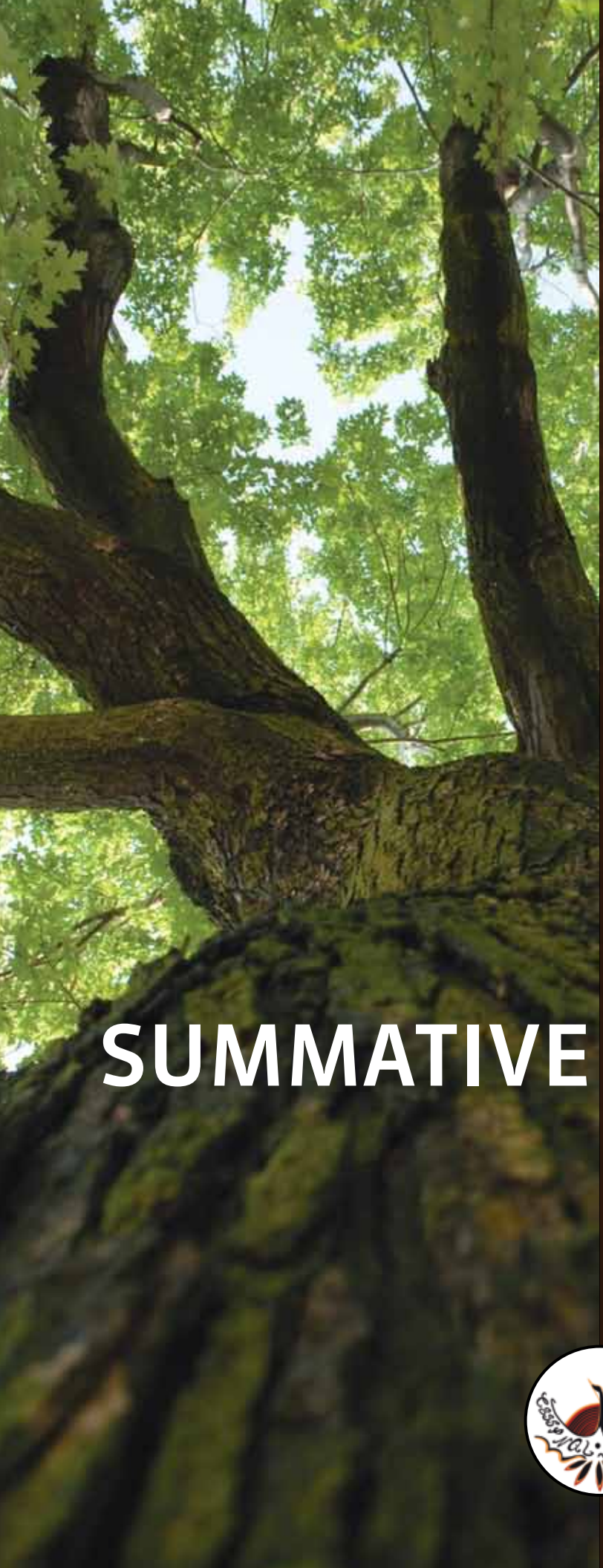

Aboriginal Health Transition Fund Quebec Region

REGIONAL EVALUATION PHASE 2

SUMMATIVE EVALUATION

Final Report
March 2011

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EXECUTIVE SUMMARY

Quebec First Nations and Inuit communities and organizations have been very involved in the Aboriginal Health Transition Fund (AHTF) even though there were delays in starting. It took much longer for the provincial partners to become implicated in the process because of communication gaps, many were not aware of the AHTF project, did not understand the need, and most had not worked with First Nations and Inuit communities before.

The Quebec Regional Project has increased in varying degrees the capacity of First Nations and Inuit communities and organizations. The projects increased institutional capacity at the local and organizational level; however, time did not allow for sufficient development for the integration projects to make systemic changes. In most cases, the changes are not sufficient to sustain any benefits envisaged by the immediate project outcomes.

The level of awareness of the partners has increased and many of the barriers and constraints have been removed. There is an increased understanding of the complex hierarchy of provincial system, and important contacts have been developed, putting faces to names.

Building capacity was true as well for the provincial partners, many of which were not aware of the structures, resources and culture of their First Nations and Inuit partners. Many of the adaptation projects worked to create an understanding of health care access issues, health disparities and social/cultural considerations for First Nations and Inuit.

The program benefits can continue after the project completion without over-burdening local organizations and partners if there are further resources provided. Some of the successful adaptation projects will require resources to be able to continue beyond the end of March such as the Clinic Minowé in Val D'Or, the ANPSS Cultural Training, and the FNQLHSSC Training Programs.

Some First Nations communities are participating to a limited extent in provincial health planning, for others there are jurisdictional issues around this participation. One or two communities have seats on the Conseil Administration of their CSSS, and one is able to confer directly with governmental agencies.

The knowledge and capacity that has been developed by these projects has been beneficial to the communities. Some have seen their members benefit from access to services that they did not have before. Others have used cultural training and information-sharing to effectively sensitize workers in their own and the provincial system about the realities and culture of First Nations and Inuit. There are important links that have been established, and in a few cases these links have been formalized by protocols and working agreements. Some programs have been adapted, and one project was able to get a provincial institution to provide services outside of their walls.

One of the key challenges was the turnover in staff in the provincial network which created a lot of delays and meant restarting the groundwork of some projects. The other was also the availability of persons working for the province and their schedules, and the limitations from the budget cutbacks. Project outcomes were sometimes limited because of regional situations. The FNQLHSSC work plans had to be changed because of the delays at the beginning with Health Canada or because the province was not in step with the work of the Commission.

Partnerships were strong and effective and there was some sharing of project responsibilities in regards to activities undertaken. Nevertheless, in most projects, the final accountability for the program results remained with the project holder, and was not equally shared by all of the partners.

Many projects felt that if they had more time, they could bring the projects forward to another level that would assure their sustainability. As described by the respondents, some things worked well and others did not. But overall, there has been increased awareness and understanding, and the establishment of collaborative working relationships on which to build in the future.

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1. INTRODUCTION

1.1 CONTEXT

The Aboriginal Health Transition Fund (AHTF) is a five-year initiative which was extended to 2011. It seeks to improve the integration of Federal, Provincial and Territorial funded health systems, adapt existing health programs and services to better serve the needs of Aboriginal peoples (First Nations, Inuit and Métis), improve access to health services, and increase the participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services.

The AHTF provides transitional funding to Provincial and Territorial governments and First Nations, Inuit and Métis organizations and communities in three areas:

- **Integration** - to support First Nations and Inuit communities to improve the coordination and integration between provincial and territorial health systems and health systems within First Nations and Inuit communities;
- **Adaptation** - to support provincial and territorial governments to adapt their existing health programs to the unique needs of all Aboriginal peoples including those in urban and Métis settlements and communities; and
- **Pan-Canadian** - to support cross-jurisdictional integration and adaptation initiatives in three streams: First Nations, Inuit and Métis; capacity funding to national Aboriginal organizations; workshops; evaluation activities; and overall administration of the AHTF.

The AHTF is based on a project proposal process which ended in March, 2011. Treasury Board requires that there be a complete detailed national evaluation to support any renewal of this federal initiative, which required regional evaluations.

The Quebec regional evaluation involved two phases: first a provisional evaluation on the implementation and design of the initiative (process) which was carried out by the Health Commission in 2010, followed by this summative evaluation of projects carried out. This evaluation will serve to assess the difference made by the fund and will provide a synthesis of the results of evaluations of various projects from the standpoint of results achieved.

1.2 BACKGROUND

The Aboriginal Health Transition Fund (AHTF) was a five-year $200-million fund set up in 2005-2006. It was established because there was increasing acknowledgement of the fact that to mitigate differences between the health status of Aboriginal individuals and non-Aboriginal Canadians, coordinated efforts were required on the part of all stakeholders involved in Aboriginal health. The investment allows federal, provincial and territorial governments (FPT) and First Nations and Inuit governments offering healthcare services and Aboriginal communities to design new means of integrating and adapting existing health services.

1.3 EXPECTED PROJECT OUTCOMES

In the long term, the AHTF aims to achieve the following outcomes:

1. Better integration of the health systems that are funded by the federal, provincial and territorial governments;
2. Enhanced access to health services;
3. Health programs and services that are better suited to Aboriginal peoples;
4. Increased participation of the Aboriginal peoples in the conception, implementation and evaluation of health programs and services.

