Nunatsiavut Government
Department of Health and Social Development

Regional Health Plan

September 1, 2007 to March 31, 2010

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1. Introduction

Background

On December 1, 2005, the Nunatsiavut Government (NG) was established. NG represents approximately 5300 Inuit and Kablunângajuit of Labrador and is responsible for advancing the aboriginal, constitutional, democratic, social, and human rights of Labrador Inuit. The term Labrador Inuit is used to refer to all beneficiaries of the Labrador Inuit Land Claim Agreement.

Nunatsiavut, which means "our beautiful land" encompasses all lands in the Labrador Inuit Settlement Area, including the communities of Nain, Hopedale, Rigolet, Makkovik, and Postville. The NG also provides certain programs and services for Labrador Inuit who live in the communities of Happy Valley-Goose Bay, Mud Lake, and North West River, as well as the Canadian Constituency (Labrador Inuit who live outside of Nunatsiavut and Upper Lake Melville). Refer to Appendix A for a map of the Labrador Inuit Settlement Area.

The NG Department of Health and Social Development (DHSD), formerly the Labrador Inuit Health Commission, is responsible for the health and social development needs within NG. The DHSD is comprised of a Regional Office located in Happy Valley-Goose Bay, as well as community offices in seven communities: North West River, Happy Valley-Goose Bay, Rigolet, Postville, Makkovik, Hopedale, and Nain. The regional and community teams work in cooperation to deliver the DHSD programs and services.

What is the Regional Health Plan?

Prior to DHSD being established, a Community Health Plan served as the blueprint for the programs and services delivered. This plan, revised every three to four years, outlined the goals, objectives and activities for the region, as well as for each community. With the establishment of the DHSD, and its modified and expanded role as a Government Department, a new regional-level plan to guide the work of the Department is now required.

This Regional Health Plan (RHP) is the first one developed for the DHSD. The plan is intended to guide the employees, programs and services of the DHSD, and is meant to be clear and understandable for both the NG as well as Labrador Inuit. The plan outlines the guiding principles for the Department, program descriptions, goals, objectives, and how the plan will be monitored and evaluated. This RHP will cover three years: September 2007 to March 2008, April 2008 to March 2009, and April 2009 to March 2010. This timeline is intended to coincide with that of the fiscal finance agreement between the NG and Indian and Northern Affairs Canada.

The RHP outlines the key priorities for the next three years. It is not meant to be an all-inclusive list of all programs, activities, and services that are provided by the DHSD. The objectives outlined in this plan are based on information gathered from consultations such as the Alcohol and Drug Hearings, program feedback from clients, community knowledge, and health and social statistics. The objectives listed in the plan should be the main focus for the next three years. However it is recognized that other issues may be of concern in some communities and may also require focus.

From a Regional Plan to Community Health Plans

The RHP has a regional focus and does not explain or mandate how these objectives will be met. The seven DHSD community offices will determine which objectives are of priority in their community, and how they intend to work towards making the objectives a reality. Communities will do this by developing their own community-specific Community Health Plans. The RHP is “what we want to achieve” and the Community Health Plans will be “how we plan to achieve it”. Each Community Health Plan (CHP) will be different, based on community needs, and may have additional objectives specific to a community. Each community will determine which activities or methods will be used to help reach these objectives.

The next step of the RHP process is to determine how the plan will be put into action. This is where the seven CHPs will come into play. The CHPs will guide the work of the Community DHSD staff. In addition, the regional DHSD office will develop a Regional Implementation Plan to outline how regional staff will work towards achieving the shared objectives of the RHP.

2. Format of Regional Health Plan

The RHP sets out the blueprint for the DHSD for the next three years. First, it outlines the key guiding principles upon which all operations of the DHSD will be based.

Section 4 lists the nine programs that are offered by the DHSD. Each program section includes a short description of the program, examples of how the program has been implemented in the past, and new ideas for shifts in focus for the future. Some programs have been implemented for many years (e.g., Non-Insured Health Benefits). Others may have a new name (e.g., Mental Wellness), and some are new areas that the DHSD has worked on, but have never been formally designated as programs (e.g., Injury Prevention).

Each Program section is comprised of:

Goal: A broad, timeless statement that explains the overall outcome the DHSD would like to see if the entire program was successful. It is our destination.

Objectives: Specific steps that can be taken to help the DHSD reach this goal. They are examples of the many roads the DHSD can travel to reach the destination.

Rationale: Explains briefly why an objective was chosen as a priority, or why it is an issue of concern.

Indicator of success: A measure that the DHSD can use to help determine whether or not an objective has been reached.

3. Guiding Principles

The DHSD will be guided by the following principles in conducting the business of the Department.

Vision: The vision of the Nunatsiavut Government Department of Health and Social Development is healthy individuals, families, and communities.

Mission: The mission of the Department of Health and Social Development is to improve the health and social status of Labrador Inuit through community-based programs and services, advocacy, and collaboration.

Values: The Department of Health and Social Development is committed to:

- Client-centered approaches (where clients refer to the people we serve)
- Practicing and promoting Labrador Inuit culture and language

- Promoting the balance between rights and responsibilities
- Empowerment: Fostering independence, self-reliance, and self-worth
- Collaboration: Working together
- Accountability: Being answerable to clients and stakeholders in a clear manner
- Consultation: Sharing knowledge and exchanging information
- Respecting yourself and others
- Leadership: Demonstrating and fostering positive role modeling
- Communication: Open sharing of information

4. Program Descriptions, Goals, and Objectives

I. Non Insured Health Benefits

The Non-Insured Health Benefits (NIHB) Program arranges for specific health services to be provided to Labrador Inuit who require them to maintain health, such as disease prevention and diagnosis, treatment of illness, injury and disability, and to promote the highest level of independent living. The benefits provided by NIHB supplement those provided by provincial/territorial health plans, private insurance plans, and the Department of Human Resources, Labour and Employment.

The general categories of NIHB are:

- Medical Transportation (which includes air, ground, accommodation and meals)
- Interpreter/Translator Services
- Vision Care
- Prescription Drugs
- Medical Supplies and Equipment
- Dental Care

Health Canada developed the policy framework that guides the benefits provided by NIHB. While NG can modify this policy, for the most part, it has adopted the Health Canada policies for standardization and evidence-based support. The existing policy manual is currently under revision.

The DHSD now manages all aspects of the NIHB program. As of 2006/2007, this includes the billing processes for dental and prescription drug services, which will be administered by the regional NIHB office. Staff have been trained in this new system, which will allow us to look more closely at areas of spending and plan for programs and services, identifying where health prevention initiatives may need to focus.

The NIHB program requires that all spending choices be made carefully. The DHSD must ensure we are providing fair, cost-effective benefits that are based on evidence. This sometimes requires changes to benefits. Any significant changes to NIHB that would impact the client will require the approval of the Nunatsiavut Assembly. The NIHB program must be valued through respect for its limitations and protecting it for future generations.

The Regional NIHB office is restructuring to meet changing needs, and will include a Program Coordinator and staff dedicated to the specific categories of benefit, such as dental. The DHSD community staff will continue to assist clients with NIHB processes and advocate for client service.

There are many strong partnerships and collaborations between NIHB and other programs and organizations, primarily Labrador-Grenfell Health and the Home and Community Care program of the DHSD. These and other partnerships will continue to be fostered.

Goal

Labrador Inuit will receive the best benefits possible under the NIHB framework.

Objectives

1. To provide NIHB services within the allocated budget until 2010.

The budget for the NIHB program is set according to the finance agreement, and can only grow by 3%. The constantly changing and increasing costs of the services and products, along with increasing numbers of Labrador Inuit makes this a challenging objective. To maintain a budget will require strict monitoring. One example of cost savings would be a reduction in transportation costs, possibly through: applying policy in a standardized way, increased use of telehealth (e.g., video-conferences), and evaluation of the ground transport service.

Indicator of success: NIHB services are provided within budget each year from September 2007 until March 2010 (Source: NIHB financial records).

2 To decrease waitlists for dental service in Nunatsiavut by 50%.

The lack of dental service in Nunatsiavut, coupled with the current policy for transport with Labrador-Grenfell Health has led to a significant waitlist for dental service. At present there are visiting dentists traveling to Nunatsiavut to help reduce the waitlists.

