Health Canada Santé canada

First Nations and Inuit Health

Program Compendium

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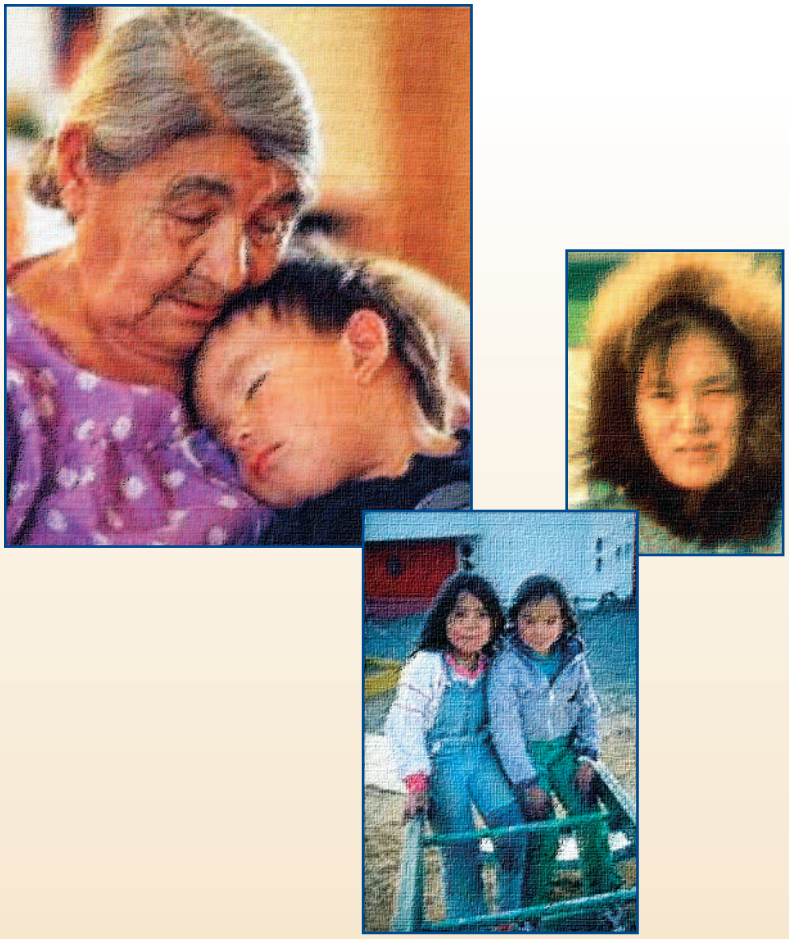
Canada

FIRST NATIONS AND INUIT HEALTH

Program Compendium



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1.0 Community Programs

Community Programs support a suite of community-based and community delivered programs, initiatives and strategies that collectively aim to improve the health outcomes and reduce health risks in three targeted areas: Children and Youth; Chronic Disease and Injury Prevention; and Mental Health and Addictions. Among children and youth, Community Programs aim to improve the health of mothers, infants and families and support the development of children in an effort to address the gap in life chances between Aboriginal and non-Aboriginal children. In the area of chronic disease and unintentional injury, community programs deliver services that reduce the rate of chronic diseases such as type-2 diabetes and injuries among Aboriginal people to levels that are consistent with other Canadians. Finally, community programs deliver services to improve the mental health outcomes of First Nations and Inuit, so that Aboriginal communities can become sustainable, culturally strong, and economically viable.

1.1 Children and Youth

1.1.1 Fetal Alcohol Spectrum Disorder (FASD)

Description

The FASD program addresses a number of health problems that are associated with alcohol use by mothers during pregnancy. The main purpose of the program is twofold: 1) reduce the number of babies born with FASD; and 2) support children who are diagnosed with FASD and their families to improve their quality of life.

This is achieved through building awareness of FASD in First Nations and Inuit communities; targeted interventions for those at risk of having an FASD birth; collaborative work with communities to address the broader determinants of health; education and training for front line workers and health professionals with First Nations and Inuit clients; and earlier diagnosis and earlier intervention for pre-school aged children with FASD and their families.

First Nations and Inuit Health work in partnership with the Public Health Agency of Canada to develop screening and diagnostic tools and cost-effective approaches for accurate identification and surveillance activities. We also work in partnership with the Canadian Perinatal Surveillance System (CPSS) regarding the collection, analysis and dissemination of information relevant to FASD.

Public education and awareness activities focus on prevention by disseminating culturally appropriate information and resource materials. Prevention information is distributed through hosting and/or facilitating conferences, workshops and focus group sessions with First Nations and Inuit. Training on FASD for health care professionals, parents, women and their partners, Elders and service providers support the program's capacity building objectives. Capacity building could also involve conducting workshops on asset mapping and multi-disciplinary team building.

Objectives

- Building awareness of FASD in First Nations and Inuit communities, with a particular focus on young people, about FASD and the risks associated with consuming alcohol during pregnancy.
- Targeted interventions for women at risk of having a child with FASD using effective prevention activities and services.
- Collaborative work with communities to address the broader determinants of health.
- Education and training for front-line workers and health professionals.
- Early diagnosis and early intervention for pre-school aged children.

Elements

A. Public Awareness and Education
Supports the delivery of public awareness and education activities about FASD. It also supports the development of practical education tools for both the national and community level.

B. Research and Capacity Development
Supports a range of research, early intervention, and capacity building activities at the community level. It supports training initiatives for community-based service providers, parents, health care professionals and other appropriate support persons.

C. Early Identification/Diagnosis
Supports the development of cost-effective approaches for the accurate identification of FASD.

D. Coordination and Integration
Involves the coordination and integration services and the sharing of information including best practices. National and regional activities related to the development, implementation, and evaluation of the program are also located under this component.

E. Surveillance
Supports partnerships with the Healthy Environment and Consumer Safety Branch of Health Canada, the Canadian Perinatal Surveillance System (CPSS), and others regarding the collection, analysis, and dissemination of information relevant to FASD. Current perinatal surveillance activities will be enhanced and priority perinatal health gaps will also be addressed by this component.

Clients

FASD services are directed towards First Nations on-reserve and Inuit individuals, children from age 0 - 6, and women of child bearing age. The main focus of the program is pregnant, at-risk women.

Types of Service Providers

Early childhood educators, community workers, administrators, parents, and community volunteers.

Provider Qualifications

Qualifications for service providers vary depending on the service being provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Children and Youth Result-based Management and Accountability Framework (RMAF).

1.1.2 Canada Prenatal Nutrition Program - First Nations and Inuit Component (CPNP - FNIC)

Description

The program primarily targets pregnant women and women with infants up to 12 months of age living on-reserve and in Inuit communities. It is delivered by community health and social service providers with additional services being provided by dietitians, nutritionists, lactation consultants, and others. The overall goal is to improve maternal and infant nutritional health. The flexible framework of CPNP-FNIC ensures that evidence-based approaches are taken to address maternal and infant nutritional health issues, while also allowing community workers to tailor their program activities to the priorities and culture of their communities.

CPNP-FNIC supports activities related to: 1) nutrition screening, education and counselling; 2) maternal nourishment; 3) breastfeeding promotion, education and support. The most common activities include group or one-on-one nutrition education sessions, the provision of food or food vouchers, efforts to promote food security such as community gardens and community kitchens, and baby food making workshops. This program also supports activities that improve women's access to the programs via support for childcare and transportation and other community support activities that are not available through other community services.

Objectives

- Improve the adequacy of the diet of prenatal and breast feeding First Nations and Inuit women.
- Increase access to nutrition information, services, and resources to eligible First Nations and Inuit women, particularly those at high risk.
- Increase breastfeeding support, initiation and duration rates.
- Increase knowledge and skill building opportunities in maternal and infant nutritional health among those involved with this program.
- Increase the number of infants fed age-appropriate foods in the first twelve months.

Elements

A. Nutrition screening, education and counselling
Involves screening for high nutritional risk for referral purposes and providing nutrition education in groups or one on one. This element also provides appropriate information, educational tools, and resources relating to prenatal nutrition, including tailored information delivered by a dietitian, nurses and doctors.

B. Maternal nourishment
Involves the use of healthy snacks, food coupons, food vouchers, food baskets to supplement the diet and to improve the food security of pregnant women, infants and mothers. Community kitchens are also supported in an effort to provide women with skills related to food preparation as well as knowledge regarding healthy eating.

C. Breastfeeding promotion, education and support
Involves raising awareness and understanding of the importance of breastfeeding and how to breastfeed through group and one-on-one sessions. This element also builds support systems for women choosing to breastfeed and providing one-on-one and group support to women who are breastfeeding.

Clients

The primary target group are pregnant First Nations and Inuit women, mothers of infants, and infants up to twelve months of age who live on-reserve or in Inuit communities, particularly those identified as high risk. The secondary target group includes First Nations and Inuit women of childbearing age on-reserve and in Inuit communities.

Types of Service Providers

Community health nurses, community health representatives, and local project coordinators are the key service providers. Additional services may be provided by dietitians/nutritionists, lactation consultants, physicians or others.

Provider Qualifications

Certification/registration according to provincial/territorial legislation is required for all dietitians, nutritionists, nurses and other professionals providing services through the program. Lay workers and community volunteers do not require the same qualifications; however, job-specific training for these providers is necessary.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Children and Youth Result-based Management and Accountability Framework (RMAF).

1.1.3 Aboriginal Head Start On Reserve (AHSOR)

Description

AHSOR provides early childhood intervention that targets the needs of young First Nations children up to six years of age. The services of the program are delivered by early childhood educators, community workers, administrators, parents and community volunteers. The primary goal of AHSOR is to demonstrate that locally controlled and designed intervention strategies can provide First Nations preschool children with a positive sense of themselves, a desire for learning and opportunities to develop fully and successfully as young people. This preschool intervention supports the development of the physical, intellectual, social, spiritual and emotional well-being of First Nations children. The six core elements of AHSOR are: 1) Promotion and Protection of First Nations Language and Culture; 2) Nutrition; 3) Education; 4) Health Promotion; 5) Social Support; and 6) Parental and Family Involvement.

A number of activities are undertaken to support the core components of the program. The AHSOR program includes: language classes to improve children's proficiency in their own First Nations language; education activities to improve school readiness; education and awareness activities promoting oral health, immunization, native foods and nutrition; physical activity; healthy life style choices; and traditional cultural practices. Also, activities such as parenting workshops, cooking classes for preparing traditional First Nations food and community kitchens are conducted to encourage parents and family involvement in the program. Building community human resource capacity through skills development of early childhood educators, community workers and volunteers is also undertaken.

Objectives

- Support the spiritual, emotional, intellectual and physical growth of each child.
- Support and encourage children to enjoy life-long learning.
- Support parents, guardians and extended family members as the primary teachers.
- Encourage parents and the broader First Nations community to play a major role in planning, developing, implementing and evaluating the AHSOR program.
- Build relationships and coordinate with other community programs and services to enhance the effectiveness of the program.
- Encourage the best use of resources for children, as well as for their parents, families and communities.

Elements

The program provides project funding for a focussed approach in cooperation with six program activities that are integrated, sustainable and viable. The main program activities are as follows:

A. Culture and Language:
Promotes and supports children experiencing their culture and learning their language.

B. Education:
Promotes life-long learning.

C. Health Promotion:
Encourages children and families to live healthy lives by following healthy lifestyle practices.

D. Nutrition:
Teaches children and families about healthy foods that will help them meet their nutritional needs.

E. Social Support:
Assists parents and guardians become aware of the resources available to assist them in achieving a healthy and holistic lifestyle.

F. Parental and Family Involvement:
Recognizes and supports the role of parents and family in being the primary teachers and care-givers of children.

Program Clients

AHSOR provides services for children from birth to 6 years of age, and their families living on-reserve.

Types of Service Providers

Early childhood educators, community workers, administrators, parents and community volunteers.

Provider Qualifications

Projects must follow applicable child care or preschool legislation, or day-dare licensing regulations in their province until First Nations develop their own standards.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Children and Youth Result-based Management and Accountability Framework (RMAF).

