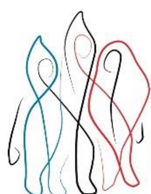
2021

Ilagiilluta Pilot projects evaluation

PROCESS EVALUATION FINAL REPORT

REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES &
INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC



RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX DU NUNAVIK
NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES

Institut national de santé publique Québec

LIST OF COLLABORATORS

Authors

Isabelle Duguay, B.Sc. Nurse, M.Sc., Scientific Advisor

Faisca Richer, M.D., M.Sc., CMSQ, FRCPC, Medical Specialist in Public Health and Preventive Medicine

Sonia Ovando-Peralez, M.Sc., Scientific Advisor

Reviewers

Imane Cheriet, Clinical lead in health promotion and disease prevention
Public Health Department
NRBHSS

Sonia Dufour, SIPPE program Coordinator,
Tulattavik Health Center

Isabelle Girard, Planning and Programming Officer, Perinatality and Early Childhood,
Public Health, Prevention and Promotion team
NRBHSS

Andrea Richardson, Head of Child, Youth, Family Programs
Ungava Tulattavik Health Centre

Marie Rochette, Public Health Director,
NRBHSS

Executive Summary

After several years of piloting the Ilagiilluta program in two communities of Nunavik, a mixed-method process evaluation was performed. The following is a summary of the evaluation findings.

IN SPITE OF THEIR SIMILARITIES, THE PROGRAM MODELS DEVELOPED BY THE TWO COMMUNITIES DISPLAYED IMPORTANT DISTINCTIONS

Both pilot projects appears to be very ***similar*** in terms of (1) their **clientele** (pregnant women and families with young children); (2) program **objectives** and **approaches** (support parents in need in order to foster healthy development of children). Yet, important ***differences*** between the two pilot models reside in (1) the **extent of services covered** (one providing community-based outreach preventive interventions, and the other focusing more on clinical interdisciplinary primary care services for families with children).

MANY FACTORS SUPPORTED THE IMPLEMENTATION OF THE PROGRAM IN THE PILOT COMMUNITIES, BUT THERE ARE STILL MANY CHALLENGES

Several factors appear to have influenced the implementation of the program in both communities, some were supportive, and others challenging. These are summarized below.

Factors category	What has helped	What has been more challenging
The program	For clients, services which are most attractive are those compatible with **Inuit practices**, as well as the support addressing **basic needs** for food, baby items, and social support For staff, the relative **simplicity** of most interventions were making the work enjoyable	Variations in program model provided between communities (leading to some **confusion** as to which services should be offered + **inequity** in service provision between communities) For staff, more challenging aspects of the jobs include the **emotional burden** of some families' difficulties, and prevention of **substance use** during pregnancy
Organizational support	Staff **competency** is essential to ensure quality of service provision Access to adequate **resources** is key, particularly the presence of local **Inuit staff**, access to mean of **transportation** for clients, as well as a community dwelling with continuous **water supply**	Areas of competency development needing reinforcement include **cultural safety** of non-Inuit staff, as well as better **support** for local Inuit staff Lack of access to adequate resources at the local level create **delays** in community-based activity development as well as occasional **interruption** of services
External context	**Strong partnerships** with other programs aimed at the same population (midwifery services, Family Houses, daycares, etc.) and is an essential	Certain **hiring regulations** can make it difficult to recruit local staff

Based on our findings, the following are a **list of suggestions** for adjustments of the Iagiilluta program model, which could be helpful prior to regional expansion of services to other communities.

Reinforcing cultural safety of services provided:

In a program which deals with pregnancy, birth and parenting of young children, cultural misunderstanding between non-Inuit staff and Inuit clientele can be quite common. Moreover, considering role of residential schools played on the breakdown of Indigenous family structures, cultural safety of the non-Inuit staff is particularly capital. This means **providing cultural safety training to non-Indigenous staff,** which emphasizes cultural humility and self-reflection on their own cultural lens and its impact on their professional practice. However, **hiring of Inuit workers to deliver services** remains most powerful way of ensuring cultural safety of the program, provided work expectations and requirements are realistic and their role, supported, respected and valued.

Facilitating client enrollment and participation

Encouraging clientele participation in the program means facilitating access to the services by providing **community-based facilities** and **transportation** available to connect with more “hard to reach” families, as well as **addressing families’ daily challenges**, including their need for healthy foods, social support and baby items, such as clothing and cribs. **Traditional** and/or on the land **activities** have also been shown to o attract pregnant women at a time when building relationships of trust is important.

Reinforcing continuity of services

It is important that the preventive focus of Ilagiilluta programs be anchored in a strong primary care system, ensuring access to medical and psychosocial services at all times within the community, as well as to well-organized basic prenatal and postnatal care. Indeed, evidence has shown that for family support programs such as ilagiilluta to work, the **staff should also be able to refer clients to a network of community services** providing a safety net to vulnerable families dealing with family violence, parental mental health and addiction, family respite services and housing. Without this support, the burden on ilagiilluta staff can be overwhelming, and the prevention mission of the program, rapidly diverted to family crisis management.

Table of Content

LIST OF COLLABORATORS 2
Executive Summary 3
1. Introduction 6
1.1. Determinants of Inuit children's health and development 6
1.2. Supporting Inuit families using multifaceted approaches 6
1.3. Piloting NFPs projects in Nunavik 7
2. Evaluation strategy 9
2.1. A participatory Evaluation approach 9
2.2. Evaluation aims, objectives and questions 10
2.3. Methods 11
2.3.1. General evaluation design 11
2.3.2. Population and sampling 11
2.3.3. Data collection procedures 12
2.3.4. Ethical issues 13
2.4. Data analysis process 13
3. Evaluation results 16
3.1. Program description 16
3.1.1. Description of the program – Community A 16
3.1.2. Description of the program - Community B 21
3.2. Factors influencing implementation 24
3.2.1. ILAGIILLUTA as an innovation – the conceptual model 24
3.2.2. Factors related to the innovation 25
3.2.3. Factors related to the internal system 37
3.2.4. Factors related to the external environment 47
4. Discussion 49
4.1. Summary of the Main Results 49
4.2. Strengths and limitations of the results 50
4.3. Recommendations for reinforcement of ilagilluta 51
4.3.1. Reinforcing cultural safety of services provided: 51
4.3.2. Facilitating client enrollment and participation – building relationships of trust 52
4.3.3. Reinforcing continuity of services 53
5. Conclusion 54
References 55
Appendices 58

1. Introduction

1.1. Determinants of Inuit children's health and development

In Nunavik, children constitute an important portion of the population, with one person in three being under 14 years of age, a proportion which is more than twice that of the Québec population. In fact, with an average of 400 children born in the region every year, the Inuit population of Nunavik is the fastest growing population in Québec overall. Unfortunately, many of these children are faced with the challenges of growing up in unfavorable living conditions, a situation that contributes to sustain the rates of various preventable conditions (such as SIDS, injuries and respiratory diseases) at higher levels among these children than among any other population in the province.

Indeed, Indigenous children are known to experience poverty at a higher rate than any other population in Canada, and children in Nunavik are no exception. In fact, with a 20% poverty rate, and a 40% housing overcrowding rate, it can be difficult, if not impossible, for many families in Nunavik to provide consistent care and an ideal nurturing environment for their children (Brittain & Blackstock, 2015).

We also know that continuous exposure to stress during childhood can adversely affect brain development and increase the likelihood of health problems later in life (Irwin et al., 2007). The combination of familial and structural risk factors can contribute to increasing a child's likelihood of experiencing school difficulties and of being exposed to violence. These disruptions in developmental pathways cumulate to create multiple barriers impeding Indigenous children from developing to their full potential, setting in play a multigenerational cycle of disadvantage (Brittain & Blackstock, 2015).

This is why there now exists an overwhelming consensus among Indigenous communities' stakeholders, as well as among Indigenous and non-Indigenous health experts on the urgency of addressing the staggering overrepresentation of Indigenous children and youth in Child Welfare Services. Yet, this cannot be done without addressing the combination of structural determinants of child abuse present in Indigenous populations, such as poverty, housing overcrowding and inadequate access to services (MacLaurin et al., 2008).

Recommendations to support the best start to early life for Inuit children in Canada (ITK, 2017)

1. *To ensure access to collaborative, culturally appropriate healthcare;*
2. *To support healthy pregnancy and birthing by bringing birthing closer to home and preventing children being born with FASD;*
3. *To increase breastfeeding rates and develop strategies for food security;*
4. *To increase support for parenting and offer Inuit-specific early childhood development programming in order for children to develop to their full potential;*
5. *To develop strategies which address inadequate housing;*
6. *To create Inuit-specific developmental screening and assessment tools for young Inuit children and ensure there is support;*
7. *To ensure there is support for pregnant mothers and young Inuit children to achieve better oral health outcomes; and*
8. *To increase data and research in the area of maternal, infant and child health.*

1.2. Supporting Inuit families using multifaceted approaches

Multiple studies have demonstrated that interventions directly addressing families' immediate need for essentials like food, rent and home repairs are strongly associated with declines in child maltreatment outcomes (Potter et al., 2015). This is why experts in the field of Indigenous health advocate in favor of replacing programs that target only one area at a time with interdisciplinary approaches that bring poverty eradication and improvement of housing conditions measures together with governance of child welfare services, and other services for parental physical and psychosocial issues, including treatment for substance misuse (Blackstock et al, 2004). This approach appears to be in line with ITK's Inuit Maternal Child Health Working

Group recommendations to support the best start to early life for Inuit children in Canada (ITK, 2017) (see box).

Studies in Canada and elsewhere in the world have indicated that the need for the increased support of families living in vulnerable contexts can be addressed using Nurse–Family Partnerships programs (NFP). NFP programs are multifaceted interventions based on theories of human ecology, self-efficacy and human attachment aimed at socially and economically disadvantaged mothers. Although there now exists various forms of the program in Canada and the U.S., the program tends to begin during pregnancy and continues throughout the child's preschool years.

Since the 1980s, the findings from multiple randomized controlled trials conducted in the U.S. have shown that NFP can have a wide range of benefits for maternal and child health, including (Tonmyr, 2015):

- Reduction of consultations for conditions associated with child maltreatment and injuries;
- Improvement in children's cognitive and language development and school readiness;
- Decline in adolescent behavioural problems, as well as reduction in child mortality;
- Enhancement of women's perinatal health, maternal economic self-sufficiency, reduction in all-cause mortality, as well as augmentation of fathers' involvement in family-life.

1.3. Piloting NFPs projects in Nunavik

Implementation of NFP programs in any new setting requires a process of carefully adapting the programs' interventions to ease their feasibility and acceptability for families. There is a consensus that fidelity to the essential components of the intervention is critical to maintain program efficiency in spite of adaptation to local realities. Such essential components include the one-to-one and long-term trust relationship between the service provider and the family, as well as the integration of the program within other community services provided in parallel and provided after the mothers have completed the NFP programs.

Yet, there is also an understanding that the feasibility of such a resource-intensive approach may be limited in low-resource settings (Mikton, 2015), making the identification of key elements all the more important.

In addition, it is thought essential to consider whether younger mothers should remain the priority target clientele in cultures where giving birth at a young age is more normative (Mikton, 2015).

These realities are in fact taken into consideration when developing NFP approaches adapted to realities of Indigenous contexts. In turn, these adapted approaches have demonstrated their efficiency in improving the health and well-being of children in Indigenous populations around the world. However, experts in Indigenous health are now unanimously calling for more than program "adaptation", but rather for early childhood development programs tailored to Indigenous children's cultural and social contexts by ensuring that Indigenous communities have a leadership role in identifying program priorities and interventions (Bowes & Grace, 2014; Sims, 2011; Richer & Robert, 2016).

In addition, a key component to ensuring the building of a long-term trust relationship with Indigenous families has been shown to rest upon ensuring that local paraprofessionals are hired and supported to play the role of main primary care givers (Bowes & Grace, 2014; Sims, 2011; HCC, 2011). In addition to bringing firsthand knowledge of various aspects of the community, they help facilitate the establishment of trust relationships with families, these being essential to the success of such family support programs. Moreover, local workers are often the only stable personnel in remote

Indigenous communities, they hence contribute to improving the continuity and cultural safety of family support services (see box below).

It is with this in mind that, in 2012, a needs assessment was conducted in Nunavik to validate the region's interest in developing such a program. The funding required to implement two initial pilot projects was obtained from the provincial authorities in 2014; the funds normally used for implementation of Quebec's 'Services intégrés en périnatalité et pour la petite enfance' (SIPPE). This recurrent funding allowed the pilot communities to develop their service delivery models and roll out their community-tailored interventions. After a period of three (3) years of initial implementation of SIPPE in both pilot communities, the Regional Board of Health proposed to evaluate these projects, notably to review the feasibility and success of each model, prior to expanding the program to all other communities across the region.

The concept of cultural safety goes beyond the concepts of cultural awareness and competencies by emphasizing the importance of recognizing the colonial, historical, and socio-political context in which Indigenous inequalities are rooted. Acting on this principle thus means questioning the power structures as they apply to all levels of conventional care settings, be it in the provider-patient relationship, the integration of traditional methods into the provision of care, and the structural barriers to accessing care for Indigenous populations (Allan & Smylie, 2015; Baba, 2013).

2. Evaluation strategy

In the spring of 2017, an initial mandate was given to the Indigenous Health team of the INSPQ from the Public Health Department of the Nunavik Regional Board of Health and Social Services (NRBHSS) to conduct an evaluation of the ILAGIILLUTA pilot projects. A preliminary consultation with the main regional and local stakeholders at the time identified the main goals of this evaluation to be as follows:

- To document the progress of the pilot projects and make required adjustments to the already existing services if need be;
- To establish a regional consensus on regional program guidelines;
- And finally, to propose recommendations for scaling up the program to other communities in the region.

This initial evaluation mandate had to be postponed until January 2019, however, given the re-organization of regional public health priorities at the time.

2.1. A participatory Evaluation approach

Stakeholder participation is critical to develop and evaluate contextually relevant public health initiatives in Inuit populations (Saini, 2017). Building on the utilization-focused evaluation approach (Cargo & Mercer, 2008), engaging in an evaluation process those who are intended to be the beneficiaries, the users and the stakeholders of an intervention has now been recognized as strengthening the capacities of health units in translating evaluation results into program adjustments and improvements.

An **Evaluation Consultative Committee (ECC)** was therefore established; it consisted of representatives of the following stakeholder groups:

ILAGIILLUTA coordinators :

- *Isabelle Girard*, Head of perinatal and early childhood programs, Inuulitsivik Health Center
- *Sonia Dufour*, ILAGIILLUTA Coordinator, Ungava Tulattavik Health Center

Regional and sub-regional stakeholders :

- *Andrea Richardson*, Head of Child, Youth, Family Programs, Ungava Tulattavik Health Centre
- *Suzanne Guay*, Planning and Programming Officer, Perinatality and Early Childhood, Public Health, Prevention and Promotion team, NRBHSS
- *Véronique Dion-Roy*, Prevention and Health Promotion Coordinator, Public Health, NRBHSS
- *Gilles Cloutier*, Coordinator – Children, Youth and Family programs, Planning and Programming department, NRBHSS
- *Marie-Claude Péloquin*, Planning and Programming Officer, Medical Affairs and Physical Health, Planning and Programming, NRBHSS
- *Geneviève Pellerin*, Psychosocial affairs and Community Services Coordinator, Planning and Programming, NRBHSS

Representative of local workers:

- *Mary Berthe*, Social Aid, Ilagiilluta program, Inuulitsivik Health Center

The **mandate** of this committee was primarily to **guide the evaluation process and ensure its utility, feasibility and transparency**. As such, the role of the ECC was, amongst other things:

1) To ensure that concerns of all evaluation users were taken into account in developing the evaluation mandate and methodology;
2) To help develop consensus on program logic models and regional guidelines;
3) To discuss and validate the interpretation of the preliminary findings' and help draw the appropriate evaluation conclusions and recommendations.

