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CHAPTER 1

INTRODUCTION

About the consultant

GRF Recherche/Évaluation was established in 1996 and is based in Quebec City. It is a team of anthropologists, social researchers and consultants specialized in assessment, counseling, program planning, population consultation, and training through workshops and support activities.[1]

For years GRF has been working with native communities all over Quebec. The basis of its working philosophy is to empower its partners for them to concretely benefit from this collaboration, putting forward and sharing any expertise they can offer no matter how modest.

Presentation of the Health Plan document

The actual document is made up of 8 parts plus appendices. The initial part is meant to present the way the community's capabilities have been assessed and a summary of the results. Chapter 2 draws the community mapping while the 3rd chapter presents the Health Services delivery system. On Chapter 4 the reader has a description of the management structure of the Health Services on the reserve territory. Chapter 6 presents the priorities and its original selection process, leading us to Chapter 7 where we present the programming designed to reach the described goals and objectives. Chapter 8 concludes with the mandatory programs.

Definition of a holistic approach

Holism and holistic approach are words often used when speaking about the way First Nations members want to address the individual as well as the nation's health.

The *Université du Québec en Abitibi-Témiscamingue* (UQAT) explains the concept of holism as the use of the 4 dimensions [*spiritual (soul), mental (head), physical (body) and emotional (heart)*] to address the healing of the individual placed at the centre of his own healing process. The overall process aims to insure or restore the equilibrium of the individual, which arrives through self-esteem, capacity development and the feeling of security and belonging.[2]

Another document about First Nations research that presents the principles of holism will complete what is meant by this word which is often-used but not always well-perceived through a Western mind set.

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[1] You can have more information about the consultant through its Web site on www.grfocus.com.
[2] http://web2.uqat.ca/chairedesjardins/documents/CAAVDmai2008FR.pdf. It presents a PowerPoint from the Val-d'Or Native Friendship Centre (VDNFC).

"Most traditional Aboriginal world views are planted firmly in the Earth. Aboriginal languages and cultural practices reflect this intimate connection. Traditionally, Aboriginal peoples thought of the Earth and their life on the Earth as an interconnected web of life functioning in a complex ecosystem of relationships (Cohen 2001). Great importance is based on the principle of "balance" in this delicate web of life (Cohen 2001; Kenny 2002). Elders are constantly reminding contemporary Aboriginal people about the importance of keeping our lives in balance.

(…) An Aboriginal world view that not only understands, but embraces change, is often left behind in policy discourse when Aboriginal people are characterized as living in the past."[3]

Holism concerns the individuals and the nations, and their way of thinking.

"Aboriginal knowledge is not a description of reality but an understanding of the processes of ecological change and ever-changing insights about diverse patterns or styles of flux. (…)To see things as permanent is to be confused about everything.

A framework for holistic research (and we add for any holistic approach whatsoever) would include: honouring the past, present and future (…), honoring the interconnectedness of all of life and the multi-dimensional aspects of life on the Earth and in the community (…),honouring the spiritual, physical, emotional and mental aspects of the person and the community (…)"[4]

The challenge now rests in the integration of the holistic mode into the reality of the current organization of health services based on a Western model.

Evaluation of the community's capabilities

Method

The current evaluation of the community's capabilities that introduces the planning is essentially based on three main sources of data provision.

First we used the evaluation report done in relation with the previous health plan (2005-2010). The report was done by our firm. It was presented to the EV health authorities and to Health Canada in June 2010.

The other main sources are three field work projects in Eagle Village F.N. The first one took place in February 2012, few weeks before the health agreement between EVFN and Health Canada was extended for a year. The second was done in June of the same year, and the final and third one was done in October 2012. At this occasion we benefited from the presence of the Health Canada's liaison officer for the EVFN.

[3] http://publications.gc.ca/collections/Collection/SW21-114-2004E.pdf
[4] Idem

Though the former Health Plan is the main document that we used, other relevant reports done from one to five years before the establishment of the current Health Plan have been of great usefulness for the making of the current Health Plan.[5]

During consultations done for the assessment of the previous Health Plan, a questionnaire was distributed within the community in order to gather data about the health status of the community, perceptions and service appraisal. In order to reinforce the results of the questionnaire, 2 focus groups have been conducted: one with men, one with women. The questionnaire and the focus groups assessed items like: general knowledge on health, life habits, community health status assessment, chronic disease status and health service evaluation.[6]

Benefitting from these consultations with the community and based on their individual work experience with and for the community, the health workers made a strong effort in establishing the new priorities of their health plan. The community's capabilities weren't only the topic of one discussion among the workers; actually it appeared on many occasions while we spoke about the priorities, the community's health status and even during the programming of the activities themselves. The consultant summarized the several mentions and ideas backed by the available research data into an intelligible form in the current document.

Results

As a summary of the community's capacities we can say that Eagle Village First Nation is a community that relies on many positive assets.

- The social tissue partly rests on a relatively good employment rate and good income level, some 53% of the households and 40% of the individuals have incomes of over $30,000[7]. The employment rate is a little less than it used to be some years ago because of the difficulties of the lumber industry but it is still better than in the other First Nations communities of the Témiscamingue region. A research paper done by the FNQLHSSC mentioned that in Témiscamingue region, aboriginal men have a higher level of unemployment than elsewhere in the province (29% vs 22%). The average revenue of aboriginal people in the region is about $21,000.[8]

  Links were established many years ago by the Band Council with Tembec and other local lumber industries in order to favor the employment of First Nations

[5] The documents we refer to in this paragraph are: the *5-Year Evaluation 2005-2010 Health Programs Evaluation* issued in June 2010; the *Evaluation of AHTF Project for Eagle Village First Nation*, dated of April, 2011; the *Maternal and Child Health Needs Assessment,* June 2008; the *Step-Evaluation of Eagle village First Nations's Health Services programs* of March 2008; the *Projet clinique autochtone*, *Eagle Village Health Centre (EVHC) – Centre de santé et de services sociaux de Témiscaming-et-de-Kipawa (CSSSTK),* finalized in February 2011.
[6] The questionnaire form is presented in an appendix of the *5-Year Evaluation 2005-2010 Health Programs Evaluation, June 2010*, presented to Health Canada.
[7] See Table 4.
[8] http://www.cssspnql.com/fr/dev-social/documents/PremieresNations-Abitibi.pdf

members. It paid off and still does by allowing First Nations members to access good jobs without the hindrance of prejudice toward their status.

- The social tissue also relies on a relatively good schooling level since, according to the results to a questionnaire passed in 2009, 55% of the population completed high school, whereas it is evaluated at less than 10% overall in the First Nations reserves of the Abitibi-Témiscamingue region. The gap between both figures might indicate a bias in the research but it seems to indicate that EVFN has more success than others in the schooling of its members.
- Constant demographic progression creates community expansion and implantation of new dwellings. This relies mostly on newcomers, band members who are on a waiting list to gain a dwelling on the reserve or members of other bands who seek membership. These people contribute strongly to the dynamism of the community. Their strong and constant will to join the community by establishing their families within the reserve's boundaries also indicates the soundness of the findings we noted previously.
- Good level of relatively recent infrastructure since the reserve has been established in the mid-70s.
- For the past decade, EVFN has developed sound political leadership guided by the separation of the politics from the administrative process, allowing the administration to increasingly base its actions on objective goal definitions.

<u>Participation of community members in the planning process</u>

The community members participated in many steps of the definition process of the current Health Plan.

Preliminary steps, first and second components[9], all these steps of the making of the current Health Plan occurred during the previous health plan (2005-2010). The community members have gained the habit of being regularly informed about administrative and clinical health issues. They have been consulted and questioned on many occasions in relation with these issues (needs assessment, longitudinal study of the FNQLHSSC, assessment of the previous Health Plan). They participated in an important needs assessment in 2003 and have been regularly asked thereafter to validate the orientations that were taken at that time. They now expect to be part of the decision making process.

The population was involved in the third component when it was asked to assess the previous Health Plan, the first step of the new priorities definition for the upcoming Health Plan. The community members then also had the opportunity to assess the service delivery of the past years and redirect the orientations and objectives selected at that time. Their voice and the expression of their values have been taken into account by the health workers when the time came to identify the priorities.

[9] In reference to the document provided by Health Canada "*Health Planning and Implementation Summary Chart*», April 2007.

The Health Centre's workers are in daily contact with the community members because most of them live within the community. In other words, each time you speak with a Health Centre worker you somehow voice your priorities and conception about the services and service delivery.

As for the Health Plan assessment and revision it is addressed each time the annual band council report is presented to the population and people are requested to voice their comments.

CHAPTER 2

COMMUNITY MAPPING AND NEEDS AND THINGS

2.1 Geography

EVFN is surrounded by the municipality of Kipawa at about 12 km north-east of the town of Témiscaming, QC. The closest cities are North Bay, ON, which is about 80 km west, and Ville-Marie, QC, about 100 km away north, a much smaller town. Lumber is the main economic activity sector.

The overall Témiscaming/Kipawa (TK) territory comprises about 3500 inhabitants, which represents some 2.5% of the regional population of the Abitibi-Témiscamingue. In the Témiscaming/Kipawa region, the overall aboriginal population represents about 19% of the total population.

The Eagle Village community is the main site of the permanent aboriginal occupation in the TK region.

EVFN is defined as a non-isolated community of 354 residents: 290 status members and 64 non-status members. Some 548 members live off-reserve in nearby communities (chiefly Témiscaming and Kipawa).

2.2 Community context

Two elements are to be put forward to describe the current situation of the community of Eagle Village First Nation under a developmental perspective.

First, the growth rate of the community is particularly strong, pushed forward by the arrival of many newcomers to the band. Many of these newcomers are known to originate from the Wolf Lake band which authority head office is based in Témiscaming but which has no territory under its jurisdiction.

Furthermore many band members (90 individuals[10]) who live on the outskirts of the community are awaiting an occasion to be granted with a house within the reserve boundaries. Already many of these band members use several services offered on the reserve.

The wood and lumber industry received severe blows in the past years. It is evaluated that nearly 20 people on-reserve and nearly another 20 off-reserve lost their jobs because of plant shutdowns. It seems though that the economic reality of the region has more impact on the non-native demographic than on the native one. "*We, "Indians", won't leave the territory, whatever happens!" (Personal conversation with the consultant*)

[10] Statistics Canada, 2006 Community Profiles

As opposed to the Village's situation, it is to be noted that the population of Kipawa has gone down by 16.1% between 2006 and 2011, as for Témiscaming it has been dropping by 11.6%.

2.3 Methods used for the assessment of the health needs of the community

The assessment of the needs and resources available to the community are chiefly based on reports done in the previous years and on the direct experience of data gathering for the purpose of these reports.

The main documents we refer to are: the *5-Year Evaluation 2005-2010 Health Programs Evaluation* issued in June 2010; the *Evaluation of AHTF Project for Eagle Village First Nation*, dated of April, 2011; the *Maternal and Child Health Needs Assessment,* June 2008; the *Step-Evaluation of Eagle village First Nations's Health Services programs* of March 2008; the *Projet clinique autochtone*, *Eagle Village Health Centre (EVHC) – Centre de santé et de services sociaux de Témiscaming-et-de-Kipawa (CSSSTK),* finalized in February 2011.

An extended Needs Assessment has been run in 2003 prior to the establishment of the 2005-2010 Health Plan. Its conclusions and findings are generally still appropriate.

After discussion with the Health Direction, it didn't appear necessary or even desirable to repeat the focus groups that had been run just few months ago since no major events nor did any other kind of change took place that could suggest major shifts in the community situation. We also took into account the EVHC's experience which reckoned that the community population was often asked to complete questionnaires and gather for meetings developing a certain dislike about these types of consultation.

For the reader's benefit let's mentioned that for the 5-year evaluation 2005-2010, the evaluation team ran 2 focus groups with members of the population (one with men and another with women) and gathered data from an original questionnaire developed by the consultant firm. The sample population who answered the questionnaire comprised 71 respondents 15 years of age and over: 33 men and 38 women. The confidence level was of 95% and the confidence interval of 10.

To complete the process of identifying the community's needs these were also discussed among the Health Centre's workers according to their experience during the selection process that took place for the definition of the priorities.

2.4 Basic health determinants

2.4.1 Demographic Portrait

EVFN is defined as a non-isolated community. As for April 2013, EVFN is made of 300 residents; 266 status members; 34 non-status members; close to 560 members live off-reserve in nearby communities (chiefly Témiscaming and Kipawa). These numbers come from the Band Council Administration.

As for the residents the current figures are:

0 to 12 years of age: 38
13 to 25 years of age: 51
26 to 55 years of age: 151
56 and more years of age: 60

2.4.2 Maternal Language

According to the latest data:

About 96 % of the adult population of EVFN use English as the usual language at home.

About 94 % of the population do not speak an aboriginal language.

2.4.3 Demographic Evolution

Currently, from 2 to 5 births occur every year in EVFN. The community loses an average of 5 people during the same period. The most recent figures show this:

Table 1: EVFN Births and Deaths

	2009	2010	2011	2012
Birth	5	5	3	4
Death	7	6	3	4

In January 2012, EVFN territory is made of 125 dwellings: 117 single houses, one duplex and one 6-unit multiplex[11].

As a result of a planned housing program in 2009, the most important impact on the future of EVFN demographics will certainly come from the ongoing implementation of about 65 new residences within the reserve territory.

Table 2: On-reserve population of Eagle Village First Nation

	1996	2001	2007	2013	2016
Population	205	242	269	300	360

[11] There were 91 dwellings in 2002.

on-reserve		(+18%)	(+11%)	(+12%)	(Hypothesis +20%)

The current house occupation ratio is of 2.4 people per housing unit.

2.4.4 EMPLOYMENT

- According to the First Nation Human Resources Development Commission of Quebec (FNHRDC), based on Stat Can's figures, in 2006, the unemployment rate in EVFN was of 14%.
- The main employer is the Band Council, followed by Tembec.

According to the Band Council data of 2013, the community working power is divided:

Table 3: Employment chart of the community members (2013)

Employer EVFN	Part time seasonal	Employer TEMBEC	Full time other employer	Part time other employer	Unemployed	Retired	Disabled	Student
45	17	27	35	7	45	41	7	8

Table 4: Income Level Summary, EVFN 2009

Annual Income 2009	Per Individual	Per Household[12]
$0-$9,999	20.1%	13%
$10,000-$19,000	16.4%	15.9%
$20,000-$29,000	24%	17.4%
$30,000 or more	39.5%	53.6%

2.4.5 EDUCATION

According to the results to a questionnaire passed in 2009[3], 43.7% of the respondents did notcomplete high school.

There is no school within the community. The children go to the school G-Théberge, English sector, in Témiscaming. On the other hand, more and more parents take the decision to send their children in North Bay, which decision is perceived by some as a major problem for the future of the Témiscaming community, since it is expected that many of these children will not come back to their original smaller town.

[12] From the results of the questionnaire run in December 2009 as part of the 5-year evaluation.

2.4.6 Social Adaptation

In a report of 2008, "*Step-evaluation of Eagle Village First Nation's Health Services programs*", it is mentioned that drug and alcohol abuse are still significant disturbance factors as for many native or non-native communities all over the country. According to local sources, neither the growth rate of the population nor the increase in the unemployment rate seems to have enhanced the seriousness or frequency of violent behaviours within the community. However the actual number of cases of vandalism escalated.