In the medium term, the AHTF is meant to improve the integration of the federal, provincial and territorial health systems, programs and services that are intended for First Nations, Inuit, Métis, as well as the adaptation of these systems, programs

and services to the needs of Aboriginal people, notably the First Nations, Inuit, Métis and Aboriginals living off-reserve and in urban settings.

The expected outcomes in the short-term are the basis on which this evaluation is focused:

1. Heightened capacity to integrate the federal, provincial and territorial health systems, programs and services while taking into consideration the needs of the First Nations and Inuit;
2. Increased capacity to adapt the provincial and territorial health systems, programs and services to the needs of First Nations, Inuit, Métis including those living off-reserve and in urban settings;
3. Enhanced awareness among the partners and interveners regarding the catalysts of adaptation and integration and the existing obstacles;
4. Increased participation of First Nations, Inuit, Métis including those living off-reserve and in urban settings, in the delivery and evaluation of the services;
5. Increased collaboration and strengthened partnerships between the federal, provincial and territorial governments and the First Nations, Inuit, Métis including those living off-reserve and in urban settings.

1.4 OVERVIEW OF QUEBEC REGION AHTF PROJECTS

The mission of the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) is to enhance the physical, mental, emotional and spiritual wellbeing of First Nations and Inuit people, families and communities while respecting their respective cultures and local autonomy. The role of the FNQLHSSC consists of assisting First Nations communities and organizations in the defence, preservation and exercise of rights inherent in health and social services and to help them in the achievement and development of these programs.

As the regional supporting organization for health and social services, the FHQLHSSC has coordinated and provided assistance to communities in the start-up of AHTF projects for Quebec. A total of 54 projects were funded for the province of Quebec (including 15 developmental projects).

Of these 54 projects, 36 (70%) were funded by the "integration" envelope of which 15 constituted funding proposals for project development, 14 (27%) were funded by the "adaptation" envelope and 4 (3%) were funded by the "pan-Canadian envelope" (including liaison and coordination services).

The FNQLHSSC itself was mandated by the First Nations and Inuit communities and organizations to coordinate the realization of nine (9) regional projects, which are broken down in the following manner: 4 adaptation projects; 4 integration projects; and, 1 pan-Canadian project for border communities. In addition, the FNQLHSSC received coordination funding through the Pan-Canadian envelope for working with communities on resolving border issues.

The AHTF projects for the Quebec Region are overseen by a Tripartite Committee, based on a partnership between the Quebec Ministry of Health and Social Services, Health Canada and the First Nations of Quebec and Labrador Health and Social Services Commission.

1.5 REGIONAL EVALUATION PHASE I

There were twenty-one recommendations that were formulated based on the results of Phase One of the Regional Evaluation in Quebec. Some of the main recommendations highlighted the following:

- The complexity of the AHTF's terms and requirements, and the general lack of communication and understanding at all levels when the program began;
- The administrative burden associated with the accountability reports which are imposed on top of regular reporting requirements;

- The lack of awareness of program developers regarding the realities experienced in the First Nations and Inuit communities and organizations and the needs associated with those realities;
- The delay in terms of securing funding for the Quebec region;
- The support provided by FNQLHSSC and Health Canada, FNIH was considered a facilitating element for the First Nations communities and organizations;
- Access to specialized human resources required for such projects was very problematic in isolated regions;
- The AHTF allowed for the development of collaborative efforts and linkages between First Nations and Quebec network organizations;
- The presence of two levels of decision-making (regional and national) added complication and frustration to the process;
- The decentralization of the AHTF management towards the regions, and more specifically towards the First Nations organizations, is highly recommended for future initiatives.

The report stated that to successfully maximize the impacts of the AHTF, all of the key informers would like to see a transfer towards the regions in terms of project development and implementation processes. Many respondents also stated that they were concerned by the delays they deemed unfair for the Quebec region projects and that all the necessary steps must be taken to ensure that it doesn't happen again. Finally, the flexibility of the AHTF terms must be ensured and they must reflect an understanding and awareness in terms of the realities and needs of the First Nations and Inuit.

Overall, it was stated that in the today's context, where the principles of collaboration, cooperation, partnership and networking are key elements to the establishment of integrated and adapted services, the AHTF Project contributed greatly to the creation of these types of connections. However, it was felt that in order to achieve the long term objectives of the AHTF, many conditions still need to be fulfilled. The partnerships will need time to develop further, and to lead to the development of culturally appropriate services based on an understanding of the cultural realities of First Nations and Inuit peoples.

2. METHODOLOGY

2.1 OBJECTIVES

The general stated objectives for the evaluation were:

- Examine the relevance of the program, its effectiveness and the modifications to be made;
- Measure the impacts, both on- and off-reserve, on the health, knowledge transfer and the maintenance and continuum of services;
- Obtain the points of view and comments of all of the partners and project holders;
- Provide a final report that is specific to the Quebec region.

To accomplish this, the evaluation was required to:

- question the benefits to the First Nations and Inuit communities and the reasons for the success, barriers and lessons learned;
- look to see if there has been an increase in First Nations and Inuit participation in decision-making related to health services;
- look at recurrent themes in project accomplishments;
- assess cultural impacts;
- look at the dynamics and effectiveness of the project partnerships;
- determine whether the short and medium term outcomes have been achieved for the AHTF program.

2.2 DESIGN

The actual detailed evaluation design was developed by the consultant in cooperation with the Tripartite Committee based on the national AHTF Logic Model.

OUTCOMES	INDICATORS	MEASUREMENTS	RESEARCH QUESTIONS
LONG-TERM			
1. Improved health programs & services for First Nations & Inuit	Long-term outcomes are much more difficult to assess because there are many factors that could influence them beyond the program itself.	Long-term outcomes are usually assessed long after a program ends.	Not to be assessed in the short term.
2. Improved access to quality health programs & services by First Nations & Inuit			Not to be assessed in the short-term.

OUTCOMES	INDICATORS	MEASUREMENTS	RESEARCH QUESTIONS
INTERMEDIATE			
1. Improved adaptation of provincial health systems, programs & services to the needs of First Nations & Inuit	▪ # and % of projects that demonstrate improved adaptation ▪ Level and extent of the adaptation ▪ # and % of successful adaptations ▪ % of sustainable adaptations	▪ Roll-up of Key Informant questionnaires and on-site visits, etc ▪ Cluster evaluations by videoconference or meetings	What results have been achieved, expected and unexpected, positive and negative? What were the reasons why some things worked well and others didn't? To what extent are gender equality considerations fully integrated in project design and implementation and reflected in the results? To what extent are cultural considerations fully integrated in project design and implementation and reflected in the results? What lessons can be drawn from the program experience, including those that may be applicable to future programming? How do you think that an improvement in access to services will favour the continuum of services for First Nations and Inuit? How do you think that the adaptation of existing services will favour the continuum of health services for First Nations and Inuit? Has there been an improved access to health services?
2. Improved integration of federal & provincial health systems, programs & services for First Nations & Inuit	▪ # and % of projects that demonstrate improved integration ▪ Level and extent to which systems, programs and services have been integrated ▪ # and % of successful integration activities as perceived by the partners ▪ % of integration initiatives that are sustainable ▪ % of clients who have increased access to services.	▪ Roll-up of Key Informant questionnaires and on-site visits, etc ▪ Cluster evaluations by videoconference or meetings	

OUTCOMES	INDICATORS	MEASUREMENTS	RESEARCH QUESTIONS
IMMEDIATE			
1. Increased capacity for integrating or for adapting	▪ # of identified capacity gaps that have been filled due to AHTF activities ▪ Depth and quality of the capacity development activities towards integration or adaptation ▪ Extent to which capacity developments are likely to be sustained.	· File and Document Review · Key Informant questionnaires · Site Visits	To what extent has the AHTF increased the capacity of First Nations and Inuit communities and organizations to develop vision, strategies and leadership to address jurisdictional issues? Has institutional capacity been developed at the individual, organizational and systems levels, and if so, is it adequate to ensure that local, provincial, federal institutions/ organizations will take over and sustain the benefits envisaged? What is the likelihood that program benefits will continue after its completion without over-burdening local organizations and partners? What is the extent of the adaptation and access to the services / programs?

