Montreal Urban Aboriginal Health Needs Assessment

Montreal Urban Aboriginal Community Strategy Network (NETWORK)

Montreal 2012

Montreal Urban Aboriginal Health Committee

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Montreal Urban Aboriginal Health Committee members:

Carrie Martin
Harry Adams
Pascale C. Annoual
Rossel Bérard
Carole Brazeau
Garry Carbonnell
Susie De Sousa
Jeffrey Drugge
Sacha Rose Kiesman
Chantal Robillard
Mike Standup
Suzanne Stephenson
Keren Tang

Written by:

Chantal Robillard
Eva Monson
Jennifer Mavritsakis

Research Coordination:

Chantal Robillard
Rossel Bérard
Carrie Martin
Morgan Phillips

Research Team:

Pascale Brunet
Marie-Céline Charron
Bita Mary Eslami
Shirene Eslani
Elizabeth Fast
Natalia Gagnon
Ainsley Jenicek
Alexandre Lapointe
Jennifer Mavritsakis
Eva Monson
Diana Neill
Shirley Pien
Rochelle Ross
Jennifer Shearer
Keren Tang

Graphic Design and Printed by:

Mikisew's Cree-ations: mikisewcreeation@gmail.com

Painting on Cover Created by:

Pascale C. Annoual

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PRESENTATION

Montreal Urban Aboriginal Community Strategy NETWORK

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Background

The Montreal Urban Aboriginal Community Strategy Network (NETWORK) is an initiative that was created on November 5, 2008, as part of a community gathering where the results of the Needs Assessment on the Aboriginal People in the Urban Setting of Montreal were presented. This is the study commissioned by the Regroupement des centres d'amitié autochtones du Québec (RCAAQ) after the Socioeconomic Forum of Mashteuiatsh and conducted by Organizational Development Services (ODS) of Kahnawake, Shakotiia'takehnhas Community Services.

Since then, the NETWORK has mobilized the Aboriginal community of Montreal on 11 occasions by organizing seasonal gatherings and now has over 600 members representing over 120 organizations

Context

According to Statistics Canada's data (2006), Montreal is the 8th city of Canadian metropolitan areas where we find the largest number of Aboriginal people. There are 17,870 Aboriginal people in the greater metropolitan area of Montreal and 57%, or 10,130 people, reported being members of a First Nation. Moreover, between 2001 and 2006, the Aboriginal population of Montreal increased by 60%, so if we make calculations based on the same percentage increase, in 2011, the Aboriginal population in Montreal could represent 28,592 people.

The need for more accurate data on the origin and profile of the members of the Aboriginal community of Montreal is a 2012 priority action for the NETWORK's Steering Committee. A study will be carried out during the year 2012-2013.

Vision, principles and mandate of the NETWORK

The NETWORK´s vision is large and aims to "improve the quality of life of Aboriginals in the greater Montreal area through a coordinated and concerted approach that will align our collective interests in supporting locally-driven initiatives." Transparency, accountability, partnership, inclusiveness, open mindedness, respect and cultural responsibility are the principles of the NETWORK, as are being sensitive to cultural differences and valuing the diversity of Aboriginal people in the greater Montreal area. The NETWORK's Assembly, which meets three times a year, acts as a decision-making structure with respect to the orientations that must be established to help organizations serving Aboriginal people in the greater Montreal area deepen and improve their activities, through the following actions:

- Sharing information and transferring knowledge about Aboriginal peoples' needs;
- Prioritizing the needs collectively;
- Developing joint projects that address the gaps and reduce the duplication of services;
- Creating and strengthening partnerships.

The NETWORK is a non-partisan initiative designed to unite all efforts to improve the quality of services available to the Aboriginal people of Montreal. By providing a forum for exchange and consultation as part of its seasonal Gatherings (3x year), the NETWORK enables the community to better identify, through the participation of individuals and organizations in Montreal, gaps in services, difficulties specific to certain organizations or to certain categories of customers and the needs for organizational supports. It therefore facilitates the development of joint projects aimed at filling the gaps and at better understanding the needs and challenges of organizations and clients, while making a network of organizational support available to all.

In Montreal, the needs are various, complex and diverse, which is very specific to the reality of the city. Here, we find members of each of the 11 Aboriginal Nations of Quebec in addition to welcoming the rest of the country's Aboriginal people. We are therefore in a landscape of unique Aboriginal multiculturalism, which implies the emergence of some excellent opportunities for collaboration, but also refers to challenges and issues highly specific to this reality.

We believe that the delivery of services in Montreal must be shared between several organizations and that is the vision that initiated the NETWORK. It is not possible for one organization to respond adequately to all the needs and the community has therefore chosen to implement an initiative that would unite efforts and facilitate collaboration.

Working Committees of the NETWORK

The NETWORK is composed of the following six Working Committees:

1. ART•CULTURE,
2. Communications,
3. Employability-Training-Education,
4. Youth,
5. Health,
6. Social Services.

Each Working Committee is comprised of Aboriginal workers, non-Aboriginal collaborators and governmental partners that have a specific expertise in the field of intervention for which they are mobilized. Each Committee has also developed a strategic plan specifying the activities to be conducted in order to best address the various problems and issues specific to its field of interest.

However, after several discussions, it was decided that certain activities, being deemed of very high importance for the community, are now considered transversal priorities to the entire NETWORK structure. This means that all Working Committees as well as the Steering Committee will collaborate in the advancement of these NETWORK-wide priorities to ensure the best partnerships and the best chances of success.

NETWORK Transversal Priorities 2012-2017
Upgrade the efficiency of the NETWORK's coordination
Create a community, cultural and artistic venue
Create a holistic health centre
Develop Cabot Square into an initial Aboriginal orientation point for resources
Develop common reference tools and networking activities
Commit to the presence of an Elder and assure the integration of Aboriginal protocols in all NETWORK activities

The steps towards creating a holistic health centre – the importance of the needs assessment results

Here is the section of the 2012-2017 NETWORK Strategic Plan on the steps needed for the creation of a holistic health centre. The needs assessment was mandatory to advance positively and pursue this transversal priority successfully. The red font refers directly to objectives or activities that could not have been achieved or initiated without the needs assessment process and/or results.

Priority # 3: Create a holistic health centre

Objective A: Ensure transversality in the development of this priority
Activities and outcomes
a) Share resources on the communication strategy plan
b) Identify service providers and users for focus group and story-telling sessions through all committees
c) Brainstorm ideas on the health centre (infrastructure, logistics) with committees with similar goals
d) Recruitment, registration, and re-evaluations of MUAHC members through the NETWORK and the other committees
e) Distribute information regarding our committee's history, mission, strengths, challenges, and processes
f) Invite through the NETWORK newsletter other committee representatives and NETWORK members (service providers) to participate in the Aboriginal health centre focus group • To ensure transparency, awareness, and sharing of ideas, resources, and information with the NETWORK, other Working Committees, and the wider community
Objective B: Define the service offer and verify the related legal and regulatory framework
Activities and outcomes
a) Gather information on service gaps from the needs assessment, story-telling, and focus groups • Fill in service gaps in order to better serve the healthcare needs of the Aboriginal community
b) Plan corridors of service based on recommendations and best practices • Ensure that the healthcare needs of the Aboriginal community are met
c) Gather legal information regarding legal framework • Ensure the health centre is aware of the legalities in the operations of a health organisation
Objective C: Support the search for funding
Activities and outcomes
a) Compile a list of potential funders; establish a project summary; initiate contact with target organisations; submit project proposal • Increased financial resources for research and establishing a fully functional health centre

Objective D: Support the planning efforts

Activities and outcomes

a) Organize a focus group session to gather advice and guidance from existing organisations in our actions

- Better awareness of the needs of Aboriginal clients, structures and services to include in the new health centre

b) Organize annual story-telling sessions to provide continuous feedback and guidance in our actions

- Better awareness of the needs of Aboriginal clients, and gaps in services that need to be included in the health centre

c) Consistent and regular meetings to evaluate project development, in terms of infrastructure, corridors of service, human resources, and partnerships

- Better development of the physical health centre space and its services

Objective E: Support the efforts to raise awareness about this centre

Activities and outcomes

a) Collaborate with other local, regional, national, and international networks on the establishment of the health centre, its functioning and its progress based on routine evaluations

- Better awareness of the needs of Aboriginal clients, and gaps in services that need to be included in the health centre

b) Educate and inform others on health system particularities pertaining to Aboriginal people

- Increased awareness of the necessary improvements in health services

Objective F: Engage in consultations with the NETWORK members and with the Aboriginal community of Montreal

Activities and outcomes

a) Implement a needs assessment in the community to identify gaps and barriers in urban health services

- Increased awareness of the necessary improvements in health services

b) Network with health service providers, governments, organizations and other committees working with the urban Aboriginal population in order to fill in gaps and barriers in health services based on the MUAHC's recommendations

- Increased awareness of the need for health services that do not already exist

c) Provide feedback to the community and the NETWORK on urban health and service needs based on the needs assessment results and recommendations

- Increased awareness of the necessary improvements in health services

Objective G: Carry out all necessary activities required to open and maintain the centre
Activities and outcomes
a) Compile recommendations based on the research findings
• Fill in service gaps in order to better serve the healthcare needs of the Aboriginal community
b) Create a database of existing health services
• Ensure that the healthcare needs of the Aboriginal community are met
c) Research possible locations for the health centre
• Better development of the physical health centre space and its services
d) On-going collaboration with other health centres and relevant networks
• Better awareness of the needs of Aboriginal clients, and gaps in services that need to be included in the health centre
e) Draft a description of the health centre (including a list of services and who will provide them) to be used in funding proposals; draft a funding proposal for the health centre
• Ensure that the healthcare needs of the Aboriginal community are met
f) Analyze financial budget with responses from potential funders
• Ensure adequate resources are available for the development of the health centre

It is therefore demonstrated that the needs assessment has allowed the NETWORK to initiate the needed consultations, analysis and research toward achieving this transversal priority.

Steering Committee of the NETWORK

The NETWORK also established a Steering Committee composed of a representative of each Working Committee, an Elder and a representative of the five government bodies/regional public administrations recognized by the Aboriginal community of Montreal. There is the federal government represented by the Office of the Federal Interlocutor from Aboriginal Affairs and Northern Development Canada, the municipal government represented by the City of Montreal, the provincial government represented by the Secretariat aux affaires autochtones of Quebec, the First Nations represented by the Assembly of the First Nations of Quebec and Labrador (delegated by the First Nations Human Resources Development Commission of Quebec) and the Inuit represented by the Makivik Corporation.

Members of the NETWORK

With over 600 members already to its credit, including 120 organizations, the NETWORK is the initiative most representative of the interests and needs of the Aboriginal community of Montreal. Its objective is to maintain, strengthen and increase the number of partnerships with Aboriginal and non-Aboriginal organizations, community groups, the private sector, government partners and community leaders in Quebec. Thus the NETWORK aims not only to improve the quality of life of Aboriginal people in the greater Montreal area, but also the quality of services available to them.

NETWORK Coordination Office

For more information, please consult the website at *www.reseaumtlnetwork.com* or contact the NETWORK Coordinator:

Pavillon Duke Nord || 5th floor, office 5151.04
801 Brennan Street || Montréal QC H3C 0G4

T: 514.872.9897 || F: 514.872.9848

reseau.mtl.autochtone@gmail.com

Odile Joannette
NETWORK's Co-Chair and AFNQL representative
Montreal Urban Aboriginal Community Strategy NETWORK
Communications Advisor | FNHRDCQ
(450)638-4903
ojoannette@cdrhpnq.qc.ca

EXECUTIVE SUMMARY

The Montreal Urban Aboriginal Health Committee (MUAHC) is a working committee of the Montreal Urban Aboriginal Community Strategy Network (NETWORK). This working committee's vision is to empower the Aboriginal community by working together towards healing. The MUAHC is composed of thirteen members from various Aboriginal and non-Aboriginal organizations, government representatives and community members. Its vision is to empower the Aboriginal community by working together towards healing; its mission is to achieve a culturally competent, holistic health service delivery model that is accessible to all Aboriginal people, within the urban setting of Montreal and surrounding areas, where emphasis is placed on quality and continuity of care.

The MUAHC's Montreal Urban Aboriginal Needs Assessment represents a timely and important opportunity for Aboriginal organizations and their partners to consider how best to resolve some of the gaps and inequities in health service delivery in Montreal. In the short-term, this initiative intends to provide evidence-based recommendations to fill the gaps in the delivery of culturally sensitive and holistic health services to the Montreal urban Aboriginal population. In the long-term, such evidence will support the creation of a fully functional holistic Aboriginal health center in Montreal. Hence, the current project will seek to answer the following questions:

a. What is the nature and the importance of health needs (spiritual, physical, emotional, mental) and health services/healing needs for the Montreal urban Aboriginal population?

b. What determines the health needs of the Montreal urban Aboriginal population?

c. What determines the response to expressed health needs by the Montreal urban Aboriginal population?

d. How can these health needs be met in light of Montreal's current context of services?