An *Agence de la Santé et des Services sociaux de l'Abitibi-Témiscamingue*'s (ASSSAT) report from December 2006 mentioned that the number of "reports" (*signalements*[13]) received by the *Centre jeunesse de l'Abitibi-Témiscamingue* increased between 2003-2004 and 2005-2006. On a regional basis the increase is 17% among non-native population; 25% among the native population off-reserve; 40% among the native population on-reserve[14].

These figures relate to 7 reserves on the territory of the region. As for EVFN itself:

Table 5: Number of the retained "reports" ("*signalements*") for evaluation, Témiscaming and Kipawa

Year	Non-native	Native off-reserve	Native on-reserve
2003-2004	17	3	7
2004-2005	18	4	3
2005-2006	19	4	9

Table 6: Reports ("*signalements*") «retained» in 2005-2006 for the Témiscaming/Kipawa territory

Causes	Non-native	Native off-reserve	Native on-reserve
Negligence	6	5	9
Physical abuse	5	0	0

[13] Information to the authorities about a potential case of abuse or negligence toward a youth under 18 years of age.
[14] The quotes and tables of this section come from: *Projet clinique: Enfance – Jeunesse – Famille. CSSS TK, janvier 2007, pp. 16-17*.

Sexual assault	3	0	1
Abandonment	0	0	0
Behaviour disorder	1	1	2

2.5 Community Health Status

2.5.1 Causes for consultation

The main causes of visit to the walk-in clinic are, sorted by frequency:

- Cardiovascular, high blood pressure & diabetes
- Injections
- Laboratories
- Dressings
- Maternal & Child Health

The diabetes prevalence rate on-reserve is about 11% as compared to 4.7% in the whole Témiscaming/Kipawa area.

Table 7: EVFN annual report on morbidity 2008 – Major systems

System	Number of initial cases	Percentage of initial cases	Number of follow-up cases	Number of referred cases
Cardio-vascular	35	13.6%	453	1
Dermatology	41	15.9%	86	
Digestive	24	9.3%	71	
Endocrine	28	10.9%	734	2
Locomotive	14	5.4%	242	
Transmissible illnesses	5	1.9%	26	
Nervous	18	7%	47	
Ophthalmology	4	1.6%	9	
Otorhinolaryngology	25	9.7%	19	1
Reproducing	5	1.9%	80	
Respiratory	26	10.1%	114	
Mental health	6	2.3%	9	
Traumatism	17	6.6%	20	
Urinary	10	3.9%	46	

TOTAL	258	100%	1956	4

This table offers only indications concerning the various causes of illnesses among the population of EVFN since many, if not most, members of the community utilise health facilities other than the EVHC, namely the "hospital" in Témiscaming and also the one in North Bay, ON. There are no possibilities to dig into the CSSS TK statistics since the aboriginal status of their clients is not indicated.

In order to help draw the health picture of the community the following table presents the causes of mortality in the community for 2004 to 2010.

Table 8: Causes of death

Causes of death EVFN 2004-2010			
Cause of death	**Men**	**Women**	**Total**
Endocrine, nutritional and metabolic diseases, and immunity disorders	1	0	1
Respiratory system	0	2	2
Ill-defined conditions	3	1	4
Motor vehicle crash	0	1	1
Snowmobile /ATV	1	0	1
Ischaemic Heart disease and Myocardial infarction	5	3	8
Cerebrovascular disease	2	1	3
All other diseases of the circulatory system - unspecified	0	1	1
Lung cancer	3	0	3
Female breast cancer	0	1	1
Neoplasms of unspecified nature	0	2	2
TOTAL	15	12	27

2.5.2 Lifestyles and Lifestyle Evolution (2002, 2009)

The following figures are issued from 2 surveys run in EVFN: the First Nation Regional Longitudinal Health Survey of 2002 identified as (2002), based on 54 respondents; the 5-year Evaluation Questionnaire identified as (2009) passed November 2009, based on 71 respondents.

The population surveyed is adult, which translates as, (2002) = 18 y.o. and over; (2009) = 15 y.o. and over.

- 45% smoked [54 respondents]; 81.9% of them smoked every day. (2002)

- 34.4% smoked [21 out of 71]; 28.6% of them smoke between 1 and 4 cigarettes a day, 28.6% between 5 and 10 a day, 42.9% between 11 and 25 cigarettes a day. (2009)
- 60.1% of homes offered smoke free environments. (69/115)
- 45.1% never or almost never drink; 32.4% drink 1 or 2 times a month; 19.7% drink 1-2 times a week; 2.8% (2) drink 3-4 times a week. (2009)

  These numbers don't seem consistent with alcohol being identified by respondents as one of the three major causes of the breach in community health. (*See the following section*)
- 30% of the respondents say that they "occasionally" do "binge drinking" (21/71); 5.7% do it "often"; 1.4%, every time. (2009)
- 31.9% used drugs during the 12 months preceding the survey; 64.4% of these drug users used marijuana and 49.6% used other hard substances. (2002)

2.5.3 Community Health Status Perception

The Question 32 of the questionnaire (2009) asked the respondents to choose what they considered as the three major causes of health breach among the community.[15]

Table 9: Causes of Threat to Community Health/ Age Groups

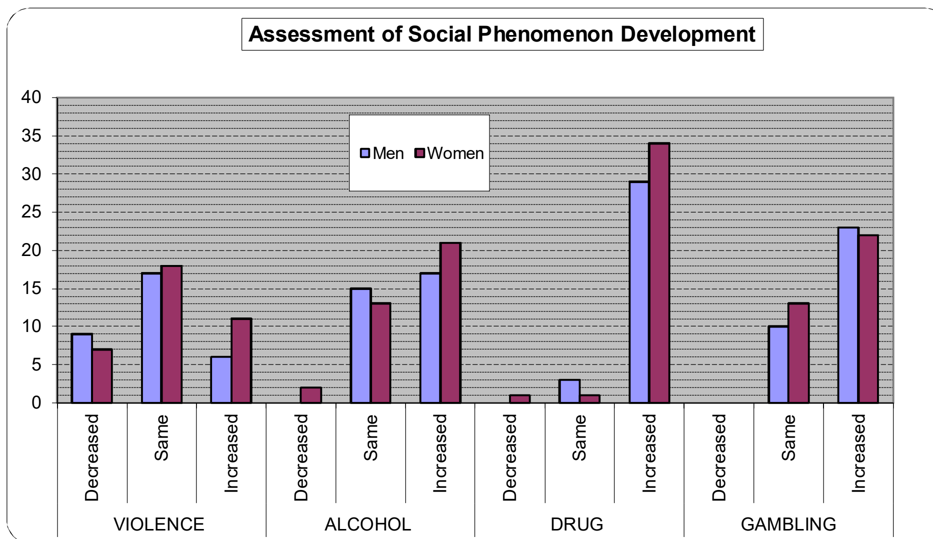
Causes	15-19 y.o.	20-29 y.o.	30-39 y.o.	40-49 y.o.	50-59 y.o.	60+ y.o.	Total
Community isolation	6	6	16	13	10	15	66
Drug use	4	3	15	13	9	12	56
Alcohol abuse	3	3	7	10	7	11	41
Bad eating habits	2	5	5	3	4	5	24
Diabetes	4	1	5	3	3	5	21
Lack physical act.	0	2	2	4	0	3	11
Lack of communication	1	0	2	1	1	3	8
Cancer	2	2	3	0	0	0	7
Gambling addiction	0	0	3	0	3	1	7
Lack jobs	0	0	1	1	0	0	2
Lack leisure activ.	0	0	0	1	1	0	2
Heart disease	0	0	0	0	0	1	1
Other	0	0	1	0	0	0	1

[15] "*Identify what you think are the **3** most important **threats** that breach the community health circle?*" Followed a list of 15 proposed answers. Violence and Tobacco Abuse have not been selected.

The order has been defined according to the total number for all age groups. There are differences according to the respondents' age group. For example, *bad eating habits* are currently more important to younger people.

To complete the population's perception about the health in the community, we've asked, through question 34 to 38, if they felt violence, drug use, alcohol consumption and gambling addiction had increased, decreased or remained the same over the past 5 years.

Chart 1: Level of Development (Violence, drug, alcohol, gambling)



The increase of drug use is close to unanimous. To a lesser degree than drug alcohol abuse and gambling addiction are perceived as growing in importance by a majority of respondents.

We conclude this section with a quote of the first paragraphs of the S*ummary and Conclusion of the Needs and Resources Assessment* of the community done in 2003.

"The participants have identified diabetes, cardiovascular diseases, alcohol and drug abuses cancer, stress and smoking as the main problems affecting the community's health situation. (…)

(…), the community has pointed out inactivity as a major factor in that occurrence of the above-mentioned illnesses. This inactivity is not looked at the same way whereas it pertains to an age group or another. For the youngsters, participants wish sporting facilities and organization so they could let go their extra energy and open themselves to others."

We can note that smoking is a habit that sustained a strong decline since 2003. On the other hand, the offer for sports has strongly improved with the hiring of a Sports & Leisure Coordinator who initiated a large array of sporting activities within the community and at school.

CHAPTER 3

SERVICE ORGANIZATION

3.1 Fundamental health values

At first, the mission and the values of the Health services were defined during the health plan definition process of 2003, when meetings with all the health staff had been run and such definitions had been thoroughly discussed to establish the services' backbone.

Later on in 2008, the Health branch, assisted by staff members, revised the mission and designed a vision to be incorporated into the 2009 annual report presented to the community. At the same time the health team added two values to the previous choices.

Recently, from that starting point, the team reassessed the mission and the vision for the current health plan but didn't feel the necessity to do the same with the values. The mission is still presented in the annual report.

A wider distribution of the mission and vision of the Health Centre is planned for the near future: documents displayed on the premises, eventually in the monthly newsletter, and during health service awareness or screening clinics, and special events.

3.1.1 THE MISSION

To deliver quality Health and Wellness Programs, and Services to our members with respect and courtesy.

To empower, promote and encourage healthy lifestyles in which illness, disease and addictions no longer threaten our people.

3.1.2 THE VISION

That our health status in no way sets us apart from the rest of the Canadians in a negative way.

That all members of our Nation live their lives to the fullest in a healthy and holistic manner.

3.1.3 THE VALUES

- Respect of Others' Lifestyle Choices

People are the first ones responsible for their own health and they are entitled to make their own choices. It is the responsibility of the Health Centre to give them the proper information but not to interfere in their decisions as long as they don't jeopardized others' health or quality of life.

- Confidentiality

People are entitled to respect of their personal life and privacy. Therefore we, as Health Workers, will perform our duties while respecting their right to confidentiality.

- Trust

Trust amongst ourselves, the Health Workers and the members of the population are a central axis of our way of working. Such value is completed by the autonomy that we should each show and the solidarity amongst ourselves that will benefit and help all of us.

- Open to Suggestion (Non-Judgmental)

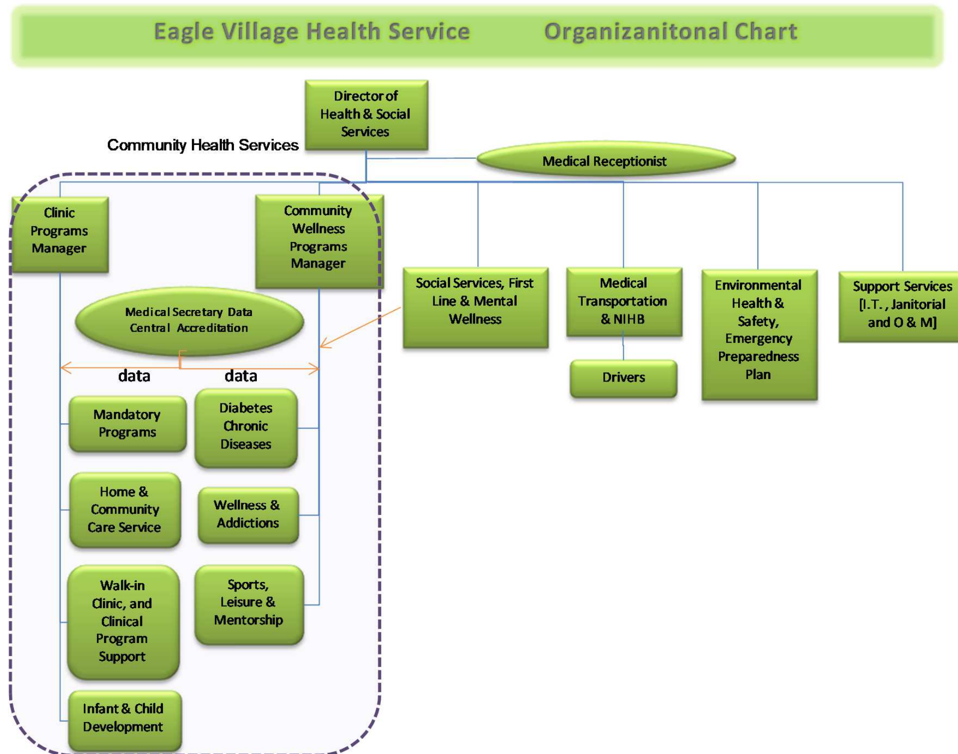
The Eagle Village Health Centre is not a self-sufficient institution and it doesn't claim to know all the answers: thus listening to others' opinions and using eventual criticisms for the betterment of our services will become a permanent attitude.

- Caring

We, the Health Workers of Eagle Village, think that we cannot be concerned with the physical and mental health of our community, if we don't care about the people and the conditions they live in.

3.2 Organizational Chart - EV Health Services

Chart 2: Organizational Chart of EV Health Services



3.3 Human Resources

EVHC rests on the work of 14 health workers, administrative personnel, and support workers whose list follows.

Officers

- Health & Social Services Director
- Clinic Programs Manager
- Community Wellness Programs Manager

Workers

- Wellness & Addictions Worker
- Community Health Nurse
- Custodian
- Diabetes & Chronic Diseases Coordinator
- Environmental Health Technician
- Frontline Services Social Worker
- Homecare Nurse
- Medical Transport Coordinator and Data Central
- Medical Receptionist
- Sports, Leisure & Mentorship Coordinator

All the job descriptions are included in Appendix 1.

The Clinic Programs Manager and the Community Wellness Programs Manager are under the direct supervision of the Health and Social Services Director.

It is to be noted that according to the agreement between EVHC and Health Canada, the latter provides 65% of the salary of the CHN. Yet, historically Health Canada has always provided the remaining difference of 35% later on during the fiscal year.

3.4 Delivery of community services

Prevention is the first mandate of the EVHC, which aims at improving health access by offering various forms of primary health care to the community members.

As shown in the organizational chart, the EVHC services developed a new organizational mode in order to better deliver services to the population while being able to concentrate on numerous administrative tasks, the development of new approaches and methods for the performing and the planning of activities, etc. all tasks that are central to an efficient organization.

The main change occurred under the box we called the Community Health Services. With that design we emphasize the links that exist between clinical services and community services. This leads to the creation of two specific management functions: the Clinical Programs Manager and the Community Wellness Programs Manager.

The mandate of these managers will be to help the workers by removing the elements that disturb their effectiveness and to react to present challenges through the development of effective partnerships, the enhancement of the HC capabilities and the development of efficient tools.

3.4.1 Community Health Services

3.4.1.1 Wellness & Addictions

Responsible for delivery of the service: 2 Wellness & Addictions Workers. Full-time employees, under the supervision of the Community Wellness Programs Manager (See job description for more details in relation with tasks).

Locations for delivery: the Wellness & Addictions Workers work at the Centre for walk-in or appointment visits. They are often needed outside for one-on-one or family interventions at home, or for leading group activities, workshops and presentations.

Services: evaluation and assessment for readiness; set up for referral (treatment, detox, counselling; post-treatment follow-up and after care; ongoing support while waiting for treatment; prevention workshops).