OUTCOMES	INDICATORS	MEASUREMENTS	RESEARCH QUESTIONS
2. Increased Awareness of concepts, barriers and enablers to integrating or adapting	▪ # of projects that contribute to increased awareness of the concepts, barriers & enablers to adaptation & integration ▪ Extent to which partners perceive that their awareness has been increased in relation the concepts, barriers & enablers to adaptation & integration	▪ File and Document Review ▪ Key Informant Questionnaires ▪ Site Visits	What have been the key challenges, constraints, enablers and barriers facing integration and adaptation projects? Has the level of awareness of the partners of the challenges, constraints, enablers and barriers increased as a result of these projects? To what extent? Has there been an increased understanding by the partners of the respective health systems and the roles and responsibilities of those within? Has there been improved understanding of the health care access issues, health disparities and social/ cultural considerations for First Nations and Inuit?

OUTCOMES	INDICATORS	MEASUREMENTS	RESEARCH QUESTIONS
3. Increased Participation in the design, delivery and evaluation of services	▪ # of First Nations, Inuit who participate directly in AHTF-funded activities in relation to the design, delivery, management & evaluation of initiatives to improve the integration & adaptation ▪ % of AHTF partners who perceive that participation has improved ▪ Quality and depth of the participation as perceived by the partners.	▪ File and Document Review ▪ Key Informant questionnaires ▪ Site visits	What has been the level of First Nations and Inuit involvement throughout the entire process? Has the level of participation of First Nations and Inuit in the design, delivery, management and evaluation of initiatives to improve integration and adaptation increased? Is there evidence of the incorporation of on-going First Nations and Inuit participation in provincial health planning and delivery processes?

OUTCOMES	INDICATORS	MEASUREMENTS	RESEARCH QUESTIONS
4. Increased collaboration & strengthened partnerships	▪ # of projects that demonstrate increased collaboration & strengthened partnerships ▪ Perception of partners on the quality of collaboration ▪ Quality of communication as perceived by partners & affected parties	▪ File and Document Review ▪ Key Informant Interviews ▪ Site visits	How strong and effective are the project partnerships? The partnerships with the governmental authorities? Is there shared responsibility and accountability for program results by all partners? How effective is the communication, coordination and cooperation among the program partners? To what extent has the AHTF allowed sufficient time to build the relationships that lead to the adaptation and integration of programs and services over the longer term? To what extent do local program partners and beneficiaries participate in the program and "own" the program's results? Is there evidence to support a new culture of collaboration between the two health systems? Are there explicit commitments to collaborative work in First Nations and Inuit health?

OUTCOMES	INDICATORS	MEASUREMENTS	RESEARCH QUESTIONS
OUTPUTS			
Minutes of Adaptation and Integration Committee meetings; kits or guides, project proposals; plans; signed contribution agreements; progress reports; financial reports; monitoring & evaluation reports; applied research	▪ # and types of outputs described through project reports.	File and Document Review	What are some of the protocols, MOU's, agreements, tools that have been developed as a result of the AHTF projects within the region?
ACTIVITIES			
Communication & collaboration with partners, meetings, preparation of documents, protocols, workshops	▪ # or % of project reports that indicate collaborative activities with partners through meetings or other actions.	File and Document Review	What are some of the collaborative activities that have been undertaken as a result of the AHTF?

2.3 ACTIVITIES

The activities undertaken in the evaluation included:

1. Review of the existing literature and documentation relevant to the projects;
2. Creation of an evaluation framework based on the AHTF Logic Model;
3. Development of questionnaires for on-site and telephone interviews;
4. Development of a consent form for interviews;
5. Emailing and faxing out the questionnaires, consent forms and covering letters;
6. Scheduling and conducting interviews by way of telephone;
7. Scheduling and holding on-site visits among the project holders;
8. Compiling and analyze the information received;
9. Making a list of the accomplishments achieved in the framework of all of the AHTF projects in accordance with various themes;
10. Drafting a preliminary report for validation by the tripartite committee;
11. Drafting a final report including a list of recommendations and a list of accomplishments achieved in the framework of the projects: agreements, protocols, publications, tools, etc.;
12. Preparation of a PowerPoint presentation on the results of the 2nd phase of the evaluation.

Nutashquan Health and Social Services Center

Nutashquan Health and Social Services Center

Code for Delivery of Services to Clients at the Nutashquan Health and Social Services Center

Nutashquan Health and Social Services Center (AHTF Coordinator, Alice Kaltush and Annette Malec, Director of Health and Social Services)

Nutashquan Health and Social Services Center (AHTF Coordinator, Alice Kaltush, Annette Malec, Director of Health and Social Services and evaluator, Linda Simon)

Hospital in Havre-Saint-Pierre (partner in AHTF Projects for Nutashquan and Ekuanitshit)

Cree Community of Mistissini (AHTF Project Committee)

Group picture of all partners for Innu Regional AHTF Project for signing of Protocol Agreement

Meeting in Quebec for Innu Regional AHTF Project for North Shore

Val-d'Or Native Friendship Center

Presentation of AHTF Project MCH Activities at Community Fair in Kanesatake

Regional Meeting In March for all AHTF Projects

2.4 RESULTS

The following table indicates the number of persons (71) and projects (31) interviewed during the course of the evaluation.

Project Holder	# Projects	Type of Interview	Project	Partners
FNQLHSSC	9 projects	In-person interview	7	0
Kahnawake	1 project	In-person interview	2	0
Kanesatake	2 projects	In-person interview	3	6
Gesgapegiag	2 projects	On-site visit	2	4
CBHSSJB	1 project	On-site visit	8	0
Val-d'Or CAA	1 project	On-site visit	6	2
Natashquan	2 projects	On-site visit	2	0
Uashat mak Mani-Utenam La Romaine Natashquan Mingan Pessamit	2 regional projects and 2 local projects	On-site visit	9	8
Nunavik	2 projects	Telephone interview	2	0
Betsiamites	2 projects	Telephone Interview	1	0
Wendake	1 project	Telephone interview	2	0
Listuguj	1 project	Telephone interview	1	2
Mashteuiatsh	1 project	Telephone interview	2	0
Manawan	1 project	Self-Completed questionnaire	1	0
ANPSS	1 project	Telephone information	1	0
Totals	**31 projects**		**49**	**22**
			71 persons	

Five project holders were not able to participate in the evaluation due to lack of availability, change of directors, renovations or other external factors.

1. Eagle Village Kipawa, 1 project
2. Odanak, 1 project
3. Essipit, 1 project
4. Wapan, 1 project
5. Winneway, 1 project

2.5 CHALLENGES

Some of the challenges in conducting this evaluation were:

- The number of requests (emails and telephone) that were required in order to secure an interview or on site visit, as everyone was so busy.
- Time available to the project partners and collaborators to respond to the evaluation questions whether by survey or interview, especially if they had not hired a resource as a project coordinator.
- Receiving the consent forms back from all of the participants in a timely manner.
- The flexibility required in the interview tool to reflect the differences in project size and scope among the First Nations and Inuit communities and organizations in the Quebec region.
- Trying to establish contact with all of the project partners and collaborators for the interview process
- Confusion between each project's own evaluation, the previous phase one evaluation, and this summative regional evaluation
- The burden of frequent reporting caused many project holders to pass over questions on the reports that may have given valuable information on the evolution of their projects
- Working with the diversity of culture and language within the Quebec Region, the regional differences in the province, and the remoteness of some communities.

3. FINDINGS

3.1 PROJECTS

The following table provides a resume of all of the AHTF projects in the Quebec Region by theme, including the types of projects, those responsible for the project and funding received.