In addition to the creation and collaboration of the ECC, some members of the **local teams** were also involved in the validation of the evaluation preliminary results.

2.2. Evaluation aims, objectives and questions

As previously mentioned, in order to support ILAGIILLUTA expand at the regional level, this evaluation mainly aimed at identifying the particularities of each SIPPE pilot project, as well as clarifying the circumstances under which each project works best. This, in turn, in order to capture the lessons learnt from each case and elaborate recommendations for improvement prior to regional expansion of SIPPE to other communities.

More specifically, the evaluation objectives and questions were the following:

Objective 1: **To describe the ILAGIILLUTA program currently being implemented in each pilot community.**

1.1. What are the services provided and activities currently deployed in each pilot community?

1.2. What are the inputs (human, material and financial resources; program promotion; community partnerships; etc.) invested in the implementation of each pilot project?

1.3. What kind of support is provided / needed to implement such programs? By whom?

Objective 2: **To identify the implementation outputs achieved by the programs in each community.**

2.1. What are the pilot projects' coverage rates? Are they reaching their intended clientele?

2.2. What are the clientele's perceptions of the services provided? Do they perceive the services as useful (answering their needs)?

2.3. What are the reasons behind some families not participating in the program?

Objective 3: **To analyze the implementation process of the program in each pilot community.**

3.3. What were some of the key chain of events that led to program implementation in each community?

3.4. What were the facilitators and barriers encountered during each pilot community's implementation process? How did these affect the implementation process and outputs in each community?

Objective 4: **To gain a better insight of the lessons learnt from the two pilot communities and propose recommendations for program improvement and expansion.**

4.1. What are the differences and similarities between the two communities' service delivery models? What are the most likely reasons explaining these?

4.2. How did the implementation process differ between communities? What are the most likely reasons explaining these?

2.3. Methods

2.3.1. General evaluation design

An embedded multiple case study was conducted, the ILAGIILLUTA program in each pilot community constituting the 2 cases to by analysed. A mixed data collection methods was used, combining quantitative and qualitative data as described in the table below.

The following table provides a summary of the population and data collection methods used to reach each evaluation objective.

Table 1: Summary table, evaluation objectives and respective methodology

Evaluation objective	Main information sources and *target population*
Objective 1: To describe the program as currently provided in each pilot community.	Qualitative: • Administrative document review, mostly activity reports; • In-depth interviews & focus group with *program staff*
Objective 2: To identify the implementation outputs achieved by the program in each community.	Quantitative: • Administrative document review, including activity participants lists
	Qualitative: • In-depth interviews with program *clients*
Objective 3: To analyze the implementation process of the program in each pilot community.	Quantitative: • Administrative document review, including action plans, activity reports & meeting minutes
	Qualitative: • In-depth individual interviews & focus group with *program staff* , as well as key *regional stakeholders*
Objective 4: To gain a better insight of lessons learnt from the pilot projects and propose recommendations for program improvement and expansion.	Qualitative: • Transversal analysis of pilot projects and focus group with *program staff* , as well as key *regional stakeholders*

2.3.2. Population and sampling

All willing program staff, including program coordinators, program clients, as well as regional stakeholders were interviewed; as such the term "evaluation participant" is used in this report to identify all individuals who agreed to be interviewed, irrespective of their role or function. Yet, each evaluation participant was more specifically classified as belonging to one of the following categories:

- ✓ The **program staff** category included any health care worker whose role is to deliver services at the local level; this category hence included both the local Inuit team members (i.e., community workers, social aids, family education workers) and non-Inuit health care professionals (nurses, physicians, social workers, psychoeducators, etc.). This group also included local team coordinators.
- ✓ The **program client** category included all individuals who have utilised the ILAGIILLUTA services; these were all new mothers who have participated in any of the activities provided by the program (either individual or group activities).
- ✓ Finally, the **program stakeholder** category refers to all evaluation participants who are not

involved in direct service delivery, but who have a responsibility in planning, supporting or collaborating in program development and implementation; these included regional Planning, Programming and Research Officers (PPROs) based at the NRBHSS, as well as some sub-regional managers working at the Health Center level (Inuulitsivik Health Centre and Tulattavik Health Centre).

A convenience sampling method was used to recruit evaluation participants from each category, considering the small number of potential participants available in each of these. Program clients were identified with the help of the local Inuit workers with the aim to select community clients representing a variety of family contexts (single-mothers, two-parent families, diverse age groups, and number of children).

Table 2: Number of participants by category and community:

Category	Community A	Community B
Program staff	4	8
Program clients	8	0
Program stakeholders	8 (regional)	

2.3.3. Data collection procedures

As described in the evaluation work plan (Appendix X), data collection was completed by a single external evaluator during the spring of 2019, with regional stakeholder interviews beginning on March 23rd all the way to April 16th. Two (2) community visits were carried out, with the Community A visit being held between March 23rd and 26th, 2019, and the Community B visit between May 6th and 10th, 2019. In each case, the data collection steps undertaken were the following:

Step 1: Administrative document review

In each community, all available administrative documents relating to program planning, activity reports and clientele participation were initially reviewed. Unfortunately, the lack of standardized monitoring tools at the regional level resulted in a lack of uniform administrative information being collected in both communities. Yet, each pilot project had developed its own monitoring tools. These were used and complemented with further questioning during the interviews with the local coordinators.

This information was used to draft an overall program description for each pilot community. These descriptive reports were then sent back to local coordinators for review and validation with their respective teams. Comments and corrections were subsequently done as per their suggestions.

Step 2: Semi-structured interviews

Subsequent to administrative document review, individual and group interviews were carried out using semi-structured interview grids. These question grids (see Appendix section) were developed using the evaluation objectives and were modulated according to participant categories.

All interviews were conducted in the program's main offices in each community, either in English or French, with occasional translation into Inuktitut during the program client group interview. Only hand-written notes were taken by the external evaluator during interviews. Program clients all signed informed consent forms (Appendix X).

While we were able to interview a fair number of program clients in Community A, we were not able to interview program clients in Community B. In both cases the same recruitment strategies were put in place, namely, the participation of the interviewer in group activities, as well as individual phone calls and Facebook announcements.

Interviews with regional and sub-regional stakeholders were also completed in English or French, either at participants' workplace or over the phone, according to their preference and availability. Validation of interview content with all evaluation participants was done either through revision of interview notes with regional stakeholders and/or revision of community case analysis results with respective program staff and clients.

2.3.4. Ethical issues

Considering that pilot project process evaluations such as this one constitute an intrinsic component of quality insurance activities of services provided to the Nunavik population, no formal ethics committee review was required. Yet, the present evaluation was nevertheless presented to the Chair of the Nunavik Nutrition and Health Committee for validation and approval. All program clients were invited to voluntarily participate in the study and signed the consent form (Appendix X) following explanation of evaluation goals, interview risks and benefits, as well as reiteration of the right to withdraw at any time and the protection of information confidentiality. Clients also received a small allowance for their participation (in the form of an extra food coupon), as per regional research guidelines.

Being identified as having participated in this evaluation could be perceived as carrying the risk that expressing unfavorable opinions regarding the program may lead to negative actions at a later stage. This is true for all interviewees, but certainly even more so for members of the program staff. Several measures were thus used to keep the risk of identification as low as possible:

- ✓ Interviews were carried out in a space that was convenient for participants.
- ✓ At all stages of the evaluation, all data was kept strictly confidential: this was done by making sure that all interview related notes were given individual identifiers and kept under lock to maintain confidentiality; consent forms and the list of respondents and their identifiers were kept in a separate locked location.
- ✓ Findings were reported anonymously and were reviewed by participants to ensure that they were comfortable with the excerpts included in the results section.

And finally, in accordance with OCAP principles (Ownership, Control, Access and Possession) of information collection done in Indigenous populations in Canada, all the data collected, results produced and reports elaborated remain the property of the NRBHSS and will not be used by the INSPQ or any other institution without explicit permission from NRBHSS representatives. (OCAP principles: https://fnigc.ca/ocap).

2.4. Data analysis process

Quantitative data was used to draft each of the community program descriptive sections as explained above.

All qualitative analyses were executed by a second external evaluator, using the notes produced by the main interviewer. Each case was first examined individually and validated by its respective community program staff, as described above. Each community's interview notes were read several times by the interviewer and the second evaluator separately. The interviewer and evaluator

subsequently discussed these notes to compare and reflect on their respective understanding of them.

A thematic analysis of all interview contents was completed using a classic framework approach (Gale, Heath, Cameron, Rashid & Redwood, 2013). The main theoretical framework used was an adapted version of Greenhalgh, Robert, MacFarlane, Bate & Kyriakidou (2004). The interview notes were fragmented and classified according to themes (see table below) and subthemes based on this framework. The interviewer and evaluator discussed the resulting subthemes in order to ensure consensus. A thematic chart was subsequently constructed for these.

Table 3: Evaluation framework themes and definitions:

Themes	Definition
FACTORS RELATED TO THE INNOVATION	
Compatibility	The innovation is compatible with the intended users' perceived needs, norms, and values
Relative advantage	The innovation has a clear, unambiguous advantage for the staff and/or the intended users
Simplicity	The innovation is perceived as simple to use and easy to adopt by the staff
FACTORS RELATED TO THE INTERNAL SYSTEM	
Capacity to implement the innovation	The staff possess the innovativeness, knowledge and skills necessary to implement the innovation; the staff can capture, interpret and share new knowledge and can put it to appropriate use
Organizational support for the staff	Support (in terms of assistance and training) is provided to increase the capacity of the staff to implement the innovation
Resources invested	Financial, human and material resources, as well as their allocation, are adequate and recurrent
System readiness for innovation	The organization's level of readiness or willingness to assimilate the innovation is facilitative
FACTORS RELATED TO THE EXTERNAL ENVIRONMENT	
Inter-organizational networks	Networks that link providers through common management and governance structures and/or shared values and goals; these help spread the innovation
Sociopolitical climate	The sociopolitical context favors the adoption, implementation and delivery of the innovation

Once the preliminary results were written out, they were sent to each community for validation, to establish whether these results accurately represented participants' thoughts and experiences. Participants were given the opportunity to discuss and suggest modifications to these results.

After finalizing the individual analysis and validation of both cases, a cross-case analysis of the results was carried out, where the results of each case were combined and contrasted, taking into account the differences or similarities in pilot project services and activities and the facilitating and hindering factors. This transversal analysis was subsequently submitted to the ECC for discussion.

An iterative process was used throughout the analysis; themes and subthemes being revised whenever necessary.

3. Evaluation results

The evaluation results are presented in two main sections: first, the description of services provided in each community are presented, and second, the transversal analysis is presented.

3.1. Program description

The program description section corresponds to the following evaluation questions:

- ✓ What are the services provided and activities currently deployed in each pilot community? (Objective 1.1)
- ✓ What are the inputs (human, material and financial resources; program promotion; community partnerships; etc.) invested in the implementation of each pilot project? (Objective 1.2)
- ✓ What are the pilot projects' coverage rates? Are they reaching their intended clientele? (Objective 2.1)

The following needs to be taken into account. First, this section resulted to some extent from the review of administrative documents in each pilot community. However, given the insufficient amount and depth of the available administrative data, information was also obtained from discussions with each community's local ILAGIILLUTA coordinator. Second, each community's program description is presented in the order data was collected (i.e., Community A's description first, Community B's second). And last, the lack of standardized monitoring tools resulted in not all information being equally available in both communities.

3.1.1. Description of the program – Community A

CONTEXT OF IMPLEMENTATION

In the spring of 2012, a needs assessment was done by the Regional Public Health Department in collaboration with local and regional decision makers in order to develop pertinent and culturally safe support for families in the region. In the summer of 2012, a complete community resources mapping was completed and Community A was confirmed as being ideal for the first pilot project, mostly because of the vitality and stability of both clinical staff and community organizations.

Consultations with local and regional stakeholders helped identify **essential factors for the success of this new parenting support intervention program**:

1) providing culturally relevant and safe services and interventions;
2) ensuring services are highly accessible to the most vulnerable families;
3) and integrating services within already existing clinical and community-based resources.

A formal request for financial, human and material resources was made through the Regional Strategic Plan and resources were granted for the 2013-2014 financial year. The head of the program in Community A was then hired in April 2014. In coherence with cultural safety principles, it was decided to modify the name of the program to Ilagiilluta (which means "let's be a family" in Inuktitut).

GOALS AND OBJECTIVES OF THE PROGRAM

According to the program guide, the main goal of the program is to **maximize the development of young children**, as well as **the general wellbeing of pregnant women, mothers and fathers.** As such, the program's intervention objectives are as follows:

- ✓ To enhance Inuit best practices, including the promotion of traditional parental skills, as well as traditional food and activities.
- ✓ To improve health behaviours of pregnant women and their families, with particular emphasis on the prevention of alcohol and drug use during pregnancy, and the promotion of food security.
- ✓ To ease access to physical and mental health follow-ups to mothers and young children.
- ✓ To optimize global child development, by increasing the uptake and duration of breast feeding, supporting caring attachment relationships between parents and children, and enhancing the psychomotor, cognitive, emotional and social development of children through early stimulation group activities.
- ✓ To improve life conditions of families, by strengthening family support networks, the creation of safe environments for families, and ensuring the access to and the continuity of public and community services.

DESCRIPTION OF SERVICES PROVIDED AND ACTIVITIES DEPLOYED

The intervention strategy includes 3 main components, as summarized in the illustration below:

Figure 1: interventions components – Community A

COMPONENT 1: FAMILY FOLLOW-UP:

This part of the program aims at working closely with families, pregnant women, young children and their main care givers to meet their **physical, emotional** and **psychosocial needs**. Pregnant women are usually initially referred to the program by midwives at the time of their first prenatal visit, they are invited to come visit the Ilagiilluta House to receive their Canada Prenatal Nutrition Program (CPNP) food coupons. However, many pregnant women also come on their own given that the program has become well known in the community. Women are also called at home by the Ilagiilluta team to remind them that they are most welcome to visit the house.

When women come for their CPNP food coupons, they are counselled on the risk of drinking and using drugs during pregnancy. They are also informed on the variety of activities and services provided at the Ilagiilluta House and are invited to drop in whenever they wish to.

Individual follow-up is then initiated and carried on depending on each client's needs and priorities, mainly through a combination of **home visits** and **clinical visits** as per families' preferences. Universal visits include a 6 to 8 weeks postpartum home visit (mostly carried out by community workers), as well as well-baby follow-ups (where teachings are carried out by community workers, vaccinations

and physical exams by nurses and the 3-year visit by a visiting doctor). Supplemental visits are mainly carried out by local social aids/community workers as needed. Referrals to clinical staff (to the walk-in clinic, pediatrician, or social workers) can be done when necessary.

