

BLUEPRINT

QUEBEC FIRST NATIONS HEALTH
AND SOCIAL SERVICES

20⁰⁷ 17

*Closing the gaps...
Accelerating change*



First Nations of Quebec and Labrador
Health and Social Services Commission

COORDINATION COMMITTEE

Marjolaine Sioui, Operations Manager, FNQLHSSC: Project coordination

Moktar Lamari, Ph.D., consortium d'évaluation et de management stratégique (CEMS): writing and development

Sophie Garant, Community Health Consultant, FNQLHSSC: writing and development

Etienne Carbonneau, M.A., Research Agent, FNQLHSSC: analysis, research and writing

Francine Tremblay: thematic literature review

SPECIAL COLLABORATION

Regional Commissions and Organizations

Assembly of First Nations of Québec and Labrador (AFNQL)

Expert committee (see the complete listing at page 6)

First Nations communities

Pictures on cover: Mamit Innuat

© FNQLHSSC. ISBN: t.b.d



4	Words from Ghislain Picard, Regional Chief, AFNQL
5	Words from Guylaine Gill, Executive Director, FNQLHSSC
6	Experts Consulted regarding Blueprint Developent
7	Introduction
9	Chapter 1- A GLOBAL VISION BASED ON GUIDING PRINCIPLES
11	A concerted blueprint based on repeated commitments
12	A plan with the promise of change
14	A plan based on guiding principles
17	Chapter 2- A RENEWED APPROACH TO GOVERNANCE FOSTERING SELF-DETERMINATION
19	The current situation
21	Challenges
24	Focus areas and actions
27	Expected outcomes by 2017
29	Chapter 3- ACCESSIBLE, TARGETED AND COMPREHENSIVE HEALTH CARE
31	The current situation
35	Challenges
36	Focus areas and actions
40	Expected outcomes by 2017
43	Chapter 4- INNOVATIVE, ACCESSIBLE AND SUSTAINABLE SOCIAL SERVICES
45	The current situation
48	Challenges
50	Focus areas and actions
54	Expected outcomes by 2017
55	Chapter 5- COHESIVE AND CONCERTED ACTION ON THE DETERMINANTS OF COLLECTIVE HEALTH AND WELL-BEING
57	The current situation
62	Challenges
64	Focus areas and actions
70	Expected outcomes by 2017
71	Chapter 6- ADEQUATE HUMAN CAPITAL SUPPORTED BY RESEARCH AND DEVELOPMENT
73	The current situation
75	Challenges
76	Focus areas and actions
81	Expected outcomes by 2017
83	Chapter 7- CONDITIONS FOR SUCCESS, OBJECTIVES AND PROGRESS MEASUREMENT
85	Factors for Success
87	Progress Measurement and Reporting
91	CONCLUSION
95	Bibliography
99	Appendix 1- HEALTH, SOCIAL SERVICES AND STANDARD OF LIVING INDICATORS
103	Appendix 2- ACRONYMS

Words from Ghislain Picard

The vitality of the nations depends largely upon the health status and quality of life of their individuals and communities. This connection has been well established throughout the world. Yet, the health of Quebec First Nations has never been as poor or alarming. Despite the work that has been done or the promises that have been repeated since the mid-eighties by governmental authorities, the health status gaps separating First Nations from the general Canadian population are increasing day by day and becoming increasingly alarming.

It is for this reason that Quebec First Nations have committed, during the last few months, to develop their own Health and Social Services Blueprint. The Health and Social Services Blueprint, which is the result of an in-depth investigation and broad consultative process, proposes a revolution in our way of doing things as indicated in the title: Closing the Gaps...Accelerating change, 2007-2017.

This ten-year plan, which constitutes a first in Quebec First Nations recent history, includes irrefutable evidence of our capacity to develop and articulate, reasonably and clearly, our own global health vision as well as the strategic options in order to bring about real change and undergo efforts to improve the health status and quality of life of our communities.

Let us be clear – this plan makes a break from the past by proposing an approach that is cohesive, global and inspired by the true needs and realities of our communities. It proposes to put an end to the exceptional approaches, fractured interventions and small amounts of funding that characterize the interventions of government. Instead, it invites governments to change their ways of doing things in order to act more efficiently upon the expectations of communities and to abandon outdated policies – which are often related to the ongoing degradation of First Nations health status and quality of life.

For us, Health constitutes an entity that cannot be fractured or divided. Consequently, this Blueprint places emphasis upon a holistic approach that draws upon our heritage and our identity. Health is not solely connected to physical well-being since it also includes social, emotional, mental and spiritual health. Furthermore, this global health approach does not only target individuals and far from it; it also embraces the health of families, communities as well as various generations – present and future.

This vision is the cornerstone of the orientations and actions proposed to the communities – notably in the areas of prevention, the struggle against chronic diseases, social services development, implementing healthy lifestyles, socio-economic development, training, research and development as well as governance.

Decisions that are taken without consulting us that often go against our cultural identity must become a thing of the past. This Blueprint is founded upon the inherent right of First Nations government to autonomy. It must be pointed out that various Health Canada documents theoretically recognize the importance of self-determination in the area of health: “Both Aboriginal peoples and health experts believe that health inequalities and concerns about the health care system will be better addressed when Aboriginal people make decisions for themselves.”¹

This Blueprint confirms the urgent need to act. As I’ve previously stated, during the Socio-Economic Forum (2006) that took place in Mashteuiatsh: the status quo is no longer acceptable...the time has come to start making, together and collaboratively, the changes that will allow us to turn the table and make sure that the health and quality of life of First Nations changes radically.

This Blueprint aims to provide First Nations with the right to make decisions in strategic, organisational and operational choices regarding the Health and Social services that are intended for our communities. It also aims to open the door on a new era of collaboration between the various stakeholders, in order to accelerate the real changes in regards to the health and quality of life of First Nations in all the communities.

We must all take on the challenge regarding the health and quality of life in our communities. We do not have the right to fail – nor disappoint future generations who, in many cases, progressively lose their health as well as their patience and hope. We have the obligation to achieve results – that is our challenge.

I would like to finish by sincerely congratulating the know how, the talent and the tact of the First Nations of Quebec and Labrador Health and Social Services Commission that skilfully guided the development and adoption process of this ten-year Blueprint. I would also like to thank the Coordination Committee that was in charge of the development - as well as all the experts and specialists who strongly supported the process and provided objective evidence on the gravity of the health status of our communities and the need to act, without delay, within the framework of the perspectives and guidelines set forth in the Quebec First Nations Health and Social Service Blueprint 2007-2017 – Closing the Gaps...Accelerating change.

*Ghislain Picard
Regional Chief,
Assembly of First Nations of Quebec and Labrador*

¹ Health Canada (1998). 1998-99 Estimates : A Report on Plans and Priorities (p. 31).

Words from Guylaine Gill

I am both honoured and pleased to present to you the Quebec First Nations Health and Social Services Blueprint 2007-2017 – Closing the Gaps...Accelerating change. This Blueprint conveys a new hope and maintains that a different future is not only possible, but achievable; one that is based on the collective health and well-being of Quebec First Nations.

It is with enthusiasm that the First Nations of Quebec and Labrador Health and Social Services Commission fully committed to carry out the development work of this Blueprint since the fall of 2006. For the elaboration of this historical Blueprint, the FNQLHSSC personnel and contributors rigorously and generously gave their all.

This Blueprint sets forth the principal milestones on the road to be followed and identifies the necessary steps to ensure that 2007-2017 is a decade of profound change for the health and well-being of Quebec First Nations.

In reality, our work focuses on the fully legitimate expectations of our communities who desire to achieve parity in health status and quality of life with the other people of Canada. Health can only be improved or preserved through a **global vision** framework that considers not only physical health – but also social, mental, psychological, environmental, cultural and economic well-being.

To ensure the adherence of all the communities and stakeholders concerned by this Blueprint, the development work was supported by a rigorous strategic assessment as well as broad consultations that included many experts, regional managers, community representatives as well as observers that were informed on the health status and quality of life of First Nations.

The analyses that were carried out confirm the scope of the challenges to be undertaken and demonstrate the urgency required in order to change the paradigms and ways of doing things in regards to controlling and administering the health care and social services intended for First Nations.

In more than one way, this Blueprint is innovative, instigative and integrative.

- > **Innovative**, because it attempts to succeed where previous governmental policies regarding First Nations health have failed since they did not conceive strategies that were innovative, integrative or adapted to the needs of First Nations - in their many contrasts and diversities.
- > **Instigative**, because it depends upon collaboration, true partnership as well as positive dialogue that is based on the good intentions of all the stakeholders.

- > **Integrative**, because it invites all partners and interveners to work hand-in-hand to ensure synergy and a total cohesion of their collective efforts, in such a way as to promote the improvement of the health status and quality of life of First Nations.

The work described in the Blueprint calls for an immediate active and concrete mobilization of all those concerned to build the foundations of a society that is more just, more innovative and completely engaged in the improvement of the health and quality of life of First Nations.

Our challenges are great. They imply improved governance and, to that end, propose self-determined participation from First Nations. Furthermore, this Blueprint recommends vigorous action, without precedence, on all fronts such as health, social services, health determinants, research and development as well as the training of competent First Nations resources that are specialised in the areas of health and social services.

I would like to thank the Coordination Committee in charge of the development of the Blueprint, the experts, the specialists, the professionals from the regional First Nations commissions and organisations and the community representatives who contributed to the development of the Blueprint, within the imposed deadlines and with the sometimes limited resources (rarity of reliable statistics, limited inventories, lack of resources dedicated to First Nations research and development, etc.)

Our Blueprint reflects our permanent commitment in terms of prevention, the promotion of life and the improvement of the health status and quality of life of our communities.

We hold the health of our First Nations close to heart.

Thanks to improved health and quality of health, our communities will not miss their opportunity to create more collective riches that will enable us to participate once again, in our way, with vigour and generosity to the prosperity of the entire society.

Even though we are very pleased with this achievement, we are aware of the work that remains to be accomplished. We are determined to move forward to ensure the efficient implementation of this ten-year Blueprint, and this, in cooperation with all the stakeholders and First Nations communities.

Guylaine Gill
Executive Director
First Nations of Quebec and Labrador Health and Social Services Commission



EXPERTS CONSULTED REGARDING BLUEPRINT DEVELOPMENT

NAME	TITLE
D ^r Gilles Fortin	Pediatric Neurologist, Ste. Justine Hospital, Development Centre
D ^r Christian Sioui	General Practitioner Mental health and geriatrics
France Dion	Pharmacist Huron Wendat Nation
D ^r Emmett Francoeur	Pediatrician Director of Child Development Program, Montreal Children's Hospital
Francine Jourdain	Psychologist
Annie Girard	Psycho-Educator Centre de forDFM
D ^{re} Suzanne Pelchat	Mental Health Team Jacques Cartier Local Community Service Centre
D ^{re} Johanne Philippe	General Practitioner Mashteuiatsh Health Centre
D ^r Renaud Leroux	Emergency Physician
Denise Paul	Charge Nurse Mashteuiatsh Health Centre
Tania Courtois	Nutrition Technician Betsiamites Health Centre
Marie Pagé	Dietician Mashteuiatsh Health Centre
Suzanne Bruneau	Coordinator, Aboriginal Health Unit Quebec Institute of Public Health, Planning, Research and Innovation Branch
Lily Lessard	Nurse and Research Officer Quebec Institute of Public Health, Planning, Research and Innovation Branch
Jean Verronneau	Dentist and searcher



Introduction

Canada is a rich country. It is so rich that it ranks as one of the seven most industrialized and wealthiest countries in the world (G7). In fact, Canadians enjoy the highest international health and living standards in the world. The First Nations of Canada, however, rank among the poorest of nations. Furthermore, according to World Health Organizations findings and reports, the state of health and quality of life of their respective populations are considered to be the most precarious and worrisome internationally (WHO, 2001).¹

In comparison with the rest of the population of Quebec and, more broadly, the population of Canada, Quebec First Nations lag far behind in terms of health and quality of life. Available statistics clearly confirm this cruel and unfair reality. They reveal disparities in virtually all the areas of health and social development. Worse, certain disparities are widening instead of contracting.

For example, in comparison with the rest of the population of Canada, a Quebec First Nations individual:

- > has a shorter life expectancy (6 to 7 years);
- > is four times more likely to lack access to health care and social services;
- > is two to three times more likely to suffer from obesity and overweight;
- > is two to three times more likely to suffer from diabetes and eight to ten times more likely to have tuberculosis;
- > is three to five times more likely to experience poverty, ill-treatment and placement in foster families at a young age;
- > is five times more likely to commit suicide.²

This Blueprint was developed to address the glaring health and quality of life disparities between members of the Quebec First Nations and Canadians with the support of the First Nations of Quebec and Labrador Health and Social Commission (FNQLHSSC) and the close collaboration of the communities and authorities concerned.

Given the magnitude of the challenges at hand, this Blueprint sets out a ten-year operating framework, from 2007 to 2017. In order to achieve consensus among First Nations communities and other stakeholders, it is based on carefully defined strategic choices. These take into account all the available relevant data and the results of their analysis. It also capitalizes on a structured planning process with broad First Nations input.

The Blueprint also draws on several consultation and validation studies by recognized health and social services experts and from the input of First Nations communities and other parties involved in the delivery of health care and social services, both within and outside communities, as well as from the input of regional organizations of the Assembly of First Nations of Quebec and Labrador (AFNQL).

¹ Organisation mondiale de la santé (2001) : Coordination du travail de l'assemblée mondiale, du Conseil exécutif et du Comité régional.

² Ces données et leurs sources sont exposées en détail dans le reste du document.

The Blueprint has two ultimate strategic objectives:

- 1- Progressively eliminate the disparities between First Nations populations and other Canadians in the areas of health and collective well-being;
- 2- Initiate structural change in the governance outlook and approaches regarding the delivery of health care and social services to First Nations populations.

The Blueprint hinges on seven chapters. Chapter 1 introduces its conceptual framework. Chapter 2 discusses governance of the health care and social services system intended for First Nations. Chapters 3, 4 and 5 respectively present strategic directions in the areas of health, social services and the determinants of health. Each chapter systematically presents a picture of the situation, key challenges and a focus for action, along with expected outcomes to be achieved by 2017. Chapter 6 discusses human resources development in health care and R&D resources for the First Nations of Quebec. Finally, Chapter 7 outlines the elements involved in the implementation of the Blueprint, the conditions of success and expected outcomes.

A GLOBAL VISION BASED ON GUIDING PRINCIPLES

The Quebec First Nations Health and Social Services Blueprint (the Blueprint) is based on the constructive consultation of the stakeholders involved. It proposes structural changes based on an innovative approach that builds on the principles and values of the First Nations' historical, political, cultural heritage and on their ethnic identity.

1.

A CONCERTED BLUEPRINT BASED ON REPEATED COMMITMENTS

The process that led to the development of the Blueprint follows on commitments by various government authorities in recent years to solve the health and quality of life problems of Quebec's First Nations. First, let us review some of these commitments.

During the deliberations at the October 2006 Quebec First Nations Socio-Economic Forum, the governments of Quebec and the First Nations agreed to launch a new era of cooperation with a special emphasis on the health care and social services intended for First Nations communities. The

Forum stressed the importance of cooperation based on mutual respect, dialogue and the acknowledgement of First Nations jurisdictions and rights. This calls for the First Nations and the governments of Quebec and Canada to redouble their efforts to achieve parity with respect to health and quality of life.

Premously that, in the wake of government commitments made when the provincial premiers and the prime minister of Canada met for a special meeting in September 2004, agreements would have been signed to expedite action on bridging the gaps between Aboriginal peoples and the rest of the population with respect to health care and quality of life.

The process initiated by the provincial and federal governments, together with First Nations, acknowledged the importance of cooperation based on government-to-government relations. It also acknowledged the commitment of the various parties to achieve three major policy objectives:

- > Immediately bridge the health care and collective well-being gaps separating First Nations and other Canadians through a coherent and comprehensive plan stretching over a 10-year period;
- > Acknowledge and respect ancestral rights and consolidate an independent self-governance approach, especially with respect to strategic choices regarding health care and social services;
- > Establish a new dialogue based on mutual respect and accountability.

Such goals cannot be achieved without significantly improving access to health care and social services and the management of health care and social services programs. That is why structural change in governance lies at the heart of the directions set out in the Blueprint. The requisite changes must take into account not only health care and social services needs, but also the major socio-economic determinants of collective and individual well-being.

The Blueprint sets out directions and priority areas based on clear findings. It was designed to provide direction for honouring the commitments made by the various levels of governments in a concerted and synergistic manner.

First Nations want the governments of Quebec and Canada to marshal all the resources and efforts required for the optimal implementation of the strategic choices and actions put forward in the Quebec First Nations Health Care and Social Services Blueprint (2007-2017) over the aforementioned 10-year period within the framework of a tripartite agreement.



First Nations also hope that the promises and announcements made during the various forums and political meetings on improving health care services and quality of life translate into concrete measures, resolute action and appropriate funding in accordance with expressed needs and priorities.

First Nations leaders and agency representatives expect to be given all the requisite latitude and independence to implement health care and social services programs in accordance with their real and diverse needs.

2. A PLAN WITH THE PROMISE OF CHANGE

The disparity between the health and well-being of First Nations and the health and well-being of Quebecers and Canadians is the result of a centralized decision-making process and top down governance.

The governance paradigms and processes that led to the current situation must be rethought and reconfigured. The awaited changes must allow all the First Nations communities to benefit from the delivery of health care services and social development that compare with the health care services and social development enjoyed by Canadians Throughout the country.

Like all Canadians, First Nations people have the right to quality health care and social services in accordance with their identity and specific needs. They also have the right to enhance their cultural and spiritual heritage within a self-directed health system.

For First Nations, living a healthy life is a major concern involving not only biological and pathological considerations, but also various aspects of social services and various determinants impacting the health of their communities regardless of their location or specificity. Health and well-being are integral elements of a holistic view of life that encompasses the capacity to access and manage one's physical environment and to control one's future.

First Nations have legitimate expectations of greater concrete efforts on the part of their various partners. Of the agencies responsible for funding and ensuring that all the First Nations communities have access to a comprehensive range of health care and social services, First Nations expect sustained measures resulting in strong actions and financial resources consistent with the challenges to be met. First Nations also expect health care and social services agencies to implement meaningful changes in the delivery of health care and social services that will involve their communities in the design, implementation and evaluation of the services they receive.

Addressing the health care disparities and the delivery of health care and social services within a framework and a vision developed by the First Nations requires a firm political commitment, sustained action and the meaningful involvement of all the First Nations communities and authorities.

The structural change in the First Nations health care and social services system will only become a reality when the following facts can be confirmed.

THE FIRST NATIONS COMMUNITIES:

- > Have reached a life expectancy and quality of life comparable to that of other Canadians;
- > Have controlled the causes and risk factors that account for avoidable illnesses, disabilities and risks to life that currently wreak greater havoc within First Nations communities than in other Canadian communities;
- > Have access to health care and social services that are comparable to those that are available in the rest of Quebec and Canada;
- > Receive health care services that are adapted to their national, historical and cultural specificities;
- > Have decision-making powers and control over the health care and social services that are provided to the individuals, the families and the communities of each First Nation;
- > Control the various determinants affecting their cultural identity and socio-economic development in such a way as to significantly improve their health, their well-being and their self-determination.

PARTNERS INVOLVED IN THE DELIVERY OF HEALTH CARE AND SOCIAL SERVICES FOR FIRST NATIONS:

- > Assume responsibility for the wrongdoings and consequences (past, present and future) of Canadian programs and policies regarding the health and quality of life of First Nations members.
- > Work in partnership with First Nations to right the wrongs stemming from historical processes that affect the global health and quality of life of First Nations populations.
- > Agree to increase funding in accordance with a proactive, sustainable, adequate and effective strategy in order to mitigate the health and quality of life problems that plague First Nations communities.
- > Acknowledge and respect the ancestral rights, culture, autonomy and way of life of First Nations;
- > Work with a sense of diligence to correct current failures and to provide First Nations with a complete range of innovative and effective health care and social services that are adapted to their needs.

3.

A PLAN BASED ON GUIDING PRINCIPLES

The vision mapped out in the Blueprint is based on a global approach, on values stemming from the ethnic and cultural heritage of First Nations, on the requirement for meaningful public investment in health care and social services and, above all, on the capacity of First Nations to define and implement the health and social services system that meets their needs.

A HOLISTIC APPROACH

that takes into account:

- > The improvement of well-being in all its dimensions: physical, mental, emotional, spiritual and intellectual;
- > Collective, cohesive and concerted action on the socio-economic, infrastructural, psychological and cultural determinants of health and quality of life;
- > The balanced and sustainable use of ecosystems as well as unrestricted access to the natural resources within the ancestral territory of First Nations communities;
- > The enhancement of community identity and the preservation of the First Nations culture and values.

AN APPROACH RESPECTFUL OF FIRST NATIONS SPECIFICITIES

- with respect to:
- > The health care priorities, needs and problems of each First Nations community across Quebec;
 - > The preferences and specific needs of various social groups, especially those that are already very vulnerable and exposed to several social and health problems;
 - > Action plans and initiatives put forward by the various First Nations communities.

A SELF-DIRECTED AND ENDOGENOUS APPROACH

based on:

- > The inalienable right of First Nations to make strategic, organizational and operational choices with respect to the delivery of health care and social services in their communities;
- > Complete jurisdiction and control over the design, development, delivery and evaluation of health care and social services available to First Nations communities;
- > The development of strategies to mitigate the negative effect of environmental factors on collective health and well-being, such as environmental degradation (water, soil, forests, etc.), climate change and other unknown factors likely to impact the economic development of community territories and quality of life.

A DISCIPLINED AND INFORMED APPROACH

based on:

- > Full and fair consideration and an in-depth analysis of a wide range of reliable empirical data;
- > The use of conclusive published data (assessment reports, evaluative research, etc.) on health care and social services for First Nations;
- > Consultation of recipients, stakeholders and experts in the area of First Nations health.



AN APPROACH BASED ON AN EFFECTIVE AND STEADFAST PARTNERSHIP in order to:

- > Strengthen collaboration between the federal and provincial governments on the one hand and First Nation authorities and agencies on the other, as well as First Nations service providers;
- > Consolidate the cohesion, integration and adaptation of health care programs and services for the benefit of First Nations (in urban, rural and remote areas, within and outside communities) in accordance with the needs and specificities of each one;
- > Foster the commitment of stakeholders, in particular within First Nations communities;
- > Honour the promises, decisions and commitments made in public by various levels of government over the past few years with respect to the need to address the disparities that exist between the health care and social services provided to the members of First Nations communities and other Canadians.