Indicator of success: Waitlists for dental services in each community in Nunatsiavut have decreased by 50% from September 2007 to March 2010 (Source: Waitlist records maintained by Community Clinics).

3. To bring back Dental Therapy service to Nunatsiavut by 2010.

The primary care services provided by dental therapy is essential to improve and maintain the oral health of our population (e.g., fluoride treatments, cleanings). Preventative treatment and education will help to increase the number of people with good dental health who can enjoy the benefits of beautiful smiles, improved self-esteem, and improved general health. Dental therapy service can also contribute to lower costs to the NIHB program.

Indicator of success: Dental Therapy Service is available in Nunatsiavut by March 2010 (Source: NIHB records).

4. To offer the Children's Oral Health Initiative (COHI) program to 100% of pregnant women and children under age seven in Nunatsiavut.

The COHI program offers preventative fluoride application, routine examinations by a therapist, and education to promote better oral care and nutrition. It is carried out in the communities by the Community Health Workers and Public Health Nurses, and as of 2007 is in its first year.

Indicator of success: COHI is accessible to all pregnant women and children under age seven in Nunatsiavut (Sources: The program records for COHI maintained by the Community Health Worker or Public Health Nurse responsible for the program in each community, and the number of pregnant women and children under seven for each year between September 2007 and March 2010 as recorded by public health).

5. To update and ratify the NIHB policy manual for the Nunatsiavut DHSD.

The current NIHB policy needs to be updated and ratified. The new manual must be circulated to NG staff and service providers so all are familiar with the policy and are using it consistently.

Indicator of success: NIHB policy manual is updated and ratified by March 2010 (Source: Copy of ratified manual from NIHB Office).

6. To design a strategy to disseminate clear and current information about the NIHB program to Labrador Inuit, NG staff, and stakeholders.

There is currently a great deal of misunderstanding about the policies of the NIHB program at all levels. The DHSD has a responsibility to create a

meaningful awareness for all stakeholders. This should reduce the amount of time currently explaining policy, and could also reduce costs to NIHB.

Indicator of success: Communication strategy is developed by March 2010 (Source: Copy of strategy from NIHB Office).

II. Injury prevention

While injury prevention activities have been ongoing in the DHSD for many years, this is the first year these activities have been grouped together under a program called Injury Prevention. DHSD defines injury as: unintentional damage to the body resulting from exposure to heat, mechanical, electrical, or chemical energy or from the absence of heat (such as frostbite) or oxygen (e.g., suffocation)**.** An injury is an event that could have been prevented, and is associated with specific risks that could have been avoided. Unintentional injury is different from an accident, which is unexpected and happens by chance.

Injury prevention activities include the promotion, education, and use of safety practices. These practices may differ between activities (e.g., wearing a helmet while riding a bike, or wearing a lifejacket while in a boat). Safety practices should be realistically used by people, and have been proven effective in reducing or preventing injuries in the past.

Currently, the DHSD injury prevention programming includes water, motor vehicle, firearm, ice and bicycle safety. Additional prevention activities could include: safe babysitting, burn prevention, poison prevention, winter fun safety, sun safety, fire prevention, electrical safety, and prevention of falls for seniors. The DHSD will be developing a resource inventory of the injury prevention programming available in each community.

Work done in the area of injury prevention is often done in partnership with other organizations or agencies. These include, but are not limited to, the RCMP, Department of Fisheries and Oceans, College of the North Atlantic, Inuit Community Governments, and Town Councils. Within the DHSD, program delivery is the primary responsibility of the Community Health Workers and Home Care/ Home Support Workers.

Goal

Prevention of injuries for Labrador Inuit.

Objectives

1. To develop a system to measure rates of injuries for Labrador Inuit by 2010.

One challenge with the area of injury prevention is that there are no statistics on the rate of injuries for Labrador Inuit, or the types and causes of injuries. While many organizations or health service providers may currently gather information on injuries (e.g., RCMP, Community Clinics, DHSD Community staff), there is no standard method or system to do so. One of the first steps in better understanding this area is to know more about the injury statistics for Labrador Inuit through the development of a system to measure injuries.

Indicator of success: System for measuring injuries for Labrador Inuit is developed by March 2010 (Source: Copy of system from Researcher/Evaluator of the DHSD).

2. To reduce injuries caused by motor vehicle accidents.

Feedback from community members indicates that injuries caused by motor vehicle accidents are a concern. This refers to any type of motor vehicle including boat, snowmobile, all-terrain vehicle, or cars/trucks. The focus and type of activities will likely differ in each community.

Indicator of success: Once the system to measure injuries has been developed, the rate/types of injuries due to motor vehicle accidents can be monitored. In the interim, indicators will be determined by community-based and regional activities conducted (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

3. To develop community-based injury prevention education by 2008.

As Injury Prevention is a newly defined program for the DHSD, community-based injury prevention education activities are needed for each community to help promote the use of safety practices. The focus and type of activities will likely differ in each community.

Indicator of success: Will be determined by community-based injury prevention education developed by March 2008 (Sources: The DHSD Community Office records).

4. To develop an Unsafe Ice Awareness Program by 2010.

Community members and research on climate change indicate that traveling on unsafe ice is becoming an increasing concern. The DHSD will develop an Unsafe Ice Awareness Program for use in all communities.

Indicator of success: Unsafe Ice Awareness Program is developed by March 2010 (Source: Copy of program from Director of Community Programs).

III. Addictions

Addiction is a complex issue, as is dealing with the problem of addiction. Addiction occurs when an individual becomes dependent either physically (in the body) or psychologically (in the mind) on a substance or behaviour. When addicted, a person often makes poor choices as the addictive behavior is placed above their own needs and those of their family, friends and community. Addictions to alcohol, tobacco, street drugs, solvents, gambling, or prescription medication are some examples. There are also a variety of *potentially* destructive behaviours besides those traditionally thought of as addictions. They include *compulsively* using things such as food, work, relationships, sex and the Internet.

Dealing with the problem of addiction is very complex. It involves addressing the problematic behaviour, but also examining attitudes and feelings that lead to unhealthy ways of coping. Added to this is the importance of the relationships in people's lives (i.e., how they have been impacted by others and how their addiction is impacting others). This includes such things as family violence, sexual abuse and suicide as well as the resulting community distress. Add to this the social concerns passed down through the generations such as poverty, historical oppression, racism, weakening of the traditional culture, undermined family ties, broken Inuit pride and in some cases, residential schooling. When Labrador Inuit struggle with addiction, many of these issues are often tangled together.

There are different ways of self-medicating (trying to find ways to escape the pain of problems to feel better.) There are also different ways of recovering. This is evident in staff observations and community self-reporting, as well as in the feedback given to the Alcohol and Drug Abuse Hearings recently held by NG. Traditional methods of focusing on the "problem" of drinking or drug use within the confines of structured clinical programs have not been effective. Because of this, the DHSD has had a shift in how to address addiction. We must focus on what is working well in our communities, on who is doing well, and on how we can support that and help it to grow.

Addiction is found within a continuum (or scale) of least affected to most severely affected. Different people with problematic behaviour may be located on different places on that scale depending on how advanced their problem is. As well, the work the DHSD does is placed on a continuum. Depending on what is needed, the focus may be on prevention, treatment or aftercare. Sometimes these may flow into each other. For example, by providing a Family Land-Based Treatment Program, treatment would be offered to some of those attending. For others, such as the children, the program may be seen as prevention because it would ensure that they have supports and understanding to live life addiction-free. For others, such as some spouses, it may be aftercare. They may have already

begun living healthier lives and this would be an opportunity to strengthen their support and skill base around this decision.

Addiction work has used such methods as awareness campaigns, education sessions, counseling, group work and circles. The DHSD has sent people to in-patient programs and encouraged participation in Alcoholics Anonymous. This must still continue. However, we also must add to our methods and expand on what is helpful. An integral part of this work will be to draw on the strengths of healthy community members. The DHSD must ensure that we identify and help make the healthy people around us more visible.