1.1.4 Maternal Child Health (MHC)

Description

The long term goal of the MCH Program is to support pregnant First Nations women and families with infants and young children, who live on reserve, to reach their fullest developmental and lifetime potential. This is achieved by providing access to a local, integrated and effective MCH Program grounded in First Nations culture that responds to individual, family and community needs in identified First Nations communities. The program supports a comprehensive approach to MCH services in First Nations communities that builds on community strengths including support from Elders, Canada Prenatal Nutrition Program, Fetal Alcohol Spectrum Disorder, nursing services, Home and Community Care, oral health and other community-based programs. Developing evidenced-based models and approaches through investment in evaluation is also crucial to the program.

In identified First Nations communities, the MCH program aims for contact with all pregnant women and new parents, with long term home visiting for those families who require additional supports. Services through the MCH program include reproductive health, screening and assessment of pregnant women and new parents to assess family needs as well as home visiting to provide follow-up, referrals, and case management as required.

For Aboriginal women and families with infants and young children living in the North (Territories, Nunavik and Labrador), the focus of MCH is on enhancing the health promotion programs for this population that Health Canada already offers in this region in order to complement the MCH services they receive from the provinces/territories. These include the CPNP and FASD programs. By expanding existing HC programming, more communities receive these programs and more intensive activities can be provided to promote the health and well-being of childbearing and child rearing Aboriginal families in the North.

Long Term Objectives

Long-term objectives of the MCH program include:

- Build on the foundation of current investments to develop a more comprehensive and integrated approach to MCH services on reserve;
- Develop programs and services for residents of First Nations communities that are comparable to those provided by provinces and territories for other Canadian families and their children; and
- Identify opportunities to bring safe birthing options closer to First Nations communities.

Short Term Goal and Objectives

The short term goal of the MCH program is to improve maternal, infant, child and family health outcomes in identified communities across Canada.

Short-term objectives include:

- Increase First Nations training opportunities for MCH service providers;
- Increase participation of community members in planning and developing MCH services on reserve;
- Increase coordination of services for pregnant women and families with infants and young children who live on reserve;
- provide access to a system of home visiting, screening, assessment and case management for pregnant women and families with infants/young children who live on reserve;
- Develop and/or use existing evaluation tools to measure progress in meeting short-term objectives and
- Expand and enhance existing health promotion and disease prevention programs in MCH services for Aboriginal people living in the North (CPNP and FASD).

Elements

A. Home Visitation

Home visiting by Community Health Nurses (CHNs) and Family Visitors (FVs) positively affects the health of mothers, infants, children and families. Home visiting can improve reproductive health, children's mental health and physical growth, maternal employment, nutrition, health habits & lifestyle, parenting, realistic expectations of children, parent child interaction, access to social support, knowledge and service utilization. Home visiting can reduce mothers' anxiety, depression, child abuse and neglect, and the use of emergency treatment-oriented services. Greater intensity of home visiting to clients who have increased risk factors is associated with better health and social outcomes. The effectiveness of home visiting is highly dependent on successful coordination with other broad strategies and programs in the community.

B. Integrating Culture Into Care:

The prevention components of MCH care can be enhanced for childbearing families by moving beyond the scope of medically-based prenatal and postpartum services to integrate cultural values, customs and beliefs into all program components.

C. Screening and Assessment:

All pregnant women and families with infants and young children in the community have access to the services provided through the MCH program. Screening and assessment is an effective way for nurses to identify the needs of families and determine the level and types of services that will benefit them most.

D. Case Management:
Case management helps families get the services and support they need. Case management includes early intervention, coordination of services for families and provision of culturally competent care. Core elements include:

- Completing the initial family assessment;
- Identifying family strengths and assets;
- Working with the family to identify and prioritize their needs and concerns;
- Working in partnership with the family, Family Visitors, the community, and other service providers to develop a family service plan that reflects the family's goals and concerns and the individual, family and community strengths that can be used;
- Identifying the need for special needs services and helping the family access these services;
- Facilitating referrals when necessary; and
- Evaluating the family service plan often, making adjustments based on the family's needs and desired outcomes.

E. Health promotion:
Health promotion strategies improve MCH in communities in many ways. Examples of health promotion interventions include promotion of physical activity and healthy nutrition, substance abuse prevention, preconception health counselling, and injury prevention. The MCH Program is linked to other public health initiatives that focus on health promotion, such as support from Elders, CPNP, FASD, nursing services, oral health and other community-based programs so that families benefit from a variety of approaches.

Program Clients

The MCH program in First Nations communities aims for contact with all pregnant women and new parents, with long term support for those families who require additional services.

Types of Service Providers

Community Health Nurses and Family Visitors provide services to pregnant women and families within the MCH program. Additional services may be offered by other health care professionals, early childhood educators, community volunteers, and Elders.

Provider Qualifications

Qualifications for service providers vary depending on the service being provided. Registration according to provincial legislation is required for all Community Health Nurses, and all other professionals providing services through the program. Family Visitors require job specific training, criminal record checks and driver's licenses.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Children and Youth Result-based Management and Accountability Framework (RMAF).

1.2 Mental Health and Addictions

1.2.1 National Native Alcohol and Drug Abuse Program (NNADAP) – Community-based Program

Description

The NNADAP community-based program provides prevention, intervention and aftercare and follow-up services in 500 First Nations and Inuit communities. Prevention strategies conducted by the program provide culturally appropriate programs to educate and create awareness about addictions and addictions-free lifestyles. As a result individuals, families, and communities learn and recognize high risk behaviours that can often lead to addictions.

Intervention strategies provide assessments and referrals to treatment centres and the preparation of clients for entry into residential treatment, or other rehabilitation treatment programs. Strategies also include the provision of short-term counselling in crisis situations and out-patient counselling services.

After care and follow-up services also provide support to clients returning home to their community from a treatment centre. These services ensure that clients maintain a connection to treatment centres and receive ongoing client care.

Objectives

- Support First Nations communities to reduce the incidence of alcohol and other substance abuse.
- Build capacity to develop and deliver culturally appropriate community-based addictions programs and services.
- Increase awareness and understanding concerning alcohol, substance abuse and alternative healthier lifestyles, for example traditional values, and individual and family wellness values.
- Strengthen relationships between community-based programs and services and residential treatment.
- Provide support to individuals and families post-treatment.

Elements

A. Prevention
Through the use of a range of prevention and promotion strategies directed at all segments of the community, individuals and families learn about and are able to recognize the high-risk behaviours that often lead to addiction.

B. Intervention
Intervention activities provide assessments, referrals to treatment centres and prepare clients for entry into a residential treatment program. Activities also include the provision of short-term counselling to address crisis situations and out-patient counselling services.

C. After-care/Follow-up
After care and follow-up services provide support to clients returning home to their community from a treatment centre. These services may include ongoing visits, counselling sessions, and referrals to other community services. Service providers also aim to ensure that clients maintain a connection with treatment centres they attended so they can obtain ongoing out-patient care.

Clients

First Nations on-reserve and Inuit in Inuit settlements.

Types of Service Providers

Services within the community-based component of NNADAP are delivered by variety of providers including: support, intervention and outreach workers; alcohol, drug and crisis counsellors; and Elders and traditional teachers.

Provider Qualifications

Qualifications for service providers vary depending on the activity or service being provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Mental Health and Addictions Result-based Management and Accountability Framework (RMAF).

1.2.2 National Native Alcohol and Drug Abuse Program (NNADAP) – Residential Treatment

Description

The Residential Treatment component of NNADAP is a national network of 50 treatment centres operated by First Nations organizations and/or communities that provide culturally appropriate in-patient and out-patient treatment services for alcohol and other forms of substance abuse.

The main activities offered by the program include treatment services, such as assessments, individual and group counselling sessions, and where available, family therapy sessions. Treatments can vary between 28 to 42 days in duration and are often followed by the delivery of aftercare or follow-up services that may be delivered by Treatment Centre service providers or by the community-based component of NNADAP.

Treatment Centres provide education and build awareness on addictions issues and provide information on treatment services that are available through the program. Treatment Centres also provide information and assistance to community-based NNADAP workers who are providing assessments and who are providing follow-up/after care support services.

Objectives

- Provide in-patient culturally sensitive treatment.
- Provide equitable access to treatment across the country.
- Build awareness and understanding of addictions-free lifestyles and promote mental wellness.
- Strengthen links between residential treatment and community-based prevention programs.
- Develop a cohesive treatment delivery system to improve access and quality of services.
- Enhance service delivery and support to communities in addressing addiction priorities.

Elements

A. Treatment
Provides culturally appropriate treatment service including individual, group, and family counselling sessions and a range of other activities that aim to address the reasons why a client has become addicted. In providing these services, most treatment centres use "non-native derived" approaches in combination with culturally-based teachings and activities. Treatment cycles vary between 28-42 days in duration. Treatment centres also offer after-care services to clients and their families to provide them with the necessary support during their recovery process.

B. Community Outreach
Treatment centres deliver and support awareness and education activities that aim to inform community members about addictions-related issues and what treatment services are available. Treatment centres also work collaboratively with community-based NNADAP workers to support their outreach efforts.

C. Research and Development
This component of the program is in the process of developing a reliable data collection system that will enable treatment centres and community-based workers to more effectively track client outcomes. Data collected will also support more effective case management, program quality assurance, evaluation activities, and will identify potential research areas.

Program Clients

First Nations and Inuit who have been assessed as requiring residential treatment.

Types of Service Providers

Services within the residential component of NNADAP are delivered by a variety of service providers including: support, intervention and outreach workers; alcohol, drug and crisis counsellors; and Elders and traditional teachers. Mental health professionals (e.g., social workers and psychologists) also provide services within treatment centres.

Provider Qualifications

Qualifications for service providers vary depending on the activity or service being provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Mental Health and Addictions Result-based Management and Accountability Framework (RMAF).

1.2.3 Building Healthy Communities

Description

The Building Healthy Communities program is designed to assist First Nations and Inuit communities (which includes the individuals and families) and territorial governments in developing community-based approaches to mental health crisis management. Mental health and crisis intervention activities include assessments, counselling services, referrals for treatment and follow-up treatment, aftercare and rehabilitation to individuals and communities in crisis. Other enabling activities of the program are providing peer support groups and services; culturally sensitive accredited training on crisis management; intervention; trauma and suicide prevention for community members and care givers; and community education and awareness of mental wellness and suicide prevention. The program also addresses community capacity building by training caregivers and community members to deliver programs and services.

Objectives

- Develop and provide the necessary tools to deal with mental health and addictions issues, targeting communities in crisis and priority crises such as suicide.
- Provide crisis intervention, after-care and training for caregivers and community members to deal with crises.
- Support intervention in crisis situations in order to reduce the number of suicide attempts and other violent crisis situations.
- Support prevention and intervention activities that reduce the number of youth who abuse solvents in First Nations and Inuit communities that have a chronic solvent abuse problem.

Elements

A. Mental Health Crisis Intervention

Provides a variety of activities related to mental health crisis intervention including: assessment and counselling programs; referrals for treatment and follow-up; after-care and rehabilitation to individuals and communities in crisis; culturally sensitive training for community members and caregivers; and community education and awareness of the nature of mental health and suicide. It has an annual budget of $30 million.

B. Solvent Abuse

Provides community-based prevention, intervention and culturally appropriate in and out-patient treatment to youth solvent abusers.

Clients

Building Healthy Communities is directed at First Nations communities, though the program approach also includes services that are directed at individuals and families.

Types of Service Providers

Services are delivered by a variety of service providers including mental health workers, wellness workers, crisis counsellors, and Elders. Mental health professionals (e.g., social workers and psychologists) also provide services within treatment centres.

Provider Qualifications

Qualifications for service providers vary by depending on the service being provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Mental Health and Addictions Result-based Management and Accountability Framework (RMAF).

1.2.4 Labrador Innu Comprehensive Healing Strategy (LICHS)

Description

The LICHS is a long-term strategy designed to improve health and social outcomes in the two Labrador Innu communities of Natuashish (formerly Davis Inlet) and Sheshatshiu. The strategy was developed in the aftermath of a gas-sniffing crisis in the Labrador Innu communities in the Fall of 2000.