The promises and commitments made by the federal and provincial governments and by First Nations governments and agencies must be based on specific principles and actions, measurable objectives and mechanisms governing bilateral, trilateral and multilateral partnerships, both present and future.

AN APPROACH CONSISTENT WITH MEANINGFUL, FORESEEABLE AND SUSTAINABLE FUNDING

In order to ensure the viability of the Blueprint, the parties acknowledge the critical and essential nature of government funding for the delivery of health care and social services to First Nations communities. The Blueprint is therefore banking on:

- > New investments and budget increases to meet human resources, material, technological and other needs to mitigate health care and social services disparities;

- > Funding adapted to national, regional and local specificities;
- > Sustainable funding commitments rather than sporadic, uncertain and unilateral funding;
- > Mutual and transparent accountability on the part of the relevant partners.

In short, First Nations consider health from a holistic standpoint that encompasses the physical, mental, spiritual, emotional, economic, environmental and cultural well-being of the individuals and families that make up their respective communities.

The analysis of the situation reveals that increasing public support for First Nations health care and well-being requires deep, self-determined and concerted changes. These changes are discussed in detail within the framework of five strategic priorities:

- 1- A renewed governance approach fostering self-determination;
- 2- Accessible, targeted and comprehensive health care services;
- 3- Innovative, accessible and sustainable social services;
- 4- Cohesive and concerted action on the determinants of collective health and well-being;
- 5- Adequate human capital supported by research & development.

A RENEWED APPROACH TO GOVERNANCE FOSTERING SELF- DETERMINATION

The First Nations of Quebec have access to a health care and social services system that is managed on a multi-jurisdictional basis involving several levels of government and decision-makers. The system is not always aware of the needs, values and realities facing First Nations recipients. The current system of governance is based on a vertical “top down” approach that does not recognize the right of First Nations to make strategic, organizational and operational choices regarding the health care and social services to which they are entitled.

Obviously, the current governance approach to the delivery of health care and social services to First Nations includes several structural limitations and presents numerous challenges.

1.

THE CURRENT SITUATION

The health of First Nations populations is currently fragile and worrisome. However, this has not always been the case. Before the arrival of Europeans and colonization, First Nations peoples were in good health, had a structured social structure, ruled their respective territory and produced a millennial civilization (Royal Commission on Aboriginal Peoples, 1996)¹.

It is only in the wake of colonization that the First Nations contracted new infectious diseases and began to lose their independence and control of their territories and heritage. As they became progressively poorer they also became exposed to new illnesses and suffered from devastating structural breakdowns of their society. This reminder emphasizes, should the need exist, the critical importance of self-determination for all nations.

Nowadays, First Nations receive health care and social services from various agencies at a number of levels outside their jurisdiction. Federal programs, initiatives and services coexist with provincial ones and, when resources are available, these are completed by local initiatives implemented by Band councils and other local and community authorities.

Universal health care is not always guaranteed because services are delivered differently depending on the status and location of First Nations populations (within or outside a community), depending on budget resources and eligibility criteria that are frequently determined by government officials, regardless of the illnesses that plague the communities.

Nowadays, and all across the world, the assessment of health policies suggest that the complexity and rigidity of this type of multi-jurisdictional governance, removed from the needs of communities, contribute to the degradation of the health of nations and communities.

This type of governance, characterized by a reluctance to involve communities in all regions in decision-making, results in several dysfunctions and deficiencies. The current delivery system is plagued by numerous grey areas, overlapping and ambiguity with respect to the responsibilities of the key players. This situation has significant consequences, especially for poorer communities that are experiencing significant distress and a glaring need for health care and social services.

Multiple procedures and overlapping of decision-making processes reduce the effectiveness of many programs (delays, waiting lists, grey areas, etc.). This results in the poor integration of services and their inadequate adaptation to specific needs. This situation is worrisome in many ways for representatives of First Nations authorities. The great number of decision-making centres prevents them from fully playing their role as stakeholders in the management of health care and social services intended for their communities.

The current health care funding approach favours a per capita allocation of funds. The system also provides specific funding for projects considered to be relevant by decision-makers. The fact is that in each case, several small, poor and remote First Nations communities do not have the critical mass to benefit from the funding required to implement health care services worthy of the name. In those communities, the few health care providers are overworked and do not have the time to implement the administrative formalities and procedures prescribed by senior federal officials who, in most cases, do not have the requisite knowledge to understand the needs and expectations of these communities.

¹ Assembly of First Nations (2004): Federal Government Funding to First Nations.

Even more glaring problems plague remote communities or communities bordering other provinces. For example, members of these communities frequently need emergency care that can only be provided by the closest physicians or health care centres, which are frequently located in neighbouring provinces. In many cases, medical fees and other costs related to interprovincial travel for medical purposes are not quickly reimbursed by the health care system. Moreover, certain services are not even covered in the absence of agreements between the governments involved.

This situation involves significant supplementary costs for destitute members of First Nations communities whose hands are tied (transportation and medication costs, waiting lists, uncertainty, incomprehension, etc.). The situation also generates high administrative management costs which are charged to the First Nations health care budgets. Recent estimates indicate that a third of government funding for First Nations do not reach target communities, but remain within the governmental management system to cover the high administration costs of a cumbersome and costly administrative system.

Under the current system, health care and social services programs delivered to First Nations are designed and unilaterally implemented by the federal government. Because of structural problems, such as irregular funding, meaningful dialogue is difficult given the uncertainty and ill-timed cuts that threaten health care funding.

First Nations authorities are rarely consulted on the delivery of services to their communities. When they are consulted, it is usually after the fact, once decisions have been taken and service standards have been cast in stone by government authorities. Such a top down approach, which is counterproductive for First Nations, is perceived as another form of loss of control over the determinants of one's health.

This type of interaction undermines the confidence and satisfaction of First Nations communities with respect to the services delivered to their communities by the health care and social services system. It reduces their sense of empowerment and self-determination with respect to their state of health. It increases the level of cultural insecurity of First Nations populations. This, in turn, erodes the ethnic pride and mental health of individuals, families and communities.

The current system does not foster transparency and accountability to First Nations populations. In fact, the delivery of health care and social services to First Nations communities is not adequately documented and monitored through updated indicators and regularly-updated reliable and shared data. The empirical, quantitative and qualitative data on health care and social services programs delivered to First Nations are stored in various government systems and are not always available to the First Nations themselves. Published data are sparse, partial and incomplete. As a result, they cannot be used by First Nations to assess the overall performance of the health care system that is available to them.

The lack of reliable statistical data and accurate information on budgets and programs for First Nations also deprives interested parties of the tools they need to:

- > produce mutual and respectful accountability reports consistent with their commitments;
- > determine the satisfaction and real needs of the communities;
- > forecast trends and monitor emerging problems;
- > account for the success or failure of programs for First Nations communities.

The flimsiness of the financial foundation of health care and social services intended for First Nations is another aspect of their precariousness. In recent years, the population and health care needs of First Nations communities increased by 10% while their health care budget increased by only 2 to 3%. These findings have been confirmed by data gathered by



the Auditor General of Canada (2006): “Funding for First Nations programs has increased in recent years, but not at a rate equal to the population growth. Indian and Northern Affairs Canada’s funding increased by only 1.6 percent, excluding inflation, in the five years from 1999 to 2004, while Canada’s Status Indian population, according to the Department, increased by 11.2 percent.”

In short, the current situation can be characterized by a lack of First Nations community participation in defining government service offerings. Furthermore, the inadequacy and unpredictability of funding jeopardizes the health of First Nations even further, thereby adding to the challenges that must be met.

2. CHALLENGES

In order to eliminate the disparities between the health care services provided to First Nations and the rest of Canadians, a change in governance paradigms is required. This change will promote a greater sense of accountability among all the stakeholders with respect to improving the health and quality of life of all First Nations communities.

BUILDING ON EFFECTIVE, BROADENED AND RESPECTFUL PARTICIPATION

In order to ensure its legitimacy and effectiveness, the requisite change must provide First Nations with a higher level of self-determination in the management of the health care and social services system intended for them.

A firm political will and a specific time horizon are critical elements for ensuring the self-determination First Nations need to make strategic, organizational and operational choices regarding the management of health care and social services that are offered to their communities.

Self-determination is essential for the good governance of the system. First Nations must recover their right of oversight and decision-making with respect to program design, development, implementation and assessment.

Respect for the culture of First Nations is the first guarantee of confidence and service quality.

PROMOTING A GLOBAL APPROACH BASED ON FIRST NATION NEEDS

The success of the proposed structural change requires the implementation of a holistic approach. Such an approach, which is already deeply rooted in First Nations culture, integrates the physical health of individuals, families and communities with their social, emotional, spiritual, cultural and environmental well-being.

A holistic approach can easily accommodate the best of traditional medicine, already ingrained in community tradition, and modern medicine based on scientific achievements, but which is frequently practiced by professionals who are not well informed about First Nations culture.

First Nations have the inalienable right to benefit from the delivery of health care and social services that are adapted to the demographic, historical and cultural specificities of their communities. These differ from those of communities established by Canadians of European origin. They also differ from Nation to Nation on both a cultural and national level.

Accordingly, First Nations demographic, geographic, historical, sociological and economic specificities generate diverse health care and social service needs. It follows, therefore, that the health care and social services program for First Nations communities must be integrative, more flexible and more closely adapted in order to adequately meet demand and the preferences expressed by the various communities.

INCREASING FIRST NATIONS HEALTH CARE FUNDING

Funding is a key issue in achieving parity in health care.

The chronic underfunding of the First Nations health care system, which has been ignored for too long, must now be taken into account. Indexing the First Nations social development budgets at less than 3% per year has only worsened the health of First Nations populations over the past few years.

Without solid and predictable funding, the health care and quality of life disparities will widen over the next few years, to the detriment of First Nations communities.

BETTING ON INNOVATION

Nowadays, more than ever before, innovation based on research & development must drive health care and social services programs in order to solve current problems and meet the expectations of First Nations communities.

The use of new health care technologies is a necessary step in the renewal of the First Nations health care and social services system.

The challenge is to better meet community needs and to provide the timely and effective care and social services they expect, regardless of their location.

New technologies and scientific knowledge can help to solve the problems stemming from factors affecting access to health care, such as distance, transportation, language skills (non-native medical personnel) and ignorance of First Nations cultural values, etc.

BETTING ON COORDINATION AND MEANINGFUL DIALOGUE

Bringing about the expected change calls for greater intersectoral, multidisciplinary and interregional coordination.

Improving health care and social services offerings requires greater synergy of efforts and the ongoing cooperation of all the stakeholders and decision-making authorities: governments (federal, provincial and local), regional and community agencies, etc.

Such coordination is even more critical given the geographical isolation of First Nations communities, the prevailing climatic conditions in their regions and their dispersion across the land.

This level of coordination also requires a change in attitudes, mutual respect and dialogue as equals between the stakeholders in the health care and social services intended for First Nations.

FOSTERING THE INTEGRATION AND ADAPTATION OF SERVICES

There needs to be greater integration and adaptation of the health care and social services programs to the needs of First Nations communities.

This will foster more cohesive and comprehensive service offerings. Service providers must therefore consult each other, complement each other's protocols and put in place more flexible mechanisms reflecting community contexts (diversity, specificities, isolation, priorities, etc.).



The adaptation and integration of services must be tailored to First Nations needs, expectations and outlooks.

BANKING ON TWO-WAY ACCOUNTABILITY

Intersectoral, multidisciplinary and interregional coordination must facilitate the effective implementation of strategic, organizational and operational policies with respect to the delivery of health care and social services.

This calls for significant efforts to simplify and ensure the credibility of the accountability process and to establish credible assessment mechanisms that are compatible with community needs.

Credible assessments and fair, equitable and totally transparent accountability processes will make it easier to obtain increased funding for First Nations health care and social services. Such mechanisms will consolidate the success of the changes proposed by this Blueprint.

INVESTMENTS IN HEALTH VS. HEALTH EXPENDITURES

Progress requires a change in public discourse to more effectively increase awareness and rally support.

Henceforth, public commitments pertaining to First Nations health care and social services must be framed in terms of investments, the value of which can be enhanced, rather than expenditures that must be reduced at all costs.

Human health is a key determinant of wealth creation and progress in the area of collective well-being. Illness adversely affects wealth creation, generates huge social costs (care, treatments, etc.) and results in lost revenues for society (inactivity, low productivity, etc.).

The cultural, historical, demographic and economic potential of First Nations is not taken into account in the assessment of the socio-economic benefits of public commitments to health care services for First Nations. By preserving their culture since time immemorial, often under hostile and difficult conditions, First Nations communities have developed invaluable know-how and a socio-economic heritage the potential of which have not been fully tapped.

This know-how and the human potential of these communities must be taken into account in the evaluation of strategic choices affecting the health of First Nations populations.

In Canada, a land of immigrants and a welcoming country, public discourse on the costs of the health care and social services provided to First Nations is paradoxically not exempt from frequently misleading bias, insinuation and evidence. Negative discourse does not foster massive investments in health care nor does it rally support for sustainable human development for all communities, regardless of their historical relationship with the State.

The benefits of investing in the health of First Nations do not apply only to the First Nations themselves, but also to all Canadians.

3.

FOCUS AREAS AND ACTIONS

The 2007-2017 Blueprint for health care and social services for Quebec First Nations proposes structural change within a framework comprising four complementary areas of focus to:

- > Foster self-directed action and the broadening of First Nations jurisdictions;
- > Increase and index public funding allocations;
- > Innovate in the delivery of services;
- > Optimize health care and social services programs.

3.1 FOSTER SELF-DIRECTED ACTION AND THE BROADENING OF FIRST NATIONS JURISDICTIONS

Fully aware of the importance of self-determination on the performance of the health system, First Nations expect to be considered with respect and as full partners in the development, delivery and assessment of health care and social services programs for their communities. Concrete action must therefore be taken in order to:

Strengthen First Nations leadership

- > Establish collaboration and consultation mechanisms pertaining to the delivery of health care and social services to First Nations involving the communities (APNQL consultative protocol, partnership protocols, etc.).
- > Support local initiatives and health care strategic planning in each community.
- > Stimulate intersectoral communication and strategic alliances between health care and social services providers on one hand and, on the other, between the players with an interest in employment, education, housing, infrastructure and justice policies as well as other determinants of health.

- > Heighten the awareness of establishments and health care and social services personnel with respect to the outlook and expectations of First Nations in the area of health care and social services.

Multiply consultation gateways

- > Reserve a seat for a First Nations representative on the boards of directors of provincial health organizations in regions where a First Nations members represent a high proportion of the population.
- > Strengthen the sharing of knowledge and data on programs and services for First Nations.
- > Strengthen direct dialogue and constructive consultation between the staff of relevant departments and First Nations authorities.
- > Acknowledge, value and improve the skills of professionals who work in the health care and social services system for First Nations.

3.2 INCREASE AND INDEX PUBLIC FUNDING ALLOCATIONS

Achieving parity of health for First Nations requires that public funding for health care and social services must be significantly increased before 2017. There are several reasons for this: population growth, rising medication costs, new risks and epidemics (obesity, diabetes, influenza, etc.), aging of the Aboriginal population, need to upgrade technologies and equipment, widening of disparities, etc.



Increase and index public funding to catch up

- > Index budget increases for the next 10 years and plan on two major increases. The first must reflect the increase in health care and social services system costs. The second must reflect the funding catch-up required to achieve parity with respect to health care and social services.
- > Offset the gap in health care and social services by proportional increases of public investments in the health and quality of life of First Nations.
- > Adopt policies to end the chronic underfunding and piecemeal funding that are the root cause of the degradation of the health and quality of life of First Nations populations and their underdevelopment.

Quantify the current and future requisite investments

- > Develop a picture of current investments in health care and social services for First Nations and their delivery mechanisms in terms of expenditures and services.
- > Conduct prospective studies to forecast trends and develop intervention scenarios.
- > Establish a dedicated Quebec First Nations health and social development monitoring body in order to observe evolving trends with respect to the health and well-being of all First Nations communities.
- > Undertake the comprehensive mapping of the delivery of health care and social services to First Nations communities in the province of Quebec.

At the moment, there is no clear picture of the service offerings to First Nations communities by various service providers. Yet this is critical information for effective service organization on a regional and national basis. Therefore, mapping the delivery of services in communities and highlighting disparities, grey areas and potential overlapping on a regional and community basis are essential activities in the short term.

Ensure funding flexibility

- > Adapt the criteria for eligibility and access to funding for health care and social services.
- > Fine-tune band funding agreements in order to include non-resident members who also have a right to receive the services provided to resident members.
- > Increase band council funding to enhance the delivery of services to individuals and families who live outside First Nations communities.
- > Facilitate the equitable and viable access to medication and to all uninsured health services by all the communities.
- > Relax program criteria and facilitate program and funding reallocation (residual amounts, etc) according to real needs and problems.
- > Establish mechanisms for the multi-year transfer of any unspent First Nations yearly budget surpluses.

3.3 INNOVATE IN THE DELIVERY OF SERVICES

Because of the enormity of the challenges involved, achieving parity in health care requires innovation in the delivery of care and social services to First Nations communities. Innovative approaches designed and implemented by creative agencies will help First Nations to benefit from best practices and new practices in providing health care and social services to their communities. The need for innovation is not limited to products and services. Processes and organizational structure must also be renewed in order to ensure the conformity of service delivery to the specificities of First Nations communities in all regions.

Innovate in the delivery of health care and social services

- > Promote the adoption of best practices and adequately subsidize First Nations leading edge activities.
- > Foster the use of new technologies in order to provide better services.
- > Take advantage of information and communication technologies to share information and support the adoption of new knowledge and best practices.
- > Intensify skills training and transfer.
- > Decentralize programs and expand the range of services to be provided.

Integrate service offerings into a holistic framework

- > Involve decision-makers at all levels of government as well as other interested agencies in the integration of services in order to favour health care over administrative process.
- > Clarify areas of jurisdiction in order to eliminate existing grey areas (zones without services) in the First Nations health care and social services system.
- > Allow each stakeholder (federal/provincial/First Nations) to play an effective and unifying role in order to enhance the governance of the health care and social services system.
- > Broaden the mandate of health care centres to include both curative and preventive care after discussion with the centres.

Adapt service offerings to community needs

- > Design service offerings to meet expressed community needs.
- > Simplify communication protocols between local, regional and national authorities by limiting the number of departmental contact persons and by streamlining procedures that only increase delays and increase program management costs.

- > Train and recruit more First Nations professionals and managers for the health care and social services system.
- > Fund training, awareness and information activities in order to break down prejudice and demeaning, if not discriminatory, attitudes towards the First Nations members.
- > Promote equity and wage parity in order to facilitate recruitment and retention of health and social services professionals.

Increase support for health professionals in smaller communities

The multiplicity of system procedures and requirements constitutes a heavier burden for smaller communities which lack the resources to develop projects and which are deprived of urgently needed funding.

- > Simplify accountability procedures and enhance transparency.
- > Avoid requiring scarce health care and social services human resources to assume functions other than their basic essential functions.
- > Implement standardized procedures to meet the expectations of various departments.
- > Subsidize the timely and temporary use of consultants to simplify and reduce the workload of managers and personnel who are frequently snowed under with work.

3.4 OPTIMIZE HEALTH CARE AND SOCIAL SERVICES PROGRAMS

Optimizing public investments in health requires an accountability process that provides for a comprehensive assessment of health care service offerings.

Optimize public investments in health care and social services

- > In cooperation with the relevant institutions, establish effective, fair and equitable accountability mechanisms.
- > Ensure that First Nations health care and social services budgets are managed to the best advantage of their communities.



- > Commit to being transparent and ensure equal access to information and data on health care programs for First Nations on the basis of a collaboration of equal and mutual respect.
 - > Establish a Council of First Nations health care and social services experts that will include both First Nations and civil society representatives (academics, elected officials, respected personalities, etc.) to objectively monitor progress on an annual basis, with a special focus on the assessment of progress in the implementation of this Blueprint.
- Strengthen the assessment of programs and services delivered to First Nations**
- > Assess on a regular and planned basis the relevance, implementation and effects of health care and social services programs for First Nations.
 - > Begin summative and formative evaluations of the main health care and social services programs for First Nations.
 - > Publish the results and recommendations from such evaluations and develop a set of indicators for measuring various aspects of health care and social services delivery in First Nations communities.
 - > Follow-up on recommendations and accountability reports.
 - > Assess policies and approaches governing the delivery of health care and social services whilst consolidating activity reports in order to eliminate cumbersome and redundant administrative procedures.
 - > Integrate information on each health care and social services program into a single report focusing on relevant components and financial backers.

4. EXPECTED OUTCOMES BY 2017

- > First Nations have assumed responsibility for effective self-determination with respect to the strategic, organizational and operational choices associated with the governance of the health care and social services system for First Nations communities.
- > First Nations are fully empowered stakeholders in decision-making bodies (boards of directors, etc.) and have a say in the delivery of health care services to their communities.
- > A reliable and mutual accountability process with respect to the delivery of health care and social services is binding on both First Nations and governments.
- > First Nations authorities and leaders negotiate with governments and health authorities on the basis of clearly defined responsibilities and procedures adapted to the needs of First Nations communities.
- > First Nations leadership in the design, implementation and assessment of health care and social services delivered to their communities is acknowledged.
- > Health and social development disparities are closely studied and rationally eliminated in a way that takes into account the concerns of First Nations communities.
- > First Nations have access to adequate public funding to strengthen the health care and social services system intended for their communities.

ACCESSIBLE, TARGETED AND COMPREHENSIVE HEALTH CARE

3

As pointed out previously, the health status of First Nations people is much more precarious than that of the Canadian or Quebec population. In more than one respect, the current situation is worrisome with regard to their longevity. There is an urgent need for restructuring to correct current disparities and give the First Nations hope for a better future based on the effective delivery of health care and social services that fully meet their needs.

It goes without saying that the different health indicators cruelly illustrate the problems of the health care system currently in place and its inability to provide care that meets the expectations of the First Nations. To correct the disparities, let us start by explaining the situational findings and the challenges to be met.

1.

