Regional Health Plan 2019-2024

Department of Health and Social Development, Nunatsiavut Government

Submitted March 2019

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Message from the Minister

April 2019

I am pleased to present the Department of Health & Social Development's Regional Health Plan for 2019- 2024. This is the culmination of: community consultations, environmental scans, input from all staff within the department and an examination of many relevant reports both internal and external. We truly hope that we have captured the health priorities of Labrador Inuit and have set realistic goals for improving health outcomes.

As Minister, it is my responsibility to ensure that we follow through on the goals and objectives outlined in this document. This is a responsibility that I take very seriously as I am committed to **improving the health & social status of Labrador Inuit through community-based programs and services, advocacy and collaboration** as reflected in our mission statement.

I would like to thank all of those who committed time and energy to the development of the Regional Health Plan and to recognize the dedication of staff who work on a daily basis to provide services to best meet the needs of Labrador Inuit. I know that we will do our utmost to implement the goals and objectives contained in this document and to make the words come to life within programs, services, educational activities and interactions with clients, peers and partners.

We have made many positive steps forward as you can see from the *Spotlight on Our Progress,* which gives us cause to celebrate. However, we recognize that we still face many challenges and we are ready to move forward with enthusiasm, energy and resourcefulness, being ever mindful of Inuit values, culture and resiliency.

I want to invite all of you to walk with us in our journey to build healthy individuals, families and communities!

Honorable Gerald Asivak

Minister

Acknowledgements

The Department of Health and Social Development (DHSD), Nunatsiavut Government (NG) established a Regional Health Plan (RHP) Working Group to guide the development of this plan. A facilitator, Mayo Consulting, was hired to support the RHP Working Group and prepare the final document. RHP membership included representation from all community health offices and the regional office. There was also elder representation. Members brought considerable knowledge and experience to the tasks at hand. The Department would like to thank all the members for their enthusiasm, their hard work and commitment. The Department also acknowledges the efforts of staff that reviewed drafts, gathered information, conducted research and provided valuable feedback. Other Nunatsiavut Government Departments also gathered information and data for this document. Your contributions are appreciated. To those of you who made the production of the document possible, be it formatting, printing or translating, thank you.

Final appreciation goes to Labrador Inuit. Your feedback to staff and government officials and your participation in health surveys, hearings, focus groups, community consultations and programming, has helped the Department to better meet your health needs and to plan for a better future. We trust your voice is reflected in this plan.

Abbreviations

APS: Aboriginal Peoples Survey

CHA: Community Health Aide

CHP: Community Health Plans

CNA: College of North Atlantic

CSSD: Department of Children, Seniors and Social Development

COPD: Chronic Obstructive Pulmonary Disease

DHCS: Department of Health and Community Services

DHSD: Department of Health and Social Development, NG

DAESL: Department of Advanced Education, Skills and Labour, NL

FASD: Fetal Alcohol Spectrum Disorder

FFA: Fiscal Financing Agreement

HCCP: Home and Community Care Program

HCN: Home Care Nurse

HSPC: Home Support Program Coordinator

HSSP: Home Support Services Program

HSW: Home Support Worker

IHSN: Inuit Health Survey Nunatsiavut

IOM: Institute of Medicine

ITK: Inuit Tapiriit Kanatami

LGH: Labrador-Grenfell Regional Health Authority

MMIWG: National Inquiry into Missing and Murdered Indigenous Women and Girls

NISPS: National Inuit Suicide Prevention Strategy

MHFAP: Mental Health First Aid Program

NG: Nunatsiavut Government

NL: Newfoundland Labrador

NLHC: Newfoundland and Labrador Housing Cooperation

NIHB: Non-Insured Health Benefits

RHP: Regional Health Plan

SLP: Supportive Living Program

STI: Sexually Transmitted Infection

ULM: Upper Lake Melville

TB: Tuberculosis

Who We Are

Introduction

Nunatsiavut, which means "our beautiful Land" in English is the homeland of Labrador Inuit. The Nunatsiavut Government (NG) was formed in 2005 as a result of the Labrador Inuit Land Claims Agreement. There are 7130 beneficiaries under this agreement as of January 22, 2019.

As a regional Inuit government within the province of Newfoundland and Labrador, NG has many of the rights and responsibilities of other governments. It is responsible for advancing the aboriginal, constitutional, democratic, social, and human rights of Labrador Inuit. The Department of Health and Social Development (DHSD) is one of seven Departments, each reflecting the unique principles of the Labrador Inuit Constitution (the fundamental law of Labrador Inuit). The other Departments include: Nunatsiavut Secretariat; Nunatsiavut Affairs; Culture, Recreation and Tourism; Lands and Natural Resources; Education and Economic Development; Finance and Human Resources and Information Technology.

Nunatsiavut encompasses all lands in the Labrador Inuit Settlement Area, including the communities of Nain, Hopedale, Makkovik, Postville and Rigolet. 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 I for a map of the Labrador Inuit Settlement Area.

Nunatsiavut Government's DHSD, formerly the Labrador Inuit Health Commission, is responsible for the health and social development needs within NG. It has seven program areas:

- Non-Insured Health Benefits (NIHB)
- Mental Wellness and Healing Services
- Communicable Disease Control
- Home and Community Care
- Healthy Lifestyles
- Healthy Children and Youth
- Social Development

The DHSD has a mandate for provision of a defined range of health services. The provincial Government of Newfoundland and Labrador through the Labrador-Grenfell Regional Health Authority (LGH), other regional health authorities, and other government departments also have mandates to provide many health services including specialized medical services, hospital and community clinic services and other tertiary health services. Health Canada and other health partners provide funding to supplement the provision of programs. The DHSD has collaborative partnerships and working relationships with these organizations in order to better address the health needs of Labrador's Inuit population. It is also well recognized that the majority of health determinants fall outside of health systems. As a result, partnerships with other organizations, government bodies and community agencies are also fostered.

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's programs and services. The Department has a workforce of two hundred and thirty-three (233) employees (154 full-time employees, 18 part-time positions, 16 temporary employees and 45 casual positions[1]). This is an increase of seventy-nine (79) employees from one hundred and fifty-four (154) employees in 2013. The Department's workforce[2] represents 64.4% of NG's total workforce. The employees include social work, nursing, and psychology positions as well as community health workers, mental health and addiction workers, community health aides, community support workers, daycare workers, program coordinators, youth workers, administrative support and other support positions etc. Over ninety percent (90%) of NG employees on the North Coast are Inuit beneficiaries and eighty-three percent (83%) of all NG employees are Nunatsiavut beneficiaries.

The Department's budget for 2017-2018 was $28,329,316.95: $22,421,331.00 (from Fiscal Financing Agreement[3]), contribution agreements from Health Canada for $1,579,249.00, funding from PHAC for $278,400.00 and funding from provincial government (Newfoundland and Labrador Housing Corporation (NLHC) and Department of Advanced Education, Skills and Labour, Newfoundland and Labrador (DAESL) for $4,050,336.95.

The Department is fortunate to have a number of volunteers and elders who assist in delivering program activities, support specific initiatives and who participate on various committees and working groups related to program planning, implementation and review.

This is the third Regional Health Plan developed by the DHSD since the establishment of NG in 2005. We are committed to improving the health of Labrador Inuit and enhancing its capability to meet the health needs of its people. This plan focuses its efforts on areas the department believes are a priority and areas in which it has the capacity and ability to affect positive change.

[1] The number of casuals differs each week.

[2] March 13, 2018 internal communications, NG private collection).

[3] The Fiscal Financing Agreement is a tri-partite agreement between the Nunatsiavut Government, Government of Canada and the Government of Newfoundland and Labrador.

Mandate, Programs and Services

Mandate: To deliver community health programs and services as described in the tri-partner Fiscal Financing Agreement

The Non-Insured Health Benefits (NIHB) Program Area

Provides a specified range of medically necessary health-related goods and services not provided through other provincial/territorial health plans or private insurance plans to Labrador Inuit. NIHB is the payer of last resort and does not replace coverage services available through Medicare to all Canadians. The benefits provided under the NIHB Program facilitate access to provincially insured health programs and services. The general categories of NIHB are: medical transportation (which includes air/ground, accommodation and meals, interpreter/translator services,) to access medically required health services to the nearest appropriate facility, vision, dental care, prescription drugs, medical supplies and equipment (MS&E), and mental health counselling.

Healthy Lifestyles Program Area

This program area provides a variety of health promotion, prevention, education and outreach services to the general population as well as identified at-risk and vulnerable individuals, families and groups. Programs and services are designed to be welcoming and easily accessible allowing individuals to participate, they may also be accessed through referrals and outreach approaches. The program components aim to achieve improved holistic health through improved physical, mental and spiritual health. DHSD uses appropriate messaging, quality programming, and harm reduction approaches to create realistic opportunities, environments and conditions that make healthy choices achievable. The program components, which are based on culture and tradition, include active living and physical activity; nutrition and food security; chronic disease management and prevention; harm reduction approaches to smoking, alcohol and other addictive substances and behaviours; healthy relationships and sexual health, strong connections to the land through land-based programming; life skills and injury prevention.

Mental Wellness and Healing Program Area

This program area provides a continuum of services that target individuals, families, groups and communities with mental health/mental illness-related issues and substance use, gambling and smoking issues or those who have been identified as at-risk or vulnerable to developing these issues. Individuals can access the services by self-referral or by a third party referral. The program components area: a. promotion, prevention, education and community supportive services, b. intervention (counseling) services and c. specialized services. The program's responsibilities have expanded to include Youth Services, Fetal Alcohol Spectrum Disorder (FASD) program, and other special projects that have term funding (examples: Tobacco Strategy and Sexual Violence Program).

Communicable Disease Control Program Area

The Public Health section of DHSD, in close collaboration with the Communicable Disease Control Nurse and Medical Officer of Health from Labrador-Grenfell Health, implement the communicable disease control 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 are: immunization programs, communicable disease follow-up and case management, surveillance, data collection, and analysis, education and awareness, prevention initiatives, and policy development and planning.

Home and Community Care Program Area

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 health care needs of the client and the family in the community. All of the components of the HCCP are delivered in Nunatsiavut but only the HSSP is delivered in Upper Lake Melville (ULM). In this region, Home Care Nursing continues to be provided by (LGH). The HCCP contains the following essential service elements: structured client assessment, managed care, program management and supervision, home care nursing, home support services, record keeping and data collection and access to medical supplies and equipment. Services provided by the HSSP include home management, personal care and in-home respite.

Healthy Children and Youth Program Area

NG delivers a number of programs focused on the developmental needs of children and youth (physical, emotional, cultural, social and intellectual growth of children/youth) and these programs and activities have now been grouped together under this program area. This program area places emphasis on parental/caregiver involvement, both at home and as part of programming. The programs and activities empower the parent/child unit as a whole by addressing needs from pre-conception to pre-adolescence. The components are: public health nursing (pre-conception, childbirth education, breastfeeding support, and school health and pre-school health checks), Fetal Alcohol Spectrum Disorder prevention programming, day cares, Language Nest Program, Aboriginal Head Start, playgroups, after-school programs, youth programs and Family Resource Centres. These Centres provide a safe and welcoming environment that promotes and supports healthy development and overall wellbeing of children and families. They provide resources for children and families that emphasize early childhood development and parenting support.

Social Development Program Area

This program area, in collaboration with partner agencies, delivers programs that focus on vulnerable children, along with individuals and families who have complex needs. Individuals can access the program by self-referral or by third party referral. Some program components require an individual to participate in screening/assessment processes. The programs aim to improve the wellbeing of every individual in society so that they can reach their potential. The programs focus on inclusiveness and support social cohesion. The program area components are: Supportive Housing, Emergency Shelter, the Family Connections program and will include Child Welfare Programs (child protection, children in care, foster parent programs etc.) when devolution takes place.

The following Vision, Mission and Values statements guide the DHSD and this plan:

Vision, Mission and Values

Vision

Healthy individuals, families, and communities

Mission

Improve the health and social status of Labrador Inuit through community-based programs and services, advocacy, and collaboration

Values

- ***Practicing and promoting Labrador Inuit culture and language***
- ***Promoting the balance between rights and responsibilities***
- ***Respecting yourself and others***
- ***Client-centered approaches (where clients refer to the people we serve)***
- ***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***
- ***Leadership: Demonstrating and fostering positive role modeling***
  Communication: Open sharing of information

Spotlight On Our Progress

Accomplishments

Over the past five years, the Department has experienced many successes and has made significant inroads in the implementation of the previous RHP. Regional and community health planning processes are now well established. The Department has also implemented a new collaborative approach between community health teams and regional staff to assist with the development of annual work plans.

The Department has seen considerable expansion in its programming.
The Language Nest Program expanded to Nain in 2014. A Family Resource Centre and Program in Nain became the responsibility of DHSD in 2013. The Family Connections Program is available in Nain, Hopedale and Happy Valley-Goose Bay. Through the Family Connections Program, parents, families, trained family visitors and community agencies work together to help families deal with their challenges and move forward in achieving their full potential. Extensive work has been undertaken in collaboration with the Department of Children, Seniors and Social Development (CSSD) to better support Inuit children and their families through policy revision, feedback on pending new legislation and tri-partite agreements. These agreements include Key Assets for provision of therapeutic placements in Hopedale, agreements for DHSD to provide foster home recruitment/retention and supervised access in Nunatsiavut. Other programs such as the oral health programs continue to evolve.

Some of the most significant progress has been made in the provision of enhanced youth services. A Youth Center was established in Nain in 2017. The Centre also provides a space for vulnerable youth (housing insecure etc.) to stay overnight. An innovative Community Shed Program[4] has been in place in Nain since 2017. The program is also being developed in Hopedale and Rigolet. All these new programs have strong participation rates. These programs have also been successful in providing opportunities to vulnerable individuals for social networking. In response to the conclusion of the Mapping The Way Project in 2015, a regional position was created for Youth Case Management Services. Youth have participated in regional, provincial, national and international events and conferences as well as Inuit-specific cultural events and programming. Youth have been involved in the implementation of smoking surveys, tuberculosis campaigns and have given input in youth specific sexual health and wellness program development.

The DHSD now provides services for clients who are homeless or are in danger of becoming homeless (eviction prevention) and enhanced supportive housing is available for people with multiple and complex needs. In 2015, NG assumed permanent administrative responsibility for one of the Provincial Government's Supportive Living Programs. Two multi-partner committees (The Action Team and The Case Management Team) oversee the program. In Happy Valley-Goose Bay, there are currently eleven units providing housing and support to approximately

[4] Nain Community Shed is a space within the community of Nain wherein Inuit youth, young men, and other community members can learn and practice skills related to carpentry/woodworking and mechanics, starting with small projects such as the building of "Kamutiks" and flats and fixing skidoos and quads and, where appropriate, engaging in larger projects as skills develop. It hopes to empower participants to pursue and engage in further education & employment opportunities.

thirty clients. These units are independent and semi-independent with a staff person offering support twenty-four hours a day.
The program also oversees a unit for LGH that has one resident [5]. Supportive Living units opened in Nain and Hopedale in March 2016. The Hopedale unit houses three (3) individuals and the Nain unit houses four (4) individuals. In December 2016, the Supportive Living Program expanded to include "The Housing Hub" which is an Emergency Shelter located Happy Valley-Goose Bay. The Housing Hub is currently able to sleep twelve (12) clients comfortably each night.

The capacity of the Department has also been enhanced.
New and vacant regional positions for the areas of food security, tobacco control strategy, youth services, sexual violence, health education, and supportive living have been hired. The Department is very proud of its success in recruiting and retaining positions. The DHSD is also pleased to report it has been successful in increasing the number of management and regional positions who reside within the Inuit Lands Settlement Area.

The Department has been engaged in many activities that have increased its visibility and presence on the regional, provincial and national stage.
The Department has participated in survey development and implementation as well as the development of the National Inuit Suicide Prevention Strategy (NISPS) and National Inuit Early Learning Child Care Framework. Staff has served on a variety of Working Groups. In partnership with Eastern Health NL, the DHSD participated in a three -year cancer project, "Journey in the Big Land". It also assisted with the adaptation of the Mental Health First Aid (MHFA) that resulted in an Inuit-specific MHFA. A Labrador Inuit youth represents Nunatsiavut on the National Inuit Youth Council. The Status of Women Office has hosted two conferences for Inuit Women (2013, 2016). They also sponsor an annual award for an "Outstanding Inuit Woman of the Year". These activities ensure the voices of Labrador Inuit are heard at various decision-making levels. This level of involvement draws attention to the needs of Labrador's Inuit, the progress being made and challenges being faced.

Progress has been made in the area of collecting Labrador Inuit specific data.
The Nunatsiavut Household Food Security Survey was conducted in 2013 and 2014 and results are now available. Nunatsiavut is the only Inuit region to now have community-level data on food security. Other surveys such as Youth Smoking Survey, Regional Housing Needs Assessment, Household Smoking Survey, the Seniors Household Survey and the Youth Sexual Health Survey are providing valuable information that will guide programming. In 2013/2014, NG's Status of Women office completed a court-monitoring project in Nain. The Department has also partnered to develop a TB database and work is ongoing.

The DHSD has further increased its capacity to provide training and professional development opportunities for its employees.
The Department now has the internal capacity to provide its own training for the following: ASIST, First Aid & CPR Training, Non-Violent Crisis Intervention and MHFA. Many professional development opportunities were also provided for DHSD employees. Much of the training focused on areas related to the priority areas established in the 2013-2018 RHP (smoking, communicable disease control and outbreak management, early childhood development,

[5] Individual requires 24/7support and care.

trauma and addictions, chronic disease self-management etc.). A DHSD partnership with the provincial College of the North Atlantic (CNA) is enabling Early Childhood Education training to take place in Nain and Hopedale. The DHSD also collaborated with the Department of Health & Community Services (DHCS), Government of NL and other Indigenous groups to develop a cultural competency- training program for health employees throughout the province.

Incorporating Inuit culture, values and traditions into programming activities and ensuring that program components remain culturally relevant still remain a priority of the Department.

Significant investments have been made in land-based programming. The Healing Lodges/Camps outside Nain, Hopedale & Rigolet are examples of investments that support these programs. Efforts were made to enhance connections between youth and elders/knowledge holders through events such as the elder and youth conference as well as Hopedale's Aullaak program. Youth Harvester Programs have taken place whereby respected knowledge holders assist youth in acquiring skills needed to be on the land. Language retreats have been held. The Status of Women office has hosted land-based summer and winter retreats for Inuit women of Nunatsiavut. Inuit women, who may not have access/means to get off on the land, were able to gather in a safe supportive environment. The Hope Walk provides opportunities for people to engage in a three-day walk on the land. Concerted efforts continue to be made to increase awareness and understanding about the impact of intergenerational trauma on individuals, families and communities. Emphasis was placed on provision of training in the areas of Inuit "Intergenerational Trauma/Addictions and Healing" and "Allies in Healing" for various health care professionals, other provincial and regional government staff, DHSD employees and foster parents. Treatment programs were also offered in various communities.

Support for residential school survivors and individuals appearing before the National Inquiry into Missing and Murdered Indigenous Women and Girls

During the past six years, the Department has also worked with and supported residential school survivors and those individuals appearing before the National Inquiry into Missing and Murdered Indigenous Women and Girls. The Department also hosted the pre engagement sessions and provided support to beneficiaries appearing before the Inquiry and their family members. Residential school survivors were provided support, especially in making application under the Labrador Residential Schools Settlement.

Enhanced NIHB benefits and Enhanced Program Efficiencies

Over the past six years, there have been increases in optometry rates, private accommodation and meal rates. There have also been policy changes that have improved benefits available to beneficiaries. Enhanced administrative functions have increased program efficiencies.
The Department also hired a professional service firm (Deloitte) to conduct business process mapping and a workflow analysis for the NIHB program. The Department is now in the process of implementing recommendations from this 2018 report.