Important elements of the family follow-up component include:

1) **Building a relationship of trust with families**: First and foremost, cultural safety of services primarily rests on employing Inuit staff, supported (when needed) by non-Inuit health professionals who are open to adapting to Inuit values and circumstances. Cultural safety also means using interventions which are coherent with Inuit values and parenting methods. Finally, cultural safety entails providing services in a setting where families feel comfortable and safe, using a combination of home visits, clinic appointments, or meetings in community hubs, according to families' preferences.
2) **Using a strength-based approach**: This means recognizing that families are experts of their own realities, acknowledging the resilience of parents in facing their daily challenges and helping them build on those strengths. This also means working in a way that avoids labelling—so that families do not feel stigmatized when accessing services.
3) **Follow-up intensity**: Although it is well documented that the more intense and longer lasting the contacts, the better the outcomes for parents and children, parents' autonomy to accept or refuse services is respected so as to maintain a relationship of trust with families regarding the program.

COMPONENT 2: GROUP ACTIVITIES:

Group activities such as relaxation sessions, community kitchen/cooking classes, traditional crafting activities, or early stimulation workshops constitute an enjoyable way for families to make initial contact with the program and start building trust with the staff. Indeed, families with complex needs are often hard to reach, so enjoyable group activities can provide a non-threatening way of breaking their isolation and opening the door for eventual personalized support.

Besides their ludic and relationship-building function, group activities are an ideal way of transmitting cultural knowledge and skills, information on health and well-being, parenting tools, as well as providing opportunities for modelling new behaviour and helping families build supportive networks.

COMPONENT 3: COMMUNITY DEVELOPMENT:

This component refers to the implementation of community projects which can help improve families' living conditions. This aspect is an essential component of the program, as it is known that program success depends on reducing families' daily stressors as much as possible. It is also necessary to prevent worker burn out; indeed, workers with good community networks will be in a better position to work with families with complex needs.

Over the years ILAGIILLUTA has participated in the development of the community kitchen, ad hoc activities encouraging fathers to participate in traditional activities with children and occasional on the land outings. Currently under development is the collaboration with the local Hunter Support program to facilitate access to traditional food, the collaboration with the local daycare to provide early stimulation activities, as well as the provision of support to women so that they obtain a better understanding of how to get CSST pregnancy preventive leave, maternity leave allocation, a spot in daycare, and so on.

DESCRIPTION OF HUMAN, MATERIAL AND FINANCIAL RESOURCES INVESTED

The tables below summarizes the resources invested in program deployment at the time of evaluation for community A

Table 4: Human, financial and material Resources – community A

Human	***Number of staff (by type)***	1 coordinator + 7 CWs (3 in Community A, 2 in another community, and 2 in another) + 1 SW in Community A Other villages are visited 1-2 x/yr. Community nurses and midwives as regular partners.
	Employment stability	5/6 CWs more than 2 years
	Type of training received (per year)	Peer coaching + Marie Victorin training + McGill management training + Conferences
Financial	***Amount of funding received per year***	NA
	Sources of funding	Mix of DGSP (Qc) + FASD (Fed)
Material	***Space provided?***	ILAGIILLUTA House in Community A + another community, partnership with Family House in another community
	Transportation provided?	Borrow the clinic's car as needed. No transportation for clients.
	Intervention tools used?	FASD material + teaching material usually produced locally
Planning	***Yearly action plan available?***	Yes, elaborated with the coordinator's support
	Delays/cancelations: Main reasons, consequences?	Lack of housing/physical space, lack of water, difficulty recruiting local staff in certain communities, lack of support from regional management

Table 5: Program promotion activities – Community A

Channels	***Type***	Facebook Radio Personal reach out
	Description	Announcement of weekly activities
Frequency of messages	***By type***	NA
	Duration (year of initiation)	many years
Quality and Acceptability	***Social and cultural relevance of activity***	Messages are transmitted by local CWs in Inuktitut
	Acceptability of activity	Never measured
	Frequency of assessment	NA

Program's coverage rates

The tools necessary to monitor the number or characteristics of families who participate in the program's diverse activities do not yet exist. Yet, the proportion of women who receive CPNP food coupons can easily be measured for each community of the Hudson Coast (see table below).

Table 6: Number of women receiving food coupons

Community	Participants of the CPNP food coupon program[1]	Estimated number of pregnancies[2]
Community A	64	79
All communities, Coast A	231	NA

Notes: (1) between 1st of April 2018 and 31st of March 2019; (2) Based on midwives' files (same dates).

Based on this data, we can say that at least 80% of pregnant women come for coupons at the ILAGIILLUTA House in Community A, where they receive counselling on FASD, breast feeding and other topics, a universal home visit at 6 to 8 weeks post-partum, as well as regular information of the program's activities. This is also done in communities where Ilagiilluta workers are present (in two other communities on this coast). For other communities, the distribution of food coupons is usually carried out by nurses who provide prenatal care, as well as by CWs and/or interpreters, but it is not possible to know whether (and if so, what type of) counselling is provided at that time.

3.1.2. Description of the program - Community B

CONTEXT

The very first program coordinator was hired in 2012 in Community B. At the time, the team included 1 social worker and a few non-Inuit midwives. Since then, the program team has grown considerably to including local workers (Family Education Workers – FEWs), and many non-Inuit health care professionals (community nurses, social workers, midwives, a psychoeducator and an addiction specialist).

As such, the Integrated perinatal and early childhood services (IPECS) program, as ILAGIILLUTA is called in Community B, aims to cover a large portion of the continuum of services for families and children aged 0 to 5, including health promotion and prevention (i.e. more classic SIPPE) services, as well as many frontline and specialist services for issues which are common in pregnant women and families with children 0 to 5 years old in the region. The services are offered both at the program's in-hospital office and at a community-based activity room.

According to the program guidelines elaborated by the Ungava Tulattavik Health Centre, IPECS's **program goals** are to maximize the potential for health and wellbeing of the families and to make the birth of children part of a successful project for parents. **Program objectives** are mainly two-fold:

- ✓ to foster healthy family relationships (through improvement of life conditions, social support) and
- ✓ to optimize child health and development (through promotion of healthy behaviours, improvement of parent-child attachment and stimulation of all domains of child development).

SERVICES PROVIDED

Community B's IPECS program offers 2 main types of services and activities, namely individual family follow-up services and group activities.

The ***family follow-up component*** includes family counselling activities, social pediatric clinical services, as well as some home visits. The goal of these is to provide support in accordance to the needs of families.

These needs are first assessed during the **initial visit** done either by a social worker or a FEW. This initial visit covers the evaluation of medical needs (prenatal care and other services needed) and of the psychosocial situation (family dynamic, concerns regarding the child's arrival, food security, use of psychoactive substances, etc.). Support to access governmental financial support programs is also offered. At the time of this initial visit, families are also offered CPNP food coupons, as well as FASD prevention counselling.

Women who choose to visit the program's office to pick up their weekly CPNP food coupons also receive further health promotion counselling according to the evolution of their pregnancy and the age of their child (e.g., diet during pregnancy, breast feeding promotion and support, safe sleeping practices for babies and other safety measures, etc.).

The family follow-up component also includes **social pediatric clinic services**, which combines medical, nursing, psychosocial and other ancillary support under one roof. The services are provided in Inuktitut through the implication of FEWs and meetings take place at the activity room which is situated only a few blocks away from the hospital. These services are offered to all families, namely through the provision of regular well-baby clinics and vaccination activities (carried out by community nurses at the clinic), as well as a universal development screening of all children 3 years

of age (carried out by an interdisciplinary team composed of a physician, an audiologist, a psychoeducator, accompanied by a FEW). Based on the results of this evaluation, early stimulation activities can be provided to children needing them; referrals to a physiotherapist, occupational therapist or psychologist are also possible, depending on the child's needs.

Home visits are also offered to mothers immediately after birth (universal home visits) in order to assess how the family is adapting to the arrival of the new baby. During these visits the importance of well-baby checkups are also emphasized to encourage parents to attend. Additional friendly visits are also offered to families to address other prevention topics as needed (baby safety, sleeping practices, breastfeeding support, introduction to solid food, etc.). Yet, according to the interviewed program staff, very few families agree to receive home visits.

Group activities are also offered to families at the activity room on a regular basis. These include the baby book program and sewing, cooking or breastfeeding support activities. Activities on the land and neighborhood celebrations are also occasionally organized. Parents who need transportation are usually driven to and from activities by one of the program staff.

RESOURCES INVESTED?

At the time of the evaluation, the IPECS program benefitted from the following resources:

Table 7: Human, financial and material Resources – community B

Human	***Number of staff***	• 1 coordinator (SW, in place x less than 1 year but had worked as SW x 1 year prior) • 2 FEW (in place since the beginning, following Marie-Victorin training) • 1 SW (in place x 2 years) • 1 psychoeducator (in place x 1 year, leaving soon) • 1 addiction specialist (1 day / week, in place x 2 years, leaving soon) • 2 community nurses (1 regular, and 1 visiting) • 2 non-Inuit midwives (1 regular and 1 visiting)
Financial	***Annual funding***	Unknown
	Sources of funding	Mix of provincial public health (SIPPE) and services funding (programme-service enfance jeunesse du MSSS), as well as federal funding (FASD)
Material	***Space provided?***	Services based at the hospital, and one activity house available for scheduled group activities
	Transport provided?	Borrow the clinic's vehicle to offer transportation to clients
	Intervention tools used?	Promotional and clinical tools produced locally with support for graphic design (in-house development screening tool used) Many toolboxes developed: family counselor, child development, pediatric nurse, Family Education Worker, as well as FASD and IPECS coordinators

Table 7: Human, financial and material Resources – community B)cont'd)

Planning	***Yearly action plan available?***	Yes, elaborated as a team, with the support of the coordinator
	Delays/ cancelations: Main reasons	Lack of staff due to • housing shortage for non-local staff • difficulty in recruiting local staff (positions vacant for many years), • insufficient specialist positions, namely in addiction and speech therapy

Table 8: Program promotion activities – Community B

Promotion tools	Facebook (announcement of weekly activities) Written promotional material (in 3 languages, available at the clinic) Radio messages (done in Inuktitut)

WHAT ARE PROGRAM'S COVERAGE RATES?

The tools necessary to monitor the number or characteristics of families who participate in the program's diverse activities do not yet exist. Yet, the proportion of women who receive CPNP food coupons can easily be measured for each community of the Ungava coast (see table below).

Table 9: Number of women receiving food coupons – Community B

Community	Participants to the food coupon program[1]	Estimated number of pregnancies
Community B	138	229
All communities, Coast B	364	NA

Based on this data, we can say that at least 60% of pregnant women come to the program's offices for coupons in Community B.

3.2. Factors influencing implementation

This section aims to answer the following evaluation questions:

- ✓ What are the clientele's perceptions of the services provided? Do they perceive the services as useful (answering their needs)? (Objective 2.2)
- ✓ What were some of the key chain of events that led to program implementation in each community? (Objective 3.1)
- ✓ What were the facilitators and barriers encountered during each pilot community's implementation process? How did these affect the implementation process and outputs in each community? (Objective 3.2)

The following results include the points of view expressed by all evaluation participants, (i.e., everyone who accepted to be interviewed for the present evaluation).

> The term **"participant(s)"** in the text below **refers to all individuals interviewed in the context of this evaluation:** program **clients**, program **staff** and program **stakeholders** (refer to *Population and sampling* in section 2.3).

The results presented in this section are a combination and a comparison and contrast of the data collected through interviews from both communities. It is however important to keep in mind that although these are the results generated from all interviews, All **program clients** interviewed were from **Community A**.

3.2.1. ILAGIILLUTA as an innovation – the conceptual model

ILAGIILLUTA is a program that brought changes to the way family and children services are delivered in Nunavik communities. It can thus be considered as an *"innovation"* as described in our conceptual model: *"a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, (…) that are implemented by planned and coordinated actions"* (Greenhalgh et al., 2004).

According to the conceptual model based on the work by Greenhalgh et al. (2004), presented in the methodology section, it is thought that the success of innovation implementation depends on a number of factors that can be grouped into three categories: the innovation per se, the actors who make the innovation happen, and the context in which the innovation takes place.

FACTORS RELATED TO THE INNOVATION ITSELF

When innovations are in coherence with both clients' and staff members' values, norms and needs, this tends to facilitate their adoption. This is the **compatibility of the innovation with norms, practices and perceived needs**. Similarly, innovations tend to be more easily implemented when they are perceived as providing visible benefits for clients (relative to other/previous services). This is referred to as the **relative advantage of the innovation**. And finally, the simpler an innovation, the easier its adoption and implementation. This is the **simplicity of the innovation**.

Factors related to the internal system

The internal system refers to the actors responsible for the implementation of the innovation. As explained by Greenhalgh et al. (2004), *"people are not passive recipients of innovations"*. Rather, they are actors, they are the ones that make the innovation happen – or not. Various elements can influence the way actors perceive and adopt an innovation. The **capacity of the staff to implement the innovation** refers to the level of experience, knowledge and openness to invention that the staff possess in order to implement said innovation. The **organizational support for the staff** refers to the support that the organization provides, in terms of assistance and training, in order to increase the

capacity of the staff to implement the innovation. The **organizational resources invested in the innovation** refers to the financial, human and material resources made available for the adequate implementation of the innovation. And finally, the **organizational readiness for the innovation** refers to the organization's level of readiness to assimilate the innovation.

Factors related to the external environment

Beyond the innovation itself, and the actors responsible for adopting it, the implementation of said innovation takes place within a particular context, a context that undeniably influences adoption and implementation through diverse factors, including the established **inter-organizational networks** and the existing **sociopolitical climate**.

3.2.2. Factors related to the innovation

The first category of factors known to influence innovation implementation relates to characteristics of the innovation itself. In the case of ILAGIILLUTA in the two pilot communities, the following factors were identified:

- ✓ The compatibility of the program with the intended clientele's perceived needs and with local norms and practices
- ✓ The relative advantage of the program for the clients
- ✓ The simplicity of the program

COMPATIBILITY OF ILAGIILLUTA WITH LOCAL NORMS, PRACTICES AND NEEDS

The services provided through the program in both communities seem to be fairly compatible with local norms and practices. Also, while many aspects of the program seem to respond to various needs faced by the intended clientele, differences between communities in terms of the services offered seem to lead to some needs being addressed in one community but not in the other, and vice versa.

COMPATIBILITY WITH INTENDED USERS' NORMS AND PRACTICES

The program appears to be sufficiently compatible with Inuit practices, as it offers culturally relevant group activities in both communities, such as the making of traditional crafts, the organization of on the land picnics and the preparation of country food dishes. All of which seem to be well received by Inuit staff and clients.

