Injury Control and Indigenous Populations in Canada: Implications for a First Nations Injury Control Framework

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It is not healthy when a nation lives within a nation as First Nations people must do living inside Canada.
A nation cannot live confident of its tomorrow if its refugees are among its citizens.

Adapted from Pearl S. Buck *What America Means to me*

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Abstract

Injury is one of the main causes of disability among First Nations people in Canada. Life expectancy at birth is seven to eight years less for First Nations people than Canadians generally. Aboriginal children are six times more likely to die by injury, poisoning or violence than Canadian children. These are caused in part by conditions in our communities which are created by the federal government because of jurisdictional wrangling and abdication of responsibility for First Nations to other jurisdictions without due consideration to our own Indigenous governments.

The objective of our research was to identify who Indigenous people are in the Canadian context and to explore the key sources of evidence to support the diversity among our Indigenous population as compared to mainstream Canadian society. We reviewed principle data sources that support the impact of injuries on Indigenous populations and identify barriers that impede injury control. From these data we have described a detailed strategy of how to address these barriers from an Indigenous world view and perspective.

The methodology utilized in this paper was a detailed review of literature from an international perspective on Indigenous populations of the world and as compared to the Canadian context. International Indigenous population data related to injury control were compared to Canada's to illustrate and quantify the scope of the problem, what strategies have been utilized to address the problem and what long term implementation implications are indicated to impact change over time.

Our Indigenous population is in crisis and we are overly represented in the number of deaths, injuries and suicides in Canada. Our population is demographically characterized as young and highly mobile. Our children are our future….. they are our joy for the present and hope for the future. Without them we will have no one to carry on our languages, culture, traditions and legacies.

Injury control in Canada is a new phenomenon. We know that research on the Indigenous populations of Canada is virtually non-existent. It is our goal to ensure that our research will be utilized by the Indigenous populations of Canada and abroad because of the fact that it will be based on an Indigenous world view of injury control and suicide prevention. As a result it is hoped that this research will stimulate discussion at a round table level and nationally to focus on injury priorities and to identify from an Indigenous world view next steps to address these priorities

Introduction

According to the World Health Organization (WHO) injuries account for more than 5 million deaths globally each year. Injuries kill more people than HIV / AIDS and malaria combined. In 1998, of the estimated 5.8 million people who died from injuries, approximately 1.2 million died from road traffic collisions and 2.3 million died from violence, including 948,000 by suicide, 736,000 by homicide, and 588,000 from war. *These figures are dwarfed by the number of survivors of injuries,* many of whom suffer life long health consequences. Traffic collisions, falls, drowning, burns and deliberate acts of violence against oneself or others are the major causes of these injuries. Most alarming of all, according to the World Health Organization, is that *most injury related deaths are preventable.*

Some people are more vulnerable than others to injuries regardless of age, sex, income or geographic region. Seven of the fifteen causes of death for men between the ages of 15-44 globally were injury related (WHO, 1999). In descending order they were *traffic injuries, interpersonal violence, self-inflicted injuries, war-related injuries, drowning, poisoning and falls*. For women of the same age, five of the fifteen causes of death globally were injury related. They include *self-inflicted injuries, war-related injuries, traffic injuries, fires and interpersonal violence*. The largest number of violence related deaths for women were the result of *domestic violence and sexual assault*.

Even more troubling, according to the World Health Organization, "*people die at a higher rate in low and middle income countries than in high income countries*." The reason for this phenomenon is that *the poor are at high risk* because *they are faced with more hazardous situations on a daily basis* than middle or higher income people. For example, transportation is often overcrowded and inadequate. Roads are unsafe and workplaces have few safety standards. Homes are poorly constructed and vulnerable to fire or other such hazards. Lack of access to health services is even a bigger problem for the poor if they are injured which results in less chances of survival long term.

In Canada, injuries *both unintentional and intentional* are a major health problem. According to 1995 data over 13,337 Canadians died as a result of injury and another 277,526 were hospitalized (Statistics Canada). Injured Canadians spend close to 2.2 million days in hospital each year and the impact of human suffering and death caused by injuries is staggering. It is estimated that the economic burden is over $14 billion for both *unintentional and intentional* injuries annually.

Within Canada some specific population groups are at greater risk of injury than others. Aboriginal people, for example, experience *three times the injury death rate* of Canadians as a whole (Health Canada 1996) and the suicide rate for

Aboriginal youth under the age of 20 is *five times greater* than that of all young Canadians (Statistics Canada 1996).

According to Health Canada, on an international scale, injury rates in Canada when compared to other developed countries, ranks seventh highest for all injuries and fifth highest for suicide (1998). This ranking is based on the rates of suicide in eleven countries.

The cost for every citizen in Canada was $300 or $8.7 billion in 1995 for preventable *unintentional* injuries. Motor vehicle crashes cost $1.7 billion, and the remaining 40 percent was attributed to a combination of costs incurred by drowning, poisoning, fires and a range of other injuries not classified during hospital admissions.

Canada is suffering an injury epidemic and in Aboriginal communities the epidemic is even more staggering. In First Nation communities injury is the leading cause of death for people under the age of 45 (Health Canada 2001). As well as being a major cause of death, injuries tend to kill at comparatively young ages in First Nation communities. The biggest cause of injury death are motor vehicle accidents, suicide and accidental drug poisoning (2001). Injury death rates in First Nations communities are *far higher for men than for women*. First Nations people die from the *same types of injuries* as other Canadians *but the rates are much higher*. The age pattern is also similar in that in both cases, *people age 15-24 are at highest risk* (2001).

According to the 1991 Aboriginal People's Survey 39% of the respondents reported that family violence was a concern in their community. In both First Nations and general Canadian populations, about two thirds of homicide victims were males (2001). Suicide rates in First Nation communities tend to be highest among youth aged 15-24 and to diminish gradually at older ages. Rates of *completed* suicide are typically *3 times higher* in First Nation males than females. However, *it is generally the case that far more women than men attempt suicide.*

One major fallout of injuries are the resulting disabilities. Aboriginal persons with disabilities in Canada live in third world conditions subject to poverty and isolation. According to the 1991 *Aboriginal People's Survey* 31 per cent of Aboriginal adults have some form of disability - this is twice the average of the general Canadian population. According to the United Nations there are over 500 million persons with disabilities world wide – or 10 per cent of the global population. In some countries nearly 20 percent of the general population is in some way disabled; *if the impact on their families is taken into account, 50 per cent of the population is affected.* If we make that analogy to the Aboriginal population of Canada *over 71 percent of the Aboriginal population is affected in some way by a disability if the impact on the family is taken into account.*

According to the United Nations, the number of persons with disabilities continues to increase in tandem with the growth of the world population. Not surprisingly, many of the disabled *are poor*. The overwhelming majority – nearly 80 percent – *live in isolated rural areas*. Almost that many live in areas where *the services needed to help them are unavailable*. Too often their lives are handicapped *by physical and social barriers in society which hamper their full participation*. (UN 2001). In addition to poverty, injury is the cause of much of this suffering.