Partnerships

The Department has continued to work in partnership with other organizations to improve access to health services, to better coordinate services and to enhance program delivery that is culturally appropriate. The mobile "Mapping the Way" clinical team project (a multi-partnership endeavor) was completed in 2015. The evaluation acknowledged NG's successful administration of the project. The Action Team and Homelessness Case Management Team for the Supportive

Living Program (SLP) are in place. They are good examples of multiple partnerships that work together to provide enhanced and coordinated services to a vulnerable population. Day care licensing processes have improved. The enhanced support from the province is appreciated. The devolution of child welfare programs is progressing. The Department will also be assuming responsibility for pharmacy services to Nunatsiavut (formerly administered by LGH). Makkovik works closely with the school to deliver monthly education programming (health promotion) to all children from kindergarten to Level III. The DHSD is a member of the Health Services Integration Fund Committee, which includes all health regions in the province as well as all Indigenous groups. The Inuit Health Liaison Committee, with senior management representation from both DHSD and LGH has resumed again. Information-sharing agreements that will improve access to Inuit-specific health data have also been negotiated with key health stakeholders. These partnerships along with other collaborative efforts and partnerships support the Department's efforts to address the health status of Labrador Inuit and the health gaps impacting Inuit health.

Challenges

Significant challenges still impact regional health planning. They include but are not limited to:

- Geographically isolated communities that limit access to equitable health services, especially medical specialists and other specialist services
- Insufficient Labrador-Inuit specific health data and the lack of an information management plan, data information-sharing barriers, and limited availability of clinical and service information
- High rates of food insecurity
- High prevalence of chronic and communicable diseases (especially tuberculosis), high smoking rates, and deficits in chronic self management programming
- Serious social issues related to drinking, violence and intergenerational trauma
- Need for improvements in culturally appropriate screening and assessment for childhood growth and development
- Stigma remains a significant impediment; health issues often remain hidden because many vulnerable populations fear being stigmatized and judged
- Barriers to accessing counseling and supportive services require attention
- Specific programming challenges are recruitment and retention of casual staff for daycares and for supportive housing in Happy Valley-Goose Bay as well as filling new and vacant positions
- Inadequate infrastructure needs still pose a significant challenge for programming despite the investments that have been made
- Human resource capacity limits some programming
- Ongoing evolution of social media and the impact on individuals, families, and communities
- Regulatory processes, jurisdictional issues and systemic barriers that inhibit the development and implementation of Inuit specific health services and programs
- The need to develop a collaborative partnership plan across federal, provincial and regional departments, programs and organizations for attracting and retaining health professionals in Labrador.

Summary

The DHSD is proud of its accomplishments, the dedication of its staff and the community members who have supported its programming.

The challenges encountered in the implementation of the previous RHP are recognized in this health plan. Broader social determinants of health such as low income, inadequate housing (overcrowding, mold, poor state of repair etc.), high cost of living and high food insecurity rates are negatively affecting health outcomes. We need, together with our partners, to build upon our collective knowledge to address underlying causes of poor health outcomes and reduce health inequities. Many of these issues can **only** be addressed by working collaboratively and respectfully across multiple sectors for mutual benefit. New levels of engagement are required. Managing these complex partnership relationships are worthwhile and necessary. The Department acknowledges collaborative relationships are time consuming and put a heavy demand on the Department's small senior executive and director team. However, success in moving towards achieving the mission for this Department requires this level of engagement. As part of its plan to address the identified priority areas, the Department is striving to:

- Identify further potential partnership/collaborative opportunities
- Promote community initiatives
- Support mobilization efforts that will enhance community capacity.

How the plan was developed

This is the third RHP developed for the DHSD. The plan is intended to guide the employees, programs and services of the Department. It is meant to be clear and understandable for both NG and Labrador Inuit. The plan guides the community health plans (CHP). This RHP will cover five years from April 2019 to March 2024. This timeline is intended to coincide with that of the fiscal finance agreement between Nunatsiavut Government, the Government of Canada and the Government of Newfoundland and Labrador.

The DHSD uses a planning process that is inclusionary, transparent and provides opportunities for participation and feedback at multiple levels. In February 2018, the DHSD established a Regional Working Group to develop this regional health plan. Part of the planning process included consultations with communities. Members of the working group represented diverse areas and included community team leaders, regional staff, elder representation, and senior management. Their responsibilities included:

- Participation in RHP Working Group meetings
- Development of a work plan to guide the development of the RHP
- Determination of regional priorities
- Review and revise the list of program areas (lines of business) and goals for these program areas.
- Review and provide input on draft program goals and objectives
- Support community consultation meetings as required
- Help determine indicators of success for the RHP
- Identification of the monitoring and evaluation process for the RHP
- Provision of feedback on RHP drafts
- Communication to staff on RHP process.

A facilitator, Mayo Consulting, was hired to coordinate the development of the plan, to conduct an environmental scan, to provide support to the working group, to facilitate community consultations and to compile the RHP document. A combination of face-to-face meetings, conference calls and email correspondences were used to complete the work of this group. In preparation for development of the plan, the working group members were tasked with:

- Reviewing the 2013-2018 RHP and identifying any specific objectives that would need to be considered or brought forward in the next RHP and the CHP
- Identifying the accomplishments of the previous five years
- Reviewing current CHP and identifying any areas for focus on in the upcoming health plans
- Bringing priority issues to the table for discussion.

The working group also considered various statistics, reports, survey results, program data etc. as well as each other's experience and expertise when selecting the themes and priority areas. Program descriptions and goals were reviewed and revised as required. The regional office was tasked with working with the facilitator to document the rationale that supports the selected themes and priority issues.

The plan directs the seven CHP. The CHP support the goals and objectives in the RHP and respond to community-specific health priorities.

The RHP and the CHP's are living documents and as such will evolve over time. New priorities may emerge over the next five years that will require consideration. The findings from this report could result in revising priorities. Other trends may also trigger adjustments to the plans.

In this way, the plans will remain responsive to the changing priorities and health needs of Labrador Inuit.

The next section will provide the context in which this plan has been developed and the rationale that supports the selection of the priority areas.

Context and rationale

Introduction

Wellness is a term often used in the context of living a healthy and balanced life and recognizing the many influences on one's wellbeing. These influences are affected by multiple interactions among various factors, some within our control and some outside our control. These factors include the physical environment as well as the social and economic influences that impact health and quality of life (World Health Organization). Connection to the land and its resources has always been a pillar of Labrador Inuit health and wellbeing. The Labrador North Coast is one of the fastest changing and one of the fastest warming areas anywhere in the world[6]. Environmental changes like these are making it more difficult to get out on the land and to engage in traditional hunting and harvesting activities. Socioeconomic transition, including an increase in wage economy participation, means this relationship is evolving. Although the specific impacts and benefits of renewable (e.g. animals) and non-renewable (e.g. minerals) resource development is relatively poorly understood across Inuit regions, the ability to sustainably co-exist with and benefit from resources will be important to the physical, mental and social health outcomes of Labrador Inuit communities. On an individual level, The Public Health Agency of Canada says wellness is also affected by our personal health practices and our coping skills, biology, gender and culture.

The health of Labrador Inuit has also been impacted by past relocations and dislocations, the 1918 Spanish influenza epidemic, Confederation, residential schools, marginalization, cultural losses, and other experiences related to oppression, dependence, colonization and isolation. Geographical distances from services have resulted in further health inequities. Today ongoing cultural, social, economic and environmental changes continue to influence Inuit health.

The DHSD operates within a rapidly changing social, economic, health and technological environment; one in which there is increasing demands for accountability and competing and rising demands for scarce healthcare resources. The Department tries to balance these demands against the pressing need to alleviate the harm caused by a long history of health inequities as well as to eliminate the major health gaps that exist between Labrador Inuit Canadians and non-Indigenous Canadians.

The Department takes a holistic approach to wellness, moving towards an emphasis on the importance of physical, mental, social, and spiritual wellbeing within the context of a strong Inuit cultural system and away from the disease model. Programs continue to be designed in a way that builds upon the strengths and resilience of Labrador Inuit.

It is within these contexts that priority issues were identified for discussion. Although the environmental scan shows the Department is making significant progress in addressing the health needs of Labrador Inuit, it also sheds light on the path that needs to be taken as we move forward.

Summarized below is a brief overview of the current environment in which health services are being delivered.

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[6] Cunsolo Willox, A. researcher, for Inuit Mental Health Adaptation to Climate Change project. CBC News · Posted: Jan 10, 2014 5:22 PM E

Environmental Scan Chart: Overview

- Labrador Inuit population is younger and growing more rapidly than general Canadian population. In Nunatsiavut, the population grew by 6.0% from 2006 to 2016. The 2016 Census says 11% of Inuit peoples in Canada are under five years of age as compared to 5% for the non-indigenous population.
- Language preservation is seen as being very important. At the 2018 Youth Symposium, all participants identified loss of culture and language as a priority issue. Similar concerns have been expressed in community consultations and in recent surveys
- Increased number of multi- partnerships/ collaborations and M.O.U's is resulting in actions that address some of the identified inequities and health needs
- The Department has been successful in hiring Inuit who have graduated from Bachelor of Social Work and other programs for health careers within DHSD
- Ongoing workforce development continues to enhance capacity and skills of DHSD health employees
- Tele-health/tele-robotics have improved access to healthcare
- Sixty-five percent of Inuit in Nunatsiavut have access to internet at home (APS 2017)
- Mental wellness programs have been strengthened, youth services has expanded, and active youth outreach has improved
- Culturally appropriate programming has been incorporated into many activities and infrastructure improvements have been made to support programming
- The Department has increased its linkages with other Indigenous groups
- Many health indicators presently being used nationally and provincially, show that Labrador Inuit have poorer health outcomes than other Canadians
- Supportive housing options for vulnerable and homeless populations have improved. However, overcrowding, a high percentage of housing requiring major repairs and housing insecurity are significant issues in most communities
- The Department has been successful in implementing early childhood development programs, but has been less successful in delivering programs that target risk factors for children and their families
- Access to appropriate and timely health services, especially specialist services, although showing signs of improvement, is still a significant issue. This limited access to specialist services is reflected in the increased cost of medical transportation outside Labrador (NIHB, Nunatsiavut Government)
- The health of Labrador Inuit families and communities continues to be affected by the impacts of intergenerational trauma and other social issues such as problematic alcohol use and related violence issues
- Food insecurity is a major problem in many homes in Nunatsiavut, but especially so in Nain and Hopedale (based on 2013-2014 data). Household food insecurity prevalence is slightly higher in households with children
- Information management systems are becoming increasingly important, especially in relationship to accessing and sharing reliable and useful health information and data. Cross-jurisdictional barriers that are preventing excellence in Aboriginal health data systems are still a reality
- Inuit –specific health data and Inuit health research have seen improvement, but considerable work lies ahead. Timely access to data gathered by other agencies remains a concern.

This environmental scan also recognizes the impact of the social determinants of health[7] such as income levels, cost of living, livelihoods, food security, language and culture, quality of early childhood development, mental wellness, safety and security, housing, education levels and availability of health services, on the health status of Labrador Inuit. These issues primarily fall outside the mandate of the DHSD; however, the Department is increasingly concerned about their influences on health inequities. According to the World Health Organization, social determinants are mostly responsible for health inequities[8]. NG communities still face many social issues that affects the wellbeing of their communities. Historical events have contributed to longstanding inter- generational trauma, social breakdown and cultural discontinuity. The Department recognizes the resulting pain, suffering and loss is playing a role in the incidences of FASD, crime, interpersonal violence, injury and suicide. It is also aware of the complex relationships between substance abuse, mental health issues, intergenerational trauma and social determinants of health. The DHSD wants to address these harms and prevent and reduce further harm.

This plan takes into account the role all these factors play in the everyday life and health of Labrador Inuit and their continued resiliency despite the challenges they face. The plan also takes into account the advocacy role the DHSD must take on in bringing these issues forward and seeking the resources and partnerships needed to improve the social determinants of health.

The next section identifies key indicators that demonstrate the disparities between the health status of Labrador's Inuit population in comparison to Provincial and Canadian populations. The disparities identified below clearly influence the direction this plan is taking

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[7] Inuit specific focus on social determinants of health as outlined in ITK's 2014 Report on, *The Social Determinants of Inuit Health in Canada.*

[8] World Health Organization. *Social Determinants of Health.* Accessed On January 11, 2013 at: http://www.who.int/social_determinants/en/

Environmental Scan Chart: Nunatsiavut Population Compared to the General Population

In the NG Seniors Household Survey (2017), 30.72% of participants in Nain and Hopedale rated their physical health as excellent or very good (fifty five years and over). In the 2012 Aboriginal Peoples Survey (APS), 50% of participants in Nunatsiavut rated their health as excellent or very good as compared to 35% of the participants in 2007-2008 Inuit Health Survey Nunatsiavut (IHSN). In 2014, 59% of Canadians rated their health as being very good to excellent (Health Canada, Chief Public Health Officer, 2016).

- The Canadian Inuit population (65,025) grew by 29.1% from 2006 to 2016. (Statistics Canada, 2016 Census) and 3.5% of the Inuit population resides in Nunatsiavut (APS 2017). The average age of Inuit in 2016 was 27.7 years, significantly younger than the non-Aboriginal population average of 40.9 years (APS 2017)
- According to the 2007-2008 Inuit Health Survey, more than 40% of participants aged 40 years and above in Nunatsiavut had been told they had high blood pressure as compared with a prevalence rate of 16% amongst Canadians. Unhealthy cholesterol rates were also high (25%). Triglyceride levels were too high for 22% of participants
- Canadian Government figures show the incidence of tuberculosis among all Canadians in 2016 was 4.8 cases per 100,000 people, while that number significantly rose to 170 cases per 100,000 people for Inuit living across Canada[9]. NG had major outbreaks of tuberculosis in 2015, 2016-17 & 2018. The average annual tuberculosis incidence rate in Nunatsiavut has risen since 1997 to 2008 (89.7 cases per 100,000) to the average rate of TB per 100,000 Population for the years 2006-2016 of 248.4 cases per 100,000. This rate is the highest of all four Inuit regions (ITK, November, 2011, ITK, 2018 Statistical Profile). Among Inuit, the Federal Government has stated the tuberculosis rate in 2015 was more than 270 times higher than the rate among Canadian-born non-Indigenous people (CBC news release, October 28, 2017). The Canadian Government and Inuit Nunangat have launched a strategy & framework to address this critical issue. NG will be participating in these efforts to eliminate tuberculosis in the Inuit populations
- Chlamydia rates for Nunatsiavut steadily declined from 2014-2017. However, Chlamydia rates for Nunatsiavut communities are still high at 1047.9 cases per 100,000 in 2017[10]. These rates are higher than the national rates (based on 2015 diagnosed number of cases, 116,499) at 325 cases per 100,000 (Public Health Agency of Canada, February 1, 2018 and LGH, Health Protection Unit)
- In the Nunatsiavut Household Smoking Survey (2015) 70.3 % of participants reported someone smoked in the home. In the 2007 Inuit Health Survey Nunatsiavut, 74% of households reported they had smokers in the home. Direct comparisons are not

[9] Public Health Agency of Canada and Health Canada, March 23, 2018. Press conference, (CTV and CBC News).

[10] Communicable Disease Control System, Department of Health and Community Services, 2013-2017; Population Estimates, Statistics Canada, Demography Division, 2013-2017.

available. However, 17.71% of other Canadians (age 12 years and over) reported smoking in 2015 and the rate was 21.7% for NL (Statistics Canada)

- Although the percentage of daily smokers (ages twelve and over) in Nunatsiavut has decreased from 57% in 2006 APS to 50% in the 2012 APS, the prevalence rate is still much higher than the national rate of daily smokers for 2016 (12%). The percentage of daily smokers in Nunatsiavut was lower than Inuit Nunangat (63%) but significantly higher than the total population of Canada aged 15 and older who were daily smokers (16%). The 2012 Inuit daily smoking rate was over three times the rate for the overall population of Canada (ITK, Statistical profile, 2018)
- In the Nunatsiavut Youth Smoking Survey (released 2017) 27.8% of youth surveyed reported they were smoking (grade 7-grade 12). In Canada, of youth aged 12 to 17 who were surveyed, 4% reporting they were smokers in 2015 (Statistics Canada, Canadian Community Health Survey, released March, 2017)
- The prevalence of food security is much lower in Nunatsiavut than it is in the province of Newfoundland and Labrador, and in Canada. In 2014, the level of food security for all Canadian households was calculated to be 88.0%. In 2012, the level of food security for Newfoundland and Labrador was calculated to be 86.6%. The number of households in Nunatsiavut that were food secure in the Food Security Survey (2013-2014) was 40.5%[11]. In Nain, only 20.2% of the households reported they were food secure and in Hopedale the percentage was only 16.9 % of households who reported they were food secure
- The 2012 APS found that 30% of Inuit aged 18 and over were overweight and 26% were obese, according to their Body Mass Index (BMI), which was calculated using self-reported height and weight. The percentage of people who were overweight or obese (adult body mass index 25 or greater) among those 18 years of age and older in Labrador Rural Secretariat Region in 2013-2014 was 75.3% (+/- 5.1%). The provincial rate was 68.8% (+/- 1.6%). (Community Accounts NL, Profiles). In 2014, the rate of Canadians (age eighteen years and over) who reported height and weight that classified them as overweight in 2014 was 40.0% for men and 27.5% for women. 20.2% of Canadians aged 18 and older reported height and weight that classified them as obese[12]
- From 1993 to 2009, sixty-four people (64) died by suicide in Nunatsiavut; the suicide rate was one hundred and sixty (165) deaths per 100,000 Population. This means that on average, there were about 1.7 deaths for every 1,000 people each year. Overall, the suicide rate was twenty (20) times higher in Labrador Inuit communities than in Newfoundland and 15 times higher than in Canada. Relative to other Indigenous/non-Indigenous suicide rate comparisons, the rate disparity for Nunatsiavut is one of the highest in the world. Suicide rates for Inuit youth are among the highest in the world, at 11 times the national average (Centre For Suicide Prevention (2016). A report from" Statistics Canada's health analysis division, found that the suicide rate among children and teens in the Inuit homelands was 30 times that of youth in the rest of Canada during the five-year period from 2004 to 2008." (Globe & Mail), July 18, 2012. The reported Canadian Suicide rate for 2015 was 12.3% (Statistics Canada)

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[11] Furgal, C.; et al: ., Inuit Health Adaptations to Climate Change (IHACC) Research Team. 2019. *Food Security in Nunatsiavut: Report on the results of community household food security surveys in Nunatsiavut (2013-14).* Report prepared for the Nunatsiavut Government, Department of Health and Social Development, Nain, Nunatsiavut [Confidential, for internal use only].

[12] Statistics Canada.2014. *Overweight and obese adults (self-report).*

- The unintentional injury [13] mortality rate in Nunatsiavut (1996-2012) is 6.7 times higher than in Newfoundland. The unintentional injury mortality rate in Canada is 31 deaths per 100,000. The rate in Nunatsaivut is 4.8 times higher than in Canada (Pollock, 2019)
- In total, there were 100 hospital admissions due to suicide attempt/self-injury [14] for patients from Nunatsiavut (2005-2014), or on average 10 admissions per year (55 among women, 45 among men). The rate in Nunatsiavut (372.7 per 100,000) was 4 times higher than the rate on the Northern Peninsula (89.4 per 100,000), 4.75 times higher than in Newfoundland (78.7 per 100,000), and 5.7 times higher than the 2015 rate in Canada (372.7 versus 66)(Pollock, 2019)
- There were 257 suicide-related Emergency Department visits for patients from Nunatsiavut communities. The rate of suicide-related Emergency Department visits was 1.78 times higher in Nunatsiavut than in Happy Valley-Goose Bay/Northwest River (27.2 versus 15.3 visits per 1,000 pop.). (Pollock, 2019)
- The median age of death in Nain for 2004-2015 was 45 years and in Hopedale it was 49 years. For the same time frame, the median age of death in Newfoundland and Labrador was 78 years (Community Accounts, Newfoundland and Labrador Statistics Agency). The median age has improved for both communities since the median age was recorded for 2004-2011. Life expectancy at birth (projected) for Canadian Inuit in 2017 was 72.4% and for the non-Indigenous Canadian population it was 82.9% (ITK, 2018 Statistical profile)
- In the APS 2012, 47% of Nunatsiavut participants surveyed reported heavy drinking[15]. This compares to 18% of total population of Canada aged 15 and older who reported heavy drinking in 2012 and 19% for 2016 (Canadian Community Health Survey, 2016). It was also the highest percentage of any of the Inuit Regions in Inuit Nunangat and an increase of 16% from the APS 2006 results of 31%
- In the APS 2012, 53.3 % of Inuit, aged eighteen years and over, rated their mental health as very good or excellent as compared to 71.6 % of the non-aboriginal Canadian population.