For this study, a total of 89 questionnaires were conducted in face-to-face interviews with Montreal urban Aboriginal service users, addressing city living, self-determination, perceived barriers to services, perceived wellness and health, spirituality and connectedness to the world, perceived health needs and perceived maternal and child health. A second questionnaire was used in a similar fashion with 94 service providers in Montreal, tackling issues of governance, perceived wellness and health and service delivery. Illness narratives were collected from 21 Montreal Aboriginal people, and a focus group was conducted with 19 service providers in order to identify solutions to gaps in services.

Results show some convergence in the concerns between the survey, narratives and focus groups with the Montreal urban Aboriginal community and service providers. Many of the Montreal urban Aboriginal participants were not born in Montreal and did not have plans to return to their communities of origin. However, they maintained close ties to their communities and participated in their communities or in overall Aboriginal cultural events. Even if Montreal was perceived as a city offering possibilities to move forward, it also presented a series of challenges that may explain some of the health concerns identified by both service users and service providers. Montreal is a culturally diverse city, which can make it difficult for an Aboriginal person to establish roots, or, at least, find cultural markers in order to ground him/herself. This is particularly important to retain as a health determinant since traditional healing and finding a "home" was identified as a key element in maintaining one's health and wellbeing.

Even if equilibrium in all aspects of life was rated high by the surveyed Aboriginal community, the community's general health was rated low. For those who did manage to find traditional services, they appeared to be dissatisfied with them. In the narratives with community members and the focus group with service providers, it was expressed that some people preferred to go back to their home communities for traditional healing services, but this brings up the difficulty of finding transportation to leave Montreal.

Most importantly, mental health concerns were identified by community members as well as service providers (qualitatively and quantitatively) as one of the most important concerns for First Nations, Métis and Inuit people, and mental health was one of the most frequently sought services. One may question if the additional concerns for tobacco, drug, and alcohol consumption, the urban stresses, or more deeply rooted historical injuries, may contribute to the perpetuation of such ailments. The importance given to sleeping difficulties, and to a certain degree, bodily aches and pains, further supports this hypothesis.

Half of Montreal's Aboriginal people interviewed, as well as service providers, are not satisfied with how services in Montreal are administered, and feel that Aboriginal people neither were involved in the management of their health services, nor as partners in their relationship with healthcare providers. Difficulty in accessing services and experiences of discrimination in mainstream services were raised, especially finding appropriate responses to mental health and drug and/or alcohol rehabilitation needs. However, when people do manage to access services for their most important concerns, they appear to be overall satisfied, even if the lack of cultural sensitivity was highlighted.

This satisfaction level can be most contrasted within the barriers experienced by the Montreal Aboriginal community while attempting to access, or once consulting, services. Most had experienced some form of barrier, especially in the case of women and people aged between 25-44 who had difficulty finding doctors and nurses, as well as in men who preferred not to seek services, possibly because they feared discrimination. Inuit on the other hand, had encountered difficulties because of lack of identification papers. Knowing about or accessing traditional healing services was also a concern, especially during pregnancy, delivery or for young children. Although long waiting lists are a general difficulty in Montreal mainstream services, other barriers are of importance such as services being disconnected from traditional Aboriginal healing.

Montreal Aboriginal people who were surveyed further identified experiences of bad treatment

based on their Indigenous origins. Social class and language discrimination were not far behind as a reason for bad treatment. This situation supports what was expressed by services providers in regards to the lack of knowledge or the presence of preconceived ideas and discrimination in mainstream services. As explained in the focus group, this situation has a negative impact on the levels of trust some Aboriginal people may have towards mainstream services. It further undermines the already fragile patient-doctor relationship, and hinders adherence to treatment. Finally, it may limit further and future consultations by Aboriginal people.

Montreal urban Aboriginal people that were interviewed in this survey identified the importance of having a good social network as the key to maintaining good health and wellbeing. Hence, connection to their communities and origins are important, but also a challenge, as stated earlier. A healing center, such as the one planned for by the MUAHC, should therefore take into account this need to reconnect with one's culture and people by providing family and social support as well as access to traditional foods.

Mainstream services appear to meet the overall needs of the community, although they do not provide a sufficient understanding of the traditional response to concerns. Although services provided to the Montreal urban Aboriginal community presented many barriers, they nonetheless appeared to meet the overall needs of the population. Challenges remained however in the access to mainstream services, as well as in their cultural appropriateness and in the integration of traditional healing. Hence, educational campaigns on Indigenous health issues and a vision of wellbeing, history and culture appear to be needed. In addition, service providers seem to know little about how to promote health and support the strength and resilience inherent in Montreal Aboriginal people. Future training of mainstream service providers should also focus on this issue, especially in the reinforcement of cultural connectedness, and Indigenous identities.

The next step for the MUAHC is to use these conclusions to support its recommendations and design of policy briefs to make the holistic health and healing center a reality for the Montreal urban Aboriginal community. In the design of a future health center, the MUAHC will need to take into account gender, age and Indigenous groups' differences, in particular women's health, where the most concerns were identified (e.g. midwifery, access to traditional foods). If women and children are the future of this community, efforts to reconnect with the community and culture should start from the womb. The involvement of the Montreal urban Aboriginal community, in all its diversity, is a key to the health center's success, as community members can contribute to bridging traditional and mainstream services.

TABLE OF CONTENTS

INTRODUCTION

According to the 2006 Census, 17,865 Aboriginal people were living in the Montreal metropolitan region, an increase of 60% since 2001, thus making it the eighth Canadian city in terms of the size of its urban Aboriginal population.* Montreal's Aboriginal people are a young population, according to Statistics Canada: their median age being between 15 to 44 years old. The majority of the Montreal Aboriginal population have completed postsecondary education. The Montreal Aboriginal population consists primarily of newcomers or "first generation" urban Aboriginal people, who do not intend to return to their communities of origin to live permanently in the future (44%). Some studies highlighted differences between genders in the various motives for the mobility of Aboriginal populations. On the one hand, women moved from communities to urban settings for family and education or to escape a bad family situation and find a better place to raise their children. On the other hand, men mostly moved to find work. According to local Aboriginal organizations, the actual size of that population could be bigger in reality as these statistics do not take into account those without a fixed address. In a report created by the Native Friendship Centre of Montreal on the issue of homelessness, it was noted that an underreporting in the 1996 Census had serious consequences on services for the urban Aboriginal population of Montreal. It has reduced federal funding allocations for programs and initiatives for this urban population and allowed the provincial and municipal governments to view Montreal's urban Aboriginal population size as insignificant compared to the city's population. The report states that the province assumes that existing non-Aboriginal services can easily accommodate Montreal's First Nations, Inuit and Métis population for all services. However, if we compare Montreal's reality to that of Toronto, which had the same percentage of Aboriginal people, we find that the latter has many more service delivery points, including health services, as well as a traditional health center (Anishnawbe Health Toronto) , which offers a large variety of traditional and clinical services.

According to the Urban Aboriginal Peoples Study (UAPS), close to half of the urban Aboriginal people of Montreal (49%) considered their health as either excellent or very good. However, in comparison to the rest of the Canadian population, Aboriginal people have a lower life expectancy and higher rates of physical disorders such as diabetes, infectious (HIV, TB, Hepatitis C) and parasitic diseases and mental health problems; as well as chronic conditions. [iii, iv, v, vi, vii, vii, ix]

According to the UAPS, 67% of the Aboriginal community of Montreal had been in contact with the healthcare system in the past twelve months, either by seeing a doctor or going to the hospital as a patient, and 15% answered that they never had any contact with these services. A higher percentage of Aboriginal respondents claimed that access to traditional healing practices was more important than access to the mainstream healthcare system (29% versus 22%). Yet close to half of the respondents (47%) still considered both services as important. Aboriginal spirituality is important to the majority of urban Aboriginal people, but has greater significance among First Nations and Inuit peoples. Among the Montreal respondents of the UAPS, half of urban Aboriginal people reported using and relying at least occasionally on Aboriginal services and organizations in their city, rising to seven out of ten among Inuit (71% versus 59% of First Nations and 48% of Métis). Aboriginal services and organizations also clearly help Aboriginal people make significant choices about their cultural, economic and social affairs – and, for some, sustain a sense of collective identity in their city.

* Including Kahnawake and the Kanesatake communities.

According to a recent study, the seven main barriers for Aboriginal people accessing care are: cultural barriers; linguistic barriers; structural barriers linked with the historical relationship of entrenched inequality; a certain mistrust of doctors and nurses; divergent expectations and experiences around medical services delivery; financial barriers/Non-Insured Health Benefits or beneficiaries and lack of knowledge about existing services. In order to avoid confusion and to have access to more culturally sensitive services, clients often go to Aboriginal service providers in Montreal, such as the Native Friendship Centre of Montreal, where some employees may have little knowledge of the health services that would answer clients' needs. In many cases, non-Aboriginal service providers send Aboriginal clients to the Native Friendship Centre of Montreal, assuming it offers culturally relevant health services.

In regards to service delivery, it has been reported that the existing health service providers in Montreal are often unaware of the specific needs of Aboriginal people, who are often confronted with cultural and linguistic barriers in services, which are perceived as confusing and bewildering. Due to the various procedures relating to status, community of origin, place of residence and linguistic preference, Aboriginal clients are often referred to multiple agencies before arriving at the right one. Due to the complexity of certain needs, there is difficulty in offering a continuum of care and support, especially after changes in Quebec's health and social services and modifications to the administration of Non-Insured Health Benefits.

In spite of the disconcerting prevalence of diseases determined by contextual and structural factors, Aboriginal people have put forward various coping strategies and have shown resilience to deal with such adversities. One of the most prevalent forms of resistance has come from the reclamation of traditional values in a contemporary context. In order for these communities to heal, unique services have been created to break the isolation prevalent amongst Aboriginal people. Many communities have experimented with various forms of sharing circles to counteract the negative impacts of isolation through collective support and healing. Communication has been pointed out as one of the most crucial elements in maintaining a healthy community. The opportunity to express oneself and not repress thoughts and feelings can help avoid the unhealthy coping strategies such as substance abuse found in many Aboriginal communities. Over the last century various practices associated with specific cultural groups have been widely adopted and serve both as effective healing rituals for groups and as symbols of shared identity and affiliation. The elements of this common spiritual tradition include a focus on the Creator, the symbolism of the medicine wheel, the use of the sweat lodge and traditional plant medicines, pow-wow regalia dances, and drumming and tobacco offerings. The healing journeys of many Aboriginal people begin with one of these elements, which become important tools on their individual or collective pathways. Whether these traditional practices belong to their cultures or not, they represent an alternative form of resilience to those offered by regular clinical health services, which often fall short in answering the specific needs of Aboriginal people.

The MUAHC's Montreal Urban Aboriginal Needs Assessment represents a timely and important opportunity for Aboriginal organizations and their partners to consider how best to resolve some of the gaps and inequities in health service delivery in Montreal. In the short-term, this initiative intends to provide evidence-based recommendations to fill the gaps in the delivery of culturally sensitive and holistic health services to the Montreal urban Aboriginal population. In the long-term, such evidence will

support the creation of a fully functional holistic Aboriginal health center in Montreal. Hence, the current project will seek to answer the following questions:

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d. How can these health needs be met in light of Montreal's current context of services?

This project has been guided by a holistic understanding of health and illness. Although conceptions of health vary across Nations, we understand that "to be healthy or well means more than having a body that is free from physical ailments because the physical part of the self is connected to the other aspects of the self, each of which needs to be considered when thinking about the meaning of health or well-being." Hence, we have attempted to combine both health views (traditional and biomedical) with the measurement of delivery and quality of services. Our assessment has focussed on balancing different aspects of life as well as on health domains (areas of physical, emotional, mental, spiritual, social life) rather than on incidence and prevalence of diseases, which, in our opinion, facilitates the bridging of both views.

In total, 89 questionaires were used in face-to-face interviews with Montreal urban Aboriginal service users, addressing city living, self-determination, perceived barriers to services, perceived wellness and health, spirituality and connectedness to the world, perceived health needs, and perceived maternal and child health. A second questionnaire was used in a similar fashion with 94 service providers in Montreal tackling issues of governance, perceived wellness and health service delivery. Illness narratives were collected from 21 Montreal Aboriginal people, and a focus group was conducted with 19 service providers in order to identify solutions to gaps in services. A full description of the sample and methodological details are available in Annex I.

I. Montreal urban Aboriginal service users

1.1 Migration and sense of belonging

Most Montreal urban Aboriginal people who participated in the survey did not grow up in the city, having lived in Montreal for an average of twelve years. Only 18 (20.2%) stated they had grown up in Montreal. Amongst the reasons identified in the survey about what brought them to Montreal, most often one or two reasons were given. The most frequent included: education/school (36.4%), family (28.6%), and employment (15.6%). Twenty-two individuals (28.6%) said they had other reasons beyond those listed as options in the questionnaire. Other reasons included vacation, moving from one parent to another, relationships, adoption and life changes, among others.

