Miyupimaatisiwin aa uhchi pimipiyihtaakinuwich utih iiyiyuu aschiihch
Direction de santé publique des Terres cries de la Baie James
Public Health Department of the Cree Territory of James Bay

Conseil Cri de la santé et des services sociaux de la Baie James
Cree Board of Health and Social Services of James Bay

Washaw Sibi Health Needs Assessment Report

Presented to the Board of Directors
by
the Washaw Sibi Administration
in collaboration with
the Specialised Services Team

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EXECUTIVE SUMMARY

As one aspect of a larger planning exercise undertaken by the Washaw Sibi Administration with the Grand Council of the Cree/Cree Regional Authority and the Cree Board of Health and Social Services of James Bay, this document reports on a small study assessing the health needs of the membership of Washaw Sibi in order to serve as a planning document for future health services. Its aim is to identify health and social services needs, to identify the barriers to access these services, and to identify the resources already present in the community. The research and the report are a joint effort of the Washaw Sibi Administration and the Specialised Services Team of the Cree Health Board.

Washaw Sibi people live in proximity to their historic traditional lands, mostly in Pikogan, Amos, La Sarre, Val d'Or and Lac Simon. Information about use of health services was only obtained from people in the focus groups who live in Pikogan or Amos. The survey found that Washaw Sibi participants are less educated, less trained, have lower levels of employment, and have greater financial insecurity – including food insecurity - than people in communities in Iiyiyiu Aschii. They also appear to have higher levels of chronic diseases, including diabetes, and to be living with more disabilities than are found in Iiyiyiu Aschii. Those over age 45 report their health as poorer than their counterparts in Iiyiyiu Aschii and they say they cannot manage life's problems so well, especially the men. And the older men are less satisfied with their lives than their age-mates in Iiyiyiu Aschii.

The focus groups reported social issues related to alcohol and drug consumption and involvement with youth protection services. The extent and complexity of the health issues identified by the survey participants implies that that group has a need for a complex range of health services on a recurrent basis. People had few complaints about access to services for physical health problems; however, they reported big gaps between the needs and the availability of mental health and addictions services, similar to Iiyiyiu Aschii. Non-Insured Health Benefits seems to be poorly understood by people, and to create certain confusions and frustrations for them. Some of these issues have to do with jurisdictional issues related to access to services.

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1. INTRODUCTION[1]

1.1. The needs assessment study and purpose of this report

As one aspect of a larger planning exercise undertaken by the Washaw Sibi Administration with the Grand Council of the Cree/Cree Regional Authority and the Cree Board of Health and Social Services of James Bay, this document reports on a small study assessing the health needs of the membership of Washaw Sibi in order to serve as a planning document for future health services. Its aim is to identify health and social services needs, to identify the barriers to access these services, and to identify the resources already present in the community. The research and the report are a joint effort of the Washaw Sibi Administration and the Specialised Services Team of the Cree Health Board.

1.2. The organization of this report

The needs assessment study carried out 100 interviews held either in-person or by telephone with adult members of Washaw Sibi and, from this group, received back 40 self-administered, mail-back Confidential Questionnaires. Two focus groups were held in Amos to discuss services and drafts of the report were discussed with the Washaw Sibi Administration before this final draft was completed.

Because it is impossible to understand why this needs assessment is being undertaken without some knowledge of the Washaw Sibi people as a group, the report begins with a brief historical section. This is followed by: the summary of the focus group discussions on current access to and use of health services; a brief analysis of the population taken from the Washaw Sibi membership list compared to the study population who responded to the survey; a report on the health status of the population taken from the 100 person survey; and the results from the Confidential Questionnaires returned by 40 of those participants. The final section summarises the main findings.

[1] All comparisons used in this report are to Statistics Canada Aboriginal Survey results for Iiyiyiu Aschii; the Mistissini Nituuchischaayihtitaau Aschii Longitudinal Health and Environment Survey which happened in 2005; the Canadian Community Health Survey – Cree Region which happened in 2003; and Cree Diabetes Information System reports. These reports can be found at www.creepublichealth.org.

1.3. Methods

Health Survey

All the interviews were carried out between August 2006 and January 2007. The survey objective was to interview 100 persons out of the 217 adults aged 18 and over on the population list. A first sample of 108 names, stratified by age and sex, was randomly selected from the list. The interviewer contacted them to ask if they would agree to answer the Health Needs Assessment Questionnaire. Of those 108 persons, 78 agreed to participate, for a participation rate of 72.2%. Only 2 persons refused, 12 were unreachable for various reasons, while no reason was reported for16.

Table 1: Participation in the survey, first list

First list	N	%
Names on list	108	100.0
Interviewed	78	72.2
Not interviewed	30	27.8
-refusal	2	1.9
-phone not in service	4	3.7
-health reasons	4	3.7
-moved away	2	1.9
-no answer	1	0.9
-deceased	1	0.9
-no reason reported	16	14.8

To complete the objective of 100 interviews, a second list of 43 names was randomly drawn and sent to the interviewer. People were contacted and interviewed until the goal of 100 was reached. Since many on the sample list lived far from Amos where the interviewer was based, a total of 21 people were interviewed by telephone. Within this sample, all women with children in their household were asked to complete a Household Questionnaire on children's dental health.

Confidential Questionnaires along with a stamped, pre-addressed envelope were distributed to everyone interviewed, either by hand or by mail for those interviewed by telephone. The Interviewer assisted with two of these questionnaires. Only 24 others had

been mailed back by the end of January. After a reminder phone call in February and March to each of the 100 participants, asking them to send in their confidential interview if they had not already done so, a further 10 questionnaires were received by the end of April and the final 4 by mid June.

Focus Groups

Two focus groups to discuss health services were held in Amos in November. The morning group had more Elders and was translated; the afternoon group had younger adults and was conducted in English.

We asked people to discuss their experience in using and receiving health services of all kinds including the kinds of services available; their experiences in using services of different kinds including waiting times and issues of access; perceived gaps in services; and language issues in services.

People were encouraged to talk about all types of services from formal to self-help; the locations where they access them; issues of jurisdiction they had encountered; and issues of cost and availability.

The groups were specifically asked about: having family doctors or nurses; access to psychologists; experiences with Social Services, Youth Protection, Home Care services, long-term care services, hospital services, dental services and use of NIHB. They were also probed for experiences obtaining services for addictions, depression and stress.

2. RELEVANT HISTORY OF THE WASHAW SIBI PEOPLE

2.1. Brief historical context

This section is intended to give the reader not familiar with the Washaw Sibi people a brief glimpse into their continuingly complex history[2]. This is the context for any understanding of their current health status and political aspirations[3].

Pikogan, where the majority of Washaw Sibi members live, is the largest community of the Abitibiwinni First Nation which is part of the Algonquin Anishinabeg Nation Tribal Council. But Washaw Sibi people have been recognized for membership within the Cree political structure. John Pollack says that in an area that is shared by two distinct political groups, "the exact size and nature of this overlap may be more of a political question than a historical one and can probably only be resolved through negotiation" (Pollack, 16).

Pollack describes the area immediately north of Abitibi Lake "as historically a boundary area for four different dialect groups",

- The "l" dialect-speaking, Moose River Cree who came up the Abitibi River and its tributaries;
- The "r" Cree dialect Kesagami Lake people in the area between Kesagami Lake and the upper parts of the Harricanaw River;
- The "y" dialect Rupert's House people living between the upper Nottaway and the upper Harricanaw; and

[2] Five sources are used:
(1) Notes of a meeting held in Amos with the Washaw Sibi Band on January 26 and identified as the focus groups.
(2) Cree Nation of Washaw Sibi., "Chronology of La Sarre Crees – Washaw Sibi Eeyou: Cree Nation of Washaw Sibi: A brief history of the Washaw Sibi Eeyou: a distinct group subject to displacement, recognition and relocation. Information package for distribution to Cree communities in preparation for community consultation purposes", November 2006, 12 p. And "A brief history of the Cree Nation of Washaw Sibi: a distinct group subject to displacement, relocation, and disenfranchisement." Unattributed. 7 p.
(3) Scott, Colin and Morrison, James. "Boundaries and territories: Eastern Cree land tenure in the Québec/Ontario border region." 63 pp. This paper was done for the Grand Council of the Cree but is unattributed. Identified in this paper as Scott and Morrison.
(4) Pollock, John W. March, 1996. Native background information report and values map for portions of the Cochrane Crown Timber Management Unit, Driftwood Forest Management Unit, Smooth Rock Falls Management Unit. Ministry of Natural Resources and Wahgoshig First Nation. 21 pp + app. This brief paper is about the Wahgoshig First Nation in Ontario who are historical neighbours of the Washaw Sibi people. Identified as Pollock.
(5) Voorhis, E. 1930. *Historic forts and trading posts of the French regime and of the English fur trading companies*. Department of the Interior, Ottawa. P. 28. Identified as Voorhis.

[3] The Cree Nation of Washaw Sibi documents listed above should be consulted for a more complete chronology.

- The Abitibi Algonguin speaking people who lived in the vicinity of the Lake (Pollack, 16).

The Cree origins of the core of the Washaw Sibi members come from this "y" dialect group which had historically traded at Fort Abitibi[4] and had "long-standing attachments to lands" on what became the Ontario side of the Ontario-Québec border[5] (Scott and Morrison, 14). As Scott and Morrison point out, the "Rupert House" designation referred to a trading post, and said nothing about whether the hunters' traditional lands fell east, west, or on both sides of the imaginary line that became the border (48).

By the first decade of the twentieth century, White colonisation had moved into the areas south of Lake Abitibi. This began the effect, which would continue for the following half century, of pushing Algonquin hunters north and creating pressure on all aboriginal groups and on their established patterns of land use (Scott and Morrison, 13).

As colonisation advanced, these pressures on all aboriginal groups intensified. Although the "y" dialect group had used lands across what would become Ontario and Québec, they were considered a 'Québec' group because of their association with Rupert's House trade. The Ontario boundary with Québec was settled after confederation in the south and in the late 1800s in the north[6]. In 1906, the Crown began negotiations to treat with the aboriginal groups on the eastern boundary of Ontario. And this began the process of excluding those groups considered to 'belong' to Québec from use of their historic hunting and trapping lands inside Ontario, thus intensifying pressure on their land use inside of Québec.

The Transcontinental Railway construction began in 1904 with surveying and later grading and tracking. The railway was completed in November 1913 but for a bridge at Québec. For the Washaw Sibi people, these developments changed transportation and trading patterns throughout the region. As Voorhis explains, "After construction of the

[4] There were several forts on Lake Abitibi operated continuously from 1686 to around 1914. Initially built by the French, the Hudson's Bay Company began operations before 1774 (Voorhis, p.28.)

[5] The citation used here is listed in footnote 1. An earlier version of this paper was: Scott, C. and Morrison, J. 1993. "The Quebec Cree Claim in the Hannah Bay/Harricanaw River Drainage in Ontario: Report of the Ontario Claim Research Project", Nemaska, Grand Council of the Crees of Quebec. A later version of this work was published as: Scott, C. and Morrison, J.) "Frontières et territories: mode de tenure des terres des Cris de l'Est dans la region frontalière Québec/Ontario – II – reconstruction et renouveau ». *Recherches Amérindiennes au Québec*, v. 35, no. 1, 2005, pp. 41-56.

[6] In 1874, after the purchase of Rupert's Land, the boundary moved north, and in 1889 the final northern boundary was established along the Albany River. http://www.archives.gov.on.ca/English/exhibits/maps/boundaries.htm

Transcontinental railway in 1914, Abitibi post was discontinued and superseded by La Sarre, a small station on the railway nearby, the furs being shipped by rail to Montreal and not sent by canoe to Moose Factory as formerly." (Voorhis, 28) As well, the survey and construction crews living in the construction sites provided a market for country produce and the sale of crafts. Already in June of 1905, the Hudson's Bay Company reported that most of the people who hunted on the northwest side of Abitibi Lake were already spending the better part of the hunting season around the National Transcontinental camps, "trading moose & deer meat & rabbits for pork & flour". Not only was the railway closer, but competition from independent traders meant that along the railway, prices for furs were higher and good cheaper than at posts on James Bay (Scott and Morrison, 17).

As late as the 1930s, Scott and Morrison report that some of the "y" dialect, or Washaw Sibi, families were hunting normally and regularly on lands between Kesagami Lake and Lake Abitibi in Ontario. In the early 1940's, they were the object not only of sustained efforts to exclude them from customary lands in Ontario, but to "return" them from La Sarre to Rupert House. In the 1940s, there were renewed "vigorous" campaigns to expulse, on the one hand, Moose Band families from their Québec grounds and, on the other hand, to exclude some Washaw Sibi families from extensive hunting grounds in Ontario, from Hannah Bay to the Upper Harricanaw and its western tributaries (Scott and Morrison, 45).

The exclusion of the La Sarre "Rupert House" group from Ontario lands increased hunting pressure on grounds in the La Sarre Section of Quebec, grounds apparently also used by Abitibi hunters. "This was no doubt a major source of the alleged resentment toward the La Sarre Rupert House group by the Low Bush Abitibi. There were extraordinary pressures on Abitibi hunting grounds in the vicinity of Lake Abitibi." (Scott and Morrison, 48) Trespass by White trappers on Indian lands was becoming "legalized" along the rail-line. As late as the Second World War, Ontario was still leaving responsibility for both beaver conservation and trap-line management in remote parts of the Moose River watershed to the Department of Indian Affairs and the Hudson's Bay Company. But within reach of the railway, the Ontario Department of Game and Fisheries had felt free to impose its "township" system of trap-line registration on Aboriginal people. If they were lucky, these aboriginal people were able to maintain their traditional areas. If not – since most game wardens were biased in favour of White trappers – they were obliged to move.

"Overcrowding on the La Sarre Section had been exacerbated by a colonization scheme in the Abitibi area. The scheme reduced hunting lands by 500 square miles, and led to increased competition from White trappers."(Scott and Morrison, 48)

Meanwhile, Larivière, Indian agent at Amos, was sending correspondence to Hoey, Superintendent of Welfare and Training, Indian Affairs (Aug. 24, 1942) which indicates resentment on the part of the Rupert House group at La Sarre at being scapegoated, and their wish to expose the reasons for their coming to La Sarre:

> Briefly, starvation pushed them out and they were told by the HBC to find a new place to live which they did and improved themselves considerably since. In connection with these Indians, there is a long story why they are at La Sarre, Quebec. Their case is similar to some among the Dominion Abitibi Band who are in great number from Rupert House Post.....Prior to a few years this group and the Dominion and Ontario bands had no difficulty to themselves. Their removal from their trapping grounds in Ontario... [and a disputatious] love affair... are the main causes of the difficulties. (Scott and Morrison, 50)

When Treaty 9 was signed in 1908, the Treaty Commissioners artificially created two Algonquin speaking groups from what had previously been one: the Dominion Abitibi families were those who choose to remain in Québec and not to go on the Band lists of the Low Bush – the Ontario Abitibi Algonquin-speaking group – who are known today as the Wahgoshig First Nation. However, Dominion Abitibi also signed the Treaty, thus giving up their lands in Ontario and also in Québec, although this latter provision was dependent upon a process beginning for being granted a reserve with the Québec Government (Scott and Morrison, 13). This left the La Sarre group of 'Rupert House' Cree speakers as the only group that had not been legally dealt with in this area (Scott and Morrison, 43).

For the following half century, both the Abitibi Dominion Algonquin-speakers, and the La Sarre Cree-speakers tried to settle their land issues with the Department of Indian Affairs. However, Québec's interests were to colonise the Abitibi and not to create Indian reserves in lands which might be of use to settlers. As a consequence, Québec did not agree to create reserve lands for the Dominion Abitibi – who had signed the treaty in 1908 – until the mid 1950s when Pikogan at Amos was set aside. Once this happened, Indian Affairs – who refused to recognise the Washaw Sibi as a separate group – put pressure to have them relocate to Pikogan if they wanted to retain their access to medical care and other social assistance.

