Sioux Lookout
First Nations
Health Authority

Community Engagement

Summary Report for January 2015 - May 2016

May 2016
Sioux Lookout First Nations Health Authority

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- Lac Seul First Nation
- Mishkeegogamang Ojibway Nation
- Nibinamik First Nation
- Sachigo Lake First Nation
- Sandy Lake First Nation
- Wapakeka First Nation
- Wabauskang First Nation
- Eagle Lake First Nation

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- Matawa Learning Center
- Thomas Fiddler Memorial High School
- Pelican Falls First Nations High School
- Dennis Franklin Cromarty High School
- Nibinamik Education Center
- Morris Thomas Memorial Christian School
- Waninitawingaang Memorial School
- Obishikokaang Elementary School

The Community Wellbeing Project Team members who conducted community visits and compiled feedback were:

- Emily Paterson, Community Wellbeing Project Coordinator
- Emma McDonald, Community and Youth Engagement Officer
- Dr. Natalie Bocking, Public Health and Preventive Medicine Specialist
- Shanna Switzer, Community Wellbeing Facilitator (report author)
- Cai-lei Matsumoto, Epidemiologist

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1.0. Introduction

The Sioux Lookout First Nations Health Authority's Community Wellbeing Project Team conducted twelve community visits between January 2015 and May 2016. The purpose of these visits was to provide information about the Approaches to Community Wellbeing model, and to gain input from each of the communities in order to develop program priorities and directions for the future. The focus of these visits was on the Raising our Children aspect of the Approaches to Community Wellbeing model. Communities that the project team visited include:

- Sandy Lake First Nation (January 2015 & January 2016)
- Sachigo Lake First Nation(January 2015 & February 2016)
- Wapakeka First Nation (August 2015)
- Mishkeegogamang Ojibway Nation (October 2015 & March 2016)
- Nibinamik First Nation (February 2016)
- Lac Seul First Nation (February and May 2016)
- Wabauskang First Nation (February 2016)
- Eagle Lake First Nation (April 2016)

During our community visits, efforts were made to meet with the Chief and Council members at the beginning of each visit. This was to provide either an update on the "Community Wellbeing Project", if they were familiar with the project, or a brief overview and introduction into the Approaches to Community Wellbeing model. The project team also tried to meet with each Health Director from the communities visited. During the Health Director Meetings, project staff provided a background on the model and how it was created. Further discussion took place around current public health and preventive health services currently within the community, along with recommendations for the future.

While in each community, efforts were made to speak with as many additional health and youth staff as possible. This was to gain information on what was currently being done in their communities as well as to help identify any gaps in services. The most frequent staff that the project team met with included:

- Health Director
- Nurse-In-Charge (NIC)
- Community Health Representative (CHR)
- Healthy Babies Healthy Children workers (HBHC)
- Early Childhood Development workers (ECD)
- Brighter Futures workers (BF) or other youth workers

The project team conducted radio shows in the communities that had radio capabilities and on some occasions, a community or youth forum was hosted. This was to share information about the model to a larger audience and to hear the community's perspective. As a way to gain feedback from the youth, 16 youth engagement sessions were conducted to more than 250 grade 5-12 students. Our school visits were designed to engage youth and to get them to think about their own health as well as the health of their community.

The following report outlines a summary of the feedback received during these sessions. The information gained is used for SLFNHA's planning purposes. Following each community visit, an individual community report was written and returned to the community to be used and shared as they deemed appropriate.

2.0. Community Visit Formats

2.1. Chief and Council Meetings

During each visit, the project team made efforts to meet with the Chief and Council at the beginning of each trip in order to thank them for hosting us and talk about the purpose of our visit. Some communities were visited more than once to gain additional feedback. Every meeting that took place was slightly different. The content of the meeting depended on what type of information was previously given and on what the Chief and Council members were most interested in. On our initial visit, the meeting consisted of an introduction to the Approaches to Community Wellbeing model. Any subsequent meetings elaborated on specific areas of the model and any updates to the project. Some of the Chief and Council members had a strong background with the Approaches to Community Wellbeing model, and were able to provide feedback on what Community Wellbeing looked like in their communities.

One of the biggest areas of concern that came up during Chief and Council meetings was on the availability of safe drinking water. Boil water advisories have been in place for many years in some communities, with little being done to correct the issues. Other communities have problems with their lagoons directly contaminating their drinking water supply. Another significant concern was infrastructure for office space and personal housing. Housing can be limited in many communities and multiple families live under one roof, causing overcrowding. Safety of the houses they are living in is a major concern due to lower building code regulations in the north, and many houses have significant mould issues. Furthermore, due to the housing shortage, there was concern over the inability to house additional personnel (i.e. nurses) even if we were able to receive funding for them.

With regards to the Preventing Infectious Disease portion of the model lack of knowledge on infectious diseases was expressed as a great concern. This was specifically in regards to MRSA, and some communities would like more information and resources in this area. Interest was also expressed on finding ways to increase traditional health promotion with emphasis placed on traditional ways, for example traditional foods and traditional practices for physical activity such as hunting, fishing and trapping.

2.2. Health Director Meetings

During the Health Directors meetings, an overview of the Approaches to Community Wellbeing and how it was created was given. Updates to the project, the new staff hired to support the Community Wellbeing Project, and the implementation of the model were provided. The new project staff included:

- Emma McDonald, Community and Youth Engagement Officer, whose role is to develop and carry out processes to engage communities and youth, to raise awareness of the project and gain feedback for the development and implementation of the model.
- Shanna Switzer, Community Wellbeing Facilitator, whose role is to engage communities and work with them to plan how to tailor and implement the Approaches to Community Wellbeing at the community level.
- Cai-lei Matsumoto, Epidemiologist, whose role is to collect, analyse, and share health information with communities and regionally, while monitoring the population for health trends.
- Dr. Natalie Bocking, Public Health and Preventive Medicine Specialist, whose role is to give direction and share her expertise on public health related issues.

Common themes that came up during the Health Directors meetings were their reporting structure, heavy workload on health staff members such as the CHRs, and a lack of community infrastructure. In many of the communities, the CHRs spend a significant amount of time on chronic medication distribution, although this area is working well it leaves little time for the CHRs to complete other aspects of their positions. It was noted, depending on the community, Health Directors could have anywhere from 6-48 staff members reporting directly to them. This can cause heavier workloads with time spent mainly on reporting, management, and administration responsibilities, leaving very little time for program planning. Additional health staff is required in many of the communities to help support the health programs for them to run efficiently; however, due to a significant lack of office space and funding, they are unable to hire the additional staff.

2.3. Radio Shows

The project team made efforts to host a one hour Radio Show towards the start of each visit in communities with radio facilities. This was to let community members know who we were, why we were there, and what messages we were trying to send. This also allowed us to promote any community or youth forums we were hosting. A translator would usually be present to translate our message in order to reach more community members who may be listening. For a copy of the script, please see Appendix E.