Nobody is 100% healthy as there is no perfection. However, there are those who have learned to not only cope but to thrive. They may have worked through an addiction or they may never have had an addiction. They can be found in all ages, from the youth to the elders. By drawing on their strengths, they become even stronger and the whole community is strengthened. As communities become stronger, there is less opportunity for addiction to be as prevalent as it currently is. The principal way that individuals and communities can become stronger is through deep connections to something meaningful in their lives, such as family, community, the land, spirituality or religion.

Goal

Individuals and communities moving forward on a healing journey away from the harms associated with unhealthy choices related to alcohol, drugs, gambling, and tobacco.

Objectives

1. To develop a framework for addictions programming.

Due to the plans for the DHSD to maintain current Addiction work such as awareness campaigns, education sessions, and counseling, but to also incorporate methods that draw on the strengths of healthy community members and expand on what is helpful, a new Addictions Framework is required.

Indicator of success: Addictions Programming Framework is developed by March 2010 (Source: Copy of Framework from Director of Mental Health and Addictions).

2. To develop a public awareness campaign on making healthy choices.

With a shift in addressing addiction by focusing on what is working well in our communities, the DHSD will develop a public awareness campaign to support making healthy choices. It will highlight the strengths of the individuals and communities around us.

Indicator of success: Public Awareness Campaign is developed by March 2010 (Source: Copy of materials from awareness campaign from Director of Mental Health and Addictions).

3. To promote and support youth and young adult activities and programs at the community level.

In focusing on making healthy choices, the DHSD will promote and support more activities and programs for this age group.

Indicator of success: Will be determined by community-based and regional programs and activities promoted and supported by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

4. To compile an inventory of addictions resources and programming for communities.

There are already numerous programs and resources available on many aspects of addictions prevention, treatment, and after-care. The challenge is knowing where they are and what they contain. The DHSD will compile an inventory of these resources for use in whole or in part at both the regional and community level.

Indicator of success: Addictions Inventory is developed by 2010 (Source: Copy of Inventory from Director of Mental Health and Addictions).

5. To reduce the smoking rate for all ages groups.

In 2001, 67% of Labrador Inuit youth age 16-18 reported smoking daily or occasionally (Risk and Resilience Survey, 2001), compared to the National average of youth age 15-19 at 26% (Canadian Community Health Survey, 2001). Furthermore, 43% of Labrador Inuit adults age 18 and over report being daily smokers (Aboriginal Peoples Survey 2001), versus the Canadian rate of 22% (age 15 and over, Canadian Tobacco Monitoring Use Survey, 2001).

Indicator of success: Rate of self-reported daily smoking is reduced for each age grouping by 2010 (Source: Aboriginal Peoples Survey, 2006 and anticipated 2011).

6. To reduce the number of people indicating that alcohol use is a problem in their community.

Concerned with the crisis levels of suicide, increased alcohol and drug abuse and increased violence, NG completed Drug and Alcohol Abuse hearings with Labrador Inuit throughout Nunatsiavut and Upper Lake Melville. The hearings confirmed that alcohol use is a problem. In 2001, 81% of Labrador Inuit reported

that Alcohol abuse was an issue in their community (Aboriginal Peoples Survey, 2001).

Indicators of success: 1) Rate of people self-reporting that alcohol use is an issue in their community has decreased by 2010 (Source: Aboriginal Peoples Survey, 2006 and anticipated 2011). 2) Rate of people reporting heavy drinking- defined as drinking 5 or more drinks on one occasion 12 or more times a year has reduced by 2011 (Source: Aboriginal Peoples Survey, 2006 and anticipated 2011). 3) Any follow-up indicators that may arise from the Alcohol and Drug Hearing Committee that has been established to follow up on the recommendations from the hearings will also be used.

7. To promote positive role models of all ages.

An integral part of this work will be to draw on the strengths of community members. The DHSD must ensure that we identify and help make more visible the strengths of the people around us.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

IV. Communicable Disease Control

The Public Health department of DHSD, in close collaboration with the Communicable Disease Control Nurse and Medical Officer of Health from Labrador-Grenfell Health, implement the communicable disease program. The program falls under the legislation of the provincial Communicable Disease Act that mandates reporting communicable diseases according to a given schedule. Provincial, regional, and NG policy governs the program, with reference to the Canadian Tuberculosis (TB) standards, Canadian Immunization standards, and Canadian, provincial and regional pandemic plans.

Components of disease control:

- The Immunization Program for adults, children, and domestic animals includes routine scheduled immunizations, immunizations for travel, influenza, and pneumonia, management of vaccines, cold chain of vaccines, wastage reporting, and adverse reactions. The immunization program in Nunatsiavut follows the provincial immunization schedule and has the ability to be enhanced as needs change and funding permits. The Public Health program is delivered in the Nunatsiavut region by Public Health Nurses, Home Care Nurses and, in Nain and Hopedale only, Public Health Aides.

- Communicable disease follow-up and case management includes TB, enteric disease (of the intestines), Sexually Transmitted Infections (STI) and dog bites.

- Surveillance, data collection, and analysis include weekly surveillance (influenza), and disease reporting both regionally and provincially.

- Education and public awareness includes the rabies program, hygiene, sexual health, and promotion of healthy choices.

- Prevention initiatives such as promoting hand washing, condom distribution, and the “Cough in Sleeve” program.

- Policy development and planning includes pandemic planning (planning for a disease that occurs over a wide geography and affects a high proportion of the population) and updates to reflect changes with emerging diseases and new immunizations.

The nature of communicable disease control is such that outbreaks take priority over all other public health programs. At times, this may require additional resources both financial and staffing.

Public Health values a proactive approach to communicable disease control. Effective surveillance provides us with information that we can use to ensure that programs meet the goals of communicable disease control and empower individuals, families and communities to take control of their own health.

Goal

Effective communicable disease control in Nunatsiavut.

Objectives

1. To improve TB follow–up.

Improved TB follow-up requires a collaborative approach with Labrador-Grenfell Health. All providers must be familiar with a standard set of policy and procedures and use them consistently. Effective two-way communication between both providers is also required.

Indicator of success: Will be determined by community-based and regional programs and activities to improve TB follow up by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

2. To have 100% compliance to sexually transmitted infection (STI) follow-up.

Currently DHSD has challenges with client compliance, particularly amongst young adult males. DHSD must explore more effective methods of reaching the high-risk population with prevention and treatment messages.

Indicator of success: All clients diagnosed with an STI will comply with follow-up by March 2010 (Source: Public Health Nurse records of STI follow-up).

3. 100% immunization rates for children, adults, dogs and cats.

All evidence shows that the best defense against vaccine preventable diseases is immunizations.

Indicator of success: 100% immunization rates by 2010 (Source: Public Health Nurses maintain immunization records, and Community Governments and NG maintain population lists).

4. Each Nunatsiavut community will have pandemic plans that link to the regional pandemic plan.

A pandemic Influenza is anticipated and DHSD must prepare staff and communities.

Indicator of success: Pandemic plans for each Nunatsiavut community that link with a regional pandemic plan are developed by March 2010 (Source: Copies of each plan from the Director of Health Services).

5. To increase public awareness of communicable diseases.

An ounce of prevention is worth a pound of cure. Public awareness and educating individuals, families, and communities on the basics like good hygiene (hand washing, coughing in sleeve campaign) decreases the risk of getting a communicable disease.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

6. To Implement Rabies prevention activities in Nunatsiavut.

Rabies is endemic or common in Labrador and does not follow the usual four-year cycle as it does in the rest of the province. This requires greater vigilance with surveillance, immunization and education programs.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

7. To have no incidence of enteric diseases.

Precautionary measures help prevent enteric disease (of the intestine) such as water monitoring and food safety.

Indicator of success: No reported enteric disease by March 2010 (Source: Public Health Records).

V. Healthy Children

In the past, the DHSD has delivered many programs and activities with a focus on the needs of children. This was accomplished through a broad range of funded and self sustained programs such as: daycares, Aboriginal Head Start (AHS), playgroups, after-school programs, Language Nest, as well as public health administered to children, and Fetal Alcohol Spectrum Disorder (FASD) related programming.