The LICHS recognizes that the issues confronting the Innu have taken generations to develop, and solutions must also be long term in nature. The strategy draws upon expert advice and evidence from the literature regarding communities in crisis, which confirm that sustained, comprehensive approaches are the most effective means of supporting community healing.

The LICHS is a horizontal initiative involving four federal departments: Indian and Northern Affairs Canada (INAC - lead), Health Canada, and Public Safety and Emergency Preparedness Canada (PSEPC), and the Royal Canadian Mounted Police. Funding for the LICHS has been allocated to INAC and Health Canada until March 31, 2010.

Objectives

The ultimate goal of the LICHS is to restore the health and hope for the Innu communities of Natuashish and Sheshatshiu in Labrador.

Achievement of the following objectives will support attainment of the ultimate goal:

- Increased capacity to plan and manage their affairs in a culturally appropriate manner;
- Safe and secure living environment for residents in these two Innu communities;
- Improved health and social conditions of communities;
- Improved educational participation and attainment;
- Enhanced employability and increased economic opportunities;
- Stable and harmonious Innu communities capable of sound governance and effective program and services delivery; and
- Improved relations between the Innu of Labrador and other levels of government.

Elements

The LICHS consists of several program components, including: Relocation of the Mushuau Innu to the new community of Natuashish (INAC); Registration and Reserve Creation for both Labrador Innu communities (INAC); Programs and Services (INAC); Community Policing (PSEPC/RCMP); and Community Health (Health Canada).

Health Canada is responsible for the Community Health component, which has four strategic program areas. These areas are described below.

A. Addictions and Mental Health

This element supports enhanced community-based addictions and mental health programming in both Labrador Innu communities, with professional support from a Mental Health and Addictions Team based in Health Canada's Labrador Health Secretariat in Goose Bay. Enhanced community-based programming includes Innu designed and delivered family country treatment and aftercare programming, professional mental health services, the development and implementation of crisis response protocols, and the establishment and operation of safehouses for youth at risk in each Labrador Innu community in partnership with INAC and Canada Mortgage and Housing Corporation (CMHC).

B. Maternal and Child Health

Activities under the Maternal and Child Health element are targeted at pre-conceptual, pre-natal and early childhood public health so that children get a healthier start. Funding is provided to both Labrador Innu communities for the delivery of enhanced parenting support and Fetal Alcohol Spectrum Disorder programming, with professional support and mentoring for community-based staff provided through the Labrador Health Secretariat's Maternal and Child Health Team. Funding also supports a local community group in Natuashish – the Next Generation Guardians – to carry out work aimed at improving the health and well-being of women and their families.

C. Community Health Planning

Under the Community Health Planning element, the Labrador Health Secretariat's Community Health Planning Team supports both Innu communities in their development of community health plans and implementation of evaluation activities. The focus is on community capacity development for health planning and evaluation.

D. Management and Support

This element entails the establishment of a Health Canada presence in Labrador through the Labrador Health Secretariat, and regional and headquarters support. The Labrador Health Secretariat, which was established in January 2001, is responsible for managing the implementation of the Community Health component of the LICHS and for providing professional health support to both Labrador Innu communities.

Program Clients

Members of the Mushuau Innu and Sheshatshiu Innu First Nations residing in the communities of Natuashish and Sheshatshiu, Labrador.

Partnerships, Roles

First Nation Partners
The Mushuau Innu and Sheshatshiu Innu First Nations - responsible for the delivery of community-based programming. Innu Nation - responsible for representing the political interests of the Labrador Innu, including negotiations towards a land claims agreement and self-government.

Federal Partners
INAC, PSEPC, RCMP, CMHC - responsible and accountable for their respective components of the LICHS. Strategic linkages are also fostered with other federal departments which provide funding to the Labrador Innu, such as Human Resources and Skills Development Canada and Canadian Heritage.

Provincial Partners
The Province of Newfoundland and Labrador and the Labrador-Grenfell Regional Integrated Health Authority - responsible for the delivery of health and social services falling under Provincial jurisdiction.

Types of Service Providers

Mental health professionals and para-professionals, addictions workers, nurses, nutritionists, parent support workers, community health planners, and FASD coordinators.

Provider Qualifications

Professional health care providers must be registered members in good standing with the college and/or professional association applicable to the provider's profession, and entitled to practice his or her profession in accordance with the laws of the Province of Newfoundland and Labrador. Qualifications for para-professionals / lay workers such as parent support workers and addictions workers are determined by each community in consultation with Health Canada.

1.2.5 Indian Residential Schools Resolution Health Support Program

Description

Health Canada's First Nations and Inuit Health Branch works in partnership with the Office of Indian Residential Schools Resolution Canada and Service Canada to coordinate and fund a variety of services. The IRS Resolution Health Support Program provides access to mental health, transportation services and emotional support services for eligible former Indian residential school students through the Health Canada regional offices. Those eligible for services include former IRS attendees with a claim against Canada who are in the process of actively resolving their claim through the Independent Assessment Process, recipients of Common Experience Payments, as well as those participating in Truth and Reconciliation and Commemoration Events. Each Health Canada regional office has a Regional Coordinator who helps eligible claimants access the services offered by the IRS Resolution Health Support Program.

Objectives

- Ensure that eligible former students of Indian residential schools, and their families, have access to an appropriate level of mental wellness support services.
- Ensure that eligible former students of Indian residential schools can safely address a broad spectrum of mental wellness issues related to the disclosure of childhood abuse(s).

Elements

A. Individual and Family Counselling
Requires the completion of a Treatment Plan by a recognized FNIHB mental health service provider. The number of counselling sessions will depend on the recommendation of the Treatment Plan in combination with the individual's eligibility period.

B. Transportation
Provides limited access to transportation to those accessing individual counselling, family counselling sessions or Elders/Healers, which are not available on the reserve or community of residence and are approved by FNIHB (nearest appropriate service).

C. Resolution Health Support Worker (RHSW)

Provides culturally appropriate emotional support services in areas where there are high numbers of claimants. These services are provided by individual RHSWs working through Aboriginal or Aboriginally-affiliated organizations funded by FNIHB regional offices. In addition to ensuring the safety of residential school claimants the RHSWs service includes, but is not limited to, providing a variety of front-line support and coordination services directly to claimants involved in the Independent Assessment Process.

D. Other Services

Provides other supportive services such as mental health and/or emotional support during truth and reconciliation and commemoration initiatives, as well as research and communications activities to ensure the program is well-known and well-suited to meet the needs of IRS claimants, their families and communities.

Clients

Eligible clients include former IRS students resolving claims through the Independent Assessment Process and their families, former IRS students receiving Common Experience Payments and their families, and those participating in Truth and Reconciliation and Commemoration events.

Partnerships, Roles

The RHSW component of the IRS Resolution Health Support Program is managed independently by First Nations, Inuit, Métis, or Aboriginal-affiliated organizations through regionally held contribution agreements.

IRS RHSP has 2 main consultation bodies

- **Health Support Steering Committee (HSSC)**
  Comprised of senior representatives from both IRSRC and Health Canada, the HSSC was established to provide guidance, direction and to oversee the development and implementation of the IRS RHSP.

- **Aboriginal Working Caucus**
  This is an advisory group of 12 Aboriginal volunteers. Each Working Caucus member has personal or professional experience in dealing with the impacts of the residential school system. The Working Caucus works with lawyers acting for former students, churches, IRSRC and Health Canada as an advisory body to guide the ongoing development of the IRS resolution process.

Types of Service Providers

Services within the RHSW and counselling components of IRS Resolution Health Support Program are delivered by a variety of providers including: FNIHB recognized mental health service providers; Elders and traditional teachers.

For the mental health counselling component, providers must meet one of the following criteria:

- Registration as a psychologist in the province/territory in which the service is being provided with clinical or counselling orientation; or
- Registration as a social worker in the province/territory in which service is being provided (MSW or PhD in social work with clinical orientation).

In addition, the provider must be a member in good standing with his/her provincial/territorial College or Association.

The recipient of contribution agreements will be an Aboriginal or Aboriginal-affiliated organizations currently working in the area of Aboriginal health and with Aboriginal communities. The organizations will ensure that the providers:

- have experience working with Aboriginal mental health issues;
- have the capacity and flexibility to meet the emotional health support needs of potentially large numbers of IRS claimants in a variety of locations spread out across considerable geographic areas;
- fulfill reporting requirements as set out in the national standard contribution agreement schedule;
- have security clearances which are appropriate for the services which are being provided, and;
- coordinate services to meet the emotional support needs of former IRS students and their families within the province or territory where the Recipient operates.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Mental Health and Addictions Result-based Management and Accountability Framework (RMAF).

1.2.6 Brighter Futures (BF)

Description

The overall purpose of the Brighter Futures program is to improve the quality of, and access to, culturally appropriate, holistic and community-directed mental health, child development, and injury prevention services at the community level to help create healthy family and community environments in which community members and children can thrive.

Objectives

- Increase the awareness in mental health, child development, healthy babies and parenting skills.
- Build on the knowledge and skills of front line health workers and community members in the areas of mental health, child development, healthy babies parenting skills and injury prevention.
- Provide opportunities to improve health services and develop community-based model projects.
- Address the serious health problems affecting children and families in a community-based, holistic and integrated manner.
- Support optimal health and social development of infants, toddlers and pre-school age children.
- Improve the health of children by facilitating the prevention of and early intervention on health problems and by promoting better integration of health services.
- Assist parents and professionals with information on the knowledge and skills necessary to effectively contribute to the improved health and development of children.
- Support community development and provide opportunity for communities to find their own solutions to the health and development needs of children, youth, family and community.
- Ensure integrated and coordinated care for children and families by coordinating human service sectors (health, social services, justice, education, employment, etc.).

Elements

A. Mental Health

Promote the development of healthy communities through community mental health programs, with the aim of improving the quality of, and access to, culturally appropriate mental health services at the community level. Activities include training; planning; consultation and information exchange; promotion of linkages among health, children and families; and comprehensive community projects.

B. Child Development

To enable First Nations and Inuit children to have a good start in their early stages of development and to ensure that they have the opportunity to achieve their full potential. The aim is to strengthen the existing child development network of social, health, medical, educational and cultural services. Among others, activities include the provision of resource centres and toy lending libraries, infant stimulation programs, and behavioural and developmental counselling involving parents and children.

C. Injury Prevention

To reduce death and acute and long-term disability due to injuries among First Nations and Inuit children. Activities include: public education in First Nations and Inuit communities; elevating the priority given to injury prevention by families, community health workers, and governments; training of community workers; identifying the main types of injury by geographical area; assisting First Nations and Inuit communities to develop appropriate legislation directed at injury prevention; and encouraging First Nations and Inuit agencies to establish injury prevention as a regular comprehensive program.

D. Healthy Babies

To improve the physical, mental and social health and well-being of First Nations and Inuit mothers and infants. Services and activities to achieve this goal include nutritional education; emphasis on regular medical examinations during pregnancy; education on the dangers of alcohol and other drug use during pregnancy; more intense surveillance of prenatal infections; training for community-based workers; and enhancement of existing maternal and child care programs.

E. Parenting Skills

To promote culturally appropriate First Nations and Inuit parenting skills by providing funding to support the development and delivery of training programs for parents of children aged two and older.

Clients

The Brighter Futures Program is directed to all members of First Nations and Inuit communities.

Types of Service Providers

Brighter Futures is delivered by a variety of service providers including mental health workers, wellness workers, youth workers, and Elders.

Provider Qualifications

Qualifications for service providers vary depending on the service being provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Mental Health and Addictions Result-based Management and Accountability Framework (RMAF).

1.2.7 Youth Solvent Abuse Program (YSAP)

Description

YSAP is a community-based prevention, intervention, after-care and in-patient treatment program that targets First Nations and Inuit youth who are addicted to, or at the risk of inhaling solvents. This includes a network of solvent addiction treatment centres and community supports. YSAP treatment centres provide culturally appropriate in-patient and out-patient treatment services to First Nations and Inuit youth. Treatment centres target youth between the ages of 12 and 19 and 16 to 25 years of age.

