Community / Regional Portrait *of the* Situation in terms of Maternal Child Heath (MCH)

FIRST NATIONS OF QUEBEC AND LABRADOR
HEALTH AND SOCIAL SERVICES COMMISSION

The FNQLHSSC would like to thank community interveners who have collaborated in this project.

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1.1 Context

1.1.1 The Maternal and Child Health Care

Very little data is available regarding maternal and child health among the First Nations of Quebec.

However, in the 2007-2017 First Nations of Quebec Health and Social Services Blueprint, developed by the FNQLHSSC, it is stated that "Access to quality maternal and child health services remains weak, and in some cases, differs greatly from one community to the next. The lack of resources, correlated to the distance of care services, prevents pregnant women and newborn babies from having access to all of the health and social services that are vital to their health. Many mothers, living in material instability, are in need of a more personalised and constant follow-up, which is impossible to obtain in many First Nations communities." (FNQLHSSC, 2007).

Furthermore, in 2005, participative action-research was carried out by the Ajunnginiq Centre and the National Aboriginal Health Organisation (NAHO) that is entitled "Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment." This research project aimed to understand the experiences and the opinions of the First Nations and Inuit women as well as those of the maternal care professionals. The objective was to identify the problems, priorities, best practices and formulate proposals that are likely to improve maternity services in the First Nations and Inuit communities (Ajunnginiq Centre and First Nations Centre, 2005: 6).

Regarding the First Nations of Quebec, their observations indicated that:

- "the participants indicated that the availability or accessibility, the level and the quality of the maternity services provided to First Nations women vary according to the geographical situation;
- The knowledge of the maternity programs and services varies between the members of the focus group;
- The participants believe that it is necessary to benefit from better information and an improved coordination of the programs and services;
- Most of the participants have experienced, in some shape or form, cultural biases on behalf of health interveners during the maternity experience;
- The participants perceive the need to provide a certain form of cultural orientation to the medical personnel who provide maternity services to First Nations women. They also perceive the need to implement programs and services that integrate and revive the traditional and cultural practices;
- The participants do not perceive the maternity services as an element that is separate from community life and perceive the need to integrate First Nations philosophies into maternity services." (2005: 97).

In addition, it seems “that there were a great number of options available in terms of maternity services for the First Nations women who lived in a community that is close to an urban centre”, that “few First Nations women can consider having received fully satisfying services”, that they “have few labour options” and that “few women have access to maternity services that are respectful of First Nations cultures and traditions.”(2005: 97-98).

This research project identified certain shortcomings regarding maternal and child health:

- “the lack of options for community maternity and labour services at home / in the community;
- The lack of Aboriginal care providers and maternity care providers who have received cultural training (non-Aboriginals);
- The lack of continuity in the maternity care and services;
- The lack of emotional and mental support, particularly regarding post-partum depression;
- The incapacity and lack of possibility to make informed decisions regarding pregnancy and labour because of the virtual absence of community services, programs and installations for maternity and birth care;
- The absence of programs and services to support the parents and the families, especially regarding the intergenerational effect of the Indian residential schools and the resulting post-traumatic stress;
- The failing to integrate the traditional and cultural practices into the delivery of maternity services because of the predominance of the western medicine model;
- The absence of shelters for women in crisis situations;
- Too much bureaucracy;
- Funding that is based on proposals for postnatal services (uncertainty regarding the funding programs);
- The absence of dental care for the young children;
- The lack of continuity with respect to the required gynaecological care and information (such as for cervical cancer);
- The shortage of support tools required for the women who suffer the loss of a baby following a miscarriage or after giving birth (at the hospital and after release – including the self-help groups);
- The need for milk reserves.” (2005: 98).

Finally, the observations of this research indicate that the respondents were also “concerned with the quality and the lack of uniformity with respect to the services.” (2005: 98).

1.1.2 The Maternal Child Health Program

In response to the identified shortcomings, Health Canada decided to implement a Maternal Child Health Program (MCH).

The long-term objectives of the MCH Program are as follows:

- “build upon the current funding bases in order to develop a process that is more global and integrated in relation to the MCH services that are provided in the reserves;

- Develop programs and services that are intended for the residents of the First Nations communities that are comparable to those that are provided by the provinces and territories to the Canadian families and their children;
- Determine the possibilities to ensure that the safe labour options are increasingly accessible to the First Nations communities."
  (http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/2007_compendium/1_comm_prog_f.html, consulted on April 18, 2008).

The short-term goal of the MCH Program is "to improve outcomes in terms of maternal and child health, as well as the health of the children and families in the targeted communities in all of Canada." The short-term objectives include the following aspects:

- "increase the First Nations training opportunities that are intended for the MCH service providers;
- Improve the participation of the community members in the planning and implementation of the MCH services in the reserves;
- Intensify the coordination of the services provided to pregnant women and families that include infants and young children who live in the reserves;
- Enable pregnant women and families that include infants and young children who live in the reserves to have access to a home visit, examination, evaluation and case management system;
- Create evaluation tools, or use existing tools, in order to measure the progress achieved in terms of the fulfilment of short-term objectives;
- Broaden and improve the existing health promotion and disease prevention programs in the framework of the MCH Programs that are provided to the Aboriginal populations that live in the reserves and in the North (CPNP and FASD)" (http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/2007_compendium/1_comm_prog_f.html, consulted on April 18, 2008).

Finally, the elements included in the MCH Program are:

- Home visits;
- Integration of the cultural dimension into the care services;
- Screening and evaluation;
- Case management,
  This includes early intervention, the coordination of services for the families and the delivery of health care that is respectful of cultural differences;
- Health promotion" (http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/2007_compendium/1_comm_prog_f.html, consulted on April 18, 2008).

Therefore, the MCH Program is intended for all the pregnant women and new parents. It also aims to provide long-term support to the families that require supplementary services.

The community health nurses and the family visitors are the health professionals that have been identified in order to provide these services. Furthermore, additional services can be provided by other health and social services professionals, early childhood educators, community volunteers as well as Elders.

According to the Assembly of First Nations (AFN), "the Maternal Child Health (MCH) Programs have proven to be effective in the Canadian and international health systems in terms

of the evolution of the state of health of pregnant women and families that include infants and young children.

Over the course of the past 10 years, the provinces and territories strengthened their MCH programs by increasing home visits on behalf of the nurses and home visitors for their residents, yet these services are often inaccessible for the First Nations families in the reserves. These services are only available off-reserve.

At the meeting of the First Ministers and Aboriginal leaders that took place on September 13, 2004, the Prime Minister announced new investments in the programs in order to improve the health status of the Aboriginal peoples – the MCH Program was one of the programs targeted for the First Nations communities. An amount of $110 Million over 5 years was anticipated.

The framework was developed in collaboration with the Assembly of First Nations" (http://www.afn.ca/article.asp?id=2269, consulted on April 18, 2008).

1.2 Objectives

1.2.1 Vision

The vision of the Maternal Child Health (MCH) Program states that pregnant women and families that include infants or young children that live in a First Nations community must receive support to reach their full potential in terms of development and longevity. This vision will be achieved by offering access to MCH services that are local, integrated and effective and that address the needs of the individuals, families and the community.

1.2.2 General direction

The period between conception and the age of six years is the most important period for cerebral development and is a determining factor regarding the behaviour and health of the child. The effects of the mother's health during pregnancy and the experience lived by the child during the first six years of his/her life have lifelong repercussions. The improvement of knowledge in the area of health before pregnancy and genesic health[1] among youth adults also helps to commence pregnancy in a healthy manner.

The long-term objective of the MCH Program is to ensure that pregnant women and families that include infants or young children have the possibility to reach their full potential in a community environment that is committed to the promotion of health and support for the families. This

[1] According to the WHO, genesic health involves the procreation mechanisms and the functioning of the reproductive system at all stages of life. It implies the possibility to have a responsible, satisfying and safe sexuality as well as the freedom for people to choose to have children if and when they so desire. This conception of genesic health supposes that women and men can choose safe, effective, affordable and acceptable fertility regulation methods, that couples can have access to appropriate health services that allow women to be monitored during their pregnancy and thus provide couples with the chance to have a child who is healthy (http://www.who.int/topics/reproductive_health/fr/, consulted on February 18, 2008).

objective will be reached through the implementation of a maternal and child health care system that is complete and effective. By strengthening the individuals, family-based and community-based capacities, the long-term benefits for health and the ensuing reduction of needs in terms of intensive services that are focused on treatment will have deep, positive impacts for the future generations.

1.2.3 Objectives of this process

In order to establish the community/regional portrait of Maternal Child Health (MCH) in the First Nations of Quebec communities, the FNQLHSSC intended to collect and analyse the most recent data on the subject.

Having come to the conclusion that the information on the subject was either missing or incomplete, the FNQLHSSC team decided to develop a questionnaire in order to gather relevant data on the issue.

This data collection enabled the FNQLHSSC to draft a report of the situation, demonstrating the resources and services that are already available. This report will enable the various partners to implement a maternal and child health program that addresses the needs of the communities and is adapted to the reality of the First Nations of Quebec.

1.3 Methodology

1.3.1 Questionnaire

In February 2008, a questionnaire was developed in order to collect data on the situation in terms of maternal and child health in the First Nations of Quebec communities.

The questionnaire was divided into seven (7) sections: the description of services, the human resources and other interveners, access to resources, the communications network, the clientele description, the community description and the identification of the respondent.

It was intended for the health professionals who work with families that include children between the ages of 0 to 6 years in the First Nations of Quebec communities. Those who occupied the following positions had the opportunity to fill out the questionnaire:

- Health and social services director;
- Community health or perinatality nurse;
- Family visitor;
- All others who are involved in maternal and child health.

Moreover, the questionnaire could be filled out alone or in a group.

The confidentiality of the information was protected. It was specified that only the statistics and general tendencies would be used. The report was therefore drafted in such a way as to ensure

that the respondents could not be identified. However, as stated in the contribution agreement, a copy of the completed questionnaires will be shared with Health Canada.

Once completed, the questionnaire was translated in order to make it available in both official languages – French and English (Annexe 2). Then, it was forwarded to all of the First Nations of Quebec communities, excluding the agreement communities, for a total of thirty (30) communities.

1.3.2 Population and final sampling

In order to obtain a portrait that is as accurate as possible, the invitation was sent out to all of the First Nations of Quebec communities, with the exception of the agreement communities, for a total of thirty (30) communities.

The final sampling is presented in figure A. In total 26 communities filled out the questionnaire.

Figure A: Final sampling

Nation	Communities invited to participate	Communities that filled out and returned the questionnaire
Abenakis	Odanak	
	Wôlinak	√
Algonquins	Lac Rapide / Barriere Lake	√
	Eagle Village - Kipawa	√
	Kitcisakik	√
	Kitigan Zibi	√
	Lac Simon	√
	Pikogan	√
	Wolf Lake	√
	Timiskaming	√
	Winneway / Long Point	√
Atikamekw	Manawan	√
	Opitciwan	√
	Wemotaci	
Hurons / Wendat	Wendake	√
Innus	Betsiamites	√
	Ekuanitshit / Mingan	√
	Essipit	√
	Mashteuiatsh	√
	Matimekush-Lac-John	√
	Natashquan	√
	Pakua Shipi	√
	Uashat mak Mani-Utenam	√
	La Romaine / Unamen Shipu	√
Malecites	Viger	√
Mi'gmaqs	Gespeg	Do not receive funding

Nation	Communities invited to participate	Communities that filled out and returned the questionnaire
	Gesgapegiag	√
	Listuguj	√
Mohawks	Kahnawake	
	Kanesatake	√
Naskapis	Kawawachikamach	
	Total	26

For variable-crossing purposes, the basic data from figure B was used.

Figure B: Basic data of the participating communities[2]

Nation	Community	Geographic zone*[3]	Size (residents)	Language
Abenakis	Wôlinak	1	Small (71)	French
Algonquins	Lac Rapide / Barriere Lake	2	Small (263)	English
	Eagle Village - Kipawa	2	Average (339)	French
	Kitcisakik	1	Average (510)	English
	Kitigan Zibi	2	Average (1496)	English
	Lac Simon	1	Average (1239)	French
	Pikogan	1	Average (554)	French
	Wolf Lake	1	Average (584)	English
	Timiskaming	2	Average (352)	English
	Winneway / Long Point	2	Small (13)	English
Atikamekw	Manawan	2	Large (1973)	French
	Opitciwan	3	Large (1969)	French
Hurons / Wendat	Wendake	1	Average (1307)	French
Innus	Betsiamites	1	Large (2725)	French
	Ekuanitshit / Mingan	1	Small (179)	French
	Essipit	4	Average (947)	French
	Mashteuiatsh	1	Large (2022)	French
	Matimekush-Lac-John	4	Average (730)	French
	Natashquan	2	Average (505)	French
	Pakua Shipi	3	Average (842)	French
	Uashat mak Mani-Utenam	4	Small (295)	French
	La Romaine / Unamen Shipu	1	Large (2824)	French
Malecites	Viger	1	Small (2)	French
Mi'gmaqs	Gesgapegiag	1	Average (554)	English
	Listuguj	1	Large (1917)	English
Mohawks	Kanesatake	1	Average (1341)	English

- Zone 1 - Urban: a zone in which the First Nations community is located at less than 50 km from the closest service centre that is connected to an access road that is open all year long.

[2] The data is taken from the *The Nations* map as well as the document entitled *Indian and Inuit Populations in Quebec as of 2005*, published by Indian and Northern Affairs Canada in 2006.

[3] For an explanation of the zones: INAC, 2005, *Band Classification Manual at* www.ainc-inac.gc.ca/pr/ra/cwb/res1_f.html

- Zone 2 - Rural: a zone in which the First Nations community is located between 50 and 350 km from the closest service centre that is connected to an access road that is open all year long.
- Zone 3 - Isolated: a zone in which the First Nations community is located at more than 350 km from the closest service centre that is connected to an access road that is open all year long.
- Zone 4 – Special access: a zone in which the First Nations community does not have an access road that is connected to a service centre all year long – thereby being subjected to higher transportation costs.

This means that the final sampling is composed of:

Nations	Size	Language	Zone
1 Abenaki	6 small	17 French	14 zone 1
9 Algonquins	14 average	9 English	7 zone 2
2 Atikamekw	6 large		2 zone 3
1 Huron-Wendat			3 zone 4
9 Innus			
1 Malecite			
2 Mi'gmaqs			
1 Mohawk			

1.3.3 Data collection

The thirty (30) questionnaires were sent out by mail at the beginning of March. The respondents had until March 28th in order to fill it out and return it to the FNQLHSSC. However, the forms were returned well beyond this date. The data collections process actually ended in July 2008.

As specified in the contribution agreement with each community, each community had to develop its community profile. A base amount of $10000 was provided to each community for this purpose - the amount could be used to fill out the questionnaire.

Furthermore, in order to facilitate the data collection process, a resource person was made available for the respondents who could contact this resource person at any time during office hours. To complement this, a follow-up process was carried out by the resource person who contacted each community approximately 15 days before sending out the questionnaires. Through this follow-up process the resource person ensured that the process would unfold properly while answering any questions the respondents may have had and encouraging them to return the questionnaire as quickly as possible.

Once the questionnaire was completed, the respondents could return it by fax, email or mail.

1.3.4 Data entry and analysis

Once the data collection process was completed, the data was transferred into an electronic format in order to perform the analysis. The *Statistical Package for Social Sciences* (SPSS) software program was used for this task.

Once the report is completed, the questionnaires will be stored in a secure manner at the FNQLHSSC and then destroyed after a period of five years.

This portrait respects the research protocol that was developed by the Assembly of First Nations of Quebec and Labrador (AFNQL), which emphases the principles of Ownership, Control, Access and Possession (OCAP).

1.3.5 Limitations of the research

Despite all of the efforts deployed in order to minimise the errors and biases that can surface in the framework of a research project – none are exempt from them.

First of all, it is important to specify that this portrait is based on the information provided by the respondents who filled out the questionnaires. This portrait does not pretend to go beyond this scope. Thus, the results presented in this report cannot be representative of all of the First Nations of Quebec communities. Therefore, they cannot be generalized.

These results do however aim to provide a brief portrait of maternal and child health in the First Nations of Quebec communities. This portrait could in the future be enhanced by research projects that are complementary and more intensive – in accordance with the needs.

Then, because of restrictions in terms of time and funding in order to perform this research, the questionnaire was self-administered, meaning that the FNQLHSSC forwarded the questionnaire to the respondents, accompanied by a letter that provided instructions. The respondents filled out the questionnaires on their own, to the best of their ability.

According to Statistics Canada, a self-administered questionnaire is generally less expensive than the other methods of data collection. This method is also useful in research that requires detailed information because the respondent can consult personal files, which can diminish errors in the responses since the respondent does not have to rely solely on his/her memory (Statistics Canada, 2003).

However, still according to Statistics Canada, this type of data collection process requires respondents who have a good understanding of the subject matter, since they must be independent enough to answer the questions on their own. Furthermore, this type of method also generates a lower response rate than the other methods because of the lack of pressure on the participant to fill out the entire questionnaire. The self-administered questionnaire also requires a high level of follow-up among the respondents to ensure quality in the responses as well as respect for the deadlines. Thus, the data collection period tends to be longer (Statistics Canada, 2003).

The repercussions of these facts caused a non-respect for the established deadlines for the data collection and the response rate may have been diminished. These limitations are the constraints that the FNQLHSSC had to work with.

In conclusion, the fact that the respondents were on their own to fill out the questionnaire to the best of their understanding may have caused interpretation biases, errors in responses and a higher rate of non-response.

Second section: Results

Now that the context, objectives and methodology have been described, this second section presents the results that were obtained once the data processing was completed. In order to facilitate tracking, the presentation of the results has been organised in accordance with the same structure as the questionnaire. Therefore, it includes seven sub-sections: description of services, human resources and other interveners, access to resources, communications network, description of the clientele, community description and identification of the respondent.

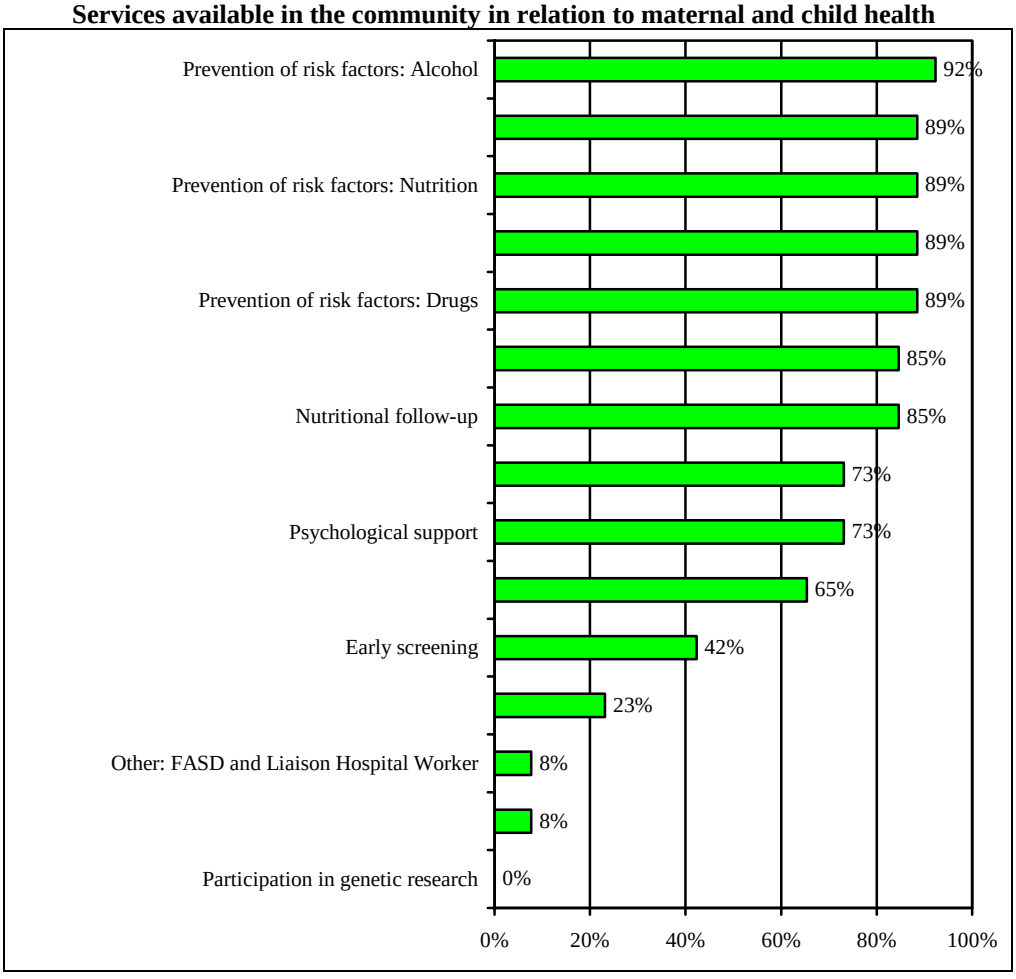
2.1 Description of services

2.1.1 Before the pregnancy

Figure 1 shows that the prevention of the risk factors, namely alcohol, medication, nutrition, tobacco and drugs, is the service that is the most available in the participating communities during the period preceding pregnancy.

On the other hand, support for elders, participation in genetic research and other services are lacking or unavailable in the participating communities.

Figure 1: Services available in the community in relation to maternal and child health



The four following graphs present the services that are available in the communities in accordance with the different variables: nation, size, language and geographic zone. However, it is important to exercise caution when interpreting these graphs because the composition of the different variables differentiate greatly (refer to section 1.3.2 Population and final sampling). These graphs are however intended to provide additional information.

Figure 1.1: Services available in the community before pregnancy by nation

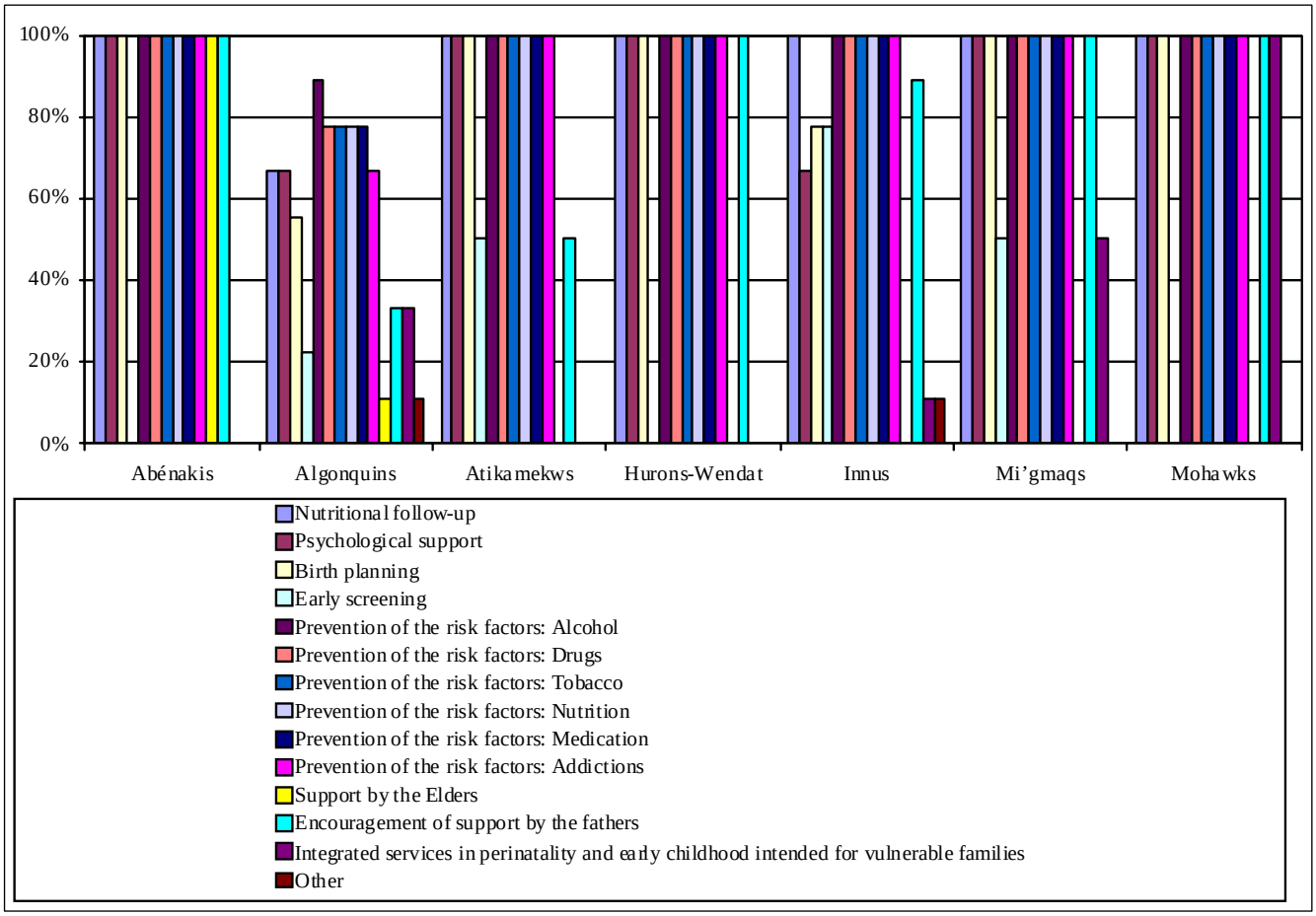


Figure 1.2: Services available in the community before pregnancy in relation to the size of the community

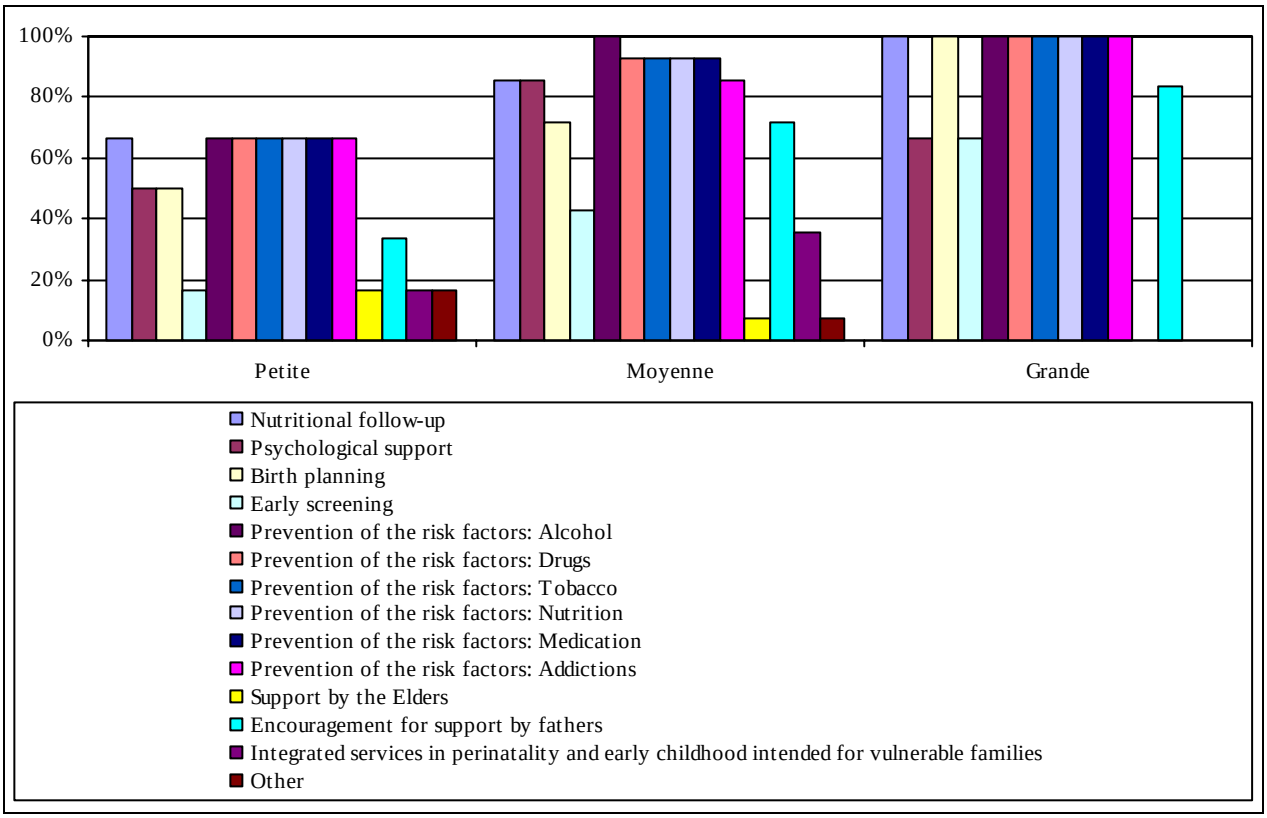


Figure 1.3: Services available in the community before pregnancy in relation to the language

