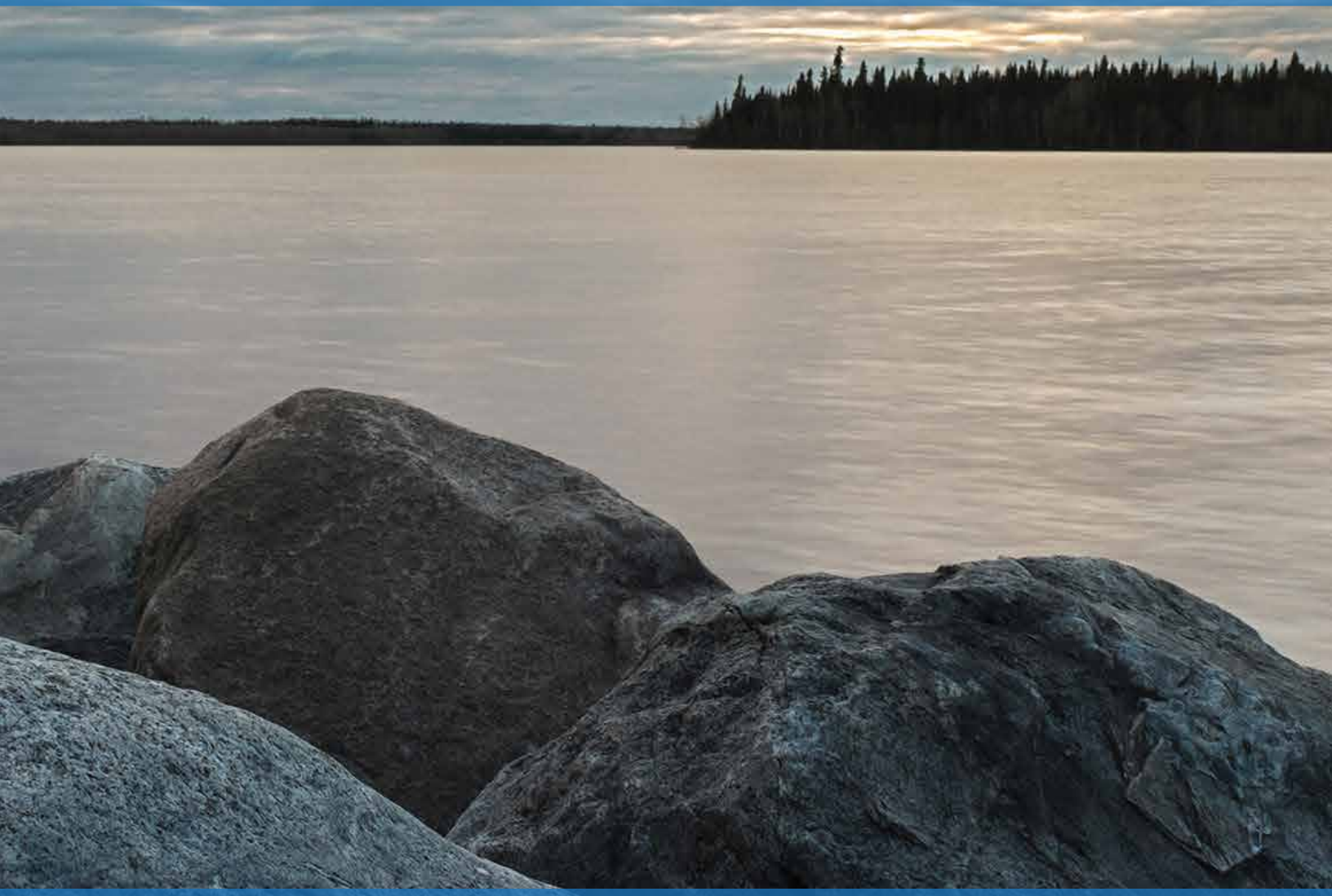
Sioux Lookout
First Nations
Health Authority



Annual Report 2013-2014

Photo of Nibinamik First Nation

ᒥᑲᐃᐧᐣᑕᑫᐃᐧᐣ - 2013/2014 ᑎᐸᒋᒧᐃᐧᐣ

ᐅᑭᒪᑲᐣ ᓄᕑᒪᐣ ᐱᕑᐊᐤᐣ

ᐊᐧᓇᓇᐊᐧᑲᐣᐠ ᑲᐱᒧᑐᐊᐧᐨ ᐊᓂᔑᓇᐯᐃᐧ ᐊᑯᓯᐃᐧ ᐃᐧᒋᐁᐧᐃᐧᐣ (SLFNHA) ᐅᒥᑲᐃᐧᐣᑕᐊᐧᐊᐧᐣ ᓄᑯᑦ ᑲᐊᐦᑭᐊᐧᐠ ᐃᒪ ᑕᓯ ᐊᐦᑭ ᑲᐃᔑ ᑎᐸᒋᒧᓇᓂᐊᐧᐠ ᐊᐁᐧ ᐅᑭᒪᑲᐣ ᓄᐧᕑᒪᐣ ᐱᕑᐊᐤᐣ.

ᑲᑭ ᐅᑭᒪᑲᓂᐸᐣ ᐃᒪ ᐊᐧᐱᑭᑲ ᒥᑲᐃᐧᓂᐣᑕᐊᐧᑲᓄ ᑲᑭ ᐃᔑ ᑭᒋ ᐊᓄᑭᐸᐣ ᐃᐁᐧᓂ ᐅᐣᒋ ᑭᒋᒪᒋᓴᐃᐧᐣ ᐊᐧᐃᐧᔭ ᑲᐅᑕᐱᓇᐣᐠ ᐅᐱᒪᑎᓯᐃᐧᐣ ᐃᒪ ᐃᐢᑯᓂᑲᓂᐣᐠ. ᓄᐧᕑᒪᐣ, 63, ᑭᐃᐢᑲᐧᐱᒪᑎᓯ ᐃᒪ ᑕᐣᑕᐯ ᑭᒋ ᐊᑯᓯᐃᐧᑲᒥᑯᐣᐠ ᐅᒋᒥᑭᔑᑲᐃᐧᐱᓯᑦ 9, 2014. ᐅᑭ ᐊᓄᑲᑕᐣ ᐅᑎᐢᑯᓂᑲᐣ ᐁᑭ ᐅᑭᒪᑲᓂᐃᐧᐨ 21 ᑕᓯᐊᐦᑭ ᒥᓇ ᐁᑭ ᐅᑭᒪᑲᓃᓯᐃᐧᐨ ᒥᓂᑯᐠ ᑲᑭ ᐊᓂ ᐃᐢᑲᐧ ᐱᒪᑎᓯᐨ.

ᓄᐧᕑᒪᐣ ᒥᔑᓂᔮᑭ ᒥᐢᑕᐦᐃ ᐅᑭ ᑭᒋ ᐃᐧᒋᑐᐣ ᒋᒥᓄᓭᓂᐠ ᑲᑭᒋᓃᐣᑕᑲᐧᓂᐠ ᐱᒪᑎᓯᐃᐧᓇᐣ ᐃᒪ ᐅᑕᔑᑫᐃᐧᓂᐠ. ᐅᑭ ᒪᑕᓄᑲᑕᓇᐸᐣ ᐊᔕ ᑲᒪᐢᑲᐃᐧᑲᐸᐃᐧᒪᑲᓂᐠ ᐅᓇᒋᑫᐃᐧᐣ ᑫᔑ ᐃᐧᒋᐦᐃᐣᑕᐧ ᑲᒪᒋᓭᓂᐠ ᐅᐱᒪᑎᓯᐃᐧᓂᐊᐧ ᑐᑲᐣ ᐊᐃᐧᔭ ᑲᐅᑕᐱᓇᐣᐠ ᐅᐱᒪᑎᓯᐃᐧᐣ, ᑕᓯ ᐊᐦᑭ ᑲᒪᒪᐃᐧᐡᑲᓂᐊᐧᐣᐠ ᐃᒪ ᐊᐧᐱᑭᑲ ᐊᔕ 20 ᑕᓯ ᐊᐦᑭ. ᐅᑭ ᐅᓇᑐᓇᐣ ᐅᓇᒋᑫᐃᐧᓇᐣ ᐃᒪ ᑭᑭᓄᐦᐊᑫᐃᐧᓂᐣᐠ, ᐅᐢᑭ ᒪᒋᑕᐃᐧᓇᐣ, ᐃᐢᑯᓂᑲᓂᐃᐧ ᐅᓇᑯᓂᑫᐃᐧᓇᐣ, ᐊᐦᑭᐃᐧ ᑫᑯᓇᐣ, ᑎᐯᓂᒥᑎᓯᐃᐧᓂᐣᐠ ᑫᐃᔑ ᐱᒍᓂᑎᓯᓂᐊᐧᐠ ᒥᓇ ᒥᐢᑕᐦᐃ ᑫᑯᓇᐣ ᑫᐅᐣᒋ ᐃᐧᒋᐦᐃᑯᐊᐧᐨ ᑫᔑ ᒥᓄᓭᓂᐠ ᐃᐡᑯᓂᑲᐣ ᑲᐊᓄᑲᑌᐠ.

ᐁᑭ ᑭᒋ ᑲᓄᒋᑫᑕᒪᑫᐨ ᒋᑲᓇᐁᐧᓂᒪᐨ ᐅᑕᓂᔑᓂᓂᒪᐣ ᒥᓇ ᐅᑕᐦᑭᒥᓂᐣ, ᓄᐧᕑᒪᐣ ᐱᕑᐊᐤᐣ ᐅᑭᒪᓯᓇᐦᐊᐣ ᑭᒋ ᐅᓇᒋᑫᐃᐧᐣ ᐃᒪ ᐅᐣᑌᕑᐃᔪ ᐃᐢᑯᓂᑲᓇᐣ ᓇᑯᒥᑐᐃᐧᓂᐣᐠ ᐃᐁᐧᓂ ᐅᐣᒋ ᐅᑕᔑᑫᐃᐧᐣ ᒣᑲᐧᐨ 2013 ᒥᓇ ᑫᐃᐧᐣ ᐃᒪ ᑭᐊᔭ ᑕᑯ ᑲᔦ ᓂᐃᐧᐣ ᐅᑭᒪᑲᓇᐠ ᑲᑭ ᑭᐱᑎᓇᒧᐊᐧᐨ ᒣᑲᐧᐨ 2005 ᐃᐁᐧᓂ ᐅᐣᒋ ᑲᓇᓇᐣᑕᐊᐧᓯᓂᐁᐧᐊᐧᐨ ᒥᓇ ᒥᑎᑯᑫᐃᐧᐣ ᐁᐧᑎ ᐊᐧᓴ ᑭᐁᐧᑎᓄᐣᐠ.

ᓄᐧᕑᒪᐣ ᑫᐃᐧᐣ ᐅᑭ ᐊᐱᑕᐣ ᐃᒪ ᑭᐁᐧᑎᓄᐣᐠ ᐊᓂᔑᓇᐯᐃᐧ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᑲᐅᓇᔕᐊᐧᑕᒧᐊᐧᐨ, ᑫᐃᐧᐣ ᑭᐊᔑᐣᑕᑭᓯ ᓂᑲᐣ ᐁᔮᓇᓂᐤ ᐃᐢᑯᓂᑲᓇᐣ ᑲᑭ ᒪᒋᑐᐊᐧᐨ ᐊᐧᓭᔭ ᐱᒍᒋᑫᐃᐧᐣ ᐁᑲᐧ ᒥᓇ ᐅᑭ ᓂᑲᓂᐡᑲᐣ ᐃᐁᐧ ᐱᒍᒋᑫᐃᐧᐣ ᐁᔮᓇᓂᐤ ᐊᐦᑭ ᐃᐁᐧᓂ ᔑᐳᑲᒪ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐊᐧᐨ ᐅᑭᒪᑲᓇᐠ.

ᑭᑲᓄᑫᒥᐣ ᑲᑭᐃᔑ ᒪᐡᑲᐊᐧᓂᐠ ᐅᓂᑲᓂᑕᒪᑫᐃᐧᐣ ᓂᑲᐣ ᐃᔑᓇᒧᐊᐧᓂᐣᐠ, ᒥᓇ ᑲᑭᐃᔑ ᐸᑭᑎᓂᑎᓯᐨ ᒥᔑᓄᐊᐦᑭ.

ᐱᕑᐊᐤᐣ ᐅᓇᑲᓇᐣ ᐅᐃᐧᒋᐊᐧᑲᓇᐣ ᑫᕑᐅ ᐱᕑᐊᐤᐣ, ᐅᓂᒐᓂᔕᐣ, ᒪᔪᐡ ᐱᕑᐊᐤᐣ, ᐱᕑᐃᓯᓫᐊ ᐸᐧᐠᐡᑎᕑ, ᐱᑕᕑ ᐱᕑᐊᐤᐣ, ᐱᕑᐁᐡᑕᐣ ᐸᐧᐠᐡ ᒥᓇ ᑕᔾᓫᐃᕑ ᓭᓇᐊᐧᑊ, ᒥᓇ ᒥᔑᐣ ᐅᑯᓯᔕᐣ ᒥᓇ ᐅᑕᓂᑯᐱᑕᑲᓇᐣ.

Dedicated to:

Chief Norman Brown

Sioux Lookout First Nations Health Authority dedicates this year's Annual Report to the late Chief Norman Brown.

The former Chief of Wapekeka First Nation is remembered for his tireless efforts to address the issue of suicide in First Nation communities. Norman, 63, died unexpectedly at the Thunder Bay Regional Health Sciences Centre on January 9, 2014. He served his community as Chief for 21 years and was Deputy Chief at the time of his passing.

Norman made many contributions over the years to improve the quality of life in his community. He began the successful Survivors of Suicide initiative, a yearly conference in Wapekeka for the last 20 years. He also lead many initiatives in education, entrepreneurship, First Nations policing, the environment, self-government and many other areas essential to First Nations success.

An advocate for the protection of his community members and their environment, Norman signed a milestone Ontario First Nation Policing Agreement for his community in 2013 and he was one of four Chiefs that declared a moratorium in 2005 on mining exploration and forestry in the far north.

Norman was also a board member for Northern Nishnawbe Education Council, was one of the founding members of the original eight communities that established the Wasaya Group and served as president of Shibogama First Nations Council for eight years.

We remember his strong leadership, insight, and dedication throughout the years. Norman is survived by his wife Carol, his children, Myles Brown, Priscilla Baxter, Peter Brown, Preston Fox and Tyler Sainnawap, and numerous grandchildren and great-grandchildren.

ᐧᐊᓂᓇᐧᐊᑲᐠ ᐊᓂᔑᓇᐯᐠ ᒪᐡᑭᑭᐧᐃᑭᒪᐧᐃᐣ

Sioux Lookout First Nations Health Authority

ᑲᓂᐱᑌᐱᐦᐃᑲᑌᑭᐣ ᐅᒪ ᑫᐊᓂᒍᒋᑲᑌᑭᐣ

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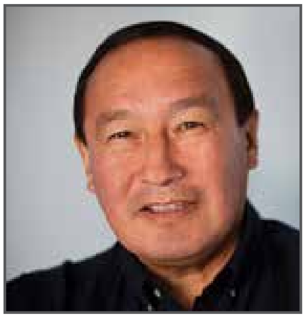
Financial statements are available from Sioux Lookout First Nations Health Authority on request.

Board of Directors



ᒍᐣ ᑲ'ᐱ', ᑲᐅᑎᑲᐧᓂᐡᑲᐠ
ᐊᐱᑕᒪᑫᐃᐧᐣ
ᑲᑎᐸᓂ ᑎᐯᓂᒥᑎᓱᐊᐧᓪ
ᐅᑭᒪᑲᓇᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᓪ
John Cutfeet
Board Chair

IFNA Representative

ᐅᑕᐱᑕᒪᑫᐠ

ᐅᑕᐱᑕᒪᑫᐠ ᐅᑐᐣᒋ ᐱᒥᐸᓂᑕᐧᓇᐊᐧ ᐊᐧᓇᓇᐊᐧᐣᑲᐣᐠ ᐊᓂᔑᓇᐯᐃᐧ ᒪᐢᑭᑭᐃᐧᑭᒪᐃᐧᐣ. ᐯᔑᑯᔕ' (11) ᐅᑕᐱᑕᒪᑫᐠ ᐊᔭᐊᐧᐠ, ᐃᒪ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐊᐧᓪ ᑲᔑ ᐸᐱᑭᔕᑭᓯᐊᐧᓪ ᐅᑭᒪᑲᓇᐠ, ᐃᐢᑯᓂᑲᓇᐣ ᑲᑎᐱᓇᐁᐧ ᐱᒧᓂᑎᓯᐊᐧᓪ, ᑭᒋᔭᐦᐊᐠ ᒥᓇ ᐃᒪ ᒪᐡᑭᑭᐃᐧᓂᓇᐣᐠ ᑲᐅᐣᒋ ᐊᓄᑭᑕᒪᑫᐊᐧᓪ. ᐅᑕᐱᑕᒪᑫᐠ ᐅᑐᓇᑐᓇᐊᐧ ᐊᓂᐣ ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᐣ ᐁᑲᐧ ᒥᓇ ᒋᐅᐣᒋ ᓇᓇᑲᒋᑐᐊᐧᓪ ᐃᐁᐧ ᐱᒥᐃᐧᒋᑫᐃᐧᐣ ᒋᐱᒥᓂᔕ"ᐃᑲᑌᐠ ᐁᑲᐧ ᒥᓇ ᐅᑕᐱᑕᒪᑫᐠ ᐅᑐᓇᑯᓂᑫᐃᐧᓃᓯᐊᐧ ᒋᐱᒥᓂᔕ"ᐃᑲᑌᑭᐣ. ᐃᐁᐧ ᐱᒎᒋᑫᐃᐧᐣ ᑲᑭ ᐅᓇᒋᑲᑌᐠ ᐃᐧᐣᒋᑫᒪᑲᐣ ᒥᓯᐁᐧ ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᐅᐁᐧ ᒪᒋᑕᐃᐧᐣ. ᐊᐁᐧ ᑕᐡ ᑲᐅᑭᒪᐃᐧᓪ ᐅᑕᐱᑕᒪᑫᐠ ᐅᑐᐣᒋ ᐅᓇᐡᐊᐧᓂᑯᐣ ᑫᒋᓇᐨ ᒋᐱᒥᓂᔕ"ᐃᑲᑌᐠ ᑭᒋ ᐅᓇᒋᑫᐃᐧᐣ ᒥᓇ ᒋᐃᓇᑭᓯᐨ ᐅᑲᓇᐁᐧᐣᑕᒪᑫ ᐃᑫᐧᓂᐊᐧᐠ ᐃᐧᒋ"ᐃᐁᐧᐃᐧᓇᐣ ᐃᒪ ᑲᐊᓄᑲᑌᑭᐣ.

The Board of Directors govern the Sioux Lookout First Nations Health Authority. There are eleven (11) board members, comprised of representation from Tribal Councils, Independent Bands, Elders, and the medical community. The board sets the Health Authority's directions and ensures these directions are implemented and board policies are followed. The strategic plan sets the overall direction for the organization. The Executive Director is accountable to the board for delivering the strategic plan for the stewardship of resources.

ᒍ ᑲᑭᑲᒥᐠ, ᐅᑕᐱᑕᒪᑫ
ᓂᐣᑲᐃᐧᓴᑲ"ᐃᑲᓂᐠ ᑲᐅᐣᒋ
ᑎᐯᐣᑕᑯᓯᐨ
Joe Kakegamic
Board Member

Sandy Lake
First Nation
Representative

ᐱᕝᑕ ᐸᐧᑐᕁ, ᐊᐱᑕᒪᑫᐃᐧ
ᐅᒪᓯᓇ"ᐃᑫᔑᐡ/
ᐅᑲᓇᐃᐧᔐᓂᔭᐁᐧ
ᐅᐱᔑᑯᑲᐠ ᐃᐡᑯᓂᑲᐣ ᑲᐅᐣᒋ
ᑎᐯᐣᑕᑯᓯᐨ
Bertha Bottle
Board Secretary/
Treasurer

Lac Seul First Nation
Representative

ᓴᐧᕓᒪᐣ ᒣᒣᑫᐧ, ᐅᑕᐱᑕᒪᑫ
ᔑᐸᐧᑲᒪ ᐅᑭᒪᑲᓇᐠ ᑲᐅᐣᒋ
ᑎᐯᐣᑕᑯᓯᐨ
Solomon Mamakwa
Board Member

Shibogama First
Nations Council
Representative

ᑕᐣ ᓱᐱᔭ, ᑲᐊᓂᑫᐡᑲᐊᐧᐨ
ᑲᐅᑎᑲᐧᓂᐡᑲᐠ ᐊᐱᑕᒪᑫᐃᐧᐣ
ᒪᑕᐊᐧ ᐅᑭᒪᑲᓇᐠ ᑲᐅᐣᒋ
ᑎᐯᐣᑕᑯᓯᐨ
Don Sofea
Board Member

Matawa First
Nations
Management
Representative

ᐃᓂᐡ ᓴᑭᒋᑲᐸᐤ, ᐅᑕᐱᑕᒪᑫ
ᐃᐧᐣᑎᑯ ᐅᑭᒪᑲᓇᐠ ᑲᐅᐣᒋ
ᑎᐯᐣᑕᑯᓯᐨ
Innes Sakchekapo
Board Member

Windigo First
Nations Council
Representative

ᐅᕝᐸ ᒪᑫᐣᓯ, ᐅᑕᐱᑕᒪᑫ
ᑭᐁᐧᑎᓄᐠ ᐅᑭᒪᑲᓇᐠ ᑲᐅᐣᒋ
ᑎᐯᐣᑕᑯᓯᐨ
Orpah McKenzie
Board Member

Keewaytinook
Okimakanak
Representative

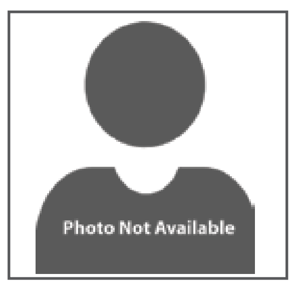
ᒣᕃᔭᐣ ᐸᓇᒋᐡ, ᐅᑕᐱᑕᒪᑫ
ᑲᑎᐯᓂᒥᑎᓱᒪᑲᐠ ᐃᐡᑯᓂᑲᐣ
ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐨ
Mary Ann
Panacheese
Board Member

Independent Band
Representative

ᑕᐧᒪᐢ ᐡᐯ', ᑭᒋᔭ"ᐊ

Thomas Spade

Board Elder



ᐁᒥᓫ ᒉᑲ', ᑭᒋᔭ"ᐊ

Emily Jacob

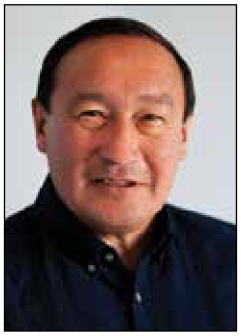
Board Elder

ᒪᐡᑭᑭᐃᐧᓂᓂ ᑌᕒ ᐸᕒᐊᕒ, ᐁᑲ
ᑲᐱᐣᒋᐁᐧᐱᓂᑫ ᐅᑕᐱᑕᒪᑫ
ᒪᐡᑭᑭᐃᐧᑭᓇᐣᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐨ
Dr. Terri Farrell
Medical
Representative

Non-Voting
Board Member

Photo of Eagle Lake First Nation, 32nd Annual Lake of the Eagles Traditional Pow-Wow in August 2014.

ᑲᐅᑎᑲᐧᓂᐡᑲᐠ ᐊᐱᑕᒪᑫᐃᐧᐣ ᐅᑎᐸᒋᒧᐃᐧᐣ



ᒍᐣ ᑲᐟᐱᐟ

John Cutfeet
Board Chair

ᐊᐧᓂᓇᐊᐧᑲᐠ ᐊᓂᔑᓇᐯᐠ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᐣ ᐊᓂᓂᑯ ᑭᐊᔦᔨᓴᐊᐧᐣ ᑫᑯᓇᐣ. ᐯᔑᑲᐧᔦᐠ ᓇᐱᐨ ᐁᑭ ᒪᒋᓴᐠ ᔕᑯᐨ ᒥᔑᐣᐊᐧᔦᐠ ᑭᐊᓂ ᒪᒦᓄᓴᐊᐧᐣ ᑲᐃᔑ ᓇᐣᑕᐁᐧᐣᑕᑲᐧᐠ ᒋᔑ ᒪᒍᒪᑲᑭᐣ.

ᐁᑲᐧ ᑕᐡ ᐁᑲᓇᐊᐧᐸᐣᒋᑲᑌᐠ ᑲᑭ ᐋᐧᓂᒥᓴᐠ ᓄᑯᑦ ᑲᑭ ᐊᐦᑭᐊᐧᐠ, ᓂᑭ ᐊᐧᐸᐣᑕᒥᐣ ᒥᐡᑕᐦᐃ ᐁᐦᐊᓂ ᑭᒋ ᐊᓂᒥᓴᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ. ᐁᑲᐧ ᐃᐁᐧ ᑭᒋᐊᓂᒥᓴᐃᐧᐣ ᑲᐃᑕᒪᐣᐠ ᑲᐊᐧᑲᐃᐧᓂᑫᒪᑲᐠ ᑕᔑᑫᐃᐧᓂᐠ ᑫᑯᐣ ᑲᐃᔦᓴᐠ ᒥᓇ ᑕᔑᑫᐃᐧᓇᐣ ᑲᓇᓇᐣᑐᑫᒧᐊᐧᐨ ᐃᐧᒋᐦᐃᑯᐃᐧᐣ ᒋᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ ᒋᑭ ᑲᑫᐧ ᒥᓄᓂᑲᑌᐠ ᐃᐁᐧ ᑲᔑ ᑭᒋᒪᒋᓴᐠ. ᐅᑕᓇᐣᐠ 20 ᐊᐦᑭᐃᐧᐣ ᐁᐃᓇᐱᓇᓂᐊᐧᐠ, ᐃᐁᐧ ᓄᑎᐣ CFI ᑲᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᑕᒧᐊᐧᐨ ᐅᑎᔑᓂᔕᐦᐊᐊᐧᐣ ᑲᑭᒋ ᐊᓂᒥᓴᓂᐠ ᑲᐊᐧᐃᐧᒋᑕᐧᐊᐧᐨ ᐃᒪ ᓇᐣᑕ 15-18 ᑕᔑᑫᐃᐧᓂᐣᐠ ᑲᔑ ᐊᒥᓂᓴᑭᐣ ᐃᒪ ᓈᑫ 32 ᑕᔑᑫᐃᐧᓇᐣ ᑲᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᑕᒪᐣᐠ. ᓄᑯᑦ ᑲᐊᐦᑭᐊᐧᐠ, ᐃᑫᐧᓂᐊᐧᐠ ᑲᐊᐧᐃᐧᒋᑕᐧᐊᐧᐨ ᑲᑭᒋ ᐊᓂᒥᓴᓂᐠ ᑭᐃᔕᐊᐧᐠ 26 ᑕᔑᑫᐃᐧᓂᐠ. ᐊᒥᑕᐡ ᐁᐃᔦᓴᐠ ᐊᐊᐧᔑᒣ 80% ᑭᑕᔑᑫᐃᐧᓂᓇᐣ ᐁᑭ ᑭᒋᒪᒋᓴᑭᐣ. ᓂᔑᐣ ᑕᔑᑫᐃᐧᓇᐣ ᑲᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᑕᒪᐣᐠ, ᒣᐡᑭᑲᐧᑲᒪᐣᐠ ᐃᐡᑯᓂᑲᐣ ᒥᓇ ᓈᐡᑲᐣᑕᑲ ᐃᐡᑯᓂᑲᐣ, ᐅᑭ ᐸᑭᑎᓇᓇᐊᐧᐨ ᐁᑭ ᐃᐣᑕᒧᐊᐧᐨ ᒪᐊᐧᐨ ᐁᑭᒋ ᐊᓂᒥᓴᐊᐧᐨ. ᐃᑫᐧᓂᐊᐧᐣ ᑕᐡ 26 ᑕᔑᑫᐃᐧᓇᐣ ᑲᑭ ᐃᔑᓂᔕᐦᐊᐧᔭᐣᐠ ᑲᐊᐧᐃᐧᒋᑕᐧᐊᐧᐨ ᒣᑲᐧᐨ ᑲᑭᒋ ᐊᓂᒥᓴᓂᐠ, ᐊᓂᐣᑕ ᑭᓇᐣᑕᐁᐧᐣᑕᑲᐧᓄᐣ ᒥᓇᐊᐧ ᒋᓇᔦᑲᐊᐧᑲᓄᐊᐧᐨ.

ᐊᒥᑕᐡ ᑫᐃᑭᑐᔭᐣᐠ ᐃᐁᐧ 2013-2014 ᒪᐊᐧᐨ ᐁᑭ ᐊᓂᒪᑭᐣ ᑕᔑᑫᐃᐧᐣ ᐅᒪ ᑭᓇᐃᐧᐣᐟ ᑲᐃᔑ ᑲᐯᔑᔭᐣᐠ. ᐊᒥᐱᑯ ᐁᔑ ᐱᒥ ᐊᒥᓂᓴᔭᐣᐠ ᐁᐣᑕᔦᑭᔑᑲ, ᒥᔑᐣᐊᐧᔦᐠ ᐁᔑ ᐊᑯᔦᒪᑲᑭᐣ ᑭᐱᒪᑎᓯᐃᐧᓇᐣ ᐃᒪ ᑭᑲᐯᔑᐃᐧᓇᐣ. ᐃᐁᐧ ᒥᓂᑫᐧᐃᐧᐣ ᓇᐣᑕ ᒥᓇ ᒪᒋᒪᐡᑭᑭᑫᐃᐧᐣ, ᑎᐯᐣᒋᑫᐃᐧᓂᐠ ᑲᒥᑲᑎᓇᓂᐊᐧᐠ, ᑲᑭᒋ ᐧᑲᐊᐧᐱᓈᓇᓂᐊᐧᐠ, ᓇᐣᑕ ᒥᓇ ᑲᔦ ᐁᑲ ᑲᑕᑲᐧᑭᐣ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᓇᐣ ᑕᔑᑫᐃᐧᓂᐠ ᑫᑭ ᐃᐧᒋᐦᐁᐃᐧᒪᑲᑲᐧᐸᐣ, ᐃᑫᐧᓂᐊᐧᐣ ᑕᐡ ᑲᑭᓇ ᑲᔑ ᐸᐯᔑᑲᐧᑭᐣ ᑕᔑᑫᐃᐧᓂᓇᐣ ᐅᒪ ᑲᔑᑕᔭᐠ ᑫᑲᑎᑯ ᐸᐯᔑᑲᐧᐣ ᐃᔑᓇᑲᐧᓄᐣ ᑲᔭᓂᒥᐦᐃᑯᐊᐧᐨ. ᐁᑲᐧ ᐃᐦᐃᐁᐧ ᑲᐊᓂ ᐱᒥ ᓇᓇᐣᑭᓴᐠ ᑭᒋᒪᒋᓴᐃᐧ ᐃᐧᒋᐦᐁᐃᐧᐃᐧᐣ ᐅᑕᓇᐣᐠ ᑲᐱᒥ ᐊᐦᑭᐊᐧᐠ ᐃᔑ ᓂᔦᑕᐃᐧᓇᑲᐧᐣ ᑭᔭᐸᐨ ᐱᑯ ᐁᐱᒥᐡᑲᒪᑲᑭᐣ ᐅᑫᐧᓂᐊᐧᐣ ᒪᒋᓴᐃᐧᓇᐣ. ᐅᐁᐧ ᑕᐡ ᓂᑎᔑ ᒥᐦᑲᐤ ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑲᑌᑭᐸᐣ ᑲᐃᔑᓂᑲᑌᐠ *ᓂᔭᑎᓯᐃᐧᐣ & ᑲᐱᒥᐡᑲᒪᑲᐠ ᑲᐊᓂᒥᐦᐁᐧᒪᑲᐠ ᑲᓂᔑᐧᑭᓴᐠ ᐃᓇᑲᓈᔭᐃᐧᐣ ᐃᒪ ᐊᓂᔑᓇᐯᑲᐣᐠ ᐃᓇᑫ*, ᒪᐃᑯ ᔕᐣᑎᐢ ᑭᒋ ᑭᑭᓄᐊᒪᑫᐃᐧᑲᒥᐠ ᐱᐢᐃᑎᐡ ᑲᐢᐊᑦᐱᔭ ᒥᓇ ᑲᐅᐣᒋ ᐃᐧᑕᓄᑭᒪᐨ ᐊᒥᐦᐃ ᑲᑭᔑ ᒥᑭᑫᐊᐧᐨ ᑭᐡᐱᐣ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓇᐣ ᑲᑲᐧᑫ ᐱᒧᓂᑎᓯᐊᐧᐨ, ᒥᔕ ᑌᐯᐧ ᐁᑲ ᓇᐱᐨ ᐁᐃᐡᐸᐠ ᑲᐊᐧᐅᑕᐱᓇᒧᐊᐧᐨ ᐅᐱᒪᑎᓯᐃᐧᓂᐊᐧ.

ᐃᐁᐧᓂ ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᐠ ᐊᓈᔑᐡᑲᑫᐧᐣ ᓂᔭᑎᓯᐃᐧᐣ ᐁᑲᐧ ᒥᓇ ᑲᔦ ᐊᓈᔑᓇᑲᐧᐠ ᐊᓂᔑᓇᐯ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓇᐣ. ᓂᑕᑦ ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᐠ, ᐣᑯᑕᐧᔭ ᑫᑯᓇᐣ ᐅᑭᔑ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᓇᐣ: ᐊᓂᔑᓇᐯ ᑲᑲᑫᐧ ᐯᔑᑯᐱᒧᓂᑎᔭᐨ, ᐊᑭ ᑲᑭᐯᐣᒋᑲᑌᑭᐣ, ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ, ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐃᐧᐃᐧᐣ, ᐊᓂᔑᓇᐯ ᐃᐧᒋᐦᐁᐃᐧᐃᐧᑲᒥᑯᐣ ᒥᓇ ᔑᒪᑲᓂᐡ/ ᐃᐡᑯᑌᐃᐧ ᐃᐧᒋᐦᐁᐃᐧᐃᐧᐣ. ᐁᑲᐧ ᑕᐡ ᒥᓇᐊᐧ ᐁᑭ ᒪᔭᓇᐦᐊᐣᐠ, ᓂᔑᐣ ᑫᑯᓇᐣ ᐅᑭ ᐅᐣᒋ ᓇᐣᑲᔭᓇᐦᐊᓇᐣ: ᐃᑫᐧᐊᐧᐠ ᑲᐅᑭᒪᐊᐧᑭᔭᐊᐧᐨ ᒥᓇ ᐊᐊᐧᔑᔕᐠ ᑲᑲᓇᐁᐧᐣᑕᑯᔭᐊᐧᐨ.

ᒥᑕᐡ ᑲᔦ ᑲᑭᔑ ᒥᑭᑫᐨ ᐃᑫᐧᓂᐊᐧᐣ ᑕᔑᑫᐃᐧᓇᐣ ᐁᑲ ᑲᑕᑲᐧᑭᐣ ᐊᓂᔑᓇᐯ ᐃᐧᒋᐦᐁᐃᐧᐃᐧᓇᐣ, ᒪᐊᐧᐨ ᐃᐡᐸ ᓂᔭᑎᓯᐃᐧᐣ. ᒥᐃᐧᓂᑯ ᐁᐃᔑᓇᑲᐧᐠ, ᐃᑫᐧᓂᐊᐧᐣ ᑕᔑᑫᐃᐧᓇᐣ ᑲᑕᑲᐧᑭᐣ ᐃᑫᐧᓂᐊᐧᐠ ᐃᐡᐱᒥᐣᐠ ᑲᑭ ᒪᔭᓇᐦᐊᒪᐣ, ᑲᐃᐧᐣ ᓇᐱᐨ ᒋᐊᔭᒪᑲᐠ ᓂᔭᑎᓯᐃᐧᐣ ᓇᐣᑕ ᑲᔦ ᑲᐃᐧᐣ ᓂᔭᑎᓯᐃᐧᐣ ᒋᐊᔭᒪᑲᐠ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ.

ᒪᐊᐧᐨ ᑕᐡ ᑭᒋᓈᐣᑕᑲᐧᐣ ᐅᐁᐧ ᐃᐧᐣᑕᒪᑫᐃᐧᐣ ᒋᑭ ᑭᑫᐣᑕᒧᐊᐧᐸᐣ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓇᐣ ᒋᑭ ᐊᐸᒋᑐᐊᐧᐸᐣ ᓂᑲᐣ ᐊᓂ ᐅᓇᒋᑫᐊᐧᐨ. ᑲᐃᐧᐣ ᓂᓇᐃᐧᐣᐟ ᐣᑲᑭ ᐃᐧᐣᑕᒪᐊᐧᔦᒥᐣ ᐅᓂᑲᓂᑕᒪᑫᐠ ᐊᓂᐣ ᑫᔑ ᐱᒧᑐᐊᐧᐨ ᐅᑕᔑᑫᐃᐧᓂᐊᐧ, ᐊᒥᑕᐡ ᐁᐃᔦᓴᐠ ᒋᒥᓇᔭᐣᐠ ᐃᐧᐣᑕᒪᑫᐃᐧᐣ ᑭᐡᐱᐣ ᐃᐧᐊᐧᐸᒋᑐᐊᐧᐨ ᑭᐡᐱᐣ ᑕᐡ ᐁᑕ ᑲᔦ ᐃᓈᐣᑕᒧᐊᐧᐨ. ᓇᐣᑕ ᑫᒋᐣ ᑕᐃᔦᓴᐸᐣ ᐅᐁᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᒋᐊᐧᐸᐣᑕᐦᐁᐃᐧᒪᑲᐠ ᐃᐁᐧ ᑲᑲᑫᐧ ᐯᔑᑯᐱᒧᓂᑎᔭᓇᓂᐊᐧᐠ ᒥᓇ ᒋᒥᓄᔭᒪᑲᐠ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐃᐧᐃᐧᐣ ᒥᐡᑕᐦᐃ ᑫᒋᐣ ᑕᐅᐣᒋ ᐃᐧᒋᐦᐃᒪᑲᐣ ᑕᔑᑫᐃᐧᐣ ᐁᑲ ᑲᒥᓄᐡᑲᒪᑲᐠ, ᑕᑯ ᑲᔦ ᒋᑲᑫᐧ ᒥᓄᓂᑲᑌᑭᐸᐣ ᐱᒪᑎᓯᐃᐧᓇᐣ ᒥᓇ ᑲᔦ ᒋᐅᐣᒋ ᑕᐸᔦᓴᐠ ᑲᐊᐧᐅᑕᐱᓇᒧᐊᐧᐨ ᐅᐱᒪᑎᓯᐃᐧᓂᐊᐧ.

ᓂᐸᑯᓴᓂᒧᒥᐣ ᒋᑭ ᐊᐧᐸᐣᑕᒪᑭᐸᐣ ᑫᒥᓂᑐᒋᑫᒪᑲᑭᐣ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᒥᓇ ᐅᒪ ᓂᐱᒧᒋᑫᐃᐧᓂᓇᐣ, ᑕᔦᐊᐦᑭ ᐊᐧᓂᓇᐊᐧᑲᐠ ᐊᓂᔑᓇᐯᐠ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᐣ ᒥᓇ ᐅᑭᒪᑲᓇᐠ ᑲᐊᐱᑕᒧᐊᐧᐨ ᒪᐡᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ (CCOH) ᐅᐸᑭᑎᓇᓇᐊᐧ ᐁᐃᐧᒋᑲᐸᐃᐧᑕᐊᐧᐊᐧᐨ ᐊᓂᔑᓇᐯᐠ ᑲᐃᐡᑯᓄᐃᐧᐣᑕᒧᐊᐧᐨ ᑲᐃᐡᐸᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ. ᑕᔦᐊᐦᑭ, ᐊᓂ ᐱᒥ ᓇᐣᑭᓄᐊᐧᐠ ᐁᑲᐧ ᓂᑕᓂ ᐊᐧᐸᐣᑕᒥᐣ ᒥᔑᐣ ᐅᐡᑲᑎᓴᐠ ᐁᐦᐊᓂ ᑭᔑᐡᑯᓄᐊᐧᐨ ᐦᔭᐡᑯᐢ ᒥᓇ ᑲᐧᐢᐃᐨ ᒥᓇ ᐧᔪᓂᐱᐢᔨᑎ ᐊᐦᐊᓂ ᐃᐡᑯᓄᐃᐧᐣᑕᒧᐊᐧᐨ. ᑕᔦᐊᐦᑭ (CCOH) ᐅᐸᑭᑎᓇᓇᐊᐧ $15,000 ᑲᐃᐧᒋᑲᐸᐃᐧᑕᒧᐊᐧᐨ ᐅᐁᐧᓂ. ᓄᑯᑦ ᑲᐊᐦᑭᐊᐧᐠ, (CCOH) ᐅᑭ ᐸᑭᑎᓇᓇᐊᐧ $30,000 ᑲᐃᐧᒋᑲᐸᐃᐧᑕᒧᐊᐧᐨ ᐅᐁᐧᓂ ᐁᐦᐊᓂ ᒥᔑᓄᐊᐧᐨ ᑲᑭᑭᓄᐦᐊᒪᑯᔭᐊᐧᐨ! ᓂᐊᐧᐸᐣᑕᒥᐣ ᐁᐦᐊᓂ ᒥᔑᓄᐊᐧᐨ ᐊᓂᔑᓇᐯ ᐅᐡᑲᑎᓴᐠ ᐁᐦᐊᓂ ᓇᑯᔭᐊᐧᐨ ᒪᐡᑭᑭᐃᐧᓂᓇᐣᐠ ᐃᓈᑫ ᐁᔑ ᑭᑭᓄᐦᐊᒪᑯᔭᐊᐧᐨ.

ᐅᑲᐧ ᐅᒪ ᐱᒧᒋᑫᐃᐧᓂᐠ, ᓂᐃᐧ ᐊᓂ ᒪᒋᐃᐧᑐᒥᐣ SLFNHA ᑭᔭᐸᐨ ᓇᐊᐧᐨ ᒋᑭ ᐊᓂ ᐃᐡᐱᐡᑲᒪᑲᑭᐸᐣ ᓂᐱᒧᒋᑫᐃᐧᓂᓇᐣ. ᐊᒥ ᑲᐃᐧᑐᑕᒪᐣᐠ ᐁᐃᐧ ᐅᓇᑐᔭᐣᐠ ᐊᐱᑕᒪᑫᐃᐧᐣ ᒋᐃᔑᓇᑲᐧᐠ ᐃᑫᐧᓂᐊᐧᐠ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ

ᐊᐊᐧᔑᒣ ᑭᑭ ᐱᒥᐸᓂᑕᐧᐊᐧᐸᐣ ᐅᐁᐧ ᐱᒍᒋᑫᐃᐧᐣ ᒋᒪᒪᐊᐧᓅᑲᑌᐠ. ᓂᐸᑯᓭᓂᒧᒥᐣ ᐅᐁᐧ ᑲᐃᐧ ᑐᑕᒪᐣᐠ ᐃᒪ ᑲᓇᓇᑲᒋᑐᔭᐣᐠ ᑲᔑ ᐱᒍᒋᑲᑌᐠ ᐅᐁᐧ ᐱᒍᒋᑫᐃᐧᐣ ᐊᔕ ᑲᐱᒥ ᓇᓇᑲᒋᑐᔭᐣᐠ ᐅᑕᓇᐣᐠ ᑲᑭ ᐊᐦᑭᐊᐧᐠ.

ᐅᐁᐧ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ, ᑯᑕᑭᔭᐠ ᑲᑭ ᐅᓇᓇᑲᒋᑐᐊᐧᐨ, ᑕᐱᑕ ᑲᔑ ᑲᓇᐊᐧᐸᐣᒋᑫᐊᐧᐨ, ᐅᑭ ᓇᓇᑲᒋᑐᓇᐊᐧ ᐊᓂᐣ ᐅᑕᐱᑕᒪᑫᐠ ᑫᑭᑐᑕᒧᐊᐧᐸᐣ ᑭᔭᐸᐨ ᑲᔑ ᐱᒍᒋᑲᑌᐠ ᐱᒍᒋᑫᐃᐧᐣ. ᐁᑲᐧ ᐃᐦᐃᐁᐧ ᐯᔑᐠ ᑫᑯᐣ ᑲᐅᐣᒋ ᑐᑕᒪᐣᐠ ᐃᐁᐧ ᑲᔑ ᐅᐸᐸᒥᓯᑲᐣᑕᒧᐊᐧᐨ ᐅᑕᐱᑕᒪᑫᐠ ᐃᒪ ᑕᔑᑫᐃᐧᓇᐣ ᑲᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᑕᒪᐣᐠ. ᐅᐁᐧ ᑕᐡ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ, ᐅᑕᐱᑕᒪᑫᐠ ᐅᑭ ᐅᓇᑐᓇᐊᐧ ᑫᐊᐱᑕᒧᐊᐧᐨ ᐱᒍᒋᑫᐃᐧ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ. ᐅᐁᐧ ᐊᐱᑕᒪᑫᐃᐧᐣ ᓂᓯᐣ ᑲᓂᑲᓂᐡᑲᒧᐊᐧᐨ ᒪᐡᑭᑭᐃᐧ ᐱᒍᒋᑫᐃᐧᓂᐠ ᒥᓇ ᓂᔑᐣ ᐊᐃᐧᔭᐠ ᑲᑭ ᐅᓇᐸᒪᐨ ᐊᐁᐧ ᑲᐅᑎᑲᐧᓂᐡᑲᐠ ᐊᐱᑕᒪᑫᐃᐧᐣ. ᐃᐁᐧ ᑕᐡ ᐊᐱᑕᒪᑫᐃᐧᐣ ᐊᒥᐦᐃ ᐁᐃᓇᓄᑭᒪᑲᐠ ᐊᐦᐊᓂ ᐃᐧᐣᑕᒪᐊᐧᐨ ᑲᐊᐱᑕᒪᑫᓂᐨ ᑲᑭᓇ ᑲᐃᔑᓭᓂᐠ ᐱᒍᒋᑫᐃᐧᓂᐠ, ᑕᑯ ᑲᔦ ᐅᑫᐧᓂᐊᐧᐣ ᑲᐃᐧᐣ ᑲᔦ ᐁᐦᑕ ᐅᓄ:

- ᑫᔑ ᐱᒍᑐᐊᐧᐨ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ ᑲᐅᑭᒪᐊᐧᑭᓯᐊᐧᐨ ᒥᓇ ᑲᐅᑭᒪᐃᐧᐊᐧᐨ ᐅᒪ ᐱᒍᒋᑫᐃᐧᓂᐠ
- ᑫᔑ ᑲᓇᐊᐧᐸᐣᑕᒧᐊᐧᐨ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ ᐃᒪ ᑲᐅᐣᒋ ᐊᔑᑕᑭᒥᐣᑕᐧ ᐱᒍᒋᑫᐃᐧᓂᐠ
- ᐊᓂᐣ ᑫᔑ ᐱᒍᑐᐊᐧᐨ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ ᐅᓇᑐᐊᐧᐨ ᐅᓇᑯᓂᑫᐃᐧᓀᓭᐣ ᒥᓇ ᐱᒥ ᓇᓇᑲᒋᑐᐊᐧᐨ ᐊᓂᐣ ᑫᔑ ᒪᒋᐡᑲᓂᐊᐧᐠ ᐅᓇᒋᑫᐃᐧᓂᐣᐠ ᐅᒪ ᐱᒍᒋᑫᐃᐧᓂᐠ ᒥᓇ ᐊᓂᐣ ᐁᐃᓇᓄᑭᒪᑲᐠ ᐅᐁᐧ ᐱᒍᒋᑫᐃᐧᐣ ᒥᓇ ᑲᔦ ᐊᓀᔑ ᐃᐧᒋᐦᐃᐁᐧᒪᑲᐠ

ᐁᑲᐧ ᑕᐡ ᐃᐁᐧ ᐁᓇᓇᑲᒋᑐᔭᐠ ᐊᐱᑕᒪᑫᐃᐧᑭᒪᐃᐧᐣ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ, ᐅᑫᐧᓂᐊᐧᐠ ᒣᑲᐧᐨ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ ᐊᓂ ᐅᓀᓇᐊᐧᐠ ᐊᓀᔑᓇᑲᐧᓂᓂᐠ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ. ᐃᐁᐧ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ ᐊᒥᐦᐃ ᑫᔑ ᐅᓇᐸᒪᐊᐧᐨ ᐊᓀᔑ ᐅᑲᐡᑭᐦᐅᐃᐧᓂᐣᐨ, ᑐᑲᐣ ᐅᑭᑫᐣᑕᒪᐃᐧᓂᓂᐨ ᐃᒪ ᒪᐡᑭᑭᐃᐧ ᐱᒍᒋᑫᐃᐧᐣ ᑲᐃᓯᐡᑲᒪᑲᐠ ᒥᓇ ᐅᑭᑫᐣᑕᒪᐃᐧᓂᐊᐧᐨ ᐅᓇᑯᓂᑫᐃᐧᐣ ᑲᐃᓯᓭᐠ, ᐱᒍᒋᑫᐃᐧᐣ, ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ, ᔐᓂᔭᐃᐧᐱᒍᒋᑫᐃᐧᐣ, ᓂᑲᓂᑕᒪᑫᐃᐧᐣ, ᑯᑕᑭᔭᐣ ᑫᑯᓇᐣ. ᐅᐁᐧ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ ᐊᒥᐦᐃ ᑲᔦ ᑫᔑ ᓇᓇᑲᒋᑐᐨ ᒋᐅᓇᑐᐊᐧᐨ ᔐᓂᔭᐃᐧ ᐱᒍᒋᑫᐃᐧᐣ, ᒪᒪᐊᐧᑭᐣᒋᑫᐃᐧᐣ & ᑫᔑ ᑲᓇᐊᐧᐸᐣᒋᑲᑌᐠ ᑲᓇᓀᓴᓂᓭᐠ ᐱᒍᒋᑫᐃᐧᐣ ᐊᐱᑕᒪᑫᐃᐧᐣ, ᐃᐁᐧ ᑲᐃᑭᑐᒪᑲᐠ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ ᒥᐱᑯ ᑫᔑ ᐱᒥ ᓇᓇᑲᒋᑐᐊᐧᐨ ᒥᓇ ᐅᓇᒋᑫᐃᐧᓂᐠ ᐃᒪ SLFNHA ᔐᓂᔭᐃᐧ ᐱᒍᒋᑫᐃᐧᓂᐠ.

ᐊᒥ ᐁᐃᑭᑐᒪᑲᐠ ᐅᑫᐧᓂᐊᐧᐣ ᑲᑭᓇ ᐅᑕᐱᑕᒪᑫᐠ ᒥᓇ SLFNHA ᐊᐊᐧᔑᒣ ᒋᐊᐧᑲᐃᐧᐊᐧᐨ ᑫᔑ ᓇᐣᑕᐁᐧᐣᑕᒧᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑲᐯᔑᐊᐧᐨ ᑲᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᑕᒪᑭᐣ ᒥᓇ ᑲᔦ ᐅᑫᐧᓂᐊᐧᐣ ᑲᑭᓇ ᑲᐱᒥᑐᔭᐣᐠ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒋᒥᓄᓭᐦᐃᐁᐧᒪᑲᑭᐣ.

ᐁᑲᐧ ᐊᔕ ᐁᐊᓂ ᑭᔑᑐᔭᐣᐠ ᓂᑎᐸᒋᒧᐃᐧᐣ, ᒥᐱᑯ ᐁᐃᐧ ᐃᓀᐣᑕᒪᐣ ᑕᓯᐊᐦᑭ, ᒥᓭᐊᐧᐨ ᑲᐱᒥ ᐊᓂᒥᓭᑭᐣ ᑭᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᑯᐃᐧᓂᓇᐣ ᑭᓇᐃᐧᐣ′ ᑲᐊᓂᔑᓇᐯᐃᐧᔭᐠ, ᐱᑯ ᐁᐃᔑᓇᑲᐧᐠ ᐃᒪ ᐁᐦᐊᓂᔑ ᐱᒋᓂᐡᑲᔭᐠ ᑲᐃᑭᑐᒪᑲᐠ ᐃᐁᐧ ᑭᑎᔑᓇᒧᐃᐧᓂᓇᐣ:

ᑲᐱᑐᒥᐣ ᐃᐁᐧ ᑎᐸᐦᐃᑲᐣ ᐊᐱ ᑭᑕᔑᑫᐃᐧᓂᓇᐣ ᐊᓂ ᒥᔑᓄᐊᐧᐨ ᐊᓂᔑᓇᐯᐠ ᑲᒥᓄᔭᒪᑲᓂᐠ ᐅᐱᒪᑎᓯᐃᐧᓂᐊᐧ, ᐊᐱ ᑎᐯᐣᒋᑫᐃᐧᓇᐣ ᒥᓇ ᑕᔑᑫᐃᐧᓇᐣ ᐃᐧᒋᑲᐸᐃᐧᑕᑎᒪᑲᑭᐣ ᒥᓇ ᒋᐅᐣᒋ ᑭᑭᓄᐡᑲᒪᑫᐊᐧᐨ ᒋᓇᑲᐧᓂᐠ ᐁᒥᓄᔭᒪᑲᓂᐠ ᐅᐱᒪᑎᓯᐃᐧᓂᐊᐧ, ᐊᐱ ᑲᑭᓇ ᑲᑭᐡᐦᐅᐊᐧᐨ ᐊᓂᔑᓇᐯᐠ ᒋᐊᓂ ᐊᓄᑭᐊᐧᐨ, ᐊᐱ ᑲᑭᓇ ᐊᓂ ᒥᓄᑌᐱᓭᐊᐧᐨ ᑲᐯᔑᐃᐧᓇᐣ ᒥᓇ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᐯᔭᑭᓇᑲᐧᐠ ᒥᓇ ᑲᐧᔭᐠ ᐃᒪ ᒋᑕᔑ ᐱᒪᑎᓯᐊᐧᐨ ᐊᐃᐧᔭᐠ ᑕᔑᑫᐃᐧᓂᐠ.

ᒥᐦᐅᒪ ᑫᔑ ᐱᒍᓭᔭᐠ SLFNHA ᐱᒪᓄᑭᐊᐧᐨ ᐃᒪ ᑲᐃᔑᐱᐦᐃᑲᑌᐠ ᐅᐁᐧ ᐃᔑᓇᒧᐃᐧᐣ.

Message from the Chair of the Board

ᒐᓐ ᑲᐢᐱᐢ

John Cutfeet
Board Chair

Sioux Lookout First Nations Health Authority has had an interesting year. One filled with lows, but also a lot of positive growth in the right direction.

In looking at the hard times this year, we saw a startling increase in crises in our communities. We define a crisis as a negative event that affects a community and in which the community finds it necessary to request help to mobilize and stabilize.

Looking back at the last 20 years, the Nodin CFI department sends crisis workers into 15-18 of the 32 communities we serve. This year, we had crisis workers in 26 communities. This means that more than 80% of our communities reported crisis situations. Two of the communities we serve, Mishkeegogamang First Nation and Neskantaga First Nation, declared a state of emergency. Of the 26 communities we sent crisis workers into, several required more than one visit.

It is safe to say that 2013-2014 was a year where we saw the continuing struggles in the communities in our region. We continue, on a daily basis, to struggle with many health issues in our homes. Whether it's alcohol or prescription drug abuse, family violence, the rise of diabetes, or lack of community-based programs and services, each community in our region has distinct yet similar struggles. And the increase in crisis response this past year shows that these plights continue.

This makes me think of a study called Suicide & the Persistence of Identity in the Face of Reduced Cultural Change, in which Michael Chandler from the University of British Columbia and his colleagues detailed findings that seem to indicate that the more control First Nations communities have over their destinies, the less suicides there are.

He studied the relationship between suicide rates and measures of cultural reconstruction. In the first study, he looked at six cultural factors: self-government, land claims, education, health, cultural facilities and police/fire. In a subsequent update of his study, he added two more factors: women in government and child protection services.

He found that in those communities that had none of those cultural factors, the suicides were extremely high. Conversely, in those communities who had all those factors, there were few or no suicides at all.

This is important information for First Nation communities to know for future planning. We cannot tell leadership how they should run their communities, we can only give them the information for them to use if they choose. Perhaps this study can demonstrate though that moving towards self-governance and improved health services will benefit many facets of community health, including raising the quality of life and directly lowering the rates of suicide.