Injury – A Definition

For the purposes of this document the following definition is used to define injury. "Injury is physical damage to the body. Amongst other causes, injuries result from road traffic collisions, burns, falls, poisonings and deliberate acts of violence against oneself or others. More technically speaking, injuries result from acute exposure to various kinds of energy – mechanical, thermal, electrical, chemical or radiant – in amounts that exceed the threshold of physiological tolerance. Public health professionals divide injuries into two categories: *unintentional injuries* that include most injuries resulting from traffic collisions, burns, falls, and poisonings; and *intentional injuries* that are injuries resulting from deliberate acts of violence against oneself or others. " (WHO 1999).

Research indicates that in addition to death and disability, injuries contribute to a variety of other health consequences depending upon the type of injury incurred. These consequences include depression, alcohol and substance abuse, smoking, eating and sleeping disorders and HIV and other sexually transmitted diseases. The consequences of these deaths and disabilities affect not only the victim, but also their families, communities and societies at large (1999).

Injuries are caused by a complex interaction of a variety of factors. From a societal perspective they include low socio-economic status, cultural norms that support violence to resolve conflict and rigid gender norms. From a community perspective, some factors could include poor safety standards in the workplace, unsafe roads, and easy access to firearms. At the family level, family relationships such as lack of care and supervision, physical abuse, and family dysfunction are factors that cause injuries. Finally, factors such as aggression, and alcohol and substance abuse by individuals contributes to injuries to oneself and others (1999).

According to WHO *injuries are not random events.* <u>They are preventable</u>. The use of seat belts, child car seats, helmets, flame resistant clothing, smoke detectors, locked storage of firearms and ammunition are a just few measures that can contribute to a decrease in injuries globally.

Injuries are costly. Emergency room, hospitalization and long term care often mean that scarce resources are diverted from other development priorities to treat injuries (1999). Injuries are a public health concern because of the cost but also because of the human price of death and disability. Prevention strategies are required and in some cases need not be expensive. To date most prevention efforts have concentrated in developed countries. As a result deaths and disabilities have declined markedly in countries where such prevention efforts were established (e.g. seat belts, designated drivers programs, child car seats, etc.). A host of strategies at the individual, family and community level have also shown promise in reducing violence related injuries. These include substance abuse programs, family counseling and school-based violence prevention initiatives.

To address the impact of injury WHO tells us that experts from the fields of medicine, education, transportation, sociology, criminology, justice, urban planning and communications can play crucial roles in creating safe and healthy communities. This will require commitment at the national, international and local levels to document the injury problem, craft, test and evaluate comprehensive solutions and disseminate lessons learned (1999).

First Nation Realities

According to the Royal Commission on Aboriginal Peoples (RCAP), Aboriginal people remain affected by poor socioeconomic conditions and as such are at disproportionate risk for injury and illness. It is estimated that 50% of all Aboriginal children are living in poverty. RCAP also identified that Canada's Aboriginal people experience ill health at far higher rates than other Canadians. This is the result of substandard housing and sanitation, poor nutrition, limited access to health care and rehabilitation facilities, poverty and discrimination. Some of the most significant barriers to healthy and safe Aboriginal communities are things that the average Canadian takes for granted. For example:

- *Poverty* - most Aboriginal people are at or below the poverty line. In major western cities in Canada, four times as many Aboriginal people as other citizens are below the poverty line (Census Canada).

- *Social problems* – 39% of Aboriginal adults report that family violence is a problem in their community. In the Inuit population 44% of Inuit adults report family violence, 35% sexual abuse and 15% rape (MSB Health Canada)

- *Suicide rates* of registered First Nation youth ages 15-24 are eight times higher than the national rates for females and five times higher for males (MSB Health Canada)

- There is a strong inverse relationship between the level of cultural continuity in a *community and the youth suicide rate.* Note: There are six protective cultural factors such as self-governance, land claims negotiation, cultural facilities (as defined by the community), and local jurisdiction over education, health services and police / fire services that are associated with substantial *decreases* in youth suicide rates. The presence of three or more of these protective factors are required to result in a decrease in suicide rates. (Chandler et al. 1998).

- *Labour force participation* for Status First Nation individuals on reserve is 47%, 57% for off-reserve First Nation persons, 57% for Inuit and 59% for Metis, compared to the national rate of 68% (1991 Census).

- *Injury is a major health concern* for First Nations and Inuit people during the first seventeen years of life. According to the *First Nation Inuit Regional Health Survey* 13% of First Nations and Inuit people will have a broken bone by the time they are seventeen, 4% will have incurred a serious head injury, 3% will have been seriously burned, 3% will have almost drowned and 2 percent will have experienced frost bite.

- *Solvent abuse is very damaging* and puts children and youth at risk of permanent injury or death. In 1990, 6% of First Nation / Metis adolescents engaged in glue sniffing compared to 1% of non-Indigenous adolescents (Indigenous Canadians: Substance Abuse Profile 1995)

- Aboriginal families with children are much more likely than non-Aboriginal families with children to live in *housing need*. CMHC uses three standards to measure *need*: housing suitability (e.g. crowding), adequacy (e.g. in need of repair) and affordability (less than 30% of income). A household is in *housing need* if its housing does not meet one or more of these standards. Aboriginal families are *twice as likely to live in housing need* as non-Aboriginal families.

- The estimated Aboriginal population (1997) is 1,01,955. Metis are estimated at 20% or 220,740, Inuit at 5% or 49,800 and First Nations (status and non-status) at 75% or 813,415 (1996 Census). The growth rate for the Aboriginal population is five times that of the Canadian population and young people under the age of 17 make up 40% of the overall Aboriginal population.

