CONDENSED VERSION

QUEBEC FIRST NATIONS HEALTH AND SOCIAL SERVICES 2007 17 BLUEPRINT

Closing the gaps... *Accelerating change*

FIRST NATIONS OF QUEBEC AND LABRADOR
HEALTH AND SOCIAL SERVICES COMMISSION

NOTE TO THE READER

The summary presentation of the Quebec First Nations Health and Social Services Blueprint was developed to offer the reader a condensed version of the Blueprint that completely respects the meaning, structure and order of the chapters.

However, the reader is more than welcome to refer to the Blueprint to obtain more detailed information on the various issues. To that end, page numbers referring to the Blueprint are included throughout the summary presentation.

The complete Blueprint document is available electronically through the First Nations of Quebec and Labrador Health and Social Services Commission and is also available on the organisation's web site located at www.cssspnql.com.

CONDENSED SUMMARY

PRESENTATION

Introduction – See p. 7

STATEMENT

In comparison with the rest of the population of Quebec and, more broadly, the population of Canada, Quebec First Nations lag far behind in terms of health and quality of life. Disparities appear in virtually all the areas of health and social development. Worse, certain disparities are widening instead of contracting.

A Quebec First Nations individual, in comparison with the rest of the population of Canada as of today:

- has a shorter life expectancy (6 to 7 years);
- is four times more likely to lack access to health care and social services;
- is two to three times more likely to suffer from obesity and being overweight;
- is two to three times more likely to suffer from diabetes and eight to ten times more likely to have tuberculosis;
- is three to five times more likely to experience poverty, maltreatment and placement in foster families at a young age;
- is five times more likely to commit suicide.

ACTION

This Blueprint was developed to address these glaring disparities and to accelerate structural change with the support of the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and the close collaboration of the communities and authorities concerned. It is based on several consultation and validation efforts that included recognized health and social services experts, First Nations communities and other parties involved in the delivery of health care and social services, both within and outside communities, as well as from the input of regional organizations of the Assembly of First Nations of Quebec and Labrador (AFNQL).

Given the magnitude of the challenges at hand, this Blueprint sets out a ten-year operating framework, from 2007 to 2017. In order to achieve consensus among First Nations communities and other stakeholders, it is based on carefully defined strategic choices and guiding principles, as described in Chapter 1.

CHAPTER 1 – BLUEPRINT DEVELOPMENT

A global vision based on guiding principles – See p. 9

The development process for the Blueprint follows on commitments by various government authorities in recent years. First Nations also hope that the promises and announcements made during the various forums and political meetings on improving health and quality of life, translate into concrete measures, resolute action and appropriate funding in accordance with expressed needs and priorities.

The disparities that characterize the collective state of health and well-being of First Nations, comparatively to the health and well-being of Quebecers and Canadians, are the result of a centralized decision-making process and unilateral governance on behalf of governments.
The governance paradigms and processes that led to the current situation must be rethought and reconfigured.

The vision mapped out in the Blueprint is based on:

- a global approach, as First Nations consider health from a holistic standpoint that encompasses the physical, mental, spiritual, emotional, economic, environmental and cultural well-being of the individuals, families and communities;
- values stemming from the ethnic and cultural heritage of First Nations, taking into account each community's specificity;
- the requirement for meaningful public investment in health care and social services;
- a respectful partnership between governments, First Nations authorities and organisations, and service providers;
- the acknowledgement of First Nations capacity to define and implement the health and social services system that meets their needs.

CHAPTER 2 – GOVERNANCE STRATEGY

A renewed approach to governance fostering self-determination – See p.17

STATEMENT

UNILATERAL GOVERNANCE

The First Nations of Quebec have access to a health care and social services system that is managed on a multi-jurisdictional basis involving several levels of government and various decision-making authorities outside the First Nations.

This governance is based on a vertical "top down" approach that does not recognize the self-determination rights of First Nations to make strategic, organizational and operational choices regarding the health care and social services that are available to them. The system is not always aware of the needs, values and realities facing First Nations recipients.