2.4. Community and Youth Forums

The Community Wellbeing Project team hosted multiple community and youth forums with support from Health Directors, Brighter Future workers and additional health or band office staff. Unfortunately, the community and youth forums were not always well attended. Low turnout rates could be due to limited advertising before events. SLFNHA will need to work with communities in advance to improve advertising of these forums. In one scenario low turnout was due to extremely cold weather and lack of heat in the youth centre and on other occasions community members were out of town (hockey tournaments, March break, and competing bingo in a nearby community). Regardless of turnout, we had engaging discussions surrounding the state of child and family health in the communities, and their hopes for the future. We would usually break up the discussion into the three components of the Raising Our Children Model: Family Health, Youth Development, and Building Healthy Relationships. In general the conversations and feedback following the presentations were very interesting and provided feedback into the current strengths in the communities and the potential needs.

Our purpose for the youth events was to discuss the health issues affecting youth, and the method they thought should be used to deal with the issues within their communities. This was similar to the intent behind the school visits; the project team usually hosted a youth event in the locations that school visits were limited. In one community, a youth forum was hosted and well attended, but the participants were children and thus we were unable to discuss the project and future goals in the desired detail. Figure 2 below illustrates the results of youth learning the skill of shield making during a community forum where we presented.

During some of the community forums, the project team asked community members what they thought Community Wellbeing might mean. Common answers are listed below and are a good baseline of Community Wellbeing:

- To be good
- Healthy eating
- Playing games and sports – being active

- Healthy relationships
- Community activities
- Vaccinations
- Hygiene
- Well baby, well women, well men visits
- Wearing proper equipment
- Stretching before an activity
- Lifejackets when out on the water, extra gear when camping
- Wearing helmets (snow machine, Quads)
- Learning to swim
- Safe food handling and safe water
- Clean houses
- Hand washing

Figure 1: Community Forum - Youth Shield

Even though Raising Our Children was the main focus for many of the project team's community visits we also compared the community wellbeing model to primary care and urgent/emergent care using diagrams that were provided. Located in Appendix A, the first illustration summarizes what Community Wellbeing, Primary Care, and Urgent/Emergent Care are in general. The next illustration provides Mental Health and Addictions as an example, and demonstrates which areas of preventing, managing, and treating mental health and addictions fall under Community Wellbeing, Primary Care, and Urgent/Emergent Care. The last illustration in Appendix A shows the same thing, except using Infectious Diseases as an example. Finally, the project team would discuss the Approaches to Community Wellbeing model; a diagram of the vision, values and goals and a diagram of the model are located in Appendix B.

3.0. Strengths in Communities

Throughout community forums and staff interviews, community members were asked about the current strengths in the communities. Through identifying strengths we can recognize opportunities to harness, and learn from things within communities that are already functioning well. Some of the highlighted strengths in many of the communities we visited include: lots of sports (hockey, ball hockey, volleyball), games for kids, people walking and jogging, cooking healthy foods and traditional foods, community events, high vaccination rates, keeping the language, playground always being used, spending time on the land (camping, fishing, hunting), taking naps, and parents being involved with their children. One community noted that youth activities was a particular strength in the community, and in addition to community-based workers and their Youth Council in the community they made an effort to bring in outside programming for youth.

As part of the feedback gathered during community meetings, some communities also listed the positions they felt were particular strengths for their communities, which include crisis coordinators, NNADAP workers, Healthy Baby Healthy Children workers, suicide prevention workers, CHRs, home and community care workers, youth workers, and Brighter Future workers

It was noted that many of these staff members, along with the nursing staff, work well together in times of crisis. Some communities have peacekeepers, which are thought to have a positive influence within the community, especially when following up with high-risk people who have expressed suicidal tendencies. Some communities mentioned visiting staff from their Tribal Councils, visiting mental health

workers, and telehealth (which can offer many education sessions i.e. diabetes, grief, exercise) as a strength and positive influence.

Other areas that were mentioned as strengths or positive influences in communities are the nursing staff, the HBHC program, Home and Community Care program and chronic medication distribution all of which are working well in many of the communities. There were mixed reviews within some of the communities about the suboxone program, but most felt it was working well and making a big difference with social problems within the communities. Immunizations are working well within a lot of communities visited with many of the children up to date. Some communities have a good attendance with prenatal visits, nurses following-up and monitoring diabetes clients. Lastly, one community mentioned that they have a community garden, which help to provide healthy produce for their community and are run by a group of devoted community members.

4.0. Community Needs and Areas of Improvement

It was mentioned that additional resources are necessary to help support the needs of each community, including funding for land-based treatment options. Financial resources, as well as additional personnel, are required in many of the communities (i.e. pharmacy technician, diabetes worker, additional CHRs) and more frequent visiting professionals (i.e. audiologist, dentist, dental hygienist, foot care nurse). Current staff could be more hands-on and work together as a team more often. Staff members in many communities are already over worked and lack support, so trying to incorporate teamwork could be a difficult task. It was noted in one community, that mental health services would benefit from more outside counsellors or more training for community-based positions since clients are cautious to come for help due to perceived confidentiality issues. It was noted that even if trustworthy staff are in the position now, previous staff may have broken the trust and relationship and people may be hesitant to return for support. One community noted that they no longer have designated Maternal and Newborn Health Workers, and thought that was an area that needed considerable strengthening.

Many programs do not have enough space to run their programs or in some cases have inadequate office spaces with no phone, running water, or indoor plumbing and have to use an “outhouse” if they require using the facilities during office hours. One community mentioned that their ECD and HBHC workers are at risk of losing their current office space, as the school they rent the space from are planning to use the space for school purposes.

A large technical barrier related to public health and information systems is that the nurses do not have access to the Electronic Medical Records (EMR). Nurses could add to statistics and be a source for health status assessment if they did have access to the EMR. Additionally, many of the communities have public health concerns relating to skin conditions such as MRSA, eczema, impetigo, and contact dermatitis, which could all be accurately tracked and reported with the proper technology.

There is a lack of nutritious, healthy, and affordable foods available in the community stores, leaving few options for parents to make healthy choices for their families. Some communities felt that there needed to be more education or training for children and community members on water safety, firearm safety, wilderness safety, and survival techniques. Lastly, it was mentioned that communities could host workshops from outside groups, for example related to traditional parenting.

5.0. Approaches to Community Wellbeing Model Feedback

The Approaches to Community Wellbeing model is divided into four main sections: Raising our Children, Healthy Living, Safe Communities, and Roots for Community Wellbeing. The following section of the report outlines community feedback as it relates to each of the sections of the model.

5.1. Raising our Children

The communities have identified the Raising our Children section of the model as a priority, and thus, it is the first area of the model SLFNHA is aiming to develop and implement. Within Raising Our Children, Youth Development is the first area of focus. Our goal is to gather the perspectives of First Nations youth on what they see as priority areas of concern regarding the health and wellbeing of their communities.

5.1.1 Youth Development

When looking at youth development, many of the communities mentioned sports as their number one way of connecting with youth. In the winter, most of the communities visited offered sports like hockey and broomball; however, not all children and youth are into sports, so different methods of engaging youth should be taken into consideration. It was noted that some communities have a youth centre and/or a Brighter Futures worker to help engage youth within the community, but this is not true for all communities. One community noted that they have lots of services for youth ages 12 and up, but there was a significant gap for children under the age of 12.