The suicide rate in Nunatsiavut is 18.2 times higher than in Canada based on Dr. Hick's estimate (200/100,00 in 2014-2017) and Statistic Canada's most recent national suicide rate (11/100,000, 2009-2013). In Inuit Nunangat, rates ranged from 60 per 100,000 in the Inuvialuit Settlement Region to 275 per 100,000 in Nunatsiavut. Nunavik and Nunavut's rates for this period were each more than 10 times the national rate[1]. The trend in rates varies by region over the entire 14-year timespan (1999-2013). In Nunatsiavut, the rate of suicide has gradually become more elevated in contrast to Nunavik, where the rate gradually decreased (Pollock, 2019).

[13] Unintentional injuries include motor vehicle collisions, drowning, fire, falls, poisoning, and all other "accidents."

[14] Please note: Data Source could not tell the difference between instances of a suicide attempt, that is, a person who hurt themself on purpose with the intent of taking their own life, and what is called "non-suicidal self-injury" in which a person harmed themself on purpose but *without* the intent to die. Often the latter involves ritualized behaviours such as cutting.

[15] Heavy drinking was determined using question ALC_03, which asked "How often in the past 12 months have you had five or more drinks on one occasion?" Response categories were Never, Less than once a month, Once a month, 2 to 3 times a month, Once a week, More than once a week.

The following chart further highlights social and economic indicators that significantly impact the health outcomes of Labrador Inuit today:

Environmental Scan Chart: Social Determinants of Health

The 2014 ITK report on" The Social Determinants of Inuit Health in Canada" acknowledges substantial work remains in addressing the underlying conditions that influence Inuit health outcomes. Inequity in social determinants of health between Inuit and other Canadians is believed to be a factor in high incidence rate for TB diseases in Inuit populations (ITK, 2018: ITK. March. 2013).

INCOME LEVELS

- The Well-Being Indicator Chart, Community Accounts NL ranked 363 communities in NL in terms of the prevalence of low income for all families in 2015. The Five North coast Inuit communities ranked from 337 out of 363 to 361 out of 363 indicating the prevalence of low income for all families was very high. Nain and Hopedale ranked 359 and 360 out of 363 NL communities in relationship to income support benefits prevalence for 2016
- The 2016 Census reported the prevalence of low income for the population in private households based on the low-income measures after tax was higher than the provincial rate (8.8%) for children aged 0-5 years and 0-17 years. The rates in the North Coast communities ranged from 16. 7% in Rigolet to 29.2% in Nain for children aged 0-5 years. The rate for Happy-Valley Goose Bay and North West River for children 0-17 years was also higher than the provincial rate (10.7 % and 11.1%)
- The percentage of individuals in Nunatsiavut who received Income Support Assistance at some point in 2016 was higher than the provincial percentage of 7.8% for the communities of Nain (22.6%), Hopedale (24.5%) and Rigolet (8.2%). The average number of months individuals were receiving income support was 8.2 months for Nain, 8.3 months for Hopedale and 5.8 months for Rigolet. (Community Profiles, Community Accounts NL, accessed February 28, 2017). These rates have significantly reduced since 1992
- The 2016 Census reported the average after tax income of households in 2015 was lower in all seven communities than the provincial average and the median after tax income in 2015 among recipients was lower than the provincial median after tax income for all five North Coast communities as well as North West River
- In the NG Seniors (55 years and over) Household Survey (2018), 20.6% of participants describe their household money situation as "they run out of money before payday" and another 7.19% said they were spending more money than they get.

Household food insecurity in Nunatsiavut is strongly linked to income and financial resources. Affording safe and healthy food was reported as a challenge for some households (Furgal, C., et al. 2019).

EMPLOYMENT LEVELS

- The 2017 APS reported 49% of core working aged (25 years -54 years) Inuit in Nunatsiavut were employed in 2016, the lowest of the regions within Inuit Nunangat
- The Canadian Census for 2016 reported that percentage of the population who did not work in 2015 was higher than the provincial average (32.8%) for the communities of Nain (38.6 %) and Hopedale (38.9%)
- The unemployment rate among Inuit in Nunatsiavut was 32% in 2016 (APS 2017). That rate was higher than Canadian Inuit rate of 22% (APS 2017).

FOOD SECURITY

- In 2017, the Nutritious Food Basket Weekly Food Cost for a Family of Four on the North Coast of Labrador was calculated as $402.00, a 34.3 % higher rate than the provincial weekly cost of $264.00 (NL Statistics Agency, 2018.) In 2016, it was about $732.00 a month for other Canadian households [16](Statistics Canada, December 13, 2017).
- The weekly cost of a basic nutritious diet of a family of four in an isolated Inuit Community was $395-$460 as compared to $226.00 for the same diet in a southern Canadian city such as Ottawa Centre (Aboriginal Affairs and Northern Development Canada, 2009)
- Nunatsiavut regional food insecurity levels (59.5%) in 2013-2014 Household Survey are higher than 2007-2008 levels (45.7% insecure) determined through the Inuit Health Survey Nunatsiavut. There is significant variance between communities. Nain and Hopedale have a high prevalence of severely food insecure households (Nain, 79.8% insecure and Hopedale 83.1% insecure)
- Overall, household food insecurity in Nunatsiavut has increased by 7% since the Inuit Health Survey Nunatsiavut in 2007-2008. The food insecurity prevalence is much higher in Nunatsiavut than in the province of Newfoundland and Labrador (13.4% in 2012) and in Canada (12% in 2014).

HOUSING

- Insufficient housing, poor quality housing, overcrowding and aging houses have been documented as serious issues facing many Labrador Inuit (NAHO, June 2012 and Nunatsiavut Regional Housing Needs Assessment, 2012)
- In the 2016 Census in Brief (Statistics Canada), it was reported 20.6% of Inuit were living in crowded housing[17]. The Nunatsiavut Regional Housing Needs Assessment 2012, found that 1 in every 6 (16.0%) dwellings was overcrowded[18]
- The proportion of Inuit residing in Nunatsiavut who were living in a dwelling that required major repairs was 32.6% (Census in Brief, Census 2016, Statistics Canada). The Nunatsiavut Regional Housing Needs Assessment 2012 shows that 44.4 % of members believe there is mold in their homes. The same survey showed 74.3% of all dwellings are in need of major or minor repairs. These rates are higher than the rates reported in the IHSN 2007(12% for mold and 22% requiring major repairs). The Census Profile, 2016 Census shows that in four of the five North Coast Inuit communities the reported percentage who said their homes were in need of **major** repairs was higher than the provincial percentage (28.7 %). Makkovik, North West River and Happy Valley-Goose Bay reported lower rates
- Many Nain and Hopedale participants in the NG Seniors Household Survey (2018) reported they were somewhat dissatisfied or very dissatisfied with their current housing situation (31.38%)
- One hundred and thirty five clients (135)[19] have stayed at the emergency shelter in HV-GB since it opened in December 2016. A significant percentage of these clients are Inuit.

EDUCATION

- Canadian Inuit have made gains in high school and post secondary completion from 2006 (26%) to 2016 (29%) (ITK, 2018, Statistical Profile)
- The percentage of the population aged 25-64 years in private households in the five North Coast Inuit communities who completed a post secondary certificate, diploma or degree ranged from

[16] Caution should be exercised in interpreting this data. Variables such as time of year survey was completed, availability of foods on list, types of food selected for inclusion etc. effect calculations and the collection of pricing information.

[17] Houses with a one bedroom or more short fall.

[18] According to the CMHC definition of 'suitable' (not crowded),

[19] Up to March, 2018, internal document, NG

35.8% to 72.2% (Census Profile, 2016)[20]

- An estimated 9 % of Inuit school aged children (aged 5-18 years) in Nunatsiavut are not in attendance at school for year 2017-2018 (NG internal documents, private collection 2018, NLESD- Enrollment by grade and school, 2017-2018)
- Canadian Census reports for 2016 show that the percentage of people aged 25-64 years who do not have at least a high school diploma is higher in Nain, Hopedale and Rigolet than of people in the entire province (34%). Happy Valley-Goose Bay, North West River, Makkovik and Postville rates were lower than the provincial percentage.

ACCESS TO HEALTH CARE

- The 2012 APS reported only 19% of Nunatsiavut participants reported they had a regular medical doctor. Only 15.8% of Canadians did **not** have a regular health care provider[21] in 2016 (Statistics Canada: Health Fact Sheet: Health Care Providers)
- Increased medical transportation costs for travel outside the region (NIHB) is a further indicator of limited access to medical specialists and services (Nunatsiavut Government, Private Collection, 2019).

ENVIRONMENT

- Water quality within Nunatsiavut is still poor, but progress is being made. Regardless of community size or location, access to clean drinking water is a basic human right[22]
- Labrador North Coast is experiencing rapid environmental changes.

CULTURE & LANGUAGE

- In the Statistics Canada, 2016 Census Brief, released October 25, 2017, 21.4% of Inuit in Nunatsiavut reported they could speak an Inuit language as compared to 83.9% of Inuit in Inuit Nunangat who reported being able to speak an Inuit language. In the NG Seniors Household Survey for Nain and Hopedale (2018), 18.3% of participants reported they used Inuktitut almost only or mostly only in the home. Another 23.53% of participants reported they used Inuktitut and English about half and half
- Access to a hunter and access to food from sharing had the greatest impact on Hopedale's individuals' reported ability to support their cultural, personal and social food needs (Emily Willson, Masters' Thesis 2016)
- In the APS 2017 survey, 2% of Nunatsiavut participants reported they hunted, fished or trapped for income or to supplement income.

In the 2017 APS, 66% of Nunatsiavut participants reported they had hunted, fished or trapped in the previous twelve months and 63% said they gathered wild plants in the twelve months before their interview.

The next section provides a more detailed picture of what is known about the physical and mental health of Labrador Inuit.

[20] Nain, 35%, Hopedale, 40.9%, Makkovik, 48.9%, Rigolet, 51.4% & Postville 72.2%

[21] Defined as general practitioner, medical specialist or nurse practitioner.

[22] (Fang, et al, 2018. *Report on Municipal Service Delivery in Labrador).*

The percentage of Inuit who reported excellent or very good health fell from 56% to 45% between 2001 and 2012.
(APS 2012, Inuit Summary)

Environmental Scan: Physical Health and Mental Health

Physical Health

Many other factors have also influenced and/or supported the selection of the key elements and priorities identified in this plan. These health issues are summarized below.

Good nutrition is an important factor in healthy child development and in positive health outcomes for any population. In the 2013-2014 Nunatsiavut Household Food Security Survey, several households reported challenges to accessing enough, healthy foods in the month prior to the survey because of financial barriers. In 47.2% of households, there were times in the last month when the food for the family just did not last and there was no money to buy more. In 48.5% of households, there was not enough money to eat what participants considered to be healthy foods. In 29.6% of Nunatsiavut households, adults ate less than they felt they should, and in 25.4% of households with children, children had not eaten enough at some time in the month before the survey because there was no money for food. A smaller number of households also reported adults going a whole day without food (12.7% of all households) and children going a whole day without food (6.3% of households with children) at some point in the previous month. Participants in the 2017 NG Seniors Household Survey for Nain and Hopedale said in the past month, there were times (sometimes 32.03%) or (often 5.88%) when the food for them and their family/household did not last and there was no money to buy more. The high levels of food insecurity are impacting physical health and are having major implications for healthy child development of Inuit children and youth.

The 2013-2014 Nunatsiavut Food Security Survey Results showed household food insecurity in Nunatsiavut is somewhat higher in households with children. Eating patterns of both adults and children are impacted by food insecurity.

Lifestyle practices also impact the health of Labrador Inuit. The 2015 Nunatsiavut Household Smoking Survey provided information related to participants' attitudes towards a healthy lifestyle. Of the participants surveyed, 66.8% rated themselves from 7-10 (on a scale of 0-10) for a healthy lifestyle. A significant percentage said a healthy diet (72.7%), exercising regularly (59.3%) and taking care of your body (79.7%)was important or very important to them and their family.

The Department recognizes that chronic illnesses are one of the most common and costly health issues facing Nunatsiavut. An analysis of the top ten most commonly dispensed medications (Non-Insured Health Benefits Plan)[23] from 2012-2013 to 2017-2018 showed that the most

[23] NIHB data, private collection

frequently dispensed drugs were those that treated inflammatory conditions (arthritis), pain and fever (ASA), high blood pressure, asthma, and Gastroesophageal Reflux Disease (GERD). This data correlates with the findings in the 2012 APS which identified the most commonly reported chronic conditions diagnosed by a health professional, (Inuit 15 and over, Nunatsiavut) as high blood pressure, arthritis & asthma. NIHB data shows that drugs to treat these conditions have been listed in the top ten dispensed drugs since 2010. A change that may require monitoring was that drugs used to treat diabetes were only listed in the ten most frequently dispensed drugs in one fiscal year since 2012-2013[24]. Also noteworthy, is that despite the high prevalence of individuals being treated for high blood pressure, drugs to treat cholesterol was not listed amongst the top ten dispensed drugs from 2012-2013 to 2017-2018. Many of the underlying causes and risk factors are similar for chronic diseases such as heart disease, stroke, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and some types of cancer. A collaborative approach is necessary if we are to address the associated risks related to chronic illnesses. Since many chronic illnesses are also preventable, concentration on the promotion of healthy lifestyle decisions and the adoption of healthy lifestyle practices will make a difference in the quality of life for Labrador Inuit population.

An analysis of NIHB dispensed drug data[25] showed that for the past three fiscal years, Methadose was the most frequently dispensed medication. However, in the same time period, four of the top ten dispensed medications were used to treat blood pressure and three of the top ten dispensed medications were used to treat inflammatory conditions, pain and fever. When these factors are taken into consideration, Methadose becomes the third or fourth most frequently dispensed medication for the past three fiscal years. This change appears to be a significant increase in the use of this medication.

Rates of cancer are increasing among Inuit in Canada. Using data from 1998 to 2007, the age-standardized rate for new cases of cancers among Inuit was 323 per 100,000 population[26]. A better understanding of the factors driving this trend is needed. Inuit have the highest rate of lung cancer in the world (Young et. al. 2016).

Communicable disease rates are high in Nunatsiavut. Tuberculosis (TB) rates and sexually transmitted infection (STI) rates are still higher than non-Indigenous populations. The Public Health Agency of Canada reported that in 2016, the incidence of tuberculosis was 170.1 per 100,000 Inuit peoples in Canada, compared with just 0.6 per 100,000 Canadian-born, non-Indigenous people,[27]. That is two hundred and ninety-six (296) times higher for Inuit than for non-Indigenous people born in Canada. The Inuit-specific Tuberculosis Strategy (2013) reported that in 2011, the incidence rate of TB disease for Inuit was almost two hundred and fifty-four (254) times the rate reported for Canadian-born non-Indigenous and roughly thirty-eight (38) times the rate reported for Canada overall. As of 2016, the incidence rate has increased to almost three hundred (300) times higher than the rate in the Canadian-born non-

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[24] As frequently dispensed drugs such as methadose make the top ten list, other drugs such as those used to treat diabetes may be moved lower on the list.

[25] NIHB, private collection, NG.

[26] Canadian Partnership Against Cancer, (2014). *Inuit Cancer Control in Canada Baseline Report*. Toronto: Canadian Partnership against Cancer as quoted in Report on Health Status of Canadians 2016.

[27] Public Health Agency of Canada: March 2018. *The Time is Now: CPHO Spotlight on eliminating tuberculosis in Canada.*

Indigenous population. Chlamydia is the most prevalent STI occurring in Nunatsiavut communities and despite significant decreases from 2013- 2017, remains a major health issue.

The 2015 NG Household Smoking Survey reported that 74.1% of participants said smoking is not allowed inside the home.

Smoking rates remain a serious concern. The 2012 APS reported 50% of Inuit in Nunatsiavut were daily smokers. At ages 25 to 44, 60% of Inuit reported daily smoking in the APS 2012. In the 2017 Nunatsiavut Youth Smoking Survey, 38.9% of youth who reported they were smokers, said they started smoking at ages 12-13 years and 48.6% of the youth respondents reported they started smoking between 12-14 years of age. Significantly, 43.4% of youth have tried to quit yet only 26.6% of youth surveyed knew about the smokers' toll-free helpline. In terms of risky health behaviours, 26.8% of youth surveyed said they sometimes shared the cigarette they smoked. Individuals, their families, communities and the health system pay a heavy price for this level of use. Cadmium levels (mainly caused by smoking) among Inuit participants in the IHSN (2007) have put many at risk of bone and kidney problems. There is also a correlation between smoking, other unhealthy lifestyle practices and many chronic illnesses. For example, in the majority of COPD cases, smoking is the underlying cause[28].
The 2016 Canadian Community Health Survey found smokers were more likely to report daily stress than non-smokers. In 2016, 30.2% of smokers reported that most days were 'quite a bit' or 'extremely' stressful. Among non-smokers, 21.1% reported daily stress. Smokers were also less likely (86.0%) than non-smokers (92.5%) to report being satisfied overall with their life. Further study is needed to determine if smokers in Nunatsiavut are more likely to report daily stress than non-smokers

Screening and assessment of pre school children continues. However, access to specialized services and appropriate interventions continues to be a challenge. Therefore, children requiring early interventions often experience delays in receiving the required services. A review of NIHB's transportation data show that an increasing number of children are being referred out of Labrador for allergy testing and for visits to ear specialists.

Heavy alcohol use is known to negatively impact physical health especially as it relates to liver disease, some cancers and injuries as well as being identified as a risk factor for chronic disease and suicide. The DHSD recognizes that problematic alcohol use is a major issue within the Labrador Inuit population. Further information is provided in the mental health section.

[28] Mayo Clinic: COPD, https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679

In the APS 2012, 87% of Nunatsiavut participants reported they had very strong or strong ties among family members living in the same community but in different households, as compared to 66% for Inuit Nunatqat.

Mental Health

Mental Wellness is a major determinant of health. Mental wellness issues impact health outcomes. For Labrador Inuit, social issues such as alcohol use, other substance use, gambling prevalence rates, violence and intergenerational trauma impact social and personal wellbeing. They also harm family networks and negatively impact personal safety and security (ITK, 2014). Communities are beginning to recognize and address the complicated relationships between these social issues, other risky behaviors or unhealthy behaviours and intergenerational trauma experiences. If we just consider alcohol use alone, we know it is "associated with injuries, chronic disease, cancer, and physical and sexual violence, and globally ranks third after high blood pressure and tobacco as a contributor to disease and disability"[29]. Climate changes have also taken a toll on the mental health of Labrador Inuit. Warming temperatures have made it more difficult to engage in traditional hunting and harvesting as well as more challenging in accessing the land.

The NG Seniors Household Survey (2017) in Nain and Hopedale reported that 48.33% of participants interviewed rated their mental health as excellent or very good (55 years and older).

This plan recognizes that social issues, historical events and climate change continue to cause distress on an individual, family & community level. The Department intends to focus on reaching vulnerable populations, addressing problematic alcohol use, strengthening childhood development, supporting and strengthening families. Data supports the decision to focus on specific aspects of social issues that affect the mental wellbeing of Labrador Inuit. The information below provides a snapshot of the data considered in the development of this plan:

Alcohol Use and Other Substance Use

- The percentage of Inuit in Nunatsiavut (2012 APS) who reported heavy drinking (having five or more drinks; 4 or more for women) on one occasion at least once a month was higher than The Labrador Rural Secretariat Region (2013-2014) and NL (2013-2014)[30]
- The 2015 *Mapping The Way Evaluation Report* showed that of the one hundred and thirty-five participants[31] who accessed clinical services from 2011-2014, 22% identified alcohol as a presenting issue[32] at intake, 27% identified FASD as a presenting issue and 10% identified family related alcohol as a presenting issue

[29] Giesbrecht, N. Dr. Centre for Addictions and Mental Health, 2013. "Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Comparison of Provincial Policies,"

[30] 47% for Nunatsiavut compared to 35.7% (+/-6.0%) for Labrador Rural Secretariat Region 2013-2014 and 33.3%(+/- 4.5%) for the province (Community Accounts NL, Profiles)

[31] 57.8% of the participants were between the ages of six years and twenty- four years.

[32] Most participants presented with more than one issue and participants primarily came from Hopedale and Sheshatshiu.