Referral: The client can be referred through other Health Centre workers or he or she can simply decide by himself to engage in a healing relationship with one of the Wellness & Addictions Workers. It is a proactive process with no formal entry access.

Comments: The culture aspect of the job has been put forward because of the Centre's needs for culturally adapted ways of acting within the community and because of the unique expertise of one of the Wellness & Addictions Worker. This aspect of the Wellness & Addictions Worker's job is intended to interact with other workers' tasks in order to bring this cultural vitality to their work and to be distributed within the community through activities that are likely to strengthen community health and reinforce the cultural identity of the First Nation. It is part of the prevention mandate of the Wellness & Addictions Workers. The other W&A Worker specialized in drug and alcohol abuse prevention activities and counselling.

Services: workshops for community members, for all age groups and in inter-generational activities; introduction of cultural elements within other workers' activities.

Table 10: Prevention activities - Suicide

Suicide Prevention Activities	
Awareness activities (e.g.: increasing knowledge of suicide rates and contributing factors, addressing myths and pre-conceptions about suicide, increasing communication about suicide, and decreasing stigma)	√
Sport, leisure and other activities to engage youth	√
Traditional activities to engage youth (e.g.: land-based activities, cultural practices, skill development)	√
Life skills activities for youth (e.g.: leadership, relationships, problem solving, developing positive coping skills)	√
Training on signs and symptoms and responding to suicidal behaviour (e.g.: ASIST, SafeTalk, Mental Health First Aid, train-the-trainer sessions, CISM)	√
Crisis intervention (e.g.: mobilizing to prevent spread of suicide)	NOT
Mental Wellness Promotion and Support: Wellness activities teach and promote ways to increase well-being, focusing on positive choices for all, regardless of the risk for mental health issues and addictions.	
Wellness activities promoting mental health (e.g.: parenting skills, self-care, managing stress, positive relationships, emotional and spiritual well-being).	√

Activities may include community celebrations and leisure activities, including physical and social activities.

Substance Abuse, Addictions and Mental Health Activities	
Presentations and workshops aimed at preventing substance abuse	√
Cultural events to support the prevention of addictions and substance abuse, as well as the awareness of mental health issues	√
Addictions recovery support groups	√
School-based programs to support awareness of substance abuse and addictions	√
Mental health crisis intervention activities (other than those specific to youth suicide prevention)	NOT

3.4.1.2 Diabetes & Chronic Diseases

Responsible for delivery of the service: the Diabetes & Chronic diseases worker. Full-time employee, under the supervision of the Community Wellness Programs Manager.

Locations for delivery: she chiefly works at the Centre in her planning activities but she can run activities at the community centre and will often participate in outside activities like screening or awareness activities.

Services: Technical training for patients during the diabetes clinics; screening clinics in collaboration with the nursing department; prevention workshops at school and with adults during awareness activities; special events organization; awareness support during other workers' activities, especially in sports & leisure.

Referral: The Diabetes & Chronic Diseases worker works in close partnership with the nursing service that will refer the diabetes or chronic disease patients (who chose to participate) to her for the awareness and knowledge transfer which is her part of the work within the diabetes and chronic disease clinics.

Table 11: Prevention activities – Chronic diseases

Chronic Disease and Injury Prevention Activities	
Physical Activity	
Awareness activities related to physical activity (e.g.: Diabetes Walks, Healthy Living Awareness Days)	√
Walking clubs	√
Sport/leisure activities (e.g.: soccer, basketball, etc.)	√
Traditional physical activities (e.g. jigging, dancing, games, snowshoeing, canoeing)	√

Nutrition	
Cooking sessions or classes (including community kitchens)	√
Additional	
Traditional harvesting, food preparation, food preservation (e.g.: berry picking, cleaning fish, canning, etc.)	√
Healthy eating awareness and education (e.g.: health fairs, radio shows, etc.)	√
Grocery tours	
Community gardens	
Good Food Boxes	
Food Vouchers	√
School-based nutrition programs	
Additional	
Diabetes information sessions or workshops	√
Development of resource materials (e.g.: posters, cookbooks, displays, guides, etc.)	√
Injury prevention training and awareness-raising (e.g.: safety committees, tool kits, "A Journey to the Teachings" training, etc.)	√

3.4.1.3 Sports, Leisure & Mentorship

Responsible for delivery of the service: The Sport, Leisure & Mentorship worker. Full-time employee, under the supervision of the Community Wellness Programs Manager.

Locations for delivery: Based in the centre for his organizing hours, the SL&M worker mainly has his activities outside, at the community's playgrounds, at school or at the community centre.

Services: the systematic organization of outdoor or indoor physical activities within the reserve for youth during after-school hours; supports the physical activity program at school in collaboration with the school personnel; inclusion of physical activities within chronic disease and diabetes program delivery for the benefit of the concerned community members; occasional set-up of adult-targeted physical activity programs or services.

Comments: The mentorship aspect of the worker's mandate refers to the Health centre's will to promote physical activities and good eating habits by offering the youth a role

model who delivers his services through personal support and small and larger group activities.

It is to be noted that the Quebec provincial "ministère de l'Éducation, du Loisir et des Sports" provides a $10,000 annual contribution to help maintain this sector of the Health Centre's services.

About activities, refer to Chronic Disease Table.

3.4.1.4 Infant & Child Development

Responsible for delivery of the service: a worker from the daycare centre assumes most of the education and counselling tasks associated with this service. The CHN is responsible for the clinical part of it. The service is under the supervision of the Clinic Programs Manager. The HCN could also take part if needed.

Locations for delivery: mostly at the Health Centre but without difficulty the worker or the nurses will do home visits to provide services to the new mother.

Services: prenatal workshops identifying 7 topics (disease, diet, physical activity, medication, self-monitoring, complications & preventive measures, lifestyle); workshops about Foetal Alcohol Spectrum Disorder; linkage with the Head Start and the Brighter Futures programs; 5 periodical visits paid to the parents (mothers) with provision of "packages" adapted to the child development period and meant to give relevant information and reinforce the verbal teaching provided. Considering the small number of births within the community most of the time these activities are achieved on a one-on-one basis.

Table 12: Activities - Nutrition

Pre- and Postnatal Nutrition Activities Offered[16]
Nutrition Screening, Education and Counselling
- One-on-one nutrition counselling/education
- Baby food making workshops/classes
Maternal Nourishment
- Food vouchers distributed
Breastfeeding Promotion, Education and Support
- One-on-one breastfeeding support
- Peer support program
Supportive Elements that address specific needs of at-risk clients (i.e., transportation, child care, etc.)

[16] More information is to be found in the *Community-based Reporting Template 2011-2012*.

Table 13: Activities AHSOR

AHSOR Activities	
Teaching children their First Nation language(s) (e.g.: reading a story, teaching letters or numbers, etc.)	√
Traditional ceremonies and activities (e.g.: smudging, gathering traditional foods, visits from Elders, etc.)	√
Early literacy skills (e.g.: reading to children, singing songs, etc.)	√
Fine and gross motor development activities (e.g.: catching a ball, holding a pencil, etc.)	√
Providing healthy foods (snacks and/or lunches)	√
Healthy personal hygiene and dental habits (e.g.: brushing teeth, hand washing, etc.)	√
Physical activity (e.g.: outdoor play, games, dance, etc.)	√
Linkages (including referrals and collaborations) to professionals and community supports and providers (e.g.: housing, education, specialists, etc.)	√
Parent and family support activities (e.g.: workshops for new mothers and young parents, support groups, etc.)	NOT
Visits from health professionals (e.g.: nurses, dental hygienists, others)	√
Safety education and awareness activities, (e.g.: playground safety, car seat technician training, car seat use, seat belt use, bike safety, etc.)	√

3.4.2 Social Services and Mental Health

Responsible for delivery of the service: First Line Social Service worker. Full-time employee, under the supervision of the Health and Social Services Director.

Locations for delivery: dispensed partly in the Health Centre and partly at the clients' home, in relation with confidentiality issues or feasibility, occasionally in public spaces.

Services: the First Line Social Service worker offers support and counselling mainly on a one-on-one basis but frequently intervenes within a family context. Individual support and/or counselling to people dealing with mental or psychological difficulties caused by work-related, family, individual, or social issues; stimulation of individual growth through leading of group activities; support to other workers involved with psycho-social difficulties within their groups.

Referral: any other worker of the team or from outside the Health Centre can refer an individual to the First Line Social Service worker. The person in need can also get in touch with him.

For activities refer to Addictions and Culture.

3.4.3 Medical Secretary, Data Central & Accreditation

Responsible for delivery of the service: the *Medical transportation & NIHB secretary* shares her time between these two tasks. Full-time employee under the supervision of the Health and Social Services Director.

Locations for delivery: Health Centre

Services: medical transportation and NIHB management; in construction: data gathering centre for the EVHC's workers.

3.4.4 Training Program

In relation to the above mentioned job summaries and the job descriptions presented in Appendix 1, a training program is established for the duration of the Health Plan. See Appendix 6.

3.5 Confidentiality

Many years ago EVHC adopted a "Protocol concerning the confidentiality and management of client files at the EVHC". Actually it was included in the previous Health Plan. The protocol completed the confidentiality standard stressed by the Band Council in its Policy and Procedure Manual:

"***10.8.1*** *Because of the nature of and their scope of work, some Departments or Activity sectors, such as the Health Center, Social Assistance, Human Resources, Membership and others, collect personal information on their clients. All Directors, Administrators and Employees in particular, entrusted with the personal information on their clients, will abide by the policies, rules and regulations of their respective Departments or Sectors of activities regarding the gathering, the filing and disposal of information for the purpose of their work."*[17]

Basically this protocol is made up of 14 sections: 1. general; 2. the basic principles concerning the user file; 3. the file's content; 4. the documents required by the Act; 5. the conditions for refusal of treatment; 6. the user file access policy; 7. user file access by a health worker; 8. user access; 9. information requests over the phone by the user; 10. access by a third party with the user's explicit authorization; 11. third-party access without the user's authorization; 12. the distribution of user files; 13. the creation of user forms.

In Appendix 2, the Reader can access the Protocol concerning confidentiality and the Confidentiality form which is to be signed by every health worker in the first days after the hiring.

[17] http://www.evfn.ca/PDF%20FILES/EVFN%20HR%20Policies%20Employees%20Handbook%20October%202011.pdf

3.6 Human resources management

As previously indicated it is possible to access what is named the "*Eagle Village First Nation Human Resources Policies Employee Handbook 2011*" on the EVFN's Web site. Once opened, actually the PDF document is entitled *"Eagle Village – Migizy Odenaw - Policy and Procedure Manual"*.

The opening sentence of the document reads as follows: *"This Policy and Procedure Manual is intended for the impartial process of Eagle Village First Nation"*[18].

Table of Contents of the Policy and Procedure Manual

- Introduction
- Mission Statement
- Table of Contents
- Section 1 Roles and Responsibilities of Chief, of Council and Management
- Section 2 Definitions
- Section 3 Organization of Work
- Section 4 Vacation, Holidays and Employee Benefits
- Section 5 Allocation of Human Resources
- Section 6 Evaluation of Human Resources
- Section 7 Development of Human Resources
- Section 8 Working Conditions
- Section 9 Travel Policy
- Section 10 Code of Ethics
- Section 11 Harassment in the Work Place
- Section 12 Conflict of Interest Code
- Section 13 Appeal and Complaints Policy
- Section 14 Purchases, Contracts and Tenders Policy
- Section 15 Electronic Etiquette, Security and Procedures
- APPENDICES
    - Appendix 1 Solemnly Declare
    - Appendix 2 Overtime Request Form
    - Appendix 3 Absence Request Form
    - Appendix 4 Benefit Program
    - Appendix 5 Evaluation Form
    - Appendix 6 Salary Scales
    - Appendix 7 Travel Claim
    - Appendix 8 List of Violent and Inappropriate Behaviours in the Workplace
    - Appendix 9 Certificate of Compliance with the Code of Ethics
    - Appendix 10 Meeting with the Appellant Form
    - Appendix 11 Complaint Form
    - Appendix 12 New Employee IT Form
    - Appendix 13 Confidentiality Declaration

[18] Idem

The Reader will note that all the elements of a sound and organized Human Resources Policy (working schedule, employee benefits, etc.) are included in the Manual. The Salary Scales introduced in Appendix 6 actually are presented on a separate precautionary document not placed on the Web site. This policy is managed through a Human Resources Department within the Band Council administration. It was revised in 2011.

3.7 Professional Supervision

Though currently under study, this topic has not come to a solution yet.

CHAPTER 4

MANAGEMENT STRUCTURE

Under the flexible funding agreement between Health Canada and EVFN, first signed in 2004, the latter receives funding for a certain number of programs, but internally uses its own labels to identify services delivered to the population.

Contribution agreement number: QC700047.

Highest type of funding: Flexible.

4.1 Initial programs offered

Here is a list of the current programs (2011) financed by the funds providers and their corresponding services as offered by the EVHC until recently when the health plan process really got engaged.

FNIHB Program Compendium	EVFN Programs
Fetal Alcohol Spectrum Disorder	
Prenatal Nutrition Program	
Aboriginal Head Start On Reserve	Maternal and Child Health
Maternal Child Health	
Children's Oral Health Initiative	
National Native Alcohol and Drug Abuse Program (NNADAP)	Addictions
Youth Solvent Abuse Program	
National Aboriginal Youth Suicide Prevention Strategy	
Building Healthy Communities	Community Wellness/ Physical Activity
Brighter Futures	
Aboriginal Diabetes Initiative	Diabetes/Nutrition/
Blood-Borne Disease and Sexually Transmitted Infections - HIV/AIDS	HIV/AIDS
Environmental Health Services	Environmental Health & Safety
Drinking Water Safety Program	
Home and Community Care	Home Care
Vaccine Preventable Diseases- Immunization	
Community Primary Care (*limited*)	Treatment Services Program
Communicable Disease Emergencies	

4.2 Health management

The Health Director is the first person responsible to the Band Council; he reports to it about the scope of the health objectives in compliance with the Council's own objectives, which are indicated in the *Political organization* paragraph of the current section. He will also regularly discuss health issues with the Chief who is the Band Council member responsible for the Health Services portfolio.

Furthermore, according to need but never less than once a year, the community is invited to information sessions about the band's management which includes health services. From time to time Health Services will set up an information session of their own in order to address special issues. These are privileged places for the public to voice comments and put forward eventual questions.

Also there is a formal procedure for client complaints though it has actually never been used; eventual complaints usually take the form of personal requests to the health director or to Band Council members. The complaint process and forms are to be found in *Chapter 13, Appeal and Complaints Policy* of the *Policy and Procedure Manual* of the Band Council, which is available on the EVFN's Web site.

4.2.1 Political organization

One chief and two councillors are elected every two years to form the EVFN's Band Council. They meet on a very regular basis to, among other things, supervise the management of seven main branches: health services, daycare centre, police department, fire department, land management, Economic Development & Natural Resources Direction, and Migizy gas station.

The Band Council's mission statement reads as follow:

"*Political:*

To adequately and transparently represent the members of the community on all government levels and issues according to the direction of its members that will ensure the growth and development of the community.

To promote and protect the collective interest of all Eagle Village First Nation members; through the strength and will of its people and guided by their values, culture and traditions.