The purpose of the school visits were to engage youth to think about their own health as well as the health of their community. During the school engagement sessions, however, content varied from

session to session depending on the age group and community visited. Youth were asked about their values, issues facing youth, what programs were already in place in their communities, and what programs they would want to see in their communities. Youth were asked about what skills and strengths they possessed and goals they had for their community. During these visits, the project team spoke to, and got feedback from, more than 250 grade 5-12 students during 16 engagement sessions.

Figure 2 below, lists the top youth values that were mentioned in feedback five or more times. The size of the font represents the number of time the value was mentioned by youth. For more detailed feedback received from the youth, please refer to the Youth Engagement report.

Figure 2: Youth Values

The project team created two surveys, which were distributed during community visits; the first was the Youth Development Survey, which was created to help understand what issues are important to youth and what SLFNHA might be able to do to a support youth in their communities. The second was the Social Media Survey, to get a better understanding as to how many youth use social media, how they access it, along with what sites they use most. This information was used to help create a social media strategy for "Approaches to Community Wellbeing". Both surveys were handed out and completed during most engagement sessions and the Youth Development Survey was also available online. For a copy of the Youth Development Survey, please see Appendix C and for a copy of the Social Media Survey, see Appendix D.

Since the youth leave the communities at a young age to go to secondary school it has been mentioned that reaching the youth in general can be particularly challenging. Some communities have expressed that they would like to see a high school in their community, or at least have the schools go to grade 10. This would aid in preparing the children to leave, so they have a more stable foundation of family values and culture before leaving the community.

Specific goals that were identified relating to Youth Development in some communities include:

- Parents are aware they have 13 years with their kids to prepare them and create strong family values and connection to culture.
- Kids are prepared to leave the community.
- In the long-term, children are kept in the community longer due to the presence of a high school.
- Youth are socially engaged (not just in social media) and have healthy outlets (sports, but also other alternatives).

5.1.2. Family Health

In regards to family health, many of the communities function differently with regard to programs and services. Some communities have significantly larger populations, therefore having a larger number of babies born each year within them. This affects the amount of support the communities receive in regards to staffing and programs available within their community. It was noted that in some communities, staff encourage both parents to attend well baby visits. Currently the primary thing done for well baby checks in these communities is immunizations, however program staff also perform home visits shortly after the baby returns home to the community.

Some communities noted that their program staff (i.e. CHRs, HBHC workers) try to help with the registration of new babies and give a list of programs to new parents. They also try to teach parents how to budget, make baby food, and how to improve care. Some communities have prenatal programs but it was noted that more support is required in areas such as breastfeeding, sewing, and cooking/nutrition classes.

It was also suggested by some communities that more training sessions or sharing of knowledge could happen more frequently within communities. It was noted that at one time, there was a community exchange program where staff could visit different communities for a week to learn from them, but this does not happen anymore. A specific goal around family health that was suggested was to increase communication (i.e. through radio shows) around some of the family health issues mentioned above.

5.1.3. Building Healthy Relationships

Getting parents involved was recognized as a key part of building healthy relationships. It was suggested that a type of parent mentorship program within the communities to gain knowledge from Elders or grandparents would be beneficial. Alternatively, if there were a way of arranging shared responsibility between parents or several family members to support parenting, the community would also benefit. That being said, some communities do feel that there is a strong link to their Elders, grandparents, and other community members who are helping to pass down their parenting skills to new parents. In these communities, all community members are helping to raise and look after the children. A gap in parenting overall was still noted, even though Elders and grandparents do try to pass on their knowledge. However, due to language barriers between youth and some Elders this can be difficult to getting their messages across.

In regards to Building Healthy Relationships, some communities stated that Elders are actively involved and attend events and program classes to explain stories and share their teachings. With traditional programs in some of the schools, Elders are available to teach students about land based teaching, how to live off the land, and how to prepare traditional meats. Elders also host radio shows in some of the communities visited, to help share their teaching and knowledge that way.

Building a connection to the land and traditional practices in some communities is a high priority, and there are many examples of programs incorporating land based and traditional practices. For example, some of the prescription drug abuse treatment programs teach survival skills and how to prepare traditional meats, some Head Start programs host a traditional week, and Ontario Works has a program with young people that teach traditional practices such as woodcutting. Additionally, most communities host an annual hunting week and host different feasts, which increase connection to traditional practices, land, and foods.

Peer pressure, gossip, and bullying can be an area of concern in some communities. It was noted that this has contributed to suicidal thoughts within the youth population in many of the communities

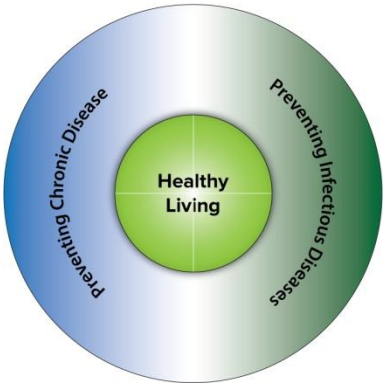
visited. A possible solution that was recommended was for programs to have a self-policing system around bullying. Furthermore, there needs to be guidelines set in place stating what acceptable behaviour is during these activities. It was also noted that more efforts are needed for building up self-esteem with the youth, especially with young women.

Teen pregnancy rates were also mentioned as being high in many communities visited, and it was noted that birth control should be promoted. However, this could be difficult in communities where some Elders and community members have been known to disapprove of it.

Specific goals that were identified relating to Building Healthy Relationships include:

- Parents are active supporters of their children's activities (i.e. watch their hockey games)
- Stronger communication and connections between generations
- More community members aware of where their ancestors came from and are engaged in traditional activities

5.2. Healthy Living



Healthy Living was also discussed to some degree while meeting with some of the health staff, including the NICs, the CHRs and the Health Directors.

5.2.1. Preventing Chronic Disease

Diabetes is a significant concern in most communities that were visited, and more education and resources are needed to help communities understand the daily impact on individuals living with diabetes. In one community, a diabetes educator visits a few times per month and offers cooking and nutrition classes; however, engaging community members to get involved is difficult and these events have low turnout. Many of the health staff try to lead by example and stay proactive; however attendance at many of the educational sessions is mainly health staff.

5.2.2. Preventing Infectious Disease

In a few of the communities visited, a particular strength has been immunizations. Parents seem to be on top of bringing in their children on the immunization schedule and understand the importance of immunizing their children. One community has also focused on Hepatitis A and Hepatitis B immunizations for their suboxone clients. It was noted by one community visited that the CHRs try to

do radio shows and work with schools to discuss the importance of hand hygiene to prevent the spread of infectious diseases.

