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Evaluation of the Healthy Living (2010-2011 to 2012-2013) and Healthy Child Development Clusters (2008-2009 to 2012-2013)

Prepared by the Office of Evaluation
Health Canada and the Public Health Agency of Canada

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List of Acronyms

ACS	Aboriginal Children's Survey
ADI	Aboriginal Diabetes Initiative
AHSOR	Aboriginal Head Start on-Reserve
CBRT	Community-based reporting template
CPNP-FNIC	Canada Prenatal Nutrition Program – First Nations and Inuit Component
COHI	Children's Oral Health Initiative
CY	Children and Youth
def	decayed-extracted-filled
FASD	Fetal Alcohol Spectrum Disorder
FNFNES	First Nations Food, Nutrition, and Environment Study
FNIHB	First Nations and Inuit Health Branch
FNIGC	First Nations Information Governance Centre
HC	Health Canada
HCD	Healthy Child Development
HL	Healthy Living
HPDP	Health Promotion Disease Prevention
ITK	Inuit Tapiriit Kanatami
MCH	Maternal Child Health
NADA	National Aboriginal Diabetes Association
NAO	National Aboriginal Organization
NGO	Non-governmental Organizations
NNC	Nutrition North Canada– Nutrition Education Initiatives
NORTH	Northern Outcome Reporting Template for Health
PAA	Program Alignment Architecture
PHAC	Public Health Agency of Canada
REIF	Regional Evaluation and Innovation Fund
RHS	First Nations Longitudinal Regional Health Survey

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Executive Summary

This evaluation covered the First Nations and Inuit Healthy Living (HL) and Healthy Child Development (HCD) clusters for the period of 2010-2011 to 2012-2013 for HL and 2008-2009 to 2012-2013 for HCD. The evaluation was undertaken in fulfillment of the requirements of the *Financial Administration Act* and the Treasury Board of Canada's *Policy on Evaluation (2009)*. This was a scheduled evaluation for 2014-2015 on the Health Canada Five-Year Departmental Evaluation Plan.

Evaluation Purpose, Scope and Design

The evaluation assessed the relevance and performance (effectiveness, economy and efficiency) of the Healthy Living (HL) and Healthy Child Development (HCD) group of programs referred herein as clusters. Evaluation findings will support decision making for policy and program improvements and in time for the planned 2015 renewal of these programs.

The HL cluster, which was previously known as the Chronic Disease and Injury Prevention Cluster, had been evaluated over the period from April 2005 to March 2010. The HCD cluster, previously known as the Children and Youth Cluster, had been evaluated over the period from April 2005 to March 2008. The Children's Oral Health Initiative (COHI), which is a component of this current evaluation, was evaluated separately in 2009. As of May 1, 2012, the HL and HCD clusters were combined into one division, with this merger affecting governance and reporting structures at regional and national levels but not at the community level. As a result, the Branch requested both clusters be combined into a single evaluation to be able to report on their similar expected outcomes and reduce evaluation burden.

The methodology used in the evaluation included input from key internal and external stakeholders through key stakeholder interviews, an online survey of FNIHB staff, and site visits to First Nations and Inuit communities to conduct interviews and focus groups. In addition, documents, data, and literature were reviewed.

Program Description

The HL and HCD clusters are funded under FNIHB's Primary Health Care suite of programs that are provided to First Nations and Inuit individuals, families, and communities living on-reserve or in Inuit communities.

The HL cluster funds and supports the following program areas: chronic disease prevention and management (including the Aboriginal Diabetes Initiative [ADI], Nutrition North Canada [NNC]–Nutrition Education Initiatives, nutrition policy, and chronic disease prevention policy), as well as injury prevention policy and dental therapy. Estimated total HL financial allocation in scope for the evaluation was \$185 million, and actual expenditures were \$173 million, of which 78% was in contribution agreement expenditures. Total HL expenditures for 2012-2013 were \$55.2 million, of which \$43.1 million was in contribution agreements.

The HCD cluster funds and supports the following program areas: healthy pregnancy and early infancy (including Fetal Alcohol Spectrum Disorder [FASD], Canada Prenatal Nutrition Program–First Nation & Inuit Component [CPNP-FNIC], and Maternal Child Health [MCH]), as well as early childhood development (Aboriginal Head Start on-Reserve [AHSOR]), and the Children’s Oral Health Initiative (COHI). Estimated total HCD financial allocation in scope for the evaluation was \$608.8 million, and actual expenditures were \$547.5 million, of which 91% were in contribution agreement expenditures. Total HCD expenditures for 2012-2013 were \$105.5 million, of which \$97.8 million was in contribution agreements.

Evaluation Key Findings, Conclusions and Recommendations

KEY FINDINGS — RELEVANCE

Continued Need for the Program

Due to the disparities in incidence of many health issues such as diabetes and other chronic diseases and prevalence of health risk factors such as deficits in nutrition, physical activity, maternal health and food security for many First Nations and Inuit communities, there is a continued need for the HL and HCD clusters to support First Nations and Inuit communities’ capacity to address the healthy living and healthy child development needs and priorities of these communities.

Alignment with Federal Roles and Responsibilities

Various legislative authorities and federal policies identify that the federal government has jurisdiction, responsibilities and/or goals regarding Aboriginal health care services, and, in particular, health care of First Nations on-reserve and certain Inuit.

Alignment with Government Priorities

Increasing access to health care and addressing the health status inequalities affecting First Nations and Inuit communities are priorities of the federal government and FNIHB, as is increased First Nations and Inuit control of health resources (e.g., programmatic and financial resources) within their communities.

KEY FINDINGS — PERFORMANCE

Achievement of Expected Outcomes (Effectiveness)

Overall, considerable progress has been made to meet the intended outcomes of the programs within the HL and HCD clusters, however, attention is still needed to ensure further progress is made and advances continue to improve overall health status of First Nations and Inuit. Through the evaluation, evidence was collected to assess the achievement of the expected outcomes which are presented below.

Immediate Outcomes

Community and stakeholder engagement and collaboration was evident at all levels and among all stakeholders. Community-level collaboration helped improve the programs and services delivered in communities. Collaboration between the national and regional offices as well as with Aboriginal organizations was difficult to sustain. This was particularly the case for HCD programs due to departmental changes in overall cluster governance and program management.

Capacity-building opportunities were widely viewed as providing community workers with the knowledge and skills to support program delivery. Community staff reported a high level of satisfaction in the amount of learning opportunities. However, regions and communities identified challenges with providing and attending training and the evaluation identified that training opportunities did not appear to be consistent across all communities and/or programs.

FNIHB implemented some approaches to further increase the ability to collect, monitor, and provide information which supported performance measurement. A range of guidance tools exist for community staff to develop, implement, and/or deliver the HL and HCD programs. FNIHB national office used available information to support policy and program development or improvement, while regional offices focussed their use of available information for supporting communities in program delivery. Maximizing the use of evidence-based information will result in additional program improvement.

Based on the communities that were visited for this evaluation, there was consensus that programs and services were accessible. Community staff took steps to facilitate accessibility. However, other communities outside the site visits indicated that access was challenged and some experienced inequities in program and funding availability. More specifically, these communities encountered issues such as competing health priorities, acquiring sufficient program and management staff, availability of facilities, as well as a lack of other resources. Lack of transportation and available child care were identified as two of the major barriers to participation in available programs and services.

The HL and HCD programs generally contributed to increased knowledge and awareness among program participants in a wide range of areas related to healthy living and healthy child development such as nutrition, physical activity, oral health and the importance of prenatal health.

Intermediate Outcomes

Efforts were made by communities as well as national and regional offices to improve integration and coordination of programs and services and reduce community program silos. Integration and coordination at the community level was occurring through efforts such as referrals, co-location of programs and pooling of resources. FNIHB supported integration and coordination by providing greater community support at the regional level through a reorganization of its governance structure.

The quality of programs improved as programs evolved and matured, but this was challenged by the continual need to recruit and train new staff. The literature indicates that enhanced program quality is achieved through increased community capacity and collaboration, implementation of standards, and improved access to services, all of which were evidenced to some degree in the evaluation.

The majority of program participants indicated improved healthy behaviours such as eating healthier, being more physically active, improving personal oral hygiene and reading more to their children. Furthermore, participants attributed their improved healthy behaviours to participation in the program. However, food insecurity, poverty and mental health issues, among others, can challenge personal efforts for increasing healthy behaviours.

Efforts were made by communities to increase supportive physical and social environments through implementing policies that encourage increased knowledge of health behaviours and participation in healthy living activities such as access to sports and cultural events as well as other cluster programming. Some smaller communities were challenged by a lack of facilities that supported healthy living activities.

Long-term Outcome

HL and HCD programs can be responsive and meet needs. Communities have flexibility in tailoring the mix of programs and services to meet their health priorities and changing health needs. Programs can be adapted to be more culturally appropriate, and, there is flexibility within funding agreements to respond to changing health needs. However, some communities, in particular small, remote and/or isolated communities, indicated that they have a lack of programs and/or supportive services and that there is a need for additional staff, which may impact the responsiveness of the HL and HCD clusters as well as overall improved First Nations and Inuit health status. There are some indications of increased health status evidenced by a decline in child tooth decay, reduced blood sugars or blood pressure, weight loss and increased breastfeeding.

Demonstration of Economy and Efficiency

The health promotion and disease prevention approach used by HL and HCD programming aligns with good practice in delivering health care in order to improve health outcomes and have demonstrated that they are cost effective (economically beneficial) over the long-term. The HL and HCD clusters promote healthy practices and disease prevention activities which are recognized in the literature as cost efficient. Efficiency was also realized through the steps FNIHB took to improve program delivery and make efficient use of resources such as mobile diabetes clinics and community-based health staff such as dental therapists. Further program delivery improvements could create additional efficiency.

CONCLUSIONS

The evaluation demonstrates an ongoing role for the federal government to address the continuing need for healthy living and healthy child development programs. These initiatives are consistent with the priorities of the department to support improved access to health care, health status and First Nations and Inuit control of health resources within their communities.

The evaluation found that programs can be responsive and meet community needs. The programs align with health promotion and disease prevention practices in delivering preventative community-based primary care to improve health outcomes at a lower cost over the long-term.

First Nation and Inuit communities know more about healthy living and healthy child development and are taking steps towards increasing healthy behaviours as a result of the HL and HCD programs. The evaluation found evidence of improved health status in the areas of children's oral health, reduced blood sugars or blood pressure, weight loss and breastfeeding.

While collaboration across programs within the HL and HCD clusters was strengthened, which supported improved program service delivery, opportunities exist between national and regional FNIHB offices as well as between FNIHB and Aboriginal organizations to further strengthen collaboration and develop cooperative approaches with other jurisdictional service providers and community partners. HCD programs, in particular, could benefit from increased collaboration and integration.

Capacity building was shown to support program delivery. However, regions and communities identified challenges with providing and attending training. Programs, where available, were accessible. Although, some communities, particularly small, remote and/or isolated communities, experienced imbalances in program and funding availability which limited access to needed programs and services.

Performance measurement has improved, particularly for measuring intermediate and long-term outcomes. However, focus on performance indicators and data collection that support immediate outcomes, specifically the reach and access of HL and HCD programs could be enhanced to better support program monitoring, for planning and reporting.

RECOMMENDATIONS

The recommendations are based on the findings for each of the outcomes assessed as part of this evaluation and the conclusions drawn from those key findings.

Recommendation #1

Improve collaboration efforts with stakeholders, partners and other service providers that ensure sustained partnerships and program integration.

- There are opportunities for the programs to improve coordination and integration at both the FNIHB and community level. Although communities have begun developing partnerships and sharing activities and services between similar programs, a review could assist communities in developing a strategy to more fully integrate programs within their own communities and collaborate with other communities and service providers in order to achieve efficiencies within the resource constraints identified.

Recommendation #2

Sustain efforts to support improved program and service access and quality.

- There are opportunities to better understand how funds were allocated across programs and communities. This would assist in identifying approaches for addressing current programming inequities that seem to exist in some communities (i.e., small, remote and isolated).
- Given the important role of community workers in the HL and HCD programs, ongoing capacity-building support was essential for ensuring workers had the necessary knowledge and skills to provide and deliver effective, quality programs and services. Supporting the efforts taken by some regions for developing capacity-building strategies could ensure greater reach and access of programs and consistency in approaches to training.

Recommendation #3

Streamline and implement improved performance measurement.

- Ongoing data collection and performance measurement was important for monitoring progress in achieving expected outcomes and supporting evaluation. Qualitative information collected as part of the evaluation along with data sources such as the Community-based Reporting Template (CBRT), the Northern Outcome Reporting Template for Health (NORTH) report and Regional Health Survey and studies completed by FNIHB, were valuable for providing context and depth, particularly when corroborated with additional evidence.

Improvements could be made to the CBRT, and possibly the NORTH reporting tool, to facilitate regular collection of data from communities that would contribute towards measuring achievement of outcomes, specifically short-term outcomes such as increased reach, participation and access to programs. A revised logic model, with fewer outcomes to measure, and clearly-defined parameters and targets around expected outcomes, would further assist in this process. As well, support and resources to regions and communities for collecting, managing, and analyzing data is important, given the continued shift in responsibilities to regions and the important role of communities in program delivery.

Management Response and Action Plan (MRAP)

FNIHB Health Living (HL) and Healthy Child Development (HCD) Program

Recommendations	Response	Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
<p>1. Improve collaborative efforts with stakeholders, partners and other service providers that ensure sustained partnerships and program integration</p> <p><i>Addressing: Engagement & Collaboration, Ongoing Access, Integration and Coordination, Responsive Services & Improved Health Status, and E&E. Also indirectly to Program Quality.</i></p> <p>Supports FNIHB Strategic Goal #2: Collaborative Planning and Relationships, especially regarding increasing First Nations and Inuit control and management of health-related programs and services.</p>	Agree ¹	<p>FNIHB has established partnership and co-management tables in all regions as a means to strengthen collaboration, joint planning, collaboration and transparency. The results of this evaluation will be shared with partners and opportunities to improve program integration and health continuum will be discussed at these tables. In addition, FNIHB will finalise with partners the Chronic Disease Prevention and Management (CDPM) Frameworks and the Oral Health Strategic Action Plan (OHSAP).</p> <p>CDPM Frameworks: Finalise both Inuit and First Nations Chronic Disease Prevention and Management Frameworks currently in progress. These Frameworks strive to strengthen partnerships and collaboration across the health continuum. They will also support community planning processes to meet the unique health needs of First Nations and Inuit.</p> <p>OHSAP: 1. Finalize the FNIHB Oral Health Strategic Action Plan as a guiding tool to strengthen partnerships and collaboration for oral health services across the health continuum.</p>	<p>CDPM Frameworks: 1a. Approved First Nations CDPM Framework 1b. Approved Inuit CDPM Framework</p> <p>OHSAP: 2. Approved FNIHB Oral Health Strategic Action Plan</p>	<p>July 2015</p> <p>September 2015</p> <p>July 2015</p>	<p>1a.-1b. Executive Director, Primary Health Care Division (PHCD), with support from Director of Population Health and Wellness Division (PHWD), FNIHB, and Regions</p> <p>2. Executive Director PHCD, FNIHB, and Regions (and/or Regional lead on dental)</p>	<p>Within existing budgets</p> <p>Within existing budgets</p>

¹ Note that for each recommendation, responses are focussed on priority issues that will have the most overall impact. The MRAP includes strong collaborative processes and shared responsibility across the Branch. These collaborative efforts are intended to enhance program performance and measurement.

Recommendations	Response	Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
		3. In partnership with AANDC and ESDC, map the current landscape of federally supported Early Childhood Development (ECD), Child Care (CC) and education programming of First Nations (FN) children living on reserve across Canada to support regions and communities in planning and leveraging/realigning existing resources and partnering with provinces where possible (e.g., co-location AHSOR and daycare).	3. Comparison chart created of current federal Aboriginal children's programming for FN children living on reserve outlining current ECD and CC programming in each First Nations community.	July 2015	2. Director PHWD, FNIHB and Regions	Within existing budgets
<p>2. Sustain efforts to support improved program and service access and quality.</p> <p><i>Addressing: Community Capacity, Use of Guidance Tools and Evidence-Based Information, Program Quality, Supportive Environments, Responsive Services & Improved Health Status; Program quality is also indirectly linked to Community Capacity, Ongoing Access, Knowledge and Awareness, Healthy Behaviours.</i></p> <p>Supports FNHB Strategic Goal #1: High Quality Health Services, including a focus on improving access to and quality of health care services, building regional capacity to deliver services, and increasing the health and well-being of individuals, families and communities.</p>	Agree	<p>1. In support of the renewal of FNIHB's upstream programs, the Branch is undertaking a financial analysis of the current funding profile for HL/HCD programs examining major cost drivers (such as population growth and social determinants). This work will define the cost drivers for those programs that do not currently have an escalator.</p> <p>2. Building on the work FNIHB has completed as part of its accreditation and service delivery standards initiative, the Branch is developing standards for Healthy Living (includes Chronic Disease Prevention, Oral Health) and Healthy Child Development activities.</p>	<p>1. A costing model for the cluster HL/HCD programs including an examination of provincial and territorial costing models and a discussion of major cost drivers (e.g., population growth) and their implications for service delivery.</p> <p>2. Standards for Healthy Living, (includes Chronic Disease Prevention, Oral Health) and Healthy Child Development activities are developed.</p>	March 2016	<p>1. Performance Measurement Unit, SPPI</p> <p>2. Executive Director PHCD, with support from Director PHWD, FNIHB.</p>	<p>1. External contract will be needed. Value to be determined.</p> <p>Within existing budgets</p>

Recommendations	Response	Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
<p>3. Streamline and implement improved performance measurement.</p> <p><i>Addressing: Ability to Collect and Monitor Information and Use of Guidance Tools and Evidence-Based Information. Program quality is also indirectly linked to E&E.</i></p> <p>Supports FNIHB Strategic Goal #3: Effective and Efficient Performance, increasing the availability of data to support decision making and development of new service delivery models.</p>	Agree	FNIHB has made great progress in establishing a branch performance measurement framework, enhancing its surveillance activities, supporting the Regional Health Survey, supporting greater access to provincial health data and capturing program activity profile through its community based reporting template while respecting the diversity of the community approaches.	<p>1. Publication of a Healthy Living / Healthy Child Fact Sheet</p> <p>2. A data collection strategy for Healthy Living that includes: a) Updated Logic Model b) Updated indicators</p>	<p>April 2015</p> <p>Healthy Living 2a: July 2015 2b: July 2015</p>	<p>SHIPCU</p> <p>PMU and SHIPCU in SPPI, with support from PHWD, PHCD, FNIHB and the Office of Evaluation</p>	<p>Within existing budgets</p>
		Current logic models and performance measurement indicators will be adjusted to enable greater precision on immediate outcomes as they pertain to reach and access.	A data collection strategy for Healthy Child that includes: a) Updated Logic Model b) Updated indicators	Healthy Child 3a: March 2016 3b: March 2016		

¹ Note that for each recommendation, responses are focussed on priority issues that will have the most overall impact. The MRAP includes strong collaborative processes and shared responsibility across the Branch. These collaborative efforts are intended to enhance program performance and measurement.

1.0 Evaluation Purpose

This evaluation assessed the relevance and performance (effectiveness, economy and efficiency) of the Healthy Living (HL) and Healthy Child Development (HCD) clusters for the period of 2010-2011 to 2012-2013 for HL and 2008-2009 to 2012-2013 for HCD.

The evaluation was required by the *Financial Administration Act* (for grants and contributions) and the Treasury Board of Canada's *Policy on Evaluation* (2009). This was a scheduled evaluation for 2014-2015 identified on the Health Canada Five-Year Departmental Evaluation Plan. The evaluation will support Health Canada's Deputy Minister and senior management in decision making for policy and program improvements and the planned 2015 renewal of these programs.

2.0 Program Description

2.1 Program Profile

The HL and HCD clusters are funded under FNIHB's Primary Health Care suite of programs that are provided to First Nations and Inuit individuals, families, and communities living on-reserve or in Inuit communities.

A brief overview of the HCD and HL clusters is provided below, with descriptions of each of the programs provided in Appendix 5.

2.1.1 Healthy Living Overview

The HL cluster funds and supports a range of community-based programs and services that aim to improve health outcomes associated with chronic diseases and injuries among First Nations and Inuit individuals, families, and communities. The cluster promotes healthy behaviours and supportive environments, particularly in the areas of healthy eating, food security, physical activity, and addresses chronic disease prevention, diabetes screening and self-management, and injury prevention. Funding also supports knowledge development, dissemination and exchange; research; monitoring and evaluation; public education and outreach; capacity building; program coordination; consultation; and other health promotion and disease prevention activities related to HL.

The HL cluster consists of the following programs and policy areas:

- Chronic Disease Prevention and Management, including Aboriginal Diabetes Initiative (ADI); Nutrition North Canada — Nutrition Education Initiative (NNC); Nutrition policy; Chronic disease prevention policy;
- Injury prevention policy; and
- Dental Therapy.

2.1.2 Healthy Child Development Overview

The HCD cluster funds and supports community-based and culturally-relevant programming, services, initiatives, and strategies that aim to improve health outcomes associated with First Nations and Inuit maternal, infant, child, and family health. The areas of focus include prenatal health; nutrition; early literacy and learning; physical, emotional, and mental health; and children's oral health. Programming aims to improve health outcomes for First Nations and Inuit infants, children, youth, families (including pregnant women), and communities.

The HCD cluster consists of the following program areas:

- Healthy Pregnancy and Early Infancy, including Fetal Alcohol Spectrum Disorder (FASD); Canada Prenatal Nutrition Program — First Nations and Inuit Component (CPNP-FNIC); Maternal Child Health (MCH);
- Early Childhood Development, including Aboriginal Head Start on-Reserve (AHSOR); and
- Children's Oral Health Initiative (COHI).

2.1.3 Program Governance and Management²

FNIHB National and Regional Offices

The HL cluster, which was previously known as the Chronic Disease and Injury Prevention Cluster, had been evaluated over the period from April 2005 to March 2010. The HCD cluster, previously known as the Children and Youth Cluster, had been evaluated over the period from April 2005 to March 2008. The Children's Oral Health Initiative (COHI), which is a component of this current evaluation, was evaluated separately in 2009. As of May 1, 2012, following Budget 2012, the HL and HCD clusters were combined into one division, with this merger affecting governance and reporting structures at regional and national levels but not at the community level.

FNIHB's national office in Ottawa leads strategic policy development and program planning in support of the HL and HCD clusters and in collaboration with First Nations and Inuit stakeholders and FNIHB regional offices. National office responsibilities include program framework design; the national program funding allocation; national program monitoring; data collection and analysis; project reporting and branch-level special studies; provision of advice and/or guidance on program delivery; and working with First Nations and Inuit partners to ensure the effective delivery of HCD and HL program areas. The national office may also issue and manage contribution agreements for national partners and stakeholders.

² Healthy Living and Healthy Child Development Evaluation Framework (FNIHB, 2013h, pp. 4–6).

Regional offices play a lead role in supporting communities with program delivery, working with First Nations and Inuit partners at regional and local levels. Regional offices are also responsible for the management of contribution agreements and program performance monitoring and information roll-up. With the exception of the Northern Region, regions also support communities with program delivery and work with First Nations and Inuit partners at regional and local levels. In British Columbia, responsibilities for federal health programs have been transferred to the First Nations Health Authority through the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Health Canada, 2011a); as a result, the Pacific region is not included in the evaluation.

Northern Region and the Territories

Governance and management of the HL and HCD clusters are somewhat different in the territories. The Northern Regional office works directly with the territorial governments and with First Nations in the Yukon. In Nunavut and the Northwest Territories, the FNIHB Northern Regional office works directly with territorial governments to negotiate contribution agreements for health programming. In turn, each territory administers funds to communities and organizations such as First Nations Band Councils, health authorities, Inuit associations, and voluntary and non-profit organizations. As a result, not all HL and HCD programs are delivered in the Northern Region, including MCH, AHSOR, and dental therapy and therefore, only those programs provided were included in this evaluation.

First Nations and Inuit Partners

FNIHB's Senior Management Committee, which is the main decision-making forum for the Branch on issues such as those related to policy development and priority setting, includes representation from national office and regional office senior management, as well as from the Assembly of First Nations (AFN) and the Inuit Tapiriit Kanatami (ITK), and from other branches of Health Canada. Regional offices collaborate with regional Aboriginal organizations and Health Canada senior management to determine and review regional priorities in the context of national priorities and to establish strategies to address regional needs. The HL and HCD clusters also collaborate with national and regional Aboriginal organizations, as well as with other stakeholders (e.g., Aboriginal Affairs and Northern Development Canada and the Public Health Agency of Canada [PHAC]), to lead or participate in advisory boards to ensure that stakeholders are represented in decision making for programs and services.

Advisory bodies consisting of representatives of regional First Nations and Inuit may also provide support to regions in the form of program guidance and/or co-management.

Communities and/or Tribal Councils are funded through contribution agreements to provide the HL and HCD programs to their community members. Communities support the implementation and delivery of programs through hiring and managing of community program staff, providing office space and program resources to staff, and working with regional offices to provide training for staff. In addition, communities may modify programming to meet their specific health priorities and needs to include cultural adaptations.

2.2 Program Resources

HL had an estimated financial allocation of \$185 million over the 2010-2011 to 2012-2013 period and actual expenditures of \$172.96 million. HCD had an estimated financial allocation of \$608.8 million over the 2008-2009 to 2012-2013 period and actual expenditures of \$547.5 million.

2.3 Program Logic Model and Narrative

The long-term expected outcome for the HL and HCD clusters is that First Nations and Inuit communities, families, and individuals receive services that are responsive to their needs so as to improve First Nations and Inuit health status. The activity areas, outputs, and immediate and intermediate outcomes for achieving this long-term outcome are organized around five theme areas of: stakeholder engagement and collaboration; capacity building; data collection, research, and surveillance; policy development and knowledge-sharing; and service provision.