Individuals who were raised outside of Montreal were asked if they planned to go back to live in the community where they grew up. Nine individuals (12.9%) said they planned to go back, 21 (30%) said they had no plans to go back, 29 (41.4%) were undecided and 11 (15.7%) said they could not go back. Forty-three participants had previously moved back to their communities of origin in the past. When asked about how close individuals felt to the place where they grew up, 68% said either they felt very close or fairly close. Few individuals (13.5%) did not feel close at all. Some persons surveyed displayed an interest in participating in local cultural or political Aboriginal community events, with 27.3% saying they always participated, 37.5% saying they sometimes did, 21.6% saying rarely, and only 13.6% saying never.

In the qualitative narratives, other reasons were mentioned as to why an individual will decide to leave his/her home community and move to an urban city. A common theme among those interviewed is the need that many Aboriginal people have to escape their communities' negative histories and start new/fresh lives where, as highlighted in the survey, there are more employment and education opportunities. Furthermore, as explained by one interviewee, urban cities are considered to be more tolerant of alternative lifestyles:

> *"There's a lot of people that are gay, homosexual or other, because it is not well accepted in the communities, hence often they can find freedom in Montreal." (First Nation woman, 25-44 y-o)*[1]

Large cities also offer more complete healthcare services and are a positive environment for artistic growth. The multicultural environment appeals to those who are curious about other cultures and intrigued by fast-paced urban city living.

While there are many reasons why an individual will choose to migrate from his/her home community, there are negative aspects to urban city living. There is great frustration with finding and accessing healthcare services and long waits and discrimination experienced in emergency rooms. The high cost of living and the level of stress in the urban setting were among the list of reasons why one would want to leave Montreal:

> *"Poverty, difficulties to find employment, often the difficulty in big cities to find a place to gather, where to have good relationship with peers, and if someone in addition to that carries psychological problems, it becomes an accumulation of difficulties that are not easy to surpass." (First Nation man, 45-64 y-o)*[2]

When reviewing the negative aspects of urban living, one should consider the fact that some Aboriginal people feel they do not have a choice but to live in an urban city and/or do not have a "home" community to return to. Some Aboriginal people were not raised in a community or were fostered by non-Native families and are left to face the struggles of living in a city that does not have the cultural resources to provide the proper

nourishment for a healthy mind, body and spirit. Recently arrived Aboriginal people have to deal with a different way of living, new cultural markers, and some may be taken advantage of because they do not know the way of life in Montreal. Historical (relationship between governments and Indigenous peoples) and intergenerational (from residential schools) traumas were also raised as difficulties that may make one more sensitive to such urban stresses.

In spite of the interest to come to Montreal for its cultural diversity, it was also mentioned that it may be difficult to find Aboriginal activities in the city or reminders of their presence:

> *"I often cite Pierre Isaac who once said in an interview that the thing that most shocked him when he arrived in Montreal, shocked him hard, is the complete absence of any trace of the first inhabitants in the city. No visible trace was there when he arrived, not one sign." (First Nation man, 45-64)*[3]

This issue of where one comes from and whether they feel as though they belong or not were sensitive subjects among those interviewed. When discussing Aboriginal origins, conflicting feelings such as pride, confusion, disappointment, embarrassment, struggle, and joy were expressed. Many individuals are proud to be Aboriginal yet struggle to stay connected with the culture. Others were raised to be embarrassed of their Aboriginal origins yet have grown to find pure joy in the traditional customs and ceremonies. For example, one interviewee explained:

> *"(My parents were) very disconnected from their own kind of Indigenous spirituality, but when I was younger I became interested in it." (First Nation man, 45-64 y-o)*

Some individuals interviewed expressed that it is a difficult road to take when one has to figure out their identity/origin and then become comfortable with it, especially when there are insecurities to overcome that have been planted since birth. For example, one interviewee was raised in an environment where her Aboriginal roots were not celebrated:

> *"From my mother's side, to be Aboriginal was not something celebrated, not something to be proud of. (…) My grandfather did not want to use his Aboriginal status to have access to services and all. For him, it was important to be able to work, feed his family, so that he would not need it, like everyone else." (First Nation woman, 45-64 y-o)*[4]

Regardless of whether one was raised in a community or brought up in a traditional Aboriginal setting or not, it was made clear that one's origin is not defined by environment but rather comes from within. For example, some individuals are dedicated to their Aboriginal origins yet were raised by a non-Aboriginal foster family and others who were raised in a community grew up wanting nothing to do with their Aboriginal origin. For some individuals, being Aboriginal has allowed them to find a community where they are welcomed. In other instances, a failure to speak one's Aboriginal language is means for rejection:

> *"I was born in Montreal, and my whole family was from Nunavik, the north and so. I was born and raised in Montreal, and I never got the real chance to completely you know or completely learn the language, the Inuktitut language. (…) They see me and they think I look Inuk, but when they talk to me, they see that I don't speak Inuktitut, and they sort of go like 'Oh, well, you're not Inuk, you're not Inuit'." (Inuit man, 25-44 y-o)*

Many of those interviewed expressed having a network of support where they felt as though they belonged, and this can serve as a health preventive measure. The make-up of each support network varied greatly between friends, family and partners.

> *"It's very easy to get depressed, and get into the hole with either drinking or drugs. When you have friends, it helps."*
> *(First Nation man, 45-64 y-o)*

1.2 Urban living

Regardless of whether one is homeless, living in a shelter or living in a home, the connection between health and living conditions was most frequently discussed by interviewees. Clean, safe and affordable living conditions allow for, or at the very least provide the potential for, good overall mental, physical and spiritual health.

Montreal urban Aboriginal people were asked if in the past year they had struggled to meet certain basic living requirements such as food, shelter, utilities, clothing, transportation and childcare. For food, though the majority (63%) said they were not struggling, 16.7% of individuals said they struggled a few times a year, 6% said they struggled monthly and 14.3% said they struggled more than once a month. For shelter, again more than half (67.5%) said they did not struggle, but of those who did, 21.7% said it was a few times a year, 6% said they struggled monthly and 4.8% said they struggled more than once a month. For clothing, 12.2% of individuals said they struggled a few times a year, and 9.8% said more than once a month. Transportation had 65.9% of individuals saying they did not struggle, 6.5% said they struggled a few times a year, 2% said monthly, and 4.3% said more than once a month. Of those with children, 87% said they did not struggle, 6.5% said they struggled a few times a year, 2.2% said monthly and 4.3% said they struggled more than once a month.

In the qualitative interviews, good living conditions were described as those that are clean and safe, make one feel happy, self-confident and organized:

> *"I live to be secure. My home is a place where I know I have like, my food at home, I have my animals, I have my bed... Now, everything's organized and clean, it's a safe place, not everyone knows where I live."*
> *(First Nation & Inuit woman, 18-24 y-o)*

At the opposite end of the living conditions spectrum, there are individuals who live in spaces that are overrun by drugs and alcohol, live with an abusive partner or have no home at all and are forced to stay in a shelter. While the conditions in an average shelter have gotten better (cleaner, better food, less violence), there is still an overwhelming sensation of negativity. Some believe a permanent address is the first step to healing and taking control of one's life:

> *"Especially if you don't have an address… you feel like you don't belong anywhere… when we moved to a nicer area, it changed my whole life."* *(Inuit woman, 18-24 y-o)*

1.3 Health needs

Health narratives shared by Aboriginal people who were interviewed for this study offer some of the context with which we can read the subsequent survey results. Indeed, some shared a vision of health where spirituality, whether in the form of Indigenous beliefs, non-Aboriginal faith, or a mix of both, plays an important role in understating health and wellbeing, as well as the origins of ailments. Connectedness to each other and the community, or to the earth, as well as equilibrium in all aspects of life (physical, emotional, mental and spiritual), are all necessary to ensure one's wellbeing. An Indigenous vision of health may not be shared by all who shared their

experiences, however, as stated below, some basic principles may be shared and beneficial to all people, non-Aboriginal people included.

> *"Health, the knowledge about traditional health, it is the spiritual knowledge, and ancestral knowing, the connection to the earth (…) We are a people, people connected to the earth. We live on earth. Surely we can be more or less connected, but we are still connected to the earth. These are universal concepts, but Aboriginal people have, in their origins, at their roots, knowledge so precious, in order to heal each other and contribute to the healing of other Aboriginals and non-Aboriginals. (…) Surely some things are different, but there something of an essence that is universal. The essence of how we recover vital heath, it is the same for everyone." (First Nation woman, 45-64 y-o)*[5]

Hence, the relationship with the physical body may be different for some as expressed in the following quote from a woman who had anaemia and needed a transfusion:

> *"I used to say: 'No, I don't want to, this is not my blood, I don't' want to, don't want it.' The doctor was nice, my specialist. He said: 'No, this will become your blood in 10 minutes." (First Nation woman, 65+ y-o)*[6]

The importance of traditional healing was hence highlighted in the narratives. It appears to be rather important in urban living where one may lose his or her roots and identity markers as expressed in the following experience of a consultation with a traditional healer:

> *"He takes your spirits, or he sees your spirits, and he can feel what you're feeling it's crazy. It's an awesome feeling. He told me, when I was doing drugs and alcohol, like he told me that, like, 'your spirits they ran away from you 'cause you're not taking care of yourself anymore. But I'm gonna get them back. But I'm gonna get them back for you, so that you stay grounded. But don't forget, you're not alone in this world'."*
> *(Inuit woman, 25-44 y-o)*

However, other Aboriginal interviewees have mentioned how traditions are in constant change and caution not to go "overboard".

> *"I find some people who are maybe kind of new traditions, they kind of go overboard. It's not necessary to smudge every time you have a meeting." (First Nation woman, 45-64 y-o)*

In addition, it was expressed that Aboriginal people do not differ in their health needs compared to the rest of the population; they only have a different culture:

> *"It's all the same needs, they all have the same needs. It's just a different culture. They all have the same needs, we see that no matter what Nation, what nationality, they all have the same needs." (Inuit woman, 25-44 y-o)*

In the quantitative survey, Montreal urban Aboriginal people who participated in the assessment were asked how they rated their general health. Overwhelmingly they rated their health as low (average of 3 on a scale of 0/poor to 10/excellent), with 24.7% rating themselves as being in poor health (zero on the 0-10 scale). When asked how often they felt they were in balance in the four aspects of their health (physical, emotional, mental and spiritual), most frequently individuals said they were somewhere at the midway between none of the time and all of the time (6 on a scale from 0-10).

When asked in the survey if they were seeking health/healing services for their concerns in the four aspects of their health (spiritual, physical, emotional, mental), 52% said they were. Of those seeking services, they felt services provided were not appropriate (average score of between 3 to 4 on a scale of 0/not at all appropriate to 10/entirely appropriate) and almost half (48.2%) felt that services they sought were not at all appropriate (0 on a scale from 0-10). In addition, they felt they were more often than not in control (average 7 on a scale of 0/no control at all to 10/control all the

time) over their lives. When asked to rate the importance of traditional Aboriginal spirituality from 0-10 in their lives, they rated it high overall (8 on average). Almost half (49.4%) of all individuals rated traditional Aboriginal spirituality as very important. Religion (e.g. Christianity, Buddhism, Islam, etc.), by comparison, was rated less important overall on the same scale (4.5 on average).

The survey also attempted to identify the perceived health needs (physical and emotional) in different health domains. Overall, when women and men were compared in their answers, women as well as 25-44 and 45-64 year olds had more concerns in the different health domains addressed. Overall, the most frequently perceived health need was problems with feelings of nervousness/anxiety, sadness or low or depressed mood within the previous month (59.6% of individuals). This health issue was amongst the most important concern for First Nations (63%), Métis (71%) and Inuit (56%) participants.

Other concerns mentioned by almost half of all individuals included bodily aches or pains in the previous month (49.4%), and issues with sleep within the previous month (49.4%). These findings are relatively high considering the difference in percentages to lower endorsed health concerns such as issues with hearing in the past month (only endorsed as a concern by 4.5%).

Within the past year, 75.3% of service users had smoked tobacco products such as cigarettes, cigars or pipes, 82% had consumed alcoholic drinks such as beer or wine, 34.8% had consumed drugs or other intoxicating substances such as solvents or prescription drugs for recreational use, and 36% had gambled in a casino, online or with friends. Of consumers, 44.8% of those who smoked in the past year were concerned, particularly amongst the Inuit (50%) that were surveyed. Of those who had consumed alcohol in the past year, 30.1% had apprehensions concerning alcohol cessation. Of the 34.8% who had consumed drugs, 29% felt concerned. The lowest concern within these health domains was for gambling cessation (15.6% of those who had gambled in the past year were concerned). Gambling was particularly a concern for women (80% of women) and 60% of concerns about gambling coming from the 45-64 years category. In general, important concerns were also expressed for injuries (70% of those having been injured in the past year).

Within the last year, 75% of those service users willing to answer had been sexually active. Of those who were sexually active, 96.8% said they had always given consent. Of the individuals who had sex in the past year, 36.5% were concerned about pregnancy and/or sexually transmitted infections (STIs).