Administrative:

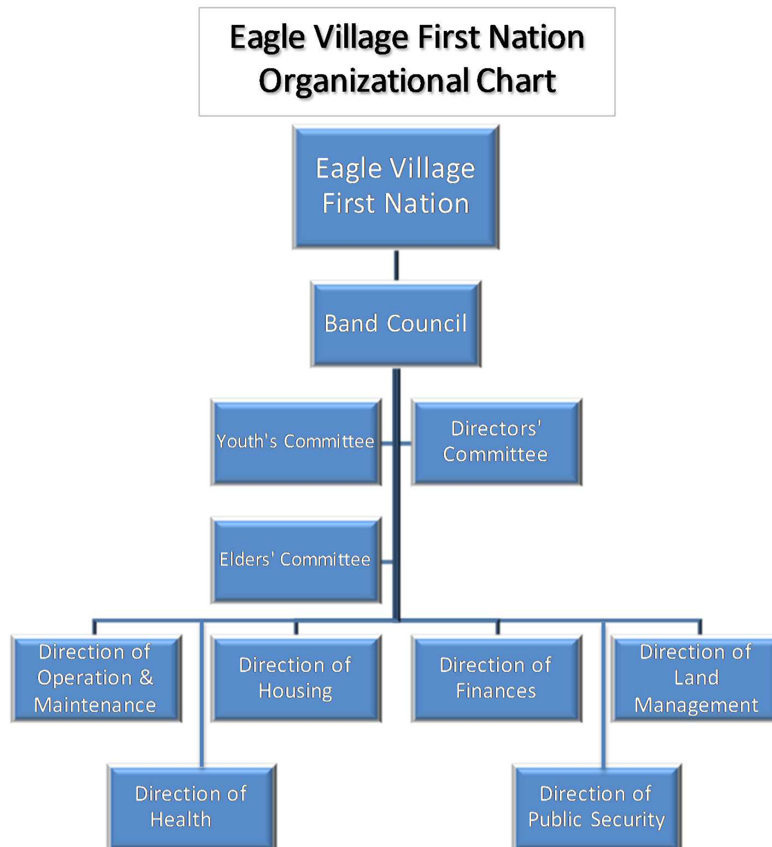
To provide equal and fair opportunities to all members accessing programs and services according to established policy and procedures for the betterment of the community." [19]

There is currently no executive (general) director.

[19] http://www.evfn.ca/PDF%20FILES/EVFN%20HR%20Policies%20Employees%20Handbook%20October%202011.pdf

The police force is made up of 2 officers and 2 auxiliaries. As for the fire department it is composed of about 16 volunteers and one part-time chief. The fire hall, built in 1998, houses one fire truck (pumper).

Chart 3: Organizational Chart EVFN



4.2.2 Health portfolio mandate in the Band Council

For the past years, the chief, as head of the Band Council, has the responsibility of the health portfolio. His, or currently her mandate is to supervise the Health Centre provision of services and management in regard to the following articles described in the *Policy and Procedure Manual* of the Band Council also presented on EVFN's Web site as the *Eagle Village First Nation Human Resource Policies Employee Handbook 2011*.

« *1.3 Responsibilities of Council*

1.3.5 Envision the development and prosperity of Eagle Village First Nation by setting long, medium and short term objectives including priorities.

1.3.10 Approve operational plans.

1.3.11 Approve annual and multi-year budgets.

1.3.12 Control the efficiency and effectiveness of the Administration."

On the other hand the program director, the Health Director, has his own responsibilities toward the Band Council authority.

"1.6 Responsibilities of the Program Directors

1.6.1 Under the direction of Council and respecting the policies, orientations and priorities of Council, the Program Director is responsible for the management and administration of the programs and services under the jurisdiction of the Council.

1.6.2 The Program Director is accountable to the Council.

1.6.3 The Program Director is responsible for implementing the Council's decisions.

1.6.4 The Program Director is responsible for serving Eagle Village First Nation members by ensuring their health, well-being and security.

It is to be taken into account that, for the past years, the Health Director is also a member of the Band Council."[20]

Committees

Both the youth and the elders have a committee that gather on an irregular basis and present their recommendations on community issues when asked by the Band Council. They can also bring forward their own preoccupations to the Band Council.

The Directors' Committee is an administrative structure that gathers all major programs directors of the Band Council administration. Their function is to discuss community issues in regard to their administrative angle, proposing solutions to the elected authorities or feasible ways to address Band Council concerns.

4.2.3 BAND COUNCIL PRIORITIES

Elected in the summer of 2011, the EVFN Band Council established three priorities in relation with the vision elaborated by the Band Council: culture, economic development, education, and safety.

The vision: "*To develop into a strong, unified community whereas our Anicinabe rights and ownership to our traditional territory have been acknowledged by all government levels.*

[20] http://www.evfn.ca/PDF%20FILES/EVFN%20HR%20Policies%20Employees%20Handbook%20October%202011.pdf

Whereas our community, through economic development, can prosper in a sustainable manner to be self-sufficient."[21]

The fact that the Health Director is an elected member of the Band Council probably influenced the adoption of culture as one of the top three priorities for the community.

Culture has grown as a priority in the Health Centre delivering of services as it has long been established that a well anchored identity is one of the 12 health determinants identified by Health Canada.

"*Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services*." [22]

In EVFN the status of the Algonquin language is seriously declining becoming very close to a loss. The community is then urging itself to regain some of its fundamentals in order to more properly address the health issues they are daily facing with eventually more efficient tools.

4.3 The challenge of data collecting

For many years the Health Centre authorities have been aware of the necessity to implement a sound data collecting system in order to better define the attendance to the activities, evaluate their level of popularity on the long term and better assess the impacts.

In order to do so and considering the new efforts done by the provincial government and the Commission (FNQLHSSC) to help provide better data collecting tools to the communities, EVHC is devoting its energy to the acquisition of the i-CLSC, the provincial network of data collecting and report producing.

4.4 Tribal Council

EVFN is part of the Algonquin Anishinabeg Nation Tribal Council (AANTC), which mainly offers technical services assistance, support with human resources hiring and research expertise.

"*The fundamental priorities of the AANTC are the protection and advancement of the aboriginal rights issues and the provision of assistance and services to the participating communities in advisory and technical fields.*

The Board of Directors of the AANTC, also known as the Nation Council, is composed of the Chief of each participating Algonquin member community, a Grand Chief and a Vice Grand Chief, as well as representatives for the Elders, Women and Youth. The AANTC is

[21] idem

[22] http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#culture

one of the very few Aboriginal organizations in Canada in which all Representatives are elected to public office by vote of the grassroots people."[23]

[23] http://www.anishinabenation.ca/eng/home_en.htm

CHAPTER 5

COMMUNITY RESOURCES

5.1 General assets

Eagle Village First Nation is a community that relies on many assets.

A good employment rate and consequently a good income level, some 53% of the households and 40% of the individuals have incomes of over $30,000.

55% of the population completed high school.

Constant demographic progression results in the community's expansion and the implantation of new dwellings. This is mostly due to newcomers who are band members on a waiting list to gain a dwelling on the reserve or members of other bands who seek membership.

5.1.1 INVENTORY CHECK LIST

In order to present to the Reader a picture as complete as possible of the current Health Centre resources, Appendix 4 presents a recent (May 2013) Inventory checklist of the Health Centre material resources.

5.2 Infrastructure

Current Facilities

- Administrative building
    - Band Council (upper storey)
    - Health Centre (lower storey)
- Police Station
- Fire Hall
- Community Hall
- Youth Centre
    - Community Access Program (Internet)
    (In the Youth Centre)
- Sports grounds
    - Baseball field
    - Skating rink
    - Children's playground
- Municipal garages
  (Bus and loader)
- Maintenance shop
- Storage for Band Office
- Day-Care Centre
- Gas Station and convenience store (Migizy: Community owned)

5.2.1 Liability

In order to demonstrate professional liability and malpractice insurance for healthcare providers/counselors and miscellaneous professionals (excluding doctors), a copy of the general liability contract of the Band Council is available in Appendix 5. See p.5. for an amount of 5 million dollars plus employee error & omission.

5.3 Partnerships and Resources

Beside the competence and dedication of its staff and direction officers, a large part of the Health Services capacities rely on the partnership network and resources they can count on. Some of these partnerships are still requesting development to reach their full potential in the future. We will present these perspectives.

Chart 4: Eagle Village Health Centre's Chart of Partners

5.3.1 Internal partners:

- Band Council

  As the leading governance institution of the community the Band Council has a crucial role of supervision and assessment over the EVHC. More details are presented in the community organization section.

- Daycare Centre

  Oriented toward the health, safety and development of the younger part of the population, the Daycare centre has natural links with the Health Center which shares the funding of the program Head Start with it.

- Public Works

  The Health Centre is located in the same building as the Band Council administration. It developed links with the Public Works mainly over the organization, maintenance, safety and comfort of the Health Centre's physical environment, for the benefit of the employees, patients and visitors.

- Police Services

  As an intervening institution the police forces of the community developed links with the social services of the Health Centre and its support services for addicts and other individuals affected with temporary or permanent social difficulties.

5.3.2 Public service partners:

- Health Centres in Timiskaming F.N. & Long Point F.N.

  Members of the Algonquin Nation and both located in the Témiscamingue region, these two health centres share many family ties, common social concerns and, eventually, services (at one point, drinking water monitoring for example) with EVFN that created links which are significant even if not defined by any protocols or memorandums of understanding.

- *Pavillon Témiscaming-Kipawa* (formerly *CSSS Témiscamingue*)

  As the mandate of the EVHC is essentially oriented toward prevention, EVFN members are standard users of the "*Pavillon Témiscaming-Kipawa du CSSS du Témiscamingue*" (Pavilion TK). Formerly the second smallest CSSS of the province[24] serving about 3500 people, the *Centre de santé et de services sociaux du Témiscamingue Pavillon Témiscaming-Kipawa* (Pavilion TK) is currently part of the CSSS Lac-Témiscamingue, the main base of which is based in Ville-Marie, about 100 km north of Témiscaming.

  The Pavilion TK offers standard first line health services. There are currently discussions between the EVHC and the Pavilion TK about improving their collaboration and exchanging information in order to improve the health services

[24] In 2011, the CSSS TK merged with the CSSS of Ville-Marie forming the CSSS du Témiscamingue.

to the population of EVFN and avoid grey areas in service delivery. The CSSS TK and EVHC have been partners in an AHTF (Aboriginal Health Transition Fund) project in 2009-2010.

Table 14: Services offered by Pavilion TK

First line services (CLSC)

- Perinatal period (regular clientele)
- Integrated services perinatal and early childhood (for vulnerable clientele)
- Child health (including vaccination and early stimulation)
- Youth 5 to 18 years old (health and social services)
- Dental health
- Speech therapy
- Health for travellers
- Infectious illnesses
- Diabetes clinic
- Public health for adults and elders (cardiovascular illnesses, tobacco use, cancer, screening)
- Anticoagulant therapy clinics
- Nutrition
- Psychosocial intake
- Psychosocial custody for emergencies during weekends
- Mental health (consultations, respite care/emergency assistance, stress management)
- Occupational health
- Home support (nursing care, home-care service, medical care, respiratory therapy, occupational therapy, social service)
- Support services for disabled persons
- Social services for self-sufficient elderly & sheltered elderly

General medical services (CH)

- Consultations (by appointement, external/emergency clinic)
- Pharmacy
- Labs, radiology & echography
- Hospitalization (6 short-term beds)
- Physical rehabilitation

Long term sheltering services (CHSLD)

- Sheltering (14 long-term beds)
- Respite care/emergency assistance
- Volunteer work services
- Beds in the pavillion (3)

<u>Perspective of development</u>

As far as health is concerned, the Pavilion TK is the main partner of EVHC. Recently significant if not yet formal links have been established between both institutions. Partners within the AHTF (Aboriginal Health Transition Fund), the process stopped for the project timeline expired and because of the merger

involving the CSSS TK, which ended with part of the institution's authorities being unknown and 100 kilometers away.[25]

The reinforcement of the partnership with the Pavilion is a challenge. The designation of 2 managers whose task, among others, is to develop processes and protocols with partners, is bound to speed up the development of effective links with our major partners, among which the Pavilion has the number one place.

- Municipality of Kipawa

  Kipawa surrounds the territory of the Eagle Village reserve. It is therefore an essential partner as far as land, road and services are concerned, which is more of a concern for the Band Council. Kipawa is also involved in the development of the emergency plan.

  Development perspective

  There is no formal protocol between EVFN or its Health Centre and the municipality of Kipawa but several links bind the people since many inhabitants of the municipality have a band number and many of these people are also regular users of the HC's facilities.

- MRC Témiscamingue

  Provides the waste and recycling matters pick-up services to the community.

  Development perspective

  Since the MRC is an important component of the provincial political organization it is expected that the links between the community and the MRC will increase significantly in the coming years as mining and park development are becoming major issues. Health, mainly through tradition and ways of living, will certainly be part of the preoccupations.

- FNIHB (First Nations and Inuit Health Branch, Health Canada)

  EVFN is a reserve as defined in the Indian Act of 1876. Therefore the delivery of health services within the community falls within the FNIHB's responsibility. New links are being established with provincial health authorities but this matter remains mainly under federal jurisdiction.

  Development perspective

  The links between FNIHB and EVFNHC are well-defined through the various existing processes, health plan and agreements that develop according to the latter's needs combined with the former's evolving policies.

- Centre Jeunesse de l'Abitibi-Témiscamingue

  The *Centres Jeunesse* are public institutions which have the mandate to provide specialized help to youngsters with occasional or recurring adaptation difficulties

[25] The reader could benefit from consulting *Evaluation of AHTF Project for Eagle Village First Nation. April, 2011.*

and to their families. They also provide help to young mothers and/or parents that have difficulties coping with the realities related to parenthood.

Development perspective

EVHC is developing the delivery of health services and support care services to its population. We look forward to developing formal protocols that will give EVHC better control over the services to its population. Currently the HC has acquired the services of a first line social service worker. This trend should grow stronger with the growth of the EVFN population and the services offered.

- Agence de la Santé et des Services Sociaux Abitibi-Témiscamingue (liaison officier)

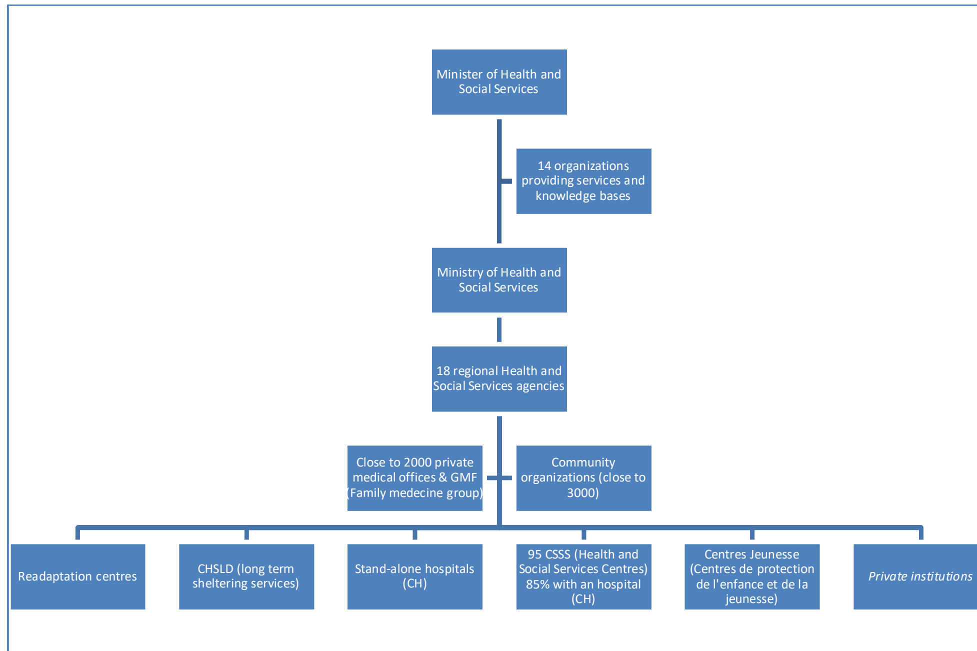
  On the regional level, the Health and Social Services Agencies are responsible to coordinate service delivery on their territory. Among other things, they have to develop the general orientations and priorities of their region; they organize public health in their region; they authorize and provide local budgets for service delivery and provide grants to community organizations.