For instance, participants commented the following:

> *"During new mom's activity, we teach mothers how to do traditional baby hats, baby wraps." (Program staff)*

> *"I like going on the land also, because it is good for the brain. Our body feels it is good to be on the land, like our ancestors. As soon as I go on the land, I can think." (Program client)*

In fact, the provision of country food appears to be a particularly attractive aspect of group activities:

> *"When there is country food [during activities], the women come." (Program staff)*

> *"Participants really seem to prefer country food when we serve snacks or do nutrition activities. They often say that they would like it to be more available." (Program staff)*
>
> *"We used to eat country food and it made us strong." (Program client)*

Not all activities that were tried seem to be fully compatible with cultural norms and values. Some of the more 'Western-style' healthy eating habits, for example, seem to be perceived by some participants as being against the social norm. One staff member in Community A commented:

> *"Nowadays, at both stores, we can get [healthier food options] like beans or tofu. Even though it is available, it is not something that people are very interested in. Same thing with baby food making. It does not seem to be something that participants are interested in… so we stopped doing that… " (Program staff)*

Staff members in this community also mentioned that it is often challenging to carry out group activities intended for pregnant women, such as prenatal and childbirth preparation classes, because they are perceived as being against the cultural norm.

> *"Mothers mostly come for our activity after the baby is born; it is not traditional to prepare for the baby during the pregnancy; it is believed to bring bad luck… Some think that if you prepare too much, the baby might have problems at birth. Once, we were offering new crib to a pregnant lady and I remember her saying 'oh no, I am going to be too ready!'" (Program staff)*

That being said, the prenatal period is often thought to be an ideal time for health care providers to start building trust relationships with expecting mothers and families. It is also a good time to convey healthy pregnancy advice to expectant women. Therefore, activities are offered in both communities to the pregnant women who are interested, as further discussed in the section below.

Compatibility with intended users' perceived needs

The program was also described by most participants in both communities as being in line with many of the basic needs faced by the intended clientele, such as the need for better access to healthy food and health education. However, the different approaches developed in each community in terms of what and how services are provided may explain why, in certain instances, some needs are better addressed in one community than in the other.

Access to healthy food

Most participants interviewed acknowledged the crucial role that the CPNP food coupons play in answering the need for financial assistance for food. The fact that these coupons are distributed in these two communities through ILAGIILLUTA is therefore considered, as reported by the majority of participants, as an aspect that greatly contributes to the success of the program. Comments to that effect were in fact raised, without prompting, by most clientele and staff in both communities.

Important note: although the CPNP coupons are distributed in the pilot communities through ILAGIILLUTA, in other communities where the program has not yet been implemented, the coupons are also available to pregnant women and recent mothers; these are usually distributed by various health professionals, including midwives, nurses or social workers involved in prenatal care, depending on personnel availability.

Indeed, the CPNP coupons were described as being very helpful, particularly for worse off families, given that some seem to depend on these for nourishment.

> *"The coupons really help." (Program client)*
>
> *"C'est certain que les coupons sont utiles parce que de nombreuses familles souffrent d'insécurité alimentaire. " (Program staff)*
>
> *"Some basically live off coupons." (Program staff)*

Some participants also emphasized the coupons' usefulness for buying healthy food, especially for pregnant and breastfeeding women, for whom a good nutrition is regarded as crucial.

> *"Eating the right food when pregnant is important." (Program client)*
>
> *"It [the coupons] is very useful to buy healthy foods; especially when we are breastfeeding, cause we need to eat lots." (Program client)*
>
> *"Our body is like a ski-doo, if you don't feed it good fuel, it won't work. But healthy food is expensive, even if it is subsidized…" (Program client)*

In fact, both clients and staff reported that most pregnant women's first contact with the program is greatly facilitated by the distribution of the food coupons.

> *"I first started coming here for the coupons, during the pregnancy." (Program client)*
>
> *"This [wanting to get the food coupons] is mostly how they [expecting mothers] start coming to see us." (Program staff)*
>
> *"I think about 50% of pregnant women come for coupons, or maybe more." (Program staff)*

Moreover, given that these coupons are considered essential, most participants in both communities suggested that the support these provide should be extended. However, because the coupons' mode of delivery differs between the two communities (see services description section), the suggestion for reinforcement varies accordingly.

For example, whereas in Community A clients emphasized the need for the CPNP coupons to be distributed for a longer period, in Community B staff members emphasized the need for these to be of higher value and include basic baby items.

> *"When it [coupons] stops at 6 weeks post-partum, it is difficult. It should be extended irrespective of whether breastfeeding or not." (Program client, Community A)*
>
> *"It would help to give a higher amount for food coupons; $80 is hardly good for one family meal here; the coupons should also cover the diaper and baby*

> *formula, because these things are expensive and they are not 'fast food'." (Program staff, Community B)*

Also, a staff member in Community B expressed her concern about limiting coupon access only to Inuit women, deeming this as problematic because some non-Inuit women are also in need of additional financial support:

> *"J'étais très déçue lorsque la décision d'exclure les femmes Non-Inuits du programme des coupons a été prise; je comprends que les budgets sont octroyés pour la population Inuit, mais il y a aussi des femmes blanches qui ne vont pas bien du tout et qui pourraient aussi bénéficier des services. Peut-être serait-il mieux de faire une sélection sur la base des besoins que sur un critère ethnique… " (Program staff)*

While this decision was perceived by some as a form of "reverse discrimination", some staff members justified it by the fact that most non-Inuit women tend to have access to alternative sources of financial support:

> *"In the past, there were non-Inuit who were foster parents and were claiming CPNP [coupons]. They were already receiving financial support from DYP [the Director of Youth Protection]. For this reason, a rule was put in place." (Program staff)*

That being said, a staff member mentioned that, given that food insecurity is highly prevalent in this community, perhaps food banks could be more useful for families than the current food coupon program:

> *"Je me demande en fait s'il ne serait pas plus utile d'avoir plutôt une banque alimentaire. Ça permettrait de répondre mieux aux besoins des familles pour lesquelles les coupons sont insuffisants… " (Program staff)*

Finally, it should be noted that, in both communities, the program gives access to healthy food not only by distributing the CPNP coupons, but also by providing healthy meals or snacks during group activities. This seems to be particularly appreciated by clients, as reported in Community A:

> *"I like the food, they offer hot meals, or breakfast." (Program client)*
>
> *"I like the healthy food." (Program client)*

Access to health education

The program was also described as addressing the need of clients for information and advice regarding health, pregnancy and early childhood.

> *"Before, we were raised by our grandmothers, who were very knowledgeable, but the young mothers now, there are no more grandmothers and they lack basic information." (Program staff)*

One area of health promotion that was consistently mentioned by participants as deserving particular attention is the prevention of fetal alcohol spectrum disorder (FASD). In fact, many clients and staff described the program's FASD prevention counselling services as essential:

> *"Prevention of FASD is important, it is our future." (Program client)*
>
> *"[After attending a conference on FASD] I started seeing how important it was to prevent this problem. So I thought we really need to implement this [FASD prevention counselling]." (Program staff)*

Also, the FASD prevention information sessions that have been held in schools in both communities seem to have been well received by the attendees.

> *"I was shy at first, because I am not an expert… But when I started putting my coat to leave, they [the teachers] said, 'stay we have more questions!'" (Program staff)*

On top of that, there also seems to be an interest from clients in being better informed about nutrition and diabetes prevention.

> *"I liked when the diabetes nurse came. We got to learn how diabetes can come from years of bad eating habits." (Program client)*
>
> *"Many parents don't know how to cook healthy foods; we could have recipes that are very simple, with a picture of the receipts, so that they know how much it costs. Maybe also a grocery list for a week which costs $45, so that we could show what to buy for the amount of the weekly coupon." (Program client)*

Access to other forms of support

ILAGIILLUTA also provides access to free basic items for children, such as clothing, cribs and other articles considered a necessity. Mothers indeed seem to welcome this:

> *"I liked the baby celebration; they gave me a bag with things you need for the baby (face cloths, diapers, lotion)." (Program client)*
>
> *"I like that people donate their kids' clothes." (Program client)*
>
> *"I liked the crib." (Program client)*

While in Community A free clothing is provided on the ILAGIILLUTA premises, in Community B it is usually provided, along with other household items, through other community-based organizations.

Staff members in Community B also provide clients with other forms of support. For instance, clients often need help accessing other assistance programs, so, the staff lend a hand:

> *"I have started helping the clients with their paper work (CSST, maternity leave, obtaining a spot in day care); I can help with making calls, otherwise, they often end up not applying and not getting the financial help they need. They should receive all the money they are entitled to." (Program staff)*

This need was in fact also discussed by clients in Community A:

> *"Getting the information from the Web on what we are allowed to have from the Quebec Parental Insurance Plan is complicated." (Program client)*

The team in this community is therefore currently developing services to address this.

Access to a safe space and social support for parents

Several participants in Community A discussed the program's important role in providing a safe space for clients. The ILAGIILLUTA House, which is open at all times during the day, certainly appears to provide such a propitious environment:

> *"They [clients] come here, they feel safe and they don't want to leave." (Program staff)*

This in turn seems to help facilitate relaxation and wellbeing. One mother commented:

> *"I used to come during my last pregnancy just to relax… take time for myself, I realized that… if I want to be a good mother, I have to take care of myself." (Program client)*

In Community B, most of the program's services are offered at an office located within the hospital or at an activity room located near the hospital. Although the latter can be considered more welcoming, given that it is not situated in a hospital setting, it is only open when activities are scheduled. One staff member in fact alluded to the need for a space where parents and families can easily come to whenever needed or desired:

> *"[Having offices at the activity room] would allow the parents to just drop by anytime, not just at the time of scheduled activities." (Program staff)*

However, ever since the interviews in this community were conducted, the program staff have begun opening the activity room on a walk-in basis for the community once a week.

In addition, closely related to the need for a safe space is the need for social inclusion. Group activities seem to help address this. For example, several clients in Community A commented on the value of these activities in allowing mothers to get together and support one another. Some mothers affirmed:

> *"It is helpful to get together, because when you first have your baby, you stay home all the time, it gets lonely. I come to bond with the other ladies. I always look forward to coming to these activities." (Program client)*
>
> *"I came a lot during my pregnancy for the getting together, bonding with the ladies and the support. I had 2 pregnancies before and this one was very different." (Program client)*

Moreover, the services provided in Community A seem to be perceived as more pleasant than those provided by other programs. One client commented:

"I meet with them [another program]… I don't really like it… I also have to see the social worker [from ILAGIILLUTA]… I like it better." (Program client)

In fact, the program appears to be well received in both communities:

"Nothing is perfect, but this program is perfect. All I want is that they keep it going." (Program client)

"I really think this program is awesome." (Program staff)

"Vous savez ce projet, c'est un peu comme mon bébé, on y a travaillé très fort, et il y a des femmes Inuits qui m'ont dit un jour, 'You know, it is our program now'. Ça me fait croire qu'il est là pour rester." (Program stakeholder)

Some participants even expressed their astonishment about the fact that the program had not been made available sooner:

"Where was this program when we were having our babies?" (Program staff)

"I was talking to my aunt about what we do and she said 'why didn't we have this 20 years ago?'" (Program staff)

And others expressed the need for activities to be available for mothers even after the end of their maternity leave:

"[We need] evening activities for women who have gone back to work." (Program client)

Access to continuity of services

Given that in Community B the program is delivered as part of a multidisciplinary set of services (such as midwifery, nursing and psychosocial support), it helps ensure the continuity of services for families, something which is deemed essential by staff and stakeholders:

"C'est pas vraiment la job des intervenant de savoir si telle ou telle famille a besoin de tel ou tel programme, mais plutôt d'offrir les services selon les besoins des familles. Ça permet une meilleure intégration des services et assure la continuité des soins pour les familles." (Program staff)

"L'intégration des services permet de couvrir tout le continuum de services; ainsi, selon les besoins de la famille, on offrira des services de promotion, de prévention, de dépistage ou curatifs, mais les intervenants sont les mêmes… " (Program stakeholder)

"Les services ILAGIILLUTA et de pédiatrie sociale sont intégrés de manière à couvrir l'ensemble des services dont peuvent avoir besoin les familles, tant en prénatal qu'après la naissance de l'enfant." (Program stakeholder)

The social pediatrics clinic, for example, allows for the early detection of development delays and the effective provision of stimulation interventions:

"La clinique de pédiatrie sociale, c'est une approche qui marche vraiment bien; on voit les familles des enfants 0-5 ans sans distinction et on met en place un soutien multidisciplinaire selon les besoins." (Program staff)

"Les enfants s'améliorent rapidement puisqu'on réussit à détecter le problème [des délais] assez précocement." (Program staff)

A staff member however commented on the need to extend the provision of care beyond the age limit of 5 years:

"J'aimerais que l'on puisse assurer une meilleure continuité lors de la première année de scolarisation… c'est un moment clé pour les familles, et si elles n'ont plus de services, cela retombe sur la première ligne." (Program staff)

In Community A, although the program specifically aims to deliver promotion and prevention services, it refers clients that require primary care, specialized diagnostics or curative services to the community's clinic:

"On fait les well-baby clinics pour les enfants de 0 à 5 ans; l'infirmière voit les enfants jusqu'à 2 ans et fait la vaccination ici, à la Maison ILAGIILLUTA. Les médecins de la clinique viennent également pour faire les suivis des enfants de 3 ans une fois par mois. Mais nous ne pouvons assurer des services de garde ou de clinique sans rendez-vous. Les clients qui ont besoin de soins de première ligne, on les accompagne à la clinique où ils pourront être vus rapidement et référés aux services sociaux ou spécialisés au besoin." (Program staff)

Yet, it seems that some clients in Community A would appreciate having more access to certain specialized services through the program itself:

"As an educator in day care, I wish they [ILAGIILLUTA workers] could come to help us know what to do with babies that have some delays." (Program participant)

All this being said, there appears to be some challenges associated with Community B's approach of integrating the program with primary care services. First, this entails that all of the psychosocial staff, namely the psychoeducators and social workers, are required to undertake emergency psychosocial on-call duties. This additional role appears to divert attention and energy away from the program's preventative objectives:

"La garde psychosociale: c'est stressant. On nous appelle souvent pour des crises suicidaires." (Program staff)

"The on-call work is difficult. Sometimes we don't sleep at night, it makes it difficult to do the community activities the next day." (Program staff)

And second, poor attendance at the social pediatrics clinic seems to be frequent. This appears to suggest that this component might not be perceived by all clients as a necessity:

> *"The parents don't always come to their scheduled appointments at the social pediatrics clinic; they don't see the need, I think. Although we call to remind them and explain the reasons for the appointment." (Program staff)*
>
> *"Les cliniques auxquelles j'ai participé, il y avait environ 50% de no show. Donc dans un après-midi, je voyais une ou 2 familles seulement." (Health professional)*

Moreover, in spite of Community B's emphasis on providing continuity of care to all families with young children, there seems to remain important gaps in speech-language therapy and in substance abuse services:

> *"Un des défis est l'absence d'orthophoniste dans la région; or, plusieurs enfants présentent des retards du langage. Souvent, les enfants se font évaluer par une orthophoniste au Sud, mais il n'y a personne ici qui a les compétences pour assurer le suivi, surtout que ça prend quelqu'un qui est compétent en contexte de diversité linguistique. Les enfants sont exposés à plusieurs langues à la maison (Inuktitut, anglais, français). Alors, j'essaie de me faire coacher par des orthophonistes pour avoir des petits trucs pour aider; je fais ce que je peux, mais ce n'est vraiment pas l'idéal." (Program staff)*
>
> *"Il y a un énorme besoin de services en dépendances dans la région… on sait tous que presque tous les problèmes de santé sont de près ou de loin liés aux problèmes de détresse et d'abus de substances… Isuarsivik développe en ce moment son offre de services de manière à ce qu'il y ait des groupes hommes et femmes en continu, mais ils ne font aucune thérapie familiale, il n'y a pas de services spécifiques pour les jeunes. Il n'y a même pas de centre de dégrisement! Ça me préoccupe énormément… Avec l'équipe ILAGIILLUTA, on a commencé à faire des interventions familiales, et ça marche bien; c'est ça qui devrait être offert partout… " (Program staff)*

Relative advantage of ILAGIILLUTA

Programs which provide numerous observable benefits to their target clients are known to be easier to implement than those that do not. In this case, the above mentioned compatibility of ILAGIILLUTA services with many client needs was reported as having resulted in various observable benefits for both communities.

