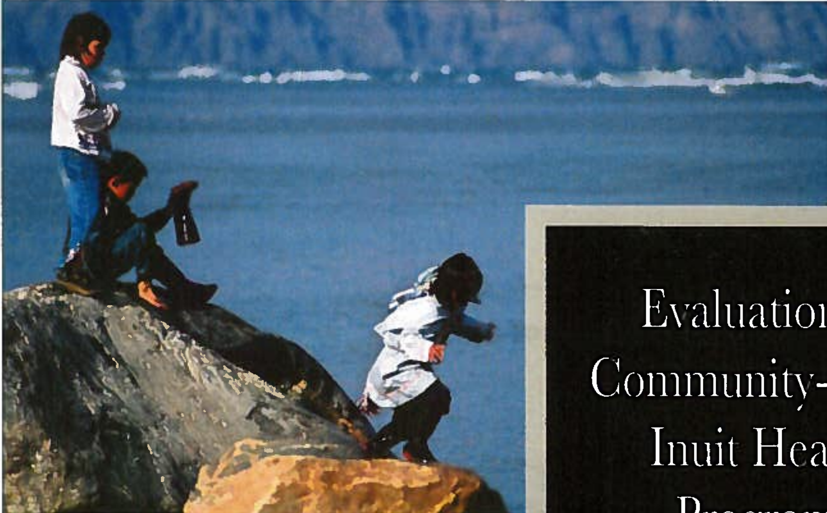
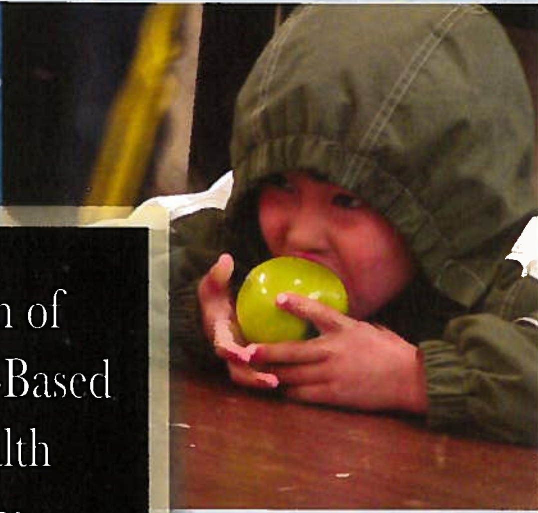

Evaluation of Community-Based Inuit Health Programs in Nunavut

FINAL REPORT

October 2006

2002-2005

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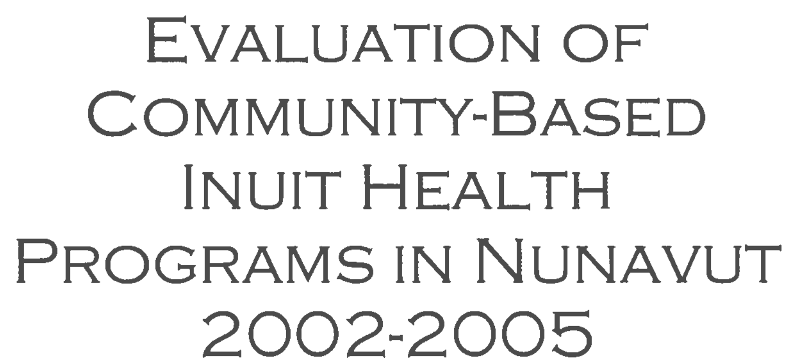
Evaluation of Community-Based Inuit Health Programs in Nunavut 2002-2005: Final Report
ISBN 1-55325-114-8

Published by
Department of Health and Social Services
P.O. Box 1000, Station 1000
Iqaluit, Nunavut X0A 0H0
P: (867) 975-5700
F: (867) 975-5780



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EVALUATION ADVISORY COMMITTEE

The Evaluation Advisory Committee (EAC) was established for the duration of this evaluation study (November 2003 to October 2006) to guide planning, implementation and reporting. The EAC is comprised of representatives from the Department of Health and Social Services, Government of Nunavut; Northern Secretariat, First Nations and Inuit Health Branch, Health Canada; and Nunavut Tunngavik Incorporated (NTI).

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The following people participated in EAC meetings and provided invaluable support to the EAC.

Sean O'Byrne
(September 2005 to October 2006)
Program Consultant, Nunavut Team
Northern Secretariat, Health Canada

Sarah Trottier
(February 2006 to October 2006)
Intern
Northern Secretariat, Health Canada

ACKNOWLEDGEMENTS

This evaluation study would not have been possible without the contributions of many individuals. The EAC would like to thank all those people who shared their experiences and opinions openly and honestly in interviews, focus groups and community meetings. We especially want to acknowledge and express our appreciation to the following:

- The local project coordinators and staff, other community workers, community members and Hamlet mayors and councils in the eight Nunavut communities who welcomed the evaluation team;
- The evaluation team from Terriplan Consultants who gathered the information about FNIHB programs from the communities and learned so much more about Nunavut in the process;
- The community evaluators who participated in training and assisted the evaluation team;
- Susan Swanson who edited the final report; and
- All Nunavut communities who are doing what they believe is right for their communities with FNIHB program dollars.

EXECUTIVE SUMMARY

INTRODUCTION

This evaluation report is intended as information for senior managers in the Department of Health and Social Services of the Government of Nunavut; the Northern Secretariat of the Public Affairs, Consultations and Regions Branch[1], Health Canada; and Nunavut Tunngavik Incorporated. It may also be of interest to community leaders and community project managers in Nunavut.

The First Nations and Inuit Health Branch (FNIHB) of Health Canada (HC) has had a number of Contribution Agreements with the Government of Nunavut (GN) Department of Health and Social Services (HSS) to administer a range of health and wellness programs for Inuit communities in Nunavut. The Northern Secretariat (NS) administers the Agreement on behalf of HC. This evaluation covers the multi-year Agreement for 2002-2005. Some programs in the Agreement are delivered directly by communities, who submit proposals to Nunavut HSS for funding. Other programs are delivered by HSS. In both cases, Inuit organizations and other stakeholders are involved, either within the communities themselves or as members of steering committees that provide overall direction for the programs by developing work plans, identifying issues, gaps or concerns, and sharing knowledge.

Nunavut Tunngavik Incorporated (NTI) is a partner in this evaluation. All GN initiatives are required to consult NTI as part of the 1993 land claims legislation, article 32, which ensures a consultative role for Inuit in all government policy and program design, development and delivery.

PURPOSE AND METHODOLOGY

The purpose of this evaluation was to determine strengths and weaknesses in management and delivery and to measure the effectiveness of the FNIHB programs implemented by HSS through the Contribution Agreement for the period of 2002-2005, and to provide recommendations for improvements. The evaluation process was guided by the Evaluation Advisory Committee (EAC), which was composed of representatives from Nunavut HSS, NS, and NTI. Planning for the evaluation began in November 2003 and the implementation began in the fall of 2005.

The following eight FNIHB programs were the focus of this evaluation:

- Aboriginal Diabetes Initiative (ADI)
- Brighter Futures (BF)
- Building Healthy Communities (BHC)
    - Mental Health Crisis Intervention Program
    - Solvent Abuse Program
- Canada Prenatal Nutrition Program (CPNP)
- Fetal Alcohol Spectrum Disorder (FASD)

[1] The Northern Secretariat was within the First Nations and Inuit Health Branch at the time of the evaluation and became part of the newly created Public Affairs, Consultations and Regions (PACR) Branch in August 2006. This report refers to the Northern Secretariat, First Nations and Inuit Health Branch throughout.

- First Nations and Inuit Home and Community Care (FNIHCC)
- National Native Alcohol and Drug Abuse Program (NNADAP) - Treatment and Training
- Tobacco Control Strategy (TCS).

The evaluation focused on the five topics of relevance, efficiency, effectiveness, sustainability, and lessons learned. Evaluation data came from three main sources: a review of program and policy documents, telephone interviews, and visits to eight Nunavut communities where interviews were conducted and focus groups and community meetings were held. The communities visited were Cape Dorset, Clyde River, Coral Harbour, Gjoa Haven, Iqaluit, Kugluktuk, Rankin Inlet, and Resolute Bay. In each community, a community evaluator was trained and hired to support the evaluation process and build community capacity in evaluation.

The limitations of the evaluation included attribution issues, limited data, aggregation of data, availability of interviewees, staff changes, and the immensity of the process.

Findings

This report provides findings for each program under the evaluation topics of relevance, efficiency, effectiveness, sustainability and lessons learned. It also provides a brief program description and financial summary. The findings common to most of the programs are summarized by evaluation topic including what worked well and what needs improving.

Program successes were attributed to greater community capacity in program management and delivery, which was in turn attributed to programs being in place for a longer period, a fulltime Wellness Coordinator working in the community, and consistent support from HSS regional and headquarters program coordinators or professional experts, such as a nutritionist.

Common issues reported as challenges by a number of programs and communities, as well as HSS, during the 2002-2005 period included recruitment and retention of qualified staff; program requirements for proposals and reports; slow funding approvals processes; inadequate funding in some communities and unspent funding in others. These challenges are closely interrelated and addressing them requires a holistic approach to increasing community capacity in program management.

Conclusions and Recommendations

Carrying out the evaluation study was a learning experience with lessons that can enhance future evaluations of FNIHB programs, not only in Nunavut but also in other regions of Canada. Lessons learned about the study are discussed in the areas of increasing the participation of community members, training and employing community evaluators, and improving evaluation tools.

The following recommendations are derived from the common findings in this report. HSS, NTI and NS all have a role to play in implementing these recommendations but specific roles will be determined through joint discussion and collaboration and in accordance with their respective mandates in the broad area of supporting FNIHB programs in Nunavut.

Recommendation #1 - Increase Community Capacity
Many of the challenges experienced in community programs are due to the limited capacity of communities in project management skills. HSS, NS and NTI should work jointly to build project management capacity in Nunavut communities through training and other learning opportunities.

> **1-a: Conduct an assessment of training needs and opportunities**
>
> **1-b: Arrange for community project staff to train in a full range of project management skills**
>
> **1-c: Host bi-annual workshops to seek input on improving cultural relevance and appropriateness of FNIHB programs for Inuit people of Nunavut, as well as on other current issues for communities**

Recommendation #2 - Simplify Processes and Procedures
Certain program procedures are considered complex and time-consuming for communities, especially when they must be repeated every year. Some process elements originate with individual FNIHB programs and others with HSS. NS and HSS should work together to ensure that procedures for communities are clearer, simpler and more efficient. Apart from decreasing the administrative work for community projects, simplified procedures and the availability of program manuals and management tools could help to diminish the effects of staff turnover. Multi-year, flexible funding arrangements and streamlined approval processes for funding would improve predictability of funding for communities, thus facilitating better program and resource planning and staff retention. A joint effort of NS, HSS and NTI will be needed to simplify process elements, prepare program manuals with appropriate management tools, and educate communities about them.

> **2-a: Clarify program requirements**
>
> **2-b: Streamline project proposals and reporting**
>
> **2-c: Prepare procedures manuals and establish lines of communication**
>
> **2-d: Work toward multi-year and flexible funding arrangements**
>
> **2-e: Examine funding allocations**

Recommendation #3 - Facilitate Community Collection of Health Data
Data on health issues in Nunavut is limited with no data on certain issues (e.g., prevalence of children with FASD) and only limited or out-of-date data on others (e.g., alcohol and drug use and addictions). The routine collection and monitoring of data specific to FNIHB programs in Nunavut would provide information needed to modify programs to reflect the needs of Nunavut residents. Consistent territory-wide data collection could also provide relevant and current information on health status in Nunavut and contribute to future FNIHB program evaluations. Most FNIHB programs have identified program indicators and the data required to support measurement of these indicators. Community capacity building is needed to facilitate routine data collection, monitoring and reporting by community programs and projects. Before this can happen effectively, existing program indicators need to be examined for their relevance in Nunavut.

3-a: Verify cultural relevance of existing FNIHB program indicators

3-b: Build community capacity in routine data collection and reporting

Recommendation #4 - Develop a Comprehensive Communications Strategy
A comprehensive communications strategy would address issues identified by community program staff – the need to increase awareness and information about FNIHB programs, and to facilitate the sharing of experiences and best practices among communities.

4-a: Develop a strategy for increasing awareness and information about FNIHB programs in Nunavut.

4-b: Organize regular conferences for sharing best practices in FNIHB programs with other communities.

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ᖃᐅᔾᔨᐊᖅᑎᑦᑎᔾᔪᑏᑦ

ᐅᑯᐊ ᖃᐅᔨᓴᖅᑐᖃᑕᐅᕐᓂᖏᓐᓄᑦ ᐅᓂᒃᑲᐅᓰᑦ ᓴᖅᑭᑎᑕᐅᔾᔪᑎᖃᖅᓯᒪᕗᑦ ᑐᓴᒃᓴᐅᓪᓗᑎᒃ ᖁᑦᑎᒃᑐᒦᓐᓂᖅᓴᓄᑦ ᐊᐅᓚᑦᑎᔨᒋᔭᐅᔪᓄᑦ ᐋᓪᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᒃᑯᓐᓂᑦ ᐃᓄᓕᕆᔨᐅᓪᓗᑎᒃᑯ ᓄᓇᕗᑦ ᒐᕙᒪᒃᑯᖏᓐᓂ; ᐅᑭᐅᖅᑕᖅᑐᒧᑦ ᑎᑎᕋᕝᕆᔭᐅᔪᒧᑦ ᑭᒃᑯᐃᓐᓇᓄᑦ ᑲᒪᔭᖃᖅᐸᖓᓂᕐᒧᑦ, ᐅᖃᖃᑎᖃᖅᐸᖓᓂᕐᒧᑦ ᐊᕕᒃᓯᒪᓂᕆᔭᐅᔪᓄᑦᑐ ᐱᓕᕆᕝᕕᖁᔭᐅᔪᒥ[2], ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᒃᑯᓐᓂ ᑲᓇᑕᒧᑦ; ᓄᓇᕗᑦ ᑐᙵᕕᒃᑯᓐᓄᑦᑐ. ᑕᑯᔭᐅᔪᒪᑐᐃᓐᓇᓇᐊᖃᖅᑐᓴᐅᒥᕗᑦ ᓄᓇᓕᖕᓂ ᓯᕗᓕᖅᑎᕆᔭᐅᔪᓄᑦ ᓄᓇᓕᖕᓂᑐ ᐱᓕᕆᐊᒃᓴᓇᑎᑕᐅᖃᑦᑕᖅᑐᓄᑦ ᐊᐅᓚᑦᑎᔨᕆᔭᐅᔪᓄᑦ ᓄᓇᕗᒻᒥ.

ᓄᓇᖃᖅᑳᖅᓯᒪᔪᓄᑦ ᐃᖅᑭᓕᖕᓄᑦ ᐃᓄᖕᓄᑦᑐ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᕐᒧᑦ ᑲᓇᑕᒥ ᐋᓐᓂᐊᖃᕐᓇᖏᑦᑐᓕᕆᔾᔪᑎᓐᓂ ᖃᔅᓯᑲᓪᓚᖕᓂᒃ ᑐᓂᔭᐅᓂᐊᕐᓂᕐᒧᑦ ᐊᖏᖃᑎᒌᒍᑎᖃᖅᓯᒪᕗᑦ ᓄᓇᕗᑦ ᒐᕙᒪᒃᑯᖏᓐᓂ ᐋᓐᓂᐊᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᓐᓂ ᐃᓄᓕᕆᔾᔪᑏᑦᑐᑎᒍᑦ ᐊᐅᓚᑦᑎᕐᑏᑦᑐᒥᑦ ᐊᔾᔨᐅᙱᑭᕈᓘᔭᖅᑐᓂᒃ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᕐᒧᑦ ᖃᓄᐃᙱᑦᑎᐊᕈᓐᓇᕐᓂᕐᒧᑦᑐ ᐱᓕᕆᐊᖑᕙᒃᑐᓂᒃ ᐃᓄᐃᑦ ᓄᓇᖏᓐᓂ ᓄᓇᕗᒻᒥ. ᐅᑭᐅᖅᑕᖅᑐᒧᑦ ᑎᑎᕋᕝᕆᔭᐅᔪᖅ ᐊᐅᓚᑦᑎᕐᑲᑦᑕᖅᐳᖅ ᐊᖏᖅᑲᑎᒌᒍᑎᒥᒃ ᑭᖕᒐᖅᑐᖅᑐᒋᑦ ᑲᓇᑕᒧᑦ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᑦ. ᑖᓐᓇ ᖃᐅᔨᓴᕐᓂᕆᔭᐅᔪᖅ ᑎᑎᕋᖅᓯᕝᕕᐅᓯᒪᕗᖅ ᐊᕐᕌᒍᓯᓴᓪᓗ ᐊᖏᖅᑲᑎᒋᒍᑎᓂᒃ 2002-ᒥᑦ 2005-ᒧᑦ. ᐃᓚᖏᑦ ᐱᓕᕆᐊᒃᓴᐃᑦ ᑕᕝᕙᓂ ᐊᖏᖅᑲᑎᒌᒍᑎᓂ ᓴᖅᑭᑎᑕᐅᖃᑦᑕᖅᐳᑦ ᓄᓇᓕᖕᓂᑦ, ᑖᒃᑯᐊᓗ ᓄᓇᓖᑦ ᐱᓇᔪᑎᓂᒃ ᑐᓂᓯᕙᒃᐳᑎᒃ ᓄᓇᕗᒻᒥ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᓐᓄᑦ ᐃᓄᓕᕆᔾᔪᑏᑦᑐᑎᒍᑦ ᑮᓇᐅᔭᖅᑖᕝᕆᓇᓱᒃᐸᒃᐳᑦ. ᐊᓯᖏᑦ ᐱᓕᕆᐊᒃᓴᐃᑦ ᑲᔪᓯᑎᑕᐅᕙᒃᐳᑦ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᓐᓂᑦ ᐃᓄᓕᕆᔾᔪᑏᑦᑐᑎᒍᑦ. ᑖᒃᑯᐊ ᑕᒪᐃᑎᒍᑦ, ᐃᓄᐃᑦ ᑲᑐᔾᔨᖃᑎᒌᖏᑦ ᐊᓯᖏᑦᑐ ᐱᑖᖃᑕᐅᓯᒪᔪᑦ ᑕᒪᑐᒧᖓ ᐃᓚᐅᕙᒃᐳᑦ, ᓄᓇᓕᖕᓂᒪᓇᓪᓗᐊᓐᓃᑦ ᐃᓚᒋᔭᐅᑦᑐᑎᓪᓗᐊᓐᓃᑦ ᐱᒋᐊᖅᑎᑦᑎᔨᓄᑦ ᑲᑎᒪᔨᑦᓖᓇᔭᐅᔪᓄᑦ ᑖᒃᑯᐊᓗ ᑐᓂᓯᔨᕙᒃᐳᑎᒃ ᖃᓄᐃᓕᐅᖁᔨᕙᑦᑕᐊᓂᒥᒃ ᑕᒪᒃᑯᓄᖓ ᐱᓕᕆᐊᒃᓴᓇᓱᐃᔪᓄᑦ ᐋᖅᑭᒃᓯᐃᓂᒃᑯᑦ ᐱᓕᕆᓂᕐᒧᑦ ᐸᕐᓇᐅᑎᒋᔭᐅᔪᓂᒃ, ᓇᓗᓇᐃᖅᓯᕙᒃᐳᑎᒃ ᐃᓯᒪᒋᔭᒃᓴᓂᒃ, ᐊᑯᓐᓂᖃᕐᓂᖏᓐᓂᓪᓗ ᐃᓯᒫᓘᑕᐅᓯᒪᔪᓂᓪᓗᐋᓐᓃᑦ, ᐊᒥᖅᑳᖅᑲᑎᖃᖅᐹᒃᐳᑎᓪᓗ ᖃᐅᔨᒪᓂᓴᒥᓂᒃ.

ᓄᓇᕗᑦ ᑐᙵᕕᒃᑯᑦ ᐱᓕᓴᖃᑎᖃᕆᔭᐅᕙᒃᐳᑦ ᑕᒪᑐᒧᖓ ᖃᐅᔨᓴᕐᓂᓴᐅᔪᒧᑦ. ᑕᒪᕐᒥᑦᑎᐊᖅ ᓄᓇᕗᑦ ᒐᕙᒪᒃᑯᖏᑦ ᐱᒋᐊᖅᑎᓯᒪᔪᖏᑦ ᐅᖃᖃᑎᖃᓇᐊᖃᖅᑲᕝᕕᐅᕗᑦ ᓄᓇᕗᑦ ᑐᙵᕕᒃᑯᓐᓂᒃ ᑕᓐᓇ ᐃᓚᒋᔭᐅᓂᖓᓄᑦ 1993-ᖑᑎᓪᓗᒍ ᓄᓇᕗᑖᒃᓂᒃᒧᑦ ᒪᓕᒐᓕᐊᕆᓂᖓᓂ, ᑎᑎᕋᖅᓯᒪᓂᖓ 32-ᖑᓪᓗᓂ, ᑖᓐᓇᓗ ᖃᐅᔨᒪᔾᔪᑕᐅᑎᑎᐊᖅᐸᒃᑐᓂ ᐃᓄᐃᑦ ᐅᖃᖃᑎᖃᕆᔭᐅᕙᕆᐊᖃᕐᓂᖏᓐᓂᒃ ᑕᒪᐃᓐᓂ ᒐᕙᒪᒃᑯᑦ ᐊᑐᐊᒐᖏᓐᓂ ᐱᓕᕆᐊᒃᓴᐃᔪ ᖃᓄᐃᓕᖓᓂᕆᔭᖏᓐᓄ, ᐋᖅᑭᒃᓯᖅᑕᐅᕙᖕᓂᖏᓐᓄᑦ ᑲᔪᓯᑎᑕᐅᕙᖕᓂᖏᓐᓄᑦᑐ

ᐱᔪᑎᒋᔭᖓ ᐊᑐᖅᑕᐅᕙᒃᑐᑦᑐ

ᐱᔪᑎᒋᔭᖓ ᑕᒪᑐᒪ ᖃᐅᔨᓴᕐᓂᕆᔭᐅᔫᑉ ᖃᐅᔨᒪᓕᕈᒪᒧᑦ ᓵᙱᓂᕆᔭᐅᔪᓂᒃ ᓵᙱᓐᓂᕆᔭᐅᔪᓂᓪᓗ ᐊᐅᓚᑦᑎᓂᕆᔭᐅᔪᒥ ᑲᔪᓯᑎᑦᑎᓂᕆᔭᐅᔪᒥᓗ ᐆᒃᑐᕋᕈᒪᒧᑦᑐ ᐊᑐᕐᓇᕐᓂᖃᑦᑎᐊᕋᓗᐊᕐᒪᖔᑕ FNIHB-ᒧᑦ ᐱᓕᕆᐊᖑᔪᑦ ᑲᔪᓯᑎᑕᐅᖃᑦᑕᖅᑐᑦ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᓐᓂᑦ ᐃᓄᓕᕆᔾᔪᑏᑦᑐᑎᒍᑦ ᑐᓂᓯᓂᐊᕐᓂᕐᒧᑦ ᐊᖏᖃᑎᒌᒍᑕᐅᓯᒪᔫᑉ ᐊᑖᒍᑦ ᐅᑯᓄᖓ ᐊᕐᕋᒍᓄᑦ 2002-ᒥᑦ 2005-ᒧᑦ, ᐱᕕᖃᖅᑎᑦᑎᔪᒪᒧᑦᑐ ᖃᓄᐃᓕᐅᖁᔨᓇᓴᕐᓂᕐᓂᒃ ᐱᐅᓯᕆᐊᖅᑎᒃᑲᓐᓂᕐᓂᐊᕐᓗᒍ. ᑕᓐᓇ ᖃᐅᔨᓴᕐᓂᓴᐅᔪᖅ ᑕᓯᐅᖅᑕᐅᓚᐅᖅᐳᖅ ᖃᐅᔨᓴᖅᓯᕗᖕᓂᕐᒧᑦ ᐅᖃᐅᔾᔭᐃᕗᖕᓂᕐᒧᑦ ᑲᑎᒪᔪᓖᓂᑦ, ᐅᑯᐊᓗ ᑭᒐᖅᑐᐃᔾᔪᑕᓚᐅᖅᓱᑎᒃ, ᓄᓇᕗᒻᒥ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᑦ ᐃᓄᓕᕆᔨᐅᓪᓗᑎᒃᑯ, ᐅᑭᐅᖅᑕᖅᑐᒥ ᑎᑎᕋᕝᕆᔭᐅᔪᖅ, ᓄᓇᕗᑦ ᑐᙵᕕᒃᑯᓪᓗ. ᐸᕐᓇᒃᑕᐅᕙᓪᓕᐊᓂᖓ ᑕᒪᑐᒪ ᖃᐅᔨᓴᕐᓂᓴᐅᔫᑉ ᐱᒋᐊᓚᐅᖅᑐᖅ ᓄᕕᐱᕆ 2003-ᖑᑎᓪᓗᒍ ᑲᔪᓯᑎᑕᐅᕙᓪᓕᐊᓂᓴᖓᓗ ᐱᒋᐊᓚᐅᖅᓱᓂ ᐅᑭᐊᒃᓴᖑᓕᖅᑎᓪᓗᒍ 2005-ᒥ.