  The Agency monitors and provides expertise to the Quebec health establishments of the region and is in the early stages to provide regular support to EVHC. In Abitibi-Témiscamingue one liaison officer is in charge of establishing the link between the Agency and the First Nations communities.

  Chart 6 presents the health and social services organization in the province of Québec, which is under the responsibility of the "*ministère de la Santé et des Services sociaux*".

Chart 5: Health and Social Services Organization in Quebec[26]

[26] http://www.msss.gouv.qc.ca/en_bref



Development perspective

Links with the Agency are not frequent but they are regular since we encounter openness with its liaison officer. The need for formal protocols does not exist yet but will be considered when the province's health services become more and more of a partner in health services delivery.

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

"The Commission's vision and mission is to promote and monitor the physical, mental, emotional and spiritual well-being of First Nations and Inuit people, families and communities while improving access to comprehensive and culturally-sensitive health and social services programs designed by First Nations organisations that are recognised and sanctioned by local authorities, all the while respecting their respective cultures and local autonomy. The Commission also assists communities that so desire, to set up, develop and promote global health and social services and programs that are adapted and conceived by First Nations organisations."[27]

In summary, the FNQLHSSC acts as a support service and an expertise provider to the community. It provides the community with studies like the longitudinal

[27] http://www.cssspnql.com/eng/a-propos/mission.htm

survey of 2002 creating sound knowledge bases around the First Nations health and social services.

Development perspective

The FNQLHSSC is, and will remain for a long time, an important player in the delivery of health services to First Nations communities. EVFN will maintain strong links with the organization but the type of links do not need to be described within any protocol or M.O.U. They correspond to FNQLHSSC mission and are used in such a way.

- Secrétariat aux affaires autochtones

Le *Secrétariat aux affaires autochtones* (SAA) is the provincial governmental organization that has the responsibility to establish and develop links between the government and the First Nations and Inuit communities for service delivery and development support. In that regard, it is an occasional funding provider to local or regional projects. Since the Aboriginal communities fall under federal jurisdiction, the *Secrétariat* is not yet a dominant player in First Nations development but it is a significant one, whose role is growing. See Appendix 6 to consult a copy of the financing agreement between EVFN and the *Secrétariat* for the hiring of a sport and recreation coordinator.

Development perspective

As a result, the formal documents that could exist between EVHC and the *Secrétariat* are occasional contracts or funding agreements. There are no foreseeable changes expected.

- *Sécurité publique Québec*

The ministry of *Sécurité publique* has the responsibility of security and police in Québec. It is thus involved in most police actions regarding drug trafficking, which has an impact on the health status of the community and the interventions of the addictions worker. Direct contacts on those matters are exceptional. The *Sécurité publique* is a current partner mostly because of the emergency plan developed in the region.

Development perspective

The link exists and it is maintained when required, currently around the development and updating of the emergency plan.

- *Ministère des Loisirs et des Sports du Québec*

The ministry of *Loisirs et des Sports* is a fund provider EVHC has an agreement with allowing the inclusion of sports & leisure activities in the community.

Development perspective

At this point, as with the *Secrétariat aux affaires autochtones*, the formal documents that could exist between EVHC and the Ministry are occasional contracts or funding agreements.

- *Forum Jeunesse Abitibi-Témiscamingue*

  The *FJAT's (Forum jeunesse de l'Abitibi-Témiscamingue)* mission is to stimulate and guide social actions, which target the youth's benefit and participation to community life. FJAT's mandates are to stimulate consultation amongst youth in order to maximize the impacts of their actions; to promote youth representation amongst local, regional and national institutions; to voice youth concerns and challenges to these institutions; to manage the *Fonds régional d'investissement jeunesse (FRIJ)* fund.

  Development perspective

  The FJAT is an occasional partner in a very specific area. Its role is not expected to increase in the coming years.

5.3.3 Other external partners

- *CMDP (Conseil des médecins, dentistes et pharmaciens)*

  The CMDP is the organization that mainly represents all physicians and other health professionals of the region. Through contacts with the physicians it is an important partner for the EVHC. Eventual discussions over a reinforced partnership with the Pavilion will automatically consider the CMDP's concerns.

- *Groupe de médecine familiale*

  The *Groupe de médicine familiale* has a link largely similar to the one of the CMDP since EVHC has a partnership with 3 physicians of this group.

- North Bay Native Friendship Centre (NBNFC)

  North Bay Friendship Centre is the closest friendship centre. Very occasional contacts are made with this institution when community member access the NBNFC for services while they are in North Bay.

- Anishinabe long term centre

  Located on Timiskaming First Nation's territory (distance: 125 km) this institution currently received most of the community's elders who need services on a daily basis to compensate their lack of autonomy. It is a well-known resource for community members. It is often considered too far away, though it puts pressure on the Band Council for the development of closer resources for aging members of the EVFN.

- Anishinabe Mikana

  Algonquin group who devotes itself to the "truth and reconciliation" process stemming from residential school trauma. Inspired by Anishinabeg values and traditions, it is also concerned with the intergenerational transmission of values. EVHC workers occasionally give support to their activities.

- Ambulance Services

A regular services used by the EVHC's clientele for safe transportation outside the community. No specific contract is required between this service and EVHC.

- Grocery store

  The IGA store in Témiscaming accepts vouchers offered to pregnant and breastfeeding women of the community. Since it closed sometimes ago the program has been suspended.

- *Québec en forme*

  Québec en forme, a provincial institution devoted to the development of more active citizens and especially youth, has liaisons officers who specifically work with First Nations communities like EVFN. Contacts between this institution and EVHC which is in charge of Sports and active life development within the community are regular. A copy of a financing agreement for sporting and recreational activities in presented in Appendix 7.

- Claude Rousseau GRF, Health Consultant

  Claude Rousseau has been collaborating on several assessments and research documents for the benefit of the EVHC since 2003. Each of these mandates has been included on the service contract.

- Psychologists in Ontario

  Rare resource used by the Health Centre

- McGill University Medicine Department

  The McGill Medicine Department provides the expertise for the analysis of the retinopathy tests done at the Health Centre.

  Also, always concerned about the importance of enticing young physicians, especially English-speaking ones, to work in the region, EVHC developed an informal partnership with McGill University and the FNQLHSSC in order to welcome some of them to pay a 2-week visit to the community to be made aware of the existing possibilities.

Childbirth, surgery and specialized health care are offered to patients mainly in Ville-Marie or, more often because of the linguistic community, in North Bay, ON, which is slightly closer, and offers a wider range of services. For mental health issues, the CSSS in Rouyn-Noranda is the first resource.

Ultimately, Montreal area hospitals provide specialized health services. Social services are under the authority of and delivered by the *Centre Jeunesse*, based in Ville-Marie.

CHAPTER 6

HEALTH PRIORITIES

6.1 Selection of priorities

6.1.1 METHOD FOR THE SELECTION OF PRIORITIES

The priorities of the Eagle Village Health Centre (EVHC) have been established in two steps.

The first step occurred in mid-year 2011 when the EVHC workers participated in a workshop led by members of the HC personnel who based their workshop on a PowerPoint document entitled "Determine your priorities".

The discussion mainly used the internal expertise of the workers, most of which work and live on the reserve.

During that exercise, 12 priorities were identified.

Step two occurred when the health team met again on February 2012 to resume the definition of priorities with the consultant. The previous list of priorities was used as a starting point. In the discussion, the main objective rapidly became the definition of between two and four priorities for the EVHC to be able to put a strong focus on precise targets in the coming five-year action plan.

Prior to the debate about the priorities, in order to give more solid ground to the workers' reflection, the consultant made a summary of the community's health portrait as presented in the Health Program Evaluation issued in June 2010. He also emphasized some comments that were brought forward by community members during focus groups run during that evaluation. The workers also exposed the negligible evolution of the health situation in the community in order to better identify the priorities. As part of their diagnosis, they considered that drug abuse is growing stronger but tobacco use is going down slightly. On the other hand, the elders have some organization but could definitely benefit from better networking activities. As for youth, they have a much greater number of organized activities since 2003, but they still request a lot of attention as the growing future of the community.

6.1.2 CRITERIA FOR THE SELECTION OF PRIORITIES

In the discussion initiated prior to the establishment of the priorities, three majors factors of selection were retained by the team of workers involved in this definition.

1. The first element related the decision to the number of people affected by the problems.
2. The second one recognized the link between the problems and the gravity of their impact over the community life.

3. Finally, it was established that the Health Centre's mandate, which was mainly about prevention, and the available resources were to be taken into account.

The discussions concluded with the establishment of 4 priorities.

6.2 The 4 Priorities

The four priorities are:

- *Diabetes*
- *Chronic Diseases*
- *Community Wellness*
- *Accessibility to Health Services*

- Diabetes has been selected since this disease has a large incidence within the community like in many other communities throughout the country. Not only does the illness have an impact on the people directly affected but it also has an important impact on relatives and other members of the person's network.
- Chronic Diseases took second place among the priorities since their incidence is quite significant in an aging population like Eagle Village. The participants also felt that it was necessary to separate these from diabetes because the latter already takes a large proportion of the resources within the heath process.
- Community Wellness established itself as a priority because it addressed the social aspect of the community life in relation with its global health status, allowing for the introduction of a holistic approach to the health services.
- The fourth priority identified a process priority. The first three priorities are directly aimed toward the community members' health while the fourth one is meant to put the focus on organizational issues that have been identified and defined as crucial to the development of quality health services in the near future of the community.

6.3 Priorities and criteria

During the selection process, as a way to measure the importance of the priorities to be chosen, the participants tried to visualize the "health future of the community in 30 years". This exercise helped by defining real long-term priorities (not without relation to the abovementioned vision) that were subsequently adapted for a shorter term.

It readily appeared that chronic diseases, diabetes were major issues since they strongly affect a growing number of people and their relatives and friends. The link with healthy living habits followed naturally.

During the 30-year considerations, exploring the future of the community, the participants in the workshop identified spontaneously chronic violence as being the most long term disruptive effect upon the population that can be imagined. They then decided to address the causes of this eventuality meaning, above all, the dependencies that lead to addiction and alcohol abuse. Here again, the link between such priorities and the healthy living habits established itself.

It is to be noted that Maternal and Child Health had been mentioned but wasn't retained as a priority due to the relatively small number of births occurring in the community. However, it will be embedded within our plan as a way to help reinforce individuals, thereby helping to prevent long term dependencies or premature physical decline for the community members. This point of view could eventually be revised in a decade or less.

6.3.1 Axis of intervention

In 1986, the World Health Organization (WHO) presented an array of 5 strategies for health promotion based on the principles that we have to take in consideration the people's environment, physical, social, political, and to enhance individual autonomy and responsibility in order to help people make the proper health choices.

The 5 strategies are:

1. Develop personal skills
2. Build a public health policy
3. Create supportive environments
4. Strengthen community action
5. Reorient health services

In the previous health plan Strategy 1 always had the largest part of the Health service activities, and still will in the current plan because somehow it gives importance to each individual of the community and reinforces awareness and personal skills, especially when it comes to the control of chronic diseases.

Strategy 4, community action, is another sound type of activity within the plan. The objective is to reinforce community and cultural bonds between the individuals to enhance their networks and their capability to address their health challenges in a proper and timely manner. For example, the Addictions Coordinator's role toward cultural development and community wellness is a strong appeal to this strategy.

Strategy 3, supportive environments, stems from the same concern which is to make existing facilities accessible to groups and individuals or put in place new tools for them to use and benefit from. The creation of support groups and the delivery of vouchers to new mothers are just few examples of what we plan to do in consideration of Strategy 3. The set-up of several screening clinics is a major part of our contribution to the reinforcement of activities responding to Strategy 3.

Strategy 2, building a health policy, somehow requires indirect work from health services. It can hardly be the number one strategy, but it is an important complement to the other strategies put into motion. The development of valid emergency plans and the reinforcement of anti-tobacco policies in the community are part of this.

Which brings us to Strategy 5, the re-orientation of health services.

6.3.2 Reorienting Health Services: The necessity of establishing plans and designing programs

The making of a health plan is a long process. But it could be a very fruitful one.

In order to be able to fully address the mentioned priorities, conscious that the health team needed to improve some of its operating methods and define proper ways and methods to provide a sound array of health services to EVFN's population, the health team decided to integrate two important elements into its Health Plan.

The first insight that appeared during the programming meetings is the necessity for the Health team to elaborate plans in order to adapt the services to the population's needs and expectations, and take into account the available resources. As a result, it has been decided that we had to take some time to carefully design programs adapted to the needs and to the capabilities of our services. However, most of the activities run during the preceding years are still good ways to address people's needs and they are maintained in order to sustain the good level of health services offered to the EV population. All of the current activities will be assessed and details will be defined (such as in the Chronic Diseases program, which diseases will be screened and addressed, and how).

The second insight which appeared early during the discussions over the priorities is the necessity to add another priority related to the way the EVHC will operate in the coming years. This gave us the Accessibility-to-services priority, as a distinction is made between the availability of services and accessibility to them, because a service's mere existence doesn't necessarily mean that people feel able to use it.

After the selection process and definition of the priorities, the health team addressed the definition of general objectives, which is summarized in the following table.

Table 15: Priorities, general objectives and services

1. Priority: Diabetes

General objective 1: *Delay the onset of diabetes complications through the delivery of structured support for all members affected by diabetes.*

General objective 2 : *Gain control over the diabetes incidence rate within the community through early detection and awareness*

2. Priority: Chronic Diseases

General objective: *Promote early detection of chronic diseases amongst the community and the adoption of healthier lifestyles by creating awareness of the latter's benefits versus the risk factors*

3. Priority: Community Wellness

General objective: *Diminish the various forms of violence and addictions within the community by strengthening the community links with holistic approaches*

4. Priority: Better accessibility to comprehensive health services

General objective: *Improve our community members' access to all health services within our organization and all other health service providers*

Mandatory Programs

- Primary Health Care (Walk-in clinic)
- Immunization & Communicable Disease
- Environmental Health & Safety (Drinking Water)
- Home Care Services

Acronyms:

ACC : Addictions & Culture Coordinator
CHN : Community Health Nurse
CNM: Clinic Programs Manager
CWPM: Community Wellness Programs Manager
Db&CDC: Diabetes & Chronic Diseases Coordinator
HCN: Homecare Nurse
SL&MC: Sport, Leisure & Mentorship Coordinator

6.4 Priorities and general objectives of the AHTF project

Since the objectives of the AHTF (Aboriginal Health Transition Fund) are still valid we felt they ought to be presented in the current document.

The purpose of the discussion process with the EVHC and the CSSSTK consisted of creating short term partnership ties between the Health Center (EVHC) and the CSSSTK and, on a longer term, establishing a permanent collaboration method that takes into account the specific needs of the EV population in the planning and delivery of health programs from the CSSS.