Today, the Dominion Abitibi group is known as the Abitibiwinni First Nation. As they explain their history today on their website:

> The presence of this community in this spot is one of the consequences of Treaty 9 concluded in 1908. The Apitipi8innik, who had up to then usually gathered near the Ontario and Québec border, were offered a reserve on the Ontario side of Lake Abitibi. But several families were settled more on the Québec side near the villages along the railway line which been built in the beginning of the 1900s. Thus, these families ended up near the City of Amos. As a result of Treaty 9, the First Nation of Abitiwinni today still enjoys rights in Ontario, among others on a part of the lands of Wahgoshig.[7]

When house construction began at Pikogan 1964, people in the focus groups said that some La Sarre families moved to the new community. But, to receive any services, these Cree families had to register on the Algonquin Band list. Many did, but some refused, preferring to depend on their own. According to the Washaw Sibi documents, the families who did not move to Pikogan either stayed near La Sarre or moved elsewhere.

Geographically, this dispersal of the Washaw Sibi is evident today in the great number of places where the Washaw Sibi people live. This has also created confusions around jurisdiction since some services for registered Indians are associated with membership in the reserve of residence. As there still is no recognised Washaw Sibi land, Washaw Sibi people have acquired memberships with other First Nations groups. This creates great confusion and leads to problems of access to services.

People in the focus group also recounted how, over time, other Iiyiyiuch registered to Iiyiyiu Aschii communities moved to Pikogan (following marriages, to be closer to their relatives already living there or to their traditional hunting territories, etc.). As a result, some members of Washaw Sibi are already Beneficiaries of the *James Bay and Northern Québec Agreement,* while others have rights to become Beneficiaries but are not.

2.2. Understanding affiliation in Washaw Sibi through language

The people who are members today of Washaw Sibi First Nation and the Algonquians of Abitibiwinni First Nation have lived in close proximity historically and they are mostly inter-related through family. The 'La Sarre' Cree and the 'Dominion Abitibi' Algonquians have had a long history together in this northwestern Québec boundary area with Ontario.

[7] Taken from: www.pikogan.ca

To explain their unique identity, within the context of their complex history, the people in the focus groups stressed that some leading 'Algonquians' in Pikogan were more 'Cree' than some members of Washaw Sibi who were participating in the focus group. Someone recounted that the last Algonquin in Pikogan, who had not been known to be related to any Cree – e.g. a "pure" Algonquin -, had died in the late 1960s; and another person joked that he must be 100% Cree because he was only 25% Algonquin.

The boundaries between the two groups called 'Cree' on the one hand, and 'Algonquin' on the other are in fact fluid; but they have historically been maintained through distinctions based on language and political jurisdiction. People married each other but they choose to retain one dialect over another and to affiliate with one group over another.

This use of language to distinguish who is of Washaw Sibi helps to put into context the concern of the members of Washaw Sibi over what they perceive as the rapid loss of the Cree language in Pikogan. For if their identity as a group is especially linked to language – and has been for a long time – then the importance of retaining that becomes apparent. If everyone spoke French in Pikogan and Cree and Algonquin were no longer heard in public, then what would distinguish the members of Washaw Sibi from the Algonquians? The problem as people explained is not that the Cree language is being subsumed by the Algonquin language, but rather that both languages are beginning to disappear as the children and youth are no longer speaking them as they should. As someone explained, "the language issue is a real problem here because the kids can't speak Cree. Here they're taught in school (to speak Algonquin) but they don't speak Algonquin." Part of the desire to have a community under Cree jurisdiction, is to be able to assert the Cree language and to ensure its reproduction in the youth since there is much higher retention of Cree in Iiyiyiu Aschii than there is of the Algonquin language in the communities to the south.

But language is also associated with subtle oppression in Pikogan because it is an Algonquin, and not a Cree, community. As someone said, the "Cree language is very discouraged. We still use it in our houses but it's mostly like used by the elders at home. Like at home I speak it with my mother and I try to speak it with my kids."

The Elders have to speak Algonquin to be understood within the administration and clinic. Or, Elders speaking Cree can be understood to some extent by other Algonquin-speaking

Elders. A person in the morning focus group mentioned the Clinic receptionist told her not to speak Cree because "we speak Algonquin here". But another person recounted how the radio station personnel did not object when she spoke Cree and English on the radio. Another person reflected that it is sometimes "stressful being Cree". Interestingly, the Pikogan website mentions that three languages are spoken but none of them are Cree which does not 'officially' exist.

People mentioned that while everyone has always gotten along together in Pikogan, and lived cooperatively together within family, between families and as neighbours, since the opening of the separate Washaw Sibi administration office in Amos there had, not surprisingly, been some tensions. However, some people said that this was earlier in the period after the office had opened and that now, at the time of the focus groups, people were again working together.

The majority of Washaw Sibi members are also Abitibiwinni First Nation band members. Therefore, the creation of Washaw Sibi as a parallel political entity has led to certain tensions within Pikogan. As discussed above, the Crees and the Algonquians are "all mixed together" as someone explained and Washaw Sibi membership has created a new jurisdictional issue inside of Pikogan and within the Abitibiwinni First Nation.

This is a threat to the financial well-being of Pikogan. If a sizeable portion of the community population were to move to a new location, this would significantly reduce the on-reserve population which would in turn have serious implications for band financing formulas.

People talked about how they have experienced these tensions which came to the surface at the time that the Washaw Sibi office opened. Now at the time of the focus groups, they spoke about how there was greater openness for discussion and dialogue between Washaw Sibi and the Abitibiwinni First Nation.

2.3. Understanding affiliation in Washaw Sibi through political jurisdiction

The history of the people of Washaw Sibi is complex because since the mid 1800s, they have been living on the boundaries between various distinct political jurisdictions: Hudson's Bay Company versus free traders; Ontario versus Québec; Moose Factory versus

Rupert House; Indian Affairs versus the province; Cree versus Algonquin; Iiyiyiu Aschii versus Algonquin lands. Their affiliation as a group has always been associated with their "y" dialect of Cree associated with the area south of Waskaganish. Today this also links them to the very distinct political jurisdictions of the Grand Council of the Crees of Eeyou Istchee under the *James Bay and Northern Québec Agreement* on the one hand and the Tribal Council of the Algonquin Anishinaabeg Nation under the *Indian Act* on the other hand.

The title of one of the historical documents produced by the Washaw Sibi Cree Nation (see footnote 1) mentions "displacement, relocation and disenfranchisement". This happened historically to the Washaw Sibi people and it continues to reflect their current situation. Without recognition of their rights to land, they continue to be dispersed living in twenty-four different communities of various types, mostly in the general vicinity of their traditional lands.

Because of this Diaspora, and because of the particular type of jurisdictional issues which have arisen as a consequence of the history of the *Indian Act* within Canada -where registration is typically affiliated with a land base - Washaw Sibi members are 'Indians' or First Nations but as the Washaw Sibi land base has never been recognized, individuals have to be affiliated with various, other land bases. The band membership and Cree beneficiary status of Washaw Sibi members is complex and the majority are not living within the jurisdiction where they are affiliated, although almost half the members of Washaw Sibi are living in Pikogan.

A participant in one of the focus groups explained that in his view 80% of the membership of Pikogan are 'Cree', "the Chief and Councilors are all Crees", meaning that in his view they could potentially meet the criteria for membership as beneficiaries within the *James Bay and Northern Québec Agreement.* Someone else said that all but two families in Pikogan – families of Scottish descent - would be eligible to become beneficiaries.

To claim membership as a beneficiary of the James Bay and Northern Québec Agreement, a person has to establish a direct genealogical line from a recognised Cree ancestor from the watershed as well as be living in the watershed. This creates a serious catch 22 situation for members of Washaw Sibi who do not have beneficiary status and are not yet living in a

recognized Cree community. Suppose such a person is living on a reserve and has an affiliation there. It is that local membership which allows the person to have access to housing and services.

Washaw Sibi members have very confused jurisdictional affiliations because of their history of dispossession. For some people, this confusion is a daily part of their lives because it excludes them from goods and services taken for granted by others. For others, who are included as members where they are living, their affiliation is different from their identity as Washaw Sibi Cree.

Members of Washaw Sibi are still very much living on jurisdictional edges, or we might say, falling through jurisdictional cracks. As the next section will discuss, these jurisdictional confusions are the defining issues in terms of their problems in receiving health services; they are likely related to the poor status of wellbeing, and low educational levels of the members of Washaw Sibi; and Washaw Sibi members say they exacerbate problems with employment.

3. HEALTH SERVICES AND HOW THEY ARE USED

Chapter 3 discusses information from the focus groups about services. It is presented under four sections. "The politics and pragmatics of health services" looks at issues of political jurisdiction and affiliation as they have an impact on: current services; future services offered in a Washaw Sibi community; and Non-Insured Health Benefits. The second section "health services and how they are used" is focused on service use by Washaw Sibi people living in Pikogan and Amos. It begins with a general outline of health services and then discusses issues of language and interpreters, social services, alcohol treatment services and youth protection services including the lack of services to support after-care and parents. The third section "Issues of access and perceived gaps" summarises what people said in terms of issues with access to services and perceived gaps in services. The principal ones concern issues with mental health services, issues around language and jurisdiction, and Non-Insured Health Benefits. Finally, the last section on "Social issues identified in the focus groups" identifies drugs and alcohol, housing, employment and back rents.

3.1. The politics and pragmatics of health services

This section looks at issues of political jurisdiction and affiliation as they have an impact on current services, potential future services and Non-Insured Health Benefits.

As someone explained in the focus group, a person has to both live on a reserve and also be a band member from that reserve in order to receive regular health services at the reserve clinic. To the extent that access depends upon affiliation or membership, this creates inequities within and between families concerning how and where specific individuals can receive certain services. Being excluded from services can lead to feelings of frustration and unfairness, and especially if the person excluded does not have access to other resources. The survey results show that Washaw Sibi members have fewer resources than people in Iiyiyiu Aschii because they are less educated, more unemployed, and experiencing more financial insecurity.

While people may logically understand why they are excluded from some services, this does not alter their lived experiences as service-users. People know that only Abitibiwinni First Nation members can benefit from federal Non-Insured Health Benefits in Pikogan.

However, someone who has lived in Pikogan for most of their life but happens to be officially a member of say, Waskaganish Cree Nation, experiences an injustice and a frustration every time when he or she has to find a ride into Amos to go to an appointment at the Hospital while the community van going in at the same time has empty places. Similarly, Abitibiwinni First Nation band members living in Amos cannot benefit from services on-reserve, even though Pikogan is visually part of Amos.

Future Cree Board of Health services could potentially also exclude some people from services, although for a different group of people. When Washaw Sibi becomes recognised as a legal reserve with a band status for its members, this does not mean that the members of all families will also be beneficiaries of the *James Bay and Northern Québec Agreement*.

Pikogan health services are owned by and provided for members of Abitibiwinni First Nation. In an emergency, services will be provided to everyone whether they are a member or not. But in non-emergency situations, people who do not have Abitibiwinni band membership will not qualify to use services which are based on this membership. Part of the reason for this is financial because the Abitibiwinni First Nation, like all other first nations, only receives funding for services based on their on-reserve membership population. There is no way for them to be reimbursed for services delivered to non-members. Another reason is that Pikogan can enforce a 'membership' restriction on services because everyone can receive services next door in Amos.

Some members of Washaw Sibi expressed some confusion about how the Non-Insured Health Benefits Program operates in Pikogan and in general for those people who use the system directly from Health Canada. Within Pikogan, these services, such as medical transportation to Amos, are only available to band members. This is similar to the way that the Cree Board of Health operates this program exclusively for beneficiaries. Of course, as long as people are legally Indian – but perhaps not affiliated with the jurisdiction in which they are resident - they can benefit from these services which are then provided through the Val d'Or office of Health Canada. Someone using the services provided through Health Canada will more often have to pay up-front and be reimbursed later.

The issues with NIHB were closely linked to how people experience financial insecurity. One person explained that he has difficulty paying for monthly drug costs while he only

receives his Income Security Program cheque every three months. There were also complaints about not receiving reimbursements for prescription medications, which seems to indicate the need for more information about the ways that the NIHP operates for status Indians. There seemed to be some confusion about what services were covered and under what circumstances services were paid directly by Health Canada to the provider and in what circumstances the individual receiving the services was obliged to pay and then submit a reimbursement claim. This is likely why more information about the NIHB Program was listed as an immediate need from the Cree Board of Health at the first planning meeting between the Washaw Sibi Administration and the Cree Board of Health.

While the way that Cree Health Board services will operate in a future Washaw Sibi community have not been planned yet, such services will certainly alleviate some of the frustrations experienced by Washaw Sibi members in accessing services today. However, because of the complex affiliations within families, and the possibility that the Cree Health Board would have to place some type of restriction on services – based on place of permanent residence for general services and based on beneficiary status for NIHB services - it is imaginable that similar kinds of frustrations could happen in relation to access to Cree Health Board services, although they would be experienced by different people than are experiencing such frustrations today. Without some local arrangements for sharing services, this issue of inclusion and exclusion from services – and the feelings it generates in those excluded – are not likely to disappear in the future.

3.2. Health services and how they are used

This section is focused on service use by Washaw Sibi people living in Pikogan and Amos for health services, social services, and youth protection services.

The Pikogan Clinic is staffed by the two nurses. At present, two doctors from Amos provide alternate weekly service and another doctor comes one day a week. The doctors speak English as well as French and the people in the morning focus group said they all have family doctors and receive good services. The Clinic management has encouraged one of the nurses to take English classes to better serve the English-speaking Crees.

The Clinic provides all health services prescribed by Health Canada for First Nations. The health services website lists a comprehensive set of preventive programs for which they receive dedicated monies from the federal government.

For patients with chronic diseases – such as diabetes – the ophthalmologist visits every six months, the nurse gives diabetes teaching and a dietician comes to the community. However, most of these services are in French which is difficult for some of the elders. For services not available at the Pikogan Clinic, people go into Amos. For specialised services such as dialysis people travel to Val d'Or.

Pikogan receives money for the federal Home Care Program. Band members can receive housekeeping services if needed. However, people returning from the Hospital do not receive Home Care but a visit from a nurse from the Pikogan Clinic. Long-term care services are only available in French-speaking facilities in Amos. People in the morning focus group discussed the situation of a non-French speaking Elder who, because he was not comfortable at this facility, signed himself out and returned home. However, another person mentioned that her mother-in-law enjoys her stays when she is sent to this same facility for respite care during times the family goes to the bush.

People gave contradictory information in the focus groups regarding the availability of Cree interpreters at the Pikogan health services. One Elder said an interpreter was always provided for her, but she may have been talking about interpreter services in Algonquin because others explained that because Pikogan only recognises the Algonquin language, there are no official interpreter services available for the unilingual Cree-speaking Elders. One of the younger members in the afternoon focus group said she is often called upon to translate, and this seemed to be an informal arrangement. The psychologist who works in Pikogan only provides services in French. Of course, for those people receiving services in Amos, interpreter services are not available either. People in the morning focus group perceive this as another example of inequity in services for the Cree-speakers. However, the younger group in the afternoon session seemed mostly trilingual so language of services was not an issue they felt concerned them personally.

The focus groups did not specifically discuss medical services in Amos except for a comment about the absence of English interpreters and a story about a young woman living

in Amos who received her prenatal services there and had to pay for her multi-vitamins compared to women sent in from Pikogan who received the multi-vitamin free-of-charge.

People said that "social services" had left Pikogan after an issue with financing, and these services were now delivered from Amos. One of the Elders mentioned trying to speak to someone at the Clinic about the social issues with her daughter's family. She was told to speak to Social Services, but to her this service was not accessible as an aid because of language and familiarity.