ᐅᑯᐊ 8-ᖑᔪᑦ FNIHB-ᒧᑦ ᐱᓕᕆᐊᖑᕙᒃᑐᑦ ᑕᐅᑦᑕᐅᓪᓗᐊᑕᓚᐅᖅᐳᑦ ᑕᒪᑐᒪᓂ ᖃᐅᔨᓴᕐᓂᓴᐅᔪᒥ:

- ❖ ᓄᓇᖃᖅᑳᖅᑐᓄᑦ ᓱᑲᖃᓗᐊᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᖑᓯᒋᐊᖅᓯᒪᔪᑦ (ADI)
- ❖ ᓯᕗᓂᒃᓴᖃᑦᑎᐊᖅᑐᓕᕆᓂᕐᒧᑦ (BF)
- ❖ ᐋᖅᑭᒃᓯᐃᕙᓪᓕᐊᓂᖅ ᖃᓄᐃᙱᑦᑎᐊᖅᑐᓂᒃ ᓄᓇᓕᖕᓂᒃ (BHC)
  - • ᐃᓱᒪᒃᑯᑦ ᖃᓄᐃᙱᑦᑎᐊᕐᓂᕐᒧᑦ ᑐᐊᕕᕐᓇᖅᑐᖅᑕᖃᓕᖅᑎᓪᓗᒍ ᐱᓕᕆᓯᖕᒫᖅᐸᖕᓂᕐᒧᑦ ᐱᓕᕆᐊᖑᕙᒃᑐᑦ
  - • ᐋᖓᔮᕐᓱᑕᐅᓕᖅᐸᒃᑐᓄᑦ ᐊᑐᕐᓂᕐᒧᒃᑕᐅᓕᖅᐸᒃᑐᓄᑦ ᐱᓕᕆᐊᖃᕐᓂᖅ
- ❖ ᑲᓇᑕᒥ ᓱᕈᐃᕙᒃᑐᓄᑦ ᓂᕿᑦᑎᐊᕙᓕᕆᓂᕐᒧᑦ ᐱᓕᕆᓂᐅᕙᒃᑐᑦ (CPNP)
- ❖ ᓱᕈᐃᑦᑎᔭᐅᔪᑦ ᐃᒥᐊᓗᖕᒧᑦ ᐊᒃᑐᖅᑕᐅᓂᕐᓗᒃᑎᑦᑎᕙᖕᓂᕐᒧᑦ (FASD)
- ❖ ᓄᓇᖃᖅᑳᖅᓯᒪᔪᑦ ᐃᖅᑭᓖᑦ ᐃᓄᐃᑦᑐ ᐊᖏᕐᕋᓕᕆᔨᖕᒋᓐᓂ ᓄᓇᖏᓐᓂᑐ ᑲᒪᔨᐅᕙᖕᓂᖏᓐᓄᑦ
- ❖ ᑲᓇᑕᓕᒥ ᓄᓇᖃᖅᑳᖅᑐᓄᑦ ᐃᒥᐊᖑᖕᒥᒃ ᐋᖕᒐᔮᕐᓇᖅᑐᓂᓪᓗ ᐊᑐᕐᓂᕐᒧᒃᓯᔪᖅᐸᖕᓂᖕᒐᓄᑦ ᐱᓕᕆᓂᐅᕙᒃᑐᖅ - ᒪᒥᓴᖅᑎᑕᐅᓂᕐᒧᑦ ᐊᔪᕈᓐᓃᖅᓴᑎᑕᐅᓂᕐᒧᑦᑐ

[2] ᐅᑭᐅᖅᑕᖅᑐᒥ ᑎᑎᕋᕝᕆᔭᐅᔪᖅ ᐅᑲᐅᓕᓚᐅᖅᓯᒪᔪᖅ ᓄᓇᖃᖅᑳᖅᑐᓄᑦ ᐃᓄᐃᑦᑐ ᖃᓄᐃᙱᑦᑎᐊᕐᓂᖏᓐᓄᑦ ᐱᓕᕆᕝᕕᖁᔭᐅᔪᒥ ᖃᐅᔨᓴᖅᑕᐅᕝᕕᖃᓕᖅᑎᓪᓗᒍ ᐃᓚᒋᔭᐅᓕᓚᐅᖅᓯᒪᓪᓗᓂᓗ ᓅᑦᑎᐊᒧᑦ ᓴᖅᑭᑎᑕᓕᕐᖅᑐᒧᑦ ᑮᑯᑐᐃᓐᓇᓄᑦ ᐱᓕᕆᕝᕕᖃᖅᐸᖓᓂᕐᒧᑦ, ᐅᖃᖃᑎᖃᖅᐸᖓᓂᕆᔭᐅᔪᓂ ᐊᕕᒃᓯᒪᓂᕆᔭᐅᔪᓂ (PACR) ᐱᓕᕆᕝᕕᖁᔭᐅᔪᒥ ᐊᐃᑉᐳᓯᑎ 2006-ᖑᑎᓪᓗᒍ. ᑖᒃᑯᐊ ᐅᓂᒃᑲᐅᓰᑦ ᐅᖃᐅᓯᐅᕝᕕᐅᔪᖃᐃᓐᓇᖅᐳᑦ ᐅᑭᐅᖅᑕᖅᑐᒧᑦ ᑎᑎᕋᕝᕆᔭᐅᔪᒥᑦ, ᓄᓇᖃᖅᑳᖅᓯᒪᔪᓂᒃ ᐃᓄᐃᓪᓗ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᕐᒧᑦ ᐱᓕᕆᕝᕕᐅᕙᖕᓂᖓᓂᒃ.

- ᑕᕝᕚᑭᓕᕆᓂᕐᒧᑦ ᑲᒪᒋᔭᕐᑲᕐᓂᕐᒧᑦ ᖃᓄᐃᓕᐅᖅᑕᐅᓚᐅᓪᓕᐊᔪᒪᔪᑦ.

ᑕᒪᓐᓇ ᖃᐅᔨᓴᕐᓂᕆᔭᐅᔪᖅ ᑕᐅᑐᒐᖃᓪᓗᐊᑦᕕᐅᓚᐅᖅᑐᖅ ᑖᓪᓕᒪᓄᑦ ᐅᑯᓄᖓ, ᐊᑐᕈᓐᓇᑦᑎᐊᕐᓂᕆᔭᕆᓐᓄᑦ, ᑲᔪᓯᓐᖃᑦᑎᐊᕈᓐᓇᕐᓂᕆᔭᕆᓐᓄᑦ, ᑲᔫᓐᓇᖅᑎᑕᐅᔫᓐᓇᕐᓂᕆᔭᕆᓐᓄᑦ, ᐃᓕᑕᐅᓚᐅᖅᑐᓪᓗ ᖃᐅᔨᒪᔭᐅᓕᕐᓂᕆᔭᕆᓐᓄᑦ. ᖃᐅᔨᓴᕐᓂᐅᓚᐅᖅᑐᒧᑦ ᑎᑎᕋᖅᓯᒪᓕᖅᑎᑕᐅᔪᑦ ᐱᔭᐅᓚᐅᖅᑐᑦ ᐱᖓᓱᓪᓗᐊᑦᕐᓂᑦ ᐱᕝᕕᐅᔫᓐᓇᖅᑐᓂ: ᕿᒥᕈᐊᒃᑲᓐᓂᕐᓂᖅ ᐱᓕᕆᐊᒃᓴᓄᑦ ᐊᑐᐊᒐᕐᓄᓪᓗ ᑎᑎᕋᖅᓯᒪᔪᓂᒃ, ᐅᖄᓚᐅᑎᒃᑯᑦ ᐊᐱᖅᓱᖅᓯᓂᖅ, ᐳᓖᕆᐊᕐᓂᕐᓗ 8-ᓄᑦ ᓄᓇᕗᒻᒥ ᓄᓇᓖᓐᓄᑦ ᐊᐱᖅᓱᕐᕕᐅᓚᐅᖅᑐᓄᑦ ᐱᓕᕆᖃᑎᖃᓪᓗᐊᑦᑐᓪᓗ ᓄᓇᓖᓐᓂᓗ ᑲᑎᒪᖃᑎᖃᖅᑏᓐᑦ ᑖᒃᑯᓇᓂ ᐱᓕᕆᐊᖑᓚᐅᕐᓗᑎᒃ. ᓄᓇᓕᓐ ᐳᓖᕆᐊᖅᑕᐅᓚᐅᖅᑐᑦ ᐅᑯᐊᖑᓚᐅᖅᐳᑦ, ᑭᙵᐃᑦ, ᑲᖏᖅᑐᖑᐱᒃ, ᓴᓪᓕᖅ, ᐅᖅᓱᖅᑑᖅ, ᐃᖃᓗᐃᑦ, ᖁᕐᓗᖅᑐᖅ, ᑲᖏᖅᖠᓂᖅ ᐊᐅᔪᐃᑦᑐᕐᓗ. ᑕᒪᐃᓐᓂ ᓄᓇᓕᖕᓂ, ᓄᓇᓕᖕᓄᑦ ᖃᐅᔨᓴᖅᑎᐅᓂᐊᖅᑐᒥᒃ ᐊᔪᕈᓐᓃᖅᓴᖅᑎᑦᑎᔪᒃᑲᑦᑕᓚᐅᖅᐳᖅ ᐃᖅᑲᐃᓯᓕᖅᑎᑕᐅᓪᓗᓂᓗ ᐃᑲᔪᖅᑐᐃᕐᑯᓯᐅᓪᓗᓂ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᖑᕙᓪᓕᐊᖃᑦᑕᖅᑐᒥᒃ ᐋᖅᑭᒃᓯᐃᕙᓪᓕᐊᓂᐊᖅᓗᓂᓗ ᓄᓇᓕᖕᓂ ᐊᔪᙱᓐᓂᕆᔭᐅᓕᕆᔭᖅᑐᓂᒃ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ.

ᐃᓱᓕᑦᑕᕝᕕᒋᔭᖕᒥᑦ ᖃᐅᔨᓴᕐᓂᕆᔭᐅᔫᑉ ᐃᓚᖃᑕᐅᖅᐳᑦ ᑭᒃᑯᓐᓄᑦ ᐱᒋᔭᐅᓂᖕᒥᓐᓄᑦ ᐃᓱᒪᒋᔭᒃᓴᐃᑦ, ᐊᑕᖑᙱᑦᑐᑦ ᑎᑎᕋᖅᑕᐅᓯᒪᔪᑦ, ᑲᑎᑕᐅᕙᓪᓕᐊᓂᖕᒥᑦ ᑎᑎᕋᖅᑕᐅᓯᒪᔪ, ᒪᓂᒪᕙᖕᓂᕆᔭᖕᒥᑦ ᐊᐱᖅᓱᖅᑕᐅᔫᒃᓴᑦ, ᐃᖅᑲᐃᔭᖅᑏᑦ ᐊᓯᔾᔨᖅᐸᖕᓂᕆᔭᖕᒥᑦ, ᖃᓄᕐᓗ ᐊᖏᑎᒋᓂᖓ ᑕᒪᑐᒪ ᑲᔪᓯᓂᕆᔭᐅᕙᓪᓕᐊᔾᔪᑦ.

ᖃᐅᔨᒪᔭᐅᓕᖅᑐᑦ

ᑖᓐᓇ ᐅᓂᒃᑳᖅᓯᒪᔪᖅ ᓴᖅᑭᑎᑦᑎᒍᖅ ᖃᐅᔨᔭᐅᓯᒪᓕᖅᑐᓂᒃ ᑕᒪᐃᓐᓄᑦ ᐱᓕᕆᐊᖑᕙᒃᑐᓄᑦ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᒃᓴᕆᔭᐅᔪᓄᑦ ᐅᑯᓄᖓ, ᐊᑐᕈᓐᓇᑦᑎᐊᕐᓂᕆᔭᕆᓐᓄᑦ, ᑲᔪᓯᓐᖃᑦᑎᐊᕈᓐᓇᕐᓂᕆᔭᕆᓐᓄᑦ, ᑲᔫᓐᓇᖅᑎᑕᐅᔫᓐᓇᕐᓂᕆᔭᕆᓐᓄᑦ, ᐃᓕᑕᐅᓚᐅᖅᑐᓪᓗ ᖃᐅᔨᒪᔭᐅᓕᕐᓂᕆᔭᕆᓐᓄᑦ. ᓴᖅᑭᑎᑦᑎᕝᕕᐅᑉᕙᖅᑕᐅᖅ ᓇᐃᓈᖅᓯᒪᔪᓂᒃ ᐱᓕᕆᐊᖑᑎᑕᐅᕙᒃᑐᓄᑦ ᐅᓂᒃᑳᖅᓯᒪᔪᓂᒃ ᑮᓇᐅᔭᑎᒨᖓᓂᖕᒋᑕ ᐅᓂᒃᑳᖅᓯᒪᔪᓂᒃ ᓇᐃᓪᓕᕆᐊᖅᓯᒪᓪᓗᑎᒃ. ᖃᐅᔨᔭᐅᓚᐅᖅᑐᑦ ᐊᔾᔨᒌᖕᓂᕆᔭᖕᒥᑦ ᑕᒪᐃᓂᒃᓴᒃ ᐱᓕᕆᐊᒃᓯᓂ ᓇᐃᓪᓕᕆᐊᖅᓯᒪᔪᓂ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᒃᓴᕆᔭᐅᔪᓂ ᐃᓚᖃᖅᑲᓂ ᑭᓱᑦ ᑲᔪᓯᖃᑦᑎᐊᓚᐅᕐᒪᖔᑕ ᑭᓱᔾ; ᐋᖅᑭᒋᐊᕆᐊᖃᒃᑲᓐᓂᕐᒪᖔᑕ.

ᐱᓕᕆᐊᖑᔪᑦ ᑲᔪᓯᑎᑕᐅᑎᐊᕐᓂᖓᓐ ᑕᐃᒪᐃᓐᓂᕋᖅᑕᐅᓚᐅᖅᐳᑦ ᓄᓇᓖᑦ ᐊᔪᙱᓐᓂᖃᑎᐊᕐᓂᖅᓴᐅᓕᕐᓂᖓᓐᓄᑦ ᐱᓕᕆᐊᖑᔪᒃ ᐊᐅᓚᑦᑎᓐᓂᕆᔭᐅᔪᒥᒃ ᑲᔪᓯᑎᑕᐅᓂᖓᓐᓂᓪᓗ, ᑕᒪᓐᓇᓗ ᑕᐃᒪᐃᑦᔪᑎᖃᓚᐅᑎᓪᓗᓂ ᑕᒃᑯᐊ ᐱᓕᕆᐊᒃᓴᐃᑦ ᐃᓂᖏᓃᑎᑕᐅᓯᒪᓕᕐᓂᖓᓐᓄᑦ ᐊᑯᓂᐅᓂᖅᓴᒃᑯᑦ, ᖃᓄᐃᙱᑦᑎᐊᕐᓂᖅ ᐃᓐᓇᕐᓂᖅᑲᓐᓇᖅᑐᖅ ᐃᓂᖓᓂᐅᑦᑐᖅᑲᕐᓂᖓᓐ ᓄᓇᓕᖕᓂ ᐱᓕᓪᓗᓂ, ᑲᔪᓯᐊᖏᓐᓇᖅᑐᒥᓪᓗ ᐃᑲᔪᖅᑐᖅᑐᕐᓂᕐᓂ ᐋᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᒃᑯᑦ ᐃᓄᓕᕆᓐᑯᑦ ᐊᕕᒃᓯᒪᓂᐅᔪᓂ ᑐᑦᑕᕝᕕᒋᔭᐅᔪᒥᓗ ᐱᓕᕆᐊᖑᔪᓐᓄᑦ ᐊᐅᓚᑦᑎᓐᓂᖅᑲᕐᓂᖏᓐᓄᑦ ᐱᓕᕆᓐᓕᓪᓚᑦᑖᖅᑕᖅᑲᕐᓂᖓᓐᓄᓪᓘᓐᓈᑦ ᐊᔪᙱᓐᓂᓕᓪᓚᑦᑖᓂᒃ, ᓱᕐᓗ ᓂᕿᑦᑎᐊᕙᓕᕆᔾᔨᒃ.

ᐊᔾᔨᒌᖕᓂᒃ ᐃᓱᒪᒋᔭᒃᓴᓂᒃ ᐅᖃᐅᓯᐅᔪᖃᑕᐅᓚᐅᖅᑐᖅ ᐊᓂᒍᕐᓯᕆᐊᖅᑲᕐᓂᖓᓐᓂᒃ ᖃᔅᓯᑲᓪᓚᖕᓄᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᓄᓇᓕᖕᒥᐅᓄᓪᓗ. ᐊᒻᒪᓗᑦᑕᐅᖅ ᐋᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓐᑎᓐᓄᑦ ᐃᓄᓕᕆᓐᑎᓐᓄᓪᓗ 2002-2005 ᐊᑐᖅᑎᓪᓗᒋᑦ ᐃᓚᖃᖅᑐᖅᐳᑦ ᐋᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᕐᒥᒃ ᐱᓯᒪᐃᓐᓇᕐᓂᕐᒥᓪᓗ ᐊᔪᙱᓐᓂᖅᑎᑕᐅᖅᑐᓂᒃ ᐋᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᐊᖅᑐᓂᒃ; ᐱᓕᕆᐊᖑᔪᓄᑦ ᐱᐅᓇᐊᕐᑲᖅᐸᒃᑐᓂᒃ ᐱᓇᔫᑕᐅᓚᐅᖅᑐᓄᑦ ᐅᓂᒃᑳᓯᕐᓄᓪᓗ; ᓯᒃᑲᐃᑦᑐᑯᓘᓚᐅᖏᓐᓂᖓᓐᓂᒃ ᑮᓇᐅᔭᓄᑦ ᐊᖏᖅᓯᓂᐊᕐᓗᓂ ᐱᓕᕆᓂᐅᓚᐅᓪᓕᐊᓚᐅᖅᑐᓄᑦ; ᐊᒥᓱᐊᕐᑲᑦᑕᕐᓂᖓᓐᓂᒃ ᑮᓇᐅᔭᖁᑎᒋᔭᐅᔪᑦ ᐃᓚᖏᓐᓂᑦ ᓄᓇᓕᖕᓂᑦ ᑮᓇᐅᔭᓂᓪᓗ ᐊᑐᐊᓂᒃᓯᒪᔪᖅᑕᖅᑲᖅᑲᙱᓐᓂᖓᓐ ᐊᓯᖏᓐᓂᑦᑕᐅᖅ ᓄᓇᓕᖕᓂ. ᑕᒃᑯᐊ ᐊᓂᒍᕐᓯᕆᐊᓖᑦ ᐊᒃᑐᐊᕐᑲᑦᑕᐅᑎᓂᖅᑲᕐᑎᐊᖅᐳᑦ ᑭᐅᓂᐊᕐᓗᒋᓪᓗ ᐊᑐᖅᑐᖅᑲᓇᐊᖅᑲᖅᓴᖅᐳᖅ ᐊᑕᖏᑦᑎᐊᖅᑐᒥᒃ ᐊᖏᓪᓕᕆᐊᖅᑎᑦᑎᔪᒪᒧᑦ ᓄᓇᓖᑦ ᐊᔪᙱᓐᓂᕆᔭᖏᓐᓂᒃ ᐱᕆᐊᒃᓴᓂᒃ ᐊᐅᓚᑦᑎᓂᐊᕐᓗᑎᒃ.

ᖃᓄᐃᓕᖓᓕᕐᓂᕆᔭᐅᔪᑦ ᖃᓄᐃᓕᐅᕐᑯᔭᐅᓇᔭᖅᑐᓪᓗ

ᖃᐅᔨᓴᕐᓂᕆᔭᐅᓚᐅᖅᑐᒥᒃ ᑲᔪᓯᑎᑎᓂᕆᔭᐅᓚᐅᖅᑐᖅ ᐃᓕᑦᑎᔾᔪᑕᐅᓚᐅᖅᐳᖅ ᐃᓕᑦᑎᕝᕕᐅᓪᓗᓂ ᐱᐅᓯᕆᐊᖅᑎᑦᑎᒃᑲᓐᓂᕈᑕᐅᔪᓐᓇᖅᑐᓂᒃ ᓯᕗᓂᒃᓯᒥ ᖃᐅᔨᓴᕐᓂᐅᓇᔭᖅᑐᓂᒃ FNIHB-ᒧᑦ ᐱᓕᕆᐊᖑᖅᑲᑦᑕᖅᑐᓄᑦ, ᓄᓇᕗᒥᑐᐃᓐᓇᐅᙱᑦᑐᖅ ᑭᓯᐊᓂᓪᓚᑦᑕᐅᖅ ᐊᕕᒃᓯᒪᓂᕆᔭᐅᖕᒥᔪᓂ ᑲᓇᑕᒥ. ᐃᓕᑕᐅᓚᐅᖅᑐᑦ ᖃᐅᔨᒪᓕᖅᑕᐅᓚᐅᖅᑐᑦ ᑕᒪᑐᒧᖓ ᖃᐅᔨᓴᕐᓂᕆᔭᐅᔪᒧᑦ ᐅᖃᐅᓯᐅᓯᒪᕗᑦ ᐊᖏᓪᓕᕆᐊᖅᑎᑎᒃᑲᓐᓂᕐᓴᕐᓂᖅ ᐃᓚᐅᑎᑎᓂᕆᔭᐅᔪᒥᒃ ᓄᓇᓕᖕᒥᐅᓂᒃ, ᐊᔪᕈᓐᓃᖅᓴᖅᑎᑎᓂᕐᒥᒃ ᐋᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓐᑎᑎᓂᕐᒥᓪᓗ ᓄᓇᓕᖕᒥᐅᓂᒃ ᖃᐅᔨᓴᖅᑎᐅᓇᔭᖅᑐᓂᒃ, ᐱᐅᓯᕆᐊᖅᑎᑎᒃᑲᓐᓂᕐᓗᑎᒡᓗ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐊᑐᖅᑕᐅᕙᒃᑐᓂᒃ.

ᐅᑯᐊ ᑕᕝᕙ ᖃᓄᐃᓕᐅᕐᑯᔭᐅᓇᔭᖅᑐᑦ ᐱᔭᐅᓚᐅᖅᐳᑦ ᐊᔾᔨᒌᓂᑦ ᖃᐅᔨᔭᐅᔪᓂᑦ ᑕᕝᕙᙵᓪᓚᑦ ᐅᓂᒃᑳᖅᓯᒪᔪᓂᑦ. ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔩᑦ ᐃᓄᓕᕆᔩᑦᑐ, ᓄᓇᕗᑦ ᑐᙵᕕᒃᑦ NS-ᑯᓪᓗ ᑕᒪᒥᑦᑎᐊᖅ ᐱᓕᔭᒃᓴᖅᑎᑕᐅᕗᑦ ᐊᑐᓕᖅᑎᑦᑎᓂᕐᒥᒃ ᑖᒃᑯᓂᖓ ᖃᓄᐃᓕᐅᕐᑯᔭᐅᓂᕆᔭᐅᔪᓂᒃ ᑭᓯᐊᓂ ᑭᓯᐊᓂᕐᒫ ᐃᓛᓪᓚᑦ ᑖᕋᔭᕐᓂᖓᓐ ᖃᐅᔨᒪᔭᐅᓕᕋᔭᖅᑐᑦ ᐊᑕᐅᑦᑎᒃᑯᑦ ᐅᖃᖅᑎᕆᕝᕚᓪᓗᑎᒃ ᐱᓕᕆᖅᑎᕆᕝᕚᓪᓗᑎᒡᓗ ᒪᓕᒡᓗᑎᒡᓗ ᐊᑐᓂᑦ ᑎᓕᔭᐅᓯᒪᔾᔪᑎᒋᔭᒥᒃ ᑭᓯᐊᓂᐅᖓᖖᒋᔭᒥᒃ ᐊᖏᔪᒥ ᐊᒃᑐᖅᓯᓂᐅᕙᒃᑐᒥ ᐃᑲᔪᖅᑐᐃᓂᕆᔭᐅᔪᒥᒃ FNIHB-ᒧᑦ ᐱᓕᕆᐊᒃᓴᕆᔭᐅᓂᖏᓐᓂ ᓄᓇᕗᒻᒥ.

ᖃᓄᐃᓕᐅᕐᑯᔭᐅᓂᕆᔭᐅᔪᖅ 1 - ᐊᖏᓪᓕᕆᐊᕐᓗᒍ ᓄᓇᓕᖕᒥᐅᑦ ᐱᓕᔪᓐᓇᕐᓂᕆᔭᖓ
ᖃᔅᓯᑲᓪᓚᐅᓂᖏᑦ ᐊᓂᒍᕐᓯᕆᐊᖃᖅᐸᒃᑐᑦ ᐊᑐᖅᑕᐅᔪᕕᓃᑦ ᓄᓇᓕᖕᓂ ᐱᓕᕆᐊᒃᓴᕆᔭᐅᔪᓂ ᐱᔾᔪᑎᖃᖅᐸᒃᐳᑦ ᐃᓱᓕᑦᑕᖅᑐᓂ ᐱᔪᓐᓇᕐᓂᕆᔭᐅᔪᓂ ᓄᓇᓕᖖᒐᐅᓄᑦ ᐱᓕᕆᐊᖑᔪᓄᑦ ᐊᐅᓚᑦᑎᓂᕐᒥ ᐊᔪᙱᓐᓂᕆᔭᐅᓕᖅᐸᒃᑐᓂ. ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔩᑦ ᐃᓄᓕᕆᔩᑦᑐᑎᒡᓗ, NS-ᑯᑦ, ᓄᓇᕗᑦ ᑐᙵᕕᒃᑯᓪᓗ ᐱᓕᕆᖃᑎᖃᕈᑎᖃᕐᓗᑎᒃ ᐊᓪᓗᐊᖅᐳᑦ ᐋᖅᑭᒃᓯᐃᖅᑎᕆᕝᕚᓪᓕᐊᓪᓗᑎᒃ ᐱᓕᕆᐊᕆᔭᐅᔪᓂᒃ ᐊᐅᓚᑦᑎᓂᕐᒧᑦ ᐊᔪᙱᓐᓂᕆᔭᐅᓕᖅᐸᒃᑐᓂᒃ ᓄᓇᕗᒻᒥ ᓄᓇᓕᖕᓂᑦ ᐋᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᒃᑯᑦ ᐊᓯᖏᓐᓄᓪᓗ ᐃᓕᐸᓪᓕᐊᓂᕐᒧᑦ ᐱᕕᒃᓴᖅᑎᑕᐅᓚᐅᖅᑐᓂ.