As we look forward to the positive things happening in the communities and our organization, every year SLFNHA and the Chiefs Committee on Health (CCOH) offer bursaries to First Nation students pursuing post-secondary education. Each year, the list grows and we see more and more young people graduating high school and pursuing college or university. Each year, CCOH puts $15,000 towards these bursaries. This year, CCOH put $30,000 towards the bursaries as the list has grown so much! We see more and more young, strong, and intelligent First Nation people stepping forward as role models in careers in health care.

In terms of the organization, we want to move SLFNHA up another level. We're looking at reorganizing the Board in such a way that the Board members will become more active in the running of the organization through Committee work. We hope to achieve this through a governance review that we have been undergoing this past year.

This review, conducted by an outside, unbiased firm, looked at ways the Board can improve how the organization is run. One of the reasons behind this is to ensure the Board's accountability to the First Nation communities we serve. With the review, the Board also assembled a Governance Review Committee. This Committee is compiled of three Directors and two other individuals selected by the Chair. The Committee advises the Board of all corporate governance issues, including but not limited to:

- Respective roles of management and governance
- Accountability of Board to stakeholders
- Role of Board in forming policies and monitoring strategic direction of the organization and program quality and effectiveness

When we look at the board governance review, the current board members are selected based on representation. The review will look at selecting members based on skill sets, such as experience in health and expertise in law, business, communications, finances, management, etc. The review also looks at setting up a Finance, Audit & Risk Management Committee, which means the board will continue to play an increased role in monitoring and planning SLFNHA's finances.

All of this means that the Board and SLFNHA will be more responsive to the needs of the community members we serve and ensure our programs and departments are delivering the best health care services.

As I wrap up this report, I can't help but think that each year, despite the ongoing health issues we face as First Nations, we are moving in a direction defined by our Vision:

We look forward to a time when our communities are filled with First Nations' people who are glowing with health, when families and communities support each other and are models of positive health status, when all able bodied people are employed, when there are sufficient quality homes for all and when the environment in each community is clean and safe for all people.

We stay on this path as SLFNHA continuously works toward this vision.

Photo taken in Sioux Lookout, Ontario

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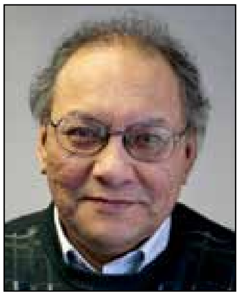

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James Morris
Executive Director

ᒥᑐᓂ ᓂᑭ ᑭᒋ ᔭᔭᓄᑭᒥᐣ ᐅᒪ ᐊᐧᓂᓇᐊᐧᑲᐠ ᐊᓂᔑᓇᐯᐠ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᐣ (SLFNHA). ᒥᔑᐣ ᒥᓄᑫᑯᓇᐣ ᑲᔦ ᓂᑭ ᐊᐧᐸᐣᑕᒥᐣ.

ᒪᐊᐧᐨ ᓂᒥᓄᓭᐊᐧᑫᐣᑕᒥᐣ ᑲᑭ ᐅᐡᑭ ᒪᑕᓄᑭᐨ ᓇᓂᔭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑫᓂᑲᓂᐡᑲᐠ, ᐊᐣᒋᕑᐊ ᒪᑐᔨ, ᐅᑕᐃᐧᐸᐃᐧᑎᑯᐠ ᑲᐅᐣᒋᐨ ᐁᑲᐧ ᑐᕑᐅᐣᑐ ᑲᑭ ᑕᔑᐡᑯᓄᐃᐧᐨ. ᐃᒪ ᒋᐅᐣᒋ ᐊᐣᑕᓄᑭ BDO ᑎᕑᐊᔾᑎᐣ ᑲᑕᑲᐧᐠ ᐁᑲᐧ ᑕᐡ ᒥᔑᓄᐊᐦᑭ ᑲᑭᐱ ᐊᓄᑭᑕᒪᑫᐨ ᓇᓂᔭᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᒥᐦᐃᐁᐧ ᑲᐅᐣᒋ ᑭᒋᓀᐣᑕᒪᐣᐠ. ᒣᑲᐧᐨ ᓇᐊᐧᐨ ᐁᐅᐡᑲᑎᔨᐨ, ᐊᒥᐦᐃ ᐁᔑ ᐸᑯᓴᓂᒧᔭᐣᐠ ᒋᑭ ᐊᓂᔑ ᑭᑭᐅᑦᐱᑭᐨ ᐅᒪ ᒪᒋᑕᐃᐧᓂᐠ ᒥᓇ ᐃᒪ SLFNHA ᓇᓂᔭᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ.

ᐯᔑᑲᐧᔦᐠ ᑫᑯᐣ ᒪᐊᐧᐨ ᑲᑭ ᒥᓀᐧᐣᑕᒧᐦᐃᑯᔭᐣ ᐅᑕᓇᐣᐠ ᑲᑭ ᐊᐦᑭᐊᐧᐠ ᐃᐁᐧ ᒥᑐᓂ ᐁᑭ ᒥᓄᓇᑲᐧᐠ ᓇᓂᔭᐃᐧ ᒪᒪᐊᐧᐣᑭᒋᑫᐃᐧᐣ (ᒣᑲᐧᐨ 2012-13), ᒪᐊᐧᐨ ᓂᑕᑦ ᐃᐁᐧ ᑲᐃᔨᓴᐠ ᐅᒪ SLFNHA. ᐅᑕᓇᐣᐠ ᑲᐱᐊᐦᑭᐊᐧᐠ ᓂᑭ ᐃᑭᒥᐣ ᐃᐁᐧ ᒪᒪᐊᐧᐣᑭᒋᑫᐃᐧᐣ ᐊᓂᐣ ᑫᑭᔑ ᐊᓄᑲᑕᒪᑭᐸᐣ ᐃᐁᐧ ᑕᐡ ᐁᑲ ᐁᑭ ᐅᐣᒋ ᐃᐣᑕᒪᐣᐠ ᑫᑯᓇᐣ ᑲᑎᐯᐣᑕᒪᐣᐠ ᐅᒪ ᓂᐱᒧᒋᑫᐃᐧᓂᓇᐣ, ᒪᐊᐧᐨ ᒥᐡᑕᐦᐃ ᐁᑭ ᓇᓂᔭᐊᐧᑭᐣ. ᒣᑲᐧᐨ ᑲᐅᔑᒋᑲᑌᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ, ᒥᐦᐃᒪ ᑲᑭ ᐅᐣᒋ ᐃᔨᓴᐠ ᒋᐊᔭᔭᐣᐠ ᒪᐊᐧᐨ ᑫᑯᐣ ᑲᐃᐡᐸᑭᑌᐠ ᐁᑲᐧ ᑕᐡ ᐊᒥᐦᐃ ᑲᑭ ᐃᔑᓇᑲᐧᐠ ᐃᒪ ᓇᓂᔭᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᐁᑭ ᒪᔨᓇᐦᐃᑫᓴᓂᐊᐧᐠ. ᐁᑲᐧ ᑕᐡ ᒣᑲᐧᐨ 2012-13, ᓂᑭ ᑕᑲᐧᑭᑕᒥᓇᐣ ᐅᑫᐧᓂᐊᐧᐣ ᑲᑭᒋᓇᐣᑭᑌᑭᐣ ᑲᑎᐯᐣᑕᒪᐣᐠ ᒥᑕᐡ ᑲᑭ ᐃᔨᓴᐠ ᒥᑐᓂ ᐁᑭ ᒥᓄᓇᑲᐧᐠ ᓂᓴᑲᑭᐱᐦᐅᑯᐃᐧᓂᓇᐣ. ᒪᐊᐧᐨ ᐅᑭᒋᓀᐣᑕᒧᐦᐃᑯᓇᐊᐧ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ ᒥᓇ ᐃᒪ ᑲᐅᐣᒋ ᐊᔑᑕᑭᔨᐊᐧᐨ, ᐃᐁᐧ ᑲᐃᔑᓇᑲᐧᐠ ᓇᓂᔭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐁᓇᑲᐧᐠ ᒪᔭᑦ ᑲᐃᓇᐱᑭᓴᐠ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐁᑲᐧ ᑕᐡ ᐊᒥ ᐁᔑᓇᑲᐧᐠ ᒋᒥᓄᓴᐦᐃᑯᔭᐣᐠ ᐁᐧᑎ ᓂᑲᐣ ᑫᐊᓂ ᐊᓂᑲᑕᒪᑭᐣ ᑫᑯᓇᐣ.

ᐁᑲᐧ ᐃᒪ ᓄᑎᐣ ᐊᐊᐧᔑᐡ ᒥᓇ ᑎᐯᐣᒋᑫᐃᐧᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ, ᐃᒪ ᒪᐊᐧᐨ ᑲᑭᔑ ᑭᒋ ᐊᓄᑭᓇᓂᐊᐧᐠ ᑕᔑᑫᐃᐧᓇᐣ ᒪᐊᐧᐨ ᑲᑭ ᑭᒋ ᒪᒋᓴᐊᐧᐨ, ᐃᒪ ᑲᑭ ᐃᔑᓂᔕᐦᐊᐧᑲᓄᐊᐧᐨ ᐅᐃᐧᒋᐦᐃᐁᐧᐠ, ᐱᑲᐣᒋᑲᒥᐣᐠ, ᓀᐣᑲᐣᑕᑲᒪ ᒥᓇ ᒣᐡᑭᑲᐧᒪᐣᐠ. ᐁᑲᐧ ᒪᒪᐤ ᐃᑫᐧᓂᐊᐧᐣ ᓂᐦᔨᐣ ᑕᔑᑫᐃᐧᓇᐣ, ᐅᐃᐧᒋᐦᐃᐁᐧᐠ ᑭᓇᑲᐧᓂ ᒪᐊᐧᐨ ᐁᑭᑭᒋ ᐊᐧᐃᒋᑕᐧᐊᐧᐨ ᐃᒪ ᑲᑭᔑ ᒪᒋᓴᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ. ᒪᒪᐤ ᑕᐡ 4,000 ᑕᓴᐧ ᐅᑭ ᓇᔨᑲᓇᐊᐧ ᑲᐯᔑᐃᐧᓇᐣ ᒥᓇ ᑕᐡ ᐊᐊᐧᔑᒣ 1,600 ᑕᔑᑫᐃᐧᓂᐠ ᑲᑲᐯᔑᓂᐨ ᐅᑭ ᐅᐣᒋ ᐃᐧᒋᐦᐊᐊᐧᐣ. ᐅᐁᐧ ᓇᑲᐧᐣ ᒥᐡᑕᐦᐃ ᐁᑭ ᐊᓄᐣᒋ ᒥᓀᐧᔭᒪᑲᓂᐠ ᐅᐱᒪᑎᔨᐃᐧᓂᐊᐧ.

ᐃᑫᐧᓂᐊᐧᐠ ᐅᐃᐧᒋᐦᐃᐁᐧᐠ ᑲᐃᐧᒋᑕᐧᐨ ᒣᑲᐧᐨ ᑲᑭᒋ ᒪᒋᓴᑭᐣ ᐱᒪᑎᔨᐃᐧᓇᐣ ᐊᒋᓇ ᐁᐦᑕ ᐃᓇᑭᔨᐊᐧᐠ ᒋᐃᐧᒋᑕᐧᐊᐧᐨ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᒥᓂᑯᐠ ᓇᐊᐧᐨ ᒋᓴᑲᑭᓴᓂᐠ ᐃᒪ, ᔕᑯᐨ ᑕᐡ ᓂᔨᑕᐃᐧᓇᑲᐧᐣ ᐃᒪ ᑲᑭ ᑎᐸᒋᒧᓇᓂᐊᐧᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐠ ᐁᐃᔑᓇᑲᐧᐠ ᒋᑭ ᐱᒥᐡᑲᒪᑲᑭᐸᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ. ᒥᐦᐃᒪ ᑲᑭ ᒥᑭᑲᑌᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐠ ᒋᑭ ᐃᔑ ᐱᒥ ᐊᓂᑲᑌᑲᐧᐸᐣ ᐅᑫᐧᓂᐊᐧᐣ ᑕᔑᑫᐃᐧᓇᐣ ᐁᑲᐧ ᒥᓇ ᑯᑕᑭᔭᐠ ᑲᐸᑭᑎᓇᒧᐊᐧᐨ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒋᑭ ᑕᑯᓇᑲᓄᐊᐧᐸᐣ.

ᐃᐁᐧ ᑕᐡ ᑲᐊᐧᐸᐣᑕᒪᐣᐠ ᑫᓇᑭᐡᑲᒪᐣᐠ ᑫᐊᓂᒥᐦᐃᑯᔭᐣᐠ ᒥᓇᐊᐧ ᐊᓂ ᐊᐦᑭᐊᐧᐠ ᐃᐁᐧ ᒋᓇᓇᐣᑎᓇᒪᐣᐠ ᐊᓂᐣ ᑫᑭᑐᑕᒪᐣᑭᐸᐣ ᒋᑭ ᐱᒥᓴᑭᐸᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᐊᔕ ᐅᑕᓇᐣᐠ ᐃᐁᐧ ᑲᐱᑐᑕᒧᐊᐧᐨ ᐅᐃᐧᒋᐦᐃᐁᐧᐠ ᐊᐱ ᑲᐃᐡᑲᐧ ᐊᐣᑕᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐊᐧᐨ. ᒥᑕᐡ ᐁᔑᓂᔨᑕᐃᐧᓇᑲᐧᐠ ᒋᑭ ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᓇᓂᐊᐧᑭᐸᐣ. ᐊᐁᐧ ᐅᑕᑯᔩ ᐁᐊᓂᒥᓇᑲᐧᓂᐠ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᐣ ᐁᑲᐧ ᑕᐡ ᒥᔑᐣᐊᐧᔦᐠ ᒋᑭ ᐅᐣᒋ ᑲᑫᐧ ᐃᐧᒋᐦᐊᑲᓄᐊᐸᐣ, ᐃᐁᐧ ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᑕᑲᐧᔭᐣᑕᓂ ᐊᐁᐧ ᑲᐊᓂᒥᐃᐧᑐᐨ ᐊᐃᐧᔭ ᐁᑲᐧ ᒥᓇ ᑯᑕᑭᔭᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑲᐸᑭᑎᓇᒧᐊᐧᐨ ᒋᑭᑫᐣᑕᒧᐊᐧᐨ ᐊᓂᐣ ᑫᔑ ᐃᐧᒋᐦᐊᐊᐧᐨ ᐅᑫᐧᓂᐊᐧᐣ ᐅᑕᑯᔩᐣ. ᒪᒪᐠ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᑲᐃᒋᑲᑌᐠ ᐃᓇᐧᑌ ᒋᐱᒥ ᑲᓇᐁᐧᐣᑕᒧᐊᐧᐨ ᑲᔑ ᐱᒥᐸᓂᒋᑲᑌᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᒥᓇ ᑲᔦ ᑲᑭᓇ ᑯᑕᑭᔭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒋᑲᐧᔭᐣᑕᓂᐠ ᑫᓇᐣᑕᐁᐧᐣᑕᐠ ᐅᑕᑯᔩ, ᔕᑯᐨ ᒋᒪᔨᓇᐦᐅᑎᔨ ᐱᓇᒪ ᐸᑭᑎᓂᑎᔨᐨ ᒋᐃᐧᒋᐦᐊᑲᓄᐨ, ᒣᑲᐧᐨ ᑲᐸᐸᒥᔨᑲᐣᑕᑯᐨ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ, ᐁᑲᐧ ᒥᓇ ᒋᐱᒥ ᑕᑎᐸᒋᒧᑕᐊᐧᐨ ᑲᓂᑲᓂᐡᑲᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧ ᐅᓇᒋᑫᐃᐧᐣ ᑲᐊᓂ ᐊᐱᒋᐡᑲᒪᑲᓂᐠ ᐅᑕᓄᑭᐃᐧᐣ. ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᒥᐱᑯ ᐁᐃᔨᓴᐠ ᐊᐁᐧ ᐅᑕᑯᔩ ᒋᓀᐱᒋᔭᓂᐠ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓇᐣ ᑲᐃᔨᓴᓂᐠ ᒋᔑ ᐃᐧᒋᐦᐊᐊᐧᐨ ᐅᑕᑯᔩᐣ ᑭᑭᔐᐊᐧᓄᒋᑲᑌᓂᐠ ᐅᑕᓂᔑᓂᓂᐃᐧ ᐸᒥᐦᐃᑯᐃᐧᐣ.

ᐃᒪ ᑫᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ, ᑲᐅᑭᒪᐊᐧᑭᔨᐊᐧᐨ ᒥᓇ ᐊᓂᑭᓇᑲᓇᐠ ᒥᑐᓂ ᑲᐧᔭᐠ ᐊᓄᑭᐊᐧᐠ, ᔕᑯᐨ ᑕᐡ ᒥᐡᑕᐦᐃ ᐊᓂᑭᐃᐧᐣ ᑕᑲᐧᐣ ᑭᔭᐸᐨ. ᐯᔑᐠ ᑫᑯᐣ ᑲᑭ ᐊᐣᑕᑐᐊᐧᐨ ᑲᐅᑭᒪᐊᐧᑭᔨᐊᐧᐨ ᐃᐁᐧ ᐊᔕᐣᑫᐃᐧᐣ. ᒥᐁᑲᐧ ᑫᑐᒋᑲᑌᐠ ᒋᑲᐧᔭᐣᒋ ᑭᔑᑌᐠ ᒥᒋᑦ ᑲᐱᒋᑲᑌᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐁᑲ ᒣᐡᑲᐧ ᒋᓇᐱ ᑭᔨᓴᒧᐊᐧᐨ ᒥᓂᑯᐠ ᑲᐃᐧ ᐊᓂ ᐊᔕᐣᑫᐊᐧᐨ. ᓂᓇᐣᑕᐁᐧᐣᑕᒥᐣ ᐃᐁᐧ ᒥᒋᑦ ᑲᐸᑭᑎᓇᒪᐣᐠ ᒋᒥᒋᐊᐧᐨ ᒥᓇ ᒋᒥᓂᐡᑯᓄᐊᐧᐨ.

ᐃᒪ ᐊᑯᔨᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᑲᐱᒧᑐᐊᐧᐨ, ᒥᐡᑕᐦᐃ ᐊᓄᑲᑌ ᒋᐅᓇᒋᑲᑌᐠ ᐃᐁᐧ ᑲᐃᔑᓂᑲᑕᒪᐣᐠ ᑭᐁᐧᑎᓄᐠ ᒪᐡᑭᑭᐃᐧᑲᒥᐠ. ᒣᑲᐧᐨ ᐃᐧᓂᑯ, ᐅᑕᑯᔨᐠ ᐃᒪ ᑕᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐠ ᑫᑌ ᐊᑯᔨᐃᐧᑲᒥᐠ ᑲᐱ ᓇᒋ ᒪᐡᑭᑭᐃᐧᑲᒥᑫᐧᐊᐧᐨ, ᔕᑯᐨ ᒥᐊᔕ ᒋᐊᓂ ᑭᐸᑲᐧᐦᐃᑲᑌᐠ ᐃᐁᐧ ᑫᑌ ᐊᑯᔨᐃᐧᑲᒥᐠ. ᑭᐅᐣᒋᔨᓴ ᑕᐡ, ᐅᑭᒪᑲᓇᐠ ᐃᒪ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᔨᐊᐧᐨ ᑲᐅᐣᒋ ᓇᓇᑲᒋᑐᔭᐣᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ ᑭᐅᓇᒋᑫᐊᐧᐨ ᒣᑲᐧᐨ ᒥᑭᔨᐃᐧᐱᔨᑦ 2014 ᒋᒪᒋᒋᑲᑌᐠ ᐊᐣᑎ ᐱᓇᒪ ᑫᑭᔑ ᐊᐧᐊᐧᐸᒪᑲᓄᐊᐧᐸᐣ ᐅᑕᑯᔨᐠ ᑭᐁᐧᑎᓄᐠ ᑲᐅᐣᑎᓴᐊᐧᐨ ᒥᓂᑯᐠ ᐅᔑᒋᑲᑌᐠ ᒪᔭᑦ ᑫᑕᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᑭᐁᐧᑎᓄᐠ ᐅᑕᑯᔨᐠ ᑲᐱᑕᑯᔑᓄᐊᐧᐨ, ᓇᐣᑕ ᓂᔭᓄᐊᐦᑭ ᐸᓂᒪ ᑕᐃᔨᓴ.

ᐁᑲᐧ ᑕᐡ ᐊᐱᒋ, ᐊᐧᓂᓇᐊᐧᑲᐠ ᒥᓄᔭᐃᐧᐣ ᐊᑯᓯᐃᐧᑲᒥᐠ ᐁᐅᐣᒋ ᐃᐧᒋᐦᐃᑯᔭᐣᐠ, ᐱᓇᒪ ᐊᐧᑲᐦᐃᑲᓅᓯᐣᐠ ᑕᑕᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐠ ᐃᒪ ᑕᐡ ᑕᔑ ᐸᑕᑭᑌ ᐊᑲᐧᒋᐣᐠ ᐊᑯᓯᐃᐧᑲᒥᐠ ᐅᐁᐧ ᑫᐊᓂ ᐱᒥ ᐊᐦᑭᐊᐧᐠ. ᐅᐁᐧ ᑕᐡ ᐅᐣᒋ, ᓂᑭ ᒪᒪᐃᐧ ᐊᓄᑲᑕᒥᐣ ᒋᑭ ᐅᐡᑭᒋᑲᑌᑭᐸᐣ ᐃᐁᐧ ᓂᐃᐧᐣ ᐱᒧᒋᑫᐃᐧᓇᐣ ᑲᑭ ᓇᑯᒥᑎᐊᐧᐸᐣ ᑲᐃᓇᑌᐠ, ᑲᐃᐧᐣ ᐁᐦᑕ ᑫᔑ ᐃᐧᑕᓄᑭᒥᑎᓇᓂᐊᐧᐠ ᐃᐁᐧ ᐅᐡᑭ ᒪᐡᑭᑭᐃᐧᑲᒥᑯᐡ ᑭᐁᐧᑎᓄᐠ ᐅᑕᑯᓲᐠ ᑫᔑ ᐊᐧᐊᐧᐸᒥᐣᑕᐧ, ᒥᓇ ᑲᔦ ᐃᐧᐱᑎᒪᐡᑭᑭᐃᐧᓂ ᑫᑕᓇᓄᑭᓐ ᒥᓇ ᑯᑕᑭᔭᐣ ᐊᑯᓯᐃᐧ ᐊᓂᑭᐃᐧᓇᐣ, ᔕᑯᓐ ᑲᔦ ᐃᑫᐧᓂᐊᐧᐣ ᑐᑲᐣ ᑭᓄᐊᐧᑲᐡ ᑲᐱᒥᓴᐠ ᐊᑯᓯᐃᐧ ᐸᒥᐦᐃᐁᐧᐃᐧᐣ.

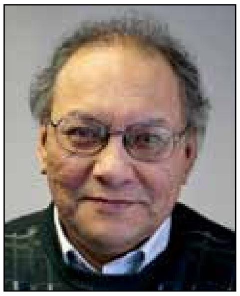
ᐅᑫᐧᓂᐊᐧᐣ ᑫᐊᓄᑲᑌᑭᐣ ᐸᐣᑭ ᐁᑕ ᓂᑐᐣᒋ ᐃᐧᐣᑕᒪᑫᒥᐣ ᑲᐃᓇᑭᒪᑲᐠ ᐅᒪ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᓂᐠ ᑲᐃᐧ ᐊᓂᔑ ᐱᒋᓂᐡᑲᔭᐣᐠ ᒋᑭ ᑲᑫᐧ ᒥᓄᓴᑭᐸᐣ ᐊᑯᓯᐃᐧ ᐸᒥᐦᐃᐁᐧᐃᐧᐣ ᑲᐊᓂᑲᐊᐧᔭᐣᐠ ᐊᓂᔑᓇᐯᐠ ᐅᒪ ᐊᐧᑲᐦᐃ ᑲᑲᐯᔑᐊᐧᓐ. ᓂᐃᐧ ᓇᓇᑯᒪᐠ ᑲᑭᓇ ᑲᐅᐣᒋ ᐃᐧᑕᓄᑭᒥᑯᔭᐣᐠ, ᐃᑫᐧᓂᐊᐧᐠ ᓂᑲᐣ ᑲᓂᑲᓂᑕᒪᑫᐊᐧᓐ ᒥᓇ ᑲᑭᓇ ᐊᓂᔑᓂᓂᐊᐧᐠ ᑲᐊᓂᑲᐊᐧᔭᐣᐠ ᑌᑎᐸᐦᐃ ᑕᔑᑫᐃᐧᓇᐣ ᑲᔑ ᑕᑲᐧᑭᐣ. ᑯᑕᑭᔭᐠ ᑲᔦ ᑲᓇᑕ ᑭᒋᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᒥᓇ ᑭᒋ ᐊᐊᐧᔑᔑᐃᐧᑭᒪ ᐅᐱᒧᒋᑫᐃᐧᐣ, ᑲᑭᒋ ᐃᐧᒋᐦᐃᑯᔭᐣᐠ ᓬᓂᔭᓈᐣᐠ, ᑲᔦ ᐊᓂᔑᓇᐯ ᐊᐡᑭ, ᑎᑭᓇᑲᐣ, ᒥᓇ ᑯᑕᑭᔭᐠ ᑲᐅᐣᒋ ᐃᐧᑕᓄᑭᒪᔭᐣᑲᐧ.

ᐃᐡᑲᐧᔭᓐ ᑕᐡ, ᒪᐊᐧᓐ ᓂᑭᒋ ᓇᓇᑯᒪᒥᐣ ᑲᑭᓇ ᐊᓂᑭᓇᑲᓇᐠ ᐅᒪ ᐊᐧᓂᓇᐊᐧᑲᐠ ᒥᓇ ᑕᔑᑫᐃᐧᓇᐣ ᑲᔑ ᐊᔭᑭᐣ ᑲᐊᔭᐊᐧᔭᐣᐠ ᓂᑕᓄᑭᓇᑲᓂᓇᐣ, ᒥᐡᑕᐦᐃ ᑲᐊᓄᑭᐊᐧᓐ. ᐁᐡᑲᓐ ᐅᑕᓇᐣᐠ ᑲᑭ ᐱᐊᐦᑭᐊᐧᐠ, ᓂᑭ ᑎᐸᒋᒧᓇᐸᐣ ᐃᑫᐧᓂᐊᐧᐠ 200 ᐊᓂᑭᓇᑲᓇᐠ ᑲᑕᔑᐊᐧᓐ, ᑭᒧᐦᒋ ᓂᔭᓇᓄᐊᐧᐠ ᐁᐦᑕ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑕᓇᓄᑭᐊᐧᓐ ᐊᓂᑭᓇᑲᓇᐠ. ᓄᑯᐨ ᑲᐊᐦᑭᐊᐧᐠ, ᓂᒥᓅᐧᐣᑕᐣ ᒋᑎᐸᒋᒨᔭᐣ ᐁᐦᐊᔭᐊᐧᔭᐣᐠ 22 ᑲᑲᐯᓭᓂᐠ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑕᓇᓄᑭᐊᐧᓐ. ᑭᐡᐱᐣ ᑕᐡ ᐃᐧᑕᑲᐧᑭᒥᐣᑕᐧ 18 ᐊᓂᑭᓇᑲᓇᐠ ᑲᐃᐧᒋᑕᐧᐊᐧᓐ ᒪᐊᐧᓐ ᑲᔑ ᑭᒋ ᒪᒋᓭᓂᐠ, ᐃᒪ ᒣᑲᐧᓐ ᑲᑕᓇᓄᑭᐊᐧᓐ ᑕᔑᑫᐃᐧᓂᐠ, ᒥᔕ ᒪᒪᐤ 40 ᐁᐦᐊᔭᐊᐧᔭᐣᐠ ᐊᓂᑭᓇᑲᓇᐠ. ᓂᑲᐱᒥ ᐊᓄᑲᑕᒥᐣ ᒋᒪᒪᐃᐧᓇᒪᐣᑭᐣ ᑯᑕᑭᔭᐣ ᐊᓂᑭᐃᐧᓇᐣ ᑫᐅᐣᑎᓇᒪᑭᐣ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ. ᒣᑫᐧᓐ ᑲᑭᓇ ᑭᑎᓂᓇᐊᐧ ᐁᑲᐧ ᒪᐊᐧᓐ ᓂᐸᑯᓭᓄᐨ ᒥᓇᐊᐧ ᒋᑭ ᒥᓄᓇᑲᐧᐠ ᑭᑕᓄᑭᐃᐧᓂᓇᐣ ᐅᐁᐧ ᑫᐊᓂ ᐸᐱᒥ ᐊᐦᑭᐊᐧᐠ.


Photo taken in Sachigo Lake First Nation

Photo taken in Sandy Lake First Nation

Message from the Executive Director



ᒉᒥᐢ ᐧᒪᕑᐃᐢ

James Morris
Executive Director

It's been a very busy year here at Sioux Lookout First Nations Health Authority (SLFNHA). We've also had a lot of good things happening.

We are very fortunate to have found a new Finance Manager, Angela Madussi, who is originally from Ear Falls and studied in Toronto. She came to us from BDO in Dryden and brings with her many years of experience in the financial field. As a young lady, it is our hope that she will grow with the organization and SLFNHA finances.

Another thing that made me happy this past year was the clean audit (for 2012-13), which is a first for SLFNHA. In previous years, we've always had qualified audit opinions due to not disclosing capital assets, which were always insignificant in value. When the hostel was constructed, it created significant capital assets and made our financial position appear in an asset shortfall. In 2012-13, we capitalized our assets and this resulted in a clean audit opinion. This is important to the Board and the stakeholders, as the finances now reflect the organization's true financial picture and places us in a better position for future projects.

In the area of Nodin Child and Family Intervention Services, the most intensive work in the communities has occurred through the Trauma Teams, which have been assigned to Pikangikum, Neskantaga and Mishkeegogamang. Overall, in all three communities, the Trauma Teams have shown a high level of involvement and engagement. The team members conducted over 4,000 home visits and connected with over 1,600 community members. This represents a lot of healing.

Trauma Teams are only intended to be short-term measures to help communities stabilize, but it is evident from the evaluation report that the work needs to continue in some fashion. An analysis of the report shows that one of the key outcomes has been the identification of continued support and connection to other services.

One of the challenges for the coming year is to find a way to continue providing the type of support that has been provided by the Trauma Teams after the projects end. The most obvious method is called Case Management. When clients have complex needs and require multiple services, a Case Management System is there to support the person and ensure that the service providers are meeting the client's needs. Case management involves monitoring the service delivery and all the resources that are available for the client, who must consent to case management and be an active participant. A Case Manager will work with the service providers, who are still responsible for their assigned tasks, but also meet regularly to review and update the coordinated service plan. Case management ultimately means the client has a circle of care which supports the client's right to compassionate, culturally competent care.

Over at the Jeremiah Mckay Kabaysheewekamik hostel, management and staff have made great strides, but there's still a lot of work to do. One of the changes that management has been working on is the quality of meals served. The menu will soon be changed to "hot meal delivery" instead of meals that were re-heated prior to serving. We want to serve food that people want and enjoy.

In our Health Services department, a lot of time and work was put into getting a new space for what we call the northern clinic. Currently, the patients who come from the communities go to the old Zone Hospital for their appointments, but the building is close to shutting down. Fortunately, the Chiefs of the communities we serve passed a resolution in March 2014 to proceed with an interim measure until the permanent Primary Health Care Facility is built, which will be in five years.

In the meantime, with the assistance of the Sioux Lookout Meno Ya Win Health Centre, a modular facility will be set up beside the hospital in the coming year. In this regard, we all have been working to revitalize the Four Part Agreement process, not only as a forum for working on the permanent Primary Health Care Facility, which will house the northern clinic, dental and other clinical work spaces, but to focus on other issues as well, such as long-term care.

These initiatives are only a few examples of the work the Health Authority is doing as we move forward to improve health care for the Anishinabe people who live in this area. I would like to thank all of our partners, starting with the leaders and the people of the communities who work with us. Others include Health Canada and the provincial Ministry of Children and Youth Services, who provide the lion's share of our funding, and also Nishnawbe Aski Nation, Tikinagan, and so many other integral partners.

Last, but not least, a Thank You to all the staff, both in Sioux Lookout and in the communities where we have staff, for doing all of the work. A few years ago, I reported that out of more than 200 employees, we only had five community-based staff. This year, I am happy to report that we have 22 full-time staff in the communities. If you count the 18 Trauma Team members, who are currently working in the communities at all times, that's 40 community-based staff. We will continue the process of de-centralizing whatever staffing positions we can to the communities. Thank you to all and we look forward to another year of growth, hard work and progress.

ᐅᑭᒪᑲᓇᐠ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ

ᑲᑭ ᐅᐣᒋᒪᒋᓴᐠ
ᐅᑭᒪᑲᓇᐠ ᑲᐊᐱᑕᒧᐊᐧᐨ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ (CCOH) ᑭᒪᒋᒋᑲᑌᐸᐣ ᒥᑭᓯᐃᐧᐱᓯᐟ 2004 (ᐅᓇᔓᐁᐧᐃᐧᐣ 04/46) ᐃᑫᐧᓂᐊᐧᐠ ᑲᑭ ᐅᓇᑐᐊᐧᐨ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐊᐧᐨ ᐅᑭᒪᑲᓇᐠ. ᐃᐁᐧ ᓂᑕᑦ ᑲᑭ ᐃᓇᐧᑌᑭᐸᐣ ᒋᐊᓄᑲᑕᒧᐊᐧᐨ ᐃᑫᐧᓂᐊᐧᐠ CCOH, ᔕᑯᐨ ᑲᐃᐧᐣ ᐁᑕ ᐅᑫᐧᓂᐊᐧᐣ, ᑲᓂᐱᑌᐱᐦᐃᑲᑌᑭᐣ:

- ᒋᑲᑫᐧ ᑲᓇᐁᐧᐣᑕᒧᐊᐧᐨ ᒣᑲᐧᐨ ᑲᐊᐸᑕᑭᐣ ᒥᓇ ᒋᓇᓇᐣᑐᓇᒧᐊᐧᐨ ᑯᑕᑭᔭᐣ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᑲᐊᔭᑭᐣ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᓇᐣ ᒥᓇ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ

- ᑲᒪᒋᒋᑲᑌᐠ ᐃᐁᐧ ᓂᑕᑦ ᐊᐧᓂᓇᐊᐧᑲᐠ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧ ᐅᓇᑯᓂᑫᐃᐧᓄᐡ

- ᒋᐅᓇᒋᑲᑌᑭᐣ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᐃᒪ ᐅᐢᑭ ᑲᐯᔑᐃᐧᑲᒥᐠ

- ᐃᐧᐸᐨ ᓇᐊᐧᐨ ᒋᐊᐸᒋᐦᐊᑲᓄᐨ ᐊᑯᓯᐃᐧᑲᒥᐠ ᑲᐸᑭᑎᓇᑲᓄᐨ ᑫᔑᐊᐸᑕᓯᐨ ᔓᓂᔭ ᐊᓂᔑᓂᓂᐊᐧᐠ ᑫᐊᐸᒋᐦᐊᐊᐧᐨ

- ᒋᐱᒥ ᐅᓇᒋᑲᑌᑭᐣ ᑫᐱᒥᓂᔕᐦᐃᑲᑌᐠ ᒥᓇ ᒋᐅᓀᐣᑕᑲᐧᐠ ᑫᐃᔑ ᐊᓄᑲᑌᐠ ᒣᑲᐧᐨ ᑲᐱᒧᒋᑲᑌᐠ ᐊᑯᓯᐃᐧ ᐅᓇᒋᑫᐃᐧᓇᐣ

- ᒋᐅᓇᒋᑲᑌᑭᐣ ᑲᐧᔭᐠ ᒋᐃᔑᓇᑲᐧᐠ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᓇᐣ ᐃᒪ ᐊᓂᔑᓂᓂᐃᐧ ᑕᔑᑫᐃᐧᓇᐣ, ᒪᒋᑕᐃᐧᓇᐣ ᒥᓇ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᑲᐸᑭᑎᓇᒧᐊᐧᐨ

ᒣᑲᐧᐨ 2006, ᐃᑫᐧᓂᐊᐧᐠ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐊᐧᐨ ᐅᑭᒪᑲᓇᐠ ᐅᑭ ᓇᐣᑭᐦᑐᓇᐊᐧᐸᐣ ᐅᓇᒋᑫᐃᐧᐣ ᐃᒪ CCOH (ᐅᓇᒋᑫᐃᐧᐣ 06/08) ᐃᑫᐧᓂᐊᐧᐠ ᑲᐊᐱᑕᒪᑫᐊᐧᐨ ᒋᐅᐣᒋ ᓂᑲᓂ ᓇᓇᑲᒋᑐᐊᐧᐨ ᐊᓂᑭᐃᐧᓇᐣ ᑲᑐᑕᒧᐊᐧᐨ SLFNHA ᑲᐃᓇᑌᐠ ᐊᓂᔑᓇᐯ ᒪᐢᑭᑭᐃᐧ ᐅᓇᒋᑫᐃᐧᐣ ᑲᒪᒋᒋᑲᑌᐠ. ᐃᐁᐧ ᐊᐦᐱ, ᐃᑫᐧᓂᐊᐧᐠ CCOH ᑭᑲᑫᐧᒋᒪᐊᐧᐠ ᒋᐱᒥ ᓇᓇᐣᑐᓇᒧᐊᐧᐨ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᐁᑲ ᑲᐃᔑ ᑕᑲᐧᑭᐣ ᐃᒪ ᐊᓂᔑᓂᓂᐊᐧᐠ ᐅᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᒥᓇ ᒋᐅᐣᒋ ᓇᓇᑲᒋᑐᐊᐧᐨ ᐃᓯᓴᐃᐧᓇᐣ ᐃᐁᐧ ᐅᐣᒋ ᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᑲᐅᐣᒋ ᑎᐸᐦᐃᑲᑌᑭᐣ.

ᐊᐦᑭᐃᐧᐣ ᑭᐁᐧᓇᓇᑲᒋᒋᑫᐃᐧᐣ
ᐃᒪ 2013-14, ᐃᑫᐧᓂᐊᐧᐠ ᐅᑭᒪᑲᓇᐠ ᑲᐊᐱᑕᒧᐊᐧᐨ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑭᐱᒥ ᒪᒪᐊᐧᒋᐦᐃᑐᐊᐧᐠ ᒥᓇ ᐅᑭ ᐸᑭᑎᓇᓇᐊᐧ ᐅᐃᐧᒋᑲᐸᐃᐧᑕᒪᑫᐃᐧᓂᐊᐧ ᒥᓇ ᐊᓂᐣ ᑫᔑ ᐱᒥᐃᐧᒋᑌᑭᐣ ᐅᑫᐧᓂᐊᐧᐣ:

- ᐅᑭᐸᑭᑎᓇᐊᐧᐣ $30,000 ᐸᑭᑎᓂᑫᐃᐧᓇᐣ ᐃᒪ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑌᑎᐸᐦᐃ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑲᐧᑭᐣ ᐃᐢᑯᓂᑲᓇᐣ ᑲᐅᑕᐱᓇᒧᐊᐧᐨ ᒪᐢᑭᑭᐃᐧ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ
- ᐁᑭ ᐃᐧᐣᑕᒪᑫᐊᐧᐨ ᑫᔑ ᒪᑕᓄᑲᑌᐠ ᐃᐁᐧ AHP, ᐁᑭ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ ᑲᔦ ᒥᓇ ᐁᑭ ᑭᑭᓄᐢᑲᒪᑫᐊᐧᐨ ᐊᓂᐣ ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᒪᐢᑭᑭᐃᐧᓂᓂᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᐣ ᒥᓇ ᑲᔦ ᐁᐦᐊᓂ ᐃᐧᐣᑕᒪᑫᐊᐧᐨ ᐊᓂᐣ ᐁᐦᐊᐱᓴᐠ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᐱᒧᒋᑲᑌᐠ ᒪᐢᑭᑭᐃᐧᓂᓂᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᐣ

- ᒋᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᐠ ᒥᓇ ᒋᐅᓇᒋᑲᑌᑭᐣ ᑫᐱᒥᓂᔕᐦᐃᑲᑌᑭᐣ ᐃᒪ ᐅᑕᑯᓯᐠ ᑲᑕᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᐱᒧᒋᑫᐃᐧᐣ ᒥᓇ ᒋᐊᓂᔑ ᐱᒋᓂᐢᑲᓂᐊᐧᐠ ᐃᐁᐧ ᐅᐢᑭ ᐊᓄᑭᐃᐧᑲᒥᐠ ᐅᑕᑯᓯᐠ ᑫᑕᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ

- ᒋᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ NIHB ᑕᑯ ᑲᔦ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᓇᐣ ᐃᓯᓴᐃᐧᓇᐣ ᒥᓇ ᑲᒪᒥᑐᓀᐣᑕᑲᐧᑭᐣ ᒧᔕᐠ ᒋᐅᐣᒋ ᓇᓇᑲᒋᒋᑲᑌᑭᐣ

- ᑭᐱᒋᓂᔕᐦᐃᑲᑌᐊᐧᐣ ᐅᐢᑭ ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᐃᒪ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑲᐧᐠ ᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ

- ᑭᐱᒋᓂᔕᐦᐃᑲᑌᐊᐧᐣ ᐅᑎᐸᒋᒧᐃᐧᓂᐊᐧ SLFNHA ᑲᐃᐧ ᐅᓇᒋᑲᑌᐠ ᐊᓂᔑᓂᓂᐊᐧᐠ ᒋᑭ ᑎᐯᐣᑕᒪᓯᐊᐧᐸᐣ ᒥᓇ ᒋᐱᒥᐸᓂᑕᐧᐊᐧᐨ ᒪᐢᑭᑭᐃᐧ ᐊᑕᐃᐧᑲᒥᐠ

- ᐅᑭ ᐃᓇᔓᐊᐧᓇᐊᐧᐣ SLFNHA ᑫᒋᓇᐨ ᐃᒪ ᒋᓇᑯᐦᐃᑎᓯᐊᐧᐨ ᒣᑲᐧᐨ ᑲᐊᐧᐸᐣᑕᐦᐃᐊᐧᓂᐊᐧᐠ ᐊᓂᑭᐃᐧᓇᐣ ᐊᐃᐧᔭ ᑫᑭ ᐅᑕᐱᓇᐣᑲᐧᐸᐣ, ᒋᑎᐸᒋᒧᐊᐧᐨ ᐊᑯᓯᐃᐧ ᐸᒥᐦᐃᐁᐧᐃᐧ ᐊᓄᑭᐃᐧᓇᐣ ᒋᑭ ᐅᑕᐱᓇᒧᐊᐧᐸᐣ ᐊᓂᔑᓇᐯᐃᐧ ᐅᐢᑲᑎᓴᐠ ᑌᑎᐸᐦᐃ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᔭᐊᐧᐨ (SLFNHA ᑭᐃᐧᒋᑕᐧᐊᐧᐠ ᓂᓴᐧ ᐅᐁᐧ ᑲᑭᑐᒋᑲᑌᐠ)
- ᑭᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌ ᐊᓀᔭᐱᒋᐢᑲᒪᑲᓄᑫᐧᐣ ᒪᒪᐤ ᐊᐃᐧᔭ ᑫᐊᐸᒋᑐᐨ ᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᐣ ᒥᓇ ᐊᓂᔑᓇᐯ ᐱᒪᑎᓯᐃᐧᐣ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐧᐣᒋᑫᐃᐧᐣ

ᑲᓇᓇᑭᐢᑭᑲᑌᑭᐣ
- ᒋᓇᓇᐣᑎᓂᑲᑌᑭᐣ ᑫᔑ ᒥᓄᓴᑭᐸᐣ ᐊᐊᐧᔑᒣ ᒋᑭ ᐃᐧᐣᑕᒪᐊᐧᑲᓄᐊᐧᐸᐣ ᐊᓂᔑᓇᐯ ᐅᐢᑲᑎᓴᐠ ᐃᐁᐧᓂ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧ ᐊᓄᑭᐃᐧᓇᐣ ᐅᐣᒋ
- ᐃᐁᐧ ᑲᐊᓂ ᐊᐧᐸᐣᑕᒪᐣᐠ ᒥᔑᐣ ᐅᑎᐢᑯᓂᐠ ᐁᐦᐊᓂ ᐅᑕᐱᓇᒧᐊᐧᐨ ᒪᐢᑭᑭᐃᐧ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᓇᐣ ᐃᒪ ᑲᑭᒋ ᐃᐢᐸᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ, ᓇᐱᐨ ᓇᓴᓯᐣᑕᐱᑭᓴᒥᐣ ᒋᑭ ᒥᓇᔭᐣᐠ ᔓᓂᔭᓇᐣ ᑫᐅᐣᒋ ᐃᐧᒋᐦᐃᑯᐊᐧᐨ ᑲᑕᓯ ᐸᐯᔑᑯᐊᐧᐨ ᐅᑎᐢᑯᓂᐠ. ᐃᐁᐧ ᒥᓂᑯᐠ ᑲᒥᓇᑲᓄᐊᐧᐨ ᒥᑭᐁᐧᐃᐧᐣ ᐅᓴᑦ ᐸᐣᑭ ᐁᐃᓯᓴᐠ ᑲᑭᓇ ᒋᑭ ᒪᓇᑲᓄᐊᐧᐸᐣ ᐅᑎᐢᑯᓂᐠ, ᓇᐣᑕ ᑲᔦ ᐅᑎᐢᑯᓂᐠ ᐁᑲ ᐃᒪ ᒋᑕᑲᐧᓯᓇᐦᐊᐧᑲᓄᐨ ᒥᑭᐁᐧᐃᐧᓇᐣ ᑲᔑ ᓂᐱᑌᐱᐦᐃᑲᑌᑭᐣ.

ᓂᑲᐣ ᑫᐊᓂᔑ ᐱᒋᓂᐢᑲᓂᐊᐧᐠ
ᒋᐱᒥ ᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᐠ ᑲᐊᓄᑲᑌᐠ ᐃᐁᐧAHP ᐃᒪ ᓄᑫ ᒪᔭᑦ:
- ᑲᑭᓇ ᐊᐃᐧᔭ ᐅᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᑯᐃᐧᐣ ᑲᐃᔑ ᐱᒧᒋᑲᑌᐠ ᑲᐅᓇᒋᑲᑌᐠ

- ᒋᐅᔑᒋᑲᑌᐠ ᑲᑭᓇ ᐊᐃᐧᔭ ᐅᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᑯᐃᐧᐣ ᑫᔑ ᐸᑕᑭᑌᐠ
- ᐅᑕᑯᓯ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᐣ ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᒋᐅᓇᒋᑲᑌᐠ
- ᒥᓯᐁᐧ ᐅᐣᑌᕐᐃᔪ ᑫᔑ ᒥᓄᔭᒪᑲᐠ ᐱᒪᑎᓯᐃᐧᓇᐣ
- ᐊᓂᔑᓇᐯ ᐱᒪᑎᓯᐃᐧᐣ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐧᐣᒋᑫᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ

ᒋᐱᒥ ᐊᐧᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᐊᑯᓯᐃᐧ ᐊᓂᑭᐃᐧᓇᐣ ᐅᐁᐧ ᒋᑐᒋᑲᑌᐠ:
- ᒋᓇᓇᑲᒋᒋᑲᑌᑭᐣ ᑫᐅᐢᑭ ᑐᒋᑲᑌᑭᐣ ᒋᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᐊᑯᓯᐃᐧ ᐊᓂᑭᐃᐧᓇᐣ ᒋᐅᑕᐱᓇᒧᐊᐧᐨ ᐊᓂᔑᓇᐯᐃᐧ ᐅᐢᑲᑎᓴᐠ ᐅᒪ ᑌᑎᐸᐦᐃᑲ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᔭᐊᐧᐨ (ᑐᑲᐣ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᒪᒪᐤ ᑎᐸᒋᒧᓇᓂᐊᐧᐠ ᒋᔑ ᐊᐧᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ, ᒋᐊᐸᒋᐦᐊᑲᓄᐊᐧᐨ ᑲᐅᐣᒋ ᑭᑭᓇᐊᐧᐸᒥᐣᑕᐧ, ᑯᑕᑭᔭᐣ ᑫᑯᓇᐣ)

- ᒋᐅᓇᒋᑲᑌᐠ ᔕᑲᐢᑭᓀᐱᐦᐃᑲᐣ ᑫᑐᒋᑲᑌᐠ ᐊᐃᐧᔭ ᓇᐣᑕᐁᐧᐣᑕᐠ ᒥᑭᐁᐧᐃᐧᐣ ᑲᒪᐢᑭᑭᐃᐧ ᐃᐢᑯᓄᐃᐧᐨ

ᐅᑭᒪᑲᓇᐠ ᑲᑭ ᐅᓇᑭᓯᐊᐧᐨ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧ ᐊᐱᑕᒪᑫᐃᐧᐣ 2012-13
- ᐅᑭᒪᑲᐣ ᑕᐧᓂ ᒪᐧᕐᐃᐢ, ᑭᒋᓇᒣᑯᓯᐟ ᐃᓂᓂᐊᐧᐠ
- ᐅᑭᒪᑲᐣ ᑭᕑᐁᐳᕐᐟ ᐳᕑ, ᐅᐱᔑᑯᑲᐠ ᐃᐢᑯᓂᑲᐣ
- ᐅᑭᒪᑲᐣ ᑲᐧᓂ ᑭᕐᐁ-ᒪᑫ, ᒣᐢᑭᑲᐧᑲᒪᐣᐠ ᐃᐢᑯᓂᑲᐣ
- ᐅᑭᒪᑲᐣ ᐊᓂᓯᐸᐟ ᐊᐟᕑᐅᑲᐣ, ᐃᔭᐱᒪᑐᐣᐠ ᐃᐢᑯᓂᑲᐣ
- ᐅᑭᒪᑲᐣ ᐊᕐᓄᕑᐟ ᑲᕐᑎᓂᕐ (ᑫᒥᐢᑲᐧᒋᐢᑲᑫᐨ ᐅᓇᔓᐁᐧᐃᐧᓂ ᕐᐊᐧᐸᐟ ᑲᕐᑎᓂᕐ), ᒥᑭᓯᐃᐧ ᓴᑲᐦᐃᑲᐣ ᐃᐢᑯᓂᑲᐣ
- ᐅᑭᒪᑲᐣ ᑫᒥᐢ ᒣᒣᑫᐧ, ᐅᑭᐢᑭᒪᓂᓯᐊᐧᐳ
- ᐅᑭᒪᑲᐣ ᑕᔭᑕᐢ ᑌᐟ, ᐊᒋᑯᓴᑲᐦᐃᑲᐣ ᐃᐢᑯᓂᑲᐣ
- ᐅᑭᒪᑲᐣ ᐸᕐᐟ ᒥᑭᐢ, ᓄᐣᑲᐃᐧᓴᑲᐦᐃᑲᐣ ᐃᐢᑯᓂᑲᐣ
- ᑎᓇ ᑲᑭᐱᑕᑦ-ᔑᕑᐟᐢ, ᑭᐁᐧᑎᓄᐠ ᐅᑭᒪᑲᓇᐠ
- ᑭᒋ ᐅᑭᒪᑲᓄᐢ ᐊᕑᐱᐣ ᐱᐟᕑᐊᕐ, ᐊᐧᓚᐢᑯᓄᒥᐣᐠ ᐃᐢᑯᓂᑲᐣ

ᑭᒋᔭᕐᐊᐠ
- ᐱᕑᐃᐢ ᓴᑦᐳᕑ, ᑭᒋᓇᒣᑯᓯᐟ ᐃᓂᓂᐊᐧᐠ
- ᒍᓇᐢ ᐱᐟᕑᐊᕐ, ᓄᐣᑲᐃᐧᓴᑲᐦᐃᑲᐣ ᐃᐢᑯᓂᑲᐣ

Chiefs Committee on Health

Background

The Chiefs Committee on Health (CCOH) was formed in March 2004 (Resolution 04/46) by the Sioux Lookout Zone Chiefs. The original tasks for the CCOH included, but were not limited to, the following:

- Lobby to safeguard current and seek additional resources for community health programs and services
- Implementation of the *Draft Sioux Lookout Zone Medical Transportation Policy*
- Secure resources for new hostel
- Accelerate the Hospital Reinvestment Funds for the First Nations
- Guide and direct the process on the current health initiatives
- Facilitate and improve communication amongst First Nation communities, organizations and service providers

In 2006, the Sioux Lookout Zone Chiefs expanded the mandate of the CCOH (Resolution 06/08) for the committee to provide oversight on activities carried out by SLFNHA as per the Anishinabe Health Plan (AHP) implementation. At that time, the CCOH was also asked to continue to lobby for resources to fill the gaps in health services for First Nations members and monitor issues relating to Non-Insured Health Benefits (NIHB).

Year in Review

Throughout 2013-14, the Chiefs Committee on Health continued to meet regularly and provide support and direction on a number of issues:

- Provided $30,000 in bursaries to Sioux Lookout area First Nation students studying in the health field
- Provided oversight to the implementation of the AHP, which included reviewing and providing direction to the physician services delivery model and keeping informed of activities of Sioux Lookout Regional Physician Services Inc.
- Provided support and guidance for the Primary Health Care Unit and moving forward with the development of a new Primary Health Care Facility
- Reviewed NIHB issues, including medical transportation issues and concerns on a regular basis
- Received reports and supported SLFNHA on the proposed development of a First Nations' owned and operated pharmacy
- Received Sioux Lookout Meno Ya Win Health Centre reports
- Directed SLFNHA to ensure presence at regional career fairs, promoting healthcare careers to First Nation youth in the Sioux Lookout area (SLFNHA attended three career fairs)
- Reviewed progress on Public Health Project and Anishinaabe Bimaadiziwin Research Program

Challenges

- Finding effective ways to promote healthcare careers to First Nation youth
- As we see an increase in the number of students studying in a healthcare field at a post-secondary institution, it's becoming increasingly challenging to adequately supply bursaries to each student. The amount of the bursary is either too low if funding all students, or students are left off the bursary list.

Moving Forward

Continue to support the implementation of the AHP specifically in the areas of:

- Public health system development
- Development of a Primary Health Care Facility
- Client coordination system development
- Regional Wellness Response Program
- Anishinaabe Bimaadiziwin Research Program

Continue to promote health careers by:

- Examining new ways to promote health careers to First Nation youth in the Sioux Lookout area (i.e. social media campaigns, using role models, etc.)
- Develop an application process for health bursaries

Representatives for 2012-13

- Chief Donny Morris, Kitchenuhmaykoosib Inninuwug
- Chief Clifford Bull, Lac Seul First Nation
- Chief Connie Gray-Mckay, Mishkeegogamang First Nation
- Chief Elizabeth Atlookan, Eabametoong First Nation
- Chief Arnold Gardner (Alternate: Coun. Robert Gardner), Eagle Lake First Nation
- Chief James Mamakwa, Kingfisher Lake First Nation
- Chief Titus Tait, Sachigo Lake First Nation
- Chief Bart Meekis, Sandy Lake First Nation
- Tina Kakepetum-Schultz, Keewaytinook Okimakanak Council
- Deputy Grand Chief Alvin Fiddler, Nishnawbe Aski Nation

Elders

- Phyllis Semple, Kitchenuhmaykoosib Inninuwug
- Jonas Fiddler, Sandy Lake First Nation

ᐊᑯᓯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑎᐸᒋᒧᐃᐧᐣ

ᒐᓃᑦ ᐧᑲᐣᑎᐣ

Janet Gordon
Director of
Health Services

ᐊᓂᔑᓇᐯ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐅᓇᒋᑫᐃᐧᐣ

ᐋᐧᓂᓇᐋᐧᑲᐠ ᐊᓂᔑᓇᐯᐠ ᒪᐢᑭᑭᐃᐧᑭᒪᐃᐧᐣ, ᐁᐅᐣᒋ ᐃᐧᑕᓄᑭᒪᐣ ᐊᓂᔑᓇᐯ ᐃᐢᑯᓂᑲᓇᐣ ᐅᒪ ᑌᑎᐸᐦᐃ ᑲᔦᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ, ᐁᑭ ᐃᐧᒋᑲᐸᐃᐧᑕᒧᐋᐧᐣ ᑲᑭ ᐅᓇᒋᑲᑌᑭᐸᐣ ᐊᓂᔑᓇᐯ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐅᓇᒋᑫᐃᐧᐣ. ᐃᐁᐧ AHP ᑲᐃᑭᑐᒪᑲᐠ ᒋᒪᒪᐃᐧᓂᑲᑌᐠ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐊᓂᔑᓇᐯ ᐅᑭᒪᐃᐧᐣ ᐃᐧᓇᐧᐊ ᐃᒪ ᒋᑭ ᐅᐣᒋ ᓂᑲᓂ ᐱᒧᒋᑲᑌᑭᐸᐣ.