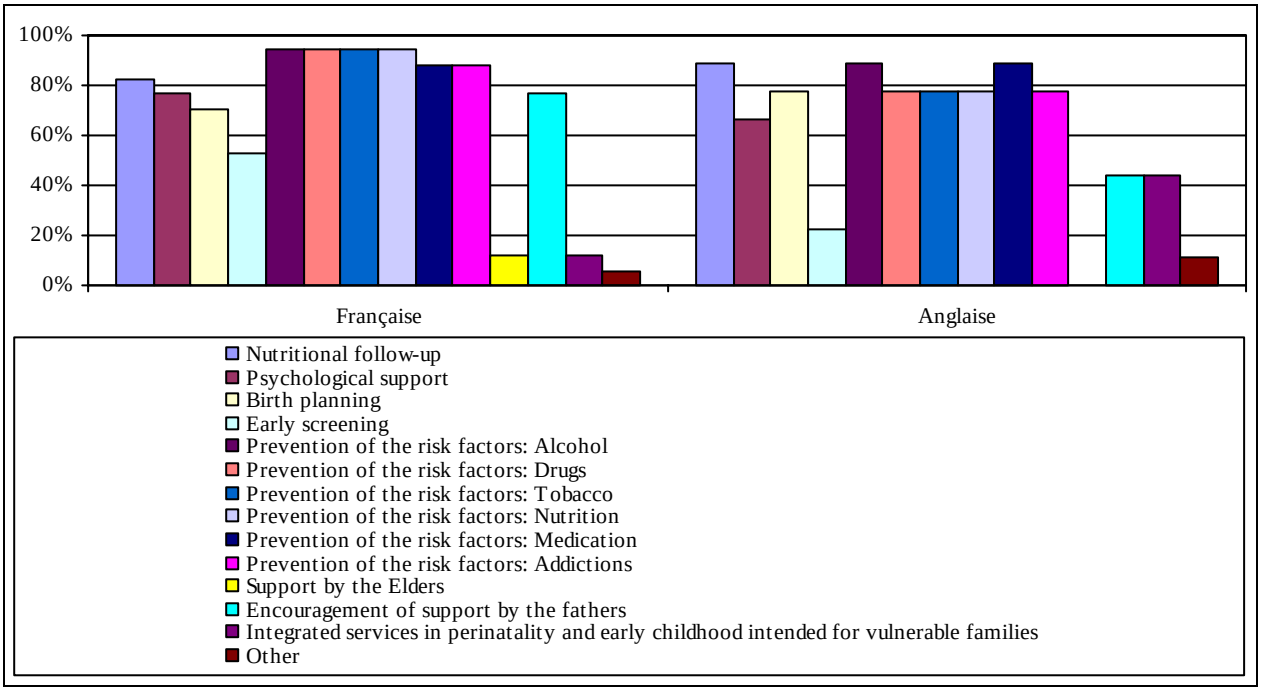
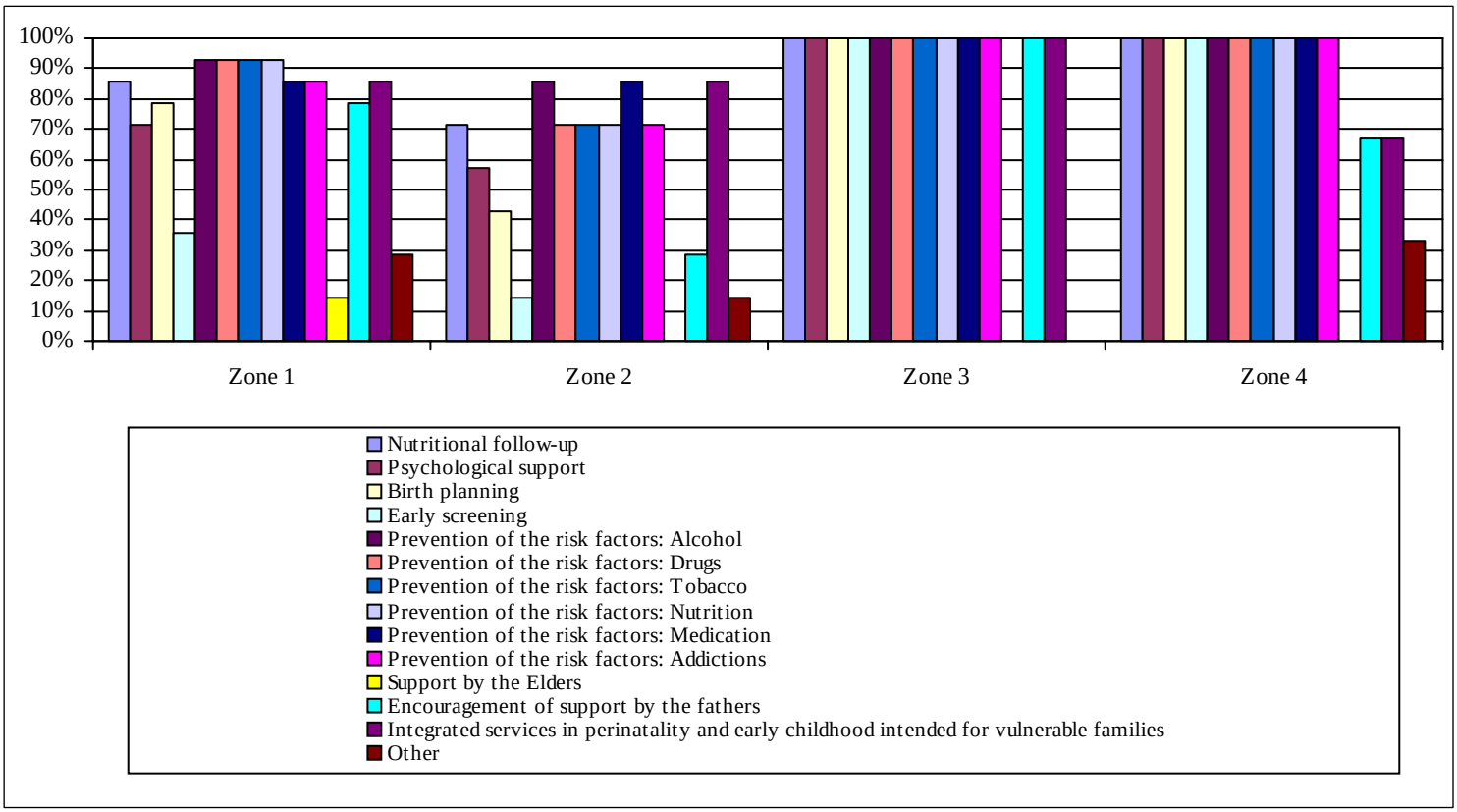


Figure 1.4: Services available in the community before pregnancy in relation with the geographic zone



As for the services, previously mentioned, that are most available, figure 2 illustrates that prevention of the risk factors related to alcohol, medication, nutrition, tobacco and drugs is mainly provided, according to 58% to 62% of the communities, by the nurses.

Figure 2: Interveners who provide the services that are available in the community related to maternal and child health before pregnancy

Services	Physician	Nurse	Family visitor	Psychologist	Social worker	Nutritionist	Other*
Nutritional follow-up	11,5%	53,8%	0,0%	3,8%	3,8%	61,5%	0,0%
Psychological support	3,8%	34,6%	3,8%	50,0%	34,6%	3,8%	0,0%
Birth planning	26,9%	65,4%	3,8%	0,0%	3,8%	0,0%	0,0%
Early screening	19,2%	38,5%	0,0%	0,0%	0,0%	0,0%	3,8%
Prevention of the risk factors: Alcohol	19,2%	57,7%	3,8%	3,8%	15,4%	0,0%	46,2%
Drugs	19,2%	57,7%	3,8%	3,8%	15,4%	0,0%	42,3%
Tobacco	15,4%	57,7%	3,8%	3,8%	7,7%	0,0%	38,5%
Nutrition	11,5%	61,5%	3,8%	0,0%	0,0%	46,2%	26,9%
Medication	26,9%	57,7%	3,8%	3,8%	3,8%	3,8%	46,2%

Services	Physician	Nurse	Family visitor	Psychologist	Social worker	Nutritionist	Other*
Addictions	19,2%	50,0%	3,8%	11,5%	11,5%	0,0%	46,2%
Support by the Elders	0,0%	7,7%	3,8%	3,8%	0,0%	3,8%	3,8%
Fostering involvement on behalf of fathers	3,8%	34,6%	7,7%	11,5%	11,5%	3,8%	11,5%
Participation in genetic research	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%
Integrated services in perinatality and early childhood that are intended for vulnerable families	0,0%	15,4%	0,0%	0,0%	7,7%	0,0%	3,8%
Other: FASD and *Liaison Hospital Worker*	0,0%	3,8%	0,0%	0,0%	0,0%	0,0%	3,8%

Table 2 also shows us that, during pregnancy, 27% of the communities stated that the role of the physicians primarily involves the prevention of the risk factors related to medication and birth planning. As for the nurses, they mainly take care of the birth planning and the prevention of the risk factors that are associated with nutrition (62% to 65% of the communities). Furthermore, few family visitors were identified by the participating communities. Nonetheless, it seems that their role especially entails the fostering of involvement on behalf of fathers (8% of the communities). As for the psychologists, they mainly take care of the psychological support (50% of the communities) as well as some prevention of risk factors related to addictions (12% of the communities). The role of the social workers is mainly psychological support (35% of the communities) and some prevention of the risk factors related to alcohol and drugs (15% of the communities). Finally, the nutritionists take care of the nutritional follow-up and prevention of the risk factors related to nutrition (46% to 62% of the communities).

Also regarding the services provided before pregnancy, figure 3 demonstrates that the service that is the most available, which is the prevention of the risk factors related to alcohol,

medication, nutrition, tobacco and drugs, is mostly provided in accordance with need (for 27% to 35% of the communities). This question however received a low rate of response.

Figure 3: Frequency of the provision of the maternal and child health services before pregnancy

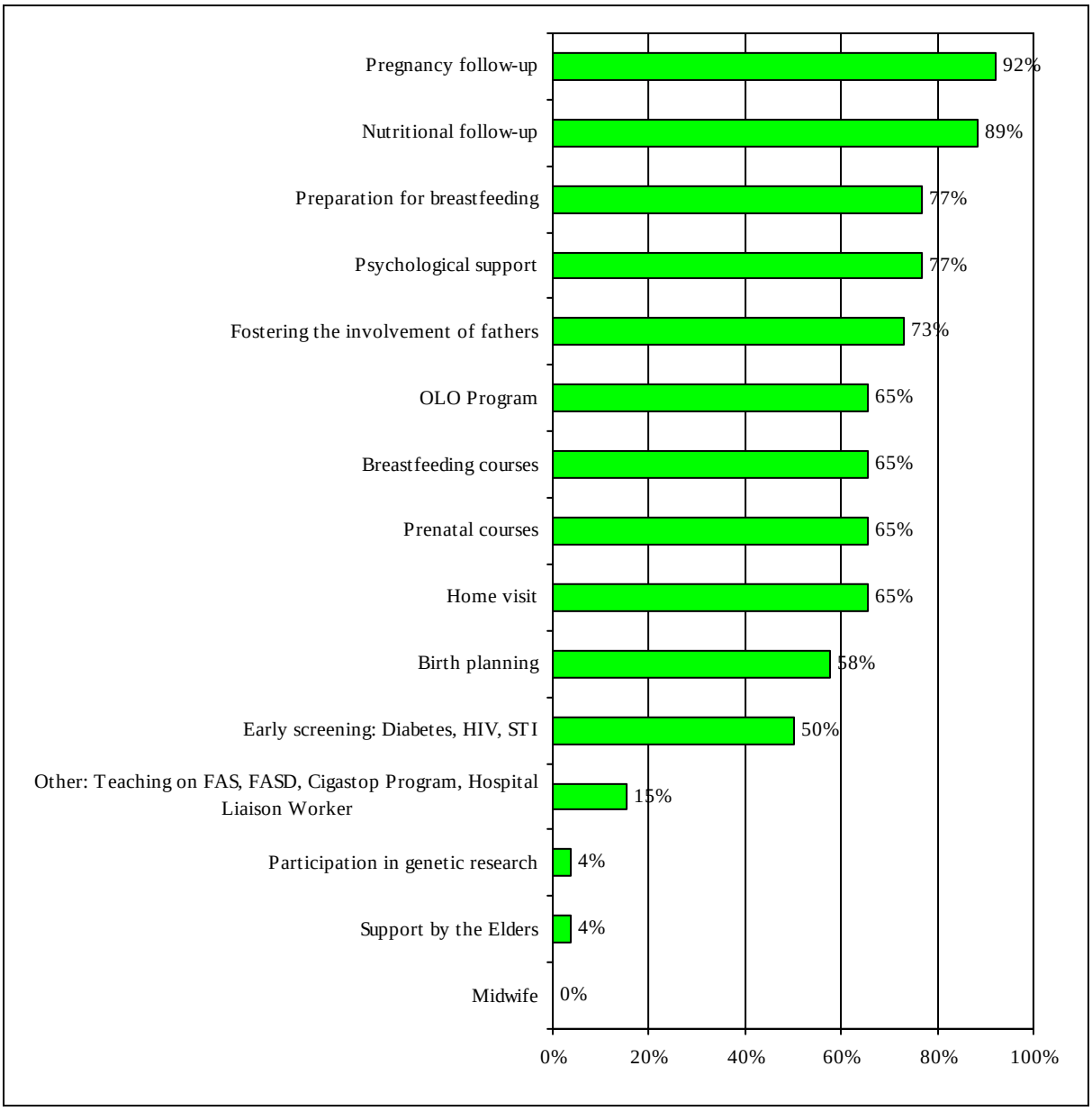
Services	More than once per week	About each week	About each month	About every three months	About once or twice per year	Other: as needed	No answer
Nutritional follow-up	7,7%	7,7%	11,5%	3,8%	0,0%	42,3%	26,9%
Psychological support	0,0%	23,1%	19,2%	3,8%	0,0%	23,1%	30,8%
Birth planning	7,7%	3,8%	15,4%	3,8%	3,8%	30,8%	34,6%
Early screening	0,0%	7,7%	7,7%	0,0%	0,0%	19,2%	65,4%
Prevention of the risk factors: Alcohol	11,5%	3,8%	15,4%	3,8%	7,7%	26,9%	30,8%
Drugs	11,5%	3,8%	15,4%	3,8%	3,8%	30,8%	30,8%
Tobacco	11,5%	3,8%	15,4%	3,8%	7,7%	26,9%	30,8%
Nutrition	15,4%	3,8%	15,4%	0,0%	7,7%	30,8%	26,9%
Medication	11,5%	3,8%	15,4%	3,8%	0,0%	30,8%	34,6%
Addictions	11,5%	3,8%	11,5%	3,8%	0,0%	30,8%	38,5%
Support by the Elders	0,0%	0,0%	3,8%	3,8%	0,0%	0,0%	92,3%
Fostering involvement on behalf of fathers	3,8%	3,8%	7,7%	0,0%	7,7%	19,2%	57,7%
Participation in genetic research	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	100%
Integrated services in perinatality and early childhood that are intended for vulnerable families	0,0%	3,8%	7,7%	0,0%	0,0%	7,7%	80,8%
Other: FASD and *Liaison Hospital Worker*	0,0%	0,0%	0,0%	0,0%	3,8%	3,8%	92,3%

2.1.2 During pregnancy

According to figure 4, pregnancy follow-up, nutritional follow-up, preparation for labour and psychological support are the services that are the most available in the participating communities during pregnancy.

Inversely, it seems that participation in genetic research, support by the Elders and the assistance of a midwife are not or seldom available in the communities.

Figure 4: Services available in the community related to maternal and child health during pregnancy



The four following figures present the services that are available in the communities in relation with the different variables: nation, size, language and geographic zone. It is however important to be cautious regarding the interpretation of these figures since the composition of the different variables varies greatly (refer to section 1.3.2 Population and Final Sampling). These figures do, however, have the added benefit of providing additional information.

Figure 4.1: Services available in the community during pregnancy by nation

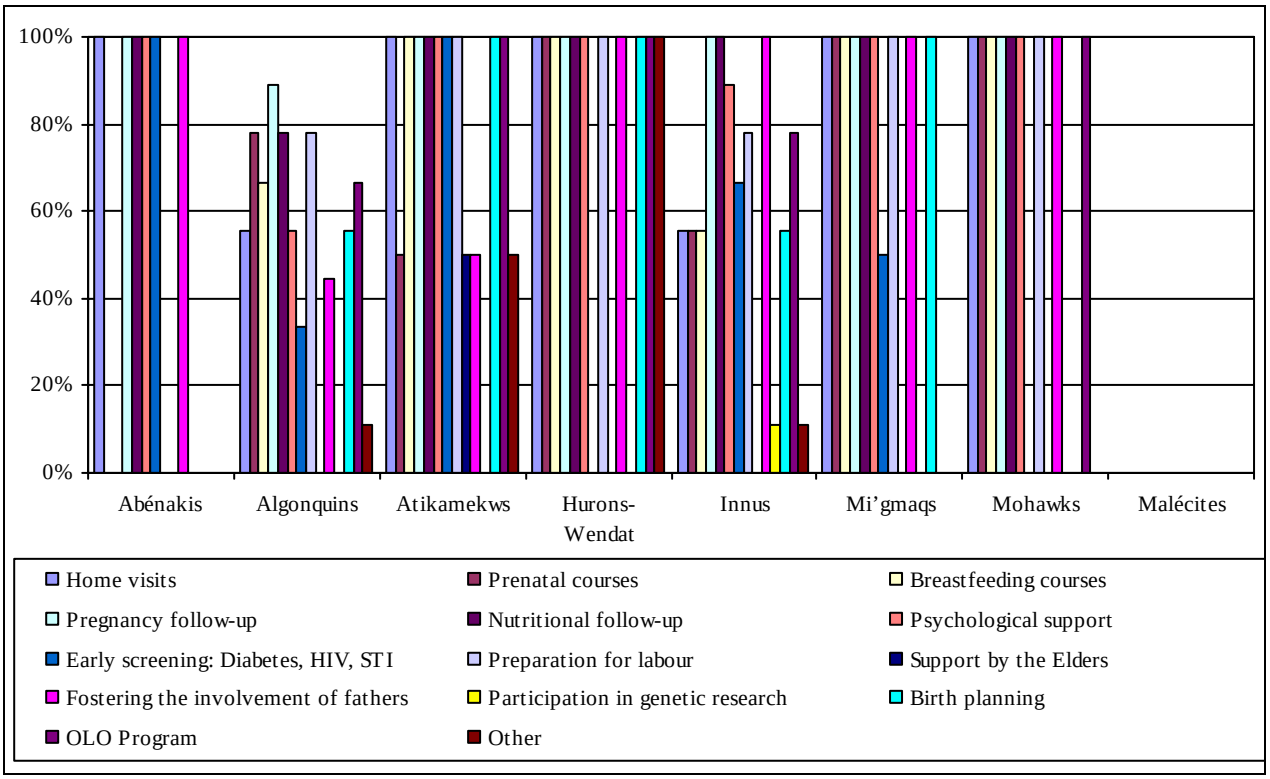


Figure 4.2: Services available in the community during pregnancy in relation to the size of the community

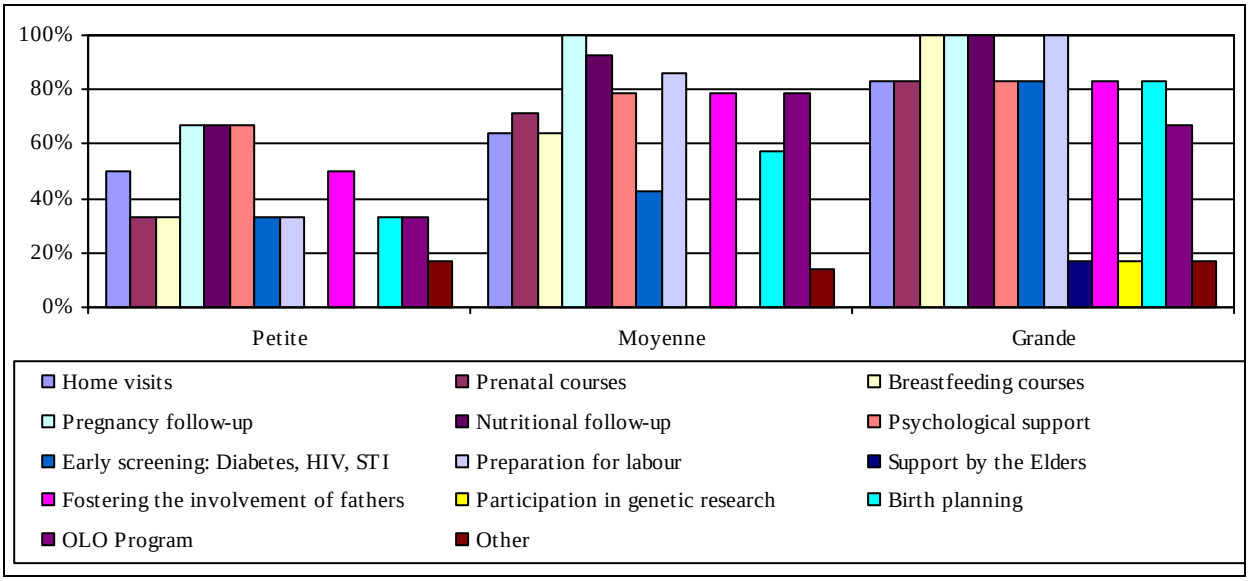


Figure 4.3: Services available in the community during pregnancy in relation to the language

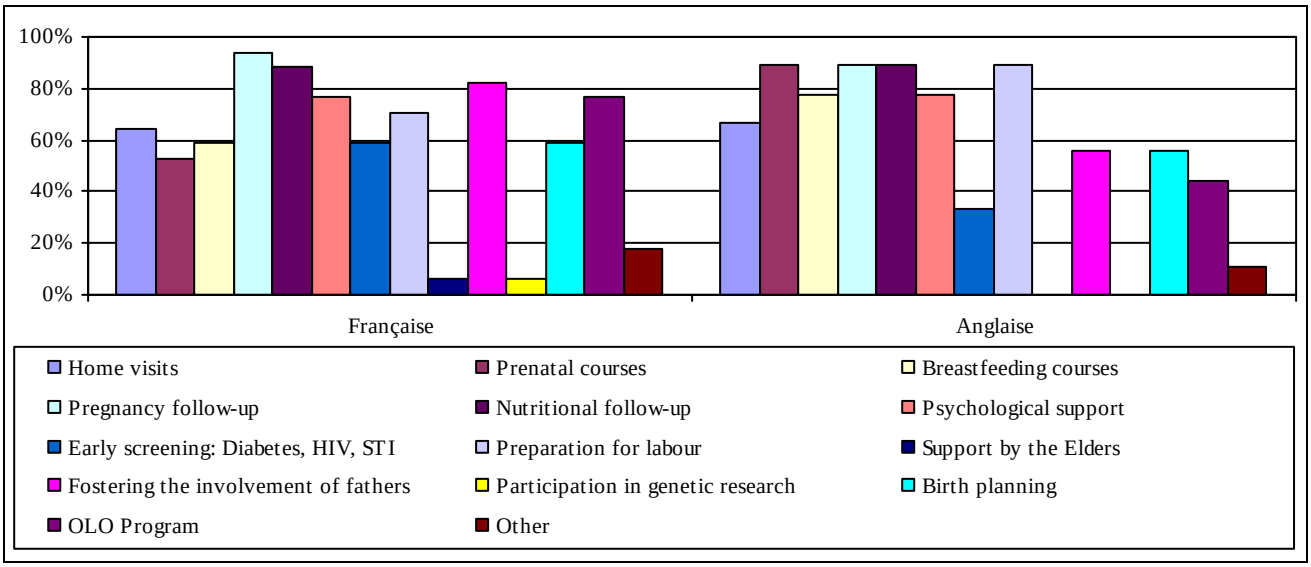
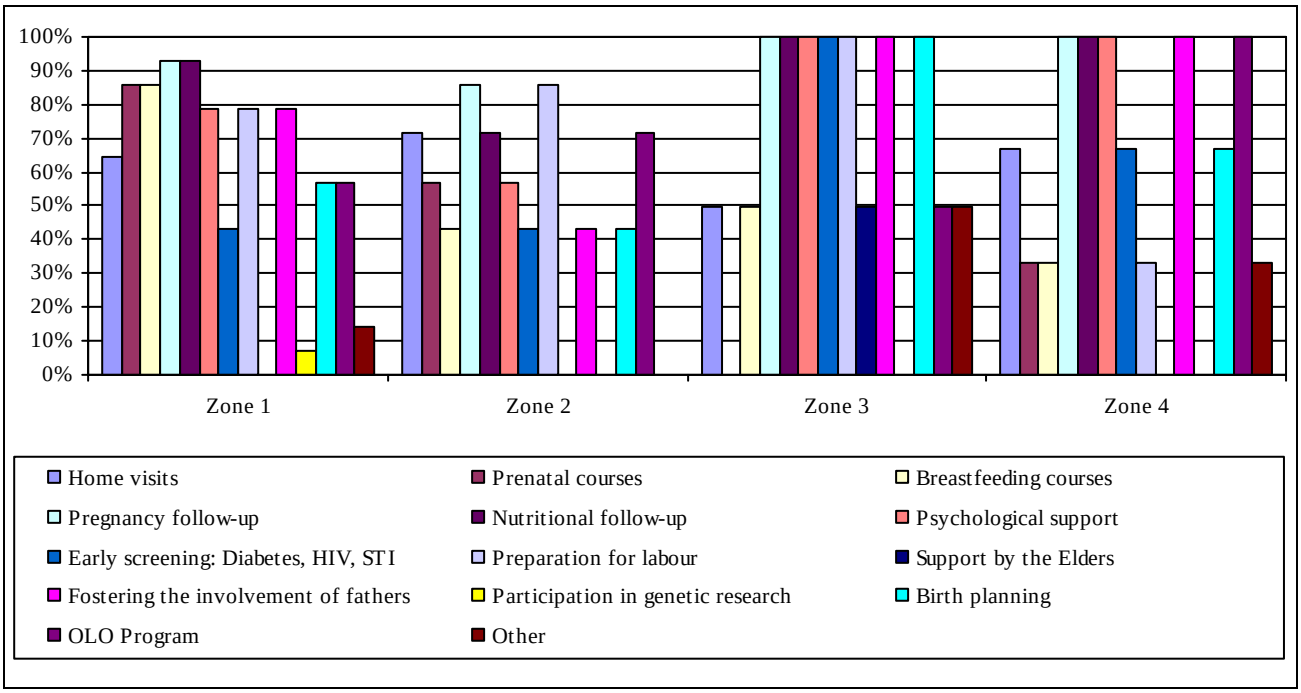


Figure 4.4: Services available in the community during pregnancy in relation with the geographic zone



As for the services that are the most available during pregnancy, figure 5 illustrates that the pregnancy follow-up services are mostly provided by the nurses (for 92% of the communities), that nutritional follow-up is especially provided by the nutritionists (for 62% of the communities), that preparation for labour is provided by the nurses (for 65% of the communities) and that psychological support is mostly provided by psychologists (for 62% of the communities).