- A significant percentage of the ninety-three (93) individuals who accessed the Emergency Shelter in Happy Valley-Goose Bay in the past fiscal year (2017-2018) were Inuit (48.4%). It was estimated approximately 58% of individuals accessing services had issues with alcohol
- In the Aboriginal Peoples Survey (APS) 2006, 82% of participants said alcohol use was a problem in their community
- Labrador Inuit who attended a Youth Symposium (March 2018) were asked to identify their vision for a healthy community and 40% of the participants envisioned a community with changes related to alcohol and drug usage. Their comments included: community without drugs or alcohol, less drugs or alcohol, limitations on alcohol or drugs, no bootlegging, or using alcohol/drugs to avoid problems or take away pain, alcohol and drug free youth, dry communities etc.
- In the thirty days before the administration of the NL Student Drug Use Survey 2012, 31.4% of students met the definition of binge drinking by consuming five or more drinks in a single sitting. This is relatively unchanged from 2007 (29.7%). Further, significantly more students from this province (27.8%) experienced drunkenness than students in New Brunswick (19.8%). This is consistent with the 2012 Canadian Alcohol and Drug Use Monitoring Survey (Health Canada, 2013) results that show Newfoundland and Labrador as having the highest rates of exceeding Canada's Low-Risk Alcohol Drinking Guidelines (Butt, Beirness, Gliksman, Paradis, & Stockwell, 2011) in the country
- In youth from Nain and Postville who had self- reported drinking, the average age when regular alcohol consumption began was 13.3 years (Brunelle et al. 2011)
- Risk of occurrence of FASD is a cause for concern because 23% of Inuit women aged 12 and over reported heavy drinking in the 2012 APS. This figure compares with 14.2% of Canadians aged 12 and over who reported heavy drinking in 2016 (Canadian Community Health Survey)
- Since November 2014, nineteen NG beneficiaries were assessed by the LGH's FASD clinic. Twelve of the nineteen referrals received some form of FASD diagnosis. The Department recorded seventy-two children/youth in Nunatsiavut who had a confirmed diagnosis along the FASD spectrum before 2013
- During 2016-2017, seventy individuals availed of the DHSD's mobile intensive intervention program "Trauma and Addictions". There were forty new participants. Eight participants had attended the program previously (NG internal Reports) [33]
- In the 2007-2008 Inuit Health Survey Nunatsiavut (IHSN), 20% of respondents reported using alcohol as a way to manage stress and one in seven participants reported having lost a close personal relationship because of their own drinking (IHSN 2007-2008)
- In the 2016 released Canadian Community Health Survey, it was reported that drug use was more than five times higher among those Canadians who were smokers or heavy drinkers (24.9%) than those who did not have either behaviour (4.5%). Furthermore, more than one-quarter (29.0%) of cigarettes smokers also reported using illicit drugs in the past year. For those aged 18 to 35, about half (46.8%) who smoked cigarettes also reported using drugs in the past year (Statistics Canada). Given that Labrador Inuit have reported high rates of smoking and heavy alcohol use, further study is required to determine if their risk level for other drug use is similar to other Canadians
- Service providers & the local police who participated in community consultations indicated Cannabis seems to be the second drug of choice (behind alcohol) for Inuit in North Coast communities. Inuit-specific data is very limited. In 2015, the prevalence of past-year cannabis use in Canada was 12%, an increase compared to 2013 (11%). In 2015, past-year cannabis use was

Between 2001 and 2012 (APS 2001, 2012), the percentage of Inuit who had not consumed alcohol in the past twelve months fell from 41% to 33% in Inuit Nunangat and from 37% to 28% in Nunatsiavut indicating an increase in the percentage of participants who engage in drinking.

[33] Data was not recorded for twenty-two participants (NG Internal reports, private collection, accessed 2018).

more prevalent among males (15%) than females (10%) and higher amongst youth than adults (Statistics Canada, prepared for Health Canada, Canadian Tobacco, Alcohol and Illicit Drugs Survey, 2015 Summary)

- DHSD's Youth Case Management Services program has identified an increasing use of drugs other than cannabis in clients accessing services in HV-GB area. These drugs include opioids, cocaine etc. In the IHSN (2007-2008), 51% of participants reported having experimented with substances in order to get high
- In the twelve months previous to the 2007-2008 IHSN survey, 25% of males and 13% of females reported having used recreational drugs
- Very little Inuit-specific data related to youth drug use prevalence and trends are available. The 2012 Student Drug Use Survey[34] (NL Highlights) found that alcohol remains the most commonly used substance (47.0%), followed by cannabis (30.0%) and tobacco use (16.4%). 30% of Newfoundland and Labrador students had used cannabis in the 12 months prior to the survey. Age of first use of cannabis was 14.2 years; up significantly from 13.5 in 2007. Other Drug Use (illicit and non-illicit) were: Drugs such as LSD (2.9%), psilocybin or mescaline (3.7%) and inhalants (2.3%) are at their lowest since 1996; while MDMA (ecstasy; 5.7%) has significantly increased since 2003. Use of caffeinated energy drinks was high with 61.6% of students reported using these drinks in the 12 months prior to the survey.

Other Mental Wellness Issues

- In Nunatsiavut, 75% of all suicide deaths (1993-2009) were by men/boys (48 male vs. 16 female). However, the suicide rate among Inuit women was 31 times higher than the rate among women in Newfoundland (Pollock, 2019)
- In the IHSN (2007-2008), 20% of respondents reported having attempted suicide at some point in their lives
- Women from Nunatsiavut communities (2005-2014) had the highest rate of hospitalization for suicide attempts/self injury (373 per 100,000) compared to women and men from all other regions in Labrador, and compared to Newfoundland (Pollock, 2019). Youth aged 15-24 accounted for 40% of patients hospitalized for suicide attempt/self injury in Labrador; in Newfoundland, youth accounted for 24% of hospital admissions (Pollock, 2019)
- The number of suicide-related Emergency Department visits from Nunatsiavut decreased by 17.7% from 2012/2013 to 2014/2015 (Pollock, 2019). The number of visits among 20-29 year olds in Nunatsiavut accounted for the largest change of any age group, going from ninety-five visits to fifty-six visits, which is a 40% decline in absolute number of visits. Overall, the incident rate of visits in Nunatsiavut was highest in this age group and accounted for the majority of all visits in Nunatsiavut (n=151, 58.8%). The majority of visits (63%) in Nunatsiavut were by women, as was the pattern in Labrador overall.
- According to Pollock, 2019, 67% of Emergency Room visits from Nunatsiavut were for suicidal thoughts, 18% were for suicide attempts, and 15% were for non-suicidal self-injury. The most common methods used in suicide attempts and self-injuries in Nunatsiavut were poisoning (41%), cutting/laceration (29%), or hanging (23%); the distribution in Labrador overall was similar (Pollock, 2019)

From 2013-2018, twenty-eight deaths by suicide were recorded in NG communities. Over that five-year period 29% of deaths recorded in Hopedale gave suicide as the cause of death and 24.6% of deaths recorded in Nain gave suicide as the cause of death. Thirty-one deaths from suicide were recorded in NG communities from 2007 – 2012.

[34] Students from grade seven to level III were surveyed. 126 classrooms were randomly selected from sevenvty-two randomly selected schools. It should be noted that **no** schools from coastal communities in Labrador were included due to the random selection process.

- In the APS 2012 Survey 5% [35] of participants reported they were diagnosed with a mood disorder[36]. Thirty-two percent of IHSN (2007-2008) respondents reported feeling depressed some or a little of the time
- In the Postville Mental Health Survey (2017) 56.2% of participants reported they had a friend or relative who would benefit from Mental Health Services. A high percentage of participants reported they wanted to learn more about stress, anxiety, depression, mental illness and grief in that order
- When asked what their vision for a healthy community was, participants in the Labrador Inuit Youth Symposium (March 2018) described a community that was caring, friendly, kind, helping and open-minded; a community where everyone was communicating and people had healthy relationships, a strong culture, and activities and events to participate in; a community with jobs, better education and a cleaner environment; a transparent government, youth involvement in major decisions and enhanced mental health services; a community without alcohol and drugs, violence, bullying, suicide and abuse

At a Labrador Inuit Youth Symposium in March 2018, 51% of the participants reported experiencing anxiety/stress and 51% said they needed mental health services while 33% of participants identified mental health issues as a key concern for their community. Other key community concerns identified were loss of language/culture (40%), bullying (33%), and rates of suicide/suicide attempts (30%).

- A review of monthly statistics for Community Shed Program and Youth Center programming demonstrates the importance of innovative outreach approaches. In a four-month period (2017-2018), a monthly average of forty- three individuals visited the shed. A high percentage of these individuals participated in individual and/or group projects (69% to 85%). The remaining individuals observed activities, shared knowledge, obtained information and made personal/social connections with staff and other participants. The Community Shed program is a safe and welcoming place for vulnerable at-risk individuals. Youth are also accessing the evening and overnight programming at the youth center in Nain. Almost all the overnight stays at the youth center are youth between the ages of sixteen years and twenty-four years
- As part of youth written feedback (2018) in preparation for development of a Nunatsiavut Youth Strategy, when asked how well things are going for you (on a scale of 1-5), around 31%[37] reported things were going terrible (I struggle with this all or most of time) in the area of mental health, 28.6 % in the area of school/education, 34.3% in the area of work and employment, & 25.7% answered the same way for fun/recreation activities
- The 2012 Student Drug Use Survey (NL Highlights) reported that based on a screening tool, significantly more students were determined to have “very elevated” depressive symptoms (8.4%) when compared to 2007 (4.8%). One out of six (17%) students reported seriously considering suicide in the 12 months before the survey, while 14.1% made plans to attempt suicide and 8.4% attempted suicide
- The most common presenting issues for youth accessing the DHSD’s Youth Case Management Services since the service began in 2015 have been: housing insecurity, suicide attempts, self-harm and alcohol use. Most youth present with more than one issue. In the “Pathways to Resilience Project (2011-2015)”, 19% of youth in two communities had a somewhat elevated risk for depression and 14% were identified as having borderline or abnormal behavior
- As of March 5 2018, approximately 53% of the Labrador Correction Centre offender population was Inuit and the majority of them were serving time for **personal offenses**. A significant

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[35] This percentage should be viewed cautiously. Inuit in Nunatsiavut have limited access to specialist services such as psychiatrists and psychologists and as a result there may be under diagnosis.

[36] Defined by Canadian Community Health Survey as including depression (major depressive episode) and bipolar disorder. Sometimes includes mania or dysthymia (Statistics Canada, 2014).

[37] Caution should be exercised in interpreting this data. It was based on a small sample size (26). The youth represented all five north coast communities as well as NWR and HV-GB.

percentage of personal offenses were related to alcohol use. Reported trauma experiences were common. On average, the percentage of the offender population who identify as Inuit ranges from 44% to 57% when at full capacity (Labrador Correction Centre, private communications)

- The 2013-2014 Nain Court Monitoring Project found there were one hundred and fifty- eight cases of violence against women observed during the period of observation. Out of these one hundred and fifty-eight cases, the most frequent types of crime were: Assault with eighty-six cases, Sexual Assault with fifty-five cases, Assault with a weapon- seventeen cases and Uttering threats to cause bodily harm- fourteen cases
- Among participants who responded to the IHSN, 29% reported having been sexually abused during childhood. 29% reported having been verbally abused sometimes during childhood. Another 14% of respondents reported having been verbally abused often during childhood (IHSN 2007-2008)
- In the IHSN (2007-2008), 18% of respondents reported being the victim of forced sexual activity as an adult
- The National Inuit Suicide Prevention Strategy (2016) recognized Inuit who have experienced adversity in childhood tend to be at greater risk for suicide than people who have had little or no adversity. Adversity includes: living with caregivers with untreated mental ill-ness, substance misuse, or experiencing childhood physical, sexual or emotional abuse. Adverse childhood experiences, including childhood maltreatment[38], dramatically increase the risk of suicidal behaviour
- In the APS 2012 Survey five percent [39] of participants reported they were diagnosed with a mood disorder[40]. Thirty-two percent of IHSN (2007-2008) respondents reported feeling depressed some or a little of the time

One hundred and fifty-five (155) Labrador Inuit children/youth were in care as of September 2018. Approximately 48% of the 155 children in care were placed outside of Labrador. Most families on the province's protective interventions caseload are placed there because of a risk of harm due to alcohol and family violence.

In summary, this section has attempted to ground this regional plan in the environment in which Labrador Inuit live and experience their health. It highlights how healthy they are, many of the factors influencing their health, and in what ways they are unhealthy. The next section identifies how the Department intends to proceed.

Unless you scan, you will always be in a reactive or crisis mode, forever busy putting out fires. Scanning shines a light on where you are and where you want to be: the path you want to take. (Author Unknown)

[38] Child maltreatment is a broad term referring to physical abuse, sexual abuse, emotional abuse, and neglect during childhood.

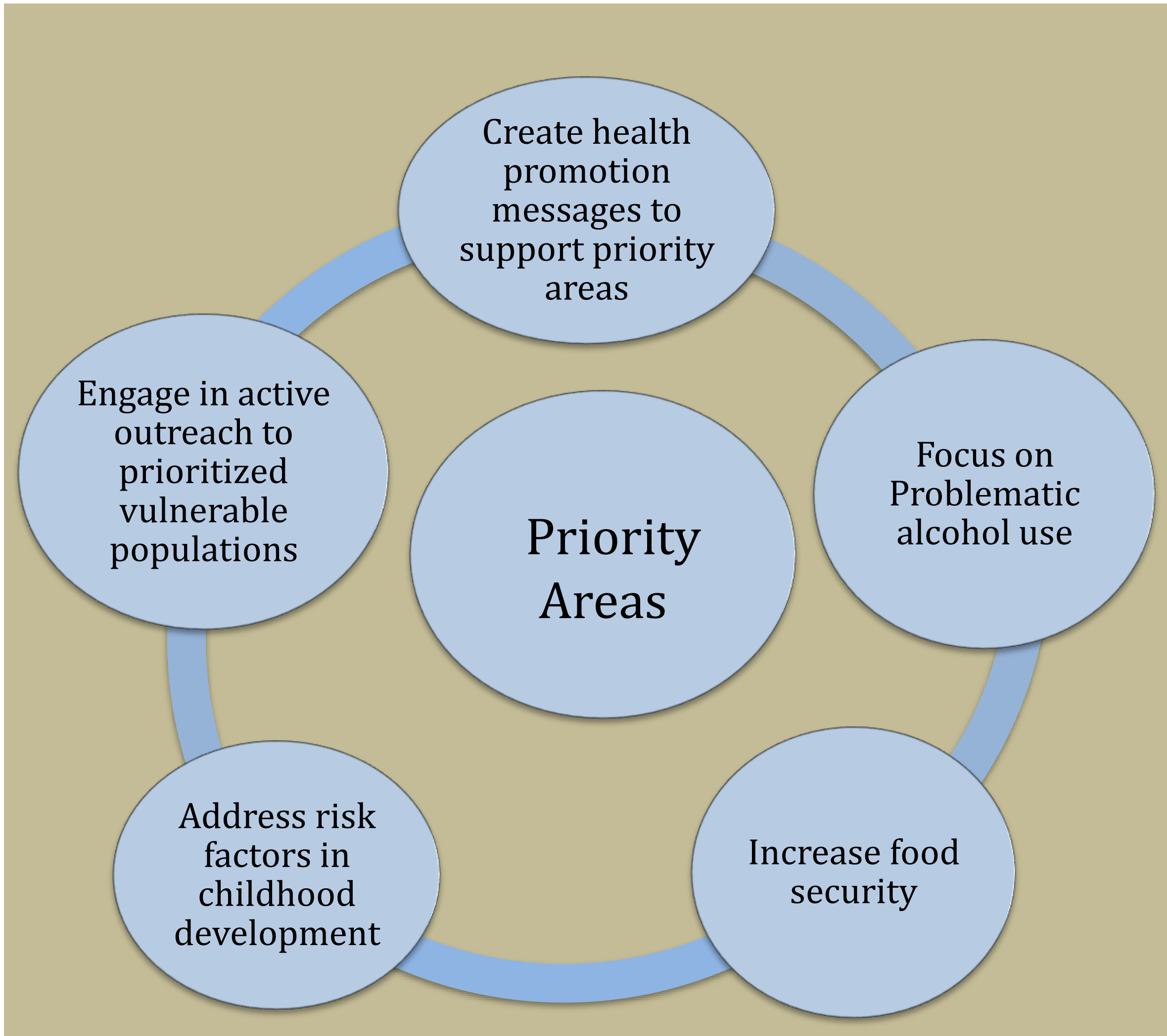
[39] This percentage should be viewed cautiously. Inuit in Nunatsiavut have limited access to specialist services such as psychiatrists and psychologists and as a result there may be a risk of under diagnosis.

[40] Defined by Canadian Community Health Survey as including depression (major depressive episode) and bipolar disorder. Sometimes includes mania or dysthymia (Statistics Canada, 2014).

Planning framework: A pathway for the next five years

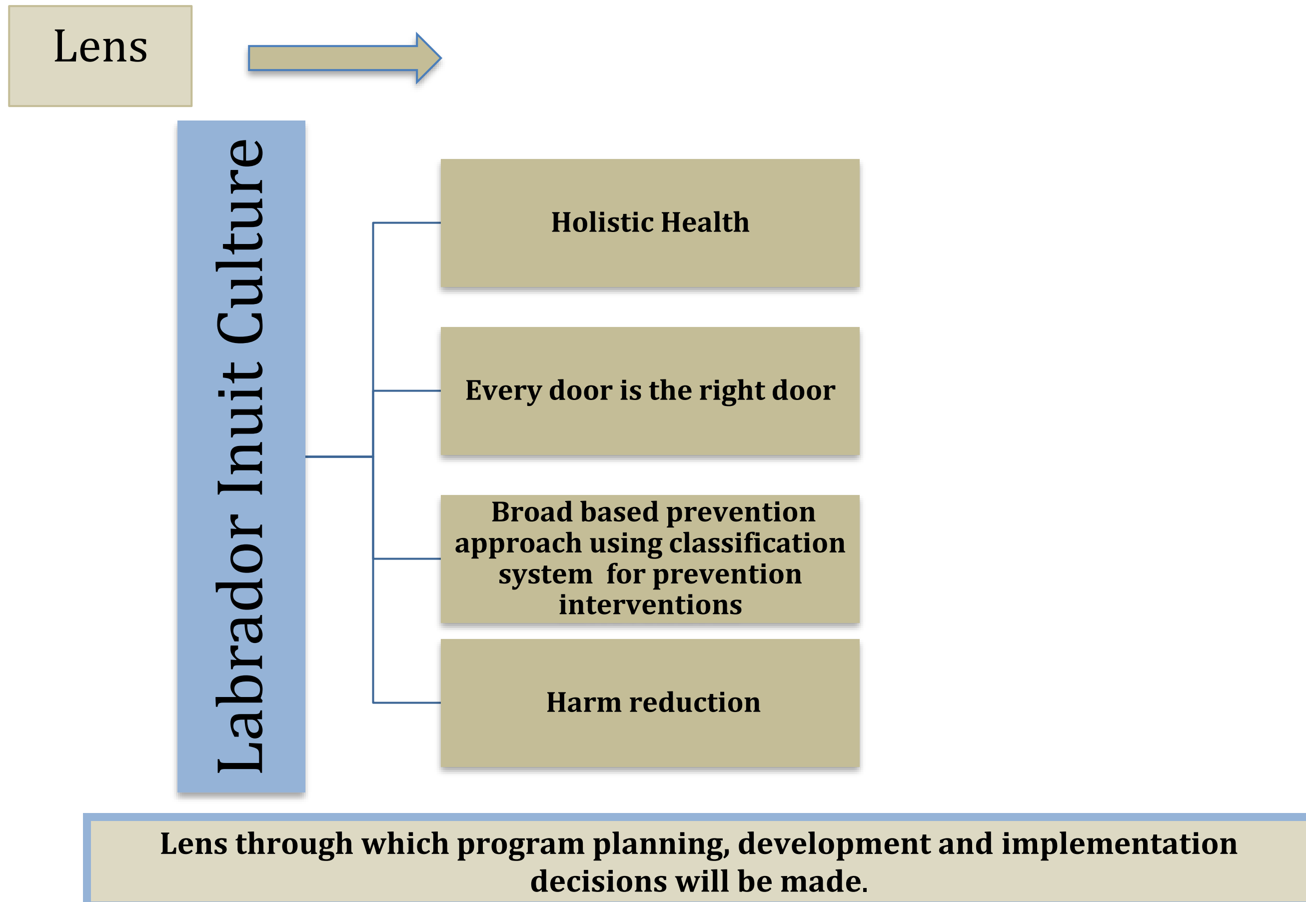
The vision of DHSD forms the foundation for this plan. The key elements in the plan are organized around the following five priority areas:

Vision: Healthy individuals, families & communities



The next two charts describe the lens through which program planning, development and implementation decisions will be made and the principles that will underlie the approaches and direct how clients will be treated.