Treatment or services sought for the three more frequent concerns were: 40.7% of people seeking services for nervousness/anxiety, sadness, or low or depressed mood within the previous month, 44.4% seeking services for bodily aches or pains in the previous month and 37.8% seeking services for issues with sleep within the previous month. Services most often sought for less frequent health concerns were injury (80%), oral health (63.4%), and breathing issues (60.9%). The least sought after services were for hearing concerns and gambling cessation (though fewer individuals had this as a concern). For both of these domains no individuals were seeking services. Fifty percent of concerns with hearing coming from the 18-24 year category (although there were few concerns for hearing overall), 54.5% of concerns about bodily aches coming from the 25-44 year category as well as from self-identified Métis.

When service users were further categorized into gender, age and Indigenous grouping, other particularities emerged. Differences between men and women were most noted with issues of self-care, of concern mostly for men (71.4% men). For individuals who identified as First Nations, the second highest concern was for diet issues within the previous year (58% of First Nation service users). This was also an important concern for Métis (71%) as well.

1.4 Health determinants and barriers in accessing services

Montreal urban Aboriginal people who participated in the survey were in general divided when they were asked about the satisfaction they had with the way health care is administered in Montreal. Approximately 50% stated they were unsatisfied (average score was 4.5 on a scale from 0/not at all satisfied to 10/entirely satisfied). A similar view was taken for satisfaction with the way the urban Aboriginal population is involved in the organizing of health and healing services in Montreal (average 4.35 on the same satisfaction scale).

The certainty of the importance of involving the urban Aboriginal population in organizing of health and healing services was overwhelming high within this surveyed population (8.9 on a scale of 0/not at all important to 10/very important). Fifty-four individuals stated outright that it was very important (rating importance as 10 on the scale mentioned above). When asked on an individual level how they felt health care in Montreal involved them in deciding what services they personally require, service users rated involvement as midway between good and bad. At the extremes, 16.5% rated very bad, while 15.2% measured it as very good. This being said, more than 60% of service users were below the midpoint (5 or less on a scale of 0/very bad to 10/very good). Similarly, on an individual level, they were asked about the way health professionals involved them in deciding what treatment/medicine they needed. Here, Aboriginal people who accepted to participate in the survey rated health professionals higher (5.6 on a scale of 0/very bad to 10/very good with 55% of individuals rating below 5).

Service users were asked to rate the appropriateness of services received for their concerns. The lowest rated were for self-care services (4.33 on a scale of 0/not at all appropriate to 10/entirely appropriate), and physical activity services (4.8 on the 0-10 scale).

Services for the three more frequent concerns (nervousness/anxiety, sadness, or low or depressed mood, bodily aches or pains in the previous month, and issues with sleep within the previous month) were well rated on a scale of 0-10 for appropriateness (7.86, 7.62 and 7.47, respectively). Similarly, the most frequent services sought (for injuries suffered, oral health concerns, and breathing issues in the past year) were well rated for appropriateness (7.64, 7.2 and 6.62, respectively on the scale from 0-10). For services addressing injury, differences amongst Indigenous groups are noticeable. They were again highly rated in the First Nations group (8.2 on a scale from 0-10) but low by Métis service users (4.5 on the same scale). In this case, no Inuit service users rated appropriateness of injury health/healing services. The appropriateness for other health domains was also rated differently depending on Aboriginal status for alcohol cessation services. First Nations service users rated services for alcohol cessation high (8.8 on a scale from 0-10) while Inuit service users rated it relatively low (3.2 on the same scale). No Métis service users rated appropriateness of alcohol cessation services (further details are provided in Annex II).

When asked about barriers to receiving health care services that they had experienced, 86.5% of service users stated at least one barrier they had

encountered. Of those who reported barriers, on average seven barriers were reported, with 26 barriers being the highest number reported by one single individual. Overall, women identified more barriers (60%) and gender specific barriers were also found. Notable differences were also found overall with the 25-44 year category having experienced the most barriers while attempting to access services (42%). More barriers were noted by First Nations service users (75% of all individuals encountering barriers) then both Métis and Inuit service users, although it should be noted that this was most likely because more service users identified as First Nations than Métis or Inuit. When taking into account the number of service users in each group, the Métis identified the most barriers to health services per capita with all service users within the group identifying at least one barrier.

The most frequently encountered barrier to health care was the waiting lists being too long: 63% of individuals, significantly identified by 45.5% of 25-44 year olds, and 37% of 45-64 year olds, as well as 56% of First Nations and 47% of Inuit participants, encountered this barrier. Other frequently mentioned barriers included: services being disconnected from traditional Aboriginal healing (45.2% overall), particularly identified as a barrier by 65% of 25-44 year olds, and 37% of 45-64 year olds, 40% of First Nations, and 29% of Inuit participants; difficulty getting traditional Aboriginal care (39.7%); and health care provided being inadequate (35.6%), particularly important to 25-44 year olds (65%) (for further details, consult Annex III).

Further particularities were identified when the population surveyed was broken down into gender, age and Indigenous group self-identification. Doctors or nurses not being available was a barrier particularly identified by women (95%), 25-44 year olds (65%) as well as the 45-64 year olds (37%). Trying to access services and being denied was identified as a barrier by 75% of 45-64 year olds. Women more frequently experienced the following barriers: health facilities not being available (80%); needed services not being available (82%); no childcare (100%); and consultation or treatment costs (94%). Men, on the other hand, identified the following barriers while trying to access services: no transportation (56%); choosing not to see a health care professional (59%); and fear of discrimination (61%). Inuit service users also had other important barriers within their group such as no identification papers and difficulty in getting Aboriginal care (29%).

In the last year, 30% of Montreal urban Aboriginal people who participated in the survey felt they had been treated badly by a healthcare professional. The most frequent reason given for poor treatment was because the individual was First Nations, Métis or Inuit (52%). Other reasons included spoken language (32%), physical appearance (24%), and social class (16%). When they had to compare their level of access to services to that of the general population in Montreal, 39.3% felt they had less access than the general population (see Annex IV for further details).

Many Montreal Aboriginal people will consult a traditional healer: 31.5% said within the last 12 months, 6.7% said every 1-2 years, and 19.1% said over 2 years ago, 32.6% said never. Access to traditional/holistic healing practices, such as natural medicines, healing circles and other ceremonies and the counsel of Elders seems feasible for most of them (75.9%). However, when asked how difficult it was to access such practices, over 20% said that it was very hard (rating it 0 on a scale from 0/very hard to 10/very easy) and 58.4% identified difficulties they faced when trying to access traditional/holistic healing practices: on average two to three difficulties were endorsed. The most frequently mentioned

difficulty was that they did not know where to go (56% of individuals), closely followed by needed services were not available (54%). Other noteworthy difficulties included no transportation (30%), transportation costs (22%), and not being able to take time off work/having other commitments (20%). When they were asked to rate the importance of having access to traditional/holistic healing compared to access to non-Aboriginal or mainstream health care services, Montreal urban Aboriginal people who participated in the survey stated overwhelmingly in favour of its importance (average score of 7.5 on a scale of 0/not at all important to 10/very important) and 44.6% said it was very important (10 on the scale of importance) (see Annex V for further details).

Overall, the narratives explained further how health can be determined by a number of essential elements. These elements, as defined by those interviewed, could either help to maintain one's health or make it better. Interviewees expressed how having access to basic life necessities such as clean living conditions, good food, and exercise are factors that determine whether one is healthy or not. Employment, income, self-confidence and support networks were also mentioned as factors. Support networks, in particular, were described as being "lifesavers". Having suitable access to healthcare services (traditional and non-traditional) was a recurring health determinant topic. As explained by a participant:

> *"There's not enough services, they're not accessible or known about, like they're not talked about enough."*
> *(First Nation man, 25-44 y-o)*

The barriers that are faced when seeking and receiving medical assistance are numerous. The majority of those interviewed expressed frustration with the public health system:

> *"For example, emergency rooms are understaffed and inefficient, the wait time is unreasonable, and patients have been victims of discrimination and stereotyping: I've had doctors who don't even look at me, I have receptionists who don't even look at me."*
> *(First Nation & Inuit woman, 18-24 y-o)*

Discrimination was also identified as a health determinant. It was further suggested that mainstream services in Montreal, since it is a multicultural city, should accept First Nations, Métis and Inuit peoples like any other ethnocultural members. Many of the participants who were interviewed explained that it is very difficult to find out what services are available, where they are, or if they exist at all. Language barriers are especially challenging for many Aboriginal people in Montreal who do not have access to a translator or are not perfectly fluent in both English and/or French. In addition, some service providers may have the misconception that all Aboriginal people are English speaking.

Another common barrier is that healthcare professionals are often uneducated when it comes to the services and products that are covered by an Indian Status Card. When faced with such barriers, many individuals will decide against seeking medical advice rather than deal with the aforementioned obstacles. The inaccessibility to psychiatrists and the absence of traditional healers/services and Elders were frequently discussed, as well as the barriers encountered when services are not centralized. In reference to mental health, one participant explained:

> *"I've seen my fair share of shrinks and stuff like that, but it was always very white. There was no Native. Like I had to really go searching." (First Nation man, 25-44 y-o)*

In the narratives, it was highlighted that it may sometimes be difficult to identify the reasons for being treated badly. Lack of knowledge from healthcare providers may be perceived as discriminatory attitudes. In another situation, long waiting times, being passed over or dismissed early, or misdiagnosis may have been perceived as a form of discrimination as in the following experience:

> *"A few times I've been misdiagnosed with something. Like they thought I had bronchitis, but I really had pneumonia. So I kept going back, and it could have gone into tuberculosis, but it didn't you know. It was not nice, I just think it's kind of, I don't know if it's because I'm Native, or I just have bad luck, or it's just the way it was at that time, in that day, in that particular hospital, or that clinic."*
> *(First Nation and Inuit woman, 18-24 y-o)*

1.5 Facilitators and potential solutions

When asked what things help make them well or healthy, service users overwhelmingly said good diet (74%), regular exercise (71%), good sleep/proper rest (58%) and good social supports such as family, friends, or coworkers (56%). Service users were asked where they go when in need of support. On average service users had between one and two main locations they went to when in need of support. The most frequent location was childhood city/community (42% of individuals endorsed this), then community centers in Montreal (37.5%), then schools in Montreal (17%) and finally work in Montreal (8%). Other locations were mentioned by 34 individuals (38.6%); these included: friends and family, and shelters in Montreal, among others.

The public system (hospitals, family doctors and CLSCs/clinics) provides adequate help and resources. The public system is not perfect (long waits in emergency rooms, discrimination, lack of family doctors, etc.) but it appears to address major health issues. Pharmacists are considered to be great facilitators by providing useful information and help.

> *"I think the pharmacist too is nicer than the clinics in the hospitals."*
> *(First Nation & Inuit woman, 18-24 y-o)*

The Native Friendship Centre of Montreal and its employees are regarded as invaluable resources, for they help direct people to appropriate healthcare providers as well as provide traditional healthcare services on site. Many of those interviewed expressed that they would be lost and in terrible health without the Native Friendship Centre of Montreal.

When faced with challenges, Aboriginal people who shared their experiences in the narratives offered other sources of strength and pride not identified in the survey. Exercise, balanced or traditional diet, and intake of vitamins were amongst the strategies mentioned to maintain good health or wellbeing. The ability to succeed in the city in caring for one's children was identified as one source of pride:

> *"What makes me proud? I guess to have been able to live in Montreal, work in Montreal and raise children here and they didn't turn out that bad."*
> *(First Nation woman, 45-64 y-o)*
>
> *"The only main motivation that I have is my children. Like I don't have any other motivation to keep… if it wasn't for them, I probably wouldn't, bad to say, but I probably wouldn't be here anymore. They are what kept me alive."*
> *(First Nation woman, 18-24 y-o)*

Healing may also come within oneself. As it is explained in the following quote, each person has the power to heal himself or herself:

> *"One thinks that the power of healing lies outside of us, but I believe that it is really inside ourselves. So bring it back, awake this healing power inside each person. This access to healing is universal. In connecting to oneself and feeling it, living it, experiencing it."*
> *(First Nation woman, 45-64 y-o)*[7]

Amongst solutions provided by those who shared their experiences for this project, it was suggested, amongst other things, to have one central center where one can receive federal payments without having to deal directly with the government. As a general suggestion, one person suggested that services should focus on positive reinforcement, push in the positive direction, as well as focus on health instead of disease and failure to improve:

> *"Instead of talking about the bad, tell me what I'm doing that's good, and maybe that'll help me go forward. Instead of pushing, putting me down, lift my spirits up. Tell me, 'Oh, you're doing a good job. Wow, it's been, it's been two weeks. Wow, you're doing well!' Instead of putting you down. In a lot of places they're like: 'Oh you're doing good, but there's this, this, this, this, this, and this, and this, and this, and this that you gotta work on.' And it's just like, wow, it's like overbearing, you know. There's always a but. And you hear: 'Oh yeah, I'm doing well, but…' 'Oh, there's this going on, but…'."*
> *(First Nation woman, 18-24 y-o)*

II. Service providers to the Montreal Aboriginal community

2.1 Urban living

Service providers also conveyed their opinions on the main challenges (barriers) faced by the Aboriginal population living in Montreal. Potential challenges suggested in the survey included, among others, education and training opportunities, funding, alcohol and drug abuse, control over decisions, housing, gang activity, culture and cultural activities, employment/number of jobs, health, food, justice, safety and security, and access to services. Of the challenges mentioned above alcohol and drug abuse was mentioned by many (81.9%) service providers. This presents a large contrast to other potential challenges, such as gang activity, which only seventeen service providers (18.1%) mentioned.