DEFICIENCIES

This type of governance results in several dysfunctions and deficiencies, which have significant consequences, especially for poorer communities.

- Non-guaranteed universal health care;
- Reluctance to involve communities in decision-making;
- Grey areas in services;
- Effectiveness of many programs reduced by the multiplication of procedures;
- Current health care funding based either on a per capita allocation of funds, or on selection of projects;
- Supplementary administrative management costs, which are charged to the First Nations health care budgets;
- Lack of consultation with First Nations authorities;
- Altered First Nations confidence and empowerment;
- Insufficient transparency and accountability from governments to First Nations people.

UNDER-FUNDING

Furthermore, the inadequacy and unpredictability of funding jeopardizes the health of First Nations even further. The population and health care needs of First Nations communities increased by 10% while their health care budget increased by only 2 to 3%.

ACTIONS

Develop **SELF-DÉTERMINATION**: First Nations to be considered with respect and as full partners must recover their right to oversee and make decisions in the decision-making process that controls program design, development, implementation and assessment.

Examples *(See p. 24)*: Establish collaboration and consultation mechanisms between communities and governments; support local initiatives; obtain a seat for First Nations on the boards of directors of provincial health agencies concerned; etc.

Increase public **FUNDING** in order to achieve parity in terms of health.

Examples *(See p. 25)*: increase funding in order to compensate for differences in budgets, to reflect the increase in health care system costs, and to provide the additional funding required in order to achieve parity; conduct rigorous studies on current and future investments; establish a dedicated Quebec First Nations health and social development monitoring body in order to observe evolving trends; undertake the comprehensive mapping of the programs; relax program criteria and facilitate program reorientation and funding reallocation; etc.

Bet on **INNOVATION** in the delivery of health care and social services: foster the use of research and development and of new technologies in order to provide better access to services and a better knowledge of the environment.

Examples *(See p. 26)*: reinforce continuous training as well as the transfer of expertise; share information and support the adoption of new knowledge and best practices through communications technologies; decompartmentalize programs; etc.

Promote a **HOLISTIC APPROACH**: accommodate physical health and social, emotional, spiritual, cultural and environmental well-being; accommodate traditional medicine and modern medicine; integrate demographic, geographic, sociological and economic specificities of the communities.

Examples *(See p. 26)*: clarify areas of jurisdiction in order to eliminate existing grey areas; broaden the mandate of health centres to include both curative and preventive care; adapt service offerings to meet expressed community needs; etc.

Fostering the **INTEGRATION** and **ADAPTATION OF SERVICES** with regard to specificities (distance, priorities and complementarities).

Examples *(See p. 26)*: simplify communication protocols and procedures; train and recruit more First Nations professionals and managers; subsidize the timely and temporary use of human resources to simplify and reduce the workload of managers and personnel who are frequently over worked; etc.

Optimize the programs: ensure the credibility of the **ACCOUNTABILITY** process and strengthen the program **ASSESSMENT** mechanisms.

Examples *(See p. 26 and 27)*: implement mechanisms that ensure access to information on health care programs; establish a Council of First Nations health care and social services experts to monitor progress on an annual basis; assess on a regular basis the results and effects of health care and social services programs; follow-up on recommendations from evaluations and accountability reports; etc.

Change the public **DISCOURSE** and discuss in terms of health investments rather than health expenditures that must be reduced at all costs. Human health is a key determinant of wealth creation and progress of collective well-being. On the other hand, illness generates huge social costs and results in significant lost revenues for society. *(See p.23)*

CHAPTER 3 – HEALTH STRATEGY

Accessible, targeted and comprehensive health care – See p. 29

STATEMENT

The disparity in life expectancy at birth between First Nations and that of the Canadian general population remains a major concern: 76 years for men and 81 years for women in the Canadian general population, compared to only 69 and 77 for First Nations men and women respectively.
(See data at the end)

Following the analysis of the available data and consultations with First Nations health and social services experts and community representatives, certain **HEALTH PROBLEMS** have been targeted as priorities:

- Obesity and being overweight,
- Diabetes,
- Smoking,
- Children's health: infant mortality, early childhood medical follow-up, parenting skills, breastfeeding, teen pregnancies, Foetal Alcohol Spectrum Disorder (FASD),
- Injuries,
- Sexually Transmitted and Blood-Borne Infections (STBI): HIV-Aids and Hepatitis C,
- Access and follow-up issues in terms of health care and services: conventional health care, maternal and child health care, Non-Insured Health Benefits (NIHB), traditional health care, telehealth.