Intervention programs provided by YSAP require working with parents and communities in an attempt to deal with health-related issues such as family violence, suicide, and depression. These issues are addressed through family treatment and community programs or pre-and-post- care and are delivered by treatment centre staff.

YSAP residential treatment provides support and guidance for youth to help them understand and overcome their addictions. Treatments emphasize personal growth and wellness and offer a continuum of care based on Aboriginal values and beliefs.

Objectives

- Provide specialized treatment and recovery programs for persons with chronic solvent abuse problems in a manner that is sensitive and respectful to their unique cultural heritage.
- Provide in-community supports to individuals and families post and pre-treatment.
- Increase awareness and understanding in communities concerning solvent abuse and alternative healthy lifestyles.
- Network and work collaboratively with other community-based programs and resources including NNADAP workers and other workers to ensure client needs are met.

Elements

A. Intervention
This component aims to work with parents and, if possible, communities to deal with problems related to solvent abuse such as family violence and suicide. These issues are addressed through family treatment and community programs or pre- and post-care delivered by the treatment centres. Referral is also a key activity within this program element.

B. Treatment
Residential treatment supports and provides guidance to youth who are trying to understand and overcome an addiction. In providing this service, residential treatment programs provide a continuum of care that employs Aboriginal values and beliefs and emphasizes personal growth and wellness.

Clients

First Nations and Inuit youth who are addicted to or at risk of inhaling solvents.

Types of Service Providers

A combination of solvent abuse workers, treatment counsellors, outreach workers, social workers, child and youth workers, and educators provides services within this program.

Provider Qualifications

Qualifications vary depending on the service being provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Mental Health and Addictions Result-based Management and Accountability Framework (RMAF).

1.2.8 National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)

Description

Youth suicide is a Canada-wide issue that is of particular urgency for Aboriginal people. While there is much variation among First Nations communities, overall suicide rates are 5 to 7 times the rate for Canadian youth overall: 126 per 100,000 for First Nations male youth aged 15-24, compared to 24 per 100,000 for Canadian male youth, and 35 per 100,000 for First Nations female youth, compared to 5 per 100,000 for Canadian female youth. Suicide rates among Inuit are the highest in Canada, at eleven times the national average.

Individual mental health and wellness are key factors against becoming suicidal. As such, suicide prevention is addressed in the context of individual, family, and community health. As a program, the NAYSPS targets resources that support a range of community-based solutions and activities that contribute to improved mental health and wellness among Aboriginal youth, families, and communities. Over time, these efforts will result in a reduction of Aboriginal youth suicide across Canada.

Objectives

The NAYSPS has articulated a number of objectives that will work in support the main goals of the program. The goals and objectives of the program include:

A. Goal: ***Increase awareness and understanding of Aboriginal youth suicide prevention.***

Objectives:

- Increase recognition of suicide risk factors, warning signs, at-risk behaviors, high-risk groups within the Aboriginal population, and the provision of effective intervention targeting key gatekeepers, volunteers and professionals.
- Provide tools and resources to promote mental wellness and to improve recognition of risk factors for parents and front-line workers in targeted settings such as educators, police, and community health/social service personnel.
- Decrease stigma related to the issue of talking about suicide prevention in Aboriginal communities in Canada.
- Provide supportive learning environments and tools to parents that encourage their involvement in the health and well being of their children/youth.

B. Goal: ***Strengthen key protective factors such as a strong sense of identity, meaning and purpose, and resilience***

Objectives:

- Support First Nations and Inuit youth leadership development.
- Engage youth, parents, families and the community in the development and implementation of suicide prevention activities.
- Develop and utilize culturally relevant tools and resources that foster resiliency, emotional and spiritual health and coping skills.

C. Goal: ***Strengthen and facilitate collaborative approaches and linkages within and across governments, agencies and organizations:***

Objectives:

- Support linkages and collaborative approaches with other federal government departments and provincial and territorial governments.
- Create and support appropriate linkages with local resources, committees, organizations and agencies including: schools, Elders, youth, community leaders, and local private industry.
- Utilize and build on existing national, regional and local efforts to improve mental wellness in First Nations and Inuit communities.

D. Goal: ***Develop and implement locally-driven suicide prevention plans in First Nations and Inuit communities:***

Objectives:

- Support the creation of collaborative, community-based approaches to develop and implement local suicide prevention plans that are linked to a larger supportive network.
- Create a suicide prevention network that supports knowledge exchange between community-based projects and front-line workers.
- Develop and utilize culturally-appropriate tools and resources to communities to create and implement local suicide prevention plans.
- Support development of practical screening tools and resources for front-line workers and other workers.
- Support skills training to increase the number of people who can effectively respond to those who are vulnerable to suicide.

E. Goal: ***Improve and increase crisis response efforts to intervene more effectively in preventing suicide and suicide clusters following a suicide-related crisis in First Nations and Inuit communities:***

- Develop crisis response and stabilization protocols.
- Support skills training for front-line workers in crisis response.
- Support increased emergency response capacity to bring in additional experts as needed, in order to support and enhance community response to suicides, reduce the after effects of loss due to suicide, and prevent suicide clusters.
- Support development of tools and resources to support those individuals and groups dealing with the aftermath of suicide(s).

F. Goal: ***To enhance knowledge development regarding what we know about what works in preventing Aboriginal youth suicide.***

Objectives:

- Support community-based participatory research.
- Ensure rigorous evaluation as a component of all new suicide prevention programming.
- Support an off-reserve Aboriginal including Métis and urban Inuit data gathering exercise.
- Support knowledge dissemination and communication.

Elements

NAYSPS activities include the following program elements:

A. Primary Prevention: support activities that focus on mental health promotion activities that increase resiliency and reduce risk among Aboriginal youth.

B. Secondary Prevention: support activities that focus on supporting collaborative, community-based approaches to suicide prevention.

C. Tertiary Prevention: support activities that focus on increasing the effectiveness of crisis response, stabilization and after care for survivors.

D. Knowledge Development: support activities that aim to improve what we know and what works in the field of Aboriginal youth suicide prevention.

Clients

First Nations youth living on reserve, Inuit youth, off reserve Aboriginal youth.

Types of Service Providers

Services within the NAYSPS are delivered by a variety of service providers including: recognized mental health service providers; Elders and traditional teachers; and mental health para-professionals.

Provider Qualifications

Mental Health Service Providers recognized by Health Canada must have the following qualifications:

- Registration as a psychologist in the province/territory in which the service is being provided with clinical or counselling orientation; or
- Registration as a social worker in the province/territory in which service is being provided (MSW or PhD in social work with clinical orientation); and
- A member in good standing with his/her provincial/territorial College or Association.

Outside of recognized Mental Health Service Providers, qualifications for service providers vary depending on the activity and/or service being provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Mental Health and Addictions Result-based Management and Accountability Framework (RMAF).

1.3 Chronic Disease and Injury Prevention

1.3.1 Aboriginal Diabetes Initiative (ADI)

Description

The Aboriginal Diabetes Initiative includes the following program components:

- promotion;
- prevention;
- screening and care;
- capacity;
- surveillance;
- research, evaluation and monitoring; and
- national coordination.

It has two funding streams:

The **First Nations On-reserve and Inuit in Inuit Communities (FNOIIC)** stream provides funding to First Nations and Inuit communities for diabetes programming. The FNOIIC ensures access to prevention and promotion programs which emphasize healthy eating and active living, and build awareness of diabetes around issues such as risk factors and complications. The program also provides resources for screening and care and resources to train health service providers and improve access to their services in communities. By year 5 (2009-10), there will be sufficient resources for some programming in all First Nations and Inuit communities. Funds are allocated based on workplans developed by the community, consistent with the program framework but flexible to ensure community specific needs can be met.

The **Métis, Off-reserve Aboriginal and Urban Inuit Prevention and Promotion (MOAUIPP)** stream supports community health promotion and prevention projects based on a national call for proposals process. Between 30 and 40 projects are supported through this process on an annual basis.

Objectives

Ultimately, the ADI aims to reduce the incidence and prevalence of diabetes among Aboriginal people and to improve the health status of First Nations and Inuit individuals, families and communities. To reduce the prevalence of type 2 diabetes and its complications in Aboriginal people the ADI supports a range of health promotion, prevention, screening and care activities that are community-based and culturally appropriate. The ADI also aims to:

- Increase physical activity and healthy eating habits to decrease prevalence of risk factors (e.g. obesity);
- Increase access to screening and improve detection of diabetes;
- improve quality of life for those living with diabetes and fewer complications (improved diabetes management);
- Improve collaboration and partnership;
- Increase awareness and knowledge of diabetes, risk factors, complications and prevention strategies;
- Increase participation in the delivery of programs and supports; and
- Improve community supports to prevent diabetes.

Types of Service Providers

Service providers may include but are not limited to:

- Doctors;
- Nurses;
- Nutritionists;
- Exercise specialists; and
- Diabetes lay-workers.

Provider Qualifications

When using a professional health care provider, the project needs to ensure that the provider is:

- A registered member in good standing of the college or professional association;
- Entitled to work in accordance with the laws of the province or territory where the care is to be provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Chronic Disease and Injury Prevention Result-based Management and Accountability Framework (RMAF).

2.0 Health Protection and Public Health

Health Canada works with the Provinces and First Nations communities to support a public health system on-reserve that includes basic services such as: infectious disease control and surveillance; prenatal education, immunization; environmental health services (drinking water testing, health inspections, etc.). Health Canada does not have public health legislation that applies to reserves and therefore works with provincial governments and First Nations to address regulatory issues.

2.1 Communicable Disease Control

2.1.1 Air Borne Diseases - Tuberculosis (TB)

Description

The mandate of the tuberculosis (TB) program is to reduce the incidence of the disease in First Nations and Inuit communities in keeping with the National goal of 3.6 cases per 100,000 by 2015. The program is delivered through primary health care services at the community level. Case findings and case holding involves the identification of active TB infections cases in an organized and systematic manner, compliant with treatment regimes. Contact tracing screens for TB infections of individuals having come in contact with individuals with active TB. The surveillance element is the collection, analysis and dissemination of information about TB infection. Community-based research projects on control and prevention of TB infections in First Nations and Inuit communities are also funded.

Community health education and training recognizes the impact of nutrition and overcrowded housing with the incidence of TB infection, and creates health education and awareness among First Nations and Inuit. It also involves the education and training of individuals such as health professionals, individuals with TB and community members. This helps to build community health human resources capacity to reduce and prevent TB infections.

Objectives

- Reduce incidence of TB infections in First Nations and Inuit communities, to 3.6 cases per 100,000 by 2015.
- Detect and diagnose TB infections among those exposed to infectious cases and prevent the spread of the disease to other people in the community.
- Provide treatment to those with active and latent disease, prevent the emergence of drug resistance and achieve life-time control of the individuals' TB infections.
- Support health care workers and communities in the prevention and control of TB infections at the community level, by supporting awareness activities, and promoting understanding of TB.

Elements

A. Collaboration
Partnerships with federal partners, other FNIHB service programs, provincial government health authorities, as well as First Nations and Inuit health authorities to increase access to support and treatment for TB to First Nations and Inuit communities.

B. Community Education and Awareness
Development of education and awareness material along with community education campaigns to increase awareness of TB as well as the participation of First Nations and Inuit communities in related activities. It also involves improving capacity to deliver services.

C. Build Capacity
TB awareness activities and provision of relevant training opportunities in order to develop capacity within First Nations and Inuit communities. Increase in the participation of health professionals, community leaders and community members in prevention education programs.

D. Design, develop, implement, coordinate and evaluate TB program
Education and training of individuals such as health professionals, patients, and community members to help control and prevent TB. Activities that facilitate the development of and implementation of operational policies regarding TB. Activities that promote program evaluation.