Each theme area has related outputs and an identified audience that each output is expected to reach, which are then expected to lead to immediate outcomes. Expected immediate outcomes include the following:

- improved community and stakeholder engagement and collaborations to support policy/program development and service delivery;
- increased community capacity (knowledge, skills, and ability) to support community-based HL and HCD programs and services³;
- increased ability to collect, monitor, and provide information for policy or program development and implementation;
- increased use of tools and evidence-based information (e.g., promising practices) to inform policy and program delivery and improvement;
- ongoing access to HL and HCD programs/services⁴; and
- increased individual knowledge of HL and HCD issues and practices.

The following intermediate outcomes should then flow from immediate outcomes:

- improved coordination and integration of HL and HCD programs and services;
- improved quality of HL and HCD programs and services;
- increased healthy behaviours; and
- increased supportive physical and social environments.

The connection between the activity areas and the expected outcomes is depicted in the logic model. The evaluation assessed the achievement of the expected outcomes and whether there were any challenges and/or barriers to achieving the expected outcomes over the evaluation time

³ PAA refers to the departmental Program Activity Architecture and supports Expected Result #2: Increased Community Capacity

⁴ PAA refers to the departmental Program Activity Architecture and supports Expected Result #1: Ongoing Access to Appropriate Programs and Services

frame. A description of the logic model is provided in Appendix 3. Some outcomes are linked to the Department PAA and are linked within the document using PAA-ER (program activity architecture - expected result).

2.4 Program Alignment

FNIHB's authority for funding programs and services is based on the programs articulated in the Program Alignment Architecture (PAA). FNIHB's current PAA identifies three programs, including one for Primary Health Care. Three sub-programs are offered under Primary Health Care, with the HL and HCD clusters offered as sub-sub-activities of the sub-program Health Promotion and Disease Prevention. Health Promotion and Disease Prevention funds and supports a suite of community-based programs, services, initiatives, and strategies that collectively aim to reduce the disparities and improve the health outcomes of First Nations and Inuit individuals, families, and communities.

Activities and priorities are established by recipients and are funded through contribution agreements (FNIHB, 2013h, p. 65). The various programs and their related services and activities are expected to contribute to the PAA Strategic Outcome 3 that First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status. At the time of the evaluation, Dental Therapy had been placed under the Primary Care sub-activity within Clinical and Client Care, and the FASD program placed under the Mental Wellness sub-sub-activity. Both are included within the scope of the evaluation under HL and HCD, given their positioning for the timeframe of the evaluation respectively.

3.0 Evaluation Description

3.1 Evaluation Scope, Approach, and Design

The evaluation questions for this evaluation were aligned with the Treasury Board of Canada *Policy on Evaluation* (2009) and considered the five core issues under the two themes of relevance and performance, as shown in Appendix 4. An evaluation matrix with questions and indicators corresponding to each of the core issues guided the evaluation process.

An outcome-based evaluation approach was used for the conduct of the evaluation to assess the progress made towards the achievement of the expected outcomes and whether there were any challenges and/or barriers to achieving the expected outcomes. A non-experimental design was used based on the Evaluation Framework document, which detailed the evaluation strategy and provided consistency in the collection of data to support the evaluation.

The evaluation was designed to gather information across all programs in both clusters in order to support the FNIHB 2015 renewal of programs. As such, the findings are presented at an aggregate level representing both clusters.

The evaluation, covering two clusters with multiple programs and components under each cluster, is complex and included a multitude of performance indicators. The evaluation relied substantially on stakeholder perception of achievement of outcomes which meant there were large number of issues to explore through surveys, interviews, and focus groups. As well, a cluster evaluation of eight programs/initiatives and several policy areas translated into a large number of topics to explore and a large pool of stakeholders to reach for input. Surveys, interview guides, and focus group moderator guides were tailored to each specific group of stakeholders in order to streamline the process as much as possible. Additionally, adjunct questionnaires were used in focus groups to expand the data gathering potential of focus groups. Health Canada organized and provided relevant documents for review and identified a broad range of key stakeholders for interviews to ensure coverage of all programs. In some cases, selected stakeholders could speak on more than one program.

Data for the evaluation was collected⁵ using various methods including a document and data review, literature review, site visits and key stakeholder interviews (more specific detail on the data collection and analysis methods is provided in Appendix 3). Data were analyzed by triangulating information gathered from the different methods listed above. The use of multiple lines of evidence and triangulation were intended to increase the reliability and credibility of the evaluation findings and conclusions.

Site visits to First Nations communities were selected to capture the broad spectrum of programs in both clusters. Findings and examples provided reflect the perspectives of the communities and individuals who participated but did not reflect or represent all First Nations and Inuit communities. Attempts were made to ensure that the communities chosen provided a sample of regions, overall community size structure, isolation level, and types of funding agreements. HL and HCD programs are provided in many small, remote and/or isolated communities however; given the limited number of site visits in these communities, not all findings or conclusions apply equally across all communities, regardless of geographic location.

Key stakeholder interviews were based on open-ended questions where respondents were not generally asked yes or no questions but, rather, asked to provide a considered response to a set of questions based on their knowledge and observations. The primary purpose of qualitative key stakeholder interviews was to gain insight into a process or problem, and, as such, they are not conducive to counting up responses. However, to provide some context to responses, the following descriptive scale is used to report on some aspects of key stakeholder interviews, with “a few” being approximately 10–15% or less of respondents, “some” being more than 15% to approximately 40%, “many” being more than 40% to approximately 60%, “most” being more than 60% to approximately 80%, and “almost all” being over 80%.

⁵ Data collection, use, disclosure, retention and disposal of personal information as well as the sharing of the report and research and surveillance (s. 2.3, p. 4) was/is done so in accordance with applicable privacy legislation, regulations and policies (e.g., *Access to Information Act, Privacy Act, Library and Archives of Canada Act*, and Government Security Policy). In addition, where aggregated and non-aggregated information and client information is collected, used and disclosed aggregated information is not re-identifiable and non-aggregated information is dealt with in accordance with applicable privacy legislation, regulation and policies.

National and regional staff input was collected using an online survey. Additional national and regional FNIHB staff who did not participate in a key stakeholder interview were included in the on-line survey. FNIHB staff with some involvement in the HL and HCD programs were provided an opportunity to input into the evaluation, either through the key stakeholder interviews or the staff survey. Health Canada provided email addresses for 22 national staff members and 46 regional staff members for the online staff survey. The survey received an overall response of 82% for national office staff and 63% for regional office staff.

British Columbia was not included in this evaluation. Responsibilities for First Nations health programs have been transferred to the First Nations Health Authority through the British Columbia Tripartite Framework Agreement on First Nations Health Governance (Health Canada, 2011a).

3.2 Limitations and Mitigation Strategies

Most evaluations face constraints that may have implications for the validity and reliability of evaluation findings and conclusions.

Table 1 outlines the limitations encountered during the implementation of the selected methods for this evaluation. Also noted are the mitigation strategies put in place to ensure that the evaluation findings can be used with confidence to guide program planning and decision making.

Table 1: Limitations and Mitigation Strategies

Limitation	Impact	Mitigation Strategy
The evaluation did not have access to trend data that spanned the entire evaluation period. For example, only one year of community-based reporting template (CBRT) data was available (2011-2012), and this data did not include Ontario or Saskatchewan. Reporting on the NNC program from eligible communities was provided for 2010-2011 and 2011-2012.	Lack of data reported on annually limited the use of time series analysis on the achievement of outcomes over time.	Assessment of changes over time was primarily obtained through key stakeholder interviews, a FNIHB staff survey, and site visits to communities.
Lack of quantifiable outcome data aggregated at a regional or national level.	Much of the available data regarding the expected outcomes of the HL and HCD clusters were largely based on non-aggregated community- or region-specific studies.	While these studies could not be generalized to the HL and HCD clusters as a whole, they did present important examples of successes and challenges and could be used to illustrate how outcomes were being achieved. Outcome data was augmented through the interviews, online survey, and site visits.
A limited number of site visits were included in the evaluation methodology. The site visits obtained limited input from communities that were not able to offer all the programs.	Small site visits do not necessarily reflect the experiences of all communities across all regions.	Key stakeholder interviews were developed to access information from a broad range of communities to better understand the success, challenges and barriers facing most communities.
There is more evidence related to health disparities available for First Nations populations than for Inuit.	Comparable data between First Nations and Inuit could not be provided in most cases.	When available, the evaluation relied on comparable data from the literature review and health surveys to highlight similarities and differences in disparities.

The information provided in the following section on Findings highlights only key evidence as it relates to both the relevance and performance of the HL and HCD clusters.

4.0 Findings

4.1 Relevance: Issue #1 — Continued Need for the Program

4.1.1 Is there a continued need for the HL and HCD clusters?

Due to the disparities in incidence of many health issues such as diabetes and other chronic diseases and prevalence of health risk factors such as deficits in nutrition, physical activity, maternal health and food security for many First Nations and Inuit communities, there is a continued need for the HL and HCD clusters to support First Nations and Inuit communities' capacity to address the healthy living and healthy child development needs and priorities of these communities.

The evaluation, through an extensive literature and document review, found that disparities with respect to incidence of many health issues and health risk factors continue to exist for many First Nations and Inuit communities⁶. The incidence of certain risk factors associated with various diseases was found to be higher for First Nations and Inuit people than in the general Canadian population, including unhealthy weights, higher smoking rates, lower physical activity, lack of good nutrition and less food security.

Diabetes and Other Chronic Diseases

Evidence shows many examples of these disparities particularly in the area of diabetes and other chronic diseases. For example, First Nations individuals experience substantially greater prevalence of diabetes and the incidence of other chronic diseases is higher in Aboriginal populations compared to the general Canadian population, including in children. Compared to the general population, First Nations individuals experience substantially greater prevalence of diabetes, with estimates of incidence ranging from two to five times that of the general Canadian population (Harris et al., 2011, p. 272; Office of the Auditor General of Canada, 2013, p. 8). In the most recent First Nations Longitudinal Regional Health Survey (RHS) (2008-2010) approximately 16% of First Nations adults on-reserve indicated having diabetes, and approximately 81% of these reported they were diagnosed with Type 2 diabetes (FNIGC, 2012, p. 131). The age standardized prevalence of diabetes in First Nations adults aged 25 and over was found to be unchanged between the 2002-2003 and 2008-2010 RHS at 20.1% and 20.7%, respectively (FNIGC, 2012, p. 126).

⁶ It should be noted that there is more evidence available on First Nations populations than for Inuit, particularly in the areas of health issues such as the incidence and prevalence of chronic diseases.

These same studies showed that, compared to the general Canadian population, Aboriginal people tend to be diagnosed with diabetes at a younger age, and experience a greater rate of complications such as nephropathy, blindness, and high blood pressure; have more risk factors associated with the disease, such as low physical activity, alcohol misuse, and unhealthy eating; and, face significant challenges such as low income and high unemployment, which are factors associated with diabetes.

Chronic respiratory diseases (particularly tuberculosis, asthma, and respiratory tract infections) have risen in prevalence among Aboriginal Canadians, especially children (Reading, 2009, pp. 11–16). Of the 1,686 new active and re-treatment tuberculosis cases reported in 2012, 23% occurred in Aboriginal people, compared to 10% in Canadian-born, non-Aboriginal people (PHAC, 2014).⁷ Tuberculosis rates are higher among First Nations children living on-reserve, and bronchitis rates have been estimated at more than twice the national average (Crengle et al., 2009, p. 31). Respiratory disease has remained the leading cause of Aboriginal infant mortality for decades (Boggild, Yuan, Low, & McGeer, 2011, p. 345; Reading, 2009, p. 11). Inuit children have the world's highest rate of hospitalization for lower respiratory tract infections: an average of 306 admissions per 1,000 infants, and over 800 per 1,000 for infants with heart defects (Egeland, Faraj, & Osborne, 2010, p. 8; Lauson et al., 2011, p. 365).

Physical Activity, Obesity, and Other Risk Factors

While relatively little information was found on patterns of physical activity among Aboriginal peoples in Canada (Young & Katzmarzyk, 2007, p. 149), according to self-reported information from the 2008-2010 RHS, 46% of First Nations adults were considered inactive, 28% moderately active, and 25% active, with the proportion of active men (33%) almost twice as high as that of women (17%) (FNIGC, 2012, p. 71). Comparatively, 52% of Canadian adults are considered active (Statistics Canada, 2008-2010). In the 2008-2010 RHS, a majority of First Nations children (62%) aged 6–11 were considered active, while 20% were considered moderately active, and 18% inactive (FNIGC, 2012, p. 359). Similar data was not available for the same age group in the general population.

In the 2008-2010 RHS, 62% of First Nations children aged 2–11 were considered overweight or obese, although the proportion of children overweight or obese fell to 43% for youth over 11 years of age (FNIGC, 2012, pp. 242, 278, 359, 365). The 2007-2008 Inuit Health Survey found that, among Inuit children aged 3–5 years, 24% of boys were considered overweight and a further 42% were considered “at risk for overweight,” while 30% of girls were considered overweight and 38% were “at risk” (Egeland & Quanuipitali Steering Committee, 2009, p. 10). While comparative figures for the general Canadian population are not available for the age groups above, 26% of all Canadian children and youth aged 2–17 were reportedly overweight or obese in 2004 (FNIGC, 2012, p. 360).

⁷ The majority of tuberculosis cases (64%) occurred in foreign-born individuals.

Further evidence reveals that smoking rates are higher in First Nations communities as well. The 2008-2010 RHS found that the prevalence of smoking in First Nations communities was 56.9%, including both daily smokers (43.2%) and occasional smokers (13.7%) (FNIGC, 2012, p. 96). In comparison, the prevalence of smoking in the general Canadian population was 20%. There were no substantial changes since the 2002-2003 RHS. According to the 2012 Aboriginal Peoples Survey, just over half (54%) of Inuit adults nationally smoke daily, which is a slight decline from the 58% found in the 2006 survey.⁸

Nutrition

Relatively little research has been conducted on the nutritional intake and habits of First Nations and Inuit children. Unfortunately, much of the research conducted, such as the 2006 Aboriginal Children's Survey (ACS) only included populations living off-reserve. However, self-reported data collected by the ACS indicated that Aboriginal children do not consume key food groups as frequently as recommended by the Canada Food Guide, particularly fruits and vegetables, and that consumption of foods high in salt, sugar, and fat was more frequent than recommended (Langlois, Findlay, & Kohen, 2013, p. 5) .

The 2008-2010 RHS data indicated that 63% of adults consumed vegetables daily and 57% consumed fruit daily (FNIGC, 2012, p. 84). Among Aboriginal children, 35% reportedly consumed vegetables several times per day, 54% multiple times per week, and 7% rarely or never, with consumption of fruit somewhat higher but generally comparable (FNIGC, 2012, p. 364). These are comparable rates with the general Canadian population (Health Canada, 2001-2012). For all age groups, eating a balanced diet, including regular consumption of fruits and vegetables, was associated with a positive overall health status (FNIGC, 2012, pp. 89-90, 365).

Finally, the First Nations Food, Nutrition, and Environment Study (FNFNES) reports for Manitoba and British Columbia compared reported consumption of food groups by adults in participating First Nations in both provinces to the recommendations in Canada's Food Guide. In both studies, consumption of fruits and vegetables, grain products, and milk and milk alternatives were below recommended levels by roughly half, while consumption of meat was higher than recommended levels (Assembly of First Nations, University of Northern British Columbia, & Université de Montréal, 2011, 2012).

⁸ Information provided by Health Canada; these statistics from the 2012 Aboriginal Peoples Survey are not yet publicly available.

Food Security⁹

The literature indicates that good nutrition is positively associated with overall physical, mental, and spiritual health, as well as healthy behaviours, such as physical activity, non-smoking, and supportive cultural norms such as sharing and consuming traditional foods (FNIGC, 2012, p. 77) and internationally recognized as a health determinant in all populations. Conversely, food insecurity in Aboriginal households was found to be associated with higher rates of poor physical and mental health, stress, unhealthy behaviours, and weak community bonds, although the causal relationships between these factors are unknown. However, they share common determinants, notably poverty (Willows, Veugelers, Raine, & Kuhle, 2011, p. 3).

Surveys and other studies identified that food insecurity is an ongoing serious issue for many First Nations and Inuit individuals and families. From the 2008-2010 RHS, over half (54%) of First Nations households were identified as moderately or severely food-insecure (FNIGC, 2012, p. 81). The 2011-2012 Canadian Community Health Survey (CCHS) collected national data on household food insecurity and showed that for the general Canadian population in 2011-2012, 8.3% of households, or almost 1.1 million households, experienced food insecurity. Of that amount, 5.8% was reported as moderate and 2.5% was severe.

The FNFNES identified that the proportion of the on-reserve households experiencing food insecurity was 29% in Ontario, 38% in Manitoba, and 41% in British Columbia (Assembly of First Nations, Université de Montréal, & University of Ottawa, 2012; Assembly of First Nations et al., 2011; Assembly of First Nations, University of Northern British Columbia, et al., 2012). Statistics from the Canadian Community Health Survey identified that food insecurity affected 6.1% to 10.0% of overall households in the provinces, while food insecurity in the NWT was 10.2%, 11.0% in the Yukon, and 28.8% in Nunavut (Health Canada, 2012a). Statistics for Inuit households underline the challenge with food insecurity in the north, with a 2007-2008 study finding food insecurity rates of 63% in Inuit households across the Arctic (Huet, Rosol, & Egeland, 2012).

Maternal Health

While the impacts of maternal health (before and during pregnancy and while nursing) on the health of the child are well-known, relatively little data is available on specific practices, such as physical activity and nutritional choices of Aboriginal mothers (Gray-Donald et al., 2000, p. 1247). Gestational Diabetes Mellitus rates are higher in First Nations women.

Adverse birth outcomes, such as low birth weight and prematurity, are associated with maternal smoking during and prior to pregnancy for all populations. Rates of smoking during pregnancy are high in First Nations and Inuit communities, with sources reporting close to half (47%) of

⁹ The WHO's World Food Summit of 1996 defined food security as existing "when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life".

First Nations women and over 80% of Nunavut women smoked during pregnancy (Health Canada, 2013b, p. 21; Lauson et al., 2011, p. 365). A survey of the general Canadian population found 10.5% of women had smoked during pregnancy, with an average of seven cigarettes per day (Al-Sahab, Saqib, Hauser, & Tamim, 2010, p. 3).

Epidemiological and public health data on breastfeeding have emphasized the benefits of breastfeeding, including improved nutrition and disease resistance for breastfed infants. The 2002-2003 RHS found 62.5% of First Nations children overall were breastfed, with this number dropping only slightly to 60.2% in the 2008-2010 RHS (FNIGC, 2012, p. 411). In comparison, the 2008 Canadian Community Health Survey (CCHS) found that 88% of children in the general Canadian population were breastfed (International Indigenous Health and Social Justice Research Group, 2011, p. 18). Inuit mothers were found to initiate breastfeeding at a rate only slightly below the general Canadian population (at a rate of approximately 81%), and Inuit mothers have been found to sustain breastfeeding longer (Egeland et al., 2010, pp. 7–8).

First Nations and Inuit communities have been found to experience higher rates of premature births, high birth weights, infant mortality, and Sudden Infant Death Syndrome, which may be related to maternal health, environment, and lifestyle habits. A recent study had found Sudden Infant Death Syndrome rates twelve times higher in Inuit populations than non-Inuit (Crengle et al., 2009, p. 31). One study in British Columbia found that the rate of premature births was 84% higher in rural First Nations compared to rural non-First Nations and 57% higher in urban First Nations compared to urban non-First Nations (Luo et al., 2004, p. 1255).

Oral Health

Early childhood caries (ECC) is defined as the presence of one or more decayed, missing (due to caries) or filled tooth surfaces in any primary tooth in a preschool-aged child.¹⁰ In urban areas of Canada, the prevalence of ECC in preschool children is 6% to 8%.¹¹

Disproportionate numbers of Aboriginal children suffer from dental decay relative to the non-First Nation and Inuit population. The 2009–2010 First Nations Oral Health Survey found that 86% of children aged 3–5 years had experienced one or more cavities, and 61% of preschool children had untreated decay in their primary teeth (FNIGC, n.d., p. 20). Further, the prevalence of caries (tooth decay causing a cavity) was shown to be highest (99%) for children in lowest-income households (<\$20,000) and remained high (70%) for households with at least \$20,000 in annual income, indicating that poverty is a significant determinant of oral health. There are no comparative studies in the general Canadian population. Other factors that could affect oral health could include the availability of fluoride in drinkable water and overall dietary habits.

¹⁰ Canadian Dental Association. Report on early childhood caries, April 2010. http://www.jcda.ca/uploads/pdf/ccsa/ECC-Report-FINAL-April-2010_for-jcda-website.pdf (Accessed November 26, 2012).

¹¹ Locker D, Matear D; Community Health Services Research Unit, Faculty of Dentistry, University of Toronto. Oral disorders, systemic health, well-being and the quality of life: A summary of recent research evidence. 2000: http://www.utoronto.ca/dentistry/facultyresearch/dri/cdhsru/health_measurement/7.%20%20No%2017.pdf (Accessed November 26, 2012).

The Inuit Oral Health Survey, conducted in 2008-2009, found that 85% of children aged 3–5 had experienced at least one cavity, for an average of 8.22 decayed, missing, or filled teeth per child (Health Canada, Nunavut Tunngavik Incorporated, Nunatsiavut Government, Inuvialuit Regional Corporation, & ITK, 2011, p. 17).

The First Nations Oral Health Survey (2009-2010) found that 40% of adolescents and adults rated their own oral health as fair or poor, and 49% reported they had found it uncomfortable to eat food at some time during the previous 12 months because of issues with their mouth (FNIGC, n.d., p. 15). Finally, the Inuit Oral Health Survey found that 41% of young adults reported poor oral health, and 30% of respondents reported they had avoided food due to issues with their mouth (Health Canada et al., 2011, p. 16).

4.2 Relevance: Issue #2 — Alignment with Federal Roles and Responsibilities

4.2.1 Do the HL and HCD cluster align with Federal Roles and Responsibilities?

Various legislative authorities and federal policies identify that the federal government has jurisdiction, responsibilities and/or goals regarding Aboriginal health care services, and, in particular, health care of First Nations on-reserve and certain Inuit.

The federal government has a clear legislated mandate in addressing these needs. Key pieces of legislation, including the *Constitution Act, 1867* and the *Indian Act, 1876*, identify jurisdictional responsibilities regarding Aboriginal health care services. Federal policies, such as the Indian Health Policy and the Indian Health Transfer Policy, outline the goals of the federal government with respect to Aboriginal health (National Collaborating Centre for Aboriginal Health, 2011). In addition, the *Canada Health Act, 1984* outlines the intent of Canadian health care policy in general and describes the conditions under which provincial and territorial governments qualify for the Canada Health Transfer.

The *Constitution Act, 1867* does not explicitly include “health” as a legislative power assigned either to Parliament (in section 91) or to the provincial legislatures (in section 92). Nonetheless, the Courts have confirmed that most aspects of the regulation of health care are within provincial jurisdiction. For example, provinces have extensive authority over public health as a local or private matter under s. 92(16) of the *Constitution Act, 1867*; over the regulation of medical professions as matters of property and civil rights under s. 92(13); and over hospitals under s. 92(7).

The federal government has the power to enact legislation in relation to certain health related matters which are ancillary to other federal powers including the federal spending power (e.g., *Canada Health Act*) and the criminal law power (e.g., drugs, tobacco and hazardous product laws). In addition, the federal government has power to enact health legislation based on its “peace, order and good government” powers under s. 91 of the *Constitution Act, 1867* (e.g., laws

pertaining to quarantine and national emergencies). These laws would apply to First Nations on or off reserve and Inuit. Additionally, the federal government may legislate in relation to First Nations and Inuit as a result of its jurisdiction over “Indians, and Land reserved for the Indians” in s. 91(24) of the *Constitution Act, 1867*.

Having “jurisdiction” to legislate means the federal government has the authority to legislate but it does not mandate the federal government to exercise that jurisdiction and enact legislation. To date, there is no health legislation enacted based on s. 91(24) powers.

There is no specific statutory authority for the provision of health care programs and services to First Nations and Inuit by the Minister of Health.

In absence of specific statutory authority, legal authority for the provision of health care programs and services by the Minister of Health to First Nations and Inuit is found in the following. Section 4 of the *Department of Health Act* provides for the general powers, duties and functions of the Minister which extend to and include all matters relating to the promotion and preservation of the health of the people of Canada over which Parliament has jurisdiction. The specific health care programs and services provided or funded by FNIHB are approved annually by means of the *Appropriations Act* which grants Parliamentary approval to the Minister for the budgets and objectives of FNIHB. Treasury Board provides authority for specific program activities.

These federal laws provide the authority by which the Minister of Health provides or funds the programs and services without however defining the mandate. In absence of any clear statutory authority which describes and defines the mandate of the programs and services, Health Canada through FNIHB provides or funds health programs and services to First Nations and Inuit based on subsequent Departmental mission and mandate statements and on policy in a manner intended to be consistent with the 1979 Indian Health Policy and as such, are subject to the discretion of the government.

The 1979 Indian Health Policy is based on the three pillars of community development; the traditional relationship of the “Indian people” to the federal government; and a single interrelated Canadian health system, consisting of federal, provincial and community-based elements.

The Indian Health Policy was adopted on September 19, 1979, during a period of transition for FNIHB. Previously, FNIHB had more involvement in providing direct health care services to First Nations and Inuit communities. However, FNIHB began shifting toward helping communities gain more direct control over community-based health services. The Policy aims to improve the health status in First Nations and Inuit communities “through mechanisms generated and maintained by the communities themselves” (National Collaborating Centre for Aboriginal Health, 2011, p. 23). The Indian Health Policy (1979) also recognizes the interdependent nature of the Canadian Health system and identifies that two of the most significant federal roles are in public health activities on reserves and health promotion (Health Canada, 2014).

The Policy describes the importance of reinforcing relationships between multiple levels of government and increasing the capacity of Aboriginal communities to “play a positive and active role within the Canadian health care system” (National Collaborating Centre for Aboriginal Health, 2011, p. 23). As a result of the policy, the federal government no longer directly provides services to First Nations people in the Northwest Territories, nor to the four Inuit regions: in Nunavut, the Inuvialuit Regional Settlement in the Northwest Territories, Nunavik in Quebec, and Nunatsiavut in Newfoundland and Labrador. Instead, federal government funding flows through transfer agreements with territorial governments and self-governments/land claim agreements.