ACTIONS

Focussing on **CHILD HEALTH**, a major issue on all human, social, cultural, political, spiritual and economic levels.

Examples *(See p. 36)*: develop prenatal and postnatal services to be offered in all communities; ensure long-term follow-up of children; provide support for teen parents; develop an early screening program for children with special needs and institute specialized programs and services close to communities; etc.

Take action against obesity, diabetes and other **CHRONIC DISEASES**.

Examples *(See p. 37)*: promote and facilitate the adoption of a healthy lifestyle, physical activity and healthy eating; develop partnerships to facilitate access to healthy food; develop food co-operatives, food banks and collective kitchens in the community; etc.

Improve **ACCESS** to health care.

Examples *(See p. 37 and 38)*: map out the services in the communities and identify the disparities; fill in the missing services at the community level; accelerate implementation of the new maternal and child health care program; transfer management of the Non-Insured Health Benefits Program (NIHB); promote and facilitate access to traditional health care; etc.

Build on health **PREVENTION** and **PROMOTION**.

Examples *(See p. 38 and 39)*: prevent in order to reduce demands for curative care; develop strategic actions oriented towards health promotion identified in the Ottawa Charter; develop a cohesive approach; develop methods to overcome the many obstacles to screening; strengthen relationships of trust between the services and the population; etc.

Upgrade **INFRASTRUCTURES** and invest in **NEW TECHNOLOGIES**.

Examples *(See p. 39)*: renew the health infrastructures; invest in capacity building; develop Telehealth and Electronic Health; initiate monitoring mechanisms through useful technologies and know-how; etc.

EXAMPLES OF LOCAL INITIATIVES

- Healthy cooking course in Betsiamites – *See p. 40*
- Wigobisan, an organisation for the prevention of child sexual and physical abuse in Lac Simon – *See p. 41*

CHAPTER 4 – SOCIAL SERVICES STRATEGY

Innovative, accessible and sustainable social services – See p. 43

STATEMENT

Access to quality social services strongly influences the health status and quality of life of individuals and communities. Due to the large number of factors influencing the psychological, emotional and social health of First Nations, a comprehensive approach that includes prevention and intervention in this regard is essential.

Nowadays, Quebec First Nations are experiencing head-on the resurgence of many **SOCIAL PROBLEMS** that jeopardize the most vulnerable social categories and sometimes whole communities:

- Suicide,
- Psychological distress,
- Alcohol, drug, medications and gambling addictions,
- Child placements,
- Violence,
- Crime,
- Mental health.

In order to better understand these social problems, many **RISK FACTORS** must be taken into consideration:

- Notably material and social poverty,
- Child neglect and mistreatment,
- Loss of identity and culture,
- Overcrowded housing,
- The Aboriginal residential schools experience,
- Racism,
- Loss of community autonomy,
- Lack of future opportunities.

(See data at the end)

ACTIONS

Several concrete structuring measures must be implemented into the communities. The programs and services must offer a holistic approach and receive long-term support through recurrent, adapted and flexible funding.

Develop and diversify social **SERVICES**.

- Conduct an exhaustive analytical assessment of all the needs and means available in social care;
- Build on prevention and the promotion of life, as essential levers for curbing social issues;

- Fill in the missing links and provide a continuum of social services;
- Incorporate social services at the community level.

Examples *(See p. 50)*: provide a complete range of services in the communities in order to counteract all the addiction issues; encourage multidisciplinary teamwork; etc.

Intensify and adapt **CHILD** development activities: it is not only a moral and human imperative; it is also cost-effective from social and economic perspectives.