People said there are both a youth worker and an Algonquin NNADAP worker in Pikogan. The NNADAP worker refers people to outside treatment services for addictions. People mentioned La Tuque, Oka, Maniwaki and Sept Îles. However, services such as after-care programs and programs to help couples are missing, although needed. There are some self-help groups organised: one for the Elders and one for NNADAP. As well, some people were said to go to town for AA meetings. However, the language issue came up in this discussion as well because the NNADAP workers are all Algonquin and not Cree speakers. This also raises a kind of inhibition among the grandparents: even though they might have problems with their children or within the family, they hesitate to contact social services because the language issue makes them uncomfortable. As in Iiyiyiu Aschii, the issue of concerns about the confidentiality of information given to social services was brought up.

For alcohol treatment services, people are sent, through referrals by the NNADAP workers, to Maniwaki, La Tuque, Sept Iles and Oka. However, another person pointed out that the services refused to send her to her preferred treatment centres, wanting to send her to ones close to Pikogan to reduce costs. This is similar to how treatment is organised within the Cree Health Board.

People in the focus group said that the Youth Protection Services, formally managed by the Band, are now delivered through the Centre de Jeunesse in Amos where the non-Aboriginal emergency workers come from. This has made some changes in the way that foster homes are recognised and used. When asked about the link with Youth Protection, people in the morning group talked about relatives who had children in care because of drinking and drug use. Some in the afternoon group were involved with Youth Protection.

From their perspective, they feel that Youth Protection intervenes a lot in their lives and makes them more difficult. They do not feel that they receive any help as parents. As someone said, "They'd rather listen to what others say and not investigate the family." The role of the schools in calling in Youth Protection was mentioned.

One woman, who may be a single mother, spoke of her issues with alcohol and her efforts to attend treatment. Her concern was that she did not receive any support in her attempts to get back together with her children. "That's what I'm pissed off. I admit I did my 12 steps AA and you go to rehab and continue your recovery and they still keep judging you and then we go into relapse. Aren't they supposed to be helping us with our children? It's better to keep the kids in a home while you get yourself together. I don't think it's good for the families to be apart, neither for the kids or the parents."

Another person complained that when Youth Protection become involved they do not really do an investigation of the family, nor do they understand or seem to want to listen to the parents. These criticisms are similar to those raised in Iiyiyiu Aschii and more recently in the 2007 resolution to have Youth Protection services work more with the entire family.

People said that previously children had been sent to a type of residential shelter outside of Amos or to French homes in Amos but that now they were placed with families inside of Pikogan. However, someone said some children are still placed in Amos.

In Iiyiyiu Aschii, extraordinary expenses facing families around episodes of illness or death are often picked up by special budgets of the local administration or the health services. These can include the costs of going to treatment centres outside of the community; helping families to travel to see sick relatives in hospital in Montreal; or helping with the costs associated with funerals. Since its opening the administrative offices for the Cree Nation of Washaw Sibi are sometime approached by members to help with these kinds of special costs. The difficulty is that the Cree Nation has a structure but is not yet financed like others. Washaw Sibi as a political organization only receives bridge financing from the Cree Regional Authority until the negotiations have been finalized. The Cree Trappers Association gives $30,000 a year and through this money a recreation worker is hired. So this creates difficulties in trying to assist members from extremely limited budgetary

resources. It was also not clear in the morning focus group if some of these types of costs might not be legitimate expenses under the NIHB.

3.3. Issues of access and perceived gaps

This third section summarises people's primary concerns about access to and perceived gaps in services, principally mental health services, issues around language and jurisdiction, and Non-Insured Health Benefits.

Wait times for services did not appear to be an issue with the people in the focus groups, with the exception of mental health services. People said that appointments with specialists were sometimes faster, sometimes slower. They spoke of regular dental appointments every six months, except for emergencies when immediate services were available.

The major issue identified in terms of availability was access to mental health services in general, and access to what are considered appropriate mental health services. In the afternoon focus group, people spoke of long waits to access psychological services; similar to what is reported in Iiyiyiu Aschii. But they also mentioned that the services were not appropriate because they were not delivered by Aboriginal psychologists. This is also an issue in Iiyiyiu Aschii.

One person raised an issue of access to treatment facilities. Her concern centred on lack of choice in deciding which centre to attend. Access to treatment facilities was available, but not to the English-speaking, female focussed centre she felt would have best helped her. Possibly with local Washaw Sibi health services in the future, the community would be better able to plan for appropriate services.

As mentioned above, not having services in Cree, or even English, was mentioned as a continuing theme of inequity for the people in the focus groups. Language is but one of the consequences arising from the continuing problems of jurisdiction. When Washaw Sibi people were mostly living near La Sarre in the 1940s, Indian Affairs accused them of being squatters, as a counter attack to denigrate their continuing claims to rights to their traditional lands. Similarly, many Washaw Sibi people are still 'squatters', or without any legal rights to where they live, falling into a continual gap between jurisdictions. One

person mentioned that a grandson has beneficiary status associated with Chisasibi and the parents have to plan trips to Chisasibi around dental appointments. A more usual situation mentioned earlier is where Washaw Sibi members living in Pikogan but without band membership, cannot use the medical transport to attend appointments in Amos. This imposes a hardship on people which other family members and neighbours with band membership, do not face.

However, even those living in Pikogan without band membership can still benefit from some of the general services available through the band. People mentioned the youth and elders groups and some NNADAP activities. However, those living off-reserve, with or without Pikogan membership, do not have access to services. This is not peculiar to Washaw Sibi as it is the major political issue addressed across Canada by some Aboriginal political organisations.

Similar to how services are provided by the Cree Board of Health, health services are not offered outside of Pikogan or Amos to people living in hunting camps. In the focus groups, this was mentioned several times as an issue of access to services. Obviously, were Cree Board of Health services available in Washaw Sibi today, extension services to hunting camps would not be part of the regular package of services offered. However, with decentralisation of services which is being planned within the Cree Board of Health, there would be no reason that Washaw Sibi might not in the future decide to provide such services.

The sense of inequity, of being treated as less than others and without the same rights of citizenship, centres around the continuing points of contention raised by the Non-Insured-Health-Benefits Program of Health Canada. Surprising to hear - since the solution appears to an outsider so simple - was the lack of information about this program, which provides health insurance for status Indians in Canada for items outside of the provincial health insurance plans. Because people lack a general understanding of how the program works, many in the morning focus group did not understand how their rights to services operate. Some had the mistaken impression that the program in Iiyiyiu Aschii provided more services. Others did not understand how to be reimbursed when they had to pay up-front for a service. And the right to services off-reserve was not well understood. Overall, we had the impression that people linked the program to on-reserve status because they saw it

operating in Pikogan. The people in the focus group did not appear to have any contact with the NIHB office of Health Canada which operates out of Val d'Or. But for people who have difficulty accessing services in Amos from Pikogan, making use of the NIHB in Val d'Or may present an insurmountable challenge.

3.4. Social issues identified in the focus groups

This last section identifies drugs and alcohol, housing, employment and back rents and the main social issues addressed by the participants.

Like communities in Iiyiyiu Aschii, Pikogan is technically 'dry'. Overall, people felt it is a safe community. People said at night they can walk around without fear of being harassed and they also mentioned that the youth walk around at night. People in each focus group discussed the social problems associated with use of drugs and alcohol, especially around involvement with Youth Protection. Babysitting was mentioned in this context as well, possibly the problem, also reported in Iiyiyiu Aschii, of people leaving children with relatives and then not returning when they were expected.

In terms of drugs, people said that the former three drug dealers known in Pikogan had now been reduced to one. They reported hearing about needle use but had not personally seen it and said that there is a needle exchange program at the clinic, although one person said he did not personally agree with it.

Pikogan appears like a small suburb of Amos. The houses are all owned by the band and there is no distinction between the houses of families who identify as Algonquians or as Crees. The morning focus group did not identify issues with housing, but someone in the afternoon focus group mentioned a couple had had a problem in obtaining a house when the husband was not registered in Pikogan, although the wife was. Issues of overcrowding were not mentioned. The survey showed that possibly this may be less of a problem in Washaw Sibi than in Iiyiyiu Aschii. However, we cannot be sure of the completeness of the information in the population profile from which we calculate the numbers of people living in houses in Washaw Sibi. Children and young adults are probably underrepresented.

The issue of employment was not directly addressed in the focus groups, but numerous people discussed having very limited financial resources. Since recognition of Washaw Sibi by the Grand Council of the Crees, the Income Security Program has been available to those people with beneficiary numbers. People said that it was mostly older women who were benefiting from the Program and that people do not stay in the bush long. The survey showed that some Elders were spending significant amounts of time in the bush, but that compared to people in Mistissini, Washaw Sibi people tended to spend more time in the bush during the summer and less in the other months.

A person in one of the focus groups was concerned about the possibility of having back rents collected from Income Security Program cheques and there was some mention of back rents as an issue in which the sense was that people were being unfairly targeted. Although we were not asking about employment or financial security in the focus groups, this kind of concern fits with the survey findings of low educational levels and high unemployment.

4. PROFILE OF THE WASHAW SIBI MEMBERSHIP

4.1. Population of the Washaw Sibi Membership List

The population profile presented here is a partial analysis from the membership list - to which membership is voluntary - while individuals retain other affiliations. Table 2 presents the breakdown of the population by age group and gender. The mean age is 27.5 years, which is about the same as the Iiyiyiu Aschii population mean age of 27 years.

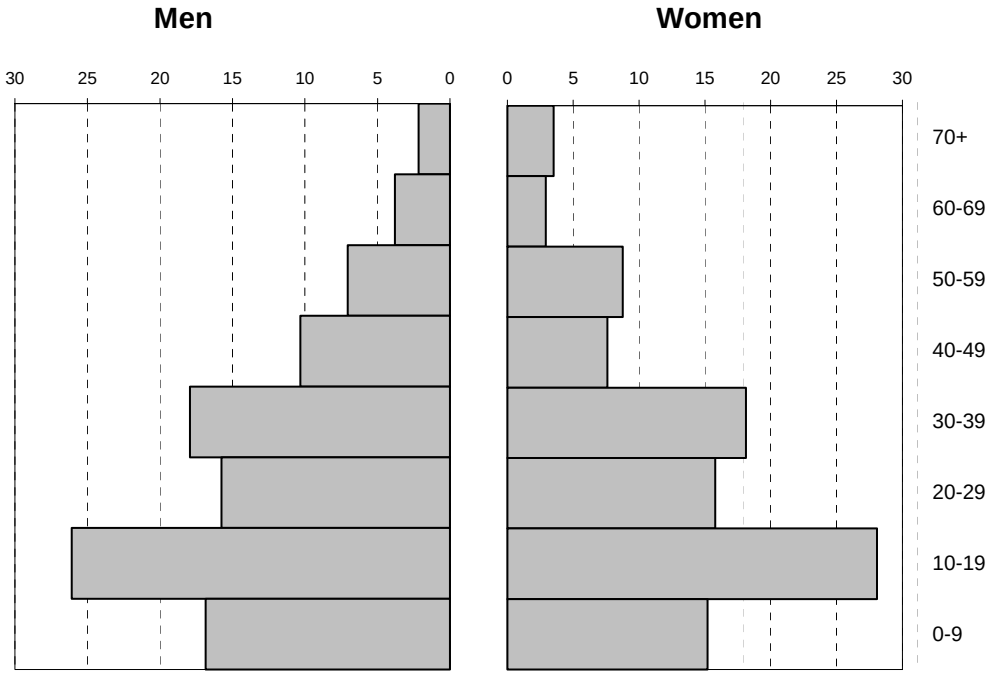
Table 2: Washaw Sibi population by age group and gender, July 2006

Age group	Female	Male	Total
0 to 9	26	31	57
10 to 19	48	48	96
20 to 29	27	29	56
30 to 39	31	33	64
40 to 49	13	19	32
50 to 59	15	13	28
60 to 69	5	7	12
70 and more	6	4	10
Age missing	6	3	9
Total	177	187	364

Source: Washaw Sibi Band population list, July 2006

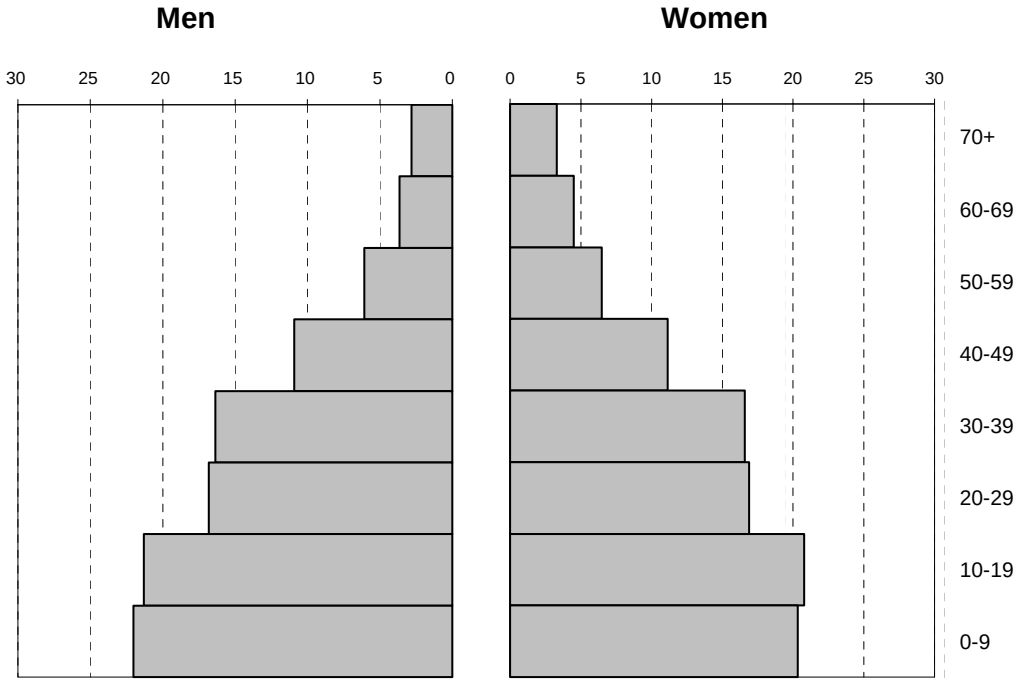
If the mean ages are comparable, the same cannot be said of the age group distribution, as shown in Figure 1 and Figure 2. The age groups 20 to 29 and 0 to 9 on the Washaw Sibi membership list represent much lower proportions of the population than similar age groups in the general population of Iiyiyiu Aschii. The voluntary nature of the membership at this time might have something to do with explaining the difference between the 20 to 29 year old groups; while the seeming under-representation of the 0 to 9 year old group in Washaw Sibi might reflect a problem of either under-representation, with some children not being registered at this time, or of the registration list not being kept up-to-date with new births (since the age was calculated from the registered birth date to July 1st, 2006).

Figure 1: Washaw Sibi age group pyramid, July 2006



Source: Washaw Sibi Band population list, July 2006

Figure 2: Iiyiyiu Aschii age group pyramid, 2006



Source: MSSS, James Bay Agreement Beneficiary list, July 2006

4.2. Communities of residence and affiliation

As Table 3 shows, almost half of the Washaw Sibi population resides on the Pikogan First Nation (46.4%) or in Amos (6.6%), while some others live further, either in Val d'Or (10.4%), La Sarre (6.9%), Lac Simon (4.9%), in other communities of Iiyiyiu Aschii (7.7%) or elsewhere (17.0%).

Table 3: Community of residence

Community of residence	N	%
Pikogan	169	46.4
Val d'Or	38	10.4
La Sarre	25	6.9
Amos	24	6.6
Lac Simon	18	4.9
Chisasibi	11	3.0
Waskaganish	9	2.5
Louvicourt	7	1.9
Matagami	7	1.9
Moose Factory	7	1.9
Notre Dame	7	1.9
Senneterre	7	1.9
Val Paradis	7	1.9
Thunder Bay	6	1.6
Wemindji	6	1.6
St. Felix	5	1.4
Timmins	3	0.8
Rouyn	2	0.5
Mattagami, Ont	1	0.3
Mistissini	1	0.3
North Bay	1	0.3
Wahgoosig	1	0.3
Waswanipi	1	0.3
Whapmagoostui	1	0.3
Total	364	100.0

Source: Washaw Sibi Band population list, July 2006

As presented in Table 4, about 2/3 (68 %) of the population reported affiliation with Waskaganish, with 22 % affiliated with Waswanipi, and the remaining 9 % having affiliations with four other communities of Iiyiyiu Aschii.