E. Enhanced TB surveillance and Research
Community-based research projects, selected for their relevance to the control and prevention of TB in First Nations and Inuit communities. Enhanced surveillance, research, prevention, treatment and support of TB control in First Nations and Inuit communities.

Clients

First Nations living on-reserve and Inuit in Labrador (Nunatsiavut).

Types of Service Providers

Community medicine specialists, TB medical consultants, and community health and TB nurses.

Provider Qualifications

TB medical consultants have expertise in TB case management, infectious diseases, and/or pulmonary medicine. Medical or communicable disease officers have the appropriate epidemiological background to carry out surveillance disease control functions. TB nurses must obtain certification for performing Mantoux tests. Certification for administering vaccines, including BCG, is available for community health nurses.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Communicable Disease Control Result-based Management and Accountability Framework (RMAF).

2.1.2 Blood Borne Diseases and Sexually Transmitted Infections – HIV/AIDS

Description

The mandate of the HIV/AIDS program is to provide HIV/AIDS education, prevention and related health services to First Nations on-reserve and some Inuit communities. The overall goal of this program is to work in partnership with First Nations and Inuit communities to prevent HIV/ AIDS transmission and support the care of those impacted by HIV and AIDS. The five program elements currently in place are: collaboration, knowledge development and dissemination, program design and implementation, prevention education and capacity building.

Objectives

- Increase knowledge of the epidemic within First Nations on-reserve through improved community-based knowledge development, improved analysis of surveillance data, and improved translation of knowledge into practice.
- Increase the availability of evidence-based HIV/AIDS interventions based on analysis of regional project results, trends in epidemiological data, and research findings generated through other Aboriginal-specific funding streams under the Federal Initiative (FI) to address HIV/AIDS in Canada.
- Increase awareness and reduce the stigma within communities to promote testing, access to prevention, education and support, and supportive social environments for those vulnerable to and living with HIV.
- Strengthen partnerships within FNIHB and provincial governments in order to increase access to care and support for First Nations living with HIV/AIDS.
- Increase effective collaboration of current and new partners towards the achievement of a coordinated and integrated response to HIV/AIDS at a regional, national and international level.

Elements

A. Collaboration
Partnerships with federal partners, other FNIHB service programs, provincial government health authorities, as well as First Nations and Inuit health authorities to increase access to care and support for First Nations and Inuit living with HIV/AIDS.

B. Knowledge Development and Dissemination
Activities that lead to programming based on best practices and evidence-based analysis, knowledge resources developed and disseminated, leading to improved HIV/AIDS surveillance data analysis.

C. Program Design and Implementation
Activities that facilitate the development and implementation of operational policies regarding HIV/AIDS. Activities that promote program evaluation.

D. Prevention Education
Activities that facilitate the development of primary and secondary prevention activities for First Nations and Inuit vulnerable to and/or living with HIV/AIDS.

E. Capacity Building
HIV/AIDS awareness activities and provision of relevant training opportunities in order to develop capacity within First Nations and some Inuit communities. Increase in the participation of health professionals, community leaders and community members in prevention education programs.

Clients

For community-oriented projects: First Nations Bands; First Nations and Inuit Associations and Tribal Councils.

For training: All professionals and semi-professional health and social service delivery personnel employed directly by FNIHB and/or Band and Tribal Councils involved in health and social service delivery on reserves.

First Nations on-reserve and some Inuit communities.

Types of Service Providers

Variety of service providers (managers, para-professionals, professionals, volunteers, support staff) with expertise in HIV/AIDS, blood borne diseases and sexually transmitted infections.

Provider Qualifications

Providers must be registered members in good standing with their relevant colleges and/or professional associations, and be entitled to practice their profession in accordance with the laws of the province or territory where the services are provided.

Partnerships, Roles

The Federal Initiative (FI) to Address HIV/AIDS in Canada, an evolution of the Canadian Strategy on HIV/AIDS (CSHA), has formalized partnerships with the Public Health Agency of Canada (PHAC), Correctional Services Canada (CSC), and the Canadian Institutes for Health Research (CIHR). PHAC is the lead federal department of the FI and is responsible for providing national direction and managing the overall administration, delivery and reporting of the FI to Treasury Board through its HIV/AIDS Policy, Coordination and Programs Division. CSC plays an important role in addressing HIV/AIDS in the correctional environment. CIHR is responsible for setting priorities and administering the FI's extramural research program, in partnership with PHAC. Health Canada (HC) is responsible for HIV/AIDS education, prevention, and related services for First Nations on-reserve and some Inuit communities. HC, in partnership with PHAC, is also responsible for coordinating global engagement activities under the FI, as well as program evaluation activities.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Communicable Disease Control Result-based Management and Accountability Framework (RMAF).

2.1.3 Vaccine Preventable Diseases (VPD) - Immunization

Description

The First Nations and Inuit Health Branch (FNIHB) has developed and implemented a Targeted Immunization Strategy (TIS) that takes into consideration the direction of the development of a National Immunization Strategy. Recognizing that vaccine-preventable diseases (VPD) easily cross provincial and territorial borders, as well as the border of reserves and Inuit communities, all Canadian jurisdictions are involved in the process. FNIHB is participating as a jurisdiction in the federal, provincial and territorial (F/P/T) activities.

The overall expected outcomes of the TIS are to improve coverage rates for routine immunizations, reduced VPD incidence, outbreaks and deaths, and the development of an integrated immunization surveillance system. The five-year funding supports the development, implementation and enhancement of the strategy until March 2008. The TIS will be evaluated and adapted as per recommendations for re-submission for on-going funding. Assessment of the need for expansion of the strategy will be made at that time.

Objectives

- Improve the coverage rates of routine immunizations in the targeted population, towards the international target of 95%.
- Implement newly recommended vaccines programs (varicella, conjugate pneumococcal, conjugate meningococcal C) for the targeted population.
- Improve data and understanding of immunization coverage rates, the incidence of vaccine preventable diseases, barriers to immunization and best practices in implementation.

Elements

A. Collaboration
Collaboration, partnerships, networks and agreements with federal, provincial, territorial as well as First Nations and Inuit stakeholders in the development and implementation of the strategy.

B. Capacity
Activities that enhance and support development of health care workers' knowledge and skills.

C. Public Health Education
Activities that inform, educate and create awareness on vaccine-preventable diseases and immunization (VPDI).

D. Promote Improved Surveillance Data Collection and Ongoing Evaluation
Activities that enhance and support development of the technical strategies required to implement a surveillance system.

Clients

First Nations children under the age of six living on-reserve or in Inuit communities where FNIHB has the responsibility of ensuring the delivery of immunization services.

Types of Service Providers

Medical officers, environmental health officers, registered nurses, and community health representatives.

Provider Qualifications

All providers require registration/licencing in compliance with provincial and territorial laws and regulations in their jurisdiction. On-the-job training is required for community health representatives.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Communicable Disease Control Result-based Management and Accountability Framework (RMAF).

2.2 Environmental Health and Environmental Research

2.2.1 Environmental Health Program (EHP)

Description

The EHP is a community-based program that aims to protect and improve First Nations (living on-reserves south of 60°) health through the reduction of health risks, injuries or deaths. This is accomplished by striving to create and maintain healthy and safe community environments through the investigation of potential environmental health related outbreaks. The EHP also raises awareness of environmental health hazards such as water, food and vector borne illnesses including health problems associated with indoor air quality, mould in housing and pest control (investigation of infestations and eradication of pests). The EHP builds community human resource capacity to adapt to environmental conditions, to maintain safe environments and to deal safely with environmental hazards.

The program monitors environmental conditions and risks and supports activities in the following areas:

- Drinking water and sewage;
- Food safety;
- Facilities health inspections;
- Housing;
- Transportation of Dangerous Goods (TDG); and
- West Nile Virus (WNV).

Objectives

- Monitor, identify, and mitigate environmental health risk: water, food and vector-borne illnesses including health problems associated with indoor air quality and mould in houses.
- Accurately define health risks, trends and emerging issues.
- Improve environmental health risk awareness among the First Nations people.
- Build community human resources capacity to manage environmental health risks.

Elements

A. Drinking Water and Sewage

Health Canada (HC) works in partnership with First Nations to ensure that programs are in place to monitor drinking water quality and assess potential public health risks in distribution systems with five or more connections, including cisterns in First Nations communities, south of 60. The objectives are to reduce the incidence of waterborne illnesses and outbreaks by increasing and improving the monitoring of and reporting on community drinking water supplies. It implements the Guidelines for Canadian Drinking Water Quality by ensuring a timely response to problems with water quality, does sampling and water quality analyses, recommends drinking water advisories if required, investigates unsatisfactory results and makes recommendations for corrective actions.

The program also offers community protection by reviewing plans and designs of community water and sewage systems from public health perspectives; inspections of community and private sewage treatment systems and safe disposal of waste, thereby preventing the transmission of diseases. Also, an early warning data base system is in place to facilitate the collection of data and reporting in most regions.

B. Food Safety

Food safety services in First Nations communities are aimed at preventing the incidence of food-borne illnesses. Grocery stores, restaurants, cafeterias, public buildings and special events such as festivals, pow wows, rodeos and traditional games are examples of events that may be routinely inspected. EHOs inspect facilities on a yearly basis at a minimum. They will also inspect facilities on an "as requested" basis by the Chief and Council or through written agreement. Food safety activities in First Nations communities include training courses on safe food handling.

C. Facilities Health Inspections

First Nations communities have a number of facilities including; solid waste management facilities; community facilities (e.g., nursing stations, community health centres, child care centres, nursing homes, group homes, treatment facilities, schools); special event facilities (e.g., pow wows, rodeos, traditional games) and recreational facilities (e.g., campgrounds, bathing facilities, arenas, casinos, bingo halls). EHOs inspect facilities on a yearly basis at a minimum. They will also inspect facilities on an "as requested" basis by the Chief and Council or through written agreement. The purpose of the inspection is to confirm that the facilities do not present a health and safety risk.

D. Housing

The objectives are to reduce the potential exposure to environmental hazards within the homes in First Nations communities through a systematic series of inspections and investigations varying from site evaluations through to occupancy and demand inspections. Existing houses are investigated for general safety, structural defects, water supply, solid and liquid waste treatment and disposal, indoor air quality, including mould, overcrowding and occupant awareness of health related issues. Potential housing developments are also assessed for health considerations. On the request of the Chief and Council, EHOs provide inspections and identify potential health risks and environmental health hazards within the living space that may lead to health problems of the occupant. The number of inspections completed depends on the number of requests received from the Chief and Council.

E. Transportation of Dangerous Goods (TDG) Program

Under the regulations of the Transportation of Dangerous Goods Act, Health Canada as an employer is responsible for ensuring that Health Canada staff who are involved in the packaging, shipping, transporting and receiving of dangerous goods received adequate TDG training. The FNIHB TDG Program provides training for the safe management and efficient shipping of dangerous goods including biomedical waste, and for the protection of all FNIHB employees who handle dangerous goods. The program aims at reducing the number of environmental accidents and emergencies (e.g., spills) occurring during transportation. FNIHB may also provide training to Band employees working in health facilities at the request of Chief and Council.

The TDG Program activities include inspecting, certification, and providing technical advice and consultation on: storage; packaging; marking/labelling; transporting; shipping/receiving and disposal of hazardous waste. EHOs are trained and certified to provide training courses to FNIHB staff on shipping, transporting and receiving dangerous goods and to provide safe management training on biomedical waste.

F. West Nile Virus (WNV)

Health Canada carries out WNV programming in order to minimize the public health risk posed by WNV on-reserve. Activities focus on public education, surveillance and mosquito control. Health Canada develops and distributes WNV public education products (e.g. pamphlets, media kits, posters, activity sheets for children) to ensure that residents of First Nations communities are aware of the WNV and the steps they can take to protect themselves. WNV surveillance activities focus on detecting the presence of the virus in birds, mosquito pools and humans as early as possible so that appropriate action can be taken in a timely manner. Health Canada funds evidence-based WNV intervention and mosquito control activities including, larviciding and adulticiding in order to reduce exposure to biting mosquitos that could potentially transmit WNV to humans. The Department works with First Nations communities (e.g. Chiefs and Councils), and provincial and regional health authorities and the Public Health Agency of Canada to ensure that the WNV programming available on-reserve is comparable to that of the respective provincial system.