Approaches Supporting Priority Areas



Labrador Inuit culture: Inuit culture is the foundation upon which all health services are based and the priority areas are addressed. It is weaved through all programming.

Holistic Health: Includes mental, physical, cultural and spiritual health. Land is central to well being. Considers individual, family and community health. Care is person-driven and family-centered.

Every door is the right door: Whichever door a person knocks on to receive service or help, they will be treated respectfully and supported to access the services they need. Goal is easy access and seamless care.

Institute of Medicine (I.O.M) classification system for prevention interventions: A broad based prevention approach that includes a balance between approaches aimed at those who are engaged in risky behaviors (Indicated), those who are at higher than average risk (Selective), and those who appear risk free or level of risk is unknown (Universal) but for whom specific interventions have been demonstrated to reduce risk.

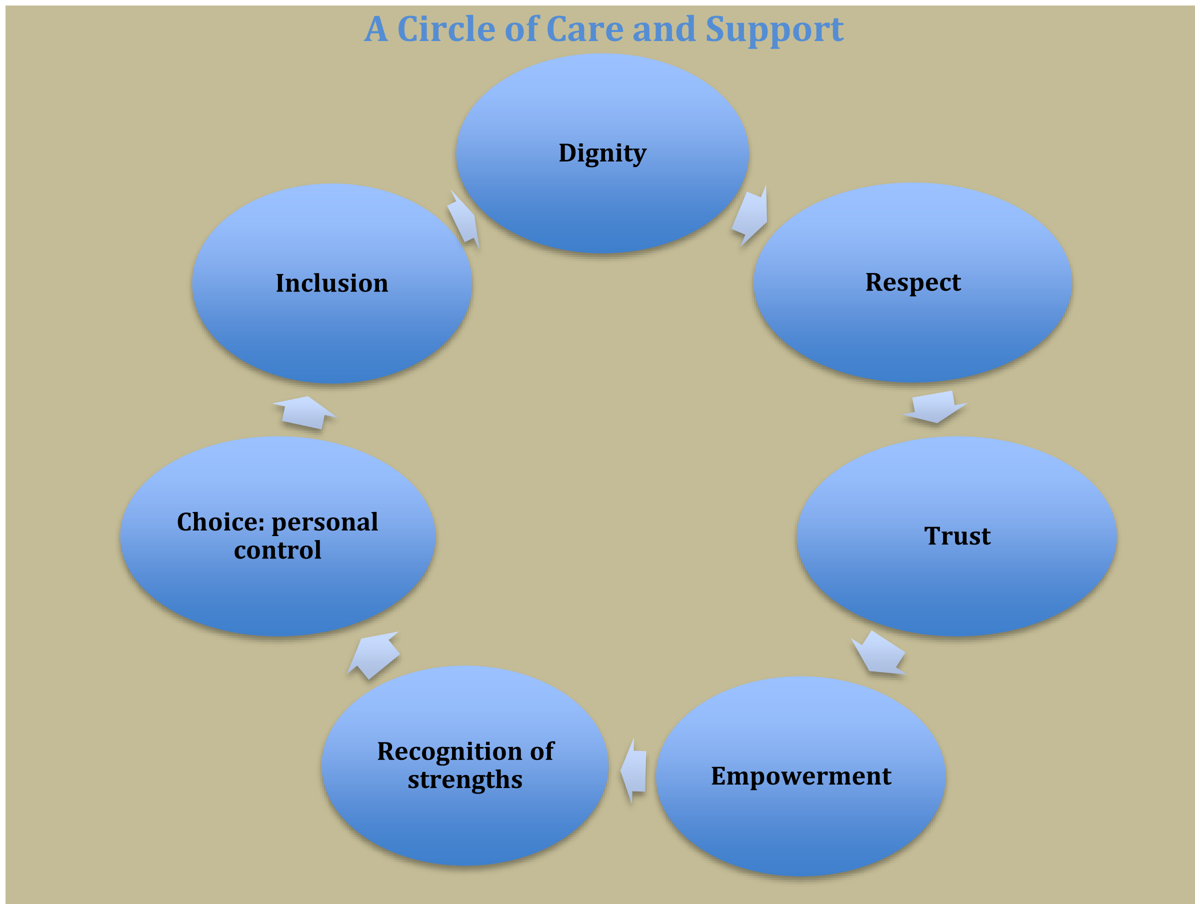
Harm reduction: It refers to programs, policies or interventions that try to reduce or minimize the harmful health and social consequences associated with substance use or other unhealthy behaviours or choices. It is a non- judgmental approach that meets users where they "are at". It does not necessarily require users to abstain. Harm reduction activities can be present at any level of prevention or intervention. It focuses on the prevention of harm, rather than the prevention of substance use or the prevention of other harmful behaviours and lifestyle practices. It offers individuals a choice of how they will minimize harm to themselves.

AIM: The Department does not only help people who ***reach*** services, but ***reaches out*** to the whole population and all who need help.

Common Principles Underlying Approaches

Supports program planning, development and implementation decisions and directs how individuals who access services are to be treated

- Respect for the rights and dignity of everyone (includes respect for individual decision-making and responsibility)
- Acknowledgment of people's strengths, their needs and their right to self-determination
- All individuals are seen as active partners in their care (client-centered and client directed goals)
- Support for people to receive the right service, at the right time and where they are
- Interventions match/fit the needs of the targeted population
- Provision of safe, caring and non-judgmental environments for those accessing services
- Service providers have a responsibility to collaborate in providing seamless[41] and coordinated care.



A welcoming environment for all: Free from stigma and racism

[41] Regardless of whom has the administrative or management responsibility for delivery of Health Services.

What We Will Take Action On

Priority actions are identified for each priority area. The priority areas and the related actions will provide focus for the strategies and operations of the DHSD as we move forward

Priority Areas	What we will take action on		
1. Create health promotion messages[42] to support priority areas	Implement a regional coordinated approach to address identified core health promotion messaging	Increase use of social media to support health promotion dissemination and communication	Develop Inuit- specific health promotion messages for targeted areas
2. Increase food security	Strengthen skills in preparation and use of traditional and other healthy food options	Develop and implement a Food Security Strategy	Advocate for coordinated approach/solutions in addressing food insecurity
3. Address risk factors in childhood development	Enhance access to childhood and family wellness programming that improve protective factors[43]	Provide active outreach[44] and supportive activities to vulnerable[45] children and their families or caregivers	Move towards Inuit self-determination of provincial and regional child, youth and family programming and regulatory processes[46]
4. Focus on problematic alcohol use[47]	Explore individual and community alcohol and substance use patterns and prevalence rates	Educate about and engage in harm reduction approaches	Explore and implement innovative interventions for problematic alcohol users and their families
5. Engage in active outreach to other prioritized vulnerable populations[48]	Increase access to supportive and safe spaces and appropriate programming	Support implementation of active outreach programming through incorporation of Inuit-specific approaches and resources	Focus on coordinated processes across the continuum of need[49]

[42] Topics include food security, nutrition, healthy relationships, unhealthy & risky behaviours, harm reduction, TB prevention & treatment, decision-making, chronic diseases (self-management), mental illness etc.

[43] Promotes healthy child development: Focus on effective communications, healthy relationships, empathy, nutrition, food security, safety and Inuit knowledge/practices of child-raising, nurturing & learning.

[44] Providing service to a target group who would not normally have access to services or would not be actively involved in programming; takes service to where client is most comfortable (home, street, public places etc.). Service providers take a more active role in adjusting to meet the needs of the individual rather than vice versa.

[45] High risk pregnant women, children witnessing family violence, children who experienced trauma, children & families impacted by problematic alcohol use, children whose parents are in conflict with the law, children in care as well as children, families/caregivers impacted by low income, housing insecurity, and food insecurity.

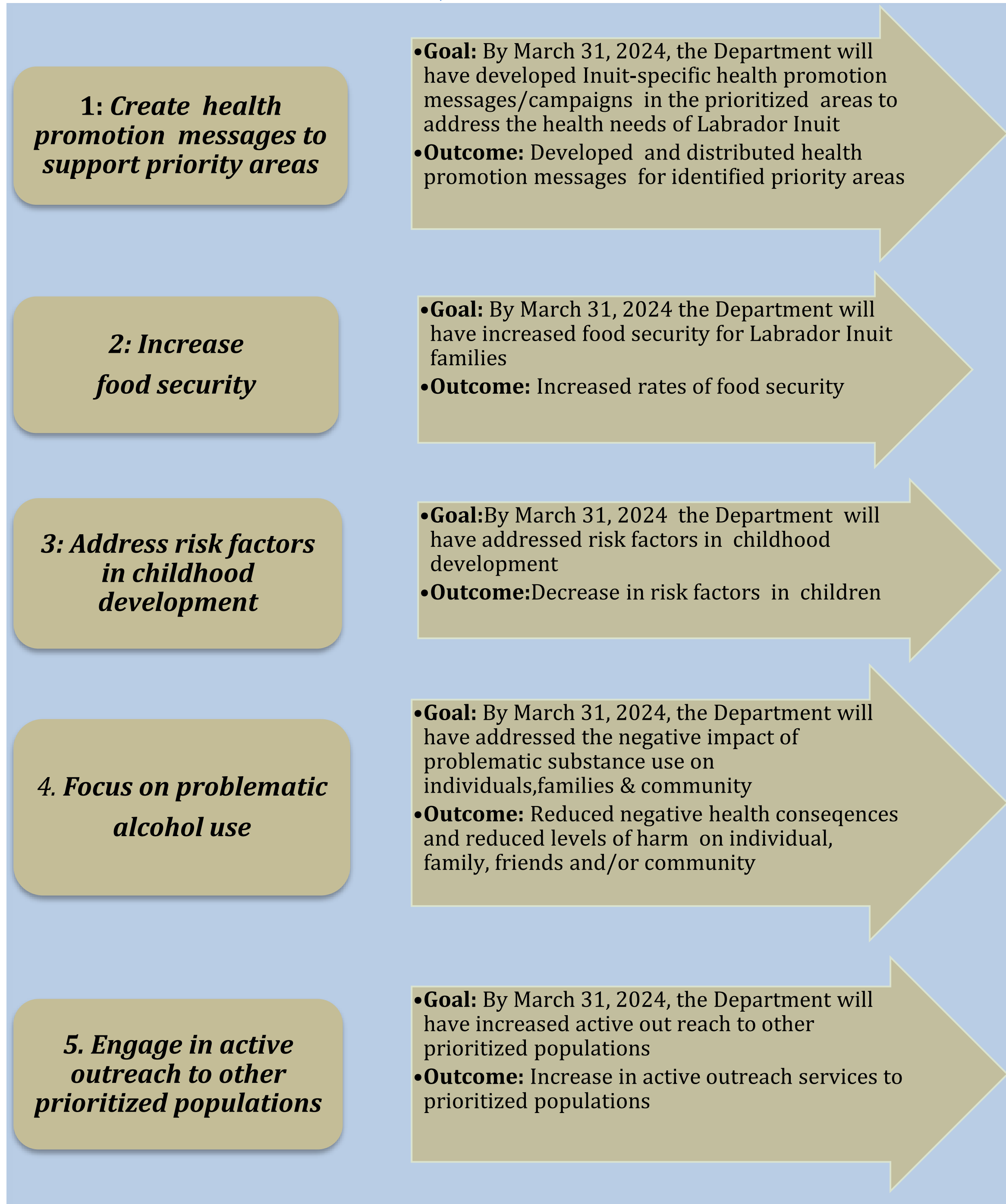
[46] Examples include devolution of child welfare, increased autonomy for daycare licensing and daycare programming etc.

[47] Harmful effect on any of following factors: physical health, friendships and social life, financial position, home life or marriage, work, studies, or employment opportunities, legal problems, difficulty learning or housing problems.

[48] Individuals requiring supportive housing, seniors who are shut-ins (isolated) and unilingual speakers, individuals with limited social supports/networks, families impacted by low income/ unemployment, those with multiple risk factors, offenders and their families, victims of violence, individuals engaged in risky & unhealthy behaviours, as well as supporting those populations listed.

[49] Assist clients in linking to supports & services, navigating systems, accessing benefits, problem solving, daily living supports /skills, as well as participating in case management, coordinating services & working together with other service providers.

Priority Areas, Goals and Objectives



[50]

[50] Individuals requiring supportive housing, seniors who are shut-ins (isolated) and unilingual speakers, individuals with limited social supports/networks, families impacted by low income/ unemployment, those with multiple risk and their families, individuals engaged in risky and unhealthy behaviours, as well as supporting those populations related to priority areas of childhood development and problematic alcohol use.

How we will get there: Action Plan

Priority Area 1: Create Health Promotion Messages to Support Priority Areas

Goal: By March 31, 2024, the Department will have developed Inuit-specific health promotion messages/campaigns in the prioritized areas to address the health needs of Labrador Inuit.

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of Progress)	Potential Partners
Implement a regional coordinated approach to address core health promotion messaging	Establish a Regional Health Promotion Committee (RHPC) consisting of Deputy Minister, Directors and regional coordinators to identify, prioritize and create **core** health promotion messages	- Regional Health Promotion Committee is in place -A regional position has been assigned to provide support in development of core messaging & to link with community offices/DHSD programs -Internal content experts for identified **core** topic messaging are identified -**Core** health promotion messages that are the lead responsibility of the regional office have been identified, prioritized and created - Documents are in place *Sources: Directors' Meeting Minutes, Regional Committee meetings, other internal documents such as monthly & annual reports, copies of messages available, email correspondence, social media marketing*	

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of Progress)	Potential Partners
	Establish sub-committees (as required) who have content expertise to support the Regional Committee	- Sub-Committees in place - Copies of health promotion messages are available *Sources: Internal documents: minutes, etc.*	
	Strengthen internal communication capacity and coordination, knowledge sharing and dissemination processes related to health promotion	-An internal process/system for sharing community-developed health promotion messages and initiatives across programs within DHSD and between communities is in place - Multiple channels of communication and vehicles to deliver and share messages are clearly identified - Inventory of health promotion resources is available - Positive changes in coordination of health promotion programming across programs and communities *Sources: Internal documents; monthly statistics, minutes of Directors' Meetings, annual reports*	

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of Progress)	Potential Partners
Increase use of social media to support health promotion dissemination and communication	Develop and implement a social media[51] strategy	- Social Media Strategy is in place - Content calendars are available[52] -Increased presence on social media platforms - Evidence of reaching intended audiences *Sources: Internal documents; program documentation, monthly & annual reports, usage data, Directors' meeting minutes, Regional Health Promotion Committee meeting minutes*	
Create health promotion messages to support the priority areas	Prioritize topics for message development through review of community consultation findings, February meeting notes and health priority areas' data	- Regional Health Committee has prioritized topics requiring special attention - Timelines for completion established - Work assigned *Sources: Internal documents; Directors' Meeting Minutes, Regional Health Promotion Meeting Minutes, copies of list and timelines*	LGH
	Develop a plan of action for creation of targeted messaging	- RHPC has Action Plan in place - Sub Committees with internal and external content experts in place for prioritized message development	LGH

[51] Social media refers to interactive digital platforms that allow users to share ideas and information with a network of contacts. Could include use of Facebook, Twitter, Hash tags etc.
[52] Identify specific target audiences, the content and information you want to disseminate, how often the contents will be posted, what should be posted and who will create the content and post etc.

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of Progress)	Potential Partners
		- Copies of messages are available and timelines met. - Increase in amount and types of health promotion messages and resources available for use *Sources: Internal documents; Directors' Meeting minutes, Regional Health Promotion Committee Minutes, monthly and annual reports, copies of messages, copies of social media marketing, email correspondence*	

Priority Area 2: Increase Food Security

Goal: By March 31, 2024 the Department will have increased food security for Labrador Inuit families.

What will we do? (Priorities/action)	How will we do it /get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
Strengthen skills in preparation and use of traditional and other healthy food options	Improve availability of traditional foods by strengthening skills in preparing traditional foods (preserving etc.)	- Reported change in skill levels for food preparation and preservation - Increase in consumption of seasonal foods year around - # Of programs and participants in programs, classes, workshops etc. *Sources: Internal documents: Monthly program reports, annual reports, internal surveys, photos, copies of resource materials available*	LGH
	Enhance staff knowledge and skills in the areas of nutrition, healthy food choices and healthy cooking	- # Training workshops, presentations that have taken place. *Sources: Internal documents: Monthly program reports, annual reports, internal surveys,*	LGH Other partners as identified
	Teach Inuit children, youth and their families about the health benefits of traditional dietary practices	- Copies of presentations available - # Presentations, information sessions - # Participants	Schools Other NG Departments LGH

What will we do? (Priorities/action)	How will we do it /get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
		Sources: Internal documents: Monthly program reports, annual reports, internal surveys	
	Partner with communities and relevant NG Departments and other agencies to teach and sustain hunting, fishing and gathering skills	- Increased access to traditional foods - # Of people who hunt, gather & fish - # Community projects & initiatives - # Partnership activities - Increase in #harvesters *Sources: Internal documents, APS Results, other surveys, email correspondence*	Department of Economic Development and other NG Departments Inuit Community Governments NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River
	Improve the consumption of nutritious meals by providing cooking classes	- # Classes offered - # Participants - Increased knowledge about nutrition - Copies of workshop, presentation and class resources are available *Sources: Internal documents: monthly program statistics, annual reports*	LGH College of North Atlantic ICG's

What will we do? (Priorities/action)	How will we do it /get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
	Explore viable models[53] for sustainable local food production through support of research efforts and project initiatives	-Evidence of engagement with key stakeholders - Models are identified - Findings are disseminated - # Community initiatives *Sources: Directors' Meeting Minutes, other minutes, email correspondence*	NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River Inuit Community Governments Department of Economic Development LGH
Develop and implement a Food Security Strategy	Use Food Security coordinator position to provide leadership	- Position in place - Copy of strategy is in place by late 2019	
	Use results of *Food Security Report Nunatsiavut, Community Consultation Findings* and other relevant reports to direct creation of Regional Food Security Strategy	- Copy of Strategy is in place - Evidence of incorporation of reports in Strategy	
	Increase capacity and resources to ensure the implementation of the strategy	- Increased resources and capacity - Nutritionist in place	Government of NL

[53] Examples could include vegetable gardening, community gardens, greenhouses etc.