Among these, the acquisition of health-related knowledge was reported as a benefit of the program. Various clients in Community A (no clients were available for interviews in Community B) actually described how they concretely benefitted from acquiring such knowledge:

> *"I learned how to stop giving the bottle at 1 year, how not to give junk food." (Program client)*
>
> *"I also learned about how to prevent flat heads, by not using baby chair so much." (Program client)*
>
> *"The one-on-one counselling regarding alcohol in pregnancy is very informative." (Program client)*

> *"I learned about breastfeeding, the chart [how long to wait after drinking alcohol]. I liked that. It helped with my breastfeeding." (Program client)*
>
> *"The 6-8 week home visit was really useful for me, because with my first child, when she got to that age, I did not understand she was teething, so when she kept crying, I thought she was hungry and I fed her solids too early." (Program client)*

A staff member in Community A also discussed how effective FASD counselling can be in reducing alcohol consumption in some clients:

> *"Sometimes it works: once, I asked a lady, 'how did your weekend go?' She answered, 'ah, I stopped, what you told me last week scared me.' I also say, 'we don't even recognize our own babies because they have the FASD facial features', and then there was this lady who told me, "I stopped, I want my baby to look like me." (Program staff)*

Simplicity of ILAGIILLUTA

The simpler the innovation, the easier it is to adopt and implement. In this case, although making the program available to clients was reported as being relatively simple, the emotional burden that the provision of this type of support may at times impose on the staff, the lack of client participation in some of the activities offered and the misunderstanding of some of the services provided were reported as some of the aspects that can at times complicate matters.

Aspects of the program that simplify its implementation

One important aspect that seems to have greatly facilitated the implementation of the program in Community A, as reported by the staff, is the positive and motivating work environment in which the program is conducted:

> *"I like to know I support healthy pregnancy." (Program staff)*
>
> *"I used to work at social services, but I burned out. When there was the opening here, I applied… It really improved my life. I am less stressed… When I used to work for social services there were crises every day, but there are no crises here, it is positive and with positive co-workers." (Program staff)*
>
> *"Beading [one of the available group activities] is a good addiction for me. It is beautiful and I started doing this when I started working here. It makes me proud and happy. When I used to work at the nursing, I was exhausted all the time… now that I work here, it is stress free… I like it here because it is like being part of a family." (Program staff)*

Another aspect that also seems to have facilitated implementation in both communities is the fact that the knowledge required for the adequate delivery of the program appears to be easily acquirable; none of the staff reported experiencing difficulty in assimilating such knowledge. Similarly, the knowledge that needs to be transferred to clients can, according to the staff, be easily simplified and adapted to each client's unique context.

> *"I am no expert [in FASD]. I just know how to explain it simply." (Program staff)*

> *"I do it [FASD counselling] privately, I try to make it short (5-10 min), especially when I see they [clients] are not into it, or they have someone waiting for them... I use pictures and simple words, I try to make it personalised." (Program staff)*

Besides this, client enrollment appears to be greatly facilitated by the cooperation of each community's maternity team and by the delegation of CPNP coupon distribution responsibilities to the program staff:

> *"[The maternity unit] tell their pregnant ladies, the first time they come to see the midwife, that if they want coupons, they can come and get them here. This is mostly how they start coming to see us." (Program staff)*
>
> *"En prénatal, les femmes sont référées par la sage-femme ou le MD, en début de grossesse, pour la distribution des coupons." (Program staff)*

This in turn creates an ideal opportunity, in both communities, to provide clients with FASD prevention counselling right at the beginning of their pregnancy:

> *"I do FASD counselling on the first coupon visit." (Program staff)*
>
> *"[When mothers come for coupons] we give FASD prevention counselling." (Program staff)*

Also, client follow-up seems to be facilitated in both communities by having the staff directly contact clients (e.g., by phone or social media) to check up on them and remind them about activities and appointments.

> *"They call me the day before [an activity], I like that." (Program client)*
>
> *"They knew I was depressed and so they called me regularly to see how I was doing." (Program client)*
>
> *"Those who don't come, we will call them and remind them that we would be excited to see them, that we have activities for them." (Program staff)*
>
> *"[We use] FM, Facebook page or private message to contact clients and remind clients." (Program staff)*

Furthermore, program accessibility seems to be highly facilitated by the fact that the program's main offices in both communities are open to clients at all times during the day.

> *"We have to be there at any time if mothers come for coupons." (Program staff)*
>
> *"On les accueille on tout temps; parfois elles viennent en passant prendre leur coupon. C'est important de pouvoir être disponible en tout temps, pour qu'elles puissent 'drop in' au moment qui leur convient." (Program staff)*

Aspects of the program that complicate its implementation

There are however certain aspects that were reported as being more complex and thus as possibly rendering the implementation of the program more difficult.

First, staff members in both communities discussed the emotional burden that can at times be associated with the nature of their roles. In Community A, for example, they discussed the emotional distress that can be felt due to the complexity of the difficulties faced by families in this community:

> *"It can be overwhelming sometimes, it shocks me to know what people go through sometimes." (Program staff)*
>
> *"Il y a des moments où c'est difficile… Pourquoi la population devrait-elle endurer des conditions de vie pareilles? Il a des fois où je me sens dépassée. On ne sait plus par où commencer." (Program staff)*
>
> *The staff also talked about the discomfort that can be experienced while carrying out some of their work responsibilities, particularly when dealing with unforeseen events or when conducting home visits:*
>
> *"Il faut faire face à de nombreux imprévus, il faut s'adapter… on ne peut pas tenter de prendre tout sur nos épaules… " (Program staff)*
>
> *"I found the home visits to be uncomfortable, mostly because of the home environment and also because it was difficult to do activities with the children in the presence of the parents or care givers (foster families, often)." (Program staff)*

Second, staff members in both communities also discussed client non-attendance, which can in turn obstruct the effective delivery of the program.

> *"Very few come for activities during pregnancy, because they work, or they are tired. Some also, because they don't really get along with some other lady… I realized that not all like the group activities for that reason." (Program staff)*
>
> *"[Some clients] don't come because they don't want to be in group activities; they may have conflicts with another lady… Or some don't want to be pregnant. They tell us." (Program staff)*
>
> *"At that time [when the staff call clients to remind them about appointments at the social pediatrics clinic], they say they are going to come, but then when I see them in the community after, they say they had other things to do." (Program staff)*

And last, but not least, there seems to be a certain level of confusion among ILAGIILLUTA's and other organizations' staff members, and even among some community members, as to the exact role of ILAGIILLUTA within the service continuum to be delivered to clients. This is observable in various instances, including in the area of FASD prevention and social services.

> *"Now that ILAGIILLUTA is doing FASD counselling [at the ILAGIILLUTA House], we have stopped doing our kiosk at the school and at the family house. But I wonder if we should not continue." (Program client)*
>
> *"I was wondering if we should continue going to school to talk [about FASD] with the students; we did this once." (Program staff)*
>
> *"I think that our [social work] services are often associated with the DYP. People are confused between the ILAGIILLUTA and the DYP services. I know sometimes people in the community will ask me if I know this or that person who works at DYP and I answer, 'No, I don't know, I don't work with them'. But they think we work together." (Program staff)*

Confusion regarding the exact mandate of ILAGIILLUTA within the continuum of care for pregnant women and young children was also discussed in the section 'ensuring the continuity of services'.

Indeed, as discussed in the services description section, Community A tends to focus on providing health promotion and prevention services only. Community B, on the other hand, presents an integrated model of all programs aimed at young children, from prevention to rehabilitation. However, while there are potential advantages to each of these approaches, the lack of consensus on this matter certainly seems to contribute to the complexity of elaborating and implementing the program at the regional level.

> *"[L'intégration des services dans la Communauté B] a créé par contre beaucoup d'incompréhension, avec la Régie surtout, qui nous dit que l'on ne fait pas du ILAGIILLUTA, et que notre guide de programme ne correspond pas au cadre de référence SIPPE." (Program staff)*
>
> *"J'ai l'impression que la perception des services offerts à [Communauté B] ne reflète pas la réalité; on entend souvent de la part des agents et des cadres que le programme de [Communauté B] ne 'fait pas de prévention'; or, selon l'expérience que j'en aie eu au moment où j'y travaillais… il y a de nombreuses activités communautaires… " (Program stakeholder)*
>
> *"This perception [that the program as offered in Community B does not provide prevention services] has affected the working relationship between the Health Centre and the Health Board." (Program staff)*
>
> *"Je pense que l'on perd trop de temps à vouloir uniformiser l'approche des deux côtes; c'est normal que les deux côtes aient développé des programmes différents, parce qu'ils avaient accès à des ressources différentes. Je pense que l'on devrait plutôt partir de ce qui existe… Il me semble que nous n'avons pas de vision régionale des programmes et des services… On ne s'entend pas sur les priorités, et les visions ne cessent de changer selon les individus. C'est très frustrant." (Program stakeholder)*

3.2.3. Factors related to the internal system

The second category of factors known to influence innovation implementation relates to characteristics of those responsible for implementing the innovation. In the case of ILAGIILLUTA in

the two pilot communities, this refers to the characteristics of the program's team members and to their immediate context within the organization. The following factors were identified:

- ✓ The capacity of the staff to implement the program
- ✓ The organization's support for the staff
- ✓ The organization's resources invested in the program
- ✓ The organization's readiness for the program

CAPACITY OF STAFF TO IMPLEMENT ILAGIILLUTA

Overall, the staff appear to possess the experience, knowledge and openness to innovation necessary for the effective implementation of the program. However, many could benefit from acquiring a better understanding of client needs and preferences.

EXISTING SKILLS AND KNOWLEDGE BASE OF STAFF

The staff in both communities seem to possess experience that is relevant to the program. In Community A, for example, the program coordinator possesses over 15 years of experience working with ILAGIILLUTA in Southern Quebec and other staff members possess previous work experience in related areas (e.g., childcare and social services). In Community B, staff members also possess relevant work experience:

> *"Je suis psychoéducatrice au sein de l'équipe depuis un peu plus d'un an, mais j'ai travaillé dans la région à plusieurs reprises au cours des dernières années." (Program staff)*
>
> *"I am currently on a 'congé nordique', from my regular job, which is to work at the Centre Jeunesse in Chaudière-Appalaches." (Program staff)*

However, the following was discussed regarding certain limitations faced by health professionals trained in Southern Quebec:

> *"Malheureusement, les professionnels de santé que l'on embauche [du sud] ont surtout une expérience d'intervenants, ils sont habitués à être réactifs aux demandes des clients. Mais le travail que l'on fait exige que nous soyons proactifs, que nous anticipions les besoins de notre population et que nous développions des activités qui permettent d'améliorer leurs conditions de vie et de leur apporter un peu de soutien. Mais ils [les intervenants du sud] ne sont pas formés pour faire ça." (Program staff)*

Moreover, the following was also discussed regarding the need for non-Inuit health professionals to modify certain aspects of their work practices in order to better serve their Inuit clients.

> *"There is a lot of miscommunications between the Qallunaat health professionals and the Inuit parents… Often parents ask me 'why is she [non-Inuit health care worker] staring at me?'… I would tell the Qallunaat 'don't stare at people', it makes them feel awkward… Have an open mind and don't talk over people. Don't ask so many questions and keep your questions simple." (Program staff)*

That being said, many of the non-Inuit staff interviewed seem to be fairly mindful of clients' circumstances and preferences:

> *"[Il faut] suggérer plutôt qu'ordonner, surtout dans un contexte de colonisation; il faut savoir écouter." (Program staff)*
>
> *"Les rendez-vous ça ne marche pas, il faut être flexible." (Program staff)*
>
> *"Une des choses qui me mettait mal à l'aise, c'est le fait que tous les intervenants étaient présents au moment de la visite avec la famille… je trouvais qu'il y avait trop de 'white faces' et que cela semblait mettre la famille mal à l'aise d'être bombardées de questions par tout le monde." (Program staff)*

Likewise, staff members overall seem to have quite an astute understanding of the local context. They reported being aware of the difficulties that working in such a context can bring:

> "Ça me met mal à l'aise parfois (le fait que ça soit nous qui distribuons les coupons du programme canadien de nutrition prénatale) : je me demande si les femmes viennent *nous voir juste pour les coupons dans le fond." (Program staff)*
>
> *"Depuis 2015, il y a comme une lourdeur dans la communauté; à cause des suicides, je pense. On sent comme un effritement de la mobilisation communautaire. Tout le monde est en survie… c'est peut-être pour ça qu'il y a moins de monde qui viennent aux activités communautaires qu'avant." (Program staff)*

They also reported being aware of differences of opinions regarding tradition among clients:

> *"But not all [mothers feel it is untraditional to prepare for the baby's arrival], some feel it is OK to get some things ready and they will sew their amauti, for example." (Program staff)*

In addition, staff members reported working towards creating a supportive and understanding environment so that clients feel at ease to ask for help no matter what.

> *"On établit un lien de confiance avec les clientes; elles savent qu'elles peuvent venir nous voir avec des demandes de toutes sortes, même des demandes floues. On n'est pas toujours obligés d'avoir des objectifs d'intervention; parfois, on est simplement en réponse aux besoins de base." (Program staff)*

Moreover, various staff members in both communities emphasized that this type of work also requires a certain level of mental aptitude and relevant life experience:

> *"If I was to train someone, I would tell them, have you had children? Because working here, you need to love babies. You can build on your experience as a mother." (Program staff)*

"It helps though when you are a little bit older than the client to give such advice or have had many kids. Otherwise, they may think, 'who are you to tell me this, you have not had as many children as I have!'" (Program staff)

"[The staff need to be] mentally strong no matter what." (Program staff)

"Pour faire ce genre de travail [en abus de substances], il faut avoir fait un travail profond sur soi-même et avoir abordé ses propres enjeux de dépendances, et ça, ce n'est pas donné à tout le monde. C'est très difficile ce genre de travail." (Program staff)

Ability of staff to integrate new knowledge

The staff in both communities seem quite able and eager to integrate new knowledge and innovative approaches in order to successfully deliver the program.

In Community A, for example, they mentioned having learned about the negative effects of stress during pregnancy, this thus being the reason why they introduced relaxation exercises in activities aimed at expecting mothers.

"What we do with pregnant ladies, when they come, is relaxation; because we have learned that cortisol can actually affect the baby's brain and so it is important to relax during pregnancy." (Program staff)

A staff member in this community also mentioned that attending a conference on FASD helped her realize the importance of FASD prevention and thus the importance of implementing corresponding counselling services. She also stated that, once she became aware of the effects of stigma regarding this issue, she modified her attitude towards clients.