Some communities identified Methicillin-resistant Staphylococcus Aureus (MRSA) and Impetigo as particular concerns, and thought that SLFNHA could support communities by providing additional information about it, and training community-based staff on how to educate the community about it. However, without access to the EMR database within the community, exact rates are difficult to assess at the community level, which could be an area of improvement SLFNHA could support. They also felt that SLFNHA could support research around MRSA. One community also highlighted Blastomycosis as a major concern within the community that was affecting community members as well as dogs. It was felt that SLFNHA could play a role in educating health workers to test for blastomycosis, since it often goes undiagnosed for a long time. Concerns in another community were raises regarding the needle distribution program and worried of condoning drug use.

There are many areas of preventing infectious disease that will need to be addressed within communities. This will include more education, resources, and hands on training sessions in order for communities to have a good understanding in regards to other aspects of preventing infectious diseases. However, understanding where different communities are currently at is a good baseline of information when moving forward.

5.3. Safe Communities

Some communities are currently implementing their own strategies to prevent injuries and prepare for emergencies. This falls under the Safe Communities aspect of the Approaches to Community Wellbeing model. This was not our main focus for the visits; however, it did come up in some of the project team's discussions while visiting communities. The communities that are currently implementing various safe community strategies could perhaps help with a framework for future initiatives.

5.3.1 Preventing Injuries

In regards to injury prevention, the CHR in one community conducts home visits to some of the middle aged or elderly people that live on their own. The CHR takes it upon himself to clear away any obvious hazards and offers education on injury prevention while also monitoring injury statistics within the community with the main focus on falls.

It was also noted that in one community, water related accidents were minimal due to the fact that many of the children know how to swim and everyone in the community looks out for each other's children. In this same community, Elders and grandparents also try to pass on their knowledge for keeping their children safe therefore baby proofing is not commonly done in this community.

5.3.2. Emergency Preparedness

In regards to emergency preparedness, it was noted that one community has a First Response team in place. It consists of six volunteer members that are all trained as paramedics. This team is the initial response team before any other medical or police services are able to arrive in the community. Funding is needed to help improve equipment and medical supplies. They also hope to have two of their first responders trained in crisis intervention.

5.3.3. Environmental Concerns

Infrastructure and housing are of great concern in all communities visited. Both personal housing and office buildings have significant mould and foundation problems, which require a substantial amount of work to fix. The Nursing Stations themselves have mould issues, some have leaky roofs, and others have noted mice infestations. One community mentioned that assistance with proposal writing to get funding for repairs in these cases would be helpful.

5.4. Roots for Community Wellbeing

5.4.1. Data Collection and Analysis

During one community visit, we focused on the health information needs of the community. The community workers discussed the current tools they used to track service delivery, which were tools that were either adapted or made by the Health Director in the community. These tools generally tracked time spent on service delivery and were meant to track service use for reporting purposes. Client information was not included in these forms. They were limited, to no, electronic records for patients and clients, which made quick reference to patient information a challenge. This was further complicated by turnover in positions, especially nursing, which led to the charts being disorganized and hard to work with. It was suggested that in order to transfer these to an electronic system, or to do a thorough chart review, it would require significant time and perhaps could be done by a short-term contractor or a nursing student.
It was felt that the amount of time spent on filling out monthly tracking sheets, and the annual Community Based Reporting Template (CBRT) was very burdensome on health staff and the Health Director. It was felt that an electronic system that could support the automatic generation of the CBRT would be extremely beneficial to the community.

Furthermore, in contrast to the amount of work that goes into reporting to Health Canada and the provincial ministries, they receive very little back in terms of useable information. The community receives a Non-Insured Health Benefits (NIHB) report annually, but it really only has dollar amounts for

each area. Although it is fairly specific on drug utilization, it provides little information regarding the number of services used. There is also a Health Canada tracking sheet, which is more useful but the data is always a couple of years behind.

6.0. Role of Community Wellbeing Nurse

Health staff was also asked what the roles and responsibilities would be of a nurse dedicated to health promotion and prevention of illnesses. This position is hypothetical at this time however; the Community Wellbeing project team hope to be able to develop this position in the future. Generally, it was felt that the Community Wellbeing Nurse (also known as a Public Health Nurse) should have knowledge of the local language and culture. Ideally, the nurse would not be sitting in an office, but active in the community conducting health education and building community relationships. Based on feedback from the community visits, as well as discussions with Health Canada and Shibogama Health Authority nurses, the project team categorized the role of the Community Wellbeing Nurse into five main areas: advocacy, coordination, mentorship, health education, and clinical roles.

6.1. Advocacy

It was felt that the Community Wellbeing Nurse could work with the community physician to provide advocacy for Community Leadership and other stakeholders related to concerns affecting community wellbeing. For example, they could provide advocacy around mental health services, housing, food security (quality, availability, and cost of food), fire department, structured fire response team, fire retardant materials, dog control, etc. In order to do this, the nurse would first need to identify key issues in the community that require advocacy.

6.2. Coordination

The Community Wellbeing Nurse could provide a coordination role by identifying key issues in the community that need to be targeted. Once the issues are identified, the Community Wellbeing Nurse could bring together appropriate workers and facilitate teamwork to address the issues. For example, the Community Wellbeing Nurse could take the lead in coordination of community pandemic plans and evacuation plans, and could run exercises/drills to practice the plans. As the work is undertaken to address the issues, the Community Wellbeing Nurse could provide ongoing support to the program staff. With this coordination role, it would avoid duplication of efforts and maximize collaboration to achieve the best results.

6.3. Mentorship

It was also felt that the Community Wellbeing Nurse could provide training opportunities to community resource staff, and could maintain an ongoing mentorship relationship with the staff. It was hoped that the Community Wellbeing Nurse would be a resource that staff could go to when they were unsure about something or needed more expertise related to specific topics.

6.4. Health Education

The Community Wellbeing Nurse should conduct health education through a variety of channels, including school health, promotional campaigns, programs, radio shows, workshops, prenatal classes, and young mothers' groups.

It was noted that the Community Wellbeing Nurse should play a key role in school health, and would be able to make a huge difference if they visited the schools to conduct health education. The Community Wellbeing Nurse could provide concrete programming for health promotion and prevention, and should involve teachers into the discussion and programming.

Prenatal classes and young mothers' groups could be done with the support of the HBHC worker. During the Young Mothers' group the nurse and HBHC worker could teach how to care for young children (including breastfeeding, hygiene, choking prevention, and infant feeding).

A long list of other health topics that should be targeted were also indicated including: water safety, bike safety, car seat use, birth control, breast feeding, sexual health, hygiene, injury prevention, preventing the spread of flu, preventing high blood pressure, how to control blood sugar, and how to deal with head lice. Additionally, the Community Wellbeing Nurse could promote swimming programs and safe swim zones, since drowning is a major cause of death in youth in some communities.

6.5. Clinical Role

There were conflicting opinions on the clinical role the Community Wellbeing Nurse could play. For example, some staff indicated that the Community Wellbeing Nurse could conduct well-baby clinics, while others thought the well-baby clinics and prenatal visits would fit better within the primary care system. Some also felt that the Community Wellbeing Nurse could do diabetes monitoring and follow-up, and possibly foot care. It was also felt that the Community Wellbeing Nurse could go on home visits. For example, they could go along with the HBHC worker to visit young children and new parents, or they could visit Elders' homes, especially those that are not mobile. This would lessen the workload of the clinic nurses.