ᒣᑲᐧᐣ ᒥᑭᓯᐃᐧᐱᓯᐨ 2006 ᐋᐧᓂᓇᐋᐧᑲᐠ ᑌᑎᐸᐦᐃ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐋᐧᐣ ᐅᑭᒪᑲᓇᐠ ᐅᑭ ᔕᐳᓇᓇᐋᐧᐸᐣ ᒥᓇ ᐁᑭ ᐸᑭᑕᓭᐋᐧᑕᒧᐋᐧᐣ SLFNHA ᒋᒪᑕᓄᑲᑕᒧᐋᐧᐣ ᑲᑭ ᐅᓇᒋᑲᑌᑭᐸᐣ AHP. ᐅᐁᐧ ᐅᓇᒋᑫᐃᐧᐣ ᐃᐣᒋᑫᒪᑲᐣ ᑫᐊᓂᑐᒋᑲᑌᑭᐣ ᒥᓇ ᑫᓇᐣᑕᐁᐧᐣᑕᑳᐧᑮᐣ ᐃᒪ ᑲᐃᐧ ᒪᒪᐃᐧ ᐱᒧᒋᑫᑕᒪᓯᔭᐠ ᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ.

ᐃᐁᐧ ᒪᐋᐧᐣ ᑲᑭᒋᓃᐣᑕᑳᐧᐠ ᐅᒪ ᐱᒧᒋᑫᐃᐧᓂᐠ ᐃᐁᐧ ᑲᑭ ᑕᑯᓂᑲᑌᐠ ᑲᑭᓇ ᐃᒪ ᐊᐃᐧᔭ ᒋᐅᐣᒋ ᐃᐧᒋᐦᐋᑲᓄᐣ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᒥᓇ ᑲᔦ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ. ᓄᑯᐨ ᑲᐋᐦᑭᐋᐧᐠ ᒥᐊᔕ ᐁᐦᐊᓂ ᐱᒋᓂᐢᑲᓂᐋᐧᐠ.

ᑲᑭᓇ ᐊᐃᐧᔭ ᒋᐅᐣᒋ ᐃᐧᒋᐦᐋᑲᓄᐣ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐋᓄᑲᑌᐠ

ᐃᒪ ᑲᐃᔑᐱᐦᐃᑲᑌᐠ ᐅᓇᒋᑫᐃᐧᐣ 10/06, ᐋᐧᓂᓇᐋᐧᑲᐠ ᐅᑭᒪᑲᓇᐠ ᐅᑭ ᐸᑭᑕᓭᐋᐧᓇᐋᐧᐣ ᐋᐧᓂᓇᐋᐧᑲᐠ ᐊᓂᔑᓇᐯ ᒪᐢᑭᑭᐃᐧᑭᒪᐃᐧᐣ ᒋᐅᓇᑐᐋᐧᐣ ᑲᑭᓇ ᐊᐃᐧᔭ ᒋᐅᐣᒋ ᐃᐧᒋᐦᐋᑲᓄᐣ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᐃᒪ 31 ᑕᔑᑫᐃᐧᓇᐣ ᑲᐅᐣᒋ ᑲᓇᐋᐧᐸᐣᑕᒪᐠ. ᐁᑲᐧ ᐃᐁᐧ ᐊᐱ, SLFNHA ᑭᒥᓇᐋᐧᐠ ᓭᓂᔭᓇᐣ ᐃᒪ ᑲᓇᑕ ᐅᑭᒪᐃᐧᐣ ᑲᐸᑭᑎᓇᐣ ᓭᓂᔭᓇᐣ ᒋᐅᐣᒋ ᒥᓄᓴᐦᐃᑯᐣ ᐊᓂᔑᓇᐯ ᐅᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᑯᐃᐧᓂᐋᐧ. ᐁᑲᐧ ᑕᐢ ᐊᑎᒥᓂᐱᓯᐨ 2012 ᒋᐅᐣᒋ ᒪᒋᐸᑭᑎᓇᑲᓄ ᓭᓂᔭ ᐁᑲᐧ ᐊᑯᓇᐠ ᒥᑭᓯᐃᐧᐱᓯᐨ 31, 2015. ᐁᑲᐧ ᐃᒪ ᐊᓂᑮᓇᑲᓇᐠ ᑲᐱᒧᑐᐋᐧᐣ ᑲᐅᐣᒋ ᓂᑲᓂᐢᑲᐠ ᐅᐁᐧ ᐊᑯᓯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ, ᒥᓇ ᑲᐅᐣᒋ ᐃᐧᒋᐦᐃᑯᐣ, ᒥᓇ ᐳᑭᑭᔑᑲ ᑲᐅᐣᒋ ᐊᐃᐧᒋᑕᐧᐣ ᐊᔭᒧᐃᐧᓂᐠ & ᑲᐅᐣᒋ ᐃᐧᒋᐦᐊᐣ ᑲᓇᓐᑕᐃᐧ ᑭᓐᑕᑭᐣ ᑫᑯᓇᐣ.

ᐃᑫᐧᓂᐋᐧᐠ SLFNHA ᑲᓂᑲᓂ ᐱᒧᑐᐋᐧᐣ ᐃᒪ ᑲᑭᓇ ᐊᐃᐧᔭ ᒋᐅᐣᒋ ᐃᐧᒋᐦᐋᑲᓄᐣ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᐁᑭ ᐅᓇᑐᐋᐧᐣ ᐊᐱᑕᒪᑫᐃᐧᐣ ᑫᐊᓄᑲᑕᒧᐋᐧᐣ ᐃᒪᑕᐢ ᑭᐅᐣᒋᐱᓇᐋᐧᐠ ᐊᓂᔑᓇᐯ ᒥᓇ ᐁᐣᑭᒣᐠ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᒥᓄᔭᐃᐧᐣ ᒥᓇ ᑭᓄᐋᐧᑲᐢ ᑲᐱᒪᓄᑲᑌᐠ ᐊᑯᓯᐃᐧ ᐸᒥᐦᐃᑯᐃᐧᐣ, ᑕᐣᑐᕀ ᐯ ᑌᑎᐸᐦᐃ ᑲᐅᐣᒋ ᐱᒧᒋᑲᑌᐠ ᐊᑯᓯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ, ᑭᐁᐧᑎᓄᐠ ᓃᐣᑲᐱᐋᐧᓄᐠ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐅᐣᒋ ᐊᓄᑲᑌᐠ, ᓂᔑᐣ ᐃᒪ ᑭᐅᐣᒋᑎᓴᐋᐧᐠ ᐅᑭᒪᑲᓇᐠ ᑲᔑ ᐸᐱᑭᔕᑭᓱᐋᐧᐣ ᒥᓇ ᓂᔑᐣ ᐊᓂᔑᓂᓂᐋᐧᐠ ᑕᔑᑫᐃᐧᓂᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐋᐧᐣ.

ᐊᐦᑭᐃᐧᐣ ᑲᑭᐁᐧᓇᓇᑲᒋᒋᑲᑌᐠ

- ᐃᑫᐧᓂᐋᐧᐣ ᓂᑕᐨ ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᑳᐧᑳᐧᐸᐣ ᐃᒪ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᒥᓇ ᐊᓂᑮᓇᑲᓇᐠ ᑲᐅᐣᒋ ᓇᓇᑲᒋᐦᐋᑲᓄᐋᐧᐣ ᑭᐸᑭᑎᓂᑲᑌᐸᐣ ᒣᑲᐧᐣ ᐅᐸᑫᐧᐃᐧᐱᓯᐨ 2013, ᐁᑲᐧ ᒥᓇ ᑯᑕᐠ ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᑭᐊᓂ ᒪᐋᐧᐣᑐᓂᑲᑌᐋᐧᐣ ᐃᐁᐧ ᐊᐦᐱ. ᐁᑲᐧ ᑕᐢ ᐅᐁᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑭᑭᔑᒋᑲᑌ ᒣᑲᐧᐣ ᒥᑭᓯᐃᐧᐱᓯᐨ 2014.
- ᒣᑲᐧᐣ ᑲᑕᑳᐧᑭᓯᐣ ᐱᓯᐨ 2014, ᑭᒪᐋᐧᐣᑐᐢᑲᓂᐋᐧᓄᐸᐣ ᐃᐁᐧ ᐅᐣᒋ ᑲᑭᓇ ᐊᐃᐧᔭ ᑫᐅᐣᒋ ᐃᐧᒋᐦᐋᑲᓄᐣ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᐅᐱᔑᑯᑲᐣ ᐃᐢᑯᓂᑲᐣ ᑲᑭᑕᔑ ᒪᐋᐧᐣᑐᐢᑲᓂᐋᐧᐠ. ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᓂᑲᓂᐢᑲᒧᐋᐧᐣ ᐅᑎᐢᑯᓂᑲᓂᐋᐧ (ᓇᐣᑕ ᑲᔦ ᑲᑭ ᐱᔕᑕᒪᑯᐋᐧᐣ) ᐃᒪ ᑲᔑ ᐸᑭᔕᑭᓱᐋᐧᐣ ᐅᑭᒪᑲᓇᐠ ᒥᓇ ᑲᑭᓇ 31 ᑕᔑᑫᐃᐧᓇᐣ ᑭᓇᐣᑕᐁᐧᓂᒪᐋᐧᐠ ᒋᐱᔕᐋᐧᐣ ᑫᐃᐧᓂᐋᐧ. ᐅᐁᐧ ᒪᐋᐧᐣᑐᐢᑲᐃᐧᐣ ᑭᑎᐸᒋᒧᑕᐋᐧᐋᐧᐠ ᓇᓇᐣᑐᐠ ᑫᑯᓇᐣ ᐃᐁᐧ ᐅᐣᒋ ᑲᐱᒪᓄᑲᑌᐠ ᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᐊᐋᐧᔑᒣ ᒋᑭ ᐅᐣᒋ ᑭᑫᐣᑕᒧᐋᐧᐸᐣ ᑲᐃᓯᓭᑭᐣ.
- ᑯᑕᑭᔭᐠ ᐸᑲᐣ ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐋᐧᐣ ᐅᑭ ᓇᓇᑲᒋᑐᓇᐋᐧᐣ ᐃᐁᐧ ᓂᓯᐣ ᐊᐦᑭᐃᐧᐣ ᐊᔕ ᑲᐅᐣᒋ ᐱᒪᓄᑲᑌᐠ ᐅᐁᐧ, ᐁᑲᐧ ᐅᑭᑭᔑᑐᓇᐋᐧᐣ ᑕᐢ ᐁᑭ ᑎᐸᒋᒧᐋᐧᐣ ᑲᑭᔑ ᒥᑭᑫᐋᐧᐣ ᐊᔑᐣ ᑲᔦ ᐁᑭ ᐸᑭᑎᓇᒧᐋᐧᐣ ᐅᑎᓃᐣᑕᒧᐃᐧᓂᐋᐧ ᑫᑭᔑ ᐊᐣᑕᒋᑲᑌᑭᐸᐣ ᑫᓇᓇᑲᒋᒋᑲᑌᐠ ᐊᓂᑮᐃᐧᐣ ᐃᒪ ᓂᓯᐣ ᐊᐦᑭᐃᐧᐣ ᐊᓂ ᒪᒋᑐᔭᐠ.
- ᐁᑭ ᐊᔭᑮᓃ ᑲᑫᐧᒋᒪᑲᓄᐋᐧᐣ ᑲᓂᑲᓂᐢᑲᒧᐋᐧᐣ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐅᑕᔑᑫᐃᐧᓂᐋᐧ, ᓂᑭ ᐊᓂ ᑭᑫᐣᑕᒥᐣ ᒋᑭ ᐊᔭᑭᐸᐣ ᑲᑫᐧᑌᐃᐧᓇᐣ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᑭᔭᐸᐣ ᐊᐋᐧᔑᒣ ᒋᑭ ᐅᐣᒋ ᐊᓄᑲᑌᑭᐸᐣ ᐅᐁᐧ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐋᓄᑲᑌᐠ. ᑐᑲᐣ, ᐊᔕ ᓂᑭ ᓂᑭ ᑭᑭᓇᐋᐧᑌᐣᑕᒥᐣ ᓂᔭᓇᐣ ᑕᔑᑫᐃᐧᓇᐣ ᒋᓇᓯᑲᒪᐠ ᓂᓯᑭᔑᑲ ᒥᓂᑯᐠ ᒋᐊᐣᑐ ᑭᐃᐧᑌᔮᐣᐠ. ᐃᑫᐧᓂᐋᐧᐣ ᑕᔑᑫᐃᐧᓇᐣ ᑲᑭ ᐅᓂᓇᒪᐣᐠ ᓇᓇᐣᑐᐠ ᐊᐱᑕᓯᓄᐋᐧᐠ ᐊᓂᔑᓂᓂᐋᐧᐠ, ᑲᐅᐣᒋ ᐃᔕᓂᐋᐧᐠ ᐃᒪ, ᐯᐸᑲᐣ ᐁᔑ ᑕᑳᐧᑮᐣ, ᒥᓇ ᐯᐸᑲᐣ ᐅᑭᒪᑲᓇᐠ ᐁᐅᐣᒋ ᑎᐯᐣᑕᑲᓯᐋᐧᐣ ᒥᓇ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐃᓇᑐᐋᐧᐣ ᐯᐸᑲᐣ ᐁᔑᓇᑳᐧᐠ.

ᑲᓇᓇᑭᐢᑭᑲᑌᑭᐣ

- ᐊᐁᐧ ᑲᓂᑲᓂᐢᑲᐠ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐋᓄᑲᑌᐠ ᑭᑕᐋᐧ ᐃᐁᐧ ᐊᓂᑮᐃᐧᐣ ᓂᑯᑖᐧᓯᐱᓯᐨ ᒥᓂᑯᐠ, ᒥᑕᐢ ᑲᑭ ᐃᓯᓴᐠ ᐁᑭ ᓴᓰᐣᑕᓄᑭᐣ ᐊᐁᐧ ᑲᐅᐣᒋ ᐋᐧᐃᐧᒋᐦᐊᐣ ᒥᓇ ᑲᔦ ᑲᐅᑭᒪᐃᐧᐣ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ. ᒥᑕᐢ ᑲᔦ ᑲᑭ ᐃᓯᓴᐠ ᐁᑭ ᐅᐣᒋ ᐸᐯᒋᓴᑭᐣ ᐊᓄᑭᐃᐧ ᐅᓇᒋᑫᐃᐧᓇᐣ.
- ᐃᐁᐧ ᓇᑯᒥᑎᐃᐧᐣ ᑫᐃᐧᓇᓄᑭᐣ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᒋᐅᐣᒋ ᐊᔭᒥᑕᒪᑫᐣ ᐃᒪ ᐅᑭᒪᐃᐧᓂᐠ ᓃᑫ ᓄᒪᑫ ᑭᐃᔭᓴ. ᒥᐃᐧᓂᑯ ᑲᑭᔑ ᐸᑯᓴᐣᑕᑳᐧᑭᐸᐣ ᐊᔕ ᒋᑭ ᒪᑕᓄᑭᐸᐣ ᐊᐁᐧ ᑫᐃᐧᓇᓄᑭᐣ ᐅᐱᒪᐦᐊᒧᐃᐧᐱᓯᐨ 1, 2014, ᑲᓇᑕ ᐅᑭᒪᐃᐧᐣ ᐅᑭ ᔕᐳᓇᐣ ᐃᒪ ᐊᓂᑮᐃᐧᐣ ᑲᑲᑫᐧᑖᐧᓂᐋᐧᐠ ᐸᓂᒪ ᑕᐢ ᓂᑭ ᑌᐱᓇᒥᐣ ᑲᐊᓂᐢᑳᐧ ᐊᐣᑭᓯᐣ ᒥᑭᓯᐃᐧᐱᓯᐨ 2014.

ᓂᑲᐣ ᐁᐊᓂᔑ ᐱᒋᓂᐡᑲᓂᐋ᐀ᐧ

- ᓂᑲ ᐱᒥ ᒪᐧᒋᐦᑎᐃᐧᓂᑫᒥᐣ ᑫᐱᒥ ᐊᐦᑭᐋᐧᐠ ᒋᐅᓇᑐᔭᐣᐠ ᐊᓂᐣ ᑫᐃᓇᑌᐠ ᑲᑭᓇ ᐊᐃᐧᔭ ᑫᐊᐸᒋᑐᐨ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ.
- ᓂᑭ ᐅᓇᑐᒥᐣ ᐊᐱᑕᒪᑫᐃᐧᓃᓴᐣ ᐃᒪ ᑲᔑ ᐊᐱᑕᒧᐋᐧᐨ ᐅᐁᐧ ᐊᓄᑭᐃᐧᐣ ᑲᐱᒪᓄᑲᑌᐠ ᒋᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᒧᐋᐧᐨ ᐊᓂᐣ ᑫᑭᔑ ᐊᓄᑲᑌᑭᐸᐣ ᐅᐁᐧ, ᐊᔑᐨ ᑲᔦ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ, ᐊᓂᐣ ᑫᑭᔑ ᒪᐡᑲᐃᐧᑲᐸᐃᐧᒪᑲᑭᐸᐣ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᒥᓇ ᒋᐊᓂ ᐊᔭᐣᑕᓯᓇᐦᐃᑲᑌᑭᐣ ᐅᓇᒋᑫᐃᐧᓇᐣ. ᐃᐁᐧ ᑕᐡ ᑲᐃᐧ ᐅᐣᒋ ᑐᒋᑲᑌᐠ ᐃᑫᐧᓂᐊᐧᐠ ᒪᔭᐨ ᑲᐊᐱᑕᒧᐋᐧᐨ ᐅᐁᐧ ᒪᒋᒋᑫᐃᐧᐣ ᐸᑲᐣ ᑫᑯᓇᐣ ᒋᑭ ᐊᓂᑲᑕᒧᐋᐧᐸᐣ ᐁᑲ ᒋᐅᐣᑕᒥᐦᐃᑯᐋᐧᐨ.
- ᐊᓇᐃᐧᓂᑯ ᓄᒪᑫ ᐁᑭ ᐃᓯᓴᐠ ᐊᐁᐧ ᑫᐃᓇᓄᑭᐨ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ ᒋᐅᐣᒋ ᐊᔭᒥᑕᒪᑫᐨ ᐃᒪ ᐅᑭᒪᐃᐧᓂᐠ ᓃᑫ, ᐊᔕ ᐱᒥᐊᓄᑲᑌ ᐁᓇᓇᐣᑎᓇᐋᐧᑲᓄᐨ ᑫᑭ ᐃᓇᓄᑭᐸᐣ.
- ᑕᔑᑫᐃᐧᓇᐣ ᑕᐊᔭᑭᓃ ᓇᓯᑭᑲᑌᐊᐧᐣ ᐃᒪ ᓃᐣᑲᐃᐧᓭᑲᐦᐃᑲᓂᐠ, ᐋᐧᓚᐡᑯᓄᒥᐠ, ᐅᐱᔑᑯᑲᐠ, ᓂᐱᓇᒥᐠ, ᒥᓇ ᐋᐧᔕᐦᐅ. ᒣᑳᐧ ᑕᐡ ᐃᒪ ᐃᔕᔭᐣᐠ ᓂᑲ ᑲᑫᐧᒋᒪᒥᐣ ᑲᐃᓯᓭᓂᐠ ᒋᑭ ᑲᑫᐧᒋᒪᔭᑭᐸᐣ ᐊᑯᓯᐃᐧ ᐊᓂᑭᓇᑲᓇᐠ ᒋᑭ ᐅᐣᒋ ᑭᑫᐣᑕᒪᑭᐸᐣ ᐊᓂᐣ ᐃᐧᓇᐊᐧ ᐁᐃᓇᐱᔑᒍᑯᐊᐧᑫᐧᐣ ᐃᐁᐧ ᑲᑭᓇ ᐊᐃᐧᔭ ᑫᐃᐧᒋᐦᐃᑯᐨ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐃᒪ ᐅᑕᔑᑫᐃᐧᓂᐊᐧ.
- ᐁᑳᐧ ᑕᐡ ᑭᐃᐡᑳᐧ ᐊᔭᑭᓃ ᑲᑫᐧᑌᐧᔭᐣᐠ, ᒥᐁᑳᐧ ᒋᐊᐣᑕᓯᓇᐦᐃᑲᑌᐠ ᑲᐃᔑᐱᐦᐃᑲᑌᐠ ᐊᐁᐧ ᑲᐊᓄᑲᑌᐠ ᒥᓇ ᒋᐃᔑᐃᐧᑕᒪᐋᐧᑲᓄᐋᐧᐨ ᑲᐃᓯᓴᓂᐠ ᒋᐋᐧᐸᐣᑕᐦᐃᐣᑕᐧ ᑲᐊᔑᑕᑭᒥᐣᑕᐧ ᐅᒪ ᑲᔑ ᐱᒪᓄᑲᑌᐠ ᐱᒧᒋᑫᐃᐧᐣ. ᐊᐱ ᑕᐡ ᑭᐃᐡᑳᐧ ᑭᔑᐱᐦᐃᑲᑌᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒥᓇ ᐊᓂᐣ ᑫᔑ ᐱᒧᒋᑲᑌᐠ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᓂᑲ ᐃᐧᑕᓄᑭᒪᒥᐣ ᐯᔓᐣ ᑲᐅᐣᒋ ᐃᐧᑕᓄᑭᒪᔭᐣᐠ ᒋᑭᑭᓇᐋᐧᑌᐣᑕᑳᐧᐠ ᔓᓂᔭ ᑫᐃᓇᐸᑎᓯᐨ ᒥᓇ ᐃᒪ ᐅᓇᑯᓂᑫᐃᐧᓂᐠ ᑲᔦ ᒋᐃᔑ ᐅᓇᒋᑲᓂᐋ᐀ᐧ.
- ᒣᑳᐧ ᑲᑕᑳᐧᑭᓯᐨ ᐱᓯᑦ 2015, ᓂᑲ ᐋᐧᐸᐣᑕᐦᐊᒥᐣ ᐅᐁᐧ ᑫᐃᓇᑌᐠ ᐱᒧᒋᑫᐃᐧᐣ ᐃᑫᐧᓂᐋᐧᐠ ᐋᐧᓂᓇᐋᐧᑲᐠ ᑌᑎᐸᐦᐃ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐋᐧᐨ ᐅᑭᒪᑲᓇᐠ ᒥᓇ ᑲᓂᑲᓂᐡᑲᒧᐋᐧᐨ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᓇᐣ ᐅᑕᔑᑫᐃᐧᓂᐋᐧ ᒋᐸᑭᑕᔕᐋᐧᑕᒧᐋᐧᐨ ᐃᒪ ᑫᒪᐋᐧᐣᑐᑲᓂᐋ᐀ᐧ ᐋᐧᓂᓇᐋᐧᑲᐠ.

ᐊᓂᔑᓇᐯ ᐱᒪᑎᓯᐃᐧᐣ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑲᐱᒧᒋᑲᑌᐠ

ᐃᐁᐧ ᐊᓂᔑᓇᐯ ᐱᒪᑎᓯᐃᐧᐣ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑲᐱᒧᒋᑲᑌᐠ ᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐨ SLFNHA ᒥᓇ ᐋᐧᓂᓇᐋᐧᑲᐠ ᒥᓄᔭᐃᐧᐣ ᐊᑯᓯᐃᐧᑲᒥᐠ (SLMHC).

ᐃᒪ ᑲᐃᔑᐱᐦᐃᑲᑌᐠ *ᐅᓇᒋᑫᐃᐧᐣ 12-08,* SLFNHA ᑭᐸᑭᑕᓀᐋᐧᓯ ᒋᒪᑕᓄᑲᑕᐠ ᒋᑭ ᐅᓇᑐᐋᐧᐸᐣ ᑕᔑᑫᐃᐧᓂᐠ ᑲᐅᐣᒋ ᐅᓇᑌᐠ ᐊᓂᐣ ᑫᑐᒋᑲᑌᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑫᐱᒧᑐᐊᐧᐨ ᐃᐧᓇᐊᐧ ᒋᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᒧᐋᐧᐨ ᑫᑯᓃᓇᐣ ᒪᐊᐧᐨ ᐁᓇᐣᑕᐁᐧᐣᑕᑳᐧᑭᐣ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᐊᑯᓯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᐅᐣᒋ. ᐅᑫᐧᓂᐋ᐀ᐧ ᑕᐡ ᑫᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐊᐧᐨ ᑫᔑ ᒥᑭᑫᐊᐧᐨ ᑕᐡ ᒥᐦᐃᒪ ᑫᐅᐣᒋ ᐃᐧᒋᐦᐃᐁᐧᓴᐠ ᐅᐁᐧ ᑲᐃᐧ ᑲᑫᐧ ᐱᒧᒋᑫᑕᒪᓯᔭᐠ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ. ᐊᒥᐦᐃ ᑲᔦ ᑫᐃᓇᓄᑭᐋᐧᐨ ᒋᐅᐣᒋ ᔕᔑᐣᑭᑕᑯᓯᐋᐧᐨ ᐃᒪ ᑕᔑᑫᐃᐧᓇᐣ ᑌᑎᐸᐦᐃ ᑲᔭᑭᐣ ᐋᐧᓂᓇᐋᐧᑲᐠ ᒋᒋᑭᐱᐦᐃᑯᐋᐧᐨ ᑫᑯᓃᓇᐣ ᒪᐊᐧᐨ ᑫᓂᑲᓃᐣᑕᑲᐧᐠ ᐅᒪ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐣᐠ.

ᐁᑳᐧ ᑕᑯ ᑲᔦ, SLMHC ᒣᑳᐧ ᐅᑕᓄᑲᑕᓇᐋᐧᐸᐣ ᐁᑭᐁᐧ ᓇᓇᑲᒋᑐᐊᐧᐨ ᐃᐁᐧ ᒣᑳᐧ ᑲᐃᓇᑌᐠ ᐱᒧᒋᑫᐃᐧᐣ ᑫᐊᐸᑕᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑲᐃᐧ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ ᐁᑳᐧ ᑕᐡ ᒋᐅᓇᑐᐊᐧᐨ ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ. ᒣᑳᐧ 2013, SLFNHA ᒥᓇ SLMHC ᐅᑭ ᐅᓇᑐᓇᐊᐧ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᒋᐃᓇᑌᐠ ᒋᒪᒪᐃᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᒧᐋᐧᐨ ᑫᑯᓇᐣ.

ᐊᐦᑭᐃᐧᐣ ᑲᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ

ᒥᐱᑯ ᐁᐃᓯᓴᐠ ᐅᐁᐧ ᑲᐊᐦᑭᐋᐧᐠ ᐁᐱᒥ ᐅᔑᓴᑭᐣ ᐃᑫᐧᓂᐋᐧᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑲᐊᓄᑲᑕᒧᐋᐧᐨ.

- ᑭᑲᐡᑭᒋᑲᑌ ᒋᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐨ SLMHC ᒋᐅᐣᒋ ᐃᐧᒋᑕᐋᐧᐨ ᐃᒪ ᑲᔑ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑲᓂᐋ᐀ᐧ
- ᑭᐅᑕᐱᓇᑲᓄ ᑫᓂᑲᓂᐡᑲᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᐅᐸᑫᐧᐃᐱᓯᑦ 2013 (ᐃᒪ ᑲᔑᑕᑳᐧᐠ SLMHC)
- ᐊᓂᑭᓇᑲᓇᐠ ᐃᒪ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐋᐧᐨ SLFNHA ᒥᓇ SLMHC ᐅᑭ ᐅᓇᑐᓇᐊᐧ ᑫᐊᐱᑕᒧᐋᐧᐨ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑫᐅᐣᒋ ᓂᑲᓂᐡᑲᐋᐧᐋᐧᐨ ᒥᓇ ᑫᐱᒥ ᑭᑭᓄᐡᑲᒪᑫᐋᐧᐨ ᐃᒪ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐠ (ᑕᓯᐱᓯᑦ ᑭᒪᒪᐋᐧᒋᐦᐃᑎᐋᐧᐨ). ᐅᑫᐧᓂᐋᐧᐠ ᑫᐱᒥᐃᐧᑐᐋᐧᐨ ᐊᒥᐦᐃ ᑫᐃᓇᑭᒪᑲᓄᐋᐧᐨ ᑐᑲᐣ ᐊᐱᑕᒪᑫᐃᐧᐣ ᑲᐊᐱᑕᑭᓯᐋᐧᐨ ᒣᑳᐧ ᐅᐁᐧ ᑲᐱᒥ ᐅᓇᒋᑲᑌᑭᐣ ᑫᑯᓇᐣ.
- ᓂᑖᑦ ᑭᐅᓇᓯᓇᐦᐃᑲᑌ ᐊᓂᑭᐃᐧ ᑭᑭᓇᐋᐧᑕᑕᒪᑫᐃᐧᐣ ᑫᐱᒥᓂᔕᐦᐊᒧᐋᐧᐨ ᐃᑫᐧᓂᐋ᐀ᐧ ᑲᐅᐣᒋ ᐊᔭᒥᑕᒧᐋᐧᐨ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ
- ᐅᑭ ᐅᓃᐣᑕᓇᐋᐧ ᐊᓂᐣ ᑫᐃᔑᓂᑲᑌᐠ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ: *ᐊᓂᔑᓇᐯ ᐱᒪᑎᓯᐃᐧᐣ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑲᐱᒧᑐᐋᐧᐨ*

ᑲᓇᓇᑭᐡᑭᒋᑲᑌᑭᐣ

- ᑲᐅᓇᒋᑲᑌᑭᐣ ᐊᓂᑭᐃᐧ ᓇᑯᒥᑎᐃᐧᓇᐣ ᒥᓇ ᑫᐱᒥᓂᔕᐦᐃᑲᑌᑭᐣ ᑫᐊᐸᑕᑭᐣ ᐊᓂᐱᒥ ᐅᔑᓴᑭᐣ ᑲᑭᓇ ᑫᑯᓇᐣ
- ᒋᐊᐣᑕᒋᑲᑌᑭᐣ ᐁᑲ ᑲᓇᐦᐃᓇᑳᐧᑭᐣ ᐃᒪ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐠ ᐁᑳᐧ ᑕᐡ ᑭᔭᐸᒣ ᐊᐋᐧᔑᒣ ᒋᑭ ᐃᐣᑕᒪᑲᓂᐋᐧᑭᐸᐣ ᐊᓂᐣ ᐁᐣᓇᐧᑌᐠ ᑕᔑᑫᐃᐧᓂᐠ ᑲᐅᐣᒋᒪᑲᑭᐣ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓇᐣ ᑲᑭ ᑭᑭᓇᐋᐧᒋᑐᐊᐧᐨ ᑫᐃᐧᒋᐦᐃᑯᐋᐧ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓇᐣ.

ᓂᑲᐣ ᑫᐊᓂᔑ ᐱᒋᓂᐡᑲᓂᐋ᐀ᐧ

- ᐁᑳᐧ ᐃᐦᐃᐁᐧ ᑲᐊᓂ ᐱᒪᓄᑭᒪᑲᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ, ᐃᒪ ᑕᓂᔑ ᐊᓂᑲᑌ ᒋᑫᒋᓇᐁᐧᐅᐣᑕᑳᐧᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᐱᒧᒋᑫᐃᐧᐣ ᒋᓇᐦᐃᓇᑳᐧᐠ ᒥᓇ ᑫᔑ ᐊᓄᑭᒪᑲᐠ ᑲᑭᓇ ᑫᔑ ᐊᐸᑕᑭᐣ ᐊᑯᓯᐃᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᐅᒪ ᐧᐊᓂᓇᐋᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑳᐧᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ. ᐅᐁᐧ ᑕᐡ ᑲᐃᒋᑲᑌᐠ ᒋᐊᓂ ᐅᔑᓴᑭᐣ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᓇᐣ ᐃᒪ ᒪᐋᐧ ᑲᐃᐡᐸᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᑲᒥᑯᐣ, ᐊᑯᓯᐃᐧᑲᒥᑯᐣ, ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᑲᒥᑯᐣ, ᑕᔑᑫᐃᐧᓇᐣ, ᑯᑕᑭᔭᐣ ᑫᑯᓇᐣ ᒋᑫᒋᓇᐁᐧᐅᐣᑕᑳᐧᑭᐣ ᐅᑫᐧᓂᐋᐧᐣ ᑲᐊᓄᑲᑌᑭᐣ ᐃᒪ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓂᐠ ᒥᓇ ᑌᑎᐸᐦᐃ ᐋᐧᓂᓇᐋᐧᑲᐠ ᒋᔑᓇᑳᐧᐠ ᑫᐃᐧᒋᒋᑫᒪᑲᐠ ᑲᔑ ᓇᐣᑕᐁᐧᐣᑕᒧᒪᑲᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ.

- ᒥᓇᐊᐧ ᐊᐦᑭᐊᐧᐠ ᐃᒪ ᑕᔑ ᐊᓂᑲᑌ ᒋᐊᐧᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᑫᑯᓀᓂᐦᐃ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐃᒋᑲᑌᐠ ᒥᓇ ᐱᑯ ᐃᒪ ᒥᓯᐁᐧ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑲᐧᑭᐣ ᐅᒪ ᐅᐣᑌᔥᐃᔨ ᑕᔑᑫᐃᐧᓇᐣ ᒥᓇ ᐱᑯ ᐃᑫᐧᓂᐊᐧᐠ ᑲᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᒧᐊᐧᐨ ᑫᑯᓇᐣ ᒋᑭ ᐊᓄᐣᒋ ᓂᔨᑐᒋᑲᑌᑭᐸᐣ ᐊᓂᐣ ᑫᑭᔑ ᐱᒋᓂᐡᑲᓂᐊᐧᑭᐸᐣ ᐅᒪ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐠ ᒥᓇ ᑲᔦ ᐊᐣᑎ ᑫᔑ ᓇᒋᐸᐦᐃᐊᐧᓂᐊᐧᐠ ᐊᐱ ᓇᐣᑕᐁᐧᐣᑕᑲᐧᐠ ᒋᐃᐧᒋᑕᐧᓂᐊᐧᐠ ᓂᑲᐣ ᑫᒋᓀᐣᑕᑲᐧᑭᑌ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓇᐣ. ᑲᔦ ᐊᓂᑭᓇᑲᓇᐠ ᑫᐱᒥᓂᔕᐦᐊᒧᐊᐧᐨ, ᑕᑯ ᑲᔦ ᒋᓇᐣᑭᓂᑲᑌᐠ ᐱᒧᒋᑫᐃᐧᐣ ᑫᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᐠ ᑭᓇᐧᑲᐡ ᑲᐱᒥᓴᐠ ᐅᓇᒋᑫᐃᐧᐣ ᑫᐊᐸᒋᑐᐊᐧᐨ ᑲᓇᐱᐡᑲᐊᐧᐊᐧᐨ ᒪᐡᑭᑭᐃᐧᓂᐊᐧᐣ
- SLFNHA ᒥᓇ ᑲᓇᑕ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐅᓇᓇᐣᑎᓇᓇᐊᐧ ᒋᑭ ᐊᓂᔑᒋᑲᑌᑲᐧᐸᐣ ᐱᐊᐧᐱᑯᐠ ᑲᔑ ᑲᓇᐁᐧᐣᑕᑲᐧᑭᐣ ᒪᐡᑭᑭᐃᐧ ᒪᓯᓇᐦᐅᑯᐃᐧᓇᐣ ᑫᐊᐸᒋᑐᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑕᑲᐧᑭᐣ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᓇᐣ.

ᑲᐅᐣᒋ ᐱᒧᒋᑲᑌᑭᐣ ᒪᐡᑭᑭᐃᐧᓂᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ

ᐊᐦᑭᐃᐧᐣ ᑲᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ

- ᑲᓇᓇᐣᑎᓇᐊᐧᑲᓄᐊᐧᐨ ᒪᐡᑭᑭᐃᐧᓂᓂᐊᐧᐠ ᐱᒥᓴ: ᐯᔑᐠ ᒪᐡᑭᑭᐃᐧᓂ ᑭᒪᓯᓇᐦᐅᑎᓯ ᑲᑲᐯᓴᓂᐠ ᐅᓇᑯᒥᑎᐃᐧᐣ ᐃᒪ ᐦᐃᔨ ᐊᔥᐊᐣ ᒪᐡᑭᑭᐃᐧᑲᒥᐠ ᐁᑲᐧ ᒥᓇ ᐯᔑᐠ ᒪᐡᑭᑭᐃᐧᓂ ᑭᒪᓯᓇᐦᐅᑎᓯ ᐁᑲ ᑲᑲᐯᓴᓂᐠ ᐅᑕᓄᑭᐃᐧ ᓇᑯᒥᑎᐃᐧᐣ (ᐊᐧᐸᓴᑎᑲᐣᐠ ᐃᐡᑯᓂᑲᐣ)
- ᐊᐧᓂᓇᐊᐧᑲᐧ ᑲᐅᐣᒋ ᐱᒧᒋᑲᑌᐠ ᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ (SLRPSI) ᐅᑭ ᔕᐳᓇᓇᐊᐧ ᐊᓂᑭᐃᐧ ᓇᑯᒥᑎᐃᐧᐣ ᐃᒪ ᑭᐁᐧᑎᓄᐠ ᒪᐡᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑫᓂᑲᓂᐡᑲᐠ ᒋᓂᑲᓂᐡᑲᐊᐧᐨ ᒥᓇ ᒋᐃᐧᒋᑲᐸᐃᐧᑕᐊᐧᒋᐣ ᑭᐁᐧᑎᓄᐠ ᒪᐡᑭᑭᐃᐧᓂᐊᐧᐣ ᑫᑕᓇᓄᑭᐊᐧᐨ
- ᐃᒪ ᐱᐊᐧᐱᑯᐠ ᑲᔑ ᑲᓇᐁᐧᐣᑕᑲᐧᑭᐣ ᒪᐡᑭᑭᐃᐧ ᒪᓯᓇᐦᐅᑯᐃᐧᓇᐣ (EMR), ᓂᑭ ᐊᐧᐸᐣᑕᒥᐣ ᒥᔑᐣ ᓇᐊᐧᐨ ᒪᐡᑭᑭᐃᐧᓂᐊᐧᐠ ᐁᐊᐸᒋᑐᐊᐧᐨ ᐅᐁᐧᓂ ᐁᑲᐧ ᑕᐡ ᑭᐃᔑᒋᑲᑌ ᓇᐊᐧᐨ ᒋᑭᔕᑕᐱᓴᐠ ᑲᓇᒋᐱᑐᐊᐧᐨ ᒪᓯᓇᐦᐅᑯᐃᐧᓇᐣ ᐃᒪ ᑭᐁᐧᑎᓄᐠ ᒪᐡᑭᑭᐃᐧᑲᒥᑯᐣ ᑲᔭᑭᐣ. ᐅᑕᑯᓯᐠ ᐅᒪᓯᓇᐦᐅᑯᐃᐧᓂᐊᐧ ᐊᔕ ᐊᓂ ᒥᔑᓇᑎᓄᐣ ᐃᒪ ᑲᔑ ᒪᐊᐧᐣᑐᓯᓇᐦᐃᑲᑌᑭᐣ ᒪᐊᐧᐨ ᑕᐡ ᐅᒥᓂᓴᐦᐃᑯᐊᐧᐣ ᒪᐡᑭᑭᐃᐧᓂᐊᐧᐠ ᑲᐊᐧᐸᒪᐊᐧᐨ ᐅᑕᑯᓯᐣ.

	2011/2012 ᒥᓂᑯᐠ ᑭᔑᑲᐊᐧᐣ ᑲᑭ ᐊᓂᑭᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ	2012/2013 ᒥᓂᑯᐠ ᑭᔑᑲᐊᐧᐣ ᑲᑭ ᐊᓂᑭᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ	2013/2014 ᒥᓂᑯᐠ ᑭᔑᑲᐊᐧᐣ ᑲᑭ ᐊᓂᑭᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ
ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑲᑭ ᐸᑭᑎᓇᒧᐊᐧᐨ	2,221	2,048	2,013

ᑲᓇᓇᑭᐡᑭᑲᑌᑭᐣ

- ᑲᑭᒋᐃᐧᓇᑲᓄᐊᐧᐨ ᒥᓇ ᑲᓇᓇᐣᑎᓇᐊᐧᑲᓄᐊᐧᐨ ᑫᓇᑯᒧᐊᐧᐨ ᒋᐊᓄᑭᑕᒪᑫᐊᐧᐨ ᒪᐡᑭᑭᐃᐧᓂᓂᐊᐧᐠ
- ᒋᑲᑫᐧ ᐃᓯᓴᒋᑲᑌᐠ ᑲᐃᔐᓀᐣᑕᑯᓯᐨ ᒪᐡᑭᑭᐃᐧᓂ ᒋᓇᓯᑲᑭᐣ ᑭᐁᐧᑎᓄᐠ ᑕᔑᑫᐃᐧᓇᐣ ᐁᑲᐧ ᒥᓇ ᐊᐧᓂᓇᐊᐧᑲᐧ ᐊᑯᓯᐃᐧᑲᒥᐠ ᑫᑭᔑ ᐊᐧᐊᐧᐸᒪᐊᐧᐸᐣ ᐅᑕᑯᓯᐣ ᒣᑲᐧᐨ ᑲᑲᑫᐧ ᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ ᑲᑭᓇ ᐅᑕᑯᓯᐠ ᑲᐊᓂᑲᐊᐧᔭᐣᐠ

ᓂᑲᐣ ᑫᐊᓂᔑ ᐱᒋᓂᐡᑲᓂᐊᐧᐠ

- ᒋᐅᓇᒋᑲᑌᑭᐣ ᒋᐯᑌᑕᑲᐧᑭᐣ ᐅᓇᑯᓂᑫᐃᐧᓄᓴᐣ ᒥᓇ ᑫᐱᒥᓂᔕᐦᐃᑲᑌᑭᐣ ᒋᓇᐊᐧᐨ ᓴᑯᓇᐠ ᒋᑭ ᐃᔕᐊᐧᐸᐣ ᒪᐡᑭᑭᐃᐧᓂᓂᐊᐧᐠ ᑭᐁᐧᑎᓄᐠ
- ᒋᐅᓇᒋᑲᑌᑭᐣ ᑲᐯᑌᑕᑲᐧᑭᐣ ᐅᓇᑯᓂᑫᐃᐧᓄᓴᐣ ᑫᐯᑌᓂᓯᑎᑕᒧᐊᐧᐨ ᑲᓇᐱᐡᑲᐊᐧᐊᐧᐨ ᒪᐡᑭᑭᐃᐧᓂᐊᐧᐣ, ᑲᒪᓯᓇᐦᐅᑎᓯᐨ ᒪᐡᑭᑭᐃᐧᓂᓂ ᐊᓂᑭᐃᐧ ᓇᑯᒥᑎᐃᐧᐣ ᒥᓇ

ᐅᑕᑯᓯᐠ ᑫᓱ ᐊᐧᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᑲᐊᓄᑲᑕᒧᐊᐧᐨ- ᑭᐁᐧᑎᓄᐠ ᐅᑕᑯᓯᐠ ᑫᓱ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ

ᐃᐁᐧ ᑭᐁᐧᑎᓄᐠ ᐅᑕᑯᓯᐠ ᑲᑕᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᒥᐦᐃᒪ ᑭᔭᐸᐨ ᐁᔑ ᑕᑲᐧᐠ ᑫᑌ ᐊᑯᓯᐃᐧᑲᒥᐠ ᐁᑲᐧ ᑕᐡ ᐅᑕᑯᓯᐣ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓂᐠ ᑲᐊᐧᐅᐣᑎᓴᐊᐧᐨ ᑲᐱ ᓇᒋ ᒪᐡᑭᑭᐃᐧᓄᐊᐧᐨ ᐊᐧᓂᓇᐊᐧᑲᐧ ᐃᒪ ᑕᔑ ᐊᐧᐸᒪᐊᐧᐠ. ᐅᐁᐧ ᑫᑌ ᒪᐡᑭᑭᐃᐧᑲᒥᐠ ᑲᑕᔑ ᐊᐧᐸᒥᐣᑕᐧ ᐅᑕᑯᓯᐠ ᐊᓂᑭᓇᑲᓇᐠ ᐃᒪ ᐊᔭᐊᐧᐠ: ᑲᓂᑲᓂᐡᑲᐊᐧᐨ ᐅᑕᓄᑭᐣ ᐃᒪ, ᒪᐡᑭᑭᐃᐧᑫᐧ, ᓂᔑᐣ ᐅᒪᓯᓇᐦᐃᑫᔑᔕᐠ ᒥᓇ ᑲᑲᐯᓴᓂᐠ ᐅᑕᓄᑭᐃᐧᐣ ᑲᑲᓇᐁᐧᐣᒋᑫᐨ.

ᐊᐦᑭᐃᐧᐣ ᑲᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ

- ᓄᑯᑦ ᔐᓂᔭᐊᐦᑭ ᑲᑭᐃᓯᓴᐠ 3,936 ᐅᑕᑯᓯᐠ ᑭᐊᐧᐸᒪᐊᐧᐠ
- 303 ᐅᑕᑯᓯᐠ ᐅᑭ ᐊᐧᐸᒥᑯᐊᐧᐣ ᐊᐃᐧᔭ ᐅᐊᐧᑲᐃᐧᐃᐧᓂᐠ ᑲᔑ ᐊᑯᓯᐨ ᑲᐃᓇᓄᑭᐨ ᒪᐡᑭᑭᐃᐧᓂ.
- ᐃᒪ ᒪᐡᑭᑭᐃᐧᓂᐊᐧᐠ ᑲᐊᐧᐸᒪᐊᐧᐨ ᐅᑯᓯᐣ ᓇᓇᐣᑐᐠ ᑲᐃᓇᐱᓀᓂᐨ:
  - ᒥᓇᐊᐧ ᑲᐊᐧᐸᒪᑲᓄᐨ ᐅᑕᑯᓯ ᐊᔕ ᑲᑭ ᐸᑭᑎᓇᑲᓄᐨ ᑲᔑ ᐸᐸᔑᓴᐠ ᐊᑯᓯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᑲᒥᐠ ᒥᓇ ᐊᑯᓯᐃᐧᑲᒥᑯᐠ ᑲᐅᐣᒋ ᐸᑭᑎᓇᑲᓄᐨ
  - ᑲᐊᓂ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᑲᐃᐡᑲᐧ ᒪᓯᓇᑌᐱᓯᐊᐧᐨ SLMHC
  - ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᒥᓇ ᑲᓴᑭᓂᑯᐊᐧᐨ ᑫᑯᓇᐣ, ᑐᑲᐣ ᓴᐟᐊᐧᐠᓯᐣ & ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᒣᑲᐧᐨ ᐊᐧᓂᓇᐊᐧᑲᐧ ᑲᐱ ᓇᒋ ᒪᐡᑭᑭᐃᐧᑲᒧᑫᐧᐊᐧᐨ
  - ᑲᓴᑲᐱᓇᓂᑯᐊᐧᐨ ᐊᑯᓯᐃᐧᓇᐣ ᑲᐅᐣᒋ ᓇᓇᑲᒋᐦᐊᑲᓄᐊᐧᐨ

ᑲᓇᓇᑭᐡᑭᑲᑌᑭᐣ

- ᑲᓇᓇᐣᑎᓇᐊᐧᑲᓄ ᒪᐡᑭᑭᐃᐧᑫᐧ ᒪᐡᑭᑭᐃᐧᓂ ᑲᐃᔕᑭᑫᐣᑕᒪᐃᐧᓂᐨ ᑲᐃᓇᓄᑭᐨ
- ᐃᒪ ᑫᑌ ᐊᑯᓯᐃᐧᑲᒥᐠ ᑲᑕᓇᓄᑭᓇᓂᐊᐧᐠ ᐁᒥᔑᓇᑎᑭᐣ ᑲᒪᒋᓴᑭᐣ (ᑲᐅᐣᒋᑲᐃᐧᑭᐣ ᓂᐱ ᑲᐃᓇᐱᑭᓯᐠ, ᐱᐣᐱᑲᒥᐠ ᐃᐡᐱᒥᐠ ᐁᒪᒋᓇᑲᐧᐠ, ᐁᓇᐃᐧᓇᑲᐧᐠ ᐃᒪ SLMHC & ᑲᐯᔑᐃᐧᑲᒥᐠ, ᑯᑕᑭᔭᐣ ᑫᑯᓇᐣ

ᓂᑲᐣ ᑫᐊᓂᔑ ᐱᒋᓂᖅᑲᓂᐊᐧᐠ

- SLFNHA & ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᒋᑯᓯᐊᐧᐣ ᒪᒋᑭᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᐣ (SLRPSI) ᐅᐃᐧᒋᓄᑭᒪᐊᐧᐣ SLMHC ᒋᐅᔑᒋᑲᑌᐠ ᐱᐦᑮᐣ ᑫᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐣ ᐅᒋᑯᓯᐠ ᒥᓇ ᑲᔭ ᑭᐁᐧᑎᓄᐠ ᑲᐅᐣᑎᓴᐊᐧᐣ ᑲᐱᓇᒋ ᒪᒋᑭᐃᐧᑲᒥᑫᐊᐧᐣ. ᒥᑕᐣ ᐃᒪ ᑫᔑ ᑕᑲᐠ ᐃᒪ ᒥᓄᔮᐃᐧᐣ ᐊᑯᓯᐃᐧᑲᒥᐠ ᑲᔑ ᐸᑕᑭᑌᐠ

- SLFNHA & SLRPSI ᐅᐱᒥ ᐊᓄᑲᑕᓇᐊᐧ ᑲᓇᐣᑕᐁᐧᐣᑕᑲᐠ ᐊᐣᑎ ᑫᔑ ᑕᑲᐠ ᐅᒋᑯᓯᐠ ᑫᑕᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐣ ᐁᐧᑲ ᒥᐦᐅᐁᐧ ᑫᓂᑲᓐᑕᑲᐠ ᐃᑫᐧᓂᐊᐧᐠ ᑲᓂᐊᐧᑲᓐᓯᐊᐧᐣ ᑲᐊᓄᑲᑕᒧᐊᐧᐣ.

- ᑭᔭᐸᐣ ᑕᓂ ᐊᓄᑲᑌ ᒋᓇᓇᐣᑎᓇᐊᐧᑲᓄᐣ ᒪᒋᑭᐃᐧᑫᐧ ᒪᒋᑭᐃᐧᓂ ᑲᐊᐱᑕᓄᑭᐣ ᒋᐃᓇᑭᓯᐣ ᐁᐧᑲ ᒥᓇ ᒋᐅᒋᑲᑌᐠ ᑫᐃᓇᓄᑭᐣ ᒥᓇ ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᐅᐁᐧ ᐊᓄᑭᐃᐧᐣ

ᑫᔑ ᒪᒪᐊᐧᓄᐦᑲᑌᐠ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᑫᐅᐣᒋ ᒥᓄᔭᒪᑲᓂᐠ ᐊᐃᐧᔭ ᐅᐱᒪᑎᓯᐃᐧᐣ (RWRP)

ᐅᑕᓇᐣᐠ ᑲᐱᒥ ᐊᐦᑭᐊᐧᐠ, ᑭᐊᓂ ᒥᓴ ᑲᐊᐸᒋᑐᐊᐧᐣ ᒪᒋ ᒪᒋᑭᑫᐃᐧᐣ ᒥᓇ ᒍᑕᑭᔭᐣ ᑲᐊᒍᓯᒋᑫᒪᑲᑭᐣ ᐊᑯᓯᐃᐧᓇᐣ (ᑐᑲᐣ ᒪᒪᐱᓐᐃᐧᐣ ᒥᓇ ᒥᒋᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐅᒍᓯᐣ ᐊᐃᐧᔭ) ᐃᒪ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓇᐣ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑫᐧᑭᐣ. ᐁᐧᑲ ᒥᓇ ᐃᐁᐧ ᑲᐊᓂ ᐱᒥ ᒥᓴᐠ ᒋᑕᐦᐃᑲᓇᐱᒍᐣ ᑲᐊᐸᒋᑐᐊᐧᐣ ᒥᓇ ᑲᓇᓇᐱ ᐊᐸᒋᑕᒧᑐᐊᐧᐣ, ᒥᓇ ᑲᔭ ᑲᓇᓂᓭᓂᓴᐊᐧᐣ ᐃᐁᐧ ᑲᑐᑕᒧᐊᐧᐣ, ᑭᑎᐸᒋᒧᓇᓂᐊᐧᐣ ᐁᐧᐦᐊᓂ ᐃᖅᐸᐠ ᒥᒋᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᓴᑲᐱᓐᐊᐧᐣ ᐊᑯᓯᐃᐧᓇᐣ ᑐᑲᐣ ᒥᒋᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᐊᐧᐣ ᒪᓂᒧᔕᐠ C (HCV) ᐁᐧᑲ ᒥᓇ ᑲᔭ ᒪᒪᐱᓐᐃᐧᐣ ᑲᑭᑭᖅᑲᑯᐊᐧᐣ (STIs).

ᐃᒪ 2011 SLFNHA ᑕᓯᐊᐦᑭ ᑭᒋᒪᐊᐧᒋᐦᐃᑎᐃᐧᓂᐠ, ᐅᑭᒪᑲᓇᐠ ᐃᒪ ᑲᑭ ᒪᐊᐧᒋᐦᐃᑎᐊᐧᐣ ᐅᑭ ᐸᑭᑕᓫᐊᐧᑕᓇᐊᐧ ᐁᐧᑭ ᐃᓇᐊᐧᐣ SLFNHA ᒋᐅᓇᑐᐣ ᒥᓯᐁᐧ ᐅᒪ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑫᐧᑭᐣ ᐅᐣᑌᐤᐃᔦ ᒪᒋ ᒪᒋᑭᑫᐃᐧᐣ ᐃᐧᒋᐦᐁᐧᐃᐧ ᐅᓇᒋᑫᐃᐧᐣ. ᓂᔑᐣ ᑲᓂᔕᔦᑭᓭᑭᐣ ᑫᓂᑲᓐᑕᑫᐧᑭᐣ ᑭᑭᑭᓇᐊᐧᑌᐣᑕᑫᐧᓄᐣ ᑫᑭ ᐊᓄᑲᑌᑲᐧᐸᐣ ᐃᐁᐧ ᒪᒋ ᒪᒋᑭᐣ ᑲᐊᐸᒋᑐᐊᐧᐣ ᒥᓇ ᒥᒋᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐊᔭᔕᐦᐅᑎᓇᓂᐊᐧᐠ ᐊᑯᓯᐃᐧᓇᐣ.

ᐃᐁᐧ ᑕᐤ ᐁᐧᐃᐧ ᐃᑭᑐᔮᐣᐠ, ᐃᐁᐧ ᑫᔑ ᒪᒪᐊᐧᓄᑲᑌᐠ ᐧᐃᒋᐦᐁᐧᐃᐧᓇᐣ ᑫᐅᐣᒋ ᒥᓄᔭᒪᑲᓂᐠ ᐊᐃᐧᔭ ᐅᐱᒪᑎᓯᐃᐧᐣ ᐱᒧᒋᑫᐃᐧᐣ (RWRP) ᒋᒪᒋᒋᑲᑌᐸᐣ ᐅᑫᒥᑭᔑᑲᓂᐱᓯᐨ 2013. ᒥᑕᐤ ᐅᑫᐧᓂᐊᐧᐣ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᐁᐧᑕᑫᐧᑭᐣ: ᒥᓯᐁᐧ ᑫᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᑕᐠ ᐱᒧᒋᑫᐃᐧᐣ, ᒋᑕᐦᐃᑲᓇᐱᒍᐣ ᑲᐸᑭᑎᓂᑲᑌᐸᐣ ᐱᒧᒋᑫᐃᐧᐣ, ᑕᔑᑫᐃᐧᓂᐠ ᑫᔑ ᒥᓄᔭᒪᑲᐠ ᑲᐊᓄᑲᑕᒧᐊᐧᐣ, ᒥᓇ ᒥᒋᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᓴᑲᐱᓐᐣ ᐊᐃᐧᔭ C ᐱᒧᒋᑫᐃᐧᐣ. ᑲᑭᓇ ᐅᑫᐧᓂᐊᐧᐣ ᐃᐣᑕᒪᑫᐊᐧᐠ ᐊᓂᐣ ᐁᐧᐃᓇᐧᑌᑭᐣ ᐅᑫᐧᓂᐊᐧᐣ ᐱᒧᒋᑫᐃᐧᓇᐣ, ᒥᐱᐨ ᐁᐧᐃᓇᑌᐠ ᐅᒪ ᐱᒧᒋᑫᐃᐧᓂᐠ. ᐃᐁᐧ RWRP ᓂᐃᐧᐣ ᐊᓂᑭᓇᑲᓇᐠ ᐃᐧᒋᓄᑭᒥᑎᐊᐧᐠ ᐃᒪ ᒪᓯᓇᐦᐃᑫᐃᐧᑲᒥᑯᐠ, ᒥᓇ ᓂᔑᐣ ᐊᔭᐊᐧᐠ ᑲᐅᐣᒋ ᐃᐧᒋᓄᑭᒪᐊᐧᐣ ᓇᑲᑌ.

