



## COMMUNITY-BASED REPORTING TEMPLATE

### Privacy statement

This statement explains the purposes for the collection and use of personal information. Only information needed to respond to program requirements will be requested. Collection and use of personal information are in accordance with the [Privacy Act](https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html) (https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html). In some cases, information may be disclosed without your consent pursuant to subsection 8(2) of the *Privacy Act*. We will use your personal information in order to respond to your requests and/or program requirements. The collection and use of your personal information provided to Indigenous Services Canada for selected program/funding reporting and administration purposes are authorized by program specific legislation and required for your participation. The information collected is described by program specific Personal Information Banks (PIB) detailed at [Info Source](https://www.sac-isc.gc.ca/eng/1353081939455) (https://www.sac-isc.gc.ca/eng/1353081939455). For further details about applicable legislative authority, PIB description and/or to notify us about incorrect information or to withdraw participation after submitting your information, contact the departmental Public Enquiries Contact Centre at 1-800-567-9604. If you require clarification about this statement, contact our Privacy Coordinator at 819-997-8277. For more information on privacy issues and the *Privacy Act* in general, you may consult the Privacy Commissioner at 1-800-282-1376.

### Section 1: Identification information

#### Identification

Recipient Name	Recipient Number
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#### Contribution Agreement

Contribution Agreement Number	Highest type of funding model in the Contribution Agreement
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#### Contact (person who can be contacted for further information about the report)

Given Name	Family Name	Title/Position
Telephone Number	Extension	Email Address

#### Reporting Period

From (YYYYMMDD): \_\_\_\_\_ To (YYYYMMDD): \_\_\_\_\_

Are the services delivered in the Contribution Agreement for multiple communities?  Yes  No

**Note:** A separate Community based Reporting Template should be completed and submitted for each community.

1.	Community Name	Health Facility Name
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### Section 2: Program Component Reporting

Complete the information for the program components that apply to the programs and services managed in your community **under your Contribution Agreement** with Indigenous Services Canada.

#### HEALTHY CHILD DEVELOPMENT

##### 1. Pre and Postnatal Nutrition Activities

Indicate the pre and postnatal nutrition activities and services that were delivered in your community by choosing Yes or No in the drop-down list. If an activity you provide could fit under more than one category provided below, choose its 'best fit', and account for it only once.

##### Nutrition Screening, Education and Counselling

Nutrition or dietary screening

One-on-one nutrition counselling/education

Group nutrition counselling/education

Baby food making workshops/classes



Grocery store tours

**Maternal Nourishment**

Food vouchers distributed

Community kitchens/community cooking classes

Food boxes or groceries distributed

Community gardens

Traditional food gathering/distribution/preparation

**Breastfeeding Promotion, Education, and Support**

Education workshops

One-on-one breastfeeding support

Group breastfeeding support

Peer support program

**Supportive Elements that address specific needs of at-risk clients**

Activities that help women access nutrition programming (i.e., transportation, childcare, etc.)

Activities that help improve the health of mothers and infants (i.e. exercise programs for women of childbearing age, smoking cessation programs, etc.)

**2. Breastfeeding: For Participants With Infants Six months or Older**

Indicate the number of participating mothers for each of the breastfeeding duration periods below. When the answer is none, please enter "0".

Participating Mothers	Total
Number of participating mothers with babies who turned 6 months (born between October 1, 2021 and September 30, 2022) during the reporting year.	
Breastfeeding Duration	Number
Mothers who initiated breastfeeding	
Mothers who breastfed for less than 1 month	
Mothers who breastfed for 1 month to less than 2 months	
Mothers who breastfed for 2 months to less than 3 months	
Mothers who breastfed for 3 months to less than 4 months	
Mothers who breastfed for 4 months to less than 5 months	
Mothers who breastfed for 5 months to less than 6 months	
Mothers who breastfed for 6 months or more	
Mothers who did not initiate breastfeeding	
Unknown whether breastfeeding was initiated	

**3. Maternal and Child Health Screening and Assessment**

Indicate which types of screening and assessment services were delivered in the reporting year by choosing Yes or No in the drop-down list. If an activity you provide could fit under more than one category provided below, choose its 'best fit', and account for it only once.

**Screening and Assessment for:**

Risk factors for pregnant women and new mothers such as postpartum depression, chronic conditions such as Type 2 diabetes, gestational diabetes, and tobacco/alcohol/drug/solvent use

Risk factors for developmental milestones for infants and children

Vision/hearing/dental screenings or assessments for referral



**4. Maternal and Child Health Home Visiting and Case Management Programming Reach**

Indicate, in the fields provided, the number of participants who received home visits and/or case management services ('participant' is defined as the primary contact for services, including their family and dependants). When the answer is none, please enter "0".

Home Visits and Case Management	Number
Total number of participants who received home visits	
Total number of participants who received case management	

**5. First Home Visit**

Of all the pregnant women and new mothers receiving home visits through maternal and child health programming during the reporting year, indicate the number who received their FIRST home visit in their 1<sup>st</sup> trimester, 2<sup>nd</sup> trimester, or 3<sup>rd</sup> trimester, and the number of participants who first received services after giving birth (postnatal). When the answer is none, please enter "0".