Themes	Type of Projects	Title of Project	Responsible	Funding
Mental Wellness	Adaptation	Improve access to mental health services for First Nations.	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$115,555
	Integration	Developing a framework for mental health services for First Nations communities of Quebec.	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$338,470
	Integration	Establishing a transitional service organization to improve continuity of and accessibility to mental health services for members of the community of Mashteuiatsh.	Mashteuiatsh (Lac-St-Jean Montagnais' Council)	$351, 855
	Integration	Developing a model of mental health intervention adapted to the Inuit communities and, more specifically, for young people.	Nunavik Board of Health and Social Services	$1,898,876

Themes	Type of Projects	Title of Project	Responsible	Funding
Pandemic	Adaptation	Support Quebec's non-agreement First Nations communities on pandemic influenza.	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$264,600
	Integration	Continue the work already begun on the pandemic at regional level and support communities in implementing their community pandemic influenza plans.	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$130,680
	Integration	Implementing the community influenza pandemic plan internally while continuing a relationship of sharing and cooperation with the CSSS du Haut-Saint-Maurice.	Wapan Rehabilitation Centre	$48,950
Drug and Alcohol	Integration	Improving the integration of detoxification services between the provincial health care system and the health centres in Gesgapegiag and Listuguj.	Gesgapegiag Health and Community Services	$449,318
	Adaptation	Adapt detoxification services to the needs of First Nations.	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$116,710
	Integration	Improving the continuum of services between NNADAP and the treatment centres through the integration of an after-care component.	Long Point (Winneway Nursing Station)	$50,000
	Pan-Canadian	Healthy Living in Schools & Substance Abuse Among Youth	Nunavik Board of Health and Social Services	$1,335,727

Themes	Type of Projects	Title of Project	Responsible	Funding
Cultural Training and adapted training	Adaptation	Algonquin cultural sensitivity training for Centre de santé et de services Sociaux (CSSS) de l'Abitibi-Temiscamingue.	Algonquin Nation Programs & Services Secretariat (ANPSS)	$112,281
	Adaptation	Adapt the Quebec National Training Program and offer it to the Quebec's non-agreement First Nations communities' managers and health and social services workers	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$262,487
	Adaptation	Developing a training and cultural awareness tool for staff of the North Shore region health care system.	Uashat mak Mani-Utenam Health and Social Services	$502,161

Themes	Type of Projects	Title of Project	Responsible	Funding
Protocols and Agreements	Adaptation	Development of cooperation agreements between the CSSS de la Minganie and Ekuanitshit (Mingan) Innu Nation	Ekuanitshit Health Centre (Mingan)	$151,340
	Adaptation	Create an awareness and understanding of Kanesatake health programs and cultural practices in order to improve liaison services with the hospital and to create new service linkages through the development of service protocols for pre-hospital, hospital, and post-hospital services.	Kanesatake Health Center Inc.	$250,000
	Integration	Sign protocols for cooperation and memoranda of understanding for the establishment of a permanent regional structure to ensure a legal framework for nursing practice and supervision of nurses working in First Nations communities of Quebec	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$114,950
	Integration	Development of health services agreements between Côte-Nord Innu Health Services and the ASSS de la Côte-Nord, to provide a continuum of health services adapted to Innu populations.	Uashat mak Mani-Utenam Health and Social Services	$461,125

Themes	Type of Projects	Title of Project	Responsible	Funding
Adaptation of existing services	Adaptation	Clinical project to adapt the services of the CSSS du Nord-de-Lanaudière to the needs of the Manawan Atikamekw community.	Manawan (Health Services Directorate of the Manawan Atikamekws Council)	$87,803
	Adaptation	Developing a local service adaptation and complementary clinical model for health services between the CSSS de la Vallée-de-l'Or and the VDNFC	Val-d'Or Native Friendship Center (VDNFC)	$534,308
	Adaptation	Adapting the principles of the population approach and service hierarchy to the Nunavik context, and adapting current health care and social services to Nunavimmiut to Inuit values, culture and traditions.	Nunavik Board of Health and Social Services	$1,212,670
	Adaptation	Developing a plan for adapting services and harmonization of collaboration protocols for Nutashkuan.	Nutashkuan (Tshukuminu Kanani Health and Social Services Center)	$171,600
	Adaptation	Adaptation of existing services through the Pessamit integrated care project.	Pessamit Health and Social Services Center	$160,000
	Integration	Quality health care services for Innu of Nutashkuan.	Nutashkuan (Tshkuminu Kanami Health and Social Services Centre)	$279,790

Themes	Type of Projects	Title of Project	Responsible	Funding
Continuum of Services	Adaptation	Adaptation Project to ensure continuity of services with the Agence de la santé et des services sociaux (ASSS) de la Gaspésie.	Gesgapegiag Health and Social Services	$214,968
	Integration	Improvement of the continuum of health services for the members of Eagle Village First Nation through the development of a partnership with the CSSS de Témiscamingue-et-de-Kipawa, in the areas of homecare, palliative care, medical visits and communicating information, among others.	Eagle Village First Nation Health Services (Kipawa)	$175,285
	Integration	Integrate the work and programs being developed at the Ekuanitshit Health Centre with the programs offered by federal and provincial governments.	Ekuanitshit Health Centre (Mingan)	$183,433
	Integration	Integration and implementation of services to the population between the Essipit Health Center and the CSSS de la Haute-Côte-Nord.	Essipit Health Centre	$59,950
	Integration	Development of an integration plan between Onkwata'kari tahtshera and federal and provincial authorities.	Kahnawake Shakotiia'takehnhas Community Services	$412,113
	Integration	Assess, enhance and create new service linkages for the elderly and young children who are the clientele most at-risk in terms of health services in Kanesatake.	Kanesatake Health Center Inc.	$360,000

Themes	Type of Projects	Title of Project	Responsible	Funding
Continuum of Services (continued)	Integration	Improving access to health care services: Listuguj (Quebec and New Brunswick) collaborative policy development and a new referral process.	Listuguj Community Health Directorate	$45,600
	Integration	Integration and implementation of services to the population by the Odanak Health Centre and the CSSS de Bécancour-Nicolet-Yamaska.	Odanak Health Center	$54,890
	Integration	Consolidation of primary health care services offered to the community by the Pessamit health and social services centre and those offered by the CSSS de Manicouagan, and development of a service delivery protocol for housing services in Pessamit	Pessamit Health and Social Services Centre	$130,031
Diabetes	Adaptation	Adaptation of existing diabetes services based on the needs of La Romaine community.	La Romaine (Unamen Shipu Health Centre)	$149,765
Health Data	Integration	Provide the Health, Leisure and Social Services Directorate of the Council of the Huron-Wendat Nation with a computerized data management system that meets their needs and that is integrated within the Quebec health and social services network	Wendake (Huron-Wendat Council)	$512,820
Telehealth	Integration	Integration of First Nations and the province of Quebec in the area of telehealth.	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$227,320
Early Childhood At Risk Families	Integration	Integrated prenatal and early childhood services for at-risk families.	James Bay Cree Health and Social Services Board	$477,955

Themes	Type of Projects	Title of Project	Responsible	Funding
Border Issues	Pan-Canadian	Cross border issues research project	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$167,299
Liaison and Coordination Activities	Pan-Canadian	Liaison and Coordination Activities for 2007-2008, 2008-2009, 2009-2010	First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)	$480,944

3.2 CAPACITY

3.2.1 CAPACITY BUILDING

For the majority of the First Nations communities in Quebec, the entire project involved capacity building. This included getting to know and understand the hierarchy and structures within the Quebec provincial system network, working to establish contact persons for their projects and putting faces to names and places. It enabled, for example, Kahnawake and their partners to understand and address language barriers created by the impact of Quebec legislation and hospital policies regarding corridors of service.

Building capacity was true as well for the provincial partners, many of which were not aware of the structures, resources and culture of their First Nations and Inuit partners. In the case of some projects, for example the Nunavik Clinical project, the Algonquin Nation Programs and Services Secretariat, the Gesgapegiag Health and Community Services, and the Natashquan and Mingan projects, the learning curve was greater for the provincial and regional partners. Most of the provincial partners had not had a lot of contact with First Nations communities or their services, and there were a lot of misconceptions. The project served to address these misconceptions and to increase understanding of cultural differences and values towards client services.

Some projects required bringing together community organizations as partners as well as the province. Communities such as Mashteuiatsh and Listuguj mentioned that services were working in silos, and the project allowed for the development of intersectorial tables. In the case of Nunavik, the project involved bringing together 30 organizations that provide services to the 14 Inuit communities. For the Regional Cote-Nord Innu project, it meant bringing together Innu communities over a distance in excess of a thousand kilometers.

The gaps in capacity that the AHTF projects worked to address included:

- Finding a common ground on which to open a dialogue
- Increased collaboration with provincial partners
- Creating awareness and understanding of cultural differences
- Increased networking with community services
- Provision of a more integrated approach to health and social services
- Ways to address language barriers
- Enhancing existing services
- Improving “fractured communication”
- To improve existing partnerships and planning cycles
- Developing an understanding of cultural differences and approaches to health care
- Addressing jurisdictional issues
- Comparison of services available and needs

- Be able to know and access second line services on referral
- Providing information on community health and social programs and services
- Understanding the provincial structures, where to go for services and what are the responsibilities of each partner
- Knowing where and to whom to make client referrals
- Increasing service efficiency and effectiveness by working together
- Creating an continuum of services for clients
- Developing a working agreement
- Increasing the capacity of interveners
- Creating a structured and informed interface between community and provincial services
- Sharing corporate memory with partners, other community services and with junior management
- Eliminating the repetition of data collection between services due to lack of centralized health and social data
- Addressing a lack of residential services in isolated communities
- Close the gap between first line and second line services
- Adapting the contents of training programs and manuals to the needs of First Nations
- Creating links with the workers in provincial services to augment the capacities of the workers in the communities
- Addressing basic differences with the province in the definition of what services are and what they entail.