Figure 5: Interveners who provide the services that are available in the community related to maternal and child health during pregnancy

Services	Physician	Nurse	Home visitor	Psychologist	Social worker	Nutritionist	Other*
Home visits	3,8%	61,5%	7,7%	3,8%	11,5%	11,5%	0,0%
Prenatal courses	0,0%	65,4%	0,0%	3,8%	3,8%	19,2%	7,7%
Breastfeeding courses	0,0%	61,5%	0,0%	0,0%	0,0%	23,1%	0,0%
Pregnancy follow-up	34,6%	92,3%	0,0%	0,0%	0,0%	7,7%	3,8%
Nutritional follow-up	7,7%	50,0%	0,0%	0,0%	0,0%	61,5%	3,8%
Psychological support	3,8%	26,9%	0,0%	61,5%	30,8%	0,0%	3,8%
Early screening: Diabetes, HIV, STI	15,4%	26,9%	0,0%	0,0%	0,0%	3,8%	0,0%
Preparation for labour	11,5%	65,4%	0,0%	0,0%	0,0%	0,0%	3,8%
Support by the Elders	0,0%	3,8%	0,0%	0,0%	0,0%	0,0%	3,8%
Fostering the involvement of fathers	11,5%	57,7%	0,0%	11,5%	11,5%	0,0%	0,0%
Participation in genetic research	3,8%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%
Birth planning	19,2%	57,7%	0,0%	0,0%	0,0%	0,0%	0,0%
OLO Program	0,0%	42,3%	0,0%	3,8%	0,0%	30,8%	11,5%
Other: Teaching of FAS, FASD, Cigastop Program, *Hospital Liaison Worker*	0,0%	7,7%	0,0%	0,0%	0,0%	0,0%	3,8%

Figure 5 also tells us that 35% of the participating communities identify the role of physicians as being mainly focused on pregnancy follow-up. As for the nurses, they mainly take care of pregnancy follow-up, preparation for labour and prenatal courses (for 65% to 92% of the communities). When the home visitors are present in the community, they mainly take care of home visits (for 8% of the communities). During pregnancy, psychologists and social workers are mainly responsible for psychological support (for 62% and 31% of the communities – respectively). Finally, the nutritionists are in charge of, according to 62% of the communities, the nutritional follow-up.

In relation with the services provided during pregnancy, figure 6 indicates that pregnancy follow-up is most often provided on a weekly or monthly basis (for 27% of the communities), that nutritional follow-up is usually provided on a monthly basis (for 35% of the communities) and that psychological support is available on an as needed basis (for 42% of the communities). However, this question received a rather low rate of response.

Figure 6: Frequency of the provision of the maternal and child health services during pregnancy

Services	More	About	About	About	About	Other:	No

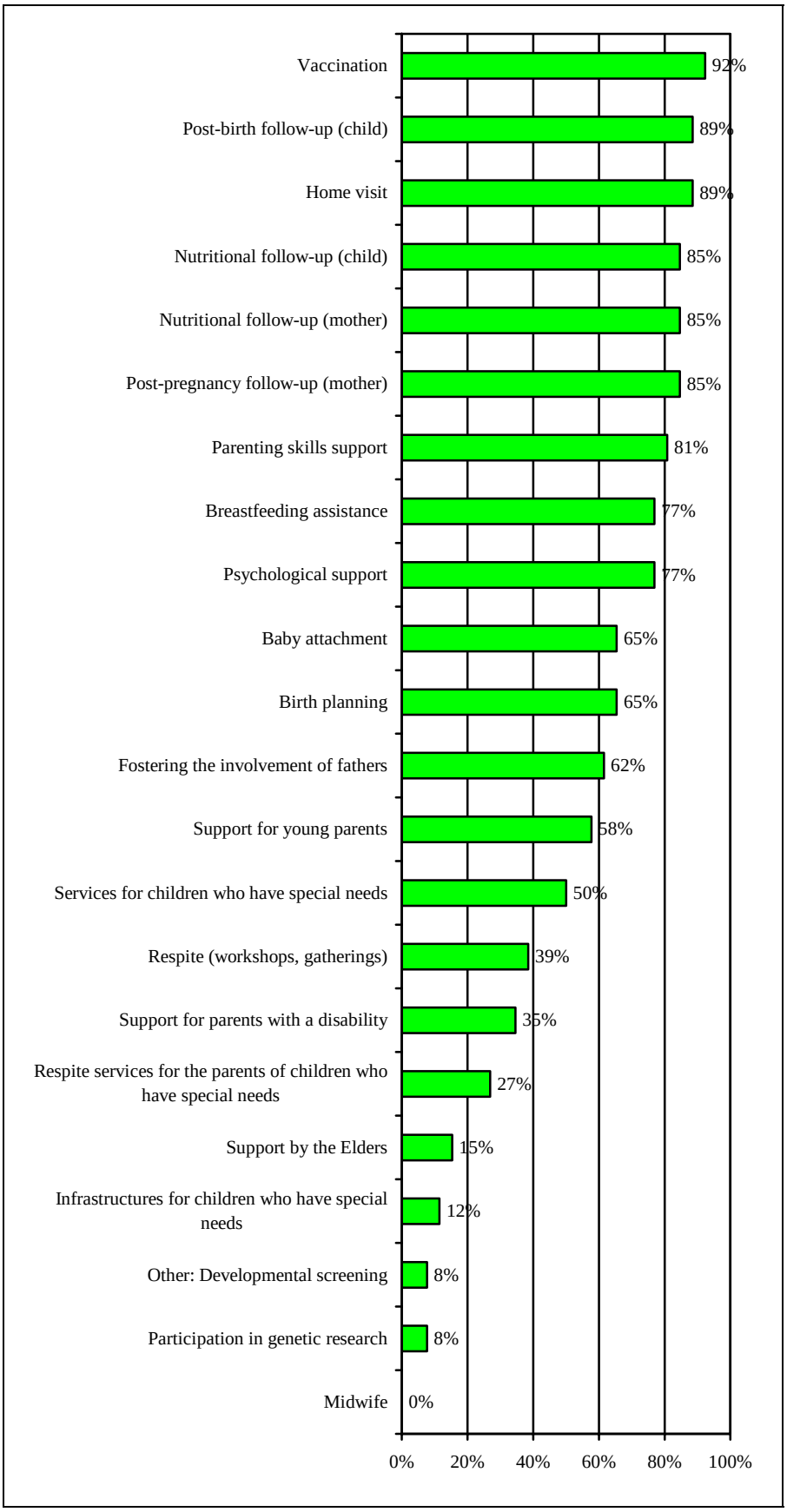
	than once per week	each week	each month	every three months	once or twice per year	As needed	answer
Home visits	3,8%	23,1%	3,8%	0,0%	3,8%	26,9%	38,5%
Prenatal courses	0,0%	11,5%	15,4%	15,4%	11,5%	7,7%	38,5%
Breastfeeding courses	0,0%	3,8%	15,4%	15,4%	11,5%	7,7%	46,2%
Pregnancy follow-up	3,8%	26,9%	26,9%	3,8%	0,0%	19,2%	19,2%
Nutritional follow-up	3,8%	7,7%	34,6%	3,8%	0,0%	26,9%	23,1%
Psychological support	0,0%	7,7%	19,2%	0,0%	0,0%	42,3%	30,8%
Early screening: Diabetes, HIV, STI	3,8%	7,7%	7,7%	0,0%	0,0%	11,5%	69,2%
Preparation for labour	3,8%	11,5%	15,4%	11,5%	3,8%	15,4%	38,5%
Support by the Elders	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	100%
Fostering the involvement of fathers	0,0%	11,5%	11,5%	7,7%	0,0%	15,4%	53,8%
Participation in genetic research	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	100%
Birth planning	3,8%	7,7%	3,8%	0,0%	7,7%	19,2%	57,5%
OLO Program	15,4%	23,1%	3,8%	3,8%	0,0%	3,8%	50,0%
Other: Teaching of FAS, FASD, Cigastop Program, *Hospital Liaison Worker*	0,0%	3,8%	0,0%	0,0%	0,0%	7,7%	88,5%

2.1.3 After pregnancy

After pregnancy, figure 7 illustrates that vaccination, post-natal follow-up for the newborn as well as home visits are the services that are the most available after pregnancy.

However, participation in genetic research and the assistance of a midwife are seldom or not available in the participating communities.

Figure 7: Services available in the community related to maternal and child health after pregnancy



The four following figures present the services that are available in the communities in relation with the different variables: nation, size, language and geographical zone. It is however important to be cautious regarding the interpretation of these charts since the composition of the different variables varies greatly (refer to section 1.3.2 Population and Final Sampling). These charts do however provide additional information.

Figure 7.1: Services available in the community after pregnancy by nation

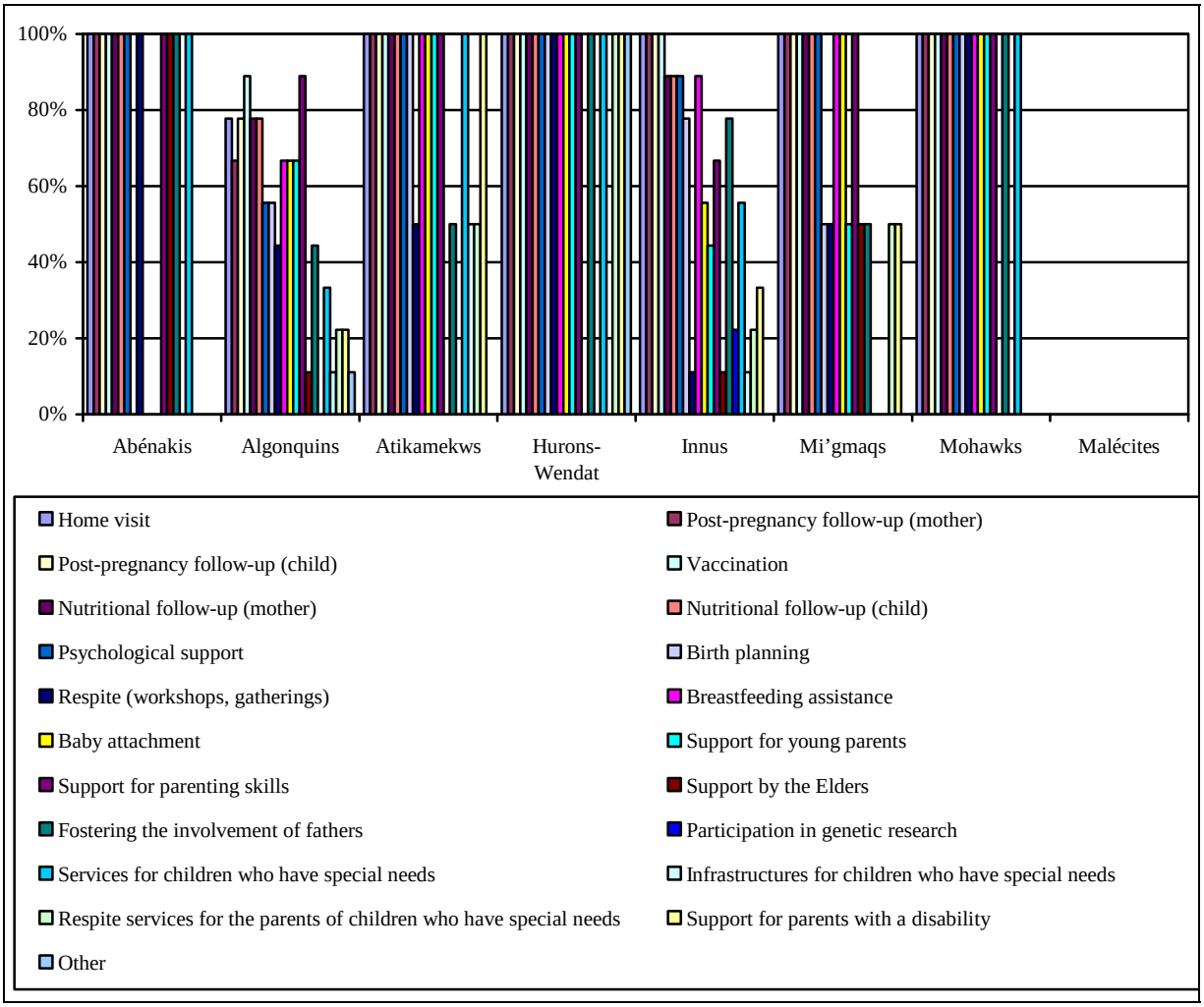


Figure 7.2: Services available in the community after pregnancy in relation to the size of the community

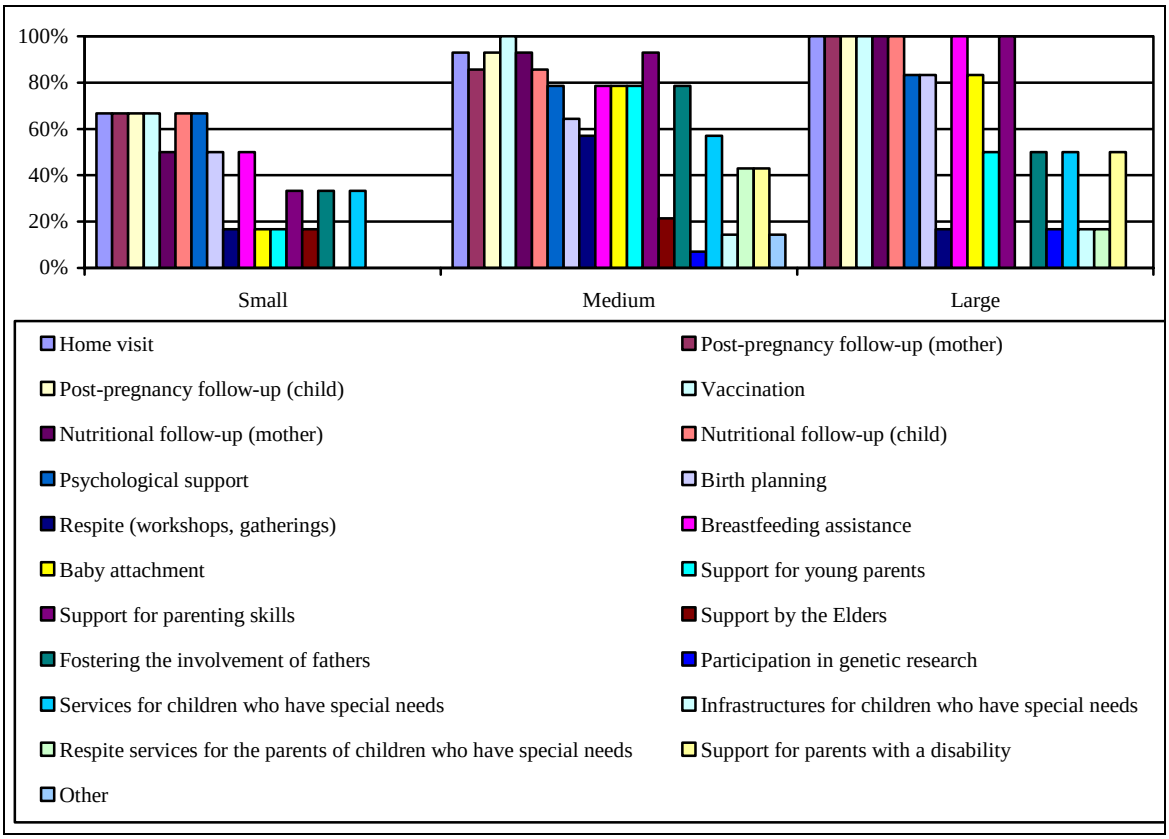


Figure 7.3: Services available in the community after pregnancy in relation to the language

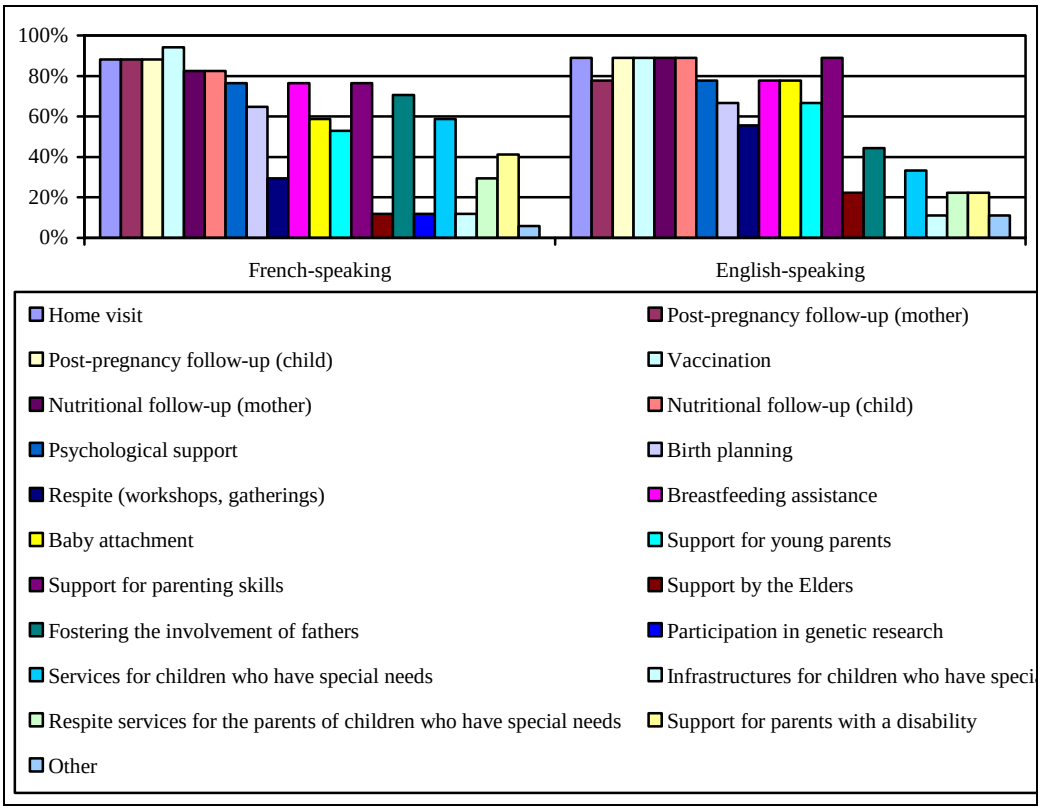
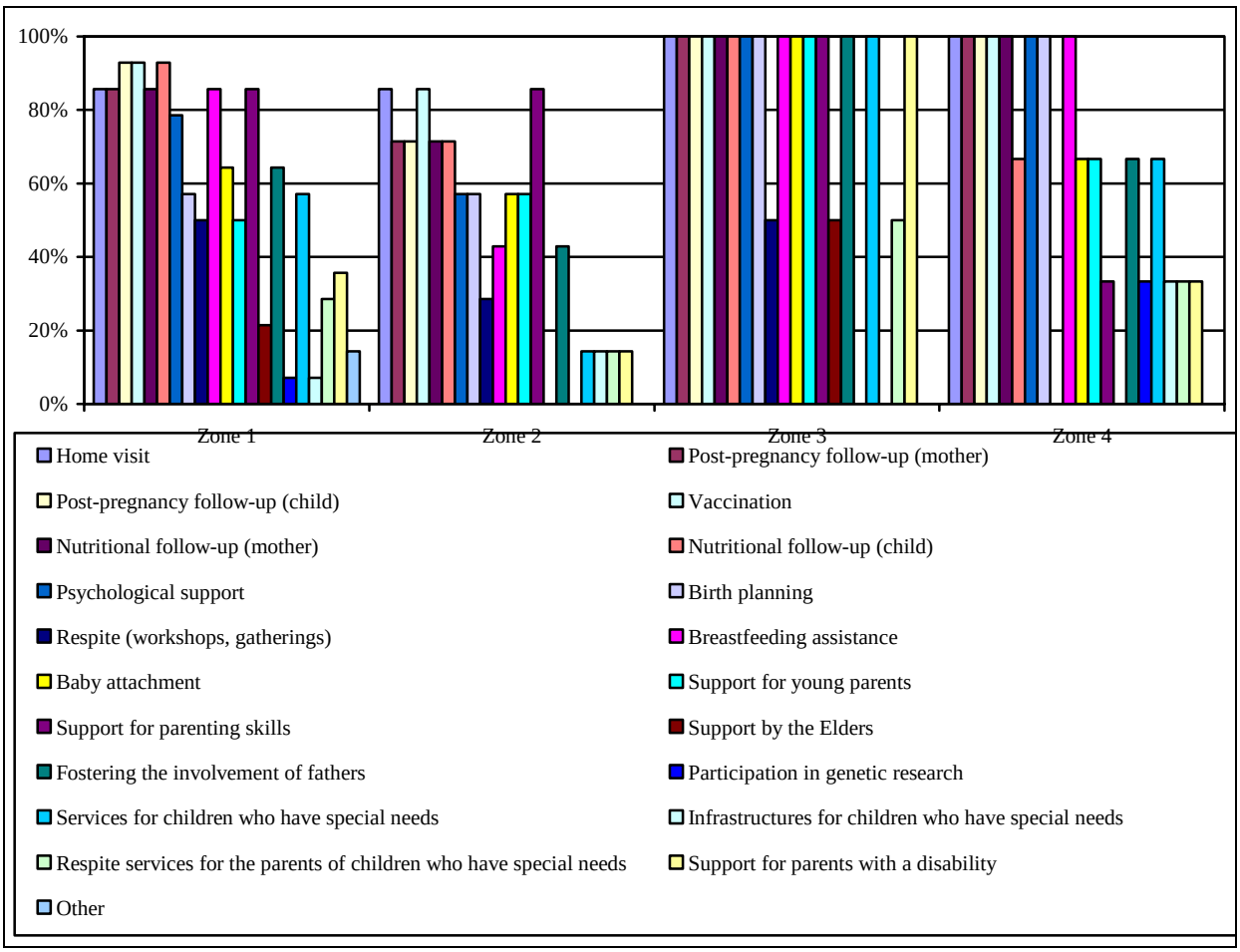


Figure 7.4: Services available in the community after pregnancy in relation with the geographic zone



Furthermore, figure 8 indicates that vaccination, post-birth follow-up for the newborn as well as home visits are mainly provided, in 77% to 89% of the communities, by the nurses.

Figure 8: Interveners who provide the services that are available in the community related to maternal and child health after pregnancy

Services	Physician	Nurse	Family visitor	Psychologist	Social worker	Nutritionist	Other*
Home visits	0,0%	88,5%	7,7%	7,7%	7,7%	11,5%	7,7%
Post-pregnancy follow-up (mother)	26,9%	76,9%	3,8%	7,7%	0,0%	7,7%	0,0%
Post-birth follow-up (child)	23,1%	76,9%	3,8%	3,8%	0,0%	3,8%	7,7%
Vaccination	0,0%	88,5%	0,0%	0,0%	0,0%	0,0%	3,8%
Nutritional follow-up (mother)	7,7%	42,3%	0,0%	0,0%	0,0%	50,0%	3,8%
Nutritional follow-up (child)	11,5%	42,3%	0,0%	0,0%	0,0%	42,3%	0,0%
Psychological support	11,5%	38,5%	0,0%	65,4%	34,6%	0,0%	3,8%
Birth planning	30,8%	57,7%	0,0%	0,0%	0,0%	0,0%	3,8%
Respite (workshops, gathering)	0,0%	15,4%	7,7%	0,0%	3,8%	11,5%	19,2%
Breastfeeding assistance	3,8%	57,7%	7,7%	0,0%	0,0%	11,5%	7,7%
Baby attachment	0,0%	42,3%	7,7%	0,0%	3,8%	0,0%	15,4%

Services	Physician	Nurse	Family visitor	Psychologist	Social worker	Nutritionist	Other*
Support for young parents	0,0%	19,2%	7,7%	7,7%	11,5%	0,0%	19,2%
Support for parenting skills	0,0%	23,1%	11,5%	11,5%	19,2%	3,8%	34,6%
Support by the Elders	0,0%	0,0%	3,8%	3,8%	0,0%	0,0%	3,8%
Fostering the involvement of fathers	7,7%	50, 0%	7,7%	15,4%	11,5%	0,0%	7,7%
Participation in genetic research	0,0%	3,8%	0,0%	0,0%	0,0%	0,0%	0,0%
Services for children who have special needs	19,2%	26,9%	0,0%	23,1%	15,4%	0,0%	11,5%
Infrastructures for children who have special needs	0,0%	3,8%	0,0%	0,0%	0,0%	0,0%	7,7%
Respite services for parents of children who have special needs	0,0%	11,5%	3,8%	11,5%	15,4%	0,0%	7,7%
Support for parents with a disability	3,8%	15,4%	3,8%	11,5%	19,2%	0,0%	7,7%
Other: Developmental screening	0,0%	3,8%	0,0%	3,8%	0,0%	3,8%	0,0%

Figure 8 also tells us that according to 31% of the communities, the role of physicians is mostly related to the planning of births once the pregnancy period has ended. It also demonstrates that the nurses mainly take care of vaccination and home visits (for 89% of the communities). The role of family visitors seems to be more important after pregnancy since, according to 12% of the communities, they are in charge of supporting parenting skills. As for the psychologists and social workers, psychological support is their primary role according to 65% and 35% of the communities – respectively. Finally, the nutritionists take care of the nutritional follow-up for the mother (for 50% of the communities) as well as the child (for 42% of the communities).

According to figure 9, vaccination services are provided mainly on an as needed basis and in accordance with the calendar (for 46% of the communities). Post-birth follow-up for the child is provided as needed in 31% of the communities and on a monthly basis for 27% of the communities. Finally, home visits are mainly available in accordance with the needs.

