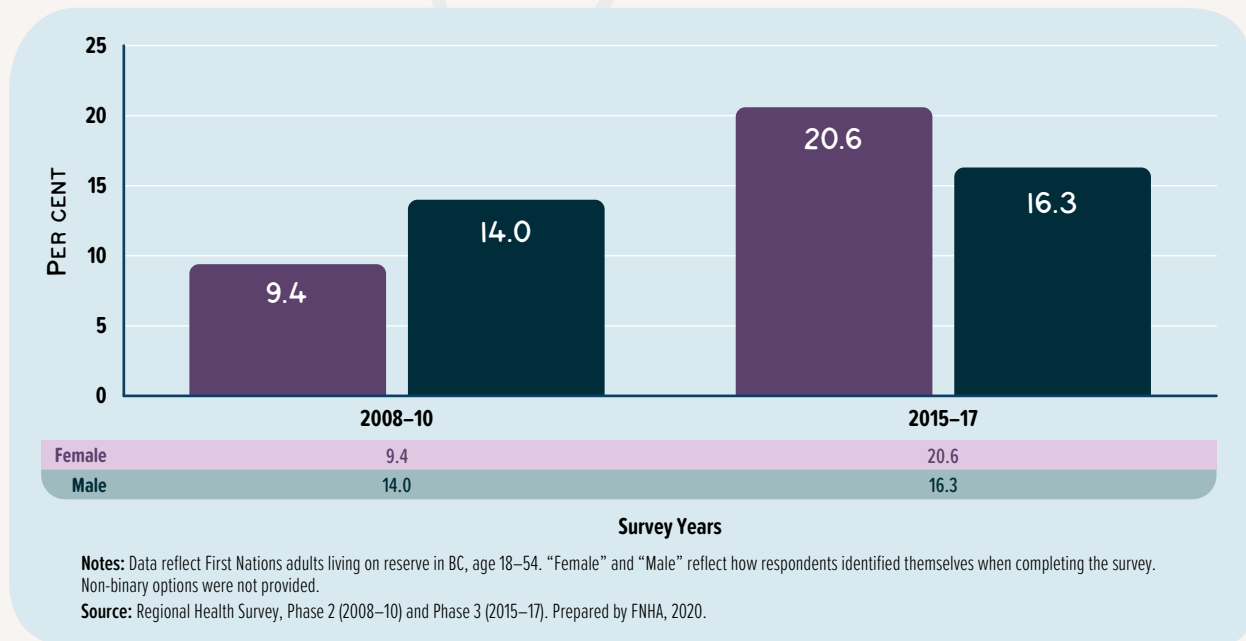


Of First Nations women age 18–54 who gambled in the past year, there was an increase in the proportion who never bet more than they could afford to lose, from 85.0% (2008–10) to 87.8% (2015–17). Although most First Nations women who engage in gambling do so responsibly (i.e., betting only what they can afford to lose), some may engage in problematic gambling as a way of coping with past traumas.⁴⁰

SUICIDES

p.87

FIG 4.4I PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED THAT THEY HAD LOST A FAMILY MEMBER OR FRIEND TO SUICIDE IN THE PAST YEAR, AGE 18–54, BY SEX, BC, 2008–10 AND 2015–17



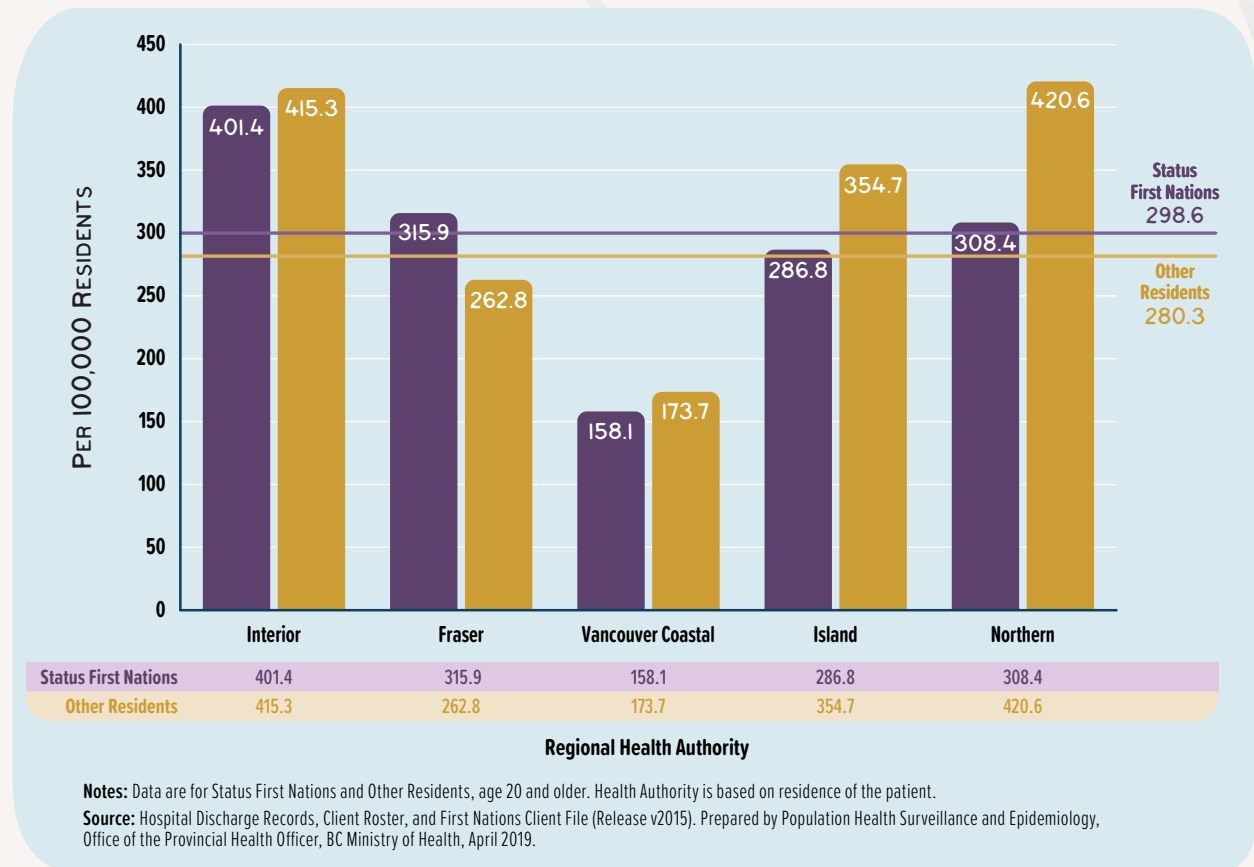
From RHS2 (2008–10) to RHS3 (2015–17), the percentage of First Nations women age 18–54 who lost a family member or friend to suicide in the past year increased by 11.2 percentage points from 9.4% to 20.6%. The roots of suicide are complex among First Nations people; they are disproportionately affected due to the intergenerational impacts of colonialism, including residential schools, the Sixties Scoop, land dispossession, and cultural genocide.³¹



HYSTERECTOMIES

p.89

FIG 4.42 AGE-STANDARDIZED HYSTERECTOMY RATE AMONG STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 20 AND OLDER, BY REGIONAL HEALTH AUTHORITY, BC, 2011–15



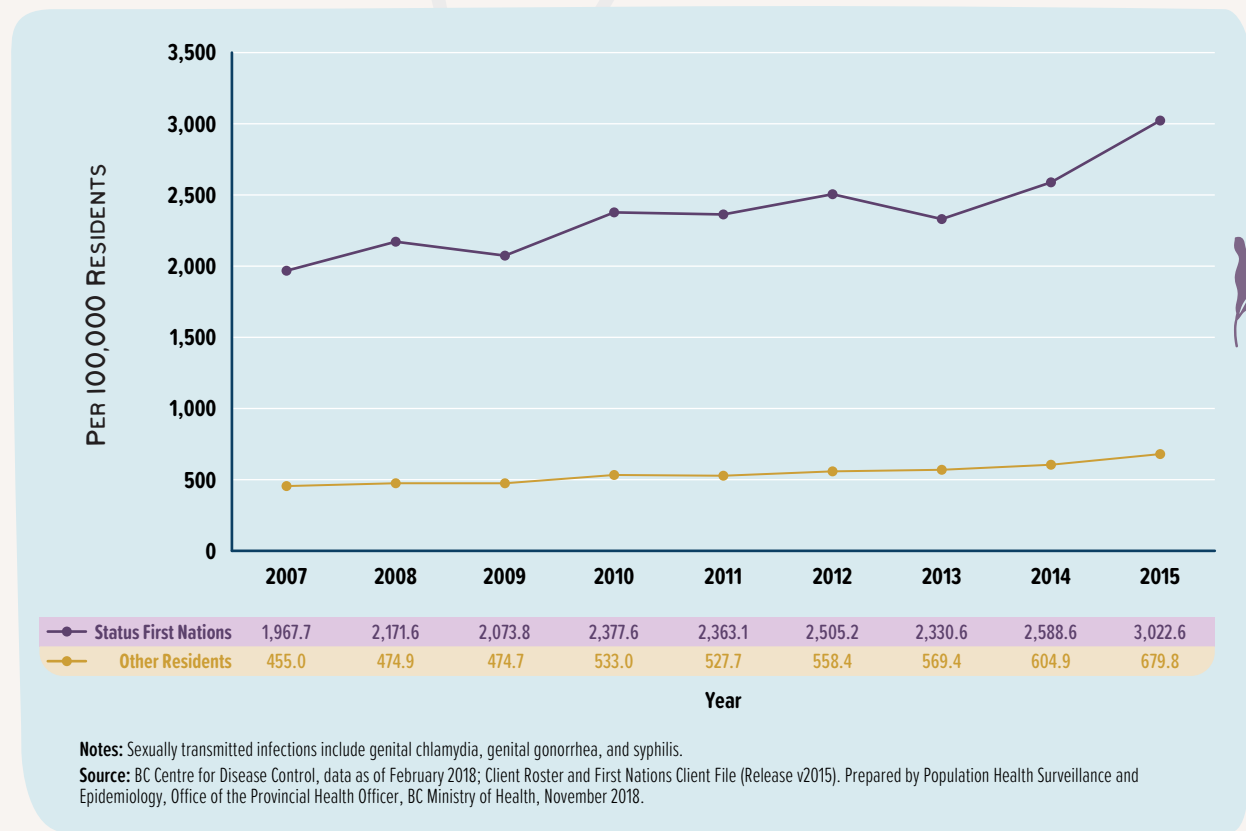
From hospital discharge records for the period spanning 2011–2015, the age-standardized hysterectomy rate was 298.6 per 100,000 among Status First Nations women age 20 and older, compared to 280.3 per 100,000 among Other Resident women in the same age group. Having control over one’s own body and fertility is a basic human right; however, First Nations women continue to be impacted by the historical and ongoing traumas of coerced and forced sterilizations, as well as racist stereotypes that undermine their reproductive health. This is a violation to their identities as mothers and women.⁵



SEXUALLY TRANSMITTED INFECTIONS

p.89

FIG 4.43 CRUDE RATE OF SEXUALLY TRANSMITTED INFECTIONS AMONG STATUS FIRST NATIONS WOMEN AND OTHER RESIDENT WOMEN, AGE 20–49, BY SEX, BC, 2007 TO 2015



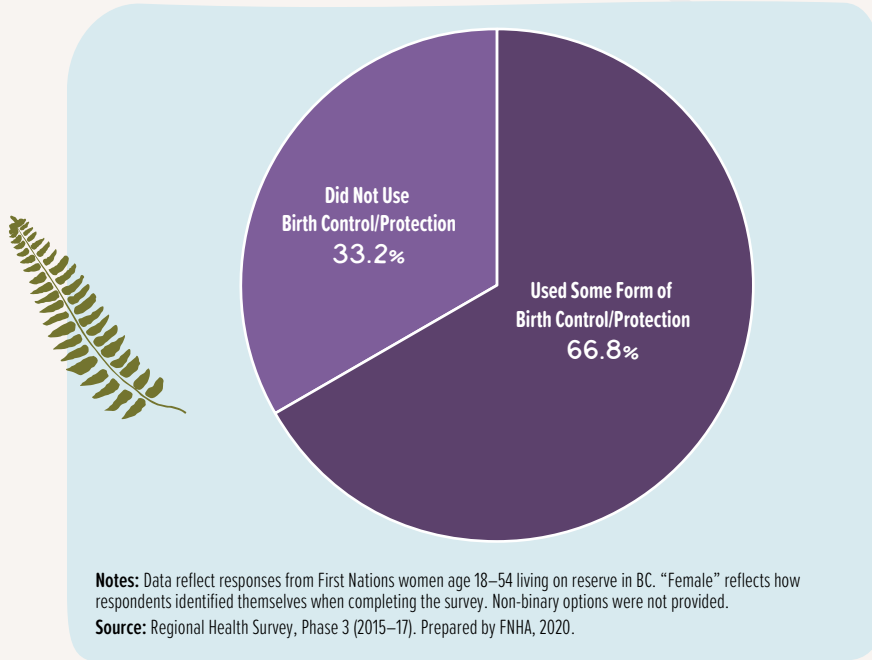
First Nations women experience anti-Indigenous racism in BC’s health care system, which creates barriers to accessing culturally safe, gender affirming, trauma-informed care, and makes it difficult for them to receive services and supplies for informed family planning that support their sexual well-being.⁴¹ From 2007 to 2015, the crude rate of sexually transmitted infections was consistently higher among Status First Nations women age 20–49 than Other Resident women in the same age group, and both populations showed increasing trends over time. In 2015, the crude rate of sexually transmitted infections among Status First Nations women was more than four times the rate of Other Resident women (3,022.6 per 100,000 vs. 679.8 per 100,000).



CONTRACEPTION

p.89

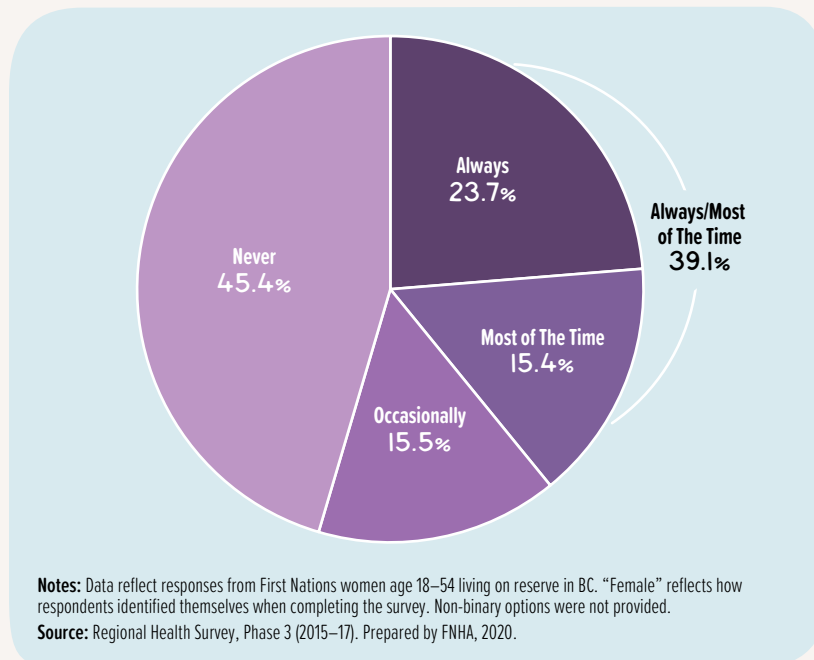
FIG 4.44 SEXUALLY ACTIVE FIRST NATIONS WOMEN WHO USED SOME FORM OF CONTRACEPTION WHEN THEY HAD SEX IN THE PAST YEAR, AGE 18–54, BC, 2015–17



First Nations women have the right to choose which type of contraception, if any, they want to use, and the right to choose a method that supports their sexual and reproductive health. Barriers affecting access to culturally safe information and services should not affect the contraception method chosen.⁴² From RHS3 (2015–17), 66.8% of sexually active First Nations women age 18–54 used some form of contraception when they had sex in the past year.

p.89

FIG 4.45 REPORTED FREQUENCY OF CONDOM USE AMONG FIRST NATIONS WOMEN WHO WERE SEXUALLY ACTIVE AND USED SOME FORM OF CONTRACEPTION WHEN THEY HAD SEX IN THE PAST YEAR, AGE 18–54, BC, 2015–17

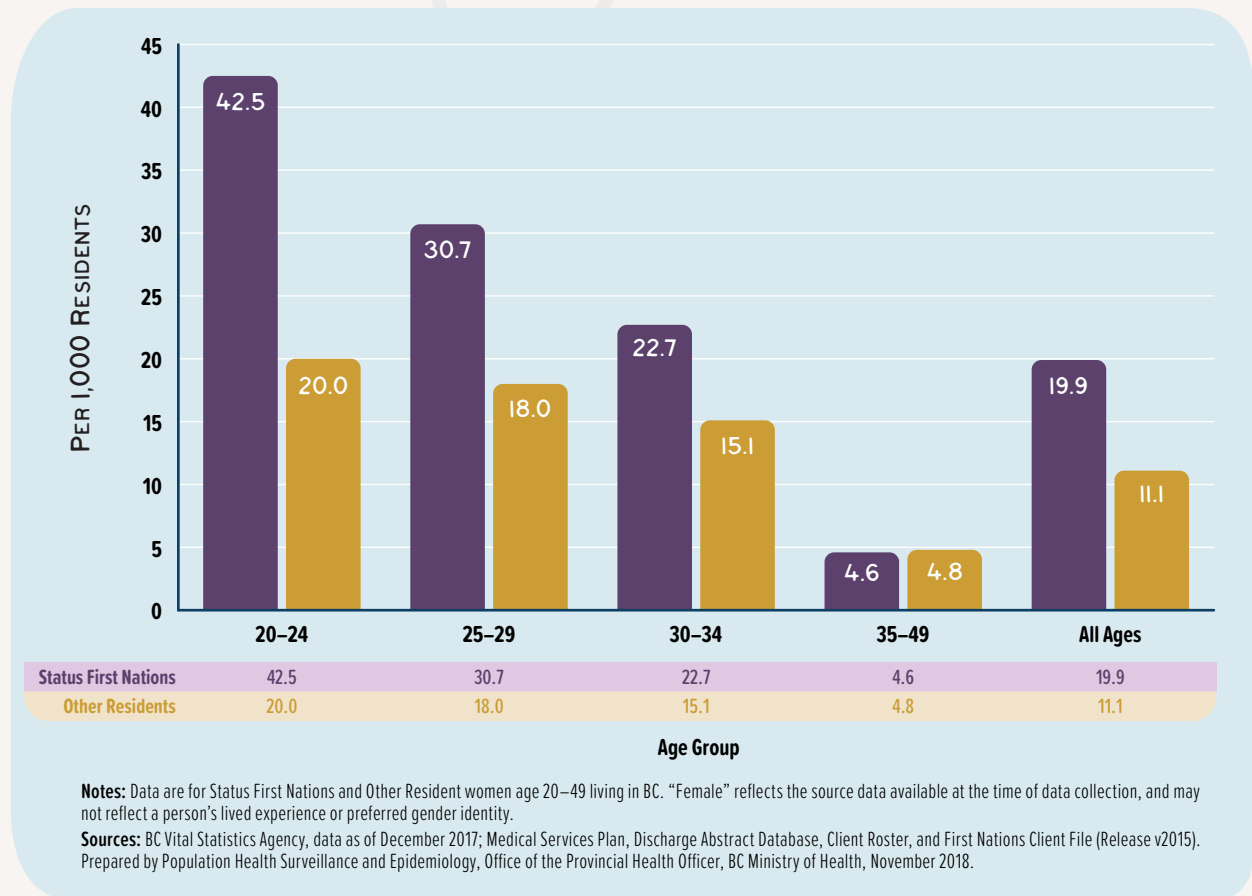


From RHS3 (2015–17), of the sexually active First Nations women age 18–54 who used some form of contraception when they had sex in the past year, 39.1% used condoms “always” or “most of the time.”