1-ᐃ: ᖃᐅᔨᓴᖅᑐᖅᑲᕐᓗᓂ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᕐᒧᑦ ᐱᔭᐅᔭᕆᐊᖃᖅᐸᒃᑐᓂᒃ ᐱᕕᒃᓴᖅᑎᑕᐅᔭᖅᐸᒃᑐᓂᓪᓗ

1-ᐱ: ᐋᖅᑭᒃᓱᐃᖃᕐᓗᓂ ᓄᓇᓕᖕᓂ ᐱᓕᕆᐊᒃᓴᓄᑦ ᐃᖅᑲᓇᐃᔭᖅᑎᒋᔭᐅᔪᑦ ᐊᔪᕈᓐᓃᖅᓴᖅᑎᑦᑎᖃᑦᑕᕐᑯᓪᓗᒋᑦ ᐊᔾᔨᒌᙱᒋᐅᓘᔭᖅᑐᓂᒃ ᐱᓕᕆᐊᒃᓴᓄᑦ ᐊᐅᓚᑦᑎᓂᕐᒧᑦ ᐊᔪᕈᓐᓃᖅᑕᐅᑦᑐᓂᒃ

1-ᑎ: ᑲᔪᓯᑎᑦᑎᔨᐅᓗᑎᒃ ᐊᕐᕌᒍ ᒫᕈᐃᖅᓱᕐᓗᒍ ᐱᓕᕆᖃᑎᒌᖕᓂᐅᖃᑦᑕᕐᓂᐊᖅᑐᓂ ᕿᓂᕈᒪᒧᑦ ᐅᖃᐅᓯᐅᓇᔭᖅᑐᓂᒃ ᐱᐅᓯᕆᐊᖅᑎᑦᑎᔪᒪᒧᑦ ᐃᓕᖅᑯᓯᕆᔭᐅᔪᓄᑦ ᐊᒃᑐᐊᓂᖃᕐᓂᕆᔭᖕᒋᓐᓂᒃ ᓈᒻᒪᖕᓂᕆᔭᖕᒋᓐᓂᓪᓗ FNIHB-ᒧᑦ ᐱᓕᕆᐊᕆᔭᐅᑦᑐᑦ ᐃᓄᖕᓄᑦ ᓄᓇᕗᒻᒥᐅᓄᑦ, ᐊᒻᒪᓗᑦᑕᐅᖅ ᐊᓯᖕᒋᓐᓄᑦ ᒫᓐᓇ ᐃᓱᒪᒋᔭᒃᓴᐅᑎᑕᐅᔪᓄᑦ ᓄᓇᓕᖕᓄᑦ

ᖃᓄᐃᓕᐅᕐᑯᔭᐅᓂᕆᔭᐅᔪᖅ 2 - ᑐᑭᓯᓇᖅᓯᑎᑦᑎᐊᕐᓗᒋᑦ ᐱᓕᕆᐊᖑᓂᐅᑦᑐᑦ ᐊᑐᖅᑕᐅᕙᓪᓕᐊᑦᑐᓪᓗ
ᐃᓚᖕᒋᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᒪᓕᒃᑕᐅᓕᕆᐊᕐᑲᖅᐸᒃᑐᑦ ᐃᓱᒪᒋᔭᐅᕙᑦ ᐃᓗᓕᖃᐅᓗᐊᕋᓯᒋᔭᐅᓪᓗᑎᒃ ᐊᑯᓂᐊᓗᒡᓗ ᐱᓕᕆᐊᖑᔭᕆᐊᖃᖅᐸᒃᓱᑎᒃ ᓄᓇᓕᖕᓄᑦ, ᐱᓗᐊᙱᐊᖅᓱᓂ ᐱᓕᕆᐊᖑᑉᑲᓐᓂᕆᐊᖃᖃᑦᑕᕋᖕᒐᑕ ᐊᕐᕌᒍᑕᓖᑦ. ᐃᓚᖕᒋᑦ ᐱᓕᕆᕙᓪᓕᐊᓂᐊᕐᓂᕐᒧᑦ ᐃᓗᓕᖕᒋᑦ ᐱᒋᐊᕐᕖᖃᖅᐳᑦ ᐃᓄᖕᒧᑦ ᐊᑕᐅᓯᕐᒧᑦ FNIHB-ᒧᑦ ᐱᓕᕆᐊᖑᕙᒃᑐᓄᑦ ᐃᓚᖕᒋᓪᓗ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᒋᓐᓂᑦ ᐃᓅᓕᕆᔾᔪᑏᓪᓗᑎᒡᓗ. NS-ᑯᑦ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑏᓪᓗ ᐱᓕᕆᖃᑎᒌᖃᑦᑖᓪᓗᐊᖅᐳᑦ ᖃᐅᔨᒪᑦᑎᐊᕈᒪᒧᑦ ᑕᒪᒃᑯᐊ ᐊᑐᖅᑕᐅᕙᓪᓕᐊᕙᑦᑐᑦ ᓄᓇᓕᖕᓄᑦ ᑐᑭᓯᓇᑦᑎᐊᖅᓯᑎᒃᑲᓐᓂᕐᓗᒋᑦ, ᐊᔪᕐᓇᙱᓐᓂᖅᓴᐅᓕᕐᓗᑎᒃ ᑲᔪᓯᕐᑲᑦᑎᐊᒃᑲᓐᓂᕈᓐᓇᓕᕐᓗᑎᒡᓗ. ᓯᓚᑖᒧᑦ ᒥᑭᓪᓕᑭᐊᖅᑎᑦᑎᓂᐅᑉ ᐊᐅᓚᑦᑎᓂᕐᒧᑦ ᐱᓕᕆᓂᐅᕙᒃᑐᒥᒃ ᓄᓇᓕᖕᓂ ᐱᓕᕆᐊᖑᕐᑲᑦᑕᖅᑐᓄᑦ, ᐊᔪᕐᓇᕈᓐᓃᕆᐊᖅᑎᓯᒪᔪᑦ ᐊᑐᖅᑕᐅᕙᓪᓕᐊᕙᑦᑐᑦ ᒪᓂᒪᑎᑕᐅᓂᖕᒋᓪᓗ ᐱᓕᕆᐊᒃᓴᓄᑦ ᒪᒃᐱᖅᑐᒐᕆᔭᐅᕙᑦᑐᑦ ᐊᐅᓚᑦᑎᓂᕐᒧᑦᓗ ᐊᑐᖅᑕᐅᕙᑦᑐᑦ ᐃᑲᔪᕈᑕᐅᓇᔭᖅᐳᑦ ᒥᑭᓪᓕᒋᐊᖅᑎᑦᑎᒃᑲᓐᓂᕈᑕᐅᓗᑎᒃ ᐊᒃᑐᖅᓯᓂᕆᔭᐅᕙᑦᑐᓂᒃ ᐃᖅᑲᓇᐃᔭᖅᑏᑦ ᐊᓯᔾᔨᖅᐸᓪᓕᐊᕙᖕᓂᖕᒋᓐᓄᑦ. ᐊᕐᕌᒍᓗᓴᖕᓄᑦ, ᐊᓯᔾᔨᕆᐊᓪᓚᒃᓴᐅᔪᓂᒃ ᑮᓇᐅᔭᖃᖅᑎᑦᑎᓂᕐᒧᑦ ᐋᑭᒃᑕᐅᓯᒪᔪᑦ ᐋᖅᑭᒃᑎᐊᖅᑕᐅᓯᒪᒃᑲᓐᓂᖅᑐᓪᓗ ᐊᖏᖅᓯᓂᕐᒧᑦ ᐊᑐᖅᑕᐅᕙᓪᓕᐊᕙᑦᑐᑦ ᑮᓇᐅᔭᖃᖅᑎᑕᐅᓂᕐᒧᑦ ᐱᐅᓯᕆᐊᖅᑎᑦᑎᓇᔭᖅᐳᑦ ᖃᓄᐃᓕᖓᓖᕐᓂᖕᒋᓐᓂᒃ ᖃᐅᔨᒪᐸᓪᓕᖕᓂᒥᒃ ᑮᓇᐅᔭᖃᖃᖅᑎᑕᐅᓂᖕᒋᓐᓄᑦ ᓄᓇᓖᑦ, ᑕᐃᒪᐃᓐᓂᖓᓄᓪᓗ ᐊᐅᓚᑦᑎᔾᔪᑕᐅᓪᓗᑎᒃ ᐱᐅᓂᖅᓴᓄᑦ ᐱᓕᕆᐊᓴᖅᑎᑦᑎᓂᕐᒧᑦ ᐊᑐᖅᑕᐅᔪᓇᖅᑐᓄᓪᓗ ᐸᕐᓇᖕᓂᕐᒥᒃ ᐃᖅᑲᓇᐃᔭᖅᑎᓂᓪᓗ ᐱᓯᒪᐃᓇᖅᓯᓂᕐᒥᒃ. ᑲᑐᔾᔨᖅᑎᕇᒃᑐᒡᓗ ᐱᓕᕆᐊᕐᑲᖅᓯᒪᓂᖕᒐᑦ ᐅᑯᐊ NS-ᑯᑦ, ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᔾᔪᑎᑦ ᐃᓅᓕᕆᔾᔪᑏᓪᓗᑎᒡᓗ ᓄᓇᕗᑦ ᑐᙵᕕᒃᑯᓪᓗ ᐱᔭᐅᔭᕆᐊᖃᕋᔭᖅᐳᑦ ᐊᔪᕐᓇᙱᓐᓂᖅᑎᑦᑎᔪᒪᒧᑦ ᐱᓕᕆᓂᐅᕙᓪᓕᐊᕙᑦᑐᒧᑦ ᐊᑐᖅᑕᐅᕙᑦᑐᓂᒃ, ᐋᖅᑭᒃᓯᐅᓗᑎᒃ ᐱᓕᕆᐊᒃᓴᓄᑦ ᒪᒃᐱᖅᑐᒐᕆᔭᐅᖃᑦᑕᕐᓂᐊᖅᑐᓂᒃ ᓈᒻᒪᒃᑐᓂᒃ ᐊᐅᓚᑦᑎᓂᕐᒧᑦ ᐱᓕᕆᔾᔪᑎᖃᕐᓗᑎᒃ, ᓄᓇᓖᓪᓗ ᐃᓕᑎᑕᐅᓗᑎᒃ ᑕᒪᒃᑯᓄᖓ.

2-ᐃ: ᑐᑭᓯᓇᖅᓯᑎᒃᑲᓂᕐᓗᒋᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᐊᑐᖅᑕᐅᔭᕆᐊᖃᖅᐸᒃᑐᑦ

2-ᐱ: ᐊᔾᔨᒌᓕᖅᑎᒃᔫᒥᓗᒋᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᐱᓇᔫᑕᐅᑦᑐᑦ ᐅᓂᒃᑲᐅᓯᐊᕆᔭᐅᑦᑐᓪᓗ

2-ᑎ: ᐋᖅᑭᒃᓯᐃᔪᖃᕐᓗᓂ ᖃᓄᐃᓕᐅᖅᐸᓪᓕᐊᓂᐊᕐᓂᕐᒧᑦ ᒪᒃᐱᖅᑐᒐᕐᓂᒃ ᐋᖅᑭᒃᓯᔪᖃᕐᓗᓂᓗ ᑐᓴᐅᒪᖃᑦᑕᐅᑎᔾᔪᑕᐅᓂᐊᖅᑐᓂᒃ

2-ᑭ: ᐱᓕᕆᔪᖃᕐᓗᓂ ᑐᕌᕆᔭᖃᕐᓗᑎᒃ ᐊᕐᕌᒍᓚᓴᖕᓄᑦ ᐊᓯᔾᔨᕆᐊᓚᒃᓴᐅᓗᑎᓪᓗ ᑮᓇᐅᔭᖃᖅᑎᑕᐅᓂᕐᒧᑦ ᐊᑐᖅᑕᐅᖃᑦᑕᕐᓂᐊᖅᑐᓂᒃ

2-ᒋ: ᕿᒥᕐᕈᓇᓱᒋᑦ ᑮᓇᐅᔭᖃᖅᑎᑕᐅᓂᕐᒧᑦ ᓴᓂᕝᕙᐃᓐᕕᐅᕙᖕᓃᑦ

ᖃᓄᐃᓕᐅᕐᑯᔭᐅᓂᕆᔭᐅᔪᖅ 3 - ᐊᐅᓚᑦᑎᓗᑎᒃ ᓄᓇᓕᖕᓂ ᖃᑎᑕᐅᕙᓪᓕᐊᓂᖕᒋᓐᓂᒃ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᕐᒧᑦ ᑎᑎᕋᖅᑕᐅᕙᓪᓕᐊᕙᑦᑐᑦ
ᑎᑎᕋᖅᑕᐅᕙᓪᓕᐊᕙᑦᑐᑦ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᕐᒧᑦ ᐃᓱᒪᒋᔭᒃᓴᐃᑦ ᓄᓇᕗᒻᒥ ᐃᓯᓕᑦᑕᕝᕕᖃᖅᐳᖅ ᐃᓚᖕᒋᓐᓄᑦ ᐃᓱᒪᒋᔭᒃᓴᐅᕙᑦᑐᓄᑦ ᑎᑎᕋᖅᓯᒪᔪᕐᑯᑎᖃᖅᑐᖃᙱᑦᑎᐊᖅᓱᓂ (ᓲᕐᓗ ᐅᓇ ᑕᑯᔫᑎᒋᓗᒍ, ᐊᒥᓲᓂᖕᒋᓐᓄᑦ ᓄᑕᕐᑯᓗᐃᑦ ᓯᖓᐃᒋᔭᐅᑎᓪᓗᒋᑦ ᐃᒥᐊᓗᖕᒧᑦ ᐊᒃᑐᕐᓂᕐᓗᒃᑕᐅᓂᑯᑦ) ᐊᒻᒪᓗ ᐱᔪᓇᖅᑕᐅᕙᑦᑐᐊᑦ ᐃᓯᓕᑦᑕᕝᕕᖃᕐᓗᑎᒃ ᐅᓪᓗᒥᒧᓪᓗᓐᓃᑦ ᐊᖑᒻᒪᑎᙱᑦᑎᐊᖅᑐᓂᒃ ᑎᑎᕋᖅᓯᒪᔪᕐᑯᑎᖃᖅᑐᖃᖅᓱᓂ ᐊᓯᖕᒋᓐᓄᑦ (ᓲᕐᓗ, ᐃᒥᐊᔫᑉ ᐋᖑᔫᕐᓇᖅᑐᓪᓗ ᐊᑐᖅᑕᐅᕙᖕᓂᕆᔭᖕᒋᓐᓄᑦ ᐅᐃᕆᐋᔪᑕᐅᕙᖕᓂᕆᔭᖕᒋᓐᓅᔅᓗ).
ᑲᑎᑕᐅᕙᓪᓕᐊᕙᖕᓂᖕᒋᑦ ᓇᐅᑦᑎᖅᓱᖅᑕᐅᓂᖕᒋᓪᓗ ᑎᑎᕋᖅᑕᐅᕙᓪᓕᐊᕙᑦᑐᑦ ᑐᕌᖕᒐᓂᖅᑐᑦ FNIHB-ᒧᑦ ᐱᓕᕆᐊᖑᕙᑦᑐᓄᑦ ᓄᓇᕗᒻᒥ ᐱᕕᖃᖅᑎᑦᑎᓇᔭᖅᐳᑦ ᑐᓴᖅᑕᐅᔭᕆᐊᖃᖅᐸᒃᑐᓄᑦ ᓄᑖᙳᕆᐊᖅᑎᑦᑎᔪᒪᒧᑦ ᐱᓕᕆᐊᒃᓴᓂᒃ ᐊᒃᑐᐊᓂᖃᓕᖅᑎᓪᓗᒋᑦ ᐱᔭᐅᔪᒪᓯᒪᔪᓄᑦ ᓄᓇᕗᒻᒥ ᓄᓇᓕᖕᒥᐅᓄᑦ. ᐊᔾᔨᒌᑎᒍᑦ ᑲᔪᓯᓂᖅᑐᑦ ᓄᓇᑦᑎᓐᓂᓕᒫᖅ ᑎᑎᕋᖅᑕᐅᓯᒪᔪᓄᑦ ᑲᑎᖅᓯᐃᕙᓪᓕᐊᓂᖅ ᐱᕕᖃᖅᑎᑦᑎᓇᔭᕆᐊᒃᑕᐅᖅ ᐊᑐᕈᓇᖅᑐᓂᒃ ᐊᒃᑐᐊᓂᖃᑦᑎᐊᕐᓂᕐᒧᑦ ᐅᓪᓗᒥᒧᓪᓗ ᐊᖑᒻᒪᑎᔪᓂᒃ ᑐᓴᖅᑕᐅᔪᒃᓴᓂᒃ ᐋᓐᓂᐊᖃᕐᓇᙱᑦᑐᓕᕆᓂᐅᑉ ᖃᓄᐃᓕᖓᓕᕐᓂᖓᓄᑦ ᓄᓇᕗᒻᒥ ᐃᑲᔪᕈᑕᐅᓗᑎᒡᓗ ᓯᕗᓂᒃᓴᓂ FNIHB-ᒧᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᖃᐅᔨᓴᕐᓂᕆᔭᐅᑦᑐᓂᒃ. ᑕᒪᕐᒥᒃᓴᒃ FNIHB-ᒧᑦ ᐱᓕᕆᓂᕆᔭᐅᔪᑦ ᓇᓗᓇᕈᓐᓃᖅᑎᑦᑎᓯᒪᕗᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᖃᐅᔾᔪᔭᖅᑕᐅᔪᓇᖅᑐᓂᒃ ᑎᑎᕋᖅᑕᐅᓯᒪᔪᓂᓪᓗ ᐱᔭᐅᔭᕆᐊᖃᖅᐸᒃᑐᓂᒃ ᐃᑲᔪᖅᑐᐃᔪᒪᒧᑦ ᐅᒃᑐᕋᕐᓂᐊᕐᓗᒋᑦ ᑕᒪᒃᑯᐊ ᖃᐅᔾᔪᔭᖅᑕᐅᔪᑦ. ᓄᓇᓕᖕᒥᐅᓂᑦ ᐊᔪᙱᓐᓂᕆᔭᐅᔪᓄᑦ ᐋᖅᑭᒃᓯᐃᓂᖅ ᐊᑐᖅᑕᐅᔭᕆᐊᖃᖅᐳᖅ ᐊᐅᓚᑦᑎᔪᒪᒧᑦ ᑎᑎᕋᖅᑕᐅᓯᒪᔪᓂᒃ ᑲᑎᖅᓯᐃᕙᓪᓕᐊᕙᖕᓂᕐᒧᑦ, ᓇᐅᑦᑎᖅᓱᕐᓂᕐᒧᑦ ᐅᓂᒃᑳᖅᑲᕐᓂᕐᒧᓪᓗ ᓄᓇᓕᖕᒥᐅᓂᑦ ᐱᓕᕆᐊᖑᕙᑦᑐᓂᑦ ᐱᓕᕆᐊᖑᓚᐅᒃᐸᒃᑐᓂᓪᓗ. ᑕᒪᓐᓇ ᑲᔪᓯᔪᓐᓇᓚᐅᙱᓐᓂᐊᓂ ᐊᑐᕐᓂᖃᕐᓇᑎᐊᕐᓗᓂ, ᓴᖅᑭᓯᒪᕖᖅᑐᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᖃᐅᔨᒪᓕᕈᑕᐅᔪᓇᖅᑐᑦ ᖃᐅᔨᓴᖅᑕᐅᔭᕆᐊᖃᕋᔭᖅᐳᑦ ᐊᑐᕈᓇᑎᐊᕋᓗᐊᕐᒪᖕᒋᑕ ᓄᓇᕗᒻᒥ.

3-ᐃ: ᓇᓗᓇᐃᑦᑎᐊᕐᓗᒋᑦ ᐃᓕᖅᑯᓯᑐᖅᑲᖅᑎᒍᑦ ᐊᑐᕈᓇᕐᓂᕆᔭᖕᒋᑦ ᓴᖅᑭᑎᑕᐅᓯᒪᕖᖅᑐᑦ FNIHB-ᒧᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᖃᐅᔨᔪᑕᐅᔪᓇᖅᐸᒃᑐᑦ

3-ᐱ: ᐋᖅᑭᒃᓯᐃᔪᖃᕐᓗᓂ ᓄᓇᓕᖕᓂ ᐊᔪᙱᓐᓂᕆᔭᐅᓇᔭᖅᑐᓂᒃ ᑎᑎᕋᖅᓯᒪᔪᓂᒃ ᑲᑎᖅᓯᐃᖃᑦᑕᕐᓂᐊᕐᓂᕐᒧᑦ ᐅᓂᒃᑳᓕᐅᕆᐊᖃᖃᑦᑕᕐᓂᕐᒧᓪᓗ

ᖃᓄᐃᓕᐅᕐᑯᔭᐅᓂᕆᔭᐅᔪᖅ 4 - ᐋᖅᑭᒃᓯᐃᔪᖃᕐᓗᓂ ᐃᓗᓕᖃᐅᑎᐊᖅᑐᒥᒃ ᑐᓴᐅᒪᖃᑦᑕᐅᑎᓂᕐᒧᑦ ᐊᑐᖅᑕᐅᖃᑦᑕᕐᓂᐊᖅᑐᓂᒃ

ᐃᓗᓕᖃᐅᑦᑎᐊᖅᑐᖅ ᑐᓴᐅᒪᖃᑦᑕᐅᑎᓂᕐᒧᑦ ᐊᑐᖅᑕᐅᖃᑦᑕᕐᓂᐊᖅᑐᖅ ᑭᐅᔾᔭᑕᐅᓇᓱᒃᑐᖅ ᐃᓱᒪᒋᔭᐅᓯᒪᔪᓄᑦ ᓇᓗᓇᐃᖅᑕᐅᓯᒪᔪᓄᑦ ᓄᓇᓕᖕᓂ ᐱᓕᕆᐊᒃᓴᕆᔭᐅᔪᓄᑦ ᐃᖅᑲᓇᐃᔭᖅᑎᒋᔭᐅᔪᓂᒃ – ᐊᖏᒃᓕᒋᐊᖅᑎᑦᑎᔪᖅᑲᕆᐊᖅᑲᖅᓂᖓᓂᒃ ᐅᔾᔨᕈᓱᖕᓂᕐᒥᒃ ᑐᓴᐅᒪᑎᑦᑎᓂᕐᒥᒡᓗ FNIHB-ᒧᑦ ᐱᓕᕆᐊᖑᕙᒃᑐᓂ, ᐊᐅᓚᑦᑎᔨᒪᒧᓪᓗ ᐊᒥᖅᑳᖅᓂᕐᒥᒃ ᐊᑐᖅᑕᐅᖃᑦᑕᖅᓯᒪᔪᓂᒃ ᐱᐅᓂᖅᐹᓂᒡᓗ ᐊᑐᖅᑕᐅᖃᑦᑕᖅᑐᓂᒃ ᓄᓇᓕᖕᒥᐅᓂᑦ.

4-a: ᐋᖅᑭᒃᓯᐃᔪᖃᖅᓗᓂ ᖃᓄᐃᓕᐅᖅᐸᓪᓕᐊᓂᐅᓂᐊᖅᑐᓂᒃ ᐅᔾᔨᕈᓯᓕᖅᑎᑦᑎᒃᑲᓐᓂᕈᑕᐅᓇᓱᒃᑐᓂᒃ ᑐᓴᐅᒪᔾᔪᑕᐅᓗᑎᒡᓗ FNIHB-ᒧᑦ ᐱᓕᕆᐊᖑᖃᑦᑕᖅᑐᓂᒃ ᓄᓇᕗᒻᒥ.

4-b: ᐋᖅᑭᒃᓯᐃᓗᑎᒃ ᑲᑎᒪᖅᔪᐊᖅᓂᐅᖃᑦᑕᕋᔭᖅᑐᓂᒃ ᐊᒥᖅᑳᖅᕕᐅᖃᑦᑕᕋᔭᖅᑐᓂᒃ ᐱᐅᓂᖅᐹᓂᒃ ᐊᑐᖅᑕᐅᕙᑦᑐᓂᒃ FNIHB-ᒧᑦ ᐱᓕᕆᐊᒃᓴᓄᑦ ᐊᓯᒥᓄᑦ ᓄᓇᓕᖕᓄᑦ.

IHUMALIURNIKKUT MAKPIRAQ

INTRODUCTION

Una Ihivriuqtauninga taiguaq pipkaitjutauyuq naunaitkutautikhamik angayukhiinut atannguyanut Munarhiliqiyikkunni Nunavut Kavamangani; tamna Ukiuqtaqtumi Katimayiryuangat Kavamaliqiyiikunnut, Tuhaqtipkainiqmut Avikturhimayut Timiqutigiyangit[3], Aaniarviitigut Kaanatami; Tunngavitkutlu. Nakuugiyauniaruknarhiuqlu nunallaani hivuliqtingitnut unalu nunallaani havauhiitigut atannguyauyuq Nunavunmi.

Tamna Allait Inuinnaitlu Aaniarviitigut Avikturhimaningit Timiqutigiyangit (qablunaatitut FNIHB) Aaniarviitigut Kaanatamiunit (qablunaatitut HC) qaffinik piqaqtuq Akiliuhianikkut Angirutit Nunavut Kavamanganut (qablunaatitut GN) Munarhiliqiyikkut Inuuhiriknirmullu Havakvingit (HSS) tunigiami atlatqiinik aaniarnaittumik inuuhiriknirmullu pinahuarutit inuinnainnut nunallaangit Nunavunmi. Tamna Ukiuqtaqtumi Katimayiryuangat (qablunaatitut NS) munarivagait Angirutingit pitqutivlugu Aaniarviitigut Kaanatamiunit. Una Ihivriuqtauninga tamainnik piyuq amigaittunik ukiunik Angirutin 2002mit – 2005mut. Ilangit pinahuarutit Angirutimi tuniyauyut nunallaanut, tuniyait tukhirutit Nunavut Munarhiliqiyikkut Inuuhiriknirmullu Havakvingitnut manikharvigiyakhangitnik. Atlat pinahuarutit pipkaitjutauvaktut Munarhiliqiyikkunnit. Talvuuna, Inuinnait timiqutigiyangit atlatlu tigumiaqtiuqatauyut ilauyullu, nunallaamiknit inmikkut katimaqataulutikluuniit hivuliutjutigiyut Katimayiingit pipkaitjutigiyut iluittumik tikinnahuaqtamiknik pinahuarutinut piliurnikkut havaatigut ihumaliurniq, ilitarinirmiklu ihumaalutigiyauningitnik, atlatqiirutigiyauyangitnik ihumaalutigiyauyut, ilihimattiarutigiiklutikluuniit.

Nunavutmi Tunngavitkut (qablunaatitut NTI) paanariyaa uumunnga Ihivriuqtauninga. Tamaita Nunavut Kavamangit havauhingit piyukhat uqariamikni Tunngavitkunnut ilaukmat 1993 nunataarutini maligaukmat, titirarhimaninga angirutiup 32mi, naunairhimayuq uqarvigiyaunikkut havaakhaq Inuinnait tamainni kavamatkut maligangitni pinahuarutingitnilu, piliurninga tunitjutinganiklu.