Figure 9: Frequency of the provision of the maternal and child health services after pregnancy

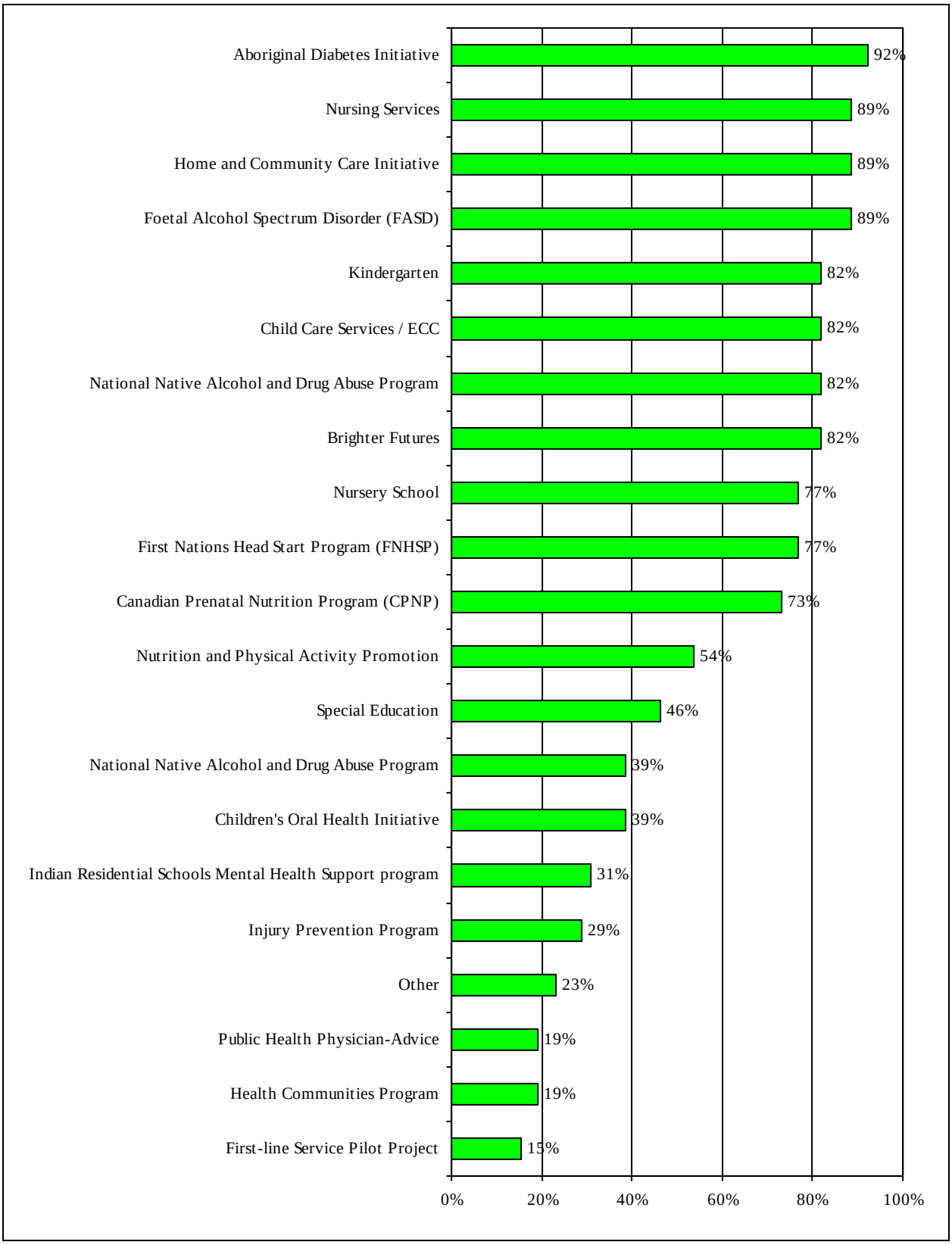
Services	More than once per week	About each week	About each month	About every three months	About once or twice per year	Other: As needed	No answer
Home visits	7,7%	11,5%	3,8%	0,0%	3,8%	53,8%	19,2%
Post-pregnancy follow-up (mother)	7,7%	7,7%	19,2%	0,0%	3,8%	34,6%	26,9%
Post-birth follow-up (child)	7,7%	11,5%	26,9%	0,0%	0,0%	30,8%	23,1%
Vaccination	3,8%	11,5%	7,7%	15,4%	0,0%	46,2%	15,4%
Nutritional follow-up (mother)	0,0%	7,7%	11,5%	7,7%	3,8%	42,3%	26,9%
Nutritional follow-up (child)	0,0%	7,7%	15,4%	7,7%	3,8%	38,5%	26,9%
Psychological support	0,0%	3,8%	19,2%	3,8%	0,0%	46,2%	26,9%
Birth planning	3,8%	7,7%	3,8%	3,8%	3,8%	26,9%	50,0%
Respite (workshops, gathering)	0,0%	3,8%	7,7%	3,8%	3,8%	3,8%	76,9%
Breastfeeding assistance	7,7%	3,8%	7,7%	7,7%	0,0%	34,6%	38,5%
Baby attachment	3,8%	3,8%	7,7%	3,8%	0,0%	26,9%	53,8%

Support for young parents	3,8%	7,7%	7,7%	3,8%	3,8%	15,4%	57,1%
Support for parenting skills	7,7%	3,8%	15,4%	7,7%	3,8%	23,1%	38,5%
Support by the Elders	0,0%	0,0%	0,0%	3,8%	0,0%	7,7%	88,5%
Fostering the involvement of fathers	0,0%	7,7%	15,4%	3,8%	0,0%	19,2%	53,8%
Participation in genetic research	0,0%	0,0%	0,0%	0,0%	0,0%	3,8%	96,2%
Services for children who have special needs	0,0%	0,0%	7,7%	0,0%	0,0%	23,1%	69,2%
Infrastructures for children who have special needs	0,0%	0,0%	0,0%	0,0%	0,0%	11,5%	88,5%
Respite services for parents of children who have special needs	3,8%	0,0%	3,8%	0,0%	0,0%	19,2%	73,1%
Support for parents with a disability	3,8%	0,0%	11,5%	0,0%	3,8%	15,4%	65,4%
Other: Developmental screening	0,0%	7,7%	0,0%	0,0%	0,0%	0,0%	92,3%

Within the participating communities, the programs that are provided most frequently are the Aboriginal Diabetes Initiative, Nursing services, Home and Community Care Initiative as well as the Foetal Alcohol Spectrum Disorder Program – as presented in figure 10.

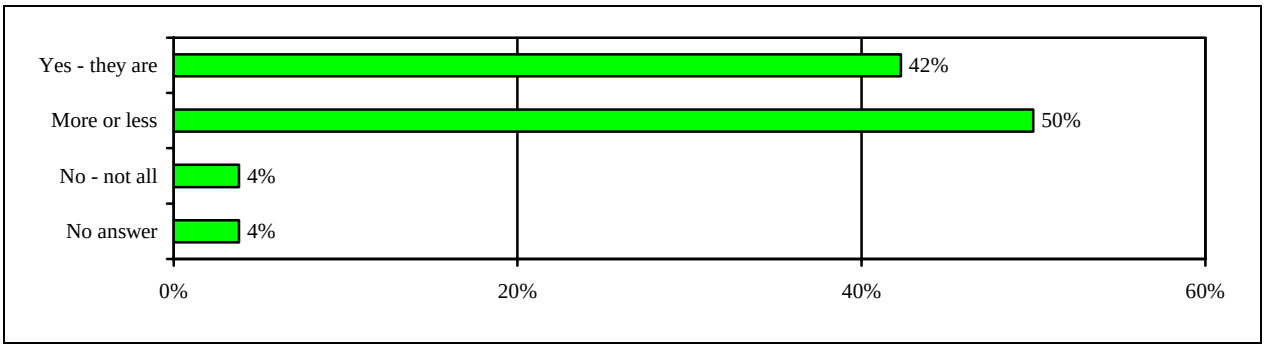
Inversely, the public health physician-advice program, the Healthy Communities Program and the First-line Services Pilot Project are seldom provided in the participating communities.

Figure 10: Programs provided in the community



Half of the respondents stated that the health services provided in their health/social services centre are not very adapted to their culture. Fewer respondents stated that the services are adapted.

Figure 11: Culturally-adapted services that are provided in the health and social services centre



In order to support them in their work, the respondents stated that they have access to pamphlets, posters, videos, DVDs, kits, tools guides, workshops, bulletins, radio, educational material, Internet access, videoconferencing, material provided by the FNQLHSSC, books, toys or conferences.

They also mentioned that they have access to material on home visits, the 0 to 5 years clientele, home care, breastfeeding, attachment, health and well-being, FASD, prenatality, the "Becoming a Father" videotape, nutritional workshops for youth and groups of pregnant women or the document "Living better with your child from birth up to age two".

2.2 Human resources and other interveners

According to figure 12, nurses, community health representatives as well as nutritionists are the maternal and child health interveners who are the most present in the participating communities.

Inversely, family counsellors, ergotherapists and pharmacists are absent from the participating communities.

Figure 12: Interveners who work in maternal and child health in the community

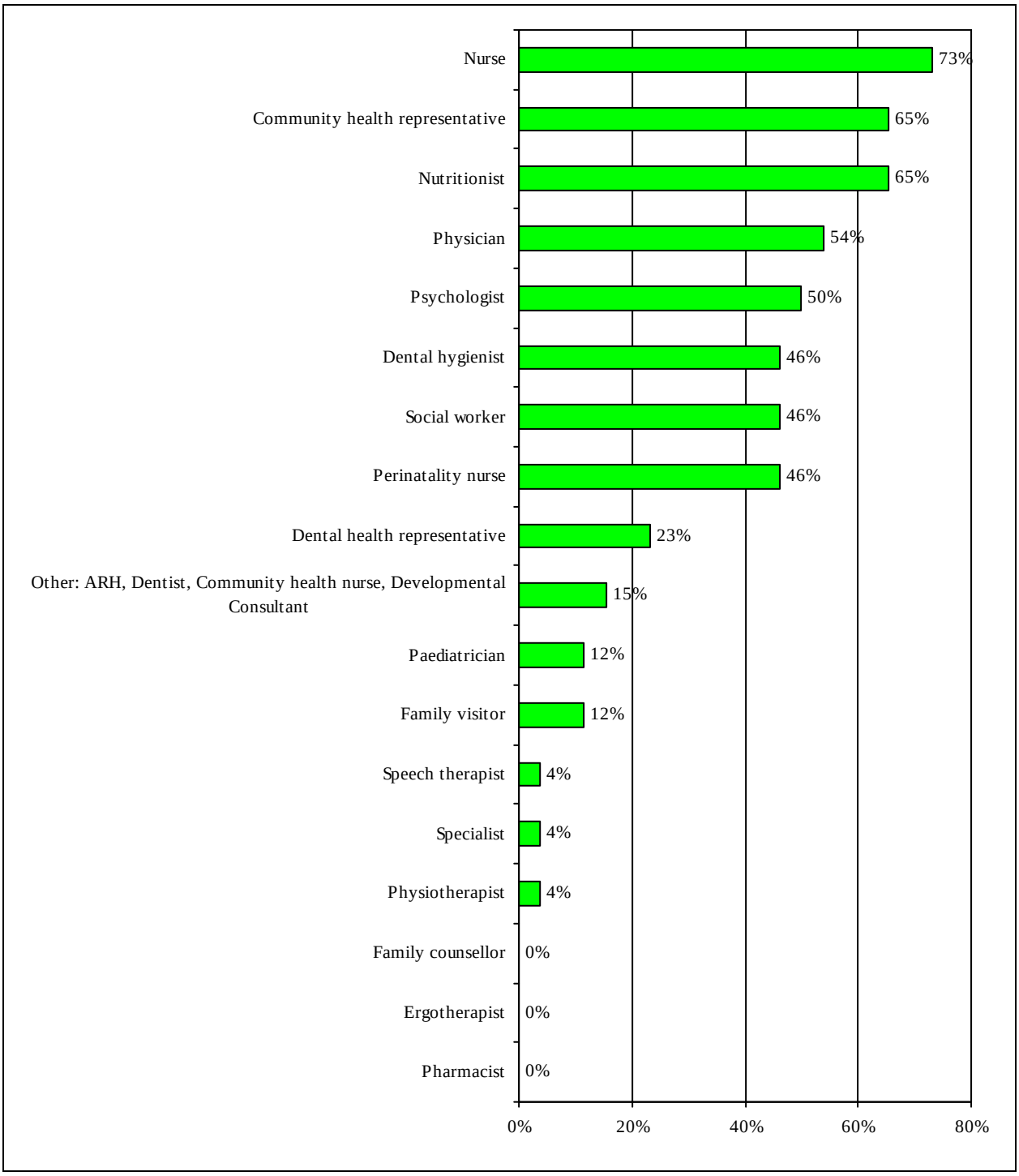


Figure 13 indicates that the participating communities most often have access to a nurse, community health representative and/or a nutritionist who work in maternal and child health. It is also interesting to observe that between 15% and 19% of the communities have more than four community health representatives and/or nurses.

Figure 13: Number of interveners who work in maternal and child health in the community

Interveners	Available	Unavailable	No answer
Nurse	73,1%	7,7%	19,2%
Perinatality nurse	46,2%	30,8%	23,1%
Family visitor	11,5%	61,5%	26,9%
Psychologist	50,0%	34,6%	15,4%
Social worker	46,2%	34,6%	19,2%
Physician	53,8%	26,9%	19,2%
Nutritionist	65,4%	23,1%	11,5%
Dental health representative	23,1%	53,8%	23,1%
Dental hygienist	46,2%	34,6%	19,2%
Physiotherapist	3,8%	76,9%	19,2%
Pharmacist	0,0%	76,9%	23,1%
Paediatrician	11,5%	69,2%	19,2%
Specialist	3,8%	76,9%	19,2%
Ergotherapist	0,0%	76,9%	23,1%
Speech therapist	3,8%	73,1%	23,1%
Family counsellor	0,0%	73,1%	26,9%
Community health representative	65,4%	23,1%	11,5%
Other: ARH, Dentist, Community health nurse, *Developmental Consultant*	15,4%	7,7%	76,9%

According to figure 14, nurses and community health representatives are the most likely to work full-time, while nutritionists are more likely to work part-time. It is however important to specify that the response rate for this question was rather low.

Figure 14: Frequency of the work on behalf of the interveners who work in maternal and child health in the community

Interveners	Full time	Part time	Both	No answer
Nurse	38,5%	23,1%	7,7%	30,8%
Perinatality nurse	30,8%	15,4%	0,0%	53,8%
Family visitor	11,5%	0,0%	0,0%	88,5%
Psychologist	3,8%	38,5%	0,0%	57,7%
Social worker	19,2%	11,5%	0,0%	69,2%
Physician	3,8%	34,6%	0,0%	61,5%
Nutritionist	19,2%	42,3%	0,0%	38,5%
Dental health representative	0,0%	23,1%	0,0%	76,9%
Dental hygienist	3,8%	34,6%	0,0%	61,5%
Physiotherapist	0,0%	3,8%	0,0%	96,2%
Pharmacist	0,0%	0,0%	0,0%	100%
Paediatrician	0,0%	11,5%	0,0%	88,5%
Specialist	0,0%	3,8%	0,0%	96,2%
Ergotherapist	0,0%	0,0%	0,0%	100%

Interveners	Full time	Part time	Both	No answer
Speech therapist	0,0%	3,8%	0,0%	96,2%
Family counsellor	0,0%	0,0%	0,0%	100%
Community health representative	38,5%	11,5%	0,0%	50,0%
Other: ARH, Dentist, Community health nurse, *Developmental Consultant*	7,7%	7,7%	0,0%	84,6%

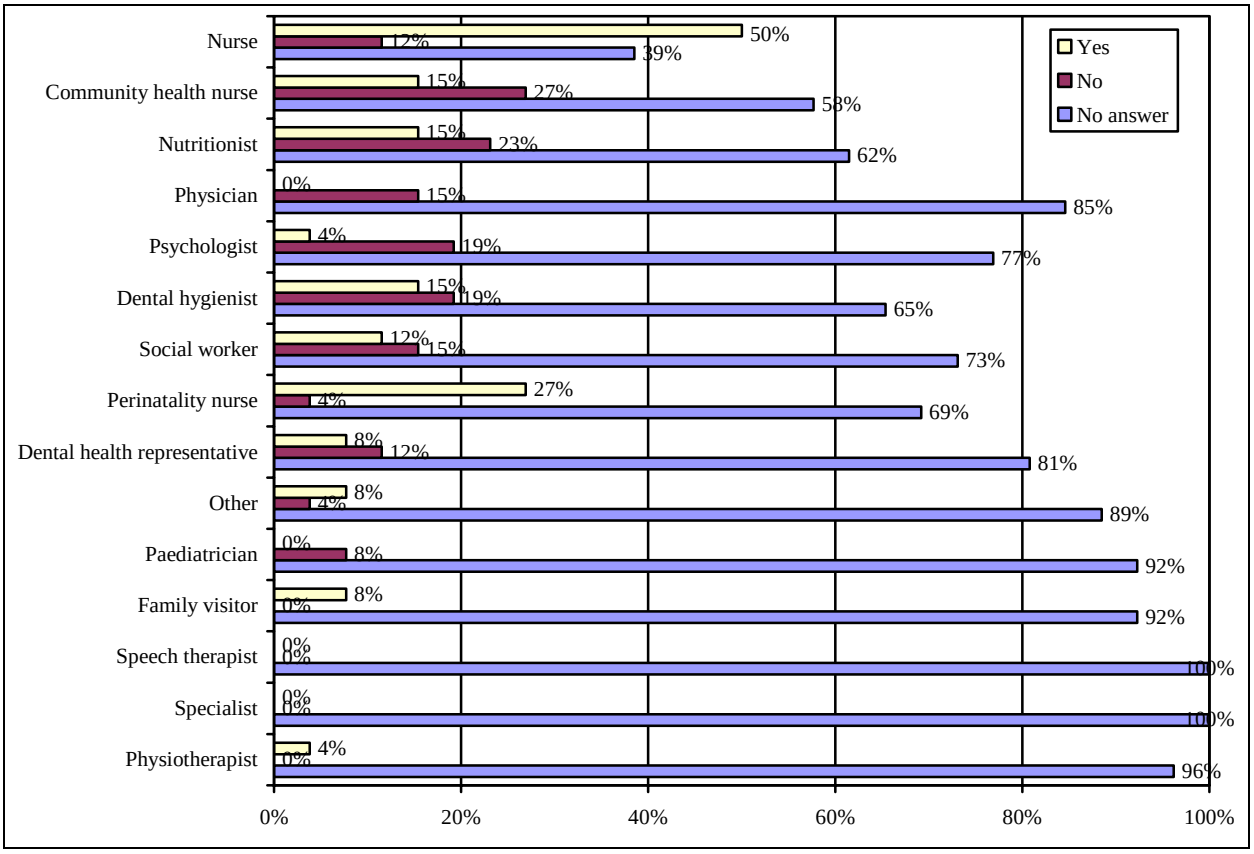
According to the respondents, family visitors, dental health representatives and the community health representatives who work within the participating communities have widely varying backgrounds and may have not finished high school or have a university-level education.

The training of nurses, perinatality nurses, social workers and nutritionists varies from a college degree to a university degree. The dental hygienists have a college degree.

The psychologists, physicians, physiotherapists and paediatricians who work within the participating communities have a university degree.

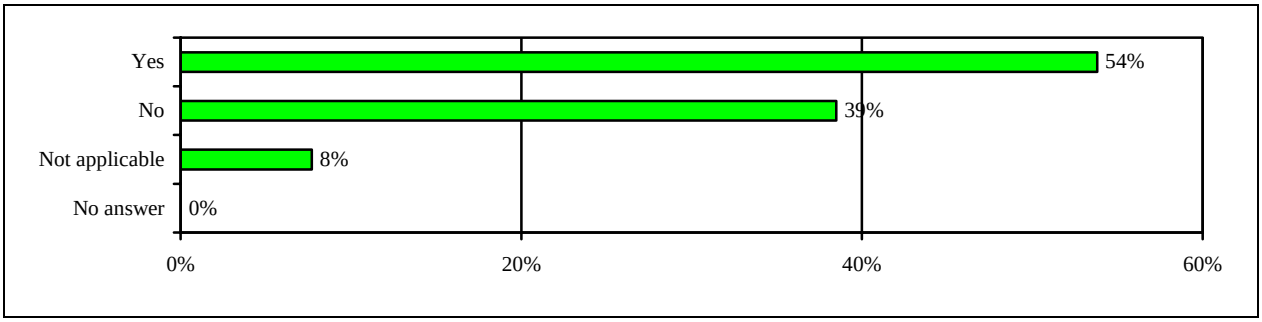
According to figure 15, only the nurses and perinatality nurses seem to benefit from supervision. It is however important to specify that the response rate for this question was rather low.

Figure 15: Supervision of the maternal and child health interveners who work in the community



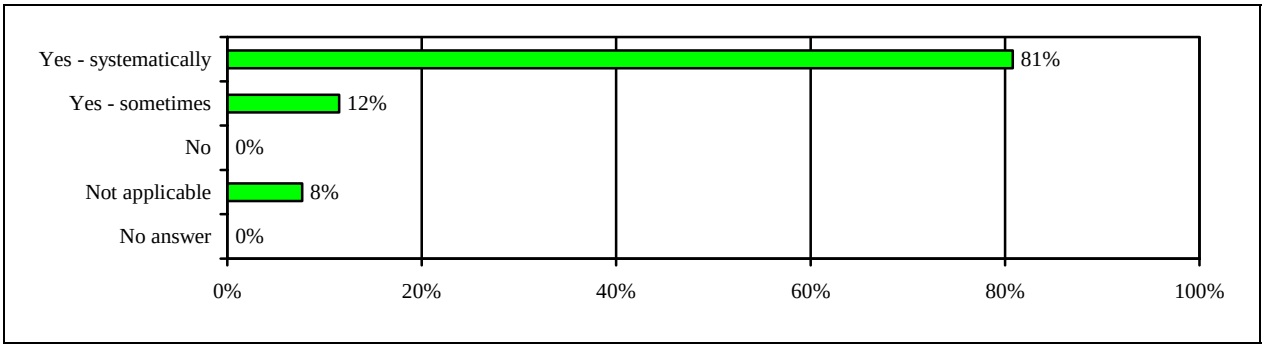
As illustrated in figure 16, more than half of the health/social services centres have a follow-up protocol for the maternal and child health clientele.

Figure 16: Health / social services centres that have a protocol in order to follow-up on the maternal and child health clientele



File management seems to unfold systematically for 81% of the participating communities and occasionally for 12% of the communities – as presented in figure 17.

Figure 17: Services for which the maternal and child health employees maintain a file



The respondents mentioned that they would like to see the FNQLHSSC provide, in the framework of maternal and child health, training sessions that focus on breastfeeding, prenatal courses, drugs and addictions, pregnancy stages, preparation for pregnancy, FAS, support and assistance during pregnancy, manipulation of the baby for mothers and fathers, perinatality, evaluation, growth and development of children ages 0 to 5 years, stimulation and development of children ages 0 to 5 years, high-risk clientele, maintenance at home, emergency labour, pre- and post-natal follow-up, nutrition for baby and pre-school aged children, food allergies, nutritional needs of pregnant women, parenting skills, early stimulation and development of children, stress management in emergency situations, special needs, behavioural problems, parental support, language, baby attachment, post-partum, support for young parents, young adolescent mothers, vulnerable families, post and prenatal mourning, involvement of fathers and Elders, obstetrical complications, physical evaluation of newborns, law, family violence, sexual abuse and shared custody.

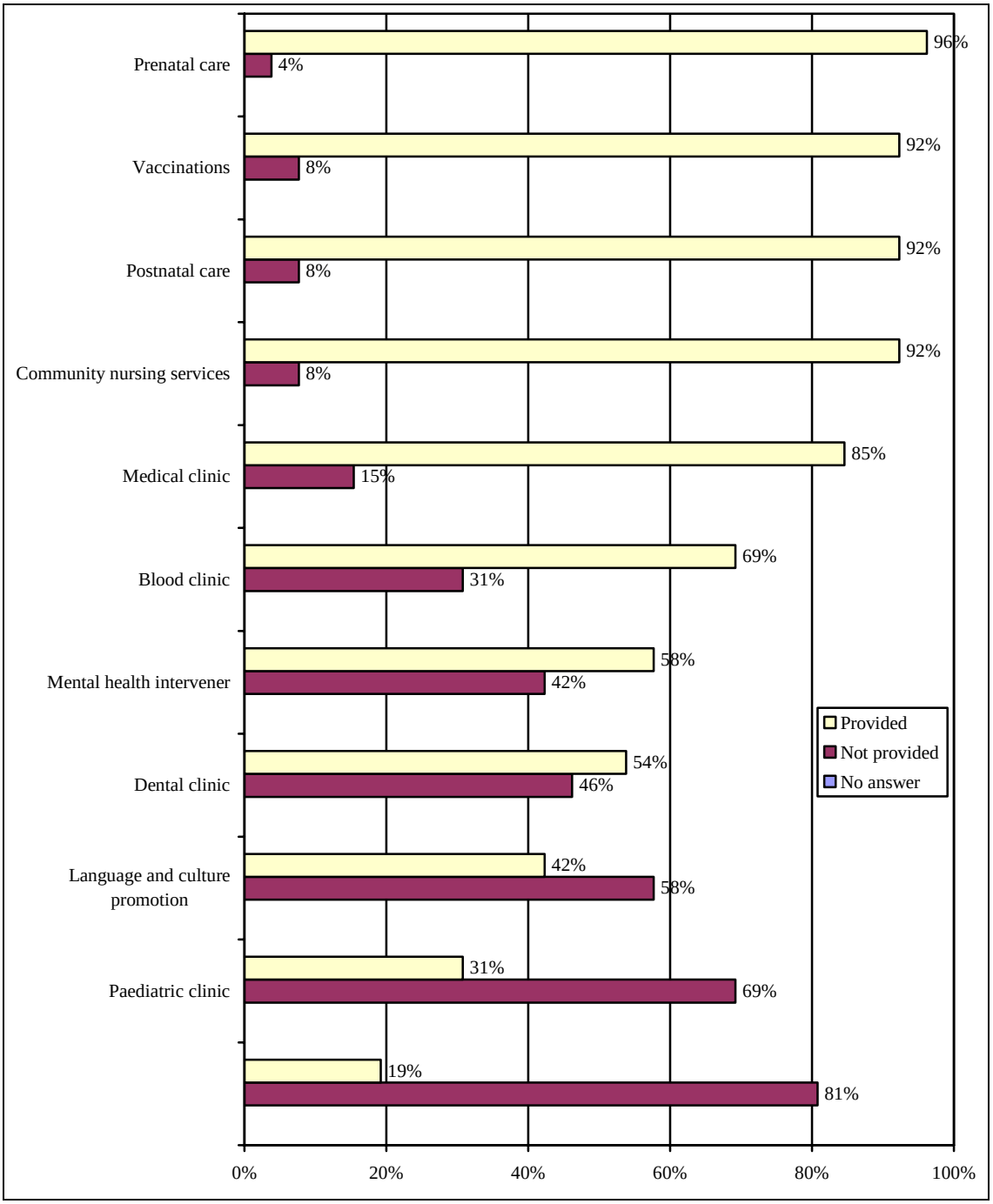
Furthermore, the respondents mentioned that they want the training to be provided locally in order to foster a high number of local participants. They also stated that the training should be adapted to the local environment and that the training and/or program tools should be left on-site.

2.3 Access to resources

Prenatal care, vaccination, postnatal care as well as community nursing care are the services that are the most available in the participating communities – according to figure 18.

Inversely, paediatric clinics, culture and language promotion and dental clinics are the services that are the least available in the communities.

Figure 18: Services provided in the community



The prevention services for diabetes, HIV/Aids as well as drugs and alcohol, through the NNADAP, are the prevention services that are most commonly found in the participating communities – according to figure 19.

Inversely, youth programs, housing programs and information programs are less present in the participating communities.