Further, the *Canada Health Act* (Section 3) states that Canadian health care policies are intended to ensure the physical and mental well-being of Canada’s residents, and to facilitate reasonable access to health care (Government of Canada, 1984). These objectives support the HL and HCD clusters, which have very similar objectives.

The *Indian Act, 1876* describes various authorities and jurisdictions related to Aboriginal health (Government of Canada, 1876). The Act states that the federal government may use reserve lands for Indian health projects, provided they obtain the consent of Band Councils (Section 18(2)). The Act states that the Governor in Council can regulate the provision of health services and medical treatment for Indians (Section 73(1)[g]). However, such regulations do not exist. Band Councils are given the authority to create bylaws regarding the provision of health services for people who live on-reserve (Section 81(1)[a]). The *Indian Act* does not apply to Inuit.

4.3 Relevance: Issue #3 — Alignment with Government Priorities

Increasing access to health care and addressing the health status inequalities affecting First Nations and Inuit communities are priorities of the federal government and FNIHB, as is increased First Nations and Inuit control of health resources (e.g., programmatic and financial resources) within their communities.

4.3.1 Do the HL and HCD clusters align with Government of Canada priorities?

The HL and HCD clusters aligned closely with Government of Canada priorities. Specifically, the clusters are aligned with Health Canada Organizational Priority 3 to strengthen First Nations and Inuit health programming (Health Canada, 2013e, p. 6). Health Canada created this priority to help address the ongoing health-related challenges experienced by First Nations people and the Inuit. Through this priority, the federal government aims to increase access to health care; increase quality of care; collaborate with provincial/territorial authorities to deliver services; improve the integration of health services; facilitate data collection and health surveillance; and increase the control of health care service development and delivery by First Nations people and the Inuit.

The HL and HCD clusters are aligned with three of FNIHB's four current priorities, including the transfer of 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; and establish a renewed relationship with First Nations people and the Inuit (FNIHB, 2012d).

Regarding the first priority, the 1988 Indian Health Transfer Policy provided a framework for the assumption of control of health services by First Nations people and set forth a developmental approach to health funding transfer centred on the concept of self-determination in health. Through this process, the decision to enter into transfer discussions with Health Canada rests with each community. Once involved in transfer, communities are able to take control of health program responsibilities at a pace determined by their individual circumstances and health management capabilities. Transfer of health services, which is entirely optional, includes three phases: Pre-Transfer Planning, Bridging, and Transfer Implementation. The process is designed to occur within the present funding base of federal health programs for First Nations and Inuit, and First Nation and Inuit communities are required to provide certain mandatory programs such as communicable disease control, environmental and occupational health and safety programs, and treatment services.¹²

The first priority above is further reflected in the capacity-building activities of the HL and HCD clusters to provide community workers with the knowledge and skills required to deliver their own HL and HCD programs. This priority is reflected in the flexibility communities have in tailoring their programs to their community needs and in the transition from Set Contribution Agreements to Flexible Funding Model contribution agreements. With the Flexible Funding Model contribution agreements, recipients are able to establish their own health plan or work plans and are able to reallocate funds within the same Program Authority without approval of the Minister (FNIHB, 2013g, p. 16).

The HL and HCD clusters address the second priority identified above through the various contribution agreements, which provide the funding for community-based health care programs and services. In the provinces, contribution agreements typically are established with Band Councils, Tribal Councils, health authorities, and Aboriginal organizations. For Nunavut and the NWT, the territorial governments receive the funds, which are then incorporated into the health programs of those territories (FNIHB, 2013h, p. 9)¹³. This priority is addressed through the research, knowledge development, and policy work that FNIHB undertakes.

Finally, the third priority is reflected in the stakeholder engagement and collaboration activities of the HL and HCD clusters, including consultations, agreements, joint projects, and the formation of committees and working groups.

¹² Information provided by Health Canada.

¹³ For the Yukon, communities work directly with HC's Northern Region.

Furthermore, the 2010 federal budget prioritized improving access to nutritious food for northerners by announcing \$45 million in funding for a new program (which led to the launch of the NNC, including a new component on nutrition education initiatives led by Health Canada). Combining the new funding with existing funding provided \$60 million annually for programming intended to reduce transportation costs of nutritious foods for northerners and encourage healthy eating habits (Government of Canada, 2010, p. 132).

4.3.2 Do the HL and HCD clusters align with departmental strategic outcomes?

The HL and HCD clusters are most closely aligned with Health Canada's Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status (Health Canada, 2013e, p. 41). Both of the clusters link to this Strategic Outcome through the First Nations and Inuit Primary Health Care program (3.1) and the Health Promotion and Disease Prevention sub-program (3.1.1).¹⁴

The HL and HCD clusters aligned with the strategic goals of FNIHB's Strategic Plan (FNIHB, 2012c, pp. 11–18). These included Strategic Goal 1: High Quality Health Services, including a focus on improving access to and quality of health care services, building regional capacity to deliver services, and increasing the health and well-being of individuals, families, and communities; Strategic Goal 2: Collaborative Planning and Relationships, especially regarding increasing First Nations and Inuit control and management of health-related programs and services; and Strategic Goal 3: Effective and Efficient Performance, including increasing the availability of data to support decision making and the development of new service delivery models.

4.4 Performance: Issue #4 — Achievement of Expected Outcomes (Effectiveness)

Overall, considerable progress has been made to meet the intended outcomes of the programs within the Healthy Living and Healthy Child Development clusters, however, attention is still needed to ensure further progress is made at the program level and to ensure that advances continue to improve the health status of First Nations and Inuit.

¹⁴ As articulated in FNIHB's PAA. The HCD and HL clusters are sub-sub-programs under 3.1.1 (denoted as 3.1.1.1 and 3.1.1.3, respectively) (FNIHB, 2013h, p. 64). Primary health care, as part of Program 3.1, includes "health promotion and disease prevention, public health protection (including surveillance), and primary care (where individuals are provided diagnostic, curative, rehabilitative, supportive, palliative/end-of-life care, and referral services)" (Health Canada, 2013e, p. 41). These activities are closely related to those undertaken within the HL and HCD clusters.

4.4.1 To What Extent Have the Immediate Outcomes Been Achieved?

Immediate Outcome #1: Improved community and stakeholder engagement and collaborations to support policy/program development and service delivery.

Community and stakeholder engagement and collaboration was evident at all levels and among all stakeholders. Community-level collaboration helped improve the programs and services delivered in communities. Collaboration between the national and regional offices as well as with Aboriginal organizations was difficult to sustain. This was particularly the case for HCD programs due to departmental changes in overall cluster governance and program management.

Collaborations between FNIHB National Office and Regional Stakeholders

All lines of evidence identify that engagement and collaboration were important to all stakeholders. Surveyed national office FNIHB staff (hereafter referred to as national office staff) reported they most frequently collaborated with FNIHB colleagues from national offices working in other programs, FNIHB colleagues from regions, and NAOs. Regional office FNIHB staff (hereafter referred to as regional office staff) most frequently collaborated with community workers, FNIHB colleagues from their region, community health directors, Tribal Councils, Regional Aboriginal Organizations, other federal departments, and national FNIHB colleagues.

FNIHB staff gave many examples of collaborations between HL and HCD programs and national and regional stakeholders, and between national and regional offices. For example, at the national level, related programs often collaborated through joint committees, working groups, joint work plans, managers/directors meetings, or strategy development, as well as collaborative support to communities. Collaborations at the regional level could similarly be through joint work plans and planning sessions and strategies; joint training sessions, conferences, and workshops; establishment of interdisciplinary groups or teams; and shared resources and networking. FNIHB staff at national office and some regional offices indicated that there had been some increased efforts for collaboration over the past few years since restructuring and merging of the HL and HCD clusters into one division at national office, with greater emphasis placed on taking a less siloed approach (between programs) than what occurred in the past.

Collaborations between FNIHB and Aboriginal Organizations

FNIHB staff provided examples of collaborations and working relationships between FNIHB national office staff and NAOs, as well as between regional office staff and Regional Aboriginal Organizations, Tribal Councils, and communities. All national office staff spoke of the importance of collaborating with NAOs. Both national office staff and NAOs reported that these collaborations were to obtain NAOs' advice on matters relevant to HL and HCD; sharing information with each other on work plans, policy, and work in progress; obtaining NAO input

on development of program frameworks, resources, strategic plans, program evaluation plans, and evaluation findings; involvement in the program renewal process; and NAO inclusion on advisory groups, committees, and working groups.

Other NAOs that national office staff worked with included the National Aboriginal Diabetes Association (which has worked with the ADI to provide training and professional development to community workers and to disseminate diabetes and health information via many channels); the First Nations Information Governance Centre (FNIGC) for special analysis of the RHS; and the National Collaborating Centre for Aboriginal Health to present national children-related showcases such as in parenting and mother/father involvement.

Aboriginal Organizations provided many examples of other organizations they collaborated with for HL and HCD programming such as non-government health-related organizations (e.g., Canadian Diabetes Association), provinces/territories, regional health authorities, universities, and a few international organizations.

Collaborations between FNIHB and Other Government Departments

Other federal government departments and agencies, particularly the PHAC and Aboriginal Affairs and Northern Development Canada, were important partners for the HL and HCD programs at both the national and regional level. Interviewed and surveyed regional office staff were generally positive about their collaborations with provincial government departments, with 66% (n=19)¹⁵ of regional office staff saying they worked with provincial government departments at least sometimes (14%, n=4 frequently; 52%, n=15 sometimes). Some FNIHB staff indicated that these collaborative efforts were good, and some believed these had been improving in recent years. Regional office staff gave examples of other organizations they worked with through the HL and HCD programs, such as health authorities, universities for training purposes, or Non-government Organizations (NGO)s for programming purposes. Of surveyed regional office staff, 45% (n=13) reported they worked with regional health authorities sometimes, and 42% reported they worked with universities at least sometimes (7%, n=2 frequently; 35%, n=10 sometimes).¹⁶

¹⁵ Due to the small sample sizes for the national and regional office staff surveys, the number (n) of respondents that percentages represent are also provided.

¹⁶ No regional office staff survey respondents reported they worked with regional health authorities frequently.

Collaborations Supporting Policy and Program Development, Service Delivery

It is important to note that from the program logic model narrative, collaborations at the FNIHB national and regional office level were expected to contribute to policy and program development and service delivery and other benefits (FNIHB, 2013h, p. 8). Several interviewed national and regional office staff spoke of how collaborations with Aboriginal partners assisted in identifying Aboriginal organizations' priorities, needs, and concerns, which then informed policy and programs.

Representatives of several Aboriginal organizations indicated that these collaborations provided them an opportunity to raise awareness of First Nations and Inuit issues and to identify gaps in service. These collaborations subsequently contributed to program policy, that is, policies that inform or direct how program services and initiatives are funded. A few regional office staff noted that collaborations contributed towards developing region-specific policies and procedures, including those at the community level. A few national office staff observed that such efforts contributed to the program renewal process by identifying how well programs worked and by identifying areas for improvements.

The majority of surveyed national and regional office staff indicated their collaborations have facilitated, to a large or moderate extent, a wide range of attributes that served to strengthen the HL and HCD programs, such as program planning and development, program delivery, coordination, and integration, information or knowledge sharing, and relationship building. Collaborations were considered to have a large or moderate impact on facilitation in the areas of policy planning and development, joint projects or research, and sharing of research or study results by national office staff, and in the areas of program implementation, capacity building planning, and training delivery by regional office staff.

However, staff reductions due to the Deficit reduction action plan 2012-2013 and Budget 2010, as well as the restructuring of the former Chronic Disease and Injury Prevention and Children and Youth (CY) divisions into the merged Health Promotion-Disease Prevention (HPDP) division, were identified as affecting the ability to collaborate both within FNIHB and between FNIHB and other organizations, particularly for the HCD programs. Reduced communication and direction from national office for the HCD programs led to several identified impacts including a perceived lack of guidance, support, and leadership; a need for more regional prioritizing; and the potential for loss of consistency in programming between regions.

FNIHB national office staff and NAOs indicated that while collaborative efforts were good in the past, these had declined for both HL and HCD programming, and particularly for the HCD cluster, not only as a result of budget cuts to FNIHB, but also due to reductions in contribution agreement funding to Assembly of First Nations and ITK. As a result, meetings and other partnerships and initiatives between FNIHB national office staff and NAOs had been less frequent, although there had been recent efforts to strengthen relationships. Another concern expressed by NAOs was that when not engaged in a timely manner, they did not have sufficient time to review and offer input on materials provided by FNIHB

Collaboration at the Community Level

Collaborations were viewed as integral components of the programs as reported by health directors and community staff participating in the site visits conducted for this evaluation. Regional office staff observed that communities were establishing partnerships and collaborations, with 55% of survey respondents believing that all (10%, n=3) or most (45%, n=13) communities had established partnerships with stakeholders either within or outside their community for their HL and HCD programs. As well, 38% (n=11) of regional office staff indicated that some communities had established such partnerships.

Some community staff reported that their collaborations were a necessity, or that their health centre worked in a collaborative-team basis, with all programs interconnected. Furthermore, of the community staff that completed the questionnaire administered during focus groups, the majority (61%) of respondents reported that these collaborations had increased over the past five years or so, and 87% agreed or strongly agreed that collaborations had helped to strengthen and improve their HL and HCD services and activities.

Community staff provided many examples of the collaborations that took place within their community, both among the HL and HCD programs, as well as with other programs and services. In particular, from the community staff questionnaire administered during focus groups, a large majority of respondents reported they worked with community health or home care nurses (79%), schools (77%), mental health or addictions workers (68%), dietitians (62%), and physicians (53%). As well, Elders played an important role in HL and HCD programs, with 62% of staff identifying involving Elders in their programs.

Regional office staff gave examples of how communities themselves worked with other organizations, such as regional health authorities or universities and NGOs, with a few believing that these types of collaborations had been increasing. A few regional office staff indicated that such collaborations depended on the communities, with some communities having greater capacity for reaching out to work with their Regional Health Authority or with researchers from universities.

Many reported benefits resulted from collaborations at the community level, such as cost-sharing, resource pooling, increased reach, idea and knowledge-sharing, service planning for clients, gaining the trust and respect of clients, community event planning, linking clients with appropriate services, and preventing duplication of effort. As well, collaboration between programs was viewed as drawing on the knowledge of not only program staff, but that of staff from other services, as well as other community members such as Elders and parents, which enhanced and strengthened programming.

Community staff collaborated with organizations and groups outside of their communities, most commonly FNIHB staff (60%), provincial governments and departments (52%), Regional Health Authorities (47%), and Aboriginal organizations (50%). Collaboration with FNIHB included various types of support for programming such as access to specialists, tools and information resources, work planning, and access to training. Collaborations with other external organizations assisted with service delivery within communities through visits by external service providers into the community, referring and linking clients with outside services, sharing client information to facilitate continuity of services, information and knowledge-sharing, and participation in committees and working groups.

Challenges

The most common collaboration-related challenge identified by community staff was the time required to establish and maintain collaborations, noting that this was time taken from serving clients. Other examples of identified challenges included scheduling conflicts, potential partners were not as willing to collaborate, or clients had privacy concerns and did not want their information disclosed to a potential partner. A few health directors commented on the challenges of establishing partnerships with provincial services or Regional Health Authority for providing services within their community.

Yet most health directors and community staff appeared satisfied with their community's involvement in decision making for their HL and HCD programs, reporting that communities had the flexibility for planning their programs and making decisions based on community needs and priorities. Some community staff indicated they did most of the planning for their program, which would be reviewed and approved by the health director, or that communities planned their programs collaboratively through a formal planning process. Program planning considered the communities' long-term planning, for example a five-year health plan, and included some form of community input.

Immediate Outcome #2: Increased community capacity (knowledge, skills, and ability) to support community-based HCD and HL programs and services (PAA ER2).

Capacity-building opportunities were widely viewed as providing community workers with the knowledge and skills to support program delivery. Community staff reported a high level of satisfaction in the amount of learning opportunities. However, regions and communities identified challenges with providing and attending training and the evaluation identified that training opportunities did not appear to be consistent across all communities and/or programs.

Capacity-building Opportunities for Community Staff

Training, continuing education, and professional development opportunities were identified by community staff as important for enhancing the knowledge, skills, and abilities of community staff for delivering HL and HCD programs. Health directors reported on the importance of learning opportunities for staff from the HL and HCD programs. Health directors reported that

learning opportunities were important to community workers for acquiring any needed skills, furthering education, maintaining licences, updating skills, and addressing any gaps in knowledge that were relevant to meeting community needs. FNIHB national staff identified that the benefits of hiring workers from within communities included: workers had specific knowledge of and connections to the community; and, workers often had a desire to remain in their home community. These frequently led to increased staff retention. Therefore, provision of training and educational opportunities was important for building capacity in programs and communities.

Learning opportunities were supported through the HL and HCD programs in a variety of formats, ranging from conferences, seminars, or workshops to more formal and longer-term programs that result in a certificate or diploma, as identified in the document review. Community workers accessed other types of training and learning opportunities with support from their community. Health Canada support to communities for capacity building was primarily at the regional level, with many regional office staff identifying how their region would facilitate access to post-secondary training for ADI or AHSOR workers, as well as other orientation or continuing education such as annual training activities or events tailored to address specific issues, with activities dependent on identified needs.

Participation in Capacity-building Opportunities

Some health directors were positive about the skills and ability of their staff members, observing that staff had made efforts to further their education and that many of their staff had some form of certification or degree. Community staff who completed the staff questionnaire confirmed health directors' observations on certifications and/or degrees, with almost half (47%) reporting they had taken courses towards earning a certificate, diploma, or degree. As well, in a recent survey of ADI community workers conducted for the ADI Capacity Building Special Study, 69% reported having completed a post-secondary program, primarily certificate programs in Community Diabetes Prevention and/or Chronic Disease Prevention (FNIHB, 2014a, pp. 13&14).

As a result of the many community-based opportunities developed and provided, most community staff (89%) reported having taken part in at least one learning activity over the past few years. Besides the 47% who reported they took courses towards a certificate, diploma, or degree, community staff most frequently reported participating in a conference (71%); a short course, seminar, or workshop (70%); some type of continuing education to upgrade or maintain their skills (53%); or a multi-day short course to learn new skills (47%). As well, most (72%, n=21) regional office staff reported that half or more of the community workers in their region had participated in some type of training, continuing education, or professional development activity over the past year.

Of the Health Canada staff survey respondents, 50% (n=8) of national office staff and 62% (n=18) of regional office staff reported that community staff knowledge, skills, and abilities had increased significantly or somewhat over the past five years or so, while a substantial proportion reported they did not know (44% and 35%, respectively), as a result of the capacity-building opportunities offered to community workers.

Community staff had a variety of opportunities to participate in capacity-building exercises. For example, community staff working in the ADI area had opportunities to access post-secondary training programs for Community Diabetes Prevention Workers, with most leading to a certificate or diploma (Aboriginal Diabetes Initiative, 2012). Other programs that had developed core competencies or standards for guiding training include MCH, FASD, CPNP-FNIC, and COHI (FNIHB, 2005, 2009b, 2013c, pp. 14-16; “Maternal child health program: Program guidelines,” n.d., p. 21). Dental therapists had a defined scope of practice that outlined the competencies obtained through their training from the National School of Dental Therapy (FNIHB, n.d.-c, pp. 3-6).¹⁷ CPNP-FNIC competencies were developed by National Office and were used to inform regional training efforts such as “CPNP-101” (FNIHB, n.d.-d; Health Canada, 2008).

Post-secondary training opportunities were available for staff working in the ADI and, in some cases, the AHSOR program. Post-secondary training was available in the past for dental therapy. Regions collaborated with post-secondary institutions to offer ADI workers opportunities for training towards a certificate or diploma. Training in early childhood education was viewed as advantageous for the AHSOR program, and workers often obtained support through the HCD cluster to access such training. Dental therapists completed a two-year program from the School of Dental Therapy, or, as it became after 1995, the National School of Dental Therapy, which was funded through Health Canada but with funding discontinued as of June 2011 (FNIHB, n.d.-c, pp. 1-2).

Impact of Capacity-building at the Community level

Available data on the impact of capacity building was primarily found in studies or evaluations on specific initiatives or programs and sometimes within a specific geographic area, with findings generally showing that capacity-building efforts were contributing to increased knowledge and skills in community workers. For example, the ADI Capacity Building Special Study found that in comparing surveyed ADI workers with and without post-secondary training, those with post-secondary training were more likely to collaborate with health professionals such as physicians, nurses, and dietitians/nutritionists, as well as with staff from HCD programs such as CPNP-FNIC, MCH, COHI, and AHSOR (FNIHB, 2014a, p. 37).

All regional office staff either agreed (45%, n=13) or strongly agreed (55%, n=16) that capacity-building opportunities contributed to community staff obtaining the needed skills and knowledge for their HL and HCD programs. As well, all of these respondents either agreed (55%, n=16) or strongly agreed (45%, n=13) that a relevant post-secondary certification provided community staff with a high level of skills and knowledge for the HL and HCD programs.

Health directors reported that staff who had utilized opportunities for training and/or certification had increased their knowledge and skill, which they could share with other staff, thus building capacity among their colleagues and community. Health directors indicated that this increased

¹⁷ Health Canada discontinued funding to the National School of Dental Therapy as of June 2011 however no training institution for dental therapy currently exists.

knowledge and skills translated into good quality programming and services to meet the needs of their community. Community staff were positive of the value of their educational activities, with almost all (87%) either agreeing (47%) or strongly agreeing (40%) that the learning opportunities they participated in over the past few years provided them with information useful to their job. Some community staff observed that learning opportunities were particularly useful for new staff starting work in an area where they had no previous background.

Some staff and a few health directors reported that learning opportunities refreshed and updated workers' knowledge and could provide incentives for staff to learn more. Furthermore, getting together with other workers provided opportunities to learn and gather new ideas and to network and develop linkages. New ideas and knowledge were then brought back to the community and used to provide improved services to clients. Some FNIHB regional staff voiced similar views on the impact of capacity-building activities, observing that training provided community workers with confidence and a greater comfort level in their area of work, which could contribute towards increased retention of staff.

Barriers to Participation in Capacity-building Opportunities

Despite the efforts made to develop and provide many learning opportunities, there were some barriers that challenged ongoing participation. For example, travelling to participate in training opportunities presented a challenge in and of itself. For example, a few community staff reported taking part in teleconferences or webinars as they could not or did not have to leave the community in order to participate. Accessing training from within the community, whether through bringing trainers in or by making increased use of telehealth and other electronic training formats, was viewed as more cost-effective than sending staff out for training. A few health directors noted they were making such efforts because training funds had been reduced.

Community staff accessed learning opportunities in a variety of formats, with 78% reporting they travelled outside their community to take part in a learning opportunity. Training within the community was important though, with 53% of community staff saying that someone visited their community to provide training and approximately one-third saying they took part by teleconference (36%) or videoconference (33%), or that someone within their community provided the training (31%). Webinars and self-directed online courses were used less frequently to participate in learning opportunities, reported by 28% and 18% of community staff, respectively.

Barriers to Building Capacity at the Community Level

All stakeholder groups, as well as a few health directors and community staff, identified retention of staff as a challenge in building community capacity. Some community staff indicated that they perceived wages as generally low, and staff with training or with particular skills may leave if a higher wage could be obtained elsewhere. Similarly, a few health directors reported workers may leave for higher wages or if they did not want to work and reside in a rural community.

Furthermore, a few community staff noted that the insecurity produced by positions that are not permanently funded or not funded year round also contributed to staff retention issues. This was reported by many national and regional office staff and most representatives of Aboriginal organizations and territorial governments. Many FNIHB staff attributed capacity building efforts with providing community staff with increased confidence and comfort in their area of work, thereby contributing to increased staff retention.

Staff turnover had cost implications for communities and Health Canada with respect to ongoing training requirements, with a few regional office staff citing the need for continual training initiatives for new employees.

Immediate Outcome #3: Increased ability to collect, monitor, and provide information for policy or program development and implementation.

FNIHB implemented some approaches to further increase the ability to collect, monitor, and provide information which supported performance measurement.

Available Data and Information

A variety of data and information exists for supporting the HL and HCD programs, with some of this data collected directly through the programs or program funding and others available through external sources including the CBRT and the Northern Outcome Reporting Template for Health (NORTH) the Regional Health Survey. Additional data was collected using the NNC reporting template, national dental database for collecting dental therapy and COHI statistics from regions. All tools collect information on project and program activities and outcomes with some qualitative data on immediate outcomes.

Other sources of data included a variety of special studies, reports, and evaluations. For example, the evaluations resulting from the Regional Renewal Project Fund (RRPF) and the Regional Evaluation and Innovation Fund (REIF) gave examples of promising projects and interventions related to diabetes and health promotion. Larger studies commissioned by FNIHB, such as the MCH and COHI studies and the previous evaluations of the Chronic Disease and Injury Prevention and Children and Youth clusters, were available. The special studies (ADI, FASD Mentoring Program, and AHSOR) presented successes and challenges of the programs, especially related to capacity building of health workers, increased community knowledge of HL and HCD issues, and changed healthy behaviours. As well, program storylines and a series of success stories highlighted the practices and achievements of individual programs and of many community-level initiatives.

A few regions, specifically Alberta and the Atlantic region, were implementing their own systems of data collection and reporting. The Atlantic Region's most recent report, *Health Status of First Nations On-Reserve in Atlantic Canada 2012*, reported on a variety of areas that were relevant to the HL and HCD programs, including populations, AHSOR, chronic disease, MCH, physical activity, COHI, and dental therapy, as well as related factors such as physical environment, education, mental and emotional health, and spiritual health (FNIHB Atlantic

Region, 2013). Alberta's *First Nations Health Status Report, Alberta Region 2011-12* reported on similar items, including demographics, maternal and child health, cancer, and health protection.