What will we do? (Priorities/action)	How will we do it /get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
		Sources: Internal documents: Directors' Meeting Minutes, Annual Reports	Government of Canada Other funders as required
	Establish a multi-partner coalition/task force to address barriers to food access, food availability and food use and support implementation of plan	-Regional Committee/Coalition in place -Community Committees in place - Designated staff serves on community committees to link community and regional level activities *Source: Internal documents: Meeting Minutes, Annual reports, monthly reports, Community Health Plan*	Nutrition North Food First NL Kids Eat Smart Foundation Newfoundland & Labrador NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River Inuit Community Governments (ICGs) Labrador-Grenfell Health Govt. of NL Applicable Federal Government Departments and Agencies
Advocate for coordinated approaches and	Explore innovative community initiatives for healthy food	- # Of community initiatives	NunaKatiget Inuit Community Corporation,

What will we do? (Priorities/action)	How will we do it /get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
solutions in addressing food insecurity	assistance and availability	- Reduction in food insecurity rates *Source: Food Security Surveys, other surveys, partnership meeting minutes, internal documents such as annual reports, monthly reports, program statistics & email correspondence*	Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River Inuit Community Governments (ICGs)
	Support efforts to increase access to nutrition programming and workshops	- Increased # programs, workshops and presentations *Source: Food Security Surveys, other surveys, partnership meeting minutes, internal documents such as annual reports, monthly reports, program statistics & email correspondence*	LGH Government of Newfoundland Labrador
	Partner with ICG's to increase availability and diversity of foods for community freezers	- Increase in food availability	Community Freezer Program (Inuit Community Council/governments) NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River

What will we do? (Priorities/action)	How will we do it /get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
			Inuit Community Governments (ICGs) Department of Economic Development
	Lobby appropriate authorities to address need for affordable food costs through use of collaborative approaches	- Decrease in cost of store bought food -Decrease in food insecurity	Nutrition North Government of Newfoundland Labrador Government of Canada (appropriate Departments and Agencies) Airlines and coastal boat services Retailers and distributors
	Support efforts and initiatives to address impacts of poverty, inadequate housing, other social determinants of health and problematic alcohol use on food insecurity	- # Initiatives - Evidence of advocacy by NG Departments and Assembly	Applicable Federal and Provincial Government Departments & Agencies Other NG Departments NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake

What will we do? (Priorities/action)	How will we do it /get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
			Sivunivut Inuit Community Corporation, North West River Inuit Community Governments

Priority Area 3: Address Risk Factors in Childhood Development

Goal: By March 31, 2024, the Department will have addressed risk factors in childhood development

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
Increase childhood and family wellness programming that enhances protective factors[54]	Strengthen effective family communication through provision of information/programming that addresses healthy relationships, effective communication, emotion regulation, conflict resolution and problem-solving	- Copies of resources available - # Sessions - # Participants *Sources: Internal documents: monthly program data, annual reports*	CSSD Family Connections Other potential partners
	Increase availability of diverse parenting programs, workshops, and awareness sessions that focus on skill development and enrichment	- Copies of parenting programs are available - # Programs completed *Sources: Internal documents: monthly program data, annual reports*	LGH CSSD
	Address gap in programming for children age 0-4 years and their families through review and realignment of current programming and seeking further partnerships and funding for supporting childhood development	Increase in programming options for children aged 0-4 years *Sources: Internal documents: monthly program data, annual reports*	Other NG Departments LGH Government of NL Government of Canada
	Provide supportive environments and increase opportunities for young families to gather and make social connections	- # Events - #Socials *Sources: Internal documents: monthly*	Other NG Departments

[54] Promotes healthy child development: Focus on effective communications, healthy relationships, empathy, nutrition, food security, safety and Inuit knowledge/practices of child-raising, nurturing and learning.

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
		program data, annual reports	
	Explore feasibility of more flexible criteria (such as age, time of day etc.) for accessing programming	- Evidence of criteria review - Documentation of changes *Sources: Internal documents, Minutes from Directors' meeting, monthly & annual reports, program statistics*	
	Advocate for increased access to children's supportive and specialist services and increased use of culturally appropriate screening and assessment tools for growth and development	- Increased access to ENT specialists, psychologists and family therapists - Enhanced access to vision & dental care - Enhanced access to Child Management Services and Behavior Management Services -# Culturally appropriate screening & assessment tools *Sources: Internal documents: Directors meeting minutes, annual reports, agreements etc.*	LGH CSSD Govt. of NL Family Connections Program
	Educate families about the benefits of healthy sleep habits	- # Presentations & awareness sessions - Copies of health promotion messages *Internal program statistics, monthly and annual reports*	Schools

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
Provision of active outreach and supportive activities to vulnerable[55] children and their families/caregivers	Strengthen provision of support to parents whose children are in care or at risk of being placed in care through expansion of innovative programming such as Family Connections, Befriending Programs etc.	- Increase in programming options - Increased Participation - Copies of programs /resources available *Sources: Internal program statistics, monthly and annual reports*	LGH CSSD
	Explore viable options/solutions that address programming access barriers such as transportation, childcare, flexible hours and stigma and regulatory barriers to Inuit-specific programming	- Plan in place to address barriers - Decrease in barriers to accessing services *Sources: Internal program statistics, monthly and annual reports,*	LGH Other NG Departments Government of Canada
	Work with schools and other partners to identify and support children at risk of quitting school or those who are not attending school	- List of children available - # Of children receiving support/accessing services - Reduction in rates of children not attending school or who have quit *Sources: Provincial School Board, Internal documents: program statistics, monthly and annual reports, NG reports, other NG Depts.*	Schools NG Department of Education Provincial School Board

[55] High risk pregnant women, children witnessing family violence, children who experienced trauma, children & families impacted by problematic alcohol use, children whose parents are in conflict with the law, children in care as well as children, families/caregivers impacted by low income and food insecurity.

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
	Link with CSSD to identify and support foster children aging out of foster care	- Supports in place - Evidence of active outreach to targeted group *Sources: Internal program statistics, monthly and annual reports etc.*	CSSD Dept. Education, NG Govt. NL
	Increase programming for children and families of offenders involved in the Justice system	- # Programs in place for targeted group - Plan articulated for active outreach opportunities *Sources: Internal documents: Director's Meeting Minutes, Annual reports*	Department of Justice Other potential partners
	Work with partners to provide appropriate and family-friendly spaces for supervised CSSD visits	- Increase in # spaces *Sources: Internal documents, email correspondence, meeting minutes*	CSSD
Move towards Inuit self-determination of provincial and regional child, youth and family programming and regulatory processes[56]	Continue negotiations with key stakeholders for devolution of prioritized services Address regulatory barriers to Inuit specific programming for early childhood development, structured after school programming and daycare programming	- Plan in place for devolution of services - Agreements signed -# Regulatory barriers reduced	Government of Newfoundland Other potential partners

56 Examples include devolution of child welfare, day care licensing etc.

The whole world gains if children grow up healthy, capable and ready to work for the good of their neighbors. ***(Eglantyne Jebb*)**

Priority Area 4: Focus on Problematic Alcohol Use

Goal: By March 31, 2024, the Department will have addressed the negative impact of problematic substance use on individuals, families and community

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
Explore individual and community alcohol and substance use patterns and prevalence rates[57]	Select relevant research questions for inclusion into planned 2021 Inuit Health Survey	- Alcohol and Substance Use questions included in survey *Source: Inuit Health Survey Labrador*	ITK and Nunangat Government of Canada (relevant Departments and Agencies)
	Partner with LGH to conduct research that will enhance understanding of issues affecting alcohol and cannabis use	- Research available - Partnership in place *Source: Meeting Minutes, Directors" Meeting Minutes*	LGH
	Identify issues faced by seniors who engage in problematic drinking through use of surveys, informal interviews etc.	- Information is collected and documented *Source: Internal documents*	Relevant partners
	Improve knowledge of factors that influence the attitudes and drinking behaviours of Inuit problematic alcohol users[58] through surveys, interviews, focus groups and internal reports etc.	- # Surveys and interviews completed - # Focus groups completed - Results are available - Benchmarks established on community-specific levels of knowledge,	Other NG Departments Inuit Community Governments NunaKatiget Inuit Community Corporation, Happy Valley-

[57] Identify levels of use across the lifespan, patterns of use, levels of harm, reasons for use and impact of problematic use etc.

[58] Reasons people give for drinking, what problematic users see as the benefits of drinking, what they identify as harm it causes, identification of their beliefs about alcohol & level of interest in changing drinking behaviours.

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
		attitudes and behaviours towards alcohol *Source: Internal documents: Meeting Minutes, Directors" Meeting Minutes, monthly & annual reports*	Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River
Educate about and engage in harm reduction approaches	Reach a consensus on definition of harm reduction and message content to be communicated about harm reduction	- Decision made and documented - Copies of messages available and disseminated *Sources: Directors' meetings minutes, Monthly & annual reports, email correspondence*	Other NG Departments
	Conduct a harm reduction campaign[59] that offers information about harm reduction and available harm reduction strategies	- Campaign in place - Mobilization of communities around harm reduction	Other NG Departments Inuit Community Governments NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River

[59] Use *Problematic Substance Use, Smoking & Gambling Prevention Action Plan* to guide development of campaign.

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
			NG liaison positions
	Promote ways individuals, families and communities can make changes to reduce harm caused by problematic alcohol use	- Health promotion messages available for use - # Presentations, teaching tools -# Educations sessions - Evidence of distribution of information - Supportive programs are in place *Sources: Directors' meetings minutes, Monthly & annual reports, email correspondence, team leader meeting minutes, program statistics*	Other NG Departments
	Collaborate with LGH to increase awareness of available medications for use in withdrawal management and relapse	- Copies of pamphlets are in place - Policies & procedures to guide use of medications available *Sources: LGH, internal documents*	LGH
	Ensure policies and practices that support harm reduction approaches are in place	-Policies in place within DHSD & NG *Source: Internal documents*	Other NG Departments

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
Explore and implement innovative interventions/support[60] for problematic alcohol users and their families	Select and implement interventions/supports that focus on those who are engaged in problematic binge drinking and problematic daily drinking patterns by researching evidenced-informed options	- Copies of research findings available - Selections made - Increase in # interventions in place *Source: Internal documents: Directors' Meetings minutes, other minutes, email correspondence*	
	Increase active outreach and education services to encourage safer alcohol use and healthier choices	- Active outreach increased - Evidence of reduced problematic patterns of use - Supporting health promotion resources & teaching tools available	
	Explore feasibility of reducing harm by examining the effectiveness of safer places such as Wet Centres[61], Sobering Up Shelters or Managed Alcohol Programs and provision of overnight child care	- Recommendations in place and decisions documented *Source: Internal documents, Directors' Meetings minutes, other minutes, email correspondence*	Appropriate Provincial and Federal Government Departments
	Ensure employees have access to resource materials that support interventions	- A variety of resource material, teaching tools and programs in place	

[60] Use *Problematic Substance Use, Smoking & Gambling Prevention Action Plan and other internal documents to guide selection & implementation of targeted outreach activities*

[61] Wet Centres are residential housing facilities for homeless people suffering from chronic alcoholism. Residents are permitted to continue drinking while they are tenants.

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
		Sources: Internal documents	
	Enhance specialized clinical interventions and supports for those with complex needs through re-establishment of the Trauma and Addictions Team	- Trauma and Addictions Team in place. - # Individuals /families accessing the service	Appropriate Provincial and Federal Government Departments

Priority Area 5: Engage in Active Outreach to Other Prioritized Vulnerable Populations

Goal: By March 31, 2024, the Department will have increased active outreach to other prioritized vulnerable populations

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
Increase access to supportive and safe spaces and appropriate programming	Work with stakeholders to provide spaces and opportunities for unilingual beneficiaries to socialize	- Socials and programs in place for unilingual beneficiaries	Other NG Departments Inuit Community Governments NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit Community Corporation, North West River
	Explore with other NG Departments how to make more spaces available as evening and weekend places to gather and socialize	- Agreements or arrangements in place - Increased # spaces available in communities for socializing and programming	Other NG Departments NunaKatiget Inuit Community Corporation, Happy Valley-Goose Bay/Mud Lake Sivunivut Inuit

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
			Community Corporation, North West River Other community organizations
	Advocate for increased housing options for people living with family violence and for other vulnerable populations	- Increased housing options	NG Government of Canada Government of Newfoundland Labrador Other Organizations as required
	Explore the feasibility of mentoring programs, pairing programs, lifestyle coaching, befriending programs etc. to enhance social supports	- # Programs in place *Sources: Internal documents: Monthly program statistics, annual reports etc.,*	
Support the implementation of active outreach programming through incorporation of Inuit – specific approaches and resources	Create a training workshop and provide resources that addresses stigma and racism	-Copies of workshop material& resources available - # Training workshops delivered to NG employees -# Training workshops delivered in communities *Sources: Internal documents: Monthly program statistics, annual reports etc.*	Other NG Departments
	Conduct a review across programs to identify	- Completion of review	

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
	types of support groups needed to enhance interventions and support active outreach activities	-Identification of types of support groups - Copies of documents available	
	Address barriers to accessing services and barriers to participating in programs for prioritized vulnerable populations	- Plan in place - Decreased barriers	LGH Government of NL Government of Canada
	Identify effective strategies for reaching out to prioritized vulnerable populations who do not normally avail of services or programs	- Strategies identified and in place - Copies of documents available *Sources: Internal documents: Monthly program statistics, annual reports etc.*	
	Enhance opportunities for teaching daily living skills in a variety of environments	- # Information sessions - # And type of locations - # Participants *Sources: Internal documents: Monthly program statistics*	Other service providers as required
	Increase opportunities for youth to learn more about their Inuit Culture through partnerships with other NG Departments and schools	- Partnerships in place	Other NG Departments Schools
	Incorporate outreach strategies, activities and approaches for prioritized vulnerable	- Plan in place to engage disadvantaged populations -Human and fiscal resources assigned	LGH Other NG Departments

What will we do? (Priorities/actions)	How will we do it/get there? (Objectives)	How will we know we are successful? (Signs of progress)	Potential Partners
	populations into program delivery	-# Activities, programming in place -Increased options available to targeted populations *Sources: Internal documents: Monthly program statistics, Community Health Plan, Minutes, Directors' meetings*	
Focus on coordinated processes across the continuum of need [62]	Provide support to those who require assistance in navigating programs internal and external to DHSD	- Evidence "Any door is the right door" approach is in use - Resource Lists in place *Sources: Internal documents*	
	Work with partners to support a case management approach for those who have complex needs and are involved with multiple services	- Processes & policies in place - # Participants availing of case management approaches *Sources: Internal documents: Case management meeting minutes, monthly program statistics, annual reports etc.*	LGH CSSD Other NG Departments Other service providers as required

[62] Assist clients in linking to supports and services, navigating systems, accessing benefits, problem solving, daily living supports /skills, as well as participating in case management, coordinating services & working together with other service providers

Outcomes

The DHSD intends to work towards and hopes to achieve the following changes as it implements this action plan over the next five years:

- Developed and distributed health promotion messages for identified priority areas
- Increased rates of food security
- Decrease in risk factors in children
- Reduced negative health consequences and reduced levels of harm from problematic alcohol use on individuals families, friends and/or communities
- Increase in outreach services to prioritized populations.

Communication Plan

The goal of this communication plan is to build a broad awareness of the RHP and to increase buy-in and support for the implementation of this plan. This is our health plan and we must work together to ensure its success. The five-year plan will be supported by an annual operational plan and annual community health plans. This communication plan is part of the DHSD's efforts to demonstrate its commitment to accountability and open communication.

This Communication Plan is a vehicle that will be used to:

- Inform the NG leadership and all DHSD employees about the five-year health plan
- Share the plan with internal and external stakeholders and partners
- Ensure the plan is accessible to all community organizations and Labrador Inuit beneficiaries
- Report on the progress of the plan and share major milestones.

The following key messages will be used in the implementation of this plan:

- The DHSD is committed to focusing on the priority issues identified in the RHP
- An evidenced- informed process has been used to determine the priorities
- The CHP's support the priorities of the RHP and address the specific priorities of the community
- Community needs and priorities determine which program components and activities are provided in each community
- We have outstanding leaders, staff, volunteers and elders whose knowledge and skills, enthusiasm and passion will provide the foundation for this plan's accomplishments
- The Department acknowledges there will be internal and external challenges; our intent is to build upon our strengths and forge new paths towards wellness
- The DHSD must be accountable for the resources it uses, the programs it delivers and for working towards the mission of DHSD. This plan is one of the ways everyone can contribute to accountability
- The DHSD exists so that it can work with Labrador Inuit to improve their health and wellbeing

The table on the next page outlines the communication schedule:

Table: Communication Plan Schedule

Audience	Action	Tools	Lead responsibility	Timeframe
DHSD ***NG Assembly*** ***NG Departments*** ***Inuit Community Governments***	Release plan	- Press release. - Copies sent by email to identified audiences. - Hard copies placed in each community health office and at regional office. - Plan will be posted on NG website - Plan will be posted on community Facebook pages - Plan tabled at NG Assembly	Minister/ Deputy Minister Minister	May 2019 June, 2019
	Plan progress/updates and major milestones' announcements	- RHP directs Community Health Plans. - Meetings with staff, other interested parties - Plan reviewed and progress report emailed to identified audiences - Update placed on NG website and community Facebook pages - Email used for announcements of major milestones.	Team leaders and regional program coordinators Deputy minister regional office, team leaders Deputy minister Deputy Minister Senior Executive	Quarterly reporting. Annually Annually
Labrador Inuit	Release Plan	- Press release/ radio spots - NG website/community Facebook pages - NG newsletter - DHSD staff will have a plan to share with their community.	Deputy Minister, Regional Positions, Team Leaders	Months of May & June 2019

	Plan progress/updates and major milestones' announcements	- Updates on NG website. - RHP themes and priorities described in NG newsletters. - Email and/or press releases used for announcements of major milestones. - Community communications processes implemented	Deputy Minister and regional office Minister, Deputy Minister Team leaders & DHSD staff	Annually Four times a year As needed. As needed
Key external stakeholders/partners such as :Inuit Tapiriit Kanatami, Health Canada, the Government of Newfoundland and Labrador: Department of Health and Community Services and NL Statistical Agency, the Labrador-Grenfell Health Authority etc.	Release Plan	- Copies provided by email and hard copies sent to designated representatives.	Deputy Minister	Deadline July 30, 2019
	Plan updates	- Summary updates available upon request. - Email used for announcements of major milestones	Deputy Minister Deputy Minister	Annual

Monitoring and Evaluation Processes

The DHSD believes that a crucial element in the implementation of the RHP is the identification of monitoring and evaluation processes. Such processes enable the Department to account for what has been accomplished or what progress is being made. They facilitate the adjustment or revision of the plan as it unfolds. They also map out how the Department will use the results of the plan's implementation for program improvement and decision-making.

The monitoring and evaluation processes will include:

- The development of annual regional operational plans
- Team Leader/Director quarterly meetings to review Community Health Plan progress in relationship to the Regional Health Plan and make revisions as needed.
- Deputy Minister/Directors quarterly meetings and use of RHP Checklist to review the plan's progress and make revisions as required.
- Documentation of baseline data being collected and survey results as part of the plan's implementation.
- Use of the plan's objectives and identified performance measures (Signs of Success) to assess the plan's progress, impacts and outcomes.
- Annual updates provided to DHSD staff, the Assembly, applicable partners and Labrador Inuit.

Detailed evaluation processes will be developed once the operational plan and the community health plans are in place. Only then can the specific activities and tasks be identified.

SUMMARY

This plan supports the DHSD's commitment to improvement and innovation. The Department intends to continue the progress that has been made and to work passionately to build upon that momentum. The specific priorities that have been identified will enable the Department to focus on enhancing the health and wellbeing of Inuit families and their communities.

The implementation of this plan is dependent on the dedication of the Department's employees. Supportive leadership will ensure the plan remains in the forefront and the necessary direction is provided. A strong, vibrant workforce will incorporate this plan into their work. Working together, the Department will demonstrate accountability for the resources it uses and the programs it delivers.

The DHSD will also work with its partners and stakeholders as part of its efforts to achieve the goals of this plan.

Most importantly, the Department will never lose sight of the health needs of Labrador Inuit. This plan will help the DHSD to move forward in achieving results that will improve health outcomes. This five-year plan will evolve over time and as such will remain responsive to changing needs, priorities and trends.

