Sioux Lookout
First Nations
Health Authority

Community Wellbeing Facilitator Program Evaluation Report

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Ownership

The data in this report is owned collectively by the First Nations in the Sioux Lookout area with SLFNHA acting as their data steward.

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For Further Inquiry

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Acronyms/Abbreviations

ACW	Approaches to Community Wellbeing
CWF	Community Wellbeing Facilitator
IFNA	Independent First Nations Alliance
KO	Keewaytinook Okimakanak
MOHLTC	Ministry of Health and Long-Term Care
SLFNHA	Sioux Lookout First Nations Health Authority

Executive Summary

Background: Sioux Lookout First Nations Health Authority (SLFNHA) has been implementing a community-based health model called the Community Wellbeing Facilitators (CWFs) program since 2017. The role of the program is to help communities determine the structure and programs for Approaches to Community Wellbeing (ACW); liaise with Tribal Councils and communities; and maintain a close working relationship with SLFNHA to help address community-based health needs and priorities.

Aim: This evaluation aimed to identify the successes and challenges of the CWF program. The findings would help improve the CWF program performance at the community level.

Methods: We used a qualitative evaluation method consisting of conducting key informant interviews and a review of the CWF program documents. The method focused on program relevance and design, program implementation, and program effectiveness and efficiency.

Findings: In the initial stage, the CWF program had some achievements. The program was able to establish an effective relationship with communities, participate in community health planning and various public health activities, and create opportunities for culturally sensitive services in the community. However, the CWF program could not keep the momentum. Gradually, the program has faced various challenges, especially funding gaps; high turnover of CWFs; COVID-19; and limited capacity in managing the CWF program including delays in submitting work plans, signing agreements, and hiring CWFs.

Recommendations: SLFNHA should conduct a discussion with Tribal Councils and independent communities on how to improve the CWF program implementation; ensure long-term funding; develop sufficient capacity in contract management, finance management, and program monitoring; integrate the program into the ACW model; add more CWFs based on the need of communities; deploy a CWF program coordinator; and direct more resources toward training to upgrade the knowledge and skills of CWFs and Health Directors. Tribal Councils and independent communities should provide timely work plans to prevent any delays in funding and agreements processes, use the CWF program funds only for the CWF program activities; give priority to the recruitment of CWFs; use SLFNHA capacity in advertising and processing the recruitment of CWFs if needed; and strengthen partnership with SLFNHA in all aspects of the CWF program.

Conclusion: Despite significant challenges, this evaluation found the CWF program is a suitable community-based health model with immense potential to emerge as an essential element of ACW. Thus, SLFNHA in partnership with Tribal Councils and independent communities should improve the CWF program performance based upon the findings of this evaluation and enhance jointly with the program's reach and effectiveness.

Contents

1. Background

In response to the Anishinabe Health Plan (2006) and growing concerns over the lack of preventative health services in communities, in 2015, the Sioux Lookout First Nations Health Authority (SLFNHA) developed a public health model named the "Approaches to Community Wellbeing" (ACW). The model was developed through a community consultation process based on the needs of 31 First Nations communities. The model represents a wholistic view of health approach that is flexible and better adapted to First Nations communities. The vision of the model is that the "Anishinabe people of this land are on a journey to good health by living healthy lifestyles rooted in our cultural knowledge." [1]

To improve the ACW program implementation and help provide further support to First Nations communities, ACW, in addition to other programs, has been implementing a community-based health model called the Community Wellbeing Facilitators (CWFs) program since 2017.

The role of the CWF program is to help communities adapt the model at the community level. This includes determining the structure and programs for ACW; liaising with Tribal Councils and communities; and maintaining a close working relationship with SLFNHA to help address community needs and priorities.[2]

CWFs are directly accountable to Health Directors. CWFs provide support to Health Directors to: assess the current state of public health services; attend regular planning, networking, and training sessions with SLFNHA; develop reports and recommendations on public health issues based on community feedback; act as focal points for communication for ACW staff visiting communities; develop relationships with internal and external organizations; and maintain a profile of community information and key contacts related to community wellbeing.[2] A copy of the CWF job description is provided in Appendix 1.

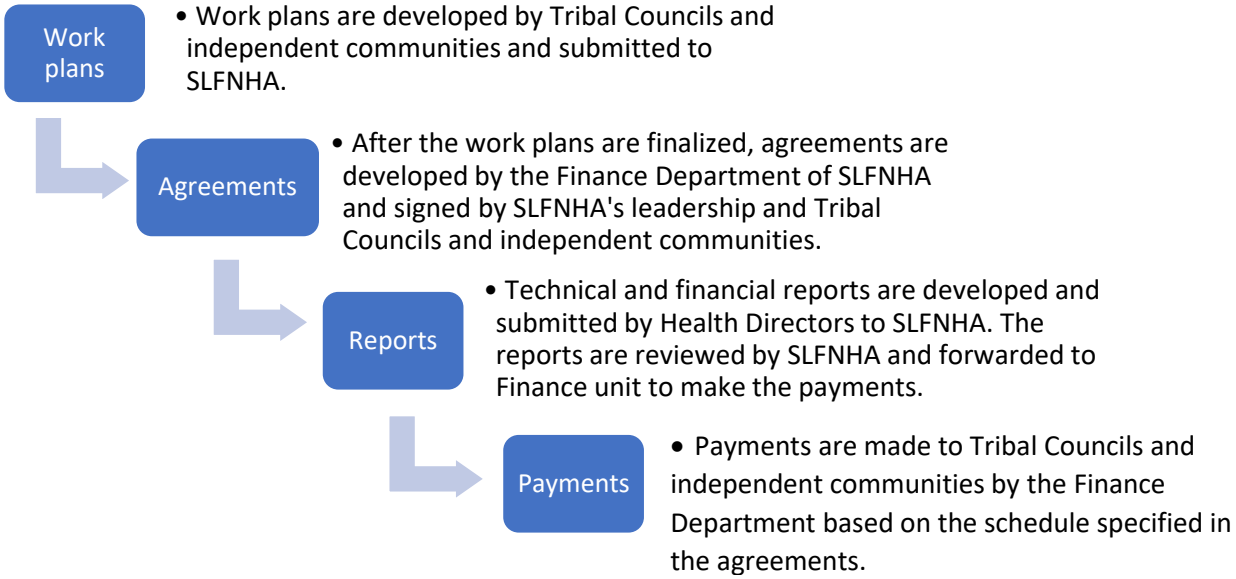
Tribal Councils and independent communities are responsible for the CWF program implementation. They are also responsible for the CWF program budget. They ensure the health and safety of CWFs and provide office space for CWFs.[3]