Table 4: Community of affiliation in Iiyiyiu Aschii

Community of affiliation	N	%
Waskaganish	247	67.9
Waswanipi	79	21.7
Nemaska	21	5.8
Chisasibi	8	2.2
Wemindji	3	0.8
Mistissini	1	0.3
None or missing	5	1.4
Total	364	100.0

Source: Washaw Sibi Band population list, July 2006

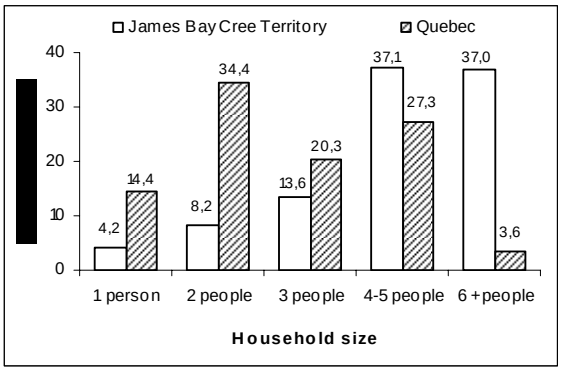
4.3. Living arrangements

The membership list that was supplied is comprised of 78 families along with 69 single individuals, as shown in Table 5. Family size is hard to analyze since this information was collected by someone who can no longer be reached and no definition of this variable was left behind. When questioned about it, the interviewer did confirm that many individuals reported as "Single family" are, in fact, living with relatives. Therefore the definition of family does not fit the definition of Statistics Canada (married or common-law couples with or without children and lone-parent families) nor does it fit their definition of "Household" (person or group of persons who occupy a private dwelling) since other residents should be taken into account.

According to the information available at this time, households in the region are very different from those in Iiyiyiu Aschii. In the survey, 25% of households had 4 or more members, whereas this describes 74% of households in Iiyiyiu Aschii. Similarly, only 8% of households had 6 or more members, while 37% of households in Iiyiyiu Aschii are of this size but only 4% of households in Québec.

Table 5: Family size

Family size	N
1	69
2	13
3	28
4	15
5	11
6	8
7	2
8	1
Total	147



Source: Washaw Sibi Band population list, July 2006

5. PROFILE OF THE NEEDS ASSESSMENT POPULATION

5.1. Age groups

By choosing to interview a sample of 100, the actual results are the same as the percentage results. The profile of those interviewed is somewhat similar to the profile of the population aged 18 and over: the average age of the interview sample was 40 years compared to 39 years for the population. Women are marginally overrepresented since they constitute 53% of the interviewed group while they only represent 49% of the population.

Table 6: Age groups by gender

Age group	Female	Male	Total
10 to 19	2	1	3
20 to 29	9	14	23
30 to 39	16	15	31
40 to 49	10	5	15
50 to 59	8	8	16
60 to 69	5	4	9
70 and more	3	-	3
Total	53	47	100

5.2. Language

Of the people interviewed, 70% speak Cree and/or Algonquin (not shown). The capacity to speak Cree seems to have diminished over time. While 98% of Iiyiyiu Aschii Iiyiyiuch speak Cree[i], only 56% of the Washaw Sibi interviewees are able to hold a conversation. Most speak English (83%) and/or French (70%). In comparison, in Iiyiyiu Aschii while 81% speak English, only 21% can hold a conversation in French.

Table 7: Capacity to hold a conversation in a language, by gender

Conversation	Female	Male	Total
Cree	33	23	56
Algonquin	16	17	33
English	40	43	83
French	36	34	70

Table 8: Capacity to hold a conversation in a language, by age group

Conversation language	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Cree	12	14	9	10	9	2	56
Algonquin	1	8	3	12	6	3	33
English	24	24	12	14	8	1	83
French	20	25	11	12	2	-	70

Interestingly, a third of the population is trilingual, speaking Cree, English and French, compared to 18% in Iiyiyiu Aschii. Fourteen individuals only speak Algonquin as an aboriginal language. Three Elders only speak an aboriginal language: one speaks only Algonquin and the two others only Cree and Algonquin.

Table 9: Capacity to hold a conversation in a language, by language

Conversation language	Total
Cree only	-
Cree and Algonquin	2
Cree and English	12
Cree and French	2
Cree, Algonquin and English	6
Cree, Algonquin and French	1
Cree, English and French	23
Cree, Algonquin, English and French	10
Algonquin only	1
Algonquin and English	-
Algonquin and French	4
Algonquin, English and French	9
English only	9
French only	7
English and French	14
Total	100

When asked "What language do you speak most often at home?", French was indicated as the language of preference for 35 individuals, Cree being mainly spoken by only 28% of the Washaw Sibi households, compared to 49% in Iiyiyiu Aschii. English comes in third, with 25% of the interviewees living in a house where that language is preferred.

Table 10: Language spoken at home

Language spoken at home	Total
Cree	28
Algonquin	3
English	25
French	35
Multiple answers	8
Total	99

5.3. Education

Only 21% or the Washaw Sibi participants aged 20 years or more reported having pursued their studies past the secondary level, compared to 30% in Iiyiyiu Aschii.

Table 11: Highest level of schooling completed, by gender, age 20 or over

Completed level (N)	Female	Male	Total
No formal schooling	3	1	4
Some or compl. elementary school	4	6	10
Some or compl. secondary school	30	32	62
Some or compl. college or higher ed. level (not university)	10	5	15
Some or compl. university	4	1	5
Total	51	45	96

Women were more likely to pursue post-secondary education (27%) than their male counterpart (13%).

Table 12: Highest level of schooling completed, % by gender, 20 years or more

Completed level (%)	Female	Male	Total
No formal schooling	5.9	2.2	4.2
Some or compl. elementary school	7.8	13.3	10.4
Some or compl. secondary school	58.8	71.1	64.6
Some or compl. college or higher ed. level (not university)	19.6	11.1	15.6
Some or compl. university	7.8	2.2	5.2
Total	100.0	100.0	100.0

Table 13: Highest level of schooling completed, by age groups

Completed level	18 - 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
No formal schooling	-	-	-	-	-	1	3	4
Some or compl. elementary school	-	2	1	-	2	5	-	10
Some or compl. secondary school	3	17	22	9	11	3	-	65
Some or compl. college or higher (not university)	-	3	7	3	2	-	-	15
Some or compl. university	-	-	1	3	1	-	-	5
Total	3	22	31	15	16	9	3	99

5.4. Employment

Only 27% of the interviewees (aged 18 years or over) reported being employed (work full time, part time or occasionally) compared to 46% of the Iiyiyiu Aschii Iiyiyiuch (aged 15 years or over)... There seems to be no difference between genders. Overall, 23% indicated that they were participants of the Income Security Program, compared to 19% reported in Mistissini for the same age group.

Table 14: Present working status, by gender

Present working status	Female	Male	Total
Work full time	10	10	20
Work part time	2	2	4
Work occasionally	1	2	3
Student	6	5	11
Housework	5	1	6
Retired or on pension	-	1	1
Unemployment insurance	4	6	10
Income Security Program	13	10	23
Social welfare	12	7	19
Not working for health reasons	-	1	1
Other	-	1	1
Total	53	46	99

Table 15: Present working status, by age group

Present working status	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Work full time	4	6	6	4	-	-	20
Work part time	-	3	1	-	-	-	4
Work occasionally	1	1	-	1	-	-	3
Student	7	2	2	-	-	-	11
Housework	1	2	-	3	-	-	6
Retired or on pension	-	-	-	-	1	-	1
Unemployment insurance	1	6	2	1	-	-	10
Income Security Program	3	4	3	2	8	3	23
Social welfare	7	7	1	4	-	-	19
Not working for health reasons	-	-	-	1	-	-	1
Other	1	-	-	-	-	-	1
Total	25	31	15	16	9	3	99

5.5. Traditional Lifestyle

The participants were asked "How often did you go out on the land or to a cottage or camp?" during the past year, for each season of the year. They were offered choices of five time periods as shown in Table 16. For purposes of analysis, a value was given to each of these time periods. When these values were averaged, spring came out as the most active season for going out, followed by fall and summer, then winter. When compared to Mistissini figures, bush or camp activities happen more frequently during the summer for residents of Washaw Sibi.

Table 16: Frequency of bush or camp activities, by season

Value	Frequency	Fall	Winter	Spring	Summer
0	Never	30	49	29	37
1	Less than once a month	8	5	6	3
2	1-3 days a month	20	11	21	14
3	1-3 days a week	25	15	22	23
4	4 or more days a week	16	19	21	22
	Total	99	99	99	99
	Averaged value	1.9	1.5	2.0	1.9
	Mistissini averaged value	1.6	1.5	2.3	1.0

Seasonal answers were also averaged to get an annual profile. When analysed by gender, men show a clear tendency to go out more often than women.

Table 17: Frequency of annual bush or camp activities, by gender

Value	Frequency	Female	Male	Total
0	Never	17	5	22
1	Less than once a month	9	8	17
2	1-3 days a month	11	17	28
3	1-3 days a week	8	7	15
4	4 or more days a week	8	9	17
	Total	53	46	99
	Averaged value	1.6	2.2	1.9

Using the same analytical approach, when observed by age groups, bush or camp activities increase greatly with age, with Elders aged 70 years or more spending almost half of their time in the bush, compared to somewhere around one day a month for youth aged 18 to 29 years.

Table 18: Frequency of annual bush or camp activities, by age group

Value	Frequency	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
0	Never	8	6	5	2	1	-	22
1	Less than once a month	6	8	1	2	-	-	17
2	1-3 days a month	8	9	4	7	-	-	28
3	1-3 days a week	1	2	3	3	4	1	14
4	4 or more days a week	2	6	2	2	4	1	17
	Total	25	31	15	16	9	2	98
	Averaged value	1.3	1.8	1.7	2.1	3.1	3.5	1.9

6. HEALTH STATUS

6.1. Chronic health conditions

Diabetes is the most frequently self-reported disease, with 24% of the participants saying they had been diagnosed. This compares to 16.9% of diagnosed cases in Iiyiyiu Aschii for the same age group, in 2006 and 20.5% for self-reported cases in Mistissini, in 2005. This self-reported rate for Mistissini was slightly higher than the 17.9% of diagnosed cases in Mistissini in that year. From this, we might presume that even were Washaw Sibi self-reports higher than actually diagnosed cases, the rate might still be higher than that found anywhere in communities of Iiyiyiu Aschii.

Table 19: Chronic health conditions, by gender

Chronic health condition	Female	Male	Total	Mistissini (%)
Anaemia (low red blood cells or low iron)	12	4	16	8.2
Cancer	1	-	1	3.5
Diabetes	19	5	24	20.7
High blood pressure	13	7	20	23.5
Heart disease	4	3	7	2.4
High cholesterol (Hypercholesterolemia)	12	6	18	9.3
Goitre or thyroid trouble	3	-	3	5.9
Respiratory trouble (such as asthma, emphysema)	16	7	23	10.0
Liver problems	2	3	5	2.3
Kidney problems	2	3	5	7.1
Osteoporosis (bone fragility)	7	2	9	4.7

Respiratory trouble is reported almost as often with 23% of those interviewed indicating that they were affected by this chronic condition. This is in contrast to 10% of the 170 Mistissini Nituuchischaayihtitaau Aschii Survey participants of the same age group who reported suffering from this problem. Heart disease and high cholesterol also seem to be important, when compared to the Mistissini data.[8]

[8] Individuals may have reported more than one health problem.

Table 20: Chronic health conditions, by age group

Chronic health condition	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Anaemia	1	2	5	2	5	1	16
Cancer	-	-	1	-	-	-	1
Diabetes	-	5	4	8	5	2	24
High blood pressure	1	3	2	5	6	3	20
Heart disease	-	-	1	2	3	1	7
High cholesterol	1	4	2	6	4	1	18
Goitre or thyroid trouble	-	-	-	-	2	1	3
Respiratory trouble	4	7	3	2	5	2	23
Liver problems	2	1	-	1	1	-	5
Kidney problems	1	-	-	2	2	-	5
Osteoporosis	-	1	1	2	3	2	9

6.2. Restriction of activities

The following figures in the Restriction of activities section are presented as information for planning future services.

Table 21: Restriction of activities, by gender

Restriction of activities	Female	Male	Total
Difficulty hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing any similar activities	15	13	28
Need help with house going	7	3	10
Need help with personal care such as washing, dressing, eating or taking medication	2	1	3
Need help with moving about inside the house	3	1	4
Need help with looking after personal finances such as making bank transactions or paying bills	4	3	7

The questions were selected from a list of questions which are usually used to build a global indicator on restriction of activities. Therefore, no comparison is available.

Of concern, is that 28% of the participants reported having difficulty hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing similar activities. Other activities causing some difficulties are "House going" (10%), "Looking after personal

finances" (7%), "Moving about inside the house" (4%) and "Personal care" (3%). Women reported more problems in moving about inside the house.

Table 22: Restriction of activities, by age group

Restriction of activities	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Difficulty hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing any similar activities	7	4	1	7	6	3	28
Need help with house going	1	1	-	-	5	3	10
Need help with personal care such as washing, dressing, eating or taking medication	1	-	-	-	1	1	3
Need help with moving about inside the house	1	1	-	1	1	-	4
Need help with looking after personal finances such as making bank transactions or paying bills	1	-	-	-	5	1	7

Table 23: Ability to remember things, by age group

Ability to remember things	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Able to remember most things	21	23	14	8	-	1	67
Somewhat forgetful	5	8	1	7	8	2	31
Very forgetful	-	-	-	1	1	-	2
Total	26	31	15	16	9	3	100

When asked "Are you usually free of pain or discomfort?" 79 persons answered "Yes".

Table 24: Presence of pain or discomfort, by age group

Pain or discomfort	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Usually free	23	28	13	9	4	2	79
Not usually free	3	3	2	7	5	1	21
Total	26	31	15	16	9	3	100

Of the 21 who answered "No", 14 individuals reported that they were limited in some or most of their activities due to the pain or discomfort they felt. No difference was reported between genders (not shown).

Table 25: Limitation of activities due to pain or discomfort, by age group

Activities	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
None	1	-	1	1	-	-	3
A few	-	1	-	2	-	1	4
Some	2	1	-	1	5	-	9
Most	-	1	1	3	-	-	5
Total	3	3	2	7	5	1	21

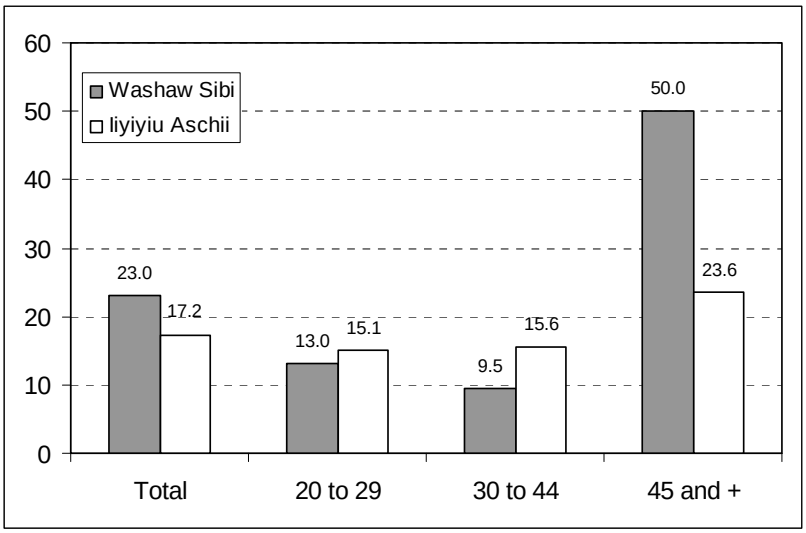
6.3. Perception of health status

People's perception of their own health decreases with age, as expected in any population.