While the CBRT was first implemented in 2008-2009 and had undergone several changes since, many national and regional office staff reported issues with the CBRT as a source of data. Many regional office staff and community staff reported that communities provided their CBRT reports as a requirement of their funding agreements. As well, based on the documents received, it would appear that communities and territories were providing the required data for the NORTH report and the NNC reporting. The most common concern expressed was that the CBRT primarily collected output information and provided little information on health or behavioural outcomes, particularly for HL programs. Other perceived issues were that the CBRT did not provide a baseline for assessing progress; the information was not always accurately recorded at the community level, thereby affecting data reliability; and there was a lack of resources at the regional level for analyzing the data.¹⁸

Communities commented on the importance of collecting CBRT data to fulfill their funding requirements with a few health directors who observed that the information did provide a snapshot of the community. Territorial government representatives indicated that they were working with the FNIHB Northern Region to improve the NORTH reporting tool to provide information that was meaningful for FNIHB, territories, and communities, including more relevant outcome information.

The national dental database collected daily service records that communities completed and submitted to regional offices. However, according to key stakeholders, little analysis of this data was completed and/or reported routinely back to regions. Analysis of the data was only provided on a request-only basis.

Examples of other FNIHB-related data and information sources reported by national and regional office staff included special studies, which could provide valuable program- or topic-specific information; studies supported by FNIHB; research projects that FNIHB participated in with other partners; literature reviews; and targeted studies of projects. Key stakeholders identified other sources for providing valuable information, including the FNIGC's Longitudinal Regional Health Survey and surveys and studies conducted such as the National Collaborating Centre for Aboriginal Health Nunavut Inuit Child Oral Health survey, and the Canadian Health Survey.

It is important to note that communities indicated that they collected and used information for their own internal reporting purposes. Most client-level data that was aggregated by communities appeared to be based primarily on number of clients served or services provided, which was used for tracking trends or reporting to community leadership. Some community staff conducted client or community surveys to obtain input on information or services needed or of interest to the community.

¹⁸ Requests for additional data for this evaluation, based on an identification of informational gaps, was not fulfilled due to a lack of available (HR) expertise.

Data Collection to Support Policy or Program Development and Implementation

Surveyed national and regional office staff were asked to what extent their program(s) had sufficient access to evidence-based information to support policy and programs. In almost all cases, other than for assessing overall training and professional development needs, national office staff were more positive about having sufficient access to information with almost all national office staff reporting they had sufficient access to information.

The results of key stakeholder interviews with national office staff suggest a need for systematic evidence-based program reporting and for assessing both training and professional development needs, and for assessing the impact of capacity-building activities. The lack of capacity at the regional level for collecting, organizing, and analyzing data that was reported by some regional office staff could be a contributing factor.

Some community staff who conducted evaluations at the end of programs or workshops assessed how helpful the information was to participants and to obtain input on further needs. Staff used this information for assessing programs and planning future programs. When staff developed their annual work plans, they indicated that they may take into consideration not only longer-term community plans (e.g., a health plan) but results of surveys and evaluations as well.

Data Collection for Performance Reporting

Other than the ongoing data collection tools previously mentioned, the evaluation found minimal quantitative data for assessing the HL and HCD program outcomes, particularly immediate outcomes such as reach, participation and access to programs. One exception was the ADI which tracked the number of community workers participating in post-secondary and other training opportunities on an annual basis, and the NNC reporting tool which asked about what kind of capacity-building activities workers had participated in. Furthermore, little trend data was available at the outcome level.

Although four years of data reports were available for the Northwest Territories (and one for Nunavut and three Yukon communities), making any comparisons across years was difficult, as reporting formats had changed, and any quantifiable information was related to numbers of activities and participants. Much of the information provided was descriptive in nature, however the information was very valuable for providing context and depth.

No ongoing and regular analysis or reporting from the dental data were available for this evaluation. The COHI dental database was only able to generate output reports and it was indicated through the regional storyline report, that generating outcome reports is time consuming and resources were not dedicated to that activity (FNIHB, 2014b, p. 6). It would appear that an untapped wealth of information exists within the dental database, given the number of years of data that exist and the number of communities providing data.

Challenges in Data Collection and Performance Reporting

A main challenge in the collection and use of data identified by some national and regional office staff was in defining appropriate indicators and collecting measurable data for tracking progress in achieving outcomes. This was particularly true for collecting quantitative data to measure short-term outcomes such as reach, participation and access to programs. As well, FNIHB staff identified a lack of baseline data upon which to measure change. Some FNIHB staff indicated there had been no clear definition of what information was required or no clear method for collecting data.

Some regional office staff reported a lack of capacity at the regional level for collecting, organizing, and analyzing data and a lack of resources at the regional level for analyzing CBRT data. A few FNIHB staff identified lack of integration with provincial health care data, as well as challenges associated with privacy issues and obtaining data sharing agreements. Health Canada's 2013 report on HL and HCD evaluation planning recognizes that as regions take on increasing roles in data management, such as for departmental evaluations, regional offices would require increased expertise and capacity to support communities with data and information management (FNIHB, 2013j, pp. 41–42). Capacity was also identified as challenging for communities.

The challenges in gathering performance data suggests that the HL and HCD clusters could benefit from a review of the logic model. The logic model identifies a large number of outcomes, which makes it challenging to gather reliable evidence, particularly in consideration of the FNIHB branch budgetary constraints that have occurred over the past few years. The logic model did not clearly identify community member participation in programs as an expected outcome, yet participation was an important step between access and increased knowledge and then adoption of healthy behaviours. As well, no parameters or definitions were given around the intermediate outcomes of improved coordination and integration of programs and improved access and quality of programs.

Immediate Outcome #4: Increased use of program guidance tools and evidence-based information (e.g., promising practices) to inform policy and program delivery and improvement.

A range of guidance tools exist for community staff to develop, implement, and/or deliver the HL and HCD programs. FNIHB national office used available information to support policy and program development or improvement, while regional offices focussed their use of available information for supporting communities in program delivery. Maximizing the use of evidence-based information will result in additional program improvement.

Use of Program Guidance Tools for Program Delivery and Improvement

Community staff reported using a wide range of program guidance tools, with a high proportion of staff reporting use of Canada's Food Guide (76%) and a sizeable proportion saying they used physical activity guidelines (40%). Community staff reported use of program-specific guidance documents such as those related to ADI, AHSOR, MCH, CPNP-FNIC, NNC, and COHI. Few community staff reported they did not use any of the materials they were asked about.

Community staff reported they used materials provided to them by Health Canada but also sought out their own materials through various organizations' websites, such as those from provincial departments, diabetes organizations, or those related to substance abuse and addictions, mental health, and nutrition. Inuit communities accessed materials available through ITK for culturally-relevant resources.

Lack of culturally-relevant materials or materials available in aboriginal languages was mentioned as an issue, with a few community staff reporting they had adapted material for their community and language. As a specific example, an evaluation of the ADI programs and activities in Nunavut found that there was a lack of health promotional materials (FNIHB, 2012e, p. 83) in community-specific languages. A few regional office staff and territorial governments reported that communities found that some frameworks, reference documents, or tools, were not user-friendly or written in a culturally-appropriate manner, and so they tended not to use these tools. Most territorial government representatives reported they had tailored some of the federally-produced resources or produced some of their own materials to better reflect the north.

From the national and regional office staff survey, about two-thirds or more of regional office staff respondents reported communities were using existing program guidance tools and templates to a large or moderate extent to develop (69%, n=20), implement (62%, n=18), and/or deliver (62%, n=18) their HL and HCD programs and activities. As well, just over half of respondents (55%, n=16) reported communities were using these guidance tools for planning their HL and HCD programs to a large or moderate extent. Perceived use of guidance materials dropped substantially for program assessment purposes, with close to half or more of survey respondents saying that communities made use of these tools only to a small extent or not at all for collecting data on their programs (48%, n=14) and for assessing the success of their programs (62%, n=18).

Use of Evidence-based Information to Inform Policy and Program Development and/or Implementation

Available information was used by Health Canada staff for informing policy and program development or improvement. National office staff indicated that information received from regions and communities provided information on how well programs were working and identified where further supports were required or for adjusting program frameworks or guidelines. Several specific examples included information from the dental database which had been useful in informing the process of developing the oral health action plan; special studies on physical activity had identified areas of successes and areas for improvements; and a special study on FASD led to steps for strengthening clinical supervision of FASD workers and

development of national core guidelines for FASD mentors. As well, departmental evaluations, program reviews, and other program data and information in general informed program-level policy development and contributed towards the program renewal process.

Regional office staff indicated that they were either involved in the flow of information from their region to national office to support the policy and program development and improvement process, or they used available information to assist communities in their programming efforts. The latter process could involve providing communities with information to assist in developing goals and objectives, demonstrating impact of programming, assessing program strengths and areas for improvements, and assisting with planning. Available data and information assisted regional office staff with reporting to and informing First Nations and Inuit partners on programs, and to provide rationale for planned actions.

Immediate Outcome #5: Ongoing access to HL and HCD programs/services (PAA 3.1.1, ER#1).

Based on the communities that were visited for this evaluation, there was consensus that programs and services were accessible. Community staff took steps to facilitate accessibility. However, other communities outside the site visits indicated that access was challenged and some experienced inequities in program and funding availability. More specifically, these communities encountered issues such as competing health priorities, acquiring sufficient program and management staff, availability of facilities, as well as a lack of other resources. Lack of transportation and available child care were identified as two of the major barriers to participation in available programs and services.

Access to the HL and HCD programs and services at the community level was a function of both the extent to which communities were able to offer the programs within their community and, for those that did offer the programs, the extent to which those services were accessible.

Extent Programs were Available in Communities

Illustrated in Table 2 below, are the numbers and proportions of communities that offered each of the HL and HCD programs by region, as of 2012-2013. The ADI and CPNP-FNIC are not shown in Table 2 as funding for both was provided to almost all communities. There was wide variation in the extent to which some programs were offered in communities across regions. For example, AHSOR was offered in almost all communities in each region except for Manitoba and Quebec, where it was offered in 68% and 69% of communities, respectively. The FASD program was offered in only 17% of communities in Alberta, 32% of communities in Atlantic, and 60% of communities in Manitoba, but was offered in most communities for the other regions. MCH was offered in most communities in Ontario and Saskatchewan, and ranged between 49% and 69% of communities for other regions.

There was wide variation across regions in the number of communities offering COHI services and communities that were served by a dental therapist. Through key stakeholder interviews, it was determined that variations on the numbers of program offerings across regions reflect

different health needs across communities and/or differences in funding allocation methods used by regions. Due to regional funding arrangements with provinces/territories, only certain remote and isolated communities within the Northern Region were eligible for NNC Nutrition Education Initiatives, with 77 eligible communities offered funding in 2012-2013.¹⁹

Table 2: Number and proportion of communities offering programs, by region 2012-2013ⁱ

Region ⁱ	Total communities per region	HCD programs ⁱⁱ				HL programs ⁱ	
		AHSOR ⁱ	FASD	MCH	COHI	NNC	Dental Therapists ⁱⁱⁱ
Number of communities offering programs							
Alberta	48	42	7	30	47	not offered	38
Atlantic	38	32	29	31	32	6	26
Manitoba	63	43	17	14	27	11	32
Ontario	138	125	127	129	70	8	not offered ⁱⁱⁱ
Quebec	54	37	54	37	19	16	not offered ⁱⁱⁱ
Saskatchewan	84	77	72	68	40	not offered	61
Total	425	356	307	309	235	41	157
Region ⁱⁱ	Total communities	Percent of total communities offering programs, by region					
Alberta	48	88%	15%	63%	98%	not offered	79%
Atlantic	38	84%	76%	82%	84%	16%	68%
Manitoba	63	68%	27%	22%	43%	17%	51%
Ontario	138	91%	92%	93%	51%	6%	not offered
Quebec	54	69%	100%	69%	35%	30%	not offered
Saskatchewan	84	92%	86%	81%	48%	not offered	73%
Total	425	84%	72%	73%	55%	10%	37%

ⁱ AHSOR could be centre-based, home-based, outreach or a combination of any of these types of approaches.

ⁱⁱ Numbers for dental therapists are the number of communities receiving services from a dental therapist. These services could be for dental therapy only, dental therapy and COHI, or COHI only.

ⁱⁱⁱ Dental therapists provide oral health services in all Regions except Ontario and Quebec where dental hygienists provide COHI services.

NCC Footnote: The remainder of the communities eligible for NNC Nutrition Education Initiatives funding were in the Territories.

Northern Region is not represented as territorial governments are funded directly, with the exception of the Yukon (see section 2.2.3). Not all HL and HCD programs are delivered in the North (i.e., PHAC manages Aboriginal Head Start in Urban and Northern Communities (AHSUNC). BC is not represented as programs are managed by the BC First Nations Health Authority and not Health Canada.

Note: ADI and CPNP-FNIC are universal programs with funding provided to almost all communities and therefore are not included in the above figures.

Sources: (FNIHB, 2010b, 2013d, 2013i)

Funding Access for Program Implementation

Although programming is based on needs identified by communities, some disparities appeared to exist. Even though all communities had access to the various HL and HCD programs, there was acknowledgement that dispersing the limited available funds across all communities left many with resource constraints for operating an increased number of programs. For example,

¹⁹ These NNC numbers do not align with Table 2 due to a lack of verifiable data from the Territories and because they also do not include the Northern Region.

some key stakeholders expressed concerns about the perceived inequity of offering programs to some communities and not to others, as well as the inequities in how communities were selected to receive funding dollars. A few regional office staff commented that where proposal-based funding was used, the communities receiving funding were those that had the capability to prepare proposals and demonstrate they had the capacity to deliver the programs. As a result, communities, particularly smaller communities, that were experiencing the same risk factors and could benefit from the programs, may not have received funding assistance for certain programs. Additional challenges existed for communities to access funding for programs. For example, in the past, communities were required to submit separate proposals for each of their programs, and some communities did not access funding due to an inability to prepare proposals. Further challenging the need to meet community-specific needs, a few Aboriginal organization representatives expressed concerns that not all communities could offer each of the programs for the same reasons. Communities were disappointed over lack of access to the MCH, FASD, and COHI programs and found it difficult when they knew a program was offered in a neighboring community but was not available to their community members. This was also reported in the site visits, with some concerns voiced by a few community staff about lack of access to specific programs. This issue was more common in the smaller communities visited. For example, one community that could not offer COHI or dental therapy services commented on the number of young children with serious oral health issues. A few community staff commented on the lack of FASD programming in their community and indicated that, given the issues with FASD, all First Nations and Inuit communities should have had access to the program.

Accessibility of Programs and Services Offered

Health directors reported there was good access to their HL and HCD programs and that staff tried to make the programs as accessible and flexible as possible. For example, staff reached out to community members directly and staff conducted home visits for some programs, and there was generally room for any community member to participate. Community staff commented that they tried to make the programs accessible to community members, with some commenting that the programs were particularly accessible when most or many of the services were offered at the health centre.

As a way to demonstrate how programs could improve access, Health Canada conducted an analysis of 2011-2012 CBRT data which demonstrated that communities with MCH funding were able to provide improved access to screening and breastfeeding activities (FNIHB, n.d.-a). For example, a higher proportion of MCH communities provided each of the following activities for breastfeeding promotion, education, and support compared to non-MCH communities: education workshops (83% versus 63%); one-on-one breastfeeding support (96% versus 73%); group breastfeeding support (48% versus 36%); and peer support program (54% versus 36%). A somewhat greater proportion of MCH communities provided pre- and postnatal nutrition counselling and education, including one-on-one counselling/education (90% versus 84%) and group counselling/education (87% versus 74%). In addition, 77% of MCH communities provided vision/hearing/dental screening and assessment compared to 57% of non-MCH communities.

Based on CBRT reporting, communities provided their members access to a range of HL and HCD activities. Most communities reported that they offered activities such as diabetes information sessions/workshops (94%), one-on-one nutrition counselling (86%), nutrition or dietary screening (74%), distribution of food vouchers (73%), cooking sessions/classes (84%), maternal community kitchens/community cooking classes (71%), one-on-one breastfeeding support (79%), breastfeeding education workshops (68%), physical activity awareness (92%), sport/recreation activities (77%), and healthy eating awareness/education (89%), among other activities (FNIHB, 2013a, pp. 9–11, 26–29). As well, 51% of communities reported they provided diagnostic diabetes screening and 79% provide non-diagnostic diabetes awareness/prevention screening services; 83% provide referrals to health professionals or services; 79% provide diabetes self-management sessions; and 77% provide diabetes support or HL groups (FNIHB, 2013a, pp. 31–33).

Challenges with Accessibility

Communities mainly related accessibility challenges to resource issues. For example, health directors and community staff indicated that resource constraints affected their ability to hire a sufficient number of staff and provide specific services. A few health directors observed they could only hire one worker for a specific program, such as one ADI or CPNP-FNIC worker and that the community was too large for these workers to reach all of the target population. Community staff identified the challenges of one COHI aide trying to reach all eligible children within a large community, or when COHI aides were not employed during the summer and dental therapists could not keep up with home visits. Some health directors and community staff identified the need for a dietitian or nutritionist within their community to assist clients with diabetes self-management and for disease prevention and health promotion purposes.

Sufficient facilities, equipment, and supplies for programs was an issue linked to accessibility as reported by some health directors and community staff. Community members observed that their health centre was not large enough to accommodate all or, in some cases, any of their HL and HCD programs, requiring communities to operate programs and services from various locations, including making use of community halls or gymnasiums. Infrastructure issues also existed with aging health centres.

Further, many of the community staff and community members interviewed reported that the spaces available for programs were often inadequate and small, requiring programs to limit the number of participants. Furthermore, a few health directors, community staff, and community members commented that the current resources and available facilities were not aligned to their community's population growth. As one example, AHSOR programs found that limited available facilities and staff were creating waiting lists in many communities. In order to expand accessibility, some communities were offering only half-day sessions of AHSOR so that one group of children could attend in the morning and another in the afternoon. A few communities reported they were offering summer sessions of AHSOR to provide opportunities to children who could not attend the regular session.

This was also true for finding dedicated space in the communities for dental therapy and COHI. COHI was often offered at the schools, where space was already limited, and COHI was often

given temporary space wherever room could be found, including in a library or staff room. Inadequate and temporary facilities for providing oral services were viewed as particularly problematic to ensure adherence to any infectious disease control protocols or guidelines.

Most community staff reported funds may have limited communities' ability to hire sufficient staff to meet demand, or may have required communities to hire only a part-time worker or share a worker between programs, therefore requiring workers to take on multiple responsibilities, which may have limited accessibility.

Many key stakeholders, including regional office staff and representatives of Aboriginal organizations and territorial governments, as well as community representatives, noted that staff recruitment and retention were issues affecting program accessibility. Finding the staff suitable for positions from within the community may have been challenging, particularly for smaller communities. Key stakeholders reported that if communities must hire from outside the community, attracting qualified staff was difficult, particularly to small or rural and remote communities. As well, high staff turnover and recruitment issues were disruptions in services if positions were not filled or while communities worked to train new staff.

National and regional staff surveyed indicated that they believed communities experience many challenges in offering programs, with a high proportion of staff viewing many issues as a challenge to at least a moderate extent. For example, the highest proportion of national office staff (83%, n=15) identified resource constraints as presenting at least a moderate challenge, while the highest proportion of regional office staff (90%, n=26) identified staff turnover. National (78%, n=14) and regional staff (76%, n=22) almost equally identified community capacity for planning programs as a large or moderate challenge. Regional staff (62%, n=18) indicated that establishing relevant partnerships with other community stakeholders was a challenge, while their national colleagues (39%, n=7) also identified this as somewhat of an issue. As well, national (44%, n=8) and regional (72%, n=21) staff felt that a lack of promotional /educational materials challenged communities in offering HL and/or HCD programs.

Regions used various measures to try to assist communities in overcoming challenges they experienced in offering their services, with support mainly in the form of assistance to help build capacity of community staff. Regional office staff reported health teams or interdisciplinary teams work with communities and provide support in program delivery. Support was provided through site visits or one-on-one services with workers or by bringing community staff from one or more program areas together to provide communities with an opportunity to share successes and best practices.

Community Member Participation in Programs and Services

In order to increase participation in programs and services, most community staff advertised through a variety of methods and provided incentives to participate. Incentives often included offering food at programs, as well as door prizes, gifts, gift certificates, or offering mothers a basket of incentives, with some of these provided when pregnant mothers attend all their doctor appointments and/or program sessions. Most community staff reported they would advertise their programs through such methods as radio, community newsletters and websites, posters, flyers,

email, word of mouth, school announcements, setting up booths at community events, personal calls, and Facebook, with the latter viewed as an effective way to reach the younger population.

Although good participation in some programs was reported by health directors, data was not available on specific numbers of eligible individuals participating in programs or on the numbers of participants in general across all programs in both HL and HCD clusters. Some data was available for the NNC, mainly in the form of the range of participant numbers for specific activities. As well, some findings from the 2008-2010 RHS included: over half (54%) of First Nations adults with diabetes attended a diabetes clinic or were receiving diabetes education, compared to 41% in the 2002-2003 RHS (FNIGC, 2012, p. 133); just over one third (36%) of all First Nations children had attended an AHSOR program (FNIGC, 2012, p. 374); and, from a special analysis of RHS data conducted for FNIHB, communities with an AHSOR outreach component of the program were more likely to have First Nations children attend AHSOR (42.2%) compared to communities without an AHSOR outreach component (33.3%).

The questionnaire administered during the site visit focus groups asked community members to identify what types of activities they, their children or grandchildren had participated in over the last year, asking participants to choose from a list of potential activities. Community members were participating in a wide range of activities relevant to the HL and HCD programs. Of those community members who completed the questionnaire, 99% reported they and/or their children/grandchildren had participated in at least one of the identified activities over the last year, and 77% reported they had participated in six or more of the activities.

Some communities tried to provide transportation to facilitate participation, such as through a bus or van for some AHSOR programs or in some cases communities had access to a medical van at times for transporting program participants. Some community staff spoke of picking up clients with their own personal vehicle in order to give them an opportunity to take part in programming. Some communities would also try to offer babysitting services for some programs so that mothers could participate (as well as fathers for some programs).

Finally, some declining participation in programs is explainable and may indicate positive outcomes. For example, there has been a declining trend in the number of individuals eight years of age and older who received at least one dental service, with an 18% overall decline between 2006-2007 and 2012-2013 for all regions that employ dental therapists (from 15,250 to 12,550 individuals). Health Canada suggests that the decline in number of individuals eight years of age and older receiving services could be due to a combination of the following: an emphasis on providing services to the younger age group (0 to 7-year-olds) through the COHI program in order to prevent the onset of oral health issues; preventive services provided in younger years, such as sealants at ages 6–7, decreased the services required when these children entered the older age group; and, the number of dental therapists providing services declined over time.

Challenges in Community Member Participation

During the site visits, most participants identified a number of barriers or challenges that impeded their ability to participate in programs. For example, a lack of transportation and lack of childcare were the two main participation challenges reported by community staff and community members, as well as by regional office staff. Communities could cover a wide

geographical area, and many families had no transportation. Participating where transportation was not readily accessible could be particularly challenging for community members with mobility issues or who were suffering from chronic illness. Some communities tried to provide transportation to programming, but this may have depended on the availability of a medical van. A few community staff and community members commented that some accessibility issues existed when programs were only offered during weekday business hours.

Other factors preventing participation that community staff identified included the stress of living with a chronic disease; difficulties in coming to terms with having a chronic disease such as diabetes and the challenge in committing long-term to programming; stigmas associated with certain issues that would make individuals reluctant to participate (such as FASD or young pregnancies); community dynamics; and other issues families and individuals may be experiencing such as housing and water supply issues, depression, or mental health and addiction issues.

Immediate Outcome #6: Increased individual knowledge of HL and/or HCD issues and practices.

The HL and HCD programs generally contributed to increased knowledge and awareness among program participants in a wide range of areas related to healthy living and healthy child development such as nutrition, physical activity, oral health and the importance of prenatal health.

Contributions to Individual Knowledge on HL and HCD Issues and Practices

There was strong agreement that the HL and HCD programs were contributing to increased individual knowledge and awareness of healthy living and healthy child development by all key stakeholder groups. Almost all (86%, n=25) regional office staff either agreed (59%, n=17) or strongly agreed (28%, n=8) that program participants were acquiring increased awareness and knowledge of health living.

Health directors and community staff reported that the HL and HCD programs and services were assisting community members in gaining awareness and knowledge of health practices related to healthy living and healthy child development. Some reported they were aware of this increased knowledge through observing participants' changes in health practices or through participant feedback, or that people in the community in general were becoming more aware of the importance of healthy living and that the younger population, in particular, was more aware of healthy living and healthy child development practices. For example, community staff observed that young people were knowledgeable of the benefits of water over juice and of the dangers of smoking and drinking, particularly drinking during pregnancy. Staff reported hearing community members talking about their diabetes and sharing information with other members.

Community members spoke positively on what they had learned through the programs and activities in which they participated. Most (79%) community members reported that taking part in the healthy living and healthy child development activities had given them a better understanding of healthy living for them and their family.

Community members gave many examples of the information and knowledge they obtained from the activities in which they participated, with examples including: gaining an understanding of the mechanics of diabetes and an understanding of insulin, blood sugars, and sodium; learning about how to better manage diabetes such as controlling and monitoring blood sugars, watching their diet, foot care, and exercising; cooking healthy through cooking classes and community kitchens; budgeting and better financial management; learning about FASD, the risks of alcohol consumption when pregnant, and FASD symptoms; learning how to take care of children's teeth and of the importance of tooth brushing; the importance of good nutrition through the prenatal program; and, understanding the benefits of exercising and being more physically active, among others.