Overall, service providers agreed that challenges arose in most areas. Ten out of the twelve challenges were recognized as being a difficulty to the Montreal urban Aboriginal population, as they were identified by more than 50% of service providers. In fact, only issues of governance (control over decisions with 40.4%) and the above-mentioned gang-related activities were not mentioned by more than half of service providers.

Other challenges, beyond those listed above, mentioned by service providers included: intergenerational trauma, institutionalized racism, violence against Aboriginal women, access to traditional healing and teaching, cultural disconnectedness, isolation, and identity issues resulting from adoption.

2.2 Health needs

When asked about Montreal's urban Aboriginal clients they had provided services to within the last year, service providers found the most frequent difficulty this population encountered

was with feelings of nervousness/anxiety, sadness, or low or depressed mood (8.45 on a scale of 0/never to 10/very often).

Other health domains that they perceived as being of concern for their clients (above 7 on a scale of 0/never to 10/very often) included problems in obtaining balance in the four aspects of life (physical, emotional, mental and spiritual), with personal relationships, with alcohol consumption and recreational consumption of drugs or solvents, in the maintenance of a balanced diet and accessibility to traditional foods.

The lowest concerns (under 4 on a scale of 0/never to 10/very often) from service providers on the list of health domains were for: child/youth physical activities (e.g. exercising); difficulty in seeing and recognizing a person across the road (i.e. from a distance of about 20 meters); difficulty in hearing a person sitting across from them (1m away); and child/youth immunization (2.71 on a scale of 0/never to 10/very often) being the lowest.

2.3 Barriers in accessing services and their delivery

Service providers to the Montreal urban Aboriginal community were asked about health service delivery in Montreal, and services they were aware of that were specific to the urban Aboriginal population. Services mentioned by over 50% of service providers included: alcohol and drug counselling, employment centers, youth centers, Aboriginal legal services and traditional/healing services.

Concerns over the gaps in culturally adapted, long-term rehabilitation centers were specifically discussed in the focus group, as some service providers worked with a population with substance misuse or abuse. The zero tolerance policy in many Aboriginal-specific facilities gives little options to alcohol and drug consumers. It was reported that some Aboriginal people would stop consuming to get into a shelter but the withdrawal may bring important health risks. Services were also identified as lacking as well as access to harm-reduction material in the western part of downtown or outside of that area as urban Aboriginal people are being more and more displaced outside the center because of developmental projects or police interventions.

On the other side, only 3.3% of service providers mentioned knowledge of services for speech/language pathologists. Other services of which they were less aware of (below 10%) were speech needs diagnosis and treatment (4.4%), smoking cessation programs (8.9%), FASD assessment and diagnosis (8.9%), mental health treatment programs (8.9%), and mental health treatment facilities (7.8%). Eleven service providers mentioned other services they were aware of; these included: peer support advocacy, Aboriginal-specific shelters, street patrol, and student services (CEGEP and university), among others.

Service providers surveyed also had been a witness or had heard of the poor treatment of an urban Aboriginal person by health care providers in Montreal in the last year. They most often said it was the result of being First Nations, Métis, or Inuit (81.7% have this as a reason for poor treatment). More than 50% said that poor treatment may also be explained by discrimination due to lack of money or financial situation, social class or spoken language (see Annex VI for further details).

The lowest reason mentioned in the survey was sexual orientation (listed by only 13% of service providers who had witnessed or heard of poor treatment). Approximately 14% of service providers mentioned other reasons for poor treatment, among others: gender dysphoria, mental health issues (i.e. not being “normal”), drug use history, sex work history and previous disrespectful behavior towards medical staff.

Similar issues were raised in the focus group with service providers that explain further these quantitative results and their impact on the access and delivery of services. Amongst barriers identified by participants, feeling discomfort because of language or cultural misunderstanding between Aboriginal people and mainstream health workers was reiterated. Some participants reported personal experiences where mainstream healthcare providers carried preconceived ideas about Aboriginal people, and felt judged by them. Services offered only in French, fear of not being understood, fear of people talking behind their backs or overall mistrust of doctors seem to render difficult the accompaniment provided by participants through an already difficult to navigate and "intimidating" urban mainstream health system. In addition, language barriers make it difficult for a patient to express his or her ailment in his or her second or third language and, in return, may hinder that person's understanding of directions given by doctors even if presented in lay language. This miscommunication also interferes in convincing the person to go to mainstream services. Hence some participants often worked as mediators between the Aboriginal person and the mainstream health care provider. Furthermore, the absence of a Régie de l'assurance maladie (RAMQ) card will limit or render difficult the access to public mainstream services.

When service providers were asked in the survey to rate the level of access to health services available to the urban Aboriginal population compared to the general population in Montreal, an overwhelming amount of participants (75.9%) said that Aboriginal people has less access than the general population. When rating access to traditional/holistic healing practices, such as natural medicines, healing circles and other ceremonies, and the counsel of Elders for the urban Aboriginal population of Montreal, service providers' ratings were low (average of 2.88 on a scale from 0/very difficult to 10/very easy) with 28% of service providers rating it outright very difficult (0 on the same scale). When asked what difficulties they perceive the urban Aboriginal population of Montreal may be facing when trying to access traditional/holistic healing practices, service providers most often mentioned that individuals feel services are disconnected from traditional values (88.8% of service providers chose this as a difficulty). Other highly mentioned difficulties included needed services not being available in their area (73%), cannot afford transportation costs (65.2%), unable to arrange transportation (61.8%), and their clients were too shy to go (60.7%). A lesser-mentioned difficulty included feeling that the traditional healer's medicine or equipment was inadequate (7.9%) (see Annex VII for further details).

The importance of culturally adapted services was also highlighted in the focus group with service providers. Indeed, according to participants, the attitude of treating everyone the same undermines the specific history some Aboriginal communities might have experienced, such as intergenerational trauma. This collective trauma translates into a search for an identity, cultural markers and has mental health outcomes. It was also highlighted that some Aboriginal people face a combination of health problems that are not addressed in Aboriginal-oriented services. Services are needed to address more than one health problem at a time (consumption problems, HIV, Hepatitis C, suicide prevention and intervention) as well as health determinants such as basic socioeconomic needs. Unfortunately, funding received by service providers who participated in the focus group is allocated to specific programs.

Additionally, service providers were asked about the appropriateness of services offered (rated on a scale of 0/not at all appropriate to 10/entirely

appropriate) for each health concern. Low rated services for appropriateness for concerns brought forth were gambling cessation, child/youth Aboriginal education, and accessibility of traditional foods (2.79 on a scale of 0-10) as the lowest in their appropriateness. Overall, results from the survey show that the importance of the concern with a health issue was met with a lower rating in the overall appropriateness of services provided (5.88 on a scale of 0/never to 10/very often, compared to 4.91 on a scale of 0/not at all appropriate to 10/entirely appropriate). It illustrates how, in general, services to the Montreal urban Aboriginal population appear to be inadequate in spite of the importance of the need. When comparing the most frequent concern with the appropriateness of the services, certain health concerns displayed an obvious lack in service provision (measured as a high level of concern for the health problems with a low score in appropriateness). An example of this can be seen by looking in depth at the results of the most frequent concern brought forth: nervousness/anxiety, sadness, or low or depressed mood. On scales from 0-10, frequency of concerns rated high (8.45 on a scale from 0-10), while appropriateness of services was rated much lower (5.21 on a scale from 0-10). Another example is the lowest rated service in terms of appropriateness: accessibility of traditional foods (2.79 on the scale of appropriateness). It too was a highly mentioned concern amongst service providers. This is another gap between needs and services available that is shown within the health domains sections (see Annex VIII for further details).

The focus group with service providers yielded additional concerns in access to services. Access to timely and affordable medication was also identified as lacking. Although some medication is covered by the government-issued Indian Status Card or James Bay and Northern Quebec Agreement, not all pharmacists are informed of or understand the rights associated with the cards, or are not willing to comply. It was reported that some pharmacists have asked the person to file their own reimbursement directly with the government, which can be a fastidious task and may present delays in receiving payments. It was reported that some Aboriginal people may prefer to go to their communities to get their medication instead of going through the long process of asking for reimbursement. This situation raises another issue: that of finding transportation to get to the community, which may become difficult for newly arrived urban Aboriginal people who do not benefit from an established social network to support transport.

2.4 Strengths in the Montreal urban Aboriginal population

The main strengths of the Montreal urban Aboriginal population were also rated by service providers. On average only four strengths of a list of thirteen potential answers were endorsed. The highest percentages of endorsements by service providers, in order, were social connections (67% of service providers), traditional culture (59.3%) and family values (51.6%). Rarely endorsed (by less than 10% of service providers) were strong economy, natural environment and the lowest (endorsed by only one organization) was low rate of suicide, crime and drugs.

2.5 Health services structure and solutions suggested by service providers

When rating the way health care in Montreal involves the urban Aboriginal population in deciding what services it provides and where it provides them, service providers within Montreal rated urban Aboriginal involvement low (on average 2.96 on a scale from 0/very bad to 10/very good). Nearly 80% of service providers rated urban Aboriginal involvement below the average

score. Similarly low ratings were given for the way that health professionals involve the urban Aboriginal population in deciding what treatments/medicine they need as well as satisfaction with the way health care is run in Montreal for the urban Aboriginal population and satisfaction with the way the urban Aboriginal population is involved in the organizing of health and healing services in Montreal (2.88, 2.54 and 3.44 respectively on a scale from 0/very bad to 10/very good).

In contrast, service providers rated the importance of having the urban Aboriginal population involved in the organizing of health and healing services in Montreal as being very important (9.48 on a scale of 0/not at all important to 10/very important). Compared to the importance in accessing mainstream services, access to traditional/holistic healing was rated very high (9.09 on a scale of 0/not at all important to 10/very important). Service providers evaluated as highly important that Montreal's urban Aboriginal people receive services from their communities of origin (e.g. health, education), if their community of origin is not Montreal (8.83 on a scale from 0/not at all important to 10/very important). Over 90% of service providers rated it as above a 5 on this scale.

For the questions of importance of Aboriginal services existing in addition to non-Aboriginal ones in Montreal, service providers identified all existing services as important, the most important being Aboriginal addictions programs (9.56 on a scale from 0/not at all important to 10/very important). Other services, with ratings of 7.5 or higher, included Aboriginal child and family services, elementary and secondary schools, colleges and universities, child care or daycares, employment centers, health centers, and housing services.

Potential solutions were identified in the focus group with service providers. To fill in the gaps in services, service providers have developed partnerships, formal and informal, between community-based organizations, referencing between each organization, and accompaniment to mainstream healthcare services. Because of the nature of funding opportunities, they will combine funds from government, private organizations, foundations and fund raising.

Participants also identified the need to have a place free of discrimination where one can consult that is not a service dedicated to people with specific needs (e.g. homeless). Other contacts and partnerships with community-based organizations can be maintained through service providers' participation in community events in Montreal or offering computers to chat with families in the community or a toll free number for long distance calls. In order to facilitate healing, collective activities must be developed to break the isolation experienced by some urban Aboriginal people now living in Montreal. For example, art and art promotion or activities can provide such opportunities, as can reaching out to people where they are and offering adapted services to each person, to his/her own rhythm and need. Integrating the medicine wheel, providing information in the users' languages, as well as adapted references, cultural development activities, reinforcement of culture and tradition, leadership skills and training, communication skills, working in teams, values, independency, housing programs, a dental clinic and mental health services, can also facilitate healing.

All these activities provide a sense of connectedness that is part of the healing process. Once such a connection is made through community activities, the Aboriginal person can then be connected with mainstream services. Hence, providing an adapted response to the

variety of experiences of such a diversified population as the Montreal urban Aboriginal population is what would be considered good health care according to service providers. It was discussed that the creation of a holistic health center, with a Native therapist and traditional healing, would adequately address a full array of issues, a breadth of users' profiles and families, as well as having everything under one roof in order to deal with previously identified underlying issues. Such a center, if it uses sound cultural competence, may also address intergenerational trauma and find ways to allow for restorative justice in cases of violence. A walk-in center was suggested as a solution and a first step to connect Aboriginal people to the mainstream services at a later stage. Governance of such a clinic would need to be grassroots, such as that of Anishnawbe Health Toronto, and could be run by the community as is done with the Pointe-Saint-Charles community clinic in Montreal.

The political support of the NETWORK was suggested as leverage to negotiate with potential funders as well as with the Agence de la santé et des services sociaux or the Ministère de la santé et des services sociaux, with Aboriginal and non-Aboriginal partnerships, as well as in doing outreach with neighbouring citizens to promote the added value of such a center and make it more socially acceptable. Awareness raising was identified as being needed to offer a space in Montreal where Aboriginal people can go once they are well; a space with Aboriginal restaurants, language classes, etc.