SLFNHA's role is to provide funding, overall program direction, and technical expertise to the CWF program at each Tribal Council and independent community level. SLFNHA is also responsible to provide support in the form of coordinated meetings with CWFs and Health Directors to maintain communication between CWFs, Health Directors, and SLFNHA. The Health Planner position at Roots for Community Wellbeing program, ACW, is responsible for providing technical support to CWF program as part of their role. SLFNHA is also responsible for the capacity development of CWFs by providing training opportunities and workshops for them.[4]

Since the establishment of the program, Tribal Councils and independent communities are required to develop work plans to enable SLFNHA to provide agreements and funds to them. Payments to Tribal Councils and independent communities were subject to the submission of

technical and financial reports. A copy of the activity report template is provided in Appendix 2. Figure 1 shows the working procedure regarding the work plans, agreements, reports, and payments.

Figure 1. Working procedure between SLFNHA and Tribal Councils & independent communities



In mid-November 2022, SLFNHA brought changes in the procedure to speed up the process of developing agreements and transferring funds to Tribal Councils and independent communities. The modified procedure allows the SLFNHA Finance Department to be directly involved in communication with community Health Directors to finalize agreements, receive financial reports, and transfer funds to Tribal Councils and independent communities.[5] Initially, the point of contact was only the Roots for Community Wellbeing program of ACW.

A study of the ACW program conducted in 2020 found that the CWF relationship with SLFNHA and communities was crucial to successful outreach and effective communication. The role of CWFs were viewed as being essential in improving the relationship between SLFNHA and the communities they serve. The study identified the need for ongoing investment in the CWF program to further improve relationships with First Nations communities.[6]

2. Objectives

This evaluation aimed to identify the successes, weaknesses, and challenges of the CWF program. The findings would help improve the CWF program performance at the community level.

3. Methods

We used an approach to CWF program evaluation, which strived to be practical and useful for CWF program *(relevant)* and resulted in program improvement *(action-oriented*).

The target population for the CWF program was 7 Tribal Councils and independent communities of the 31 First Nations communities in the Sioux Lookout region served by SLFNHA's ACW program. Table 1 shows the list of Tribal Councils, independent communities, and 31 First Nations Communities.[7]

Table 1. Tribal Councils and First Nations communities

No	***Tribal Councils and Independent Communities***	***First Nations Communities***
1	Independent First Nations Alliance **(**IFNA)	Pikangikum
		Kitchenuhmaykoosib Inninuwug
		Muskrat Dam
		Lac Seul
2	Keewaytinook Okimakanak (KO)	Deer Lake
		North Spirit Lake
		Poplar Hill
		Keewaywin
		McDowell Lake
		Fort Severn
3	Matawa First Nations Management	Nibinamik
		Webequie
		Eabametoong
		Neskantaga
4	Mishkeegogamang Ojibway Nation	Mishkeegogamang
5	Sandy Lake First Nation	Sandy Lake
6	Shibogama First Nations Council	Kasabonika
		Wapekeka
		Wunnumin
		Kingfisher Lake
		Wawakapewin
7	Windigo First Nations Council	Bearskin
		Sachigo
		North Caribou Lake
		Slate Falls
		Cat Lake
		Koocheching

To evaluate the program, we used a qualitative evaluation method consisting of conducting key informant interviews and a review of the CWF program documents.

The method involved capturing respondents' perceptions of CWF program successes, challenges, and weaknesses that were experienced during the CWF program implementation. The method focused on the following thematic areas: program relevance and design; program implementation; and program effectiveness and efficiency. 'Relevance and design' questions gave clarity on the need for the program and will help to make design adjustments. Implementation questions helped to identify strengths and challenges of program delivery. 'Effectiveness and efficiency' questions considered what has been achieved and level of resource used (Appendix 3) to provide a better idea on resource allocation and use in the future.

We sought voluntary informed consent from respondents and assured anonymity and confidentiality. We consensually recorded interviews to provide complete data for analysis. We destroyed recorded interviews as soon as they were transcribed. We assigned all interviews codes to ensure anonymity when citing quotations (Annex 4). Data were stored on the ACW secure drive.

We interviewed 7 respondents consisting of current and former CWFs, Health Directors, and SLFNHA staff (Table 2). The number of interviews was based on the notion of 'saturation as a foundation', which was the point at which the data collection process no longer offered any new or relevant data. The average length of interviews was 60 minutes.

In addition, we reviewed the CWF program documents such as agreements, technical and financial reports, and meeting minutes.

Table 2. Key respondents

	SLFNHA staff	***CWF***	***Health Director***
Respondents	3	2	2

We transcribed and analyzed qualitative data manually. We undertook a 'content analysis' approach to analyze the presence, meaning and relationships of certain issues, elements, themes, and outcomes. In 'content analysis', the key issues, core elements, and shared outcomes were considered and analysed .[8] We identified and highlighted topics and concepts and placed them in the classification of association. We selected representative quotes and anonymously allocated them to relevant classifications. We described common viewpoints. Finally, we developed interpretations of the data to address the purpose of this evaluation.

Additionally, we estimated the financial costs of implementing the CWF program. The CWF program financial costs were obtained from the program accounts and financial reports.