7.0. SLFNHA Support

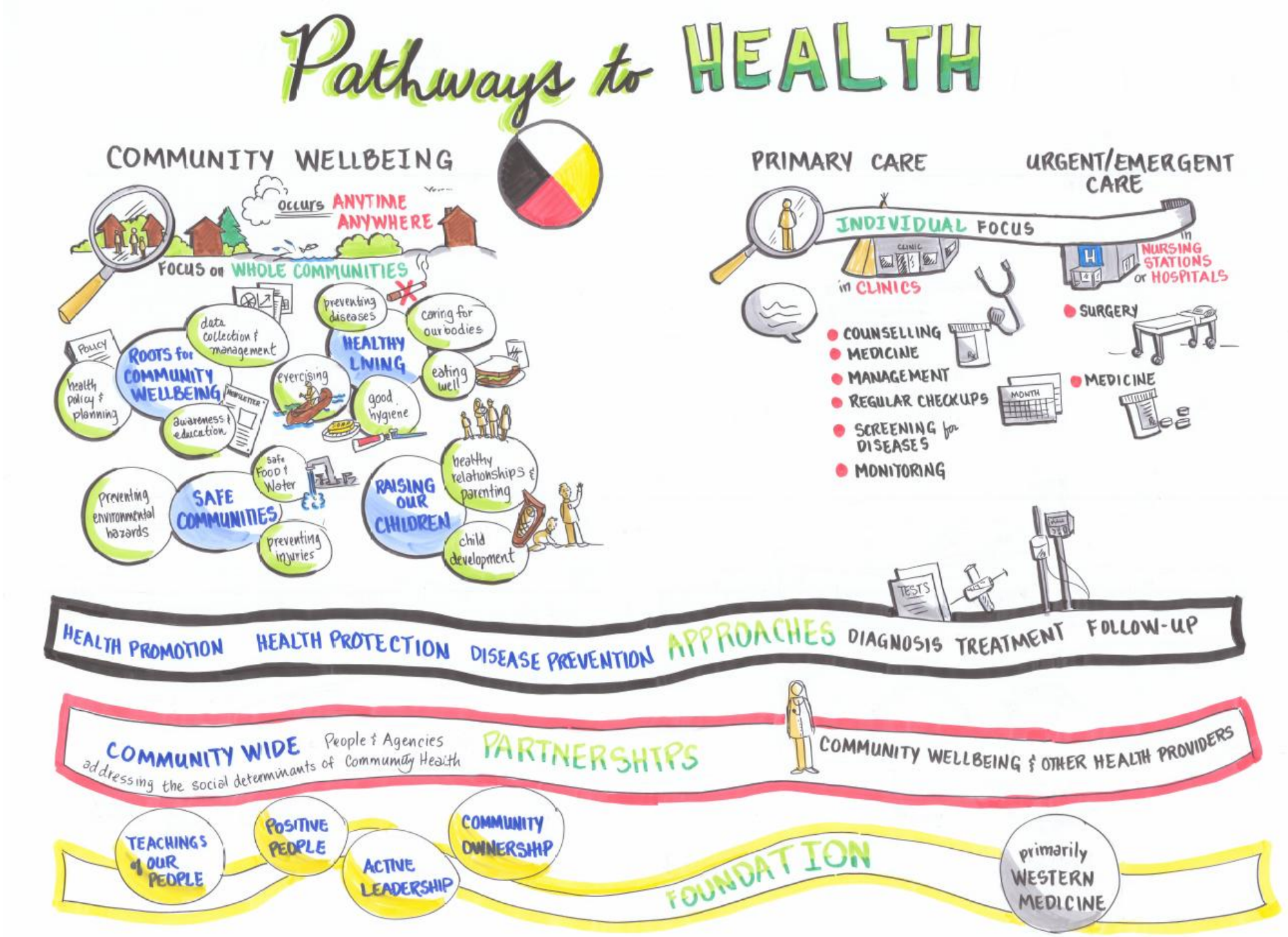
Communities were asked about current gaps in services or additional support they would like to receive from SLFNHA. This additional support would be to strengthen programs and services related to the Approaches to Community Wellbeing model. From the feedback given, it was suggested that SLFNHA could advocate on behalf of communities for additional funding and human resources in areas that fall under Approaches to Community Wellbeing. SLFNHA could also advocate for, or develop, additional health messages that are more culturally appropriate and relevant to the area in which they live. Community members also suggested that SLFNHA could assist with, or promote, Elders passing on their language to youth. Currently, many youth may understand it, but most do not speak it.

Furthermore, it mentioned that SLFNHA could provide additional support for more training opportunities, such as; train the trainer programs for health and youth staff that fall under the Approaches to Community Wellbeing. SLFNHA could provide education on Healthy Relationships as it relates to the Raising Our Children section of the model, and provide communities with anti-bullying strategies when necessary. Additional areas of support that were noted were assisting communities with more communication regarding existing jobs within the communities. As well as, information regarding what role the staff members have within those positions. SLFNHA could assist with resources for making communities safer (i.e. having security or a presence of some sort in the community walking around to ensure everyone's safety). Finally, it was mentioned that a role for SLFNHA would be to gather population and health data and provide the results back at the community level.

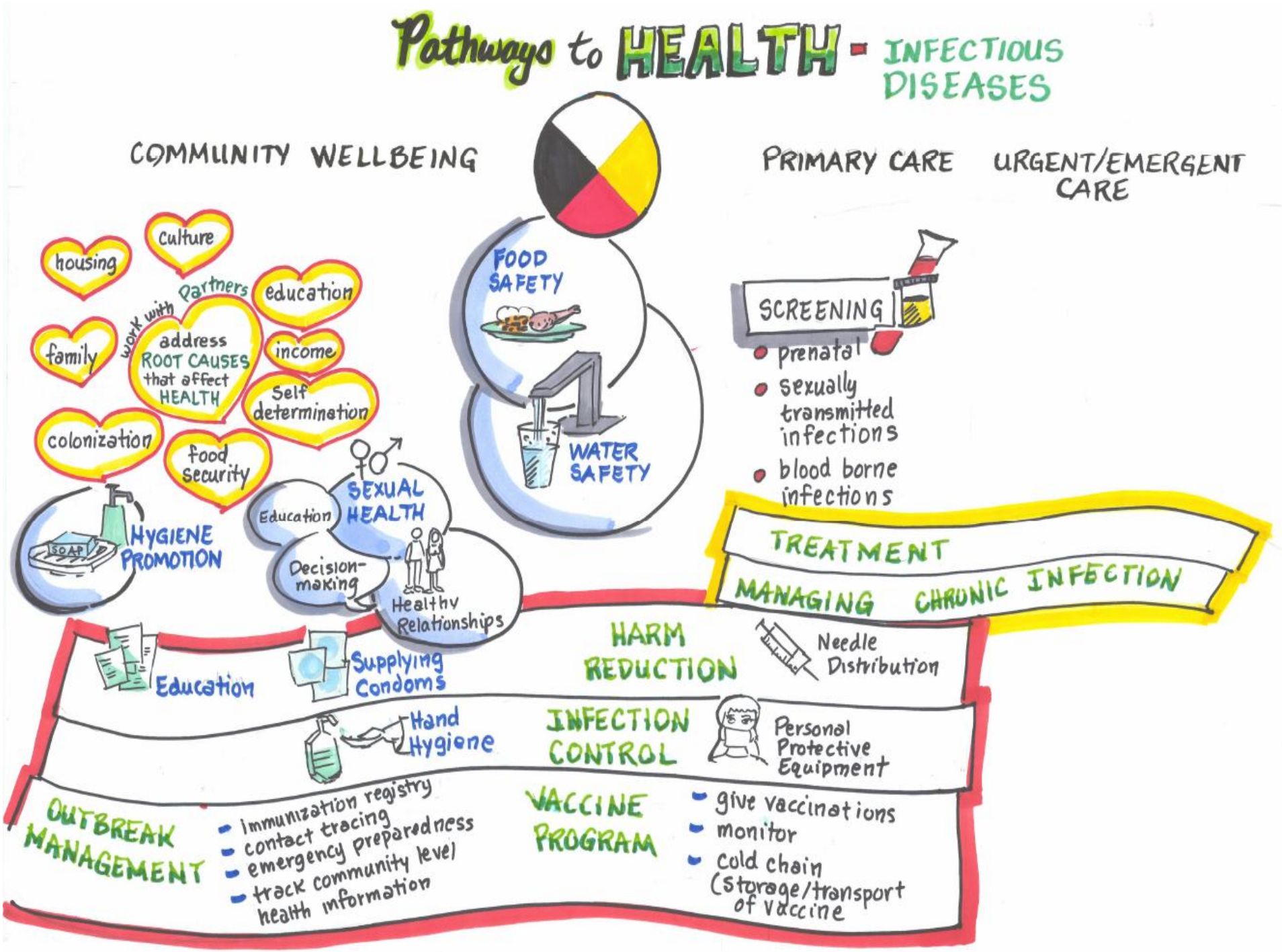
8.0. Conclusion

Following the oultined community visits, the project team was able to get a relatively good impression of what resourses are currently available within many of the communities in regards to Raising Our Children. This was made possible through the support of the communities that allowed the Community Wellbeing Team to visit and the Chief & Council members, Health Directors, NICs and many other health and band office staff that gave their time for events and interviews with the Project Team. Additionally, the project team was able to get a sense of what the SLFNHA might be able to do in regards to supporting these communities going forward, whether its through advocacy, support or service delivery.

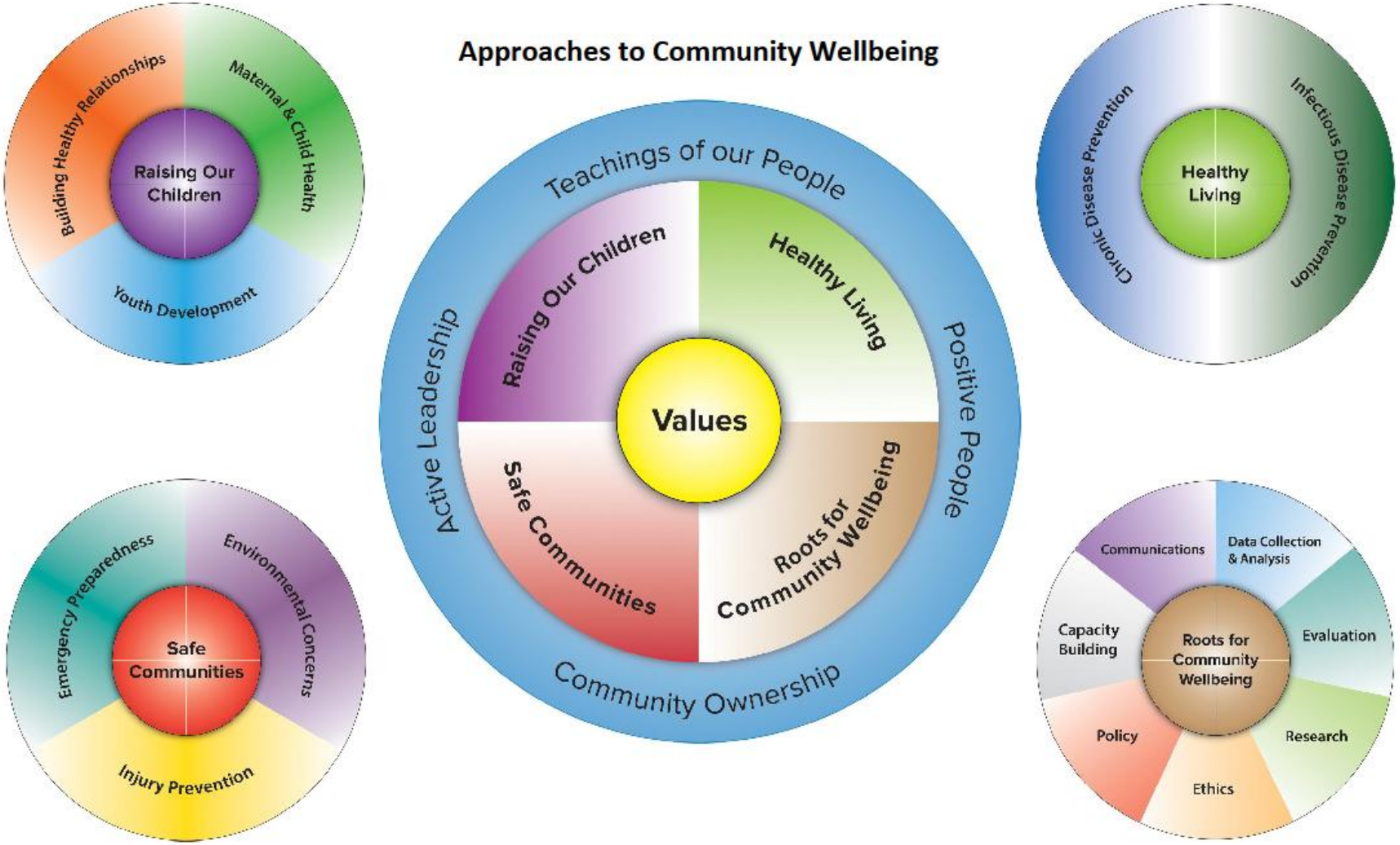
Appendix A: Community Forum Education Pictures




Pathways to MENTAL HEALTH
COMMUNITY WELLBEING
PRIMARY CARE
URGENT/EMERGENT CARE
housing
Culture
education
family
work with Partners
address ROOT CAUSES that affect HEALTH
income
self determination
colonization
food security
create SUPPORTIVE COMMUNITIES
ANTI BULLYING
People to talk to
Self Esteem
Safe places to TALK
STRESS management
reducing STIGMA
HEALTHY RELATIONSHIPS & OUTLETS
MENTAL & EMOTIONAL Health Counselling
TREATMENT of SELF HARM
CULTURALLY APPROPRIATE Health Education
Promote CONNECTION to Spirituality, Culture & Land
community LEADERS support POSITIVE MENTAL HEALTH & fight ADDICTIONS
Chief's Resolutions
Band Council Resolutions
Teachings
SCREENING for MENTAL ILLNESS
TREATMENT & MANAGEMENT of mental illness
TRADITIONAL MEDICINES & TEACHINGS of our people
TREATMENT of drug addictions
COMMUNITY & FAMILY
AFTERCARE for Recovering Addicts


Pathways to HEALTH - INFECTIOUS DISEASES
COMMUNITY WELLBEING
PRIMARY CARE
URGENT/EMERGENT CARE
housing
culture
family
Partners work with
education
address ROOT CAUSES that affect HEALTH
income
Self determination
colonization
food security
HYGIENE PROMOTION
SOAP
FOOD SAFETY
WATER SAFETY
SEXUAL HEALTH
Education
Decision-making
Healthy Relationships
SCREENING
prenatal
sexually transmitted infections
blood borne infections
TREATMENT
MANAGING CHRONIC INFECTION
Education
Supplying Condoms
HARM REDUCTION
Needle Distribution
Hand Hygiene
INFECTION CONTROL
Personal Protective Equipment
OUTBREAK MANAGEMENT
Immunization registry
contact tracing
emergency preparedness
track community level health information
VACCINE PROGRAM
give vaccinations
monitor
Cold chain (storage/transport of vaccine

Appendix B: Approaches to Community Wellbeing


Approaches to Community Wellbeing
Raising Our Children
Building Healthy Relationships
Maternal & Child Health
Youth Development
Teachings of our People
Active Leadership
Positive People
Community Ownership
Raising Our Children
Healthy Living
Safe Communities
Roots for Community Wellbeing
Values
Healthy Living
Chronic Disease Prevention
Infectious Disease Prevention
Safe Communities
Emergency Preparedness
Environmental Concerns
Injury Prevention
Roots for Community Wellbeing
Communications
Data Collection & Analysis
Capacity Building
Evaluation
Policy
Research
Ethics

Appendix C: Youth Development Survey

This survey is intended to gain input into the Youth Development section of the Sioux Lookout First Nations Health Authority's Approaches to Community Wellbeing model. We are looking for ideas of how to prevent illnesses and promote healthy lifestyles amongst youth, and how to improve services within your community. This survey will take you approximately 10-15 minutes.

Although you may leave any question blank, and end the survey at any time, only completed questionnaires will be entered into the draw. If you decide afterwards that you would like your responses removed from the analysis, please contact Emily.Paterson@slfnha.com

Health Issues

1. *What are the most important health issues affecting youth in your community?*

- ☐ Injuries/Accidents
- ☐ Breathing problems (i.e. asthma, tuberculosis, bronchitis)
- ☐ Bullying
- ☐ Relationship problems
- ☐ Low self-esteem
- ☐ Don't have people to give you guidance
- ☐ Smoking
- ☐ Addictions/substance abuse
- ☐ Suicide
- ☐ Self-harm
- ☐ Eating disorders
- ☐ Diabetes
- ☐ Lack of access to healthy foods
- ☐ Not eating the right foods
- ☐ Lack of access to physical activity
- ☐ Dental/oral health issues
- ☐ Other (please specify)

2. *What can communities do to solve these health issues?*

3. *Who should be involved in fixing these problems?*

4. How do you think the youth could get involved in fixing these problems?

5. What is happening in your community to keep youth healthy?

6. What else would you like to see happening in your community to keep youth healthy?

7. What would make you join in to health activities?

8. What do you think would make you healthier?

Relationships with Elders

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9. Do you feel connected to Elders?

- Yes, very much
- Yes, a little
- No

10. Would you like to feel more connected with Elders?

- Yes
- No

11. What should/could be done to help Elders and Youth connect?

Contact Information

The contact information collected here will only be used for the participation draw. When we analyze the results, we will remove the personal contact information.

We are collecting the community name so we will be able to see which communities have provided us with information. This will help us in future engagement strategies.

12. Address

Name
Email Address
Phone Number

13. Community Name

14. In what year were you born? (enter 4-digit birth year; for example, 1996)

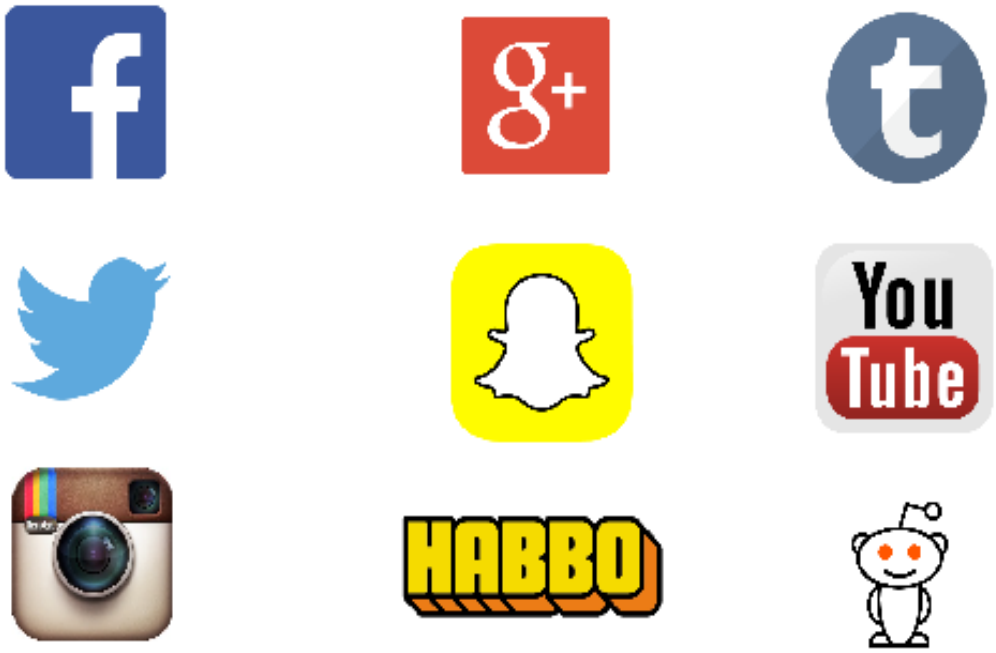
Thank You/Miigwetch! Thank you for participating in our youth survey. If you have any questions, please contact Emily Paterson, Community Wellbeing Project Coordinator, Sioux Lookout First Nations Health Authority at Emily.paterson@slfnha.com or 1-800-842-0681.

Miigwetch!

Appendix D: Social Media Survey

What **Social Media** sites do you use?