These specific objectives are:

- To provide continual home care and palliative care within the community.
- To integrate the community into the regional emergency plan
- To integrate the needs of EVFN into the planning for a seniors facility
- To reinforce prevention and treatment services for the EVFN population[28]

[28] Aboriginal Health Transition Fund. Integration Project. Eagle Village First Nation. June 2008 p.3.

Further in the document with regard to the presentation of the project's objectives submitted to Health Canada, it states "The goals of these steps are essentially to obtain improved and continuous access to quality services that are better suited to the cultural realities of the native population and to increase the integration of this same population into the local structure of physical and mental health services, all this in conformity with the AHTF objectives.[29]

Consequently, the project objectives closely matched those of the AHTF:

a) A better integration of health systems that are guaranteed by reinforcing the continued delivery of care, specifically for those with chronic diseases and requiring home care, a significant component of the provincial MSSS guidelines;

b) A better access to services, once again reinforcing the continuity so as to supplement the structural limits of the EVHC whose mission is primarily prevention and whose budgets are so limited that they are unable to provide accessibility to all services, which includes evenings and weekends.

c) Services which are better suited to the needs of the native population through a dialogue between the institutions in regards to the local development of an alternative resource to answer the needs of the EVFN seniors. This implies providing alternative housing adapted to individuals with decreasing independence.

d) Increased native participation in the design, delivery and evaluation of health programs through collaborative ties requiring the participation of all parties involved (CSSSTK, EV, Wolf Lake, English sector of the school), in all phases of the development and periodic adjustments of the health programs delivered on the territory.

[29] Idem, p.5.

Chapter 7

Eagle Village First Nation Health Plan Programing

2013-2018

PRIORITY **Diabetes**

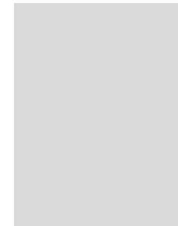
GENERAL OBJECTIVE **Delay the onset of complications of diabetes through the provision of a structured support for all members affected by diabetes.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By the end of 2015, all members of the community diagnosed with diabetes will be integrated in the EVFN Diabetes program or referred by our personnel to other health care facilities in order to maintain these people at the lowest level of illness evolution and to delay the onset of complications	Development of a comprehensive formal protocol (Diabetes Program) encompassing prevention, promotion, detection and all aspects of the treatment plan for members diagnosed with diabetes. Definition of a comprehensive strategy to address early detection of diabetes and implementation of a healthy life style within the community	Eagle Village First Nation Band members.	• CWPM • (CPM co-responsible)	• D&CDC • Sports & Mentorship • CHN • HCN • Health Director	• The Complete Diabetes Guide		• Before December 2014.	• Actual Diabetes Program	• Implementation of the Diabetes Plan. • Number/proportion of members of the community with diabetes integrated within the Diabetes Program or referred	• The complete Diabetes Guide

PRIORITY **Diabetes**

GENERAL OBJECTIVE **Delay the onset of complications of diabetes through the provision of a structured support for all members affected by diabetes.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
2. Maintain the current services, support and follow up to our members with diabetes while the development of the comprehensive Diabetes Program takes place	Quarterly Diabetic Clinics	Community members diagnosed with diabetes.	• CPM	• D&CDC • CWPM • CHN • HCN	• Medical equipment and supplies		• January, April, July and October each year.	• Participation rate of diabetics at each quarterly clinic	Rate of diabetics whose level of illness remain constant	• Nursing statistics at the EVHC and the CSSS-TK. • Activity Reports • Attendance Report • Evaluation Form
	Retinopathy Screening Clinics	Community members diagnosed with diabetes.	• CPN • CWPM	• D&CDC	• Retinopathy Camera • Laptop • Medical supplies		• April of each year.	• Early diagnosis and referral to Ophthalmologist		• Activity Reports • Retinopathy Report Form • Lab Results
	Nurse consultation; Consultation And Follow up according to identified results or requests.	Community members diagnosed with diabetes.	• CHN	• CPM • D&CDC • Sports & Mentorship	• Diabetes resource materials		• When initiated by nurse, physician or by client request.	• Number of consultations • Appropriate treatment plan and follow up • Referrals		• Activity Reports • Individual Report

Foot Care Services	Community members diagnosed with diabetes.	• HCN	• CPM		• Medical foot care supplies		• When initiated by nurse, physician or by client request.	• Number of diabetics receiving foot care services. • Number of foot care sessions per month.		• Nursing statistics at the EVHC and the CSSS-TK. • Foot Care Evaluation Form

PRIORITY **Diabetes**

GENERAL OBJECTIVE **Gain control over the incidence rate of diabetes within the community through early detection and awareness**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
3. By 2018, 80% of the members of the community over 14 years of age will have been checked at least once for their blood glucose level	Reach out to the non-participating members over the age of 14 years old.	Eagle Village First Nation Band members.	• CPM • CWPM	• D&CDC • CHN • HCN	• Booth set up • Medical equipment and supplies • Promotional material • Advertising material: invitations, newsletter, posters etc • Participation incentives		• Spring (Health Fair) and Fall (National Diabetes Day) and 2 other open session clinics (To be determined)	• Number of people tested during the screening clinics. • Frequency of an individual's participation.	• Baseline to be determined by: percentage of the targeted community members who have been tested for diabetes within the last two years (2011 - 2012). Success indicator will be the increase of participation over the next 5 years.	• Baseline Activity Participation Report • Band List • Activity Reports • Screening Clinic Report Sheet

PRIORITY	Diabetes									
GENERAL OBJECTIVE	Gain control over the incidence rate of diabetes within the community through early detection and awareness									
SPECIFIC OBJECTIVE	**ACTIVITIES**	**POPULATION TARGETED**	**IN CHARGE**	**COLLABORATORS**	**RESOURCES : MATERIAL**	**RESOURCES : FINANCIAL**	**DATE**	**PROCESS INDICATOR**	**SUCCESS INDICATOR**	**DATA SOURCE**
4. By 2018, create awareness over diabetes and develop healthier life habits in the community by increasing by 20% the number of hours spent by community members participating to events or activities related to good nutrition or physical activities.	Provide diabetes related articles for the monthly community newsletter.	All band members	• D&CDC	• CWPM • CPM • Sports & Mentorship	• Computer with internet access • Diabetes related books and resources		• Monthly according to the newsletter schedule	• Number of relevant articles published • Number of newsletter copies distributed	• Number of hours/person devoted to good nutrition and physical activities in the community	• Newsletter archives.
	Diabetes Youth Summer Camp focusing on Healthy Lifestyle including good nutrition and physical activities.	Community members between 6 and 17 years old. 2 groups: 11 yrs and under and 12 – 17 yrs	• D&CDC	• Sports & Mentorship • CWPM • CPM • CHN • HCN • Addictions & Wellness • Front Line Services • Environmental Health	• Facilities in Hunter's Point • Transportation (van, boats, trucks) • First Aid supplies • Activity supplies		• Two weeks in July of each year • 1 week prep	• Number of youth participants per year		• Activity Reports • Evaluation Forms • Band List
	Organize two Workshops/Information Sessions related to diabetes.	Community members	• D&CDC	• CWPM • CPM	• Venue • Guest speakers • Participation incentives • Diabetes		• Two per year	• Number of participants	• Evaluation of knowledge and satisfaction of workshop	• Activity Reports • Attendance Record • Evaluation Forms

					related resources • Refreshments and supplies				• Number of new cases of diabetes diagnosed on reserve and among the band members in relation with total population	
	Organize two diabetes cooking classes and nutrition classes	Community members	• D&CDC	• CWPM • CPM	• Community kitchen • Cooking material and supplies • Recipe books • Nutrition resource guide		• Two per year	• Number of participants		• Activity Reports • Attendance Record • Evaluation Forms
	"Eldercize" (Exercise group targeting Elders and diabetics of all ages)	Community members with chronic diseases	• Sports & Mentor-ship	• D&CDC	• Venue • Exercise equipment and supplies		• Three times per week (Monday, Tuesday, Thursday) for ten months of the year	• Number of participants to each session • Yearly evaluation to be completed by participants		• Activity Reports • Attendance Record • Evaluation Forms
	Organize a workshop with all parents about proper portion size and good nutrition.	All parents	• D&CDC	• CWPM • CPM	• Venue • Nutrition resources • Portion plates and food models		• One per year (Septemb er prior to school year)	• Holding of the workshop • Number of participants		• Activity Reports • Attendance Record • Evaluation Forms

	Milk Program	School age youth	• D&CDC	• CWPM • School Bus Monitor • School Administrator	• Refrigerators Milk		• Five days a week following the school calendar	• Number of students participating		• Activity Reports • Student List • Participation Report Sheet
	Kirano Program (Exercise and good nutrition program)	Adults of the Community	• Sports & Mentor-ship	• D&CDC • CHN	• Community Hall • Exercise Equipment • Other sporting facilities • Kirano Program Guide		• January to April each year (classes held 2 to 4 times a week)	• Number of participants at the beginning and at the end of each program	• Number of inches at the waist lost by person between the beginning and the end of the program	• Activity Reports • Individual Reports

PRIORITY **Chronic Disease**

GENERAL OBJECTIVE **Promote early detection of chronic diseases amongst the community and the adoption of healthier lifestyles by creating awareness toward risk factors versus its benefits.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By the end of 2015, all members of the community diagnosed with a chronic disease will be integrated in the EVFN Chronic Disease Program or referred by our personnel to other health care facilities in order to maintain these people at the lowest level of illness evolution and to delay the onset of complications.	Development and implementation of a comprehensive formal program (Chronic Disease Program) encompassing prevention, promotion, detection and all aspects of the treatment plan for members diagnosed with a chronic disease, and the definition of screening standards.	Eagle Village First Nation Band members.	• CWPM • CPM (co-responsible)	• D&CDC • Sports & Mentorship • CHN • HCN • Health Director	• To be determined.		• Before June 2015.	• Actual Chronic Disease Program	• Implementation of the Diabetes Plan. • Number/proportion of members of the community with chronic diseases integrated within the Chronic Disease Program or referred	• Activity reports • Program statistics

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PRIORITY **Chronic Disease**

GENERAL OBJECTIVE **Promote early detection of chronic diseases amongst the community and the adoption of healthier lifestyles by creating awareness toward risk factors versus its benefits.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
2. By the end of 2017, we will engage the women in the community over the age of 18 years in view of having 60% of them seen by a physician and follow the recommended provincial screening standards for cancers and cardio-vascular diseases	Women's Health Check Clinic: Screening Update health info Pap and mammogram verification Primary care MD follow up Info session	Female Community members 18 years of age and older	• CPM	• D&CDC • CWPM • CHN • HCN	• Venue/Booth • Medical equipment and supplies • Health info and resource material		• March (International Women's Day).	• Number of women screened/referred/assisted and identified for follow up during the event. • Rate of people participating during the event	• Percentage of the women in the community who have been screened and seen by a MD regarding chronic diseases within a period of 2 years	• Activity Reports • Band List • Evaluation Form • Screening/Health Verification Form
	Annual Cancer Awareness Walk	Female Community members 18 years of age and older	• D&CDC • CWPM (co-responsible)	• CPM • CHN • HCN	• Venue • Guest Speaker • Info table • Promotional material		• October of each year (Breast Cancer Month)	• Number of people participating in the walk. • Number of people attending the information session and information table	• Increased number of participants for the session /walk per year. • Evaluation of knowledge and satisfaction of the info session	• Activity Reports • Attendance Record • Evaluation Forms

PRIORITY **Chronic Disease**

GENERAL OBJECTIVE **Promote early detection of chronic diseases amongst the community and the adoption of healthier lifestyles by creating awareness toward risk factors versus its benefits.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
3. By the end of 2017, we will engage the men in the community over the age of 18 years in view of having 50% of them seen by a physician and follow the recommended provincial screening standards for cancers and cardio-vascular diseases	Men's Health Check Clinic: Screening Update health info Primary care MD follow up Info session	Male Community members 18 years of age and older	• CPM	• D&CDC • CWPM • CHN • HCN	• Venue/Booth • Medical equipment and supplies • Health info and resource material		• December (ending "Movember" activities OR June for Father's day / Men's Health Day (to be determined)	• Number of men screened/referred/assisted and identified for follow up during the event. • Rate of people participating during the event	• Percentage of the men in the community who have been screened and seen by a MD regarding chronic diseases within a period of 2 years • Number of new male cases of chronic diseases diagnosed on reserve and among the band members /total population	• Activity Reports • Band List • Evaluation Form • Screening/Health Verification Form

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PRIORITY **Chronic Disease**

GENERAL OBJECTIVE **Promote early detection of chronic diseases amongst the community and the adoption of healthier lifestyles by creating awareness toward risk factors versus its benefits.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
4. By 2018, create awareness over chronic diseases and develop healthier life habits in the community by increasing by 20% the number of hours spent by community members participating to events or activities related to good nutrition or physical activities	Provide chronic disease related articles for the monthly community newsletter.	All band members	• D&CDC	• CWPM • CPM • Sports & Mentorship	• Computer with internet access • Chronic disease related books and resources		• Monthly according to the newsletter schedule	• Number of relevant articles published • Number of newsletter copies distributed	Number of hours/person devoted to good nutrition and physical activities in the community	• Newsletter archives
	Diabetes Youth Summer Camp focusing on Healthy Lifestyle including good nutrition and physical activities.	Community members between 6 and 17 years old. 2 groups: 11 yrs and under and 12 – 17 yrs	• D&CDC	• Sports & Mentorship • CWPM • CPM • CHN • HCN • Addictions & Wellness • Front Line Services • Environmental Health	• Facilities in Hunter's Point • Transportation (van, boats, trucks) • First Aid supplies • Activity supplies		• Two weeks in July of each year • 1 week prep	• Number of youth participants per year	Evaluation of knowledge and satisfaction of workshop	• Activity Reports • Evaluation Forms • Band List
	Organize one Workshops/Information Sessions related to chronic disease.	Community members	• D&CDC	• CWPM • CPM	• Venue • Guest speakers • Participation incentives • Chronic		• One per year	• Number of participants	Number of new cases of chronic diseases diagnosed on reserve and among	• Activity Reports • Attendance Record • Evaluation Forms

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				disease related resources • Refreshments and supplies				the band members in relation with total population	
"Eldercize" (Exercise group targeting Elders and diabetics of all ages)	Community members with chronic diseases	• Sports & Mentor-ship	• D&CDC	• Venue • Exercise equipment and supplies		• Three times per week (Monday, Tuesday, Thursday) for ten months of the year.	• Number of participants to each session • Yearly evaluation to be completed by participants		• Activity Reports • Attendance Record • Evaluation Forms
Milk Program	School age youth	• D&CDC	• CWPM • School Bus Monitor • School Administrator	• Refrigerators Milk		• Five days a week following the school calendar	• Number of students participating		• Activity Reports • Student List • Participation Report Sheet
Kirano Program (Exercise and good nutrition program)	Adults of the Community	• Sports & Mentor-ship	• D&CDC • CHN	• Community Hall • Exercise Equipment • Other sporting facilities • Kirano Program Guide		• January to April each year (classes held 2 to 4 times a week)	• Number of participants at the beginning and at the end of each program		• Activity Reports • Individual Reports