HUUQ PITQUHINGITNIKLU

Huuq una Ihivriuqtauninga pipkaiyuq naunairiami hakuginngningit ayurhautigiyangitniklu munarinikkut tunitjutaunikkutlu uuktuutigiqupl ugulu nakuurutingitnik FNIHB-kut pinahuarutit atuqtitauliqtut Munarhiliqiyikkut Inuuhiriknirmullu Havakvingitnit ukunuuna Akiliuhianikkut Angirutit uumani ukiungitni 2002mit-2005mut, tunigiamilu atuquyauyuq ihuarhainingitnik. Tamna Ihivriuqtauninga havaanga hivuliqtitauyuq Ihivriuqtauninga Uqaqtiuningit Katimayiingit (qablunaatitut EAC), piliurhimayuq katimaqatauhimayunik Nunavut Munarhiliqiyikkut Inuuhiriknirmullu Havakvingitnik, Ukiuqtaqtumi Katimayiryuangatnik, Tunngavitkutnitlu. Ihumaliurningat Ihivriuqtauninganut piliqtuq Nuvaipa 2003mi aulapkainingalu piliqtuq ukiaghami 2005mi.

Hapkuat 8nguyut FNIHB pinahuarutit akhuurutauyut una Ihivriuqtauninganik:

[3] Ukiuqtaqtumi Katimayiryuangat iluani ittuq Allait Inuinnaitlu Aaniarviitigut Avikturhimaningit Timiqutigiyangit ihivriuqtauliqtitlugit ilauyut nutaamik piliulihaaqtumik Kavamaliqiyikkunnut, Tuhaqtipkainirmut Avikturhimayunutlu (qablunaatitut PACR) Avikturhimaningit Timiqutigiyangitnut Aagasi 2006mi. Una taiguagakhaq pipkaiyuq Ukiuqtaqtumi Katimayiryuanganut, Allait Inuinnaitlu Aaniarviitigut Avikturhimaningit Timiqutigiyangit tamainnut.

- Nunaqaqaarhimayut Aaniarutilik Aungagut Havauhiq (qablunaatitut ADI)
- Inuuhaat Iliharviat (qablunaatitut BF)
- Angikliyuumiqniq Aaniarnaittumik Nunallaat (qablunaatitut BHC)
    - Ihumatigut Aaniaqtailiniq Qilamiuqtaqaqqat Nutqaqtitainahuarniq Pinahuarutit
    - Hupluuqtailinikkut Pinahuarutit
- Kaanatamiut Hingaiyaitigut Nakuuyunik Nirinikkut Pinahuarutit (qablunaatitut CPNP)
- **Najjitaaqtilluni Aangayaaqattarnirmut Aaniarut** (qablunaatitut FASD)
- Allait Inuinnaitlu Aihimavingit Nunallaanilu Munariniq (qablunaatitut FNIHCC)
- Kaanatami Allait Inuinnaitlu Imitigut Aangayaarnaqtunik Higaanik Kapuqtituniklu Aturumainnarniq Pinahuarutit (qablunaatitut NNADAP) – Mamihainiq Ilihainiqlu
- Tipaakunik Atuqpallaarnaittumik Maligaq (qablunaatitut TCS).

Tamna Ihivriuqtauninga akhuuqtauyaat tallimauyut uqaqtakhamiknik akhuuqtautjutinik, ilihimattiarniq, atuqtautjutinganik, nunngaulaittininganik, ilihaqtamikniklu ayuiqtangitnik. Ihivriuqtauninga qaffiuyut naunaiqtauningit piyauyut pingahunit atuqtauningitnik: ihivriurninganik pinahuarutingitnik maligatigutlu titiqat, hivayautikkutlu apirhuqhutik, pulaarhutiklu 8nguyunut Nunavunmi nunallaat apirhuqtauyut akhuurutauyullu katimayut unalu nunallaanut katimatjutautigigamik,. Tapkuat nunallaat pulaaqtauyut Kinngait, Kangirluaapik, Salliq, Urhuqtuuq, Iqaluit, Kugluktuk, Kangirliniq, Qausuittuq. Tahapkunani, nunangitni ihivriuqtauyungit ilihaqtipkaiyuq havaktitauliqturlu ikayuriami Ihivriuqtauninganik angikliyuumiriamiknilu nunallaani aktiktulaangigut Ihivriuqtauninganik.

Kikliqarninganik Ihivriuqtauninga ilauyut ilitariyaunikkut ihumaalutigiyauyuq, kikliqarhimayut naunaitkutingit, katitiriniq qaffiuyut naunaiqtauningit, apirhuqtauqtaaqqataluuniit, havaktut himmautangit, angivallaarningalu havaaq.

KIUTJUTAUTIGIYAIT

Una taiguaq pipkaiyuq kiutjutautigyainnik tamainnut pinahuarutinut ataani Ihivriuqtauninga uqaqtakhangitniklu akhuurutauyut, ilihimattiarniq, atuqtautjutinganik, nunngaulaittininganik, ilihaqtamikniklu ayuiqtangitnik. Pipkaiyurlu naittumik pinahuarutimik naunaitkutinga kiinauyakkutlu qanuritaakhaanganik. Kiutjutautigiyait atlaqaqtaunngittuq talvunnga pinahuarutinut tuakliqtitauyut ihivriuqtautinganik kitutlu nakuuyumik havaktauyut kitutlu ihuarhaqtauyukhat.

Pinahuarutit iniqtirutingit ilitariyauyut angitqiamut nunallaani aktikulaangit pinahuarutini munariniq tunitjutauninganilu, talvannga ilitariyauyuq pinahuarutinut talvaniittuq qangaraalukmut, havakhimaaqtuq Inuuhiriknirmut Nakuruqtiyi havaktuq nunamikni, ikayurhirhimmaaqturlu HSSkut avikturhimayuni ataniqarvinganitlu pinahuarutit munaqtingit ayuittiarhimayunitlu, ukunatut niqiliqinirmut ayuittiarhimayuq.

Atuqtauyut ihumaalutit uqaqtauyut uuktuutigiyautjutimut qaffiuyunit pinahuarutimit nunallaanilu, HSSkullu, uumani 2002mit-2005mut ilauyut Havaktugharhiuqti Aulahimmaariangnilu ayuittiarhimayunikluuniit havaktiitnik; pinahuarutit ihariagiyangit tukhirutinut taiguaqtakhanutlu; utaqqiraaqpaktangitlu manikharvigiyakhangit angiqtauningit; ihuanngittutlu manikharvigiyakhangit ilangani nunallaani atuqtaunngitangitniklu maniit allani. Hapkuat uuktuutigiyauyut atayut uqaqtauningitlu iharigiyait ihumaalutigiyauyuq iluitturinirmut piyauyangit angikliyuumiriami nunallaat aktikulaangit pinahuarutini munariniq.

INIQTIRUTIIT ATUQUYAUYUITLU

Pipkainiq Ihivriuqtauninga naunaiyainiq ayuirhautigiyauyuq talvuuna nakuruqtitautjutikhaq ihivriuqtautjutikhanut FNIHB pinahuarutinik, Nunavunmiinginnaunngittuq kihimi allani avikturhimayuni Kaanataup. Ilihainiit ilihaqtarhimayut naunaiyainirmik uqaqtauyut tahapkunani angikliqtuumiyunik ilaunirmut nunallaani katimayiit, ilihainiq havaktitauliriniq nunallaani qanuritaakhaanik ihivriuqtinut, nakuruqtigiamilu Ihivriuqtauninga hanalrutautigiyangit.

Hapkuat atuquyauyuq atjikutaliurhimayut nalvaaqtarhimaningitnit uumani taiguaqmi. Munarhiliqiyikkut Inuuhiriknirmullu Havakvingit, Nunavutmi Tunngavitkut Ukiuqtaqtumi Katimayiryuangatlu tamaita pipkaiyut pipkaqtiriami hapkuat atuquyauyuq kihimi tapkuat havaat naunaiqtauniaqut atayunit uqaqtaunikkut havaqatigiiknikkut talvuunalu atuquyauyut hivutuyuniittunit ikayurnirmut FNIHBkut pinahuarutit Nunavunmi.

Atuquyauyuq #1 – Angikliyuumirlugit Nunallaani Aktikulaangit
Amigaittut uuktuutit mihigimayait nunallaani pinahuarutini piyut kikliqarhimayunit aktikulaangitnit nunallaanut havauhirmut munariniq ayuittiarnikkut. Munarhiliqiyikkut Inuuhiriknirmullu Havakvingit, Ukiuqtaqtumi Katimayiryuangat Nunavut Tunngavitkut havaktukhaugaluat ilaulutik pigiamikni havauhiitigut munariniq aktikulaatigut Nunavunmi ilihaitjautikkut atlatlu ayuirhaitjutigiyaunikkut.

> **1-a: Pilugu ihivriurnimik ilihainirmut ihariagiyauningitnik kitutlu ilihautigiyakhangit**
>
> **1-b: Ihuarhilugu nunallaani havauhitigut havaktingit ilihariamikni tamainnut havauhitigut munarinikkut ayuittiarniqmut**
>
> **1-c: Pipkailutit malruukni ukiumi katimaqatauniqmik naunairiami nakuruqtitauninganik pitquhiitigut akhuurutauyut ihuatqiariyangitniklu FNIHBkunnik pinahuarutit inuinnainut Nunavunmi, atlanutlu nutaat ihumaalutigiyauyut nunallaanut**

Atuquyauyuq #2 – Ayurnaittumik Pilirlugu Havauhingit Pitjutingitlu
Ilangit pinahuarutit havauhingit ihumagiyauyut ayurnaqtumik akuniraaluklu pivagait nunallaanut, piinaliraangamitku ukiuq tamaat. Ilangit havauhingit pitjutingit pilihaaqtut atauhirmut FNIHB pinahuarutit atlanut Munarhiliqiyikkut Inuuhiriknirmullu Havakvingitnit. Ukiuqtaqtumi Katimayiryuangat Munarhiliqiyikkut Inuuhiriknirmullu Havakvingitlu havaqatigiiktukhaugaluat naunairiami havauhiingit nunallaanut naunaittiarhimayut, ayurnaittumiklu ihuatqiamiklu. Ikikliyuumiutilluni titiraliqiyikkut havaangit nunallaanut havauhingitnut, ayurnaittut havauhiit piinarialaqininganiklu pinahuarutingut atuqtakhangit munarinikkutlu hanalrutautigiyangitnik ikikliyuumiutiginiaqtaraluannga pitjutautingit havaktiit himmautigitnik. Amigaittuni ukiuni, ihuaqtunik manikharvigiyautjutingit unalu nutaanguqtiriyauyut angirutit havauhingit manikharvigiyakhangitnik nakuuhitjutauniaqtuq ilihimatjutiginingit manikharvigiyautingitnik nunallaanut, talvuuna pipkaitjutauniq nakuuyunik pinahuarutit ilihimayuniklu ihumaliurnikkut havaktinutlu aulahimaarianganiklu. Akhuurutauhimayut NSkunnik, Munarhiliqiyikkut Inuuhiriknirmullu Havakvingit Nunavut Tunngavikkutlu ihariagiyauniaqtut ayurnaittumik pigiami havauhingitigut, piliurlugu pinahuarutit maliktakhangit ihuatqiamik munarinikkut hanalrutautigiyangitnik, ilihapkairlugitlu nunallaat talvuuna.

2-a: Naunairlugu pinahuarutit ihariagiyamiknik

2-b: Nutaanguqtirilugit havauhiit tukhirutit taiguagitlu

2-c: Piliurlugu havauhiitigut maliktakhangit piliurlugulu naunaipkainiq

2-d: Havaarilugu malruukni ukiuni ihuaqtunik manikharvigiyautjutigiyangitnik

2-e: Ihivriurlugit maniit tuniyauningit

Atuquyauyuq #3 – Ihuarhipkailugu Nunallaani Katitiriyut Aaniarutilirinikkut Qaffiuyut Naunaitkutingit
Qaffiuyut naunaitkutingit aaniarutiirinikkut ihumaalutigiyauyut nunavunmi kikliqaqtuq naunaitkutaittumik ilangitni ihumaalutigiyauyunik (ukunatut, pihimaarniq nutaqqanut FASD-qaqtunik) ikiklihimayullu utuqqauyutluuniit atlanut (ukunatut, Imitigut Aangayaarnaqtunik aturninga aturuilimaittutingalu). Aturhimaarninga katitirinirmut munarinirmullu qaffiuyut naunaitkutinganik FNIHBkut pinahuarutigitnik Nunavunmi pipkaitjutauniaqtuq naunaitkutinik ihariagiyauyut himmiriami pinahuarutit atjikutariamikni ihariagiyangitnik Nunavunmiutat. Ihuatqianik Nunavut tamaani qaffiuyut naunaitkutingit katitiriniq pipkainiaqtuugaluaq akhuuqtauyunik nutaatlu naunaitkutinik aaniarviitigut qanuritaakhaangitnik Nunavunmi tunilunilu hivuniptikni FNIHB pinahuarutit Ihivriuqtauninganik. Tamarmik FNIHB pinahuarutit ilitariyait pinahuarutit naunaitkutauyut qaffiuyut naunaitkutingitlu ihariagiyauyut ikayuutaugiami aktikulaangutingit hapkuat naunaitkutingit. Nunallaani aktikulaangit angikliyuumiutingit ihariagiyauyuq pipkaigiami atuqtamiknik qaffiuyut naunaitkutingit katitiriniq, muuunariniq tuhaqtipkainiqlu nunallaat pinahuarutit havauhiitlu. Pitinnagu nakuuyumik, tapkuat pinahuarutit naunaitkutingit ihivriuqtauyukhat akhuurutaunikkut Nunavunmi.

3-a: Naunairlutu pitquhitigut akhuurutauningit atuqtauyunit FNIHB pinahuarutit naunaitkutingitnik

3-b: Piliurlugu nunallaani aktikkulaangit atuqtauhimaarhimayunit qaffiuyut naunaitkutingitnik katitiriniq tuhaqtipkainirlu

Atuquyauyuq #4 - Piliurlugu Iluittumik Tuhaqtipkaitjutauniq
Iluittumik tuhaqtipkaitjutauniq naunaiqtauniaqtuq ihumaalutigiyauyunik ilitariyauyut nunallaani pinahuarutit havaktingitnit – ihariagiyauyuniq angikliyuumiqlugit ilihimaniq naunaitkutinirlu FNIHB-tigut pinahuarutit, ayurnaittumiklu pilugu uqarhimaarutauyuniq atuqtamiknik unalu nakuutqianik atuqtamiknik nunallaani.

4-a: Piliurlugu ihumaliurniqmik angikliyuumiriami ilihimattiarniq naunaipkainirmiklu FNIHB-tigut pinahuarutit Nunavunmi.

4-b: Pipkailugu katimaqatiginiq qakunnguqqat uqarhimaarutaugiami nakuutqianik piyakhat FNIHB-kunni pinahuarutit allanut nunallaanut.

RÉSUMÉ

INTRODUCTION

Le présent rapport d'évaluation est destiné aux dirigeants du ministère de la Santé et des Services sociaux du Nunavut, du Secrétariat du Nord de la Direction générale des affaires publiques, de la consultation et des régions[4], de Santé Canada et de la Nunavut Tunngavik Incorporated. Il peut également intéresser les dirigeants des collectivités et les gestionnaires de projets communautaires du Nunavut.

La Direction générale de la santé des Premières nations et des Inuit (DGSPNI) de Santé Canada (SC) a conclu plusieurs ententes de contribution avec le ministère de la Santé et des Services sociaux (MSSS) du Nunavut concernant la gestion de divers programmes de santé et de bien-être destinés aux collectivités inuit du Nunavut. Le Secrétariat du Nord (SN) gère ces programmes au nom de SC. La présente évaluation porte sur l'entente pluriannuelle 2002-2005. Certains des programmes prévus à l'entente sont offerts directement par les collectivités qui présentent des propositions au MSSS du Nunavut afin d'obtenir du financement. D'autres programmes sont offerts directement par le MSSS. Dans les deux cas, les organismes inuit et d'autres intervenants participent à la prestation des programmes, soit au sein des collectivités ou comme membres de comités directeurs qui fournissent des orientations générales en élaborant des plans de travail, en identifiant les problèmes, les lacunes ou les préoccupations et en partageant leurs connaissances.

La Nunavut Tunngavik Incorporated (NTI) participe à la présente évaluation. En effet, en vertu du chapitre 32 de l'Accord sur les revendications territoriales du Nunavut, la NTI doit être consultée concernant toutes les politiques gouvernementales et la conception des programmes, y compris leur mécanisme d'exécution.

BUT ET MÉTHODOLOGIE

Le but de la présente évaluation est d'établir les forces et les faiblesses concernant la gestion et la prestation des programmes, de mesurer l'efficacité des programmes de la DGSPNI offerts par le MSSS pour la période 2002-2005, et d'émettre des recommandations pour l'avenir. Le processus d'évaluation a été guidé par le Comité consultatif de l'évaluation (CCE) qui était composé de représentants du MSSS du Nunavut, de SC et de la NTI. La planification de l'évaluation a été entreprise en novembre 2003 et sa mise en œuvre a commencé au cours de l'automne 2005.

Les huit programmes de la DGSPIN mentionnés ci-dessous ont été évalués :

- Initiative sur le diabète chez les Autochtones (IDA)
- Grandir ensemble (GE)
- Pour des collectivités en bonne santé (CBS)
    - Programme d'intervention d'urgence en santé mentale
    - Programme de lutte contre l'abus de solvants

[4] Le Secrétariat du Nord appartenait à la Direction générale de la santé des Premières nations et des Inuit au moment de l'évaluation avant de joindre la nouvelle Direction générale des affaires publiques, de la consultation et des régions en août 2006. Le présent rapport fait référence au Secrétariat du Nord de la Direction générale de la santé des Premières nations et des Inuit.

- Programme canadien de nutrition prénatale (PCNP)
- Ensemble des troubles causés par l'alcoolisation fœtale (ETCAF)
- Programme de soins à domicile et en milieu communautaire des Premières nations et des Inuit (PSDMCPNI)
- Programme national de lutte contre l'abus de l'alcool et des drogues chez les Autochtones (PNLAADA) – Traitement et formation
- Stratégie de lutte contre le tabagisme (SLCT).

L'évaluation porte sur les cinq éléments suivants : pertinence, efficacité, efficience, viabilité et leçons tirées. Les données ayant servi à l'évaluation proviennent de trois sources principales : l'examen des documents relatifs aux programmes et aux politiques, une série d'entrevues téléphoniques et des visites dans huit collectivités du Nunavut pour y mener des entrevues, tenir des groupes de discussions et participer à des assemblées communautaires. Les huit collectivités visitées sont : Cape Dorset, Clyde River, Coral Harbour, Gjoa Haven, Iqaluit, Kugluktuk, Rankin Inlet et Resolute Bay. Dans chacune de ces collectivités, un évaluateur communautaire a été embauché et formé afin de soutenir le processus d'évaluation et de renforcer les capacités communautaires dans le domaine de l'évaluation.

Le processus d'évaluation a connu un certain nombre de contraintes : difficultés de répartition des tâches, données parcellaires, recoupement des données, manque de disponibilité des personnes pour les entrevues, roulement de personnel et ampleur de la tâche à accomplir.

CONSTATS

Pour chaque programme, le rapport présente des constats regroupés sous les thèmes d'évaluation suivants : pertinence, efficacité, efficience, viabilité et leçons tirées. Il contient également une brève description des programmes évalués ainsi qu'un résumé financier. Les constats communs à la plupart des programmes sont résumés sous chacun des thèmes d'évaluation, y compris ce qui a bien fonctionné et ce qui doit être amélioré.

Le succès des programmes est le résultat d'une meilleure capacité communautaire dans le domaine de la gestion et de la prestation des programmes. Cela est notamment lié au fait que certains programmes sont en place depuis plusieurs années, à l'existence d'un poste à plein temps de coordonnateur en bien-être dans la collectivité, au soutien offert par les coordonnateurs de programmes ou les professionnels, comme les nutritionnistes, rattachés au bureau central ou régional du MSSS.

Les représentants des collectivités et du MSSS ont identifié divers problèmes et défis communs à plusieurs programmes offerts au cours de la période 2002-2005. On note par exemple les difficultés de recrutement et de rétention du personnel qualifié, les exigences des programmes concernant la formulation des propositions et la production de rapports, la lenteur du processus d'approbation des demandes, le financement insuffisant dans certaines collectivités et les fonds non dépensés à d'autres endroits. Ces défis et difficultés sont étroitement liés. Pour y faire face, il faudra mettre en place une approche holistique et renforcer les capacités communautaires dans le domaine de la gestion de programmes.

CONCLUSIONS ET RECOMMANDATIONS

Le processus d'évaluation a constitué pour tous un apprentissage dont il faudra tenir compte lors des prochains exercices d'évaluation des programmes de la DGSPNI, non seulement au Nunavut, mais ailleurs au Canada. Les leçons tirées dans le cadre de la présente évaluation sont présentées dans les sections portant sur la participation accrue des membres des collectivités, l'embauche et la formation d'évaluateurs communautaires, et l'amélioration des outils d'évaluation.

Les recommandations qui suivent sont tirées des constats communs présentés dans le présent rapport. Le MSSS, la NTI et le SN ont tous un rôle à jouer pour la mise en œuvre de ces recommandations. Le rôle de chacun sera précisé dans le cadre de discussions conjointes en tenant compte de leur mandat respectif et du soutien qu'ils peuvent apporter aux programmes offerts par la DGSPNI au Nunavut.

1re recommandation – Renforcer les capacités communautaires
Un grand nombre de défis rencontrés pour la prestation des programmes communautaires sont liés aux compétences limitées des collectivités dans le domaine de la gestion de projets. Le MSSS, le SN et la NTI doivent travailler en collaboration afin de renforcer les capacités de gestion dans les collectivités du Nunavut en offrant des occasions de formation et d'apprentissage.

> **1-a : Procéder à l'évaluation des besoins et des occasions de formation**
>
> **1-b : Offrir au personnel des projets communautaires la possibilité d'acquérir une gamme complète de compétences dans le domaine de la gestion de projets**
>
> **1-c : Tenir des ateliers semestriels afin de recueillir des commentaires sur les moyens à prendre afin d'accroître la pertinence culturelle des programmes de la DGSPNI pour les Inuit du Nunavut et sur d'autres questions d'intérêt pour les collectivités.**

2e recommandation – Simplifier les processus et les procédures
Certaines procédures sont jugées trop complexes et exigent trop de temps de la part des collectivités, tout particulièrement lorsqu'elles doivent être répétées tous les ans. Ces procédures sont soit liées directement aux programmes de la DGSPNI ou établies par le MSSS. Le SN et le MSSS doivent collaborer afin de clarifier, simplifier et accroître l'efficacité des procédures. Outre le fait de diminuer les tâches administratives devant être accomplies par les collectivités, il faudra simplifier les procédures et élaborer des manuels et des outils de gestion pour les divers programmes, ce qui pourrait atténuer les effets du roulement de personnel. La mise en place d'ententes pluriannuelles et flexibles de financement et de processus d'approbation simplifiés aurait pour effet d'accroître la prévisibilité du financement pour les collectivités, facilitant ainsi la planification des programmes et des ressources et la rétention du personnel. Un effort concerté du SN, du MSSS et de la NTI est requis afin de simplifier les procédures, d'élaborer des manuels contenant des outils de gestion appropriés et d'offrir la formation requise dans les collectivités pour qu'elles puissent utiliser efficacement ces outils.

> **2-a : Clarifier les exigences des programmes**
>
> **2-b : Simplifier la procédure de présentation de propositions et le mécanisme de production de rapports**

2-c : Élaborer des manuels de procédures et mettre en place des mécanismes de communication

2-d : Mettre en place des ententes de financement pluriannuelles et flexibles

2-e : Revoir les mécanismes d'octroi du financement

3e recommandation – Faciliter la collecte de données sur la santé dans les collectivités

Les données sur la santé au Nunavut sont limitées. Elles sont souvent inexistantes (par ex. : au sujet des enfants atteints de TSAF), parcellaires ou désuètes (au sujet de la consommation de drogue ou d'alcool et de la toxicomanie). La collecte régulière de données relatives aux programmes de la DGSPNI fournirait de l'information utile qui permettrait d'ajuster les programmes afin de répondre plus adéquatement aux besoins des résidants du Nunavut. L'uniformisation de la collecte de données à l'échelle du territoire pourrait également fournir de l'information sur l'état de santé de la population du Nunavut et servir dans le cadre de futures évaluations des programmes de la DGSPNI. La plupart des programmes de la DGSPNI ont défini les indicateurs et le type de données requises pour mesurer ces indicateurs. Il est nécessaire de renforcer les capacités communautaires pour faciliter la collecte régulière de données, assurer le suivi des programmes et des projets et faciliter la production de rapports. Toutefois, il faut au préalable examiner les indicateurs de programmes existants pour vérifier leur pertinence dans le contexte du Nunavut.

3-a : Vérifier la pertinence culturelle des indicateurs existants pour les programmes de la DGSPNI

3-b : Renforcer les capacités communautaires pour la collecte et la production régulières de données

4e recommandation – Élaborer une stratégie globale de communication
L'élaboration d'une stratégie globale de communication permettrait de répondre aux préoccupations soulevées par les personnes responsables de la prestation des programmes dans les collectivités. Cela permettrait de mieux sensibiliser et informer la population concernant les programmes de la DGSPNI et faciliterait le partage des expériences et des pratiques exemplaires entre les collectivités.

4-a : Élaborer une stratégie pour mieux sensibiliser et informer la population du Nunavut au sujet des programmes de la DGSPNI.

4-b : Tenir sur une base régulière des rencontres permettant aux collectivités de partager les pratiques exemplaires concernant les programmes de la DGSPNI.

List of Acronyms

ADI	Aboriginal Diabetes Initiative
BF	Brighter Futures
BHC	Building Healthy Communities
CDS	Canadian Diabetes Strategy
CHR	Community Health Representative
CLEY	Department of Culture, Language, Elders and Youth
CPNP	Canada Prenatal Nutrition Program
EAC	Evaluation Advisory Committee
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
FNIHB	First Nations and Inuit Health Branch
FNIHCC	First Nation and Inuit Home and Community Care
HC	Health Canada
GN	Government of Nunavut
HECS	Healthy Environments and Consumer Safety Branch
HSS	Health and Social Services
NNADAP	National Native Alcohol and Drug Abuse Program
NTI	Nunavut Tunngavik Incorporated
PACR	Public Affairs, Consultations and Regions Branch
PHAC	Public Health Agency of Canada
TCS	Tobacco Control Strategy

1.0 INTRODUCTION

1.1 WHO THIS REPORT IS FOR

This evaluation report is intended as information for senior managers in the Department of Health and Social Services of the Government of Nunavut; the Northern Secretariat of the Public Affairs, Consultations and Regions Branch[5], Health Canada; and Nunavut Tunngavik Incorporated. It may also be of interest to community leaders and community project managers in Nunavut.