Clients

First Nations communities and individuals.

Partnerships, Roles

The role of First Nations communities, with respect to infrastructure and housing in their communities, is to ensure that there are occupancy policies and guidelines in place for any and all public housing, to develop and implement a community maintenance program for all public housing, and to make available all information on maintenance and housing for all occupants of both public housing and privately owned houses in their respective First Nations communities. The First Nations and Inuit Health Branch works with First Nations communities to enable them to assume greater control and ownership of the housing and maintenance program.

The provinces and territories implement West Nile Virus programs. Programs are based on the *National Guidelines for Response to West Nile Virus*, produced by the National Steering Committee on West Nile Virus that is led by the Public Health Agency of Canada.

Transport Canada applies regulations through the Transportation and Dangerous Goods Act. Transport Canada also develops and updates regulations and standards for the safe shipping and handling of dangerous goods in order to ensure safe transportation.

Types of Service Providers

Environmental Health Officers.

Provider Qualifications

Service providers must possess a Certificate in Public Health Inspection (Canada) C.P.H.I. (Canada) issued by the Canadian Institute of Public Health Inspectors or the acceptable authorized equivalent, which is to be defined and approved by Health Canada. Service providers must be entitled to practice in accordance with the professional governing body (Board of Certification of Public Health Inspectors of the Canadian Institute of Public Health Inspectors) and laws of the province and/or territory where the services are to be provided.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Environmental Health and Research Result-based Management and Accountability Framework (RMAF).

2.2.2 Environmental Research (ER)

Description

Carries out laboratory and field studies, research, monitoring and surveillance; and predictive modelling efforts, in the context of risks posed by environmental contaminants (chemical, biological and radiological) to the First Nations and Inuit peoples and the balancing of health protection measures including remediation with traditional knowledge and the broader determinants of health.

Objectives

- Provide scientific research into concerns expressed by First Nations and Inuit communities regarding human health and environmental linkages.
- Provide laboratory and statistical services with respect to scientific research and monitoring.
- Monitor and assess scientific developments in the field of the environment's impact on human health at local, national and international levels.
- Improve environmental health risk awareness and community human resources capacity through community research and monitoring projects.

Elements

A. Research and Monitoring (RM)

Activities are aimed at helping First Nations and Inuit peoples improve their health and well-being by supporting their capacity to identify, understand and control the impact of exposure to environmental contaminants through community-based research, risk assessment and education. Although RM initiates and conducts research; it focuses its efforts on assisting First Nations communities in determining the scope of research to be done, reviewing the proposals for scientific merit, peer reviewing the research reports and disseminating the information to decision makers through various fora including scientific/technical committees and conferences and aboriginals organizations and communities. The scope of Research and Monitoring activities also includes integration and interpretation of existing scientific data or results to understand the exposure level and possible impacts of environmental contaminants on the health status of Aboriginal peoples; standard and guideline development, research, monitoring and reporting activities that provide feedback on the results of environmental contaminants programs and identify emerging research needs. A major effort by RM is providing information on the potential health risks associated with consuming various country foods possibly affected by environmental contaminants, while promoting the importance of traditional diet.

B. Statistical Analysis (SA)

The SA conducts research and data gathering activities to support the First Nations Water Management Strategy (FNWMS) and the continuous improvement of policy and program delivery. To date, a key deliverable is the annual publication of an annual FNWMS - Performance National Report which tracks progress towards achieving the FNWMS objectives over a five year period, from 2003–2008. The research activities focus on drinking water monitoring to establish baseline information, identify knowledge gaps and establish research priorities, with the goal to improve the evidence-base for FNIHB public health programs and policies regarding First Nation drinking water. In addition, SA provides research and statistical analysis support and advice to other environmental health programs.

C. FNIHB Fuel Tanks and Contaminated Sites Remediation (FT&CSR)

As part of FNIHBs compliance with regulations under the Canadian Environmental Protection Act (CEPA), the Canadian Environmental Assessment Acts (CEAA), the Fisheries Act and Treasury Board directives regarding the remediation of contaminated sites and fuel storage tank upgrades and replacements; staff of the FT&CSR work with Health Canada's regional Facility Managers to assess the extent and cost of remediation of fuel oil contamination at Health Canada health facilities on First Nations reserves, prioritize these remediation efforts across Canada, upgrade or replace fuel storage tank systems, and train First Nations on fuel tank system.

D. FNIHB Laboratory

The Laboratory performs analysis of persistent organic pollutants in biological samples (hair, urine, blood and fish) in support of First Nations and Inuit research programs. The laboratory, while providing routine analysis, is increasingly specializing in international/national Quality Assurance.

Clients

First Nations and Inuit communities.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Environmental Health and Research Result-based Management and Accountability Framework (RMAF).

3.0 Primary Care

FNIHB provides directly or funds the provision of 24/7 primary care treatment services in 76 nursing stations located in remote and isolated reserves, where there are no provincial services readily available, and provides home and community care on all reserves. As well, some primary care services are provided in isolated and small reserves.

3.1 First Nations and Inuit Home and Community Care (FNIHCC)

Description

The FNIHCC provides a continuum of home and community care services that are comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians. The program responds to the unique health and social needs of First Nations and Inuit. It is a coordinated system of home and community-based health care services that enable First Nations and Inuit people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities.

The program is delivered primarily by trained and certified personal care workers at the community level, supported and supervised by home care nurses. A number of essential Home and Community Care (HCC) services are delivered in the majority of communities. The structured client assessment service includes on-going reassessment and determination of client needs and service allocation. The managed care service incorporates case management, referrals and service linkages to existing service providers inside the community or elsewhere. Home care nursing services includes direct service delivery, supervision and teaching of personal care service providers. Home support personal care services such as bathing, grooming, dressing, etc., that enhance Indian and Northern Affairs Canada's in-home care services, form part of the continuing care services that are provided by the federal government. Other HCC essential services includes the provision of or access to in-home respite care service; establishment of linkages with other professional and social services; access to medical equipment and supplies; and a system of record keeping and data collection.

The HCC essential services in some communities may be expanded to include supportive services. Supportive services that may be provided might include but are not limited to: facilitation and linkages for rehabilitation and therapy services; respite care; adult day care; meal programs; mental health home-based services such as traditional counselling and healing and medication monitoring for long-term psychiatric clients and clients experiencing mental or emotional illness. Support services also include assistance to HCC clients with special transportation needs, grocery shopping, accessing specialized services and interpretative services, home-based palliative care, social services related to continuing care issues and specialized health promotion, wellness and fitness.

Objectives

- Build the capacity within First Nations and Inuit communities to plan, develop and deliver comprehensive, culturally sensitive, accessible and effective home care services.
- Assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.
- Facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan.
- Ensure that all clients with an assessed need for home care services have access to a comprehensive continuum of services within the community, where possible.
- Assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients.
- Build the capacity within First Nations and Inuit communities to deliver home care services through continuing education sessions, evolving technology, and the development and implementation of information systems that enable program monitoring, research, defining best practice and evaluation.

Elements

A. Structured Client Assessment
The assessment process utilizes an assessment tool and includes ongoing reassessment to determine client needs and service allocation.

B. Managed Care
This process incorporates case management, referrals and service linkages to existing services provided in the community or elsewhere.

C. Home Care Nursing Services
Home nursing services include direct service delivery and care planning, as well as supervision and teaching of personnel providing personal care services.

D. Home Support Personal Care
Personal care services could include bathing, grooming, dressing, transferring and turning. This component enhances, but does not duplicate, INAC's in-home adult care services.

E. Provision or Access to In-Home Respite Care
This service is intended to provide family and other informal caregivers with short-term relief from caring for dependent family members.

F. Established Linkages with other Services
The linkages with other services may include other health and social programs available both within the community and outside of the community, such as respite and therapeutic services, gerontology programs and cancer clinics.

G. Access to Medical Equipment and Supplies
This involves the provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals to provide the care required to maintain patients in homes or communities.

H. A System of Record Keeping and Data Collection
This component develops and maintains a client chart and an information system that enables program monitoring, ongoing planning, reporting and evaluation activities.

Clients

First Nations and Inuit people with disabilities, chronic or acute illnesses and the elderly. First Nations and Inuit of any age:

- who live in a First Nations reserve community (or in a First Nations community North of 60,) or Inuit settlement;
- who have undergone a formal assessment of continuing care service needs and have been assessed as requiring one or more of the essential services; and
- who have access to services which can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulations for service practice.

Types of Service Providers

Home and Community Care nurses, Personal Care Workers, and other community health and social development team members.

Provider Qualifications

Nurses must be registered under the Nursing Act in their province of work. Personal care workers require certification from a community college or other recognized institution, based on the requirements in place for such workers in their Province or Territory.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Primary Health Care Result-based Management and Accountability Framework (RMAF).

3.2 Oral Health Care (OHC)

Description

Oral Health Care is comprised of three elements: support to the National School of Dental Therapy; provision of oral health/dental therapy services to the First Nations and Inuit, and the Children's Oral Health Initiative (COHI). It strives to improve, and ultimately to maintain the oral health of First Nations and Inuit at a level comparable to other Canadians. In collaboration with the First Nations University of Canada, OHC delivers a two year diploma program to train dental providers to deliver basic clinical, preventive dental care services and health promotion programs and strategies in First Nations and Inuit communities.

The oral health/dental therapy service providers including salaried dental professionals and contract service providers, deliver and manage a broad range of oral health activities including prevention, oral health promotion and basic restorative services. The majority of restorative dental services are provided through Non-Insured Health Benefits rather than through the Oral Health Care program.

The Children's Oral Health Initiative (COHI) was launched in the Fall of 2004. COHI is largely delivered by dental therapists and dental hygienists. COHI focuses on the prevention of dental disease and promotion of good oral health practices. The goal of the COHI is to shift the emphasis from a primarily treatment based approach to a more balanced prevention and treatment focus. The initial focus for oral health promotion is directed at three groups:

- pregnant women and primary caregivers;
- pre-school children, 0-4 years of age; and
- school-aged children, 5-7 years of age.

Activities include dental screenings, assistance to improve oral hygiene, fluoride treatments, dental sealants and referrals for complex treatment. In addition, there are opportunities to inform and build capacity among parents, caregivers, and dental health professionals through clinical and educational strategies.

Other oral health promotion activities at the community level are delivered through awareness campaigns and presentations to target groups such as Aboriginal Head Start; day care; preschools; nurseries; parent participants; and specific community groups. Oral health promotion also includes media promotion; home visits and the promotion of Aboriginal professional oral health training, such as dental therapy.

Objectives

- Reduce, prevent or eliminate oral disease and the need for dental treatment through prevention, education and oral health promotion.
- Increase the number of First Nations, Inuit and Métis qualified oral health care providers.

Elements

A. National School of Dental Therapy

Until the end of June 2006, this program is delivered under a contract with the First Nations University of Canada, and from July 2006, will be funded through a contribution agreement. This two-year training program of dental therapists enables those graduating from the program to deliver restorative, surgical and oral disease prevention services, and health promotion programs and strategies in First Nations and Inuit communities as well as a limited number of other jurisdictions. Dental therapists play an important role in the delivery of the Children Oral Health Initiative (COHI).

B. Oral Health Promotion and Prevention

This component comprises strategies and programs that promote the development of oral health resources and programs specific to the needs of First Nations and Inuit communities and supporting the other elements of the Oral Health Strategy.

C. Children's Oral Health Initiative (COHI)

The Children's Oral Health Initiative is a program based on prevention of dental disease and promotion of good oral health and is targeted to children aged 0 - 7 and their care-givers. The Children's Oral Health Initiative has been developed to help close the gap between First Nations and Inuit and other Canadians in terms of oral health status, as well as build community and local capacity.

Program Clients

First Nations Communities and individual First Nations, Inuit or Innu people of all ages.