3.2.2 ACTIVITIES

For the most part, the capacity building activities undertaken by the projects were exchanges of information and cultural training. These were done through workshops or mini-conferences, contact with the management of the provincial agencies, meetings between project partners, interviews, gaps assessment interviews, creation of joint committees, creation of information binders, development of working groups and project teams, establishment of on-line training sites, clinical meetings, community meetings, and sharing activities such as in-service training. There were a lot of exchanges on both sides.

Most of the communities reported that these were beneficial towards building the partnership and continuum of services; however, one community recounted that in the field of mental health, there was still a lack of confidence in community services and distrust in the qualifications of community workers that meant the duplication of assessments, and limited access to consultations with specialists.

With the regional FNQLHSSC projects, activities included an evaluation session with project partners for a validation of research done on Mental Health issues for First Nations. A Mental Health Directory on the provincial network was prepared according to the various regions in which we find First Nations communities, as well as a document for governments to understand the realities of First Nations and what structures are available. Four modules of the provincial training for health and social services managers and workers were adapted for First Nations.

While the Innu Regional Project developed a Protocol to work together at the regional level, the Gesgapegiag and Listuguj project established a formal referral process locally for external services in the area of addictions and mental health services, and had more than 240 persons attend cultural awareness workshops. Addictions workers from this project have been able to hold a videoconference meeting with Dr. Gabor Maté from Vancouver, a renowned medical doctor working in the field of addictions.

Wendake worked in collaboration with the ASSS de-la-Capital-Nationale to develop a model for a data management information system that will facilitate data collection, and allow the Health Center Clinics to be connected to the provincial network. Natashquan, Mingan and Pessamit were able to build upon existing partnerships with the hospital in Havre St-Pierre and Baie-Comeau, and with the ASSS de la Cote-Nord to make cultural adaptations to the way that their clients are received. Manawan worked with the CSSS du Nord de Lanaudière to adapt programs to meet the cultural needs of their community.

The Native Friendship Center in Val D'Or created a partnership with the CSSS de-la-Vallée-de-l' Or and the Centre Jeunesse de l'Abitibi-Temiscamingue to develop a model for maternal child clinical services (Minowé Clinic) that would be part of the Center's regular client services yet integrated within the Vallé-de-l'Or health and social services network as an aboriginal resource.

Kahnawake held a conference to create awareness and provide a cultural and historical background to their community and in particular their relationship to the province in the areas of health and social services. This conference also provided them with an opportunity to pass on their corporate knowledge to junior staffers in the services in Kahnawake.

In addition to a gaps assessment, Kanesatake, working with both the ASSS des Laurentides and the CSSS des Deux-Montagnes, has developed an on-line cultural training, provided training for a multi-disciplinary collaborative approach, provided a binder of information for the hospital and is working towards accreditation under the WHO Baby Friendly initiative.

The Algonquin Nation Programs and Services Secretariat have provided cultural training to more than 350 health and social services workers in the region of Abitibi-Témiscamingue. In Nunavik they worked on a "new approach" to place Inuit leaders and Elders on oversight committees and boards in an effort to increase the participation of Inuit in future health and social services planning and service delivery.

3.2.3 INSTITUTIONAL CAPACITY

Many of the projects indicated that it is too early to tell if institutional capacity has developed to such a level that the partners can take over. Most were comfortable to say that local institutional capacity has increased, but did not feel that this was true of the system.

For the Inuit projects, it was stated that there are limited resources in the north, and most of the persons implicated in the project are also working in other capacities in their own villages or organizations. Often they were divided between their own crises, and making the changes that will eventually reduce these crises.

There were similar situations for those First Nations communities who did not hire external resources, but added the responsibilities of the AHTF projects to their own staff. However, although this overextended existing staff, the capacity developed through the project stayed within the community.

3.2.4 SUSTAINABILITY

Continued sustainability for many projects is dependent on finding other sources of funding as is the case for the project in Mistissini, and for the Clinic Minowé in Val D'Or. Many projects answered that if they had more time, they could bring the projects forward to another level that would assure their sustainability. Although many projects hope to continue on their own, there was a general feeling that the projects would not have the same force as they did under the AHTF. Additionally, there was not always an assurance that the province would or could continue to participate.

Kanesatake was able to have its partners sign new terms of reference to meet twice a year over the next ten years. In addition, this community put its cultural training on-line with links from its website, as well as integrating it into an orientation package for new employees. This will allow individuals to access the training long after the project is finished, and ensure sustainability. The ANPSS has refined their training, and secured a trainer so that the training can be delivered on a contractual basis long after the project is finished.

Respondents from the FNQLHSSC said that capacity building was the main reason for which all of the projects were developed. They stated that having completed a training model, the assessment of First Nations mental health structures, a directory of provincial services, the work on the Pandemic, and research on the clinical supervision of Nurses, they are more knowledgeable and have better tools going forward.

The Innu communities of the Cote-Nord project feel that the signed Protocol for Services will provide sustainability after the AHTF project is finished. It will provide the impetus for the partners to continue to discuss and exchange after the project is complete.

Some communities stated that the work will only be sustainable if there are mechanisms put in place to formalize the relationships such as signed protocols or terms of reference or working agreements.

3.2.4 IMPROVED ACCESS

Many communities stated that they no longer feel isolated and that they are able to collaborate with their provincial partners to work towards improving access and creating a continuum of services. In regards to whether or not there is improved access; most felt it is too early to tell. Communities stated that although their projects were to ensure that they have access to services that are needed in the long-term for their populations, there is still a need to develop the mechanisms and actions to make it work.

For Gesgapegiag and Listuguj, the project has had a significant effect on improving access to services. Before the project began, the CSSS de la Baie des Chaleurs, Centre L' Escale, and Restigouche Addictions Services were under the impression that CLSC-type services did not have to be offered to First Nations people as they believed similar services existed in the communities. Now, following the AHTF meetings, members from the communities are freely using the services offered by local CLSC's including services for addictions.

For another community, the project has increased and improved access and the integration of mental health services within the community, but the desired changes at the hospital with second line services has not happened.

For Kahnawake, the project enabled the community to build on its singular relationship with the province, and to negotiate a different corridor of service for its clients based on the distinctive status of its hospital.

3.2.5 ADAPTATION OF SERVICES

The Friendship Center in Val D'Or felt that it had been very successful in having services adapted to the needs of its clients by having the provincial network agree to provide services outside of its walls.

Most communities believe that there is a lot more to do to adapt services to the needs of First Nations communities. One of the communities mentioned that they do not believe that the word "adaptation" is suitable because it infers that something has to be diluted or altered. This concept is incorrect because First Nations and Inuit have a right to fully access all health and social services; the communities simply wish to have this done in a manner that is culturally appropriate.

Another community stated that there were not sure if "adapting" services was going to address the lack of confidence by community members in outside services, particularly in mental health and addictions. It is felt that First Nations mental health issues are so different, and not easily addressed by western therapies. Adaptation has its limits because we do not have the same history of oppression and colonization. First Nations want to go to a First Nations person because they understand them and their situation. They use a holistic approach, communication and empathy is there, and the ceremonies are available for those who are traditional.

3.3 AWARENESS

3.3.1 CHALLENGES AND CONSTRAINTS

It was very difficult at the beginning to understand what the AHTF projects were, and even the regional and national offices provided different information. There was a lack of communication on the provincial side about the project, and it was often left to the communities to try and communicate the information to their partners.

The biggest challenge stated by the respondents were the delays in starting the project in the Quebec region due to lack of understanding, waiting for documents to be translated, deciding who would manage the Adaptation funds, changing criteria for applications, having to create a proposal to request the funding to create a proposal, and the regional-national approval process. The communities all said that the delays took far too much time away from the projects.

This shortened time frame created difficulties for the projects, as an example the FNQLHSSC who had changes in project costs and work plan because of the delay in starting.

Even with the extension of one year, most communities had an average of 18 months of funding even though the initiative was originally planned over five years. Some had even less time because of waiting for approval, or start-up difficulties such as finding a project manager or a nursing consultant.