These have often been successful programs, which we will continue to deliver, evaluate and enhance in the next three years. However, this is the first year that these and other activities focused on children's needs are grouped under one program called Healthy Children. The basic intent of the program, to foster physical, emotional, cultural, social and intellectual growth of children, is maintained. Additional emphasis will now be placed on parental/caregiver involvement, both at home and as part of programming, which was always encouraged but not always achieved. The Healthy Children Program will be driven primarily by the needs of the community, as opposed to funding priority.

Previous evaluations, assessments, and research have identified healthy pregnancy outcomes and positive parenting as areas the DHSD needs to focus on. Recognizing a mother's womb as baby's first home, and the parent/caregiver as both the primary caregiver and first teacher, the DHSD must value and support this through programming. Components of programs and activities must empower the parent/child unit as a whole by addressing needs from pre-conception to pre-adolescence.

The Healthy Children program is broad, and therefore requires a range of staff for delivery. Community Health Workers deliver playgroup programs, which vary in each community by focusing on a particular age group. Generally this may be three to five year olds, six to nine year olds, or ten to twelve year olds. In addition to playgroups, Community Health Workers are responsible for delivery of other activities such as the Boys to Men Program and FASD programming.

Individuals with Early Childhood Education training staff the daycares. The three licensed daycares meet the minimum standards of childcare in a regulated setting as set out by the Government of Newfoundland and Labrador. Fluent Inuktitut speakers deliver the Language Nest program in Hopedale. Individuals with varied backgrounds, including Early Childhood Education staff the Hopedale AHS program. Public Health Nurses are responsible for the pre-conception, childbirth education, breastfeeding support, and school health and pre-school health checks.

Goals

1. Healthy children born to healthy parents.

2. Parents/caregivers who participate in their child's early learning and development.

Objectives

1. To offer prenatal support to 100% of pregnant women in Nunatsiavut.

Currently, Public Health Nurses and Community staff offer a significant number of activities for prenatal support, including Born a Non-Smoker, Healthy You-Healthy Me, and the Canada Prenatal Nutrition Program (CPNP). Continued emphasis will be placed on the area of prenatal support, with the objective of all pregnant women being given the opportunity to avail of such supports.

Indicator of success: Records of activities/programs show prenatal support offered to all pregnant women in each community in Nunatsiavut for each year from September 2007 until March 2010 (Source: Public Health Nurse and Community Health Worker program records, and Live Birth Notification from Public Health Nurses).

2. To have appropriate assessments and plans to meet the needs for 75% of children at school entry in Nunatsiavut.

The majority of children that require assessment and plans to meet their specific needs are not receiving this service. This could include Individual Support Services Plan (ISSP), daycare, child development, FASD diagnostic referrals, Child Development Team, Behavioural Management/child Specialists, Speech and Language, or Family Support.

Indicator of success: Review of Preschool Health Checks each year from September 2007 to March 2010 shows 75% of children at school entry received appropriate assessments and plans were developed (Source: Preschool Health Check, conducted by Public Health Nurses).

3. To increase curriculum in child development/child care that reflects Inuit language and culture.

While there is currently Inuit-specific curriculum in all child development and daycares, more varied and Labrador-Inuit specific curriculum is needed. This was a priority highlighted in the Nunatsiavut Early Learning and Child Care Consultation of 2006.

Indicator of success: Records of child development programs and daycares reflect the number, type (e.g., topic and medium), and Labrador Inuit specific curriculum has increased from September 2007 until March 2010 (Source: Day care and child development program records for each community).

4. To conduct a needs assessment and develop a plan for programs for preadolescent age groups.

The preadolescent age group is one that does not often have specific programs. A needs assessment will help determine what types of programs are needed for this group, and the plan will help set implementation in motion.

Indicator of success: Needs assessment and plan developed for programs for preadolescents by March 2010 (Source: Copy of needs assessment report and plan from Director of Community Programs).

5. To enhance community capacity to address the special needs of children (e.g., those affected by FASD).

Of the eight priorities highlighted in the Nunatsiavut Early Learning and Child Care Consultation of 2006, one was the issue of services for children with special needs, and another specified services for children with FASD.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

6. To increase the rate of breastfeeding in Nunatsiavut.

The benefits of breastfeeding are numerous and include: the unparalleled health benefit to baby, it is free, is not reliant on availability of formula or milk to purchase, and it helps establish a maternal-child bond.

Indicator of success: Rate of breastfeeding at time of discharge has increased for each year from September 2007 until March 2010 for each community in Nunatsiavut (Source: Live Birth Notification to Public Health Nurses, Child Health Clinic flow sheet (PHN), and CPNP program records).

7. To develop a model for parent support.

The Nunatsiavut Early Learning and Child Care Consultation of 2006 identified a need for a model of parent support (e.g., parenting skills, supports for low income families, single-parent families, young parents, families with limited social network, parents with substance abuse problems). Some tasks outlined in the consultation included adapting/developing parent programs and assessing why parents who need programs are not accessing them.

Indicator of success: Model for Parent Support is developed by March 2010 (Source: Copy of Model from Director of Community Programs).

8. To increase client access to pre-conception health information by 25% for Nunatsiavut.

Offering pre-conception health information is another way to help give children the healthiest possible start in life (e.g., information on folic acid intake and prevention of some birth defects).

Indicator of success: Records of clients provided with pre-conception health information have increased by 25% in each community in Nunatsiavut from September 2007 to March 2010 (Source: Public Health Nurse end of month reporting forms).

VI. Home and Community Care

The Home and Community Care program (HCCP), which consists of the Home Support Services Program (HSSP) and Home Care Nursing, is designed to support the client and the family. It is not meant to replace the care and support provided by families. The HCCP was established in 1996 when the Home Support Services program was introduced in Nunatsiavut. In 2003 the HSSP was expanded to include the Upper Lake Melville region. The HSSP consists of home management, personal care and in-home respite, which is provided by both trained and untrained Home Support Workers.

The Home Care Nursing component of the program was introduced in Nunatsiavut in the spring of 2005. Prior to the introduction of this program, the Public Health Nurses and nurses of the Community Clinic provided home care nursing on an ad hoc, unstructured basis as the need arose. Since the inception of the HCCP, care is now delivered in a consistent and formalized manner.

The HCCP contains the following essential service elements:

- Structured client assessment
- Managed care
- Program management and supervision
- Home care nursing

- Home support services
- In-home respite care
- Record keeping and data collection
- Access to medical supplies and equipment
- Palliative care
- Long term care assessment and placement

The HCCP presently only services Labrador Inuit who meet specific assessment criteria.

The home care nurse (HCN) acts as a case manager to advocate for and ensure that the client has an appropriate service plan, access to necessary services, monitored service delivery and evaluation of service outcomes. The HCN is also responsible for the overall management of the HCCP and works in close collaboration with Labrador-Grenfell Health to case manage all Labrador Inuit with diabetes.

Goal

Individuals and families maintaining independence at home.

Objectives

1. To develop one module of a Home Support Worker training program that can be piloted and delivered by the Home Care Nurse at the community level.

Previous training programs have not been cost-effective. We need to build capacity at the community level so that training is sustainable and culturally appropriate. This will ease the financial burden to NG as well as the potential trainees who have commitments in their home communities. By removing barriers, such as time away from families, there should be more interest in such training within the communities.

Indicator of success: Module of Home Support Worker training program is developed by March 2010 (Source: Copy of module from Director of Health Services).

2. To develop a policy within the Home and Community Care program pertaining to diabetes screening and management within Nunatsiavut.

Practice must be guided by policies and standards. Standardized diabetes care across Nunatsiavut will ensure the optimal level of care for clients. This care should be guided by the national standards that have been set forth by the Canadian Diabetes Association in the 2003 Clinical Practice Guidelines.

Indicator of success: Policy pertaining to diabetes screening and management for Nunatsiavut is developed by March 2010 (Source: Copy of policy from Director of Health Services).

3. To screen 50% of the population at risk for diabetes in each of the Nunatsiavut communities.

An estimated one-third of people with diabetes are unaware that they have the disease. According to the World Health Organization, the direct costs of treating diabetes and its complications can consume up to 15% of health-care budgets. Furthermore, the identification of pre-diabetes (which puts people at risk of developing diabetes) should, through appropriate intervention, increase the likelihood that such individuals do not progress to Type 2 Diabetes (Canadian Journal of Diabetes, 2006).