THE CURRENT SITUATION

Although life expectancy at birth has increased significantly in the past two decades, the disparity between life expectancy at birth of First Nations people and that of the rest of Canada's population nonetheless remains a major concern. Today, life expectancy at birth for Canadians is 76 years for men and 81 for women, while it is only 69 and 77 for First Nations men and women respectively⁵.

After analyzing the available data and consulting with First Nations health and social services experts and community representatives, certain health problems have been targeted as priorities. The following table shows the disparities in order of magnitude.

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

⁵ Statistics Canada (2000).

⁶ The data in these columns refer only to adults, unless otherwise indicated. The data are from the Report on First Nations living in FNLHSC communities in the Quebec region, 2002-2003 (FNQLHSSC 2006), except where otherwise indicated.

⁷ Only general cardio-vascular problems are documented for FN in FNQLHSSC 2006

⁸ Baby bottle syndrome

OBESITY AND OVERWEIGHT are escalating afflictions everywhere in Canada, but are especially devastating within the First Nations communities in Quebec. In the communities, a large majority of children, adults and seniors are developing excess weight (52%, 67% and 81% respectively)⁹. The First Nations have twice as many obese people as the general population. This presages a significant increase in cardiovascular diseases and diabetes in the next few years; obesity and overweight are determinants of several chronic diseases.

DIABETES threatens the health and quality of life of First Nations peoples. Almost 15% of adults and 33% of seniors suffer from one or the other type of diabetes. Diabetes is 3.5 times more prevalent among First Nations people than in the general population. This disease seriously jeopardizes quality of life, results in long-term health care needs and involves significant economic costs for the communities, families and individuals.

Due to a lack of means and sufficient services, the incidence of diabetes screening is low for adults (55 %) and very low for children (8%). All the evidence leads us to believe that there will be a continued, indeed, exponential increase in the prevalence of diabetes in the next few years, in particular due to the prevalence of obesity and overweight, especially in children and adolescents¹⁰.

CHILDREN'S HEALTH is at the heart of First Nations' concerns. Health problems in early childhood are numerous and they are not fully detected in time. The inaccessibility of adequate services prevents children from getting the specific required services that they need in the first six years of life. Add to this often weak parenting skills that prevent parents from identifying the special needs of their children.

Although **INFANT MORTALITY** has declined in the past 30 years, it is still much higher among the First Nations than in the rest of Canada's population. In fact, infant mortality is 6.2 per 1000 live births for the First Nations, compared to 5.4 per 1000 for the general population, or almost 15% higher for the First Nations¹¹.

TEEN PREGNANCIES are common. In First Nations communities in Canada, in 2000, one birth out of five (20%) involved an adolescent mother compared to only one birth in twenty (5.6%) for Canada's general population¹².

With respect to **BREASTFEEDING**, in 2002, 63% of Canada's First Nations babies were breastfed, compared to approximately 75% of babies in Canada's general population¹³.

Breastfeeding is not heavily or wholly promoted due to a lack of community resources. Also, it is known that breastfeeding requires appropriate support, in view of the effort required on the part of the mother. Moreover, the hospitals where First Nations mothers must go to give birth do little or nothing to promote breastfeeding among First Nations mothers.

Even though **FETAL ALCOHOL SPECTRUM DISORDER (FASD)** is present in all social strata and groups in Canada, it is reported to be much more prevalent in certain First Nations communities than in the rest of Quebec. According to Health Canada, the prevalence of FASD in high-risk populations, including First Nations communities, may be as high as 1 child in 5¹⁴. FASD-related disorders are caused by alcohol intoxication of the embryo or fetus, as a result of the mother consuming alcohol during her pregnancy. It should be noted that in First Nations newborns, FASD tends to be under-diagnosed and its prevalence has not yet been sufficiently documented¹⁵.

⁹ FNQLHSSC, 2006, First Nations Regional Longitudinal Health Survey - Quebec Region - 2002 – Report of First Nations living in the communities.

¹⁰ FNHSSC-Quebec Region (2006).

¹¹ Government of Canada Report (2003): The Well-Being of Canada's Young Children.

¹² Health Canada (2000). Statistical Profile on the Health of First Nations for the Year 2000.

¹³ NAHO (2006). Report by selected indicators by gender. First Nations Regional Longitudinal Health Survey (RHS) 2002/03.

¹⁴ Health Canada, http://www.hc-sc.gc.ca/fnih-spni/famil/preg-gros/intro_e.html (consulted April 21, 2007).

¹⁵ INSPQ (2004). État de la situation sur le Syndrome d'alcoolisation fœtal au Québec. Government of Quebec.



INJURIES, whether intentional or not, still take a heavy toll on First Nations men and women today. Injuries are the principal cause of death in those under 45 years. The number of potential years of life lost due to injuries is higher by far than that of all other causes of death combined. This number (relativized per 1000 inhabitants) is almost 3.5 times higher than for all Canadians¹⁶. As shown in the preceding table, the Quebec First Nations are twice as susceptible to physical injuries as the general population. Many social problems, such as alcohol and drug use, violence and psychological distress contribute to the increase in injuries. Taking care of injured people has severe repercussions on families and communities, as well as creating considerable pressure in terms of health care demands and costs.

The available data show that **HIV/AIDS** is wreaking havoc on First Nations. These data indicate that 15% of new cases of HIV/AIDS in Canada are detected in Aboriginal peoples, while these populations represent less than 4% of Canada's population¹⁷.

Unfortunately, HIV screening is still unusual and prevention is largely insufficient. The results of the Quebec Region FNRLHS (2002) show that only 30% of adult men and 45% of adult women have had a screening test. The risks of HIV are higher than ever before, especially among young people, due to negligence associated with alcohol and drug use habits, unprotected sex and the sharing of intravenous injection paraphernalia.

Although data for Quebec First Nations are not yet available, we know that the incidence of **HEPATITIS C** is seven times higher in Canada's Aboriginals than in the rest of the Canadian population¹⁸. In addition, **BLOOD-BORNE AND SEXUALLY TRANSMITTED INFECTIONS (BBSTI)** are on the rise, due to the increased presence of risk factors in First Nations people.

Accessibility to **CONVENTIONAL HEALTH CARE** constitutes a major issue for the First Nations and varies from one community to the next. According to the available data, First Nations members are four times more likely to have encountered obstacles in accessing health care.

The reality of access to health care is not the same for First Nations members living in small communities in remote areas as for those living in large communities in urban areas. Some communities are not accessible by land year-round or in winter. Besides the isolation, the lack and turnover of health care workers have a significant effect on the accessibility of health care. Some services are not offered in the communities and, consequently, people must travel long distances to obtain the necessary care.

Access to quality **MATERNAL AND CHILD HEALTH CARE** remains poor in certain cases and differs vastly from one community to the next. The lack of resources, combined with the distance from health care services, prevents pregnant women and newborns from accessing all the care and social services vital to their health. Many mothers, living in impoverished circumstances, need more constant personalized follow-up, which is impossible to obtain in many First Nations communities.

¹⁶ Health Canada (2000). Statistical Profile on the Health of First Nations for the Year 2000.

¹⁷ Health Canada, 2000.

¹⁸ Public Health Agency of Canada, http://www.phac-aspc.gc.ca/hcai-iamss/bbp-pts/pdf/hepbc_ab_e.pdf

Access to Health Canada's **NON-INSURED HEALTH BENEFITS (NIHB)** program is not available to all First Nations. This highly problematic situation requires a thorough revision and better governance of this program. In fact, the program is unable to meet all of the First Nations' needs due to its funding and administrative complexity. The burgeoning First Nations youth population, with its many cumulative health problems and other risk factors, will considerably intensify the demand for NIHB over the next few years.

CONTINUING CARE is very fragmented in Quebec First Nations communities. Only seven communities out of thirty-three have a long-term care centre¹⁹. In addition, many services are lacking or incomplete, notably palliative care, extended care, mental health services, services for persons with disabilities, etc. Consequently, a high proportion of seniors must leave their community to obtain the care they need. Those who remain in their community are able to receive various types of home care and services, although, due to a lack of community resources, the delivery of much of the care and services falls to informal caregivers. These people are not always given the support and recognition they deserve for the range and quality of duties that they have to perform.

Access to **TRADITIONAL HEALTH CARE** is also an important issue. A large number of First Nations members use traditional means to meet their physical, emotional, spiritual and social health needs. According to a survey conducted by NAHO in 2002, half of First Nations members have used the services of a traditional Aboriginal healer or traditional medicines²⁰. However, in the Quebec communities, many have encountered difficulty accessing these services (43% of adults in 2002)²¹. Another issue concerns the marginalization of traditional medicine in the programs unilaterally designed by federal authorities.

In circumstances where access to services is difficult, **TELEHEALTH** is a very promising technological tool. However, development of this technology has been seriously delayed for First Nations in Quebec compared to Aboriginal communities in the rest of Canada. There are currently only 2 First Nations communities in Quebec out of 33 that have a Telehealth project.

The medical staff does not necessarily know the culture and is not proficient in the languages or aware of the social reality of the First Nations, which leads to misunderstandings and dissatisfaction in the recipients. Also, once back in their community, after-care and services are not always available.

The various deficiencies described above significantly affect the health and quality of life of First Nations communities. In this regard, the Human Development Index, created by the United Nations Development Program (UNDP), in the 2001 database, ranked the First Nations at the equivalent of 76th place (out of 174 nations). At the same time, Canada occupied 8th place²². The extent of the inequalities in terms of health and social development between the First Nations and the rest of the Canadian population is once again underscored by irrefutable data. This indicator gives priority to variables that measure a people's social development and health.

A similar index, created to compare the well-being of First Nations communities with other Canadian non-native communities, shows that the First Nations of Quebec are clearly behind the First Nations of Ontario, British Columbia and the Atlantic Provinces²³.

¹⁹ FNQLHSSC- (2006): An Assessment of Continuing Care Requirements in First Nations and Inuit Communities. Quebec Regional Report.

²⁰ AFN (2004): First Nations Health Action Plan. First Ministers Meeting.

²¹ FNHSSC-Quebec Region, FNQLRLHS, 2006.

²² Assembly of First Nations (2006): Ten years after the Royal Commission on Aboriginal Peoples: Report. http://www.afn.ca/cmslib/general/afn_crpa.pdf

²³ Department of Indian Affairs and Northern Development Canada (2006): First Nations Community Well-Being. http://www.aicn-inac.gc.ca/pr/ra/wbp_e.pdf

2. CHALLENGES

MAKE CHILDREN'S HEALTH A PRIORITY FOR EVERYONE

Investing in children's health is recognized as one of the priorities unanimously agreed upon by First Nations stakeholders and representatives. Failure to act on the deterioration of children's health is catastrophic for the future of First Nations peoples from a human, social, cultural, political, spiritual and economic perspective. Children's health is historically the collective responsibility of all social players, governments, First Nations leaders and families.

PREVENT OBESITY, DIABETES AND OTHER CHRONIC DISEASES

These scourges are flourishing and could increase dramatically in the near future. Current action is insufficient to prevent these severe problems that have physical, psychological and social consequences.

IMPROVE ACCESS TO HEALTH CARE FOR ALL POPULATIONS

This challenge largely determines the achievement of health parity for First Nations over the next decades. To meet the challenge of parity, additional effort must be made to facilitate access to health care and services and allow the First Nations to benefit, like other Canadians, from advances in terms of health and quality of life. Without these efforts, the health status of First Nations people could continue to be jeopardized or even further deteriorate during the next few years. This deterioration would certainly have a damaging socio-economic effect on local development and on the standard of living and quality of life of the populations.

REVITALIZE HEALTH PREVENTION AND PROMOTION

The health prevention and promotion component must feature the new health strategies for proactive and strategic action on problems before they even appear. The current structure is a concern and federal programs very often espouse a view favouring curative care at the expense of preventive services. Today, due to the lack of financial and human resources, communities are obliged to attend to the most urgent matters, for the most part sacrificing prevention for curative action. In the future, prevention, including the early screening of diseases, cannot be ignored. Concrete measures are mandatory to avoid an escalation of health problems.

RECONCILE TRADITIONAL AND CONVENTIONAL MEDICINE

In view of the needs of First Nations members with regard to traditional medicine, the health system must give it priority in the First Nations programs. In addition, effort must be made to allow the First Nations to increase the role of traditional medicine in the communities. The marginalization or discarding of this important aspect of Aboriginal culture cannot in any way help in adapting health programs and services to the needs of the First Nations.

MAKE MORE HEALTHY AND AFFORDABLE FOOD AVAILABLE TO POPULATIONS IN ISOLATED AREAS

Communities in remote and/or isolated areas do not always have equitable access to food deemed healthy or beneficial to health. Transportation costs raise the selling price of many food products: dairy, vegetables, meats, fruits, beverages, etc.

Because of this, in some communities, the price of dairy products, produce, etc. is three times higher than the selling price seen in major cities in Quebec. The situation is disturbing; especially since the wages and standard of living of First Nations people are not as high as those in the rest of Quebec.

3. FOCUS AREAS AND ACTIONS

In order to meet these challenges, different focus areas have been identified and must be given priority when deciding on actions to take during the next decade.

3.1 BUILD ON CHILDREN'S HEALTH

The future of the First Nations depends on the health of their children. The review of the current situation shows the extent of the scourges affecting this vulnerable population. Action must be initiated to preserve this treasure and ensure a better future for our next generations.

Improve maternal and child health care

- > Develop prenatal and postnatal services to be offered in all communities in order to provide valuable instructions on adopting a healthy lifestyle during and after pregnancy and valuable information about childbirth and living with one's child.
- > Ensure long-term follow-up of children to prevent different child health problems, reinforce parenting skills, prevent and screen at an early age for various health and social problems, identify and refer children with special needs, provide support for parents and promote healthy child development.
- > Pay special attention to these services that are crucial to the health of mothers and children.

Adopt a family approach to health

- > Build on family health by promoting the health of the parents, in all its dimensions, based on an integrated family health approach, in order to avoid "piecemeal" programs that only cover part of the family's health needs and aspects, as is currently the case. Developing and implementing a new approach is indispensable to improving the health of children, families and communities.
- > Develop services and programs for home-based health care.
- > Initiate effective improved programs to promote breastfeeding, prevent teen pregnancy, support teen parents, and prevent various early childhood syndromes, dental cavities, etc.
- > Design programs and services adapted to the needs of elders and guarantee the constant care required in their regions.

Create specialized services for children with special needs

- > Establish an early screening program as part of early childhood services in order to avoid late detection of children with special needs, as is so often the case.



- > Institute specialized programs and services close to communities so that children with special needs don't have to leave their community to obtain specialized services, which are quite often not adapted to their culture or their needs.

3.2 TAKE COMPREHENSIVE ACTION AGAINST OBESITY, DIABETES AND OTHER CHRONIC DISEASES

Of all the health priorities identified by the First Nations, the fight against obesity and diabetes tops the list. It is essential to mobilize the necessary resources and effort to fight against these growing and devastating afflictions. The First Nations have many times stressed these priorities, considering the magnitude of the obesity and diabetes epidemic that threatens all population groups, especially children and youth.

In this regard, the following actions must be implemented as soon as possible:

- > Adopt a holistic community approach based on programs for the prevention of obesity and diabetes that include significant participation by First Nations authorities in related Federal, Provincial and Territorial government projects;
- > Promote and facilitate the adoption of a healthy lifestyle;
- > Work in cooperation with various local authorities (health, education, sports, recreation, band council) to mobilize the community;
- > Develop or strengthen health promotion activities based on physical activity and healthy eating;
- > Promote the nutritional benefits of traditional foods and facilitate access to these;
- > Develop partnerships to facilitate access to healthy food in all First Nations communities;
- > Continue work to develop practical workshops on nutrition in the schools, daycare centres, early childhood centres and other exemplary community initiatives;

- > Promote all activities and practices that will have a beneficial effect on mental health and quality of life in general;
- > Facilitate access to fresh, healthy food in isolated and remote areas and subsidize transportation and marketing costs in these regions.
- > Develop food co-operatives, food bank and collective kitchens in the community.

3.3 TAKE CONCERTED ACTION TO IMPROVE ACCESS TO HEALTH CARE

Obviously, the many issues concerning access to health care experienced by First Nations people are injustices that cannot be tolerated in a country recognized throughout the world for the quality of its health care system. In order to improve First Nations' access to health care and services, the following actions are recommended.

Develop a map of existing health care and fill in the missing services

- > Develop a clear picture of the services offered in the various communities and the different types of providers, in order to better meet the needs and improve access to care and services.
- > Mapping the services in the communities and identifying the disparities between the different types of providers, between the regions and between the communities, are essential short-term activities.
- > Strengthen the human resources and medical staff in the communities and increase investments in infrastructure, furnishings and medical equipment, based on needs identified by mapping.
- > Fill in the missing services at the community level in order to ensure a true continuum of health care services provided to the communities.

Implement the new maternal and child health care program in all communities

- > Accelerate implementation of the new maternal and child health care program so that the services are no longer fragmented or under-funded, as is the case in most of the communities.
- > Expand its implementation to all First Nations communities in Quebec.

Reform the Non-Insured Health Benefits Program (NIHB)

- > Transfer management of this program, to adapt it to the real needs of the First Nations people, and not just to predetermined budget allowances.
- > Reform the administration of and access to the services covered as soon as possible, to reflect the real needs of the First Nations people and ensure more equitable access.

Promote and facilitate access to traditional health care

- > Provide necessary support to traditional healers in terms of recognition and funding of research and training, the same as for medical staff, so that they can pursue and revitalize their activities.
- > Ensure the next generation of traditional healers and encourage the transfer of expertise from those who have ancestral medicinal know-how; with the aging of these healers and experts we risk irretrievably losing ancient know-how based on their history and lifestyle.
- > Ensure that conventional medicine and traditional medicine form two important pillars of the medical system.

3.4 BUILD ON HEALTH PREVENTION AND PROMOTION AND STRENGTHEN CONNECTIONS BETWEEN THE SERVICES AND THE COMMUNITIES

Invest in health prevention and promotion

- > Implement effective prevention to reduce later demands for curative care, as do many industrialized countries, including Canada, especially promoting the adoption of a healthy lifestyle.
- > Develop actions oriented towards the five strategic sectors of health promotion identified in the Ottawa Charter (1986): i) Build healthy public policy, ii) Create supportive environments, iii) Strengthen community action, iv) Develop personal skills, v) Reorient health services. These strategies must be incorporated in a First Nations public health framework. Any action in this regard will have a beneficial impact on First Nations health.

Integrate prevention as part of a cohesive comprehensive approach

- > Develop a holistic community approach based on a regional model, to put an end to fragmented actions and adopt a consistent strategy that can have the desired impact on several health determinants, including non-medical determinants, such as poverty and social conditions, housing, etc.

Reinforce activities for the early screening of disease

- > Develop methods to overcome the many obstacles to screening identified by the First Nations that suggest an under-estimation of the prevalence of certain treatable diseases.
- > Extend early screening to reduce the number of First Nations persons, which is probably considerable right now, who are infected or afflicted by certain diseases without knowing it. Current deficiencies in terms of screening have serious repercussions on the reliability of situational diagnoses and on the relevance of health and social services programs and priorities.
- > Reinforce policy instruments in order to control the growth of various cancers.



Strengthen relationships of trust between the services and the population

- > Rigorously evaluate the health care services and ensure that the First Nations play an active role in conducting these evaluations, in order to more accurately target needs and create trust between service providers and recipients. Without the trust of the First Nations and the communities, the efforts and awareness and prevention documents could all be for nothing.
- > Review their funding methods to ensure continuity of the activities necessary to achieve the expected results. Funding by program (vs. by policy) and repeated cuts in prevention programs jeopardize progress and the acquisition of knowledge.

3.5 UPGRADE INFRASTRUCTURES AND INVEST IN NEW TECHNOLOGIES

Upgrade health infrastructures

- > Aim for parity in terms of infrastructures and new technologies. Health centres must have access to the most up-to-date medical equipment and in sufficient quantity to provide care to all patients. In the absence of a clear situational review, the communities are in agreement that the medical infrastructures available to them, especially in remote areas, are very often obsolete.
- > Provide First Nations with the same advances in health and social services knowledge and technologies as populations living in Canada's urban centres. Without these advances, the disparities can only multiply and the health status of the First Nations could deteriorate.

Invest in skills development

- > Facilitate access to current knowledge and leading edge technological skills by human resources responsible for community health while promoting better training and retention of staff working in the communities.
- > Ultimately, facilitate the decentralization of decision-making in order to help provide First Nations with the human capital required for effective self-determined management.
- > Promote the integration between training issued by First Nations and those issued by government institutions, and this, for health and social services.

Establish the required infrastructures for Telehealth and Electronic Health

- > Establish Telehealth infrastructures, as it is a significant asset in making health and social services available to the most remote and most vulnerable communities.
- > Develop Telehealth and Electronic Health in First Nations communities in view of the isolation of certain communities, the lack of specialized staff in remote areas, the difficulties encountered by First Nations people in accessing health care services and the costs related to transportation for medical reasons.
- > Combine this with skills development at the community level. Skills development can occur through distance education, especially through communications facilitated by new electronic technologies.

Initiate monitoring mechanisms on useful technologies and know-how

- > Develop a monitoring system for new technologies offered to the general population in order to facilitate the dissemination of knowledge and information useful for health and social services.
- > Invest in establishing communications networks, virtual clinics and virtual co-locations to allow First Nations communities to take advantage of new technologies. When daily priorities monopolize most efforts of First Nations communities, new technologies could be a big help in the development and quality of care provided to First Nations peoples.



HEALTHY COOKING COURSE IN BETSIAMITES

In 2005, the community of Betsiamites organized outdoor camps for diabetics featuring awareness-raising activities on the need for nutritious food in preventing and mitigating the adverse effects of diabetes. In addition to generating widespread community interest in the topic, these initiatives also encouraged the local nutritionist to design and deliver courses on healthy diets and cooking to a larger audience. These projects, funded by Health Canada's Aboriginal Diabetes Initiative, were tailored to meet the real needs of community members—i.e., to acquire healthier eating habits and incorporate them into their daily lives. Some 40 people, together with family and friends, took part in the courses.

In order to optimize results, the nutritionist arranged for the services of a professional chef, who adjusted course contents to community circumstances. Participants learned to identify healthy foods that were available locally and make them part of a healthy diet, while discovering and learning to appreciate new flavours. This innovative health-promotion project met the needs expressed by diabetics in the community.