Disability as a Consequence of Injury

The federal government has a fiduciary obligation to provide the services necessary for First Nations people. First Nation people with disabilities resulting from injuries rely on their social supports based on their treaty and Aboriginal rights relationships. There are inadequate resources to meet the needs of First

Nations people for capacity building, education, injury prevention awareness, communication, financial, human resource development and rehabilitation. *Jurisdiction is a problem* with the federal and provincial/territories disclaiming responsibility between one another and with neither of them willing to give control or responsibility for program or service design, delivery and implementation to First Nations themselves.

There is also *no federal policy on disability* or *injury prevention* nor is there a proper definition for *disability*. The needs of the First Nations populations are *not a one size fits all*. There are northern issues, youth, Elders and women's issues and *portability of rights* issues for First Nations people living in urban centres. There are *no policies* that address these issues either.

For any prevention program or service to be effective in meeting the needs of First Nations people they must be *holistic*. They must be characterized by *coordination, collaboration, education, participation, be socially and physically supportive, adequately resourced and address the self-government goals* of the First Nation population of Canada.

Injury rates vary substantially among different racial groups. In Canada First Nation populations with disabilities resulting from injuries represent the highest rates of injured *than any other racial group in the country*. Ethnicity plays a role in injury rates. Injury and disability is a social phenomenon resulting not only from medical considerations like injury, disease and impairment but also *from the interactions of a person with society*. This can *either help or hinder access* to support services, *encourage or discourage independence*, and *provide or deny opportunities* for jobs, recreation, socializing, etc. *Economic factors are also important* in determining access to education, jobs, health care and personal assistance services, lending to even further differences along racial and ethnic lines. Specific policies and social reform is required to address the *essential rights of people with disabilities resulting from injuries, to live a life of independence and dignity* in Canada and in this particular case: First Nations people with disabilities.

Risk Factors That Contribute to Injuries in First Nation Communities

Researchers indicate that there are various factors that predispose an individual to injury. These are identified as "risk factors." Risk factors are characteristics of risk that relate to society, community, family and the individual and can be best described as indicators of an environment that would preclude someone to injury. For example, drug or alcohol abuse and driving are a combination of factors that certainly result in increased risk to injury. In this case we have described several categories of risk which have been further refined into characteristic descriptors that are quantified by statistical data. The following

tables illustrate in detail the risks First Nation communities are predisposed to because of social conditions, policies and government neglect.

Table 1 (a)
Risk Factors in First Nation Communities that are Pre-dispositions to Injury

Risk Factor Category	Characteristic	Statistical Indicators of Risk
Community Environment	Poverty	Most Aboriginal people are at or below the poverty line. In major western cities, four times as many Aboriginal people as other citizens are below the poverty line.
	High unemployment	50% of First Nation children living on or off-reserve are living in poverty. Aboriginal people are less active in the labour force. They represent 47% of the those employed on-reserve and 57% off-reserve compared to the national labor force employment rate of 68%
	Inadequate Housing	First Nations houses on-reserve are ten times more likely to be crowded than houses the general population live in. Only 54% of houses have adequate water supplies and 47% have adequate sewage disposal. More than 20% of First Nations have problems with their water supply which threatens health and safety.
	Cultural devaluation	There are 633 First Nations in Canada, 52 Nations and cultural groups. There are 57 Aboriginal languages and 12 language families represented in Canada and only 3 languages are predicted to survive – Cree, Inuktitut and Ojibway.
Family Environment	Alcohol, tobacco and other dependency of parents	According to the FNIRHS 78% of respondents said they used tobacco in non-traditional ways. 62% smoked cigarettes, 4% used snuff and 1% used chewing tobacco. The majority of the population of smokers are under the age of 40 and the smoking rates are up to 72% for the youngest adult age group (age 20-24). Smoking for Aboriginal children begins as early as 6 to 8 years (0-8%) but rapidly increases at age 11 to 12 (10% to 65%) with a peak initiation at about age 16 years. – alcohol and smoking, particularly in combination, represent the main cause of domestic fires – smoking is given as the cause of fatal fires in First Nation communities 50% of the time - alcohol is a co-factor with cigarette smoking in about half of all fire deaths

Source: INAC Social development Health and Social Indicators 1999, Aboriginal People's Survey, Statistics Canada 1996, Census Canada and CMHC

Table 1(b)
Risk Factors in First Nation Communities that are Pre-dispositions to Injury

Risk Factor Category	Characteristic	Statistical Indicators of Risk
Vulnerability of the individual	Parental abuse and neglect	25% of Aboriginal adults reported sexual abuse is a problem in their community and 15% reported rape as problems. 25% of First Nation youth reside in one parent households and 18% live in non-family settings. Compared to their non-Aboriginal counterparts First Nations youth are 1.6 more times likely to report living in a non-family setting. Mortality rates among Aboriginal youth indicate there are 250 deaths per 100,000 persons, a rate of approximately 3.6 times higher than deaths reported for all Canadian youth.
	Financial strain	More than 45% of all First Nation youth were living in a low income household, a rate of roughly 1.9 times that of non-First Nation youth
	Large, overcrowded family	More than half (52%) of First Nation households live in homes that fall below one or more of the housing standards as compared to 32% for Non-First Nation households
	Unemployed or underemployed parents	Earned income per employed Aboriginal person in 1991 was $14,561 compared to $24,001 for the general Canadian population. First Nations people are economically disadvantaged in that they earn an average of half what Canadians earn and subsist on social assistance at a rate of five times higher than the rest of the Canadian population.
	Single female parent without family / other support	32% of Aboriginal children live in households with a lone-parent and are at elevated risk for living in poverty
	Family violence or conflict	39% of Aboriginal adults reported that family violence is a problem in their community. Incarceration rates of Aboriginal people are 5-6 times higher than the national average. The highest rates of Aboriginal sentenced admissions were in the NWT (80%), the prairies (50%) and BC (20%)
	Frequent family moves	High rates of mobility characterize the First Nation youth population. Between 1995 and 1996, more than one third of First Nation youth reported a change in residence, a rate roughly 1.4 times higher than that of non-Aboriginal youth
	Low parent / child contact	5% of First Nations children were in the custody of Child and Family services in 1996 / 97.
	Child of an alcohol, tobacco or drug abuser	Incidences of FAS / FAE in First Nation communities are 30 times the national average.
	Physical or mental health problems	The most prevalent health problems among First Nation children include ear infections, respiratory conditions, broken bones, emotional and behavioral problems

Table 1(c)
Risk Factors in First Nation Communities that are Pre-dispositions to Injury