Indicator of success: Records of screening indicate that 50% of people at risk have been screened in each Nunatsiavut community by March 2010 (Source: Home Care Nurse records, using the CDA Clinical Practice Guidelines).

4. To create a standardized basic diabetes management and client education course for the Home Care nurses.

Nurses must have a thorough knowledge base about diabetes to be able to competently provide care and education to individuals with diabetes and their families. The foundation for this knowledge is laid during basic nursing education, but requires further development for the professional who is providing comprehensive care and education to clients.

Indicator of success: Diabetes management and client education course is created by March 2010 (Source: Copy of course materials from Director of Health Services).

5. To create a plan for the inclusion of those who are not Labrador Inuit in the HCN program in Nunatsiavut.

The DHSD is the only provider of home care nursing in Nunatsiavut. As the only service provider, the DHSD will need to expand our services to cover home care clients who are not Labrador Inuit.

Indicator of success: Plan for HCN program in Nunatsiavut is developed by March 2010 (Source: Copy of plan from Director of Health Services).

VII. Sexual Health

Traditionally the focus of Sexual Health for the DHSD was on the prevention of sexually transmitted infection, with a special focus on HIV/AIDS and Hepatitis C. Education and awareness activities in the communities were delivered by Public Health Nurses and Community Health Workers and included school based teachings, health fairs, displays, radio shows, the annual HIV/AIDS walk and activities during the National HIV/AIDS Week. The Regional Health Educator in partnership with Pauktuutit facilitates an HIV/AIDS and Hepatitis C Fair in the communities on a rotating basis, involving the community through school and social events.

Public Health staff provides the case management and contact tracing for sexually transmitted infections. Community Health workers and Public Health staff deliver preventative education and promotion of safe practices. Some forms of contraception are provided through the Community Clinics by prescription, while condoms are provided at the DHSD Community Offices. Public Health staff and the Community Health Workers provide the education components.

In spite of all efforts, the indicators point to an increase in unhealthy sexual behaviours including the age of intercourse, multiple partners, a very high rate of sexually transmitted infections and unintended pregnancy.

This is the first year that the sexual health activities of the DHSD have been grouped under one program called Sexual Health. The focus will not only be on disease prevention, but on the more holistic concept of sexual health. Sexual health is an important part of general health, and not merely the absence of disease. It is a state of well being as we experience our sexuality: physically, emotionally, psychologically, spiritually, socially and culturally. It relies on responsible sexual choices that are based on healthy relationships. The DHSD will extend initiatives to focus more on fostering healthy relationships and healthy choices.

The issues relating to responsible sexuality are connected with a person's self-esteem, sense of worth and decision-making abilities and are potentially complicated by alcohol and drug abuse. Our Sexual Health program must incorporate these realities in a creative and participatory way. Young people have told us that the messages are often boring and they would prefer them to be delivered in an up to date manner, with age appropriate messages.

We must also meet the needs of persons who are struggling with sexual identity, and who are considering new sexual relationships following divorce or loss of a partner. Awareness and education needs to be responsive, non judgmental and current.

Goal

Positive sexual health.

Objectives

1. To decrease the rate of reported sexually transmitted infections by 15% by 2010.

Communicable disease data shows rates of sexually transmitted infections in our communities that are many times the provincial and national averages. The age range of affected individuals is 15-52 years, and multiple partners are named for each case. The consequence of untreated and repeat infections can be infertility and health issues in later years. Some infections such as HPV (Human Papilloma Virus) may precede cervical cancer in women.

Indicator of success: Rates of sexually transmitted infections that are reported to Public Health Nurses in each Community by the Regional Communicable Disease Control Nurse have decreased by 15% by 2010 (Source: Communicable Disease Control Nurse with Labrador Grenfell Health provides data annually to Director of Health Services with rates by disease, community, and age group. Data is also provided to each PHN for their respective community.)

2. To decrease the rate of unintended pregnancy by 25 % by 2010.

Some unintended pregnancies are manifested by deliveries of children that were not planned for. This may have social and health consequences, including abortions performed outside the region.

Indicator of success: As we do not know rate of unintended pregnancies, two proxy measures will be used: adoption rate decreased by 2010 (Source: Live Birth Notification system) and; abortion rate decreased by 25% by 2010 (Source: NIHB transport for purposes of abortion). It is recognized that both measures do not only capture the results of unintended pregnancies.

3. To promote healthy relationships.

Healthy relationships are at the crux of healthy sexual behaviours. The mental health component of sexual behaviour is one that has not received as much attention; the focus has been on biology. It is now acknowledged that improved self-esteem, problem solving and decision-making skills are essential to the development of healthy relationships, which will promote healthy choices.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

4. To develop sensitive and innovative ways to reach high-risk groups with sexual health information.

The current dissemination of sexual health information is primarily through school programs and health fairs. It is recognized that the highest risk group is young adults who are challenging to reach, and older adults who may be re-entering the sexual realm.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

5. To prevent new HIV and Hepatitis C infections.

The impacts of Hepatitis C and HIV on individuals, families and communities are long lasting and may result in premature deaths. The diseases challenge all supports and are very costly emotionally, socially and financially.

Indicator of success: No new cases of HIV and Hepatitis C are reported to Public Health Nurses in each Community by the Regional Communicable Disease Control Nurse by 2010 (Source: Communicable Disease Control Nurse with Labrador Grenfell Health provides data annually to Director of Health Services with rates by community and age group. Data is also provided to each PHN for their respective community.)

VIII. Healthy Lifestyles

A healthy lifestyle is all about making positive choices leading to physical, spiritual, and mental health. By encouraging and supporting people to make healthy choices, they take personal responsibility for their overall health and wellbeing. A healthier lifestyle means reduced risk of some preventable diseases such as heart disease and diabetes.

The DHSD has a history of providing activities and programming that address healthy eating, active living, being smoke free, and healthy coping skills. However, this is the first year that these activities have been officially grouped under the Healthy Lifestyles Program. The activities used to promote healthy lifestyles have been many and varied and have included such methods as posters, health fairs, presentations, programming, flyers, and special events.

The healthy lifestyles program will continue to do health promotion, and will focus on creating environments and conditions that make healthy choices easier to make (e.g., building healthy public policies).

The health sector alone cannot accomplish population-wide changes, as healthy lifestyles are linked with so many other aspects of life (e.g., education,

employment, environment). Therefore collaboration with other organizations and groups is important, and will be maintained and strengthened.

Goal

Individuals making healthy lifestyle choices.

Objectives

1. To increase active living for people of all ages.

Active living is linked to many positive health outcomes including prevention of onset of chronic diseases such as Type 2 Diabetes. Therefore DHSD plans to focus more effort and attention into active living and increasing physical activity in our communities. We know the prevalence of diabetes among the Labrador Inuit is greater than that of non-aboriginal populations in Labrador (Labrador Inuit Health Commission 1999.) We also know research shows that just 30 minutes of physical activity a day will provide sound health benefits. Active living is a means of building more physical activity into our daily lives; activities that we enjoy which are a key part of our daily routines.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

2. To decrease the consumption of junk food.

Junk foods are more than just pop, potato chips and candy. They also include foods that are high in sugar, salt, fat or calories and which are low in nutritional value such as cookies, cakes, and prepackaged pizzas. While there are many issues around food security in the north such as the high cost of food, transportation, low incomes and accessibility, individuals and families can make a difference in some of the basic healthier food choices (e.g., dropping pop and choosing water).

Indicators of success: Junk food consumption for youth age 15 and under (e.g., soft drinks, salty snacks, fast food, sweets) has decreased by 2010 (Aboriginal Peoples Survey 2006 and anticipated 2011). Junk food consumption for children age 6 and under has decreased by 2010 (Aboriginal Children Survey 2006 and anticipated 2011).