The considerable interest engendered by the initiative has encouraged local stakeholders to extend it to other recipients; as a result, children and young parents will soon be able to enrol in courses on healthy eating offered by health centre experts. This extremely promising endeavour will benefit all members of the community by promoting good eating habits.



**WIGOBISAN:
LAC SIMON AGENCY FOR THE PREVENTION OF CHILD SEXUAL
AND PHYSICAL ABUSE**

Founded in 2000 as an innovative, pioneering initiative in the area of sexual-abuse and violence prevention, Wigobisan was designed and developed for and by the Lac Simon Algonquin community. The problem was identified thanks to an extensive degree of local mobilization; Wigobisan relies on the involvement of all members of the community while continuing to transmit Aboriginal values and traditions. With a view to ensuring maximum understanding of, and participation in, the Wigobisan program, a number of community measures, including campaigns to raise awareness among key stakeholders, meetings with elders and the public, and training of workers in the community, have been implemented. This strong community component aims at involving parents and all other community members in solving the problem, promoting the use of services, and foster awareness of, prevent and correct related risk factors while supporting team action with the children and families involved.

From its inception, Wigobisan has informed and consulted the public to ensure that the approaches developed respect the needs and pace of community life. The spirit of the Anishnabe culture was the driving force behind each and every development stage, with considerable importance placed on the central role of the family and transmission of family values.

Wigobisan provides several specialized individual and group treatment, prevention, education, awareness and healing services (e.g.: prevention and sex education workshops conducted in schools, awareness and information workshops for adults in the community, traditional healing activities held outdoors, treatment for abusers).

In 2002, on the occasion of International Children's Day, the Wigobisan agency was presented with the prestigious Marie-Vincent Foundation's prestigious award for its work. It is a shining example of a health prevention and promotion approach with its roots in the needs and priorities of a First Nations community that is entirely operated by that community.

4. WHAT WILL CHANGE BETWEEN NOW AND 2017

- > Services targeting children are incorporated in a family health approach that meets the needs of families and communities.
- > Children with special needs have access to quality health care services.
- > The spread of obesity is halted and programs to fight this affliction are developed and reinforced at the community level.
- > Diabetes screening is conducted at an early age and persons with diabetes have access to the required care.
- > Sufficient appropriate resources are made available to First Nations so that they have access to a complete range of curative and preventive health care, especially in the areas of maternal and child care, non-insured health benefits and continuing care.
- > The First Nations can enjoy accessible and revitalized traditional health care.
- > First Nations people live longer and are in better health. They are less vulnerable to contracting preventable diseases.
- > First Nations communities have access to better health promotion programs and services for the prevention of disease, risk-factors and injuries, to drastically reduce the ravages of mortality and morbidity.
- > Communities benefit from up-to-date infrastructures and medical equipment that is constantly updated.
- > Remote communities and/or communities that do not have nearby services have access to Telehealth and liaison services that ensure quality service for them.
- > Exemplary programs and initiatives are managed by the First Nations in order to ensure that children have the necessary resources and support for their development and protection.
- > Aggressive action is taken to reinforce parenting skills and support for parents and guardians living in unstable, destitute conditions.

INNOVATIVE, ACCESSIBLE AND SUSTAINABLE SOCIAL SERVICES

Access to quality social services strongly influences the health status and quality of life of individuals and communities. In troubled and at risk situations, social services, in all their forms, provide valuable comfort care and vital support for persons suffering from psychological problems and other symptoms of ill-being.

4

1.

THE CURRENT SITUATION

Access to quality social services strongly influences the health status and quality of life of individuals and communities. In troubled and at risk situations, social services, in all their forms, provide valuable comfort care and vital support for persons suffering from psychological problems and other symptoms of ill-being.

Nowadays, Quebec First Nations are experiencing head-on the resurgence of many social problems that jeopardize the most vulnerable social categories and sometimes whole communities. The available statistics show that the First Nations are more vulnerable than the rest of Canada's population to many disturbing

risks that require more aggressive, better orchestrated and, especially, more appropriate action. Failing that, the problems could worsen an already alarming situation marked by the accumulation of

many social ills: drug and alcohol addiction, mental illnesses, violence, abuse, suicide, child placements, etc.

In order to better understand these social problems, many risk factors must be taken into consideration, notably material and social poverty, childhood neglect and mistreatment, loss of identity and culture, overcrowded housing,²⁴ the Aboriginal residential schools experience, racism, segregation, loss of community autonomy, lack of future opportunities, despair, etc. Due to the large number of factors influencing the psychological, emotional and social health of First Nations peoples, a comprehensive approach that includes prevention and intervention in this regard is essential²⁵.

The available data confirm the extent of the ills requiring action.

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

The sources of these data are indicated in the appendices

²⁴ Scott Kim and Conn (1987). Pathogenèse sociopolitique de la maladie.

²⁵ Kim Scott (2006). Broadening the lens. Proceeding of a roundtable on aboriginal people's health.

I The data in these columns refer only to adults, unless otherwise indicated.

The data are from the Report on First Nations living in FNLRRHS communities in the Quebec region, 2002-2003 (FNQLHSSC 2006), except where otherwise indicated.

II In those 15 years and older, 1998, in Quebec.

<http://www.inspq.qc.ca/pdf/publications/283-FeuilletEpidemiologieSuicide.pdf>

SUICIDE is at the top of the list of evils flourishing in the communities. This tragic cause of premature death is widespread in First Nations communities. In all age groups combined, First Nations persons are 4 to 5 times more likely to commit suicide than the general population of Canada. The FNRLHS (Quebec Region) shows that in the Quebec First Nations, 47% of adolescent girls and 24% of adolescent boys have already thought about suicide during their lifetime and 12% of them have attempted suicide at least once. Among adults, 39% have thought about suicide and 18% of these have attempted suicide. Suicide has dramatic repercussions on families and communities.

Although the signs of **PSYCHOLOGICAL DISTRESS** are increasing everywhere in Canada, the situation is even more dramatic in the First Nations. Considered a taboo, psychological distress is still very poorly diagnosed and treated in First Nations communities. It is estimated that the rates of moderate to severe depression in First Nations adults are twice as high as the rates recorded in non-native communities.²⁶

Worse still, First Nations persons consult specialists for psychological distress half as often as the rest of Canadians. It should also be mentioned that most of the communities suffer from a chronic lack of funds for providing the required services and for equipping their communities with infrastructures and special services in terms of mental health-related services.

ALCOHOL, DRUG, MEDICATIONS AND GAMBLING ADDICTIONS are mounting afflictions that are very devastating for the First Nations. These addictions have serious consequences on family life and on health. They destroy entire families and significantly disturb the psychological balance of individuals and communities. The First Nations do not have enough resources for the treatment or prevention of these addictions. Aside from

the few existing treatment centres, the number of addiction prevention officers in the communities is insufficient to provide preventive action and appropriate treatment.

In this increasingly dangerous situation, early childhood pays a heavy toll. The data show a high incidence of child neglect. To protect them, the authorities intervene by removing the children from the family environment. The data concerning First Nations **CHILD PLACEMENTS** are alarming. In 2005-2006, there were between 191,000 and 200,000 person-night placements for over 1,000 children placed.²⁷

Thus, out of a total of approximately 11,000 surveyed children in the Quebec First Nations, the problem of placement affects approximately 10% of them. In some communities, this proportion can reach 40%. It should be noted that very often children are placed outside of their home community, which does not suit the parents or, even less, the children. The children are doubly penalized by being forcibly removed from their communities, thereby losing all privileged contact with their culture, their roots and their most comforting points of reference. We should add that most of the communities cannot fund the required support for families with specific problems who need specialized services that are rarely available in the regions. Services aimed at improving parenting skills do not meet the needs.

The placement of children as currently practiced is an exceptional measure (under provincial law), applied systematically, due to a lack of resources targeting prevention and support for the families and children concerned. The level of public funding allocated for child protection is still insufficient and the types of intervention currently in use are censured by the communities and the experts consulted.

²⁶ National Aboriginal Health Organization First Nations and Inuit Regional Health Survey 1997, Summary of national and regional reports, January 2004.

²⁷ AFNQL, 2006, Final Report of the First Nations Socio-Economic Forum, Act now...for the future, Mashteuiatsh, October 2006.



VIOLENCE, including sexual abuse, is rampant in many homes. Even though accurate data on this subject is often lacking, the few estimates used by specialized authorities are disturbing. According to a study conducted of practitioners in different local First Nations agencies, 57.1% of the respondents surveyed estimate that at least half of the members of their community have, in the past, been victims of sexual abuse, while 42.8% of the respondents estimate that the proportion is in the neighbourhood of 70% or more.²⁸

In spite of the many complaints and requests made by First Nations communities and authorities, social services for persons who are victims of abuse remain cruelly insufficient.

The available data show that a large proportion of today's parents suffered various abuses during their stay at "**INDIAN RESIDENTIAL SCHOOLS**". These parents, marked by these disconcerting and damaging experiences with parenting skills, find themselves unable to fully assume their role as parents. Add to this the share of social and health problems experienced by parents living in jeopardy (unemployment, poverty, inadequate housing, low level of education, various addictions, etc.). These situations cannot be corrected without aggressive collective action towards developing parenting skills.

CRIMINALITY is another evil that jeopardizes the well-being of First Nations people. It is constantly increasing and directly affects communities, families and even First Nations youth. Although they only account for approximately 4% of Canada's population, the First Nations constitute 17% of Canada's prison population.²⁹ Various addictions to harmful substances and, especially, to pathological gambling are factors favouring involvement in illegal activities, insecurity within the communities and the breakdown of a social fabric already jeopardized by various unenviable social and sanitary conditions.

The **ACCESSIBILITY AND QUALITY OF SOCIAL SERVICES** vary considerably from one community to the next. Due to an insufficient number of First Nations social workers, drug education officers, psychologists and other psychosocial practitioners, a growing number of individuals and families do not receive the care or services they need. In addition, many social workers are not from the community in which they work and/or are non-native, which makes it more difficult to create the relationship of trust (and confidentiality) necessary for psychosocial treatment.

MENTAL HEALTH also poses serious problems for many individuals and communities. The most vulnerable persons do not always have access to the resources required to deal with difficult and sometimes dramatic situations. This peril is said to be largely related to an accumulation of life problems, a loss of control over choices and resources, a loss of identity and, sometimes, to intergenerational sequelae from the Indian residential schools system experienced by survivors, their families and the communities.

²⁸ GRIPMA, 2005, Projet USSI-INIUM, Étude sur l'abus sexuel chez les Premières Nations du Québec, Final Report, March 2005.

²⁹ FNQLHSSC, 2006, Prevention of criminal activity in First Nations children 0-6 and families.

2. CHALLENGES

The delivery of social services provided to the First Nations is obviously insufficient to deal with the resurgence of social problems. The challenges are many and complex.

Start with an exhaustive analytical assessment of social services needs

At this time, there are few statistical data or formal analyses available concerning the current

situation of all of the social services provided to the First Nations. The available data are limited and incomplete, despite the constantly expressed concerns of the communities and political decision-makers regarding the seriousness of the social problems experienced by First Nations communities.

In order to act effectively in terms of social services delivery, the First Nations must conduct an exhaustive analytical assessment of all the services and means available to their communities. This assessment must identify the deficiencies and disparities that characterize the offer of social services, taking into consideration the documented problems and needs in the communities and regions.

In the absence of a detailed picture of the current state of social services provided to the First Nations and without a prospective analysis of needs, the battle against the social ills can only be limited and insufficient to effectively meet all of the needs of the First Nations in this regard.

Create a continuum of social services

The First Nations have the right to benefit from the provision of social services adapted to their needs. There is every indication that the range of available social services is lacking in almost all of the communities. Specialized services provided by First Nations practitioners and paraprofessionals are rare and difficult to access.

Despite the efforts made, community-led initiatives to counter certain problems remain insufficient, fragmented and funded by the government on a fairly discretionary and rarely predictable basis. Still, these initiatives must be increased, strengthened and better coordinated to eradicate the aforementioned problems.

To broaden the offer of social services, an integrated tailored approach must be adopted. This will make it possible to provide a continuum of services that includes different preventive, screening, treatment and postvention services.

Innovative service delivery is synonymous with intensified research-action-evaluation. The required services must be designed by and for the First Nations to avoid funding programs that have not been proven in the First Nations context.

Build on prevention and the promotion of life

Prevention and the promotion of life are essential pillars for any approach to mental health promotion.

Experience has shown that fragmented programs dispensed piecemeal by paltry, selective and inflexible funding are destined to fail.

Only a comprehensive approach combining prevention and promotion of life can sustainably curtail the problems that are flourishing in various First Nations social categories.

Services to counteract violence, psychological distress, suicide, alcoholism, drug addiction, pathological gambling, etc. cannot be effective without synergy and complementarity.



Mobilize and raise awareness to be more effective

The magnitude of their social problems is jeopardizing many First Nations communities. These problems require firm political support to come to the aid of already very vulnerable social categories that are highly exposed to social problems, especially violence and various types of abuse.

It is impossible to counteract these evils without unequivocal straightforward political commitment. The mobilization of all stakeholders (political decision-makers, government institutions, First Nations communities, Aboriginal organizations, the media, etc.), in Quebec and Canada must also be influenced by interest in collective action targeting the health and quality of life of the First Nations.

Without firm political commitment or mobilizing the necessary means, the First Nations and, especially, the most vulnerable communities, are in danger of losing hope and sinking further into marginalization and decline.

Back social development in early childhood

First Nations children suffer from a multitude of social problems and disabilities that are collectively inherited. The next decade is crucial in counteracting these limitations and disabilities. Concrete action must be taken.

Investing in social services provided in early childhood is not only a moral and human imperative, it is also cost-effective from social and economic perspectives. As Nobel Prize winner in Economics (2000), James Heckman, showed, investments in social services are more cost-effective when they target young children than when they target adults. Dealing with social services made available to young children, this internationally renowned economist shows that the earlier young people are supported by appropriate social services, the better it is for them and for society in general³⁰.

Providing required care to children with special needs, improving parenting skills, providing help for families in trouble, etc., are some of the necessary actions for helping First Nations children and future generations.

Relieving psychological distress and its consequences makes it possible to break the infernal cycle of neglect, mistreatment, violence, child placements, etc.

³⁰ James J. Heckman and Dimitriy V. Masterov, "The Productivity Argument for Investing in Young Children", Working Paper 5, Invest in Kids Working Group, Committee for Economic Development, October 4, 2004.

3.

FOCUS AREAS AND ACTIONS

The Blueprint for Health Care and Social Services for Quebec First Nations, 2007-2017, sets out structural interventions that are part of the four complementary focus areas:

- > Develop and diversify social services;
- > Intensify and adapt measures aimed at healthy child development;
- > Improve availability and accessibility of first-line practitioners;
- > Adapt and improve services provided to the most vulnerable populations.

3.1: DEVELOP AND DIVERSIFY SOCIAL SERVICES

In a situation with a multitude of social problems where human and financial resources are limited, the prevention and promotion of life component is often neglected, or non-existent, in the health care system operating for the benefit of the First Nations. Compared to services provided for non-natives, the disparities are enormous. In spite of the magnitude of the needs, the Federal Government continues to underfund these services for which it is solely responsible.

Prevention and the promotion of life are essential levers for curbing social ills and overcoming obstacles that compromise the future and hope of current populations and future generations. Several concrete structuring measures must be implemented to benefit the communities.

Assess and properly fund promising initiatives

- > Establish a stringent assessment strategy in conjunction with the First Nations to assess several social services funded by the Federal Government (such as the National Native Alcohol and Drug Abuse Program, etc.). These assessments make it possible to improve the effectiveness of these programs and might even justify the mobilization of new funding.

- > Update and adjust the social services programs to promote better adaptation of the programs to the increasing and specific needs of each community.
- > Allocate additional funding to support exemplary community and regional initiatives and expand their scope.

Fill in the missing links and provide a complete range of social services

- > Initiate and diversify the measures required to complete the continuum of missing services, based on an exhaustive analytical assessment of needs and available services at the community level, to:
- > Allow the First Nations to develop initiatives to counteract all forms of violence, for all population groups affected by this evil;
- > Establish and promote alternative resources within the community and region and outside the community;
- > Provide a complete range of services in the communities and Treatment Centres in order to counteract all the evils of addiction, including pathological gambling and synthetic drugs, etc.

Incorporate social services at the community level

- > Incorporate the programs in place and make them viable in order to provide continuous diversified service. Due to fragmented funding and rigid government management criteria, Aboriginal communities and organizations are currently doing their best to conduct prevention and promotion of life activities based on their specific needs and the rare resources available to them.



- > Develop and encourage multidisciplinary teamwork at the community and regional levels to foster the development and implementation of a comprehensive approach to prevention and promotion of life and to encourage the mobilization of all community players for the well-being of the population.
- > Initiate innovative programs to make the promotion of life a common denominator in all social services provided to the First Nations.

Create a First Nations entity to be responsible for child placement

- > Revise the current structure for the placement of First Nations children, which is at this time characterized by excessive legal action that reflects a profound lack of understanding of the situational reality. In fact, due to gaps in social services at the community level, community practitioners must often call upon the services of the Direction de la protection de la jeunesse (DPJ) du Québec [Quebec Youth Protection Services] to ensure access to services. Children apprehended by the DPJ are usually housed in a non-native environment where they are isolated from their community and lose their identity.
- > Overcome the negative repercussions of placements for children, families and the communities through the self-determined development of an Aboriginal youth protection service.
- > Ensure that this new service has the necessary means to be able to adapt the services to First Nations children and to bridge the gap with services that assist families in difficulty in the community setting. The current situation shows that parents whose children have been apprehended do not receive the necessary help and support to resolve the problems that caused their children to be placed; hence the children are repeatedly bounced between their families and DPJ.
- > Develop discussion and collaboration management with public security agencies.

3.2 INTENSIFY AND ADAPT CHILD DEVELOPMENT ACTIVITIES

As previously mentioned, child development is at the heart of First Nations' concerns. The children are currently dealing with various social problems that jeopardize their development, their quality of life and their future. Urgent action is necessary to promote healthy and promising development for all First Nations children.

Align the First Nations Head Start on Reserve Program (FNHSOR) more closely to the needs of the communities

- > Hire staff and provide them with ongoing training in order to achieve and implement the FNHSOR objectives.
- > Adapt and adjust the services to better accommodate the heterogeneous needs and priorities expressed by the communities.

Adapt and incorporate services targeting early childhood

- > Establish and strengthen activities for adapting and incorporating Federal and Provincial programs targeting early childhood.
- > Strengthen the provincial educational program to more effectively deal with the diversity and realities of First Nations.

Invest in developing parenting skills

- > Invest in sound childhood development by developing activities for parents and extended families.
- > Support parents, guardians and adoptive parents and make them aware of their role in their child's healthy development;
- > Create aid and mutual aid resources for mothers and fathers struggling with problems that impair their parenting skills;
- > Develop a coherent and culturally adapted program of therapeutic support for persons affected by the intergenerational repercussions of the Indian residential school system.

3.3 Improve the availability and accessibility of first-line social service practitioners within and outside of the community

Persons struggling with different social problems who need help must be able to access the services of first-line practitioners easily and quickly. However, the reality is that, in First Nations communities, there are many obstacles and barriers limiting access to social services. Steps must be taken to improve the availability and accessibility of first-line practitioners within and outside of the community.

Reinforce human resources trained in prevention and psychosocial intervention

- > Strongly support the practitioners through activities and programs initiated at the community, local and regional levels. There are currently very few programs that provide prevention and clinical intervention services for the benefit of First Nations communities. The few practitioners available are often burned out, due to a lack of financial and human resources.
- > Motivate and encourage the practitioners, because many of them end up losing their motivation and dropping out, due to a lack of necessary support to continue their work.
- > Encourage retention and recognize the merits and efforts of health and social services staff in First Nations communities.
- > Create health and social services training programs for informal caregivers.

Create multidisciplinary teams in the First Nations communities

- > Encourage projects initiated by multidisciplinary teams that provide complementarity that is difficult to find otherwise: sharing of knowledge, motivation, support for incumbent practitioners, etc.
- > Develop a dynamic of support for colleagues, to support the work of practitioners who, at present, must, alone, face various, sometimes desperate, demands and expectations.
- > Create the required collaboration with concerned authorities to prevent the progression of prostitution and drug dealing networks.

Create synergies between the practitioners concerned

At-risk groups are often difficult to reach to provide them with all the health care and social services that they need.

- > Promote a complete decompartmentalization of public services in the communities: health, revenue, education, businesses, band council, community media, etc., to reverse the trend, because only comprehensive integrated action fostering prevention and the promotion of life can make health and well-being a social project for all First Nations communities.
- > Involve the different living environments in which people develop in prevention activities. Living environments are the preferred fields for continuous prevention and promotion of life activities because they can incorporate these aspects into their regular activities.
- > Initiate programs to create collaborative and synergistic networks to generate complementarities and the required expertise to more easily contact hard-to-reach populations that require support from social services.

Offer a complete range of social services in the Native Friendship Centres

- > Encourage Native Friendship Centres to provide more services adapted to the Aboriginal way of life. First Nations people living outside their community in an urban setting visit these centres frequently, not only when they need services, but also to maintain contact with their culture and identity.
- > Financially support these Centres that suffer from a chronic lack of financial and material resources so that they can offer a complete range of services, including social services. In many cases, these Centres cannot meet the increasing demands of First Nations individuals living outside of their community.



3.4 ADAPT AND IMPROVE SERVICES PROVIDED TO THE MOST VULNERABLE POPULATIONS

The delivery of quality innovative, sustainable social services involves an approach that targets groups exposed to risks related to various social problems. In order to meet their specific needs, the social services must be adapted to prioritize actions that reach the most vulnerable groups.

Establish services within and outside of communities to help vulnerable populations

- > Adapt the health services and social services based on the needs expressed by the different groups and social categories. The services may take different forms, such as First Nations youth centres, Women's shelters, Family centres, assistance centres for men, detox centres and other types of community organizations.
- > Strengthen these infrastructures and better equip them to help vulnerable populations.
- > Create specific programs benefiting persons with a disability from all regions.

Adapt services provided to the population outside of the community to the First Nations reality and needs

- > Strengthen support for different vulnerable populations, whether they are persons living with HIV, female victims of violence, homeless or persons suffering from addictions, etc. in all of the communities.
- > Adjust the services to the various needs of these populations, especially those living outside the community who must also deal with prejudice and discrimination that is, unfortunately, too often found in services provided by the Quebec system.