4. Findings

The key findings from the CWF program evaluation are presented in three broad themes based on the evaluation objectives and design: (i) relevance and design; (ii) implementation; (iii) and effectiveness and efficiency of the CWF program.

4.1 Program Relevance and Design

The CWF program was developed by a working group consisting of SLFNHA, a Tribal Council, and two Health Directors to increase direct communication with Tribal Councils and communities and to adapt the ACW model to the community.[9]

Our findings show that the CWF program was a relevant intervention. Respondents believed that the CWF program enabled a new way to strengthen the ACW model and by ensuring that Tribal Councils and independent communities were engaged in decisions regarding their health and wellbeing.

> *"When the CWF role was established, we looked for people who were from the community, who could speak the language, and who could support the development of public health at the community level – sort of building relationships with Tribal Councils. We were hoping that CWFs would be engaged and committed to the ACW model, which was designed through community involvement." [Interview 1]*

All study respondents acknowledged the need for the CWF program to build a meaningful relationship with communities and help enhance public awareness around public health issues.

> *"The CWF program collaborates with communities, identify what their needs are, and find out how to help them." [Interview 6]*

> *"This is a public health program to improve preventive measures in our communities. I should say, there are different areas that the program helps like safe communities, preventing infectious disease, mental wellness, youth wellness, and family wellbeing." [Interview 5]*

Most of the study respondents indicated that the CWF program was appropriately designed, and it brought forward a perspective of the needs of First Nations communities.

> *"The program was designed for First Nations sovereignty and community ownership, which is in line with the ACW values that were decided by the communities. It was designed to meet the needs and the request of the communities." [Interview 2]*

Respondents also explained that the CWF program was designed to be a flexible model to serve each community according to their needs.

> *"The intended outcome of the program is to have a strong Approach to Community Wellbeing adapted to the communities needs. That would differ across communities based on what their priorities are. Some communities might focus more on 'Safe Communities' or look at environmental concerns or emergency preparedness. Some communities might be more interested in 'Raising our Children', ensuring that children are brought up with healthy relationships and healthy development." [Interview 4]*

Respondents were satisfied about the CWF program approach to develop the capacity of CWFs. Respondents explained that the design of the program allowed SLFNHA to provide orientation sessions to CWFs. SLFNHA also enrolled new CWFs in some training courses such as a facilitation course offered by SLFNHA in partnership with the Winnipeg Transition Centre, first aid, opioid overdose prevention, community comprehensive planning, and courses in partnership with the First Nations Health Managers Association.

> *"SLFNHA will provide an orientation to the organization itself, the Community Wellbeing Project, and public health. Information will be provided with scenarios to help the Community Wellbeing Facilitators understand the roles of the provincial and federal government".* [3]

On the other hand, many respondents felt that the number of CWFs employed was limited compared to the needs of communities. They believed that the community population size should be used as a yardstick in deciding the number of CWFs for each Tribal Council and independent community. They thought that at least two CWFs were needed for each Tribal Council and independent community to improve access to the program, and ensure timely services were offered to communities in need. They also thought that having an experienced CWF at the SLFNHA level to coordinate all CWF activities, link the CWFs with each other and SLFNHA units, and provide timely support to CWFs would have given a better design to the program.

> *"If there was one more CWF at the community level or at the SLFNHA office, the implementation would have been much better, the pace would have been faster. Though the support system to CWFs is extremely helpful, having one more CWF would have made a big difference." [Interview 7]*

4.2 Program Implementation

SLFNHA signed the first agreements with Independent First Nations Alliance (IFNA), Keewaytinook Okimakanak (KO) First Nations, Matawa First Nations Management, Shibogama First Nations Council, Windigo First Nations Council, Mishkeegogamang Ojibway Nation, and

Sandy Lake First Nation in late 2017. However, the agreement came into effect from April 1st, 2017, onward.[10]

Most respondents believed that the program got off to a bad start. They expressed their concern of significant delays in program implementation in the initial stage of the program at different levels. Reviewing the CWF program documents, we confirm the delays that led to a setback at the start of the program and some interruptions and inconsistencies during implementation of the program. Our findings show that in July 2016, the Ministry of Health and Long-Term Care (MOHLTC) pledged funding for the CWF program.[9] However, the funds were not made available until early 2017. SLFNHA informed the 5 Tribal Councils and 2 independent communities that they could start the program and hire CWFs, while SLFNHA would fund the positions (retroactively) as soon as the funding was released. IFNA[11] and KO[12] completed the CWF hiring process in early 2017. Windigo[13], Matawa[14], Sandy Lake[15], Mishkeegoamanag[16], and Shibogma[17] postponed the hiring process until late 2017.

> *"Our first agreement was for three years, but we didn't get the funding until February of the first year. We started falling behind schedule. We had verbal confirmation that the funding was coming, so we wrote a letter to each Tribal Council and said that we intend to fund the program for you; feel free to get started if you could manage it. We said that when we get the agreement, we'll fund you for this. Some Health Directors or Tribal Councils decided to risk manage that and recruit CWFs." [Interview 2]*

Other than the challenges from the funder, there were also delays resulting from the Tribal Councils and independent communities and SLFNHA.

At the level of Tribal Councils and independent communities, there were significant delays in terms of submitting work plans to SLFNHA. To avoid dictating program requirements, SLFNHA required a work plan from Tribal Councils and independent communities. Funding agreements could not be developed until these were received. SLFNHA's recent communications with Tribal Councils and independent communities demonstrated that there has been over 5 months of delay in receiving work plans from Health Directors in spite of sending several reminders to them.[18,19] Consequently, there have been extensive delays in signing agreements between SLFNHA and Tribal Councils and independent communities. As of November 30, 2022, only four agreements have been signed for IFNA, KO, Matawa, and Sandy Lake. Windigo has not submitted a work plan; therefore, they have not been provided with a CWF program agreement yet for the 2022-2023 fiscal year. Mishkeegogamang and Shibogama have postponed the submission of work plans until the next fiscal year due to competing priorities.[10]

Our findings also revealed that there have been some delays by SLFNHA in developing agreements for Tribal Councils and independent communities in the initial stage of the program and later in renewing the agreements.