Supporting Evidence of Increased Knowledge of HL and HCD Issues and Practices from Other Studies

Several previous evaluations or special studies had identified evidence of increased knowledge, as described below:

- Surveyed community workers in the ADI Capacity Building Special Study reported that, overall, community knowledge of various aspects of diabetes and healthy living had increased either “a lot” or “somewhat” since 1999. In particular, over 80% of community workers reported community members’ knowledge had increased a lot or somewhat in the areas of healthy eating (85%), the importance of physical activity (84%), the importance of diabetes screening (83%), and the importance of diabetes self-management (82%) (FNIHB, 2014a, p. 28).
- From two summary evaluation reports for the NNC Nutrition Education Initiatives for the years 2010-2011 and 2011-2012, nutrition and healthy eating awareness was an identified important success of the Nutrition Education Initiatives (Health Canada, 2012b, p. 22, 2013d, p. 24).
- From a 2010 evaluation, the COHI program was found to be “improving knowledge of oral health issues and decreasing the incidence of poor oral health in children aged 0-7 years” (Health Canada, 2010b, p. 38).
- The 2009 evaluation of the Tsuu T’ina First Nation Guja Project identified that community members had increased their awareness about the importance of healthy food as a result of the project (FNIHB, 2012e, pp. 44–46).
- A survey of Quebec’s Collective Kitchen 2-Day Workshop provided in four different locations in the province found that the workshops had contributed to participants’ knowledge of food security and access to nutritious food (FNIHB, 2012e, pp. 70–72).
- The evaluation of the Atlantic Region’s Chapel Island First Nation Living in Balance Program found that program participants had gained knowledge about healthy living and food and improved their health-related behaviours (FNIHB, 2012e, pp. 76–78).
- In Nunavut, an evaluation of the ADI community-based programs and clinical support activities identified increased awareness of diabetes and risk factors, as well as the value of healthier lifestyles (FNIHB, 2012e, pp. 82–85).

4.4.2 To What Extent Have the Intermediate Outcomes Been Achieved?

Intermediate Outcome #1: Improved coordination and integration of HCD and/or HL programs and services.

Efforts were made by communities as well as national and regional offices to improve integration and coordination of programs and services and reduce community program silos. Integration and coordination at the community level was occurring through efforts such as referrals, co-location of programs and pooling of resources. FNIHB supported integration and coordination by providing greater community support at the regional level through a reorganization of its governance structure.

Community Perceptions of Improved Coordination and Integration

HL and HCD programs were coordinating and integrating services at least to some extent, as reported by almost all health directors. Most community staff reported there was already good coordination and integration not only between their HCD/HL programs and services but also with other community programs and services. And, as was mentioned in Immediate Outcome 1, the majority (61%) of community staff reported that, overall, collaborations had increased over the past five years. Most Aboriginal organizations reported that coordination and integration was a common practice at the community level.

In contrast, although a few regional office staff reported that coordination was common in communities, with some stating that this coordination was increasing, it was noted that coordination varied by community. Some communities were coordinating proactively, yet it was reported that some communities were struggling with this issue due to a lack of internal capacity.

Of the regional staff surveyed 79% (n=23), most differed in their perspective on coordination. Some reported that communities combined their HL and HCD programs together to a large or moderate extent while only 45% (n=13) reported the HL and HCD programs were coordinating with other community services somewhat. An equal percentage reported communities were coordinating their HL and HCD programs with programs and services offered in another community.

Regarding the integration of community programs and services, 69% (n=20) of regional office staff reported community integration of their HL and HCD programs together or with other community programs had increased over the past five years or so.²⁰ A few health directors stated that while programs were doing some integration, more was needed.

²⁰ National office staff was not asked this question.

The CBRT asked communities to report their perspectives on formal or informal service linkages with organizations and agencies outside their communities. Communities reported they most frequently linked with their Regional Health Authority/Health Service Zone for such services as those related to diagnostics/screening (61%), healthy eating/nutrition (59%), treatment/management (58%), and specialist care (51%).²¹ Linkages for physical activity/recreation were most frequently with educational organizations (43%).

Coordination and Integration at the Community Level

The identified benefits of communities' HL and HCD coordination and integration have already been described in Immediate Outcome 1, such as cost- and resource-sharing, collaborative planning, linking clients to services and ensuring that clients were receiving appropriate referrals to other community programs and external services, extending program reach, networking and sharing knowledge with other programs and services, developing community relationships and trust, providing opportunities to conduct prevention services, reducing duplication of services, and facilitating case management.

As an example of how communities coordinated or integrated services, a few community staff reported that offering programs from one central location, primarily the health centre, essentially created a "one stop shop," and that clients were more likely to access other services if they did not need to travel to another location. However, due to lack of space in some facilities, not all communities were able to offer all programs from one central location. As well, as reported by regional office staff, coordination and integration would be expected where community workers had responsibilities in more than one program. Observations during site visits identified the strong rapport and connections that exist between community workers, which would be expected to further facilitate collaboration and program coordination.

Community staff gave many specific examples of how their HL and HCD programs coordinated and integrated their services between the programs as well as with other community services. Community staff commonly provided assistance and support to other community services, particularly schools and daycares. Some include:

- Programs coordinating activities together, such as AHSOR and CPNP-FNIC with Kids in the Kitchen cooking classes.
- Dental therapy/COHI working with AHSOR and daycares to screen children and working with MCH to target children for COHI services. In some cases, dental therapy/COHI worked with AHSOR to encourage reduction in juice consumption in children and promote tooth brushing. Another example includes a dental therapist partnering with a parent support worker to access hard-to-reach families to ensure children were receiving COHI services.

²¹ Although the CBRT requested data on service linkages, there is only current data for HL.

- CPNP-FNIC drawing on other community services to support prenatal women, such as midwives, dietitians/nutritionists, nurses, or social services. In a specific example from one community, CPNP-FNIC vouchers were distributed by a social services worker who used that opportunity to establish a relationship with mothers and assessed whether other supports were needed to arrange appropriate linkages.
- FASD, MCH, and CPNP-FNIC partnering on prenatal and other programming and home visits; examples of prenatal programming include prenatal classes and presentations to pregnant and/or young women, as well as high school programs for preventing FASD.
- Prenatal women having access to all programs at the health centre to learn about prenatal care, proper nutrition, diabetes, and FASD.
- AHSOR and daycares sharing resources for fieldtrips and facility resources, such as food shopping.

Coordination and Integration with Stakeholders

Immediate Outcome 5 indicates that one of the deterrents to participating in programs was the existence of stigmas, such as those associated with FASD. One way that communities had tried to address these stigmas, as reported in the MCH regional storylines, was that MCH and FASD services were often delivered together to help reduce the stigma associated with services related to substance use (FNIHB, 2014d, p. 8). In another example from the storylines, this one from the ADI, NNC nutrition education funding was often integrated with ADI funding (in NNC eligible communities) to improve nutrition and food security programming. In Nunavut, the funds were pooled at the territorial level to support regional programming, since NNC funding was universal in that region (FNIHB, 2014e, p. 3). In addition, the COHI storyline also indicated that COHI programming was often integrated with provincial programming. For example, partnerships with the Care for a Smile program in Alberta had extended the age groups that were reached (FNIHB, 2014b, pp. 3–4).

From a program coordination perspective, efforts by national and regional office staff included the merging of the HL and HCD clusters into one division. However, the staff reductions that had occurred with the deficit reduction action plan had resulted in some program managers at both the national and regional levels carrying responsibilities for more than one program, which resulted in the encouragement of further integration by necessity. This is further illustrated in the FNIHB staff survey, where 50% (n=9) of national office staff and 86% (n=25) of regional office staff reported the collaborations and partnerships they were involved in had contributed to program coordination and integration to a large or moderate extent, and of the regional office staff, over half (55%, n=16) reported these collaborations had contributed to coordination to a large extent.

Challenges for Improved Coordination and Integration of Programs and Services

Although communities have made positive steps in finding opportunities to better coordinate and integrate programs and services, a few pragmatic challenges remain in the areas of human resource recruitment and retention, and internal capacity to manage multiple activities across programs.

Intermediate Outcome #2: Improved quality of HCD and/or HL programs and services.

The quality of programs improved as programs evolved and matured, but this was challenged by the continual need to recruit and train new staff. The literature indicates that enhanced program quality is achieved through increased community capacity and collaboration, implementation of standards, and improved access to services, all of which were evidenced to some degree in the evaluation.

From the literature review conducted for the evaluation, evidence suggested that improved quality in programs could be expected to result from a range of contributing factors, such as increased community capacity, collaborations and partnerships, implementation of standards and guidelines, achievement of accreditation or licensing, increased coordination or services, and increased access to program and services. Various past program-level evaluations and other studies related to HL and HCD have reported that many of these contributing factors have been achieved for individual programs or specific initiatives within the clusters.

Some FNIHB staff identified that some programs had implemented standards, processes and program guidelines which increased program implementation consistency and improved quality. Health plans and wellness plans that provided communities with standards against which to assess their programs were viewed as having positive impacts on program quality. One example given was the implementation of a standards guide for all AHSOR programs in Alberta developed by FNIHB and First Nations partners that outlined, for example, educational requirements of different staff positions, safety requirements, and program curricula.

The common practice of obtaining community input on program needs was viewed as providing responsive, quality programming, and client successes were considered to attest to that quality. Regional office staff reported that they had observed improved quality as programs evolved and workers took part in training and gained knowledge and increased comfort level in their positions. This increased quality was reflected in more efficient work planning, development of creative approaches for delivering programs to reach the target population, an increased range and frequency of activities, establishment of partnerships with other services, creation of interdisciplinary teams, and more leadership at the program level. Furthermore, program quality was viewed as enhanced when strong support was provided from the community leadership.

The flexibility in the structure and delivery model for all HL and HCD programming created a range of alternative approaches adopted by communities. The literature supports the flexible and locally-determined design adopted by HL and HCD, which aligns with studies showing

increased program quality and effectiveness associated with sense of ownership (Preston, 2008, pp. 108–113). Community representatives reported that ongoing funding facilitated longer-term planning and program continuity, which also contributed to program quality.

Communities and most national and regional office staff reported that program quality had improved over the time period covered in this evaluation. Regional staff (69%, n=20) reported program quality had increased significantly or somewhat over the past five years. Although most health directors reported their programs were of high quality, there was agreement that financial constraints had an overall impact. A few of the longer-term community staff commented that they had a wider range of programs and services to offer community members than in the past, and a few community staff commented that their programs took flexible approaches to adapt to community needs, and as a result, program quality had improved as the programs evolved and matured.

With respect to training, many national and regional office staff attributed improved program quality to the increased capacity of community workers. The efforts that had been made to provide opportunities to access formal education and other types of training was viewed as contributing to the knowledge and skills of community workers. In particular, programs were perceived to be of good quality when at least some workers had some type of formal certification. Some national and regional office staff observed that increased support from regions, such as from physical activity specialists and nutritionists, and more collaborative efforts between communities and regions had also contributed to improved program quality.

Program were perceived to be of good quality when communities achieved accreditation, such as accreditation of their health centre, or Baby Friendly accreditation of community centres. For example, through funding support from the Maternal Child Health Program (MCH), the Kanestake Health Centre in Quebec was the first community in North America to receive Baby Friendly Initiative (BFI) Accreditation, through implementation of World Health Organization recommendations, with the accreditation attributed to significantly improved breastfeeding rates in the community (FNIHB Quebec Region, 2014, p. 1).

Challenges for Improved Quality of Programs and Services

The quality of programming can be affected by many factors. Key stakeholders identified issues such as a lack of collaboration and partnerships, low use of relevant guidance documents and standards and resource constraints to facilitate access to programs. Staff turnover could affect program quality when communities need to continually recruit and train new staff, which could interrupt programming and affect consistency of services. Other challenges included the communities' ability to hire sufficient staff, access to suitable facilities, and needed supplies and equipment.

Intermediate Outcome #3: Increased healthy behaviour.

The majority of program participants indicated improved healthy behaviours such as eating healthier, being more physically active, improving personal oral hygiene and reading more to their children. Furthermore, participants

attributed their improved healthy behaviours to participation in the program. However, food insecurity, poverty and mental health issues, among others, can challenge personal efforts for increasing healthy behaviours.

Assessment of increased healthy behaviours was based on the Community-based Reporting Template (CBRT), FNIHB special studies, the First Nations Regional Health Survey (RHS) as well as participant reporting of healthy practices and other stakeholder perceptions of increased healthy behaviours in program participants.

Some health directors commented that they were seeing, in general, increased healthy behaviours in their community, with a few attributing these changes to their community's HL and HCD programs or indicating that the programs facilitated these changes. Most (83%) community staff reported that at least some of the participants of their program were taking steps towards healthier lifestyles and healthy child development.

Community members who participated in the programs were positive about changes they had made over the last few years. Most community members reported they were eating healthier (79%), making healthier meals and snacks for their family (70%), encouraging their children to be more physically active (69%), increasing tooth brushing (61%), increasing their (adult) physical activity (59%), eating more traditional foods (58%), and reading more to their children (54%). A majority (65%) of community members attributed the changes they had made to their participation in HL and HCD activities.

Some of the same changes reported above by community staff and community members had also been confirmed through other data sourced including the Community-based Reporting Template (CBRT), FNIHB special studies, the First Nations Regional Health Survey (RHS) which are summarized below.

- A study on First Nations Culture and Language in AHSOR involving 36 First Nations communities, found that some of the reported positive impacts of the AHSOR program on participating children included increased language use and cultural awareness, as well as improved confidence, greater self-esteem, increased self-respect, and increased respect for others (FNIHB, 2012a, p. 10).
- Comparing children who had and had not attended AHSOR, those who had attended were more likely to have participated in healthy physical activities (35% versus 26%, respectively) and traditional cultural extracurricular activities (18% versus 10%), and were more likely to spend more than 30 minutes a day reading (51% versus 43%).
- The 2008–10 RHS found that more than half (56%) of First Nations children who had attended AHSOR were able to speak or understand a First Nations language compared to 45% of the children who had not attended AHSOR, although the authors acknowledge that this was not necessarily a causal relationship (FNIGC, 2012, p. 374).
- A success story describing the benefits of the CPNP-FNIC in the First Nation community of Sagkeeng, Manitoba, and focussed on breastfeeding and healthy diets, reported increased breastfeeding rates, with 95% of the program participants starting out breastfeeding (FNIHB, 2010a, p. 3).

- A special analysis of the RHS data conducted for FNIHB found (FNIGC, 2014) of children who were breastfed, a higher proportion were breastfed for over six months if they lived in a community with a MCH program (49%) compared to if they lived in a community without a MCH program (40%).
- The special study on the FASD Mentoring Program, while finding that changes varied among participants, reported increased healthy choices by women as a result of the program, as well as increased independence, personal growth, improved organization, and reduced alcohol/substance abuse (FNIHB, 2011, p. viii).
- In the ADI Capacity Building Special Study, most community workers reported that since the implementation of the ADI, widespread or at least moderate changes by community members had been made in the areas of healthy eating (83%), physical activity (79%), diabetes self-management (79%), diabetes screening (75%), screening for diabetes complications (72%), and other chronic disease screening (65%) (FNIHB, 2014a, p. 29).
- Findings from the Diabetes and Pregnancy TeleForm Project were that in obese pregnant clients, those who had the most frequent prenatal visits from community workers were more likely to stay within the recommended weight gains over the course of their pregnancy (Health Canada, 2013a, p. 32).

During the site visit focus group sessions, community staff reported many examples of increased healthy behaviour including increased breastfeeding, improved social skills and healthy eating habits, and increased parental involvement, which are described in detail below.

- Prenatal programs: Many staff reported they had observed an increased number of mothers breastfeeding their babies and for longer periods of time, and some mothers had told staff it was the support they received through the HCD programs that encouraged them to breastfeed. Staff reported prenatal mothers were making efforts to improve their diet and were more knowledgeable about pregnancy issues. Mothers gave examples of changes they had made as a result of the assistance received through the prenatal programs, such as making their own baby food, eating healthier, breastfeeding their babies, and also feeding their babies and older children healthy foods.
- AHSOR: Elementary school teachers provided positive feedback to parents and community staff on how well-prepared children who had gone to AHSOR were when they entered school. Teachers reported that the children were more confident, had better social skills, and were better able to take direction compared to children that had not gone to AHSOR. Community staff reported parents noticed that children were more conscious of healthy eating; they were enjoying the healthy foods offered through AHSOR and were asking parents for the same foods at home; and were practicing the good hygiene skills learned at AHSOR at home, such as brushing their teeth and washing their hands. Parents participating in focus groups echoed many of these same thoughts. Some parents were especially proud about their children learning their Aboriginal language and about their culture, particularly when the parent did not know their language.
- Parental involvement: Community staff reported that parents were reading more to their children, were becoming more informed on parenting strategies, and seemed to be more involved with their children. The supports provided to parents during home visits were

helping them with identifying goals and in making small changes towards achieving those goals. A few parents of children in AHSOR reported they had benefited from the program, such as in enjoying activities with their children, and learning how to be more patient with their children.

- **COHI\dental therapy:** Community staff observed that young children receiving COHI services displayed less tooth decay, and more children were receiving treatment and receiving needed fillings and dental surgery. Parents reported their children had gained a greater understanding of the importance of tooth brushing and were doing so now at home as a matter of habit.
- **Diet and nutrition:** Community staff reported that community members taking cooking classes were trying the recipes at home, were buying healthier foods and eating healthier and some community members were purchasing healthy foods that were new to them. As well, people purchasing good food boxes were learning to cook the healthy foods provided in the box. Children and some adults were reducing or no longer were drinking pop and children replacing juice with water. Community members reported many of these same changes, with common changes made including reducing salt and sugar intake, cutting out junk foods and eating more fruit and vegetables, and cooking more meals rather than using convenience foods. Community members reported they were more nutrition conscious when food shopping and a few reported they were growing their own garden.
- **School nutrition programming:** Community staff reported that school nutrition programming funded through ADI was providing a large number of students with healthy foods, and students were asking parents for the same foods at home. A few parents commented on how helpful the program was, and that children were learning better as a result. Furthermore, lunch programs were attributed to increasing school attendance, with community members again noting that before the program parents were often not sending children to school out of embarrassment about having no lunch for them.
- **Traditional/country foods:** Community staff noted that large numbers of community members were interested in and attending events where traditional foods were offered. Some community members commented on the consumption of traditional meats, with a few commenting that wild meat and/or fish were a regular part of their diet, although others reported traditional food was not readily available anymore, or that younger people often did not like traditional food.
- **Physical activity:** Community staff reported that more people were walking, taking part in walking clubs and walking challenges, or generally showing an interest in increased physical activity. Some community members reported they and their children were more physically active, with examples including going to the gymnasium in the evenings with their children, taking part in walking groups, making use of the community fitness centre, attending exercise classes, wearing pedometers, and taking part in fitness challenges, and that their children were involved in sports and other types of physical activities. Some community members spoke of the benefits of the physical activity and dietary changes they had made, with several observing they had lost 10, or 20, or even over 100 pounds, or that their children were losing weight.
- **Diabetes:** Community staff reported that some community members were showing improvements in managing their diabetes with respect to taking their medication, monitoring

their blood sugars and blood pressure, improving their eating habits, and increasing their physical activity. A few community members reported they were taking steps to better manage their diabetes, including planning their menus with a dietitian/nutritionist, making dietary changes, monitoring and managing their sugars, brushing their teeth, taking their medicine, going to the foot clinic, and getting more exercise. And a few community members reported that their sugars were now in normal ranges or even that they were able to stop taking insulin.

- Smoking and substance use: A few community staff reported they had clients who had reduced their smoking, and that many houses in the community were going smoke free. Reported changes included clients that had quit or reduced alcohol and drug use; pregnant mothers who either reduced or quit smoking and quit drinking alcohol while pregnant; and clients who had gone for rehabilitation and made significant life changes. A few community members reported they had either quit smoking, or reduced smoking, while a few reported they would like to quit smoking. A few participants shared that they had either quit or reduced their use of alcohol and/or drugs. Furthermore, several participants of the FASD program spoke of how helpful the program was, and that the mentors were their “biggest cheerleaders,” giving them one-on-one support and referrals.

Many of the changes made by community members were motivated by their desire to give their children a positive, healthy environment and to ensure their children understood the importance of healthy eating and physical activity. Many of the participants spoke of their appreciation of and the value of the support received from community staff members in helping them make healthy lifestyle changes. Community staff, however, cautioned about expectations around the pace of changes in adopting healthy behaviours, and that individual changes come in small steps. Community workers had to be willing to work with people according to where they were at the moment, and to help them recognize the small successes and gain confidence, so that participants did not become overwhelmed and stopped trying.

Challenges in Adopting Healthy Behaviors

Access to healthy and affordable food was a main challenge to First Nations and Inuit communities in adopting a healthier lifestyle, as identified widely by health directors, community staff and community members and almost all key stakeholder groups and surveyed regional office staff. Regional staff (90%, n=26) identified lack of access to affordable healthy food as a main challenge. Regional staff (62%, n=18) reported a lack of access to affordable healthy food challenged communities to a large extent, while the same group of regional staff (28%, n=8) indicated a moderate extent. Some community members pointed to the high price of eating healthy as a barrier to increasing healthy behaviour, noting that junk foods were cheaper than healthy foods, that fruit and vegetables were expensive, and it was difficult to afford fresh fruit, vegetables, and meat on a low income, particularly when trying to feed a family. As well, many communities had no grocery stores other than convenience stores, creating challenges for many families with no vehicles for accessing grocery stores. As a result, community members were often relying on unhealthy snack and convenience foods, and on canned goods. Northern communities and particularly remote communities with no road access were significantly challenged with access to healthy foods, because food costs were even higher, foods shipments occur less frequently, and fresh, healthy foods were often unavailable.

While there was an interest in traditional foods, some community members reported there was declining hunting and fishing knowledge or people were uncertain about the safety of consuming wild meat or fish. Furthermore, communities may have experienced reduced availability of their traditional foods, such as the Inuit in Labrador who could not access their traditional protein source due to a ban on caribou hunting.

Other challenges identified by health directors, community staff, and community members in adopting increased healthy behaviours included a lack of facilities and services, such as health, mental health, and social support services, as well as recreational facilities. Safety concerns and lack of appropriate infrastructure conducive to physical activity discouraged healthy behaviours. For example, some community members reported that walking was difficult due to fear of stray dogs and dog packs, as well as other wild animals, such as bears, moose, and elk. With respect to infrastructure, most communities lack sidewalks, and country roads were difficult to walk on, particularly for the elderly and other individuals who might have had mobility issues, or for parents with strollers. Just over half (55%, n=16) of regional office staff identified lack of access to recreational facilities as challenging communities to a large or moderate extent.

In addition, community staff observed that poverty, lack of education and employment, poor and crowded housing conditions, as well as possible addictions, mental health or domestic violence issues could present challenges to taking steps to manage diabetes, eat healthy, or increase physical activity. Most regional office staff reported that overcrowded housing conditions (72%, n=21) and inadequate basic home amenities (72%, n=21) presented challenges for adoption of increased healthy behaviours to a large or moderate extent. Many community staff and community members noted that lifelong habits were difficult to change, motivation was a necessary requirement for making healthy lifestyle changes, and a person needed to be at the appropriate point in his or her life to be ready to make those changes.

Intermediate Outcome #4: Increased supportive physical and social environments.

Efforts were made by communities to increase supportive physical and social environments through implementing policies that encourage increased knowledge of healthy behaviours and participation in healthy living activities such as access to sports and cultural events as well as other cluster programming. Some smaller communities were challenged by a lack of facilities that supported healthy living activities.

Community Efforts to Address Supportive Environments

There are many factors that contribute to the impact of HL and HCD programs within communities including those that indirectly support program activities, such as community capacity, physical space, facilities and other determinants that impact individual wellness. Through site visits, community participants who were engaged in the focus groups gave examples of where they saw supportive environments existing and examples of changes taking place within their communities to support healthy behaviours, with some of these changes the result of or influenced by the HL and HCD programs.

For example, some community workers reported changes taking place in schools including the provision of healthy breakfast, lunch, or snack programs and incorporating healthy lifestyle lessons into school programming. HL and HCD program staff often worked closely with schools and daycares to provide nutrition advice and COHI services were often located within schools and worked in conjunction with daycares and AHSOR sites.

Some health directors, community staff, and community members identified other supports in their communities for healthy living. Some communities had facilities for sports and recreation, such as a hockey arena, community centre, or fitness centre. Many schools opened their gymnasiums to the community in the evening for children, youth, and families to participate in recreational activities. Having access to school gymnasiums was particularly important for smaller communities with few to no other recreational facilities. Some communities were able to offer a wide range of activities for both children and adults, including sports, martial arts, various types of exercise classes, and yoga classes. As well, community ‘challenges’ appeared to be gaining in popularity, such as Biggest Loser or fitness challenges. All communities appear to have participated in a range of outdoor community events, such as powwows, community walks, feasts, winter festivals, culture camps, and other traditional activities.

As may be expected, larger communities with more resources appeared to have had greater capacity for offering community members more opportunities and a variety of options for participating in physical activities.

National/Regional Office Efforts to Address Supportive Environments

Interviewed national and regional office staff gave examples of other supportive environments facilitated through the HL and HCD programs, such as: dental therapists working with schools to implement a tooth brushing program or with community leaders to facilitate water fluoridations; communities assigning permanent space for clinics for dental therapy and COHI; physical incentive funds used for development of walking paths and green gyms in communities; ADI funding used to support community greenhouses, community gardens, and community freezers; community staff working with retailers for food security activities and to encourage retailers to provide healthy foods; support for community kitchens and cooking classes; the use of the *Eating Well with Canada’s Food Guide – First Nations, Inuit and Métis* by AHSOR programs, as well as other community organizations (e.g., daycares) for menu planning; and program funding support to community events and traditional activities.

A majority (62%, n=18) of regional office staff indicated that the HL and HCD programs had contributed to or encouraged supportive environments in communities to a large or moderate extent, although just over one-quarter (28%, n=8) reported they did not know if this was occurring. Just over half of both national (56%, n=10) and regional (52%, n=15) office staff reported that supportive environments had increased in communities somewhat over the past five years.

Challenges for Increased Supportive Physical and Social Environments

Challenges in achieving supportive physical and social environments primarily occurred when communities lacked the resources for providing their members with services and facilities that supported healthier lifestyles. In particular, smaller communities may have lacked resources for providing recreational facilities or other needed health services. Resource constraints in general may have made it challenging for communities to provide supportive environments (e.g., some communities had aging health centres or had health centres that no longer met the needs of the growing population, and/or lacked the funds to purchase necessary equipment and supplies for programs). A few community members, particularly those from smaller communities, reported their community was in need of more facilities and/or opportunities for organized sports for children.