Risk Factor Category	Characteristic	Statistical Indicators of Risk
Early Behavior Problems	Emotional problems	The suicide rates for First Nations females are 4 times higher than for Canadian females and 32.6 times higher for First Nation males than Canadian males
	Inability to cope with stress	Solvent abuse by youth is a particular concern: 22% of First Nations youth who report solvent abuse are chronic users and come from homes where there is financial hardship, neglect, family conflict or child abuse. Suicide rates for registered First Nation youth ages 15-24 are eight times higher than the national rate for females and five times higher for males.
	Low self-esteem	Incidences of FAS/FAE in First Nation communities are 30 times the national average
	Aggressiveness	Rates of incarceration (age group 15-19) are nine times higher among the First Nation population at approximately 45.7 per 10,000 compared to non-First Nation youth at 4.9 per 10,0000.
Adolescent Problems	School failure and dropout	65% of First Nation youth never complete high school compared to 31% of non-Aboriginal children.
	At risk of dropping out	31% of First Nation youth do not attend school compared to the 69% who do
	Violent Acts	Rates of incarceration for violent crimes are nearly 9 times higher for First Nation youth at 103 per 10,000 compared rates of 11.8 per 10,000
	Drug use and abuse	62% of First Nations people aged 15 and over perceive alcohol abuse as a problem in their community while 48% state that drug abuse is an issue.
	Teenage pregnancy/teen parenthood	Aboriginal youth are at elevated risk of becoming pregnant at an early age and greater risk of contracting a sexually transmitted disease
	Unemployed/under-employed	Earnings from employment per person aged 15+ First Nation persons = $9,140 compared to $17,020 for the Canadian population
	Suicidal	Suicide rates for registered First Nation youth ages 15-24 are eight times higher than the national rate for females and five times higher for males.

As indicated in Tables 1a-c there are several risk factor categories that indicate significantly higher risks for First Nations citizens than Canadians in general. This predisposition to injury is a result of social policy and forced poverty conditions created by a government bent on crushing First Nation communities, leaders and future generations. *Our children and youth are at greatest risk.*

Strategies for Change/A Prevention Model

Identification of community factors associated with risk and who is most at risk.

Table 2.0

Poverty	Parental Abuse, domestic violence, neglect, rape
Inadequate and Substandard Housing	Unemployment and underemployment
Cultural Devaluation	Low self esteem and high feelings of insecurity
Alcohol and Drug Abuse	Peer Pressure

Source: Health Canada, Inuit Environmental Scan

A Continuum of Risk

Table 3.0
A Comparison of Injury Rates by Cause and Age Group
First Nations, 1989-1993
Health Canada Medical Services In-house Statistics

Age Group	Motor Vehicle	Suicide	Other	Fire	Drown-ing	Falls	Poison/ OD	Firearms
Age 0-1Years	5.2	0	43	15.5	3.4	6.9	1.7	0
Age 1-14 Years	14.3	4.2	5.6	9.3	9.6	0.6	1.4	2
Age 15-24 Years	62.2	80.7	19.9	7.4	9.3	1.9	10.7	4
Age 25-44 Years	55.6	40.9	21.3	9.3	15.2	4.2	27.5	1.1
Age 45-64 Years	56.2	19	38.9	10.9	19	10.4	25.8	3.2
Age 65+ Years	50.5	12.8	42.7	16.8	7.8	56.9	12.9	1.3

* Death per 100,000 population
** Note: OD = overdose
Note: Other category = suffocation, exposure, homicide, industrial accident and aircraft crash
Source: Medical Services Branch In-house Statistics

Table 4.0

Death Rates Due to Injury & Poisoning by Cause
First Nations, Three Year Averages 1979-1993 (Health Canada)

Injury Category	1979-1981	1982-1984	1985-1987	1988-1990	1991-1993
Motor Vehicle	66.8	46.4	62.6	46.3	40.5
Suicide	38.2	35.8	36.6	32.7	38.0
Other	66.2	53.2	34.7	34.8	30.3
Poisoning/OD	6.9	7.2	9.3	10.8	16.5
Drowning	27.3	17.3	14.5	12.6	11.8
Fire	18.3	17.1	13.0	10.3	10.2
Falls	8.1	7.1	5.2	6.3	4.6
Firearms	10.6	5.6	6.0	3.3	2.3

* Death per 100,000 population
** Note: OD = overdose
Note: Other category = suffocation, exposure, homicide, industrial accident and aircraft crash
Source: Medical Services Branch In-house Statistics

Table 5.0
Percent Injury and Poisoning Deaths by Cause and Gender
First Nations 1991-1993 (Health Canada)

Cause	Male	Female
Motor Vehicle	25.6%	27.8%
Homicide	8.9%	9.7%
Fire	6.2%	7.8%
Drowning	9.5%	3.3%
Suicide	26.3%	20.7%
Poisoning/OD	8.9%	14.9%
Other	16.5%	16.1%

* Note OD = overdose
** Other = includes suffocation, exposure, homicide, industrial accident and aircraft crash
Source: Medical Services Branch In-house Statistics

Data Limitations notation: Health Canada reports that there are limitations to the data collection methods and the populations included in their statistics. FNIHB regions and other data sources include only First Nations people living on-reserve, while others include all First Nations people, regardless of where they live. It was also not usually possible to separate out the data for First Nations and Inuit.

Reasons for High Injury Rates in First Nation communities:

Table 6.0
Risk Factors and Causes of Higher Percentages of Injuries in First Nation communities

Risk Factor Category	Causes
Motor Vehicle Accidents	♦ First Nations communities are greater distances from places where regular activities, commodities or services can be undertaken ♦ Riskier types of vehicles like snowmobiles and all-terrain vehicles are utilized in unsafe conditions such as on ice, public or poor roads, etc. – they are hard to see and roll over easily causing injury – ♦ There are significant influences of alcohol and substance abuse in First Nation communities ♦ Emergency facilities are greater distances from First Nation communities increasing risk of death
Suicide and Violence	♦ Many First Nation communities are in close proximity to rivers and lakes, often with important services such as stores, heath centres, air strips located across a body of water ♦ In northern areas cold water temperatures increase likelihood of hypothermia and consequent death. In northern areas there is also less access to swimming lessons and lifesaving training ♦ Safety and lifestyle habits do not emphasize safety practices such as use of flotation devices or limiting alcohol consumption when in or on the water.
Fire	♦ Many homes in First Nation communities are wood frame construction ♦ There is limited presence of smoke detectors in many First Nation communities ♦ Smoking habits contribute to fires and injury
Drowning	♦ Poor social conditions and community dysfunction result in greater risks of violence and suicide. High suicide rates correlate with community characteristics such as a higher number of occupants per household, more single parent families, fewer Elders, low average income and lower average education. ♦ Overcrowded and poor housing increases the risk of injuries and can aggravate stress levels and contribute to family violence ♦ Hunting and subsistence lifestyles contribute to the risk of injuries due to firearms as well as the risk of suicide by these weapons.