Table 26: Self perception of health, by age group

Self perception of health	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Excellent	5	4	4	2	-	-	15
Very Good	12	12	4	3	1	-	32
Good	6	11	6	5	1	1	30
Fair	3	4	1	5	4	2	19
Poor	-	-	-	1	3	-	4
Total	26	31	15	16	9	3	100

Figure 3: Perception of health as 'fair' or 'poor' by age group, Washaw Sibi and Iiyiyiu Aschii



As presented in

Figure 3, the age groups under age 45 perceive themselves more or less like those in Iiyiyiu Aschii; however half of those aged 45 and over say their health is only "Fair" or "Poor". This is quite different from Iiyiyiu Aschii Crees where only 24% of those 45 and older say they are in only fair or poor health.

Surprisingly, a third of participants said their health was better ("somewhat better" or "much better") than it was a year ago.

Table 27: Perception of actual health compared to one year ago, by age group

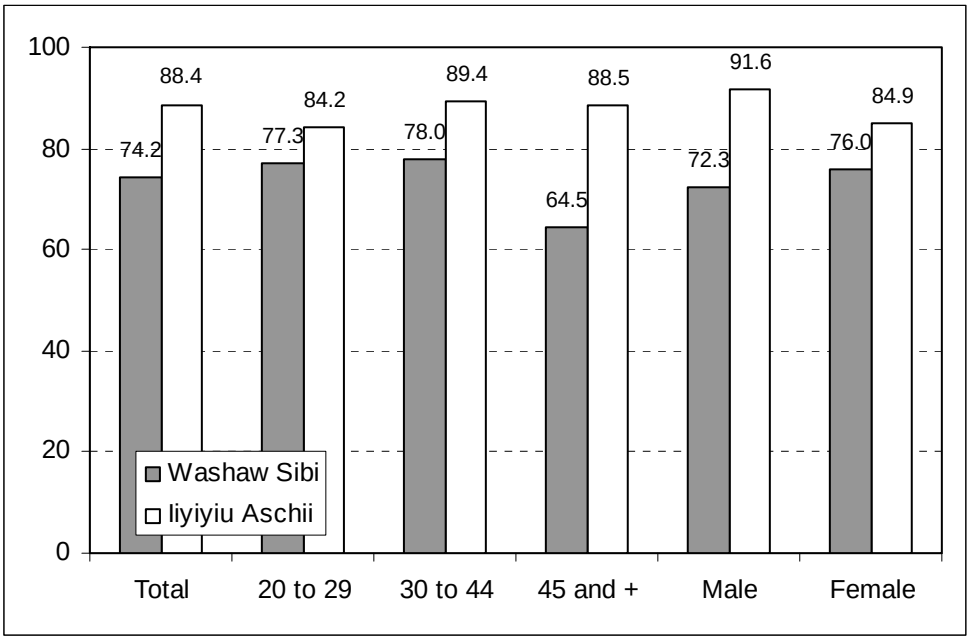
Perception of actual health	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Much better now than 1 year ago	8	4	7	1	1	-	21
Somewhat better now than 1 year ago	-	9	1	2	1	-	13
About the same	17	16	6	9	5	3	56
Somewhat worse now than 1 year ago	1	2	1	4	1	-	9
Much worse now than 1 year ago	-	-	-	-	1	-	1
Total	26	31	15	16	9	3	100

Participants from Washaw Sibi reported less satisfaction with life in general than was reported by people in Iiyiyiu Aschii. This was true for each age group and for each gender. Men show the biggest gap between the two regions since only 72% of Washaw Sibi male participants answered being "Very satisfied" or "Satisfied" with their life in general compared to 92% for their counterparts in Iiyiyiu Aschii.

Table 28: Satisfaction with life, by age group

Satisfaction with life	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Very satisfied	8	5	3	1	-	-	17
Satisfied	12	18	9	8	6	2	55
Neither satisfied nor dissatisfied	4	8	2	4	2	-	20
Dissatisfied	1	-	-	3	1	-	5
Total	25	31	14	16	9	2	97

Figure 4: Satisfaction with life (Very satisfied or Satisfied) by age group and gender, Washaw Sibi and Iiyiyiu Aschii



6.4. Body Mass Index

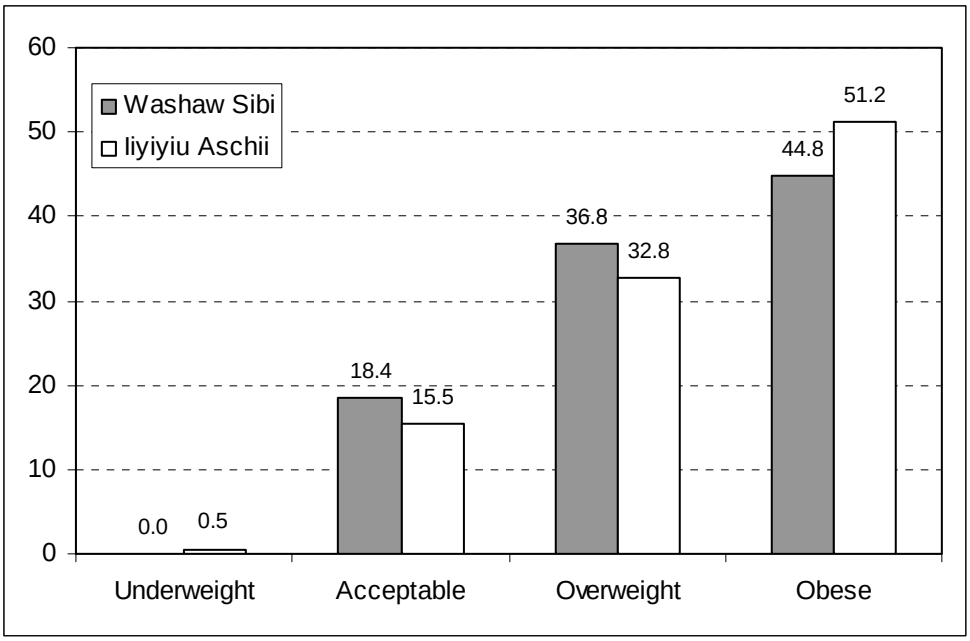
Body Mass Index (BMI) is a measure that looks at a person's weight as compared to their height. It is calculated as weight (kg) divided by height in meters squared. The cut-off points used here are those currently recommended by the World Health Organization (WHO), and differ slightly from the Canadian standard in past years.

Weight and height were reported by 87 participants. Overall, if we compare BMI's produced from their self-reported weight and height, 82% of these 87 Washaw Sibi participants are overweight or obese compared to 84% for Iiyiyiu Aschii Cree residents of the same age group (18 years or more).

Table 29: Body Mass Index, by WHO category

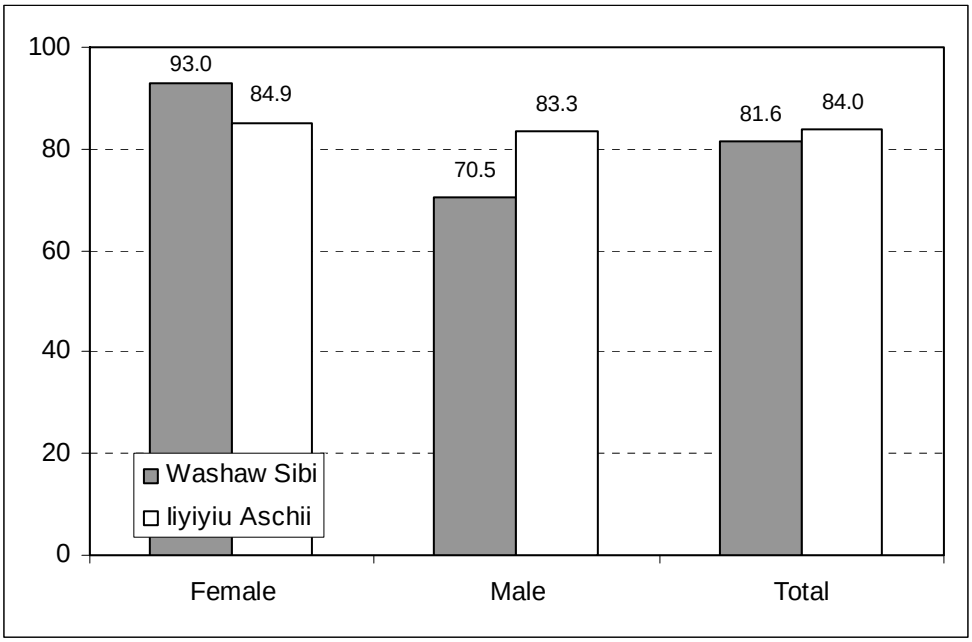
BMI category	N	%
Underweight (BMI <18.5)	-	-
Acceptable (BMI 18.5 to 24.9)	16	18.4
Overweight (BMI 25 to 29.9)	32	36.8
Obese (BMI 30+)	39	44.8
Sub-total	87	100.0
Missing information	13	
Total	100	

Figure 5: Body Mass Index by WHO category, Washaw Sibi and Iiyiyiu Aschii



While the proportion of all overweight and obese persons is similar in Washaw Sibi and Iiyiyiu Aschii, the same cannot be said if the results are considered by gender. In Washaw Sibi, female rates are much higher than those of males, while in Iiyiyiu Aschii, they are about the same.

Figure 6: Overweight and obese according to WHO category by gender, Washaw Sibi and Iiyiyiu Aschii



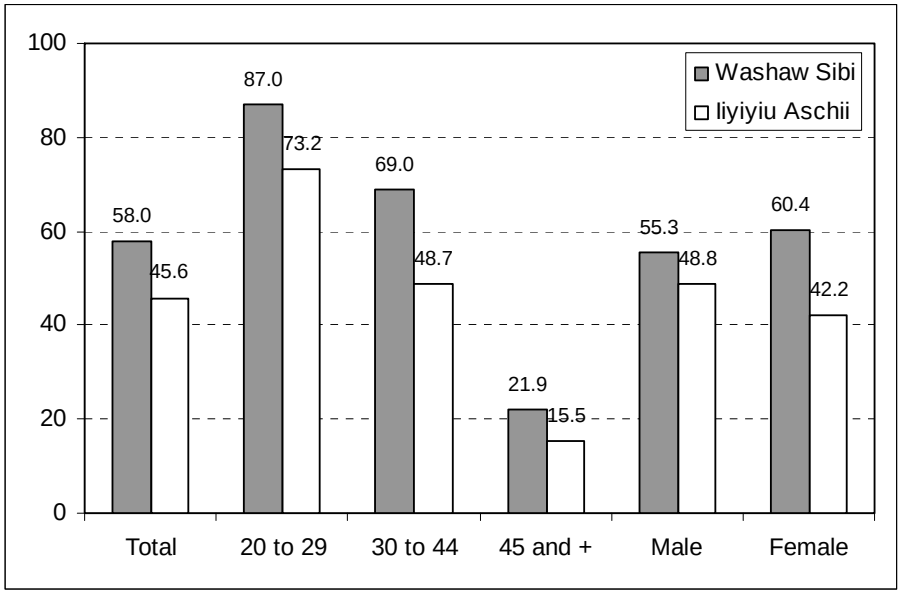
6.5. Smoking

As in other regions, Washaw Sibi youth are more likely to smoke daily or occasionally than older persons. If we compare the community results to those of Iiyiyiu Aschii residents, Washaw Sibi residents are much more likely to smoke. This is observed across all age groups and for both genders, females showing the greatest difference. The average number of cigarettes consumed by daily smokers is 8.8, compared to 9.9 for the region.

Table 30: Smoking frequency by age group

Smoking frequency	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Daily	15	16	5	4	-	1	41
Occasionally	7	7	3	-	-	-	17
Not at all	4	8	7	12	9	2	42
Total	26	31	15	16	9	3	100

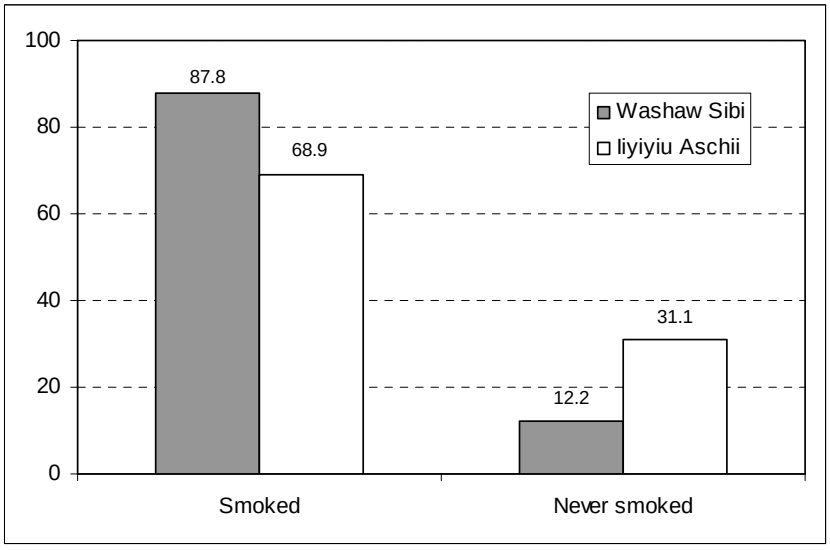
Figure 7: Daily and occasional smokers by age group and gender, Washaw Sibi and Iiyiyiu Aschii



Note: Total and gender results for Iiyiyiu Aschii are produced for persons aged 12 years or more

The higher rates of smoking even show up in the group reporting that they did not smoke. Among the 42 persons that answered that they are non-smokers, 88% reported smoking daily in the past, compared to non-smokers in Iiyiyiu Aschii of which 69% reported smoking either daily or only occasionally in the past.

Figure 8: Washaw Sibi non-smokers who smoked daily and Iiyiyiu Aschii non-smokers who smoked daily or occasionally in the past



Note: Results for Iiyiyiu Aschii are for persons aged 12 years or more

The more people smoke, the less restrictions there are about smoking in their home. Overall, the proportion of households where smoking is not allowed (86%) is the same as in Iiyiyiu Aschii households (85%).

Table 31: Household smoking restrictions by frequency of smoking

Type of smoker	Smoking allowed	No smoking	Total	%
Daily	10	31	41	24.4
Occasionally	3	14	17	17.6
Not at all	1	41	42	2.4
Total	14	86	100	14.0

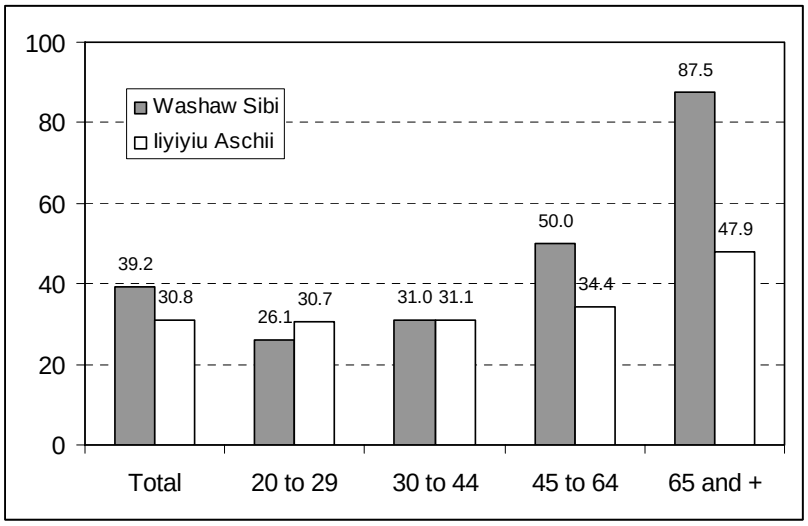
6.6. Dental health

For people aged 45 and over, and especially for those aged 65 and over, report having poorer dental health than similar age groups in Iiyiyiu Aschii.