4.4.3 To what extent has the long-term outcome been achieved?

Long-term outcome: First Nations and Inuit communities, families, and individuals receive services that are responsive to their needs (PAA 3.1 ER#1) so as to improve First Nations and Inuit health status.

HL and HCD programs can be responsive and meet needs. Communities have flexibility in tailoring the mix of programs and services to meet their health priorities and changing health needs. Programs can be adapted to be more culturally appropriate, and, there is flexibility within funding agreements to respond to changing health needs. However, some communities, in particular small, remote and/or isolated communities, indicated that they have a lack of programs and/or supportive services and that there is a need for additional staff, which may impact the responsiveness of the HL and HCD clusters as well as overall improved First Nations and Inuit health status. There are some indications of increased health status evidenced by a decline in child tooth decay, reduced blood sugars or blood pressure, weight loss and increased breastfeeding.

Responsive Programs and Services to Community Needs

There were positive reports on the responsiveness of the HL and HCD programs during the site visits by health directors, community staff, and community members. Some health directors indicated the programs were meeting their community's health needs to a certain extent, or to the best they could, given the available level of funding, but that gaps still existed. As well, a few community staff and community members reported that their communities were able to offer a range of services and activities to address health needs. Most community staff responded positively on their ability to make decisions and plan programming according to community needs, and that staff sought community input to assist in planning programs, through such means as surveys, project evaluations, and informal feedback. Most (84%) surveyed community staff either strongly agreed or agreed that the HL and HCD programs were meeting the needs of their community, and most (75%) community members reported the available activities were meeting their community's needs.

Most national and regional office staff also reported that the HL and HCD programs were responsive to community needs, with some pointing out that a key feature was to provide the programs with flexibility so communities could tailor programs to their health priorities and changing health needs. FNIHB staff reported that the programs were designed to meet the health needs identified by First Nations and Inuit partners regarding managing and preventing chronic disease and the supporting children and mothers. Communities mainly drew program staff from their own community members. This was viewed as a key strength of the programs for ensuring they responded to community priorities.

The efforts made in working with First Nations and Inuit partners to move to more flexible funding agreements was seen as enhancing communities' capability for focussing funds into priority program areas. Interviewed territorial government representatives reported the programs were tailored to meet community needs.

During the community site visits, community health directors, staff and community members indicated that programs which were responsive to their specific needs included involvement by Elders in their programs, incorporated traditional foods or crafts, or incorporated traditional parenting or teachings. Programs also ensured they respected the types of cultural practices desired by community members, noting that not all community members want to take part in traditional activities. Several evaluations of specific programs or projects had attributed some of the program success to incorporation of cultural relevance, such as the Kahnawake Schools Diabetes Prevention Project in Quebec for inclusion of traditional activities and customs (FNIHB, 2012e, p. 74) and the Diabetes Self-Management Journey, which was an initiative that provided diabetes-related teaching sessions to members of Aboriginal communities in the Atlantic Region for delivering diabetes education sessions in a culturally-appropriate way (FNIHB, 2012e, p. 80).

Many community representatives identified the need for incorporation of culturally-relevant approaches to ensure programs and services met community needs. Many community leaders and staff indicated that this was a common feature of communities' HL and HCD programs. For example, a few community health directors identified a growing recognition in their community of the health and well-being benefits of their traditional activities and diets, and indicated that steps were being taken to incorporate language programming, traditional parenting, traditional teachings, traditional foods, and other traditional aspects into programming. In all focus group sessions with community staff, staff spoke of the importance of incorporating cultural activities, with some mentioning this was a growing area of focus, while others noted cultural aspects had always been an important program feature. Some community members identified that traditional activities and teachings were important, or that they appreciated the cultural aspects provided in the programs.

Community staff reported that parents wanted their children to gain knowledge on their culture and spoke of how pleased parents were when the children were able to speak their traditional language. A few parents in the community member focus groups confirmed their support for cultural activities, and how proud they were that their children were learning their traditional language, particularly if the parent themselves could not speak the language. Similarly, in an evaluation of AHSOR programs in Manitoba, the majority of respondents (80% of the parents and 87% of other stakeholders) reported that AHSOR programs were “based on Aboriginal cultural values and beliefs” (Kaplan & Komishin, 2011, pp. 19–20).²²

Additional Community-Identified Needs

There are, however, further areas of need or gaps in services that require addressing. Some community staff identified the need for certain programs that were not available to their community, such as dental therapy/COHI, FASD, and MCH, or for other supportive services to complement their existing programs, such as specialists, diagnostic services, and therapists. A few interviewed Aboriginal organization representatives voiced similar concerns — for example, that the programs required increased linkages with other services, such as mental health services and that not all communities were able to offer each program.

During site visits, all levels of community representatives agreed the need for more staff, facilities, and resources to better develop programming. Some health directors pointed out the need for more staff for specific programs, such as ADI, CPNP-FNIC, and COHI. For example, funding levels were not always viewed as adequate for ADI, given the serious issue diabetes was presenting to communities, and health directors, as well as community members, identified that their community could benefit from more educational or screening activities or from more health-related programs in general, all of which would require additional funding. A few Aboriginal organization representatives indicated they felt that funding had not kept pace with population growth.

Other examples provided by community staff included the need to address issues associated with poverty, food security (of particular focus in northern and remote communities), poor housing, and addictions.

Participant Health Status Outcomes

The documents reviewed for the evaluation gave examples of improved health status, including:

- Some participants of the Diabetes Self-Management Journey (DSMJ) program reported weight loss, less use of medication, and reduced smoking (FNIHB, 2012e, pp. 79–81).

²² Other stakeholders included AHSOR staff, managers, and coordinators; educators; and health care providers.

- The Chapel Island First Nation Living in Balance Program in the Atlantic Region included a walking program (10,000 steps per day) and also involved diabetes awareness, diabetes prevention, education related to healthy eating, and cooking classes. Many participants experienced reduced blood pressure and glucose levels, as well as weight loss (FNIHB, 2012e, pp. 76–78).
- Children participating in AHSOR had been found to gain increased confidence, self-esteem, independence, and social skills.
- A review of the 18 communities visited for this evaluation found that the mean percentage of clients in communities with zero deficiencies and decayed, missing or filled teeth (permanent teeth) increased from 30.4% in 2005 to 36.6% in 2008 (FNIHB, 2009a, p. 1).
- A more recent analysis conducted by the Manitoba Region, Regional Dental Unit, illustrated the impact of COHI and dental services on First Nations communities in that region. Comparing two communities with COHI services and dental therapy to four communities without these services, children in communities with COHI and dental therapy services had substantially fewer permanent teeth with decay among other positive findings. (FNIHB, Manitoba Region, Regional Dental Unit, 2014, pp. 3–4).
- The average number of decayed permanent teeth per child was 0.84 in COHI and dental therapy communities compared to 1.95 in non- COHI and dental therapy communities, and, for missing permanent teeth, the average was 0.10 and 0.51 respectively. Over one-third (39.8%) of the children in COHI and dental therapy communities had no decayed, missing or filled teeth (permanent teeth), compared to 13.1% of children in the non- COHI and dental therapy communities. The analysis found that sealant placement reduces prevalence of decay and that there was a positive correlation between reduced decay and presence of COHI and dental therapy in communities (FNIHB, Manitoba Region, Regional Dental Unit, 2014, p. 3).

Other reported improvements in health status were provided during the site visits including a few program participants who reported improved blood sugars, weight loss, and healthier teeth in children.

Challenges in Achieving Long-term Outcomes

Gaps in services and other areas of need exist, and make it challenging to achieve fully-responsive HL and HCD programs and improved First Nations and Inuit health status. Although this was identified as problematic across the spectrum, it was particularly problematic for small, remote and/or isolated communities. For example, resource constraints exist for acquiring needed staff, facilities, and supplies/equipment to fully develop programs and lack of access to other supportive services to complement the HL and HCD programs may impede the responsiveness of the services and have an impact on health status. Furthermore, the presence of other factors such as poverty, poor housing, addictions and mental health issues could further challenge efforts for improved health status.

4.5 Performance: Issue #5 – Demonstration of Economy and Efficiency

Context for Measuring Economy and Efficiency

The Treasury Board of Canada's *Policy on Evaluation* (2009) and guidance document, *Assessing Program Resource Utilization When Evaluating Federal Programs* (2013), defines the demonstration of economy and efficiency as an assessment of resource utilization in relation to the production of outputs and progress toward expected outcomes. This assessment is based on the assumption that departments have standardized performance measurement systems and that financial systems link information about program costs to specific inputs, activities, outputs and expected results.

The financial information provided for the program did not facilitate the assessment of whether program outputs were produced efficiently, or whether expected outcomes were produced economically. The lack of output/outcome-specific costing data limited the ability to use cost-comparative approaches. In terms of assessing economy, challenges in tracking funding within the broader program envelope limited the assessment. As a result, the evaluation provides observations on economy and efficiency based on findings from the literature review, key stakeholder interviews and available relevant financial data. These findings provide observations on the adequacy and use of performance measurement information to support economical and efficient program delivery and evaluation.

The structure of the HL and HCD clusters presents the following critical challenges that limit the analysis of economy and efficiency:

- In grants and contributions programs, it is possible to measure “program level efficiency” at the federal level in terms of the cost of administering the funding. Typically, wide variations exist in the ratio of operating costs (Vote 1) to grants and contributions disbursed (Vote 10). Regional factors, capacity at the community level, and nature of the issue being addressed can all trigger wide variation in this ratio. It is important for management to track this variation, as it will offer insights into overall efficiency in delivering resources to the communities. As a result, the evaluation could only provide general observations on program-level efficiency based on findings from the literature review, key stakeholder interviews, and available relevant financial data given that programs do not track expenditures by discrete activities (object costing).
- Measurement of economy and efficiency could be feasible for individual projects at the community level, where the total resources (from all funders) may be aligned to the activities, outputs, and outcomes realized in a specific service line. This “project level efficiency” requires community-level data on resources utilized and results realized. The performance tracking (CBRT), however, does not collect information at a sufficiently detailed level for such assessments.

As a result of this assessment on economy and efficiency, including a review of the literature on program models similar to the HL and HCD clusters, the approach to program development and implementation aligns with established best practices. Although many aspects of program delivery are making efficient use of current resources, there are opportunities to further improve on the overall cost effectiveness of the HL and HCD programs.

Observations on Economy

The health promotion and disease prevention approach used by HL and HCD programming aligns with good practice in delivering health care in order to improve health outcomes and have demonstrated that they are cost effective (economically beneficial) over the long-term.

Actual expenditures for the evaluation period for each of HL and HCD are presented below. HL had an estimated financial allocation of \$185 million over the 2010-2011 to 2012-2013 period (FNIHB, 2013h, p. 6) and, from Table 4, actual expenditures of \$172.96 million, of which 78% was contributions, 16% was salaries and wages, and 6% was other operating. HCD, from Table 3, actual expenditures of \$547.5 million, of which 91% was contributions, 6% was salaries and wages, and 3% was other operating. Of note, salaries and other operating expenses represented 17% of 2012-2013 expenditures for HL but only 6% for HCD indicating a significant difference in the overall governance approach between the two clusters..

Actual expenditures for each of the HL and HCD programs or components are provided in Table 3 and 4 with the ADI representing 71% of HL expenditures in 2012-2013, and AHSOR 44% of HCD expenditures²³.

Table 3: Actual expenditures (\$million) for HL, 2010-2011 to 2012-2013 and HCD, 2008-2009 to 2012-2013ⁱ

Expenditure	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	Totals
	\$ million					
Healthy Living						
Salaries & Wages / Student Program			8.517	9.562	9.256	
Other Operating			3.759	3.564	2.805	
Minor Capital			0.065	0.102	0.069	
Contributions			48.090	44.067	43.101	
Total			\$60.431	\$57.295	\$55.231	\$172.96
Healthy Child Development						
Salaries & Wages /Student Program	5.740	6.386	6.425	6.210	5.992	
Other Operating	5.494	4.396	3.348	2.381	1.715	

²³ The dollars of contribution agreements distributed varies considerably between programs and regions, which reflects many contextual factors that influence the costs of delivering the different programming and the costs of delivering programming to communities. This contextual variation may reflect such factors as: community size, capacity, and needs; levels of support provided by region/program; program elements that comprise HL and HCD; and cost drivers such as remoteness.

Expenditure	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	Totals
	\$ million					
Minor Capital	0.031	0.062	0.163	-	-	
Contributions	98.256	100.801	99.517	102.803	97.768	
Total	\$109.520	\$111.645	\$109.452	\$111.393	\$105.475	\$547.50
i Includes expenditures for all regions. Note: Columns may not all add to totals due to rounding. Source: (FNIHB, 2013e, 2013f)						

Table 4: Actual expenditures (\$million) for HL program components, 2010-2011 to 2012-2013ⁱ

Programs/Components	2010-2011	2011-2012	2012-2013	Total for 2010-2011 to 2012-2013	
	\$ million			\$ million	%
ADI	38.95	42.66	41.74	123.35	71%
NN ⁱⁱ	1.27	2.63	2.64	6.54	4%
Nutrition	1.95	1.73	1.44	5.12	3%
Chronic Disease Prevention	0.52	0.66	0.74	1.91	1%
Injury Prevention	-	0.50	0.36	0.86	<1%
Dental Therapy	8.67	9.12	8.30	26.09	15%
CDIP transfer	9.08	-	-	9.08	5%
Total	\$60.43	\$57.30	\$55.23	\$172.96	100%
i Includes expenditures for all regions. ii No salary expenditures for NNC. Includes only expenditures from December 2010 to March 2011. Note: Totals may not add due to rounding. Source: (FNIHB, 2013f).					

Table 5: Actual expenditures (\$million) for HCD programs, 2008-2009 to 2012-2013ⁱ

Programs/Components	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	Total 2008-2009 to 2012-2013	
	\$ million					\$ million	%
FASD	12.01	12.72	9.74	10.50	9.68	54.65	10%
CPNP-FNIC	10.90	11.83	11.31	14.65	14.08	62.77	11%
MCH	21.91	21.76	21.04	23.23	20.56	108.50	20%
AHSOR	48.52	48.27	48.18	49.32	44.29	238.59	44%
COHI	4.53	4.78	5.61	5.02	4.88	24.82	5%
HCD Center ON	-	-	-	7.91	11.48	19.39	4%
ECD HQ	6.81	7.97	10.53	0.77	0.50	26.58	5%
HCD Transfer	4.84	4.31	3.05	-	-	12.20	2%
Total	\$109.52	\$111.64	\$109.45	\$111.39	\$105.48	\$547.49	100%
i Includes expenditures for all regions. Note: Totals may not add due to rounding. Source: (FNIHB, 2013e)							

Observations on Efficiency

The HL and HCD clusters promote healthy practices and disease prevention activities which are recognized in the literature as cost efficient. Efficiency was also realized through the steps FNIHB took to improve program delivery and make efficient use of resources such as mobile diabetes clinics and community-based health staff such as dental therapists. Further program delivery improvements could create additional efficiency.

A review of the literature substantiates and supports the core aspect of HL and HCD programming of focussing on a broad range of determinants of health. For HCD this focus is on improving First Nations and Inuit children's health as early in life as possible. Studies consistently find that the earlier in life an intervention was made, the greater the probability of mitigating risks and disadvantages (Conti & Heckman, 2013, p. 135). Furthermore, an overall consensus exists in health care literature that chronic disease management and primary care that promotes wellness, screening and other preventive care results in improved outcomes and lower overall health care costs (Barr et al., 2003, p. 75; Weintraub et al., 2011, pp. 970–972).

The literature indicates that the HL and HCD programs aligned with approaches taken in programming in other jurisdictions. For example, the AHSOR programs were closely based on Head Start programming in the United States, and preserved the model's flexible delivery and curricula to ensure programs addressed community needs and cultural relevance (Zhai, Brooks-Gunn, & Waldfogel, 2011, pp. 4–5). Other HCD programs, as well as HL programming, reflected these same principles. In Australia, the government introduced the Indigenous Chronic Disease Package to address the increased incidence of diabetes, chronic respiratory diseases, cardiovascular diseases, and other conditions in the Aboriginal and Torres Strait Islander populations (Department of Health and Ageing, 2010, p. 2). Similar to the ADI, the Indigenous Chronic Disease Package focussed on community-initiated activities to support healthy lifestyles and disease prevention through education and intervention programs, and increased capacity for health workers in communities (Australian Institute of Health and Welfare & Australian Institute of Family Studies, 2012, pp. 4–5).

With regard to the HL and HCD programs, the flexibility in the structure and delivery models created a range of alternative approaches adopted by communities. These alternative approaches might produce comparable outputs more efficiently or effectively, however, little quantitative detail existed to allow for this direct assessment of efficiency.

The literature supports the cost effectiveness of the community-based staffing model used in the HL and HCD programs. Current practices for health promotion and disease prevention in many jurisdictions rely upon community health workers, particularly where cultural and geographic barriers may exist (AADE, 2009, p. 1).²⁴ A study of a diabetes management program with Community Health Workers in Hawaii, serving largely native Hawaiian and Samoan clients with elevated blood glucose, found that Community Health Workers developed strong personal connections with clients, acted as liaisons to other members of a multidisciplinary team to facilitate development of an appropriate management plan, and contributed towards reducing client risk levels and overall costs to the healthcare system (Beckham, Bradley, Washburn, & Taumua, 2008, p. 416).

While economic benefits from such programs are difficult to estimate and some controversy exists on overall cost savings from preventive interventions, one such assessment of the Perry Preschool Project estimated a return on investment between 7% and 11% and overall social benefits of between \$8–\$14 per dollar spent (Trefler, 2009, pp. 681–682). Another study of the United States Head Start program found the program was an efficient government investment, contributing an estimated return of \$3.69 per dollar in reductions to future government costs, such as costs related to crime (Garces, Thomas, & Currie, 2000, p. 3).

Specific interventions in the literature used by some communities have also been shown to be cost effective in the sense of avoiding future costs. For example, mobile diabetes clinics have been shown to yield important cost savings at several sites across Canada, some of which have received funding from First Nations and Inuit HL and HCD clusters (Jin, 2014).

National and regional office staff interviewed for this evaluation observed that community-based staffing was expected to contribute to program effectiveness, as these members of the community already had the valuable knowledge and linkages within their community. Hiring from within the community created efficiencies when communities did not have to incur any relocation costs and because community-based staff were more likely to want to remain in their community and therefore stay in their positions, reducing staff turnover.

FNIHB staff interviewed for this evaluation identified the high-quality services provided by dental therapists and the cost efficiencies compared to services provided by higher cost dentists, particularly when factoring transportation costs of either the dentist visiting the community or the client leaving their community for service. Similarly, PHAC's evaluation of the Canada Prenatal Nutrition Program found evidence of immediate health benefits and expected health care savings, although the actual cost-efficiency could not be estimated (Public Health Agency of Canada, 2010). However, it should be noted that most of the HL and HCD components were not individually evaluated for economy and efficiency.

²⁴ The role of the Community Health Worker was twofold: to provide education and to support local action to increase participation in the health system, and to inform health care providers about the community's needs, including cultural appropriateness of program interventions (Canadian Diabetes Association, n.d.).

Another specific example of efficiency was developed by The Canadian Diabetes Association - the Canadian Diabetes Cost Model, which estimated that the total economic burden of diabetes overall in Canada would increase to \$12.2 billion in 2010 (2005 dollars), almost double that of the \$5.9 billion in 2000, and would further increase to \$16.9 billion by 2020 (Canadian Diabetes Association, 2009, pp. 12–13). Through the model, the Canadian Diabetes Association estimated that its prevention strategy would, all else equal, reduce the total number of people with diabetes in 2020 by 16% and would reduce direct costs by 9% (\$0.3 billion) and indirect costs by 7% (\$1.0 billion) (Canadian Diabetes Association, 2009, pp. 16–17). The Canadian Diabetes Association recommended enhancements to the ADI, including increased investment, further translation of research into practical interventions, and greater emphasis on cultural appropriateness and relevance in diabetes prevention and management programs (Canadian Diabetes Association, 2009, p. 19).

Some of the other perceived efficiencies of the HL and HCD programs identified by interviewed national office and regional office staff that had resulted from the delivery approaches taken include the following:

- A few community representatives commented that some communities, particularly larger ones with more resources and linkages, were able to access other sources of funds to leverage their HL and HCD funds and to strengthen their programming.
- Multidisciplinary teams were viewed as a highly-effective way to support communities in making efficient use of resources for planning and providing programming including the use of telehealth services for training and other service delivery initiatives.
- Collaborations between programs, as well as with other stakeholders, to partner on activities, planning, or training initiatives were viewed as an effective use of resources for minimizing costs.
- The implementation of the Northern Wellness Agreements in the territories had reduced community requirements for submitting annual multiple proposals to territories, allowing workers to make better use of their time in focussing more on programming. The multi-year funding contributed to more predictable funding, which benefited longer-term program planning and contributed to increased staff retention.

One aspect of efficiency was whether program stakeholders perceived that alternatives existed for providing the HL and HCD programming, with many of the suggestions made related to ways to improve existing programs. Some FNIHB staff suggested further integration of programs to make more efficient use of existing funds and to make continued progress in reducing the previous practices of working in silos. A few of these key stakeholders reported the HCD programs could be further integrated. As well, a few FNIHB staff suggested that there might be alternative approaches similar to those mentioned above to ensure more equitable access to programs for all communities.

Many contextual factors influenced delivering programming to communities including geographical location, co-location to other communities and community capacity for planning, developing and implementing programs as well as levels of support provided by region/program; program elements that comprised HL and HCD; and cost drivers such as remoteness. These variations, however, could serve as the basis for management review to increase understanding of how to adjust delivery mechanisms and capacity to increase efficiency.²⁵

5.0 Conclusions

1. The evaluation demonstrates an ongoing role for the federal government to address the continuing need for healthy living and healthy child development programs. These initiatives are consistent with the priorities of the department to support improved access to health care, health status and First Nations and Inuit control of health resources within their communities.
2. First Nation and Inuit communities know more about healthy living and healthy child development and are taking steps towards increasing healthy behaviours as a result of the HL and HCD programs. The evaluation found evidence of improved health status in the areas of children's oral health, reduced blood sugars or blood pressure, weight loss and breastfeeding.
3. While collaboration across programs within the HL and HCD clusters was strengthened, which supported improved program service delivery, opportunities exist between national and regional FNIHB offices as well as between FNIHB and Aboriginal organizations to further strengthen collaboration and develop cooperative approaches with other jurisdictional service providers and community partners. HCD programs, in particular, could benefit from increased collaboration and integration.
4. Capacity building was shown to support program delivery. However, regions and communities identified challenges with providing and attending training. Programs, where available, were accessible. Although, some communities, particularly small, remote and/or isolated communities, experienced imbalances in program and funding availability which limited access to needed programs and services.
5. The evaluation found that programs can be responsive and meet community needs. The programs align with health promotion and disease prevention practices in delivering preventative community-based primary care to improve health outcomes at a lower cost over the long-term.

²⁵ It is important to note that using financial data to infer economy and efficiency can be problematic without full data disclosure. Some program financial records did not capture all expenditures in which transfers had been made to other directorates for work to support HL, such as \$5 million transferred to Home and Community Care for training nurses on clinical practice guidelines. There is wide variation in the program costs region by region, reflecting the many contextual factors that influence the costs of delivering the different programming in the regions and communities.

6. Performance measurement has improved, particularly for measuring intermediate and long-term outcomes. However, focus on performance indicators and data collection that support immediate outcomes, specifically the reach and access of HL and HCD programs, could be enhanced to better support program monitoring for planning and reporting.

6.0 Recommendations

The recommendations are based on the findings for each of the outcomes assessed as part of this evaluation and the conclusions drawn from those key findings.

- 1. Improve collaboration efforts with stakeholders, partners and other service providers that ensure sustained partnerships and program integration.**

There are opportunities for the programs to improve coordination and integration at both the FNIHB and community level. Although communities have begun developing partnerships and sharing activities and services between similar programs, a review could assist communities in developing a strategy to more fully integrate programs within their own communities and collaborate with other communities and service providers in order to achieve efficiencies within the resource constraints identified.

- 2. Sustain efforts to support improved program and service access and quality.**

There are opportunities to better understand how funds were allocated across programs and communities. This would assist in identifying approaches for addressing current programming inequities that seem to exist in some communities (i.e., small, remote and isolated).

Given the important role of community workers in the HL and HCD programs, ongoing capacity-building support was essential for ensuring workers had the necessary knowledge and skills to provide and deliver effective, quality programs and services. Supporting the efforts taken by some regions for developing capacity-building strategies could ensure greater reach and access of programs and consistency in approaches to training.

- 3. Streamline and implement improved performance measurement.**

Ongoing data collection and performance measurement was important for monitoring progress in achieving expected outcomes and supporting evaluation. Qualitative information collected as part of the evaluation along with data sources such as the Community-based Reporting Template (CBRT), the Northern Outcome Reporting Template for Health (NORTH) report and Regional Healthy Survey and studies completed by FNIHB, were valuable for providing context and depth, particularly when corroborated with additional evidence.

Improvements could be made to the CBRT, and possibly the NORTH reporting tool, to facilitate regular collection of data from communities that would contribute towards measuring achievement of outcomes, specifically short-term outcomes such as increased reach, participation and access to programs. A revised logic model, with fewer outcomes to measure, and clearly-defined parameters and targets around expected outcomes, would further assist in this process. As well, support and resources to regions and communities for collecting, managing, and analyzing data is important, given the continued shift in responsibilities to regions and the important role of communities in program delivery.

Appendix 1 – References

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Appendix 2 – Summary Ratings Table

Rating of Findings

Ratings have been provided to indicate the degree to which each evaluation issue and question have been addressed.

Relevance Rating Symbols and Significance:

A summary of Relevance ratings is presented in Table 1 below. A description of the Relevance Ratings Symbols and Significance can be found in the Legend.