3.5 STRENGTHEN MENTAL HEALTH SERVICES

Aggressive action must be initiated to strengthen specialized mental health services. Many activities must be implemented in the coming years.

- > Describe the deficiencies in service delivery, especially as the current data show the lack of multidisciplinary teams or doctors available on site to provide services and report on changes in mental health status in the communities.
- > Facilitate access, especially in remote communities that are isolated from large urban centres.
- > Adapt services to a community's situation by aligning them with the culture and the languages of the community.
- > Reinforce screening, treatment and follow-up of persons at risk, both within and outside of the community.
- > Act on perceptions of risk, especially to mitigate alcohol and drug abuse, sexual abuse, violence, the absence of a mobilizing project, feelings of lack of control over one's life, etc. The currently offered services do not always measure the impact of these determinants on the mental health of First Nations people. Also, the communities harbour attitudes of social condemnation associated with depression, which engender various feelings in the affected person, including shame and withdrawal, which do nothing to improve his condition and which may even prevent him from moving forward or seeking the help that he needs.

4.

WHAT WILL CHANGE BETWEEN NOW AND 2017

- > Like the rest of Canadians, the First Nations have access to a complete range of social services adapted to their needs and their culture.
- > Vulnerable persons are identified early and are supported by First Nations practitioners, in their community and in their living environment.
- > Children and their families are better supported and have access to appropriate services.
- > The programs and services adopt a holistic approach and receive long-term support through recurrent, adapted and flexible funding.
- > Appropriate services are made available to persons with disabilities and persons suffering from mental health problems.

COHESIVE AND CONCERTED ACTION ON THE DETERMINANTS OF COLLECTIVE HEALTH AND WELL-BEING

The health status of individuals and communities is not determined solely by the quality of care delivered by physicians and other health practitioners: on the contrary, it is influenced considerably by the following:

- > socio-economic status of individuals: education level (formal and informal, tacit or codified, etc.), distribution of wealth, degree of wealth activity and creation, disposable income, etc.;
- > lifestyle: diet, physical and sedentary activity, use of harmful substances, smoking, sexual practices, etc.;
- > strength of cultural values, spirituality, language, art and other forms of expression, etc.;
- > individual psychosocial status: pride in identity, resilience, self-esteem, etc.;
- > quality of child-, parent- and family-support services: specific early-childhood requirements, parenting, pregnancy, etc.;
- > quality of the environment: availability of basic infrastructures, quality of housing, access to drinking water, air quality, access to natural resources, etc.;
- > health-service organization: accessibility, availability, equity, quality, “fit” with First Nations culture and needs;
- > First Nations control over health care and social-service, natural-resource and education- management systems; self-regulation; decision-making power; access to funding, etc.³¹

Improvements to the health and quality of life for First Nations individuals and communities is thus multidimensional, and cannot be made without comprehensive, concerted, consistent action on the various determinants involved. At present, the First Nations situation is cause for concern in a number of ways.

³¹ Kim Scott (2006). Broadening the Lens, Proceedings of a Roundtable on Aboriginal Peoples' Health. Online: Canadian Population Health Initiative http://secure.cihi.ca/cihiweb/en/downloads/CPHIBroadeningtheLens_e.pdf (consulted March 21, 2007).

1.

THE CURRENT SITUATION

The precarious nature of First Nations' living standards has been confirmed by several indicators.

Unemployment rates are unequalled anywhere else in Canada. According to available statistics, 52% of the First Nations population of labour-force age is currently unemployed, and therefore without a decent income. In 2001,³² the unemployment rate for First Nations adults was 20.2%—double that of Quebec non-Natives.³³ Large portions of the population live modestly or in total uncertainty.

Poverty is rampant. Almost 60% of adults have an annual income of less than \$20,000. Women are more affected even than men: for every two out of three women, the figure stands at less than \$10,000. First Nations' dependence on government assistance is five times greater than that of other Quebec or Canadian communities.³⁴

This, combined with low education levels and few opportunities for stable, well-paid jobs, means the First Nations are trapped in a vicious circle of poverty and uncertainty, which in turn reduces household purchasing power and has a drastic impact on the living conditions of families and communities. Early-childhood development, adult self-esteem, nutrition, care, and psychological stressors are exacerbated by this widespread poverty, which does not spare any social group (in or

outside the community, children, women, elders, etc.). Deterioration in mental and physical health is closely linked to the standard of living of individuals, families and groups, as well as to a loss of autonomy, destructuring of the socio-economic system, and loss of connection with traditional lands and ways of life.

It is well known that control over schooling considerably influences health and the standard of living. Education is an important step toward gainful employment and promotes healthy, self-actualizing lifestyles; it also provides access to the knowledge and know-how favourable to the adoption of healthy behaviour. The First Nations are characterized by extremely low education levels: failure and drop-out rates are high. As mentioned previously, almost half³⁵ of all First Nations members have not completed secondary school (as compared with 31%³⁶ of the rest of Canadians). This enormous disparity helps maintain significant inequities and paves the road to unemployment, idleness and extremely precarious living and housing conditions. The lack of hope for a productive future in First Nations communities, together with the need to leave the family environment to pursue secondary or post-secondary studies elsewhere, constitutes a real obstacle to education.

³² FNQLHSSC (2006). FNRLHS 2002, Report on First Nations Living in Communities, p.106.

³³ INSPQ (2001). Le Québec et les 18 régions socio-sanitaires. http://www.inspq.qc.ca/pdf/publications/050_portrait_sante_2001.pdf (consulted March 21, 2007)

³⁴ In 2001, 72.2% of First Nations people were receiving income or allowances from at least on level of government. FNQLHSSC (2006). FNRLHS 2002, Report on First Nations Living in Communities, p.106.

³⁵ FNQLHSSC (2006) FNRLHS 2002, Report on First Nations Living in Communities, p.104.

³⁶ [http://www.stat.gouv.qc.ca/donstat/societe/education/etat_scolr/\(2\)15-24niv_sco_hist.htm](http://www.stat.gouv.qc.ca/donstat/societe/education/etat_scolr/(2)15-24niv_sco_hist.htm) (25 years and over, Québec, 2001)

INDICATORS OF WELL-BEING and SOCIAL PROBLEMS	Quebec First Nations ^{III}			Canada and/or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a/b
Has attempted suicide during lifetime	13.1%	18.5%	18.4%	3.5%	5.25
Has attempted suicide in the past 12 months			1.2%	0.5%	2.4
Suicidal ideation during lifetime			39.0%	N/D	N/D
Suicidal ideation in the past 12 months			4.5%	3.9%	1.15
Secondary education not completed			49.0%	31.0%	1.58
College education completed (BA or higher)			6.1%	19.3%	0.31
Consume considerable amounts of alcohol (5 or + drinks at least once/week)			43.3%	29.8%	1.5
Consume considerable amounts of alcohol (5 or + drinks at least 5 times/12 months)			70.2%	23.2%	0.31
Use of drugs or non-prescription medications in the past 12 months			65.8%	20.0%	3.29

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

DEMOGRAPHICS	Quebec First Nations ^{III}			Canada and/or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a/b
Life expectancy at birth	70.4	75.5 ^{VIII}		77.7H et 82.2F ^{IX}	0.9H et 0.92F
Birth rate			23.4/1000	10.3/1000	2.33
Infant mortality rate			6.4/1000	5.4/1000	1.18
Median age (years)			24.7	37.1	0.66

III The data in those columns represent only adults, except when indicated.

The data were taken from the Report on First Nations Living in Communities of FNQLRHS 2002-03, Quebec region (FNQLHSSC 2006), except when indicated.

IV These data relate to children.

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

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

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

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

Data are valid for 2001, for First Nations throughout Canada.

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

DEMOGRAPHICS and SOCIAL PROBLEMS	Quebec First Nations ^{III}			Canada and/or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a\b
Family with fewer than 2 children under 18 years (%)	N/A	N/A	41.0%	23%	2
Annual household income < \$20,000	N/A	N/A	24.3%	11%	2.21
Annual personal income < \$20,000 ^x	55.2%	65.5%	60.3%	51%	1.18
Receive government assistance ^{xi}	60.3%	80.9%	72.2% ^{xii}	13%	5.5
Child living below poverty line			25% ^{xiii}	10%	2.5
Indicator of collective well-being	0.71	0.74	0.72	0.89	0.8
Employment Assistance recipients	24.3%	16.1%	20.2% ^{xiv}	9.6% ^{xv}	2.1
% of individuals gainfully employed	51.1%	47.0%	49.0% ^{xvi}	61.1% ^{xvii}	0.80
Single-parent families			43.7% ^{xviii}	20.5% ^{xix}	2.13
Proportion of aged living alone (aged 65-74)			33.2% ^{xx}	24.9% ^{xxi}	1.33

It would appear that First Nations impoverishment has been accompanied by a rapid deterioration in ancestral values centred around mutual assistance, social reciprocity and the sharing of hard-to-come-by resources during difficult times (unemployment, psychological distress, other crises). This social capital, which has always been pivotal in ensuring the survival of the First Nations peoples, is now subject to considerable strain. Even today, many public policies are aimed at assimilating and

acculturating the First Nations by fundamentally altering their lifestyle (land access, etc.) and knowingly undermining the value of ancestral cultural references.

At the same time, a number of Canadian and Quebec studies show a positive association between developing a community's social capital and the health of its members.³⁷

³⁷ Health Canada (2003). Social Capital as a Health Determinant - How is it Defined? ISBN 0-662-32985-6

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

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

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

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

XVI In 2001

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

XVI In 2001, regardless of length of employment.

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

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

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

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

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

A vehicle for all social values and a cornerstone of Native cultures and civilizations, ancestral First Nations languages are now, more than ever before, threatened with extinction. This loss has resulted in broken inter-generational ties, interfered with the transfer of knowledge and expertise, and irretrievably weakened the cultural “cement” that has allowed Native cultures to endure for thousands of years.

Lifestyles constitute another risk to health. Several bad habits and dependencies have had a direct, negative impact on First Nations members. Smoking has taken a gigantic toll, with 35% more First Nations peoples indulging in this vice than the Canadian populace as a whole.³⁸ Furthermore, Natives are starting to use tobacco at an increasingly early age, with more than 35% of adult smokers having begun at age 13 or before.³⁹ Poverty and low education levels are often associated with a high prevalence of smoking. The combination of these determinants would indicate concomitant levels of cardio-respiratory disease and other related pathologies will continue to be maintained. Given these facts, an increase in life expectancy (which is already low for the First Nations) does not seem hopeful.

Excessive alcohol use is 30% more frequent among First Nations peoples than other Quebecers;⁴⁰ the ravages of alcoholism are widespread. Disturbingly, drug consumption is also becoming increasingly prevalent. In 2001, 66% of First Nations youth aged 18 to 24 were using drugs or non-prescription medication,⁴¹ as opposed to only 20% in 1998.⁴²

These overwhelming statistics, which are well known to stakeholders in the First Nations milieu, have had terrible consequences: violence, criminality, disease, injuries, and so on. Even in the face of these problems, however, community social services are rare, despite such federal programs as the National Native Alcohol and Drug Abuse Program.

A healthy diet is also critical to good health. However, First Nations communities—especially adolescents—tend to eat food that is totally unsuitable and to their detriment. Two teens out of three (65%) base their daily diet (three meals a day) on non-nutritious choices.⁴³ By way of comparison, in Quebec, only one teenager in five (22%)⁴⁴ consumes this type of food (and only once per day).

The precarious nature of the First Nations diet is also a result of food costs, which, in the outlying areas, can be three times higher than those in urban centres well served by transportation infrastructures. These prohibitive costs only exacerbate the nutrition problems of households already living below the poverty line.

The rapid transition from a nomadic to a sedentary lifestyle, the marginalization of healthy foods, and the progressive loss of the means to preserve and prepare traditional foodstuffs have all helped establish diets that are harmful to the health of First Nations peoples. A lack of prevention and of promotion for healthy eating habits continues to adversely affect their health.

³⁸ 21.6% of smokers in Canada in 2001. Heneman (2006), *Prévalence du tabagisme au Québec: Qu'en est-il?* <http://www.santepub-mtl.qc.ca/Publication/pdf/tabac/prevalence-etabagisme.pdf> (consulted April 17, 2007). In 2002, 55% of First Nations adults smoked. FNQLHSSC (2006) FNRLHS 2002, *Rapport sur le tabagisme*, p. 19.

³⁹ Calculated on the basis of FNQLHSSC (2006) FNRLHS 2002, *Rapport sur le tabagisme*, p.26.

⁴⁰ 72.2% of First Nations members consumed five glasses of alcohol or more on a single occasion at least five times in 12 months. FNQLHSSC (2006) FNRLHS 2002, *Report on First Nations Living in Communities*, p.144.

⁴¹ FNQLHSSC (2006) Special compilation of data contained in FNQLRHS 2002-03 (unpublished). FNQLHSSC 2007.

⁴² FNQLHSSC (1999) *First Nations Regional Health Survey*.

⁴³ Special compilation of data contained in FNQLRHS 2002 (unpublished). FNQLHSSC 2007.

⁴⁴ http://www.stat.gouv.qc.ca/publications/sante/pdf2004/enq_nutrition04c7.pdf (consulted April 17, 2007).



In another regard, the current situation is marked by a rapid increase in sexually transmitted infections/blood-borne pathogens (STI/BBP) and hepatitis C. In northern Quebec, for example, Native populations have extremely high prevalence rates for genital Chlamydia and gonococcal infections (up to ten times higher than for Quebec as a whole). Similarly, more than 60% of new hepatitis C cases are caused by intravenous-drug injections.⁴⁵ To ensure healthy sexual practices are adopted and reduce the adverse effects of intravenous-drug consumption among youth and adults, awareness-raising and prevention activities geared toward First Nations cultures must be implemented.

Residential infrastructures constitute another determinant of health and quality of life. Many First Nations families do not yet have access to decent, viable housing. This shortage tends to be exacerbated by a major population explosion stimulated by a First Nations birth rate that is twice as high as that for Quebec non-Natives. That explosion has put housing for First Nations under considerable pressure, especially in communities that cannot expand for lack of serviced land.

Overcrowding is another factor that negatively affects good health, creating poor hygiene conditions and facilitating the spread of contagious diseases. In some communities, tuberculosis is eight to ten times more prevalent than in the rest of Canada.⁴⁶

2006 data reveal a veritable housing crisis in First Nations communities, with construction delayed in almost 10,000 cases. Furthermore, some 40% of dwellings were in need of repair and renovation.⁴⁷ Funding currently available for First Nations housing will not make it possible to meet this essential condition of health and quality of life. Everything would indicate that overcrowding will continue to increase, bringing in its wake the associated health, high density and disease problems. Cardio-respiratory difficulties and pulmonary disease could increase tenfold if the situation is not rectified in the near future.

Access to potable water is vital to making First Nations housing viable. Existing data show that one dwelling out of four has no pollutant-free running water. A number of surveys also show that First Nations' trust in water supply and treatment systems is steadily eroding, with water available in houses deemed unfit for use by a third of First Nations adults.⁴⁸

Environmental pollution is not limited to water. Many lakes, forests and rivers have been exposed to intensive, unsuitable and damaging exploitation. With their notion of health that goes beyond the biological aspect, First Nations peoples, whose culture is rooted in the concept of an unrestricted, diversified homeland, were stricken to the core when the management of those lands ceased to meet their cultural criteria and expectations. Moreover, the political conflicts stemming from divergent First Nations and government interests have kept communities in a state of disarray that compromises access to and use of natural resources and ancestral lands.

Because of their proximity to threatened or contaminated ecosystems, environmental degradation has had an even more negative impact on the First Nations than on other Quebecers and Canadians. At the same time, it is non-Natives who benefit from the intensive exploitation of resources, and cause the resulting deterioration. Similarly, environmental conservation plans are still being established and implemented by governments whose thought processes and ideas are often foreign to Native ways of life. If contamination is depriving First Nations of access to sound resources, conservation schemes established without their input may well keep them away from the resources vital to their survival (for example, in the case of strict conservation zones that fail to take account of traditional land use).

⁴⁵ MSSS (2004): *Portrait des infections transmissibles sexuellement et par la santé (ITSS), de l'hépatite C, de l'infection par le VIH et du Sida au Québec*. Government of Quebec.

⁴⁶ Socioeconomic forum of the First Nations (2006), Government of Quebec.

⁴⁷ AFNQL 2007 (unpublished preliminary data).

⁴⁸ FNQLHSSC, 2007 (unpublished data).

2. CHALLENGES

Improvements to health cannot be made without comprehensive action on all fronts affecting the determinants involved.

Those determinants constitute considerable challenges for First Nations peoples. The development of a model that includes all First Nations health determinants is an absolute “must”, and political will is vital if those determinants are to be considered in all negotiations and decisions affecting the First Nations. Comprehensive action in this regard involves the following main challenges:

ERADICATE POVERTY AND SOCIAL EXCLUSION

If First Nations peoples are to have a healthy, promising future, poverty and social exclusion must be fought. Federal and Quebec policies have already addressed this major health determinant, with a number of measures taken.

The First Nations, just like other Canadians and Quebecers, are entitled to specific initiatives aimed at eradicating poverty and social exclusion that take into consideration their own aspirations and needs. If this is to be done, an unambiguous political will is paramount.

ENHANCE LEARNING IN ALL ITS FORMS, AND REDUCE THE DROP-OUT RATE

Learning and education constitute key health and quality-of-life determinants. First Nations peoples do not enjoy all opportunities available in Canada for ongoing, universal access to adaptive learning and quality education. The lack of post-secondary (and sometimes secondary) institutions is a real obstacle to First Nations education.

Dropping out of school is pandemic in First Nations communities. This is accompanied by a lack of worthwhile job prospects. As a result, the First Nations are highly dependent on government income and at the mercy of the rare community openings available.

The development of competent managers and leaders constitutes a catalyst for the changes needed to improve First Nations health and well-being.

REVITALIZE FIRST NATIONS LANGUAGE AND CULTURE

Because the preservation and revitalization of First Nations cultures and languages promote social health and a strong, flourishing cultural identity, they are central to health.

Promoting these cultures and languages will give First Nations youth the strong, assertive identity they need to ensure their health and pursue efforts to improve living conditions.

ADOPT HEALTHY LIFESTYLES

As we all know, lifestyle is influenced by individual, environmental and structural factors.

The lifestyle of a large percentage of First Nations populations has been jeopardized by poverty, low education levels (formal and informal), violence, substance abuse, and so on. If First Nations' health and social development is to be improved, vulnerability to these factors must be controlled.



Access to nutritious and affordable food, sports and leisure activities, and appropriate infrastructures is imperative.

Health awareness and education must give individuals access to all the information they need to make informed lifestyle choices.

FACILITATE ACCESS TO PROPER HOUSING

Considering that all Canadians are entitled to decent housing, it is imperative that all First Nations members have such access, regardless of income, age or family size.

Overcrowding and promiscuity, which lead to stressful family life and undesirable sanitary conditions, must be eliminated via new construction and renovation of existing housing.

Meeting this challenge will involve government commitments and major, desperately needed investments if a sufficient number of dwellings are to be built.

DEVELOP LAND AND PRESERVE NATURAL RESOURCES

The challenge of real and complete First Nations participation in land use and land conservation initiatives is vital to community development.

In partnership and compliance with the needs of all land users, such participation would make it possible to take advantage of resources and integrate technologies into communities.

In a country as wealthy and developed as Canada, it is unacceptable that some communities do not have access to potable water. The availability of quality water for all is a crucial challenge.

ANTICIPATE CLIMATE CHANGES

Because the First Nations occupy areas that will be especially exposed to climate changes, communities must be able to anticipate and take steps to reduce the impact of these changes on their health, way of life and collective well-being.

Owing to a lack of resources, nothing has been done to plan for these changes and take them fully into account in First Nations agendas. Government measures on ecosystem conservation and biodiversity must also be adjusted accordingly.

Government support for international agreements recognizing the right of First Nations to a sound, viable environment must be translated into concrete action, including appropriate measures recognizing First Nations' vested rights, needs and special characteristics.

3.

FOCUS AREAS AND ACTIONS

The 2007-2017 First Nations Health and Social Services Blueprint opts for structural intervention as part of a complementary action plan undertaken by various First Nations bodies working in such core fields as education, culture, economic development, human resources development, sustainable development, housing, and youth promotion. There are five main aspects of the plan:

3.1 ESTABLISH A STRATEGY TO PREVENT POVERTY, SOCIAL EXCLUSION AND UNCERTAINTY

First Nations poverty constitutes the gravest social injustice in Canada. The fight against poverty, social exclusion and uncertainty must mobilize initiatives designed to allow First Nations peoples to enjoy healthy lives and have access to a decent quality of life.

Quebec is aware of the scope of the problem and, since 2003, has implemented a “National Strategy to Combat Poverty and Social Exclusion”. This strategy, which aims to improve the living conditions for the most disadvantaged, promoting their independence and building a better society, must be bolstered and adjusted for First Nations communities.

The First Nations, which are struggling to cope with huge the socio-economic discrepancies existing between them and the Quebec and Canadian population, must benefit more from resources and new programs established to combat poverty and exclusion.

Create more employment, income and wealth-creation opportunities in First Nations communities

Several First Nations communities remain in a precarious state, notably because of a lack of well-paid, permanent employment opportunities. This situation keeps the First Nations dependent on

government income-assistance programs. The circle of dependency must be broken by increasing the number of local, regional and public initiatives to create wealth and jobs, in particular by the following means:

Aim to create 10,000 jobs over the next ten years, in order to obtain employment parity with the general population of Quebec. Let us mention a few of the measures envisaged to reach this goal:

- > Establish major programs promoting job creation in the First Nations;
- > Develop poverty-fighting measures custom-designed for First Nations peoples;
- > Transfer and develop First Nations income-security management skills;
- > Promote the emergence of businesses that create jobs in First Nations communities, especially in promising trades and economic sectors;
- > Develop more information and support services for job seekers;
- > Bolster continuing-education and occupational-integration programs in established trades and professional bodies for First Nations members;
- > Promote jobs for First Nations women in non-traditional fields;
- > Establish programs that reconcile social and occupational integration for community members;
- > Give the First Nations the resources needed to launch job-creation collective-wealth programs.