ᐊᐦᑭᐃᐧᐣ ᑲᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ

ᒥᓯᐁᐧ ᑲᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᒋᑲᑌᐠ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ

- ᐁᐧᑭ ᒥᓄᓴᑭᐣ ᑲᐃᐧᒋᓄᑭᒪᑲᓄᐊᐧᐣ ᑕᔑᑫᐃᐧᓂᐠ ᐅᓂᑲᓂᑕᒪᑫᐠ, ᐊᓂᑭᓇᑲᓇᐠ ᐱᒪᑎᓯᐃᐧᓇᐣ ᑲᐊᓂᑲᓂᑕᒧᐊᐧᐣ, ᐊᑯᓯᐃᐧ ᐊᓂᑭᓇᑲᓇᐠ, ᒍᑕᑭᔭᐣ ᑫᒍᑲᐣ, ᐁᐧᑭ ᐅᐣᒋ ᐃᓯᓭᐠ ᐊᐊᐧᔑᒣ ᑭᔭᐸᐣ ᒋᐊᓂ ᐅᓇᒋᑲᑌᑭᐣ ᑲᔑ ᓇᐣᑕᐁᐧᐣᑕᒧᒪᑲᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ ᒥᓇ ᑲᔭ ᐁᐧᐊᓄᑲᑌᑭᐣ ᑲᒥᒋᑎᓐᐣᑕᒧᐦᐁᐧᒪᑲᑭᐣ.

- ᒋᒪᒪᐃᐧ ᐃᐧᑕᓄᑭᒥᑎᓇᓂᐊᐧᐠ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᒥᓇ ᐁᐧᐊᓄᑲᑌᑭᐣ ᑲᒥᒋᑎᓐᐣᑕᒧᐦᐁᐧᒪᑲᑭᐣ.

- ᐱᒧᒋᑫᐃᐧᐣ ᒪᓯᓇᐦᐃᑲᐣ ᑭᐅᔑᒋᑲᑌ, ᐁᐧᑲ ᐃᐁᐧ ᐃᐣᑕᒪᑫᐃᐧᐣ ᑭᐊᒋᑲᑌ ᐃᒪ SLFNHA ᐱᐊᐧᐱᑯᐠ, ᒥᓇ ᑲᔭ ᑎᐸᒋᒧᒪᓯᓇᐦᐃᑲᓂᐠ ᑲᔭ ᒋᑎᐸᒋᒧᓇᓂᐊᐧᐠ ᐁᐧᐃᐧᐣᒋᑲᑌᐠ ᑫᑯᓐᐣ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐁᐧᐃᓇᓄᑭᒪᑲᐠ.

ᒋᑕᐦᐃᑲᓇᐱᒍᐣ ᑲᐊᔭᑭᓐ ᐸᑭᑎᓂᑲᑌᑭᐣ ᐱᒧᒋᑫᐃᐧᐣ

- ᒥᑕᐦᐃ ᐊᔕ ᐊᓄᑲᑌ ᐊᐱ ᓂᑕᐨ ᑲᑭ ᒪᑕᓄᑲᑌᑭᐸᐣ- ᒥᑕᐤ ᐁᐧᐃᓯᓭᐠ ᐁᐧᐱᒥ ᐊᐧᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᑫᒍᑐᓂᐊᐧᐠ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᒥᓇ ᐁᐧᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᒪᐊᐧᐣ ᐃᓭᐣ ᐁᐧᑭᒋᑐᐣᑕᑫᐧᐠ ᐁᐧᑲ ᐊᐃᐧᔭ ᒋᑭ ᐅᐣᒋ ᒪᒋᓭᐸᐣ ᐅᐱᒪᑎᓯᐃᐧᓂᐠ ᒥᓇ ᐁᐧᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᐊᓂᐣ ᐊᐃᐧᔭ ᑫᑐᑕᐣ ᐁᐧᑲ ᒋᑭ ᑌᐱᓂᒍᐸᐣ ᐊᑯᓯᐃᐧᓇᐣ.

- ᐅᐣᒋ ᒪᒋ ᐅᐱᒪᐦᐊᐊᒧᐃᐧᐱᓯᐨ 2013 ᐱᓂᐤ ᒥᑭᓯᐃᐧᐱᓯᐨ 2014, ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐅᑭ ᒪᒋᓂᔕᐦᐊᓇᐊᐧ 96 ᐯᐸᓂᐊᐧᔕᐣ. ᓇᐣᒋ ᐱᑯ 11 ᑕᔑᑫᐃᐧᓇᐣ ᐅᑕᐸᒋᑐᓇᐊᐧ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐃᓇᓄᑭᒪᒪᑲᐠ.

- ᐅᐣᒋ ᒪᒋ ᐅᐱᒪᐦᐊᒧᐃᐧᐱᓯᐨ 2013 ᐱᓂᐤ ᒥᑭᓯᐃᐧᐱᓯᐨ 2014: 9,404 ᐊᑭᑯᓴᐣ ᑭᒪᒋᓂᔕᐦᐊᑲᑌᐊᐧᐣ, ᐁᐧᑲ ᐃᐁᐧ ᐃᓯᓴ 94,040 ᒋᑕᐦᐃᑲᓇᐱᒍᐣ ᐁᐧᑭ ᒪᒋᓂᔕᐦᐊᑲᑌᑭᐣ.

ᒥᒋᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᒪᑲᐠ ᐊᑯᓯᐃᐧᐣ C ᐱᒧᒋᑫᐃᐧᐣ

- ᑕᓯ ᐊᐦᑭ ᑲᐸᑭᑎᓇᑲᓄᐣ ᓀᓂᔮ (ᐃᒪ MOHLTC) ᑭᐅᑕᐱᓇᑲᓄ ᐊᓂᑭᓇᑲᐣ ᒋᓂᑲᓂ ᐱᒥᐃᐧᑐᐣ ᒥᒋᑭᐧᑲᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᒪᑲᐠ ᐊᑯᓯᐃᐧᐣ ᒋᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐃᐁᐧ ᑲᐃᓇᐱᓐᓂᐣ ᒥᓇ ᑲᓇᓂᓭᓂᓴᐊᐧᐣ ᒋᓴᑲᐱᓐᐊᐧᐣ ᐃᐁᐧᓂ ᐊᑯᓯᐃᐧᐣ (HCV).

- ᑫᐃᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᐊᐃᐧᔭ ᐱᐣᑎᑫᓯᓇᐦᐊᐧᑲᓄᐣ ᐅᒪ ᐃᐧᒋᐦᐁᐧᐃᐧᓂᐠ, ᔕᑲᐢᑭᓐᐱᓐᐦᐃᑲᓇᐣ, ᒥᓇ ᐃᐣᑕᒪᑫᐃᐧ ᒪᓯᓇᐦᐃᑲᓐᓴᐣ.

- ᒋᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑲᑌᐊᐧᐣ ᐅᒪ ᑲᑕᑫᐧᐸᐣ ᐃᐧᒋᐦᐁᐧᐃᐧᑲᒥᑯᐣ ᒥᓇ ᑲᔭ ᒋᒪᒪᐃᐧᓄᑲᓂᐊᐧ ᐅᒋᐅᓇᒋᑲᑌᐠ ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᐅᐁᐧ ᐯᔑᐠ ᐃᐧᒋᐦᐁᐧᐃᐧᐣ HCV.

- ᐊᐊᐧᔑᒣ ᒋᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᒥᓇ ᒋᑲᑫᐧ ᑭᑫᐣᒋᑲᑌᐠ HCV ᐊᓂᐣ ᐁᐧᐃᐸᓂᐦᐁᐧᒪᑲᐠ ᐊᐁᐧ ᐊᑯᓯᐃᐧᐣ ᒥᓇ ᑲᔭ ᑕᔑᑫᐃᐧᓂᐠ ᒥᓇ ᐃᐢᑯᓄᐃᐧᑲᒥᑯᐣ ᑲᔑᔭᑭᐣ ᒋᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ.

ᑕᔑᑫᐃᐧᓂᐠ ᑲᐊᓄᑲᑕᒧᐊᐧᐣ ᑫᐅᐣᒋ ᒥᓄᔭᐣ ᐊᐃᐧᔭ ᐅᐱᒪᑎᓯᐃᐧᓂᐠ (CWDT)

- ᐣᑯᑕᑲᐧᔦ ᑕᔑᑫᐃᐧᓇᐣ ᑭᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᐊᐧᐣ ᐁᐧᑭ ᒪᒋᑐᐊᐧᐣ, ᐅᓇᑐᐊᐧᐣ, ᒥᓇ ᐁᐧᑭᔑ ᒪᑕᓄᑲᑕᒧᐊᐧᐣ ᐃᒪ ᐅᑕᔑᑫᐃᐧᓂᐊᐧ ᑲᑲᑫᐧ ᒥᑲᒧᐊᐧᐣ ᑫᑭᔑ ᐃᐧᒋᑐᐊᐧᐸᐣ ᐃᐁᐧ ᒥᑕᐦᐃ ᑲᐊᔭᒪᑲᐠ ᒪᒋ ᒪᒋᑭᑫᐃᐧᐣ ᒥᓇ ᒪᒥᑎᓐᐣᒋᑲᓇᐱᓐᐃᐧᓇᐣ.

- 14 ᑕᓯᐣᐊᐧ ᑭᓇᓯᑭᑲᑌᐊᐧᐣ ᐅᑫᐧᓂᐊᐧᐣ ᑕᔑᑫᐃᐧᓇᐣ (14 ᐯᐸᑲᓄᐊᐧᔦᐠ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ ᐁᐧᑭ ᐅᐣᒋ ᐃᔕᓂᐊᐧᐠ).

- ᑭᐅᓇᒋᑲᑌ ᐃᐧᐣᑕᒪᑫᐃᐧ ᒪᓯᓇᐦᐃᑲᓇᐣ (ᑐᑲᐣ ᐃᐧᐣᑕᒪᑫᐃᐧ ᒪᓯᓇᐦᐃᑲᓀᓴᐣ, ᐁᑭ ᒪᓯᓇᐦᐊᒪᐊᐧᑲᓄᐊᐧᐨ ᐊᐃᐧᔭᐠ ᒋᐅᑕᐱᓇᒧᐊᐧᐨ ᐃᐧᒋᐦᐃᑯᐃᐧᐣ, ᐁᑭ ᓂᐱᑌᐱᐦᐃᑲᑌᑭᐣ, ᒥᓇ ᐁᑭ ᔕᑲᐡᑭᓀᐱᐦᐃᑲᓂᐊᐧᐠ) ᐁᑲᐧ ᑭᐃᔑᓂᔕᐦᐃᑲᑌᐊᐧᐣ 36 ᑕᔑᑫᐃᐧᓂᐠ ᐃᒪ ᑲᐅᐣᒋ ᐊᓄᑲᑕᑭᐣ ᐊᐁᐧ ᒪᔭᑦ ᑲᓂᑲᓂ ᐱᒥᐃᐧᑐᐨ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ. ᒪᒪᐤ 79 ᑭᒪᒋᓂᔕᐦᐃᑲᑌᐊᐧᐣ ᒣᑲᐧᐨ ᒪᑯᐱᓯᑦ 20, 2014 ᐁᑭ ᐃᔑᓂᔕᐦᐊᒪᐊᐧᑲᓄᐊᐧᐨ ᑲᑭᓇ ᐅᑭᒪᑲᓇᐠ, ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᓂᑲᓂᐡᑲᒧᐊᐧᐨ, ᐅᑭᒪᑲᓇᐠ ᑲᔑ ᐸᐱᑭᔕᑭᓯᐊᐧᐨ ᑌᑎᐸᐦᐃ ᐊᐧᓂᓇᐊᐧᑲᐠ, ᑲᔦ ᐊᓂᑭᓇᑲᓇᐠ ᐃᒪ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐊᐧᐨ CWDT ᑲᒪᑕᓄᑲᑕᒧᐊᐧᐨ ᑲᐊᑭᑕᐃᐧ ᐊᐱᑕᒪᑫᐊᐧᐨ.

- ᐁᑲᐧ ᑲᐊᓂ ᐃᐡᑲᐧ ᐊᐣᑭᓯᐨ ᒥᑭᓯᐃᐧᐱᓯᑦ 2014 ᐱᓂᐡ ᓄᑯᑦ, ᐃᐣᑯᑕᐧᓯ ᑕᔑᑫᐃᐧᓇᐣ ᐅᒪᒥᑎᓀᐣᑕᓇᐊᐧ ᒥᓇ ᐊᔕ ᐊᑎᐟ ᓂᒪᑕᓄᑲᑕᒥᐣ ᐁᐅᐣᒋ ᐃᐧᒋᐦᐊᔭᐣᐠ.

ᑲᓇᓇᑭᐡᑭᑲᑌᑭᐣ

- CWDT ᔓᓂᔭ ᑲᐸᑭᑎᓇᑲᓄᐨ ᐊᔕ ᑲᐧᔭᐣᑕᐱ ᐊᑯᓇᐠ ᐊᐧᑌᐸᑲᐃᐧᐱᓯᑦ 30, 2014 ᐁᑲᐧ ᑫᐱᒥ ᐸᑭᑎᓇᑲᓄᐨ ᔓᓂᔭ ᐃᒪ ᑕᐅᐣᒋ ᐅᓀᐣᑕᑲᐧᐣ ᐊᓂᐣ ᑫᔑ ᒥᑭᑲᑌᑫᐧᐣ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑲᑭ ᓇᐣᑕᐁᐧᐣᑕᒧᐊᐧᐨ ᑲᓂᓴᐧᔦ̇ᑲᓂᓯᐊᐧᐨ ᐊᓂᔑᓇᐯ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐊᐱᑕᒧᐊᐧᐨ.

- ᐃᐁᐧ ᐁᑲ ᒪᔑ ᑲᑭᑫᐣᑕᑲᐧᑭᐣ ᔕᑯᓇᐣ ᓇᐱᐨ ᐊᓂᒪᐣ ᒋᑭ ᐅᓇᒋᑲᑌᐠ CWDT ᑫᔑ ᐱᒥᐃᐧᒋᑲᑌᐠ ᒥᓇ ᑫᐊᓂ ᐊᔭᐊᐧᐨ ᐊᓂᑭᓇᑲᓇᐠ.

- ᐊᐁᐧ ᐯᔑᐠ ᐳᑭᑭᔑᑲ ᑲᐃᐧᑕᓄᑭᒪᐨ ᐅᒪ ᐱᒧᒋᑫᐃᐧᓂᐠ ᑲᐃᐧᐣ ᒋᑭ ᑌᐱ ᐊᓂᑲᑕᒧᐊᐧᐨ ᑲᑲᐧᔭᐣᒋᑐᐊᐧᐨ ᒋᑕᐦᐃᑲᓇᐱᑯᐣ ᑲᐊᔭᑭᓀᓂᔕᐦᐊᒧᐊᐧᐨ.

ᓂᑲᐣ ᑫᐊᓂᔑ ᐱᒋᓂᐡᑲᓂᐊᐧᐠ

- ᑭᐊᐣᑐᑕᒪᓂᐊᐧᐣ ᔓᓂᔭᐣ ᐁᐃᐧ ᓇᐣᑭᓂᑲᑌᑭᐣ ᐅᒪ:
    - ᓇᐊᐧᐨ ᒋᒥᓇᐧᒋᑲᑌᐠ ᑲᐃᓇᑌᐠ ᐱᒧᒋᑫᐃᐧᐣ
    - ᒋᐅᐣᒋ ᑎᐸᐦᐃᑫᓯᒋᑲᑌᑭᐣ ᒋᑕᐦᐃᑲᓇᐱᑯᐣ ᑲᐊᔭᑭᓀᓂᔕᐦᐃᑲᑌᑭᐣ ᑲᓇᐣᑕᐁᐧᐣᑕᑲᐧᑭᐣ
    - ᒋᐱᒥ ᐊᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᒋᐅᓇᒋᑲᑌᐠ ᒥᓇ ᒋᐊᔭᑭᓀᓂᔕᐦᐃᑲᑌᑭᐣ ᑭᑭᓄᐦᐊᒪᑫᐃᐧ ᑎᐸᒋᒧᐃᐧ ᒪᓯᓇᐦᐃᑲᓀᓴᐣ
    - ᒋᐅᑕᐱᓇᑲᓄᐨ ᑫᑲᐯᓴᓂᐠ ᐅᑕᓄᑭᐃᐧᐣ ᐊᐁᐧ ᑫᑭᑭᓄᐦᐊᒪᑫᐨ ᐃᑫᐧᓂᐊᐧᐣ ᑲᓴᑭᓂᐁᐧᒪᑲᑭᐣ ᑫᑯᓇᐣ
    - ᒋᐊᐣᑕᓴᑲᓄᐨ ᐊᐁᐧ ᐳᑭᑭᔑᑲ ᑲᐃᐧᑕᓄᑭᒪᐨ ᐁᑲᐧ ᑕᐡ ᒋᑲᐯᓴᓂᐠ ᐅᑕᓄᑭᐃᐧᐣ ᒋᐃᓇᑭᒪᑲᓄᐨ

- ᒋᒪᒋᓂᔕᐦᐃᑲᑌᑭᐣ ᑲᑭ ᐅᐡᑭ ᐅᔑᒋᑲᑌᑭᐣ ᐃᐁᐧ ᒥᐡᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᒪᑲᐠ ᐊᑯᓯᐃᐧᐣ C ᐃᐧᐣᑕᒪᑫᐃᐧ ᒪᓯᓇᐦᐃᑲᓀᓴᐣ, ᑫᐊᐸᒋᑐᐊᐧᐨ ᒪᓯᓇᐦᐃᑲᓂ ᐊᐧᐸᒪᐊᐧᐨ ᐅᑕᑯᓰᐣ (ᐊᑯᓯᐃᐧ ᐸᒥᐦᐃᐁᐧᐃᐧᐣ, ᒥᓇ ᐱᒪᑎᓯᐃᐧᓇᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ) ᒥᓇ ᐯᐸᐣ ᑲᒪᐣᑲᑌᓯᐣᐠ ᐅᐁᐧ ᐅᐣᒋ ᐊᑯᓯᐃᐧᐣ ᒋᒥᓇᑲᓄᐊᐧᐨ ᐅᑕᔑᑫᐃᐧ ᐅᓂᑲᓂᑕᒪᑫᐠ, ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᓂᑲᓂᐡᑲᒧᐊᐧᐨ, ᑭᐁᐧᑎᓄᐠ ᒪᐡᑭᑭᐃᐧᑲᒥᑯᐣ, ᐅᑕᔭᒥᐦᐃᐁᐧᐠ ᒥᓇ ᑲᔦ ᑲᐊᓄᑲᑕᒧᐊᐧᐨ ᑲᓴᑭᓂᐁᐧᒪᑲᑭᐣ ᒪᒋ ᒪᐡᑭᑭᑫᐃᐧᐣ ᒥᓇ ᒥᓂᑫᐧᐃᐧᐣ.

- ᒋᐅᐣᒋ ᓇᓇᑲᒋᐦᐊᑲᓄᐊᐧᐨ ᑲᒪᒥᑎᓀᐣᑕᒧᐊᐧᐨ ᒥᓇ ᒋᓂᓯᑐᒋᑲᑌᐠ ᐃᐁᐧ ᒥᐡᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᒪᑲᐠ ᐊᑯᓯᐃᐧᐣ C ᑲᐱᒧᑐᐊᐧᐨ ᒥᓇ ᒋᐊᓂᒧᒋᑲᑌᑭᐣ ᐅᐁᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᒥᓇ ᐅᐁᐧ ᒥᐡᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᒪᑲᐠ ᐊᑯᓯᐃᐧᐣ C. ᐊᒥ ᐁᔑ ᐅᓀᐣᑕᑲᐧᐠ ᐊᔕ ᒋᑭ ᒪᒋᒋᑲᑌᑭᐸᐣ ᐅᑕᑯᓯᐠ ᒋᐅᑕᐱᓇᑲᓄᐊᐧᐨ ᐊᓂ ᑭᔑᐸᑭᓯᐨ ᐊᐧᑌᐸᑲᐃᐧᐱᓯᑦ 2014.

- ᒋᐅᔑᒋᑲᑌᐠ ᐃᐧᐣᑕᒪᑫᐃᐧ ᒪᓯᓇᐦᐃᑲᓀᐡ ᒋᐃᐧᐣᑕᒪᑫᒪᑲᐠ ᒋᑕᐦᐃᑲᓇᐱᑯᐣ ᑲᐸᑭᑎᓂᑲᑌᑭᐣ ᑫᐃᔑᓂᔕᐦᐃᑲᑌᑭᐣ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᐁᑲ ᒪᔑ ᑲᐊᐸᒋᑐᐊᐧᐨ ᐅᐁᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ, ᐃᒪ ᒋᐅᐣᒋ ᑲᑫᐧ ᓇᒋᐱᓂᐣᑕᐧ, ᑭᐡᐱᐣ ᑭᔭᐸᐨ ᐅᐣᑎᓇᒧᐊᐧᐨ ᐃᐧᐣᑕᒪᑫᐃᐧᐣ ᐅᐁᐧ ᐅᐣᒋ, ᒋᑭ ᒪᒥᑎᓀᐣᑕᒧᐊᐧᐸᐣ ᒪᐡᑯᐨ ᑫᐃᐧᓂᐊᐧ ᐃᐧᐊᒋᑐᐊᐧᐨ ᐅᐁᐧ ᐯᔑᐨ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ.

- ᒋᐱᒥ ᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ ᑲᑲᑫᐧ ᐅᓇᑐᐊᐧᐨ ᑲᐃᐧ ᑲᑫᐧ ᐃᐧᒋᐦᐃᑎᓯᐊᐧᐨ ᒥᓇ ᒋᐊᓄᑲᑕᒧᐊᐧᐨ ᒥᐡᑭᐧᑲᐣᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᒪᑲᐠ ᐊᑯᓯᐃᐧᓇᐣ.

- ᐊᐊᐧᔑᒣ ᒋᐅᐣᒋ ᑭᑫᐣᒋᑲᑌᐠ ᒥᓇ ᒋᐊᐧᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᐃᐁᐧ HCV, ᐊᓂᐣ ᑕᐡ ᑲᔦ ᑫᑐᑕᐣᐠ ᐁᑲ ᒋᐅᐣᒋ ᐊᑯᓯᐨ ᐃᐁᐧᓂ ᐅᐣᒋ, ᐁᑲᐧ ᒥᓇ ᒋᐅᐣᒋ ᑕᐸᓯᐡᑲᒪᑲᐠ ᑲᓇᓀᐯᐃᐧᐦᐃᑯᐊᐧᐨ ᒪᒋ ᒪᐡᑭᑭᐣ ᑲᐊᐸᒋᑐᐊᐧᐨ ᒥᓇ ᓇᐣᑕ ᑲᔦ ᑲᐅᐣᒋ ᓴᑲᐱᓀᐊᐧᐨ ᒥᐡᑭᐧᑲᐠ ᑲᐅᐣᒋ ᐅᔑᐦᐅᒪᑲᐠ ᐊᑯᓯᐃᐧᐣ.

ᒪᓯᓇᑌᓯᒋᑲᓂᐠ ᑲᐅᐣᒋ ᐊᐧᐸᒪᑲᓄᐨ ᐊᐃᐧᔭ ᑲᐊᓄᑲᑕᒧᐊᐧᐨ

ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᐁᑎᐸᒋᒧᓇᓂᐊᐧᐠ:
ᐃᐁᐧ ᒪᔭᑦ ᑲᐃᓇᓄᑭᒪᑲᐠ ᒪᓯᓇᑌᓯᒋᑲᓂᐠ ᑲᐅᐣᒋ ᐊᐧᐸᒪᑲᓄᐨ ᐊᐃᐧᔭ ᑲᐊᓄᑲᑕᒧᐊᐧᐨ ᒋᑭ ᐅᐣᒋ ᑌᐱᓇᒧᐊᐧᐸᐣ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᒥᓇ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ ᒪᓯᓇᑌᓯᒋᑲᓂᐠ ᑲᐅᐣᒋ ᐊᔭᒥᐦᐊᑲᓄᐊᐧᐨ.

ᑭᑭᓄᐦᐊᒪᑫᐃᐧᓇᐣ, ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᒥᓇ ᑲᐅᑭᒪᐃᐧᐊᐧᐨ ᑲᒪᐊᐧᒋᐦᐃᑐᐊᐧᐨ ᒥᐦᐃᒪ ᐁᐧᐣᒋ ᐊᓄᑲᑕᒧᐊᐧᐨ ᒪᓯᓇᑌᓯᒋᑲᓂᐠ ᑲᐅᐣᒋ ᐊᔭᒥᐦᐃᑎᓇᓂᐊᐧᐠ, ᐁᐅᐣᒋ ᐃᐧᒋᐦᐃᑯᐊᐧᐨ ᐃᒪ ᑲᐊᓄᑭᐊᐧᐨ SLFNHA ᐊᓂᑭᓇᑲᓇᐠ, ᑕᔑᑫᐃᐧᓂᐠ ᑲᑲᐯᔑᐊᐧᐨ ᒥᓇ ᑲᐅᐣᒋ ᐃᐧᑕᓄᑭᒥᐁᐧᐊᐧᐨ ᑯᑕᑭᔭᐣ ᒪᒋᑕᐃᐧᓇᐣ.

ᓂᐃᐧᒋᑲᐸᐃᐧᑕᒪᐊᐧᒥᓇᐣ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓇᐣ ᑌᑎᐸᐦᐃ ᐊᐧᓇᓂᓇᐊᐧᑲᐠ ᑲᔭᑭᐣ, ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐅᑐᐣᒋ ᐃᐧᑕᓄᑭᒪᐊᐧᐣ KO-ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᑲᑭᑐᐊᐧᐨ ᒪᐡᑭᑭᐃᐧ ᐊᓂᑭᓇᑲᓇᐠ, K-ᓀᐟ, ᐅᐣᑌᕑᐃᔪ ᑌᕑᐃ ᒪᐡᑭᑭ ᑲᐅᐣᒋ ᐊᓂᑭᒪᑲᐠ ᐱᐊᐧᐱᑯᐠ (OTN), ᑎᑭᓇᑲᐣ CFS ᐁᑲᐧ ᒥᓇ ᐊᐊᐧᔑᔑᐃᐧ ᒪᐡᑭᑭᐃᐧᑲᒥᐠ ᑐᕑᐅᐣᑐ ᑲᔑᑕᑲᐧᐠ.

ᑕᓯᐊᐦᑭ ᐊᐣᑭᒋᑫᐃᐧᐣ ᑲᐃᓯᓴᐠ:

ᑲᑭ ᑐᒋᑲᑌᑭᐣ	ᒥᓂᑯᐠ ᑲᑭ ᑐᒋᑲᑌᐠ	ᐅᑕᑯᓰᐠ ᑲᑭ ᐊᐧᐸᒥᐣᑕᐧ	ᑲᑭ ᐃᐧᒋᑕᐧᐊᐧᐨ
ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ	284	284	
ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ (ᐊᔑᐨ ᑲᔦ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᒪᐊᐧᒋᐦᐃᑎᓇᓂᐊᐧᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ)	60		190
ᑲᑭ ᐊᓂᑲᑕᒧᐊᐧᐨ ᑲᐅᑭᒪᐃᐧᐊᐧᐨ	68		
ᒪᒪᐤ	**412**	**284**	**190**

ᐊᐦᑭᐃᐧᐣ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ

- ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑫᐊᓂᑲᑌᑭᐣ:
  - ᒋᐸᑭᑎᓂᑲᑌᐠ ᔓᓂᔭᐃᐧ ᓇᐣᑐᑕᒪᐃᐧᐣ ᐃᒪ ᒋᔑᐊᐸᑕᐠ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᒋᐃᓇᐣᑭᒋᑲᑌᐠ ᑌᓫᐃ ᒪᐢᑭᑭ ᐊᑯᓯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑲᐅᐣᒋ ᓂᑲᓂ ᐱᒧᒋᑲᑌᐠ ᐱᒧᒋᑫᐃᐧᐣ.
  - ᒋᐃᐧᒋᑕᐧᓂᐊᐧᐠ ᐊᐱ ᐅᓂ ᐅᓇᒋᑲᑌᑭᐣ ᑫᔑ ᐱᒥᐸᓂᒋᑲᑌᑭᐣ ᐊᓂᑭᐃᐧ ᓇᑯᒥᑎᐃᐧᓇᐣ & ᑫᔑ ᐱᒥᔭᒪᑲᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑫᐅᐣᒋ ᐃᐧᒋᒋᑲᑌᐠ ᐅᒪ ᒪᒋᑕᐃᐧᓇᐣ ᑲᔭᑭᐣ ᐊᐧᓂᓇᐊᐧᑲᐠ.
  - ᓂᑕᑦ ᑭᐁᐧᓇᓇᑲᒋᒋᑫᐃᐧᐣ ᐃᒪ ᑌᓫᐃ ᒪᐢᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧ ᓇᑯᒥᑎᐃᐧᐣ, ᑫᐃᓇᓄᑭᒪᑲᐠ & ᑫᐃᔑ ᐸᐸᒥᓯᐃᐧᓂᐊᐧᐠ
  - ᒋᐅᓇᒋᑲᑌᐠ ᑫᒥᓄᓭᐠ ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᑲᐅᑕᐱᓇᑲᓄᐊᐧᐨ ᐃᒪ ᑫᓯ ᐃᐧᒋᐦᐃᐣᑕᐧ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᐃᐧᒋᐦᐃᑲᓄᐨ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᐅᐣᒋ ᒥᓇ ᐅᑕᑯᓰᐠ ᑲᐊᓂ ᓇᓇᑲᒋᐦᐊᑲᓄᐊᐧᐨ ᑲᐃᐢᑲᐧ ᑭᔑᑐᐊᐧᐨ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ
  - ᒋᐊᓂ ᐅᓇᒋᑲᑌᑭᐣ ᑫᑲᐯᔕᑭᐣ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᒪᐊᐧᒋᐦᐃᑎᐊᐧᐨ ᓄᑎᐣ ᐊᓂᑭᓇᑲᓇᐠ ᒥᓇ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᑲᐊᓄᑲᑕᐠ;
  - ᒋᐱᒥᐃᐧᒋᑲᑌᐠ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᑲᑭᑐᓇᓂᐊᐧᐠ ᐊᐃᐧᔭ ᑲᐊᐧᐃᐧᐣᑕᒪᐊᐧᑲᓄᐨ ᓂᑕᑦ ᐁᐱᐣᑎᑲᑕᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᒥᐠ ᒥᓇ ᐊᐃᐧᔭ ᑲᐃᔑᓂᔕᐦᐊᐧᑲᓄᐨ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᐊᔭᒥᐦᐊᑲᓄᐨ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᐃᒪ ᐊᐊᐧᔑᔑᐃᐧ ᒪᐢᑭᑭᐃᐧᑲᒥᐠ ᑐᕑᐅᐣᑐ ᑲᑕᑲᐧᐠ
- ᑫᐊᐸᐣᑕᐦᐃᐊᐧᓂᐊᐧᐠ ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᑫᐊᓂ ᑐᒋᑲᑌᑭᐣ:
  - ᑲᑎᐸᒋᒧᓇᓂᐊᐧᐠ ᐃᒪ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᐊᔭᒥᐦᐊᑲᓄᐨ ᐅᑕᑯᓯ ᑲᐃᐧ ᐊᐧᐸᐣᑕᐦᐃᐊᐧᓂᐊᐧᐠ ᐊᐧᓂᓇᐊᐧᑲᐠ ᒣᑲᐧᐨ ᐱᓇᑭᐧᐃᐧᐱᓯᑦ 2013
  - ᒋᐅᔑᒋᑲᑌᑭᐣ ᐅᐢᑭ ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᐃᒪ ᐃᐧᐣᑕᒪᑫᐃᐧ ᒪᓯᓇᐦᐃᑲᓀᓴᐣ ᐃᐁᐧ ᐅᐣᒋ ᑌᓫᐃ ᒪᐢᑭᑭ ᐱᒥᐃᐧᒋᑫᐃᐧᐣ
  - ᒋᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᑫᐊᓂ ᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᐱᐊᐧᐱᑯᐠ & ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᐃᒪ ᒋᔑ ᑎᐸᒋᒧᓇᓂᐊᐧᐠ SLFNHA ᐅᑎᐸᒋᒧᐃᐧᓂᐊᐧ ᑲᔑ ᐊᑐᐊᐧᐨ ᐱᐊᐧᐱᑯᐠ & ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᐊᔭᑭᓀ ᒪᓯᓇᐦᐊᒪᐃᐧᑎᓇᓂᐊᐧᐠ

ᑲᓇᓇᑭᐢᑭᑲᑌᑭᐣ:

- ᐊᐸᒋᑕᑲᓇᐣ ᐁᓇᐣᑕᐁᐧᐣᑕᑲᐧᑭᐣ ᑫᔑ ᒪᐊᐧᒋᐦᐃᑎᓇᓂᐊᐧᐠ ᐱᐊᐧᐱᑯᐠ ᑲᐃᐧᐣ ᒣᑲᐧᐨ ᒋᑕᑲᐧᐠ ᐃᒪ ᐊᑯᓯᐃᐧᑲᒥᐠ ᑲᔑ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᐅᑕᑯᓰᐠ ᒥᓇ ᑲᔦ ᐃᒪ ᓄᑎᐣ ᐅᒪᓯᓂᐱᐦᐃᑫᐃᐧᑲᒥᐠ ᑲᐊᐸᒋᑐᐊᐧᐨ ᐊᐃᐧᔭᐣ ᑲᐊᐧᐸᒪᐊᐧᐨ. ᐃᐁᐧ ᑌᓫᐃ ᒪᐢᑭᑭ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐃᐧᐣ ᐊᔭᓯᐣ ᔓᓂᔭ ᐅᐁᐧ ᑫᐃᓇᐸᑎᓯᐨ ᒋᐊᐧᐁᐧᔑᒋᑲᑌᑭᐣ ᐊᐸᒋᑕᑲᓇᐣ.
- ᑲᐅᐣᒋ ᐃᐧᑕᓄᑭᒥᑎᐊᐧᐨ ᒥᓇ ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᑲᐊᔭᓂᑫ ᐃᐧᐣᑕᒪᑎᐊᐧᐨ ᓂᔑᐣ ᐱᒧᒋᑫᐃᐧᓇᐣ ᒥᓇ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓇᐣ
- ᒥᐁᐧᑕ ᑫᑭ ᐱᒥᐃᐧᒋᑲᑌᐠ ᑌᓫᐃ ᒪᐢᑭᑭ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐊᐸᑕᑭᐣ ᐅᐢᑭ ᐊᐸᒋᑕᑲᓇᐣ, ᔓᓂᔭᐣ ᑕᓇᐣᑕᐁᐧᐣᑕᑯᓯ ᐅᐣᒋ ᐱᒥᐃᐧᒋᑲᑌᑭᐣ ᐅᐁᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ.

ᑫᐊᓂᔑ ᐱᒋᓂᐢᑲᓂᐊᐧᐠ:

- ᒋᐱᒥ ᐅᓇᒋᑲᑌᑭᐣ ᒥᓯᐁᐧ ᑫᐊᐸᒋᒋᑲᑌᐠ ᐃᒪ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑫᔑ ᐱᒧᒋᑲᑌᐠ ᒋᐃᓇᑌᐠ ᑲᔑ ᓇᐣᑕᐁᐧᐣᑕᒧᒪᑲᑭᐣ ᐊᑯᓯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᐃᒪ ᐃᐢᑯᓂᑲᓇᐣ ᑲᔑᑕᑲᐧᑭᐣ.
- ᒋᐱᒥ ᐊᔭᒥᓄᐣᑌᐠ ᑫᔑ ᒥᓄᐢᑲᒪᑲᐠ ᐱᐊᐧᐱᑯᐠ ᑲᐅᐣᒋ ᒪᐊᐧᒋᐦᐃᑎᓇᓂᐊᐧᐠ, ᐃᒪ ᒪᔭᑦ ᓀᑫ ᑲᑭᓇ ᐊᐃᐧᔭ ᑲᐅᐣᒋ ᑲᑫᐧ ᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄᐨ ᑫᐅᐣᒋ ᒥᓀᐧᔭᒪᑲᓂᐠ ᐅᐱᒪᑎᓯᐃᐧᐣ, ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧ ᒪᒥᓄᒧᐁᐧᐃᐧᐣ ᒥᓇ ᑲᐊᓂ ᓇᓇᑲᒋᐦᐊᑲᓄᐨ ᐅᑕᑯᓰ ᐊᐱ ᑲᐃᐢᑲᐧ ᐸᑭᑎᓇᑲᓄᐨ.

ᐊᐊᐧᔑᔑᐃᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ

ᒥᓯᐁᐧᑲᒥᐠ ᑲᐅᐣᒋ ᒪᒪᐃᐧ ᐃᐧᑕᓄᑭᒥᑎᐊᐧᐨ ᐊᓂᔑᓇᐯᐃᐧ ᐊᑯᓯᐃᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ, ᐊᐊᐧᔑᔑᐃᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ (BTT) ᓂᓯᐊᐦᑭ ᐱᒥᓭ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑲᑌᐠ ᓇᐊᐧᐨ ᒋᑭ ᑕᐸᓯᐢᑲᒪᑲᑭᐸᐣ ᐊᐊᐧᔑᔕᐠ ᑲᐱᑲᐧᐱᑌᐢᑲᐊᐧᐨ ᐃᒪ ᒋᐅᐣᒋ ᑲᑫᐧ ᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄᐊᐧᐨ ᐅᒪᒪᒥᒪᐠ ᒣᑲᐧᐨ ᑲᑭᑭᐢᑲᐊᐧᐊᐧᓯᐊᐧᐨ. ᐊᒥᑕᐢ ᐃᑫᐧᓂᐊᐧᐣ ᐊᐦᑭᐣ ᑲᐃᐧᒋᑕᐧᐊᐧᐨ ᐊᐢᑎᕑᐁᓫᐃᔭ, ᓄᓯᕑᐊᐣᐟ ᒥᓇ.

BTT ᐅᑭ ᐅᐣᑎᓇᓇᐊᐧ 544 ᑲᑭᑭᐢᑲᐊᐧᐊᐧᓯᐊᐧᐨ ᐊᓂᔑᓇᐯᑫᐧᐠ ᒥᓇ ᐃᐧᓴᑯᑌᐃᐧᓂᐊᐧᐠ ᑲᐃᑫᐧᐃᐊᐧᐨ ᐅᑌᓇᐣᐠ ᑲᔑ ᑲᐯᔑᐊᐧᐨ ᒥᓇ ᐃᐢᑯᓂᑲᓂᐠ ᑲᑲᐯᔑᐊᐧᐨ ᐃᒪ ᐅᐣᑌᕑᐃᔪ ᒥᓇ ᒪᓇᑐᐸ ᐅᑕᓇᐣᐠ ᓂᔓᐊᐦᑭ ᒥᓇ ᐊᐱᑕ ᐁᑲᐧ ᑕᐢ ᐃᑫᐧᓂᐊᐧᐠ, ᐊᐊᐧᔑᒣ 200 ᐊᓂᔑᓇᐯᑫᐃᐧᐠ ᑭᐱᔕᐊᐧᐠ ᐃᒪ ᑌᑎᐸᐦᐃ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐊᐧᐨ.

ᓄᑯᑦ ᐃᐧᓂᑯ, ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑲᑌᐠ ᑲᑭᓇ ᐃᑫᐧᓂᐊᐧᐠ ᐊᔕ ᑭᓂᑕᐃᐧᑭᐦᐊᐊᐧᓯᐊᐧᐠ. ᐊᐧᐁᐧᔕᐦᐊᐱᑌᐦᐊᐊᐧᐠ ᐅᐢᑭ ᐊᐊᐧᔑᓴᓴᐠ ᑲᐊᓂ ᐅᐃᐧᐱᑎᐊᐧᐨ ᓂᔕᐧ ᐯᔑᑯᐊᐦᑭ, ᓂᓯᐊᐦᑭ ᒥᓂᑯᐠ. ᒥᐦᐃᐁᐧ ᑲᐃᐧᑐᒋᑲᑌᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᐃᐧᐸᐨ ᒋᑭ ᑲᑫᐧ ᑲᒋᑎᓇᑲᓄᐊᐧᐸᐣ ᐊᐊᐧᔑᔕᐠ ᑲᐊᑲᓫᔑᐊᐧᐨ ᐁᑲ ᐃᐧᐸᐨ ᒋᑭ ᐱᑲᐧᐱᑌᐊᐧᐸᐣ, ᓇᐣᑕ ᐱᑯ ᑲᓇᑫ, ᓇᐊᐧᐨ ᒋᑭ ᑕᐸᓯᐢᑲᑭᐸᓂᐣ ᐊᑯᓯᐃᐧᓇᐣ ᐅᒪ ᒥᓯᐁᐧ ᑲᓇᑕ ᑲᐊᔭᐊᐧᐨ ᒥᓂᑯᐠ ᑲᐊᑯᓯᐊᐧᐨ ᐁᑲᐧ ᒥᓇᐊᐧ ᐁᑲ ᒥᔑᐣ ᒋᑭ ᐊᑯᓯᐊᐧᐸᐣ ᐊᐊᐧᔑᓴᓴᐠ ᐅᐃᐧᐱᑎᐊᐧᑲᐣᐠ ᑲᐱᓂᓴᐱᑌᐦᐊᐧᑲᓄᐊᐧᐨ ᑲᓂᐯᐦᐊᐧᑲᓄᐊᐧᐨ.

ᐊᐦᑭᐃᐧ ᑭᐁᐧᓇᓇᑲᒋᑫᐃᐧᐣ – ᓂᔕᐧ ᑲᓂ ᐊᐱᒋᐢᑲᓂᐊᐧᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐠ

- ᒣᑲᐧᐨ ᓂᒪᒋᑐᒥᐣ ᓂᔕᐧ ᑲᐊᐱᒋᐢᑲᓂᐊᐧᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ. ᐃᒪ ᑕᐢ ᑲᔑ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᒪᐣᐠ ᑲᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᐅᐃᐧᐱᑎᐊᐧᐣ 2 ᑲᐅᓯᐱᐳᓀᐊᐧᐨ ᐊᐊᐧᔑᔕᐠ ᐁᐃᐧ ᓇᓇᑲᒋᑐᔭᐣᐠ ᑭᐢᐱᐣ ᐃᐁᐧ ᑲᑭ ᑲᑫᐧ ᑭᑭᓄᐦᐊᒪᐊᐧᔭᐣᐠ ᐊᓂᐣ ᑫᑐᑕᒧᐊᐧᐨ ᒣᑲᐧᐨ ᑲᑭᑭᐢᑲᐊᐧᐊᐧᓯᐊᐧᐨ ᒥᓇ ᑲᐃᐢᑲᐧ ᐊᐧᐸᒪᐊᐧᓯᐊᐧᐨ ᒥᓇ ᑲᔦ ᑫᑐᑕᒧᐊᐧᐨ ᐁᑲ ᒋᒪᒐᐱᑌᓂᐨ ᐅᓂᒐᓂᔑᐊᐧᐣ.
- ᒣᑲᐧᐨ ᑲᑕᑲᐧᑭᓯᐨ ᐱᓯᑦ 2014 ᓂᑮ ᒪᒋᑐᒥᐣ ᓂᔕᐧ ᑲᐊᓂ ᐊᐱᒋᐢᑲᒪᑲᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ, ᑲᑭ ᑭᑭᓄᐦᐊᒪᑫᔭᐣᐠ ᓇᑕᒪᑫᐃᐧᐣ ᐁᑲ ᒋᐱᑲᐧᐱᑌᐢᑲᐊᐧᐨ ᐊᐊᐧᔑᔕᐠ ᑲᐊᑲᓫᔑᐊᐧᐨ ᒥᓇ ᐃᑫᐧᓂᐊᐧᐠ ᑲᔦ ᐁᑲ ᐃᐧᐸᑦ ᑲᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ

ᐁᑲ ᒋᐱᑳᐱᐅᒃᑲᓂᐨ ᐅᓂᒐᓂᔑᐋᐤ. ᐊᒥᑕᒃ ᑲᑭᔑ ᓇᑖᑕᐍᑖᑕᑯᓯᐋᐨ ᐅᒪᒪᒥᒪᐠ ᓇᑖᑕ ᑲᐸ ᑲᑲᓇᐍᓂᒪᐋᐨ ᐊᐋᔑᔕᑦ ᒋᔕᑲᒃᑭᓀᐱᐦᐊᒍᐋᐨ ᑲᑫᐌᐃ ᒪᓯᓇᐦᐃᑳᑦ ᒥᓇ ᑲᐸ 2 ᑲᑕᓱᐱᐳᓀᐋᐨ ᒋᑭᓯᔦᐱᐌᐦᐋᑳᓄᐋᐨ ᐅᑭᓯᔦᐱᐌᐦᐅᐍᐤ.

- ᒉᑳᐨ ᒥᑭᓯᐃᐱᓯᙾ 2014, ᑭᒋᐊᑯᓯᐃ ᐱᒍᒋᑫᐃᐤ ᑲᓇᑕ ᐅᑭ ᔕᐳᓇᓇᑦ ᓂᐃᐤ ᑲᐸᑭᑎᓂᑎᓱᐋᐨ ᒋᒍᑕᓄᑭᑕᒪᑫᐋᐨ ᐅᑭᓯᔦᐱᐌᐦᐳᐍᐠ ᐅᐍ ᑲᐱᒍᒋᑲᐌᐠ ᕓᔑᐠ ᐃᒋᐦᐃᐍᐃᐤ ᒋᓇᓇᑲᒋᐦᐊᐋᐨ 2 ᑲᑕᓯᕓᐳᓀᐋᐨ ᐊᐋᔑᔕᐠ ᒉᑳᐨ ᑲᐱᒥ ᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑲᐌᐠ.

- ᐃᑫᓂᐋᐠ ᐅᑭᓯᔦᐱᐌᐦᐅᐍᐠ ᑲᑭᑭᓄᐦᐊᒪᐃᐤᑕᐧ ᒥᓇ ᕓᑭ ᐅᓇᓯᑦᑕᐧ ᐃᒪ ᐋᓂᓇᐋᑳᐠ ᐃᐱᑎᒪᐠᑭᑭᐃᑲᒥᐠ ᒉᑳᐨ ᒥᑭᓯᐃᐱᓯᙾ 16, 2014 ᕓᑳ ᑕᐠ ᑭᓇᓇᑲᒋᒋᑲᐌᐋᐤ ᑲᒪᓯᓇᐌᐱᓇᑲᓄᐋᐨ ᐃᐱᑕᐠ ᑲᑐᒋᑲᐌᐠ ᒥᓇ ᑲᐸ ᑲᔕᑲᒃᑭᓀᐱᐦᐃᑲᐌᑭᑦ, ᐱᓂᐠ ᐊᐸᑦ ᕓᑭ ᐊᓂ ᓇᓇᑲᒋᐦᐊᑲᓄᐋᐨ ᓂᔦᓇᑦ ᐊᐋᔑᔕᐠ ᕓᔑᑳᐤ ᕓᑕᓱᐱᐳᓀᐋᐨ ᕓᑭ ᐊᐸᑎᓱᐋᐨ ᐃᒪ ᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑫᐃᓂᐠ, ᔕᑯᐨ ᑲᐃᐤ ᐃᒪ ᒋᐅᑦᒋ ᑕᑭᐋᐨ ᒪᔦᙾ ᑭᒋ ᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑫᐃᓂᐠ. ᐅᑫᓂᐋᐠ ᑕᐠ ᐊᐋᔑᔕᐠ ᑭᓇᓇᑲᒋᐦᐃᒪᐋᐤ ᐅᐃᐱᑎᐋ.

ᐊᑦᑭᑕᓱᓇᑦ ᑲᑭ ᐃᓯᓭᐠ ᓂᔕᐃ ᑲᐊᐱᒋᐠᑲᓂᐋᐠ ᐊᐋᔑᔕᐠ ᐅᐃᐱᑎᐊ ᑲᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑲᐌᑭᑦ ᐅᑦᒋ ᒪᒋ ᐅᐱᒪᐦᐊᒍᐃᐱᓯᙾ 1, 2013 – ᒥᑭᓯᐃᐱᓯᙾ 31, 2014 (ᑭᔦᐸᐨ ᑐᒋᑲᐌ)

ᑕᔑᑫᐃᓇᑦ ᐋᓇᓂᐋᑳᐠ ᑲᐅᑦᒋ ᑎᕓᑦᑕᑳᑭᑦ	ᓇᑕᒪᑫᐃ ᐃᒋᐦᐃᐍᐃᐤ & ᕓᑲ ᐃᐸᐨ ᑲᐃᒋᐦᐊᑲᓄᐋᐨ	ᑲᑭᔑᒋᑲᐌᑭᑦ 2nd ᑲᑫᐌᐃ ᒪᓯᓇᐦᐃᑲᓇᑦ	ᑲᑭᔑᓇᓇᑲᒋᐦᐊᑲᓄᓂᐨ ᐅᐃᐱᑎᐋᐤ
4	19	19	11

ᑲᓇᓇᑲᑭᐠᑭᑲᐌᑭᑦ

- ᒋᓇᓇᑦᑎᓂᑲᐌᓂᐠ ᐊᑦᑎ ᑫᑭᔑ ᑲᕓᔑᐸᑦ ᐊᐍ ᑫᓇᓇᑦᑕᐃ ᑭᑫᑦᑕᑭᑦ ᒉᑳᐨ ᑭᐌᑎᓄᐠ ᑕᔑᑫᐃᓂᐠ ᐃᔕᐨ ᕓᑭᐠ ᑲᐸ ᒋᑭᑭᓄᐦᐊᒪᑫᐨ ᐁᑲ ᐃᐸᐨ ᑫᔑ ᒪᒐᐱᐌᓂᐠ ᐊᐋᔑᔕᑦ

- ᐃᑫᓂᐋᐠ ᑕᐠ ᒪᔦᙾ ᑲᐸᑭᑎᓂᑎᓱᐋᐨ ᒋᐃᒋᑕᐋᐨ ᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑫᐃᓂᐠ ᒉᑳᐨ ᑲᐃᐤ ᐃᒪ ᑭᐊᔦᓯᐋᐠ ᑕᔑᑫᐃᓂᐠ ᑲᐱᔕᓂᐨ ᐅᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑫᑦ

- ᒋᐅᓇᒋᑲᐌᐟ/ᒋᐃᐤᑕᒪᐋᑲᓄᐋᐨ ᑲᐃᒋᑕᐋᐨ ᒥᓇᐋ ᒋᐱᐋᐸᒪᑲᓄᐋᐨ

- ᒥᐠᑕᐦᐃ ᕓᐃᓇᑦᑭᐌ ᐱᒥᔦᐃᐤ, ᐱᒥᔮᐃᓂᐠ ᒥᓇ ᑲᒍᒋ ᐱᒥᐱᓱᓇᓂᐋᐠ

- ᑲᒪᒪᒋᑭᔑᑲᐠ

ᓂᑳᑦ ᑫᐊᓂᔑ ᐱᒋᓂᐠᑲᓂᐋᐠ

- ᐃᐍ ᑲᐃᓐᑑᑕᒪᑦᐠ ᒋᐃᓯᔮᐠ ᐃᐍ ᒥᓂᑯᐠ ᑕᓯᑦ ᐊᐋᔑᔕᐠ ᑲᐸᑭᑎᓇᑲᓄᐋᐨ ᒋᑕᑭᐋᐨ ᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑫᐃᓂᐠ ᕓᔑᑳᐤ ᒋᑕᓱᐋᐨ.
- ᑭᒥᓂᑕᑳᓄᑦ ᕓᑭ ᐃᐱᑭᕓᒪᑲᓂᐠ ᐅᑎᑭᑐᐃᓂᐋ ᐃᑫᓂᐋᐠ ᑲᑭ ᐃᒋᑕᐋᐨ ᓇᓇᑦᑕᐃ ᑭᑫᑦᒋᑫᐃᓂᐠ

ᑲᒪᑲᑎᓱᐋᐨ ᑲᐃᒋᐦᐃᑦᑕᐃ

ᑲᒪᑲᑎᓱᐋᐨ ᑲᐃᒋᐦᐊᑲᓄᐋᐨ ᐱᒍᒋᑫᐃᐤ

ᐃᐍ ᑲᒪᑲᑎᓱᐋᐨ ᑲᐃᒋᐦᐊᑲᓄᐋᐨ ᐱᒍᒋᑫᐃᐤ ᐅᑕᓄᑲᐋᐋᐤ ᑭᒋᔦᐦᐊᑦ ᒥᓇ ᐅᐠᑲᑎᓭᑦ ᑲᒪᑲᑎᓱᓂᐨ, ᑲᒪᒥᑎᓀᑦᒋᑲᓇᐱᓀᐋᐨ ᒥᓇᓇᑦᑕ ᑲᐸ ᑲᐊᓂᒪᑎᓱᐋᐨ. ᐃᐍ ᐱᒍᒋᑫᐃᐤ ᓂᔕᐧᐸᐠ ᐃᔑ ᐊᓄᑭᒪᑳᑦ: ᒪᐠᑭᑭᐃᑲᒥᑯᐠ ᑲᑕᔑ ᓇᓇᑲᒋᐦᐃᑦᑕᐃ (MMW) ᒥᓇ ᐸᑳᑦ ᑲᐊᓂᔑ ᑲᑫᐃ ᐃᒋᐦᐊᑲᓄᐋᐨ.

- ᐅᐍ ᐱᒍᒋᑫᐃᐤ ᓂᔑᑦ ᐊᓂᑭᓇᑲᓇᐠ ᒉᑳᐨ ᐊᓂᑭᐦᐊᐋᐠ ᕓᐅᑦᒋ ᐃᒋᐦᐊᐋᐨ ᐅᑕᑯᓱᐟ ᒥᓇ ᐅᑎᕓᑦᒋᑫᐃᓂᐋ, ᐊᔑᐨ ᑲᐸ ᕓᐅᑦᒋ ᐃᒋᐦᐊᒋᑦ ᑯᑕᑭᔦᑦ ᒪᐠᑭᑭᐃ ᐸᒥᓂᑫᐃᐤ ᑲᐱᒥᐃᑐᐋᐨ ᒥᓇ ᑯᑕᑭᔦᐠ ᑲᐸ ᐱᒪᑎᓱᐃᓇᑦ ᑲᐊᓄᑲᑕᒍᐋᐨ, ᕓᑳ ᑲᐸ ᑎᐸᒋᒍᐋᐨ ᑕᔑᑫᐃᓂᐠ ᑫᑯᓀᓂᐋᐠ ᐅᐍ ᐃᒋᐦᐃᐍᐃᐤ.

- 115 ᐃᒪ ᐅᑦᒋ ᑲᓇᐋᐸᒪᐋᐠ. 68 ᐅᑕᑯᓯᐠ ᒉᑳᐨ ᐱᒥ ᓇᓇᑲᒋᐦᐊᐋᐠ ᕓᑳ ᓂᔦᓇᑦ ᐱᐦᐳᐋᐠ ᒋᑕᐋᓂᐠ ᒋᑭ ᐅᑦᒋ ᓇᓇᑲᒋᐦᐊᑲᓄᐋᐸᑦ ᐃᒪ ᑲᒪᑲᑎᓱᐋᐨ ᐃᒋᐦᐃᐍᐃᐤ ᐅᑦᑌᐃᔪ.