Figure 19: Prevention services provided in the community

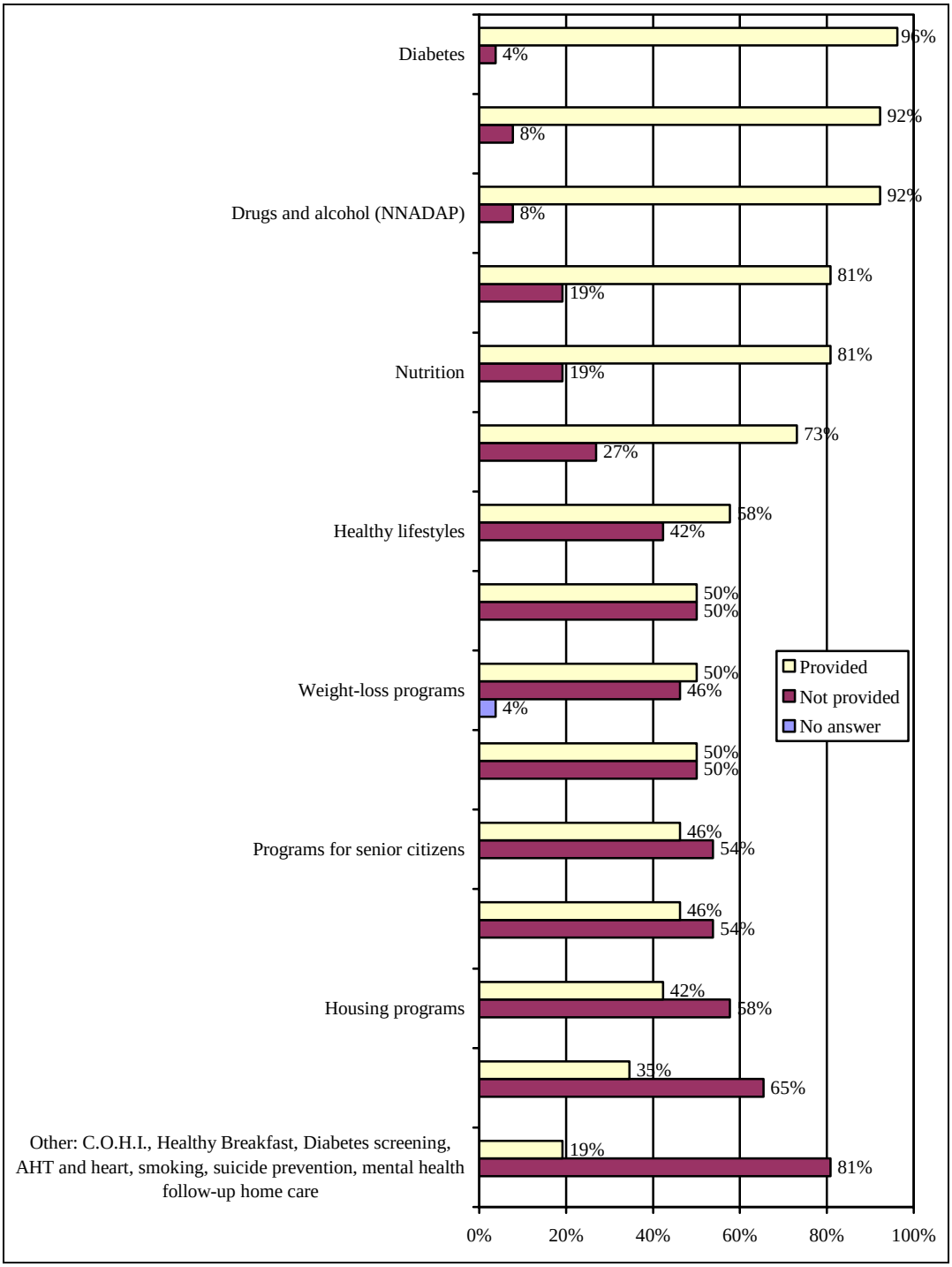


Figure 20 illustrates that general practitioners, NNADAP agents and social workers are the professional resources that are the most available in order to address the needs of the maternal and child health clientele.

Ergotherapists and audiologists are the professional resources that are the least available in the participating communities.

Figure 20: Available professional resources in order to address the needs of the clients in terms of maternal and child health

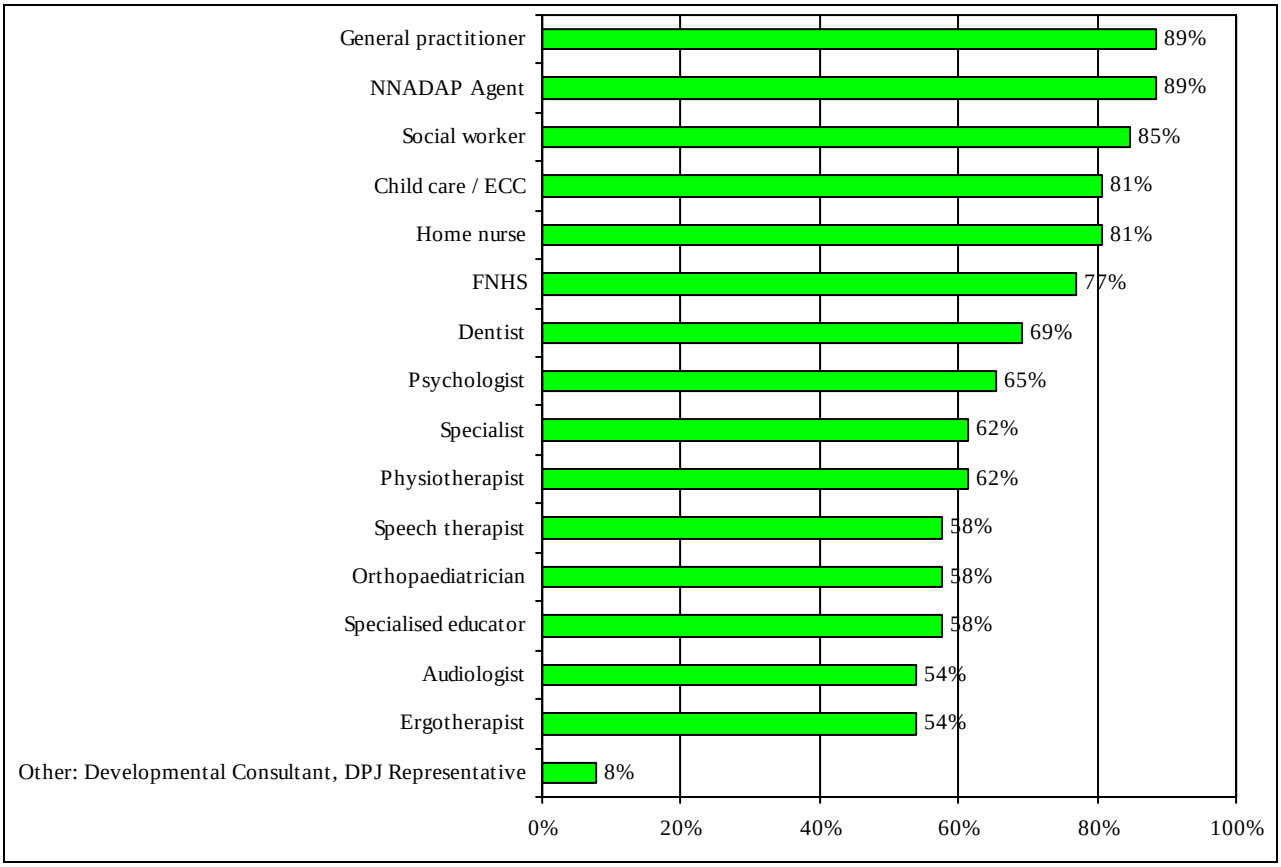


Figure 21 indicates that general practitioners, NNADAP Agents and social workers are the most available in the communities (from 35% to 81% of communities).

Figure 21: Locations where the professional resources are available in order to address the needs of the clients in terms of maternal and child health

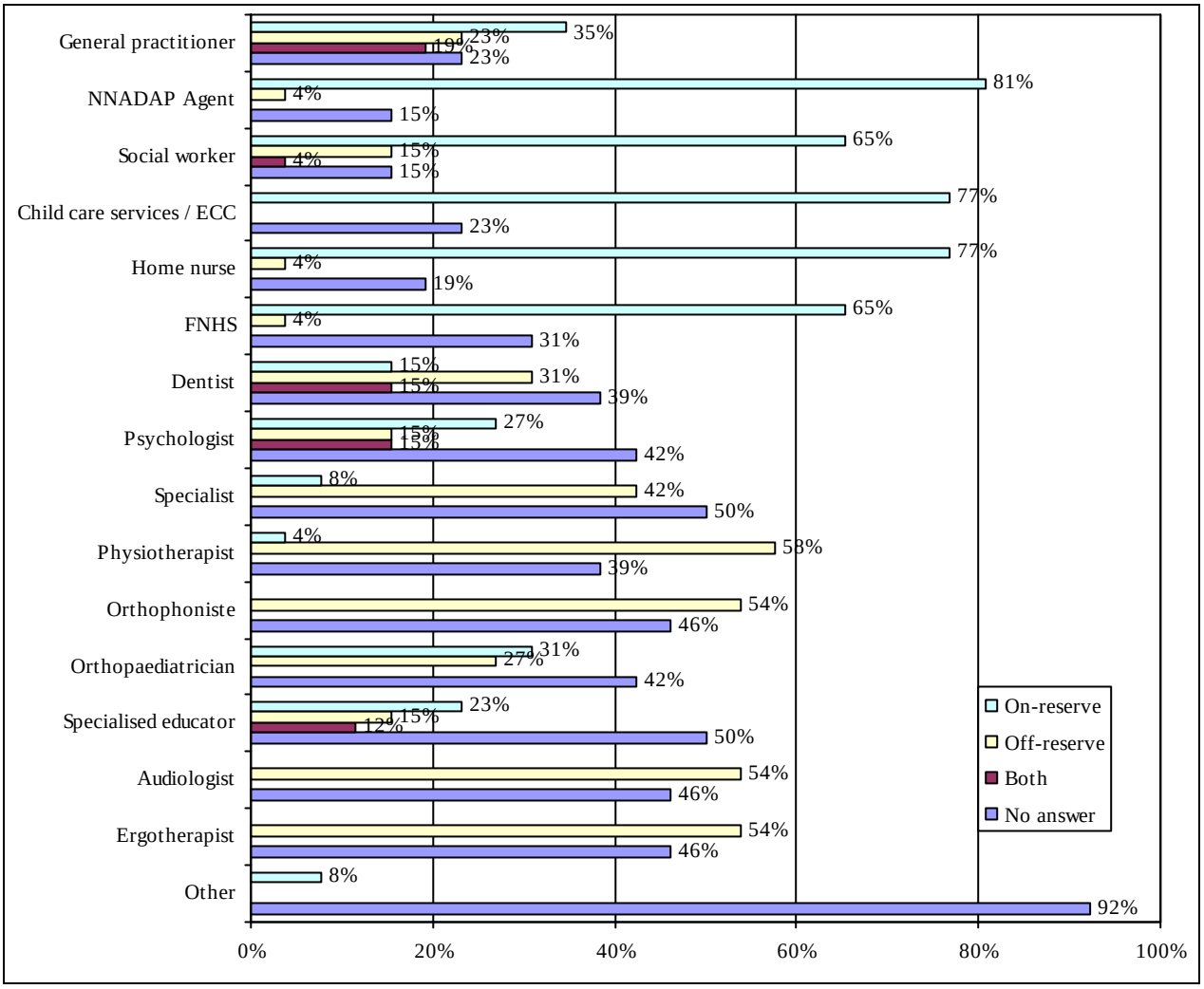
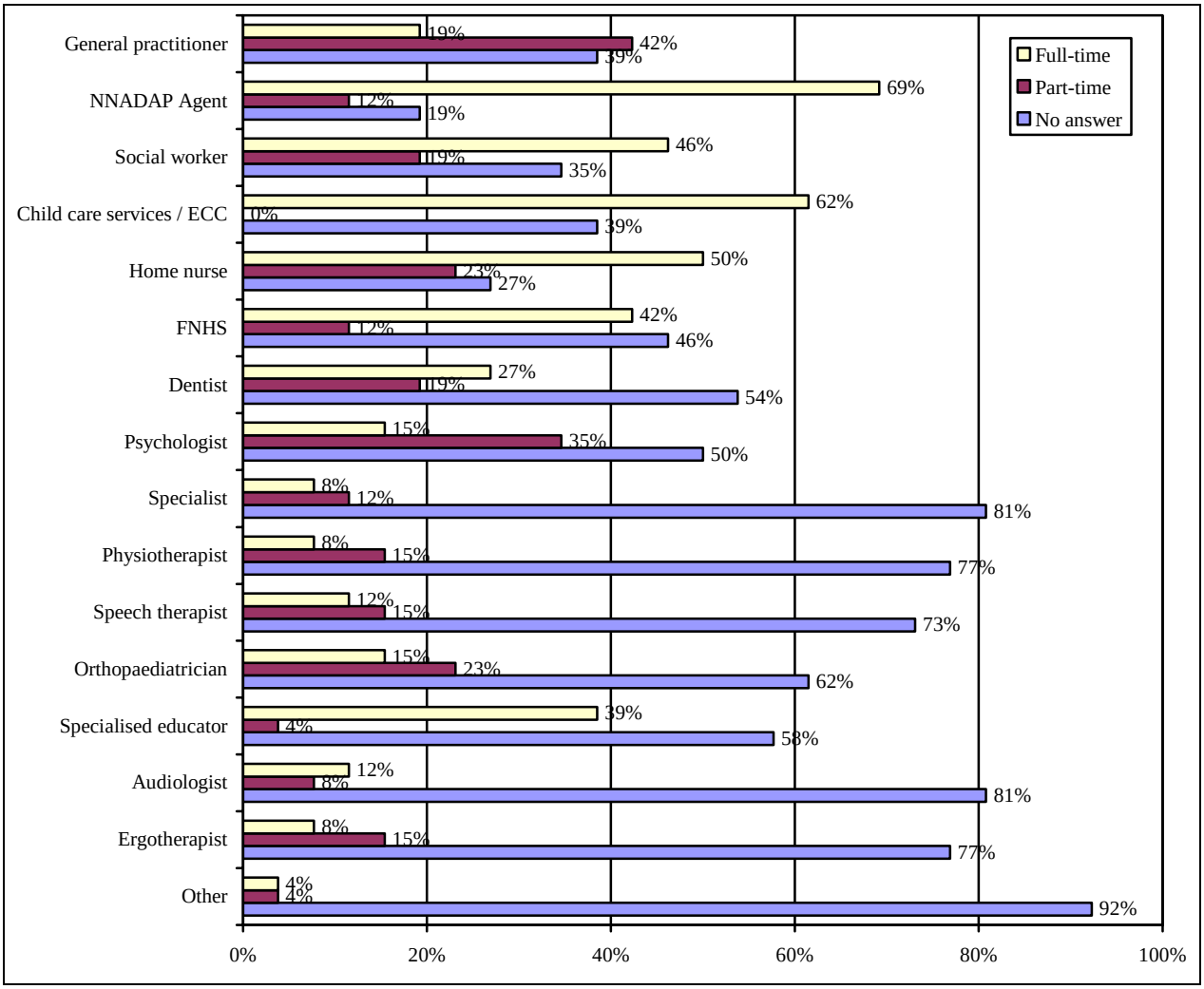


Figure 22 shows that general practitioners are mainly available part-time in order to address the needs of the maternal and child health clientele while the NNADAP Agents and social workers are more often available full-time.

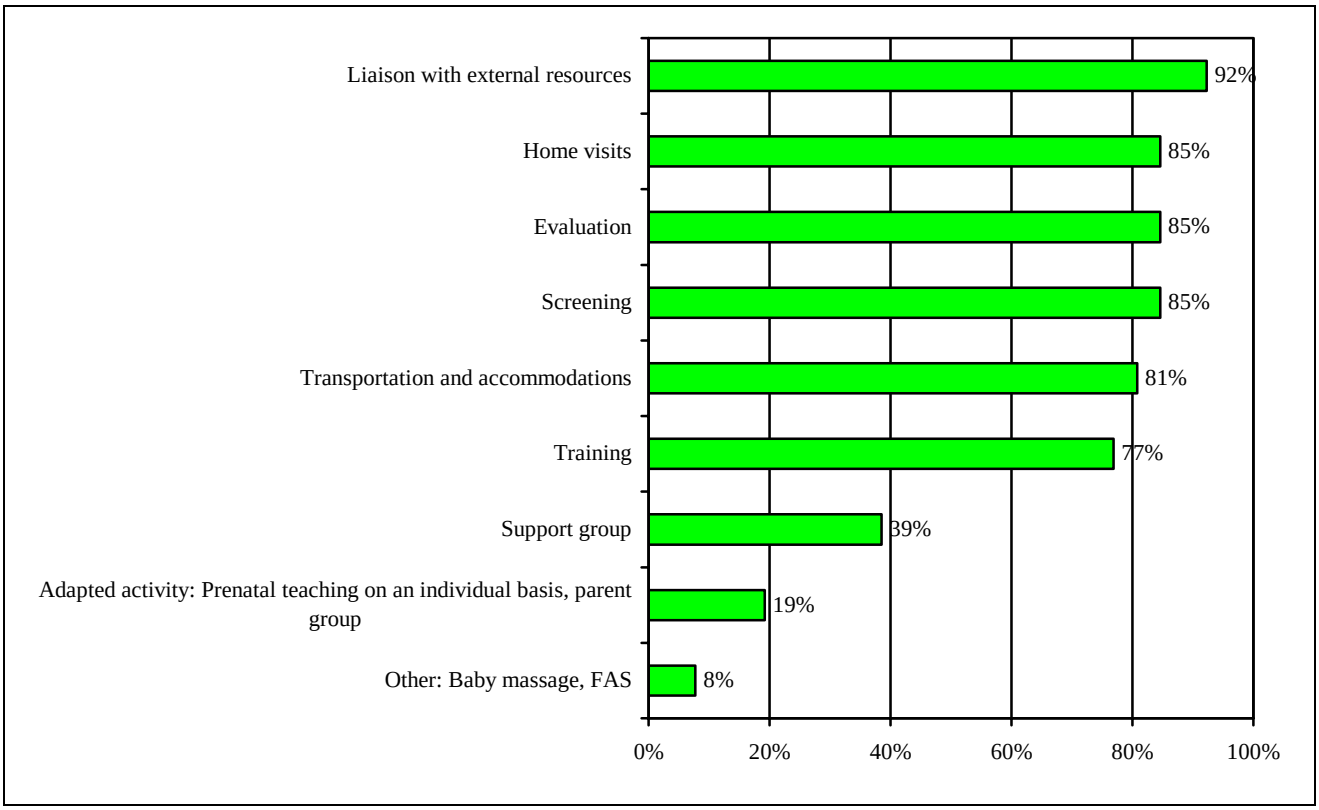
Figure 22: Frequency at which the professional resources are available in order to address the needs of the clients in terms of maternal and child health



According to figure 23, liaison services with external resources, home visits, evaluation and screening are the types of services that are most commonly provided to the maternal and child health clients in the participating communities.

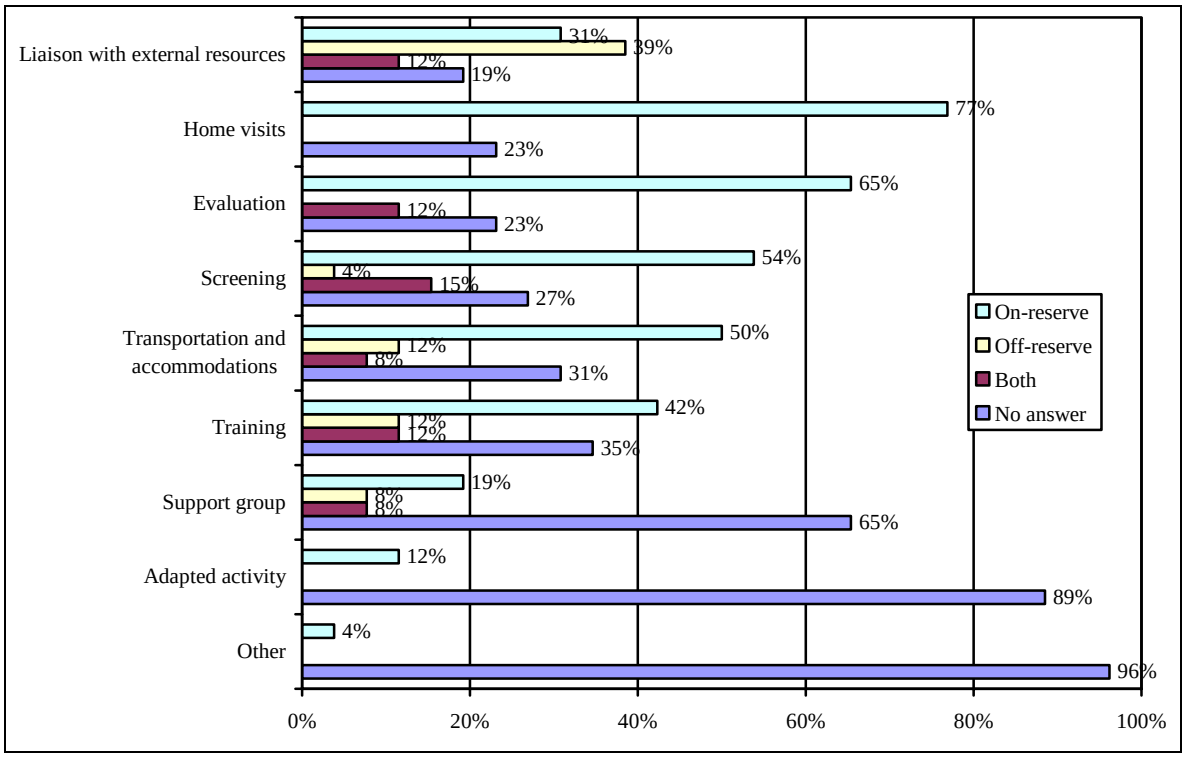
Adapted activities and support groups are, inversely, the services that are the least often provided.

Figure 23: Types of services provided to the maternal and child health clients



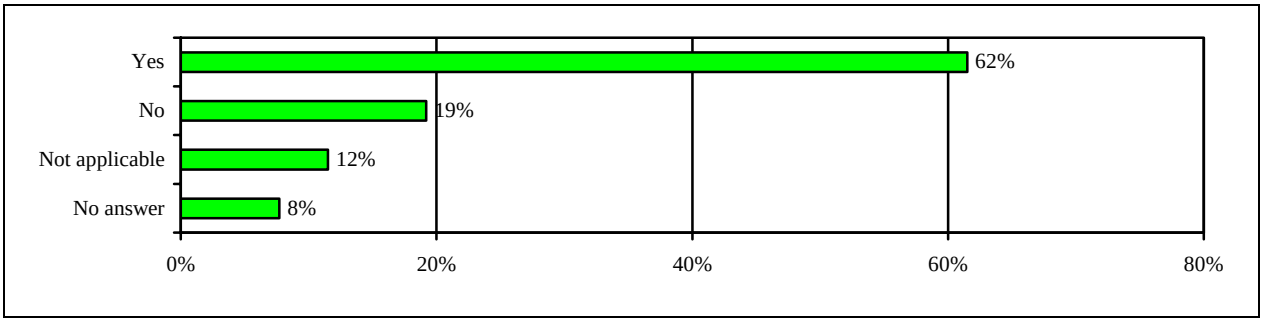
According to figure 24, home visit, evaluation and screening services are the services that are provided most often in the communities (for 54% to 77% of the communities). As for liaison services with external resources, they are provided a bit more often outside of the community.

Figure 24: Places where the types of services are provided to the clients for maternal and child health



62% of the respondents stated that the interveners in their health/social services centre have easy access to the types of services that are provided to the maternal and child health clients in their communities – as presented in figure 25.

Figure 25: Interveners from the health / social services centre who have easy access to the types of services provided to clients in terms of maternal and child health



According to figure 26, the communities collaborate with the *Centre de Santé et des Services sociaux* (CSSS), the hospital, the rehabilitation centre, the social services, the school, the child care services and, to a lesser extent, the Public Health Agency.