The communities mentioned that they had to spend a lot of time in learning about each other. Many stated that they had to overcome the barriers created by the false information and stereotypes that the education system has provided. There were difficulties in the beginning because the communities were not known, and the provincial organizations did not understand the projects or the realities of the communities.

For some more isolated areas, just organizing meetings was difficult due to distance. In these regions, the territory of the provincial organizations CSSS, ASSS or Centre Jeunesse extends quite far, usually across three communities or more. This meant that there could be three times or more meetings for the same persons from the CSSS for each individual community AHTF project. Some communities had to group to overcome this difficulty.

The availability of persons was a barrier as was trying to harmonize schedules. The changeover in staffing, particularly the directors, within the provincial organizations for a number of projects meant starting over or losing the continuity of the project. Sometimes these positions remained vacant for 3 or 4 months.

Another difficulty was the announced budget cuts to health institutions in Quebec which directly affected the ASSS and CSSS partners. The result was that the scope of many projects was affected due to the limitations of their partners. For example, the Algonquin Nation Programs and Services Secretariat Cultural Training which did not receive the number of participants as originally planned due to these budget cuts.

Kahnawake had secured a Memorandum of Understanding on their working relationship with the CSSS Montérégie, and a letter of agreement with the Director of the Montérégie that all correspondence would be in English. When the Director left, no one knew about these documents. It took about 8 months to get direct contact with the new director. They suggested that transition planning should be mandatory.

The willingness of all persons in the projects was a big enabler, but it was said that the systems they operate are the biggest challenge. A few mentioned that hiring a separate project manager kept the work focused and moving forward.

Some communities stated that it took a lot of time to create the partnerships through sharing information, creating awareness, and dispelling misconceptions. For some there were jurisdictional issues, they were invited by the CSSS to sit on committees as a “community organization” but they were not seen as a separate jurisdiction.

One community said that they had great difficulty with the hierarchy of the provincial structures; as example, one ‘Director’ would only speak to another “director” and not to a “responsable” like the AHTF Project Coordinator. Another said the difficulty was in getting all of the personnel implicated in the file together for a meeting due to their work schedules.

For the anglophone communities, working with partners from the province meant facing language barriers. This sometimes meant doubling the work by translating documents and materials. For Nunavik, the biggest obstacle at the beginning was the distrust between the Health Board and its partners but this was eventually overcome.

While one community mentioned that the lack of a formal data exchange to gather statistics was a barrier to the work of their project; Wendake faced many technological barriers in trying to address this need with a system that would meet the needs of their health and social services system.

For the Commission, they sometimes had to wait for the province to come through with their side of the work which took a long time because of all the other files they work with. In addition, when working on a joint project, a consultation with the communities could not take place because the province had not completed their own approvals prior to implementation, and due to provincial

regulations regarding confidentiality, the work could not be shared with the communities. The Commission had to conduct their own consultation with the nurses.

Many project-holders mentioned the burden of the repetitive reporting required by the AHTF as a challenge among all of the other responsibilities that the communities have for all of the other programs. The amount of reporting could be lessened, as well as the repetition of the same questions in different reports.

On the other hand, the more isolated Innu communities stated that the progression of the AHTF projects was easier because they and the province were in the same boat, as there were fewer services available in that part of the province, and pooling resources and efforts benefited everyone. The hospital in the area had a large number of its clients from the Innu communities of Natashquan and Mingan, and also for Pessamit. This was an enabling factor as well as the fact that the three communities had already established a working relationship with the provincial partners prior to the AHTF project.

A few communities also indicated that an enabling factor for their projects was being able to get directly to the "direction" in each CSSS. A good example was the Algonquin Nation Programs and Services Secretariat which was able to meet and get approval from the Directors of the CSSS Lac-Témiscamingue, CSSS Les Eskers de l'Abitibi, and the CSSS de-la-Vallée-D'Or as well as the ASSS de l'Abitibi-Témiscamingue. This approval translated into 12 scheduled training sessions and over 350 participants from health and social services sectors and their partners.

Others also stated that a project enabler was having a key person officially designated to the project from the provincial partner, someone who could make decisions.

3.3.2 LEVEL OF AWARENESS

A majority of the projects, even those with negative experiences, agreed that the level of awareness of each of the partners had increased over the extent of the project. For many projects, the information sharing and education was extensive on both sides, but moving forward, both sides have a better understanding of each other.

Many agreed, however, that the awareness has been limited to those individuals implicated in the projects, and is not very often communicated further than that. Two or three of the respondents mentioned that it is necessary to start training successors as well as persons in positions so that awareness and understanding will grow and continue forward, and everyone will not have to start over when the resources leave.

The awareness and knowledge-sharing has resulted in some changes but these are not system-wide. Some CSSS have been very receptive and others have only made token changes because First Nations do not represent a major portion of their clients, and there are limitations to what can be done within the larger system over a short period of time.

3.3.3 IMPROVED UNDERSTANDING

The communities who undertook cultural training sessions, in particular, indicated that there had been an increased awareness of the impact of residential schooling on health and social issues, and discussion on health disparities. However, the training needs to be continued.

One community mentioned that there was an improved understanding of the difficulties of access and health disparities for First Nations and Inuit, but that this was an indirect result of the project, and not an objective.

For the communities themselves, there was an improved understanding of provincial structures, corridors of service, and the various hierarchies and modes of operation within the institutions. For the Kahnawake project, there was an improved understanding of the grey areas that exist between provincial and federal jurisdictions.

3.3.4 INTEGRATION OF CULTURAL AND GENDER CONSIDERATIONS

Cultural considerations were incorporated in most of the projects with the possible exception of the health data management project in Wendake which focused on the application of technology to fill a need.

However, gender considerations were not incorporated. Most communities do not consider differences for male and female in their planning. This concept seems not to be appropriate culturally; approaches are holistic in nature, distinctions may be made in the roles of males and females, but each role is equally valued. There are no divisions in traditional concepts, and no biases. It was felt in many cases that this was potentially an issue that had been brought in by the larger society with a different value base.

In Natashquan, for example, the charter of client rights for health and social services requires that all activities be opened to all community members without distinction for males or females, youth or elders, parents or children.

3.4 PARTICIPATION

3.4.1 INCLUSION IN PLANNING

Some communities were invited to participate on health planning committees. Some were invited to work on five-year strategic plans for the CSSS. Two or three communities are fortunate to have a seat on the Conseil Administrative of their local CSSS. The community of Manawan is on the mailing list for communications from the CSSS Nord-Lanaudière and from the ASSS des Laurentides, and other communities stated they receive information on training.

The majority of communities did participate in regional meetings for the AHTF, and in the regional evaluation; however, as mentioned in Phase 1 of the evaluation, the communities did not have any input in the design or implementation of the AHTF projects, with an unfortunate result in Quebec.

At the national level, the Quebec region is represented by the Health and Social Services Commission, but one community stated that it would be helpful to have additional representation from communities who are really involved at the grassroots level. The commission has stated that it meets regularly with community representatives in various programs.

3.4.2 FUTURE COMMITMENTS

In the future, health establishments in Quebec will be required to include their partners in their evaluation and planning. A few communities stated that there are commitments between the partners for communication and for future training. The Innu Cote Nord Regional Project respondents stated that the AHTF project allowed the partners to get together and to open their doors to each other for future development.

3.5 COLLABORATION AND PARTNERSHIPS

3.5.1 CHALLENGES

Some challenges that were identified by the respondents included:

- The terminology of the work, as communities and the provincial institutions do not refer to services and processes in the same way.
- The availability of persons working for the province and their schedules
- A lack of respect for established dates for meetings by partners who had to give priority to their own work commitments
- Harmonization with services and finding ways to link together
- Provincial regulations and the rules of the game in health services
- Language and geography were challenges
- Sense of competition and fear from some partners who did not understand what the project was about
- Over-participation on committees by same individuals
- Building partnerships, it took a lot of time to get certain partners implicated in the project
- Changeover in staff, one major event for one project was delayed by five months because of a retirement of a provincial partner with no transfer of information forward
- Not having a communication plan as part of the project

- Having to account separately for carry-forward funding and for the regular funding
- Trying to get technical partner to understand needs and situation on the ground
- Spending so much time on laying the groundwork and not on rolling out the activities.

3.5.2 STRUCTURES IN PLACE

Steering Committees, working groups, joint work teams, intersectorial tables and committees were all cited as structures that were used by the AHTF projects to allow for exchange and development. Advisory committees, focus groups, partnership forums and regular conference calls were used to receive feedback and to launch ideas.