First Home Visits	Number
Pregnant women who received their <b>first</b> Maternal and Child Health home visit in their 1 <sup>st</sup> trimester	
Pregnant women who received their <b>first</b> Maternal and Child Health home visit in their 2 <sup>nd</sup> trimester	
Pregnant women who received their <b>first</b> Maternal and Child Health home visit in their 3 <sup>rd</sup> trimester	
Women who received their <b>first</b> Maternal and Child Health home visit within 6 months of giving birth (postnatal)	

**6. Fetal Alcohol Spectrum Disorder (FASD)**

Indicate which types of FASD activities were delivered in the reporting year by choosing Yes or No in the drop-down list.

**FASD Activities**

FASD community capacity building activities (i.e., awareness and prevention activities, and development of action plans)
FASD community coordination/FASD case management
FASD mentoring

**7. Aboriginal Head Start On Reserve (AHSOR) Activities**

Indicate which activities were provided by choosing Yes or No in the drop-down list.

**Activity Type**

Teaching children their First Nation language(s) (e.g., reading a story, teaching letters or numbers, etc.)
Traditional ceremonies and activities (e.g., smudging, gathering traditional foods, visits from Elders, etc.)
Early literacy skills (e.g., reading to children, singing songs, etc.)
Fine and gross motor development activities (e.g., catching a ball, holding a pencil, etc.)
Providing healthy foods (i.e., snacks and/or lunches)
Healthy personal hygiene and dental habits (e.g., teeth brushing, hand washing, etc.)
Physical activity (e.g., outdoor play, games, dance, etc.)
Linkages (including referrals and collaborations) to professionals and community supports and providers (e.g., housing, education, specialists, etc.)
Parent and family support activities (e.g., workshops for new mothers and young parents, support groups, etc.)
Visits from health professionals (e.g., nurses, dental hygienists, etc.)
Safety education and awareness activities, (e.g., playground safety, car seat technician training, car seat use, seat belt use, bike safety, etc.)



### 8. Number of Children in AHSOR Programming

Indicate total participation in AHSOR programming by age and program delivery type (centre-based and/or outreach/home visiting) and the number of children on a waiting list, if applicable. When the answer is none for the number of participants, please enter "0". If you keep a waiting list, but there are no children on the waiting list at the end of the reporting period, please enter "0".

Age	Number of Participants by Program Delivery Type		Does the program keep a waiting list? (Yes or No)	If Yes, how many children are on the waiting list?
	Centre-Based	Outreach/Home Visiting		
Number of children younger than 3 years old				
Number of children 3 to 6 years old				
<b>Total</b>				

### 9. AHSOR Children and Special Needs

For each program type, indicate the number of children in the AHSOR program who have been diagnosed, screened/assessed, or referred for special needs during the reporting year, as well as the number of children on a waiting list at the end of the reporting year. A single child may be counted in more than one category if it applies. When the answer is none, please enter "0".

Special Needs Diagnosis, Screening/Assessment, Referrals, Waiting List	Number of Children by Program Type	
	Centre-Based	Outreach/Home Visiting
Number of AHSOR children who have been diagnosed with special needs		
Number of AHSOR children screened/assessed for special needs		
Number of AHSOR children referred to other community resources (e.g., nurses, doctors, specialists, etc.) for special needs support or diagnosis		
Number of AHSOR children on a waiting list for special needs diagnostic assessment		

## HEALTHY LIVING

### 10. Chronic Disease and Injury Prevention Activities

Indicate which activities and services were provided by choosing Yes or No in the drop-down list. If an activity you provide could fit under more than one category provided below, choose whichever one is the 'best fit', and identify only once.

#### Physical Activity

Awareness activities related to physical activity (e.g., Diabetes Walks, Healthy Living Awareness Days, physical activity presentations)

Walking clubs, running clubs

Sport/recreation activities (e.g., soccer, basketball, etc.), open gym nights at school, opened/ran a community gym (weights, fitness classes, personal training, etc.)

Traditional physical activities (e.g. jigging, dancing, games, snowshoeing, canoeing)

#### Nutrition

Cooking sessions or classes (including community kitchens)

Traditional harvesting, food preparation, food preservation (e.g., berry picking, cleaning fish, canning, etc.)



Healthy eating awareness and education (e.g., health fairs, radio shows, social media nutrition posts); displaying nutrition information (e.g., posters, nutrition displays, etc.); taste tests; cooking demos; nutrition presentations; games/challenges; community feasts; nutrition education in schools, preschools or daycares; etc.

Grocery tours

Community gardens

Good Food Boxes

Food Vouchers

School-based feeding programs (includes land-based activities)

**Additional**

Diabetes information sessions or workshops

Information sessions or workshops on other chronic diseases (e.g., cancer, heart disease, etc.)

Development of resource materials (e.g., posters, cookbooks, displays, guides, etc.)

Injury prevention training and awareness raising (e.g., safety committees (water safety, properly using helmets), tool kits, "A Journey to the Teachings" training, community data collection etc.)