- Align the First Nations Head Start on Reserve Program (FNHSOR) more closely to the needs of the communities;
- Create a First Nations entity to be responsible for child placement;
- Adapt and integrate services targeting early childhood;
- Invest in developing parenting skills.

Examples *(See p.51)*: hire staff and provide them with ongoing training in order to achieve and implement the FNHSOR objectives; adapt the provincial educational program to early childhood; create aid and mutual assistance resources for parents struggling with problems that hamper their parenting skills;

Improve the accessibility of **FIRST-LINE SOCIAL SERVICES WORKERS** within and outside of the community.

- Reinforce human resources trained in psychosocial prevention and intervention;
- Create multidisciplinary teams;
- Create synergies between the interveners concerned;
- Offer a complete range of social services in the Native Friendship Centres.

Examples *(See p. 52)*: motivate and encourage the interveners; create health and social services training programs for informal caregivers; develop a dynamic of support for colleagues between interveners; etc.

Improve services provided to the most **VULNERABLE POPULATIONS** (persons living with HIV, women who are victims of violence, homeless people or persons suffering from addictions).

- Implement services within and outside of communities;
- Strengthen mental health services: describe the deficiencies in service delivery; facilitate access and adapt services; reinforce screening; etc.

Examples *(See p. 53)*: adapt the health and social services based on the needs expressed and taking different forms, such as First Nations youth centres, Family centres, Women's shelters, assistance centres for men, etc.

CHAPTER 5 – STRATEGY REGARDING THE HEALTH DETERMINANTS

Cohesive and concerted action on the determinants of collective health and well-being - See p. 55

The health status of individuals and communities is not determined solely by the quality of delivered care. It is influenced considerably by many other **DETERMINANTS** such as:

- socio-economic status of individuals,
- lifestyle,
- strength of cultural values,
- individual psychosocial status,
- quality of child, parent and family support services,
- quality of the environment (living environment and natural resources),
- health-service organization,
- Self-determination of health care and social services, natural resource and education management systems.

STATEMENT

The precarious nature of First Nations' living standards is confirmed by several **INDICATORS**, which have direct influence on quality of life and status of individuals:

UNEMPLOYMENT: 52% of the First Nations population of labour-force age is currently unemployed;

- **POVERTY**: almost 60% of adults have an annual income of less than $20,000;
- **EDUCATION**: 49% of adults have not completed high school;
- Use of **ANCESTRAL LANGUAGES**: this vehicle for all social values and cornerstone of Native cultures and civilizations is in gradual decline;
- **LIFESTYLES**: smoking (35% more First Nations people indulging in this habit than the Canadian populace as a whole), excessive alcohol use (30% more frequent among First Nations than other Quebecers), drug consumption (66% of First Nations youth aged 18 to 24);
- **NUTRITION**: 65% of adolescents base their daily diet only on non-nutritious choices;
- **SEXUAL PRACTICES**: extremely high prevalence rates for genital Chlamydia and Gonococcal infections (up to ten times higher than for Quebec as a whole);
- **RESIDENTIAL INFRASTRUCTURES**: housing shortage trends, exacerbated by a major First Nations population explosion. Much of the housing is too old, cramped or unsafe;
- Access to quality **RUNNING WATER**: one dwelling out of four does not have access to pollutant-free running water;
- **ENVIRONMENT**: environmental degradation has had an even more negative impact on First Nations than on other Quebecers and Canadians.

(See data at the end)

ACTIONS

Eradicate **POVERTY** and **SOCIAL EXCLUSION**.

- Create more employment, income and wealth-creation opportunities in First Nations communities in order to break the cycle of dependency to government income-assistance programs;
- Stimulate public and private investments, to further deploy innovative job-creation initiatives;
- Encourage and promote the development of a social economy, based on innovative organizational forms.

Examples *(See p. 64 and 65)*: create business partnerships; create housing cooperatives, micro-credit systems, foundations; etc.

Renovate and reinforce **RESIDENTIAL AND COLLECTIVE INFRASTRUCTURES**.

- Eliminate the housing deficit and stem its progression by 2012;
- Invest in the collective infrastructures (roads, water network, recreation facilities, etc.).