Source: First Nations and Inuit Injury Prevention Working Group 2001 Health Canada

International Data on Injury

Injuries, intentional and unintentional, are now the leading cause of child death in all of the world's developed countries. According to the World Health Organization almost 40 percent of deaths are in the age group of 1-14. The following table illustrates the total number of injury deaths among 1-14 year olds during 1991-1995. There are 29 countries that form the Organization for Economic Co-operation and Development (OECD). These countries produce two-thirds of the world's goods and services. The OECD members as of December 2000 are listed in the table below with a ranking of their number of child deaths during 1991-1995:

Table 7.0
Number of Child Deaths 1991-1995
Among 1-14 Year Olds by Country

Country	Child Injury Deaths 1991-1995	Share of Injury Deaths in all Deaths (%)
Australia	1,715	42
Austria	608	42
Belgium	781	40
Canada	2,665	44
Czech Republic	1,138	42
Denmark	334	36
Finland	368	43
France	4,701	41
Germany	5,171	38
Greece	666	40
Hungary	982	36
Ireland	357	39
Italy	2,563	28
Japan	7,909	36
Korea	12,624	53
Mexico	29,745	30
Netherlands	864	30
New Zealand	519	47
Norway	294	37
Poland	5,756	44
Portugal	1,524	40
Spain	2,643	33
Sweden	391	33
Switzerland	537	40
UK	3,183	29
USA	37,265	49
OECD Total	125,303	39

Source: UNICEF Innocenti Report Card Issue No. 2 February 2001

As illustrated in Table 7.0 for the over 125,000 children age 1-14 who died of injuries in the OECD nations during 1991-1995 almost 1/3 of those deaths were in the United States and 1/4 in Mexico.

It is noted that for every *one* death among children age 0-14 in the Netherlands during 1991-1995 (home and leisure accidents) there were 150 hospital admissions and 2,000 accident and emergency department visits. *Death is only the tip of the "injury iceburg."* According to OECD data, *each death* represents *a much larger number* of non-fatal injuries, traumas and disabilities. Using the Netherlands, as an example, and if this ratio were to prevail for all OECD nations, the toll would amount to approximately 50 million accident and emergency visits and 4 million admissions per year.

The major causes of child injury death in OECD countries are illustrated below:

Table 8.0
Causes of Child Injury Death in the OECD
1991-1995

Cause of Death	*Percentage*
Transport Accidents	41%
Drowning	15%
Fire	7%
Falls	7%
Poisoning	2%
Firearm Accidents	1%
Other Unintentional	16%
Other Intentional	14%

Source: UNICEF Innocenti Report Card Issue No. 2 February 2001

As indicated above the highest percentage of child deaths were caused by transport accidents (41%) followed by drowning (15%).

Table 9.0
Injury deaths by age and gender
1991-1995

Age Category	*Girls*	*Boys*	*Ratio*
Age 1-4	14.4	20.3	1.41
Age 5-9	7.3	12.8	1.72
Age 10-14	7.3	15.7	2.15
All children Aged 1-14	9.2	15.9	1.73

Source: UNICEF Innocenti Report Card Issue No. 2 February 2001

Death by injury as indicated in Table 9.0 is *more common for boys than for girls*. Boys aged 1-14 were 70 percent more likely than girls to die from injuries in 1991-1995. The difference between the sexes is even greater for older children ages 10-14 with an injury death rate that is double for boys than for girls. The reasons for this disparity may be that boys take more risks or that parents are more permissive with boys than girls. Even at the youngest age, however, boys aged 1-4 are still 40% more likely to die of injury than girls.

For most of the causes of child injury deaths there are prevention strategies that could save lives. These strategies have yet to be implemented in a comprehensive and consistent way with a well-informed emphasis on those most at risk (2001).

It must be noted that the *Innocenti Report Cards* only focus on problems facing children of the industrialized nations. UNICEF further reports that 98 percent of all child injury deaths occur *in the developing world*. This statistic reflects not only larger numbers of children but also *higher numbers of risk* (2001). For every 100,000 children born in OECD nations, fewer than 200 will die from injuries before the age of 15. In developing countries the corresponding figure is over 1,000. For example, in Africa drowning vies with traffic accidents as the most important cause of the estimated one million child injury deaths a year in Africa. Over 10,000 children die each year in rich countries and in the rest of the world the figure is closer to 240,000. *That is the equivalent of two jumbo jets full of children crashing every single day (2001).*

Even though in developing countries car ownership averages only 30 per 1,000 people, compared to 500 in industrialized nations, the rates in Africa and India for child traffic deaths are 4-5 times higher than in developed countries (2001). The reason for the higher number of deaths is in the fact that roads in the *poor* world carry fewer cars, and more pedestrians and cyclists. The lack of well developed safety infrastructure to keep walkers and cyclists vulnerable to vehicles apart is a significant problem. Also, there are few traffic "calming" measures, law enforcement and road safety cultures in developing countries. The result is a higher rate of road deaths; but there is a significant difference in their distribution. In the United States, for example, pedestrians and cyclists account *for less than 20 per cent of road deaths for all ages*; in comparison the proportion in Ethiopia *is more than 80 percent* (2001).