ABORTIONS

p.89

FIG 4.46 AGE-SPECIFIC ABORTION RATES AMONG STATUS FIRST NATIONS WOMEN AND OTHER RESIDENT WOMEN, AGE 20–49, BC, 2015

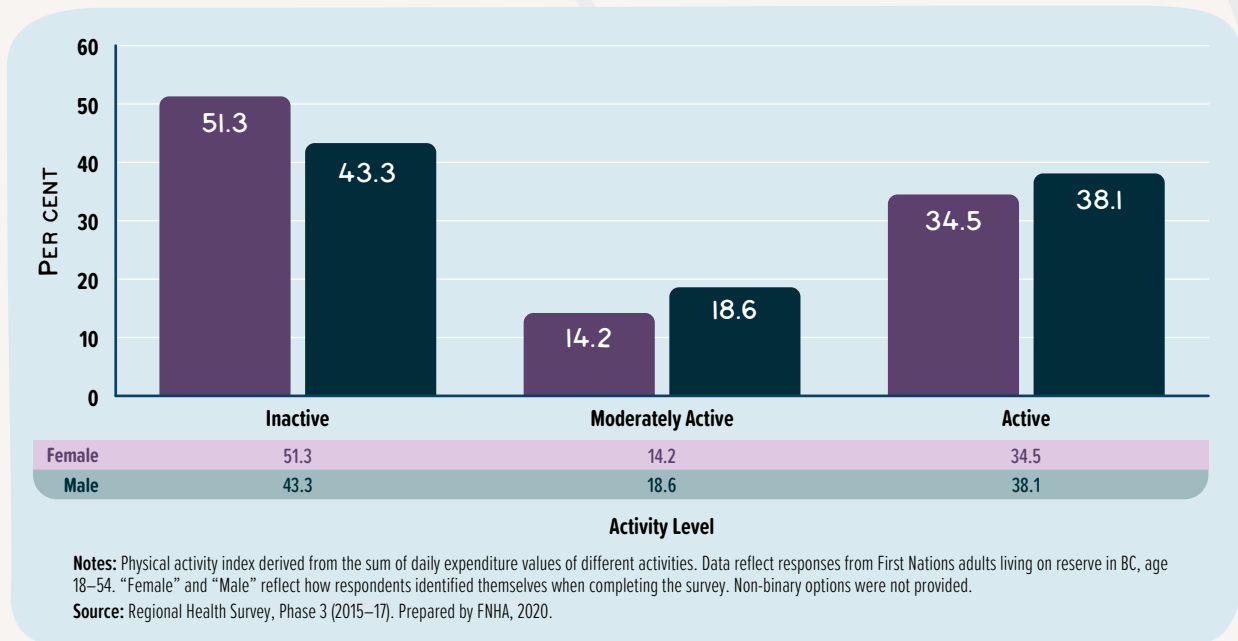


In 2015, the age-specific abortion rates among Status First Nations women age 20–49, 25–29, and 30–34 were higher than the rates among Other Resident women in the same age groups. First Nations women have the inherent right to make decisions about whether to have children, when to have children, and how many children to have. They have the right to learn about their options in a safe, non-judgemental, and trauma-informed environment that does not influence their decisions.⁴²

PHYSICAL ACTIVITY

p.90

FIG 4.47 PERCENTAGE SELF-REPORTED PHYSICAL ACTIVITY LEVEL AMONG FIRST NATIONS ADULTS, AGE 18–54, BY SEX, BC, 2015–17



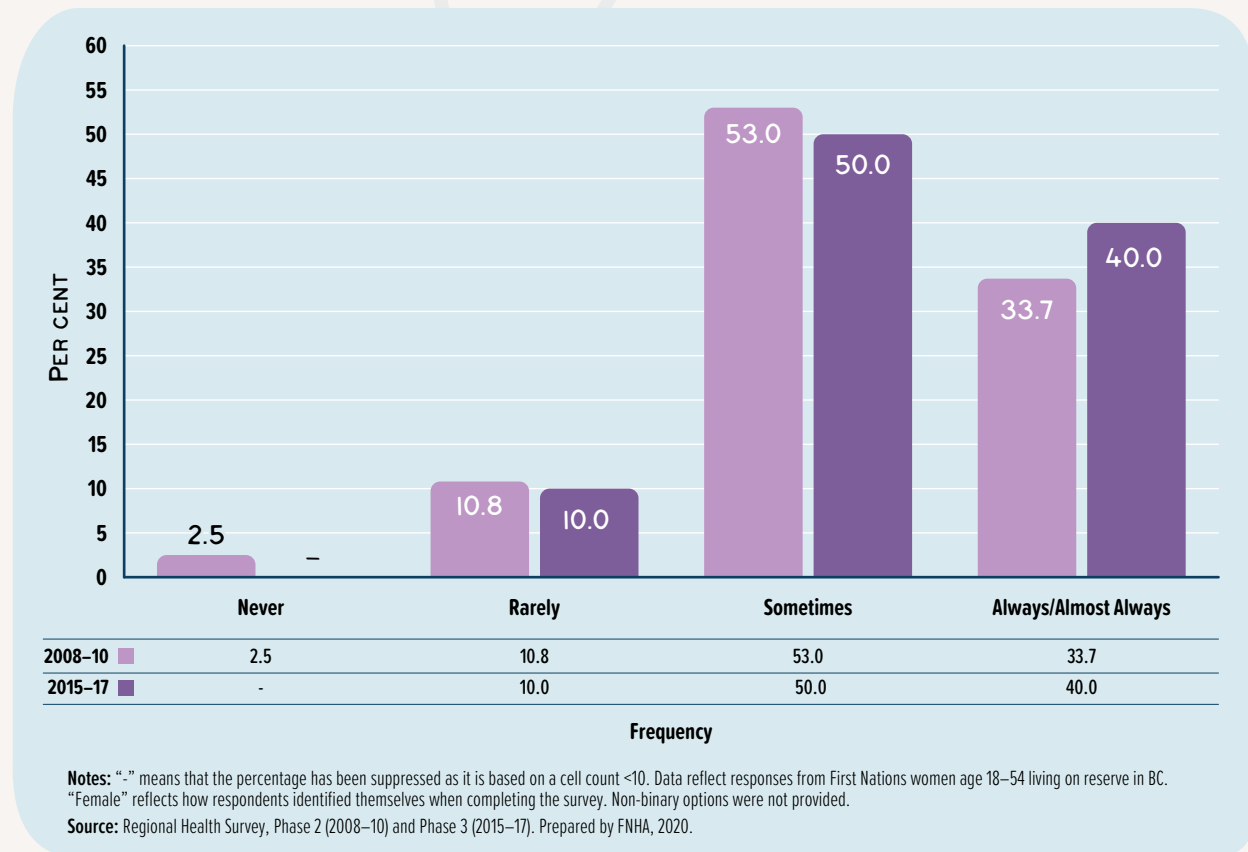
From RHS3 (2015–17), 34.5% of First Nations women age 18–54 rated their level of physical activity as “active” over the past three months, while 14.2% rated their level as “moderately active.” Many First Nations people participate in land-based activities—such as gardening, gathering medicines, fishing, hunting, or canoeing—that help them stay physically active and connected to the land.¹⁰



EATING NUTRITIOUS MEALS

p.90

FIG 4.48 PERCENTAGE REPORTED FREQUENCY OF EATING NUTRITIOUS, BALANCED MEALS IN THE PAST YEAR AMONG FIRST NATIONS WOMEN, AGE 18–54, BC, 2008–10 AND 2015–17



From RHS2 (2008–10) and RHS3 (2015–17), there was an increase of 6.3 percentage points in First Nations women age 18–54 who ate nutritious, balanced meals in the past year “always/ almost always,” from 33.7% to 40.0%. Approximately half of First Nations women ate nutritious, balanced meals “sometimes” across RHS2 and RHS3. First Nations women are re-integrating traditional foods into their diet; however, occupied and stolen lands, contamination, and environmental degradation have affected their ability to be nourished solely by the land.⁴³

“It is our connection to the earth and all of creation, which was given to all of us by the Creator to share. It is not just for our physical body, but for our mind and spirit. Through harvesting, social gatherings, and ceremony, food brings family and community/social cohesion and facilitates the passing down of cultural traditions.”

- Elder Syexwáliya Ann Whonnock, Skwxwú7mesh Úxwumixw (Squamish Nation)
 - Sacred and Strong: Upholding our Matriarchal Roles (p.79)





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ELDERHOOD



This chapter on Elderhood provides detailed charts to illustrate the findings presented in the corresponding chapter of the report, *Sacred and Strong: Upholding our Matriarchal Roles*.¹ The chapter focuses on the health and wellness of older First Nations women and Elders. It considers how older First Nations women and Elders live in wellness, connected to culture and community, and the various systems that support women into Elderhood and through the sacred end-of-life passage. Please refer to the main report—[*Sacred and Strong: Upholding our Matriarchal Roles*](#)—for further interpretation of the data presented here.

Elders are the keepers of First Nations wisdom, history, and knowledge.² As grandmothers, mothers, and aunties, older First Nations women and Elders are the trusted supports for younger generations of First Nations women, and are essential sources of wisdom and advice about healthy ways of living.³ Achieving the vision of healthy and thriving, self-determining Nations and communities supports older First Nations women and Elders in their journeys to live long, happy, and healthy lives as outlined in the teachings.⁴ It also involves honouring the final years and days of their journeys as they prepare to cross over to the Spirit World.

- Adapted from *Sacred and Strong: Upholding our Matriarchal Roles* (p.92)

“Elder” is a sacred title that one earns from their community for their depth of knowledge and understanding of First Nations teachings, practices and ceremonies and through the harmony and balance of their actions. Elders possess wisdom gained through time and life experience, but the honour is not defined by age. All older adults have important roles within First Nations communities and hold vital knowledge and experiences of resilience. However, not all older adults are Elders.

- *Sacred and Strong: Upholding our Matriarchal Roles* (p.92)



HEALTHY, SELF-DETERMINING ELDER & COMMUNITIES – ROOTS OF WELLNESS

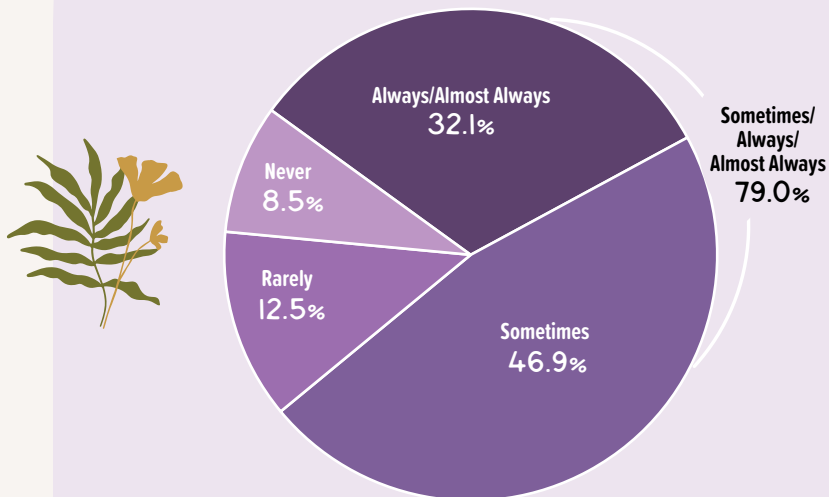


The foundational roots of health and wellness for older First Nations women and Elders are the connections and relationships they forge with land, culture, ceremony, and ancestors. These roots help them to transition into their final stage of life while continuing to thrive as vibrant, self-determining individuals and role models for their community.

p.93

PARTICIPATION IN CULTURAL EVENTS

FIG 5.1 REPORTED PARTICIPATION IN CULTURAL EVENTS IN THEIR LOCAL COMMUNITY, FIRST NATIONS WOMEN, AGE 55 AND OLDER, BY DEGREE OF PARTICIPATION, BC, 2015–17



Cultural events are a way for older First Nations women to rekindle their connection with the community, pass on knowledge and traditions, and heal from past traumas.⁵ From Regional Health Survey Phase 3 (RHS3; 2015–17), 79.0% of First Nations women age 55 and older sometimes, always, or almost always took part in the cultural events happening in their community, as compared to 12.5% who rarely took part, and 8.5% who never took part in cultural events.

Notes: Data reflect responses from First Nations women living on reserve in BC, age 55 and older. “Female” reflects how respondents identified themselves when completing the survey. Non-binary options were not provided.
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

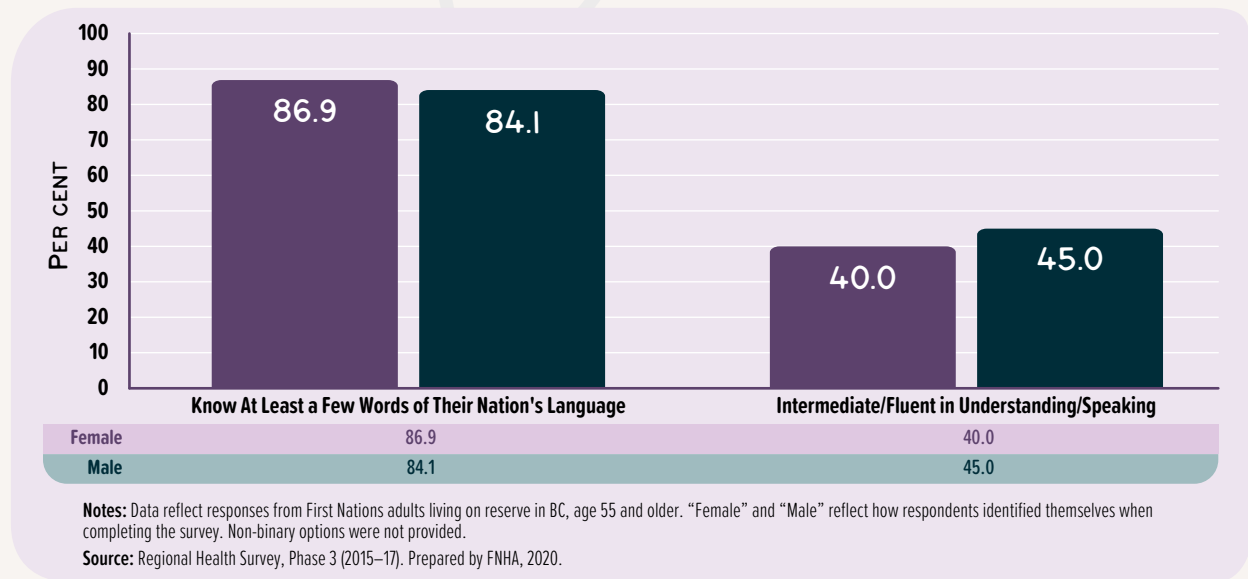




FIRST NATIONS LANGUAGE FLUENCY

p.93

FIG 5.2 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED KNOWING AT LEAST A FEW WORDS OF THEIR NATION'S LANGUAGE, AND PERCENTAGE AMONG THEM WHO WERE FLUENT IN SPEAKING AND UNDERSTANDING, AGE 55 AND OLDER, BY SEX, BC, 2015–17

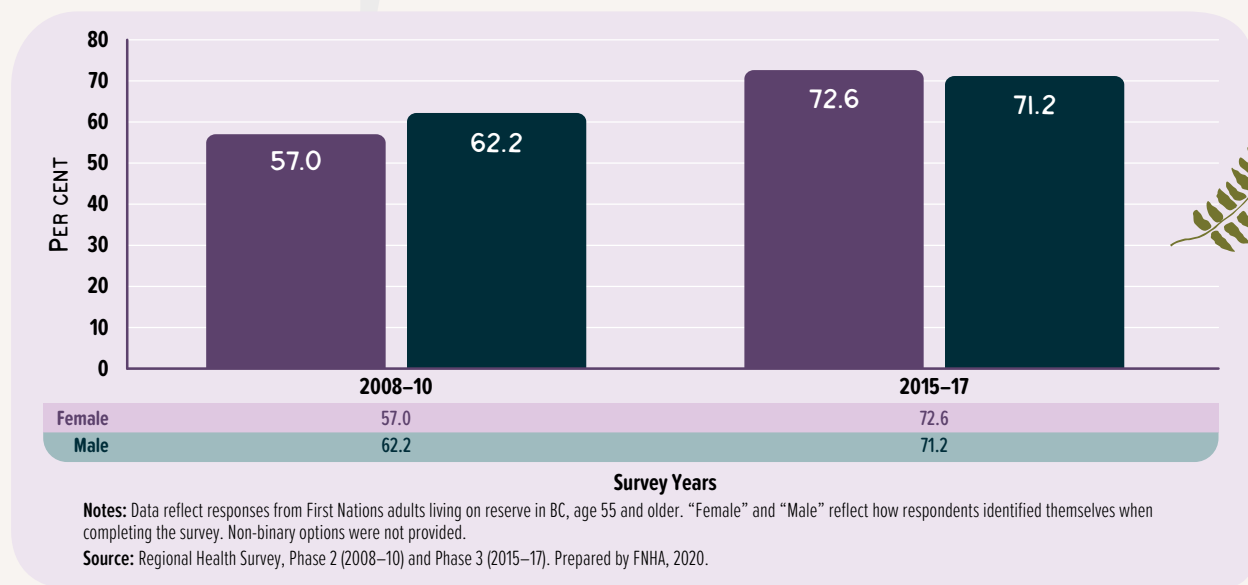


Older First Nations women are the primary speakers of First Nations languages. As holders of this knowledge, older First Nations women are pivotal in preserving and passing on traditional languages to their communities.⁶ Results from RHS3 (2015–17) showed that 86.9% of First Nations women age 55 and older knew at least a few words of their Nation’s language, and 40.0% of those women were intermediate or fluent in speaking *and* understanding their Nation’s language.