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APPENDIX 1: MAP OF NUNATSIAVUT

APPENDIX 2: GLOSSARY OF KEY TERMS AND CONCEPTS

Active Outreach: Outreach programs seek face-to-face contact with prioritized vulnerable populations. It delivers information, resources and services to hard to reach populations and establishes links between isolated individuals/families and critical health services (Government of British Columbia, 2005). Outreach approaches always take place in the direct living environment of people, both in the private and public domain. Outreach approaches are grounded in the principles of harm reduction, and the theories of behaviour change, and social determinants of health; all of which contribute to individual health-related behaviours (NCCID's Outreach Planning Guide (2014). This type of approach requires services to take a more active role in adjusting to meet the needs of the individual rather than vice versa (Handbook of Mental Health Nursing, 2005). It addresses the barriers to accessing services and programs or barriers to program participation.
Outreach should be understood as:

- Providing activities to a targeted vulnerable group who would otherwise not have access to services/programs or would not normally be active in programming
- Connecting with vulnerable individuals (including children, youth, adults, seniors) and/or families in their home or a public space (such as on the street, at the store, etc.)
- Supporting an environment of inclusion (European Youth Parliament, 2017)
- Engaging in a mutually trusting working relationship that is open and non- judgmental
- Using these connections with vulnerable individuals and/or families to build supportive relationships and promote wellbeing; it is expected that this work may take time and requires repeated acts of connection
- Responding directly and immediately to clients' needs
- Linking the individual in engaging with other services and/or activities available to them when and if appropriate[63]

Food Security: United Nation's Food and Agriculture Organization (FAO), says food security exists "when all people, at all times, have physical, social and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life" (Fergurson, H. Fall, 2011). Food security then is a measure of the ability of a household to get the foods they need, want and prefer on a regular basis to live a healthy life (Food Security in Nunatsiavut Survey Results, 2016). Household food insecurity is "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so (quoted by Government of Canada, 2012). Food security is achieved when people have access to sufficient, safe, nutritious and culturally appropriate food that meets their dietary needs. *Food insecurity* "exists when a person does not have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. This can range from not having the ability to afford a balanced diet, to not being able to eat culturally acceptable foods, to missing meals or not eating for days at a time. Adults in food insecure households tend to have poorer physical and mental health, including higher rates of heart disease, diabetes and depression. Food insecurity also has very negative consequences for children's cognitive, academic and psychosocial development. For Inuit, the impacts of food insecurity also

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[63] Such as helping them make and meet appointments with service providers, accommodating them to appointments and activities, and/or picking them up to go to services or activities.

extend to cultural well-being because of the continued importance of country foods such as seal, whale, and fish harvested from the local environment" (2018, Inuit Tapiriit Kanatami, *The Nuluaq Project. Inuit Food Insecurity in Canada)*

Harm Reduction: Harm reduction has become an increasingly popular intervention in the alcohol and drug abuse fields. It seeks to lessen the harms associated with substance use without necessarily requiring a reduction in use. It focuses on the harm from alcohol or other substance use rather than on alcohol/substance of choice itself. Harm reduction is a non-judgmental response that meets users 'where they are' with regard to their substance use..."(Thomas, 2005, p. 1). Harm reduction includes a broad continuum of responses, from safer substance use to abstinence. Essential to a harm reduction approach is that it offers users a choice of how they will minimize harms to themselves (Dell & Lyons 2007). In summary, "harm reduction refers to programs, policies or interventions that are trying to reduce or minimize the adverse health and social consequences associated with drug use" (Beirness, Jesseman, Notarandrea, & Perron, May 20th, 2008, p.2).

In recent years, harm reduction has also been adopted as a public health strategy to address a variety of other risky health behaviours. Harm reduction approaches have been used in addressing communicable diseases, sexual health, injury prevention etc. The aim is to reduce harms associated with certain behaviours.

Health Promotion: The Ottawa Charter of Health Promotion (1986) defines health promotion as "the process of enabling people to increase control over and improve their health." "This definition is premised on the understanding that both social conditions and personal actions determine health. Accordingly, health promotion activities move beyond disease prevention and health education to address social change, institutional change and community change in addition to changes in the behaviours of individuals." (Hyndman, B., Alder Group for Health Promotion Ontario 2007).

IOM Classification System for Prevention: This classification system was based on the work of R. Gordon (1987). The US Institute of Medicine adapted it for use in the prevention of mental disorders in 1994. In 1997, The National Institute on Drug Abuse began to use it in discussing preventing drug use among children and youth. It classifies prevention interventions into three categories: universal, selective and indicated (described in more detail below). These categories can be used to organize prevention activities/interventions and to match the interventions with the needs of population being targeted (Spencer-Smith, 2012; Roberts et al, 2001). They have begun to replace the Public Health terms of primary, secondary and tertiary prevention because the IOM classification is seen as providing a finer or clearer breakdown of primary prevention. They are defined below:
Universal prevention interventions: Target the general population with the goal of promoting health or preventing or delaying the onset of substance, physical/mental health issues etc. Examples are media and awareness campaigns, school drug education programs and various measures to control the availability and price of alcohol and tobacco (for example all students in a particular grade) or early psychosis awareness programs. Children, youth, parents and families are often the focus of universal prevention interventions (Roberts et al., 2001 & Kumpfer et al.,1998).
*Selective prevention interventions (*sometimes referred to as targeted prevention): Selective prevention target high-risk individuals or families. They have been identified as members of at-risk subgroups. They are targeted because of established risk factors (family history of substance use problems, poverty, marginalization, other psychosocial environmental, demographic risk factors and

genetic risk factors, etc.) and not because of individualized needs assessments/diagnoses. Selective prevention activities hope to reduce the influence of these risks, and to build on strengths to prevent or reduce substance use problems. The interventions usually last longer, involve smaller numbers of participants and since the interventions target behavioural changes, they are generally seen as more intrusive. An example would be delivering a program to children living with substance abusing parents/family or delivering a program to children who witness family violence. Service providers need to pay attention to the risk of labeling and stigmatizing children and youth targeted for this type of intervention.
Indicated prevention intervention: This type of intervention targets more advanced substance use, mental health issues etc. It is usually designed to address multiple risk factors. Participants are already engaged in substance use and may be engaged in problematic substance/gambling use or have been diagnosed with a mental health issue. For youth in particular, indicated prevention may involve an outreach component & case management component. Indicated prevention programs are the most intrusive of the three types and often the longest. They often involve screening and assessments prior to selection of participants. An example would be a family focused program that involves indicated prevention and treatment.
Activities carried out at the universal level can impact activities carried out at the selected and indicated levels. There is also a relationship between all three types of prevention interventions and treatment interventions. Each component supports the other components.

Problematic Alcohol Use: Alcohol use which has a harmful effect on any of following factors: physical health, friendships and social life, financial position, home life or marriage, work, studies, employment opportunities, legal problems, difficulty learning or housing problems. Problematic alcohol use can affect the user's concentration, speech, balance, vision, coordination, judgment, and overall health and in long term can lead to more serious health problems.

Protective factors & Risk factors: Protective factors help prevent the development or worsening of an undesirable health condition. Risk factors are the opposite; they may contribute to the development or worsening of an undesirable health condition. For example, physical activity is a protective factor for obesity and other conditions while smoking is a risk factor for lung cancer and other conditions (Government of New Brunswick et al; January 2016). These terms are usually used to" identify aspects of a person and his or her environment that make the development of a given problem less likely (protective factor) or more likely (risk factor)" (Roberts et al, 2001). These terms are interrelated with resiliency. They help service providers better understand target populations (who you are trying to reach). "**Risk factors** are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. **Protective factors** are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events. Some risk and protective factors are fixed: they do not change over time. Other risk and protective factors are considered variable and can change over time. **Variable risk factors** include income level, peer group, adverse childhood experiences and employment status. **Individual-level risk factors** may include a person's genetic predisposition to addiction or exposure to alcohol prenatally. **Individual-level protective factors** might include positive self-image, self-control, or social competence" (SAMHSA, 2018). Everyone, including children have a mixture of risk and protective factors. It is believed that the most important protective factors, like risk, come from within the family. It is important to emphasize protective factors are not simply the

absence of risk factors; rather, they may reduce or lessen the negative impact of risk factors (NIDA, 2016).

Risk and protective factors can affect people of all groups. The potential impact of specific risk and protective factors change with age. The effects of these factors can be different depending on a " person's age, gender, ethnicity, culture and environment" (NIDA Info facts, February 2004). Examples of risk factors that impact health outcomes are:

- The devaluation of Labrador Innu & Inuit culture, history & language, a history of conquest and marginalization and the resulting traumas and loss are seen as contributing to risk factors for this population group (ITK, 2016, Ajunniginiq Centre, Oct 2007 and CCSA, Dell and Lyons, 2007, Taylor, June, 2007). .
- Risk factors for harms from substance use can include genetic factors, parental substance use, childhood trauma, inadequate income and/or housing, and early initiation to use etc. (CARBC, 2006).
- Suicide risk factors for Inuit can include historical trauma, community distress, wounded family, traumatic stress and early adversity, mental distress, and acute stress or loss (National Inuit Suicide Prevention Strategy, 2016).
- Those that influence a child's early development within the family (ie. parents who abuse drugs or who experience mental illness, lack of strong parent-child attachments in a nurturing environment, poor parent monitoring, ineffective parenting, etc.). Risk factors outside the home can include failing school performance or lack of bonding with school, poor social skills, affiliation with peers who are experiencing problems, and a perception that drug use is acceptable within peer, school and/or community settings (NIDA NOTES, March, 2000).

Examples of protective factors are:

- Positive cultural identity and connectedness with Indigenous heritage, traditions and values (ITK, 2016, Ajunniginiq Centre, Oct 2007 and CCSA, Dell and Lyons, 2007, Taylor, June, 2007).
- Those that can alleviate the risk factors for early or problematic substance use include "easy temperament, social and emotional competence, healthy family attachment, school connectedness, participation in a faith community and having meaningful adult role-model relationship during adolescence or a supportive relationship in adulthood" (CARBC, 2006). Others include cultural identity, and active involvement in the community. For youth, having caring adults (within or outside the family) involved in their life and positive peer support are important protective factors.
- Inuit suicide protective factors include: cultural continuity, social equity, family strength, healthy childhood development and mental wellness (National Inuit Suicide Prevention Strategy, 2016)
- For Inuit, Inuit-centered early learning and childcare (ELCC) has the potential to reinforce a strong sense of identity, positive self-image, encourage social and economic participation for Inuit women and families, and impart coping and other behavioural skills that are critical for healthy growth and development. Cultural revitalization through support of Inuit centred early learning will build resilience (ITK et al; 2017).
- Key protective factors critical to bolstering development for all children and serving to protect children exposed to chronic risk as " caring relationships with supportive caregivers and pro-social adults who have high expectations of them and provide them with opportunities for meaningful participation" (heard and respected in their homes, schools,

and communities) and contribution (opportunity to perform services for others and contribute to their communities). (Child & Youth Officer for BC. March 29, 2006).

Vulnerable Populations: Vulnerable populations are groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability (National Collaborating Centre For Determinants of Health). In general, a vulnerable population is a group of people who are disadvantaged in some way. They are often impacted by social inequities and as a result are underserved. Typically, they have less power than the majority of their peers and fewer resources to dedicate to their health (Duquesne University, 2012 as quoted in Flores and Zydor, 2014). In targeting vulnerable populations, one must keep in mind the need to protect and support those at greater risk. They require tailored responses and individual risk-taking behaviours should be understood in the context of underlying factors that make such actions difficult to change. Professionals are often undereducated about the lives and concerns of vulnerable populations.
This plan focuses on individuals requiring supportive housing, seniors who are shut-ins (isolated) and unilingual speakers, individuals with limited social supports/networks, families impacted by low income/ unemployment, those with multiple risk factors, offenders and their families, victims of violence, individuals engaged in risky and unhealthy behaviours, as well as supporting those populations listed in the other priority areas.

Appendix 3: Checklist for Regional Health Plan Implementation

Priority Area 1: Create health promotion messages for priority areas

Goal	Specific Priority Issue (focus)	Addressed in		Follow up Action
		Regional Operational Plan	Community Health Plan	
By March 31, 2024, the Department will have developed Inuit-specific health promotion messages/campaigns in the prioritized areas to address the health needs of Labrador Inuit.	Implement a regional coordinated approach to address identified core health promotion messaging			
	Increase use of social media to support health promotion dissemination and communication			
	Develop Inuit- specific health promotion messages for targeted areas			

Priority Area 2: Increase Food Security

Goal	Specific Priority Issues (focus)	Addressed in		Follow up Actions
		Regional Operational Plan	Community Health Plan	
By March 31, 2024 the Department will have increased food security for Labrador Inuit families	Strengthen skills in preparation in preparation & use of traditional and other healthy food options			
	Develop and implement of Food Security Strategy			
	Advocate for coordinated approaches/solutions in addressing food insecurity with key stakeholders			

Priority Area 3: Address Risk Factors in Childhood Development

Goal	Specific Priority Issues (focus)	Addressed in		Follow Up
		Regional Operational Plan	Community Health Plan	Actions
By March 31, 2024, the Department will have addressed risk factors in childhood development	Enhance access to childhood and family wellness programming that improve protective factors[64]			
	Provide active outreach and supportive activities to vulnerable[65] children and their families/caregivers			
	Move towards Inuit self-determination of provincial and regional child, youth and family programming and regulatory processes[66]			

Priority Area 4: Focus on Problematic Alcohol Use

Goal	Specific Priority Issues (focus)	Addressed in		Follow Up
		Regional Operational Plan	Community Health Plans	Actions
By March 31, 2024, the Department will have addressed the negative impact of problematic substance use on individuals, families and community	Explore individual and community alcohol and other substance use patterns and prevalence rates [67]			
	Educate about and engage in harm reduction approaches			
	Explore and implement innovative interventions/support for problematic alcohol users and their families			

[64] Promotes healthy child development: Focus on effective communications, healthy relationships, empathy, nutrition, food security, safety and Inuit knowledge/practices of child-raising, nurturing and learning.
[65] High risk pregnant women, children witnessing family violence, children who experienced trauma, children & families impacted by problematic alcohol use, children whose parents are in conflict with the law, children in care as well as children, families/caregivers impacted by low income and food insecurity.
[66] Examples include devolution of child welfare, day care licensing etc.
[67] Identify levels of use across the lifespan, patterns of use, levels of harm, etc.

Priority Area 5: Engage in Active Outreach to Other Prioritized Vulnerable Populations

Goal	Specific Priority Issues (focus)	Addressed in		Follow Up
		Regional Operational Plan	Community Health Plans	Actions
By March 31, 2024, the Department will have increased active outreach to other prioritized vulnerable populations	Increase access to supportive and safe spaces and appropriate programming			
	Support the implementation of active outreach programming through incorporation of Inuit –specific approaches and resources			
	Focus on coordinated processes across the continuum of need [68]			

[68] Support clients in linking to supports and services, navigating systems, accessing benefits, problem solving, daily living skills, case management etc.

APPENDIX 4. DETAILED PROGRAM DESCRIPTIONS

Program Description: Non-Insured Health Benefits (NIHB)

***Goal: Labrador Inuit will receive the best benefits possible under the NIHB Framework*.**

The Non-Insured Health Benefits (NIHB) Program provides coverage for a number of medically necessary goods and services that are not covered by provincial or territorial health plans (e.g. MCP, OHIP), provincial agencies for income support (e.g. Advanced Education and Skills in NL), agencies responsible for child protection and welfare, or third-party insurance plans (e.g. Blue Cross). NIHB is the payer of last resort.

The Nunatsiavut Department of Health and Social Development (DHSD) administer the NIHB program on behalf of Health Canada to Beneficiaries of the Labrador Inuit Land Claims Agreement. The beneficiaries' membership card is required when accessing NIHB benefits.

The general categories of NIHB include:

- Medical Transportation (which includes air, ground, accommodations and meals);
- Pharmacy;
- Dental;
- Vision Care;
- Medical Supplies and Equipment (MSE);
- Mental Health Counselling
-

Beneficiaries may require approval or have to meet eligibility criteria for coverage under some of the general categories. Please refer to NIHB information sheet for details.

The NIHB policy framework is based on that of Health Canada's. While NIHB can modify policy with the appropriate approval(s), for the most part, it has adopted the Health Canada policies for standardization and evidence-based support. The existing policy manual was revised and updated in the fall of 2008 and is continually being reviewed and amended on an as needed basis moving forward.

The DHSD manages all aspects of the NIHB program including: program management, client interaction, billing processes, etc. Regional staffs have been trained in the electronic data base system, which allows the Department to continue to look more closely at areas of spending and plan for programs and services, identifying where health prevention initiatives may need to focus. Community staff continues to assist clients with NIHB processes.

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 the limitations and protecting the program for future generations.

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.

Program Description: Healthy Lifestyles

Goal: Labrador Inuit individuals, families and communities making healthy lifestyle choices and taking positive action to keep themselves safe & healthy.

This new program area combines the services provided by the former Injury Prevention Program and the Healthy Lifestyles Program as well as including some of the activities of the Sexual Health Program. These changes have been made to address issues raised in the implementation & evaluation of the previous regional health plan particularly as it relates to duplication and overlap of program activities. The Department of Health and Social Development anticipates this realignment will bring a sharper focus to activities that target improved health & the reduction of chronic disease rates and injury rates.

The Healthy Lifestyles program is designed to increase awareness of positive health practices within the context of Inuit culture and values, and to encourage individuals and communities to make healthy choices that have positive impacts on their lives by providing information, support and opportunities for acquiring skills. The long term desired outcome is to increase life expectancy and overall health of Labrador Inuit.

The Healthy Lifestyles program area will provide a variety of health promotion, prevention, education and community wellness services to the general population and identified at-risk/vulnerable individuals, families and groups. Individuals or groups can access the program area themselves or be referred to the program. Some program initiatives/activities may require individuals to participate in screening/ assessment processes.

Community health workers and home support/home care/community health aides positions primarily deliver these programs with support/resources from other programs & staff within Nunatsiavut Government's community health team structure, regional DHSD staff, and some provincially mandated programs. The department frequently cooperates and collaborates with other departments and agencies to further enhance program resources, delivery and support. Such agencies may include the RCMP, Department of Fisheries and Oceans, College of the North Atlantic, Public Health, Schools, Recreation, Community Governments and others.
The program components are: injury prevention, active living & recreation, nutrition and food security, chronic disease prevention, and life skills[69]. A detailed description of the components is

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[69] ***Life skills as defined by WHO:*** the abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life". The focus is on knowledge, attitude change and behavior change, UNICEF, UNESCO and WHO list ten core life Social skill strategies and techniques such as: ***problem solving, critical thinking, effective communication skills, decision-making, creative thinking, interpersonal relationship skills, self- awareness building skills, empathy, and coping with stress and emotions (accessed on December 2, 2012)*** at http://www.unodc.org/pdf/youthnet/action/message/escap_peers_07.pdf***).***

available upon request. The focus is placed on healthy eating, physical activity, positive sexual health, the prevention of injuries and chronic illnesses and the prevention, delay and reduction of tobacco use. Community needs & priorities determine which components or activities are offered in each community.

These activities may include, but are certainly not limited to, cooking demonstrations, Kids Eat Smart Program, community freezer promotion, Drop the Pop initiative; availability of exercise equipment such as snowshoes, skis, treadmills, etc. to encourage physical activity; distribution of condoms; information on various safety approaches such as boating, ice, water, food, sun, fire, etc.; and smoking cessation programs, training and education programs related to critical thinking/decision-making skills, &interpersonal/communication skills , diabetes, strengthening parents programs etc. All activities strive, when possible, to strengthen Inuit cultural identity by incorporating Inuit cultural activities, traditions and practices into programming.

The impact of healthy lifestyle practices is far reaching. Responsible sexuality, effective and realistic safety practices and individuals taking responsibility for their overall health not only enhance physical health; it also serves to improve mental & spiritual wellbeing (improved self-esteem, decision-making abilities, and sense of worth).

This program area faces significant challenges in achieving its desired outcomes. 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, and environment). Other agencies & organizations also have responsibilities and mandates that overlap with or impact this program area. Therefore, formal and informal partnerships are essential and the creation and management of partnerships take considerable time, effort and planning.

DHSD believes that in order for people to make healthy lifestyle choices, they need to be given information and support to help them make positive changes. Yet there are often factors beyond their control that limit choices and impede the adoption of positive health practices. These include the social determinants of health, individual and community resources and capacity. Major issues are housing, food security issues, geographical isolation, financial resources, accessibility to land-based activities, problematic substance use, availability of meaningful work etc. Broader issues include the effects of colonization, re-location, residential schools, and loss of cultural identity that impact individual, family and community capacity. This program area's intent is to work within the realities of individuals, families and communities. This approach can be successful in supporting individuals to acquire the skills they need to adopt positive health practices.

Program Description: Mental Wellness and Healing Program Area

Goal: Individuals, families and communities have the knowledge, skills and resources necessary to achieve and maintain mental wellbeing and resilient & inclusive communities.

This program area covers the services provided by the former mental health and addictions programs. In 2006, NG began a process to review all its addiction programs. In 2009, the Department of Health and Social Development, as part of its strategic health plan, developed a service delivery model that would combine mental health and addictions programs. This reorganized program area provides a continuum of services that target individuals, families, groups and communities with mental health/mental illness-related issues and substance use, gambling and smoking issues or those who have been identified as at-risk or vulnerable to developing these issues. Individuals can access the services by self-referral or by a third party referral. Youth Services was added in 2016.
The program components area: a. promotion, prevention, education and community supportive services, b. intervention (individual & group clinical services) services and c. specialized services. Not all services are offered in every community. Staff delivers the programs with support from other programs within the community health team structure of DHSD, Nunatsiavut Government's regional programs, partnerships and specialized provincially mandated programs. Outlined below is a detailed description of the services:

a. Promotion, Prevention, Education & Community Supportive Services:

Promotion:

Supports public awareness activities through promoting and distributing accurate information, strengthening protective factors, promotion of self-help and promotion of partnership/collaborative efforts. Examples include:

- Suicide awareness campaign, poster displays on tobacco, alcohol, drugs, self-esteem etc. Aboriginal Day, health fairs, heritage fairs, Boys to Men program, support to AA groups etc. programs that strengthen families and cultural identity such as mom's & tots yoga, family snowshoeing,etc.