PRIORITY **Community Wellness**

GENERAL OBJECTIVE **Diminish the various forms of violence and addictions within the community by strengthening the community links with holistic approaches.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES MATERIAL	RESOURCES FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By 2017, 90% of the school age children of the community are regularly involved in sporting or social activities meant to develop the quality of their social network and reinforce their ability to adopt a healthy lifestyle	"Teen Outings" Teen activities that incorporate life skills	High school students	• Sports, Leisure & Mentorship Coordinator	• Front Line Social Services • YAP Group	• EVFN facilities and equipment		• 8 times per year, monthly	• Number of participants to the event	• Evaluation of knowledge and satisfaction of workshop	• Activity reports • Success: results of a questionnaire form or an evaluation form
	Twice a week sport sessions at school	Youth GTS Students	• Sports, Leisure & Mentorship Coordinator	• School Administrators • Teachers	• School facilities and equipment		• During the school period. Selected days designated by the school	• Number of participants to the event		• Activity reports Success: Social Service statistics
	"August Sport & Leisure". Sporting activities and good nutrition animation	Youth	• Sports, Leisure & Mentorship Coordinator	• 2 summer students • Front Line Social Services • A&WC • C&RS Coordinator	• EVFN facilities and equipment • Activity supplies • Healthy snacks		• 7 weeks within the summer calendar	• Number of participants to the event	• Receding number of crisis interventions from community and social services	• Activity reports • Evaluation questionnaire

Youth Soccer Camp	Youth	• Sports, Leisure & Mentorship Coordinator	• 2 hired soccer coaches • Municipality of Kipawa	• EVFN facilities and equipment		• 7 weeks within the summer calendar	• Number of participants to the event	• Receding number of suspensions and other disciplinary measures for school age residents of the community Diminution of police calls referring to youth violence and vandalism	• Attendance Record
Weekend Activities	Youth	• A&W C	• Front Line Social Services • YAP Group • A&WC • C&RS Coordinator	• Youth Center • EVFN facilities and equipment		• Monthly	• Number of participants to the event		• Activity reports • Attendance Records
Develop and implement a 6 week program for post secondary students (Workshops for graduating students and parents relayed to life skills i.e. budgeting, cooking, shopping, stress, time management, study habits, etc.)	Youth and Parents	• Front Line Social Services	• School Authorities • Education Coordinator • Respective related Health Team Members	• EVFN facilities and equipment		• December 2013	• Actual six week program		• Student Lists • Activity reports • Evaluation Forms
Newsletter articles related to physical activity, wellness and culture	All members of the community.	• CWPM	• Wellness Team	• Computers • Internet		• Monthly	• Number of relevant articles published • Number of newsletter distributed		• Newsletter archives

March Break and PD Day Activities including sports, and traditional activities such as ice fishing and trapping.	Youth	• Sports, Leisure & Mentorship Coordinator	• A&WC • C&RS Coordinator • YAP Group	• EVFN facilities and equipment		• As per school calendar	• Number of participants • Content of activities	• Activity Reports • Evaluation Forms

PRIORITY **Community Wellness**

GENERAL OBJECTIVE **Diminish the various forms of violence and addictions within the community by strengthening the community links with holistic approaches.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES MATERIAL	RESOURCES FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
2. By 2017, 95% of the youth of 0 to 6 years old and parents will be engaged in a continuum of services providing information, support and useful tools for their positive physical, social, intellectual and mental development	Provision to parents of youth 0 to 5 ½ years old with assessment and teaching material related to their children's development, safety, physical integrity and protection Development and implementation of an integration plan of other health team workers into the MCH program to include their respective roles and program activities	Children from 0 to 6 years old and their parents.	• CPM	• MCH Worker • Health Centre Team	• Teaching Aids • Nutrition Resources • Computer		• By 2017	• Number and contents of meetings with team members • Calendar and activity planning	• Qualitative evaluation of the children's integration to CPE life	• Attendance Record • Knowledge evaluation pre/post • Activity Reports • 3rd party evaluation

PRIORITY **Community Wellness**

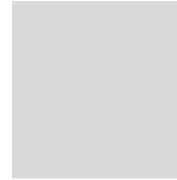
GENERAL OBJECTIVE **Diminish the various forms of violence and addictions within the community by strengthening the community links with holistic approaches.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES MATERIAL	RESOURCES FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Family dances. Alcohol and drug free dance night to build confidence in our youth	All families in the community.	• A&WC	• SL&M • C&RS Coordinator • Front Line Social Services	• Community Facilities		• Every two months (6 times per year)	• Number of participants • Number of events	minution of police calls referring to family violence minution of police interventions referring to substance abuse in the community itio of development of new community activities, associations or groups, measured each year	• Activity Reports • Evaluation Forms
	Family outings (parent/grandparent /child) Skating, Bowling, Family Meals, Berry picking, Ice Fishing	All families in the community	• Front Line Social Services	• A&WC • SL&M • C&RS Coordinator			• 4 to 6 times per year	• Number of participants • Number of events		• Activity Reports • Evaluation Forms
3. By 2017 develop community networking through increasing by 15% the overall participation ratio of the parents of the community to family oriented, cultural and recreational activities	Develop and implement a Cultural Teachings Program: crafts, medicines, traditions, craftsmanship	Youth, Adults and families in the community			• Community Facilities		• By the end of 2013	• Actual implementation of the plan • Number of participants • Number of events		• Activity Reports • Evaluation Forms

PRIORITY Community Wellness

GENERAL OBJECTIVE Diminish the various forms of violence and addictions within the community by strengthening the community links with holistic approaches.

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES MATERIAL	RESOURCES FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Residential School Impact Trauma Group (Anicinabe Mikana): Cultural awareness, activity organization and workshops	Elders	• C&RS Coordinator	• Front Line Social Services	• EVFN facilities and equipment		• Every Month	• Maintain the group participation at 7. • Yearly number of activities • Yearly number of participants to the group activities	Quantitative evaluation of the Elder's life quality and extent of their network . Diminutions of police calls referring to violence and abuses toward Elders	• Activity reports and Minutes of Meetings
4. By 2017, 80% of the Elders in the community (60 years of age or older) are regularly provided with knowledge and support tools for managing their personal situation	Personal contact with 60 + (Meant to create bonding with Homecare Staff and Front Line Services)	Elders	• CPM	• HCN • Front Line Social Services			• Ongoing	• Percentage of Elders reached. • Frequency of contacts with Elders	Receding number of social service interventions related to Elders	• Activity data and reports • Police statistics
	Information sessions for advanced directives and useful capabilities: apply for Old Age Security, Wills, Monthly budgeting	Elders	• Frontline Social Services	• HCN • CPM			• Quarterly	• Number of information sessions held		• Social Service data

Social networking activities	Elders	• Front Line Social Services	• Health Centre Team	• EVFN facilities and equipment		• Quarterly	• Number of activities held • Participation of Elders	• Activity Reports • Evaluation Forms

PRIORITY **Community Wellness**

GENERAL OBJECTIVE **Diminish the various forms of violence and addictions within the community by strengthening the community links with holistic approaches.**

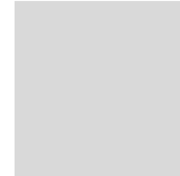
SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES MATERIAL	RESOURCES FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
5. Reduce the causes of destructive behavior in the community through the implementation of a comprehensive Addictions and Wellness Program that encompasses prevention, promotion, treatment and aftercare	Establishment of a protocol for referrals and a program for aftercare services for people affected by addiction.	Eagle Village Community Members	• A&WC	• Front Line Social Services • YAP Group			• December 2013	• Completed Protocol for referrals and aftercare	. Diminution of police calls referring to youth violence, vandalism and substance abuse	• Activity reports
	MADD Presentation	School aged children	• A&WC	• Front Line Social Services • Sports, Leisure & Mentorship Coordinator	• School facilities and equipment		• Once during the school year.	• Number of participants to the event.	minution of police calls referring to family violence	• Activity reports Success: Social Service statistics
	Monthly Newsletter articles for topics including drinking and driving, prevention, drugs, alcohol, treatment etc.	Eagle Village Community Members	• A&WC	• Front Line Social Services	• Computer • Internet		• Once per month according to newsletter schedule	• Number of articles • Number of newsletter sent out	Diminution of police interventions referring to substance abuse in the community	• Newsletter archives
	Spring Fair Participation with an information booth with addictions and wellness information	Eagle Village Community Members	• A&WC		• Booth • Resource Materials		• Once per year according to date set for Spring Health fair	• Number of visitors to booth		• Evaluations Forms • Activity Reports • Attendance Records

National Addictions Awareness Week Activities	Eagle Village Community members	• A&WC	• Health Team		• Once per year for one week during the month of November.	• Number of activities held. • Number of participants at activities	• Evaluation Forms • Activity reports • Attendance Records
Individual counselling & referring into the NAADAP network	Youth, young adults and adults of the community	To be determined			According to needs	Numbers of people met Number of people referred Number of people referred having their therapy completed	Activity data and report

PRIORITY **Better accessibility to comprehensive health services.**

GENERAL OBJECTIVE **Improve our community member's access to all health services within our organization and all other health service providers.**

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By December 2014, all non-participant members will have a follow-up in attempt to integrate them into the respective health program. (internal or external)	Identify all non-participating members and establish a protocol for follow-up	Non-participating **members.**	• CPM	• D&CDC • CHN • HCN • CWPM			• Before December 2014	• Number of people contacted and integrated into a health care program (internal or external)	• Development and implementation of a follow up and integration protocol • Number of people integrated into the EVHC's services or other services/number of people contacted	• Activity reports • Band List
2. By 2016, the Health Centre will have its own building for service delivery to respond to the growing needs of the community and have the capacity to attract the proper professionals to deliver programs and services	Regular contacts with the Band Council, Health Canada, AANDC and other concerned stakeholders within and outside the community for promotion and financing of the project	Band Council, Health Canada, AANDC and others.	• Health Director	• Upon needs			• December 2016	• Contents of the discussions with concerned parties • BCR • Plans and specs • Financing demand • Financing	• Actual new building	• Minutes of formal meetings • Contracts • Agreements • Plans and specs

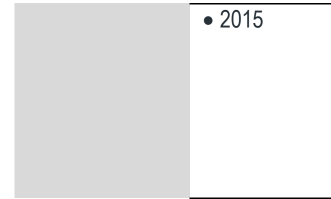


agreement

PRIORITY Better accessibility to comprehensive health services.

GENERAL OBJECTIVE Improve our community member's access to all health services within our organization and all other health service providers.

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
3. By 2015, the Health Centre will be ready to integrate a Home Support Program in such a way as to assume more comprehensive services	Advocacy about the financial and human resources required to manage the program	AADDC Health Canada	• Health Director	• Chief and Council • FNQLHSSC			• 2014	• Actual meeting with stakeholders	• Approved sufficient funding	
	Develop the Comprehensive Home Support Program	Community Members	• CPM	• Health Canada • AANDC • Centre Jeunesse • HCN			• 2014	• Actual Comprehensi ve Home Support Program	• Implementation of the Comprehensive Home Support Program	• Minutes of formal meetings • Contracts • Agreements
	Recruiting and Training Plan for Personal Support Workers	Community Members	• CPM	• HCN			• 2015	• Actual training plan for Personal Support Workers	• Increased number of accredited and trained Personal Support Workers	

Integration Plan of both programs upon transfer date (Support Program / Home and Community Care)	Eagle Village First Nation	• CPM	• Social Service Worker • HCN		• 2015	• Actual plan of integration of Home Support and Home and Community Care	• Integration of the Home Support Program with the Home and Community Care Program

PRIORITY Better accessibility to comprehensive health services.

GENERAL OBJECTIVE Improve our community member's access to all health services within our organization and all other health service providers.

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
4. By 2014 the Eagle Village Health Centre will have a functional and efficient system for data gathering and report making	Implementation of Archivist / Data / Accreditation position within our new organizational chart		• Health Director	• Band Council • External Interview Panel			• April 2013	• Job Description Development • Job Posting • Development of Interview Questionnaire	• New person hired for the position	• Interview questionnaire and formula for interview process
	Create and implement a data collection system		• Person to be hired for position	• CPM • CWPM	• Office space • Computer • Specialized software		• Mach 2014	• Set up of efficient and functional system	• Successful implementation of data collection system	• Reference other methods of data collection. • Current files and reports

PRIORITY Better accessibility to comprehensive health services.

GENERAL OBJECTIVE Improve our community member's access to all health services within our organization and all other health service providers.

SPECIFIC OBJECTIVE	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLABORATORS	RESOURCES : MATERIAL	RESOURCES : FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
5. By December 2013 the Eagle Village Health Centre will conduct a survey on current community health status to gather quantitative data and support orientation of services and tools for evaluation	Determine what health data is required and develop a questionnaire accordingly Strategically administer questionnaire to maximize participation and results Analyze data	Eagle Village Health Centre Band Members	• CWPM • CPM	• Health Team • Technical Expert			• December 2013	• Actual survey development • Survey results	• Quantitative data about lifestyle, health status and perceptions within the community .	• Survey data
6. Continuation of the AHTF project objectives. (Integration of services between Eagle Village Health centre and CSSS-TK)	Initiate contact between CSSS-TK and EVFN authorities to re-establish and renew the AHTF process. Readdress protocol signatures and establish defines communication process with CSSS-TK	CSSS-TK and Eagle Village Health Centre	• Health Director	• CWPM • CPM			• End of 2014	• Actual discussions and protocols	• Fluent communication system for information exchange between the Eagle Village Health Centre and CSSS-TK	• Formal assessment of the communication process between both institutions

CHAPTER 8

PRIMARY HEALTH CARE AND MANDATORY PROGRAMS

8.1 Primary care

8.1.1 CLINICAL AND CLIENT CARE

Objectives

As described in the FNIHB's Program Compendium 2011-2012

• 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 coordination and consultation services with other appropriate health care providers and/or institutions as indicated by client needs.

Responsible for delivery of the service: the CHN, with the occasional support of the HCN. Under the Clinic Program Manager's responsibility.

Locations for delivery: Health Centre.

Services

Non-urgent care; coordination and care management; chronic disease aftercare; walk-in clinic as described below; retinopathy testing; foot care (also done within the home care program).

Details: walk-in clinic, and clinical support

See the following schedule. The monthly number of visits to the clinic goes from 50 to 154 with an average of 94.7 visits.

Table 16: Health Centre opening hours

Eagle Village Health Centre opening hours					
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8:00 - 12:00	Walk-in clinic (1 nurse)	Walk-in clinic and labs (bloodwork)	Walk-in clinic (could be in PM)	Walk-in clinic and labs (bloodwork)	Walk-in clinic

12:45 - 16:00	No open clinic	Walk-in clinic	By appointment (could be in AM) & programming (db, chronic, footcare)	Walk-in clinic	Closed

Three physicians from the Pavilion TK alternate in visiting the EVHC half a day every week and a half or so, according to demand and physicians' availability. They bring on their patients' files from the Pavilion TK and take them back with them. The follow-up with the patients might take place at the Health Centre or at the Pavilion. The nursing staffs are not systematically kept informed of the cases' development. This proximity service is a much appreciated service particularly by seniors.

8.1.1.1 Inventory Control and Handling of Medications

In order to comply with Health Canada's obligation, EVHC established a protocol for "inventory control and handling of medications" to be read in Appendix 8. A separate protocol has also been established in relation to "expired medications and bio-hazard material", which is to be found in the same appendix.

8.1.2 Home and Community Care

Objectives

As described in the FNIHB's Program Compendium 2011-2012

• 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 the 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.

• Help clients and their families participate in the development and implementation of the client's care plan to the fullest extent and utilize available community support services where available and appropriate in the care of clients.

• Build the capacity within First Nations and Inuit communities to support the delivery of quality client-centered home care services that promote safety.

Responsible for delivery of the service: Home Care Nurse (HCN). Currently, with a contract of 3 days a week. Under the supervision of the Clinic Programs Manager (See job description for more details in relation with tasks).