FIRST NATIONS FOODS

p.95

FIG 5.3 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED EATING TRADITIONAL FOODS (NOT INCLUDING BANNOCK) “OFTEN” IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17



Older First Nations women often teach younger generations the cultural significance of food as a medicine, teacher, and relative. They also advocate for healthy Indigenous food for younger generations.⁷ From RHS2 (2008–10) to RHS3 (2015–17), the proportion of First Nations women age 55 and older who reported eating traditional foods often in the past year increased from 57.0% to 72.6%, showing an overall increase of 15.6 percentage points.



USE OF TRADITIONAL MEDICINE

p-95

FIG 5.4 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING USED TRADITIONAL MEDICINE IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17



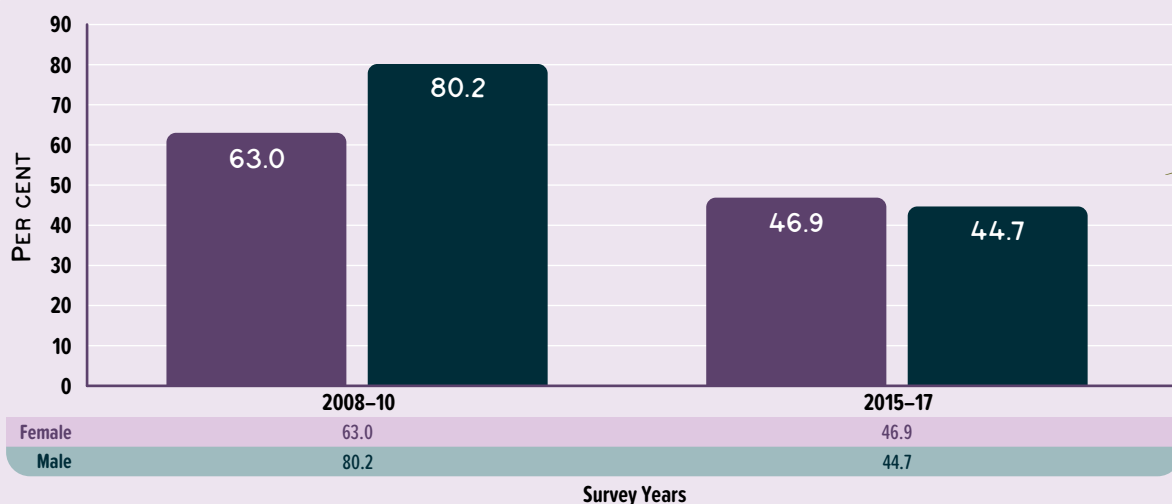
Notes: Data reflect responses from First Nations adults living on reserve in BC, age 55 and older. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 2 (2008–10) and Phase 3 (2015–17). Prepared by FNHA, 2020.

Traditional medicine is used by older First Nations women to maintain wellness, promote healing, and feel connected to the land, culture, and ancestors. From RHS2 (2008–10) to RHS3 (2015–17), the proportion of First Nations women age 55 and older reporting having used traditional medicines in the past year remained the same (47.7% in 2008–10 and 48.1% in 2015–17).

p-95

FIG 5.5 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING NO DIFFICULTIES ACCESSING TRADITIONAL MEDICINE IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17



Notes: Data reflect responses from First Nations adults living on reserve in BC, age 55 and older. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 2 (2008–10) and Phase 3 (2015–17). Prepared by FNHA, 2020.

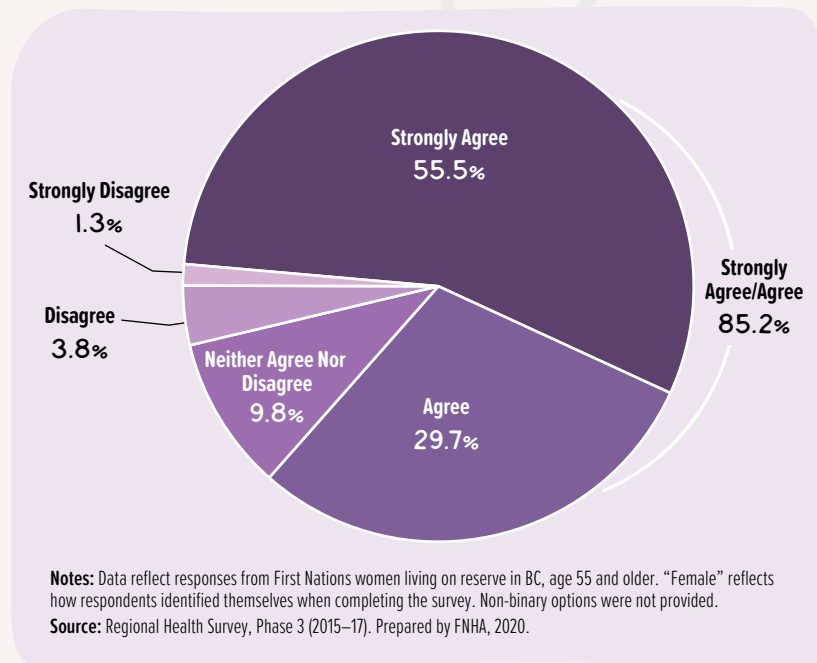
From RHS3 (2015–17), 46.9% of First Nations women age 55 and older reported having no difficulties accessing traditional medicine in the past year. This value had decreased from 63.0% as reported in RHS2 (2008–10).



IMPORTANCE OF SPIRITUALITY

p.95

FIG 5.6 REPORTED IMPORTANCE OF TRADITIONAL SPIRITUALITY AMONG FIRST NATIONS WOMEN, AGE 55 AND OLDER, BY LEVEL OF AGREEMENT, BC, 2015–17



Traditional spiritual practices provide older First Nations women with the strength and foundation to deal with past traumas as well as the ongoing intergenerational legacy of colonialism.⁸ The majority (85.2%) of First Nations women age 55 and older reported “agreeing” or “strongly agreeing” with the statement “traditional spirituality is important to me.” Only 5.1% “disagreed” or “strongly disagreed” with the statement.



SENSE OF BELONGING

p.96

FIG 5.7 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING A STRONG SENSE OF BELONGING TO THEIR LOCAL COMMUNITY, AGE 55 AND OLDER, BY SEX, BC, 2015–17



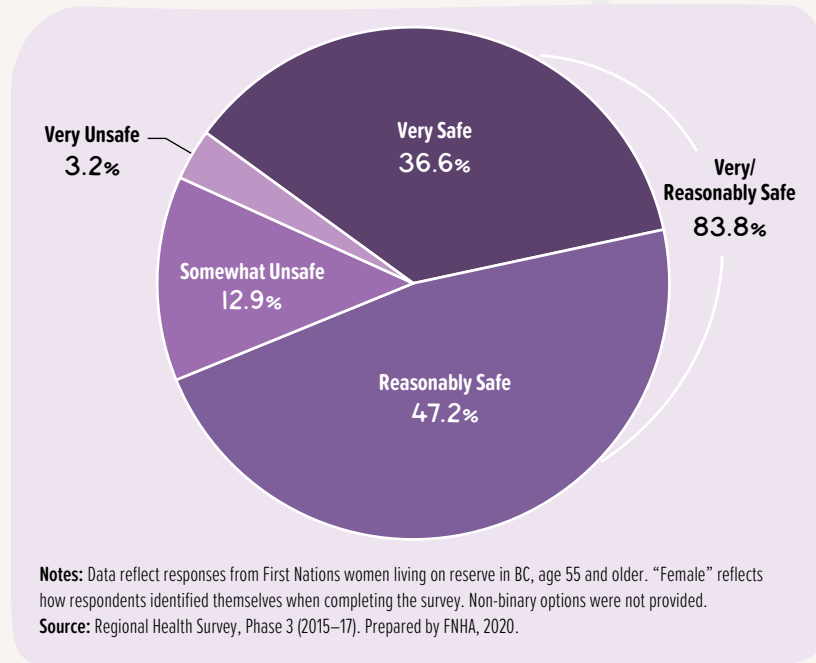
Community support and connections provide older First Nations women with the strength and resilience to deal with the unknown during their next stage of life.⁹ From RHS3 (2015–17), 86.4% of First Nations women age 55 and older reported having a strong sense of belonging to their local community.



FEELING SAFE

p.96

FIG 5.8 REPORTED FEELINGS OF SAFETY IN THEIR COMMUNITY AMONG FIRST NATIONS WOMEN, AGE 55 AND OLDER, BY DEGREE, BC, 2015–17



Older First Nations women’s perceptions of personal safety are closely tied to their connections with community. Historical traumas may still have an impact on the ways in which older First Nations women feel connected to their community.¹⁰ However, RHS3 (2015–17) results showed that 83.8% of First Nations women age 55 and older reported feeling either “very safe” or “reasonably safe” in their communities. Only 3.2% reported feeling “very unsafe.”



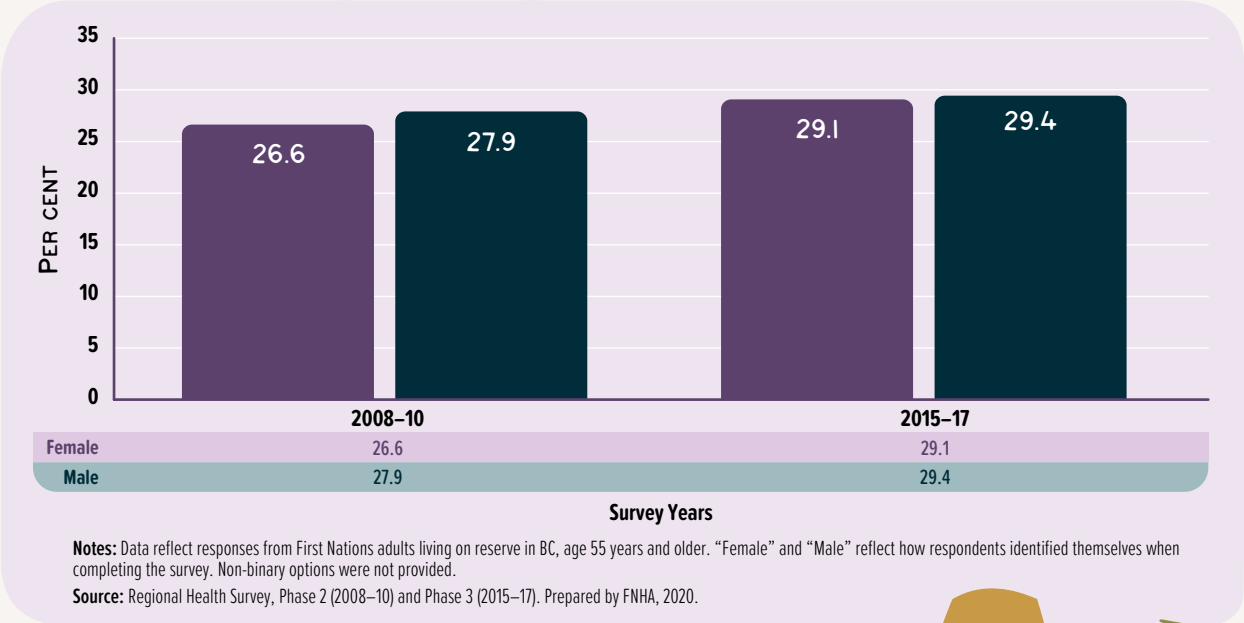
SUPPORTIVE SYSTEMS

The systems and protocols that BC First Nations have developed over generations to support their communities were negatively impacted by colonialism and continue to be undermined by structural racism. Manifesting in multiple ways—as land appropriation, cultural genocide, marginalization, violence and oppression—racism and discrimination have negatively impacted, and continue to negatively impact, the health and wellness of older First Nations women and Elders.¹¹ Yet, older First Nations women and Elders are strong and resilient pillars in the community and remain steadfast in pushing past these barriers to spend their final phases of life focusing on their wellness and celebrating their culture and traditions.

RACISM

p.98

FIG 5.9 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING PERSONALLY EXPERIENCED INSTANCES OF RACISM IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17



From RHS3 (2015–17), 29.1% of First Nations women age 55 and older reported personally experiencing instances of racism in the past year. This is an increase from 26.6% in RHS2 (2008–10). Since contact, older First Nations women have shown resilience in living with and resisting racial discrimination by relying on their culture, land, and community.

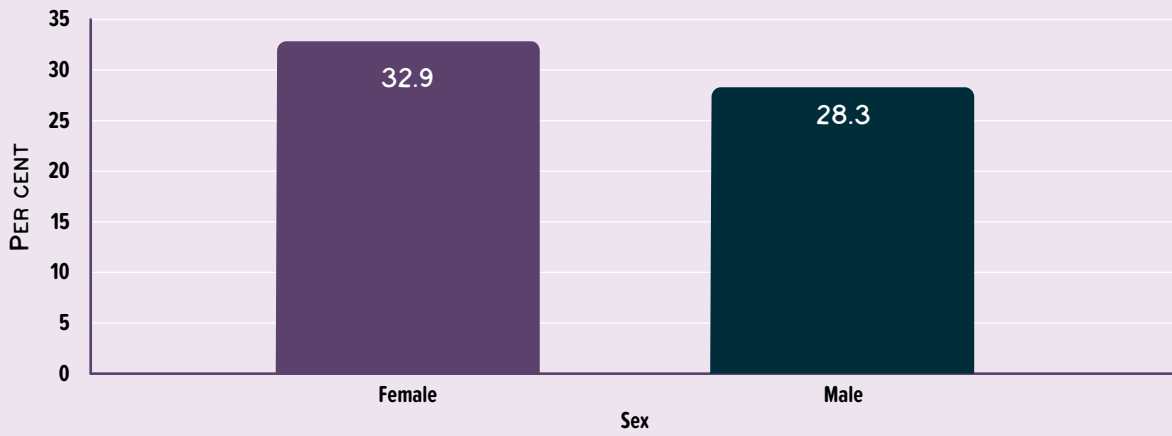




EXPERIENCES OF VERBAL OR PHYSICAL AGGRESSION

p.98

FIG 5.10 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING EXPERIENCED PHYSICAL OR VERBAL AGGRESSION TOWARDS THEM IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2015–17



Notes: Data reflect responses from First Nations adults living on reserve in BC, age 55 and older. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.