Prevention:

Provides a variety of community- based programs designed to prevent and reduce the harm caused by mental health issues and problematic substance use and problem gambling through focusing on increasing protective factors and decreasing risk factors. Examples include:

- Programs to prevent suicide; programs for children and youth impacted by family violence, other traumas, problematic substance use, second-hand smoking (Blue Light Campaign), youth grief workshops, drinking and driving campaigns and other program initiatives based on specific community needs.

Education:

Provides tools, training and support to other government departments and agencies, schools and community groups to screen and offer first line support in areas of mental wellness, substance use and gambling. Examples include:

- FASD screening sessions, Inuit cultural awareness seminars etc.

Community Supportive Services:

Provides and/or supports a variety of activities that promote healthy and caring communities and enhance community capacity. They may include:

- Land based outings (men's hunt, berry-picking etc. retreats), recreational activities or events such as socials, dances, culture night, craft night etc., mentoring opportunities, positive role model campaigns), mom and dad appreciation events, honoring abstinence program, engaging in partnerships & collaborative initiatives and supporting local community groups (crisis response teams, MADD, bike rodeo etc.).

b. Intervention (individual and group clinical) Services:

Provides a broad range of community-based counseling and support programs that support Labrador Inuit in their healing journey and in recovering from problems associated with mental health issues, problematic substance use, smoking and problem gambling. Programs and services may include:

- Screening, assessment, supportive and clinical counseling, crisis response services, psycho-education programming, case management services, and other community-based programming, follow-up and aftercare services, consultative services, outreach services to vulnerable individuals and referral services.

c. *Specialized Services*:

Provides intensive programs and services for Labrador Inuit who have complex needs and require more specialized interventions and supports. Specialized services include:

- Mobile Trauma and Addictions team for treatment of those suffering from problematic substance use, problem gambling and/or trauma
- Youth Case Management Intervention Services (travelling service)

This program area also links to specialized clinical services that are the responsibility and mandate of the provincial government. They include but are not limited to:

- Labrador-Grenfell Health (acute mental health care and counseling services etc.)
- Eastern Health (Waterford Hospital, Janeway Children's Hospital, Recovery Centre, Early Psychosis Program etc.)
- Western Health (Humberwood Centre, inpatient addictions treatment program)
- Eastern Health's detoxification and inpatient addictions programs
- It links with out of province NNADAP services and other treatment centers.

Challenges

The Mental Wellness and Healing Program area is in a period of transition; moving away from a Western approach that primarily focused on the individual and illness and moving towards a holistic Inuit approach that focuses on community wellness and supporting individuals in the context of their families, social networks and community. The journey towards mentally well Inuit communities is challenging.

The legacy of colonization, oppression, relocations, residential schools, epidemics and the resulting loss of cultural behaviors, rituals, traditions and history have played havoc in our communities. The effects are still being felt today. Part of this program's responsibilities is to help families and communities better understand the impact of intergenerational trauma. We now recognize that alcohol abuse, violence, depression and other social problems facing our communities are linked to these historical and present day experiences. The normalization of substance abuse and violence in communities is one of the consequences of the losses and trauma Labrador Inuit have had to shoulder. Programming must challenge these unhealthy norms and work with others to encourage positive social norms that reflect Labrador Inuit traditional values and resilience.

Our programming needs to address collective trauma by supporting community and relationship healing efforts. Emphasis will be placed on helping community members understand that some parts of problem substance use and mental wellness issues can only be made sense of at the collective level. Our communities have been used to services that were crisis-driven. Resources focused on those suffering with severe addiction and mental illness issues. We are now trying to restore a balance to the services by acknowledging the importance of prevention and early intervention programming. Programming will focus on providing knowledge and support to those trying to make healthy lifestyle choices. Unfortunately, there is limited Inuit-specific research that this program area can use to select effective prevention and education strategies. Sometimes, we will have to learn what works best in prevention as we implement programming.

Another challenge facing this program is that mental wellness and healing is impacted by broader social determinants of health that are often outside of this program's control. Lack of housing, limited employment opportunities, poverty, and education levels etc. result in health inequities that place Inuit individuals, families and communities at increased risk for developing mental health and substance use issues. These social and environmental factors complicate prevention and education efforts as well as a community's will to make changes.

As we travel on this journey towards mentally well communities, we know we have many tools to guide us. Connection to the land will prepare us for the journey. There are many positive role models in our communities who can pick us up when we fall or make a mistake. Strengthening our Inuit cultural identity will protect us from harm. Our elders can share their knowledge and experiences to prevent us from getting lost. Drawing upon the resilience of our staff and community members will help us when we encounter roadblocks. We do not have to carry all the weight ourselves. We will reach out to others when we require their support. We will change our travel plans to accommodate new learning. Although challenging, this new journey is filled with hope.

Program Description: Communicable Disease Control

Goal: Effective communicable disease control in Nunatsiavut

The Public Health Department of DHSD, in close collaboration with the Communicable Disease Control Nurse (CDCN) and Medical Officer of Health (MOH) 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.

Public Health Nurses and Community Health Aides deliver all of the program components in Nunatsiavut under the management of the Community Health Nursing Coordinator. Community Health Workers also help to provide the components related to education, awareness and prevention initiatives in Nunatsiavut and in the settlement area of Upper Lake Melville.

Clients can access the programs through their local DHSD offices by contacting the public health nurse, community health aide or community health worker. Communicable disease follow up is directed by referrals from the CDCN, at LGH, to the Public Health Nurse.

The program components of communicable disease control include: immunization programs, communicable disease follow-up and case management, surveillance, data collection and analysis, education and awareness, prevention initiatives, and policy development and planning. The nature of communicable disease control is such that outbreaks take priority over all other public health programs. At times, this may require additional financial and staffing resources.

Components of disease control:

<u>Immunization program for adults, children and domestic animals:</u>

This component 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.

<u>Communicable disease follow-up and case management:</u>

Diseases such as TB, enteric disease (of the intestine), sexually transmitted infections (STI) and dog bites are investigated and followed up in accordance with provincial legislation under the direction of the CDCN and MOH from Labrador-Grenfell health.

<u>Surveillance, data collection and analysis:</u>

This component includes weekly surveillance (influenza), and disease reporting both regionally and provincially. 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.

<u>Education and awareness:</u>

This component focuses on health promotion activities that include education about the rabies program, hygiene, sexual health, and the promotion of healthy choices.

<u>Prevention initiatives:</u>

This component includes activities such as hand washing, condom distribution and the 'cough in sleeve' program.

Policy development and planning:

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

Challenges:

Effective communicable disease control can be challenging to accomplish without access to current, Inuit -specific data. Education and awareness initiatives should be targeted to address specific issues in the community. This is difficult when there is no community specific data available to assist with the identification of community-specific priorities. Programs are then delivered based on anecdotal evidence and may be missing some important components. Data is also required to measure the success that programs are making in reducing communicable disease rates. This enables the program to adjust and target its interventions as the needs change. Presently, there is limited availability of communicable disease specific data.

Elements of the program fall under provincial legislation. These complexities can create challenges with program delivery. The components are mandated by the province of Newfoundland and Labrador and cannot be changed to reflect the unique challenges of service delivery in Nunatsiavut. The program area must constantly balance the program requirements of Labrador-Grenfell and the province with the unique needs of the Labrador Inuit communities.

Program Description: Home and Community Care

Goal: To support clients with acute and chronic illnesses to maintain their optimum level of health, wellbeing and independence.

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 health care needs of the client and the family in the community. All the components of the HCCP are delivered in Nunatsiavut but only the HSSP is delivered in the settlement area of Upper Lake Melville (ULM). In this region Home care nursing continues to be provided by Labrador Grenfell Health (LGH) because of jurisdictional issues.

The Department of Health and Social Development delivers this program. Staff works in close collaboration with LGH and the province to provide safe and competent client care. Services provided by LGH include acute care services that can be obtained in the communities through the Regional Community Clinics, the Labrador Health Center in Happy Valley-Goose Bay or referral to specialists in other tertiary care centers outside of Labrador. The services provided by the HCCP and LGH are unique to one another but clients often require access to care and services provided by both for comprehensive health care. This requires a collaborative approach with both service providers to ensure seamless access and provision of health care services.

The Home Care Nurse (HCN), Community Health Aide (CHA) and Home Support Workers (HSW) deliver care for clients in the HCCP in Nunatsiavut, under the management of the Community Health Nursing Coordinator (CHNC). In the ULM region the Home Support Program coordinator (HSPC), a registered nurse, coordinates the care provided by home support workers under the management of the Community Health Nursing Coordinator. Clients can access the HCCP in Nunatsiavut by contacting the home care nurse or community health aide. Referrals can be made by the clients themselves, friends, family members or other professionals such as physicians, nurses or social workers. In ULM, clients can access the HSSP by contacting the HSPC. Referral sources can be from clients themselves, friends, family members or other professionals. Upon receipt of referrals in Nunatsiavut, the HCN will visit the client to do an assessment to see if the client meets admission criteria. In ULM this is completed by the HSPC.

Nunatsiavut now has the ability to train HSW's as they are hired through a culturally appropriate, formalized training program that is facilitated by the HCN in the community. This program is also used to update training and education needs for formerly trained HSW's as they arise.

Essential services elements of the HCCP:
Structured Client Assessment. Clients' needs are assessed using the provincial standardized assessment tool. Other tools, such as the palliative care assessment tool, are also used to help determine how to best meet client needs.
Managed Care. The HCN acts as a case manager to advocate for and to ensure that the client has an appropriate service plan, access to necessary services, monitored service delivery and evaluation of outcomes.
Program Management and Supervision. The home care nurse is responsible for the overall management of the HCCP and works in close collaboration with the TL, CHA, HSW and LGH.

Home Care Nursing. Home Care nurses provide services such as diabetes management, foot care, palliative care, wound care, venipuncture, assessment for long term care, medication management and routine monitoring and follow up in the clients home or during an office visit.

Home Support Services. This program provides:

Home management

- ❖ The home care nurse and community health aide coordinate the health support workers to assist clients in maintaining the cleanliness and safety of their home. HSW's assist with home making activities that the client is no longer able to do because of health problems or advanced age.

Personal care

- ❖ HSW's can provide help with bathing, dressing, grooming, feeding, turning, positioning and other tasks for clients who can no longer do these independently.

In-Home respite Care

- ❖ This care is provided by HSW's for clients who are being cared for at home by a family or other community member because they cannot be safely left alone. The goal is to provide safe care for the client while the caregiver has a break from caregiver responsibilities.

Record Keeping and Data Collection. Each client has a secured chart that is used to document all client care. Service delivery and nursing month end reports are completed by the HCN, and the CHA each month and forwarded to the CHNC for review. The data in these reports are used for program planning and evaluation.

Access to Medical Supplies and Equipment. Clients have access to medical supplies and equipment through the Non-Insured Health Benefits program if needed. The HCN and CHA can assist clients with accessing the benefits of this program. The HCCP also has equipment, such as electric hospital beds, that can be loaned to clients as required.

Challenges:

The HCCP works in close collaboration with Labrador Grenfell Health to provide health care services. Some of these services, such as medical investigations and specialist appointments, are located outside of the community and sometimes within the region. Access to these services can create challenges for families who have to travel for these services. Communication issues often arise when staff is trying to co-ordinate care/services across sectors or trying to support clients as they navigate the various systems. Planning for a client to come back home after cancer treatment, surgery or other major illness requires open communication and collaboration to ensure the appropriate services are in place for the clients return. Sometimes health care providers outside of the Labrador region do not realize the limitations of communities in terms of the type of support, medical supplies and equipment that can be provided in communities. They do not always involve HCCP staff in the discharge plans. These challenges speak to the need for further education of health care providers and policy that can guide the various processes.

Capacity in the community is sometimes a challenge. The HCCP requires a minimum number of nurses, CHA's and HSW's to provide services effectively. Nunatsiavut now has the ability to train HSW's in their community, but it is still often difficult to recruit people for this type of work. Competition from other sources of employment and a limited number of eligible, employable individuals are just some of the recruitment challenges faced by the HCCP.

Program Description: Healthy Children & Youth Program Area

Goals:
1. Inuit families provide secure, healthy environments in which to raise children.
2. Inuit children & youth grow up in communities that respect their cultural heritage & provide opportunities for them to reach their full potential.
3. Labrador Inuit communities will have high quality child & youth development programs that are family-focused, culturally relevant, & Inuit directed & controlled.
4. Healthy children born to healthy families.

This program area combines a number of services that used to be spread across a variety of programs. These changes have been made in order to better coordinate these programs and to focus on the needs of children and youth. The basic intent of the healthy children programs are to foster physical, emotional, cultural, social and intellectual growth and to support families in raising healthy and capable children and youth.

The services target the needs of family units from pre-conception to adolescence. Parents and caregivers access many of the programs by contacting their local DHSD office to self-refer and third-party referrals are also accepted. Some initiatives/activities may require individuals to participate in screening/assessment processes. The childcare programs are currently delivered from September to June.

This program area covers a broad range of services and the staffing resources reflect this diversity. Community health workers deliver playgroup programs, FASD prevention programming and support other program components. Public health nurses are responsible for the pre-conception & childbirth education, breast-feeding support, pre-school health checks & school health. Individuals with Early Childhood Education training staff the daycare centres. Fluent Inuktitut speakers deliver the Language Nest program and a variety of paraprofessionals deliver the Aboriginal Head Start program. Programs receive funding from a variety of sources. The Healthy Children's program area requires coordination & collaboration with other program areas of the DHSD, Labrador Grenfell Health, the Provincial Department of Child, Youth and Family Services, the Department of Health and Community Services, the Labrador School Board, recreation centres, church groups etc. as well as the support of elders, craft persons, hunters etc. for successful delivery.

The program components are: Daycares, Aboriginal Head Start, Playgroups and After-school group programming, Language Nest program, FASD prevention, & Public Health Nursing (pre-conception health, childbirth education, breastfeeding support, child health clinics, pre-school health checks and school health). Outlined below is a more detailed description of the services:

Daycares: Nunatsiavut Department of Health and Social Development operates the Daycares with support from the First Nations/Inuit Child Care Initiative (FN/ICCI), funded through the Aboriginal Skills Employment Training Strategy since 1998. This program was designed to develop and enhance child-care spaces in the 5 Labrador Inuit Communities, with an age

range from 2 year olds to 5 year olds. In addition, the DHSD receives funding from the province of NL, under ELCCI, Early Childhood Education Childcare Initiative. Licensed daycares meet the minimum standards of childcare in a regulated setting as set out by the Government of Newfoundland and Labrador.

Aboriginal Head Start: The Suguset Centre, Aboriginal Head Start Program is funded by the Public Health Agency of Canada and has been in operation since 1997. A range of child-care programs is offered in Hopedale providing options for children from infancy to age 12. This includes the Suguset Centre, Language Nest, Day-care and Afterschool program. As per its mission statement, the Suguset Centre Aboriginal Head Start Program is designed to promote social, cultural, educational, physical, emotional and nutritional growth of Aboriginal children (3-5 years) and their parents/caregivers. The Centre can accommodate up to twenty Aboriginal children.

Play Groups and Afterschool Programs: Play groups and after school programs are less formal than the regulated childcare**.** They do not provide full time care, and operates for only a few hours a day, the intent of both groups is to provide children and youth an opportunity to socialize, in a safe environment. These groups vary in each community depending on the need of the community. Generally they target three to five year olds, six to nine year olds, or ten to twelve year olds.

Language Nest: The Language Nest is accomplished with the Inuaggualuit Program through a partnership with the Torngâsok Cultural Center and DHSD. Torngâsok is the cultural affiliate of the Nunatsiavut Government, mandated to promote, preserve and protect Labrador Inuit language, customs, and culture. Fluent Inuktitut speakers deliver the Language Nest program.

FASD Prevention: The DHSD receives funding from First Nations Inuit Health Branch of Health Canada for supporting communities with FASD prevention, intervention and planning. This involves: support to pregnant women, services to children and youth affected by FASD, their families and caregivers, workshops on FASD prevention and intervention and planning/networking sessions to community workers, and networking with agency representatives.

Public Health: Public Health Nurses, Community Health Aides and other Community Health staff offer a significant number of programs to improve maternal-child health through prenatal education and support. Born a Non-Smoker, Healthy You-Healthy Me, and the Canadian Prenatal Nutrition Program (CPNP) are a few of the resources used in program delivery. Education and support are also provided to families through the provision of child health clinics, pre-school checks, and school health activities.

Barriers and Challenges:

Many of the challenges facing Inuit families and this program area have a historical origin and must be considered in the implementation of these programs. Rapid social changes have impacted Inuit over the past fifty years. Fifty years ago, the majority of Inuit continued to live primarily in small semi-nomadic groups relying upon the resources of the land and sea for sustenance. Camp life centered on extended family groupings, which regarded the rearing of

children as a responsibility of the larger group, and not solely that of the immediate family. Children could turn to any adult or older child for comfort or food or to learn life skills. Older children assumed many childcare responsibilities early in life and learned critical parenting skills as they themselves were growing up. Elders were revered for their wisdom and knowledge including their valuable advice and expertise in the area of child rearing and parenting.

Families have always been responsible for raising children. Traditionally, extended families played an important role in child rearing throughout the child's life. With the establishment of a wage economy, Inuit social ties became strained and language usage declined. Inuit society was in the process of rapid transformation. The traditional role of elders altered and the responsibility for child rearing became more focused upon the immediate family.

Three other traumatic events affected Labrador Inuit's traditional child-rearing practices: the flu epidemic of 1918, the relocations of 1956 & 1959 & residential schools. Within a few months of the 1918 Spanish influenza outbreak, almost one-third of the entire Inuit population perished, including 204 of 263 residents at Okak and 86 of the 100 Hebron residents (Higgins, J. 2007). The disaster had a profound emotional, psychological, spiritual, and cultural impact on the remaining Inuit society. Environmental knowledge traditionally passed from one generation to another, close kinship ties and a sense of identity and place based on a long history of residence were lost particularly at Okak. The relocations from Nutak in 1956 & Hebron in 1959 also had serious consequences for Inuit families. Family groups were separated, cultural bonds were severed and the expelled northern Inuit often faced prejudices and humiliation in the communities where they were placed (Mental Wellness & Healing Service Delivery Model Report, 2009.). Residential schools were also responsible for removing Inuit children from the families for extended periods of time. This has had an impact on current early childhood development issues, such as the critical bond between parents and children, and the transference of essential skills and knowledge including parenting skills, was broken for many Inuit. Many of the survivors, and their children, continue to be impacted by these traumatic historical experiences.

That is why one of this program area's priorities is to reclaim and strengthen the cultural identity of Labrador Inuit children and their families by incorporating Inuit culture and values into program curriculums, activities and initiatives and increasing the use of fluent Inuktitut speakers in certain aspects of programming delivery. Communities are aware of many of the challenges facing early childhood development, and in next 5 years the Regional Health Plan and Community Health Plans will focus on addressing issues identified in these plans.

Program Description: Social Development Area

Goals:

1. ***Improved services to vulnerable populations***
2. ***Reduced levels of homelessness***
3. **Increased safe and supportive places for Inuit to belong**
4. ***Successful devolution of child welfare programs***

This program area, in collaboration with partner agencies, delivers programs that focus on vulnerable children, individuals and families who have complex needs. Individuals can access the program by self-referral or by third party referral. Some program components require an individual to participate in screening/assessment processes. The program area components are: Supportive Housing, Emergency Shelter and the Family Connections program. It will also include the devolution of child welfare programs (child protection, children in care, foster parent programs etc.).

Challenges

Vulnerable populations often face stigma and barriers to accessing services or reaching out for help. This program area makes a concerted effort to address these issues and to provide a welcoming and supportive environment for all. Two other significant challenges in program delivery are human resource capacity and sufficient financial support/funding to meet the needs of vulnerable populations who have complex needs.