Table 1: Relevance Rating Symbols and Significance

Issues	Indicators	Overall Rating	Summary
Continued Need for the Program			
Is there a continued need for the Healthy Living and Healthy Child Development components?	Assessment of the extent to which the programs continue to address a demonstrable need and is responsive to the needs of First Nations and Inuit communities.	High	Due to the disparities in incidence of many health issues such as diabetes and other chronic diseases and prevalence of health risk factors such as deficits in nutrition, physical activity, maternal health and food security for many First Nations and Inuit communities, there is a continued need for the HL and HCD clusters to support First Nations and Inuit communities' capacity to address the healthy living and healthy child development needs and priorities of these communities.
Alignment with Federal Roles and Responsibilities			
Are the Healthy Living and Healthy Child Development components aligned with the department's jurisdictional, mandated and/or legislated role?	Assessment of the role and responsibilities for the federal government in delivering the program.	High	Various legislative authorities and federal policies identify that the federal government has jurisdiction, responsibilities and/or goals regarding Aboriginal health care services, and, in particular, health care of First Nations on-reserve and certain Inuit.
Alignment with Government Priorities			
Do the Healthy Living and Healthy Child Development components align with Government of Canada priorities?	Assessment of the linkages between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes.	High	Increasing access to health care and addressing the health status inequalities affecting First Nations and Inuit communities are priorities of the federal government and FNIHB, as is increased First Nations and Inuit control of health resources (e.g., programmatic and financial resources) within their communities.
Do the Healthy Living and Healthy Child Development components align with departmental strategic outcomes?			

Legend – Relevance Rating Symbols and Significance:

- High** There is a demonstrable need for program activities; there is a demonstrated link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are clear.
- Partial** There is a partial need for program activities; there is some direct or indirect link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are partially clear.
- Low** There is no demonstrable need for program activities; there is no clear link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program have not clearly been articulated.

Table 3: Summary of Relevance Ratings

Evaluation Issue	High	Partial	Low
Issue 1: Continued need for the program			
Is there a continued need for the Healthy Living and Healthy Child Development components?	High	N/A	N/A
Issue 2: Aligned to federal government priorities			
Do the Healthy Living and Healthy Child Development components align with Government of Canada priorities?	High	N/A	N/A
Do the Healthy Living and Healthy Child Development components align with departmental strategic outcomes?	High	N/A	N/A
Issue 3: Program consistent with federal roles and responsibilities			
Are the Healthy Living and Healthy Child Development components aligned with the department's jurisdictional, mandated and/or legislated role?	High	N/A	N/A
Legend – Relevance Rating Symbols:			
High	There is a demonstrable need for program activities; there is a demonstrated link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are clear.		
Partial	There is a partial need for program activities; there is some direct or indirect link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are partially clear.		
Low	There is no demonstrable need for program activities; there is no clear link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program have not clearly been articulated.		

Table 4: Summary of Performance Ratings

Evaluation Issue	Achieved	Progress Made; Further Work Warranted	Little Progress; Priority for Attention
Issue 4: Achievement of intended outcomes (effectiveness)			
Is the Program achieving the outcomes expected as outlined in the Logic Model?	N/A	Progress Made; Further Work Warranted	N/A
Issue 5: Demonstrated economy and efficiency			
Have the Healthy Living and Healthy Child Development components been managed efficiently and economically?	N/A	Progress Made; Further Work Warranted	N/A
Legend – Performance Rating Symbols:			
Achieved	The intended outcomes or goals have been achieved or met.		
Progress Made; Further Work Warranted	Considerable progress has been made to meet the intended outcomes or goals, but attention is still needed.		
Little Progress; Priority for Attention	Little progress has been made to meet the intended outcomes or goals and attention is needed on a priority basis.		

Appendix 3 – Description of Logic Model²⁶

Logic Model Narrative²⁷

The HL and HCD logic models included in the Consolidation of First Nations and Inuit Health Contribution Program Authorities (2011) were refined and combined into one to guide the planning of the 2014 HL and HCD evaluation. The logic model is laid out in a way to demonstrate a theory of change. The assumptions and expectations built into the logic model are supported by an evidence base built over the lifespan of the HL and HCD programs, including special studies, previous evaluations, and other forms of data collection. Mapping to the 2012 PAA and its Performance Measurement Framework is identified.

The overall assumption in a logic model is that the outputs of the intervention will lead to the expected outcomes (Mayne, p.2, 2011). The narrative below provides a description of the causal linkages depicted in the HL and HCD logic model.

OUTPUTS

Within the logic model, outputs are direct products of HL and HCD activities at the national, regional, and community levels.

Collaborative processes and practices (consultations, agreements, joint projects, and committees/working groups) initiated

Collaborative processes and practices happen both formally and informally and are found at the community, regional, and national levels. For example, at the national level, Health Canada staff consults with National Aboriginal Organizations to develop policies and programs. At the regional level, Health Canada staff and regional First Nations organizations may work together on joint priority setting. At the community level, staff from the Canada Prenatal Nutrition Program and the Aboriginal Diabetes Initiative work together on programming to prevent or manage gestational diabetes. Partners bring knowledge (e.g., knowledge of cultural norms) and expertise that ensure programs are designed and delivered effectively. Collaborative processes and practices are a way of working that spans all the logic model themes.

Training, continuing education, and professional development opportunities provided

Training, continuing education, and professional development opportunities contribute to increased knowledge of effective service delivery practices and/or relevant HL and HCD issues increasing the capacity of staff in the community to deliver effective services.

Data collection tools and support developed

HL and HCD collaborate with FNIHB program staff in regions and with communities to develop, pilot, and implement data collection tools and support to promote community-level data collection of

²⁶ To obtain a copy of the Logic Model graphic please use the following e-mail “Evaluation Reports HC - Rappports Evaluation@hc-sc.gc.ca”.

²⁷ The logic model narrative was obtained from the Evaluation Framework (FNIHB, 2013h, pp. 8–12).

information about services. The tools and related support documents are designed by FNIHB national and regional HL and HCD staff to be user-friendly to program and community-based staff.

Dental Therapy utilises the national dental database in which all oral health care services (preventive & restorative services) provided by all oral health providers (Health Canada employed and hired dental therapists through contribution agreements) is captured. The information in the database contains client identifiers and services provided and enables the tracking of oral health services based on specific communities and specific populations. It also facilitates the tracking of service delivery by the oral health providers.

Data/information and/or research relevant to services, determinants of health, and health status

HL and HCD work with federal partners, national research organizations, and other external researchers who produce data/information about services, determinants of health, and/or health status that is relevant to HL and HCD programs and services in order to analyze and integrate this information into studies, reports, and frameworks, all of which can be used for policy and program improvement.

Program guidance tools (e.g., policies, procedures, frameworks, guidelines) developed/refined

HL and HCD work collaboratively to produce program guidance tools that outline program design, parameters, and information about program implementation and operations. An example of a program guidance tool output is a program framework, which provides guidance on the types of activities that can be funded for First Nations and Inuit communities, health authorities, and health/other service providers.

Mechanisms and processes to share promising practices developed/implemented

HL and HCD support the development and implementation of mechanisms and processes to support knowledge sharing about what has worked in communities. For example, HL and HCD provide opportunities to test possible approaches to service delivery at the community level so that knowledge about the responsiveness (cultural and context relevance) of approaches can be assessed, adapted, and shared with stakeholders and inform policy.

Funding provided for community-based HL and HCD programs and services

Funding is provided for community-based program and service delivery. Service provision is funded through contribution agreements to band councils, tribal councils, health authorities, and incorporated Aboriginal organizations that manage the contribution agreements and are responsible for services. In the territories, the funding flows to the territorial governments, and the funds are integrated into Territorial health program delivery.

Dental therapy services directly provided by FNIHB

Dental Therapy and COHI services may be provided by FNIHB staff or through contribution agreements. Dental Therapy services are provided by over 60 FNIHB staff in more than 200 First Nations communities, some of which include COHI communities. COHI services may also be provided by dental hygienists, and some providers serve more than one community.

IMMEDIATE OUTCOMES

The immediate outcomes are directly attributable to HL and HCD outputs.

Improved community and stakeholder engagement and collaboration to support program and policy development and service delivery

Stakeholder engagement and collaboration is a mechanism for ensuring that programs, policy, and service delivery are developed and delivered in a way that is responsive to the needs in First Nation and Inuit communities. Collaboration processes (practices and the products of them) allow stakeholders to:

- provide information about effective HL and HCD programs/services and/or the context shaping those programs/services (or the effectiveness of them) for First Nations and Inuit living on reserve/in communities;
- play a meaningful role in providing advice and in decision making about policy and program development and service delivery; and
- inform policy/program development and service delivery.

Increased community capacity (knowledge, skills, and ability) to support community-based HL and HCD programs and services (PAA, Expected Result [ER] 2)

Training, continuing education, and professional development enhances the capacity (i.e., knowledge, skills and ability) of community-level staff (lay, para, and/or professionals) to deliver community-based HL and HCD programs and services.

Community capacity depends on the knowledge, skills, and ability to deliver culturally- and contextually-relevant HL and HCD programs and services. This may be promoted through culturally-appropriate training delivery models, or training, continuing education, and professional development that provide information about how to develop and deliver culturally-relevant and contextually-appropriate HL and HCD programs and services.

Increased ability to collect, monitor, and provide information for policy or program development and implementation

An increase in the ability to collect and monitor information using data collection tools contributes to the collection of reliable program level information. Information is primarily collected in the following ways:

- Communities collect and report data related to programming, as per responsibilities outlined in the contribution agreement, through data collection tools such as the community based reporting template and the NNC Annual Reporting Template.
- Aboriginal Organizations, universities, researchers, and consultants are engaged to collect, analyze, and/or disseminate information related to First Nations and Inuit health through data-sharing agreements, contribution agreements, or contracts.

The data from all sources is used to support ongoing accountability and program improvement purposes, as well as policy development.

Increased use of tools and evidence-based information (e.g., promising practices) to inform policy and program delivery and improvement

Using multiple lines of evidence to develop program guidance tools and other knowledge sharing mechanisms and approaches is intended to promote and increase the use of effective and responsive HL and HCD programs and services.

Ongoing access to HL and HCD programs/services (PAA, ER1)

Funding provides access to HL and HCD programs and services based on community-identified priorities and needs. It is important to ensure that programs and services are delivered in a way that is inclusive and responsive to participants (where, how they need them). If programs are more responsive to people's needs, people are more likely to participate and benefit.

Increased individual knowledge of HL and HCD issues and practices

HL and HCD programs and services are intended to build knowledge and awareness among program participants at the community level. The level of increase in knowledge and awareness among participants is expected to vary in relation to:

- the specific types of HL and HCD programs and services (or activities) that participants have had the opportunity to access, or been exposed to (for example, as a result of population-based health promotion campaigns or initiatives); and
- the length of time of participation or exposure.

INTERMEDIATE OUTCOMES

Intermediate outcomes are logically expected to occur once one more immediate outcomes have been achieved. Often, intermediate outcomes describe behavioural changes that result from increases in a target population's skills, knowledge, awareness, and/or access. The change may occur at the individual, community, or organizational level.

Improved coordination and integration of HL and HCD programs and services

The strategic benefits of intersectoral collaboration are in mobilizing resources and capabilities in support of coordinated and integrated approaches to address common risk factors and health objectives. Improved coordination and cooperation means addressing First Nations and Inuit healthy living and healthy child development through an integrated and non-duplicative approach. Once community, stakeholder, and partner engagement occurs, coordination and integration of HL and HCD programs and services are expected to improve over time, offering services that better meet needs of the target population.

Improved quality of HL and HCD programs and services

By increasing the workforce capacity (i.e., skills, knowledge, and expertise) and collecting information and evidence to inform program planning and delivery, HL and HCD programs and services will improve (i.e., services will be more responsive to the changing and diverse needs of the clients and meet the needs).

Increased healthy behaviours

Increased adoption of healthy practices includes participant-level impacts that are:

- broader than the medical concept of “health” alone; and
- based on First Nations and Inuit concepts of health (physical, mental, spiritual, and emotional).

These positive impacts on participants are linked, and contribute to, physical health and well-being objectives of programs and services under HL and HCD.

Increased supportive HL and HCD physical and social environments

The choice and ability to practice positive health behaviours is influenced by broader social and economic factors. Systemic partnerships and collaboration at the community level optimize the use of community-based resources to support HL and HCD. Supportive physical and social environments for healthy living and healthy child development are evidenced by:

- systematic coordination between HL and HCD programs, services and service providers, and multi-sector partners;
- policy support for programs and services focused on HL and HCD at the community, regional, and national levels; and
- availability of and access to resources to support HL and HCD at the individual, family, and community level.

LONGER-TERM OUTCOME

The longer-term outcome on the logic model is a consequence of one or more intermediate outcomes having been achieved.

First Nations and Inuit communities, families, and individuals receive HL and HCD services that are responsive to their needs so as to improve First Nations and Inuit health status (PAA 3.1, ER1).

Appendix 4 – Evaluation Description

Evaluation Scope

The scope of the evaluation covered the period from 2010-2011 to 2012-2013 for HL and 2008-2009 to 2012-2013 for HCD. The HL cluster consists of the programs and policy areas related to chronic disease prevention and management, injury prevention policy, and dental therapy. The HCD cluster consists of the program areas related to healthy pregnancy and early infancy, early childhood development, and the Children's Oral Health Initiative.

The evaluation issues were aligned with the Treasury Board of Canada's *Policy on Evaluation* (2009) and considered the five core issues under the two themes of relevance and performance. An evaluation matrix with questions, indicators, and data sources corresponding to each of the core issues guided the evaluation process.

An outcome-based evaluation approach was used for the conduct of the evaluation to assess the progress made towards the achievement of the expected outcomes and whether there were any challenges and/or barriers to achieving the expected outcomes.

The Treasury Board's *Policy on Evaluation* (2009) guided the identification of the evaluation design and data collection methods so that the evaluation would meet the objectives and requirements of the policy. A non-experimental design was used based on the Evaluation Framework document, which detailed the evaluation strategy for this program and provided consistency in the collection of data to support the evaluation. The Office of Evaluation, Public Health Agency of Canada–Health Canada (PHAC-HC) was the project authority for the evaluation, with assistance from Health Canada's Performance Measurement Unit. An Evaluation Working Group with representation from FNIHB national and regional offices provided guidance through review of data collection tools, technical reports, and final reporting. Furthermore, Assembly of First Nations (AFN) and Inuit Tapiriit Kanatami (ITK) provided guidance and input through review of community data collection tools, preliminary findings and a draft of the final report.

Evaluation Issues

The specific evaluation questions used in this evaluation were based on the five core issues prescribed in the Treasury Board of Canada's *Directive on Evaluation* (2009). These are noted in Table 1. Corresponding to each of the core issues, evaluation questions were tailored to the program and guided the evaluation process.

Table 1: Core Evaluation Issues and Questions

Core Issues		Evaluation Questions
Relevance		
Issue #1:	Continued Need for Program	Assessment of the extent to which the program continues to address a demonstrable need and is responsive to the needs of Canadians. 1.1 Is there a continued need for the HL and HCD Components?
Issue #2:	Alignment with Federal Roles and Responsibilities	Assessment of the role and responsibilities for the federal government in delivering the program. 2.1 Are the HL and HCD components aligned with the department's jurisdictional, mandated, and/or legislated role?

Core Issues		Evaluation Questions
Issue #3:	Alignment with Government Priorities	<p>Assessment of the linkages between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes.</p> <p>3.1 Do the HL and HCD components align with Government of Canada priorities? 3.2 Do the HL and HCD components align with departmental strategic outcomes?</p>
Performance (effectiveness, economy, and efficiency)		
Issue #4:	Achievement of Expected Outcomes (Effectiveness)	<p>Assessment of progress toward expected outcomes (incl. immediate, intermediate, and ultimate outcomes) with reference to performance targets and program reach and program design, including the linkage and contribution of outputs to outcomes.</p> <p>4.1 Are the HL and HCD clusters achieving the outcomes expected, as identified in the logic model?</p> <p>Immediate outcomes:</p> <ul style="list-style-type: none"> • Improved community and stakeholder engagement and collaborations to support policy/program development and service delivery • Increased community capacity (knowledge, skills, and ability) to support community-based HCD and HL programs and services (PAA ER2) • Increased ability to collect, monitor, and provide information for policy or program development and implementation • Increased use of program guidance tools and evidence-based information (e.g., promising practices) to inform policy and program delivery and improvement • Ongoing access to HCD and HL programs/services (PAA 3.1.1, ER#1) • Increased individual knowledge of HCD and/or HL issues and practices • Challenges and/or barriers to achieving immediate outcomes <p>Intermediate outcomes:</p> <ul style="list-style-type: none"> • Improved coordination and integration of HCD and/or HL programs and services • Improved quality of HCD and/or HL programs and services • Increased healthy behaviours • Increased supportive physical and social environments • Challenges and/or barriers to achieving intermediate outcomes <p>Long-term outcomes:</p> <ul style="list-style-type: none"> • First Nations and Inuit communities, families, and individuals receive services that are responsive to their needs (PAA 3.1 ER#1) so as to improve First Nations and Inuit health status • Challenges and/or barriers encountered in achieving longer-term outcome • Unintended results and/or consequences as a result of program implementation
Issue #5:	Demonstration of Economy and Efficiency	<p>Assessment of resource utilization in relation to the production of outputs and progress toward expected outcomes.</p> <p>5.1 Have the HL and HCD components been managed efficiently and economically?</p>

Evaluation Data Collection and Analysis Methods

The evaluation collected and analyzed data from multiple sources, including a literature review, document and data review, online survey, key stakeholder interviews, and site visits. Methodological details for each line of evidence are provided below.

Data collection methods

Literature review

The literature review relied primarily on peer-reviewed journals (scientific and academic) and relevant grey literature. FNIHB provided an initial selection of literature from an internal RefWorks database, as well as additional documents provided at several later dates, which were incorporated into a Zotero library for further review and analysis. Following a preliminary review of these documents, supplementary literature was collected through targeted searches. Abstracts of the key articles and reports were reviewed for their relevance in addressing the evaluation questions. Furthermore, bibliographies from reviewed literature sources were used to identify additional material for review.

Documents were included if they addressed at least one indicator of an evaluation question designated as using the literature review as a data source. Data on incidence rates was preferred if it encompassed the entirety of First Nations or Inuit populations, although regional data was included if it highlighted key issues or variations, or if no larger-scale study was available. The most recent statistical information was preferred, generally limiting the review to studies undertaken over the period 2004–14.

Additional documents were identified and collected by web search, using the Google Scholar engine specialized to search academic/peer-reviewed literature and searching within journal archives (as available). The bibliographies of already-acquired documents were reviewed to find original sources of data or publications focused on specific sub-topics. Below are the key search terms used, which may have been used in varying combinations (commonly combining terms from the first and second column) to locate documents on specific subjects.

Search Terms

- First Nations
- Inuit
- Aboriginal peoples
- Indigenous peoples
- Aboriginal children
- Determinants of health
- Early childhood development
- Healthy behaviours/lifestyle
- Maternal health
- Life course
- Community health workers
- Cultural relevance
- Remote/rural communities
- Health outcomes
- Economic impact
- Chronic disease
- Type 2 diabetes
- Diabetes risk factors
- Gestational diabetes
- Respiratory infections
- Oral/dental health
- Early childhood caries
- Breastfeeding
- Nutrition
- Food security/insecurity

- Traditional/country food
- Sedentary behaviours/lifestyle
- Physical activity/inactivity
- Obesity
- Substance use/abuse

Document review

FNIHB provided most of the documents and data for review via a RefWorks database and a USB stick. This included 176 documents from the RefWorks database, and 408 files on the USB stick (including many blank templates, as well as duplicates from the RefWorks database). These files were scanned for whether they best fit the document and data review or the literature review (a separate report). Some additional documents were obtained through preliminary interviews and web searches. As well, during the review period, additional documents and data were requested from FNIHB based on any identified information gaps. After reviewing the documents for their usefulness, references were entered into a Zotero library for further review and analysis.

- Health Canada and other government documents were kept for the document and data review, while non-government documents and literature were reallocated to the literature review.
- Documents were reviewed and sorted based on the evaluation questions that they could be used to address. If a particular document was found not to address any of the evaluation questions, it was excluded from the review.

Survey

A survey of FNIHB national and regional office staff was conducted online and was available in both French and English. National and regional office staff who had not participated in a key stakeholder interview were invited to participate (a total of 22 national staff members and 46 regional staff members). Health Canada provided national and regional office staff names and contact information.²⁸ Of these, 82% (n=18) of national office staff and 63% (n=29) of regional office staff responded to the survey.

Survey questionnaires were developed to address the outcomes/issues from the evaluation matrix in consultation with the Office of Evaluation and Health Canada's Performance Measurement Unit. The HL and HCD Evaluation Working Group (Working Group), consisting of Health Canada national and regional office staff members, reviewed and commented on survey questionnaires. Separate questionnaires were developed for regional and national office staff, with the questionnaire for the latter similar to but with fewer questions than that for regional staff. Regional office staff were expected to have greater familiarity with program operational aspects at the community level, and therefore would be better positioned to answer many of the community-oriented questions.

Prior to initiation of the survey, all FNIHB staff whose names had been provided by Health Canada received an email from the contractor informing them of the evaluation, the tasks involved, and that they would be asked to participate in either a telephone interview or the online survey. Staff were provided with both a FNIHB Performance Measurement Unit and an Office of Evaluation contact for any questions regarding to the evaluation. Health Canada requested that Working Group members email and encourage their colleagues to complete the survey, providing members with a draft email that could be used.

²⁸ Some regional office staff were inadvertently left off the list, and, therefore, the 46 regional staff did not represent all staff members who had not been included in interviews.

- The Office of Evaluation and Performance Measurement Unit received links to both surveys to review and pretest. Surveys were released in two waves on the days of release, with approximately five surveys first sent as a pretest. After several respondents had completed the survey and the answers were reviewed, the remaining surveys were released.
- Staff could choose to complete their survey in English or French, and could also leave the survey at any time and return at a later time to complete the questions. The regional office staff survey was released on January 14, 2014 and the national office staff survey on January 15. Both surveys remained open until the morning of February 6. To encourage responses, email reminders were sent to non-respondents on January 21, 29, and 31. To increase response rates, the final survey closing date was extended to February 6.
- Most survey questions were constructed as closed-ended questions with a choice of responses provided that could then be quantified for findings presentations. All stakeholders were also asked several open-ended questions to give them the opportunity to verbally express their varying perspectives. Verbatim responses were first reviewed to identify and develop themes/categories emerging from the data, and then coded according to these themes/categories. This facilitated quantification of responses.

Key stakeholder interviews

The key stakeholder interviews included three stakeholder groups: FNIHB staff from regional and national offices, territorial government representatives, and representatives from National and Regional Aboriginal Organizations (NAOs and Regional Aboriginal Organizations), including land claim organizations.

- Regional and national office staff participants were chosen to provide representation from all programs for national office and regional offices, taking into consideration that there were a large number of programs to cover and that a limited number of interviews could be conducted per region. However, in order to provide other FNIHB staff with involvement in the HL and HCD programs an opportunity to provide input into the evaluation, most staff not interviewed were included in the online staff survey task. Interviews and surveys involved FNIHB staff from the following regions: National Office (Headquarters), Northern, Atlantic, Quebec, Ontario, Manitoba, Saskatchewan, and Alberta.
- The two NAOs included in the interview task were the AFN and ITK. At the request of ITK, each of the four land claim organizations was also invited to participate in the interview process.
- Each FNIHB region was asked to identify one Regional Aboriginal Organization that they frequently work with either through consultations, collaborations, and/or partnerships.

Representatives from the Departments of Health for Nunavut and the Northwest Territories were invited to participate in the interviews. FNIHB does not have funding agreements with communities in these territories, but rather has a funding agreement with the territorial governments who, in turn, have funding agreements with communities to deliver HL and HCD programs. No representatives of the Yukon government were interviewed, as most communities (11 of 14 communities) have a self-governing agreement.

The interview task involved a total of 42 interviews with 55 participants. This included:

- 30 interviews with FNIHB staff (nine with national office and 21 with regional offices),
- two with representatives the territorial governments (Nunavut and the Northwest Territories), and

- 10 interviews with Aboriginal organizations, including 3 with representatives of the NAOs (two with Assembly of First Nations and one with ITK), five with representatives of Regional Aboriginal Organizations, and two with representatives of land claim organizations.

Separate interview guides for each stakeholder group were developed to address the relevant evaluation question and according to the participant groups' expected area of knowledge. Guides were developed in consultation with the Office of Evaluation and the Evaluation Working Group, with further input from Assembly of First Nations and ITK. The first few interviews served to pretest the guides; only minor changes were made as a result of the pretesting.

Health Canada FNIHB staff received an email from the contractor informing them of the evaluation, the tasks involved, and that they would be asked to participate in either the interview process or the online survey. Staff were provided with both a FNIHB Performance Measurement and a Health Canada Office of Evaluation contact for any questions regarding the evaluation. Potential participants were then contacted to schedule the interview at a time convenient to the interviewee. Participants received the interview guide in advance to allow them to prepare a considered response. Interviewees had the option of including several other staff members in the conversation. Interviews took from 1.0 to 1.5 hours and were conducted by telephone in the official language of the interviewees' choice. Interviews were digitally recorded, with the participant's permission, and interviewees received copies of their interview notes for their records and to give them an opportunity to make revisions or additions to the notes.

Site visits

Site visits were conducted with 17 First Nations and Inuit communities in the Atlantic, Quebec, Ontario, Manitoba, Saskatchewan, and Alberta FNIHB regions. The Northern region was not included in site visits, as FNIHB does not have funding agreements with communities in these territories but rather has a funding agreement with the territorial governments who, in turn, have funding agreements with their communities. To ensure objective selection of communities, Health Canada requested the contractor choose the communities to visit, based on information provided about community characteristics. Sites were initially selected based on the following criteria:

- The number of sites per region was determined according to the proportion each region's First Nations and Inuit population represented for the six regions overall.
- At least one community per region should have a set funding model, with others chosen from more flexible funding models.
- Within each region, communities should be chosen to include those that are non-isolated, semi-isolated, and remote and isolated, as possible and dependent on the number of sites per region.
- Communities should be chosen from those offering as many of the HL and HCD programs as possible.
- Communities should represent a range of population sizes.