Stimulate public and private investments

Implementing action to address the causes of poverty, reduce inequities and promote inclusion requires an ongoing, committed mobilization from all stakeholders. Governments and First Nations must cement their leadership in this area to further promote innovative job-creation initiatives for First Nations populations. To do so, First Nations bodies must have the appropriate means of action to:

- > diversify their economy and make the most of opportunities in local, regional, national and international markets;
- > strengthen technological partnerships and innovation;
- > create business partnerships beneficial to the First Nations;
- > develop First Nations tourist ventures;
- > establish new incentives and funding tools appropriate to First Nations community economic development.

Encourage and promote the development of a social economy

The First Nations have shown special interest in developing a social economy based on innovative organizational forms and the establishment of foundations, cooperatives, micro-credit systems, etc. Since the values underlying this type of development are apparently consistent with those of the First Nations, it would be advisable to:

- > create incentives to establish cooperatives and new organizational forms for productive activities anchored in community life;
- > enhance mutual assistance among First Nations communities;
- > create housing cooperatives;
- > establish training and monitoring procedures, as well as a financial-support mechanism, for social-development initiatives.

3.2 REINFORCE AND RENOVATE RESIDENTIAL AND COLLECTIVE INFRASTRUCTURES

Access to safe, affordable housing is an inalienable right for anyone living in Canada. To be viable, dwellings must comply with public-health standards on hygiene, sanitation and space for each resident. In First Nations communities, residential infrastructures are often in very poor condition. More than anywhere else in Quebec, much of the housing is antiquated, cramped or unsafe.

A new approach to housing has often been advocated by the First Nations in order to counter the existing crisis and relieve members of the associated difficulties. This approach covers, in particular, authority over new management and funding methods, the development of a construction, renovation and conversion policy, etc.

Considerable work on housing has already been done by the AFNQL. In order to move further ahead and boost the quality and quantity of housing, as well as community infrastructures, it is important that the construction and renovation rate be accelerated.

Eliminate the housing deficit in First Nations communities by 2012

Quality housing would allow the First Nations to more effectively combat a number of pathologies related to precarious housing, gain access to a decent quality of life, and provide future generations with better conditions in which to develop and grow. To rectify the housing situation, measures must be implemented in order to:

- > expedite the transfer and distribution of new land for construction;
- > clean up the environment and areas dedicated to or occupied by residential buildings;
- > facilitate First Nations access to residential construction and development financing and initiatives;

- > facilitate housing renovation and decontamination;
- > establish a mechanism for joint action and negotiation to develop a new on- and off-community housing approach;
- > promote housing for senior shut-ins and the disabled.

Invest in the creation and maintenance of the required infrastructures

Providing proper living conditions would be considerably facilitated by distributing sufficient infrastructures equitably among communities and outlying areas. As mentioned earlier, the First Nations are experiencing growing delays as concerns the provision of infrastructures needed for access to quality drinking water, wastewater treatment, connection to a safe, functional road network, and an enhanced exchange of goods and services. To counter these delays, measures must be implemented in order to:

- > relieve the isolation experienced by numerous Aboriginal communities by constructing a safe, custom-designed road network;
- > standardize existing community road networks;
- > renew and expand the water-supply and wastewater-treatment system;
- > involve the First Nations in managing roads, water-supply and wastewater-treatment infrastructure management;
- > build sports and recreation facilities in all First Nations communities.

3.3 ENHANCE LEARNING AND PROMOTE KNOWLEDGE

The existing situation is characterized by a considerable, growing disparity between First Nations peoples and non-Natives in the area of education, especially as concerns the successful completion of studies. It is also marked by a decline in cultural values and languages, and a lack of awareness of healthy lifestyles.

Specific, urgent action must be taken to increase First Nations education levels, improve school success, reduce drop-out rates, and enhance skills. Accordingly, collective intervention is needed in a number of areas identified by First Nations bodies.

Reduce the drop-out rate and reward success

- > Launch and diversify incentives and rewards in order to keep young people in school;
- > Create or strengthen partnerships with Quebec educational institutions for the development of specific First Nations programs;
- > Tailor education to the cultural, language and identity requirements of the First Nations;
- > Develop teaching material specifically for the regions and communities;
- > Support parents in their efforts to assist children in school.

Introduce new technologies into the education system

- > Put technology at the disposal of all First Nations communities. New technologies are a valuable tool for dispensing quality education leading to job qualifications.
- > Install the equipment and infrastructures required to connect all communities to high-speed and wireless Internet networks;
- > Encourage interest in knowledge and initiate the proper practices and values related to new-technology acquisition and proficiency;
- > Invest in the construction of landscaped playgrounds.

Equip schools and communities with sufficient sports materials and equipment

- > Invest in the upgrading of existing sports equipment in order to encourage participation.
- > Build new sports centres in all communities;
- > Subsidize sports equipment, maintenance and activity costs in all such venues.



Promote the development of skills leading to job qualifications

- > Given that skills development facilitates the creation of wealth and reduces poverty, and that today, education is a lifelong process taking various forms, encourage First Nations members in and outside the community to go back to school.
- > Bolster in and outside community vocational and technical training;
- > Develop First Nations labour-market skills in the technical and vocational fields;
- > Make First Nations youth aware of related job opportunities, and support them in the acquisition of the skills required;
- > Establish a First Nations body to take charge of standardizing and optimizing adult-education activities;
- > Facilitate access to professional qualifications in sectors in demand with good potential for the future;
- > Develop and tailor specific training programs to be implemented in the communities, in accordance with the needs expressed by the latter.

3.4 PROMOTE AND FACILITATE THE ADOPTION OF HEALTHY LIFESTYLES

- > Develop an integrated, systematic approach to facilitate lifestyle changes;
- > Pursue and step up initiatives in the fight against smoking among First Nations members;
- > Make the younger generations aware of the harmful effects of a sedentary lifestyle and lack of physical activity;
- > Reinforce and maintain initiatives aimed at raising consciousness about the benefits of good, balanced nutrition and traditional diets (courses in healthy cooking, nutritious school breakfasts, etc.);
- > Facilitate access to healthy, affordable food and promote physical activity;
- > Create living environments favourable to the adoption of healthy lifestyles, by implementing, for example, approaches such as Healthy School and Healthy Communities;

- > Take action against the behaviour and pernicious effects associated with drug dependency;
- > Create innovative sex-education programs in order to promote the adoption of healthy sexual practices.

3.5 PROMOTE CULTURAL IDENTITY, EMPOWERMENT AND COMMUNITY CONTROL OF NATURAL RESOURCES

Today, First Nations' autonomy in managing community affairs is only partial. Reinforced leadership and control for First Nations, both so crucial for the years to come, can be attained by the following actions:

Promote cultural identity and re-establish a feeling of belonging

The First Nations are suffering from a progressive loss of culture and identity. To combat this situation, it is important to:

- > implement initiatives aimed at reviving optimism among First Nations peoples. This includes the chance to live in a safe, secure, peaceful, independent community; see individual life plans through to fruition; and take advantage of job opportunities;
- > provide public support to promote culture, reinstate community values and reaffirm identity right from childhood;
- > recognize the value added by First Nations peoples across Canada and throughout the world, thus strengthening members' pride in their identity and reducing the racism and segregation too often experienced by First Nations members;
- > incorporate cultural identity and security into all health and social-development policies. A strong, secure and proud sense of identity will resuscitate hope, re-establish confidence, and doubtless help establish self-government and promote the First Nations image throughout the country and around the world.
- > Reinforce communication and public awareness campaigns concerning First Nations health and living conditions.



Promote natural-resources development beneficial to the First Nations

- > Include the First Nations in all decisions on the management and development of natural resources and lands historically used by members, as these lie at the heart of any process designed to improve health and quality of life;
- > Incorporate appreciation for First Nations cultures, including land-organization methods, into social blueprints and human-development projects for the residents of resource-rich areas;
- > Re-establish and protect ancestral rights in managing resources;
- > Consult the First Nations regarding environmental-policy principles having an impact on their way and quality of life.

Anticipate climate changes and take proactive action

- > Give the First Nations the right and the means to fully participate in federal decisions aimed at combating climate changes and reducing greenhouse-gas emissions, as well as at meeting Kyoto Protocol objectives;
- > Develop new renewable-energy sources that are compatible with the sustainability of natural resources in ecosystems inhabited or occupied by First Nations peoples, or vested in First Nations' rights;
- > Make First Nations communities aware of climate changes;
- > Help communities cope with ecosystem changes and facilitate enhanced coordination among the government departments concerned;
- > Draw up an inventory of the possible and foreseeable impacts of climate changes and their effects on the First Nations.



WAPIKONI MOBILE: MOTION PICTURE PROJECT IN THE INNU, ALGONQUIN, AND ATIKAMEKW COMMUNITIES

The Wapikoni Mobile, a movie studio on wheels that has been travelling to Innu, Algonquin and Atikamekw communities since June 2004, gives young people the chance to live their dreams, meet others with the same interests, express themselves, learn new techniques, discuss their experiences, and develop skills. In the past year alone, the Mobile has racked up more than 16,000 km, and is still going strong. At each stop, instructors welcome a dozen young creative people interested in the shooting, editing, training or screening aspect of filmmaking. Since it was launched, the project has reached out to some 25 communities. A Web site with links to more than 70 films is accessible to the general public, providing access to the world and experiences of young Aboriginal cinematographers.

The purpose of the initiative is to give young people a voice and assist them in expressing their sometimes difficult experiences, helping them develop a sense of pride and renewed identity while building on their artistic talents. Their productions also provide a window onto the daily lives of First Nations youth, thus breaking down some of the prejudice to which they are often subjected. To the considerable enthusiasm of their parents, elders and political authorities, who see this innovative project as a true vehicle for Aboriginal identity, participants are hopeful and motivated.

Thanks to the support of its partners and the hard work of local stakeholders who appreciate the value of the initiative, the project has branched out. The Wapikoni Mobile now has permanent studios in the communities of Mashteuiatsh, Kitchisakik and Wemontaci where young people can get together to make films and grow and develop both personally and socially. This innovative initiative not only boosts self-esteem and the ability to take individual and collective action, but also prevents a number of social problems affecting youth.

4.

WHAT WILL CHANGE BETWEEN NOW AND 2017

- > Governments will take vigorous action to combat poverty and social among the First Nations, making this issue a national priority;
- > The percentage of families and children living under the poverty line will be similar to that observed in the rest of Canada;
- > The drop-out rate will fall in all First Nations regions and communities;
- > Employment and partnership opportunities, as well as income available for First Nations families and communities, will rise on a regular basis;
- > Satisfactory collective and residential infrastructures, including housing, will be present in sufficient number in all First Nations communities.
- > First Nations' identity and cultural heritage will be revitalized, resulting in a return of self-esteem, hope, and community esteem;
- > Communities will access, develop and preserve the natural resources on their land;
- > Programs to promote the adoption of healthy lifestyles will be implemented in schools, workplaces and premises used for socialization;
- > Sports venues and equipment will be available and completely functional in all First Nations communities.

ADEQUATE HUMAN CAPITAL SUPPORTED BY RESEARCH AND DEVELOPMENT

At present, the First Nations are experiencing a serious lack of human resources and research institutions able to meet the challenge of improving community health and quality of life from within. Meeting the health challenges involved requires highly skilled human capital. It goes without saying that First Nations communities need to be better understood and cared for, in their own languages and with respect for their cultural identity and values. In more than one regard, cultural health care and social-service delivery competencies constitute a major concern for First Nations communities.

With the resources currently available, the First Nations of Quebec are not always able to gather enough reliable, up-to-date data to document and analyze health and social problems. This lack of accurate information prevents the First Nations and agencies in charge of healthcare delivery from identifying trends, priorities, and scope of the problems involved. It also deprives the First Nations of the expertise needed to promote innovation and experiment with new methods in all health and social-service fields.

1.

THE CURRENT SITUATION

Attachment to cultural heritage and ancestral values means traditional medicine plays an important role in the health and social-service system. Recent surveys show that more than one-third of all members of First Nations communities (37%) use traditional medicines, and more than half the population (51%) consult traditional healers. It is obvious that healers and traditional care providers constitute resources highly prized by the First Nations.

Given the paucity of First Nations healthcare professionals, few First Nations members are able to take advantage of health-care services dispensed by practitioners who speak their language and understand their culture and way of life. Existing data show that, among First Nations members, almost one in every two individuals prefers to consult and be treated by First Nations care providers. The lack of such providers and professionals would appear to cause several members to deprive themselves of the health care and social services required.

Education levels are also of concern. The drop-out and failure rates constitute another reason for the lack of human resources specializing in health and social services. Available data show that almost half of all adults (49%) have not completed secondary school. More than half of all teens have had to repeat a year, and some two-thirds (63%) claimed to have learning difficulties,⁴⁹ making it likely that the drop-out rate among adolescents will be considerable in the years to come. In most cases, young people must leave home and study with non-Natives in urban centres. They do so unwillingly, as leaving the community is often frowned upon—a fact that in itself jeopardizes success at school (already compromised by distance and a lack of family support).

In comparison with Quebec non-Natives, First Nations members are three times less likely to complete secondary school, and four times less likely to obtain an undergraduate degree. These problems make it difficult to educate a sufficient number of skilled healthcare professionals familiar with Native cultures and languages.

In relation to the total of health care professionals for Canada as a whole, Aboriginal health professionals have never exceeded a 3:1,000 ratio, even though the First Nations' demographic weight is 4% (40:1,000). In 1996, the Royal Commission on Aboriginal Peoples felt that more than 10,000 Canadian First Nations health care professionals had to be trained to bolster cultural health and social service delivery skills.

It is also for this reason that First Nations health-program planning and development continue to be the almost-exclusive prerogative of the federal and provincial authorities, who seem insufficiently concerned with the need for health care resources education and training. However, the Report of the Royal Commission on Aboriginal Peoples stressed the importance of local human resources in the development of health and social services, stating: "It is clear to us that more services, if imposed by outside agencies, will not lead to the desired outcomes."

⁴⁹ FNQLHSSC, 2002, First Nations Regional Longitudinal Health Survey, Quebec and Labrador – Report of First Nations living in the communities.



The high rotation of health care professionals is another cause for concern. Data show considerable mobility of medical personnel in First Nations communities, which deprives patients of the cultural connection and compassion required to mitigate suffering, as well as preventing health care professionals and clinics from accumulating the experience needed to deliver suitable, ongoing and reassuring services.

The health challenge also requires the production of enough new statistical data to inform decision making on the health and social service programs and services to be established. However, the production of those and other useful statistics is problematic from several standpoints.

Public data-gathering organizations and institutes almost invariably exclude First Nations communities from sampling, failing to distinguish among the various Aboriginal groups (First Nations, Inuit, Métis) and producing reductive data and necessarily biased analyses. Accordingly, communities are increasingly hesitant about cooperating in data-gathering activities involving any agencies except their own.

For moral reasons, as well, the First Nations often oppose the gathering of data on their populations if they receive few benefits, are not involved in the design process, or fail to understand the motive behind the study. More often than not, polls conducted by statistical and research agencies do not comply with the research protocol of the Assembly of First Nations of Quebec and Labrador, which includes ownership, control, access and possession (OCAP) principles.

Non-Aboriginal surveys paint a national picture of First Nations peoples, rarely giving precise data on those from Quebec. It is not easy today to obtain statistics by community or nation, which considerably hinders the identification of needs and required services. This shortcoming is even more deplorable when one considers the size of the budgets bestowed upon various federal statistical bodies, especially the First Nations Statistical Institute, which works with Statistics Canada and collects only segmented data that are not really representative of the First Nations experience in all Quebec communities.

As regards research and development (R&D), the deficit is even more pronounced. Because the First Nations of Quebec do not have at their disposal enough R&D structures and resources to deal with the state of health care and social service in their communities, this adversely affects the production of new knowledge and the establishment of related innovations.

The few up-and-coming First Nations research organizations that do exist are under-funded, a fact that does not facilitate the enhancement of skills or continuing education. Typically taking the shape of grants, this funding is available only to support surveys that reflect government priorities (rarely those of the First Nations). Furthermore, the First Nations are hardly ever consulted, and research agendas are often dictated by government agencies. Funding also gives special weight to studies that do not necessarily correspond to First Nations aspirations or research programs.

As a result, research initiated and directed by the First Nations is in a precarious position; if it does not fall into line with funding-party strategies, resources dry up—meaning that, in short, very few resources have been earmarked to develop First Nations' research capabilities.



Moral issues also come into play, especially as certain First Nations communities are not sufficiently familiar with research-ethic imperatives or OCAP principles. While a few communities have ethical protocols governing research, several others participate in studies without the least benefit to themselves.

Apart from management tools for federal programs intended to supply government bodies with statistics, there is no systematic collection of administrative data at the community level. An information-compilation tool created by and for the First Nations could be used to plan and manage community and regional services.

Because of a lack of resources, First Nations peoples do not benefit enough from knowledge and expertise transfers from other Aboriginal groups in Canada and elsewhere in the world. Such transfers, however, could be instrumental in enhancing know-how and taking advantage of healthcare experiences and models designed for First Nations and other Aboriginal peoples.

All these factors mean that the understanding and monitoring of First Nations' public health remain insufficiently developed to meet existing health and social-service challenges.

2. CHALLENGES

RELY ON FIRST NATIONS SKILLS

To improve the planning and quality of First Nations health and social-service delivery, training of human capital is a “must”—hence the importance of a human resources education strategy.

Healthcare and social services tailored to First Nations needs require considerable participation by and representation from First Nations professionals, as regards both service delivery and strategic health planning.

Like other Canadians, First Nations peoples are entitled to services in the language of their choice. Significant strengthening of cultural and language skills for all non-native (and Aboriginal, where applicable) personnel is required to cope with the many First Nations contexts.

The education and training of qualified health care professionals will require a rapid increase in the number of high-school graduates, as well as the establishment of strategies and special arrangements with universities and colleges for First Nations members wishing to pursue careers in priority health and social-service sectors.

ATTRACT AND RETAIN HEALTH CARE PROFESSIONALS

Attracting and retaining competent First Nations health care human resources necessitate the design and establishment of incentives to rectify the lack and high mobility of such resources in isolated areas.

Experience has shown that only a small number of young First Nations professionals trained outside their community return to practise in that community. The dearth of worthwhile employment opportunities certainly contributes to this massive, irreversible brain drain.

INVEST IN RESEARCH AND DEVELOPMENT

Although general health research has benefited from major public funding, that specific to First Nations health and social services remains marginal.

At the same time, those health and social-service problems cannot be solved without innovation and the intensive use of new technologies and knowledge. Evidence shows that, to bring about change,

innovation cannot be based purely on imitation—hence the importance of R&D in the development and skills and capabilities. First Nations agencies need additional, regular funding to conduct R&D activities associated with health and social-service issues in Quebec.

This innovation and R&D challenge goes hand in hand with that of collecting epidemiological statistics and developing analysis, planning and training skills tailored to the ad-hoc requirements of First Nations communities and organizations.

Bodies representing the First Nations, in particular the FNQLHSSC, must play an increasingly large role in health and social-service delivery planning, analysis and assessment. This, in turn, will require increased, reliable, recurring funding in order to develop analysis and R&D capacities.

3. FOCUS AREAS AND ACTIONS

In order to meet these challenges, various courses of action have been identified.

3.1 TRAIN, ATTRACT AND RETAIN QUALIFIED HEALTH AND SOCIAL-SERVICE RESOURCES

For the next few years, the education and training of a sufficient number of First Nations health care and social-service professionals will constitute the cornerstone of all policies aimed at rectifying existing disparities and improving the health of First Nations' peoples. Success at school depends largely on the quality and availability of infrastructures, curricula, and competent instructors able to

stimulate young people in their quest for learning; for the younger generation, it demands concerted collective action involving the collaboration of various agencies that act on behalf of the First Nations (the First Nations Education Council, Institut culturel et éducatif montagnais (ICEM), FNQLHSSC, etc.).

Vigorous action must be initiated in this area, as it is solely in this way that the First Nations will interest young people in knowledge, success and health.



Enhance young people's motivation to study

- > Ensure that schools in all regions have competent, motivated teaching staff;
- > Provide youth with qualified support staff able to sponsor projects and inspire hope;
- > Equip all schools with the latest in educational technology (computers, manuals, software, laboratories);
- > Provide the schools and regions with sufficient premises, equipment and supervisory staff to encourage sports and recreation year-round.

Encourage academic success and merit

- > Encourage young people to persevere with their education and training (formal or informal);
- > Promote access to instruction leading to job qualifications, even in the most isolated regions;
- > Promote excellence and merit in all schools and social strata;
- > Establish innovative means to prevent dropping out.
- > Multiply partnership agreements to adapt training curriculum to First Nations needs and realities.

Promote higher learning leading to careers in the health field

- > Bring health and social-service professionals, particularly those from the First Nations, into more frequent contact with young people;
- > Establish models to instill a desire for greater involvement in improving community health and well-being;
- > Establish academic scholarships and grants to better help First Nations young people pursue with their studies;
- > By 2017, train at least 1,000 additional health care and social-service professionals from the First Nations of Quebec.

Establish incentives to retain health and social-service professionals

- > Implement effective incentives, such as tax credits, tax holidays, and financial rewards to attract and retain health care professionals in areas inhabited by the First Nations;

- > Encourage these professionals, whether or not they are First Nations members, to work in isolated communities, and to regard this as a valuable opportunity;
- > Facilitate settlement in, or return to, the regions for community members studying in the health care and social-service field;
- > Encourage healthcare professionals to settle in the regions and practise medicine and provide social services in areas inhabited by the First Nations;
- > Establish distinctions and other forms of recognition for First Nations professionals who, through perseverance and excellence, have improved health care and social services in the regions.

3.2 RECOGNIZE AND PROMOTE CULTURAL COMPETENCE

The First Nations have a culture, history, social organization and way of life different from those of Quebec or Canadian society. However, several such differences are not taken into account by the existing health and social-service delivery system. It is thus difficult, if not impossible, to respond adequately and efficiently to First Nations requirements without tailoring training to the needs of the community. The adaptation of educational curricula must be the focus of such changes. Health care practitioners, whether or not they are First Nations members, must be given the opportunity, in an educational context, to acquire the competences associated with care delivery in a First Nations environment.

Tailor health care and social-service education and training to the needs of the community

- > Incorporate cultural competence into curricula for health care professionals and social-service delivery staff interacting with Aboriginal communities;
- > Establish concise training protocols and modules to update cultural competencies;
- > Improve professional training by offering paid internships in First Nations communities.