Implications for Social Policy

A strategy for injury prevention is *essential* to reducing death and disability in First Nation communities. As we have seen in the data presented throughout this document each community or country's *state of development* has an impact on what strategies would work for that environment. In the case of First Nations an effective injury control strategy must be *First Nation driven, demographically sensitive and culturally appropriate.*

According to WHO the most important measures for prevention of death, disability and impairment are:

- improvement of the educational, economic and social status of the least privileged groups,
- identification of types of injury and impairment and their causes within defined geographical areas
- introduction of intervention measures through better health and prevention practices
- legislation and regulations that are geared towards prevention
- modification of unsafe lifestyles
- education regarding environmental hazards and potential for injuries
- fostering better informed and strengthened families and communities
- training and regulations to reduce accidents in industry, agriculture, on the roads and in the home
- control of the use and abuse of drugs and alcohol

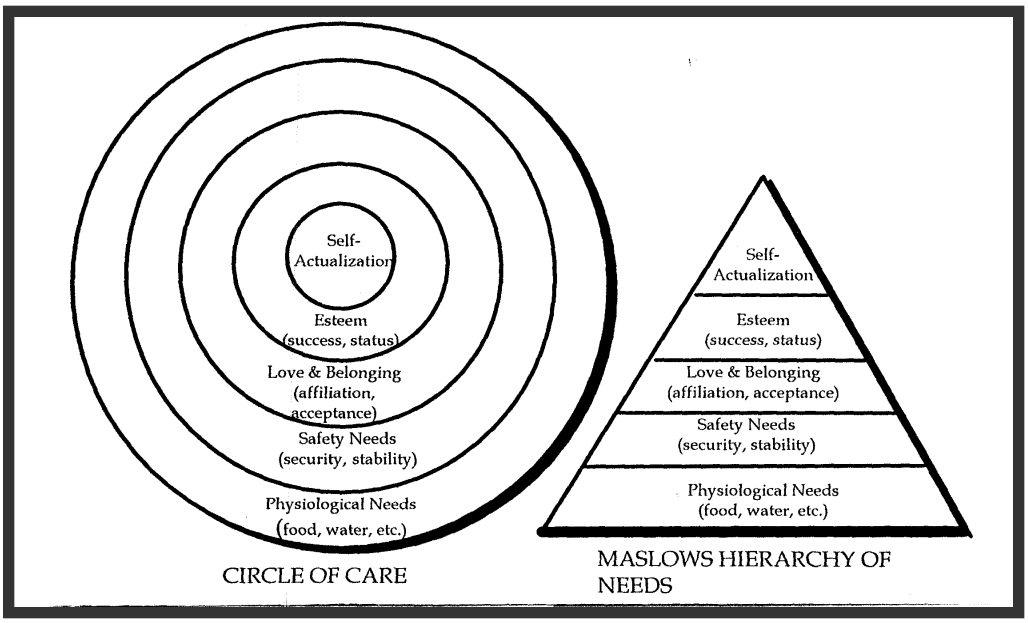
In Canada the momentum for injury prevention is growing. In 1999 a conference of Deputy Ministers of Health endorsed the recommendations of the paper entitled ***National Injury Prevention and Control Strategy*** recognizing injury as an important public health problem that required a coordinated response. On January 17, 2000 Health Canada established *the Secretariat for Injury Prevention and Control* that would coordinate the development of a national framework (Health Canada 2001). Some of the prevention goals for a national strategy on injury prevention and control are as follows:

- to reduce injury death and disability across Canada
- to strengthen public policy regarding injury prevention
- to improve awareness and education programs in injury prevention
- to create safe environments
- to decrease the incidence of injuries related to alcohol and substance use / abuse
- to improve systems of trauma care and rehabilitation

In February 2000 the *National First Nations and Inuit Injury Prevention Working Group* was established. The mandate of this group is to establish strategic and collaborative linkages and to be a "national voice" in injury prevention and control by supporting: a high level of visibility of the First Nations and Inuit injury problem in Canada; priority attention and action on the injury problem for First Nations and Inuit as *high risk* populations; and active partnerships that leverage and build upon existing and emerging opportunities for action.

From a First Nation perspective it is essential that not only the goal of injury prevention be achieved by any process or strategy that is developed but that the endemic problems of government subjugation of Aboriginal people historically be acknowledged and addressed as part of the underlying conditions in First Nation communities that predisposes First Nation citizens to injury, and consequently, death and disability.

Maslow's hierarchy of needs clearly illustrates the basic physiological and safety needs that must be met to address the social and environmental risk factors that are so desperately and devastatingly apparent in First Nation communities.



Source: Sharing Solutions First Nations Social Security Reform AFN 1999

Stakeholders in Prevention:

Government and Community Agencies and Organizations

- Health Canada and Health Agencies
- Indian and Northern Affairs Canada
- Human Resources Development Canada
- Transport Canada
- Environment Canada
- Heritage Canada
- Industry Canada
- National Defense
- Department of Fisheries and Oceans
- The Privy Council Office
- Revenue Canada
- Department of Finance
- Department of Agriculture
- CMHC
- Justice
- The RCMP
- Social Service Agencies
- Mental Health Agencies
- Police Departments
- Justice
- Fire Departments
- Housing Authorities
- Education Authorities and Schools
- First Nation Councils and Tribal Councils

Professional Groups and Service Organizations

- Aboriginal Veterans
- Aboriginal Medical Associations
- Aboriginal Nursing Associations
- Schools of Public Health
- Legal Associations (Indigenous Bar Association)
- Regional Economic Development Organizations
- Provincial/Territorial Organizations
- Churches
- Colleges and Universities
- Aboriginal and Non-Aboriginal Media – newspaper, radio and television (APTN)
- Entertainers
- Professional sports organizations
- Domestic Violence prevention groups
- Child and Family Service Agencies
- Local businesses
- Hospitals, clinics, mental health institutions and rehabilitation organizations
- Youth clubs

Target Populations Based on High Risk Data:

First Nation Children 0-15	First Nation Youth Age 15-24
First Nation Women	First Nation Men
First Nation Elders	First Nation Persons w / Disabilities

Each target population requires its own cadre of prevention strategies. Based on our data the following table identifies prevention strategies targeted towards the needs of the population identified.