III. Maternal and child health

3.1 Service users' perspective

A specific section in the survey addressed maternal and child health. Within the group of service users interviewed, 44.9% had been pregnant in the past. The average number of pregnancies was between two and three, with the highest number of pregnancies being six. On average, 9.6 years had passed since the last pregnancies. Within this group, 65% of mothers' last pregnancies happened in Montreal. Twenty-six mothers sought maternal care while pregnant in Montreal. Of those who sought maternal care, 25 (62.5%) visited a doctor during their pregnancy (average 9 visits over the course of the pregnancy). Twelve women (30%) visited a nurse/midwife (average of 10 visits over the course of the pregnancy), and three mothers (7.3%) sought maternal services from an auxiliary nurse/midwife (average of eighteen visits during their pregnancy). One mother sought services from a traditional birth attendant (three visits over the course of the pregnancy). The primary people assisting with delivery were most frequently doctors and nurses, then the father of the child or another family member (siblings, step-parent, cousins, etc.). Child delivery happened most frequently in the hospital or a maternity house (62%).

Mothers were asked if they had access to methods to space pregnancies. Of those who gave responses, 75% said they did have access to such a method. Another 80% said they had access to abortion services.

Amongst women and men who answered the child and maternal health section, 17% said they had not come up against barriers while pregnant, while 21.3% said they had not experienced barriers while seeking services for their child (children). Of those who did come up against barriers to receiving health care (83%), the largest

barrier (47.2% of the individuals for this section) while pregnant was difficulty in getting traditional Aboriginal care (e.g. healer, medicine person or Elder). The second highest was feelings that services were disconnected from traditional Aboriginal healing (41.2%). Third were the waiting lists being too long (35.3%). Concerning barriers when seeking health services for a child/children (78.7%), the most important barrier was again feelings that services are disconnected from traditional Aboriginal healing (38.1%). Second highest (33.3%) were both feeling that health care provided was inadequate and difficulties getting traditional Aboriginal care (e.g. healer, medicine person, or Elder).

Mothers were asked about any health concerns they may have had during their last pregnancy and the appropriateness of the health/healing services they received while in Montreal. When asked if during their last pregnancy they had smoked any tobacco products such as cigarettes, cigars, or pipes, 31.1% said they had smoked, and of those who did 78% said they were concerned by their smoking. Although this was a concern, none had sought health/healing services for smoking cessation. When asked if they had consumed a drink that contains alcohol (such as beer, wine, etc.) during their last pregnancy, 20% said they had, although only three of these individuals were concerned by their drinking, and only one individual had sought services for their concern. This individual rated the appropriateness incredibly low (1 on a scale of 0/not at all appropriate to 10/entirely appropriate). Mothers were asked if, during their last pregnancy, they had consumed drugs or other intoxicating substances (such as solvents, prescription drugs) for recreational use. A minority (6.6%) said they had consumed drugs or other substances, and all of these individuals had been concerned about their consumption. Still, only one individual had sought heath/healing services for their concern, and the person rated the appropriateness of services to be moderate (5 on a scale from 0-10).

Multiple women (24.4%) said they had difficulty in maintaining a balanced diet during their last pregnancy, although only two had sought services for their concern. The two individuals who had sought services had different experiences; one rated the appropriateness low (2 on a scale of 0-10) and the other rated services higher (7 on a scale of 0-10). A similar concern within the group of mothers was difficulty in accessing traditional foods (also 24.4%), although no individuals had sought services for their concern. Finally, mothers were asked if during their last pregnancy they had difficulty exercising, to which 20% said yes. Of those who had difficulty, only one had sought services and she felt they were appropriate (9 on a scale of 0-10).

Caregivers (24 individuals within the group who answered this section) were asked how many children they had under their care and their relationship with the child/children. On average, caregivers reported between one or two children under their care, and all but one were the birth parents (one individual was a grandparent).

Caregivers were asked about health and services concerns they had with regard to their children. For example, caregivers were asked if, in the last year, they had difficulty providing a balanced diet to the child (children) under their care (20% said yes, two had sought services which one rated high on a scale from 0-10 and another rated low on the same scale). Other concerns highlighted were 41.7% of caregivers having issues with accessibility to traditional foods in the past year (none sought services as a result of their concern), 25% having difficulties providing enough food for their child or children (one sought services and rated them entirely appropriate – 10 on a scale from 0-10), and 16.7 % having concerns within the past month, that their child (children) had

difficulty with his/her vision, hearing, or had problems with his/her mouth/teeth (three caregivers had sought services, and overall services were rated highly appropriate (8.5 on a scale from 0-10). Caregivers were also asked if, in the last month, their child/children had difficulty exercising. No caregivers had this as a concern. Almost all (91.7%) of children under caregivers care had received routine vaccinations/immunizations.

Five caregivers had children who had been injured in the past year. When asked about the types of injuries children had suffered, there was one injury to an internal organ, two dental injuries, one major sprain/strain, one hypothermia/frostbite, four minor cuts, scrapes or bruises and one repetitive strain. Locations of these injuries varied: two happened while playing sports or doing physical exercises, two happened while doing leisure activities or hobbies, and one happened while doing chores around the house.

Caregivers were asked if their children were currently attending school (57.7% said yes, although some of the caregivers had children who were out of high school) and if their children spoke an Aboriginal language (54.2% said yes). When asked about how important it was that their child (children) learns their traditional Aboriginal language, on average caregivers felt it was incredibly important (above 8.5 on a scale of 0/not at all important to 10/very important). Similarly when asked how important it was to them that that their child (children) take part in traditional cultural events (including powwows, sweat lodges, and community feasts, among others), caregivers felt that it was incredibly important (average of 8.9 on a 0-10 scale). (See Annexes IX & X for further details)

3.2 Service providers' perspective

On average, there appear to be frequent maternal health concerns and some inappropriateness in the delivery of services (on scales from 0-10, 6.15 for frequency versus 4.86 for appropriateness of services). Children's Aboriginal education was a frequent concern in the Montreal Aboriginal population according to service providers. (6.05 on average). With this in mind, it had one of the lowest rated appropriateness of services of all health concerns even outside of the child/maternal health domains (3.65 on the 0-10 scale for appropriateness).

Child immunization and child physical activity appeared to be of less concern compared to other health problems. Again, participants rated the appropriateness of services provided in that domain as overall low ratings (5.69 and 4.86, respectively, on a scale of 0/not at all appropriate to 10/entirely appropriate).

Youth centers and child and family services were most commonly known by service providers (57.8% and 48.9% respectively) as services available to the urban Aboriginal population. Few service providers knew of Aboriginal-specific services of pre/post natal care services, with only 12.2% of service providers being aware of them.

CONCLUSION

The Montreal Urban Aboriginal Health Committee (MUAHC) initiated this health needs assessment to answer four questions in support of its effort to establish a fully functional holistic health center in Montreal. Results show some convergence in the concerns between the survey, narratives and focus group with the Montreal urban Aboriginal community and with service providers.

The first two questions to be answered by this assessment are the following:

> (1) What is the nature and the importance of health needs (spiritual, physical, emotional, mental) and health services/healing needs for the Montreal urban Aboriginal population?
>
> (2) What determines the health needs of the Montreal urban Aboriginal population?

Many members of the Montreal urban Aboriginal community that were interviewed or surveyed were not born in Montreal nor did they have plans to go back to their home communities. However, they maintained close ties to their communities and participated in their communities or in overall Aboriginal cultural events. Even if Montreal was perceived as a city offering possibilities to move forward, it also presented a series of challenges that may explain some of the health concerns identified by both service users and service providers. Montreal is a culturally diverse city, which can make it difficult for an Aboriginal person to establish roots, or at least, find markers in order to ground him/herself. This is particularly important to retain as a health determinant since traditional healing and finding a "home" were identified as key elements in maintaining one's health and wellbeing.

Even if equilibrium in all aspects of life was rated high by the surveyed Aboriginal community, their general health was however rated low. For those who did manage to find traditional services, they appeared to be dissatisfied with them. In the narratives with community members and in the focus group with service providers, it was expressed that some people preferred to go back to their home communities for traditional healing services, but this brings forward the difficulty of finding transportation to leave Montreal.

Most importantly, mental health concerns were identified by community members as well as service providers (qualitatively and quantitatively) as one of the most important concerns for First Nations, Métis and Inuit people and mental health was one of the most frequently sought services. One may question if the additional concerns for tobacco, drug and alcohol consumption, the urban stresses, or more deeply rooted historical injuries, may contribute to the perpetuation of such ailments. The importance given to sleeping difficulties, and to a certain degree, bodily aches and pains, further supports this hypothesis.

A third question this survey attempted to answer was:

> (3) What determines the response to expressed health needs by the Montreal urban Aboriginal population?

Half of Montreal's Aboriginal people interviewed, as well as service providers, are not satisfied with how services in Montreal are administered, and felt that Aboriginal people neither were involved in the management of health services, nor as partners in their relationship with healthcare providers. Difficulty in accessing services and experiences of discrimination in mainstream services were raised, especially finding appropriate responses to mental health, drug and/or alcohol rehabilitation needs. However, when people did manage to access services for most important concerns, they appear to be satisfied, even if the lack of cultural sensitivity was highlighted.

This satisfaction level can be most contrasted within the barriers experienced by the Montreal Aboriginal community while attempting to access, once consulting, services. Most had experienced some form of barrier, especially in the case of women and 25-44 year olds who had difficulty finding doctors and nurses, as well as in men who preferred not to seek services possibly because they feared discrimination. Inuit on the other hand had encountered difficulties because of lack of identification papers. Knowing about or accessing traditional healing services was also a concern, especially during pregnancy, delivery or for young children. Although long waiting lists are a general difficulty in Montreal mainstream services, other barriers are of importance such as services being disconnected from traditional Aboriginal healing.

Montreal Aboriginal people who were surveyed further identified experiences of poor treatment based on their Indigenous origins. Social class and language discrimination were not far behind as a reason for bad treatment. This situation supports what was expressed by services providers in regards to the lack of knowledge or the presence of preconceived ideas and discrimination in mainstream services. As explained in the focus group, this situation has a negative impact on levels of trust some Aboriginal people may have towards mainstream services. It further undermines the already fragile patient-doctor relationship, and hinders adherence to treatment. Finally, it may limit further and future consultations by Aboriginal people.

The final question this assessment attempted to answer was:

> (4) How can these health needs be met in light of Montreal's current context of services?

Montreal urban Aboriginal people that were interviewed in this survey identified the importance of having a good social network as the key to maintaining good health and wellbeing. Hence, connection to their communities and origins are important, but also a challenge as stated earlier. A healing center, such as the one planned for by the MUAHC, should therefore take into account this need to reconnect with one's culture and people by providing family and social support as well as access to traditional foods.

Mainstream services appear to meet the overall needs of the community, although they do not provide a sufficient understanding of the traditional response to concerns. Although services provided to the Montreal urban Aboriginal community presented many barriers, they nonetheless appeared to meet the overall needs of the population. Challenges remained however in the access to mainstream services, as well as in their cultural appropriateness and integration of traditional healing. Hence, educational campaigns on Indigenous health issues and vision of wellbeing, history and culture appear to be needed. In addition, service providers seem to know little about how to promote health and support the strength and resilience inherent to Montreal Aboriginal people. Future training of mainstream service providers should also focus on this issue, especially in the reinforcement of cultural connectedness, and Indigenous identities.

The next step for the MUAHC is to use these conclusions to support its recommendations and design of policy briefs to make the holistic health and healing center a reality for the Montreal urban Aboriginal community. In the design of a future health center, the MUAHC will need to take into account gender, age and Indigenous groups' differences, in particular women's health where the most concerns were identified (e.g. midwifery, access to traditional foods). If women and children are the future of this community, efforts to reconnect with the community and culture should start from the womb. The involvement of the Montreal urban Aboriginal community, in all its diversity, is a key to its success. They could contribute to bridging traditional and mainstream services.

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ANNEX I

SAMPLE DESCRIPTION AND METHODOLOGICAL DETAILS

SAMPLE SELECTION CRITERIA

a) Urban Aboriginal service users: Inclusion: self-identified Aboriginal person, 18 years and older, who are staying or living in Montreal for more than 6 months (in order to exclude transient populations). Exclusion: transient population who have stayed in Montreal for less than 6 months. b) Service providers/community-based organizations: Inclusion: urban Aboriginal people must be amongst their targeted population.

RECRUITMENT METHOD

Using snowball or network-based sampling techniques, most participants were recruited through contact with the Montreal Urban Aboriginal Community Strategy NETWORK: publicities in the NETWORK's newsletter, contacting the NETWORK's members for their help in recruitment. In addition, for urban Aboriginal peoples (service users), the research team asked permission to accompany outreach workers of organizations, that are part of the NETWORK, to directly recruit potential participants in their milieus.