Increase the number of consultations and encourage initiatives

- > Establish forums for deliberation and consultation on motivating and encouraging the professional skills involved in the practice of medicine and delivery of social services among the First Nations;
- > In partnership with the college and university milieu, develop evaluative studies on cultural competence in the health field;
- > Give salary bonuses to professionals with the cultural competence required for health care and social-service delivery in First Nations communities.
- > Diversify training and act towards insuring better integration between training issued by First Nations and those insured by educational institutions.

3.3 PROMOTE STRATEGIC INTELLIGENCE AND KNOWLEDGE TRANSFER

Develop strategic intelligence in health care and social services

- > Develop resources making it possible to be aware of, anticipate, quantify and analyze health care and social-service problems in Quebec's First Nations communities. These capabilities are needed to inform decision making and develop knowledge and exemplary practices as regards the design, administration, delivery and assessment of measures with an impact on the health of First Nations peoples;
- > Encourage strategic intelligence initiatives in health care and social services for First Nations;
- > Strengthen health and social-service strategic planning and programs in First Nations bodies in order to adapt and develop initiatives;
- > Increase the number of cooperative agreements with other First Nations and non-Native institutions, so as to better observe and provide information on the problems to be contained and solutions to be implemented.

Develop networks of expertise and facilitate knowledge transfers

- > Fund the establishment of mechanisms facilitating the development of knowledge transfers (Web sites, publications, conferences, First Nations professional symposia, e-services list, etc.);
- > Establish mentoring mechanisms, capitalizing on expertise by transferring it from one generation to the next;
- > Promote initiatives to transfer elders' health and social-service knowledge;
- > Create networks bringing together experts and competencies specializing in social services for the First Nations.

3.4 ENHANCE INFORMED DECISION MAKING VIA RESEARCH AND DEVELOPMENT

Improvements to health care and social services delivered to the First Nations would gain from R&D efforts tailored to community problems and needs. Such efforts would enhance decision-making via meaningful evidence and reliable statistics (otherwise impossible to obtain) on the First Nations of Quebec.

The problems experienced by the First Nations are specific to them; they pose special challenges rarely explored by R&D applied to non-Native populations.

- > Establish R&D structures controlled by First Nations bodies and aimed at solving First Nations socio-economic problems;
- > Call up additional budgets to undertake R&D centred on the problems of the First Nations of Quebec;
- > Promote R&D conducted by and/or for the First Nations (based on AFNQL research protocols and OCAP principles) in public and university institutions;
- > Invest in R&D infrastructures focused on the health and social-service problems so prevalent among the First Nations;



- > Develop reliable health indicators and assign resources to First Nations bodies to ensure monitoring;
- > Maintain and enhance the First Nations Regional Longitudinal Health Survey and obtain adequate funding to improve and update it;
- > Implement effective procedures to ensure decisions on health and collective well-being are at all times based on the latest R&D knowledge;
- > Establish systematic action-research procedures to optimize health and well-being project, program and policy performance;
- > Make use of tacit knowledge from the health and social-service milieu in First Nations communities;
- > Disseminate and build on health and social-service knowledge from R&D programs in a First Nations context;
- > Reinforce understanding of determinants for health and well-being project, program and policy performance in First Nations communities, and establish indicators to track those determinants;
- > Encourage and supervise training for First Nations R&D professionals.



FIRST NATIONS OF QUEBEC AND LABRADOR REGIONAL LONGITUDINAL HEALTH SURVEY

In parallel with other surveys on health conducted by Statistics Canada, the First Nations of Quebec and Labrador Regional Longitudinal Health Survey (FNQLRHS) was created to satisfy the need for data on First Nations' health (other Canada-wide surveys exclude FN communities) and allow the First Nations to take charge of the process of collecting information on the health of their members and communities. The initiative is a major step toward FN self-determination and governance in the research field.

In the 2002 wave, data collected in the Quebec region involved 3,785 respondents and an exhaustive questionnaire dealing with all holistic aspects of health (physical, psychological, community, spiritual, etc.). This extensive campaign was made possible thanks to 100 First Nations interviewers trained in 23 FN communities and three urban centres. The FNQLRHS code of ethics, which complies four basic principles (i.e., ownership, control, access and possession (OCAP)) that ensure all survey stages are controlled by the First Nations and designed to promote their well-being, was implemented throughout the process. An independent Harvard University assessment committee approved the scientific and ethical value of the RHS approach at the national and regional (Quebec) levels.

In 2006, four survey reports mobilized public opinion on the social and health inequities existing between the First Nations and other Quebecers, with survey findings providing First Nations political leaders and stakeholders—who now possess a valid, representative tool designed by and for the First Nations of Quebec—with much-needed “ammunition” to identify health priorities and attain parity at the community and regional levels. A resounding success, with three more waves (ending in 2014) still to come!

4.

WHAT WILL CHANGE BETWEEN NOW AND 2017

- > The First Nations will have enough human-resources skills to rectify existing health and social-service disparities;
- > In comparison with the situation in 2007, more than 1,000 new First Nations health care professionals will be in the service of their communities;
- > Students from various First Nations communities will be receiving more support, and successfully completing their studies, for health and social-service careers in First Nations communities;
- > Incentives will be established to promote the retention of personnel and reduce mobility and turnover among health practitioners, so as to ensure quality health care and social services and provide care that is tailored to the specific culture and needs of First Nations;
- > An agency specializing in First Nations of Quebec R&D and statistics will be founded, and provide communities and First Nations agencies with useful, reliable and up-to-date data in order to ensure regular planning and follow-up on First Nations health care and social services.
- > The First Nations will be able to consult dynamic, valid trend charts on the health status, health problems, social problems and health determinants in their communities.

CONDITIONS FOR SUCCESS, OBJECTIVES AND PROGRESS MEASUREMENT

The purpose of the First Nations of Quebec Health and Social Services Blueprint is to improve First Nations' health and quality of life, thereby establishing parity with the rest of the Canadian population. Accordingly, it advocates a comprehensive approach incorporating various strategies and courses of action. The scope of the document covers updated health-system governance, the necessity to bolster health care, social-services integration, the management of health determinants, the need for properly trained human resources, and the enhancement of research and development resources allocated in a First Nations context.

The changes discussed in this blueprint are aimed at establishing a cohesive, efficient health care and social-service system that:

- > assumes responsibility for the outcomes obtained to date or in the future;
- > gives the First Nations the right to make their own strategic, organizational and operational decisions;
- > reflects the diverse requirements and priorities of First Nations communities;
- > encourages individuals, families and communities to take charge of their health and adopt preventive measures;
- > provides funding to meet the health care and social-service challenges of Quebec's First Nations communities in a viable, sustainable manner.

1.

FACTORS FOR SUCCESS

Several conditions are required to ensure successful blueprint outcome and performance.

These include the following:

A CUSTOM-DESIGNED, INTEGRATED SERVICE OFFER

More than ever before, health care and social services delivered to the First Nations of Quebec must be managed so as to:

- > give the First Nations complete legal authority and control over the health care and social services intended for their own communities. The First Nations have a responsibility to assume in designing, implementing and evaluating the care and services available in those communities;
- > mobilize the budgetary and physical resources needed as part of a proactive, continually fine-tuned, equitable approach aimed at establishing parity in the area of individual and community health;
- > ensure that additional budgets cover, not only increases in recurring health care and social-service costs, but also the “catch-up” measures needed to ensure health and quality-of-life parity;
- > take comprehensive, effective and cohesive action on other health determinants (i.e., education levels, the fight against poverty, job creation, improved housing, lifestyles, environmental ecosystem enhancement, etc.);
- > respect the First Nations’ centuries-old culture, heritage and identity. Health care and social services must be delivered in a reassuring environment that preserves First Nations’ identity and linguistic heritage;
- > ensure that traditional and conventional medicine complement each other as part of an integrated vision of health care and social-service delivery;
- > develop a holistic approach in which health and social-service delivery covers the physical health and social, emotional, spiritual and cultural well-being of First Nations communities;
- > take innovative measures to establish health care and social-service models consistent with diverse requirements, given that communities are not culturally or socially homogeneous;
- > encourage innovation, adaptation and accessibility for health care and social services delivered to the First Nations;
- > provide ongoing, sustainable front-line services. Increased life expectancy, reduced morbidity, and improved quality of life in First Nations communities all depend on access to quality services;
- > coordinate and integrate health care and social-service delivery among sectors, disciplines and institutions. The various government levels concerned (federal, provincial, regional, local, etc.), service providers (primary care, secondary care, etc.), funding parties and representatives of First Nations communities must all work together to meet this challenge.



REAFFIRMED COMMITMENTS BINDING WORDS TO ACTIONS

To be effective, structural changes to the First Nations health care and social-service system must be backed by commitments binding words and promises to specific measures and accountability.

- > Henceforth, larger budgets and more political and media initiatives to enhance the health and quality of life of all First Nations communities must be established, with the various government levels and parties in power incorporating these goals into their political agendas and priorities.
- > Health and quality of life of First Nations must be part of the political agenda and one of the prime preoccupations of the various levels of government and the parties in power. The federal and provincial governments must keep their promises and take concrete steps to rectify the alarming disparities that now exist.

A WELL THOUGHT-OUT, REGULARLY UPDATED PLANNING PROCESS

The First Nations of Quebec Health and Social Services Blueprint identifies the challenges and strategic choices involved in delivering health and social services to the First Nations in the ten-year period from 2007 to 2017.

- > Effective implementation of the blueprint requires medium-term strategic planning. Accordingly, a three-year strategic plan for the years 2007 to 2010 has been established, with updates to be made on a tri-annual basis.
- > Obviously, annual planning is also required to render all future action and measure operational.
- > Follow-up, assessment and accountability efforts will accompany the implementation of blueprint programs. These efforts will bear on the steps and indicators used to report on the outcomes obtained, responsibilities involved, and improvements to be made.
- > The planning process must be based on an informed, innovative and flexible approach that takes account of changes and contingencies, and leaves room for continuous fine-tuning.

2. PROGRESS MEASUREMENT AND REPORTING

- > The First Nations and the governments of Quebec and Canada will work together, cooperatively and harmoniously, to attain the blueprint's objectives and outcomes.
- > Together, they are accountable and responsible for the ongoing, effective implementation of this initial First Nations of Quebec Health and Social Services Blueprint.
- > Performance monitoring will also allow the stakeholders involved to assume their responsibilities in accordance with pre-established rights and duties, in a concerted, respectful manner.
- > Progress will be tracked and measured by means of indicators established by the experts and other parties consulted when the blueprint was drafted. These measurements and indicators are associated with a specific set of objectives.

2.1 OBJECTIVES

General Objective

The purpose of the blueprint is to ensure that First Nations members enjoy a health status and quality of life at least equal to those of the Canadian populace in general, while respecting First Nations peoples' cultural identity and right to self-determination, individual dignity, and the principles of justice and equality.

Specific Objectives

In order for this general strategic objective to be met, specific objectives have also been established; these apply to life expectancy, morbidity, mortality, access to services, and control of certain social phenomenon that are deleterious to health and quality of life.

These specific objectives are as follows:

- > To increase the life expectancy of First Nations members;
- > To reduce the mortality rate;
- > To reduce the infant mortality rate;
- > To enhance access to services and improve care-delivery quality for all First Nations peoples, so as to better relieve and considerably reduce:
 - chronic illnesses (especially diabetes, cardiovascular disease, and respiratory disease);
 - contagious diseases (especially infectious diseases among children and elders), sexually transmitted diseases, and hepatitis C;
 - mental illness, psychological distress, trauma and suicide;
 - injuries, poisoning and harmful dependencies;
 - violence, abuse and maltreatment;
 - uncertainties related to maternal and child health.

2.2 PROGRESS-MONITORING TARGETS

To facilitate the measurement of progress and improvement to First Nations' health care and social services, the blueprint sets out specific targets and outcomes.

Given that the blueprint's ultimate goal is to gradually eliminate the gulf between the health status of the First Nations and that of other Canadians, targets will be based on the magnitude of reductions in those disparities, in the light of the latest data available (i.e., those from 2007).

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

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

Another target is to train 1,000 First Nations professionals and insert them into the health and social-services network by 2017.

These objectives are theoretically attainable; a number of analyses and informed opinions confirm their feasibility for the coming decade, provided all measures in the Blueprint are approved and implemented.

The enhancement of health services, especially front-line services, is likely to have an impact in the medium and long term that will considerably increase life expectancy and drastically reduce the mortality rate.

Evidence of this has been observed throughout the world: in only ten years (between the 1940s and 1950s), the life expectancy of Native Americans in the United States went up by nine years.⁵⁰ In New Zealand, the life expectancy of indigenous peoples rose by an average of 12 years between 1940 and 1960.⁵¹

2.3 ADVISORY BOARD RESPONSIBLE FOR PROGRESS REPORTS

To give the Blueprint the best possible chance of success, follow-up must be ensured by a committee made up of First Nations health partners in association with elected officials, universities, and civil society.

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

2.4 IMPACT AND SUCCESS INDICATORS

The Blueprint also proposes indicators that go hand in hand with the strategies and courses of action advocated. More than 70 indicators have been suggested thus far, and the list is not exhaustive.

Governance Strategy

1. Level of community control over health care and social services.
2. Federal and provincial investments in FNQL health care and social services (in and outside the community).
3. Budgets managed by the First Nations in relation to total expenditures allocated to FNQ health care and social services.
4. Costs related to government management of budgets allocated to First Nations' health in relation to the total of those budgets.
5. Number of federal and provincial health and social-service agencies with First Nations members on their boards of directors.

⁵⁰ Indian Health Service (1989). Trends in Indian Health, 1989 Tables. Rockville, MD

⁵¹ Tilton E. (2001). "Aboriginal Health: An Historical Approach," in Condon J., Warman G., & Arnold (eds.), The Health and Welfare of Territorians. Territory Health Services, Darwin.



Health Strategy

Health Indicators (for entire population)

6. Life expectancy at birth.
7. Healthy life expectancy (no disabilities).
8. Infant mortality rate.
9. Child immunization rate.
10. Inoculation against the most common contagious diseases.
11. Screening for diabetes, cardiovascular disease, cancer, HIV/AIDS, STI/BBP, hepatitis C, etc.
12. Prevalence of diabetes.
13. Prevalence of excess body weight or obesity.
14. Victims of accidental injuries (road accidents, drowning, poisoning, etc.)
15. Prevalence of sexually transmitted infections/blood-borne pathogens (STI/BBP), hepatitis C and HIV-AIDS.
16. Ratio of hospitalization for serious causes to that of the population as a whole.
17. Ratio of emergency hospital admissions.
18. Ratio of diabetes-related hospitalizations.
19. Ratio of mental-illness related hospitalizations.
20. Low birth weights.
21. Children with specific needs.
22. Teen pregnancies.
23. Prevalence of FASD.
24. Potential years of life lost (per 1,000 people).
25. Diabetes-related mortality rate.
26. Mortality rate related to cardiovascular disease.
27. Mortality rate related to unintentional injuries.
28. Cancer-related mortality rate.

Health Care and Social Service Accessibility Indicators

29. Satisfaction of recipients with health care and social services.
30. People having had problems accessing health care and social services.
31. People having had problems accessing the Non-Insured Health Benefits Program (NIHB).
32. Access to comprehensive maternal and child health care in the community.
33. People having had problems accessing traditional health care.
34. Access to home and long-term care.
35. Access to support services for caregivers.
36. Distance to health care centre and hospital.
37. Access to traditional medicine.

Social Service Strategy

38. Alcohol, drug or gambling problems.
39. Ratio of admission to dependency-treatment centres.
40. Children who have been assaulted or neglected (number of reports and/or placements).
41. Female victims of spousal violence.
42. Placement of children (proportion, incidence rate, average duration, etc.).
43. Serious contemplation of suicide.
44. Suicide attempts.
45. Suicide mortality rate.
46. Victims of intentional injuries (suicide, self-mutilation, violence, etc.).
47. Psychological distress (anxiety, depression, etc.).
48. Consultation for mental-health reasons.
49. Crimes against the person.
50. Proportion of First Nations members in prison as a proportion of the total offender population.
51. Population without a sense of belonging to one's local community.



Health Determinant Strategy

52. Use of First Nations languages and traditional knowledge.
53. Participation in traditional activities and traditional use of land.
54. Participation in First Nations ceremonies and rituals.
55. Consumption and accessibility of healthy food and traditional foodstuffs.
56. Availability and use of sports infrastructures and equipment.
57. Practice of physical activity on a weekly basis.
58. Use of tobacco.
59. Exposure to second-hand smoke.
60. High-school diploma.
61. Education level.
62. Annual family income.
63. Proportion of population living below the low-income cutoff.
64. Employment rate.
65. Unemployment rate.
66. Ratio of Employment Insurance recipients.
67. People in substandard housing in relation to the total for First Nations populations.
68. Private dwellings requiring major repairs.
69. People with access to potable water.
70. People affected daily by a notice to boil or not to drink water.
71. First Nations control over land and natural-resource management.

Human Resources and Research & Development Strategy

72. Proportion of First Nations professionals in relation to all health care and social-service professionals.
73. Ratio of health care personnel/First Nations population, in comparison to the ratio for the general population.
74. Level of cultural competence of non-Aboriginal professionals serving First Nations peoples.
75. Proportion of First Nations members in the health and social-service sector (in relation to the total of Canadian and Quebec professionals, by professional category and specialty).
76. Number of First Nations physicians and other practitioners.
77. Number of traditional healers, in and outside the community.
78. Efforts to fund research and development for and by the First Nations.

CONCLUSION

The years from 2007 to 2017 will bring considerable change to First Nations health and well-being. The First Nations Health and Social Services Blueprint, *Closing the gaps... Accelerating change*, is a source for hope of a better future—a future based on the collective health and well-being of the First Nations of Quebec.

For the First Nations, the Blueprint defends a just cause that goes hand in hand with **parity** with the health and quality of life enjoyed by the rest of Canada's citizens. Accordingly, it is based on a credo anchored in the cultural heritage and identity of the First Nations of Quebec. That credo maintains that health can be improved or preserved only as part of a **comprehensive** approach that takes account, not only of physical health, but also of mental, psychological, environmental, cultural and economic well-being.

The Blueprint calls on all health and social-service stakeholders involved to give the First Nations legitimate authority over their health and choice to live in harmony with their preferences, cultures and identity. The need for cultural continuity and First Nations' **self-determination** of their own health policies is essential in the fight against the diseases and social uncertainty experienced by various First Nations communities throughout Quebec.

Analyses of the existing situation demonstrate the pressing need for government action to ensure that the promises made by various public bodies translate into specific financial commitments on the health and quality of life of First Nations peoples. A number of challenges must be met, and consistent action must be initiated to rectify the discrepancies and inequities on all fronts and lines of health care and social-service delivery. The Blueprint is therefore an historic, all-encompassing call to action.

- > **HISTORIC**, because it hopes to succeed where previous government approaches have failed to establish innovative, integrated strategies adapted to meet the contrasting, diverse needs of the First Nations.
- > **A CALL TO ACTION**, because it marks the vital need for a change of direction in the organization and governance of health care and social services. The Blueprint unveils numerous health and social inequities experienced by the First Nations of Quebec in a country boasting the best living conditions and health in

the world. The aim is clear: to mobilize efforts and initiatives with a view to establishing aggressive policies committed to reducing existing disparities.

- > **ALL-ENCOMPASSING**, because it invites all stakeholders to work together to ensure their joint efforts are completely cohesive, so as to improve First Nations' health and quality of life regardless of the red tape and jurisdictional conflicts that exist between government levels and service providers.

The Blueprint calls for all players concerned and all others of good conscience to act now to lay the foundations of a more just, egalitarian, innovative society committed to the improvement of First Nations' health and quality of life.

Unafraid to pose major challenges, the Blueprint advocates **better governance**, proposing First Nations control based on:

1. the adoption of a comprehensive health approach, including health determinants;
2. funding to satisfy First Nations ambitions and requirements;
3. a "between equals" approach to relationships between the First Nations and government bodies;
4. mutual accountability;
5. actions leading to specific, measurable health outcomes by 2017.



Naturally, the Blueprint also banks on **improved health status** for First Nations members, proposing battery of structuring measures designed to:

- > make health a societal project involving all community, regional, provincial and national players;
- > make children's health a top priority;
- > reduce alarming rates of obesity, diabetes, etc.;
- > take action on health determinants;
- > reconcile traditional and conventional medicine;
- > identify the health and social services now offered, as well as those still lacking;
- > establish a continuum for services offered;
- > build on innovation, integration and adaptation in health and social-service delivery;
- > rely on prevention and health/life promotion;
- > improve the services available to the most disadvantaged.

The Blueprint also advocates unprecedented and vigorous action to improve social services with a view to eliminating the social problems prevailing so dramatically in First Nations communities (dependencies, violence, abuse, suffering, suicide, etc.). Early-childhood development, support for families, appreciation for First Nations' cultural identity and awareness-raising are just some of the priorities mentioned.

Another characteristic of the Blueprint resides in the specific, structuring measures proposed regarding health determinants, such as the need to:

- > fight poverty and social exclusion;
- > improve education levels and reduce drop-out rates;
- > revitalize First Nations cultures and languages;
- > promote healthy lifestyles;
- > facilitate access to proper housing;
- > develop land and preserve natural resources.

The development of human capital also plays a major role, with several structuring measures suggested in order to:

- > educate and train more First Nations human resources;
- > develop First Nations skills;
- > foster higher learning leading to careers in the health field;
- > attract and retain health care professionals in disadvantaged communities;
- > recognize and promote cultural competence.

To ensure the plan has every chance of success, a progress-tracking framework is also suggested. This framework would involve the implementation of a three-year strategic plan and an annual plan for the entire 2007-2017 period. The Blueprint also clearly identifies objectives, outcomes, and follow-up and assessment indicators.

First Nations peoples today are entitled to accessible, quality health care and a health status comparable to that of other Canadians. The time has come to eliminate the disparities between the health of First Nations members and that of the Canadian populace as a whole. Needless to say, this ambitious goal will require the reaffirmation of ongoing commitments from all partners and the mobilization of First Nations wisdom and energy.

The vitality of the First Nations will contribute to the wealth and prosperity of all society. We are determined to work together over the next ten years and, through motivated action, establish communication to rally all parties and firm commitments to make the objectives set out in the Blueprint a reality.