Table 32: Health of teeth and mouth

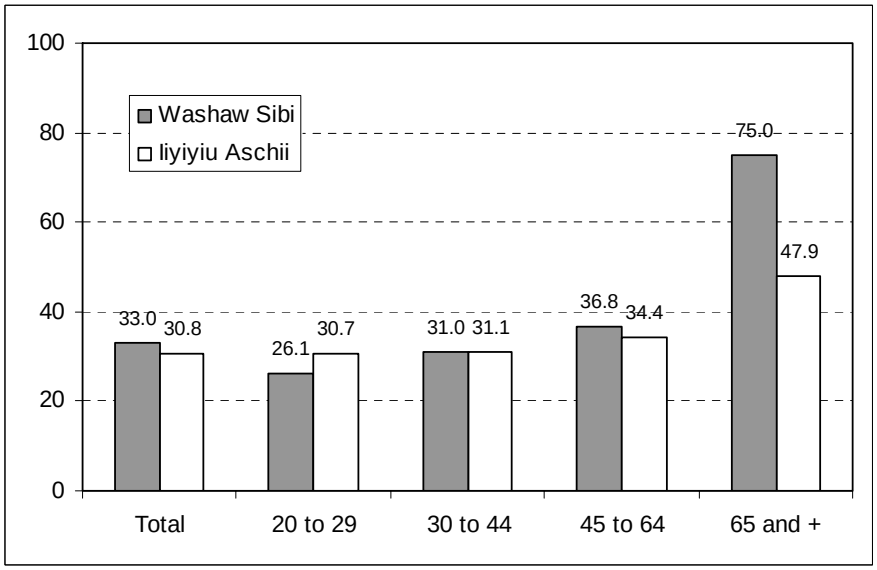
Health of teeth and mouth	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Excellent	1	2	2	-	-	-	5
Very Good	4	7	1	1	-	-	13
Good	14	11	8	9	-	-	42
Fair	6	8	2	2	1	-	19
Poor	1	3	1	2	3	1	11
Sub-total	26	31	14	14	4	1	90
Dentures wearer	-	-	1	2	5	1	9

Figure 9: Self report of the health of teeth and mouth being only Fair or Poor by age group, and including denture wearers, Washaw Sibi and Iiyiyiu Aschii



The figure below compares people in Washaw Sibi and Iiyiyiu Aschii who report having only fair or poor dental health while excluding everyone who said they wear dentures. Four Elders, aged 65 and over and who do not wear dentures, were interviewed. Three reported only fair or poor dental health. However this was very few people so we do not know if it is a general problem or only specific to these individuals.

Figure 10: Self report of the health of teeth and mouth being only Fair or Poor, by age group, and excluding denture wearers, Washaw Sibi and Iiyiyiu Aschii



5% of the participants answered that they were unable to chew firm foods. This level is similar to the 4% reported in Iiyiyiu Aschii.

Table 33: Ability to chew different type of food

Ability to chew some food items	Dentures	No dentures	Total
N	9	90	99
Unable to chew firm foods (e.g., meat)	1	4	5
Unable to bite off and chew a piece of fresh apple	4	6	10
Unable to chew boiled vegetables	-	1	1

Only those who do not wear dentures were asked when they had last visited the dentist. Their results compare to those of Iiyiyiu Aschii, except for persons aged 45 years and over who reported less recent visits than people in Iiyiyiu Aschii.

Table 34: Last visit to a dentist, by age group

Last time went to a dentist	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Less than 1 year ago	14	17	12	5	-	-	48
1 year to less than 2 years ago	4	6	2	3	1	-	16
2 years to less than 3 years ago	3	4	-	3	1	-	11
3 years to less than 4 years ago	3	1	-	-	1	-	5
4 years to less than 5 years ago	1	2	-	2	-	-	5
5 or more years ago	1	1	-	1	1	1	5
Total	26	31	14	14	4	1	90

Figure 11: Last visit to a dentist, by age group, Washaw Sibi

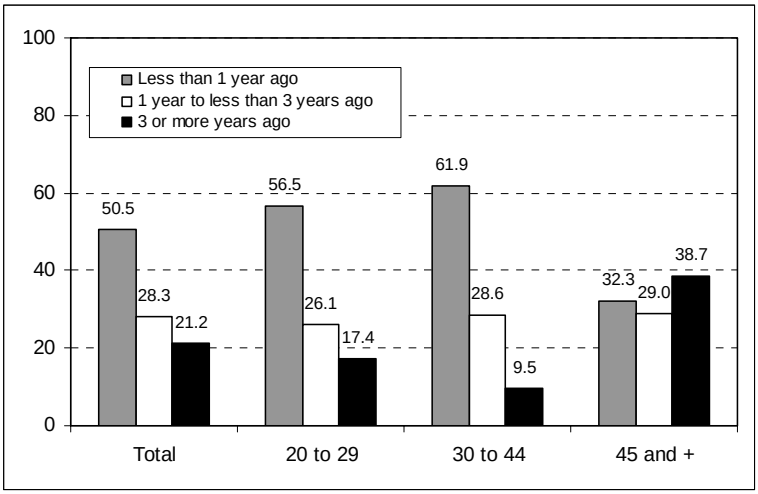
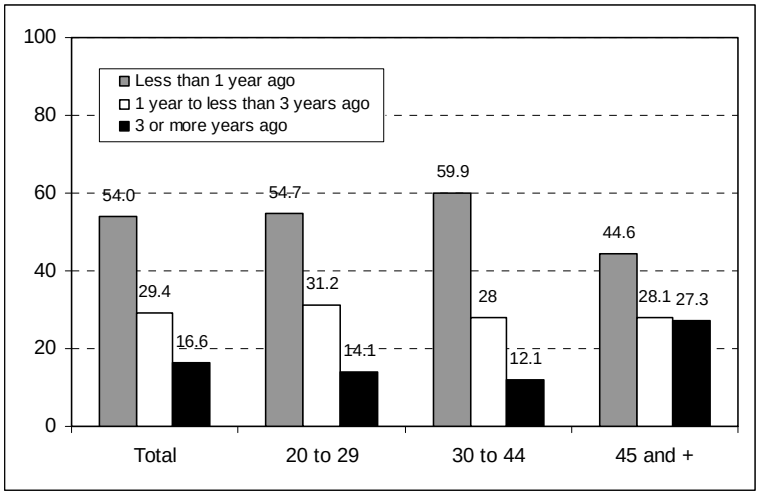


Figure 12: Last visit to a dentist, by age group, Iiyiyiu Aschii



6.7. Mental health

The evaluation of perceptions of personal stress shows that younger people report feeling less stress than their elders. This is even more evident in Washaw Sibi than in Iiyiyiu Aschii since 62% of the persons aged 18 to 24 years old report being "Not at all stressful" or "Not very stressful" compared to only 48% further north. This difference tends to disappear with age.

Interestingly, those aged between 18 and 24 from Washaw Sibi report lower levels of stress than their age group in the rest of Québec (8% vs. 28% for those aged 15 to 24). This difference is even more evident with those aged 25 to 44 (10% vs. 36%).

Table 35: Evaluation of personal stress level by age group

Stress level	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Not at all stressful	2	2	1	1	1	-	7
Not very stressful	11	9	6	5	1	2	34
A bit stressful	11	16	7	7	4	-	45
Quite a bit stressful	1	3	1	3	3	-	11
Extremely stressful	-	1	-	-	-	-	1
Total	25	31	15	16	9	2	98

Figure 13: Evaluation of personal stress level by age group, Washaw Sibi

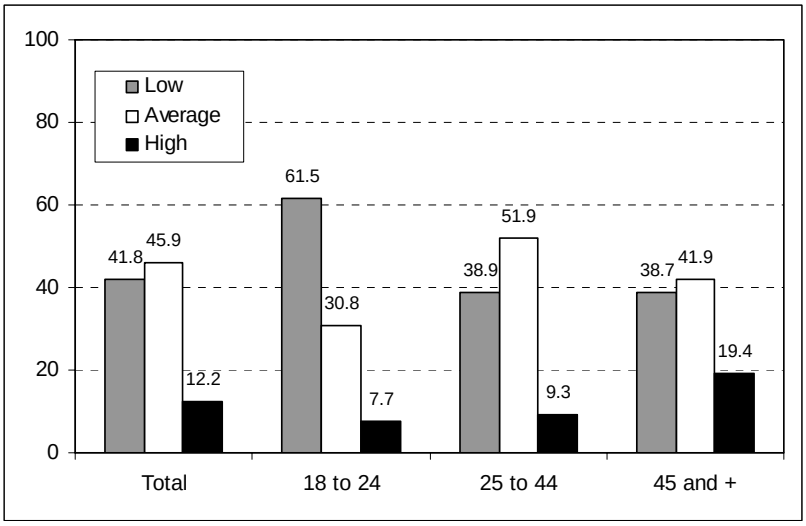
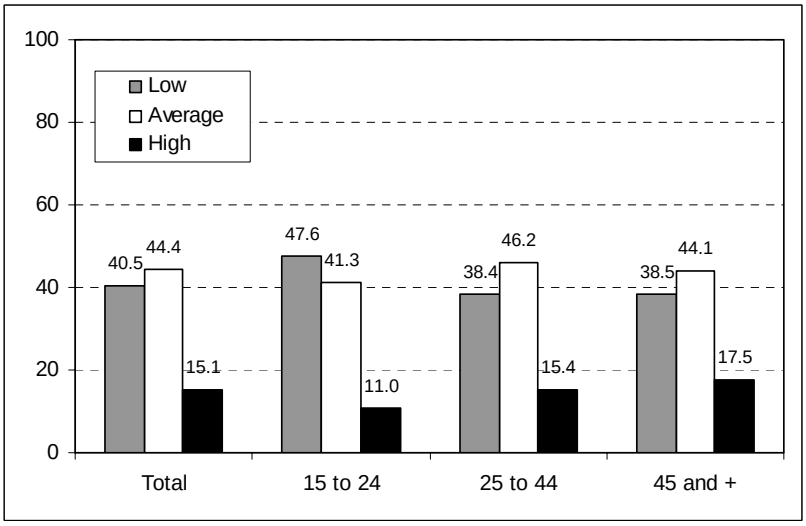


Figure 14: Evaluation of personal stress level by age group, Iiyiyiu Aschii

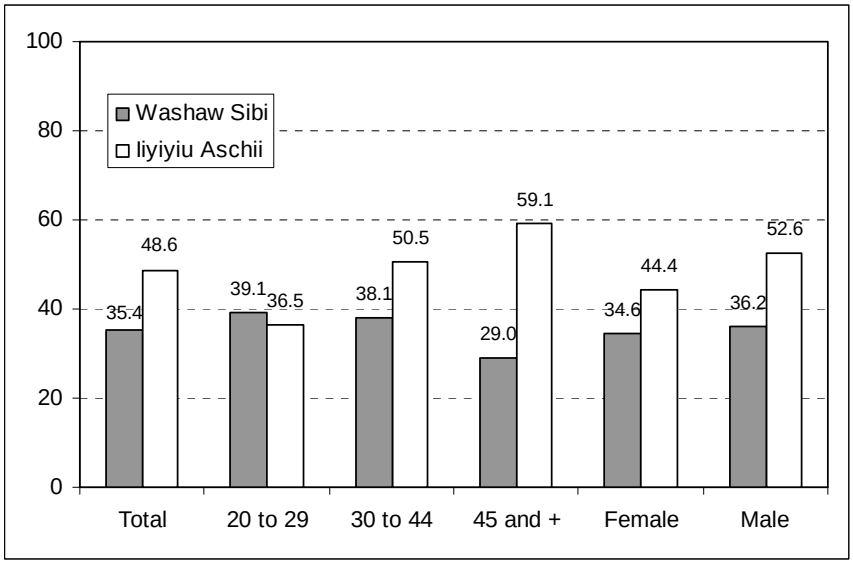


Reports of personal ability to handle unexpected and difficult problems show a very different pattern between Washaw Sibi and Iiyiyiu Aschii when looked at by age groups. In Iiyiyiu Aschii, as people age they report greater ability to manage problems. However, in Washaw Sibi, the pattern is reversed and older people report less ability to manage problems. The greatest difference shows in the pattern reported by men.

Table 36: Ability to handle unexpected and difficult problems, by age group

Ability to handle problems	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Excellent	5	4	1	1	1	-	12
Very Good	5	7	6	4	-	1	23
Good	10	16	7	5	4	-	42
Fair	5	4	1	6	4	1	21
Poor	1	-	-	-	-	-	1
Total	26	31	15	16	9	2	99

Figure 15: Ability to handle unexpected and difficult problems, by age group and gender, Washaw Sibi and Iiyiyiu Aschii



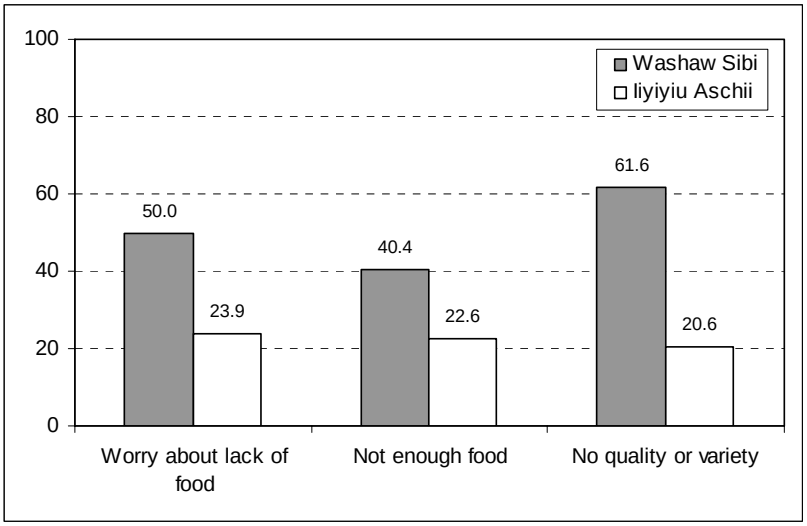
6.8. Food insecurity

Participants from Washaw Sibi are clearly more insecure than Iiyiyiu Aschii residents about having access to enough food or to food of good quality and variety and this could be related to the reported low rates of employment and low levels of personal income.

Table 37: Food insecurity, by gender

Worry often or sometimes about:	Female	Male	Total	Female	Male	Total
	N	N	N	%	%	%
Not be enough to eat	29	20	49	55.8	42.6	49.5
Not have enough because lack of $	24	16	40	46.2	34.0	40.4
Not eat quality or variety of foods	34	27	61	65.4	57.4	61.6
Total sample size	52	47	99	100.0	100.0	100.0

Figure 16: Food insecurity, Washaw Sibi and Iiyiyiu Aschii



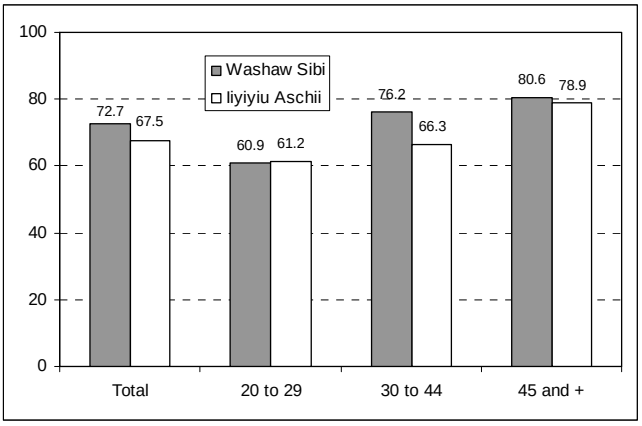
6.9. Spiritual values

Iiyiyiuch consider spiritual values important, and this increases with age. The group from Washaw Sibi aged 30 to 44 report greater importance to spiritual values than their counterparts in Iiyiyiu Aschii (76% compared to 66%).