The Introduction to this evaluation report briefly describes the background to the evaluation and the parties involved; the purpose of the evaluation; and the timeframe of the evaluation.

1.2 BACKGROUND

The First Nations and Inuit Health Branch (FNIHB) of Health Canada (HC) has had a number of Contribution Agreements with the Government of Nunavut (GN), Department of Health and Social Services (HSS) to administer a range of health and wellness programs for Inuit communities in Nunavut. The Northern Secretariat (NS) administers the Agreement on behalf of HC. This evaluation covers the multi-year Agreement for 2002-2005.

Some of the programs in the Agreement are delivered directly by communities, who submit proposals to Nunavut HSS for funding. Other programs are delivered directly by HSS. In both cases, Inuit organizations and other stakeholders are involved, either within the communities themselves or as members of steering committees that provide overall direction for the programs by developing work plans, identifying issues, gaps, or concerns, and sharing knowledge.

Nunavut Tunngavik Incorporated (NTI) is a partner in this evaluation. All GN initiatives are required to consult NTI as part of the 1993 land claims legislation, article 32, which ensures a consultative role for Inuit in all government policy and program design, development and delivery.

(The mission statements and/or strategic plans of HC, FNIHB, HSS and NTI are provided in Appendix A.)

1.3 PURPOSE OF THE EVALUATION

The purpose of this evaluation was to determine strengths and weaknesses in management and delivery and to measure the effectiveness of the FNIHB programs implemented by HSS through the Contribution Agreement for the period of 2002-2005, and to provide recommendations for

[5] The Northern Secretariat was within the First Nations and Inuit Health Branch at the time of the evaluation and became part of the newly created Public Affairs, Consultations and Regions (PACR) Branch in August 2006. This report refers to the Northern Secretariat, First Nations and Inuit Health Branch throughout.

improvements. The evaluation focused on the topics of relevance, efficiency, effectiveness, sustainability, and lessons learned.

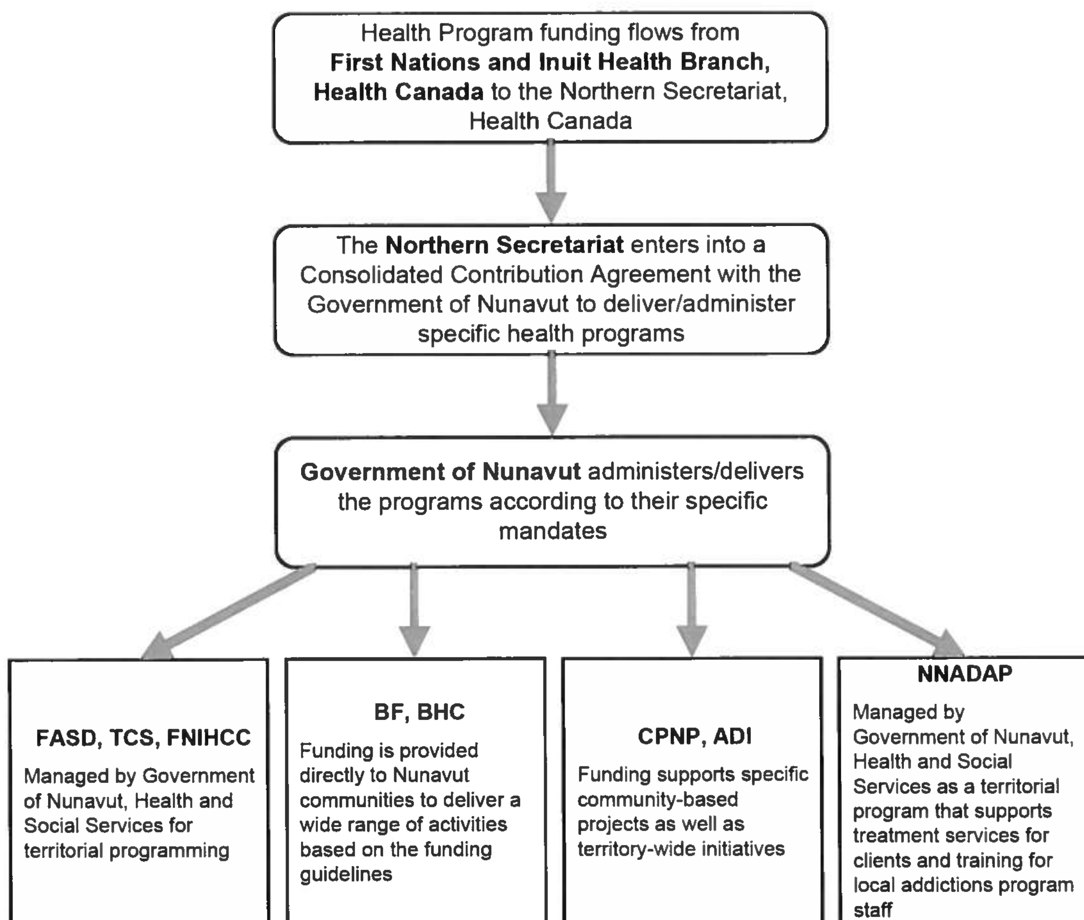
The evaluation process was guided by the Evaluation Advisory Committee (EAC), which was composed of representatives from Nunavut HSS, NS, and NTI.

The following eight FNIHB programs delivered in Nunavut during 2002-2005 were the focus of this evaluation:

1. Aboriginal Diabetes Initiative (ADI)
2. Brighter Futures (BF)
3. Building Healthy Communities (BHC)
   a. Mental Health Crisis Intervention
   b. Solvent Abuse Program
4. Canada Prenatal Nutrition Program (CPNP)
5. Fetal Alcohol Spectrum Disorder (FASD)
6. First Nations and Inuit Home and Community Care (FNIHCC)
7. National Native Alcohol and Drug Abuse Program (NNADAP) - Treatment and Training
8. Tobacco Control Strategy (TCS)

Figure 1-1 illustrates the flow of funding for FNIHB programs from Health Canada to the Government of Nunavut to communities.

Figure 1-1: Flow of FNIHB Funding from Health Canada to Government of Nunavut to Communities



1.4 TIMEFRAME OF THE EVALUATION

The evaluation examined the management and delivery of FNIHB programs in Nunavut for a three-year period from April 2002 through March 2005. This period was chosen by HC and the GN to reflect the period of their recently completed Contribution Agreement, and in accordance with program management guidelines and best practices for evaluating programs. Planning for the evaluation began in the fall of 2003 and implementation began in the fall of 2005.

2.0 METHODOLOGY

This section of the evaluation report describes the evaluation topics and themes, data sources, assumptions made in the methodology, and its limitations.

2.1 Evaluation Topics

The evaluation covered five main topics with themes as shown in Table 2-1.

Table 2-1: Evaluation Topics and Themes

Evaluation Topics	Themes
Relevance	❖ Addressing current health needs in communities ❖ Gaps in addressing health needs; overlaps with non-FNIHB community-based health programs ❖ Reflecting missions and strategic plans of HC, FNIHB, HSS and NTI
Efficiency	❖ Program requirements clear and consistent ❖ Areas of management and administration needing improvement ❖ Linkages/collaboration among programs ❖ Impact of existing community capacity in program management ❖ Challenges to utilizing the resources ❖ Value compared to other similar GN programs (cost per participant, leveraging of additional funds, innovation in stretching funding)
Effectiveness	❖ Access to health resources that help to improve health status ❖ Promoting cultural appropriateness ❖ Target populations reached ❖ Building community capacity in program management
Sustainability	❖ Ability to continue without current funding ❖ Funding available through other sources ❖ Promote a preventative approach to health maintenance
Lessons Learned about:	❖ Improving impact ❖ Enhancing awareness and uptake of programs ❖ Adequacy of funding levels

2.2 DATA SOURCES

Evaluation data came from three main sources:

2.2.1 Program and policy document review

The document review included program and policy documents such as program frameworks, program evaluation reports, annual program reports, project activity reports, strategic plans, statistical reports, financial summaries, and the Contribution Agreement. See Appendix B for a list of the documents reviewed.

2.2.2 Telephone interviews

Telephone interviews were conducted with HC, HSS and NTI representatives involved in the management or administration of the FNIHB programs as follows: 11 interviews with HSS, 10 with HC, and 1 with NTI.

2.2.3 Community visits

Eight communities were selected in consultation with the EAC based on criteria to ensure representation from:

- all three regions in Nunavut;
- smaller communities and regional centres;
- communities with all or a majority of the FNIHB programs;
- communities with active programs or pilot projects; and
- communities with different levels of program success.

The communities visited were Cape Dorset, Clyde River, Coral Harbour, Gjoa Haven, Iqaluit, Kugluktuk, Rankin Inlet, and Resolute Bay. A total of 274 community members were involved in evaluation activities, i.e., community meetings, personal interviews or focus groups. In each community, a community evaluator was trained and hired to support the evaluation process and build community capacity by providing translation and interpretation and conducting some interviews if required.

2.3 LIMITATIONS

2.3.1 Attribution of Effects on Health Status

Given the variety of agents that influence change, the range of determinants of health (e.g., housing, employment, poverty), and the impact of other community-based programs in some Inuit communities, it is difficult to assess long-term outcomes and effectiveness or to establish direct causal linkages between FNIHB programs and any changes in health status of Inuit in Nunavut. For this evaluation, reliance was placed on the perceptions of project staff and clients in communities, and HC and HSS staff concerning effects of projects and programs.

2.3.2 Limited Data on Certain Themes

Data were not sufficient to comment on certain themes under the evaluation topics.

2.3.3 Availability for Interviews

Not all local program coordinators or clients were available for interviews due to a variety of circumstances such as inclement weather and concurrent activities. The community data reflect only the views of the people who were available while the evaluators were in the communities.

2.3.4 A Snapshot from a Different Time

The interviews reflect a snapshot in time for program delivery. In some instances, staff at community, regional and senior levels at HSS and HC who were interviewed for this evaluation were not the same staff there during the 3-year period evaluated. Thus, the data collected may not precisely reflect the experience during the period evaluated.

2.3.5 Aggregation of Data

Data were aggregated across the eight communities studied in Nunavut and the various administrative levels within HSS, HC, and NTI. Not all results will be applicable to all communities in Nunavut or necessarily to all coordinators and clients of a specific program.

2.3.6 Scope of the Evaluation Process

The scope and complexity of evaluating eight programs in eight communities across different levels of management and delivery presented some challenges in data collection and analysis. Geography and timing of interviews also were challenges.

3.0 FINDINGS

This section is organized by program, with findings as follows: a brief description of the program and its emphasis in Nunavut, the framework for program delivery, a financial summary for the evaluation period, and what was learned about each program in the areas of the five evaluation topics.[6]

Table 3-1 provides examples of community activities and territory-wide initiatives in Nunavut for each of the eight evaluated programs. During the period of the evaluation, FASD, NNADAP and TCS provided only territory-wide initiatives.

Table 3-1: Examples of Activities in FNIHB Programs Evaluated in Nunavut

FNIHB Program	Examples of Activities
Aboriginal Diabetes Initiative	Cooking classes; physical activity groups; Elder's lunch/health awareness programs; school-based on-the-land programs
Brighter Futures	School nutrition programs (for example, breakfast and healthy snack programs); after-school activities for children; sports programs for children
Building Healthy Communities • Mental Health Crisis Intervention • Solvent Abuse	On-the-land programs; programs that bring elders and youth together; activities for children after school and during the holidays
Canada Prenatal Nutrition Program	Cooking and nutrition programs for pregnant women and women with babies; providing healthy food to pregnant women in the community
Fetal Alcohol Spectrum Disorder	Territory-wide initiatives to train CHRs, teachers, and corrections staff to provide awareness programs and support for pregnant women on the effects of alcohol on their child, and to educate parents whose children have FASD
First Nations and Inuit Home and Community Care Program	HSS staff in communities manage provision of care for elders or sick people in their homes, special homes for elders or sick people; training for home care nurses and workers
National Native Alcohol and Drug Abuse Program	Top-up funds help to cover the costs of travel and in-patient treatment in the South; territory-wide training for alcohol and drug workers supports GN alcohol and drug addictions services
Tobacco Control Strategy	Territory-wide initiatives support a range of community activities: school activities for children to teach them not to start smoking; programs for teachers and counsellors to learn how to prevent children from smoking; youth activities to encourage them not to start smoking or to quit

[6] The findings for a specific program may not include all of the themes under an evaluation topic because limited data were available for some themes. One theme under the "relevance" topic, concerning whether a program reflects the missions and strategic plans of HC, FNIHB, HSS and NTI, is not included in the findings for any evaluated program because all were seen to fulfill this theme.

3.1 Aboriginal Diabetes Initiative

3.1.1 Program Description

As one of four components of the Canadian Diabetes Strategy, the Aboriginal Diabetes Initiative (ADI) addresses the epidemic of diabetes among Aboriginal people with three main program areas: care and treatment; prevention and promotion; and lifestyle support.

The goal of the national ADI program is to address the high rates of diabetes and its complications, and provide First Nations and Inuit communities with opportunities to design, develop, and participate in projects to address diabetes within their communities.

Because diabetes is not as prevalent in the territories as in First Nations in the South, the ADI program in Nunavut has focussed on prevention and health promotion. Care and treatment and lifestyle support are provided as determined by individual community projects.

Activities funded through ADI began in Nunavut in 2001-2002. The ADI program includes territory-wide initiatives and community projects. Over the period of the evaluation, territory-wide initiatives included public awareness campaigns and on-line training for CHRs, nurses, and community project leads. The number of communities operating ADI projects was 4 in 2002-2003, 9 in 2003-2004, and 16 in 2004-2005. See Table 3-1 for examples of community projects.

3.1.2 Program Delivery

ADI funding is based on a GN work plan. HSS manages territory-wide initiatives and administers approved community projects through Contribution Agreements with sponsoring community agencies. An ADI proposal review group reviews and approves community project proposals. Each region has an ADI lead, i.e., the HSS Regional Nutritionist or Regional Wellness Program Coordinator.

3.1.3 Financial Summary

Table 3-2 provides a financial summary for ADI funding to GN for 2002-2005.

Table 3-2: ADI Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$572,235	--	$318,436	$253,799
2003/04	$572,235	--	$420,001	$152,234
2004/05	$572,235	--	$531,623	$40,612

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.1.4 Analysis of Findings

Relevance

Recent reports[7] provide data on the incidence and prevalence of diabetes:

- The prevalence of diabetes in Inuit in Nunavut is 0.9%, which is 4-5 times lower than the national average.
- From 1997-2002, on average, 41 new diabetes cases were diagnosed each year in Nunavut.

These data suggest that, while the incidence of diabetes is relatively stable, the number of persons with the disease is increasing in Nunavut communities. Other related health issues, such as low levels of activity and obesity, continue to present significant risks for diabetes. For example in 2003, over 28% of Nunavut residents were overweight, 20% were obese, and nearly 60% were physically inactive. Smoking and high blood pressure are also a concern because of diabetes complications.[8]

HSS program staff, community project staff, participants, and community members indicated that, through ADI projects, people have become aware of diabetes, its causes and preventative measures (e.g., eating healthy foods, recognizing the importance of exercise and related health issues, and the negative effects of smoking related to diabetes). In addition, community project staff felt that community members are learning to make better lifestyle choices to prevent the onset of diabetes (i.e., choosing healthier foods, reducing sugar intake, and becoming physically active).

Efficiency

HSS program staff indicated that the ADI program is more successful than some other FNIHB programs because all ADI community projects are well supported by regional program coordinators, although support is sometimes inconsistent if a position is vacant. Also, the territorial program coordinator and regional coordinators work closely in support of community projects.

Furthermore, although the ADI program has been active in Nunavut since only 2001-2002, it has many strong linkages with other FNIHB programs in the territory. ADI, Canada Prenatal Nutrition Program (CPNP), Brighter Futures (BF), First Nations and Inuit Home and Community Care (FNIHCC), and the Tobacco Control Strategy (TCS) collaborate in several aspects including program delivery and training for project staff (e.g., an on-line nutrition course in partnership with CPNP, Home and Community Care, and McGill University). ADI and CPNP have a Nunavut Joint Steering Committee with representatives from NTI, other Inuit

Project Story: Kugluktuk - Fun with Food and Activity: Making Healthy Food and Physical Activity Choices – In 2004, Kugluktuk Youth Centre held activities to promote better nutrition, physical activity and diabetes prevention for youth. Programs included lessons on nutrition and cooking, Nunavut Food Guide games and crafts, and preparing nutritious snacks. The goal was to educate children about the importance of healthy choices and how to prevent diabetes. The themes focussed on healthy lifestyles, physical activity, and making healthy food choices. The youth also participated in preparing a monthly feast attended by Elders, who discussed hunting and physical activity. The Kugluktuk project was a collaborative effort among youth and Elders programs and benefited approximately 462 youth in 2004/05.

[7] Government of Nunavut, Department of Health and Social Services. *Diabetes in Nunavut, 1997-2002*, July 2004; and *Nunavut Diabetes Strategy 2005-2010*. June 2005.
[8] Government of Nunavut, Department of Health and Social Services. *2004-2005 Community Wellness Annual Report*. 2005.

organizations, and HSS, including health promotion and health protection staff and regional coordinators. Other health staff in communities often collaborate with community ADI project staff.

The document review indicated that ADI provides clearly defined program requirements to communities as guidelines for project activities and reporting.

Areas for improvement identified by respondents included:

- need to increase community capacity to manage projects;
- ensuring that communities with program management capacity receive adequate funds;
- lack of time and experience among community project staff for writing proposals;
- need for more flexibility in reviewing proposals and processing funding applications; and
- recruitment and retention of qualified HSS staff and community staff (turnover of ADI program staff in communities is particularly high).

Effectiveness

Overall, ADI was seen by HSS staff as one of the more effective health programs, noting that there is significant interest among community members about healthy lifestyles and healthy children. The number of participants in ADI projects steadily increased from approximately 6,000 in 2002-2003 to over 9,500 in 2004-2005, although there was no indication of the potential numbers in the target population for these programs. Community members echoed the support for the program, stating that ADI projects have been successful in educating children regarding diet and consumption of sugary foods through healthy eating initiatives and healthy cooking classes for youth. Data are not available but some community members and HSS staff stated that community projects have resulted in people losing weight and learning to control diabetes.

Some HSS program staff and community project staff noted that certain objectives of the national ADI program focus on First Nations issues in the South (i.e., care and treatment) and may not be appropriate to the needs of Inuit in Nunavut.

Sustainability

The many linkages between the ADI program and other programs, agencies and organizations, as noted above, were viewed by HC and HSS staff as positive for sustainability. However, HSS staff and community project staff felt that it is essential to increase the capacity of communities so that they can administer, manage and sustain ADI projects over time. Many staff in communities raised the concern that there is not enough funding to run programs, buy program supplies, or to train or hire qualified human resources. Staff in some communities indicated that it may be difficult to sustain their ADI projects due to the high cost of food, the scarcity of healthy foods, and the lack of refrigeration.

Lessons Learned

HSS staff and community project staff indicated that educational materials such as posters and brochures have been helpful in raising awareness of diabetes, its causes and ways to prevent it. At the same time, staff in some communities noted that the health of their community members is deteriorating, the occurrence of diabetes is increasing, and the local population needs to become more aware of the disease, its impacts and how to prevent it.

A number of suggestions were provided by HC, HSS and community project staff to improve ADI program delivery. These included: providing incentives to get people interested in programs; using visual materials for better understanding; and building community capacity to

administer and manage programs. The document review yielded other suggestions including: early program planning each year; more partnerships with schools; involving more youth; and employing local people.

3.1.5 Conclusions

An early measure of the relevance and success of ADI programs in communities in Nunavut is the increasing number of people participating in the programs, an indication of greater awareness of diabetes among community members. As the prevalence of diabetes increases, the demand for community ADI prevention and health promotion will also increase, and more care and treatment and lifestyle support will be needed.

While the ADI program is generally administered efficiently, it is subject to challenges common in the early stages of national or provincial/territorial programs that fund community-based projects, but which are exacerbated when these programs are operating in the high Arctic:

- improving the funding approvals process and reporting requirements;
- recruiting and retaining qualified territorial and community staff;
- need for more funding;
- need for better understanding and recognition of community needs by the national ADI program;
- building community capacity in all aspects of program management;
- increasing the accessibility of tools, materials and knowledge to help build awareness of the health issues; and
- finding facilities for programs.

ADI in Nunavut has made great strides in fostering partnerships and implementing activities in communities, including remote and isolated hamlets. Community staff and community members largely view their ADI projects as effective in promoting healthier lifestyles that will prevent diabetes and help those with diabetes to be healthier.

3.2 Brighter Futures

3.2.1 Program Description

The Aboriginal component of Brighter Futures (BF) is designed to foster the health and social development of Aboriginal children, particularly young children at risk. BF funding is designed to assist First Nations and Inuit communities in developing community-based approaches to managing mental health and child development programs. Funding criteria relate to mental health, child development, healthy babies, injury prevention, and parenting skills. BF is directed to children 0-6 years of age but includes families and communities.

BF is one of the longer established FNIHB programs in the Territories and has been operating there since the early 1990s.

3.2.2 Program Delivery

BF funding allocations are made to each community on a per capita basis and administered through a contribution agreement with the GN. Communities must provide project proposals to

the GN. Proposals are reviewed by a regional review committee and territorial coordinator to ensure consistency with funding guidelines.

3.2.3 Financial Summary

Table 3-3 provides a financial summary for BF funding to GN for 2002-2005.

Table 3-3: BF Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$2,016,008	--	$1,930,193	$85,815
2003/04	$2,021,008	--	$1,895,999	$125,009
2004/05	$2,021,008	$2,039,816	$2,039,816	$0

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.2.4 Analysis of Findings

Relevance
The document review indicated that health issues for Nunavut children include poor nutrition, poor dental health, high smoking rates, sexual health issues, poor health of babies, and unintentional injury.[9]

Community project staff and community members were asked to identify the most important health issues for them and their community. Among them were the following: healthy children and youth, mental and emotional health, and traditions and traditional food, all of which are addressed by BF funding. HC and HSS staff indicated that BF funding assists in the healthy development of children and youth through initiatives to provide healthy snacks and meals for school children (e.g., breakfast programs), cultural programs that bring elders and children together, and after-school programs for teens (e.g., teen dances and suicide prevention programs).

HSS staff indicated that the flexibility of BF has made it more relevant to community needs. This flexibility facilitates cohesiveness among community health services, allowing them to provide holistic community health programs. According to HSS staff, an additional benefit of the flexibility of BF is the sense of ownership and trust that community members have developed for their own community wellness programs.

Efficiency
BF is carried out in partnership with other FNIHB programs (e.g., BHC, CPNP, ADI, FASD and TCS). HSS staff indicated that management and administration of BF is efficient in communities where it has been delivered for a longer period of time. However, both HSS and HC staff recommended measures to further improve efficiency in management and administration. Some communities do not differentiate between funding from BF and BHC. HC and HSS staff reported

[9] Government of Nunavut, Department of Health and Social Services. *Report on Comparable Health Indicators for Nunavut and Canada*. September 2002; and Government of Nunavut, Department of Health and Social Services. *Nunavut Report on Comparable Health Indicators*. November 2004.

that eligibility for BF and BHC funding should be clarified for communities to ensure that project activities meet the respective requirements.

Although flexibility is viewed as a positive aspect of BF, HSS staff suggested that the BF objectives are too broad and that, in practice, too great a range of activities are eligible. Some felt that certain activities undertaken with BF funding, such as hockey tournaments, do not appear to relate to the intent of the program objectives. HSS staff noted that it is important for communities to make the link between the objectives of their activities and BF objectives in both project proposals and reports.

HSS staff indicated that efficiency could be improved through building community capacity and increasing support to communities for preparing funding applications and writing reports (e.g., applications and reports are not received on time). The document review and HSS staff indicated that delays in community activities, high staff turnover, reporting challenges, insufficient community capacity in program management, and the complexity of the funding process all affected program efficiency. HSS staff also noted that communities with the support of a Community Wellness Coordinator tend to do better in producing program proposals and reports.

Effectiveness

In general, HSS staff, community project staff, participants, and community members indicated that BF projects have been effective in improving the health and development of children in Nunavut. Some observations respondents made include:

- Child and infant health and nutrition – children eating healthier foods; improvements in overall children's health; stronger and bigger babies; happier children; and distribution of important nutritional information to mothers.
- Nutrition and traditional foods – mothers learning how to prepare traditional foods; learning healthier recipes; and enjoying more activities, such as cooking and sewing.
- Social development – children learning traditional stories and more about traditional ways, culture and cooking; better understanding of culture and tradition through interaction with elders; developing extracurricular interests through after-school activities (e.g., sewing, arts and crafts, sports); and interacting happily with other children.

Project Story: Clyde River Breakfast Program
Throughout the school year, funds from the Brighter Futures program were used to pay the salary of a cook and to buy food provided in a breakfast program in Clyde River. Program workers spent three hours each morning to cook, clean and provide breakfasts for 250 people a day over the course of the year. High school staff and students assisted the cooks in providing macaroni, soup, milk, cereal, fresh fruits and bannock to students, as well as some parents who are on income support. Many parents have expressed enthusiasm for the program for ensuring that their children receive at least one balanced meal every day. It is well recognized that students who eat a balanced breakfast are more alert and calm, more able to concentrate and better behaved than children who do not eat breakfast.

In addition, BF promotes cultural appropriateness in projects by being sufficiently flexible for communities to design their own projects.

Sustainability

There is general consensus that, if funding is received regularly by communities from HSS, if proposals are submitted by communities on time, if there is adequate and appropriate staff support, and if necessary materials, services, and facilities are available, then it is possible for projects supported by BF funding to be sustained.

HSS staff reported that some communities have found it difficult to run projects on a regular basis due to high turnover rates of community staff. A project can be successful for two years but, if the community program coordinator leaves, the project may not continue.

A number of HSS staff and community program staff stated that some projects do not receive enough funding or do not receive funding on time to continue year after year. Several suggestions were made for a multi-year funding approach for community projects to overcome problems related to funding.

Lessons Learned
Community projects benefit from the flexibility of BF funding but it is critical to clarify funding objectives and requirements for communities so that projects are in line with the purpose of BF. Communities improve over time in their capacity to manage projects.

3.2.5 Conclusions

BF is clearly relevant and effective for communities in Nunavut. BF funding has supported culturally appropriate projects that meet unique community needs in improving the health and social development of children and youth. Flexibility has been critical to the success of BF -- communities can direct funding to the development of wellness programs that meet their unique needs. The flexibility of BF facilitates holistic approaches and encourages a sense of ownership among community members.