"When I started doing this, I was quite aggressive, but I calmed down, because of the stigma. Now, [when] some women tell me they have drank, I say, 'It's OK, it happens. As long as you quit right now, it is never too late.'" (Program staff)

In another example, when the program was first rolled out in this community, and participation in FASD counselling was low, one staff member took action:

"For 1 month, nobody came, and this is when I started thinking about asking the maternity if we could distribute the [CPNP] coupons… this is how we started doing FASD counselling with the first coupon [when pregnant women come to get them]."(Program staff)

In Community B, once the staff realized that home visits to carry out stimulation activities for children were not always effective, they modified things:

"When [the previous coordinator joined the team], this [individual stimulation activities] was changed to play groups for children 3, 4 and 5 years of age, at the activity room or day care, and this works much better. I have found that children improve much faster when they are in interactions with others. Particularly when they have speech delay." (Program staff)

Also, as discussed in a previous section, once the team's social workers in this community realized that many clients do not apply to other assistance programs, and thus do not get all the financial aid that they are entitled to, they began helping them with the necessary paperwork. This services is also under development in Community A.

Finally, not only are the staff able and eager to learn and adopt new practices, but they also are keen to exchange newly acquired knowledge amongst themselves:

> *"I like it because we share each other's trainings." (Program staff)*

ORGANIZATIONAL SUPPORT FOR THE STAFF

No matter how competent the staff members of an organization might be, they still require adequate support from the organization itself to function effectively and in turn implement programs successfully.

In this case, although some support is indeed provided, certain concerns were voiced regarding the need for standardized training at the regional level and improved internal communication.

Training provided

Given the context and constraints under which the program operates in these communities, suitable training for the staff is a must. Local staff in both communities have the opportunity to regularly attend conferences and workshops on specific topics such as child development and FASD. Moreover, they have the opportunity to enroll in the "Communication in Helping Relationships for Inuit workers" program provided on-site by Marie-Victorin College; this prepares those enrolled in the program to assess clients' needs and develop and carry out intervention plans. Local staff members from both communities are currently enrolled in this program, except for two local staff members who have already successfully completed it.

In Community A, the staff are also offered the possibility to enroll in the Inuit management program provided by McGill University. One staff member in fact recently graduated from this program. In addition, local staff members in this community affirmed having received informal training and coaching from their coordinator and other co-workers when they first joined the team (see next section).

Nevertheless, the staff expressed the wish to receive additional training. First, there is a need for formal training better tailored to the work conducted by the Inuit staff. And second, there is a need for more cultural safety training for the non-Inuit staff.

> *"We should have a specific training for the type of work that we do; we have often asked for this, but it never happened. There is the Marie-Victorin training, but it is mostly for crisis intervention stuff, not what we do here." (Program staff)*
>
> *"Since the beginning of the program, we have been asking for regional training for Family education workers. Unfortunately, it never happened and we still don't have a specific training for the workers." (Program staff)*
>
> *"We need more structured training, either on site or in another community, does not matter… but it also needs to be hands on." (Program staff)*
>
> *"Once we had a reconciliation activity with some of the Non-Inuit health professionals; [the activity facilitator] explained about our history, so that they*

understand the Inuit better and be less judging. I think the people at the hospital really need more of this kind of activity." (Program staff)

Other sources of support

Aside from training, other forms of support can also help facilitate program implementation.

In Community A, for example, the coordinator described having been directly involved at the program's outset, helping set up services and activities, and subsequently stepping back and delegating once everything was up and running:

> *"Au début j'étais présente à toutes les activités, j'apportais mon appui très concrètement aux intervenantes pour la mise en place des services et des interventions. Mon rôle depuis environ un an est d'avantage la planification et la gestion de l'équipe; les intervenantes font toutes les activités." (Program coordinator)*

She also discussed the strong support the team has received from higher management to continue expanding the program into other communities:

> *"Mes gestionnaires sont très motivés à poursuivre l'expansion du programme aux autres communautés de la côte. Encore récemment, ils me demandaient quels étaient mes besoins en ressources humaines." (Program coordinator)*

In fact, there seems to be strong support for program expansion at the regional level:

> *"Il est incontournable que ILAGIILLUTA est requis dans toutes les communautés; en fait, ceci a été réitéré par la direction générale à la table jeunesse et le Regional Advisory Committee récemment." (Program stakeholder)*

Moreover, Community A's team also lends assistance to workers located in smaller communities; they conduct regular visits and provide training. Putting this aside, an adequate flow of information throughout an organization is also likely to facilitate the creation of a supportive work environment. For instance, in Community B, weekly team meetings are held to discuss cases and issues:

> *"We meet every other Friday afternoons to discuss our organizational issues. The other Friday afternoons, we meet the 'big table', where we are joined by the physiotherapist, the occupational therapist, the addiction worker, the community nurses, the midwifes, etc. This is when we do our case discussions." (Program staff)*

However, there are certain instances where communication does not seem to be optimal. There particularly seems to be some degree of misunderstanding between the local teams and the regional decision-makers.

> *"We are being told there is no more budget to buy food and do activities, I don't understand why." (Program staff)*
>
> *"J'en ai parlé à plein de monde [à propos des services de traitement des dépendances], au Centre de Santé, à la Régie, et ça n'avance pas assez vite. On nous dit que les services seront en place pour 2023… Je ne comprends pas pourquoi ça prend tant de temps!" (Program staff)*

> *"Les relations ont changé dans les dernières années avec la Régie; avant on pouvait appeler les agents et discuter directement avec eux. Alors que maintenant, la consigne est qu'il faut absolument passer par nos gestionnaires. Je ne sais pas d'où vient la consigne, mais c'est très curieux. Et ça ne facilite pas les liens." (Program staff)*

ORGANIZATIONAL RESOURCES INVESTED IN ILAGIILLUTA

Adequacy of resources is undeniably a vital element to the success of any program. As described below, although financial resources seem to be adequate overall, this does not seem to fully translate into an adequate supply of much needed human and material resources.

Financial resources

Funding appears to be adequate in both communities. In Community A, for example, the coordinator explained:

> *"Nous disposons d'un budget annuel qui est suffisant actuellement pour déployer les activités. Par contre, nous souhaitons obtenir du financement pour des postes dans les autres communautés et le processus est long." (Program staff)*

However, the transfer of funds from the regional to the local level is not always optimal:

> *"Even though we have an adequate running budget for activities, material and training, there can sometimes be a delay in accessing it from the regional level. This year, the financing letter came in in August and the financial year starts in April (that is why some staff members are sometimes told there is no funding, because it has not arrived yet)." (Program staff)*

When such delays occur, temporary budget cuts at the local level ensue. As mentioned in the previous section, at the time interviews were conducted in Community A, staff members reported a lack of funding for the purchase of items necessary to carry out activities.

That being said, the manner in which budgets are managed in each community appears to differ greatly. While in Community A the budget is controlled by the coordinator, in Community B it is controlled at a higher level of management, at the Tulattavik Health Centre. The latter allows for the merging of all budgets destined for the implementation of the full continuum of care for maternal, newborn, and child health.

> *"Ici, les budgets sont mis en communs, ils agissent comme des vases communicants. C'est plus simple." (Program staff)*

Human resources

In spite of a seemingly adequate amount of financial resources, human resources seem to be lacking. This appears to be mostly due to challenges in recruiting community workers and health professionals.

Although the amount of local workers seemed to be adequate in Community A and in other neighbouring communities when the program was first rolled out, difficulties in hiring local workers soon emerged as an important roadblock to program expansion.

"Nous avons embauché les intervenantes locales et débuté les activités. Rapidement nous avons recruté du personnel local dans 2 autres communautés. Nous avons donc maintenant une équipe de 7 intervenantes réparties dans 3 communautés… Nous avons également déjà une Maison ILAGIILLUTA [dans une autre communauté], mais pas encore de personnel (nous sommes en attente de postes du Ministère… les demandes ont été faites mais le processus est très long)… Le défi pour les plus petites communautés est de trouver une façon d'embaucher du personnel local qui ne travaillera pas seul… Nous essayons donc de voir comment on peut s'allier à d'autres programmes, comme celui des maisons de la famille, par exemple. On est toujours plus motivé lorsque l'on travaille en équipe." (Program staff)

Yet, scarcity of human resources seems to be more deeply felt in Community B. There particularly seems to be a need for more local community workers, as they contribute to the development and execution of health promotion activities.

"There is a lack of staff." (Program staff)

"Eventually we received enough budget to open more community worker positions, and at some point, there were 3 or 4 of us. Now we are only 2… I would like that they hire another community worker, so that we could do more, and there are no service gaps when we go on vacation… " (Program staff)

"On [les travailleuses sociales] est déjà pas mal occupées, juste à effectuer nos suivis, on n'a pas vraiment le temps de faire les activités de promotion prévention." (Program staff)

Also, as discussed in an earlier section, the staff in this community expressed the urgent need for additional health professionals, particularly in the field of substance abuse and language therapy.

"À la Régie, il y a 4 personnes qui travaillent sur des dossiers dépendance, alors que sur le terrain, je suis la seule… Alors je suis complètement débordée, je ne suffis pas à la tâche loin de là! Il faudrait en plus que je visite les autres villages de la côte pour faire des activités de prévention, mais dans la dernière année, je n'ai pas pu en faire aucune." (Program staff)

"Je me demande pourquoi on ne peut pas engager une professionnelle du privé [une orthophoniste] à contrat, comme on le fait pour l'audiologiste qui vient faire les évaluations et les suivis à intervalle régulier. Si au moins on avait ce genre d'entente, je pourrais assurer le suivi de l'intervention entre les visites." (Program staff)

Material and general resources

In addition to discussing human resource challenges, most participants interviewed in both communities talked about material resource difficulties, mostly in terms of inadequate infrastructure. In Community A, staff members and clients commented on the need for larger and better equipped facilities:

"They need a bigger place, with a larger activity room and more small rooms for the workers to work." (Program client)

"We need a bigger place with a kitchen, so that we can cook here." (Program staff)

"We should have a permanent station on FASD. So that we don't have to get things each time. It takes time, and we look disorganized. We should have a permanent station for FASD counselling in a confidential place." (Program staff)

In Community B, staff members mostly discussed the need for more private offices:

"Il faut un espace de confidentialité; c'est pour ça qu'il est important d'avoir un bureau à soi. Quand on partage un bureau, on ne peut pas créer d'opportunité d'échange et ça crée des malaises." (Program staff)

"I wish I could work closer to the activity room, or perhaps even at the activity room itself… There are offices in this building, but they are being used by another team than the ILAGIILLUTA." (Program staff)

The need for means of transportation was also discussed in both communities:

"We should have a van to go on the land" (Program client)

"We need to have a vehicle to pick up the clients, an SUV so we have many seats." (Program staff)

"Ça nous prendrait aussi un plus gros véhicule, pour aller chercher les parents; ou peut-être 2 véhicules plus petits." (Program staff)

"I think we should have our own vehicle, a good size van, for example, so we can pick the mothers up and go on picnics on the land like we did last year." (Program staff)

Also, staff from both communities expressed the need for better access to country food:

"We should have more country food for our activities." (Program staff)

"We need to buy a freezer so that when country food is available, we could buy it from the hunters." (Program staff)

Moreover, the free distribution of baby cribs, as an effort to reduce the risk of sudden infant death syndrome, is an essential aspect of the program. Yet, administrative processes appear to create unnecessary roadblocks to this important service:

"The baby cribs are back ordered and purchasing at Inuulitsivik refuses to order them because they come from the US… I think we need to solve this problem ASAP." (Program staff)

"We really need to get beds again. We need at least 10 just now." (Program staff)

Last, but not least, staff members in Community A expressed dissatisfaction over the frequent water supply interruptions:

> *"Durant la dernière année, nous avons manqué d'eau dans la communauté à plusieurs reprises, parfois même pour des périodes allant jusqu'à 10 jours. Personnellement je crois que, quand la maison ILAGIILLUTA n'a pas d'eau, ça n'est tout simplement pas possible de faire les activités. On ne pourrait même pas utiliser la toilette. Les clientes ne viendront pas alors qu'elles ne peuvent laver ou nourrir leurs enfants correctement… " (Program staff)*

ORGANIZATIONAL READINESS FOR ILAGIILLUTA

An organization's level of readiness to adequately assimilate and implement an innovation is highly dependent on the organization's ability to establish strong ties with the intended beneficiaries. Hiring local staff as frontline workers therefore constitutes the corner stone for the success of the program. While team members in both communities, as well as stakeholders, seem to recognize this essential fact, this does not appear to be fully understood by higher management at the coastal health centers.

> *"Il y a les activités communautaires qui pourraient être principalement la responsabilité des travailleurs en éducation familiale… Je pense en fait que les collègues Inuits se sentiraient plus à l'aise si on leur laissait toute la place dans ces activités." (Program staff)*
>
> *"[Le personnel Inuit] est important pour la réussite du programme, étant donné qu'elles sont essentielles à l'établissement du lien de confiance qui permettra aux familles de faire appel au programme selon leurs besoins." (Program stakeholder)*
>
> *"On [les gestionnaires supérieurs] proposait surtout d'ouvrir plus de postes de professionnels de la santé (infirmières ou travailleurs sociaux), alors que selon moi, [nous avons] surtout besoin de travailleuses locales." (Program staff)*

Indeed, the local staff have a better grasp of their community's needs. For instance, when asked about what advice should be given to new employees, a local staff member commented:

> *"Keep your teachings short, smile a lot. Be supportive and understand that many people go through a lot… be flexible and adapt to their situations." (Program staff)*
>
> *It however appears that certain rules, some of them imposed by the provincial government on the Health Board, do not necessarily support the recruitment of local staff.*
>
> *"J'aimerais parfois que l'organisation soit plus flexible; les règles d'embauche pour le personnel local, par exemple, sont parfois pas du tout aidantes." (Program staff)*
>
> *"Nous avons constaté que lorsque le personnel local doit travailler isolément, ça ne marche pas. Elles se sentent seules et rapidement elles quittent. Or, dans les*

petites communautés, il est plus difficile de justifier l'embauche de 2 travailleuses pour ILAGIILLUTA uniquement." (Program staff)

"There was a young lady who applied last year, but she was not accepted. They said she was too young. I think the bosses are too picky. Because now this girl has taken another job in the community and she would have been very good." (Program staff)

This situation can at times be interpreted by the local staff as suggesting that the organization does not acknowledge the essential role that they play within the program:

"There was a time when I was alone here for a long time… I was wondering why it takes so long to hire Inuit, whereas when the social worker position opens it gets filled immediately." (Program staff)

Yet, labour regulations appear to be more beneficial and flexible in other local and regional *organizations (some of which are not subject to provincial control):*

"I was told by people at Makivik that we have access to these [social worker] jobs now. For example, I worked for them as a justice officer for a while. Rules are more flexible there. They are starting to stand up for Inuit there, why not here?"(Program staff)

"I used to work in social services and I was making more money (working part time) than now (working full time). I used to have a position of community worker, but now I have a position of a social aid, it is $300 less per week." (Program staff)

"J'aimerais que l'on puisse embaucher plus de personnel local… Les community workers ici ont beaucoup de choix d'emploi, plus que dans d'autres communautés; il y a donc plus de compétition." (Program staff)

3.2.4. Factors related to the external environment

The third and final category of factors known to influence innovation implementation relates to characteristics of the outer context. In the case of ILAGIILLUTA in the two pilot communities, the following factors were identified: (1) The quality of inter-organizational collaboration and networks, and (2) The sociopolitical context in which the program operates

INTER-ORGANIZATIONAL NETWORKS

In both communities, program implementation was greatly facilitated by the establishment of strong partnerships, right from the outset, with other programs aimed at the same population.