"There have been some delays on SLFNHA finance side. When the funding was available, there was no reason not to give Tribal Councils funding agreements till October or November. The agreements should have been in place in April." [Interview 2]

The delays led to some interruptions in funding the CWF program. Our findings demonstrated that the CWF program faced funding gaps for several months when the initial three-year program agreement with MOHLTC ended. Once more, community Health Directors had to take a risk to maintain CWFs in their positions while SLFNHA was waiting for renewed funding for the program.

"SLFNHA couldn't give money to the Tribal Councils until SLFNHA got confirmation and money. So, there was a gap, and some Tribal Councils decided to risk and keep that person [CWF] going until we got our agreement and were able to fund them." [Interview 2]

Meanwhile, some respondents showed concerns about the short timeframe of funding for the CWF program. The initial period of funding was for three years. Later, the program was extended on yearly basis.[10]

"Community relationship is so important. You don't want to get people's hopes up and then dash them. It's important to make sure that the program achieves its goals in a realistic timeframe. It's taking time to develop relationships." [Interview 5]

"The instability of the funding agreements created high CWFs' turnover and impacted relationships." [Interview 4]

On the other hand, our findings showed that a multi-year agreement was discussed and decided at the end of the 2019-2020 fiscal year with the Tribal Councils and independent communities. However, the COVID-19 crisis changed the plans. Given Tribal Councils and independent communities found it hard to think ahead for workplans amid COVID-19 pandemic, it was decided to do a one-year agreement until the pandemic was managed.

Another challenge with the CWF program implementation was the recruitment of CWFs. Our findings show that currently only one CWF position is filled, while other CWF positions are vacant. Some respondents thought that finding suitable candidates for CWF positions was challenging.

CWF program agreements signed between SLFNHA, and Tribal Councils and independent communities set the qualifications and competencies of a CWF as being at least a graduate of grade 12; having a certificate or diploma in a health-related field; having previous experience working in health and or health planning; and having ability in a formal presentation, strategic thinking, strategic networking, entrepreneurial innovation, and facilitation. The job description that sets out qualifications was developed by a working group consisting of SLFNHA and community members.[20]

Limited capacity in managing the CWF program was also discussed by some respondents. They believed that some Tribal Councils and independent communities have competing priorities as well as limited capacity to recruit CWFs and manage the CWF program.

> *"There have been repeated efforts to reach out to Health Directors to get the positions filled since a long time, but very difficult to get a hold of the communities [given] competing priorities." [Interview 3]*

> *"Some Tribal Councils may have limitations. They may not have the time and capacity to recruit, hire, and train CWFs." [Interview 5]*

Some respondents thought that SLFNHA should directly support Health Directors in recruiting CWFs. However, the respondents clarified that SLFNHA support should be limited only to technical assistance and should not influence the recruitment process.

> *"Hiring is now very much up to the individual Tribal Council and communities. One thing I wonder is if SLFNHA could take responsibility for the hiring process but of course not the selection. Just kind of technical support to Health Directors." [Interview 7]*

In addition, respondents believed that some turnover of community Health Directors notably impacted CWF program implementation. Some positions had remained vacant for a long time, which subsequently affected recruitment of CWF positions, supervision of CWFs, and overall program implementation.

> *"One of the things that we started was a community wellbeing plan, and because there was a leadership change, which got delayed and then we couldn't restart." [Interview 6]*

4.3 Program Effectiveness and Efficiency

As described earlier, the CWF program has faced substantial delays in various stages. Nevertheless, in the initial years, the program was able to establish short-term gains. This was acknowledged by most of the respondents because of the full recruitment of CWFs, the close link of the program with the community, and the alignment of the CWF program objectives with community needs and priorities. The recruited CWFs were able to establish good relationships with communities and took part in various public health activities. The following are some examples of CWF activities conducted in different communities between 2017 and 2020.[21,22]

- Conducted community visits
- Coordinated community engagement sessions with the Chief and Council, Health Directors, health staff, school staff, and Elders to discuss ACW programs
- Shared information about ACW on community radio shows
- Supported Health Directors in building teamwork around community wellbeing
- Identified training and capacity building needs for community-based workers
- Facilitated partnerships within communities and with external partners

- Strengthened and expanded harm reduction services in communities
- Supported communities to establish and improve needle distribution services
- Supported health promotion and public health infrastructure development in communities
- Supported health promotion campaigns for infection prevention and control
- Held discussion groups with parents and caregivers on infant and child care and dental care
- Identified health-related educational support for a community school and with a dental hygiene awareness campaign
- Supported planning processes for preventing chronic diseases
- Provided health teachings to youth and their boarding parents
- Held meetings with mental wellness counselors
- Identified and created an inventory of health programs, services, and resources available to the community
- Supported Health Directors in coordinating events and team activities
- Organized group sessions with health and social programs staff to discuss community wellbeing and health issues, leading to the design and development of prospective projects
- Participated in community activities such as kitchens, cooking workshops, Elders bingo (with prizes of socks, blankets, pillows, lotions, shampoos, etc.), and wood cutting for community events
- Etc.

Meanwhile, respondents considered the partnership between CWFs and communities beneficial and productive.

> *"People are coming and asking us for services. They know that the right services will be provided to them and that is the right person to talk to. All that reactions that we get from community members, I feel that I am doing right, or I am doing things that they feel it's good, they are satisfied." [Interview 7]*

Respondents also found the CWF program created opportunities for culturally sensitive services in the community.