Locations for delivery: Health Centre for the preparation of visits and clerical tasks. At home for the service delivery itself.

Services

Client assessment; home care planning; acute care nursing; medication management; wound management; teaching clients to care for themselves; managing chronic illnesses. The home care support staff comprises between 14 to 18 home support workers under the supervision of a liaison officer from *Centre Jeunesse* who is based in the Health Centre.

Referral: requests for services may come from the hospital, a health professional, a family or community member, the patient, etc. Patient's needs are evaluated within 72 hours (workable). The evaluation report recommendations may be studied by the homecare committee in the event of an appeal to the initial decision rendered.

The complete Service delivery plan for home care service is to be found in Appendix 9.

8.2 Communicable Disease Control and Management (CDCM)

"Communicable disease control and management programs aim to reduce the incidence, spread and human health effects of communicable diseases, as well as improve health through prevention and health promotion activities, of on-reserve First Nations (…)."

8.2.1 Objectives of the Programs

As presented in FNIHB's Program Compendium 2011-2012.

8.2.1.1 Vaccine Preventable Diseases – Immunization Program

• Ensure access to newly recommended vaccines.
• Improve the coverage rates of routine immunizations.
• Improve data and understanding of immunization coverage rates, the incidence of vaccine preventable diseases, barriers to immunization and best practices in implementation.

8.2.1.2 Blood Borne Diseases and Sexually Transmitted Infections (BBSTI) - HIV/AIDS Program

• Increase awareness of BBSTI-HIV/AIDS through improved community-based knowledge development.
• Increase the availability of evidence-based BBSTI-HIV/AIDS interventions.
• Reduce the stigma of BBSTI-HIV/AIDS within communities.
• Promote testing, access to prevention, education and support, and supportive social environments for those vulnerable to and living with BBSTI-HIV/AIDS.
• Increase effective collaboration towards the achievement of a coordinated and integrated response to BBSTI-HIV/AIDS across jurisdictions.

8.2.1.3 Respiratory Infections - Tuberculosis (TB) Program

• Reduce the incidence of TB disease in First Nations and Inuit communities.
• Detect and diagnose TB disease early to eliminate the cycle of transmission among those exposed to infectious cases.
• Provide treatment via Directly Observed Therapy (DOT) to those with active TB disease and latent TB infection to prevent the emergence of drug resistance.
• Support health care workers and communities in the prevention and control of TB disease at the community level.
• Strengthen TB research through collaboration with local, regional, provincial, national and international partners.

8.2.1.4 Communicable Disease Emergencies - Pandemic Influenza

• Support communities in preparing for an influenza pandemic by facilitating testing and revision of community level plans as needed.
• Facilitate communities' response to an influenza pandemic (e.g., support mass immunization clinics; provide training, guidance documents, etc.).
• Ensure health facilities have access to personal protective equipment (e.g., masks, gloves, gowns) during a pandemic.
• Ensure that First Nations circumstances are reflected in overall pandemic planning at all levels of government.

8.2.2 SERVICE DELIVERY

Table 17: CDCM Service Delivery

<table>
<tr><th>STBBI</th><th>Immunization</th><th>TB</th></tr>
<tr><td colspan="3">List of the type of personnel who will provide clinical services linked to CDCM programs.
EVFN has 3 nurses currently working full time; 1 Clinical Programs Manager for Mgmt of all the above mentioned programs with 1 RN as CHN and 1 LPN as HCare / Special Projects Nurse.

Immunization (childhood vaccines and influenza) primarily assigned under CHN.
STBBI education, prevention and promotion assigned under CHN with Community Wellness Worker
HIV/AIDs assigned to HCare / Special Project Nurse with Community Wellness Worker and CHN.
TB assigned under CHN (no activity related to this domain thus far)</td></tr>
<tr><td colspan="3">Description of activities and clinical services offered:</td></tr>
<tr><td>• testing
• diagnosis
• treatment
• client follow-up
• counselling and support services
• targeted interventions for vulnerable populations (ex: youth clinics, needle exchange program, outreach services)
• referrals and services for the follow-up and treatment of chronic infections (hepatitis C, HIV)</td><td>• targeted populations
• access to immunization services (school based, on demand, immunization clinics)
• vaccines administered (according to the provincial calendar)
• type of call back system
• cold chain management (equipment and procedures)</td><td>• testing
• contact tracing
• management and follow-up of active cases
• procedure for directly observed therapy (DOT)</td></tr>
</table>

<table>
<tr><td colspan="3">If the above services are not offered on reserve, identify the providers (ex: CLSC) that offer them, as well as the types of services available to community members.
TB testing /screening is done at the local CSSST-K
TB test reading / measurements also done at CSSST-K</td></tr>
<tr><td colspan="3">Describe the collaborative approach used with the local Public Health Authority (DSP) for the reporting, management and follow-up of cases and contacts:
We may be called upon for assistance with the follow up process by the local CSSST-K for MADO but the follow-up is done by them according to the provincial protocol.</td></tr>
<tr><td>• management and follow-up of index cases
• partner tracing (IPPAP)</td><td>• management and follow-up of cases of vaccine preventable diseases and their contacts</td><td>• management, follow-up and treatment compliance for active tuberculosis</td></tr>
</table>

8.2.3 Public Education and Awareness

Here is a table of all activities run and material used to better inform the EVFN members about communicable diseases

Table 18: CDCM program activities[30]

Communicable Disease Control and Management Awareness and Education Activities				
Program and Initiative Areas	National	Regional	Local/community	Number of Activities
HIV/AIDS-Blood Borne and Sexual Transmitted Infections	-	-	-Condom distribution -Condom dispensers installed in 3 locations in community	2
Tuberculosis	-	-	-	-
Immunization	-	-Posted influenza season awareness posters	-Influenza Posters -Newsletter influenza awareness article -Seasonal influenza clinics -Prevention & promotion items for influenza prevention	5
Pandemic Planning	-	-	-	-
Infection Prevention and Control	-	-	-	-

[30] *Community-based Report Template 2011-2012*

8.2.4 Capacity Development

See Training Program in Appendix 3.

8.2.5 Surveillance, data collection and evaluation

Public Health Authority: Direction de la santé publique de l'Abitibi-Témiscamingue (Rouyn-Noranda)

Health and Social Services Agency : Agence de la santé et des services sociaux de l'Abitibi-Témiscamingue (Rouyn-Noranda)

List of the mandatory reportable diseases in Québec[31]

Acute flaccid paralysis
AIDS: only if the person gave or received blood, blood derivatives, organs or tissues
Angiosarcome of liver
Anthrax
Asbestosis
Asthma as an occupational disease
Babesiosis
Berylliosis
Botulism
Brucellosis
Byssinosis
Chagas disease
Chimicaly caused bronchopulmonary disease
Chimicaly caused disease to the heart, liver, kidney, lung, gastrointestinal or nervous systems
Chlamydia trachomatis infection
Chancroid
Cholera
Creutzfeldt-Jakob disease
Diphteria
Enterococus vancomycin resistant
Encephalitis viral transmitted by arthropods
Epidemical gastroenteritis
Gonococcic infection
Hantavirus Pulmonary Syndrome
Hemangiosarcoma
Hemorrhagic fevers, including:

1. Ebola virus disease
2. Marburg virus disease
3. Other viral causes

Inguinal granuloma
Invasive infection by Escherichia coli
Invasive infection by Hæmophilus influenzæ
Invasive infection by meningococus
Invasive infection by streptococus A
Invasive infection by Streptococcus pneumoniæ
Legionellosis
Leprosy
Lung cancer due to exposure to asbestos
Lyme disease
Lymphogranuloma venereal
Malaria
Measles
Mesothelioma
Mumps

[31] http://publications.msss.gouv.qc.ca/acrobat/f/documentation/preventioncontrole/03-268-05.pdf

Paratyphoid Fever
Pertussis
Plague
Poliomyelitis
Psittacosis
Q fever
Rabies
Rubella
Severe Acute Respiratory Syndrome (SARS)
Silicosis
Smallpox
Staphylococcus aureus methicillin resistant
Syphilis
Tetanus
Trichinosis
Tuberculosis
Tularemia
Typhoid fever
Viral hepatitis (ex: VHA, VHB, VHC, VHD)
West Nile Virus illness
Yellow fever

8.2.5.1 Communicable diseases; immunization

Communicable disease diagnoses are managed according to provincial bylaws on communicable diseases. However, the Health Centre has never had to proceed with this since this type and level of diagnosis is only done by physicians and/or laboratories at the CSSS Pavilion in Témiscaming.

Immunization is done at the Health Centre, and sometimes at home, on appointment for the younger children. For school age children most of the vaccination is done at school but occasionally the CHN provides the service on appointment, in collaboration with the school nurse.

Table 19: Regular vaccination schedule
List of recommended vaccinations according to age[32]

Age	Vaccine(s)
2 months	DTaP-Polio-Hib Vaccine Pneumococcal Conjugate Vaccine
4 months	DTaP-Polio-Hib Vaccine Pneumococcal Conjugate Vaccine
6 months	DTaP-Polio-Hib Vaccine
Between 6 and 23 months	Influenza (flu) Vaccine (in influenza season)
12 months	Pneumococcal Conjugate Vaccine Meningococcal Conjugate Vaccine

[32] http://www.msss.gouv.qc.ca/sujets/santepub/vaccination/index.php?calendrier_de_vaccination_en

	MMR-Var Vaccine
18 months	DTaP-Polio-Hib Vaccine MMR Vaccine
Between 4 and 6 years of age	Tdap-Polio Vaccine
4th year of elementary school	Hepatitis B Vaccine (hepatitis A protection included) Human Papilloma Virus (HPV) Vaccine (for girls)
Between 14 and 16 years of age	Tdap Vaccine
From 60 years of age	Influenza Vaccine (in influenza season)
65 years of age	Pneumococcal Polysaccharide Vaccine

8.2.5.2 Immunization Material Handling and Storage

The protocol referring to the storage and handling of immunization-related products will be found in Appendix 10.

8.3 Environmental Health

8.3.1 Objectives of the programs

As presented in the FNIHB's Program Compendium 2011-2012.

8.3.1.1 Environmental Public Health Program (EPHP)

• Identify and prevent environmental public health risks that could affect the health of community residents.

• Recommend corrective action and health promotion that may be taken by community leaders and residents to reduce these risks.

8.3.1.2 Environmental Health Research Program (EHRP)

• Increase environmental health risk awareness and community capacity through community-based research and monitoring projects.

• Provide scientific information and knowledge to First Nations and Inuit communities as well as policy-makers, decision-makers and academia regarding human health and environmental linkages.

• Provide laboratory and statistical services for scientific research and monitoring on environmental health.

• Monitor and assess scientific developments in the field of environmental impact on human health at local, national and international levels.

8.3.2 Environmental Health & Safety (Emergency Preparedness Plan)

Responsible for delivery of the service: the Environment Health & Safety Technician, under the supervision of the Health and Social Services Director.

Locations for delivery: the services are planned in the centre but the technician, because of the nature of his activities, is often on the premises in order to gather samples or inspect facilities.

Services

Community-based water monitoring including sampling, quality control analysis and counter control; water plant operation; research (biologist) assistance; house inspection for mold, reporting and follow-up; other types of cooperation referring to the environment with the Housing Direction.

Other responsibilities: action plan for environment health, emergency preparedness plan updating and management for the Health Centre; links between health and other areas in the community: Housing services, Hunter's Point, Green Action Plan.

The following grid presents the summary of the EHT's tasks

Table 20: EHT's objectives and activities

OBJECTIVE	ACTIVITIES	POPULATION TARGETED	COLLABORATORS	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
Water plant monitoring	*Compagnonnage (192 hr 3 days a week over 8 to 9 weeks)*						
	Water plant operation : ozone system monitoring				*P5A certified water plant disinfection operator*		
Water quality monitoring	*Water quality sampling* *Coliform – E.coli – chlorine level measure*				*4 samples a week. Pump station and 3 random* *Quarterly 10 samples (himself – HC)*	*Quality control and quality insurance with HC* *No discrepancy in quarterly testing*	*HC report* *Ea V report*
	Monthly writing of an article related to water quality or other environmental issue						
Assist for researcher availability							
Mold detection	*Establish a*	*100 to 140 houses still*	*Housing officer of Band*	*Beginning*	*20 houses(estimated)*		

OBJECTIVE	ACTIVITIES	POPULATION TARGETED	COLLABORATORS	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
and treatment program. On request and systematic inspection starting with oldest houses	*control plan* *Inspection* *Report writing including recommendations* *Second testing for problem correction*	*owned by Band Council*	*Council*	*of 2013*	*a year for systematic inspection*		
Green Action Plan and annual clean-ups	*Information workshops (2) – sorting, domestic waste/recyclable*	*All community members*		*In spring time and fall before clean-up days*	*Number of workshops* *Number of participants*		*Activity reports* *Evaluation form* *Pictures of the event*
	Partnerships ?						
	Actual pick-up (spring and fall)		*Bearn EcoCentre*		*Number of households deserved*	*Number of truck loads sent to the EcoCentre* *Weighing if*	

OBJECTIVE	ACTIVITIES	POPULATION TARGETED	COLLABORATORS	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
						possible on site	
Emergency preparedness plan	*Approval by Band Council*		*Band Council*	*By end of 2012*			
	Contact with mentor in Kahnawà:ke to learn to define scenarios		*Mentor in Kahnawà:ke*				
	Workshop in Ottawa with the Public Safety Canada		*Public Safety Canada*	*2013*			
	Definition of a scenario – Priority scenarios: *fire & smoke* *ice storm power outage* *heavy rain – isolation*		*Band Council* *& related departments* *Kipawa municipality* *Témiscaming municipality and related services* *CSSS Témiscamingue*	*Once a year in January*			

OBJECTIVE	ACTIVITIES	POPULATION TARGETED	COLLABORATORS	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	chemical spillage & harmful fumes		*Pav. TK* *Quebec Public Safety Ministry*				
	Oral practice of the scenario			*Once a year*			
	Mock disaster practice			*2014*			

8.3.3 Emergency Preparedness Plan

An emergency preparedness plan is currently under definition with the partners. The EHT is coordinating the project for EVFN. The ongoing action plan is presented in Appendix 11.

8.3.4 Community Pandemic Influenza Plan

After evaluation of different types of existing templates, it is has been decided to establish a community pandemic influenza plan based on Health Canada's document entitled "Framework for a Community Pandemic Influenza Plan – Health Mission. Technical Sheets.

The plan should be completed by the end of September 2013.

8.4 Children's Oral Health Initiative (COHI)

Objectives

As described in the FNIHB's Program Compendium 2011-2012

• Reduce and prevent oral disease through prevention, education and oral health promotion.

• Increase access to oral health care

Responsible for delivery of the service: the dental hygienist under contract with Health Canada. She receives help from the CHN if needed.

Locations for delivery: Health Centre, Daycare Centre and school; occasionally at home.

Services

Four times a year the dental hygienist spends 3 to 4 days in the Témiscaming/Kipawa area to provide dental services to the children of the community from birth to 7 years old. Services include screenings, topical fluoride applications, placement of dental sealants, alternative restorative treatment, oral health information sessions and referrals to other dental care professionals for treatments beyond their scope of practice. It also provides information to their parents /caregivers and even expectant mothers to help children build and maintain healthy smiles from the start.

COHI reached out to children by providing:

- Dental check-up (oral screening)
- Fluoride applications to help prevent cavities
- Education and information regarding oral hygiene
- Sealants to prevent cavities.