"[Quand] nous avons tout d'abord développé le projet… je me suis d'abord concentrée sur l'établissement des partenariats avec la communauté et la clinique, [avec l'équipe de] sages-femmes surtout." (Program coordinator)

"The maternity [unit] gives us their updated list of pregnant ladies every Friday… The midwives also check on us to see whether we are up to date with our 6-8 weeks [visits]." (Program staff)

> *"Pour nous ça faisait plus de sens de déployer l'ensemble des services pour les 0-5 ans, incluant, ILAGIILLUTA, la première ligne psychosociale, les services jeunes en difficultés, le programme négligence, la clinique de pédiatrie sociale, etc… " (Program staff)*

Also, in smaller communities, partnerships with other programs help prevent the staff from working in isolation. These types of partnerships can be beneficial not only to the program, but also to the community as a whole. For example, although a ILAGIILLUTA House located in a community near Community A is not currently staffed, it is being used to serve young children:

> *"Les professeurs de l'école l'utilisent pour faire des activités d'éveil à la lecture avec les enfants de 3 à 5 ans." (Program staff)*

There are nevertheless other partnerships which could be developed. For instance, as suggested by some participants, partnering with local hunters could allow for better access to country food, something which is in fact currently under development across the region. Also, partnering with local day care centres, as explained by a client who works as a child educator in Community A.

Sociopolitical context

This aspect was discussed during the interviews conducted in Community A.

As with all programs deployed under the governance of the NRBHSS, ILAGIILLUTA is subject to the regulations of the Government of Quebec.

Some of the discussions that surfaced in this community seem to suggest that some policies may contribute to the difficulty of hiring local staff:

> *"When the social worker position opened, I asked whether I could apply for it and I was told that you need to have a certificate to apply. But when I worked for social services, I learned how to work with clients; I am used to do this… I have been taking the Marie-Victorin training since 2013. I know how to deal with clients." (Program staff)*
>
> *"Les règles d'embauche pour le personnel local… Ça me met mal à l'aise par rapport aux employées, parce que je sais que c'est injuste… [C'est un] système qui crée tellement d'injustice et de discrimination." (Program staff)*

What is more, in some instances, the sum of policies across different levels of governance can make living conditions difficult for community members:

> *"When you are on maternity leave, even with the government allowance, it is only 75% or 55% of your income… and our rent [is] based on income from last year, when you are working full time. I want to stay with my baby for 12 months, but it is difficult because everything is so expensive… even the day care for my older kids is based on the income I had last year, and so I cannot afford it… Did you know our rent increases by 8% per year here? [Landlords] ask about our notice of assessment to see our income and then they know they can increase our rents." (Program client)*

4. Discussion

As previously mentioned, this evaluation mainly aimed at identifying the particularities of each ILAGIILLUTA pilot project, as well as clarifying the circumstances under which each project works best. This information is meant to support ILAGIILLUTA expand at the regional level. This section will present:

- ✓ Brief summary of our main findings
- ✓ Appreciation of the strengths and limitations of the methodology
- ✓ Suggestions for program adjustments prior to expansion

4.1. Summary of the Main Results

PROGRAM DESCRIPTION: MANY SIMILARITIES, BUT VARIATIONS IN THE SCOPE OF SERVICES PROVIDED

The first phase of the evaluation allowed to observe that both pilot projects are similar in many ways:

- They aim to serve the same clientele (pregnant women and families with young children).
- They have similar objectives (support parents in need in order to foster healthy development of children).
- They use similar approaches (provide support services as needed).

The main difference, on the other hand, is the extent of services covered in each community (Community A focuses mainly on providing **community-based outreach preventive interventions**; Community B tends to be more **clinically-based, offering interdisciplinary services** that cover the full continuum of primary care services for families with children, based on the social pediatrics model).

FACTORS HAVING INFLUENCED IMPLEMENTATION IN THE PILOT COMMUNITIES

In spite of differences, several common factors appear to have facilitated the implementation of the program in both communities. In terms of **factors related to the program itself**, the following were observed:

- ✓ **Community-based activities compatible with Inuit practices are offered:** Traditional crafts, picnics on the land and the preparation of country food dishes. Indeed, traditional activities were consistently reported as fostering participation of Inuit clients by program staff and as being greatly appreciated by program clients.
- ✓ **On-site support directly connected to the basic needs of clients is offered:** Access to healthy foods and basic baby items, among other things. This aspect of the program was repetitively saluted by both staff and clients alike.
- ✓ **Provision of program interventions is relatively simple.** However, there remains certain **areas of complexity** linked to the provision of services:
    - o **Emotional burden:** Burden sometimes felt by the staff given the complex situations often faced by the clientele.
    - o **Complexity of providing FASD prevention services:** Besides providing FASD counselling during pregnancy, should also include preconception health education to teens in schools, as well as adequate support for families dealing with addiction issues.
- ✓ Still, differences between the pilot communities in terms of the scope of services offered

may explain why **some needs may be better addressed in one community than in the other**, and vice versa: For instance, while the availability of a ILAGIILLUTA House in Community A was often mentioned as addressing the need for a relaxing and safe space, rapid access to specialized services was mentioned as being a benefit in Community B.

In terms of **factors related to the organization responsible for the program** (i.e., the program staff and their immediate context), the following were observed:

- ✓ **Staff competency is essential** to ensure good quality service provision. Yet, although both communities have hired experienced staff, certain areas of practice may need further reinforcement. For example, there appears to be a need for further cultural safety training for non-Indigenous staff. Similarly, local workers would benefit from further training and support to feel more comfortable with their daily tasks.
- ✓ In spite of a **seemingly adequate amount of financial resources,** budgets do not always become available at the local level in a timely manner, creating difficulties for community-based activity planning and development.
- ✓ **Human resources are insufficient**. While the challenges linked to recruitment of health professionals in Nunavik is well known, province-wide hiring regulations can make it difficult to offer attractive working conditions for local staff. Yet, local workers constitute the corner stone for the success of the program given that services need to be provided in Inuktitut according to Inuit norms and customs.
- ✓ Finally, several **material resources** are essential to the adequate provision of services:
- ✓ **Community-based facilities**: Outreach services are more accessible to clients when available on a walk-in basis and in a community-based facility, rather than at a clinic or hospital. However, this entails that such a space be available and that it be sufficiently large and well-equipped to host all activities.
- ✓ **Transportation**: This greatly facilitates access to the program and allows to carry out group activities (e.g., on the land picnics). Access to a sufficiently large vehicle (e.g., a mini-van) can be considered as an essential component of the program.
- ✓ **Adequate water supply**: Needless to say, an unfailing water supply is essential to the proper functioning of the program.

Finally, in terms of **factors related to the outer context of the program**, the following were observed:

- ✓ Establishment of **strong partnerships** with midwifery services, Family Houses, daycares and other programs aimed at the same population is an essential element of the community development component of the program.
- ✓ Although the NRBHSS supports the expansion of the program to all communities in the region, certain **provincial hiring regulations** seem to significantly impede recruitment of essential local staff

4.2. Strengths and limitations of the results

PERTINENCE OF THE FINDINGS

The main strength of this evaluation is that it is the first to generate information that can be used to improve the program and expand it to other communities in the region. Indeed, this evaluation helped gain a better understanding of key factors that influenced program implementation and

delivery, including enrollment of clientele. In addition, the participatory approach used throughout the process helped ensure that the reported findings reflect the realities of the communities involved.

Yet, as with any evaluation, the methodology used presented a certain number of limitations, which need to be taken into account when interpreting results.

MISSING INFORMATION

Although all staff members involved in both pilot projects accepted to participate in the evaluation, the low number of participants is undeniably an unavoidable weakness of our methodology. Also, given that it was only possible to interview clients in one community, this potentially limited our understanding of clients' perspectives. In addition, given that convenience sampling was carried out, this likely led to self-selection bias, attracting participants who most likely had a positive perception of the program. Social desirability and recall biases may have also affected the information collected and need to be taken into consideration when interpreting results.

It is therefore very likely that this evaluation was not able to capture all potential perspectives on the program and, as such, the possibility that certain important issues may have been missed cannot be excluded. Yet, triangulation was applied and data saturation was reached within the selected sample; these criteria were in fact used when highlighting the evaluation's main findings in the summary above.

Moreover, the lack of standardized monitoring tools at the regional level resulted in a lack of uniform administrative information and in a limited amount of quantitative information being collected in both communities. It was therefore not possible to provide valid statistics on the profile of the program's clientele. This means that it remains difficult to conclude whether the program is reaching its intended clientele, namely the families who are most in need.

4.3. Recommendations for reinforcement of ilagilluta

Based on our findings, the following are a **list of suggestions** for adjustments of the Iagiilluta program model, which could be helpful prior to regional expansion of services to other communities

4.3.1. Reinforcing cultural safety of services provided:

Cultural miscommunication and value conflicts are quite common in transcultural settings, particularly so in health care milieus where misunderstandings around the perception of time, the notions of family (structure and organization), the educational model, the conception of health, disease and death, etc. can be quite common (Gravel & Battaglini, 2000). In a program such as ILAGIILLUTA, which deals with pregnancy, birth and parenting of young children, the potential for cultural misunderstanding is indeed very high.

In fact, there is an evident gap between the Western conception of parenting practices and that rooted in Indigenous parenting practices, where the extended family, relatives and the whole community play a role in raising children (Best Start, 2011). Moreover, considering the unquestionable role that residential schools played on the breakdown of Indigenous family structures and values, it is not surprising that Indigenous communities distrust institutional services that target parents and children (Health Council of Canada, 2012).

CULTURALLY SAFE STAFF

Based on the evidence available, recommendations for improving cultural safety of the staff include

the following

Cultural safety training to non-Indigenous staff:

Evidence supporting this: Providing culturally safe services also calls for non-Indigenous staff to be culturally safe (Sims, 2011). Agencies need to offer training to all non-Indigenous staff to facilitate reflection on their own cultural lens and its impact on their professional practice, as well as to facilitate development of skills necessary to support children and families whose goals and practices are significantly different from their own (Allan & Smylie, 2015; Baba, 2013).

Support hiring of Inuit workers to provide outreach services

Evidence supporting this: The employment of local community members to deliver services is a key element for the successful implementation of effective parenting support programs intended for Indigenous families (Bowes et al., 2014; Mildon et al., 2012; Sims, 2011). Scientific evidence indeed shows that ensuring that programs are culturally safe, meaningful and accepted by the community contributes to improved outcomes (Kreuter et al., 2003). Yet, programs are only considered culturally safe when the staff members delivering the services are in fact Indigenous themselves (Wade, 1999).

Hiring Inuit workers also entails that workplaces be culturally safe spaces (Sims, 2011). More specifically, this means that work expectations need to be realistic; that work requirements do not put Inuit workers into conflict with their community and that their position as representatives of the community is well respected. Furthermore, besides providing ongoing support for Inuit workers, enforcing clear rules on not tolerating stigmatizing attitudes and behaviours, as well as teaching skills on transcultural conflict resolution and mediation are essential.

Many authors affirm that local paraprofessionals can deliver family support interventions with the same level of quality as nursing staff; yet, to be successful, paraprofessionals need to receive extensive training in all areas of such interventions (Beauregard et al., 2010; Poissant, 2014; Wade et al., 1999).

Appropriate teaching methods based on Indigenous learning styles should be favoured. Indigenous people tend to demonstrate a strong visual-spatial learning style; this means that they learn better by observation and modeling, rather than by being given theoretical instructions (Best start, 2010). Hence, experiential learning teaching methods, such as mentoring and role modeling, along with slowing the pace and simplifying messages, can be more suitable. Consequently, the regional implementation support team needs to provide adapted training and clinical supervision.

In addition, workers in prenatal and early childhood services are at risk of burn out because of the nature of their job (Best Start, 2012). Dealing with clients' difficult situations can be even harder for local workers who may be experiencing the same challenges in their own personal lives. Moreover, working in the same community where one lives and is personally invested makes distinguishing professional life from personal life almost impossible. This in turn can make one more vulnerable to vicarious trauma, especially so in Indigenous settings (Goodleaf & Gabriel, 2009).

4.3.2. Facilitating client enrollment and participation – building relationships of **trust**

Improving access means we begin by

- Providing community-based facilities and transportation available to reach "hard to reach" families: Indeed, amilies with complex needs are often characterized as "hard to reach" given that they tend not to engage in regular clinical services. However, it is often the services themselves that are 'hard to reach'; parenting programs thus need be more successful in reaching out to families.

- Addressing food insecurity: Ensuring sufficient funding for coupons, clarification that criteria for access is not ethnically-based, development of food banks.
- Addressing the need for baby items, including clothing and cribs (which is also important to prevent SIDS):
    - Evidence supporting this: The propensity of targeted populations to participate in social support programs is low when their basic needs are not met (Poissant, 2014). Consequently, supporting clients in meeting their basic needs or in solving on-going crises, all while respecting their autonomy and preferences, have been identified as facilitating family engagement in many contexts (Gendron et al., 2013).

- Importance of community-based, traditional or on the land activities to attract pregnant women at a time when building relationships of trust is important:
    - Evidence supporting this: Developing connections in the prenatal phase is known to bolster continuity of care in the postnatal phase, when most needs for intensive follow-up are more likely to occur (Boyer et Laverdure, 2000). In fact, staff involved in parenting programs must remember that it may take time for clients to trust them (Best start, 2011). Taking the time to get to know families through regular non-threatening activities is thus key in building trust (Beauregard et al., 2010; Poissant, 2014).

4.3.3. Reinforcing continuity of services

It is important that the preventive focus of ILAGIILLUTA be complemented by access to the continuum of perinatal and early childhood services based on a common vision of the needs of children and their families. In Nunavik, ILAGIILLUTA is offered to all families. Yet, the nature of the support provided and the intensity of services should be adapted to each community's needs: This adaptation was made not only to take into account the fact that the vast majority of families would actually fit the selection criteria, but also to avoid stigmatization of the most vulnerable. Yet, these preventive services need to be anchored in a strong primary care system, ensuring access to medical and psychosocial services at all times within the community, as well as to well-organized basic prenatal and postnatal care.

A network of community services that deal with matters such as family violence, parental mental health and addiction, family respite services and housing provide a safety net to vulnerable families: besides staff competency, the literature reports that, for family support programs to work, the staff should also be able to refer clients to relevant services when necessary (Beauregard et al., 2010; Poissant, 2014; Peacock et al., 2013). The availability and accessibility of such services within the community should contribute to taking some of the pressure off the program's staff, simply by allowing the staff to share some of their workload with other helpers/services (Sims, 2011).

5. Conclusion

Setting up pilot experiences is extremely beneficial when it comes to implementing Quebec programs and services in Nunavik, to ensure that these adequately meet the needs of the Inuit population. Rigorous evaluations of these pilot projects improve our understanding of what worked well in the field, as well as the reasons for this success. This information can then be used to adjust the program prior to its regional expansion.