**11. Diabetes Screening**

Indicate which activities and services were provided during the reporting year by choosing Yes or No in the drop-down list. If an activity could fit under more than one category provided below, choose whichever one is the 'best fit' and identify it only once. When the answer is No, please enter "0".

Do you conduct diabetes diagnostic screening in your community (e.g., fasting glucose, Oral Glucose Tolerance Test (OGTT))? (See Instruction for definitions.)

If **Yes**, how many individuals were screened in the reporting year?

Do you conduct non-diagnostic diabetes awareness/prevention screening in your community? (i.e., non-diagnostic screenings at schools, workplaces, sporting events, health fairs, etc.)

If **Yes**, provide an estimate of how many non-diagnostic screenings were conducted during the reporting year.

**12. Diabetes Management**

Indicate which activities and services were provided by choosing Yes or No in the drop-down list. If an activity could fit under more than one category provided below, choose whichever one is the 'best fit' and identify it only once.

**Diabetes Management Activities**

Diabetes support or healthy living groups

Screening for complications, i.e., eye (retinal) screening

Screening for complications, i.e., kidney (renal) screening

Screening for complications, i.e., cardiovascular disease screening

Referrals to health professionals or services

Diabetes self-management sessions

**13. Diabetes Clinics and Training**

Indicate which activities and services were provided by choosing Yes or No in the drop-down list. When the answer is No, please enter "0".

Do you provide or support diabetes education clinics and training for clients to support their self-management (e.g., blood sugar testing, foot care, diet and exercise advice, traditional activities, etc.)?

If **Yes**, how many individuals were served in the reporting year?

Do you provide foot care clinics?

If **Yes**, how many individuals were served in the reporting year?



**COMMUNICABLE DISEASE CONTROL AND MANAGEMENT (CDCM)**

The reporting period for CDCM is April 1, 2022 to March 31, 2023 unless otherwise indicated for a specific question.

Programs/initiatives included under CDCM are:

- Vaccine Preventable Diseases and Immunization;
- Sexually Transmitted and Blood Borne Infections
- Communicable Disease Emergencies; and
- Respiratory Infections (Tuberculosis)

**14. Awareness and Education Activities**

For each of the program areas listed, indicate the number of related awareness and education activities conducted in your community or organization. When the answer is none, please enter "0".

Program and Initiative Areas	Number of Activities		
	For Healthcare Providers (optional)	For Community Members (optional)	Total Activities
Sexually Transmitted and Blood Borne Infections			
Tuberculosis			
Vaccine Preventable Diseases and Immunization			
Community Based Infection Prevention and Control			

**15. All Hazards Emergency Plans**

Does your community have an all hazards emergency plan with a health component?  
(If **No**, go to **16. Access to Services for HIV Testing and Treatment**)

When was your community all hazards emergency plan last updated (YYYYMMDD)?

When was your community plan last tested (YYYYMMDD)?

Is your community served by an emergency management/health coordinator?

- Yes, at the community level
- Yes, at the tribal council level
- No

**16. Access to Services for HIV Testing and Treatment**

Indicate your responses by choosing Yes or No in the drop-down list.

Is HIV **testing** accessible on the reserve?

Is HIV **treatment** accessible on the reserve?

If not on-reserve:  
For a definition of "near", see the Instruction.

Is HIV **testing** accessible near the reserve?

Is HIV **treatment** accessible near the reserve?

**17. Access to Services for other Sexually Transmitted and Blood Borne Infection (STBBI) Testing and Treatment**

Indicate your response by choosing Yes or No in the drop-down list.

Is **testing** for other STBBIs (e.g. beyond HIV) accessible on the reserve?

Is **treatment** for other STBBIs (e.g. beyond HIV) accessible on the reserve?

If not on-reserve:

Is **testing** for other STBBIs (e.g. beyond HIV) accessible near the reserve?

Is **treatment** for other STBBIs (e.g. beyond HIV) accessible near the reserve?



**18. Access to Sexually Transmitted and Blood-Borne Infection Testing Technologies**

Indicate your response by choosing Yes or No in the drop-down list.

Are new sexually transmitted and blood-borne infection testing technologies (e.g. self-test kits, dried blood spot testing) accessible on the reserve?

**19. Access to Services for Tuberculosis (TB) Testing and Treatment**

Indicate your responses with by choosing Yes, No or N/A in the drop-down list. N/A should only be selected if tuberculosis is not a concern in your community.

Is TB **testing** accessible on the reserve?

Is **rapid point-of-care testing** available on the reserve (Gene Xpert)?

Is TB **treatment** accessible on the reserve?

If not on-reserve:

Is TB **testing** accessible near the reserve?

Is **rapid point-of-care testing** available near the reserve (Gene Xpert)?

Is TB **treatment** accessible near the reserve?

**Supporting Documents** (if applicable)

This table allows you to identify the supporting documents being submitted and the method of submission.

Title	Submission Method

**Declaration**

The information provided is accurate to the best of my knowledge.

Given Name	Family Name
Title	Date (YYYYMMDD)