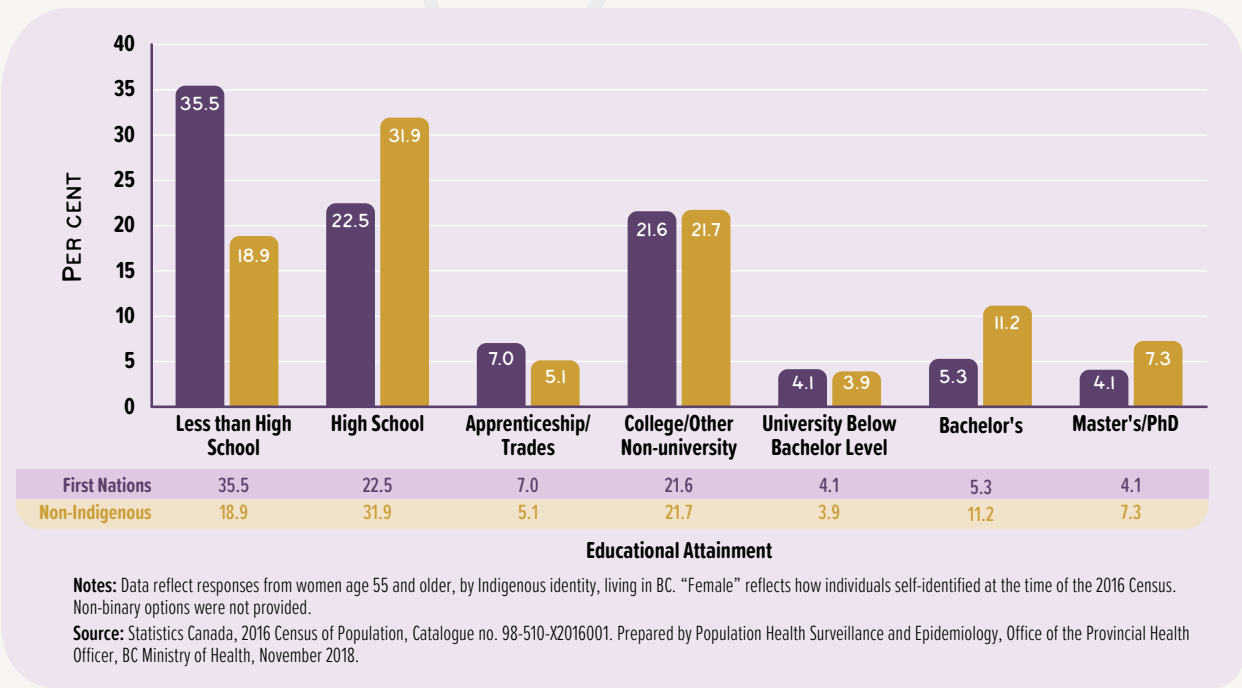
RHS3 (2015–17) data indicated that 32.9% of First Nations women age 55 and older reported some form of physical or verbal aggression towards them in the past year.



EDUCATIONAL ATTAINMENT – STUDENT OUTCOMES

p.99

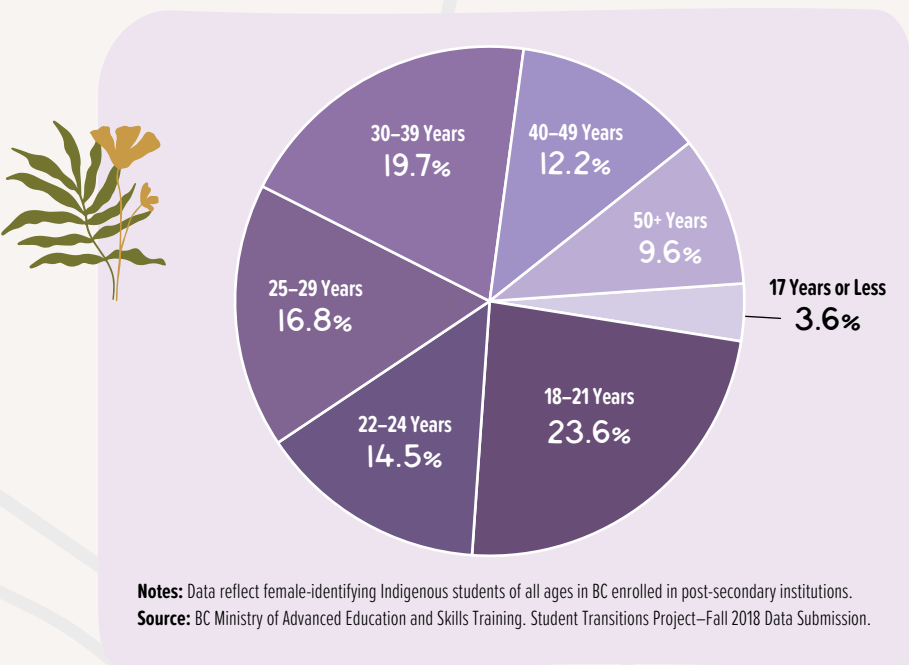
FIG 5.11 PERCENTAGE EDUCATIONAL ATTAINMENT AMONG FIRST NATIONS AND NON-INDIGENOUS WOMEN, AGE 55 AND OLDER, BC, 2016



In 2016, Statistics Canada reported that First Nations women age 55 and older were as likely or more likely than non-Indigenous respondents to have completed education in trades and apprenticeships, college and other non-university courses, and some university below the bachelor level. Non-Indigenous respondents reported higher attainment in high school diplomas, undergraduate, and graduate degrees.

p.99

FIG 5.12 FEMALE INDIGENOUS STUDENTS ENROLLED IN POST-SECONDARY INSTITUTIONS, BY AGE GROUP, BC, 2017/18



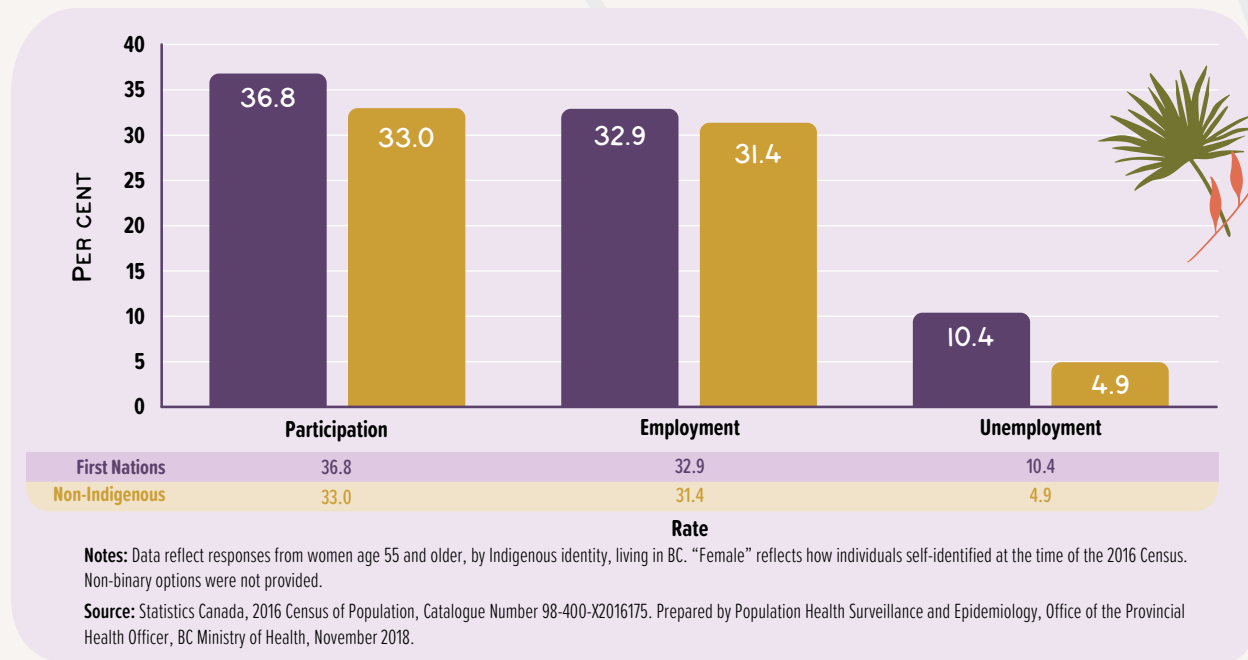
Older First Nations women value learning both Western and traditional ways of knowing. Lifelong learning among First Nations women contributes to their mental, emotional, and physical wellness; similarly, education and the ability to participate in learning are strongly associated with First Nations health and wellness.^{12,13,14} From 2017/18, the BC Ministry of Advanced Education and Skills Training reported that 9.6% of female Indigenous students enrolled in post-secondary institutions in BC were age 50 and older.



EMPLOYMENT

p.100

FIG 5.13 PERCENTAGE OF LABOUR FORCE PARTICIPATION, EMPLOYMENT, AND UNEMPLOYMENT AMONG FIRST NATIONS AND NON-INDIGENOUS WOMEN, AGE 55 AND OLDER, BC, 2016

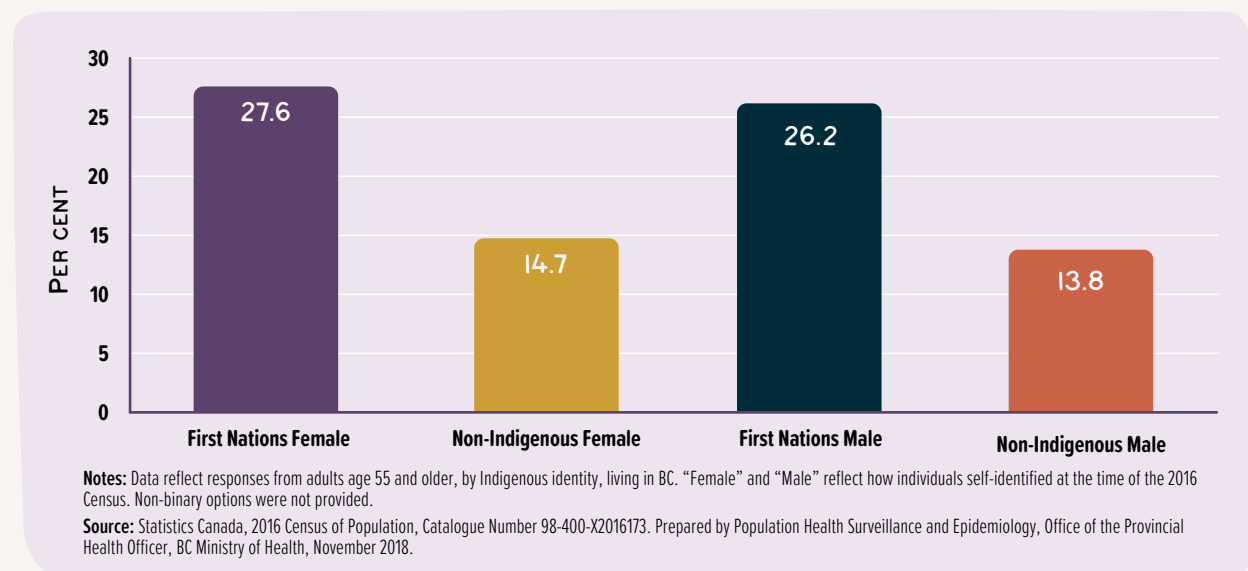


In 2016, Statistics Canada reported that among Indigenous women age 55 and older, 36.8% were participating in the labour force, 32.9% were employed, and 10.4% were unemployed. Individuals are considered to be participating in the labour force if they are employed or unemployed and looking for work.¹⁵ In each employment category, the proportion of Indigenous women age 55 and older was higher than non-Indigenous women of the same age.

INCOME

p.100

FIG 5.14 PERCENTAGE OF FIRST NATIONS AND NON-INDIGENOUS ADULTS LIVING ON INCOMES THAT FELL BELOW THE SPECIFIED LOW-INCOME LINE, AGE 55 AND OLDER, BY SEX, BC, 2016



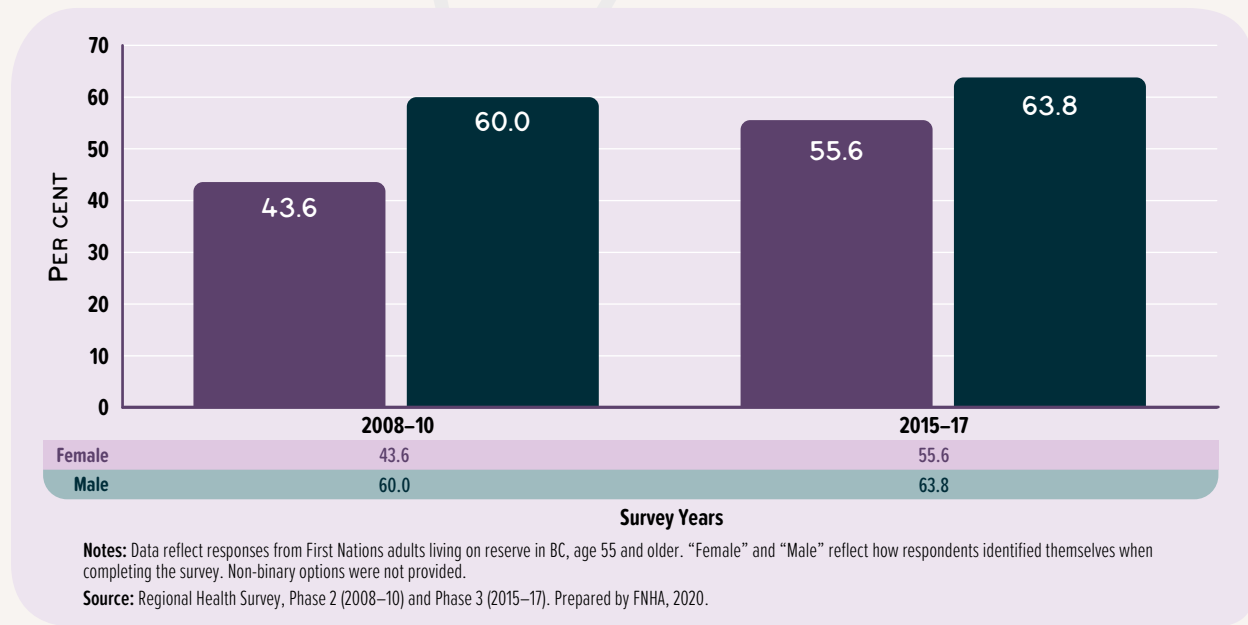
In their 2016 Census responses, 27.6% of First Nations women age 55 and older reported living on incomes below the specified low-income line, a higher percentage than First Nations men, non-Indigenous men, and non-Indigenous women of the same age.



MEETING BASIC NEEDS

p.100

FIG 5.15 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED THAT THEY NEVER HAD DIFFICULTY MEETING THEIR BASIC NEEDS IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008-10 AND 2015-17



The percentage of First Nations women age 55 and older who reported never having difficulty meeting their basic needs in the past year increased from 43.6% to 55.6% between RHS2 (2008-10) and RHS3 (2015-17). Older First Nations women face disproportionate barriers to meeting their basic needs as a result of colonialism. However, they remain strong and resilient and continue to find opportunities for employment to support themselves.

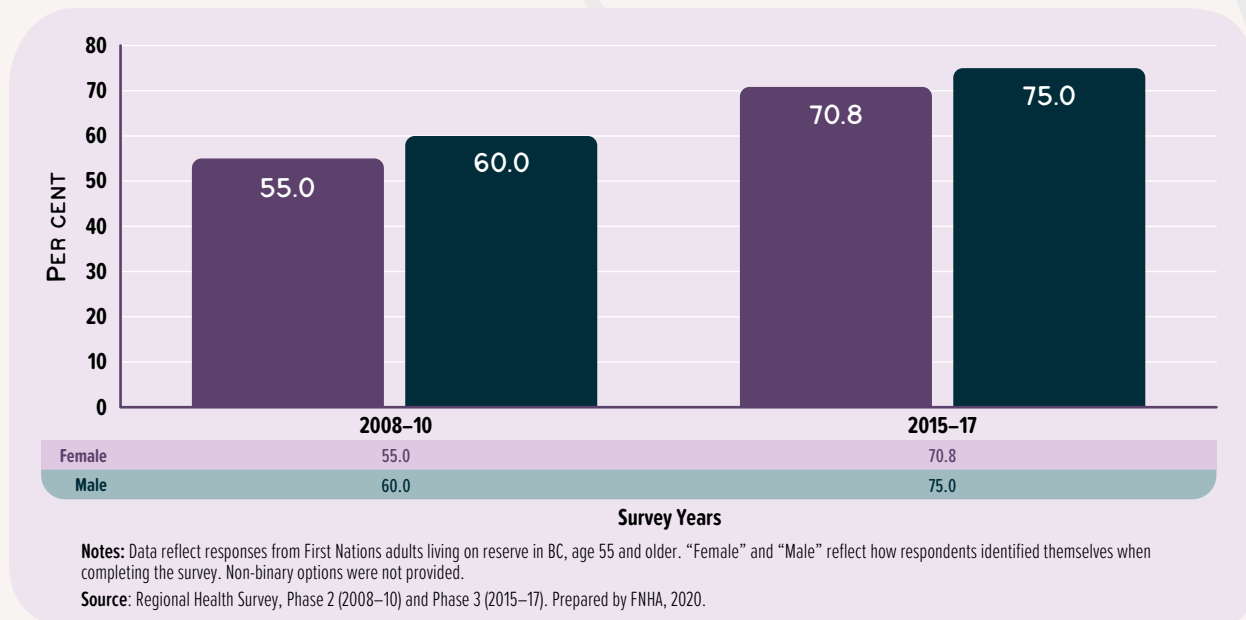




AFFORDING FOOD

p.100

FIG 5.16 PERCENTAGE OF FIRST NATIONS ADULTS WHO NEVER HAD DIFFICULTY COVERING THE COSTS OF FOOD IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17



The percentage of First Nations women age 55 and older who reported never having difficulty covering the costs of food in the past year increased from 55.0% to 70.8% between RHS2 (2008–10) and RHS3 (2015–17). A growing number of BC First Nations are now looking to Elder women for their teachings and knowledge as they work to revive First Nations diets and food practices, revitalize the cultural rituals and perspectives around food, and re-establish control over their food security.¹