First Nation Prevention Strategy by Target Group

Target Population	Prevention Strategies Recommended
Children	♦ Child safety car seats ♦ Parent training to prevent SIDS ♦ Safety at home to prevent falls, poisoning, fire, etc. ♦ Baby-sitting courses for caretakers ♦ Swimming and water safety
Youth	♦ Suicide prevention programs ♦ Crisis / help lines ♦ Drug and alcohol awareness ♦ Self-esteem development ♦ How to deal with peer pressure ♦ Bicycle, ATV, motor vehicle safety ♦ Violence Prevention ♦ Fire Prevention
Women	♦ Drug and alcohol awareness ♦ Crisis shelters for women and children ♦ Parenting Programs ♦ Suicide prevention programs ♦ Fire prevention
Men	♦ Drug and alcohol awareness ♦ Safe Driving and vehicle safety ♦ Gun Safety ♦ Violence Prevention ♦ Fire Prevention ♦ On the land safety programs ♦ Water and basic safety for boating, skidoo's, ATV's
Elders	♦ Falls prevention and home safety ♦ Fire and home safety ♦ Drug and alcohol awareness ♦ Help lines
First Nations Persons with Disabilities	♦ Help lines ♦ Fire safety ♦ Drug and alcohol awareness ♦ Self-esteem

Community prevention strategies:

The first step in designing an injury prevention program is determining exactly what the community's needs are. Collaboration between injury prevention

workers, mental health workers, home care workers, nurses, school representatives, law enforcement, etc. is required to survey and identify a map of the injury "hot spots" in our communities. Once the data is collected and analyzed priorities can be established and prevention programs put in place. For example, if the problem is motor vehicle accidents on a certain curve in the road, road work and warning signs can be implemented to address the problem. Whatever program is put in place needs to be continuously evaluated to ensure effectiveness and to ensure changes are made as required. Proactive injury prevention programming empowers First Nations to move beyond *crisis management* to well maintained healthy and safe communities. This can be done through:

1. *Identification of risk and protective factors*

2. *Intervention development*

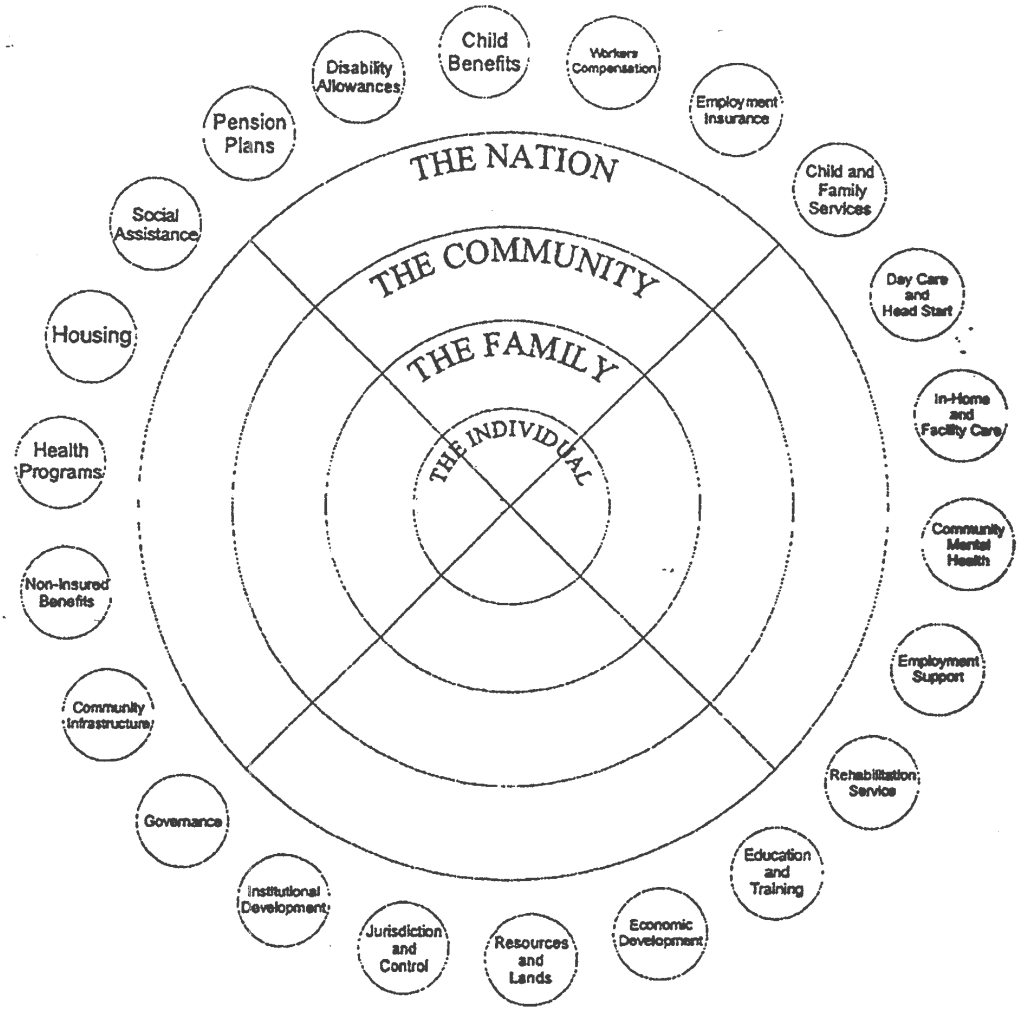
3. *Evaluations to document progress, success and/or failure*

4. *Implementation of interventions eg. suicide prevention programs, drug and alcohol awareness, violence prevention, etc.*

Most importantly, any interventions must be *culturally sensitive and appropriate* to the population targeted. For example, in 1997 the *Manitoba Red Cross Society* did a video on boating safety specifically designed for First Nations people. The script was written by a First Nations individual with input from First Nation community representatives. It was translated into four major Aboriginal languages represented in the region and filming was done in a First Nation community using local residents as actors. This video was positively received by First Nations in the targeted area because it responded to their cultural values, traditions and unique dialect/language requirements.

Injuries are caused in First Nation communities because of complex interactions of a variety of factors related to socio-economic status, cultural norms and poverty. Injury control programs *must be* designed from a nation, community, family and individual perspective to be successful.

The following is an adaptation from the 1999Assembly of First Nations research document *Sharing Solutions First Nations Social Security Reform the Final Report of the Aboriginal Strategic Initiative.* This diagram illustrates a First Nation *holistic* approach to intervention from a community, family and individual basis as part of the nation building process.



Source: Sharing Solutions First Nations Social Security Reform AFN 1999

The collaboration, linkages, relationships and stakeholders illustrated above are required to ensure a holistic approach to injury prevention. This diagram truly indicates from a First Nations perspective how important each partnership is with the other. The themes of these collaborations are based on four pillar foundations: *jurisdiction, capacity building, self-sufficiency and partnerships.* Each must be in place for one to build upon the other.