Figure 26: Communities that collaborate with these services in order to ensure maternal and child health care for the clients

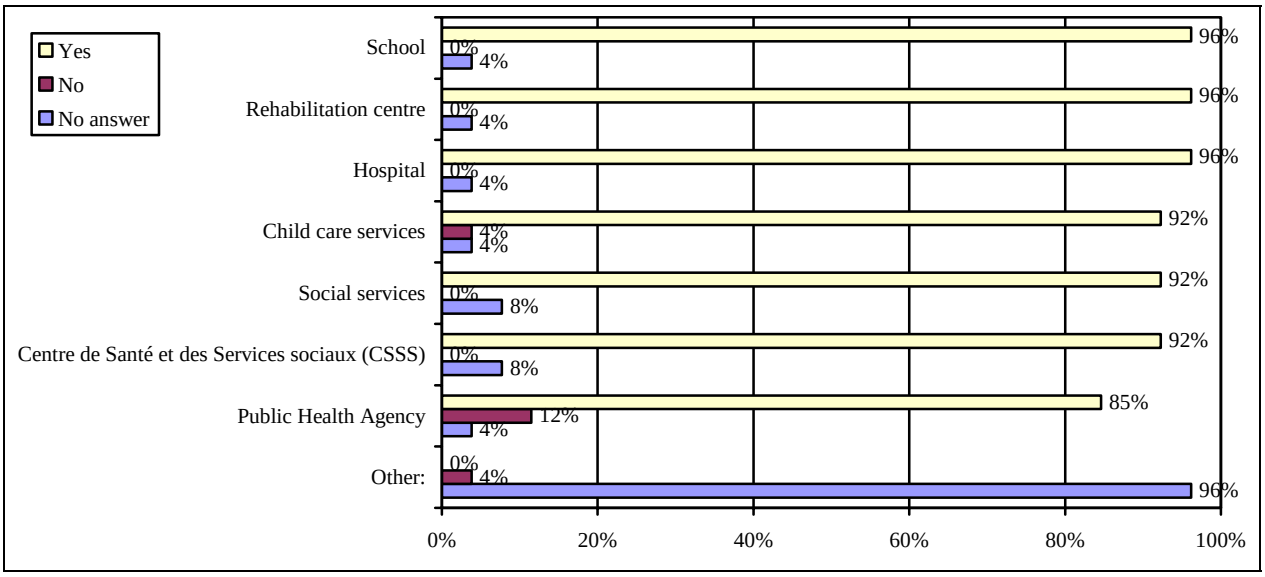
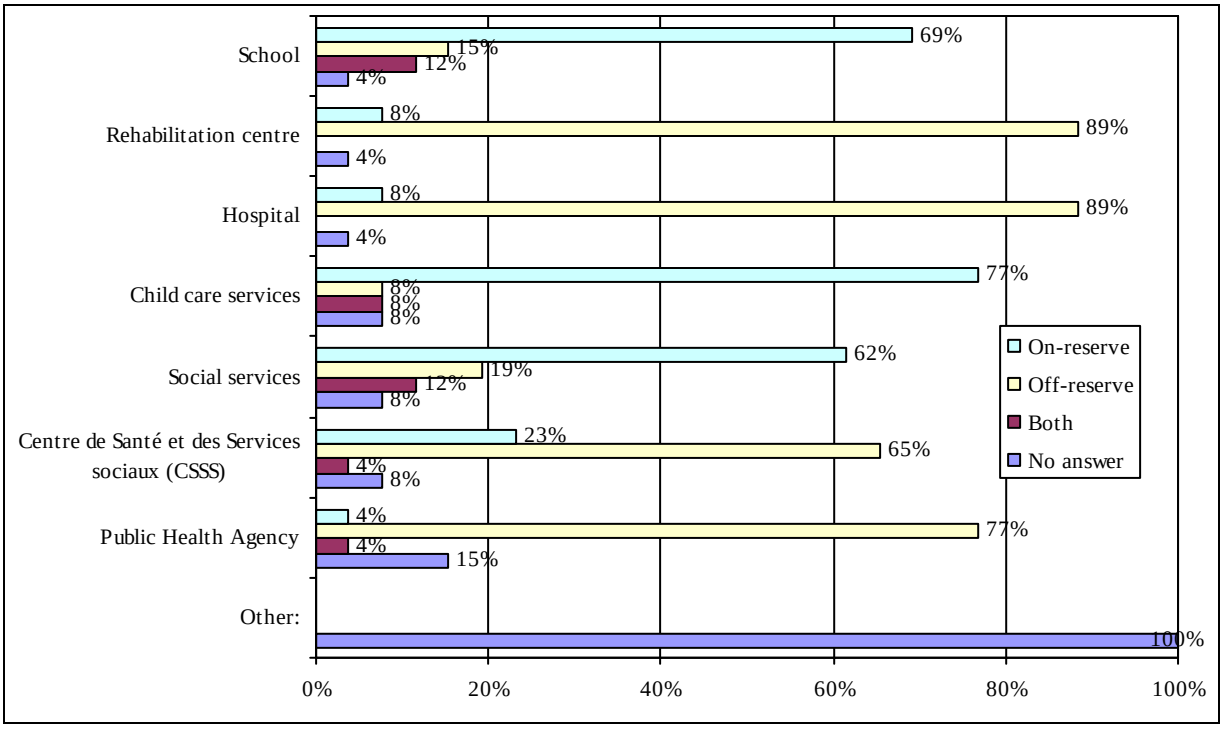


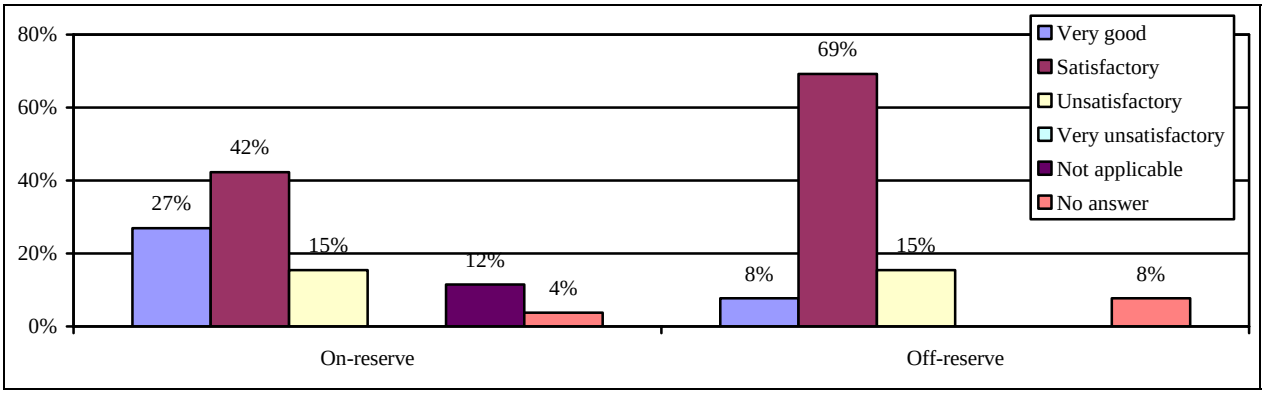
Figure 27 indicates that collaboration with the rehabilitation centre, hospital, *Centre de Santé et des Services sociaux* (CSSS) and the Public Health Agency takes place outside of the community. Collaboration with the school, child care services and social services takes place within the community.

Figure 27: Locations of the services with which the communities collaborate in order to ensure the maternal and child health services for the clients



According to figure 28, collaboration between the health/social services centre and the services provided are more satisfactory within the community than outside of the community.

Figure 28: Definition of the collaboration between the health/social services centre and the services available inside and outside of the community



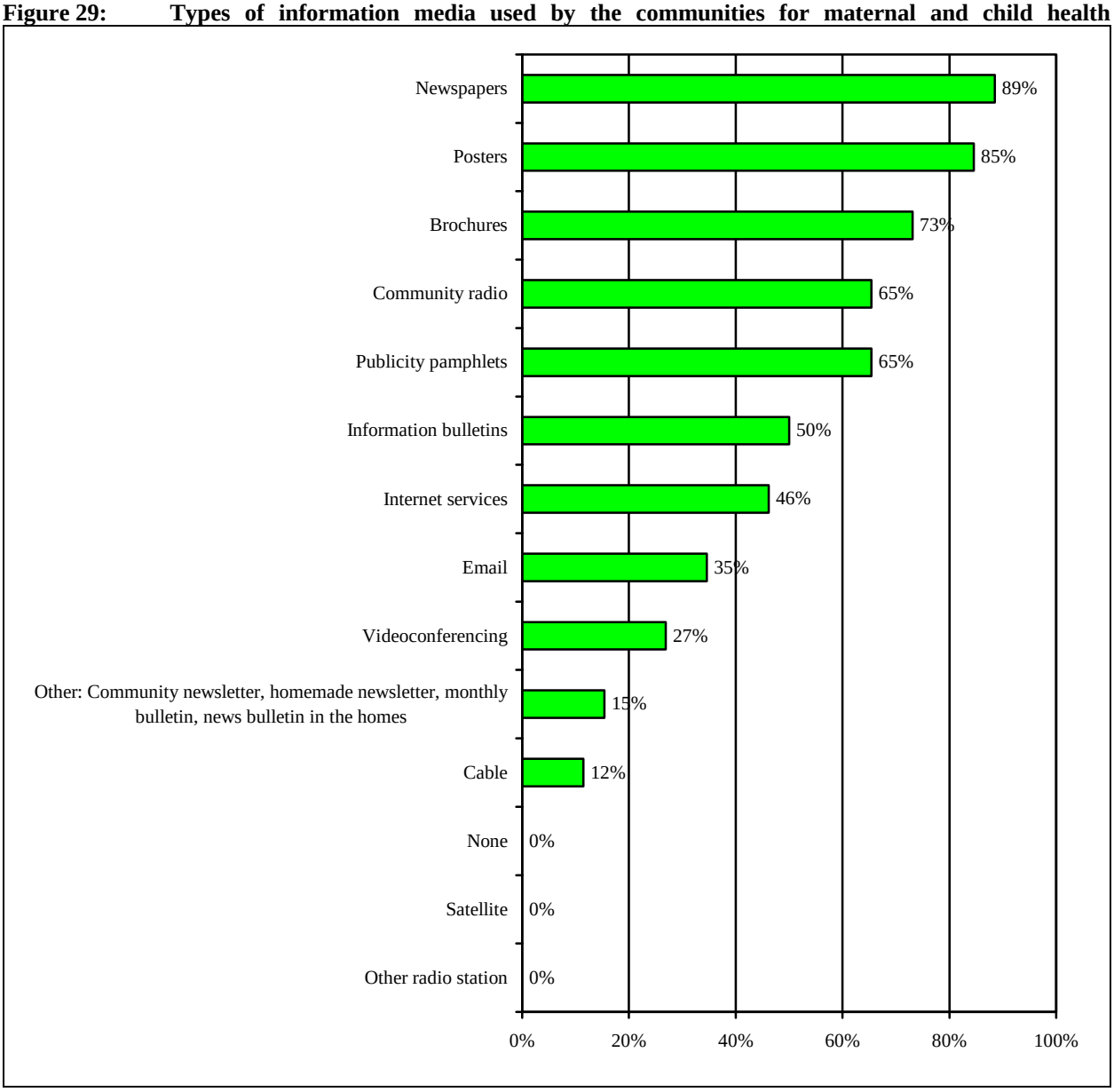
The respondents stated that they would like to receive, in order to support them in their Maternal Child Health Program, information and tools regarding the MCH Program, pregnancy stages, preparation for pregnancy, breastfeeding, FAS, support and assistance during pregnancy, baby manipulation for mothers and fathers, perinatality, early screening for young children, “Rourke” scale for follow-up of children that is adapted for First Nations, prenatal courses, human resources, multidisciplinary approach, vulnerable families, obstetrical follow-up, the different activities regarding MCH and the family week as well as an example of a Maternal and Child Health Program.

Furthermore, the respondents added that they would like to have the opportunity to share information, protocols and best practices with other communities.

2.4 Communications network

According to figure 29, newspapers, posters and brochures are the types of information media that are most commonly used by the communities for maternal and child health.

Figure 29: Types of information media used by the communities for maternal and child health



Foetal Alcohol Syndrome, primary health and parenting skills are the issues that are focused on the most, in the information media, by the health/social services centres of the participating communities, in relation to maternal and child health – as indicated in figure 30.

Inversely, family and birth planning, Shaken Baby Syndrome and baby attachment are the issues that are addressed the least.

Figure 30: Issues addressed by the health/social services centre in the information media in relation to maternal and child health

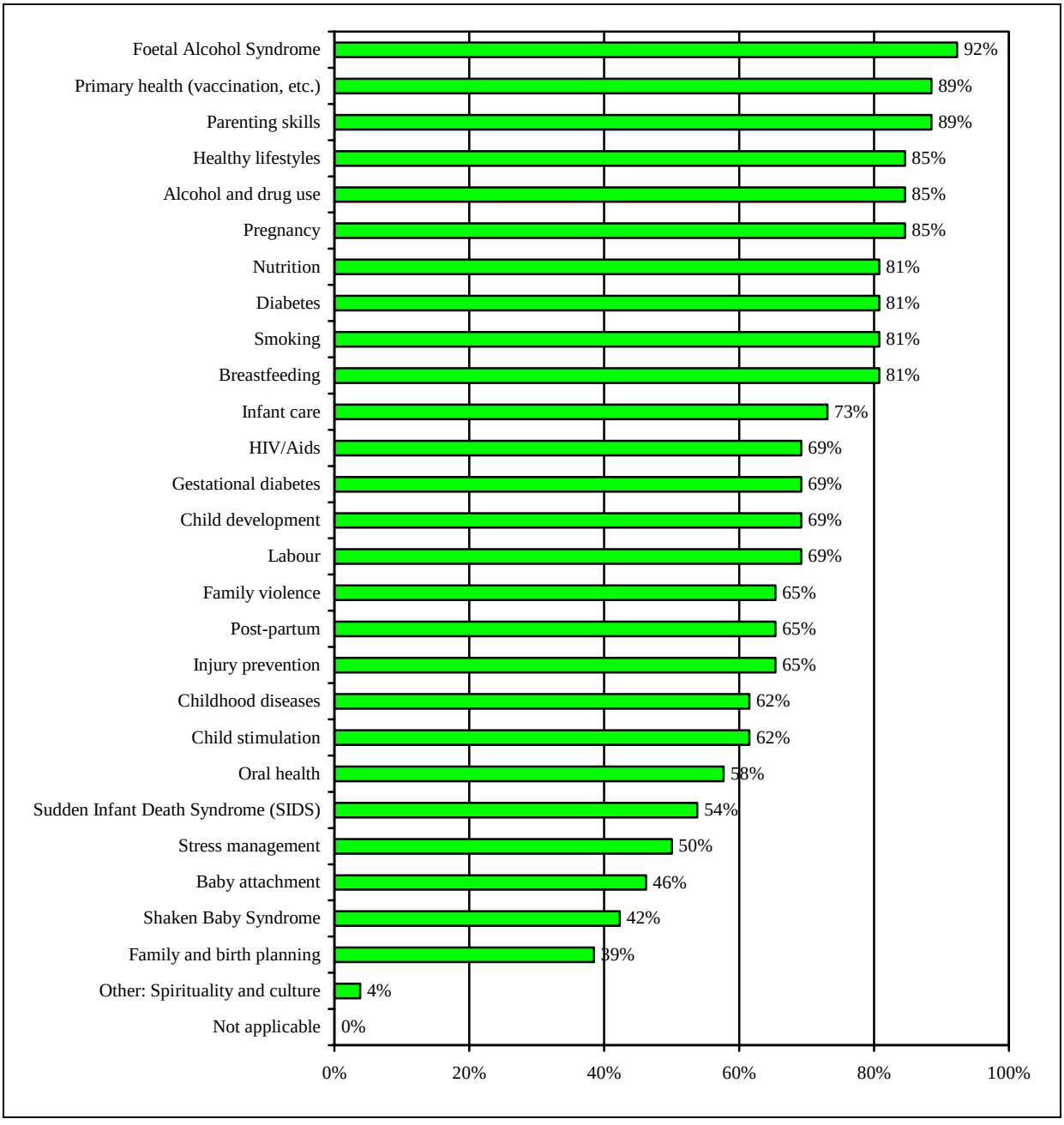
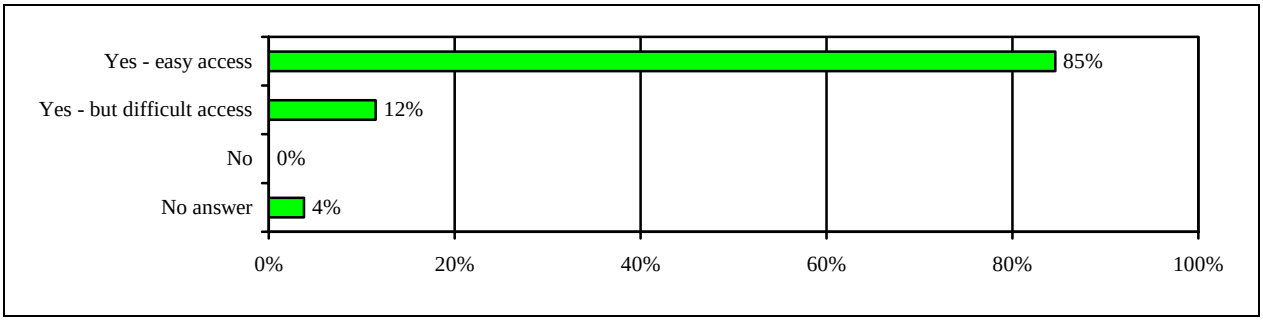


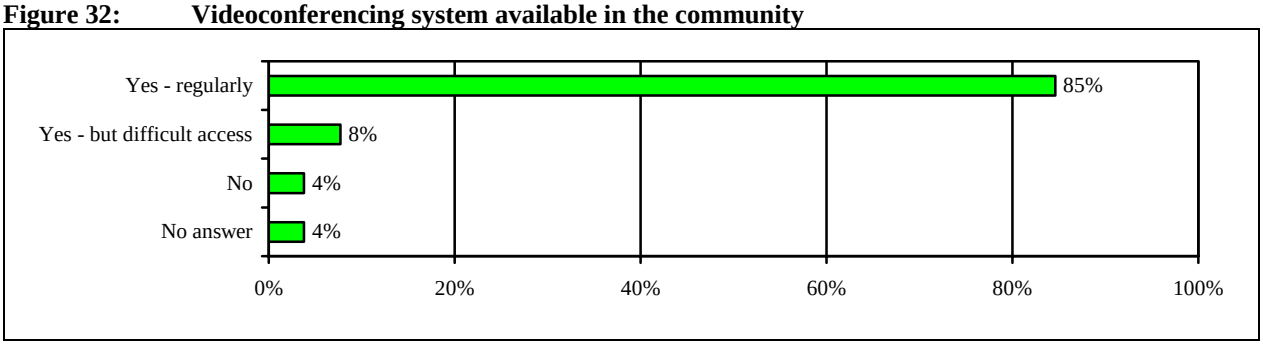
Figure 31 illustrates that 85% of the communities have access to the Internet. However, the respondents specified that in certain communities, only half of the homes are online and that in some others, Internet is only available at the health centre.

Figure 31: Internet services available in the community



On a related matter, figure 32 indicates that 85% of the communities also have access to a videoconferencing system.

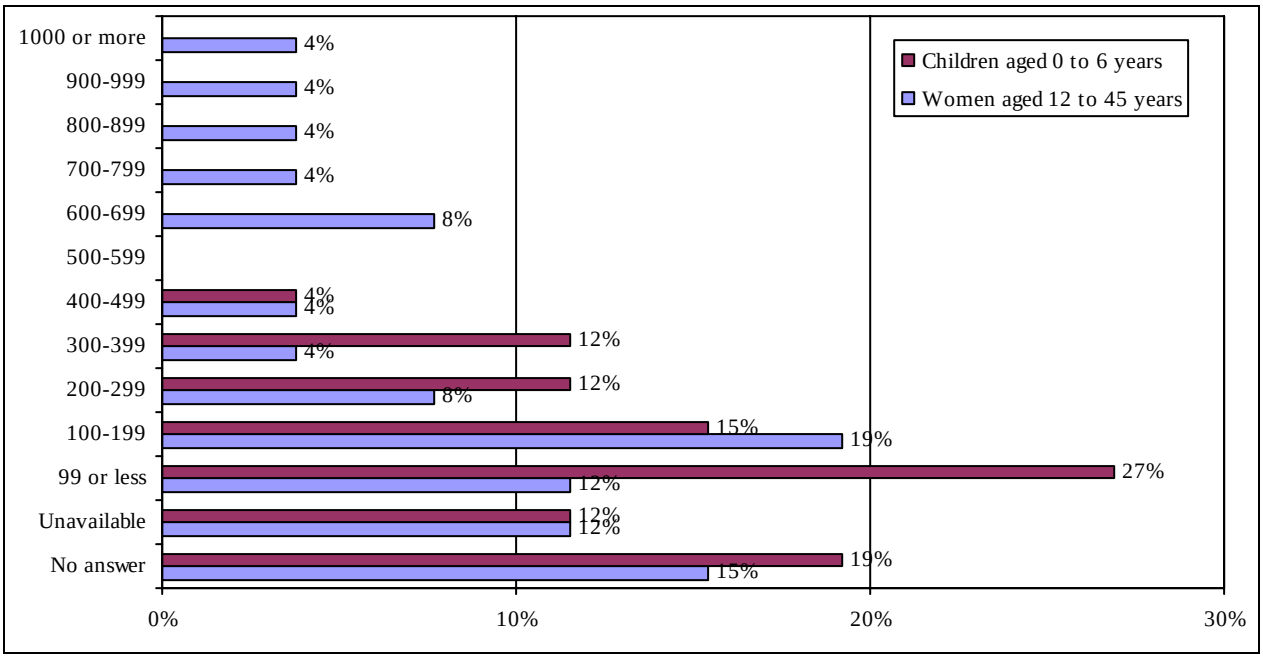
Figure 32: Videoconferencing system available in the community



2.5 Description of the clientele

Figure 33 indicates that 27% of the communities have less than 100 children between the ages of 0 to 6 years and that 19% of the communities have been 100 and 199 women between the ages of 12 and 45 years. The results, however, vary greatly.

Figure 33: Number of women between the ages of 12 to 45 years and children between the ages of 0 to 6 years



Figures 34 and 35 illustrate that 23% of the communities have an average number of children per family of 4 or more and an average number of people per household between 4 and 5,99.

Figure 34: Average number of children per family

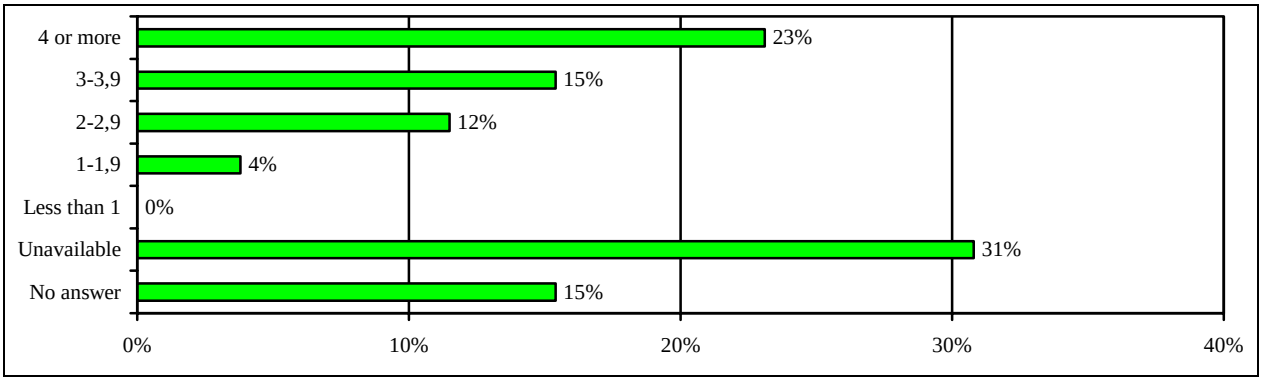
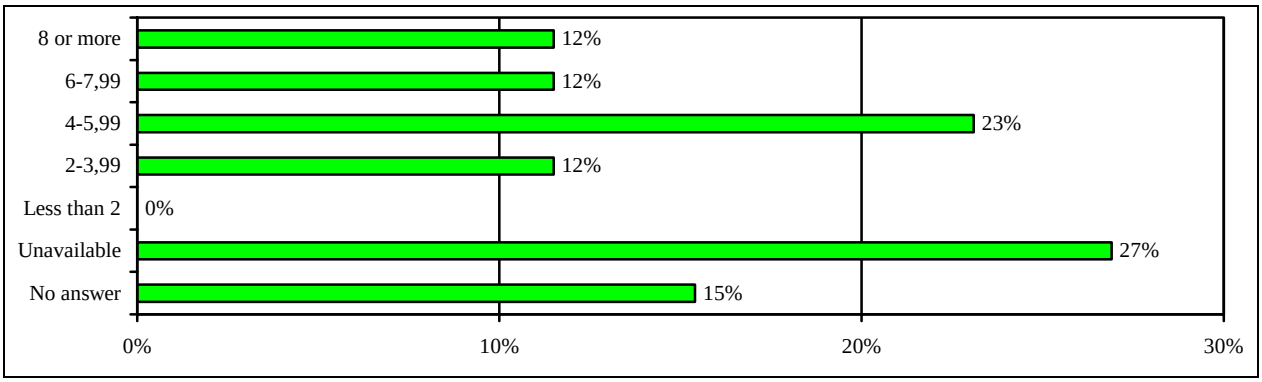
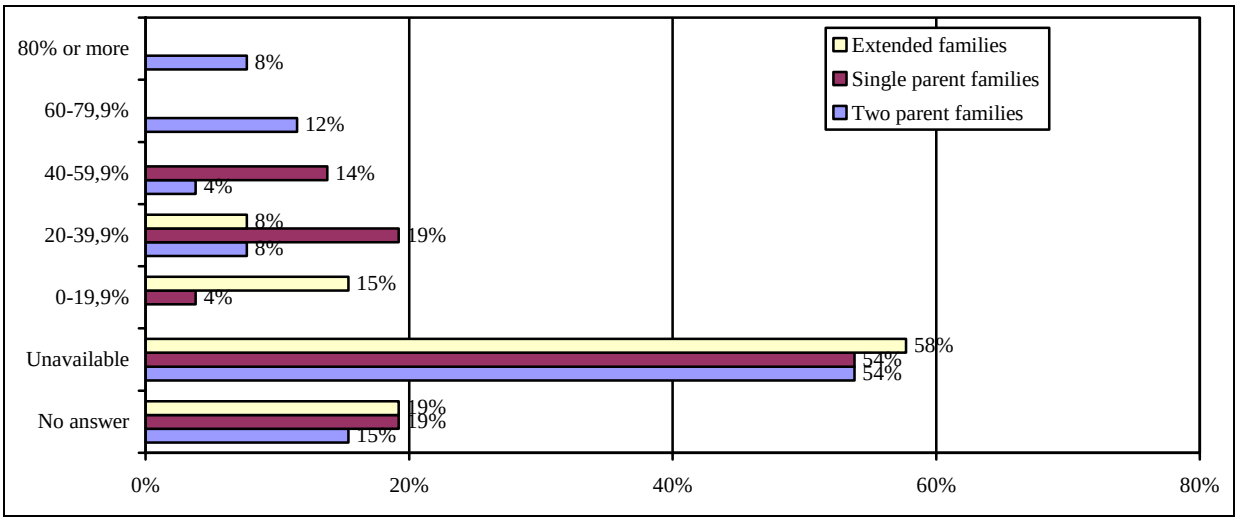


Figure 35: Average number of people per household



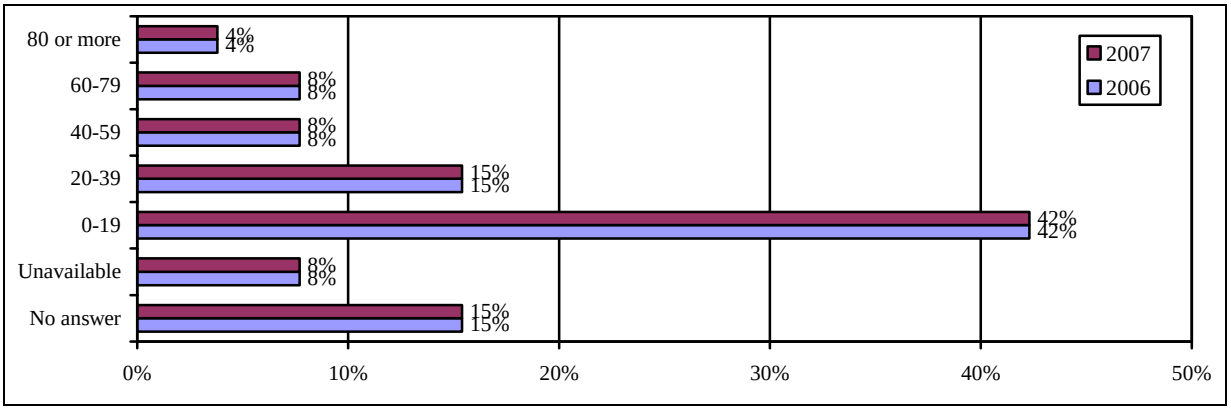
Barely half of the data was available regarding two parent families, single parent families and extended families. Nonetheless, 19% of the communities had rates between 20% and 39,9% of single parent families and 14% had rates between 60% and 79,9% of single parent families – as indicated in figure 36.

Figure 36: Percentage of two parent, single parent and extended families



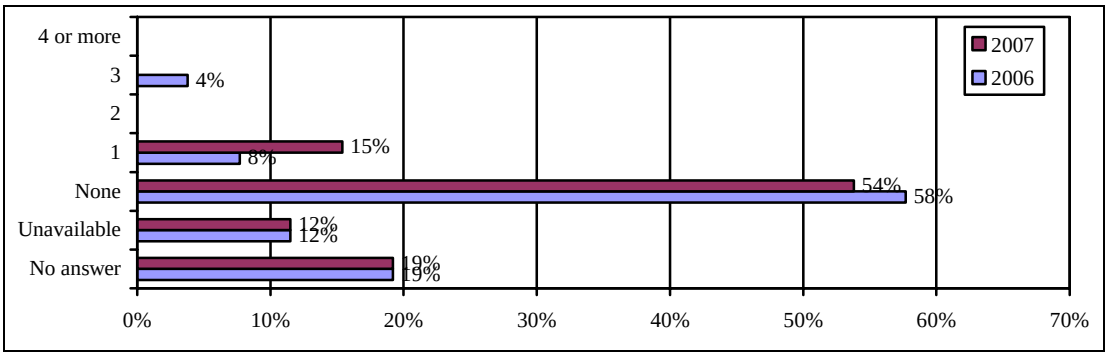
According to figure 37, the same number of births took place in 2006 and 2007 and 42% of the communities counted between 0 and 19 births for both of these two years.