ᒪᐠᑭᑭᐃᑲᒥᐠ ᑲᑕᔑ ᓇᓇᑲᒋᐦᐊᑲᓄᐋᐨ

- ᐅᐍ ᐱᒍᒋᑫᐃᐤ ᐅᑕᓄᑲᐋᐋᐤ 18 ᑲᑕᓯ ᐱᐳᓀᓂᐨ ᒥᓇ ᐃᐠᐱᒥᐠ ᑲᐸ ᑎᕓᑦᒋᑫᐃᓇᑦ ᑲᐃᒋᔦᒪᐋᐨ ᑲᒪᑲᑎᓱᓂᐨ.
- ᐃᐍ ᒪᐠᑭᑭᐃᓂᓂᐋᐠ ᒪᓯᓇᑌᓯᒋᑳᑦ ᐃᒋᐦᐃᐍᐃᐤ (MMW) ᐱᒍᒋᑫᐃᐤ ᐅᑕᐸᒋᑐᓇᐋᐧ ᒪᓯᓇᑌᓯᒋᑲᓂᐠ ᕓᐅᑦᒋ ᓇᑭᐠᑲᑎᐋᐨ ᐃᒪ ᑭᐌᑎᓄᐠᐠ ᐅᑦᑌᐃᔪ ᑕᔑᑫᐃᓇᑦ ᒋᑭ ᐅᑦᒋ ᑌᐱᓇᒍᐋᐸᑦ ᒪᐠᑭᑭᐃ ᐃᒋᐦᐃᐍᐃᐤ ᒥᓇ ᑯᑕᑭᔦᑦ ᐃᒋᐦᐃᐍᐃᓇᑦ ᐃᑫᓂᐋᐠ ᑲᑭᒋᐦᐊᐃᐋᐨ ᑲᒪᑲᑎᓱᐋᐨ.
- ᐃᑕᓄᑭᒪᑲᓄᐋᐠ ᓱᐁᐃ ᐃᒋᐦᐃᐍᐃᑲᒥᐠ ᐃᒪ ᑎᐁᐅᑦᑐ ᒥᓇ ᒪᑲᑎᓱᐃᑲᒥᐠ ᑎᐁᐊᔦᑎᑦ/ᐋᓂᓇᐋᑳᐠ.

ᑲᐊᓂᔑ ᐊᑦᒋ ᑭᑭᓄᐦᐊᒪᐋᑲᓄᐋᐨ ᐅᒪᑲᑎᓭᐠ ᐱᒍᒋᑫᐃᐤ

- ᐃᑫᓂᐋᐠ ᑲᐃᒋᐦᐊᑲᓄᐋᐨ ᑭᒋ ᐅᐠᑲᑎᓭᐠ 18 ᐱᓂᐠ 24 ᑲᑕᓱᐱᐳᓀᐋᐨ ᑲᑭᑫᑦᑕᑯᓯᐋᐨ ᕓᒪᑲᑎᓱᐋᐨ ᕓᑳ ᒥᓇ ᑲᑭ ᑭᓯᐠᑯᓄᐃᐋᐨ ᐦᐊᔦᐠᑯᕽ ᓇᑦᑕ ᑲᐸ ᒥᓇ ᐊᐋᔑᒉ ᓂᐡᐊᐦᑭ ᕓᑲ ᕓᐃᐠᑯᓄᐃᐋᐨ ᐦᐊᔦᐠᑯᕽ

ᐊᐦᑭᐃᐤ ᑭᐍᓇᓇᑲᒋᒋᑫᐃᐤ

- 25 ᑕᔑᑫᐃᓇᑦ ᑭᓇᓯᑭᑲᐌᐋᐤ (10 ᑲᕓᔑᐃᓇᑦ ᑭᓇᓯᑭᑲᐌᐋᐤ)
- ᑭᐃᒋᑲᐸᐃᑕᐋᐠ ᐅᑕᑯᓲᐠ ᒉᑳᐨ ᑲᐅᓇᑯᓇᑲᓄᐋᐨ
- ᑭᐃᒋᑲᐸᐃᑕᐋᐋᐟ/ᑭᐱᒥᐃᒋᑲᐌ 94 ᒪᐠᑭᑭᐃ ᓇᓇᑲᒋᐦᐃᑯᐃᓇᑦ
- ᕓᐸᑦ ᑲᐊᐸᑕᐠ ᑲᔮᑲᐦᐃᑲᐌᐠ ᑲᓇᑕᐃ ᔓᓂᔦ ᑲᐸᑭᑎᓇᑲᓄᐨ ᐱᒍᒋᑫᐃᐤ – 4 ᐅᔕᑲᐠᑭᓀᐱᐦᐃᑫᐠ ᑭᒥᓇᑲᓄᐋᐠ
- ᕓᔾᓇᓀ° ᑲᕓᔑᐃᓇᑦ ᑭᑎᐸᐦᐃᑲᐌᐋᐤ ᑲᒪᑲᑎᓯᐨ ᑫᔑ ᑲᕓᔑᐦᐊᑲᓄᐨ
- ᓂᔮᐧᓯ ᐊᒋᓇ ᑲᐱᒥᔮᐠ ᐃᒋᐦᐃᐍᐃᐤ ᔓᓂᔦ ᑭᐸᑭᑎᓇᑲᓄ
- ᑭᐱᒥᐃᒋᑲᐌ ᒥᓇ ᑭᐃᒋᑲᐸᐃᒋᑲᐌ ᓇᐋᐧᑫᐧᒋᑫᐃᐤ

ᑲᐱᒍᕆᑲᐅᑦ
- ᑭᐃᕆᑲᐸᐃᑕᐋᐋᑦ ᐅᑕᑯᓰᑦ ᑲᐋᓂ ᐋᕆᒃᑳᓐ ᑫᑕᔑ ᑭᑭᓅᐊᒪᐚᑲᓄᐋᓐ ᐱᓂᒃ ᕆᑭ ᐊᓂ ᐅᑕᓄᑭᐃᓂᐋᓐ
- ᑕᓱᐊᐦᑭ ᒫᕆᐦᐃᑎᐄᐣ ᑭᑐᕆᑲᐅ ᐁᑭ ᒫᕆᐦᐊᑲᓄᐋᓐ ᐅᑕᑯᓰᑦ ᒥᓇ ᐅᑲᓇᐍᐣᕆᑫᑦ. 26 ᐅᑕᑯᓰᑦ ᑭᐃᔅᐋᑦ.
- ᑭᐱᒥᐃᕆᑲᐅ ᕆᒪᒪᐄᒃᑳᓐ ᐅᑕᑯᓰᑦ ᑲᒪᑲᑎᓯᐋᓐ

ᑲᓇᓇᑭᒃᑭᑲᐅᑭᐣ
- ᐁᑲ ᐅᐯᐧ ᐁᐃᕆᑲᐸᐃᕆᑲᐅᑦ ᐅᐁᐧ ᐃᕆᐦᐃᐍᐄᐣ ᒥᓇ ᐁᑲ ᑫᑯᐣ ᐅᐯᐧ ᐁᑕᑳᑦ ᐃᕆᐦᐃᐍᐃᓇᐣ ᐃᒪ ᑕᔑᑫᐃᓂᑦ
- ᕆᓇᓇᐣᑕᐄ ᑭᑫᐣᑖᑦ ᐊᐚᓈᑦ ᑫᑭ ᐃᕆᐦᐊᐚᐸᐣ ᐅᑕᑰᐣ ᑲᒪᑲᑎᓯᓂᓐ ᑭᒃᐱᐣ ᓇᐣᑕᐍᐣᑖᑦ

ᓂᑲᐣ ᑫᐊᓂᔑ ᐱᕆᓂᒃᑲᓂᐋᑦ:
- ᕆᐱᒥ ᐃᑕᓄᑭᒪᑲᓄᐋᓐ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᓇᐣ ᕆᑭᑭᓅᐊᒪᑲᓂᐋᑦ, ᕆᐃᕆᑲᐸᐃᕆᑲᐅᑭᐣ ᒥᓇ ᓇᐣᑕ ᑲᔦ ᐃᕆᐦᐃᐍᐃᓇᐣ ᑲᔦ ᕆᐃᕆᐦᐊᑲᓄᐋᓐ ᑲᒪᑲᑎᓯᐋᓐ ᐃᕆᐦᐃᑯᐄᐣ ᕆᑌᐱᓇᒎᐋᓐ
- ᕆᐱᒥ ᑲᓄᕆᑫᑕᒪᑲᓂᐋᑦ ᓇᐋᓐ ᕆᑭ ᒥᓄᕴᑭᐸᐣ ᐅᐁᐧ ᐃᕆᐦᐃᑕᐍᐃᓇᐣ ᒥᓇ ᕆᓇᓇᐣᑎᓂᑫᑕᒪᐋᑲᓄᐋᓐ ᐅᑕᑯᓯᑦ ᐃᕆᐦᐃᐍᐃᓇᐣ
- ᕆᐱᒥ ᑎᐸᕆᒍᓇᓂᐋᑦ ᑫᑯᓃᓂᐋᑦ ᐅᐁᐧ ᐃᕆᐦᐃᐍᐄᐣ ᑲᐱᒍᕆᑲᐅᑦ ᒥᓯᐁᐧ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᓇᐣ ᑲᔑ ᑕᑳᑭᐣ

ᐊᓂᔑᓂᓂᐃ ᒥᓇ ᐃᓄᐃᐧ ᒥᓄᐃᔦᐃ ᐄᐣᑕᒪᑫᐃᓇᐣ ᑲᐅᐣᕆ ᐱᒍᕆᑲᐅᑭᐣ (FNIHIS)

FNIHIS ᑲᐃᕆᑲᐅᑦ ᐄᐣᑕᒪᑫᐃᓇᐣ ᑲᐅᐣᕆ ᒪᐄᐣᑐᓯᓇᐦᐃᑲᐅᑭᐣ ᐱᐋᐱᑯᑦ ᑲᐊᐸᕆᑐᐋᓐ ᐊᑯᓯᐃ ᐱᒍᕆᑫᐄᐣ ᑲᐅᓇᑐᐋᓐ, ᑲᔑ ᑲᓇᐍᐣᑖᑭᐣ ᒪᓯᓇᐦᐃᑲᓇᐣ ᒥᓇ ᑲᐅᐣᕆ ᐃᕆᕆᑫᒪᑦ ᑲᐱᒥᐃᕆᑲᐅᑦ ᐱᒍᕆᑫᐄᐣ. ᒥᑕᐢ ᐁᐊᓂᓇᓄᑭᒪᑦ ᐁᐦᐊᓂ ᑲᓇᐍᐣᕆᑲᐅᑭᐣ ᐃᒪ ᒥᓄᔦᐃ ᒪᓯᓇᐦᐅᑯᐃᓇᐣ ᐁᑳ ᑕᐢ ᐁᐅᐣᕆ ᐃᕆᕆᑫᒪᑦ ᑲᑲᓇᐍᐣᑖᑭᐣ ᐊᓂᔑᓂᓂᐋᑦ ᒥᓇ ᐃᓄᐃᑖᑦ ᐅᑕᑯᓯᐃ ᒪᓯᓇᐦᐅᑯᐃᓂᐋ.

ᑕᓯᐱᓯᐡ, ᒪᐢᑭᑭᐃᑲᒥᑯᐣ ᐃᒪ ᑲᑕᓰ ᐸᐯᔑᑳᑭᐣ ᑕᔑᑫᐃᓇᐣ ᑲᐅᐣᕆ ᑲᓇᐋᐸᐣᕆᑲᐅᑭᐣ ᐅᑐᑎᓯᑯᓇᐋᐣ ᕆᑕᐦᐅᑎᐄᐣ ᑫᐊᓂᔑ ᔕᕆᑕᐦᐋᑲᓄᐋᓐ ᐅᑕᑯᓯᑦ, ᑲᑭᔑᓂᑕᐄᑭᐋᓐ ᒥᓇ ᑯᑕᑭᔾᐣ ᑫᑯᓇᐣ ᑲᑖᓯᓇᐦᐃᑲᐅᑭᐣ ᐃᐁᐧᓂ ᐅᕆᑕᐦᐅᑯᐄᐣ.

ᕆᑕᐦᐅᑎᐄᐣ/ᒪᐣᑐ (TB) ᒪᓯᓇᐦᐅᑯᐃᓇᐣ ᒥᓇ ᐃᑫᐧᓂᐋᑦ ᑲᓇᐣᑕᐍᐣᑕᑯᓯᐋᓐ ᑎᐱ ᕆᑕᐦᐅᑎᐄᐣ ᑲᓇᐣᑕᐍᐣᑕᒍᐋᓐ ᒪᐢᑭᑭᐃᑲᒥᑯᐣ, ᐊᑯᓯᐃ ᐱᒍᕆᑫᐃᓇᐣ, ᐊᑯᓯᐃᑲᒥᑯᐣ ᒥᓇ ᓇᓇᐣᑐᑦ ᐊᐋᔑᔑᐃ ᐱᒍᕆᑫᐃᓇᐣ ᑲᔑᔦᑭᐣ.

ᐊᐦᑭᐄᐣ ᑲᑭᐁᐧ ᓇᓇᑲᕆᕆᑲᐅᑦ

ᐅᑕᑯᓯᑦ ᑲᓇᐣᑕᐍᐣᑕᑯᓯᐋᓐ ᕆᕆᑕᐦᐋᑲᓄᐋᓐ	
ᐅᐢᑭ ᐅᑕᑯᓰᑦ	484
ᑲᐋᐣᕆᓴᑦ ᑫᕆᑕᐦᐋᑲᓄᐋᓐ ᐅᑕᑯᓰᑦ	782
ᑲᐃᐢᑳᐱᒪᑎᓯᐋᓐ	99

ᕆᑕᐦᐃᑫᐃ ᒪᐄᐣᑐᐱᐦᐃᑫᐄᐣ	
ᕆᑕᐦᐅᑎᐄᐣ ᑲᒪᐄᐣᑐᐱᐦᐃᑲᐅᑦ	16,274
ᑲᓇᓇᑲᕆᐦᐊᑲᓄᐣ ᐊᐃᔦ ᑭᐢᐱᐣ ᑫᑭ ᕆᑕᐦᐋᑲᓄᑫᐄᐣ	563
ᕆᑕᐦᐅᑎᐄᐣ/ ᒪᐣᑐ ᒪᓯᓇᐦᐅᑯᐃᓇᐣ ᑲᓇᐣᑕᐍᐣᑕᑳᑭᐣ	1,522

ᑲᓇᓇᑭᒃᑭᑲᐅᑭᐣ
- ᒉᑳᐣ 2013 ᔐᓂᔦᐊᐦᑭ ᑲᐱᒥᓴᑦ ᑭᐦᐊᔦᐋᑦ 7,037 ᐊᑭᑯᐃ ᕆᑕᐦᐅᑎᐄᐣ ᑭᐸᑭᑎᓂᑲᐅ (ᑫᑳᐟ ᓂᐋ ᐊᐋᔑᒉ ᑕᓱᐣ ᑲᑭ ᕆᑕᐦᐋᑲᓄᐋᓐ ᒉᑳᐣ 2012). ᐃᐁᐧ ᑕᐢ ᑲᒥᔑᓄᐋᓐ, ᑕᑯ ᑲᔦ ᑲᓵᕆᑕᐦᐅᐣᑖ, ᒪᐋᓐ ᑭᐊᓂᒥᓴ ᑲᑭᓇ ᕆᑭ ᐊᓂ ᒪᐄᐣᑐᐱᐦᐃᑲᐅᑭᐣ.

ᓂᑲᐣ ᑫᐊᓂᔑ ᐱᕆᓂᒃᑲᓂᐋᑦ
- ᐃᐁᐧ FNIHIS ᐱᒍᕆᑫᐄᐣ ᑕᐱᒥᓄᑭᒪᑳᐣ ᕆᐊᓂ ᒪᐄᐣᑐᐱᐦᐅᐣᑖ ᑫᐊᓂ ᓴᕆᑕᐦᐋᑲᓄᐋᓐ ᐃᒪ ᐊᓂᔑᓇᐯᐃ ᑕᔑᑫᐃᓂᑦ.

ᒥᓂᐋᐱᓅᐄᐣ ᑲᐅᐣᕆ ᐱᒍᑐᐋᓐ

SLFNHA ᐅᐱᒍᑐᓇᐋ ᒥᓂᐋᐱᓅᐄᐣ (TB) ᐃᕆᐦᐃᐍᐄᐣ ᐅᐣᕆ ᒪᕆ 1997. ᐃᐁᐧ ᐱᒍᕆᑫᐄᐣ ᐃᓇᐍ ᕆᑳᑫᐧ ᑭᐱᑎᓂᑲᐅᑦ ᒥᓂᐋᐱᓅᐄᐣ ᐃᒪ 31 ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᓇᐣ SLFNHA ᑲᐅᐣᕆ ᑲᓇᐋᐸᑕᒎᐋᓐ, ᐃᒪ ᑲᔑ ᓇᓇᑲᕆᕆᑫᐋᓐ, ᒥᓇ ᑲᐱ ᓇᐣᑕᐃᐧᑐᐋᓐ ᐃᐁᐧᓂ ᐊᑯᓯᐄᐣ, ᑲᐅᐣᕆ ᑲᓇᐋᐸᐣᕆᑲᐅᑭᐣ, ᑭᑭᓅᐊᒪᑫᐄᐣ, ᒥᓇ ᐄᐣᑕᒪᑫᐄᐣ, ᔐᓂᔦ ᑲᐅᐣᕆ ᐸᑭᑎᓇᑲᓄᐣ ᕆᐱᒥᐃᕆᑲᐅᑦ ᐅᐁᐧ ᐃᕆᐦᐃᐍᐄᐣ ᑕᓱᐊᐦᑭ ᓇᑯᒥᑎᐄᐣ ᐁᐸᑭᑎᓂᑲᐅᑦ ᕆᐃᕆᕆᑲᐅᑭᐣ ᐃᒪ ᐊᓂᔑᓇᐯ ᒥᓇ ᐃᓄᐃᐧ ᐊᑯᓯᐃ ᐱᒍᕆᑫᐄᐣ (FNIH).

ᐃᐁᐧ TB ᐱᒍᕆᑫᐄᐣ ᑲᐊᓂᑲᑕᒍᐋᓐ ᐅᑕᓄᑭᑦ ᐅᐸᑭᑎᓇᓇᐋ ᐃᕆᐦᐃᐍᐄᐣ ᒥᓇ ᐁᐅᐣᕆ ᐊᔦᒥᑕᒪᐋᐋᓐ ᐅᑕᑯᓯᐣ ᑲᑎᐱᐋᐱᓅᓂᓐ ᒥᓇ ᐅᑎᐯᐣᕆᑫᐃᓂᐋ ᒉᑳᐣ ᐊᑯᓯᐃᑲᒥᑦ ᐁᑲᓇᐍᐣᑕᑯᓯᐋᓐ. ᒥᓇᐋ ᑕᐢ ᐊᓂ ᐱᒥ ᓇᓇᑲᕆᐦᐊᐋᑦ ᐅᑕᔑᑫᐃᓂᐋ ᐃᒪ ᕆᐅᐣᕆ ᓇᓇᑲᕆᑲᐅᑦ ᑭᓄᐋᑳᐢ ᕆᐱᒥ ᑲᑫᐃᕆᐦᐊᑲᓄᐋᓐ. ᓇᓇᓯᑭᑲᐅᐊᐣ ᑲᔦ ᑕᔑᑫᐃᓇᐣ ᕆᐅᐣᕆ ᐃᕆᐦᐊᑲᓄᐋᓐ ᐅᑕᑯᓰᑦ ᒥᓇ ᐅᑎᐯᐣᕆᑫᐃᓂᐋ, ᐁᓇᓇᑲᕆᐦᐊᑲᓄᐋᓐ ᑭᐢᐱᐣ ᐅᐣᕆ ᑲᕆᑎᓇᒍᐋᓐ ᑎᐱᐋᐱᓅᐄᐣ TB, ᐁᐃᕆᑲᐸᐃᑕᐋᑲᓄᐋᓐ ᑕᔑᑫᐃᓂᑦ ᑲᐅᐣᕆ ᐸᒥᐦᐊᐋᓐ, ᒥᓇ ᐁᐸᑭᑎᓂᑲᐅᑦ ᑭᑭᓅᐊᒪᑫᐃᓇᐣ.

ᒥᑕᐢ ᑲᑭ ᐃᑭᑐᐋᓐ BCG ᑲᐊᓄᑲᑕᒍᐋᓐ ᐃᐁᐧᓂ ᕆᑕᐦᐅᑎᐄᐣ ᑲᐸᑭᑎᓂᑲᐅᑦ ᒥᓇ ᐊᐋᔑᒉ ᕆᑭ ᑲᑫᐧ ᓇᓇᑲᕆᑲᐅᑦ TB ᒉᑳᐣ ᐁᐱᒥ ᐊᓄᑲᐅᑦ. ᑲᐱᒥ ᓇᓇᑲᕆᐦᐊᑲᓄᐋᓐ BCG ᕆᑕᐦᐅᑎᐄᐣ ᑭᑭᐱᑎᓂᑲᐅᐸᐣ

ᐃᒪ 28 ᑕᔑᑫᐃᐧᓇᐣ ᑲᔑᔭᑭᐣ. ᐃᐁᐧ ᑲᒋᑕᐦᐅᑎᓇᓂᐊᐧᐠ BCG, ᑕᑯ ᑲᔦ ᑲᒋᑕᐧᐦᐊᑲᓄᐊᐧᐨ ᐁᑲ ᒪᔑ ᑲᐅᑎᐱᓇᒧᐊᐧᐨ ᑯᑕᑭᔭᐣ ᒋᑕᐦᐅᑎᐃᐧᓇᐣ, ᐅᐱᒥ ᑐᑕᓇᐊᐧ ᓂᓯᐣ ᑕᔑᑫᐃᐧᓇᐣ.i

- TB ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᑲᑭᓇ ᑕᔑᑫᐃᐧᓇᐣ ᑭᔭᐸᐨ ᐱᒥᑐᒋᑲᑌ. TB ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᐸᐸᑭᑎᓂᑲᑌ ᑲᑭᓇ ᑕᔑᑫᐃᐧᓇᐣ ᑲᔑᔭᑭᐣ.

- TB ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᐃᐧᐣᑕᒪᐃᐧ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᐱᒥ ᑐᒋᑲᑌ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ. ᐃᒪ ᒉᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒥᓇᐊᐧ ᐅᑭ ᓂᑲᓂ ᐱᒧᑐᓇᐊᐧ ᐃᐧᐣᑕᒪᑫᐃᐧᐣ ᐃᐁᐧ ᐅᐣᒋ ᒥᓯᐁᐧᑲᒥᐠ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᑲᑭᑭᓇᐊᐧᒋᒋᑲᑌᐠ, ᒥᑭᓯᐃᐧᐱᓯᑦ 24. ᑭᑭᓄᐦᐊᒪᑫᐃᐧ ᒪᓯᓇᐦᐃᑲᓇᐣ ᒥᓇ ᐊᐧᐸᐣᑕᐦᐃᐁᐧᐃᐧᓇᐣ ᑭᐊᔭᑭᓂᓂᔕᐦᐊᒪᐊᐧᐠ ᑕᔑᑫᐃᐧᓂᐠ ᑲᓂᑲᓂᐡᑲᒧᐊᐧᐨ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᒥᓇ ᐃᒪ ᑲᐊᓄᑭᐊᐧᐨ ᒋᐅᐣᒋ ᐊᐧᐸᐣᑕᒧᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑲᐯᔑᐊᐧᐨ.

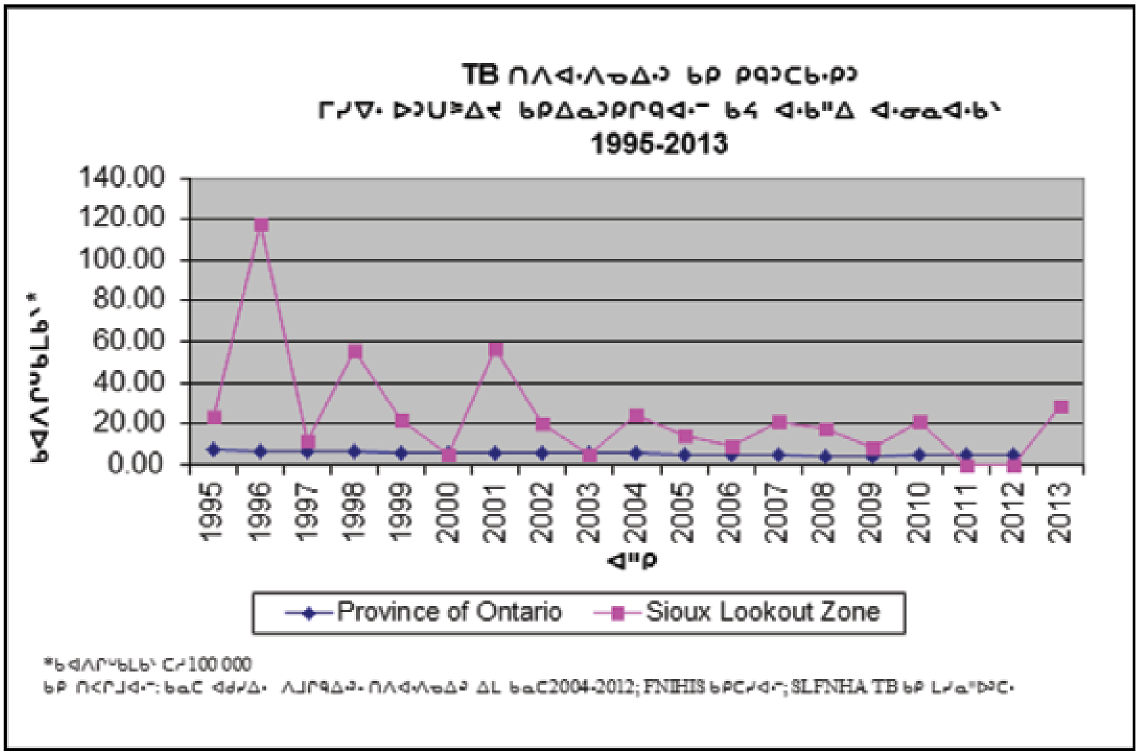
- ᐅᐡᑭ ᐊᐸᒋᑕᑲᓇᐣ ᑲᐅᐣᒋ ᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᐅᑕᐸᒋᑐᓇᐊᐧ ᑕᔑᑫᐃᐧᓇᐣ ᐁᑲᐧ ᓂᐃᐧᒋᑲᐸᐃᐧᑕᒥᐣ ᐃᒪ SLFNHA ᐱᐊᐧᐱᑯᐠ ᑲᐊᑐᐊᐧᐨ ᐃᐧᐣᑕᒪᑫᐃᐧᐣ, ᓴᑯᓇᐠ ᐅᐡᑭ ᑎᐸᒋᒧᐃᐧᓇᐣ ᐊᓂ ᐊᒋᑲᑌᐊᐧᐣ.

- ᐊᐁᐧ TB ᐅᑭᑭᓄᐦᐊᒪᑫ ᐅᑭ ᒪᒋᑐᓇᐣ ᐁᐃᐧᐣᑕᒪᑫᐨ ᑫᑯᓂᓂᐊᐧᓂᐠ ᐃᐁᐧ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᒪᓯᓇᑌᓯᒋᑲᓂᐠ ᐁᐅᐣᒋ ᑲᑭᑐᐨ ᐁᑭ ᐊᔭᒥᐦᐊᒋᐣ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑕᓇᓄᑭᐊᐧᐨ ᒪᐡᑭᑭᐃᐧ ᐊᓂᑭᓇᑲᓇᐠ. ᐃᒪ ᑲᔑᒥᑲᐣ ᐅᐁᐧ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ SLF-NHA ᐱᐊᐧᐱᑯᐠ.

ᑲᓇᓇᑭᐡᑭᑲᑌᐠ:

- ᐃᐁᐧ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᒥᐡᑕᐦᐃ ᑲᑭᔭᒪᑲᑭᐸᐣ ᐅᒪ ᑌᑎᐸᐦᐃ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑲᐧᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ ᑭᐊᓂ ᑕᐸᓯᓭᐊᐧᐣ ᒣᑲᐧᐨ 2001, ᔕᑯᐨ ᑕᐡ, ᓂᓴᐧᓯ ᑭᐅᐣᒋ ᐅᐡᑭ ᐅᔑᐦᐅᒪᑲᐣ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᐅᐣᒋ ᒪᒋ ᒪᑯᐱᓯᑦ 2013.

- ᔐᓂᔭ ᑲᐸᑭᑎᓇᐊᐧᐨ FNIH ᒥᐱᑯ ᐯᔑᑲᐧᐣ ᒥᓂᑯᐠ ᐁᐸᑭᑎᓇᐊᐧᐨ ᑲᑭ ᐸᑭᑎᓇᐊᐧᐸᐣ 1997.



ᑫᐊᓂᔑ ᐱᒋᓂᐡᑲᓂᐊᐧᐠ:

ᐃᐁᐧ ᐁᐅᐣᒋ ᐱᒥᓂᔕᐦᐃᑲᑌᐠ ᑲᐃᓇᑌᐠ ᐊᓂᔑᓇᐯ ᐊᑯᓯᐃᐧ ᐅᓇᒋᑫᐃᐧᐣ, ᐃᐁᐧ SLFNHA TB ᑲᐱᒥᐃᐧᑐᐊᐧᐨ ᐊᒥᐦᐃ ᐁᐃᓇᓄᑭᐊᐧᐨ ᐁᑲᑫᐧ ᑕᐸᓯᓇᒧᐊᐧᐨ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ, ᐊᔑᐨ ᑲᔦ ᐁᐅᐣᒋ ᑲᓇᐁᐧᐣᑕᑲᐧᑭᐣ ᐱᒪᑎᓯᐃᐧᓇᐣ. ᐃᒪ ᑲᐅᐣᒋ ᑭᒋ ᐊᓄᑲᑌᑭᐣ ᑕᔑᑫᐃᐧᓂᐠ, ᒥᐦᐁᐧ ᑲᐃᐧ ᑐᑕᒪᐣᐠ:

- ᒋᐊᐧᐃᐧᐣᑕᒪᑲᓂᐊᐧᐠ ᐊᓂᐣ ᑫᑭᔑ ᐊᓄᑲᑌᑲᐧᐸᐣ ᐃᑫᐧᓂᐊᐧᐣ ᑲᐊᑯᓯᐡᑲᑯᐊᐧᐨ ᐊᓂᔑᓂᓂᐊᐧᐠ

- ᒋᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄᐊᐧᐨ ᑲᔑ ᐸᐯᔑᑯᐊᐧᐨ ᐊᐃᐧᔭᐠ ᒥᓇ ᑕᔑᑫᐃᐧᓇᐣ ᐃᐁᐧ ᐅᐣᒋ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᐊᓂᐣ ᑫᑭᑐᒋᑲᑌᑭᐸᐣ ᐁᑲ ᒋᑭ ᐅᐣᒋ ᐊᑯᓯᐸᐣ ᐊᐃᐧᔭ

- ᒋᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᑭᐣ ᒥᓇ ᒋᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᐊᓂᐣ ᑫᔑ ᐃᐧᑕᓄᑭᒥᑎᓇᓂᐊᐧᐠ ᒥᓇ ᐊᐊᐧᔑᒣ ᒋᑭ ᓇᓇᑲᒋᒋᑲᑌᑭᐸᐣ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᑲᑭᓇ ᑕᔑᑫᐃᐧᓇᐣ ᑲᔑ ᑕᑲᐧᑭᐣ

- ᒋᑲᓇᐁᐧᐣᑕᑲᐧᑭᐣ ᑭᒋᔭᐦᐊᐠ ᑲᔑ ᑭᑫᐣᑕᒧᐊᐧᐨ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ, ᑲᑭᑐᑕᒧᐊᐧᐨ ᐁᓇᐣᑕᐃᐧᐦᐊᐊᐧᐨ ᑲᐊᑯᓯᓂᐨ, ᒥᒋᑦ ᑲᑲᐧᔭᐣᒋᑐᐊᐧᐨ ᒥᓇ ᑲᐃᔑᑲᑌᐳᐊᐧᐨ ᑲᑭᓇ ᐅᑫᐧᓂᐊᐧᐣ ᒋᑭ ᒪᐊᐧᐣᑐᐱᐦᐃᑲᑌᑲᐧᐸᐣ

- ᒋᐊᓄᑲᑌᐠ ᐊᓂᐣ ᒥᓇᐊᐧ ᑫᑭᔑ ᐊᓄᑲᑌᑭᐸᐣ ᑎᐱᐊᐧᐱᓂᐃᐧᐣ ᐁᑲ ᒋᑭ ᒥᓯᑌᐡᑲᒪᑲᑭᐸᐣ ᑫᑭᔑ ᐃᐧᒋᐦᐃᑯᐊᐧᓴᐣ ᑕᔑᑫᐃᐧᓇᐣ

Participants at a public health community forum in Lac Seul First Nation in May 2014.

Health Services

ᒐᓀᐟ ᐧᑳᙿᑎᐣ

Janet Gordon
Director of Health Services

Anishinabe Health Plan

Sioux Lookout First Nations Health Authority (SLFNHA), in conjunction with the First Nation communities in our region, supported the development of the Anishinabe Health Plan (AHP). The AHP envisions a unified, regional primary health care system under First Nation governance and management.

In March 2006, the Sioux Lookout District Chiefs approved and mandated SLFNHA to proceed with the implementation of the AHP. This plan details the steps and requirements necessary for the implementation of an integrated regional primary health care system.

An essential feature of this system is the inclusion of comprehensive public health programming and services. This year was an integral step forward.

Public Health Project

Under Resolution 10/06, the Sioux Lookout area Chiefs mandated Sioux Lookout First Nations Health Authority (SLFNHA) to develop a public health system for the 31 communities we serve. Since then, SLFNHA has received funding from the Health Services Integration Fund (HSIF) of Health Canada. Funding began in August 2012 and ends March 31, 2015. The program staff includes a Public Health Project Coordinator, a Public Health Project Assistant, and a part-time Communications Officer & Research Assistant.

The SLFNHA Public Health team has developed a public health working group with representatives from First Nations and Inuit Health Branch, Ministry of Health and Long-Term Care, Thunder Bay District Health Unit, Northwestern Health Unit, two representatives from the Tribal Councils and two community representatives.

Year in Review

- Preliminary results from a Health Services and Human Resources assessment were produced in July 2013, and further information was gathered after that. The latest draft was completed in March 2014.
- In February 2014, a Public Health Conference was hosted in Lac Seul First Nation. Health Directors (or their delegates) from the Tribal Councils and all 31 communities were invited to attend. The conference provided the participants with presentations on various components of public health in order to expand their knowledge.
- External evaluators conducted a process evaluation for year two of the project, and they have completed a report of their findings along with recommendations for changes to our evaluation framework for year three.
- Through consultation with the Health Directors, we identified that consultation needs to take place at the community level prior to further development of the public health framework. As such, we have identified five communities to visit for three-days each. Communities were selected to ensure a variety of population sizes, access, geographical location, Tribal Council and health structure.

Challenges

- The Public Health Project Coordinator position was vacant for over six months, which led to an increased workload on the Project Assistant and Director of Health Services. It also slowed down some of the progress on our work plan.
- Agreement on the Associate Medical Officer of Health position took longer than expected. Although it was hoped that the start date for the position would be April 1, 2014, federal approval for the position was not achieved until late March 2014.

Moving Forward

- We will have meetings throughout the upcoming year to develop the public health model.
- We will be developing sub-committees in the Working Group to tackle various aspects of the project, including evaluation, sustainability, and model revisions. This will focus the work of the Group more and allow for better use of representatives' time.
- Although the approval process for the Associate Medical Officer of Health took longer than expected, the recruitment process is underway.
- Community visits will take place in Sandy Lake, Muskrat Dam, Lac Seul, Nibinamik, and Sachigo Lake. During our visits we will conduct key informant interviews with health workers to gain insights into how they see the public health system working at the community-level.
- Following the community consultation processes, the model will be revised and presented back to key stakeholders for revisions. After solidifying the services and governance structure of the model, we will work closely with our partners to identify the funding and legal structure.
- In February 2015, we will present the model to the Sioux Lookout area Chiefs and Health Directors for approval at a conference hosted in Sioux Lookout.

Anishinaabe Bimaadiziwin Research Program

The Anishinaabe Bimaadiziwin Research Program is a partnership between SLFNHA and Sioux Lookout Meno Ya Win Health Centre (SLMHC).

Through *Resolution 12-08,* SLFNHA was mandated to begin the process to establish a community-directed research unit to facilitate research based on community health priorities. The research unit would result in regional service providers having sufficient health data and evidence to support and advocate for the delivery of appropriate, adequate and proactive health care at the community-level. The unit would also ensure that the communities in the Sioux Lookout area set priorities for health research.

At the same time, SLMHC was in the processing of reviewing the existing structure for research review and creating a research program. In 2013, SLFNHA and SLMHC created the partnership to form a joint research unit.

Year in Review

- Successfully partnered with SLMHC to form a joint research unit
- Hired a Research Program Lead in July 2013 (located at SLMHC)
- Representatives from SLFNHA and SLMHC formed a Research Advisory Committee to lead the creation and direction of the unit (began holding monthly meetings). This group will act in a board capacity during the development stage.
- Draft Terms of Reference developed to guide the advisory group
- Chose a name for the unit: *Anishinaabe Bimaadiziwin Research Program.*

Challenges

- Development of protocols and procedures as the program and projects continue to develop and are initiated
- Changing negative perceptions of research and providing more education about community-based participatory research methodology which has had positive outcomes for First Nation communities.

Moving Forward

- As development of the unit continues, focus will shift to ensure the Research Program is a reliable and credible go-to source for all things related to health research in the Sioux Lookout region. This will mean developing partnerships with universities, hospitals, research centres, communities, etc. to ensure activities taking place in First Nation communities and in the Sioux Lookout area are relevant to community needs.
- The next year will be focused on promoting the research program locally and across the region for both communities and researchers so that there is a general understanding of how to move forward with research and who to go to for assistance when approached to participate in potentially valuable research projects.

Physician Services

Year in Review

- Recruitment efforts continue: one physician signed a full-time contract with the Hugh Allen Clinic and a physician signed a part-time contract (Poplar Hill First Nation)
- Sioux Lookout Regional Physician Services Inc. (SLRPSI) has approved a contract of service for Northern Practice Coordinator who provides leadership and support for the Northern Physician Group
- For Electronic Medical Records (EMR), we saw an increased number of physicians working within the system and improvements made in the speed and access in nursing stations. Chart information is increasing and improving information available to physicians.

	2011/2012 Community Days	2012/2013 Community Days	2013/2014 Community Days
Service Provided	2,221	2,048	2,013

Challenges

- Maintaining and recruiting contracted physicians
- Fulfilling all Northern community days and Sioux Lookout hospital service days while trying to maintain continuity of care for our clients

Moving Forward

- Developing enhanced policies and procedures to increase Northern community days
- Developing clear policies that are easy for locums, contracted physicians and staff to abide by, as well as increased structure supporting long-term planning for locums
- SLFNHA and Health Canada are exploring expanding electronic medical record access for all community-based service providers.

Primary Health Care Unit - Northern Appointment Clinic

The Northern Appointment Clinic is still located at the 7h Avenue site (old Zone hospital) and serves clients from First Nation communities coming to Sioux Lookout for medical appointments. The Clinic is staffed by a Clinic Coordinator, Nurse, two clerks and a full-time security guard.

Year in Review

- During this fiscal year 3,936 clients were seen
- 303 patients were seen by the Sports Medicine physician.
- Physicians at the Clinic saw a range of clients:
  - Follow-up from emergency room and hospital discharges
  - Follow-up after going to the Imaging Department at SLMHC
  - Mental Health and Addiction, including Suboxone treatment & support while in Sioux Lookout for medical appointments
  - Chronic disease management

Challenges

- Recruitment of a Nurse Practitioner
- Working in the old building has many challenges (pipes leaking, ceiling, distance from SLMHC & Hostel, etc.)

Moving Forward

- SLFNHA & Sioux Lookout Regional Physician Services Inc. (SLRPSI) is working with SLMHC to build an interim Primary Health Care Facility and Northern Clinic. This would be located at the Meno Ya Win health campus
- SLFNHA & SLRPSI continue to address the need for a permanent Primary Health Care Facility and will be a priority throughout the Four-Party process.
- More targeted recruitment efforts for the Nurse Practitioner and to develop the role and program delivery

Regional Wellness Response Program

In recent years, there was an emergence and steady increase of prescription drug abuse and associated harms (i.e. sexually transmitted infections and blood-borne infections) in First Nation communities of the Sioux Lookout region. With increased needle usage and sharing, and high-risk behaviour, there was an increase in reported cases of blood-borne infections such as Hepatitis C and sexually transmitted infections.

At the 2011 SLFNHA Annual General Meeting, the Chiefs in Assembly passed a resolution mandating SLFNHA to develop a Regional Opiate Drug Abuse Strategy. Two interrelated priority areas identified to tackle were substance abuse and blood-borne infections.

In response, the Regional Wellness Response Program (RWRP) was established in January 2013. The following services are in place: Regional Coordination, Needle Distribution Program, Community Wellness Development Team, and Hepatitis C Program. All have education and awareness campaigns, which are an integral part of the program. The RWRP has four staff working collectively in the same office space, and two consultants off-site.

Year in Review

Regional Coordination

- Successful liaison with community leadership, frontline workers, health care providers, etc., to allow for further development of strategies which will address community health needs and concerns.
- Collaborated for coordination of health service delivery and responsive to community concerns
- Program banner developed, program information added to SLFNHA website, and newspaper ads placed to promote and explain the program.

Needle Distribution Program

- Significant growth since inception- a result of the continuous promotion of the program, and education on the importance of harm reduction and prevention.
- From April 2013 to March 2014, the program sent 96 boxes. Approximately 11 communities were regularly using the program.
- From April 2013 to March 2014: 9,404 kits sent out, therefore 94,040 needles.

Hepatitis C Program

- Annual funding (from MOHLTC) received to hire a Hepatitis Case Coordinator to provide case management support to those living with, at risk of acquiring or affected by Hepatitis C (HCV).
- Design of intake, referral forms, and brochure
- Explored regional treatment options and group involvement to strategize service delivery improvement across the system responding to HCV.
- Increased knowledge and awareness of HCV through educational campaign and community/school presentations.

Community Wellness Development Team (CWDT)

- Supported six communities to prepare, plan, and implement their own community-driven treatment approaches to address prescription drug abuse and underlying mental health issues.
- 14 trips into these communities (14 different service options).
- Developed an information package (i.e. brochure, letter of invitation, flowchart, and referral form) and sent out to 36 communities within the team's catchment area. A total of 79 packages were sent on May 20, 2014 to all Chiefs,

Health Directors, Tribal Councils within the Sioux Lookout area, and representatives of the CWDT Implementation Subcommittee.
- Since the end of March 2014 to present, six communities have expressed interest and we have already started to provide service to some.

Challenges
- CWDT funding is secured until September 30, 2014 and continued funding will be based on the results of an evaluation requested by the Trilateral First Nations Health Senior Officials Committee.
- The unknown makes it very difficult to plan CWDT service delivery and to maintain staff.
- One part-time Program Assistant is not enough to keep up with increased demand for needle kits.

Moving Forward
- Funding request submitted for an increase to:
  - enhance the program
  - cover the costs associated with a growing needle distribution program
  - continue advertising/awareness campaigns, develop/distribute educational material
  - hire a full-time Addictions Educator
  - change the Program Assistant position to a full-time position

- To send newly developed Hepatitis C brochure, referrals (for health care and social service providers) and Hep C posters to community leadership, health directors, nursing stations, counsellors or addiction programs.

- Follow-up to assess interest and understanding of the Hep C program and presentations on the service and on Hep C. Goal is to begin working directly with clients by the end of September 2014.

- To develop a brochure on the Needle Distribution Program to send to communities currently not using the service, as a means to reach out to others who, with further information, may want to start a program.

- To continue supporting communities in their efforts to build capacity to develop community-driven treatment responses and to respond to blood-borne infections.

- To increase knowledge and awareness of HCV, harm reduction initiatives, and reduce the stigma associated with drug using and/or having a blood-borne infection.

The Telemedicine Program

The primary purpose of the Telemedicine Program is to provide access to professional health care and mental health specialized services via private video-conference consultations.

Education and training, presentations and administrative meetings are delivered through video-conferencing technology on ongoing bases, benefiting SLFNHA staff, community members and partner organizations.

Supporting First Nation communities within the Sioux Lookout area, the Program operates in partnership with KO-eHealth, K-Net, Ontario Telemedicine Network, Tikinagan Child and Family Services and The Hospital for Sick Children in Toronto.

Annual Statistics:

Event Type	Sessions	Clients Seen	Participants
Clinical	284	284	
Education (incl. webinar presentations)	60		190
Administrative	68		
TOTAL	412	284	190

Year in Review

Program Development Activities:
- Submission of funding proposal to become a Tele-Mental Health Service Coordination Agency.
- Participation in development of operational protocols & service pathways with partner organizations in Sioux Lookout
- Preliminary review of Telemedicine Service Agreement, Roles, & Responsibilities
- Development of effective coordination of intake referrals to tele-psychiatry and client follow-ups
- Establishment of regular video meetings between community-based Nodin workers and a mental health specialist
- Delivery of orientation on video-conferencing at the workplace and referral process to Tele-psychiatry of Hospital to Sick Children

Program Promotional Activities:
- Presentation at the Virtual Care Retreat Showcase in Sioux Lookout in October 2013
- Developed an updated Telemedicine Program brochure
- Advertisement of upcoming educational video-conferences & webinars via the SLFNHA website & email distribution

Challenges

- Equipment needed to access video-conferencing is currently unavailable at the Primary Health Care Unit and Nodin's Art Therapy room. The Telemedicine Program does not have the funds to fix the equipment.
- Communication and information sharing between agencies and First Nation communities
- In order for the Telemedicine Program to continue to provide high-quality services, we need core funding which adequately supports the ongoing program development.

Moving Forward

- Continue in comprehensive development of mental health service pathway that corresponds to specific health care needs of remote First Nations
- Continue to advocate the practical application of videoconferencing, particularly in the areas of public health education, mental health counselling and client follow-up.

Baby Teeth Talk Study

International Collaborative Indigenous Health Research, Baby Teeth Talk Study (BTT) is a three-year project which involves reducing early childhood caries by focussing on intervention during pregnancy. The participating countries are Australia, New Zealand and Canada.

BTT has recruited 544 pregnant First Nations and Métis women living in urban and on-reserve communities in Ontario and Manitoba in the past two and a half years and out of those, nearly 200 First Nations women came from the Sioux Lookout area.

Presently, study participants have all given birth. Fluoride varnish is being applied to their babies' teeth bi-annually, for three years. The goal of the study's multi-pronged approach is to intervene early enough in the child's life to prevent the onset of early childhood caries, or at least, reduce the rates of the disease to levels comparable to the general Canadian population so that fewer Indigenous children require dental treatment under general anesthesia.

Year in Review – Second Phase of the Study

- We have currently started the second phase of the Study. This involves the clinical oral examinations of the 2-year-old participants to assess the effectiveness of our pre- and post-natal preventive and behavioral interventions to prevent caries.
- The second phase of the Study began in February 2014, where both intervention and delayed intervention groups were targeted. This required mothers or primary caregivers to complete the follow-up questionnaire and the 2-year-olds to undertake an intra-oral examination by a registered dental hygienist.
- In March 2014, Health Canada approved four contracted dental hygienists to provide in-kind-contribution to the project by examining the 2-year-old participants of the Study.
- The registered dental hygienists' training and calibration session took place at the Sioux Lookout Zone Dental office on March 16, 2014 and involved the review of the dental caries diagnostic criteria and forms, followed by the examination of five children of the same ages as the study participants, but who were not participants in the study. These children received a standard intra-oral examination.

Statistics for Second Phase of the Baby Teeth Talk Study as of April 1, 2013 – March 31, 2014 (still on-going)

Communities in the Sioux Lookout Zone	Intervention & Delayed Intervention	Completed 2nd Questionnaire	Completed Clinical Oral Examination
4	19	19	11

Challenges

- Finding accommodations in the northern communities for the Study Coordinator while providing the interventions and during data collection
- Participants were often out of town during community visits
- Arranging/contacting participants for follow-up visits
- High cost of transportation, both air and land
- Inclement weather

Moving Forward

- Our goal is to maintain the current number of participants in the Study.
- We've received positive feedback from participants

Developmental Services Program

The Developmental Services Program works with adults and youth with developmental disabilities, mental health issues and/or challenging behaviours. The Developmental Services has two components: Clinical Assessment Program (MMW) and Transitions Program.

- The program is currently staffed with two workers who support clients and their families, act as a resource for health care providers/social workers, and promote programs to communities.
- 115 referrals to date. 68 clients are active and five individuals on waiting list for eligibility assessment from Developmental Services Ontario.

Clinical Assessment Program

- The program serves adults 18 years of age and older and their families living with developmental disabilities.
- The Mashkikiiwininiwag Mazinaatesijigan Wichiiwewin (MMW) program uses video conferencing technology to provide northern Ontario communities with enhanced access to clinical services and resources for adults living with developmental disabilities.
- Partnership with Surrey Place Centre based in Toronto and Community Living Dryden/Sioux Lookout.

Transitions Program

- Designed for young adult ages 18 to 24 who have been identified with a developmental disability and who have graduated or have been out of high school for two years

Year in Review

- 25 community visits (10 home visits)
- Supported Clients while attending court
- Supported/Coordinated 94 Clinical Assessments
- Passport Funding Program – 4 applicants approved
- Eight approved specialized accommodation funding
- Seven temporary support funding
- Coordinate and support lunch programs
- Supporting clients to transition to acquiring employment
- Annual workshop for clients and caregivers. 26 clients attended.
- Coordinated social outings for clients

Challenges

- Lack of supports and limited resources in the communities
- Identifying people to work with clients if needed

Moving Forward:

- Continue to work with First Nation communities to provide education, supports and/or services and accessing resource for people living with developmental disabilities
- Continue to lobby for improved/enhanced services and resources for clients
- Continue to promote the program and services to all First Nation communities

First Nations and Inuit Health Information System (FNIHIS)

FNIHIS is an information technology tool which supports health program planning and development, data management and capacity building. It ultimately leads to control over health information and improves the health status of First Nations and Inuit.

Every month, the nursing stations in each community serviced receive an immunization schedule which details all vaccinations due, the clients' names, date of birth and any other relevant information pertaining to his/her vaccinations.

The immunization/Mantoux (TB) records and specific client core are available upon request for nursing stations, clinics, health units, hospitals and multiple children's social service agencies.

Year in Review

Client Core Data	
New Clients	484
Changes to Client Core	782
Deaths	99

Immunization Data	
Immunization Entries	16,274
Mantoux Testing Entries	563
Immunization/Mantoux Records Requested	1,522

Challenges

- In the 2013 fiscal year there were 7,037 Flu Shots given (almost four times the amount in 2012). The increased volume, alongside the regular immunizations, proved to be very difficult to keep up with entering the data.

Moving Forward

- The FNIHIS program will continue to provide accurate Client Core Data and Immunization Data to the First Nation communities.

Tuberculosis Control Program

SLFNHA has delivered the Tuberculosis (TB) Program since 1997. The mandate of the Program is to decrease the incidence of tuberculosis in the 31 First Nation communities SLFNHA serves, through case and contact management, surveillance, education, and awareness. Program funding is through a yearly contribution agreement with First Nations and Inuit Health (FNIH).

The TB program staff provide support and advocacy for clients with tuberculosis and their families while in hospital. Follow-up care at the community level continues to be a main focus during the long treatment regimens. Trips to communities continue to provide client and family support, screen contacts of TB cases, provide support for community caregivers, and provide educational sessions.

Year in review

- Recommendations of the BCG Working Group concerning vaccine administration and enhanced screening for TB are being implemented. Routine BCG vaccination has been discontinued in 28 communities. Administration of BCG, including a vaccine catch-up program, continues in three communities.
- TB screening for all communities continues. TB education is offered to all communities.
- Regular TB information sessions are provided at the Hostel. The Jeremiah Mckay Kabayshewekamik Hostel was again the venue to commemorate World TB Day, March 24. Educational packages with community specific information were sent to all Health Directors and nursing station staff.
- New technologies for learning are being embraced by communities and we support this through the SLFNHA website, which is up-dated regularly.
- The TB Educator has commenced a series of educational sessions via videoconference for community healthcare providers. These Power Point presentations are available on the SLFNHA website.

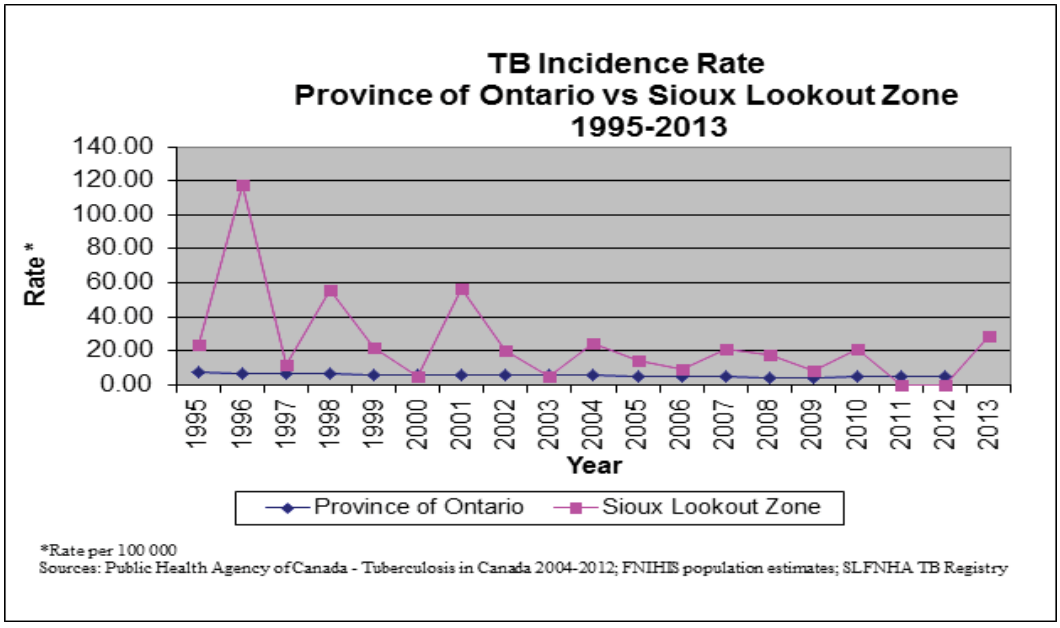
Challenges

- The rate of tuberculosis in Sioux Lookout area communities had been declining steadily since 2001, however, seven new cases of TB have been diagnosed since May 2013.
- Funding from FNIH continues at the same level since 1997.

Moving forward

In alignment with the principles of the Anishinabe Health Plan, the SLFNHA TB Program aims to continue a targeted approach towards the reduction of TB, as well as health protection. Through community driven processes, we aim to:

- Promote initiatives to improve determinants of indigenous health
- Educate individuals and communities about TB risk management
- Support and promote case management and enhanced TB surveillance in all communities
- Preserve knowledge through collection and documentation of Elders' stories of TB experiences, traditional health practices, food preparation and recipes
- Work to implement alternative TB control options to more effectively meet the needs of the communities



Participants at a public health community forum in Nibinamik First Nation in May 2014.

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Darryl Quedent
Director of
Client Services

ᐃᒪ ᑲᐃᓇᑌᐠ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ ᐊᓂᔑᓇᐯᐠ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᐣ (SLFNHA), ᐃᐁᐧ ᐅᑕᑯᓯᐠ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᑲᐱᒧᑐᐊᐧᐨ (CSD) ᑭᐅᓇᒋᑲᑌᐸᐣ 1995 ᑲᐊᐦᑭᐊᐧᐠ ᒋᐅᐣᒋ ᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐠ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑲᐱ ᓇᒋ ᒪᐡᑭᑭᐃᐧᑲᒧᑫᐊᐧᐨ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ. ᐅᐡᑭ ᑲᐯᔑᐃᐧᑲᒥᐠ 38,000 ᑲᑫᒥᓯᐦ ᑎᐸᐦᐃᑲᐣ ᐁᐃᓂᑯᑲᐧᐠ ᐁᓂᔕᐃᐧ ᐊᑮᑕᐊᐧᐠ ᑭᐅᔑᒋᑲᑌᐸᐣ ᐁᑲᐧ ᑕᐡ ᑲᑕᑲᐧᑭᓯᐨ ᐱᓯᑦ 2011 ᑲᑭ ᒪᒋ ᐊᐸᑕᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ. ᐁᑲᐧ 56 ᓂᐯᐃᐧᑲᒥᑯᐣ ᒥᓇ 100 ᓂᐯᐃᐧᓈᐣ, ᐊᒥ ᑲᑭ ᐃᑭᑐᒪᑲᐠ ᐃᔑᓇᒧᐃᐧᐣ ᒋᒥᓄ ᐅᑕᐱᓇᑲᓄᐊᐧᐨ ᐃᒪ ᑫᐱᐣᑎᑫᐊᐧᐨ ᑲᐱ ᓇᒋᒪᐡᑭᑭᐃᐧᑲᒧᑫᐊᐧᐨ.