Examples *(See p. 65 and 66)*: facilitate access to residential construction; address the isolation experienced by numerous communities by constructing a safe and adapted road network; maintain high standards regarding the water-supply; etc.

Enhance **LEARNING** and promote knowledge.

- Reduce the drop-out rate and reward success;
- Introduce new technologies into the education system;
- Equip schools and communities with sufficient sports materials and equipment;
- Promote the development of skills leading to job qualifications.

Examples *(See p. 66 and 67)*: enhance incentives and rewards in order to promote school success; invest in equipment, sports centres and landscaped playgrounds; install the equipment and infrastructures required to connect all communities to high-speed and wireless Internet networks; encourage members to go back to school; etc.

Promote the adoption of **HEALTHY LIFESTYLES**.

Examples *(See p. 67)*: pursue initiatives in the fight against smoking; make the younger generations aware of the harmful effects of an inactive lifestyle; facilitate access to healthy and affordable food; etc.

Promote **CULTURAL IDENTITY**, **EMPOWERMENT** and community **CONTROL OF NATURAL RESOURCES**.

- Protect the cultural identity;
- Promote natural resources development beneficial to First Nations;
- Anticipate climate changes and be proactive.

Examples *(See p. 68)*: reinforce communication and public awareness campaigns concerning First Nations health and living conditions; consult First Nations regarding environmental policy principles; inform First Nations communities about climate changes; develop new renewable energy sources; etc.

EXAMPLE OF AN INSPIRING INITIATIVE

- Wapikoni - a motion picture project in the Innu, Algonquin and Atikamekw communities - *See p. 69*

CHAPTER 6 – STRATEGY REGARDING HUMAN RESOURCES AND RESEARCH & DEVELOPMENT

Adequate human capital supported by research and development – See p. 71)

Currently, First Nations are experiencing a serious lack of human resources and research institutions able to meet the challenge of improving community health and quality of life from within. Meeting the health challenges involved requires highly skilled human capital.

STATEMENT

- Shortage of First Nations health professionals: one in every two individuals prefers to consult and be treated by First Nations care providers; several deprive themselves of the health care and social services required;
- Worrisome levels of education and drop-out rates: barriers to the training of new First Nations professionals;
- Lack of training in health care: because of the lack of First Nations professionals, First Nations health program planning and development continue to be the almost exclusive prerogative of the federal and provincial authorities, who seem insufficiently concerned with the need for First Nations health education and training;
- High turnover rate of health care professionals;
- Problems concerning the statistical data production to inform decision-making on the First Nations health and social services programs:
  - Producing reductive data,
  - Lack of respect for the FNQLA research protocol (OCAP principles: ownership, control, access and possession): First Nations hesitate to cooperate in data-gathering activities,
  - Not enough specific data in regards to the situation of the Quebec First Nations, in comparison with Canada.
- Deficit in research and development (R&D): roadblock to the production of new knowledge and establishment of related innovations in terms of First Nations health and social services:
  - Funding deficiency,
  - Lack of ethics protocols,
  - No structures for systematic collection of administrative data at the community level,
  - Not enough knowledge transfers and expertise exchanges with other Aboriginal groups in Canada and elsewhere in the world.

ACTIONS

Train, attract and retain qualified health and social services **HUMAN RESOURCES**:

- Enhance young people's motivation to study;
- Encourage academic success and merit;

- Promote higher learning that leads to careers in the health field;
- Establish incentives to retain health and social services professionals.

Examples *(See p. 77)*: equip all schools with the latest in educational technology (computers, manuals, software, laboratories); promote access to instruction leading to job qualifications; establish academic scholarships and grants; by 2017, train at least 1,000 additional health care and social services professionals from the First Nations of Quebec; implement effective incentives, such as tax credits, tax holidays, financial rewards, etc. to attract and retain health care professionals.

Recognize and promote **CULTURAL COMPETENCE**:

- Adapt health and social services education and training to the needs of the community;
- Increase consultations and encourage initiatives.