BIBLIOGRAPHY

- AFFAIRES INDIENNES ET DU NORD CANADA (2006). *Mesurer le bien-être des Premières Nations*. www.aicn-inac.gc.ca/pr/ra/wbp_f.pdf
- ANDERSEN, R.E. (2000). The spread of the childhood obesity epidemic. *Journal de l'Association médicale canadienne*, vol. 163, no 11, p. 1461-1462.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2004). *Financement accordé aux Premières Nations par le gouvernement fédéral*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2004). *Plan d'action pour la santé des Premières Nations*. Rencontre des Premiers ministres, septembre 2004.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2004). *Plan d'action sur la santé des Premières Nations*. Rencontre des Premiers ministres.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2005). *Modèle holistique de planification et de politiques des Premières Nations : Les déterminants de la santé*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2005). *Plan d'action des Premières Nations sur les soins continus*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2005). *Plan d'action sur les services de santé non assurés des Premières Nations*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2005). *Plan directeur pour la santé des Autochtones. Un plan décennal*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2006). *Étude sur la prévention des blessures : Le coût inhérent aux blessures et les répercussions des blessures sur l'avenir des Premières Nations*. Katenies Research and Management Services.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2006). *Fiches de renseignements sur la prévention des blessures*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2006). *Guide de l'APN pour la prévention des blessures dans les collectivités des Premières Nations*. Katenies Research and Management Services.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2006). *Les dix ans de la Commission royale sur les peuples autochtones : Bilan*. www.afn.ca/cmslib/general/afn_crpa.pdf.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2006). *Les dix ans de la Commission Royale sur les peuples autochtones : Bilan*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2006). *Protéger nos enfants et assurer notre avenir. Les enfants des Premières Nations et l'obésité : Une épidémie en constante progression*. Carol Seto & Associates.
- ASSEMBLÉE DES PREMIÈRES NATIONS (2006). *Rapport final du Forum socioéconomique des Premières Nations, Agir maintenant...pour l'avenir*, Mashteuiatsh.
- ASSEMBLÉE DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2007). *Rapport final du Forum : Agir maintenant...pour l'avenir*.
- ASSEMBLÉE DES PREMIÈRES NATIONS (s.d.). *Explication du mythe des 9 milliards de dollars : Pourquoi la pauvreté perdure-t-elle parmi les Premières Nations*.
- ASSOCIATION CANADIENNE DES SOINS DE SANTÉ (1995). *Health Facts: Made in Canada*, Presses de l'ACS.
- BALL, J. (2006). *Early Childhood Care and Development Programs as Hook and Hub: Promising Practices in First Nations Communities*. University of Victoria, School of Child and Youth Care.
- BATTCKOCK, A. (2005). *Plan stratégique de télésanté triennal pour la province de Terre-Neuve-et-Labrador*.
- BIRMINGHAM, C.L., J.L. MULLER, A. PAPELU, J. J. SPINELLI et A.H. ANIS (1999). *The cost of obesity in Canada*. *Journal de l'Association médicale canadienne*, vol. 160, no 4, p. 483-488.
- BRITISH COLUMBIA ASSEMBLY OF FIRST NATIONS (2006). *The Transformative Change Accord: First Nations Health Plan*. Supporting the Health and Wellness of First Nations in British Columbia.
- BRITISH COLUMBIA FIRST NATIONS LEADERSHIP COUNCIL (2005). *First Nations Health Blueprint of British Columbia*.
- CAMPBELL, J.C. (2002). *Health consequences of intimate partner violence*. *The Lancet*, vol. 359, p. 1331-1336.
- CENTRE DES PREMIÈRES NATIONS (2004). *Enquête régionale sur la santé des Premières Nations et des Inuits, 1997*. Résumé du rapport national et des rapports régionaux.
- CHE-ALFORD, J. & B. HAMM (1999). *Under one roof: Three generations living together*. *Canadian Social Trends*, 53, 6-9.
- COMMISSION ROYALE SUR LES PEUPLES AUTOCHTONES (1996). *Rapport de la Commission royale sur les peuples autochtones*.
- COMMISSION SUR L'ÉDUCATION DE L'ASSEMBLÉE NATIONALE DU QUÉBEC (2007). *La réussite scolaire des Autochtones*.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR : www.cssspnql.com
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (1999). *Enquête médicale régionale portant sur la santé des membres des Premières Nations*.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR L (2002). *État de la situation. Planification pour la SLTPNI. Rapport final*. Simon Management Services.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2002). *Portrait régional des services de garde à l'enfance des Premières Nations. Région du Québec*.

- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2005). *Des communautés branchées*. Forum régional sur la télésanté des Premières Nations et des Inuits du Québec.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2006). *Consultation régionale sur les besoins communautaires en santé électronique chez les Premières Nations du Québec. Rapport régional*.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2006). *Enquête régionale longitudinale sur la santé des Premières Nations - Région du Québec- 2002 – Rapport des Premières Nations vivant dans les communautés*.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2006). *Enquête régionale longitudinale sur la santé des Premières Nations du Québec et du Labrador, 2002. Rapport des Premières Nations vivant dans les communautés*.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2006). *Évaluation des exigences des soins continus dans les communautés des Premières Nations et des Inuit. Rapport régional du Québec*.
- COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR (2006). *Prévention de la criminalité chez les enfants 0-6 ans et les familles des Premières Nations*.
- CONSEIL CANADIEN SUR L'APPRENTISSAGE (2005). *State of First Nations Learning*.
- CONSEIL CONSULTATIF DE L'INFORMATION SUR LA SANTÉ (1998). *Connexions pour une meilleure santé : Questions stratégiques, ministère des Travaux publics et des Services gouvernementaux du Canada, Ottawa*.
- DIRECTION GÉNÉRALE DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS : www.dgspni.gc.ca
- DUPUIS, R. (1991). *La Question indienne au Canada*, Boréal express Montréal.
- EVANS, R. et G. STODDART (1990). *Producing Health, Consuming Health Care, Social Science and Medicine*, vol. 31, no 12.
- COMITÉ DIRECTEUR NATIONAL DE L'ENQUÊTE RÉGIONALE SUR LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS (1999). *Enquête régionale sur la santé des Premières Nations et des Inuits.. Rapport national*.
- CENTRE DES PREMIÈRES NATIONS (2005). *Enquête régionale longitudinale régionale sur la santé des Premières Nations (ERS) 2002-2003. Le rapport pour les peuples*.
- FROHLICH, N. et K. C. CARRIÈRE (1997). *Issues in Developing Indicators for Needs-Based Funding, Centre d'élaboration et d'évaluation de la politique des soins de santé du Manitoba, Winnipeg*.
- GOVERNEMENT DU CANADA (2003). *Le bien-être des jeunes enfants au Canada. Faits saillants : socialunion.gc.ca*
- GOVERNEMENT DU CANADA (2003). *Les enfants d'abord. Analyse du contexte de la coopération entre les ministères pour l'exécution de la Stratégie de développement de la petite enfance autochtone. Développement des ressources humaines Canada, Santé Canada et Affaires indiennes et du Nord Canada*.
- GOVERNEMENT DU NOUVEAU-BRUNSWICK (2005). *Plan stratégique de la télésanté au Nouveau-Brunswick 2005-2010*.
- GOVERNEMENT DU QUÉBEC (2004). *État de la situation sur le Syndrome d'alcoolisation fœtal au Québec*, INSPQ.
- GRUPE D'EXPERTS (2006). *Rapport du Groupe d'experts sur la salubrité de l'eau potable dans les collectivités des Premières Nations*.
- HECKMAN, J.J. et D. MASTEROV (2004). *The Productivity Argument for Investing in Young Children*, Working Paper 5, Invest in Kids Working Group, Committee for Economic Development, October 4, 2004.
- HENEMAN, B. (2006). *Prévalence du tabagisme au Québec : Qu'en est-il?* www.santepub-mtl.qc.ca/Publication/pdf/tabac/prevalencetabagisme.pdf (consulté le 17 avril 2007),
- HOLLANDER ANALYTICAL SERVICES (2006). *Évaluation des exigences des soins continus dans les communautés des Premières Nations et des Inuit. Rapport synthèse*.
- INDIAN HEALTH SERVICE (1989). *Trends in Indian Health, 1989 Tables*, Rockville, MD Indians and Inuit.
- INFOROUTE SANTÉ DU CANADA (2004). *Stratégies d'affaires du Réseau North*. Préparé par le Réseau North et Hasham Consulting.
- INSTITUT DE LA STATISTIQUE DU QUÉBEC (2004). *Enquête québécoise sur le tabac, l'alcool, la drogue et le jeu chez les élèves du secondaire (ETADJES)*, www.stat.gouv.qc.ca/publications/sante/rapport_tabagisme.htm.
- JAN, S. et V. WISEMAN (1996). *Equity in health care: some conceptual and practical issues*. Australia and New Zealand Journal of Public Health, vol. 1, no 1, p. 13-15.
- JENKINS, R. (2002). *Addressing suicide as a public health problem*. The Lancet, vol. 359, p. 813-814.
- KATZMARZYK, P.T., N. GLEDHILL, et R.J. SHEPHARD. (2000). *The economic burden of physical inactivity in Canada*. Journal de l'Association médicale canadienne, 163(11), 1435-1440.
- LEFEBVRE, S. (2002). *Housing: An income issue. Autumn 2002 Perspectives*, 28-35.
- LINDSAY, C. (1999). *Seniors: A diverse group aging well*. Canadian Social Trends, 52, 24-26.
- LOCUST, C.S. (1999). *Overview of health programs for Canadian Aboriginal Peoples*. In J.M. Galloway, B.W. Godber, et J.S. Alpert (dir.), Primary care of Native American patients (p. 17-21). Woburn, MA: Butterworth-Heinemann.
- LONG, R., NJOO, H., & E. HERSHFIELD. (1999). *Tuberculosis: Epidemiology of the disease in Canada*. Journal de l'Association médicale canadienne, vol. 160. no 8, p. 1185-1190.



- MANGA, P. et L. LEMCHUK-FAVEL (1993). *Health Care Financing and Health Status of Registered Indians*, Assemblée des Premières Nations, Ottawa.
- MARCIL-GRATTON, N. (1998). *Grandir avec maman et papa? : les trajectoires familiales complexes des enfants canadiens*. Ottawa.
- MARIS, R.W. (2002). *Suicide*. The Lancet, vol. 360, p. 319-326.
- MARMOT, M.G. (2001). *Inequalities in health*. New England Journal of Medicine, vol. 345, no 2, p. 134-136.
- MARMOT, M. et R.G. Wilkinson (1999). *Social determinants of health*. Marmot et Wilkinson (dir.). Oxford et New York, Oxford University Press.
- MBT TELEHEALTH SENIOR MANAGEMENT TEAM (2005). *MBT Telehealth First Nations Expansion Project Plan (MBT 2005-07)*.
- MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (2004). *Portrait des infections transmissibles sexuellement et par le sang (ITSS), de l'hépatite C, de l'infection par le VIH et du sida au Québec*. Gouvernement du Québec.
- MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (2004). *Stratégie québécoise de lutte contre l'infection par le VIH et le sida, l'infection par le VHC et les infections transmissibles sexuellement*. Gouvernement du Québec.
- MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (2005). *Portrait des infections transmissibles sexuellement et par le sang (ITSS), de l'hépatite C, de l'infection par le VIH et du sida au Québec*. Gouvernement du Québec.
- MINISTÈRE DES AFFAIRES INDIENNES ET DU NORD CANADA (2002). *Population indienne inscrite selon le sexe et le lieu de résidence, 2002*.
- MINORE, B., BOONE, M., KATT, M. et P. KINCH (1991). *Looking in looking out : Coping with adolescent suicide in the Cree and Ojibway communities of northern Ontario*, Canadian Journal of Native Studies, vol. 11, p. 1-24.
- MURRAY, C. et A. LOPEZ (1996). *Alternative visions of the future: Projecting mortality and disability, 1990 – 2020. The Global Burden of Disease*. Cambridge: Harvard University Press.
- NORRIS, M.J., D. KERR et F. NAULT (1995). *Summary report on the projections of the population with Aboriginal identity, Canada, 1991- 2016*. Statistique Canada.
- OBSERVATOIRE DE L'ABITIBI-TÉMISCAMINGUE (2007). *Partager la prospérité du Canada – un coup de main, pas la charité*.
- ORGANISATION MONDIALE DE LA SANTÉ (2001). *Coordination du travail de l'assemblée mondiale, du Conseil exécutif et du Comité régional*.
- ORGANISATION MONDIALE DE LA SANTÉ (1995). *Physical status: the use and interpretation of anthropometry: Rapport d'un comité d'experts de l'OMS*. Organisation mondiale de la santé, vol. 854, p. 1-452.
- ORGANISATION MONDIALE DE LA SANTÉ (2001). *Rapport sur la santé dans le monde, 2001 – La santé mentale : Nouvelle conception, nouveaux espoirs*. Genève : Organisation mondiale de la santé.
- ORGANISATION NATIONALE DE LA SANTÉ AUTOCHTONE (2004). *Ce que les Premières Nations pensent de leur santé et de leurs soins de santé. Sondage de l'ONSA et de Santé Canada sur ce que pensent les Premières Nations de leur santé et de leurs soins de santé au Canada*.
- ORGANISATION NATIONALE DE LA SANTÉ AUTOCHTONE (2004). *Enquête régionale sur la santé des Premières Nations et des Inuits 1997, Résumé du rapport national et des rapports régionaux, janvier 2004*.
- POMERANTZ, B.H. (1998). *Incidence of adverse drug reactions in hospitalized patients*. Journal of the American Medical Association, vol. 279, p. 1200-1205.
- RACINE, Y. et M.H. BOYLE (2002). *Family Functioning and Children's Behaviour Problems*, (p. 199-209) dans J. Douglas Willms (dir.) *Vulnerable Children*. Edmonton: University of Alberta Press et Développement des ressources humaines du Canada.
- RAPPORT DU GOUVERNEMENT DU CANADA (2003): *Le bien-être des jeunes enfants au Canada*.
- RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX NUNAVIK (2005). *Plan directeur de la télésanté au Nunavik*.
- SANTÉ CANADA (2003). *Le capital social comme déterminant de la santé: Comment le définir?* ISBN 0-662-32985-6.
- SANTÉ CANADA, DIRECTION GÉNÉRALE DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS (2002). *Stratégie de lutte contre le tabagisme chez les Premières Nations et les Inuits : Cadre du Programme*.
- SANTÉ CANADA. (2002). *Le fardeau économique de la maladie au Canada, 1998*. Ottawa: Santé Canada.
- SANTÉ CANADA – DGSPNI (2001). *Les services communautaires au XXI^e siècle : Services de télésanté destinés aux Premières nations et aux Inuits. Projet national de recherche sur la télésanté pour les Premières nations NA402 1998 – 2001*.
- SANTÉ CANADA (2000). *Profil statistique de la santé des Premières Nations pour l'année 2000*.
- SANTÉ CANADA (2006). *Enquête de la surveillance de l'usage du tabac au Canada (ESUTC)*, www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/ctums-esutc/2006/index_f.html
- SANTÉ CANADA (s.d.). *Incidence d'hépatite B et d'hépatite C aiguës dans la population autochtone du Canada, 1999-2000*.
- SCOTT K. (2006). *Broadening the lens, Proceedings of a Roundtable on Aboriginal peoples health*.
- SCOTT K. (1987). *Pathogenèse sociopolitique de la maladie*.
- SCRIMGEOUR, D. (1996). *Funding for Community Control of Indigenous Health Services*, Australia and New Zealand Journal of Public Health, vol. 20 no 1, p. 17-18.

SECRÉTARIAT À LA SANTÉ ET AU DÉVELOPPEMENT SOCIAL DE L'ASSEMBLÉE DES PREMIÈRES NATIONS

(2005). *Cadre de rapports sur la santé des Premières Nations*.

SKOWRONSKI, D.M. et coll. (2002). *The changing age and seasonal profile of pertussis in Canada*. The Journal of Infectious Diseases, vol. 185, no 10, p. 1448-1538.

STATISTIQUE CANADA (1996). *Espérance de vie sans incapacité, par province et territoire*. Ottawa.

STATISTIQUE CANADA (1999). *Le nouveau visage des maladies cardiovasculaires et des accidents vasculaires cérébraux au Canada, 2000*.

STATISTIQUE CANADA (1999). *Un portrait des aînés au Canada (3e édition)*. Ottawa, Statistique Canada.

STATISTIQUE CANADA (2000). *L'activité humaine et l'environnement*. Ottawa: Statistique Canada.

STATISTIQUE CANADA (2001). *Accès aux services de santé au Canada*. Ottawa: Statistique Canada.

STATISTIQUE CANADA (2001). *Cancer incidence, 1999 national data and 2000 partial data*. Ottawa.

STATISTIQUE CANADA (2002). *Enquête longitudinale nationale sur les enfants et les jeunes : Obésité infantile*. Le Quotidien, www.statcan.ca/Daily/Francais/021018/q021018b.htm

STATISTIQUE CANADA (2002). *Profil des familles et des ménages canadiens : la diversification se poursuit*.

STATISTIQUE CANADA (2003). *Analyse du revenu au Canada, 2001*. Ottawa: Statistique Canada.

STATISTIQUE CANADA (2003). *Enquête sur la santé dans les collectivités canadiennes – Santé mentale et bien-être*. Le Quotidien.

STATISTIQUE CANADA (2003). *La vie après l'aide sociale*. Le Quotidien.

STATISTIQUE CANADA (2005). *Projections des populations autochtones, Canada, provinces et territoires 2010 à 2017*.

STATISTIQUE CANADA (2006). *Enquête auprès des peuples autochtones de 2001 – Rapports provinciaux et territoriaux : Population autochtone hors réserve*.

SUTHERLAND, C. (1997). *Indigenous Health Systems: A review and analysis of successful programs in Canada, US and Australia, designed and delivered by First Nations and indigenous peoples*. Part II: study examples, Assemblée des Premières Nations, Ottawa, 1997.

TILTON, E. (2001). *Aboriginal Health: an historical approach*, dans Condon J, G. Warman G et Arnold (dir.), *The health and welfare of territorians*. Territory Health services, Darwin.

TREMBLAY, M.S. et J.D. Willms (2000). *Secular trends in the body mass index of Canadian children*. Journal de l'Association médicale canadienne, vol. 163, no 11, p. 1429-1433.

WEIR, E. (2001). *Suicide: the hidden epidemic*. Journal de l'Association médicale canadienne, vol. 165, no 5, p. 634-635.

WHARTON, B. et I. Booth (2001). *Fortification of flour with folic acid*. British Medical Journal, vol. 323, p. 1198-1199.

WILENSKY, G.R. (2003). *The implications of regional variations in Medicare – What does it mean for Medicare*. [Éditorial] Annals of Internal Medicine, vol. 138, p. 350-351.

WILSON, R.M., RUNCIMAN, W.B., GIBBERD, R.W., et coll. (1995). *The Quality in Australian Healthcare Study*. Medical Journal of Australia, vol. 163, no 9, p. 458-471

WRIGHT, C.J., CHAMBERS, G.K. et Y. Robens-Paradise (2002). *Evaluation of indications for and outcomes of elective surgery*, Journal de l'Association médicale canadienne, vol. 167, p. 461-466.

WU, T., M. TREVISAN, R.J. GENCO, J.P. DORN, K.L. FALKNER et C.T. SEMPOS (2000). *Periodontal disease and risk of cerebrovascular disease: The first national health and nutritional examination survey and its follow up*. Archives of Internal Medicine, vol. 160, no 18, p. 2749-2755.

YOUNG, T. K. (1996). *Sioux Lookout First Nations Health Authority Participatory Research Project. Final Report I - Health Needs Assessment (revised)*, Northern Health Research Unit, Université du Manitoba, Winnipeg.

Appendix 1

HEALTH, SOCIAL SERVICES AND STANDARD OF LIVING INDICATORS



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

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

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

⁶ The data in these columns refer only to adults, unless otherwise indicated. The data are from the Report on First Nations living in FNLRHS communities in the Quebec region, 2002-2003 (FNQLHSSC 2006), except where otherwise indicated.

⁷ Only general cardio-vascular problems are documented for FN in FNQLHSSC 2006

⁸ Baby bottle syndrome



DEMOGRAPHICS	Quebec First Nations ^{III}			Canada and/or Quebec	Disparity Ratio
	Men	Women	Total (a)	Population (b)	a\b
Life expectancy at birth	70.4	75.5 ^{VIII}		77.7 H et 82.2 ^{IX}	0.9H et 0.92F
Birth rate			23.4/1000	10.3/1000	2.33
Infant mortality rate			6.4/1000	5.4/1000	1.18
Median age (years)			24.7	37.1	0.66

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

I The data in these columns refer only to adults, unless otherwise indicated.

The data are from the Report on First Nations living in FNLRHS communities in the Quebec region, 2002-2003 (FNQLHSSC 2006), except where otherwise indicated.

II In those 15 years and older, 1998, in Quebec.

<http://www.inspq.qc.ca/publications/283-FeuilletEpidemieSuicide.pdf>

III The data in these columns represent only adults, except when indicated.

The data were taken from the Report on First Nations Living in Communities of FNQLRHS 2002-03, Quebec region (FNQLHSSC 2006), except when indicated.

IV These data relate to children.

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

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

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

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

Data are valid for 2001, for First Nations throughout Canada.

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

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

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

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

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

XVI In 2001

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

XVI In 2001, regardless of length of employment.

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

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

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

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

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

Appendix 2

ACRONYMS

**ACRONYMS**

AFNQL:	Assembly of First Nations of Quebec and Labrador
DIAND:	Department of Indian Affairs and Northern Development
FASD:	Fetal alcohol spectrum disorder
FNHSOR:	First Nations Head Start on Reserve program
FNIHB:	First Nations and Inuit Health Branch
FNQLHSSC:	First Nations of Quebec and Labrador Health and Social Services Commission
FNQLRLHS:	First Nations of Quebec and Labrador Regional Longitudinal Health Survey
MSSSQ:	Ministère de la Santé et des Services sociaux du Québec
NIHB:	Non-insured health benefits
OCAP:	Ownership, control, access and possession
R&D:	Research and development
WHO:	World Health Organization



First Nations of Quebec and Labrador
Health and Social Services Commission

www.cssspnql.com