ᐃᐁᐧ ᒣᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ (ᐦᐊᐧᐡᑐᕑ) ᑭᓇᐱᓂᐦᑲᑌ ᐊᐁᐧ ᒣᓂᒪᔭ ᒪᐠᑫ ᑲᑭ ᐃᓇᑲᓄᐨ, ᐁᑭ ᑭᒋᓀᐣᑕᑯᓯᐨ ᐃᒪ ᑲᓴᐸᓇᑲ ᐃᐡᑯᓂᑲᐣ, ᒥᓇ ᒥᐡᑕᐦᐃ ᐁᑭ ᐊᓄᑲᑕᐠ ᐊᓂᔑᓇᐯᐠ ᐅᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ. ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᐃᑕᐠ ᐊᓂᔑᓇᐯ ᐃᑭᑐᒪᑲᐣ "ᑲᑕᔑ ᐊᓀᐧᔑᓇᓂᐊᐧᐠ."

SLFNHA ᐅᑭ ᐅᓇᑐᓇᐸᐣ ᑫᔑ ᐱᒥᐃᐧᑐᐨ ᐅᐁᐧ ᐅᐡᑭ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᐃᔑ ᐃᓀᐣᑕᑲᐧᐠ ᒋᑭᔑ ᐊᓄᑭᒪᑲᑭᐸᐣ:

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- ᒋᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ ᐅᑲᓇᐁᐧᐣᒋᑫᐠ
- ᒋᐱᒥᐃᐧᓇᑲᓄᐊᐧᐨ ᐅᑕᑯᓰᐣᐠ ᒥᓇ ᒋᐊᔕᒥᐣᑕᐧ ᑲᔦ ᐃᒪ ᑲᑲᐯᔑᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ

ᓄᑯᑦ ᑕᐡ ᑲᑭᔑᑲᐠ, ᐅᑕᑯᓯᐠ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᑲᐱᒧᑐᐊᐧᐨ ᒥᓇ ᐊᓂᑭᓇᑲᓇᐠ ᐃᒪ ᒣᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐅᐱᒥ ᐃᐧᒋᐦᐊᐊᐧᐣ ᐅᑕᑯᓯᐣ ᑲᐱᓇᒋ ᒪᐡᑭᑭᐃᐧᑲᒥᑯᐁᐧᐃᓂᐨ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ. ᐁᐃᐧᒋᑕᐧᐊᐧᐨ ᑲᑭᓇ ᐅᑕᓄᑭᐠ, ᐊᔕ ᑲᑭ ᑭᑫᐣᑕᒧᐊᐧᐨ ᐊᓀᔑᓴᓂᐠ ᑲᑲᑫᐧ ᑌᐱᓈᐣᐠ ᐊᐃᐧᔭ ᑲᐧᔭᐠ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᐣ. ᐃᐁᐧ CSD ᐅᑐᓇᑐᓇᐊᐧ ᒋᒥᓄᓴᓂᐠ ᐊᐃᐧᔭ ᐅᐱᒪᑎᓯᐃᐧᐣ ᑲᐧᔭᐠ ᒋᑲᐯᔑᐦᐊᑲᓄᐨ ᒥᓇ ᐃᐧᒋᐦᐁᐧᐃᐧᓈᐣ ᑲᔦ ᒋᑕᑯᓯᐣᑭᐣ ᐃᒪ ᒣᑲᐧᐨ ᐅᑕᑯᓰᐣ ᑲᐯᔑᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ.

ᑲᐯᔑᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ

ᐃᑫᐧᓂᐊᐧᐠ ᑲᐱᒧᑐᐊᐧᐨ ᑲᐯᔑᐃᐧᐣ ᐃᐧᓇᐊᐧ ᐸᐸᒥᓯᐊᐧᐠ ᒋᓇᓇᑲᒋᑐᐊᐧᐨ ᑭᐡᐱᐣ ᐊᔕ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᓂᐠ ᐅᐣᒋ ᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ (ᑲᓇᑕ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐁᐧᐃᐧᐣ) ᒥᓇ ᑲᔦ ᒋᐅᐣᒋ ᑲᓇᐊᐧᐸᐣᑕᒧᐊᐧᐨ ᑲᐱᐣᑎᑫᓯᓇᐦᐊᐧᑲᓄᐊᐧᐨ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᒥᓇ ᑲᔦ ᒋᐊᓂ ᑭᔑᐱᐦᐊᒧᐊᐧᐨ ᐯᐸᓂᓂ ᑕᐃᐧᓂᐠ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᒋᔑ ᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ ᑭᐡᐱᐣ ᔕᑲᐡᑭᓀᓴᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ. ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᐃᐧᓇᐊᐧ ᐅᐸᐸᒥᓯᑲᑕᓇᐊᐧ ᒋᐃᐧᐣᑕᒪᑫᐊᐧᐨ ᐊᓀᔑᓴᑲᓂᐠ ᑲᐯᔑᐃᐧᑲᒥᑯᓂ ᒥᓇ ᒋᐃᐧᐣᑕᒪᐊᐧᐨ ᐅᑕᑯᓰᐣ ᐊᓀᐣ ᑫᔑ ᐱᒥᓂᔕᐦᐊᒧᐊᐧᐨ ᐅᓇᒋᑫᐃᐧᐣ ᐃᒪ ᑲᔑ ᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ. ᐃᐁᐧ ᒣᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᐯᔑᐦᐊᐊᐧᐠ ᐊᐊᐧᔑᒣ 42,500 ᐊᐃᐧᔭᐠ ᑕᓯᐊᐦᑭ ᑲᐱᓇᒋ ᒪᐡᑭᑭᐃᐧᑲᒧᑫᐊᐧᐨ ᐅᒪ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ.

ᐃᒪ ᑲᒪᓯᓇᐦᐃᑲᑌᐠ ᑕᐸᔑᐡ *ᒪᓯᓇᐦᐃᑲᐣ* 1, ᑫᑲᐟ ᑲᑭᓇ ᐅᑕᑯᓯᐠ ᑲᑲᐯᔑᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐯᔑᑯᑯᐣ ᐁᐦᑕ ᐃᒪ ᐁᐦᐊᔭᐊᐧᐨ. ᐅᑫᐧᓂᐊᐧᐠ ᐅᑕᑯᓯᐠ ᐱᐣᑎᑫᓯᓇᐦᐊᐧᐊᐧᐠ ᓂᔑᐣ ᒥᓇ ᓂᓯᑎᐱᑲ ᐁᑲᐧ ᒥᓇ ᐊᓂ ᐅᓇᒋᑲᑌᓂ ᒋᑭᐁᐧᐊᐧᐨ ᐊᐱ ᑭᑭᔑᑐᐊᐧᐨ ᐅᐊᐧᐸᒥᑯᐃᐧᓂᐊᐧ. ᒥᑕᐡ ᐁᐃᓯᓴᐠ ᓇᐣᑕ ᐱᑯ 94% ᐅᑕᑯᓯᐠ ᐁᑲᐯᔑᐊᐧᐨ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ. ᐅᑕᑯᓯᐠ ᑕᐡ ᓄᒪᑫ ᑲᑭᒋᐃᐧᓇᑲᓄᐊᐧᐨ 90 ᑭᔑᑲ ᒥᓂᑯᐠ ᑕᑭ ᑲᐯᔑᐊᐧᐠ ᐁᑲᐧ ᑕᐡ 5% ᒥᓂᑯᐠ ᑕᔑᐊᐧᐠ ᐅᑕᑯᓯᐠ ᐅᐁᐧ ᑲᐃᓯᓴᐊᐧᐨ. ᑭᓄᐊᐧᑲᐡ ᑲᑲᐯᔑᐊᐧᐨ ᐅᑕᑯᓯᐠ ᐊᐊᐧᔑᒣ 90 ᑭᔑᑲ ᓇᐣᑕᐱᑯ ᐁᐦᑕ 1% ᐊᔭᐊᐧᐠ ᐅᐁᐧ ᑲᐃᓯᓴᐊᐧᐨ ᐅᑕᑯᓰᐣᐠ.

ᒪᓯᓇᐦᐃᑲᐣ *1:* ᑫᑯᓀᐣ ᐃᒪ ᑲᐅᐣᒋᔑ ᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ ᐅᑕᑯᓰᐣᐠ

ᑫᑯᓀᐣ ᐅᐣᒋ	ᑲᔑ ᐃᐧᐣᒋᑫᒪᑲᐠ
ᑕᓯᑭᔑᑲ ᑲᐯᔑᐦᐃᐁᐧᐃᐧᐣ	CSD ᐅᐸᑭᑎᓇᓇᐊᐧ ᐁᑲᐯᔑᐦᐊᐊᐧᐨ ᐅᑕᑯᓯᐣ ᑲᐱᓇᒋ ᒪᐡᑭᑭᐃᐧᑲᒥᑯᐁᐧᐃᓂᐨ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ. ᐅᑕᑯᓯᐠ ᓂᔕᑭᔑᑲ ᒥᓇ ᓂᓯᑭᔑᑲ ᐱᐣᑎᑫᓯᓇᐦᐊᐧᐊᐧᐠ, ᑲᐃᔑᐱᐦᐃᑲᑌᓂᐠ ᐯᐸᓂ ᐅᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ (FNIHB). ᒪᐡᑭᑭᐃᐧᑲᒥᑯᐃᐧ ᓇᒋᒪᐡᑭᑭᐁᐧᐃᐧᐣ ᑲᐃᒋᑲᑌᐠ ᒪᐡᑭᑭᐃᐧᓂ ᑲᐱᐊᐧᐸᒪᑲᓄᐨ, ᓇᓇᑲᒋᐦᐃᐁᐧᐃᐧᐣ ᒥᓇ ᑲᓇᐱ ᓇᓇᑲᒋᐦᐊᑲᓄᐨ ᐊᐃᐧᔭ ᐅᑕᑯᓯᐃᐧᓂᐠ.
ᐊᒋᓇ ᑲᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ	CSD ᐅᐸᑭᑎᓇᓇᐊᐧ ᐊᒋᓇ ᑲᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐠ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ ᑲᐱ ᐊᐧᐸᒪᐊᐧᓯᐊᐧᐨ, ᒪᒥᓄᒧᐁᐧᐃᐧᓂᐠ ᑲᐱᔕᐊᐧᐨ, ᒥᓇ ᒪᐡᑭᑭᐃᐧᓂ ᑲᑭᔕᑎᓇᐨ. ᐅᑕᑯᓯᐠ ᑕᑭ ᐱᐣᑎᑫᓯᓇᐦᐊᐧᑲᓄᐊᐧᐠ ᐊᑯᓇᐠ ᓂᓴᐧᓯ ᑭᔑᑲ ᐁᑲᐧ ᒥᓇ FNIHB ᐅᑕ ᐸᑭᑕᔓᐊᐧᑕᐣ ᒋᑎᐸᐦᐃᑲᑫᐨ ᐊᑯᓇᐠ 90 ᑭᔑᑲ.
ᑭᓄᐊᐧᑲᐡ ᑲᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ	CSD ᐅᐸᑭᑎᓈᐣ ᑭᓄᐊᐧᑲᐡ ᑲᑲᐯᔑᐦᐊᑲᓄᐊᐧᐨ ᑭᐡᐱᐣ ᐅᑕᑯᓯ ᐁᐱᑐᐨ ᒋᒥᓇᑲᓄᐨ ᑲᐯᔑᐃᐧᓂ ᐅᒪ ᑕᐃᐧᓂᐣᐠ ᐁᑲᐧ ᑕᐡ ᑭᐡᐱᐣ ᐁᑲ ᓇᐣᑕ ᑭᐃᔑ ᑲᐯᔑᐨ. ᐅᑫᐧᓂᐊᐧᐠ ᑕᐡ ᑲᐃᓯᓴᐊᐧᐨ FNIHB ᐃᐧᐣ ᐅᑲᐸᑭᑕᔓᐊᐧᑕᐣ ᑭᐡᐱᐣ ᑌᐯᐧ ᐃᒪ ᑫᑭ ᑲᐯᔑᑫᐧᐣ ᒥᓇ ᑲᔦ ᐊᐊᐧᔑᒣ 90 ᑭᔑᑲ ᐱᐦᐅᐨ ᐊᐃᐧᔭ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ ᒣᑲᐧᐨ 2013-2014

- ᓂᑭ ᐊᓂᑲᑕᒥᐣ ᐊᓂᑭᐃᐧᐣ ᑲᐊᐱᒋᐡᑲᒪᑲᐠ ᐁᑲᐧ ᑕᐡ ᑯᑕᐠ ᓂᑭ ᐊᓴᒥᐣ ᐅᑲᐯᔑᐦᐃᐁᐧ ᒋᐃᐧᒋᑕᐧ
- ᐃᒪ ᑲᑕᓇᓄᑭᐊᐧᐨ ᑲᐅᐣᒋ ᐱᐣᑎᑲᓂᐊᐧᐠ ᑭᑭᓄᐦᐊᒪᐊᐧᐊᐧᐠ ᐊᓂᐣ ᑫᔑ ᐱᒥᐃᐧᑐᐊᐧᐨ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ ᐅᐱᒪᑎᓴᐣ ᑲᐊᓂᑲᐊᐧᐊᐧᐨ
- ᐃᒪ ᑲᑕᔑ ᐅᔑᑲᐯᔑᐦᐃᐊᐧᓂᐊᐧᐠ ᐱᐦᑭᐢ ᐃᔑᑕᑲᐧᐣ ᐯᔭᑕᐠ ᒋᐅᔑᑲᐯᔑᐦᐃᐁᐧᐊᐧᐨ
- SLFNHA ᐅᐡᑭ ᐊᐸᒋᑕᑲᓇᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᐅᑭ ᐊᑐᓇᐊᐧ ᐁᑲ ᑕᑕᑲᐨ ᐊᐃᐧᔭ ᒋᓇᐸᐱᑫᓇᐠ ᐅᐱᐊᐧᐱᑯᑦ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᔑᑕᑲᐧᐠ
- SLFNHA ᐅᐡᑭ ᐊᐸᒋᑕᑲᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ, ᐊᔑᐨ ᑲᔦ ᑌᕑᐃᑯ, ᐅᑭ ᐅᐡᑭᑐᓇᐊᐧ 911 ᑲᐃᔑᑭᑐᓇᓂᐊᐧᐠ ᑲᐸᐸᔑᓴᐠ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓃᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014 ᒥᓇ ᐃᔑᓂᑲᐣ

- ᐃᑫᐧᓂᐊᐧᐠ ᑲᐅᐣᒋ ᐱᐣᑎᑲᓂᐊᐧᓂᐠ ᑲᑕᓇᓄᑭᐊᐧᐨ ᐅᑕᐸᒋᑐᓇᐊᐧ ᑕᐃᐧᓂᐣᐠ ᑲᐯᔑᐃᐧᑲᒥᑯᐣ ᑲᔭᑭᐣ ᑲᔕᑲᐡᑭᓄᓴᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒪᐊᐧᐨ ᑕᐡ ᐅᐣᒋ ᐊᓂᒥᐃᐧᑐᐊᐧᐠ ᐅᑕᑯᓯᐢ ᑲᐊᔭᔕᐃᐧᐡᑲᐊᐧᐨ ᑲᐊᐣᑐᐃᐧᓯᓂᐊᐧᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ, ᑲᓇᒋᒪᐡᑭᑭᐃᐧᑲᒥᑯᐁᐧᐊᐧᐨ ᒥᓇ ᑲᐱᐣᑎᑫᓯᓇᐦᐊᐧᑲᐧᓄᐊᐧᐨ/ᑲᓴᑲᐦᐊᐧᒧᐊᐧᐨ ᐃᒪ ᑕᐃᐧᓂᐠ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑲᑭᔑ ᑲᐯᔑᐦᐊᐧᑲᐧᓄᐊᐧᐨ

- ᐁᑲ ᒪᔑ ᑲᒪᓯᓇᐦᐃᑲᓯᐊᐧᐨ ᐅᑭᒪᐃᐧᓂᐣᐠ ᐊᐊᐧᔑᔕᐠ ᒥᐱᑯ ᑭᔭᐸᐨ ᐁᔑ ᐱᒥ ᐊᓂᒥᓴᐠ ᐁᑲᐧ ᑕᐡ ᑲᔦ ᐁᑲ ᐊᐃᐧᔭ ᑲᑭ ᑎᐸᐦᐊᐣᐠ ᐯᔑᑯᑎᐱᑲ ᒋᑭ ᑲᐯᔑᐦᐊᐧᑲᐧᓄᐸᐣ ᑲᐯᔑᐃᐧᑲᒥᐠ

- ᐅᑕᑯᓯᐢ ᑲᐃᐧᐣ ᓇᐣᑕ ᒋᑭᔑ ᑲᐯᔑᐊᐧᐨ ᑲᑭᔑᐱᓴᓂᐠ 90-ᑭᔑᑲ ᑲᑎᐸᐦᐊᐣᐠ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ. ᐃᑫᐧᓂᐊᐧᐠ ᑲᐃᓂᐣᑕᐧ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ ᑲᐃᔑᓂᔕᐦᐊᐧᑲᐧᓄᐊᐧᐨ ᒋᐊᐣᑕᐃᐧᐦᐊᐧᑲᐧᓄᐊᐧᐨ (ᑐᑲᐣ ᑕᔭᐊᓯᐡ, ᑲᐱᐊᐧᐸᒪᐊᐧᓯᐊᐧᐨ ᐃᒪ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐊᐧᐨ IPP ᐱᒧᒋᑫᐃᐧᐣ)

ᐱᒥᐃᐧᒋᑫᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ

ᐱᒥᐃᐧᒋᑫᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᐅᐸᐸᒥᓯᑲᐣᑕᓇᐊᐧ ᒋᐸᑭᑎᓇᒧᐊᐧᐨ ᐅᒪ ᑕᐃᐧᓂᐠ ᐱᒥᐃᐧᒋᑫᐃᐧᐣ ᐃᒪ ᑲᐱᑕᑯᔑᓄᐊᐧᐨ ᒥᓇ ᑲᑭᐁᐧᐊᐧᐨ ᐃᒪ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ ᐳᓂᐃᐧᓂᐠ, ᒋᐃᔑᐃᐧᓇᑲᓄᐊᐧᐨ ᑲᐃᐧ ᐃᔑᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᒥᓇ ᒪᐡᑭᑭᐃᐧ ᐊᑕᐃᐧᑲᒥᐠ. ᐃᑫᐧᓂᐊᐧᐠ ᐱᒥᐃᐧᒋᑫᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᐅᑎᔑᑕᐸᓇᐊᐧᐣ ᑲᔦ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑭᐡᐱᐣ ᐁᑲ ᑲᑕᐊᐧᓂᐠ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ. ᑕᓯᐊᐦᑭ, ᑲᐱᒥᐃᐧᒋᑫᐊᐧᐨ ᐅᐱᒥᐃᐧᓇᐊᐧᐣ ᐊᐊᐧᔑᒣ 100,000 ᐊᐃᐧᔭᐠ ᒥᓇ ᓇᐣᑕ 50,000 ᑕᓯᐣᐊᐧᔦᐠ ᐃᔑᐃᐧᒋᑫᐊᐧᐠ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ ᒣᑲᐧᐨ 2013/2014

- ᐅᐱᒥᐱᓯᐠ ᑭᑭᓄᐦᐊᒪᐊᐧᐊᐧᐠ ᐊᓂᐣ ᑫᔑ ᓇᓂᒋᑲᐣᑕᒧᐊᐧᐨ ᑲᐱᒥᐃᐧᒋᑫᐊᐧᐨ *ᓇᓂᒋᑲᐣᒋᑫᐃᐧᐣ ᑭᒋᓃᐣᑕᑲᐧᐣ* ᑲᑭ ᑭᑭᓄᐦᐊᒪᑫᐊᐧᐨ

- ᓂᐦᓯᐣ ᐱᒥᐃᐧᒋᑫᐃᐧᑕᐸᓇᐠ ᑭᐅᑕᐱᓇᑲᓄᐊᐧᐠ ᐁᑭ ᐅᐡᑭᐦᐊᑲᓄᐊᐧᐨ ᑫᑌᐅᑕᐸᓇᐠ ᐁᑲᐧ ᑕᐡ SLFNHA ᐅᑭ ᐃᐧᑕᓄᑭᒪᐊᐧᐣ *ᑯᑯᐊ ᒪᓯᓂᐱᐦᐃᑫᐃᐧᐣ* ᑫᐊᑯᑲᑌᓂᐨ ᐃᒪ ᐅᐡᑭᑕᐸᓂᐠ

- ᐅᐡᑭ ᐅᐱᒥᐱᓯ ᑕᐊᔭ ᐅᓴᐨ ᐁᐊᔭᓄᒋᓴᐊᐧᐨ ᑲᐱᒥᐃᐧᒋᑫᐊᐧᐨ ᐁᑲᐧ ᑕᐡ ᓃᐊᐧᒋ ᐱᒧᑯᓇᑲ ᐁᐦᑕ ᑕᔑᐱᒥᐃᐧᒋᑫ

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓃᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014

- ᑲᐊᓂᑲᑌᐠ ᑲᒪᒥᑎᓃᐣᑕᒧᐦᐃᑯᐊᐧᐨ ᐅᐱᒥᐱᓯᐠ ᐁᑲ ᐅᓂᑭᐦᐃᑯᒪᐠ ᑲᐊᐸᒋᑐᐊᐧᐨ ᐊᐊᐧᔑᔑᐃᐧ ᑌᓴᐱᐃᐧᓇᐣ ᒣᑲᐧᐨ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑕᐸᓂᐠ ᑲᐱᒥᐃᐧᓂᐣᑕᐧ

- ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᐅᐱᒥ ᐊᓄᑲᓇᐊᐧᐣ ᐅᑕᑯᓯᐣ ᐃᐁᐧ ᐅᐣᒋ ᓂᔑᐣ ᐸᐡᑫᐧᐊᐧᔕᐣ ᒋᐊᔭᐊᐧᐨ ᑲᐱᒥᐃᐧᓇᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐢ

ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᓇᐁᐧᐣᒋᑫᐃᐧᐣ ᑲᐱᒥᐃᐧᑐᐊᐧᐨ

ᑲᐯᔑᐃᐧᑲᒥᐠ ᓇᔑᓃ 24/7 ᐊᔭᐊᐧᐠ ᑲᑲᓇᐁᐧᐣᒋᑫᐊᐧᐨ ᐁᑲᐧ ᐸᐸᒥᓯᐣᑕᒧᐠ ᑲᑭᓇ ᐅᑕᑯᓯᐣᐠ ᒥᓇ ᐊᓂᑭᓇᑲᓇᐠ ᐁᑲ ᓇᐣᑕ ᒋᔑ ᒪᒋᓴᐊᐧᐨ. ᐃᑫᐧᓂᐊᐧᐠ ᑲᑲᓇᐁᐧᐣᒋᑫᐊᐧᐨ ᐅᓇᓇᑲᒋᐦᐊᐊᐧᐣ ᐁᑲ ᐱᐣᑎᑲᒥᐣᐠ ᐊᐃᐧᔭ ᒋᑕᔑ ᓴᑲᓯᐁᐧᐨ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᒥᓇ ᑲᔦ ᐁᑲ ᐊᐃᐧᔭ ᒥᓂᑫᐧᐃᐧᐣ ᒥᓇ ᒪᒋᒪᐡᑭᑭᑫᐃᐧᐣ ᐃᒪ ᒋᐱᐣᑎᑲᑐᐨ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- ᐊᓂᑭᓇᑲᓇᐠ ᐅᑭ ᐅᑕᐱᓇᓇᐊᐧ ᐁᑲ ᓇᐱᐨ ᑲᑭᒋᓯᓴᐠ ᑫᑯᐣ ᑫᔑ ᐊᓂᑲᑕᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᑭᐡᐱᐣ ᐅᑕᑯᓯᐟ ᒥᓂᑫᐃᐧᐣ ᒥᓇ ᒪᒋᒪᐡᑭᑭᑫᐃᐧᐣ ᑲᐊᐸᒋᑐᐨ

- ᒪᓯᓇᑭᓯᑲᓇᐣ ᑭᓇᐣᑲᒋᑲᑌᐊᐧᐣ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᐊᐊᐧᔑᒣ ᑲᐧᔭᐠ ᒋᓇᓇᑲᒋᒋᑲᓂᐊᐧᐠ
- ᑲᐯᔑᐃᑲᐧᒥᑯᐃᐧᑭᒪᐠ ᑭᐃᑭᑐᐊᐧᐠ ᓇᔑᓃ ᒋᓇᓇᑲᒋᐦᐊᑲᓄᐊᐧᐨ ᐃᒪ ᑲᑲᐯᔑᐊᐧᐨ ᐁᑲ ᑫᑯᐣ ᒋᔑ ᒪᒋᓴᐊᐧᐨ ᐅᑕᑯᓯᐢ

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓃᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014

- ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐅᑲᓇᐁᐧᐣᒋᑫᐠ 784 ᑕᓯᐣᐊᐧ ᑭᓇᑕᒪᑫᐊᐧᐠ ᐃᒪ ᐱᐣᑎᑲᒥᐣᐠ ᑲᑕᔑ ᒥᓂᑫᐧᐊᐧᐨ. ᑲᐃᐧᐣ ᓇᐣᑕᐁᐧᐣᑕᑲᐧᓯᓄᐣ ᐃᒪ ᐊᐃᐧᔭ ᒋᑕᔑ ᒥᓂᑫᐧᐃᐧᓂᑫᐨ ᐁᑲᐧ ᑕᐡ ᑭᔭᐸᐨ ᐅᑲ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᓇᐊᐧ ᐊᓂᐣ ᐊᐊᐧᔑᒣ ᑫᑭᔑ ᐊᓄᑲᑕᒧᐊᐧᐸᐣ ᐅᐁᐧ ᑲᐃᓯᓴᐠ.
- ᐁᑲᐧ ᑕᐡ ᐃᑫᐧᓂᐊᐧᐠ ᑲᑲᓇᐁᐧᐣᒋᑫᐊᐧᐨ ᑭᒥᓇᑲᓄᐊᐧᐠ ᑫᑭᑭᐡᑲᒧᐊᐧᐨ ᒋᐊᑲᐧᐱᓯᐊᐧᐨ ᒋᐯᑌᓇᑯᓯᐊᐧᐨ ᒣᑲᐧᐨ ᐃᒪ ᑲᑕᓇᓄᑭᐊᐧᐨ ᐁᑲᐧ ᑕᐡ ᐅᐡᑭᒪᒋᓴᐠ ᔓᓂᔭᐊᐧᐦᑭ ᑕᒪᒋᒋᑲᑌ

- ᒋᐊᒋᑲᑌᑭᐣ ᑫᒪᑯᐁᐧᐃᓇᒧᐊᐧᐨ ᐃᒪ ᑲᑕᓇᓄᑭᐊᐧᐨ ᑭᐡᐱᐣ ᑫᑯᐣ ᐅᐣᒋ ᐃᓯᓴᐠ

- ᐁᑲᐧ ᑕᐡ ᐊᐃᐧᔭ ᑲᒥᓂᑫᐧᐨ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐁᐧᑎ ᐃᔑᓂᔕᐦᐊᐧᑲᐧᓄᐊᐧᐠ ᐁᑲ *ᑲᐅᑲᐯᔑᐃᐧᓂᐊᐧᐨ ᑲᔑ ᐱᐣᑎᑲᓂᐣᑕᐧ* ᐁᑲ ᓇᐣᑕ ᒋᐅᐣᒋ ᑭᒋᒪᒋᓴᐊᐧᐨ ᐃᒪ ᑯᑕᑭᔭᐠ ᑲᑲᐯᔑᐊᐧᐨ ᒥᓇ ᑲᔦ ᐊᓂᑭᓇᑲᓇᐠ. ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᑭᐊᐣᑐᒪᐊᐧᐠ ᒋᐃᐧᒋᑕᐊᐧᐨ ᐃᒪ *ᑲᐊᓄᑲᑌᑭᐣ ᒋᒥᓄᔭᒪᑲᑭᐣ ᑕᔑᑫᐃᐧᓇᐣ, ᒋᒪᒋ ᐱᒥᐃᐧᑐᐊᐧᐨ ᑲᐅᐣᒋ ᒪᐡᑲᐃᐧᑲᐸᐃᐧᒪᑲᐧ ᐊᐱᑕᒪᑫᐃᐧᓇᐣ* ᐅᐁᐧᓂ ᒋᐊᓂᑲᑕᒧᐊᐧᐨ ᑲᒪᒥᑎᓃᐣᑕᒧᐦᐁᐃᐧᒪᑲᑭᐣ.

- ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᐅᐃᐧᑕᓄᑭᒪᐣ ᐊᐧᓂᓇᐊᐧᑲᐧᐠ ᒥᓄᔭᐃᐧᐣ ᐊᑯᓯᐃᐧᑲᒥᐠ (SLMHC) ᐁᐅᓇᑐᐊᐧᐨ ᐊᓂᐣ ᑫᔑ ᐊᓂᑲᓇᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐢ ᑲᐸᑭᑎᓂᑯᐊᐧᐨ ᐅᒪᐡᑭᑭᐃᐧᒧᐊᐧᐣ ᐊᔕ ᑲᑭᐸᑯᓯᐠ ᒪᓯᓇᐦᐃᑫᐃᐧᑲᒥᐠ

ᐅᑕᑯᓱᓐ ᑲᐊᔭᒥᑕᒪᐧᑲᓄᐊᐧᐣ ᒥᓇ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ

ᐊᐁᐧ ᐅᑕᑯᓲᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐅᐱᒥ ᐃᐧᒋᐦᐊᐣ:

- ᒋᐱᒥ ᑭᑭᓄᐦᐊᒪᐊᐧᒋᐣ ᒪᐢᑭᑭᐃᐧ ᐊᓂᑮᓇᑲᓇᐠ ᐊᓂᐣ ᑫᔑ ᑲᓇᐊᐧᐸᒪᐊᐧᐣ ᐊᓂᔑᓇᐯᐣ ᒥᓇ ᐁᐃᐧᒋᐦᐊᐊᐧᐣ ᒪᐢᑭᑭᐃᐧᑲᒥᑯᐃᐧ ᐊᓂᑮᓇᑲᓇᐠ ᑲᐊᔭᑮᓀᐢᑲᐊᐧᐊᐧᐣ ᐅᑕᑯᓱᐣ

- ᒋᐃᐧᑕᓄᑭᒪᐊᐧᐣ ᐅᑕᑯᓱᐣ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑲᑲᐯᔑᓂᐣ ᑲᓇᐣᑕᐁᐧᐣᑕᒨᓂᐣ ᒋᑭ ᐅᐣᒋᑕᒪᐊᐧᑲᓄᐊᐧᐣ ᑲᐯᔑᐃᐧᐣ ᐅᒪ ᑕᐃᐧᓂᐠ ᒥᓇ ᑲᔦ ᑯᑕᑭᔭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᑲᔭᑭᐣ ᑕᐃᐧᓂᐠ

- ᒋᐃᓀᑕᒪᑫᐊᐧᐣ

ᑲᓇᐊᐧᐸᑕᐣ **ᒪᓯᓇᐦᐃᑲᐣ** 2 ᑕᐸᔑᐢ ᒋᐊᐧᐸᐣᑕᒪᐣ ᐊᓀᓯᐧᑭᐣ ᐊᐣᑭᑕᓱᓇᐣ ᐅᑕᓇᐣᐠ 12 ᐱᓯᐨ ᑕᓱᐣ ᐅᑕᑯᓱᐣ ᑲᐅᐣᒋ ᑲᓇᐊᐧᐸᒪᑲᓄᐊᐧᐣ:

ᒪᓯᓇᐦᐃᑲᐣ *2:* ᐅᑕᑯᓱᐠ ᑲᐅᐣᒋ ᐊᔭᒥᑕᒪᐊᐧᑲᓄᐊᐧᐣ ᒥᓇ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᐊᐣᑭᒋᑫᐃᐧᐣ ᑲᐃᓱᐢᐠ

ᐊᓂᑮᐃᐧᐣ ᑲᑭᑐᒋᑲᑌᐠ	ᒪᒪᐤ
ᐅᑕᑯᓯᐣ ᑲᐅᐣᒋ ᐊᔭᒥᑕᒪᐊᐧᑲᓄᐣ ᐱᐣᒋ ᐊᑯᓯᐃᐧᑲᒥᐠ	48
ᑲᐅᐣᒋ ᐃᐧᒋᐦᐊᑲᓄᐣ ᐊᑯᓯᐃᐧᑲᒥᐠ ᑲᐱᒥᔑᓂᐊᐧᐣ ᐅᑕᑯᓲᐠ	65
ᑲᐅᐣᒋ ᐃᐧᒋᐦᐊᑲᓄᐊᐧᐣ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑲᑲᐯᔑᐊᐧᐣ ᐅᑕᑯᓲᐠ	2,335
ᑲᐯᔑᐃᐧᑲᒥᐠ ᐅᑕᑯᓲᐠ ᑲᔑ ᐊᓇᐊᐧᐸᐣᑕᒧᐊᐧᐣ ᑫᑯᓇᐣ	16
NIHB ᐁᑲ ᑲᑭ ᑎᐸᐦᐅᑯᐊᐧᐣ	22
ᒪᐢᑭᑭᐃᐧ ᐊᓂᑮᓇᑲᓇᐠ ᑲᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄᐊᐧᐣ	38
ᑲᐅᐣᒋ ᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐣ ᐊᓂᔑᓇᐯ ᑕᔑᑫᐃᐧᓇᐣ	133

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- ᐊᐁᐧ ᐅᑕᑯᓲᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐅᐱᒥ ᐃᐧᒋᐦᐊᐣ ᐅᑕᑯᓲᐣ ᒋᔕᑲᐢᑭᓀᐱᐦᐊᒧᐊᐧᐣ ᐊᐧᑲᐦᐃᑲᐣ ᑲᓇᐣᑕᐁᐧᐣᑕᒧᐊᐧᐣ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᓀᐱᒋ ᑭᔕᑎᓂᑯᐊᐧᐣ ᒪᐢᑭᑭᐃᐧᓂᐊᐧᐣ

- ᐊᐁᐧ ᐅᑕᑯᓱᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐅᑕᓂ ᓇᓇᑲᒋᐦᐊᐣ ᐅᑕᑯᓱᐣ ᐊᓀᐱᒋᐃᐧᑐᓂᑫᐧᐣ ᐅᑕᑯᓱᐣ ᐊᐱ ᑲᑭ ᓴᑭᒋᐁᐧᐱᓇᑲᓄᐊᐧᐣ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒣᑲᐧᐣ ᒥᓂᑫᐧᐃᐧᐣ ᑲᑭ ᐊᐸᒋᑐᐊᐧᐣ ᐁᑲᐧ ᒥᓇ ᓇᐣᑕᐁᐧᐣᑕᑯᓯᐊᐧᐠ ᐃᑫᐧᓂᐊᐧᐠ ᒋᒪᓯᓇᐦᐅᑎᓱᐊᐧᐣ ᓇᑯᒥᑎᐃᐧ ᐯᐸᐣ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧ ᐅᓇᑯᓂᑫᐃᐧᐣ ᑲᐃᓇᑌᐠ

- ᐊᐁᐧ ᐅᑕᑯᓱᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐅᐃᐧᑕᓄᑭᒪᐣ ᑲᐅᐢᑲᒋ ᒪᑕᓄᑭᐊᐧᐣ SLMHC ᐊᓂᑮᓇᑲᓇᐠ ᒋᐊᐧᐃᐧᐣᑕᒪᐊᐧᑲᓄᐊᐧᐣ ᐊᓂᐣ ᑫᔑ ᑲᓇᐊᐧᐸᒪᐊᐧᐣ ᐊᓂᔑᓇᐯᐣ ᐃᒪ ᑲᐱ ᓇᒋᒪᐢᑭᑭᐃᐧᑲᒥᑫᐧᓂᐣ

- ᐊᐁᐧ ᐅᑕᑯᓱᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᑭᐅᑕᐱᓇᑲᓄ ᐃᒪ ᒋᔑ ᐊᐱᑕᒪᑫᐣ ᓂᑕᐃᐧᐣ ᐊᐧᑲᐦᐃᑲᓂᐃᐧ ᐊᐱᑕᒪᑫᐃᐧᓂᐠ ᒋᐅᑎᑲᐧᓂᐢᑲᐠ

ᑲᓇᑮᐢᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓀᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐣ 2013-2014

- ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᒥᓇ ᐊᐁᐧ ᐅᑕᑯᓱᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐊᐱᒥ ᐊᓂᑲᑕᓇᐊᐧ ᒋᐱᒥᓂᔕᐦᐃᑲᑌᓂᐠ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᐅᓇᑯᓂᑫᐃᐧᓀᔅᐣ ᑲᐃᓇᑌᐠ ᐃᒪ ᐊᐧᐊᐧᑌ ᐊᐣᑐᑕᒧᐃᐧᓂᐠ ᐁᐅᐣᒋ ᑲᑭᑐᐊᐧᐣ ᐁᑲᐧ ᒥᓇ ᐁᐅᔑᑐᐊᐧᐣ ᒪᓯᓇᐦᐃᑲᓀᐢ ᒋᐊᓂᒧᒋᑫᒪᑲᐠ ᑫᔑ ᑲᓇᐊᐧᐸᑕᐠ ᐊᐃᐧᔭ ᐃᒪ ᑲᑲᐯᔑᐣ ᒥᓇ ᑫᐱᒥᓂᔕᐦᐊᑭᐣ ᐅᓇᑯᓂᑫᐃᐧᓀᔅᐣ ᐃᒪ ᑲᐯᔑᐣ

- ᐃᑫᐧᓂᐊᐧᐠ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᒥᓇ ᐊᐁᐧ ᐅᑕᑯᓱᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐅᑭ ᒥᓇᐊᐧᐣ *ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᐅᐣᑌᐢᐃᐧᔦ ᐅᑭᒪᑲᓇᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑯᓯᐣ ᐅᑕᑯᓱᐠ ᑫᔑ ᐊᓂᑲᓇᑲᓄᐊᐧᐣ ᐊᐱᑕᒪᑫᐃᐧᐣ ᒥᓇ ᐊᓂᔑᓇᐯ ᐊᐢᑭ ᒪᐢᑭᑭᐃᐧ ᒪᓯᓇᐦᐃᑫᐃᐧᑲᒥᐠ ᑲᒪᒥᑎᓀᐣᑕᒧᐦᐃᑯᐊᐧᐣ*

- ᐊᐁᐧ ᐅᑕᑯᓱᐣ ᑲᐅᐣᒋ ᐊᐧᐃᐧᒋᐦᐊᐣ ᐯᔓᐣ ᐅᐃᐧᑕᓄᑭᒪᐣ ᐊᓂᔑᓇᐯ ᐃᐢᑯᓂᑲᓇᐣ ᑲᐊᓂᒥᐦᐃᑯᐊᐧᐣ ᐃᒪ ᒣᑲᐧᐣ ᑲᑲᐯᔑᐊᐧᐣ ᐅᑕᑯᓱᐠ

ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᒪᐊᐧᐣᑐᓯᓇᐦᐃᑲᑌᑭᐣ ᒪᓯᓇᐦᐅᑯᐃᐧᓇᐣ

ᐊᐁᐧ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧ ᐊᓂᑮᓇᑲᐣ ᑲᒪᐊᐧᐣᑐᓯᓇᐦᐃᑫᐣ ᐃᐣ ᐅᐸᐸᒥᓯᑲᑕᓇᐣ ᒋᐊᓂ ᒪᐊᐧᐣᑐᓯᓇᐦᐊᑭᐣ ᒪᓯᓇᐦᐅᑯᐃᐧᓇᐣ ᑫᓇᓇᑲᒋᑐᐊᐧᐣ ᓀᓂᔭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐣ ᑲᑮᓇ ᐅᑕᑯᓯᐠ ᐃᒪ ᑲᑲᐯᔑᐊᐧᐣ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑕᓱᑎᐱᐠ. ᐊᐁᐧ ᐊᓂᑮᓇᑲᓇᐣ ᐸᐸᒥᓯ ᑫᒋᓇᐣ ᑲᐧᔭᐠ ᒋᑲᓇᐁᐧᐣᑕᑲᐧᓂᐠ ᐅᑕᑯᓯ ᐅᒪᓯᓇᐦᐅᑯᐃᐧᓇᐣ ᐃᒪ FNIHB ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᔑ ᒪᓯᓇᐦᐃᑲᑌᑭᐣ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- ᐃᑫᐧᓂᐊᐧᐠ SLFNHA ᐅᐢᑭ ᐊᐸᒋᑕᑲᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐣ ᐅᑭ ᐃᐧᑕᓄᑭᒪᐊᐧᐣ ᐃᑫᐧᓂᐊᐧᐣ ᑲᐊᓂ ᒪᐊᐧᐣᑐᐱᐦᐃᑫᐣ ᐁᑭ ᐊᐣᑕᑐᐊᐧᐣ ᑲᐃᔑᐱᐦᐃᑲᑌᓂᐠ ᐁᐣᑕᓯᑭᔑᑲ ᑲᑲᐧᔭᐣᒋᒋᑲᑌᐠ ᑫᐸᑭᑎᓂᑲᑌᐠ ᐃᒪ FNIHB ᒋᑎᐸᐦᐊᑭᐣ

- ᑲᓂᐹ ᒪᒪᐊᐧᑭᐣᒋᑲᓂᐊᐧᐠ ᒥᓇ ᒪᐊᐧᐣᑐᐱᐦᐃᑫᐃᐧᐣ ᑲᑐᒋᑲᑌᐠ ᑭᐊᐣᒋᒋᑲᑌᐸᐣ ᐃᐁᐧ ᑕᐢ ᑲᑭ ᐅᐣᒋ ᑐᒋᑲᑌᐠ ᐊᐁᐧ ᑲᐅᔑ ᑲᐯᔑᐦᐃᐁᐧᐣ ᒋᑲᐧᔭᐣᑕᓂᐠ ᐅᑕᓇᐣᐢ ᐁᑭᔑᑲᐠ ᑲᑭ ᐃᔑᐱᐦᑲᓂᐊᐧᐠ ᐁᐧᑎ ᑕᐢ ᑲᐃᐧᔑ ᑎᐸᐦᐃᑲᑌᑭᐣ ᑲᐯᔑᐃᐧᐣ ᒋᐃᔑᓂᔕᐦᐊᒧᐊᐧᐣ

- SLFNHA ᐅᐱᒥ ᐃᐧᑕᓄᑭᒪᐣ *5 ᐢᑕᕀ ᐱᐣᑎᑫᓯᓇᐦᐅᐁᐧᐃᐧᐣ* ᒋᒪᒪᐃᐧᐱᐦᐃᑲᑌᐠ ᒥᓇ ᒋᑲᓇᐁᐧᐣᑕᑲᐧᑭᐣ ᐃᐣᑕᒪᑫᐃᐧᓇᐣ ᑕᓯᑭᔑᑲ ᑲᐱᐣᑎᑫᓯᓇᐦᐊᐧᑲᓄᐊᐧᐣ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ

- SLFNHA ᐅᑕᔭᐣ ᑫᔑ ᐃᐧᑕᓄᑭᒪᐣ FNIHB ᒋᑌᐱᓂᑲᑌᑭᐣ ᐅᐣᑌᐢᐃᐧᔦ ᒪᐢᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᒪᐊᐧᐣᑐᐱᐦᐃᑲᑌᐠ ᑲᓇᔑ ᑲᓇᐁᐧᐣᑕᑲᐧᐠ ᒋᐅᐣᒋ ᐁᐧᐣᒋᓴᓂᐠ ᒋᑎᐸᐦᐃᑲᑌᑭᐣ ᐅᑕᑯᓯᐠ ᐊᔕ ᑲᔕᐳᓴᓂᐠ ᐅᑲᐯᔑᐃᐧᓂᐊᐧ

ᑲᓇᑮᐢᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓀᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐣ 2013-2014

- ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᐅᐃᐧᑕᓄᑭᒪᐊᐧᐣ ᓀᓂᔭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐣ ᒋᒥᓄᓴᓂᐠ ᑫᔑ ᑕᑎᐸᐦᐃᑲᓂᐊᐧᐠ ᒥᓇ ᐃᐧᐸᐣ ᒋᑭ ᐅᑎᓯᑯᐁᐧᒪᑲᑭᐸᐣ ᑎᐸᐦᐃᑫᐃᐧᓇᐣ

ᐅᑕᑯᓯᐠ ᑲᐅᐣᑕᒥᐦᐊᑲᓄᐊᐧᐨ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ

ᐊᐁᐧ ᐅᑕᑯᓯᐣ ᑲᐅᐣᒋᑕᒥᐦᐊᐨ ᐊᓂᑭᓇᑲᐣ ᐅᑐᓇᑐᐣ ᒥᓇ ᐅᐱᒥᐸᓂᑕᐧᐣ ᑫᔑ ᐊᐧᐅᐣᑕᒥᐦᐊᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐠ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᒣᑲᐧᐨ ᑲᑲᐯᔑᐊᐧᐨ. ᐅᐁᐧ ᑕᐡ ᐃᔑᒋᑫᐃᐧᓂᑫ; ᒪᓯᓂᐱᐦᐃᑫᐃᐧᓂᑫ ᒥᓇ ᑲᐡᑲᐧᓯᐃᐧᓂᑫ, ᐊᐧᐸᐣᒋᑲᓇᐣ ᐊᔭᑭᓀᒥᑭᐁᐧ, ᐊᔭᑭᓀ ᒥᑭᐁᐧ ᒪᓯᓇᐦᐃᑲᓂ ᐯᐸᑲᐣ ᑫᐅᐣᑕᒥᑲᒧᐊᐧᐨ, ᐱᐣᑯᑫᐃᐧᓂᑫ ᒥᓇ ᒪᓯᓇᑌᓯᒋᑫᐃᐧᓂᑫ. ᐊᐁᐧ ᑕᐡ ᐊᓂᑭᓇᑲᐣ ᑲᔦ ᐅᐃᐧᑕᓄᑭᒪᐣ ᑕᐃᐧᓂᐠ ᑲᐸᑭᑎᓇᒧᐊᐧᐨ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒋᒥᔑᓇᑎᓂᐠ ᑫᐅᐣᒋᐦᐃᑯᐊᐧᐨ ᐅᑕᑯᓯᐠ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ. ᑲᔦ ᑕᐡ, ᐊᐁᐧ ᐊᓂᑭᓇᑲᐣ ᐊᒥᐦᐃ ᑲᔦ ᐁᐃᓇᓄᑭᐨ ᐃᐅᐣᒋ ᐃᐧᒋᐦᐊᐨ ᐅᑕᑯᓯᐣ ᑭᐡᐱᐣ ᑲᓇᐣᑕᐁᐧᐣᑕᒧᓂᐨ ᐃᐧᒋᐦᐃᑯᐃᐧᐣ ᒥᓇ ᒋᐃᓀᐧᑕᒪᑫᐨ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- ᒪᑯᔐᑭᔑᑲᐃᐧ ᒥᓂᐁᐧᐃᐧᓇᐣ ᑭᒥᓇᐊᐧᐠ ᐅᑕᑯᓯᐠ ᐁᑲ ᑲᑭᐃᓯᓴᓂᐠ ᒋᑭᑭᐁᐧᐊᐧᐨ ᒣᑲᐧᐨ ᑲᒪᑯᔐᑭᔑᑲᓂᐠ
- ᐅᐡᑭ ᐊᐦᑭᐃᐧ ᐅᐡᑭ ᐊᐊᐧᔑᐡ ᑭᒥᓇᑲᓄ ᒥᑭᐁᐧᐃᐧᐣ
- ᑕᓯᐱᓯᑦ ᐱᐣᑯᑫᐃᐧᐣ ᒥᓇ ᑭᔑᑌᐳᐃᐧ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᑭᐸᑭᑎᓂᑲᑌ ᐊᐃᐧᔭ ᑲᐃᐧ ᑐᑕᐣᐠ
- ᐊᐁᐧ ᐅᑕᑯᓯᐣ ᑲᐊᐧᐅᐣᑕᒥᐦᐊᐨ ᐅᑭ ᐃᐧᑕᓄᑭᒪᐣ ᑲᒧᑕᓄᑭᐊᐧᐨ ᐁᑭ ᒪᐊᐧᐣᑐᓇᒧᐊᐧᐨ ᔑᑯᐡᑭᑲᓇᐣ ᒥᓇ ᑕᔑᑭᑲᓇᐣ/ ᒪᓯᓇᐦᐃᑲᓇᐣ ᒋᒥᓇᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐠ ᐃᒪ ᑲᑲᐯᔑᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ
- ᑭᐃᐧᒋᑕᐧ ᐁᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᐅᐡᑭ ᑫᑯᐣ ᐃᒪ SLMHC, ᑫᐃᐧᒋᐦᐃᑯᐊᐧᐨ ᐊᐊᐧᔑᔕᐠ ᒥᓇ ᐅᐡᑲᑎᓴᐠ ᑲᑲᐯᔑᐊᐧᐨ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓀᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014

- ᐊᐁᐧ ᐅᑕᑯᓯᐣ ᑲᐊᐧᐅᐣᑕᒥᐦᐊᐨ ᐅᑭ ᐃᐧᑕᓄᑭᒪᐣ ᑯᑕᑭᔭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᑲᐸᑭᑎᓇᒧᐊᐧᐨ ᐁᑭ ᐸᑭᑎᓇᒧᐊᐧᐨ ᑕᓯᑭᔑᑲ ᑫᔑ ᐅᐣᑕᒥᐦᐊᑲᓄᐊᐧᐨ ᒥᓇ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᓇᐣ ᑫᑭ ᐅᑕᐱᓇᒧᐊᐧᐸᐣ ᐅᑕᑯᓯᐠ ᒣᑲᐧᐨ ᑲᑲᐯᔑᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ, ᔕᑯᐨ ᑕᐡ ᑲᐃᐧᐣ ᐊᐃᐧᔭ ᒋᐅᑕᐱᓇᐣᐠ ᐅᐁᐧᓂ ᐃᔑᒋᑫᐃᐧᐣ ᐃᒪ ᑲᑲᐯᔑᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ. ᐊᐁᐧ ᐊᓂᑭᓂᓇᑲᐣ ᐊᒥᐱᑯ ᑫᔑ ᓇᓇᐣᑎᓇᐣᐠ ᐊᓂᐣ ᑫᑭ ᑐᑕᑭᐸᐣ ᒋᑭ ᐸᐱᐡᑫᐣᑕᒪᑫᐊᐧᐨ ᐃᒪ ᐅᑕᑯᓯᐠ ᑲᑲᐯᔑᐊᐧᐨ. ᒥᑕᐡ ᐃᔑ ᒥᓴᐁᐧᐣᑕᑲᐧᐠ ᐁᑲ ᒋᑭ ᑲᑭᓇᐁᐧ ᐃᔑᒋᑫᐊᐧᐸᐣ ᐅᑕᑯᓯᐠ ᒣᑲᐧᐨ ᐃᒪ ᑲᑲᐯᔑᐊᐧᐨ.

ᐊᔕᐣᑫᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ

ᐊᔕᐣᑫᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᐅᐸᑭᑎᓇᓇᐊᐧ ᓂᓴᐧ ᐯᔑᑯᑭᔑᑲ ᒋᐊᔕᒪᑲᓄᐨ ᐯᔑᐠ ᐅᑕᑯᓯ. ᑭᔑᑌᐳᐃᐧᑲᒥᑯᐡ ᐊᔭ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑫᐊᐸᒋᑐᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᑲᐯᔑᐊᐧᐨ ᒋᐅᔑᑐᐊᐧᐨ ᑲᐧᐱ ᒥᓇ ᑎ ᒥᓇ ᑲᔦ ᔕᑲᒧᓇᐣ. ᐃᐁᐧ ᒣᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐊᔕᐣᑫᐊᐧᐠ 132,600 ᑕᓴᐧ ᑲᐊᔕᒪᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐠ ᑕᓯᐊᐦᑭ. ᐅᐁᐧ ᑲᐃᓇᐣᑭᒋᑲᓂᐊᐧᐠ ᒪᒪᐤ ᐁᐊᔕᒪᑲᓄᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᐊᔭᐊᐧᐨ ᒥᓇ ᑲᔦ ᑕᐃᐧᓂᐠ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑲᔑ ᐱᓇᐦᐊᐧᑲᓄᐊᐧᐨ, ᐊᔑᐨ ᑲᔦ ᑲᓂᒪᐦᐊᑲᓄᐊᐧᐨ ᑲᐊᓂ ᑲᑭᐁᐧᐊᐧᐨ ᐅᑕᑯᓯᐠ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᒥᓇ ᐊ≽ᐊᒪ≽ᐠ ᑲᓇᑕ ᑕᓯᐱᒧᑯᓇᑲ ᐅᑕᓂ ᐊᓂᑲᑕᓇᐊᐧ ᑲᐊᔕᐣᑲᓂᐊᐧᐠ ᒥᒋᒪᐣ ᒥᓇ ᐁᐦᐊᓂ ᐊᔭᐣᒋᑐᐊᐧᐨ ᑲᐊᔕᐣᑫᐊᐧᐨ ᐁᑲᓇᐊᐧᐸᐣᑕᒧᐊᐧᐨ ᐃᑭᑐᐃᐧᓇᐣ ᑲᐸᑭᑎᓇᒧᐊᐧᐨ ᒥᒋᒥ ᑫᑯᐣ ᐅᐣᒋ
- ᑭᔐᐸᒥᒋᑦ ᐸᑭᑎᓂᑲᑌ ᑲᔦ ᐸᑭᑎᓂᑲᑌ ᐃᑫᐧᓂᐊᐧᐠ ᐅᑕᑯᓯᐠ ᐳᓂᐃᐧᓂᐠ ᑲᐃᔕᐊᐧᐨ ᐁᒪᐧᔦ 7 ᐁᑭᔐᐸᔭᐠ
- SLMHC’s ᑲᐊᔓᐣᑫᐊᐧᐨ ᐊᓂᔑᓇᐯᐃᐧᒥᒋᑦ ᐊᔕᒪᐊᐧᐠ ᐅᑕᑯᓯᐠ ᐯᔑᑯᑭᔑᑲ ᑲᐱᒧᑯᓇᑲᐠ ᑐᑲᐣ ᑭᓄᔐ, ᒧᐡ ᒥᓇ ᔑᔑᑊ
- ᐊᐁᐧ ᑲᓇᓇᑲᒋᑐᐨ ᒥᒋᒪᐣ ᓂᔕᐧ ᐯᔑᑯᐊᐦᑭ ᐅᓇᓇᑲᒋᑐᓇᐣ ᒥᓇ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᐊᔕᒥᑎᓇᓂᐊᐧᐠ ᒥᓄᓴ ᑲᐧᔭᐠ ᐁᐃᔑᓇᑲᐧᐠ ᒥᒋᑦ

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓀᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014

- SLFNHA ᒥᓇ SLMHC ᐃᐧᑕᓄᑭᒥᑎᐊᐧᐠ ᐁᓇᓇᐣᑎᓇᐊᐧᐨ ᐊᐊᐧᓀᓇᐣ ᑫᐸᑭᑎᓇᒧᑫᐧᐣ ᑭᔑᑌᐳᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᐊᐱ ᐅᐡᑭᓴᐠ ᔓᓂᔭᐊᐧᐦᑭ ᐁᑲᐧ ᒥᓇ ᒋᐊᐣᑕᒋᑲᑌᐠ ᒋᑭᔑᑌᐠ ᒥᒋᑦ ᑲᐃᔑᐃᐧᒋᑲᑌᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ
- SLFNHA ᒥᓇ SLMHC ᐅᑭ ᐊᓂᒧᑕᓇᐊᐧ ᒋᑭ ᓇᐣᑭᓇᒧᐊᐧᐸᐣ ᐊᓂᔑᓇᐯᐃᐧᒥᒋᑦ ᓇᐣᑕ ᓂᔕᐧ ᒥᓇ ᓂᓴᐧ ᐯᔑᑯᐱᒧᑯᓇᑲ ᒋᐊᔕᑲᓂᐊᐧᐠ. SLMHC ᐊᓂᒥᐃᐧᑐᐊᐧᐠ ᒋᑭ ᐅᐣᑎᓇᒧᐊᐧᐨ ᑲᒥᓇᐧᔑᐠ ᐊᓂᔑᓇᐯᐃᐧ ᒥᒋᑦ ᐊᐃᐧᔭ ᒋᐸᑭᑎᓂᑫᐨ.
- ᑲᑭᔑᑌᐳᐊᐧᐨ ᑭᑭᐧᐁ ᒥᓇᑲᓄᐊᐧᐠ ᒪᓯᓇᐦᐃᑲᓀᓯᓂ ᐊᓂᐣ ᑫᔑ ᐸᒥᓇᒧᐊᐧᐨ ᒥᒋᒪᐣ ᐁᑲᐧ ᒥᓇ ᐅᐡᑭ ᐅᑭᔑᑌᐳᐠ ᑲᔦ ᑕᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄᐊᐧᐠ ᑫᐃᐧᓇᐊᐧ
- SLFNHA ᐅᑎᓀᐣᑕᓇᐊᐧ ᐃᐁᐧ ᑲᑭᔑᑌᐠ ᒥᒋᑦ ᑫᐃᔑᐃᐧᑌᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒋᒪᒋᓴᐠ ᐅᐸᑫᐧᐃᐱᓯᑦ 2014.

ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᑲᐯᔑᐊᐧᐨ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ

ᐃᐁᐧ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᑲᐯᔑᐊᐧᐨ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᑕᑲᐧᐣ ᐃᒪ ᑲᔭᐊᐧᐨ ᐅᑕᑯᓯᐠ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᓇᐣᑕᐁᐧᐣᑕᒧᐊᐧᐨ ᒋᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ ᒥᓇ ᐃᐧᐣᑕᒪᑫᐃᐧᐣ ᑲᓇᐣᑕᐁᐧᐣᑕᒧᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒥᓇ ᐊᑯᓯᐃᐧᑲᒥᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᐅᐣᒋ. ᐊᐁᐧ ᑕᐡ ᑲᐃᓇᓄᑭᐨ ᐃᒪ ᑲᔦ ᑕᓇᓄᑭ ᑲᐅᐣᒋ ᐱᐣᑎᑲᓂᐊᐧᐠ ᑲᔑ ᐊᐱᐨ, ᐁᐊᐧᒋᔦᒪᐨ ᑲᐱᑭᐅᑌᐊᐧᐨ ᒥᓇ ᐁᐅᐣᒋ ᐃᓀᐧᑕᒪᑫᐨ ᑲᔦ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- ᐊᐁᐧ ᐊᓂᑭᓇᑲᐣ ᐊᐊᐧᔑᒣ ᐅᑕᓄᑲᓇᐣ ᐅᑕᑯᓯᐣ ᒥᓇ ᐁᐸᑭᑎᓇᑭᐣ ᑫᔓᑲᐡᑭᓀᐱᐦᐊᒧᐊᐧᐨ ᐯᐸᓂ ᑲᐱᒥ ᐊᐦᑭᐊᐧᓂᐠ. ᐁᑲᐧ ᑕᐡ ᐃᑫᐧᓂᐊᐧᐣ ᑲᐱᑭᐁᐧᒪᑲᑭᐣ ᔓᑲᐡᑭᓀᐱᐦᐃᑲᓇᐣ ᒪᐊᐧᐨ ᒥᓄᑕᑲᐧᓄᐣ.
- ᐁᑲᐧ ᐃᑫᐧᓂᐊᐧᐣ ᒪᐊᐧᐨ ᑲᐊᓂᒧᑕᒧᐊᐧᐨ ᐅᑕᑯᓯᐠ ᑲᐃᔑᓇᑲᐧᓂᐠ ᐅᑕᔓᒥᑯᐃᐧᓂᐊᐧ ᒥᓇ ᑲᔦ ᑲᐃᔑ ᑲᓇᐊᐧᐸᒪᐊᐧᐨ ᐅᑕᑯᓯᐣ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᑕᓇᓄᑭᐊᐧᐨ.

- ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᐅᑕᓄᑲᑕᓇᐊᐧ ᒥᔑᐣ ᐃᑫᐧᓂᐊᐧᐣ ᐅᑎᑭᑐᐃᐧᓂᐊᐧ ᐅᑕᑯᓯᐠ, ᔓᑯᐨ ᑕᐡ ᐃᑫᐧᓂᐊᐧᐣ ᐃᑭᑐᐃᐧᓇᐣ ᐃᒪ ᐃᔑ ᑕᑯᓴᐊᐧᐣ ᒥᓂᑯᐠ ᑲᐸᑭᑎᓇᑲᓄᐨ ᔕᓂᔭ ᒥᓇ ᐁᑲ ᑲᑌᐱᓴᐊᐧᐨ ᐊᓂᑭᓇᑲᓇᐠ ᒥᐅᑫᐧᓂᐊᐧᐣ ᑫᐊᓂᑲᑕᑭᐣ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪ.

- ᑲᓇᐊᐧᐸᑕᐣ **ᒪᓯᓇᐦᐃᑲᐣ 3** ᑕᐸᔑᐡ ᑲᑭ ᐃᔑᐱᐦᐃᑲᑌᑭᐣ ᐅᑕᑯᓯᐠ ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᑲᐧᓂᐠ ᐊᓂᐣ ᐁᐃᓯᓴᐊᐧᑫᐣᑕᒧᐊᐧᑫᐧᐣ

ᒪᓯᓇᐦᐃᑲᐣ 3: ᑲᔑ ᓇᐦᐃᓴᐊᐧᑫᐣᑕᒧᐊᐧᐨ ᐅᑕᑯᓯᐠ ᒥᓇ ᐳᓴᐣᐟ ᑲᐃᓯᓴᐠ

ᑲᔑ ᐸᐱᑭᔓᑭᑌᐠ	ᒥᓂᑯᐠ ᑲᔑ ᓇᐦᐃᓴᐊᐧᑫᐣᑕᒧᐊᐧᐨ (%)
ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧ ᑲᐯᔑᐦᐃᐁᐧᐃᐧᐣ	96
ᒥᒋᒥ ᐱᒧᒋᑫᐃᐧᐣ	82
ᑲᐯᔭᑕᑫᐣᑕᑲᐧᐠ ᒥᓇ ᑲᓇᐁᐧᐣᒋᑫᐃᐧᐣ	95
ᑲᐃᔑ ᑲᓇᐊᐧᐸᐣᒋᑲᑌᐠ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ	98
ᐊᓂᑭᓇᑲᓇᐠ	91
ᒥᓯᐁᐧ ᑲᐃᓂᑯᑲᐧᑭᐣ ᐃᐧᒋᐦᐁᐧᐃᐧᓇᐣ	92

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓅᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014 ᒥᓇ ᐃᔑᓂᑲᐣ

- ᐊᐁᐧ ᐊᓂᑭᓇᑲᐣ ᑲᐊᐧᒋᔦᒪᐨ ᐅᑭᐅᑌᐣ ᐅᐱᒥ ᐃᐧᑕᓄᑭᒪᐣ ᑭᒋᔭᐦᐊᐣ ᒥᓇ ᑲᒪᑲᑎᓯᓂᐨ ᐅᑕᑯᓯᐣ ᐁᑲ ᑲᑭ ᐃᐧᒋᐦᐃᑎᓱᐊᐧᐨ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒥᓇ ᑲᔦ ᐊᑯᓯᐃᐧᑲᒥᑯᐠ.

- ᐊᐁᐧ ᐊᓂᑭᓇᑲᐣ ᑲᐊᐧᒋᔦᒪᐨ ᐅᑭᐅᑌᐣ ᐅᐱᒥ ᐃᐧᑕᓄᑭᒪᐣ ᐅᑕᑯᓯᐣ ᒋᐊᐸᒋᑐᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ ᑲᑕᑲᐧᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ.

- ᐊᐁᐧ ᐊᓂᑭᓇᑲᐣ ᐅᑲ ᓇᓇᐣᑎᓇᐣ ᐊᓂᐣ ᑫᑭᑐᒋᑲᑌᑭᐸᐣ ᒋᑭ ᒥᓄᓴᑭᐸᐣ ᑲᔑ ᐃᐧᑕᓄᑭᒥᑎᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧ ᐊᓂᑭᓇᑲᓇᐠ ᒥᓇ ᐅᑕᑯᓯᐠ. ᐅᐁᐧ ᑲᔦ ᓇᐊᐧᐨ ᓇᔑᓅ ᒋᑕᑲᐧᐠ ᐅᑕᑯᓯᐠ ᒋᔓᑲᐡᑭᓅᐱᐦᐊᒧᐊᐧᐨ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ, ᓴᑯᓇᐠ ᒋᐊᔭᒥᐦᐊᑲᓄᐊᐧᐨ ᐅᑕᑯᓯᐠ ᐃᐁᐧ ᐅᐣᒋ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑲᐸᑭᑎᓂᑲᑌᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ, ᒥᓇ ᑲᔦ ᒋᑭ ᐊᔭᑭᓅᓂᑲᑌᑲᐧᐸᐣ ᒪᓯᓇᐦᐃᑲᓅᓴᐣ ᒋᑎᐸᒋᒧᒪᑲᑭᐣ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒥᓇ ᑲᔦ ᐊᐣᑐᑕᒧᐃᐧᑲᒥᐠ ᒋᐊᐸᑕᐠ.

ᑭᓯᓂᑫᐃᐧᐣ/ᑭᓯᐱᑭᓂᑫᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ

ᐅᑭᓯᓂᑫᐠ ᐃᐧᓇᐊᐧ ᐸᐸᒥᓯᐊᐧᐠ ᒋᐸᒥᑐᐊᐧᐨ ᓂᐯᐃᐧᑲᒥᑯᐣ ᑕᓱᑭᔑᑲ ᒥᓇ ᒋᐯᔭᑲᑭᐣ ᒧᔓᐠ ᒪᓯᓇᐦᐃᑫᐃᐧᑲᒥᑯᐣ ᒥᓇ ᐱᑯ ᐃᒪ ᑲᑕᓇᐱᓇᓂᐊᐧᐠ. ᐅᑭᓯᓂᑫ ᐃᓇᐧᓯᐊᐧᐠ ᒋᐅᓄᑭᓯᑐᐊᐧᐨ ᓂᐯᐃᐧᓇᐣ, ᒥᓯᐃᐧᑲᒥᑯᐣ ᒋᐯᔭᑲᑭᐣ, ᑲᓯᑲᐧᓂᑭᓄᐠ ᒋᐊᐣᒋᐦᐊᑲᓄᐊᐧᐨ ᑕᓱᑭᔑᑲ ᐁᑲᐧ ᒥᓇ ᐁᐧᐱᓂᑫᐃᐧᐣ ᒋᐅᑕᐱᓂᑲᑌᐠ. ᐅᑭᓯᐱᑭᓂᑫᐠ ᐸᐸᒥᓯᐊᐧᐠ ᓂᐯᐃᐧᓅᑭᓄᐣ ᒥᓇ ᑲᓯᑲᐧᓂᑭᓄᐠ ᑕᓱᑭᔑᑲ ᒋᑭᓯᐱᑭᓂᑲᑌᑭᐣ ᐁᑲᐧ ᒥᓇ ᑲᑭᓇ ᐊᐸᒋᒋᑲᓇᐣ ᒋᓇᐸᒋᑲᑌᑭᐣ ᐁᐦᐊᓂ ᐊᐧᐸᐠ ᑫᐊᐸᑕᑭᐣ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- WHMIS ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᑭᑭᑭᓄᐦᐊᒪᐊᐧᐊᐧᐠ ᐅᑭᓯᓂᑫᐠ ᒥᓇ ᐅᑭᓯᐱᑭᓂᑫᐠ

- *ᑭᐁᐧᑎᓄᐠ ᓅᐣᑲᐱᐦᐊᑲᓄᐨ ᑲᓇᓇᑲᒋᑐᐊᐧᐨ ᒪᓂᒧᔑᐃᐧ ᑫᑯᓇᐣ ᑕᓱᓯᑦ* ᐅᓇᓇᑲᒋᑐᓇᐊᐧ ᑲᑭᓇ ᓂᐯᐃᐧᑲᒥᑯᐣ ᐁᑲᐧ ᑕᐡ ᐃᐧᐁ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ ᑲᐃᐧᐣ ᐃᐧᑲ ᒋᐊᔭᐊᐧᐨ ᓂᐯᐃᐧᓂᐠ ᑲᔭᐊᐧᐨ ᒪᓂᒧᔓᐠ. ᐅᑫᐧᓂᐊᐧᐠ ᑲᓄᒋ ᒪᓂᒧᔕᐁᐧᐊᐧᐨ ᓂᔭᓇᐧ ᑭᑲᓄᓇᐊᐧᐠ ᐁᑭ ᐊᐧᐸᒪᑲᓄᐊᐧᐨ ᒪᓂᒧᔓᐠ ᓂᐯᐃᐧᑲᒥᑯᐠ. *ᑲᓄᒋ ᒪᓂᒧᔕᐁᐧᐊᐧᐨ* ᐅᑭ ᑭᔑ ᓇᓇᑲᒋᑐᓇᐊᐧ ᓂᐯᐃᐧᑲᒥᑯᐣ ᑲᐃᐧᐣ ᒪᓂᒧᔓᐠ ᒋᑭ ᐅᐣᒋ ᒥᑲᐊᐧᑲᓄᐊᐧᐨ.

- ᐊᐁᐧ ᑕᐡ ᑲᓂᑲᓂᐡᑲᐊᐧᐨ ᐊᓂᑭᓇᑲᓇᐣ ᐅᐱᒥ ᑭᑭᓄᐦᐊᒪᐊᐧᐣ ᐊᓂᑭᓇᑲᓇᐣ ᐊᓂᐣ ᑫᑐᑕᒧᐊᐧᐨ ᑲᐧᔭᐠ ᒋᐸᔭᑭᓂᑫᐊᐧᐨ

- *ᐃᑯ᐀ᐊᐟ* ᑭᑭᔑ ᓇᓇᑲᒋᒋᑫᐊᐧᐠ ᐯᔑᑲᐧ ᑲᔑ ᐱᑭᔓᑭᑌᐠ ᔕᓂᔭᐊᐧᐦᑭ ᐁᑭ ᓇᓇᑲᒋᑐᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐊᐸᒋᑕᑲᓇᐣ /ᒥᓇ ᐁᑭ ᓇᓇᑲᒋᒋᑫᐨ ᒥᓇ ᑲᔦ ᐁᑭ ᑭᑭᓄᐦᐊᒪᐊᐧᐨ ᐊᓂᑭᓇᑲᓇᐣ

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓅᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014

- SLFNHA ᑲᐃᐧᐣ ᒥᓇᐊᐧ ᐅᑲᔭᐸᒋᐦᐊᔭᐣ ᐊ᐀ᐊᒪ᐀ᐠ ᑲᓇᑕ ᐃᒪ ᑲᔑ ᐱᒥᐃᐧᑐᐊᐧᐨ ᑭᓯᐱᑭᓂᑫᐃᐧᐣ ᒥᓇ ᑭᓯᓂᑫᐃᐧᐣ SLFNHA ᐅᑭ ᐅᓇᑐᐣ ᒥᓇ ᒋᐱᒥᐃᑐᐊᐧᐨ ᐃᐧᓇᐊᐧ ᐃᒪ ᒋᑲᓇᐊᐧᐸᐣᑕᒧᐊᐧᐨ ᐅᑫᐧᓂᐊᐧᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ.

- ᐊᐁᐧ ᑲᐯᔑᐃᐧᑲᒥᑯᐠ ᑲᐅᐣᒋ ᓂᑲᓂᐡᑲᐊᐧᐨ ᐊᓂᑭᓇᑲᓇᐣ ᑭᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄ ᐊᓂᐣ ᑫᑭ ᑐᒋᑲᑌᑭᐸᐣ ᑭᓯᓂᑫᐃᐧᐣ ᒥᓇ ᑭᓯᐱᑭᓂᑫᐃᐧᐣ, ᒥᓇ ᐃᐧᐣ ᒋᑭᑭᓄᐦᐊᒪᐊᐧᐨ ᐊᓂᑭᓇᑲᓇᐣ.

- SLFNHA ᒥᓇ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᐅᑕᓂᒧᑕᐊᐧᐊᐧᐣ ᑯᑕᑭᔭᐠ ᐅᐸᒥᓂᑫᐠ ᑲᒪᒥᑎᓅᐣᑕᒧᐊᐧᐨ ᒋᑭ ᐃᓇᓄᑭᑕᒪᑫᐊᐧᐸᐣ ᐁᑲ ᓇᐱᐨ ᒥᐡᑕᐦᐃ ᒣᑎᓂᑫᐃᐧᐣ ᒋᑭ ᐊᔭᑭᐸᐣ ᐊᑕᐁᐧᓇᓂᐊᐧᐠ ᐊᐸᒋᑕᑲᓇᐣ ᐅᒪ ᐱᒧᒋᑫᐃᐧᓂᐠ

ᐊᐧᐁᐧᔑᓂᑫᐃᐧᐣ ᑲ ᐱᒧᑐᐊᐧᐨ

ᐃᐁᐧ ᐊᐧᐁᐧᔑᓂᑫᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ ᐅᓇᓇᑲᒋᑐᓇᐊᐧ ᑲᐧᔭᐠ ᒋᐃᓯᓴᑭᐣ ᑲᑭᓇ ᐃᒪ ᑲᔭᑭᐣ ᐱᐣᑎᑲᒥᐠ ᑲᔦ ᑲᑭ ᐊᐧᐁᐧᔑᒋᑲᑌᑭᐣ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐊᔓ ᐅᑭᑭᔑᑐᓇᐊᐧ.

ᑲᑭ ᑭᒋᐊᓂᑲᑌᑭᐣ ᒥᓇ ᑲᑭ ᑭᔑᒋᑲᑌᑭᐣ

- ᐃᑫᐧᓂᐊᐧᐠ ᐅᐊᐧᐁᐧᔑᓂᑫᐠ ᓇᐣᑕ ᐱᑯ 10-15 ᑕᐟᐣᐊᐧ ᐊᐁᐧᔑᓂᑫᐊᐧᐠ ᑕᓱᐱᒧᑯᓇᑲ ᒥᓇ ᑲᔦ ᐁᐊᐣᒋᐦᐊᐊᐧᐨ ᐅᐱᑲᐧᒋᐣ ᑲᐊᑕᐁᐧᓂᐨ, ᓂᐯᐃᐧᑲᒥᑯᐠ ᑭᓯᓯᑲᐣ ᒥᓇ ᑲᑕᑲᓯᒋᑫᒪᑲᐠ ᑲᒪᒋᓴᑭᐣ, ᑲᒪᒋᓴᑭᐣ HVAC ᑲᐅᐣᒋ ᐊᓂᑭᒪᑲᑭᐣ ᐃᒪ ᐱᐣᑎᑲᒥᐠ, ᐁᐧᐱᓂᑲᓇᐳ ᑲᐅᐣᒋ ᒪᒋᔭᔑᑲᐃᐧᐠ ᒥᓇ ᑲᐊᑲᓭᐣᑕᑲᐧᐠ ᐃᐡᑯᑌᐃᐧᔭ' ᑲᒪᒋᓴᐠ

- SLFNHA ᐅᑕᔭᓇᐣ ᐊᓂᑭᐃᐧ ᓇᑯᒥᑎᐃᐧᓇᐣ ᐃᒪ *ᑕᔭᓯᐣ ᑭ᐀ᐊᐟ ᐃᐡᐸᐱᑫᓴᐃᐧᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ* ᒥᓇ *ᐸ᐀ᑯ᐀ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐅᐣᒋ ᓇᓇᑲᒋᑐᐊᐧᐨ ᐊᐸᒋᑕᑲᓇᐣ ᑕᓯᐱᓯᑦ*. SLFNHA ᐅᑭᒋᐃᐧᓇᐣ *ᓯᐱ᐀ᐃᔦ᐀ ᐱ᐀ᐅᐯᐣ, ᑎ᐀ᐊᔭᑎᐣ ᐃᐡᑯᑌ ᒥᓇ ᑲᓇᐁᐧᐣᒋᑫᐃᐧᐣ* ᑕᓯᐊᐦᑭ ᑲᐱ ᓇᓇᑲᒋᑐᐊᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᐠ.

ᑲᓇᑭᐡᑭᑲᑌᑭᐣ ᒥᓇ ᑲᓂᑲᓅᐣᑕᑲᐧᑭᐣ ᒣᑲᐧᐨ 2013-2014

- ᐃᑫᐧᓂᐊᐧᐠ ᑲᐊᐧᐁᐧᔑᓂᑫᐊᐧᐨ ᑲᐱᒧᑐᐊᐧᐨ ᒥᓇ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪ ᐅᐱᒥ ᓇᓇᑲᒋᑐᓇᐊᐧ ᐊᐣᑕᓴᐧ ᑲᐊᐧᐁᐧᔑᓂᑫᓂᐨ ᒥᓇ ᑲᐅᐡᑭᒋᑲᑌᐠ ᑫᑯᓇᐣ.

- ᐁᑳ ᑕᐡ ᐅᓀᔾᒋᑫᐃᐧᔾ ᓇᔾᑕᐁᐧᔾᒋᑲᑌ ᓂᑲᔾ ᐊᓂᔾ ᑫᑭᔑ ᒥᓄᓭᑭᐸᔾ ᐋᐁᐧᔑᓂᑫᐃᐧᔾ ᑳᔑ ᓇᔾᑕᐁᐧᔾᑕᑳᐧᐠ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒥᓇ ᑲᐦ ᑲᐋᐧᐅᐡᑭᒋᑲᑌᑭᔾ ᑫᑯᓇᔾ, ᑲᐦ ᐊᓀᐱᒋᐡᑲᒪᑲᐠ ᐊᓄᑭᐃᐧᔾ ᐅᒪ ᑳᔑ ᐱᒍᒋᑲᓂᐋᐧᐠ ᐁᑳ ᒥᓇ ᑭᐡᐱᔾ ᓇᔾᑕᐁᐧᔾᑕᑳᐧᐠ ᑭᔭᐸᐨ ᒋᑭ ᐅᑕᐱᓇᑲᓄᐋᐧᐨ ᐊᓂᑭᓇᑲᓇᐠ ᑫᐃᐧᒋᑕᐋᐧᐨ.

ᒉᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ: ᓂᑲᔾ ᐁᐊᓂᔑ ᐱᒋᓂᐡᑲᓂᐊᐧᐠ

ᐃᒪ ᑲᐅᑭᒪᐃᐧᐊᐧᐨ ᒉᓂᒪᔭ ᒪᐠᑫ ᑲᐯᔑᐃᐧᑲᒥᐠ ᒧᔕᐠ ᐅᓇᓇᔾᑎᓇᓇᐋᐧ ᐊᓂᔾ ᑫᑭᔑ ᒥᓄᓭᑭᔾ ᑲᑭᓇ ᑫᑯᓇᔾ ᐃᒪ ᑲᐯᔑᐃᐧᑲᒥᐠ ᐊᓂᔑᓇᐯ ᑳᔑ ᐅᐱᒪᑎᓯᐃᐧᓂᐨ ᓀᑫ ᐁᑳ ᒥᓇ ᒋᑭ ᐯᔭᑕᑫᓂᒧᐋᐧᐸᔾ ᐅᑕᑰᔾᐠ ᑲᐊᐸᒋᑐᐋᐧᐨ ᐅᐁᐧ ᑲᐯᔑᐃᐧᑲᒥᐠ. ᐃᐁᐧ ᑕᐡ ᒪᐋᐧᐨ ᑲᓂᑲᓀᔾᑕᑳᐧᐠ ᐅᑕᑰᔾ ᑳᔑ ᓇᔾᑕᐁᐧᔾᑕᐠ. ᓂᑲᔾ ᐁᐊᓂᔑ ᐱᒋᓂᐡᑲᓂᐊᐧᐠ, ᐊᑎᐟ ᑫᑯᓇᔾ ᑲᑭ ᒥᑯᓂᔐᐦᐊᒧᐋᐧᐨ ᑲᐯᔑᐃᐧᑲᒥᑯᐃᐧᑭᒪᐠ ᒋᑭ ᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄᐋᐧᐸᔾ ᐊᓂᑭᓇᑲᓇᐠᓇᐋᐧᐨ ᒋᑭ ᒥᓄᓭᓂᑭᐸᔾ ᑳᔑ ᐊᓂᑲᐋᐧᐊᐧᐨ ᐅᑕᑰᔾᔾ ᐁᑳ ᒥᓇ ᒋᑫᒋᓇᐦᐅᐋᐧᐨ ᒋᑭ ᑲᐡᑭᑐᐋᐧᐨ ᑳᔑ ᓇᔾᑕᐁᐧᔾᑕᐠ ᐅᑕᑯᔾ. ᒪᐋᐧᐨ ᓂᓂᑲᓀᔾᑕᒥᔾ ᐅᑕᑰᔾ ᐅᐸᒥᐦᐃᑯᐃᐧᔾ.

Barb Peetwayway, Guest Services Representative, sits with a family staying at the Jeremiah McKay Kabayshewekami.

Client Services

ᑌᕑᐊᓫ ᐧᑭᑌᑐᐟ

Darryl Quedent
Director of Client Services

Under Sioux Lookout First Nations Health Authority (SLFNHA), the Client Services Department (CSD) was established in 1995 to provide hostel services for clients travelling to Sioux lookout for medical appointments. A new 38,000 sq. ft. multi-level hostel was constructed and we commenced operations in February 2011. With 56 guestrooms and 100 beds, the vision for the hostel is to create a warm, welcoming home-away-from-home environment for clients who need to live away from their home communities for short periods of time.

The Jeremiah McKay Kabayshewekamik (hostel) was named after Jeremiah McKay, a respected member of Kasabonika Lake First Nation, and a passionate crusader for health care services for Aboriginal people. Kabayshewekamik in the Anishinabe language means "a place of rest."

SLFNHA developed a business plan for the new hostel with the vision for:

- providing overnight accommodations for clients from northern First Nation communities
- providing extended stays for short-term clients
- providing accommodations for client escorts
- providing ground transportation and meal services for clients staying at the hostel

Today, the Client Services Department and staff of the Jeremiah McKay Kabayshewekamik continue to assist clients when accessing medical services in Sioux Lookout. It does so through the efforts of each and every staff, many of whom have first-hand experience of the difficulties in attaining good health care services. The CSD sets its sites on improving the quality of life through the delivery of good accommodations and support services while the client is staying at the hostel.

Accommodations Program

The Accommodations Programs is responsible for confirming prior approval information from Non-Insured Health Benefits (Health Canada) and coordinating guestroom check-in for the hostel and completing referrals to hotels when the hostel is full. This program is also responsible for providing orientation about the building and informing the client of house rules. The Jeremiah McKay Kabayshewekamik provides accommodations for more than 42,500 persons a year for people travelling to Sioux Lookout for medical appointments.

As shown below in Table 1, the majority of clients who stay at the hostel are here for day accommodations. These Daily Clients are booked for accommodations for two to three nights and are normally discharged to return home at the conclusion of their medical appointments. This user-group makes up approximately 94% of patients staying at the hostel. Clients referred to as Short-Term will stay up to 90 days and make up about 5% of the client population. Long-Term Clients who stay at the hostel for longer than 90 days make up approximately 1% of the client population.

Table 1: Why Medical Clients Stay with Us

Reason	Description
Daily Accommodations	CSD provides daily accommodations for clients attending medical appointments in Sioux lookout. Clients are booked for two to three days, based on First Nations and Inuit Health Benefits (FNIHB) Prior Approval. Medical appointments include general physician visits, testing and follow-up treatment.
Short-Term Accommodations	CSD provides short-term accommodations for clients travelling to Sioux Lookout for maternal care, mental health counselling, and referrals for long-term care. Clients may be booked for seven-day segments and may be approved by FNIHB for up to 90 days
Long-Term Accommodations	CSD provides long-term accommodations where a client is waiting for social housing and there is no other option for the client. These exceptional cases would be approved by FNIHB on a case-by-case basis and last longer than 90 days.

Highlights and Achievements from 2013-2014

- We addressed workload issues and an additional Accommodations Clerk was added to weekly schedule to provide the much-needed coverage
- Frontline staff received training in Customer Service Excellence to better serve the public
- Accommodation Centre was relocated to separate office for privacy and confidentiality
- SLFNHA IT department added wireless Internet Service for Hostel Property
- SLFNHA IT department, along with Teleco, upgraded 911 Emergency Services at the Hostel

Challenges and Priorities for 2013-2014 and Beyond

- Frontline workers continue to utilize hotels and motels for overflow and this is a hardship for clients who must travel back and forth for meals to the hostel, medical appointments and daily check-in/check-out of hotels
- Unregistered children continues to be a problem and there is no one to cover costs for overnight accommodations at the hostel
- Clients have nowhere to stay after 90-day prior approval runs out. Most have been referred to Sioux Lookout for long-term treatment (i.e. Dialysis Treatment, Prenatal under Integrated Pregnancy Program)

Transportation Program

The Transportation Program is responsible for providing ground transportation to and from the Sioux Lookout airport, medical appointment locations and pharmacies. The transportation program will also provide rides to local hotels when there is no room at the hostel. Every year, the Transportation Program moves more than 100,000 passengers and completes an average of 50,000 trips.

Highlights and Achievements in 2013/2014

- Drivers were provided with Defensive Driving and Transportation of Dangerous Goods Training by Safety Matters
- Three new Dodge Grand Caravans were purchased to replace old vans and SLFNHA worked with Korkola Design on new minivan logos
- New driver added to weekly shift rotation to address an increased demand for Ground Transportation services from Monday to Friday

Challenges and Priorities for 2013-2014

- Addressing concerns by drivers that parents are not using child restraining devices when travelling in hostel vans
- Hostel management continues to work with clients regarding the two-piece luggage policy

Hostel Security Program

The hostel operates a 24/7 Security Program and it is responsible for ensuring safety for all clients and employees. The security enforces no smoking inside of the hostel as well as zero-tolerance for alcohol and illegal drug-use on hostel property.

Highlights and Achievements

- Staff enrolled in Non-Violent Crisis Intervention Training to properly deal with clients under the influence of alcohol and illegal drugs
- Additional security cameras were added to the hostel to better monitor the premises
- Hostel management implemented more frequent guestroom checks to ensure safety of clients

Challenges and Priorities for 2013-2014

- The Hostel Security responded to 784 incidents regarding public intoxication at the hostel. Hostel management needs to find ways to effectively communicate with hostel clients about the zero-tolerance policy on drug and alcohol use.
- In order to address concerns for Security Personnel visibility in the hostel, new uniforms and jackets will be implemented in the new fiscal year
- Installing additional panic button hardware in administration offices

- To ensure the safety of clients and staff, all persons under the influence of alcohol are referred to The Out of the Cold Shelter. Hostel management have also been invited to participate on the Building Healthy Communities, Enforcement Pillar Committee to address this concern.
- Hostel management is also working with Sioux Lookout Meno Ya Win Health Centre (SLMHC) on protocol to deal with clients for after-hour discharges

Client Advocacy and Support

The Client Representative continues to:

- Provide cross-cultural orientations to health care professionals and attend patient rounds with medical staff
- Work with clients at the hostel for referral services to low-income housing and local services
- Assist with translation services.

Please see **Table 2** below for program statistics for past 12 months for number of clients served.

Table 2: Client Advocacy and Support Statistics

Activity	Total
Client Advocate Hospital Visits	48
Liaison with Hospital patients	65
Liaison with Hostel Clients	2,335
Hostel Complaints	16
NIHB Denials	22
Medical Staff Orientations	38
Liaison with First Nation Communities	133

Highlights and Achievements

- The Client Representative continues to assist clients in filling out applications for low-income housing when referred to Sioux Lookout for long-term medical treatment
- The Client Rep. follows up with clients who were dismissed from Hostel for public intoxication and completes the Hostel House Rules Agreement form
- The Client Rep. works with new SLMHC staff to provide overview on Cultural Awareness Training
- The Client Rep. has been selected to sit as Nitawin Housing Board Chairman

Challenges and Priorities for 2013-2014

- Hostel management and Client Representative continue to promote Hostel House Rules Policy through Wawatay Radio shows and the development of a pamphlet which highlights guest services and house rules for the building
- Hostel management and Client Rep. provide information to Chiefs of Ontario Patient Safety Committee and Nishinabwe-Aski Nation Health Office for concerns
- The Client Rep. will be working directly with local First Nation communities when dealing with clients who are having social issues while staying at the Hostel

Hostel Data Entry

The hostel Data Entry Clerk is responsible for compiling data for the Finance Department for all clients who stay at the Hostel each night. The Clerk is also responsible for ensuring that all client information is stored in FNIHB Medical Transportation Logbooks.

Highlights and Achievements

- The SLFNHA IT department worked with the Data Entry Clerk to revise and reformat what type of information was needed to complete daily invoicing to FNIHB
- Night Audit Reports and data collection processes were changed to ensure that Accommodation Clerks could send the previous day entries for billing
- SLFNHA continues to work with 5 Star Reservation Systems to compile and store information for daily registrations at the hostel
- SLFNHA has a working arrangement with FNIHB to access the Ontario Medical Transportation Database System to coordinate an effective billing process for all prior-approved clients

Challenges and Priorities for 2013-2014

- Hostel management is working with the Finance Department to enhance and improve the billing process and to ensure quick turnaround time for payments

Activity Program

The Activity Program Coordinator plans and coordinates recreational and social activities for clients at the Hostel. Activities include; arts and crafts, distribution of magazines, distribution of games and puzzles, group bingo games and movie nights. The Coordinator also works with local service providers to enhance activities for clients at the hostel. Additionally, the Coordinator acts as a liaison for clients requiring assistance and translation.

Highlights and Achievements

- Christmas presents were provided for those clients who were unable to return home during the Christmas holidays
- The New Year's Baby was presented with a gift basket
- Monthly fun bingos and cooking classes were provided for those interested
- Activity Coordinator worked with volunteer groups for used clothing and toy/book drives for clients staying at the hostel
- Provided assistance to promote a new educational program at the SLMHC, which benefited children and youth staying at the hostel .

Challenges and Priorities for 2013-2014

The Activity Coordinator has been able to partner with local service providers to provide daily programming and training opportunities for clients of the hostel, but has not been able to generate interest from hostel guests to attend. The Coordinator will continue to promote these opportunities for clients to get involved. It is expected that this involvement will alleviate some of the boredom that clients feel when they have nothing to do.

Food Services Program

The Food Services Program provides three nutritious meals per day, per client. A domestic kitchen is open for hostel guests to use to make coffee/tea and light snacks. The Jeremiah McKay Kabayshewekamik serves 132,600 meals for hostel clients each year. This total includes meals provided to clients accommodated in local hotels/motels, as well as airport bagged-lunches for clients whose departure times often resulted in missing the served meals.

Highlights and Achievements

- Hostel management and Aramark Canada meet weekly to address food menu and changes made in response to concerns about food quality
- A continental breakfast option was added for clients required to go the airport before 7 a.m.
- SLMHC's traditional Miichim Program provides hostel clients with weekly food specials such as fish, moose and duck
- The Health Inspector conducts semi-annual inspections and the hostel dietary department has been able to maintain cleanliness standards

Challenges and Priorities for 2013-2014

- SLFNHA and SLMHC working collaboratively towards Request For Proposals for food services for new fiscal year and includes the switch to hot food delivery for the Hostel
- SLFNHA and SLMHC in discussions to increase weekly traditional food items on the menu, to two or three times per week. SLMHC struggling to maintain good quantity for wild game donations.
- Dietary staff to be recertified on Safe Food Handling Course and new staff hires will be trained
- SLFNHA anticipates new hot food delivery program to be implemented in July 2014.

Hostel Guest Services Program

A Hostel Guest Services Program is available for hostel clients who require assistance and information about hostel and hospital services. The Guest Representative also provides front desk coverage, meets and greets incoming visitors to the hostel and provides translation services.

Highlights and Achievements

- The Guest Representative increased communication with clients and handed out comment cards throughout the year. Feedback from clients about their stay at the hostel has been mostly positive.
- Issues most often raised by clients were the quality and quantity of food/meals and hostel staff services.
- Management addressed the majority of issues raised by clients, but it should be noted that some comments were directly related to budgetary and staffing limitations which management must work with.

See Table 3 below for a breakdown of client satisfaction surveys

Table 3: Satisfaction Categories and percentages

Category	Satisfaction (%)
Hostel Accommodation	96
Food Services	82
Safety and Security	95
Cultural Environment	98
Staff	91
Overall Service	92

Challenges and Priorities for 2013-2014 and Beyond

- The Guest Service Representative will continue to work with elderly and disabled clients who are having problems navigating in and around the hostel and hospital properties
- The Guest Service Representative will continue to work with clients on the promotion of the hostel guest services program
- The Representative will look at ways to improve the communication between hostel staff and clients. This includes more frequent client surveys, more contact with clients to discuss hostel services, and promotion of hostel services using pamphlets and radio shows.

Housekeeping/Laundry Services

Housekeeping Services is responsible for cleaning each guestroom daily and maintaining cleanliness in the administration offices and public areas. The housekeepers will ensure the bed is made, washroom is sanitized, towels are replaced daily and garbage is removed. Laundry is responsible for ensuring that linens and towels are washed on a daily basis and all items are stocked for next day use.

Highlights and Achievements

- WHMIS training provide to Housekeeping and Laundry staff
- Northwest Pest Controls conducts monthly guestroom inspections and all inspections have reported no bed bugs. Northwest Pest Controls has been called in on five separate occasions where bed bugs have been found in rooms. Northwest completed rooms-cleaning and no further infestations were reported.
- Team Leader provides regular staff training in area of Industry Best Quality Cleaning Practices
- Ecolab completed quarterly service visits to the hostel for equipment/inspections and staff training

Challenges and Priorities for 2013-2014

- SLFNHA is not renewing contract service with Aramark Canada Ltd. for hostel management services for Laundry and Housekeeping. SLFNHA plans to develop and coordinate our own in-house management services for those services.
- The Hostel Team Leader attended regular training for improvements to housekeeping and laundry services, and provides in-house training for staff.
- SLFNHA and Hostel management are in discussions with service providers who are interested in working to provide a cost-effective way to purchase materials and supplies for the organization

Maintenance Program

The Maintenance Program ensures that general maintenance functions and building repairs are completed for the hostel.

Highlights and Achievements

- Maintenance responds to an average of 10-15 maintenance/ repair requests per week and includes requests for light-bulb replacement, guestroom heating and cooling problems, issues with building HVAC systems, plumbing and minor electrical
- SLFNHA has contracts with Thyssen Krupp Elevators and Barcol Controls for monthly equipment maintenance. SLFNHA retains services from Superior Propane, Dryden Fire/Security and Troy Life for annual inspection of building systems.

Challenges and Priorities for 2013-2014

- The maintenance department and hostel manager continue to monitor the number of maintenance and repair requests.
- A decision must be made in near future on how the maintenance program currently reflects hostel repair and replacement needs, as well as workload issues for the program and if it needs to increase staffing.

Jeremiah McKay Kabayshewekamik: Moving Forward

The management at the Jeremiah McKay Kabayshewekamik (hostel) is constantly looking for better ways to measure and improve on the extent to which the hostel provides culturally appropriate and a comfortable environment for clients accessing the facility. The prime objective is to focus on client needs. Moving forward, some opportunities that have been identified by the hostel management team include training hostel staff to provide better support services for the client and to ensure that they meet the needs of clients. Caring for clients is our priority.

SLFNHA's Client Services Department staff. Front row, from left: Juda Mckay, Evangeline Chapman, Elaine Elliott, Nancy Greaves, Candace Widmeyer, Mary Kejick, Barb Peetwayway, Chris St. Cyr, Neebin Morris and Jeanette Moonias. Back row, from left: Mary Cantin and Genesis Tamson.

Missing from photo: Darryl Quedent, Lorna Fiddler, Barb Friesen, Randy Wilson, Barry Waboose, Bridget Barron, Charlotte Carpenter, Roy Carpenter, Wayne Cecchetto, Grahama Chisel, Delphine Crane, Tim Davies, Ronnie Elliot, Lennie Fiddler, Seepa Grey, Nicole Jacob, Renato Galarde Jaravata, Robert Keesic, Dwayne Kejick, Genevieve Loon, Roseann Lyon, Peter MacKenchnie, Sandra Macleod, David Makahnouk, Elizabeth Masakayash, Julie McKay, Anna Skunk, Nancy Skunk, April Tuesday, April Gray, Velma Wesley and Cody Wiskeychan.

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Kevin Berube, Director Of Treatment Services

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- ᑲᑭᒋᓯᓴᓂᐠ ᑲᐊᐧᐃᐧᒋᐦᐃᐁᐧᐊᐧᐨ ᑭᐃᔕᐊᐧᐠ ᐱᑲᐣᒋᑲᒥᐣᐠ, ᐅᐡᑲᐣᑕᑲ ᒥᓇ ᒍᐡᑭᑲᐧᑲᒧᐠ
- ᑲᑭ ᐅᑕᐱᓇᑲᓄᐊᐧᐨ ᑲᑭᓇ ᐊᓂᔑᓇᐯ ᒪᒥᑎᐅᐣᒋᑲᓇᐱᐅᐃᐧ ᒥᓄᔭᐃᐧᐣ ᒥᓇ ᑲᓴᑲᐱᓇᓂᑯᐊᐧᐨ ᑫᑯᓇᐣ ᑲᐊᓂᑭᑕᒪᑫᐊᐧᐨ ᒋᐊᓂᑲᑕᒧᐊᐧᐨ ᐃᒪ 13 ᑕᔑᑫᐃᐧᓇᐣ ᑲᑭ ᑭᑭᓇᐊᐧᑌᐣᑕᑭᐣ ᑭᒋ ᐊᐊᐧᔑᔑᐃᐧᑭᒪ
- ᑲᑭᔑᒋᑲᑌᐠ ᑲᑭ ᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐨ ᐱᑲᐣᒋᑲᒥᐣᐠ ᑲᑭ ᐅᓇᑐᐊᐧᐨ ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᑫᐃᓇᑌᐠ ᒥᓇ ᑲᐃᔑᓇᑲᐧᐠ ᑕᔑᑫᐃᐧᐣ ᐁᑭ ᐅᔑᑐᐊᐧᐨ ᐊᑭᐃᐧᒪᔨᓇᐦᐃᑲᐣ
- ᑲᑭ ᑭᔑᒋᑲᑌᐠ ᑲᓇᐣᑕᐁᐧᐣᑕᑲᐧᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᒥᓇ ᒋᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑲᑌᐠ ᐊᐣᑎ ᐁᔑ ᓇᓄᐣᑌᓭᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒥᓇ ᐊᐣᑎ ᐃᐅᑫ ᐁᔑ ᒥᓄᓭᑭᐣ ᒋᑭ ᐅᓇᒋᑲᑌᑭᐸᐣ ᐊᐊᐧᔑᔑᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᑲᒥᐠ ᐃᒪ ᒋᑭ ᐅᐣᒋ ᐃᐧᒋᒋᑲᑌᑲᐧᐸᐣ ᑭᑕᓂᔑᓂᓂᐃᐧ ᑕᔑᑫᐃᐧᓂᓇᐣ ᐅᒪ ᑌᑎᐸᐦᐃ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑲᐧᑭᐣ;
- ᒋᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᐠ SLMHC ᒋᐸᑭᑎᓇᒍᐊᐧᐨ ᑲᐃᐡᑲᐧ ᑭᐸᑯᓯᐠ ᒪᔨᓇᐦᐃᑫᐃᐧᑲᒥᐠ ᒋᒪᒥᓄᒥᐣᑕᐧ ᐅᑕᑯᓯᐠ ᑲᓇᓂᓴᓂᓴᐊᐧᐨ
- ᒋᐅᓇᒋᑲᑌᐠ ᑭᒋᒪᒋᓴᐃᐧᐣ ᑫᐃᔑ ᐊᓄᑲᑌᐠ ᐃᑫᐧᓂᐊᐧᐣ 61 ᓇᐣᑐᑕᒪᐃᐧᓇᐣ ᑲᐅᐣᒋᓴᑭᐣ ᑭᑕᔑᑫᐃᐧᓂᓇᐣ.

ᒪᒥᓄᒥᐁᐧᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ

ᐃᒪ ᒉᑲᐧᐨ 2013/14 ᑲᐊᐦᑭᐊᐧᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓂᐠ, ᐃᒪ ᑕᐡ ᑲᑕᔑ ᒪᒥᓄᒍᐊᐧᓂᐊᐧᐠ, ᑭᒋᒪᐡᑭᑭᐃᐧᓂᓂᐊᐧᐠ ᑲᐊᐧᐸᒪᐊᐧᐨ ᐅᑕᑯᓯᐣ ᒥᓇ ᐊᓂᔑᓂᓂᐃᐧ ᐃᔑᒋᑫᐃᐧᓇᐣ ᑲᐃᐧᒋᑲᐸᐃᐧᒋᑲᑌᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᑲᑭ ᐊᓄᑲᑕᒪᐣᑭᐣ ᐃᒪ ᒪᒥᑐᐡᒋᑲᓇᐱᐅᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑲᓇᐣᑕᐁᐧᐣᑕᒍᐊᐧᐨ 5,370 ᐅᑕᑯᓯᐠ. ᐁᑲ ᐃᑫᐧᓂᐊᐧᐣ ᐊᔕ ᓂᑲᐣ ᑲᑭᐱᐃᐧᐣᒋᑲᑌᑭᐣ ᒪᒥᓄᒍᐁᐧᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ, ᓄᑎᐣ ᐅᑕᓄᑭᓇᑲᓇᐣ ᑲᔑᑭᒋᓯᓴᓂᐠ ᑲᔑ ᐊᓄᑭᐊᐧᐨ ᐅᑭ ᐊᓄᑲᐊᐧᐊᐧᐣ 4,831 ᐅᑕᑯᓯᐣ.

ᐅᒪ ᑌᑎᐸᐦᐃ ᐊᐧᓂᓇᐊᐧᑲᐠ ᐅᒪᒥᓄᒥᐁᐧᐠ ᑲᐊᔭᐊᐧᐨ ᒥᐱᑯ ᐁᐱᒥ ᒪᒥᓄᒪᐊᐧᐨ ᐅᑕᑯᓯᐣ ᑭᐁᐧᑎᓄᐠ ᑲᔭᐊᐧᐨ. ᐅᑕᓇᐣᐠ ᑲᑭ ᐊᐦᑭᐊᐧᐠ ᓂᑭ ᐊᐧᐸᒪᒥᐣ 1,909 ᐅᑕᑯᓯᐠ. ᐃᑫᐧᓂᐊᐧᐠ 1,909 ᐅᑕᑯᓯᐠ ᑲᐊᓂᑲᐊᐧᔭᐠ, 567 ᐅᑫᐧᓂᐊᐧᐠ ᐅᑕᑯᓯᐠ ᐃᒪ ᑭᑕᔑ ᐊᐧᐸᒪᐊᐧᐠ ᐊᑯᓯᐃᐧᑲᒥᑯᐠ. ᒥᔑᐣ ᐅᑕᑯᓯᐠ ᐃᒪ ᑲᑭ ᐃᔑᓂᔕᐦᐊᑲᓄᐊᐧᐨ ᐱᐣᒋ ᐊᑯᓯᐃᐧᑲᒥᑯᐠ ᒋᑕᔑ

ᐋᐸᒪᑲᓄᐋᓐ ᒥᓇᐋ ᑭᐊᓂ ᐋᐸᒪᑲᓄᐋᐠ ᑲᑭᐁᐋᓐ ᐅᑕᔑᑫᐄᓂᐋ ᐁᑳ ᐃᑫᓂᐋᐤ ᓄᑎᐣ ᐅᒪᒥᓄᒍᐁᐤ ᐅᐋᐸᒥᑯᐋᐤ ᓇᐣᑕ ᑲᔦ ᑕᔑᑫᐄᓂᐠ ᑲᑕᓇᓄᑭᓐ ᐅᒪᒥᓄᒍᐁ.

ᐃᑫᓂᐋᐤ ᑯᑕᑭᔭᐣ ᐄᒋᐦᐃᐁᐄᓇᐣ (ᓇᓇᐣᑐᐠ ᒪᒥᑐᓃᐣᒋᑲᓇᐱᓃ ᐄᒋᐦᐃᐁᐄᓇᐣ, ᒥᓇ ᒪᓯᓂᐱᐦᐃᑫᐃ ᐄᒋᐦᐃᐁᐄᐤ ᑲᐅᐣᒋ ᑎᐸᒋᒍᐋᓐ ᐅᑎᓃᐣᑕᒍᐄᓂᐋ) ᐅᑭ ᓇᓇᐣᑐ ᑭᑫᐣᑕᓇᐋ, ᐅᑭ ᐱᒥ ᓇᓇᑲᒋᐦᐊᐋᐤ ᒥᓇ ᐁᑭ ᐅᐣᒋ ᐊᔭᒥᐦᐋᓐ ᐃᑫᓂᐋᐤ 585 ᐅᑕᑯᓭᐣ ᓄᑯᐨ ᑲᐊᐦᑭᐋᐠ. ᒥᔑᐣ ᐅᑫᓂᐋᐠ ᐅᑕᑯᓭᐠ ᓄᒪᑫ ᑭᔭᐸᓐ ᐃᒪ ᑕᐅᐣᒋ ᑲᓇᐁᐣᑕᑯᓯᐋᐠ ᒪᒥᓄᒍᐁᐄᓂᐠ ᐊᐱ ᓂᑕᐨ ᑭᐃᐢᑳ ᓇᓇᑲᒋᐦᐊᑲᓄᐋᓐ. ᐅᑫᓂᐋᐤ ᑯᑕᑭᔭᐣ ᐄᒋᐦᐃᐁᐄᓇᐣ ᐊᒥ ᑲᑭᑐᑕᒍᐋᓐ ᐁᑭ ᒪᒪᐃ ᒪᒥᓄᒪᐋᓐ ᐊᐄᔭᐣ ᓇᐣᑕ ᑲᔦ ᒣᑳᓐ ᑲᐱᒥᐄᑐᐋᓐ ᐅᒥᐣᒋᓇᐁᐟᐃᓂᐋ. ᐊᔑᓐ ᑲᔦ, ᐅᑫᓂᐋᐤ ᑯᑕᑭᔭᐣ ᐄᒋᐦᐃᐁᐄᓇᐣ ᑕᐱᒥ ᑭᑭᓄᐦᐊᒪᐋᐠ ᐅᒪᒥᓄᒍᐁᐠ ᑭᐢᐱᐣ ᐃᔑ ᓇᐣᑐᑕᒪᐋᓐ.

ᐃᑫᓂᐋᐠ ᐊᓂᔑᓂᓂᐃ ᐄᒋᐦᐃᐁᐄᐤ ᑲᐊᓄᑲᑕᒍᐋᓐ ᐄᒋᐦᐃᐁᐄᓇᐣ ᐃᑫᓂᐋᐠ 2,876 ᐅᑕᑯᓭᐠ ᓄᑯᐨ ᑲᐊᐦᑭᐋᐠ. ᐅᐁ ᐊᓂᔑᓂᓂᐃ ᐄᒋᐦᐃᐁᐄᐤ ᑲᐊᓄᑲᑕᒍᐋᓐ ᐄᒋᐦᐃᐁᐄᓇᐣ ᐅᐸᑭᑎᓇᓇᐋ ᓇᓇᐣᑐᐠ ᐄᒋᐦᐃᐁᐄᓇᐣ: ᒪᑐᑎᓭᐋᓇᐣ, ᐊᓂᔑᓂᓂᐃ ᐃᔑᓂᑲᓭᐃᓇᐣ ᑲᒥᓇᑲᓄᐋᓐ, ᑲᑭᓂᑳᓇᐱᓇᓂᐋᐠ ᑲᑎᐸᒋᒍᓇᓂᐋᐠ ᐊᐄᔭ ᐅᑎᓭᓴᐄᐤ, ᒥᑲᐄᐣᑕᒪᑫᐃ ᒪᑯᓊᐄᓇᐣ, ᐍᐢᑳᓐ ᐊᐋᔑᔕᐠ ᑲᑭ ᑲᑳᑕᑭᐦᐊᑲᓄᐋᐸᐣ ᑲᑭ ᔕᐳᐢᑲᒍᐋᓐ ᐅᐄᒋᐦᐃᑯᐄᓂᐋ, ᑲᐸᐢᑭᓃᓂᑲᓂᐋᐠ ᐊᓂᔑᓂᓂᐋᐠ ᑲᑐᑕᒍᐋᓐ, ᐊᓂᔑᓂᓂᐃ ᒪᐢᑭᑭᐃ ᑭᑭᓄᐦᐊᒪᑫᐄᐤ, ᑲ ᑲᑳᑕᑭᐦᐊᑲᓄᐋᓐ ᐊᐄᔭᐠ ᐄᒋᐦᐃᐁᐄᓇᐣ ᒥᓇ ᒥᐣᒋᓇᐁᐟᐃ ᐄᒋᐦᐃᐁᐄᐤ. ᐅᑫᓂᐋᐠ ᐊᓂᔑᓂᓂᐃ ᐄᒋᐦᐃᐁᐄᓇᐣ ᑲᐊᓂᑲᑕᒍᐋᓐ ᑲᐄᐤ ᒋᒪᐋᐤᑐᓯᓇᐦᐊᒍᐋᓐ ᑲᐄᒋᐦᐊᐋᓐ ᐊᐄᔭᐣ, ᔕᑯᓐ ᐅᑐᑕᓇᐋ ᑭᐢᐱᐣ ᑲᔑ ᓇᐣᑕᐁᐤᑕᐠ ᐊᐁ ᑲᐄᒋᐦᐊᑲᓄᓐ ᓇᐣᑕ ᐃᒪ ᑕᔑᑫᐄᓂᐠ.

ᐃᐁ ᐄᒋᐦᐃᐁᐄᐤ, ᐋᓇᒪᐣ ᓴᑳᐦᐃᑲᓂᐠ ᑲᐃᔑᑕᑳᐠ, ᑭᒋᒪᒋᓴᐃ ᐄᒋᐦᐃᐁᐄᐤ ᑲᐃᔑ ᑭᑐᓇᓂᐋᐠ ᒪᒋᑭᑐᐃᓂᐠ ᑭᒋᐊᐋᔑᔑᐄᑭᒪ ᑲᐸᑭᑎᓇᓐ ᓀᓂᔭᓇᐣ ᑭᐅᐣᒋ ᐄᒋᒋᑲᑌᑭᐣ ᑯᑕᑭᔭᐣ ᑕᔑᑫᐃᓇᐣ. ᐅᑕᓇᐣᐠ ᑲᐱᐊᐦᑭᐋᐠ, ᐅᐁ ᐄᒋᐦᐃᐁᐄᐤ ᐅᑭ ᐅᐣᒋ ᐊᔭᒥᐦᐊᐋᐤ 150 ᐅᑕᑯᓭᐣ ᒥᑕᐢ ᒥᓂᑯᐠ ᑲᑭᐄᒋᐦᐊᐋᓐ 54 ᑎᐸᐦᐃᑳᐣ ᑲᒪᓯᓇᐦᐃᑲᑌᐠ ᐄᒋᐦᐃᐁᐄᐤ. ᐅᐁ ᐄᒋᐦᐃᐁᐄᐤ ᑲᐄᐤ ᒋᐅᐣᒋ ᐱᑭᑐᐋᓐ ᐊᐋᔑᔕᐠ ᒥᓇ ᐅᐢᑲᑎᓴᐠ ᐅᒪ ᑌᑎᐸᐦᐃ ᑲᔭᐋᓐ. ᑭᒋ ᐊᐋᔑᔑᐄᑭᒪ (MCYS) ᐅᐸᑭᑎᓇᐣ ᓀᓂᔭᓇᐣ ᒋᐱᒥᐄᒋᑲᑌᐠ ᐅᐁ ᐄᒋᐦᐃᐁᐄᐤ ᐃᑫᓂᐋᐠ 0 - 17 ᑲᑕᓯᐱᐳᓃᐋᓐ ᐅᐢᑲᑎᓴᐠ, ᒥᑕᐢ ᑲᑭ ᐃᓯᓴᐠ MCYS ᐁᑭ ᐃᓃᐣᑕᐠ ᐅᐁ ᐄᒋᐦᐃᐁᐄᐤ ᓀᓂᔭ ᑲᐸᑭᑎᓇᑲᓄᓐ ᐸᑳᐣ ᒋᑭ ᐃᓇᐸᑎᓭᐸᐣ ᒋᑭ ᐅᐣᒋ ᐄᒋᐦᐊᑲᓄᐋᐸᐣ ᐊᐋᔑᔕᐠ ᒥᓇ ᐅᐢᑲᑎᓴᐠ.