Efficiency could be improved through clarification of eligibility requirements (e.g., what types of activities can be included to meet BF objectives) while still allowing flexibility for communities to design projects according to their needs. Enhanced project monitoring and reporting would also improve program administration. Projects in communities with the support of a Community Wellness Coordinator have generally improved in their capacity to manage programs efficiently.

Support is needed in recruiting and retaining qualified staff to run projects and programs (e.g., more attractive salaries and benefits). Encouraging staff to stay for the long term was seen as important for continued success of BF. Increased, stable, multi-year community funding was also emphasized.

3.3 Building Healthy Communities

3.3.1 Program Description

BHC has two components: mental health crisis intervention, and a solvent abuse component for First Nations and Inuit youth. The mental health component supports assessment, counselling, referrals for treatment, aftercare and rehabilitation, training for community members and caregivers, and community education and awareness. The solvent abuse component supports residential treatment to help youth to overcome solvent addiction, and intervention programs for parents and the community to deal with problems related to solvent abuse, such as family violence and suicide. BHC was introduced to the Territories in 1994. In Nunavut, the emphasis for the mental health component has been on elder/youth approaches and wellness workshops. The emphasis for the solvent abuse component has been on residential treatment for youth.

3.3.2 Program Delivery

Similar to BF, the GN administers BHC by allocating funding through a contribution agreement with each community on a per capita basis. Communities must provide project proposals to the GN. Proposals are reviewed by a regional review committee and territorial coordinator to ensure consistency with program guidelines. Funding to communities for BF and BHC projects is issued together under one contribution arrangement because individual projects often integrate activities and funding from the two programs.

3.3.3 Financial Summary

Table 3-4 provides a financial summary for BHC funding to GN for 2002-2005.

Table 3-4: BHC Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$1,334,812	--	$1,326,843	$7,969
2003/04	$1,334,812	$1,274,812	$1,178,430	$96,382
2004/05	$1,355,812	$1,213,187	$1,213,187	$0

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.3.4 Analysis of Findings

Relevance

Suicide rates are almost six times higher in Nunavut than in the rest of Canada, with reported rates of 77.4 per 100,000 population for Nunavut compared with 13 per 100,000 population for all of Canada. From April 1, 1999 to August 29, 2005, the Chief Coroner for Nunavut reported a total of 177 suicides in the territory.[10]

HSS and HC staff, community project staff, participants, and community members all felt that suicide and mental health are important ongoing concerns for communities. Community project staff and participants indicated high levels of support for BHC funding, as it has generated participation from many groups within the community, especially youth and elders. Community members suggested that the initiative has led to a greater sense of culture and community.

Community members and project staff recognized the need for a balanced lifestyle and a broad approach to individual community health. BHC initiatives, such as traditional lifestyle training, programs for elders, and activities focused on youth were identified by HSS program coordinators, HC staff, community project staff and participants as successful preventative activities that contribute to the overall health of community members.

[10] Ajunnginiq Centre. On-line resource: "Facts About Suicide in Inuit Regions." <http://www.naho.ca/inuit/english/FactsaboutInuitSuicide.php>. Accessed Dec 2, 2005.

The document review and interviews with HSS and HC staff, community project staff and participants suggest that, while program goals are being met in communities where the program is active, there needs to be a broader range of BHC funded activities in each of the communities and additional funding.

Efficiency

There were differences of opinion among HSS and HC staff interviewed on the efficiency of program administration. Some of the staff suggested that the requirements and possible activities that can be funded under the program are too broad. According to these staff, there is sometimes little knowledge of what is going on in the communities and programs generally lack direction.

Other HSS and HC staff identified the broad scope of BHC as key to its success. They indicated that the scope of eligible activities enables communities to prioritize and design programs that are best suited to their unique needs. They also suggested that the broad scope ensures that funding proposals are community-driven, helping to build the capacity of communities to develop and run programs at the local level.

Community BHC activities are highly integrated with BF activities. BHC projects also work closely with local alcohol and drug addiction services and certain FASD community activities, and a number of projects receive additional funding support from Correctional Services Canada and the Aboriginal Healing Foundation.

Several HSS staff reported that BF and BHC were perhaps overly integrated, to the extent that it was difficult to separate community program budgets for BF and BHC. Although the flexibility in program design at the community level has been a successful aspect of BF and BHC, some staff indicated that clearer guidelines are needed on the range of community-based activities and projects that are appropriate for meeting the goals and objectives of BF and BHC.

The document review and HSS staff also indicated challenges related to: the lack of deadlines for proposals; reporting and accountability; and insufficient understanding of the objectives of BHC funding. Community project staff reported that resources need to be expanded for BHC as available funding tends to be spread thinly among competing projects, and proposals often are turned down.

Project Story: Clyde River - "Ataata Ammalu Irniq Nunami"

This project provided an opportunity for men, youth and elders to share life skills, knowledge and experiences and to build bonds of trust. The primary activity was a week-long father and son hunting trip to reaffirm traditional men's roles and connection to the land, and to promote mentoring relationships and the transfer from Elders to youth of Inuit Qaujimajatuqangit associated with hunting, travelling, camping and being on the land. This project promoted mental, spiritual and physical well-being, addressing critical gaps in mental health services.

A total of 64 Clyde River citizens participated in the hunting trip. The community celebrated the return of the hunters with a picnic and igloo building and then officially recognized the hunters during an evening community feast. The youth learned to hunt and have more confidence and self-esteem to go on the land with their knowledge.

Effectiveness

Community project staff reported high levels of participation in youth/elder activities and felt that these activities have been effective in helping youth experiencing mental health problems. Staff in one community reported a reduction in suicide rates within the first six months of certain activities. HSS staff reported that BHC funding has helped communities to think differently:

rather than expecting the government to take action on community issues, communities learn to design and implement their own strategies.

Sustainability
HSS staff indicated that the community-driven nature of BHC funded projects has provided opportunities for program sustainability through skills development among project staff. Community staff have identified several additional requirements for sustainability, i.e., GN support for proposal writing, mechanisms for sharing knowledge among communities on proposal writing, and long-term budgets to expand on initiatives developed by communities. HSS staff identified the need for CHRs to work closely with the Regional Wellness Coordinator to provide support to community projects.

Lessons Learned
Community members identified several types of initiatives funded by BHC as notable successes in encouraging the participation of youth. Traditional lifestyle training, gym and physical health activities, and initiatives directed at solvent abuse and mental health issues were identified as guiding community members to a more balanced approach to lifestyle decisions, leading to an increase in the general health of community members. The BHC projects were successful in bringing people together in cultural and community events, especially youth and elders.

Suggestions by HSS staff and project staff for improving BHC were generally focused on increasing available resources for program expansion, but also included developing more detailed proposals, establishing proposal deadlines, and developing greater coordination between the Regional Wellness Coordinator and CHRs.

3.3.5 Conclusions

BHC funding is relevant and effective in contributing to the overall health of community members, through prevention and treatment of mental health problems and solvent abuse. Activities carried out under BHC have achieved high levels of participation from youth, elders, and other segments of the community that may be at risk of being affected by solvent abuse and mental health issues.

For increased efficiency, there is a need for clearer requirements and guidelines for the program, while retaining the flexibility that has led to program success thus far. BHC flexibility was seen as a positive characteristic of the program as it encourages communities to take initiative and design activities that are culturally sensitive and are tailored to meet the needs of particular communities.

More funding is needed to expand the program throughout the year, to reach more community members, and to sustain the program over time.

3.4 Canada Prenatal Nutrition Program

3.4.1 Program Description

The First Nations and Inuit component of the Canada Prenatal Nutrition Program (CPNP) is a comprehensive community-based program that supports pregnant First Nations and Inuit women who face conditions of risk that threaten their health and the development of their babies. The overall goal is to improve maternal and infant nutritional health with a particular focus on those at risk. The program themes are: nutrition screening, education and counselling; breastfeeding promotion, education, and support; and maternal nourishment.

CPNP initiated projects in the Territories ten years before the creation of Nunavut in 1999 and uptake has been progressive over time with FNIHB projects in 19 of the 25 Nunavut communities. CPNP funding for 6 additional communities goes directly from NS to communities through a Memorandum of Understanding with the Public Health Agency of Canada (PHAC, formerly part of Health Canada).

3.4.2 Program Delivery

FNIHB CPNP funding is allocated to GN based on a work plan and the funding supports primarily community-derived, proposal-driven projects, as well as some territory-wide initiatives. Community project proposals are reviewed and approved by a regional committee. Approved community projects are administered through contribution agreements between the GN and the sponsoring community agency. Territory-wide initiatives have included a breastfeeding campaign, ongoing on-line nutrition training for community program staff, and training events every year for community CPNP project leads and CHRs.

3.4.3 Financial Summary

Table 3-5 provides a financial summary for CPNP funding to GN for 2002-2005.

Table 3-5: CPNP Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$866,261	$891,261	$499,995	$391,266
2003/04	$841,966	---	$670,803	$171,163
2004/05	$878,966	$835,985	$796,995	$38,990

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.4.4 Analysis of Findings

Relevance
In 2001, the infant mortality rate in Nunavut was 15.6 deaths per 1000 live births, more than triple the rate in Canada (4.4) and the NWT (4.9), and nearly double that of the Yukon (8.7). Even though infant mortality rates in Nunavut are extremely high, they have steadily declined since recording began in 1991. The decline has been attributed to increased early and regular prenatal care, obstetrical care during labour and delivery, and postpartum care and maternal education.[11]

[11] Government of Nunavut, Department of Health and Social Services. *Nunavut Report on Comparable Health Indicators*, 2004, p. 13.

HSS staff indicated that considerable community interest exists regarding healthy lifestyles, breastfeeding and healthy children. Overall, it was felt by HC, HSS and community project staff that CPNP ran successfully over the three-year period of the evaluation with positive results. Clients of the CPNP program and community members generally agreed that program participants experienced significant benefits from the program, such as:

- learning how to cook nutritional and healthy food;
- improving the emotional health of pregnant women through sharing their issues and prenatal experiences;
- receiving nutritional food while pregnant and milk for infants; and
- taking prenatal classes to prepare for childbirth, and caring for a newborn child and themselves during and after pregnancy.

Community project staff stated that because of CPNP and other health programs (e.g., BF and BHC) there are more healthy babies (i.e., infants are bigger and stronger), mothers are receiving important information regarding nutrition, people are learning how to cook healthy food and pregnant women are receiving more health care than in the past.

Efficiency

Overall, both HC and HSS staff felt that CPNP is run efficiently with strong partnerships and good communication and support between the national, territorial and regional program staff. HC staff stated that CPNP has a flexible framework enabling funds to be moved from community to community, as well as among territorial initiatives, while ensuring quality and consistency in program administration and delivery. HC and HSS staff felt that CPNP is one of the more successful FNIHB programs and attributed this success in part to the CPNP coordinators at the national, territorial and GN regional levels who provide support at regional and community levels.

CPNP links with other FNIHB programs that have nutrition components including ADI, BF breakfast programs, and FNIHCC. Joint training is carried out with CPNP projects managed by NS on behalf of PHAC, and resources developed by or for PHAC CPNP projects are shared with the FNIHB projects, e.g., a cookbook on country foods, a healthy babies manual.

In spite of the program's success, HC and HSS staff identified areas for improvement in regard to program efficiency. Some observations included:

- A mechanism is needed for program staff to raise and resolve issues (e.g., a committee comprised of stakeholders to look at issues formally).
- Community project staff need more support from regional program staff.
- A standard is needed for the type of information provided in reports from communities and how it is reported, so that data is comparable from all projects. A small questionnaire with basic questions and an option for a qualitative response was suggested.
- Procedures for funding approvals need to be streamlined so that community programs are not delayed. HSS staff suggested a more flexible funding arrangement.

The document review identified other areas for improvements in the CPNP program including staff support for proposal development throughout the fiscal year; sufficient facility space for programs; funding for additional community personnel, such as a coordinator, CHR or other community assistance workers; and addressing staff turnover and low staffing levels.

Effectiveness

HC, HSS and community project staff agreed that CPNP has been successful in meeting program objectives and goals due to strong community involvement, training and employment of local community members, and provision of education for pregnant women on basic health needs and nutrition. The program has provided workshops and training for community project staff. Over the years, the program has grown in popularity and gained the trust of local community members. Numerous community clients indicated that they were satisfied with CPNP community programs.

> **Project Story: Igloolik** – The Igloolik CPNP program provides food for pregnant women and postnatal mothers, especially women at risk. The program has helped mothers to understand the importance of keeping their babies healthy. Elders are also involved in educational programs for mothers regarding parenting, raising healthy children, and skills such as sewing baby items, e.g., blankets, bunting bags, amoutik (a baby-carrying parka), and duffel socks.

CPNP was evaluated each year prior to this evaluation by an external evaluator contracted by the GN. In the 2003-2004 evaluation, the reported beneficial impacts of the program for the target population included: increased nutritional knowledge; improved nutrition and diet for mother's and babies; increased breastfeeding knowledge; and increased rates of breastfeeding.[12]

Sustainability

Receiving funding on time was a key issue identified by many CPNP community project staff. When funding is not received on time, many projects must stop operating. Insufficient funding was an issue identified by staff in some communities where funding levels do not permit buying healthy food or purchasing important supplies or equipment (e.g., refrigerator).

Community project staff noted some communities found it difficult to retain knowledgeable staff, hampering efforts to keep projects running. Trained or experienced human resources to replace outgoing staff are not easy to find. HSS staff and community project staff suggested multi-year funding or a long-term plan (e.g., 5-year plan) for the program.

Lessons Learned

Community project staff, project clients, and community members felt that educational materials provided by the program (e.g., the food guide) were important and useful tools. Community members suggested that more educational tools and information for pregnant women and new mothers would be helpful (e.g., effects of smoking when pregnant). Some respondents suggested extending activities to mothers with children up to six years of age, and having a lunch program for pregnant women so that they would have at least one nutritional meal a day. Community members and project clients found prenatal classes very useful and felt that more classes should be offered and held more frequently.

3.4.5 Conclusions

CPNP is a relevant and effective health program in Nunavut. The program has been successfully implemented and has been effective in meeting program goals in communities throughout the Territory. CPNP has helped to improve the health and well-being of pregnant women, mothers and infants, especially in the provision of healthy and nutritious food.

[12] Government of Nunavut, Department of Health and Social Services. *Canada Prenatal Nutrition Program FNIHB: Summary Evaluation Report 2003-2004*, 2004.

Overall CPNP is run efficiently with strong partnerships and good communications between all levels of the program (i.e., national, territorial, regional and local). Suggested areas for improvement included: a process to identify and resolve issues; more communication with communities on their program needs; and improvements in reporting methods and the funding approvals process. The program can be sustained if a process for stable long-term funding is established and measures put in place to train and retain project staff in communities.

3.5 Fetal Alcohol Spectrum Disorder

3.5.1 Program Description

The Fetal Alcohol Spectrum Disorder (FASD)[13] program goals are to reduce the number of babies born with FASD (prevention) and to help make life better for children who have FASD and their families (intervention). The program is delivered through a number of national and regional projects. Project activities focus on: prevention of FASD births, public awareness and education, FASD training and capacity building, development of practical tools for community-based programs, increased early identification and diagnosis, coordination and integration of services, and surveillance.

The FASD program is relatively new compared to other FNIHB programs in Nunavut. The program began with limited funding of $11,000 in 2001-2002 and had substantial funding increases during the three-year evaluation period, beginning in November 2003 (see Table 3-6). The program focus in Nunavut is prevention of alcohol consumption among pregnant women and support to families where FASD is suspected. The initial emphasis has been on territory-wide initiatives: raising awareness among young women, young mothers, families, communities, educators and youth in the school system; training for teachers and corrections staff to support service delivery; establishment and training of multi-disciplinary teams; and preliminary steps to institute diagnostic services. A pilot program was launched in one community to build capacity for diagnosis and provision of community supports for expectant mothers and children with FASD. The results of this pilot will be used to make decisions concerning expansion to other Nunavut communities.

3.5.2 Program Delivery

The FASD program is based on a GN work plan and is carried out in collaboration with the Nunavut FASD Steering Committee with representatives from NTI, HSS, the GN Departments of Education and Justice, Qulliit Nunavut Status of Women Council, and community members.

3.5.3 Financial Summary

Table 3-6 provides a financial summary for FASD funding to GN for 2002-2005.

[13] The name, Fetal Alcohol Spectrum Disorder (FASD), changed from Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) in October 2003 during the period of this evaluation. This report uses the name Fetal Alcohol Spectrum Disorder (FASD).

Table 3-6: FASD Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$221,562	--	$155,220	$66,342
2003/04	$308,562	--	$282,126	$26,436
2004/05	$447,562	$504,360	$504,360	$0

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.5.4 Analysis of Findings

Relevance

No data exist on the prevalence of FASD in Nunavut but unsubstantiated claims indicate high prevalence. Although physicians and nurses may be trained in helping parents and teachers to deal with problem behaviours often associated with FASD, they are not trained to diagnose the disorder. Diagnosis of FASD is a lengthy process over the stages of a child's development and it is only recently that diagnostic skills are being developed across Canada.

HSS program staff, HC staff, and local service providers indicated strong support for the territory-wide FASD initiatives to build broad awareness and understanding, such as workshops, presentations to school children and businesses, posters, videos, and displays at events and meeting places. Community members agreed that it was important to learn about the effects of prenatal alcohol on children and to provide support for mothers who admit to drinking alcohol while pregnant.

Awareness of FASD has been growing over the years. HC and HSS staff indicated that in the past, FASD was difficult for people to discuss, but they are now starting to talk about alcohol problems more readily. However, the need to develop more awareness and better understanding of the effects of alcohol was emphasized by community staff, community leadership, and community members.

Efficiency

HC and HSS staff agreed that the FASD program is managed efficiently, in part because of a dedicated point of contact (i.e., the Nunavut FASD Coordinator), effective teamwork by all agencies, and good communications between the FASD Coordinator and the FASD Steering Committee.
The community leadership wanted to know more about how funding for the program could be obtained and who would be responsible for delivering the programs. The document

Project Story: Government of Nunavut - Territory-wide FASD Training and Awareness - Training and awareness have been a major activity under the FASD program in Nunavut. HSS collaborated with Pauktuutit's "Children Come First" program to offer periodic training opportunities across the Territory. At least two individuals from each community have been trained on how to deliver the Pauktuutit program in their communities. In 2002-2003, various FASD activities across Nunavut involved 420 community members, 200 youth, 26 prenatal and early childhood workers, 153 health professionals and 42 educators. As a result of these training and awareness initiatives, local activities have included presentations to schools, working with youth, videos, workshops, posters, t-shirts and prenatal programs.

review showed that Program Guidelines provide a description of the program, possible projects that may be funded, and the relevant funding application forms, including a description of what information is required in project proposals.

The FASD Steering Committee is a strong collaboration of Inuit organizations and GN Departments. In addition, the FASD program in Nunavut links with CPNP and TCS around issues of prenatal health, and collaborates with PHAC and Pauktuutit to develop resources and provide training. Nunavut is a member of the Canada Northwest FASD Partnership, a collaboration of the western provinces and the three territories to facilitate information sharing, joint support for research, and conference planning. Other examples of partnerships include FASD telehealth video conference link-ups, formation of multi-disciplinary FASD teams, and on-line courses for front-line workers and community staff.

Effectiveness
The document review, HSS staff, community program staff, community members and program clients indicated that GN FASD initiatives and resources supported communities with a broad range of prevention and promotion materials, partnerships, and training opportunities. Respondents who participated in such activities expressed support and suggested that understanding the effects of FASD was important for families and community members.

Sustainability
Some community service providers acknowledged that funding was available from other sources for community-based FASD activities (e.g., through PHAC) but noted that the funding was limited and the application process lengthy and complex. Community program coordinators and project staff indicated that more knowledge of funding application processes and greater capacity to access funding are required for FASD activities to be sustained in Nunavut communities.

HSS staff indicated that staff turnover in the Kugluktuk Pilot Project has been a challenge and finding qualified and interested community members to coordinate this project has been a challenge to the sustainability of the project.

Lessons Learned
Many community members indicated that it was valuable to learn what alcohol can do to children and expressed the need for ways to increase the parents' awareness of FASD. A number of communities mentioned the need for support to parents dealing with the disorder, such as a community support network of parents dealing with the issues.

Community program staff, community members and program clients suggested ways to improve awareness and community involvement. They suggested activities such as wellness fairs, draws and prizes, television spots and visual aids. It was pointed out that simply sending large posters to communities was not enough – materials need to be supplemented with telephone communication with a community contact to discuss local needs and provide further information and guidance on the disorder.

3.5.5 Conclusions

The value of the FASD initiative was recognized in communities where awareness and education programs were taking place. The FASD program was seen to be efficiently managed due to the involvement of a range of organizations and an effective network for communication and information sharing.

To increase the effectiveness and sustainability of the FASD initiative, the following needs were identified: increased education and awareness of parents and families of the effects of alcohol during pregnancy and of FASD, support for parents dealing with the disorder, and capacity building in communities to improve access to program funding. Increased awareness measures need to be discussed with community contacts to ensure that materials sent are appropriate for the particular community.

3.6 First Nations and Inuit Home and Community Care

3.6.1 Program Description

The First Nations and Inuit Home and Community Care (FNIHCC) program was announced in February 1999. The objective is to implement or enhance home and community care. This is comprised of a continuum of services, under First Nations and Inuit control, that are culturally sensitive, accessible, comprehensive and effective, and that respond to the unique health and social needs of First Nations and Inuit. Various health and personal care services are provided in homes and in the community to people of all ages with disabilities, or acute or chronic illnesses.

Activities funded through the FNIHCC program began in Nunavut in 2000-2001. The program is delivered by HSS staff and all Nunavut communities have had the program in place from its inception.

3.6.2 Program Delivery

The FNIHCC program is based on a GN work plan. In Nunavut, the program began with a territory-wide consultation process that resulted in Nunavut communities supporting the development and delivery of the program by HSS. In all but one of the Nunavut communities, services are managed and delivered by GN nurses and other home care staff. HSS is responsible for aspects of program administration including recruitment of home care staff, training, setting practice standards, budget management and reporting.

3.6.3 Financial Summary

Table 3-7 provides a financial summary for FNIHCC funding to GN for 2002-2005.

Table 3-7: FNIHCC Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$4,817,804	--	$4,914,413	($96,609)
2003/04	$4,817,770	--	$4,817,770	$0
2004/05	$4,896,250	$4,906,250	$4,906,250	$0

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.6.4 Analysis of Findings

Relevance

The FNIHCC program is clearly relevant to the needs of people in Nunavut communities, as stated by HC and HSS staff, clients, family members, and Inuit groups, and supported by the document review. Prior to the establishment of the program, family members had the responsibility for caring for the elderly, ill, or disabled. The initiation of the program brought about nursing assessments, quality assurance, nursing skills, training for family members, and on-call support. The program is said to be meeting increasing needs, which are due to more assessments, more awareness, an aging population, increased levels of disease, and improved technologies.

Project Story – Home and Community Care, Rankin Inlet
"The chronically ill have seen improvements from home care. The frequency of hospitalization has gone way down. For example, one elder was medivac'd three times in six weeks, but now she is in home care and in a year she hasn't been flown out to the hospital. We have probably cut down in health care costs. There has been less illness; things are caught before they develop further. People can call us."
(Quote from a GN Home Care

HSS program staff indicated that the FNIHCC program has resulted in reduced frequency of hospitalization, shorter stays in hospital, and more medical services administered at home (e.g., IVs, change of dressings). HC and HSS staff and the document review suggested that certain home care needs are still not met including chronic disease management, long-term care, physical therapy, palliative care, and rehabilitation.

Efficiency

HC and HSS staff agreed that the FNIHCC program is generally well-administered, managed and reported on, and over the three-year period of the evaluation, it has expanded its services. The communities that have completed the planning process successfully have a good understanding of the program objectives and activities. The territorial FNIHCC coordinator role was seen as a strong contribution to program efficiency because advice can be provided to communities by telephone. FNIHCC collaborates with ADI foot care programs, FASD initiatives, and HC's Non-Insured Health Benefits program.

HC staff, HSS staff in communities, and the document review indicated that further improvements could be achieved through addressing problems of high staff turnover, a short planning timeframe, yearly proposal writing, management of funding, timely receipt of supplies, and better coordination with other GN departments.

It was noted by HSS staff that a regular review of FNIHCC program objectives is needed to ensure that the program respects the unique cultural and community environment of the Inuit in Nunavut communities.

Effectiveness

Generally, respondents felt that the FNIHCC program was effective in meeting the needs of community members. However, HSS staff in communities mentioned that access to care is affected in many communities by a shortage of trained home care nursing staff, and the need for additional training in clinical aspects of care and other professional development for nurses. Other training needs identified in the document review were specialized training in palliative care, emergency intervention, and first aid. A problem identified by small and isolated

communities was the difficulty in recruiting and retaining home care nursing staff willing to work on an "as needed" basis, since trained personnel want a full-time position.

Some HSS staff in communities felt that information, materials and tools in local languages and dialects would improve access.

Sustainability
A key to sustaining the FNIHCC program over the long term is recruiting and retaining professional nursing staff for home care. In some communities, HSS staff indicated that hiring reliable home care workers is a significant problem, e.g., staff that do not show up for work create problems for the Department or local community health centres and for clients. Other communities reported that high turnover of home care nurses and home care workers negatively affects program sustainability.

Lessons Learned
HSS community program staff, community leadership, clients and families indicated broad community support for the home care workers -- people want to be cared for and to die in their own community. Community program staff did indicate problems with access to home care in some communities, but these problems appeared to be related to issues of securing and keeping trained staff rather than to lack of awareness of the program. A number of communities encountered problems because some families thought that the home and community care services meant that they no longer needed to provide care for their family members. The issue has been and continues to be addressed with an ongoing awareness campaign of brochures and posters describing home care as a way to enhance, not replace, the care that the family provides.

3.6.5 Conclusions

The FNIHCC program is relevant in that it serves a valuable need in communities for at-home care for the ill, disabled, elderly and chronically ill and for people at the end of their lives. The program is effective, enabling cost savings due to reduced trips to hospitals. It also assists in educating families about caring for family members and, through its services, allows people to get the care they need in their own communities. The biggest challenge for sustaining the program is recruiting and retaining sufficient professional home care staff so that staff are not overworked, contributing to high turnover and burn-out. Additional training is required to maintain and enhance the level of care currently provided in communities, such as specialized training for palliative care, emergency intervention and first aid.