Table 38: Importance of Spiritual values, by age group

Spiritual values important	18 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and more	Total
Yes	15	21	14	10	9	3	72
No	6	10	1	3	-	-	20
Sub-total	21	31	15	13	9	3	92
DNK/NR/R	5	-	-	2	-	-	7
Total	26	31	15	15	9	3	99

Figure 17: Importance of Spiritual values, by age group, Washaw Sibi and Iiyiyiu Aschii



Of the Washaw Sibi members interviewed, 37% identify as Roman Catholics, 20% as Pentecostals, and 17% as Anglicans. The interviewer proposed a supplementary response of "Spiritual". Since this was not included in the Iiyiyiu Aschii surveys, the results are not comparable. In Iiyiyiu Aschii in 2003, 66% of people from the Inland communities identified themselves as Pentecostals and 42% from Coastal communities identified themselves as Anglicans.

Table 39: Religion of participants, Washaw Sibi and sub-regions of Iiyiyiu Aschii

Religion	Washaw Sibi		Iiyiyiu Aschii	
			Inland	Coastal
	N	%	%	%
Roman Catholic	34	37.0	6.5	8.1
Anglican (Church of England, Episcopalian)	15	16.3	26.8	66.3
Pentecostal	18	19.6	42.0	10.4
Other (Spiritual 22, Baptist 2)	24	26.1	6.2	8.7
No religion (Agnostic, Atheist)	1	1.1	18.5	6.5
Sub-total	92	100.0	100.0	100.0
DNK/NR/R	8			
Total	100			

6.10. Pregnancy and childbirth

Only ten of the women interviewed had given birth during the past 5 years. Consequently, the results reported below for intake of vitamin supplements and breastfeeding practices are only descriptive based on the responses of these ten women.

Table 40: Women having given birth in the past 5 years

Given birth in the past 5 years	N
Yes	10
No	40
Sub-total	50
Missing	3
Total	53

Most of the women had taken a vitamin supplement containing folic acid during their pregnancy.

Table 41: Vitamin intake during pregnancy, women having given birth in the past 5 years

Took vitamin supplement	N
Yes	9
No	1
Total	10

6 out of the 10 women who gave birth during the 5 years preceding the survey had chosen to breastfeed their child. The duration of breastfeeding varied from less than a week to about 6 months (not presented)

Table 42: Breastfeeding, women having given birth in the past 5 years

Breastfead	N
Yes	6
No	4
Total	10

6.11. Children's dental health

In the survey, 53 women were asked if there were any children aged 17 or under living in their household. The 35 responding positively were then asked to answer a Household Questionnaire on dental visits for these children. The results, when compared to Iiyiyiu Aschii Cree children show no differences.

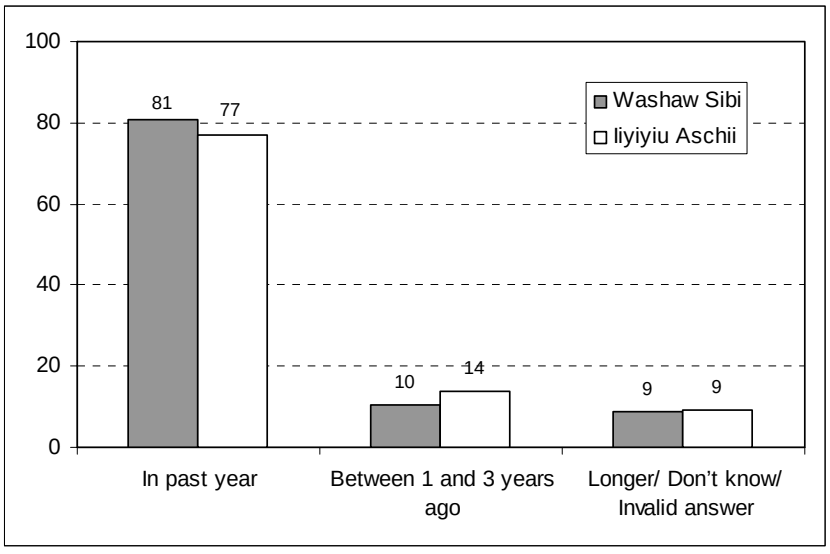
Table 43: Presence of children aged 17 years or less in the household

Any children living in household	N
Yes	35
No	15
Sub-total	50
Missing	3
Total	53

Table 44: Last visit to a dentist, children aged 17 years or less, by age group

Last visit at dentist	0 to 4	5 to 9	10 to 14	15 to 17	Total
Never	4	-	-	-	4
Less than 1 year ago	4	20	28	11	63
1 year to less than 2 years ago	-	1	2	1	4
2 years to less than 3 years ago	-	1	3	-	4
Sub-total	8	22	33	12	75
DNK/NR/R	2	-	-	1	3
Total	10	22	33	13	78

Figure 18: Time since last visit to then dentist, children aged 17 or less by age group, Washaw Sibi and Iiyiyiu Aschii



7. CONFIDENTIAL QUESTIONNAIRE SAMPLE

By mid-June, 2007, 40 confidential interviews had been received. This is a minority of the group who answered the survey. As a result, caution must be used in reading this section because it describes what the people replying reported; but it might not be true of the 60 other persons who did not reply. In other words, this must be always read as a minority sample which does not necessarily represent the majority,

In some discussions below, we present the comparisons to the population of Iiyiyiu Aschii for information purposes only. The information from Iiyiyiu Aschii is not comparable to the descriptive results from this small confidential sample. To understand why we say this, consider the following. In the confidential sample, only 3 persons reported drinking 2-3 times a week or more. This was 20% of the sample of drinkers. Had only one person answered drinking less often, this figure would have dropped to 13%.

7.1. Sample population

If those who answered the Individual Questionnaire had an average age of 40 years, those who answered the Confidential Questionnaire were older with an average age of 46 years. More women than men responded.

Table 45: Individual Questionnaire participants, by age group and gender

Age group	Female	Male	Total
18 to 29	4	4	8
30 to 39	5	2	7
40 to 49	4	3	7
50 to 59	5	3	8
60 to 69	6	2	8
70 and more	2	-	2
Total	26	14	40

7.2. Alcohol use

Among the 40 participants, 17 reported that they had drunk an alcohol beverage in the past 12 months. While everyone aged 18 to 29 said they had had a drink, this pattern decreased with age. None of the 8 people over the age of 60 who responded to the Confidential Questionnaire reported having consumed alcohol during the same period.

Table 46: Age of the 17 persons who had had a drinking in the past 12 months

Age group	Yes	No	Total
18 to 29	8	-	8
30 to 39	5	2	7
40 to 49	2	5	7
50 to 59	2	6	8
60 to 69	-	8	8
70 and more	-	2	2
Total	17	23	40

As only 17 persons reported any drinking in the confidential sample, this group represents less than 2/5 of the people who were interviewed in the general survey.

Table 47: Gender of the 17 persons who had had a drink in the past 12 months

Gender	N			%		
	Yes	No	Total	Yes	No	Total
Female	9	17	26	34.6	65.4	100.0
Male	8	6	14	57.1	42.9	100.0
Total	17	23	40	42.5	57.5	100.0

For those who responded to the confidential interview, most women reported not drinking while a majority of men reported drinking. As the numbers are small, this only tells us about the people who sent in these surveys.

Table 48: Frequency with which the 17 persons had been drinking

Frequency of drinking	N
Less than once a month	5
Once a month	2
2 to 3 times a month	3
Once a week	3
2 to 3 times a week	3
4 to 6 times a week	1
Total	17

The reported frequency of drinking of the 17 persons is very similar to the frequency reported in the Iiyiyiu Aschii survey in 2001.

Table 49: Frequency of drinking, Washaw Sibi and Iiyiyiu Aschii

Frequency of drinking among adults who drink at all	Washaw Sibi	Iiyiyiu Aschii
Once a month or less	41.2	49.0
From 2-3 times per month to once a week	35.3	39.0
From 2-6 times per week to every day	23.5	8.0
Don't know	-	4.0
Total	100.0	100.0

Caution: Only 17 people are represented in the Washaw Sibi results and this only describes their behaviour.

On the days the 17 participants drank, most of them (71%) usually had 6 drinks or more.

Table 50: Quantity of alcohol usually consumed in one occasion

Quantity	N
1 beer or glass of wine or liquor	2
2–5 beers or glasses of wine or liquor	3
6–10 beers or glasses of wine or liquor	3
More than 10 beers or glasses of wine or liquor	9
Total	17

The term "Binge" drinking is used in surveys to report drinking patterns where the person consumes five or more drinks on one occasion. This pattern of drinking is considered as heavy alcohol use and increases the risk of alcohol-related problems.

More than half (59%) of the 17 participants who drank at least once in the past 12 months "binged" at least once a month during that period. This is similar to what was found in the Iiyiyiu Aschii survey.

Table 51: Frequency of "binge" drinking

Frequency	N
Never	1
Less than once a month	6
Once a month	2
2 to 3 times a month	3
Once a week	2
More than once a week	3
Total	17

Table 52: Frequency of "binge" drinking, Washaw Sibi and Iiyiyiu Aschii

Frequency of "binge" drinking	Washaw Sibi	Iiyiyiu Aschii
Never binge	5.9	8.0
Once a month or less	47.1	53.0
2-3 times/month or once a week	29.4	31.0
More than once a week	17.6	8.0
Total	100.0	100.0

Caution: Only 17 people are represented in the Washaw Sibi results and this only describes their behaviour.

7.3. Illegal drug use

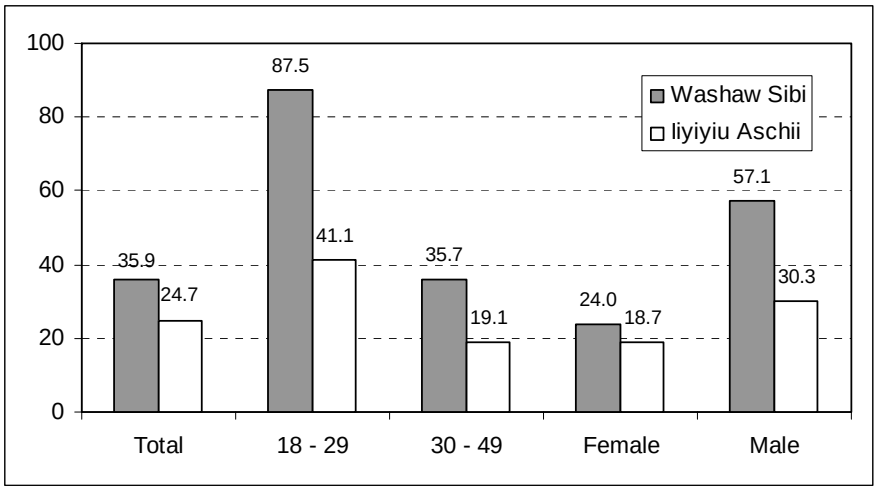
Once again, the drug consumption information only reports on 11 participants. These tables and figures are presented to suggest some trends among the group that responded.

36% of those completing the Confidential Questionnaire reported having consumed at least one type of drug in the past 12 months. The age group reporting most of this drug use is males aged 18 to 29 years. Cocaine or crack was consumed more frequently and by more persons than marijuana, the second drug of choice. This can be observed especially among women. Cocaine seems also more frequently consumed in the group responding from Washaw Sibi than in Iiyiyiu Aschii, however, the Iiyiyiu Aschii survey included people aged 12 and over while the Washaw Sibi survey included those 18 and over.

Table 53: Frequency of illegal drug use

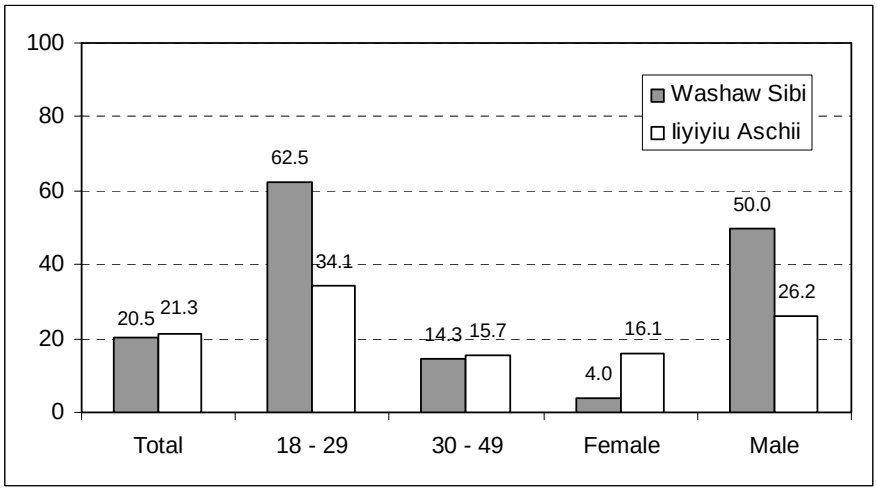
Have you used or tried	Yes	No	Missing	Less than once a month	Once a month	2 to 3 times a month	Once a week	2 to 3 times a week	4 to 6 times a week	Every day
Marijuana, cannabis or hashish	8	30	2	2	-	2	-	2	1	1
Cocaine or crack	11	28	1	1	1	5	2	2	-	-
Speed (amphetamines)	1	34	1	1	-	-	-	-	-	-
Ecstasy or other similar drugs, hallucinogens, PCP or LSD (acid), heroin or sniffed glue, gasoline, other solvents	-	35	1	-	-	-	-	-	-	-
A needle (syringe) to inject illicit drugs	1	33	2	1	-	-	-	-	-	-

Figure 19: Persons who consumed at least one illegal drug in the past 12 months by age group and gender, Washaw Sibi Confidential Questionnaire and Iiyiyiu Aschii



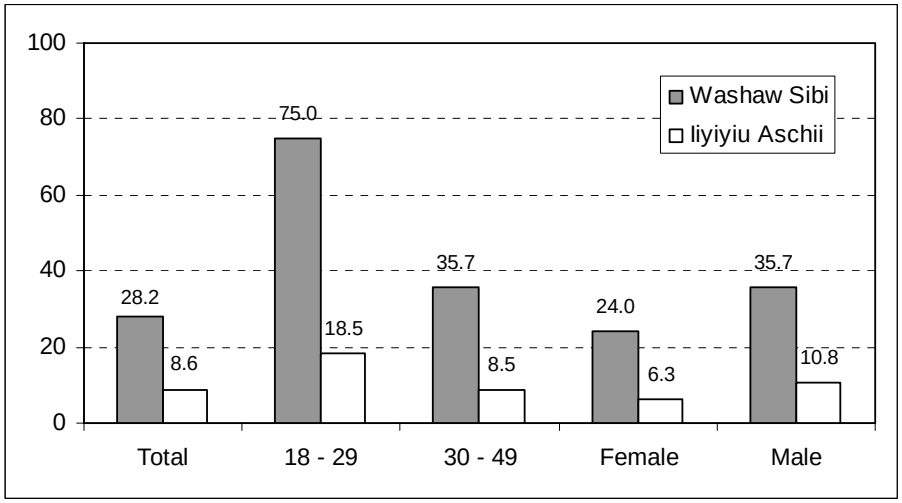
Caution: Only 11 people are represented in the Washaw Sibi results and this only describes their behaviour.

Figure 20: Persons who consumed marijuana, cannabis or hashish in the past 12 months by age group and gender, Washaw Sibi Confidential Q. and Iiyiyiu Aschii



Caution: Only 11 people are represented in the Washaw Sibi results and this only describes their behaviour.

Figure 21: Persons who consumed cocaine or crack in the past 12 months by age group and gender, Washaw Sibi Confidential Q. and Iiyiyiu Aschii



Caution: Only 11 people are represented in the Washaw Sibi results and this only describes their behaviour.