> *"CWFs are very much aware of community culture and traditions and are respectful of that. They were involved in setting up a lot of cultural events. Sometimes also getting Elders involved with that. When there is a death or a crisis in the community, sometimes the CWFs are called on to support."* [Interview 2]

However, the COVID-19 pandemic significantly changed the direction of the CWF program. All respondents believed that the COVID-19 pandemic had a substantial impact on the outcome of the CWF program. As attention and resources were directed toward managing the pandemic, the CWF program received limited attentions from the concerned parties (SLFNHA and Tribal and independent communities).

> *"COVID-19 obviously had a big impact on the CWF program over the past two and a half years." [Interview 5]*

One of the respondents believed that though the COVID-19 pandemic created a considerable crisis, it was an opportunity for SLFNHA and Tribal Councils and independent communities to further connect with communities through the CWF program. The respondent thought that the CWFs should have played an essential role in managing the COVID-19 pandemic crisis.

> *"COVID-19 was a huge opportunity to respond to public health issues because the community was so responsive to health services. The CWF program should have played a key role in taking part in the management of COVID." [Interview 1]*

Regarding the costs of the CWF program, our findings demonstrated that the total allocated budget for the program from April 1, 2017 to March 31, 2022 was $3,976,759, while only $3,087,913 (77.6%) was spent on the program. Table 3 shows the total budget and expenditure and the variance between them. Table 4 demonstrates the overall program budget and expenses across years and budget lines.

Table 3. Total budget and expenditure and the variance between the budget and expenditure

Item	Budget	Expenditure	Variance
Salary and benefits	2,245,630	1,876,701	368,929
Travel	622,500	361,747	260,753
Meetings	285,000	164,538	120,462
Training	80,945	56,748	24,197
Equipment & supplies	67,200	69,124	(1,924)
Rent, utilities, telephone, fax, internet	265,880	205,677	60,203
Admin cost Tribal Councils and independent communities	347,665	226,190	121,475
Admin cost SLFNHA	61,939	89,249	(27,310)
Total (Can$)	**3,976,759**	**3,049,974**	**926,785**

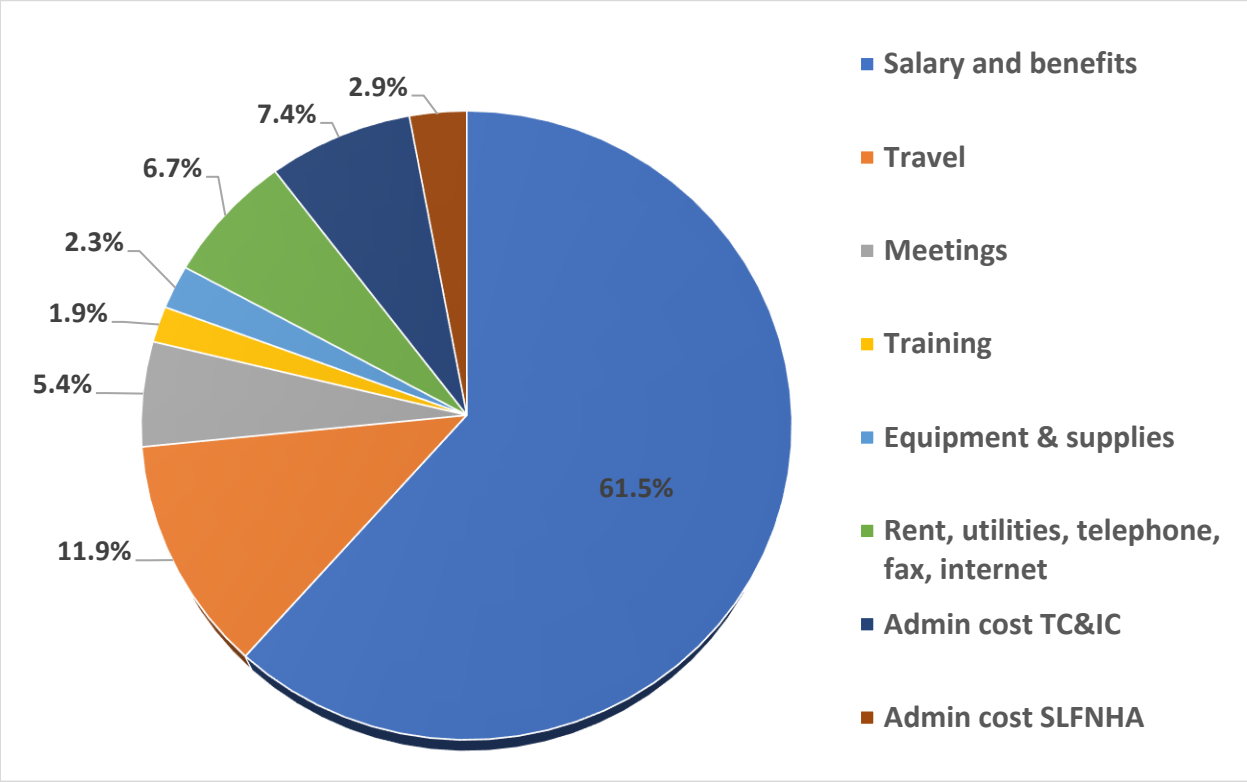
Table 4. Total budget and expenditure across years and budget lines

Year	2017-2018		2018-2019		2019-2020		2020-2021		2021-2022	
Item	**Budget**	**Expenditure**	**Budget**	**Expenditure**	**Budget**	**Expenditure**	**Budget**	**Expenditure**	**Budget**	**Expenditure**
Salary and benefits	390,750	615,549	417,350	390,750	417,350	220,899	491,680	264,410	528,500	385,093
Travel	128,500	50,600	118,500	119,812	118,500	51,229	128,500	48,513	128,500	91,593
Meetings	57,000	17,600	57,000	57,524	57,000	31,400	57,000	17,777	57,000	40,237
Training	19,315	3,300	19,315	17,256	19,315	10,542	21,000	6,450	2,000	19,200
Equipment & supplies	14,000	4,400	14,000	13,800	14,000	6,940	12,600	37,167	12,600	6,817
Rent, utility, telephone, fax, internet	67,600	21,560	51,000	67,785	51,000	31,036	42,840	38,143	53,440	47,153
Admin cost TC&IC*	66,835	22,176	66,835	66,836	66,835	35,382	68,956	39,398	78,204	41,055
Admin cost SLFNHA	6,000	6,000	6,000	6,000	32,600	6,000	6,000	43,939	0	65,249
Total (Can$)	**750,000**	**741,185**	**750,000**	**739,763**	**750,000**	**393,428**	**828,576**	**495,797**	**860,797**	**717,741**