Types of Service Providers

Regional or contract oral health professionals including dentists, dental therapists, dental hygienists, dental assistants and denturists, community-based dental support staff or educators.

Provider Qualifications

Oral health professional staff must be licensed and/or registered as required by the specific jurisdiction.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Primary Health Care Result-based Management and Accountability Framework (RMAF).

3.3 Community Primary Care (CPC)

Description

Community primary care services encompass a spectrum of sectors and activities that influence health, including illness and injury prevention, health promotion, cure and rehabilitation (WHO, 1998). Primary Care is the first client contact with the health care system at the community level where resources are mobilized to diagnose and treat minor illnesses, manage chronic diseases, identify cases requiring complex care and coordinate care needs. It is the delivery of a comprehensive range of Community Primary Care services by a multi-disciplinary team of service providers including nursing services.

Community primary care services are provided to remote and/or isolated First Nations and Inuit communities where such services are not provided by provincial or regional health authorities. The first point of contact is the community health nurse[1] or community health worker who is responsible for health assessments. The situation is assessed and the need for urgent or non-urgent health care is determined. Urgent care involves the treatment of injured and or ill clients and arranging medical transportation if required. Non-urgent care services include physical assessments; problem identification, provision of pharmaceutical care and case management; family care and follow-up; managing communicable diseases and immunization coverage; and the provision of consultation services with other health care service providers and institutions.

The continuum of community primary care services is inclusive of illness and injury prevention and health promotion activities. These services are based in nursing stations and community health centres. Community nursing stations provide Primary Care services 24/7, which includes both urgent and non-urgent care. Physician visits are part of the Primary Care services provided in some First Nations and Inuit communities.

Objectives

- Provide access to urgent and non-urgent health services to community members including those who reside in remote/isolated communities where access to health services is not available through provincial or regional health authorities.
- Provide access to consultation services with other appropriate health care providers and/or institutions as indicated by client conditions.

[1] Due to the isolation of First Nations and Inuit residing North of 60, the role of the community health nurse is expanded to include a continuum of primary care services to meet the health care needs of First Nations and Inuit individuals, families, and communities. Also, these services are provided to transferred facilities South of 60*.

Elements

A. Emergency Care
Emergency care involves immediate assessment of a seriously injured or ill client to determine the severity of the condition and the type of care needed. It may involve treatment with stabilizing measures and arranging for immediate transport to a tertiary care centre, or keeping the client under observation. Where available, this is done in consultation with a physician. In isolated/remote communities, this is done by the nursing staff often in consultation with a physician by telephone or internet.

B. Non-Urgent Care
Non-urgent care involves the assessment, identification of problem(s) and generation of a plan of management for a client who is seeking care and treatment for a non-life threatening specific health concern. Other health care providers may be consulted depending on the nature of the condition.

Program Clients

First Nations on-reserve and Inuit in Inuit communities of any age. Services may be provided to non-First Nations clients where these services are not otherwise readily available.

Types of Service Providers

Registered Nurses, nurse practitioners, community health representatives, dental staff, mental health workers, addictions workers, home care workers and pharmacists.

Provider Qualifications

Community health nurses who are registered in the province of practice and who have the appropriate clinical skills and education to meet the competencies required for practices in the expanded role. Para-professionals who have a role in the Primary Care service delivery within the community. Within the community primary health care continuum, there are identified competencies and qualifications specific to each area of practice.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Primary Care Result-based Management and Accountability Framework (RMAF).

4.0 Supplementary Health Benefits

4.1 Non-Insured Health Benefits (NIHB)

Description

The NIHB Program provides approximately 780,000 eligible First Nations and Inuit with a limited range of medically necessary health-related goods and services not provided through private insurance plans, provincial/territorial health or social programs or other publicly funded programs. The benefits provided under the NIHB Program supplement private insurance and provincial/territorial health and social programs include drugs, dental care, vision care, medical supplies and equipment, mental health services, medical transportation to access medical services not available on reserve or in the community of residence, and health care premiums in Alberta and British Columbia. These benefits are to be provided without a means or income test, based on the assumption that the beneficiary has taken all reasonable efforts to first access those programs of a private or public nature to which he or she may be eligible. The Program is publicly funded and differs from private insurance plans in a number of ways: it uses a needs-based approach and there are no client premiums, co-payments, deductibles or annual maximums.

The following principles govern the NIHB Program:

- All registered Indians and recognized Inuit normally resident in Canada are eligible for non-insured health benefits regardless of residency or income level.
- Benefits are based on professional medical or dental judgement, consistent with the best practices of health services delivery and evidence-based standards of care.
- There shall be national consistency of mandatory benefits, equitable access and portability of benefits and services.
- The program will be managed in a sustainable and cost-effective manner.
- Management processes will involve transparency and joint review structures whenever agreed to by First Nations and Inuit Organizations.
- In cases where a benefit is covered under another plan, NIHB will act as the primary facilitator in coordinating payment in order to ensure that the other plan meets its obligations and that clients are not denied service.

Objectives

The purpose of the NIHB Program is to provide non-insured health benefits to First Nations and Inuit in a manner that:

- Is appropriate to their unique health needs;
- Contributes to the achievement of an overall health status for First Nations and Inuit people that is comparable to that of the Canadian population as a whole;
- Is sustainable from a fiscal and benefit management perspective; and
- Facilitates First Nations and Inuit control at a time and pace of their choosing.

Elements

A. Dental Health

Eligible dental benefits and services include diagnostic, preventive, restorative, endodontic, removable prosthodontic, orthodontic, adjuctive and emergency dental services. These benefits and services must be supplied by licensed practitioners; for example, dentists, denturists, orthodontists, prosthodontists, endodontists, oral surgeons, paedontists and periodontists. Eligible dental benefits and services are listed in the NIHB Schedule of Dental Services.

B. Medical Transportation

Financial assistance is available for medical transportation to allow eligible clients to access medically required services (including accessing specialists, alcohol, drug and solvent abuse treatment centres) which are not available in their community. Eligible benefits include land and water transportation, scheduled and chartered airlines, road and air ambulance, clients in transit outside their communities, escort and/or interpreter services.

C. Drugs

Eligible drug benefits include prescription and some over-the-counter drugs that are available through pharmacies for administration in a home setting or other ambulatory setting and require a prescription by a licensed medical practitioner or other provincially licensed prescriber. Eligible drug benefits are listed in the NIHB Drug Benefit List which is published annually with quarterly updates.

D. Medical Supplies & Equipment

Eligible medical supplies and equipment are available through pharmacies or recognized medical supply houses. Medical supplies and equipment for usage in a home setting or other ambulatory setting require a prescription by a licensed medical practitioner or other provincially approved health practitioner. Eligible medical supplies and equipment benefits are listed in the NIHB Medical Supplies and Equipment List which is published annually.

E. Vision Care
Eligible vision care benefits and services include, when not covered by the province or territory, eye glasses, repairs, eye prosthesis and eye examinations that have been prescribed by a recognized Vision Care prescriber. Eligible vision care benefits and services are listed in the NIHB Vision Care Benefit List.

F. Short-term Crisis Intervention Mental Health
Eligible mental health services include mental health assessments, treatment and referral as required on Fan early intervention, short-term basis, to address at-risk, crisis situations when such services are not available elsewhere. Mental health benefits may be provided by therapists who are registered with a regulatory body from the disciplines of clinical psychology, clinical social work in the province in which the service is provided.

Clients

Registered Indians and recognized Inuit in Canada.

Type of Service Providers

Dentists, orthodontists, pharmacists, opticians, optometrists, psychologists, social workers and other licensed specialists as designated by the NIHB Program.

Provider Qualifications

Practitioners who are licensed or certified in the province or territory in which they practice.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Non-Insured Health Benefits Result-based Management and Accountability Framework (RMAF).

5.0 Health Governance and Infrastructure Support

The components of the Health Governance and Infrastructure Support assists eligible First Nations and Inuit Provincial, Territorial, NGO's and other recipients to deliver activities/programs that support the delivery of health programs and services. The Health Governance and Infrastructure Support is delivered at the national, regional and community levels.

5.1 Health Facilities and Capital Program (HFCP)

Description

The HFCP supports the construction, acquisition, leasing, operation and maintenance of nursing stations, health centres, health stations, health offices, treatment centres, staff residences, and operational support buildings. These facilities allow Health Canada to efficiently and effectively offer health programs and services to FNIHB clients, even in remote and isolated regions. The HFCP also supports the acquisition and repair of moveable assets, including equipment, vehicles, and furniture.

Objectives

- Provide the facility space required to support on-reserve health programs and accommodate staff, where necessary.
- Support the operation and maintenance of existing health facilities and staff residences.
- Provide a safe and secure physical working environment for staff and clients.
- Support the effective environmental management of health facilities, staff residences, and operational support facilities.

Elements

A. Capital Investment
Provides FNIHB-supported health programs and operations with the modern space and equipment required to effectively deliver health services directly to First Nations communities and Inuit settlements.

B. Facilities Management
Supports the efficient operation and maintenance of FNIHB-supported health facilities.

C. Physical Security Management and Emergency Planning
Ensures that FNIHB-supported health facilities provide a safe and secure physical environment for staff, clients, and visitors, as well as for health equipment, pharmaceuticals, and medical files.

D. Environmental Management
Minimizes the environmental impact of construction and operation activities stemming from FNIHB-supported health facilities as well as brings these health facilities into compliance with applicable environmental regulations.

E. Real Property Planning and Policy Development
Provides guidelines, manuals, management tools and strategic direction to Health Canada and First Nations and Inuit community staff for the planning, implementation, and reporting of HFCP activities.

Clients

First Nations and Inuit community members, and health facility staff and other health facility workers, such as visiting specialists.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Facilities and Capital Result-based Management and Accountability Framework (RMAF).

5.2 Health Planning and Management

Description

The objective of Health Planning and Management is to support First Nations and Inuit planning and management of health programs and services. This funding supports community health planning and the development of both health services and programs delivery model and its requisite infrastructure at the community, regional or national levels. Sound health planning and development of a health infrastructure are two critical conditions to access the Flexible funding model under Community Program, Health Protection, Primary Care and Health Benefits Class Contributions. The Health Planning and Management funding supports First Nations and Inuit recipients in the establishment of a strong, effective and sustainable health planning, administration and delivery infrastructure.

Objectives

Health Planning and Management enables increased First Nations and Inuit control and capacity building around health programming that, when combined with the use of flexible arrangements including ongoing health planning, supports operational plans and administration, which:

- Enable recipients to design health programs, develop health plans, establish services and/or allocate funds according to health priorities;
- Ensure that recipients have an optimized flexibility for health programming and services; and
- Strengthen and enhance the accountability of recipients regarding the management and the delivery of health programs and services.

Clients

First Nations and Inuit communities, District and Tribal Councils, First Nations Health Boards, health organizations and corporations.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.3 Health Consultation and Liaison

Description

Ensuring Aboriginal peoples, an effective role in the planning and delivery of health programs and services also requires the capacity to engage in health consultation activities at the international, national and regional levels. Enhanced Aboriginal consultations and liaison capacity will result in greater participation in planning, budgeting and delivery of health services and programs. This increase in participation will have direct effects towards improving Aboriginal health outcomes, and will reduce health inequalities between Aboriginal populations and other Canadians. More specifically, Health Consultations and Liaison funding is allocated to:

- Establish and maintain productive lines of communication and exchanges of policy, research, evaluation and program delivery information between Aboriginal peoples, health care delivery agencies, and other levels of government;
- Ensure substantive involvement of Aboriginal leaders and community representatives in decisions relating to health care policy and delivery;
- Pursue and secure recognition of First Nations rights to health care and jurisdictional control of health care;
- Develop and maintain health consultation processes; and
- Develop Aboriginal awareness and expertise in the field of health care, and build capacity to provide consultation on health matters.

Two types of funding are available for health consultation and liaison: base funding and project specific funding for health consultation to address health priorities. The base funding aims at supporting and maintaining core capacity of Canadian national and regional Aboriginal organizations to participate and lead consultation and liaison processes while project specific funding for health consultation to address health priorities is available for Canadian Aboriginal organizations as well as non-governmental organizations and associations.