This evaluation of the ILAGIILLUTA pilot projects was therefore vital to ensure adequacy of their regional expansion. Despite the relative simplicity of our methodology, this evaluation has however provided a valuable portrait of the services deployed in the two pilot communities, as well as identified some of the elements which seemed to best meet the needs of clientele.

A significant finding of our evaluation consisted in the essential role of Inuit personnel in ensuring service access, continuity, and cultural safety. Hiring more Inuit local workers may however call for greater flexibility in some of the provincially defined qualification criteria and improvement of working conditions, as well as the establishment of adequate accompaniment and support at the regional level. Although we realise the sensitive and complex nature of this aspect of the program, we should not loose track of the fact that local Inuit workers are unquestionably the best placed to provide the staff stability, as well as service continuity and cultural safety that families need.

Another observation we made were the variations in the service models used in each of the two pilot communities, reflecting important differences in the vision and mandate of the ILAGIILLUTA program between the two. This led to some confusion regarding the exact mandate of the ILAGIILLUTA within the continuum of care for pregnant women and young children, both in staff and clientele. Although adaptations to local specificities is always desirable, coming to a consensus on the place of the program in the continuum of perinatal and early childhood services would be a necessary condition to its expansion at the regional level. A commonly shared vision and objectives for program would allow for more equitable access to services and support to the program throughout the region.

In closing, we would like to convey our sincere gratefulness to everyone who participate in this evaluation. We sincerely hope that it supports the continuation of the exemplary work of the many people we met, all of whom in their own way contribute to the well-being of families in Nunavik. because the health of Nunavik's children today will guarantee the health of the next generation of Nunavimmiut. And the future of Nunavik deserves no less.

Bibliography

Beauregard, D., Comeau, L. and Poissant, J. (2010). Avis scientifique sur l'efficacité des interventions de type Services intégrés en périnatalité et pour la petite enfance en fonction de différentes clientèles. INSPQ. Retrieved from : https://www.inspq.qc.ca/pdf/publications/1141_EfficaciteInterventionsSIPPE.pdf

Best Start Resource Centre. (2010). Founded in Culture: Strategies to Promote Early Learning in First Nations Children in Ontario. Toronto, Ontario, Canada. Retrieved from: https://resources.beststart.org/wp-content/uploads/2011/01/K13-A.pdf

Best Start Resource Centre. (2011). A Sense of Belonging: Supporting Healthy Child Development in Aboriginal Families. Toronto, Ontario, Canada. Retrieved from: https://resources.beststart.org/wp-content/uploads/2019/01/K04-A.pdf

Best Start Resource Centre. (2012). When Compassion Hurts: Burnout, Vicarious Trauma and Secondary Trauma in Prenatal and Early Childhood Service Providers. Toronto, Ontario, Canada. Retrieved from: https://resources.beststart.org/wp-content/uploads/2019/01/J13-E.pdf

Boyer, G. & Laverdure, J. (2000). Le déploiement des programmes de type Naître égaux -

Grandir en santé au Québec. Québec : Institut national de santé publique du Québec. Retrieved from: https://www.inspq.qc.ca/sites/default/files/publications/002_negs.pdf

Gendron, S., Dupuis, G., Moreau, J., Lachance-Fiola, J., & Dupuis, F. (2013). Évaluation du programme de soutien aux jeunes parents (PSJP) des Services intégrés en périnatalité et pour la petite enfance à l'intention des familles vivant en contexte de vulnérabilité. Partie 1. Évaluation de l'actualisation du PSJP: Axe Accompagnement des familles. Rapport de recherche adressé au MSSS, Faculté des sciences infirmières, Université de Montréal. Retrieved from: http://numerique.banq.qc.ca/patrimoine/details/52327/2405203

Goodleaf, S., & Gabriel, W. (2009). The Frontline of Revitationalization: Influences Impacting Aboriginal Helpers. First Peoples Child & Family Review, 4(2), 18-29. Retrieved from: http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/135

Gravel, S. & Battaglini, A. (2000). Culture, santé et ethnicité : vers une santé publique pluraliste. Régie régionale de la santé et des services sociaux de Montréal-Centre, Direction de la santé publique de Montréal-Centre. Retrieved from: https://santemontreal.qc.ca/professionnels/drsp/publications/publication-description/publication/culture-sante-et-ethnicite-vers-une-sante-publique-pluraliste-rapport-detaillee/

Health Council of Canada. (2012). Empathy, dignity, and respect. Creating cultural safety for Aboriginal people in urban health care. Retrieved from: https://healthcouncilcanada.ca/files/Aboriginal_Report_EN_web_final.pdf

Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving Cultural Appropriateness in Health Promotion Programs: Targeted and Tailored Approaches. Health Education & Behavior, 30(2), 133–146. https://doi.org/10.1177/1090198102251021

Mildon, R. & Polimeni, M. (2012). Parenting in the early years: effectiveness of parenting education and home visiting programs for Indigenous families. Resource sheet no. 16. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Retrieved from: https://www.aihw.gov.au/reports/indigenous-australians/parenting-in-the-early-years-effectiveness-of-par/contents/table-of-contents

Peacock, S., Konrad, S., Watson, E. et al. (2013). Effectiveness of home visiting programs on child outcomes: a systematic review. BMC Public Health 13, 17. doi:10.1186/1471-2458-13-17

Poissant, J. (2014). Les conditions de succès des actions favorisant le développement global des enfants : état des connaissances. INSPQ. Retrieved from: https://www.inspq.qc.ca/publications/1771

Wade, K. (1999). A Systematic Review of the Effectiveness of Peer/paraprofessional 1:1 Interventions Targeted Towards Mothers (parents) of 0-6 Year Old Children in Promoting Positive Maternal (parental) And/or Child Health/developmental Outcomes. Region of Hamilton-Wentworth, Social and Public Health Services Division, Community Support and Research Branch, PHRED Program.

References

Allan, B., & Smylie, J. (2015). *First Peoples, Second Class Treatment. The role of racism in the health and wellbeing of Indigenous peoples in Canada*. Toronto: The Wellesley Institute. Retrieved from: http://www.wellesleyinstitute.com/wpcontent/uploads/2015/02/Full-Report-FPSCTUpdated.pdf

Baba, L. (2013). *Cultural safety in First Nations, Inuit and Métis public health: Environmental scan of cultural competency and safety in education, training and health services*. Prince George, BC: National Collaborating Centre for Aboriginal Health. Retrieved from: https://www.ccnsa-nccah.ca/docs/emerging/RPT-CulturalSafetyPublicHealth-Baba-EN.pdf

Blackstock, C. (2011). Why if Canada wins, Canadians lose: The Canadian Human Rights Tribunal on First Nations Child Welfare. *Children and Youth Services Review , 33*, pp. 187-194.

Blackstock, C., Cross, T., George, J., Brown, I., & Formsma, J. (2006). *Reconciliation in child welfare : touchstones of hope for Indigenous children, youth, and families.* National Indian Child Welfare Association.

Blackstock, C., Trocme, N., & Bennett, M. (2004). Child Maltreatment Investigations among Aboriginal and Non-Aboriginal Families in Canada. *Violence against Women*, *10* (8), pp. 901–16.

Bowes, J., & Grace, R. (2014). *Review of early childhood parenting, education and health intervention programs for Indigenous children and families in Australia.* Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies: Issues paper no. 8. Produced for the Closing the Gap Clearinghouse.

Brittain, M., & Blackstock, C. (2015). *First nations children poverty; a literature review and analysis.* First Nation Action Research and Education Service.

Cargo, M., & Mercer, S. (2008). The Value and Challenges of Participatory Research. *Annu. Rev. Public Health . , 29*, pp. 325–50.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology, 13*, 117. doi:10.1186/1471-2288-13-117

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly, 82* (4), pp. 581-629.

Health council of canada. (2011). *Understanding and Improving Aboriginal Maternal and Child Health in Canada: Conversations about Promising Practices across Canada.* Health council of canada.

Inuit Tapiriit Kanatami. (2014). *SOCIAL DETERMINANTS OF INUIT HEALTH IN CANADA.* Inuit Tapiriit Kanatami.

Irvine, J., Kitty, D., & Pekeleys, G. (2012). Healing winds: Aboriginal child and youth health in Canada. *Paediatr Child Health , 17* (7), pp. 363-4.

IRVINE, K. (2009). *Supporting Aboriginal Parents: Teachings for the Future.* National Collaborating Centre for Aboriginal Health.

Irwin, L. G., Siddiqi, A., & Hertzman. (2007). *Early Child Development : A Powerful Equalizer - Final Report for the World Health Organizations' Commission on the Social Determinants of Health.* Vancouver: Human Early Learning Partnership.

MacLaurin, B., Trocmé, N., Fallon, B., Blackstock, C., & Pitman, L. (2008). *Comparaison entre les cas d'enfants autochtones et non autochtones ayant fait l'objet d'enquête sur la maltraitance au Canada en 2003.* Le Centre d'excellence pour la protection et le bien-être des enfants.

Mikton, C. (2015). Adapting and retesting evidence-based child maltreatment prevention programs: a case study in Canada. *Health Promotion and Chronic Disease Prevention in Canada , 35* (8/9).

Potter, D., Nasserie, T., & Tonmyr, L. (2015). A review of recent analyses of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS). *Health Promotion and Chronic Disease Prevention in Canada , 35* (8/9).

Richer, F., & Robert, É. (2016). *Â Mashkûpimâtsît Awash Process Evaluation - Final Report .* Cree Board of Health and Social Services of James Bay.

Robert, E., & Ridde, V. (2013). L'approche réaliste pour l'évaluation de programmes et la revue systématique De la théorie à la pratique. *Mesure et évaluation en éducation , 36* (3), pp. 79-108.

Saini, M. (2017). Participatory methods for Inuit public health promotion and programme. *INTERNATIONAL JOURNAL OF CIRCUMPOLAR HEALTH , 76*.

Sims, M. (2011). *Early childhood and education services for Indigenous children prior to starting school.* Resource sheet no. 7 for the Closing the Gap Clearinghouse.

Tonmyr, L. (2015). The Nurse–Family Partnership: evidence-based public health in response to child maltreatment. *Health Promotion and Chronic Disease Prevention in Canada , 35* (8/9).

Vareilles, G., Pommier, J., Kane, S., Pictet, G., & Marchal, B. (2015). Understanding the motivation and performance of community health volunteers involved in the delivery of health programmes in Kampala, Uganda: a realist evaluation protocol. *BMJ Open , 5*, p. e006752.

Wade, K., Cava, M., Douglas, C., Feldman, L., Irving, H., & al. (1999). *A Systematic Review of the Effectiveness of Peer/Paraprofessional 1:1 Interventions Targetted towards Mothers (Parents) of 0-6 Year Old Children in Promoting Positive Maternal (Parental) and/or Child Health/Developmental Outcomes.* Effective Public Health Practice Project.

Appendices

Individual interviews with program staff

Introduction:

1. Role as part of the program,
2. Since when
3. How do you like it? What are the advantages / disadvantages of working here?

About your job:

1. What motivates you?
2. What do you like / don't like? Comment trouver l'énergie pour s'en sortir ? comment cela s'est finalement réglé ?
3. What would help you? If you could ask for anything what would it be?

Final question:

1. What else do you think we need to know, to really understand how this programme has worked here?

INFORMATION FOR INTERVIEW WITH CLIENTS

WHAT IS ILLAGILLUTA PROGRAM?

Illagilluta is a program that was created to support families in Nunavik in ensuring the best development and health of their children. The program includes many activities for pregnant women, for children aged 5 years and under and their families.

WHY MONITOR ILLAGILLUTA PROGRAM?

The initial program was adapted to Nunavik realities from programs aimed at supporting Indigenous and non-Indigenous families developed elsewhere in Canada, Québec and around the world. This new program has been piloted in 2 communities, in Inukjuak and Kuujjuaq.

It is time to look back and assess what has been done in the 2 communities so far, and whether the activities are well adjusted to fit Nunavik families' needs and realities; this will help draw the lessons learned from the way Illagilluta has been implemented in the 2 pilot communities so that we can adjust the program as needed before its expansion to other communities of the region.

WHO LEADS THIS MONITORING PROCESS?

The Public Health Department of the Nunavik Regional Board of Health and Social Services has asked the collaboration of the Indigenous health team of the Institut national de santé publique du Québec (INSPQ) to conduct this monitoring. The person responsible of this process is Dr **Faisca Richer** from the INSPQ.

AS A PARTICIPANT, WHAT WILL I HAVE TO DO?

If you accept to participate, you will be invited to take part in **one individual or group interview**, depending on your preference. You will have the choice to do your interview in **English, Inuktitut or in French.** If you agree, the interviewer will take notes during your interview. To thank you for your time, we will give you a small compensation.

WILL MY ANSWERS CONFIDENTIAL?

YES, all your answers will be kept confidential. This is how:

- Your name will not be written on the interview notes;
- The list of participants, as well as this consent form will be kept under key and separate from your interview notes and will be seen by the interviewers only;
- Once all interviews are completed, your answers will be pooled with those of all other participants; the results of this evaluation will hence be a collection of the answers of all participants, and it will not be possible to identify your specific answers.
- If you agree to take part in a group interview, all people who take part in the discussion will be told that they cannot share the names nor the responses of the other participants;
- Each member of the team havs to strictly respect confidentiality.

ARE THERE OTHER RISKS IN PARTICIPATING IN THIS INTERVIEW?

To the best of our knowledge, this interview should not involve any risk to you or your family. However, if some of the questions make you feel uncomfortable, **you can decide not to answer**. You can also decide to withdraw from the interview or group discussion at anytime. That is totally fine. If you or any of the participants need assistance, we will provide the necessary resources to support you.

Your participation in this interview is appreciated, as it is essential to help us make informed decisions about the future direction of the Illagilluta program. Yet, **your participation is entirely voluntary**, and neither refusing nor withdrawing from participation will have any impact on your relationship with the program staff.

WHO CAN I TALK TO IF I HAVE QUESTIONS / COMMENTS REGARDING THIS PROCESS?

Faisca Richer Medical Doctor in public health, INSPQ	514-864-1600, ext:3712 faisca.richer@inspq.qc.ca
Véronique Dion-Roy Coordinator of prevention and health promotion division, Public Health Department, NRBHSS	819 964 2222, ext: 284 veronique.dion-roy@ssss.gouv.qc.ca

If you agree to participate in this evaluation, we would like to ask you to sign the following consent form. A copy will be kept by the evaluation team and another copy will be given to you, so that you can refer back to it anytime you need.

Please check (√ or x) the appropriate box and sign below.

	YES	NO	NA
• **I have carefully read (or have been explained in detail) the information section above**			
• **I understand the information described above**			
• **I have obtained answers to my questions to my satisfaction**			
• **I freely consent to take part in this evaluation by participating in an interview**			
• **If this is a group interview, I understand that I cannot share the name nor the information given by any of the other participants**			
• **I agree that the interviewer takes notes during the interview**			
• **I have been given a copy of this form**			

____

My name

______________________________ ______________________________

My signature Date

As the interviewer, I have explained this evaluation and am always available to answer your questions.

______________________________ ______________________________

Intervener signature Date