Chosen sites were then submitted to Health Canada, and some adjustments were subsequently made based on regional input, with several suggestions made for changing sites, mainly for the following reasons:

- Some of the suggested communities may be experiencing internal issues and would not be in a position to participate in a research project.

- Some communities either were already participating in a Health Canada study or had been asked to participate in numerous studies and therefore may experience study fatigue.
- Changes were suggested for Quebec to ensure a French community and an Inuit community were involved.

Of the 17 communities, two were from Alberta, four from Saskatchewan, four from Manitoba, three from Ontario, two from Quebec, and two from the Atlantic region. Furthermore, 13 communities were non-isolated, one was semi-isolated, and three were isolated. With respect to community size, three had populations under 1,000; five had populations of 1,000 to under 2,500; three had populations of 2,500 to under 5,000, three had populations of 5,000 to under 7,500; and three had populations of 7,500 and up to close to 10,000.

Each visit included key stakeholder interviews with community leadership and health directors, and focus groups/questionnaires with program staff and participants. (One community participated remotely by teleconference, and no focus groups were conducted.) Overall, 13 health directors, five community leaders, three other community representatives, 112 community staff, and 111 community members participated in the site visit process, for 244 total participants across the 17 communities.

Interview guides for the health director and community leadership, as well as separate focus group moderator guides for the staff and participant focus groups, were developed to address the relevant evaluation questions and according to the participant groups' expected area of knowledge. Furthermore, adjunct questionnaires were developed for staff and program participants in order to collect some quantitative information through the focus groups. As with key stakeholder interviews, the Evaluation Directorate, the Evaluation Working Group, Assembly of First Nations, and ITK had the opportunity to review and comment on the guides and questionnaires. The first few site visits served to pretest the guides; no changes were determined necessary as a result of the pretesting.

Once communities had agreed to participate, Health Canada provided contact names to the contractor, and the consultant then called to provide further details, answer any questions, and arrange dates and times. Community contacts were asked to identify and invite staff members involved in the HL and HCD programs for the staff focus group and arrange for community members who participated in their HL and HCD programs for the participant focus groups. For the latter, communities were asked to invite participants from each of the HL and HCD programs, including parents or grandparents whose children had taken part in one of the children's programs.

Contacts were emailed a summary of the process and the interview guide that would be used for health directors and community leaders, were given a list of topics that would be addressed through the staff focus group, and were told that participant focus groups would mainly address what they participated in, what they learned, how these helped them or their children, and any healthy lifestyle changes they might have made. Focus group participants received a thank-you note with an enclosed honorarium for participating.

Data Analysis

Data were analyzed by triangulating information gathered from the different sources and methods listed above and were summarized in separate data summary reports for each line of evidence.

- All materials in the literature and document reviews were compiled in a Zotero file management library for comprehensive review and analysis. Documents were included and organized or rejected based on their relevance to the questions in the evaluation framework. Where possible, data in the literature and document reviews were compared over time to identify any trends or patterns over time.

- Transcripts were produced for key stakeholder interviews, including the interviews and focus groups conducted as part of the site visits, and responses were coded and organized according to evaluation questions and issues. All responses were analyzed for similarities and divergences of opinion.
- All findings from the literature and document reviews, key stakeholder interviews, and site visits were summarized in separate technical documents based on the evaluation framework, to organize information relevant to each indicator. Key findings were then summarized to address each applicable evaluation question directly with each line of evidence.
- Data from the staff online survey and the adjunct questionnaires administered during site visit focus groups were each compiled and analyzed to provide a narrative analysis of responses to each evaluation question. Responses to closed-ended questions were quantified into frequency tables using SPSS software. Responses to open-ended questions were reviewed in order to identify themes and categories, then coded and similarly quantified. The key findings were then summarized in relation to each applicable evaluation question.

For the final report, the key findings from each line of evidence were compared in order to validate conclusions and identify any discrepancies or mutually-supportive findings.

Appendix 5 – Healthy Living and Healthy Child Development Program Profile Descriptions²⁹

Health Living (HL)

The HL component includes the following areas:

- Chronic Disease Prevention and Management
- Injury Prevention Policy
- Dental Therapy

The activities and objectives of each are explained below.

Chronic Disease Prevention and Management

Chronic Disease Prevention and Management includes two community-based initiatives (the Aboriginal Diabetes Initiative and Nutrition North Canada–Nutrition Education Initiatives) and two policy areas (Nutrition Policy and Chronic Disease Prevention Policy).

Aboriginal Diabetes Initiative (ADI)

The Aboriginal Diabetes Initiative (ADI) is the largest component of HL and delivers community-based programs and services in over 600 First Nations and Inuit communities. The ADI was allocated \$55M in 2010-2011 and 2011-2012 and \$51.1 in 2012-2013. The ADI was created in 1999 to help improve the health status of First Nations, Inuit, and Métis individuals, families, and communities through actions aimed at reducing the prevalence (rate) and incidence (reported new cases) of diabetes and its risk factors.

The goal of the ADI is to reduce Type 2 diabetes among Aboriginal people by supporting health promotion and prevention activities and services delivered by trained community diabetes workers and health service providers. The current funding period (2010-2015) features four areas of enhanced focus:

- initiatives for children, youth, parents, and families
- diabetes in pre-pregnancy and pregnancy
- community-led food security planning to improve access to healthy foods, including traditional and market foods
- enhanced training for health professionals on clinical practice guidelines and chronic disease management strategies

The objectives of the ADI include the following:

- creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy food and promotion of healthy eating, physical activity, and healthy body weights

²⁹ Program profile descriptions were taken from the Evaluation Framework, Appendix A (FNIHB, 2013h, pp. 53–63).

- increasing awareness of diabetes, diabetes risk factors and complications, and approaches to prevent diabetes and associated complications among all Aboriginal people
- increasing the early detection and screening for complications of diabetes in First Nations and Inuit communities
- increasing community ownership of diabetes programs and capacity to prevent, delay, and manage diabetes
- increasing knowledge development and information sharing to inform community-led, evidence-based activities in Aboriginal communities
- developing partnerships to maximize the reach and impact of primary prevention and health promotion activities

These objectives are pursued through the following activities.

The ADI achieves its objectives through activities in four component areas:

- 1) **Community-based Health Promotion and Primary Prevention**
Activities to support health promotion and disease prevention with a focus on creating supportive environments and increasing the practice of healthy behaviours. This is achieved through improved access to healthy food; promotion of healthy eating, physical activity, and healthy body weights; and diabetes awareness. These activities are delivered in over 600 First Nations and Inuit communities and reach children, youth, parents, adults, Elders, and families
- 2) **Screening and Management**
Activities that support the early detection of diabetes and related complications before they are apparent and maintain the appropriate management to improve health outcomes. In some regions (Alberta, Manitoba, and Quebec), screening for diabetes complications (such as limbs, eye, cardiovascular, or kidney complications) are delivered through mobile screening initiatives in rural and remote areas. In other regions, screening is carried out through local health care providers. Some communities form partnerships with neighbouring provincial health care services to increase screening opportunities.
- 3) **Capacity Building and Training**
Activities to enhance community worker and health professional capacity to deliver effective health promotion and diabetes prevention programming. ADI supports capacity building and training for community diabetes prevention workers who play a key role in diabetes prevention activities and work in partnership with health care professionals and other members of their community. Over 350 workers have completed college-based training programs. Continuing education activities enhance the skills and knowledge of community workers and health professionals in a wide variety of areas relevant to diabetes prevention and management, including foot care, nutrition, food security, cultural competency, and clinical practice guidelines. In addition, regional multidisciplinary teams provide subject-matter expertise to communities on diabetes, physical activity, and nutrition. The ADI supports training to those working with communities, including home and community care nurses, on clinical practice guidelines and chronic disease management strategies.
- 4) **Knowledge Mobilization**

Activities that will improve and promote knowledge sharing on what works to promote health and prevent diabetes and associated risk factors. Knowledge mobilization provides important information on what is working to support communities, develops knowledge on emerging issues, helps describe trends, and facilitates decision making at the community, regional, and national levels by providing information on the effectiveness of interventions.

Knowledge mobilization includes activities in the following areas:

- knowledge development (e.g., support to the federal Innovation Strategy [healthy weights] led by PHAC; support for regional evaluation and innovation projects)
- knowledge translation and exchange (e.g., support for a repository of health promotion and disease prevention information on the National Aboriginal Diabetes Association's website); and
- evaluation and monitoring.

Nutrition North Canada (NNC) Nutrition Education Initiatives:

Nutrition North Canada (NNC) was launched on April 1, 2011, replacing the Food Mail Program. The new program supports improved access to healthy food for Northerners. As part of the program, Aboriginal Affairs and Northern Development Canada subsidizes retailers and suppliers for the cost of shipping perishable healthy food to isolated northern communities. Under NNC, Health Canada receives funding to support retail and community-based nutrition education initiatives in First Nations and Inuit communities that are eligible for the full retail subsidy. Beginning in 2010–11, Health Canada provided funding to support nutrition education activities to complement the Aboriginal Affairs and Northern Development Canada retail subsidy in influencing healthy eating patterns in isolated northern communities. The objective of these nutrition education activities is to increase knowledge of healthy eating and develop skills for the selection and preparation of healthy store-bought and traditional or country foods.

National office provides leadership in the NNC nutrition education initiatives by:

- providing general program leadership and advice to support program coordination and implementation;
- working with Health Canada Regions, the territorial governments, the Assembly of First Nations, Inuit Tapiriit Kanatami, and partners to support community implementation and capacity building;
- working with Aboriginal Affairs and Northern Development Canada on the overall implementation of NNC, including communications, promotion and marketing, and the evaluation and reporting requirements for the program; and
- providing nutrition advice to Aboriginal Affairs and Northern Development Canada.

Policy Areas

The policy areas within Chronic Disease Prevention and Management differ from the community-based initiatives in that no activities are funded at the community level.

The overall goals of Nutrition Policy and Chronic Disease Prevention Policy are knowledge development and exchange and to establish and maintain partnerships to inform policy and programs. The objectives of each policy area are outlined below. It may be worth noting that as a result of the new Branch Strategic Plan and upcoming strategic planning activities, some priorities within the policy areas may shift and evolve.

Nutrition Policy and Food Security Policy

Nutrition and food security aims to enhance the nutritional health of First Nations and Inuit by working with partners across sectors in the following priority areas: food security; healthy weights; dietary adequacy; and chronic disease prevention.

The objectives of the Nutrition Policy are as follows:

- collaborate with partners and stakeholders who work in the area of nutrition and food security/health promotion/chronic disease prevention to exchange information and to provide opportunities for input of First Nations and Inuit considerations into policy and programming
- identify needs related to First Nations and Inuit nutrition (and, in some cases, Aboriginal peoples more generally) and develop or strengthen policies, strategies, programs, projects, research, and capacity-building initiatives to respond
- build and strengthen capacity, including human resource capacity, to deliver nutrition-related programs and services through resources, tools, supports, and training
- facilitate the creation of supportive environments that contribute to improved nutrition and healthy living practices within First Nations and Inuit communities through policy and program efforts

Activity areas include the following:

- supporting efforts to build the evidence base for nutrition and food security (e.g., First Nations Food Nutrition and Environment Study) to identify baselines and inform policy and program development, performance measurement, and evaluation
- tailoring national dietary guidance for Aboriginal peoples (e.g., Eating Well with Canada's Food Guide — First Nations, Inuit, and Métis)
- collaborating with First Nations and Inuit partners and other stakeholders to address issues related to nutrition and food security (e.g., Food Security Reference Group, Federal-Provincial-Territorial Group on Nutrition, and NNC Advisory Board)
- providing advice for health promotion programming and policy development (e.g., enhanced focus on community-led food security planning within the Aboriginal Diabetes Initiative, development of Nutrition North Canada)

Chronic Disease Prevention Policy

Chronic Disease Prevention Policy contributes to the reduction of the incidence, prevalence, and impact of chronic diseases among First Nations and Inuit by working with First Nations and Inuit partners, as well as chronic disease organizations, the Public Health Agency of Canada (PHAC), and the Primary Health Care and Public Health Directorate of FNIHB, on the following objectives:

- raise awareness about chronic disease prevention at the national, regional, and community levels
- support knowledge development, analysis, and exchange, and inform policy, strategies, programs, and research agendas in the area of chronic disease prevention
- support integration and quality improvement of services at the community level for chronic disease prevention and management

The Chronic Disease Prevention Policy informs policy and program development in specific chronic disease prevention areas (such as cancer, heart health and stroke, lung health), promoting an integrated approach to disease prevention at the national, regional, and community levels. Main areas of activity include: support knowledge development, translation, and exchange on evidence-based practices for chronic disease prevention and management in First Nations and Inuit communities; provide input to national disease strategies relative to First Nations and Inuit; support the engagement of First Nations and Inuit national organizations in policy development; and capacity building for the development and delivery of chronic disease prevention and management activities in First Nations and Inuit communities.

Injury Prevention Policy

Similar to the two policy areas reported above, injury prevention policy efforts do not include specific funding for activities at the community level. The focus of injury prevention policy is to contribute to the reduction of the incidence and severity of non-intentional injuries (e.g., related to fire, falls, motor vehicle collisions, drowning, and poisoning) among First Nations and Inuit by working with partners. Efforts related to injury prevention policy include policy development, knowledge development, translation, and exchange; capacity building; and collaboration and partnership development to incorporate injury prevention into other First Nations and Inuit programs.

Dental Therapy³⁰

Dental therapy services

Dental Therapy strives to improve, and ultimately maintain the oral health of First Nations living on-reserve and Inuit living in communities at a level comparable to other Canadians living in similar conditions. Dental Therapy increases access to care in First Nations and Inuit communities, particularly in remote and isolated locations, by offering basic clinical care, emergency and preventive services as per their scope of practice.

Dental therapists play a key part in the Children's Oral Health Initiative (COHI) in communities in which COHI is present. This is an add-on to the services already rendered by dental therapists.

Dental therapy services are delivered by federal employees, or through contractual or contribution agreements with regional or local First Nations health care organizations or provincial/territorial health authorities. This occurs in all Health Canada regions, except Ontario and Quebec, where there are no dental therapists, due to provincial legislation. Under the general supervision of a dentist, dental therapists deliver a range of basic services including oral health promotion activities, clinical care, and emergency and preventive services. They refer clients to dentists for services beyond their scope of practice. Health Canada funded dental therapy services are offered south of 60°. In collaboration with Nunavut, Northwest Territories, and the Yukon, they are offered in a number of First Nations and Inuit communities in the north, where there are dental therapists employed by the territorial governments.

³⁰ Dental Therapy Services are offered to all members of a community. Where the community receives additional funding for the Children's Oral Health Initiative (COHI), the target clientele for this health promotion initiative is children aged 0-7, parents and caregivers, and pregnant women.

The objectives of Dental Therapy are to reduce and prevent oral disease through prevention, education, and oral health promotion, and to increase access to oral health services. The following elements are used to reach the objectives: direct oral health service delivery and COHI and referral. In most First Nations and Inuit health regions, dental therapists serve all members of a community. In communities in which dental therapists are associated with COHI, their target clientele is children aged 0–7, their parents and caregivers, and pregnant women.

Target Population of Healthy Living

The target population of HL activities is First Nations residing in traditional First Nations communities, Inuit residing in traditional Inuit communities. That said, HL includes some support for all Aboriginal peoples.

The HL cluster targets over 600 First Nations and Inuit communities through the ADI. The ADI reaches urban First Nations, Inuit, and Métis populations by funding diabetes primary prevention and health promotion projects through a Request for Applications (RFA) process. There were 21 projects selected in 2011 for funding over a period of 24 months. In addition, seven³¹ Demonstration Projects were funded via a targeted solicitation approach. The Demonstration Projects aim to help build urban First Nations, Inuit, and Métis organizations' capacity to evaluate promising practices and disseminate new knowledge.

Nutrition North Canada (NNC) Nutrition Education Initiatives provide programming in isolated First Nations and Inuit communities that are eligible for the full NNC retail subsidy by Aboriginal Affairs and Northern Development Canada.

Oral health services (both COHI and dental therapy services) are delivered by dental therapists in over 200 First Nations and Inuit communities.

HL directly or indirectly targets all Aboriginal populations through a range of policy, knowledge development and advisory activities in support of Branch, and departmental and government-wide programs and services. HL activities include the generation of evidence/knowledge; partnering, collaborating, and consulting with First Nations and Inuit and health care organizations; leading and contributing to policy initiatives; development of information resources; and building capacity. These activities contribute to the HL program and policy areas, as well as, initiatives of the federal government, provincial/territorial and local governments, and national and local Aboriginal organizations.

Strategic Environment/Context of Healthy Living Programs

A number of recently announced strategies, initiatives, and pledges have been made supporting HL Activities within the current Government of Canada priorities. Some examples include the following:

- **United Nations (UN) General Assembly High-Level Meeting (HLM) on the Prevention and Control of Non-communicable Disease (UN NCD Summit)** — In September 2011, the UN NCD Summit reinforced a global commitment to integrate efforts to reduce risks for chronic diseases. Tobacco smoking as well as physical inactivity, unhealthy eating, and alcohol abuse are the four

³¹ One of the seven demonstration projects was unable to complete the work plan activities associated with the delivery of their promising practices. As such, the organization is currently delivering a community-based diabetes prevention and health promotion project, consistent with the objectives of all RFA-funded projects. This means there are currently (June 2012) six demonstration projects and 22 RFA-funded projects.

major risk factors. Canada endorsed the UN Summit Declaration and committed to work with the public, private, and voluntary sectors to tackle these health risks.

- **Federal Tobacco Control Strategy** — The March 2012 federal budget announced a renewal of Federal Tobacco Control Strategy (FTCS) with \$25 million over five years for tobacco projects in First Nations and Inuit communities.
- **Aboriginal Diabetes Initiative Renewal** — Budget 2010 announced a commitment to continue funding “upstream” investments, such the ADI.
- **Creating a Healthier Canada: Making Prevention a Priority** — In 2010, Canada’s health ministers endorsed this declaration, which lays out a vision of how governments will work together, and with other organizations in the promotion of health, and the prevention of disease, disability, and injury.
- **Federal/Provincial/Territorial Framework for Action to Promote Healthy Weights** — In 2010, Federal/Provincial/Territorial Ministers of Health agreed to focus efforts on curbing childhood obesity rates and promoting healthy weights as a critical first step in helping Canadians live longer, healthier lives. Under this framework, Federal/Provincial/Territorial Ministers will work together and with stakeholders to identify joint and/or complementary actions.
- **Actions Taken and Future Directions, Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights, Nov 25, 2011** — In 2012, Federal/Provincial/Territorial ministers agreed to continue to work together in efforts to curb childhood obesity.
- **Nutrition North Canada** — In 2010, the Ministers of Indian Affairs and Northern Development (now Aboriginal Affairs and Northern Development Canada, Aboriginal Affairs and Northern Development Canada) and Health jointly announced this new program. Aboriginal Affairs and Northern Development Canada subsidizes the cost of shipping healthy perishable foods to isolated northern communities for retailers, and Health Canada funds nutrition education activities in First Nations and Inuit communities that are eligible for the full NNC retail subsidy. Nutrition North Canada replaced the Food Mail Program on April 1, 2011.

Healthy Child Development

The HCD component funds and supports community-based and culturally-relevant programming, services, initiatives, and strategies that aim to improve health outcomes associated with First Nations and Inuit maternal, infant, child, and family health. The areas of focus include prenatal health; nutrition; early literacy and learning; physical, emotional, and mental health; and children’s oral health. Programming aims to improve health outcomes for First Nations and Inuit infants, children, youth, families (including pregnant women), and communities. These are delivered through: community-based programs such as Fetal Alcohol Spectrum Disorder, Canada Prenatal Nutrition Program – First Nations and Inuit Component, Aboriginal Head Start on-Reserve (AHSOR), Maternal Child Health, and COHI.

The HCD component focuses on three key areas: Healthy Pregnancy and Early Infancy, Early Childhood Development, and COHI. Each program area has unique objectives and target populations with some overlap.

Healthy Pregnancy and Early Infancy

Programming in this area relates to the promotion of healthy pregnancies and the health of infants and young children, and focuses on prenatal nutrition, maternal and child health, and Fetal Alcohol Spectrum Disorder (FASD). Key objectives of these program areas within the HCD include the following:

Prenatal Nutrition

- Support the improvement of maternal and infant health. Activities fall under three core elements which include: nutrition screening, education and counselling; maternal nourishment; and breastfeeding promotion, education, and support.

Maternal Child Health

- Implement support services which include: screening and assessment of pregnant women and new parents to assess family needs; reproductive and pre-conception health promotion; as well as home visiting by nurses and community-based workers to provide follow up, referrals, and case management as required. The prevention components of maternal child health care have been enhanced for childbearing families by moving beyond the scope of medically-based prenatal and postpartum services to integrate cultural values, customs, and beliefs into many program components.
- Enable home visiting to offer education and support to pregnant women and families with infants with respect to parenting skills and knowledge, healthy child development, positive lifestyle changes, pre-conception health, improved maternal reproductive health, and access to social supports.
- Reduce and prevent oral disease through prevention, education, and oral health.
- Integrate cultural values, customs, and beliefs into all program components.

Fetal Alcohol Spectrum Disorder (FASD)

- Support the development of culturally appropriate and evidence-based prevention and early intervention programs related to FASD.
- Support capacity building and training of community workers and professional staff; development of action plans; and prevention, education, and awareness activities.
- Implement prevention programs through mentoring projects, using an evidence-based home visitation model. (e.g., mentors help a woman identify her strengths and challenges and link her to appropriate services/supports that can help to reduce her risk of having a baby affected by FASD).
- Implement intervention programs through case management and community coordination, to facilitate access to diagnosis, and to help families connect with multi-disciplinary diagnostic teams and other supports and services.

Early Childhood Development

AHSOR funds early childhood intervention strategies that support the health and developmental needs of First Nations children from birth to age six and their families. The goal is to support programming that is designed and delivered by First Nations communities in an effort to meet their unique needs. Key objectives of AHSOR include the following:

- Support the spiritual, emotional, intellectual, and physical growth of each child.
- Support and encourage children to enjoy life-long learning.
- Support parents, guardians, and extended family members as the primary teachers.
- Encourage parents and the broader First Nations community to play a role in planning.
- Build relationships and coordinate with other community programs and services to enhance the effectiveness of the program.
- Encourage the best use of community resources for children, as well as for their parents, families, and communities.

Children's Oral Health Initiative

The COHI is a program that strives to improve, and ultimately maintain the oral health of First Nations living on-reserve and Inuit living in Inuit communities at a level comparable to other Canadians living in similar conditions. Training is provided for community members to become COHI Aides in order to provide limited oral health services in some communities. COHI activities are delivered primarily in communities south of 60°. In collaboration with the governments of Nunavut and the Northwest Territories, they are offered in a number of First Nations and Inuit communities in the north, where there are dental therapists employed by the territorial governments. Northern Region receives funding for COHI projects. Services managed and delivered by COHI include a broad range of oral health activities, including dental disease prevention, promotion of good oral health practices, and basic clinical services (e.g., screenings, topical fluoride applications, placement of dental sealants, alternative restorative treatment, referrals to other services). Prevention and promotion activities include awareness campaigns and presentations (including oral health specific presentations) to target sites and groups such as Aboriginal Head Start locations, day cares, preschools, nurseries, parent participants, expectant parents, immunization clinics, and other community groups. COHI objectives are: to reduce³² and prevent oral disease through prevention, education and oral health promotion and to increase access to oral care.

Target Population

The primary target populations for the Healthy Pregnancy and Early Infancy programming is pregnant First Nations and Inuit women, mothers, and their infants and young children (ages 0–6 years) who live on-reserve or in Inuit communities, particularly those identified as high risk. The secondary target group includes First Nations and Inuit women of childbearing age on-reserve or in the North (north of 60 degrees). The Children's Oral Health Initiative clients are First Nations living on-reserve and Inuit living in Inuit communities, children 0–7 years of age, their parents and caregivers, and pregnant women. The AHSOR Program provides services and/or supports for children from age 0 to 6 years and their families living on-reserve.

³² Note that other factors influence the success in which oral disease is reduced and/or prevented. The goal here, although not specifically articulated, is to help, assist and/or influence this goal through the COHI.

Current Levels of Programming

Healthy Pregnancy and Early Infancy

- The First Nations and Inuit component of the Canada Prenatal Nutrition Program (CPNP-FNIC) serves more than 600 communities, reach approximately 9,000 First Nations and Inuit women per year.
- The Maternal Child Health Program (MCH) provides home visiting by nurses and family visitors to approximately 8,000 families, while approximately 3,500 families receive case management services³³.
- The Fetal Alcohol Spectrum Disorder (FASD) Program reach more than 600 women. In addition, community coordinator positions help increase families' access to multi-disciplinary FASD diagnostic teams and related services and support.

Early Childhood Development

- AHSOR serves over 11,000 children in over 300 First Nations communities across Canada.
- Prior to 2005, programming was mostly limited to centre-based settings (delivered in a space/building used specifically for AHSOR, and often co-located with other daycare/health programs). Since 2005, AHSOR has been able to expand its reach to serve more children and families through the outreach/home-visiting delivery model. Currently, approximately one third of all sites across Canada use outreach/home-visiting as a way of increasing the number of children served.
- Programming can be centre-based, delivered through outreach services/home visits, or a combination of the two.

The Public Health Agency of Canada provides funding for programming in some Inuit communities through the Aboriginal Head Start Urban and Northern Communities (AHSUNC) program.

Children's Oral Health Initiative

- COHI provides services to approximately 20,000 children across Canada. Typically delivered by dental therapists and dental hygienists, COHI focuses on prevention of oral disease and promotion of positive oral health practices. COHI delivers preventive procedures, such as fluoride varnish applications, sealants and stabilization therapy to children aged 0-7 years and oral health instructions and information to parents/caregivers and pregnant women.

³³ This program is not offered in Inuit communities