QUALITATIVE SAMPLE DESCRIPTION

Illness narratives participants (N=21)*	
Gender	**10**
Women	1
Men	9
Age	**20**
18-24	3
25-44	6
45-64	10
65+	1
Aboriginal Status#	**21**
First Nation	15
Métis	1
Inuit	5
Have children	**20**
Yes	7
No	13
First/Mother tongue	**20**
English	6
French	8
Inuktitut/Inuit	3
Mohawk	1
Micmac	1
Ojibwe	1

* Missing information for one participant.
# One participant had two self-identified statuses.

Focus group with service providers (N=19)

Position	Years at work	PopulationTargeted	Main Services	Source of Funding	Date of creation
Owner\CEO	2,5	Aboriginal	Fitness & wellness	various	2010
Director	2	Aboriginal	Fitness & wellness	various	2010
Founder	1	Aboriginal artists	Promotion (arts)		2011
Director	5	Frontline worker	Training, conference	SAA	2011
Community organizer	3	General	Health and social services	MSSS	1968
Director	4	Aboriginal (homelessness)	Shelter	Government	2004
Coordinator	2	Aboriginal artists	Art-community space	n/a	2009
Outreach	0,58	General-sex workers	Outreach, support	Public Health	1996
Agent de suivi	0,66	Aboriginal	Work training	Emploi Québec, Service Canada	
Coordinator	3,5	Aboriginal students	Student support	Student fees	1997
Outreach	1,5	General-homelessness, drug users, sex workers	Outreach, accompaniment, referrals	Public Health	1989
Educator	0,08	Aboriginal families	Support, referrals	Government	2009
HRA, recruitment	20	General	Youth protection, foster care	Government	
Court worker, counsellor	15,5	Aboriginal	Judicial	Justice Canada	1980
Outreach	23	Aboriginal-homelessness	Outreach	Federal government	1999
Coordinator-youth	2	Aboriginal-youth	Referrals, leadership development	Federal government	1999
Outreach	16	Aboriginal-homelessness	Outreach, welfare	Federal government	1999
Animator	20	Aboriginal-homelessness	Referrals	Federal government	1999
Coordinator-council	3	Aboriginal women in distress	Housing, food	Federal government	1986

QUANTITATIVE SAMPLE DESCRIPTION

Service Users (N = 89)

Gender (% female)	**62**
Age (average years)	
Age (%)	
18-24 years	17
25-44 years	39
45-64 years	42
65+ years	2
Aboriginal Status (%)	
First Nation	71
Inuit	19
Métis	8
Self Identifying	1
First Nation and Métis	1
Birth Certificate or ID Papers (%)	**91**
Health Card (%)	**92**
First/Mother Tongue (%)	
English	39
French	20
Inuktitut	16
Cree	4
Innu/Montagnais	8
Mohawk	2
Other Indigenous Languages	11
Highest Level of Education (%)	
No Degree	20
High School	40
CEGEP	12
University	27
Marital Status	
Single	73
Married/Common-law	12
Divorced/Legally Separated	10
Widowed	2
Living Situation	
Homeowner	6
Renting Apartment/House	65
Renting Room	7
Living with Friends/Family	7
Temporary Shelter	12
Living on Streets	2
Children (% yes)	**60**
Number of Children (average)	**2**
Custody of Children (%)	
Both Parents	28
Full Custody	15
Shared Custody	7
Foster care	11
Adoption	11
Other	28
Personal Annual Income (%)	
Under $10 000	51
$10 000 to $29 999	25
$30 000 to $59 999	19
$60 000 to $99 999	5

Service Providers (N = 94)

Gender (% female)	**80**
Age (average years)	**40**
Length of Employment (average years)	**6**
Member of Professional Association (%)	**22**
Health Services Provided (average)	**4+**
Referrals Required (%)	**22**
Appointments Required (%)	**34**
Service Languages Offered (%)	
English	100
French	83
Inuktitut	20
Cree	9
Innu/Montagnais	5
Mohawk	5
Other Indigenous Languages	6

QUALITATIVE AND QUANTITATIVE TOOLS

Illness Narratives: Questions were selected and adapted from the McGill Illness Narrative Interview (MINI) schedule, the Urban Aboriginal Peoples Study (UAPS) and the Regional Health Survey (RHS). The MINI can be used to elicit information within cultural contexts on the temporal narrative of symptom and illness experience, attribution of meanings and modes of reasoning related to the illness experience, help seeking behaviours and pathways to care, treatment experience, and impact of the illness on identity, self-perception and relationships with others. The UAPS has been used in eleven Canadian cities to survey urban realities such as urban Aboriginal peoples' communities of origin; Aboriginal cultures; community belonging; education; work; health; political engagement and activity; justice; relationships with Aboriginal and non-Aboriginal peoples; life aspirations and definitions of success; and experiences with discrimination. The RHS was conducted across ten regions in Canada, surveying participants in over two hundred First Nations communities on themes ranging from community wellness and traditional culture, to diabetes, personal wellness, general health, housing, etc.

Focus Group Discussion (FGD): FGD examined appropriateness and effectiveness of the institutional response and potential solutions to Montreal urban Aboriginal health needs.

Quantitative Tools: Due to the diversity of experiences within the Montreal urban Aboriginal populations and the specificity of their Indigenous conceptions of health, we have chosen to construct an instrument by selecting and adapting questions from established tools that have proven to be culturally sensitive or have been used in research with Canadian First Nations, Métis and Inuit. Indeed the World Health Survey (WHS) 2002 Individual Questionnaire has been used in more than 70 countries. The Regional Health Survey (RHS) and Urban Aboriginal Peoples Survey (UAPS) have been used within the Canadian urban Aboriginal population and Aboriginal communities. Each survey uses different types of questions and response categories, such as closed-ended questions with categorical choices, ordinal choices, numerical choices or open-ended questions. Because of the lack of specific urban health surveys and MUAHC specific objectives, we have constructed 2 syncretistic surveys, one for a) Aboriginal health service users and non-users, b) service providers and community-based/civil-society organizations. Questions were added to the sections on perceived wellness and health and perceived health needs section to provide continuous data on the satisfaction of services received in relation to each of the identified needs. Finally, questions related to the importance and the challenges regarding certain services were also transformed in a similar continuous manner.

Distribution of Instruments: Each interview, whether qualitative or quantitative, were conducted in a face-to-face meeting with participants by the research teams who received prior training. A compensation of 20$ was provided for participation in qualitative and quantitative interviewing, as well as in the focus group discussion. Written informed consent was provided by each participant.

ANALYSIS

Illness narratives were transcribed verbatim for content analysis using Atlas-Ti v4.1, which allowed coding of the narratives following a coding manual developed on the basis of our theoretical framework and original questioning. Focus group discussions were not transcribed but content analysis followed the same coding manual. Particular attention was given to city living and migration experiences, health needs and wellbeing, help seeking strategies, resources and coping mechanisms, barriers to services and determinants of health and potential solutions to such limitations. Statistical analyses were conducted using SPSS statistical software (version 20.0, SPSS Inc, Chicago, Ill). Demographic characteristics and descriptive analyses for both service providers and service users were analysed by chi-square (categorical variables) or Fisher's exact test (dichotomies), and analysis of variance (ANOVA) for interval variables.

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ANNEX II

SERVICE USERS - HEALTH CONCERNS AND APPROPRIATENESS OF SERVICES

Sample question

How often do you feel that you are in balance in the four aspects of your health (physical, emotional, mental and spiritual health)?

0 1 2 3 4 5 6 7 8 9 10 DK 88 RF 99

None of the time — All the time — DK/NA — Refuse

Did you seek health/healing services for this state? ___ Yes ___ No
From whom: _____; In a few words, describe why not:
_____

On average, how appropriate were the health/healing services you received?

0 1 2 3 4 5 6 7 8 9 10 DK 88 RF 99

Not at all appropriate — Entirely appropriate — DK/NA — Refuse

Health Domains	Individuals affected % of total pop	Concern - % of total pop (% of affected)	Seeking Services (%)	Appropriateness (average)
Mobility Services	n/a	16.9	50	6.75
Self Care Services	n/a	7.9	27.3	4.33
Bodily Aches Services	n/a	49.4	44.4	7.62
Concentration Memory Services	n/a	44.9	31.7	7.33
Personal Relationship Services	n/a	32.6	32.3	7.60
Vision Services	n/a	20.2	27.3	5.80
Hearing Services	m/a	4.5	0	-
Oral Health Services	n/a	44.9	63.4	7.20
Sleep Services	n/a	49.4	37.8	7.47
Anxiety/Depression Services	n/a	59.6	40.7	7.86
Self Harming/Suicide Prevention Services	n/a	21.3	57.1	7.75
Injury Health/Healing Services	22.5	15.7 (70.0)	80	7.64
Tobacco Cessation Services	75.3	33.7 (44.8)	24.2	6.50
Alcohol Cessation Serivices	82.0	24.7 (30.1)	41.7	6.60
Drug Cessation Services	34.8	10.1 (29.0)	54.5	8.83
Gambling Cessation Services	36.0	5.6 (15.6)	0	-
Pregnancy/STI Services	70.8	25.8 (36.5)	47.8	9.09
Dieting Services	n/a	48.3	27.9	6.42
Traditional Foods Accessibility Services	n/a	47.2	19.5	7.50
Physical Activity Services	n/a	28.1	20	4.80
Breathing Issue Services	n/a	24.7	60.9	7.62

ANNEX III

SERVICE USERS – BARRIERS TO HEALTH SERVICES

Sample question

Thinking of all these services you have used, have you experienced any of the following barriers to receiving health care? Please specify the services you had consulted.

		Responses		Percent of Cases
		N	Percent	
Barriers to Health Services[a]	No identification papers	16	2.9%	21.9%
	No medicare	25	4.5%	34.2%
	Doctor/nurse not available	20	3.6%	27.4%
	Health facility not available	10	1.8%	13.7%
	Needed services not available	17	3.1%	23.3%
	Didn't know where to go	22	4.0%	30.1%
	Waiting list too long	46	8.3%	63.0%
	Services disconnected from traditional Aboriginal healing	33	6.0%	45.2%
	Health care provided was inadequate	26	4.7%	35.6%
	Service was culturally inappropriate	21	3.8%	28.8%
	Medication/equipment inadequate	9	1.6%	12.3%
	Health care provider skills inadequate	19	3.4%	26.0%
	Difficulty getting traditional Aboriginal care	29	5.3%	39.7%
	Language barrier	21	3.8%	28.8%
	Unable to arrange transportation	18	3.3%	24.7%
	Could not afford transportation costs	23	4.2%	31.5%
	Cost not covered by Non-Insured Health Benefits	20	3.6%	27.4%
	Prior approval of Non-Insured Health Benefits was denied	13	2.4%	17.8%
	Could not afford direct cost of care/services	21	3.8%	28.8%
	Could not arrange for childcare	4	0.7%	5.5%
	Could not afford the medicine costs	15	2.7%	20.5%
	Could not afford the consultation or treatment costs	17	3.1%	23.3%
	Could not afford the prescribed medical device	9	1.6%	12.3%
	Chose not to see health care professional	17	3.1%	23.3%
	Could not take time off work or had other commitments	14	2.5%	19.2%
	Thought too sick to go	14	2.5%	19.2%
	Were previously badly treated	16	2.9%	21.9%
	Tried but denied health care	4	0.7%	5.5%
	Fear of discrimination	18	3.3%	24.7%
	Were too ashamed to go	10	1.8%	13.7%
	Other	5	0.9%	6.8%
Total		552	100.0%	756.2%

a. Dichotomy group tabulated at value 1.

ANNEX IV

SERVICE USERS – REASONS FOR POOR TREATMENT

Sample question

In the last year did you feel that you were treated badly by health care providers? ___ Yes; ___ No; DK ___; Refuse ___

Due to your…

		Responses		Percent of Cases
		N	Percent	
Poor Treatment Reason[a]	Gender	3	5.8%	12.0%
	Age	2	3.8%	8.0%
	Lack of money	4	7.7%	16.0%
	Social class	4	7.7%	16.0%
	Being First Nation, Métis, Inuit	13	25.0%	52.0%
	Type of illness	3	5.8%	12.0%
	Health status	3	5.8%	12.0%
	Spoken language	8	15.4%	32.0%
	Physical appearance	6	11.5%	24.0%
	Other - quantitative	6	11.5%	24.0%
Total		52	100.0%	208.0%

a. Dichotomy group tabulated at value 1.

ANNEX V

SERVICE USERS – DIFFICULTIES ACCESSING HEALING SERVICES

Sample question

Have you had any of the following difficulties when trying to access traditional/holistic healing services?