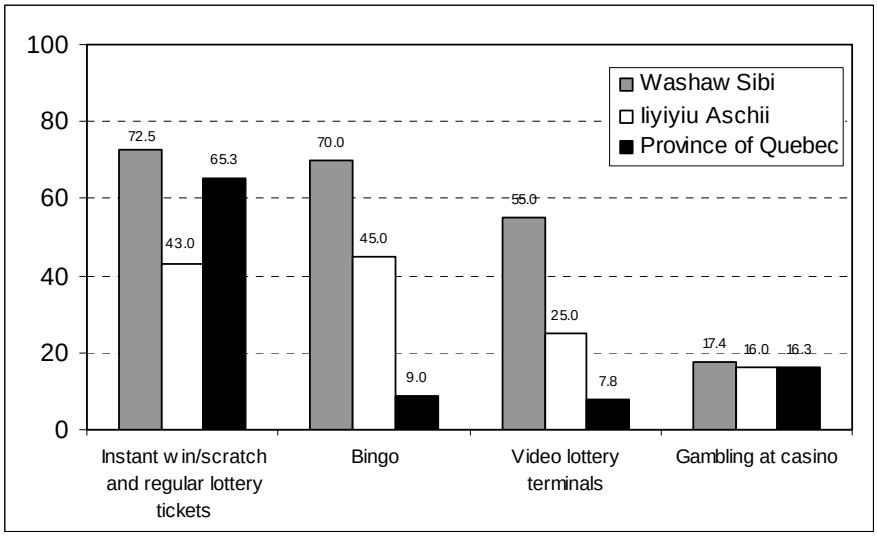
7.4. Gambling

The majority of those from Washaw Sibi responding to the Confidential Questionnaire reported that they have gambled in the past year. Almost 3 out of 5 participants (73%) said they had played Instant-win/regular lottery tickets, Bingo and Video lottery terminals, most of them at least once a month. A higher proportion of people answering the Confidential Questionnaire reported playing bingo and using Video lottery terminals more than would have been expected when compared to results for Iiyiyiu Aschii and Québec.

Table 54: Frequency of gambling activities

How often have you bet or spent money:	Between 2 to 6 times a week	About once a week	Between 2 to 3 times a month	About once a month	Between 6 to 11 times a year	Between 1 to 5 times a year	Never	Missing	Total
On instant win/scratch tickets, lottery tickets, raffles or fund–raising tickets, sports lotteries, sports pool or sporting events	5	6	7	6	2	3	11	-	40
On Bingo	3	6	6	6	2	5	12	-	40
On video lottery terminals (VLTs) outside of casinos	1	3	7	8	2	1	17	1	40
Gambling at a casino	-	1	1	-	-	4	32	2	40
On Internet or arcade gambling	-	-	-	-	-	1	38	1	40

Figure 22: Frequency of gambling activities, Washaw Sibi, Iiyiyiu Aschii and province of Quebec



Note: Instant win/scratch tickets and regular lottery tickets were two distinct questions in the Iiyiyiu Aschii and province of Quebec surveys. The highest value between both categories was kept and is presented for these regions in the regrouped category.
Caution: Only up to 29 people are represented in the Washaw Sibi results and this only describes their behaviour.

12 participants indicated that they had not spent any money on gambling in the 12 months preceding the survey.

Table 55: Average amount of money invested in gambling

Amount	N
None	12
Between 1 dollar and 50 dollars	8
Between 51 dollars and 100 dollars	6
Between 101 dollars and 250 dollars	6
Between 251 dollars and 500 dollars	7
More than 1000 dollars	1
Total	40

In order to investigate gambling practices among Washaw Sibi residents responding to the Confidential Questionnaire, some questions were selected from a set of 22 questions used to produce the Canadian Problem Gambling Index.

15 participants answered that they were not gamblers. 2 participants only answered the first question, but one of them indicated, before stopping to answer, that he had spent more money than he wanted to. Among the 23 others who answered the full set of questions, 21

reported having had, in the past 12 months, one or more of the problems mentioned: spending more money than intended and going back to win lost money were the answers given most often. It is interesting to observe that the amount of money reportedly spent gambling during the same period is quite low compared to the problems reported. Of the 8 individuals indicating problems in 5 or more of the 6 categories, half of them reported only spending between 1 and $100 on average over the past year.

Among those 8 persons reporting the most problems with gambling, 6 are cocaine users, 5 of them consuming 2 to 3 times a month or more. It is also among these individuals that are found 3 of the 6 persons who answered "Yes" when asked "In the past 12 months have you seen, or talked on the telephone, to a health professional about your emotional or mental health?" And, finally, they are the group who report having the lowest when asked about the state of their mental health. Their answers averaged 2.8 on a scale ranging from "1: Excellent" to "5: Poor", compared to 2.2 for the other 17 gamblers and 2.1 for the 15 individuals who reported not being gamblers.

Table 56: Categories of problems created by gambling

Categtory of problem	Never	Some-times	Most of the time	Almost always	Sub-total	Missing	Total
Bet or spent more money than they wanted to	6	16	3	-	25	-	25
Went back to try to win back the money they lost	8	12	2	1	23	2	25
Felt that they might have a problem with gambling	12	5	3	3	23	2	25
People criticized them or told them that they had a problem	13	9	1	-	23	2	25
Their gambling caused financial problems	13	6	1	2	22	3	25
Wanted to stop, but didn't think they could	11	8	2	2	23	2	25

7.5. Mental health

Table 57: Persons who saw, or talked on the telephone, to a health professional about their emotional or mental health

Have you seen, or talked to a health professional about your emotional or mental health	Total	Gamblers		Non gamblers
		Problems in 5-6 categories	Problems in 4 or - categories	
Yes	6	3	3	-
No	34	5	14	15
Total	40	8	17	15

Table 58: Self-perceived state of mental health

Self-perceived state of mental heath	Total	Gamblers		Non gamblers
		Problems in 5-6 categories	Problems in 4 or - categories	
Excellent	11	2	5	4
Very good	14	1	6	7
Good	10	3	4	3
Fair	4	1	2	1
Poor	1	1	-	-
Total	40	8	17	15

The majority of participants had either not had a sexual partner in the past 12 months, or had had only one. 3 people reported having had sexual intercourse with more than 1 partner. These include 2 of the 6 individuals who reported having been diagnosed with a sexually transmitted disease in the past; as well as 2 of the 3 participants who reported using a condom the last time they had had sexual intercourse.

Table 59: Number of sexual partners in the past 12 months

# of partners	N
None	23
1 partner	14
2 partners	1
3 partners	1
4 or more partners	1
Total	40

Table 60: Persons diagnosed with a sexually transmitted disease in the past; used a condom during last sexual intercourse

	Have you ever been diagnosed with an STD	Did you use a condom
	N	N
Yes	6	3
No	33	33
Sub-total	39	36
Missing	1	4
Total	40	40

8. ASSESSMENT OF FUTURE NEEDS FOR SERVICES

Today, most Washaw Sibi families live in proximity to their historic land use area, residing in Pikogan, Amos, Val d'Or, La Sarre and Lac Simon. They speak more French and less Cree than their relatives to the north. This report involves a small study assessing the health needs of the membership of Washaw Sibi in order to serve as a planning document for future health services. Its aim was to identify health and social services needs, to identify the barriers to services, and to identify the resources already present in the community. Health and social services needs were identified primarily through a survey of 100 members of Washaw Sibi. Potential needs concerning mental health services, alcohol and drug use and safe sexual health were addressed in a mail-in confidential questionnaire. Because of the low return of the confidential questionnaires, the information reported from them only describes the people who replied and may not reflect the majority of members of Washaw Sibi. Information about services and resources was obtained in two focus groups with people living in Pikogan and Amos. The focus groups were held before the survey results were available.

Issues with availability of and access to services are similar to what is seen in Iiyiyiu Aschii. People had no real complaints about their physical health services; they did identify serious shortcomings in mental health services and social services. However, the extent of health problems identified by the survey participants implies that they are, or should be, a group which requires regular and extensive access to a full-range of services.

The findings about people's physical health should raise some concerns. As is well known, staying healthy into old age is also linked to financial security in life. The old Cree producing what they needed from the bush had financial security, as do most people today with stable, well-paying jobs. However, most people living on the Income Security Program or social welfare will not be receiving enough to pay for what they need to consume to assure their financial security.

Among the survey participants, almost a quarter reported having diabetes and almost the same number reported having respiratory trouble. The diabetes rate is higher than any self-reported rates from studies in Iiyiyiu Aschii. Respiratory disease is also much higher than has been reported in Iiyiyiu Aschii where only 10% of participants in the Mistissini Nituuchischaayihtitaau Aschii Survey reported suffering from this problem. Reported

rates of smoking were slightly higher than in Iiyiyiu Aschii but people said they smoke slightly fewer cigarettes each day. More people over 45 reported having poor dental health than in Iiyiyiu Aschii. Perhaps this finding is linked to some of the confusions about the Non-Insured Health Benefits Program, although people in the focus group did not complain about their dental services.

While heart disease, high cholesterol and diabetes were reported more frequently than in the Mistissini data, overweight and obesity were similar to the results for Iiyiyiu Aschii, except that women in Washaw Sibi report being more overweight and obese than men.

The results identifying the numbers of people who had some type of restriction of activities was high with almost one-third of participants on the survey reporting some problems. Also, eleven of these people were aged 18 to 39.

In keeping with the high numbers of people reporting they have chronic diseases and restrictions in their movement, survey participants reported they are more than twice as likely as the same age group from Iiyiyiu Aschii to judge their health as only 'fair' or 'poor'. However, one-third of participants said their health had improved since last year. Another similar finding was that fewer survey participants reported being generally satisfied with their life compared to their counterparts in Iiyiyiu Aschii. This was especially true for men.

However, the younger age groups among the Washaw Sibi participants reported that they experience little stress in their life. More Washaw Sibi young adults report living with low levels of stress than their counterparts in Iiyiyiu Aschii.

In Iiyiyiu Aschii, as people age they report greater ability to manage problems. However, in Washaw Sibi, the pattern is reversed and older people report less ability to manage problems, especially men. This may reflect back on the financial insecurity with which many people are living

Where Washaw Sibi members do require services seems to be in education and training and in employment. Of Washaw Sibi participants in the survey aged 20 and over, only one-fifth had any education or training past the secondary level compared to one-third of people in Iiyiyiu Aschii. And only 13% of men had any training past the secondary level.

Similarly in employment, only 27% of those interviewed reported working compared to 46% in Iiyiyiu Aschii. A total of 42% reported living from either the Income Security Program – a guaranteed income program – or social welfare. Of those living on social welfare, 73% are aged 18 to 39. Looking at this another way, of those survey participants aged 18 to 39, 38% , or almost 4 in 10, report living on the Income Security Program or social welfare.

The results of the survey reinforced the discussions within the focus groups. The survey showed that, as a group, Washaw Sibi members are less educated, less trained, have lower levels of employment, and have greater financial insecurity – including food insecurity - than people in communities in Iiyiyiu Aschii. They also appear to have higher levels of chronic diseases, including diabetes, and to be living with more disabilities than are found in Iiyiyiu Aschii.

In the focus groups, people explained how they experience these realities in their daily lives. Some of the confusions and concerns about Non-Insured Health Benefits and about access to services were explained in relation to living with very little financial security. If you have a steady income then it is not such an issue to pay medications when you receive them and be reimbursed later. But if you are living on an Income Security Program cheque every three months, paying for monthly medication costs presents a completely different kind of challenge.

Many comments in the focus groups had to do with people being poor and trying to manage. For example, the discussions of the youth protection services concerned people living in poverty with young children and also using alcohol and drugs inappropriately. In the confidential survey, of 17 people reporting they had drunk alcohol in the past year, 12 classified themselves as heavy and very heavy binge drinkers. This pattern of alcohol consumption can lead to many social problems for families. We know that neglect of children happens within families of all socio-economic levels. However, richer parents have the resources to manage the results of their neglect in ways that do not come to the attention of state officials. They also can purchase support for themselves when they are ready to make changes. For the Washaw Sibi members who discussed this, their families are not only legally bound up with youth protection services but those services do not work

with these families as a whole to help support parents when they are ready to begin to make changes.

These issues will not disappear if Washaw Sibi begin to offer health and social services through the Cree Board of Health; but they could begin to change if Washaw Sibi members had concentrated new training programs and employment possibilities, along with focussed mental health and addictions services, even though these latter are still not completely developed within communities in Iiyiyiu Aschii.

Because Washaw Sibi people were refused a land base but were registered as Indians, they have acquired various affiliations. This creates confusions in terms of access to services when these jurisdictional affiliations are tied to residency. Having Cree Board of Health services will change this situation; however, it may in turn create new types of exclusions if services are tied to beneficiary status. Will the Cree Board of Health restrict services to those people living in the future Washaw Sibi community? These are decisions that have not yet been discussed but they will involve some kind of balancing between the financing of health and social services on the one hand and the inclusiveness of those services on the other.

APPENDIX 1: Context of this report and delays in its preparation

The idea for needs assessment was first presented in the Board Briefing Sheet of December 2005 along with five other activities. The persons or entity responsible for five of these activities were identified in the briefing sheet:

- Conducting a needs assessment study to identify health and social services needs, to identify the barriers to access these services, and to identify the resources already present within the community (Specialised Services) .
- Exploring interregional cooperation to increase the accessibility to services (?).
- Identifying legal and political steps necessary to have Washaw Sibi legally recognized at long last (CRA).
- Appointing a Washaw Sibi representative to participate as observer to the Board meetings (Board of Directors).
- Addressing the existing confusion around access to provincial and federal NIHB programs (Caroline Rosa and Janie Moar).
- Exploring the availability of different resources like the "projet novateur" (Suzanne Roy).

Within this list of needs, the Cree Nation had specifically requested some help to address social issues, as this was seen as a basic need prior to establishing a healthy community.

At that time the needs assessment was seen and planned as a rapid project which would take no more than two-months.

At the meeting on January 26, 2006, the following undertakings were agreed upon:

- Negotiate with Amos regarding improved health services for members of Washaw Sibi (CBHSSJB).
- Produce a Health Needs Assessment (Specialised Services and the Washaw Sibi Band).
- Provide services on-site (CBHSSJB/CRA/Washaw Sibi Band)
- Produce a Technical and Functional Plan for an on-site clinic (CBHSSJB)
- Explore sources of funding (CBHSSJB /CRA/Washaw Sibi Band)

On February 1, 2006, the Specialised Services Team submitted a draft health needs assessment plan which proposed beginning the project in March and submitting the report to the Board of Directors in September.

From the first meeting with the Washaw Sibi representatives on February 20 until the meeting in Ottawa on April 7, where the draft questionnaires were submitted, the work proceeded more or less according to the plan. However, after this, everything slowed down for awhile. The fieldworker assigned to the project returned to school. The Specialised Services team did not have the electronic version of the population list from which to select the random sample for the interviews.

Interviews with a 100 members of Washaw Sibi were carried out between August 2006 and January 2007. Two focus groups were held in Amos on November 21, 2006. The briefing sheet to the December 2006 Board of Directors said:

> Because of delays in receiving the population list, changes of interviewers, and delays in the interview process, we now estimate that the report will be prepared for the March Board. At present, the interviews are advancing well and the report from the focus groups is being prepared. Barring unexpected delays, the analysis of the questionnaires should begin sometime in January.

However, an unexpected delay arose in January when it was realised that almost no confidential mail-return interviews had been returned because of confusion about their distribution. A new plan was developed and more confidential interviews continued to arrive. Finally, a cut-off date of April 30 was set. The 36 interviews received by then were included in the analysis of the first draft report shared, on May 16, 2007, with the Chair of the CBHSSJB and the Washaw Sibi Council. Before this draft could be finalised, four more confidential interviews arrived. Because of the low return rate for the confidential interviews, Pierre Lejeune reworked all of the data from the confidential interviews to report all the results received. The draft report was discussed in Amos in July 2007. At the end of July, the Cree Nation sent the historical documents they had produced. Following this, the draft was revised and then set aside amidst other files of the Director of Specialised Services. So with apologies it was finally presented in January, 2008.