3.7 National Native Alcohol and Drug Abuse Program

3.7.1 Program Description

This evaluation report covers initiatives supported by NNADAP funding that is allocated by NS to the GN in the Contribution Agreement as top-up to help with the costs of residential treatment and also to support territory-wide training initiatives.

3.7.2 Program Delivery

Approximately two-thirds of the funding goes toward the costs of sending Nunavut residents to in-patient treatment centres in the South and one-third is used for training for community alcohol and drug workers. GN allocates funds to the regions on a per capita basis as top-up for treatment costs. The funds are administered by GN staff.

3.7.3 Financial Summary

Table 3-8 provides a financial summary for NNADAP funding to GN for 2002-2005.

Table 3-8: NNADAP Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$317,076	--	$317,076	$0
2003/04	$317,076	$377,076	$377,076	$0
2004/05	$317,076	$417,076	$417,076	$0

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.7.4 Analysis of Findings

Community alcohol and drug program staff and others interviewed in this evaluation study noted a number of important issues for their community-based alcohol and drug programming. However, many aspects of the community programming were not the subject of this evaluation. These findings focus on issues specific to FNIHB funding, which is for treatment and training.

Relevance

NNADAP community initiatives were described by most respondents as very positive, e.g., worker training (Nunavut Arctic College), films and discussions in schools, monthly radio talks, and support from alcohol and drug counsellors.

Several problems were identified by community program staff, clients and their families related to the process of sending people out of the community for treatment:

- When a person is identified as needing treatment and has decided to go, the waiting period may be four weeks or longer, sometimes months. During this time, clients frequently change their minds or revert back to their problem behaviour, sometimes feeling that no one has helped them.
- Some people do not want to leave their family and community to obtain treatment.
- After treatment, clients return to Nunavut and often go back to their former habits after a week or so of abstinence.

The need for ongoing training was often identified as an element of increasing the capacity of alcohol and drug workers to deal with the stressful demands of their work with addictions clients. This need for training, viewed as one way to support staff and improve staff retention, was identified by all sources: the document review, HC staff, HSS staff, community program staff, community leadership, clients, and families.

Efficiency
HC staff indicated that the efficiency of NNADAP could be improved through a dedicated territorial point of contact, similar to FASD and TCS programs. HSS staff and community program staff indicated that limited community capacity in various aspects of program management was a problem.

Project Story: Territory-wide 10-day NNADAP Training Course
In 2003-2004, a 10-day training course was held for community alcohol and drug workers to learn group theory, group counselling skills and working in groups. Participants were encouraged to bring with them specific examples and issues that they faced in doing group work in their home communities. One day of training was devoted to an educational workshop on FASD. Training sessions such as this one build capacity by enabling community alcohol and drug workers to gain knowledge and develop new skills.

Effectiveness
HSS staff identified a variety of territory-wide training initiatives to meet the needs of alcohol and drug workers. The training was intended to build knowledge and skills to help workers to do better community programming and to ensure that they could work directly with clients. Examples of training include:

- a 2-week workshop on the pharmacology of alcohol and other drugs;
- a 2-week workshop as an introduction to group work (see Project Story);
- a 2-week course on assessment and early intervention; and
- participation by alcohol and drug workers, some social workers and CHRs at the National Native Addictions Partnership Foundation training on "Mental Health and FASD".

Apart from helping to cover the costs of treatment in the South, a portion of the treatment funding supported a 28-day live-in treatment program for twelve women in the Kitikmeot Region for the first time in 2004-2005. This program is the only one of its kind in Nunavut.

Sustainability
Training is critical to the sustainability of NNADAP in Nunavut. The limited number of well-trained staff to run community programs and qualified alcohol and drug workers was highlighted by all sources: the document review, HC staff, HSS staff, community program staff, community leadership, clients, and families. It was noted that NNADAP counsellors would benefit from greater support in their work (e.g., back-up counsellors, confidential discussions with other professionals about cases, and training and professional development).

The issue of insufficient funding, particularly for retaining trained professional counsellors in communities, was mentioned by HSS staff, community program staff, community leadership, and clients.

The need for treatment approaches that are more appropriate to the Inuit culture is also a sustainability issue.

Lessons Learned
Ongoing training is needed by alcohol and drug workers to address the changing drug environment for young people and to address the related prevention and treatment issues.

HSS staff noted that they are constantly training new staff because of the high rate of turnover among alcohol and drug workers. These trained workers are often lost to other GN Departments because wages in the field of addictions are low and the work is so stressful.

3.7.5 Conclusions

The top-up NNADAP funding is relevant and important for assisting with the costs of treatment and addressing key training issues for alcohol and drug workers in Nunavut. In communities where alcohol and drug workers are actively involved in prevention, counselling and sending people out for treatment, the emphasis for improving effectiveness and efficiency was on the need for additional qualified personnel and training to sustain the quality of services. In communities with fewer workers, the need for one or more well-trained counsellors to address drug and alcohol addiction was a priority. A need exists for treatment that is more culturally appropriate.

Some of the community observations about NNADAP were beyond the scope of HSS's role because the funding from FNIHB is strictly to help cover the costs of treatment and to support training initiatives.

3.8 Tobacco Control Strategy

3.8.1 Program Description

The overall purpose of the First Nations and Inuit Tobacco Control Strategy (TCS), a sub-component of the Federal Tobacco Control Strategy, is to reduce smoking rates among First Nations and Inuit with the long-term goal of reducing tobacco-induced illness and death among First Nations and Inuit. The First Nations and Inuit tobacco initiative focuses on: reducing consumption, especially among First Nations and Inuit youth; addressing preventable conditions through promotional activities; building awareness levels; and respecting traditional tobacco use. The TCS has four themes: influencing behaviours and attitudes; building capacity and community support; provider compliance; and coordination and development.

TCS is a relatively new program in Nunavut, beginning in 2002-2003. In Nunavut, the emphasis for the TCS program has been on territory-wide initiatives with the focus on youth such as support for the Minister's Youth Action Team on Tobacco. These initiatives are designed to increase public awareness, to encourage youth not to take up smoking, and to support cessation of smoking.

3.8.2 Program Delivery

Similar to FASD, delivery of TCS funding is based on a GN work plan. The TCS funding in Nunavut is for territory-wide awareness initiatives. The Contribution Agreement permits funding to be set aside for community-based projects supported by community proposals but the emphasis in 2002-2005 was on building capacity with territory-wide initiatives.

3.8.3 Financial Summary

Table 3-9 provides a financial summary for TCS funding to GN for 2002-2005.

Table 3-9: TCS Financial Summary for GN, 2002-2005

Year	Initial Contribution	*Amended Contribution	Actual Expenditures	**Variance
2002/03	$212,866	--	$174,927	$37,939
2003/04	$203,429	--	$166,472	$36,957
2004/05	$276,932	--	$207,266	$69,666

*The GN can shift funds among programs in the Contribution Agreement with NS approval. An amended contribution indicates that funding was shifted in or out of the program.
**The variance is the difference between the amended contribution and actual expenditures. Variance figures in brackets denote overspending and figures without brackets denote unspent funds.

3.8.4 Analysis of Findings

Relevance

Teen smoking in Nunavut is dramatically higher than in the rest of Canada. In 2003, almost 65% of Nunavut residents over 15 years of age were smokers, compared to 23% of Canadians. The number of teenagers in Nunavut who smoked currently (46.3%) was almost two and a half times the national average (18.7%). Although the daily or occasional smoking rates in teenagers within Canada are low and on a downward trend, rates in Nunavut are very high and have continued to rise. For Canada, the rate of teen smoking was 14.8% in 2003, down from 18.7% in 2000. For Nunavut, the rate increased from 46.3% in 2000 to 56% in 2003.[14]

Project staff in various communities reported that tobacco use and addiction were important health issues. Health care workers, counselors and CHRs smoke, and children as young as four years of age smoke and chew tobacco. HC and HSS staff, community staff, clients and community members reported that TCS prevention initiatives, such as information for schools (e.g., "Breathe Easy", a manual from Pauktuutit), participation in "No Smoking Day", activities of the Minister's Youth Action Team on Tobacco, training workshops, videos for schools and anti-smoking advertisements are important for making people aware of the effects of smoking on health. Community project staff and Inuit organizations in some communities without TCS programs or services indicated that a program should be initiated in their communities due to the importance of smoking problems.

Project Story: MYATT (Minister's Youth Action Team on Tobacco)
In 2003-2004, during National Non-Smoking Week and World No Tobacco Day, MYATT youth teamed with their local CHRs, teachers, school principals, and other supportive community members for the first time. Together they carried out community projects such as radio interviews, poster making, booths in their schools, and presentations in both elementary and high schools. The presentations informed students on the harmful effects of smoking and encouraged them to not start or to quit. These local activities now happen every year. MYATT also developed three TV public service advertisements on the harmful effects of smoking for youth, such as how it affects health and the ability to participate in sports and other traditional games. MYATT continues and the TV ads are still shown on CBC North and APTN.

Efficiency

The GN also receives funding from the Healthy Environments and Consumer Safety (HECS) Branch of Health Canada for mass media campaigns. The GN has developed and broadcast TV commercials with youth participation in the ads.

[14] Government of Nunavut, Department of Health and Social Services. *Nunavut Report on Comparable Health Indicators*, 2004.

TCS works jointly with CPNP, FASD, and ADI to provide training for CHRs on smoking cessation with resources developed by Pauktuutit.

Effectiveness
The TCS initiatives mentioned in the section on "Relevance" were reported by community staff to be effective in reducing the level of smoking for some people, i.e., they now smoke only outside of the home, have reduced the number of cigarettes smoked per day, or in some cases have stopping smoking. However, there was broad agreement among all groups of respondents on the need to further increase awareness among youth and adults of the dangers of smoking.[15]

The TCS joint training workshops for CHRs on smoking cessation provide them with "quit kits", videos of the TV commercials and other aids. Community staff highlighted the need for additional cessation initiatives, e.g., regular workshops for community members and more training workshops for CHRs and other staff.

Sustainability
HSS staff noted that the TCS initiatives in Nunavut are relatively new and more effort will be needed to raise awareness of the health issues across the Territory and to build community capacity in program management before local projects can begin.

Lessons Learned
The need for additional measures to increase awareness and encourage cessation was supported by HSS staff, community staff, community leadership, and community members. An increased emphasis on cessation initiatives and on starting TCS activities in some communities was highlighted in discussions with HSS staff, community staff and community members.

3.8.5 Conclusions

The TCS initiative was recognized as important by all groups of respondents. While it was acknowledged that there have been successes in reducing tobacco use, more community tools and staff resources are needed for the program, beginning in areas where no TCS activities are reported to be taking place. Stable, multi-year funding was seen as essential for an efficient and sustainable tobacco control strategy.

[15] New data released after the completion of the evaluation indicate that smoking rates among youth aged 12 to 19 dropped in Nunavut from 65% in 2004 to 53% in 2005. Statistics Canada, *The Daily* (Tuesday June 13, 2006), Canadian Community Health Survey, New data on smoking and on diabetes 2005, on-line at http://www.statcan.ca/Daily/English/060613/d060613a.htm

4.0 COMMON FINDINGS

Although the eight programs have different target populations and approaches, key findings were common to most programs. This section identifies these common findings, what worked well and what needs improving, for each of the evaluation topics.

4.1 RELEVANCE

What worked well?
The program goals and objectives reflect the missions and strategic plans of Health Canada, FNIHB, and HSS and NTI. These missions and strategic plans share common elements that are operationalized in the FNIHB programs -- prevention, capacity building, partnerships and collaboration, and cultural sensitivity.

Available data demonstrate that serious health issues exist in Nunavut – suicide, smoking, infant mortality, and addictions to alcohol, drugs and other substances are at rates higher than the rest of Canada.[16] The goals and objectives of the FNIHB programs administered by HSS address these critical health issues. Moreover, according to community program staff, program clients, and community members, the programs are relevant to the health needs in their communities and the benefits that the programs provide are recognized and appreciated. The flexibility given in some programs concerning the eligibility of program activities or projects was generally viewed as increasing program relevance to unique community needs.

What needs improving?
At the same time, program implementation has varied from community to community and over time, resulting in gaps in addressing health needs. Key gaps identified were related to mental health, suicide prevention, alcohol and other substance abuse, and activities for children. Many of these gaps have been attributed to the complexity of certain health issues, to the impact of conditions beyond the scope of FNIHB programs (e.g., a scarcity of facilities, substandard housing, high unemployment, cost of food and other goods), as well as to program efficiency issues.

Pertinent to the relevance of all FNIHB programs delivered in Nunavut was the general acknowledgement that for most programs, the national program objectives are geared to First Nations in the South and that only some objectives are relevant to the Inuit of Nunavut.

4.2 EFFICIENCY

Program efficiency, in its broadest sense, was the topic most often mentioned by respondents in the evaluation. The management challenges often experienced by new initiatives were common to all of the FNIHB programs to varying degrees. In addition, program efficiency was affected by

[16] Specific data have been included in the findings for each program. Additional information may be found in documents listed in Appendix B, Policy and Program Documents Reviewed.

additional difficulties associated with providing programs to small, isolated communities scattered over a vast geographical area, regions of which are not accessible during certain times of the year.

At the federal and territorial levels, both the NS and the GN are relatively new organizations, established in 1998 and 1999 respectively. Both have been building their program management capacity by increasing staff and expertise, and enhancing program management systems and tools.

What worked well?
Many aspects of NS and HSS program planning and administration have been designed to facilitate efficient planning, and the preparation of work plans and reports. For example, program requirements are clearly set out in the Contribution Agreement and templates for project reports; HSS work plans increasingly link activities to program objectives, and more and more effective communication channels exist between HC and HSS staff to address issues as they arise. Where available, Community Wellness Coordinators, CHRs, Regional Wellness Coordinators and Territorial program coordinators have assisted in the preparation of proposals and reports according to program requirements.

Based on the review of financial information on the programs, it generally appears that:

- Program funding responds to community priorities.
- All expenditures were reported and accounted for.

Over the three-year period of the evaluation, variances generally decreased in number and dollar amounts as more of the available funds were spent. This is likely due to increases in the capacity of program coordinators to understand program and reporting requirements and to plan effectively, and to the increasing awareness and uptake of programs by community members.

Community programs and HSS staff often attributed greater capacity in program management and delivery to the following:

- programs in place for a longer period, such as CPNP and ADI;
- a fulltime Wellness Coordinator working in the community;
- consistent support by HSS regional and Territorial program coordinators and/or professional expertise (e.g., a nutritionist).

At all levels, linkages, partnerships and collaboration contributed to efficiency. Most community-based programs are managed and administered by hamlets, which in many cases contribute facilities and utilities (i.e., water, heat, electricity) beyond the administrative fee provided by programs, and arguably outside their legislated responsibilities. Joint FNIHB program activities provide economies of scale by sharing resources, space, information, and expertise. For example, community ADI, BF, BHC, and CPNP programs often collaborate on nutrition activities such as breakfast programs, educational activities in schools, and community cooking classes; and on-line nutrition training for community staff is shared across Nunavut by ADI, CPNP and FNIHCC. Partnerships between FNIHB and GN programs offer similar efficiencies (e.g., joint community programming between BF/BHC and the GN Department of Culture, Language, Elders and Youth, whereby youth learn traditions and wisdom from community Elders).

What needs improving?
With few exceptions, community capacity to manage programs was a common factor affecting program efficiency and the effective use of funding. Community capacity varied from community to community and among community programs within a community.

Common program management issues for communities included the following, in no particular order of importance:

- ***Recruitment and retention of qualified staff*** – Staffing was a common problem for all of the community programs as well as HSS. Both HSS positions and community positions remain vacant because of a scarcity of qualified people to fill them. Training new staff to enhance their qualifications for a position was no guarantee that they would stay because trained staff were often lost to other GN employers. Low wages and benefits, job stress and lack of support were all factors affecting staff retention.

- ***Program guidelines on eligible activities*** – Limited understanding of the types of activities eligible for funding was common, especially in communities without the support of a Community Wellness Coordinator and/or regional program coordinator.

- ***Program requirements for proposals and reports*** – Many communities lacked the capacity to prepare adequate proposals and to monitor programs and prepare financial and activity progress reports. Again, these requirements were especially difficult for communities lacking the support of a Community Wellness Coordinator and/or regional program coordinator.

- ***Funding approvals processes*** – For programs requiring proposals, communities found the approvals process took too long and caused delays in funding, making it difficult for them to hire and retain staff, plan activities, and spend all the funding in the time remaining. Having to submit proposals every year was time consuming and it made these problems worse.

- ***Inadequate funding*** – Communities often identified the need for increased program funding to: meet needs resulting from increased participation in programs (more activities needed over a longer period of the year); improve wages and benefits to attract and retain sufficient qualified staff; and provide the tools, materials and infrastructure to run the programs. At the same time, significant underspending was common to many of the programs over the period of the evaluation. Underspending generally decreased over the three years and this decrease could be attributed to the growing capacity of community agencies to plan projects and manage program funding, as well as to the GN's development of management and operational procedures for monitoring projects and shifting unspent funds to communities that could use it. Stable, multi-year funding was a common suggestion to facilitate program planning and more efficient program administration, and to resolve issues related to staff retention.

- ***Accessibility of programs*** – Sometimes communities were not aware of the availability of funding, and if they were aware, they did not know who to contact to apply.

4.3 Effectiveness

What worked well?
Clients, program coordinators, and community members viewed the FNIHB programs as improving access to health services and helping to address very serious health issues.

However, community perspectives on the success of programs varied from community to community and positive views were expressed more often in communities with higher capacity in program management, and with qualified and more stable staffing.

Many of the FNIHB programs (i.e., BF, BHC, CPNP, FASD and FNIHCC) were seen to promote culturally appropriate health programs – they used or taught traditional language and were open to using traditional practices.

Community capacity to manage FNIHB programs improved somewhat across the eight programs over the three-year evaluation period. While capacity improved in time management, financial management, and proposal and report preparation, work needs to continue in these areas to further increase community capacity. Knowledge has increased about program content, funding sources and how to access them, and about the roles of regional staff.

What needs improving?
The evidence of health benefits reported by communities was strictly anecdotal. Insufficient data were collected by the communities to allow an assessment of either short- or long-term impacts and health outcomes. Only certain programs (i.e., ADI, CPNP, and FNIHCC) specified indicators and data to be collected routinely to give a measure of health outcomes.

Although there was a better understanding of how to build community capacity and some improvements were seen over the three-year period evaluated, capacity building activities in communities should be enhanced to increase knowledge and skills in program management and also to help resolve staffing issues.

4.4 SUSTAINABILITY

The common findings related to sustainability have already been noted in common findings for relevance, efficiency and effectiveness. There was general agreement that FNIHB program funding is essential to sustain the types of health programs and services it supports in Nunavut. Funding available from other sources, such as other parts of Health Canada, other federal Departments, the GN and hamlets, enables communities to integrate additional elements into their community health programs and facilitates a holistic approach to health based on determinants of health.

If FNIHB funding were not in place, the GN would not have the fiscal means to assume the costs and communities would lose these programs and services.

4.5 LESSONS LEARNED

Most programs were frequently identified as being successful. The key lessons learned about what is needed for success were:

- a good support system in place to manage the program (CPNP, ADI, FASD, FNIHCC)
- strong community involvement, popular with the community (ADI, BF/BHC, CPNP, FNIHCC)

- training or employing local community members (ADI, CPNP, FASD, FNIHCC, NNADAP)
- providing basic needs to community members (ADI, CPNP, FNIHCC)
- health experts having input into the program (ADI, CPNP, FNIHCC)
- community members more open in discussing sensitive health issues (ADI, FASD, NNADAP, TCS)
- involvement of many people in the community (ADI, BF/BHC, CPNP, FASD, TCS)
- the value of educational activities (ADI, CPNP, FASD, NNADAP, TCS).

5.0 CONCLUSIONS AND RECOMMENDATIONS

This evaluation examined the strengths and weaknesses of the eight FNIHB programs managed and delivered in Nunavut by the GN HSS over a three-year period from April 2002 to March 2005. This report has provided findings for each program and also findings common across programs on the topics of program relevance, efficiency, effectiveness, sustainability, and lessons learned. The findings reflect input from a document review; interviews with FNIHB and HSS staff; and interviews, community meetings and focus groups conducted in visits to eight communities.

This section provides a brief overview of lessons learned about the evaluation process itself, and presents recommendations for enhancing FNIHB program management and delivery in Nunavut.

5.1 THE EVALUATION PROCESS AS A LEARNING EXPERIENCE

Carrying out this evaluation study was a learning experience in itself with lessons that can enhance future evaluations of FNIHB programs, not only in Nunavut but also in other regions of Canada. The evaluation research team and members of the EAC noted the following lessons learned from the evaluation process:

- **Participation by community members** in focus groups and community meetings was not as high as anticipated. More time should be given to planning community visits and organizing for participation of community members in advance of visiting a community.
  - Contacts with communities should be established early and maintained before the visits to book the best dates and times for community evaluation activities and encourage more participation.
  - Study teams should plan longer stays in communities to allow for travel delays and unexpected postponement of evaluation activities.
  - As much as possible, visits to communities in the far north should be planned to avoid those times of the year when the weather can be unexpectedly harsh, or when many community members will be involved in annual community activities or be away from the community.

- **Community evaluators** were trained for this evaluation in each community and employed for one week to provide the study team with knowledge of local issues and customs, key contact information and introductions to community members, translation services for interviews, and carrying out interviews. Their services were invaluable. However, more time should be allowed for identifying and preparing community evaluators.
  - Community evaluators should be identified earlier in the planning process.
  - Time for more skills practice should be built into the training sessions on evaluation activities and interviewing techniques.
  - Additional community participants should be identified earlier for an effective training process.

5.2 RECOMMENDATIONS

Over the three years examined in this evaluation, progress was made in all programs. Nonetheless, challenges remain in several aspects of FNIHB program management and delivery in Nunavut. The following recommendations are derived from the common findings in this report and are made to the EAC to address these challenges.

The recommendations are intended to address program aspects that need improvements, taking into account what has been learned from the evaluation about what worked well. It should be noted that the identified issues – increasing community capacity, program processes and procedures, community collection of health data, and communications – are closely interrelated. Thus, the recommended mechanisms and initiatives are interdependent and success will require a holistic approach to addressing all of the recommendations.

HSS, NTI and NS each have a role to play in implementing these recommendations but specific roles will be determined through joint discussion and collaboration and in accordance with their respective mandates in the broad area of supporting FNIHB programs in Nunavut.

Recommendation #1 – Increase Community Capacity
Many of the challenges experienced in community programs are due to the limited capacity of communities in project management skills. HSS, NS and NTI should work jointly to increase project management capacity in Nunavut communities through training and other learning opportunities.

1-a: Conduct an assessment of training needs and opportunities
An assessment of training needs and resources should be conducted involving HSS program staff, community project staff and representatives of Inuit organizations. The needs assessment should include not only content for training but also training options (on-line, on-site training, off-site classroom training), teaching methods and styles, availability to travel for training, and a variety of other considerations. Existing and/or joint training opportunities such as Nunavut Arctic College and the Federal Council (a council of all federal departments with programs in Nunavut) should be assessed, as well as existing funding opportunities.

1-b: Arrange for community project staff to train in a full range of project management skills
Training opportunities should cover a full range of project management skills and administrative procedures including preparing proposals, gathering and recording information on program activities and finances, monitoring and managing financial aspects of programs, writing reports, time management, and a variety of administrative procedures. The training should be hands-on as much as possible and provide take-away management tools.

1-c: Host bi-annual workshops to seek input on improving cultural relevance and appropriateness of FNIHB programs for Inuit people of Nunavut, as well as on other current issues for communities
Workshops should be held every two years to obtain the views of community members, community staff and Inuit organizations (at local, regional and territorial levels within Nunavut), territorial officials and HC on how to enhance programs to make them more relevant and appropriate for Inuit in Nunavut.

Recommendation #2 – Simplify Processes and Procedures
Certain program procedures are considered complex and time-consuming for communities, especially when they must be repeated every year. Some process elements originate with individual FNIHB programs and others with HSS. NS and HSS should work together to ensure that procedures for communities are clearer, simpler and more efficient. Apart from decreasing the administrative work for community projects, simplified procedures and the availability of program manuals and management tools could help to diminish the effects of staff turnover. Multi-year, flexible funding arrangements and streamlined approval processes for funding would improve predictability of funding for communities, thus facilitating better program and resource planning and staff retention. A joint effort of NS, HSS and NTI will be needed to simplify process elements, prepare program manuals with appropriate management tools, and educate communities about them.

2-a: Clarify program requirements
HSS should develop mechanisms to clarify for communities the FNIHB program requirements for types of eligible activities, financial and activity reporting, and other aspects of program management, as specified in the Contribution Agreement between GN and FNIHB. HSS also should ensure that all program manuals and management tools encourage and facilitate communities to ensure that their project activities address program objectives.

2-b: Streamline project proposals and reporting
HSS should develop templates for proposals and reports, and streamline approval processes for proposals. Templates should be sensitive to Inuit needs and capacities, while still meeting FNIHB program requirements. A comprehensive and transparent system of financial record-keeping and reporting should be implemented for community programs and projects. The possibility of including a process to obtain reports orally at the regional level should be considered.

2-c: Prepare procedures manuals and establish lines of communication
HSS should prepare procedures manuals with appropriate management tools for community programs and establish clear lines of communication for community staff to ask questions and access ongoing program support, including a back-up contact.

2-d: Work toward multi-year and flexible funding arrangements
NS and HSS should work toward developing multi-year, flexible Contribution Agreements between FNIHB and the GN. In turn, HSS should institute multi-year funding arrangements with communities. Eligibility criteria should be developed for communities to receive multi-year funding.

2-e: Examine funding allocations
HSS and NS should develop a plan to address funding levels in communities where there is a demonstrated need for more funding. As awareness and uptake of the FNIHB programs increase in communities, funding should increase to meet the growing demand in communities where a program exists and to establish programs in communities where none exists. Increased funding is needed for program equipment and supplies and better wages and benefits for staff. Programs should continue to permit shifting of funds from one community to another to address changes in local circumstances.