3. To promote harm reduction of environmental tobacco smoke.

Environmental tobacco smoke (both second hand and side stream smoke) contains harmful chemicals. Each cigarette contains 4,000 different chemicals, of which 50 are cancer-causing agents. An estimated 2.8 million Canadian

children under the age of 15 are exposed to tobacco smoke in their own homes (Health Canada). We also know that 43% of Labrador Inuit adults report smoking daily (APS, 2001). DHSD must acknowledge the benefits of smoke-free lifestyles for the individual, family, and community.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

4. To promote healthy coping skills.

In small communities where supports and services are limited, it is crucial that individuals learn and engage in a wide range of healthy coping skills in the areas of problem solving and goal setting, social skills, cognitive skills and stress management. Such skill sets contribute to strong well-rounded individuals who can go a long way in helping themselves, their families and their community. These skills also contribute to mental wellness. Learning different coping skills, particularly in the area of stress management, gives individuals options for how they can best support themselves and their community in times of need.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

5. To increase consumption of traditional foods.

Traditional food choices for Inuit far outweigh the value of store bought foods in terms of the nutritional value, cost, and contribution to cultural and overall mental wellbeing. Traditional foods by nature contain more nutrients, have fewer calories, are lower in saturated fats and may provide the added bonus of physical activity. They also contribute to the culture of the Inuit in terms of sharing traditional ecological knowledge (i.e. hunting patterns and migratory animal patterns), and cultural values such as respect and sharing.

Indicator of success: Self-reported proportion of meat and fish consumed that is country food (Source: Aboriginal Peoples Survey, 2006 and anticipated 2011).

6. To maintain healthy weights

Overweight and obese individuals face a complex number of risk factors to their health. Unhealthy weight is a risk factor for high blood pressure, stroke, heart disease, type 2 diabetes, respiratory problems, some cancers, and mental health issues. Achieving and maintaining a healthy weight through exercise and proper nutrition is imperative. In 1997, 26% of Labrador Inuit male adults and 36% of females were overweight or obese according to Body Mass Index (BMI), a ratio of height and weight.

Indicator of success: While Body Mass Index is not a perfect measure of healthy weight for Inuit, it will be used as a proxy measure until an alternative (preferably waist-hip ratio) is possible. Source: BMI as reported on the Aboriginal Peoples Survey, 2006 and anticipated 2011.

IX. Mental Wellness

Mental Wellness is not a state to be achieved but rather a continual process that brings the physical, emotional, mental, spiritual and social components of one's life into balance. Life is a constant series of up and downs. There will be problems encountered and negative life events. The focus should not be on avoiding or eliminating these events but rather developing strengths and skills, which will help in coping with these situations and recovering from their impact.

Mental Wellness is often thought of as an abstract concept and difficult to define. Mental Wellness is basically demonstrated by: a positive sense of being (positive self esteem, coping skills, spirituality, values, purpose), a sense of belonging (positive attachments, culture/traditions, social supports) and a sense of becoming (hope/goals for the future, making healthy choices, resiliency). Mental Wellness is influenced by messages received from many sources including: families, peers, school, work, social environments and the media.

The role of the Mental Wellness Program is to recognize and strengthen individual and collective capacities and to assist them in achieving their full potential. The focus of the Mental Wellness Program will be to support individuals, families and communities to enhance protective factors (self esteem, coping skills and social supports) and to reduce risk factors (isolation, low self esteem, drug/alcohol abuse, family dysfunction). This is accomplished by providing a continuum of mental wellness supports and programs which include: promotion of healthy relationships and lifestyles, reinforcing pride in self and community, providing opportunities for positive social interaction, traditional/cultural healing practices as well as clinical/therapeutic approaches.

Goal

Communities where each individual feels a sense of purpose, belonging and hope for the future.

Objectives

1. To provide a continuum of mental wellness programs and supports.

Mental wellness needs vary greatly depending on the individual and community. Examples include: promoting healthy lifestyles, raising self-esteem, reducing daily stress levels, supportive counseling, care for caregivers, clinical

intervention, facilitating support groups/therapeutic groups, assessments for individuals held under the Mental Health Act, crisis response/intervention, and psychiatric illness. While the focus has often been on the middle of the continuum (e.g., counseling, crisis response), the DHSD will focus on broadening our perspective to include the whole continuum.

Indicator of success: Will be determined by community-based and regional programs and supports by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

2. To create and strengthen community, DHSD, and regional networks that support mental wellness programs and services.

The DHSD has a limited mandate and funds for mental wellness services. The original intended focus of the mental health program was on community-based programs (e.g., prevention, education and supportive counseling). However, due to the high needs and limited resources in the region, we have increased programming to include things such as clinical services and assessments. In addition, the Provincial Department of Health and Community Services and the Labrador-Grenfell Health Authority (LGHA) still have the mandate to provide acute care services (i.e., hospital-based and intensive services). The RCMP is also involved in the network of mental wellness services in terms of people held under the Mental Health Act. Supporting and strengthening these networks is required in order to meet client needs.

Indicators of success: Regional indicators include: 1) Development of a memorandum of understanding between DHSD and LGHA on mental wellness program and service provision (Source: Copy of MOU from Director of Mental Health and Addictions by March 2010); 2) Information package for public on available regional and provincial resources and how to access them (Source: Copy of Information Package from Director of Mental Health and Addictions by 2010). Community level indicators will be determined by community-based activities by March 2010 (Sources: The DHSD Community Health Plans).

3. To promote mental wellness and available programs and services.

Many services offered by the DHSD or other providers are not well known or advertised (e.g., parenting programs, Boys to Men, support groups, Provincial Crisis Line, Early Psychosis Program, Channel). More promotion of existing programs and services is needed. Promotion must also include a shift in focus from suicides and community crisis, to promoting mental wellness.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

4. To reduce the number of suicides and attempted suicides for Labrador Inuit.

The rate of suicide among Labrador Inuit is of great concern. Between 1993 and 2005 there were fifty-six suicides. Based on Vital Statistics from the three census years of 1991, 1996, and 2001, the rate of suicide in Nunatsiavut was the highest of the four Inuit regions of Canada. When asked about suicide in the 1997 Regional Health Survey, 22% of Labrador Inuit said they had seriously thought about attempting suicide, and 15% said they had made an attempt.

NG completed Drug and Alcohol Abuse hearings to determine the issues in more detail, and seek appropriate solutions. The Alcohol and Drug Hearing Committee (as appointed by the Nunatsiavut Assembly) are now addressing recommendations from the hearings. Some ongoing initiatives include the work of the Community Healing Coordinator, and prevention programs such as Boys to Men.

Indicators of success: The number of suicides for Labrador Inuit is reduced by March 2010 (Source: Public Health Offices). The number of individuals detained under the Mental Health Act for attempted suicide is reduced by 2010 for Nunatsiavut (Source: RCMP).

5. To increase programs and activities that promote mental wellness by building self-esteem, independence, competence, positive relationships and support.

Self-esteem, positive relationships and support systems, a sense of purpose, and social competence are some of the greatest indicators of resilience within individuals and communities. Programs such as those that focus on culture and offer a sense of completion (e.g., building, creating, developing something) help serve to promote these characteristics. Other initiatives such as Care for the Caregiver and Honouring Labrador Inuit Role Models encourage these positive attributes. The DHSD will encourage the development of healthy individuals and communities by increasing programs and activities aimed at fostering these characteristics.

Indicator of success: Will be determined by community-based and regional activities by March 2010 (Sources: The DHSD Community Health Plans, and Regional Implementation Plan).

5. Monitoring and Evaluation

The RHP will be monitored and evaluated using the indicators outlined under each program objective. Refer to Appendix B (Table 1) for indicators of success including where the information can be found, who is responsible for gathering the information, and when it should be gathered and reported.

The complete evaluation plan cannot be determined until all CHPs and the Regional Implementation Plan are developed. Eighteen of the fifty-three objectives in the plan do not have indictors of success identified because their measures will depend on what activities are put in place. Appendix B (Table 2) lists the objectives that do not have defined indicators, as they will depend on the activities set out in the CHPs and Regional Implementation Plan. Part of the development of these plans will be to determine how we will know if the activities are successful. When all plans are developed, a standard reporting template will be developed so all reports are comparable.