*TC&IC: Tribal Councils and independent communities

Our analysis of the program expenditures showed that personnel salaries and benefits made up the largest portion of the cost of the program (61.5%); followed by CWFs travel to communities cost (11.9%); Tribal Councils and independent communities' administration cost (7.4%); rent, utility, telephone, fax, and internet cost (6.7%); meeting cost (5.4%); SLFNHA's administration cost (2.9%); and office equipment and supplies cost (2.3%). Trainings to CWFs incurred the smallest portion of the CWF program cost (1.9%). It is worth mentioning that SLFNHA used other sources to provide training programs to CWFs. We have not provided estimations of other resources that were used for this purpose. Figure 2 shows the total CWF program cost from April 1, 2017 to March 31, 2022.

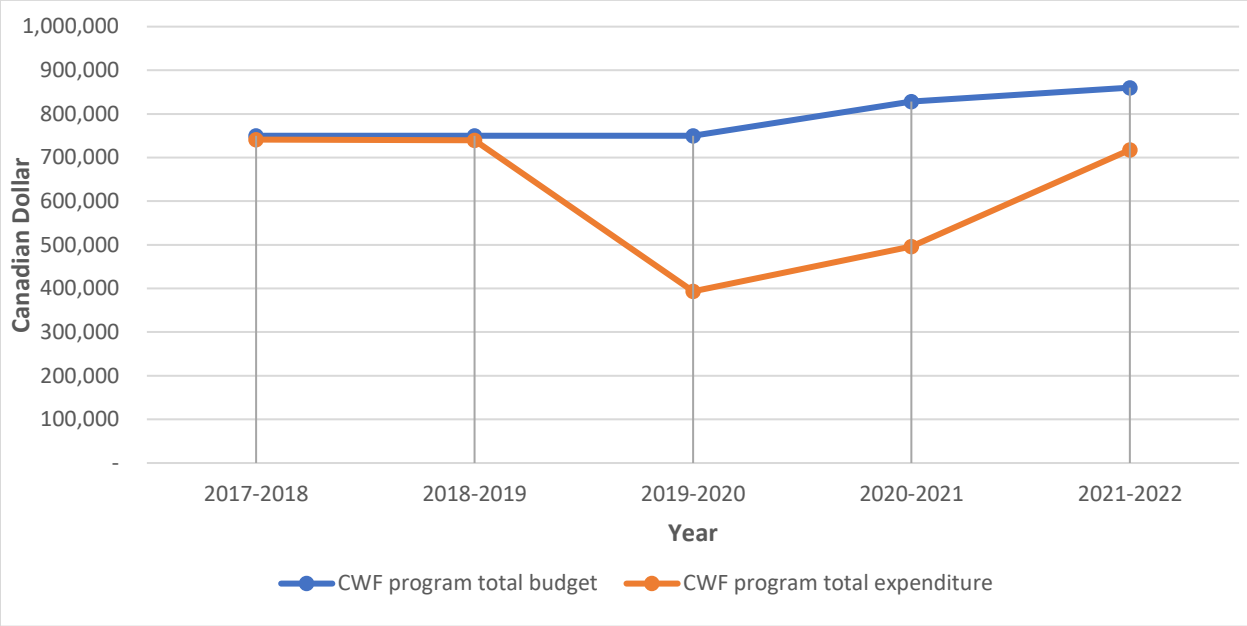
Figure 2. Total CWF program expenditures from April 01, 2017 to March 31, 2022



*TC&IC: Tribal Councils and independent communities

Our analysis also revealed that Tribal Councils and independent communities spent the allocated budget in years 2017-2018 and 2018-2019 almost entirely. However, they had spent only 52% and 60% of their total budget in 2019-2020 and 2020-2021, respectively. In 2021-2022, the budget expenditure increased to 83%. Figure 3 shows the CWF program allocated budget and the expenditures from April 1, 2017 to March 31, 2022.

Figure 3. CWF program budget and expenditure



5. Limitations

The present evaluation is based on the opinion of respondents in individual interviews and review of program documents. Therefore, for methodological reasons, it should not be generalized to other settings, programs, and conditions.

In addition, we were unable to assess the impact of the CWF program on community awareness and public satisfaction due to the limitation of resources and the unavailability of a baseline evaluation.

6. Summary of Findings and Recommendations

Community-based health interventions are the cornerstone of a successful public health program. The CWF program is a community-based health model that was beautifully designed by Tribal Councils and independent communities and SLFNHA to strengthen ACW program implementation and improve the partnership between communities, Tribal Councils and SLFNHA, and help enhance public awareness around public health issues at the community level. The need for such an important community-based program is acknowledged in this evaluation.

The CWF program started in 2017 with significant delays. Despite that, in the initial stage of the program, Tribal Councils and independent communities were ahead in filling the CWFs positions, orienting new CWFs with the scope of work, and providing CWFs with the necessary

support. As well, SLFNHA, in partnership with Tribal Councils and independent communities, provided some short-term training programs to CWFs. Recruited CWFs were able to establish an effective relationship with communities and participate in community health planning and various other public health activities. CWFs were also able to create opportunities for culturally sensitive services in the community.

However, the CWF program could not keep the momentum as it was in the beginning. Gradually, the program faced various challenges, especially funding gaps; high turnover of CWFs; COVID-19; poor capacity in managing the CWF program, including delays in submitting work plans, signing agreements, and hiring CWFs.