Examples *(See p. 77 and 78)*: incorporate cultural competence into curricula for health care professionals and workers who interact with Aboriginal communities; offer paid internships in First Nations communities; in partnership with the college and university milieu, develop evaluative studies on cultural competence in the health field; etc.

Promote **STRATEGIC INTELLIGENCE** and **KNOWLEDGE TRANSFERS**:

- Develop strategic intelligence on health and social services;
- Develop networks of expertise and facilitate knowledge transfers.

Examples *(See p. 78)*: increase the number of cooperative agreements with other First Nations and non-Aboriginal institutions; fund mechanisms facilitating the development of knowledge transfers (Web sites, conferences, etc.); establish mentoring mechanisms; etc.

Enhance informed decision-making through **RESEARCH AND DEVELOPMENT** (R&D).

Examples *(See p. 78 and 79)*: establish R&D structures controlled by and aimed at First Nations; maintain and enhance the First Nations Regional Longitudinal Health Survey *(See text on FNRLHS on p. 80)*; encourage and supervise training for First Nations R&D professionals; etc.

CHAPTER 7 – BLUEPRINT FULFILMENT

Conditions for success, objectives and progress measurement – See p. 83

IMPLEMENTATION

The Quebec First Nations Health and Social Services Blueprint identifies the challenges and strategic choices that will guide the interventions to be carried out in terms of health and social services provided to the First Nations in the ten-year period from 2007 to 2017. Its **IMPLEMENTATION** requires:

- Medium-term strategic planning: a three-year strategic plan is established for the years 2007 to 2010, with planning updates to be made on a tri-annual basis;
- Annual planning to render all future actions and measures operational for each of the coming years;
- Follow-up, assessment and accountability efforts will accompany the implementation of blueprint programs;
- The planning process must be based on an informed, innovative and flexible approach that considers changes, contingencies and leaves room for continuous fine-tuning.

The First Nations and the governments of Quebec and Canada must work together, cooperatively and harmoniously, to attain the blueprint's objectives and outcomes - the blueprint objective being to provide First Nations with a health status and quality of life that is at least equal to those of the Canadian general population.

To facilitate the measurement of progress and improvement to First Nations' health care and social services, the Blueprint sets out specific 2017 targets and outcomes, based on the magnitude of reductions in the disparities, in light of the latest data available (i.e. those from 2007).

These 2017 **TARGETS**, which have been defined in accordance with average rates for Canada as a whole, are as follows:

- To reduce discrepancy in life expectancy by 35%;
- To reduce discrepancy in mortality by 35%;
- To reduce the discrepancy in the suicide rate by 50%;
- To reduce the discrepancy in the infant mortality rate by 50%;
- To reduce the discrepancy in the prevalence of diabetes by 50%;
- To reduce the discrepancy in the prevalence of child obesity by 50%.

Furthermore, another target is to train 1,000 First Nations health and social services professionals and integrate them into the health and social services network by 2017.

FOLLOW-UP

Follow-up of the Blueprint must be ensured by a **COMMITTEE** made up of First Nations health partners in association with elected officials, academics and members of civil society.

This Advisory Board will meet regularly and issue periodic progress reports on First Nations' health, quality of life, and blueprint-related progress. Objective and impartial evidence from this board will help clarify responsibilities and identify solutions with a view to rectifying any potential shortcomings.

In order to measure the progress, more than 70 **INDICATORS** have been suggested, following the strategies and focus areas advocated in the Blueprint.

(See listing p. 88 to 90)

Some examples related to:

Governance

- Federal and provincial government investments in First Nations of Quebec and Labrador health care and social services.
- Number of federal and provincial health and social services agencies with First Nations members on their boards of directors.

Health

- Life expectancy at birth.
- Number of teen pregnancies.
- Diabetes-related mortality rate.

Social services

- Distance to health care centre and hospital.
- Placement of children.
- Suicide attempts.

Health determinants

- Use of First Nations languages and traditional knowledge.
- Number of people with access to potable water.
- Ratio of Employment Insurance recipients.