5. Communication Plan

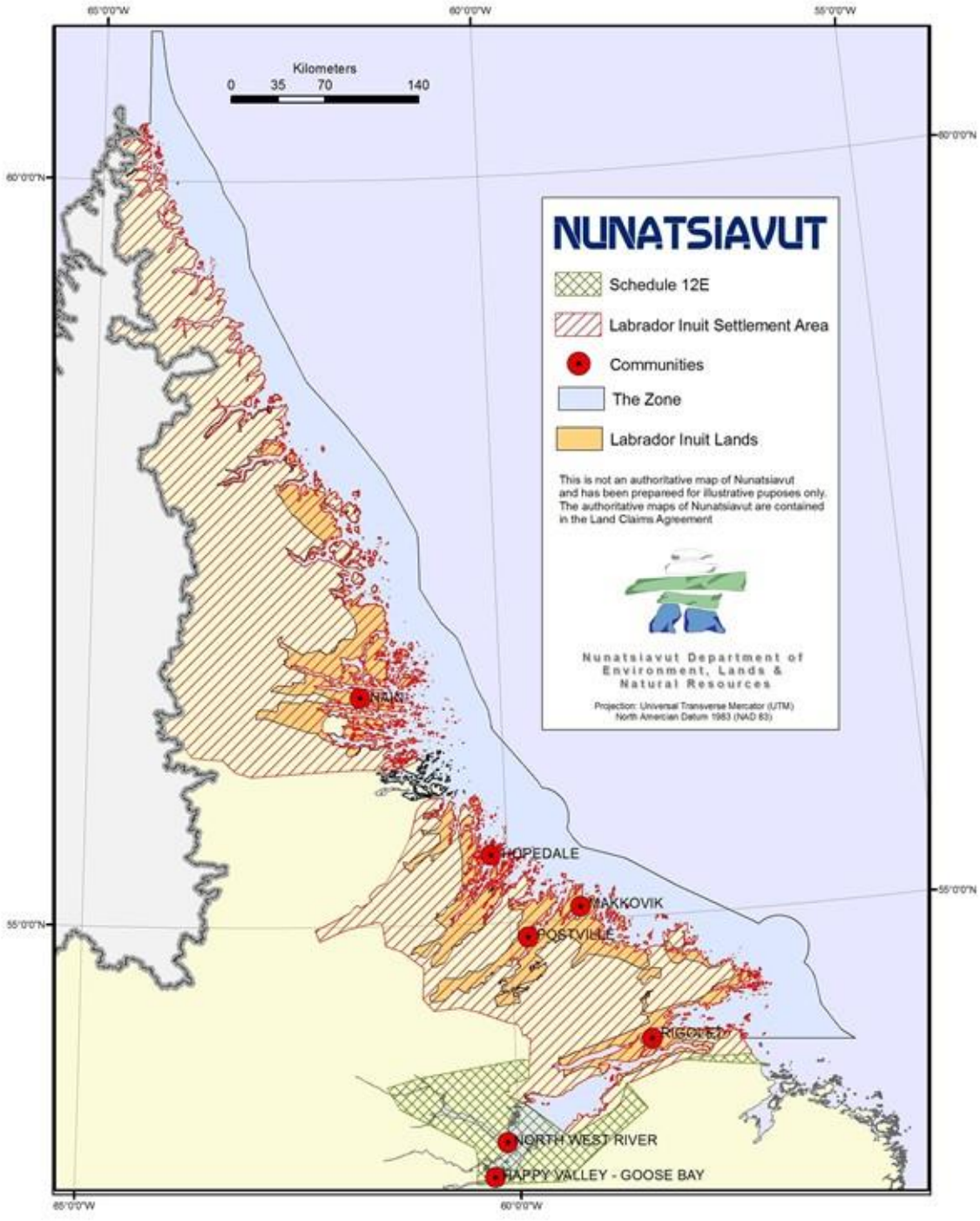
The RHP can only be successful if people know about it, are familiar with what is in it, and put it into action. An important part of ensuring this happens is sharing the plan with all DHSD staff, partners, and Labrador Inuit. All DHSD staff will be provided with a copy via email, and hard copies will be available at each Community Office and the Regional office. In order to maintain momentum and attention on the plan, there will be articles in each issue of the DHSD Newsletter focusing on different components of the RHP, and inserts to the Nunatsiavut Newsletter, which are provided to all Labrador Inuit. Every DHSD staff member is responsible to be familiar with the RHP and how their work can play a part in making it a success. Finally, the plan will be posted on the NG website at www.Nunatsiavut.com for anyone who is interested.

In efforts to maintain accountability and collaboration, the RHP will also be provided to our partners such as Inuit Tapiriit Kanatami, Health Canada, the Government of Newfoundland and Labrador Department of Health and Community Services, and the Labrador-Grenfell Health Authority.

Each CHP will also incorporate a section on how the community-specific plan will be shared with their community. The methods of communication are up to the community, but may include an open house, drop in sessions, or newsletters. The CHPs, like the RHP, must be promoted on an ongoing basis to ensure it continues to provide the blueprint for the DHSD for the next three years.

Appendix A:

Map of Labrador Inuit Lands and Labrador Inuit Settlement Area


65°0'0"W
60°0'0"W
55°0'0"W
60°0'0"N
55°0'0"N
Kilometers
0 35 70 140
NUNATSIAVUT
Schedule 12E
Labrador Inuit Settlement Area
Communities
The Zone
Labrador Inuit Lands
This is not an authoritative map of Nunatsiavut and has been prepareed for illustrative puposes only. The authoritative maps of Nunatsiavut are contained in the Land Claims Agreement
Nunatsiavut Department of Environment, Lands & Natural Resources
Projection: Universal Transverse Mercator (UTM)
North Amercian Datum 1983 (NAD 83)
NAIN
HOPEDALE
MAKKOVIK
POSTVILLE
RIGOLET
NORTH WEST RIVER
HAPPY VALLEY - GOOSE BAY

Appendix B:

Tables of Success Indicators

Table 1: Indicators of success outlined in the Regional Health Plan.

Indicator	Source	Who is responsible	Timeframe
Non-Insured Health Benefits			
NIHB services are provided within budget each year from September 2007 until March 2010	NIHB financial records	NIHB Coordinator and Finance Manager	Maintain records from Sept 2007 until March 2010. Report financial statement March of each year.
Waitlists for dental services in each community in Nunatsiavut have decreased by 50% from September 2007 to March 2010	Waitlist records maintained by Community Clinics	Director of Health Services to create MOU for data sharing	Maintain records from Sept 2007 until March 2010. Report waitlist numbers March of each year.
Dental Therapy Services is available in Nunatsiavut by March 2010	NIHB records	NIHB Coordinator	Maintain records from Sept 2007 until March 2010. Report status of dental therapy services in March each year.
COHI is accessible to all pregnant women and children under age seven in Nunatsiavut for each year between Sept 2007 and March 2010	COHI program records (For # offered program) Public Health Records (For # pregnant women and children under seven)	Community Health Worker or Public Health Nurse responsible for the program and Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report numbers in March of each year.
NIHB policy manual is updated and ratified by March 2010	Copy of ratified manual	NIHB Coordinator	Update on status March of each year. Report that manual is ratified by March 2010.
Communication strategy is developed by March 2010	Copy of strategy	NIHB Coordinator	Update on status March of each year. Report that strategy is developed by March 2010.

Indicator	Source	Who is responsible	Timeframe
Injury Prevention			
System for measuring injuries for Labrador Inuit is developed by March 2010	Copy of system	Researcher/Evaluator	Update on status March of each year. Report that system is developed by March 2010.
Unsafe Ice Awareness Program is developed by March 2010	Copy of program	Director of Community Programs	Update on status March of each year. Report that program is developed by March 2010.
Addictions			
Addictions Programming Framework is developed by March 2010	Copy of Framework	Director of Mental Health and Addictions	Update on status March of each year. Report that framework is developed by March 2010.
Public Awareness Campaign is developed by March 2010	Copy of materials from awareness campaign from	Director of Mental Health and Addictions	Update on status March of each year. Report that campaign is developed by March 2010.
Addictions Inventory is developed by 2010	Copy of Inventory	Director of Mental Health and Addictions	Update on status March of each year. Report that inventory is developed by March 2010.
Rate of self-reported daily smoking is reduced for each age grouping by 2010	Aboriginal Peoples Survey, 2006 and anticipated 2011	Researcher/Evaluator	Update on 2006 results and status of 2011 survey March each year.
Rate of people reporting alcohol use is an issue in their community has decreased	Aboriginal Peoples Survey, 2006 and anticipated 2011	Researcher/Evaluator	Update on 2006 results and status of 2011 survey March each year.