In summary, the following factors contributed to the underperformance of the CWF program:

- SLFNHA is not a funder but an implementing organization. To play the role of a funder, SLFNHA needed to build capacity in contract (agreement) management, financial management, and contract monitoring. This would have reduced delays in developing agreements, reviewing financial and technical reports, ensuring the program was meeting program objectives, and transferring funds to Tribal Councils and independent communities without delays.
- CWFs have been accountable to community Health Directors. At the SLFNHA level, the CWF program was supported by ACW with many other competing priorities, especially in the time of the COVID-19 crisis.
- SLFNHA showed flexibility in allowing Health Directors to use CWF program funds for other purposes deemed appropriate. This was a deviation from the original design of the CWF program, which was exclusively planned for CWF salaries and CWF program activities.
- Community Health Directors have gradually lost interest in the CWF program, probably due to the funding gaps and short-term agreements. In addition, there were other challenges that the program faced, such as the limited capacity of some Tribal Councils and independent communities in recruiting CWFs, some turnover of community Health Directors, and unfamiliarity of new Health Directors with the CWF program.
- CWFs were not equitably deployed across Tribal Council and independent communities. The size of the population and number of communities under each Tribal Council were not considered essential in deciding on the number of CWFs for each community.

To improve CWF program performance and achieve intended outcomes, respondents provided the following recommendations:

At the SLFNA level

- Conduct a discussion with Tribal Councils and independent communities on how to improve the CWF program implementation
- Ensure long-term funding and agreements
- Integrate the CWF program into the ACW model to ensure the sustainability of the CWF program
- Revisit the design of the program and add more CWFs based on the need of communities. The number of communities served by Tribal Councils and population size of Tribal Councils and independent communities could be useful criterium to decide upon the number of CWFs
- Advocate for increased funding to allow for revisiting the design and expanding the program
- Develop sufficient capacity in contract management, finance management, and program monitoring
- Remove flexibility term in the CWF program budget and use the fund dedicatedly for the CWF program activities
- Deploy a CWF program coordinator at the SLFNHA level to dedicatedly work for the CWF program
- Direct more resources toward training to upgrade the knowledge and skills of CWFs and Health Directors. Trainings should be based on the need of each participant
- Strengthen partnership with Tribal Councils and independent communities in all aspects of the CWF program

At the Tribal Council and independent communities level:

- Share any concerns regarding the CWF program with SLFNHA on a regular basis
- Provide timely work plans to prevent any delays in funding and agreements processes
- Use the CWF program fund only for the CWF program activities
- Give priority to the recruitment of CWFs and provide timely support to the program
- Use SLFNHA capacity in advertising and processing the recruitment of CWFs if needed
- Ask SLFNHA for capacity development of CWFs and other staff who are working closely with the CWFs program if needed
- Strengthen partnership with SLFNHA in all aspects of the CWF program

7. Conclusion

This evaluation identified the successes and weaknesses of the CWF program. Despite significant challenges, the evaluation found the program a suitable community-based health model with immense potential to emerge as an essential element of the ACW program. The program can strengthen community participation in public health programs and services, improve relationship with Health Directors, Tribal Councils, and independent communities, create an opportunity to address health differences and community health needs for improved health and wellbeing, and strengthen the operationalization of ACW as a decentralized model of public health programs and services. Furthermore, the CWF program can be utilized to improve data collection, monitoring, and reporting on priority health issues.

Thus, SLFNHA, in partnership with Tribal Councils and independent communities, should improve the CWF program based upon the findings of this evaluation and enhance jointly the program's reach and effectiveness.

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Appendices

Appendix 1. Community Wellbeing Facilitator Job Description

Job Summary

The Approaches to Community Wellbeing is a regional resource to 31 First Nations Communities. The Approaches to Community Wellbeing provides expertise, support, services, and programming in public health to the region. The program also supports communities in the development, implementation, and monitoring of their own Approaches to Community Wellbeing.

The Community Wellbeing Facilitator will be responsible for liaising with Tribal Councils and communities to facilitate the planning of Approaches to Community Wellbeing at the community level. The Community Wellbeing Facilitator will help communities decide the structure, programs, and job descriptions for Approaches to Community Wellbeing.

Accountability

The Community Wellbeing Facilitator will be directly accountable to the Community Wellbeing Project Coordinator.

Core Competencies

- Formal presentation
- Strategic thinking and planning
- Strategic networking and developing trusting relationships
- Entrepreneurial creation and innovation
- Open-mindedness
- Facilitating teamwork

Qualifications

- Minimum Grade 12
- Certificate/Diploma in a health-related field
- Previous experience working in health and/or health planning

Knowledge and Ability

- Understanding of Health Systems (federal, provincial, and First Nations primary and public health systems)
- Knowledge of public health

- Ability to develop and maintain respectful/cooperative relationships with First Nations people, communities, Tribal Councils, and service providers to promote an integrated seamless delivery of service
- Facilitation and presentation skills
- Experience working both independently and, in a collaborative, collaborative environment is essential
- Strong written and oral communication skills
- Strong interpersonal skills
- Superior time management and organizational skills
- Ability to effectively prioritize and execute tasks in a high-pressure environment
- Computer skills
- Ability to communicate in one of the First Nations dialects within the Sioux Lookout Zone
- Must be willing to travel
- Must be willing to relocate and live in Sioux Lookout