Recommendation #3 – Facilitate Community Collection of Health Data
Data on health issues in Nunavut is limited with no data on certain issues (e.g., children with FASD) and only limited or out-of-date data on others (e.g., alcohol and drug use and addictions). The routine collection and monitoring of data specific to FNIHB programs in Nunavut would provide information needed to modify programs to reflect the needs of Nunavut residents. Consistent, territory-wide data collection would provide relevant and current information on health status in Nunavut and contribute to future FNIHB program evaluations. An increasing number of FNIHB programs have identified program indicators and the data required to support measurement of these indicators. Community capacity building is needed to facilitate routine data collection, monitoring and reporting by community programs and projects. Before this can happen effectively, existing program indicators need to be examined for their relevance in Nunavut.

3-a: Verify cultural relevance of existing FNIHB program indicators
HSS, NTI and NS should establish an initiative to verify the cultural relevance of existing FNIHB program indicators and to agree on modifications or additions to the program indicators to improve their relevance to the unique circumstances of Inuit culture and life in the high Arctic.

3-b: Build community capacity in routine data collection and reporting
HSS, NTI, and NS should establish initiatives to inform communities about the benefits and uses of up-to-date data on health status in Nunavut. Training for communities in project management skills should include ways in which community program and project staff can collect data easily on a day-to-day basis, and produce reports on indicators that will benefit their projects, as well as fulfill FNIHB program reporting requirements.

Recommendation #4 – Develop a Comprehensive Communications Strategy
A comprehensive communications strategy would address issues identified by community program staff – the need to increase awareness and information about FNIHB programs, and to facilitate the sharing of experiences and best practices among communities.

4-a: Develop a strategy for increasing awareness and information about FNIHB programs in Nunavut
HSS and NTI should develop an awareness strategy with input from Inuit organizations, territorial and regional partners, and community members. The strategy should be multi-faceted. A toll-free "first contact" line would serve as a central source for referrals to other contacts who could provide the needed information on FNIHB programs. An on-line source should also be available with information about FNIHB programs in Nunavut as a resource for community program staff and community members with access to the Internet. Both sources should be advertised in communities.

4-b: Organize regular conferences for sharing best practices in FNIHB programs with other communities
HSS and NTI should organize a conference at least once in each evaluation period for communities to share best practices and discuss issues with regional and territorial HSS staff and NS staff.

APPENDIX A: MISSIONS AND STRATEGIC PLANS OF HC, FNIHB & H&SS

Agency	Missions and Strategic Plans
Health Canada	Heath Canada's stated mission is a commitment "to improving the lives of all of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system."[17] Health Canada has developed a series of strategic outcome that serve as a basis for directing all programs and activities. These include: ❖ **Strategic Outcome #1:** Strengthened Knowledge Base to Address Health and Health Care Priorities ❖ **Strategic Outcome #2:** Access to Safe and Effective Health Products and Food Information for Healthy Choices ❖ **Strategic Outcome #3**: Reduced Health and Environmental Risk from Products and Substances, and Safer Living and Working Environments ❖ **Strategic Outcome #4:** Better Health Outcomes and Reduction of Health Inequalities Between First Nations and Inuit and Other Canadians Moving into the future, Health Canada has identified several key areas that will enhance its delivery of health programming throughout Canada. These include prevention, promotion, partnerships, and collaborative efforts among the various levels of government. Health Canada states "...that prevention and health promotion can hold health care costs down and improve quality of life in the long term. To this end, the Department is committed to meeting the challenges of tomorrow by supporting research and fostering partnerships with researchers across the country and the world. We also work collaboratively with the provinces and territories to test ways in which the Canadian health care system can be improved and ensure its sustainability for the future."[18]
First Nations and Inuit Health Branch (FNIHB)	Through the First Nations and Inuit Health Branch (FNIHB), Health Canada supports the delivery of public health and health promotion services. In areas for which no provincial services are available, primary care services are also provided by Health Canada. These include the following services: ❖ Pharmaceuticals, ❖ Dental services, ❖ Vision services, ❖ Medical transportation, ❖ Medical supplies and equipment, and ❖ Crisis intervention mental health counseling.[19]

[17] Health Canada. On-line resource: "About Mission, Values, Activities". < http://www.hc-sc.gc.ca/ahc-asc/activit/about-apropos/index_e.html>. Accessed Nov. 30, 2005.
[18] Health Canada. On-line resource: "About Health Canada". < http://www.hc-sc.gc.ca/ahc-asc/index_e.html >. Accessed Dec. 10, 2005.
[19] Ibid.

Agency	Missions and Strategic Plans
	Each of the services mentioned above are provided under the FNIHB's three-fold mandate, which is to: 1) "Ensure the availability of, or access to, health services for First Nations and Inuit communities; 2) Assist First Nations and Inuit communities to address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and 3) Build strong partnerships with First Nations and Inuit to improve the health system."[20] Within this mandate, the FNIHB has established a number of priorities to guide all programs and activities. These are to: ❖ "Manage the cost-effective delivery of health services within the fiscal limits of the First Nations and Inuit Health Envelope. ❖ Transfer existing health resources to First Nations and Inuit control within a time-frame to be determined with them. ❖ Support action on health status inequalities affecting First Nations and Inuit communities, according to their identified priorities. ❖ Establish a renewed relationship with First Nations and Inuit people."[21] Within the 2004-2005 report on Plans and Priorities, the following priorities were also identified: ❖ "Enhance health promotion and prevention programs. ❖ Improve the quality, accessibility and effectiveness of health care services. ❖ Collaborate and cooperate with FN/I communities, provinces and territories, and service providers to modernize and adapt the health service system for FN/I. ❖ Strengthen information and knowledge management to improve delivery of health care services and programs. ❖ Improve the management practices of Health Canada and FN/I communities by implementing effective evaluation and accountability mechanisms."[22] The mandate and priorities of FNIHB reflect the *Inherent Right of Self-Government*, a federal policy established in 1995, and the need for First Nations and Inuit communities to be provided with adequate resources for involvement in program development and implementation. They also reveal similar features to those plans already identified for Health Canada, such as a focus on prevention, awareness, partnerships, and collaboration.

[20] Health Canada. On-line resource: "Mandate and Priorities". <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/mandat_e.html>. Accessed Nov. 30, 2005.
[21] Ibid.
[22] Health Canada. On-line resource: "2004-2005 Report on Plans and Priorities". <http://www.tbs-sct.gc.ca/est-pre/20042005/HLTH-SANT/pdf/HLTH-SANT_e.pdf>. Accessed Dec. 10, 2005.

Agency	Missions and Strategic Plans
Government of Nunavut Department of Health and Social Services (HSS)	The mission of the Department of Health and Social Services (HSS) is "to promote, protect and provide for the health and well-being of Nunavut residents, in support of leading self-reliant and productive lives."[23] HSS operates in areas such as primary and acute health, child protection, family services, mental health, health promotion and protection, and injury prevention. Within these areas, the goals of HSS are to: ❖ "Improve the health status of Nunavut residents. ❖ Provide supportive environments for individuals, families and communities in making decisions that affect their health, well-being and independence. ❖ Deliver integrated and co-ordinate health and social services to individuals, families and communities. ❖ Develop healthy public policy. ❖ Be a Department that is accountable and responsive to the people of Nunavut; that delivers flexible and excellent programming; and that is able to demonstrate effective use of public resources." HSS seeks to provide health services that have been adapted to the special characteristics of Nunavut. For example, the Telehealth network is a new and innovative initiative that provides communities with a wide range of health care, social programs and services through teleconferencing. The Department is also committed to working with the federal government and collaboratively administering a number to programs that take a holistic approach to managing health issues in Nunavut. This emphasis encompasses physical, mental, and social well-being of Nunavut.[24]
Nunavut Tunngavik Incorporated (NTI)	The mission statement of NTI is "to foster Inuit economic, social and cultural well-being through the implementation of the Nunavut Land Claims Agreement".[25]

[23] Government of Nunavut – Health and Social Services. On-line resource: "Our Mission". <http://www.gov.nu.ca/hsssite/hssmain.shtml>. Accessed Nov. 30, 2005.
[24] Ibid.
[25] Nunavut Iunngavik Incorporated. On-line at <www.tunngavik.ca/english/about.html>

Appendix B: Policy and Program Documents Reviewed

Aboriginal Diabetes Initiative (ADI)

1. Evaluation of the Aboriginal Diabetes Initiative (ADI) – Nunavut – 2003-2004 – Summary Report (March 2004)
2. Aboriginal Diabetes Initiative (ADI) Evaluation Study II "Design and Progress" – Revised Draft Final Report (April 21, 2005)
3. Nunavut Diabetes Strategy 2005-2010 – Draft 2
4. Aboriginal Diabetes Initiative (ADI) Evaluation Framework – February 2002
5. Aboriginal Diabetes Initiative (ADI) Final Report – April 1, 2003 – March 31, 2004
6. A Diabetes Strategy for Nunavut: Prevention and Management, July 2004
7. Aboriginal Diabetes Initiative (ADI) 2004-2005 Year-End Report – Fun with Food Projects - Hamlet of Kugluktuk
8. Aboriginal Diabetes Initiative (ADI) 2004-2005 Year-End Report – Elders Healthy Living and Diabetes Awareness Lunch Program - Hamlet of Gjoa Haven
9. Aboriginal Diabetes Initiative (ADI) 2004-2005 Year-End Report – ADI Community Fitness Program - Clyde River
10. Aboriginal Diabetes Initiative (ADI) 2004-2005 Year-End Report –Cape Dorset ADI - Cape Dorset
11. Aboriginal Diabetes Initiative (ADI) 2004-2005 Year-End Report – Tupalirit, the Judo School Program - Iqaluit
12. Aboriginal Diabetes Initiative Regional Annual Report – FN On-Reserve and Inuit in Inuit Communities (FNIIC) Program, 2002-2003
13. Aboriginal Diabetes Initiative Regional Annual Report – FN On-Reserve and Inuit in Inuit Communities (FNIIC) Program, 2003-2004
14. Aboriginal Diabetes Initiative (ADI) Program Framework – July 5, 2000 – FN On-Reserve and Inuit in Inuit Communities (FNIIC) Program
15. Aboriginal Diabetes Initiative (ADI) Workplan: FNIHB Funding – Nunavut 2002/03
16. Aboriginal Diabetes Initiative (ADI) Workplan Nunavut 2004-05: Current Funding $572,235.00
17. Aboriginal Diabetes Initiative (ADI) Regional Activity Report for Period April 1, 2003 – July 31, 2003
18. Aboriginal Diabetes Initiative– February 7, 2005 Letter by the Department of Health and Social Services
19. ADI Report Template Supplement: ADI 2003-2004 Year-End Report
20. Aboriginal Diabetes Initiative Template for 2004-2005 Year End Report
21. Aboriginal Diabetes Initiative Proposal Form
22. Aboriginal Diabetes Initiative Budget 2004-2004 (no source)
23. Aboriginal Diabetes Initiative Report, April 1 to October 31, 2003
24. A Diabetes Strategy for Nunavut: Prevention and Management submitted by Debbie Leach
25. Aboriginal Diabetes Initiative Activity Report – Nunavut October 2002

BRIGHTER FUTURES AND BUILDING HEALTHY COMMUNITIES

26. Evaluation of the Brighter Futures and Building Healthy Communities Programs: Final Evaluation Report, by Auguste Solutions and Associates Inc., December 31, 2004
27. Brighter Futures/Building Healthy Communities Programs: Action Plan Draft #3, January 21, 2005
28. Brighter Futures/Building Healthy Communities, 2003-2004 Annual Report, Kugluktuk, NU, November 12, 2004
29. Brighter Futures (BF) and Building Healthy Communities (BHC)
30. Brighter Futures/Building Healthy Communities – April 1 – July 31, 2003 – Community Activity Report
31. Brighter Futures/Building Healthy Communities – April 1 – October 31, 2003 – Community Activity Report
32. Email correspondence re. H&CC program – December 4, 2003
33. Brighter Futures: Policy Framework/Authority, First Nations and Inuit Health Program Compendium, 1993
34. Brighter Futures: Provider Qualifications (No source provided)
35. Brighter Futures: Reporting Template, Health and Social Services, Government of Nunavut
36. Brighter Futures: Proposal and Budget Worksheet, Health and Social Services GN
37. Brighter Futures: Clyde River Report on Brighter Futures Project: Community Wellness Coordinator, July 1, 2005
38. Brighter Futures: Coral Harbour Cover Pages of Reports
39. Brighter Futures: Coral Harbour Report on Brighter Futures Project: Caribou Skin Project October 1, 2002
40. Brighter Futures: Coral Harbour Brighter Futures Activity Report, November 12, 2004
41. Brighter Futures: Gjoa Haven Community Summary of Brighter Futures Projects, December 15-16, 2003
42. Brighter Futures: Iqaluit Report on Brighter Futures Project: Hip Hop Teens Issues Focused Workshop December 16, 2003
43. Brighter Futures: Kugluktuk Report on Brighter Futures Projects: Teaching Traditional Copper Skills to Youth and Children Participating in Elder's Gatherings, February 11, 2005
44. Brighter Futures: Rankin Inlet Reports and Proposal Form on Brighter Futures Project: Breakfast Program, June 15, 2005
45. Brighter Futures: Rankin Inlet Report on Brighter Futures Project: Drop-In Center, October 1, 2003
46. Brighter Futures: Rankin Inlet Report on Brighter Futures Projects: A Bridge for Change Workshop, November 26-28, 2002
47. Brighter Futures: Rankin Inlet Brighter Futures Progress and Financial Reports (Summary Pages only December 18, 2002 and October 27, 2003
48. Brighter Futures: Resolute Bay Report on Brighter Futures Projects: Jewellery Making Workshop, January 4, 2005
49. Building Healthy Communities: Policy Framework/Authority, First Nations and Inuit Health Program Compendium, 1994
50. Building Healthy Communities: Provider Qualifications (no source indicated)

51. Building Healthy Communities: Reporting Templates, Health and Social Services, Government of Nunavut

52. Building Healthy Communities: Clyde River Report on BHC Project: Suqqakkut Committee, July 1, 2005

53. Building Healthy Communities: Coral Harbour

54. Building Healthy Communities: Gjoa Haven Reports on BHC Project: Food Bank, December 15, 2003 and February 11, 2005

55. Building Healthy Communities: Gjoa Haven Reports on BHC Project: Tungatiit Committee, December 15, 2003 and February 11, 2005

56. Building Healthy Communities: Gjoa Haven Report on BHC Project: Suicide Awareness, December 15, 2003

57. Building Healthy Communities: Community Summary of all projects, December 16, 2003

58. Building Healthy Communities: Iqaluit Report on BHC Project: Iqaluit Music Camp, October 18, 2004

59. Building Healthy Communities: BHC – SAP Activity Report 2003-2004: Kitikmeot Tour (December 8-12, 2003) and Igloolik Support Worker for Youth Involved in Substance Abuse (September 1, 2003 to March 31, 2004)

60. Building Healthy Communities: Rankin Inlet Report on BHC Project: DARE Program, June 15, 2005

61. Building Healthy Communities: Rankin Inlet Report on BHC Project: Drop-In Centre Program, October 1, 2003

62. Building Healthy Communities: Rankin Inlet Proposal for BHC Project: DARE Canada – Grade Six Child Development. Health/Alcohol and Drugs Awareness, May 17, 2004

63. Building Healthy Communities: Resolute Bay Report on BHC Project: Quarmartalik School Snack Program, June 15, 2005

CANADA PRENATAL NUTRITION PROGRAM (CPNP)

64. Canada Prenatal Nutrition Program (CPNP) Final Report 2005– 2006, Iqualuit, 2005 Reporting Template

65. Canada Prenatal Nutrition Program (CPNP) FNIHB – Summary Evaluation Report 2003-2004

66. Canada Prenatal Nutrition Program (CPNP) FNIHB – Summary Evaluation Report - March 2002

67. Canada Prenatal Nutrition Program (CPNP) – Activity and Finance Report – April 1, 2004 – March 31, 2005 – Resolute Bay Food for Moms

68. Canada Prenatal Nutrition Program (CPNP) – Activity and Finance Report – April 1, 2004 – March 31, 2005 – Gjoa Haven Food for Moms

69. Canada Prenatal Nutrition Program (CPNP) – Final Report – April 1, 2004 – March 31, 2005 – Cape Dorset Food for Moms

70. Canada Prenatal Nutrition Program (CPNP) Training Workshop Evaluation Form, Rankin Workshop, November 15-19, 2004

71. Canada Prenatal Nutrition Program (CPNP) Training Workshop Evaluation Form, Iqaluit Workshop, October 19-22, 2004

72. Canada Prenatal Nutrition Program (CPNP) Funding Guidelines – February 7, 2005 Letter

73. Canada Prenatal Nutrition Program (CPNP) – First Nations and Inuit Component – National Framework for Program Expansion – April 2000

74. Canada Prenatal Nutrition Program (CPNP) – First Nations and Inuit Component – Program Guidelines – Revised June 2000

75. Canada Prenatal Nutrition Program (CPNP) – Proposal Form

76. Canada Prenatal Nutrition Program (CPNP) – Nunavut, 2003 – 2004

77. Canada Prenatal Nutrition Program (CPNP) – Summary of Funding Segments

78. Canada Prenatal Nutrition Program FNIHB – Government of Nunavut Summary Evaluation Report 2003-2004 Appendix B

79. Canada Prenatal Nutrition Program (CPNP) – Summary of Funding Segments

FETAL ALCOHOL SPECTRUM DISORDER (FASD)

80. Fetal Alcohol Spectrum Disorder (FASD) Program Guidelines and Application Forms – Program Expansion for 2003-2004

81. Fetal Alcohol Spectrum/Fetal Alcohol Effects Initiative Regional Workplan – 2002/03 - Nunavut

82. Fetal Alcohol Spectrum Disorder (FASD) Program Workplan 2004-2005; Current Funding Request ($447,562.00)

83. Fetal Alcohol Spectrum Disorder (FASD) - Form 3 – Workplan for Activity

84. Fetal Alcohol Spectrum Disorder – April 1 – October 31, 2003 – Status Report

85. Fetal Alcohol Spectrum Disorder Regional Activity Report – April 1 – July 31, 2003

86. Fetal Alcohol Spectrum Disorder (FASD) Final Report – April 1, 2003 – March 31, 2004

87. Appendix B – Coordinated Community Approach: Healthy Moms and Babies Pilot Project

88. Fetal Alcohol Spectrum Disorder

89. Draft FASD 2003/04 Workplan #2 – Budget $447,562

90. Health Canada/Government of Nunavut Consolidated Agreement Workplan based Programs – Progress Report April1 – October 31, 2003

91. FASD Workplan Budget 2003-04

FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE (FNIHCC)

92. Activities for First Nations and Inuit Home and Community Care (FNIHCC) – Fiscal Year 2002/03

93. First Nations and Inuit Home and Community Care (FNIHCC) Workplan FY 2003-04 – September 2003

94. First Nations and Inuit Home and Community Care (FNIHCC) Workplan FY 2003-04 – September 2003

95. First Nations and Inuit Home and Community Care (FNIHCC) Workplan FY 2003-04 – March 2004

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109. First Nations and Inuit Home and Community Care (FNIHCC) - Planning Resource Kit: Evaluation Guide – Health Transition Fund Project NA108

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Appendix C: Interview Questions

Senior Health Canada Staff

1. Which FNIHB programs have you worked on in the last three years?

   (A list of the eight programs will be read out to the respondent if necessary)

2. What problems are you facing with these programs? Why?

   (Prompts: Problems with the program itself? Programs with particular projects? Problems delivering the program in particular communities? Community capacity to deliver the program?)

3. How are you involved in running these programs?
4. What you would change about your role if you could? Why?
5. What do you like about the way the programs are managed by all the groups involved (Government of Nunavut, Health Canada, communities, etc.)?
   - Are the programs being administered and managed efficiently? If so, provide examples. If not, where are the areas needed for improvements?
   - Can you describe any success stories?
6. What would you change about the way the programs are managed? Why?
7. Have you seen any changes in the ability of communities to manage these programs over the last three years?
8. Are GN program requirements for FNIHB programs clear and consistent?
9. What are the sources of funding for these programs?
10. Are there any other sources of funding for these programs?
11. Are there health issues which you feel are not being addressed by any of the programs? If so, what are they? In which programs?
12. Can you think of any redundancy with programs/projects whereby services are overlapping one another? If so, which ones?
13. Are there any other programs that support community-based health projects (not through FNIHB)? What are they?

    (If more than one program is mentioned, the interviewer will repeat the two follow-up questions for each of the programs)

14. What are the goal(s) of the other program(s)?
15. How much money can a community get through the other programs?

Senior HSS Staff

1. Which FNIHB programs have you worked on in the last three years?

   (A list of the eight programs will be read out to the respondent if necessary)

2. Which of these programs have been most successful? Why?

3. What problems are you facing with these programs? Why?

   (Prompts: Problems with the program itself? Programs with particular projects? Problems delivering the program in particular communities? Community capacity to deliver the program?)

4. Are these programs administered and managed efficiently?
5. How are you involved in running these programs?
6. What you would change about your role if you could? Why?
7. What do you like about the way the programs are managed by all the groups involved (Government of Nunavut, Health Canada, communities, etc.)?
8. How could the administration and management of the programs improve?
9. What would you change about the way the programs are managed? Why?
10. Do you think the project funding levels reflect the program objectives and outlines? For which programs?
11. Have you seen any changes in the ability of communities to manage these programs over the last three years?
12. Are there any other programs that support community-based health projects (not through FNIHB)? What are they?

    (If more than one program is mentioned, the interviewer will repeat the two follow-up questions for each of the programs)

13. What are the goal(s) of this program(s)?
14. How much money can a community get through the other program(s)?

HSS Program Coordinators

1. Which FNIHB programs have you worked on in the last three years?

   (A list of the eight programs will be read out to the respondent if necessary)

2. Which of these programs have been most successful? Why?
3. What problems/challenges are you facing with these programs? Why?

   (Prompts: Problems with the program itself? Programs with particular projects? Problems delivering the program in particular communities? Community capacity to deliver the program?)

4. Are the programs meeting their objectives, goals and outcomes? Which programs?
5. Do they have adequate funding? Which programs?
6. How are you involved in these programs? Which programs?
7. What you would change about your role if you could? Why?
8. What do you like about the way the programs are managed by all the groups involved (Government of Nunavut, Health Canada, communities, etc.)?
   - Is the administrative and management of the programs efficient?
9. What would you change about the way the programs are managed? Why?
10. How do the various stakeholders (GN, HC, NTI, Community groups) work together in carrying out the programs?

- What are the challenges?
- What are the successes?

11. Do you think community members have learned more about how to manage these programs over the last three years? What have they learned?
12. What changes would make people more aware of these programs?
13. What changes would make people more interested in participating in these programs?

COMMUNITY-LEVEL PROJECT STAFF

1. What activities or projects received money from Health and Social Services in your community?

   (A list of the eight programs will be read out to the respondent if necessary)

   (If the respondent names projects – confirm which program)
2. Which of these projects have been most successful? Why?
3. Have you noticed any improvements to the health status of community people?
4. How could communities maximize the impacts of programs?
5. What problems/challenges are you facing with these projects? Why? Which projects?
6. How are you involved in these projects?
7. What you would change about your role if you could? Why?
8. What do you like about the way the programs are managed by all the groups involved (Government of Nunavut, Health Canada, communities, etc.)?
9. What do you not like about the way the programs are managed?
10. What would you change about the way the programs are managed? Why?
11. Do you think you've learned more about how to manage this sort of program over the last three years? What have you learned?
12. Did any of your projects get money from other organizations as well as from Health and Social Services? Which other organizations gave you money? For which projects and programs?
13. *(If yes)* Do you have suggestions for improving the coordination of funding from the various sources?
14. *(If no)* Why not?

    (Prompt: Did you apply for funding but not receive any?)
15. What sorts of things do you do to make the money stretch further?

    (Prompts: Do you share a staff person with other projects? Do you share a building? Do you do activities together?)
16. Would you still be able to run the project if you didn't get money from Health and Social Services?
17. What changes would make people more aware of these programs?
18. What changes would make people more interested in participating in these programs?
19. What are the most important health issues for you? For your family? In your community?

20. Are the current programs addressing the health needs of Inuit Communities? If not, why not? If yes, why?
21. Are there other programs that complement the GN programs? If so, which programs? What are the goal(s) of the other program(s)?

CLIENTS/USERS (PROJECT PARTICIPANTS AND COMMUNITY MEMBERS)

1. In the last three years, have you participated in any of these health-related projects in your community?

   (The interviewer will have a list of all of the FNIHB projects in the community to read from as examples)

   If the person has participated, the interviewer will go on to questions 2 – 9.

   If the person has not participated, the interviewer will go on to questions 10 – 17.
2. In the last three years, have other people you know participated in these projects?

   (The interviewer will record the other people – sister, daughter, uncle, friend, etc.) – which projects

   The interviewer will ask the follow up questions (questions 3-8) for the respondent first, and then over again for the other people they identify.
3. How did you find out about the project?
4. What did you learn from the project?
5. Do you do anything different now because of the project?

   (Prompts: Eat different food? Get more exercise? Manage illness?)
6. What did you like about the project?

6a. What did you not like about the project?

7. What would you change about the project?
8. Did the project take into account your culture and traditions? How or how not?
9. What are the most important health issues for you? For your family? In your community?

9a. Are the projects you are involved in addressing your health issues? Why? Why not?

9b. Did your participation in these projects improve your health status?

10. Did you know about these types of projects?

    If yes, the interview will ask questions 11 – 13.

    If no, the interview will go on to questions 14 – 17.
11. Why aren't you participating in these projects?

    (Prompts: Not interested? Bad timing? Only for a specific group? Other reasons?)
12. What changes would make you want to participate in these projects?
13. Would you be interested in participating in these projects? Which ones?
14. Would other people you know be interested in participating in these projects? Which ones?
15. Where do you usually go to get information about projects happening in your community?

INUIT ORGANIZATIONS

1. Which FNIHB programs have you worked on in the last three years?

   (A list of the eight programs will be read out to the respondent if necessary)

2. Which of these programs have been most successful? Why?
3. What problems/challenges are you facing with these programs? Why? Which programs?

   (Prompts: Problems with the program itself? Programs with particular projects? Problems delivering the program in particular communities? Community capacity to deliver the program?)

4. How are you involved in these programs?
5. What you would change about your role if you could? Why?
6. What do you like about the way the programs are managed by all the groups involved (Government of Nunavut, Health Canada, communities, etc.)?
   - Are these groups working well together?
7. What would you change about the way the programs are managed? Why?
8. Do these programs take into account Inuit culture and traditions? How or how not?
9. What changes would make these programs more suitable for Inuit?

9a. What changes would improve the impact of the programs?

10. What changes would make people more aware of these programs?
11. What changes would make people more interested in participating in these programs?