Indicator	Source	Who is responsible	Timeframe
Rate of people reporting heavy drinking has decreased	Aboriginal Peoples Survey, 2006 and anticipated 2011	Researcher/Evaluator	Update on 2006 results and status of 2011 survey March each year.
Communicable Disease Control			
All clients diagnosed with an STI will comply with follow-up by March 2010	Public Health Nurse records	Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report numbers in March of each year.
100% immunization rates by 2010	Immunization records Population statistics	Public Health Nurses (Immunization records) and Community Governments and NG (Population stats)	Maintain records from Sept 2007 until March 2010 Report numbers in March of each year.
Pandemic plans for each Nunatsiavut community that link with a regional pandemic are developed by March 2010	Copies of each plan	Director of Health Services	Update on status March of each year. Report that plans are developed by March 2010.
No reported enteric disease by March 2010	Public Health Records	Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report numbers in March of each year.
Healthy Children			
Prenatal support offered to all pregnant women in each community in Nunatsiavut for each year from September 2007 until March 2010	Public Health Nurse and Community Health Worker program records, and Live Birth Notification	Public Health Nurses and Community Health Workers	Maintain records from Sept 2007 until March 2010. Report numbers in March of each year.

Indicator	Source	Who is responsible	Timeframe
Preschool Health Checks Sept 2007 to Mar 2010 shows 75% of children at school entry received appropriate assessments and plans developed	Preschool Health Check records	Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report numbers in March of each year.
Records of child development programs and daycares reflect the number, type and Labrador Inuit specific curriculum has increased from September 2007 until March 2010	Day care and child development program records for each community	Daycare operators, Community Health Workers responsible for child development and Child Development Program Developer	Maintain records from Sept 2007 until March 2010. Report update in March of each year.
Needs assessment and plan developed for programs for preadolescents by March 2010	Copy of needs assessment report and plan	Director of Community Programs	Update on status March of each year. Report that assessment and plans are complete by Mar 2010
Rate of breastfeeding at time of discharge has increased for each year from September 2007 until March 2010 for each community in Nunatsiavut	Live Birth Notification to Public Health Nurses, Child Health Clinic flow sheet (PHN), and CPNP program records	Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report rates in March of each year.
Model for Parent Support is developed by March 2010	Copy of Model	Director of Community Programs	Update on status March of each year. Report that model is developed by March 2010.
Clients provided with pre-conception health information have increased by 25% in each community in Nunatsiavut from September 2007 to March 2010	Public Health Nurse end of month reporting forms	Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report numbers in March of each year.

Indicator	Source	Who is responsible	Timeframe
Home and Community Care			
Module of Home Support Worker training program is developed by March 2010	Copy of module	Director of Health Services	Update on status March of each year. Report that module is developed by March 2010.
Policy pertaining to diabetes screening and management for Nunatsiavut is developed by March 2010	Copy of policy	Director of Health Services	Update on status March of each year. Report that policy is developed by March 2010.
50% of people at risk for diabetes have been screened in each Nunatsiavut community by March 2010	Home Care Nurse screening records (using the CDA Clinical Practice Guidelines).	Home Care Nurses	Maintain records from Sept 2007 until March 2010. Report rates in March of each year.
Diabetes management and client education course is created by March 2010	Copy of course materials	Director of Health Services	Update on status March of each year. Report that course is created by March 2010.
Plan for HCN program in Nunatsiavut is developed by March 2010	Copy of plan	Director of Health Service	Update on status March of each year. Report that plan is developed by March 2010.
Sexual Health			
Rates of sexually transmitted infections have decreased by 15% by 2010	STI reported to Public Health Nurses by the Regional Communicable Disease Control Nurse with rates by disease, community, and age	CDC Nurse with Labrador Grenfell Health, Director of Health Services	Maintain records from Sept 2007 until March 2010. Report rates in March of each year.

Indicator	Source	Who is responsible	Timeframe
Adoption rate decreased by 2010	Live Birth Notification system	Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report rates in March of each year.
Abortion rate decreased by 25% by 2010	NIHB transport records for purposes of abortion.	NIHB Coordinator	Maintain records from Sept 2007 until March 2010. Report rates in March of each year.
No new cases of HIV and Hepatitis C are reported by 2010	Public Health Nurse records of communicable diseases	Public Health Nurses, the Regional Communicable Disease Control Nurse	Maintain records from Sept 2007 until March 2010. Report rates in March of each year.
Healthy Lifestyles			
Junk food consumption for youth age 15 and under, and children under 6 has decreased by 2010	Aboriginal Peoples Survey 2006 and anticipated 2011. Aboriginal Children Survey 2006 and anticipated 2011.	Researcher/Evaluator	Update on 2006 results and status of 2011 survey March each year.
Self-reported proportion of meat and fish consumed that is country food	Aboriginal Peoples Survey 2006 and anticipated 2011	Researcher/Evaluator	Update on 2006 results and status of 2011 survey March each year.
Body Mass Index	Aboriginal Peoples Survey 2006 and anticipated 2011	Researcher/Evaluator	Update on 2006 results and status of 2011 survey March each year.

Indicator	Source	Who is responsible	Timeframe
Mental Wellness			
A memorandum of understanding between DHSD and LGHA on mental wellness program and service provision by 2010	Copy of MOU	Director of Mental Health and Addictions	Update on status March of each year. Report that MOU is developed by March 2010.
Information package for public on available regional and provincial resources and how to access them	Copy of Information Package	Director of Mental Health and Addictions	Update on status March of each year. Report that information package is developed by March 2010.
The number of suicides for Labrador Inuit is reduced by March 2010	Public Health records	Public Health Nurses	Maintain records from Sept 2007 until March 2010. Report number in March of each year.
The number of individuals detained under the Mental Health Act for attempted suicide is reduced by March 2010 for Nunatsiavut	RCMP	Public Health Nurses get data from RCMP	Obtain records from Sept 2007 until March 2010. Report number in March of each year.

Table 2: Objectives that do not yet have defined indicators.

Objective	Indicator will depend on	Measure(s) will be defined in
Injury Prevention		
To reduce injuries caused by motor vehicle accidents	Community-based and regional activities conducted	Community Health Plans and Regional Implementation Plan
To develop community-based injury prevention education by 2008	Community-based injury prevention education developed	Community Health Plans
Addictions		
To promote and support youth and young adult activities and programs at the community level	Community-based and regional activities conducted	Community Health Plans and Regional Implementation Plan
To reduce the number of people reporting that alcohol use is a problem in their community	Community-based and regional activities conducted	Community Health Plans and Regional Implementation Plan
To promote positive role models of all ages	Community-based and regional activities conducted	Community Health Plans and Regional Implementation Plan
Communicable Disease Control		
To improve TB follow–up	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
To increase public awareness of communicable diseases	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
To Implement Rabies prevention activities in Nunatsiavut	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
Healthy Children		
To enhance community capacity to address the special needs of children (e.g., those affected by FASD)	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan

Objective	Indicator will depend on	Measure(s) will be defined in
Sexual Health		
To promote healthy relationships.	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
To develop sensitive and innovative ways to reach high-risk groups with sexual health information	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
Health Lifestyles		
To increase active living for people of all ages	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
To promote harm reduction of environmental tobacco smoke	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
To promote healthy coping skills	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
Mental Wellness		
To provide a continuum of mental wellness programs and supports	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
To create and strengthen community, DHSD, and regional networks that support mental wellness programs and services	Community-based programs and activities	Community Health Plans
To promote mental wellness and available programs and services	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan
To increase programs and activities that promotes mental wellness by building self-esteem, independence, competence, positive relationships and support	Community-based and regional programs and activities	Community Health Plans and Regional Implementation Plan