It was pointed out by some of the respondents that we have to put more and more responsibilities on our own human resources as we don't have the extra resources we need. There is a need to put in place conditions for success which includes having more resources for all of the additional programs and responsibilities.

3.5.3 EFFECTIVENESS OF PARTNERSHIPS

The partnerships allowed doors to open that had not been opened before. For many communities, the partnerships were considered to be informal, but links have been established with other partners in the provincial and other networks for example with: Maternal Child Telehealth, Baby Friendly, etc.

One community said they now have a stronger working relationship with Health Canada, and with the province. Wendake stated that they had a very good working relationship with the ASSS de-la-Capital-Nationale who was interested, collaborated and provided support for their project.

The Friendship Center in Val D'Or said that working through the process helped them to test certain things and to see how the relationship would work in the long-term. Another mentioned that the project's joint work teams, with participation from the province, shared responsibilities and researched information to bring back to the team.
At the regional level, the Commission created openings for First Nations and improved relationships with the governmental agencies such as the MSSS (Health and Social Services) and the DGSP (Public Health).

However one community felt that their partnership was not effective because they did not achieve the working agreement that had been the goal of the project in the first place.

Overall, the communities all stated that it is too early to say if the partnerships that were created have resulted in improved access to health services for First Nations. The communities have only just begun to make links with the province, and it will take time to see the results.

3.5.4 SHARED RESPONSIBILITIES

The responsibility and control of the AHTF projects remained with communities and First Nations and Inuit organizations. The project partners shared some responsibilities, depending on the project, but the final accountability and ownership remained with the project holders, the First Nations and Inuit communities and their organizations.

3.5.5 COMMUNICATION AND COORDINATION

Most stated that the communication was good but with the turnover in provincial resources, communication was sometimes delayed. Having a project manager facilitated the communication and coordination of the projects. The Commission stated that the communication with the MSSS was very good and much improved.

A few of the projects such as the ANPSS Cultural Training and the Native Friendship Center of Val D'Or Minowé Clinic used a press conference with the media to officially launch their projects which proved to be very successful.

3.5.6 FUTURE COLLABORATIVE WORK

There have been verbal or informal commitments made by partners but many communities wanted to see written agreements or protocols to work together such as the regional protocol developed by the Innu communities of Cote Nord and their partners.

The Native Friendship Center of Val D'Or now has a model for a Maternal Child Health Clinic that is exportable to other Native Friendship Centers and there is a lot of interest among this network of centers to collaborate on this.

3.5.7 LESSONS LEARNED

There were many lessons learned by the participants for the AHTF project, each is particular to their project, but a few are provided here. A few mentioned that the AHTF project re-emphasized the need for an electronic method for collecting data and generating statistics.

For Nunavik, the project was a circular and iterative process, not linear. It became very time-consuming and costly because it implicated everyone. For the future, there is need to rethink ways to reduce the level of involvement and work.

The FNQLHSSC felt that they gave too much information for the train-the-trainer workshop that was given over a period of two days. There were 350 pages of information that the participants were expected to absorb, and then they were expected to give the same training in their own communities.

The respondents from the FNQLHSSC also mentioned that they had learned that training should be done in the communities, rather than pulling representatives out, to increase the number of participants, and the long-term effectiveness of the training. For the ANPSS, they learned that groups of 40 participants are too large for cultural training, and that smaller groups provided for enriching exchanges between participants.

An unexpected benefit for Listuguj was that the referral process they developed through the project, forced their clients to take ownership for their health issues, and to take responsibilities themselves.

3.6 ACTIVITIES

3.6.1 ACTIVITIES NOT COMPLETED

Although most of the work that was planned was completed, in some cases, there were activities not done or which were modified due to situations that occurred:

- There were some activities in a few projects that were not done due to staff being overwhelmed with regular tasks.
- For the FNQLHSSC projects, the telehealth projects could not be integrated as there are no telehealth projects in Quebec.
- For Manawan, it was impossible to schedule face to face meetings with provincial partners for the work, as they had planned, so they exchanged the dialogue and materials necessary for the work to be done on adapting the programs.
- For Nunavik, there was to be a pilot project for Mental Health at the end, but it is impossible for this to happen as there was not enough time left to properly develop this part of the project.
- For Kanesatake, some activities were modified as the project evolved due to the short time frames and unforeseen delays due to language issues around translation.
- For Mashteuiatsh, the goal of the project, which was to have a written agreement, was not reached.
- For the FNQLHSSC, there is still training to be done for Detox in the communities but the nurses have so much else to do that it will take time for this training to be completed in all of the communities.
- A few communities mentioned that the way in which the activities were done changed as the project evolved but the objectives were met.

3.6.2 OUTSIDE FACTORS OR INFLUENCES

The FNQLHSSC stated that jurisdictional issues slowed down their projects. In addition, a lot of misunderstanding and confusion between Detox services and Treatment Services in the communities affected the results of the survey that was done in this area.

The Pandemic and other natural events such as flooding got in the way of many of the projects, but actually accelerated those projects working on the pandemic. Delays in the arrival of funding affected the length of time available to many projects as most communities could not start without a signed funding agreement. The delays meant there was not enough time to follow through as thoroughly with everything as was originally intended.

Project delays and set-backs were also associated with changes due to community elections, changes in Health Directors and a turnover of provincial representatives on steering committees or working groups. As mentioned before, the budget cutbacks to provincial health institutions limited the participation of the CSSS in many ways, which limited the scope of some of the projects.

Natashquan and Mingan had already established a prior working process with the local hospital and CSSS which put in place certain things which were difficult to get around when the Innu Regional Project for the AHTF started; but, eventually this work facilitated the evolution of the project because the working relationships were already there. The Innu Regional Project benefitted from the continuity of services and persons, always having the same people since the beginning.

The improvement of First Line Services had a positive impact on the Mental Health Project in Mashteuiatsh. In addition, some changes in the provincial organization allowed for an improvement in the working relationships.

The project in Kanesatake was impacted by the tension created by the various situations that arose in the community over the length of the project. On the other hand, the project in Nunavik benefited from the developmental activity and strategic planning that focused around the "Plan Nord" of Quebec Minister Jean Charest.

3.6.3 PROJECT LEGACIES

Some of the project legacies that were mentioned by the respondents included:

- Better understanding of the two systems of health and social services
- Open doors, open dialogue
- A model for an Aboriginal Maternal Child Clinic in an urban milieu
- Reference Manuals and Binders of Information
- Directories and Resource Manuals
- Training Manual
- Protocols
- Power-point presentations
- Cultural Training Programs
- On-line cultural training program
- Pilot project for implementing "Home Detox"
- Power sharing between Quebec Health Institutions and the Inuit of Nunavik
- Strategy and Work Plan for legalizing the work of the community nurses
- Definitions of roles and responsibilities of the persons in the provincial network
- Political awareness of how things can be done to address the issues that are faced by the Inuit of Nunavik
- Contract between jurisdictions for English Services (on referral)
- New program 'Awasiaw' in Manawan
- Information on the availability of Quebec 811 telephone referral services for health and social services
- Baby Friendly Policy
- Self-Help Guide for the Pandemic and Posters
- Placenta kit for the hospital
- Policies for Post-partum Care
- Increased engagement from the community
- Orientation Manual for Multi-Disciplinary Team
- New programs

- Contacts established in the provincial network
- Guide for Suicide Intervention
- Repertory of all the Detox services in Quebec
- Tools for the managers and supervisors to increase their competencies
- Adaptation of training for disaster and crises
- Research conducted on Mental Health issues for First Nations
- New Formal Referral Process for Mental Health and Addictions
- Mental Health Directory on provincial network
- Participation in activities with the Regie Regionale through the English language Access program
- Crisis Management Protocol
- Crisis Intervention Training

3.7 PARTNERS' COMMENTS

Although the individual members of the Tripartite Committee were not interviewed during the course of the evaluation, they were represented during the evaluation process. A representative of Health Canada did participate as a partner in the on-site regional meeting for the Cote-Nord, as well as a representative of the Agence de santé et services sociaux (ASSS) Cote-Nord, and representatives from three CSSS.

In the on-site meeting in Kanesatake, a representative of the ASSS des Laurentides participated as well as representatives from the CSSS Lac des Deux Montagnes. Other evaluation meetings had representation from their CSSS as well as other provincial agencies such as Centre Jeunesse, provincial addictions agencies, and the CLSC.