Human Resources and R-D

- Proportion of First Nations professionals in relation to all health care and social services professionals.
- Number of traditional healers, in and outside the community.
- Efforts to fund research and development for and by First Nations.

CONCLUSION

(See p. 93)

The Blueprint calls on all health and social services stakeholders involved to give the First Nations legitimate authority over their health and choice to live in harmony with their preferences, cultures and identity.

Analyses of the existing situation demonstrate the pressing need for public action. Many challenges must be met, and consistent action must be initiated to rectify the discrepancies and inequities on all fronts and lines of health care and social services delivery. The Blueprint is therefore a historic, all-encompassing call to action *(See p.93)*.

In brief, the Blueprint advocates better governance and banks on improved health status for First Nations and social services. It proposes specific and structuring measures regarding health determinants, development of human capital and means for research and development. It also ensures a progress-tracking framework.

The time has come to close the gaps between the health of First Nations members and that of the Canadian populace as a whole. The vitality of the First Nations will contribute to the wealth and prosperity of all society.

We are determined to work together over the next ten years and, through motivated action, establish communication to rally all parties and obtain firm commitments to make the objectives set out in the Blueprint a reality.

DATA

HEALTH INDICATORS	Quebec First Nations[6]			Canada and/or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a/b
Overweight	41.2%	32.2%	36.9%	33%	1.12
Obesity	27.7%	32.7%	30.1%	14%	2.15
Diabetics	12.5%	16.4%	14.5%	4.1%	3.5
Arthritis	15.1%	21.9%	18.4%	14%	1.3
Allergies	15.2%	22.0%	18.6%	9.1%	2
Hypertension	12.9%	17.0%	14.9%[7]	8.5%	1.75
Asthma	7.3%	12.2%	9.7%	5.6%	1.7
Physical injuries (previous year)	N/A	N/A	22.0%	11.3%	1.94
Dental caries in children	N/A	N/A	14.8%[8]	7%	2.1
Encountered obstacles to health care	N/A	N/A	46.5%	12.5%	3.72

INDICATORS OF WELL-BEING and SOCIAL PROBLEMS	Quebec First Nations[I]			Canada and\or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a\b
Has attempted suicide during lifetime	13.1%	18.5%	18.4%	3.5%	5.25
Has attempted suicide in the past 12 months			1.2%	0.5%[II]	2.4
Suicidal ideation during lifetime			39.0%	N/D	N/D
Suicidal ideation in the past 12 months			4.5%	3.9%	1.15
Secondary education not completed			49.0%	31.0%	1.58
Post-secondary education completed (BA or higher)			6.1%	19.3%	0.31
Heavy alcohol use (5 or + drinks – once/week			43.3%	29.8%	1.5
Heavy alcohol use (5 or + drinks – 5 times / 12 months)			70.2%	23.2%	0.31
Use of drugs or non-prescription medications in the past 12 months			65.8%	20%	3.29

HEALTH DETERMINANTS	Quebec First Nations[III]			Canada and\or Quebec	Disparity Ratio
Lifestyle	Men	Women	Total (a)	Population (b)	a\b
Smoking: daily or occasionally tobacco use	53.9%	56.1%	55.0%	20%	2.75
Traditional medicine use	37.5 %	39%	38.3%[IV]	N/A	
Breastfeeding	N/A		38.7%	80%	0.48
Physical activity (equivalent to 30 min. a day/6 days a week)	53.6%[V]	37.3%[VI]	45.5%	37%	1.23
Consumption of non-nutritional food by adolescents at least once per day			57.8 – 65.2%	17% – 22%[VII]	2.96

[6] The data in these columns refers only to adults, unless otherwise indicated. The data is from the Report on First Nations living in FNLRHS communities in the Quebec region, 2002-2003 (FNQLHSSC 2006), except where otherwise indicated.
[7] Only general cardio-vascular problems are documented for FN in FNQLHSSC 2006
[8] Baby bottle syndrome