Objectives

The First Nations and Inuit Consultation and Liaison activities are designed to increase the capacity of its eligible recipients to consult and liaise with Federal/Provincial/Territorial governments, regional Aboriginal associations and relevant Aboriginal organizations, and other non-governmental organizations in order to provide policy advice, analysis, input, and guidance relating to federal health policy as a means of ensuring that such policy is reflective of Aboriginal health issues, initiatives, needs, and priorities.

Elements

- Health Liaison
- Health Consultation
- Other one-time special projects

Clients

First Nations, Inuit, and Métis populations.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.4 Health Research and Co-ordination Projects

Description

Health Canada provides funding to support Aboriginal health research and co-ordination projects including community, regional, national and international initiatives, that will contribute to enhancing knowledge related to Aboriginal health (including health human resources). Through FNIHB, Health Canada engages in capacity-building, information dissemination, knowledge translation, original research, data gathering and analysis, and other research activities and partnerships with other government institutions and Aboriginal organizations, such as the Canadian Institutes of Health Research, and the National Aboriginal Health Organization (for NAHO specifics, refer to the Organization for the Advancement of Aboriginal Peoples' Health authority Terms and Conditions). In addition to providing funding for international initiatives to Aboriginal organizations, Health Canada also engages in international activities directly through collaboration with other countries to exchange information, generate knowledge, reinforce best practices, and to seek and provide advice with the objective of contributing to the improvement of Aboriginal health practices and knowledge.

Objectives

- To establish and maintain productive lines of communications and exchange of policy, research, and program delivery information between First Nations and Inuit, health care delivery agencies, and other levels of governments.
- To ensure substantive involvement of First Nations and Inuit in decisions relating to health care policy and delivery.
- To develop and maintain awareness and expertise in the field of health care.

Clients

All First Nations and Inuit.

Type of Service Providers

Canadian First Nations Bands, District, Tribal Councils and Associations; Inuit Associations and Councils; National Aboriginal organizations; Canadian non-governmental and voluntary associations and organizations, including non-profit corporations; Canadian educational institutions and hospitals; Provincial and territorial governments and agencies.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.5 e-Health Solutions

Description

e-Health is defined as the coordinated and integrated use of information technology to support, manage and enhance the delivery of health programs and services. In line with e-Health activities in provinces and territories, FNIHB has enhanced its activities from the support of one application (First Nations and Inuit Health Information System) to a multi-faceted approach to respond to the needs of First Nations and Inuit and the Branch. Health Canada provides funding to e-Health Solutions to support the programs within FNIHB in the selection, deployment and support of e-Health infrastructure to ensure that First Nations and Inuit communities are connected and informed.

e-Health Solutions applications provide case management, health surveillance and planning tools for public health nurses and other health professionals providing care in health facilities on reserve and in Inuit communities as well as in support of regional and national programming. e-Health Solutions will enable First Nations and Inuit communities to improve health outcomes and promote healthy lifestyles through the innovative use of partnerships, technology and e-Health tools and services; providing the right information to the right people, at the right time.

Objectives

- Develop and maintain the necessary technical and human capacity and skills needed to operate, maintain, use and develop e-Health applications and connectivity.
- Develop a viable regional e-Health capacity and structure capable of supporting the delivery of health programs and services.
- Contribute to and strengthen health programs in the community by providing them access to e-Health solutions and information technologies that support program management, delivery, priority setting, planning and evaluation.

Elements

A. Program Management, Planning and Governance

Includes development and implementation of good management practices, involving Enhanced Management Framework project management and practices, and secretariat support services for the various program committees. It also supports communication and promotion of the program, and accountability and reporting requirements.

B. Infostructure
Addresses the building of the infostructure components to support e-Health solutions, change management, Help Desk, technical infrastructure, telecommunications, application maintenance and upgrades.

C. Implementation
Focuses on continued introduction of applications in the communities through investments in community readiness.

D. Education and Information Management
Education activities have been incorporated into Capacity Development and the Information Management activities into Implementation.

E. Capacity Development
Focuses on the sustainment of community health personnel at the regional and local level through education with the goal to improve health service delivery, health service planning and community health program development. It also addresses partnership with other government organizations and non-government organizations (NGO) to build e-health capacity in First Nations and Inuit communities.

F. Integration
Predominantly focuses on linking activities by building relationships with other health organizations and other jurisdictions, to facilitate the development of data sharing agreements and the exchange of health information.

Clients

First clients are health professionals in health facilities. Secondary clients are program managers and administrators.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.6 Security Services for FNIHB Health Facilities

Description

Security services for FNIHB health facilities supports the establishment of a safe and secure workplace environment for nursing staff providing services in nursing stations and other health facilities on reserve land across the country. By promoting and providing a safe and secure workplace environment, security services will contribute to the recruitment and retention of nursing staff who are vital assets for delivering upon the branch's mandated programs and services.

The provision of funds ensures that security personnel are posted in facilities where threat and risk assessments have identified personal and physical security threats. This funding is provided for the recruitment, training and retention of security guards by First Nations communities. In addition, the funding is complementary to the physical security funding provided through the Health Facilities and Capital Authority.

Objectives

The overarching objectives of Security Services for FNIHB Health Facilities is to ensure a safe and secure workplace environment for nurses other health facility workers and patients receiving care, through prevention, awareness, and continuous risk assessments.

Elements

Include ongoing threat and risk assessments for health facilities on reserve and implementation of baseline security measures, including the staffing of security guards in high risk locations. Other elements include the development of policies, guidelines and procedures for the management of security functions in remote-isolated nursing stations.

Clients

Nursing and other health staff providing services in First Nations communities across the country.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.7 Aboriginal Health Services Accreditation (AHSA)

Description

The objective of the AHSA initiative is to support Aboriginal health services as they apply national standards to improve the quality of health care. The accreditation process supports full involvement of the First Nations and Inuit health services organizations, community leadership, educational services, provincial and territorial health services, medical professionals and community members who receive the services (clients). As well as building essential linkages within and between communities and provinces and territories, it provides opportunities for community members to have an ongoing voice in the direction of their health organization. Funding supports First Nations and Inuit organizations to engage in the accreditation process and use standards of excellence in the areas of Leadership and Partnership, Information Management, Human Resources, Environment and direct health service delivery.

Objectives

- Work in collaboration with the Canadian Council on Health Services Accreditation (CCHSA) to ensure standards are culturally relevant and guidance and support is available to organizations.
- Develop strong regional capacity and structures to support organizations through the accreditation process.
- Increase of number of accredited Aboriginal health services.
- Incorporate ongoing quality improvement into the Aboriginal healthcare system.

Clients

The target populations for the AHSA are:

- All Aboriginal health organizations and/or organizations providing services to Aboriginal people.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.8 Aboriginal Health Transition Fund (AHTF)

Description

There has been growing recognition that closing the gap in health status between Aboriginal and non-Aboriginal Canadians requires coordinated efforts by all involved in Aboriginal health. In budget 2005, funding of $200M over 5 years was provided to establish the Aboriginal Health Transition Fund. The AHTF will support:

- First Nations and Inuit communities and organizations to improve the integration of existing federally funded health systems within First Nations and Inuit communities with provincial and territorial (P/T) health systems; and
- P/Ts to adapt their existing health services to better meet the needs of all Aboriginal peoples, including First Nations, Inuit, Métis, and those living off reserve and in urban areas.

Over the long term the AHTF is intended to result in:

- improved integration of federal, provincial, territorial (F/P/T) funded health systems;
- improved access to health services;
- health programs and services that are better suited to Aboriginal peoples; and
- increased participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services

Elements

Under the AHTF:

- The integration of services is a tripartite process involving First Nations and Inuit communities (including organizations and tribal councils), F/P/T health authorities;
- The adaptation of services is a bipartite process involving P/T governments and health authorities and Aboriginal communities; and
- Researchers and experts may lend their knowledge and skills to assist in improving the integration and adaptation of health services

Clients

Aboriginal individuals and communities.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.9 Aboriginal Health Human Resources Initiative (AHHRI)

Description

The AHHRI comes from a commitment made by the federal government at the Special Meeting of the First Ministers and Aboriginal Leaders in September 2004. The commitment builds on the previous Health Accord in 2003, which directed provincial and territorial and federal governments to work together with Aboriginal people to advance a health care system that is more responsive to the needs of Aboriginal people. Through the Initiative, health human resources strategies responding to the unique needs and diversity among Aboriginals will be developed and implemented while at the same time seeking to provide the right balance and numbers of Aboriginal health care providers, increase the level of cultural competency of all health care providers as well as respond to the current, new and emerging health services issues and priorities while integrating with the pan-Canadian Health Human Resources Strategy. The goal of this collaboration is to reduce the gap in health status that currently exists between Aboriginal people and the rest of the Canadian population, through improved access to health care, and the resultant better health outcomes.

Objectives

- To increase the number of Aboriginals who are aware of health careers as viable career options, focussing particularly on youth awareness.
- To increase the number of Aboriginal students entering into, and succeeding in health career studies.
- To increase the number of post-secondary educational institutions that are supportive of and conducive to Aboriginal students in health career studies (eg., have culturally appropriate curricula; student support; access and mentoring programs; reduced barriers to admissions).
- To identify the conditions that create supportive and conducive work environments that will increase the retention of Aboriginal health care workers, and non-Aboriginal health care workers working in Aboriginal communities.
- To establish standards of practice and certification processes for Aboriginal community-based para-professional health care workers, which will help to ensure a properly trained and mobile para-professional work force, and help improve retention of para-professional community-based workers.

- To establish the foundations for collaboration so that all partners accept the appropriate roles and responsibilities and are committed to act upon them.
- To initiate the establishment of baseline information (including on-going collection), and to initiate targeted research and analysis on the supply and demand for Aboriginal health care workers and best practices and approaches in order to support policy, planning and program decisions.

Clients

The target populations for the AHHRI are:

- All First Nations, Inuit and Métis regardless of their status and where they reside;
- Health care providers providing services to First Nations, Inuit and Métis;
- Universities and colleges delivering health sciences programs that are interested in making changes to their curricula in order to provide more culturally relevant health science programming; and those that would like to provide culturally relevant health care programs; and
- First Nations, Inuit and Métis and non-Aboriginal health professional and para-professional organizations, associations and associations representing colleges and universities.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

5.10 Health Careers Program

Description

The First Nations and Inuit Health Careers Program (FNIHCP) was created in 1984 in response to the disproportionately low numbers of Aboriginal people working in health professions. It is intended to increase awareness of health career opportunities and foster an interest in health science studies in Aboriginal students. It also provides the supports necessary to ensure success for the students. The overall goal of the program is to increase the number of Aboriginal health professionals.

The FNIHCP provides contributions to support Aboriginal participation in education leading to careers in the health field. The program is designed to address career needs at the national, regional and community levels - and consists of the Bursaries and Scholarships programS, which is administered by the National Aboriginal Achievement Foundation on behalf of Health Canada, health career promotion, including NAAF's Blueprint for the Future career fairs, career-related summer employment, community-based activities, and post secondary institutional programs.

At the Regional level, annual allocations are provided to deliver regionally based programs as well as community based programs, depending on regional priorities. The national portion of the program focuses on Bursaries and Scholarships and health career promotion activities.

Objectives

The objective is to build capacity of Aboriginal peoples by encouraging and supporting Aboriginal participation in health educational opportunities and by providing supports to learning environments. This is achieved through the promotion of health study programs, the provision of bursaries and scholarships for health career programs, provision of internship and summer student work opportunities and support for the Blueprint for the Future career fairs.

Clients

All Aboriginal peoples (status, non-status, Métis and Inuit).

Types of Service Providers

A variety of personnel are involved in the delivery of the national and regional health career initiatives, including health career coordinators, managers, volunteers and support staff.

For information on the performance measurement strategy, the performance indicators, the reporting requirements and the evaluation strategy, please refer to the Health Governance and Infrastructure Support Result-based Management and Accountability Framework (RMAF).

Notes