An Injury Prevention Strategy

An Injury Prevention and First Nations Injury Control Model

Target	Prevention Methodology
Nation	Strengthened policy regarding injury prevention Improved public awareness and education regarding injury prevention Decreased incidence of injuries related to alcohol and substance abuse / use Creation of safe and healthy environments
Community	Improved safety standards Safer roads Greater control over firearms Alcohol and substance abuse programs
Family	Improved care and supervision of children Improved prevention of physical abuse and domestic violence Improved family functioning / less family dysfunction through family counseling
Individual	Less violence and aggression Less alcohol and substance abuse Stronger cultural, individual values and improved self esteem

For any prevention program or service to be effective in meeting the needs of First Nations people they must be *holistic*. The needs of First Nations populations are *not a one size fits all*. They must be characterized by *coordination, collaboration, education , participation, be social and physically supportive, adequately resourced and address the self-government goals* of the *First Nations population of Canada.*

First Nations children and youth are the most *at risk* for child injury, death and suicide. Prevention strategies *can save lives.* These strategies *must be* implemented in a consistent and comprehensive way with a well informed emphasis on those *most at risk.* Physical environments such as those in the north which are characterized by remoteness, cold temperatures, subsistence lifestyles; housing conditions that are overcrowded, poor and dilapidated; social conditions that are poor and dysfunctional; use of "riskier" kinds of vehicles such as snowmobiles, ATV's, boats, etc.; alcohol, substance and tobacco use / abuse; all put First Nations populations at higher risk for injury, death and violence.

As described by National Chief Mathew Coon Come to the members of the Pre-Budget Hearing Committee, on October 30, 2001: "Whatever social indicator you examine – poverty, unemployment, crime, incarceration, suicide, addiction, illiteracy – First Nation's rates are higher than Canadian rates generally. The root

cause is that Aboriginal people for more than a century have tried to maintain their own land base and derive a decent living from the national resources and revenues on their traditional territories, but these aspirations have been frustrated. Reserves and community lands have shrunk drastically in size over the past century and have been stripped of their most valuable resources. Moreover, as governments allocated resources and economic opportunities on traditional territories Aboriginal peoples found themselves either excluded or positioned at the back of the line. *It is not difficult to identify the solution.* Aboriginal people need much more territory to become economically, culturally and politically self-sufficient. If they cannot obtain a greater share of the lands and resources in this country *their institutions and self-government will fail*…. Currently *at the margins of Canadian society, they will be pushed to the edge of economic, cultural and political extinction.* The government must act forcefully, generously and swiftly to assure the economic, cultural and political survival of Aboriginal nations."

"*Aboriginal people have limited resources.* Their land and resources were taken from them by settler society and became the basis for the high standard of living enjoyed by *other* Canadians over the years. Only a small proportion of Canada's resource income has come back to Aboriginal people, mostly in the form of transfer payments such as social assistance. *This has never been, and is not now, the choice of Aboriginal people.* They want to free themselves from the destructive burden of welfare and dependency. But to do this they need to have back some of what was taken away. They need land and they need resources…. *Our objective is self-sufficiency. "*

According to the November 2001 series *Canada's Apartheid* in the *Toronto Globe and Mail*, the sad state of Native communities is *hardly a secret*. The lack of will on the part of Canadians to deal with their *most enduring crisis* is compounded even more greatly with the tragic events of September 11, 2001. "If Canada is to say to Afghans or Americans, Palestinians or Israelis, Indians or Pakistanis, that we believe humans of different faiths, languages and skin colour can live together in peace, *then we have to understand why this is not the case in our own country."*

Despite improvements in efforts to address the crisis of injury, death and disability in First Nations communities, First Nations people continue to have poorer health and social status than the general Canadian population. To improve this situation, First Nation cultural beliefs, values and traditional views must be taken into account so that injury control solutions are flexible in design and in terms of program and service delivery. First Nation communities must be *empowered* to identify and address their own needs through capacity building, partnerships, technical support, and health and safety promotion so that solutions will be *relevant and appropriate.*

Conclusion

On December 6, 2000 in a post election speech Prime Minister Jean Chretien told more than 2,000 party faithful that "*too many Aboriginal Canadians live in third world conditions. And as a Liberal that he deeply believes the government has responsibility to promote social justice*." As Prime Minister he stated, he is "*committed to carry out that responsibility*." Given this commitment we are duty bound to do the following to ensure the health, safety and *survival* of First Nation communities:

- National data gathering is required to be able to track injuries and *at risk* populations. First Nations leadership must make a clear position statement to government based on the problems identified through this activity so that the crisis in First Nations communities and the injury and deaths caused by poverty and social conditions are documented;

- Promotion of a coordinated and integrated First Nations approach to injury control and prevention in the form of a national strategy must be developed immediately and *endorsed by First Nations leaders*;

- Heightened awareness to enable First Nation communities to better understand that injuries are *preventable* is required through an information campaign to bring attention to this dire situation. *Community education* is also required as a preventative measure for the control of future injuries, death and disability through improved health and safety standards in First Nation communities;

- The cost to government for *inaction* must be correlated to the savings for immediate and long-term injury control intervention re: the cost for the maintenance of an injured or disabled person over their lifetime.

- Adequate and sustainable resourcing of First Nation injury prevention and control programs along with research to support and identify models and programs that work is also required.

POPULATION PROJECTIONS 1991-2015
For First Nation Populations – A Demographic Profile

Canada's registered *Indian* population is projected to grow by approximately 379,000 persons within the next 25 years, from 511,000 in 1990 to 890,000, plus or minus 44,000 to 66,000 by 2015, depending on the growth scenario considered.

In 1990, the registered *Indian* population comprised 1.9% of Canada's total population; by 2015 this population would increase to 2.7%

The youth population (aged 0-17) would increase from 204,000 in 1990 to 277,000 in 2015.

The working age population (18-64) would double from 286,000 in 1990 to 666,000 in 2015.

Of the projected 890,000 *Indians* in 2015, some 484,000 will live on-reserve (54%) and about 406,000 off-reserve (46%), assuming the continuation of the recent slow decline in the on-reserve population (Statistics Canada 1993:1).

Canada's registered *Indian* population grew substantially during the last decade. The growth rate was almost five times that of the Canadian population. (Statistics Canada 1993:1).

The age distribution illustrates the case of a young demographic structure with a large proportion of children and a small proportion of elderly persons. Young people (age 0-17) make up about 40% of the *Indian* population while the labor force age group (age 18-64) accounted for 56% and the elderly (age 65+), only 4%.

Population growth projections are essential in the planning and policy development of government and First Nations for the next foreseeable future given the above described trends.

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