ᓄᑎᐣ ᐊᓂᑲᐋᑕᑭᐣ ᑲᑭᒋᓯᓴᓂᐠ 61 ᑕᓯᐣᐊᐃ ᑭᐱᑲᓄᓇᑲᓄᐋᐠ ᒋᐄᒋᑖᐋᓐ ᐃᒪ 26 ᑕᔑᑫᐄᓂᐠ ᐃᒪ ᒪᒪᐤ 30 ᑕᔑᑫᐄᓇᐣ ᑲᐅᐣᒋ ᑲᓇᐋᐸᐣᑕᒍᐋᓐ. 63 ᑕᓯᐣᐊᐃ ᓂᑭ ᐃᔑᓂᔕᐦᐋᒥᐣ ᑲᐄᒋᑖᐋᓐ ᑲᔑ ᑭᒋ ᐊᓂᒥᓴᓂᐠ ᒥᓇ 271 ᑲᑭᒋ ᐊᓂᒥᓴᓂᐠ ᑲᒪᒥᓂᒍᐁᐋᓐ ᑲᔑ ᐊᓂᒥᓴᓂᐠ. ᑲᑭᒋ ᐊᓂᒥᓴᐠ ᐄᒋᐦᐃᐁᐄᑌ 4,831 ᐅᑕᑯᓭᐣ ᐅᑭ ᐋᐸᒪᐋᐤ. ᒥᓇᐋ ᑲᑭ ᐊᐦᑭᐋᐠ ᒪᐋᓐ ᓂᑭ ᑭᒋᐊᓄᑭᒥᐣ ᒥᓂᑯᐠ ᑲᐅᐣᒋ ᐱᒥᐃᑐᔭᐣ ᐅᐁ ᐄᒋᐦᐃᐁᐄᐤ ᑲᑭ ᐅᑕᐱᓇᒪᑭᐸᐣ ᐃᒪ ᑲᓇᑕ ᑭᒋᒪᐢᑭᑭᐃ ᐱᒍᒋᑫᐄᓂᐠ. ᐁᑳ ᑕᐢ ᑲᑭᓇ ᑲᑭ ᓇᓇᓯᑲᒪᑭᐣ ᑲᔑ ᑭᒋᐊᓂᒥᓴᑭᐣ ᑕᔑᑫᐄᐤ ᒥᑐᓂ ᓂᑭ ᐅᐣᒋ ᒪᓯᓇᐦᐃᑫᓴᒥᐣ. ᑕᓯᐊᐦᑭ, ᓂᒥᓂᑯᒥᐣ $650,000 ᑲᓇᑕ ᑭᒋ ᐊᑯᓯᐃ ᐱᒍᒋᑫᐄᓂᐠ ᐃᒪ ᒋᔑ ᐊᐸᒋᐦᐊᔭᐣᐠ ᒪᐋᓐ ᑲᔑ ᐊᓂᒪᐠ ᐄᒋᐦᐃᐁᐄᐤ. ᐅᑕᓇᐣᐠ ᑲᑭ ᐊᐦᑭᐋᐠ, ᐃᐁ ᓂᐱᒍᒋᑫᐄᓂᓇᐣ ᐃᒪ ᑲᔑ ᑭᒋᐊᓂᒪᐠ ᐄᒋᐦᐃᐁᐄᐤ ᑲᐅᐣᒋ ᐱᒍᒋᑲᑌᐠ ᓂᑭ ᑌᐱᓇᒥᐣ $1.6 ᒣᐃᔭᐣ ᑕᓴᐧᐱᐠ. ᓂᐄᑕᓄᑭᒪᒥᐣ ᑲᓇᑕ ᑭᒋᐊᑯᓯᐃ ᐱᒍᒋᑫᐄᐤ ᒥᓇ ᓂᑕᔑᑫᐄᓂᓇᐣ ᒋᑭ ᒪᑲᒪᐣᑭᐸᐣ ᐊᓂᐣ ᑫᑭᔑ ᐄᒋᑖᔭᑭᐸᐣ ᑲᔑᑭᒋ ᒪᒋᓴᐠ ᑕᔑᑫᐄᐤ ᐁᑲ ᒋᑭ ᐅᓴᒪᐱᑭᓂᑫᔭᑭᐸᐣ ᑕᓯᐊᐦᑭ.

ᐋᐋᔑᔕᐠ ᒪᒥᓄᒍᐁᐄᐤ ᒥᓇ ᑲᓴᑭᓂᐁᒪᑲᑭᐣ ᑫᑯᓇᐣ ᐄᒋᐦᐃᐁᐄᐤ

ᓄᑎᐣ CFI ᒥᓇᐋᐠ ᐄᒋᐦᐃᐁᐄᐤ ᒋᐅᑕᐱᓇᐋᓐ 13 ᐋᐋᔑᔕᐠ ᒪᒥᓄᒍᐁᐄᐤ ᒥᓇ ᑲᓴᑭᓂᐁᒪᑲᑭᐣ ᑫᑯᓇᐣ ᐄᒋᐦᐃᐁᐄᐤ ᑫᐃᓇᓄᑭᓂᓐ. ᐃᐁ ᑕᐡ ᑭᒋ ᐋᐋᔑᔑᐄᑭᒪ (MCYS) ᑲᐃᓇᓊᐁᓐ ᐅᑫᓂᐋᐤ ᐊᓂᑭᐄᓇᐣ ᒋᑭ ᑕᓇᓄᑭᐦᐊᑲᓄᐋᐸᐣ ᑕᔑᑫᐄᓂᐠ ᑲᑭᔑ ᑭᑭᓇᐋᐅᑌᐣᑕᑭᐣ MCYS. ᒥᑕᐢ ᐅᑫᓂᐋᐤ ᑕᔑᑫᐄᓇᐣ: ᐁᕓᐅᕓᐊᐣ', ᑭᒋᓇᒣᑯᓯ' ᐃᓂᓂᐋᐠ, ᐱᔑᐄᓴᑳᐦᐃᑲᓂᐠ, ᐃᔭᐱᒪᑐᐣᐠ, ᑲᓇᓴᐸᓇᑲ, ᐊᑲᐧᑭᐣᐠ, ᒣᐢᑭᑲᐧᑲᒪᐣᐠ, ᓃᐢᑳᐣᑕᑲ, ᐋᐸᓴᑎᑳᐣᐠ, ᐱᑳᐣᒋᑲᒥᐣᐠ, ᓃᐣᑲᐄᓴᑳᐦᐃᑲᓂᐠ, ᓂᐱᓇᒥᐠ ᒥᓇ ᐁᐧᐱᑫᐧ. ᐅᑕᓇᐣᐠ ᑲᑭ ᐊᐦᑭᐋᐠ,ᐊᔕ ᓂᑭ ᐅᑕᐱᓇᒥᐣ 13 ᑫᐃᓇᓄᑭᐋᓐ. ᓂᑭ ᐋᐅᐢᑲᓂᑭᐦᐊᒥᐣ ᐊᓂᑭᓇᑲᓇᐠ ᒣᑳᓐ ᑲᐱᒪᑭᑌᐠ ᐊᐦᑭ, ᔕᑯᓐ ᐊᔕ ᑲᑭᓇ ᐊᔭᐋᐣ ᐃᒪ ᑫᑭ ᐃᓇᓄᑭᐋᐸᐣ ᐃᒪ ᑲᑭᓇ ᑕᔑᑫᐄᓇᐣ ᑲᑭ ᑭᑭᓇᐋᐅᑌᐣᑕᑳᑭᐣ. ᓂᐄᑕᓄᑭᒪᒥᐣ ᑲᓴᑲᐱᓇᓂᑯᐋᓐ ᑫᑯᓇᐣ ᒥᓇ ᒪᒥᑎᓃᐣᒋᑲᓇᐱᓃ ᐄᒋᐦᐃᐁᐄᑲᒥᐠ ᒋᐅᔑᑐᔭᐣ ᑭᑭᓄᐦᐊᒪᑫᐄᐤ ᑫᐃᓇᑌᐠ ᒋᑭᑭᓄᐦᐊᒪᐃᐣᑕᐧ ᐅᑫᓂᐋᐠ ᐊᓂᑭᓇᑲᓇᐠ.

	2009-10	2010-11	2011-12	2012-13	2013-14
ᒪᒥᓄᒧᐍᐃᐧᐣ	1,006	2,798	2,888	1,443	1,909
ᓇᓇᐣᑐᐠ ᐃᐧᒋᐦᐃᐁᐃᐧᓇᐣ	215	473	526	647	585
ᐊᓂᔑᓂᓂᐃᐧ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐃᐧᐣ	2,853	2,500	2,452	1,780	2,876
ᒪᒪᐤ # ᐅᑕᑯᔾᐠ ᑲᑭ ᐊᐧᐸᒥᐣᑕᐧ	4,074	5,771	5,866	3,870	5,370

ᑭᒋᒪᒋᓴᐃᐧᐣ	ᑲᑭᐃᔾᓴᐠ	2009-10	2010-11	2011-12	2012-13	2013-14
ᓂᔾᑎᓱᐃᐧᐣ	ᑲᑭ ᓂᔕᐧᓇᒋᐦᐃᑎᓱᐊᐧᐨ	14	10	12	12	16
	ᑲᑭ ᑲᑫᐧ ᓂᔕᐧᓇᒋᐦᐃᑎᓱᐊᐧᐨ	103	78	91	73	97
ᐅᐃᐧᒋᐦᐃᐁᐧᐠ ᑲᑭ ᐃᔑᓂᔕᐦᐊᐧᑲᓄᐊᐧᐨ		58	55	50	46	61

ᒥᑭᓇᑯᐡ – ᐊᒋᓇ ᑲᐅᐣᒋ ᓇᓇᑲᒋᐦᐊᑲᓄᐊᐧᐨ ᒥᓇ ᑲᐅᐣᒋ ᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ ᐃᐧᒋᐦᐃᐁᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ

ᒥᑭᓇᑯᐡ – STAT ᐱᒧᒋᑫᐃᐧᐣ ᑭᑭᐱᑎᓂᑲᑌ ᐅᑕᓇᐣᐠ ᑲᐊᐦᑭᐊᐧᐠ ᐃᑫᐧᓂᐊᐧᐠ ᑕᐡ SLFNHA ᐅᑕᔦᒥᐦᐊᐊᐧᐣ ᐅᐱᔑᑯᑲᐣᐠ ᐊᐡᑯᓂᑲᐣ ᒋᐅᔑᑐᐊᐧᐨ ᐅᐡᑭ ᐊᐧᑲᐦᐃᑲᐣ ᐃᒪ ᑫᑕᓇᓄᑭᒪᑲᐠ ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ. ᐅᐁᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑭᑭᐱᑎᓂᑲᑌ ᐅᐱᒪᐦᐊᒧᐃᐧᐱᔾᑦ 2013, ᒣᑲᐧᐨ ᑲᑭ ᓇᓇᑲᒋᒋᑲᑌᐠ ᐊᐧᑲᐦᐃᑲᐣ ᐁᐦᐊᔦᒪᑲᐠ ᐁᒪᑲᑌᐃᐧ ᐊᑲᐧᑭᔑᐊᐧᐠ ᐃᒪ ᑲᔑ ᐊᓇᒪᑲᒥᑯᐊᐧᐠ. ᐊᒥᑕᐡ ᑲᑭ ᐃᓅᐣᑕᑲᐧᐠ ᐸᓂᒪ ᑲᐧᔦᐠ ᐃᔑᓇᑲᐧᐠ ᐊᐧᑲᐦᐃᑲᐣ ᐸᐡᑲᐣ ᒥᓇᐊᐧ ᒋᒪᑕᓄᑭᒪᑲᐠ ᐅᐁᐧ ᐃᐧᒋᐦᐃᐁᐃᐧᐣ.

ᒣᑲᐧᐨ ᑲᐱᒪᓄᑲᑌᑭᐣ

ᓄᑎᐣ – ᐱᑲᐣᒋᑲᒥᐣᐠ ᑲᑕᓇᓄᑭᓇᓂᐊᐧᐠ: ᓄᑎᐣ ᐅᑭᑭᔑᑐᓇᐊᐧ ᓂᔾᐊᐦᑭ ᑲᑭ ᐱᒥ ᐊᓄᑲᑕᒧᐊᐧᐨ ᐱᑲᐣᒋᑲᒥᐣᐠ ᐃᐡᑯᓂᑲᐣ ᐃᒪ ᑲᑭ ᐅᐣᒋ ᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐨ ᐊᑯᔾᐃᐧ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᒥᓇ ᑲᑭ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᑕᒧᐊᐧᐨ ᑲᑭ ᐃᐧᑕᓄᑭᒪᐊᐧᐨ ᐱᑲᐣᒋᑲᒥᐣᐠ ᐱᒪᑎᓯᐃᐧᓇᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᐃᒪ ᐚᑫ ᑕᔑᑫᐃᐧᓂᐠ ᑲᔦᐊᐧᐨ ᑫᐃᐧᓇᐊᐧ ᒋᐃᐧᑐᑲᑫᐊᐧᐨ, ᒋᑭᑭᓄᐦᐊᒪᐊᐧᑲᓄᐊᐧᐨ ᒥᓇ ᒋᐅᓇᔾᐣᑕᐧ ᑕᔑᑫᐃᐧᓂᐠ ᑫᑕᓇᓄᑭᐊᐧᐨ ᐱᒪᑎᓯᐃᐧᓇᐣ ᑫᐊᓂᑲᑕᒧᐊᐧᐨ, ᒋᐅᓇᒋᑲᑌᐠ ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᑫᐃᓇᑌᐠ ᒥᓇ ᒋᓇᓇᑲᒋᒋᑲᑌᐠ ᐅᐁᐧ ᐯᔑᐠ ᐊᓂᑭᐃᐧᐣ. ᑭᐅᔑᒋᑲᑌ ᐊᑭᐃᐧᒪᔾᓇᐦᐃᑲᐣ ᑲᐃᔑᓇᑲᐧᐠ ᐃᐁᐧ ᑕᔑᑫᐃᐧᐣ ᒋᐅᐣᒋ ᑭᑫᐣᑕᑲᐧᐠ ᐊᐣᑎ ᑫᔑ ᐸᑭᑎᓂᑲᑌᐠ ᐃᐧᒋᐦᐃᐁᐃᐧᓇᐣ ᑫᓇᐣᑎᓇᒧᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑲᐯᔑᐊᐧᐨ. ᐅᐁᐧ ᐅᓄᑭᐃᐧᐣ ᑲᑭ ᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐨ ᐅᒪᒥᓄᒧᐁᐧᐠ ᒥᓇ ᑲᓴᑲᐱᑐᐦᐁᐃᐧᒪᑲᑭᐣ ᑫᑯᓇᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᐃᒪ ᐱᑲᐣᒋᑲᒥᐣᐠ ᐅᐱᒥ ᐊᓂᑲᑕᓇᐊᐧ ᐅᐁᐧ ᐊᓇᐃᐧᓂᑯ ᐊᔕ ᐁᑭ ᑭᔑᒋᑲᑌᐠ ᑲᐃᐧᑐᒋᑲᑌᑭᐸᐣ.

ᑲᑭᒋ ᐊᓂᒪᓂᐠ ᑲᐊᐧᐃᐧᒋᐦᐃᐁᐊᐧᐨ: ᐊᐧᓂᓇᐊᐧᑲᐠ ᐊᓂᔑᓂᓂᐃᐧ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᐣ ᐅᑭ ᐃᔑᓂᔕᐦᐊᐧᐊᐧᐣ ᐅᐃᐧᒋᐦᐃᐁᐧᐣ ᐃᒪ ᐱᑲᐣᒋᑲᒥᐣᐠ, ᑗᐡᑲᐣᑕᑲ ᒥᓇ ᒣᐡᑭᑲᐧᑲᒪᐣᐠ. ᐅᐁᐧ ᑕᐡ ᑲᑭ ᐃᓇᓄᑭᐊᐧᐨ ᒋᐅᐣᒋ ᐃᐧᒋᐦᐊᐊᐧᐨ ᑕᔑᑫᐃᐧᓂᐠ ᐱᒪᑎᓯᐃᐧᓇᐣ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᒋᑲᑫᐧ ᒥᓄᓇᒧᐊᐧᐨ ᑲᔑ ᑭᒋ ᐊᓂᒥᓴᐊᐧᐨ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᑲᔦᐊᐧᐨ. ᐅᑫᐧᓂᐊᐧᐠ ᐅᐃᐧᒋᐦᐃᐁᐧᐠ ᑕᐱᒥᓴᓂ ᐅᑕᓄᑭᐃᐧᓂᐊᐧ ᐸᓂᒪ ᐊᓂᑭᔑᐸᑭᔾᐨ ᐊᐧᑌᐸᑲᐃᐧᐱᔾᑦ 2014. ᐃᑫᐧᓂᐊᐧᐠ ᑕᐡ ᑲᑭᒋ ᐃᔾᓴᓂᐠ ᑲᐊᓂᑲᑕᒧᐊᐧᐨ ᐅᑕᓂᔑ ᐊᐣᒋᓂᔕᐦᐊᐧᐊᐧᐣ ᐊᐃᐧᔦᐣ ᐃᒪ ᑕᔑᑫᐃᐧᓂᐠ ᑲᑕᑲᐧᑭᐣ ᐃᐧᒋᐦᐃᐁᐃᐧᓇᐣ (ᓄᑎᐣ, ᑕᔑᑫᐃᐧᓂᐠ ᑲᑕᓇᓄᑭᐨ ᐅᒪᒥᓄᒧᐁᐧ) ᒋᐊᓂ ᓇᓇᑲᒋᐦᐊᑲᓄᐊᐧᐨ ᐊᓂᐣ ᑲᑭᔑ ᐱᐊᓄᑭᑕᒪᑫᐊᐧᐨ ᐅᒪ ᑕᔑᑫᐃᐧᓂᐠ. ᓄᑯᑦ ᑕᐡ, ᐅᑫᐧᓂᐊᐧᐠ ᐅᐃᐧᒋᐦᐃᐁᐧᐠ, ᐊᐊᐧᔑᒣ 1,600 ᑕᔑᑫᐃᐧᓂᐠ ᑲᑲᐯᔑᐊᐧᐨ ᐅᐃᐧᒋᐦᐊᐊᐧᐣ ᐅᒪ ᓂᐦᔾᐣ ᑕᔑᑫᐃᐧᓇᐣ ᑲᔑᔦᑭᐣ.

ᑲᐅᐣᒋᐊᔦᒥᑕᒪᐃᐧᐣᑕᐧᐊᐊᐧᔑᔕᐠᒥᓇᐅᐡᑲᑎᓴᐠᐃᐧᒋᐦᐃᐁᐃᐧᑲᒥᐠ: ᐃᐁᐧ ᑲᔑ ᓇᐣᑕᐁᐧᐣᑕᒧᒪᑲᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᒥᓇ ᑲᐊᐱᑕᓄᑭᒪᑲᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᐣ ᐊᔕ ᑭᑭᔑᒋᑲᑌ ᒋᑭᑭᓇᐊᐧᑌᐣᑕᑲᐧᐠ ᐃᐁᐧ ᒋᐅᐣᒋ ᐊᔦᒥᑕᒪᐃᐧᐣᑕᐧ ᐊᐊᐧᔑᔕᐠ ᒥᓇ ᐅᐡᑲᑎᓴᐠ ᐃᐧᒋᐦᐃᐁᐃᐧᑲᒥᐠ ᑫᐅᐣᒋ ᐊᓄᑲᑕᒧᐊᐧᐨ ᐊᓂᔑᓂᓂᐃᐧ ᑕᔑᑫᐃᐧᓇᐣ ᐊᐧᓂᓇᐊᐧᑲᐠ ᑌᑎᐸᐦᐃ ᑲᔦᑭᐣ. ᐃᐁᐧ ᒋᐅᐣᒋ ᐊᔦᒥᑕᒪᐃᐧᐣᑕᐧ ᐊᐊᐧᔑᔕᐠ ᒥᓇ ᐅᐡᑲᑎᓴᐠ ᐃᐧᒋᐦᐃᐁᐃᐧᑲᒥᐠ ᑲᐃᒋᑲᑌᐠ ᐃᐧᒋᐦᐃᐁᐃᐧᐣ ᑲᐅᐣᒋ ᑲᑫᐧ ᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ ᐊᐊᐧᔑᔕᐠ ᑲᒪᒋᓴᐊᐧᐨ. ᐅᐁᐧ ᐃᐧᒋᐦᐃᐁᐃᐧᑲᒥᐠ ᑲᑭᓇ ᒪᒪᐃᐧᓂᑲᑌᐊᐧᐣ ᐃᐧᒋᐦᐃᐁᐃᐧᓇᐣ ᑫᐊᐸᑕᓂᐠ ᐊᐊᐧᔑᐡ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᐣ (ᐊᑯᔾᐃᐧ ᐱᒧᒋᑫᐃᐧᓂᐠ, ᒪᒥᓄᒧᐁᐃᐧᓂᐠ, ᐊᐊᐧᔑᔑᐃᐧᑭᒪᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᔑᒪᑲᓂᐡ, ᐅᑭᒪᐃᐧᐣ ᐅᑕᔦᒥᑕᒪᑫᐃᐧᓂᓂᒪᐣ) ᒋᐅᓇᑐᐊᐧᐨ ᐅᐃᐧᒋᐦᐃᐁᐃᐧᐃᓂᐊᐧ ᐁᑲ ᐁᐧᓴ ᒥᐡᑕᐦᐃ ᒋᑲᑲᐧᑕᑫᐣᑕᐠ ᐊᐊᐧᔑᐡ ᒣᑲᐧᐨ ᑲᐱᒥ ᒪᐊᐧᐣᑐᓂᑲᑌᑭᐣ ᐃᐧᐣᑕᒪᑫᐃᐧᓇᐣ ᐃᒪ ᐅᓇᑯᓂᑫᐃᐧᓂᐠ ᑲᐃᔾᓴᐠ

ᑫᑯᐣ. ᐃᐧᐸᐨ ᑲᔦ ᐁᐦᐊᓄᓇᒋᑲᑌᓂᐠ ᐊᐊᐧᓯᐡ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓇᐣ. ᐅᐁᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᓭᓂᔭ ᑭᐅᐣᒋ ᐸᑭᑎᓇᑲᓄ ᐃᒪ ᐅᓇᑯᓂᑫᐃᓂᐧᐠ ᑲᐅᐣᒋ ᐱᒧᒋᑲᑌᐠ, ᑲᓇᑕ ᑭᒋ ᑎᐸᑯᓂᑫᐃᐧᑭᒪᐃᐧᐣ – ᐅᐣᑌᐢᐃᔦ ᑲᐅᐣᒋ ᐅᓇᓴᑲᓄᐊᐧᐨ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᑲᑲᑕᑭᐦᐊᑲᓄᐊᐧᐨ ᐊᐱᑕᒪᑫᐃᐧᐣ. ᐃᐁᐧ ᑕᐡ ᐃᐧᐣᑕᒪᑫᐃᐧᐣ ᑲᑭᓯ ᒥᑭᑲᑌᐠ ᓇᓇᐣᑕᐃᐧ ᑭᑫᐣᒋᑫᐃᐧᓂᐠ ᑭᐃᓯᓂᔕᐦᐃᑲᑌ ᐃᒪ ᐅᓇᑯᓂᑫᐃᐧᐣ ᑲᐅᐣᒋ ᐱᒧᒋᑲᑌᐠ 1 ᑲᐊᓂ ᐊᐱᒋᐡᑲᒪᑲᐠ ᐊᓂᑭᐃᐧᐣ. 2 ᑲᐊᓂ ᐊᐱᒋᐡᑲᒪᐠ ᐊᓂᑭᐃᐧᐣ ᑕᐃᓇᐧᐣ ᒋᐅᓯᒋᑲᑌᐠ ᐃᐧᒋᐦᐃᐧᐁᐧᑲᒥᐠ ᐅᒪ ᐅᐣᑌᐢᐃᔦ. ᑯᑕᐠ ᐊᓂᑭᐃᐧ ᓇᐣᑐᑕᒪᐃᐧᐣ ᓇᐣᑕᐁᐧᐣᑕᑲᐧᐣ ᐊᒥᐁᑕ ᒋᑭ ᐸᑭᑎᓇᑲᓄᐨ ᓭᓂᔭ 2 ᑲᐊᐱᒋᐡᑲᒪᑲᐠ ᐊᓂᑭᐃᐧᓂᐠ.

ᑲᓇᓇᑭᐡᑭᑲᑌᑭᐣ

ᑲᐸᑭᑎᓂᑲᑌᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᑲᓯ ᑭᒋ ᐊᓂᒥᓴᐠ ᐁᑭ ᒪᔨᓇᐦᐃᑫᓴᐊᐧᐨ ᐊᐧᓂᓇᐊᑲᐧᐠ ᐊᓂᓯᓂᓂᐃᐧ ᒪᐡᑭᑭᐃᐧᑭᒪᐃᐧᐣ.

ᓂᑲ ᑲᐡᑭᑐᒥᐣ ᒋᑎᐸᐦᐃᑫᔨᑐᔭᐣᐠ ᑲᓯ ᒪᔨᓇᐦᐃᑫᓴᐠ ᐁᑭ ᓇᓇᐣᑕᐊᐧᐱᑭᓂᑲᓂᐊᐧᐠ ᐃᒪ ᐱᒧᒋᑫᐃᐧᐣ ᓭᓂᔭ ᑲᐸᑭᑎᓇᑲᓄ, ᔕᑯᐨ ᑕᐡ ᑲᐃᐧᐣ ᒥᔨᐁᐧ ᒋᑭ ᐅᐣᒋ ᑎᐸᐦᐃᑫᔨᑐᔭᐣᐠ ᒪᔨᓇᐦᐃᑫᐃᐧᐣ. ᓂᐱᒥ ᐃᐧᑕᓄᑭᒪᒥᐣ ᑲᓇᑕ ᑭᒋ ᒪᐡᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᑭᒋ ᐊᐊᐧᓯᓯᐃᐧᑭᒪ ᒥᓇ ᐊᓂᓯᓂᓂᐃᐧ ᓂᑲᓂᑕᒪᑫᐃᐧᓇᐣ ᐊᓂᐣ ᑫᑭᑐᒋᑲᑌᑭᐸᐣ ᐁᑲ ᒥᓇᐊᐧ ᐅᐁᐧ ᒋᐃᔨᓴᐠ ᓂᑲᐣ ᑕᐱᓇᑲ ᑲᐃᐧᐣ ᒋᑭ ᐃᔨᓴᐠ ᒋᓀᐱᒋ ᒪᔨᓇᐦᐃᑫᔨᑐᔭᐣᐠ ᐅᐁᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ.

ᐊᓇᐃᐧᓂᑯ ᒪᐊᐧᐨ ᐁᐊᓂᒥᐃᐧᑐᔭᐣᐠ, ᓂᑌᐯᐧᑕᒥᐣ ᑲᒥᓇᐧᓯᐠ ᑫᑯᐣ ᐅᒪ ᒋᐅᐣᒋᓴᐠ. ᐅᑭᒪᑲᓇᐠ, ᑲᔦ ᑲᓇᑕ ᑭᒋ ᒪᐡᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ, ᑭᓇᐣᑐᑕᒪᐊᐧᐠ ᒋᑭᐁᐧ ᓇᓇᑲᒋᒋᑲᑌᐠ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᒥᓇ ᑲᓴᑲᐱᓀᐦᐃᐁᐧᒪᑲᑭᐣ ᑫᑯᓇᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᐅᒪ ᐅᐣᑌᐢᐃᔦ. ᐅᐁᐧ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ ᑲᐃᐧ ᐅᐣᒋ ᑐᒋᑲᑌᐠ ᐁᐃᐧ ᓇᓇᑲᒋᒋᑲᑌᑭᐣ ᒉᑲᐧᐨ ᑲᐱᒥᐃᐧᒋᑲᑌᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒋᑭᑭᓇᐊᐧᑌᐣᑕᑲᐧᑭᐣ ᑫᑯᓀᓇᐣ ᐃᐧᒋᐦᐃᐁᐧᒪᑲᓄᐊᐧᑫᐧᐣ, ᐊᐣᑎ ᑲᔦ ᑫᑭᓯ ᐊᓄᑲᑌᑭᐸᓂᐣ ᒋᑭ ᐅᓇᒋᑲᑌᑭᐸᐣ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧ ᒥᓄᔭᐃᐧᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᐅᒪ ᐅᐣᑌᐢᐃᔦ ᒋᑭ ᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᒥᓇ ᐊᓂᐣ ᑫᑐᒋᑲᑌᑭᐣ ᐁᑲ ᑭᒋ ᐃᔨᓴᑭᐸᓂᐣ ᐊᓂᒥᓴᐃᐧᓇᐣ ᐱᓂᐡ ᐃᐁᐧᓂᐊᐧᐣ ᑲᓯ ᑲᓇᐁᐧᐣᑕᑯᔨᐊᐧᐨ ᐊᐊᐧᓯᔕᐠ.

ᓂᑲᐣ ᑫᐊᓂᓯ ᐱᒋᓂᐡᑲᓂᐊᐧᐠ

ᒥᑕᐡ ᐁᑐᑕᒪᐣ ᐁᐱᒥ ᐊᐧᐅᓇᑐᔭᐣᐠ ᓂᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᐊᐧᓯᐨ ᑲᔦ ᒋᐊᓯᑎᓇᒪᐣᐠ ᒋᐃᐧᑕᓄᑭᒪᔭᐣᐠ ᑕᓯᑫᐃᐧᓇᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᑲᔭᑭᐣ ᒋᐅᐣᒋ ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᓇᓂᐊᐧᐠ ᐃᒪ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᒥᓇ ᑲᓴᑲᐱᓀᐦᐃᐁᐧᒪᑲᑭᐣ ᑫᑯᓇᐣ ᐅᒪ ᐅᐣᑌᐢᐃᔦ. ᒥᑕᐡ ᐅᑫᐧᓂᐊᐧᐣ:

- ᒋᐱᒥ ᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐨ ᑲᓴᑲᐱᓀᐦᐃᐁᐧᒪᑲᑭᐣ ᑫᑯᓇᐣ ᒥᓇ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧ ᐅᐃᐧᒋᐦᐃᑯᐃᐧᓂᐊᐧ ᑭᒋᔭᐦᐊᐠ ᐅᒪᒥᑎᓀᐣᒋᑲᓂᐊᐧ ᑲᓯ ᐊᑯᔨᐊᐧᐨ, ᒋᑭᑭᓄᐦᐊᒪᑲᓂᐊᐧᐠ ᒥᓇ ᒋᐅᓇᒋᑲᑌᐠ ᑫᐃᓇᑌᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᐃᐁᐧ ᑲᐃᓇᓄᑭᐊᐧᐨ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧᐣ ᒥᓇ ᑲᓴᑲᐱᓀᐦᐃᐁᐧᒪᑲᑭᐣ ᑫᑯᓇᐣ

- ᒋᐅᓇᒋᑲᑌᐠ 10 ᓂᐯᐃᐧᓇᐣ ᒋᐊᔭᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᑲᒥᐠ ᐅᐱᓯᑯᑲᐣ ᐃᐡᑯᓂᑲᐣ ᒋᓯ ᑕᑲᐧᐠ ᑫᓯ ᐱᒥᐃᐧᒋᑲᑌᐠ ᒥᑭᓇᑯᐡ – STAT ᐃᐧᒋᐦᐃᐁᐧᐃᐧᑲᒥᐠ

- ᒋᐅᐣᒋ ᐊᔭᒥᑕᒪᐊᐧᑌᑭᐣ ᑕᓯᑫᐃᐧᓂᐠ ᑲᔭᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒋᑭ ᒥᓇᑲᓄᐊᐧᐸᐣ ᐃᐧᒋᐦᐃᑯᐃᐧᐣ ᐃᒪ ᑫᐱᒥᓴᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᒥᓇ ᑫᓯᐱᒥᐃᐧᒋᑲᑌᐠ, ᐊᑯᔨᐃᐧᑲᒥᐠ ᒋᐅᐣᒋ ᓇᓇᑲᒋᐦᐊᑲᓄᐊᐧᐨ ᒥᓇ ᓴᑯᓇᐠ ᒋᒪᒥᓄᒪᑲᓄᐊᐧᐨ.

- ᒋᐅᓇᒋᑲᑌᐠ ᒪᒪᐤ ᐃᐧᑕᓄᑭᒥᑎᐃᐧᐣ ᐅᓇᒋᑫᐃᐧᐣ ᒋᐃᐧᑕᓄᑭᒪᑲᓄᐊᐧᐨ ᑕᓯᑫᐃᐧᓂᐠ ᑲᔭᑭᐣ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᒥᓇ ᐅᐣᑌᐢᐃᔦ ᑲᔭᑭᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧ ᐱᒧᒋᑫᐃᐧᓇᐣ (ᑐᑲᐣ ᑎᑭᓇᑲᐣ) ᐊᐊᐧᓯᒉ ᒋᒥ ᒥᓄᓴᑭᐸᐣ ᑲᓯ ᐱᒥᐃᐧᒋᑲᑌᐠ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ, ᒥᐦᐃᒪ ᑫᐊᓄᐣᒋ ᐃᔨᓴᐠ ᒋᑭ ᐃᐧᒋᐦᐊᑲᓄᐊᐧᐨ ᐅᑕᑯᔨᐠ.

- ᒋᐃᐧᒋᑕᐧᓂᐊᐧᐠ ᐃᒪ ᐅᐣᑌᐢᐃᔦ ᑭᐁᐧ ᓇᓇᑲᒋᒋᑫᐃᐧᐣ ᐃᒪ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᒥᓇ ᑲᓴᑲᐱᓀᐦᐃᐁᐧᒪᑲᑭᐣ ᑫᑯᓇᐣ ᐃᐧᒋᐦᐃᐧᐁᐧᐃᐧᓇᐣ, ᐃᐁᐧ ᒋᑲᑫᐧ ᑌᐱᓂᑲᑌᐠ ᒋᑭ ᐊᓂ ᐅᓇᒋᑲᑌᑭᐸᐣ ᑫᓯᐱᒥᐃᐧᒋᑲᑌᐠ ᒪᒥᑎᓀᐣᒋᑲᓇᐱᓀᐃᐧ ᒥᓄᔭᐃᐧᐣ ᑫᐃᐧᒋᐦᐃᑯᐊᐧᐨ ᑲᑭᓇ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᓇᐣ ᐃᒪ ᒉᑲᐧᐨ ᑲᐊᐸᑕᑭᐣ ᒥᓇ ᑫᐊᓂ ᐊᐧᐅᐡᑭ ᐅᓇᑌᑭᐣ ᑲᑭ ᑭᑭᓇᐊᐧᑌᐣᑕᑲᐧᑭᐣ, ᒋᑭ ᐅᐣᒋ ᒥᓀᐧᔭᐊᐧᐸᐣ ᐅᑕᑯᔨᐠ ᐅᒪ ᐅᐣᑌᐢᐃᔦ ᑲᔭᐊᐧᐨ.

Nodin Child and Family Intervention Services

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Kevin Berube, Director Of Treatment Services

Nodin Child and Family Intervention Services delivers mental health services for children, adults and families in the Sioux Lookout area First Nation communities. Services include; mental health counselling and assessments, early interventions, specialized clinics, cultural services support, crisis management support and special needs case management. Nodin also provides training and planning to support community-based staff.

Nodin's services are funded by the Ministry of Community and Social Services, Ministry of Children and Youth Services and Health Canada's First Nations and Inuit Health branch.

Our Partners

First Nation communities
Tribal Councils
Sioux Lookout Meno Ya Win Health Centre (SLMHC)
Nishnawbe-Aski Nation
Community Counselling and Addictions Services
Tikinagan Child and Family Services
Keewaytinook Okimakanak Telemedicine
Kinark Child and Family Services
Centre for Addictions and Mental Health
Ontario Sick Kids Telepsychiatry
Children's Mental Health Centre of Excellence – CHEO
Firefly Children's Mental Health

This year our accomplishments include:

- Facilitation of mental health first aid training to community resource staff and Nishnawbe Aski Nation resource staff
- Trauma team support in the communities of Pikangikum, Neskantaga and Mishkeegogamang
- Hiring of all of our Aboriginal Mental Health and Addictions Workers to work with the 13 communities identified by the Ministry of Children and Youth Services
- Completion of work with Pikangikum on developing a community case management model and community resource map
- Completion of a needs assessment and feasibility study to develop a Child and Youth Advocacy Centre to serve the First Nation communities in the Sioux Lookout area
- Support for SLMHC to provide after-hours counselling coverage to high risk patients
- Provision of crisis response services to 61 requests from the communities served

Mental Health Services

In the 2013/14 service year, counselling services, specialty clinics and cultural support responded to the mental health needs of 5,370 clients. Apart from the aforementioned counselling services, Nodin's crisis response services worked with an additional 4,831 clients.

Our area teams provide ongoing counselling support to clients in the northern communities. This past year, we provided service to 1,909 clients. Of the 1,909 clients served, 567 of these clients were seen through our acute care services. Many of the clients referred to acute care services are referred for follow-up in their home communities and are then seen by either a Nodin counsellor or the community mental health worker.

Our specialized services (psychology, psychiatry, expressive arts therapy) provided assessments, direct clinical service or client consultation to 585 clients in this year. Many of these clients will be referred to ongoing services through our mental health counsellors after the initial services have been conducted. Our specialized services also conduct group sessions for debriefing or grief processing. In addition, our specialized services will conduct training sessions for our counselling staff upon request.

Our cultural services team provided services to 2,876 clients in this service year. Our cultural services team provides a variety of services including: sweat lodge ceremonies, name giving ceremonies, sharing circles, memorial feasts, residential school survivor support, smudging ceremonies, educational sessions on medicinal plants, abuse/victim support and grief/loss support. Our cultural services team does open and carry client files, but responds to requests for support by individuals or the community.

The Wee Chee Way Win crisis line, based in Wunnumin Lake, is a crisis line funded by the Ministry of Children and Youth Services to provide telephone crisis response services to the communities we serve. In the past service year, the crisis line provided telephone crisis services to approximately 150 clients resulting in 54 hours of recorded service. The crisis line has not received calls from the child and youth population in our area. The Ministry of Children and Youth Services (MCYS) funds this service for the 0 - 17 age group, therefore MCYS believes the crisis line funding should be utilized differently so it could be responsive to the child and youth population.

Nodin's crisis response service responded to 61 requests for crisis response services from 26 of the 30 communities we work with. We deployed 63 crisis teams and 271 crisis counsellors in response to crisis requests. Crisis services saw 4,831 clients. This past service year has been our busiest on record since taking

crisis services from Health Canada – NIHB. Responding to all of the requests for crisis support had put our overall services in deficit. Each year, we receive $650,000 from Health Canada to provide crisis support. In this past year, our operational costs in the crisis department reached $1.6 million. We are working with Health Canada and our communities to come up with solutions to provide crisis response in a way that ensures the crisis funds will be sustainable each year.

Children's Mental Health and Addictions Services

Nodin CFI receives resources for 13 children's mental health and addictions workers. The direction from the Ministry of Children and Youth Services (MCYS) is that these positions are to be filled within the community that has been identified by MCYS. The communities are: Aroland, Kitchenuhmaykoosib Inninuwug, Cat Lake, Eabametoong, Kasabonika, Marten Falls, Mishkeegogamang, Neskantaga, Pikangikum, Poplar Hill, Sandy Lake, Summer Beaver and Webequie. This past year, we had filled the 13 positions. We have had some turnover in staffing throughout the year, but the positions are now established in each of the communities that were identified. We are working with the Centre for Addictions and Mental Health to develop training modules for these workers.

Mikinakoos – Short Term Assessment and Treatment Unit

The Mikinakoos – STAT unit program has been suspended for the past year as SLFNHA consults with Lac Seul First Nation to build a new facility that the program can operate out of. The program suspended operations in April 2013, as building inspection found mold in the basement. It was decided to wait until a proper building could be identified for the program as there had been issues with the size of the original building to operate the program effectively.

	2009-10	2010-11	2011-12	2012-13	2013-14
Counselling	1,006	2,798	2,888	1,443	1,909
Specialty Clinics	215	473	526	647	585
Cultural Services	2,853	2,500	2,452	1,780	2,876
Total # of Clients Seen	4,074	5,771	5,866	3,870	5,370

Crisis	Description	2009-10	2010-11	2011-12	2012-13	2013-14
Suicide	**Completions**	14	10	12	12	16
	Attempts	103	78	91	73	97
Crisis Responses		58	55	50	46	61

Current Projects

Nodin – Pikangikum Project

Nodin completed a three-year project with Pikangikum First Nation through a partnership with a clinical research and evaluation team to work with the Pikangikum resource staff in the areas of community engagement, training and development of community resource workers, development of a community case management model and evaluation of the project. A community resource map and service coordination mapping for mental health were developed for the community staff so they had a clear idea of how to access the different mental health and addictions resources available to community members. The work with the mental health and addictions services in Pikangikum continues even though this project is complete.

Trauma Teams

Sioux Lookout First Nations Health Authority has been deploying trauma teams in the communities of Pikangikum, Neskantaga and Mishkeegogamang. The purpose of the trauma teams is to work alongside the community resources to address the impact of current and historical trauma felt by community members. The trauma teams will continue to operate until the end of September 2014. The trauma team clinicians are referring cases to existing services in the community (Nodin, community mental health) to follow up on the work they have been doing in these communities. To date, the trauma teams have worked with over 1,600 community members from these three communities.

Child and Youth Advocacy Centre

The needs assessment and feasibility study has been completed to identify a child and youth advocacy centre that would serve the First Nation communities in the Sioux Lookout area. A child and youth advocacy centre is a service that provides a child-friendly environment to work with child victims of crime. The centre brings together all of the services that would work with child victims (health services, mental health services, child welfare, police, crown attorney) to organize their efforts so that the least amount of trauma is incurred by the child from the process of gathering information in a criminal case. It also ensures that timely supports are in place for the child victim.

The project was funded by the Department of Justice, Ministry of the Attorney General – Ontario Victims Service Secretariat. The information from the study is being sent to the Department of Justice as a Phase 1 project. Phase 2 of the project would focus on the development of a centre in the region. Another proposal is required for consideration of Phase 2 funding.

Challenges

Providing crisis response services has created a deficit for Sioux Lookout First Nations Health Authority.

We managed to reduce the deficit through a re-distribution of administration funds, but we weren't able to erase the deficit. We have been communicating with Health Canada, MCYS and the First Nations leadership about ways we can prevent this from happening in the future because we can no longer continue to incur deficits in crisis response.

Although this has been a challenge for us, we believe that something good is coming out of this. The Chiefs, along with Health Canada, have requested a review of mental health and addictions services in the region. The review intends to look at existing services to identify what's working, where the gaps are and where we need to go to build a mental wellness continuum for the region that ranges from education and prevention to residential services.

Moving Forward

Our efforts to continue to develop our services also include efforts to work with community services in a collaboration to build capacity in mental health and addictions in the region. Our efforts include:

- Continued partnership with the Centre for Addictions and Mental Health for adult psychiatric support service, training opportunities and development of module training for mental health and addictions workers.
- Planning for a 10-bed facility to be built on Lac Seul First Nation for the Mikinakoos – STAT unit program
- Advocacy for community services to receive support in the areas of ongoing training and development, clinical supervision and regular debriefing.
- Structured case-management planning with community mental health services and regional services agencies (ie. Tikinagan) to improve service coordination, which leads to more positive client outcomes.
- Participation in a regional review of mental health and addictions services, with an aim to develop a complete mental wellness continuum that supports all of the services through existing and new structures identified, to improve client service outcomes in the region.

Staff at SLFNHA's Nodin CFI site. Back row, from left: Brenda Morison, Wava Fox, Ann McDonald, Violet Tuesday, Sara Rea, Stephen Edwards, Leanna Trout, Brian McIvor, Norman Barratt, Vincent Ostberg, Brian Logan, Tom Chisel, Hilda Derose, Walter Lyon, Dave Poulin, Ravin Walker and David Segerts. Front row, from left: Lyn Manitowabi, Jennifer Beaver, Nicole Anderson, Susan Barkman, Melenie Cheesequay, Annie Capay, Linda Magotte, Dorothy Ross, Trish Hancharak, Rose Gunderson and Raye Landry.
Missing from photo: Kevin Berube, Doris Dematos, Tina Jacobson, Marilyn Lewis, Marion Morris, Patti Roussin, Mary Jane Chisel, Bob Smith, Stephanie Kitchkeesick, Marjorie Griffiths, Donna Roundhead, Dean Cachagee, Seegwun Morris, Florence Bouchard, Maxine Poulin, Aaron Therriault, Glenda Meshake, Cathy Therriault, Brent Beardy, Mary Childsforever, Bertha Quisses, Christine Ostomas, Jeff Lewis, Joseph Missewace, Angeline Wassaykeesic, Rhonda Goodman and Beulah Wabasse.

SLFNHA's Primary Health Care Unit staff. Front row, from left: Sue Haukeness and Jeanette Wisnoski. Second row, from left: Michelle Farlinger, Mary Ombash, Trina Kakekagumick, Charlie Binguis, Cindy Wilson, Mary-Ann Beardy, Dennis Dumphy, Stephanie Bandola and Alice Dodsworth. Missing from photo: Joanie Gulka and Penny Bergman.

SLFNHA's Health Services staff at the 61 King Street site. From left: Paddy Dasno, James Bergman, Janine Arpin, Kelly McIntosh, Donna Morris, Ann Cleland, Tina Quequish, Christine Sawanas and Hana Beitl. Missing from photo: Susan Chapman.

SLFNHA's Finance Staff. From left: Laureen Machimity, Angela Madussi, Judy Buchan, Carolyn Horbas, Linda Bourrier, Joanne Mainville, Delaine Fiddler, Audry Trimble and Aalayiah Nestrovich. Missing from photo: Evangeline Kanakakeesic.

Staff at SLFNHA's main Administrative Building (61 Queen Street). Back row, from left: Maureen Chabbert,Emily Paterson, Cheryl Otis, Suzanne Snow, Bobbi Christink, Georgina Chapman and James Morris. Middle row, from left: Cindy Moffat, Irene Dube, Dorothy Binguis, Christine Chisel and Serena Kenny. Front row, from left: Brent Wesley, Charlene Samuel, Janet Gordon, Star Mamakwa and Crystal Brown. Missing from photo: Rod Horsman, Pierre Parsons, Chris Duval, Kadey Kennedy, April Derouin, Alyssa Pronger, Charlene Dyment, Terri Farrell and Jamie Sitar

ᑲᐃᐧᑕᓄᑭᒥᐁᐧᐊᐧᐨ ᒥᓇ ᔓᓂᔭᓇᐣ ᑲᐸᑭᑎᓇᐊᐧᐨ

ᐃᑫᐧᓂᐊᐧᐠ SLFNHA ᑲᐊᐱᑕᒪᑫᐊᐧᐨ, ᑲᐅᑭᒪᐊᐧᑭᓯᐊᐧᐨ ᒥᓇ ᐊᓂᑭᓇᑲᓇᐠ ᓄᐃᐧ ᓇᓇᑯᒪᒥᐣ ᑲᐃᐧᑕᓄᑭᒪᐁᐧᐊᐧᐨ ᒥᓇ ᔓᓂᔭᓇᐣ ᑲᐸᑭᑎᓇᐊᐧᐨ ᐅᒪ.

ᐊᓂᔑᓂᓂᐃᐧ ᒥᓄᔭᐃᐧᐣ & ᒥᓄᐱᒪᑎᓯᐃᐧᐣ ᐅᓇᒋᑫᐃᐧᐣ
ᐊᑦᑕᐧᐠᐡ
ᑲᐢᑲᐱᓇᓂᐁᐧᒪᑲᐠ ᒥᓇ ᒪᒥᑎᓃᐣᒋᑲᓇᐱᓃᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᑲᒥᐠ
ᐅᑭᒪᑲᓇᐠ ᑲᐊᐱᑕᒧᐊᐧᐨ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ
ᐅᐣᑌ≥ᐃᔦ ᐅᑭᒪᑲᓇᐠ
ᐊᐊᐧᔑᔕᐠ ᒪᒥᑎᓃᐣᒋᑲᓇᐱᓃᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᑲᒥᐠ
ᐊᐊᐧᔑᔑᐃᐧ ᐊᑯᓯᐃᐧᑲᒥᐠ ᔕᐧᐊᓄᐠ ᐅᐣᑌ≥ᐃᔦ
ᐸᔦ≥ᐱ≥ᐊᔾ
ᐊᓂᔑᓂᓂᐃᐧ ᑎᐯᐣᒋᑫᐃᐧᓇᐣ ᑲᐅᐣᒋ ᓇᓇᑲᒋᑐᐊᐧᐨ ᒪᐡᑭᑭᐃᐧᓂᓂᐊᐧᐠ ᒥᓇ ᒥᓄᔭᐃᐧᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ
ᑲᓇᑕ ᐊᑯᓯᐃᐧ ᐧᐃᒋᐦᐃᐧᐁᐧᐃᐧᐣ - ᐊᓂᔑᓂᓂᐊᐧᐠ & ᐃᓄᐃᐧᐟ ᒪᐡᑭᑭᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ
ᐦᔦ ᐊ≤ᐊᐣ ᒪᐡᑭᑭᐃᐧᑲᒥᐠ ᑎᐯᐣᒋᑫᐃᐧ ᒥᓄᔭᐃᐧᐣ ᑲᐅᐣᒋ ᓇᓇᑲᒋᑐᐊᐧᐨ
ᑭᐁᐧᑎᓄᐠ ᐅᑭᒪᑲᓇᐠ ᑌ≤ᐃᒪᐡᑭᑭ
ᑭᓇ≥ᐊᐠ ᐊᐊᐧᔑᐡ ᒥᓇ ᑎᐯᐣᒋᑫᐃᐧᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ
ᒪᐡᑭᑭᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ ᑲᐅᐣᒋ ᒪᒪᐃᐧ ᐱᒧᒋᑲᑌᐠ
ᐊᓂᔑᓇᐯ ᐊᐡᑭ
ᑭᐁᐧᑎᓄᐠ ᓃᐣᑲᐱᐦᐊᓄᐠ ᒥᓄᔭᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ
ᑭᐁᐧᑎᓄᐠ ᓃᐣᑲᐱᐦᐊᑲᓄᐠ ᐱᒋᐳᐊᐧᐱᓃᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ
ᑭᐁᐧᑎᓄᐠ ᐅᐣᑌ≥ᐃᔦ ᒪᐡᑭᑭᐃᐧ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ
ᐅᐣᑌ≥ᐃᔦ ᐊᐊᐧᔑᔕᐠ ᒪᒥᑎᓃᐣᒋᑲᓇᐱᓃᐃᐧᐣ ᒪᓯᓇᑌᓯᒋᑲᓂᐠ ᑲᐱᒧᑐᐊᐧᐨ
ᐅᐣ≥ᐃᔦ ᑎ≥ᐃ≤ᐃᔭᑦ ᔓᓂᔭᓇᐣ ᑲᐸᑭᑎᓇᐊᐧᐨ
ᐅᐣᑌ≥ᐃᔦ - ᑭᒋᐊᔕᒥᑎᐃᐧᑭᒪ
ᐅᐣᑌ≥ᐃᔦ - ᑭᒋ ᐊᐊᐧᔑᔑᐃᐧᑭᒪ
ᐅᐣᑌ≥ᐃᔦ - ᐅᑭᒪᐃᐧᐣ ᒥᓄᔭᐃᐧᐣ & ᑭᓄᐊᐧᑲᐡ ᑲᐱᒪᓄᑲᑌᐠ ᐊᑯᓯᐃᐧ ᐸᒥᐦᐃᑯᐃᐧᐣ
ᐊᐧᓂᓇᐊᐧᑲᐠ ᑌᑎᐸᐦᐃ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑲᐧᑭᐣ ᐃᐡᑯᓂᑲᓇᐣ
ᐊᐧᓂᓇᐊᐧᑲᐠ ᑲᐅᐣᒋ ᑎᐯᐣᑕᑲᐧᑭᐣ ᓂᑲᓂᑕᒪᑫᐃᐧᓇᐣ
- ᑲᑎᐸᓂ ᐱᒧᓂᑎᓯᐊᐧᐨ
- ᑭᐧᐁᑎᓄᐠ ᐅᑭᒪᑲᓇᐠ
- ᒪᑕᐊᐧ ᐊᓂᔑᓂᓂᐃᐧᑭᒪᐃᐧᐣ
- ᔑᐸᐧᑲᒪ ᐅᑭᒪᑲᓇᐠ
- ᐃᐧᐣᑎᑯ ᐅᑭᒪᑲᓇᐠ
ᐊᐧᓂᓇᐊᐧᑲᐠ- ᐦᐊᐟᓯᐣ ᐅᒪᑲᑎᐢᐣ ᑲᐃᐧᒋᐦᐊᐊᐧᐨ
ᐊᐧᓂᓇᐊᐧᑲᐠ ᒥᓄᔭᐃᐧᐣ ᐊᑯᓯᐃᐧᑲᒥᐠ
ᐊᐧᓂᓇᐊᐧᑲᐠ ᒥᓄᔭᐃᐧᐣ ᐊᑯᓯᐃᐧᑲᒥᐠ– ᒪᒥᑎᓃᐣᒋᑲᓇᐱᓃᐃᐧᐣ ᒥᓇ ᑲᐢᑲᐱᓃᐦᐃᐁᐧᒪᑲᐠ ᑫᑯᓇᐣ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ
ᐊᐧᓂᓇᐊᐧᑲᐠ ᐊᒥᐦᐊᐃᐧᐣ ᑲᐊᐱᑕᒧᐊᐧᐨ
ᐊᐧᓂᓇᐊᐧᑲᐠ ᒪᐡᑭᑭᐃᐧᐱᒧᒋᑫᐃᐧᐣ
ᓯ≥ᐃ ᐱ≤ᐁᐡ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᑲᒥᐠ
ᑎᑭᓇᑲᐣ ᐊᐊᐧᔑᔕᐠ ᒥᓇ ᑎᐯᐣᒋᑫᐃᐧᐣ ᐱᒧᒋᑫᐃᐧᐣ
ᑕᐣᑐ≥ ᐯ ᐊᑯᓯᐃᐧ ᐱᒧᒋᑫᐃᐧᐣ
ᑲᑭᒋᐡᐸᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᑲᒥᐠ ᐊᑯᓯᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ
ᑲᑭᒋᐡᐸᐠ ᑭᑭᓄᐦᐊᒪᑫᐃᐧᐣ ᑐ≥ᐊᐣᑐ ᑭᐊᐧᐡᑫᔭᐱᓃᐃᐧ ᐃᐧᒋᐦᐃᐁᐧᐃᐧᐣ ᑲᐱᒧᑐᐊᐧᐨ

Our Partners and Funders

The SLFNHA Board of Directors, management and staff extend our appreciation to our partners and funders for their contributions.

- Aboriginal Healing & Wellness Strategy
- Amdocs
- Centre for Addiction and Mental Health
- Chiefs Committee on Health
- Chiefs of Ontario
- Children's Hospital of Eastern Ontario
- Firefly Children's Mental Health
- First Nations Family Physicians and Health Services
- Health Canada - First Nations & Inuit Health Branch
- The Hospital for Sick Children (SickKids) - Telepyschiatry
- Hugh Allen Clinic Family Health Group
- Keewaytinook Okimakanak Telemedicine
- Kinark Child and Family Services
- Local Health Integration Network
- Nishnawbe Aski Nation
- The Northern Psychiatric Outreach Program at the Centre for Addiction and Mental Health (formerly known as University of Toronto Psychiatric Outreach Program)
- Northwestern Health Unit
- Northwestern Ontario Infection Control Network
- Northern Ontario School of Medicine
- Ontario Centre of Excellence for Child and Youth Mental Health
- Ontario Trillium Foundation
- Province of Ontario - Ministry of Community & Social Services
- Province of Ontario - Ministry of Children and Youth Services
- Province of Ontario - Ministry of Health & Long Term Care
- Sioux Lookout area First Nations
- Sioux Lookout area Tribal Councils
  - Independent First Nations Alliance
  - Keewaytinook Okimakanak
  - Matawa First Nations Management
  - Shibogama First Nations Council
  - Windigo First Nations Council
- Sioux Lookout-Hudson Association for Community Living
- Sioux Lookout Meno Ya Win Health Centre
- Sioux Lookout Meno Ya Win Health Centre - Community Counselling and Addiction Services
- Sioux Lookout Pastoral Care Committee
- Sioux Lookout Regional Physicians Services Inc.
- Surrey Place Centre
- Tikinagan Child and Family Services
- Thunder Bay District Health Unit
- University Health Network

Sioux Lookout First Nations Health Authority

View our past Annual Reports, Chief's Resolutions, Upcoming Events and Career Opportunities online, anytime!

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