Responsibilities and duties

- Liaise with Tribal Councils, communities, and Community Wellbeing Project team
- Travel to communities
- Conduct presentations (videoconference and in-person) about the Community Wellbeing Project and Approaches to Community Wellbeing
- Work with the Tribal Councils and communities to identify priority areas within Approaches to Community Wellbeing and focus on those areas to develop the system
- Support community Health Directors to bring people together to assess the current state of public health services and to develop a team approach to strengthen services
- Work with Tribal Councils and communities to develop job descriptions, structure, work plans, and training needs at the community level
- Work with Tribal Councils and communities to develop job descriptions, work plans, and training needs at the Tribal Council level
- Develop reports and recommendations summarizing community feedback and engagement sessions
- Maintain portfolio/profile of community information and key contacts related to community wellbeing
- Develop relationships with organizations within the communities, or which support the communities regionally, related to community wellbeing
- Report plans and community feedback to the Approaches to Community Wellbeing Working Group
- Act as a focal point for communication for Approaches to Community Wellbeing staff visiting communities

- Work with Health Director and Finance staff to ensure reporting requirements are met every three months
- Attend regular planning, training, and debriefing sessions with SLFNHA both in person and through teleconference/videoconference
- Provide help when required and any other duties assigned

Appendix 2. Community Wellbeing Facilitator Activity Report Template

Reports Due:

Q1 (April – June) - July 1st of Funding Year
Q2 (August – September) - October 1st of Funding Year
Q3 (October – December) - January 1st of Funding Year
Q4 (January – March) - June 1st of the following Funding Year

Funding Year	
Quarter Ending	
Project Name	Approaches to Community Wellbeing (ACW) – Public Health Planning

Project Activities	**Deliverables**	**Completion Date**
Share information about Approaches to Community Wellbeing with communities and stakeholders.	Examples: Radio shows, community forums, community visits.	
Identify roles and responsibilities of community-based staff in Approaches to Community Wellbeing.	Examples: Met with health staff to identify roles and in XXX related to safe communities, streamlined job descriptions to prevent duplicating duties.	
Support Health Directors in building teamwork around Community Wellbeing.	Examples: Team meetings about public health roles, monthly meetings with XX health teams to schedule events.	
Identify training and capacity building needs for community-based workers.	Developed needs assessment questionnaire for training needs, discussed and addressed training needs with Health Director, researched training opportunities in region, supported community to bring in a trainer to do training.	
Support communities in developing training plans.	Identified training needs in community through surveys, brought in trainers, did research on trainings.	

Project Activities	Deliverables	Completion Date
Share community roles and responsibilities, training, and capacity building needs with SLFNHA to support regional planning.	Sent SLFNHA report, called SLFNHA and informed Health Planner.	
Networking and planning meetings between SLFNHA and community wellbeing facilitators.	CWF meeting attendance, attended 2 – day Health Directors meeting, participated in teleconference.	
Function as a liaison between SLFNHA, Tribal Councils, and communities around Approaches to Community Wellbeing.	Went to community with SLFNHA staff, supported SLFNHA staff in meeting in community, took part in SLFNHA ACW Working Group, worked with SLFNHA staff to bring Mental Health First Aid First Nations to community.	
CWFs support communities in: • Priority setting • Breaking down silos between funding streams and departments • Fostering teamwork • Developing their ACW • Evaluating programs • Seeking funding		
Development of 2020-22 work plan		
Can add in additional project activities if they do not fit within this work plan.		

Report completed by	Signature	Date

Appendix 3. CWF program evaluation interview questions

Themes	***Questions***
Relevance and Design	1. Why did the CWF program start and what were the objectives and intended outcomes of the CWF program? 2. How well was the design of the CWF program adapted to the needs of First Nations communities?
Implementation	3. Was the program implemented according to the work plans and agreements? 4. To what extent is there an understanding of the CWF program and role in communities? Do you think that role is used and appreciated by communities? 5. How do you assess the relationship (partnership) of CWF with community? 6. What factors facilitated the CWF program implementation? 7. What factors limited the CWF program implementation?
Efficiency and Effectiveness	8. Were required resources in place and enough to successfully implement the CWF program? 9. What achievements have been obtained? 10. What recommendations would you have to improve the CWF program?

Appendix 4. CWF program evaluation consent form

Sioux Lookout
First Nations
Health Authority

Community Wellbeing Facilitator (CWF) Program Evaluation

Purpose of the evaluation: This evaluation will assess the performance of the CWF program to identify the strengths and challenges. The findings of the evaluation will be used for planning purposes to improve the CWF program at the community level.

Purpose of the CWF program: The purpose of the CWF program is to support Tribal Councils and First Nation communities to facilitate the implementation of ACW at the community level. The CWF program helps communities to determine the structure and programs for ACW. The CWF liaise with other CWFs and Tribal Councils and have a close working relationship with Sioux Lookout First Nation Health Authority (SLFNHA).

The CWF program focuses on two major areas: community planning; and community coordination and collaboration. However, the scope of work of CWFs is not limited to the indicated areas and their contributions proved to be in many aspects of the Approaches to Community Wellbeing.

The Evaluation Design: This evaluation is qualitative in nature using interviews. Collecting qualitative data involves capturing partners' perceptions of success and strengths, as well as challenges and weaknesses that were experienced during the CWF program implementation in the region. You will be asked 10 questions regarding the CWF program, mainly focusing on the strengths and challenges of the program and how to improve the program. The interview will take around 60 minutes in length.

Please note that your participation in the interview is voluntary. We would like to seek informed consent from you. If you decide to not participate in this evaluation, it will not affect your relationship with SLFNHA. If you are willing to participate in this evaluation, we assure you that your identity will be protected and all information in the evaluation report will be provided anonymously. You can withdraw from the interview at any point if you choose not to continue.

Interviews will be recorded only you agree. If you are reluctant to be recorded, we will only take notes from the interviews. We will store recordings in a password protected computer.

We will compensate you at our half-day honorarium rate ($100) for your time and sharing experiences. The honorarium does not apply to any SLFNHA staff being interviewed.

If you have questions, please contact Ahmad Salehi through ahmad.salehi@slfnha.com.

I voluntarily agree to participate in this evaluation study.

□ Yes

□ No

Name of participant:

Signature:

Date:

Name of person obtaining consent:

Signature:

Date: