Community Health Indicators

Engagement Summary Report

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- Nibinamik First Nation
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- Sachigo Lake First Nation
- Sandy Lake First Nation
- Slate Falls First Nation
- Wabigoon Lake First Nation
- Wapekeka First Nation
- Wawakapewin First Nation
- Webequie First Nation
- Wunnumin Lake First Nation
- Independent First Nations Alliance
- Matawa First Nations Management
- Shibogama First Nations Council

Approaches to Community Wellbeing staff that conducted community visits were:

- Emily Paterson, Director of Approaches to Community Wellbeing
- Shanna Miller, Community Wellbeing Facilitator
- Cai-lei Matsumoto, Epidemiologist (report author)

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2.0 Introduction

Approaches to Community Wellbeing was developed by the Sioux Lookout First Nations Health Authority (SLFNHA) together with the 31 rural and remote First Nation communities it serves. Approaches to Community Wellbeing (ACW) is working to develop integrated, sustainable, and community-owned approaches to community wellbeing. It is rooted with the traditional teachings of our people and will promote healthy lifestyles, active leaders, and positive Anishinabe people.

This report outlines the information gathered during the health indicator engagement process and provides community input into health status measures. Results are compiled from community visits, Health Directors meeting, individual meetings, and telephone interviews. The information will be used for SLFNHA's planning purposes, and will be returned to all communities to use and share as they feel appropriate.

3.0 Background

One of the four main program areas under ACW is Roots for Community Wellbeing. This program area provides support and key information to the other three program areas through capacity building, policy, ethics, and communications, as a few examples. Most relevant to this report is the responsibility of data collection and analysis, which involves the collection, use, and sharing of health information to support public health decision-making. To support this, health status reports will be completed and a health surveillance system created. These functions are supported by resolutions #12-07 Health Monitoring Surveillance, and #15-25 Health Data Management passed by the Sioux Lookout area Chiefs in Assembly.

The collection and use of information that involves First Nations, should follow the principles of Ownership, Control, Access, and Possession (OCAP®). These principles were established by what is now called the First Nations Information Governance Centre (FNIGC) through the Assembly of First Nations. OCAP® principles were established to ensure First Nations communities and their community members own their information and that they are stewards of their information. Additionally, collecting and sharing the information is controlled by First Nations to ensure they benefit with minimal harm.

As stated by the FNIGC, Ownership refers to the relationship between a community and its culture, traditional knowledge, data, and information. This relationship is the same as one owning their personal information. Control allows the First Nations people, communities, and other representative bodies to control how their information is collected, used, disclosed, and discarded. Access allows First Nations to be able to have their information and data regardless of where it is held. Finally, possession allows for ownership, control and access to be possible. This means the data is within First Nations jurisdiction, which can be through direct possession or through approved stewards. This information and more can be found on the FNIGC website[1].

The previously mentioned resolutions enable SLFNHA to be a data steward for the First Nation communities it serves. They also allow SLFNHA to develop and distribute health status reports, which are reports that have different health indicators that help describe the health of a population. Health indicators are summarized numbers of de-identified health information, which are used to measure

[1] www.fnigc.ca

health. Health status reports will be created at both the regional and community level. Community level reports could also be supplemented with summaries specific to each community, as requested. This will help ensure the entire community can be informed. At the regional level communities will remain anonymous, however, ACW will be able to facilitate conversations between communities who want to learn from one another. These steps help ACW meet the principles of OCAP®.

With the implementation of ACW, as approved by the Sioux Lookout area Chiefs in Assembly, ACW wanted to hear from the communities what health indicators they would like to see included in health status reports. ACW undertook this engagement process to hear from communities about indicators they would like in health status reports, as the current system for health information collection and feedback to communities is not working well. Additionally, by having data collection and analysis done within the region, public health priorities can be identified.

The engagement process sought to:

- identify community priorities for illness indicators;
- identify wellness indicators;
- determine how communities would like their information shared back with them;
- identify how communities would like to be updated; and

identify future measures that will help communities with current program planning and evaluation.

4.0 Community Participation

Thirty-one communities are supported by ACW, under six Tribal Councils and three Independent Bands. Communities were invited to participate in determining health indicators by invitation as seen in Appendix A. Invitations were faxed to communities on July 27th, 2016 with an RSVP date of one week later. Communities were called on July 28th, 2016 to ensure the fax was received. Health Directors at Tribal Councils were also emailed an invitation, so they could forward it on to their community Health Directors. A week after the initial fax, communities were called to determine if they would like to participate. Community visits were to be scheduled with one community from each Tribal council, while individual meetings were held with the Health Directors of two Independent Bands. Communities that ACW was unable to travel to were reached through other means, described further in this report. Communities selected for community visits were notified within one and a half weeks of the initial fax. Community participation can be seen in the table attached in Appendix B.

Visits occurred between September 2016 and November 2016 with remaining engagement from November 2016 to June 2017. Visits were determined with the ACW Director to ensure communities that had not been visited previously were a high priority.

Videoconferences were attempted with the remaining interested communities, however they were not successful and had to be cancelled due to unavailability of Health Directors and videoconference space. The remaining Health Directors were then contacted by phone and asked if they would like to participate through a phone meeting if they were available, or receive a call back at a later date.

The following outlines how the different engagement methods were conducted.

4.1 Community Meetings

Community visits were conducted by the Epidemiologist and Director of Approaches to Community Wellbeing or the Community Wellbeing Facilitator. Prior to the visit, arrangements were made with the Health Director to identify which health staff and other community workers or members the ACW team should meet with. At the beginning of each visit the team would meet with Chief and Council to introduce the ACW program, discuss the purpose of the visit, and hear feedback into the priorities for the community. A radio show would be conducted on the first day to let the community know why ACW was there. The radio show is attached in Appendix C. Near the end of the visit a meeting was held with the Health Director where additional updates on how the visit went and who the team was able to connect with were provided.

While in the community the ACW team would try to connect with the youth through suggestions from Health Directors. Sometimes they were reached in the evening while they were playing games outside and other times the ACW team would spend half a day at the school. When youth were reached in the evening it was an informal process asking what wellness would look like in their community. At the school, students from grade six to nine were also asked what wellness would look like in their community and discussed the differences between public health and health.

Meetings were held with individual workers, unless they specified they would like to meet in groups. At each meeting the ACW program was introduced and the difference between health surveillance and health research was discussed. A copy of this information was provided to each individual and is attached in Appendix D and E, respectively. Attached in Appendix F are the health indicator questions that were asked to determine what information is currently collected, what information they would like to see collected, what wellness means to the community, and how the information should be shared back.

Following a community visit the feedback was compiled into a report and provided back to each community.

4.2 Interviews

For communities that indicated they would like to participate but could not be reached by community visit, videoconferences were attempted. However, when both attempts at a videoconference could not be done, telephone interviews were done instead. Additionally, if a Health Director was in Sioux Lookout they were asked questions in person.

During the interviews, Health Directors were introduced to the ACW program if they were unfamiliar with it. Similarly, to the community meetings, the difference between health surveillance and health research was also discussed. Health Directors were then asked the same questions as outlined in Appendix F. Feedback from interviews has been included in this report.

4.3 Health Directors Meeting

During the engagement period a Health Directors meeting was held in Sioux Lookout from November 8-10, 2016. During this time, the Epidemiologist presented on what health surveillance is, the difference between health surveillance and health research, and an update to the engagement strategy.

The room was then broken into smaller sub-groups to allow discussion about what wellness looks like and what other information they would like collected. Each question was given 15 minutes for discussion with answers shared back with the large group at the end. The feedback from this meeting has also been included in this report. Appendix G includes the graphic summary capturing Health Directors' feedback on both questions.

5.0 Information Currently Collected

Each community collects a different amount of information depending on the programs run. Programs that are run in each community will collect the same basic information for reporting purposes but some communities will also collect additional information. For example, all Healthy Babies Healthy Children (HBHC) programs collect the number of events that they put on each month to provide to the funders, some communities will collect additional information about the clients they serve to help with programming. Overall communities mostly collect information for reporting to funders. There is little information collected for program planning, and advocacy.

Most Health Directors have health workers report their activities to them each month, with the number of clients seen, the number of programs run, and what type of activity it was. Health Directors have found this to be the easiest way to complete funding reports at the end of the year. Often information is tracked and reported on paper, however some health workers will enter information into Microsoft Word or Excel afterwards and send that information to the Health Director. Information that is not summarized monthly is done either quarterly or yearly.

As mentioned, some programs will collect more specific details on clients depending on the community. These details are kept in client files and can include things like age, sex, number of children, and any health conditions. Some communities use intake forms for some programs where this will be collected, while other programs have client information sheets to collect this on. This information is only collected for the knowledge of the health workers running the programs.

If a program enters information into an electronic system of any kind, that system is supplied by the funder. Communities mentioned that they rarely receive a report back from funders, and if they do it is not very helpful. One example, is a Non-Insured Health Benefits summary communities receive, which includes the dollar value spent on different services, but does not help Health Directors determine if there could be a health concern within the community. Another program that can receive reports back is the Right to Play program, yet ACW heard that it is not always received by all communities.

Some areas within communities that could have electronic databases include the nursing station, Ontario Works, Home and Community Care, and the schools. Some nursing stations use a Service Administration Log to record information about client visits. However, ACW heard that not all nurses have the time to enter into this database. Yearly reports are provided back to nursing stations from Health Canada from this database. It is then up to the Nurse In Charge to share it with community

leadership. Ontario Works uses a system called General Welfare System, in which all client information is stored. The information helps to determine if community members are eligible for financial assistance. Home and Community Care enters into an electronic system supplied by Health Canada, however communities mentioned often due to connectivity issues this can be very difficult. This system also includes information on clients and the services they require, in addition to the number of clients visited and what services were performed. Lastly, depending on the grades of schools within communities they either use Maplewood (high school) or Dadavan (elementary). These systems hold all student records and can be used to determine the number of students in the school and the number that graduate. Some communities also mentioned that these systems can be difficult to use due to training issues and poor connectivity.

As mentioned, the majority of information currently collected within communities is for funding purposes. For Health Canada, the Community Based Reporting Template is completed each year, while Nishnawbe Aski Nation also requires end of year reports depending on the programs a community has. The ACW team heard that these reports are often difficult to complete and can take many hours.

6.0 Identified Indicators

Throughout the engagement process, communities identified a significant number of indicators relating to programming, health, and wellbeing. A few indicators relate to all areas of health and wellbeing within the community.

One indicator identified was seeing an increase in available space for programming within communities. There is a lack of available space for health workers, limiting the amount of programming that can be offered within communities. Some communities mentioned that there is extra space available but it is not safe for the type of programming that is being offered. Some examples communities mentioned were baby friendly space, a gym, an arena, and a community hall. To ensure space being provided is used, communities could keep track of the number of times programming is offered there. An example of how to keep track of space used is provided in Appendix H1. This is something that may not change frequently, so new space could be reported as it comes available as well.

Another indicator identified was seeing an increase in attendance by community members when programming is offered. The ACW team heard that clients seem interested in programming when it is discussed but then often do not show up at the times it is offered. To try and increase attendance in some communities, health workers have done polls to see what times work best for clients. Communities would also like to see an increase in the number of new participants coming to programming. Seeing an increase in new participants will help ensure the entire community is being reached. Having sign-in sheets for programming will allow health workers to keep track of the number of participants and see if there are new participants. Attached in Appendix H2 is an example of how to keep track of the number of participants and determine the percentage of new participants.

It was also identified that seeing an increase in education within communities for both health workers and community members would be an important indicator. Examples of increased education needs included what immunizations are for and what is in them, why medication compliance is important, and different chronic diseases. To support education sessions, communities wanted more handouts or pamphlets that community members could take from education sessions on these topics in both

traditional languages and English. Appendix H3 has an example of how communities can keep track of the number of education sessions that are held.

The remainder of the indicators identified by communities are organized according to the area of Approaches to Community Wellbeing they fall under.

6.1 Raising our Children

6.1.1 Family Health

Within communities there are many programs that ACW could support under the Family Health section of the program. They include but are not limited to: Aboriginal Head Start, HBHC, Maternal Child Health, Early Childhood Development, Canada Prenatal Nutrition, and Fetal Alcohol Spectrum Disorder. Each of these programs offer unique programming. Yet among all the different communities they have similar priorities and experience some of the same difficulties.

It was important to communities to know the number of children in care, as communities would prefer to see children staying within the community and with family instead of ending up in care outside of the community. Having more discussion within the community with family prior to children being removed from parents would be preferred. Many felt this could result in healthier solutions for children and as a result see a decrease in the number of children in care. Attached in Appendix H4 is an example of how the number of children in care can be calculated.

There is concern in communities around the rates of Fetal Alcohol Spectrum Disorder (FASD). Health workers find this a difficult topic to discuss with families. It is believed that families can become defensive as some may take it as they made a mistake. Due to this belief, children are often not diagnosed until they are in school, showing behavioural problems. Appendix H5 has an example of how to determine the rates of FASD.

Throughout the engagement sessions, concerns were heard about the overall health of the family. These types of concerns included the rates of miscarriage within communities, the rates of babies with birth defects, and the number of babies born addicted to opioids. Communities felt knowing these rates would allow them to plan adequate programming to support families and provide education where necessary. Calculations to determine these three rates are attached in Appendix H6.

6.1.2 Building Healthy Relationships

Within communities there are no specific programs that currently fit under this section of the ACW program. There are other programs that could incorporate aspects of Building Healthy Relationships to address some concerns. Having a focus on strong relationships and connections was an important topic brought up in all engagement sessions. One respondent stated, “the community feels it takes a village to raise a child, with grandparents being the piece that holds it all together.” Some communities felt this has been lost and would like to see it return, which could improve family life and improve relationships within communities.

Communities mentioned there also seems to be a decrease in community togetherness, including community members supporting one another. Previously, the entire community would come to

community gatherings and children would be well behaved. Now there seems to be fewer community gatherings occurring, and fewer community members attending those that do occur. Previously in some communities, people used to visit with each other regardless of how short the visit was. Now it seems as if people do not talk to each other. With the decrease in community togetherness, more community events were identified as a wellness indicator. Some event examples identified were sports games, fishing derbies, and culture weeks. Appendix H7 provides a way to track the number of community events. It also provides a calculation for determining the percent of the community that is attending these events.

Within communities there is an issue with bullying towards both children and adults, online and off. Often frustrations from community members towards health programs are expressed online, which leads to cyber bullying. Once one person raises a concern about a health program, many others begin to contribute negatively. This impacts the families involved with that health program because everyone can see it online, including family members. Children are bullied online and at school, and it seems that those who face struggles at home are targeted for bullying at school. Parents are not always happy with the way health workers deal with bullying, however these issues do not seem to be addressed at home either. Attached in Appendix H8 is an example of how bullying can be tracked. Seeing a decrease in the amount of bullying within communities was an identified sign of wellness.

In addition to cyber bullying, community members felt technology has contributed to decreased family life. Technology has impacted both children and adults within communities. Children spend more time inside in front of the screen instead of outside. Additionally, parents spend more time on technology and are less engaged with their children. Seeing a decrease in screen time for both children and adults was an identified sign of wellness. Appendix H9 provides a way to determine screen time use within a community.

Communities felt that the increased screen time was also leading to a disconnect between parents and their children. Parents are no longer spending time with their children doing homework, preparing healthy meals or doing land based activities. Additionally, there is little support from parents for the activities children participate in at school. In some communities, parents show up for report cards and class graduations but that is all. Some health workers were concerned with the lack of attendance by parents because they understand the importance of involving parents. One respondent stated, “parents have the greatest influence on their children despite what children might learn outside of the home, so it is important to ensure parents are engaged.” Another respondent stated, “family values have been lost because children are growing up in unstable homes, as parents no longer have one partner.” From the lack of family togetherness and parental involvement described above, an identified indicator was seeing an increase in both. Some communities felt measuring parental involvement could be difficult, however an example of how this could be determined through an education session is attached in Appendix H10. Additionally, in Appendix H11 there is a way to keep track of family involvement.

Lastly, communities felt that respect for Elders has decreased, especially among the youth. Previously, when an Elder passed away, communities did not work that day and there was no school, however, now there is no time to pay respect. Additionally, there is limited space for Elders programming to be offered within communities. Seeing an increase in respect for Elders would be a sign of wellness for communities. Communities identified that a good start would be seeing an increase in events specific to Elders. A way to track these events is attached in Appendix H12.

6.1.3 Youth Development

Within communities there are programs that could fall under this area of the model, including Brighter Futures, Right to Play, and programming through the school. Sessions that these programs have offered include cooking class, language class, and cultural awareness. Despite the programs that exist and the sessions offered, many believed more should be done for the youth.

During each of the visits ACW was able to reach youth through evening activities outside, or during the day at school. Below is a summary of the results obtained when grade 6, 7, 8 and 9 students were asked what wellness means to them. At the same time ACW also discussed with the students the differences between health and public health. Below is a picture that shows what the youth said and how common an idea was. The bigger the word the more times it was mentioned.

The table below shows some of the answers students provided. These answers in the right column were put under broad categories (left column) that were used to create the word cloud above. For example, the eating healthy category was created from combining student answers such as community garden,

eating fruits and vegetables, and lower food prices. Words that were mentioned once are included in the word cloud on their own.

Category	Examples
Eating Healthy	Community garden, eating fruits and vegetables, lower food prices
Sports	Playing hockey, volleyball, baseball
Exercise	Dock for swimming, running, working out, swimming pool
Healthy body	Clean teeth, showering, sleep
Better healthcare	Upgraded nursing station, more nurses and doctors, having a hospital
Land based activities	Hunting, fishing, camping
Youth activities	Games, karaoke, music, art

Additionally, throughout all of the meetings other important indicators were identified for the youth by communities. They have noticed that many youth are not able to speak and understand Ojibway, Oji-Cree, or Cree. Many felt that seeing an increase in the number of youth that are able to speak their languages could also improve the relationship between youth and Elders, as the biggest barrier expressed was the difference in language. Attached in Appendix H13 is a way to determine the percent of youth that speak the language within communities. Seeing an increase in this number would be a sign of wellness within communities.

Communities would like to see an increase in the number of youth returning to the land. It was felt that having programming available for youth that is land based would be important. This programming could happen both inside and outside of school. Some examples included were hunting, fishing, and camping. Appendix H14 has an example of how communities can keep track of this.

There is limited programming specific to youth happening in communities currently. Many felt this should be changed and an increase in youth specific programming should be seen. Suggestions on different programming included how to take care of themselves, physical activity sessions, and education on when one should seek help. Attached in Appendix H15 is a way to help communities keep track of the amount of youth programming.

Communities also identified indicators that involved the school. First, some communities identified that children seem to struggle at school and get into trouble. Seeing a decrease in this would be beneficial for community wellness. To help address this, communities suggested having a support group that children with behavioural issues could participate in and tracking performance issues reported at school. Appendix F16 has a way to keep track of the participants in the support group, as well as how to determine the number of students with behavioural issues.

Finally, communities would like to know school retention rates and graduation rates. A sign of wellness within communities would be having more students graduate and more students complete each school year. This is something that could already be available from schools through the Dadavan database. School retention rate and graduation rate is attached in Appendix H17.

6.2 Healthy living

6.2.1 Preventing Chronic Disease

Within communities the Aboriginal Diabetes Initiative, Home and Community Care, and Personal Support programs can provide support to those dealing with chronic disease. These programs offer a walking club, home visits, laundry services, Elder gatherings, and northern store food inspections, as a few examples.

Diabetes was a concern brought up in every engagement session. Many believe the rate of diabetes is high in their community because community members do not understand the importance of taking their medications and how to cook and eat healthy foods. Some community members believe that people pass away due to complications from diabetes due to not taking their medications. Communities feel there are few educational sessions for clients with diabetes. This was concerning for some communities because they believe there is an increase in the number of youth developing Type II Diabetes. To help health workers address diabetes within their communities it was identified that knowing the rate of community members with diabetes would be helpful. Appendix H18 has a way to calculate the incidence of diabetes and the prevalence of diabetes within communities. Incidence means the number of new cases of diabetes that are diagnosed in a year, while the prevalence means the total number of cases of diabetes within a community. Communities felt that knowing these rates will allow them to better plan programming.

Health workers felt that community members do not always understand the importance of eating healthy and how it can relate to chronic diseases and one's overall health. They mentioned that eating healthy is often impacted by the prices of food at the northern store. Further, the way displays are set up within the store encourages unhealthy eating. To try and address this concern some communities have community gardens for all to enjoy. While others have tried or asked for education sessions for community members to learn what is healthy versus what is not. Communities felt that having community gardens, more community members eating off the land, and increased exercise would all be signs of wellness. Appendix H19 has examples of how to keep track of community garden use and community members eating off the land. Appendix H20 has an example of how to keep track of increased exercise among community members.

Within some communities there is a perceived increase in drug and alcohol use. Health workers would like to have baseline numbers for the consumption of drugs and alcohol by youth and adults to be able to plan adequate programming. In the future, being able to collect the type of drug, method of use, and clients coping method if they have one would be helpful. It would provide health workers the chance to let clients know about more specific services that could help them as well as allow for better referrals. Opioid use, and its relation to Suboxone®, will be discussed in the next section. Attached in Appendix H21 is an example of how communities can determine the consumption of drugs and alcohol and in turn see a decrease as a sign of wellness.

6.2.2 Preventing Infectious Disease

Some communities have concerns surrounding skin infections and respiratory infections. They can be hard to manage in communities that have issues with running water. Additionally, some felt that crowded housing contributes to these infections. Communities would like to see a decrease in these

infections, however some recognize it may be difficult until issues with running water can be fixed. In addition to these two infections, communities were also concerned with tuberculosis, whooping cough, sexually transmitted infections, and Hepatitis C. Some community members have heard that tuberculosis is on the rise again within the area, so many felt knowing the rates and seeing a decrease in all the infections described above would be a sign of wellness. Appendix H22 has an example of how the rates of these infectious diseases can be determined for communities.

Some communities that have a Needle Distribution program find it is in high demand. With some giving out on average 1,000 needles per month there is difficulty keeping up with the demand. Supplies simply cannot get to communities fast enough, from when the requests are sent to SLFNHA's Needle Distribution Service to when they arrive in communities. More work is required to address the issue of getting a greater return of used injection equipment. Compared to the demand of needles going out to the communities, some see roughly only 200 used needles returned per month. In the future seeing a decrease in the number of needles requested and more needles returned would be a sign of wellness within communities, as some felt a decrease in needles would indicate community members are moving away from intravenous drug use. It is important to note that a decrease in needles requested could also mean that there are the same numbers of intravenous drug users but that they are using unsafe practices, such as sharing needles. Similarly, if an increase is seen in the number of needles requested it could mean that there are more people using safe injection methods and might not mean there is an increase in drug use. Appendix H23 has an example of how needle distribution can be tracked.

6.2.3 Suboxone® Programs

Currently some Suboxone® programs are challenged with a significant case load and a lack of resources, including workers. Due to a lack of resources, some programs have had to stop the land-based programming, which was beneficial for clients. It was also noted that some workers face abuse from clients during dosing times. This has made for a challenging work environment, and has also left workers feeling like the clients do not support or value the program. It was noted that they would like to be able to bring back land-based programming, as well as offer programming around nutrition, pregnancy and drug use, and other specific education around pregnancy. In the future to determine what kind of programming would be beneficial knowing the exact number of clients compared to the number of community members would be beneficial, as well as knowing how many are pregnant. An example of the chart that could be used to keep track of this is included in Appendix H24.

Many health workers felt the Suboxone® programs have been helpful for community members. Since the introduction of Suboxone® programs the following positive changes have been seen within communities: an increase in family outings, more participants in baseball and volleyball games, and an increase in volunteers for community events, as a few examples. There has also been a decrease in community members selling their belongings door-to-door, or through other ways, to obtain money for drugs. Some communities felt they can also see that parents are paying closer attention to their children with adequate clothing and food. Seeing more community members caring for their children would be a sign of wellness, Appendix H25 discusses how it can be tracked.

The last concern mentioned by some communities around Suboxone® programs was a disconnect between physicians and the programs. Some community members noted that doses are sometimes provided to clients despite suspected intoxication and this leads to decreased effectiveness of the program. They noted that this prevents clients from being held accountable and puts them at increased

risk of side effects. There was also a perception that physicians' priorities when in communities is to support Suboxone® and emergency cases only. Many feel only a handful of days out of physicians' visits are devoted to non-Suboxone® clients and believe having another physician for some communities would be beneficial. Seeing a doctor, ideally an addictions specialist, only for the Suboxone® program within some communities was suggested as a wellness indicator. Appendix H26 has ways to look at specialist and physician visits in a community.

6.3 Safe communities

6.3.1 Environmental concerns

A big concern within communities is the problem of bed bugs and cockroaches as many homes have these pests. They are transferred between buildings by being carried on clothing or furniture. One community mentioned that they have tried sanitizing homes using Northwest Pest Control and other exterminators, but have not had success in addressing the problem. The community mentioned they use a log book to keep track of the homes that have bed bugs, however not everyone comes forward so it is not a complete list. Other communities mentioned community members do not realize they have this issue until it is too late. Communities felt a sign of wellness would be seeing a decrease in the number of homes that have these pests. Appendix H27 has an example of how the number of homes with pests can be determined.

Mould was another environmental concern that was raised by communities, especially in older homes. There is no education for community members on how to adequately clean mould, and communities reported feeling that it is a silent killer causing a lot of medical issues. One community mentioned that community members are upset that they have to live with it and see it all the time. Seeing fewer homes with mould was a suggested sign of wellness. Appendix H28 has a method to determine the number of homes within a community that have issues with mould.

Concern was also mentioned around overcrowded homes in communities. Many felt that having additional housing would be good for the community. Some communities felt seeing a decrease in overcrowding would allow improvement in other health conditions for community members. Appendix H29 has examples of how overcrowding can be measured.

Not every home within a community has running water for showering or drinking. If homes in the community could have indoor plumbing, community members would no longer need to go to distribution points to pick up water. One community stated that until every home has running water, it would be difficult to identify other signs of wellness. Seeing running water in every home within a community was an identified sign of wellness by communities. Appendix H30 has an example of how to determine the number of homes that have running water.

6.3.2 Preventing Injuries

During the meetings, the ACW team heard that stray dogs within communities are a concern. People are afraid to go out walking and at times community members are bitten. Communities mentioned a sign of wellness would be seeing fewer stray dogs. It could be difficult to keep track of the number of dogs, so another way to measure this could be through seeing a decrease in the number of bites. Appendix H31 has an example of how the number of dog bites can be tracked.

6.4 Roots for Community Wellbeing

6.4.1 Capacity Building

A common concern identified by all communities throughout the meetings, was the lack of training for health workers. One community stated that there is very little training available, and workers learn on the fly. They further recommended that if training isn't available, educational material would be helpful. Having adequate training for the health workers would benefit the clients who seek services. One health worker suggested travelling to other communities to learn from those that are doing well would help as well. Communities felt seeing more training for staff would be a sign of wellness and would help with worker retention. Appendix H32 has a way communities could keep track of staff training.

7.0 Additional information to collect

Many health workers mentioned that they were unsure if there is any other information that they can collect due to confidentiality. Yet some felt that they would also like to see information collected in an electronic system, as they feel it would make it easier and allow for better sharing, when appropriate, between programs for improved client care. One community mentioned that they would likely need support in using more electronic methods through training and better connectivity.

One community stated that they would like to do evaluations after programs are run to learn how the event went, what clients want to see in the future, and what information or education they would also like to see in the future. An example of and evaluation form that could be used by programs is attached in Appendix I. They also want to know if clients have any barriers that prevent them from participating in programming.

Some of the programs that do not currently have intake forms, thought having them in the future would be helpful. Right now, it is not always clear why services are required and/or being provided from some clients, so they felt this would help clients more. On intake forms it would be good to include the age of clients to allow for more targeted programming for clients.

8.0 Sharing information back

Communities would like to see information shared back to them in a variety of ways. They would like information shared every year.

Most communities felt the best way to share information back would be in person with a community gathering. If the information could not be shared back in person some communities suggested it could be done through videoconference or through teleconference. Whether it is provided in person, video or teleconference, communities would also like to see well organized reports with clear headings that are easy to follow. From these reports, they also felt a radio show could be done by the Health Director to share the information throughout the community. In addition to the radio show, one community thought sharing the information on the TV would be good too.

Along with the reports, communities suggested infographics that are bright and colorful would attract community members' attention if placed around the community. Some communities mentioned they

could place these infographics on their website as well. However, having them in both English and the appropriate traditional language would be beneficial. To further help sharing the information with all community members, some thought a newsletter format would be good and it could be delivered to all houses in the community. Additionally, some communities felt Facebook would be a good option, although some were cautious of the information being shared to other communities.

9.0 Conclusion

In conclusion, although the ACW team was not able to receive feedback from every community, the engagement process was insightful. These indicators will be considered for SLFNHA's development of a regional surveillance system and health status reporting. The information in this report can be used by communities to begin collecting health information and monitoring these indicators, should they choose. SLFNHA was able to learn what currently exists in communities relating to health information, and what health indicators communities would like to see included in health status reports. Furthermore, SLFNHA learnt what areas we may be able to provide additional support to communities, whether through advocacy, support, or service delivery.

SLFNHA wishes to thank all those who took the time to meet with them and appreciate all the feedback that was provided.

Appendix A: Community Invitation

Sioux Lookout
First Nations
Health Authority

July 27th, 2016

Invitation for Health Indicators

Dear Health Director,

The Approaches to Community Wellbeing project was developed under the Sioux Lookout First Nations Health Authority in response to resolution #10-06, where the Sioux Lookout area Chiefs in Assembly mandated SLFNHA to establish a tripartite process between Sioux Lookout area First Nations, First Nations and Inuit Health – Ontario Region, and the Province of Ontario to develop and implement an integrated public health system. The project is currently underway and has begun implementation under resolutions #15-03 and #15-04. As part of the implementation plan, work has begun under a section of the model called Roots for Community Wellbeing, which involves data collection and analysis. We would like to visit communities to build on this section through discussions of health indicators. Health indicators are the result of data analysis that support public health decisions. In addition, they are often included in health status reports that are produced repeatedly at specified time intervals.

We would like to travel to approximately 5 communities and the remaining communities may be reached through videoconferences. We aim to have all the travel or videoconference completed by the end of November 2016. During the engagement we're looking to meet with you, Chief and Council, Community Health Representative, other health workers, elders, and youth. There will be questions that guide our discussions around health indicators.

If you are interested in having your community participate in this discussion please contact Cai-lei Matsumoto, Epidemiologist of Approaches to Community Wellbeing in any of the following methods by August 5th, 2016:

FAX: 807-737-4527

☐ Yes, please contact us for participation

☐ No, please do not contact us for participation

EMAIL: cai-lei.matsumoto@slfnha.com

PHONE: 807-737-5645

Thank you,

Janet Gordon
Chief Operating Officer
Sioux Lookout First Nations Health Authority
Phone: (807) 737-6101

Appendix B: Community Participation

Tribal Council	Community	Faxed Invitation	Phone Call Follow-up	Interested in Participating	Participated	Participation Method
Shibogama First Nations Council	Kasabonika	July 28/16	Aug 2/16	Yes	No	--
	Kingfisher Lake	July 28/16	Aug 2/16	No	--	--
	Wapekeka	July 28/16	Aug 2/16	Yes	No	--
	Wawakapewin	July 28/16	Aug 2/16	Yes	Yes	Interview
	Wunnumin	July 28/16	Aug 2/16	Unsure	No	--
Windigo First Nations Council	Bearskin Lake	July 28/16	Aug 2/16 & Aug 5/16	Yes	Yes	Meeting
	Cat Lake	July 28/16	Aug 2/16	Yes	Yes	Community Visit
	Koocheching	July 28/16	Aug 2/16	No Answer	--	--
	Sachigo	July 28/16	Aug 2/16	Yes	No	--
	Slate Falls	July 28/16	Aug 2/16 & Aug 8/16	No Answer	--	--
	Weagamow Lake	July 28/16	Aug 2/16	Yes	No	--
Independent First Nations Alliance	Kitchenuhmaykoosib Inninuwug	July 28/16	Aug 2/16	Yes	No	--
	Lac Seul	July 28/16	Aug 2/16 & Aug 5/16	No Answer	--	--
	Muskrat Dam	July 28/16	Aug 2/16 & Aug 5/16	No Answer	--	--
	Pikangikum	July 28/16	Aug 2/16	Yes	Yes	Community Visit
Keewaytinook Okimakarak	Deer Lake	July 28/16	Aug 2/16	Yes	No	--
	Fort Severn	July 28/16	Aug 2/16	Yes	No	--
	Keewaywin	July 28/16	Aug 2/16 & Aug 5/16	No Answer	--	--
	McDowell Lake	July 28/16 & Aug 2/16	Aug 2/16	No Answer	--	--
	North Spirit Lake	July 28/16	Aug 2/16 & Aug 5/16	No Answer	--	--
	Poplar Hill	July 28/16	Aug 2/16	Yes	Yes	Community Visit
Matawa First Nations Management	Eabametoong	July 28/16	Aug 2/16	Yes	Yes	Community Visit
	Neskatanga	July 28/16	Aug 2/16 & Aug 5/16	No Answer	--	--
	Nibinamik	July 28/16	Aug 2/16	Yes	Yes	Interview
	Webequie	July 28/16	Aug 2/16	Yes	Yes	Interview

Tribal Council	Community	Faxed Invitation	Phone Call Follow-up	Interested in Participating	Participated	Participation Method
Independent Bands	Mishkeegogamang	July 28/16	Aug 2/16	Yes	Yes	Interview
	Sandy Lake	July 28/16	Aug 2/16	Yes	Yes	Interview
	Saugeen	July 28/16	Aug 2/16	No Answer	--	--
Paawidigong First Nations Forum (Grand Council Treaty 3 First Nations)	Eagle Lake	July 28/16	Aug 2/16	No	--	--
	Wabauskang	July 28/16	Aug 2/16 & Aug 5/16	No Answer	--	--
	Wabigoon Lake	July 28/16	Aug 2/16 & Aug 5/16	No Answer	--	--

Appendix C: Radio show for Roots for Community Wellbeing

Community Member: Good Afternoon,

Joining us today is ***SLFNHA 1 & 2*** with the Sioux Lookout First Nations Health Authority. Welcome!

SLFNHA 1**:** Thank you for having us.

Community Member: You both work with the Sioux Lookout First Nations Health Authority's Approaches to Community Wellbeing. I understand community wellbeing is also known as public health, can you explain what that means?

SLFNHA 1**:** I would like to start with a story...

One day you're fishing on the bank of a river. Suddenly a flailing, drowning child comes floating by. Without thinking, you dive in, grab the child, and swim to shore. Before you can recover another person comes floating by. You dive in and rescue them as well.

**** (Translation) ****

Then another person drifts into sight, and another, and another. You call for help, and people come and take turns fishing out the people drowning in the river.

*** (Translation) ***

Before too long a wise person asks, "How do these people keep ending up in the river?" And a group of people head upstream to find out.

*** (Translation) ***

Once upstream the people notice there is a cliff where people and families climb up to view the beautiful river. However this cliff is not safe a people are continuously falling into the river and ending up downstream. The group gets to work building a railing and putting up signs to make the cliff safer and educate people how to avoid ending up in the river.

**** (Translation) ****

When the group heads back down stream they notice that the river is now calm and no more people are drowning or in need of saving.

**** (Translation) ****

This is the benefit of upstream thinking. This is what the community wellbeing model is striving for.

**** (Translation) ****

***SLFNHA 2*:** Public health or Community Wellbeing refers to initiatives focused on improving the health of communities as a whole, instead of individuals. It aims to keep people as healthy as possible for as long as possible, prevent illnesses or injuries before they happen, and it promotes an overall healthy lifestyle.

*** (Translation) ***

Approaches to Community Wellbeing uses upstream thinking to work on creating conditions for all people to enjoy complete physical, mental, emotional and spiritual well-being.

*** (Translation) ***

Community Member: How did this project get started?

SLNHFA 1: In 2006 the Sioux Lookout First Nations Health Authority developed the Anishinabe Health Plan, which outlines how services should be provided to the 33 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 Assembly in 2010, which directed SLFNHA to develop a regional public health system.

**** (Translation) ****

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 based on the feedback. This model is called "Approaches to Community Wellbeing."

*** (Translation) ***

Community Member: Can you share a bit about the Approaches to Community Wellbeing model?

SLFNHA 2: The model's vision is that: "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."

*** (Translation) ***

We also developed a series of **values** for the system that will be reflected in all programing, these core values are: 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.

**** (Translation) ****

Community Member: What are the overall goals for this system?

SLFNHA 1: 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.

**** (Translation) ****

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

***SLFNHA 2*:** The goals will be accomplished through a series of programs and services that fall under four main sections, were here to talk about one of them so we will briefly describe the other three first. *Raising our Children* section makes sure all the children and families within the communities are supported and that children are being raised with strong connections to family, community, spirituality, land, culture, language, and each other. It also creates a supportive environment for children to grow and helps to put people on a healthy life path from a young age.

**** (Translation) ****

Healthy Living: will look at healthy lifestyles in order to prevent infectious diseases such as sexually transmitted and blood-borne infections, TB control, and harm reduction. Also to prevent chronic diseases, such as, diabetes, cancer heart problems, addiction issues, and mental health concerns.

**** (Translation) ****

Safe Communities: looks at ensuring communities are prepared for emergencies, addressing environmental concerns, and preventing injuries before they happen. This can include but is not limited to safe drinking water, dog bites, wearing life jackets while boating, wearing helmets on snow machines & quads.

**** (Translation) ****

Community Member: You're both here to meet with community health staff, what are you hoping to achieve? Shanna would you like to start?

***SLFNHA 1*:** Sure,
The purpose of this visit is to provide information about the ACW model and gain input from community members and health staff into the priorities of ***Community X*** and direction for the future. The focus of this community visit is on Roots for Community Wellbeing the fourth section of the model.

*** (Translation) ***

As you mentioned we will be talking with many of the health and youth staff. We hope to gain their perspectives on what services are currently being done in the community, identify if there are any gaps in services and what support SLFNHA can provide.

*** (Translation) ***

Community Member: Thanks ***SLFNHA 1***, what about you ***SLFNHA 2***?

SLFNHA 2: Thanks ***Community Member,***
I am here to talk about health statistics, from the section Roots for Community Wellbeing which provides support to the other sections of the model to make sure the services provided are effective, sustainable, ethical, and culturally appropriate. The bulk of the work in this area may be done at the regional level but the information gained will be provided back to the community.

*** (Translation) ***

My role at SLFNHA under Roots for Community Wellbeing is as an Epidemiologist. An epidemiologist looks at health within groups of people. Mainly looking for trends in different conditions to see if they are on the rise or not.

*** (Translation) ***

This is determined through analysis of health statistics which is sometimes called health data or health information. Health statistics are numbers that are used to describe the populations' health. The main way this is achieved is through health surveillance which refers to the ongoing collection, analysis, and sharing of health statistics.

*** (Translation) ***

This is different from health research which refers to projects that try to find an answer to specific questions with ethics approval. When handling First Nations health statistics in either capacity, be it research or surveillance, it is important to ensure the principles of OCAP are respected, which refer to Ownership, Control, Access and Possession. Finally, health statistics are important because they can be used to show the success of a program, identify areas that may require programming, and help advocate for funding.

*** (Translation) ***

While we are in the community we want to find out which health statistics are important and useful for programs and the community. An example of health statistics could be the number of children who received the measles vaccine when they turned one. We also want to know what makes the community healthy, so we can also identify wellness measures. Further, I am looking to determine how communities would like this information shared back with them and how frequently.

*** (Translation) ***

Community Member: Thank you for sharing this with us today, I understand you guys are here in ***Community X*** until ***DATE***, is there anything else you'd like to share with us?

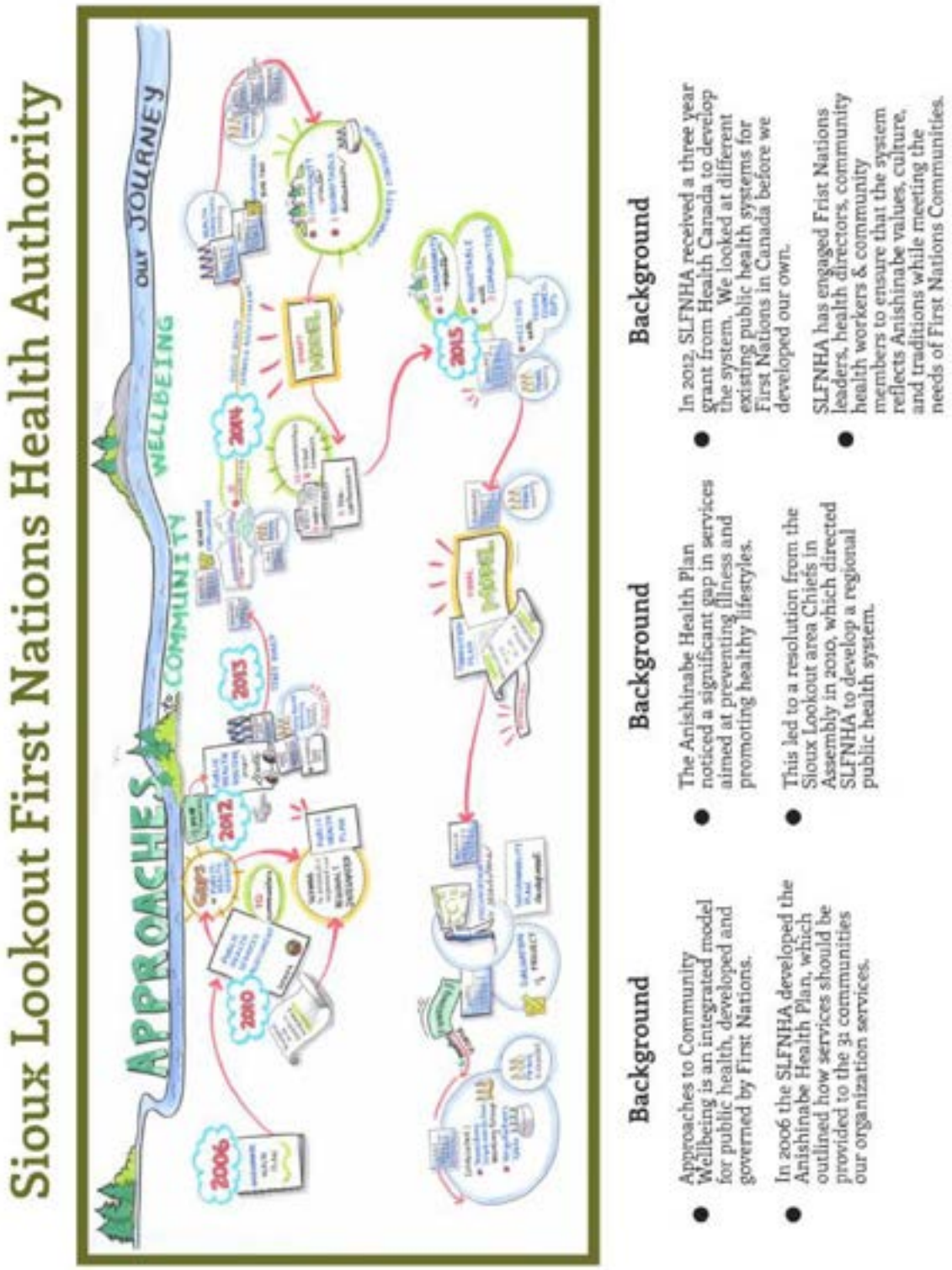
SLFNHA 1: Yes, we are planning on visiting the school on ***DATE*** to meet with the grades 7/8 & 9's to get their perspective on what a healthy community looks like to them. We are looking forward to meeting the students and will have prizes for willing participants.

SLFNHA 2: If there are any questions please call in, or feel free to contact any one of us at ACW through your Health Director ***NAME***.

*** (Translation) ***

***SLFNHA 1 & 2*:** Thank you for having us today.

Appendix D: ACW Background



Who Manages & Governs ACW

- First Nations in the Sioux Lookout area will provide governance of the Approaches to Community Wellbeing.
- By working with various partners, SLFNHA will manage and deliver the regional Approaches to Community Wellbeing.
- Communities will develop, manage and govern their own Approaches to Community Wellbeing.

ACW Working Group

- The Approaches to Community Wellbeing Working Group is made up of representatives from Tribal Councils & Independent Communities
- The purpose of the group is to assist the SLFNHA Community Wellbeing Project team in planning and decision-making associated with the transition and implementation period.
- Once ACW is implemented this group may transition into an Advisory Group to support governance and service delivery. At that time the make up of the committee may change.

ACW Negotiations Table

- Made up of representatives from Thunder District Health Unit, Northwestern Health Unit, Ontario Ministry of Health and Long Term Care, Health Canada, Chiefs Committee on Health, and SLFNHA
- The purpose of the group is to develop agreements to support the transition of services and resources into the new Approaches to Community Wellbeing.

Approaches to Community Wellbeing
Our Vision, Mission, Goals & Values

Vision

THE **ANISHINABE** people of this **LAND** are on a **JOURNEY** to **GOOD HEALTH** by living healthy lifestyles rooted in our **CULTURAL KNOWLEDGE**

Mission

Our MISSION 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

Goals

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

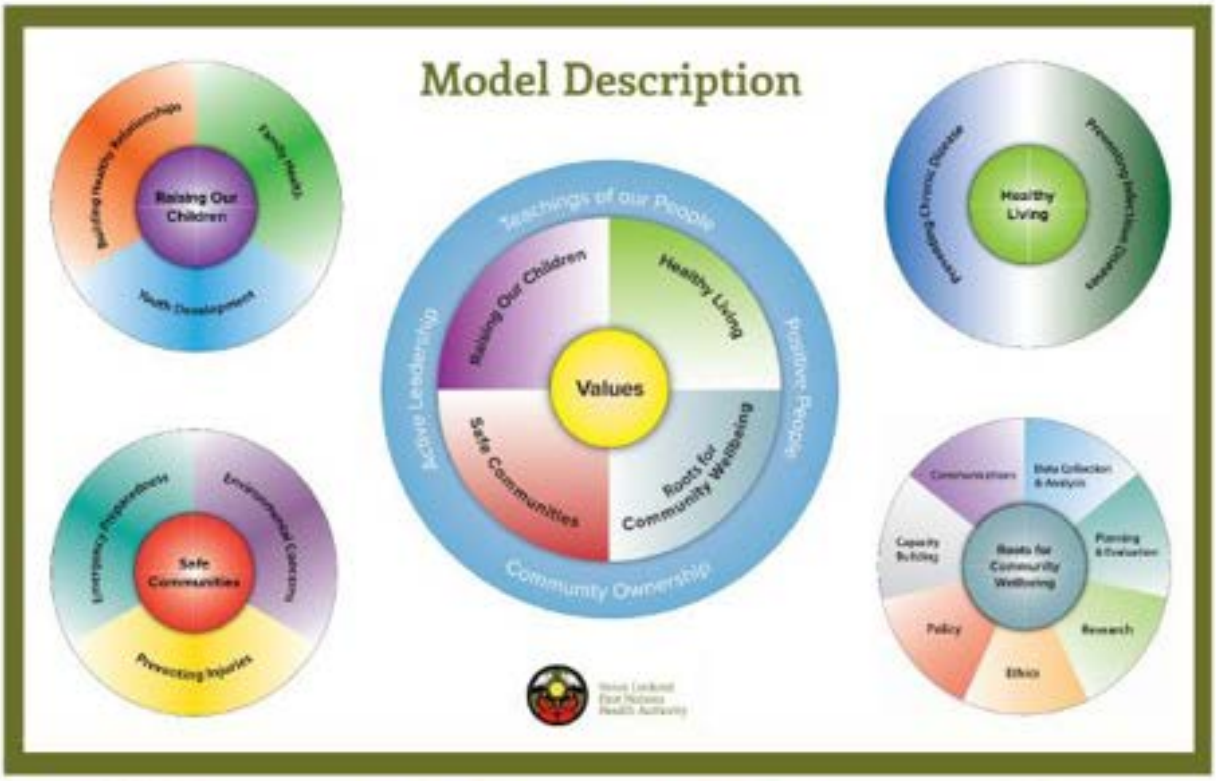
Safer communities

Increased number of people making healthy choices

Increased number of children raised as healthy community members

Increased connection to the teachings of our People

Approaches to Community Wellbeing



Raising Our Children

This section makes sure all the children and families in the communities are supported, and that children are being raised with strong connections to family, community, spirituality, land, culture, language and each other.

It also creates a supportive environment for children to grow and helps to put people on a healthy life path from a young age.

Healthy Living

This section looks at preventing chronic diseases such as heart problems, diabetes, cancer, addiction issues, and other mental health concerns.

This area will also look at preventing infectious diseases such as sexually transmitted and blood-borne infections, tuberculosis control, harm reduction (needle exchange), and investigating outbreaks.

Safe Communities

This section works on decreasing health hazards (dog bites, safe water, etc.) to make communities safer for community members.

It also looks at how to prevent injuries and prepare for emergencies before they happen.

Roots for Community Wellbeing

This section provides support to the other areas of the model to make sure the services provided are effective, sustainable, ethical, and culturally appropriate.

The bulk of the work in this area may be done at the regional level, but the information gained will be provided back to the community level.

Approaches to Community Wellbeing
Sioux Lookout First Nations Health Authority
Toll Free: 1-866-337-0081

Appendix E: Frequently asked questions handout

Approaches to Community Wellbeing

Frequently Asked Questions: Health Statistics

Roots for Community Wellbeing

Roots For Community Wellbeing is a program area under the Approaches to Community Wellbeing model. This area provides necessary information and support to the other program areas while respecting **OCAP®**.

Roots For Community Wellbeing includes data collection and analysis, which looks at **health statistics** for **health surveillance** purposes and to determine the health status of communities.

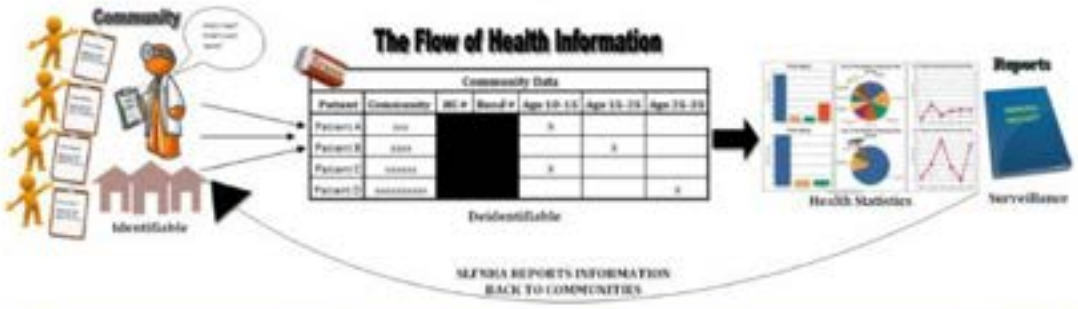
It also looks at evaluation, ethics, policy, capacity building, communications and research.

This will help to ensure services provided are effective, sustainable, ethical, and culturally appropriate. The bulk of the work in this area may be done at the regional level, but the information gained will be provided back to the community level.

Are There Different Types of Health Information?

Yes, there are two types, **identifiable** and **deidentifiable. Identifiable** is data that can directly identify an individual like personal health information in a chart at the Nursing Station. **Deidentifiable** is data that cannot identify an individual on its own, such as a list of diabetes clients that doesn't have their names on it.

Identifiable personal health information is collected for health workers providing direct care. **Deidentifiable** health information can be summarized and used for **health surveillance.**



What are Health Statistics?

Health statistics are summarised numbers of deidentified health information that are used to measure health. **Health statistics** can also be called health data.

For example, **health statistics** can show that 20% of adults in a community have diabetes or that 75% of children received the measles vaccine when they turned one.

What is Health Surveillance?

Health surveillance is the ongoing collection, analysis, interpretation and sharing of **health statistics** to see if there are any changes or patterns in the health of a community. Knowing the health of a community can allow one to see if their programs are working, help to advocate for funding and support decision making.

For example, **surveillance** helps us see if there is an outbreak of an infectious disease (like chicken pox or the flu).

What is Health Research?

Health research refers to projects that try to find answers to specific questions. These questions can come from the community, doctors, universities, or other sources.

An example could be trying to find out why there is an increase in the number of kids with asthma. Any type of research that involves humans must be reviewed and approved by an ethics committee. If it involves First Nations communities, it should also respect **OCAP®**.

How is Health Research Different than Health Surveillance?

Health research is different from **health surveillance** as it has a specific time period and question it answers. **Health surveillance** is the on-going continuous collection of **health statistics.**

Health research often results in papers being published in academic journals whereas, **surveillance** results in health status reports at community, regional, and national levels.

What is OCAP®?

OCAP® was developed by the Assembly of First Nations to ensure that data is collected from First Nations communities, remains in control of the community. These are guiding principles and values, but each individual community can decide how they are implemented. **OCAP® Stands for:**

Ownership - individuals "own" information about themselves, and First Nations communities "own" information about the community as a whole.

Control - First Nations people and communities have control over how their information is collected, used, and shared.

Access - First Nations have access to information about their communities no matter where it is held.

Possession - First Nations data is under First Nations jurisdiction.

For more information on **OCAP®** go to www.FNIGC.ca

Approaches to Community Wellbeing
Sioux Lookout First Nations Health Authority
Toll Free: 1-866-337-0081

Appendix F: Indicator Questions

Sioux Lookout
First Nations
Health Authority

August 2016

Indicator/Measure Questions

For: Chief and Council, Health Directors, and all Community Health Workers

1. Current data practices:
    a. What health statistics/data do you collect currently?
        i. *What do you contribute into the CBRT?*
    b. What health statistics/data do you have access to?
    c. Why do you collect it?
    d. How do you get the data?
        i. *Ie. FNIHB, Pharmacy, Community Programs, Hospital*
    e. What is done with it?

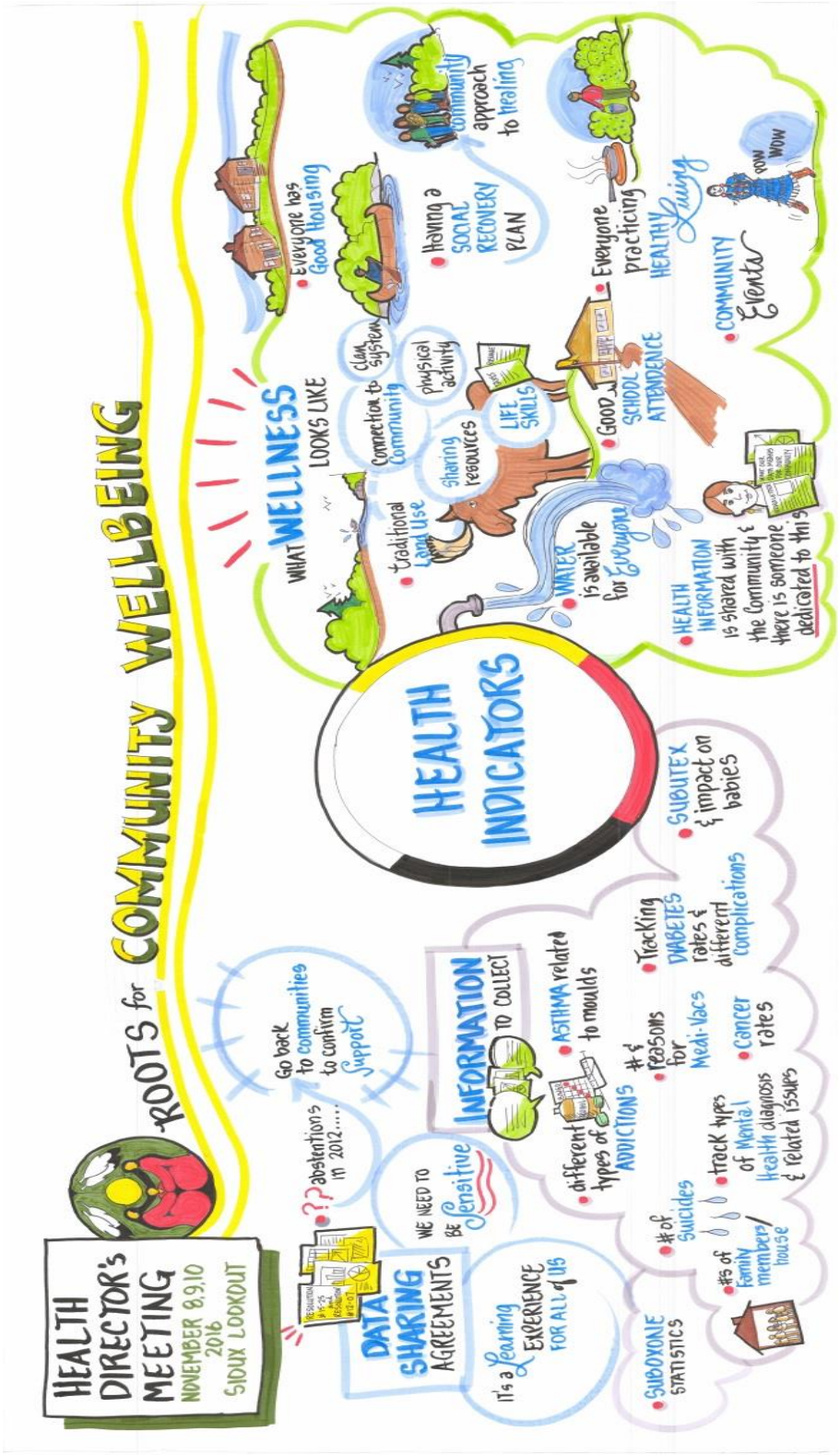
2. Suggestions for current programs:
    a. If you could collect different statistics/data that would help your program/service what would it be?
        i. *Ask about different categories of age*
    b. How would you collect it?
    c. How often would you collect it?
    d. What would you do with the information?

3. Wellness:
    a. How can you tell if your community is well?
        i. *What does being well look like?*
        ii. *Ask about different categories of age*
        iii. *Ie. Participation in community events, employment, parent participation, # of kids in care, number of community events.*
    b. How do you measure that?
        i. *How do you turn it into numbers*
        ii. *Ask about all the measures mentioned in 3a*
        iii. *Sign in sheets, counts of the number of events*
    c. How frequently would you want to measure them?
    d. What would you do with this information?

4. Sharing the information:
    a. Do you want the data findings shared back to you?
    b. What is the best way to give this information back to you?
        i. *Best way to summarize*
        ii. *Provide report, infographic, alerts, newsletters*
        iii. *Radio reports*
    c. Are there any other things you think are important to be included?
        i. *Provide background and examples of health status reports*
        ii. *Preventable measures such as diabetes complications*

5. How can we help you share the information with the community? (Specific to Health Director and Chief and Council)
6. Do you have a health plan? (Health Director)
7. What is your population total? (Health Director/Chief and Council)
    a. How do you determine the population total?
    b. Who do you send the population total to?
8. Make sure the HD understands what we're doing and ask about whether or not we need DSA with all communities or if the resolutions are enough?
9. Do you receive reports back and if so are they useful and do you do anything with them?
        i. *Immunization, SAL, CBRT, Meno Ya Win, EHO*
10. Do you have a sample of the reports you receive back from FNIHB that you would be willing to share with us? (Health Director)

Appendix G: Graphic facilitation of Health Directors



Appendix H: Identified Indicator Calculations

1. Programming Space

Keeping track of the use of space would allow communities to see if they are being used and, if so, justify the need for more space to provide more opportunities for programming. Below is a method which can be used to keep track of how often space is used in communities. The table also provides a way to keep track of the number of new spaces available.

Facility	Number of times sessions are held		
	2017	2018	2019
Outdoor rink	#	#	#
Community hall	#	#	#
School gym	#	#	#
Baby friendly space			
Number of new facilities opened	#	#	#

2. Programming Attendance

By having sign-in sheets at each program session offered, the number of participants can be counted and recorded as shown below. By recording this over the year and comparing it year to year, health workers will be able to see if there is an increase in participation. Additionally, with sign-in sheets it will be possible to keep track of the number of participants at a session as well as the number of new participants. For the number of participants in the community the population of the community will also be required. Below is also an example of how these can be calculated. Using these calculations health workers can determine if they are reaching more community members.

	Jan-Apr 2018	May-Aug 2018	Sep-Dec 2018
HBHC	#	#	#
MHC	#	#	#
FASD	#	#	#

$$Paticipation\ percent = \frac{Number\ of\ community\ members\ at\ event}{Total\ number\ of\ communuity\ members\ in\ Community\ X} \times 100\%$$

$$New\ participants = \frac{Number\ of\ new\ participants\ in\ a\ session}{Total\ number\ of\ participants\ in\ a\ session} \times 100\%$$

3. Education Sessions

To keep track of the number of education sessions offered within communities the table below could be created. By filling in the number of community members at each education session communities will be able to see if there are more sessions happening each year, as well as if there are more participants. To keep track of the number of participants at education sessions a sign-in sheet would be helpful to

ensure it is recorded somewhere. Additionally, communities will be able to see the different kind of education sessions that are offered.

Event Type	Number of community members attended		
	2018	2019	2020
Immunization Education	#	#	#
Diabetes Education	#	#	#
Medication compliance	#	#	#
Healthy eating	#	#	#
Total number of events	#	#	#

4. Children in Care

Tikinagan currently collects information on the number of children in care. To compile this year to year would require Tikinagan to share these numbers. If these numbers were shared, communities could determine the rate of children in care using the example below. To determine the rate, the population of a community would be required.

$$Rate\ of\ children\ in\ care = \frac{Number\ of\ children\ in\ care}{Population\ of\ children\ 0-18\ years\ in\ community\ X} \times 1{,}000$$

5. Fetal Alcohol Spectrum Disorder

Knowing the number of suspected and confirmed FASD clients will help address the difficulties that are experienced within the school and help with resource distribution and program planning. Suspected and confirmed cases of FASD can be defined by the community based on what they feel appropriate for the behaviours of their children. This can be something that is tracked through different health programs, the nursing station, and at the school however, it would be important to ensure these numbers are combined so that all cases are counted. This can be calculated by specific age groups or for all children within the community. By looking at this each year it can be tracked to monitor for any increases or decreases. Below is an example of the two rates that can be calculated.

$$Suspected\ rate\ of\ FASD\ cases = \frac{Number\ of\ suspected\ FASD\ cases}{Number\ of\ children\ age\ X\ in\ Cat\ Lake} \times 1{,}000$$

$$Rate\ of\ FASD\ cases = \frac{number\ of\ confirmed\ FASD\ cases}{Number\ of\ children\ age\ X\ in\ Cat\ Lake} \times 1{,}000$$

6. Family Health Indicators

For communities to determine the rate of birth defects they will need to keep track of the number of babies born each year with a defect. Communities will also need to decide what they see as a birth defect. Below is an example of how the rate of birth defects can be calculated. Additionally, communities will also need to know the total number of births for the same year. This rate may not change frequently so looking at it every couple of years would be beneficial.

$$rate\ of\ birth\ defects = \frac{total\ number\ of\ live\ births\ or\ still\ births\ that\ have\ a\ birth\ defect}{total\ number\ of\ births\ (live\ \&\ still)} \times 1{,}000$$

For communities to determine the rate of miscarriage they will need to keep track of the number of miscarriages that happen in a year. Communities will also need the total number of births in the same year. If all clients do not receive medical attention at the nursing station after a miscarriage communities will need to have a health worker that miscarriages could be reported to. Below is an example of how this rate can be calculated.

$$rate\ of\ miscarriage = \frac{number\ of\ miscarriages}{total\ number\ of\ births\ (live\ \&\ still)} \times 1{,}000$$

To determine the rate of babies born addicted to opioids, communities will need to be aware of the mothers that are currently using opioids. If a community has a Suboxone® program this may already be recorded. Additionally, to determine this rate there would need to be a process set up for the doctor to provide information about the baby back to the community. This is also something that may already be done through the nursing station. If not, this rate could be difficult to determine and would have to be based on a client's permission. To calculate the rate below the total number of births for the community in the same year would be required. This rate could be compared year to year to see whether it is increasing or decreasing. Below is an example of how this rate can be calculated.

$$rate\ of\ subutex\ addiction = \frac{number\ of\ babies\ addicted\ to\ subutex}{number\ of\ births\ (live\ \&\ still)} \times 1{,}000$$

7. Community Events

Recording attendance at each event through a registration list, and also having a master list of the events that happen in communities throughout the year will provide communities a way to track community togetherness. By recording the information this way, it would be possible to see if there is an increase in the number of participants at events, as well as an increase in the number of events overall and compare it year to year. On the next page there is an example of the different ways this information could be recorded.

Event	Number of community members attended		
	2017	2018	2019
Annual fishing derby	#	#	#
Baseball Tournament	#	#	#
Cultural Week	#	#	#
Woman's gatherings			
Summer feast			
Total number of events	3	3	3

$$Participants\ percent = \frac{Number\ of\ community\ members\ at\ event}{Total\ number\ of\ community\ members\ in\ community\ X} \times 100\%$$

8. Bullying

To measure bullying incidents online or at school, incidents need to be reported somewhere and recorded. This could be done at either the school or through a health worker. Communities would need to define what bullying is within their community. Additionally, community members may feel better reporting bullying if it could be done anonymously. Below is an example of the calculation that can be done and compared year to year to see if there is improvement. The number of bullying incidents is not specific to the number of people bullied, as some people may be bullied multiple times.

$$Bullying = \frac{Number\ of\ bullying\ incidents}{Number\ of\ community\ members\ in\ community\ X} \times 1{,}000$$

9. Screen time

To determine screen time a survey would be required to ask the amount of time spent on electronics with a follow up survey done every year to see how it has changed. This survey could be done door-to-door or through visits to other services within the community, such as the nursing station. The overall screen time for the community could be calculated as shown below.

$$Screentime\ use = \frac{number\ of\ hours\ that\ month}{total\ number\ of\ hours\ in\ a\ month^2 \times population\ of\ community} \times 100\%$$

10. Parent Involvement

Measuring parental involvement could be difficult, so some communities believed having a program that taught parents how to better bond with their children would be beneficial. This program could provide on-going support through education on different topics that parents would find helpful. With these sessions, a sign-in sheet could be used to keep track of those that attend. Below is an example of

[2] In months with 31 days there are 744 hours, in months with 30 days there are 720 hours, and in February (28 days) there is 672 hours.

the calculation that can be done. For the number of parents that attend a session communities would decide whether this means one parent or both parents attended.

$$Parent\ involvement = \frac{number\ of\ parents\ that\ attend\ a\ session}{number\ of\ families\ in\ Community\ X} \times 100\%$$

In addition to having a program that could show increased support from parents for their children, a survey could be created. A survey would need a worker to ask the questions either door to door, at the nursing station, or at events. Questions could be picked by communities, but could include examples like, how often did you eat a meal with your family? How often did you do something fun together? How often did you help with homework? For these questions, a desired time frame would need to be created. It is recommended that the timeframe not be too long, as that will decrease the accuracy of people's memory (i.e. In the past week, two weeks, or month could be chosen). The results from the survey questions could be put together into a graph, and compared year to year.

11. Family Involvement

Recording the number of parents that attend events through sign-in sheets and reporting it yearly will allow communities to see if there is any improvement as time goes on. By tracking each event there will be opportunity to compare similar events year to year, and to determine if there is an increase over the course of a year. Additionally, combining similar events and determining the average participation through the year at events could be done. An example could be for family friendly events. The number of families with parents present at an event can be defined as communities feel appropriate. For example, they could decide that they will count if at least one parent is present, or they could decide that both parents need to be present for it to count (in this case, exceptions would be needed for single parent families). The number of families represented could be counted by the number of children that represent unique families (whether or not their parents are there). For example, a brother and sister at the same event would be counted as one unique family represented. Below is an example of how this could be calculated.

$$Family\ Involvement = \frac{Number\ of\ children\ with\ parents\ present\ at\ event}{Number\ of\ all\ families\ represented\ at\ event} \times 100\%$$

12. Respect for Elders

To see if there is an increase in respect for Elders, a health worker would need to track the number of events held that are specific to Elders. Sign-in sheets would help keep track of the number of events as well as the number of Elders that attend. Below is an example of how the number of events can be tracked and compared year to year. Previously, in Appendix H2 a method was provided that could be used to determine if the number of Elders attending events has increased as well.

	Number of Elders attended		
	2017	2018	2019
Elder specific event	#	#	#
Elder specific event	#	#	#
Total number of events	#	#	#

13. Youth that Speak the Language

To keep track of the percent of youth that speak the language, an initial count of the number that currently do would be needed. Communities suggested that to start tracking this it would be best done through the schools. Some schools already have language classes or after school programming offered. Once this is established each year it can be counted and the calculation below can be used by communities to determine what percent of youth speak the language. Comparisons year to year will also be able to be made to determine if this number increases over time. One consideration would be the youth that do not attend school as they will be missed. Communities could consider a survey being conducted or having one of the youth health workers keep track of this.

$$Youth\ that\ speak\ the\ language = \frac{Number\ of\ youth\ that\ speak\ the\ language}{Number\ of\ youth\ in\ Cat\ Lake} \times 100\%$$

14. Youth Land Activities

The number of activities offered within a year could be recorded both at the school and through youth workers. Combining the information from the two different sources would be important to get a full understanding of what happened in the community that year. Additionally, through sign-in sheets, keeping track of the number of attendees will help establish if more youth are attending events as time goes on. Comparing this each year will allow communities to see if the youth are being reached. An example of how to keep track of the activities is below, while determining if more youth are attending events can be done using the calculation in Appendix H2.

	Jan-Apr 2018	May-Aug 2018	Sep-Dec 2018
Youth Hunting	#	#	#
Youth Fishing	#	#	#
Youth Camping	#	#	#
Total number of events	#	#	#

$$Youth\ land\ based\ activities = \frac{Number\ of\ new\ participants\ in\ a\ session}{Total\ number\ of\ participants\ in\ a\ session} \times 100\%$$

15. Youth Specific Events

Similar to the above indicator, keeping track of the number of youth specific events offered and the number of participants will allow communities to see if youth are engaged. This can be compared year to year, to see if there are improvements. Having a sign-in sheet for youth specific events will make it

easier for youth workers to keep track of the number of events. This information can be summarized in the table below. Additionally, using the calculation from Appendix H2 will allow communities to determine the percent of youth being reached in each community.

Event	Number of youth attended		
	2017	2018	2019
Youth fishing derby	#	#	#
Baseball tournament	#	#	#
Health education sessions	#	#	#
Total number of events	#	#	#

$$Youth\ specific\ event\ participation = \frac{number\ of\ youth\ at\ event}{number\ of\ youth\ in\ Community\ X} \times 100\%$$

16. Troubled Students

Below are examples of how to track the number of participants, the percent of students with behavioural issues and the rate of incidents that involve students with behavioural issues. By calculating the percent of students that have behavioural issues, the school will be able to determine if it is a large group of students or a small group of students that contribute to the incidents. This will allow the school to determine the type of approach and resources required to address the incidents. Additionally, the rate of incidents at school that involve students with behavioural issues will allow the school to see if there is an increase or decrease in incidents year to year.

Year	Number of participants at support group
2016	#
2017	#
2018	#

$$Behavioural\ issues = \frac{Number\ of\ \ students\ with\ behavioural\ issues}{Number\ of\ students} \times\ 100\%$$

$$Rate\ of\ behavioural\ issues = \frac{Number\ of\ incidents\ with\ students\ with\ behavioural\ issues}{Number\ of\ students} \times\ 1000$$

17. School Retention and Graduation Rates

Using the number of students that started a school year and the number that finished in the same year, it will be possible to see if all students complete a school year and compare this year to year. It will also be possible to track graduation rates from communities for those moving from grade eight into high school. This can be compared year to year as well.

$$School\ retention = \frac{number\ of\ students\ that\ finish\ the\ year}{number\ of\ students\ that\ start\ the\ year} \times 100\%$$

$$Graduation = \frac{number\ of\ students\ that\ complete\ grade\ 8}{number\ of\ students\ in\ grade\ 8} \times 100\%$$

18. Diabetes

Rates of diabetes are not currently calculated by communities but could be through a registry at the nursing station. Having a registry would allow communities to determine the incidence and prevalence of diabetes within the community. Comparing this year to year will allow communities to see if educational sessions and other programs have improved the rate of diabetes. Below is an example of how both new cases and overall cases can be calculated if a registry was set up at nursing stations.

$$Incidence\ rate\ of\ diabetes = \frac{Number\ of\ new\ cases\ of\ diabetes}{Number\ of\ community\ members\ in\ Community\ X} \times 1{,}000$$

$$Prevalence\ of\ diabetes = \frac{Number\ of\ cases\ of\ diabetes\ in\ a\ year}{Number\ of\ community\ members\ in\ Community\ X\ in\ the\ same\ year} \times 1{,}000$$

19. Community Garden and Eating off the Land

To monitor community garden use a sign-up sheet for those who use it and what they took would be needed. This can be used to determine how many people in the community are using the garden. This information can be gathered to compare garden use year to year. Below is an example of how to keep track of what is used. There is also an example calculation of how to determine the percent of families that participate in garden use. From the sign-up sheet the number of different families could be determined and divided by the total number of families within a community.

Community Garden Use		
Name	**Date**	**Items taken**
Bob Smith	August 15, 2017	Carrots, Cucumber
Jane Smith	August 28, 2017	Potato
Joe Smith	September 3, 2017	Onion
…	…	…

$$Use\ of\ community\ garden = \frac{Number\ of\ families\ using\ the\ garden}{Number\ of\ families\ in\ Community\ X} \times 100\%$$

To further support the use of community gardens, many felt that eating off the land in other ways would be a good indicator of wellness. This could mean hunting, fishing, trapping, or berry picking. This information would be harder to track but could be done through a survey in communities. The survey could be completed door-to-door or while community members access other services in the community. Comparing this month to month and/or year to year would allow communities to see the number of people collecting and eating traditional foods. This information could be used to determine future programming to teach the skills required to gather food off the land and how to cook it.

20. Increased Exercise

With more community members eating off the land, there would be an increase in physical activity, which could be another indicator that shows wellness. Physical activity could include activities such as hunting, fishing, walking, running, or swimming. They could also include more organized events such as baseball games, fitness classes or walking clubs. It would be a challenge to measure individual physical activity, but could be done through a survey at the nursing stations when clients are seen. For the organized sports, a chart similar to the one below could be used to keep track of the number of times physical activity sessions are offered. Comparing this year to year would be important to determine what type of programming could be offered to encourage physical activity within communities.

Event type	Number of times sessions are held		
	2017	2018	2019
Evening Baseball	#	#	#
Evening Broomball	#	#	#
Ladies fitness	#	#	#
Walking program	#	#	#
Total	#	#	#

21. Drug and Alcohol Consumption

To track the decrease in drug and alcohol use, a baseline would first need to be established which would require collection of the information through a survey. Example questions are, how often do you use drugs or alcohol, and what types of drugs do you use? Asking the frequency of alcohol use will allow communities to identify how many community members could have an addiction to alcohol. Communities would need to determine whether they would want to measure this by the number of drinks a week a community member may have or the number of drinks they have a day. Example categories for the number of drinks a week are 1-5 drinks, 6-10 drinks, 11-15 drinks, and 16 or more drinks. Example categories for the number of drinks in a day are 0 drinks, 1 drink, 2 drinks, and 3 or more drinks. This survey could be conducted when community members visit nursing stations, however some community members would be missed, as some may not access services through the nursing station. Having an anonymous survey that could be delivered to each house with a drop off location could help, but could be difficult given that people do not like to share their drug and alcohol use. Once a baseline is established, this information can be collected again through similar means. This is something that can be done every couple of years and compared to see if the number of drug and alcohol users has decreased, as shown in the table below. The table below shows how the number of people who consume drugs and alcohol can be recorded. Additionally, determining the number of drug and alcohol users in the community compared to the population will allow comparisons to other communities or regions, to determine if other programming to support users is working, also shown below.

Year	Number who consume alcohol	Number who use drugs
2016	#	#
2018	#	#
2020	#	#

$$Prevalence\ of drug\ \ use = \frac{Number\ who\ use\ drugs}{Number\ of\ community\ members\ who\ responded} \times 1{,}000$$

$$Prevalence\ of\ alcohol\ consumption = \frac{Number\ who\ consume\ alcohol}{Number\ of\ community\ members\ who\ responded} \times 1{,}000$$

22. Incidence Rate of Infectious Diseases

With concerns raised about rates of skin and respiratory infections, hepatitis C, whooping cough, sexually transmitted infections, and tuberculosis within communities, it would be beneficial for each community to know their summarized rates year to year. This information is currently collected when new cases present at the nursing stations through a reportable disease form completed by the nurse. Additionally, in some nursing stations the reason for visit is included in the System Administration Log Health Canada uses, so this could be looked at to determine how frequent visits are. By providing the rates of infectious diseases back to the community with a comparison to the SLFNHA area, communities will be able to determine if this is a concern for them. Below is an example of how these rates are calculated, they can also be summarized through graphs. These rates can also be done for age specific groups.

$$Incidence\ rate\ of\ infectious\ disease\ (X) = \frac{Number\ of\ new\ cases\ of\ infectious\ disease\ (X)}{Number\ of\ community\ members\ in\ Community\ X} \times 1{,}000$$

23. Needle Exchange

To keep track of the number of needles requested, a chart as shown below could be used. It will require the health worker who is responsible for ordering needles to record how much they request in a time period. Additionally, to see if there is an increase in the number of needles being returned and disposed of properly, the approximate number of needles exchanged would also need to be recorded by the health worker. Both of these numbers could be summarized each year and compared to see if there are improvements. Below is an example of how the percent of needles exchanged can be calculated. For the percent of needles exchanged, the number of needles returned would be an estimate, as it is unsafe to open up sharps containers. Keeping track of the number of full sharps containers will allow estimates to be made. Additionally, estimates are currently required for reporting to SLFNHA so this could be summarized and calculated in communities, or SLFNHA could do this annually and report it back to communities who use the service.

Month	2017		2018		2019	
	Needles Requested	Needles Exchanged	Needles Requested	Needles Exchanged	Needles Requested	Needles Exchanged
January – March	#	#	#	#	#	#
April – June	#	#	#	#	#	#
July – September	#	#	#	#	#	#
October – December	#	#	#	#	#	#

$$Percent\ of\ needles\ exchanged = \frac{number\ of\ needles\ returned}{number\ of\ needles\ given\ out} \times 100\%$$

24. Suboxone® Program

This information may already be collected by Suboxone® programs within communities. The table below is a method to keep track of all Suboxone® clients. Additionally, the number of community members could be confirmed through the number of Suboxone®/Subutex® prescriptions received by the community pharmacy. Comparing this each month will allow communities to see if there are any sudden increases, in addition to comparing each year overall.

Year	Month	Number of new clients enrolled	Number of repeat clients enrolled	Number of clients that withdrew	Number of clients that completed	Number of new pregnancies identified
2016	January					
	December					
2017	January					
	December					

25. Caring for Children

Measuring the amount that parents care for their children would be difficult because they are feelings that could only be answered through interviews with community members. Some communities felt that seeing more family togetherness as identified in Appendix H10 and H11 would be a positive indicator that Suboxone® programs are working and could be used as an indicator.

26. Specialist Visits and Physician Days

An update on whether or not there is an addictions specialist could be done, as well as tracking the number of days they spend in the community.

	Number of days			
	Jan-Mar 2017	Apr – June 2017	July – September 2017	October – December 2017
Addictions Specialist				

For physicians, the number of days the physician spends in the community can be used to determine if they fulfill their allocated amount based on the agreement. Below is an example of how this can be calculated.

$$Physician\ days = \frac{number\ of\ days\ physician\ was\ in\ Community\ X}{number\ of\ physician\ days\ allocated\ to\ Community\ X} \times 100\%$$

27. Pest Infested Homes

To determine the number of homes that have bed bugs or cockroaches, community members would need somewhere within the community that it could be reported, such as a log book. There would need to be separate lists for each pest, if a community has a problem with both in their homes. It would also be important to know the number of homes a community has in total. Below is an example of the

calculation that can be done to determine the percent of infested homes. If both pests are a problem within a community, then two separate calculations would need to be done using the example below. It would be important to compare these numbers year to year to determine if there is improvement in housing conditions.

$$Pest\ infested\ houses = \frac{Number\ of\ houses\ with\ Pest\ X}{Number\ of\ houses} \times 100\%$$

28. Mould in Homes

Additionally, keeping track of the number of homes with mould, would require a worker who community members can contact to report mould. By having a list of all the homes in a community, one can keep track of the homes that have mould. Each year the number of homes can be added to compare and determine if there is any improvement. These numbers can also be used for the calculation below to determine the percent of houses affected.

$$Mould\ in\ homes = \frac{Number\ of\ occupied\ houses\ with\ mould}{Number\ of\ houses} \times 100\%$$

29. Overcrowding

To calculate overcrowding there will need to be a log of how many people live in a home as well as the number of rooms within a home. Below is an example of how these numbers would be used to calculate the number of people per room. If this calculation results in a number that is high it indicates that there is a high level of crowding within home. Once this is calculated per home in a community the numbers can be combined to determine the average number of people per room in the community. It would be important to track this year to year to determine if there is improvement in housing.

$$Persons\ per\ room = \frac{Number\ of\ people\ in\ a\ house}{Number\ of\ rooms\ in\ the\ same\ house}$$

Another indicator that could be used for crowded housing is shown below as the average number of community members per household. This would require knowing how many occupied houses there are in a community.

$$Average\ number\ of\ community\ members\ per\ house = \frac{Total\ population\ in\ Community\ X}{Number\ of\ houses}$$

30. Houses with Water

This is an indicator that would need to be monitored until all homes have water, at that time it could be discontinued. To monitor this there would need to be a list of all homes within communities and a spot to identify if they have water. This could also be looked at in combination with other indicators to see if there is improvement in the overall health of communities as access to water improves. Below is an example of how the community can see how many houses have water.

$$Houses\ with\ water = \frac{Number\ of\ houses\ with\ water}{Number\ of\ houses} \times 100\%$$

31. Dog Bites

Given the challenge of tracking dogs, seeing a decrease in the number of dog bites could be an indication that there are fewer stray dogs. This is something that is already tracked by Health Canada, as dog bites are reported to the environmental health officer in Sioux Lookout. Communities would also need to know the total population. Comparing this year to year will allow the community to see if the problem is increasing. Below is an example of how to calculate the dog bite rate.

$$Dog\ bite\ rate = \frac{Number\ of\ dog\ bites\ in\ a\ year}{Number\ of\ community\ members\ in\ the\ same\ year} \times 1{,}000$$

32. Training Opportunities

Given the of the lack of training opportunities mentioned when starting in health positions, keeping track of the ones that are provided each year overall, and by position, will allow communities to see when health workers are being adequately trained. Keeping track of the number of training opportunities whether within communities or outside of them will be important. Below is an example of how this can be calculated for overall staff and additionally, using the same calculation, for positions.

$$Training\ opportunities = \frac{Number\ of\ training\ session\ staff\ attend}{Number\ of\ training\ sessions\ offered} \times 100\%$$

Appendix I: Program Evaluation Questionnaire

1. What did you like about the $\frac{(insert\ title)}{program\ name,event,or\ education\ session}$?

2. What could be done to improve today's session?

3. What other $\frac{(insert\ title)}{program\ name,event,or\ education\ session}$ would you like to see in the future?