Figure 37: Number of births in 2006 and 2007



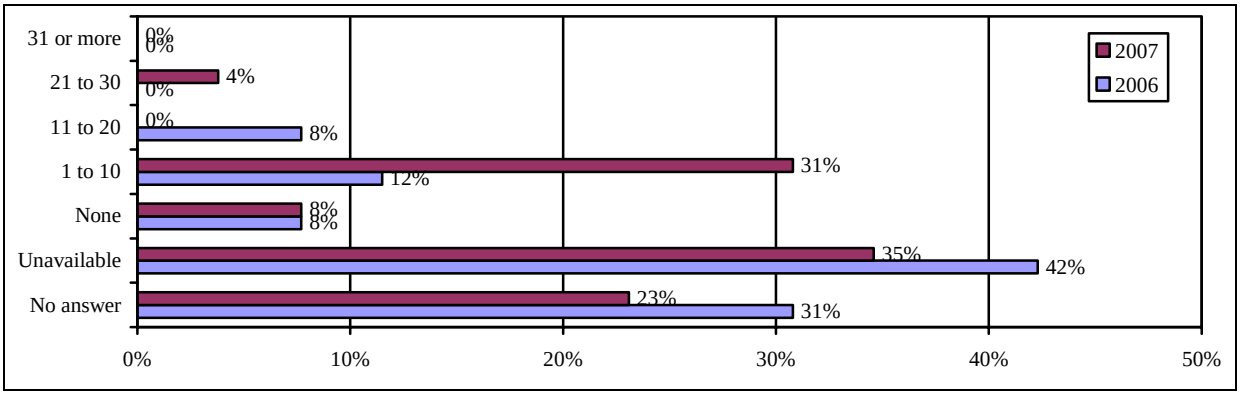
More than half of the communities did not have any infant mortalities in 2006 or in 2007, according to figure 38.

Figure 38: Number of infant mortalities in 2006 and 2007



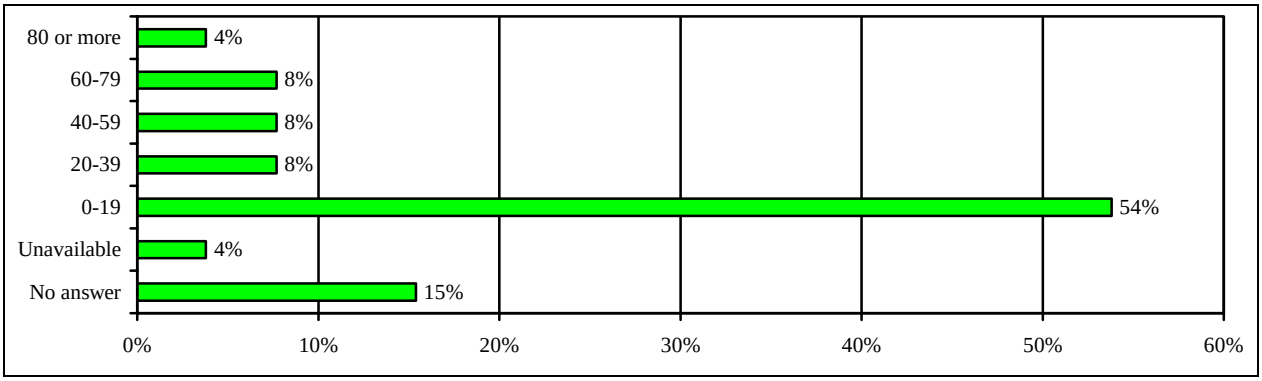
According to figure 39, abortions seem to have increased in 2007 when compared to 2006. However, it is important to exercise caution given the high level of unavailable data and non-responses.

Figure 39: Number of abortions, spontaneous or not, in 2006 and 2007



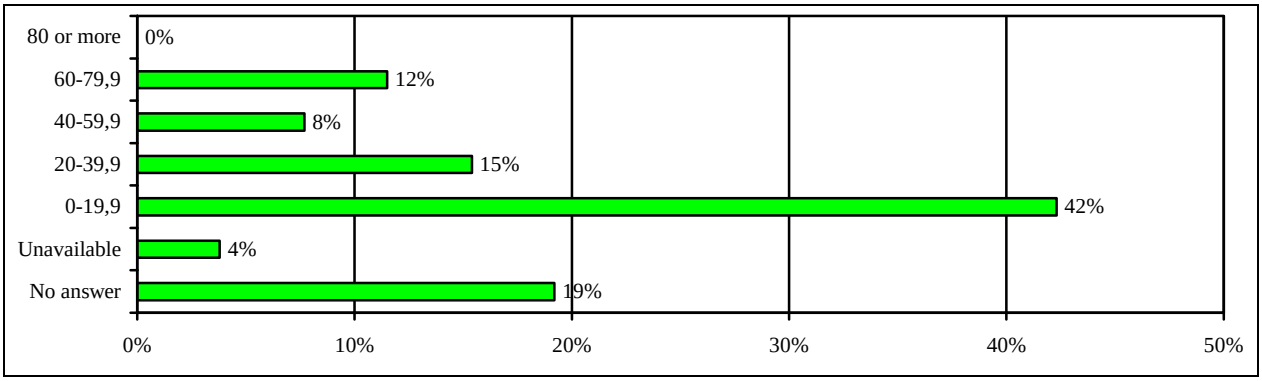
According to figure 40, more than half of the communities expect between 0 and 19 pregnancies for the year 2008.

Figure 40: Number of pregnancies anticipated for the year 2008



According to figure 41, 42% of the communities have an average number of births that is between 0 and 19,9 over the past five years.

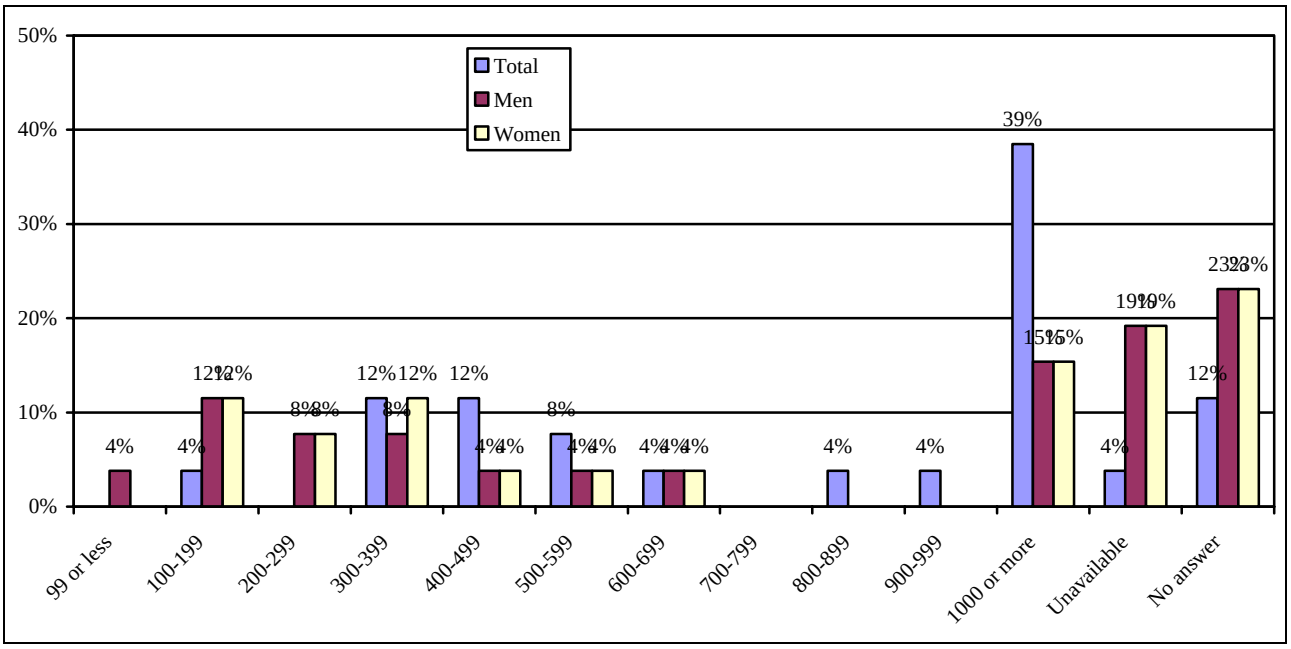
Figure 41: Average number of births over the past five years



2.6 Description of the community

According to figure 42, there seems to be approximately the same number of men and women in the participating communities.

Figure 42: Total population – of men and women



Figures 43 and 44 present the population of boys and girls between the ages of 0 to 6 years.

Figure 43: Population of boys between the ages of 0 to 6 years

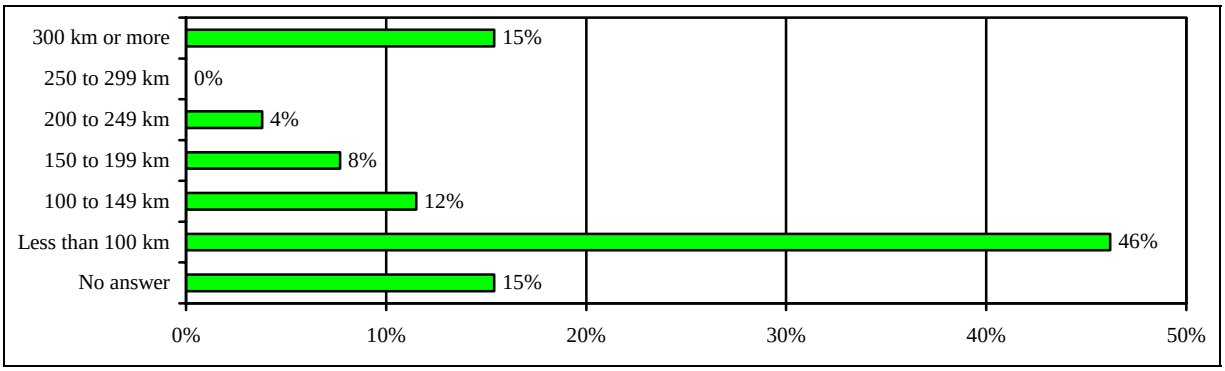
Age	None	1-10	11-20	21-30	Unavailable	No answer
0	2 7,7%	10 38,5%	0 0,0%	0 0,0%	5 19,2%	9 34,6%
1	1 3,8%	9 34,6%	2 7,7%	1 3,8%	5 19,2%	8 30,8%
2	2 7,7%	6 23,1%	2 7,7%	2 7,7%	5 19,2%	9 34,6%
3	1 3,8%	8 30,8%	2 7,7%	1 3,8%	5 19,2%	9 34,6%
4	0 0,0%	8 30,8%	3 11,5%	1 3,8%	5 19,2%	9 34,6%
5	0 0,0%	9 34,6%	2 7,7%	1 3,8%	5 19,2%	9 34,6%
6	0 0,0%	7 26,9%	3 11,5%	1 3,8%	6 23,1%	9 34,6%

Figure 44: Population of girls between the ages of 0 to 6 years

Age	None	1-10	11-20	21-30	Unavailable	No answer
0	0 0,0%	10 38,5%	2 7,7%	0 0,0%	5 19,2%	9 34,6%
1	1 3,8%	8 30,8%	3 11,5%	1 3,8%	5 19,2%	8 30,8%
2	0 0,0%	8 30,8%	2 7,7%	2 7,7%	5 19,2%	9 34,6%
3	1 3,8%	7 26,9%	3 11,5%	1 3,8%	5 19,2%	9 34,6%
4	1 3,8%	7 26,9%	4 15,4%	0 0,0%	5 19,2%	9 34,6%
5	0 0,0%	8 30,8%	3 11,5%	1 3,8%	5 19,2%	9 34,6%
6	0 0,0%	9 34,6%	1 3,8%	1 3,8%	6 23,1%	9 34,6%

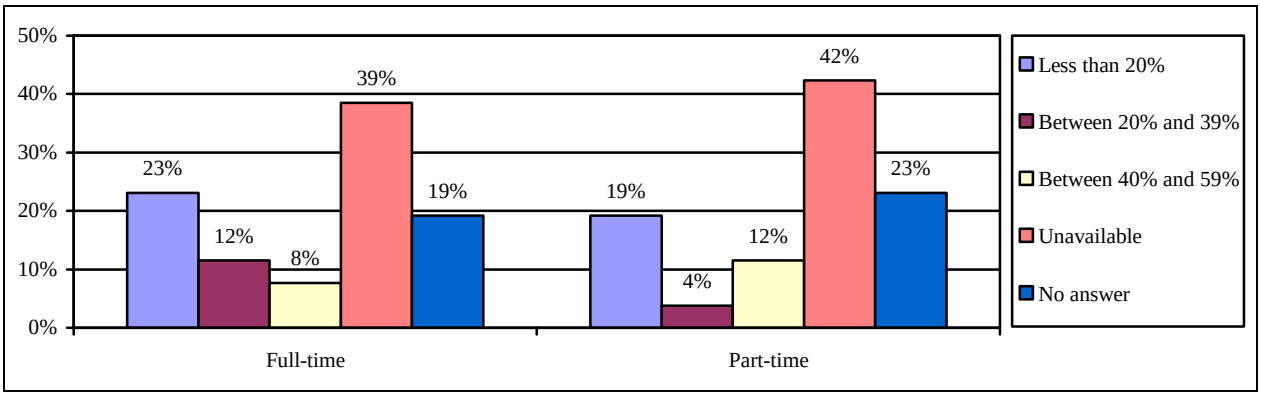
Nearly half of the participating communities have access to a hospital that provides perinatality services and is less than 100 km away – according to figure 45.

Figure 45: Distance separating the communities from the closest hospital that provides perinatal services



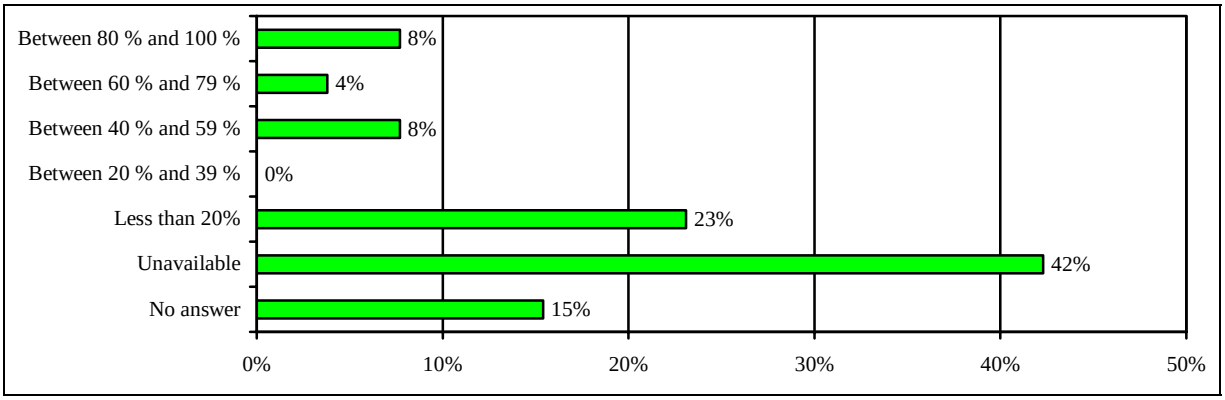
The data regarding employment was unavailable for several communities. Nonetheless, figure 46 indicates that 23% of the communities stated that less than 20% of their population of 16 years of age and up have full-time employment.

Figure 46: Percentage of the population that is 16 years old and up that is employed



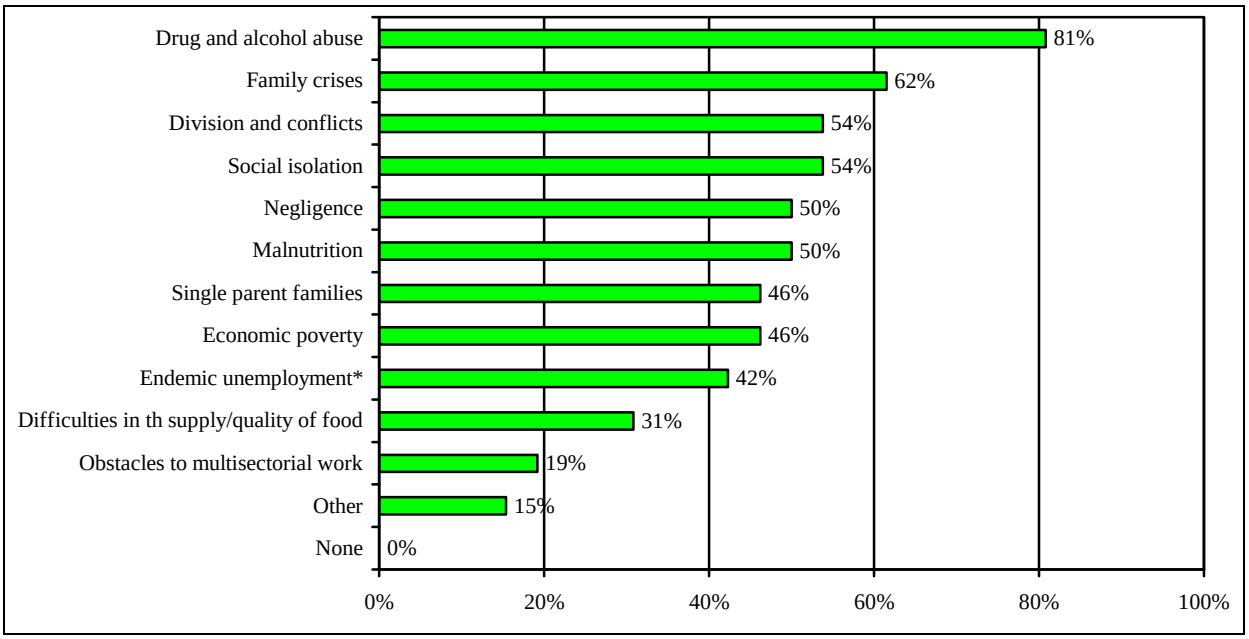
The data regarding social assistance was unavailable for several communities. Figure 47 however indicates that 23% of the communities mention that at least 20% of the population that is 16 years of age and up receives social assistance.

Figure 47: Percentage of the population that is 16 years old and up that receives social assistance



According to figure 48, more than half of the respondents stated that drug and alcohol abuse problems, family crises and division and conflicts are present in their community.

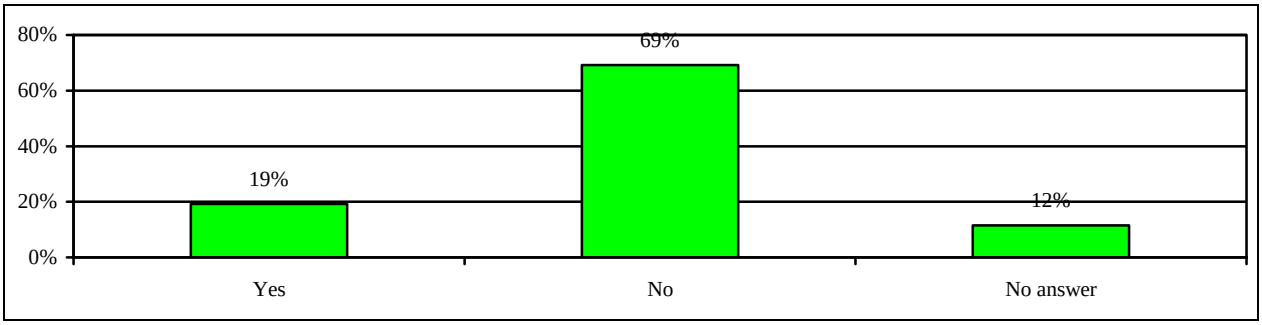
Figure 48: Presence of general social problems within the communities



* According to the Office québécois de la langue française, endemic unemployment is a form of persisting unemployment. It can affect people with certain physical, mental or professional characteristics that render employment nearly impossible; it can also affect regions that are in a state of economic under-development that is manifested through abundant and prolonged unemployment. In the latter case, it is believed that only vigorous action on behalf of the State, or the mass transfer of the populations, can provide for an effective solution to this type of unemployment (http://www.granddictionnaire.com/BTML/FRA/r_Motclef/index800_1.asp, consulted on February 29, 2008).

Figure 49 illustrates that 69% of the participating communities consider having a sufficient number of adequate housing and infrastructures.

Figure 49: Sufficiency in terms of adequate housing and infrastructures in the community



According to figure 50, 35% of the communities have an average number of people per household that varies between 4 and 5,99.

Figure 50: Sufficiency in terms of adequate housing and infrastructures in the community

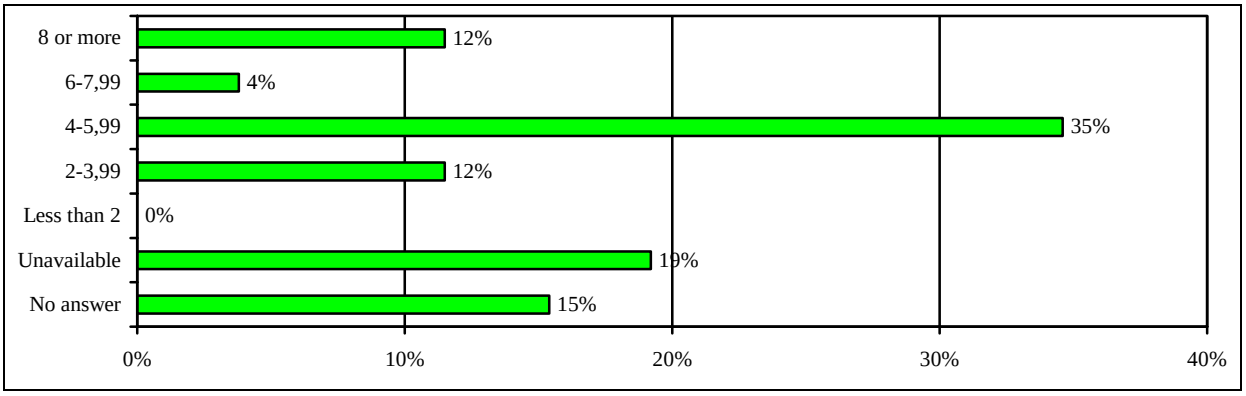
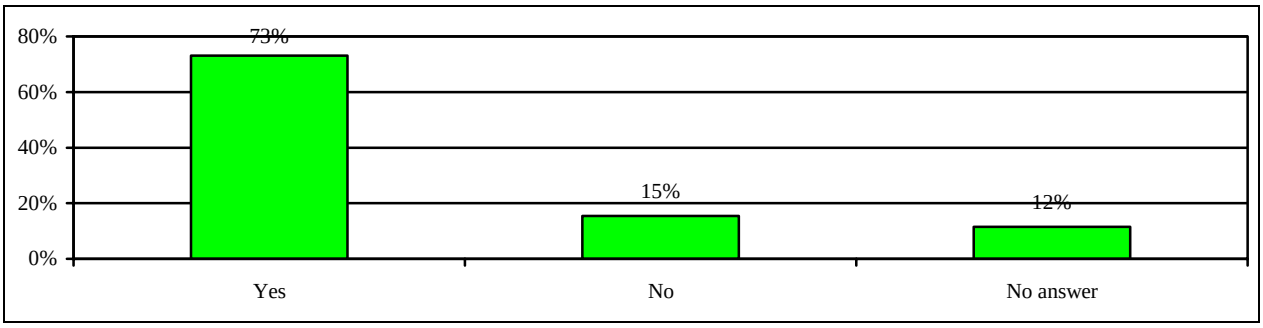


Figure 51 illustrates that almost three-quarters of the participating communities have recreational and leisure installations. Arenas, youth centres, youth camps, rinks, indoor and outdoor pools, parks, baseball fields, soccer fields, volleyball courts, libraries, gymnasiums, community centres and cafeterias are the types of installations that were mentioned.

Figure 51: Presence of recreational or leisure installations in the community

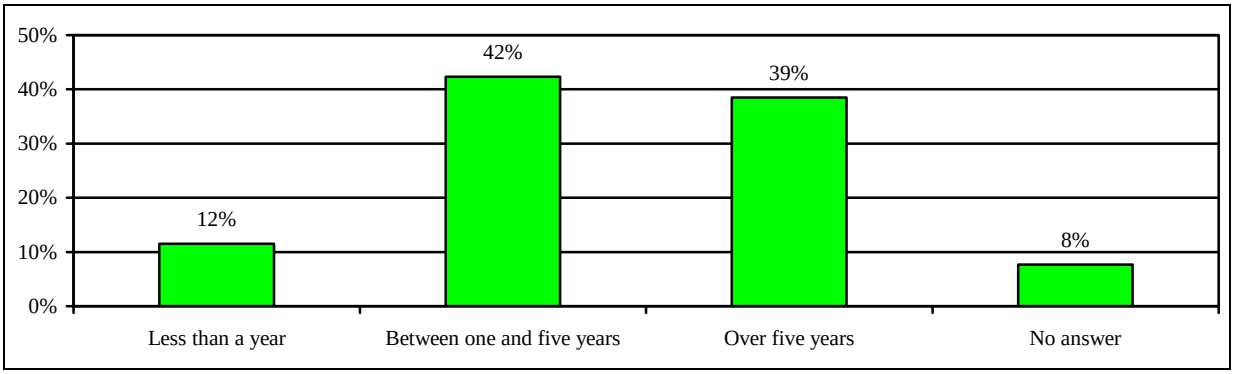


2.7 Identification of the respondent

Various professionals filled out the questionnaire. Among these professionals are nurses, head nurses, health and social services coordinators, health and social services directors, research and project agents and technicians.

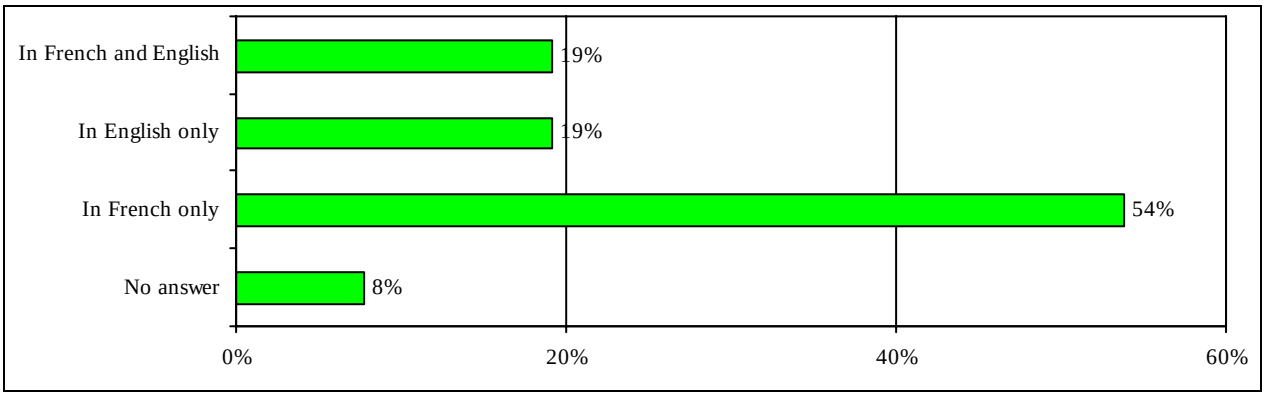
As presented in figure 52, 42% of the responding professionals have held the mentioned position for between one and five years.

Figure 52: Number of years in the mentioned position



More than half of the respondents mentioned that they would like to receive the information that is intended for their community's population in the French language only – as illustrated by figure 53.