		Responses		Percent of Cases
		N	Percent	
Difficulties Accessing Traditional Healing Services[a]	Needed services not available	27	18.1%	54.0%
	Didn't know where to go	28	18.8%	56.0%
	Traditional healing provided is inadequate	4	2.7%	8.0%
	Traditional healing is culturally inappropriate	4	2.7%	8.0%
	Traditional healer's medicine or equipment inadequate	2	1.3%	4.0%
	Traditional healer's skills inadequate	3	2.0%	6.0%
	Language barrier	2	1.3%	4.0%
	Unable to arrange transportation	15	10.1%	30.0%
	Could not afford transportation costs	11	7.4%	22.0%
	Could not afford direct cost of healing	7	4.7%	14.0%
	Could not arrange for childcare	2	1.3%	4.0%
	Could not afford the medicine costs	2	1.3%	4.0%
	Could not afford the consultation or treatment costs	1	0.7%	2.0%
	Chose not to see traditional healer	7	4.7%	14.0%
	No time off work/other commitments	10	6.7%	20.0%
	Thought too sick to go	2	1.3%	4.0%
	Were previously badly treatmed	1	0.7%	2.0%
	Tried but denied health care	2	1.3%	4.0%
	Fear of discrimination	5	3.4%	10.0%
	Were too ashamed to go	2	1.3%	4.0%
	Other - qualitative	12	8.1%	24.0%
Total		149	100.0%	298.0%

a. Dichotomy group tabulated at value 1.

ANNEX VI

SERVICE PROVIDERS – REASONS FOR POOR TREATMENT

Sample question

In the last year, have you witnessed or heard of the poor treatment of an urban Aboriginal person by health care providers in Montreal for any of the following reasons? Due to:

		Responses		Percent of Cases
		N	Percent	
Poor Treatment Reason[a]	Gender	14	7.0%	23.3%
	Sexual orientation	8	4.0%	13.3%
	Age	9	4.5%	15.0%
	Lack of money	30	14.9%	50.0%
	Social class	30	14.9%	50.0%
	Being First Nation, Métis, Inuit	49	24.4%	81.7%
	Type of illness	14	7.0%	23.3%
	Health status	14	7.0%	23.3%
	Spoken language	33	16.4%	55.0%
Total		201	100.0%	335.0%

a. Dichotomy group tabulated at value 1.

ANNEX VII

SERVICE PROVIDERS – DIFFICULTIES ACCESSING TRADITIONAL HEALING SERVICES

Sample question

What difficulties do you perceive the urban Aboriginal population of Montreal is facing when trying to access traditional/holistic healing practices?

		Responses		Percent of Cases
		N	Percent	
Difficulties Accessing Traditional Healing Services[a]	No identification papers	30	3.6%	33.7%
	No medicare	27	3.3%	30.3%
	Needed services not available	65	7.9%	73.0%
	Services disconnected from traditional values	79	9.6%	88.8%
	Traditional healing provided is inadequate	45	5.5%	50.6%
	Traditional healing is culturally inappropriate	24	2.9%	27.0%
	Traditional healer's medicine or equipment are inadequate	19	2.3%	21.3%
	Feel traditional healer's medicine or equipment are inappropriate	11	1.3%	12.4%
	Traditional healer's skills inadequate	7	0.9%	7.9%
	Traditional healer's skills inappropriate	13	1.6%	14.6%
	Feel traditional healers do not speak their preferred language	31	3.8%	34.8%
	Unable to arrange transportation	55	6.7%	61.8%
	Cannot afford transportation costs	58	7.1%	65.2%
	Cannot afford direct cost of healing	33	4.0%	37.1%
	Cannot arrange for childcare	45	5.5%	50.6%
	Cannot afford the medicine	31	3.8%	34.8%
	Cannot afford the consultation fees or the treatment	34	4.1%	38.2%
	Cannot take time off work or had other commitments	28	3.4%	31.5%
	Too sick to go	15	1.8%	16.9%
	Previous badly treated	26	3.2%	29.2%
	Tried but denied health care	14	1.7%	15.7%

a. Dichotomy group tabulated at value 1.

ANNEX VIII

SERVICE PROVIDERS - HEALTH CONCERNS AND APPROPRIATENESS OF SERVICES

Sample question

Pointing to a box on the line, please rate each concern. If you choose the first box on the line, please move to the next field (number).

How often was (the health problem) of concern for your clients?

0 1 2 3 4 5 6 7 8 9 10 DK 88 RF 99

Never — Very often — DK/NA — Refuse

On average, how appropriate are services for this issue?

0 1 2 3 4 5 6 7 8 9 10 DK 88 RF 99

Not at all appropriate — Entirely appropriate — DK/NA — Refuse

Health Domains	Frequency Mean (average)	Appropriateness Mean (average)	Difference
Difficulty obtaining life aspects balance	7.91	4.36	3.55
Mobility issues	4.90	4.38	0.51
Self-care concerns	4.54	5.67	-1.13
Bodily aches concerns	6.69	5.47	1.22
Concentration memory concerns	5.85	5.03	0.82
Personal relationship concerns	8.03	5.04	3.00
Vision difficulties	3.71	5.57	-1.85
Hearing difficulties	2.81	5.44	-2.63
Oral health concerns	6.62	5.53	1.09
Sleep concerns	6.68	4.94	1.75
Anxiety/depression concerns	8.45	5.21	3.24
Physical injuries	6.36	5.81	0.55
Tobacco consumption concerns	6.82	4.24	2.59
Alcohol concerns	8.06	4.62	3.44
Drug concerns	7.75	4.48	3.28
Gambling concerns	4.32	3.73	0.59
STI concerns	6.18	5.74	0.44
Unwanted pregnancy concerns	5.45	5.14	0.31
Diet concerns	7.59	4.60	2.98
Traditional foods accessibility concerns	7.09	2.79	4.30
Physical activity concerns	5.69	5.17	0.51
Breathing concerns	5.08	5.81	-0.73
Maternal health concerns	6.15	4.86	1.29
Pre-natal health concerns	5.12	4.79	0.34
Child health concerns	5.20	4.87	0.33
Child nutrition concerns	5.53	4.65	0.88
Child immunization concerns	2.71	5.69	-2.98
Child physical activity concerns	3.41	4.86	-1.45
Child education concerns	5.81	5.09	0.71
Child Aboriginal education concerns	6.05	3.65	2.39
Total	**5.88**	**4.90664332**	**0.98**

ANNEX IX

SERVICE USERS – BARRIERS TO HEALTH SERVICES WHILE PREGNANT

Sample question

Have you experienced any of the following barriers to receiving health care?
Please specify the services you consulted when experiencing the barrier.
While pregnant or in seeking services for the child (children)?

		Responses		Percent of Cases
		N	Percent	
Barriers to Health Services - pregnant[a]	No identification papers	1	1.1%	5.9%
	No medicare	1	1.1%	5.9%
	Doctor/nurse not available	4	4.5%	23.5%
	Health facility not available	2	2.3%	11.8%
	Needed services not available	4	4.5%	23.5%
	Didn't know where to go	5	5.7%	29.4%
	Wait list too long	6	6.8%	35.3%
	Services disconnected from traditional Aboriginal healing	7	8.0%	41.2%
	Health care provided was inadequate	5	5.7%	29.4%
	Service was culturally inappropriate	2	2.3%	11.8%
	Medication/equipment inadequate	1	1.1%	5.9%
	Health care provider skills inadequate	1	1.1%	5.9%
	Difficulty getting traditional Aboriginal care	8	9.1%	47.1%
	Language barrier	3	3.4%	17.6%
	Unable to arrange transportation	4	4.5%	23.5%
	Could not afford transportation costs	3	3.4%	17.6%
	Cost not covered by Non-Insured Health Benefits	2	2.3%	11.8%
	Prior approval of Non-Insured Health Benefits was denied	1	1.1%	5.9%
	Could not afford direct cost of care/services	3	3.4%	17.6%
	Could not arrange for childcare	3	3.4%	17.6%
	Could not afford the medicine costs	4	4.5%	23.5%
	Could not afford the consultation or treatment costs	1	1.1%	5.9%
	Could not afford the prescribed medical device	1	1.1%	5.9%
	Chose not to see health care professional	3	3.4%	17.6%
	Could not take time off work or had other commitments	3	3.4%	17.6%
	Thought too sick to go	2	2.3%	11.8%
	Were previously badly treated	2	2.3%	11.8%
	Tried but denied health care	2	2.3%	11.8%
	Fear of discrimination	3	3.4%	17.6%
	Was too ashamed to go	1	1.1%	5.9%
Total		88	100.0%	517.6%

a. Dichotomy group tabulated at value 1.

ANNEX X

SERVICE USERS – BARRIERS TO SERVICES FOR CHILD

Sample question

Have you experienced any of the following barriers to receiving health care?
Please specify the services you consulted when experiencing the barrier.
While pregnant or in seeking services for the child (children)?

		Responses		Percent of Cases
		N	Percent	
Barriers to Health Services - child[a]	No identification papers	2	1.8%	9.5%
	No medicare	2	1.8%	9.5%
	Doctor/nurse not available	6	5.5%	28.6%
	Health facility not available	4	3.6%	19.0%
	Needed services not available	5	4.5%	23.8%
	Didn't know where to go	4	3.6%	19.0%
	Wait list too long	6	5.5% 2	8.6%
	Services disconnected from traditional Aboriginal healing	8	7.3%	38.1%
	Health care provided was inadequate	7	6.4%	33.3%
	Service was culturally inappropriate	5	4.5%	23.8%
	Medication/equipment inadequate	3	2.7%	14.3%
	Health care provider skills inadequate	4	3.6%	19.0%
	Difficulty getting traditional Aboriginal care	7	6.4%	33.3%
	Language barrier	4	3.6%	19.0%
	Unable to arrange transportation	3	2.7%	14.3%
	Could not afford transportation costs	4	3.6%	19.0%
	Cost not covered by Non-Insured Health Benefits	4	3.6%	19.0%
	Prior approval of Non-Insured Health Benefits was denied	1	0.9%	4.8%
	Could not afford direct cost of care/services	3	2.7%	14.3%
	Could not arrange for childcare	5	4.5%	23.8%
	Could not afford the medicine costs	3	2.7%	14.3%
	Could not afford the consultation or treatment costs	3	2.7%	14.3%
	Could not afford the prescribed medical device	1	0.9%	4.8%
	Chose not to see health care professional	2	1.8%	9.5%
	Could not take time off work or had other commitments	2	1.8%	9.5%
	Thought too sick to go	4	3.6%	19.0%
	Were previously badly treated	3	2.7%	14.3%
	Tried but denied health care	2	1.8%	9.5%
	Fear of discrimination	2	1.8%	9.5%
	Was too ashamed to go	1	0.9%	4.8%
Total		110	100.0%	523.8%

a. Dichotomy group tabulated at value 1.

ANNEX XI

ORIGINAL CITATIONS IN FRENCH

1. « …il y a beaucoup de gens qui sont gais, homosexuels ou autres, parce que justement c'est mal accepté dans les communautés, fait que souvent c'est à Montréal qu'ils vont trouver la liberté. »

2. « …la pauvreté, la difficulté de trouver un emploi, souvent la difficulté dans une grande ville de trouver des lieux de rassemblement, où t'as un bon rapport avec tes semblables, s'il y a quelqu'un qui traîne des blessures psychologique en plus, ça fait une accumulation de difficultés qui est pas facile forcément à surmonter. »

3. « Je cite souvent Pierre Isaac qui avait dit dans une entrevue, que la chose qui l'avait choqué en arrivant à Montréal, choqué noir, c'est qu'il y avait aucune trace des premiers habitants du pays dans la Ville. Aucune trace visible était là quand il est arrivé, pis pas un signe nulle part. »

4. « Du côté de ma mère, ce n'est pas quelque chose qui était célébré d'être autochtone, c'est pas quelque chose pour en être fier. (…) Mon grand-père lui, il ne voulait absolument pas utiliser son statut autochtone pour avoir accès aux services et tout ça. Pour lui, c'était vraiment important de montrer qu'il était capable de travailler, puis nourrir sa famille, puis pour qu'il n'en avait pas besoin, comme tout le monde. »

5. « La santé, la connaissance par rapport à la santé traditionnelle, c'est un savoir spirituel, c'est un savoir ancestral, c'est la connexion à la terre. (…) On est un peuple, des gens connectés à la terre. On vit sur terre. Évidemment qu'on peut être plus ou moins connecté, mais on est quand même sur la terre. Donc, c'est des concepts qui sont universels, mais les peuples autochtones ont, dans les origines, dans les racines, des connaissances qui sont tellement précieuses, donc de se guérir chacun et de contribuer à guérir les autres Autochtones et non-Autochtones. (…) C'est sûr qu'il y a des choses qui sont différentes, mais il y a quelque chose… il y a l'essence de qu'est-ce qui est universel. L'essence de comment on retrouve notre santé vitale, c'est la même chose pour tout le monde. »

6. « Je disais : 'Non, je n'en veux pas, ce n'est pas mon sang, je n'en veux pas. Je n'en veux pas'. Le médecin il était fin, mon spécialiste. Il dit : 'Non.' Il dit : 'Madame, votre sang dans dix minutes est le vôtre.' »

7. « On pense que le pouvoir de guérison est à l'extérieur de nous, alors que moi je crois que c'est vraiment à l'intérieur de nous. Donc de ramener, de réveiller en chaque personne cet accès à la guérison qui est universel. En se connectant à soi et de ressentir, de le vivre, de l'expérimenter. »