1. Circle the sites you use the most



2. How do you use these sites (Circle all that apply)

None Ipod Phone Tablet Computer

3. Do you use any websites for First Nations Youth? What sites?

4. Do you want a Facebook Page for First Nations Youth?

Appendix E: Radio Show

Good afternoon
Joining us today is Emily Paterson and Shanna Switzer. Emily is the Community Wellbeing Project Coordinator and Shanna Switzer is the Community Wellbeing Facilitator at the Sioux Lookout First Nations Health Authority. Welcome!

Shanna and Emily: Thank you for having us.

Community member: You both work with the Sioux Lookout First Nations Health Authority's Community Wellbeing Project. Can you tell us about the project?

Shanna: Before I explain about the project, I need to provide a bit of history. In 2006 the Sioux Lookout First Nations Health Authority developed the Anishinabe Health Plan, which outlines how services should be provided to the 32 communities our organization services. That report noticed a significant gap in services aimed at preventing illness and promoting healthy lifestyles. This led to a resolution from the Sioux Lookout area Chiefs in 2010, which mandated SLFNHA to develop a regional public health system. SLFNHA received a three year grant from Health Canada to develop the system. We looked at different existing public health systems for First Nations in Canada before we developed our own. We also looked at the existing human resources and services in the communities to identify where some of the gaps are. After this work was done, we did a series of community engagement initiatives, through meetings, videoconferences, and community visits, to gain input into the model. We then developed a model and called it "Approaches to Community Wellbeing"

Community Member: Why did you call it approaches to Community Wellbeing?

Shanna: We found through our community engagement sessions that people had a hard time relating to the term public health. So instead of saying "public" we changed it to the word "community" and instead of saying "health" we took a more wholistic approach, and used the word "wellbeing". And the term approaches came out of a discussion around the terms model or system, and we decided that all the programs and services that will be undertaken to achieve community wellbeing, are really just our different approaches to community wellbeing.

Community member: For those who don't know…what is public health? Or community wellbeing

Emily: Public health or Community Wellbeing refers to initiatives focused on improving the health of communities as a whole. It looks at the whole community instead of individuals. It aims to keep people as healthy as possible for as long as possible. It aims to prevent illnesses or injuries in the first place, and it promotes an overall healthy lifestyle.

Community member: Oh okay, thanks. Now that we know a bit about what community wellbeing is, and how the project started, can you share a bit about the model you developed with us?

Emily: The model was put together using all of the feedback from the community consultations. From that feedback, we developed a vision for the system, which is: "The Anishinabe people of this land are on a

journey to good health by living healthy lifestyles rooted in our cultural knowledge." From there we developed a mission, which is: "to develop integrated, sustainable, and community-owned approaches to community wellbeing. The approach will be rooted with the traditional teachings of our people and will promote healthy lifestyles, active leaders, and positive Anishinabe people."

Shanna: We also developed a series of core values for the system, which include: the teachings of our people, family, language, history, wholistic, honour choices and respect differences, share knowledge, connection to the land, and supportive relationships and collaboration.

Community Members: Can you elaborate more on what each of those values means?

Shanna: Sure…

The Teachings of our People: We recognize and use the teachings of our people, including respect, wisdom, love, bravery, humility, trust, truth, sharing, and kindness.
Family: Our families take responsibility for each other and are integral to community wellbeing.
Language: Language is rooted in our culture as Anishinabe. It connects us with the land, our ancestors, and each other.
History: We learn from our history and allow it to guide us toward the future. Through understanding our history, we can recognize and embrace our resilience.
Wholistic: We honour the Circle of Life and ensuring balance between the four elements: spiritual, mental, physical, and emotional.
Honour Choices and Respect Differences: Everyone is different and we honour and respect these differences. Everyone has the ability to make the choices that are best for them.
Share Knowledge: We share the teachings of our people from generation to generation. We share best practices and learn from each other.
Connection to the Land: We are the stewards of the land and we value our connections to the land. The land is our teacher, provider, and medicine-healer.
Supportive Relationships and Collaboration: We build supportive connections and relationships both within and outside the community, which promote participation and inclusiveness.

Community Member: And what are the goals for this system?

Emily: The overall goals for the system are:

- Improved approaches to community wellbeing, which are integrated, wholistic, sustainable, and proactive
- Increased community ownership over our health and approaches to wellbeing
- Increased number of people leading the way who are committed to healthy communities
- Safer communities
- Increased number of people making healthy choices
- Increased number of children raised as healthy community members
- Increased connection to the teachings of our people

As we move forward into the system, each community will adapt these goals and make them more specific according to their community needs and priorities.

Community member: That sounds like a lot of work! How will those goals be accomplished?

Emily: The goals will be accomplished through a series of programs that fall under four main categories: Roots for Community Wellbeing, Safe Communities, Healthy Living, and Raising our Children. Roots for Community Wellbeing will look at things like data collection, program planning and evaluation, capacity building, ethics, communication, etc. to ensure that all of the other program areas are well supported in order to work effectively. Safe communities looks at ensuring communities are prepared for emergencies, addressing environmental concerns, and preventing injuries. Healthy living will look at healthy lifestyles in order to prevent infectious and chronic diseases. Finally, Raising our Children will look at the health of families and youth development. It also looks at building healthy relationships, whether that is with yourself, your peers, parents, etc.

Shanna: We also identified four key themes that need to be included in everything we do throughout the Approaches, and these are the teachings of our people, active leadership, community ownership, and positive people. Everything throughout the system will need active leaders, whether Chief and Council, health staff, Elders or youth, in order to work well. We also need positive people to work in the system. Furthermore, communities and individuals need to take ownership over their health and their health system, for the initiatives to work. As part of this each community will look at the regional model and determine how it will look at the community level. The vision, values, goals, and programs can be adapted by the community to meet their needs. Hopefully, by implementing these approaches, these four areas will be strengthened in each community as well

Community Member: So what brings you to our community then?
Emily: We are here to get more information about what is needed in the Raising our Children section of the model. So we are here to meet with the Health Director, Assistant Health Director, and workers involved with child, youth, and family health. We are also working to engage youth about what they want to see available for youth, so we are doing presentations in classes at Thomas Fiddler Memorial High School. We are also co-hosting a youth event tonight from 6-8pm at the Youth Centre. There will be prizes and snacks available, so we encourage all youth to attend.

Community Member: Speaking of youth, I understand you have survey for youth going on right now. Can you speak about that?

Shanna: Yes, we have a survey available online for youth to fill out. The survey asks questions about what the key health issues are that face youth in communities, and what can be done to improve services and programs for youth. The survey is available at https://www.surveymonkey.com/r/CJRZ9LD. Once again that is https://www.surveymonkey.com/r/CJRZ9LD.

Community Member: Thank you for sitting down today to chat about the Community Wellbeing Project. You have given us a ton of information! We will now open it up for questions if anyone wants to call in….

Questions?

Community Member: Any last words?

Shanna: Just a reminder for youth to attend the youth event from 6-8pm at the Youth Centre.
Community member: Thanks for coming to our community, and for speaking sharing this information with us today.

Shanna and/or Emily: Thanks for having us….we are glad to be here