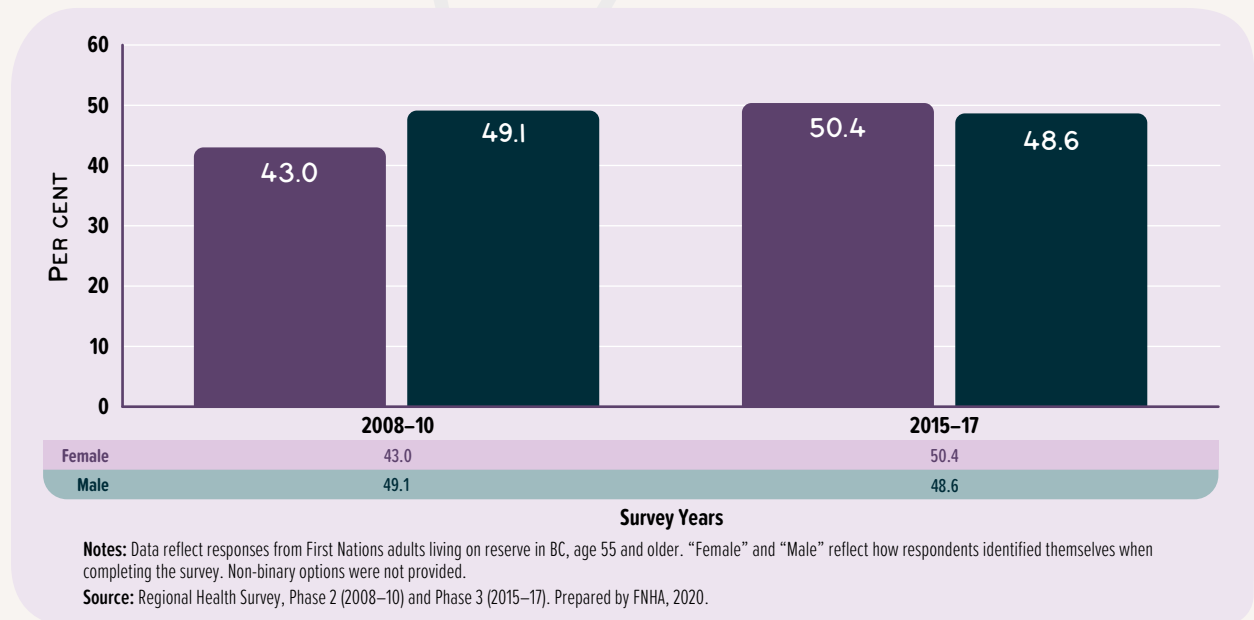




FOOD SECURITY

p.100

FIG 5.17 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED BEING FOOD INSECURE IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17



The percentage of First Nations women age 55 and older who reported being food insecure in the past year increased from 43.0% to 50.4% between RHS2 (2008–10) and RHS3 (2015–17). Older First Nations women are leaders and advocates in the Indigenous food sovereignty movement. They are responsible for passing on the intergenerational knowledge of traditional foods and practices (e.g., harvesting, hunting) to support younger generations in reclaiming and revitalizing these important elements of cultural connectedness and well-being.¹⁶

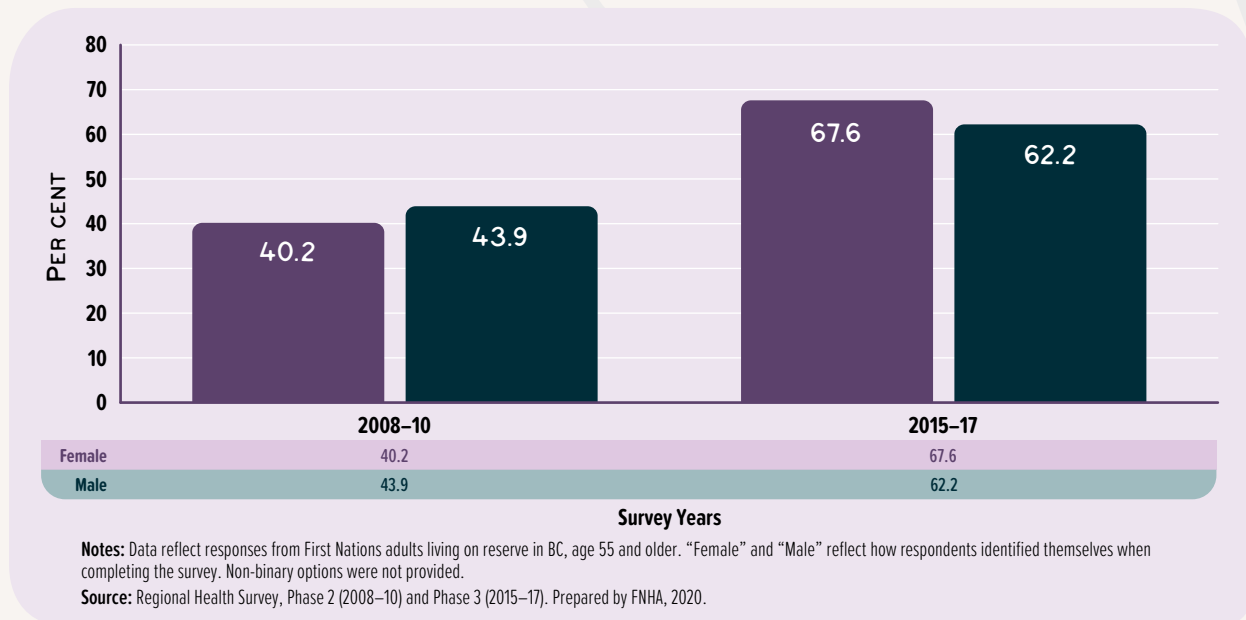




ACCESS TO INTERNET

p.101

FIG 5.18 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED HAVING A CONNECTION TO THE INTERNET IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17



Internet connectivity impacts various determinants of health, including an individual’s access to health care, education, and employment.¹⁷ The percentage of First Nations women age 55 and older who reported having an Internet connection in the past year increased from 40.2% to 67.6% between RHS2 (2008–10) and RHS3 (2015–17). However, affordable, secure access to the Internet has not been made available to all First Nations communities.¹⁸

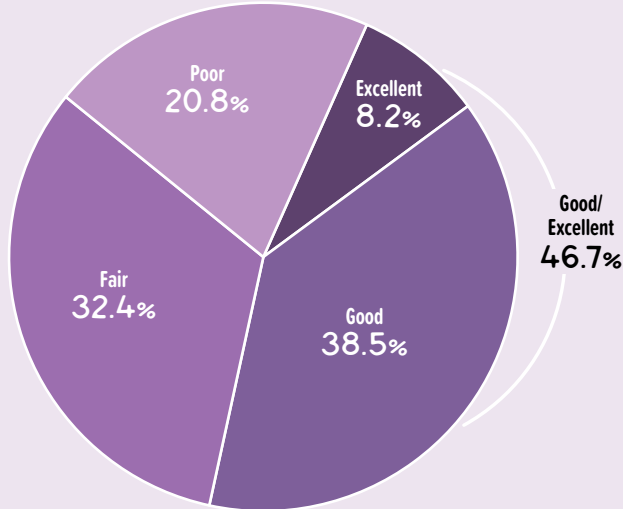




QUALITY OF AVAILABLE HEALTH SERVICES

p.102

FIG 5.19 SELF-REPORTED RATINGS OF THE HEALTH CARE SERVICES IN THEIR COMMUNITY, FIRST NATIONS WOMEN, AGE 55 AND OLDER, BC, 2015-17



Notes: Data reflect responses from First Nations women living on reserve in BC, age 55 and older. “Female” reflects how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015-17). Prepared by FNHA, 2020.

Access to timely and appropriate health services, specifically primary care, is critical for older First Nations women to maintain their health and well-being.¹⁹ RHS3 (2015-17) showed that 46.7% of First Nations women age 55 and older rated the quality of available health care services in their community as “good” or “excellent.”

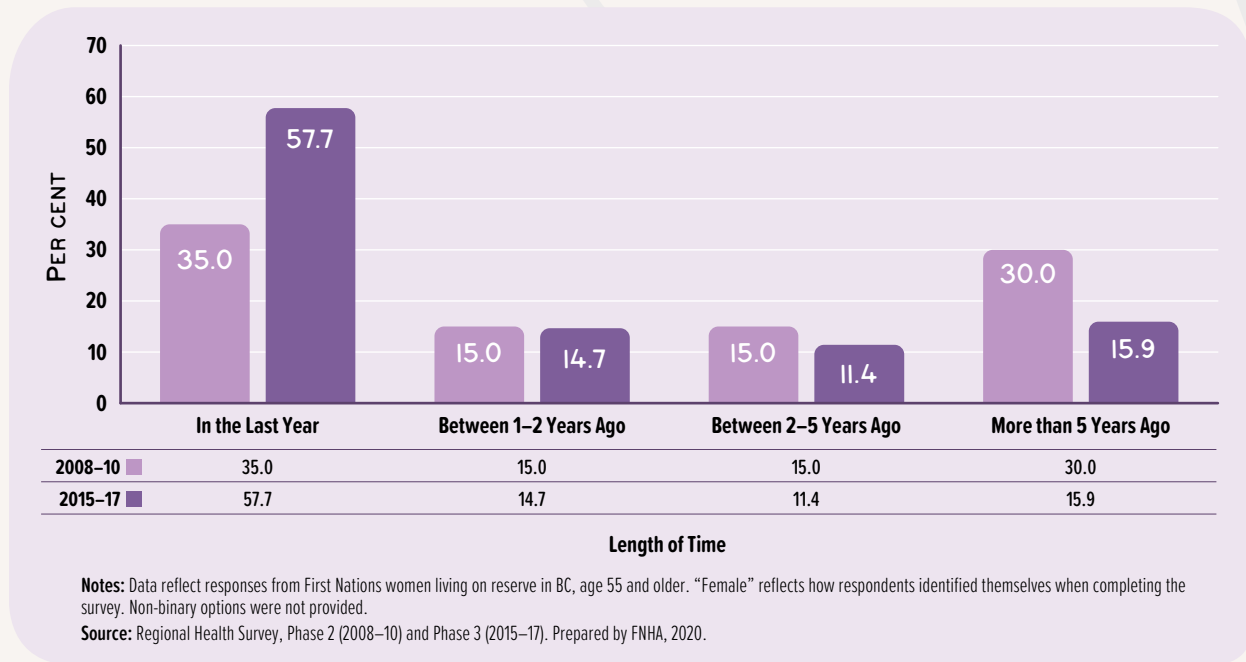




ACCESSING DENTAL CARE

p.102

FIG 5.20 PERCENTAGE OF FIRST NATIONS WOMEN WHO REPORTED HAVING RECEIVED DENTAL CARE, AGE 55 AND OLDER, BY LENGTH OF TIME SINCE CARE RECEIVED, BC, 2008–10 AND 2015–17



Some older First Nations women may face barriers in accessing dental services due to needing to travel to access these services, as well as fears of—or re-traumatization resulting from—negative health care experiences or trauma experienced in residential schools and other colonial systems.²⁰ The proportion of First Nations women age 55 and older who reported receiving dental care in the last year increased from 35.0% to 57.7% between RHS2 (2008–10) and RHS3 (2015–17). In RHS3 (2015–17), 72.4% of First Nations women age 55 and older reported receiving dental care at least once in the last two years (57.7% in the last year and 14.7% between one and two years ago). Passing on positive experiences in accessing dental care builds community resilience, strength, and healing.



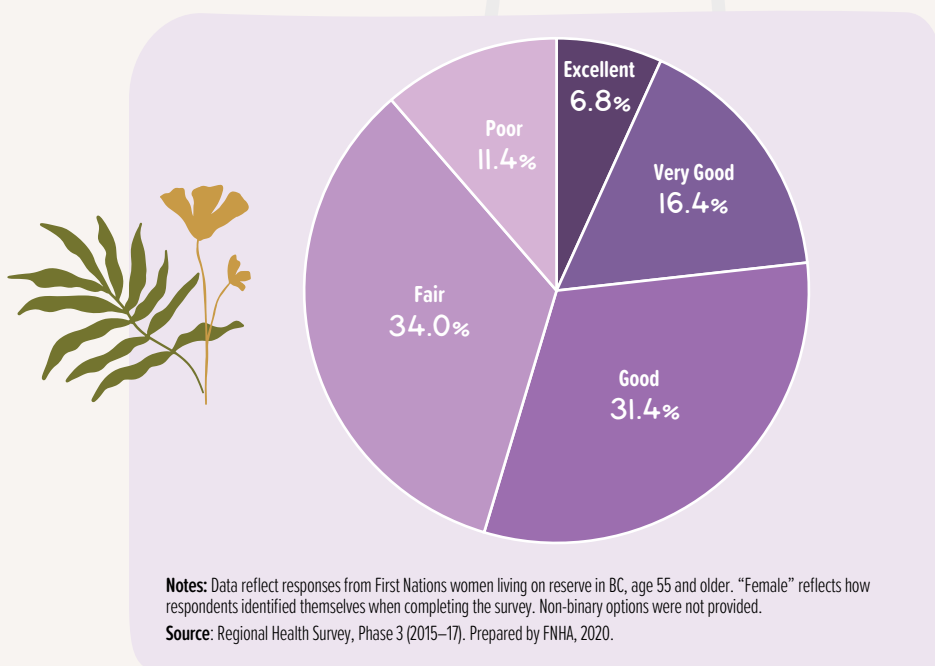
HEALTHY BODIES, MINDS AND SPIRITS

The systemic barriers created by colonialism, in addition to the longstanding impacts of intergenerational trauma, are the root causes of chronic disease and health inequities among older First Nations women and Elders.²¹ Older First Nations women and Elders are on a journey of healing. They lean on their community to help support them in their wellness and re-centre themselves to the land, culture, and their ancestors.^{22,23}

SELF-RATED HEALTH

p.103

FIG 5.21 SELF-RATED GENERAL HEALTH OF FIRST NATIONS WOMEN, AGE 55 AND OLDER, BY QUALITY LEVEL, BC, 2015-17

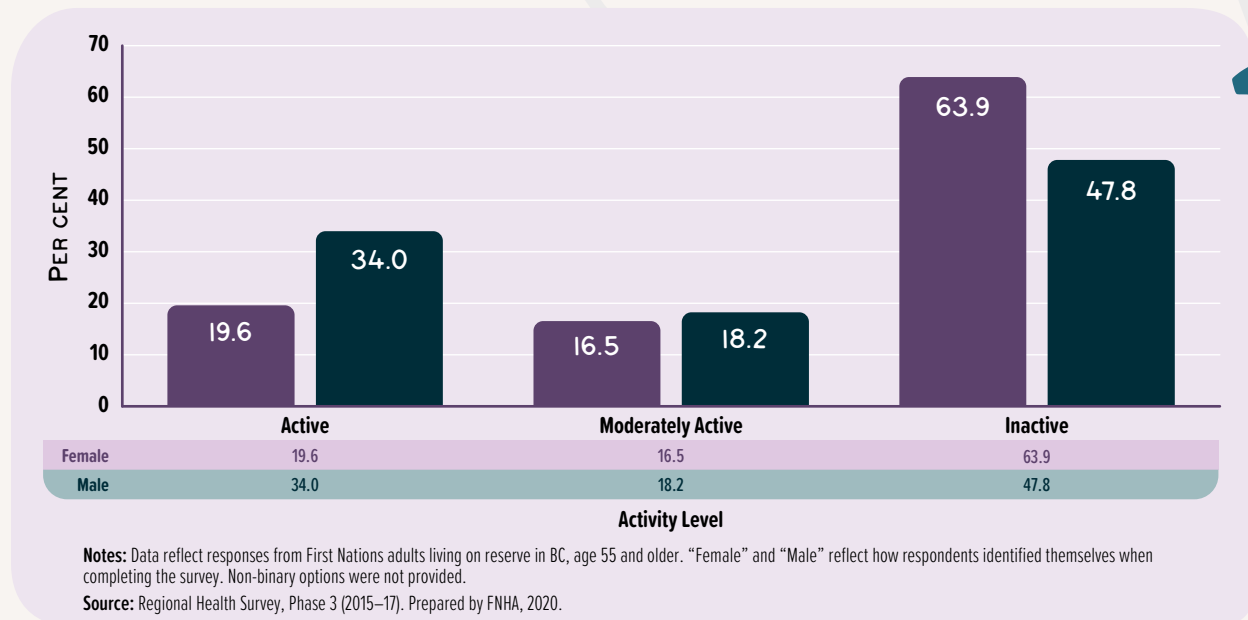


Older First Nations women are on a healing journey to address the trauma and intergenerational trauma that have affected their physical, mental, emotional, and spiritual health and wellness.⁹ From RHS3 (2015–17), 23.2% of First Nations women age 55 and older reported that their general health was either “excellent” or “very good,” and nearly a third reported that their general health was “good” (31.4%).

PHYSICAL ACTIVITY

p.104

FIG 5.22 PERCENTAGE SELF-REPORTED PHYSICAL ACTIVITY OF FIRST NATIONS ADULTS, AGE 55 AND OLDER, BY SEX AND ACTIVITY LEVEL, BC, 2015-17

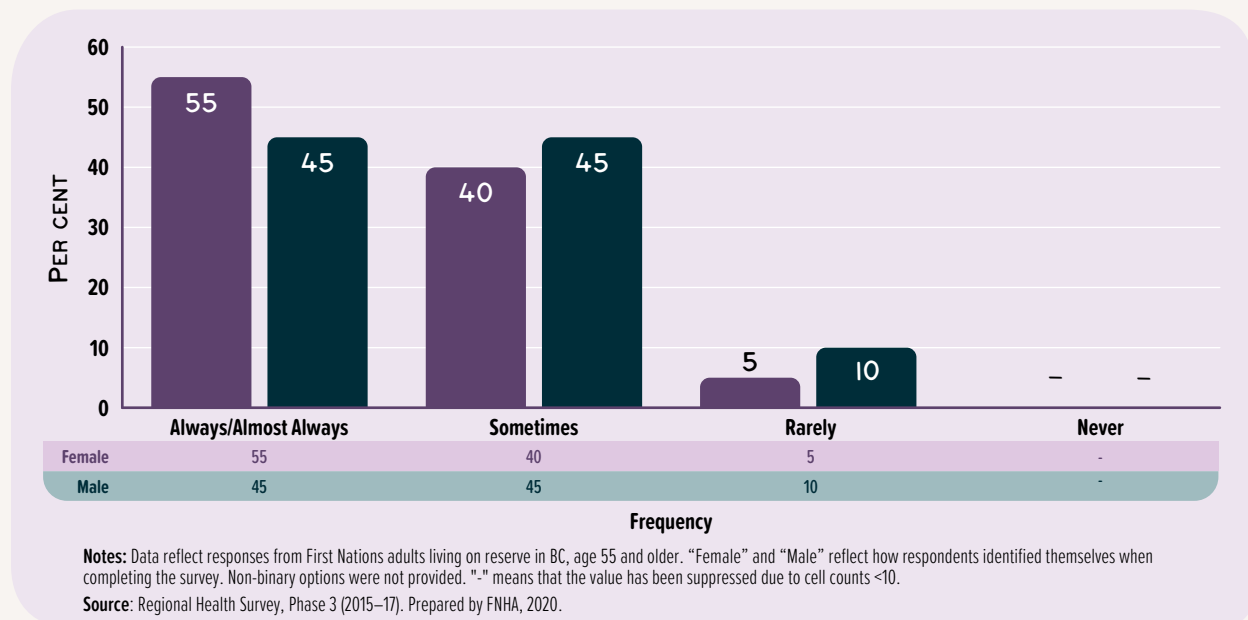


Many older First Nations women continue to stay physically active by participating in cultural activities; however, mobility or physical disabilities may impair their ability to do so.³ RHS3 (2015-17) data showed that 19.6% of First Nations women age 55 and older reported being “active” and 16.5% reported being “moderately active” in the past three months.

EATING NUTRITIOUS MEALS

p.104

FIG 5.23 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED EATING NUTRITIOUS, BALANCED MEALS IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX AND FREQUENCY, BC, 2015-17



Many older First Nations women continue to eat traditional foods, which have provided women with healthy, balanced diets for centuries.³ RHS3 (2015-17) data showed that 55% of First Nations women age 55 and older reported “always or almost always” eating nutritious, balanced meals, while 40% reported eating nutritious, balanced meals “sometimes.”

NON-SMOKING RATES

p.105

FIG 5.24 PERCENTAGE OF FIRST NATIONS ADULTS WHO WERE NON-SMOKERS, AGE 55 AND OLDER, BY SEX, BC, 2008-10 AND 2015-17



Notes: Data reflect responses from First Nations adults living on reserve in BC, aged 55 years and older. "Female" and "Male" reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

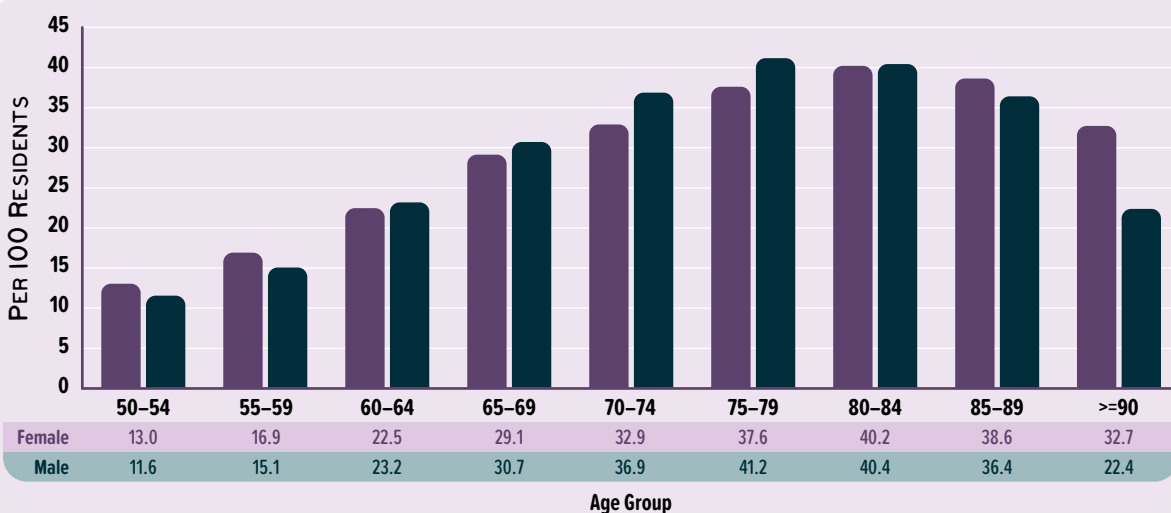
Source: Regional Health Survey, Phase 2 (2008-10) and Phase 3 (2015-17). Prepared by FNHA, 2020.

The proportion of First Nations women age 55 and older who reported being non-smokers decreased 7.4 percentage points, from 76.2% to 68.8%, between RHS2 (2008-10) and RHS3 (2015-17).

DIABETES

p.106

FIG 5.25 AGE-SPECIFIC PREVALENCE OF DIABETES, STATUS FIRST NATIONS, AGE 50 AND OLDER, BY SEX AND AGE GROUP, BC, 2004/05 TO 2015/16



Notes: Data are for Status First Nations age 50 and older. "Female" and "Male" reflect the source data available at the time of data collection, and may not reflect a person's lived experience or preferred gender identity.

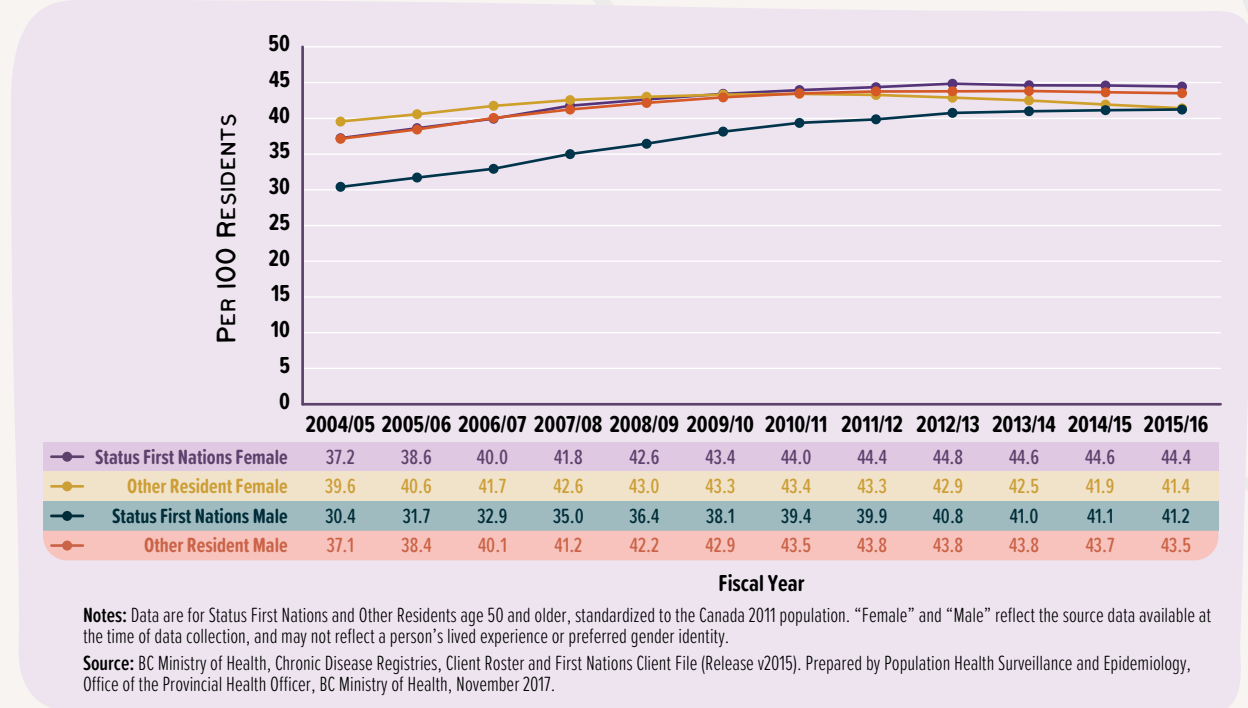
Source: BC Ministry of Health, Chronic Disease Registries, Client Roster and First Nations Client File (Release v2015). Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2018.

The age-specific prevalence of diabetes among Status First Nations women over the age of 50 is highest among women age 80-84 (40.2%), followed by 85-89 (38.6%), and 75-79 (37.6%). It is lowest among the younger age groups. A similar trend is seen among older Status First Nations men.

HYPERTENSION

p.106

FIG 5.26 AGE-STANDARDIZED PREVALENCE OF HYPERTENSION, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 50 AND OLDER, BY SEX, BC, 2004/05 TO 2015/16



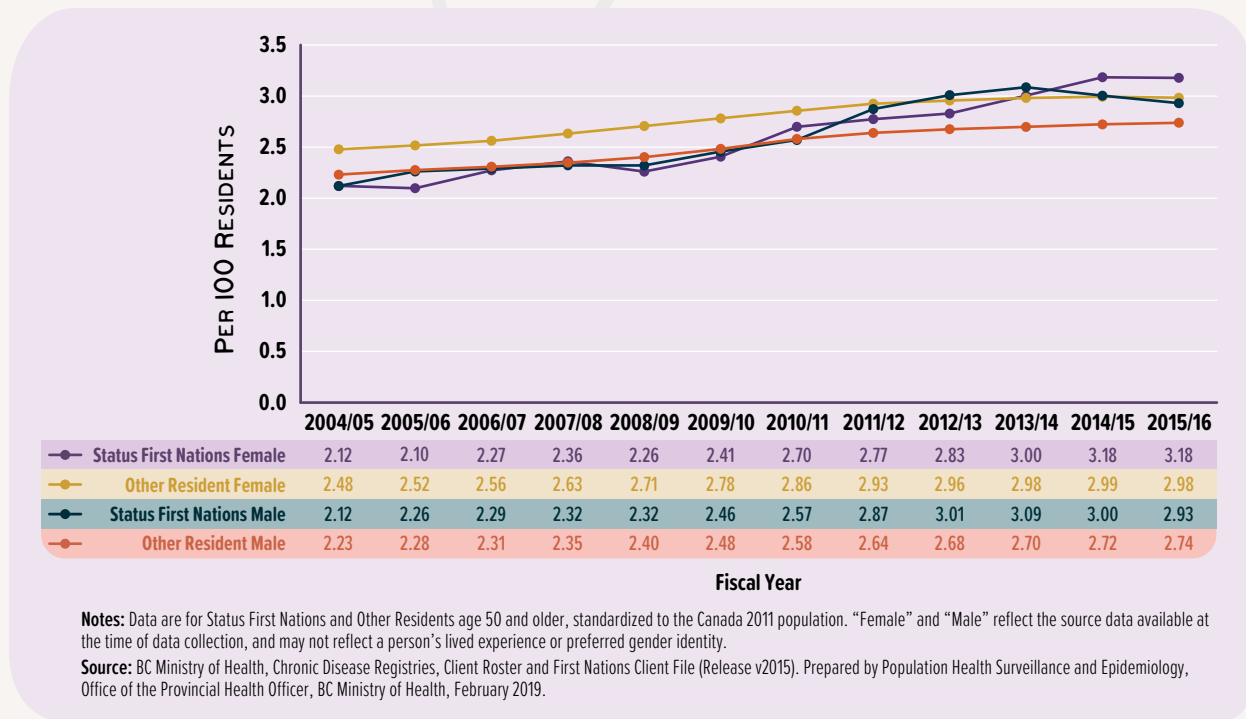
The age-standardized prevalence of hypertension was highest among Other Resident women age 50 and older from 2004/05–2008/09. Subsequent years show prevalence of hypertension was consistently higher among Status First Nations women age 50 and older.



ALZHEIMER'S DISEASE

p.108

FIG 5.27 AGE-STANDARDIZED PREVALENCE OF ALZHEIMER'S DISEASE AND OTHER DEMENTIA, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 50 AND OLDER, BY SEX, BC, 2004/05 TO 2015/16



Older First Nations women are more likely to have risk factors for Alzheimer's disease (e.g., diabetes, low socioeconomic status, poverty, obesity, cardiovascular disease) due to the impacts of colonialism.²⁴ From 2004/05 to 2015/16, the age-standardized prevalence of Alzheimer's disease and other forms of dementia steadily increased for all groups. Among Status First Nations women age 50 and older, the prevalence increased from 2.12% (2004/05) to 3.18% (2015/16).



OSTEOARTHRITIS

p.108

FIG 5.28 AGE-STANDARDIZED PREVALENCE OF OSTEOARTHRITIS, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 50 AND OLDER, BY SEX, BC, 2004/05 TO 2015/16



Notes: Data are for Status First Nations and Other Residents age 50 and older, standardized to the Canada 2011 population. “Female” and “Male” reflect the source data available at the time of data collection, and may not reflect a person’s lived experience or preferred gender identity.

Source: BC Ministry of Health, Chronic Disease Registries, Client Roster and First Nations Client File (Release v2015). Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2019.

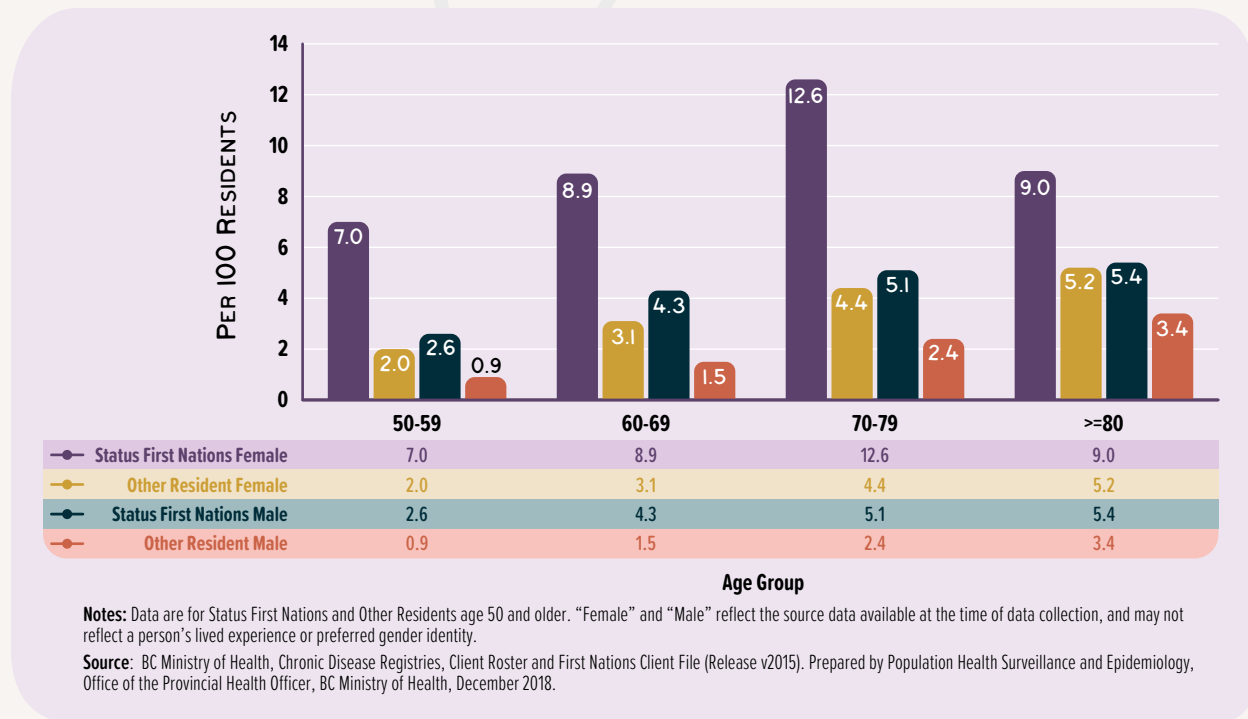


From 2004/05 to 2015/16, the age-standardized prevalence of osteoarthritis among Status First Nations women age 50 and older remained consistently higher than all other groups (e.g., older Other Resident women).

RHEUMATOID ARTHRITIS

p.108

FIG 5.29 AGE-SPECIFIC PREVALENCE OF RHEUMATOID ARTHRITIS, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 50 AND OLDER, BY SEX AND AGE GROUP, BC, 2015/16



The age-specific prevalence of rheumatoid arthritis is consistently higher among Status First Nations women age 50 and older in each age group, as compared to the other groups. The highest prevalence is seen among Status First Nations women age 70–79 (12.6%).



ASTHMA

p.108

FIG 5.30 AGE-STANDARDIZED PREVALENCE OF ASTHMA, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 50 AND OLDER, BY SEX, BC, 2004/05 TO 2015/16



Notes: These are cases of Status First Nations and Other Residents age 50 and older receiving asthma care during the fiscal year (newly diagnosed cases and previously diagnosed cases receiving continuing asthma care), standardized to the Canada 2011 population. "Female" and "Male" reflect the source data available at the time of data collection, and may not reflect a person's lived experience or preferred gender identity.

Sources: BC Ministry of Health, Chronic Disease Registries, Client Roster and First Nations Client File (Release v2015). Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, January 2019.



The age-standardized prevalence of asthma was consistently higher among Status First Nations women age 50 and older than other groups from 2004–05 to 2015–16. In 2015–16, the prevalence for Status First Nations women age 50 and older was twice that of Other Resident women.



SEXUALLY TRANSMITTED INFECTIONS

p.108

FIG 5.31 CRUDE RATE OF SEXUALLY TRANSMITTED INFECTIONS, STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 50 AND OLDER, BY SEX, BC, 2009–11 AND 2012–14



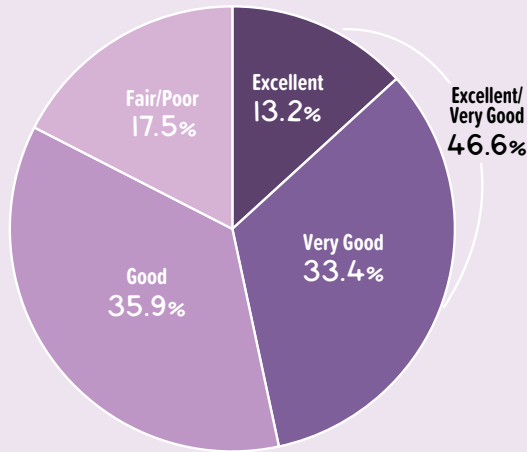
First Nations women describe a collective silence around issues related to female sexuality due to the repression of sexual health teaching and sexual abuse that occurred in residential schools and other colonial institutions.^{25,26} Many indicate that they do not feel comfortable talking about their sexual and reproductive health, which creates a barrier for First Nations women when it comes to accessing sexual health and preventative services.²⁷

In 2012–14, the crude rate of sexually transmitted infections among Status First Nations women age 50 and older was 57.2 per 100,000, higher than Other Resident women and Other Resident men. Status First Nations men age 50 and older had the highest rate at 91.2 per 100,000.

SELF-RATED MENTAL HEALTH

p.110

FIG 5.32 SELF-RATED MENTAL HEALTH OF FIRST NATIONS WOMEN, AGE 55 AND OLDER, BY QUALITY LEVEL, BC, 2015-17



Notes: Data reflect responses from First Nations women living on reserve in BC, age 55 and older. “Female” reflects how respondents identified themselves when completing the survey. Non-binary options were not provided.

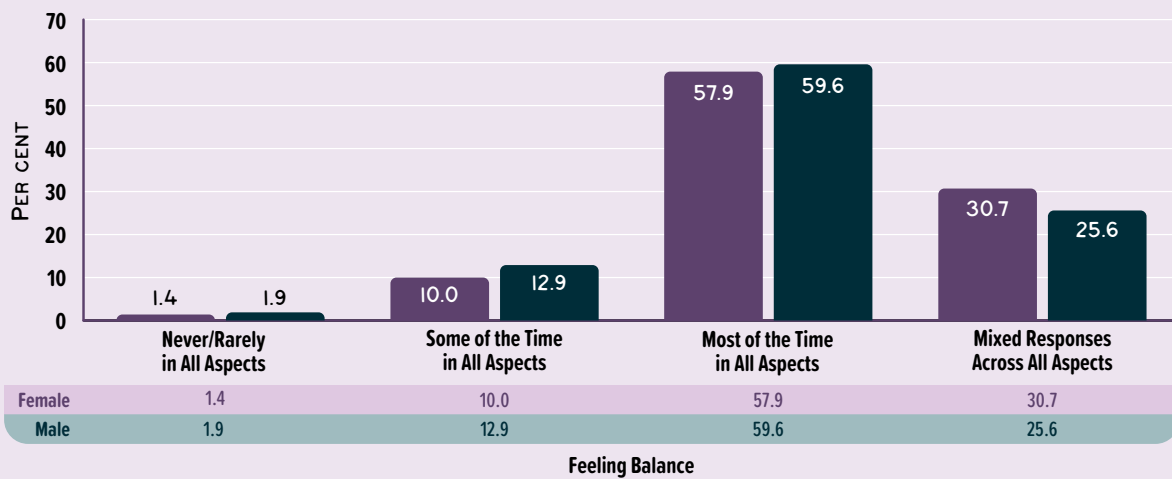
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

The mental health of older First Nations women is tightly interwoven with their spiritual, physical, and emotional health. Having close connections and relationships with the community impacts the mental health of older First Nations women.²⁸ RHS3 (2015–17) data showed that 46.6% of First Nations women age 55 and older reported “excellent” or “very good” mental health.

SENSE OF BALANCE

p.110

FIG 5.33 PERCENTAGE SELF-RATED BALANCE IN WELLNESS ASPECTS OF LIFE (PHYSICAL, MENTAL, SPIRITUAL, AND EMOTIONAL) AMONG FIRST NATIONS ADULTS, AGE 55 AND OLDER, BY SEX AND FREQUENCY OF FEELINGS OF BALANCE, BC, 2015-17



Notes: Data reflect First Nations adults living on reserve in BC, age 55 and older. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

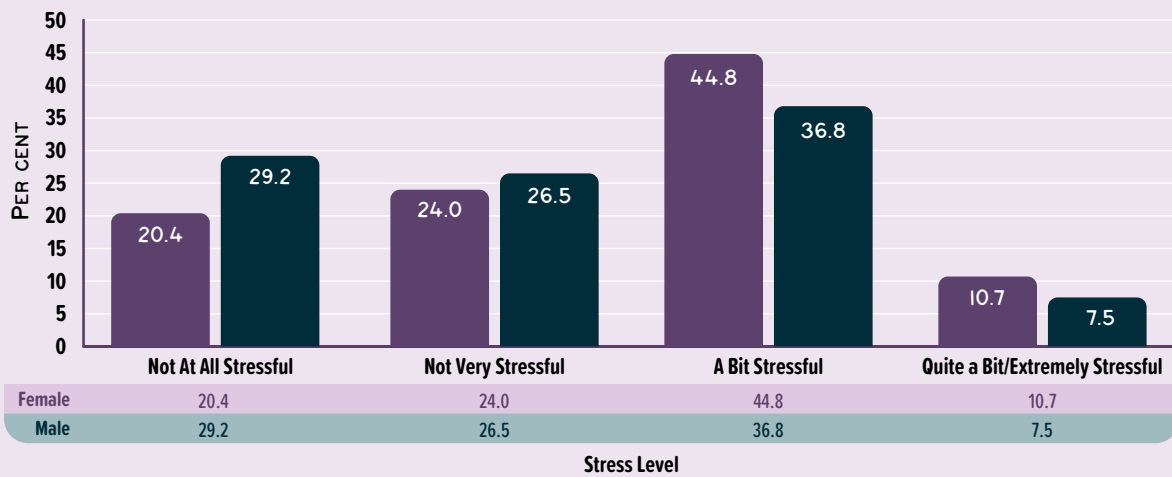
Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

Older First Nations women’s wellness is supported by their connections to the land, community, and culture.²⁹ RHS3 (2015–17) data showed that 57.9% of First Nations women age 55 and older felt a sense of balance most of the time across all aspects of wellness, while only 10.0% reported feeling balanced some of the time.

LIFE STRESS

p.110

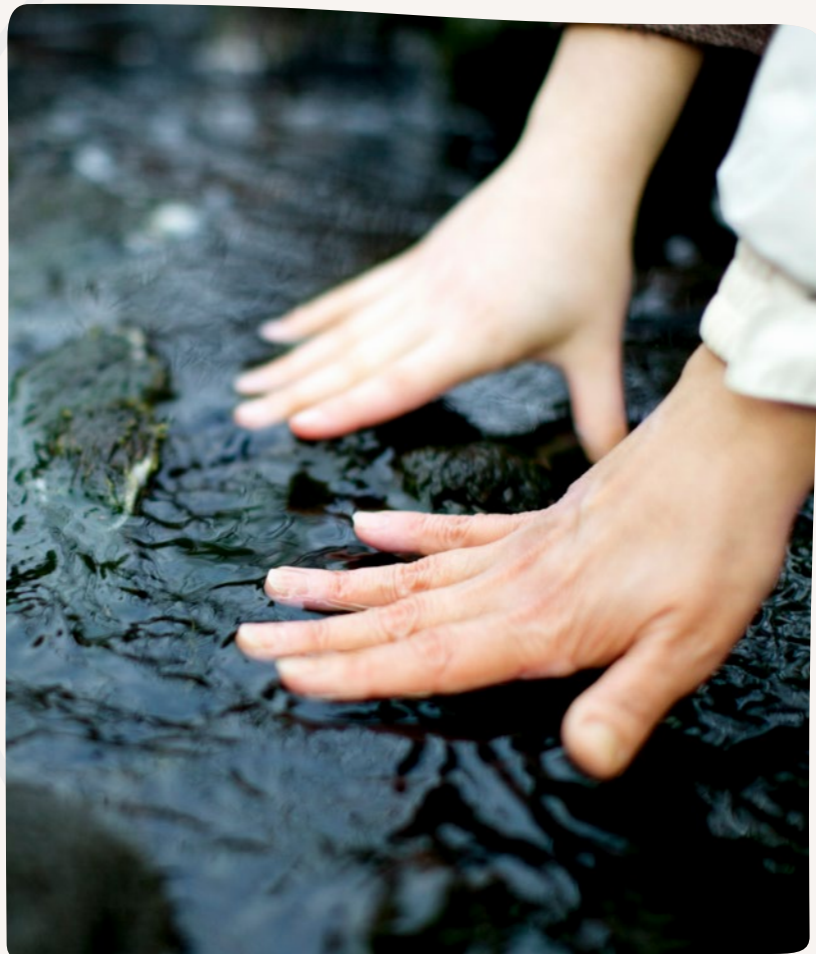
FIG 5.34 PERCENTAGE REPORTED STRESS LEVEL OF MOST DAYS IN LIFE AMONG FIRST NATIONS ADULTS, AGE 55 AND OLDER, BY SEX, BC, 2015–17



Notes: Data reflect First Nations adults living on reserve in BC, age 55 and older. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

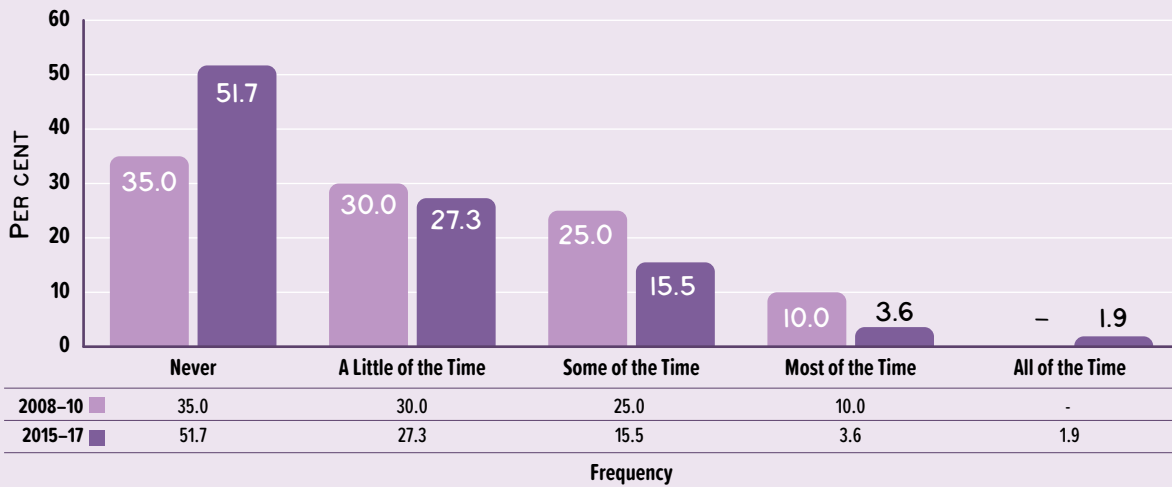
Older First Nations women have developed healthy coping strategies for dealing with daily sources of stress by staying connected to their families, community, land, and culture.³ RHS3 (2015–17) data showed that 89.2% of First Nations women age 55 and older reported that most days ranged from “not at all stressful” to “a bit stressful,” with only 10.7% reporting that most days were “quite a bit/extremely stressful.”



DEPRESSION

p.110

FIG 5.35 PERCENTAGE REPORTED FEELINGS OF DEPRESSION IN THE PAST MONTH AMONG FIRST NATIONS WOMEN, AGE 55 AND OLDER, BY FREQUENCY, BC, 2008–10 AND 2015–17

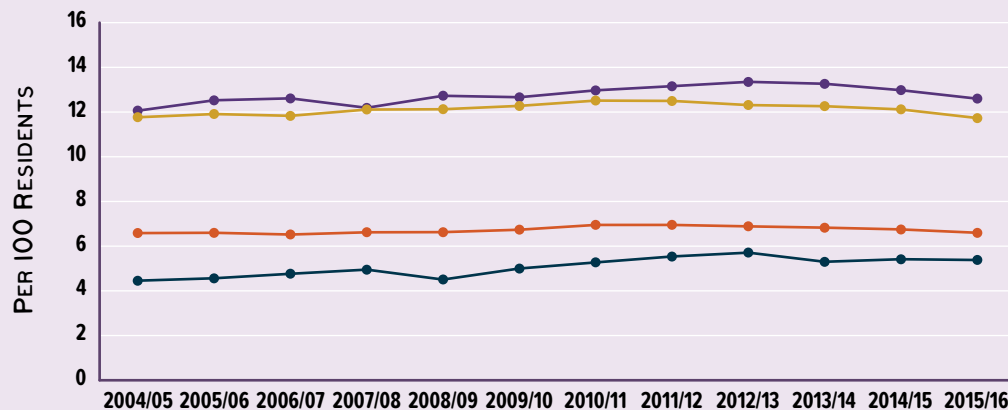


Notes: Data reflect responses from First Nations women living on reserve in BC, age 55 and older. “Female” reflects how respondents identified themselves when completing the survey. Non-binary options were not provided. “-” means that the value has been suppressed due to co-efficient of variation>0.333.
Source: Regional Health Survey, Phase 2 (2008–10) and Phase 3 (2015–17). Prepared by FNHA, 2020.

The proportion of First Nations women age 55 and older who reported never feeling depressed in the past month increased 16.7 percentage points, from 35.0% to 51.7% between RHS2 (2008–10) and RHS3 (2015–17).

p.111

FIG 5.36 AGE-STANDARDIZED PREVALENCE OF DEPRESSION AMONG STATUS FIRST NATIONS AND OTHER RESIDENTS, AGE 50 AND OLDER, BY SEX, BC, 2004/05 TO 2015/16



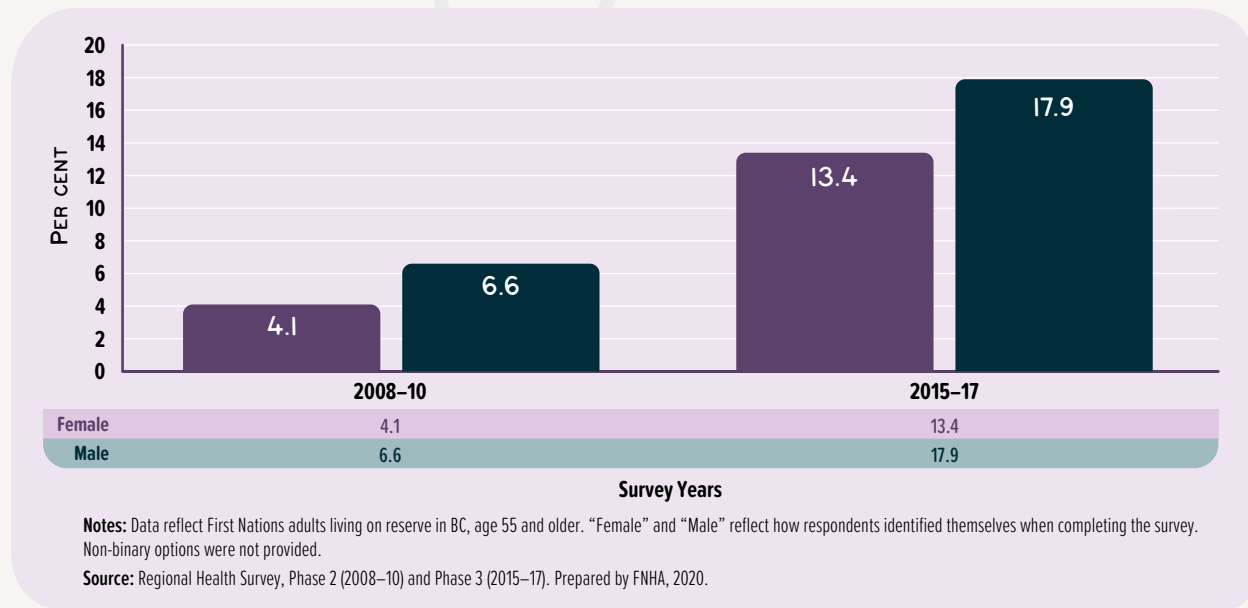
Notes: These data are for Status First Nations and Other Residents age 50 and older receiving depression care (newly diagnosed cases and previously diagnosed cases receiving continuing depression care), during the fiscal year standardized to the Canada 2011 population. “Female” and “Male” reflect the source data available at the time of data collection, and may not reflect a person’s lived experience or preferred gender identity.
Sources: BC Ministry of Health, Chronic Disease Registries, Client Roster and First Nations Client File (Release v2015). Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2018.

Older First Nations women’s mental health is impacted by intergenerational trauma, the legacy of colonialism, and the hormonal changes faced by older women as they approach menopause.³⁰ The age-standardized prevalence of depression among Status First Nations women age 50 and older who are receiving medical services has remained consistent from 2004/05 to 2015/16.

DEATHS BY SUICIDE

p.111

FIG 5.37 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED THAT THEY HAD LOST A FAMILY MEMBER OR FRIEND TO SUICIDE IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17

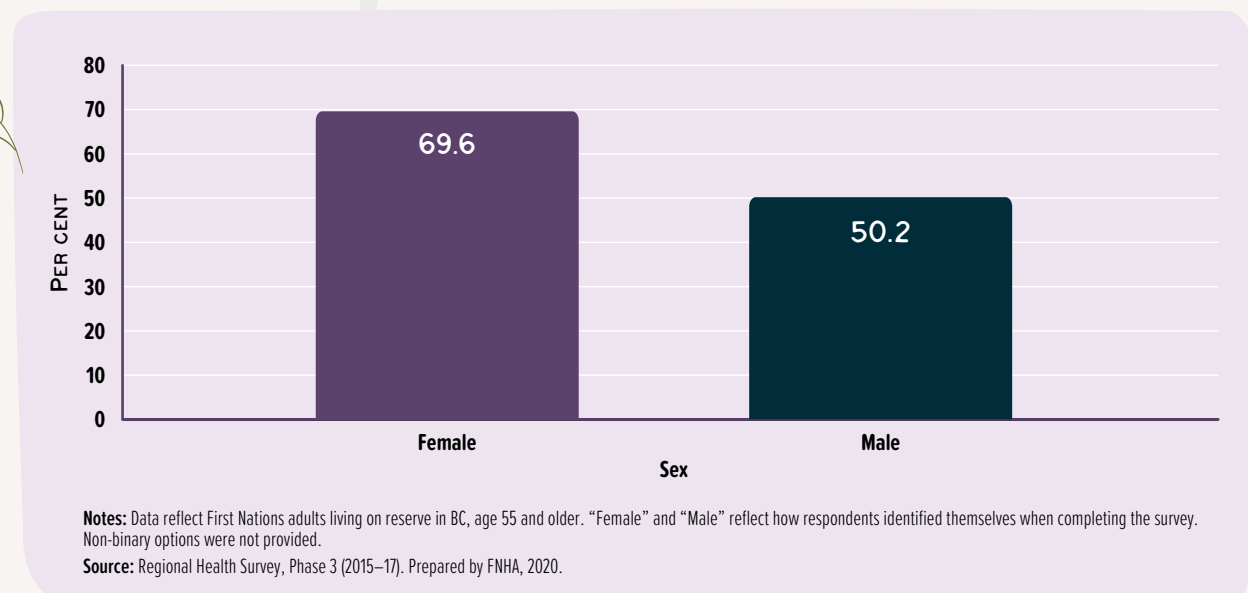


The ongoing legacy of colonialism has resulted in First Nations communities having disproportionate rates of death by suicide compared to non-First Nations communities.²⁸ RHS3 (2015–17) data showed that 13.4% of First Nations women age 55 and older reported having lost a family member or friend to suicide in the past year.

REACHING OUT FOR SUPPORT

p.111

FIG 5.38 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED THAT THEY SPOKE TO SOMEONE ABOUT THEIR EMOTIONAL OR MENTAL HEALTH IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2015–17

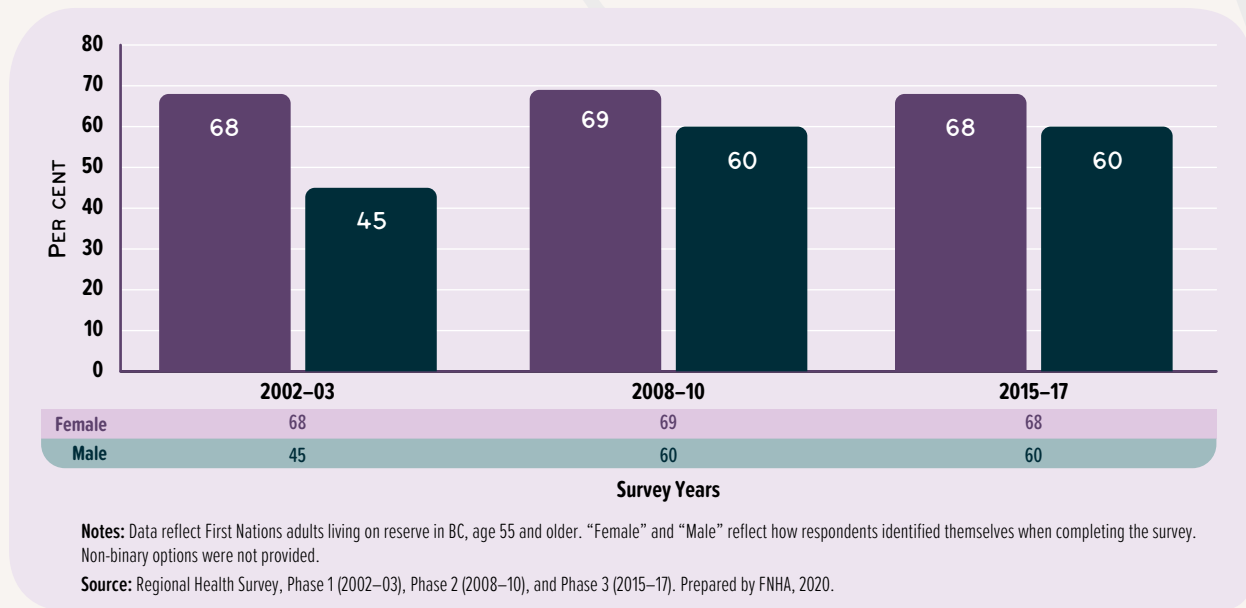


It is traditional for older First Nations women to reach out to their community when they need emotional support and when they are struggling with their mental health.³¹ RHS3 (2015–17) data showed that 69.6% of First Nations women age 55 and older reported speaking to someone about their emotional or mental health in the past year compared to only 50.2% of First Nations men age 55 and older.

ALCOHOL USE

p.112

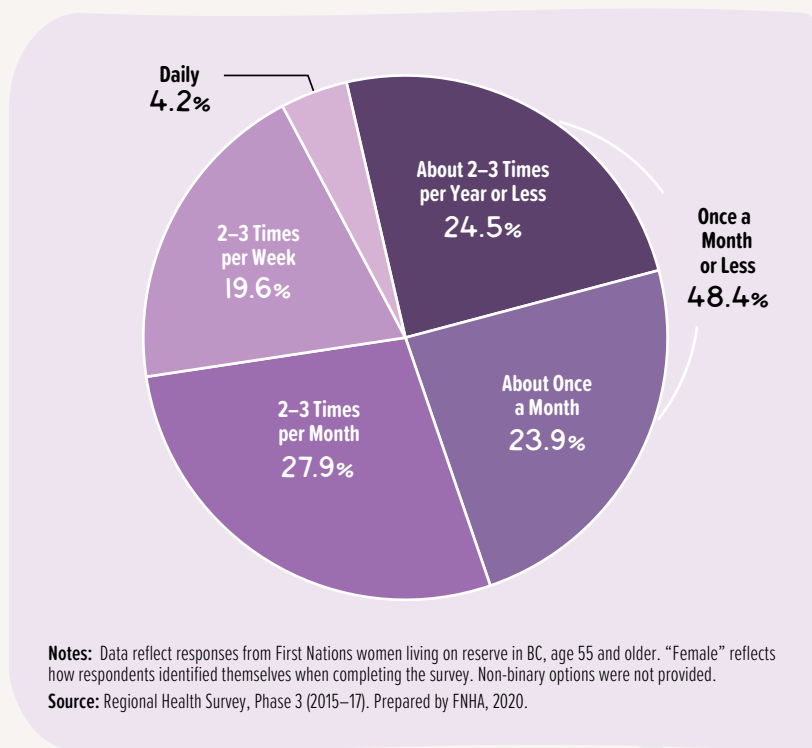
FIG 5.39 PERCENTAGE OF FIRST NATIONS ADULTS WHO DID NOT DRINK ALCOHOL IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2002–03, 2008–10, AND 2015–17



Older First Nations women have a diversity of relationships to alcohol, and many have lived experience witnessing the impacts of alcohol use on social, emotional, mental, and spiritual wellness of individuals, families and communities.³² The proportion of First Nations women age 55 and older who reported not drinking alcohol in the past year has remained constant throughout all three phases of the RHS: 68% (2002–03), 69% (2008–10), and 68% (2015–17).

p.112

FIG 5.40 FIRST NATIONS WOMEN WHO REPORTED DRINKING ALCOHOL IN THE PAST YEAR, AGE 55 AND OLDER, BY FREQUENCY, BC, 2015–17

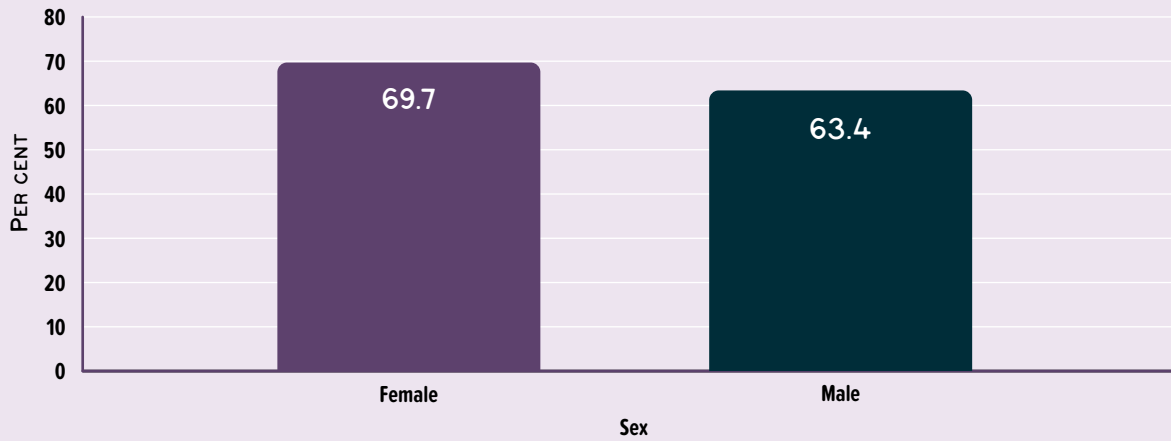


RHS3 (2015–17) data showed that 48.4% of First Nations women age 55 and older reported very infrequent drinking, either “about two to three times a year” or “about once a month.” The smallest proportion (4.2%) reported drinking alcohol daily. Some older First Nations women use alcohol as one way to ease the pain and suffering of longstanding traumas including gendered discrimination under the *Indian Act*, discrimination in child welfare leading to disproportionate child apprehensions that resulted in many First Nations women losing their children and breaking apart families, attempted genocides of residential schools and the Sixties Scoop, and pervasive anti-Indigenous racism that disproportionately impacts Indigenous women.^{32,33}

GAMBLING

p.112

FIG 5.41 PERCENTAGE OF FIRST NATIONS ADULTS WHO REPORTED GAMBLING IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2015–17



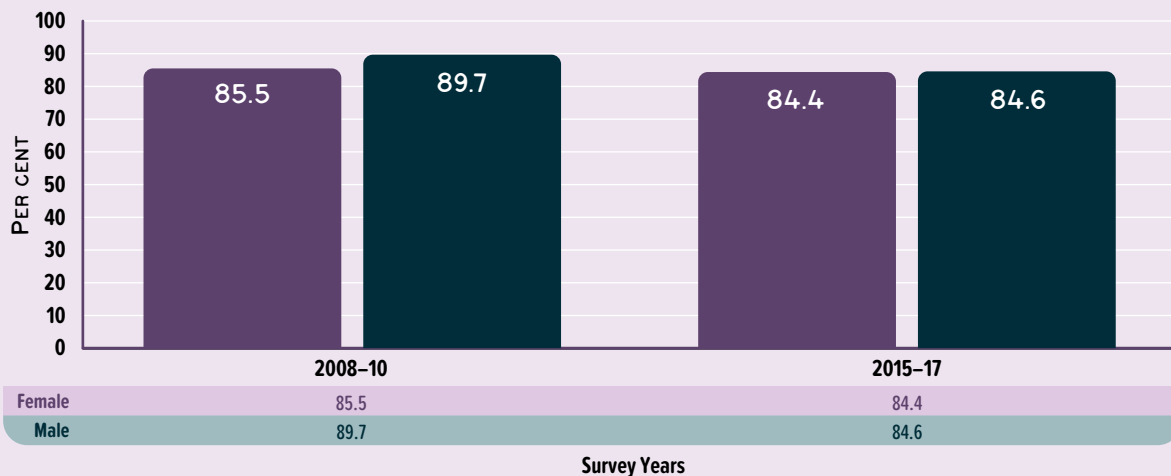
Notes: Data reflect First Nations adults living on reserve in BC, age 55 and older. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 3 (2015–17). Prepared by FNHA, 2020.

RHS3 (2015–17) data showed that 69.7% of First Nations women age 55 and older reported gambling in the past year. Gambling is considered a social activity that is done recreationally by older First Nations women; however, it can be addictive, and, for some, it may negatively affect their wellness.³⁴

p.112

FIG 5.42 PERCENTAGE OF FIRST NATIONS ADULTS WHO NEVER BET MORE THAN THEY COULD AFFORD TO LOSE, AMONG THOSE WHO REPORTED GAMBLING IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008–10 AND 2015–17

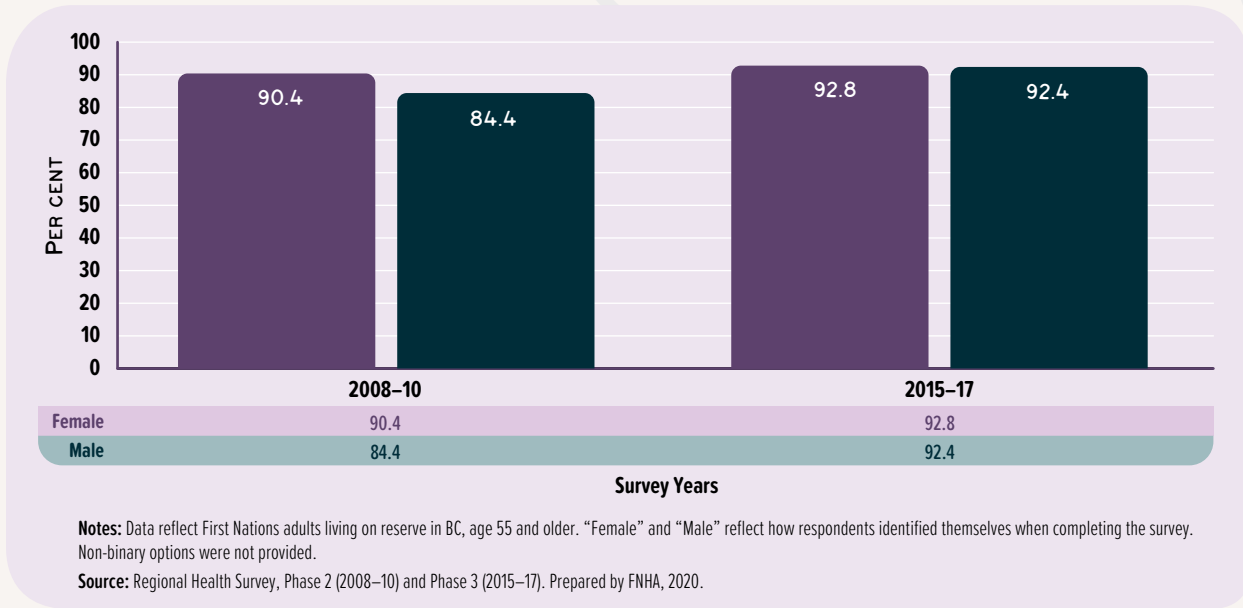


Notes: Data reflect First Nations adults living on reserve in BC, age 55 and older. “Female” and “Male” reflect how respondents identified themselves when completing the survey. Non-binary options were not provided.

Source: Regional Health Survey, Phase 2 (2008–10) and Phase 3 (2015–17). Prepared by FNHA, 2020.

RHS3 (2015–17) data showed that among First Nations women age 55 and older who reported gambling in the past year, the vast majority (84.4%) never bet more than they could afford to lose.

FIG 5.43 PERCENTAGE OF FIRST NATIONS ADULTS WHO DID NOT CAUSE THEMSELVES OR THEIR FAMILIES ANY FINANCIAL DIFFICULTIES, AMONG THOSE WHO REPORTED GAMBLING IN THE PAST YEAR, AGE 55 AND OLDER, BY SEX, BC, 2008-10 AND 2015-17

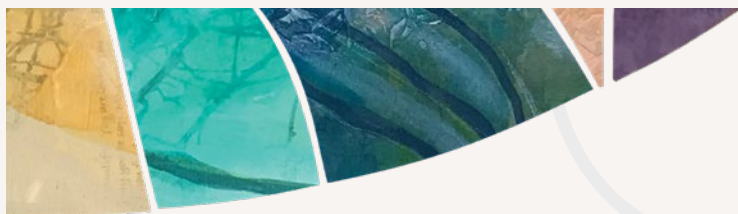


“Where there’s a lack of identity – who they are, where they come from – that’s one of the biggest concerns. Feeling like they don’t belong, or a disconnection. Rebuilding those connections, bringing back culture and traditions, helps guide people back and builds self-esteem. Culture is the biggest component of health and wellness. We need to empower our people and not break them down. They are someone’s child, sister, brother, aunt, uncle, niece or nephew. Connection is the correction for our people.”

- Kemaxa’las Milly Price, Da’naxda’xw/We Wai Kai/Wei Wai Kum First Nation
 - Sacred and Strong: Upholding our Matriarchal Roles (p.111)

RHS3 (2015-17) data showed that among First Nations women age 55 and older who reported gambling in the past year, 92.8% reported that their gambling did not cause themselves or their families any financial difficulties.





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