M. Carl Thibaudeau, AHTF Coordinator, as well as Mr. Richard Gray, Manager Social Sector, Ms. Sophie Picard, Manager Health Sector and other program coordinators from the CSSSPNQL, participated in the two evaluation meetings in Wendake. Mr. Thibaudeau also participated in four of the on-site evaluation visits.

There was general agreement from all of the partners that many difficulties were created, directly or indirectly, by the manner in which the project was rolled out (in Quebec). The changes to information created a lot of confusion on all sides, some partnerships were difficult to establish due to communication difficulties, resources were hard to find, and the amount of time needed for start-up limited the scope and results of many projects.

3.8 ADDED COMMENTS

Some of the evaluation participants provided additional comments to the questionnaires. They stated that any future initiatives should take into account the amount of time needed to develop the project, and to "walk with the community" during the process. Understanding the community dynamics does take time for outside resources and partners.

Long-term funding to see the projects through to the end, and become fully operational should have been looked at. There is a need for a 'continuation' of our projects to be able to move forward and take the project to the next level.

4. SUMMARY AND CONCLUSIONS

4.1 REGIONAL PROJECTS

4.1.1 INPUTS

The AHTF Quebec Region was overseen by a Tripartite Committee which included representation from the Quebec Ministry of Health and Social Services, Health Canada and the First Nations of Quebec and Labrador Health and Social Services Commission. There were a total of 36 projects funded in Quebec under the Aboriginal Health Transition Fund, as well as 15 developmental projects. The 36 funded projects comprised 14 adaptation projects, 21 integration projects and 1 pan-Canadian project in addition to liaison and coordination which was funded under the pan-Canadian envelope.

The project themes included: Mental Wellness, Drugs and Alcohol, Pandemic, Cultural Training, Protocols and Agreements, Continuum of Services, Adaptation (of existing service), Telehealth, Health Data Management, Border Issues, Diabetes, Early Childhood at Risk Families, and Liaison and Coordination.

Besides the funding received from Health Canada, the projects themselves provided in-kind contributions such as human resources, offices, staff support, etc or they contributed additional funding from other sources such as in the case of Wendake which covered costs above the project contribution.

4.1.2 ACTIVITIES

The main activities that were undertaken by these projects contributed to establishing partnerships, capacity building and information sharing including cultural training.

4.1.3 OUTPUTS

Some of the main outputs included: Training Manuals, Cultural Training Programs, On-line Training, Resource Guides, a model for an Aboriginal Clinic in an urban milieu, Reference Manuals, Binders of Information, Directories and Resource Manuals, Protocols and Working Agreements, Power-point presentations, a Pilot for “Home Detox”, newly adapted Health Programs, a Health Data Management Database, a Model for an Aboriginal Clinic in an urban milieu, a Model for Clinical Supervision and Intersectorial Tables.

4.1.4 IMMEDIATE OUTCOMES

First Nations and Inuit communities and organizations have been very involved in the AHTF even though there were delays in starting. It took much longer for the provincial partners to become implicated in the process because of communication gaps, many were not aware of the AHTF project, did not understand the need, and most had not worked with First Nations and Inuit communities before.

The Quebec Regional Project has increased in varying degrees the capacity of First Nations and Inuit communities and organizations. The projects increased institutional capacity at the local and organizational level; however, time did not allow for sufficient development for the integration projects to make systemic changes. In most cases, the changes are not sufficient to sustain any benefits envisaged by the immediate project outcomes.

The level of awareness of the partners has increased and many of the barriers and constraints have been removed. There is an increased understanding of the complex hierarchy of provincial system, and important contacts have been developed, putting faces to names.

Building capacity was true as well for the provincial partners, many of which were not aware of the structures, resources and culture of their First Nations and Inuit partners. Many of the adaptation projects worked to create an understanding of health care access issues, health disparities and social/cultural considerations for First Nations and Inuit.

The program benefits can continue after the project completion without over-burdening local organizations and partners if there are further resources provided. Some of the successful adaptation projects will require resources to be able to continue beyond the end of March such as the Clinic Minowé in Val D'Or, the ANPSS Cultural Training, and the FNQLHSSC Training Programs.

Some First Nations communities are participating to a limited extent in provincial health planning, for others there are jurisdictional issues around this participation. One or two communities have seats on the Conseil Administration of their CSSS, and one is able to confer directly with governmental agencies.

4.2 RESULTS

The knowledge and capacity that has been developed by these projects has been beneficial to the communities. Some have seen their members benefit from access to services that they did not have before. Others have used cultural training and information-sharing to effectively sensitize workers in their own and the provincial system about the realities and culture of First Nations and Inuit. There are important links that have been established, and in a few cases these links have been formalized by protocols and working agreements. Some programs have been adapted, and one project was able to get a provincial institution to provide services outside of their walls.

One of the key challenges was the turnover in staff in the provincial network which created a lot of delays and meant restarting the groundwork of some projects. The other was also the availability of persons working for the province and their schedules, and the limitations from the budget cutbacks. Project outcomes were sometimes limited because of regional situations. The FNQLHSSC work plans had to be changed because of the delays at the beginning with Health Canada or because the province was not in step with the work of the Commission.

Partnerships were strong and effective and did share responsibilities. However the final accountability for the program results remained with the project holder and was not equally shared by all of the partners.

Many projects felt that if they had more time, they could bring the projects forward to another level that would assure their sustainability. As described by the respondents, some things worked well and others did not. But overall, there has been increased awareness and understanding, and the establishment of collaborative working relationships on which to build in the future.

4.3 EFFECTIVENESS

Those projects that were able to achieve their objectives did so because of at least one of the following factors:

A. They were able to meet directly with, and get the approval and support of the Director or "direction" of the provincial agency;

B. They had a prior working relationship with the provincial agencies on which to build;

C. They are in a 'win-win' relationship with the provincial agencies where each will benefit from cooperation with one another

D. The project leadership and communication was very effective

E. They were able to achieve a complete "buy-in" from their partners

F. The individuals representing the provincial partners were appointed to be there and had a mandate from their establishments to make decisions

G. They had support from the Agence (ASSS) in their region, and sometimes from the MSSS.

4.4 IMPACT

As was stated in the Report for Phase 1 of the Project Evaluation, the partnerships will need time to develop further, and to lead to the development of culturally appropriate services based on

an understanding of the cultural realities of First Nations and Inuit peoples. The projects provided a unique experience for both jurisdictions. With one or two exceptions, the communities and the province have not had the experience of sitting together at the table to discuss health and social services issues.

In general, there has not been sufficient time to build the relationships that can lead to the adaptation and integration of projects and services over the long term. Perhaps the most important impact that the AHTF project had in Quebec was to "open doors, open dialogue".

5. RECOMMENDATIONS

The following recommendations address the expected outcomes for the Aboriginal Health Transition Fund (AHTF) project. They are based on the interviews and information received from the 71 persons interviewed, and the review of the documentation provided by the Aboriginal Health Transition Fund projects:

1. The individual AHTF projects require more time and resources to fully reach their objectives. There has not been enough time and resources to fully develop the partnerships and to make the required systemic changes in capacity building. In many cases, the immediate outcomes are limited. Therefore, the initiatives should be continued over the next five years with sufficient resources to make changes, and to reach the stated outcomes for the AHTF initiatives.

2. The AHTF initiative should be renewed incorporating the recommendations that were made in Phase 1 and Phase 2 of the Regional Evaluation regarding AHTF design, management, delivery and implementation.

3. More communication and support should be provided by the MSSS to the ASSS and the CSSS on the AHTF initiative to create the "win-win" situations that make the projects successful.

4. The objectives of the AHTF can only be reached through capacity building among all of the partners. This translates into training, whether cultural training for provincial partners, or training for community workers. There should be additional resources provided to support and coordinate these training needs outside of funding for AHTF projects.

5. The AHTF in the Quebec region has been successful in the short term mainly due to the efforts of First Nations and Inuit communities and organizations. Many communities struggled to bring their partners on board, and to be seen on an equal footing.

   The stated long term objectives of the AHTF initiative cannot be reached unless there is some rethinking on the approaches to be taken in re-launching such initiatives as the AHTF. The initiatives should be implemented slowly with enough time for appropriate and effective communication to the grassroots level among the three jurisdictions.

6. The stated AHTF objectives speak of First Nations and Inuit collectively. In order to ensure that these objectives are achieved for all First Nations and Inuit, the AHTF has to:

   A. be more inclusive possibly grouping together smaller communities, if necessary, and,

   B. move away from proposal driven funding which reduces access for some communities.

6. REFERENCES

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