DEMOGRAPHICS	Quebec First Nations[III]			Canada and\or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a\b
Life expectancy at birth	70.4	75.5[VIII]		77.7 H et 82.2F[IX]	0.9H et 0.92F
Birth rate			23.4/1000	10.3/1000	2.33
Infant mortality rate			6. 4/1000	5.4/1000	1.18
Median age (years)			24.7	37.1	0.66

DEMOGRAPHICS and SOCIAL PROBLEMS	Quebec First Nations[III]			Canada and\or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a\b
Family with at least 2 children under 18 years (%)	N/A	N/A	41.0%	23%	2
Annual household income < $20,000	N/A	N/A	24.3%	11%	2.21
Annual personal income < $20,000[X]	55.2%	65.5%	60.3%	51%	1.18
Receive government assistance[XI]	60.3%	80.9%	72.2%[XII]	13%	5.5
Child living below poverty line			25%[XIII]	10%	2.5
Indicator of collective well-being	0.71	0.74	0.72	0.89	0.8
Employment Assistance recipients	24.3%	16.1%	20.2%[XIV]	9.6%[XV]	2.1
% of individuals gainfully employed	51.1%	47.0%	49.0%[XVI]	61.1%[XVII]	0.80
Single-parent families			43.7%[XVIII]	20.5%[XIX]	2.13
Proportion of senior citizen living alone (aged 65-74)			33.2%[XX]	24.9%[XXI]	1.33

I The data in these columns refer only to adults, unless otherwise indicated.
The data is from the Report on First Nations living in FNLRHS communities in the Quebec region, 2002-2003 (FNQLHSSC 2006), except where otherwise indicated.

II In those 15 years and older, 1998, in Quebec.
http://www.inspq.qc.ca/pdf/publications/283-FeuilletEpidemioSuicide.pdf

III The data in these columns represent only adults, except when indicated.
The data was taken from the Report on First Nations Living in Communities of FNQLRHS 2002-03, Quebec region (FNQLHSSC 2006), except when indicated.

IV This data relate to children.

V Special compilation of data contained in FNQLRHS 2002-03 (unpublished). FNQLHSSC 2007.

VI Special compilation of data contained in FNQLRHS 2002-03 (unpublished). FNQLHSSC 2007.

VII http://www.stat.gouv.qc.ca/publications/sante/pdf2004/enq_nutrition04c7.pdf

VIII Both figures have been taken from: http://www.tbs-sct.gc.ca/report/govrev/05/ann304_f.asp
Data is valid for 2001, for First Nations throughout Canada.

IX Both figures have been taken from: http://www.tbs-sct.gc.ca/report/govrev/05/ann304_f.asp

X First Nations figures come from a special compilation of data contained in ERSPNQL 2002-03 (unpublished). CSSSPNQL 2007

XI First Nations figures come from a special compilation of data contained in ERSPNQL 2002-03 (unpublished). CSSSPNQL 2007

XII Revised figure from FNQLRHS 2002-03, special compilation of data contained in FNQLRHS 2002-03 (unpublished). FNQLHSSC 2007.

XIII http://action.web.ca/home/c2000/alerts.shtml?x=93174&AA_EX_Session=6766226b4e3173e98abb0ea55940c096

XVI In 2001

XV INSPQ, 2001 http://www.inspq.qc.ca/pdf/publications/050_portrait_sante_2001.pdf

XVI In 2001, regardless of length of employment.

XVII http://www.cmquebec.qc.ca/documents/terr_pop/t2.6_copy1.pdf. The rate shown includes those aged 15 to 64; the First Nations rate includes those aged 18 to 54.

XVIII Special compilation of data contained in FNQLRHS 2002-03 (unpublished). FNQLHSSC 2007 (proportion of households with only one and at least one child 17 years or under).

XIX INSPQ, 2001 http://www.inspq.qc.ca/pdf/publications/050_portrait_sante_2001.pdf

XX Special compilation of data contained in FNQLRHS 2002-03 (unpublished). FNQLHSSC 2007. 55 years and over.

XXI INSPQ, 2001 http://www.inspq.qc.ca/pdf/publications/050_portrait_sante_2001.pdf

FIRST NATIONS OF QUEBEC AND LABRADOR
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