Figure 53: Language in which the respondents would like to receive the information that is intended for their community's population



Third section: Highlights

Available services

It is interesting to compare the services that are available in the communities related to maternal and child health before, during and after pregnancy.

Available before pregnancy in most of the communities that were surveyed:

- The prevention of the risk factors related to alcohol, medication, nutrition, tobacco and drugs.

Available during pregnancy in most of the communities that were surveyed:

- Pregnancy follow-up;
- Nutritional follow-up;
- Preparation for labour;
- Psychological support.

Available after pregnancy in most of the communities that were surveyed:

- Vaccinations;
- Post-natal follow-up for the child;
- Home visits.

Unavailable services

Inversely, certain services are lacking or are unavailable in the communities before, during and after pregnancy.

Available before pregnancy in the least of the communities that were surveyed:

- Support by the Elders;
- Participation in genetic research.

Available during pregnancy in the least of the communities that were surveyed:

- Participation in genetic research;
- Support by the Elders;
- Assistance of a midwife.

Available after pregnancy in the least of the communities that were surveyed:

- Participation in genetic research;
- Assistance of a midwife.

Role of the health professionals

Regarding the different health professionals who work in maternal and child health, the respondents identified their roles before, during and after pregnancy.

The physicians:

- Before pregnancy:
  - Prevention of risk factors related to medication;
  - Birth planning.
- During pregnancy:
  - Pregnancy follow-up.
- After the pregnancy:
  - Birth planning.

The nurses:

- Before pregnancy:
  - Birth planning;
  - Prevention of risk factors related to nutrition.
- During pregnancy:
  - Pregnancy follow-up;
  - Preparation for labour;
  - Prenatal courses.
- After the pregnancy:
  - Vaccination;
  - Home visits.

Few family visitors were surveyed. Their role primarily consists of:

- Before pregnancy:
  - Encouragement in the involvement of fathers.
- During pregnancy:
  - Home visits.
- After the pregnancy:
  - Support for parenting skills.

The psychologists:

- Before pregnancy:
  - Psychological support;
  - Prevention of risk factors related to addictions.
- During pregnancy:
  - Psychological support.
- After the pregnancy:
  - Psychological support.

Social workers:

- Before pregnancy:
  - Psychological support;
  - Prevention of risk factors related to alcohol and drugs.
- During pregnancy:
  - Psychological support.
- After the pregnancy:
  - Psychological support.

The nutritionists:

- Before pregnancy:
  - Nutritional follow-up;

    - Prevention of risk-factors related to nutrition.
- During pregnancy:
    - Nutritional follow-up.
- After the pregnancy:
    - Nutritional follow-up for the mother;
    - Nutritional follow-up for the child.

Programs provided

Many programs are provided in the communities. According to the respondents, the most common are:

- Aboriginal Diabetes Initiative;
- Nursing services;
- Home and Community Care Initiative;
- Foetal Alcohol Spectrum Disorder Program (FASDP)

Inversely, certain programs are seldom provided in the communities:

- Public health physician-advisor program;
- Healthy Communities Program;
- First-line Services Pilot Project.

Culturally-adapted services

Half of the respondents stated that the health services that are provided in their health/social services centre are not very adapted to their culture. A little bit less than half stated that they are indeed adapted.

Maternal and child health interveners who are the most present

According to the respondents, certain interveners are more commonly found in their communities:

- Nurses;
- Community health representatives;
- Nutritionists.

Inversely, some are less accessible in the communities:

- Family counsellors;
- Ergotherapists;
- Pharmacists.

Protocol and file management

According to the respondents, more than half of the health/social services centres have a protocol to follow-up on the maternal and child health clientele.

Furthermore, file management appears to be systematic for more than three-quarters of the participating communities.

Accessible resources

Certain services were identified as being the most available in the surveyed communities:

- Prenatal care;
- Vaccination;
- Postnatal care;
- Community nursing services.

Inversely, certain services do not seem to be very present:

- Paediatric clinic;
- Language and culture promotion;
- Dental clinic.

Prevention services provided

Certain prevention services were identified as being the most provided in the surveyed communities:

- Diabetes;
- HIV/Aids;
- Drugs and alcohol through the NNADAP.

Inversely, certain services do not seem very present:

- Youth programs;
- Housing programs;
- Information programs.

Available professional resources

The professional resources that the respondents identified as the most available in order to address the needs of the maternal and child health clientele are:

- General practitioner;
- NNADAP agent;
- Social worker.

However, certain professional resources are not or seldom available:

- Ergotherapist;
- Audiologist.

Types of services provided

The types of services that are most commonly provided to the maternal and child health clientele in the participating communities are:

- External resource liaison services;
- Home visits;
- Evaluation;
- Screening.

Inversely, the types of services that are not or seldom provided are:

- Adapted activities;
- Support groups.

Access to types of services

More than half of the respondents stated that the interveners in their health/social services centre have easy access to the types of services provided to the maternal and child health clients in their community.

Collaboration with the services

According to the respondents, the communities collaborate with the *Centre de Santé et des Services sociaux* (CSSS), the hospital, the rehabilitation centre, the social services, the school, the child care services and, to a lesser extent, with the Public Health Agency.

However, it seems that the collaboration between the health/social services centre and the services provided are more satisfactory within the community than outside of the community.

Information media

The communities use different strategies in order to reach out to the community members in terms of the maternal and child health issue. The most common are:

- Daily newsletters;
- Posters;
- Brochures.

Issues addressed

Certain issues that are related to maternal and child health are addressed in most of the communities. These issues are:

- Foetal Alcohol Spectrum Disorder;
- Primary health;
- Parenting skills.

Inversely, certain subjects are seldom addressed by the health/social services centres:

- Birth and family planning;
- Shaken baby syndrome;
- Baby attachment.

Videoconferencing and Internet access

More than three-quarters of the respondents stated that the Internet is available in their community. However, they specified that in some communities, only half of the homes have Internet while in other communities, the Internet is only available at the health centre.

In a related issue, the same proportion of communities has access to a videoconferencing system.

Description of the communities

Nearly half of the participating communities have access to a hospital that is less than 100 km away that provides perinatality services.

More than half of the respondents stated that alcohol and drug problems, family crisis issues as well as division and conflict are present in their community.

More than half of the participating communities consider that they have an insufficient number of adequate homes and infrastructures.

Fourth section: Recommendations

To help create conditions that are conducive to the development of First Nations maternal and child health services, and in accordance with the Master Plan entitled “Closing the Gaps – Accelerating Change”, which targets action upstream of the problems by giving priority to children in family health care and education, action will also be taken to improve prevention and first-line services.

The Master Plan proposes these actions as a means of achieving one of its objectives, namely to reduce infant mortality rates by 50%. After reading the report, we make the following recommendations:

- Seek to standardize access to adapted maternal and child health services, based on the situation of each community.
- Develop the home visit service component in the communities by allowing for the recruitment and training of human resources. This will help ease the task of nurses and will foster prevention rather than intervention.
- Develop and introduce mechanisms conducive to interdisciplinary and inter-sector teamwork.
- Find ways of providing access to pre- and post-natal services that are adjusted to the situation of families in more remote communities, who have had to leave their communities in order to give birth.
- -this could be done by offering the services of midwives or doulas who would be available in the hospitals.
- Make sure an inter-sector preventive approach to FASD is taken in the communities.
- Make sure the community’s seniors are given a greater role in the various maternal and child health prevention and knowledge transfer messages.
- Make sure promotion and prevention activities and services reflect the culture and situation of the First Nations.
- Make sure the maternal and child health program is viable by providing enough funding to meet the need for human, material and technological resources, based on the needs and expectations expressed by the communities.
- Improve access to specialist resources (e.g. occupational therapist, speech therapist, other specialists, etc.).

Although not stipulated in the questionnaire, it should be noted that it was difficult, in the field, to contact families with children aged between 2 and 5. Home visits should therefore be used to develop a continuum of services after the visits proposed on the vaccination schedule.

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Annexe 1:
Questionnaire

QUESTIONNAIRE

A Community/Regional Portrait of Maternal and Child Health Care (MCHC)

The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)

INTRODUCTION

VISION

The vision of the Maternal and Child Health Care (MCHC) program is to ensure pregnant women and families with infants and/or young children living in First Nations communities receive adequate support to reach their full development and longevity potential. This will be achieved through improved access to local, integrated and efficient MCHC services that meet the needs of individuals, families and the community at large.

GENERAL ORIENTATIONS

Early years, from conception to age six, have the most important influence of any time in the life cycle on brain development and subsequent learning, behaviour and health. The mother's health during pregnancy and experiences from conception to age six have lifelong effects on the child. Improved general and reproductive health awareness in young adults also contributes to healthy pregnancy.

The long-term goal of the MCHC program is to ensure expectant mothers and families with infants and/or children live their lives to the fullest in a supportive community environment that promotes health and family support. This goal can be achieved by implementing a comprehensive and effective maternal and child health care system. Individual, family and community capacity-building and its long-term health impact in reducing the need for acute care and other intensive treatment will have significant positive consequences for future generations.

[1] According to WHO, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (http://www.who.int/reproductive-health/topics.htm) (consulted January 8, 2008).

PROJECT OBJECTIVES

To develop a regional portrait of the situation of maternal and child health care (MCHC) in Quebec First Nations communities, the RNQLHSSC needs to collect and analyse the most recent data on the subject.

Due to a lack of information on maternal and child health care, and in order to collect relevant information on the subject, the RNQLHSSC had to develop a questionnaire.

The FNQLHSSC will use the collected data to develop a final report which will serve as a basis for establishing a maternal and child health care program that meets the needs and realities of Quebec First Nations communities.

The form below consists of the seven (7) following sections: services; human resources and other workers; access to resources; communications network; clients' profile; community profile; and respondent identification.

DO I HAVE TO FILL OUT THE WHOLE FORM?

As mentioned in the contribution agreement, each community must develop their own community profile. The basic amount of $10,000 allocated to each community can be used for that purpose. Once all the required information has been collected, the FNQLHSSC will develop a regional report depicting the current situation of MCHC. The FNQLHSSC will use this information to demonstrate existing resources and services, analyse them, and meet the guidelines of the program.

It is important to us that you answer all the questions. There are no correct or incorrect answers. If a particular situation does not apply to your community, simply indicate N/A (not applicable) or check the box "not applicable". Your answers will enable us to ensure accuracy of the results and obtain a picture that is as close to reality as possible.

You can complete the form individually or as a team.

WHO SHOULD COMPLETE THE QUESTIONNAIRE?

The questionnaire is intended for health professionals working with families with children aged 0 à 6 years in Quebec First Nations communities, excluding the Cree and the Inuit.

People holding the following positions may fill out the questionnaire:

- Health directors;
- Community health or perinatal nurses;
- Family visitors;
- Any other person involved in maternal and child health.

WILL THE INFORMATION PROVIDED IN THE QUESTIONNAIRE REMAIN CONFIDENTIAL?

Yes. All the information provided in the form shall be kept confidential. Only general statistics and trends will be used in the final report, which will ensure no respondent can be identified.

* As indicated in your contribution agreement, a copy of your questionnaire will be shared with Health Canada.

In addition, the collected data will be used solely for this purpose. Once the report has been completed, the data will be stored in a secure manner for three (3) years on the FNQLHSSC premises before being destroyed.

This questionnaire is conducted in accordance with the Assembly of First Nations of Quebec and Labrador (AFNQL) research protocol, which sets out the principles of data ownership, control, access and possession - or OCAP.

WHAT IF I HAVE QUESTIONS OR NEED HELP?

Should you have any questions about the questionnaire, please contact:

Julie Bernier
Maternal and ChildHealth Care Program Officer
(418) 842-1540 ext. 243
Email: jbernier@cssspnql.com

In addition,for follow-up purposes, Julie Bernier wi lcontact you withi two (2) weeks of sending you ite questionnaire.

WHEN SHOULD I HAVE THE QUESTIONNAIRE COMPLETED?

When you receive the questionnaire, it is imporant that you fil t out and return it to us as soon as possibé and no later than **Friday, March 28, 2008**.

WHAT'S NEXT?

Once youhave compleéd thequestionnaire, please send it offto Julé Bernier:

- by fax at (418) 842-7045;

or

- as an email attachment at jbernier@cssspnql.com;

or

- by regular mail at:

First Nations o fQuebec and Labrador Health and Social Services Commissón (FNQLHSSC)
250, Place Chef Michel-Laveau, Wendake (Québec), G0A 4V0
do Julé Bernier

SECTION ONE: SERVICES

SER1.1 What maternal and child health services are available in your community BEFORE pregnancy?

Please check appropriate boxes	Availability		Service provider(in theaffirmative)							In the affirmative, how often?					
	Yes	No	Physician	Nurse	Family Worker	Psychologist	Social Worker	Nutritionist	Other, (please specify)	More than once a week	Once a week basis	Once a month basis	Every 3 months	Once in a year	Other (please specify)
Nutritional care															
Psychological support															
Birth planning															
Early detection (please specify):															
Risk factor prevention:															
• Alcohol															
• Substance															
• Tobacco															
• Nutrition															
• Drugs															
• Addictions															
Elder support (to parents)															
Father involvement initiatives															
Participation in genetic research															
Integrated perinatal and early childhood services for vulnerable families															
Other (s):															

SECTION ONE: SERVICES

SER1.2 What maternal and child health services are available in your community DURING pregnancy?

Please check appropriate boxes	Availability		Service provider(in the affirmative)							In the affirmative, how often?					
	Yes	No	Physician	Nurse	Family Worker	Psychologist	Social Worker	Nutritionist	Other, (please specify)	More than once a week	Once a week basis	Once a month basis	Every 3 months	Once to twice a year	Other (please specify)
Home visits															
Prenatal classes															
Breastfeeding classes															
Prenatal care															
Nutritional care															
Psychological support															
Early detection (please specify):															
Childbirth preparation															
Midwife															
Elder support (to parents)															
Father involvement initiatives															
Participation in genetic research															
Birth planning															
OLO program															
Other(s):															

SECTION ONE: SERVICES

SER1.3 What maternal and child health services are available in your community AFTER pregnancy?

Please check appropriate boxes	Availability		Service provider (in the affirmative)							In the affirmative, how often?					
	Yes	No	Physician	Nurse	Family Worker	Psychologist	Social Worker	Nutritionist	Other, (please specify)	More than once a week	Once a week basis	Once a month basis	Every 3 months	Once to twice a year	Other (please specify)
Home visits															
Postnatal care (mother)															
Postnatal care (newborn)															
Vaccination															
Nutritional care (mother)															
Nutritional care (newborn)															
Psychological support															
Birth planning															
Respite care (workshops, support groups, etc.)															
Breastfeeding support															
Infant attachment															
Young parents support															
Parenting skills support															
Midwife															

CONT. →

SECTION ONE: SERVICES

SER1.3 What maternal and child health services are available in your community AFTER pregnancy? (cont.)

Please check appropriate boxes	Availability		Service provider(in the affirmative)							In the affirmative, how often?					
	Yes	No	Physician	Nurse	Family Visitor	Psychologist	Social Worker	Nutritionist	Other, (please specify)	More than once a week	Once a week	Once a month	Every 3 months	Once to twice a year	Other (please specify)
Elder support (to parents)															
Father involvement initiatives															
Participation in genetic research															
Services for children with special needs															
Facilities for children with special needs															
Respite care for parents with special needs children															
Support for disabled parents															
Other(s):															

SECTION ONE: SERVICES

SER1.4 Which of the following programs are available in your community? Check all that apply.

- ☐ Canada Prenatal Nutrition Program (CPNP)
- ☐ Aboriginal Head Start On Reserve (AHSOR)
- ☐ Brighter Futures
- ☐ Foetal Alcohol Spectrum Disorder (FASD) program
- ☐ Home and Community Care Program
- ☐ Building Healthy Communities program
- ☐ Children's Oral Health Initiative (COHI)
- ☐ National Native Alcohol and Drug Abuse Program (NNADAP)
- ☐ Aboriginal Diabetes Initiative
- ☐ Indian Residential Schools Mental Health Support Program
- ☐ Injury Prevention Program
- ☐ Medical Health Officer
- ☐ Nursing services
- ☐ Nutrition and physical activity promotion
- ☐ National Youth Solvent Abuse Program
- ☐ Special education
- ☐ Child care services / Early childhood services
- ☐ Junior kindergarten
- ☐ Kindergarten
- ☐ Pilot project on front line services
- ☐ Other(s) :

_____
_____
_____

SER1.5 Generally speaking, are the services provided by your healthcare/social services centre culturally appropriate?

- ☐ Yes, absolutely
- ☐ More or less
- ☐ Not at all

SER1.6. What tools are available to professionals in your community to assist them in performing their work (videoclips, leaflets /home visit kits, etc.)?

_____
_____
_____
_____
_____
_____

SECTION TWO: HUMAN RESOURCES AND OTHER WORKERS

RES2.1 How many of the following professionals are currently working in maternal and child health in your community? If none, please indicate Ø.

HUMAN RESOURCES	NUMBER	STATUS		What academic qualifications do they have?	What type of professional development/training opportunities does your health centre have to offer?	Is clinical supervision available to staff?	
		Full-time	Part-time (hrs/week)			Yes	No
Nurses							
Perinatal nurses							
Family visitors							
Psychologist							
Social worker							
Physician							
Nutritionist							
Dental health representative							
Dental hygienist							
Physiotherapist							
Pharmacist							
Paediatrician							
Medical specialist							
Occupational therapist							
Speech pathologist							
Family counsellor							
Community health representative							
Other(s):							

SECTION TWO: HUMAN RESOURCES AND OTHER WORKERS

RES2.2 Does your health/social services centre have a follow-up protocol in place for maternal and child health clients?

- ☐ Yes
- ☐ No
- ☐ Not applicable

RES2.3 Do employees in your service who provide maternal and child health care keep records?

- ☐ Yes, systematically
- ☐ Yes, from time to time
- ☐ No
- ☐ Not applicable

RES2.4 What training would you like the FNQLHSSC to offer as far as maternal and child health is concerned?

_____
_____
_____
_____
_____
_____
_____
_____

SECTION THREE: ACCESS TO RESOURCES

ACC3.1 What services are available in your community? Check all that apply.

- ☐ Mental health worker
- ☐ Vaccination
- ☐ Prenatal care
- ☐ Postnatal care
- ☐ Medical clinic
- ☐ Child clinic
- ☐ Dental clinic
- ☐ Community nursing care
- ☐ Blood clinic
- ☐ Culture and language promotion
- ☐ Other(s):

_____
_____
_____
_____

ACC3.2 What prevention services are available in your community? Check all that apply.

- ☐ Substance and alcohol abuse (PNLAADA)
- ☐ Diabetes
- ☐ Parent training programs (e.g. parent-child groups)
- ☐ Healthy lifestyles
- ☐ Weight loss programs
- ☐ HIV/AIDS
- ☐ Prenatal programs
- ☐ Nutrition
- ☐ Family/birth planning
- ☐ Information programs
- ☐ Youth programs
- ☐ Brighter Futures
- ☐ Elder programs
- ☐ Housing programs
- ☐ Other(s):

_____
_____
_____
_____

SECTION THREE: ACCESS TO RESOURCES

ACC33 What professional resources are available to meet maternal and child health care needs?

PROFESSIONAL RESOURCES	ACCESSIBILITY		LOCATION		STATUS	
	YES	NO	ON-RESERVE	OFF-RESERVE	FULL-TIME	PART-TIME (hrs/week)
In-home nurse						
NNADAP worker						
Dentist						
Specialized educator						
Occupational therapist						
Physiotherapist						
Remedial teacher						
Audiologist						
Psychologist						
Speech pathologist						
General practitioner						
Medical specialist						
Social worker						
Child care services/ECD						
FNHS						
Other(s):						

SECTION THREE: ACCESS TO RESOURCES

ACC3.4 What types of services are available to maternal and child health care clients?

TYPE OF SERVICES	ACCESSIBILITY		LOCATION	
	YES	NO	ON-RESERVE	OFF-RESERVE
Detection				
Assessment				
Adapted activity (please specify):				
Contact with external resources				
Transportation and housing				
Education/training				
Home visits				
Support group				
Other(s):				

ACC3.5 Do workers in your health/social services centre have easy access to the various types of services offered to maternal and child health care clients (detection, assessment, adapted activities, etc.)?

☐ Yes
☐ No (please explain why)

_____
_____
_____

☐ Not applicable

SECTION THREE: ACCESS TO RESOURCES

ACC3.6 Does your community cooperate with the services listed below to provide maternal and child health care?

SERVICES	YES		NO
	AVAILABLE ON-RESERVE	AVAILABLE OFF-RESERVE	
Public health agency			
Health and social services centre (HSSC)			
Hospital			
Rehabilitation centre			
Social services			
School			
Child care services			
Other(s):			

ACC3.7 How would you describe the cooperation between your health/social services centre and other services on- and off-reserve (public health agency, HSSC, hospital, etc.)?

ON-RESERVE	OFF-RESERVE
☐ Very Good ☐ Good ☐ Poor ☐ Bad ☐ Not applicable	☐ Very Good ☐ Good ☐ Poor ☐ Bad ☐ Not applicable

ACC3.8 What information and tools would assist you in delivering your maternal and child health program?

_____
_____
_____

SECTION FOUR: COMMUNICATIONS NETWORK

COM4.1 What types of media does your community use to disseminate child and maternal health information?
Check all that apply.

- ☐ Daily newspapers
- ☐ Newsletters
- ☐ Promotional leaflets
- ☐ Posters
- ☐ Brochures
- ☐ Community radio
- ☐ Other radio stations
- ☐ Videoconferencing
- ☐ Email
- ☐ Cable television
- ☐ Satellite dish
- ☐ Internet services
- ☐ Other(s):

_____
_____

- ☐ None of the above

COM4.2 What maternal and child health-related topics does your health/social services centre address (daily newspapers, newsletters, promotional leaflets, etc.)? Check all that apply.

- ☐ Parenting skills
- ☐ Pregnancy
- ☐ Childbirth
- ☐ Infant care
- ☐ Infant attachment
- ☐ Breastfeeding
- ☐ Child stimulation
- ☐ Child development
- ☐ Injury prevention
- ☐ Sudden Infant Death Syndrome (SIDS)
- ☐ Shaken Baby Syndrome (SBS)
- ☐ Child diseases
- ☐ Primary health care (vaccination, etc.)
- ☐ Oral health
- ☐ Alcohol and substance abuse
- ☐ Smoking
- ☐ Foetal alcohol
- ☐ Diabetes
- ☐ Gestational diabetes
- ☐ Healthy lifestyles
- ☐ AIDS/HIV
- ☐ Nutrition
- ☐ Family/birth planning
- ☐ Postpartum
- ☐ Stress management
- ☐ Family violence
- ☐ Other:

_____
_____

- ☐ Not applicable

SECTION FOUR: COMMUNICATIONS NETWORK

COM4.3 Is the Internet available in your community?

- ☐ Yes, on a regular basis
- ☐ Yes, on a limited basis
- ☐ No

COM4.4 Is a videoconferencing system available in your community?

- ☐ Yes, on a regular basis
- ☐ Yes, on a limited basis
- ☐ No

SECTION FIVE: CLIENTS PROFILE

The client population for this program includes:

- *Women;*
- *Pregnant women and families with young children aged 0 to 6 years living in Quebec First Nations communities;*
- *First Nations youth and couples looking for pre-pregnancy and reproductive health information.*

CLI5.1 In your community, how many people belong to the following categories?

Females aged 12 to 45 years: _____
☐ Not available

Children aged 0 à 6 years: _____
☐ Not available

CLI5.2 In your community, what is the average number of:

Children per family: _____
☐ Not available

Persons per household: _____
☐ Not available

CLI5.3 Please indicate the percentage of each family type in your community.

Two-parent families: _____%
☐ Not available

Single-parent families : _____ %
☐ Not available

Extended families: _____ %
☐ Not available

CLI5.4 In 2006 and 2007, in your community, what was the number of:

	2006	2007
Births: ☐ Not available	_____	_____
Child deaths: ☐ Not available	_____	_____
Abortions (spontaneous or not): ☐ Not available	_____	_____

CLI5.5 What is the number of anticipated pregnancies for 2008 in your community?

_____ ☐ Not available

CLI5.6 What was the average annual number of births in your community for the past five (5) years?

_____ ☐ Not available

SECTION SIX: COMMUNITY PROFILE

DES6.1 What is your community's total population?

_____ ☐ Not available

DES6.2 How many are:

Male: _____
☐ Not available

Female: _____
☐ Not available

DES6.3 Please indicate the number of children in your community by age and gender:

	Male	Female
0 year:	_____	_____
1 year:	_____	_____
2 years:	_____	_____
3 years:	_____	_____
4 years:	_____	_____
5 years:	_____	_____
6 years:	_____	_____

DES6.4 What is the distance from your community to the closest hospital offering perinatal services?

☐ Less than 100 km
☐ 100 - 149 km
☐ 150 - 199 km
☐ 200 - 249 km
☐ 250 - 299 km
☐ 300 km and more

DES6.5 What percentage of the 16-year old population in your community is employed?

Full-Time	Part-Time or seasonal
☐ Less than 20 %	☐ Less than 20 %
☐ 20 % - 39 %	☐ 20 % - 39 %
☐ 40 % - 59 %	☐ 40 % - 59 %
☐ 60 % - 79 %	☐ 60 % - 79 %
☐ 80 % - 100 %	☐ 80 % - 100 %
☐ Not available	☐ Not available

DES6.6 What percentage of the 16-year old population in your community receives social insurance benefits?

☐ Less than 20 %
☐ 20 % - 39 %
☐ 40 % - 59 %
☐ 60 % - 79 %
☐ 80 % - 100 %
☐ Not available

SECTION SIX: COMMUNITY PROFILE

DES6.7 Is your community facing general social issues that should be taken into consideration in developing programs for children aged 0 to 8 years? Check all that apply.

- ☐ Chronic unemployment[2]
- ☐ Substance and alcohol abuse
- ☐ Malnutrition
- ☐ Food shortages (poor quality of food)
- ☐ Family break-up
- ☐ Economic poverty
- ☐ Social isolation
- ☐ Tensions and conflicts
- ☐ Single-parent families
- ☐ Neglect
- ☐ Obstacles to multisectoral collaboration
- ☐ Other(s):

_____
_____

- ☐ None

DES6.8 Is there adequate housing and infrastructure in your community?

- ☐ Yes
- ☐ No

DES6.9 What is the average number of persons per household in your community?

_____ ☐ Not available

DES6.10 Does your community have recreation or leisure facilities?

- ☐ Yes, please specify: _____

_____
_____
_____
_____
_____
_____

- ☐ No

[2] The Office québécois de la langue française defines chronic unemployment as a long-term form of unemployment which affects either individuals whose physical, mental or professional characteristics make them almost unemployable or geographic regions whose economic underdevelopment translates into long-term and widespread unemployment. In the latter case, massive government intervention or population displacement are the only solutions. (http://www.granddictionnaire.com/BTML/FRA/r_Motcle/Index800_1.asp, consulted February 29, 2008 – case translation).

SECTION SEVEN: RESPONDENT IDENTIFICATION

REP7.1 What is your position in your health/social services centre?

_____
_____

REP7.2 How long have you been holding this position?

- ☐ Less than a year
- ☐ 1 to 5 years
- ☐ More than 5 years

REP7.3 In what language(s) would you like to receive information for your community?

- ☐ French only
- ☐ English only
- ☐ Both in English and French

REP7.4 Any other comment you would like to make?

_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____

Thanks for your cooperation!